Aboriginal Adolescent Girls and Smoking: A Qualitative Study

Report of Key Findings

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OVERVIEW OF THE STUDY

When I smoked, I ran out of breath really fast and I felt my heart beating in my head and my fingers and I felt like I was going to pass out just by playing basketball for about 15 minutes. But now my lungs are working back and it's way easier for me to play basketball and all the other sports that I like.

Being involved in the dancing and feasts and preparing food—it makes you proud of yourself. It gave me some pride, and I feel good about myself.

I think my community overall is trying to look after the health and well-being of our community. The community is really open to any kind of prevention with our people, and they're trying to raise a healthy community.

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

—research participants

This report presents key findings from a qualitative study on smoking and Aboriginal adolescent girls (ages 13 to 19). The study was conducted in 2007-08 in partnership with six Aboriginal communities in British Columbia and researchers affiliated with the British Columbia Centre of Excellence for Women's Health and the University of British Columbia. The study's findings shed light on how age, gender, culture, and context intersect to shape Aboriginal girls' experiences of smoking. The need for the study emerged from our experiences with tobacco prevention and several research projects undertaken since 2002, which identified the need for culturally based and gender-sensitive evidence and frameworks to inform tobacco-control programming among Aboriginal girls. This project was designed to facilitate educational development and knowledge generation among a multidisciplinary team of Aboriginal and non-Aboriginal researchers.

Relevance of the Study

The study responds to an urgent need for smoking-related research, policy, and practice initiatives better tailored to the realities of Aboriginal girls. Smoking rates among Aboriginal teenaged girls are the highest of any group in British Columbia. Thirty two percent of female Aboriginal teenagers report current smoking, compared with 22 percent of Aboriginal male teenagers, 17 percent of all BC female teens, and 13 percent of all BC male teens.[1,2] Prevalence rates among both Aboriginal and non-Aboriginal teens are higher in the northern and more remote areas of the province.[1,2] Aboriginal youth also initiate smoking early; 87 percent of smokers have begun by age 14, and 31 percent started at age 10 or before.[3] Encouragingly, 73 percent of Aboriginal smokers report an attempt at quitting in the past six months, and 4 percent of Aboriginal girls aged 13 to 18 (vs. 2% of the total population) have quit smoking.[1]

Goals

While the voices and health knowledge of girls—and Aboriginal girls in particular—are often silenced and discredited in health research, or simply not present, this study placed their perspectives at the centre of the research process. The goals of the study were to:

1. Increase knowledge about girls' and communities' perceptions and about factors that influence smoking;
2. Define the influence of gender, age, and cultural identity regarding smoking;
3. Provide community partners with relevant information about what influences tobacco use among Aboriginal girls in each community;
4. Amplify the presence of Aboriginal knowledge in smoking-related research, policy, and programming; and
5. Identify young Aboriginal women and community partners for future initiatives.

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[1] *Lighting Up: Tobacco Use among BC Youth.* Burnaby BC: McCreary Centre Society, 2000.
[2] *Mirror Images: Weight Issues among BC Youth. Results from the Adolescent Health Survey.* Burnaby BC: McCreary Centre Society, 2000.
[3] *Raven's Children: Aboriginal Youth Health in BC.* Burnaby BC: McCreary Centre Society, 2000.

Aboriginal Partners

When health research is conducted in Aboriginal communities, the process and outcomes are too often disconnected from community needs and perspectives. An important goal of this study was to work with Aboriginal communities to strengthen community-based knowledge and approaches to smoking interventions, while conducting effective community-based research. Six Aboriginal partners played a central role in developing and conducting the study:

1. Laichwiltach Family Life Society
   Team: Audrey Wilson, Executive Director
   Debbie Weir, Community-based Collaborator

2. Sliammon First Nation, Tla'Amin Community Health Services Society
   Team: Laurette Bloomquist, Executive Director
   Vicki Harry, 1st Community-based Collaborator
   Cathy Paul, 2nd Community-based Collaborator

3. Kermode Friendship Society
   Team: Arleen Thomas, former Executive Director
   Diane Collins, Executive Director
   Caroline Daniels, Community-based Collaborator

4. Penticton Indian Band
   Team: Lynn Kruger, Health Director
   Elaine Alec, Community-based Collaborator

5. Port Alberni Friendship Centre
   Team: Cyndi Stevens, Executive Director
   Joanne Touchie, 1st Community-based Collaborator
   Lexus Kang, 2nd Community-based Collaborator
   Darlene Leonew, 3rd Community-based Collaborator

6. Metakatla Band
   Team: Patricia Silieff, Health Director
   Fanny Nelson, Community-based Collaborator

Each community developed a Memorandum of Understanding (MoU) to entrench their rights and values into the research process and to clarify appropriate protocols and ethical guidelines for the conduct of research in partnership. Each community decided how the results of the study would be shared, evaluated, and implemented.

Co-investigators

Denise Lecoy, BC Ministry of Health, Aboriginal Health Branch

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RESEARCH DESIGN

The qualitative design involved multiple methods and was exploratory and descriptive in nature. As such, the participants and findings are not representative of each community's population, or of Aboriginal teen girls in British Columbia. What can be gleaned from the data are insights about recurring patterns, important themes, identified gaps and resources, recommendations for effective intervention related to prevention and smoking cessation, areas for future research, and implications for gender-sensitive and culturally relevant practice and policy development.

Community Leadership

Community-based collaborators (CBCs), members of the community involved in the health sector, took a leadership role in the research. The CBCs completed research training, coordinated community outreach, helped to develop and pilot research questions, recruited participants, conducted the individual interviews, planned focus groups, participated in analysis, and facilitated community dissemination and evaluation.

Recruitment

In total, 63 girls between the ages of 13 and 19 participated in a mix of individual and focus-group interviews. Girls were selected through purposive sampling: they were recruited by the community-based collaborators (CBCs) and/or by snowball sampling, based on invitations

from other participants or community members. All of the girls participated on a voluntary basis and received an honorarium.

Data Sources and Analysis

The questions we asked in the semi-structured individual and focus-group interviews were developed and revised collaboratively, and piloted with volunteer adults and girls. The findings presented in this report are based on a collective team analysis of the following data sources:

1. Individual interviews with 50 girls from 6 communities;[2]
2. Five focus groups with 23 girls from 5 communities;[3]
3. Individual interviews with 5 CBCs;
4. Focus-group interviews with community service providers;
5. Field notes and transcripts from research team and community meetings.

FINDINGS AT A GLANCE

> *[What benefited me most was] learning from my background and teachings from the Elders—I can do whatever I want if I just believe in myself.*
>
> —research participant

Breakdown of Smoking Habits: Individual Interviews

Out of 50 Aboriginal girls:

- 42 percent have never smoked
- 58 percent of girls are smokers or former smokers
- 32 percent of girls currently smoke
- Almost 7 percent of current smokers are cutting back
- Almost 45 percent of former smokers quit before the age of 19
- Most smokers try quitting numerous times (up to 15 times)

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[2] 63 girls participated in individual interviews *and* focus groups. That is, we interviewed 50 girls and then out of the 23 girls in the focus groups, 13 did not participate in the interviews

[3] Out of these 23 girls, 10 had previously participated in the individual interviews.

- The majority started smoking around age 12 or 13 (grades 7 to 8)
- Several girls reported trying smoking for the first time before age 6
- 60 percent of all girls have tried other substances such as alcohol or marijuana

Self-described	Out of total (n = 50)	% of total	Out of smokers (29) & non-smokers (21)	% of smokers
Have smoked/ Currently smoke	29/50	58%	n/a	
Smokers	21/50		n/a	
Non-smokers	21/50	42%	n/a	
Non-smokers who tried once/few times[4]	7/50	14%	7/21	33% of non-smokers
Quit smoking	13/50	26%	13/29	44.8% of all smokers
Cutting back	2/50	4%	2/29	6.8% of all smokers
Total quit/cutting back	15/50	30%	15/29	51.7% of all smokers
Currently smoking Incl. cutting back Excl. cutting back	 16/50 14/50	 32% 28%	n/a	

Key Demographic Characteristics

- The majority of girls do not work; almost all attend school.
- Common career goals include: culinary arts, beautician/aesthetics/hairdressing, photography, early childhood, counselling, and other college/university goals.
- 70 percent are engaged in physical activity: basketball, soccer, and volleyball are the most popular sports in and out of school.
- Swimming, walking, and hiking are also popular.
- Many mention "partying" as a favourite social activity.

[4] Seven non-smokers reported trying it once/a few times (ages not consistently specified) but were not listed under the "have smoked" category.

- Other favourite pastimes: music, art, dance, hanging out with friends, shopping, playing video games, and watching movies and television.
- A few volunteer in youth groups.
- Less than 10 percent report having children.
- Girls live in diverse families: with single and dual parents, in blended families, with multiple siblings and/or extended family members, and in government care.

Reasons for Smoking

The most commonly stated reasons for starting smoking were:

1. Relational and peer pressures: to fit in, be cool, and please others, including friends, family, and community members. This is how some of the girls described social pressures:

   I wanted to be cool like them.

   I wanted to fit in.

   Everyone was out at the smoke pit, offering everyone cigarettes. And everyone kept on [saying] "smoke one, go ahead, you'll like it fine."

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

2. Stress relief: Girls deal with a range of emotions such as anger, grief, sadness, isolation, moodiness, the pressures of "being a girl," as well as conflict with family, friends, and school.

   I had to watch [babysit] my brother a lot and probably that.

   All the pressure of teachers and schoolwork.

   A loss of loved ones.

   Mostly just the way my family is now—it's all messed up.

3. When drinking and partying.

   Just everyone around me was smoking or I'd be drinking and smoking at the same time.

   When I was drinking that's how I started smoking.

4. Curiosity and experimentation, "just to try it."

   She pulled them out and she said "why don't you just try it" and I tried it.

   Things that make girls smoke are stress and curiosity.

Relationship of Tobacco Use to Other Substance Use

- 30/50 (60%) use, have used, or have tried alcohol and/or marijuana.
- Many girls were drinking before they smoked or when they started smoking.
- The majority of smokers report smoking more when drinking. Many say: *I smoke a lot when I drink.*
- Girls drink alcohol for other reasons than they smoke: *to socialize, let loose, party, have fun, lose control, forget.*
- Reasons and patterns for marijuana use are not clearly linked to tobacco use.
- Even if each substance is used for different effects, the common factors in all substance use are peer and relational pressure.

Summary of Prevention and Cessation Strategies

The girls suggested the following prevention and cessation strategies:

- Health and social costs should be highlighted
- Much earlier prevention
- Role models of all ages from the community
- Role models girls can relate to
- Personal stories of success through struggle
- More activities: youth and cultural activities, sports, arts, etc.
- Stress-relief supports
- Prevention and cessation supports such as drop-in programs, peer supports, cessation rewards, etc.
- Life-skills training
- Counselling supports and safe places tailored to girls, to address girls' issues that go beyond "stress"
- Cultural modelling of healthy girls/women
- Family and community interventions
- Healthy communities

Summary of Findings by Theme[5]

1. Physical activity

Fifteen of the fifty girls (30%) did not report engaging in physical activity.

Nine out of those fifteen reported other non-physical activities only (3 smokers, 3 former smokers, 3 non-smokers).

Walking and swimming were the two most popular after-school physical activities.

2. *Gender: Differences between boys and girls*

Twenty-one of the fifty girls (42%) saw differences in smoking between boys and girls.

Nineteen (38%) saw no difference.

Ten (20%) were not sure / gave no response / said maybe (4% maybe).

3. *Culture: Differences between Aboriginal and non-Aboriginal girls (smoking)*

Thirteen of the fifty in the study (26%) saw differences.

Twenty (40%) saw no difference—1 observed that non-Aboriginal girls smoke more.

Seventeen (34%) were not sure / gave no response / said maybe (2% maybe).

4. *Discrimination against Aboriginal people*

Eleven girls (22%) noticed discrimination against Aboriginal people.

Four (8%) did not notice discrimination.

Thirty-five (70%) did not respond to the question.

5. *Other drug or substance use*

Thirty of the fifty girls (60%) use, have used, or have tried other substances.

Approximately twenty-seven (54%) currently use at least one substance.

Two (4%) do not use other substances.

Eighteen (36%) did not respond (mostly non-smokers).

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[5] Findings are descriptive due to small sample size. All numbers are approximate.

Of substance users (out of 30)

twenty (67%) use, have used, or have tried marijuana.

16/30 currently use marijuana.

2/30 tried it once.

2/30 have quit.

10/30 (33.3%) drink or have tried alcohol.

1/30 tried it once.

1/30 has stopped.

18/30 (60%) use marijuana and drink alcohol together.

6. *Smoke more when drinking*

15/50 (30%) smoke/smoked more when drinking.

8/50 (16%) do not smoke more when drinking.

3/50 (6%) do not drink.

24/50 (48%) did not respond (mostly non-smokers).

7. *Smoke more when smoking marijuana*

13/50 (26%) smoke marijuana.

3/50 (6%) smoke more when smoking marijuana.

4/50 (8%) do not smoke marijuana.

30/50 (60%) did not respond (mostly non-smokers).

8. *Culture: Proud to be First Nations/Native/Aboriginal*

35/50 (70%) feel proud or very proud of being Aboriginal.

4/50 (8%) think ethnic/cultural background does not / should not matter.

4/50 (8%) feel in the middle/ambiguous or are not notably proud.

7/50 (14%) did not respond.

KEY FINDINGS

Smoking is a Multifaceted Strategy

Smoking serves as a multifaceted strategy to address a variety of physical, emotional, cognitive, social, and relational needs. Girls use tobacco to:

- Self-soothe emotions such as anger, sadness, frustration, anxiety, and grief.

  I get angry and mad and frustrated.

  Another part of stress is fighting—fighting with others.

  Losing someone in your family—that's really hard.

- Cope with chronic stress.

  Family problems, school problems.

  Living in a foster home.

- Decompress when an incident or issue comes up.

  I'd want to go for a walk, have a cigarette, you know? It was a way out of a lot of things.

- Alleviate addiction cravings.

  Even if nothing is going on, I need a smoke because I'm addicted.

  I could get cravings at any time.

- Mitigate boredom and pass time.

  There's nothing to do in that village.

  The bus drops us off early at school.

  When we're bored … when we're in school … in between breaks and lunch and then after school—that's about it.

- Cope with chronic discrimination, racism, and social exclusion.

  A lot of people, like, look at us and think we're all the same, like they're discriminating.

  They all think that we're all really drunks and we all do drugs—that kind of stuff.

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

- Gain social acceptance and lessen peer and relational pressure.

  I did it to fit in. They just bugged me until I smoked.

- Have fun while drinking/partying, usually at house parties or outdoors.

  We all party together—it's just normal.

Because girls report a lack of healthy outlets in these areas, prevention strategies should be multifaceted rather than addressing physical, emotional, cognitive, social, and relational needs in isolation.

Smoking Behaviour and Stress

Addiction is a powerful driver for smoking. Many girls reported smoking simply because they were addicted and/or for the nicotine. As such, the stress of smoking (cravings, cost, health effects, moodiness, smell, etc.) creates a vicious cycle for smokers.

> *Girls who smoke are like "oh I have to have a cigarette" and the girls who don't smoke don't have to worry about a cigarette … but the other ones get more stressed out and frantic if they don't have a smoke.*

The majority observed that smokers are simply dealing with stress differently and in a way that negatively impacts them, as opposed to non-smokers who may make other (and in some cases, healthier) choices:

> *I think the stress is equal.*
>
> *[So not the level of stress, but they way they handle it?]*
>
> *Yeah; yeah; yes because they smoke.*
>
> *[Girls who don't smoke are more active?]*
>
> *Yeah, they [deal with stress differently], to relieve their stress, yeah.*

Nonetheless, a few girls emphasized that smokers do face more pressures and/or isolation:

> *That's why we started smoking in the first place.*
>
> *People go to smoking because they have no one to talk to.*

In terms of cessation strategies, we noted that supports in managing stress have limited effectiveness once the girls are already addicted. When asked if they would be inclined to smoke less or quit if given alternatives to dealing with stress, the majority of girls answered "no."

> *It makes no difference, especially when you're living with somebody who smokes.*

However, for a few girls the responses were more favourable:

> *It would probably help quit smoking altogether, slowing down first.*
>
> *I'd probably quit. Not right away, but I'd quit.*

You just have to drop that lifeline.

Stress was reported as an important trigger for smoking. Girls report a range of issues that create stress in their lives: exposure to different forms of violence; family and home tensions, including conflict with parents, caregivers, siblings, and family members; school pressures such as scheduling and homework; worries about the future, success, employment, and money; as well as peer pressure and peer-group issues such as cliques and gossip. Girls have a broad vocabulary to describe emotional, social, and physical manifestations of stress. These are some of the things they said when asked "How do you know when you're under stress?"

> *Crabby; really hyper; anxious; fighting; a lot more snappy; kind of like self anger; frustrated; I don't want to be around anyone; freaking out; legs tapping on the floor; like really nuts; I get anxious; you're like really pissed off and you just start crying because you're so mad; I feel lazy; depressed; stomach in knots; hands are sweaty; being nervous; like really, really, really nervous; moody; I just zone out; I get snappy; crabby; moody; bad temper; sleep all day; get angry a lot; I feel like I almost break down; I try to control everybody; I just get so mad; I get tired; When I'm angry the first thing I want to do is smoke.*

Because "stress" is a catch-all word that is also used to describe depression, trauma, PMS, conflict, anger, social isolation, violence, and many other experiences, it's important to consider the implication of subsuming such a spectrum of experiences under the broader category of "stress." For example, do hormonal changes, depression, anger, and conflict in girls become reconstituted as "stress" because of gender norms? It is possible that saying they are "stressed out" is more socially acceptable than addressing girls' anger, resistance/defiance, and potential aggression. To what extent are girls constrained by gender norms that provide narrow avenues for expressing and dealing with stress and its sources?

Partying and Related Behaviours

The study yielded valuable information related to the prevalence of "partying" and related behaviours (drinking, smoking, pot use, and sexual activity).

Partying

[What group do you see yourself in?]

Party.

Play lots of video games and smoke a lot of weed.

Party; party people; same; party people; yeah, all of us.

[Anybody else hang out with another group?]

No.

[So what activities do you do?]

Drink; drink; party; smoke; smoke; and dance.

[Do you guys do drugs?]

What counts as drugs?

[Pot, ecstasy] Oh (laughter).

I've tried pot; yeah; I've tried pot too; I've tried pot.

[What activities do you do when you hang out with your friends: smoke, drink, party, do recreational drugs, play videogames, have sex?]

All of the above (laughter).

None of that!

How much do I drink? … Ten drinks.

Like once you start drinking it's like you can't stop.

[Do you guys drink very often?]

Lots; yeah; a lot; yes; I don't … or smoke.

[Do you sometimes do drugs?]

Sometimes; yeah; yeah, like every day.

We just consider it pot—for us it's not necessarily considered a drug.

Most girls did not describe cigarettes or marijuana as drugs—as substances, these were significantly normalized, and practically a non-issue compared to other drug use.

Many girls report sexual activity at house parties or while engaging in partying, where they may face pressure from boys to engage in sexual activity. When asked about what activities they engaged in when hanging out / partying with peers, the girls said they:

> *Probably play video games, smoke pot, drink, party, and have sex.*
>
> *[Do you have sex?]*
>
> *Once or twice a month; once a month; quite often.*
>
> *Sex can be a pressure.*
>
> *When you don't want to have sex and the guy's like, you know…*

Non-Smokers and Marijuana, and Alcohol Use

The data did not conclusively reveal whether non-smokers drink or use marijuana as much, more, or less than smokers. Some non-smokers reported drinking whether or not they smoke, and as much as smokers do.

Some of the non-smoking girls reported using alcohol for coping instead of cigarettes. Some non-smokers stressed that they do not rely on drinking to relieve stress. They answered "no" when they were asked: *For those of you who don't smoke, do you use alcohol for coping when you're stressed out instead of cigarettes?*

Other reasons for non-smokers to drink included: *when stressed, confused, to party, to socialize, when bored*. Frequency of drinking ranged from never, rarely, once in a while, once or twice a month, every weekend, to every day. The main reason for drinking seemed to focus primarily on its fun, social aspects:

> *Drink for fun; Fun; Because I'm bored.*
>
> *You meet new people.*
>
> *It's like social … I like getting drunk because it's fun, and you do more crazy stuff when you're on autopilot.*

Some of the girls who do not smoke cigarettes but do smoke marijuana reported smoking more when drinking. A few girls reported using no drugs at all.

Smokers Mixing Substances

Across all communities, drinking leads to an increase in cigarette use for the majority of smoking girls:

> *[Does your smoking increase when drinking?]*
>
> *Yeah, oh yeah, totally; probably a lot; yes.*

Drinking patterns for smokers included rarely, weekends, breaks, summertime, every day, and all week. While the majority of girls reported smoking and drinking together, most cigarette smokers do not typically smoke marijuana and cigarettes together—approximately one third of the girls claimed they may do so, in part because it enhances their buzz or further relaxes them.[6] There were almost no reported examples of "hidden" tobacco use. Only one girl reported having used tobacco in joints, while another stated she had heard it could be done.

Most girls reported that they do not typically mix pot and alcohol, but a few specified they do: *But it's not a good mix—you tend to black out.* Many girls emphasized that each substance has a different effect: *They each do their own little thing.*

Physical Activity

Determining where, when, and how girls engage in physical activity, and the effects of smoking on physical activity, is difficult because of the diversity within and across communities. However, it is clear that girls are extremely knowledgeable about the negative effects of smoking. In their own words, girls reported effects including: *yellow teeth; heart palpitations; out of breath; yellow fingers; can't exercise as much; wrinkles/bad skin; looking older; lung cancer and other cancers; heart problems; lack of energy and lung capacity; reduced energy; cardiovascular problems; limits endurance; bad smell; slows you down; can't run as much as I used to; run out of breath faster; wheeze; cough; phlegm; chest hurts, runny nose.*

Even the girls who are active reported negative health effects due to smoking:

> *Like before I used to do like track and field and run a 400 metre, 800 metre. Now, phuff, yeah right, get me to run a 100 metre and I'd … I need a smoke!*

---

[6] This question did not clarify a time frame (smoking cigarettes and joints concurrently, in rapid succession, or within the same evening, for example).

I realize I can't run as much anymore or I'll get out of breath and very tired. I used to be very good at soccer and be able to keep up with most of the players. Now I just like tend to play back and not push myself as hard because I can't, I have a hard time breathing. And I seem to get sick a lot more, like when I used to before—not very good.

Although physical education is mandated until grade 11, many of the girls do not attend consistently or opt out when they can. They described their experiences in physical education classes as: *boring; real easy; we just don't like it; too hard for smokers; I can't run; we're out of breath easy; it's easy to get out of it; I get sweaty and the showers are cold; we don't really know anyone in our class.*

The majority of the communities offered a range of activities, including basketball, soccer, skating, recreational or community centres, swimming pools, and some cultural activities such as dance. However, girls reported barriers to engaging in extracurricular activities, such as cost, access, age restrictions, and lack of choice and variety. Many girls reported that people smoke outside their drop-in and recreational centres.

In terms of other activities, the majority of girls enjoy playing video games and watching television and movies. There was some mention of computer use and online activity, but no mention of social networking sites such as Facebook; however, the questions did not probe for specific examples. Other popular pastimes included walking and driving around. A few girls reported being involved in *Indian carving, First Nations art,* and *Native dancing.*

Peer Pressure, Being Cool, and Fitting in

Smoking was identified as a social behaviour with tangible social benefits (fitting in, being cool and accepted, having a good image, etc.):

I think that was one of the biggest things why I started smoking—because I thought is was cool.

[Who is popular?] A lot of people smoke, drink, do every stupid stuff like drugs.

Some girls identified strategic social smoking (smoking to gain social benefits in specific situations) as a prominent smoking behaviour.

A lot of girls do it just for like popularity reasons or it's like cooler.

For peers or for other social groups in school or whatever. But a lot of them don't really smoke—they'll smoke at school and then they'll go home and they'll stop.

Many measures of popularity were not necessarily related to smoking, but rather to being socially integrated and accepted, and having the right attitude, social skills, look, and image:

Nowadays you have to have a [fashionable image].

Do what everyone else is doing.

Trying to look the way everyone else looks.

You want to be unique but fit in.

The same people who try to be cool are people who are really, really outgoing and do a lot of activities and aren't shy to talk to people.

Just the way they look.

Measures of unpopularity included being shy, too different, a loner, weird, or not well dressed. Being "preppy" was sometimes mentioned as a measure of popularity. None of the girls reported smoking to lose weight, emphasizing that industry standards of beauty are not a factor. The girls may be less susceptible to external or mainstream ideas of popularity because peer pressure comes mainly from within their own social group:

Like the popular kids at school are like the preps … [but] totally your own opinion of what popular is.

Yeah they all differ, so.

Like the preps are what you consider the popular ones or whatever but really … it's different for everyone.

I don't care about popular.

You've got your cliques when you come to high school, so I mean it's depending on what you think is popular.

[Do you ever feel pressured by your friends?]

All the time.

The girls emphasize that whatever the standard (fight, smoke, drink, work out, do drugs, play a certain sport or video game, dress or look a certain way, etc.), peer pressure centres on meeting whatever standard is established by one's group or clique.

For some girls, measures of popularity and belonging are racialized:

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

There were some differences noted between what is popular for Aboriginal and non-Aboriginal girls, particularly in relation to how girls are expected to behave, such as pressures to party, smoke, and have a strong attitude:

> *No. It's not the same issues.*
>
> *Well I think with Native girls it's like you have to party and smoke weed and stuff.*
>
> *They're expected to be, like, tough.*
>
> *Aboriginals are kind, but we can show other people [white girls] our snobby side.*
>
> *For Native girls it's a little bit the personality, like their attitude.*

Family as Peer Group

Many of the girls reported strong intergenerational relationships, as well as spending a lot of time with immediate and extended family. For many, family members are integral to their peer group:

> *I hang out with my cousins.*
>
> *My family [is who I hang out with].*
>
> *I hang out with my friends and my mom.*
>
> *My mom [is my peer group].*

The strength of family influence is particularly evident in the normalizing effect smoking in families has on girls' smoking behaviours. Given these findings, notions of peer groups and peer pressure may need to be redefined to account for very strong family and intergenerational ties in girls' lives.

Two Trends: Secrecy and Normalization

We identified two trends for smoking with family and in the community, each with its own factors and implications.

Secrecy. Although our findings suggest that secrecy is not prominent, there are still some girls who do hide their smoking because it is not commonly accepted. Girls who reported that their families (particularly their Elders) do not smoke seemed more likely to hide it. Girls who smoke in secret may experience shame, guilt, or embarrassment. Peer pressure and the desire to be cool or defiant may play a larger role in secretive smoking behaviours:

> *My mom hates it when I smoke. My family says that I should stop while I can. My grandpa told me it's a bad habit.*
>
> *We didn't hang out in public, we just went behind buildings … in bushes and stuff like that, so nobody really seen, just my friends.*
>
> *I don't really care what they think, I'll smoke anyway.*
>
> *[My family does not know] They probably would have reacted by grounding me and taking my cell phone away.*

Heavy smokers report that regulations and no-smoking zones do not have an impact on their smoking rates: *I don't care, I'll go in the bushes if I need to smoke.*

The impact of secrecy is that girls may be less likely to seek supports even when they're needed.

Normalization. The second trend is that smoking is accepted and normalized in many families and communities. In all communities, a majority of girls have parents, siblings, caregivers, or other family members who smoke, often in the home.

> *My mom smokes, my brother smokes, and my brother's girlfriend smokes.*
>
> *If your parents smoke you might as well smoke because you're getting second-hand.*
>
> *[So it was acceptable?] Yeah, it was like normal.*
>
> *Like my parents smoke, like at least one or two packs a day.*
>
> *When I did smoke my mom bought them for me and she didn't care.*

These observations point to the normalization of smoking and other substance use by family members. Normalization can take many forms:

> Non-interference: *My mom only found out this year. [What did she say?] Nothing.*
>
> Some family and community members tacitly encourage smoking.

I grew up around it. My mom smokes, my dad smokes, my [two] grandmas smoke—so it was just one of those things I grew up with … I guess just some people they, like, just smoke to fit in.

Some adults model a "partying" lifestyle by drinking and smoking.

My dad only smokes when he's drinking.

My mom smokes when she's drinking.

My dad smokes when he drinks … my mom smokes.

Some parents and family members also facilitate girls' access to cigarettes.

My mom used to give them to me.

My mom buys them for me.

[I get them from] my brother's girlfriend.

Family and relational pressures, the need for community acceptance, and values of non-interference may play a larger role in normalized smoking behaviours than researchers have understood. While peer pressure is often understood as a contributing factor to youth smoking, findings from this study indicate that categories of influence may need to be extended to also account for family and community members who have an impact on Aboriginal teen girls' smoking behaviour.

Accessing Cigarettes

Girls gain access to cigarettes through a variety of means.

- Adults/older youth buy packs and resell them for profit in schools, at parties, etc. Girls have access to tax-free cigarettes.

  There's people that buy smokes on the reserve and come to school and sell them.

- Many steal them, sneak them from others, or ask strangers to buy them.

  My mom smokes, so I'd just take some now and then, and she didn't really notice.

  I'll just ask someone in front of the store and they'll often do it.

- ID may not get checked in stores.

  At some stores you don't need ID for lighters and cigarettes.

- Relatives and community members may buy or gift cigarettes.

  Friends, sometimes my aunties, cousins … relatives.

My mom buys cigarettes for anyone else in the family.

- Older friends who can get cigarettes share them with the group.

  I can get a friend, he's old enough to buy it or sometimes I can do it—I can buy cigarettes.

Impact of Gender on Smoking

- Girls do not smoke to lose weight.[7]
- "Being a girl" affects girls' daily lives and the issues they deal with.
- Almost half of the girls feel that boys "have it easier" than girls.
- Almost all of the girls agreed that girls face different pressures than boys related to gender roles and expectations.
-

Girls report that they face stereotypes and gender bias in many forms:

> *Yeah, I think so, boys are just thought of as being stronger than girls … some people think guys are smarter than girls.*
>
> *I think guys have more choices in jobs than girls.*
>
> *My brothers just call me down for no reason, punch me, push me into the wall.*
>
> *If you're a girl in my family you might get treated more harder because they don't want you to wreck your future.*

Girls deal with more demanding beauty norms:

> *They like try to get all pretty so the guys will like them.*
>
> *Guys don't really care about how they look.*
>
> *Girls are always like obsessing about their body shape.*
>
> *[also pressure from] culture … and the way they look.*

Girls tend to worry and are more emotionally involved than boys:

> *We take things more like harshly, like breakups or something.*
>
> *Yeah; oh yeah; oh yeah, big time!*
>
> *I think so—yeah—girls are too emotional.*
>
> *Girls worry a lot more than guys do. Guys are kind of like "uh, whatever, who cares."*

Girls face higher social standards to be more mature and responsible than boys:

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[7] This finding is supported by other research that underscores a disconnection between corporate marketing of female beauty, and what girls actually experience in their day-to-day lives.

[Girls] do things; they put themselves out there; they want to work. The guys just kind of sit back and expect things to be handed to them.

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

[They] totally treat girls differently from boys.

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

Findings reveal a notable prevalence of clear gender distinctions in girls' lives. This contributes to a sense of vulnerability for girls, while boys were described as having more social power.

I think girls care a lot more about being popular than guys do.

[Girls experience] low self-esteem.

I think males have it easy.

Yeah; yeah; being boss in school (laughter) … being the centre of the universe.

Many girls have additional responsibilities related to household chores and care-giving, including cooking, cleaning, and taking care of siblings:

My dad doesn't do anything—me and my sisters have to cook and clean.

I have to take care of my siblings and it's a huge pressure on me.

Discrimination, Trauma, and Colonial Effects

The study raised questions about how the health impacts of colonialism manifest across generations. The majority of girls did not make these links explicit, but a few articulated connections between colonial policies, systemic discrimination, and smoking.

[Do you think stereotyping/discrimination of First Nations leads to unhealthy behaviours such as smoking?]

I don't think so, not because I'm First Nations.

Yeah, I think so; oh yeah.

They advertise it, you know, for Natives and stuff, and people think they used to smoke tobacco and some kind of blessing tea.

Residential school. I think that's somewhat of an effect.

Yes; it can be and usually that's what the excuse is, and it shouldn't be.

I think a lot of brown people smoke because it's what's expected of them. They shouldn't, but it's expected.

That's what non-Aboriginals are saying.

An important prevention insight is that while Aboriginal girls may live with the ongoing effects of colonialism, they can still be supported to make healthy choices about their health and well-being.

Cultural Differences

Differences Between Aboriginal and Non-Aboriginal Girls

Most respondents observed no differences in culture or ethnicity affecting smoking behaviours. This applied even when the girls had mixed groups of friends, including friends of mixed ages and cultural backgrounds.

I thought that everybody smoked the same. I wouldn't stop and think that Aboriginals smoke more than non-Aboriginal girls.

It was all equal amounts—it's not like there was more of one race, like, than another.

It's what I see [they smoke the same amount].

There were a few exceptions, but no explanation for the perceived differences.

It's mostly just the Natives.

Yeah, it looks like it's more Natives or Aboriginals.

Many girls reported hanging out with more non-Aboriginal youth at school, and with Aboriginal friends and family at home and in the community, pointing to the importance of context in shaping social relations, experiences of peer pressure, and smoking behaviours.

Two Trends: Cultural Identity

- None of the girls reported using tobacco for traditional cultural or spiritual reasons.
- Girls have very diverse backgrounds; many report mixed backgrounds (mixed Aboriginal or mixed Aboriginal/non-Aboriginal).

- Knowledge of culture seems to matter: 62 percent of the girls who are current or former smokers report not knowing a lot about their Aboriginal cultural backgrounds and traditions, compared to 38 percent of non-smokers.

Given this finding, two trends can be identified related to girls' cultural identities, and each requires very different interventions.

"I'm not too sure": Ambiguity and Disconnection

One trend is that some girls share a sense of cultural ambiguity and disconnection from their Aboriginal backgrounds.

> *I don't know [my mom's] band's name.*
>
> *I kind of move back and forth from [the reserve] to out of town, so when I was here I was in dances and some of the language classes.*
>
> *I don't really know too much about [my Native background] because we stayed in town and moved a lot.*
>
> *Not really, because my mom wasn't told about it. My dad, he doesn't know much either because his parents weren't really around when he was young either.*
>
> *I don't really know that much about it right now, so I'm trying to look into it.*

Many of the girls lack information about their background, come from Aboriginal groups that are not represented at the community level, or have mobile families that move back and forth between on and off reserve. This has an impact on their access to cultural activities, teachings, community supports, and resources. For example, such mobility can make it difficult for a girl to access a consistent program and find stable supports that may buffer her from high-risk behaviours.

These findings challenge the notion of creating smoking interventions rooted in formulaic, culturalist approaches that do not account for the diverse cultural identities and experiences that young Aboriginal girls may have.

"I Have Good Teachers": Identity Rooted in Community

The second trend shaping cultural identity is that many of the girls are rooted in a specific Aboriginal community, and/or have access to specific cultural teachings and community resources.

Quite a bit. Like the food I can make and I know about feasts and stuff, and things we studied in school. I did dancing and all that when I was younger.

They teach our language at school.

I learned a lot from my grandma and my mom. We've gone to the longhouses … and been to a couple of burnings. I know basics about the language.

Pow-wow, salmon release, like camping field trips—I'll try to go. I know some things but not all.

Like the sweats. I just came back from canoeing.

I know a lot. I know a lot about Indian dancing, basket weaving, making cedar roses, making regalia, and part of our history.

One key finding is that the majority of girls report that involvement in cultural activities and pride in their Aboriginal background has a positive impact on their sense of self and on the choices they make.

Interviews with Community-based Collaborators

Following interviews and focus groups with teen girls, we individually interviewed five of the six community-based collaborators to gather their reflections on the findings and research process. Selected quotes from these interviews support findings on: the impact of secrecy on youth's support-seeking, the breakdown of women's leadership roles as a legacy of colonialism, and the effect of girls' mobility on cultural knowledge.

From what I gather from the girls' smoking it's very secretive—their folks don't know, some of their family members don't know… they feel kind of shamed to some degree. They tried to talk to their parents about smoking but were afraid.

The girls mentioned that they smoked because of stress and most of their stressors were family-related and having too much responsibility caring for younger siblings and the differences with raising boys as opposed to girls. The girls have a lot more responsibility than the boys did and I believe it's changes in our culture as a result of the missionaries and the church where they enforced things. They made our people believe that the man is the head of the household and the women and children under that, and our people still suffer because of that. Like in our system, most of BC is matrilineal, where the heritage and the inheritance is passed on through the mother. But

the mothers, the matriarchs are token in our society right now. I think that was the contributing factor to the girls having more or too much responsibility for their younger siblings, because of that mindset that, you know, the man is the head of the household.

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

We have a large Aboriginal population and not any one specific Aboriginal group and, because it's sort of a transient community moving in and out, there tends to a lot of drug and alcohol use among the Aboriginal people, and especially the youth. The area has been dealing with things like suicide, high rates of alcohol and drug abuse, not just marijuana but crack cocaine, crystal meth, and heroin and ecstasy. The very young are experimenting, they're using marijuana and tobacco, but the prevalence of ecstasy is really high among the really young.

RECOMMENDATIONS

Prevention and Cessation Strategies

It is clear that girls are dealing with a multitude of intersecting issues that affect their physical, emotional, cognitive, spiritual, and social health. Culture and gender are not fixed and uniform but rather shaped by the intersection of multiple forces, including individual and family circumstances, traditional values and teachings, shifting community realities, socio-cultural, economic, and political factors, and historical effects. If they are to speak to the complex and continuously evolving realities of Aboriginal girls' lives, interventions must be suitably flexible and multidimensional.

While the girls who participated in this study are incredibly diverse, they also share common experiences—sexism, racism, ageism, among other structural barriers—that shape risk factors for smoking. It is critical that prevention and cessation strategies not place the blame for structural inequities on Aboriginal girls and their communities. Instead, research participants recommend strategies that support a community-wellness and development approach. What is

also evident is the tremendous resilience and capacity of Aboriginal communities to provide interventions that are culturally congruent and that resonate with community needs and values.

The girls identified the following prevention and cessation strategies.

Tailored Interventions

- Interventions should focus on both the negative aspects of smoking (health problems, grief, poor choice, financial cost, etc.) and the positive aspects of health and wellness (healthy self-image, health and body consciousness, making good choices/caring for yourself, healthy communities, healing, cultural knowledge, etc.)
- Graphic information, pictures, stories, posters, and videos work for prevention, but are not as effective once a smoker is addicted.
- Except for heavy smokers, cost is not necessarily a deterrent because cigarettes are often gifted. However, cost does control the amount girls smoke; many reported smoking less when/if they have to buy their own cigarettes.
- The fact that only one girl mentioned the use of online interventions, suggests that solutions should be integrated into community life.
- Interventions should reflect the diversity of Aboriginal girls' experiences and speak to the needs of both highly mobile families and girls who are firmly rooted in one community.
- Smoking interventions should address intersecting factors related to substance use.

It was interesting—when I was growing up— when young people smoke it's kind of the jumping board to other activities like drinking or pot or all three. So it's not an issue that easily can be taken apart and you can figure out what are the causes. I think there's a multitude of issues going on. (Community-based collaborator).

Role Models

There was a strong need expressed for healthy role models.

> *My mom is not a role model to me … because she's a drunk.*
>
> *It makes me know that I can do better, that I can try harder—like my mom didn't get a job and she should have … and dad moved away and we haven't seen him since.*

Healthy role models included girls who had successfully quit smoking, local heroes such as athletes, and respected community members who live healthy lives and/or have experienced success.

[A good role model is] someone who got what they wanted in life.

When they have a job; an Elder would be nice; an athlete; girls that will talk to everyone … in my leadership group we do that.

The girls emphasized that personal stories (i.e., *real stories from other girls*) would have a strong impact, and that effective girl speakers should be young, entertaining, interactive, and have knowledge of Aboriginal realities and local communities.

When it is not grounded in girls' needs, health education has important limitations.

In all schools, you get in this personal health class that tells you shouldn't be smoking, and like all the health problems that you'll get … Nobody listens so nobody understands how to help.

Someone from the community … because it's kind of boring in school like hearing other people's stories that you don't know and it's not like an emotional connection.

Early Intervention

A prevention message should reach children at a much earlier age, with grades 4 to 5 as the upper limit.

Like six; kindergarten; when they're young.

When they're little so they know that it's bad and they should have like workshops in elementary school.

I think they need to start advertising sooner than on the pack of cigarettes … that's too late. [So pictures on the cigarette carton don't work?]

No; no; no; no; no.

The girls suggest the need for older girls to mentor younger girls. The following are suggestions for a non-smoking health message:

Tell them it's bad; it's not cool; it's unhealthy. If they don't want any problems they shouldn't smoke. It's bad for their health. Instead of programs to stop smoking, just keep them occupied

so they don't have time to smoke—activities like hiking. Reward them for not smoking. Show really scary pictures of babies with breathers when they are still really young.

Girl-Centred Supports and Counselling

Girls may be more vulnerable to stresses related to gendered social pressures and expectations. Support therefore must:

- Provide a safe space tailored to girls' needs
- Be personalized to deal with issues that go beyond "stress," including abuse, chronic trauma, MCFD (Ministry of Children and Family Development) involvement, crisis management, sexism, disclosures, grief counselling, etc.

Youth-Friendly School and Community Interventions

Meetings, workshops, and drop-in or support groups should:

- be non-judgmental, fun, and accessible
- Provide alternatives, and keep youth busy in positive ways through volunteering, playing active roles in the community, teen role modelling and leadership roles.
  Show that you can do other stuff than smoke; more clubs and be more occupied; youth gatherings and sports; walks or fundraisers for cancer. Find out how you could replace smoking. Help them figure it out and just support them. Having more little groups. Keep them busy and they won't even think about smoking. Stay athletic; be a role model. Do more sports, after-school activities, lunch-time activities. Get involved with a band or community newsletter; band youth programs; youth activities. Aim high.
- Some girls suggest that rewards for non-smoking might be effective.
  Like in school, you have the non-smoker, you get some kind of cash … so you guys can do fun stuff. We do one-dollar gift certificates to go to the cantina.
- Cultural activities are also important.
  Get involved with their culture and our Indian dancing, basket weaving.

[I asked them what they think about the interview]: This is kind of fun. If we had something else to do besides just sitting home or outside our back door or in the bushes sneaking a cigarette away from our parents. We need more stuff to do in our community. I said "Okay, well let's start weaving. I'll teach you girls how to weave. Then you could keep your hands busy." (Community-based collaborator).

Family and Community Education and Healing

Because the reasons girls give for smoking are often relational, interventions should emphasize relational responsibility. Many girls stated that as long as parents smoke, children will also smoke.

- Encourage policy change at the community level to stop the sale of cigarettes to anyone.
- Encourage family and community members to provide healthy role modelling.
- Support adults in stopping smoking and in enforcing smoke- and drug-free environments.
- In order to break the cycle of intergenerational trauma, healing has to include everyone.

A lot of girls mentioned that what helped them was attending cultural events and I know that's really true with myself. I, along with all the other Aboriginal families, suffered from Residential school and drug and alcohol abuse—alcohol abuse among my parents and having that responsibility—but I always remember attending cultural events. That gave me something to look forward to as a young child, and I heard that with these girls. I heard the very same thing. Something that they look forward to is attending the feasting … they still had that desire to participate in their cultural system, and well, that was the same for myself. (Community-based collaborator)

Important Findings and Areas for Further Study

The Limitations of Essentialized Approaches

Ideally, effective interventions should be contextualized to the realities of each community, address the full spectrum of Aboriginal identities (including on- and off-reserve, mixed-race, and rural and urban Aboriginal girls), and reflect the way cultural identity is mediated by other factors such as context, family history, gender, social class, sexuality, and age. This study highlights the limitations of monolithic, culturalist assumptions in health research, policy, and practice.

The same caution should be heeded for gender-specific health messages. While a health message for Aboriginal girls might emphasize girls and women's strengths and

spiritual/cultural values around healing and wellness, such messages become ineffective when they re-gender girls (i.e., further strengthen problematic gender roles for girls who already feel pressured or limited by such roles).

Ambiguity and Mixed Messaging

Knowledge and values around smoking are characterized by ambiguity and contradiction (i.e., "mixed messages"). Girls are expected to be good and responsible on the one hand, and tough and cool on the other. While girls may be exposed to cultural values related to women's strength and roles as caretakers, healers, and helpers, they are also inundated with unhealthy messages that are sometimes condoned by community members.

Mixed messages extend to contradictions about contemporary socio-cultural norms and expectations. For example, beyond their own families, girls report that some community members smoke with young people, sharing with and selling them discounted (often tax-free) cigarettes. Some girls observed that community members smoke in places that feature prominently in many of their lives: *In bingo halls, they always smoke. We always have bingo in my life. Every day of the week, even on Sunday there's bingo.* Here again, girls are faced with the pressure of "fitting in" at the community level.

Respect for intergenerational and kinship ties, especially when they are socialized to take care of others, may make it difficult for girls to make different choices in the midst of social pressures to smoke and fit into community life and community events.

Discrimination and Trauma

More information is needed on the relationship between discrimination/social exclusion/inequity, trauma, smoking, and other health concerns such as substance use and mental health. While the interviews do not always make these links explicit, other research points to the effects of social exclusion on health outcomes in Aboriginal communities[8,9] Chronic discrimination manifests in social exclusion, including poverty, substandard-housing,

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[8] Blackstock, C., Bruyere, D. & Moreau, E. *Many Hands, One Dream: Principles for a New Perspective on the Health of First Nations, Inuit and Métis Children and Youth.* Ottawa: Canadian Paediatric Society, 2005.

[9] Browne, A. & Varcoe, C.A. Critical Cultural Approach to Health Care for Aboriginal People. *Contemporary Nurse, 22*,2 (2006): 155-168.

lack of access to services, intergenerational trauma, subtle and overt racism, ageism, sexism, over-representation in foster care, educational and employment barriers, among other determinants of exclusion, all of which have health effects. Future research could explicate how exactly systemic discrimination and social exclusion impact Aboriginal girls' health behaviours and health knowledge.

LGBQTTIQ Girls

Other research with BC Aboriginal youth points to the specific risk factors facing lesbian, gay, bisexual, questioning, transgender, two-spirited, intersexed, and queer youth.[10] Girls who live with non-mainstream gender and sexual identities may experience unique traumas, isolation, limited access to supports, and issues regarding dualistic constructions of gender and the negotiation of compulsory heterosexuality.

Finally, it is critical that smoking research highlight barriers and gaps in communities without further pathologizing them for structural inequities or for the ongoing effects of colonial policies and practices. Effective health research underscores not only gaps and risk factors, but also the strengths, resources, and different types of knowledge of Aboriginal communities.

RESEARCH EVALUATION

Transparent and accessible evaluation is a critical component of ethical research in Aboriginal communities. Each community decided how they wanted to conduct the presentation and evaluation of their process and findings (final report, feast, workshop, presentations, etc.). In addition, the community-based collaborators were interviewed to provide feedback on the challenges and benefits of the research process. Here is a brief summary of their reflections on the benefits of participating in this project.

Benefits and Strengths

- Participants developed research skills and other relevant tools.

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

The interview, the training we had was great, and I picked up a lot of skills. And it encouraged us that we were important to the process … after the training in Vancouver I felt much more confident and felt that I could do this right.

I thought it was great. I was really thankful for this training because this is my second research project, and for the first one, I went into it blind, like no background at all in research. And through the training I got, you know, a better grip on exactly what research is and so I think that was really beneficial.

- Varied and consistent communication was critical.

I thought communication between the coordinator [and] the CBCs was very good. I quite liked the idea of regular meetings, be it conference calls or in person, and e-mails are really helpful, just to touch base and to get ideas.

- Participants developed knowledge of community-based research and of the issues around smoking.

They learned research, so "I'm doing a research project in school—is that the same thing you're doing with us with smoking?" At first they didn't really know research.

The whole project's affected a couple of girls in regards to smoking. I know one girl that, shortly after we had gone into the interview, had quit for a month. Well you know, you have seen certain changes in them that way.

I've learned a lot and I think my girls did, and now they're using it at school. One girl is using smoking as one of her projects at school, so I fill her with all the stuff that I have.

- The project created connections and visibility in and across communities.

The experience of meeting other CBCs from other communities was great. I learned that my community is not so different than anyone else's. Everybody is experiencing the same issues, the same problems in their communities.

You know, these 18-or-so girls that I connected with through the project, I knew them to see them before, but now I can walk into the school system and call them by name, ask how they're doing, talk about their progress with their support workers.

I got the training, which I didn't have before, so I was thankful. I believe that it enhanced my job connecting with the girls, the support workers, and [community] people.

- Research can enhance intervention and follow-up services at the community level.

When they were talking about [whether] smoking affected relationships with people in their family, that brought out a lot, so it was great to be able to … check in the following day to see how they were doing; to also make sure that they were aware of what services were available, so if they wanted to get into counselling, if there was stuff going on at home, that they knew where they could go.

Because we were doing other smoking projects, cessation groups, I have noticed that … it's out there now. Before it was just "smoking was cool—everybody's smoking" but now with the cessation and the smoking research, there's a lot more out there for them.

- Participants were part of a process of community healing and transformation.

In our band office they used to smoke all outside [and now] they're not allowed—our leaders are saying they don't want to see it. In doing this research I've had leaders come over to me and you know, really thank me for doing what I'm doing with the kids, the younger ones. We don't want to get them into that habit.

RECOMMENDATIONS FOR FUTURE RESEARCH

The following recommendations are based on the project coordinator's experience over the past three years.

1. More time and funding are required to conduct research in Aboriginal communities.
   - Developing a relationship with most communities requires a minimum of three to six months.
   - Constant communication with communities is required. For example, more informal information sessions are critical so that participants can make an informed decision to agree to an interview.
2. Ensure community has input regarding the research topic. What will they gain from participating? Internal versus external motivators should be considered.

3. Ensure communities are very clear on the levels of dissemination of research outcomes. It may be necessary to review this numerous times before signing a Memorandum of Understanding.
4. Ensure that each community reviews and approves data analysis before dissemination of outcomes.
5. More training is necessary for community members who conduct the interviews at the onset of the project (i.e., monthly sessions for at least six months with an evaluation of their training before they begin the actual interviews).
6. Involve community-based collaborators who hold part-time rather than full-time positions, so they are capable of committing the required time to the project.

LESSONS LEARNED

Conducting research in First Nations communities with non-Aboriginal partnerships is still a very new process. The approach requires more time than typical research projects based out of universities, etc. Building relationships with the community partners is crucial before conducting the interviews. Most participants require a great deal of clarity about how the information will be used and who will have access to information.

Who conducts the interviews in the community is also a huge factor in the quantity and quality of information obtained. The participants must feel safe with the individual conducting the interview. Most communities felt it was important to have First Nations interviewers; however, we had a non-First Nations person conducting the focus groups and the girls were quite comfortable. Having a First Nations project coordinator as part of the team was also important to the communities.

Staff changes within the communities and the British Columbia Centre of Excellence for Women's Health during the project were difficult. Much time was lost due to the many changes, and dates had to be adjusted to accommodate these challenges. Fortunately, the partners and BC Centre Excellence for Women's Health team weathered it quite well.

CONCLUSION

Smoking among Aboriginal teen girls appears to be a multifactoral issue. Peer pressure, family context, experiences of colonialism and discrimination, access to cultural knowledge, gendered roles and responsibilities, stress, and co-substance use, were some of the factors that girls identified as influencing their smoking behaviour.

Understanding exactly how context, age, culture, and gender, among other factors, interact to influence smoking in this population will provide a more complete picture of Aboriginal girls' realities, and will facilitate the design of comprehensive smoking prevention and cessation interventions. Partnerships between Aboriginal communities and Aboriginal and non-Aboriginal researchers will help facilitate much-needed bi-directional knowledge transfer in this field and inform future research and policy development. Communities can draw on study findings and the multidisciplinary partnership model to effect public health change in their own communities.

In the Community-based Collaborators' Own Words

[The biggest learning was] that I can get them away from their bad habits by finding other things for them to do. And they may forget about "we never had a smoke today." Listening to my stories was a big thing, the stories that my grandparents and my mother had taught me about our way of life, how we were disciplined then. There was no physical abuse used on us, it was just sitting us down—talk. Even though the project's finished I still talk about smoking and they all come in my office after school and I always find something for them to do. (Community-based collaborator).

I think my community is trying to look after the health and well-being of our community. They're getting very strict with smoking and alcoholism. Years back there used to be a lot of parties. Alcoholism was the number one thing they'd find. And now, in the last probably 25 years, even pop, juice, they don't even serve anymore—it's water or our own traditional teas, and yeah, the community is really open to any kind of prevention with our people, and they're trying to raise a healthy community. (Community-based collaborator)

Appendix 1: Interview Guide

BC Centre of Excellence for Women's Health

CHILDREN'S AND WOMEN'S HEALTH CENTRE OF BC

VANCOUVER, BC

Code Name :_______

ABORIGINAL ADOLESCENT GIRLS SMOKING RESEARCH PROJECT INTERVIEW QUESTIONS

Age: _________ ☐ Smoker ☐ Never Smoked ☐ Quit Smoking

Gender and Youth

- Can you share some of the things in your life that you are proud of?
- What kind of things are you involved in, in your community? How long have you been in this community?
- Can you tell me what teenage girls and boys are "in to" these days in your community?
- Is there a difference between girls who smoke and girls who do not smoke? What do you think of the girls who do smoke?
- In your opinion, why do girls smoke/start smoking? *(Suggested probes: Are there things in your life that make you or other girls smoke? Specific times, etc. If stress is a factor, probe thoroughly into what causes them stress and what they mean by stress, then ignore stress question below)*
- Are boys and girls treated differently in your community? Can you tell me about it or describe a recent example? *(can be a trigger question)*

- Do you think there is a difference between how much boys and girls smoke? If yes, what are some of the reasons?

Stress

- What does the word “stress” mean to you”? Some girls seem to be under a lot of stress, is this true for you? Some girls have told me _____, _____, ______. Is this true for you?

Culture

- What teachings have you had around being a First Nations, Native, Métis, and/or Aboriginal girl?
- What do the Elders/family members in your community think about smoking?
- What are some of the cultural teachings in your community around being female / a woman?
- Do you participate in any cultural events or ceremonies? Please describe your involvement. Do you feel it changes your views on life or makes a difference on how you conduct your life?
- Have you heard any stories about how smoking has affected a family member? *(can be a trigger question)*

Tobacco Use (Smokers and Quitters only)

- Tell me about the first time you smoked? *(Probes: When and how did you start, etc).*
- Why do you think you smoke(d)? *(Suggested probes: Are there things in your life that make you smoke? Specific times or situations or events, etc.) If stress is a factor, probe thoroughly into what causes them stress)*
- At what time or when do you smoke?
- How do (did) you get cigarettes? Can you tell me how girls would go about getting cigarettes?
- Are there times when you think you *really* need(ed) / could (have) use(d) a smoke?
- Were there times when you tried to quit or cut back? What happened?
- Do (did) you notice any reactions from others to your smoking? Please describe.

- What effect does (did) your smoking have in your life? (probes: health, finances, relationships)
- Are there things that make you smoke less or things that make you smoke more? For example: what happens when the price goes up? Do warning ads make a difference? What about the laws/restricted areas? People's reaction to your smoking? Anything else?
- Do (did) you drink alcohol as well as smoke cigarettes? If yes, is your drinking connected to your smoking in any way? Do you drink for the same reasons you smoke?
- Do (did) you use marijuana as well as smoke cigarettes? If yes, is your marijuana use connected to your smoking in any way? Do you use marijuana for the same reasons you smoke cigarettes?

(For never smokers)

- Tell me if you have ever smoked? (Why did you not continue/quit?)

Life Experience and Social Norms (inclusive of all)

- Do you ever get cigarettes for others? (Who, for, how, and where from?)
- How do you spend your time on any given day? *Probe more on what they say and ask what else do you do with your time?*
- What did you use to think about smoking when you were younger? *May need to probe on age especially if it's a 13 year old versus a 19 year old.*
- Do your friends and family affect your decision to smoke/decision not to smoke? How?

In closing, we'd like to invite you to share what this experience was like for you today. Would you recommend others participate or would you participate in another research project?

THANK YOU for participating. You will be notified when the final report is ready and you will receive a copy of the findings. And I'd like to acknowledge your courage to be part of this interview/project.

Appendix 2: Smoking Habits Statistical Breakdown

Individual Interviews Only

50 girls total (n = 50)

By community (first letter of each community):

K (1000) = 10

S (2000) = 10

L (3000) = 7

PA (4000) = 5

P (5000) = 9

M (6000) =9

n = 50

Individual Interviews: Smoking Habits

Self-described	Out of total/ total percentage		Out of smokers/ smoker percentage
Have smoked/ Currently smoke	29/50	58%	n/a
Non-smokers	21/50	42%	n/a
Non-smokers who tried once/few times	7/50	14%	7/21 = 33% of non-smokers
Quit smoking	13/50	26%	13/29 = 44.8% of all smokers
Cutting back	2/50	4%	2/29 = 6.8% of all smokers
Total quit/cutting back	15/50	30%	15/29 = 51.7% of all smokers
Currently smoking			
Incl. cutting back	16/50	32%	n/a
Excl. cutting back	14/50	28%	n/a

*Seven non-smokers reported trying it once (ages not consistently specified, three at 13-14) but were not listed under "have smoked" category.

Appendix 3: Breakdown of Individual and Focus Groups Smoking Habits

Individual Interviews and Focus Groups

All respondents: N = 63

50 girls total (n = 50) + 13 FG

N = 63 (individual interviews plus new focus group girls)

By community (first letter of each community)

K (1000) = 10 + 3 FG = 13

S (2000) = 10

L (3000) = 7 + 5 FG = 12

PA (4000) = 5 + 5FG = 10

P (5000) = 9

M (6000) = 9

n = 50 (individual interviews)

FG = 13 (girls who had not been individually interviewed)

n + FG = 63 (total girls)

Final Breakdown of Smoking Habits for All Respondents

Self-described	Out of total	/ Total Percentage
Smoker	26/63	41.3%
Non-smoker	21/63	33.3%
Quit smoking	16/63	25.4%