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Paulo Freire and Public Health: A Commentary by a North American Health Professional

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Although Paulo Freire is best known in the United States and worldwide for his work in adult education, his ideas have had substantial impact on the field of public health, especially within health education and health promotion. Freire's philosophy of "education for critical consciousness" and his educational approach of problem-posing dialogue have been adopted by health practitioners in such diverse public health fields as: worker health and safety (Wallerstein and Weinger, 1992; Weinger and Lyons, 1992); lay health workers (McFarlane and Fehir, 1994; Eng and Parker, 1994; Killian, 1988; Booker et al, 1997); work with the homeless (Ovrebo et al, 1994; Sachs, 1991); infant mortality prevention (Howell, 1998; Plough and Olafson, 1994); breast cancer control (Hubbell et al, 1995); senior citizen organizing (Minkler 1997); HIV/AIDS prevention (Parker, 1996; Ferreira-Pinto and Ramos, 1995; Zimmerman et al, 1997; Beeker et al, 1998); adolescent health programs (Wallerstein et al, 1997; Wallerstein and Sanchez-Merki, 1994); social work education (Gutierrez et al, 1998; Lee, 1994; Carroll and Minkler, submitted); community health development (Minkler and Cox, 1980; Purdey et al, 1994; Rivera and Erhlich, 1992; Braithwaite et al, 1989); and participatory research and empowerment evaluation (Israel et al, 1994; Fetterman et al, 1996).

This review of Freire's influence on the field of public health will focus on the United States and Canada, though public health and community development workers internationally have developed Freire-inspired health programs, alternatively called popular education or empowerment education for health.

In a worldwide context, the integration of Freire's ideas into public health practice has been strengthened with the increased recognition of powerlessness as a broad-based risk factor for disease, and empowerment as a core strategy to enhance health (Wallerstein, 1992).

Since the twelfth century, epidemiologic studies have documented that people living in poverty have greater mortality and morbidity than people from higher socio-economic classes. Studies of workers on the lower rungs of occupational hierarchies, and workers who labor under conditions of high demand and low control document higher rates of disease and death as compared to workers with higher status and more control. Countries with vast inequities between rich and poor have greater disease distributed in the population than countries with smaller gaps.

Although common explanations for these higher disease rates include unsanitary conditions, poor housing, poverty, malnutrition, greater percentage of risky behaviors, or hazardous jobs, current research has encouraged a search for a unifying concept of susceptibility to disease, such as powerlessness or lack of control over destiny. While many conditions of

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poverty certainly generate disease, once above the threshold of poverty, powerlessness and the stress of one's position in the hierarchy may be more important than material conditions. The trends of objective and subjective perceptions of powerlessness are only increasing, with globalization of economic markets, urbanization with insufficient infrastructure development, and the resultant expansion of income inequities within and between countries.

As powerlessness has become recognized as a compelling risk factor, then empowerment strategies become critical to understand as a core public health intervention. To explore the relation of empowerment to health, North American public health practitioners have turned both to community psychology and to Paulo Freire's writings of education for transformation.

In community psychology, empowerment theorists propose that people facilitate their own solutions to problems, as opposed to traditional prevention programs in which experts attempt to solve peoples' problems (Rappaport, 1981; Zimmerman and Perkins, 1995). Public health practitioners and researchers expand on this direction from community psychology to define community empowerment as a social action process that involves people assuming control and mastery over their lives in the context of their social environment. Empowerment has come to mean the intertwining of individual, organizational, and community-level changes as people participate in the democratic life of their community for social change (Israel et al, 1994; Zimmerman and Rapapport, 1988). Similar public health concepts also emphasize people's partipation in community change: WHO's 1986 Ottawa Charter for health promotion; community competence (Eng and Parker, 1994); community capacity (Goodman et al, 1998); healthy municipalities/cities (Duhl, 1994); and coalition-building (Goodman et al, 1993).

Though Paulo Freire's seminal works from Brazil, Chile, and later, Africa, never used the term empowerment, his writings, have been a rich source of inspiration for public health empowerment practitioners. Only in his later dialogue works with North American activists and writers, Myles Horton and Ira Shor, did Freire include the term in his discussions:

Even when you individually feel yourself most free, if this feeling is not a social feeling, if you are not able to use your recent freedom to help others to be free by transforming the totality of society, then you are exercising only an individualist attitude towards empowerment or freedom. (Shor and Freire, 1987, pg. 109)

The starting point of concern for the powerless is reflected in Freire's initial work in the favelas and barrios with the marginalized poor, who had a naive or magical consciousness that they could not be actors in their own fate. Freire's method for teaching literacy was using generative words to engage people in praxis to facilitate transformation to critical consciousness. These methods were easily adapted and adopted in the North to the adult education fields of English literacy and English as a Second Language programs (Auerbach and Wallerstein, 1987).

For health education and health promotion, however, the important Freirian concepts and tools have been the overarching approach of listening/dialogue/action; problem-posing dialogue; and praxis, or the continuous cycle of reflection and action. The concept of conscientization provides the foundation to link the three levels of empowerment; through participation in social action, people develop a new sense of identification with the group, a belief of self and collective efficacy, and the ability to influence change on the organizational and community levels.

Much of the creativity of Freirian health promoters and health educators has been in the development of codifications or codes (sometimes called triggers or discussion catalysts) based on generative themes and contradictions to instill the importance of critical thinking and social action skill development in health education programs. Health and safety worker educators, for example, have developed codes in the form of pictures, videos, role-plays for a breadth of

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educational endeavors: right to know education, pesticide education for workers in Nicaragua and New Jersey; asbestos handling; hazardous materials clean-up (Wallerstein and Weinger, 1992; McQuiston et al 1994). The network of health and safety educators using Freire's ideas and Agosto Boal's Theater of the Oppressed has spread throughout North America as the labor movement has expanded its organizing agenda.

These health and safety codes (similar to codes developed for other health education content areas) consistently present a problem familiar to the community members, include the social and emotional context and contradictions within the problem, and avoid delineating a solution, so that social action strategies can emerge from the group dialogue. Popular education materials from the United States, Canada, and Africa have been widely adapted to health education programs (Hope and Timmel, 1984; Barndt, 1989; Zerkel, 1997; Nadeau, 1996; Arnold et al, 1995; Vella, 1995; Habana-Hafner and Reed, 1989; Srinivasan, 1990).

Health promoters and educators have often worked with groups to develop their own problem-posing materials to trigger discussion, as videos, fotonovelas in the Latin American tradition (ASAP, 1997; Rudd et al, 1994); or as photodocumentaries (Wang et al, 1994). This participatory process provides the opportunity for community members to shape their own learning and to have a safe environment in which to engage in reflection/action praxis that they need to take to their outside lives.

Two examples of health education programs in the United States will illustrate how deeply Freirian ideas have been incorporated into public health practice.

The Tenderloin Senior Organizing Project (TSOP), 1979 - 1995, was established in a high-crime 45-block area of San Francisco, populated by large numbers of elderly on fixed incomes and by other marginalized populations, the homeless, the mentally and physically disabled, and poor immigrant families (Minkler, 1997). The high density of housing, lack of enforcement of building codes, absence of major grocery chains, and high density of liquor outlets contributed to the interrelated problems of poor health, alcoholism, undernutrition, social isolation, and powerlessness.

Originally conceived as a Freirian project to work with the urban elderly who lived in single-room occupancy hotels, the overall goal was to facilitate empowerment and build on the strengths of the elderly residents as they worked to improve their lives and their communities. Starting with dialogue circles and refreshments in hotel lobbies, the groups began to identify their generative themes, ie., lack of fresh food availability, fear of attack on the streets, loneliness, and family isolation. TSOP was early able to organize two interventions on the food and safety issues; a weekly mini-market of fresh fruits and vegetables and a weekly cooperative breakfast; and the Safehouse project, for which 48 local businesses served as safe havens when people felt threatened on the street. The safehouse publicity convinced the mayor to increase police patrols with a sharp reduction in crime rate after the first year. Over the years, TSOP adopted the Alinsky approach of direct organizing, establishing a community board, founding tenant's associations to demand housing improvements, and providing leadership trainings to foster resident empowerment. Forced to close the project after 16 years with the increased difficulties of finding funding, TSOP has served as an inspiration for other community projects which aspire towards reducing social isolation and promoting empowerment.

The Adolescent Social Action Program (ASAP), started in 1982, works with Hispanic, Native American, African-American, and Anglo youth in urban and rural high-risk New Mexico communities, and has a long history of applying Freirian ideas to its curriculum and social action organizing (Wallerstein et al, 1997). ASAP's goals are to reduce the excessive rates of morbidity and mortality from drinking and other risky behaviors, and to facilitate youth active

engagement in political change. As an interdisciplinary, primary prevention program, ASAP has fostered collaboration between the University, over 30 school systems in New Mexico, the University hospital and county detention center.

The ASAP curriculum consists of a seven-week experience for small groups of youth brought to the hospital and jail to interview patients and jail residents who have experienced problems with drug and alcohol, smoking, violence, or gang-related activity. College students facilitate the small groups through a defined curriculum, based on the Freirian listening, dialogue and action cycle, which also includes exercises on communication, cultural identity, media literacy, resistance to peer pressure, etc. The youth listen to the patients' and jail residents' stories as triggers, engage in problem-posing dialogue about how their lives are affected by these issues, and develop action strategies for changing their school or community environments. Over the years, youth social action projects have favored creative projects, such as fotonovelas, murals, or videos depicting issues in their lives to share with other youth; the youth have also participated in community-wide gang and alcohol prevention activities.

In addition to developing health programs based on an empowerment philosophy and methodology, Freirian public health practitioners have adopted a reflexive stance of questioning their own relationships of power to the communities in which they work (Labonte, 1994; Wallerstein and Bernstein, 1994). Many health practitioners live in contradictory roles of having power within marginalized communities, yet of not having power within their own bureaucracies, nor in the larger society. Liberatory education and transformation therefore becomes a mutual goal, as health educators must give up their power in order to facilitate community empowerment, yet together, with communities, must identify strategies to challenge inequities and work for social justice.

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