PUBLIC HEALTH AND OPPRESSION: 
NEUTRALIZING SELF-OPPRESSIVE HEALTH COMPROMISES WITHIN 
THE SOCIAL JUSTICE FRAMEWORK

by
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ABSTRACT

Social justice framework is a plausible moral guide for public health, but it has a major drawback: It cannot address cases where individuals autonomously perpetuate their own oppression. Systemic oppression is incompatible with the social justice aims of public health because it perpetuates systemic disadvantage. Adaptive preferences, on the other hand, expose a blind spot for public health institutions pursuing social justice ideals. Social justice theory is conflicted when socially unjust conditions lead oppressed people to support policies and practices that undermine their well-being. Public health cannot be overly paternalistic or individualistic while addressing self-oppression without undermining its moral commitment to social justice. When dealing with oppressive social customs, practices, or compromises that oppressed individuals have chosen, public health institutions have to remember that oppressed people who reinforce their oppression do not lose their agency. One plausible way for public health to address these compromises within the social justice framework would be to adopt the harm neutralization approach. Loosely based in Walzer's concept of complex equality, this strategy includes harm isolation, disincentivization, and harm reduction. In practice, public health would allow individuals to make health compromises that reinforce their oppression, but public health would also work to neutralize, isolate, and reduce harms oppressed populations face when making these health compromises.

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I dedicate my thesis to my two late aunts, Michelle and Regina Griffin.
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INTRODUCTION

In *Social Justice: The Moral Foundations of Public Health and Health Policy*, bioethicists Powers and Faden answer the question: How much inequality in health can a just society tolerate? While answering this question, Powers and Faden develop an anti-oppressive sufficiency theory of social justice, which they argue is the moral foundation of public health. Social justice framework of public health is an account of social justice that morally requires public health to pursue two aims: the establishment of a sufficient amount of six essential dimensions of well-being for everyone, especially health, and the elimination of systematic disadvantage plaguing the most oppression. While promising, the social justice framework of public health cannot fulfill its moral obligations without an answer to the following question: How can public health maintain sufficiency of self-determination for individuals while limiting individual action for the sake of population-level sufficiency of health?

This puzzle is exacerbated by the fact that many people who experience oppression seem to perpetuate their own oppression. Oppression is necessarily an injustice; it is the fundamental injustice of societal institutions. Oppression has always posed a problem for public health institutions, but justice theorists have neglected a phenomenon that allows oppression to continue to plague oppressed population: self-oppression¹. One of the most characteristic and ubiquitous features of the world as

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¹ I purposely use the term self-oppression instead of internalized oppression because this paper does not address the internal or psychological effects of oppression on oppressed people, but instead seeks to propose a plausible solution to a concerning phenomenon. The term, “self-oppression” also is not meant to imply that oppressed people are only oppressed because they think they are or that their oppression is solely the product of their own actions.
experienced by oppressed people is the double bind – situations in which options are reduced to a very few and all of them expose one to penalty, censure or deprivation. Through socialization and internalization, oppressed people can be complicit in their own oppression making compromises and supporting practices that undermine their sufficiency of well-being.

How should public health respond to people who compromise their own health by reducing their oppression? What if their decision to do so worsens their oppression and the oppression of others? Without answer to these questions, public health cannot properly address oppression, allowing the lives of the disadvantaged to continue to be unfairly burdened.

Social justice plausibly grounds public health practice as an endeavor with twin moral impulses: to improve human well-being by improving health and to do so in particular by focusing on the needs and wants of those who are the most disadvantaged and oppressed (82). Socially just public health institutions should be worried about oppression-reinforcing preferences because they are legitimate expression of self-determination, not the procedural deficits in preference formation. Oppressed individuals often develop preferences that undermine their well-being and the well-being of others within their oppressed group and make compromises between dimensions of well-being that place themselves and individuals within their social group at greater disadvantage, warranting moral concern. For example, people who experience racial oppression may develop a preference for a lighter skin color and may compromise their health by bleaching their skin, legitimizing norms that privilege lighter skin. Practically, public
health can address these preferences by being vigilant of self-oppressive health compromises, which have following three qualities:

1. They lead to compromises that undermine the holder’s sufficiency of well-being.
2. They lead to compromises that affect the sufficiency of well-being of other members of the holder’s social group.
3. The holder must be a member of an oppressed group.

In this paper, I propose a plausible approach to neutralizing self-oppressive compromises. Using aspects of harm reduction literature and Michael Walzer’s theory of spheres of justice, I give a plausible justification for public health reducing, disincentivizing, and isolating harmful aspects of self-oppressive compromises without subjecting oppressed populations to unwarranted paternalism, scrutiny, and disrespect. I will conclude this paper with practical implementations of this approach (i.e. public dialogue, ant oppressive campaigns, and community empowerment) and discuss how they integrate into and improve the social justice framework.

Section 1: Social Justice Framework

Though many plausible views of social justice ground and orient public health practice, the social justice framework is particularly apt to address the moral issues endemic to public health. Anthony Downs asserts that the most pressing public issues have two compelling characteristics: They occur to a relative minority of the population, and they are the result of the social arrangements that provide advantages to the majority or to a powerful minority of citizens. Thus, Downs argues, truly addressing these
problems requires painful losses and drastic restructuring, but historically, we have been unwilling to make the sacrifices necessary to address these public problems. In short, our public ethic has not fit our public problems (Downs 1970).

Despite being one of the biggest domains of public life, public health has historically been unwilling to adopt an ethic that addresses the compelling characteristics of public problems. Historically, public health has focused on the population-wide dangers that plague society (i.e. tobacco, alcohol, pollution, infectious disease, etc.). Dan Beauchamp argues that to tackle these public health problems we must abandon an unjust social ethic that allows the most numerous and most powerful to shirk their responsibility to the disadvantaged. Justice, in a social sense, is the belief that each person in society ought to receive their due and that the benefits and burdens of society be fairly and equitably distributed (Beauchamp, 1976; Jonsen and Hellegers, 1974). The moral concern of public health should shift from the most powerful to the most disadvantaged, marginalized, and oppressed. In order to make institutions more socially just, Powers and Faden create a plausible and promising theory of social justice that animates and guides public health’s moral concern. Focusing on social determinants of health, Powers and Faden argue that public health should seek to ensure all people achieve a sufficient level of well-being in six distinct, but interrelated dimensions, and as a matter of social justice, public health should seek to dissolve complex webs of disadvantage that plague the most vulnerable.

1a. Six Entitlements and Sufficiency

Powers and Faden’s version of social justice theory is primarily concerned with
the well-being of populations and individuals, and well-being can be measured by the levels of six basic dimensions: health, personal security, respect, attachment, reason, and self-determination. These dimensions are irreducible and of independent moral importance. Particularly important to public health, sufficiency of health is being in a state of full biological function. Their understanding of health is not limited to an ordinary-language understanding of physical and mental health since it also includes deficits that are not the product of disease, illness, or injury, such as infertility and sexual dysfunction.²

Independent of health, entitlements to personal security protect people from constant fear of physical or psychological abuse³. Independent of, but interrelated to, personal security, sufficiency of respect is achieved when one is seen as a moral equal and has moral worth in one’s own eyes as well as the eyes of others. As a matter of social justice, individuals should be guaranteed respect; others should sympathetically identify with their existence as well as the existence of other members of their group/identity.

Beyond simply having respect for another human being, Powers and Faden argue that social institutions should facilitate the formation and preservation of human attachment. They argue that the ability to care for others is needed to create a socially just society, due to society’s dependence on people who can form attachments (Powers and Faden, 2006, p. 24-26). Reason is the fifth basic entitlement of social justice because the

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² On the other hand, their idea of health is not as broad as the World Health Organization’s definition. To Powers and Faden, health has an independent moral significance and captures the unique biological/organic aspects of human flourishing that are of concern for public health and clinical medicine (Powers and Faden 2006).

³ Injustices like rape, assault, enslavement, etc. are more than issues of respect or health, because they generate an element of fear, trauma, and uncertainty that may not manifest as psychological illness.
development of sufficient critical faculties and independence of judgement is crucial to the establishment of a socially just society (20-22).

The sixth basic dimension of well-being is self-determination. Generally, self-determination is the ability and freedom to have some control over one’s life course. More specifically, individuals should have some control over who they are and what they will become. To Powers and Faden, a socially just society allows the lives of individuals to at least partly be influenced by their choices, interests, and values. None of these six dimensions of well-being take priority over each other; they are all essential.

From the aforementioned six essential dimensions of well-being, Powers and Faden argue that social justice demands all people are guaranteed a minimum level of sufficiency of each dimension of well-being within their socio-technological context. Establishing sufficiency is more than setting a floor. Powers and Faden are concerned with any social inequality that could potentially bring a person below a certain level of well-being. Thus, a sufficient minimal level of well-being is not something that can be determined irrespective of social context, technological and scientific development, and social organization.

1b. Health and Cascading Disadvantage

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4 Powers and Faden argue that sufficiency of health can only be determined in relation with what is technologically feasible (61).
5 Inequalities in income, both absolute and relative, are prime example of the types of inequalities that Powers and Faden worry will eventually lead some to fall below sufficiency of well-being (59). Additionally, Powers and Faden argue that this sufficiency of well-being is “relative to the level of social organization and technological and scientific development in which that must be realized” (60).
6 Furthermore, measures of sufficiency in health and other dimensions must be done on a population level, such that substantial inequalities among populations both within nations and internationally are presumptive evidence of injustice (62).
Public health cannot simply address only issues directly regarding sufficiency of health because social factors determine the health of individuals (Marmot et al, 2008). Understanding the relationship between health, social determinants, and cascading disadvantage is crucial to understanding the task of the social justice framework of public health. Social determinants of health are social factors that affect health. The deterioration in social determinants of health can cause and be caused by the deterioration of any of the dimensions of well-being. Public health must grapple with the interconnectedness of six dimensions of well-being to address the cyclical nature of disadvantage (Powers and Faden, 2006).

The cascading corrosive effect that one insufficiency of well-being has on other dimensions of well-being, as well as social determinants, affects how Powers and Faden decide which inequality is of highest moral concern. According to Powers and Faden,

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7 Some social factors (i.e. poverty) can not only lead to deficiencies of health, but simultaneously lead to deficiencies in other dimensions as well. Other social factors (i.e. lack of health insurance) can lead to deficiencies in health, which then compound into deficiencies in other dimensions of well-being. Though both result in disadvantages in health, there is an important difference between a social determinant that affects multiple dimensions of well-being (including health), and a social determinant that affects health and sets off a domino effect that impacts other dimension of well-being. In the former case, the social determinant could be a dominant good (like money), such that the accumulation or deprivation of said good unfairly affects several aspects of well-being. In this case, the inequality needs to be addressed and the good’s dominance needs to be undermined. The latter case is a complex causal chain that can lead to a downward cascade (65-70).

8 For example, living in poverty can affect an individual’s health, which can in turn drive them further into poverty. However, this interaction may not be isolated. Deterioration in health can strain attachments and undermines one’s ability to reason. Furthermore, as this person is driving further into poverty, their living conditions may become unstable, undermining their sufficiency of personal security and self-determination. As a result the person experiences homelessness and social stigma, which undermines their sufficiency of respect. In this case, poverty affects health, and health, in turn, affects other dimensions and determinants.

9 For example, Ted lives in poverty. Given public schools and free healthcare, Ted’s lack of funds only impacts his sufficiency of respect. In another case, Van is experiencing homelessness. Exposed to the elements and stigma, Van’s lack of shelter could directly affect her health, personal security, and respect attachment. Though both Ted and Van could experience insufficiencies of well-being, there is a morally important difference.
we should give priority to addressing inequalities in the social determinants that affect
more than one dimension of well-being. Thus, systematic disadvantage should have
moral priority because the remediation of inequalities in these social determinants
address issues in more dimensions, which is key to addressing clusters of disadvantage
(70).

Powers and Faden’s view of social justice takes a moderate essentialist view of
human flourishing, arguing that as a matter of justice, public health should ensure all
people are sufficient in each independent dimension of well-being. In their view, the
aforementioned six independent dimensions of well-being are characteristically present
within a decent life\textsuperscript{10}. Though each dimension is commonly present within a decent life, they do not define a life worth living. Furthermore, this moderate essentialist account
serves only as the basis for judging social institutions and practices, not whether a life has
moral worth or whether those with fewer sufficient dimensions of well-being are entitled
to the same moral considered as others. The job of social justice is to facilitate sufficient
levels of well-being in each separate indicator of a decent life. Clearly, failure to achieve
this goal does not necessarily mean a society is unjust, but lack of sufficient levels of
well-being in an essential dimension may be evidence of a deeper social injustice. Thus,
each dimension must independently be a matter of moral concern for social justice.

\textbf{1c. Social Justice Framework of Public Health}

Characterized above, Powers and Faden’s social justice theory seeks to lay the

\textsuperscript{10} They contend that there exists no threshold level for each dimension of well-being that is a necessary
condition for a decent life, but instead believe that each dimension is such that a life substantially lacking in
any one lacks in what is reasonable for anyone to want, whatever that may be.
moral foundation for public health, creating a social justice framework for public health. This social justice framework is an ethical framework with which public health interventions are justified, guided, and evaluated based on their adherence to Powers and Faden’s social justice theory. Within this framework, public health has two social justice-related obligations: elimination of systematic disadvantages and facilitation of sufficiency of health.

The negative point of social justice requires public health to be vigilant of determinants that compound and reinforce insufficiencies across multiple dimensions of well-being that make flourishing difficult if not impossible. Moreover, public health should monitor the health of those experiencing systematic disadvantage and intervene to reduce inequalities. If people are faring worse based on their group membership, then public health should be concerned, especially when these groups are based on non-voluntary social categories like race, gender, disability.

The positive point, on the other hand, requires public health and others institutions to ensure a sufficient amount of each essential dimension of well-being for everyone. Sufficiency, as mentioned before, is context-dependent, and thus, public health cannot determine precise levels (numerical or otherwise) of health guaranteed to everyone everywhere. Instead, Powers and Faden make use of a less demanding account of sufficiency in health: public health should aspire to guarantee everyone enough health over a long enough life span to live a decent life. This account does not demand perfect

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11 It is important to note that public health should monitor the health inequality between subordinate and dominant populations, not only individuals.
equality of health between persons, and thus, some being healthier than others is not necessarily a matter of justice. Inequalities, however, raise moral concern and may be evidence of a deeper injustice.\(^{12}\)

Beyond guiding priorities for public health actions, the social justice framework requires public health to address dimensions outside the typical scope of public health. By focusing on six dimensions of well-being, the social justice framework draws attention to the cascading relationship between health and other aspects of life like education and housing. As previously mentioned, public health has historically been attentive to population health in a narrow sense, improving health as determined through biomarkers of mortality and morbidity rates, but public health has since adopted the social determinants of health framework (Downs, 1970; Marmot et al, 2008). The social determinant of health framework requires public health to move beyond narrow ideas of health and address cultural and structural determinants that influence health.\(^{13}\) Powers and Faden’s theory of social justice is the moral foundation for public health’s adoption of social determinants of health framework.

Public health is fundamentally anti-oppressive. Public health seeks to eliminate densely-woven webs of systematic disadvantage and establish sufficiency of well-being. Prime obstacles of this, according to Powers and Faden, are racism, sexism, and other

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\(^{12}\) The difference between a mere inequality and injustice cannot be determined solely by the size of disparity, but by the existence of social disadvantages or an established relationship between a social determinant and a health disparity.

\(^{13}\) Powers and Faden argue that public health has a special moral relationship with health, such that public health should strive to establish sufficiency of health. This does not mean however that public health can neglect the impact health has on other dimensions of well-being or the impact other dimensions of well-being have on health.
forms of non-voluntary group oppression (Powers & Faden 2006). Thus, public health must seek to eliminate oppression since it drives systematic disadvantage and undermines sufficiency of well-being. Furthermore, group domination, discrimination, and oppression have cascading effects on the health of the public, and thus, a social justice-driven public health must address these issues. This focus on the vulnerable defies Down’s criticism of public health ethics. Powers and Faden call for a radical reorientation of public health towards the most vulnerable and a restructuring of social and institutional arrangements to ensure sufficiency and eliminate disadvantage.

**Section 2: Compromising Dimensions**

While promising, the social justice framework response to individual trade-offs between dimensions of well-being is underdeveloped. By focusing on population-level sufficiency, the social justice framework necessarily places limits on individual actions for the sake of population health and well-being. Limiting actions that have negative effects on others (i.e. infectious diseases) or burden society (i.e. motorcycle helmet laws) allows public health to achieve sufficient population levels of well-being. These limitations, however, impact the self-determination of those who have preferences that, if acted upon, would undermine the population-level sufficiency of well-being. How can public health maintain sufficiency of self-determination for individuals while limiting individual action for the sake of population-level sufficiency of health? By focusing on the direct harm an individual trade-off does to others, public health may justify limiting self-determination, but this severely limits the social justice framework’s ability to address compromises that indirectly harm others in ways that are morally concerning to
In this section, I will argue that since self-determination is an essential dimension of well-being, public health must allow people to compromise their sufficiency of health if they so choose. I will also argue that social justice theory requires public health to limit some individual choices for the sake of population level sufficiency. I will show that the conflict between these two moral requirements raises questions about the theory’s ability to address health compromises that indirectly harm others.

2a. Self-Determination

Given the importance of sufficiency of self-determination, the social justice framework places no restrictions on individuals who want to make compromises that undermine their sufficiency of well-being if there is no direct foreseeable harm to others. Powers and Faden have good reasons for allowing individuals to compromise their levels of well-being; they claim: “While our theory is one that sets some limits on trade-offs among the separate dimensions of well-being, limits on trade-offs are applicable in certain contexts. We do not claim that individuals would be acting irrationally or unjustly if they themselves make trade-offs among the dimensions” (30). Powers and Faden’s stance stems from the fact that self-determination is an essential dimension of well-being and that their theory is moderately essentialist. If people can live decent lives without all dimensions of well-being, then they should be allowed to sacrifice one for another. Furthermore, if people were not allowed to compromise their sufficiency well-being, their self-determination would be severely impacted. For example, students often drink caffeine-laced energy drinks and forgo sleep to study and write papers (like the one you
are reading). These students are making the choice to sacrifice their health to refine their reasoning abilities. Pulling an all-nighter, however ill-advised from a health perspective, is commonplace and intuitively acceptable. Moreover, restricting this type of trade-off would unfairly burden the individual since only the student’s sufficiency is directly affected by this compromise (unless they plan on operating heavy machinery or driving a vehicle home).

2b. Limiting Individual Compromises

In pursuit of population-wide sufficiency of health, the social justice framework of public health limits individual health compromises between dimensions of well-being. Since social justice focuses on population-level sufficiency, some health choices would be too extreme to tolerate. For example, if a person wanted to contract multidrug-resistant tuberculosis, public health would have major difficulties allowing the fulfillment of this preference. The genuineness of this desire would undoubtedly be questioned. Could anyone rationally desire to have a deadly infectious disease? If it were determined that the desire was genuine, then our primary concern would be the transmission of infection to others, which threatens population-level health insufficiency. This concern about an action’s impact on others grounds many of public health’s limitations of individual actions. For example, the justification for motorcycle helmet laws lies in similar logic. Motorcycle accidents without helmets pose not only a great risk to the

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14 I use the term “compromise” and “tradeoffs” interchangeably to denote actions that sacrifice one dimension of well-being for another. In many cases, health is sacrificed for self-determination.

15 This example is purposefully ridiculous to capture the intuition that some things are so unpleasant we could not imagine anyone rationally choosing to be exposed to it.
individual but also place a great economic and social burden on others. Motorcyclists may argue that being able to feel the wind in their hair is a crucial part of their sufficiency of self-determination, but this joy does not seem to outweigh the risks and burdens their behavior invites on others. Thus, social justice has good reason to limit individual compromises if they threaten the sufficiency of well-being of others.

Though public health has good reason to limit some individual compromises, ensuring sufficiency of self-determination is equally important to the pursuit of socially just public health; this creates a tension within the social justice framework. Public health cannot maintain sufficiency of self-determination for individuals while limiting their behavior for the sake of population-level sufficiency of health. The harm or burden an action places on others serves as a common justification for limiting individual autonomy. Another common justification would be that the desire for the compromise is dubious. What about cases where the harm is not obvious and the genuineness of the choice is in dispute? How should public health respond to these individual compromises?

Section 3: Choice, Adaptation, and Self-Oppression

It has been a longstanding problem for theorists of justice that people under oppressive circumstances seem to perpetuate their own oppression. Worse, many victims of injustice and oppression seem to perpetuate/reproduce their own oppression after oppressive circumstances have ceased (Cudd, 1994; Khader, 2012; Freire, 1968). There are many different names for this phenomenon across many different fields, but for the
purposes of this paper, I will refer to this phenomenon as self-oppression\textsuperscript{16}.

Many theorists of justice address this issue by stating that the preferences that drive this phenomenon are adaptive, irrational, involuntary, or in some other way invalid, rendering them inconsequential to or subordinate within theories of justice (Baber, 2007; Narayan, 2002; Elster, 1982). Other theorists consider these preferences to be what the oppressed are “made to prefer”, and thus argue they cannot be excluded from social justice considerations (Teschl and Comim, 2005, p.236; Nussbaum, 2001; Sen, 2002; Sen, 2001). Depending on how we classify the preferences of those who want to make these compromises, social justice can dismiss them as illegitimate expressions of self-determination, resolving any conflict between population level sufficiency and individual self-determination. Since by public health must focus on the “needs and wants” of those who are the most disadvantaged and oppressed, we must explore whether or not self-oppression can be dismissed as disingenuous (Powers and Faden, 2006, p.82).

Public health must reconcile individual entitlements to self-determination with population-level concerns about sufficiency to achieve its goals. In section 2, I argued that the social justice framework is able to respond to a limited case of tradeoffs, tradeoffs that directly harm other. In this section, I will give an account of self-oppression that indirectly harms others, which reveals a conflict between social justice theories

\textsuperscript{16} For example, sociologists following a Marxist tradition have argued that the colonized and dominated develop a false consciousness in response to their domination (Freire, 1970; Engels, 1893). Marxist and socialist feminists have accused women who choose to be oppressed of having a false consciousness as a result of their oppression (Stanley & Wise, 1993). Feminist and anti-oppression scholars believe the root cause to be an internalization of oppression (Frye, 1983; Walker, 1995; Pyke, 2010). Educational scholars argue that the agents learn their own oppression and then act it out because they have no other frame from which to act (Tatum 1997; Tappan 2006; Tappan, 2005). Psychologists argue that this is a form of Stockholm syndrome caused by oppression (Adorjan et al, 2012).
commitment to self-determination and population-level sufficiency’s ability. In order to show that conflict is problem, I will show that self-oppression as it relates to public health is not merely the product of procedural deficits in preference formation, and thus, cannot be dismissed as disingenuous.

3a. Choosing Genital Cutting

Scholars, journalists, and experts have documented the tendency for oppressed people to adopt preferences that undermine their health, their empowerment, and/or their liberation (Peters 1987). “No, no, she was proud,” said Bettina Shell-Duncan, an anthropology professor at the University of Washington, referring to witnessing a female genital cutting (FGC) ritual for the first time. There was no struggle or dispute. The bride, 16, did not even flinch as her clitoris and inner labia were removed by an elder woman. This ritual was not about modesty or virginity, but about womanhood. After the ritual, the bride joined the other villagers in dancing. She was overcome with joy. This was 1996. Female genital cutting was normal among the Rendille, and very little has changed (Khazan, 2015). Typically done by elderly women, female genital cutting is practiced extensively throughout the Middle East and Africa (UNICEF, 2016). Many western liberal feminists have called this practice a form of male control of female sexuality and sexual pleasure, but many women within the aforementioned cultures disagree (Khazan 2015). Data from around Africa shows that support for female genital cutting is stronger among women than men, but data also supports the claim that certain forms of female genital cutting have severe health consequences (UNICEF, 2016). To these women, deciding between being viewed as a legitimate women, proper Muslim, and sexually
desirable wife or suffering the health consequences of female genital cutting is not
difficult. For many, the social benefits outweigh the possible detriment to their health.
For decades, western feminist scholars have struggled to disentangle genuine preferences
for female genital cutting from preferences influenced by the deeply patriarchal and
socially unjust conditions of these societies.

The desire to undergo female genital cutting is a paradigmatic example of a
preference that reinforces and recreates one’s own oppression. As previously stated,
female genital cutting has real health effects, but there are still women who would desire
to be cut. To be proud after this experience reveals a deep preference for the action,
despite severe health effects. The health effects of female genital cutting further
disenfranchise women and perpetuate their subordinate role in societies that practice
female genital cutting. Though female genital cutting is a paradigmatic case, there are
several accounts of oppressed people supporting their own oppression through
preferences that undermine their health, empowerment, and/or liberation. Additionally,
there are no quantitative measures of how often oppressed people reinforce their
oppression, but this phenomenon is backed by qualitative studies.

17 This claim does not assign blame to oppressed people for being oppressed or for being a part of their
oppression. Also, I do not claim that the oppression itself is not a problem for the social justice framework
or that the people who experience oppression have the primary responsibility for combating oppression. I
am simply establishing a well-documented phenomenon and its negative effects.
18 Similarly, a study of village women in Bangladesh, who are illiterate and lack any access to education,
found that they had no desire for educational opportunities (Chen 1986). Without these opportunities, these
women had fewer opportunities to exercise freedom from their male counterparts. Another example would
be women starving themselves or limiting how much they eat in order to adhere to some value-laden
concept of femininity or male-created beauty standard. Skin-bleaching amongst dark-skinned people can
have severe health consequences. Like female genital cutting, it may afford someone greater self-esteem,
but there is no way to disentangle this confidence boost from a system that oppresses the individual and a
social group of which they are a part. Sen, Nussbaum, and Levy captured a dizzying array of empirical
Unlike the cases of motorcycle helmets and infectious disease, this case poses a different challenge to the social justice framework. It is unclear how self-oppression harms others and it is unclear if why anyone would choose to oppress themselves. For female genital cutting, the harm is primarily focused on the individual, but there is possible indirect harm on others through the reinforcement of gender oppression. The legitimacy of the desire to undergo female genital cutting is under dispute. The societies in which female genital cutting takes place are all deeply patriarchal, but in some cases, women are not forced to be cut. Like Shell-Duncan observed, they seemingly volunteer. If, like critics argue, these preferences are procedurally deficient and disingenuous, then they are not a problem for public health because acting on them is not self-determination. A moral commitment to self-determination limits public health’s ability to address actions where the harm is more indirect and desire is genuine. If it is not possible to genuinely choose to undergo female genital cutting or take part in similarly problematic acts, then public health can limit female genital cutting and other self-oppression without undermining sufficiency of self-determination.

3b. Genuineness, Adaption and Procedural Deficits

How does someone come to prefer behavior that reinforces their oppression?
Adapting one’s preferences to one’s circumstances is common and innocuous, but adaptation to unjust circumstances raises moral suspicion. Individual preferences and
desires are not formed independent of environmental and structural circumstances. In fact, many of our preferences are responsive to a wide range of structural, social, economic, interpersonal, and cultural factors. Most arise in response to our understanding of worth and value (i.e. we think something is good, and thus, develop a desire for it). Walker calls these preferences “responsive preferences.” Nearly all preferences we hold are responsive preferences in one way or another. Technically these responsive preferences are adaptive to circumstance, but Walker points out that this use the phrase, "adaptive preference" (AP) is wholly innocuous, and thus, useless (Walker, 1995). Instead, he uses the phrase to denote a class of responsive preferences that are formed in response to oppressive conditions. Political philosophers and justice theorists argue that self-oppression stems from adaptive preference formation, but there is considerable disagreement on how adaptive preferences are formed (Elster, 1982, Nussbaum, 2001, Sen 2002, Khader 2011, Cudd 2006, Charles 2010; Levey, 2005).

Jon Elster and others agree that one can adapt to their circumstances and thus, reinforce their oppression; however, they argue that this is not a genuine choice and that deficits in preference formation, not oppression, are the morally relevant issue. Proceduralists argue that the causes and content do not matter, but instead the flaws in formation of the preference or compromises in autonomy are morally relevant. This proceduralist account of adaptive preferences argues that these adaptive preferences be ignored from justice considerations. Jon Elster’s standard definition of adaptive preference is modeled from the Aesop and La Fontaine’s “Fox and Grapes” parable. Upon realizing that he cannot reach the grapes he wants, the fox insists that “grapes are
too sour for foxes,” and that he did not want them any way (Elster, 1982). Elster uses this example to claim that the unconscious, irrational nature of adaptive preferences makes them morally suspicious. To Elster, the procedure by which adaptive preferences are formed make them dubious and worthy of exclusion from social consideration.

Elster views adaptive preferences as fundamentally irrational and involuntary. The fox is fooling himself into believing the grapes are sour. More importantly, he does not know that he is deluding himself; the process by which he comes to devalue the grapes is subconscious. If the fox decided he would focus on acquiring a taste for fruit he could reach, Elster would no longer consider his preference adaptive. For Elster, preferences formed consciously, rationally, and with autonomous character planning are not adaptive, even if they are made under oppressive conditions or reinforce oppression.

Other justice theorists reject Elster’s proceduralist view of adaptive preferences and other similar criteria for adaptive preferences. Nussbaum argues that it does not matter whether or not a desire is formed unconsciously (2001). Though the type of preferences she tries to distinguish could be formed unconsciously, consciousness alone is not a reasonable criterion for denoting a preference as adaptive. Many people unconsciously revise their life plans, deciding to be accountants instead of astronauts. A crucial part of growing up, there is no reason to distrust this preference solely because it is unconscious or trust it merely because it is conscious. More importantly, many people unconsciously decide not to undergo female genital cutting, but we do intuitively find that preference suspect.

Similarly, other scholars have argued that a lack of critical reflection or positive
self-esteem/worth explains why adaptive preferences are worthy of moral suspicion (de Koning, 1995; Nussbaum, 2000; Charles, 2010). Khader points out that there is no reason to assume oppressed people who exhibit behavior commonly associated with adaptive preferences reflect less than people without them. Khader argues that it does not follow that a restricted set of options would lead to impaired self-reflectiveness or rationality (Khader, 2011); Stoljar argue that even with reflection preferences made under oppressive conditions will still be influenced by those conditions (Stoljar & Mackenzie 2000).

Many non-proceduralist theorists accept that oppression can have negative effects on one’s self view (Powers and Faden 2006; Cudd 1994). Khader argues, however, that what makes adaptive preferences morally suspicious is not that they come from someone with a damaged sense of self-worth. Empirically, Khader notes that several studies showed that women with a diminished sense of self-worth only exhibited this lack of self-worth in interactions with men. They often asserted their dominance in relation to other women (Gujit and Shah, 1998; Kothari, 2001). This supports Khader’s larger point that it is implausible that every person who has adaptive preferences just does not see themselves as valuable. Self-esteem and self-worth fluctuate heavily based on a myriad of contextual factors, and thus, there are clearly ways in which someone can think poorly of themselves, develop preference that correlates to that self-view, and fail to arouse moral suspicion. For example, if I have a low self-esteem when I do math and it turns out that I am, in fact, terrible at math, then my preference to be a musician does not seem to be adaptive. In conclusion, it is possible for a person with adaptive preferences to have
compromised self-worth or autonomy, but it is not necessary for characterizing the morally concerning aspect of adaptive preferences\footnote{This claim will be defended again when I outline how public health must treat those who hold adaptive preferences in Section 6.}.

Proceduralist accounts do not capture what is morally suspicious about preferences for female genital cutting nor do they prove that these preferences are illegitimate. Based on proceduralist accounts, someone can have major procedural deficits and still choose not to undergo female genital cutting and conversely, someone with no procedural deficits in their decision-making can still choose female genital cutting. Thus, if someone can consciously, rationally, and reflectively choose to reinforce their oppression, then procedural accounts do not adequately capture what about these preferences are morally concerning to public health.

**Section 4: Preferences for Oppression**

Public health should not be concerned with all preferences made in response to changing circumstances nor should public health be concerned with all preferences made with procedural deficits. What, then, is the preference to undergo female genital cutting? As shown in section 3, the procedural accounts do not sufficiently define what makes the preferences that reinforce oppression relevant to public health nor do they rule out these preferences are illegitimate based on procedural deficits. Instead of focusing on the process by which preferences are formed, we should analyze the content. In our case, defining adaptive preferences is inevitably a partly normative project because we cannot establish basis for moral concern solely on the process by which the preference was
formed. Since public health is anti-oppressive, it is concerned about the desire to undergo female genital cutting because it perpetuates oppression and undermines sufficiency of health. Preferences like these are a special class of adaptive preferences that should be of interest to public health because of their normative relationship to oppressive socialization and oppressive norms.

In this section, I argue that a preference for female genital cutting is a self-oppressive preference. Expanding on Cudd’s analysis, I characterize this type of normative adaptive preference and explain the mechanisms by which they reinforce oppression.

4a. Expectations, Socialization, and Oppression

Recall that within the social justice framework, public health is anti-oppressive. Given public health’s obligation to eliminate oppression, preferences that reinforce oppression should be problematic for public health. Intuitively, we care about people reinforcing their oppression because oppression is social injustice. The moral suspiciousness of a preference may be derived solely from the fact that it reinforces the holder’s oppression or that it jeopardizes the holder’s ability to self-determine. Additionally, a major concern for public health is the effect individual action has on others. Thus, the main issue with adaptive preferences, as they relate to public health, is that they reinforce oppression and legitimize of harm on others. Thus, I argue that preferences that reinforce oppression undermine social justice, and thus warrant moral concern from public health.

In her paper, “Adaptations to Oppression,” Ann Cudd (2014) defines a type of
adaptive preferences that are caused by oppressive circumstances and reinforce oppressive conditions. These preferences adaptive to and for oppression (PAO) are the type of preferences for self-oppression that public health should address. Preferences to and for oppression are held by oppressed people and problematic for two key reasons: they are formed under oppressive conditions and harm others when acted on. Cudd sees this as the primary harm of preferences to and for oppression. Preferences to and for oppression do not just harm the holder; they harm other members of the oppressed group by restricting the feasible set for the oppressed group. Cudd argues that non-voluntary social groups like classes, genders, and races are at the center of systems of group domination made worse by the legitimization of certain norms (2006). By legitimizing structural dominance, preferences to and for oppression restrict the feasible set of options for the oppressed group. For example, gender oppression may lead a woman to starve herself for her family. What makes her preference problematic is that it is formed in response to gender oppression and reinforces that oppression by legitimizing structural dominance that limits their options based on their gender. Paradigmatic cases like female genital cutting, skin bleaching, and self-starvation are considered preferences to and for oppression.

Walker and Levey’s characterization of adaptive preferences highlight two important components of preferences to and for oppression. First, preferences to and for oppression are influenced by expectations. Walker focuses on the denigration of certain

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20 For any particular pair of identities, there are alphas, which are structurally dominant over the subordinated betas. Part of this subordination is the restriction of the beta’s feasible set of options.
options and expectations as by-products of oppressive structures. For example, a person with homosexual desires may come to prefer not to live an openly gay life because that way of life is relentlessly portrayed as evil in her culture and/or she would be subjected to major social stigma. This limitation of options may lead her to say it is better to deny her desires. Similarly, she could view living a life that is happy and openly gay as impossible, and thus resign to living a life hiding her desires. If either of these preferences were formed largely as a result of oppressive social structures, then, to Walker, they are adaptive preferences (Walker, 1991). From Walker’s argument, it is clear that what oppressed people can expect to experience plays an important role in self-oppression.

The second component of preferences to and for oppression is socialization. Expanding on Walker’s claim, Ann Levey argues that the oppressive circumstances of one’s upbringing plays a key role in what one perceives as a legitimate option. She attributes her affinity to socialism as a product of her socialist upbringing, saying “not being a socialist of some sort was never presented to me as a live option” (Levey, 2005). We intuitively know that the things we prefer are not solely products of intrinsic wants, but by-products of interplay between social, environmental, genetic, and political factors. According to Levey, people routinely adapt their preferences based on their perceived legitimate options, and one’s upbringing largely both determines what these options are and whether or not they perceive them as legitimate. Levey claims we should be concerned by gendered adaption if this leads to a restriction of legitimate options,

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21 For example, young girls who receive more praise for being quiet and pretty are likely to form preferences for fashion over sports. Similarly, fashion careers reward these traits while sports careers do not. Thus, young girls given this praise early in life will seek out more of this praise in a fashion career.
perceived or otherwise (i.e. girls believing girls should do fashion or girls can’t play sports).

Many oppressed people are socialized into their oppression. Powers and Faden also recognize that socialization and social conditions can affect what compromises people want/choose. Mill claims that the customs and social practices that subjugate women create “mental chains” that interfere with their development (Mill, 1869). Drawing from Mills’ observations about the subjugation of women, Powers and Faden acknowledge that custom and culture can augment what one demands for themselves and what they understand as an appropriate moral claims in regards to others (Powers and Faden, 2006, p. 32). General preference adaptivity via socialization does not pose a problem for the social justice framework, but socialization based on gender oppression is of moral concern because it reinforces oppression.

4b. Choosing Oppression

Can preference to and for oppression be a rational choice? Under oppressive conditions, individual decision-making is influenced by social expectations, stereotypes, and norms, which in concert can perpetuate inequality through rational choice. The oppressive social beliefs and customs about a given group can superimpose onto individual behavior, reinforcing expectations, norms, and beliefs that are oppressive to the individual. Under these circumstances, their choices are limited but rational nonetheless. According to Cudd, we should assume that “the social environment systematically rewards andpunishes behaviors by members of specific social groups and thereby induces a preference structure on (most) members” (Cudd, 2005; p.45). An
example of this would be the norms of femininity. Cudd argues that women are rewarded for being passive and sanctioned for being assertive. The stereotype of passivity serves as a reference point for favored behaviors, pressuring women to act accordingly. Women are often aware of these stereotypes and form expectations based on their presence. These expectations, Cudd argues, are constraints that motivate individual behaviors in ways that tend to reinforce the oppressive norms upon which the expectation is built (Cudd, 2005).

In other words, the reasonable choice can also be the one that legitimizes oppression. Thus, oppressed individuals can rationally choose to act on a preference to and for oppression. Based on this discussion, I take preferences to and for oppression to be legitimate preferences and thus, a type of self-determining desire that cannot be ignored by the social justice framework.

In the following section, I will further analyze the relationship between preferences to and for oppression and oppression within the social justice framework of public health.

**Section 5: Libertarian Approach to Self-Oppression**

Considering preferences to and for oppression can be chosen rationally, they can be legitimate aspects of self-determination. Thus, public health may take a libertarian approach to preferences to and for oppression, allowing individuals to freely act on them. Preferences to and for oppression are, however, problematic within the social justice framework. Like infectious diseases and motorcycle helmets, preferences to and for oppression harm and burden others. Oppressive norms pose a threat to the sufficiency of well-being of oppressed people and preferences to and for oppression approve and
reinforce these norms. Social justice should care about preferences to and for oppression because they support oppression and oppressive norms, which breed systematic disadvantage. Allowing them to go unaddressed interferes with public health’s ability to fulfill its moral obligations.

In this section, I will argue that giving oppressed individuals complete freedom to act on preferences to and for oppression will lead to health compromises that reinforce and recreate oppressive social customs and norms, jeopardizing population-level sufficiency of health.

5a. Pitfalls of Libertarianism

Individuals can choose to experience lower levels of health to increase another dimension of well-being, but preferences to and for oppression jeopardize population level sufficiency of well-being, posing a problem for social justice-driven public health. Imagine this scenario: A woman starves herself to maintain her attachment to her husband. Health is being undermined for the sake of another dimension of well-being, (in this case, attachment). This case, however, is alarming because it could potentially fit the criteria for a preference to and for oppression. Starving oneself can have dire effects on health and cascading consequences beyond health. If this preference formed under gender oppressive conditions (i.e. the number of feasible options for her is limited because she is a woman) and she was socialized under these conditions, then this preference would be a preference to and for oppression. As an individual preference, this preference is questionable, but as a group preference or a trend amongst a population, addressing this preference and the subsequent gendered health inequality becomes a moral necessity for
socially just public health.

Imagine a scenario where women are starving themselves for their husbands. We can imagine a social trend might arise where women starves themselves, not solely for attachment but also for respect. In this case, starving yourself raises your social standing as a woman. Individually, each preference to and for oppression does not seem to warrant attention from public health on moral grounds, but taken as a group preference, preferences to and for oppression create and perpetuate social trends, customs, and norms that oppress all members of the group. Health trends that arise from oppressed people acting on these preferences can create or widen inequality between social groups. This inequality may have cascading negative effects on individual and population health, further disadvantaging the disadvantaged.

5b. Preferences and Public Health

Public health should be specifically concerned with preferences to and for oppression because when acted upon by groups, they reinforces and further entrench oppression by supporting oppressive norms. By legitimizing oppressive norms, preferences to and for oppression restrict the feasible set of options for other members of an oppressed people, undermining their sufficiency of self-determination. For example, women who undergo female genital cutting have been socialized into a culture that values female genital cutting from a young age. The oppressive norm of female genital cutting certainly reinforces the oppression for women in societies that practice female genital cutting by increasing their mortality and morbidity rates of women who get cut and socially sanctioning and economically depriving women who do not get cut. On an
individual level, increased mortality does not constitute a social injustice, but the social forces around this norm that unfairly pressure more women to get cut are legitimized when women seemingly choose to get cut. The oppressive norm not only goes unchallenged, but gains the tacit approval of those who cut. These individual compromises culminate in a health disparity between men and women, and this health disparity could have cascading disadvantages on attachment, self-determination, and/or respect, leaving women burdened by clusters of disadvantages. Thus, given the moral obligations of public health, it must be concerned with preferences to and for oppression because they disadvantage already disadvantaged groups.

Preferences to and for oppression influenced by oppressive socialization and oppressive norms can mislead and undermine public health interventions. Let us turn to an empirical example of women with adaptive preferences. In a 1944 study of widowers and widows in India, 45.6% of the widowers reported their health as “ill” or “indifferent,” while only 2.5% of the widows reported their health to be “ill” (none reported “indifferent”). Compared to the real situation, and what one knows about widows’ in India – they are often particularly bad off in terms of health and nutrition – this is quite a striking result. It can teach us how “quiet acceptance of deprivation and bad fate affects the scale of dissatisfaction generated (Sen, 1999).

In this case, public health should establish sufficient levels of health and nutrition for all people. Sufficiency, as explained earlier, is context-dependent and based on empirical data. This study would lead us to believe that the widowers are in need of public health interventions instead of the widows. Furthermore, gendered customs around
acceptance of deprivation must be addressed if public health has any hope of eliminating
the systemic disadvantages these women face. As previously stated oppressive norms and
customs are not the only obstacle. These women were likely socialized into a society
where they were taught to accept these levels of health and this may reinforce systematic
disadvantage. Thus, simply allowing these women to make health compromises allows
them to reinforce oppressive norms, which, in turn, impacts socialization, and
subsequently, preferences. Thus, the disparity seen in the study could go unaddressed and
the cycle of oppression continues.

Section 6: Paternalistic Approach to Self-Oppression

In the previous section, I argued that the social justice framework needs to address
the fact that people hold preferences that reinforce their oppression and these preferences
lead to health tradeoffs that perpetuate oppression. Preferences to and for oppression and
compromises motivated by preferences to and for oppression pose a threat to public
health’s ability to establish sufficiency of well-being and eliminate systematic
disadvantage. According to positive and negative points of social justice, public health
has a moral obligation to address preferences to and for oppression. Based on the
negative point of social justice, public health cannot ignore oppressive social customs and
trends which perpetuate densely-woven systems of disadvantage. As shown, giving
individuals with preferences to and for oppression no limitations for health compromises
allows them to recreate their own oppression. Thus, this libertarian approach to address
preferences to and for oppression violates the moral obligations of public health and thus
public health is justified in addressing preferences to and for oppression.
Since oppression is a serious injustice, public health’s first instinct may be to set strict prohibitions on the type of compromises oppressed people can make. Since public health cannot police thoughts, individuals would still have preferences to and for oppression, but they would be forbidden to act on them. This response is the precise opposite of libertarian approach to individual compromises, and as such, it prevents individuals from reinforcing their own oppression. This liberty-limiting approach, however, may be unjustifiably paternalistic, denying the agency of people who hold preferences to and for oppression and violating the moral obligations imbued in public health by the social justice framework. Thus, public health needs guidance on how to address this problem without being overly paternalistic (violating self-determination), overly individualistic (ignoring oppressive social customs and trends among populations), or insensitive to the moral standing of those with preferences that reinforce their own oppression. Clearly, public health's response to this issue must not undermine its social justice obligations. To this end, public health’s approach to preferences to and for oppression must recognize the agency of those with adaptive preferences and treat them as moral equals. Moreover, public health should not disrespect the oppressed, threaten their ability to self-determine, perpetuate disadvantage, or ignore the input of the oppressed.

In this section, I explain why paternalistic approaches to preferences to and for oppression are incompatible with the social justice framework and explore how public health conceptualizes treat individuals who reinforce their own oppression. Based on Khader’s analysis and the moral obligations of public health, I will also outline some
conceptual and practical requirements for treating people who are complicit in their own oppression respectfully and fairly.

6a. Pitfalls of Paternalism

Paternalistic approaches to preferences to and for oppression can disrespect oppressed people, further disadvantaging the disadvantaged. There has always been tension between paternalism and libertarianism within public health ethics. For my uses, paternalism is an approach that limits some individual’s or group of individuals’ liberty or autonomy for what is presumed to be their own good (Dworkin 2010). In the case of adaptive preferences, this approach could yield disastrous results. Let’s return to the example of women starving themselves for their husbands. Public health can combat this trend by forcing these women to eat as much as their husband or as much as they need to no longer feel the negative effects of starvation, establishing a sufficiency of health. As individuals, these women, however, are entitled to a degree of self-determination and personal security. These dimensions of well-being would be undoubtedly limited by a public health intervention that compels them to eat through force. Other forms of manipulation would also be morally problematic because there is no reason to assume these women cannot reason. Moreover, in order to justify the paternalistic approach, one must assume that those who have preferences to and for oppression all have compromised autonomy or are being coerced in the starving themselves. These women could be making the most rational choice given insufficiency in food access. Upon further analysis, public health interventionists could discover that starving themselves gives more food for their husbands and children. In this case, starving oneself is a logical
choice. Within a patriarchal structure, her husband’s health matters more to the economic viability of the family (Khader 2012).

Take a less coercive and intrusive example. Imagine a minority group that refuses to fulfill basic hygiene requirements for school. For the sake of the relevancy, this group has this preference as a result of oppressive norms, and this preference also feeds into their own oppression. Public health could respond by placing harsh penalties on people who do not fulfill basic hygiene requirements. This may lead to better health and educational outcomes, but this approach violates their self-determination and respect. Instead of giving this population the freedom to choose whether or not they wanted to achieve a sufficiency of health or education, public health pressured them into the choice. Assuming imperfect compliance, there would be some disadvantaged people who would have to deal with harsh penalties, no education, and poor health. Since placing additional burdens on disadvantaged populations can have cascading negative effects, this approach could alleviate systematic disadvantage for some and worsen it for others.

Additionally, the benefits of paternalistic approaches are contingent on public health being correct in its assessment of the benefits and burdens. The educational system could be underfunded and unable to sustain an influx of disadvantaged students. The economic cost of basic hygiene may undercut people’s ability to buy food or pay for shelter. Clearly, there are unforeseen consequences of any public health intervention, but paternalistic approaches, in particular, are vulnerable to this criticism because they limit options and restrict liberty. No matter how benevolent the intentions may be, paternalistic approaches are intrusive and restrictive, potentially undermining several dimensions of
well-being of already disadvantaged populations.

6b. Criteria for Socially Just Approaches to Adaptive preferences

Based on the social justice framework, public health is obligated to address the cascading disadvantage the oppressed may experience from their preferences to and for oppression, but this obligation must be tempered by an obligation to ensure sufficiency of self-determination and respect. While trying to paternalistically address preferences to and for oppression, public health may have to make a compromise between autonomy and health. According to Powers and Faden, institutions like public health cannot make these compromises for individuals, even if it keeps the individual from acting on preferences to and for oppression. Public health must establish sufficiency of all dimensions of well-being including self-determination and respect. Furthermore, force-feeding women or penalizing minority groups for noncompliance would render public health’s moral goal unattainable. Based on the positive point of social justice, public health cannot be overly paternalistic without violating sufficiency of self-determination, and based on the negative point, public health cannot be too laissez faire without allowing systematic disadvantage to go unchallenged. Thus, public health interventions aimed at remedying preferences to and for oppression must maintain sufficient levels of respect and self-determination for those who support hold and act on preferences to and for oppression.

Any public health approach to preferences to and for oppression must recognize that those who reinforce their own oppression retain agency and deserve respect. To that end, public health approaches to preferences to and for oppression must follow Khader’s
three moral criteria for respecting the rationality of people with adaptive preferences: 
cognitive capacity, complex moral psychology, and limited option set criteria. The
cognitive capacity criterion requires public health to recognize that the oppressed retain
the ability to make accurate non-normative judgements about their opportunities. Though
a restriction on feasible options is a necessary component of preferences to and for
oppression, compromised cognitive ability is not. Assuming that a person with
preferences to and for oppression cannot make an accurate assessment of their
opportunities misrepresents the nature of preferences to and for oppression. For example,
the Pirzada women of Delphi practice religious veiling and seclusion. Following these
practices limits their public access and educational opportunities, but raises their class
status. Narayan, who has in-depth empirical knowledge of the Pirzada and many
populations most frequently described as having adaptive preferences, argues that the
Pirzada women can be right about their lack of skills and opportunities to move freely in
public (Narayan, 2002).

The complex moral psychology criterion requires public health to acknowledge
that the oppressed often have ambivalent feelings about unjust norms. As rational agents,
the oppressed may hold conflicting thoughts about oppressive norms, despite being
complicit in them. For example, Narayan found that the Pirzada women actively question
the norms around seclusion. While affirming norms of female modesty, they bemoan the
effect seclusion has on their educational opportunities. The oppressed may even suppress
what was once an active desire for liberation to avoid the dissonance and anguish of
wishing for a world that can never come.
The last criterion, limited option sets, requires public health to acknowledge both the agency of oppressed people and nature of oppression as an option-limiting structure. This criterion requires public health to acknowledge that the oppressed can simultaneously do the best they can to advance their own interests and perpetuate their own oppression. It could be the case that oppression-complicit behaviors are rationally chosen, revealing active strategizing and reflecting undistorted values (Khader 2012). By following these three criteria, public health can conceptualize people with preferences to and for oppression without undermining their agency and avoid disrespecting their rationality.

Building off Khader’s three conditions for respecting agency, public health should adopt practical requirements: the non-coercion and dialogue requirement. Based on rational choice theory, the non-coercion requires public health to acknowledge that an oppressed person can participate in an injustice against herself without being a legitimate object of coercion by their community or society. This requirement is important for two reasons. First, if public health acknowledges that people can reflectively and rationally engage in behavior whereby they reproduce their oppression, then public health cannot justify coercing them out of that behavior. Second, people with adaptive preferences who are doing their best to advance their correctly perceived interest may actually experience worse outcomes when coerced to change their behavior. I have already established the possible negative effects paternalistic approaches can have on dimensions of well-being. Additionally, Narayan supports this point by arguing that the Pirzada women might lose mobility and class status if coerced into abandoning veiling (Narayan, 2002).
The second requirement, *dialogue*, is based in concerns of epistemic humility. Given that people with preferences to and for oppression can retain rationality and agency, approaches to preferences to and for oppression must not characterize the oppressed as unreasonable or savage. One major criticism of Nussbaum's assessment of people with preferences to and for oppression is that her assessment focuses heavily on third world women and aligns with preexisting Western stereotypes of third-world women. In order to avoid bias, public health must attempt to engage in dialogue with oppressed people with preferences to and for oppression. There are clear benefits to this approach. As previously stated, approaches to preferences to and for oppression hinge on the proper assessment of the benefits and burdens of an intervention. Without attempting to understand the context under which the oppressed make their decisions and their rationale for their preferences, public health runs the risk of mistaking non oppressive conceptions of the good for preferences to and for oppression.

Additionally, the dialogue requirement requires public health to include the input of those with preferences to and for oppression in its attempts to address preferences to and for oppression. As a matter of respect, public health should seek to collaborate with people with preferences to and for oppression. Powers and Faden support the dialogue requirements, arguing that the “voices and perspectives of those whose life experience reflect the cumulative weight of multiple disadvantage” are of critical value (2006, p.79). Based on the aforementioned requirements, public health must also approach those who reinforce their own oppression fairly and must respect their agency enough to seek their input and cooperation.
Given the positive and negative point of social justice, public health’s attempts to address self-oppressive preferences must respect those who reproduce their own oppression, and thus, must fulfill the aforementioned criteria and practical requirements.

Section 7: Addressing Self-Oppressive Health Compromises

In section 6, I established that public health cannot make use of overly paternalistic approaches or overly libertarian approaches to individuals with preferences to and for oppression that lead to health compromises that reproduce oppression. Before we can explore the strategies that fulfill the criteria for a socially just response to preferences to and for oppression, we need to translate our understanding of preferences to and for oppression into a set of characteristics for discerning health compromises that warrant moral concern for public health. The definition of preferences to and for oppression used so far captures why they are morally problematic to social justice theory, but public health is primarily interested in the effects these individual compromises have on the health and well-being of populations. As a practical institution, public health has limited ability to identify internal phenomena like preferences. As a result, there are clear limits on public health’s ability to readily locate preferences made in response to oppressive socialization that also reinforces oppressive norms. Since preferences to and for oppression are at least partially indiscernible on a systemic level, public health must be looked at partially for the behaviors with characteristics consistent with preferences to

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22 Public health can, however, discern through empirical research whether or not their behavior or desired behavior would result in the reproduction of oppression. Additionally, public health can intuit based on existing social norms and historical evidence of oppression whether or not a population or individual likely formed their preferences under oppressive conditions.
and for oppression. To this end, social justice needs clear characteristics with which the framework can decide which compromises warrant moral concern.  

7a. Identifying Self-Oppressive Health Compromises

Public health can address preferences to and for oppression by examining self-oppressive health compromises (SHCs). Made by oppressed people, these compromises are self-harming, harmful to others within their non-voluntary oppressed social group, and poorly guide distributive justice. The three criteria for self-oppressive compromise are as follows: (1) the behavior must be self-harming (harm criterion); (2) the behavior must have cause harm to others (collateral criterion); and (3) one must be a member of an oppressed group (identity criterion).

All three criteria must be present for a compromise to warrant public health’s highest moral concern. Compromises lacking one criterion are less morally concerning. Fueled by preferences to and for oppression, self-oppressive compromises, when acted on, cause direct harm to the individual and threaten their sufficiency of health. The direct self-harm criteria allow us to differentiate between preferences that are particularly self-destructive (female genital cutting) and preferences that are group-defeating.

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23 It is important to note that warranting moral concern means simply raising our moral intuition about potential injustice (i.e. something about the preference seems to run counter to the moral goals of social justice). This does not mean, however, that this preference or the action(s) taken on its behalf must be prohibited.

24 Since public health primarily forces on health, I built my definition of self-oppressive compromises around health, but it is easily possible that preferences that threaten other dimensions of well-being would warrant public health response considering the cascading relationship between dimensions of well-being. Despite some differences, my proposed response to self-oppressive compromises would still apply to these cases.

25 Many of the paradigmatic cases of preferences to and for oppression involve bodily harm to the holder, but it is possible for this harm to manifest itself in a multitude of ways. What matters is that this harm threatens the holder’s sufficiency of health.

26 What constitutes harm must be derived from empirical data.
(wearing lipstick). Since wearing lipstick does not do harm directly to an individual, but instead affects them through reinforced gender oppression, it rightfully warrants less moral concern than female genital cutting.

Beyond direct threats to health sufficiency, self-oppressive compromise causes harm to others. This harm can take various forms, but the way we are most concerned with involves existing oppression. Given how preferences to and for oppression work, this harm is different from the earlier motorcycle example. For example, the woman who undergoes female genital cutting harms both herself and other women by reinforcing norms of female sexuality. These norms restrict what women in their society can do and be, undermining various dimensions of their well-being. By making a self-oppressive compromise, an individual legitimizes a series of oppressive norms, which restricts the set of options available to members of their non-voluntary social group, including themselves. This criterion captures our earlier intuitions about the collateral damage certain preferences have on other members of oppressed group. The collateral criterion is important because without oppressed groups are unfairly burdened. For example, a member of religious minority fasting should not warrant moral concern if this does not worsen the oppression of other members via reinforcing oppressive norms.

In order to make a self-oppressive health compromise, one must first be oppressed. People are oppressed for a myriad of arbitrary reasons including, but not limited to, their gender, race, sexuality, nationality, skin color, language, religion, etc. Stereotypes and oppressive norms are often created about oppressed groups by their oppressors, limiting and pressuring their feasible set of options. External oppression links
self-harming actions to the collateral damage experience by other oppressed people. Thus, the identity criterion allows us to differentiate between preferences that reinforce existing oppression and those that do not. For example, a white man who desires to remove his legs will cause harm to himself, but not to all other white men because there are no oppressive norms or socialization that links being white or male to the removal of one’s legs. This compromise does not reinforce a preexisting stereotype about white men nor does it restrict other white male’s expected or feasible set of options. It fails the collateral criteria because it fails the identity criteria. Moreover, the identity criterion also distinguishes between actions that are self-oppressive and other-oppressive. For example, white women who are oppressed for their gender are not making self-oppressive compromises when they act in a way that furthers the racial oppression for black men and vice versa. This type of behavior can easily be limited by the social justice framework. Since different types of oppression intersect, the individual making the compromise has to share the same oppression as those who are negatively affected by their compromise for the compromise to be regarded as a self-oppressive compromise. Each criterion is necessary for determining which health compromises warrant the most moral concern.

7b. Self-Oppressive Compromises and Sufficiency

Self-oppressive health compromises are poor guides for distributive justice and thus, are problematic for the social justice framework because they cannot be used to determine sufficiency of well-being. By reinforcing existing oppression, self-oppressive health compromises restrict other members of their non-voluntary social group, threatening their sufficiency of well-being. They also threaten the actor’s sufficiency.
health and well-being. These characteristics of self-oppressive compromises lead them to skew measurements of sufficiency and guide for distributive justice poorly. Social justice framework cannot include all behaviors in its determinations of sufficiency; some actions are not generalizable distributive entitlements. For example, a person can threaten their sufficiency of health by fasting. This behavior is not a reliable guide for the distribution of goods and entitlements in a society. In other words, what is good for them is not good for everyone. If public health were to support their decision to fast on a structural level, there would be major health disparities, skewing measures of sufficiency. The same is true of the woman who, in response to oppressive socialization, starves herself for her husband, but this case is far worse. A system built to support gendered self-starvation would result in intolerable restrictions on women. Similarly, a system of justice that aimed to fulfill preferences to and for oppression for female genital cutting would necessitate rigid gender roles and allow discrimination based on genital cutting to fulfill the preferences. This system would burden many women who do not have a preference for female genital cutting, creating a system of disadvantage based on gender. Considering the aim of social justice, public health cannot adopt this unjust system and cannot allow self-oppressive compromises to guide measures of sufficiency or distributive justice.

To return to the case of female genital cutting, we can see that our problem with female genital cutting is that it is a self-oppressive compromise and the preference for it is a preference to and for oppression. Female genital cutting is not problematic because the people who have a preference lack agency, rationality, or information. Undergoing
female genital cutting can be consistent with someone’s life plan. Whether the decision to undergo female genital cutting is procedurally autonomous or not, the normative status of the preference warrants moral concern. Female genital cutting most often occurs under oppressive conditions and most often occurs in response to these oppressive norms and socialization. Our concern over female genital cutting, however, does not solely lie in its temporal relationship with oppression or the conditions under which a preference for it occurs; it also stems from the negative health effects of the behavior, the harm it legitimizes, and the oppressive norms it reproduces. This preference, when acted upon, does restrict the possible set of options for the oppressed individual and other women in their society. Moreover, when taken as a basis for distributing resources and opportunities/sets, female genital cutting would lead public health to adopt a distributional system that systematically disadvantages women. For these reasons, a self-oppressive health compromise for female genital cutting is one that should warrant serious moral concern. Overall, compromises that should concern public health threaten the sufficiency of well-being of the actor and members of their non-voluntary social group.

In the next section, I will explore a plausible conceptual and practical approach to addressing self-oppressive compromises within the social justice framework of public health response.

**Section 8: Neutralizing Self-Oppressive Health Compromises**

Self-oppressive health compromises are a unique threat to public health because they undermine public health’s efforts to establish sufficiency and eliminate systematic
disadvantage. If what I have argued so far is true, then self-oppressive compromises are a major concern for the framework of social justice and must be addressed in a way that is conducive to both the positive and negative points of social justice. Even though self-oppressive compromises can harm others, public health cannot outright ban self-oppressive compromises without further restricting the autonomy of oppressed populations. Thus, public health must address the harms of self-oppressive compromises without liberty-limiting measures.

Public health should seek to neutralize self-oppressive compromises by augmenting conditions around the compromises. More specifically, public health should address self-oppressive compromises through the inclusion of harm reduction, soft disincentivization, and harm isolation into the social justice framework. These strategies respect the agency of oppressed people without allowing oppressive norms to be reproduced by their behavior.

8a. Changing the Stakes

Public health should simultaneously allow individuals to make self-oppressive compromises and minimize the harm individuals and communities experience as a result of these compromises. Public health cannot justifiably restrict someone’s desire to starve themselves, even if the decision to do so was clearly a response to oppression. Some could argue that the collateral characteristic alone justifies coercive intervention. This is

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27 The three approaches to self-oppressive compromises are hard to conceptualize because they are highly context and culture dependent, but their adoption allows public health to address oppression without perpetuating it. Like Powers and Faden’s theory of social justice, these approaches are designed for the non-ideal world, which means they depend on culture and social context. These strategies for addressing self-oppressive compromises only make sense within a given society. They take for granted the existence of sociological information about oppression and stereotypes.
the type of argument frequently used to justify motorcycle helmet laws. There are, however, important differences between self-oppressive compromises and preferences to ride a motorcycle dangerously. People who ride motorcycles are not a vulnerable population. They do not, by virtue of their desire to ride a motorcycle, experience oppression nor are they subject to oppressive socialization. In this sense, they do not have an already limited set of feasible options. Paternalistic approaches to helmets are more justified because there are no direct identity-based restrictions on who can or cannot have a motorcycle, and thus, restrictive helmet laws do not disproportionately affect disadvantaged groups. A paternalistic approach to self-oppressive compromises, however, would place burdens on the already burdened. Thus, public health cannot forbid individuals to make these compromises. Public health cannot, however, ignore these compromises either. Instead, public health should justifiably augment the conditions under which these compromises are made in an effort to neutralize the net effect of these compromises.

**8b. Isolating and Neutralizing Harm**

Public health should reduce the damage suffered by the individual in response to these compromises (harm reduction), reduce any benefits individuals get from making the compromises (soft disincentivization), and protect individuals and communities from the potential cascading effects of these compromises (harm isolation). Reducing the amount of harm an individual behavior has on an individual and society is not a new concept in public health. Harm reduction models are incredibly common in public health literature and practice, but its primary use has been for victimless public health threats like drug
abuse or prostitution. Nevertheless, key strategies from the harm reduction literature can be used to address self-oppressive compromises. For example, a common tactic is peer education about safer ways to inject drugs. In the case of female genital cutting, practitioners and communities could talk about ways to perform female genital cutting without increasing morbidity, infertility, or mortality. Similarly, the creation of safe places to carry out female genital cutting and a decriminalization of the procedure on adults could mitigate the harms of behavior on a community level.

Public health should also seek to curtail the illegitimate benefits and advantages individuals gain from self-oppressive compromises. As previously stated, there are wide spectrums of reasons, rational or otherwise, why people have preferences to and for oppression and make self-oppressive compromises. Public health should aim to undermine and eliminate any incentives for or benefits of self-oppressive compromises. Considering the relationship between self-oppressive compromises and oppression, this approach is deeply anti-oppressive. Public health should take steps to reduce these type of incentivizes for self-oppressive compromises, especially if they are deeply rooted in oppression. For example, there are a multitude of reasons why someone may bleach their skin, but public health can remove a myriad of incentives for skin-bleaching by undermining colorism and white supremacy. More concretely, this justifies public health interventions that create counter norms. For example, public health could support a campaign to show people with dark-skin in more positive roles. Individuals should not be respected more, make more money, have more relationships, or have any other advantage merely for having lighter skin. These cultural forces unfairly incentivize self-oppressive
compromises with the promise of acceptance and social desirability. Thus, a counter narrative campaign that disentangles associations between prosperity and skin color would considered a public health intervention. Resistance and subversion of oppressive norms and stereotypes is another aspect of this approach Public health should be wary of refusing dominant narratives about oppressed people that incentivize them to make self-oppressive compromises.

Public health should tolerate differences in health as a result of self-oppressive compromises, but should seek to undermine the cascading effects of self-oppressive compromises on other dimensions of well-being. Originally proposed by Walzer, the concept of complex equality best describes the virtue of isolating disadvantage to one dimension of well-being and striving to undermine the effects of cascading disadvantage. In Spheres of Justice, Walzer defines this concept as follows:

“In formal terms, complex equality means that no citizen's standing in one sphere or with regard to one social good can be undercut by his standing in some other sphere, with regard to some other good. Thus, citizen X may be chosen over citizen Y for political office, and then the two of them will be unequal in the sphere of politics. But they will not be unequal generally so long as X's office gives him no advantage over Y in any other sphere – superior medical care, access to better schools for his children, entrepreneurial opportunities, and so on” (Walzer, 1983, p.19).

Though Walzer’s focus was on the distribution of goods and the danger of dominance, the same logic justifies isolating oppression-reinforcing behavior in oppressed populations. Within the dimension of health, an individual may choose a health behavior that leads them to fall below sufficiency. Based on Walzer’s theory, the inequality
between this person and everyone else is tolerable as long as choosing this behavior does not give everyone else an advantage over this person in other aspects of well-being.

Powers and Faden explicitly reject the idea that there are distinct spheres or domains of justice because it allows public health to ignore how others are “faring in other with regards to the rest of their lives” (2006 p.82). To them public health must acknowledge the interrelated and cascading relationship between different aspects of well-being. In this sense Powers and Faden are concerned with the scope of public health, not complex equality. While I agree that public health should not narrow its view to solely the sphere of health, the goal of public health should be to isolate the dimension of spheres of health when addressing self-oppressive compromises. Public health can acknowledge the cascading relationship between different dimensions of well-being and attempt to sever this relationship in order to prevent the oppressed populations for experiences clusters of disadvantage. A difference of health between someone who choose female genital cutting and everyone can cascade into an inequality in respect, attachment, and self-determination, but public health should seek to insulate the individual from the risk of cascading disadvantage by buttressing their other dimensions of well-being. To this end, public health should employ strategies that increase the sufficiency of well-being of oppressed individuals who make self-oppressive compromises.

Harm isolation should not only eliminate cascading disadvantage on the individual level as a result of self-oppressive compromise, but it should also disrupt the effect the individual’s behavior has on the treatment of other member of their non-
voluntary social group. As previously mentioned self-oppressive compromises legitimize oppressive norms and stereotypes which in turn, pressures and limits the set of options of other members of their non-voluntary social group. Public health already has a moral obligation to eliminate systematic disadvantage, which is primarily caused by oppression and domination. In order to prevent the harm of self-oppressive compromises to other similarly oppressed people, public health must also undermine and disrupt any oppressive norms and stereotype that stem from self-oppressive compromises or reinforce a self-oppressive compromises. Public health should also buttress the other members of individual’s non-voluntary social group to offset the collateral damage inherent in self-oppressive compromises.

8c. Social Justice and Harm Neutralization

By adopting harm reduction, harm isolation, and soft disincentivization into the social justice framework, public health can successfully respect the agency of those with preferences to and for oppression without allowing their compromises to reproduce oppression. These approaches satisfy all of Khader’s criteria for recognizing the agency of those with preferences to and for oppression. None of these approaches assume that oppressed people have comprised autonomy, satisfying the cognitive capacity criteria. By focusing on self-oppressive compromises as a proxy for preferences to and for oppression, this approach also acknowledges that oppressed people have complex moral psychology. A person can have a self-oppressive desire for female genital cutting, but also have conflicted feelings about female genital cutting. Instead of seeking to eradicate
preferences to and for oppression from the minds of the oppressed\textsuperscript{28}, this approach focuses on compromises and actions, focusing on behavior and its effects instead of potentially conflicted feelings. Considering all of these approaches aim to reduce the burden oppression has on the decision-making of oppressed people, these approaches also acknowledge that oppression is fundamentally liberty-limiting.

These approaches can satisfy the non-coercion and dialogue requirements by employing a non-paternalistic, collaborative approach to self-oppressive compromises like public dialogues. Instead of outright banning female genital cutting, which could have many negative consequences (i.e. the criminalization of oppressed populations), these strategies require the input and perspective of oppressed populations. For example, in an effort to establish sufficiency of self-determination within a community, public health practitioners may host a public dialogue about the cultural importance of female genital cutting. Offering only information on the health benefits and burdens, public health can acknowledge that people can reflectively and rationally engage in behavior whereby they reproduce their oppression. Public dialogue maximizes autonomy and allows those with preferences that reinforce oppression to have input. Furthermore, it allows opportunities for public health practitioners to listen to those with preferences to and for oppression to make arguments for seeing their preferences are reliable guides of distributional entitlements.

\textsuperscript{28} It is highly improbable that preferences to and for oppression can ever be truly eradicated without the eradication of oppression. Even if active oppression was eliminated, these preferences can outlive the conditions they were fostered under.
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