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Abstract

This paper briefly introduces Freire's philosophy of education, as well as examples of how this philosophy can be used in health education. Concepts from Freire's work are highlighted along with how they are applicable to educating adults about colorectal cancer (CRC) screening, a health behavior that is less prevalent among poor and minority populations. Concepts highlighted in Freire's writing can be directly applied to reducing disparities in health.

Keywords

Cancer – Prevention; Colon (Anatomy) – Cancer; Colorectal Cancer; Discrimination in medical care; Discrimination in medical education; Freire; Health Disparities; Health education; Minorities – Medical care; Rectum – Cancer; Urban poor – Medical care

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ABSTRACT

This paper briefly introduces Freire’s philosophy of education, as well as examples of how this philosophy can be used in health education. Concepts from Freire’s work are highlighted along with how they are applicable to educating adults about colorectal cancer (CRC) screening, a health behavior that is less prevalent among poor and minority populations. Concepts highlighted in Freire’s writing can be directly applied to reducing disparities in health.

Keywords: Freire, Health Disparities, Colorectal Cancer

INTRODUCTION

Paulo Freire was a Brazilian educator who encouraged those he worked with to take control of their lives. He felt as if oppression was the result of prescription in that “every prescription represents the imposition of one individual’s choice upon another, transforming the consciousness of the person prescribed to into one that conforms with the prescriber’s consciousness” (p. 47).¹ In order to combat prescription, he proposes that the most important thing is “subjectivity and objectivity in a constant dialectical relationship” (p. 50).¹ Dialogue is central to Freire’s philosophy of education, a philosophy that encourages reflective participation and action.

There are several aspects of Freire’s work that have particular significance to health education. Freire believed there should be a strong emphasis on dialogue and that dialogue must involve respect and that it should not involve one person telling the other what to do, but rather working cooperatively with each other. He was opposed to the concept of ‘banking,’ which implies that the educator is simply making ‘deposits’ to the person they are educating, “which they patiently receive, memorize, and repeat (p. 72).”¹ Instead, educators should employ problem-posing education, a concept whereby people develop their power to perceive critically the way they exist in the world, and that they come to see the world as always changing, which implies that education can be constantly remade, instead of being static.

Several published articles discuss how different components of Freire’s philosophy of education has been used in health education, for example promoting empowerment for adolescents in

psychiatric settings,² having a dialogue with adolescents about life projects³ and empowerment focused school based substance abuse prevention program.⁴ Nursing education,⁵⁻⁷ patient education,⁸ medical adherence,⁹ and community health education¹⁰ were the focus of other articles focusing on his educational philosophy that also discussed oppression in the context of health education. This paper adds to the literature by illustrating the applicability and value of concepts of Freire's philosophy to the early detection and treatment of colorectal cancer.

Colorectal cancer is the second leading cause of cancer death in the U.S. with Blacks experiencing higher incidence and mortality than Whites.¹¹ This can be, at least partly, attributed to the fact that Blacks have lower participation in CRC screening and, as a result, are often diagnosed when their cancer is at a later stage.¹¹⁻¹⁷ It has been proven that receipt of early detection and treatment of CRC can result in a reduction of incidence and mortality.¹⁸⁻²¹ Despite this knowledge, most people over age 50 do not receive timely and appropriate CRC screening, and approximately 60,000 people die annually from CRC.²²

The Healthy Colon Project

The paragraphs below illustrate how some of Freire's ideas were directly applicable to an NIH-funded study to increase colorectal cancer (CRC) screening in a low income, urban, minority population. The Healthy Colon Project was a randomized trial funded by the National Cancer Institute to evaluate the effectiveness of two health education approaches to increase participation in CRC screening in 456 minority participants from the New York metropolitan area.²³ The majority of participants were women (69.9%), aged 55-59 (47.8%), were Black (67.7), and married (63.3).²³ The Healthy Colon Project took place from 2000-2005.

All participants were members of a health benefit fund or were a beneficiary.²³ None of these participants had received CRC screening, but did have health insurance which covered the cost of the CRC screening. A two group randomized control group design was used in which the control group received print communication and the experimental group received tailored telephone education (TTE). The TTE took place over a six month period by a trained health education specialist and was conducted entirely by telephone. The main study findings were that 27% of the telephone group and 6.1% of the control group received screening for CRC.²³ The methods and results of this study have been published in greater detail elsewhere.²³

Concepts from Freire's Pedagogy of the Oppressed

The following excerpts were extracted from Freire's *Pedagogy of the Oppressed*. They were selected to highlight important concepts within the book, and are followed by an explanation of how each quote was applicable to educating adults about colorectal cancer (CRC) screening.

"Accordingly, the practice of problem-posing education entails at the outset that teacher-student contradiction be resolved" (p.79).¹

Using problem-posing in education entails engaging in a dialogue in which the educator and the study participant are equally involved in the process. Given that both parties are actively engaged and participate in asking and answering questions, problem-posing can be used to get to the root of an issue.

Health education about CRC screening was conducted by trying to discuss the issue with the participants as people rather than as a more traditional teacher-student or clinician-patient relationship.²⁴ The situation could realistically be approached in this way since the participants had no obligation whatsoever to talk with the health education specialist and their willingness to do so was completely voluntary. This is, of course, unlike other educational contexts in which the students may be mandated to participate in certain training programs to, for example, maintain their certification or gain advancement in some way. It should be noted that this reflects the idea that education need not be static, which is a characteristic of problem posing education that Freire

highlights.

"The teacher is no longer merely the-one-who-teaches, but one who is himself taught in dialogue with the students, who in turn while being taught also teach. They become jointly responsible for a process in which all grow" (p. 80).¹

The learning process in this case was one in which both the health education specialist and the participant were responsible for learning and growing, however, the nature and scope of what was to be learned was quite different. For the participants, the learning content included: screening recommendations and guidelines for CRC; information about the nature of the disease and the fact that it can only be treated effectively when diagnosed in the early stages; characteristics of alternative screening tests; and ways to receive different kinds of CRC screening. In addition, overcoming emotional and logistical barriers was an important goal of the educational process.

Learning material was tailored to the individual needs of each participant based on factors such as their motivation to receive CRC screening, barriers affecting their ability to receive CRC screening, social and emotional support that may have been required, skills related to communicating with health care providers and actually conducting the home screening test. The ultimate goal was to assist the participant to make an informed decision about CRC screening and, if they chose to do so, help enable them to act on their motivation.

For the health education specialist, one of the most important aspects of the learning process was to learn about the participant. Once a good rapport was established, the health education specialist was challenged to learn about the kind of educational content that would be most useful in assisting each individual make an informed choice about CRC screening. This included assessing their levels of knowledge, fears that may result in defense mechanisms and inhibit CRC screening, and barriers that may have impeded the participant from acting on their motivation and strategies to help overcome these barriers. The health education specialist also had to learn how to establish rapport with each participant. The ways of relating to different individuals varied greatly. In some cases, establishing a strong interpersonal connection was achieved by listening and being empathetic to a participant's situation, while in other cases rapport might have been achieved by providing information or helping to overcome barriers that were identified. In all cases, an important part of the learning process for the health education specialist was to discover ways to connect with each individual.

"The problem-posing method does not dichotomize the activity of the teacher-student: she is not "cognitive" at one point and "narrative" at another. She is always "cognitive," whether preparing a project or engaging in a dialogue with the students" (p. 80).¹

This point builds on the previous one concerning the need for an effective educator to be learning throughout the interactive process with students. One of the main ways such cognitive awareness is important is recognizing and appreciating the psychological and social contexts characterizing a particular learning interaction. It was essential for the health education specialist in the CRC context to be cognizant of the many barriers that a participant may have faced prior to making and acting upon a decision to receive CRC screening. Such cognition may have indicated the need to abandon the topic of CRC screening and attend to other issues that were a more urgent priority at the time such as sickness in the family, financial issues, or problems in the workplace. Indeed, this was a central part of the education process.

"Whereas banking education anesthetizes and inhibits creative power, problem-posing education involves a constant unveiling of reality. The former attempts to maintain the submersion of consciousness; the latter strives for the emergence of consciousness and critical intervention in

reality" (81).¹

In the CRC education, one of the problems that had to be understood by the participant was that almost 60,000 people per year die of CRC,²² but a large proportion of these deaths could be prevented through early detection and treatment.¹⁸⁻²¹ The goal of education was not only to increase awareness about the content mentioned above, but far more importantly, to help the participant make an informed choice and act on that choice. This entailed helping participants to understand the psychological, social, or logistical barriers that may impede receiving CRC screening. Sadly, in this case, the unveiling of reality often revealed that participants were too busy dealing with urgent personal issues and that health care providers were not reportedly sufficiently assertive in encouraging CRC screening. Thus, achieving the goal stated above was often very challenging.

"Education as the practice of freedom-as opposed to education as the practice of domination-denies that man is abstract, isolated, independent, and unattached to the world; it also denies that the world exists as a reality apart from people" (p. 81).¹

This concept is related to the notion mentioned above that education as the practice of freedom must be conducted with a very keen awareness of the context in which we live. This context for so many people in the world involves what might be termed oppressive. The dialogue with the participants showed many examples of this. For example, the participants who can't afford to take time off from work or afford transportation. Or the participant who feels dominated by the healthcare system and is not confident of their ability to discuss options for screening with their doctor. Considering these exigencies, it is not surprising that a participant would not be in a strong position to practice a preventive health behavior such as CRC screening. Given this, health educators should be aware of these oppressive barriers and training programs should address these barriers in detail.

"In problem-posing education, people develop their power to perceive critically the way they exist in the world with which and in which they find themselves; they come to see the world not as a static reality; but as a reality in process, in transformation" (p. 83).¹

In a sense, one of the greatest challenges of the health education specialist was to bring about this change or perspective in an attempt to help participants become empowered to make an informed choice. The intent was to help the people realize that even if they were within a healthcare system that was dominated by a corporate culture oriented to profit rather than placing an emphasis on disease prevention and health promotion, the participants had the ability to become in charge, at least to some degree, of the health care they received. Many participants initially believed that if CRC screening was necessary, their provider would see to it that screening was performed. But there are limited incentives for primary care providers to devote time and energy to help ensure that patients receive CRC screening. In contrast, they are stretched for time and have been trained to address acute problems versus to emphasize prevention and education.

"Problem-posing education, as a humanist and liberating praxis, posits as fundamental that the people subjected to domination must fight for their emancipation" (p. 86).¹

In this case, the issue is domination of the health care process by the medical personnel and health care system. The issue is not so much finding ways to help the participants attain emancipation, but rather to be partners with the health care providers in determining their care. As such, the doctor-patient relationship has to be re-defined away from the "banking" approach to one of shared decision-making. In order for this to occur, the patient must not only be well informed about the issues, but also have the motivation and skills to communicate with the physician and other health care personnel.

"Dialogue cannot exist, however, in the absence of a profound love for the world and for people"

(p. 89).¹

It was clear from the outset that most of the participants enjoyed talking with the health education specialist, even though they were discussing an unpleasant, stigmatized and frightening topic. It is speculated that the reason for this was their sense that the health education specialist genuinely cared about them as people and was not calling to impose her goals upon them. In contrast, she was calling to help them make a decision for themselves. The health education specialist really enjoyed interacting with the people over the course of the project as well, which we believe contributed greatly to the success of the educational effort.

“Authentic education is not carried on by “A” for “B” or by “A” about “B,” but rather by “A” with “B,” mediated by the world- a world which impresses and challenges both parties, giving rise to views or opinions about it” (p. 93).¹

While the hope was that all of the participants would choose to seek CRC screening, it became clear to the health education specialist that many participants had legitimate reasons why they were hesitant to seek screening that was invasive, namely because while the risks were small they were nevertheless present. While all participants had health insurance, some of the tests (e.g. colonoscopy) required taking time off from work and possibly losing wages, which was problematic for many participants. Further, some participants’ prior experience with the healthcare system, or the experience of others they know, gave them reasons for concern to go through some of the more invasive procedures.

“Thematic investigation thus becomes a common striving towards awareness of reality and towards self-awareness, which makes the investigation a starting point for the educational process or for cultural action of a liberating character” (p. 107).¹

The initial goal of this educational project was to improve participants’ understanding and enable action about CRC screening, but the ultimate goal was to influence the character of the participant concerning the way in which they interacted with the health care system, and the extent to which they took part in their own health care. Thus the goal was not only to influence informed choices about CRC screening but, more importantly, to help the participants realize their power in affecting their health care in general. Using CRC as a starting point not only enabled the participant to develop a sense of self-efficacy, but also helped them to become aware of their potential power as a health care consumer.

CONCLUSION

Disparities in health between those who are more and less affluent, have higher versus lower educational attainment and between majorities versus minority ethnic populations are the major goal of the United States Public Health Service (Healthy People 2010).²⁵ These disparities are dramatic and can be seen with respect to mortality, morbidity, disability, physiological and behavioral risk factors. The minority populations with low income and educational attainment in the United States clearly seem oppressed in many respects concerning their chances for healthfulness and a good quality of life.²⁶⁻²⁸

Poverty has dramatic influences on health in so many different ways. Examples include, but are not limited to, having to spend time working just to get by that there is insufficient time to be physically active²⁹⁻³² or schedule and attend visits for preventive healthcare like cancer screening,³³⁻³⁵ inability to afford high quality foods leading to a tendency to eat lower quality, less expensive, convenience foods (e.g. fast foods);³⁶⁻³⁷ inability to pay for healthcare and being forced to accept what care is available, which is often of inferior quality,³⁸⁻³⁹ living in neighborhoods that have higher rates of crime and violence,⁴⁰⁻⁴² among many other examples.

An analysis of health status reveals that the health of a community is largely determined by individuals' lifestyle choices including diet, physical activity, tobacco, alcohol and drug use, sexual practices, and use of preventive services. Research clearly shows that those with low levels of income and educational attainment are far less likely to exhibit positive lifestyle choices than those who are advantaged in these respects.⁴³ It seems clear, therefore, that the concepts in Freire's Pedagogy of the Oppressed can be applied by health educators in a meaningful effort to reduce health disparities, particularly with regard to CRC.

While educational programs directed to individuals such as the one described here are useful as a short-term strategy, given the social and economic causes of health disparities, it is clear that a more comprehensive approach is needed. Closing the gap in CRC mortality and in other major public health problems will require social and environmental changes that not only improve access to health care, but that address the learning and maintenance of health-related behaviors that adversely affect health and quality of life. In many cases, the problem is that what we already know is not being translated into policy and practice. We believe that Freire's orientation is very useful because of his emphasis on involving the people in identifying and solving problems. While there have been some recent steps in this direction (e.g. community participatory research), far more emphasis in this direction is needed.

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