

NO GIFT

TOBACCO POLICY AND
ABORIGINAL PEOPLE IN CANADA

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Glossary

Gender refers to the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power, and influence that society ascribes to the two sexes on a differential basis. Gender is relational and refers not simply to women or men but to the relationship between them (Health Canada, 2003a).

Sex refers to the biological characteristics such as anatomy (e.g., body size and shape) and physiology (e.g., hormonal activity or functioning of organs) that distinguish males and females (Health Canada, 2003a).

Indian collectively describes all the Indigenous people in Canada who are not Inuit or Métis. Indian people are one of three peoples recognized as Aboriginal in the Constitution Act, 1982 — Indian, Inuit, and Métis. In addition, three categories apply to Indians in Canada: Status Indian, Non-Status Indians, and Treaty Indians. Some people may fit into more than one of these categories (Indian and Northern Affairs Canada [INAC], 2003).

First Nations is the preferred form of self-identification for many people who find the term “Indian” outdated and offensive. Although the term “First Nations” is now widely used, there is no legal definition for it (INAC, 2003).

Treaty Indians are Indians registered or affiliated with a treaty band and are descendants of Indians who signed treaties with the Crown (INAC, 2003).

Registered or Status Indian is a person listed in the Indian Register, the official record identifying all Status Indians in Canada. The Indian Act sets out the requirements for determining who is a Status Indian (INAC, 2003).

Non-Status Indian refers to an Indian person not registered as an Indian under the Indian Act. This may be because she or he never applied to be registered. This may also be because she or he, although a descendant of persons who are or were registered or entitled to be registered under the Indian Act, is not entitled to be registered under the terms of the Indian Act (INAC, 2003).

Inuit are the Aboriginal people of Arctic Canada. They live primarily in Nunavut, the Northwest Territories, Labrador, and Northern Quebec. *Inuit* means “the people” in Inuktitut, the Inuit language (INAC, 2003).

Métis is the historical term applied to the children of French fur traders and Cree women in the Prairies, and of English and Scottish traders and Dene women in the North. Today, the term is used broadly to describe people of mixed First Nations and European ancestry who identify themselves as Métis, distinct from First Nations people, Inuit, or non-Aboriginal people. The Métis organizations in Canada have differing criteria about who qualifies as a Métis person (INAC, 2003). The Métis have a unique culture that draws on their diverse ancestral origins.

Non-traditional tobacco use refers to the misuse of commercial tobacco, characterized by smoking cigarettes, cigars, or pipes and using smokeless tobacco, distinct from the traditional use of tobacco for sacred or ceremonial purposes among many Aboriginal cultures (BC Ministry of Health and Ministry Responsible for Seniors, 2001).

Smoke runners. There are various definitions for this term. In the context of this project, it refers to non-Aboriginal persons who take advantage of impoverished Aboriginal people by offering them a small amount of money (e.g., ten dollars) to obtain tax-exempt tobacco products that the smoke runners then sell to non-Aboriginal people for a profit.

EXECUTIVE SUMMARY

Smoking – the number one preventable cause of death and disease – is decreasing in Canada. Regulatory measures such as legislation and taxation, and the policies that support them, have been the cornerstones of federal and provincial tobacco-reduction strategies. Although research suggests that these measures have been relatively effective at reducing tobacco use across the population as a whole, they may not have been as effective at changing smoking rates among key subgroups within the population. Smoking rates among Aboriginal people are not declining and the non-traditional use of tobacco may actually be increasing. In fact, Aboriginal people consistently report smoking rates that are double the Canadian average.

We know little about why smoking rates among Aboriginal people may be resistant to the regulatory measures that have proven effective elsewhere or about the impact of such measures on tobacco use among Aboriginal people in Canada. We know even less about the differences of such measures for Aboriginal women and men, but given systematic gender differences in such things as income, social support, and family responsibilities, there is good reason to expect that there will be differences. Given current smoking patterns, there is an urgent need to address these knowledge gaps, both to improve our understanding of smoking among Aboriginal people and to develop appropriate, effective policy responses.

No Gift: Tobacco Policy and Aboriginal People in Canada describes a preliminary examination of the intersections of gender, tobacco policy, and Aboriginal status. This project emerged during the development and implementation of the Aboriginal Tobacco Strategy in British Columbia. During that process, researchers with the British Columbia Centre of Excellence for Women's Health (BCCEWH) proposed to explore the differential needs, concerns, and consequences of tobacco control policy from the perspectives of both gender and Aboriginal issues. We felt that such a dual analysis could enhance the effectiveness of the Aboriginal Tobacco Strategy for both Aboriginal men and women.

This discussion paper examines issues related to tobacco control policy, taxation, and legislation as they affect Aboriginal women and men in BC, and identifies potentially differential impacts when gender differences are taken into account. Gender was used as a lens to examine three issues critical to understanding the gendered effects of tobacco policy: income adequacy, childcare responsibilities, and the nature of women's work. This approach allowed us to draw comparisons among Aboriginal men and women and the general Canadian population of men and women, as well as among and between subgroups of Aboriginal men and women.

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This report summarizes the legislative framework that authorizes and supports the regulatory basis of tobacco control efforts in Canada and BC, identifies the various general and targeted tobacco control strategies that operate at the federal and provincial levels in BC, and delineates the process and procedures for obtaining an Exempt Sale Retail Dealer permit in order to sell tax-exempt tobacco on reserves in BC. It also raises questions about important differences that can be expected to have implications for the development and evaluation of effective and ethical tobacco control policies. These differences point to the need to adopt a multifaceted approach to developing policies that address the broader health and social inequities experienced by many Aboriginal groups and individuals.

From this examination, we conclude that policy research, development, and evaluation should be conducted within a framework that considers the differing circumstances and life realities of both women and men. It is vital that tobacco research and policy development acknowledge and respect the diversity of various Aboriginal cultures in Canada. A key recommendation is therefore to review tobacco reduction strategies through the consistently blended perspective of a gender-based and Aboriginal-based analysis.

By design, this project necessarily raises more questions than it answers. We intended to provide a foundation for future research by identifying information gaps and critical areas for future exploration. Future work must involve a wider set of actors, in particular, those who are most affected by research and policy decisions. This means that both Aboriginal women and men must be invited to participate in the design and assessment of responses to the tobacco epidemic within their communities.

In Canada, regulatory measures are the cornerstone of federal and provincial tobacco reduction strategies including, among other things, legislation and taxation, and the policy decisions that support them. Efforts to reduce tobacco use have largely focused on macro tobacco control measures designed to reduce or eliminate tobacco use across the entire population. While there is evidence to show that smoking among the general population has declined steadily over the past 40 years, this does not appear to hold true for Aboriginal people (Reading, 1999). Do these same tobacco control measures then have the same impact on the non-traditional use of tobacco among Aboriginal people? Are there unintended consequences due to the marginalized socio-economic position many Aboriginal people face? What role do cultural or geographic factors play in supporting or detracting from efforts to address tobacco misuse? In the same vein, what is the impact of these measures on Aboriginal men and women, given their differing social realities, personal life expectations, and economic circumstances? Is there an Aboriginal approach to policy development that reflects and builds on the strengths and richness of Aboriginal culture and traditions more appropriately and effectively than the macro tobacco control measures currently in effect?

This project aimed to identify issues that require further research on the impact of tobacco control regulations by conducting a preliminary investigation that asked “what are the intended and unintended impacts and consequences of tobacco control policy, tobacco taxation policy, and legislation on Aboriginal men and women in British Columbia?” Given the complexities of the issue, and limitations of time and resources, this was considered phase 1 of what could potentially be a multiphase project. This first phase proposed to assist in defining the need for and scope of future research efforts by identifying information gaps and critical elements for further exploration, as well as key informants, stakeholders, and potential research collaborators.

The overriding purpose of the project in all its phases is to contribute to a body of knowledge that will assist law and policy makers to develop and assess not only relevant, effective, and ethical tobacco control strategies and policies but also ones that will ultimately reduce health inequalities that contribute to tobacco misuse in the first place. An equally important objective is that this information will assist Aboriginal people to fully participate in the processes that lead to legislative and policy developments, thereby enabling them to exert influence over and shape the policy decisions that can ultimately produce solutions to achieve health equity.

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This project incorporates both an Aboriginal and a gender perspective.

This collaborative project signals the importance of exploring the differential needs, concerns, and consequences of tobacco control policy in order to make it more relevant and appropriate to both Aboriginal men and women in British Columbia. It builds on the knowledge and wisdom of Aboriginal people and on what was learned from the BC Aboriginal Tobacco Strategy Compliance Education Projects implemented under the auspices of the BC Ministry of Health Planning, 1999-2001 (personal communication with D. Schwartz, special advisor for Aboriginal Health, BC Ministry of Health Planning, 4 February 2003), as well as the expertise of the BCCEWH with respect to health research and gender-based policy analysis. As such, the project incorporates both an Aboriginal and a gender perspective.

By examining the issues through an Aboriginal lens, we recognize the social, political, and economic realities of Aboriginal men and women and incorporate these, as well as the unique cultural and spiritual values of First Nations and Aboriginal communities into our analysis. The gender lens adds another important dimension, allowing exploration of tobacco use and the impacts of regulatory policy within the context of Aboriginal men and women's lives.

Gender-based policy analysis

Gender-based analysis (GBA) is a process that assesses the differential impact of proposed and/or existing policies, programs, and legislation on women and men. In 1995, the federal government adopted a policy that requires federal departments and agencies to conduct GBA of future policies and legislation so that they will have intended and equitable results for women and men. According to the Status of Women Canada "Gender-based Analysis: A Guide for Policy-Making" (1998), gender-based analysis:

makes it possible for policy to be undertaken with an appreciation of gender differences, of the nature of relationships between women and men and of their different social realities, life expectations, and economic circumstances. It is a tool for understanding social processes and for responding with informed and equitable options. It compares how and why women and men are affected by policy issues ... The potentially differential effects of policies, programs and legislation on women or men can often be masked or obscured. When gender is explicitly considered in policy analysis, these effects are revealed, and previously hidden implications come to light. (p. 3)

In spite of the fact that the federal government and (some) provinces have adopted GBA as a policy tool, there are problems in both its application and understanding. Grant (2002) notes that GBA appears not to be applied in any

systematic way, and that in spite of the federal government directive, most policies have been developed without serious consideration of how women and men will be differently affected. Further, she observes that the purpose of GBA is often misunderstood: “too often it is assumed that GBA addresses women’s issues only. The whole point of GBA is to identify if and how programs and policies affect women and men similarly or differently – it is a question to be answered” (p. 16).

It is precisely this question that this report seeks to address with respect to tobacco policy and legislation. This project proposes to build on the foundational work made explicit in “Filtered Policy: Women and Tobacco in Canada” (Greaves & Barr, 2000) – a document that assesses the gendered differences in tobacco use in Canada and the potential impacts of regulatory legislation and policy on women and men. In keeping with the direction of “Filtered Policy,” three issues are analyzed, all of them critical to understanding the gendered effects of policy: income adequacy, childcare responsibilities, and the nature of women’s work.

Cultural context

While this report consistently uses the term “Aboriginal people” to refer to the descendants of the first inhabitants of North America, it also acknowledges and appreciates that Aboriginal people are a culturally diverse group. The Canadian constitution recognizes three groups of Aboriginal people – Indians, Métis people, and Inuit. These are three separate peoples with unique heritages, languages, cultural practices, and spiritual beliefs (INAC, 2002). In addition to being culturally and linguistically diverse, Aboriginal people are also geographically dispersed and experience differing social and economic realities.

Similarly, because Aboriginal women are not a single, monolithic entity, “effective research practices call for the disaggregation of each sub-population of Aboriginal women, to permit a more nuanced understanding of their similarities and differences” (Dion Stout & Kipling, 1998, p. 14). Dion Stout and Kipling raise an important issue with respect to the degree to which “homogenization” of Aboriginal women characterizes past policy work. They point out that this practice has “led to recommendations and implementation of policies which, while appropriate to status Indian women living off-reserve, have no relevance whatsoever for Inuit women or Indian women living on-reserve” (p. 14).

Therefore, it is vital that policy development, assessment, and future research endeavours ensure that these similarities and differences are respected and incorporated.

Traditional tobacco use

Tobacco, considered a sacred plant by North American tribes, has been used in rituals, ceremonies, and prayers for thousands of years. *Nicotiana rustica*, the tobacco plant grown by Aboriginal peoples, was a cherished gift from the earth and not a commodity to be traded. Many (but not all) tribes in British Columbia and the Métis had an ancient/traditional relationship with tobacco, although the same was probably not true for Aboriginal peoples in the far North, or the Inuit.

Accounts of tobacco use among First Nations people in Canada cannot be easily extrapolated to Aboriginal peoples in the NWT. It was never cultivated here, and it is uncertain whether ceremonial tobacco use was an indigenous practice, or whether it became such after contact with non-Aboriginal traders ... In Nunavut, Inuit have not traditionally held tobacco as a sacred substance although there are conflicting reports of spiritual use of tobacco among some groups. (Workers' Compensation Board of the NWT and Nunavut, 2003, p. 4)

The tobacco introduced by the Europeans – *Nicotiana tabacum* – was considered non-sacred and was used for recreational and trading purposes. European trading companies used both tobacco and alcohol to induce trade with Aboriginal people (Reading, 1996).

Traditional teachings about tobacco were never lost, and today, Aboriginal people continue to use tobacco in ceremonies and rituals and teach their children to know tobacco as a sacred plant and medicine (BC Ministry of Health and Ministry Responsible for Seniors, 2001). However, the misuse of tobacco (defined as the non-traditional use of commercial tobacco, and characterized by smoking cigarettes, cigars, or pipes and using smokeless tobacco), is a serious and growing threat to the health of Aboriginal people. There is also speculation that the special status afforded tobacco as a sacred and medicinal substance has led to ambivalent or reluctant support for tobacco control measures among Aboriginal people (Reading, 1996).

Mortality and morbidity related to non-traditional tobacco use remain very high among Aboriginal people.

Men and women on native reserves have a 40% higher rate of stroke and a 60% higher rate of heart disease than other Canadians. Lung cancer is a major cause of death – Inuit women have among the highest rates in the world. There is also evidence that environmental tobacco smoke (ETS) contributes significantly to respiratory disease in Aboriginal children. (Canadian Paediatric Society, 1999, p. 277)

Wardman and Khan (2005), citing their 2004 publication on smoking-attributable mortality among First Nations in British Columbia, noted that tobacco use accounts for 17 to 19 percent of adult mortality among Registered Indians. These alarming statistics have prompted increased efforts at the federal and provincial government levels and among Aboriginal organizations, communities, and people to develop strategies aimed at reducing the rates of non-traditional tobacco use among Aboriginal people in Canada.

Prevalence

CANADIAN STATISTICS

In 1999, Health Canada initiated the “Canadian Tobacco Use Monitoring Survey” (CTUMS) to collect comparable data on tobacco use in Canada. Recent data from the summary of results for 2004 (Health Canada, 2005) revealed that 20 percent of the population aged 15 years and older are current smokers; approximately 22 percent of men and 17 percent of women aged 15 years and older are current smokers. The survey also confirmed that the prevalence of smoking continues to decline in Canada, from a rate of 21 percent in 2002 and 25 percent in 1999.

The decreasing trend holds true among youth aged 15 to 19 years. Among teens of this age group, 19 percent reported themselves as current smokers, down from 22 percent in 2002 and 28 percent in 1999. More teen boys (21%) than girls (18%) reported themselves as current smokers. This rate for teen girls is the lowest since monitoring began in 1965. Young adults aged 20 to 24 continue to smoke the most, but rates are also declining at 29 percent compared to rates of 31 percent in 2002 and 35 percent in 1999. British Columbia reported the lowest prevalence of smoking among Canadians aged 15 years and older at 15 percent.

ABORIGINAL STATISTICS

Due to high costs, CTUMS does not collect data in the northern regions of Canada (Communication Canada, 2002). To address this gap, and to provide a means of comparing data on tobacco use in the northern regions to that collected through CTUMS, Health Canada designated funds to conduct tobacco use surveys in the three northern territories (Northwest Territories Health and Social Services, 2004). In 2004, the NWT Bureau of Statistics completed the Northern Tobacco Use Monitoring Survey (NTUMS). The survey revealed that approximately 41 percent of residents of the NWT aged 15 years and older identified themselves as current cigarette smokers, a smoking prevalence rate two times higher than that among Canadians as a whole (NWT Bureau of Statistics, 2004). The survey further revealed that smoking prevalence among residents of the NWT is much higher among the Aboriginal population (60%) compared to the non-Aboriginal population (25%). This

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holds true for prevalence of daily smoking as well, with rates among the Aboriginal population double those of the non-Aboriginal population (40% vs. 19%) residing in the NWT.

Smoking prevalence rates were found to be highest among the NWT Aboriginal population aged 25 to 44 years (66%), somewhat lower for those in the 15-24 year age group (63%), and lowest among those aged 45 and over (49%). Comparatively, smoking prevalence rates among the non-Aboriginal population living in the NWT remained relatively constant among all age groups (24%, 25%, and 26% respectively).

An important source for data pertaining to smoking among First Nations and the Inuit in Labrador comes from the “First Nations and Inuit Regional Health Survey” (FNIRHS) conducted in 1997. This survey, which reported results for those aged 15 years and over, identified prevalence rates of 62 percent among First Nations adult smokers and 72 percent for the Inuit (Reading, 1999). Smoking rates for the youngest adult age group (20-24 years) are up to 72 percent. The survey also revealed that smoking begins as early as 6 to 8 years, and rapidly increases by the age of 11 and 12 years.

When compared to data from the earlier 1991 “Aboriginal Peoples Survey” (APS) which identified rates of 57 percent in the adult Aboriginal population, the rates appear to be increasing, although sampling problems could account for the increase (Reading, 1999). If rates are increasing among the Aboriginal population, they are in sharp contrast to decreasing prevalence rates among the general population. Unfortunately, more recent data are not yet available. The “Aboriginal Peoples Survey 2001” (Statistics Canada, 2003) did not report on smoking prevalence rates among the Aboriginal population living in non-reserve areas across Canada, although these data may be discussed in subsequent releases.

In 1997, the BC Ministry of Health funded the Heart and Stroke Foundation of BC and the Yukon (who in turn, commissioned the Angus Reid Group) to conduct a survey on tobacco use in BC – “Tobacco Use in British Columbia 1997.” The results pertaining to Aboriginal people aged 12 and over were based on 725 randomly obtained telephone interviews. The report indicated current smoking prevalence at 45 percent among the Aboriginal population compared to 23 percent among the BC population as a whole, with virtually no difference in rates between Aboriginal male (45%) and Aboriginal female (44%) smokers (BC Ministry of Health, 1997). Prevalence rates in this survey may be lower than in the FNIRHS and APS surveys due to the inclusion of a younger age cohort.

Nevertheless, no matter what survey is referred to, smoking prevalence rates among Aboriginal people are consistently reported as at least double those for

the non-Aboriginal population. The statistics for Aboriginal people prompted Reading (1999) to observe that:

the exceedingly high and stable smoking rates would not be expected in a population that is so culturally diverse and geographically dispersed. Such a result could suggest a strong cultural identification with tobacco, a reluctance to view it as harmful to health and an association to social and economic health determinants. (p. 108)

Research has consistently shown that, in general, tobacco use is concentrated in populations characterized by poverty and limited economic and social development opportunities. It should be no surprise then, given the marginalized and oppressive conditions facing many Aboriginal people and communities, that prevalence rates for tobacco use are significantly higher than those found in the general population. It is important to note that, as in the non-Aboriginal population, smoking is much less common among Aboriginal people who are employed, who have higher incomes, and who have a university education (BCMOH, 1997). As the BC Provincial Health Officer describes it, “tobacco use seems to be a marker for the stresses that disadvantaged groups experience” (BCPHO 2002, p. 63).

Demographic, social, and economic indicators

Comprehensive data are difficult to obtain on the Aboriginal population. This is partly because there are differing concepts of “Aboriginality” based on ancestry, self-identity, and legal Indian status (BCPHO, 2002). Disaggregated data for Aboriginal women are even harder to come by and almost non-existent for some subgroups. Dion Stout and Kipling (1998) point out the simple fact that more is written about some groups than about others. They further state that:

this imbalance is the product of any number of factors, ranging from the relative accessibility of particular populations, to the political priorities of research funders. Notably, this does not alter the underlying fact that sound policy decisions cannot be made in an information vacuum. (p. 13)

The following data pertain to Aboriginal people in British Columbia, and are based primarily on the 1996 census. Unless otherwise noted, they are taken from the Provincial Health Officer’s annual report for 2001 – “The Health and Well-Being of Aboriginal People in BC” (BCPHO, 2002).

AGE

- The Aboriginal population is much younger than the BC population as a whole. Half of the Aboriginal population is less than 25 years old,

compared to one-third of the non-Aboriginal population.

FAMILIES

- The average family size of Aboriginal families on-reserve is 4.2 people and off-reserve is 3.5, compared with a family size of 3.1 for the province overall.
- Single-parent families are more common among Aboriginal families. About one-third of Aboriginal children under the age of 12 live in single-parent families, twice the rate of the general BC population. In urban areas, almost half of Aboriginal children live in a single-parent family arrangement.

PREGNANCY PATTERNS

- Aboriginal women have more children and have them earlier in life.
- Teen pregnancy rates are declining faster for Status Indian women than for other BC women, although the rates are still much higher. In 1999 teen pregnancy rates for Status Indian women were approximately 140 per 1,000 women aged 15 to 19 years compared to approximately 40 per 1,000 for other BC women in the same age bracket.

EMPLOYMENT

- Employment prospects are much worse for the Aboriginal population than for other British Columbians. The unemployment rate is 25 percent for Aboriginal people and this figure does not include those who are no longer actively looking for a job.

OCCUPATIONS

- Aboriginal people are often employed in lower paying or more hazardous jobs, typically in primary industries (men) or service jobs (women).
- About three-quarters of Aboriginal women work in three occupations groups: sales and service, clerical and secretarial, and social science and education.

INCOME

- Aboriginal people with paid employment earn substantially less than the provincial average.
- In 1996, Aboriginal men working full-time earned an average of \$35,384, about 79 percent of what non-Aboriginal men earned (\$44,947).
- Aboriginal women earned 83 percent of what non-Aboriginal women earned.
- 41 percent of Aboriginal children live in families with incomes under \$20,000, compared to 17 percent for other BC children.

EDUCATION

- Although improving, the Aboriginal population – especially those living on-reserve – has levels of formal education that are below the provincial average.
- On average, the Aboriginal population has levels of employment, income, and educational attainment that are about 80 percent of those of other British Columbians.

VIOLENCE AND ABUSE

- About one in three Aboriginal women report being abused by their partners, compared to about one in eight for other Canadian women.

CRIME

- In Saskatchewan, Aboriginal people are more likely to be victims of crime, and more involved in the criminal justice system; about 26 percent of Aboriginal accused are women, compared to 16 percent of non-Aboriginal accused.
- In BC, Aboriginal youth have rates of institutionalization that are three to five times higher than for non-Aboriginal youth.

HOUSING

- 44 percent of on-reserve housing units are in substandard condition, and three-quarters of Aboriginal lone-parent households in Vancouver are considered to be in “core housing need.”
- The need for adequate, affordable housing may be the most pressing environmental health issue facing Aboriginal people in BC today.

HEALTH STATUS

- Although the health status of Aboriginal people is improving, traditional health status measures indicate that Aboriginal people continue to have a level of health that is below that of the general population.
- Status Indians in BC can expect to live 7.5 years less than other British Columbians. For almost every cause of death, Status Indians die at higher rates and younger ages. HIV/AIDS and alcohol-related deaths show a worsening trend.
- National surveys have found that chronic conditions such as heart disease, diabetes, and arthritis are more common among Aboriginal people.
- Tjepkema (2002) points to the fact that some diseases that were previously rare in Aboriginal communities have become more common over the past several decades. “It is thought that these ‘new’ diseases, such as diabetes and cardiovascular disease, can be attributed to the rapid social, dietary

and lifestyle changes experienced by some Aboriginal communities over this period” (p. 10).

The BC Provincial Health Officer, noting that most of the available health statistics on Aboriginal people relate to Registered Indians or those who live on reserves, identified the critical need for accurate, region-specific data about the health problems that Aboriginal people experience, including Non-Status First Nations, Métis, and Aboriginal people living in urban areas.

The above statistics are not meant to draw a complete picture of the economic, social, and (broadly defined) health conditions of BC Aboriginal people. Rather, given that a broad range of social and economic factors determines health, they are presented as examples of many of the forces that promote and sustain smoking behaviour. They also illustrate the need for a comprehensive strategy that not only addresses tobacco reduction but that also reduces health inequities across the board.

The need for this project emerged during the development of the Aboriginal Tobacco Strategy in BC. This strategy was largely informed by the experience acquired through the implementation of community-based initiatives designed to reduce the non-traditional use of tobacco (1999-2001). Throughout these initiatives, and in particular, the Compliance Education Projects, participants found many unanswered questions regarding the exact nature of the non-traditional use of tobacco among Aboriginal people in this province. In particular, we identified information gaps pertaining to tobacco sales, distribution, legislation, taxation, enforcement, and environmental tobacco smoke (ETS). Areas/issues that required clarification and/or further exploration and analysis included the current situation with respect (but not exclusive) to:

Access, sale, and supply of tobacco products

- Where do Aboriginal people buy tobacco?
- Youth access to tobacco – some young people sell their parents' cigarettes at school. How important is this type of revenue generation?
- Quotas and permits system (Exempt Sales by Retail Dealers – ESRDs) – how many permits are issued? How is the quota calculated? What is the process?
- Vendors – who are they and how do they get the tobacco? Bands are vendors sometimes.
- Enforcement practices – what is the role and practice of tobacco enforcement officers (TEOs) on reserves?
- How prevalent are smuggling and “smoke runners” (see glossary) and what is the impact of criminalization?
- Regulatory acts and legislation — what are they and what do they do?

Taxation and pricing

- What are the taxes? How do they break down?
- What are the effects of increases in pricing? An accepted public health approach is to increase price, leading to decreased consumption – increased taxation on reserves has been suggested. What evidence is there to show that increased taxes/prices lead to decreased consumption in Aboriginal communities?
- What are the taxation implications? What are the jurisdictional issues? Will self-government and community control of taxation change the situation? How?

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Participants found many unanswered questions regarding non-traditional use of tobacco among Aboriginal people.

Environmental Tobacco Smoke (ETS) and smoke-free policies

- Smoking policies on reserves – who has policies? Are they informal or written policies and how were they developed? Are they effective? Where do they apply (council meeting rooms, reception areas, private work areas, schools, bingo halls, etc.)?
- ETS in the home – who is affected? What is the impact of small houses and/or extreme climate? What impact do issues such as power and control around the home have on smoking behaviour?
- What approaches have been used in communities outside British Columbia and Canada? How effective are they (i.e., best practices)?

Gender issues

- How does policy differentially impact women and men with respect to the issues described here, and in the context of
 - Childcare responsibilities (amount, sole motherhood, female relatives assisting) and pregnancy?
 - The gendered nature of work – occupations, community roles (governance and leadership)?
 - Income adequacy – employment rates, income, control of family income?
- Gender and culture – how does the community view tobacco use? How does the community regard tobacco control (response to government control, response to treaty issues on taxation)? How does the culture affect the gendered aspects of tobacco use and responses to tobacco policy?

These questions and issues, most of which require further investigation and analysis, are related in one way or another to developing a fuller and critical understanding of the effectiveness and impacts of tobacco control regulatory and policy measures; together, they form the nexus of this research. We anticipate that additional research, utilizing holistic methods and gender-based approaches, will uncover further underlying issues.

Our multimethod approach included:

Literature scan

Computerized searches of various electronic databases were conducted, as well as comprehensive internet searches. The literature scan revealed a serious lack of both qualitative and quantitative data with respect to Aboriginal tobacco use specifically, and health issues in general. Reading (1999) refers to this as a lack of “health intelligence information” and cites examples where this gap has been noted in various reports and commissions. For example, he notes that the 1991 British Columbia Royal Commission on Health Care and Costs stated that:

lack of access to properly integrated health and social services is an additional contributor to poor health. However, the current information on Native health and the conditions which affect it are not adequate for planning and policy purposes. (Reading, 1999, p. 93)

In their report called “Filtered Policy,” Greaves and Barr (2000) identified “data gaps which need to be filled in order to inform the research and policy decision-making process” (p. 47), leading them to recommend the improvement of data collection and survey techniques to establish accurate sex-disaggregated (smoking) prevalence rates among the Inuit, First Nations, and Métis.

Dion Stout and Kipling, in their paper entitled “Aboriginal Women in Canada: Strategic Research Directions for Policy Development,” also noted that scant attention has been paid to Aboriginal women’s issues and concerns, and that the existing literature is characterized by several serious flaws (1998, p. 6).

These include:

- A limited set of issues are addressed. Despite the heterogeneous nature of the problems and challenges facing Canadian Aboriginal women, the literature continues to be dominated by an extremely limited range of issues.
- Some groups of Aboriginal women are ignored. At the same time as Inuit women and Registered Indian women living on reserve attract substantial research attention, others, including Métis women, Non-Status Indian women, and Aboriginal women with disabilities, remain seriously under-represented within the existing research literature.
- A narrow focus. Although much of the work undertaken on Aboriginal women makes some reference to the complex and multifaceted nature of the problems currently facing this population, little effort is made to follow up with analyses that transcend the narrow boundaries of the problem at

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**Scant attention
has been paid to
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issues and concerns.**

hand. There is a widespread tendency in the literature to eschew holistic approaches in favour of ones that consider only one policy field at a time.

- A singular, negative orientation. With surprisingly few exceptions, work dealing with Aboriginal women has tended to be highly problem-focused, and has pathologized the agency and realities of these women. This in turn has allowed little room for an understanding of the real complexities at work and has provided little insight into the strategies that are actually effective.

Dion Stout and Kipling further point out the need for longitudinal data for all relevant program and policy areas in order to make sound policy decisions concerning Aboriginal women's health and involvement in economic activities.

The literature scan also revealed how little is known about the potential consequences/impacts of tobacco control legislation and policy on Aboriginal people, and points to the need for further, systematic research into this complex area.

It is evident that both primary research and secondary analyses are needed. While this glaring knowledge gap presents challenges to research efforts in the immediate future, it also underscores the importance and urgency of undertaking initiatives such as those proposed for subsequent phases of this project.

Advisory circle consultation

An advisory circle made up of individuals representing Aboriginal organizations, tobacco educators, and tobacco program staff from across the province met in March 2003 to review a draft project plan and provide direction on both the content and process for this and subsequent phases of the project. A list of those in attendance can be found on page iv.

Key informant interviews

Additional insights, information, and direction were gathered through informal interviews with key individuals from tobacco control programs and Aboriginal organizations. See page iv for a list of the people who were interviewed.

Currently, four tobacco control strategies (two federal and two provincial) have bearing on reducing tobacco use among British Columbians. Two of these, the federal tobacco control strategy and the provincial BC tobacco strategy, are directed toward the general population. The other two, the First Nations and Inuit tobacco control strategy and the BC Aboriginal tobacco strategy, are targeted specifically to Aboriginal people.

The Tobacco Control Strategy (Federal)

The federal tobacco control strategy, launched in 2001, aims to reduce disease and death associated with tobacco use. Its four components include:

- **Protection** – Ensuring smoke-free environments
- **Prevention** – Keeping youth from starting to smoke
- **Cessation** – Helping smokers to quit
- **Denormalization** – Educating Canadians about the marketing strategies and tactics of the tobacco industry and the effects of tobacco products on health so that social attitudes toward tobacco will be consistent with the hazardous, addictive nature of tobacco products (Communication Canada, 2002).

Because higher prices deter tobacco use, particularly among youth, support for increased taxation (leading to higher prices) is an additional feature of the strategy. Significant resources have been allocated to monitoring and enforcement activities, including those that address smuggling (Communication Canada, 2002).

The First Nations and Inuit Tobacco Control Strategy (Federal)

One outgrowth of the tobacco control strategy is the recently announced First Nations and Inuit tobacco control strategy that targets First Nations people living on reserves south of 60° latitude, First Nations communities north of 60° latitude, and Inuit communities (First Nations and Inuit Health Branch, January 2002). Its mission is: “to promote and support policy, program and project initiatives designed to create healthy First Nations and Inuit communities free of tobacco misuse and addiction” (p. 3).

British Columbia’s Tobacco Control Strategy (Provincial)

British Columbia’s tobacco control strategy, “Targeting Our Efforts,” falls under the mandate of the Ministry of Health. The primary objectives of the strategy are to:

- stop youth and young adults from starting to use tobacco;

- encourage and assist tobacco users to quit or reduce their use of tobacco products, focusing on the three groups with the highest rates of tobacco use; and
- protect British Columbians, particularly infants and children, from exposure to second-hand smoke.

The three groups with the highest use are young adults 20 to 24 years of age; adults 25 to 44 years of age; and Aboriginal populations (BC Ministry of Health Services, 2004).

Aboriginal Tobacco Strategy for British Columbia (Provincial)

In 2001, the BC Ministry of Health and Ministry Responsible for Seniors announced the Aboriginal Tobacco Strategy for British Columbia. This strategy “to protect and promote the health and well-being of Aboriginal people and their traditions by stopping tobacco misuse” is outlined in a document called “Honouring Our Health” (BC Ministry of Health and Ministry Responsible for Seniors, 2001). As Canada’s first Aboriginal tobacco strategy, its community-based approach is directed toward creating a social climate that discourages tobacco misuse while respecting traditional ceremonial uses of tobacco. Its purpose is to strengthen the provincial strategy by ensuring it meets the needs of Aboriginal people by including the ideas, values, and participation of Aboriginal people (BC Ministry of Health and Ministry Responsible for Seniors, 2001).

There are numerous acts and regulations at the federal and provincial levels that together form the regulatory basis of tobacco control efforts. An objective of this project was to delineate these efforts. Here is a summary of several of the principle pieces of legislation.

Tobacco Act (Canada, 1997, c.13) – Federal Legislation

The Tobacco Act regulates the manufacture, sale, labelling, and promotion of tobacco products and provides the legislative authority for various regulations and policies, including the Federal Tobacco Control Strategy. In simple terms, this act addresses such things as the sale of tobacco products to minors, where and how tobacco can be advertised, regulations for tobacco manufacturers with respect to what information must be printed on each package regarding tobacco ingredients and emissions, as well as enforcement regulations, offences, and penalties.

Tobacco Sales Act, c.451

[RSBC 1996] – Provincial Legislation

This act is concerned with protecting youth by prohibiting the retail sale of tobacco products to minors under the age of 19. Under the Tobacco Sales Act, it is illegal to sell, offer to sell, distribute, advertise, or promote the use of tobacco to minors under 19 years of age. Retailers who sell tobacco products are required to post signs indicating the dangers of tobacco and the fact that tobacco products cannot be sold to minors. Retailers are also prohibited from selling cigarettes from open packages, or selling “kiddie” packs containing fewer than 20 cigarettes

The Tobacco Reduction and Control Program (BC Ministry of Health, 2005, August) is the vehicle used to monitor compliance and enforce this act. While tobacco enforcement officers employed through the Health Authorities have the authority for monitoring and surveillance (BC Ministry of Health, 2005, July), it is not evident to what extent such monitoring takes place in First Nations communities. (Issues related to monitoring and compliance are discussed further in subsequent sections of this report, and in particular in the Appendix.)

Tobacco Tax Act, c.452 [RSBC 1996]

(Consolidated 2002, July) – Provincial Legislation

This act provides the authority to impose and collect taxes on the purchase of cigarettes, loose tobacco, cigars, and other tobacco products, and is adminis-

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tobacco control.**

tered through the Consumer Taxation Branch, Ministry of Small Business and Revenue (BC Ministry of Small Business and Revenue, no date). The act also provides the authority for allocating permits to sell tobacco products (wholesalers and retail dealers), to make exempt sales, and to investigate compliance with tax collection and remittance to the provincial government, including inspection and audit powers, assessments, offences, and penalties.

The Consumer Taxation Branch oversees compliance of this act through audits and monitoring of tobacco wholesalers' reports and sales records. Tobacco enforcement teams (TETs) also conduct routine inspections of retail outlets that sell tobacco and focus on identifying counterfeit and smuggled tobacco products. Investigations are undertaken by the police and/or the Special Investigations Section (P. Rantucci, Manager, Tobacco Tax Section, Consumer Taxation Branch, BC Ministry of Provincial Revenue , personal communication, 11 March 2003).

Each of these acts is discussed in more detail in the Appendix.

Tobacco sales on reserves

In general, Aboriginal people in Canada are required to pay taxes on the same basis as other people in Canada, except where the limited exemption under section 87 of the Indian Act applies (INAC, 2002). Section 87 states that “the personal property of an Indian or a band situated on a reserve” is tax exempt (INAC, 2002). This exemption applies only to Registered Indians (under the Indian Act) and therefore does not include Métis people, Inuit, or non-Canadian Aboriginals. Although the Nisga’a nation is no longer an Indian band (i.e., in treaty terms), members of the Nisga’a nation who are Status Indians were eligible for point-of-sale exemptions on former Nisga’a lands until June 2008. (BC Ministry of Small Business and Revenue, 2001).

To accommodate this federal legislation, British Columbia established a tobacco tax exemption program. If they are located on a reserve or on designated lands, businesses wishing to sell tax-exempt tobacco products (sometimes referred to as “Indian Cigarettes”) to Indians can apply for an Exempt Sale Retail Dealer (ESRD) permit.

The goals of this program are to deliver the exemption to those persons who qualify for it, and to protect provincial revenue by ensuring that tobacco intended for exempt sales is not available for purchase by persons who are not entitled to the exemption. (BC Ministry of Small Business and Revenue, 2004, p. 1)

The issues related to selling tobacco products (including the processes and procedures related to obtaining an ESRD permit), youth access, monitoring practices, and compliance are discussed in some detail in the Appendix (section B “Tobacco Sales on Reserves”).

Taxation, pricing, and tobacco control

An accepted public health approach to tobacco control is to increase the price of tobacco products which leads to decreased consumption – often the price increase comes about through higher taxation. As awareness and concern have grown regarding the prevalence of smoking and the resulting health effects on Aboriginal people, so has the suggestion to increase taxes on tax-exempt tobacco products sold on reserves (Wardman & Khan, 2005). However, while price increases have proven to be effective in reducing the prevalence of tobacco use in the general population, little is known about any specific or additional effects on subpopulations. In other words, there is scant evidence to show that increased taxes/price would lead to decreased preva-

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pricing.**

lence or consumption in Aboriginal communities. More research is needed to discern what, if any, potential financial and related health impacts there are to increased pricing, given the economic challenges faced by many Aboriginal smokers (Wardman & Khan, 2005), and in particular, Aboriginal women, many of whom can be counted among the poorest of the nation's poor.

Because Indian reserves are often characterized by low incomes, investments, and business activity, taxation there is generally less viable than in other communities (Fiscal Realities, n.d.). Even if price increases turn out to work in deterring smokers, the issue of further taxation is politically sensitive within First Nations communities.

Political resistance within First Nation communities stems from a philosophical opposition to taxation, a fear that developing tax authorities will lead to declines in federal transfers and the end of the statutory exemption for registered Indians, and the difficulty of selling taxation to people already suffering poverty.
(p. iv)

In 1997, the federal government passed Bill C-93 which contains provisions to allow Registered Indian communities to impose a tax similar to that imposed under a provincial tax act (Wardman & Khan, 2005). However, uptake has been slow in most communities. Although over 600 Registered Indian communities could impose this tax, only 10 collect a First Nations Tax (FNT) and one collects the provincial tax (Wardman & Khan, 2005). In BC, Section 43.1 of the Tobacco Tax Act allows for a "band tobacco tax" which refers to a tax collected on tobacco products imposed by a band bylaw. Several band councils in BC have passed bylaws and implemented a First Nations Tax (FNT), including the Westbank Band Council (1998), the Kamloops Band Council (1998), the Sliammon Band Council (1999, under the name of the Sliammon First Nation Community Improvement Fee), and the Chemainus First Nation (2000). This 7 percent tax is similar to the GST except that everyone, including those who are currently exempt, must pay the tax (Westmacott, 2001). On these reserves, implementing the FNT or similar tax has resulted in increasing the price of tobacco products as well as providing a much-needed revenue source for the bands. However, it is not yet known what the positive (decreased prevalence) or negative (financial impacts on the individual, retailers, etc.) effects have been. This would be an ideal area for further study.

Although Wardman and Khan argue that "it is reasonable to expect price increase will reduce tobacco use, particularly within a comprehensive strategy" (2005, p. 452), they acknowledge that resistance to implementing taxation within Registered Indian (RI) communities may reflect that taxation is

not a culturally appropriate strategy. “Perhaps incentives for both smokers and non-smokers are more appropriate and congruent with RI culture, which places an emphasis on self-empowerment rather than punitive action, as would be the case with tobacco taxation and smokers” (p. 452).

The overall effect of tobacco price increases on prevalence, consumption, and price elasticity on subpopulations is a matter of some debate among researchers. However, evidence in Canada and the United Kingdom shows that tax hikes may have little effect on consumption for a number of smokers in the lower income groups (Greaves & Barr, 2000). As smoking continues to be concentrated among the poor and marginalized populations in spite of price increases, it is probable that for many in this group, higher prices simply lead to increased expenditures on cigarettes rather than reduced consumption. While Greaves and Barr note that the differentiated impact of taxation and pricing on women is not yet fully understood, they point out that, given the disproportionate number of women among the poor, “the impact of taxation increases is inevitably gendered. Low-income women will tend to spend a disproportionately large share of their income on cigarettes. Smoking not only harms health – it also reduces the economic resources available to women smokers and their families” (p. 44).

Greaves and Barr further note that although many women want to quit smoking, the stresses associated with the daily struggle to survive conspire against their efforts, particularly for low-income women. If they are unable to quit, and more of their income goes into purchasing cigarettes, their ability to provide the essentials such as food, clothing, and other basics is diminished. In addition to the more obvious direct impacts on health (e.g., poorer nutrition), this in turn weakens women’s feelings of optimism, which are considered an important psychological influence on the ability to quit smoking. A vicious circle emerges when increased pessimism further discourages cessation and “the economic cost of smoking deepens hardship” (p. 44).

The advisory circle to this project provided examples that indicate some of the less obvious impacts of increased pricing of tobacco products. One member shared the story of an elderly Inuit woman’s loss of dignity as she was forced to search for discarded cigarettes butts to smoke because she could no longer afford to purchase tobacco. Another member had observed how people in her community were increasingly smoking their cigarettes right down to the filter, thereby concentrating the intake of tar and other toxins. There are no doubt other, subtler ways that increased prices do and will affect Aboriginal women and men. How these factors interplay and are experienced in their daily lives and the resulting health, social, and economic consequences can only be surmised in the absence of comprehensive, gender-based, quantitative and qualitative research.

Greaves and Barr (2000) contend that ethically, “the consequences of increased taxation and the gendered and class-related effects of price increases must be factored into the policy development process and ameliorated using other means” (p. 45). Their suggestions for amelioration include free cessation programming and therapies for low-income people. They also recommend, at a systems level, using captured tobacco tax to directly fund targeted health promotion initiatives. However, appropriate means for Aboriginal people may be different, and can be discerned only through research initiatives that involve their active participation at the community level and that consider the differing social, economic, and health experiences of men and women.

Self-government and community control of taxation among First Nations will create new fiscal relationships with the governments of Canada and British Columbia and with their own citizens. How will the drive to collect much-needed tax revenues, including those derived from tobacco products, influence efforts to reduce tobacco use? How would the imposition of increased taxation affect the overall socioeconomic situation of band members? Will taxation revenues generate new opportunities to positively address the broader social and economic forces that support and sustain smoking behaviour?

As more First Nations enter into treaty negotiations, it would be extremely timely and useful to have a more comprehensive understanding of both the positive and negative implications of tobacco taxation. A thorough delineation and analysis of the impacts of taxation policy (such as that proposed in subsequent phases of this project) would assist in ensuring that if taxation is deemed to be an effective tobacco control strategy, then the necessary policies and programs that mitigate its negative impacts have to be developed.

From a public health perspective, second-hand (or environmental tobacco) smoke is the most important indoor air pollutant in BC today (BC Provincial Health Officer, 2002). According to the Provincial Health Officer, ETS is a major contributor to the higher rate of respiratory illness in the Aboriginal population.

Irritation from exposure to ETS

The 1997 "Tobacco Use in BC" survey found that 68 percent of Aboriginal non-smokers reported that they are usually physically irritated (eyes, breathing, or throat) by tobacco smoke. Forty-six percent of Aboriginal smokers also reported physical irritation. Both Aboriginal smokers and non-smokers were generally more likely than were non-Aboriginal residents of the province to report irritation (BC Ministry of Health, 1997).

TABLE 7.1 PERCENTAGE OF NON-SMOKING POPULATION AGED 12+, REPORTING PHYSICAL IRRITATION FROM ETS, BY AGE AND GENDER, BRITISH COLUMBIA, 1997

		Aboriginal	BC
Gender	All	68%	63%
	Male	61%	58%
	Female	74%	67%
Age	12-18 yrs**	57%	55%
	19-24 yrs**	75%	68%
	25-44 yrs	67%	67%
	45-64 yrs*	69%	65%
	65+ yrs**	68%	51%

Source: *Tobacco Use in British Columbia*, 1997. BC Ministry of Health.

* Interpret with caution, subsample base size less than 100.

** Interpret with caution, subsample base size less than 50.

Gender differences are evident with 61 percent of Aboriginal males versus 74 percent of Aboriginal females indicating they are usually irritated by ETS.

Exposure to ETS

Although little is known about the precise levels of ETS in Aboriginal homes and communities, the "Tobacco Use in BC" survey found higher rates of ETS exposure among the non-smoking Aboriginal population than among the non-smoking population of the province as a whole (BC Ministry of Health, 1997).

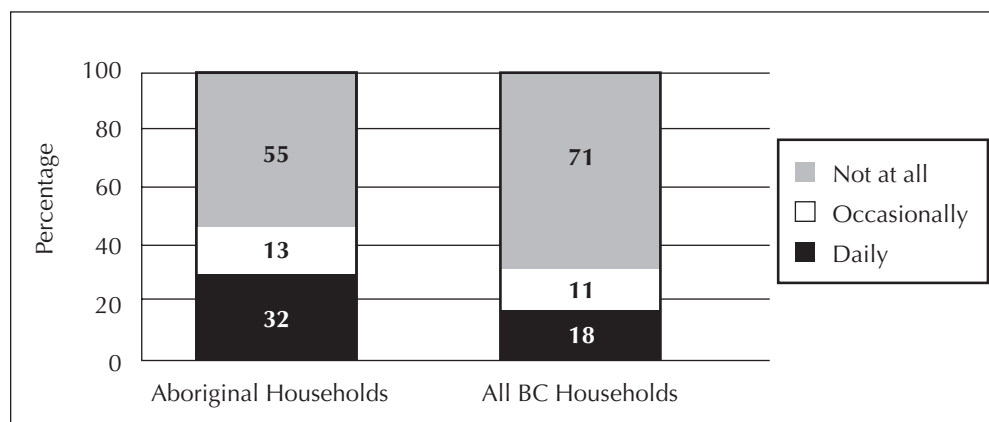
Table 7.2 displays the proportion of non-smoking residents who have daily or nearly daily exposure to ETS at home, at work or school, and in other public settings. It indicates that 36 percent of Aboriginals who do not currently smoke are exposed to ETS daily or nearly daily in at least one of these three different types of settings. This proportion is twice that observed for non-smoking residents of the province (18%). Moreover, ETS exposure for the non-smoking Aboriginal population in the home environment (20%) is nearly triple that of the non-smoking population of the province as a whole (7%) (BC Ministry of Health, 1997).

TABLE 7.2 PERCENTAGE OF NON-SMOKING POPULATION AGED 12+, EXPOSED TO ETS EVERY DAY OR NEARLY EVERY DAY, BRITISH COLUMBIA, 1997

	Aboriginal	BC
At home	20%	7%
At work/school	16%	9%
Other indoor settings	12%	6%
Any of the above	36%	18%

Source: *Tobacco Use in British Columbia*, 1997. BC Ministry of Health.

While the 1997 survey provides general information regarding ETS exposure among Aboriginal people, it should be noted that the survey included only those with telephones and it made no distinction between Status/Non-Status, reserve/off-reserve, Métis, or Inuit people. When we acknowledge that the Aboriginal community is not homogeneous in nature, it's reasonable to expect that ETS exposure rates could vary significantly depending on community, social, and economic factors. The existence of smoke-free policies in public buildings and workplaces would also affect overall ETS exposure considerably.

FIGURE 7.1 EXPOSURE TO SECOND-HAND SMOKE, HOUSEHOLDS WITH CHILDREN AGE 11 AND UNDER, BRITISH COLUMBIA, 1997

Source: *Tobacco Use in British Columbia, 1997*. BCMOH and Heart and Stroke Foundation of BC & Yukon.

TABLE 7.3 PERCENT OF NON-SMOKERS, AGED 12+, WITH ETS-FREE HOUSEHOLDS BY GENDER, INCOME ADEQUACY, EDUCATION, AND LABOUR FORCE STATUS

		Aboriginal	BC
Gender	Male	60%	83%
	Female	66%	83%
Income Adequacy	*Lower	61%	78%
	Middle	62%	81%
	Higher	67%	86%
Education	Some or < high school	46%	73%
	Completed HS &/or some post-secondary	71%	83%
	**Completed technical/community college	66%	84%
	*Completed university	75%	91%
Labour Force Status	Working full or part-time	65%	84%
	**Looking for/unable to work	52%	72%
	*Student	41%	73%
	**Retired	81%	87%
	**Keeping house	78%	88%

Source: *Tobacco Use in British Columbia, 1997*. BC Ministry of Health.

* Interpret with caution, subsample base size less than 100.

** Interpret with caution, subsample base size less than 50.

Exposure to ETS in the home

Exposure to ETS in Aboriginal population households with children aged 11 and under is highlighted in Figure 7.1. In 32 percent of these households, there is daily or nearly daily exposure to ETS, almost double that of households in the BC population as a whole (18%). Encouragingly, there is no

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Gender and economic issues are rarely considered in strategies to address ETS.

exposure whatsoever in 55 percent of Aboriginal households with children 11 years and under, although this is substantially lower than in BC households as a whole (72%).

Table 7.3 depicts selected findings (gender, income adequacy, education, and labour force status) pertaining to ETS-free households. A gender difference is noted with respect to Aboriginal households in that a higher percentage of non-smoking females (66%) report ETS-free households than non-smoking males (60%). No gender difference was reported among the non-smoking BC population as a whole. As with smoking prevalence rates, exposure to ETS among the non-smoking Aboriginal population declines as income adequacy and education increases.

Children are particularly vulnerable to the effects of ETS and much of the literature, as well as public education efforts, are (for good reason) concerned with protecting them. Many education and health promotion efforts are directed at getting parents to quit smoking in order to protect their children. For example, tobacco package warnings display messages that warn parents how second-hand smoke will harm their children. Specific efforts are targeted to women with respect to maternal health and protecting the fetus from the effects of smoking, both through health warnings on tobacco packages (e.g., “smoking during pregnancy can harm your baby”) and through education programs. Community health representatives are addressing these concerns head-on by offering education programs on reserves (M. Horn, executive director, National Indian & Inuit Community Health Representatives Organization [NIICHO], personal communication, 2 April 2003).

In their document called “Filtered Policy,” Greaves and Barr (2000) discuss the ways in which gender is an important consideration when it comes to warnings about ETS. First, on average, mothers spend more time with children than do fathers, and consequently, messages aimed at reducing children’s exposure to ETS have a primary impact on women. Given the high prevalence of female lone parents in the Aboriginal community, this would hold true for Aboriginal women, as well. Second, a clear relationship has been established between socioeconomic status and ETS exposure. Greaves and Barr cite Physicians for a Smoke-Free Canada, who reported that, among Canadian children under the age of 12, ETS exposure is highest in disadvantaged households and lowest for children living with both parents in upper income families. Table 7.3 indicates that among the Aboriginal population, the percentage of smoke-free homes increases with higher levels of income and education. Many low-income households in Canada are headed by lone-parent women, as is the case in the Aboriginal population.

However, because gender and economic issues are rarely considered in strategies to address ETS, the issue is often oversimplified and strategies typically

place sole responsibility on the parents (usually women) to rectify the situation. Greaves and Barr argue that:

rather than assisting parents with the struggle to raise children in poverty, this view blames parents (mostly mothers) for harming their children, and assumes parents are doing so because they lack the will or intelligence to know any better. In fact, the knowledge of the health risks of ETS is fairly widespread.
(p. 38)

Greaves and Barr also note that many of the anti-ETS messages imply that smoking cessation is something that a woman should do for the benefit of others, not herself. The message is that women are important only insofar as they are “vessels” or caregivers, which further runs the risk of increasing the guilt that smoking mothers feel. “When parents are told to ‘protect’ their children from ETS exposure, they are receiving the message that they are bad parents if they smoke in front of their kids” (p. 38). The effect of these guilt-producing messages may actually be counterproductive by increasing the stress that many women, particularly those who are low-income, already experience in the course of their daily lives, thereby perpetuating women’s smoking as a response to stress. They also point out that, in some situations, women’s smoking around children has been framed as a custody, neglect, and abuse issue.

Greaves and Barr suggest that message campaigns should take a more holistic, supportive, and non-blaming approach that addresses the meanings of smoking for women and considers the social determinants that influence smoking. “Honouring Our Health” (BC Ministry of Health & Ministry Responsible for Seniors, 2001) strongly suggests, and members of the advisory circle to this project unanimously agreed, that messages should be positive and reflect the strengths and values of Aboriginal culture and communities.

ETS exposure in the home is further influenced by interpersonal and power dynamics between men and women, and “generally it cannot be assumed that women will have control over family air space, particularly if the male partner is the smoker” (Greaves & Barr, 2000). While little is published in this regard specifically pertaining to Aboriginal women, there are several related issues from which inferences can be drawn. The following examples offer insight into the power imbalances in the home environment that some Aboriginal women may face, influencing their ability to control or live in a smoke-free environment.

As far as violence and abuse are concerned, the precise extent of the problem is not known. However, we *do* know that a significant proportion of *all* women in Canada report victimization in this way. Estimates of the number of Aboriginal women who are victims of violence and abuse range from 30 to

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**Not having space of
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80 percent (Dion Stout & Kipling, 1998). "Given the central role played by Aboriginal women in the lives of their families, it is both ironic and tragic that so many are the victims of sexual, physical, and emotional abuse at the hands of their husbands, boyfriends and male relatives" (p. 27). The threat of violence or abuse makes it more unlikely that the woman in the relationship would insist on a smoke-free environment if the male partner smokes or chooses to allow smoking by others in the home.

The second issue relates to the lack of housing on many reserves and the lack of affordable housing in many urban communities. Both of these situations result in Aboriginal women and their children having to share accommodation with relatives or friends. Not having space of their own effectively means having less control over the environment.

The third issue is in relation to the issue of "matrimonial real property" on reserve. Aboriginal women living on reserves are not afforded the same right as women living off reserves to an equal share of matrimonial property at the time of marriage breakdown – this is just one example of many gender biases manifest in the historical legacy of the Indian Act. The final report of the Aboriginal justice inquiry of Manitoba stated:

there is no equal division of property upon marriage breakdown recognized under the Indian Act. This has to be rectified. While we recognize that amending the Indian Act is not a high priority for either the federal government or the Aboriginal leadership of Canada, we do believe that this matter warrants immediate attention. The Act's failure to deal fairly and equitably with Aboriginal women is not only quite probably unconstitutional, but also appears to encourage administrative discrimination in the provision of housing and other services to Aboriginal women by the Department of Indian Affairs and local governments. (Cornet and Lendor, 2002, p. 8)

The fact that Aboriginal women have no right to the matrimonial home when marriage breaks down, coupled with administrative discrimination in the provision of housing (as noted here) and the shortage of housing in general, limits Aboriginal women's choices about where to live. This is an issue of no small consequence and exerts pressure on a woman in several ways. She may tolerate behaviour (such as smoking in the home) that she would not otherwise put up with in order to keep a roof over her head. Also, from what we know regarding the relationship between smoking and stress, the anxiety and stress associated with being able to provide for herself and her children may serve to perpetuate a woman's smoking behaviour or interfere with any attempts to quit.

ETS in the workplace

In BC, workers are protected from the effects of ETS in the workplace by occupational health and safety regulations under the authority of the *Workers' Compensation Act*. Essentially, these regulations stipulate that an employer must protect workers at any workplace from exposure to ETS by either prohibiting smoking in the workplace or restricting smoking to designated smoking areas such as a safe outdoor location or a designated smoking room (Workers' Compensation Board BC [WCBBC] 2003). Many municipalities in BC have developed even more stringent restrictions that have a 100 percent prohibition on smoking in public places.

During the course of this research, the question arose as to why bands would have to consider developing ETS policies. It turns out that the regulatory side of the provincial *Workers' Compensation Act* does not apply to band-controlled workplaces or worksites. This would include places like the band offices, health centres, band-run schools, stores, etc. The act does apply to private workplaces that operate on reserve lands and to band members who have their own businesses and employ others – as long as the nature of the activity is not on behalf of the band. However, any venue that is “staffed” exclusively by volunteers, such as a bingo hall, is also not covered by the act (P. Newman, WCB Manager, S. Vancouver Island, personal communication, 15 August 2003).

As on-reserve Aboriginal women are employed to a large extent by the band, and are concentrated in low-level and service occupations generally characterized by little control or input into working conditions, ETS exposure in the workplace and policy development to address it are areas of prime concern. (This is discussed in chapter 9.)

Smoke-free policies

Reading (1999) noted that among respondents in the First Nations and Inuit Regional Health Survey (FNIRHS), only one third were aware of smoking controls within their community. Further, only one in eight respondents thought that the controls were effective. Reading concluded that Aboriginal communities need to establish smoking controls for public areas, and to develop enforcement regulations. We still do not know the extent to which First Nations communities in BC have instituted smoke-free policies or controls. For communities that have, their information describing policy content, developmental and implementation processes, community acceptance and compliance, and evaluation measures, would be extremely useful to share – to both motivate and support effective policy development in other communities.

It is likely that some Aboriginal communities have either formal or informal ETS policies. One advisory circle member noted that her band had gone

“smoke-free” with respect to band offices and other public buildings. However, to what extent this is the case among bands in the province is not known. Again, this would be an ideal area for further study (and could include identifying the existence of tobacco policy beyond that pertaining to ETS). An undertaking of this sort would likely require the cooperation of the political leadership to legitimate the process and band resources to identify and collect both formal and informal policy. Arrangements would have to be made with other Aboriginal organizations to gather policy from non-reserve settings (e.g., friendship centres).

The published literature reveals little substantial information regarding tobacco control policies in Aboriginal communities. In general, when policy is mentioned it is primarily in the context of ETS and few details are discussed. However, Lichtenstein and colleagues (1995) reported on one study that had some interesting findings that are potentially applicable to Canada regarding the policy development process. The study involved 39 Northwest Indian tribes in the United States and was directed toward developing and evaluating the effectiveness of a culturally sensitive consultation process designed to assist tribal councils in adopting more effective tobacco control policies (with respect to ETS). The 39 tribes were divided into two groups – a control group, called the “early intervention group” and a study group, called the “late intervention group.” The study revealed that the early intervention group, the tribes who participated in the consultation process, were more likely to develop or improve on ETS policy than those tribes who did not participate (i.e., the late intervention group).

The consultation process, which was facilitated by two Indian staff members of the Northwest Portland Area Indian Health Board, took place over approximately two years and started with a regional workshop directed toward tribal representatives. The workshop was made up of an overview of the project, a presentation on the health risks of smoking and ETS, a viewing of a video, and an introduction to the “Tribal Tobacco Policy Workbook.” The workbook included sections on forming a tobacco policy committee, key decisions in developing a policy, how to publicize and implement a tribal policy, a sample tribal tobacco policy, and information on the health consequences of smoking and ETS. The regional meetings were followed by one or more visits to each tribe as well as telephone consultation to help with the policy-development process. The consultation process proved to have a significant impact on the development or improvement of the early intervention group’s tobacco-use policies.

The late intervention tribes participated in an initial session (where they gave consent to participate in the study) that provided an overview of the study but offered no special encouragement or assistance in the policy-development area.

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**Tobacco use is not
 seen as a high
 priority in many
 Aboriginal
 communities.**

After the study was completed and the strategy was evaluated, these tribes were subsequently offered the same assistance as the early intervention group. Although some tribes in the late intervention group did develop policies on their own over the two-year period, they did so to a significantly lesser extent and the policies were considered less stringent than those of the early intervention group. An important study finding was that a “cookie cutter” approach to policy development did not work because both the process and the resulting policies had to be tailored to meet the individual needs and circumstances of each tribe.

A similar process might prove useful in helping First Nations and Aboriginal organizations in BC to develop tobacco control policies, including those that extend beyond the parameters of ETS. Policy-development tools, such as the workbook described here, would have to include guidance on how to conduct gender-based policy analysis, thereby ensuring that the differential impacts of policy on men and women would be considered and identified.

How does the community view tobacco use?

The literature, the Compliance Education Projects, the key informants, and the advisory circle members all commented that tobacco use is not seen as a high priority, or perhaps even a serious problem, in many Aboriginal communities when compared to the other social, economic, and health issues they currently face. Smoking is considered by many as a normal part of everyday life, which is evident in the high smoking prevalence rates among Aboriginal people. Community attitudes toward smoking and its place in the “hierarchy of community needs” present significant challenges to smoking-reduction efforts.

This view toward smoking in Aboriginal communities is not unique to BC or Canada and has been noted in Aboriginal communities in other countries that share the same shameful history of oppression toward indigenous peoples, many of whom continue to be socially and economically marginalized today (Lichtenstein et al., 1996; Lindorff, 2002). For example, the final report of the Aboriginal and Torres Strait Islander study on tobacco-reduction strategies in Australia, entitled *Tobacco – Time for Action* (Lindorff, 2002), describes the widespread community acceptance of tobacco use in this way:

In the words of one respondent “smoking is incorporated into people’s lifestyles, and the forces that keep people smoking are very powerful.” It was emphasised ... that in an environment where smoking is a normal part of life, and where there is peer pressure and family acceptance of smoking, people are far more likely to take up smoking, and be less motivated to quit. The relationship of smoking with drinking and other drug used

was also noted. The importance of sharing of goods in Aboriginal and Torres Strait Islander culture was also noted, and it was commented that sharing cigarettes is felt to be part of a ritual of community and friendship. (p. 160)

This account illustrates the importance of the “powerful forces” that determine smoking behaviour and the significant cultural factors that may not be immediately obvious, particularly to those outside the community. By involving Aboriginal men and women in delineating these factors that may vary from nation to nation and community to community, tobacco control policy development must also further consider how these factors influence women and men differently in order to ensure that policy achieves its intended results in an equitable way.

Aboriginal leadership will play an important role by supporting the development of policy that’s aimed at reducing tobacco use and by encouraging and facilitating the involvement of community members in future community-based tobacco control policy endeavours. In their paper “Tobacco Use Policies and Practices in Diverse Indian Settings,” Hall and colleagues (1995) discussed the successful approach used among 39 Northwest tribes. They noted that this intervention – supporting tribal governments to develop tobacco control policy – was different from many that seek to reduce tobacco consumption at the individual level. An important finding of the research was that tribes were taking responsibility to control their social environments so that individual young people did not have to bear the entire burden of making individual health choices.

Through research efforts such as those proposed by this project, the factors that contribute to the larger social, economic, and health problems experienced by Aboriginal people and communities can be understood as the same ones that give rise to and support smoking behaviour. In this way, efforts to reduce tobacco use will not be seen in “competition” with addressing other significant social and economic inequities, but can be named, targeted, and considered part of the legitimate process to improve the overall health and well-being of Aboriginal people. Strategies and the policies that support tobacco-reduction efforts can then be comprehensive in nature, taking into consideration the interaction between various determinants of health, and how these determinants differentially influence the daily lives and experiences of Aboriginal women and men.

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Aboriginal leadership will play an important role by supporting the development of policy.

For over 25 years, since the release of the 1974 Lalonde report (*A New Perspective on the Health of Canadians*), there has been a growing recognition that health is more than simply the absence of disease. In 1986, the federal government released *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986), which expanded on the Lalonde report and drew attention to underlying prerequisites of health and illness. Influences such as social, economic, cultural, and physical circumstances and the interactions of these variables with individuals' biology and behaviour were identified as important influences on the health and well-being of the entire population.

Today, it is generally accepted that a range of factors, interacting in complex ways, determine our health. These determinants of health include income and social status, social support networks, education, employment and working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture (Health Canada, 1999a). This framework, which recognizes that social and economic forces are vital to understanding what shapes our health, takes us beyond the traditional view that health is a result of personal behaviours and/or the provision of health care services. The term "population health" describes this way of thinking and leads to the conclusion that making improvements in the health and well-being of Canadians must include action on the broad determinants of health. This conclusion is central to developing informed, comprehensive, and integrated public health and social policy.

While all of the determinants interact to influence health, income and social status are considered the most influential. As one Health Canada report finds:

there is strong and growing evidence that higher social and economic status is associated with better health. In fact, these two factors seem to be the most important determinants of health (*Population Health. What Determines Health?*)

This evidence led the Provincial Health Officer of BC to note that:

there is a close relationship between income and health. An adequate income is important for health, and, conversely, low income is associated with poor health status. Certainly, not all people with low incomes have poor health, just as not all people in well-off families have excellent health. But studies in Canada and elsewhere consistently show that, on average, people at each step on the income scale are healthier than those on the step below. (BC Provincial Health Officer, 2000, p. 26)

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**Economic and
social factors affect
individual decisions
about health.**

This framework does not negate the importance of individual responsibility for healthy behaviours, such as eating nutritiously, getting enough exercise, and avoiding excessive drinking and smoking. However, it recognizes that there are many social and economic circumstances that are often beyond individual control – circumstances that cause, contribute to, or maintain these healthy or unhealthy behaviours.

Raphael (2001) discusses the relationship between economic and social conditions, heart disease (which is found at a significantly higher rate in the Aboriginal population than among Canadians as a whole), and smoking in his report *Inequality Is Bad for Our Hearts: Why Low Income and Social Exclusion Are Major Causes of Heart Disease*. He contends that, contrary to the messages that Canadians are given about the means of preventing heart disease, income level is the greatest predictor of incidence. His report concludes that poverty and low income lead to heart disease in the following ways:

- People on low incomes live under conditions of material deprivation that produce a cardiovascular health burden that accumulates over the life span;
- Living on a low income creates excessive psychosocial stress that damages the cardiovascular system;
- The stressful conditions associated with low income lead to the adoption of health-threatening behaviours such as tobacco use.

Raphael concludes that while the majority of heart-health initiatives focus on increasing physical activity, promoting healthy eating, and decreasing tobacco use – all of them important objectives – this type of approach does not deal with the whole picture. He argues that “health professionals, policy and decision makers, and community networks must begin to acknowledge and address fundamental risks factors such as poverty, social exclusion and the growing economic gap, in order to decrease cardiovascular disease and improve the health of our communities” (p. vii).

Heart disease is only one of many diseases and/or causes of death that are more common among the disadvantaged. Disadvantage comes in many forms, such as not having enough food to eat, having a poor education, unemployment and job insecurity, living in substandard housing, or trying to raise a family in difficult circumstances. The effects of disadvantage on health are cumulative: the longer people live in stressful economic and social circumstances, the greater the physiologic wear and tear they suffer (World Health Organization, 1998). Economic and social factors obviously affect individual decisions about health.

With respect to Aboriginal health, the Federal, Provincial and Territorial Advisory Committee on Population Health stated that “failure to address inequities in the health and socioeconomic status of Aboriginal people will inevitably lead to continuing disparities and to increase in illness, suffering and early deaths for this population” (1999, p. 31). Because policy plays an important role in shaping the social and economic lives of Canadians, it is therefore essential that, at the very least, policy (including tobacco policy) at all levels does not contribute to health inequalities, though it should ultimately be geared toward eliminating them altogether.

While policy makers and academic researchers have known for some time the problems in Aboriginal communities (e.g., economic marginalization and the poor health status of Aboriginal people), and have made recommendations about how these problems might be addressed, the recommendations have not gone far enough. As Dion Stout and Kipling (1998) point out:

leaving aside the fact that many of the recommendations were ill-conceived or ill-executed, what is most noteworthy in this early work is its near complete gender blindness. In other words, if women were considered at all, they were deemed to experience marginalization the same as men, with the only exception being matters related to fertility and childbirth.
(p. 20)

This observation underscores the importance and need to undertake policy research and development within a framework that considers the differing circumstances and life realities of both women and men.

Gender is an important determinant of health that crosscuts all populations and works in concert with other social and biological determinants to affect women's health status and smoking behaviour (Greaves & Barr, 2000). By gender we refer to the array of roles, personality traits, attitudes, behaviours, values, relative power, and influence that society ascribes to the two sexes on a differential basis. Tait (2000) finds that Aboriginal women, as a group, may be doubly disadvantaged in that they face discrimination based not only on their race, but also on their gender.

There are large gaps in the literature that make it difficult to undertake an adequate gender analysis of health issues facing Aboriginal women and men. What little data are available are generally not sex disaggregated. Dion Stout and Kipling (1998) insist that this situation must be addressed if there is to be a lasting impact on the health of Aboriginal women. They argue that:

first of all, much of the research undertaken to date has focused on Inuit women and registered Indian women living on-reserve. Comparatively little work has been carried out in the area of Métis and off-reserve Indian women's health. Given that these women are among the most marginalized of all Aboriginal people, this silence is intolerable, and must be addressed through the collection of appropriate baseline data, along with the identification of policy and program measures oriented specifically toward this population. As well, there is a severe dearth of material related to Aboriginal women's health through the life-course, with the bulk of research attention directed toward infants and women of childbearing age. Only very recently has work begun to emerge which is attentive to the particular problems and issues faced by Aboriginal girls and elders. (p. 22)

Our work begins to respond to this challenge.

Gender and health

Gender has varying effects on health status. The following examples from a recent report on the health of Canadians (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999) portray just a few of the ways that these effects are made manifest in the population as a whole.

- Life expectancy is higher for women than for men. While women can expect to live approximately six years longer than men, this gap is narrowing (from 7.5 years in 1978 to 5.7 years in 1996) and may be due to a number of factors, including increased stress on women and decreased

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Much less is known regarding health status and gender differences within the Aboriginal population.

causes of premature death among men, especially heart disease and cancer.

- At the same time that deaths from cancer and heart disease are decreasing among men, deaths from heart disease and cancer are increasing among women. An alarming trend is increased smoking rates among young women. "Unless the trend toward increased smoking among young women is quickly reversed, lung cancer will increasingly become a major killer of women" (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999, p. 32).
- Men are more likely than women to die from unintentional injuries and from suicide.
- Women are more likely to be injured or die from family violence.

The interaction between sex-linked factors and gender-based factors plays an important role in determining health in Canadian men and women. Using myocardial infarction as an example, we know that women experience symptoms differently than men do (i.e., the sex-linked factor). We also know that gender-related factors affect the responses of health care professionals to men and women differently, and women may go undiagnosed because their symptoms do not mimic those of men, whose symptoms are most often used as diagnostic tools in patient assessment (Greaves, 1999).

Aboriginal people generally score lower on conventional measures of health status and, as a result, are considered to have poorer health compared to the Canadian population as a whole. While many of these disparities are documented, they are usually discussed in terms of comparing the Aboriginal population as a whole to the Canadian population as a whole. Much less is known, or at least published, regarding health status and gender differences within the Aboriginal population, and less still for the various Aboriginal sub-groups. Nevertheless, and not surprisingly, what information is available indicates that gender differences in relation to health status are evident. For example:

- Life expectancy for Status Indian women in BC is 75.0 years compared to 69.7 years for Status Indian men (BC Provincial Health Officer, 2000).
- The prevalence of all self-reported major chronic diseases is significantly higher in Aboriginal communities and appears to be increasing. First Nations and Inuit women, for example, are five times more likely to experience diabetes than other Canadian women; for First Nations and Inuit men, the rate is three times that of all Canadian men (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999).
- In the year 2000, Status Indian women in BC were more than twice as likely as Status Indian men to be prescribed a benzodiazepine such as

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**Aboriginal women's
smoking behaviour
is often discussed
in terms of
reproduction or
maternal health
issues.**

Valium or Ativan, drugs commonly used to treat anxiety, depression, or insomnia. Further, Status Indian women were more than twice as likely, and depending on age, three times more likely to be prescribed an anti-depressant than Status Indian men (BC Provincial Health Officer, 2002).

- The Aboriginal Peoples Survey 2001 (Statistics Canada, 2003) reported that Aboriginal men were somewhat more likely than Aboriginal women to rate their health as excellent or very good (59% to 54%). Young men (74%) between the ages of 15 and 24 were more likely than young women (65%) to rate their health the same way.

While the above examples offer some insight into the differences in health status between Aboriginal men and women, the lack of sex-disaggregated data seriously detracts from developing a full understanding of the effect of sex and gender on their health. A recent example of this failure to report information based on sex is illustrated in the initial release of the supporting tables to the *Aboriginal Peoples Survey 2001* (Statistics Canada, 2003). All of the tables present aggregated data. Given that it is an initial report, the final document may still offer comparative data on a sex-disaggregated basis.

Given the high smoking-prevalence rates among Aboriginal people and the long-term health consequences of smoking behaviour, it is reasonable to assume that there would be abundant literature reflecting both quantitative and qualitative research on smoking. Unfortunately, this is not the case. The literature scan and subsequent review of various reports and documents revealed that there is very little written on this subject. What does exist relies heavily on a few primary sources of data such as Reading (1999) and the 1991 *Aboriginal Peoples Survey*. While these sources make an important contribution to understanding factors and consequences associated with smoking among Aboriginal people, neither discusses these consequences in terms of sex or gender differences to any great extent, other than in the context of reproductive or maternal health, or to report prevalence rates.

Much of the research on Aboriginal women's health suffers the same flaw that is evident in research on women's health in general – the focus is often on either reproductive or maternal health only. While these are important dimensions of women's health, they are in fact, only dimensions. Similarly, Aboriginal women's smoking behaviour is often discussed in terms of reproductive or maternal health issues (e.g., smoking and low birth weight) and protecting children from the effects of ETS. Again, while these are important issues in their own right, the continual equation of women's health with reproductive health not only serves to reinforce gender stereotypes but also belies the context and complexity of women's lives and the social, economic, and political forces that influence their health.

The lack of sex-disaggregated data and/or analysis conveys the impression

that our experience of health and the factors that influence it are “gender neutral.” The following discussion of three interrelated gendered aspects of the social and economic experiences of Aboriginal men and women reveals that this is not the case. Because the determinants of health framework is helpful for understanding the complexities and patterns of tobacco use (Greaves & Barr, 2000), the following discussion is framed within that context.

Gender and income adequacy

Gender is a major factor affecting income, which is itself an important determinant of health. Income adequacy is an indicator of socioeconomic status that accounts for both household income and household size. The term *adequacy* refers to the amount of income determined to be sufficient to support the number of people in the household. “Low-income cut-offs” (LICOs), a Statistics Canada measure of income adequacy, are based upon the relative proportion of family income spent on food, clothing, and shelter, and vary according to family size and size of community. A characteristic of LICOs that bears noting is that calculations do not include families and unattached individuals living in the Territories or on Indian reserves.

There are various ways of looking at income, but no matter what unit of analysis is used, Aboriginal people have substantially less income than non-Aboriginal people. Further, on average, Aboriginal women have very low incomes. According to 1996 census data, Aboriginal women had an average income from all sources of \$13,300 – over \$6,000 less than the figure for non-Aboriginal women (\$19,350) and \$5,000 less than that for Aboriginal men (\$18,200) (Tait, 2000).

Table 9.1 illustrates how income among Aboriginal people varies considerably depending on where they live. For example, in 1996, average income for Aboriginal men living on reserve was \$13,400 compared to \$21,300 for those living in urban areas. Aboriginal women’s average income varied to a lesser

TABLE 9.1 AVERAGE INCOME OF ABORIGINAL WOMEN AND MEN, BY AREA OF RESIDENCE, 1996

	On Reserve*	Census Metropolitan Area	Other Urban	Rural
Women	11,000	14,800	14,000	13,300
Men	13,400	19,800	21,300	20,200

Source: Statistics Canada, 1996 Census of Canada. (Tait, 2000).

*Includes reserves in urban areas. Does not include an estimated 44,000 people living in 77 incompletely enumerated Indian reserves and settlements.

extent, from a low of \$11,000 for those living on reserve, to a high of \$14,800 for those living in a census metropolitan area (Tait, 2000).

A higher percentage of Aboriginal people fall below the low-income cut-offs (LICOs) as defined by Statistics Canada, than found in the general Canadian population. Again, this is particularly true for Aboriginal women. Table 9.2 illustrates that in 1996, almost 43 percent of Aboriginal women aged 15 and over had incomes below the LICO, compared to 35 percent of Aboriginal men, 20 percent of non-Aboriginal women, and 16 percent of non-Aboriginal men.

As Table 9.2 shows, younger Aboriginal women experience the highest rates of low income: almost 50 percent between the ages of 15 and 34 years fall below the low-income cut-offs. In all age groups, however, Aboriginal women have higher rates of low income compared to non-Aboriginal women, Aboriginal men, or non-Aboriginal men.

Sixty percent of Aboriginal children under the age of six lived below the LICO in 1996 and these figures are likely underestimates, given that some 44,000 people living on reserves and settlements were incompletely enumerated in the census (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999).

TABLE 9.2 INCIDENCE OF LOW INCOME* AMONG ABORIGINAL AND NON-ABORIGINAL PEOPLE AGE 15+, 1995

	Aboriginal People		Non-Aboriginal People	
	Women	Men	Women	Men
	%		%	
People aged				
15-24	49.8	40.6	25.6	21.4
25-34	47.6	36.7	21.4	18.2
35-44	37.2	31.0	17.3	15.4
45-54	32.8	28.9	14.4	13.1
55-64	39.1	35.4	19.2	16.4
65 and over	35.8	27.1	23.8	13.2
TOTAL	42.7	35.1	20.3	16.4

Source: Statistics Canada, 1996 Census of Canada. (Tait, 2000).

*The plain language definition for LICOs is income levels at which families or unattached individuals spend 20% more than average on food, shelter, and clothing. It should be noted that the calculations of the low income cut-offs exclude people living on Indian reserves and the Territories.

SOURCE OF PERSONAL INCOME

The largest share of Aboriginal women's income comes from employment sources, as is the case with women in the general population. Tait (2000) reported that in 1996, 64 percent of all the income of Aboriginal women came from either wages and salaries or net income from self-employment.

This income is, however, substantially less than for non-Aboriginal women (70%) and Aboriginal men (75%). The share for Aboriginal men from these same sources was also less than that of non-Aboriginal men (79%). At the same time, a greater share of Aboriginal women's income comes from government transfer payments (32.2%) than that of Aboriginal men (21.4%), non-Aboriginal women (17.9%), or non-Aboriginal men (11.3%). Government transfers include payments such as old age security, guaranteed income supplements, social assistance benefits, and employment insurance benefits.

EDUCATION

There are many interrelated factors that affect employment and income; an important one (employment opportunity notwithstanding) is educational attainment. While clear progress has been made in Aboriginal post-secondary education attainment in recent years, in general, Aboriginal people still have lower levels of educational attainment than non-Aboriginal people (Hull, 2000; Statistics Canada, 2003). For example, according to 1996 census data, of those aged 15 years and over, 4.9 percent of Aboriginal women and 3.4 percent of Aboriginal men have a university degree compared to 14.4 percent of non-Aboriginal women and 16.7 percent of non-Aboriginal men. At the other end of the scale, 23.4 percent of Aboriginal women and 23.8 percent of Aboriginal men have less than a grade nine education, compared to 14.5 percent of non-Aboriginal women and 13.4 percent of non-Aboriginal men (Tait, 2000).

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There are differences in education attainment depending on where Aboriginal people live.

There are also differences in education attainment depending on where Aboriginal people live. As of 1996, 34 percent of Aboriginal women aged 25 and over living on-reserve had some post-secondary education experience, compared with 46 percent of those living in a census metropolitan area (Tait, 2000). Tait suggests that this could be due, in part, to the lack of opportunities to pursue higher education on the reserve and/or the fact that those with higher levels of schooling may leave their communities to secure employment.

On a more positive note, Aboriginal people are more likely to return to school later on in life and this is particularly true for Aboriginal women (Tait, 2000). Aboriginal single mothers are also more likely than other Canadian single mothers to be attending school full time, especially among older age groups. This is particularly true in the 25 to 34 age group, who are 75 percent more likely than other single mothers to be attending university full time (Hull, 2001).

According to the *Aboriginal Peoples Survey 2001* (Statistics Canada, 2003), family responsibilities and finances were reported as the most common reasons among the Aboriginal non-reserve population between the ages of 25 and 44 years for not completing post-secondary studies, with 24 percent cit-

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**Aboriginal women
and men are less
likely to live in
husband-wife
families.**

ing family responsibilities and 22 percent citing financial reasons. The reasons differed between men and women. Men were most likely to report financial reasons (24%) while the reason most frequently cited by women was family responsibilities (34%).

It is not clear why Aboriginal women tend to outperform Aboriginal men with respect to university education. While further research is needed in this area, Dion Stout and Kipling (1998) refer to studies that identify factors contributing to Aboriginal women's professionalization in recent years. They state that "in short, Aboriginal women increasingly view education as a means for them and their daughters to escape socio-economic marginalization on the one hand, and the risk or actuality of abuse at the hands of their partner on the other" (p. 23). In spite of their greater success at university, Aboriginal women face substantial obstacles beyond the realm of limited finances and the pressures of family in their pursuit of higher education. Dion Stout and Kipling go on to say that "Aboriginal women in university settings often face latent or overt racism and sexism, as well as an academic discourse many find profoundly alienating." They also point out that if these obstacles are to be dismantled, more documentation on their effects is needed, along with a realignment of Aboriginal women's educational experiences with their life goals and contexts (p. 23).

Higher education has a positive effect on employability. In 1996, all women, including Aboriginal women, with greater education levels had higher labour force participation rates and higher employment rates than those with less education. However, the unemployment rate for Aboriginal women with university as the highest level of schooling (12%) is higher than that for non-Aboriginal women (5%). "This discrepancy suggests that education is not enough to raise employment levels for Aboriginal women, and that other situational factors, such as discrimination or lack of opportunity also play an important role" (INAC, 2001, p. 4-4).

FAMILY COMPOSITION

The number of people in a household, both contributing to and depending on family income, affects income adequacy. Table 9.3 illustrates that Aboriginal women and men are less likely than their non-Aboriginal counterparts to live in husband-wife families. In 1996, 32 percent of Aboriginal women aged 15 and over and 31 percent of Aboriginal men, versus 50 percent and 53 percent of non-Aboriginal women and men respectively, lived with their husbands/wives. On the other hand, Aboriginal women and men were more likely to live in common-law relationships than non-Aboriginal women and men (roughly 17% compared to 8%). Combining totals living in husband/wife and common-law partner relationships reveals that Aboriginal women (49%) and Aboriginal men (48%) were less likely than non-Aboriginal women (58%) or

non-Aboriginal men (62%) to be living in male-female couple relationships. Aboriginal women were also more likely to live with family and less likely to live alone than Aboriginal men or non-Aboriginal men or women.

TABLE 9.3 FAMILY STATUS OF ABORIGINAL AND NON-ABORIGINAL PEOPLE AGED 15 AND OVER, 1996

	Aboriginal People		Non-Aboriginal People	
	Women	Men	Women	Men
	%		%	
Living with family				
With husband or wife	31.7	31.0	50.4	53.3
With common-law partner	17.3	16.9	7.7	8.2
Lone parent	17.9	3.2	8.0	1.7
Child living with parents	15.9	24.4	13.6	18.4
Living with extended family members	5.2	7.1	3.6	2.9
Total living with family	88.0	82.8	83.4	84.4
Not living with family				
Living alone	7.4	10.6	13.0	10.4
Living with non-relatives	4.7	6.9	3.6	5.2
Total not living with family	12.7	17.4	16.6	15.5
TOTAL	100.0	100.0	100.0	100.0

Source: Statistics Canada, 1996 Census of Canada (Tait, 2000).

Single Parents. In his study *Aboriginal Single Mothers in Canada, 1996. A Statistical Profile*, Hull (2001) reported that, as in the general population, the prevalence of Aboriginal single-mother families has been increasing over time. He also pointed to the fact that research has shown that single mothers are more likely than other women to experience employment and income difficulties. Aboriginal women are much more likely to be lone parents than are non-Aboriginal women. In 1996, 18 percent of Aboriginal women aged 15 and over headed families on their own compared to 8 percent of non-Aboriginal women. They were also much more likely to be lone parents than their male counterparts; in that year, just 3 percent of Aboriginal men were lone parents.

Although the census data provide a snapshot of the numbers of lone-parent families at a point in time, it does not provide a longitudinal view of how women and families move into and out of lone-parent status (Hull, 2001). While more research is required in this area, the fact remains that single parenthood for many presents significant financial and other personal challenges. Again, there is a gendered effect in how these are experienced. For example, Noreau and colleagues (1997) studied the financial impacts of separation and determined that it has differing economic results for men and women.

Analyzing the family income of married persons with children, they found that after separation, women experienced losses in adjusted family income of approximately 23 percent between the year before and the year following separation, while men experienced a 10 percent increase. Five years after separation, women still had a 5 percent income shortfall, whereas men had made gains of 15 percent.

Hull (2001) examined single motherhood among Aboriginal women in Canada and found significant differences in terms of prevalence compared to non-Aboriginal women. For example:

- Young Aboriginal women, 15 to 24 years old, are more than three times as likely to be single mothers as other young Canadian women.
- In 1996, about one of three (33%) Aboriginal mothers was a single mother compared to one of six (16%) other Canadian mothers.

He also found differences based on area of residence:

- In rural areas 13 percent of Aboriginal women were lone parents in 1996 compared to 5 percent of other Canadian women
- In urban areas 22 percent of Aboriginal women were lone parents in 1996 compared to 8 percent of other Canadian women

Differences also exist between various subgroups of Aboriginal women. The Registered Indian population had the highest prevalence of single mothers, with Métis and Non-Status Indian prevalence rates slightly lower. Lowest rates were found among the Inuit. Table 9.4 illustrates a comparison of single mothers by age and identity group.

TABLE 9.4 SINGLE MOTHERS AS A PERCENTAGE OF WOMEN IN PRIVATE HOUSEHOLDS BY AGE AND IDENTITY GROUP, CANADA, 1996

Age of Women	Registered Indian	Métis Identity only	Inuit Identity Status	Non-Status Indian	Total Aboriginal Identity	Other Canadians
			%			
15-24	10.3	9.7	3.8	9.5	9.7	2.9
25-34	24.3	23.3	15.3	21.1	23.4	9.4
35-44	24.8	23.9	15.9	21.5	23.9	11.8
45-54	18.5	14.3	16.5	13.3	16.8	10.0
55-64	15.7	8.1	24.1	9.6	13.8	6.2
65+	17.8	12.5	31.6	10.3	16.1	5.8
Women 15+	19.0	17.0	13.2	15.6	17.9	8.0

Source: Indian and Northern Affairs Canada, custom tabulation based on the 1996 Census of Canada (Hull, 2001).

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In general, Aboriginal families have more children than non-Aboriginal families.

Of particular note is the high percentage of single mothers among older Inuit women, especially those over 65 years old. The health, social, and economic challenges facing older women are well known, including such things as increased chronic health conditions, and diminished mobility and income – all of which are likely to be exacerbated with the additional responsibility of caring for children by one's self.

Number of Children. The number of children in families is important for several reasons, including the additional income needs of larger families and the need for childcare and educational services (Hull, 2001). In general, Aboriginal families have more children than non-Aboriginal families. Based on the 1996 census, Hull reported that 76 percent of Registered Indian two-parent families have more than 2 children, with an average of 2.5 children, whereas 73 percent of non-Aboriginal two-parent families have more than 2 children, with an average of 2.1 children.

The percentage of Aboriginal children living in single-parent families is also higher than that of non-Aboriginal children and the rate varies widely depending on family type and location of residence. For example, almost 40 percent of Registered Indian children living in an urban location live in a single-parent family. Of these, 93 percent live in a family headed by a female single parent. In comparison, 19 percent of Registered Indian children residing in a rural location live in a single-parent family. Table 9.5 illustrates further differences broken down by ethnic group and rural versus urban residence.

Tait (2000) noted that low income is far more common among Aboriginal lone mothers than Aboriginal women in general. In 1996, while 43 percent of Aboriginal women in general had low incomes, among Aboriginal lone mothers, 73 percent lived below the LICO. This was substantially worse than the 45 percent figure for families headed by non-Aboriginal female lone parents.

In his study of Aboriginal single mothers in Canada, Hull (2001) used the term “triple jeopardy” to describe Aboriginal single-mother households: they risk experiencing poor social and economic conditions because they are women, because they are Aboriginal, and because they are lone-parent families. He concluded that:

the findings of this study point to some preliminary policy-related implications. The relatively large and increasing number of young Aboriginal single mothers suggests a need for housing, parenting support and education.

... Aboriginal single mothers are a substantial segment of the Canadian population, particularly in urban areas, who have disproportionately high needs. The success that we as a society

have in enabling Aboriginal single mothers to improve their circumstances will have a major impact on Aboriginal children and on the future of Canada. (p. xiii)

TABLE 9.5 NUMBER OF CHILDREN LIVING IN CENSUS FAMILIES WITH CHILDREN 0-15 YEARS OLD BY FAMILY TYPE AND ETHNIC GROUP, CANADA, 1996

Family Type	Rural	Urban	Total
REGISTERED INDIAN			
Total children in families with children 0-15	118,463	91,812	210,228
Children in single-mother families with children 0-15	18,996	34,125	53,163
Percent in single-mother families	16.0	37.2	25.3
Children in single-father families with children 0-15	3,773	2,376	6,080
Percent in single-father families	3.2	2.6	2.9
Children in all single-parent families with children 0-15	22,769	36,501	59,243
Percent in all single-parent families	19.2	39.8	28.2
OTHERS WITH ABORIGINAL ANCESTRY			
Total children in families with children 0-15	89,175	182,958	274,751
Children in single-mother families with children 0-15	9,662	37,477	47,127
Percent in single-mother families	10.8	20.5	17.2
Children in single-father families with children 0-15	1,645	3,736	5,035
Percent in single-father families	1.8%	2.0	1.8
Children in all single-parent families with children 0-15	11,307	41,212	52,162
Percent in all single-parent families	12.7	22.5	19.0
OTHER CANADIANS			
Total children in families with children 0-15	1,524,555	5,075,850	6,440,361
Children in single-mother families with children 0-15	109,567	760,880	912,111
Percent in single-mother families	7.2	15.0	14.2
Children in single-father families with children 0-15	28,013	108,105	134,573
Percent in single-father families	1.8%	2.1	2.1
Children in all single-parent families with children 0-15	137,580	868,985	1,046,684
Percent in all single-parent families	9.0%	17.1	16.3

Source: Indian and Northern Affairs Canada, custom tabulation based on the 1996 Census of Canada (Hull, 2001).

High smoking levels among people with low incomes can be considered a general response to conditions of inequality and poverty, whereby the stresses of everyday living and the struggle to survive supersede consideration of long-term health consequences. In their comprehensive discussion of the factors that support and maintain smoking among women in general, Greaves and Barr (2000) reveal that women have identified smoking as a way of coping with the stresses in their daily lives caused by gender inequalities, multiple roles, and violence – conditions exacerbated by inadequate income and poverty. Women with multiple disadvantages have described cigarettes as one small “luxury” in their lives. (See Greaves and Barr for a more thorough discussion of these factors.)

As this discussion illustrates, Aboriginal women are more likely to have lower incomes and have more children to raise throughout the life course when fewer personal and financial resources are available. Care must be taken to ensure that tobacco control policy (e.g., increased taxation) does not exacerbate the already-tenuous economic situation facing many Aboriginal men and (in particular) Aboriginal women.

Gender and child-care responsibilities

Data collected through the 1996 census confirmed statistically that there are major gender differences when it comes to the amount of time spent caring for children. Aboriginal women, like their non-Aboriginal sisters, spend significantly more time caring for children than do their male counterparts. For example, approximately three times as many Aboriginal and non-Aboriginal women spend more than 60 hours per week on child care compared to their male counterparts (table 9.7). The census findings are discussed further in the section of this chapter called “Gender and the Nature of Work.”

Another way of looking at child-care (and care-giving) responsibilities is through dependency ratios. A dependency ratio represents the ratio of the dependent population (defined as those younger than 15 and older than 65) to the working-age population (ages 15 to 64); it is a way of examining population distributions by age. Dependency ratios can provide insight into policy and service needs related to the provision of care for both children and the elderly. Because women are the primary providers of both child and elder care, dependency ratios offer some insight into the burden of care they bear.

In 1996, the total Aboriginal population experienced a dependency ratio of 60. This means that for every 100 Aboriginal people of working age, there were 60 dependents (young and old). The range of dependency ratios varies among ethnic designations, from 47 in the non-Aboriginal population to 77 in the Inuit population. The dependency ratio differed significantly between populations located on or off reserves. On-reserve Registered Indians had a

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dependency ratio of 73 compared to one of 59 for Registered Indians living off reserves. The majority of dependents in the Aboriginal population are children: 54 child dependents and 5 elderly dependents. Again, there were variations among the Aboriginal ethnic populations and between them and the non-Aboriginal population. For example, the Inuit population had 73 child and 4 elderly dependents for every 100 working-aged people. In contrast, the non-Aboriginal population had 30 child and 17 elderly dependents for every 100 working-aged people. "Dependency ratios suggest implications for services intended to relieve the burdens of care for the respective populations" (INAC, 2001 p. 1-2). Considering that women are the primary caregivers, these "implications" will be of great importance to them.

A myriad of social and economic factors influence the nature and experience of child-care responsibilities. Aboriginal women are more likely to be mothers and more likely to have more children than the population of Canadian women as a whole. They are more likely than their male counterparts to be single parents, and more likely to be poor. A Statistics Canada study found that among Canadian women, the major factor in the wage gap is not age, marriage, or education but the presence of children (Morris, 2002) and this presumably applies to Aboriginal women as well. Child-care responsibilities often restrict women to part-time or low-paid work, and create barriers toward their full participation in economic decision making (Hanson et al., 2001).

Access to organized child care is an important area of public policy and a factor that has an impact not only on labour force participation but also healthy child development. Friendly, quoting from a National Council of Welfare study, points out the importance of child care to all families, but particularly to those who are poor.

Good child care makes an enormous difference in the ability of poor families to find and keep jobs. Affordable child care supports those families that are not poor to stay in the workforce. But beyond all this, good child care is an excellent opportunity to provide early childhood education and to ensure that all children have the same chances for good development.

Good early childhood education has enormous benefits for children, their families and their communities. All the population health research tells us that early childhood experiences are among the most important determinants of a person's health ... Preventing problems and ensuring that children have the best possible early development makes good economic sense.

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in current
child-care services.**

... Many social programs support families but child care is the backbone of them all. (Friendly, 2000, p. 4)

Access to affordable, quality child care is an issue facing all Canadian families, but it has particular importance for women. While all Aboriginal groups have child populations that are larger than the national average, Aboriginal children are under-represented in current child-care services, according to a report on early childhood care and education in Canada (Childcare Resource and Research Unit [CRRU], 2000). The report identifies that there is a particular need for a wide range of flexible services that will accommodate the diverse needs of the Aboriginal community. A major issue of concern is cultural integrity.

The maintenance of indigenous culture is a major concern for all Aboriginal peoples. Aboriginal organizations point out that general standards for child care centres are sometimes too rigid for northern and/or remote communities and that they may not reflect traditional cultural norms and practices.

Culturally sensitive early childhood education, as it pertains to training and service delivery, is of special concern. There is a strong interest among Aboriginal groups in developing child care that is operated and controlled by the communities themselves. (p. 91)

The province of BC funds and licenses on-reserve child care, and in 2001 there were 65 First Nations communities that had licensed child-care facilities. In November 2002, the federal government announced additional funding to expand the Aboriginal Head Start Program and the First Nations and Inuit Child Care Program (Friendly et al., 2002). While this is a welcome development, given the current and projected number of Aboriginal children in BC and across Canada requiring child care programs, access will likely continue to be an issue.

There are many aspects related to gender and child-care responsibilities that cannot be captured by statistics alone, for example, family dynamics and power imbalances between men and women. The extent to which Aboriginal men support their partners and share responsibility for child care, both in terms of time and finances, will affect not only women's stress levels (and consequently their mental and physical health) but also their ability to participate in the paid economy. However, the literature is basically silent on this issue, pointing to the need for further research.

Raising children in two-parent families with the benefit of adequate income is stressful enough. Single parenting, particularly when one is young and poor, can be an extremely stressful situation. It is an experience that is common for many Aboriginal women. There are many aspects to nurturing children that

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The importance of traditional Aboriginal economies is often ignored and undervalued.

remain invisible, are time consuming, and cause considerable anxiety, particularly for single parents who often lack another adult in their immediate environment from whom to draw support. Everyday occurrences such as attending parent-teacher interviews, helping children with homework, or taking them to the doctor or recreational activities are all more difficult to arrange on one's own, particularly if transportation is lacking or child care is needed for other children in the home. Many women have even more to deal with than these everyday challenges. A study involving women on social assistance in Saskatchewan revealed that study participants spent considerable time nurturing their children, developing coping skills, and finding counselling for themselves and their children in order to deal with past and present abuse issues (Hanson et al., 2001).

The guilt and self-blame many poor women experience in not being able to provide their children with adequate housing, food, clothing, or the toys they see other children enjoying is related to self-destructive coping mechanisms. "Poverty erodes the spirit and the body. The blame is often internalized, sometimes turning into self-abuse, increasing self-destructive coping mechanisms like smoking, alcohol and substance abuse" (Morris, 2002).

Gender and the nature of work

There are a number of dimensions in the nature of work that may influence responses to tobacco policy. In spite of multiple barriers to employment, Aboriginal people make a significant contribution to the economy – both in terms of paid and unpaid work, although, as in the general population, Aboriginal women contribute more to the latter sphere with respect to household activities, child care, and elder care (INAC, 2001). While census statistics help to paint a picture of involvement in the wage economy, much less is known about the non-wage economy.

This realm of life is particularly relevant for Aboriginal people historically, and still today to varying degrees. Activities such as fishing or hunting for sustenance rather than commercial purposes, bartering goods and services, and the unpaid labours that sustain a household are missing from the census picture of the labour force. (INAC, 2001, p. 5-1)

Kenny (2002) argues that the importance of traditional Aboriginal economies is often ignored and undervalued. Women's traditional work (e.g., craft work) and bush work are important forms of economic activity, particularly for northern Aboriginal women. She comments that while one study revealed how the women's craft industry in the Northwest Territories amounted to \$22 million in external sales in 1987 (a figure deceptively low as it does not account for "informal sales" and "in-kind" transactions), craft work is viewed by Western culture as distinct from fine art and consequently undervalued

and often exploited. The following discussion of paid and unpaid work recognizes this important dimension that characterizes the nature of work for many Aboriginal women, while acknowledging that policy issues, particularly in relation to the exploitation and conditions of women's work, have been largely ignored.

PAID WORK

Measured by indicators such as participation, unemployment, and unemployment rates, both Aboriginal men and women have less success in the paid economy when compared to the Canadian population as a whole. However, this is particularly true for Aboriginal women.

Statistics Canada uses several indicators to describe labour market activity. The labour force participation rate is defined as all those (15 or older) who were employed or looking for work during the week prior to enumeration, divided by the total population (aged 15 or older). The employment rate is the number of people (15 or older) employed during the week prior to enumeration divided by the total population (aged 15 or older). This is referred to as the "employment/population ratio." The unemployment rate is the number of people (15 or older) who were unemployed and actively looking for work during the week prior to enumeration, divided by the total number of labour force participants, as described here. Those who are not working and not looking for work because they are on temporary layoff, or expect to start a job within the next four weeks, are also considered unemployed (Hull, 2000, p. xxii).

Using these indicators, Indian and Northern Affairs Canada published a socio-economic profile of Aboriginal people that focused on Aboriginal women (2001). In an effort to reveal the distinct challenges facing Aboriginal women and to help inform and support the policy-making process, the report focused on Aboriginal women,

since their experience, and the socio-economic variables used to profile them, reveal a population group distinct from non-Aboriginal women, as well as Aboriginal men.

Gender and race impact on the socio-economic well being of Aboriginal women as individuals, as mothers and as members of their communities. Understanding the unique challenges facing Aboriginal women is therefore an integral part of any strategy to build stronger peoples, communities and economies.
(p. viii)

Table 9.6 illustrates that, although slightly lower, labour force participation rates are somewhat comparable between Aboriginal women (57%) and non-Aboriginal women (59%) and between Aboriginal men (70%) and non-Aboriginal men (73%). However, despite Aboriginal women tending to be better edu-

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cated than Aboriginal men, their participation rate in the labour force is much lower than Aboriginal men's – 57 percent versus 70 percent. Registered Indian women living on reserves experience the lowest participation rates across both sexes and ethnic groups.

Aboriginal women and men experience higher unemployment rates in general, and among some Aboriginal groups, double that of their non-Aboriginal counterparts. Among those who participate in the labour force, Aboriginal women fare better than Aboriginal men do. Aboriginal women's unemployment rate is 18 percent, compared to 22 percent for Aboriginal men. The difference is most noticeable on reserves, where Registered Indian males experienced an unemployment rate 12 percentage points higher than that of their female counterparts. Higher levels of education among Aboriginal women and the types of employment opportunities on reserves (i.e., those that are typically female dominated) may play a role in this. The low participation rates among Aboriginal women on reserves may also account somewhat for the higher unemployment rate among males (i.e., if women are not looking for work, they are not considered in the unemployment figures).

PART-TIME WORK

Similar to the population of Canadian women as a whole, a large proportion of employed Aboriginal women work part-time. In 1996, 29.7 percent of employed Aboriginal women worked part-time compared to 29.4 percent of non-Aboriginal women and 17.6 percent of Aboriginal men. The figure for non-Aboriginal men was 12.7 percent (Tait, 2000).

OCCUPATION

Occupation is another aspect of work and is related to factors such as level of education, job market factors, and geographic location. Gender, however, is a major factor. Aboriginal women are heavily concentrated in low-paying occupations traditionally held by women. Of all Aboriginal women employed at some time in 1995, approximately 64 percent worked in either sales and service (40%) or clerical and administrative (23%) jobs. These figures are only slightly higher than those for their non-Aboriginal counterparts of whom 60 percent were employed in these areas. Compared to Aboriginal men (25%) however, they were more than twice as likely to be working in these types of jobs (Tait, 2000). Aboriginal men work more often in trade, transportation, and equipment operations (32%) than do Aboriginal women (3%).

Within occupational groups, Aboriginal men and women are often concentrated in support or helper positions. The Royal Commission on Aboriginal Peoples (1996a) reported that while Aboriginal women work more in teaching and health-related occupations than Aboriginal men do, they often work in a para-professional capacity. In BC, within the trades and transport category, the

most common occupation for Aboriginal men is “trades helpers and labourers” (BC Provincial Health Officer, 2002).

Aboriginal people also face discrimination and racism in the workplace and issues around gender and socioeconomic status compound the difficulties experienced by Aboriginal women. Kenny (2002) claims that “issues identified for women generally are present for Aboriginal women, but magnified, and made many times more complex by cultural and economic differences, and by the systemic racism and sexism entrenched in Canadian culture” (p. 4). In addition to the social and economic effects, racism also manifests itself in psychological ways, contributing to low self-esteem, feelings of inadequacy, and high levels of stress.

Policy, at all levels of government, plays an important role in the work lives of Aboriginal men and women. Kenny (2002) examined how policy directly or indirectly affects Aboriginal women’s work experiences and identified how the Indian Act (which provides for the structure, composition, and powers of band councils), in particular, has left a legacy of inequality in this sphere of Aboriginal women’s lives. She finds:

there are no sections that focus specifically on the needs of Aboriginal women or that guarantee a place for Aboriginal women on council. This has a bearing on Aboriginal women and their work both within and outside the community. If they are not guaranteed a place on council, they have no power to make decisions regarding their work opportunities and the

TABLE 9.6 POPULATION 15+ BY LABOUR FORCE ACTIVITY BY SEX, 1996

	Total Aboriginal	Registered Indians			Inuit	Métis	Other Aboriginal	Non- Aboriginal
		Total	On- reserve	Off- reserve				
FEMALE								
Participation rate (%)	57	48	45	50	56	59	66	59
Unemployment rate (%)	18	23	22	24	20	18	14	10
Employment/ population ratio	47	37	35	38	45	49	57	53
MALE								
Participation rate (%)	70	62	58	66	64	73	77	73
Unemployment rate (%)	22	31	34	28	23	22	15	10
Employment/ population ratio	55	43	38	47	50	57	66	66

Source: Indian and Northern Affairs Canada, 2001.

treatment of workers in the community. Further, they cannot participate in negotiations with employers and government outside the community to further their interests. In sum, they cannot formally make decisions respecting work policies on any level whether in respect of work or education in their own communities or outside the community. Any opportunity for Aboriginal women to have a choice, to take leadership and to ensure support for an issue (i.e., day care) in this system will be accidental, and very much dependent on the whims of those with the power to make decisions. (p. 9)

Kenny points out that because there are no sections in the Indian Act that specifically address employment or protect the property interests of Aboriginal women living on reserve lands, self-employment is thus affected. “Self-employment opportunities for women become difficult, if not impossible, when they are denied access to land use in their own communities and cannot obtain a division of matrimonial property on reserve lands” (p. 10). Aboriginal women are much less likely than Aboriginal men to be self-employed. The Royal Commission on Aboriginal Peoples reported that the percentage of Aboriginal women who are self-employed is half that of Aboriginal men and well below that of all Canadian women (RCAP, 1996a).

All of these factors, including the concentration of Aboriginal women’s occupations in lower-level sectors, help to explain their low incomes. However, the presence of children also has a significant effect on the nature of work and income. In spite of women’s participation in the labour force, they are still expected to perform the majority of household chores and take care of the children. In the case of single parents, they have little choice.

Women are expected to cut down on their paid work, quit their jobs, take emergency leave from work, or refuse promotions, in order to care for children, elderly parents or in-laws, or disabled relatives. Men are not. This has a lifelong impact on a woman’s wages, accumulation of pension benefits, and experience in her chosen occupation. Largely because of the lack of balance and fairness in terms of women’s and men’s family responsibilities, the vast majority of part-time workers (70%) are women. (Morris, 2002, par. 2)

UNPAID WORK

In our market economy, paid work is the primary recognized form of economic activity, with little recognition or value given to the unpaid activities – which are undertaken primarily by women – that are necessary for keeping the family and the economy working. While women’s groups and researchers have stressed the importance of unpaid work, and the 1995 “Beijing Platform

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 more hours per week
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 did men.**

for Action on the 12 Critical Areas for Women's Equality" drew international attention to these issues, many aspects of unpaid work are still misunderstood and undervalued (Hanson et al., 2001).

For the first time in its history, Statistics Canada included questions on time spent doing unpaid household activities in the 1996 census survey. Based on this census, Table 9.7 indicates that both Aboriginal and non-Aboriginal women spend significantly more time on these vital, but unpaid activities than do their male counterparts. Women of all ethnic designations reported spending more hours per week on housework than did men. For example, among the total Aboriginal population, 30 percent of Aboriginal women compared to less than 12 percent of Aboriginal men reported spending 30 hours or more per week on housework. Among the off-reserve Registered Indian population, the differences were even larger, with 29 percent of women and 9 percent of men claiming 30 or more hours per week.

The pattern for hours spent on child care is similar. Thirty-one percent of Aboriginal women reported spending 30 hours or more per week on child care while 13 percent of Aboriginal men claimed the same. On-reserve Registered Indian women reported spending the most time on child care, with 54 percent spending more than 30 hours per week. This may have something to do with the lack of organized child care available on reserves and larger, extended families requiring more time spent on child care activities. Aboriginal men (43%) are more likely to spend time providing child care than non-Aboriginal men (34%) and this is particularly true for on-reserve Registered Indian men. While a larger percentage of on-reserve Registered Indian men spend more than 30 hours per week on child care (21%), this figure is still less than half that for on-reserve Registered Indian women (54%).

Slightly more Aboriginal women (21%) and men (17%) spend time caring for seniors than non-Aboriginal women (19%) and non-Aboriginal men (13%). More on-reserve Registered Indian women and men provide care to seniors than any of the other Aboriginal groups or the non-Aboriginal population. Further, they spend more hours providing care, with 12 percent of on-reserve Registered Indian women providing 10 or more hours per week of care, and 10 percent of on-reserve Registered Indian men claiming the same. This is substantially greater than non-Aboriginal women (3%) or non-Aboriginal men (<2%).

These statistics offer a glimpse into only three aspects of a broad array of unpaid activities that women undertake in the course of their daily lives. One area of importance, where little, if any, statistical information related to Aboriginal people is available, is that pertaining to volunteer and community activities. Aboriginal women play an important role in the social and cultural life of their communities. Wakes, feasts, and cultural events are an important

TABLE 9.7 POPULATION 15+ BY HOUSEHOLD ACTIVITY, AND BY SEX, 1996

	REGISTERED INDIANS										Non-Aboriginal Male	
	Total Aboriginal Female Male		Total		On-reserve		Off-reserve		Female Male			
			Female	Male	Female	Male	Female	Male				
Total – household activities	404,720	366,290	167,430	144,975	72,185	75,965	95,245	69,005	11,201,750	10,656,165		
No hours of housework (%)	7.0	16.2	8.2	18.4	8.3	18.3	8.2	18.5	7.8	15.5		
Subtotal – with hours of housework	376,240	306,795	153,650	118,315	66,175	62,045	87,475	56,265	10,332,630	9,001,185		
Less than 5 hours of housework (%)	14.2	27.0	12.4	23.3	9.4	18.6	14.6	28.4	15.7	30.2		
5 to 14 hours of housework (%)	26.1	30.1	24.2	27.5	20.1	25.2	27.3	30.0	28.2	32.8		
15 to 29 hours of housework (%)	22.4	15.0	21.2	15.7	21.1	17.6	21.4	13.8	24.0	14.2		
30-59 hours of housework (%)	16.9	7.1	17.0	8.4	18.3	10.5	16.1	6.1	16.9	5.5		
60 or more hours of housework (%)	13.4	4.5	16.9	6.7	22.8	9.8	12.4	3.3	7.4	1.7		
No hours of child care (%)	41.6	56.8	35.4	51.8	26.3	44.9	42.4	59.4	58.3	66.0		
Subtotal – with hours of child care	236,200	158,190	108,080	69,905	53,230	41,865	54,850	28,035	4,673,550	3,623,575		
Less than 5 hours of child care (%)	8.4	10.9	8.1	11.1	7.6	11.5	8.5	10.6	8.7	10.9		
5 to 14 hours of child care (%)	10.0	11.5	10.6	11.8	11.5	12.7	9.9	10.9	9.6	10.8		
15 to 29 hours of child care (%)	8.7	7.9	9.5	8.4	10.6	9.4	8.7	7.3	7.1	6.3		
30 to 59 hours of child care (%)	9.5	5.5	10.4	6.5	12.3	7.6	9.0	5.2	6.7	3.4		
60 or more hours of child care (%)	21.7	7.4	25.9	10.4	31.7	13.8	21.5	6.7	9.6	2.6		
No hours of care to seniors (%)	78.7	82.9	76.6	79.1	67.2	71.5	83.7	87.5	80.9	86.5		
Subtotal – with hours of care to seniors	86,320	62,800	39,150	30,235	23,650	21,625	15,500	8,610	2,138,105	1,436,220		
Less than 5 hours of care to seniors (%)	11.4	9.8	10.9	10.1	13.4	12.4	9.0	7.6	12.0	9.6		
5 to 9 hours of care to seniors (%)	4.7	3.4	5.3	4.4	7.3	6.2	3.7	2.5	4.1	2.3		
10 or more hours of care to seniors (%)	5.2	4.0	7.2	6.3	12.0	9.8	3.5	2.4	3.0	1.6		

Source: Indian and Northern Affairs Canada (2001) based on the 1996 Census of Canada.

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**Aboriginal women
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design, and under-
taking of further
research.**

part of the social fabric of many Aboriginal communities, and women have typically shouldered the responsibility for these events.

Census statistics are useful in identifying gender differences surrounding unpaid work in the home. However, they really provide only a one-dimensional and limited categorical view of a complex web of personal and social interactions and negotiations that characterize women's relationships to their partners and to the demands of the unpaid work environment. In addition, numerous social and economic factors influence the experience and nature of unpaid work – adequacy of income being an extremely important one.

Low-income women, many of whom are Aboriginal, generally do not have access to the labour-saving devices that many higher income earners take for granted. Things like dishwashers, freezers, self-cleaning ovens, time-saving kitchen gadgets, or even automatic laundry machines are rarely found in the homes of poor families. Further, lack of transportation to get to the grocery store, appointments, or work means taking additional time to access public transportation or to negotiate rides (a difficult process for those who cannot afford phones). For those living in rural or remote areas, public transportation is often not available. Inadequate income prevents buying in quantity or bulk, which means that more and frequent trips to the store are necessary. Everything is more complicated, difficult, and time consuming. Women who work in the paid workforce are still expected to perform the majority of unpaid work activities – they just have less time to do it in, and therefore additional stresses and strains on their physical and mental well-being.

Statistics cannot capture the social and psychological effects that result from the juggling act that characterizes many women's lives. More research, utilizing qualitative research methods, is required. Aboriginal women must be involved in the conceptualization, design, and undertaking of further research in what may be considered a culturally sensitive area, both within and among the various Aboriginal subgroups. The link between gender-based, culturally sensitive research and policy development is critical. "Recognition and value for the time women spend on unpaid caregiving activities is a necessary component of gender analysis in public policy" (Hanson et al., 2001, background par. 2).

The discussion here sheds some light on three gendered aspects of Aboriginal men and women's lives: income, child-care responsibilities, and the nature of work. While there is a growing body of literature on gender differences and smoking behaviour in the general population, little has been written in the same vein regarding Aboriginal women and men. Other factors that are known to play an important role in supporting and sustaining smoking behaviour which have not been discussed include the role of tobacco advertising in presenting smoking as a relaxing response to the daily stress women experi-

ence and the media's influence on women's body image and smoking as a weight-control measure (Health Canada, 1999b). Notwithstanding the fact that many girls and women in general are consumed by efforts to control their weight in order to conform to the idealized image of beauty, one key informant mentioned that the current focus on weight control as a means to prevent diabetes may be supporting Aboriginal women's smoking as a weight-control method.

While it is presumed that these factors influence smoking behaviour among Aboriginal women as members of the Canadian population as a whole, it would be a mistake to assume that they do so in the same way they affect non-Aboriginal smokers. Aboriginal women's voices need to be heard in order to ensure that their circumstances and experiences are fully considered and understood.

Aboriginal women's role in future policy development

Historically, women played a prominent part in the political and cultural life of many traditional Aboriginal societies. Women were honoured as the givers of life – they were seen as having a special gift from the Creator that was a source of power and equal responsibility (RCAP, 1996b). Although women's leadership roles varied from nation to nation, their skills and knowledge gave them an essential and valued role in the community (RCAP, 1996a; 1996b). This all changed upon contact with Europeans and the introduction of Victorian attitudes toward women and women's roles in Aboriginal societies. While all Aboriginal people were affected by the discriminatory and oppressive policies and legislation of the colonial powers, women were doubly affected by legislation such as the Indian Act.

We are under no illusion that women's lives before contact were free of social problems. But Aboriginal women told us that, with the coming of colonial powers, a disturbing mind-set crept into their own societies. Policies and laws imposed by foreign governments ruptured cultural traditions and introduced discrimination against women. (RCAP, 1996b. *Voices of Women*, par. 3)

Dion Stout and Kipling (1998) echo this view in their discussion of the context of family violence within Aboriginal communities. They point out that this legacy of colonial oppression has left Aboriginal women marginalized within their own communities, "at the hands of a predominantly male leadership that has internalized the sexism of the dominant society" (p. 29).

Attempts to modify the effects of policy and legislation such as the Indian Act have been only partially successful from an Aboriginal woman's perspective. For example, Kenny (2002) points out that Bill C-31 amendments to the

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Many Aboriginal women are justifiably concerned that their issues may not be addressed through self-government.

Indian Act have created divided opinions and conflict within some communities regarding band authority to determine membership. While Bill C-31 led to reinstatement of status for women and community members who had previously lost their status, band membership is not guaranteed. She finds that “for many communities, band lands have not been increased to accommodate the influx of Bill C-31 members, and land disputes have created conflicts” (p. 12). Kenny further points out that the amendments do not provide for continued status and membership of the descendants of the Aboriginal women who lost their status.

Many Aboriginal women are justifiably concerned that their issues may not be addressed through self-government. Kenny identified that participants in her study expressed fear with respect to aspects of self-government in their communities. “Many questioned whether current councils would be willing to address the needs of Aboriginal women or give women a voice in government” (p. 12).

Dion Stout and Kipling (1998) point out that although Aboriginal women may appear to be relatively invisible with respect to political decision making, they have always had their own organizations and societies and have been involved in a wide range of community-based and issue-specific movements. It has only been recently, however, that attention has been paid to their activism and influence.

The time is past when the federal government and the Aboriginal leadership are able to enter into and conclude negotiations without giving thought to the likely implications of the issue at hand for Aboriginal women. Not inconsequential in this regard is the fact the Native Women’s Association of Canada has maintained a strong presence in self-government debates, publishing a number of works which analyse and critique various aspects of the constitutional process from an Aboriginal woman’s perspective (p. 33).

Both Dion Stout and Kipling’s (1998) and Kenny’s (1998) research emphasize the need to include Aboriginal women’s voices in future policy work to ensure that its impacts on Aboriginal women are addressed. Dion Stout and Kipling outline three points to underpin future policy development.

First, Canadian Aboriginal women carry out their daily activities in the face of ongoing challenges, such as racism and sexism, which are partly responsible for a range of negative health and socio-economic outcomes. Second, Aboriginal women are resilient to a degree that has allowed them to move forward and succeed, as demonstrated, for example, by their educational achievements, despite the countervailing force of multi-

faceted discrimination. Finally, Aboriginal women embody differences which must neither be erased nor forgotten, if one hopes to formulate policy that is truly responsive to their needs and concerns. (p. 19)

In light of the complex intersection of gender issues with socioeconomic challenges and the difficult legacy of colonialism, it is clear that tobacco control policy will not achieve its intended results unless those who are most affected by it are sitting at the table.

This project was directed toward developing a fuller understanding of the intended and unintended consequences of tobacco control policy in relation to Aboriginal men and women in British Columbia. As such, it points to the need for further, and more comprehensive qualitative and quantitative research in order to better inform tobacco-reduction strategies and the regulatory frameworks and policy decisions that support them. By design, the project was a foundational piece or preface to further research endeavours. Obvious and specific areas for further research are discussed within the document and are summarized under general headings in the “Recommendation” section. We expect that further research will uncover other, perhaps more subtle issues of no less importance than those delineated here.

It was important to this project to synthesize the perspectives of both Aboriginal and gender interests to examine three issues critical to understanding the gendered effects of tobacco policy: income adequacy, child-care responsibilities, and the nature of women’s work. This allowed for comparisons between Aboriginal men and Aboriginal women and the general population of men and women, and among and between subgroups of Aboriginal men and women. Important differences were uncovered that have implications for the development and evaluation of effective and ethical tobacco control policies, as well as those that address the broader health and social inequities experienced by many Aboriginal groups and individuals. While this project focused on Aboriginal people in BC, the findings should nevertheless challenge our thinking about tobacco control policy across the nation.

Although the goals of general and targeted Aboriginal tobacco-reduction strategies are similar, a “one size fits all” approach will, at the least, be inadequate, and perhaps in some ways will exacerbate other health and social conditions. Each strategy needs to be harmonized with a greater understanding of how the determinants of health – reflecting the differing and gendered circumstances and social, economic, and cultural realities of men and women, Aboriginal and non-Aboriginal – will influence the effectiveness of the intended outcomes of each. In other words, each strategy will benefit and be strengthened by the application of gender-based analysis, an Aboriginal lens, or both. An obvious place to begin is the national tobacco-reduction strategy.

The literature review, as well as the advisory circle members and key informants, provided suggestions for potential participants/collaborators (particularly at the national level) in designing or advising on subsequent efforts arising from this project. These include:

- Assembly of First Nations (AFN)
- British Columbia Centre of Excellence for Women’s Health (BCCEWH)

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perspectives of both
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gender interests
to examine
tobacco policy.

- Canadian Institutes of Health Research (CIHR) – Institute of Aboriginal Peoples Health
- Métis National Council of Women
- National Aboriginal Health Organization (NAHO)
- National Indian & Inuit Community Health Representatives Organization (NIICHO)
- Native Women’s Association of Canada (NWAC)
- NECHI Institute
- PAUKTUUTIT Inuit Women’s Association
- Federal and Provincial tobacco strategy representatives

Significant policy work has already been well under way with respect to Aboriginal women and policy issues in general (such as Dion Stout & Kipling, 1998 and Kenny, 1998) and women and tobacco policy specifically (such as “Filtered Policy,” Greaves & Barr, 2000). This work should be built upon in a way that acknowledges the range of needs to be addressed. As the Royal Commission on Aboriginal Peoples reminds us,

the importance of recognizing diversity for public policy is this: no one answer will do for all Aboriginal people. No one model – be it self-government, healing centre or housing design – will speak to all Aboriginal nations. Just as there are many voices, there must be many responses. (RCAP, 1996b)

The following recommendations derived from this project will assist in ensuring the development of relevant, effective, and appropriate tobacco control strategies and policies that will also ultimately reduce the health inequalities that contribute to the non-traditional use of tobacco in the first place.

Policy and legislation

- Conduct a review of federal and provincial tobacco-reduction strategies by looking through the lens or perspective of gender (i.e., gender-based analysis) and Aboriginal interests.
- Conduct a comprehensive gender-impact assessment of current tobacco policy with particular emphasis on taxation and fiscal measures as they impact Aboriginal people.
- Conduct policy research, development, and evaluation within a framework that considers the differing circumstances and life realities of both women and men.
- Connect and converge policy development with approaches that take into consideration the determinants of health and the cultural and spiritual beliefs and traditions of Aboriginal peoples.
- Develop and conduct policy workshops at the community level through a process that reflects community-identified issues and approaches.
- Develop a process and framework for ensuring that the various tobacco-reduction programs and strategies are compatible and harmonized. Encourage collaboration between tobacco-reduction strategies and programs at all levels.
- Conduct a review of monitoring and compliance practices by involving community stakeholders to ensure that practices are appropriate and relevant to Aboriginal communities.

Public education

- Develop messages that are holistic, supportive, and non-blaming. Messages should address the meanings of smoking for women and men and consider the social determinants that influence smoking.
- Develop messages that are positive and reflect the strengths and values of Aboriginal cultures and communities.

Research

- Conduct comprehensive research that improves our knowledge base with respect to the potential impacts and consequences of tobacco control legislation and policy on Aboriginal men and women.
- Improve data collection and survey techniques to establish accurate sex-disaggregated prevalence rates among Inuit, First Nations, and Métis peoples.
- Improve research practices and increase research relevance by disaggregating data for each subpopulation of Aboriginal women and men, thereby respecting important cultural and social differences and reducing the “homogenization” of past policy work.
- Augment data with qualitative research, utilizing methods designed with input from the various Aboriginal constituencies, in order to ensure that they are appropriate and acceptable.
- Compile an inventory of First Nations communities in BC that have instituted smoke-free policies or controls. The inventory should further describe policy content, developmental and implementation processes, community acceptance and compliance, and evaluation measures. This information will help to further motivate and support effective policy development in other communities as well as contribute to an understanding of best practices.

Building and supporting capacity for action

- Encourage the cooperation of the Aboriginal political leadership because their support is crucial to the development of tobacco policies that will lead to the successful reduction of tobacco use.
- Support research, policy, public education, and program initiatives at all levels that are comprehensive in nature – that name and target tobacco reduction efforts as integrally tied to addressing the larger social, economic, and health issues experienced by Aboriginal people and communities – so that efforts to reduce tobacco use will not be seen in competition with addressing other, significant inequalities.

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APPENDIX A. Tobacco control legislation and regulations

There are numerous acts and regulations at the federal and provincial levels that together form the regulatory basis of tobacco control efforts. The following appendices summarize several of the principle pieces.

TOBACCO ACT (CANADA, 1997, C.13) – FEDERAL LEGISLATION

The Tobacco Act regulates the manufacture, sale, labelling, and promotion of tobacco products (Health Canada, Tobacco Act). It provides the legislative response to a serious national public health problem and aims to:

- protect the health of Canadians in light of conclusive evidence implicating tobacco use in the incidence of numerous debilitating and fatal diseases;
- protect young persons and others from inducements to use tobacco products and the consequent dependence on them;
- protect the health of young persons by restricting access to tobacco products; and
- enhance public awareness of the health hazards of using tobacco products.

Here are some of the key regulations of the act (Health Canada, Tobacco Act):

- Tobacco products must be manufactured in conformity with product standards.
- Manufacturers of a tobacco product must provide information about the product and its emissions.
- Tobacco products may not be furnished to a young person in a public place or in a place to which the public reasonably has access.
- Retailers must post signs that inform the public that the sale or giving of a tobacco product to a young person is prohibited by law, or that contain a prescribed health message.
- Retailers may not sell a tobacco product by means of a display that permits a person to handle the tobacco product before paying for it.
- Manufacturers or retailers may not sell a tobacco product unless the package containing it displays information about the product and its emissions, and about the health hazards and health effects arising from the use of the product or from its emissions.
- Tobacco products or tobacco product-related brand elements may not be promoted, except as authorized by this act or the regulations.
- Inspectors may enter any place in which they believe a tobacco product is manufactured, tested, stored, packaged, labelled, or sold.

In simple terms, this act addresses such things as the sale of tobacco products to minors, where and how tobacco can be advertised, regulations for tobacco manufacturers with respect to what information must be printed on each package (regarding tobacco ingredients and emissions), enforcement regulations, and offences and penalties.

EXAMPLES OF TOBACCO ACT REGULATIONS

(See the complete act to review all components)

SALES TO MINORS (PART II). Retailers cannot furnish tobacco products to anyone 18 years of age and under. Retailers must post signs that either inform the public that law prohibits the sale or giving of a tobacco product to a young person, or that contain a prescribed health message. In British Columbia, the Tobacco Sales Act (TSA) stipulates the age at 19 years and this supersedes the minimum age requirement of the Tobacco Act.

HEALTH WARNING LABELS (PART III). Labels must be in French and English and displayed on two principal display surfaces. Examples of warnings include messages such as “Cigarettes Are Highly Addictive” and “Cigarettes Cause Mouth Diseases.”

TOXIC EMISSIONS/CONSTITUENT REQUIREMENTS (PART III). Information must be presented for the following ingredients: tar, nicotine, carbon monoxide, formaldehyde, hydrogen cyanide, and benzene. The English version looks similar to this:

Toxic emissions/unit
Tar 4-25 mg, Nicotine 0.4-2.1 mg, Carbon monoxide 5-25 mg, Formaldehyde 0.018-0.11 mg, Hydrogen cyanide 0.040-0.21 mg, Benzene 0.025-0.071 mg

PROMOTION (PART IV). No one can advertise a tobacco product unless it is in a mailed publication and addressed to an adult, or in a publication that has an adult readership in excess of 85 percent. Signs can be in places only where young persons are not permitted by law. Sponsorship promotions are prohibited.

ENFORCEMENT (PART V). This section designates inspectors and details the rules with respect to inspection and seizures when the act has been contravened.

OFFENCES AND PENALTIES (PART VI). This section covers such things as violations of packaging and promotion, sales to youth, interprovincial mailing, advertising, etc.

In British Columbia, on behalf of Health Canada, the Tobacco Act was enforced by the then Ministry of Health Planning by way of a memorandum of understanding. Monitoring and enforcement activities are the responsibility of tobacco enforcement officers (TEOs), who are employees of the regional health authorities throughout the province.

TOBACCO SALES ACT C.451 [RSBC 1996] (1999, NOVEMBER) – PROVINCIAL LEGISLATION

This act is concerned with protecting youth by prohibiting the retail sale of tobacco products to minors under the age of 19. Under the Tobacco Sales Act, it is illegal to sell, offer to sell, distribute, advertise, or promote the use of tobacco to minors under 19 years of age. Retailers who sell tobacco products are required to post signs indicating the dangers of tobacco and the fact that tobacco products cannot be sold to minors. Retailers are also prohibited from selling cigarettes from open packages and selling “kiddie” packs – packs containing fewer than 20 cigarettes.

The BC Tobacco Control Program is the vehicle used to monitor compliance and enforce the act. According to C. Avison, Manager of Tobacco Programs with the then BC Ministry of Health Planning, the program uses progressive enforcement to obtain retailer compliance (personal communication, 31 March 2003). This begins with retailer education and includes inspections, administrative checks, enforcement

checks, and surveillance operations. These activities are conducted by the tobacco enforcement officers (TEOs) employed by the health regions.

Retailer compliance has improved since the inception of the program, with rates increasing from 65 percent in 1995-1996 to 91 percent in 2003-2004 (BC Ministry of Health, July 2005a).

While TEOs have the authority for monitoring and surveillance in First Nations communities, it is not evident to what extent these activities take place. (See Appendix B for further discussion.)

Definitions of enforcement activities (BC Ministry of Health, July 2005b)

COMPLIANCE RATE refers to the percentage of retailers who were not willing to sell tobacco to minors during administrative checks or enforcement checks.

ROUTINE INSPECTIONS involve visits to retailers to confirm that the required signs are posted and to advise retailers that it is illegal to sell or give tobacco to minors.

ADMINISTRATIVE CHECKS are the first round of checks that use shoppers who are minors to test retailer compliance. Retailers who are willing to sell tobacco to the test shoppers are usually issued a warning letter.

ENFORCEMENT CHECKS are the second round of using minor test shoppers to verify retailer compliance. Enforcement checks are conducted only at retail locations where it is suspected that tobacco is being sold to minors.

VIOLATION TICKETS are usually issued after a retailer has sold tobacco to a test shopper during an enforcement check. Discretion to issue violation tickets rests with the tobacco enforcement officer.

RETAILER SUSPENSIONS Where a retailer has two or more convictions relating to a store location, that retailer may be prohibited from selling tobacco at that store. Suspensions last between 3 months and 24 months, depending on the number of convictions and when the convictions occurred.

TOBACCO TAX ACT C.452 [RSBC 1996] (CONSOLIDATED 2002, JULY) – PROVINCIAL LEGISLATION

This act provides the authority to impose and collect taxes on the purchase of cigarettes, loose tobacco, cigars, and other tobacco products and is administered through the Consumer Taxation Branch, Ministry of Small Business and Revenue (BC Ministry of Small Business and Revenue, n.d.). The act also provides the authority for allocating permits to sell tobacco products (wholesalers and retail dealers), to make exempt sales, and to investigate compliance with tax collection and remittance to the provincial government, including inspection and audit powers, assessments, offences, and penalties.

The Consumer Taxation Branch oversees compliance, and monitoring takes place through audits and the monitoring of tobacco wholesalers' reports and sales records. Tobacco enforcement teams (TETs) also conduct routine inspections of retail outlets that sell tobacco, and focus on identifying counterfeit and smuggled tobacco products. Investigations are undertaken by the police and/or the special investigations

section (P. Rantucci, Manager, Tobacco Tax Section, Consumer Taxation Branch, BC Ministry of Provincial Revenue, personal communication, 11 March 2003).

The Tobacco Tax Act Regulations (British Columbia, March 2002) support the administration of the act and stipulate, among other things:

- the forms and records to be used;
- the amounts and methods for collecting and remitting taxes;
- limits on the quantity of tobacco that may be sold to or purchased by a person at a single retail sale or at retail sales during a specified period;
- establishment of a marking system for identifying tobacco that is to be sold to persons who are required to pay tax under this act, and identification of tobacco that is to be sold to persons whose purchase of tobacco is exempt from tax;
- exemption of certain tobaccos, dealers, or purchasers from all or any part of the act or the regulations.

APPENDIX B. Tobacco sales on reserves

Aboriginal people in Canada are, in general, required to pay taxes on the same basis as other people in Canada, except where the limited exemption under section 87 of the Indian Act applies (INAC, 2002). Section 87 states that “the personal property of an Indian or a band situated on a reserve” is tax-exempt (INAC, 2002). This exemption applies only to Registered Indians (under the Indian Act) and therefore does not include Métis people, Inuit, or non-Canadian Aboriginals. Although the Nisga’a nation is no longer an Indian band (i.e., in treaty terms), members of the Nisga’a nation who are Status Indians were eligible for point-of-sale exemptions on former Nisga’a lands until June 2008. (BC Ministry of Small Business and Revenue, 2001).

As the taxation chapter of this report (chapter 6) mentions, British Columbia established a tobacco tax exemption program, the Exempt Sale Retail Dealer (ESRD) permit, to accommodate this federal legislation. Businesses located on reserve or designated lands wishing to sell tax-exempt tobacco products (sometimes referred to as “Indian cigarettes”) to Indians can apply for an Exempt Sale Retail Dealer (ESRD) permit. The goals of this program are to deliver the exemption to those persons who qualify for it, and to protect provincial revenue by ensuring that tobacco intended for exempt sales is not available for purchase by persons who are not entitled to the exemption (BC Ministry of Small Business and Revenue, 2004, p. 1).

Because one objective of this project was to outline the processes related to selling tobacco, including obtaining an ESRD permit, the following briefly summarizes those processes, as described in Consumer Taxation Branch Bulletin TTA 001, Exempt Sales by Retail Dealers (ESRDs) (BC Ministry of Small Business and Revenue, 2004). Links to this and other bulletins and publications related to the Tobacco Tax Act are available on the BC Ministry of Small Business and Revenue website.

OBTAINING AN ESRD PERMIT

Businesses on reserves must apply to the director of the Tobacco Tax Act (BC Consumer Taxation Branch of the Ministry of Small Business and Revenue) for an ESRD permit. To apply for an ESRD permit, businesses must complete an “Application for Registration as an Exempt Sale Retail Dealer” (FIN 259) and attach the following information:

- a business plan;
- a map showing the business location and the location of other ESRDs in the market area;
- a band council resolution approving the sale of tax-exempt tobacco products on the reserve by the proposed business;
- the name of the tobacco wholesaler for the proposed business; and
- photographs of business premises and tobacco sales and storage facilities.

Additional details regarding other required information are provided on the application form.

The Tobacco Tax Act provides the director with the discretion to determine whether an ESRD permit will be issued or not. An applicant may be refused if the director determines that there are already sufficient dealers holding ESRD permits in the proposed market area. The director considers the following factors when determining whether a new ESRD permit will be issued:

- the Indian (as defined by the Indian Act) population of the market area;
- the number and location of ESRDs in the market area;
- the location of the applicant's business in relation to other ESRDs;
- the quantity of exempt tobacco products currently available in the market area;
- the sales patterns of existing ESRDs in the area;
- the nature of the applicant's proposed business (including hours of operation, type of business); and
- other relevant factors.

The director may refuse to issue an ESRD permit when other relevant factors indicate a permit should not be issued. These factors include the following situations:

- The applicant, or a person with an interest in the applicant (e.g., the director of a company), has a history of non-compliance with the Tobacco Tax Act;
- The applicant does not have a permanent location, secure tobacco storage, adequate accounting controls, approval from the band council, or a business plan indicating a viable business;
- There are a sufficient number of dealers in the market area;
- There is a sufficient quantity of exempt tobacco available in the market area;
- The applicant's business does not offer any significant added convenience to potential Indian customers;
- The sales patterns of existing ESRDs in the area indicate that tobacco is being purchased for a purpose other than the purchasers' own consumption or use.

When deciding if a permit will be issued, the director considers the number of existing permits in the area and sales volume. While there are no formal recorded rules, the "rule of thumb" is that the total monthly number of cartons sold cannot exceed 1.5 times the population (E. Wainwright, Exemption Specialist, Tobacco Tax Section, BC Ministry of Provincial Revenue, personal communication, February 2003).

Applicants identify the wholesaler they wish to purchase their tobacco products from, and once the decision is made to issue a permit, the Consumer Taxation Branch sends a letter to the specified wholesaler identifying the amount of tobacco products the retailer is authorized to purchase each month. All cartons and cases of cigarettes must bear the federal government's black stock mark that indicates that no provincial tobacco tax has been applied to the tobacco.

Obligations of those issued an ESRD permit

Persons who are issued an ESRD permit are authorized to make retail sales only. They have a legal obligation to take reasonable measures to ensure that they sell tobacco to persons who are purchasing it only for their own consumption or use. Effective 1 May 2000, the act established that an exempt consumer may purchase a maximum of two cartons of cigarettes per day, to a maximum of eight cartons per

month. ESRDs cannot sell more than this quantity of cigarettes to an exempt consumer.

ESRDs must maintain records to substantiate each exempt sale. For each exempt sale, the ESRD must record the following information:

- date of sale;
- customer's registry number as shown on the Status card;
- quantity and type of tobacco products sold exempt from tax; and
- name and signature of the customer.

All of the above information must be provided for each exempt sale. If any of the information is not provided or recorded, the branch will not accept the sale as an exempt sale, and the ESRD will be responsible for remitting the tax due on the sale.

Taxable sales

Tax must be collected on all sales of tobacco products to persons who do not qualify for exemption or verify their status. The tax rates on tobacco products change periodically. The rates effective in 2005 are outlined in the table below (BC Ministry of Small Business and Revenue, January 2005).

TABLE B.1 TAX RATES ON TOBACCO PRODUCTS

Tobacco Product	Tax Rate effective 19 February 2003	Previous Tax Rate	Change
Cigarettes: Individual Carton of 200	16¢ / cigarette \$32 / carton	15¢ / cigarette \$30 / carton	+ 1¢ / cigarette + \$2 / carton
Tobacco sticks: Individual Carton of 200	16¢ / stick \$32 / carton	15¢ / stick \$30 / carton	+ 1¢ / cigarette + \$2 / carton
Loose Tobacco: Per gram	16¢ / gram	15¢ / gram	+ 1¢ / gram
Cigars: Individual	77% of the retail selling price, to a maximum tax of \$5/cigar	77% of the retail selling price, to a maximum tax of \$5/cigar	No change

Source: BC Ministry of Small Business and Revenue, 2005.

The tax rate of 16¢ per cigarette, or \$32 per carton, represents the amount of tax that is exempt on "Indian cigarettes". On reserves, all health regulations still apply – cigarette packages must still display health warning signs and sales to minors are still illegal.

The following shows which taxes are exempt for Indians purchasing tobacco from an ESRD:

- **Provincial tobacco tax** – Indians are exempt (\$32/carton in BC, 2005);

- **Federal excise tax** – Paid by the manufacturer upon delivery to the purchaser;
- **Federal excise duty** – Paid by manufacturer at the time of production;
- **PST** – Included in the Provincial tobacco tax – Indians are exempt; and
- **GST** – Indians are exempt.

Many questions remain with respect to access, sale, and supply of tobacco products so there is a clear need for further research. The following delineates some of these questions, and where possible, includes a brief discussion based (primarily) on information and insights gathered from the project's advisory circle, key informant interviews, and a review of the final reports of the tobacco education compliance projects (funded by the BC Aboriginal Tobacco Strategy).

Vendors

It is not known how many ESRDs (vendors) there are on reserves in BC or who they are. According to a Ministry of Revenue employee, this information is protected under the Freedom of Information and Privacy Protection Act (FOIPP); in order to obtain this information, a FOIPP application would have to be made (P. Rantucci, Manager, Tobacco Tax Section, Consumer Taxation Branch, BC Ministry of Provincial Revenue, personal communication, 11 March 2003). A summary report on the Nisga'a Tobacco Compliance Education Project (March 2000), stated that there are 250 on-reserve retailers in BC.

It is known that the vendor situation varies from community to community. In some cases, the band runs the store. In other cases, the vendors are private entrepreneurs and could be non-band members. Elsewhere, particularly in northern and Inuit communities, the retailer may be operating out of his/her own home. It is not known how many of these enterprises are run by women.

Youth access to tobacco products

The reports from the compliance education projects offer some insight, and to a certain extent conflicting information, on youth access to tobacco on reserves. Several of the reports state that youth have difficulty obtaining tobacco products from vendors. However, one report noted that 35.5 percent of youth who participated in a project focus group stated that they were able to obtain tobacco products in stores, although no indication was given about whether or not these stores were on reserve (Osoyoos Indian Band Tobacco Reduction Project Report, 28 March 2000). By and large, young people probably get their tobacco from older friends and family, although one key informant is convinced that they also obtain tobacco quite readily from band stores (M. Horn, Executive Director, National Indian & Inuit Community Health Representatives Organization [NIICHO], personal communication, 2 April 2003).

Compliance and enforcement practices

Most vendors do not knowingly sell tobacco products to youth. What remains unclear is if, and how, monitoring and enforcement activities take place in practice, and whether or not current enforcement legislation and policy is effective or even accepted in First Nations communities. While TEOs are authorized by the Tobacco Act and the Tobacco Sales Act to monitor vendor compliance on reserves, the extent to which these activities are undertaken appears to be left to the discretion of individual TEOs in consultation with individual bands (C. Avison, Manager, Tobacco Programs, BC Ministry of Health

Planning, personal communication, 31 March 2003).

A common theme in Aboriginal tobacco strategies (e.g., First Nations and Inuit Tobacco Control Strategy [Health Canada, 2002], Alberta Aboriginal Tobacco Use Strategy [Alberta Alcohol and Drug Abuse Commission [2002]]), and noted among advisory circle members and key informants was that monitoring and enforcement practices need to be improved. Many people believe that community education and changing social norms are a better approach that is more in keeping with traditional Aboriginal values and culture (BC Ministry of Health and Ministry Responsible for Seniors, 2001).

THE NISGA'A EXAMPLE

In their Compliance Education Project (CEP), the Nisga'a First Nation sought to address tobacco control by exploring existing legislation and the potential to enact new legislation under the Nisga'a Lisim authority. An objective of the CEP was to provide a framework for the Nisga'a government's initiatives and policy options for achieving future reductions in tobacco use among its people (Nisga'a Nation Tobacco Reduction Strategy Proposal, 22 February 2000). The framework that was developed was an "enforcement option matrix" of regulations and prohibitions.

In a discussion paper supporting the framework, R. Seltenrich (*Discussion Paper on Enforcement Options for Tobacco Control in the Nisga'a Nation*, 31 March 2000) identifies several areas where current policy falls short. He points out that some of the enforcement options are not appropriate for use in a close-knit community made up of families with relations in nearby communities. For example, "the practice of using teens from a different community as test purchasers to protect their identity would not be viable, as the youth would be known" (p. 4). With respect to penalties, he highlights the importance of the store (sometimes the only one for miles around) both in terms of serving the community and its economic viability. "Suspending tobacco sales may be considered too punitive in communities where the economic reality of tobacco sales is the difference between closing and continuing to operate" and "forcing the only store in the community to close would be an economic hardship on the whole community" (p. 4). He insists that penalties for violation must respect the traditional laws of the community and he recommends the establishment of an elders council to "adjudicate and mediate suspected violations" (p. 4). Seltenrich also finds that some RCMP detachments do not enforce the Tobacco Sales Act and the Tobacco Act because there are other priorities that take up their time.

The enforcement matrix included options for the Nisga'a Lisim government to create its own laws, regulations, and penalties with respect to regulation of vendors, sales to minors, enforcement activities, mandatory health warnings (to be displayed in the Nisga'a language), and offences. It was submitted for a legal analysis, and at the risk of oversimplifying the 46-page legal opinion, this approach was not encouraged, at least not until further analysis is undertaken to determine the broader beneficial and detrimental impacts of each option (internal MOHP document, legal opinion report, Singleton Urquhart, 21 June 2000). While it is beyond the scope of this report to reiterate the detail of legal counsel's opinion for each proposed option, the following examples illustrate the gist of the opinion and the need for further analysis in the area of tobacco control policy.

With respect to the proposal that manufacturers be required to display all health warnings in the Nisga'a language, legal counsel raised concerns that this "might render tobacco distribution in the region uneconomic for tobacco producers, or substantially increase the cost to consumers. When this type of price

anomaly occurs, one might expect black markets to develop, resulting in new health risks resulting from unregulated activity, as well as organized crime” (p. 35). Counsel advised that a cost benefit analysis should be undertaken to provide clear evidence that enhancements to the existing strategy would be achieved, as well as to reveal detriments arising from the proposal.

With respect to the proposal to enact a Nisga’a law to prohibit tobacco vendors from selling to those under age 19, counsel pointed to existing provincial and federal legislation and suggested that if there is an enforcement deficiency, “then the remedy would be to pursue better enforcement of existing laws, rather than passing a third layer of legislation aimed at accomplishing the same objective” (p. 40). The proposal requiring tobacco vendors to require anyone who appears to be under the age of 27 to supply proof of age in order to purchase tobacco products was also cautioned against. Counsel advised against repeating the provisions within provincial and federal legislative schemes, stating that “if the federal and provincial programs are flawed ... then efforts should be directed at making the existing schemes work better rather than creating a third program” (p. 41).

With respect to the creation of an offence for all persons under the age of 19 who purchase cigarettes, counsel suggested “that it would be necessary to have a better understanding of the reasons why this policy choice has not been made elsewhere, the potential social implications of the law, and whether there is any unique aspect to Nisga’a society that would indicate or contra-indicate the potential utility of such a law” (p. 42).

Regarding the proposal that all consumers be required to fill out forms stating their name and age as a precondition to purchasing tobacco, there were concerns with respect to the charter and privacy issues. “The NLG is a new government. It should not be seen as intruding on the civil liberties and privacy of its citizens, particularly with a policy that other governments could enact but have chosen not to” (p. 27).

In summary, the opinion concluded that:

most of the enforcement matrix proposed above would appear to be legally capable of enactment by the Nisga’a governments. However, some require further consideration and others are, in our view, inadvisable ... In the case of all of the proposed laws, it should be first established that the evidence clearly justifies the law, after a comparison of costs and benefits, before the NLG considers adopting any policy. (p. 28)

While the Nisga’a are obviously concerned with reducing tobacco consumption among citizens of their nation and should be applauded for their proactive stance, their foray into this arena highlights the broader implications of tobacco control legislation and policy and supports the need for further, rigorous, and comprehensive analysis, such as that proposed in this project. Clearly, more consultation, research, and analysis are needed.

APPENDIX C. Self-government and taxation

HOW WILL SELF-GOVERNMENT AND COMMUNITY CONTROL OF TAXATION CHANGE THE SITUATION?

In 1995, the government of Canada recognized the inherent right of self-government as an existing Aboriginal right under section 35 of the Constitution Act, 1982, and instituted a policy framework for self-government negotiations. The Department of Indian Affairs and Northern Development (DIAND) is currently engaged in self-government negotiations at some 80 tables, including comprehensive self-government negotiations (including land claims) and jurisdictional issues such as education and child welfare (DIAND, 2003).

Canada gave royal assent to the Nisga'a Final Agreement Act in April 2000 and the treaty came into effect on 11 May 2000. The Nisga'a Agreement is the first modern-day treaty to explicitly extend protection to both land and self-government rights (DIAND, 2003). There are countless questions to be addressed relating to the impact of self-government on tobacco control efforts that are beyond the scope of this research. However, the recent negotiation of the Nisga'a Agreement provides an opportunity to anticipate some of the questions that will arise.

The Nisga'a Agreement provides for the Nisga'a government to make laws for direct taxation applicable to Nisga'a citizens on Nisga'a lands; the power of "direct taxation" is the same power of taxation that British Columbia has (*Understanding the Nisga'a Agreement*, n.d.). Section 87 of the Indian Act (which provides the basis for tax-exempt tobacco) ceases to apply to Nisga'a citizens in two stages. A remission order provides Nisga'a citizens with eight years' exemption from "transaction taxes," such as provincial sales tax, and twelve years from other taxes, such as income tax. When the remission orders expire, Nisga'a citizens will not be eligible for exemptions on other Indian reserves (Fiscal Realities, 1997), thereby eliminating the opportunity for Nisga'a citizens to purchase tax-exempt cigarettes on other First Nations' lands.

Although provision for taxing tobacco products currently exists (see discussion on First Nations tax), very few of the nearly 200 bands in BC have chosen to exercise that option. The expanded taxation authority of the Nisga'a Lisim government will create new fiscal relationships with not only the governments of Canada and BC, but with its own citizens. How will the drive to collect much-needed tax revenues, including those derived from tobacco products, influence efforts to reduce tobacco consumption? How would the imposition of increased taxation affect the overall socioeconomic situation of Nisga'a citizens? Will taxation revenues generate new opportunities to positively address the broader social and economic forces that support and sustain smoking behaviour? New opportunities and challenges will no doubt be revealed.

As more First Nations enter into treaty negotiations, it would be extremely timely and useful to have a more comprehensive understanding of both the positive and negative implications of tobacco taxation. A thorough delineation and analysis of the impacts of taxation policy (such as that proposed in subsequent phases of this project) would assist in ensuring that if taxation is deemed to be an effective tobacco control strategy, then policies and programs that mitigate its negative impacts are developed.

APPENDIX D. Tobacco Taxes

Tobacco taxes include a provincial tobacco tax, a federal excise tax, a federal excise duty, a provincial sales tax (in some provinces), and the GST. Amounts vary by province. The following table shows the estimated price for a carton of cigarettes with all taxes included.

TABLE D.1 ESTIMATED DETAILED RETAIL PRICE FOR A CARTON OF 200 CIGARETTES PER PROVINCE (IN DOLLARS), AS OF APRIL 2003

Province	Provincial Tobacco Tax	Federal Excise Tax	Federal Excise Duty	Product Cost	Retail Price Before Sales Tax	Provincial Sales Tax (PST)	Federal Goods and Services Tax (GST)	Final Retail Price
Newfoundland	27.00	10.35	5.50	16.50	59.35	4.75	4.15	68.25
Prince Edward Island	29.90	10.35	5.50	16.50	62.25	0.00	4.36	66.61
Nova Scotia	26.04	10.35	5.50	16.50	58.39	4.67	4.09	67.15
New Brunswick	19.50	10.35	5.50	16.50	51.85	4.15	3.63	59.63
Quebec	18.10	10.35	5.50	16.50	50.45	0.00	3.53	53.98
Ontario	17.20	10.35	5.50	16.50	46.25	0.00	3.47	53.02
Manitoba	29.00	10.35	5.50	16.50	61.35	4.29	4.29	69.94
Saskatchewan	32.00	10.35	5.50	16.50	64.35	3.86	4.50	72.72
Alberta	32.00	10.35	5.50	16.50	64.35	0.00	4.50	68.85
British Columbia	32.00	10.35	5.50	16.50	64.35	0.00	4.50	68.85
Yukon	20.40	10.35	5.50	16.50	52.75	0.00	3.69	56.44
Northwest Territories	33.20	10.35	5.50	16.50	65.55	0.00	4.59	70.14
Nunavut	31.20	10.35	5.50	16.50	63.55	0.00	4.45	68.00

Sources: Finance Department, Provincial Governments.