What Are the Odds? Community Readiness for Smoke-Free Bingos in First Nation Communities

Peter James Hutchinson, Ph.D., M.A., BHK, Institute for Healthy Living and Chronic Disease Prevention, University of British Columbia Okanagan Campus, Kelowna, British Columbia

Joan L. Bottorff, Ph.D., RN, FCAHS, University of British Columbia Okanagan Campus, Kelowna, British Columbia

Natalie Chambers, M.A., University of British Columbia Okanagan Campus, Kelowna, British Columbia

Roberta Mowatt, Community Development Leader, Canadian Cancer Society, Hazelton, British Columbia

Dennis Wardman, MD, FRCPC, MCM, First Nation Inuit Health – British Columbia Region, Health Canada, Vancouver, British Columbia

Debbie Sullivan M.Ed., RN, Gitsegukla Health Programs & Service, Gitsegukla, British Columbia

Wanda Williams, CHR, Gitsegukla Health Programs & Services, Gitsegukla, British Columbia

ABSTRACT

Community members have identified second-hand smoke exposure among young women and children within First Nations communities as a concern. As part of a community-based research project, we analyzed experiences related to establishing smoke-free public spaces and the challenges related to smoking and bingo. The purpose of this study was to a) describe and compare community smoking at bingo in First Nations communities, and b) draw implications for assessing and supporting community readiness for comprehensive tobacco control policies (TCPs). Data were collected using individual interviews, group discussions, and observations in the community. The establishment of smoke-free public spaces in communities evolved out of concern by people traditionally responsible for the well-being of the community. Despite close proximity and similar socioeconomic contexts, readiness to extend these successes to bingos held in community halls was influenced by three main factors: a) economic drivers, b) the smoking majority, and c) grassroots support. Although models for assessing community readiness provide a useful starting point for understanding local TCP development and implementation in First Nations communities, other factors also need to be considered. Using a comprehensive approach to assessing community readiness has the potential to increase success in extending TCPs and practices in First Nations communities in ways that are culturally relevant, address local conditions, and build on existing efforts.

KEYWORDS

Second-hand smoke, tobacco control, policy, public health, Aboriginal

INTRODUCTION

The prevalence of cigarette smoking in First Nations communities in Canada is estimated to be three times that of the general population (First Nations and Inuit Health Committee, 2006). Regardless of age, health-related consequences are evident (Assembly of First Nations, First Nations Information Governance Committee, 2007; Hutchinson et al., 2008; Johnson et al., 2004). Smoking-attributed deaths account for 8.5 potential years of life lost amongst Status Indians compared to 5.8 years for the general population in BC (Office of the Provincial Health Officer, 2007). An effective strategy to reduce second-hand smoke (SHS) exposure and decrease smoking overall is to implement tobacco control policies (TCPs) (Rohrbach et al., 2002). While TCPs have been a topic of much research, there is a lack of understanding about the development and implementation of tobacco policies in First Nations communities to curb cigarette smoking and exposure to SHS.

As part of a community-based research project exploring ways to support young First Nations women in their efforts to protect their children from SHS, we became interested in community efforts to develop, implement, and maintain policies to create smoke-free public spaces, and the challenges that were experienced regarding extending smoke-free policies to bingos. The objectives of this paper are to a) describe and compare community responses to smoking and bingos in First Nations communities and b) draw implications for assessing and supporting community readiness for comprehensive TCPs.

BACKGROUND

Smoking is related to social disadvantage and health inequities (Graham, 2006), a relationship clearly reflected in First Nations communities in Canada where chronic socioeconomic disadvantage exists because of colonization, multigenerational effects of residential schools, and high rates of unemployment. Research suggests that these experiences create unique challenges associated with reducing tobacco use and creating smoke-free spaces in reserve communities (Greaves & Jategaonkar, 2006). As a result, the rate of tobacco use by First Nations people is decreasing at a slower rate than in the general population (First Nations and Inuit Health Committee, 2006)

Results of studies indicate that while TCPs in indigenous communities may be formally implemented and maintained in government and school buildings, these same policies often do not extend to other public spaces (Glasgow et al., 1995; Hall et al., 1995; Ivers et al., 2006; Lichtenstein et al., 1996). Tobacco use persists where smoking is linked to sources of community revenue, such as recreational spaces that are used for sports, fundraisers, casinos, and bingo (Glasgow et al., 1995). A better understanding of the enactment of smoke-free policies in First Nations communities is needed to identify factors influencing community readiness for comprehensive TCP development and implementation as well as considerations in tailoring these to local conditions and cultural influences.

The community readiness model (CRM) (Oetting et al., 1995) was originally developed to assess and guide community capacity for alcohol and drug prevention and treatment programs. The model includes six dimensions (i.e., knowledge, leadership, resources, community climate, existing policy efforts, and political climate) that are believed to determine community readiness for change. These dimensions are used to assess the community's overall stage of readiness. Recently, the model was adapted to assess community capacity for planning and implementing smoke-free policies in Kentucky (York et al., 2008). Although the model has shown promise for assessing Aboriginal community readiness for drug and alcohol programming and other initiatives (e.g., breast cancer and HIV/AIDS prevention) (Borrayo, 2007; Jumper-Thurman et al., 2007), it has not been used to assess readiness for TCP change.

In Canada, TCPs are not consistently applied within First Nations communities because of the recognized inherent rights to self-governance and successful challenges by individual First Nations to the jurisdictional applicability of particular policies. When this research was conducted, First Nations reserves in most provinces, including

TABLE 1. TOBACCO CONTROL PRACTICES AND POLICIES IN THE STUDY COMMUNITIES

Community	Description of Smoking Practices in Community Halls	Tobacco Control Policies and Strategies				Activities Held at Community Halls		
		Written Policy	Informal Policy – Accepted practice	Environmental Control of SHS (e.g., strategies to promote air exchange)	Designated Non-smoking Room	Bingo	Community Events	Sport and Recreational Activities
#1	Partial Ban: Smoke-free dances/meetings/ feasts. Smoking allowed at bingo. Non-smoking room and heating /cooling/air exchange system (inoperable during bingos)		X	X	X	X		
#2	Partial Ban: Smoke-free during youth/ school activities and community events. Smoking permitted during bingo and dances		X			X	X	X
#3	100% Smoke-free for all events: Financial penalties to event organizers if smoking occurs in hall	X				X	X	X
#4	Partial Ban: Only upstairs section of the building is smoke-free		X		X	X	X	X
#5	Partial Ban: Non-smoking during feasts		X					
#6	Partial Ban: Non-smoking during feasts		X					

British Columbia, were largely exempt from provincial regulations governing tobacco control (First Nations and Inuit Health Committee, 2006). As this project came to an end, the province of British Columbia enacted changes to the Tobacco Control Act (British Columbia, 1996) to extend tobacco control measures by prohibiting smoking within any enclosed or partially enclosed public structure. Although this new policy was meant to protect all British Columbians, its implementation in First Nations reserve communities in British Columbia remains uncertain. So, it is becoming increasingly important to understand the systematic influences on the creation of smoke-free spaces and community readiness for change in First Nation communities and to provide strategies to support TCPs that are relevant to First Nation communities. We believed that a close examination of First Nation communities' responses to smoking in the context of increasing regulation of smoking in the province could provide important information for assessing and supporting community readiness for comprehensive TCPs as well as a basis for evaluating the potential usefulness of the CRM in guiding future initiatives.

METHODS

This study was conducted as part of a larger community-based research project that investigated exposure of young women and their children to SHS. To address this concern, a partnership between community members, university researchers, and the First Nations and Inuit Health Branch of Health Canada was established to obtain funding to conduct the research and facilitate knowledge exchange.

Study context

The research took place in a region that included six small First Nations reserve communities and a small off-reserve town in close proximity to one another. The communities ranged in size from 200–700 residents. At the time of the study, unemployment rates were reported to be 33–50% for men and 11–41% for women. Median annual incomes ranged from $8–14,000, with women reporting slightly higher incomes than men (Statistics Canada, 2008). Anecdotal evidence gained from informal community surveys suggests that almost half of local residents smoke cigarettes. SHS was consistently prevalent in these First Nations communities at several locations including homes, bingo, and sporting events.

In each community, elected band councils set policies for their respective community and managed community affairs. Each band council was also responsible for managing a community-owned hall, including setting rental fees and smoking policies. Differences arose in the formal and informal policies that were developed and carried out relating to smoking among the communities. Formal written policies related to smoking were in place for only one community and in the remaining communities, informal practices reflected community decisions related to smoking (see Table 1).

These halls were centrally located in communities and provided a venue for feasts, private functions (e.g., weddings, funerals), and other community activities including bingo. In one community, the hall was attached to a school and served as the school gymnasium during the day. Hall managers were often hired to take care of the building and report compliance with policies. Community halls provided a valuable source of revenue for each band in the selected communities.

Data collection

Data was collected over a two-year period and involved tape-recorded individual interviews and focus group discussions with 26 women, 17–35 years of age who were pregnant or parenting young children. The smoking status of these women were ex-smokers (7), occasional smokers (9) and daily smokers (10). Also interviewed were key informants (15), elders (9), middle-aged women (7), youth (6) and men (3). Most interviews were conducted by the community research assistant who grew up in the area and was also a band member from one of the other participating communities. The University of BC behavioral ethics review board confirmed that this research project met all ethical guidelines.

Discussions focused on what life was like in the communities for pregnant women and women with small children with respect to smoking and SHS, challenges and changes needed in communities to minimize exposure to second-hand smoke, strategies employed to reduce or minimize exposure to SHS, how smoking was addressed in relation to community events including bingo, what decisions were made and by whom, and what factors influenced policy decisions related to tobacco and creating smoke-free spaces in community halls and other public spaces. All interviews and small group discussions were tape recorded and transcribed word for word. These data were supplemented with participant observations about areas and events where smoking took place and how smoking was

managed. Finally, documents related to federal, provincial, and regional written policies on smoking in public places were analyzed and compared with study findings.

Data analysis

Qualitative analysis was done on the transcribed interviews, focus group data, and field notes. The data analysis began with a close reading of these data by members of the research team. Through a repeated process of reviewing the data, posing sensitizing questions (e.g., what is going on there?), and team discussions of the data, themes were identified. A coding scheme was developed based on these themes and was used to code the data. NVivo (QSR International, 2008), a computer software program for qualitative analysis, was used to retrieve the data to allow the team to examine issues and dynamics related to tobacco control in each village, and to compare experiences across the study settings. For this paper, we focused on data related to bingos because it consistently appeared in the data as controversial space for both smokers and non-smokers and presented the most consistent experiences of exposure to second-hand smoke among participants. Preliminary insights were shared with representatives of the community to validate and refine findings.

RESULTS

Among the six community-owned and operated halls in the study, there were variations in accepted practices and policies related to smoking in the community halls (see Table 1). The most successful maintenance of a smoke-free environment was the accepted practice of banning smoking in community halls during feasts, a practice that was evident in all of the communities. The development of this practice occurred outside formally recognized policy development structures, i.e., band council, tribal association, or other governing bodies. Rather, it evolved out of concern by those people who were traditionally responsible for the well-being of the community, the hereditary chiefs, and supported by a high regard for demonstrating respect for others' choices. However, these successes in establishing smoke-free public spaces had not translated to bingos with the same consistency. In some of the same community halls where feasts were hosted, bingos were held where there were no restrictions on smoking. In comparing efforts to extend smoke-free practices to bingos, several factors were identified as influencing differences in community readiness: a) economic drivers, b) the smoking majority, and c) community and grassroots support. Each of these factors and their influence on developing and implementing smoking restrictions at bingos is discussed in the following sections and illustrated by using community experiences.

The economic drivers of tobacco control policy: The case of Hall #1

> P2: They did try to cut [smoking] out in our hall twice and they didn't pull very many people in for bingo [so they gave up].
> P1: All they think of is profit, they don't think of the end results.

The economic influences on tobacco policy were most clearly reflected in Hall #1. Although smoking has been prohibited in all community-owned buildings including a smaller hall since the 1970s, exceptions are made for bingos in the main community hall. In 2002, two steps were taken to reduce exposure to SHS during bingos. The band council authorized a non-smoking room for bingo players with a wall of windows and a door opening into the main area of the hall. In addition, a heating and air exchange system for reducing second-hand smoke was also installed at great expense. Participants commented that the non-smoking room was a "strange approach" to addressing SHS because it isolated the people trying to make healthy choices. One elder remarked that the comfort of the smokers was clearly prioritized over that of non-smoking bingo players. The poor design of the non-smoking room resulted in some non-smoking bingo players staying in the smoking area and enduring the smoke rather than be isolated in the non-smoking room. Moreover, when the powerful heating and air exchange system disrupted the enjoyment of bingo players, complaints led to a decision to completely turn off the exhaust system during bingo games. Ultimately, the non-smoking space and the expensive exhaust system became unpopular among non-smokers and smokers, and did not serve as an effective intervention to protect the health of those in attendance.

Economic pressures underpinned efforts to accommodate smoking during bingos. These pressures were related to the lack of alternative revenues to support community activities (e.g., recreational activities, purchase of sports equipment) and for the operation and maintenance of the hall. Bingos were key revenue generators when the sale of cigarettes, the rental fee paid by bingo hosts, and the proceeds of each bingo were considered. One participant underscored the importance of retaining smoking for bingo at the hall by stating

> We [would] have a revolt if we [let non-smoking] get in. Unfortunately, it generates a source of revenue, cigarette sales at the bingos. It generates revenue because we have a quota of cigarette from the government for that purpose.

The importance of generating revenue through bingo resulted in the hall being used less frequently for its original intended purpose, i.e., sports and recreation.

Research participants remarked that an effort to communicate with the band council about the smoking policy at hall bingos was not productive. In fact, at the time of the study, the band leadership was considering increasing the investment in ventilation for the hall and turning it "into a bingo facility 100%, because that's all it's used for."

The smoking majority: The case of Hall #2

The influence of the smoking majority was clearly shown in Hall #2. This community had a multipurpose building, which served as their community hall to host a variety of events and as a gymnasium because it was connected to a school for kindergarten to grade 7. There were no written smoking policies for this hall. Although there were smoking restrictions during feasts and similar community events when children and elders were present, smoking was permitted during bingos. Even though the school also used the building, smoking bans on all school grounds in the province did not appear to work.

> Our band council tried to make it a non-smoking hall but bingo is our source of income for programs in our community and you can't stop having them 'cause we need them…. For other activities, like when we have children, babies, people that are chronically ill that come to feasts and we don't allow [smoking] because of second-hand smoke.

Some community members noted there were problems with current practices. Although the multipurpose hall was supposed to be available for school athletic activities, with bingos occurring Friday, Saturday, Sunday, Monday, and Thursday each week, it was more convenient to leave the tables and chairs set up for bingo, resulting in cancellations or restrictions of other activities, including those for children.

> They don't consider our students … It just went to show you know, they left it set up for bingo all those days, didn't let those poor kids in there and just still had a bingo. So, I think they think bingo is just more important.

Some also complained that the hall often smelled of smoke, making it an unpleasant and unhealthy space for children's athletic activities. In addition, non-smokers were frustrated that the bingo revenue was not being used to maintain or improve the facility for the children. Despite these concerns, the popularity of bingo and the smoking majority were barriers to creating a smoke-free hall in this community. Some held little hope that bingo hosts and band council would change the smoking policy because they themselves were smokers and bingo players. The fact that one of the bingo hosts was on the school board added additional complexity to making any changes.

Non-smokers were clearly the minority amongst bingo players, and the few non-smokers who complained about SHS in the hall to the band council and school board were met with silence.

> I'm not sure why it's so hard to keep the smoking from the bingos. I know in our community centre here we've addressed the issue with letters and during planning sessions with band council. We've addressed the issue as well when this new council got in. They had a planning session with the community and that issue was also addressed and still like it's almost two years now and they still haven't responded to any requests of having a non-smoking hall when it comes to bingo.

While the multipurpose building in this community provided a shared space for community members to interact, the imagined and real importance of bingo and the reluctance to institute smoking restrictions for bingos reduced the accessibility and intended use of this multipurpose site.

Community and grassroots support: The case of Hall #3

The influence of community and grassroots support for smoke-free spaces was most clearly shown in Hall #3. Here, the community hall was a large stand-alone facility equipped with a kitchen, exercise room (that was closed at the time of the study), snack bar, and several small meeting rooms used

by community groups (e.g., Head Start program) and for band council meetings. Unlike other halls in the area, smoking was not permitted in the building for any event. The decision to "go smoke-free" was made by the band council following a grassroots community consultation. Support from a cross section of the community was perceived as important in the process:

> When we went non-smoking, we did have the support of the elders and we did have support of some youth and youth programming coordinators so, it was a full spectrum. So, maybe that was why it was an easy thing for us to do 'cause we knew it was a concern from all age demographics.

In taking on the often unpopular decision to implement a smoke-free policy, band councilors and others did not expect it to be easy and anticipated complaints from smokers as well as lost revenue. However, a resolve to make the right decision for the community, being prepared to respond to criticism, and a desire to protect their newly renovated hall helped them stand their ground:

> When we walked into the non-smoking, we said half a year minimum. Give it six months you know 'cause the first two, three months people are going to grumble about it and then the last four to six months people are getting use to it. So it's not something that you can't just try for a month … you just must ride it out. And then about four to six [months] people start seeing the benefits. They start noticing, "Gees I don't smell like an ashtray."

At the time of our study, the hall had been smoke-free for approximately two years. When the smoking ban was introduced, bingo attendance declined as smokers gravitated to halls hosting bingos where smoking was allowed. However, over time attendance improved, and individuals who had previously quit going to bingo because of the smoke returned to the hall. Because attendance had not returned to previous levels, other sources of revenue generating activities were being considered, including renovations to refurbish the hall as a "fully functioning sports facility" to host popular all-Native hockey and basketball tournaments. Supporting Native sports was considered a "big business" activity that could generate much needed revenue for the community and also benefit youth in the community. Finding the resources to make these changes was identified as a priority.

Competition for bingo players and revenue

There was fierce competition among the six communities for bingo players and revenue generated from bingo that was fuelled in part by geographic proximity, the lack of other recreational opportunities, and shared economic circumstances. Accordingly, the non-smoking policy at Hall #3 and the temporary closure of another hall (#4) for renovations resulted in the opportunity for attracting larger numbers of people to bingos that allowed smoking. This resulted in increased revenues for those venues—a circumstance that was noticed by band councils. In an otherwise economically deprived region, there was very little profit or incentive for band councils to mandate smoke-free bingos when the demand for smoking bingos appeared to be increasing.

Contrary to the perception that a "revolt" would break out if smoking was banned at bingo events, the experience of implementing a non-smoking policy at Hall #3 bingos suggested that responses might be milder than anticipated. Most regular players, many of whom are smokers, continued to attend the bingos at Hall #3 when it went smoke-free. One participant observed, "I don't think the demographic has changed much, I think people just taught themselves to live by the policy." However, it appears that there were some limits to a non-smoking policy for bingo venues because of the uneven playing field. When a large number of bingo players was needed to provide "big prizes," bingo organizers made sure to hold the bingo at a hall that allowed smoking to "get the crowd."

DISCUSSION

The findings of this study illustrate the challenges that face First Nations communities when they try to develop, implement, and maintain comprehensive TCPs to protect community members from SHS, as well as successes in establishing smoke-free spaces. Knowledge of the health effects of SHS and the actions of key stakeholders in the community have been effective in changing smoking practices at community events such that smoking restrictions have become accepted. Despite these successes, smoke-free measures are trumped when economics are at play, as in the case of bingo. The uneven economic and social field created by band councils making different decisions about smoking at bingo was a disincentive to change.

The findings provide support for the use of the CRM (Jumper-Thurman et al., 2007; Oetting et al., 1995; Plested et al., 1999) and its refinement for TCP development (York et al., 2008). Important dimensions of community readiness, including knowledge of the effects of SHS, leadership, resources, community climate, existing smoke-free policy efforts, and political climate, were reflected in experiences in the study communities and explain some of the differences in policies relating to smoke-free public space. For example, the importance of community climate was reflected in shared values and norms related to respect for others' beliefs and differences, the high regard for elders, the importance placed on child and youth health, and the significance of socializing with family and friends in rural communities, all of which create a positive climate for introducing smoking bans. Previous efforts to gain support for smoke-free feasts in study communities drew on these values in building grassroots support for voluntary changes.

Similar to other findings (York et al., 2008), however, voluntary practices related to banning smoking at some community events showed weakness in influencing the expansion of TCPs to bingos. Although the CRM provides a useful starting point in understanding the processes involved, it does not appear to be comprehensive enough to capture complexities found in the study communities. Important factors identified in this study that influenced community readiness were economic pressures (related to the lack of dependable sources of revenue) and the smoking majority (related to social circumstances underpinning high rates of smoking). The close proximity of the study communities coupled with their shared experiences of disadvantage resulted in competition for scarce economic resources and a lack of political will to change local policies relating to extending smoke-free space. Another important dimension of readiness for change was grassroots support. With a strong base of community support for extending smoking bans to bingo at Hall #3, those in formal leadership positions were willing to take risks for the health of their community and introduce smoke-free bingos. Although leadership is included as an important dimension in the CRM (Oetting et al., 1995), findings related to the influence of economic and social factors are not clearly reflected in the model.

In disadvantaged Aboriginal communities, the use of models of community readiness to guide the development and implementation of TCPs need to account for the underlying factors that underpin tobacco policy on reserves, particularly social and economic factors underpinning smoking (Wardman et al., 2007). Graham et al. (2006) have argued for more attention to "leveling-up" opportunities and living standards in disadvantaged communities to address these factors. Our findings also reflect this direction. Policies and programs to support economic development, provide stable employment, and expand opportunities for social support, recreation and social networking to reduce reliance on bingos are likely to increase readiness for extending TCPs and support tobacco reduction efforts in First Nations communities. Although a surcharge on tobacco sales on reserve can provide additional revenues and is an effective population-based approach to reducing tobacco use (Wardman & Kahn, 2005), other revenues will also be needed. Our findings suggest that communities that see opportunities to develop sustainable sources of revenue (e.g., providing venues for growing interest in Aboriginal sports) are more willing to implement smoke-free policies. Supportive structures that increase attendance at non-smoking bingos, such as child minding or other incentives, may provide an interim solution.

CONCLUSIONS

In summary, only one of six First Nations communities at the time of this study was successful in extending smoke-free policies to include bingos. Using a comprehensive approach to assessing community readiness has the potential to increase success in implementing comprehensive TCPs and practices in First Nations communities in ways that are culturally relevant, address local conditions, and build on existing efforts.

ACKNOWLEDGEMENTS

This study was conducted as part of the Gitxsan TRYAMP (Tobacco Reduction for Young Aboriginal Mothers and Families) Project funded by the Canadian Institutes for Health Research (#ACB-77334), and supported by Gitxsan Health Society and Gitsegukla Health programs and services. The First Nation Inuit Health Branch (FNIHB) of Health Canada provided funding to supplement the costs of research activities and support tobacco reduction strategies. This research was also supported by CIHR and Michael Smith Foundation for Health Research (MSFHR) Postdoctoral Awards to Dr. Hutchinson, and NEXUS, a MSFHR-funded research team.

REFERENCES

Assembly of First Nations, First Nations Information Governance Committee. (2007). *First nations regional longitudinal health survey 2002/2003; results for adults, youth and children living in first nation communities*. Ottawa: Assembly of First Nations.

Borrayo, E. (2007). Using a community readiness model to help overcome breast health disparities among U.S. latinas. *Substance use & Misuse*, *42*, 603-619.

First Nations and Inuit Health Committee. (2006). Use and misuse of tobacco among aboriginal peoples - update 2006. Canadian Paediatric Society, 11(10), 681-685.

Glasgow, R., Lichtenstein, E., Wilder, D., Hall, R., McRae Gilbert, S., & Liberty, B. (1995). The tribal tobacco policy project: Working with northwest Indian tribes on smoking policies. *Preventive Medicine*, *24*, 434-440.

Graham, H., Inskip, H. M., Francis, B., & Harman, J. (2006). Pathways of smoking and smoking careers: Evidence and policy implications. *Journal of Epidemiology & Community Health*, *60*(Supplement 2), ii7-ii12.

Graham, H. (2006). Pathways of disadvantage and smoking careers: Evidence and policy implications. *Journal of Epidemiology and Community Health*, *60*(Supplement 2), 7.

Greaves, L., & Jategaonkar, N. (2006). Tobacco policies and vulnerable girls and women: Toward a framework for gender sensitive policy development. *Journal of Epidemiology & Community Health*, *60*, ii57-ii65.

Hall, R., Lichtenstein, E., Burhansstipanov, L., Davis, S., Hodge, F., Schinke, S., et al. (1995). Tobacco use policies and practices in diverse Indian settings. *American Indian Culture and Research Journal*, *19*(3), 165-180.

Hutchinson, P., Richardson, C., & Bottorff, J. (2008). Emergent cigarette smoking, correlations with depression and interest in cessation amongst aboriginal adolescents in British Columbia. *Canadian Journal of Public Health*, *99*(5), 418-422.

Ivers, R., Castro, A., Parfitt, D., Bailie, R., Richmond, R., & D'Abbs, P. (2006). The role of remote community stores in reducing the harm resulting from tobacco to aboriginal people. *Drug & Alcohol Review*, *25*(3), 195-199.

Johnson, J., Tucker, R., Ratner, P., Bottorff, J., Prkachin, K., Shoveller, J., et al. (2004). Socio-demographic correlates of cigarette smoking among high school students: Results form the British Columbia youth survey on smoking and health. *Canadian Journal of Public Health*, *95*(4), 268-271.

Jumper-Thurman, P., Vernon, I., & Plested, B. (2007). Advancing HIV/AIDS prevention among American Indians through capacity building and the community readiness model. *Journal of Public Health Management and Practice*, *13*, s49-s54.

Lichtenstein, E., Lopez, K., Glasgow, R. E., Gilbert-McRae, S., & Hall, R. (1996). Effectiveness of a consultation intervention to promote tobacco control policies in northwest Indian tribes: Integrating experimental evaluation and service delivery. *American Journal of Community Psychology*, *24*(5), 639-655.

Oetting, E., Donnermeyer, J., Plested, B., Edwards, R., Kelly, K., & & Beauvais, F. (1995). Assessing community readiness for prevention. *The International Journal of Addictions*, *30*(6), 659-683.

Office of the Provincial Health Officer. (2007). *The health and well-being of the aboriginal population in British Columbia: Interim update*. Victoria: Ministry of Health Services. Retrieved October 6, 2008, from http://www.health.gov.bc.ca/pho/pdf/Interim_report_Final.pdf.

Plested, B., Smitham, D., Jumper Thurman, P., Oetting, E., & Edward, R. W. (1999). Readiness for drug use prevention in rural minority communities. *Substance use & Misuse*, *4&5*(521), 544.

QSR International. (2008). *NVivo 8*. Victoria, Australia: QSR International Pty Ltd. Retrieved October 39, 2008, from http://www.qsrinternational.com/.

Rohrbach, L., Howard-Pitney, B., Unger, J., Dent, C., Howard, K., Cruz, T., et al. (2002). Independent evaluation of the California tobacco control program: Relationships between program exposure and outcome, 1996-1998. *American Journal of Public Health*, *92*(6), 975-983.

Statistics Canada. (2006) *2006 Community profiles*. Retrieved October 6, 2008, from http://www12.statcan.ca/english/census06/data/profiles/community/Index.cfm?Lang=E.

Tobacco Control Act, (1996). Retrieved October 31, 2008, from http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96451_01.

Wardman, D., & Kahn, N. (2005). Registered Indians and tobacco taxation: A culturally appropriate strategy? Canadian Journal of Public Health, 96(6), 451-453.

Wardman, D., Quantz, D., Tootoosis, J., & Khan, N. (2007). Tobacco cessation drug therapy among Canada's aboriginal people. *Nicotine and Tobacco Research*, *9*(5), 607-611.

York, N., Hahn, E., Rayens, M., & & Talbert, J. (2008). Community readiness for local smoke free policy change. *American Journal of Health Promotion*, *23*(2), 112-120.