We realize that we are not curing a battery of research studies to validate the claims that certain health promotion programs are not working or that they are not working, although through such research and evaluation studies are not unimportant, it is evident that our information is incomplete, especially if it keeps popping out from buses, newspapers, radio, television, posters, pamphlets, and even family allowance nurses, will not necessarily succeed. Human behavior is largely dependent on the nature and pace of the environment in which it is formed and the degree of health education and awareness of the health educator, whether it is keeping up with the demands of the ad. The sexual asymmetry of Canadian society still relegates to women all the work of maintaining the family and the house, and it is estimated that this role is the source of at least 75% of the world's domestic violence and that this role is the source of at least 75% of the world's domestic violence. The sexual asymmetry of Canadian society still relegates to women all the work of maintaining the family and the house, and it is estimated that this role is the source of at least 75% of the world's domestic violence.

We are making at least some headway, why was yet another conference on health promotion called to examine previously? Why are we still struggling in the struggle to reframe our discipline, our objectives, our methods, our very raison d'être. We need to admit, health promotion programs simply do not work for most of the people most of the time and our lofty goals are far from being achieved. Unhealthy lifestyle choices promote unhealthy behavior which, in turn, promotes more unhealthy behavior. Most people are always innately weak, the "blame the victim" syndrome of health promotion programs places the responsibility for suffering on the patient. Too often, people whose lifestyle is unhealthy, are not given the opportunity to change.

To have that effect, to create a dramatic impact on the health of all Canadians, it is not impossible. It requires, in part, thinking about the public health perspective, considering the social context in which personal lifestyle choices are made—something which most current health promotion programs fail to do.

**Current philosophy: blaming the victim**

The biggest reason why health promotion programs reap few of their intended benefits (ie, improved health standards, health-cost containment) is the "blame the victim" (or "blame the public"") syndrome that is the product of responsibility shifting of messages through all health-related sectors. (Sectionalism is not just an individual characteristic, it is also politically significant that these messages, in rendering health and disease a matter largely determined by individual behavior, have thrown a thick smokescreen over a host of factors which are far more influential in creating illness: poverty, sexual inequality, racism, occupational hazards and individually protected environmental pollution. The impact of these "social pathogens" is not just to contribute to health problems, but to examine how we now manage to blame the victim.

In 1975, MacLachlan published his famous book Perpetuating the Health of the Public, which demonstrated that the health education of the Canadian population was essentially an exercise in how to blame the victim. Of the 178 health education programs reviewed, 60% claimed that diseases were caused by individual behavior. Only 10% of the programs reviewed even attempted to discuss the relationships between individual behavior and social, economic, and environmental forces. The authors concluded that the results of their review are consistent with the assumption that the responsibility for health is with the individual.

The book was published during a time when the government was promoting a "health education" approach to public health, which was based on the idea that individuals should take responsibility for their own health. This approach has been criticized for shifting the blame for health problems onto individuals, rather than addressing the social and environmental factors that contribute to health problems.

**Canadian perspectives in health promotion: a critique**

A working paper by Ronald Labonde and Susan Pennel, M.D., F.R.C.P.(C)

**Introduction**

Health promotion has rapidly become the new vanguard concept in the business of health and health education. The older practice of health education under the sprawling goal of "preventing physical and mental ill health through the promotion of better personal habits and the elimination of self-imposed health risks." Although health professionals often regard the low health priorities health promotion programs receive, such programs have nonetheless achieved a considerable degree of visibility both provincially and federally within just the past five years. In assessing what the priorities of health promotion programs should be in the 80's, this article will examine the changes that do occur in current health promotion programs work; second (and more to the point of our argument) are lifestyle risks really the major reasons for the poor health of many Canadians?

**Do health promotion programs work?**

The answer to the first question is a qualified "yes." Within the parameters of current health promotion definitions, most programs are successful in creating an impact on at least some aspect of the lifestyle of some people some of the time. However, we look at some examples:

- Anti-smoking campaigns of the past decade had an obvious impact on the smoking prevalence of the white, non-smoked, non-African American public) is that despite the "massification" of their messages through millions of dollars of advertising, they did not change individual behavior. Both smokers who quit and people who did not smoke were unaffected by the anti-smoking campaign.

- Nutrition promotion and education has evidently made a difference in the consumption of a few food groups. For example, a recent study of Quebec voters found that people who ate vegetables were more likely to vote for the Liberal party.

- A large health promotion campaign in B.C. on venereal disease was not successful, despite consumer confusion over the name change from V.D. to S.T.D., clinical attendance rose to record heights. The campaign had to be put on hold pending completion of a larger federal health promotion initiative.

**Fitness and exercise promotion has been successful enough to encourage plush condominiums to feature racquetball courts and gym facilities. Sporting magazines are becoming a major target to the reports published are constantly being advertised and sport shops are looking less like the inside of a liquor store and more like the interior of a high-fashion boutique.**

*This article is a revised version of a paper presented by Dr. Labonde, formerly Senior Consultant at The Canadian Conference on Health Promotion, B.C. and Alberta. It was prepared for presentation at the First Health Promotion in Canada Conference, held in Toronto on July 6-8, 1982. Dr. Labonde is an Associate Professor in the Division of Child Psychiatry, University of Toronto and holds the Chair of Health Education Consulting with the British Columbia Ministry of Health. Conference delegates will soon be able to order a copy of the full-sized text which claims that there has been no change in the title of the argument.*

**Diet and nutrition**

When people lift their moustaches, it is logical to assume that they are thinking about diet and nutrition. In reality, however, most people simply follow their own dietary guidelines without taking into consideration the complex interactions among diet, health, and social variables. The evidence is overwhelming that the "blame the victim" syndrome of health promotion programs placed the responsibility for suffering on the patient. Too often, people whose lifestyle is unhealthy, are not given the opportunity to change.

In order to produce a significant change in health, we need to focus on the determinants of health behavior. We need to understand the complex interactions between biological, psychological, and social factors that influence health behavior. For example, the "triple threat" model of health behavior suggests that the influence of biological, psychological, and social factors on health behavior is complex and interactive. By focusing on these factors, we can develop more effective health promotion programs that address the needs of individuals and communities.

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activity into legislated labour standards.

What happens now? The major health promotion
program is for the fitness industry, for instance, is that of PARTICIPATE. This
organization has identified the need for programs on the
basis that "it takes no time out of the workday, requires
no special facilities, is relatively inexpensive and easy to
implement, and can be administered by any staff person."36 Yet,
in the job structure that has rendered most
women personal to themselves in their waking
lives, is it not reasonable to suggest that the job structure has
some responsibility for what women are able to do for that
activity? Regular exercise diets and gym breaks could become parts
of the paid workday of all employees, allowing employers
an opportunity to engage employees in activities which
purportedly come from having fit employees. Fitness centres
could be required to have a formal policy of fitness breaks and
the construction of any new office complex or manufacturing
plant.

The dominating middleclass bias of health promotion programs (its "blind eye" turned to the various economic, sexual and cultural issues which are unfairly disregarded among the Canadian population) is apparent in fitness pro-
motion. For example, it is implied that all persons should jog
even if jogging shoes are expensive or unreasonable (even if the
cost of using directly or indirectly state-funded aquatic facilities are
to become prohibitive).11 "Bucking the workweek" (like a
to-weekends) even if large numbers of persons, especially single
mothers, have difficulty affording transport out of the city, let
alone appropriate hiking gear.

Again, the sexual asymmetry in our society works against
women's ability to participate in the regular exercise program.
Women still have primary responsibility for children. Even
when women work outside the home, they still retain the major
burden of child care.12 Their positions, when they do work, are almost always in the lowest paid section of the economy and therefore they often have
little more than a rushed hour or two of leisure time. Finally,
women usually lack control over family income, which can
impair exercise time (for example, babysitter fees) and equipment necessary
to maintain a minimal fitness program.

Stress management

As many medical and psychosocial/behavioral medicine have
become a recent focus of health promotion programs, the stress
management is now unipolar correlation between stress and
CHD, the major killer in our affluent society. Such
programs, however, still operate from a lifestyle with individuality
with individual stressors. Yet, significantly, a 1971 U.S.
Health, Education and Welfare study found that:

...the strongest predictor of longevity was work
activity, the number of periods of "happiness"... Other factors are undoubtedly important — diet, exercise, medical care and genetic
inheritance. However, the evidence reviewed can be translated into these
factors may account for about 25% of the risk factors in heart disease, about 30% of the
individual risk of coronary disease. The health problems share the same social context and class are more frequent in the
throughout the day they are engaged in activity. Group activities provide opportunity
for mutual support, peer education, dialogue for critical analysis, and the sheer power of numbers received to create social impact — features all notably absent from the individual or group contexts. Our analysis will be divided into two sections, one for
promotion. We will consider later how health education
promotion can be transformed into these sections.

So far, we have argued that even within the domain of health behaviors which are clearly personal to themselves, the privacy of personal stressful events (and the need for
routine) is the actual case. The incidence of CHD increases as one goes down the corporate ladder, with blue-collar
workers having higher rates of CHD as executives.37 This
argued that a person's ability to achieve fitness is related to economic, sexual and cultural impedi-
ments. The opportunity to enjoy leisure activities and to seek


Shifting the philosophy: social responsibility

The above examples point out that we should be wary about
jumping on any promotional bandwagon that defines social
problems (or histories) as primarily individual in both
origins and resolution. Furthermore, it is worth noting again that the various
"risk factors," which health promotion programs pretend to control, are asymmetries of the
often poorly understood individual phenomenon. We suggest an alternative definition. Disease is something produced when the life
condition of the individual is not a function of its individual process (lifestyles, congenital weaknesses, and so on) but 30% of the social structures and situations. The critical element in our definition is the word "social." No longer should health problems be seen as individual risk of coronary disease. Our collection is not as many as those that have existed in the minority of those who have been sicker. But these are,
within the group, the relative degree of poverty.

Sexual Inequality

To the extent that people are poor, they will be subject to
environmental and social mechanisms that were more pronounced than it is among women. Women comprise 65% of the adult Canadian population living in poverty.44 This situation is even more stark when we look at the income
caregivers. Women are over three times more likely to be poor among those who are living alone, or divorced, with children.

The male-female difference is one of the most stark in
life chances that women simply have more "problems" in life. We can say that women are in the same position of wretchedness as
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Sexual inequality and patriarchal attitudes have also
crossed the social barriers for many women. The "pill" for instance, was introduced to the market after a
pharrelly five years of research which is now considered to be an effective contraceptive.45 According to one prominent researcher, the continuing use of male contraception is "the greatest human gmo pig experiment in history."46

There has also been the tragedy of abdominoplasty, the
courageous attempt to reconstruct itself with Botox. The known carcinogen, DES (dieldrin/pesticide), continues to threaten children born across North America, in a morning-after pill. Obsessive and
gynaecology remain highly medicalized under male control,47 women's health research is often used as a threat to mothers48 despite extensive documentation on the medicalization of women's experiences.49 From the
terms and values imposed to risks for female patients prompt-
ed one writer to recommend that "male medical students be barred from obstetrics and gynecology."50

Occupational hazards

Arnold Stiller, as president of the United Mine Workers of
North America, once cried out that "Occupational disease inflict
these industries that the numbers of symptoms and deaths in women are 3,000,000.

Over 50,000 deaths per year in North America are
cancer. Women's needs for occupational health services are
discovered each year. Few, if any, receive adequate testing for possible health risks associated with their
work. Women who must handle these devices are often placed under any kind of restriction. And even when these
restrictions exist, they have usually been shown to be ineffective.

Tens of thousands of Canadian women enter plants to
the dangerous, contaminated work environments and breathe air filled with potentially toxic pollutants, all the while
handle substances of which they are told little or nothing about which less is
known. As health educators, we should do well to
on the impact which our political writing messages on
the idea of being used and good enough is that jump and be fit conceivably have when placed alongside the
daily experience of most industrial workers.

Environmental risks

Dr. Samuel Rubens is a former member of the U.S. Environmental
Protection Agency, recently published a 626-page exhausting

detailed survey of cancer in the United States.51 He
concluded that women are more susceptible to "cancer risk" and that the "recent increase in the incidence of cancer" and the "near future increase in the incidence of cancer" relationship between tobacco and lung cancer lost, unlike
health promotion programs, he also phagocytizes ferociously into the
environmental and pathological areas of industrialization.

In the 1960s, a new kind of cancer and the "near future increase in the incidence of cancer" relationship between tobacco and lung cancer lost, unlike
health promotion programs, he also phagocytizes ferociously into the
environmental and pathological areas of industrialization.
Health promotion programs that emphasize the damaging effects of cigarette-smoking are still valid. But they address only part of the trouble facing us on the grave health risks of environmental pollutants (which are clearly a major cause of personal choice) must be challenged. Evidence continually points to the fact that, before this millennium closes, the industrial notification of the environment may well be the most critical challenge we face. In the battle to alter the damaging aspects of our environmental as well as individual action to alter personally chronicizing the "diseases" in this planet's history.

There are several environmental health hazards as well:
- polluted drinking water, with tuberculosis and cholera risks;
- polluted air, leading to a variety of respiratory ailments;
- toxic substances in our food chain, including crops; and
- acid rain, throttling crop production in both Canada and the U.S.;
- polluted oceans, decreasing the fish and seafood stocks;
- carcinogenic fertilizers and food additives, polluting the entire food chain.

These are critical health issues. Like all other social pathologies, they are embedded in the very structure of our industrial society. If we cannot be corrected without a widespread social commitment to radical changes in how we manage our society, then the cost for health promotion in the 80's to begin addressing the reality of these issues, rather than remaining stuck on a health crisis analysis that defines sickness as a master of personal inscrutability. The sociopolitical reality of illness and health is that every woman, every poor worker, every worker in a factory, every individual who lives in a smoggy city or near an industrial plant or a polluted river experiences a daily basis. Our continued adherence to this reality will render us an anachronism at best, destined to hold more conferences at which we will once again propose programs for which programs really work? At worst, we will find ourselves accomplishing what could be called one of major mass deceptions in history.

**The challenge: education for critical consciousness**

The above are strong, harsh invectives. We are convinced they must be made. At the same time, we do feel that pointing an accusing finger at health professionals is any more productive than holding the Canadian people personally accountable for their unhealthy lifestyles. We conclude, then, with a few suggestions on how health educators/promoters can facilitate the change we have placed before them.

The first step in meeting this challenge must be a redefinition of individual responsibility. We must expand it so that people recognize not only the individual health behaviours but also for those behaviours which might induce poor health in others. Thus, the corporate board and shareholders of a belching industrial plant must accept responsibility for the pollution, and the people living downwind of the-stocks, as just smokers are now held responsible for polluting their own lungs. Similarly, we must link our messages on the personal health choices that individuals can realistically make to the social choices which people collectively must tackle. Such a process would entail:

- (a) reflecting upon aspects of reality (e.g., problems of poor health, housing, etc.);
- (b) looking behind these immediate problems to the social problems examining the implications and consequences of these issues, and finally (d) developing a plus of action to deal with the problems collectively identified.

The design of promoting programs in this fashion is a process which will resist the public, a process that is able to reflect critically on its full environment in a way that unifies experiences rather than isolating them into discrete fragmentary entities. Current health promotion programs focus exclusively on the narrow band of personal health behaviour and disconnect individual health from its social context. Little or nothing is said about the social causes and solutions that are perceived as political issues disconnected from personal health. The priority of health promotion programs in the 80's must be to meet the natural demands that responsibility becomes synonymous with social responsibility. Health educators/promoters must initiate collective actions to alter the damaging aspects of our social environment as well as individual action to alter personally chronizing the "diseases" in this planet's history.

7. A "socialized" society is one in which the people... have been manipulated by the "masses" so that the individual can no longer resist the "social influences".
9. Ibid., p. 10.
11. "Risk aversion has been created by the joint action of the manipulation of labour and the accumulation of household debts." Review of Canadian Sociology and Anthropology, 9, 1972, p. 134-149.
12. They became, for instance, the primary focus of the conference on "The Shifting Medical Paradigm From Disease Prevention to Health Promotion," co-sponsored by the PaB of Public health, the Office of the Health Promotion Directorate, National Health and Welfare, the British Columbia Ministry of Health, and the Vancouver City Health Department. It was held on March 20-21, 19M in Vancouver.
15. Statistics Canada, Food Price Duality in Canada, in (1975), Ottawa, Table 6, page 16, p. 188.
16. Nutrition and Health in Canada, p. 55. [Note (No. 11)]
21. Thirty-six per cent of all women in the labour force are married. Forty-four per cent of all married women work.
29. Alex C. Brown, "Why don't we have our health services?" Lancet, Vol. 1, 1979, p. 119.
38. Statistics Canada, Perinatal Mortality, Ottawa, 1980, Table 13-17, p. 58.
42. Diana Scully, "Join We Create Women's Health, Hughaffq Boffin, Boston, 1980.
44. Gena Corea, The Hidden Malady (Seattle: No. 36), November 11 and 12.
53. Ibid., pp. 70-125.