"These Girls are our Future": Exploring Aboriginal Ownership of Nontraditional Tobacco Control Research

Lynne Baillie, Ph.D.[1]
British Columbia Cancer Agency Centre for the Southern Interior

Judy Maas
Interior Health British Columbia
Dunne-za, Blueberry River First Nation

Shawna Buchholz, B.Sc.
Centre for Disease Control
Shuswap First Nation

Lea Mutch, B.Sc.
University of Winnipeg School of Graduate Studies
Métis

1. Corresponding author. BCCA Centre for the Southern Interior, 399 Royal Avenue, Kelowna, BC, V1Y 5L3. Telephone: 250-712-3925; fax: 250-712-3911, email: lbaillie@bccancer.bc.ca. Host Institution: British Columbia Cancer Agency Centre for the Southern Interior.

Acknowledgements: This research was supported by grants from the National Cancer Institute of Canada (NCIC) and from the Canadian Tobacco Control Research Initiative (CTCRI), and by funding from BC Cancer Foundation, Southern Interior. The authors would like to thank the Splats'in Nation for their collaboration, support, and encouragement throughout this project.

Abstract

While it is recognized that tobacco misuse among young females has serious health implications for Aboriginal populations, there is a worrying lack of representation from this community in current tobacco control research. We review the present state of Aboriginal tobacco control across Canada and report on the design, development, and implementation of the weekend workshop for Aboriginal women and girls. We suggest that not only are borrowed tobacco control initiatives failing to protect young Aboriginal females due to their lack of relevance, but that the voice of the Aboriginal community appears to be completely absent when it comes to defining social determinants of nontraditional tobacco use. We suggest that the extent to which the disproportionate burden of nontraditional tobacco use among its young women can be addressed is contingent upon increasing the presence of Aboriginal researchers and recognizing the central importance of community-relevant social determinants.

Key words: Tobacco control; Aboriginal health; social determinants

Introduction

Canada has one of the world's largest tobacco control infrastructures (World Health Organization [WHO], 2006). However, tobacco misuse remains a major public health concern among Canadian Aboriginal peoples (Henderson et al., 2005). Aboriginal youth are particularly vulnerable, with more than half (54%) smoking: this rate increases to 65% among girls aged 15–17yrs (First Nations Centre, 2005). In Canada, smoking rates among Aboriginal populations are dramatically higher than for the non-Aboriginal population (First Nations Centre, 2005). For example, among girls aged 15–17 yrs, Aboriginal smoking rates are four times the Canadian rates (61% vs 15%) (RHS, 2004).

While it is recognized that tobacco misuse among young females has serious health implications for the Aboriginal population, there is a worrying lack of representation from this community in current tobacco control research. To date, Aboriginal tobacco control has tended to focus on the delivery and implementation of strategies, not on research (eg., Health Canada, 2002a). As an example, in British Columbia presently there are twenty-six First Nations and Inuit Health Branch (FNIHB) coalition sites. Although there are plans for a new tobacco control strategy (pending funding from the federal government) the tobacco program used by FNIHB fo-

cuses primarily on cessation. There is no Aboriginal research network dedicated to addressing Aboriginal tobacco misuse; neither is there adequate recruitment and participation in the discipline. Against this background, in a province which boasts one of the lowest rates of smoking in Canada, young female Aboriginals are lighting up at a rate that not only more than quadruples that of the non-Aboriginal population, but is highest of any other ethnocultural gender group in the province (BC Centre for Excellence for Women's Health, 2006).

There are many factors affecting tobacco misuse among Aboriginal girls requiring investigation which can only be appropriately addressed from within the Aboriginal community (Glanz and Maskarinec, 2005). Aboriginal researchers are therefore an essential element. In this paper, we present the findings from two phases of a study investigating the present state of Aboriginal tobacco control across Canada and report on the collaborative design, development, and implementation of a weekend workshop for Aboriginal women and girls.

Methods

This research study consisted of two separately funded phases. The first phase was guided by two major objectives: to locate First Nation workers across Canada in the field of tobacco control, and to create a contact list of these workers and the programs they were using, or found to be of use. Data was collected using publicly available information to locate Aboriginal tobacco control workers, who were then contacted by telephone and asked to describe their work. Ethics approval was unnecessary for phase 1 as this information fell within the public domain and was collected as it existed without personal information, comment, or opinion.

The second phase involved working collaboratively with an Aboriginal community over an eleven-week period to develop a weekend workshop addressing the tobacco control needs of Aboriginal girls and women. These needs were defined and directed, but not researched by the community; therefore this should not be considered community-based participatory research. Data was collected during the course of the resulting weekend workshop using a qualitative description approach. This approach is drawn from naturalistic enquiry and does not lay claim to theoretical or philosophical underpinnings. The focus of research is to provide a comprehensive summary of words and events without interpretation or inference. "Qualitative description is especially amenable to obtaining straight and largely un-

adorned (i.e., minimally theorized or otherwise transformed or spun) answers to questions of special relevance to practitioners and policy makers" (Sandelowski, 2000, p. 337) and qualitatively analyzed by the research team. Member checking was conducted to ensure the validity of emergent themes. Ethics approval for phase 2 was obtained from the Chief and Council of the community supporting this project, rather than from an external agency. The conditions of approval followed the guidelines as set out by the BC Aboriginal Capacity and Developmental Research Environments (ACADRE), and were approved accordingly (BC ACADRE, 2005). Rigor was maintained by constant member checking among the research team and the involved community members.

Phase I: Review

In the first phase, using web-based contact information (for example Band Health Offices and School District Aboriginal Liaison) and then a snowballing technique, we identified areas across Canada where Aboriginal tobacco control personnel, initiatives, and programs might be located. These locations were then contacted by mail, telephone, and email to ascertain if they were involved in tobacco control and the degree of that involvement. Where contact was made, permission was also sought to add their names and contact information to a master list to be made available to the Canadian Tobacco Control Research Initiative. Overall, 17 locations across Canada having connections to Aboriginal tobacco control were contacted; as relevant personnel were identified and located, each location usually involved several people and departments. Within these locations, only 7 individuals self-identified as being tobacco control workers. Volunteered reasons for nonidentification included: lack of time to include tobacco control in their daily responsibilities; tobacco control was not, or no longer was, a high priority; and doubts that, although concerned about tobacco misuse, they possessed enough knowledge or information to self-identify as tobacco control workers.

Phase II: The workshop

The second phase of this research project was determined by the information obtained during phase 1, and by the issues identified by the collaborating community. An initial concern of the research team was that this project should result in more than academic research findings; there should be a practical and relevant "product" in place. Consequently, after consultation with the community, the goal became to provide a one-day workshop

to address both the identified needs of phase 1; that is, to initiate a process of networking and dialogue among the Aboriginal community regarding tobacco control and the issues raised during collaboration. With further support later, the process could continue to be productive. Including the workshop in a larger community gathering ensured that our area of interest, namely tobacco control within the Aboriginal female teen population, was contained within the more holistic perception of community health. It also put the Aboriginal community itself in charge of how, where, and when this information should be shared.

For financial reasons, it was determined that the workshop should focus on the provincial, rather than the national, level. This restricted invitations to those involved with, and interested in, Aboriginal tobacco control in British Columbia.

This is something that we have to do: These girls are our future

Through contacts with Judy Maas, one of the authors, we were invited to present our proposal to the Splats'in Circle of Women, a group of female Elders dedicated to promoting and supporting the physical, emotional, and spiritual health of Aboriginal women. After several meetings with this group, we were generously granted the entire second day of their third annual weekend conference (A Sacred Journey through Healing) to present our tobacco control workshop. Details of proposed workshop processes were presented to local Chiefs and Band Councils from whom approval was then obtained. The workshop was facilitated by two of the authors; Judy Maas, Aboriginal health liaison worker and former local Band Chief, and Shawna Buchholz, CDC Aboriginal outreach nurse and local band member.

Three hundred invitations were emailed and mailed to School District Aboriginal Liaison Workers, Band Health offices, Honour your Health participants and Friendship Centres across BC. Some funding was made available for accommodation and travel assistance. Bags were provided for those attending the workshop: 125 book bags were ordered for adults, 25 sling packs for teens. Each bag contained Quit Now, Clean Air Coalition, BC Lung Association and British Columbia Cancer Agency (BCCA) information booklets, stickers, pens, a Tobacco Industry Denormalization Pack from the Program Training and Consultation Centre (PTCC) Ottawa, and a comment form. The teen packs also contained a Students Working Against Tobacco (SWAT) DVD.

Three specific aspects of Aboriginal female teen smoking were presented

in the workshop: The dangers of active and passive smoking during pregnancy; the role and influence of family, friends, and community; and designing and implementing a tobacco control initiative in the home and the community. Lunch break entertainment was provided by 7th Generation, a mixed group of youth from the Okanagan Nation, Gitxsan Nation, and Cree Nation, who donated some of their CDs as draw prizes. They perform their messages of empowerment and identity in hip hop and rap style.

Findings

Phase I: The Review

The process of establishing contact with tobacco control workers in the Aboriginal community proved extremely difficult. We found that there are few specifically dedicated and trained personnel in the field; that the availability, time, and funding of health care workers in Aboriginal communities is very limited; and that tobacco control research is not a high priority in the face of more acute problems. For example, a recent bibliography of Aboriginal women's health did not contain a single mention of tobacco in 338 pages of 1,057 references (Aboriginal Women's Health and Healing Group, 2005). Overall, we found that:

- The way that Aboriginal health is currently organized and managed does not allow for much community research in tobacco control.
- There is an expressed concern over lack of preparation, education, and direction of Aboriginal health workers in all aspects of tobacco control — not just research.
- Funding and job security are major concerns within Aboriginal tobacco control. There is no sense of real commitment from the federal government. This makes community research, development, and implementation of tobacco control almost impossible.

Faced with these challenges, contacts frequently reported feeling overwhelmed and isolated in their work. However, they also reported a real commitment to addressing the increasing incidence of smoking among the young women in their communities in three major areas: alerting girls to the dangers of smoking during pregnancy; the influence of the overwhelming presence of smoking, and the ready availability of smoking materials on girls; and how to create capacity within the community to counter tobacco use in youth — particularly females.

Phase II: The Workshop

Attendance

All teen packs and 54 of the adult bags were picked up. The rest were given to conference delegates and workshop attendees from Aboriginal bands, centres, and clinics around the province for distribution in their home communities. The immediate bag pick-up gives us some idea of attendance. Rather than officially preregister for the entire weekend, people preferred a "come and go" approach due to other commitments, gatherings, and community events occurring during this weekend — the closest to Aboriginal Day.

Evaluation response

Thirty-six completed workshop evaluation forms were returned. These written comments about the workshop, and conversation during the workshop, indicated that attendees found it informative, useful, and enjoyable. Many of these women and teens were current smokers and their written and spoken comments suggest practical responses to the information presented.

> *As of this moment, I'd never really given this (becoming involved in tobacco control) any thought — but after meeting so many knowledgeable, heartwarming people, I'll be learning more to teach my children and family first. Be proud and keep moving forward; never give up — networking works tremendously.*

For others, the workshop offered a safe environment to openly discuss what they saw happening in their own communities and to voice their opinions, concerns, and, for at least one young woman, confusion.

> *Many Aboriginal ways are helping people smoke. Many parents smoke and do not pass on information not to smoke. Many bond by smoking with youth or rolling cigarettes with youth.*
>
> *Smoking is pointless, it's become a way of life. It's supposed to be spiritual, but it's not.*

Hosting the workshop within the Splats'in Conference not only provided a more holistic approach to tobacco control within the Aboriginal community, it also reflected Aboriginal ownership and authority, both for content and presentation. This opened up some dialogue around the possibility for taking this further with the creation of Aboriginal research in the field of nontraditional tobacco control.

> *This weekend was great because usually people use the "beating up" method of treatment and don't treat it as an addiction and Aboriginal people are addicted to cigarettes. An Aboriginal Network for Tobacco Control would recognize tobacco as an addiction, it would recognize health, and it would recognize Aboriginals.*

The presence of youth at the workshop had an effect beyond the impact on youth themselves. It brought forward what these young women were dealing with in their lives, their concerns for their health and the health of their babies, and their struggles to deal with it all.

> *Youth representation made me cry … my heart feels happy and I'm proud of this Nation.*

The most heartening response was that of realization that change could occur and that they could be instrumental in that change.

> *I'm not involved in tobacco control, but after today, I see that I could be.*

Discussion

The context of tobacco use among young Aboriginal females differs in one important way from that of the general population: Aboriginal girls grow up in an environment where tobacco use is woven into the fabric of their everyday lives. This extends far beyond the presence of the sacred aspects of noncommercial tobacco to include entire communities where the smoking of commercial tobacco for nonsacred reasons is, in perception and fact, the norm. These young women, therefore, grow up immersed in a world that provides the opportunities, role models, and materials for initiating and continuing smoking behaviours.

Although the decline in smoking prevalence among female teens has slowed somewhat in recent years (Health Canada, 2007), the steady overall reduction in tobacco use among the general population has been attributed to the successful exposure to educational, media, and public health initiatives (Pierce, 2007). Aboriginal communities do not exist in a vacuum: they are composed of people who also read, hear, and see these messages and who are deeply concerned about the health of their young women. The question that has to be addressed is *why* have these initiatives failed to have an effect on the Aboriginal community and consequently young Aboriginal females? Based on our findings and experiences from both projects, we offer the following possible considerations.

Social Determinants and their Relevance

There is currently a recognition that preventive health must incorporate an appreciation of the role played by social determinants. This requires a major shift from the long-held focus on a simplified and individualized "lifestyle choices" approach toward a more complex and global perception of the societal causes of preventable disease. During recent years, the urgency of this shift has becoming increasingly apparent. For example, in 1989, Wilkins et al. estimated that those living within the poorest 20% of Canadian neighbourhoods were at greater risk of dying prematurely from preventable illness such as cancers, heart and respiratory diseases, and diabetes than those in more well-off communities. Thirteen years later, Raphael (2002) provided the conservative estimate of 22% premature loss of life in Canada attributable to income differences. Cigarette smoking is a major health risk behaviour in these statistics and further analysis reveals the devastating impact it has upon young, less-educated, low-income women and their children (Ernster et al., 2000; Kirkland et al., 2004; Seltzer, 2003; Al Mamun et al., 2006). Aboriginal women are overrepresented in this group, placing them at particular risk from preventable disease.

However, while a step in the right direction, it is not enough to acknowledge that health is socially determined. How it is determined, and by whom, is also crucial. Raphael (2004) argues that social health determinant definitions are shaped by ideological, political, and institutional factors. In other words, social determinants are themselves socially determined. Concepts of what constitutes health, health risks, and the actions required to improve health are not universal but contested within political power and economy, and shaped by how health-promoting institutions define their own mandates and capacities. This, in turn, influences the ways in which communities and health intersect. Disease prevention programs — including tobacco use control — depend on how governments and institutions identify themselves and their responsibilities within the community. Given the current economic climate and the proclivity for the quick fix, it is easier, faster, and less contentious to continue to define the problem by placing the onus on choices. It is much harder, and certainly much more expensive, to unravel and address the deep-rooted pressures on health made by the created environment. From our findings, we suggest that not only are global tobacco control initiatives failing to protect young Aboriginal females, but that the voice of the Aboriginal community is completely absent in defining social determinants of nontraditional tobacco use.

Cultural Safety and Cultural Appropriateness

The irrelevance of nontraditional tobacco-control initiatives for young Aboriginal females implies the need for both more research and more collaboration. While we believe this to be true, our research suggests the following caveats.

Non-Aboriginal researchers are outsiders; even after extensive and careful collaboration, they remain outsiders. They can contribute expertise and knowledge of their particular academic field of study, but they can never know the community, in which they are applying that knowledge, from the inside. This, inevitably, leaves the way open for assumptions regarding cultural safety and cultural appropriateness. Non-Aboriginal researchers can confuse and misinterpret what they are seeing, hearing, and experiencing with dangerous results. The greatest of these is deficit-based research, which reinforces lack of control, feelings of hopelessness, and loss of esteem in the Aboriginal community (Oberly and Macedo, 2004). Identifying weaknesses, rather than highlighting strengths, also paves the way for the continued use of programs focusing on individual responsibility for health decisions.

Questions raised by non-Aboriginal researchers still drive the research of Aboriginal community health, including tobacco misuse. The act of framing a question, no matter how sensitively done, also defines the range of responses which will fit that frame. In other words, whoever frames the research question also shapes the answers — and the resultant programs and interventions are based upon those answers. If relevant social determinants are to be uncovered, does the non-Aboriginal researcher have the right to decide the questions? What value do answers have if the question itself does not originate and resonate with the Aboriginal community?

Collaboration is offered as a way to overcome, or at least dilute, the unintentional bias brought by the non-Aboriginal researcher. However, that too, can become a vehicle for further misconception if personal issues of knowledge and competence are not acknowledged and accommodated. The validity of lay knowledge is largely unrecognized and many Aboriginal community members, including health workers, feel that they are not in a position to direct or challenge research decisions (Baezconde-Garbanati et al., 2007). We suggest that the extent to which the disproportionate burden of nontraditional tobacco use among Aboriginal young women can be addressed is contingent upon the increasing the presence of Aboriginal researchers and recognizing the central importance of community-relevant social determinants.

Conclusion

The few Aboriginal tobacco control researchers report themselves to be overwhelmed and underfunded (Baillie et al., 2006). This situation does not seem likely to change with the 2007 announcement of a $10 million reduction for Aboriginal tobacco control in Canada. Another concern for Aboriginal tobacco control is the current necessity of utilizing "evidence" from non-Aboriginal findings (eg., Health Canada, 2002b). The foundations of non-Aboriginal youth tobacco control research are findings regarding smoking trajectories and transitions, initiation, decision-making, quit attempts and control methods. This research generates evidence-based approaches to tobacco control. However, the concept of "Best Practices," as identified by the non-Aboriginal research community, includes assumptions that are not appropriate in an Aboriginal context (Ivers, 2004).

The best exposition of health determinants may be those given by the community members themselves. Inquiry with groups of other populations will likely identify health determinants very different to those currently recognized by various health organizations.

References

Aboriginal Women's Health and Healing Group. (2005). *Annotated Bibliography of Aboriginal Women's Health and Healing Research*. Vancouver: Aboriginal Women's Health and Healing Group.

Al Mamun, A., O'Callaghan, F., and Alati, R. (2006). Does maternal smoking during pregnancy predict the smoking patterns of young adult offspring? *Tobacco Control: An International Journal, 15*(6), 452–457.

Baillie, L., Hardy, S., Doucette, M., Elton-Marshall, T., Brosky, G., and Mutch, L. (2006). *Creating an Aboriginal Community of Practice for Tobacco Control*. Presented at 3rd Annual Invitational Symposium for Research to Inform Tobacco Control. Toronto, Canada.

Baezconde-Garbanati, L., Beebe, L., and Perez-Stable, E. (2007). Building capacity to address tobacco-related disparities among American Indian and Hispanic/Latino communities: Conceptual and systematic considerations. *Addiction, 102*(Suppl 2), 112–122.

BC Centre for Excellence for Women's Health (2006). *Turning a New Leaf*. Vancouver: BC Centre for Excellence for Women's Health.

BC Aboriginal Capacity and Development Research (2005). www.health-disciplines.ubc.ca/iah/acadre/ Accessed November, 2008.

Ernster, V., Kaufman, N., Nichter, M., Sarnet, J., and Yoon, S. (2000). Women and tobacco: Moving from policy to action. *Bulletin of the World Health Organization, 78*(7), 891–901.

First Nations Centre. (2005). First Nations Regional Longitudinal Health Survey (RHS): 2002/2003 Youth Survey. Ottawa: National Aboriginal Health Organization.

Glanz, K. and Maskarinec, G. (2005). Ethnicity, sense of coherence and tobacco use among adolescents. *Annals of Behavioural Medicine, 29*(3), 192–199.

Health Canada. (2002a). *Program Framework: Aboriginal and Inuit Tobacco Control Strategy*. Ottawa: Health Canada.

Health Canada. (2002b). *Promising Strategies and Potential for Best Practices*. First Nations and Inuit Health Branch, National Aboriginal Health Organization. Ottawa: Health Canada.

Health Canada. (2007). *Canadian Tobacco Use Monitoring Survey*. Ottawa: Health Canada.

Henderson, P., Jacobsen, C., and Beals, J. (2005). Correlates of cigarette smoking among selected Southwest and Northern Plains tribal groups: The AI-SUPERPFP study. *American Journal of Public Health, 95*, 867–872.

Ivers, R. (2004). An evidence-based approach to planning tobacco interventions for Aboriginal people. *Drug and Alcohol Review, 23*, 5–9.

Kirkland, S., Greaves, L., and Devichand, P. (2004). Gender differences in smoking and self reported indicators of health. *BioMed Central Women's Health, 4*(S1), 7.

Oberly, J. and Macedo, J. (2004). The R word in Indian country: Culturally appropriate commercial tobacco-use research strategies. *Health Promotion Practice, 5*(4), 355–361.

Pierce, J. (2007). Tobacco industry marketing, population-based tobacco control and smoking behavior. *American Journal of Preventive Medicine, 33*(6, Suppl), S.327–S.334.

Raphael, D. (2002). Addressing health inequalities in Canada. *Leadership in Health Services, 15*(2), i-viii.

Raphael, D. (2004). *The Social Determinants of Health*. Toronto: Canadian Scholars' Press.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health, 23*:334–340.

Seltzer, V. (2003). Smoking as a factor in the health of women. *International Journal of Gynecology and Obstetrics, 82*, 393–397.

Wilkins, R., Adams, O., and Branckner, A. (1989). Changes in mortality by income in urban Canada from 1971 to 1986. *Health Reports, 1*(2), 137–174.

World Health Organization (WHO). (2006). *Framework Convention on Tobacco Control.* Available from: http://www.who.int/tobacco/framework/download/en/index.html