"I had to Grow up Pretty Quickly": Social, Cultural, and Gender Contexts of Aboriginal Girls' Smoking

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Abstract

The goals of this community-based study were to investigate Aboriginal girls' interpretations of the impact of social context, gender, and cultural background on their smoking patterns, and contribute to research capacity in Aboriginal communities. A partnership with six Aboriginal communities in British Columbia involved community consultations; memoranda of understanding; team research training; and collaborative development, conduct, and evaluation of the research process. Focus groups and interviews were held with 63 Aboriginal girls (ages 13–19) of varying smoking statuses, and analyzed using qualitative techniques. Girls who identified as smokers or former smokers described four main contexts in which their smoking began and continued: experimentation and boredom; relational and peer pressures; drinking and partying; and stress relief. Among the stressors girls identified were gender inequities that placed more expectations for care-giving and domestic work on them compared to boys. While girls reported a mix of cultural influences and varying strengths of identification with their diverse Aboriginal backgrounds, girls who smoked generally expressed less knowledge about their Aboriginal backgrounds and local community cultural context. The complex interrelated influences of social context, gender, and cultural background indicate that smoking prevention programs for Aboriginal girls need to be tailored to community needs and address girls' calls for girl- and culture-centred supports.

Keywords: gender, culture, tobacco use, Aboriginal, adolescent, community-based research

Introduction

> I had to grow up pretty quickly, I guess that's why I started drinking and smoking. So if there was someone there I guess I wouldn't have started, just someone to talk to me about it. (Study participant)

Despite their overrepresentation among teen smokers, there is a lack of health programming seeking to understand and prevent or reduce smoking among Aboriginal girls. Critical to understanding Aboriginal girls' smoking is its relationship to social context as well as its gender and cultural dimensions. However, few studies have explored these dimensions of tobacco use or smoking among Aboriginal girls, particularly from a girl-centred perspective, and in partnership with Aboriginal communities. Of interest are the intersecting factors that shape Aboriginal girls' tobacco use, specifically in small towns or rural or remote communities. In this article we examine key findings from a community-based qualitative study on smoking and Aboriginal

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adolescent girls (ages 13–19) in six communities in British Columbia, Canada. Drawn from focus group and individual interviews with girls and community collaborators, the study findings shed light on how age, gender, culture, and context interact to shape Aboriginal girls' experiences of smoking, and the supports and interventions that girls have identified as important in the context of their communities.

The study was conducted as a partnership among six Aboriginal community partners in British Columbia and Aboriginal and non-Aboriginal researchers affiliated with the British Columbia Centre of Excellence for Women's Health.[1] The following six Aboriginal partners played a central role in developing, conducting, and evaluating the study: Laichwiltach Family Life Society; Sliammon First Nation; Tla'Amin Community Health Services Society; Kermode Friendship Society Penticton Indian Band; Port Alberni Friendship Centre; and Metakatla Band.

The need for a collaborative study emerged from the experiences of the research team with tobacco prevention and tobacco policy development. Research projects and analyses undertaken in the past have highlighted the need for smoking-related research, policy and practice initiatives better tailored to the realities of Aboriginal girls (Pearce et al., 2008). Thus an important objective of this research was to strengthen community-based knowledge and approaches to smoking interventions, especially with girls. The study was also designed to facilitate mutual research development and knowledge generation among a multidisciplinary team of Aboriginal and non-Aboriginal researchers.

Each of the six Aboriginal partners developed a Memorandum of Understanding (MoU) to clarify appropriate protocols and ethical guidelines for the conduct of research in their community. Aboriginal Community-Based Collaborators (CBCs), who were members of the partner communities involved in the health sector, took a leadership role in conducting the research. To ensure that the study was contextualized and reflected community realities and needs, each partner decided on community specific protocols and processes, and how the study results would be shared, evaluated, and implemented.

Need for the Study

The study used a community-based approach with an explicit focus on the social, gender, and cultural aspects of smoking. This approach emerged from consultations held with Aboriginal women and young women in the course of developing a report on Aboriginal tobacco use in BC (Pearce et al., 2008), an expressed need by the six community partners to explore the contextual factors that affect smoking among girls in their communities, and for smoking-related interventions tailored to these realities.

In Canada, smoking rates among Aboriginal people have been measured in a variety of surveys so reported rates vary. However, smoking rates are higher among First Nations people of all ages, and First Nations teenaged girls report the highest smoking rates across all age categories[2] (Assembly of First Nations RHS National Team, 2007). Smoking rates from the Youth Smoking Survey (YSS) for Aboriginal youth[3] (including those who self-identify as First Nations, Inuit, or Metis) in BC are 47% for boys and 61% for girls aged 15–17(Health Canada, 2010). A secondary analysis of the results from the 08/09 Canadian Youth Smoking Survey (grades 9–12) found that Aboriginal girls in Canada were more likely to be current smokers (27.1%) than Aboriginal boys (22.9%) and non-Aboriginal girls (8.5%) (Elton-Marshall et al., 2011). Another secondary analysis conducted by Hutchinson and colleagues (2008), examining data from the 2004 British Columbia Youth Survey on Smoking and Health II, found that a greater percentage of Aboriginal girls (41%) smoked compared to Aboriginal boys (29%).[4]

1 The research team included: Lorraine Greaves, Denise Lecoy, Joy Johnson, Nancy Poole, Annette Browne, Natasha Jategaonkar, Karen Devries and Deborah Schwartz. The Project Coordinator was Pauline Janyst and Sandrina de Finney was a Research Associate with the project. Funding for this project was provided by a grant from the Canadian Institutes of Health Research (CIHR).

2 The 2002/03 Regional Health survey sample represents First Nations populations living in First Nations communities in all provinces and territories except Nunavut.

3 Survey sample is drawn from youth attending public and private schools in Canada's 10 provinces. Youth from the Yukon Territory, Nunavut and NW Territories, and youth living on a First Nations reserve are excluded.

4 This survey sampled adolescents in grades 8–12 from regional school districts outside of Vancouver. Aboriginal identity was measured via self-identification as Aboriginal (including First Nations, North American Indian, Métis, Inuit), and participants were asked to indicate if they were a member of a First Nations band (and if so, to list which First Nation).

Smoking often begins early among Aboriginal youth (including First Nations, Inuit, and Metis), with reports of initiation as early as age 7 or 8 (First Nations and Inuit Health Committee and Canadian Paediatric Society [CPS], 2006). This is problematic, given that research findings suggest that those who begin smoking at a young age are less likely to quit than those who start smoking later in life (Muller, 2007). However, one study found that 79% of Aboriginal girls in BC who are current smokers have considered quitting smoking, 65% had attempted to quit within the last year, and 44% reported that they continue smoking because it is difficult to quit (Hutchinson et al., 2008). The large discrepancies in smoking rates among Aboriginal and non-Aboriginal youth, and between boys and girls, coupled with the high interest in quitting reported by some Aboriginal girls suggest that smoking prevention and cessation research as well as the development of tailored interventions are timely and imperative. The necessity of tobacco control work among Aboriginal youth is further underscored by the fact that 46% of the Aboriginal population is under the age of 24 (British Columbia Provincial Health Officer, 2009). Preventing and reducing smoking would significantly reduce the rates of smoking-related deaths and disease among Aboriginal girls and women, including but not limited to cancer, lung, and heart disease. In addition, reducing smoking in Aboriginal communities in BC could have significant positive impacts for the communities in which Aboriginal girls and women live (British Columbia Provincial Health Officer, 2009).

Exploratory work such as this study examining factors associated with tobacco use for Aboriginal girls in British Columbia is important for the integration of community-based knowledge into programming for smoking prevention and cessation. One important gap in current tobacco research is the lack of information about how social, cultural, and community contexts shape Aboriginal girls' gender and cultural identities. A small number of studies have focused on Aboriginal youth in larger provincial and national surveys (Elton-Marshall et al., 2011; Hutchinson et al., 2008). However, little is known about Aboriginal girls' experiences, and even less about Aboriginal girls in smaller and rural communities, an important focus of this study.

The links between gender identity and smoking have been investigated minimally in Aboriginal and non-Aboriginal adult women (Greaves, 1996). Several authors contend that the tobacco industry has linked women's equality with smoking since 1920 and that this link has affected identity among women (Amos and Haglund, 2000; Greaves, 1996). How these issues manifest in girls, specifically Aboriginal girls, is unknown. The intergenerational effects of residential schools, child protection interventions and chronic structural inequity, discrimination, and poverty have clearly affected the gender roles of Aboriginal peoples (Anderson et al., 2001; Fast and Collin-Vézina, 2010) and may contribute to smoking and other substance use (Dion Stout, 2009; Niccols et al., 2009; Wesley-Esquimaux, 2009). Colonial policies targeting Aboriginal women specifically, such as the introduction of Bill C-31, have engendered a process of gendered racialization that has been shown to negatively affect Aboriginal women and girls' wellbeing, their sociocultural and economic inclusion, and their roles in their communities[5] (de Finney and Saraceno, in press; Ruttan et al., 2010). However, the effects of these policies and processes on girls' health outcomes and more specifically their tobacco use is under researched.

Research shows that the formation of ethnic and cultural identity may influence mental health and substance use. Several authors have proposed that enculturation — identification with one's Indigenous cultural background — (Berry, 2003) is protective for American Indian peoples (Whitbeck et al., 2004a; Zimmerman et al., 1996). For example, Whitbeck and colleagues (2004a) recently found evidence that higher enculturation scores are associated with a decreased likelihood of alcohol abuse among American Indian women. Although some studies have investigated the impact of culture and gender on youth's smoking behaviours (Epstein et al., 1998; Rugkåsa et al., 2003), these studies have tended to

5 The *Indian Act* stripped many Aboriginal women of the dignity and power they traditionally held in their communities by restricting who could be considered "Indian" and positioning women in roles of dependency on men (Anderson, 2000). Although Bill C-31 reversed the disenfranchising membership policies of the *Indian Act* to some extent with the 1985 reinstatement of status to women and their children, the policy maintains significant restrictions and negative impacts. For example, many women who were disenfranchised from their communities and the grandchildren of women who had lost their status are still not included (Sayers and MacDonald, 2001).

use quantitative scales with predetermined definitions and measures. For instance, studies investigating the impact of ethnicity on smoking using ethnic identity models (Berry, 2003; Berry, 1997; Zimmerman et al., 1996) typically compartmentalize ethnic identities into overly individualized, mutually exclusive categories that underestimate their contextual and interactive nature. Such models assume that youth identify with only one identity, minimizing the complex experiences of Aboriginal youth with mixed backgrounds and those who may know little or nothing about their Aboriginal background. An exclusive focus on culture and ethnicity may also minimize important differences between urban and rural contexts, as well as the impact of historical colonial policies and complex social processes of gendered racialization on young people.

We take the view that gender and cultural identities and experiences cannot be understood as essential, one-dimensional, and static. Rather, they are always evolving and are affected by an interaction of complex factors including socioeconomic status, age, geographic location, family, and community dynamics, as well as broader historical, sociocultural, economic, and political forces (Benoit and Shumka, 2009). Understanding the mediating effects of these factors on Aboriginal girls' tobacco use requires an exploration of how girls themselves make meaning of labels such as "girl," "Aboriginal," "culture," "stress," "health," and "smoker." Since the voices and health knowledge of girls — and Aboriginal girls in particular — are often ignored and discredited in health research, the goal of this study was to place their and their communities' perspectives and histories at the centre of the research process.

The Partnership Process

The collaborative, exploratory research design drew on multiple qualitative methods, including individual interviews and focus groups with 63 teen girls. The project was descriptive in nature and relied on purposive sampling, so the participants and findings are not representative of each community's population. At the end of data collection, we conducted individual interviews with five of the CBCs who were asked to share their reflections on their work with girls in their communities, and on the process and outcomes of the study itself.[6] The depth of the reflective information provided by the CBCs enriched the study and contributed to contextualizing the analyses. These reflections also informed the evaluation framework on the relevance and impact of the study at the community level.

The study was grounded in a partnership research model entrenched in memoranda of understanding, and solidified by the research coordinator through several community visits and consultations. Paddles were carved and presented to each community partner, symbolizing the mutual journey of the research project and anticipating the rough and smooth waters that would be traversed together. These relationships were strengthened in the course of the collective development, implementation, and evaluation of the study by community partners in each community.

With the assistance of their community partners, the CBCs, all of whom were Aboriginal women involved in the health sector, developed the study at the community level. The CBCs coordinated community outreach, helped to develop and refine pilot research questions, recruited participants, conducted the individual interviews, planned focus groups, participated in analysis, and facilitated community dissemination and evaluation. The CBCs met together with the rest of the research team on three occasions to share information, experiences, and contribute to the data collection and analysis processes. These meetings among community and academic research team members took place at key points during the study. Each aspect of the research design, including the conceptualization of research concepts, data collection and analysis, and dissemination of findings, was conducted in an iterative process that enabled cross-community and cross-disciplinary collaboration. Such collaboration was key to producing balanced and meaningful results that are directly useful to communities and enhance knowledge translation across disciplines. These processes were also key to enhancing mutual learning and cross-training among all team members.

6 To protect confidentiality, the quotes presented in this article are not attributed to specific participants or communities.

The CBCs completed detailed research training in community-based research which included training related to community outreach and recruitment, protocols for respectful research in Aboriginal communities, conducting research with girls, dealing with disclosures, observation, and collaborative data analysis. The training focused on research methods and processes that were carefully tailored to be relevant and meaningful to Aboriginal girls, and that reflected principles of respectful community-based research.

Participants

A total of 63 girls participated in the research project (individual interviews and/or focus groups): 50 girls participated in individual interviews, and 23 girls participated in focus groups. That is, 10 of the 23 girls who participated in the focus group portion of the study also participated in the individual interviews. Prior to recruitment, ethical approval was received by the University of British Columbia Behavioural Research Ethics Board. Girls were selected through purposive sampling; they were recruited by the CBCs and other participants or community members. To understand the contexts that shape girls' smoking patterns, the CBCs asked the study participants to share information about their background; family, home, and community life; peer and social groups; activities and hobbies; and education and employment history. The majority of the girls reported that they were not currently employed, and almost all attended school. Seventy percent were engaged in some form of physical activity, with basketball, soccer, and volleyball listed as the most popular sports in and out of school. "Partying" was mentioned by the majority as their favourite social activity. Other favourite pastimes included hiking, music, art, dance, hanging out with friends, shopping, playing video games, watching movies and television, and volunteering in youth groups and cultural activities. Only one girl stated that she had a child. The girls reported that they lived in diverse family settings, including single and dual parents, blended and extended families, and foster care. Most had multiple siblings.

Overall the girls came from very diverse cultural backgrounds. Some reported they knew they were Aboriginal, First Nations, or Native but did not know much about their background; several identified as belonging to one or more specific First Nations community(ies); none identified as Métis or Inuit; and many had mixed backgrounds (mixed Aboriginal or mixed Aboriginal/non-Aboriginal). The girls lived both on and off reserve, and some girls reported living both on and off reserve at different times in their lives. Some also talked about moving on and off reserve on an ongoing basis, depending on factors such as the availability of employment and housing, or because they lived with different guardians such as foster care providers or relatives.

Methods

During the recruitment phase, the CBCs recruited girls who were identified or who self-identified as "Aboriginal girls." We are aware that both the terms "Aboriginal" and "girl" have diverse and often contested meanings and uses; we used them as broad umbrella terms to communicate the goals of the study and generate discussion. Similarly, the construction of gender is contested and emergent, and issues connected to its measurement and interpretation are myriad, especially in the context of methods in health research (Oliffe and Greaves, 2011). Nonetheless, a strength of the qualitative nature of this study is that it encouraged girls to discuss how being an "Aboriginal girl" affected their health and wellbeing. They were encouraged to define terminology in their own words through questions such as "how would you describe yourself" and "what does this term mean to you?" This allowed the girls to speak about their cultural background by using diverse terms such as "mixed," "Native," "First Nations," "Indian," and even "I don't know," and "I'm not sure." It also allowed the girls to reflect on being "girls" in their own way, sometimes with reference to boys, and sometimes independent of comparison.

The interview and focus group guides included questions on: personal descriptors (how girls describe themselves, including their daily activities and home lives); tobacco use (smoking behaviours, quit attempts, smoking setting and use with alcohol or

other drugs); social norms (family and peer relations and support; peer pressure; opinions on "popularity" and "fitting in," etc.); stress (meanings and experiences of stress, how girls experience stress); how the girls conceive gender in their lives (perceptions of "differences" between boys and girls, the treatment they were accorded as girls, understandings of gender itself, and whether gender and girlhood affect the girls' smoking habits); culture (how girls describe their cultural background(s), involvement with community life, and perceptions of Aboriginal and non-Aboriginal youth in their community); and finally, their reflections on prevention and intervention strategies.

The questions used in the semistructured individual and focus group interviews were developed and revised collaboratively by the research team, and then piloted with girls in each community. The girls' feedback on the questions and research process and the CBCs sharing their own experiences with smoking in their own lives and communities greatly enriched the development of the study and our understanding of girls' smoking in Aboriginal communities from an intergenerational perspective.

The focus groups and interview data were analyzed using a qualitative thematic analysis approach (Braun and Clarke, 2006; M. Byrne, 2001). The collaborative analysis process involved multiple, cumulative readings and coding of all data sources to identify patterns, connections, contradictions, and silences within and across individual and group interviews, leading to the identification of key themes and subthemes. In keeping with the principles of community-based research, emerging findings were reviewed by team members and community partners to ensure congruence, reliability, and the relevance of findings for the community partners.

Findings

Of the 50 girls who participated in individual interviews, 42% had never smoked.[7] Of the 58% who identified as having smoked more than once, 32% stated that they currently smoke. The majority started smoking around 12–13 years of age, and several girls reported trying smoking for the first time before age 6. Almost 7% of current smokers said they were now cutting back.

In the following section, we describe the girls' four most commonly stated reasons for initiating smoking and for continuing to smoke. Although reasons for tobacco initiation and maintenance are frequently discussed separately in the literature, we include them together as they were often discussed by the girls in tandem as interacting processes and hence were difficult to isolate in the girls' responses.

Curiosity, Experimentation, and Boredom

As with many youth, a prevalent factor in the girls' tobacco initiation was experimentation, which some girls described as smoking due to "curiosity," or "just to try it":

> She pulled them out and she said "why don't you just try it" and I tried it. (age 14)

Experimentation can lead to nicotine dependence after which the reasons for maintaining smoking are different than those for initiation. While some girls might begin smoking "just to try it," they described continuing "just because it's there." Thus a factor related to the desire to smoke out of curiosity is the desire to mitigate boredom. Several girls stressed that they smoked because they had "nothing else to do" or "when we're bored" to fill times between breaks at school and when hanging out. Once girls were "hooked," many reported that they continued smoking to alleviate addiction cravings. As one girl stated, "even if nothing is going on, I need a smoke because I'm addicted." They described "cravings" that can "happen at any time," being "hooked," and "having a need" as strong motivators for continued smoking.

Relational and Peer Pressure

Another commonly stated reason for starting and continuing to smoke was relational and peer pressure. Girls reported that they started and continued smoking in part to gain social acceptance and lessen peer and relational pressure. This included a desire to "fit in," "be cool," and "please others." The girls shared many examples of peer pressure, such as the

7 We did not systematically collect information about individual smoking habits during the focus groups.

following example describing smoking initiation on school grounds:

> Everyone was out at the smoke pit, offering everyone cigarettes. And everyone kept on "smoke one, go ahead, you'll like it fine." (age 19)

In addition to the direct influence of peers, relational pressure was also identified by the girls as an important factor in their smoking. By relational pressure, we refer to the influence of people close to the girls (in addition to what is commonly considered a peer group), such as parents, siblings, extended family, and community members. Since many of the girls were from small communities and had large extended families, it was often difficult to differentiate between peers, family, and community members. Such distinctions are not helpful in making visible the overlapping relations that girls negotiate on a day-to-day basis. As one girl put it "my family are my friends." Many girls emphasized that smoking was "all around" them and that they experienced both explicit and implicit support for smoking from family and community members:

> I always wanted to try it, I've always seen my mom smoking, most of my family smoking. Everyone smokes, I just got hooked on it from them. (age 15)

Relational pressure was amplified when smoking became normalized by community members. Several girls reported that some community members smoke with young people, give them cigarettes as gifts, or sell them discounted (often tax-free) cigarettes at locales including homes and bootleg or smoke shops. Some girls observed that there was "always a cloud of smoke" in places that featured prominently in their lives, such as recreational centres and bingo halls:

> In bingo halls, they always smoke. We always have bingo in my life. Every day of the week, even on Sunday there's bingo. (age 16)

Many of the girls commented that it is difficult not to smoke when they face this range of both implicit and explicit social pressures to smoke and fit into family and community life:

> I grew up around it. My mum smokes, my dad smokes, my [two] grandmas smoke, so it was just one of those things I grew up with ... I guess just some people they like just smoke to fit in.... (age 16)

Girls' emphasis that smoking is "something [they] grew up with" that is "always around" them underscores the critical need for multigenerational community initiatives, and family- and community-focused supports to smoking prevention and cessation initiatives.

"Drinking" and "Partying"

A third theme shaping girls' tobacco use was the relationship among smoking, other substance use, and "partying." Just over 60% of the girls, both smokers and nonsmokers, have tried other substances such as alcohol or marijuana.

Also, some girls who do not smoke tobacco reported that they smoke marijuana or consume alcohol. In this particular group of girls, those who smoke cigarettes were not more likely to smoke marijuana and/or to consume alcohol than those who did not smoke cigarettes. The girls who identified as smokers or former smokers did identify a connection between their smoking and drinking.

> When I was drinking that's how I started smoking. (age 16)

> Just everyone around me was smoking or I'd be drinking and smoking at the same time. (age 16)

The majority of girls who smoked and also indicated that they drink alcohol reported smoking more when drinking. For the smokers who drink, the girls' concomitant use of tobacco and alcohol intersects with the prevalence of partying as a common social activity. Several participants shared that they started and continued to smoke when drinking at parties, including house parties and outdoor/beach parties: "A lot of it happens at house, yeah, and backyard parties"; "a lot of times I do drink and smoke, we party at the beach"; "we all party together, it's just normal."

Some also noted that the relational influences of family members affected their introduction to smoking and drinking. Girls said that "my dad only smokes when he's drinking" or "my mom smokes when she's drinking."

Stress Relief

Stress was a common theme related to how and why girls initiated and continued smoking. To ex-

plore more fully how girls understand and experience stress, we asked them about definitions, experiences, causes, and outcomes of stress. Their responses reveal information about their stress in contexts such as school; with peers, families, and other caregivers; as well as in relation to experiences of loss, grief, conflict, disruption, and isolation. When asked about what caused them stress, girls reported that they often deal with a range of stressful situations related to family, caregivers, friends, school, and other everyday life events:

> I had to watch [baby-sit] my brother a lot and probably that. (age 16)
>
> Family problems, school problems. Fighting with friends. (age 16)
>
> Living in a foster home. (age 15)
>
> Losing someone in your family, that's really hard. (age 17)
>
> Mostly just the way my family is now, it's all messed up. (age 13)

Similar to previous studies on the meanings of smoking to girls and women (Greaves, 1996), the girls in this study reported that they use tobacco to self-soothe what they consider to be "stressful emotions" such as anger, sadness, frustration, anxiety, and grief. One girl described smoking when she gets "angry and mad and frustrated" while another talked about "just feeling really sad, a lot of loss in my life." A third stressed that smoking helps her cope with situations when "you're like really pissed off and you just start crying because you're so mad."

A few girls linked their smoking to the sense of isolation or lack of supports they experienced in dealing with stressful or difficult circumstances in their lives. One said that "people go to smoking because they have no one to talk to" while another stressed that

> I had to grow up pretty quickly, I guess that's why I started drinking and smoking. So if there was someone there I guess I wouldn't have started, just someone to talk to me about it.

The girls' emphasis on the need for supports, for "someone to talk to me about it" highlights how stress is intertwined with the other factors they identified that support their smoking — peer and relational pressures, curiosity, experimentation and boredom, and drinking and partying. Based on the girls' responses, it is also difficult to separate factors that generate the initiation of smoking from those that support longer term use and maintenance of smoking, particularly in how they are experienced in different ways by Aboriginal girls, in the context of smaller and rural Aboriginal communities. To put these findings in context, we now expand on how the girls described the role that gender and culture play in shaping their smoking behaviours.

The Impact of Culture and Gender

In both individual interviews and focus groups, we asked girls to reflect on their sense of cultural identity, engagement, and belonging, and on gender relations in their families, peer groups, and communities. These reflections have provided valuable insights into contextual influences on their smoking and the kinds of supports and interventions that might best meet their needs.

Gender

The girls provided rich and varied examples of "being a girl" and how gendered roles and relationships influenced the expectations they face in their families and communities. Almost half of the girls stated that in their communities, boys "have it easier" than girls, and that girls face higher social expectations and more negative gender stereotypes. For instance, one girl pointed out that "guys have more choices in kind of jobs than girls." Another explained that girls are seen as "less than" boys:

> boys are just thought of as being stronger than girls ... some people think guys are smarter than girls.

Some girls underscored that relational and peer pressures experienced by girls are uniquely gendered:

> If you're a girl in my family you might get treated more harder because they don't want you to wreck your future. (age 16)

Gendered expectations affected how girls were treated and the types of stress they experienced, in the sense that girls may face additional pressures to

"have higher standards," "look nice," "be good," or "work harder":

> Because you're expected to be good and if a boy does something bad, then it's bad. And if a girl does something bad then your parents will scream at you. (age 15)

> Girls have more expectations ... because guys can do like whatever, you know, and they don't have to try to look nice ... I think [girls] have higher standards. (age not specified)

The higher expectations placed on girls relating to their appearance, activities, and future prospects, among others, are rooted in part in the fact that girls are expected to be caretakers of their families and communities. Many of the girls talked about having responsibilities such as cooking, cleaning, and taking care of siblings, and they stressed that men and boys do not typically face the same responsibilities:

> My dad doesn't do anything, me and my sisters have to cook and clean. (age 18)

> I look after my little sister, my brother doesn't do much of that. (age not specified)

The additional expectations that some girls face in their families and communities were also emphasized in our discussions with service providers. The impact of changing gender roles and inequities, and their relationship to tobacco use and stress in the lives of Aboriginal girls was reiterated by some of the community-based collaborators (CBCs), as in this example:

> The girls mentioned that they smoked because of stress and most of their stressors were family related and having too much responsibility caring for younger siblings and the differences with raising boys as opposed to girls. (CBC)

Some of the CBCs expressed a link between the gender inequity facing girls and women and the legacy of gender roles imposed by missionary practices on generations of Aboriginal people:

> The girls ended up having a lot more responsibility than the boys did and I believe it's changes in our culture as a result of the missionaries and the church where they enforced things, they made our people believe that you know, the man is the head of the household and the women and children under that, and our people still suffer because of that. (CBC)

One CBC described the contemporary impact of the imposition of external gender norms onto traditionally matrilineal Aboriginal communities:

> Like in our system, most of B.C. is matrilineal, where the heritage and the inheritance is passed on through the mother. But the mothers, the matriarchs are token in our society right now. I think that was the contributing factor to the girls having more or too much responsibility for their younger siblings, because of that mindset that, you know, the man is the head of the household. (CBC)

Clearly, the impact of gender relations on girls' health and smoking behaviours must be explored in the context of historical constructions of gender imposed on Aboriginal communities through colonial contact. The various examples shared by the girls and the CBCs illustrate the everyday impact of external gender norms on girls' understanding of their roles and place in their families and communities. It is not surprising then that among suggestions for smoking prevention strategies many of the girls stressed the need to support family and community health and healing more broadly. They also identified the importance of more varied, healthy representations of Aboriginal girls in the media and in popular culture, of healthy female role models at the community level, and of life skills training, counseling supports, and safe places tailored to girls.

Cultural Identity

Key insights emerged from how the girls described their backgrounds and community contexts, level of knowledge of their Aboriginal culture(s), perceived differences between Aboriginal and non-Aboriginal people, experiences of racialized discrimination, and relationship among gender, age, and cultural identity; cultural engagement; and cultural belonging. The girls were also asked to reflect on if and how they think their cultural background affects their smoking habits. On this point, it was not a goal of this study to define "Aboriginal culture," but rather to invite the girls to describe in their own terms what their background(s) and cultural heritage mean to

them, given that they self-identified in some way as Aboriginal, Native, First Nations, etc.

Overall, the participants came from very diverse backgrounds and contexts, underscoring the need to avoid generalizations and essentialist assumptions about "Aboriginal cultures" in shaping Aboriginal girls' smoking habits. For instance, while there is cultural and spiritual importance to tobacco for some Aboriginal groups, none of the girls reported using tobacco for cultural or spiritual reasons. This could in large part be attributed to the fact that the cultural and spiritual use of tobacco is not traditional to west coast First Nations, and that none of the girls reported following the traditions of communities that use tobacco for such purposes.

When asked to share their views on how Aboriginal people are perceived, girls in every community spoke about the impact of racialized stereotypes held by non-Aboriginal members of their communities, such as this example:

> Yes, if non-Native people look at Native people badly or the way they talk or act or around them, I'm pretty sure that gets a lot of Natives upset.

Some girls talked about chronic discrimination and racism from non-Aboriginal community members:

> A lot of people like look at us and think we're all the same, like they're discriminating. They all think that we're all really drunks and we all do drugs, that kind of stuff.

Some also emphasized that measures of popularity and appearance, which they identified as important aspects of peer pressure, were also racialized:

> That's how people judge you, they see you and they're like 'well, Native dress,' right. They kind of look conceited, 'I'm not going to talk to them.'

While the girls did not directly link their smoking to experiences of discrimination and racialization, they did make connections between these experiences and their sense of belonging and popularity among peers, their school experiences, and stress. As we discuss later on it is important to understand broader structural issues that lead to chronic racialization because they affect girls' general health, well-being, sense of belonging, and cultural identities.

One important finding related to girls' engagement with their Aboriginal backgrounds is that their knowledge of their local community culture and personal Aboriginal cultural histories seemed to matter when it came to their tobacco use and smoking. More of the girls who are current or former smokers reported not knowing a lot about their Aboriginal cultural background and traditions, compared to nonsmokers. In the following section, we explore two themes that support this finding.

"I'm not too sure" — knowledge of Aboriginal backgrounds

A majority of smokers reported that they are "not too sure" and "don't know a lot" about their Aboriginal backgrounds, however they chose to define it. For example, one girl said "My mom's from Winnipeg and I don't know the band's name" while another shared that

> My mom wasn't told about it, my dad, he doesn't know much either because his parents weren't really around when he was young either.

Others indicated that they lacked basic information and were looking for more details about their backgrounds and cultural traditions: "I don't really know that much about it right now, so I'm trying to look into it"; "[I don't know] a whole lot, I want to learn more about it though."

Some of the girls explained that information about their backgrounds was difficult to find because their parents and families had limited connection to their Aboriginal communities due to factors such as family breakdown, residential schools, foster care, and growing up off reserve. Some pointed out that their families were disconnected from a specific Aboriginal community due to frequent moves:

> I don't really know too much about [my native background] because we stayed in town and moved a lot.

While this may not be true in all communities, it seems that some families who move back and forth between on and off reserve may have more access to community cultural activities and traditions when they are on reserve:

> I kind of move back and forth from [community name] to out of town, so when I was here I was in

> dances and some of the [community name] language classes. (age unknown)

The CBCs also echoed the impact of high mobility on limiting the girls' access to consistent community supports and resources:

> Most of the girls may have become transient during the summer and their lifestyle or residence, stuff going on at home really affected whether or not they were able to kind of follow through. (CBC)

Several CBCs stressed that girls' experiences of cultural discontinuity must also be understood in relation to the impact on Aboriginal communities of broader economic and social pressures and changing demographics that increase exposure to substance use:

> We have a large Aboriginal population and not any one specific Aboriginal group ... and because it's sort of a transient community that means they're moving in and out there tends to a lot of drug and alcohol use amongst the Aboriginal people, and especially the youth. (CBC)

Some expressed that transiency hinders girls' ability to follow through with supports and programs such as those designed for substance use prevention and cessation:

> The issue is they may start a program or connect with a counsellor or whatever, but then they move so that gain is lost. (CBC)

These high rates of mobility, a sense of cultural ambiguity and a desire to learn more about their backgrounds, described by a majority of the girls who smoke, challenge smoking interventions rooted in formulaic, culturalist approaches. Girls who lack information about their background and/or who feel disconnected from their Aboriginal communities may find it more difficult to consistently access and/or relate to community-based and culturally grounded smoking prevention and cessation interventions. Such interventions need to be suitably flexible and responsive to girls' diverse experiences while also supporting a sense of cultural continuity that seems important to so many of the girls.

"I have good teachers": Identity and community

A second theme related to girls' descriptions of cultural engagement and belonging indicated that some girls were more strongly connected to at least one identifiable Aboriginal community, and had more access to cultural resources in their community. The majority of the girls who fell under this category were nonsmokers. Overall they reported not only greater knowledge of their Aboriginal backgrounds, but more active engagement with learning cultural skills, teachings and traditions:

> [How much do you know about your culture?]
>
> Quite a bit. Like the food I can make and I know about feasts and stuff, and things we studied in school. I did dancing and all that when I was younger. (age 14)
>
> Pow-wow, salmon release, like camping field trip, I'll try to go. I know some things but not all. (age 16)
>
> Like the sweats, I just came back from canoeing. (age 15)
>
> I know a lot. I know a lot about Indian dancing, basket weaving, making cedar roses, making regalia, and part of our history. (age 16)

An important factor in supporting these girls' knowledge of cultural teachings appeared to be their access to consistent cultural resources. For instance, several girls reported that they learned their language at school and/or at various community programs. Some also stressed the importance of cultural mentors such as Elders and family members:

> I learned a lot from my grandma. My mum. We've gone to the longhouses ... and been to a couple of burnings. I know basics about the language. (age 16)
>
> I learn from the Elders, they take the time, at feasts and things like that. (age 13)

A majority of the girls who reported positive engagement with cultural activities and teachings also commented it had a positive impact on their sense of self and culture, and on the choices they make. The following quotes by two girls who are nonsmokers emphasize the value they place on cultural mentors such as Elders as well as their participation in cultural activities:

> Learning from my background and teachings from the Elders, I can do whatever I want if I just believe in myself. (age 15)

> Being involved in the dancing and feasts and preparing food, it makes you proud of yourself. It gave me some pride, and I feel good about myself. (age not specified)

The sense of pride, purpose, and belonging that is nurtured through community and school culturally grounded activities, access to mentors, and traditional teachings is a point stressed by both girls and community participants. In the same vein, the following reflection from a community-based collaborator illustrates the importance of addressing the intergenerational effects of residential schools and substance use by strengthening access to cultural events in communities:

> A lot of the girls mentioned that some of the things that helped them was attending cultural events and I know that's really true with myself. I, along with all the other Aboriginal families suffered from residential school and drug and alcohol abuse, alcohol abuse amongst my parents and having that responsibility, but I always remember attending cultural events. That was something that gave me something to look forward to as a young child, and I heard that with these girls. I heard the very same thing. You know that's something that they look forward to is attending the feasting ... they still had that desire to participate in their cultural system. (CBC)

The positive impact of community cultural systems noted by both girls and CBCs brings to light the importance of cultural continuity in supporting girls and women's sense of belonging and wellbeing in their communities. That so many of the girls have access to cultural mentors and culturally grounded activities is a testament to the continued positive significance of cultural traditions and systems in these communities. As we discuss in the following section, this finding accentuates the value of a community-centred, strength-based lens in health research; it also raises important policy and programming implications, particularly since a majority of smokers and nonsmokers stressed their desire for more cultural role modeling and increased engagement in cultural activities.

Discussion

This community-based study explored the relationships between gender, culture, and smoking from the perspectives of Aboriginal girls, in the context of smaller Aboriginal communities in British Columbia. Study findings indicate that the girls attach a range of experiences and meanings to smoking including: curiosity; the alleviation of boredom, stress, anger, and isolation; a link to alcohol use and partying activity; a response to peer and relational pressure and conflict; and limited and/or inconsistent access to social and cultural supports and activities. An important finding for prevention and cessation strategies, girls described these factors as part of daily life, normalized through complex, interacting factors that include: timing; peer and family histories and relationships; dynamics of gendering and racialization; and community, sociocultural, and economic contexts.

The use of tobacco to relax, cope, alleviate boredom, and to exercise experimentation and curiosity is typical of many young, experimental smokers in general populations (Moffat and Johnson, 2001; Nichter et al., 1997). Further, peer smoking is generally understood to increase the odds of youth smoking, as did having depressive symptoms (Hutchinson et al., 2008). In contrast, in this study, peer influences were merged with influences from family and community members in the girls' interviews. A broad range of both peer and family relations affected the girls' decisions and behaviours with respect to smoking. These relationships included friends, relatives, family members, and community members, and their separate influences were difficult to disentangle. For example, bingo halls were cited in this study, and in other research (Bottorff et al., 2009) as a common space where peers, relatives, and community members gather, and where smoking is common. Girls who smoked often cited the presence of friends, family, and community members who smoked and helped them acquire cigarettes, as factors contributing to their smoking and to an overall normalization of smoking. This reflects a key influence in small Aboriginal communities where the interweaving of friends and family affect the girls' lives, leading to more difficulty in

separating these different sources of pressure. Thus the notion of "peer pressure" as a construct in research and intervention development has specific Aboriginal community qualities, according to this study. Further, the findings point to a critical link between gendered expectations and the impact of relational pressures on girls. When they are socialized to take care of others, respect for intergenerational and kinship ties may support girls' desire to fit in and maintain strong relationships with family and community members, and thus inadvertently support unhealthy behaviours such as smoking.

The links between alcohol use and tobacco use are consistent with non-Aboriginal samples of youth. Use of alcohol and tobacco are mutually reinforcing (Leatherdale and Ahmed, 2010). However, the stated connection between smoking and drinking by the study participants is an important finding, as often the literature only cites the coexisting use of the two substances without connecting these activities to the context (such as partying). These links are also important to note given the increased negative physical and mental health impacts when both tobacco and alcohol are used. Surveys show a recent increase in heavy drinking by girls in Canada (Ahmad et al., 2008) and internationally (Simons-Morton et al., 2009). These trends appear to be equally applicable to the Aboriginal girls in this study and do not bode well for short and long-term health outcomes for girls. These dual use trends need more investigation.

An important finding of this study is that smoking seems to be a multifaceted strategy to address a variety of physical, emotional, cognitive, social, and relational needs that are somehow related to stress. Several studies have also found links between stress and smoking. One review found that adolescents who experience affective stress are more likely to begin and continue smoking (Kassel et al., 2003). Other research suggests that both stress and low self-esteem are associated with adolescent smoking (Byrne and Mazanov, 2001), and that the association between stress and smoking may be greater for young girls (Byrne and Mazanov, 2003). Certainly the girls in this study reported this link.

The influences of gender and culture on Aboriginal girls' smoking were marked and interrelated. Although the girls who participated in this study are incredibly diverse, they also shared common experiences related to historical processes of gendering and racialization in Aboriginal communities that shape risk factors for smoking.

The girls who identified as smokers or former smokers were more likely to report a lack of knowledge about their Aboriginal backgrounds and lower connection to community cultural resources and teachings. While we resist categorical distinctions between "girls who know culture" and "girls who do not," these findings are illuminating. They illustrate the diversity and complexity of cultural experiences as shaped by numerous factors including relationships with cultural mentors, proximity and access to cultural resources, community contexts, family histories, and levels of mobility. The sense of ambiguity and the gaps in cultural knowledge and access described by some of the girls must be understood as more than the natural and inevitable outcome of growing cultural hybridity and mobility in Aboriginal families. Assimilative colonial policies related to the *Indian Act* have had particularly harmful effects on generations of Aboriginal women, resulting in their exclusion from status rights, alienation from their communities and cultures, and their migration to towns and cities (Lawrence, 2004). Compounding this is the ongoing impact of residential schools, child apprehension, and external foster care and adoptions that has been so damaging to the fabric of Aboriginal communities. Downe (2005, p. 2) calls for an examination of how this history established a pattern of "dislocation and uprootedness" that "continues to characterize the lives of Aboriginal girls."

Our findings around cultural continuity emphasize the importance of further exploring the link between health behaviours and the impact of colonial policies and effects on gender roles, since gendered expectations affect girls' relationships with peers, family, and community members and their experiences of stress and coping. The erosion of women's community leadership roles as a result of colonial processes has been extensively documented (Anderson, 2000; Downe, 2005; Fleming and Kowalski, 2009; Sikka, 2009). Smith (2007, p. 37) argues that the im-

position of a gender hierarchy was a deliberate outcome of the residential school system:

> For the most part, schools prepared Native boys for manual labour or farming and Native girls for domestic work ... the primary role of this education for Indian girls was to inculcate patriarchal norms into Native communities so that women would lose their place of leadership in Native communities.

Recognition of the connections between colonial legacies and the unique stresses and additional responsibilities facing Aboriginal girls is critical to understanding how these processes operate to shape social contexts and the unique life stressors of Aboriginal girls.

As a final finding, an important facet of our discussion of cultural dimensions is the experience of cultural engagement described by a majority of girls who had never smoked. The noted positive impact of community cultural systems by both girls and CBCs is compelling evidence for the value of community-governed health initiatives. This is supported by other BC health research including research by Chandler and Lalonde (2003) who found that suicides among Aboriginal youth in British Columbia are less likely to occur in communities that are revitalizing their cultural traditions, have acquired self government, or have strengthened other aspects of their community social fabric (Chandler et al., 2003). The linkages between a community's sense of cultural identity and self-rated levels of health, wellness, and quality of life have also been identified by other health researchers (British Columbia Provincial Health Officer, 2009; Dockery, 2009; McKee et al., 2009; National Collaborating Centre for Aboriginal Health, 2010). Certainly it is impossible to attribute lower smoking rates to any one factor. Yet taken together, consistent engagement with Aboriginal cultural resources, mentors, and traditions seems to strengthen community resilience and healing (Chandler et al., 2003) and act as a protective factor against substance use (McCormick, 2007), including smoking.

Implications for Smoking Interventions with Aboriginal Girls

This exploratory, qualitative study explored the experiences of Aboriginal girls in a context of community, through a methodological approach developed by six Aboriginal partners and an interdisciplinary research team. The study has revealed some important themes for health promotion, interventions, and further research and analysis, but cannot draw conclusions about Aboriginal girls in British Columbia or Canada, in general. Also, many of the girls were sharing information in interviews with CBCs whom they knew and who often held professional helping roles in the community. These prior relationships will have affected the girls' responses in ways that are not predictable. The study highlights valuable, richly contextualized perspectives from girls on a multitude of intersecting issues that affect their physical, emotional, cognitive, spiritual, and social health, as well as the sociocultural and economic contexts of their communities.

Amaro and colleagues (2001) discuss the importance of understanding specific gender and cultural influences on girls' substance use in theory-based design of interventions. Given the breadth of experiences of "Aboriginal girlhood," the interpretation of gender and culture in the context of Aboriginal girls' lives needs to be suitably fluid, contextualized, and rooted in the lived experiences of Aboriginal girls. A useful approach is to consider experiences and interpretations of gender and cultural identity as a spectrum of beliefs, experiences, and behaviours. Our analysis stresses that culture, gender, and context are not fixed and uniform but rather shaped at the intersection of multiple forces, affecting Aboriginal communities generally, and women and girls specifically. These multiple forces include: individual and family histories and circumstances; cultural values and teachings; shifting community realities; sociocultural, economic, and political factors; and historical and structural effects of colonial policies, among others.

To speak to the complex and continuously evolving realities of Aboriginal girls' lives, smoking interventions must be fittingly flexible and multidimensional. In this regard, it is critical not to assume that interventions designed for women — and more specifically for Aboriginal women — will automatically apply to Aboriginal girls, or that Aboriginal girls are a monolithic group. The girls' insistence on a divers-

ity of interventions, including girl-centred spaces and programs that also nurture cultural knowledge and belonging eschew the value of essentialized, simplistic "culturally sensitive" and "gender-sensitive" approaches (Browne and Varcoe, 2006). While a health message for Aboriginal girls might emphasize girls and women's roles and spiritual/cultural values around healing and wellness, such messages become ineffective if they conflate women and girls' unique experiences, "re-gender" girls (i.e., further strengthen problematic gender roles for girls who already feel pressured by such roles), or impose essentialist cultural approaches to which girls cannot relate. It is critical to introduce approaches that assist in transforming historical effects and structural inequities that affect Aboriginal girls' lives as opposed to accommodating existing patterns that reinforce inequitable gender relations and/or the racialization of Aboriginal girls. Effective interventions should also be contextualized to the realities of each community and address the full spectrum of girls' Aboriginal identifications (including on and off reserve, mixed, and rural and urban Aboriginal girls).

One limitation of this study is that it did not specifically ask girls about the role that sexuality or sexual orientation plays in mediating gender and culture, nor did it explicitly explore the experiences of young people who may not identify as "girls." Young people who live with alternative and/or nonconforming gender and sexual identities may have unique needs and strengths, and experience increased isolation and limited access to supports, an important focus for future research and one not addressed in this study. Other research with BC Aboriginal youth points to the specific risk factors facing lesbian, gay, bisexual, questioning, transgender, two spirit, intersexed, and queer youth.[8] Research reveals that lesbian and bisexual girls report higher rates of tobacco use (Austin et al., 2004), and that bisexual youth of all genders are more likely to initiate and continue to smoke (Easton et al., 2008).

More information is needed on the relationship between discrimination/social exclusion/inequity, trauma, smoking, and other health concerns such as other substance use and mental health (Bourassa et al., 2004; Dion Stout, 2008, 2009; McKay-McNabb, 2006). While the interviews reported here do not always make these links explicit, other research points to the effects of discrimination and social exclusion on health outcomes in Aboriginal communities (Browne, 2007; Browne et al., 2009; Fiske and Browne, 2006; Newhouse, 2004; Reading and Wein, 2009). Chronic discrimination often manifests in determinants of social exclusion, all of which have negative health consequences. Aboriginal women, compared to all other groups of women in Canada, experience higher rates of incarceration, involvement in the child welfare system, residence in substandard housing, unequal access to employment and to health and social services, and experiences of gendered and sexualized racism and discrimination (Downe, 2005; Fast and Collin-Vézina, 2010). Yet we lack understanding from Aboriginal girls' perspectives of how structural inequities facing women manifest in their lives. Future research could explicate how exactly systemic discrimination and social exclusion affect Aboriginal girls' health behaviours and health knowledge, and how, or if, Aboriginal girls might link these factors to their tobacco use.

It is critical that tobacco research highlight community barriers and gaps without implying culpability to Aboriginal communities for structural inequities or for the ongoing effects of colonial policies and practices. Effective health research and subsequent health promotion underscore not only gaps and risk factors, but also the strengths, resources, and knowledge of Aboriginal communities *vis à vis* prevention of tobacco use among Aboriginal girls. At the centre of this study are the rich cultural knowledge and skills that Aboriginal girls hold, the importance of their engagement in community life, and the leadership roles they play in their families and communities. Their experiences highlight the tremendous cultural diversity and resilience held in Aboriginal communities and the importance of supporting this capacity in health-related research, policy and program leadership.

Conclusion

The study findings provide valuable information about factors influencing smoking among Aboriginal adolescent girls in British Columbia,

8 See http://www.unya.bc.ca/resources for a report on two-spirit youth in BC Aboriginal communities.

Canada. An understanding of how culture, gender, racialization, and family, community, socioeconomic and historical contexts, among other factors, interact to influence girls' smoking provides a nuanced picture of Aboriginal girls' realities, and will facilitate the design of interventions to prevent or reduce smoking among girls. These findings highlight the potential limitations of monolithic, culturalist assumptions in health research, policy, and practice, as well as the value of community-based research for documenting effective community and cultural resources. Future partnerships between Aboriginal communities, and Aboriginal and non-Aboriginal researchers will facilitate much-needed multidirectional knowledge transfer in this field and inform future research and program and policy development. Communities can draw on the findings to contextualize the factors that lead to girls' smoking patterns, and to affect public health change in their own communities.

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Dr. Sandrina de Finney, corresponding author, is an Associate Professor in the School of Child and Youth Care at the University of Victoria. She has trained hundreds of community members, students, research teams and organizations in using community-based, participatory research approaches. Dr. de Finney is co-founder of Antidote, an award-winning grassroots network for racialized girls and women, and a research advisor for the Siem Smun'eem Indigenous Child Welfare Research Network (http://web.uvic.ca/icwr/home.htm). In this role she develops and delivers research training, conducts ongoing cycles of community-based research, and provides consultation to Indigenous communities and

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Dr. Lorraine Greaves is Senior Investigator and former Executive Director of the British Columbia Centre of Excellence for Women's Health. She has published widely on women's health, gender, and health and tobacco use, programs, and policy. She is lead mentor of IMPART, a CIHR funded training program, bringing together studies on gender, addiction, and trauma and violence. She has researched the impact of tobacco use, policy, and programs in a range of settings. She has worked with women, girls, pregnant women and expectant fathers, and new parents, Aboriginal peoples and communities, and is particularly interested in tailored and community-based programs of prevention and treatment of tobacco use. She was principal investigator on this grant.

Pauline M. Janyst, MA, has worked with First Nations organizations at the community, provincial, and national level for the last 20 years. Her background has resulted in a wide range of multidisciplinary skills, knowledge and experience. The co-development of Laichwiltach Family Life Society in Campbell River is one of her proudest accomplishments. She is of Kwakiutl ancestry belonging to the Da'naxda'xe First Nation on Harbledown Island, B.C. where she was born and raised. In the ensuing years, she has gained much experience in a variety of positions with First Nations organizations, focusing primarily on family and health. She entered the world of Aboriginal Research in 2003–2008 as the project coordinator for the Indigenous CHILD project at University of Victoria with 4 First Nations. Most recently, she has moved back to Campbell River to head the Sasamans Society (www.sasamans.ca). She was the Project Coordinator and Community Liaison for this project, and assisted in the development, analysis, write-up, and dissemination of research findings.

Natalie Hemsing, MA, is a Research Associate at the British Columbia Centre of Excellence for Women's Health. She has extensive background in primary and secondary research on sex- and gender-based analysis, health promotion, smoking prevention, cessation and tobacco policy among diverse populations, and systematic reviews and knowledge syntheses. She has been involved in managing and delivering several projects related to tobacco use and cessation among girls and women, including: reviews on smoking cessation during pregnancy, a review of partner support and cessation during pregnancy, and a qualitative project examining the gendered effects of secondhand smoke policies. She served as a Research Coordinator on this research project and was also involved in the analysis and writing of research findings.

Natasha Jategaonkar, MSc, was employed as the Tobacco Research Coordinator at the British Columbia Centre of Excellence for Women's Health from 2004–2006, and has since held several other positions as a community-based researcher in the fields of tobacco use, women's health, and housing. She was involved in the conceptualization and implementation of this project, including drafting questions and guidelines for focus groups and interviews, contributing to a preliminary framework for data analysis, and maintaining collaborative relationships among the researchers and participants. She also contributed to the writing and editing of this manuscript. Natasha is currently a student in the Faculty of Law at the University of British Columbia in Vancouver, Canada.

Annette J. Browne is a Professor in the School of Nursing at the University of British Columbia in Vancouver. Annette's research stems from her clinical work as an outpost nurse who lived and worked in First Nations and Inuit communities in Canada. Her research focuses on health and health care inequities, with a particular focus on implications for Indigenous peoples in Canada. Examples of studies she is currently leading are focused on: fostering access to health care for Aboriginal people in urban areas; addressing the health effects of structural inequities and structural violence through PHC interventions; and studying the relevance of cultural safety to health services. Annette was a co-investigator on this study, and was involved in working with the community-based researchers on interviewing approaches, and on the analysis of the narrative data.

Karen Devries is a social epidemiologist specializing in gender and health. Her current interests include the relationships between gender, violence, and coercion, and health outcomes including HIV, mental health, and substance use. She is involved in a number of international projects across these areas, which consist of systematic review and modelling work, as well as randomized controlled trials. Currently, she coordinates the work of the Expert Group on Violence for the current round of the Global Burden of Disease Study. She is also leading a separate review of evidence on interventions to prevent gender-based violence and prevent HIV in various HIV epidemic settings. She coordinates SASA!, a cluster-randomized trial of a violence and HIV prevention intervention in Kampala, Uganda. She is also conducting a second cluster-randomized trial of an intervention to prevent violence against youth in schools in Uganda. Her previous research focused on the mental health of women in low and middle income countries, and the sexual health of urban and rural Canadian Indigenous

adolescents, including determinants of suicidal behaviour, and links between sexual behaviour and experiences of sexual violence. She served as a co-investigator on this project and was involved in the development, analysis, and write-up of findings.

Joy Johnson is a Professor in the School of Nursing at the University of British Columbia with a long standing interest and leadership in the field of gender and health. She was appointed Scientific Director of the CIHR Institute of Gender and Health commencing January 2008. In this role she works with the Canadian gender, sex, and health research community and stakeholders to identify research priorities, develop research funding opportunities, strengthen research capacity, build partnerships and translate research evidence to improve the health of Canadians. Dr. Johnson has a highly productive program of research focusing on health promotion and health behaviour change. Drawing on a broad array of theoretical perspectives her work explores the social, structural, and individual factors that influence the health behaviour of individuals. A major thrust of her work focuses on sex and gender issues in substance use and mental health and involves community-based approaches to knowledge development and system change. Professor Johnson served as a co-investigator on this research project and was involved in the project development, analysis, and the writing of research results.

Nancy Poole is the Director of Research and Knowledge Translation for the British Columbia Centre of Excellence for Women's Health, and the Provincial Research Consultant on Women and Substance Use issues for BC Women's Hospital in Vancouver. To the planning and writing up of this research, Nancy brought her research experience on girls and health promotion, the links between alcohol and tobacco use by girls and young women, and issues related to substance use by First Nations women in Canada. Nancy is engaged in knowledge exchange processes on improving policy and practice for women with substance use concerns, linking Inuit, First Nations, Metis, and non-Aboriginal women across Canada in reflection and action towards expanding women-centred and culturally relevant treatment, harm reduction, and health promotion.