



Revista Brasileira em  
**PROMOÇÃO DA SAÚDE**

*Brazilian Journal in Health Promotion*  
Antiga RECCS - Revista do Centro de Ciências da Saúde

Revista Brasileira em Promoção da Saúde

Universidade de Fortaleza

rbps@unifor.br

ISSN (Versión impresa): 1806-1222

ISSN (Versión en línea): 1806-1230

BRASIL

2007

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*Revista Brasileira em Promoção da Saúde*, año/vol. 20, número 001

Universidade de Fortaleza

Fortaleza, Brasil

pp. 3-11

Red de Revistas Científicas de América Latina y el Caribe, España y Portugal



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# HEALTH PROMOTION IN CANADA: PERSPECTIVES & FUTURE PROSPECTS

Artigo original

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This text is a reworked version of a presentation entitled “Promoção da saúde no Canadá: avanços e perspectivas”, *Seminário Internacional de Promoção da Saúde*, Universidade de Fortaleza (UNIFOR), Fortaleza, Brazil, April 19, 2006. I would like to thank Anya P G F Vieira, Francisco Cavalcante Jr., Juliana de Braga, and Nicolas Ayres for their warm friendship and for assistance with logistics, translation, and editing.

## Introduction

Thank-you for the opportunity to be with you today in this fascinating panel on the state of health promotion in Brazil, Canada and around the world. It is a great pleasure to be here, and to share my thoughts and reflections with you, not as an expert here to tell you how it ‘should’ be, but as a colleague interested in dialogue around points of mutual concern. I feel we have much to learn from what has been happening here in Brazil, and the work of Paolo Freire and many contemporary colleagues who continue this tradition of critical pedagogy for health (like my colleague and friend here at UNIFOR, Dr. Francisco Cavalcante Jr.). So in this spirit of friendship, dialogue and mutual learning, I will be very frank with you about the lessons learned in Canada, including some of our failures and mistakes which I hope you can successfully avoid.

Also, I offer my apologies for not being able to speak with you in your own language. I wish to thank my friends Nicolas Ayres and Francisco Cavalcante Jr. for their assistance with translation.

In addition to a brief overview of the development of health promotion in Canada, I would like to share some reflections on the social, political and economic context in which the field has evolved, both in Canada and internationally. I will address three (3) key tensions I see in the field at the moment (from a Canadian perspective), and reflect on our successes and our failures. I will close with a few thoughts on future prospects and some of the challenges that I see that lie ahead.

I would like to emphasize that any brief history of health promotion in Canada, and any assessment of its strengths, contributions and failures is inherently ‘subjective’ and idiosyncratic. Rather than repeat the work of other analysts and commentators (see for example – cite PHAC/HC docs), I offer my observations based on over a decade of involvement in the field (including involvement in the Critical Social Science and Health group at the University of Toronto), and in my capacity as Director of the Masters of Health Science program in health promotion at the University of Toronto. Doubtless, those with different interests, orientations, and practice backgrounds would come to (slightly or substantially) different conclusions.

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*Recebido em:* 16/05/2006  
*Revisado em:* 16/11/2006  
*Aceito em:* 12/02/2007

**Text Box 1**

**Text Box 1**

**What is Health Promotion?**

*The process of enabling people to increase control of, and to improve, their health (Ottawa Charter for Health Promotion, 1986)*

*The process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health (Nutbeam, 1986)*

- or bureaucratically driven, but involving and responding to diverse social movements)
- building individual and community capacity
- intersectoral collaboration

**Key Milestones in the Development of Health Promotion in Canada**

While many strands of thought, events, and actors coalesced to produce what we might call ‘a Canadian perspective on health promotion’, several developments in the late 1970s and early 1980s are widely credited as contributing. This included the release, in 1974, of the “Health Field Concept” document by then Minister of Health Marc Lalonde, the creation of the federal Health Promotion Directorate within Health and Welfare Canada in 1978, the Beyond Health Care conference in 1984, and of course the landmark Ottawa Charter for Health Promotion as well as the (influential, in Canada, but less internationally recognized) “Achieving Health For All” document released in 1986 by then Minister of Health Jake Epp (see Text Box 3 for fuller, if selective, list of Canadian milestones in health promotion).

The latter half of the 1980s and the early 1990s was, arguably, the ‘heyday’ of health promotion in Canada. Major national and provincial health promotion initiatives were undertaken, in the areas of healthy communities, healthy eating, tobacco control, drugs, HIV-AIDS prevention, and active living. The National Health Research and Development Program (1987-2000) was created. Within the provinces, initiatives like the Ontario Premiere’s Council on Health Strategy (1987-1990) were designed as high level intersectoral bodies that put health high on the political agenda. A series of national conferences on health promotion were launched (early 1990s), as well as 12 new Health Promotion Research Centres across the country; as well as a National Forum on Health (1994-1997).

The emergence in Canada of a the ‘Population Health’ paradigm by the Canadian Institute for Advanced Research (Evans & Stoddart, 1990; Evans et al, 1994) marked something of a turning point in the fortunes of health promotion in Canada. The release of “Why Are Some People Healthy and Others Not” (Evans et al, 1994) coincided (not coincidentally, we argued, in Poland et al, 1998) with the strong emergence in Canada of neoliberal discourse that favoured smaller government as well as fiscal and social conservatism. As championed by the CIAR (Canadian Institutes of Advanced Research), and bolstered by compelling epidemiological evidence, the population health paradigm argued that it was economic growth, not healthcare (or health promotion, which they equated with healthy lifestyles programming) which determined the

**Health Promotion in Canada – An Overview**

As many of you know, health promotion has a long history in Canada, and we have had some leadership internationally in this field.

The definitions in text box 1 are doubtless familiar to most in this room, having achieved considerable notoriety. What is interesting about these definitions is: (a) a recognition of a broad scope of determinants of health (beyond curative or palliative medical care); and (b) an emphasis on *enabling* and working with people to enhance their capacity and capacity to influence these determinants.

Key values that underpin modern health promotion include, but may not be limited to, those listed in text box 2. While it is important to discuss values, and to make values explicit, the assumption is that behaviour is driven by (consonant with) one’s values. History suggests otherwise. Indeed some have suggested that values are redefined to be consistent with behaviour, the latter being driven largely by one’s (economic, institutional, career, etc) interests. So we must ask not only what values are espoused in health promotion but also how these are lived out in practice, an issue to which I will return later in this presentation.

**Text Box 2**

**Text Box 2**

**Key Health Promotion Values**

- equity and social justice
- holistic definition of health (well-being)
- enhances health, not just preventing disease
- encompass full range of determinants of health
- recognizes role of environments (settings) in shaping human behaviour
- empowerment
- meaningful social participation (not just tokenistic

health of populations. Issues of equity and social justice were less explicitly addressed, the assumption being that in economic terms “a rising tide lifts all boats”. Amidst growing debate regarding the significance of population health and its relationship to health promotion, Health Canada released a “Population Health Promotion” framework (Hamilton & Bhatti, 1996) that sought reconciliation between the two paradigms and the blending of the best insights from both perspectives. Meanwhile, federal and provincial agencies were quick to realign themselves under the population health banner, and many health promotion agencies (including the federal directorate) were disbanded or renamed. As a result, much of the progressive social justice rhetoric of the new (post-Ottawa Charter) health promotion was abandoned, leading to some angst and attempts to ‘reinvent’ or take stock of health promotion (see Bhatti & Hamilton, 1996; CPHA, 1996). In its place were community-based early childhood development projects and continued funding for primarily lifestyles-oriented health promotion programming aimed at improving the diets and exercise of Canadians and curtailing their smoking. (For example, our new Ministry of Health Promotion in Ontario is focussed primarily on the promotion of healthy lifestyles and not broader social change, community-driven efforts at systemic social change to improve equity in the distribution of burden of broader social and economic determinants of health). Evident throughout the debate has been disagreement, if not also confusion, about what health promotion is or should be (an issue to which I return below).

### Text Box 3

#### Text Box 3

##### Key Canadian Milestones in Health Promotion

Lalonde ‘Health Field Concept’ (1974)  
 Creation of federal Health Promotion Directorate (1978)  
 Beyond Health Care conference (1984)  
 National Health Promotion Survey (1985, 1990)  
 Ottawa Charter on Health Promotion (1986)  
 Achieving Health For All (‘Epp framework’) (1986)  
 Major national & provincial initiatives in healthy communities, healthy eating, tobacco control, drug strategies, HIV-AIDS prevention, active living (late 1980s, early 1990s)  
 National Health Research Development Program (1987-2000)  
 Ontario Premier’s Council on Health Strategy (1987-1990)

A series of national conferences on health promotion research in the early 1990s

12 new Health Promotion Research Centres (1990s)

emergence of ‘Population Health’ paradigm (CIAR, early 1990s)

National Forum on Health (1994-1997)

Health Canada releases ‘Population Health Promotion’ framework (Hamilton & Bhatti, 1996)

CPHA Action Statement on Health Promotion (1996)

Canadian Consortium for Health Promotion Research (1996)

Public Health Agency of Canada (2005)

Ontario Ministry of Health Promotion (2006)

### Changing Context

The development of health promotion in Canada needs to be understood in the context of social, political, and economic trends both nationally and internationally, as well as the realities of public health practice in Canada. Part of the background required is an appreciation of the realities of public health practice in Canada, a geographically vast country in the Northern Hemisphere with a relatively small and prosperous (albeit not uniformly so) population concentrated in a discontinuous thin band along the border with the United States, our primary trading partner. We are a country of several founding nations including diverse indigenous populations (survivors of decades of colonial oppression), french canadians (concentrated primarily, but not exclusively, in the province of Quebec and New Brunswick, but also in significant pockets in virtually every other province of the country), and the dominant english canadian culture. Culturally, our heritage is as much informed, even today, by ties to Europe (principally UK and France) as it is with our hegemonic neighbour to the south (the USA). In addition, Canada is a country of immigrants, and the ethno-racial diversity of, in particular, our large urban centres has grown considerably (we are not immune to institutional and interpersonal racism, nor have we always been as welcoming as we would like to think we are). These proximities and heritages, and our history, influence what is seen as relevant, doable and worth doing (and for whom).

Also relevant is the way in which responsibilities for health, education and other social programs are split between the federal government and the provinces. While the former retains powers of taxation and ties funding allocations to the provinces to national standards in health and education,

jurisdiction in these areas is almost exclusively a provincial one, with predictable differences in specific coverages and policies (notwithstanding stipulations embedded in the Canada Health Act).

While it is beyond the scope of this presentation to analyse these in detail, also relevant to an understanding of the emergence of health promotion in Canada (and its subsequent fate/development) is (a) the ascendancy of social movements (women's movement, environmental movement, gay rights movement, etc) to which some analysts have argued health promotion is a bureaucratic response, rather than a movement in and of itself (see Pederson et al, 1994); (b) increasing concern in the 1990s with the containment of rapidly expanding healthcare costs; (c) the ongoing devolution of responsibilities, coupled (as is so often the case) with reductions in funding, from the federal to the provincial governments, from the provinces to municipalities, and from all these layers to the non-profit and voluntary sectors (under the guise of 'community' control and participation); (d) the emergence of 'public participation' as an expectation of how programs and institutions will be governed and decisions made (even if the results are frequently more tokenistic than a real empowerment of the people); (e) waning federal leadership in health promotion (with closure of the Health Promotion Directorate, with withdrawal of federal funding for healthy communities, etc); (f) the emergence of managerialism (fiscal accountability, strict managerial control, demarcation of regulated/funded and unregulated/non-funded procedures); and (g) the call for evidence-based practice, often interpreted in terms of a priori specification of 'what works' (and therefore what will be funded) regardless, for the most part, of the particular needs and contexts of local application, which necessarily vary from place to place. These trends are not unique to Canada, though they combine in interesting ways with consequences (and unequal distributions of those consequences) that differ qualitatively from those realized in other countries. [Readers with an interest in how some of these trends have shaped the discourse and practice of health promotion in Canada, as well as its outcomes, are invited to consult Pederson et al, 2007.]

Moving from a contextualization of health promotion practice to its effects, accomplishments, limitations, the next two sections address both the successes and 'failures' of health promotion in Canada, before addressing key tensions, challenges, and future prospects.

## Successes

Even a critical review of health promotion in Canada cannot overlook the many successes that have been achieved. Canada continues to be looked to from around the world as

a leader in this field. Despite recent challenges and setbacks, there is no denying that our early conceptual leadership in the field (with Lalonde, Epp, the Ottawa Charter, early leadership in the healthy communities movement, etc) made a lasting impression both nationally and internationally.

What have been some of the successes of health promotion *practice*? One area that is often lauded as advanced, by global standards, is the inroads that tobacco control has made in curbing the prevalence of smoking and in protecting the public from exposure to second-hand smoke. Canadian laws governing where smoking is permitted in public (and private) spaces are amongst the most restrictive in the world, and our population rates of smoking are amongst the lowest in the world. With over 20 years experience, much has been learned about how to get healthy public policies enacted at municipal, provincial, and federal levels, and how to encourage and support smoking cessation. On the other hand, while smoking has been increasingly shunned by the middle class, smoking rates remain high among some subpopulations (the homeless, psychiatric consumer/survivors, and in many aboriginal communities), suggesting that insufficient attention has been paid to issues of social context and equity/social justice (Poland et al, 2005).

Determinations of success are always relative to one's starting point and frame(s) of reference, but qualified success should be attributed in a number of other areas of health promotion practice, including: (a) municipal leadership in enacting healthy public policy (in areas where municipalities continue to have key responsibility such as public transportation, environmental protection, social service funding) (some of this instigated by a healthy communities movement that remains vibrant in some areas of the country, notably the provinces of Quebec, British Columbia, and also Ontario), (b) the uptake of health promotion in sectors outside public health infrastructure (e.g., by hospitals, within the school system, by business/workplaces), where graduates of health promotion programmes are increasingly finding employment, (c) growing acknowledgement of the need for environmental supports for behaviour change (going beyond health education to address community barriers to behaviour change); (d) increased recognition of the need for, and competence in, the design and delivery of more culturally appropriate programs and services for increasingly diverse populations; and (e) greater integration of health promotion into the healthcare system (what the Ottawa Charter referred to as "reorienting healthcare"). Of course, much remains to be done in each of these domains, where criticisms of current practice continue to be, often, well justified.

Last but not least, Canada has played an important role in the training of health promotion practitioners (from

Canada and from around the world) with the knowledge and skills to address the full scope of practice as envisaged in the Ottawa Charter, not just the narrower focus on social marketing and healthy lifestyles education more common south of the border (see Box 4 for a sample list of core competencies). Longstanding training programs at the Masters level such as the University of Toronto's Masters of Health Science program in health promotion (started in 1975) have been joined by programs at Dalhousie University (Halifax), the University of Alberta (Edmonton), among others). Graduates of Canadian health promotion Masters programs are employed around the world.

### Failures & Shortcomings

While Canada's successes in health promotion are well publicized, it is important to remember that much remains to be done in each of these domains. Less well publicized, but equally important to a reflexive appreciation of the challenges to and opportunities for health promotion, are the mistakes that have been made along the way, as well as the ongoing failures to make significant progress on a number of key fronts. It's important to be honest about these if we are to correctly assess what needs to be done, and if we are to solicit the advice of colleagues from around the world who face similar challenges. A fair accounting of the successes and failures of health promotion in Canada is also necessary to ensure that we are not credited with greater leadership, expertise, and power to effect change than is warranted.

What I'm calling 'failures' constitute, primarily, a mix of (a) inability to make meaningful, sustained progress on key health disparities, and (b) the persistently narrow scope and framing of mainstream health promotion.

In the first category (failure to make significant progress on key health disparities), I would point to the following:

- a growing gap between rich and poor (in terms of wealth, income, and health): "between 1996 and 2004, the *gap* between the lowest and highest income families rose from \$82,500 to \$102,700. By 2004, average after-tax income was \$125,000 for the one-fifth of families with the highest incomes and a mere \$22,300 for families in the lowest fifth." (Toronto Star, 2006). Recently, it was reported that "the 100 highest-paid corporate CEOs in Canada are paid an average of \$9 million a year, and the \$22,000 raise that Ontario MPPs\* recently voted themselves exceeds Ontario's \$19,032 in annual welfare assistance for a couple with two children (a 17.5 per cent drop since 1989)" (Olive, 2007).
- too many children (and families and individuals) still live in poverty (the number of children living

in poverty in the Canadian province of Ontario increased 99% from 254,000 poor children in 1989 to 506,000 in 1995 – Curry-Stevens, 2000; and almost 70,000 people in the city of Toronto alone are on waiting lists for affordable housing - Olive, 2007)

- dreadful living conditions on many aboriginal reserves (lack of fresh water, adequate housing, affordable nutritious foods, meaningful paid employment) and the social consequences and health status consequences that inevitably result from these deplorable living conditions (plus decades of colonial rule, discrimination and institutional racism faced by aboriginal people both on and off reserves)
- a growing number of individuals and families are homeless and underhoused (there is no federal housing strategy in Canada, or meaningful, sustained funding from any level of government for social housing). Also growing are the ranks of the 'working poor' for whom the 'minimum wage' (which varies by province but is as low as \$6.70/hr in New Brunswick – Olive, 2007) is insufficient to provide for basic needs: they are increasingly users of food banks and charitable feeding programs.
- an epidemic of early onset diabetes and childhood obesity, particularly amongst the less advantaged and aboriginal populations (attributable to a combination of 'fast food' promotion, lack of affordable fresh food in northern locations, sedentary lifestyles, inadequate physical activity programs in schools, inequitable access to public recreation facilities)
- since the 1990s in particular, a steady erosion of the social safety net (funding for social programs) by successive provincial and federal governments, in keeping with a 'neoliberal' turn in North American politics (Coburn, 2000)

These failures to addressing health disparities have been complicated by many other developments, including a decade (or more) of health care system reform in which the savings accrued from cuts to institutional treatment services were not reinvested into community care, prevention and health promotion as originally promised. As a result, communities were ill-prepared for the extra load on the already strained and underpaid community service (or voluntary) workforce (particularly within disadvantaged communities) (Bullock, 1990).

In the face of the lack of meaningful sustained progress on these difficult issues of health equity and social justice, public health and health promotion have been unable to mount an adequate response. In particular, it is concerning that:

- in Canada, we have no national health goals/targets
- federal leadership in health promotion has diminished during and since the 1990s
- meaningful deliberative social participation is still the exception rather than the norm
- an overwhelming emphasis on individual lifestyles modification (diet, exercise and smoking) remains – these capture the lion’s share of attention and funding in health promotion despite plentiful evidence of the importance of broader social, economic and environmental determinants of health
- despite widespread acknowledgement of the need for multidisciplinary, multisectoral action and collaboration, and the interconnected nature of many determinants of health, there is still too much emphasis given to single-issue approaches (funding ‘silos’ target only tobacco, diet or exercise and fail to see the connections between them and capitalize upon these)
- notwithstanding a handful of internet forums, there are fewer forums for discussing health promotion practice and research now that we no longer have national health promotion conferences in Canada
- there has been a widespread failure to ‘deepen the social analysis’ regarding the underlying root causes of socio-economic, ethno-racial, and gender disparities in health status. Instead, most programming is hamstrung by time-limited piecemeal funding and a mindset that focusses on “trying to mop up the effects of social inequality, rather than tackling structural causes” (Green, 2006). I’m not dismissing the importance of what Geronimus (2000) calls ‘ameliorative’ (as opposed to ‘transformative’) approaches; it’s just that those who benefit from the status quo remain entrenched when the systemic and structural roots of health disparity go unaddressed and unchallenged.
- most health promotion programming continues to be designed by professionals who are white and middle class, but populations that are increasingly non-white (especially in Canada’s biggest cities, where non-whites will soon be a majority – forcing us to reconsider the term “visible minorities”) and who are more often working class or unemployed (where concentrations of smoking and diets high in fat and low in fresh vegetables remain the highest). Too many health education programs continue to frame their mandate in terms of ‘educating’ people about the merits of healthy behaviour, although there is increasing recognition of the role played by environmental supports and barriers (availability, affordability, time, etc). Still, opportunities for

affected groups to play a key role in agenda setting as well as in program design and implementation are infrequent, despite the obvious merits of doing so. The result is often programs and policies that are blind to / do not reflect the realities of the lives of the people they are intended to help or reform. The results are predictable: equivocal short and longer term impacts (and indeed, in some cases, resistance and an exacerbation of the problem), and programming that, by not reflecting the reality and perspectives of those affected, arguably constitutes a form of what french sociologist Pierre Bourdieu called “symbolic violence” (Bourdieu, 1990; Wacquant, 1993; see also Cockerham et al, 1997; Williams, 1995) . A taken-for-granted perspective on life that sees the body as a long-term project of health protection and advancement, and that frames human existence in terms of self-actualization and personal growth: this sounds wonderful, and it is the unspoken premise underlying many health education campaigns. It is also a fundamentally middle class and privileged perspective, since taken for granted is the ability to prioritize goals, plan for the future, and invest in health. These are not subjective positions of the poor or disenfranchised in Canada, nor of many people around the world.

- although students are often more progressive than their teachers, education programs in health promotion have been slow to incorporate qualitative, action research, and participatory methods, community development, and anti-oppression perspectives and to value these as at least *equal* to the dominant paradigm of post-positivist/epidemiological/quantitative methods, risk factor reduction priorities, and top-down approaches to program design and implementation (and to demonstrate that valuation with better coverage of these issues and higher placement in the curriculum).

## Future Prospects & Challenges

As the pace of change quickens, globalization of trade shrinks the world, populations surge in numbers, and competition for scarce resources (especially fresh water & oil) intensifies, we can expect turbulent times ahead. The conditions for the incubation, propagation and spread of infectious and drug-resistant infections are expected to heighten the likelihood of global disease pandemics. Armed conflicts can be expected to proliferate as the arms trade makes weapons more easily available, as conflicts over scarce resources and the gap between rich and poor grow, and as environmental degradation pushes disenfranchised

populations into increasingly marginal land, leading to their radicalization and widespread social unrest. Widespread communication will heighten awareness of growing social, political and economic polarization between and within nation-states, polarization that has been exacerbated by trade liberalization under NAFTA, the WTO, and 'structural adjustment' policies of the IMF and World Bank. To this will be added the pressures of environmental degradation and global warming, whose consequences seem more real and closer than ever before. Furthermore, as economic development intensifies in populous countries such as India and China, pressures on scarce oil reserves will reach a 'tipping point' of 'peak oil', wherein rapid price increases will set off a cascade of consequences that will fundamentally transform modern life as we know it today (which is currently predicated on cheap energy, cheap transport of goods around the world, etc). In the face of these threats, we have seen both a (re)emergence of strong social movements and popular resistance as well as neo-fascist, survivalist and extremist movements. We can expect this to intensify in the years to come.

In the face of these daunting threats, what are the future prospects for health promotion? While there are many possibilities, I believe we can expect the following:

- we can expect the centre of gravity of health promotion to shift significantly from countries of the North (who have had the luxury of resources and privileged access to international scholarly journals, and have thus appeared to have 'led' the development of health promotion) to countries of the global South where the most pressing problems (and creative solutions) will be seen. Increasingly, the voice of the South must be heard in mainstream and international health journals, conferences, and forums (this process has begun, but many barriers remain). Too much wisdom and experience is not being made available to the rest of the world. Processes and opportunities for cross-cultural dialogue must be intensified as we unite to address global health threats
- several foci within health promotion that are still relatively new will experience significant new growth in interest, funding, and innovation. These include environmental health promotion, mental health promotion, 'global health promotion' (addressing globalization from a health promotion perspective), and the use of health promotion in conflict resolution. Indeed, as global environmental degradation, inequalities and conflicts worsen we may see a relative 'falling away' of current emphasis on 'healthy lifestyles' (a preoccupation of 'rich' countries of the North that has 'infected' how health

promotion is framed around the world), in favour of these other more pressing concerns

- health promoters will have to become much more skilled at handling issues of diversity of all kinds (cultural/ethno-racial, sexual orientation, physical ability). As a field, we need to go beyond training in 'cultural competence' to address systemic barriers to full participation, including inter-personal and institutional practices rooted in racism, ableism, sexism, homophobia, and classism. Furthermore, we will be challenged to go beyond the appropriation of alternative discourses ('cherry picking' ideas from around the world and appropriating terms with which to repackage – or slightly modify - dominant 'business-as-usual'), to more actively decentering dominant discourses about health and health promotion (making way for entirely new visions, relationships, and ways of working)
- acceptance of qualitative methods and postmodern perspectives will continue to grow, as will our theoretical and methodological sophistication regarding social context and environment-behaviour interaction. These are necessary to break health promotion out of a dominant post-positivist paradigm in which quantification and standardization (of 'best practice') are accorded disproportionate weight and importance in comparison to context-sensitivity, participation, and local appropriateness. New ways of thinking and practicing, informed by critical realism, complexity theory, and community development provide promising opportunities for reclaiming health promotion as a fundamentally relational enterprise focussed on community building, social justice, and sustainability (Dooris et al, 2007; Westley, Zimmerman & Patton, 2006; Bopp & Bopp, 2006; Poland, Fröhlich & Cargo, 2007)
- spirituality, human connection, quality of social relations, and environmental sustainability will assume greater importance as people become increasingly disenchanted with the alienating and destructive consequences of rampant (and largely unconstrained) global capitalism. The ongoing example of Cuba and Kerala State in India, as well as Scandinavia, point (each in their own diverse ways) to the benefits of public policy making that emphasizes equity and accessible education, health services, and progressive labour legislation. The election of left leaning regimes in Venezuela, Bolivia and here in Brazil is a further sign that people are ready for change and that the old system of benefits for the few of the exploitation of the many is not

politically, socially, culturally, environmentally, or economically sustainable.

- we desperately need (and are starting to build) new forums for interdisciplinary debate and action, an international community of critical public health scholars and activists (forums such as *Spirit of 1848*, the Society for Equity and Health, etc) (Green, 2006)
- exciting new approaches to understanding the human condition, and new ways of working in community, will, as Freire (1990) did before us, emphasize the importance of finding ways to work with people in dialogue, in solidarity, and in recognition of the inherent dignity and worth of every human being, to help unlock the creative power and unique contribution each person has to offer, drawing on multiple literacies (Cavalcante, 1999/2000, 2005) to engage in life-affirming, mindful exploration of *culture* as a medium of both oppression and of radical renewal and revitalization. I am very hopeful about the tremendous potential of loving, mindful, dialogical approaches that position *culture work* as central to health promotion practice, not as a substitute for 'real' change in the policies and practices that perpetuate oppression and inequity, but as the first step towards personal, community and social transformation (Poland & Cavalcante, 2007)

In closing, I want to express my appreciation for the opportunity to share my views with you. I hope that, in my honesty, I may have helped you see ways in which you might learn from and avoid our mistakes, while taking inspiration from our common humanity, struggles, and modest successes. Most of all, I take hope in the idea that this dialogue today is part of a wider project of building bridges and solidarity amongst colleagues of all countries and backgrounds who are committed to equity, social justice and progressive social change.

\* MPP stands for "Members of Provincial Parliament" – provincial politicians/elected representatives

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