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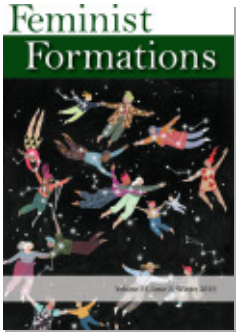

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Women's and gender studies courses on personal health grew out of the feminist health movements of the 1970s and remain an important component of how undergraduate students gain political consciousness around bodies and health. However, similar to many introductory women's studies courses, health courses tend to exclude transgender people through their reliance on stable understandings of gendered bodies. Although scholars have analyzed the tensions and conflicts between trans studies and women's studies more broadly, they have not yet analyzed the challenge that transgender brings to the feminist health classroom. I review the history of "women's health" in the feminist classroom and make the case for a transfeminist pedagogy. I consider what it looks like to "trans" the women's health curriculum and demonstrate this by detailing my revisions to a long-standing undergraduate women's health course. Finally, I consider the political and practical importance of incorporating trans knowledges and bodies in feminist health courses.

Keywords: feminist health movement / feminist pedagogy / higher education / transgender health / transgender studies / women's health / women's and gender studies

On the first day of my 240-student introductory lecture course on gender and health, I distribute notecards and ask students to jot down one thing about the course they are excited about and one thing they are concerned or nervous about. I then ask them to turn to a neighbor and share what they wrote. Next, after reviewing the course learning objectives, content, and policies, I ask them to turn over the notecard and write down at least one personal learning goal for the class: "What do you hope to be able to *do* by semester's end?" The responses to all three prompts tend to be homogenous, and are grounded in the

course's long-held reputation as a class where women get to learn about their bodies through topics such as sexual and reproductive anatomy, menstruation, childbirth, and sexuality. In many respects, the answers are not surprising given that the forty-year-old course, a requirement for the undergraduate degree in Gender and Women's Studies, retains its original title, "Women and Their Bodies in Health and Disease."[1] In response to what they are excited about, students generally write something along the lines of "I am excited to learn about my body" and "I am excited to learn about women." Learning goals reflect these sites of excitement: "I will understand how the female body works" or "I will know more about the health of all women." Invariably, students write that they are concerned about the rigor of taking a course that counts for natural science credit. And, probably in response to the fact that a professor of an indeterminate gender just introduced the course content by explaining that some women have penises and some do not, many write that they will "not know all the right words/say something wrong."

During the history of "Women and Their Bodies in Health and Disease," transgender women have been excluded from the content. I suspect that over the years there have been few, if any, students in the course who were trans women or persons on a trans feminine spectrum. I am the first faculty member to teach the course who is not a woman. Although I do not consider myself a man, I am often read that way by others. I have facial hair that requires daily shaving to style, I do not have breasts, and I wear clothing from the men's department. The first time I taught "Women and Their Bodies," I was shocked by the nationwide and historic reputation surrounding the course. For instance, it was not uncommon to find myself making small talk with a stranger—a thousand miles away from my home institution—and have the stranger realize that I currently teach the course that revolutionized her understanding of her body during college. This was a sentiment shared by many women, including the cisgender faculty members and teaching assistants who have taught the course over the years. At the same time, trans and queer students confided in me their stories of having to choose between dropping the Gender and Women's Studies major and taking a class that literally erased them. Students questioning their gender identity reported feeling uneasy about the course emphasis on cisgender women. In addition, a good number of cisgender students over the years have denounced its persistent cis-centrism by calling on the department to change the course name and content.

Although "Women and Their Bodies" was born from feminist activism to push back against the exclusion of (cisgender) women from knowledge about health and healthcare, the course historically had done exactly that to trans and gender nonconforming students, as well as other minoritized students. While some cisgender students expressed gaining their feminist consciousness in the course, trans students told me they often found it so traumatic that they had to get their roommate to attend lectures and take notes for them. For me, and for

students of a variety of genders, the traditional "women's health" classroom is not a site of liberation; rather, it functions as a site of violence that reproduces essentialist, normativizing, and disciplinary discourses about bodies and health. Yet, it is also a site of great possibility for articulating and developing a feminist health pedagogy that works for all of us.

While scholars have increasingly called attention to the limitations of cis-centric pedagogy in women's, gender, feminist, and sexualities studies courses and envisioned trans epistemologies and pedagogies, this work has focused on courses in the humanities or social sciences (Beauchamp and D'Harlingue 2012; Clarkson 2017; Drabinski 2011; Malatino 2015; Muñoz and Garrison 2008; Noble 2012). To the best of my knowledge, no one has yet analyzed the challenge that transgender brings to the feminist health classroom. Indeed, it seems that the long-standing focus on white, cisgender women as the proper subject of the W/F/G/S/S[2] discipline is most intractable when it comes to health courses. Humanities and social sciences courses appear more likely than health courses to acknowledge the instability of sex, gender, and bodies: when it comes to learning about actual bodies, the proper subject rears her ugly head.

"Women and Their Bodies" is somewhat unique among college courses in that it is a class *doing* health education, rather than a class surveying a scholarly field. That is, instructors are teaching students about their own bodies and how to promote their own health, not teaching *about* the field of health education. Although college personal health classes are not uncommon, they are generally taught through departments such as public health or human development. Likewise, the majority of "women's health" courses are taught through nursing, medicine public health, and occasionally anthropology departments. These courses take the approach of "about," rather than "for" health. In other words, they cover scholarly literature on gender bias in medicine (and sometimes, but not always, race, class, and other biases), gender disparities in health outcomes, and gendered political processes related to health. As in biomedicine and scientific research more broadly, "women's health" is generally a stand-in for "reproductive health," itself a problem that scholars have sought to unpack (Inhorn and Whittle 2001). Narrowly framing cisgender women's health in terms of their capacity to reproduce reduces women to baby-making vessels at the expense of their other health needs. Although the direct health education model is not common among W/F/G/S/S course offerings across institutions, the lessons learned from teaching it through a transfeminist pedagogy are important for thinking about many of the main tensions between "trans/trans*[3] studies" and "women's studies": embodiment, social construction, oppression, and so on (Keegan 2018). "Women's health" is full of potential both for reproducing essentialism and trans-exclusionism *and* for reconfiguring feminist health promotion with a radical vision that promotes the well-being of all students, with particular attention to remedying historic injustices and present-day health inequities.

In this essay, I detail the stakes and necessity of bringing transfeminist perspectives to the "women's health" classroom. By "transfeminist," I am referring to an intersectional politics that not only includes transgender people but also signals a way of thinking about and doing feminism that recognizes how multiple oppressions "intersect, converge, overlap, and sometimes diverge in complex ways" (Stryker and Bettcher 2016, 8). I begin by reviewing the history of "women's health" in the feminist classroom and the precarious place of trans studies and trans people in the W/F/G/S/S discipline more generally. Next, I argue for a transfeminist pedagogy in the women's health classroom by considering what it would look like to "trans," in all senses of the term, the women's health curriculum. At the heart of transing the curriculum is a pedagogy that organizes content not around a stable, essential category ("women") but instead gender-based oppression as it works with and through racism, classism, ableism, colonialism, homophobia, and transphobia. With the goal of offering educators conceptual and practical tools, I demonstrate this pedagogy through documenting my approach to teaching "Women and Their Bodies in Health and Disease." Finally, I make a case for the political and practical urgency of incorporating trans knowledges and bodies in W/F/G/S/S in our current moment of increased visibility and sustained health inequities. I offer my critique of how the course has traditionally been taught in the spirit both of pushing back against power and as a strategy to improve the learning of the broad range of students attracted to W/F/G/S/S courses. The feminist health classroom is simultaneously a place where a cisgender female college student may first learn the difference between her vagina and her vulva, and it is also a place where a transgender female college student may first see her body depicted in an accurate and affirming way. There is nothing preventing these two students from learning together in the same classroom. Indeed, their sharing this learning community is imperative to the vision of the feminist health movement that sought to politicize our bodies and push back against oppressive healthcare systems.

Trans, Feminism, and Health

In the late 1960s, the feminist health movement in the United States began to coalesce around a political vision to address the long history of a patriarchal medical system that ignored, pathologized, and/or medicalized cisgender women's bodies (Murphy 2012; Norsigan 1992). Consciousness-raising groups, medical providers, and feminist scholars carried out a variety of activist and scholarly projects ranging from establishing feminist health centers to advocating for greater inclusion of cisgender women in clinical trials. A great deal of this work focused on reproductive rights, such as access to safe legal abortion or choices around childbirth experiences. Simultaneously, as part of what activists in the 1990s would term "reproductive justice," women of color fought against injustices that limited their ability to have the children they wanted, such as coerced and

forced sterilization practices and racist policies in the child welfare system (Ross et al. 2016).[4] Around this same time period, scholars established Women's Studies programs and departments in colleges and universities across the country. The growth of academic feminism was itself an activist project to push back against the epistemological, ontological, and material erasure of cisgender women in both scholarly discourse and in institutions of higher education (Boxer 1998).

College courses in women's health grew out of the imbricated processes of the feminist health movement and the institutionalization of women's studies. At my institution, "Women and Their Bodies" was first offered in 1978. In the 1980s, a course instructor articulated the purpose of the course as "to rectify the version of biology based on studies of men." The primary aim was to "educate [cisgender] women in the language and information needed for knowledge about and control of their own bodies," and a secondary aim was to present health and biology within a women's studies framework (Rosser 1986). Writing in 2003 about her course "Politics and Issues in Women's Health," which largely mirrors "Women and Their Bodies" prior to my revisions, Carolyn DiPalma states that a feminist health course emphasizes the "ways in which we [cisgender women] can inform and help ourselves" (2003, 236). DiPalma's course materials and discussions "pose questions about what has and has not been asked in the past, what has counted as fact and fiction," and, importantly, "who and what has been accepted as natural, normal, and abnormal, and why" (236). This last assertion highlights the paradox inherent in excluding trans people from the feminist health curriculum. Biomedicine's insistence on a gender binary and pathologization of trans bodies makes trans health an exemplar of the disciplinary medical practices that feminist health education seeks to unpack. Likewise, trans populations experience numerous health inequalities (Reisner et al. 2016) and often find inaccurate (or an absence of) representations of themselves in health education materials (Sevelius 2009). Because health inequalities and a lack of adequate health education were motivating factors in the women's health movement, it would make sense to include trans populations and trans health in posing questions about what has not been asked or what has been accepted as abnormal.

Alice Dan and Sue Rosser (2003) outline the phases of curricular transformation in feminist/women's health that illustrate the stakes of this paradoxical exclusion. In my most generous estimation, I would argue that transgender and intersex issues in feminist health curricula are somewhere between phase one and phase two of Dan and Rosser's typology. In the first phase, Dan and Rosser state that the absence of women and women's health in the curricula is not noted. In the second phase, researchers, teachers, and practitioners attempt an "add and stir" approach to women's health issues; that is, they simply add women to the study of health using a white male standard. In the third phase, faculty realize the limitations of the add-and-stir approach and begin to recognize women's health differences from men. Dan and Rosser argue that in the

early 2000s curricula reached phase four, where cisgender women are a specific focus and researchers, educators, and practitioners recognize the bias that their exclusion has previously introduced to their work. Finally, in the fifth phase, which they term "curricula to include us all," the ultimate goal is to "integrate the information on [cisgender] women's health into research in all specialties and to transform all aspects of the health curriculum to include [cisgender] women and their health" (16). At the time of their writing, this fifth phase was as yet unrealized.

Of course, the erasure of trans bodies and the tensions between trans studies and women's studies is not limited to health courses and topics. Although a grammar of gender self-determination and a resistance to binary gender norms and gender-based oppression has always been central to academic feminism, at best trans studies has an "ambivalent home" in the discipline (Enke 2012). Although scholars sometimes narrate trans studies as emerging in the Anglophone academy in the 1990s, the scholarship, activism, and existence of people who cross culturally, medically, and politically imposed notions of gender have existed for much longer. As Susan Stryker and Aren Aizura (2013, 1) note, what changed in the 1990s was "the relatively sudden appearance of new possibilities for thinking about, talking about, encountering, and living transgender bodies and lives." Work in trans studies cuts across all possible academic fields—from medicine to medieval history—but institutionally tends to fall under the purview of W/F/G/S/S and/or LGBTQ+ studies. This institutional landing has prompted numerous crises and tensions within academic feminism concomitant with titular shifts in the naming of departments from "Women's Studies" to "W/F/G/S/S" without also actually shifting content, methods, and pedagogies (Noble 2012). That is, cisgender women remain at the heart of the curriculum, and the investments in or constitution of sex/gender as a normative set of binary systems is rarely actually analyzed in relation to the categories woman and man as presumably fixed subjects.

Three of the tensions between women's and trans studies are particularly relevant to the teaching of bodies and health in the feminist classroom. First, as Kate Drabinski (2011, 10) notes, a primary tension hinges on how the field understands its subject as either the category of "woman" or the *production* of categories such as woman, man, gender, transgender, intersex, and so on. It is a problem we like to imagine we have solved. For instance, W/F/G/S/S courses frequently posit transgender, gender nonconforming, and/or intersex people as evidence of how gender is a slippery, performative, social construction or process, yet maintain a stable, unmarked referent of (white) cisgender women as their subject (Beauchamp and D'Harlingue 2012; Duncan 2002; Keegan 2018; Lee 2002; Malatino 2012). Toby Beauchamp and Benjamin D'Harlingue (2012, 38) characterize the use of trans people to demonstrate the production of gendered categories as a risky strategy that "forecloses further complexities by implying that the burden of gendering processes rests only transgender people, and that

transgender and nontransgender populations understand their gendered bodies in fundamentally different ways." In this approach, "transgender" is a means to an end illuminating the study of "gender," rather than a topic worthy of study in its own right. As Viviane Namaste (2009) argues, this pedagogy is a form of epistemic violence. Moreover, as Cáel Keegan (2018, 5) notes, this approach also "ensures that trans* studies cannot raise the question of what the category of 'woman' might contain or whether the object ('woman') actually exists as invoked."

The focus on this unmarked category of woman is also an old tension that feminists of color in the United States and feminists from the Global South have long challenged (Green and Bey 2017; Lee 2002; Mohanty 1988; Zinn et al. 1986); indeed, in many syllabi and textbooks, these women remain relegated to the "women of color" or "global perspectives" week or a separate course altogether. By pretending the field has resolved the tension over its focus on the categories of gender or their production, W/F/G/S/S departments and courses are able to ignore the fact that separate courses on "women's health" and "transgender health" make little sense. If transgender women are indeed women, their bodies and health would fall under the "women's health" course.

The second tension, inextricably bound up in the first, is whether the discipline rejects biological essentialism or not. Oddly enough, most W/F/G/S/S courses take a social constructionist approach to gender while nonetheless assuming woman = vagina (Beauchamp and D'Harlingue 2012). Trans men, trans masculine people, and nonbinary people assigned female at birth may enter the purview of "women's studies" due to the fiction of a shared experience of oppression *as women*, thereby reducing them to their anatomy and capacity for reproduction. That is, trans men may be included in a class on women's health because they sometimes carry a pregnancy, despite the fact that they are not women. Trans women may be excluded from that same class because they do not carry pregnancies.[5] If the field truly rejected biological essentialism and wanted to organize a health course around the social category of "woman," the only internally coherent way to do so would be to teach about all possible people that fall under this category, including cisgender and transgender women. It would not make sense to include trans men and transmasculine people, even though they may have some of the same anatomical structures as cisgender women and may experience the same health processes (e.g., menstruation and childbirth).

The third tension between women's and trans studies relates to how W/F/G/S/S curricula tend to incorporate trans topics with an "add and stir" tactic, although often without very much stirring. Critics have termed this phenomenon the "special guest" approach to trans studies, in which transgender content is relegated to a specific week of the course, rather than integrated throughout and/or forming an epistemological or pedagogical basis. Despite the growing prevalence of trans topics in W/F/G/S/S courses and handfuls of upper-division courses dedicated to trans studies, trans topics and scholars have moved little

from their special guest status. This approach is an easy pedagogical device that does little to dislodge cisgender, white women as the unmarked referent of women's studies (Malatino 2015). Tacked onto syllabi in the name of feel-good, multicultural pluralism, trans people nonetheless remain "impossible figures" that exist outside the scope of Women's Studies' proper subject (Beauchamp and D'Harlingue 2012; Keegan 2018; Malatino 2015). Similar to the phase two of women's health curricula described above, departments and courses add transgender to their domain without challenging the status quo. Trans people, trans epistemologies, and trans bodies are welcome for their nod to neoliberal modes of inclusion (Ahmed 2012), but must remain on the margins. To take up the example used above, if transgender women are women, then their health needs ought to be incorporated throughout a "women's health" course rather than confined to a separate trans health week or separate course altogether.

Transing the Women's Health Curriculum

Transfeminist epistemologies and pedagogies are strategies to negotiate the tensions between women's and trans studies and imagine a feminist classroom inclusive of a range of genders (Galarte 2014; Muñoz 2012; Muñoz and Garrison 2008; Nicolazzo 2017; Noble 2012). This must include feminist health classrooms. Transgender health belongs in the feminist health classroom epistemologically, politically, and pedagogically. To "trans" feminist health education—in higher education and beyond—means more than simply adding trans bodies and trans health issues to the curriculum. As Susan Stryker, Paisley Currah, and Lisa Jean Moore (2008, 13) describe it, transing is "a practice that takes place within, as well as across or between, gendered spaces." Katy Jaekel and Z Nicolazzo (2017) understand "transing" pedagogy in the college classroom to include teaching *as* trans, teaching *about* trans, and teaching *with* trans epistemologies. In other words, to trans pedagogy means to consider the implications of teaching *as* a trans person, teaching *about* trans topics, and teaching *with* trans forms of knowledge. Any combination of these strategies can work together to "trans" the women's health classroom, and an instructor need not be trans in order to teach with trans forms of knowledge. Before more fully laying out my pedagogical approach to "Women and Their Bodies in Health and Disease," I want to consider what it means to trans feminist health education not only by including trans health in the content but also "transing" the curriculum in the sense of thinking across and between genders, embodiments, and health issues.

Transing the women's health curriculum requires us to "think trans" by making broad connections across analytically distinct areas (Drabinski 2011), adding specific content about trans health, and considering the politics of someone who is not a woman teaching a women's health course (Jaekel and Nicolazzo 2017). First, conceptualizing, organizing, and teaching a feminist health course through making these broad connections means we cannot rely on a stable gendered category ("woman") to form the political basis of

health-related oppression. In transing the introductory W/F/G/S/S humanities course, Beauchamp and D'Harlingue (2012, 26) suggest thinking genealogically with attention to "broad historical process such as colonialism, modernity, (trans) nationalism, globalization, and the rise of disciplines and institutions such as medical science and prisons." They argue that this focus offers students a critical analysis of the processes by which gender emerges and works, rather than giving them tools to locate and analyze particular, stable gendered subjects.

In the same fashion, transing the feminist health education course requires us to think about the processes by which certain groups, bodies, and health issues are ignored, pathologized, and/or medicalized. This perspective mirrors those taken by feminist health activists in the 1970s, but rather than organizing the course around an assumed stable category of "woman," the course is arranged around gender-based oppression as it is linked to and mutually constitutive of a wide range of systems of oppression including racism, classism, ableism, colonialism, and so on. It is these same systems that structure, say, white cisgender women's access to safe legal abortion and trans women of color's disproportionate rates of HIV infection, albeit in vastly different ways. Transing the feminist health course requires us to cover content that cuts across various health issues and bodies, rather than hinging on a fiction of shared biological womanhood. This linking enables us to make broad connections across seemingly distinct health concerns, as I illustrate in the next section. In many queer feminist community spaces—ranging from bike repair classes to martial arts studios—cisgender men are excluded based on this lack of a shared experience around gender-based oppression.[6] This is not to say that cisgender men never experience oppression related to gender, especially men of color, effeminate men, or gender nonconforming men. Rather, it is a political strategy to center those most marginalized by the dominant sex/gender/sexuality system (Rubin 2011).

Second, the erasure of trans people and trans health from the women's/feminist health course is not merely an act of epistemic violence; it also has significant material implications. Transgender people, including transgender college students, experience numerous health inequities as well as violence and discrimination in healthcare settings (Messman and Leslie 2019). An ever-growing body of evidence demonstrates that trans people are more likely than cisgender people to report overall poor health in addition to disproportionate rates of psychological distress, suicidal thoughts and behaviors, HIV/AIDS, and interpersonal and intimate violence (James et al. 2016). In the healthcare realm, trans people experience discrimination and violence from individual providers (White Hughto, Reisner, and Pachankis 2015), an absence of representation in biomedical and epidemiological research (MacCarthy et al. 2015), and categorical health insurance exclusions for gender-affirming care that result in extraordinary out-of-pocket costs (Stroumsa 2014). Transgender women of color are especially impacted by racism and transphobia in ways that govern their life chances (Spade 2015), making them disproportionately at risk for poor health (Reisner

et al. 2016) and disproportionately likely to experience physical violence (James et al. 2016). Additionally, transgender college students report numerous barriers to their success on campus, ranging from neglect to explicit violence (Goldberg 2018). Colleges and universities are often ill-equipped to accommodate the needs of transgender students in areas including administrative systems, physical and mental health services, and housing (Goldberg 2018). These material conditions illustrate the political importance of a feminist health pedagogy that takes the health effects of interlocking systems of oppression as its organizing concept. Transing the feminist health education curriculum requires us to see our liberation as bound up together. As I discuss in the next section, this transing includes the politics of nonwomen teaching a "women's" health course.

Making the Impossible Possible

Before I began teaching "Women and Their Bodies," previous instructors had somewhat shifted the course content from its inception in the 1970s. Although the course topics and sequence remained the same, some of the course language was reframed in terms of "female-assigned" bodies and "female-identified" people. This language reframing was limited to the course lectures; almost all of the course readings used the word "woman." With the exception of one assigned blog post reading added in, the content did not specifically address the bodies or health needs of trans women. The course topics grouped trans men and nonbinary people assigned female at birth under the rubric of "women" by virtue of their anatomy and capacity to reproduce—ironic since so much feminist scholarship and activism has worked against the reducing of cisgender women to their capacity as potential reproducers. A minimal amount of material covered trans health issues in general. This included a glossary of terminology related to the category of transgender that included a brief discussion of health inequalities in trans populations, a statement from the American College of Nurse Midwives about healthcare for trans people, a blog post by a trans woman about periods, and an essay about culturally appropriate doula care for queer and trans parents. Former course TAs wrote half of these readings, and none were scientific articles. The specifically trans content together (without collapsing transgender under the rubric of LGBT) comprised approximately 0.03 percent of course readings.[7] This selection of readings framed health topics as if the students reading them were not trans, mirroring the tendency to use transgender and intersex issues as pedagogical tools but assuming there are no trans or intersex students in the class. None of the readings focused on health issues specific to trans people, such as gender-affirming hormones or surgeries, and two of the four readings were focused on reproduction.

In calling attention to the epistemological and pedagogical problems in "Women and Their Bodies in Health and Disease," I became a trans killjoy—someone who becomes a problem by virtue of bringing up a problem (Ahmed

2017; Niccolazo 2017). That is, as a trans person seeking to fix the problem of trans erasure in the course by promoting the health of all students who are marginalized by interlocking systems of oppression that originate with gender, I *became* the problem. My revisions to the course content may have been acceptable under the guise of academic freedom, but my proposal to change the name of the course to the more capacious "Gender and Health" was met with responses ranging from resistance to violence.[8]

Yet, to paraphrase Cameron Awkward-Rich (2017, 832), the problem was not so much that (some) feminists would like to see me gone; the problem is that I am here, and we all have to figure out to live with that. In other words, by placing my queerly gendered body in front of the legendary "Women and Their Bodies in Health and Disease," the curriculum was forced to wrestle with a thorny set of epistemological and practical questions at the heart of the tension between trans and women's studies: Is a woman a person with a vagina and breasts? Can someone who is not a woman teach a "women's health" course, or does that go against the political premise of the women's health pedagogy? Is it the shared capacity for reproduction that structures the health inequalities at the heart of feminist health education? Can trans health be integrated into an existing feminist health course? Does W/F/G/S/S only want to be inclusive of transgender so long as it stays in its own lane? If I am the trans killjoy of women's health, the proverbial thorn in the side of gender and women's studies, then what does that mean for the transgressive potential of feminist health education at this particular moment (Nicolazzo 2017, 212)? As Keegan (2018, 6) puts it, trans* studies and trans scholars who find themselves in the position of challenging the stable referent of women's studies "might feel impossible—or, rather, it might produce the feeling that one is being made into an impossibility."

And yet, it was not impossible to revise the course to meet the needs of a wide variety of students while maintaining the political motivations that birthed the course in the 1970s. I am trained as an adult educator and have worked for many years in sexual and reproductive health, ranging from serving as a doula to low-income cisgender women to teaching safer sex to LGBTQ youth and adults. My research analyzes the politics of knowledge in public health and focuses on reproductive justice, queer sexuality, and trans health. Therefore, although it was a great deal of work, it was neither epistemologically nor pedagogically challenging to make the course inclusive to the learning needs of a broad range of students, regardless of their genders.

In the following sections, I highlight aspects of how I brought a transfeminist perspective to the women's health course. My objective is to provide other instructors with the beginnings of the conceptual and practical tools to incorporate trans into feminist health education courses. First, I describe my use of intentional language around bodies and how I work against the "special guest" problem. Next, I discuss how I link seemingly disparate health topics through making broad analytic connections rather than focusing on stable notions of

gender or bodies. I demonstrate these linkages through my approach to specific health topics such as anatomy and reproduction as well as new additions to the course, such as chronic illness. Finally, I consider how readings, written assignments, and discussion sections figure into the transfeminist health classroom.

Setting the Stage for the Transfeminist Health Course

"Women and Their Bodies" is set up similarly to most large undergraduate lecture courses at my institution. The instructor delivers twice-weekly lectures and a team of graduate teaching assistants facilitates weekly discussion sections and grade assignments. As the instructor, I begin by situating the class in the history of the feminist health movement and explain how it is indebted to the feminist activists that came before us; I also describe how the course has evolved to reflect our present moment. That is, I explain that the course focuses on how intersecting systems of oppression affect health care and health status, and note that although these might be new or abstract concepts, they will soon come into focus. I emphasize to students that they will learn about their own bodies but also the bodies of people not like them. An important component of setting the stage is laying out terminology related to sex, gender, and sexuality while emphasizing that language is imperfect and constantly changing. Although many introductory W/F/G/S/S courses simply distribute a glossary of terms such as cisgender, transgender, sexual orientation, and so on, in all of my courses I incorporate this as a full-fledged topic. I teach it, rather than allow it to be self-evident or an "add-on" to the actual course content. Doing so ensures that students actually take in the material (rather than casting it aside or misunderstanding it), and communicates that it is a core part of the course's working vocabulary, as in any other course.

I also explicitly discuss my intentional use of language around sex and gender and reiterate this throughout the semester. When I say "women," I am talking about a social and political category that includes anyone who considers herself to be a woman, regardless of anatomy or sex assigned at birth. When I am talking about a health issue or process that is specific to a certain kind of anatomy—for example, childbirth—I refer to that particular anatomical part (e.g., "In the first stage of labor, the cervix dilates to approximately 8 centimeters" instead of "In the first stage of labor, the woman's cervix dilates to approximately 8 centimeters"). In referencing data, I point out that when researchers say "women" they generally mean "cisgender women." This is an opportunity to emphasize the lack of robust research in trans populations and the dangers of assuming stable sex and gender categories: we can't do anything about health inequalities if we can't even identify them in the first place. When referring to a hypothetical group of people, I use language such as "pregnant people" or "people with penises" (Spade 2011). De-gendering language in this way has raised ire in both academic and activist feminist circles on charges of "erasing women." To the contrary, I also demonstrate to students that the social and

political category of "women" *does* in fact matter and often plays out in important ways with its intersection with race. For instance, when we are discussing disproportionate rates of maternal mortality, it makes sense analytically and politically to distinguish that we are talking about the fact that Black cisgender women are three times more likely to die during childbirth than white cisgender women (Petersen et al. 2019). This does not mean that Black transgender men who carry a pregnancy do not disproportionately experience negative health outcomes—they likely do, but current vital statistics data collection in the United States has no way to identify them. When discussing the disproportionate number of Black women who become HIV-positive, I emphasize that this inequality affects both cisgender and transgender women. In other words, there are some ways in which health issues cut across the cisgender-transgender continuum, and others in which they do not. Making this distinction clear to students is important, just as it is important not to assume that all people who menstruate are women or that all women are born with a vagina.

An important component of the course topics and sequence is to balance incorporating content specific to trans health without making trans people special guests or reducing trans health issues to medical transition. Because many of the students in the course are new to transgender topics, and may very well be accustomed to thinking about trans bodies through pathologizing or medicalizing discourses, I introduce trans health by making a broad connection to how we *all* have gendered aspects of our bodies that impact our health and well-being. Using Top Hat,[9] I ask students to name one thing they would like to change about their bodies other than weight. Most answers are gendered, such as body hair growth or the shape of breasts and buttocks. This discussion allows me to normalize gender-affirming hormones and surgeries as one of the many ways that all people wish to and do modify their bodies to affirm their gender identity and expression. However, I also discuss how the medical system pathologizes trans identities and bodies and restricts access to care through gatekeeping practices—this is another opportunity to make connections to health issues with which students may be more familiar, such as abortion access.

I integrate health issues specific to trans people throughout the semester rather than segregating them into a "trans health" week. To do so would replicate the special guest approach to teaching transgender and communicates to students that trans health needs are wholly distinct from cisgender health needs. Trans people menstruate, get cancer, use alcohol, and so on. Therefore, I include material specifically relevant to trans people during topics germane to all students; for example, menstruation includes a reading about how trans women may describe the hormonal fluctuations they experience through gender-affirming estrogen use as "periods" and a reading about how trans masculine people who menstruate may prefer menstrual management products that are gender affirming. I also include content specific to transgender people, such as gender-affirming care through hormones and surgeries. For some students, this

is important medical information that they need for their own health, either now or in the future. For the large number of nursing and premedical students that take the course, it is vital information for them to serve their future patients competently. For all students, learning about health issues specific to transgender people helps to destigmatize trans lives and bodies as exoticized or fundamentally othered. As Dean Spade (2015) argues, working against the impossibility or unfathomability of trans lives is a strategy to promote the livability of trans lives. In this way, including content specific to trans health is one part of addressing the vast health inequities experienced by trans populations.

Teaching Health Topics through Making Broad Analytic Connections

When I began teaching the course, the sequence of the topics had changed little in the last forty years. It started with sexual and reproductive anatomy and moved from there to menstruation, sexuality, contraception, pregnancy, childbirth, reproductive cancers, and menopause. Rather than starting with anatomy, I begin by framing health as a social and political process in order to ground students in the feminist politics of the course. In these introductory sessions, I introduce concepts like the social determinants of health, health inequalities versus health inequities, and social versus medical models of health. As a public health scholar, this approach just makes sense, given that we know social determinants of health account for more of our health status than do individual health behaviors. Although I cover many of the traditional "Women and Their Bodies" topics (e.g., pregnancy, menstruation) at some point, I reframe how they are taught as both domains of knowledge and embodied health processes by framing them in terms of cross-cutting analytic topics. For instance, I include menstruation in a unit titled "The Biology and Politics of Hormones" alongside topics such as the role of environmental endocrine disruptors or how some trans people use gender-affirming hormones for medical transition. This unit is an opportunity for students both to learn about how hormones function in the body and to think about how they function politically in society. I present menstruation as one among the many physical processes related to hormones, rather than as attached to a particular identity or assumed to be part of the experience of every student in the course. This approach also makes more sense biologically; to teach something like menstruation in its own unit makes it seem as if menstruation is a physiological process unrelated to other health issues and processes.[10] Similarly, before moving onto topics related to human reproduction, students learn about reproductive justice as a framework, vision, and social movement. In the lecture, I emphasize that issues related to reproduction are important to study because of their history as sites of racialized social control, not because I assume that all students in the class will become or are capable of becoming pregnant and giving birth. Likewise, this is an opportunity to discuss how in many states and countries, transgender people cannot change their

legal gender marker without having surgical procedures (often not covered by insurance) that render them sterile. By using reproductive justice as the analytic concept, I link seemingly disparate health topics including abortion, coercive sterilization practices, midwifery, and trans health.

Anatomy is a topic rife with essentialism but also an excellent area in which to demonstrate the pedagogical utility of linking health topics through broader analytic concepts. I begin the unit on anatomy by explaining that we will focus specifically on sexual and reproductive anatomy because they are politicized. I introduce this idea by posing a question to students through Top Hat: "What did the adults in your life tell you to call your genitals when you were growing up?" For the most part, the responses are nonspecific euphemisms like "down there" and "private parts." That students were never even told the anatomical names for certain parts of their body drives home the point that the vulva and scrotum have much different social meanings attached to them than do the intestines or lungs. This discussion is also an example of my use of second-person language throughout the course: by speaking directly to students while using language inclusive to all genders, all students can see themselves as the subject of the course material.

After establishing the political importance of studying the sexual and reproductive systems, I remind students that there is no such thing as "female" or "male" reproductive anatomy. Penises and vaginas do not have a gender, and a person's anatomy does not dictate their gender. Using Top Hat, I ask students what words they now use to describe their genitals. I then distinguish between clinical/scientific and self-named words used to describe genitals and why it's important to use words that affirm your body while also having the vocabulary to talk to medical providers who may use different terminology. Next, I present a chart identifying the clinical terms for sexual and reproductive anatomy alongside the terms that people of a range of genders use to describe their own bodies. This demonstrates to cisgender female students that the part of their body that they call their "box" a physician will refer to as "vagina," and a trans man might call his "front hole." It also affirms to trans students in the class that I take seriously their embodied self-naming, regardless of their gender or sex assigned at birth.

Next, I discuss embryonic "sex differentiation" through the use of colored diagrams illustrating the anatomical structures that form homologous equivalent organs in humans. That is, one color illustrates the structure that becomes the phalloclitoris,[11] one illustrates the folds that become scrotum or labia, and so on. This discussion sets us up to view anatomical drawings[12] of internal and external anatomy and to study how homologous equivalents are similar structures in terms of location, purpose, and function in the human body, but have very different social meanings depending on the gender society attaches to them. In the past, the course only covered the internal anatomical system composed of

a uterus/ovaries and the external system composed of a vagina/vulva, thereby excluding the anatomy of many trans women. Instead, I cover all configurations of internal and external sexual and reproductive anatomy based on their functions, characteristics, and locations rather than assigning them a gender or assuming anything about my students' anatomies. At the same time, I still emphasize the gendered politics of anatomy—for instance, how the clitoris is the only known part of human anatomy whose sole purpose is sexual pleasure, yet the cultural devaluing of sexual pleasure results in few people with a clitoris knowing its full shape, size, and purpose. This is also an opportunity to reiterate the importance of both self-naming and having a shared vocabulary to talk to healthcare providers or read medical research. Although the drawings are labeled with the clinical terms for the structures, I note that what a diagram labels "penis" a trans women might refer to as her clit, and what the diagram labels a "clit" a trans man might refer to as his dick.

Historically, "Women and Their Bodies" covered intersex as part of a unit on embryonic sex development in order to illustrate the mutability of biological sex. This approach emphasized the problem of coerced genital surgeries on intersex infants as an issue of bodily autonomy (Davis 2015), but nonetheless presented intersex as a means to an end for students (presumed to not be intersex) to learn about their own bodies. This strategy erased actual intersex people, thereby reducing their bodies and social movements to an interesting way to think about how biological sex is not a binary—an act of epistemic violence (Namaste 2009). I cover intersex traits in the anatomy unit by positioning intersex as part of the normal continuum of human sex characteristics, but I also center intersex people and the intersex justice movement through readings and videos. This strategy normalizes intersex anatomy while also highlighting how intersex is part of the broader analytic concept of how bodies are pathologized and regulated on the basis of sex and gender.

Whereas in the past the majority of the course topics related to sexual and reproductive health, I scaled back this content to make room for topics such as disability and chronic illness, substance use and dependency, and health at every size. My strategy here is twofold. First, maintaining content on sexual and reproductive health is important because these are deeply political health issues, but overemphasizing them risks a singular focus on cisgender women. Second, overemphasizing reproductive health risks emphasizes heteronormativity and reduces cisgender women to their capacity for reproduction. Disability and chronic illness, substance use and dependency, and health at every size all function as broad analytic concepts that allow me to illustrate race, class, disability, and gender health inequalities as well as teach students information useful for their own health. For example, the disability and chronic illness unit covers specific conditions, such as myalgic encephalomyelitis (chronic fatigue syndrome) or cancer, in addition to the gender politics of chronic illness and the disability justice movement.

Transing Readings, Assignments, and Discussion

A notable challenge to making a gender and health course inclusive to a range of bodies, identities, and experiences is that there is no single textbook that uses inclusive language and meaningfully engages trans health. Teaching an inclusive health education course requires assembling a course reader from disparate sources. Like when I emphasize to students that the course involves learning about their body and bodies not like theirs, I explain that some of the readings will speak directly to them, and others will not. The reader includes content broadly framed to a variety of genders, such as Heather Corinna's (2016) excellent book *S.E.X: The All-You-Need-To-Know Sexuality Guide to Get You Through Your Teens and Twenties*, which is an exemplar of using inclusive language to teach about sexual and reproductive health.[13] I also include content aimed at specific groups of people, such as chapters from *Our Bodies, Ourselves* (Boston Women's Health Book Collective 2011) (the previously used textbook in the course) and chapters from *Trans Bodies, Trans Selves* (Erickson-Schroth 2014). This latter book drew inspiration from the former and is the first comprehensive popular press volume to address the personal health of transgender and gender nonconforming people. In addition to scientific health information, my reader includes blogs and personal narratives, news articles from sites like the reproductive justice blog *Rewire.com*, and data briefs from policy organizations. As in all of my courses, I prioritize readings by people of color, LGBTQI people, and disabled/chronically ill authors.[14]

Although recent iterations of the course had updated the traditional course assignments of "Women and Sexual Anatomy" and "Charting," I chose to introduce brand new assignments. The Women and Sexual Anatomy assignment required students to interview a woman of any age about how she learned about her sexual and reproductive anatomy, and the Charting assignment required students to spend a month charting and analyzing some aspect of their health. Although this could be anything ranging from mood to migraines, the assignment was designed to track ovulation and menstruation. These assignments grew out of feminist consciousness-raising activities popular in the women's health movement; however, their original grounding as assignments for cisgender women who menstruate proved too difficult to amend them to fit a feminist health course about a variety of genders. In keeping with the consciousness-raising and scientific literacy aims of the course, I developed two new assignments: the "Resource Scavenger Hunt" and a "Scientific Health Research" paper. The scavenger hunt requires students to pick three health services from a list I provide (e.g., a therapist who is a person of color, a primary care clinic with LGBTQI-competent providers, a homebirth midwife who accepts Medicaid) and locate how to access these services in both their hometown and in the city where our university is located. In their write-up, students analyze disparities in access related to cost, transportation, availability of culturally competent providers, and so on. This process allows students to select and investigate health

services they themselves may need to access and enables them to connect the availability of resources to course concepts such as the social determinants of health. The scientific health research paper requires students to pick a specific health topic covered in the course (e.g., cesarean birth, gender-affirming surgery, fibromyalgia), formulate a research question (e.g., how does race affect the likelihood of a fibromyalgia diagnosis?), identify and analyze three scientific articles, and write up their results. This assignment also enables students to focus on a health issue relevant to their own bodies/lives/identities while giving them tools to navigate and understand scientific health literature.

As in any large lecture course with discussion sections, the teaching assistants are a backbone of "Women and Their Bodies." Discussion sections are an opportunity for experiential learning and a deeper exploration of concepts covered in lecture. The comparatively intimate setting of a twenty-five-student discussion section allows TAs to meet students where they are, whereas in the lecture I push them to their learning edges. In lecture, I might explode their assumption that all women have a vulva or that heterosexual women do not get HIV, whereas in discussion section TAs have an opportunity to consolidate that learning. For example, TAs might model using inclusive language to talk about bodies or sexualities and how to correct yourself when you "mess up." By and large, graduate students in a gender and women's studies program frequently know more about trans issues than the majority of faculty members, and all of my teaching assistants readily recognize the importance of a trans-inclusive pedagogy.

The reorienting of the course away from health issues as attached to particular gendered bodies and toward overarching analytic concepts helped restructure the discussion sections, and TAs also modified existing facilitation resources or created new ones. Some activities involved a simple revision, such as a traditional activity of using Play-Doh to sculpt a vulva—in this case TAs simply instructed students to sculpt a model of any of the internal or external anatomies we covered in lecture. Other activities required TAs to start anew, such as designing discussion questions to help students make conceptual linkages between how medical providers tend to assume cisgender women's primary health need is contraception, whereas they tend to assume transgender women's primary need is HIV prevention. Thus, TA training and professional development is another way to trans a feminist health course by ensuring that future educators are competent in trans topics and pedagogies.

Working Our Way Out of Being Trapped in the Wrong Classroom

Vic Muñoz (2012, 23) writes that, as a trans educator, to be "trapped in the wrong classroom is to be aware of but not to take action against how colonization, racism, classism, sexism, heterosexism, ableism, transphobia, and language structure and constrain everything I do as an educator. It is to be dehumanized

through a process of forgetting, denying, and being made invisible." Transing the women's health curriculum is not only a way for me to work my way out of being trapped in the wrong classroom; it is also a necessary and vital strategy to meet the needs of *all* of our students. The content, sequencing, framing, readings, and discussion activities I described here are important first steps to finding a way out of the essentialist feminist health course, but there is still much work to be done. Instructors must continue to work against a recipe for a feminist personal health course that does not simply add and stir trans people assigned female at birth to the traditional sequence of sexual and reproductive anatomy, menstruation, childbirth, and so on. Likewise, although I de-emphasized topics related to reproduction in my course revisions in order to work against the conflation of "women's health" with "reproductive health," I do imagine their inclusion may exacerbate the gender dysphoria that some (but of course, not all) trans feminine students may experience around their inability to carry a pregnancy. Furthermore, the availability of health education materials aimed at trans women that are not about HIV is significantly limited. My course content absolutely has room to grow in order to be more fully welcoming of trans students assigned male at birth by including content specifically related to their bodies and health needs.

Despite reservations among (some) cisgender feminists about the place of trans studies and trans people in W/F/G/S/S spaces, both are here to stay. Trans health issues are feminist health issues, and they belong in the feminist health classroom, rather than solely in a "trans health" week or course of their own. They deserve to be integrated throughout the curriculum, rather than invited as special guests or sidelined as impossible figures that disrupt "real" women's learning. Ironically, the legacy of the women's health curricula has the potential to do to trans people the same thing that the male-dominated healthcare system did to ignite the women's health movement: ignoring, marginalizing, pathologizing, and/or medicalizing their health issues. A trans-affirmative, intersectional focus on how gender-based oppression affects health makes it logical and necessary to teach feminist health courses about a range of different genders. A transfeminist pedagogy has great potential to teach us as educators about the tensions in our discipline as well as what we want it to become. Trans health belongs in the feminist health classroom epistemologically, politically, and practically.

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Race and Reproduction in Youth Sexual Health Promotion *will be published by the University of California Press in 2020.*

Notes

1. This is also the title of the precursor to what would become the book *Our Bodies, Ourselves* (Boston Women's Health Book Collective 2011). "Women and Their Bodies in Health and Disease" was a stapled 193-page booklet produced in 1970. See https://www.ourbodiesourselves.org/cms/assets/uploads/2014/04/Women-and-Their-Bodies-1970.pdf. After a year of heated deliberation, in the spring of 2019 the department voted to change the title to "Gender, Women, Bodies, and Health." At the time of this writing, the change had not yet taken effect. Throughout the article I use the title that was in place during the time I taught the course.

2. Reflecting the many ways in which departments name themselves, I use this portmanteau acronym to represent Women's/Feminist/Gender/Sexualities Studies. See Wiegman (2002) for analyses of the various stakes of how we name our (inter)discipline.

3. The use of the asterisk to denote a capacious understanding of transgender identity, community, or field of study is contested. Avery Thompkins (2014, 26) describes its purpose as "to open up transgender or trans to a greater range of meanings." There are strong arguments for and against the asterisk's use. I do not use it in this article simply for visual consistency, although I do employ "trans" in its most capacious sense.

4. Trans health activism and feminist health movements have a tangled relationship of both convergences and divergences in their framing and strategies; see Hanssman 2016.

5. Although nascent, there is a growing body of academic and activist work reconfiguring and imaging reproduction among trans women and trans feminine people; see cárdenas 2016.

6. Other examples include roller derby leagues, softball leagues, car mechanics classes, sex parties, writing workshops, contra dances, and circuit parties.

7. By number of pages.

8. These reactions are not unprecedented. Research has demonstrated that transgender faculty routinely experience harassment, bullying, marginalization, and erasure in colleges and universities; see Pitcher 2018.

9. Top Hat is a personal response system used to create interactive learning environments in large classrooms. The platform allows faculty to pose a poll or open-ended question on the screen that students respond to using their smart phones or laptops. The screen then displays bar charts, text, and/or word clouds of the student responses.

10. Consider how odd it would be to teach a course in urban planning in which the weeks are broken down into topics like "Chicago," "New York," and "Los Angeles," instead of "design elements," "transportation systems," and "zoning laws."

11. Thanks to Cary Gabriel Costello for introducing me to this term.

12. I also explain to students why I use illustrations and not photos to teach anatomy. Although it is important to demystify our genitals, medical photography is not always conducted with fully informed consent of the subject. Historically, intersex, transgender, and disabled people have been subject to medical photography in harmful ways. In concert with a long-standing course tradition, I encourage students to look at

their own genitals if they are comfortable doing so, and note that although previous generations used a small handheld mirror for this purpose, the selfie mode on their phone will work just fine.

13. Although the book and related website, Scarleteen.com, are aimed at teens and young adults, I find that the language nonetheless speaks to people of all ages who want to learn more about their sexual and reproductive health in an affirming, nonjudgmental way.

14. Readers of this article are encouraged to contact me for the reader's table of contents: barcelos@wisc.edu.

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