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In U.S. history, there has never been a time when the health status of African Americans, Native Americans, Latinos, or Asians has come close to that of white Americans. On the whole, non-white groups persistently experience higher degrees of chronic illness, disability and premature death. There have been varied explanations for the vast disparities in health status that exist among differing racial, class, and gender groups. The most commonly accepted understanding of these differences is either one of (1) genetic diversity – that is, people are biologically predetermined to be at risk for certain diseases or health issues or (2) behavioral choice – people are either uninformed or unwilling to make decisions that support optimal health. Using a critical intersectional lens to understand health disparities, we come to a very different conclusion. Rather than understanding individuals as solely responsible for their own health status (biologically or behaviorally), we can instead deconstruct the various social, political and historical contexts which shape both our health care and educational systems as well as individuals' contextual understanding of health.

This paper explores constructs of health, health education, and health literacy through a critical historical perspective relative to disparities in health. A qualitative examination of the state of public school health education provides the foundation for understanding the existing problems in health education policy and practice. Implications for school and public policy are discussed as potential solutions to health inequities.

TOWARDS EQUITY IN HEALTH: ENVISIONING AUTHENTIC
HEALTH EDUCATION IN SCHOOLS

by

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PREFACE

Over the past 15 years, I have had the great fortune to work in a variety of settings with the objective of improving the health of the people of North Carolina. In my earliest work, I was responsible for taking hospital screening services out into a rural community. I visited senior adult nutrition sites, factories, schools, textile mills, processing plants, civic clubs and manufacturing sites. The vast disparities in health and health knowledge were palpable, with the disparate variable seeming to be education. As a (very) young adult, with a newly minted master's degree in public health, I thought I could make a difference by providing individuals with access to information about their own health as well as a prescriptive formula for achieving optimal health. I set about designing a wellness program for employees of the hospital where I worked, focusing on helping each individual person where they were – fit and healthy with a desire to maintain health, unhealthy with an awareness that they needed to make life changes, or even dangerously unhealthy with no idea that a health threat existed. The program provided a series of health screenings followed by a personal health counseling session, referral to community medical resources and follow-up group education classes. At the time, this idea was novel and went on to win a number of regional and national awards for its ingenuity and short-term results. I was proud of my accomplishment and learned how important personal context was to health. It was readily apparent that race, class, gender, and level of education played an important role in people's knowledge about health and health care, but I had no idea how to address these issues, other than on an individual, case by case basis.

One great truth that became apparent to me was how our education system was failing to prepare people to care for themselves. I was continually astounded by how little people knew about general health issues, much less the latest health news being proffered by the media. I began teaching community education classes to help people understand basic nutrition, food labels, and how to communicate with their doctors, as well as classes on specific health topics (asthma, ADHD, breast cancer, etc.). I taught group exercise classes and helped individuals plan goals for their own health improvement – everything from starting exercise programs to planning mammograms — I felt a great need to model and promote healthful life choices for everyone who came seeking help. Somewhere along the line, however, I became tired and frustrated with the seemingly endless line of people who wanted help with understanding their health. I felt like I was repeating myself over and over every day with very basic health advice. It occurred to me that most of the people I worked with had had some contact with the process of schooling (though I certainly worked with quite a few people who had minimal schooling –maybe through elementary school), but still had little or no practical information about how to care for their bodies or even where to get health information when they needed it.

At that same time, the hospital where I worked happened to recruit two new physicians from Canada, who came with a very different perspective on access to health. They were particularly interested in helping adolescents and I felt a call to work with them and reach out to young people. Together, we created a forum for community agencies to work towards a common goal. That goal became reality with the opening of

four school-based clinics located in the county high schools. I became the Director of the health centers and established health and mental health care services for the students at these schools. The need in the schools was astounding. Within the first week of opening the doors, all four health centers were overwhelmed with students seeking help. Some needed urgent care (from falls, sports injuries, etc.), many had psychosomatic complaints (headaches and stomachaches brought on by various stressors), and almost all needed a supportive, knowledgeable adult to whom they could talk about health issues. I was exhilarated by knowing that we were providing needed help, but at the same time deeply troubled by the enormous need.

For the past ten years, I have worked developing and evaluating various projects in schools to help improve children's health. I have come to the belief that comprehensive critical health education is largely absent from our formal schooling process and is greatly needed in order for people to understand and exert control over situations which affect their health and quality of life.

I fully recognize that health itself is a socially constructed concept, modeled largely by the historically white patriarchal medical system in our country, and I am deeply conflicted about making assumptions and recommendations for improving the health and well-being of all people. The intent of this paper is to encourage an inclusive human-focused way of talking about and supporting health in our schools, as a first step in moving towards social changes that promote health for all people.

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CHAPTER I

HEALTHY YOUTH?

Health is an asset which affects the quality of human life as well as the ability of people to seek and reach their aspirations. While it could be argued that the U.S. population as a whole exhibits symptoms of poor health, the chronic and growing gaps in health status among minority groups is particularly troubling. In our history, there has never been a time when the health status of African Americans, Native Americans, Latinos, or Asians has come close to that of white Americans (National Center for Health Statistics, 2003). On the whole, non-white groups persistently experience higher degrees of chronic illness, disability and premature death. There have been varied explanations for the vast disparities in health status that exist among differing racial, class, and gender groups. The most commonly accepted understanding of these differences is either one of (1) genetic diversity – that is, people are biologically predetermined to be at risk for certain diseases or health issues or (2) behavioral choice – people are either uninformed or unwilling to make decisions that support optimal health. Using a critical intersectional lens to understand health disparities, we come to a very different conclusion. Rather than understanding individuals as solely responsible for their own health status (biologically or behaviorally), we can instead deconstruct the various social, political and historical contexts which shape both our health care and educational systems as well as individuals' contextual understanding of health.

The long-standing myths of “the American Dream,” democracy and equal rights have prevented a critical social understanding of health disparities; it is much easier to assume that good health is available to everyone if they just try hard enough.

Unfortunately, it just isn't so. Americans are not taught to think critically, health and the human body are not discussed openly, and extreme bias, racism, sexism and classism are rampant in our society.

The quality of individuals' health is deeply impacted by issues of race, socio-economic status, gender, class, and the environment. As a society, we are morally responsible for seeking equity for all people to better ensure the health and well-being of each individual. Awareness of these issues, coupled with action towards improving human life can have a major impact on both the lives of individuals and the state of health for humankind.

Purpose

The threats to the health of young people are widespread, and of significant consequence to society in term of community safety, education, fiscal spending and most importantly the quality of our individual and collective human lives. Public schools have an opportunity to play an important role in improving the health and well-being for hundreds of thousands of children. As the only institution which comes into regular contact with children and youth, schools have an obligation to help attend to the preventive health, health education and health care needs of students. To adequately respond to this obligation, schools must embrace this responsibility and infuse both the

school environment and the curriculum of schooling with health-promoting supports, modeling, affirmation, and most importantly the critical examination of the social constructions which affect health. This paper will address the possibilities for immersing our schools in a wholistic health-promoting atmosphere.

What is Health?

Childhood and adolescence are typically considered healthy periods of the lifetime. Most children do not suffer from debilitating or chronic illnesses and when we think of childhood, we conjure up images of active play and general well-being. Health statistics belie these images, however, and public health language uses the terminology ‘risk factors’ or ‘risk behaviors’ to talk about less than ideal states of child health and the behavioral choices that are linked to poor health. However, to consider what a healthy childhood really is, we must first define what health is and what it would mean for all children to experience ideal states of health. Also, within the discourse about health is the assumption that ‘good’ health is a goal that is attainable by choosing the ‘right’ behaviors. In order to fully understand child health, we must instead consider the past and present social environment, and how social circumstances contribute to health status, particularly for children belonging to socially marginalized groups.

According to Webster’s Dictionary (1996), health is, “the overall condition or functioning of an organism at a particular time” or “optimal mental and physical soundness and well-being.” The former definition leaves room for judgmental terminology like “good”, “poor”, “ill” or “excellent” to fall before the word health. The

latter definition assumes a loose goal of optimal functioning. Both fall short in terms of helping us to understand what exactly health is or isn't.

Public health scholars have attempted to define health by epidemiological methods – how disease is controlled and monitored. In this paradigm, health (at a community level) means controlling mental illness, stress, violence, the spread of communicable disease, injury, community water and waste, housing, environments, food-borne disease, air quality and the promotion of community recreation and 'positive lifestyles' (Green, 1990). This definition provides a scope of concern for community health, but again fails to precisely describe health itself.

Understood in each of these definitions, is some normative state of health, resulting from the conditions one lives in, combined with individual behavior. Its origin is uncertain, but the values expressed by society's understanding of "good health" in America is clear and is reinforced by multiple institutions, include federal, state and local government agencies -- individuals are responsible for determining their own health and for striving for "good health."

Historically, health has been an object of community concern when ill health or disease was widespread, causing high rates of death and disability among populations. While the human factor was high in these instances, the primary reason for public health solutions to disease problems was to preserve an economic center (town, city, port). This is evidenced by the historic and present lag in reaching rural residents with health interventions (Greene, 1990).

From ancient times through the middle of the last century, virtually all public health measures were aimed at protecting populations from disease, resulting in water and sanitation systems, policies and laws governing safety, and the establishment of health care systems to treat those who become ill. In these instances, there was an understanding that large-scale changes were needed to protect the well-being of the citizens. While those in powerful positions undoubtedly benefited personally from early public health measures, there is also no question that the public good was served as well and those in poverty were intentionally targeted for receiving services to improve health conditions, particularly when their ill health threatened the health of others (Green, 1990). The implementation of quarantines, sanitation measures, food inspection, immunization, pest control, water purification, and many other widespread public health measures undoubtedly saved lives and improved the quality of life for millions of people.

It has only been in the past few decades that health has begun to be discussed as an issue of individual lifestyle, rather than in the domain of the community environment. Many of the major public health concerns in America had been solved by the mid-twentieth century (water supply, immunizations, etc.) and in an attempt to further decrease premature mortality and morbidity public health began to examine other major contributors to human disease. For the past fifty years, the leading causes of death were three chronic diseases -- heart disease, cancer and stroke. In the 1980's, health promotion came into being as a discipline, with a primary understanding that people needed to be responsible for their own health choices. This assumption was made as chronic diseases were labeled "lifestyle diseases" and the onus was put squarely on the individual to

monitor and regulate personal health. For example, in the Surgeon General's Report on Nutrition and Health (1988), it was noted that dietary practices play a direct role in five of the ten leading causes of death. The common understanding of this and other data was that, "Life-style diseases are, by and large, the result of behavior and can often be altered by positive changes in behavior" (Glanz, Lewis, & Rimer, 1990). It was generally accepted by the public health community that these "positive behavior changes" included smoking cessation, weight reduction, increased exercise, dietary change, injury prevention, protected sexual activity, and participation in health screening programs. Though these behaviors may well indeed be linked to chronic disease prevention, context was never part of the discussion about how or why people engaged in particular behaviors. It was simply assumed that one set of behaviors was "good" and everything else was not.

In relation to children, since children rarely exhibited symptoms of the big three chronic diseases, their health habits were largely ignored. Children were viewed as active and healthy already. Indeed, typical measures of child health in the United States indicate a relatively high degree of health compared with developing countries. Infant mortality, for instance, reached an all time low of 7 deaths per 1,000 live births in 2000 (though African American infants still experience a much higher incidence of mortality). In addition, upwards of 80% of all children are fully immunized against preventable diseases and the great majority of children are considered to be in excellent health, according to their caregivers (Rosenbaum and Yoder, 2006). However, when we consider that child development is perhaps the most important indicator of health

outcomes later in life, a different set of indicators is needed. “Because poor health in children tends to be expressed in developmental, rather than overt and diagnosable terms, the health status and needs of children differ from those of adults” (Rosenbaum and Yoder, 2006, p. 91). Using the U.S. Department of Health and Human Services definition of children with special needs as an indicator for child health, it is estimated that 18% of all children under age 18 have health concerns and nearly 20% of all children have at least one mental health problem (Children’s Defense Fund, 2001). Child health, then, can be defined as being liberated from preventable illnesses as well as from social threats that affect long-term development.

Notwithstanding, the advent of health promotion to prevent ‘life-style diseases’ laid the groundwork for parents or caregivers to be held responsible for ensuring that children adopted healthy behaviors. It was not until the childhood obesity epidemic was recognized in the 1990’s that it occurred to the public health field to focus on childhood health promotion/disease prevention activities. Since parents generally do the grocery shopping and cooking and make decisions about children’s activities, it was assumed that they were accountable for their children’s health, so early interventions focused mainly on parents and families, with a few studies examining the role of schools in promoting health. These programs assumed the same dominant themes as the adult health promotion programs of the 1980’s to 1990’s. In a nutshell, children were told that people have choices and it is up to individuals to make the correct health behavior choices.

The State of Children's Health

To debunk the idea of childhood as a healthful time of life, we need only consider statistics describing various facets of health and well-being. While some health issues have improved over the past decade (infant mortality, immunizations), others have gotten worse, with the obesity epidemic leading the list (NC Institute of Medicine, 2004). While the use of statistics to describe problems can be problematic in that numbers can be manipulated to support varying viewpoints, there is wide agreement in the literature that many quantifiable indicators show problems in the state of child health. How health is defined and whether specific conditions indicate a lack of health are debatable and subject to constantly changing circumstances. However, many facts point to a compelling picture of life for North Carolina children that is stark and troubling:

- 11% of children have been diagnosed with asthma while 28% report recurrent asthma symptoms; this means at least 17% of children have untreated, undiagnosed asthma.
- 22% of kindergarten children have untreated tooth decay; only about 29% of Medicaid-eligible children receive dental services.
- In 2004, 113,557 children were assessed for reported abuse & neglect; 27,310 of those claims were substantiated. 31 children died from abuse in 2004.
- In 2004, 342 children died from injuries sustained from firearms, bicycles, fire, drowning, or motor vehicles. 23 of these children committed suicide; 51 were murdered.

- One quarter of high school students are smokers and one quarter use marijuana; 40% of high school students use alcohol.
- Fewer than 1/3 of high school students exercise at least 3 times a week for 20 minutes or more.
- Over 40% of children are overweight or obese.
- The overall teen pregnancy rate (for girls ages 15-17) is 36 per 1,000. For minority teens, the rate is 53 per 1,000.

Taken as a whole, these statistics scream out for intervention to improve the status of children's health. When considered by subgroups, the need for attention is even greater. People of color, people who are poor, and people who have little formal education are many times more likely to become ill, live with chronic disease, and die prematurely than those who are dominant in this society. "The traditional components of socioeconomic status – income, education, and occupation – all have been found to be independently associated with health status" (Schultz & Mullings, p. 267). These things are inextricably tied together – without one, the others are not available. This frequently leaves families and groups of people in cycles of low educational attainment and poverty. "Perhaps the single most important determinant of ill health, long known, is absolute poverty, particularly as it relates to life expectancy, high infant mortality, and a wide range of diseases" (Hofrichter, p. 16). The condition of living in poverty predisposes people to chronic diseases, regardless of all other factors. "Since race and ethnicity are deeply confounded with income, wealth, education, and occupation in American society, these

combined factors are major determinants of disparities in health status” (Schultz & Mullings, p. 267)

The 2003 Racial and Ethnic Disparities in North Carolina Report Card points out some of the factors contributing to the inequitable distribution of health among our state’s children. For example, African American, Native American and Latino children are three times more likely to live in poverty than white children. Children born to mothers who are African American, American Indian, or Latina are more than twice as likely to be born prematurely and to have had late or no prenatal care. In addition, minorities in North Carolina are less likely to have health insurance, resulting in a lower likelihood of receiving routine preventive health care. These factors may in part account for the higher rates of heart disease, stroke, and diabetes observed in adult minority groups. (NC Department of Health and Human Services, 2003)

Health Disparities

These disparities demonstrate gross inequities in the distribution of health in our society. The impact of the social issues that contribute to the current state of health cannot be overlooked. At the heart of the matter, rugged individualism, capitalism, racism, classism and sexism have converged to create an environment which fails to support health.

The messages of health promotion advocates of the 1990’s were understood and adopted by some, yet it has taken a considerable amount of time for public health to

recognize the vast disparities in health that continue to exist (and perhaps widen), despite best efforts to educate people about health choices and consequences. “At no time in the history of the United States has the health status of African Americans, Native Americans, Hispanics, and members of many Asian subgroups equaled or even approximated that of white Americans. While the health of all American racial, ethnic and social class groups has improved dramatically over that long time span, people of color and the less affluent continue to experience excess morbidity and mortality” (Schultz & Mullings, p. 262). What was missing from the massive health promotion campaigns of the late 21st century?

What public health failed to grasp then and continues to ignore now is the way in which social power is used to oppress groups and define and shape ideas about what is or isn't healthy. “Built into any definition of wellness are overt and covert expressions of values. Because values differ across cultures as well as among subgroups (and indeed individuals) within a culture, the ideal of a uniformly acceptable definition of the construct is illusory” (Cowen, p. 152). Instead of understanding health as a function of a multiplicity of individual and environmental factors, public health has been locked into a one size fits all mentality. If exercise is inversely related to heart disease, then everyone should exercise more. Thus came various government reports and studies urging us to get at least 30 minutes of physical activity daily. While this message might be on target for educated, upper middle class white citizens (since the messages were crafted primarily by this group), where does that leave everyone else?

Public health was founded on the ideals of social justice and public health practitioners have historically been linked with advocating for social health and welfare. Early public health efforts included demands for better working conditions, racial and sexual equality, improved sanitation, and quality education, but we have strayed from that mission over the past several decades. We have instead come to rely on a biomedical model for understanding individual health while neglecting the urgent needs of the society. This situation has resulted in the growing health disparities we witness today.

Attempts to explain these disparities by the mainstream have been made by a variety of hypotheses including racial differences, gender differences, and more recently - genetic differences. A critical examination of these justifications, however, comes up short. The scientific evidence to back these theories is limited and disputable. For example, the genetic differences between those of white, European descent and those of any other descent is miniscule – less than .1%. Most human genetic variation (85%) is within the same subgroup (racial, ethnic, religious, etc.). Unrelated people from the same subgroup are no more the same (genetically) than people from any other subgroup (Ossorio & Duster, 2005).

Beyond the lack of scientific evidence to support an understanding of health disparities as racial/ethnic/genetic disparities, this type of argument also fails to take into account the historical, institutional and environmental influences which shape individuals. “A person’s past social experiences become written into the physiology and pathology of their body. The social, is literally, embodied; and the body records the past”

(Blane, p. 64). A pattern of victim-blaming is at the center of the health promotion discipline.

The myth of genetic determinism cuts both ways, however, for although it absolves the individual from responsibility, it also absolves the society at large. Deterministic biological explanations (it's in my genes)—much like theological explanations (the devil made me do it)—locate problems (and therefore solutions) within individuals (Kaufman and Hall, 2003, p. 117).

Racial/genetic explanations for health disparities then situate the problem within racial groups, essentially blaming them for the problem, rather than deconstructing the social or contextual issues which may be at the heart of the matter.

What has been forgotten by the broad public health community, are the ways in which social constructions may be the most important determinant in whether someone is healthy. By lumping groups of people together (racially, economically, etc.) we see only the disparities, not the conditions which create or exacerbate the divide. “Social determinants of health inequity themselves are not causes of social injustice and inequity. They reflect deeper social divisions which generate multiple social risks, reproduced over time” (Hofrichter, Ed., 2006). In his recent book, Health and Social Justice (2006), Richard Hofrichter touched on the mechanism for how this comes about. “While behavior clearly influences premature mortality and health, more basic ongoing socioeconomic conditions affect and condition behavior” (p. 12). In addition to the socioeconomic conditions Hofrichter criticizes, the discussion also needs to examine social and political institutions and the role they play in continuing to marginalize groups from conditions that promote health. “These inequities are institutional to the extent that

they arise from laws, policies, and restrictions on participation in decision making. They also result from efforts by the state to incorporate people of color into the dominant culture and stabilize the social order in ways that deny people's culture and history and otherwise constrain their lives" (Hofrichter, 2006, p. 17). By keeping all discussions about what health is, and how it is achieved in the dominant culture, groups who are "other" are kept from creating and living their own understanding of health.

Some scholars have attempted to describe and analyze the relationship between social constructions and health disparities as social determinants of health. This paradigm understands disparity as a function of social dominance. However, social determinants are viewed as individual factors, rather than intersecting forces. "Hierarchies of power considered through the lens of deeply embedded class, race, and gender relations provide the connections between these social and economic determinants, their distribution, and the basis of inequality more adequately than a determinant-by-determinant analysis" (Hofrichter, 2006, p. 8). Consider for example, women's health issues.

As a group, women are affected by conditions that marginalize their gender and limit health. Inequities in women's health include morbidity and mortality rates, maternal mortality rates, depression, and chronic conditions, regardless of socioeconomic status and race. "This suggests that interrelated conditions and experiences, including social status, working conditions, segregation, limited employment opportunities, and neighborhood safety, are important determinants of health inequities" (Hofrichter, 2006,

p. 18). By excluding contextual factors and the way they interact together, we continue to impose dominant thinking on already marginalized people.

We must also acknowledge that “Adversity is not randomly distributed; instead, it tends to cluster and to accumulate present on top of previous disadvantage” (Blane, p. 77). In this way, those who have been historically disadvantaged continue down the same pathway. “Cross-sectionally, advantage or disadvantage in one sphere of life is likely to be accompanied by similar advantage or disadvantage in other spheres” (Blane, p. 65). For example, those who are poor are more likely to live in sub-standard housing, with more environmental pollution, less access to quality food sources, and more likely to be employed in jobs that are hazardous. These conditions multiply to create situations which deprive people of health. These suppositions are widely understood, but the root causes have yet to be openly discussed and examined.

“Social exclusion refers not only to the economic hardship of relative economic poverty, but also incorporates the notion of the process of marginalization – how individuals come, through their lives, to be excluded from various aspects of social and community life” (Shaw, Dorling & Smith, 1999, p. 222). There is considerable evidence to support the idea that this type of exclusion (sometimes named oppression) alone contributes to cycles of ill health. For an individual, marginalization might result in feelings of depression, isolation, anger, vulnerability, hopelessness and low self-worth, resulting in lowered ability to function productively in society. White (1998) refers to four types of exclusion: exclusion from participation in society by legal means, exclusion

by failing to supply goods or services, exclusion from social production, and exclusion from normal social consumption. Figure 1 shows how this exclusion comes about. To this figure, it would seem prudent to add to the list of affected indicators of social exclusion, most notably, depression, chronic disease, educational attainment, and violence. There are strong links in the literature between these indicators and the conditions of social exclusion.

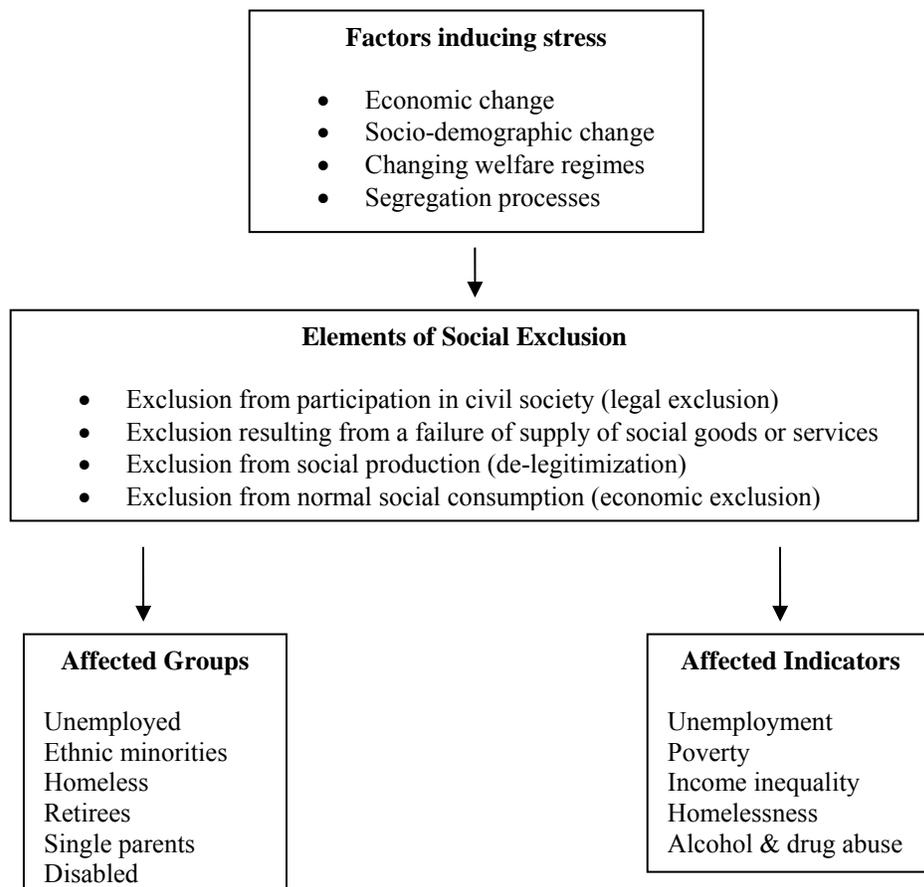


Figure 1. The Process and Outcome of Social Exclusion (adapted from White 1998).

Economic issues would seem to be at the center of the discussion of social exclusion, but the class issue is confounded by the intersecting forces of the social construction of race and gender. All of these issues are influenced and shaped by social power and the ability to make decisions that affect the quality of life. For example, racial segregation continues to be supported by the real estate industry, banks, and federal housing policy. “Segregation leads to isolation and economic deprivation resulting from the poor quality of education and lack of good jobs. In poor, segregated communities, the lack of investment, along with disinvestment, creates stressors leading to health inequities” (Hofrichter, Ed., 2006, p. 17). While economic sanctions are at the center of racial segregation, it must also be known that the lack of social power in segregated communities creates further health inequities as these communities experience disproportionate levels of environmental hazards (pollution, noise, violence) as well as a lack of high quality housing options. The interrelation of these conditions and experiences no doubt limit health and quality of life for residents.

These inequities are deeply rooted in our federal, social and economic institutions. Numerous studies have demonstrated the relationship between working class power and population health, yet the U.S. continues to devolve and limit the ability of laborers and the poor to participate in society. In the past thirty years, the combination of exported production, decline of labor unions, reduction of social welfare programs (welfare and Medicaid) and reduced voter participation have weakened the power of the working class. These conditions, along with the historical divisions of race, class and gender have helped increase disparities in health. This intersection is where social justice and public

health collide. Social justice demands social and economic equality in addition to political democracy. These themes are inextricably linked to population health, as a lack of social and economic equality results in unfair distribution of advantages and the inability of all people experience a high quality of life. Similarly, lack of a true and full democracy results in the exclusion of those with less social power and therefore, a continued cycle of inadequate and unfair resource distribution.

Figure 2 illustrates how complex social structures combine to marginalize people and create patterns of poor health. Classism, racism and gender discrimination (alone or in combination) create situations where power is unequally distributed. Those who are “less” have fewer opportunities to participate in democratic processes and wield little influence over the making and enforcing of policies, laws and regulations. This power differential creates circumstances where the voices and needs of those who are marginalized are not heard and not met. Socially, this produces unfair labor practices, educational opportunities, and access to social resources, along with conditions of social exclusion and isolation, lessened social welfare programs, and a demand for financial globalization and capitalistic greed. Together, this state of affairs generates the cycle that destines socially marginalized people for ill health. When combined with the effects of historical marginalization, it is easy to see how the patterns of health disparities we are currently witnessing have evolved and created a nearly impossible health predicament for those who have experienced social injustice.

Clearly, there are larger social processes at work that contribute to or cause health disparities. “The bias and discrimination that lead to differences in access to the resources and opportunities for health between social groups is unfair. This touches on the special place that health holds in human rights: everyone has the right to enjoy the highest attainable standard of health in their society (WHO, 1946). Health is also a unique resource for achieving other objectives in life, such as better education and employment. Health is therefore a way of promoting the freedom of individuals and societies” (Sen, 2000).

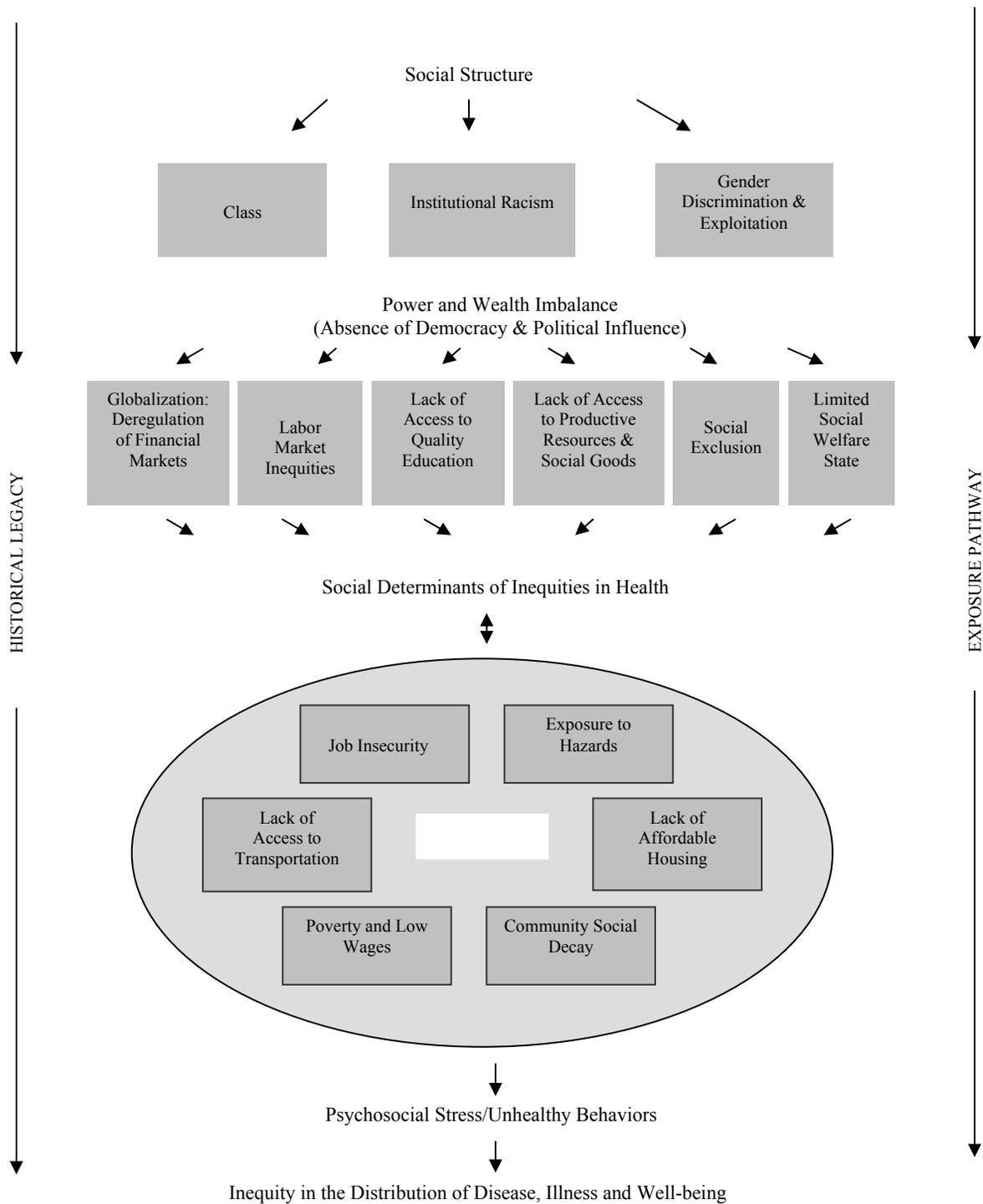


Figure 2. How Social Injustice Becomes Embodied in Differential Disease and Mortality Rates (Adapted from Hofrichter, R., (2006) Tackling Health Inequities Through Public Health Practice)

Our failure to recognize and address these inequities has produced the current state of affairs, and it is incumbent upon public health professionals to demand social solutions to public health problems. “That which can’t be named as a potential cause cannot be touched upon in looking for a plausible solution. The search for less provocative solutions makes it possible perhaps for those who shepherd the debate to stay away from problematic places” (Kozol, 2005). Therein lies the rub. Our failure to name and deal with the “isms” leaves us with continued disparities in health until we muster the courage to speak the truth about our social failures.

Critical Pedagogy and Health Education

The pedagogy of critical theory is based on the idea of education as a transformative process for individuals and the world, initiated by the act of conscious reflection on understanding the self and the social milieu in which we exist. The major critical theorists write about the importance of critical reflection to better understand the self and the world. Paulo Freire was the first to articulate the importance of reflecting on our experiences and our place in the world in order to change the world. He was very concerned with helping people read their world, both literally (in terms of literacy), but also in a more abstract sense—to name and understand the forces at work around us. Freire advocates developing an epistemological curiosity – that is, encouraging the questioning of why things are, how things are, and the historical context of people and ideas.

As global citizens, we fail to grasp the magnitude of the issues. Not because we *cannot* understand, but to begin to understand, we must first encounter new ideas about our society and then critically reflect on those ideas. Critical thinking about society and its health effects is not encouraged through our schooling process. Health is a subject to be absorbed and regurgitated, without any reflection or personal connection. In order to *fully* educate, the education system must take into consideration and reflect upon the various social pressures, political agendas, points of view, and historical perceptions that circulate around us. Ideally, this process would enable the learner to struggle with personal positions, ideologies, and myths and come to a better understanding of what it means to belong to and contribute to society, and how this impacts our health.

With our current method of health education, an opportunity is lost to educate students and potentially improve the quality and length of their life. By relying on dominant hierarchies to define and construct health education, what matters to students and their families is never uncovered or addressed. Instead, health consists of specific categories of information such as nutrition, physical activity, safety, substance use, and hygiene. The North Carolina Department of Public Instruction describes the purpose for the Healthful Living curriculum as:

“The purpose of Healthful Living Education is to provide appropriate instruction for the acquisition of behaviors, which contribute to a healthy lifestyle. Some of the most important behaviors and/or risks include:

- involvement in violent acts, including physical fighting, bullying, weapon carrying and homicide;
- consuming excessive fat, calories, and sodium; and consuming insufficient fiber, foliate and variety of foods;

- engaging in sexual intercourse which could lead to pregnancy and disease;
- insufficient physical activity;
- attempting suicide;
- driving while under the influence of alcohol and/or other drugs, traveling as a passenger with a driver who is impaired, driving too fast, and not using passenger restraints;
- not wearing bicycle helmets when riding;
- using harmful or illegal substances, including alcohol and tobacco;
- engaging in water-related recreation without appropriate floatation devices or supervision, or without skill in swimming and staying afloat, or while using alcohol and/or other drugs;
- inadequately preventing or responding to fire emergencies;
- participating in activity or sport without proper knowledge, supervision, and/or equipment.”

Arguably, these ideals are important for supporting and preserving human life.

However, without the input, collaboration, and partnership (the *with* of Freirian pedagogy) of students and families, it is unclear whether these topics will resonate with students or simply fall on deaf ears as the party line of the establishment. In addition, social context is critically important for students to examine how these topics pertain to their lives. Individual behavior choices should be de-emphasized in health education and students should be educated and empowered to advocate for more healthful social conditions.

In addition to the social forces that have placed health on the fringe by valuing individual achievement over community, the dominant thinking about self-determinism has placed the blame for health disparities on the victims. The long-standing myths of “the American Dream,” democracy and equal rights have prevented a critical social understanding of health disparities; it is much easier to assume that good health is available to everyone if they just try hard enough. Unfortunately, it just isn’t so.

The historical treatment of oppressed groups as well as the contemporary contexts of individuals and groups unquestionably plays a role in determining health status. Consider, for example, infant mortality rates. Traditional understanding of health disparities would lead us to believe that infant death is a function of the age and education level of the mother. Statistics would certainly support this idea, as teen mothers and mothers with lower levels of education have definitely experienced higher levels of infant death. However, this analysis fails to uncover deeper social realities. In the table below, are recent infant mortality rates for adult women of either black or white, non-Hispanic origin. The earlier analysis holds true. Mothers with lower education levels have higher rates of infant mortality. Also, black mothers consistently experience higher rates of infant mortality than white mothers. While we could assume that some genetic factors, or cultural practices account for this difference, none of these explanations hold up to scientific reality. What is remarkable is the comparison between the black mothers with the highest education levels and the white mothers with the lowest education levels. How could this disparity be possible? The only plausible explanation lies in examining the current and past social forces that have shaped the behaviors, roles, homes, responsibilities and stressors of the individual mothers. These statistics point to an obvious disparity. They do not explain the human factors that create the disparity. In addition, our understanding of health as only a behavioral dimension of human life has set up a mythological conception of this and other disparities. Our schooling process reinforces this ideology by relying on a binary system of right and wrong to define what is acceptable or not. This is carried through to health education (some choices or

behaviors are “good” and some are “bad”) with no understanding of context or history and how individuals and groups are prevented from reaching the dominant definitions of health. As a society, we are not thought to think critically (so as to dispel these social myths), health and the human body are not discussed openly, and bias, racism, sexism and classism are rampant in the creation and enactment of health education. To overcome this divisiveness, we need health education that helps us see our commonalities through the eyes of our fellow human beings and that deconstructs the history and culture that have shaped the current state of our society.

Table 1. Infant Mortality Rates, Mothers Aged Twenty Years and Older, 1995 (Adapted from Schulz & Mullings, 2006)

<i>Maternal Education</i>	<i>White</i>	<i>Black</i>	<i>Black-to-White Ratio</i>
Less than 12 years	9.9	17.3	1.74
12 years	6.5	14.8	2.28
13-15 years	5.1	12.3	2.41
15 years or more	4.2	11.4	2.71

Disparities are further normalized through popular culture. In Popular Culture, Schooling & Everyday Life, Peter McLaren and Richard Smith discuss the pedagogy of popular culture. “Popular culture becomes an arena of exchange between the culture and ideology of dominant and subordinate social groups” (p. 160). In their exposition, they describe how the dominant groups become political forces, using popular culture to direct mass thinking. Popular culture defines societal norms in terms of common sense,

emotional ties, and individual identities. These shared societal values are manipulated by the circulation of power among and between individuals, corporations, the media, politicians and other entities with an interest in gaining the support of consumers in general and youth in particular. In terms of health, the dialogue is virtually absent, except for pseudo-health media that are more focused on image than wellness. This phenomenon points to the need to include media literacy in the conversation about what it means to be healthy and what a healthy culture/community looks like.

Finally, the U.S. economic policy continues to keep families living in poverty. The United States leads all industrialized nations in the percentage of children who are poor. In addition, our country has the smallest proportion of children who are lifted out of poverty by government policies and aid (Children's Defense Fund, 2001). This degree of poverty, coupled with a health care system which does not guarantee access to anyone without the ability to pay, virtually ensures that health will be inequitably distributed among the population. Lack of access to care means that the poor do not seek preventive care or health screenings for chronic disease. They therefore typically present themselves for emergency care when their illness has progressed to an advanced stage. This certainly accounts for many of the disparities observed in mortality rates from cancer and heart disease, as well as more severe cases of diabetes, hypertension and other chronic conditions.

Health education should be concerned with life outcomes including positive work and family life, mastery of age and ability-appropriate tasks, having a sense of

connectedness to others, engagement in key social settings, and a sense of efficacy in those interactions. (Felner, 2000). It follows that health education should seek to discuss and develop skills that will enhance and promote these objectives.

This thinking is not echoed in the current health education curriculum. The current health education curriculum is typically incorporated into the curriculum in one of two ways. At the elementary level, classroom teachers cover a health unit each year. The unit varies from Kindergarten through fifth grades, and usually includes something very basic like understanding the food groups. These units last one to two weeks for 15-30 minutes per day, totaling a maximum of 5 hours of health instruction per year. At the middle and high school levels, students experience a health class for one semester per year from sixth through ninth grades. These classes are usually taught by the physical education teacher and typical instruction requires the students to read a textbook chapter and answer the questions at the end. In this situation, students learn very little about their health and certainly are not engaged in making connections between health class and their personal lives – critical thinking about health is completely absent.

The result of this type of health education is a story of missed opportunity. Students miss the opportunity to learn about and reflect on how their actions, beliefs, and social contexts affect the health of their bodies. Teachers miss the opportunity to impact the quality of children's lives. A great number of the tragic health problems facing young people could be reduced or eliminated if health education was more about a critical examination of the self and society.

Dissertation Intent

“Child health is of the greatest importance for the future of health of a nation, not only because today’s children grow up the next generation of parents and workers, but also because recent research in child health shows that early life health is, for each child, the basis of health in adult life. Therefore the investment in health in early life has beneficial effects, specifically on the future health of a nation as well as on the future functioning of its citizens” (Wadsworth, 1999, p. 44). The time has come for our society to confront the social factors at the root of our ill-health. We must face our social flaws and thoughtfully enact policy to ensure the health and well-being of our citizens.

The aim of this paper is to more fully explore the connections between social justice, health, critical theory and public policy. To that end, the remainder of this document will discuss the current state of health education, the promises of critical health literacy as a methodology for working towards equity and the policies needed to create and support health in the school environment.

To more fully understand the nature and effects of the current state of health education, Chapter Two will review interviews with undergraduate students about their health education experiences in NC schools, K-12. This chapter will discuss the nature and quality of school health education experiences and how those experiences have translated into health behavior and/or health literacy for young adults. The research is intended to provide a deeper understanding of the current conditions around health

education and develop a rationale for how and why health education should be changed for future students. Questions addressed include:

- Are schools healthy? Is health a priority?
- What does health education in NC schools look like? Any memorable health education experiences (formal or informal)? Any memories of what health knowledge/lessons were personally relevant?
- How does the school environment impact health?
- Is health addressed in other settings (home, peer groups, churches, youth groups, etc.)?
- Is there a relationship between the health education of youth and the health literacy of young adults?
- Does health education in schools make a difference in who participates in high risk activities (tobacco use, substance use, sexual behavior, etc.)?
- What role should schools play in helping students promote or protect their health?
- How does schooling affect understanding of the body? What are the effects?
- What is the relationship between knowing your own body and protecting your health?

The narratives of young adult students around these questions will be juxtaposed with a critical pedagogy of health education and a discussion of the gaps in current health education practice.

Chapter Three will discuss critical health literacy as a means to address the health crisis of American youth. The ability to obtain, understand, and use the information needed to make wise health choices is known as health literacy (DHHS, 2005). Low health literacy among members of marginalized groups including older adults, people with poor reading skills, those with limited mastery of the English language, members of ethnic and cultural minorities, and immigrants is likely a major contributor to health disparities in this country, according to *Healthy People 2010*.

This fundamental but narrow understanding of health literacy misses much of the deeper meaning and purpose of literacy -- what is it that literacy enables us to do? One research team (Freebody and Luke, 1990). attempted to define the answer to this question by categorizing the types or levels of literacy one might have:

- *Basic/functional literacy*—sufficient basic skills in reading and writing to be able to function effectively in everyday situations, broadly compatible with the narrow definition of ‘health literacy’ referred to above.
- *Communicative/interactive literacy*—more advanced cognitive and literacy skills which, together with social skills, can be used to actively participate in everyday activities, to extract information and derive meaning from different forms of communication, and to apply new information to changing circumstances.
- *Critical literacy*—more advanced cognitive skills which, together with social skills, can be applied to critically analyze information, and to use this information to exert greater control over life events and situations.

In this framework, I am advocating for the development of critical health literacy in our society. People need basic health knowledge in addition to critical skills and empowerment to understand and advocate for their own position and needs, as well as for larger social change. Chapter Three will explore what it would mean for health education to be critical, based on the works of critical theorists Paulo Freire and Maxine Greene. The chapter will also include a discussion about how a lack of criticality about health further marginalizes those already at a disadvantage in the society.

The final chapter of this paper will examine health disparities as a function of public policy. Recognizing that health is much more than individual behavior choices and is rooted in various social, institutional and environmental constructs, public policy certainly contributes to the relative health of a population. As a primary force in determining social practices, our government and the legislation they enact is responsible for protecting and promoting the health of the public. Without a critical examination of current policy and the inequities it produces, we will continue to seek solutions for health problems through individual behavior change methodologies, rather than social change movements.

The state of health for most Americans clearly meets the definition of health inequity. Furthermore, this inequitable distribution is a probable cause for the vast health disparities we witness among groups of people in our country. Health equity must be a goal for our society and to achieve it we must design and implement social policy to distribute resources fairly. At the level of education and schooling, there must also be a push towards critical thinking about health.

American public policy has intentionally limited education, jobs, and housing and therefore the social mobility of people of color. Not only has this resulted in disproportionate levels of poverty, it has had serious health implications as well. Segregated housing limits access to care and public services and increases exposure to detrimental environmental conditions, in addition to differential access to health promoting conditions (grocery stores, parks, etc). Limited or low-quality education causes low levels of health literacy and decreases the likelihood of earning a living wage.

Low-skilled jobs have minimal health benefits and are often dangerous or health-limiting themselves. Added together, these conditions restrict socioeconomic attainment and access to health resources, in addition to creating cultural norms that fail to support health. Institutional, policy-enforced racism, sexism, and classism systematically ensure inequity and therefore produce health disparities.

On a local level, policy changes to enact critical health education can start to awaken the population to the need for larger scale policy reform. If we see the inequities, understand the true causes, and have the skills to advocate for change, significant strides can be made in promoting and ensuring health equity. These larger goals must be the new course for public health.

CHAPTER II

AN INCOMPLETE EDUCATION

To build a healthful society, it is reasonable to assume that some degree of health education will be required to help children and adolescents acquire both knowledge and applied skills to maintain their personal health. Our schooling system has taken up this idea nearly since its inception, teaching personal hygiene, physical education and related health topics. A critical examination of health education, however, reveals a lack of comprehensiveness, as well as the persistent marginalization of health as a serious academic or vocational subject of schooling. As a result of the way health is taught in schools, many if not most people confine their understanding of health to nutrition and physical activity, and further understand these two issues as falling within the domain of personal responsibility for one's health. Health education is given little emphasis throughout schooling in terms of time, resources and attention. It is almost an afterthought – a required portion of the curriculum, but destined to a quiet death as schools focus more and more attention on the “core” academic topics. To understand the ways in which health is marginalized, this chapter will retrospectively consider the K-12 health education experiences of college women in North Carolina public schools.

In developing my thoughts around school health education leading to the present research, I reflected on previous school health research I conducted around child health. One study in particular helped shape my beliefs about the state of school health

education. During the 2001-2002 school year, I conducted portions of a multifaceted study of student health in the Guilford County School (GCS) System. The study was a cooperative effort involving faculty from the UNC Greensboro (UNCG) Departments of Public Health Education and Nutrition, the UNCG Institute for Health, Science and Society, and the Guilford County Schools Nutrition Services. Nine principals voluntarily agreed to have their schools participate in the study. These included two elementary schools (Lindley and Allen Jay), four middle schools (Aycock, Ferndale, Southeast and Jackson), and two high schools (Eastern Guilford and Grimsley). The study consisted of six components, including: administrator interviews; a student survey of nutrient intakes and activity patterns; cafeteria observations; parent and student focus groups; the School Health Index process; and school performance measures. Of particular interest to this dissertation are the focus groups and the School Health Index.

K-12 Student Focus Groups

The purpose of the focus groups was to learn about how students and parents in Guilford County Schools perceived school health practices and how those practices may relate to obesity prevention. While the study was focused primarily on obesity, the findings have relevance to all areas of student health. The focus group sessions provided a wealth of information and insight into the attitudes and concerns of students about school health. Focus groups were conducted with a total of 39 students in seven schools (Aycock Middle, Cone Elementary, Eastern High, Ferndale Middle, Grimsley High, Lindley Elementary, and Southeast Guilford Middle).

Elementary School

Two elementary schools participated in the student focus groups, with a total of seven student participants combined. Students frequently described school as fun and friendly and their teachers as “great.” It was noted that some students are not native English-speakers and that they sometimes encounter difficulties communicating with teachers and/or school staff. No specific school cultural issues were discussed, though some students mentioned that “some kids are mean” and “some kids aren’t treated fairly.”

Students were asked what they thought the school could do to help students be healthier. Several students suggested that the school should serve healthier food; one student said, “Teachers and parents should have conferences with the cafeteria ladies about healthier foods” and one student said, “Kids should go to the doctor to be sure they are healthy.”

It is not surprising that the comments and insights of elementary aged children were aimed primarily at nutrition, as this area is the main focus of elementary school health education. It is interesting to note, however, that some students picked up on issues of kindness and fairness as contributors to the overall health of the school.

Middle School

Three middle schools participated in the student focus groups, with a total of eighteen student participants combined. Students described fellow students by separating them into two groups, well-behaved students and “troublemakers.” The “troublemakers” group was described using the following words: “mean, fight, bad, slack, jerks, bomb

threats.” Some students viewed the “troublemakers” as the more respected group, while other students felt that no group was more respected than the other. It was noted that some students are from other countries and speak different languages. Students who liked the school described it in terms of being friendly, safe, and fun, with nice students. Students who did not like the school described it in terms of being boring and having bomb threats. The major health issue that students identified is peer pressure. While some students see no health/quality of life concerns among their peers, other students felt that the following were areas of concern: overweight/obesity, eating disorders, asthma, allergies, family issues (lack of concern for health, abuse, neglect), and poor hygiene. In regards to pregnancy, smoking, and other drug use, some students viewed them as big problems and others did not.

When asked if there were things that can be done in the classroom, social clubs, athletic events that would improve health among students, students replied with the following ideas: provide healthier foods at sport events; have daily snack time; have a school Olympic Day; ask for student input; teach us how to be healthy not just how to play games; provide workout clubs; offer weight training classes; kids only like to exercise as sports; gym should be longer. Students were also asked what they thought the school could do to help students be healthier. Participants responded with: more PE; cook healthy food; make better tasting food; promote the SNACs program; better free time; better fitness; more fruits and vegetables; more fun games for PE; less work. Interestingly, middle school students focused their ideas about improving health almost entirely on eating and exercise, while simultaneously noting peer pressure as their biggest

health concern. Also, in describing peer groups, the students' terminology identified students as either following the rules and being generally compliant, or as causing trouble. The words used to describe the troublemakers clearly indicate potential violence (mean, bomb threats, fights), though violence and related health issues (like substance abuse) were not specifically mentioned as a major concerns.

High School

Two high schools participated in the student focus groups, with a total of fourteen student participants combined. Students felt that their peer groups could be described as a smart group, those who are "stupid," bullies, and athletes (who are the most respected). Some students described school as a friendly place with good administrators who enforce the dress code and gun laws. A majority of the students felt school has a negative atmosphere, where students have no school pride and are more interested in playing around than learning. Three students felt that low self-esteem was a common issue kids deal with. Another major issue students seemed to have was insecurity due to problems accepting who they are. Two students felt that lack of parental attention led to a number of health problems (depression, alcoholism, suicide). Other health concerns included pregnancy, drugs, drinking, smoking, dieting, being overweight, and diabetes. Many students felt that school provided limited opportunities for them to get involved so only a small group of people were able to do so. Sports appeared to be the main avenue of involvement, with boys being perceived as more involved than girls. Students saw

parent-teacher involvement as positive and would like to see more involvement of this kind.

Students were asked what they thought the school could do to help students be healthier. Participants responded with the following suggestions: fitness day; learn to overlook and correctly interpret advertisements for unhealthy foods and diet plans/fads; more involved in weight classes; healthy lunch day every month; fitness pep-rally; classes that help with “real life” problems; eat more foods that are alive; eat fruits/vegetables; learn to cook vegetables; drink more fluids when hungry; eat low fat foods when snacking (such as Special K and green beans).

In general, high school students touched on most of the major health issues plaguing youth in the United States. As with the younger students, they looked to nutrition and exercise as the main focus for solving health problems. Without further investigation, it is impossible to know why students of all age groups consistently identify these two areas as priority areas for intervention. It is possible that because health education classes begin teaching these subjects at elementary school and continue throughout high school, that students have internalized them as “health education” and left other health concerns out due to limited engagement with the issues throughout schooling. It may also be a function of the recent obesity epidemic and media focus on diet and exercise as a means to promote health and avoid health problems associated with obesity. Either way, it is clear that students have a limited view of what health education is about, while simultaneously recognizing that there are larger social issues at play which affect their health.

School Health Index

The School Health Index process brought together representatives of all segments of the school community to assess their school's strengths and weakness, and make recommendations for actions the following areas: School Policies & Environment; Health Education; Physical Education; Nutrition Services; School Health Services; School Counseling, Psychological, & Social Services; Health Promotion for Staff; and Family and Community Involvement. After mapping strengths and weaknesses, participants engaged in prioritizing what could and should be done in their school for improvement in each area. Although the results of this process for each school had unique aspects, a specific set of issues was identified as having overarching priority, across all schools. These issues are identified in Table 2.

Table 2. Priority School Health Issues – Physical Activity and Nutrition

SHI Module	Key Weaknesses - Composite
School Policies and Environment	No representative committee to oversee school health programs
	No written policies on nutrition or physical activity
	No prohibition on access to foods of low nutritive value
	Fund-raising efforts frequently include the sale of low nutritive foods
	Food frequently used as a reward
Health Education	Little continuing education available for teachers
Physical Education	Inadequate time for PE
	Lack of individualized fitness plans for students
	Little continuing education available for teachers
Nutrition Services	Little variety in school meals
	Some low-fat choices available, but not appealing or easily accessible
	No low-fat fruits, vegetables, grains or dairy products available outside cafeteria
	Middle and High schools use deep-fat fryers for many foods
	Healthy offerings not promoted
	Little collaboration between food service staff and teachers
	A la carte offerings are typically high-fat dessert items
School Health Services	Nurses available in schools only ½ day to 1 day per week
	Limited nurse time in schools a barrier to collaboration and involvement in nutrition and physical activity education
School Counseling, Psychological and Social Services	Counselors rarely provide information or counseling on nutrition or physical activity
Health Promotion for Staff	No health promotion activities offered for staff by school or district
	No budget for staff health promotion
Family and Community Involvement	Students and families provide little or no input into health programs
	Students and parents not involved in planning school meals
	Community access to school facilities very limited

Although the School Health Index was specifically designed to assess schools' capacity to address physical activity and nutrition, the process required participants to critically analyze and reflect on the schools' engagement in all areas of health education. For example, because no schools had representative school health committees to oversee, plan or make recommendations for health policies, all areas of health education are impacted, not just nutrition and physical activity. Likewise, the other main components of a comprehensive school health plan were assessed for content, perceived effectiveness, weaknesses, and opportunities for improvement. It was clear that a number of areas were sorely lacking and that the low priority of health in the school was communicated to teachers, parents and students by the lack of time, effort and resources allocated to health activities and the school health environment. Participants in the process quickly and clearly identified methods for addressing each of the weaknesses identified and noted their enthusiasm and support for beginning the change process in their schools.

Lessons Learned and Questions Remaining

My involvement with these studies included conducting the seven focus groups with students and guiding each school team through the School Health Index process in a series of 5-10 team meetings at each of the nine schools. This repeated contact and questioning of the methods, intent, and support of school health education led me to believe that North Carolina schools were doing an inadequate job of providing basic health education in addition to failing to provide environments supportive of optimal health. In order to more fully understand the consequences of this type of health

education, I wanted to talk with young adults about their health education experiences in K-12 public schools and their perceptions about how their education experiences impacted their current health decisions and practices. It seemed that college-aged students would have sufficient distance from their public school experience that they would be able to reflect back critically and thoughtfully, but not so much distance that they would forget their earlier experiences entirely.

I wanted to know, “How does the process of schooling in general and health education in particular impact the health status of children, youth and adults?” I believe that the lack of high-quality, comprehensive health education must certainly have an effect on students that cannot be measured with typical health statistics. The object of this study was to relate the stories and memories of former North Carolina public school students to an understanding of what it would mean for health education to be critical. That is to say, if health education took a more in-depth look at the social, political and environmental structures creating and limiting health conditions, how would that differ from current health education practice? Is it possible to imagine health education for all that provides meaning and purpose for students and their families? These are the questions I hoped to answer through this study.

UNCG Focus Group

In May 2006, I conducted a focus group with undergraduate UNCG students enrolled in cultural foundations teacher education courses. All students in three sections of ELC 381 were invited to participate. A total of 5 women self-selected to participate in

the focus group. All five women were upperclassmen, all were white and from middle to upper-middle class backgrounds. Three of the five participants had been in the class section which I taught; this relationship added depth to my analysis of the responses. Detailed information about the research methods for this study can be found in Appendix A. The goal of the focus group was to understand what former NC public school students perceived as the nature and quality of school health education experiences and how those experiences have translated into health behavior and/or health literacy as young adults. Participants were asked a series of questions for group discussion regarding health in schools, memorable health education experiences, and ideas for how to make health education meaningful. A complete list of questions follows in Appendix B. During the focus groups, I used prompts to probe and better understand the meaning and intent of participants' stories. The questions were designed to provide descriptive information about participants' experiences in health education as well as ideas about how to better serve young people through health education. This study uses narrative analysis methods to understand participant responses. This method was chosen to provide the depth and personal understanding available only through qualitative research. Strong themes emerged from analysis of the focus group. The major issues can be summarized into five categories: current health education practices, the school environment, marginalization of the body, how to make health education relevant, and personal health. Relative to the overall dissertation, this study provides a snapshot of the inherent problems of our current health education practices and offers an opportunity to suggest alternate ways of viewing and enacting health education towards a healthier citizenry.

Current Health Education Practices

Participants were quick to criticize both the quality and quantity of health education in NC schools. For the most part, they recalled that physical education (PE) was required minimally (one semester in high school) and health was ever further marginalized. Interestingly, none of the participants initially remembered much about their health education classes. This is particularly curious, as the participants were only a few years removed from the experience. After warming up and dialoguing about other aspects of school health, a few health education memories emerged, largely with negative associations.

I just remember the only thing I actually remember from my health education is when I missed a class and then had to go make up watching a movie. And it was a movie on bulimia starring Calista Flockheart. And I remember thinking, "you're on Ally McBeal." And that's the only thing I remember about it.

I don't remember much of my high school health class. We had the same kind of deal where we only had to take one semester of it. I don't really remember much of the health class portion. I remember we did watch a lot of those stupid videos.

The only thing I remember was the teacher was really hard. And all we did was bookwork. And it was like notes out of the book. And we didn't learn anything. Our hands really just got tired because we had to write sentences about health and listen to her go on and on and on and yet she wasn't really teaching us anything because she was reading straight from the book. So, I don't think my health experience was good.

We didn't even have a health class. It was... PE a week, health a week. But it was PE for a week and then sit on the bleachers while the basketball team practiced. Well, they did have two weeks of health. And that was the school nurse talking about sex ed. And it wasn't even her job. And, so that was the only health that you ever got.

It was kind of dumb.

I don't even think they took attendance in that class. I don't think if you didn't even show up they would care. It was that bad.

Our health consisted of like cardiovascular health and like stretches you could do and we talked about peer pressure a lot.

I don't know that I really ever learned anything, especially in like health classes just because it was kind of just one of those classes that you just showed up for and, you know, you got credit for. And I'm trying to think. I just, I mean, I watch a lot of the Discovery Channel, so that sort of that thing would teach me, you know, "Don't eat bad food. It's bad for you." But other than that, I wouldn't say I really learned anything about health through the education system.

Like I had to take it. I'll be here. I'll sit here, and I'll do the work. But I'm not really going to care. I probably learned more about being healthy in my biology class than I did in my health class.

Health was just one of those classes that you tried to sit and talk to your friends during. Like you pass notes back and forth. And you just keep watching clock hoping it will be over. I don't know of a lesson that I took with it either.

Despite the consensus that health education experiences in public schools were dismal endurance contests rather than engaging education, one young woman in the focus group did have a positive memory later in our conversation.

Now I just thought of it. But in middle school my health teacher had a nurse come in and bring like dummies. And we did CPR. We had to learn CPR. And we had the little slips that you put over their mouths and blew in it and their chest rose up. And you could mash it. But that was effective because I had a lot of fun playing with the dummies. But like thinking about now, I couldn't do CPR. Like I don't remember. I remember having the lesson. I remember doing the hands-on activity. But walking away from it a few weeks later I had already forgot like how many times you blow in their mouth and how many times you mash their chest. So, it was effective because it was fun and I knew what I was doing. But at the same time I didn't actually learn what I was doing.

This memory begs the question of the effectiveness of even the most memorable health education experiences that we offer students. This remembrance clearly illustrates the concept that hand-on, active learning is more interesting and fun for students. However, the student noted that within a very short period of time, she had forgotten the specific details of the lesson – crucial knowledge for performing CPR in an emergency situation. If most health education is remembered as boring at best, how can we expect that health education lessons will carry through and be applied to life experiences?

At least part of the problems lies in the inherent marginalization of real discussions about health and the human body. The focus group participants noted that sexuality education was minimal and typically occurred in late elementary school.

In high school, we never even went over sex ed.

We didn't ever have sex ed.

Our town did everything in fifth grade. It was one of those really small like middle of the Bible Belt towns. And they tried to do everything embarrassing in one year and never speak about it again. So, we had DARE, we had our sex talks, and we had this 'I'm special' training. We even got a little certificate at the end that said "I'm Special." That was like the peer pressure talk. It was all fifth grade. And then it was never spoken about again.

This comment sums up the conversation well. The participants believed that their teachers and schools were negligent about sexuality education because it was too controversial or embarrassing. The result of this situation was that students learned important lessons about their bodies and their emerging selves – “don't talk about it.”

Participants further recognized how the body is marginalized through schooling. In particular, they were concerned about the idea of being still for the entire school day and controlling the body through limited bathroom breaks.

I know in middle school I had a teacher and he would not let you go to the bathroom for any reason. I mean like he didn't care if it was an emergency. You still wasn't going. And if you did go you had to spend break with him. Like that was your punishment. And I mean while I guess he was doing it just so people wouldn't goof off and go to the bathroom numerous times during class, it was still kind of bad. Because like, you know, nobody has time to go spend their break with him. And I don't think he should have punished people for having to go to the bathroom. We had the class like right after lunch. So, obviously, people was going to have to go to the bathroom. And, you know, you would be in pain. Like I know I would have to go to the bathroom and I would be like hurting because I didn't get to go to the bathroom. And you would raise your hand and go, "Can I please just go. It's an emergency." And he would like, "You have to spend break with me." And you know you didn't – and like your choice was if you couldn't do break you had to stay after school which meant you had to get a ride. And I just thought that was a bad way. I mean I think he was trying to teach people to control, you know, going to the bathroom, but sometimes you can't. In middle school I didn't think that was a time to be making you do that. So, I thought that was a bad impact of what he was doing where in elementary school you raise your hand and you have to go. And the teacher would be like, "Is it emergency? Can you wait?" And you know normally you would get scared if you really didn't have to go. And be like, "Yeah, I can wait." But you did have to go you would go, "Yes, I have to go." And she would let you go. So, I thought that was teaching better control because it teaches you, well, if it an emergency, you can go during class. And if not wait till break time or something.

I just think it's interesting that like in high school you still have to ask. But all of a sudden in college, all of a sudden you realize when you have to go to the bathroom, and then you don't have to ask any more? Like in high school do you really not know when you have to go to the bathroom?

Like, you know, I think that most of my teachers, we had to have a special pass or something. And sometimes the teachers would make these enormous like huge signs that was like Bathroom Pass, and it would be as big as your body, you know. So, you feel like stupid walking down the hall.

So, of course, we are not going to do it just to goof off like you feel really stupid just walking around.

As future teachers, the participants were particularly attuned to issues sitting still and related stories of feeling unable to sit still themselves, as well as observing other students' difficulties with requirements for sitting for long periods.

I think about sitting, especially for kids, but I know in high school I had block schedules. So you had a class for an hour and an half. And it was hard to sit there for an hour and a half especially when you just had a lecture class. And you are just like sitting there for an hour and a half. It was horrible, horrible. So, I think that it's important to realize that you don't – no matter what age maybe every 45 minutes you should at least let everybody get up and move around for a couple of minutes and then sit down. Because it's just hard. And by the end of the class period you are just so ready to move that you just can't even pay attention. You are just, "Oh, God, if five more minutes."

One of the elementary schools that my mom works at she made a rule and whatever, you know, she was the principal that these kids are growing their bones. They are growing like crazy. They thought all these growing pains like you're saying every hour you need to let the kids stretch. She was just like, you're not going to be like let your teachers keep their kids from PE. A lot of the teachers were going, "Now in Kindergarten you five-year-olds didn't pick up your toys the right way, so you are going to sit in your little desk all through PE." And it's a big – it's like it causes a lot of problem with their growth. So, now there's like one school in the county lets them stretch. And they all have to go to PE. And the rest of them just, "We don't think that's a good idea." So, that's a big issue in our county right now.

I know that was a huge issue when I was in high school. They were talking about the superintendent enforced a rule saying that kids had to go to recess because teachers were punishing their kids by talking by taking away recess. So, then, of course the kids are misbehaving for the rest of the day because they didn't get that time to let out all their energy and run around and, you know, scream and yell and do what kids need to be doing. So, instead they just, you know, continued to misbehave. And it was just horrible.

The participants also related the expectation that kids have to be still to ADHD diagnosis and the perceived over-medication of children. They believed that many behavior problems could be solved by allowing children (and adolescents) to move more during the school day, and that inattention may really just be the need to be active and move the body.

They med all these kids up, and then it's harder to get them to do anything when they get to high school because they've been drugged their whole lives because they're ADHD. In reality they just wanted to run around for half an hour and go take a nap.

There's no quick way to say, "Oh, it must not be he wants to go out front and play. It must be, let's stick him on drugs."

I know my mom subbed for a semester when I was a senior. And every time she would go into a elementary or middle school classroom she would bring a kickball and say, "If you guys work for 30 minutes straight, we will go outside for the rest of your class period, and we will go play ball." And those kids would work their little butts off for those 30 minutes because then they knew they got to go outside and they got to play and they got to be crazy. And I think that works way better than like, "If you guys misbehave you're not going to be able to go outside." Like, you know, reward works better than punishment. You know? If you give those kids something to work for and that's fun and they get to run around, be crazy, then they will focus on what you want them to.

At the same time, the participants were attempting to be realistic about their jobs as future teachers. They recognized that teachers need to be flexible and allow students the opportunity to move freely at times in order to be productive in the classroom. They also noted the role of schooling in preparing students for their future as adult workers.

I think teachers also operate under the misconception that it's easier. It's easier to make kids have to hold their bladders. It's easier to have kids sit completely still in their desks for the entire day. Whereas, I think if teachers realize that, you know, maybe once every hour if you like had a

special signal where you're like, "OK, go crazy," they had five minutes they could run around and scream and do whatever they wanted that they would, you know, then be able to focus back down. But they think it's just easier to have them sit the entire time and, you know, but they don't realize that the kids need to get up.

We got so busy in class she had a little stop light on her desk. And we would be sitting there working, and she would be just like, "OK." And she would flicker a little button and it would go to yellow. And then you would hear all these little snickers around the room. And everybody would be going, "What?" And then you would look up and you would see it. And then it would go green. And then everybody would jump up and like run around. And books would get knocked off the tables. And it was like ridiculous. And then it would go back to red and you knew to get back to your seat. You picked those books up because if we didn't, then the stop light was going to go away. And we did not want that stop light to go away.

Interestingly, the participants uniformly agreed that this method might actually be a useful way of both controlling their future students and allowing them some "freedom" in the classroom. Clearly, these future teachers were struggling with the war stories they had heard about unruly classrooms while attempting to think about other ways of dealing with classroom discipline.

Like I was thinking maybe like some teachers don't think that they would get control back of their class if they let them run around and be crazy, that they weren't going to be able to, "OK, now you need to sit down," because now they are going to be like, "No, because we're having too much fun." But something like that would be really effective. Like we had something like that in our cafeteria in our elementary school. We had a huge stop light in our cafeteria where when it was green we could talk and everything. If it got too loud they would switch it to yellow. And you knew OK, we need to quiet down a little or it's going to go red. If it went red, you had to be silent. And they would not put the stop light back to green until it was silent. Like I don't really know what motivation we had to ever make it go back to green other than we just felt like talking. But I mean it did work. I mean after 30 seconds of it being red, you know, "Shut up." And then it would be go back to green you can be loud again. So, something like that it seems it would be really effective.

I mean it just comes down to the fact when you an adult you are going to have to sit there in a job, and you are going to have to control your bladder, and you are going to have to act like you have commonsense and not randomly jump up and run around and, you know, so if – it's like a life thing. It's not really school things but life things where you just sit there and be a little adult so when you grow up you can be a big adult.

Participants readily recognized the way health, the body and well-being are marginalized through typical schooling processes. They noted the need to push practices in a different direction in order to be fair to students, but stopped short of advocating for major changes in the approach to managing classroom learning. They had been sufficiently schooled in the belief that learning bodily control is a necessary part of our school and work lives and that schools should in fact play a role in teaching children to control their bodies.

The School Environment

When asked about the school environment, the participants related their experiences primarily to the physical facilities, health education and physical education. They had diverse experiences with the quality of the school facilities, but agreed that cafeterias and bathrooms were generally unpleasant. Regarding the cafeteria, they said,

Don't eat the food.

I know in high school I don't think I ate lunch in the cafeteria one day.

Always we made fun of the fact that there were food pyramid posters around the caf. And then you look at the food which is way too overcooked or way past frozen and then microwaved. You're like, "OK, so are we learning satire and irony or are we going to eat?"

Yeah, I know in high school I don't think I ate lunch in the cafeteria one day. Like I would either take my lunch or just not eat all when I was in

high school. Because like they had pizza and fries every single day. And the pizza was not even good. It was a greasy – like I know a lot of my friends would take napkins and like blot the grease off of it before they would eat it. Because it was so nasty. And I never ate there.

We had the regular food lines in the cafeteria. And then we had like the cart that had like pizza and chicken sandwiches and fries every single day. And, so, I would usually go to that and just get a chicken sandwich every single day. Because I didn't want to eat like the regular food or anything.

I always brought my lunch because I refused to eat chicken sandwiches every day and fries. But I went back there for a trip for teaching fellows and actually had lunch there for the first time ever. And it was actually really tasty. But I couldn't help but thinking about how unhealthy it was because the fries were amazing but they were incredibly salty and incredibly greasy.

The cafeteria food was thought to be unappetizing, unhealthy and generally unappealing. In addition, participants brought up issues of sanitation in the cafeteria and believed that the schools provided inadequate dining facilities.

School bathrooms were also viewed extremely negatively. Issues of sanitation were mentioned, but the primary discussion of bathroom facilities focused on student smoking behavior.

The bathrooms are gross.

I think the bathrooms were like the biggest issue because you could walk in and like get emphysema from like breathing. I mean it was just, you know, and I think there really – they didn't really enforce the whole like don't smoke rule except for like one time my friend went in and like she clearly was never had a cigarette in her life. And she walked out and got yelled out for like smoking in the bathroom. And she was like, "I was just in there. Other people were doing it. It wasn't me." But, you know, but that was how bad it was that you could come out smelling like you just smoked three cigarettes. And, you know, they just never really did anything about that.

Obviously, the kids weren't supposed to [smoke] because they were all underage anyway. But I don't know about the teachers and anything like that. I just know like it wasn't enforced no matter what. I mean inside or outside.

At my school you weren't supposed to smoke (like teachers or students). And people would sneak into the bathrooms all the time and try to smoke. And you would go in. The arts bathrooms were always the nicest ones because the art students were typically the ones that were like, "I don't want to smoke in my bathroom. I have to use that bathroom." But every once in awhile you would go in there and somebody had smoked a cigarette and you were like, "Oh, it's so gross." And it would just be disgusting.

There was just the boy bathroom, and it was the bathroom that was with the bus hall lobby which is a big lobby that everybody congregated at. And it was really, really bad my freshman year. And then for some reason it slacked off. But my freshman year like you could be standing outside the class change and just the smoke kind of like waver out of the top. And there would always be teachers standing there and looking for someone suspicious to come out.

In discussing smoking, the conversation strayed from the physical school environment to the school culture and enforcement of policy. As non-smokers, the participants held a common belief that the schools should do more to enforce smoking policies, but sympathized with the difficulty of that enforcement, particularly in larger schools.

And all they could do was search you. If you had them [cigarettes] on you, and they said, "OK, you did it even if you didn't." But it was supposed to be smoke free. But the teachers would go out all the time and smoke. Nobody really cared one way or the other.

Yeah, my principal would – you would see him go out of his office and get in his car and pull like across the street. There was a church right across there. And everybody knew that he was going over there to smoke. But we didn't really have a big problem with people smoking in the bathroom. If the teachers ever did think somebody was, they would go out and they would smell everybody's breath that came out of the bathroom. So, I thought that was a little strange that they were willing to smell everybody's breath just to catch a smoker.

I think that was why we didn't have a big problem because they knew that they would get caught. Because if you were in class and a teacher was teaching and smelled like smoke, she would like dart down the hallway. It was like stop what she was doing, go down the hallway and catch 'em. So, I guess that's why we didn't have a big problem with it.

I think my school was just too big to enforce the rules. Like because we had four completely separate like areas. Like there was – that were completely separated from the rest of the school. And, so, like it was just so hard to enforce them or else they just didn't care. But like it just happened all the time. Especially in the bathrooms. And I never understood why you would go in the bathrooms and not just like wait until the end of the day and do it in your car as you were driving away or something like that.

Everybody dips and actually dipping is a bigger thing than smoking in my town. And guys would do that in class. And as long as you weren't parading your dip bottle around, nobody even really cared at that.

Although my principal did play tricks on the freshmen. And like if you were caught smoking in the bathroom he told all of us to say that you needed a smoking pass. So, if we ever saw someone in the bathroom smoking or knew it was happened, like as older kids in the school we were supposed to ask them if they had a smoking pass. And just make sure they went and got one because if you were caught smoking without one you were going to get in serious trouble. But if you had one, you know, you might get a slap on the wrist and you might get them taken away because you're under age, but nothing's going to happen to you because you have a pass. So, they would go to the office and ask for a smoking pass which would lead them to asking if they had cigarettes on them. Well, let me see what cigarettes you have. Let me write the brand down so we know. Like it's a car or something. And then they would take them and get in trouble and their parents were called. It's a small town. We have to think of something to do.

I was actually at another school for like a band function like for All District trials or something like that. And it was a school that was in Charlotte. And they actually went so far as they closed the bathrooms if they were not – if they had been smoked in a lot or they were too dirty or something like that. Like something happened and they would close the bathrooms. And they would put signs on the doors that said, "This bathroom will be reopened when, you know, everybody like promises not to smoke in it," or whatever happened to get them to close it. I thought that was really weird because I mean – it's an OK way, I guess, to get

people to smoking in the bathroom, I guess. But I didn't really think you were supposed to not have bathroom facilities open in your school, you know?

That is what our school does. Only like between classes and lunch are all the bathrooms open. And the only one that is open all day long is the one that is right beside the office.

Interestingly, the participants said little about preventing smoking behavior in teens. It was assumed that some students will smoke and will try to smoke in school. Their concern was more for the environmental effects of others' smoking in the bathrooms, and how that made them personally feel about using the facilities. This dialogue brings up numerous issues of how health is treated in the school environment. First, smoking and possession of smoking material by minors is unlawful in North Carolina. Though many school systems have recently adopted 100% tobacco-free campuses, the enforcement of this policy remains an issue. Clearly if students universally recognize that smoking occurs in the school bathrooms, not enough is being done to curtail this behavior, much less prevent the circumstances which would lead youth to begin smoking at all. In addition, when schools attempt to deal with smoking, they are either punitive (closing down the bathrooms at the expense of all students) or negligent (ignoring the behavior). Either way, the message to students is clear – your health is not important.

Further into the discussion of the school environment, participants brought up the apparent favoritism afforded to athletics. It was noted that athletic teams typically had better facilities than the rest of the student body. However, the idea of physical fitness did not extend to everyone. PE classes were discussed as having minimal requirements and focusing largely on sports skills.

They pushed sports a lot.

But the other facilities at school as far as like physical education were immaculate because we had two gyms. We had a regular gym. Then we had an auxiliary gym. And then we had – it's like an oval, a separate weight room that was huge along with all the fields. So, those classes, I'm sure were probably a little bit better than the ones that I had. Because we had four PE classes of over 30 people stuffed into one gymnasium that wasn't even that big. Like when we were actually going through the physical part of it. And I remember your options were either to play basketball or else the teachers didn't care if you sat out because if all the kids were playing basketball at once it would be just too crazy. So, any day we were inside it would be just like, "Oh, I'm going to just sit here and hang out and get my little A for the day."

My school was kind of old but we had a gym and an auxiliary gym which the aerobic class used. And then we had a weight room that was out in the field house. And my school was like, I mean, our teams were never that good. But they like to think that they were. And they pushed the sports a lot. So, the weight room was probably nice. But I've never been in it because I never had a reason to.

This method of physical education certainly supports the idea that physical activity is for athletes, and does little to engage students in learning about physical activity and how it applies to everyday life.

The Relevance of Health Education

The students in the discussion group were highly cognizant of the fact that their health education was not relevant to their everyday lives. The things they remembered and attempted to apply in their lives were clearly driven by a connection to something that personally engaged or interested them. For example, one student talked about her own focus on healthful eating, largely related to image and avoiding obesity:

I think what I learned in class is like I don't really know which class we actually learned it in. But it was like the food pyramid and eating right. Because I know that's the main reason I wouldn't eat in high school because I was like, "I'm going to get fat if I eat pizza every day." And, you know, I know that I try to exercise every day. Just little lessons like that. But as far as drugs and sex and stuff I didn't learn any of that through school work and books and stuff. But I think the most lesson I took to be like eating right and food pyramid and what you need to eat. Because I know like if we ever did cover that in class I would be interested in it. Like I would try to listen and pay attention. Where all the other stuff I'd be just like yeah, yeah, you know, I know. I know. And not pay it no mind. I know if I ever saw an article or something talking about eating right, I would pay more attention to that. So, I think I learned a lot from school, books and stuff from that.

She noted that she paid attention during nutrition lessons at school because she found the topic interesting and important to her. For the most part, the participants were more compelled by informal health education experiences than school experiences. They mentioned youth groups, television, the family physician, movies, family members and friends as having influence over their health education.

But those were the ones that make a big influence when you go somewhere and they have the STD talk. And when they like show you the pictures. Like because I didn't even really have – when I got to college I went just one of these things with my friends. And it was like an STD talk kind of thing. And they had all the pictures. And that is the only thing that really sticks in your mind.

My uncle, like a favorite uncle, he's passed on now. But he went through all of that. And he had to have like three-fourths of his tongue cut out, all of it. He had to have all this meat from his chest brought up. And like I went to see him in the hospital. And it's one of those things where like I promised that day I would never smoke a cigarette.

These personal experiences seemed to have the most meaningful impact on participants.

The shocking messages they got from family members and from cold hard facts were remembered as highly impactful over their beliefs and health decisions. Only one

participant mentioned the family physician during this conversation, and she rated this interaction about sexuality education as strange and not particularly helpful.

My doctor actually gave me a book. My doctor was like, "Here you should read this." And I'm like, "OK." I mean I really had to be like 10 or 11. And I remember like I read it. And I was like, this is too much information. Like Barbara is going to have a baby. You know, she's in school. What should she do? I don't know. Like weird. I didn't learn anything from the book.

Media, in particular were noted as having a lasting impact. All participants remembered at least one health education lesson they gleaned from either a television program or public service announcement on drugs or alcohol.

I kind of watched the TV like most people. And I remember just thinking back like looking at the drug commercials of like awhile ago and looking at the anti-drug commercials like now. And the ones now are so much more effective I think then like the cracking of the egg and like ... but like the ones now are so funny that you're just like, "Oh my God." Like the one with there's a guy who like has his fist stuck in his mouth. And he's like, "My friends told me yesterday to smoke pot, so I did. And today they told me to put my fist in my mouth, and now I can't get it out. I'm such an idiot." And it's so funny. It's like, "What?" Like and it makes it sound – it's kind of lighter than you know, "This is your brain," and they crack the egg. But I think it is so much better. And the best one I think I've ever seen was actually directed towards parents talking to their kids about drugs. And this guy, this dad like runs into his daughter's room with this blanket, throws it down on the floor, licks part of it and rolls himself up in it and like, "What am I?" And she's like, "A burrito?" And he's like, "No, I'm a joint." And she's like, "You don't look like a joint." And then he's like, "You already know about this?" And it was just really so funny that it was – it sticks with you longer than the stupid egg ones.

I find the ones [television commercials] of the people that have emphysema that are talking out of life – that was the most effective for me. Because it's so gross to me that I was never touch a cigarette because I didn't want to turn out like that.

Maybe more – more than anything just for me like TV. Like I said I watched Discovery Channel. And when you are a kid they would have like Bill Nye, the science guy, talking about science and things. And those things impacted me so much more because I could like see it. Like even now they've got the show, "Honey, we're killing the kids" where it's talking about like lifestyle changes and things like that. And I think that impacted me so much more than just health decisions I think now way more than, you know, education. Because like I said the only thing I remember is the bulimia video. And that's only because Calista Flockheart was on it. And it was when everyone was saying that she was anorexic.

I think that one thing that could possibly help as far as, you know, just health education as far as eating and that sort of thing is I remember watching the Oprah Show on the super foods. And that taught me so much more about like what good foods are to eat and how foods that sometimes thought of as bad foods can be really, really good foods. And I think that if they taught something like that that was like, "Here is an actual applicable way to do something." Because I feel like so many times when health education does talk about food choices they talk about it so much in this realm of non-reality. Like, "This is what you should be having." And it's like, OK, so greens. Apples are green. Like you know, they don't really put it in an applicable way of like, "If these are the types of food you eat every day then this is what is going to happen."

One participant also mentioned the factor of community resources and how the availability of health resources may impact student health. In particular, she remembered differences in her high school experience with pregnant classmates compared to other participants from smaller towns.

Since I went to high school in a slightly bigger city, of course, there was not [sex ed] in schools, but there was just more general education. Like, you know, from your surroundings which there were so many more people. And, so, we did not have quite that high of a pregnancy rate. Like we had maybe six or seven out of my 300-person graduating class who was – girls who had had babies. Just because simply like I guess the education was more so out there which I think shows something. You know? Because I think they knew that they had options. Because you just knew.

There was much discussion about having “the talk” about sexuality with their parents, though none of the participants found that particular interaction to be educational.

I just will always remember this. In middle school my mom got me one of those books, you know, and those books like, “You and Your Body,” those sort of books. And it was just to me it was the funniest thing ever. Because I read it. And it didn’t give so much information. It was just like here’s what this is, la, la, la. And I did remember looking back it now like that book was completely useless to me. But that was – because my mom maybe would have felt uncomfortable actually talking. So, she just came and got me the book.

My mom did the same thing. She gave me a book. And what was funny is by the time she gave it to me like I had already learned most of it from like my peers and just hearing stuff and TV, you know, just informal learning. And she like came in there and gave me the book and acted like it was such a big deal. And then I don’t even know that I hardly read it. Because it was just so stupid. Like it just briefly talked about each thing. And it made it so light. And I don’t know. It was just – didn’t help me any. So, the book didn’t help me. I learned most of my stuff just from hearing people talk about it. And you’re like, “What’s that”? And then they tell you about it.

I never had a book before or a talk or anything. Like my mom’s a school nurse and my granddad is a surgeon. And half my family is doctors. And like at the dinner table you don’t talk about what you did today. But like, “Yeah, we cut open a something, something today.” And it was never an issue. It was like, “You can’t bite your fingernails, you’re going to get this, this, this.” But I never listened to them.

My mom is a nurse. So, like five or six, “Watch these videos for the fifth-grade class.” So, I’ve seen 90,000 of those. And it was awful.

I never got anything from my parents to this day. My parents would not even go into halfway talking about anything of that nature. I was never given a book. I was never having the talk. I was never even looked at. Like, OK, do you want to have this talk? Do we have to do this? Like it was nothing. Like it is not talked about even now for all they know, I know nothing.

The lack of sexuality education was definitely a bone of contention for the participants.

The hidden curriculum of this discourse was that their bodies are embarrassing and shouldn't be discussed. As young women still coming to terms with adulthood and sexuality, the difficulties caused by this lack of knowledge were readily apparent.

Though they didn't discuss their personal relationships outright, the participants were clear that they had to learn things on their own or from peers and this was not a comfortable situation. They were also highly aware of the disconnect between health as a lived subject and the failure of their education to help make those connections.

I think it's really important [to understand the connections between your body and your health]. Like I think that if you realize the health effects of bad things like drugs and excessive drinking and those sort of things, I think if you realized how bad it actually is for you, it encourages you to not do it. But I think just saying, "Don't do it," isn't effective. But I think if you actually got the full education and you fully understood it, it would be much more effective. And I don't think people would do it half as much as they do.

Because when you say, "Don't do it," you're still wondering, "Why shouldn't I do it, you know, what's it going to do just somebody telling me not to do it?" Is that the only effects of it? And I think when they actually get the education of, you know, this is what drinking does to your body. This is what smoking does to your lungs, stuff like that; I think it's more of an impact. Because they say, "Ooh, I don't want my lungs looking like that," rather than somebody just saying, "Don't smoke. You don't need to smoke." I think it's more effective, and that's why I think they need to teach people.

All we see is, "Oh, it's socially acceptable and it's cool, and we're going to be seen as really popular if we can do this. And I'm going to have lots of friends if I smoke pot or whatever." And we don't really see the – we don't really get the whole effect of afterwards. Well, what happens after I'm out of school and I'm no longer dependent on my, you know, my friends don't smoke anymore or whatever. When does it need to stop so that this doesn't happen to me?

They believed that it would have made a difference to them if their experiences had included the ‘why’ part of the discussion. Instead, their experiences consisted of a string of “Just say NO” lessons that left them hanging with no understanding of why. The students also believed that lessons with shock value were highly memorable and important in influencing their choices.

Actually in middle school you started showing like what a lung looks like after 20 years of smoking. Right there... Over half the class immediately, “I am never going to do that because that is disgusting.” And like seeing those visuals it scares you almost so much you’re like, “Not going to happen.” Like, you know, showing a liver after you’ve been drinking excessively for so many years. Like actually showing like in comparison to what it should look like and what it does. And I think that would be way more effective than just saying, “Don’t do it. Bad.”

You know the driver education videos where they actually show the wrecks and the bodies afterwards because it scares you into driving normal. And it’s the only class through any school that’s gotten the concept: scare the crap out of them; they’re not going to do it.” Like even when you go back to the sex education classes and the schools that do it beyond fifth grade. Like they show you the happy little pregnancy video where, “Oh, she had a baby. Now, she has bills and this.” “OK, so she has bills.” But if they showed like the driver education version of a birth, that would scare so many teens. Because you’re showing them a birth, not bills. And it’s just like even with the smoking thing you show them someone posed up with the face thing. OK, so, there you go, don’t say that smoking is bad.

The impact of these “shock” lessons was palpable and clearly caused an emotional/visceral reaction in the participants. They went on to say,

Let me just say earlier this year I took sex – human sexuality here at UNCG. And we saw two birth videos. And let me tell you that scared the ever living crap out of me. Yeah, if I had seen that when I was in middle school---I would never even think about having sex when I was in high school! I would be traumatized. I mean if I knew, “I don’t think so. I remember the video.” Like I – that I think would be more effective.

That would require a comprehensive sex education which is never going to happen in North Carolina quite frankly which is sad because you know look at the statistics, comprehensive sex education, it's so much more effective because you're showing options versus, again, "Don't do it. It's bad." "OK, whatever." They don't understand. Then they don't understand how to protect themselves. Then they end up in a bad situation.

But I also don't think – I mean I agree that like scare tactics can be really, really effective. However, I don't think that like making kids feel like, OK, if this does happen to me, especially with the sex thing, like with the drugs and stuff like that, it's different usually. But with the sex thing like, you know, making them feel like, "Well, if this happens to me. Then, oh, God this is going to be really scary and what's going to happen now?" Like I think on the flip side I think we also have to make sure that they understand that like if something like that happens, if you become pregnant, or you know father or whatever, then, you know, there are still options that you have. Like I don't think you want to scare them to the point that they're like afraid to do something like if that happens to them. I don't think you want to scare them to the point that they wouldn't seek help or something like that.

The impact of the "Just say NO" lessons was also evident to the participants. They remembered school cultures where anything that was 'other' than the accepted behavior was overlooked and talked about fellow classmates who suffered the consequences. They clearly felt that open discussions about health issues would have made a difference for many students.

There was a lot of girls that would go through my school and they would get pregnant and have babies. But like at the same time my school's policy was, "Don't do it. No sex." Our sex Ed consisted of, "Don't do it." Like there wasn't options of where you can get protection and everything. But then when someone would be pregnant it was just like not spoken of. Like the teachers would walk past them like, you know, "She's not pregnant. I didn't just see that." And it wasn't mentioned. Nobody would talk about it. It was like a secret. Girls would try to hide it. They would wear the baggy shirts so that nobody would know because they were ashamed of it.

Well, I graduated with 38 girls who had either already had babies or were pregnant at the time. And like a couple of girls were on their second kid when we graduated. And I mean it was – it got to the point where, yeah, they did the bad thing. And, no, they didn't want to come out with it. But at the same time it was just looked past. It was like, "OK, you got pregnant. Now, you have to take your fourth period and drive to the hospital and take this little mommy class." Like that was the whole thing. With so many girls walking around like pulling the little book bags behind them. And it was just looked over. I mean it wasn't even addressed because, "We can't see this." It's like, "Hear no evil. See no evil. Speak no evil," kind of thing. And like reality all you have to do is print up the list of like all the numbers that you can call and distribute them in a health class. You know, if you are that uncomfortable with talking, at least you can provide them with the information.

There was a guy that he was a member of this class. He's older than me. And he weighed so much that they would take him down to the cattle market to weigh him. And it was really sad. And he was the biggest bully in the whole universe I think. But when I asked one of them, why is he such a butt? It was like his parents don't care about him. And I met his parents. And his parents are bigger than he is. And they're banned from all you can eat. So, it's like the community already says, "Well, you're awful." And so the only thing he can do is try to stand up for himself. So, he's going to do anything to get accepted, like accepted. So, the drugs would become an issue. Like whatever he could get to do friends. So, he was going to go downhill forever and ever.

The failure of the schools to address these difficult issues – sexuality, familial abuse, obesity, drug use, and others – leaves children to suffer the consequences. The participants loudly believed that the schools should be responsible for helping students with these issues. They critiqued the lack of relevance of health education to their lives and offered suggestions about how things could be made better.

Because you are just like, "OK, great. Food pyramid. OK. Check that off. I'm supposed to have six to 11 servings of grains. OK, let's get on that." You know, like you don't really do it. Like, that's why I think I learned more about health issues in my biology class. Because – or even in my anatomy class. Like I learned a lot in there because we were like looking at it. And like we're doing it. You know, we dissected stuff. We

were looking at, “Oh, this, OK. Well this is what happens to your liver if you know drink or whatever.” Stuff like that. You know, we watched videos and really talk about it and really learn it. And I think, you know, if there was a way that they could get you to be more interactive with health class, then I think it would be more effective.

It’s like the ... the most hands on. Like because health issues are so about you and your body and what you are doing and what’s going on. But it’s like in the classroom you just sit there and you are listening to your teacher about whatever the health issue of today is. And you know if you’re not really relating to it.

It is going to be more integrated. Like we were talking about before like trying to get health all the way through everything. I mean in just trying to promote everybody does some kind of activity. You know, you lose recess after elementary school. You know, you lose that ability to able to go out except maybe in gym class. You go outside and play. I mean just being active in some way. I think if schools could promote that, you know, in any class. Any kinds of hands-on thing or just even mentioning, “Hey, you know try this.” Or, you know, I mean, whatever. You can relate health pretty much everything I mean every subject.

I think you have to make it fun, too. Like you have to learn how to make learning about health interesting and fun so it becomes memorable. Because none of us remember our health classes.

They were committed to trying to engage their future students and thought of a number of ways to make health education more normalized and integrated into the schooling experience.

They were so boring and they just didn’t make an impact. And, so, I think if you make it in a fun way, you know, like in your biology class as you are dissecting a frog, talk about, “This is the liver. This is what it does. And you know you make bad decisions in your life, this is what could happen to it.” You know? Things like that make more sense to certain types of kids. Because, you know, obviously sitting lecturing, reading out of the book, doesn’t really affect anybody if none of us remember it.

Yeah, I think integrated in. Like you can – if the school lunches can ever get better besides pizza and fries. But, you know, the teacher can be like, “What did we eat for lunch today?” And what you need to try to eat

before you go to lunch. Like the teacher could be like, "The lunch menu is," and tell. And then maybe integrate some way about what foods on your plate is going to be the healthiest and why you need that type of food and what it does for your body and just like integrate it in and then also like when you are going over school policies like not smoking in the bathrooms and stuff you could say, you could bring in the lesson about why you shouldn't smoke in the bathrooms instead of just saying, "It's against the rules. Do not smoke in the bathroom." You could be like, "The effects of smoking are – that's why we prefer for you not to smoke while you are at school is for your health. That's why we're enforcing it. You know, it's not because we're mean teachers. It's because it's for your health." I just think all throughout school, not just in the classes they should have health education but when they're going over rules, when they're giving the lunch menu, when they're about to go outside for recess, they can explain like some exercises they could try doing and what they target, you know? I think it should just be integrated throughout the whole school.

Any school class you take, no matter what it is going to like being able to open you up to be able to ask the questions and have an understanding of it. It's one of those things where if you are in the situation as crappy as the situation may be as far as your teacher or your situation, if you really want to ask the questions when you get to the point you are able to as opposed to if you didn't have a class at all you wouldn't even have the opportunity to ask the questions.

Though they were highly critical of the curriculum, they also squarely placed the responsibility for teaching health effectively on the individual teachers. They remembered their own teachers as having little interest or passion for teaching health, which built on the ongoing marginalization of health issues in the school.

I just think so much like the training for physical education teachers or like if I was wanting to be a PE teacher like I would want to do it for the sports aspect and not for the health aspect. So, I think so many times you get these teachers who don't really care about the health aspect. Like my – my teacher was the track teacher. So, we had to run a mile every week. She didn't really care about the health part. It wasn't important to her. All she wanted to do is get us outside, play softball, go run. So, she didn't really care about, you know, the sex ed part, the health part. And, so, it made us not care. Because she just didn't seem to – she didn't think it

mattered all that much. Like she would even make fun of it. She would be like, "Oh, yeah, we have to go do the health stuff now, rah, rah."

I think a lot of it is that way. A lot of kids are like, "Yeah, let's go around outside." And even though my teacher especially in high school wasn't a great teacher. She wasn't very nice to us all the time. Like we would – we would always have fun. She was a volleyball coach. So, we would play volleyball a lot or we would play kickball or whatever. And like every kid wants to get outside and run around I don't care how old you are. I mean, you know, and I think that if they – if they – if they don't put less focus on the physical education part, but they could incorporate it more. Like this is why you should, you know, exercise. This is why you should run. This is why playing volleyball and kickball is good for you and incorporate it with the health part. And then it wouldn't have to be so boring. And it would all make sense. Instead of like today we're going to run a mile and tomorrow we're going to talk about drugs. You know, it doesn't really relate to anything.

They went on to say that health education is the responsibility of all teachers and that it should be an integral part of schooling from a very early age.

I think school should certainly [play a role in protecting kids' health]. I don't think it does. But I think that, you know, education as a whole in the school system should play a part, a huge part, in the way kids make their decisions and feel about themselves. And I think that if everybody felt good about themselves and everybody knew all of the actual reasons why you should not do something. Like you know it's one thing to say, "Don't smoke pot because it's bad." But it's another thing to say, "You know, if you smoke pot this could happen to you. This could happen to you. It could happen to you." And actually like say what could happen to you other than like, "Just don't do it." It's – just don't do it just doesn't really work for most people. It's like, OK, well, why? I guess I'll go try it and see what it is. You know? So, I think education should play a huge, huge role. But it just doesn't.

I think it's got to start young, too. Like it's got to start younger than you think because by the time you hit middle school you're not in the classes all the time. Like in elementary school you're like basically in the same class all the time. You have the same teacher for everything all together. In middle school you start taking classes. In high school you never see half the people that are in the class. I mean I don't know half the people I graduated with, stuff like that. And I think, you know, I mean it depends

on, you know, when you get older, it depends on what kind of teacher you are. Like for music teachers we get a lot of, you know, we get a lot of different kids as opposed to like the honors English teacher is only get the people who are making honors English which are normally the, you know, smarter people in the school or whatever, you know, that are already kind of on the right track or whatever you want to say. You know, the people who are taking, you know, shop classes. If you have shop class you have the stereotypical, you know, stigma for that as well. I mean it is not always going to be the people who are taking AP calculus that are going to be in the shop classes. It's not the same kids. And I think, you know, so you kind of have to look at that as opposed to have classes like, you know, drama or, you know, music or anything like that. Where we get a culmination of all the kids. You know? And I think that if you start earlier, then we don't have that problem where the kids are separated. You know, they are all together. So, I think you could start there and then if we could keep it going with every teacher in every subject then it would impact the kids a lot more than what we are saying now.

They powerfully felt the obligation they will have as teachers to lead and provide healthful models for their students. One participant explained,

We did an internship together at Jackson Middle School which is kind of in the project area of Guilford County. And something one of the teacher told me really stuck with me awhile. She said she spends more time with these kids than their parents do. And that maybe the kids may get worse than their parents. So, the mother, father figure is there one of those, isn't even a factor in their life. When they come to that classroom like they completely change face. They're happy. They come hug her. It's just a wonderful environment. She is so – anything that you can give these kids and feed to them they're going to suck up because as soon as they get home they go and sit in their room and do nothing. Otherwise they will get beat or their parents like, "Shut up while we're drinking" or whatever. So, it's real important to the teacher to know that you might be the only influence on the little kids.

They also noted the need for more continuity and connectivity between health issues and other subjects across the years of schooling. They despised the state of testing in schools and how that affects a teacher's ability to teach in an integrated and thoughtful way.

It's so hard when you have one class of fifth grade. You get one class in middle school. One class in high school. Like that's just not enough to make a difference. You know? Because especially when the classes aren't even that effective. But if you constantly got it at least a little bit, you know, in your science classes you learn these are the effects of something. And let's dissect a frog. And you know things like that that are so much more important than visual and tactile. And they make more sense. I think that would be so much more effective than, "Oh, we're going to sit in a room, or we are going to watch a couple of movies. And I don't care if you go to sleep because I don't care about this anyway."

I think it is also important that in the reading curriculum or so called like math and science and all the ones with the EOCs and EOGs they integrate together really well because it benefits them. But a lot of the arts programs and health it's all the same thing. They're like, "Oh, you guys don't have any course test, and you're not an important class." Our programs are getting cut and everything. I think it's that – if you integrate a program you need to integrate the whole curriculum together. It's going to be more beneficial than just saying, "Well, these are the ones that, you know, you get tested on." And we put so much emphasis on it. These are the ones that are important. The ones we don't test on, no test, they're not important. I think that's another issue.

That goes along with the classes being separated. Because, you know, it's harder to integrate when you've got different kids in every class or whatever. But, you know, if you are able to start in elementary school before they even get separated and then you can try to keep it, you know, even if you have to keep the classes separated if you keep the same ideas and the same concepts going. Then it will still be beneficial to everybody.

It wouldn't kill high schools to actually add health education. Like, yeah, I was in PE and stuff all the way through. Because I remember being a junior and only having my senior English to take. Like that was the only thing I had left because I did the zero periods and the ending, and I had everything done. And I went to my community college while I was in high school. So, I started going to community college my junior year because I was just bored. By the time I had senior year I was driving around to all the middle schools. And I taught ESL to all the Mexican students and stuff that had come in and couldn't speak English. So, I don't even – I even go to school with the exception of like one or two periods a day like my whole last two years of school. So, there is room to do things like there's room for more things.

As future teachers, these young women saw an obvious potential for doing more with health education in schools. Despite their awareness of the testing and curriculum realities, they believed that health could and should play a larger role in the school.

Personal Health

To understand how their health education experiences had shaped their lives, we discussed their personal health issues. Interestingly, all of the participants said that their parents had had the greatest impact on decisions they had made.

I think it has a lot to do with the parents more than school in my case. Because, you know, if I went somewhere my parents would say, "Where are you going? Who are you going to be with and what time are you going to be home? Call me when you're there. Call me when you are on your way home." And like the kids who their parents would just like, "OK, so are you going to home tonight? Or am I going to see you tomorrow?" Or don't ask where they're going, don't ask who they are going with, they were the ones that were more likely, you know, use drugs and do other things. Because, you know, I knew that my parents were going to ask me. And if I was going to go out and do something bad I would have to lie about it. Which I didn't want to lie to them. So, I think in my town it had more to do with parents than school. Because I don't really think they learn through health classes what was good and what was bad. I think it was really what their parents had taught them and having them talk to their parents about what they're going to do. Because I know I couldn't get by with anything. My parents knew everything I was doing.

I mean I think it was more like my parents cared about what I was doing and where I was. And I didn't want to disappoint them by saying, "Oh, well, I was out all night." Or, "I smoked pot last night," or whatever. It was more like not only did I not want to do it for myself but like they cared so much about me and they put those values in my head that I didn't want to disappoint them by saying, "Oh, I've done something that you wouldn't approve of." And I think that and I mean just the fact that I just chose friends who had the same kind of values. Like, you know, it's a parent thing. It's a social thing. I mean it just kind of depends.

While four of the five participants agreed that they chose not to take particular risks out of fear of disappointing their parents, one young woman came from a family that believed in natural consequences for behavior.

My parents kind of had an opposite theory. Their theory was go try it, and when you come back and you're hung over and you feel like crap, guess what? We're still going to make you go to work, and you're going to have to suck it up and deal. And, so, like that was kind of the thing. That and also like I had an older brother who was four years older than me. So, I saw him do everything wrong. And I was like, "Not going to do that one." Check, done. So, I think it's part of the parents. But I think also like so many times that the obese kids and the kids who are doing drugs get written off so much in schools. You know, the teachers just don't expect very much out of them. Because they're in the back, you know, goofing off. And the teachers just don't really reach out and like, "No, you need to pay attention." They're just like, "Oh, they're just stupid potheads, whatever, we'll just keep them in the corner. And as long as they don't disturb anyone else." So, I think they just don't get the – I don't know. They feel like they have to act out in some way to get some form attention because they just get written off so much.

Interestingly, both parenting techniques were effective for avoiding certain behaviors, particularly drug and alcohol use. Also, having older siblings who experimented and then suffered the consequences was noted by three of the five participants as having an effect on their behavior.

I had an older brother who was like 10 years older than me. So, I mean, he was driving by the time I was in kindergarten, whatever. But I think I definitely did see him go through some stuff that I was like, OK, I definitely saw how he reacted to that, and I saw how my parents reacted to that. I was not going to do it. So, I think I mean it's a combination I think. I think it's family. Like I say it's friends. It's social. It's teachers. It's your community. I think everybody kind of has an impact on how you feel about yourself and how you aren't treating yourself.

I think what you are saying about your parents like telling you like, "Go try it and see what happens." Like my parents were always like, "If you

want to try cigarettes come tell us. You know we can, you can do it with us. Tell us, and we'll do it together or whatever." So, that you know that at least knew that it was in a controlled environment. I mean that – I was like, "Who wants to try cigarettes with your parents." You so want to be cool, you know. If I want to be cool, I'm not going to do it with my parents. So, I think I mean I think I kind of had the reverse effect that they were going for. They would probably never going to say, "Yeah, I'm going to go smoke pot with my parents." That certainly isn't going to happen. Especially today like, you know, when we were going up our generation is so about not being with parents and not – just kind of being independent and everything. Like you are certainly not going to go drinking with your mom or something like that.

I think that was kind of the philosophy of my parents, too. Because, you know, we would do things and like I would party in high school. But all the parties would happen at my house and everybody would stay at my house. And everybody's parents knew what was going on. And everybody, you know, nobody would leave. Because the moment that I think that I would have done something that was, you know, a little bit too crazy or dangerous or something like that. Like my parents would have been right there. Like I would never be leaving the house again. And I knew that. Because I knew it's OK within a certain bound. And then once you go past that, it's over.

They also philosophized about why health issues are so marginalized in society. They mentioned the fast pace of our lives, our inattention to our bodies, and the difficulties of using our health care system as factors that affect our health.

We're all like we don't have no time to do anything. Well, parents have no time to cook. So, they are going to, you know, they're going to get fast food or get Chinese take out or whatever they're going to get. And let their kids eat whatever. Or the parents aren't home and the kids are eating whatever they can make for themselves or whatever the babysitter can make or whatever. Like I think we've just become so detached from what we need as opposed to what we have time for.

I think we are taught so many times to like ignore certain things. Because I remember hearing it in an interview with Lance Armstrong who said that like he only realized that like he had cancer – he had all the symptoms but just was ignoring them and like, you know, writing them off as, oh, you know, it must be because of this or it must be because of this. But I think so

many times we learn that we can just write it off because going to the doctor is too much time. It's too much money.

It's not just the time and the money. I just don't like it.

This propensity to ignore the body is perhaps a symptom of the lack of critical health literacy afforded to students in our educational system. The inability to recognize symptoms that something is not right with our bodies, coupled with either misconceptions about medical care and/or the unavailability of high quality care and our failure to understand the larger contextual issues affecting health create conditions where health continues to be marginalized in life.

The last time I went to the doctor was because I almost passed out in the middle of doing a tour because I was just that sick. And finally like my adviser says, "You have to go to the doctor." And I'm like, "I don't want to go to the doctor." And so I think it's – it's got such a bad stigma that we're almost taught, you know, to suck it up and deal unless you know you're dying because it's just too much of a hassle. And I don't know. I think that we should learn that to take signs early, you know, and learn what they mean. And do something about them. Because so many times like I know I ignore signs all the time. Like, "Oh, look, I can't swallow. Oh, well, too bad." And then a week later I find out I had strep throat which is kind of a big deal."

I mean a lot of times we do ignore symptoms and things if we don't view them as being too serious until it gets to the point where we have to. And I think some of that is because I like I know with me like I can't afford to just run into the doctor every time I get a sore throat or whatever. I think there are so many people that can't really afford to go to the doctor unless they absolutely have to. You know, and then they end up having more serious problems than they would have if they had been able to go earlier on. Because by the time it gets serious, you know, you can end up in the hospital and have thousand dollars worth of medical bills as opposed if you would have gotten checked out, you know, in your yearly check up, you know, maybe you would have caught something earlier and not have to do as much. But because, you know, you don't think you can afford to do it every year or every six months or whatever then you are not going to go. And I mean I worry about that all the time. Because I mean I don't

have health insurance. I can't afford to be running to the doctor all the time. So, I mean I think it's good to understand that like, you know, you should check out some things if you think you have something.

Though none of the participants described a personal experience with having no access to health care they were aware of and sympathetic to those who may have problems understanding the system and/or advocating for their own health care needs.

I think so many times like people go in to doctors and they just don't have the education, so they don't realize you know when they could be taken advantage of.

The last time I went to the doctor I went to the urgent care when I had that throat thing. And I went. And this guy came in and they ended up turning him away because he had Medicaid and they couldn't get up with his people or whatever. And as he's walking out the door she's like, "Hey, what's wrong with you?" And he's like, "Oh, I've had chest pain for two days and I had a stroke a couple of months ago." That was the first time that they were like, "Oh, come in." And I'm like if you have had a stroke before and you have chest pain for two days it takes you two days to come to an urgent care. Like, do you not think you would come in before that if you already know that, you know, that this is a possibility?

If we don't have the money to go to the doctor. And we can't go to the doctor because, you know, if that happens and we lose our job we won't have the money to see the doctor anyway. So, it's kind of – it's a vicious circle that, you know, that I think we tend to ignore our health and everything as much as we think we can get away with in order to not lose money or lose whatever so that we can do whatever we do with our, you know, because it's so – everything is just about do I have money for this? Do I have money for that?

Some people might not even know that they are sick. I mean if you are 40 years old and, you know, you grew up in a sewer house or something that you were sick your entire life, and you know you have some nasty disease but that's how you've always felt. You've always thought this is normal, that you wouldn't know to go to the doctor.

Without saying it directly, the students acknowledged that those who are poor, with little formal education, or who are marginalized in society may have both greater health needs and greater difficulty receiving help for those needs.

Discussion

The focus group discussion illustrated in graphic detail the essential problems of health education today. Though the participants came from schools across the state, all had similar experiences in health. The classes were boring, the teachers were disinterested, the content was not relevant and they learned negligible amounts of basic information about their health. Is it any wonder that our state is continuing to experience a chronic disease crisis? This study set out to answer a series of critical questions about health education in our schools. Based on the responses of participants, several of these questions can be answered unequivocally.

Are schools healthy? Is health a priority? Clearly our public schools do not support health. Participants noted poor facilities, unhealthful cafeteria and vending machine food, limited health education classes, and perhaps most importantly, a culture which denies the body and open dialogue about health issues. The young women in the focus group were unmistakable in their belief that their schools had failed to provide them with adequate health education. Health education classes were an endurance test rather than an opportunity to encounter bodily and worldly knowledge and create applicability.

By making health a low priority at school, children learn that it is not important. Since kids spend six or more hours a day at school, this influence looms large in their lives. Without a strong family or personal interest in health issues, a great potential exists for basic health knowledge to be lost entirely. Also, the surface nature of health education fails to fully educate students about their health and the world around them. The discussion in the focus group centered almost entirely on topics found in a typical health education curriculum – nutrition, exercise, sexuality, peer pressure, substance use – none of the larger social issues which impact health (such as poverty, racism, sexism, or homophobia) were mentioned. The participants either have not made this connection or did not see the relationship as pertinent to a discussion about schooling. Though they did briefly touch on issues related to access to health care, the participants never mentioned the environment, media, race, socioeconomic status, or other social factors as having a role in health or health education. I found this particularly startling as all the participants had just completed the Cultural Foundations course for undergraduate education majors where they had spent the semester discussing and learning about social issues.

How does the school environment impact health? While this question was not answered explicitly, the participants did discuss related issues. For example, students were concerned about the quality of cafeteria food, exposure to cigarette smoke in the bathrooms, the lack of physical activity, and the poor quality of their health education experiences. Though no definitive relationship can be made to health status, it is clear that these environmental concerns set the tone for the school culture. The culture, in turn, can have influence over the students' understanding of the priority of health and therefore

the way they interact with health issues in their own lives. Indirectly, the participants made this connection by discussing their own lack of understanding about their bodies and how to care for them.

Schools have an awesome opportunity to influence both the individual health status of students and the larger picture of how health is prioritized in the society. By creating and supporting an environment that is conducive to an open understanding of health, schools can raise the consciousness of students as to the importance of issues which impact our individual and collective health. As the only institution with this broad potential for influence, it is a moral and ethical obligation for schools to examine and implement a strong health education program.

Is health addressed in other settings (home, peer groups, churches, youth groups)? The participants acknowledged learning much of what they know from informal educational experiences – discussions with peers, family members, television, and magazines. They noted a high degree of relationship between their personal interest in a health issue and how much they know or internalized about feelings about health behaviors. This suggests that in order to make an impact on students, health education needs to be made relevant to their lives. Without an understanding of how the issue applies to them individually, students are likely to be bored. To that end, health teachers (in both school and informal settings) must make an effort to understand location, position, and interests of students and engage the students in creating relevant health knowledge. Because the participants noted learning and remembering more from

informal education, these experiences should also be made widely available to children and teens.

Is there a relationship between the health education of youth and the health literacy of young adults? Participants in the focus group were college Sophomores and Juniors and were obviously literate young adults with the advantage of having attended at least two years of college. Despite this advantage, their health literacy was questionable. Certainly, they understood basic health issues as discussed in school health. They were aware of the need to exercise and eat healthfully, and despite being critical of the “Just say NO” lessons in sexuality, tobacco, alcohol and drug use, they appeared to have adhered to those lessons at least somewhat. Around other health issues, including health care, they were less sure and seemed to have not yet mastered the skills needed to question and advocate for better health. To clarify, they did recognize and question the health curriculum and its delivery, but the conversation stayed on the surface of education and did not dig deeper into the social issues surrounding health. These are the skills I believe are needed to begin to impact health in our society.

What role should schools play in helping students promote or protect their health? The focus group participants were quite outspoken in their belief that schools should be more accountable for student health. I chose future teachers as participants for their ability to reflect on both their past experiences and their expectations as they prepare to enter the classroom. In both respects, the participants agreed that health should be a priority. As former students, they felt the impact of boring, uninteresting, irrelevant health education lessons and understood the consequences of a missed opportunity for

learning about themselves. As future teachers, they were hopeful about the possibilities for health education and were committed to the idea of integrating health into their teaching, at least as a surface issue. What remains unclear is their understanding of how to bring the critical understanding of health into schooling. Because they did not make these connections in the discussion group, I cannot speculate about whether they would see that as a possibility. It was quite apparent, however, that they felt that schools and teachers needed to actively take a role in health promotion.

How does schooling affect understanding of the body? What are the effects? The young women in the group experienced similar methods of distancing themselves from their bodies through schooling. They were particularly concerned about the requirement that students must sit in one place for extended periods of time, without acknowledging the body's need to move. As students, they found this to be painful and recognized that long periods in the classroom caused them to have difficulty concentrating, paying attention to the teacher, and learning. They highly favored active, hands-on learning and remembered these lessons as more interesting, engaging and likely to be remembered in the long-term. They also spoke favorably about teachers who had allowed them the opportunity to move during class and had both higher opinions about the teachers and their learning experiences in those classrooms.

The participants also universally experienced difficulties with the expectation that the body's elimination processes be controlled on the school's terms. They related experiences of embarrassment, frustration, and even physical pain because of rules preventing trips to the bathroom. While they understood the teachers' need to exert

control over students who over-use bathroom privileges, they all felt that this was taken to an extreme that ended up humiliating students and forcing students to deny their body's needs.

There is a significant body of literature discussing the ways in which women's bodies are ignored or objectified in our society. The focus group participants did not mention gender differences in regard to denying the body in school and this lack of discussion could be explained a number of ways. It is possible that they were sufficiently schooled in ignoring their bodies that they failed to recognize the issue (they had internalized the oppressor in Freirian language) or perhaps they believed that issues of controlling the body in school are universal, regardless of gender. The latter explanation has merit, particularly as young boys who demonstrate physical expression in school are viewed as potentially dangerous or threatening (especially boys of color). Either way, it is clear that they lacked the insight and perhaps the ability to critically reflect on issues of the body and gender in this process. To be fair, they were not posed questions that explicitly asked for a gender analysis of the body, but if they had already thought about these issues, they surely would have arisen during the discussion.

What is the relationship between knowing your own body and protecting your health? This forced denial of bodily needs was directly related to the participants' understanding of how we relate to our health. They talked repeatedly about denying their own body's signals regarding illness and how they felt they had been conditioned to ignore those signals. They also talked about the pervasiveness of this symptom in our society and mentioned the story of Lance Armstrong as a symbol of ignoring early

warning signs of illness. All of the participants saw this as a significant problem and said that we need a better understanding of our bodies in order to take care of them.

Nonetheless, there was no conversation about how this should be enacted in the classroom. The participants understood the connections between denying the body in school and ignoring the body's signals, but were unsure about how to deal with this in school. They talked about allowing their students to move or to work hard in a short period of time to be rewarded with movement, but deeper conversation about understanding and listening to the body was absent from the discussion. It is possible that this was an underlying assumption, but without making it explicit, it is impossible to know.

This study makes clear the gaps in current health education practice. Health is continually marginalized by the curriculum, the school environment, the teachers, the schooling practices, and the society as we remain in denial of our bodies and the social issues which impact our health. With our low expectations and shallow understanding of the meaning of health to our society, there is no hope for improving health. I believe, however, that we can come to a greater understanding of what it means to enact and support health for all children and that the schools are up to the challenge to take on and deliver a more critical health education. What remains is to understand the means and methods for moving towards a critical understanding of health in our world and how we can each have an impact on making good health a possibility. In the next chapter, I will explore the idea of health literacy and how the development of a critical health literacy

among our society could produce a more equitable distribution of health and health resources.

CHAPTER III

HĚLTH LĪT'ƏR-Ə-SĒ

The ability to obtain, understand, and use the information needed to make wise health choices is known as health literacy (DHHS, 2000). Low health literacy among members of marginalized groups including older adults, people with poor reading skills, those with limited mastery of the English language, members of ethnic and cultural minorities, and immigrants is likely a major contributor to health disparities in this country, according to *Healthy People 2010*.

This fundamental but narrow understanding of health literacy misses much of the deeper meaning and purpose of literacy -- what it is that literacy enables us to do? One research team (Freebody and Luke, 1990) attempted to define the answer to this question by categorizing the types or levels of literacy one might have:

- *Basic/functional literacy*—sufficient basic skills in reading and writing to be able to function effectively in everyday situations, broadly compatible with the narrow definition of ‘health literacy’ referred to above.
- *Communicative/interactive literacy*—more advanced cognitive and literacy skills which, together with social skills, can be used to actively participate in everyday activities, to extract information and derive meaning from different forms of communication, and to apply new information to changing circumstances.

- *Critical literacy*—more advanced cognitive skills which, together with social skills, can be applied to critically analyze information, and to use this information to exert greater control over life events and situations.

In this framework, I am advocating for the development of critical health literacy in our society. People need basic health knowledge in addition to critical skills and empowerment to understand and advocate for their own position and needs, as well as for larger social change. This chapter will explore what it would mean for health education to be critical, based on the works of critical theorists Lisa Delpit, Paulo Freire and Maxine Greene. Contemporary social problems will be used to illustrate how the absence of a critical education has created a void that virtually destines people to be health illiterate and experience ill health. The chapter will also include a discussion about how a lack of criticality about health further marginalizes those already at a disadvantage in the society.

Health Literacy

Health literacy includes the skills and knowledge people need to maintain or improve their health. People with low health literacy often lack not only the ability to read well but also knowledge about the body, its functioning, and the nature and causes of different types of disease (Agency for Health Care Policy and Research, 1997). Low health literacy can affect anyone, regardless of age, race, education or income, but as with most health issues, disproportionately affects those who are poor, have little education, or who are ethnic or cultural minorities. In this way, low health literacy is yet another

symptom of the social issues confronting our country. Apart from the human factor of decreased quality of life, low health literacy costs the nation's health system as much as \$73 billion a year – funds which could more appropriately be used for improving the quality of life for millions of citizens. Leading health literacy researcher Darren Dewalt reported in *Literacy and Health Outcomes* that “patients with low health literacy have poorer health outcomes including knowledge, intermediate disease markers, measures of morbidity, general health status, and use of health resources (Dewalt, et al., 2004). Patients with low literacy are generally 1.5 to 3 times more likely to experience a given poor health outcome. Because the issue of health literacy is widespread and impacts nearly every American, it is perhaps the most significant challenge to improving the health of the nation.

Low health literacy skills impact health status in several ways and create barriers to access and comprehension of diagnosis and treatment options. Those with low health literacy often have greater difficulty understanding their conditions and making decisions related to treatment. An individual's difficulty is exacerbated when their health care providers do not fully understand the degree to which they are lacking in understanding. Beyond immediate health concerns, those with low health literacy are unlikely to understand the social and environmental circumstances related to health, and therefore are unable to voice their concerns and advocate for changes.

Basic or functional health literacy includes sufficient basic skills in reading and writing to be able to function effectively in everyday situations, broadly compatible with

the narrow definition of ‘health literacy’ referred to at the beginning of the chapter (Freebody and Luke, 1990). Poor functional health literacy poses a major barrier to helping individuals manage chronic diseases, and represents major costs in health and life outcomes through inadequate or inappropriate use of medicines and health services (Williams, Baker, Parker, and Nurss, 1998). The consequences for immigrants are especially daunting. Immigrants make up a growing segment of the US population. Approximately 26.3 million immigrants now live in the United States, the largest number recorded in the nation’s history, and a 33 percent increase over 1990 (Camarota, 1999). In addition to the language and cultural barriers faced by immigrants, they also must often contend with conditions of poverty. The foreign-born account for 10 percent of the U.S. population, yet they make up 14 percent of the country’s low-income population (Passel, 2000). While only a small body of literature exists around immigrants and the healthcare system, the existing evidence suggests that immigrants find the system confusing, difficult to access and bureaucratic.

Many societal barriers—including poverty, limited education, low reading levels, and inadequate English-language skills—stand in the way of developing basic health literacy. Beyond gaps in the education and reading skills of Americans, however, additional barriers arise because healthcare professionals often inadvertently make it difficult for lay people to understand what to do. This is directly related to the way our institutions and systems reproduce patterns of social dominance and hierarchy. Medical providers have historically been above questioning and their position as dominant over healthcare consumers has been accepted without much discussion. Also, throughout their

professional education and training, healthcare providers are taught to use precise technical language to discuss body parts and processes, disorders, and treatments—a habit that usually continues throughout their professional careers (AHCPR, 1997). This practice marginalizes many people from healthcare because they have neither the language to understand the orders of the healthcare practitioner nor the power to demand understandable language. The need for change in communication patterns is further being bolstered as the health care system begins to move away from a ‘doctor knows best’ model to one where patients must partner with providers to care for themselves (Scudder, 2006). For years, consumers have been expected to listen to the advice and instructions of providers without questioning. This model has created a power differential – doctors hold the knowledge and the power, while patients are subservient and must obey the orders or else be labeled “noncompliant.” In addition to the routine challenges this system change brings about, patients with low literacy skills are further saddled with the responsibility of recognizing and communicating their lack of understanding. Several studies have already illustrated how ESOL patients are less likely to understand medical instructions and literacy has been singled out as a likely contributor to disparities. Health literacy problems have grown as the health system has become more complex: diagnostic and treatment options have skyrocketed and people are asked to assume more responsibility for self-care (Ratzan, 2006). This knowledge provides a compelling and urgent reason for understanding issues around health basic literacy. To that end, we need infrastructure and supports to create a health literate society. Beyond that, we must move towards a critical understanding of health education

and health literacy. Basic health literacy (where individuals acquire knowledge about health) can provide a foundation upon which we can begin to problematize health disparities and unpack the social constraints placed around health for those in non-dominant social groups. In this way, health literacy can be described as both a goal and an outcome, becoming the currency and capital needed to develop and sustain health (Nutbeam, 2000). In order to build health literacy in our society, we must first examine why we lack health literacy, then scaffold in the supports to help people become critically health literate, making health literacy a tool for social change.

Concepts of Health

Ideas about the nature of health can be broadly described in four categories: traditional/medical, lifestyle/behavioral, socio-environmental, and structural/critical. Each of these concepts carries with it different approaches and ideas about how to improve health. Leading health disparities researcher Dennis Raphael described these differences in a recent lecture; his assessment is summarized in the chart below (Raphael, 2007).

Table 3. Comparison of Concepts of Health

	Medical - Traditional	Lifestyle – Behavioral	Socio-Environmental	Structural-Critical
Concept of Health	biomedical; absence of disease	individualized: health as energy, functional ability	positive state; connectedness to family, friends, community; ability to do things that have meaning	equitable distribution of resources and exercise of political and economic power
Leading Health Problems	disease(s) and risk factors: diabetes, obesity, hypertension, etc.	behavioral risk factors: smoking, eating habits, drug/alcohol use, etc.	psychosocial risk factors and socio-environmental conditions; poverty, isolation, pollution, hazardous living/working conditions	inequitable distribution and control of economic and social power
Principal Strategies	medical: surgery, drug therapy, health care, screening, etc.	health education, social marketing, advocacy	small group development, community development, political action/advocacy, societal change	political action by organized labor and political parties, regulation of business, public policy
Target	High risk individuals	high risk groups, children/youth	high risk societal conditions	influence of wealthy and powerful
General Approach	individualized	individualized, elements of societal focus related to public policy	societal: focused on development of just political/economic policies	structural: focused on political and economic organization of society
Actors	physicians, nurses, allied health	public health, advocacy groups, governments	citizens, social development orgs., political movements/parties	political movements and parties

These ideas have drastically different views of what health promotion (and therefore health education) should be about. These distinctions lead us to ask: Is health promotion about improving medical treatment? Changing lifestyles? Helping people

cope with social conditions? Changing social conditions? According to the World Health Organization, health promotion is the process of enabling people to increase control over and improve their health. This definition requires that health promotion be an empowering process and assumes that social change is an inevitable part of improving human health.

For the most part, however, current health education practice focuses on the lifestyle/behavioral concept of health, while health care practitioners work in the traditional medical model. These versions of health are closely related and both regard individuals as responsible for their own health outcomes. Since we have been operating under these models for at least the past century, this idea of self-determination of health status has become deeply ingrained in our belief system. At the same time, public health practice has found that population-level changes in health have occurred when policies aimed at improving social welfare have been enacted. As research clearly shows, when resources and power are more equally distributed, health disparities are eliminated and measures of total population health improve (Whitehead & Dahlgren, 2006). The real problem lies in how the larger social issues are ignored in education as major contributors to health status.

At the Structural-Critical end of the spectrum, we can understand that it is the imbalance of power that determines who has access to health. As a theoretically democratic society, it would be a reasonable assumption that the power to determine health is in the hands of the citizens of the society. However, our society is democratic

only in theory. Powerful lobbying interests (including pharmaceutical, industrial, tobacco, and other health-limiting entities) have the support and ear of our elected officials who are responsible for making and enacting our social laws. If our representatives had our collective best interest in mind, many social (and therefore health) ills would have long been eliminated.

The most obvious example of how health is marginalized for the benefit of those in power is the tobacco industry. In the mid-1990's, newly appointed FDA commissioner David Kessler undertook a battle to regulate tobacco as a drug. Citing nicotine as having the properties of a drug, Kessler attempted to change legislation to limit tobacco use and protect public health. The tobacco industry rallied and following a lengthy trial in Greensboro, NC, the FDA was not given jurisdiction to regulate tobacco. Tobacco is responsible for hundreds of thousands of premature deaths in America each year and greatly decreases the quality of life for those who smoke or who live with smokers. By exerting their longtime social and economic power, Big Tobacco was successful in continuing to addict and kill our fellow citizens, many of whom use tobacco as a result of already being marginalized in society. The issue is complex, but democracy was certainly not in action. Since only about 20% of the population uses tobacco, and the great majority of both smokers and nonsmokers support laws that limit the use of tobacco and effects of secondhand smoke, clearly the public interest was not served.

In addition to this example, an examination of our current national economic policies reveals a worrisome trend that will certainly cause further health burdens on

society. Specifically, because of the 2001-2003 tax cuts, the wealthiest Americans will receive huge tax reductions costing the nation over \$27 billion over the next five years (2006-2011). The federal budget deficit is expected to increase by \$4.8 trillion over the next ten years primarily due to these tax cuts plus the increased defense and homeland security budgets. In attempt to control this deficit, Congress authorized a \$39 billion cut in the federal budget in 2006. For North Carolinians, this means that at least 24,000 people will lose Medicaid coverage; \$26.9 million will be cut from Elementary and Secondary education; \$7.2 million will be cut from Head Start and services for abused and neglected children; \$2 million will be cut from Child Care Assistance; 1700 families will not get rental housing assistance; at least 22 school nurse positions will be cut; and \$4.5 million will be cut from funds to ensure clean drinking water (Searing, 2005). The health and well-being of our citizenry is clearly not at the forefront of our budgeting practices and the disparities in health we see will continue to widen as the rich get richer and the poor continue to get marginalized.

Before we can begin to address these issues of power, democracy and public good and move towards better health, we must first come to a common understanding of what it means to be healthy from a critical-social perspective. This process will take time and a systematic approach to reaching all the involved parties. I propose that the most practical way of achieving this goal is to first create a health-literate populace that has a comprehensive understanding of health, and the social justice issues associated with the inequitable distribution of health in our society. Once the injustices are recognized, we can more powerfully advocate for change in public policy. This process will require

working across the dimensions noted in the above chart so that medical providers, consumers, advocacy groups, and government entities can together understand and change the social structures which contribute to the inequities.

In order to move towards the place where we can talk about health in this way, we must deconstruct the current state of health education, to understand how to change it. The education system serves the function of reproducing and reinforcing societal structures. At the very outset, public schools were a way to ensure that citizens understood and obeyed the rules of society. While clearly serving the purpose of instilling obedience to authority, schools also (intentionally or not) reproduced the hierarchies of dominance in the society. These patterns are clear even today, some 200 years later. Understanding this structure and how it affects schooling is the first step in deconstructing school health.

School Health Education and Societal Power

Health education curriculum in schools has traditionally been determined by privileged groups. What should be known and how it is taught is based on the experiences of those in power, with little or no input from students, parents, and particularly cultural or ethnic minorities. Content is driven by standards of ‘normal’ for child development and may not reflect the actual needs or interests of particular children and their families. In addition, typical teaching methods for health education are not applicable to real-life situations for anyone – regardless of their race, class, gender, or ethnicity. The usual health education class consists of reading a health textbook, then

answering the questions at the end of the chapter – no practice, no application of concepts, no discussion of what the information means or why anyone should really care about it. These common practices were clearly illustrated by the young women whose stories are told in Chapter Two. Health education as it is understood and practiced in our schools is the antithesis of what I believe to be meaningful health education.

In Other People's Children, Lisa Delpit discusses the way educational practices are created and applied. “In education, we set about solving educational problems as if they exist in a vacuum. We isolate the problem and then seek technical solutions” (p. 93). The result of this system is education devoid of the people it is intended to serve. Students and their parents are marginalized from the outset, because the education is irrelevant to students and is constructed from a top-down approach. This is a manifestation of the way power circulates in our society – those who have power dictate what we should know and how we should learn it. “Traditional bastions of academe distance people from one another as they create power relationships whereby one group maintains the power to ‘name’ the other. They decontextualize people as their research subjects are scrutinized and analyzed outside of their own lives” (Delpit, p. 91). This is certainly the situation in today's typical education as those in power name the educational goals (i.e. test scores) and carefully assess which groups don't measure up to the arbitrary standards. In this case, health is entirely disregarded as insignificant – an untested subject.

The impact of cultural power on our educational practices cannot be minimized. The privileged few are making huge decisions which will have lasting effects on the lives

of children. Sadly, these decisions are too often made without regard for other ways of thinking or being. “The worldviews of those with privileged positions are taken as the only reality, while the worldviews of those less powerful are dismissed as inconsequential. Indeed, in the educational institutions of this country, the possibilities for poor people and for people of color to define themselves, to determine the self each should be, involve a power that lies outside of the self. It is others who determine how they should act, how they are to be judged” (Delpit, p. xv). Not only does this circumstance set up a singular “right” way of being, it destines kids for failure. Human beings are naturally diverse in learning styles, thought processes, cultural practices, belief systems, and development (among other characteristics). To expect that all people should be able to master a narrow set of concepts in a specific time frame and through a certain teaching practice is problematic. Whose interest does this serve?

Delpit talks about the “Culture of Power” in schools. She lists a set of five rules that we need to acknowledge to discuss the way power makes people’s truths unimportant in the classroom.

1. Issues of power are enacted in classrooms
2. There are codes or rules for participating in power; that is, there is a “culture of power.”
3. The rules of the culture of power are a reflection of the rules of the culture of those who have power.
4. If you are not already a participant in the culture of power, being told explicitly the rules of that culture makes acquiring power easier.
5. Those with power are frequently least aware of – or least willing to acknowledge – its existence. Those with less power are often most aware of its existence. (Delpit, p. 24)

Delpit argues that those who are usually marginalized (children and families that are poor and/or people of color) benefit when they are told the rules of the game. If they

understand the expectations, they can then negotiate (or accommodate) the system to succeed. For health education, this includes understanding the rules for defining health, the outward behaviors associated with ‘good health’ practices, and how the health care system works in our society. In Delpit’s understanding, this is where the cultural rules are made explicit. She would also advocate for students, parents and families to be consulted in determining educational practices and processes to ensure that all voices are heard and their needs are appropriately met.

In education, this means that the students and their families must be able to understand the rules of the schooling game, who made the rules and how those rules impact them. Once they have named those things, they can engage in negotiating for change – for education that provides meaning for them. This results in a shift of power. When the rules are made explicit, the students and their families can assume some power and use it to advocate for change.

The enacting of power plays a significant role in health outcomes. What is taught in health education, how it is taught, and the underlying assumptions in determining the answers to those questions has the potential for a major impact on the health and quality of life for children and their families. The North Carolina “Healthful Living” curriculum was conceived in the mid-1990’s as a way to instill “healthy life skills” in NC students. While the curriculum is an attempt to define health, because it was developed without the people who it serves, it is conceivably negligent in helping kids develop the knowledge and skills needed to live the best quality of life possible. In addition, the curriculum is

based solely on the biomedical model; there is no acknowledgement or discussion or societal influences on health at any grade level.

Delpit argues that, “Students need technical skills to open doors, but they need to be able to think critically and creatively to participate in meaningful and potentially liberating work inside those doors” (Delpit, p. 19). Applied to health education, students need some core knowledge about their bodies, how they function, and how to care for them, but more importantly, they need the skills to seek health knowledge throughout life, to negotiate our complex health care system, to care for future children or family members, and to advocate for healthful conditions in their workplaces and communities when they grow up. Acquiring these skills means that children need relevant education – learning methods and content that are interesting and applicable to their daily lives. How can this be possible if health education curriculum is determined by an elite, highly educated group of people, governed by the misguided bastions of power that are the state legislatures? Where are the people in this process?

People need basic health knowledge in addition to critical skills and empowerment to understand and advocate for their own position and needs. This health education should be wholistic, culturally sensitive, needs-based, and most importantly, relevant to children and their families. This type of education necessitates a process of reaching out to students, families and communities to understand context, and gain input on what the education should look like. “Appropriate education for poor children and children of color can only be devised in consultation with adults who share their culture”

(Delpit, p. 45). The same is certainly true for immigrants and other minority groups. Educators must truly know their audience in order to teach effectively.

Drawing on Lisa Delpit's work, the only way to accomplish the latter objective is to involve students and families in the development and enactment of the curriculum. "The key is to understand the variety of meanings available for any human interaction, and not to assume that the voices of the majority speak for all" (Delpit, p. 20). She is especially critical of the way minority opinions are left out of the education discussion and urges careful inclusion of multiple perspectives. "It is time to look closely at elements of our educational system, particularly those elements we consider progressive; time to see whether there is minority involvement and support, and if not, to ask why; time to reassess what we are doing in public schools and universities to include other voices, other experiences, time to seek the diversity in our educational movements that we talk about seeking in our classrooms" (Delpit, p. 20)

We must also carefully consider the humanity of all children and how our educational practices dehumanize and remove us from living in our bodies, in the present. As discussed by the college students interviewed for the study outlined in Chapter 2, traditional schooling practices mandate that children must learn to control their bodies and conform to others' standards of bodily experiences. For example, the most frequently mentioned example of this idea is when students are required to use the bathroom facilities on a set schedule, rather than according to their body's signals. This learning process, while seemingly benign, teaches children to ignore their bodies and put real needs aside in order to obey the rules of the classroom.

Too often, I believe, we rely on statistics to understand health problems while forgetting about the impact of health on human lives. “It is the result of coming face-to-face with the teachers, the psychologists, the school administrators who look at ‘other people’s children’ and see damaged and dangerous caricatures of the vulnerable and impressionable beings before them... We live in a society that nurtures and maintains stereotypes: we are all bombarded daily, for instance, with the portrayal of the young black male as monster” (Delpit, p. xiii). When curriculum is designed in a removed, abstract way and delivered in a robotic, impersonal format, how can we expect it to make a difference? “The answers, I believe, lie not in a proliferation of new reform programs but in some basic understandings of who we are and how we are connected to and disconnected from one another” (Delpit, p. xv)

The practice of health education is in desperate need of connecting students to each other and to the world. Teachers and public health practitioners wonder why we see epidemics of obesity, substance abuse and eating disorders. Clearly, multiple factors are at play, but certainly a more engaging style of educational practice could make a difference in how health is understood and practiced.

Health Literacy and Schooling

According to the young women in the school health education focus group I conducted, our schools are doing a dismal job of teaching basic health literacy, much less a critical understanding of health. In studies of functional health literacy nationally, about half of the population has inadequate health literacy – that is, the ability to

understand and carry out basic instructions for maintaining their health. In a recent mini-study I conducted in Greensboro, NC, this statistic was also borne out. Half of the patients interviewed in an internal medicine clinic could not complete the Short Test of Functional Health Literacy (STOFHLA). This instrument indicates the ability to read and understand simple terminology that one might encounter in health education literature, a physician's office or hospital, nothing more. If our fellow citizens have this little knowledge about basic health issues, it is doubtful that they are comfortable asking questions about their health, much less the societal influences on their health status. Without at least some fundamental knowledge, they are certainly not in a position to advocate for changes to our health education or health care systems.

How have schools contributed to inadequate health literacy? The disengaging teaching practices, irrelevant curriculum, and lack of critical examination of health issues have prevented students from even a rudimentary engagement with health issues, much less the development of critical health literacy. As long as the curriculum is pre-determined by the legislature, and governed by policies such as "No Child Left Behind," there is little hope for creating a health curriculum that supports the development of health literacy. Students, parents and communities must be involved in shaping and implementing a meaningful health education experience.

Critical Pedagogy and Health Education

Critical pedagogy is concerned with the use of democratic, dialogical teaching to empower students to change the world. It is grounded in the notion that a critical

examination of social issues, coupled with personal reflection, allows students to assign meaning to the process of making knowledge about themselves and the world. This type of education transforms students into agents of change who are empowered and emboldened to advocate for social improvements. Critical pedagogy is political by definition and relies on understanding power as a force to both oppress and liberate. The key is to think critically and dig deeply into questions of why things are as they are and whose interest is served by the status quo?

Critical Pedagogy and Oppression

Critical pedagogues point to oppression of people as the starting point for creating knowledge about the world. By using critical thinking skills to name and dialogue about the world and the oppressors, students can begin to understand the role of social power in shaping their understanding of the world. Though American schools are not outright violently oppressive (in the sense that students are not physically punished for disobedience), Ira Shor describes a system that is passively violent and oppressive to most students. “This environment is symbolically violent because it is based on manipulation and subordination. It openly declares itself ‘democratic’ while actually constructing and reproducing inequality. The advantages of the elite are hidden behind a myth of ‘equal opportunity’” (Shor & Freire, 1986, p. 123). This type of oppression is so insidious as to be virtually unrecognizable to those within its grips. We accept that our great democracy is looking out for our best interests while suffering the ongoing violence of forced curriculum standards without the voices of the people. Our schools are not (and

never have been) democratically run and in many instances, input from the community is met with anger and disrespect. For health, this leaves us being force-fed the biomedical model of self-determined health as the dominant voice for understanding health. Since health education is further deemed unimportant as an untested subject and is devoted only marginal instructional time, there is no opportunity for raising the status of social issues as they relate to people's lives and health.

In Pedagogy of the Oppressed, Paulo Freire talks about the process of naming the world as the first step to becoming liberated from oppression. Freire contends that all people seek freedom, and that education is the key to unlocking liberation. He describes the process of rising out of dehumanization, in which the oppressed must first name the world. Through education, the oppressed perceive oppression as a "limiting situation which they can transform." "[The oppressed] discover that without freedom they cannot exist authentically. Yet, although they desire authentic existence, they fear it. ... This is the tragic dilemma of the oppressed which their education must take into account" (Freire, p. 48). Inherent in this transformation is the belief that every human being can learn and think critically and that the world is not static. Change is a possibility.

In *Pedagogy for Liberation*, Ira Shor and Paulo Freire discuss how the idea of liberation can be seen as unnecessary for American students (as a democratic society), but the authors go to great lengths to uncover the various ways American students are oppressed. "The wealth in the North only disguises great manipulation, domination in the culture... with ruling elites as privileged minorities who command the whole society ... they hide their control by naming their interests as national ones" (Shor & Freire,

1986, p. 139). In particular, our American economic policies favor big business and ignore the needs of citizens. The power of the wealthy elite is exercised to maintain and even expand their social domination. For example, recent tax relief legislation (2003) was aimed at helping the wealthiest citizens while falsely touting the benefits to the entire population, particularly the poor. In education, we have been schooled to believe that those in power are looking out for our best interests and that we are personally responsible for our lot in life--if we work hard enough, we can achieve wealth and enjoy the privileges of power and comfort. This takes the blame off of social and economic policy and places it on individuals. This concept transfers precisely to our health education system and the biomedical model for understanding health. We are solely responsible for our own health and that health problems are a result of our personal failure to preserve our health.

Freire and Shor explain that the signs and symptoms of oppression are present in American classrooms. "The widespread disorder in school means that the process is resisted by many students" (Shor & Freire, 1986, p. 124). "They don't know how to make organized demands for change. Instead, they get better and better at aggression and sabotage, or they fall into deeper silences, or more drugs and alcohol" (Shor & Freire, 1986, p.125). This evidence is certainly present across America today in all communities, regardless of differences of class, race, ethnicity, and urban or rural location. In particular, the standardized curriculum and testing required by No Child Left Behind has left students with virtually no ability to choose their own educational course and become fully engaged in learning. Locally, high school students have lost the ability

to choose virtually their entire course of study. While the state mandates the number of credit hours required for each subject for graduation, the local system has further restricted choices by placing all students who qualify for Advanced Placement in those courses, regardless as to whether they want or need the courses for their future education. This process gives the appearance of highly capable high school students in the district, but neglects the limited opportunities students have to study the subjects that nurture their interests. Logically, if students were engaged in the learning process and were fulfilling their authentic ontological vocation of freedom and self-determination, the signs of unrest Shor speaks of would not be present in the great numbers currently seen.

Critical pedagogy and critical thinking

Freire specifically explains why critical thinking skills are crucial to the liberation of the oppressed. "...apart from inquiry, apart from the praxis, individuals cannot be truly human. Knowledge emerges only through invention and re-invention, through the restless, impatient, continuing, hopeful inquiry human beings pursue in the world, with the world, and with each other" (Freire, p. 72). Freire further contends that the "banking" type of educational system (as is typical in health education) does a great disservice to the oppressed by preventing them from developing the ability to think for themselves. "The more students work at storing the deposits entrusted to them, the less they develop the critical consciousness which would result from their intervention in the world as transformers of that world. The more completely they accept the passive role imposed on them, the more they tend simply to adapt to the world as it is and to the fragmented view

of reality deposited in them” (Freire, p. 73). This methodology allows the oppressors to continue in their role without challenge. “The banking concept of education ... transforms students into receiving objects. It attempts to control thinking and action, leads women and men to adjust to the world, and inhibits their creative power” (Freire, p. 77). Without the freedom to think critically and creatively, people are forced to adapt to oppressive situations. They cannot even question the situation, much less move themselves towards liberation.

The idea that change is good and that people must seek critical inquiry permeates Freire’s thinking. Indeed, Freire sees this as the only way to liberation from oppressive situations. “If men and women are searchers and their ontological vocation is humanization, sooner or later they may perceive the contradiction in which banking education seeks to maintain them, and then engage themselves in the struggle for their liberation” (Freire, p. 75). As before, liberation is the ultimate goal for the oppressed. This liberation is clearly defined -- “Liberation is a praxis: the action and reflection of men and women upon their world in order to transform it” (Freire, p. 79) – and is impossible without the development of critical thinking skills.

Inherent in developing critical thinking is an assumption that the difficult issues in our world are obviated, brought to the fore and discussed with fellow learners. Second, those with authority (teachers, parents, administrators, youth group leaders, etc.) must model democracy, love, compassion, and concern for others through their words and actions. Without seeing how a more just world can be enacted, it is difficult, if not impossible for us to engage with the issues and see a vision of how things could be.

Applied to health education, both Freire and fellow critical pedagogue Maxine Greene would advocate reflection to understand the conditions and social forces that both encourage and inhibit health. Understanding some critical concepts including media literacy; United States and world history; the ways power is used to marginalize groups of people; responsibility to the earth and the environment; and the strength of the human spirit to connect and unite all people run counter to traditional health education and the American education system, but would ground students and prepare them to become advocates for themselves and for others. A larger understanding of health and society would allow us to see ourselves and others more fully and would create openings for understanding both our individual health symptoms and the warning signs of societal illnesses. Instead of blaming those who are poor, or immigrants, or minorities, for their health problems, we can instead see the social issues that limit health for these groups of people. Instead of expecting that each individual is responsible for becoming health literate, we can understand that social, medical and political systems converge to make certain groups more susceptible to experiencing low health literacy. Instead of locating problems within individuals, we can see the big picture and act to change the systems which continue to oppress and marginalize our fellow citizens. This connected understanding of our selves and our context in the world is a part of understanding our humanity and that of others and the beginning of creating a wholeness that supports and encourages human health. Without this connectedness, we will continue to demonize those who are different or whose contexts we have failed to understand.

Critical pedagogy and dialogue

In terms of educational practice, many teachers have a concern for engaging students. However, institutional structures and curricula seem to go out of their way to disaffect and disenfranchise youth and those who seek to educate them. “If practices define possibilities, all of these elitisms [hierarchical, dialogic, and praxical] assume that the teacher already understands history, and people’s positions within it better than they do” (Shor and Freire, p. 92). Because of this practice, history is made with the available information and limits to that information, resulting in a struggle to construct discourse. This is certainly true of health education, where it is based on teacher and/or curriculum writers’ experiences and patriarchal edicts about right and wrong behaviors. There is no room for discourse based on students’ knowledge about themselves and the world.

The education system in America is guilty of denying students a liberatory education, even through post-secondary schooling. This seems contrary to the purpose of higher education, however, in most large universities, professors lecture to enormous classes, while graduate students lead smaller class discussions. “Professor contact is reserved for graduate students, or undergraduate majors, or honors classes, or for students at the most costly universities where money is invested in small classes for the elite. In the lower grades, richer school districts and private schools also offer their students smaller classes to give students more personal attention” (Shor & Freire, 1986, p.98). The current system makes it nearly impossible for enacting critical health education.

Large class sizes, coupled with proscribed curriculum allow little opportunity for dialogue and meaningful interaction with the issues.

Why is this so? If “dialogue is a challenge to the existing domination” as Freire says (Shor & Freire, 1986, p. 99), then American students are clearly being dominated and taught to quietly do as they are told. If “the right to have a small discussion begins as a class privilege” (Shor & Freire, 1986, p. 98), then the lower and middle classes have been systematically shortchanged in their educations. If America is to experience social change through education, then we must first practice liberating pedagogy in our classrooms. Before we can reach a state of criticality, we must press for smaller classes, open dialogue, student participation in the curriculum and the freedom for teachers to teach as they see fit.

Achieving a critical educational experience requires an educator who is dedicated to the give and take of a dialogical discourse. According to Freire, dialogue is the main tool of the educator in building liberated people. “Dialogue is the encounter between men, mediated by the world, in order to name the world” (Freire, p. 88). This process is crucial to the oppressed’s ability to realize their ontological vocation and is a difficult one for both the educator and the student. The teachers must put down their personal views and agendas in order to be solidary with the students. In fact, for true dialogue to happen, the educator must act with great and humble compassion in order to earn the trust of the student. “Founding itself upon love, humility, and faith, dialogue becomes a horizontal relationship of which mutual trust between the dialoguers is the logical consequence” (Freire, p. 91)

In terms of health education, what could be more effective? If educators are acting out of love and dialoguing with students, a true opportunity exists for relevant, empowering education. Too often, health educators take a binary view of health. One set of behaviors is “good,” another is “bad.” There is little room for discourse or fuzzy boundaries – you either choose healthy behaviors or not.

Freire speaks to this problem too. He notes that an important aspect of the dialogical educator is the ability to suppress personal opinions. “It is not our role to speak to the people about our own view of the world, nor to attempt to impose that view on them, but rather to dialogue with the people about their view and ours” (Freire, p. 96). This dialogical interaction allows both the educator and the oppressed to seek understanding of one another and problem-solve to change an oppressive situation. This process is critical to liberation. Freire continually points out that dialogue is the only means to education and liberation from oppression. “Only dialogue, which requires critical thinking, is also capable of generating critical thinking. Without dialogue there is no communication, and without communication there can be no true education” (Freire, p. 93).

This follows naturally to health. There are, of course, medical facts and bodies of knowledge that explain the human body, disease processes, and what is technically needed to maintain various functions of life. However, an opportunity exists for dialogue around how that knowledge is used. What does it mean to individual students? To their families? To their context in life? These types of questions require critical thinking skills and exploration with an authentic, concerned educator.

Critical pedagogy, power & politics

Critical pedagogical methods are ultimately political in nature and are driven by a need to change the status quo. By uncovering the inequalities, inequities, and disparities, we become more awakened to the injustices and theoretically begin to act to change the world. Paulo Freire argues that those in power are driven by money and the desire to have more, which causes them to see people as objects, rather than fellow human beings. “Humanity is a ‘thing’ and [the oppressors] possess it as an exclusive right, as inherited property. To the oppressor consciousness, the humanization of the ‘others,’ of the people, appears not as the pursuit of full humanity, but as subversion” (Freire, p. 59). In this way, both the oppressors and the oppressed lose their humanity, and both are then unable to act with justice and genuine generosity. Resource distribution is a function of power – those who hold power determine what is important and therefore how resources are allocated. As the US income gap continues to widen, those who are most advantaged socially and financially make the rules for social welfare. As they continue to accumulate more, they see less and less value in providing for the needs of the disadvantaged. American history is rife with examples of how this system of resource distribution has effectively marginalized various groups of people, contributing to the wide disparities in health we witness today.

Maxine Greene also pushes us to consider what systems are at the root of society’s problems. She is interested in exposing the political nature of schooling. Greene challenges the hegemonic forces that control our schools and urges a definition of freedom that recognizes the fact that we can refuse the dominant ideology. She defines

freedom as a struggle against an obstacle which forces us to make choices. In this sense, freedom is not a state of being, but rather a process of continuous struggle against the injustices in the world. She calls this process the dialectic—the struggle between human possibility and the forces that control and shape our society.

Critical pedagogy and transformative education

Critical theorists call educators to action to bring about change and meaning in our world. Freire ardently states that critical education is the key to transformation. He is clear that teachers must take an active role in the process and transform themselves in order to work dialogically with students toward liberation. He urges teachers seeking to enact transformative education to understand that personal reflection is critical to the process and is necessary for both the teacher and the student. A transformative education then, is a process in which teacher and student can together come to a better understanding of themselves and the world, and the multiple truths of humanity. In a safe, engaging and open educational setting, individuals can have the freedom to speak about their experiences and understanding of the world. Under these circumstances, teacher and student(s) can modify their understandings and incorporate the new knowledge that has been created into their system of beliefs. If the door is opened to a greater understanding, we then have great reason for hope. That is the ultimate meaning of a transformative education – when individuals have become more wide-awake, they can collectively work towards a more humane society for everyone.

Maxine Greene also talks about transformation. She tells us that there is no T Truth, but we increase our understanding from being exposed to multiple t truths. Greene notes

that the first step to changing the world is to see things from another perspective.

Teachers and schools can play a major role in broadening our understanding of the world and learning about the lives and truths of other people, if the policies and practices of schooling allow this deep and broad view of education. This type of education is a first step in the process of transforming the world; without an understanding of other people's truths, we cannot imagine a world other than the one we inhabit, nor see the injustices as they are played out in the lives of others. We can only see the "Truth" of hard work and personal responsibility as the means to success.

The oppressed (in this case, students and their families) must engage in a struggle for liberation. "This pedagogy [*with* the oppressed] makes oppression and its causes objects of reflection by the oppressed, and from that reflection will come their necessary engagement in the struggle for liberation" (Freire, p. 48). This pedagogy has two parts. First, the oppressed must "unveil the world of oppression and through praxis commit themselves to its transformation" (Freire, p. 54). Second, the pedagogy becomes entrenched in the society, and so belongs to all the people in process of permanent liberation.

For health education, students must be able to encounter the competing social forces which play a significant role in health outcomes. By recognizing and understanding the social constructs which help define and limit health, students can begin to see the possibilities for change and launch advocacy efforts towards those changes. To see the possibilities, we need only look at the progress in environmental education begun with the first Earth Day over thirty years ago. While we still have miles to go before our

environment is sufficiently protected, this movement has been catching on and has resulted in major changes in factory and automobile emissions, protection of endangered species, and improved water quality for many lakes and rivers. Earth Day was the brainchild of Wisconsin Senator Gaylord Nelson and was first celebrated in April 1970. When reflecting on the tenth anniversary of Earth Day, Sen. Nelson said, “It was on that day that Americans made it clear that they understood and were deeply concerned over the deterioration of our environment and the mindless dissipation of our resources. That day left a permanent impact on the politics of America. It forcibly thrust the issue of environmental quality and resources conservation into the political dialogue of the Nation. That was the important objective and achievement of Earth Day. It showed the political and opinion leadership of the country that the people cared, that they were ready for political action, that the politicians had better get ready, too. In short, Earth Day launched the Environmental decade with a bang” (Nelson, 1980). This type of global awareness of how the health of humanity is connected to the bigger world is required to advocate for and enact the type of social and political changes needed to bring justice to society and is a small example of how critical health education can bring about change in the world.

Critical pedagogy and democracy

The need for democratic instruction in schools is demonstrated over and over again by the lack of civic engagement of our citizenry, along with our propensity for accepting things at face value, rather than questioning the deeper meaning or intent. For example, our current media are flooded with “reality” television programs, airbrushed

images of “ideal” human specimens, and pervasive messages that the ability to consume more equates with achievement. Most of us lack both the ability and the desire to question these ideas, and rely instead on habits of mindless consumption learned through our schooling, resulting in the dichotomous, divisive society we are currently experiencing. Rather than questioning the messages we receive from media, colleagues, and political leaders, we either agree or disagree completely, rather than examining the gray areas in between. This process damages our humanity and creates a cycle where we fail to see others for their human worth, but instead relate only as contrary and opposite forces in the world. Svi Shapiro, in his recent book “Losing Heart” gets to the heart of the importance of democratic schools when he asks, “Is it not the role of education in a democracy... to cultivate the Socratic art of questioning? Was not the very essence of a democratic culture one where citizens had the willingness and capability to challenge the things that were being presented to them, to unearth its basic assumptions, and to ask the question—who benefits from keeping things the way they are?” (Shapiro, 2006). He goes on to assert that the ability to critically question and examine issues is the basis for a *meaningful* democratic life. This ability to create meaning and to achieve an authentic ontological vocation is the true hallmark of a successful education.

Ideological Discord

Freirian pedagogy seeks to liberate people from oppression through education by creating conditions for social transformation. “But in action, the goals of liberation or opposition to oppression have not always been easy to understand or achieve. As

universal goals, these ideals do not address the specificity of people's lives; they do not directly analyze the contradictions between conflicting oppressed groups or the ways in which a single individual can experience oppression in one sphere while being privileged or oppressive in another" (Weiler, 1991, p. 450). By locating individuals in their context(s), we can instead see the various social, cultural, environmental and institutional forces which shape and influence behavior. "The intersectional lens refocuses our perspective on health and illness in several important ways. It invites us to understand race, class and gender as relational concepts: not as attributes of people of color, the dispossessed, or women but as historically created relationships of differential distribution of resources, privilege, and power, of advantage and disadvantage" (Schultz & Mullings, p. 346). This allows us to see that the ways in which resources have historically been distributed plays a significant role in the development of health, not simple voluntary lifestyle choices. Traditional health education not only ignores a contextual understanding of health issues, but even blames those who are disadvantaged for not having the "willpower" to follow the prescription for healthy living.

If we agree that there are essentially three forms of knowledge: instrumental, interactive, and critical (Park, 1993), then we can see that health has focused purely on the instrumental. Instrumental knowledge is developed through traditional scientific methods and is akin to the biomedical model of understanding health. Interactive knowledge is derived from sharing lived experiences and understanding the connectedness of humans. Critical knowledge comes from reflection and action on what is just and right. To move towards critical knowledge in health education, we must adopt

the methods and theories of critical pedagogy to bring about a contextual understanding of health for individuals and groups, an appreciation for multiple truths and a vision for social change.

Based on an individualistic view of health and reinforced by the banking style of education, there has been no opportunity to envision a critical epistemological view of health education. This instrumental view of health knowledge, coupled with the biomedical belief system that labels lifestyles as right or wrong feeds directly into our society's understanding of the self. The American view of rugged individualism as the ideal has prevented a more critical understanding of health.

The American myth of success and personal responsibility has its roots in our Puritan ancestors who believed that success was a function of moral living and hard work. "The idea that ours is an open society where birth, family, and class do not significantly circumscribe individual possibilities has a strong hold on the popular imagination and reflects what millions believe society is or ought to be" (Sandlin, 2004). Our capitalist economy contributes to and reinforces our sense of individualism. It is much too easy today to only be concerned about our own private lives. Capitalism encourages us to spend and consume to make *our* lives better – as if where we stand and what we own is never sufficient – there is always something better, newer, improved, or miraculous that will make us smarter, more attractive, richer, happier or help us achieve a higher social standing. As we get caught up in this frenzy of consumer fetishism, we cannot (or at least do not) take the time to understand why we are compelled to behave in

this fashion. We certainly don't think about the impact of our actions on others or the environment, and when those questions are raised, they are immediately quelled by society's messages that tell us that "it's the American way" or "we have the freedom of choice" or some other nonsensical explanation for our obsessive consumer behaviors. Health is marginalized from this scenario as an afterthought – something to think about only when you are afflicted with illness or when health is equivalent to image – certainly not something to be concerned about unless it affects you personally. Our sense of the common good has been grossly warped and applies only if it benefits us. As public health is about the common good at its core, we are failing to support the members of our society and instead are allowing them to fend for themselves.

A real education involves confronting our fears, hopes, anxieties and beliefs and undertaking a struggle to find meaning in our lives. In becoming critically aware of the powerful social forces that contribute to our individual ways of being, we can thoughtfully make choices about how we act in our world and in how we act *on* our world. A critical social consciousness enables us to see injustices personally and hopefully makes us want to change the world into a more just and healing world for all people. Health literacy education is merely a tool that can be used to deconstruct the various causes and forces that have made things as they currently are and how our individual and collective health has been impacted by these processes. The importance of this tool is significant; comprehensive critical health education is greatly needed in order for young people to understand and exert control over situations which affect their health and quality of life.

Critical theorists remind us how to be better members of the human race and force us to reflect on our own practices and ways of being in the world. The ability to think critically is perhaps the most important tool we can use to work towards a healthier society. In particular, consumers need to be able to deconstruct the images, stories, ads, music, television shows, and movies we encounter and find the intent and positionality of the originating source. Otherwise, we are just happily taking in what is fed to us and accepting it at face value. In my work with tobacco prevention, media literacy education has been a successful tool in helping middle and high school aged youth understand the force exerted by the tobacco industry to pull youth into a culture of tobacco use acceptance. In a short time, kids are able to critically examine magazines, television and other media sources and extract the hidden messages. This skill needs to be accessible to all of us as global citizens, and it needs to be taught at an early age. I think about my own young daughters, who are probably somewhat sheltered from the media relative to others their age, but still feel the influences on a daily basis through children's literature, public television, and interaction with peers. Because we have discussed the health and environmental ills of tobacco, they are particularly attuned to tobacco issues. When we read or watch television or movies together, they are quick to notice any characters using tobacco and immediately start asking questions. We can then discuss product placement issues and talk about why tobacco companies might want kids to see these images. I think this process is of paramount importance, not just in protecting children's health in the tobacco example, but for developing critical thinkers who can question all of the messages they receive, dissect them and understand where they are coming from. This is

the only way we can combat the marketing forces intended to push us into an addicted frenzy of consumerism and prevent us from focusing on the real issues that face us as a society.

To begin to construct this radical vision for health education, we as health educators, must embrace a contextual view of individuals situated within intersecting and competing social, environmental and cultural conditions. The dominant view of health as a function of individual behavior choices is insufficient for pursuing real solutions for complex problems rooted in social locations. We must instead press for a broader understanding of health and advocate for changes in social conditions to improve health for all people.

Health education must be critical if people are to acquire the skills and knowledge they need to apply basic health concepts to their everyday living. If health education continues to focus only on a limited set of health issues (nutrition, exercise, substance abuse, etc.), an opportunity is lost to help students understand and improve their lives. Not only are students bored by hearing the same lessons repeated ad nauseum throughout their schooling careers, if the lessons are not relevant, the content is lost regardless. It is time to address the difficult issues posed by a critical examination of health. Why do such vast disparities exist between groups of people? How does being poor or black or Hispanic put individuals at a higher risk for substance abuse, violence, obesity, heart disease, cancer, or teen pregnancy? These disparities are not the result of genetic or cultural differences but are the manifestation of socially constructed conditions that marginalize people and prevent access to health. The questions posed here are not for

educational researchers and theorists to tackle from the ivory towers. They are questions that should be lived in the classrooms, where students and educators can critically examine the social and cultural aspects of health and what it means to them personally.

The social issues facing us as global citizens are beyond the grasp of most people at present. Not because we cannot understand, but to even begin to appreciate the ways in which we are influenced requires an almost constant, serious study of global happenings. This fact, coupled with the rapid pace of daily American life, leaves little time for understanding, much less reflecting on the dangerous forces influencing our daily decisions. To be an engaged citizen in today's society requires a strong grounding in a number of important elements typically absent from the American education system, particularly an understanding of our humanity. This human factor is what allows us to connect to the stories of others, feel empathy for them and motivate us to try to change things, and this is what seems to be the most important element for citizenship education. Once we can understand and truly see the "other," we can more easily transcend our self-absorption and feel the presence of our fellow global citizens. The development of a humane health education curriculum can help us progress towards that goal.

Towards Truly Comprehensive Health Education

In order to move towards a society which embraces critical health literacy for all citizens, we must first embark on changing our schooling practices to include a focus on truly comprehensive health education. We need all three types of knowledge about health – instrumental, interactive, and critical – to thoroughly understand our individual

and collective health. This type of education would include critical pedagogy examining issues such as poverty, racism, institutional power, history, capitalism and how they impact health care, health disparities, intersections of health issues and socially constructed categories of human beings. It would also include understanding some core knowledge of the body, such as the proper names and function of body parts, and learning how to listen to the body's signals. Finally, comprehensive education would examine health system issues including power and self-advocacy and understanding one's rights and responsibilities.

What would this look like? “[Parents] want to ensure that the school provides their children with discourse patterns, interactional styles, and the spoken and written language codes that will allow them success in the larger society” (Delpit, p. 29). For health education, this might mean role playing for interacting with health care providers, field trips to health care clinics, and explicit teaching about the power roles played out in health settings. “Students must be taught the codes needed to participate fully in the mainstream of American life, not be being forced to attend to hollow, inane, decontextualized subskills, but rather within the context of meaningful communicative endeavors; that they must be allowed the resource of the teacher's expert knowledge, while being helped to acknowledge their own ‘expertness’ as well; and that even while students are assisted in learning the culture of power, they must also be helped to learn about the arbitrariness of those codes and about the power relationships they represent” (Delpit, p. 45). Health education should not be, “read the chapter and answer the questions in the book” week after week after week. This typical teaching method not

only relegates the content to the back of the room, but also fails to engage students in any meaningful way.

Students have a wealth of knowledge about health just by virtue of living with and around other people. They experience the effects health, disease, and disability on a daily basis. Tapping into this expertise and making health relevant creates an opportunity for real education. It also recognizes their capability to understand their own self and their own context. This experience in being an “expert in myself” can build self-esteem and empower students to advocate for themselves throughout life.

A transformative health education would lead to breaking down the societal barriers that prevent healthful conditions for those who have been marginalized. Health itself would be redefined as much more than an individual’s health status, but would also include social and environmental conditions that impact health and well-being. Rather than understanding health as a condition of behaviors or choices, we would understand the social forces that create health conditions and force individuals and groups into less healthful situations.

Public health as a discipline is facing the crossroads of social determinism and self determinism. For decades, health promotion has focused on understanding human behavior as driven by a combination of education and choice. Without an understanding of social factors, this work is incomplete. The next era of health education must understand and embrace a contextual understanding of both individuals and groups within the social structure, political forces, and dominating ideologies. By integrating

this new understanding in our schooling process, society will begin to experience a transformation that protects and promotes health for everyone.

Our challenge is to begin to transform the practice of health education so that young people and their families can begin to understand the social issues influencing them and others in the world. This first step will create the base of the scaffold for developing advocates for a healthier world, which in turn will affect the policies and practices of our legislators and public administrators. The next chapter will examine health disparities as a function of public policy and will outline policy goals for achieving health equity for Americans.

CHAPTER IV

POLICY AND PREJUDICE

Recognizing that health is more than a function of individual behavior choices and is rooted in various social, institutional and environmental constructs, we must consider how public policy contributes to health disparities. As a primary force in determining social practices, our government and the legislation they enact is responsible for protecting and promoting the health of the public. Without a critical examination of public policy and the inequities it produces, we will continue to seek solutions for health problems through individual behavior change methodologies, rather than social change movements.

The state of health in America clearly meets the definition for health inequity. Furthermore, this inequitable distribution of resources and power is the probable cause for the vast health disparities we witness among groups of people in our country. Health equity must be goal for our society and to achieve it we must design and implement social policy to distribute resources fairly. At the level of education and schooling, the first step in changing our social consciousness must include a push towards critical thinking about health and the way it is affected by social policy. Without a critical understanding of health, we will continue down the flawed path of believing that health is only a personal issue, impacted by individuals' behavior choices. This brand of thinking has done little to improve the health of the population over the past several decades and

has possibly even widened the gap in health disparities. Without a critical examination of health issues, we will never achieve the admirable goals set forth by the US Department of Health and Human Services some twenty-seven years ago through the Healthy People objectives for the nation. The overarching goals of this massive public health undertaking are: (1) Increase quality and years of healthy life and (2) Eliminate health disparities (US DHHS, 2007). It is easy to agree that these are worthwhile goals. However, the programmatic, behavior-change nature of the solutions currently sought for these issues is lacking in criticality and understanding of the root causes of disparities.

American public policy has intentionally limited education, jobs, housing and therefore the social mobility of non-dominant groups, particularly people of color and women. Not only has this resulted in disproportionate levels of poverty, it has had serious health implications as well. Segregated housing limits access to care and public services and increases exposure to detrimental environmental conditions, in addition to differential access to health promoting conditions (grocery stores, parks, etc). Limited or low-quality education causes low levels of health literacy and decreases the likelihood of earning a living wage. Low-skilled jobs have minimal health benefits and are often dangerous or health-limiting themselves. Added together, these conditions restrict socioeconomic attainment and access to health resources, in addition to creating cultural norms that fail to support health. Institutional, policy-enforced racism, sexism, and classism systematically ensure inequity and therefore produce health disparities.

Public health scholars are beginning to understand these connections and call for policy reforms. House and Williams (2006) noted in their recent book chapter, “The

main message we want to deliver is that socioeconomic policy and practice and racial/ethnic policy and practice are the most significant levers for reducing socioeconomic and racial/ethnic disparities and hence improving overall population health in our society, more important even than health care policy” (p. 111). They further note that policies are needed to ensure that all people live in conditions that promote health; macrosocial change (improved education and jobs) has historically led to better health, and programs of social welfare have also historically improved population health.

On a grassroots level, policy changes to enact critical health education can start to awaken the population to the need for larger scale policy reform. If we see the inequities, understand the true causes, and have the skills to advocate for change, significant strides can be made in promoting and ensuring health equity. These larger goals must be the new course for public health.

This chapter will bring together the issues discussed in chapters 1-3 and discuss implications for school and public policies. This chapter will further discuss the social roots of health inequities and how social policy can improve the health of the population.

The Injustice of it All

Historically, the U.S. government has taken action to protect public health when threats to health were widespread. For example, immunizations for children became required as vaccines were discovered to prevent diseases that posed a major risk to the population. Polio, smallpox, rubella, and other serious diseases were indiscriminate—they impacted people of all ages, races, ethnicities and socioeconomic strata. The

requirement for global immunizations for school-aged children eliminated several diseases and seriously curtailed the impact of others. Since the intervention was universally required, the impact was universal as well. “In the twentieth century, the greatest reductions in inequality in health status occurred as a result of the introduction of major policy initiatives and legislations whereby the government accepted responsibility for the collective health of the nation. Social supports and the productive use of resources matter much more than economic growth” (Hofrichter, p. 20). For immunizations, the government currently monitors the status of every child through day cares and school systems, and provides low cost or free vaccines through public health departments. The systems are in place to ensure that all children receive protection from serious diseases.

When health problems are established as affecting most or all of the population, solutions have been relatively quick in forthcoming (Green, 1990). However, when great disparities exist in health status among population subgroups, the outcomes have been quite different, creating cycles of continued or widening gaps in health. These circumstances call for a critical examination of disparities as a function of public policy.

“Disparities in health status among different population groups are unjust and inequitable because they result from preventable, avoidable, systemic conditions and policies based on imbalances in political power. Without a perspective grounded in values of social justice, approaches to inequities in health will likely aim at symptoms, continuing to rely on cures, treatments, or individual interventions rather than

transforming institutions that cause health inequities.” (Hofrichter, p. 12) If we take a global view of population health, it is clear that social welfare is the most important contributor to health status. The World Health Organization (1998) has cited several factors as social determinants of health and delineated the social gradient (i.e. class status), early life, work, social support, food, stress, social exclusion, unemployment, addictions, and transportation as the key issues in health status. More importantly, economically unequal societies have greater levels of poverty, greater hierarchy and provide fewer safety nets for citizens, contributing to an unequal distribution of health. Within the US, the most egalitarian states, rather than the richest, are the healthiest (Kennedy, Kawachi & Prothrow-Stith, 1996). This is borne out globally, as countries with higher degrees of social welfare have higher degrees of population health compared to countries with income inequalities and higher relative poverty. Those countries with inequitable wealth distribution experience higher rates of infant mortality, as well as shorter life expectancies (Marmot, 2006). These large-scale social issues must be examined in order to seek a more equitable level of societal health.

The constructs of racism, classism and sexism (and others) can further inform our understanding of health disparities. These ‘isms’ refer to ideologies that are used to justify differential treatment and beliefs of superiority/inferiority. These constructs are deeply rooted in American society and have played significant roles in shaping public policy. To further understand this concept, it is important to define how health disparities are a result of inequitable distribution of resources. To establish a situation as

inequitable, differences in distributions of a good, such as health resources or even the larger determinants of health status, must satisfy each of the following criteria:

- The differences in distribution must *be avoidable*.
- The difference must *not reflect free choice*.
- The claim must *link the distribution to a responsible agent* (Hofrichter, 2006).

The state of health for most Americans clearly meets this definition of health inequity.

Furthermore, this inequitable distribution is a probable cause for the vast health disparities we witness among groups of people in our country. Poverty is a prime example of this inequity and is certainly linked with poor health outcomes, including infant mortality, chronic disease, and premature death. Poverty disproportionately affects those who are black or Hispanic in our country for all age groups. The differences are particularly striking for children, where black and Hispanic children are more than twice as likely to be poor than their white or Asian counterparts.

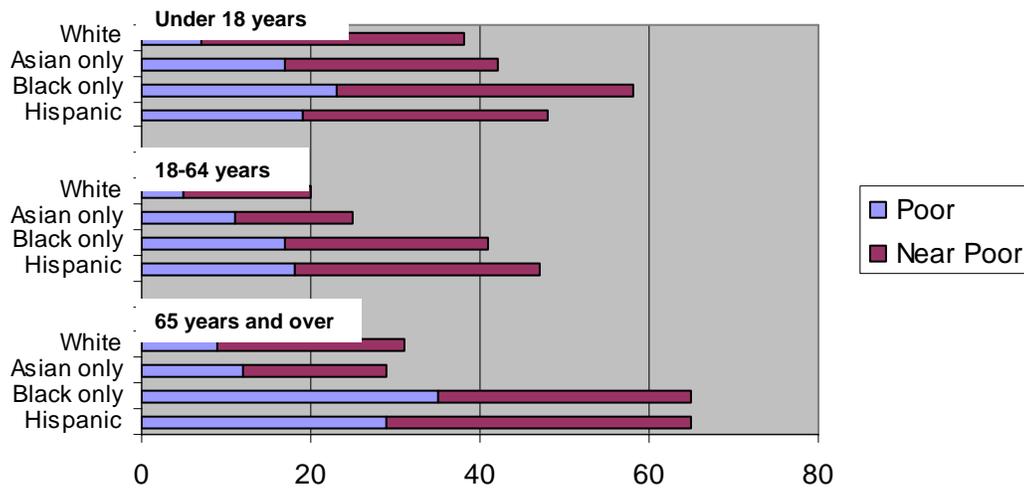


Figure 3. US Poverty Rates in 2003 (CDC, 2005)

Looking at poverty rates, it is clear that there is an unfair disadvantage to minorities and single parents. This is not merely a function of our country's diversity. Simulations placing US demographics onto other countries show that this factor plays only a minor role in the differences in child poverty rates among countries. "It is primarily the exceptional US income packaging that produces high child poverty rates, not an exceptional US demography" (Rainwater & Smeeding, 2003, p. 53). 'Income packaging' refers to all the political economic institutions of society that produce, distribute, constrain or recoup the stream of income in the exchange between society and the family unit. A number of factors impact income packaging:

Political structure - The construction of political parties, their ideologies and support from the citizenry have a major impact on public policies related to distribution of wealth

and resources. In social-democratic countries, for example, wealth is fairly evenly distributed and poverty rates are low. The ability to organize labor unions further impacts income packaging, as collective bargaining and strong support for the working class generally results in policies benefiting the workers. Figure 4 below shows a clear correlation between high rates of unionization and low rates of child poverty. The constitutional structure of a country provides the parameters for politics and further defines the rights and guarantees of citizenship.

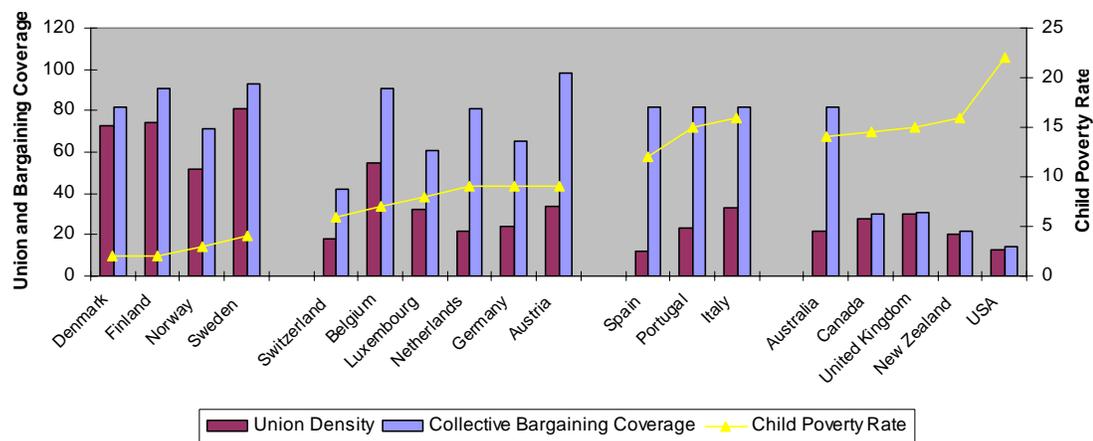


Figure 4. Union Density, Collective Bargaining Coverage and Child Poverty, 2000

Social protection programs – The availability of social welfare programs, eligibility requirements for those programs and the ways in which benefits are distributed play an important role in the redistribution of wealth. For example, the level at which one is considered living in poverty varies greatly among industrialized nations, and therefore governmental aid is afforded to individuals at varying degrees of income, depending

upon where they live. Countries with lower thresholds for the poverty level therefore have higher rates of poverty and “working poor.” For example, Figure 5 below shows the rates at which families qualify for governmental assistance in various countries. The US rate is almost two-thirds lower than most other industrialized countries. Only Hungary, Greece and Italy are below the US.

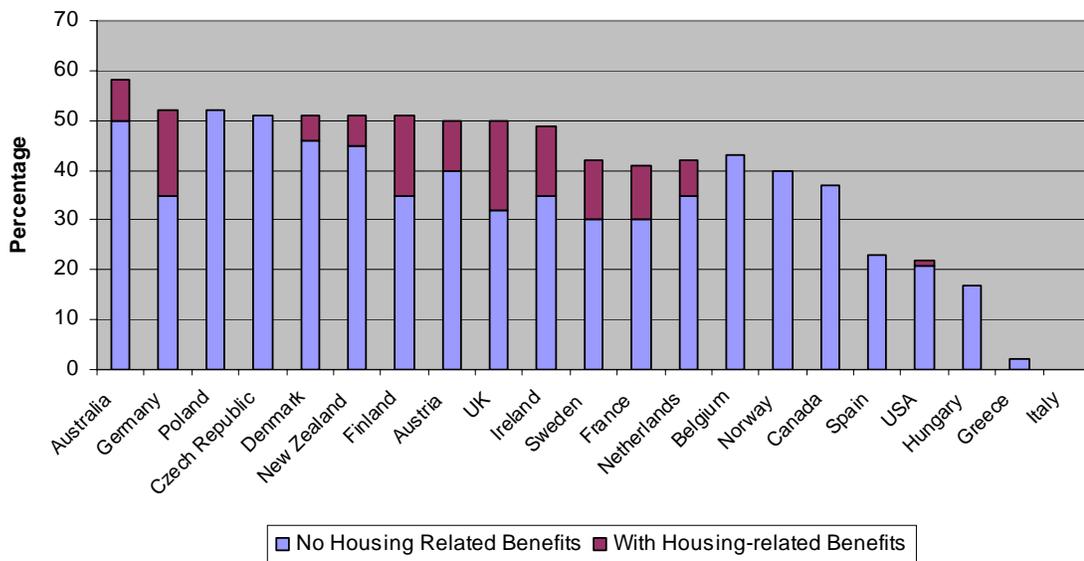


Figure 5. Average Net Incomes of Social Assistance Recipients as a Percent of Median Equivalent Household Income, 2001

Tax programs – How income taxes are applied defines not only who is responsible for funding government programs, but also how much funding is available for redistribution. For example, the elimination of the estate tax in the U.S. not only benefits the wealthy through reduced inheritance taxes, but also limits the funds available for public spending.

Labor policy – The federal minimum wage laws and whether employers pay a living wage are examples of how labor policy impacts income packaging. When the government has a greater involvement in regulating wages, the poverty rate is reduced. This concept also applies to trade agreements and the globalization of the economy. As the US government allows goods to be produced in low-wage countries, not only are American working class jobs lost, but we are also complicit in supporting the abuse of workers globally, as they are not paid fair wages.

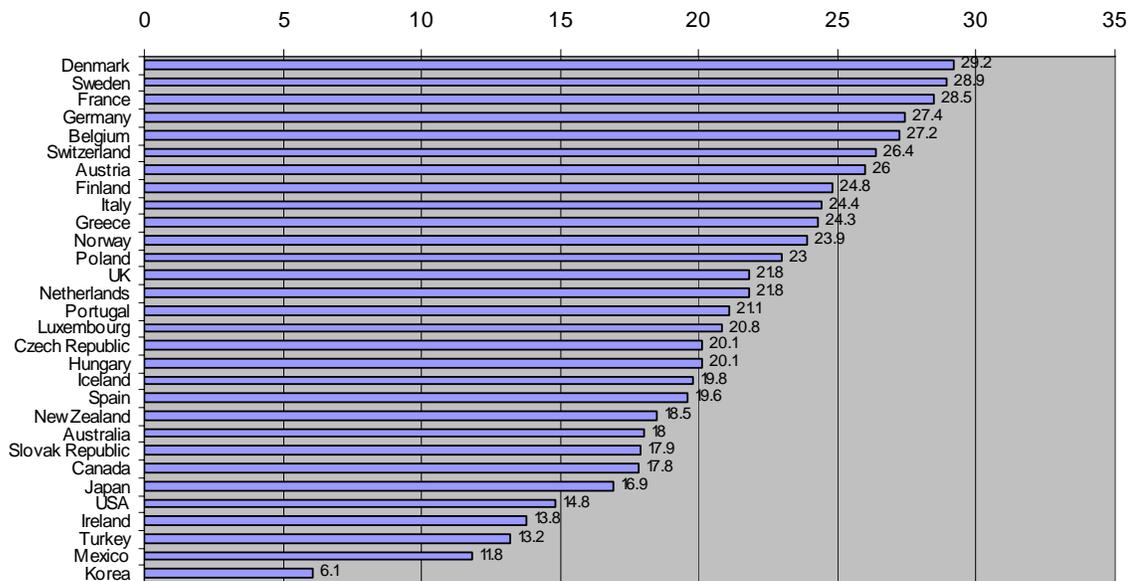


Figure 6. Total Public Expenditure as a Percent of Gross Domestic Product, 2001

The political structure, social welfare programs, tax structure, and labor policies account for the bulk of income packaging structures. Wealth distribution, however, is further impacted by the availability of public child care, antidiscrimination/affirmative action

policies, parental leave (especially for single mothers), and guaranteed child support. These policies directly impact the overall income of families and therefore the health of individual family members. As with other measures of social welfare, the US ranks near the bottom of developed countries in spending on public needs as a percentage of gross domestic product (see Figure 4). This pattern is indicative of the country's values and beliefs around poverty, economic policy and individualism. "It is the responsibility of every democracy to provide an equal opportunity from birth for every child" (Rainwater & Smeeding, p. 138, 2003). If our country were true to this statement, our policies and practices would reflect a very different set of values than we currently proscribe.

Poverty in America

The War on Poverty was launched in 1964 by Lyndon B. Johnson, yet high rates of poverty continue to exist for children, particularly those who are African-American or Hispanic, or who live in single-parent households. The condition of poverty severely limits children in terms of education, health, general well-being and opportunities for positive life outcomes. While it is easy to adopt a fatalistic view of poverty, when we observe poverty levels in other industrialized nations, it is clear that it is possible to drastically reduce if not eliminate child poverty.

The data in the chart below come from the Luxembourg Income Study, which indexes after-tax family income and uses half of the median income to denote poverty. Interestingly, there was approximately the same number of children in America as there were in the twelve European countries in the year 2000 – approximately 72 million

children each. However, about 14 million American children were living in poverty, compared with 7 million in Europe (Rainwater & Smeeding, 2003).

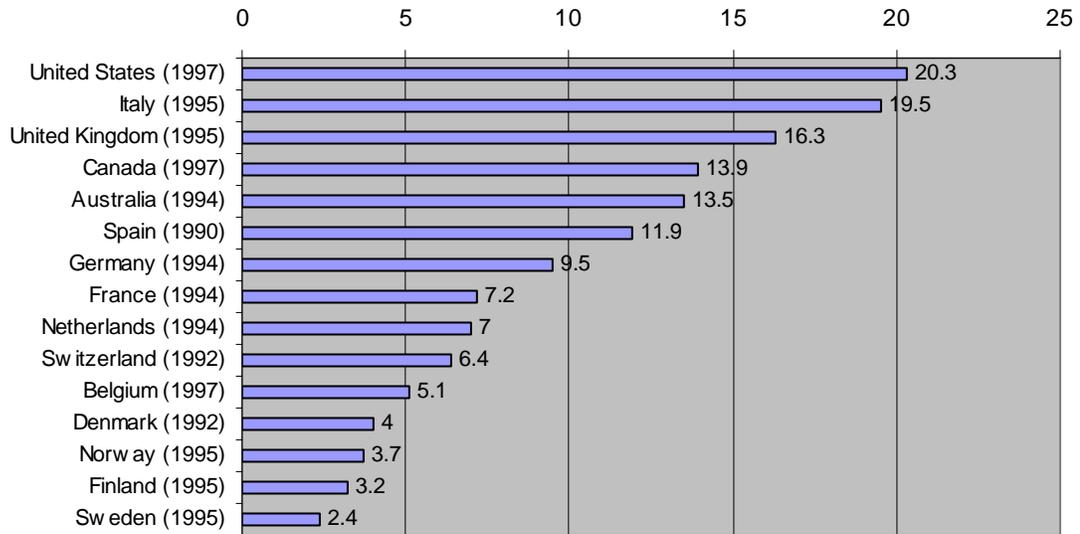


Figure 7. Child Poverty Rates in Fifteen Countries (Adapted from Rainwater & Smeeding, 2003)

While neither poverty rate is acceptable, it is astounding that there are twice as many poor children in the richest country in the world. Even more troubling, perhaps, is the way in which the income gap is widening in the United States. During the past two decades, the wealthiest Americans have grown considerably wealthier, while the poorest Americans have gained almost nothing.

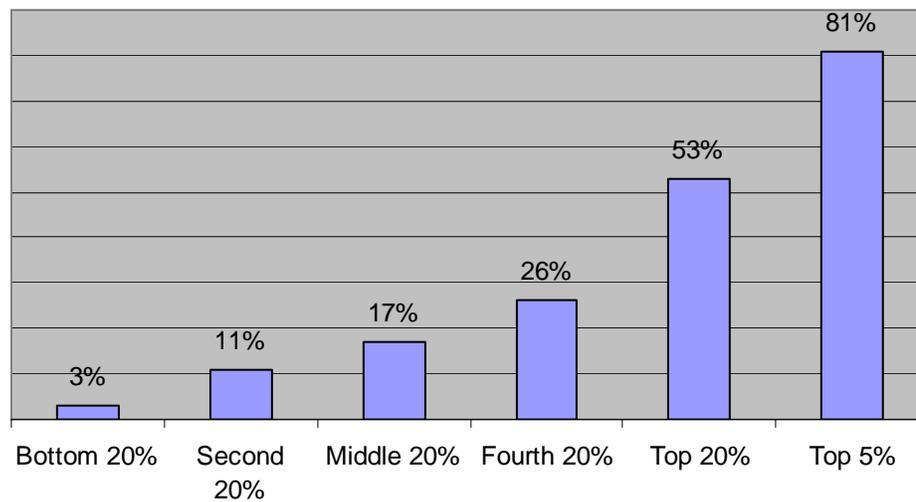


Figure 8. Change in Family Income, 1979-2001 by Quintile and Top 5%

This change in wealth distribution is due in part to the surge in Neoliberal philosophies regarding social policy. Neoliberalism is grounded in the belief that (1) markets are the most efficient allocators of resources in production and distribution; (2) societies are composed of autonomous individuals (producers and consumers) motivated chiefly by material or economic considerations; and (3) competition is the major market vehicle for innovations (Coburn, 2000). Neoliberals deny the existence of society and instead focus on individuals as the driving force in income, wealth, and resource distribution. This idea of individualism is a longstanding myth and is deeply ingrained in the American consciousness. Reinforced by stories of those who went from rags to riches, we are encouraged to believe that with hard work, strong will and determination, anyone can achieve the American dream. As discussed in chapter three, this belief carries over to health and prevents a discussion about the effects of social circumstance on people's

lives. Absent from the mainstream discourse is an understanding of context, social policy, and history on the development, enactment and repercussions of socially constructed norms, expectations and values. “The assumption that the lifestyles of different socioeconomic groups are freely chosen is flawed, as the social and economic environments in which people live are of critical importance for shaping their lifestyles” (Whitehead & Dahlgren, 2006). We must understand that the poor did not choose to live in poverty and it is incumbent upon those with power to assist in creating an equitable playing field.

Who are the poor? “The poor shall be taken to mean persons, families and groups of persons whose resources (material, cultural, and societal) are so limited as to exclude them from the minimum acceptable way of life in the member state in which they live” (European Commission, 1985). This definition competes with the American definition (and Neoliberal belief) of poverty as simply an economic problem, not a social problem. This problem bleeds into the discussion about whether to address absolute poverty or relative poverty, and whether the application of a “poverty line” to define absolute poverty is meaningful.

The debate on the merits of absolute versus relative definitions of poverty has obscured the more fundamental difference between economic and social definitions of poverty. An economic measure of poverty determines the income needed to provide a minimum level of consumption of goods and services and implicitly assigns a given level of utility or satisfaction to the output of consumption... A social measure of poverty is concerned ultimately not with consumption but with social activities and participation. Researchers with this orientation... focus instead on the social and personal consequences of poor individuals’ inability to consume at more than an extremely modest level. Without a requisite level of goods and services, individuals cannot act and participate as full

members of their society, and it is this participation in social activities that confers utility, not consumption (Rainwater & Smeeding, p. 9-10, 2003).

For the purposes of advocating for improving the quality of health and life, relative poverty is the appropriate measure. Without some means of wielding social power, even those in relative poverty are at a disadvantage and are likely to experience the effects of ill health. Marmot (2004) described a phenomenon known as the social gradient. In this analysis, a linear decrease in health is seen with decreasing social and economic position. This is in sharp contrast to the way disparities are often viewed as polar opposites – those “with” (higher social position, education, SES) are in good health vs. those “without” are in poor health. Instead, it is clear that morbidity and mortality rates increase stepwise in relation to social advantage, as measured by characteristics such as education, employment and social class.

The Roots of Health Disparities

Health promotion has always been in the purview of the health sector. “Health, however, does not arise from actions solely by the health sector, but as the result of all public policies and how they individually, or in interaction with each other, promote or damage health. A narrow focus on the health sector alone obscures the socially constructed roles and expectations that may exacerbate health inequalities.” (Hofrichter, p. 144) Institutional and policy-driven racism, sexism, class-ism, and other discriminatory practices must be examined as root causes of health problems.

This idea is not new. “The recognition by policy makers that something can be done about gender inequalities in health has long been obscured by the strong biological and individualistic orientation of medical research. Analysis of socioeconomic, cultural and environmental influences has consequently been overshadowed by genetic and biomedical models. The resulting view that the determinants of gender inequalities in health are mainly of genetic and biological origin has led policy makers and practitioners to pay insufficient attention to which of these inequalities are genuinely unchangeable and fixed and which are in fact quite amenable to change” (Hofrichter, p. 144). Our thinking about how health is constructed must broaden to allow for the contextual factors which impact individuals and groups.

Related to problems of chronic disease, for example, social policies which support and promote health for all people would, over time, result in lowered rates of chronic illnesses. We are currently experiencing an epidemic of obesity in the US. If we theorize that obesity is not simply the result of “wrong behavior,” but is instead a symptom of a society that does not provide the environmental and social support needed to promote health, then it is easy to see where to intervene. As a major health concern that deeply affects the length and quality of life for millions of people, especially minorities, obesity is a prime example of health promotion gone wrong. Obesity, for example, has always disproportionately affected minority groups in the U.S. Health promotion/prevention efforts around obesity, for the most part, have centered on identifying individual behavior patterns (eating and exercise) that contribute to obesity. Typical obesity prevention programs have included health education and behavior modification in attempt to

increase physical activity and change eating habits. While these strategies may have worked for some individuals, they clearly have not made any significant impact on the prevalence of obesity in the population, particularly in minority subgroups.

Obesity in the United States has reached epidemic proportions in children as well as adults, increasing steadily since the 1970's – during the same timeframe that health promotion came into the forefront with nutrition and physical activity messages (Proimos & Sawyer, 2000). In 2000, data from the NC Health Services Information System show that 20.6% of 4-11 year olds and 26% of 12-18 year olds are overweight (BMI at or above the 95th percentile for gender and age). Recently, large scale epidemiologic studies have established worrisome trends in increasing prevalence of obesity in pre-school, primary school, and adolescents (Mei, 1998, and Troiano & Flegal, 1998). From 1980 to 1994, the prevalence of obesity among children increased by 100% (Troiano, Flegal, Kuczmarski, Campbell, & Johnson, 1995). Obesity disproportionately affects children who are black or Hispanic, and those who are poor, translating into increased levels of chronic disease and suffering for those who are already marginalized by society.

The health problems associated with childhood obesity are staggering. Obesity is an independent risk factor for cardiovascular disease in adults (Oken & Lightdale, 2000) and 70-80% of obese adolescents will persist in their obesity into adulthood (Proimos & Sawyer, 2000). In addition, recent evidence suggests that obesity is associated with severe morbidity in childhood. 60% of overweight children ages 5-10 already have at least one risk factor for heart disease (CDC, 2000). The Bogalusa Heart Study

(Freedman, Dietz, Srinivasan, & Berenson, 1999) linked childhood obesity with elevated total cholesterol, low-density lipoprotein, triglycerides, and systolic and diastolic blood pressure. Obesity has been implicated in the development of adult onset diabetes (Type II) that is now developing at alarming rates in adolescents (Oken & Lightdale, 2000).

If health status is a function of knowledge about health, Americans should be at a very low level of obesity. Collectively, we have never known more about eating right and exercising, yet obesity levels are exploding. While interventions that have relied on behavior change models have been tested over and over with minimal success, the big picture has been overlooked. We in public health have failed to address the heart of the obesity epidemic. We only asked the ‘what’ question – what are the causes of obesity? – and the simple answer of too much food and too little exercise were the result. We failed to dig deeper and really ask ‘why?’ – why does obesity afflict so many people of color? If we had asked this question in a critical way, we would have come up with a decidedly different answer. The easy answer to why has led us to ‘culturally sensitive’ behavioral interventions. While this is better than previous iterations of health promotion, it still does not look at the larger social and contextual issues that have created health disparities in the first place.

According to the Universal Declaration of Human Rights (WHO), everyone has a right to a standard of living that supports health and well-being. If this statement were truly enacted, the world would look very different. Jobs would pay a living wage, education would support individuals to develop their ontological vocation, equitable

health care would be available to everyone, high quality foods would be available and affordable to everyone, safe and affordable housing would be abundant, and social support services would provide a high quality safety net for all people.

How can these basic human rights be related to obesity? If an individual works in a minimum wage job, she probably has no medical insurance, no permanent housing, and insufficient financial resources to purchase nutritious foods. She might also struggle with issues of personal safety or lack of education. It does not matter if she has been told to exercise and eat healthfully. Her concerns are more immediate. Where am I going to live? How am I going to feed myself (or my family)? How am I going to get to work? What if I lose my job? Or maybe even ... Who will care for my children when I'm at work? Will they be safe? When people's basic needs are not met, they do not have the time, energy or inclination to be concerned about distal health outcomes. They must operate in the moment and take care of the most immediate needs – which rarely include health promotion needs that the individual-behavior oriented health promotion messages would have us believe are important.

American public policy has intentionally limited education, jobs, and housing and therefore the social mobility of non-dominant social groups, particularly people of color. Not only has this resulted in disproportionate levels of poverty, it has had serious health implications as well. Segregated housing limits access to care and public services and increases exposure to detrimental environmental conditions, in addition to differential access to health promoting conditions (grocery stores, parks, etc). Limited or low-quality education causes low levels of health literacy and decreases the likelihood of earning a

living wage. Low-skilled jobs have minimal health benefits and are often dangerous or health-limiting themselves. Added together, these conditions restrict socioeconomic attainment and access to health resources, in addition to creating cultural norms that fail to support health. Institutional, policy-enforced racism, sexism, and classism systematically ensure inequity and therefore produce health disparities.

Attempts have been made to proscribe policy that promotes health equity. The 1948 Universal Declaration of Human Rights lays out some basic supports for human health that should theoretically be available to all people (Hofrichter, p. 321).

Article 25. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Article 2. Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.

This statement sets parameters for ensuring supports for health and human well-being around all people, but is not enforced through policy or legislation. Since our culture values competition and individualism, these essential human rights have become commodities, where some have more and many have less.

The argument can easily be made that the system of health education and health care has been intentionally set up to distribute health inequitably. In fact, *equality* of

resource distribution has not even been achieved. Those who are poor, who speak a language other than English, and those who are minorities have unequal health resources. For example, Medicaid is administered by the government to provide health insurance to the poor. While it is admirable that an attempt has been made to ensure access to health care, this program is not equal in quantity or quality to private health insurance – the number of health providers is limited, the location of those providers may be difficult to access, the quality of providers may be lesser – in addition, Medicaid will not pay for many procedures and treatments covered by private insurers. Even worse, these problems pale in comparison to the health care issues faced by those who have no health insurance. Not only are they faced with finding a way to finance exorbitant health care costs when they need care, their health is typically compromised by forgoing expensive preventive care and early treatment, resulting in prolonged, acute illnesses and sometimes permanent disability. While defining parameters for conditions that support health and directly prohibiting discriminatory practices, the methods for ensuring these rights have not been fully devised or enforced, resulting in continued health disparities.

Recognizing the absence of equity, the United States government in the 1980's began to address some of the inequity through new policy. "These changes included the creation of offices for minority and women's health within some federal agencies; changes in biomedical research protocols to require inclusion of women and minorities; some improvement in medical school admissions (especially for white women); increased funding for particular health problems affecting people of color and women; and growing attention by policy makers to what is now referred to as health 'disparities' by gender and

race (Schulz, Freudenberg & Daniels, 2006, p. 404).” However, it was not until 1998 that the Surgeon General announced the Initiative to Eliminate Racial and Ethnic Disparities in Health, followed by a congressional commission to study disparities in 1999. Unfortunately, these acts fell far short of what is needed to establish equity. No new policy or legislation has been enacted to address health disparities. While there has been federal funding available to study health disparities, these studies continue to skim the surface.

In attempting to break down health disparities, the government reports and studies focused on individual behaviors, rather than examining the institutionalized structures and forces which influence health. While federal health policy nominally recognizes the need to address disparities, none of the federally supported work to eliminate disparities is examining racism, sexism and economic polarization as root causes of disparities. The work has stayed safely on the surface of the issue, acknowledging the difference while complicitly ignoring the deeper issues. Public health scholar Sherman James explained it this way, “Because racism, operating through varied interpersonal and institutional pathways, is a fundamental cause of racial/ethnic health disparities, the elimination of these disparities—the magnificently democratic goal of Healthy People 2010—cannot be achieved without first undoing racism” (James, 2003, p. 198).

Social Policy and Health

Public policy is a course of action or inaction chosen by those in power to address a given problem. Policy is anchored in values regarding appropriate public goals and a belief system about the best way of achieving those goals. Public policy assumes that the issue is not a private affair (Wolf, 2005). Our history provides conclusive evidence that our legislators and policy makers are well aware of their ability to impact public health through social policy. Aside from the obvious regulations aimed specifically at health (sanitation, immunization, clean water supplies, etc.), social welfare policies have been directly linked with health improvements time and time again. For example, during the Depression, high levels of unemployment led to widespread poverty and hunger. In 1935, the federal government formed and funded the Works Progress Administration (WPA) to provide jobs for millions of unemployed Americans. One of the tasks undertaken by the WPA was a School Lunch Program, eventually serving lunch to 500,000 children daily in 10,000 schools across the country. The success of the lunch program was measured by the children's weight gains, as well as school performance. All of the examples noted significant gains in weight for the children served, and most cited related changes, including increased energy, general alertness, and "improved physical condition." These sites also mentioned greater accomplishment in school work, "above average intelligence," and improved school attendance as a result of the program. The National School Lunch Act made permanent an earlier law (Public Law 320, 1936), also enacted to support agriculture. According to Gordon Gunderson (former U.S. Department of Agriculture representative to Wisconsin, 1931-1969), this law kept

surpluses out of the normal distribution channels, “The object of this legislation was to remove price-depressing surplus foods from the market through government purchase and dispose of them through exports and domestic donations to consumers in such a way as not to interfere with normal sales” (Gunderson, 1971). The school lunch program is a prime example of public and economic policy converging to benefit health. By providing employment and agricultural support, this program was successful in providing food support to hungry children.

Politics is the process by which society decides who gets what. Though politics is generally applied to governments, it is also a part of all human group structures (corporate, academic, religious, school, etc.) and is manifested as an assertion of power and influence on decision-making processes. An international study looking at relationships between political variables and health indicators found a significant correlation between working-class power and overall population health (Muntaner, 2002). Other studies have found that more conservative governments are associated with worsened health for disadvantaged groups.

“The welfare state is a capitalist society in which the state has intervened in the form of social policies, programs, standards, and regulations in order to mitigate class conflict and to provide for, answer, or accommodate certain social needs for which the capitalist mode of production in itself has no solution or makes no provision (Teepie, 2000, p. 15). Social determinants of health, including equitable distribution and social service infrastructures are failing because of policies driven by powerful corporate interests and associated with the globalization of the economy (Raphael, 2003). Trans-

national corporations actively oppose reforms associated with the welfare state in order to maximize profits by reducing labor costs, limiting government regulation, and using their power to influence policies. Neo-liberalism (by emphasizing the market as the arbiter of social values) is largely responsible for this discourse. By supporting reductions in income and corporate taxes, these policies result in increasing social and economic disparities.

Social Justice: Leveling Up for Better Health

Historically, at least two features define the application of social justice: an opposition to inequality, based on recognition of common human interests, and support for democracy. First, social justice demands an equitable distribution of collective goods, institutional resources (such as social wealth), and life opportunities. Beyond distributional questions, Amartya Sen (1992) defines a just society as one that ensures the development and the capacities of all of its members. Second, social justice calls for democracy—the empowerment of all social members, along with democratic and transparent structures to promote social goals. This is another way of describing political equality.

In order to move towards social justice and address the severe disparities in health existing in our society, a series of policy changes are needed, beginning with a critical understanding of health through radically revised health education policy and practice, followed by changes to social and economic policy to produce equitable conditions for education, life, work, and health for all people. “Efforts to promote social equity in health are therefore aimed at creating opportunities and removing barriers to achieving

the health potential of all people. It involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill. The outcome of these efforts would be a gradual reduction of all systematic differences in health between different socioeconomic groups. The ultimate vision is the elimination of such inequities, by leveling up to the health of the most advantaged” (Whitehead & Dahlgren, 2006). These larger goals must be the new course for public health. Limiting health promotion and health education to small-scale, individually-based behavior change will continue to produce injustice and will not serve the greater good of the population.

The goal of equity in health is to eliminate the systematic differences in health status between socioeconomic, racial and gender groups. “Policies shape how money, power and material resources flow through society and therefore affect the determinants of health. Advocating healthy public policies is the most important strategy we can use to act on the determinants of health” (CPHA, 1996).

In *Levelling Up* (2006), the authors suggest ten principles for policy action to improve public health. These principles frame the broad context for work aimed at reducing health disparities through large-scale policies:

1. Policies should strive to level up, not level down.
2. The three main approaches to reducing social inequities in health are interdependent and should build on one another. (focusing on people in poverty, narrowing the health divide, and reducing social inequities throughout the entire population)
3. Population health policies should have the dual purpose of promoting health gains in the population as a whole and reducing health inequities.

4. Actions should be concerned with tackling the social determinants of health inequities.
5. Stated policy intentions are not enough; the possibility of actions doing harm must be monitored.
6. Select appropriate tools to measure the extent of inequities and the progress towards goals.
7. Make concerted efforts to give a voice to the voiceless.
8. Wherever possible, social inequities in health should be described and analyzed separately for men and women.
9. Relate differences in health by ethnic background or geography to socioeconomic background.
10. Health systems should be built on equity principles. (i.e. not driven by profit, services provided according to need, equal standards of care for all people)

While leaving out the specific details, these principles supply the larger vision and define what a social justice approach to public health should encompass. With our local and national focus on economic issues, we lost sight of the human element. We need to embrace a perspective where economic growth is seen as a resource for human development and health improvement, not an end unto itself. Our understanding needs to shift from a focus on people as the servant to the economy to one of the economy and political process as servant to the people. This idea is supported by the very founding of our country as laid out in the Declaration of Independence in 1776.

We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness. --That to secure these rights, Governments are instituted among Men, deriving their just powers from the consent of the governed, --That whenever any Form of Government becomes destructive of these ends, it is the Right of the People to alter or to abolish it, and to institute new Government, laying its foundation on such principles and organizing its powers in such form, as to them shall seem most likely to effect their Safety and Happiness.

Our country's founders clearly had in mind that the government should be responsible for ensuring the safety and happiness of its citizens, and that the people have the power to hold the government to that task. Reclaiming this position will require a radical shift in our politics. To achieve this change, we need critical education of our citizenry to awaken our consciousness to the injustices and advocate for social change.

Health Education for Social Change

As previously established, schools provide less than optimal conditions for promoting health. In addition to poorly teaching basic health education concepts, schools systematically prevent the development of the critical thinking skills needed to deconstruct the social and political issues which impact health. In critique of the government's most recent attempts at controlling public schools, the Children's Defense Fund (2002) nicely summed up the most significant problems with our schools:

The Bush administration's budget choices before and after September 11th leave millions of children behind; favor powerful corporate interests and the wealthiest taxpayers over children's urgent needs; widen the gap between rich and poor—already at its largest recorded point in over 30 years; and repeatedly break promises and fail to seize opportunities to Leave No Child Behind. While thousands of children, parents, and grandparents stand in unemployment and soup kitchen and homeless shelter lines waiting for food and a stable place to live across America, lobbyists for powerful corporations like Enron and rich individuals and special interests line up inside Congress and the White House to get hundreds of billions of dollars in new tax breaks and government handouts.

Because educational achievement is unequally distributed, those living in economic disadvantage have lower levels of education overall, as well as less access to quality education. Quality education is a function of resource distribution and is manifested materially as smaller class sizes, access to technology and teaching resources, highly-educated and experienced teachers, and well-maintained or modern facilities. These resources, along with a democratically administered school and support for teachers as professionals provide the space and opportunity for teachers and students to generate knowledge together. This is not the norm among public schools today. “Bereft of financial support and confronted by myriad problems that include overcrowded classrooms, crumbling school buildings, chronic shortages of classroom materials, demoralized teachers, and budget shortfalls, many of the nation’s schools are in dire straits and can no longer provide a decent, quality education, especially to those children who live in poor rural or urban areas (Giroux, 2003).

Generally, participation in quality education provides opportunities for higher-paying jobs and increased standards of living. This is directly related to health in terms of access to safe, quality housing; more nutritious food; participation in society; and improved working conditions. Empowerment to change these issues is an important outcome of education (Whitehead & Dahlgren, 2006). Ideally, education also encourages participation in community as well as in the democratic process. This type of social empowerment is critical to helping those who are marginalized gain control over their lives and their health. This process is at the heart of reducing inequities in health.

There must be a push towards critical thinking in schools and health education provides an ideal way to incorporate critical pedagogy into schooling. Health is not subjected to standardized testing and the links between personal lived experiences, health, and social issues are clear, relevant and tangible to students. Paulo Freire ardently argued against the banking system of education currently in use for health, whereby teachers dump information into students who are seen as empty vessels. On the contrary, health teachers should help students think critically by posing questions and working with students to find the answers. “Education must begin with the solution of the teacher-student contradiction, by reconciling the poles of the contradiction so that both are simultaneously teachers *and* students.” (Freire, p. 72) In this way, knowledge becomes more fluid for both students and teachers and the students can recognize that the world (and their situation in the world) is changeable, and that they have the ability to create change. For health education, this concept would mean that students would develop knowledge about the world and how it impacts health, hopefully moving people towards a critical understanding that they have the right (and perhaps the responsibility) to use that knowledge to advocate for change.

Henry Giroux and Peter McLaren co-edited a volume on critical pedagogy and noted that successful teaching in cultural studies must combine “theory and practice in order to affirm and demonstrate pedagogical practices engaged in creating a new language, rupturing disciplinary boundaries, decentering authority, and rewriting the institutional and discursive borderlands in which politics becomes a condition for reasserting the relationship between agency, power, and struggle” (Giroux & McLaren,

1994, foreward). In applying this concept to health education, students can witness and practice pedagogy for hope and change. Experiencing a different, critical way of learning and being in the world can open up students to the possibilities, creating a sense of hopefulness and empowering students with the tools to create social change.

Noted feminist scholar and theorist bell hooks described her first encounter with critical pedagogy and the different it made in her personal life, “in making sense out of what was happening... I found a place where I could imagine possible futures, a place where life could be lived differently. This ‘lived’ experience of critical thinking, of reflection and analysis became a place where I worked at explaining the hurt and making it go away. ... Theory is not inherently healing, liberatory, or revolutionary. It fulfills this function only when we ask that it do so and direct our theorizing towards this end” (hooks, p. 61). Health education that directly reflects the lives of students and their families has the opportunity to help them understand the world, as well as prepares them to act on the world for change. Hooks goes on to discuss the importance of critical theory and talks about working on a television documentary on feminism. She discussed what she believed to be the most important tool for feminist thinking, “to me, ‘critical thinking’ was the primary element allowing the possibility for change. Passionately insisting that no matter what one’s class, race, gender, or social standing, I shared my beliefs that without the capacity to think critically about our selves and our lives, none of us would be able to move forward, to change, to grow. ... Conditions of radical openness exist in any learning situation where students and teachers celebrate their abilities to think critically, to engage in pedagogical praxis (hooks, p. 202).

Rather than using power to silence and marginalize groups of people, as has been the traditional practice of schooling, teachers have an opportunity to share power and empower students. Another feminist theorist, Jennifer Gore, notes that, “Critical and feminist discourses conceive power to be both repressive and productive” (Gore, p. 120). Rather than focusing on the historical use of power for repression, radical discourses have embraced the idea of empowerment and productive power to improve social conditions. Gore dismisses potential critics of her focus on radical pedagogies with an offensive approach, “such questions conceive of power in precisely the terms that Foucault questions – power as possession, power as repression/ domination, rather than power as circulating, power as productive” (Gore, p. 135). This shift in understanding of power in the classroom will require significant changes in teacher training, as well as in curriculum and school policy.

A number of existing policies and structures are competing to prevent the practice of critical pedagogy in health. Not only are teachers unprepared for using critical teaching methods, but perhaps more importantly, cultural norms and expectations work against a critical understanding of health. These factors will need to be addressed through programs of teacher preparation so that a common understanding of health as a social construct is developed. Specific issues to address include undoing the myth of individualism, understanding how power is enacted in the classroom, how popular culture and social policy shape cultural norms, as well as grounding in the critical pedagogical practices of dialogue, empowerment, and democracy in the classroom.

Individualism is a powerful and deeply entrenched American philosophy which limits the public space for social activism. By transforming public issues (such as health) into private matters of lifestyle, self-empowerment and assertiveness, individualism precludes organized efforts at social change. It is a reflection of the declining welfare state and directly influences public health responses to health issues. Individualism presumes that individuals exist in parallel with society instead of being formed by society. It is not surprising that the teachers and students in a study of adult education programs upheld the main assumptions of this myth. The teachers, most of whom were white and middle class, constructed themselves as having become successful in their careers as a result of working hard and having the right personal qualities. For them, the success myth is not a myth at all; it is a reality. They see that they have been able to ‘make it’ and believe their students can too. What the teachers ignore, however, are the factors that contributed to their success – a good education, good job qualifications and experience, and a great deal of cultural capital. Instead of recognizing these factors as tied to their race and class positions, they focused on internal qualities (Sandlin, 2003).

Preparing teachers to create a critical classroom will require a significant amount of exposure to the realities of racism, classism, and cultural privilege, as well as personal reflection on their own identities, history and context in the world. A successful critical classroom mandates that the teacher has the ability to see multiple truths and negotiate the discourse of students coming from different perspectives. “Biases imposed by essentialist standpoints or identity politics, alongside those perspectives that insist that experience has no place in the classroom (both stances can create an atmosphere of

coercion and exclusion), must be interrogated by pedagogical practices. Pedagogical strategies can determine the extent to which all students learn to engage more fully the ideas and issues that seem to have no direct relation to their experience” (hooks, p. 86).

Feminist theorist Jennifer Gore acknowledges that this type of shift in teaching practice requires thinking about power relationships and how teachers exert power over students. She relates her ideas to the classroom and how power is applied through authority. “From the very beginning, mass, popular education has been centrally concerned with teacher-authority.” (Gore, p. 123) Teachers have been expected to set a ‘moral example’ and have been given the political authority to wield power over students. At the same time, teachers are seen as social models in traditional schooling methods and this ‘teacher as authority to be pleased’ notion is difficult for students to overcome.

Shifting to critical health education will require more energy and effort on the part of the teachers and the students. “Complicity often happens because professors and students alike are afraid to challenge, because that would mean more work. Engaged pedagogy is physically exhausting!” (hooks, p. 160). Large class sizes, long workdays, and the daily demands of teaching already work against large-scale changes in schools. “These [critical] practices are undermined by sheer numbers. Overcrowded classes are like overcrowded buildings—the structure can collapse” (hooks, p. 160). Part of the teacher training will necessarily include advocacy for conditions that facilitate critical teaching methods.

Practically speaking, teachers need both the skills and the freedom to practice critical pedagogical methods. The skills can be learned through critically taught

education classes where teachers can observe, practice and live critical pedagogy and experiment with various ways critical skills might be brought into K-12 education. Beyond a broad understanding of cultural foundations, teachers also need the ability to set new parameters for learning. “To educate for freedom, we have to challenge and change the way everyone thinks about pedagogical process... Before we try to engage them [students] in a dialectical discussion of ideas that is mutual, we have to teach about process” (hooks, p. 144). Teachers themselves must understand this process well in order to advocate for the freedom to use dialogical methods.

To achieve the goal of transformative health education for social change, the power structure of the classroom must be altered to promote student empowerment. “The classroom should be a space we’re all in power in different ways. This is one of the primary differences between education as a practice of freedom and the conservative banking system which encourages professors to believe deep down...that they have nothing to learn from their students” (hooks, p. 152). Because health education is currently marginalized from the core curriculum, it provides an opportunity for teachers to explore transformational education practices and facilitate the creation of shared knowledge; “we must intervene to alter the existing pedagogical structure and to teach students how to listen, how to hear one another” (hooks, p. 150). Teachers committed to the process can create spaces of free discussion in existing health classrooms by simply setting new ground rules, encouraging dialogue and creating a safe space for encountering difficult and potential painful ideas. “A more flexible grading process must go hand in hand with a transformed classroom. Standards must always be high.

Excellence must be valued, but standards cannot be absolute and fixed. ... The obsession with good grades has so much to do with fear of failure. Progressive teaching tries to eradicate that fear, both in students and in professors” (hooks, p. 157).

The measure of success in the critical health education classroom would be observation that both teacher and students are fully engaged in the process, listening and trying to understand each other and actively questioning the issues. Students would have the opportunity to find their voices and use them to share their experience and expertise around health issues. Teachers would understand their authority as power and use it to claim the classroom as a compassionate community where all students have equal voice. Democracy would be understood and practiced as each member of the classroom asserted their voices.

By observation, a critical health education classroom would look more like a discussion and less like a traditional classroom, where students and a teacher/facilitator dialogue around issues that impact human health. True dialogue is very clearly defined as a two-sided conversation, with equal power for both parties. “Dialogue does not impose, does not manipulate, does not domesticate, does not ‘sloganize” (Freire, p. 168). Dialogue is done *with* the people, not *to* the people or *for* the people. This is the process that empowers the participants and moves them towards action for social change. “Liberatory education is fundamentally a situation where the teacher and the students both have to be learners, both have to be cognitive subjects, in spite of being different. This for me is the first test of liberating education, for teachers and students both to be critical agents in the act of knowing” (Freire, p. 33). For the teacher, this process is

unmistakably one of submitting humbly and recognizing that the teacher is more of a facilitator than a vessel of knowledge.

To those who would deride the idea of critical health education, I offer a recent example from the group of third-grade girl scouts that I lead. The girls were preparing to start a service project to help children in crisis. We were making fleece blankets for Project Linus, which distributes the blankets to the Red Cross, homeless shelters, and other organizations who help people in need. I opened the discussion by asking them about situations where children might need comforting so they could imagine the context of other children. Their discussion was poignant and clearly showed their ability to see the painfulness and truth of others. They talked about Hurricane Katrina, local house fires, the tsunami in Indonesia, divorce, floods and tornados. They understood that all of these situations were frightening and unfair and caused pain and suffering among other people. The girls were able to relate the feelings of other children to personal experiences of loss. They talked about losing pets and relatives and how they needed the comfort of others to process their grief. While their understanding of the larger social issues around human tragedy was limited, they fully grasped and empathized with the needs of other children. This is the type of discussion we need to encourage through health education throughout the schooling process. When eight-year olds can appreciate the humanity and needs of those who are different and want to do something to help and change the situation, we have great hope that the world can be better.

School Policy for Health

Creating a healthier world will require multiple levels of change. On a large scale, we need changes to the economic and social welfare policies which impact poverty, disparities and population health. At the smallest level, we need bold teachers who are committed to transformational health education so that we can all see the changes that need to be made. We further need changes to education policies to encourage critical health education and model a healthful society through schools. In a recent World Health Organization position paper, a series of policy recommendations were outlined for promoting health equity through education (Whitehead & Dahlgren, 2006). These mirror many of the larger social changes needed to improve population health:

1. Identify and reduce economic, social and other barriers to accessing education
2. Provide life-long education, particularly for disadvantaged groups.
3. Provide comprehensive support programs for children in underprivileged families to promote preschool development (such as Head Start and Smart Start)
4. Reduce social segregation within schools
5. Provide extra support to schools serving low-income and poor students and families.
6. Provide adult-education programs for those with limited basic education.

These changes would require large-scale education reform, including changes in funding and the repeal of No Child Left Behind. The high-stakes testing mandated by this legislation does nothing to improve equity in education and potentially creates situations

which constrain mental health as children and teachers are exposed to multiple, repeated stressors. Research clearly indicates that relying on testing to monitor educational achievement falls far short of its intended outcome. In *The Achievement Gap: How Minority Students are Faring in North Carolina's Public Schools* (2006), the NC Justice Center outlines the negative consequences of our current testing requirements:

- High-stakes tests are unfair to many students because they attend poorly funded schools with large class sizes, too many teachers without certification, and inadequate resources;
- High-stakes testing leads to increased grade retention and dropping out because students who are retained do not improve academically, are emotionally damaged by retention, suffer a loss of interest in school, and are more likely to drop out;
- High-stakes testing promotes 'teaching to the test,' forcing teachers to ignore curricular objectives that are important but not tested;
- High-stakes testing drives out many good teachers who are discouraged by the over-emphasis on testing, and, when tests are used to hold schools accountable, encourages excellent teachers to leave low-performing schools where they are needed most; and
- High-stakes testing fails to accurately communicate a school's quality, as 'teaching to the test' may cause score inflation, leading the public to think that a particular school is improving when it may actually be doing worse. Non-school factors such as poverty, hunger, student mobility, safety, and parent education are not taken into consideration in the test results. (p. 16)

The pressure has been mounting for over a decade as more and more tests are constructed and required for children at all grade levels. I believe the pendulum can be swung the other way, but it will require critical thinkers – teachers, students, parents, and administrators – to demand changes to our educational policies. If equitable education

requires (at a minimum) the reforms outlined by the World Health Organization above, we are currently on the wrong track. No Child Left Behind maintains and even widens the achievement gap. A combination of modifications to our teacher training programs (towards critical education), changes to teaching practice (towards transformational education) and social action on the part of citizens concerned with education can exert enough pressure on the system to force a change. These changes are crucial to the future health of our citizens. If schools continue to perpetuate the cultural concerns which divide, marginalize and oppress non-dominant social groups, health disparities will continue to increase, resulting in bigger and ongoing problems with chronic disease, disability, and premature death.

This cycle must be broken. The task looms large and will require significant time and concerted efforts to achieve the overall goal of improving population health and eliminating health disparities. To start, we need to awaken to the current state of inequitable affairs and understand the possibilities for things to be different. This action can start with the enactment of critical health education. Even at the smallest point of one teacher daring to create a transformational classroom around health, we can begin to see changes. Noted anthropologist Margaret Mead once said, “Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.” Her observation is apropos to this situation. While I concede that this tiny step towards improving health will probably not change the world, we must approach the problem from a comprehensive perspective. By awakening people, one-by-one, to the issues while simultaneously encouraging critical education for everyone *and* using our

voices to advocate for change now, we can move the mountain of public schooling and effect a gradual swing towards intellectualism. The greatness of our country lies in our constitutional right to voice our concerns and speak for change. It is time to stand up and demand a revolution in schooling – our health and well-being depends on it.

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APPENDIX A

FOCUS GROUP METHODS

All students in three sections of ELC 381 during the spring semester of 2006 were invited to participate in the focus groups. A flyer indicating the time, place and discussion topic was passed out following an announcement by the instructor. A modest incentive of a \$20 shopping card was offered for their time. A total of 5 women self-selected to participate in the focus group. The focus group was held in a conference room in the School of Education on Reading Day, when it was believed that the students would have ample time to participate. The young women in the focus group represented small and medium sized towns across the state of North Carolina. Participation was completely voluntary and participants were fully advised of their rights as human subjects in research, as per the protocol approved by the IRB of the University of North Carolina at Greensboro. The focus group lasted approximately two hours.

The focus group was moderated by the researcher and audio-taped using Marantz recorders and multi-directional microphones. The tapes were subsequently transcribed and these transcriptions provided the basis for data analysis. As a descriptive study, the researcher relied on open coding to identify emergent themes, categories, patterns and linkages across focus groups and participants. A wholistic thematic approach was used to derive essential meaning from the statements of participants. These themes were organized into hierarchical categories to describe the stories of participants.

APPENDIX B

FOCUS GROUP QUESTIONS

Health Education in School

If you could rate the healthiness of your school(s), how would you say they were doing? Was health a priority (for students, teachers, others)?

Think about your experiences in elementary, middle and high school in NC. What do you remember about health education?

Can you think of any particular health lessons that made an impact on you or made you think about your personal health?

Tell me about the school environment. Do you remember anything about your school cafeterias, classrooms, gymnasiums, etc. that had an impact on how you thought about your health?

What about informal health education (from peers, parents, churches, youth groups, etc)... what do you remember about how health issues were addressed in places other than school? What else can be done to address literacy needs?

Health Literacy

Health literacy is the ability to read, understand, and act on health care information. This includes reading consent forms, medicine labels, and other written information; understanding written and oral information from health care providers; and acting on procedures and instructions, such as medications and appointment schedules.

How has the health education you received in school impacted your health literacy as a young adult? Do you have access to the health information and health care you need? Do you feel like you have the knowledge you need to make informed decisions about your health?

What about students who make less healthful choices, like to engage in risky sexual behavior, abuse substances, use tobacco, etc? What do you think impacts their decisions? Does health education or health literacy make a difference? What are some of the life events/contexts that lead a young person to engage in risks with their health?

What role should schools play in helping students promote or protect their health?

The Body and Health

Think about your experiences as an embodied person in school. What memories do you have relating to how you learned to understand and control your body in school?

Why do you think we expect children to exercise control of their bodies in the classroom? Does this have any negative health effects?

What is the relationship between knowing your own body and protecting your health?

Solving the Problem

Tell me about what an ideal health education curriculum would look like (remember to think like a student, not a teacher!). When you were a kid, what would have been an exciting, interesting, and relevant way to learn about your body and your health? How would you envision teaching your students about health? How would you make it relevant?