BEYOND FEAR SHAME AND GUILT: A NEW PARADIGM FOR HEALTH

EDUCATION

By

Ravin D. Craig

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Committee Membership

Dr. Maxwell Schnurer, Committee Chair

Dr. Kim Berry, Committee Member

Mira Friedman, Committee Member

Dr. Mark Baker, Program Graduate Coordinator

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ABSTRACT

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Intersectional Feminists are deeply informed by the interlocking systems and ideologies of power, privilege, and oppression foundational to both dominant U.S. social institutions and U.S. society. It is my assertion that the use of shame, blame, and scare tactics tacks in health education do not create healthier communities and it is only through a more holistic understanding of ourselves, our environment, and the systems of power that we can begin the process of sincere health education.

This purpose of this paper is to point towards a shift from the predominant model of health education to one that centralizes compassionate communication. Social justice theories and activist will largely inform this model of health education. In this paper I assert that by creating a sustainable and adaptable peer health education program built on empowerment, liberatory education, agency, and the capacity to both recognize and meet the needs of a diverse array of people and communities, we can start to shift the collegiate health education model to one that is more effective and more importantly not actively harmful. Central to this concept is the empowerment of student's voices and needs in the context of a college campus community. In order to more fully address the health needs of students, health education needs to be viewed through a lens of social

justice in order to understand the intricate ways identity is tied to the health of an individual and community.

It is by this process that Humboldt State University has created a sustainable and adaptable multi-tier health education program that is responsive to our community and decentralizes the use of fear, shame, and guilt as motivators for change.

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INTRODUCTION

The guiding question of public health models and health education programs is, "what motivates us to change?" Public health has focused on the ways that people can be manipulated into making changes for the good of their personal health and for the health of the populous. The foundational text for modern day public health notes this tendency, "The greatest potential for improving the health of the American people is to be found in what they do and don't do to and for themselves. Individual decisions about diet, exercise, stress, and smoking are of critical importance (Wilner 5)." Because of this focus on individual behaviors, for better or worse, health education has centralized the use of fear, shame, and guilt in order to motivate individual health changes. The emotions of fear, shame, and guilt are a staple of educational structures all over world. Conventional knowledge states that if we are ashamed of something, feel guilty, bad, or wrong about an action we won't continue to do that action. This has been the guiding principle of health education for years. If one were to look at major public health education rhetoric fear, shame, and guilt are commonly reoccurring themes in most if not all; for example the systematic public shaming of people who smoke cigarettes, or people who are labeled obese (Wiley 131). Both of these large scale health initiatives (that are often geared towards children) are rooted in the idea that there is something wrong with the person who does or is those things, a smoker is a bad person, fat people are bad people and only when we hate that part of ourselves enough will we make a change to our habits and lifestyles. The "denormalization" of "unhealthy" lifestyles and habits is a common tactic

used by the public health model (Wiley 131). This is where things get complicated. Not only are these initiatives failing to make long term significant changes in behavior in the most vulnerable populations, more importantly they are creating harm by increasing stigma and lowering self-worth (Puhl et. Al 775).

For example there have been large campaigns using the fear of death and disease to motivate people to stop smoking tobacco. This includes public health initiatives like the Truth campaign and D.A.R.E. These movements have then been bolstered by the use of shame tactics to ostracized people who smoke. The issue with these campaigns doesn't lie in their effectiveness but more in the unexamined costs. If we are taught to hate the behavior and therefore the person associated with the behavior it becomes impossible to escape from a perpetuating cycle of stigma. Stigma is defined by five components; the labeling of difference, stereotyping of difference to negative characteristics, labeling (us vs. them), devaluing of the person, and finally the exercise of power (Link). This process is one that public health campaigns should be fighting, but instead it is very commonly used to educate about particularly sensitive issues in public health, with very serious consequences.

The changes that are made when motivated by guilt, shame, or fears are often based on an appeal to the individual and because of this the larger systemic influences are ignored. If someone feels guilty about large amounts of trash in the ocean they may start recycling. This action may do the work of alleviating the guilt but cover the larger issues of the consumption and the environment. To look at a health example, a young woman may feel guilty about her body weight because the images of what is "beautiful" in

magazines doesn't match what she sees in her mirror. That woman may decide to lose

weight through diet and exercise (one of many different ways she may approach this

issue) using guilt as a motivator. This action may or may not alleviate the guilt but the

young woman is not encouraged to build a loving and healthy relationship with her body

and will likely never reach the goal of looking like the model in the magazine. This

pressure for individual action based off of guilt masks the larger systemic issues of

western ideas of beauty and sexism in the media, the equating of thin bodies and healthy

bodies, and turns problem back in to one for an individual person to solve. As Naomi

Wolf puts it, "The beauty myth tells a story: the quality called "beauty" objectively and

universally exists (Wolf 12)." That myth encourages the singular focus on individual

action (usually through consumer culture) and obscures the larger systemic issues.

Health education doesn't just teach us about what we should and shouldn't do, it

teaches us how to have a relationship with our body and with our health and in turn our

community. Health education that is bound in fear, smothered in guilt, and packaged with

shame teaches us to hate ourselves, to punish our bodies, and be afraid of not fitting in.

When health education is done correctly it has the power to remove barriers to healthier

lifestyles by demystifying and destigmatizing the complicated relationship we have to our

health. I started in health education as an undergraduate student desperate to find a

community that didn't encourage me to hate my body but that encouraged compassion

and self-care. As Audre Lorde once wrote, "Caring for myself is not self-indulgence, it is

self-preservation, and that is an act of political warfare (Lorde 127)." As my body was

punished for being non-normative (fat, queer, poor) it was essential to my survival to

engage in self-care and in turn for me to see it as a revolutionary act. I found that community in the work of one office, and a very small group of people in health education. I have been a part of that community for about 7 years and have been profoundly touched by witnessing the lives that are saved by transformative health education practices, much of which has been done by my supervisor, Mira Friedman, with the assistance of passionate student volunteers.

Health education is all around us, both in formal structures and informal narratives. The focus of my work is on the more formal structure of health education in a university setting, however this work has far reaching uses including community organizing and street outreach. I chose higher education not because this is the most valuable or only institution in which I see a need for change in health education models, in fact many of the suggestions that have come from my work would work in other settings. However, I was first introduced to this holistic health education conversation in the context of college health education. There is also revolutionary potential in radically changing the way we think about health on college campuses by contributing to the support of students who have traditionally have had restricted access to higher education (and success in higher education). Often these populations are referred to as, 'underrepresented.' By this I mean that the structure of universities, including health education, is often geared toward supporting the success of students that fall under the identities of white, straight, cisgender, able-bodied, and upper/middle class.

This purpose of this paper is to point towards a shift from the predominant model of health education to one that centralizes compassionate communication. Social

justice theories and activist will largely inform this model of health education. I am deeply influenced by the intersectional feminist frameworks of bell hooks, Kimberle Crenshaw, and Audre Lorde as well as the role the critical pedagogy argued by Paulo Freire can play in health education. In this paper I assert that by creating a sustainable and adaptable peer health education program built on empowerment, liberatory education, agency, and the capacity to both recognize and meet the needs of a diverse array of people and communities, we can start to shift the collegiate health education model to one that is more effective and more importantly not actively harmful. Central to this concept is the empowerment of students' voices and needs in the context of a college campus community. In order to more fully address the health needs of students, health education needs to be viewed through a lens of social justice in order to understand the intricate ways identity is tied to the health of an individual and community.

The starting point is to understand why fear, shame, and guilt don't work, in the first chapter of my thesis I will take a brief look at the ways shame, guilt, fear, and stigma have shaped how health education is done and why it is ineffective. Next, I will look to some examples of innovative theoretical models that have influenced the work I did with the Humboldt State Peer Health Education program, and point to a new paradigm of health education. My project is framed by a combination of different theories, approaches, and modes of activism including intersectional feminist disability studies, trans feminist theory, fat feminist theory and as well as models of reproductive justice and harm reduction as they relate to health education. I will then move on to documenting the creation and structure of the Humboldt State Health Education program, which serves

currently as an example of a sustainable model of student lead health education that

moves beyond fear, shame, and guilt.

CHAPTER I: FRAMING THE PROBLEM

It is valuable to examine promoting fear, shame, guilt and ultimately stigma as a way to educate about health. This exploration is necessary for a few reasons. The first and most obvious being the need to understand a problem before developing solutions, as unlearning is as essential to health education as learning. It is my goal to move beyond fear, shame, and guilt in order to develop the tools to forge different connections through health education. The problem with the use of fear, shame, and guilt is twofold; the first is that the use of fear, shame, and guilt are used to target singular actions; the behaviors and actions of a person, an individual. This singular focus on individual behaviors ignores the role of systems in determining health. These processes are built on the idea that the goal of health education is to change, adjust, or stop the negative choices that we take as individuals. I have, and will continue to argue that the goal of health education should not be focused on the stigmatizing of an individual's actions or choices as this stigma has negative long-term effects that undercut health initiatives. Effective health education is about empowering people to create positive relationships with their bodies that go beyond "good" and "bad" choices. The second is that the use of fear, shame, and guilt can be linked directly to systems of power and privilege, as they are tools of otherizing and oppression.

Understanding the problem of fear, shame, and guilt in relation to health education is central to the methodology and construction of a more successful and sustainable the Health Education program. By this I mean that much of the work I (and

the students and staff I work with) have done is not the creation of new information but the creation of filters[1] which we use to sort through the fear mongering and stigma creation that is bound up in health education literature and prevailing assumptions of the general population about health. The literature in the section serves to point out the rhetoric we are trying to avoid as well as change through a different approach to health education. In many ways while this section serves as a literature review it is also deeply tied to the methodology of my thesis.

The use of fear as a tool of health education is well known to anyone who has spent any significant period of time in the American public education system. We are taught from a young age that there are very serious consequences for our actions. If we have sex we are told from a young age that the consequences have a wide range from pregnancy to death, the same goes for drug use, exercise, not washing our hands, and almost any health related action or inaction. There is literature supporting the idea that fear is an effective and important motivator in changing the behaviors of individuals. In "A Meta-Analysis of Fear Appeals: Implications for Effective Public Health Campaigns" Dr. Kim Witte goes through the different theories that are used to argue for the effectiveness of fear based tactics in health education and outreach campaigns. The detailed analysis of the different fear tactics reveals that the stronger the fear appeal the more likely a person will change a behavior.

According to the EPPM (Extended Parallel Process Model), the evaluation

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[1] For list of filters and tools see Appendix A

of a fear appeal initiates two appraisals of the message, which result in one

of three outcomes. First, individuals appraise the threat of an issue from a

message. The more individuals believe they are susceptible to a serious

threat, the more motivated they are to begin the second appraisal, which is

an evaluation of the efficacy of the recommended response. If the threat is

perceived as irrelevant or insignificant (i.e., low perceived threat), then

there is no motivation to process the message further, and people simply

ignore the fear appeal. In contrast, when a threat is portrayed as and

believed to be serious and relevant (e.g., "I'm susceptible to contracting a

terrible disease"), individuals become scared. Their fear motivates them to

take some sort of action—any action—that will reduce their fear. (Witte

594)

In this example Witte argues that the data shows that fear, in extreme cases, motivates

actions. These fear tactics are things like images of disease-ridden genitals and blood-

splattered concrete (Witte). Fear is tested time and again and proven to have "weak but

reliable effect on attitudes, intentions, and behaviors (Witte 602)." There are two

significant problems with Witte's argument for the use of fear to motivate changes in

health behavior; the first being that it's not entirely accurate. In a 2003 study, researchers

explored if negative emotions (shame, fear, and guilt) in health education advertising

were effective in stopping unhealthy drinking behaviors in college students. Not only

were they found to be ineffective, sometimes they increased the unhealthy behavior.

Our results suggest that shame-laden (guilt-laden) consumers are particularly resistant to messages that lead to greater shame (guilt) but are open to processing messages that lead to another emotion. The current results also suggest that consumers repair their emotions and guard against exacerbating their negative emotions through a defensive processing mechanism, resulting in a belief that their actions will not lead to those emotions in the future. We found that shame-laden (guilt-laden) consumers, when exposed to messages that asserted that drinking might lead to additional shame-inducing (guilt-inducing) situations, believed that their own drinking would not lead to those consequences. (Agrawal & Duhachek 35)

Students convinced themselves that they were not a part of the problem, and that the message, because it made them feel so badly about their actions, didn't really apply to them. This caused them to either ignore the message and continue on as usual or increase the behavior to spite the message. While there is research on both sides of the argument about the effectiveness of fear, shame, and guilt in health education the more significant issue is the cost of that type of education. If a portion of the target population of the education is ignoring the message that is an issue, moreover if people are internalizing those messages and in turn we are using the messages to create stigma around behaviors. This not only undercuts the success of these programs, but also encourages labeling and

otherizing.

      If students believe that they are not the primary targets of a message, then who do they think is? I would argue that the people who are most often and most reliably affected by fear messages are people who are often not at risk for the most severe of the consequences of that behavior to begin with. What I mean by this is that the target audiences for messages imbued with scare tactics are people who are at lower risk for things like STIs, alcohol and other drug addiction, unplanned pregnancy and a host of other negative health consequences, or perceive themselves to be at a lower risk. Fear based education approaches do something other than small ineffective behavioral changes. Fear based education is excellent at creating stigma. Using fear as a tactic for health education teaches that we should be afraid of people who have made bad choices and who have suffered the consequence. We internalize these messages and use them to police the bodies and actions of people around us. Because people want to avoid fear, shame and guilt, it may lead participants to self-label or shift responsibility elsewhere. The fear used to educate about health is then used against people, we become afraid not just of the consequences of our actions but of the people who embody those consequences. Fear based education obscures the systemic issues of health communication and puts all of the blame, shame, and guilt on the individual and their actions. Sharlene Hesse-Biber explains this phenomenon within the diagnosis and treatment of eating disorders,

      These alternative views imply that the solution to an eating disorder lies

within the individual or the family unit. Since the problem centers there it

is also the target for change. Clearly it is important to help individuals or

families overcome their personality and even chemical "defects" by

identifying those at risk. But this approach often amounts to 'blaming the

victim.' (Hesse-Biber 15)

This stigma is at the heart of the process of victim blaming. Not only, does fear based

education only produce minimal results (if by results you mean behavior changes) but it

also has the long lasting side effect of producing and perpetrating stigma, one of the

biggest issues facing college health educators.

This can be seen further when looking at shame and guilt models of health

education, specifically in research done about the role shame, guilt and fear play in

obesity studies. Dorothy Schmalz's research points to that ways in which the production

of stigma through shame and guilt distances people from exercise.

Common weight-related stereotypes that fuel weight stigma are that

overweight individuals are lazy, sloppy, unhappy, stupid, and that they

lack motivation, willpower, education, and friends [12]. Experiences with,

and internalization of, weight-related stereotypes has been shown to

negatively affect individuals' psychological well-being [5, 13, 14], eating

behaviors [14], and physical activity [2, 4–7]. Stereotypes that overweight

people are 'lazy' and 'unmotivated' support personal and social

misconceptions that physical activity is for thin people, thus perpetuating

personally imposed barriers to participation among people who are

sensitive to the stigmata assigned people based on weight. (Schmalz 16)

According to Schmalz weight based stereotypes are at the heart of why people shy away

from exercise. Instilling people with shame about their bodies, guilt about their choices,

and fear of the consequences of their actions causes self-hatred, hatred of others, and an

inability to act. It is a cycle that the consumer driven diet and weight-loss industry rely

on, and should not be used in health promotion. Fear, shame and guilt are both unreliable

as methods of changing health behaviors but they also have huge unintended negative

effects that cannot be ignored.

Stigma is harmful to the development and health of college students. A health

education model that is informed by the core concepts of social justice movements is

aware of the connection our health has to our identities and lived experiences. The

process of creating stigmatized behaviors and eventually identities around health

behaviors doesn't help end health problems but instead creates obstacles to people

seeking help.

Stigma is also directly related to systems of inequality. The process of otherzing

based on perceptions of health and healthy choice making is not unconnected from

systems of racism, sexism, classism, ableism, sizeism, and every other systemic

inequality. The further use of fear, shame, and guilt in health promotion only furthers

these systems of inequality. Take, for example, the recently produced anti-smoking and

other drug ads by the United States Food and Drug Administration (USDA). The campaign is called, "The Real Cost" and in the videos young adults and teens are seen paying for their unhealthy behaviors with their literal body parts (i.e. skin, teeth) (USDA 2014). In particular, the tobacco video shows a young women paying for a pack of cigarettes with her skin. It is very graphic and can be frightening. This tactic is common in health promotion material and relies on shock value to engage viewers in changing behaviors. The commercial employs the dual tactics of sexism and stigma to frighten teen girls from smoking. Conventional ideas of the priorities of young women are centered on the prioritization of beauty above all. Commercials like this one further those ideas and feed on those fears. This is one example among countless examples.

If we continue to rely on the tools that have made us unhealthy to make us healthy we will continue to perpetuate those systems we strive to fight. When discussing the decentralizing of ideas it is nearly impossible not to recall Audre Lorde's iconic words, "For the master's tools will never dismantle the master's house. They may allow us to temporarily to beat him at his own game, but they will never enable us to bring about genuine change (Lorde 1984)." If we believe that health education is important to contribute to the wellbeing of society we cannot continue to use the tools that encourage negative health behaviors (bullying, stigma, peer pressure) to change those behaviors. It may have worked for some to be scared in to changing behaviors but not without contributing to systems of inequality and damaging community health in the process.

CHAPTER II: THEORETICAL FOUNDATIONS

The second section of literature review is to develop an understanding of the different

theoretical frameworks to move toward better health education. I firmly believe that the

shifting of the health promotion/education paradigm to one that takes into account a more

radical view of health and wellness is necessary and that this work that will never fully be

finished. The Okanagan Charter, an international call for health promoting colleges and

universities to change the way we do health promotion, written as collaboration at the

2015 International Conference on Health Promoting Universities and Colleges, states

> Health promotion requires a positive proactive approach, moving beyond a
>
> focus on individual behavior towards a wide range of social and
>
> environmental interventions that create and enhance health in settings
>
> organization and systems, and address health determinants. As such,
>
> health promotion is not just the responsibility of the health sector, but
>
> must engage all sectors to take an explicit stance in favor of health,
>
> equality, social justice and sustainability for all, while recognizing that the
>
> well-being of people, places and the planet are interdependent. (Okanagan
>
> Charter 2015)

The question becomes how to do this work? In order to make such broad systemic

changes in the focus of health promotion I argue that we need new tools to work in

tandem to build socially focused, community positive, and compassionate health education programs.

Many of the theorists, educators and activists listed in this section have already started this work (some specifically in the field of health). The gathering of these frameworks is critical because, we may begin to develop an in-depth understanding of one's self, one's environment and community, as well as the complicated the meanings of "health," "wellness," and even "education." It is by this process that we are creating a sustainable and adaptable health education program that is built on empowerment, liberatory education, agency, and the capacity to both recognize and meet the needs of a diverse array of people and communities. Central to this concept is the empowerment of students' voices and needs. All of this highlights the first steps towards challenging the damage of health education that relies on fear, shame, and guilt to influence behaviors.

In order for health education to be effective and inclusive and to move away from the trappings of fear, shame, and guilt of health educators we need to have new methods to think about education. These theoretical models all contribute to a new way of educating about health that takes into account the importance of the connections between identity and health the complexity of holistic wellness. Central to this work is creating positive relationships with one's body throughout education. These frameworks illuminate the ways in which we filter through health education materials. It is important to note that the theoretical frameworks and tools included in this section are a starting point for a shift in the health education conversation. In the next section I will take the theoretical models introduced here and show how they can be used as specific tools to

shift the conversation about health education. Health education informed by critical identity theoretical models is required to center the relationship between health, identity, and systemic oppression.

The stress of structural inequality has been linked to a number of health consequences. Educator and activist Jeffery Duncan-Andrade writes, "The exposure to chronic stress associated with living in these types of "socially toxic environments" is not thought of as one of the most – if not the most – significant contributors to poor health… confirming what we have known intuitively for years: inequality is making us sick (Duncan-Andrade 5)." Both the social and physical environment in which we live and were raised is directly connected to our health and wellness.[2] This fact is essential in understanding the importance of using critical theoretical models to inform health education programs. Duncan-Andrade's argument for educators to engage the processes of fostering "critical hope" (Duncan-Andrade) in order to support urban youth is significant for health education purposes as well. Health education in colleges and universities has the potential to assist students who are systemically disadvantaged in a university setting. By shifting away from a model that is rooted in systemic oppression to one that is dedicated to fostering radical wellness and critical hope we can carve out spaces for student success until a time comes where when are able to re-envision the entire system. The theoretical models included in this section all contribute to an environment of critical hope. For the purposes of this project I have given a brief

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[2] For more information on this research see the PBS documentary Unnatural Causes, http://www.unnaturalcauses.org/

explanation of the theoretical model or activist framework, highlighted leading literature from the field, and explained what key incites can be influential to shifting the paradigm of health education.

Liberatory Education and Critical Pedagogy

In order to frame the shift from fear, shame, and guilt based health education we need to first access a new model for talking about education. The model I've chosen is one that pulls from the vast knowledge produced by the theories of intersectional feminists, liberatory education is often discussed with the concept of a classroom specifically in mind, however many of the tenets apply to other forms of education and in fact support that there are many ways to educate that are not dictated by a traditional classroom style. Liberatory education is the act of using education as a form of activism.

> To educate as the practice of freedom is a way of teaching that anyone can learn. That learning process comes easiest to those of us who teach who also believe that there is an aspect of our vocation that is sacred; who believe that our work is not merely to share information but to share in the intellectual and spiritual growth of our students. To teach in a manner that respects and cares for the souls of our students is essential if we are to provide the necessary conditions where learning can most deeply and intimately begin (hooks 13).

The notion that as educators we can share in the growth of our students and that teaching

from this place is a revolutionary act is the beginning of creating a health education

framework that rejects fear, shame, and guilt. Health education that centers the

experiences of both educator and student as relevant and critical to the topics must first

recognize the roles fear, shame, and guilt have played in forming our relationships with

health and wellness then move past them to create a new relationship. In conjunction with

Liberatory Education practices is the discourse of Critical Pedagogy. Paulo Freire's

critical pedagogy is a challenge of conventional education and educators to turn

education spaces into cooperative co-learning spaces engaged in the processes of

decolonization. This awareness comes from empowering students through education,

Freire wrote in Pedagogy of the Oppressed**,**

> Education either functions as an instrument which is used to facilitate
>
> integration of the younger generation into the logic of the present system
>
> and bring about conformity or it becomes the practice of freedom, the
>
> means by which men and women deal critically and creatively with reality
>
> and discover how to participate in the transformation of their world (Freire
>
> 34).

The old models of health education serve the purpose of advancing systems of oppression

based on class, race, size, ability, gender, sexuality and so on. Fear, shame, and guilt do

the work of maintain the status quo, the students who are most at risk are left out of the education that can in many instances be life-saving. This is Freire's notion of conformity. This is education as terrorism and gate keeping. The realities of living in a world that purposely builds barriers to accessing potentially lifesaving information can be seen in the staggeringly high rates of HIV infection in queer youth of color (Bridges 2007) and the huge increase in college aged students living with clinical mental illness (Henriques 2016). These are examples of the lack of understanding the connected that health has to our identity. In order to unlearn the damaging negative relationships that we have been taught to have with our bodies and health, health educators need to use new tools. Health education that is founded in a space of liberation can start the process of changing those relationships. The examples found in the liberatory education models work well with health education because they reject the traditional hierarchical models of the classroom and challenge educators to engage with their own lived experiences around the topics they teach. This model connects very well to a peer-to-peer model of education. The practice of liberatory health education has the ability to empower students to engage with and change their world.

This is not the first time that Critical Pedagogy has been introduced to the world of health education. In *Critical Pedagogy in Health Education* Catherine Matthews outlines a three-tiered approach to using the tools of Freire and power-sharing education models in health education. "It (Critical Pedagogy) has the advantage of enabling learners to engage with health information rather than to simply be passive recipients of it, as occurs in health education program which continue on providing information in a

transmission approach (Matthews 2)." This type of health education has to centralize

educating about power and privilege in tandem with health information (because they are

inextricable). Matthews calls on educators to move beyond transmitting facts and figures

to students but to instead engage in a process of exploration and co-learning where there

is no "predetermined answers to problems" (Matthews 3). This is a significant step to

moving beyond fear, shame, and guilt and points to a co-creating on knowledge between

health educators and students. The idea that there is no "right" way to do health is

revolutionary in changing the way we approach health education.

The foundation of liberatory health education models is to meet students where

they are at in the processes of building a positive relationship to their bodies. In order to

do this health educators should be ready to be vulnerable and engage their own

experiences, and invested in learning as well as teaching. By integrating the tenets of

liberatory education, health educators are tasked with tapping into their own struggles

and are guided to teach from a place of compassion. It is essential to removing shame,

fear, and guilt from health education so that educators teach from a place of non-

judgment. Liberatory education gives us the tools to do this vulnerability, which is

fundamental to the process between educator and student.

Anti-Racism & Intersectional Feminism

This paper is a call to shift the discussion about health education. The very idea of

a paradigm shift, the refocusing of an issue in order to highlight the pieces of the

narrative that are missing from the conversation, is inspired by the work of intersectional feminist scholars and activists like Kimblere Crenshaw. Intersectional feminism challenges the narrow focus of white-centric feminism to examine the ways in which our experiences with privilege and oppression are determined by a complex interweaving of identity.

> Cultural patterns of oppression are not only interrelated, but are bound together and influenced by the intersectional systems of society. Examples of this include race, gender, class, ability, and ethnicity. (Crenshaw 1989)

Crenshaw and other founders of intersectional feminist discourse challenged feminist activists and discourse and anti-racist movements to look to the margins of the struggle, to those whose voices are never foregrounded and to re-think the complexity of identity. In order for holistic health education to work it must be influenced by intersectionality. A holistic health education model is concerned with people's whole selves, not just the segmented pieces of identity. This means acknowledging the complexity of identity and its relationship to health, i.e. the connections between alcohol and other drug use and mental health, the relationship nutrition and exercise have to the environment in which we were raised, or the interplay of our sexual health and our religious beliefs. Health education guided by intersectional feminist theory is tasked with thinking about people as whole and complex.

In our culture it is necessary that our education model to be actively anti-racist. There is established literature that shows active racial bias in health care and medical

research[3]. This bias also exists within health education models. Colonialism and the portrayal of the continent of Africa as 'diseased' have bleed into the way health educators discuss HIV/AIDs education and other sexual transmitted infections (Flint & Hewitt 295). In my own work I have witnessed students with the best of intentions portraying people they perceive to be sexual promiscuous, aggressive, or predatory coded in the mannerisms of black and brown stereotypes. These stereotypes are harmful and limiting to the potential transformative nature of holistic health education. Being actively anti-racist and intersectional challenges health educators to ask the questions, "who is missing from this conversation, who is being portrayed as a stereotype, and what is being represented?"

<div align="center">Reproductive Justice</div>

Reproductive justice is the idea that we have to move beyond a rights or choice based narrative surrounding reproductive health to something more encompassing. Mirim Perez describes the reproductive justice movement as, "working to build a world where everyone has what they need to create the family they want to create (Perez)." In college health education this is a significant concept for undoing the scare tactic narratives about reproductive health that students come to school with and for building healthy relationships between students and their bodies. Often students have learned that reproductive 'rights' are the summation of the struggle. They may have absorbed the

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[3] Paradies et. al. (2013), Shavers & Shavers (2006)

simplistic political analysis of access to health care or abortion that permeates the national political landscape. Access to comprehensive reproductive health choices goes beyond free condoms and STI testing to a place where the experiences and choices of student around their reproductive health are validated. Students require access to non-judgmental education about all reproductive health, pregnancy or abortion. Sistersong, a worldwide collective of organizations working to ensure reproductive justice for women of color complicates the traditional rights based arguments about sexual and reproductive health by offering a different perspective.

> …for Indigenous women and women of color it is important to fight equally for (1) the right to have a child; (2) the right not to have a child; and (3) the right to parent the children we have, as well as to control our birthing options, such as midwifery. We also fight for the necessary enabling conditions to realize these rights. This is in contrast to the singular focus on abortion by the pro-choice movement that excludes other social justice movements (Ross 2007).

When using a lens of reproductive justice we can see the ways in which previous models of health education have obscured and limited choices. Reproductive justice points to a way of educating that validates different ways for creating health knowledge. Holistic reproductive health education foregrounds indigenous knowledge, experience-

based health knowledge, and community knowledge that is often tossed out by medical

health infrastructures.

> Access to resources and services, economic rights, freedom from violence,
>
> and safe and healthy communities are all integral to their expanded vision.
>
> While each group (activist groups) draws on its unique history, their
>
> similar definitions of reproductive rights reflect significant commonalities
>
> of experience and overall socioeconomic status. These include
>
> disproportionate rates of poverty, lack of access to health care information
>
> and services, lack of insurance coverage, and limited access to
>
> contraceptive services. For example, 23 percent of African American
>
> women, 42 percent of Latinas, and 25 percent of Asian American women
>
> lack health insurance compared with 13 percent of white women. For
>
> women of color reproductive and sexual health problems are not isolated
>
> from the socio economic inequalities in their lives. (Silliman et. al. 6)

A health education model that is informed by this movement would welcome workshops

by birthing dulas, local indigenous lactation groups, and international activists fighting

for the rights of all people to make informed reproductive choices. All of which is

necessary to an inclusive health education program that refuses to leave out the voices of

those most at risk. It is vital that we intentionally emphasize people who are not

considered by mainstream health care: women of color, people who are young and

pregnant, poor and pregnant, or who don't want to be pregnant now but also don't want those choices taken away from them.

The book, *Undivided Rights: Women of Color Organize for Reproductive Justice* gives an overview of the history of the Reproductive Justice Movement. One of the most significant things that can be gained from integrating reproductive justice frameworks in university health education programs is the intersections between access and quality of health care and autonomy and racial and gender identity.

Disability Theory

Critical disability studies challenges us to rethink our relationship to our physical environment as a space of privilege or disadvantage and intersectional or feminist disability theory takes the analysis further to discuss ability intrinsically linked to other forms of identity. Critical disability theory is founded in complicating the idea of disability as an identity. "…disability is not fundamentally a question of medicine of health, nor is it just an issue of sensitivity and compassion; rather it is a question of politics and powerlessness, power over, and power to… critical disability theory gives rise to its own particular set of challenges to the core assumptions of liberalism (Pothier and Devlin 4)." Disability is thought of as a category of identity much like gender or race in that it is both socially constructed and physically represented and has far reaching consequence no matter it's construction or reality.

From both a practical and a theoretical standpoint disability theory has direct impacts on moving beyond shame, fear, and guilt in health education. Practically we are called on to be intentional in creating spaces that are accessible both physically and in terms of content, rhetorically. Much of the work of college health education is in the creation of events and workshops. From the inception of these events educators need to consider if the space is physically accessible and scrutinize invitations and communication. This might be language, imagery, or, the where when and how we advertise events. Our spaces need to be informed by disability/ability frameworks. When engaged in a crucial disability framework it is not the body or individual who has/is disabled[4] that is the problem but the physical or mental construction of the space and language that is at fault. While it is an important piece of disability politics that the spaces in which we organize and educate are accessible there is real value to a health education model informed by disability politics.

Disability justice calls on us to educate in a way that moves beyond the rhetoric of awareness campaigns and to do health education in a way that does not require bodies to be health, sane, or fixed in anyway. This is complicated to do in the framework of "health."

If our goal is to help people to lead "healthier" lives then how can we incorporate disability justice rhetoric that values people who are disabled when this contradicts the idea that people "need" to be healthy? Disability justice helps us to reframe the purpose

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[4] The language of disability is largely contested; there is not one way to refer to people with a disability (i.e. person first language).

of health education. Through a lens of disability justice we might have to critique what the very idea of what "healthy" means. As health educators we are tasked with thinking about health and health choices as dynamic and complicated. Not only should we not be othering people because of a disability but also we should be celebrating those differences. Health education that is informed by feminist disability theory shifts health education away from healthy versus unhealthy dualities and reduces the potential of othering students.

Transfeminist Theory

As with other forms of identity, health is directly connected to our gender identity and gender expression. This is different than the biological connections between genitals and health Transfeminist theory challenges health education to work on deconstructing the medicalized connection between gender and sex and it is essential that health education models include trans students and gender nonconforming students for a robust health education. This means health educators have to foreground the experiences of trans and gender non-conforming people in health education. To give some context to the discussion of Transfeminist theory I will start with a definition of transgender.

> *Transgender* is often used to refer to people who "do not conform to
> prevailing expectations about gender" by presenting and living genders
> that were not assigned to them at birth or by presenting and living genders

in ways that may not be readily intelligible in terms of more traditional

conceptions of gender. Used as an umbrella term, it generally aims to

group several different kinds of people such as transsexuals, drag queens

and kings, some butch lesbians, and (heterosexual) male cross dressers

(Bettcher 2014).

The short hand, trans is used to denote the umbrella use of the term to include the list

shown in the above quote.

When speaking of Transfeminist theory and Trans activist work I am talking

about the work of such writers as Emi Koyama, Sandy Stone, and Kate Bornstein in

response to the exclusion and often rejection of trans people, more specifically

transwomen, from society and the mainstream feminist movement. It is a movement and

theoretical framework that calls in to question the essentialism that is a cis-based gender

system, a system that links biological sex to two genders, male and female.

Transfeminism is a movement that has particular value for health educators as Koyama

notes:

Transfeminism believes in the notion that there are as many ways of being

a woman as there are women and that we should be free to make our own

decisions without guilt. To this end transfeminism confronts social and

political institutions that inhibit or narrow our individual choices, while

refusing to blame individual women for making whatever personal

decisions (Koyama 2001).

Like many of the frameworks outlined in this chapter trans activism asks health education to move beyond the idea of inclusivity to reframing conversations to include perspectives from the voices of people who are often delegated to the margins, in this case folks who identify as trans.

There are many ways that the literature and activism of transfeminism has direct links to the work of revolutionary health education. In one of the foundational texts for transfeminist thought, "The Empire Strikes Back: A (post)transsexual manifesto" Sandy Stone explores the ways in which trans bodies and stories exist outside of the binary framework of traditional gender, and she argues that the stories of transition for trans people in a medicalized context attempts to force bodies back to the gender binary. Stone argues for that there is a border existence as a part of trans experiences. The enforcement of cultural gender norms on bodies is harmful to everyone as it creates a barrier to relevant health information. This can be seen specifically when talking about sexual health. Sexual health is a large part of what we discuss it is very difficult if not impossible to educate about sex-positive sexual health without using names for genitals. There is no perfect way to educate about sex and discussions of genitals is a necessary part of the process, however this can be done without being actively harmful towards trans folks and transfeminism can require us to shift the primary focus away from binary genders. We can mitigate some of that by choosing not to associate a specific gender with

a specific body part, this goes farther by being conscientious that lots of people of all different bodies and gender presentations have sex in a variety of ways, so sex acts themselves should never be gendered. This is not only the case with sex but also all aspects of health and the body. Health is a highly gendered field; reproductive health is often referred to as "women's health," medical forms are often tailored specifically to a binary sex/gender system, and health statistics are often broken down so that we can see how issues affect "men" vs "women." Focusing health education on trans experiences can help to decenter this binary and offers a more useful health education for everyone.

In order to move beyond inclusiveness we as health educators have to actively create spaces for trans people to have access to health education topics that have traditionally been created for and by cisgendered people. This means gathering community resources and national for trans folks, advocating for changes in our health centers, and doing non-binary health education. It also means not tokenizing trans staff members by requiring them to educate only about trans issues.

Harm Reduction Education

Harm reduction models of health education have become increasingly more common and important for health education since their introduction to public health in the 1970s (Duncan 1994). Most commonly these tools are used when doing outreach and education around alcohol and other drugs (AOD), however the tools have been adopted in many areas of health education that include "risky" behaviors. The goal of harm

reduction is to give people tools to mitigate harm and potential death when engaging in activities that are high risk. Some examples include needle exchange programs, condom demonstrations, and teaching safe drinking habits. One of the first examples comes out off the huffing epidemic of the early 1970s. There were a number of deaths among adolescents inhaling the fumes from paint in order to get a quick high, the deaths were often a result not of the actual fumes but avoidable accidents. Educators started ending their presentations with tools on how to be safer if people were going to engage in the activity, Duncan (281) argues that this change in health education resulted in fewer deaths.

There is still resistance to harm reduction models. Often people misconstrue the education and fear that educators are teaching people how to do drugs or how to have sex. In reality harm reduction is an important tool to overcoming the barriers created by stigma. In the previous section I discussed the damage fear, shame, and guilt based health education programs can do, harm reduction models give health educators the tools to build trust based relationships with students and are significant because they strive to meet people where they are at in their relationship with their body. Students are given the tools to keep themselves safe while removing the traditional shaming aspects of health education.

Fat Feminism

Using the word "fat" in relation to the word "health" is a very controversial. Fat feminism asks that we recognize fat as an identity that it looked upon much in the way of class, race, gender, and ability, and challenge the way size discrimination interacts with and is compounded by sexism. Fat feminism calls into question the idea that a person's worth or health can be determined by their size and calls out a society that emphasizes harmful standards of beauty and encourages a dangerous and costly diet culture. Fat activist, theorist, and writer Virgie Tovar dissects the assumptions behind weight loss with an eye on holistic health,

> When people say they want to lose weight they often mean I want to be respected. I want to be loved. I want to be seen. I want liberation from fear and self-loathing. Weight-loss culture will never give us those things because it is founded in fear/hate based systems like sexism, racism, classism and ableism (Tovar).

Traditional fear, shame, and guilt based health education is bound up in the-system of diet culture culture. Health education serves as a backbone to the idea that being fat is bad and will kill you. Much of the work of fat activism is dismantling the unfounded idea that weight and health are directly linked. The *Health at Every Size* movement is a specific example of this. In order to successfully build positive relationships with our bodies it is a necessity for health education paradigms to stop using the rhetoric of obesity. This means no longer using statistics tying obesity to death, and

ridding our education of any and all fat shaming tactics. There is significant harm done by the shame-based model of the "war on obesity." The persuasiveness of this perspective can be seen in the public support for First Lady, Michelle Obama's "Let's Move" campaign. This public health project proposes, "to put a stop to the challenge of childhood obesity within a generation, so children who are born today grow up at a healthy weight." (Obama 2014). The "Let's Move" campaign could have been about getting children more active for their overall health, however by tying it to an obesity framework the stigma of fat and the eradication of "bad" bodies becomes paramount. Some children might lose weight by moving more, some won't. Making health initiatives about fat, means they are no longer about health but about body policing. This is an example of the overwhelming pervasive nature of internalized stigma on our common knowledge about the workings of health.

Health education can encourage healthy nutrition and exercise while still being body positive. It is not only counterintuitive for health educators to be educating about the dangers of eating disorders while simultaneously shaming fat people, but also actively harmful. Diet and weight loss culture use the rhetoric of health as tools to shame people about their bodies, this isn't actually about increasing the overall health of individuals or society but about shaming difference. A health education program that takes inspiration from fat activism is actively critical of diet culture and promotes healthy connections with food and physical activity based from a place of compassion and holistic wellness.

Sex-Positive Sexual Health Education

A sex-positive health education model means educating not only about the potential negative impacts of sex but also about the benefits of sex and enjoyable ways to enjoy safe sex. This means talking openly about the function of the clitoris, how to massage a prostate, and the benefits of masturbation to name a few topics.

> Sex education that does not involve discussions of pleasure is innately sexist. Why? Because one can discuss pregnancy, STDs, and prevention in relation to heterosexual sex without a single mention of the clitoris. Educators definitely should not do this, but the fact is that it's entirely possible to give a scientifically accurate and even practical description of birth control, condom use, vaginal intercourse, and other sex education stales without ever acknowledging the clitoris's existence. And the same holds true for the female orgasm (Kulwicki 306).

Sex-positive health education allows us to see the ramifications of shame, fear, and guilt on healthy sexuality. A health education curriculum that included information for people with Sexually Transmitted Infections (STIs) that acknowledged that they have desires and still can enjoy sex could be valuable. This example of sex-positivity exposes the stigmatization of people with STIs and points to the ways in which sex negative or even sex "neutral" models of health education contributes to the spread of STIs through stigmatization. People are more likely to get tested for an STI and actively communicate their status if they know that they will not be ostracized for their status. People are more

likely to communicate about their status, about protection when they feel comfortable. The comfort can come when we emphasize the positive aspects of sex, which means centering programs in a sex positivity framework.

Sex-positive sexual health education does not mean sex only or that all sex is okay. Sex-positive sexual health education has to validate the experiences of people who are often at the margins including the voices of queer folks and asexual folks. All of this should be done through a lens of enthusiastic consent. Sex-positive, consent based sexual health education is not only significant to lessening STIs and unwanted pregnancies but also sexual assault. A cultural shift that emphasizes the positive aspects of sexuality and encourages healthy and appropriate communication about sex will result in less rape. Sex-positive health education holds people accountable for engaging their partners in sex that is based in positive consent. Health education models that rely on fear, shame, and guilt are contributing to the pervasive culture of sexualized violence on college campuses.

Sex-positive sexual health education models challenge us to reframe the conversation about sex, to come up with new scripts and metaphors for thinking about sex. In ""Toward a Performance Model of Sex," Thomas Macaulay Millar argues that we should shift the way we think about sex from a commodity model to one that is more equivalent to a musical performance. This shift in perspective is revolutionary to ending rape culture and diffusing the impacts of fear shame and guilt on conversations about sexual health.

Because it centers on collaboration, a performance model better fits the

conventional feminist wisdom that consent is not the absence of "no," but

affirmative participation. Who picks up a guitar and jams with a bassist

who just stands there? Who dances with a partner who is just standing and

staring? In the absence of affirmative participation, there is no

collaboration. (Millar 38).

This shift in the narrative about sex that comes with sex-positivity sets an

example for the larger narrative shift that we need to have around health

education. It represents a new way to challenge stigmas (STIs, slut shaming, lack

of experience, non-traditional sexual desire) that are barriers to successful health

education. Sex positivity allows health educators to show there are other messages

about bodies and health that aren't actively frightening and shameful, but that

allow us to celebrate our bodies.

Peer-to-Peer Education

There are an abundance of examples of programs (health based and other-wise)

that use peer-to-peer education to spread messages. The strengths of these programs lie in

the research that people are more receptive to information given to them by someone they

can relate to especially around issues that are typically viewed as sensitive, for example

alcohol and other drugs and sexual health. (Sawyer, Pinciaro, & Bedwell 1997). Peer-to-

peer education programs are successful in many different situations, from university

health programs to farmer-to-farmer knowledge sharing in rural South American communities (Holt-Giménez 2006), however much of what makes them successful is the accuracy of the information and authentic engagement of peers in creating that information.

Peer health education program should center on the voices and experience of those students as well. A peer health education program has the potential to be a proponent of critical pedagogy, however if educators are not allowed to adapt to their environment and engage in co-learning strategies because they are required to use fear/shame/guilt based health curriculum they undermine the potential of critical engagement. An essential part of disengaging health education from models based of shame, fear, and guilt is to create health education moments that are reflective of the community one is educating, and empowering to the students doing the education. In an investigation of effective peer-to-peer education programs in hepatitis C prevention, researchers found that programs with funding tied to structural constraints on adaptability and messaging for peer health education programs were ineffective and the authors make recommendations that support the argument for peer health education programs founded in critical pedagogy.

> "While there is a legitimate place for building the skills and knowledge
> base of peer educators, our findings indicate the need to allow peer
> educators to develop ways in which to acknowledge the social production
> of their own and their peers' experiences including the realities of social

and economic marginalization. Drawing explicitly on structural influences and beginning to challenge or reframe them may result in more resonate and authentic peer education messages than the current focus on an information-driven blood-borne virus (hepatitis C) prevention agenda (Trelor et al. 7)."

Utilizing student leaders as mouthpieces for provider controlled health education is backwards, health providers should be listening and learning from the communities in which they work.

However it is necessary to note that peer health education that isn't informed by medically accurate and evidence-based education has potential for creating significant harm. In my experience it takes a lot of effort to redirect people away from using anecdotal information in educating about any topic especially health.

I feel it is important to mention that I firmly believe that any PHE (Peer Health Education) program should be largely student run. This does not mean that they cannot and should not work or be a part of formalized structures at universities or high schools, but that the students involved should have a certain amount of autonomy and flexibility, with support, training, and structure provided by health education departments. It takes a significant amount of work to both have authentic student voices and leadership as well as guidance by a mentor who can make sure the information given is accurate and responsible. This is a constant balancing act that requires engagement by staff and the student leadership.

Peer health educators are uniquely suited to the work of shifting the health education paradigm from focuses on shame, guilt, and fear for many reasons. The first is, the accessibility of peer-to-peer education. It is true that students are more likely to talk to students about life issues, including those around health, but accessibility is more than that. Students who work as health educators can do the decoding work for health jargon; they can give health information without the baggage of judgment that can come from asking a provider or even Google. The majority of the skills that should be taught to peer health educators (PHEs) aren't health facts but how to do research and how to impart knowledge without judgment. The second reason why PHEs are effective at combating old methods of health education is their lived experience. PHEs are students, have survived high school health education, and are currently trying to make their way through college and stay alive while doing it. While it is impossible to create a PHE group that can speak for the entirety of a campus, it is possible to teach PHEs to actively engage with their own experience and to listen to the needs of the community they are serving. Because they are connected to student communities, Peer Health Educators can help a campus to respond to health needs that may be particular to that place and time. Compassion is essential to reframing health education without the driving need for purity.

The work of PHEs is significant to communities because of their potential to become advocates for systemic change. Health education that centers community's experiences and that is detached from models of shame, guilt, and fear is necessarily connected to the politics of identity. Students who can share their struggles for health and empowerment can work in solidarity to support each other and organize for change. This

model of health education is a part of a larger picture of social justice education. PHEs serve as activists in reframing the value judgments attached to health, in many ways they are essential to fighting stigma around health issues.

In order for education to be liberatory, educators have to put themselves at risk:

> Any classroom that employs a holistic model of learning will also be a place where teachers grow, and are empowered by the process. That empowerment cannot happen if we refuse to be vulnerable while encouraging students to take risks. Professors who expect students to share confessional narratives but who are themselves unwilling to share are exercising power in a manner that could be coercive (hooks 21).

We have to be vulnerable and open to sharing experiences, in order to be effective teachers, this is also true for student Peer Health Educators. Shared compassion and vulnerability are fundamental tools to effective teaching. In that vein it is important to talk about the place that fear, shame, and guilt hold not only in overall health education but also specifically in the experiences of health educators as educators. Guilt is especially prevalent when doing any kind of social justice education and more so when focused on health.

Every single student I've worked with has had to grapple with inconsistencies in what they educate about and the choices they make in their lives. Recognizing these inconsistencies and the guilt and shame that goes along with them is very significant.

When educating about health our own struggles can make topics relatable. This is especially true when attempting to educate without the trappings of guilt, shame, and fear. In many ways we must acknowledge that they are there, even for us. Using and interpreting these experiences can help educators to get past the initial guilt, shame, fear reactions associated with health conversations. This is true for our choices, what we eat, if we chose to exercise or not, when we go to bed, if we decided to use alcohol or other, or if we've ever had unprotected sex. Honesty can mean using our own experiences and working through our own inconsistencies to enhance peer health education programming.

Peer-to-peer education models are perfect spaces to model bystander education. These education models follow the idea that bystander intervention is significant to mitigating harm in a number of different settings including, sexualized violence, domestic violence, alcohol and drug abuse, and discrimination. These programs focus on training bystanders to recognize moments where they can and should intervene to disrupt actions that could lead to harm. It is necessary to teach individuals how to overcome social and mental barriers we have erected to keep us from speaking up and interacting in situations where we often feel we have no business intervening. There is another side to bystander intervention, which is a model of community accountability; these actions and often reactions are a part of what happens after moments of harm. For examples we would go to the organizers in spaces like CARA (Communities Against Rape and Abuse) in Seattle and Sista II Sista both of which are a part of Incite! Women, Gender Non-Conforming, and Trans people of Color* Against Violence.

Community accountability and bystander intervention models have the potential to be based in places of fear, shame, and guilt. It is easy to create an alcohol poisoning intervention program that teaches, if you don't help someone get help they will die and you will go to jail. However, effective community accountability and bystander intervention models orient training to build compassionate communities centered on the ideas of shared vulnerability and our obligation as humans to care about what happens to each other. Health education models that use the tools of community accountability can move beyond simplistic stigma of inaction by emphasizing the development of community. This is part of holistic health education, to move beyond individual choices and changes around health issues and allow health education programs to effect systemic and cultural changes.

The strengths of peer-to-peer education programs lay in the ability to tap into common experiences and shared vulnerability. There is a significant amount of trust that can be built through compassion.

Liberatory education, reproductive justice, Trans feminism, harm reduction, fat feminism, sex positivity and peer education are tools that are useful for health education. Putting these tools into operation takes work, time and support. In the next section I will discuss how the Humboldt State University health education program utilizes all of these theoretical models.

CHAPTER III: HEALTH EDUCATION AT HUMBOLDT STATE UNIVERSITY

This final section is written as an articulation of the current model of health education at Humboldt State University and to give examples of the frameworks from section III in action. The model has three different programs, The Peer Health Education Program (PHE), The Oh SNAP Campus Food Program, and CHECK IT.

As a graduate student I was given the opportunity to create a peer health education program to meet the needs identified by Mira Friedman, the health educator who guided me as an undergraduate. As an undergrad at Humboldt State University I worked for the Health Education program, which at that time consisted of the Health Educator, Mira Friedman and one to two students she hired to help her in the office. The program worked diligently to create a campus culture of holistic wellness, working out of the Student Health Center. We were given a small budget to expand the program and bring on more student staff when a new Recreation and Wellness Center was slated to open on campus. This task became mine as a part of my Graduate Assistantship. We hired ten student employees and very quickly realized that the program needed a solid foundation to remain sustainable.

We modeled the Peer Health Education program after the frameworks in this paper and I currently coordinate that program and co-coordinate the Oh SNAP Campus Food Program. All three programs explicitly draw from the theoretical models outlined in the previous section. This thesis is intended to give explicit tools to people who want to change the way health education is done. This section gives some of those tools and also

outlines some of the lessons I learned doing this work. I will mostly talk about the Peer

Health Education Program, but I will also touch on the other programs, as it is important

to understand the ways in which they work in collaboration in order to be more effective.

It is my ultimate goal in this section to point toward a sustainable justice based model of

health education that moves away from fear, shame, and guilt. In this section I cover the

basics of the program including our basic program structures, examples of theoretical

frameworks in action, and the filters/tools we use to navigate, identify, and avoid health

education materials and programing that is based in fear, shame, and guilt.

Oh SNAP Campus Food Programs

The Oh SNAP Campus Food Programs were started by a group of HSU Social

Work Students who were concerned about food security among college students. The

program consists of a campus food pantry (like a small food bank), assistance with

CalFresh Applications, shuttle service to local farmer's markets and food banks, a

campus food waste diversion program, and a weekly farm stand featuring free locally

grown organic produce.

The Oh SNAP program represents the use of student lead peer-to-peer education.

It was the students that first recognized the need on campus and it is them who run the

day-to-day operations of all the programs. This is an incredible example of how peer-to-

peer models can overcome stigma. Shame is the most common emotion felt by people

who use the services provided by food banks (Horst). Having a staff of students who are

not only familiar with the services provided but also have used them helps in creating a welcoming environment.

The Oh Snap's weekly cooking classes teach student to cook foods they have on equipment that can be found in a dorm room. The food is nutritious however there is no calorie counting or food shaming that is a part of the nutrition education initiatives. This is an example of how students can be introduced to health food without using the shame that often accompanies diet culture rhetoric.

It is written in the Oh Snap mission that they not only seek to feed hungry students but to provide them with tools to understanding the role that food plays in our identity development and in a larger sociopolitical context. The program has developed relationships with local farmers to not only provide free fresh produce but to also educate students about how that produce was grown. As of Fall 2015 the Oh Snap program has also been a part of creating a university wide food collective to consolidate food justice efforts from all over campus, emulating much of the food sovereignty work of La Via Campesina on a very small scale.

CHECK IT: Bystander Intervention Program

The CHECK IT program is Humboldt State's health education program's answer to creating a campus culture that doesn't tolerate sexualized violence, dating violence, or stalking. CHECK IT is Humboldt State's student led multifaceted bystander education program that teaches community accountability. CHECK IT represents years of work done by HSU's Sexual Assault Prevention Committee (SAPC). CHECK IT represents a

successful collaboration between faculty, staff, students, community members, and organizations; it is an extension of the work done in the SAPC and works out of the Recreation and Wellness. The language and imagery of CHECK IT was created by students for students and is a phenomenal example of the process of co-learning in action. CHECK IT is a verb and a movement. CHECK IT as a movement is a student led movement meant to empower the community to take action when incidences of sexualized violence, dating violence, or stalking occur, it also means to create a campus community that is supportive to both people who are known to us and who aren't, and is supportive of the choices and experiences of those who have survived violence. To CHECK IT means to intervene when harm is about to occur.

The CHECK IT program has a detailed and comprehensive outreach program that engages communities and student groups in the process of learning about issues of violence and meets them where they are at in that process. This is an example of harm reduction education at it's finest. It is impossible in the world of violence prevention to guarantee safety and as a community accountability harm reduction focused program CHECK IT is able to meet individuals and communities where they are at in the process of uncovering connections to rape supportive culture while sustaining the hope that one day we will have communities where acts of violence don't occur.

CHECK IT also (like all the HSU Health Education programs) uses a peer-to-peer education model, however an engaged staff member who is able to take responsibility for the message and reputation of CHECK IT also leads them. Programs like this one set

Humboldt State apart from other universities, because CHECK IT embodies many of the themes of this essay -- liberatory education, harm reduction and peer to peer education.

Peer Health Education

A peer health education program needs to have a solid structure in order to educate and remain functioning. The students who do the work need to be aware of the political frameworks that I identify in this paper, be representative of an array of student experiences, and be comfortable educating their peers about uncomfortable topics,

When starting the HSU PHE program it was essential to hire a dedicated, passionate group of students, and I also felt that it was important that they have some knowledge of power and privilege. The actual content of health education (how to put on a condom, what is an STI, signs of alcoholism) are things that can be taught as well as their connections to issues of identity. However, if I needed to start with basic power and privilege education as well as health education and presentation techniques I would need months to train educators. I didn't have months, and most people running programs like mine don't either. The nationally recognized PHE certification program by The BACCHUS Network is 12 hours long and normally done over the course of a weekend. I wouldn't point to this training as a particularly good example, but it does show how long we can realistically expect students to sit for training. So we made Humboldt State's introductory power and privilege class a job requirement. We open the application to everyone and recruited from LGBTQ groups, the Women's Resource

Center, Planned Parenthood's on campus club, campus activist events, and student

leadership groups. It was important to have students who were from a variety of

backgrounds. Training happens over the course of a weekend in August and throughout

the year with weekly staff meetings. It was important to call on local groups to present

and interact with the students. This is good because the majority of a PHEs job is often

connecting students to appropriate resources. It is essential that they be familiar with

these resources. This training coincides with the CHECK IT educator training and we do

many sessions together. There is a natural collaboration between Peer Health and

CHECK IT as we are working toward similar goals and are able to support each other's

work.

While training covers many health education topics, a large portion is spent on

understanding the connections between health and identity. Students are asked to identify

the ways that they have experiences these connections and we spend time pointing out the

role fear, shame, and guilt have had in shaping our relationship to health and our bodies.

The students are given basic background on each lens and then are tasked with drawing

specific connections between health education and the theories that form our program. It

is essential to establish a co-learning environment from the beginning starting in the

training. Peer health educators themselves do much of the training and much of it is

practice in engaging in challenging educational moments. The training is where PHEs get

foundational information, but more importantly it is where they learn that their views and

experiences and valuable and they should use them to engage in cooperative learning

with their peers about issues of health. While we try to cover a lot during the training it is essential to the program that learning be weaved throughout the year.[5]

One of the biggest struggles for organizing the PHE program is the task of figuring out what topics to cover. Health is a big field and it is important that the topics we cover speak to the experiences of our audience and are influenced by the theoretical and activist models I discussed earlier. There are endless studies trying to determine the top health concerns of college students, all with concerning statistics about the health and welfare of students. For example, a 2011 American Public Health Association study showed that the number one killer of students at 4-year universities is suicide and that alcohol related deaths are significantly lower than was generally assumed (Turner et. al. 31)**.** In order to get a handle on these numbers and to reflect the experiences of our student leaders we organize the health concerns of our students in to four categories. These are mental health, sexual health, alcohol and other drugs, and general wellness. Our aim is to have large-scale events that target each of the topics every semester and to foster smaller more specialized education around topics that fall under each umbrella as they become relevant to the experiences of our students and are highlighted in the broader conversation around health. Although it is important for our work not to be derailed by fear, shame and guilt driven national conversations that do not apply to our students or that are ineffective mandates.

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[5] For some examples of journaling techniques and group activities we use for training and evaluation see Appendix C.

Many PHE programs have students hired to cover specific topics, for example a student that is hired to specifically educate about sexual health. However our program is structured differently. In order for our program to be student lead and student-centered I encourage students to spend their first semester exploring a variety of topics. This allows them find something they are passionate about and have a connection to. Second semester they choose a topic to focus on and to research further. If a student stays in the program past one academic year they are required to create a lesson plan about their topic of focus. This has been amazingly rewarding for the program. We have gotten interesting and evocative lesson plans about non-violent communication and condom use, the importance of spiritual health and wellness, asserting your needs with your medical provider, and the cost of culturally insensitive costumes. However it is a struggle with this model to make sure we are covering topics evenly. We rely on feedback from student participants and comprehensive relationship with our Student Health Center to make sure we are reflecting the needs of our campus community. For example Humboldt's student health center as seen a steady rise in students seeking services for anxiety and depression, so much so that the Health Center and Counseling Services has been overwhelmed with the increase. As health educators we reflect that need by organizing events like Mental Health Awareness Week.

Currently we have subcommittees of the PHEs that are topic focused, also smaller committees do Peer Health Education event planning. Our ATOD program is called, Humboldt Haze, the goal of which is to, "clear the air around alcohol and other drug myths." It is an interactive harm reduction program that was created by students for

students to meet them where they are at in ATOD education. The PHEs host an annual event called Sexland which is a body positive sexual health event, dedicated to teaching students about pleasure based sexual health from a gender inclusive perspective. We collaborate with CHECK IT on The Consent Project, which reflects the values of survivor-centered education dedicated to building a campus community of enthusiastic consent. While much of the work of the PHEs is on large scale events we also offer small workshops on a variety of topics like; cervical health, how to talk to a fat phobic medical provider, mindfulness, self care, and navigating college drug culture. All of which call back to the theoretical models from Section III. We support all this work with open office hours and an engaging social media presence so that we can connect with students one on one.

A crucial part of building a sustainable PHE program has been structuring the program. By this I mean that we need to talk about leadership, set clear expectations about job requirements, and keep detailed records of our successes and failures and stay in communication with other offices on campus. Student run programs can be amazing, and yet they often fall apart because eventually students leave campus**.**

I encourage students to journal about their experiences as well as do formal evaluations. The formal evaluation process is done through setting learning objectives for events and workshops and doing and evaluation pre and post-test statistics of workshops. Some examples of our evaluations can be seen in the appendix. While these formal models of program evaluation are important it is also significant to encourage the

students to reflect on their experience in a multitude of ways. In the appendix you will also find journaling prompts and two group activities that we use to process events.

In order for the program to be sustainable we also must be realistic about the requirements of student leaders and make self-care and boundary setting a priority. As I suggested when talking about shared vulnerability and the importance of liberatory education the experiences of educators is significant to the process of educating about any topic but even more so when talking about health and the body. However this processes can be draining, spiritually, mentally, and physically. That is why it is so important to teach student leaders to set boundaries with their work as well as centering the practice of self-care. It is ironic that people teaching about wellness do not always use the tools we teach in our own lives. A survey of studies about mental health workers and burn out states that anywhere from, "21-67% of mental health workers may be experiencing high levels of burnout (Morse et al 341)." Burnout is defined as, "emotional exhaustion, depersonalization, and reduced personal accomplishment (Mores 341)." Similar studies have not been done specifically for people serving in the capacity of Health Educators but often both student leaders and professional health education staff are tasked with the burdens of students seeking help and this is without the necessary training or support that people specifically in the mental health field receive. In my office we often see students who have "timed out" of counseling sessions and who are desperate for help. This means that they no longer have sessions available to them through our limited mental health services on campus. College campuses all over the world are seeing huge increases in mental health needs from their student populations and often the burden

falls not to trained professionals but to student leaders. These student leaders need to be empowered to set clear and firm boundaries about what they can and more importantly cannot provide as well as they need to be encouraged to practice rigors self care. Peer Health Educators are not councilors and that needs to be centered in their training.

The last piece of creating the Peer Health Education program's structure is about the benefits of the program to the students participating. It is difficult if not impossible to quantify the actual effect of a Peer Health Education program on a college campus community. Which can mean that it is difficult to prove the necessity of these programs. But there is hope. The most significant change and benefit can be seen in the growth of the peer health educators themselves. While it is not the focus of this paper so I will not include gathered quotes or statistics I have witnessed the changed lives of many students who have done this work, myself included. By empowering their peers to build positive relationships with their, bodies peer health educators are doing that work for themselves as well.

CONCLUSION

My beginning as a health educator came out of my own struggles as an undergrad and is heavily influenced by my life growing up. When I came to school I had no money, I knew no one in the area, and I didn't have any support from home. I am not unique in this; there are many students who start college in the same way, who often don't make it to graduation. I almost didn't. After my first few weeks of school I couldn't afford to eat, and I stopped going to classes. After my first semester I was put on academic probation. After my first year I was disqualified from the university. I went through the long and difficult the process of petitioning to stay. It was this experience that brought me to working in Student Affairs. I am deeply aware of the external forces that disrupt students as well as the lack of internal support systems help balance the many pressures that come with college. College campuses are a unique kind of community. They have communities that are a temporary space filled with a lifetime of pressure and stress. They are institutions built to both break students down and rebuild them. There is both great potential for learning and growth and for oppression and colonization of the mind in a campus community. Within my own struggles with depression, drug use, self-hatred, and monthly colds I was lead to the offices of health education.

There are many ways of doing health education. Up until college my interactions with information about my body was always framed in the same ways, fear, shame, and guilt. Fear, that I was going to die because of my choices, shame because my body wasn't

the right kind of body, and guilt that I was unable to make the changes I needed to make in order to be healthy.

In my own way I had already developed a distrust of the use of fear tactics. The ever-present messages of my youth regarding my health were that of the public service announcements, public school sex-ED, and D.A.R.E. (Drug Abuse Resistance Education) instructors. If you do drugs, you'll go to jail or die or both. If you have sex you will get pregnant or get a disease or both. If you're fat you will die, also bonus no one will ever love you. I remember very vividly writing an essay for my D.A.R.E. program when I was in the 5th grade about how the best way to keep kids from using drugs was for them to witness the horrible things that happened to people who do drugs. Having grown up in a family of drug users and dealers I had witnessed these things first hand. It was only later that I realized that the only thing I learned from those fear messages was how to hate my family and how to surveil their actions. After going through my own bout of drug use brought on by my extended stay in the foster care system I realized that perhaps those messages of fear aren't really meant for the kids who are already set up to fail. Those education methods that taught us to hate our bodies and then to hate ourselves for hating our bodies don't work at all really and if they ever did it was only for the people who were in a position to not have to worry about those things anyways. As important as these insights were to bringing my to writing this now I still struggle with shame and guilt and I imagine that relationship will not change anytime in the future.

Coming to health education from this background I was surprised at the openness at which my now supervisor and mentor, health educator Mira Friedman talked about the

things I was still struggling to name. In Mira's office I learned that we could educate

about sex from a fully positive and nonjudgmental place. I learned that it is more

effective to give people the tools to take actions that reduce the harm and risk of

decisions then to try and scare them away from making them. I was then able to find my

voice as a health educator and to explore the importance and significance of peers talking

to peers about issues of health. However, I also learned of the gaps in our outreach, the

places where we were missing tools. Every time we were faced with a new health topic to

educate about we had to dig through tons of educational tools steeped in fear, shame, and

guilt, every single topic from bed bugs to recreational use of prescription drugs. There

was also a big gap in what we were teaching and if it was information that the students

needed/wanted to hear. It was then that we realized while we have some tools, they aren't

cohesive and we need to better represent the community we were educating in.

There are many positive models of health education currently. There is the harm-

reduction movement that centers the teaching of tools and the creation of programs that

reduce the amount of harm of already harmful actions. Examples of these can be seen in

needle exchange programs, health drinking models, and safer sex supply distribution.

There are sex-positive sexual health education programs that shun the concepts of fear

and shame of sex and empower people to be proactive in their sexual experiences and to

communicate with themselves and their partners. There are fat activist movements that

question the idea that fat people are inherently unhealthy and that undeserving of respect.

There are disability justice scholars that argue that people who are 'unhealthy' are not

less than other people. There are intersectional feminists that claim that health and

identity are deeply linked and these are things that have to be accounted for in health care and education models. The gap lies in the lack of integration. How do we take these models, make them accessible to a campus community, and move past shame, guilt, and fear as primary educational tools all the while being cognizant of the needs and reality of the community where we are located.

The creation of the Peer Health Education program was our way of locating the health education needs of the campus community, their work combined with the work of OH Snap and CHECK IT point toward a new model of how to do health education in a way that doesn't create barriers, it breaks them down. I hope that the work of the HSU's Health Education Model can be a step towards the integration and creation of a health education model that takes into account the wholeness of identity and challenges and complicates the way we think about health and wellness. It was my goal to point towards a new paradigm for health education that pushes beyond the limiting ideas of fear shame and guilt.

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APPENDIX

As health educators we are inundated with health promotion materials from companies, non-profits, and government agencies all working to do different health promotion campaigns. In the university setting we are often introduced to campaigns we are "highly encouraged" to use or sometime mandated to use. This can make things difficult in trying to move towards a social justice minded health education framework that doesn't rely on guilt, shame, and fear to influence its audience. What this has often meant in our program is that we have to vet health promotion campaigns; often taking information that is useful and leaving behind the extraneous pedagogically questionable frameworks. The following is a quick guide to analyzing health promotion material in order to filter out the educational tools that rely on the old methods of fear, shame, and guilt to get their message across. This list is in no way meant to be exhaustive; it is a starting point to encourage critical engagement with the myriad of health promotion materials and workshops available in the discipline of student health. The filter can be used with many types of health promotion material including both digital and physical promotional information (e.g. posters, blog posts, pamphlets), workshop and presentation lesson plans, and peer health educator training materials. The filter is broken into two parts; the first is focused on triggers that can be picked up when going over materials. This is to point to the frameworks and rhetoric devices that I argue against using for effective, inclusive, and holistic peer health education. The second part is focused on what materials should do, it is important to note that most materials would be missing some pieces of this

section. This is to say that there is no perfect health promotion material, however this is a

place to start to avoid doing more harm and to always be open to new ideas.

Filter Part I: What should catch your attention and point to an underlying issue

- Language:
  - Is it reliant explicitly or implicitly on the gender-binary
    - People with vaginas are referred to as women, people with penis' are referred to as men (see Transfeminist Theory)
  - Is the language heteronormative
    - Are relationships (sexual or romantic) framed between men and women or penis' and vaginas (see Transfeminist Theory)
  - Is the language racialized
    - Does it portray a specific race of people as the "bad guy" can this be seen in the way people talk (see Anti-racism)
  - Does the argument rely on blaming the poor
    - "unwanted babies" "mouths to feed" "over population"
  - Is it framed around "scary statistics" "1-3 people will die…"
  - Is death the focus of the language
    - Watch out for words like: dead, death, die, alive
- Does it assume a normative body
  - A normative body is a body that is healthy, and this body is often thin, white, straight, able bodied, and some would argue male (in that women are inherently unhealthy) (see Disability Theory)
- Does it apologize for the focus?
  - Apologizing for the "negative" behavior or the people who are effected, like fat people or people with disabilities (See Fat Feminism)
- Is it dictatorial? Does it tell people what to do to fix a problem?
- Is it framed in a way where there is a problem and a solution (is it a dichotomy)?
- Is it framed around someone's credibility
  - Authority on the subject
  - Leading research
- If it has graphics, what kind are they?
  - Colors/images used in fear based mediums
    - Pictures of disease
    - Blood
    - "sad" people
    - dead people
    - passed out people

- o   Who is represented in the pictures?
    - ▪   Gender, race, class, ability, size, sexuality

Filter Part II: Suggestions for doing it better:

- •   Does it allow room for disagreement? Growth? New information?
- •   Are students invited to engage?
- •   Is it accessible? Is accessibility something thought of?
    - o   Physically
    - o   Intellectually? Jargon is bad, but we also want to give people access to new language so they can interact with a hostile world (how to interpret/talk to/question a medical professional)
- •   Is it timely? Is the information up to date? By whose standards?
- •   Is it actually an issue faced by the audience?

Suggested Journal Prompts & Group Activities:

Before Event: So you're planning an event! An important part of this process is to understand what it is you want this event to achieve. Please spend 3 minutes free writing on what you want to come out of this event, for example; what information do you hope people take away, do you want people to change their behaviors, why/why not, how does this event connect to your personal experience?

After Event: How do you define a successful event? Draw two columns, on one side list the ways in which events are a "success" and in the other ways in which they are a "failure." Then take 2 minutes to write about how your last event compares to this list.

Write a letter to yourself during the planning stages of your last event, what do you wish you had known then that you know now?

Stop, Start, Continue: On a white board write: stop, start, and continue brainstorm things about the event that the group thinks should stop happening, start happening, and that they should continue doing.

Everyone has a piece of paper with their name written on the top, each person spends approximately 30 seconds writing what they thought was that person's most valuable contribution to the event (or to the overall program).