The correlates of current smoking among adult Métis: Evidence from the *Aboriginal Peoples Survey* and *Métis Supplement*

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ABSTRACT

OBJECTIVE: To examine the correlates of current smoking among Métis aged 18 years and older, with a particular focus on culturally-specific factors. Cultural factors included spirituality, knowledge of an Aboriginal language, membership in a Métis organization and attendance at Métis cultural events. Demographic, geographic, socio-economic and health-related variables were also considered.

METHODS: Data from 6,610 adult Métis aged 18 years and older who responded to the 2006 *Aboriginal Peoples Survey* and *Métis supplement* were used to examine the correlates of current smoking using sequential binary logistic regression modelling.

RESULTS: Overall, 39.9% of adult Métis respondents in the sample were current smokers. Adult Métis who reported a high level of spirituality were less likely to be current smokers. Those who spoke an Aboriginal language, or lived in a house where an Aboriginal language was spoken, were more likely to be current smokers. Being a member of a Métis organization and attending cultural events were not independently associated with current smoking. Métis with higher household income, greater education, higher self-perceived health, and greater physical activity participation were less likely to be current smokers, whereas those who reported heavy alcohol consumption were more likely to be current smokers.

CONCLUSIONS: The results of this study suggest that interventions aimed at reducing smoking among adult Métis might be more successful if they include some connection to spirituality. It is also evident that co-occurring risk behaviours, in addition to demographic and socio-economic factors, are important considerations when developing interventions to reduce smoking among this population.

KEY WORDS: Smoking; tobacco; Indigenous population; adult; Canada

La traduction du résumé se trouve à la fin de l'article.

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Aboriginal Canadians suffer from poorer health than non-Aboriginal Canadians.¹ Among the most notable medical conditions that characterize this diminished health status are cardiovascular and pulmonary diseases.^{1,2} It is well established that smoking, a behaviour more prevalent among Aboriginal Canadians compared to their non-Aboriginal counterparts,³ is an important contributory factor to these diseases.⁴

Prior research has suggested that cultural identity and practices are important to the health of Aboriginal peoples.⁵ Retention of Aboriginal languages, participation in traditional activities, environmental and cultural connections, and spirituality have been identified as components of an Aboriginal-specific health framework.^{5–7} One could therefore hypothesize that these determinants of health might be connected to health behaviours among Aboriginal peoples, including the Métis.

The Métis, a distinct and constitutionally recognized Aboriginal Canadian group with a population of close to 400,000 people,⁸ like other Aboriginal Canadians, are at higher risk of suffering from chronic health conditions, such as respiratory and cardiovascular disease, than are non-Aboriginal Canadians.⁸ Recent data revealed that 30% of Métis over the age of 12 reported smoking cigarettes daily, approximately two times greater than the daily smoking rate of non-Aboriginal Canadians.³ However, there is a paucity of research that has

examined the correlates of smoking among Métis, particularly with a focus on culturally-specific factors.

A significant body of literature exists on the correlates of smoking among the general population. Those with low income and education are more likely to smoke.⁹ In addition, low physical activity levels, heavy drinking, and low body mass index are health-related variables correlated with smoking among the general population.^{10–12} Prior research has also demonstrated that spiritual well-being and religiosity might be protective against smoking among adults in the general population.^{13,14}

Given the importance of cultural identity to health,⁵ the historical and cultural significance of tobacco among Aboriginal peoples,^{15,16} and the potential negative association between spirituality and smoking,^{13,14,17} an examination of how culturally-specific factors are correlated with smoking among

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Métis is warranted to guide the development of public health interventions to decrease rates of smoking among this population. Guided by an Aboriginal-specific determinants of health framework,⁵⁻⁷ and prior evidence on the correlates of smoking among the general population,¹⁰⁻¹⁴ this study used data from the 2006 *Aboriginal Peoples Survey* (APS) and *Métis Supplement* to investigate factors associated with current smoking among Métis 18 years of age and older.*

METHODS

Data and sample

The APS, a postcensal survey, was administered to a sample of Aboriginal Canadians, including Métis, First Nations people living off-reserve and Inuit.¹⁸ Despite the availability of the 2012 APS, the 2006 version is the most recent to include, through the *Métis Supplement*, measures of spirituality, membership in a Métis organization, and attendance at Métis cultural events. A total of 8,830 Métis aged 15 years and older responded to the 2006 APS and *Métis Supplement*, including 8,160 aged 18 and older. Once respondents with missing responses and 110 women who reported being pregnant and therefore missing BMI measures, were excluded, 6,610 Métis were included in the sample. Less than 1% of the sample had missing responses on the smoking measure. For the independent variables, the combination of “don’t know”, “not stated” and “refused” responses ranged from 0% to 4.1%. We determined that missing cases could be safely treated as missing at random after examining the relationships between non-response and the outcome variable.

Variables

The outcome variable was measured by a binary variable, current smoking, which includes daily and occasional smoking.¹⁹ The APS assessed current smoking via the question “at the present time do you smoke cigarettes daily, occasionally or not at all?”

Several culturally-specific factors were considered based on the components of an Aboriginal-specific determinants of health framework,⁵⁻⁷ including level of spirituality, knowledge of an Aboriginal language, membership in a Métis organization, and last time attending a Métis cultural event or a pilgrimage, or having seen Métis artists perform. Level of spirituality was coded into four categories: “very religious or spiritual”, “moderately religious or spiritual”, “not very religious or spiritual”, and “not at all religious or spiritual”. We measured knowledge of an Aboriginal language by combining two APS questions: “Do you speak an Aboriginal language?” and “Is any Aboriginal language, such as Michif, Cree, Saulteaux, or Dene, ever spoken at home?” As a result, knowledge of an Aboriginal language was coded into three categories: “speaks an Aboriginal language”, “does not speak an Aboriginal language but an Aboriginal language is spoken at home”, and “neither speaks an Aboriginal language nor lives in a home where an Aboriginal language is spoken”. Membership in a Métis organization was assessed by a binary variable (yes/no) based on the APS response

categories. Finally, last time having attended a Métis cultural event was categorized into four levels based on the sample distribution: “less than 1 year ago”, “from 1 to 5 years ago”, “5 or more years ago”, and “never”.

Demographic, geographic, socio-economic and health-related covariates were selected based on prior research showing significant associations between these factors and smoking among the general population.^{9-11,20,21} Age was grouped into five categories (18–19 years, 20–34 years, 35–49 years, 50–64 years, and 65 years and older), similar to previous research that has examined smoking among the general Canadian population.²⁰ Urban/rural geography was coded into four categories: “Census Metropolitan Areas (CMAs)”,[†] “Census Agglomerations (CAs)”,[‡] “Rural with moderate to high Metropolitan Influence (MIZ)”,[§] or “Rural with no to weak MIZ”. Regional geographic classifications included in the analyses were “Atlantic”, “Quebec”, “Ontario”, “Prairies”, “British Columbia” and “Territories”. Annual household income was divided into quartiles (less than \$35,000, \$35,000–\$60,899, \$60,900–\$95,899, and greater than \$95,899). Educational attainment was grouped into three categories: “less than high school diploma”, “high school diploma or high school equivalency” or “some post-secondary or more”.

The health-related variables considered in this study were self-perceived health, heavy drinking, body mass index (BMI) and leisure-time physical activity (LTPA). Self-perceived health was categorized as “excellent”, “very good”, “good” and “fair or poor”. Heavy drinking was dichotomized as “consumes 5 or more drinks once per month or more” or “does not consume 5 or more drinks once per month or more”, according to the definition of heavy drinking that was employed by Statistics Canada for men and women from 2001 to 2012.²³ For women, drinking 4 or more drinks once per month or more is considered heavy drinking, by recent guidelines accepted by Statistics Canada.²³ However, the 2006 APS question relating to alcohol consumption prevented us from using the new definition of heavy drinking for women.²² For BMI, standard cutoffs for adults aged 18 and older were used to create “underweight or normal weight”, “overweight” and “obese” categories.²⁴ LTPA was classified as participating in 3 or more hours (180 minutes) of physical activity per week or less than 3 hours per week, a cutoff close to, although more stringent than, the 150 minutes of moderate to vigorous physical activity per week recommended by the Canadian Society of Exercise Physiology.²⁵

Analyses

Chi square tests of independence were used to examine the sample distribution and to test for bivariate associations. Multivariate analyses were conducted using a sequential logistic regression method. The first model included only culturally-specific factors. Subsequent models were estimated with the addition of various blocks of variables to test for associations between culturally-specific factors and current smoking independent of potential

† A CMA is a geographic area that has a population of 100,000 people or more, with at least 50,000 people living in the core area.²²

‡ A CA is a geographic area that has a core population of at least 10,000 people.²²

§ A MIZ category of “strong”, “moderate”, “weak” or “no” is assigned to census subdivisions outside of CAs and CMAs based on the percentage of the workforce that commute to a CA or CMA.²²

* The data for this study were provided by Statistics Canada and accessed at the South-Western Ontario Research Data Centre at the University of Waterloo. The analyses and results are the authors’ alone.

confounders. Demographic and geographic variables were added to the second model. Socio-economic and health-related variables were added to the third and fourth models respectively. We also estimated a model with age and gender interaction terms. All models were estimated using the bootstrap weights that were specially designed for the APS to account for the survey's complex sampling design.

RESULTS

Overall, 39.9% of adult Métis respondents in the sample reported being current smokers. Table 1 presents the sample characteristics and bivariate associations between the independent variables and current smoking. As predicted, bivariate associations show that those who reported high levels of spirituality were less likely to smoke. Respondents who were members of a Métis cultural organization were also somewhat less likely to smoke compared to non-members. On the other hand, respondents who spoke an Aboriginal language or lived in a household where one was spoken were more likely to smoke than those who neither spoke nor lived in a house where an Aboriginal language was spoken. In addition, those who had more recently attended a Métis cultural event were more likely to smoke (Table 1).

In general, the directions of the bivariate associations between current smoking and health-related variables were as expected. Those who were more physically active, had higher ratings of self-perceived health, and higher BMI were less likely to smoke, whereas those who drank heavily were more likely to smoke (Table 1).

The multivariate results presented below relate to the full model (Table 2, model IV), which includes culturally-specific, demographic, geographic, socio-economic and health-related variables.

Consistent with the bivariate results, respondents who reported speaking an Aboriginal language were more likely to smoke (OR = 1.80, 95% CI 1.45–2.24) compared to those who did not speak an Aboriginal language and did not live in a home where an Aboriginal language was spoken. In addition, those who reported not speaking an Aboriginal language but living in a home where an Aboriginal language was spoken were more likely to smoke (OR = 1.46, 95% CI 1.11–1.95) compared to those who neither spoke an Aboriginal language nor lived in a home where an Aboriginal language was spoken.

As hypothesized, Métis adults who reported higher levels of spirituality were less likely to smoke. In particular, adult Métis who reported being “very religious or spiritual” or “moderately religious or spiritual” were less likely to smoke (OR = 0.74, 95% CI 0.58–0.93; OR = 0.78, 95% CI 0.62–0.96 respectively) compared to those who were “not at all religious or spiritual”. Attending Métis cultural events and being a member of a Métis organization were not significantly correlated with current smoking.

Women were significantly more likely to smoke (OR = 1.23, 95% CI 1.07–1.42) than men. Respondents aged 18–19 were less likely to smoke (OR = 0.55, 95% CI 0.40–0.74) than those aged 20–34. Similarly, respondents aged 50–64 and over 65 were significantly less likely to smoke (OR = 0.67, 95% CI 0.54–0.82; OR = 0.24, 95% CI 0.17–0.34 respectively) compared to adult Métis aged 20–34.

Table 1. Sample characteristics by smoking status, Métis 18 years of age and older, Canada (2006 Aboriginal Peoples Survey and Métis Supplement)

Characteristic	N	Current smoker		p-value
		No (%)	Yes (%)	
Last time having attended a Métis cultural event				
Less than 1 year ago	1830	58.5	41.5	0.0497
From 1 to 5 years ago	1490	59.1	40.9	
5 or more years ago	1250	60.0	40.0	
Never	2030	62.6	37.4	
Speaks an Aboriginal language				
Yes	670	45.0	55.0	<0.0001
No, but spoken in home	350	51.5	48.5	
Does not speak Aboriginal language and one is never spoken at home	5590	62.3	37.7	
Member of a Métis cultural or political organization				
No	5350	59.2	40.8	0.0010
Yes	1260	64.3	35.7	
Level of spirituality				
Very	1500	64.0	36.0	<0.0001
Moderately	3030	60.7	39.3	
Not very	1230	58.5	41.5	
Not at all	850	54.1	45.9	
Gender and age				
Women	3440	57.8	42.2	0.0001
Men	3170	62.5	37.5	
Age group 18–19	370	64.9	35.1	<0.0001
Age group 20–34	1990	55.8	44.2	
Age group 35–49	2340	56.4	43.6	
Age group 50–64	1470	65.3	34.7	
Age group 65 and older	440	77.3	22.7	
Urban/rural geography				
CMA	3200	60.9	39.1	0.0251
CA	1300	57.7	42.3	
Rural with moderate to strong MIZ	950	63.2	36.8	
Rural with no to weak MIZ	1200	58.3	41.7	
Regional geography				
Ontario	1420	64.1	35.9	<0.0001
Atlantic	360	69.4	30.6	
Quebec	640	59.4	40.6	
Prairies	3120	55.4	44.6	
British Columbia	1020	66.7	33.3	
Territories	70	57.1	42.9	
Highest level of education				
Less than high school	1460	49.3	50.7	<0.0001
High school or equivalent	1170	56.4	43.6	
Some post-secondary or more	3980	65.3	34.7	
Household income				
Less than \$35,000	1630	48.5	51.5	<0.0001
\$35,000–\$60,899	1670	55.7	44.3	
\$60,900–\$95,899	1650	64.8	35.2	
Greater than \$95,899	1650	71.5	28.5	
Self-perceived health				
Excellent	1500	71.3	28.7	<0.0001
Very good	2390	60.7	39.3	
Good	1690	53.8	46.2	
Fair or poor	1040	52.9	47.1	
Binge drinking				
No	5060	63.4	36.6	<0.0001
Yes	1560	49.4	50.6	
Body mass index				
Underweight or normal weight	2450	51.8	48.2	<0.0001
Overweight	2410	63.5	36.5	
Obese	1750	73.5	26.5	
Leisure-time physical activity				
Less than 3 hours/week	3380	56.8	43.2	<0.0001
3 or more hours/week	3230	63.8	36.2	

Smoking (current smoker: $n = 2640$; non-smoker: $n = 3970$).

Frequency counts for all variables were rounded to the nearest ten, other than the urban/rural geographic variable, which was rounded to the nearest fifty.

CMA = Census Metropolitan Area; CA = Census Agglomeration; MIZ = Metropolitan Influence Zone.

Although urban/rural geography was not significantly associated with smoking, Métis living in the Prairies were more likely to smoke compared to those living in Ontario (OR = 1.23, 95% CI 1.02–1.49).

Table 2. Odds ratios relating current smoking to culturally-specific variables based on the inclusion of various control variables, Métis 18 years of age and older, Canada (2006 Aboriginal Peoples Survey and Métis Supplement)

	I OR (95% CI)	II OR (95% CI)	III OR (95% CI)	IV OR (95% CI)
Level of spirituality				
Very	0.62* (0.50–0.77)	0.66* (0.53–0.83)	0.66* (0.52–0.83)	0.74* (0.58–0.93)
Moderately	0.73* (0.60–0.88)	0.75* (0.61–0.91)	0.76* (0.62–0.93)	0.78* (0.62–0.96)
Not very	0.80* (0.65–0.99)	0.80* (0.64–0.99)	0.83 (0.66–1.04)	0.87 (0.69–1.09)
Not at all†	1.00 (–)	1.00 (–)	1.00 (–)	1.00 (–)
Speaks an Aboriginal language				
Yes	2.11* (1.75–2.56)	2.12* (1.74–2.58)	1.82* (1.48–2.23)	1.80* (1.45–2.24)
No, but spoken in home	1.57* (1.19–2.05)	1.44* (1.09–1.90)	1.43* (1.09–1.89)	1.46* (1.11–1.95)
Does not speak Aboriginal language and one is never spoken at home†	1.00 (–)	1.00 (–)	1.00 (–)	1.00 (–)
Last time attending a Métis cultural event				
Less than 1 year ago	1.19 (0.99–1.42)	1.11 (0.92–1.33)	1.13 (0.93–1.36)	1.17 (0.97–1.42)
From 1 to 5 years ago	1.17 (0.97–1.40)	1.12 (0.93–1.35)	1.14 (0.94–1.37)	1.15 (0.95–1.40)
5 or more years ago	1.12 (0.92–1.33)	1.07 (0.88–1.29)	1.07 (0.88–1.30)	1.03 (0.85–1.25)
Never†	1.00 (–)	1.00 (–)	1.00 (–)	1.00 (–)
Member of a Métis organization				
Yes	0.76* (0.65–0.88)	0.76* (0.65–0.89)	0.85 (0.72–1.01)	0.89 (0.75–1.05)
No†	1.00 (–)	1.00 (–)	1.00 (–)	1.00 (–)
C-statistic	0.58	0.61	0.69	0.71

Smoking (current smoker: $n = 2640$; non-smoker: $n = 3970$).

Bootstrapped estimates are shown.

I: Culturally-specific variables only; II: controlling for demographic and geographic variables; III: controlling for demographic, geographic and socio-economic variables; IV: controlling for demographic, geographic, socio-economic and health-related variables.

* Significantly different from reference category ($p < 0.05$).

† Reference category.

As expected, annual household income and educational attainment were negatively associated with current smoking. Métis with a household income in the first, second and third lowest quartiles were more likely to smoke (OR = 2.32, 95% CI 1.90–2.85; OR = 1.84, 95% CI 1.53–2.22; OR = 1.25, 95% CI 1.04–1.51 respectively) relative to respondents with an income in the highest quartile. Respondents with less than a high school education were more likely to smoke (OR = 1.86, 95% CI 1.56–2.22) than those who had attained some post-secondary education or more. Métis who had completed high school were also more likely to smoke (OR = 1.42, 95% CI 1.19–1.69) than those with at least some post-secondary education.

Adult Métis who reported excellent and very good self-perceived health were less likely to smoke than those with poor health (OR = 0.41, 95% CI 0.32–0.52; OR = 0.70, 95% CI 0.57–0.87 respectively). In addition, those who reported participating in 3 or more hours of LTPA per week were less likely to smoke (OR = 0.78, 95% CI 0.69–0.89) than respondents who reported less than 3 hours of LTPA per week. Respondents who reported heavy drinking were more likely to smoke (OR = 1.84, 95% CI 1.55–2.18) than those who did not report drinking heavily. Compared to normal weight respondents, those who were overweight or obese were less likely to smoke (OR = 0.60, 95% CI 0.51–0.70; OR = 0.41, 95% CI 0.34–0.49 respectively).

In a separate model-building procedure, we estimated a model to investigate how age and gender interact with culturally-specific variables (results not shown). Although this model did not substantially change the interpretation of the results of this study, a significant interaction term was found between age and spirituality. While spirituality was independently associated with smoking at all ages, respondents aged 50–64 who reported being “not very spiritual” were significantly more likely to smoke than those in other age groups who reported the same

level of spirituality (Figure 1). The full table of this model is available from the authors on request.

DISCUSSION

This study examined the correlates of current smoking among Métis 18 years of age and older using data from the 2006 Aboriginal Peoples Survey and Métis Supplement. To our knowledge, this is the first study to examine the associations between culturally-specific factors and smoking among this population. The associations between smoking and various

Figure 1. Predicted probability of current smoking by age and level of spirituality, Métis aged 18 and over, Canada (2006 Aboriginal Peoples Survey and Métis Supplement)

demographic, geographic, socio-economic and health-related factors were also considered.

Two fifths of Métis 18 years of age and older were current smokers in 2006, more than double the 19% smoking rate in 2006 found in the general Canadian population aged 15 and older.²⁶ Similarly, research using data combined from the 2007 to 2010 CCHS cycles found that 30% of Métis over the age of 12 were daily smokers, compared to 15% of the non-Aboriginal population.³ The high rate of smoking among Métis clearly demonstrates the need to develop a better understanding of what predicts smoking among this population to guide effective public health interventions.

A particularly interesting finding in the current study was that a high level of spirituality or religiosity was negatively associated with current smoking among the Métis respondents in this sample. Specifically, adult Métis who reported being “very” or “moderately” spiritual or religious were significantly less likely to smoke than those who were “not at all” religious or spiritual. Although these findings might be explained by social factors not captured in the models, they are intriguing for a number of reasons. First, spirituality has been identified as an important constituent of an Aboriginal-specific health framework.⁵⁻⁷ Second, among the general population, prior research has demonstrated that smoking is less prevalent among those who report higher spiritual well-being and more religious activity.^{13,14} This is perhaps because those with higher levels of religiousness or spirituality benefit from stronger social support, positive coping mechanisms against stress, and discouragement to smoke from religious leaders.¹⁴ However, further research is needed to determine how these mechanisms might be related to current smoking among adult Métis.

Contrary to the significant negative association between spirituality and smoking, we found that adult Métis who spoke an Aboriginal language or lived in a household where an Aboriginal language was spoken were more likely to be current smokers, independent of the covariates included in the analyses. However, these results do not suggest that speaking an Aboriginal language or living in a household where one is spoken are, in themselves, risk factors for smoking. Language is a social phenomenon and a strong component of Aboriginal identity.²⁷ In this case, the relationship between Aboriginal language and current smoking might be explained by social factors not captured in the models. Among possible directions for future research, qualitative studies using focus group methodology could help to contextualize the relationships among spirituality, Aboriginal language and current smoking among Métis.

With regard to socio-economic and health-related covariates, many factors associated with smoking among Métis are similar to what has been observed among the general population, including low income, low education,⁹ low levels of physical activity,¹⁰ and heavy alcohol consumption.¹¹ Although smoking cessation interventions should target all Métis who smoke, these findings emphasize that interventions should particularly target those with low income and education, and those who engage in other health behaviours that are not health-promoting. In addition, our results demonstrated that age and gender were

correlates of current smoking, suggesting that age- and gender-specific interventions should be considered among Métis.

There are a number of limitations associated with the APS data. One is that the data are observational and cross-sectional, making it impossible to infer causality. In addition, there is an inflated possibility of type 1 error, since many comparisons were made in this study. Another limitation is that smoking is self-reported, creating the possibility for reporting bias. However, recent literature that used data from the 2007 to 2009 Canadian Health Measures Survey has suggested that self-reporting is a valid tool for measuring smoking status.²⁸ There is also the possibility that the sample of Métis included in the APS is somewhat biased. Since the APS is a postcensal survey, those who did not respond to the Census would not have been included in the sample for the APS. This is a concern since the population least likely to respond to the Census is one that is young, highly mobile and of lower income, characteristics more common among Métis than among the general population.²⁹ Nonetheless, the results of this study provide strong evidence that interventions aimed at reducing the prevalence of smoking among Métis should consider culturally-specific factors, such as spirituality and Aboriginal language, as well as demographic, socio-economic and health-related factors.

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RÉSUMÉ

OBJECTIF : Examiner les corrélats du tabagisme actuel chez les Métis de 18 ans et plus, en accordant une attention particulière aux facteurs propres à la culture. Les facteurs culturels étaient la spiritualité, la connaissance d'une langue autochtone, l'appartenance à une organisation métisse et la participation à des activités culturelles métisses. Des variables démographiques, géographiques, socioéconomiques et sanitaires ont aussi été prises en compte.

MÉTHODE : Les données des 6 610 Métis adultes de 18 ans et plus ayant répondu à l'Enquête auprès des peuples autochtones de 2006 et au Supplément destiné aux Métis ont servi à examiner les corrélats du tabagisme actuel selon un modèle de régression logistique binaire séquentielle.

RÉSULTATS : Globalement, 39,9 % des répondants métis adultes de l'échantillon étaient des fumeurs actuels. Les Métis adultes ayant déclaré un haut niveau de spiritualité étaient moins susceptibles d'être des fumeurs actuels. Ceux qui parlaient une langue autochtone ou qui vivaient dans une maison où l'on parlait une langue autochtone étaient plus susceptibles d'être des fumeurs actuels. L'appartenance à une organisation métisse et la participation à des manifestations culturelles n'étaient pas indépendamment associées au tabagisme actuel. Les Métis dont le revenu du ménage, le niveau de scolarité, la santé autoperçue et le niveau d'activité physique étaient plus élevés étaient moins susceptibles d'être des fumeurs actuels, tandis que ceux ayant déclaré une forte consommation d'alcool étaient plus susceptibles d'être des fumeurs actuels.

CONCLUSIONS : Les interventions visant à réduire le tabagisme chez les Métis adultes pourraient être plus fructueuses si elles incluaient un lien avec la spiritualité. On voit aussi que les comportements à risque concomitants, en plus des facteurs démographiques et socioéconomiques, sont d'importants facteurs à prendre en compte lorsqu'on élabore des interventions pour réduire le tabagisme dans cette population.

MOTS CLÉS : tabagisme; tabac; population d'origine amérindienne; adulte; Canada