

**Staging a conference to expand and reframe the University of Washington
Department of Global Health's approach to sexuality**

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Abstract

Staging a Conference to expand and reframe the University of Washington Department of Global Health's Approach to Sexuality

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In this paper I examine the framing of global sexual health employed by the University of Washington Department of Global Health (UW DGH) by examining a number of indicators such as faculty expertise, courses offered, and funding streams. The UW DGH employs a relatively narrow framing of global sexual health that prioritizes a biomedical model over other socially and politically contextualized models. Global, multicultural and postcolonial feminist and queer theories suggest that a narrow framing of global sexual health may be less effective in addressing complex public health issues, and may reinforce traditional gender/sexuality binaries and negative stereotypes and perceptions of gender non-conforming and LGBTIQⁱ individuals. I offer some suggestions of what a broader framing of global sexual health would look like, and how to move toward such a broader, more contextualized framing.

ⁱ LGBTIQ stands for Lesbian, Gay, Bisexual, Trans*/Transgender, Intersex, and

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Introduction

Sexuality and sexual health are vital components of an individual's overall health. Given the importance of sexuality and the explosion in the last 30 years of the sexually transmitted infection HIV, it is of little surprise that sexual and reproductive health garner significant attention in the field of global health. There are perhaps as many different definitions of sexual health as there are programs that seek to improve it, but there exist two ends of a continuum for framing sexual health. On one end is a narrow framing, in which sexual health is understood in purely biomedical terms: a sexually healthy person is someone with no sexually transmitted infections, and biomedical solutions such as vaccines and drug treatments can help ensure that people stay sexually healthy. The other end opens to frame sexual health as broad, nuanced, and contextualized. Gender and sexuality are seen as complex, fluid identities, and sexual health is understood to be linked to the economic, social, and political environments in which individuals and communities are situated. This broader framing is essential to making significant improvements in population health. Utilizing a broad framing will improve public health research, program implementation, health professional education and, ultimately, can save lives.

In a 2005 paper on contemporary myths and misconceptions of HIV and STDs among *bodabodamen* (motorbike-taxi drivers) in Southwest Uganda, Nyanzi et al. identified a number of commonly held misconceptions and misinformation regarding sexual health among the *bodabodamen*.¹ The authors found that many of the *bodabodamen* engaged in sexual behavior that is deemed 'risky' by the medical and public health communities, such as having multiple sexual relationships and failing to use condoms or other forms of protection. In order to make sense of and validate their apparently risky sexual behavior, the men drew upon both traditional and modern cultural myths – defined by the authors as “pragmatic values that are used to create a sense of social solidarity through common beliefs.”¹ For instance, many of the *bodabodamen* referenced the cultural myth that abstinence can cause severe disease and is unnatural and impossible, or myths about condoms, such as ‘condoms lead to impotence in men.’ While narrow framing of sexuality in the medical and public health communities may lead to the assessment of these myths as ignorant or irrational, Nyanzi et al. posit that for the *bodabodamen*, relying on the myths is a manifestation of their agency as sexually active men in a high-risk area. The myths enable the men to rationalize their risky choices in an environment that is flooded with sexual health education messages that are often incomprehensible.

The example illustrated above is just one of a myriad examples of how a broader framing of sexuality in public health can help achieve a higher standard of health across diverse populations, globally and nationally. For instance, exceptionally high rates of HIV among transwomen and girls can be partly attributed to very narrow framings that employ a strictly binary view of gender and sexuality. As a result of their exclusion from a system that ignores transgender identities and experiences, transwomen are at exceptionally high risk for acquiring HIV, and multiple structural barriers make it difficult for them to get tested and treated. However, some public health practitioners are employing a broader, more inclusive framing of gender and sexuality to address the

unique needs faced by transwomen and girls. In a 2011 paper, Sevelius et al. outline issues such as transphobia, substance use, incarceration, sex work, and mental health issues that put transwomen at high risk for HIV, and suggest that public health experts commit more resources to research, programs, and interventions that are specifically geared toward addressing these issues and improving health for transgender people.²

Shari Dworkin provides another excellent example of the perils of narrowly framing sexuality in public health. In an article entitled “Who is epidemiologically fathomable in the HIV/AIDS epidemic? Gender, sexuality, and intersectionality in public health,” Dworkin critically examines widespread assumptions in public health that heterosexual women are categorically vulnerable and at-risk for acquiring HIV/AIDS due to their passivity and femininity.³ Heterosexual men, by virtue of being powerful and aggressive, are assumed to be invulnerable, yet they also pose the threat of transmitting HIV to their heterosexual female partners. Dworkin points out the logical fallacy here when she writes that “women cannot be put at risk via sexual transmission with a heterosexually active male partner unless that male partner is already infected and hence clearly vulnerable and at risk.”³ A narrow framing of sexuality, gender, and gender roles cannot adequately capture risk and vulnerability among various and diverse sexually active individuals. Contemporary narrow classifications of gender and sexuality in relation to risk also erase the vulnerability of lesbian and bisexual women. Dworkin suggests that intersectional analyses of race and class in addition to gender and sexuality are critical to future progress in the HIV epidemic.

The examples above represent a wider problem in global health, in which a narrow framing of sexuality prioritizes a biomedical understanding of health and sometimes fails to take into account the social, political, and economic context in which individuals and communities exist, with mortal consequences. Employing broader, contextualized and nuanced framings of sexuality and sexual health enable us to understand the risky sexual behaviors of the *bodabodamen* and to implement more appropriate interventions to reduce their risk of acquiring HIV, to recognize the unique situation of transwomen and girls, advocate for more research that is trans* inclusiveⁱⁱ, and to develop interventions that are appropriate for transwomen and girls, and to use theories of intersectionality to address the complex vulnerabilities of men and women to HIV.

There are four specific aims for this thesis. First I explore the overarching core problems presented by employing only a narrow biomedical focus on global health. Next, I use the UW DGH as a case study by describing the current framing of global sexual health within the University of Washington Department of Global Health (UW DGH). My third aim is to investigate whether the 11th Annual Western Regional International Health Conference (WRIHC), a student-led conference which had an explicit focus on global

ⁱⁱ The term “trans*” with an asterisk is an umbrella term that is typically used to refer to anyone who is not a cisgender man or woman. Trans* can refer to anyone who may identify as transgender, genderqueer, non-binary, agender, non-gender, genderfluid, two-spirit, etc.

sexual health, successfully contributed to a broader reframing of global sexual health in the UW DGH. My fourth and final aim is to recommend ways that the UW DGH can shift its framing of global sexual health to a model that more closely resembles the broad, comprehensive framing put forth by the WRIHC.

Literature Review of Theoretical Frameworks for the Research

In my critiques of narrow framing of global sexual health and my development of an alternative framing that is expansive and contextualized, I draw on global feminist and queer theory and anti-racist scholarship from the Global South. A broad, comprehensive framing of global sexual health necessarily incorporates feminist and anti-racist perspectives on global health approaches. Sexism, racism, and heterosexism play an integral role in shaping our societies, our lives, and our health both in the United States and abroad. It is only by addressing these complex and intersecting oppressions that we can begin to get at the root of health inequalities and the many public health issues that affect straight and LGBTIQ people; white people and people of color; US citizens, immigrants and refugees, and people in the Global South.

Incorporating feminist perspectives in global health entails more than simply highlighting “women’s health” issues; it demands that we critically examine and deconstruct notions in public health and society regarding women and men, femininity and masculinity, straight and gay, vulnerability and invulnerability, normal and deviant. Below is a brief overview of some of the critical theory and scholarship that informs the arguments in this thesis. I draw on the work of bell hooks, Sylvia Tamale and Jane Bennett. These scholars are global feminists who stress theories of intersectionality in relation to racism, sexism, and classism, and challenge the racist and sexist assumption that African understandings of sexuality can be reduced to any one uniform view.

The black American feminist scholar and activist, bell hooks, writes that feminist struggle happens anywhere someone resists sexism or gender-based oppression.⁴ Feminist movement occurs when groups of people unite with an organized strategy to tackle gender-based oppression. Feminist struggles and feminist movements occur in the Global South as well as the Global North, but feminism may look very different in developing countries than it does in the United States. Regardless of setting, global health improves when populations are free of racism, sexism, and class differences. Resisting gender-based oppression is essential to improving global health, and it is crucial for this resistance to be led by feminists of color and feminists from the Global South, with white and American feminists in the role of ally or supporter.

Sylvia Tamale, a Ugandan feminist lawyer and academic, advises against oversimplifying or essentializing sexualities in Africa, and reminds us that sexualities will always have multiple and contextual meanings.⁵ Referencing sexualities in the plural is a reminder that the term comprises multiple and diverse identities, and these identities cannot be distilled to binary oppositions or simplistic research labels. Jane Bennett, Director of the African Gender Institute at the University of Cape Town, describes how current African voices are represented in the Western press and social media and in international spaces as conservative, sexist, and anti-gay.⁷ Certainly there are many African countries that

have enacted anti-homosexuality legislation, much of which stipulates homosexual or “indecent” behavior be punishable by fine, imprisonment, or even death.⁶ However, such a narrow representation both disregards the complex influence of decades of colonialism and neocolonialism on anti-homosexuality legislation and sentiment in African nations, and effectively serves to even further marginalize and invisibilize vibrant African feminist discourse. In fact, there are ample examples of African progressive efforts to push back on anti-gay discourse and legislation, including the magazine *Sexuality in Africa* produced by the Africa Regional Sexuality Resource Center, popular local publications like *Straight Talk* in Uganda that discuss sexuality and reproductive health and rights, books like *Rethinking Sexualities in Africa*, and other publications like the Women’s Manifesto, a political statement issued by Ghanaian women in 2004.⁷

Both Tamale and Bennett caution against the flattening of African sexualities, particularly by Western researchers who work in Africa but cannot claim to have the lived experience of being African. The oversimplification of African cultures has strong racist undertones, especially when it is perpetrated by mostly white, mostly American researchers. The long and painful history of colonialism in Africa has meant colonial powers erasing, marginalizing, and essentializing dynamic and diverse African cultures. This kind of oppression is ongoing in many forms, including American Christian evangelical groups that promote anti-homosexuality sentiment in many African communities by disguising it as religious fervor. Colonial and neocolonial patterns are in part a consequence of a narrow, simplistic framing of global sexuality, but they also have costs of their own, some of them lethal. Ignoring or erasing the rich multiplicity of sexualities that exist on the African continent is disempowering and oppressive, results in inadequate public health response to the complex needs of dynamic groups, and can lead to increased homophobia, sexism, and intolerance.

Fortunately, feminists across Africa are working for women’s rights, reproductive health, and sexual rights. The work of these activists is not only distinct from the work of feminist activists in the Global North, there are also important differentials in the history and context of the work between countries and cultures within Africa and across the Global South.⁸ Tamale writes:

“It is crucial that the strategies employed by African feminists be informed by the lived experiences of women and men on the continent and the specificities of what they hold as their culture, taking into account that there is not always agreement among people in the same locale about the nuances and meanings of culture.”

In challenging the current framing of global sexual health and proposing a nuanced, contextualized, and broadly inclusive framing, I center the arguments in this thesis in black feminist theory, critical perspectives on gender and sexuality, and scholarship and activism from the Global South.

Methods

Case Study: University of Washington Department of Global Health

In this thesis, I operationalize the UW DGH's focus and approach to global sexual health in a number of ways. My case study inventory includes the DGH website and strategic plan; course offerings and seminars; the demographics and areas of expertise of core faculty; centers, programs, and initiatives associated with the UW DGH; and research and projects. I reviewed the UW DGH website to find course titles and faculty specialty areas, and I reviewed the websites of the various centers, programs, and initiatives (CPIs) housed in the UW DGH to determine what kinds of frames each of them use to contextualize their work in global health. I looked at the focus areas of each of the CPIs, as well as the language that is used to describe the work that they do.

To understand the origins of the current framing of global sexual health, I looked at the history of how the UW DGH was founded, and at the funding streams related to HIV. I found and analyzed the websites and budgets of the UW School of Public Health, the UW School of Medicine, and the Gates Foundation. I examined the language and content on their websites to determine the focus and approach of each of these entities.

Examination of Broad Frames of Global Sexual Health

To develop an understanding of existing alternate framings of sexual health, I analyzed some of the framings that exist in domestic public health communities. I examined the titles of sessions offered at the 142nd Annual Meeting and Exposition in November 2014, searching for titles that indicated broad frames, and titles that indicated sessions that were narrower or strictly biomedical in scope. In order to form a basis for reframing the concept of global sexual health, I consider a new definition of sexual health that was researched and developed by a public health student in the UW Department of Health Services.

The Western Regional International Health Conference (WRIHC) is a student-led, student-initiated conference that typically focuses on neglected topics in global health. The 11th annual WRIHC was hosted in April 2014 by the UW DGH, with the theme "Uncensored: Gender, Sexuality, and Social Movements in Global Health." One of the stated goals of this conference was to put forth a broader framing of global sexual health than the narrow biomedical model that is often engaged in the UW DGH. The 2014 WRIHC aimed to broaden the discourse on global sexual health beyond HIV and STIs, to include robust sexual health of heterosexual and LGBTIQ individuals and communities around the world. The conference planners were an interdisciplinary group of undergraduate and graduate students, and staff of the Global Health Resource Center of the UW DGH. We planned the content of the conference, chose themes for plenaries and breakout sessions, and invited speakers to supplement the limited ways in which sexuality in global health is addressed in courses, seminars, lectures, and events offered by the UW DGH.

Postcolonial Feminist/Queer and Social Change Theory

I provide an overview of global, multicultural and postcolonial feminist and queer literature to inform my analysis of the UW DGH's framing of global sexual health, as well as the development of an alternate framing for global sexual health like the one put forth at the 2014 WRIHC. I also provide a brief review of some social change theorists

to inform my own theory of how staging a conference can serve to reframe global sexual health within the UW DGH. To measure changes in framing, I administered a survey to conference attendees, including speakers and volunteers, asking about their framing of global sexual health before and after the conference, as well as other questions about what participants may have gained from attending this conference.

Tracking Progress

I develop a “report card” that can be used to monitor progress toward a more inclusive framing of global sexual health. The report card includes interpretive statements that correspond to the letter grades A, B, C, and F. I award the department a letter grade that is based on the interpretive statements and my evaluation of the UW DGH.

Results

There are a number of different frames for global sexual health that are employed by the UW DGH, and the various centers, programs, initiatives (CPIs), courses, projects, and faculty housed within the department draw on different frames to contextualize their work in global sexual health. The most common topic within global sexual health to be prioritized is HIV/AIDS, with many of the CPIs, courses, projects, and faculty also focusing on other STDS, reproductive health, and maternal and child health.

Figure 1 portrays an organizational chart of the UW DGH. The centers, programs, initiatives (CPIs) and projects indicated with red arrows are ones that have HIV/AIDS as an explicit focus, as measured by their descriptions on the UW DGH website and, when available, the respective websites of the CPIs and projects. The centers and programs indicated in blue are those that address other aspects of sexuality, mainly reproductive health. In addition, six courses are explicitly focused on HIV/AIDS, comprising 16% of all graduate-level course offerings. Only one class includes LGBTIQ content beyond STI-focused topics.

The UW DGH offers two classes that have an explicit focus on women’s health: GH 564 (HIV and STIs in Women and Children) and GH 544 (Maternal and Child Health in Developing Countries). In addition, the Global Center for Integrated Health of Women, Adolescents, and Children (Global WACH) is housed in the UW DGH.⁹ These courses provide critical instruction on some of the most pressing issues in women’s health globally, and Global WACH provides an important interdisciplinary space for global public health practitioners and researchers, pediatricians, obstetricians, and gynecologists to work together to improve the health of women, adolescents, and children. Global WACH is interdisciplinary in that it incorporates expertise from three UW departments (Global Health, Pediatrics, and Obstetrics/Gynecology). Furthermore, Global WACH contextualizes the health issues affecting women, adolescents, and children in their varied educational, social, and economic environments.⁹ However, while these programs do provide a topical focus on women’s health issues, they largely fail to incorporate feminist theory and critique in the framing of these issues.

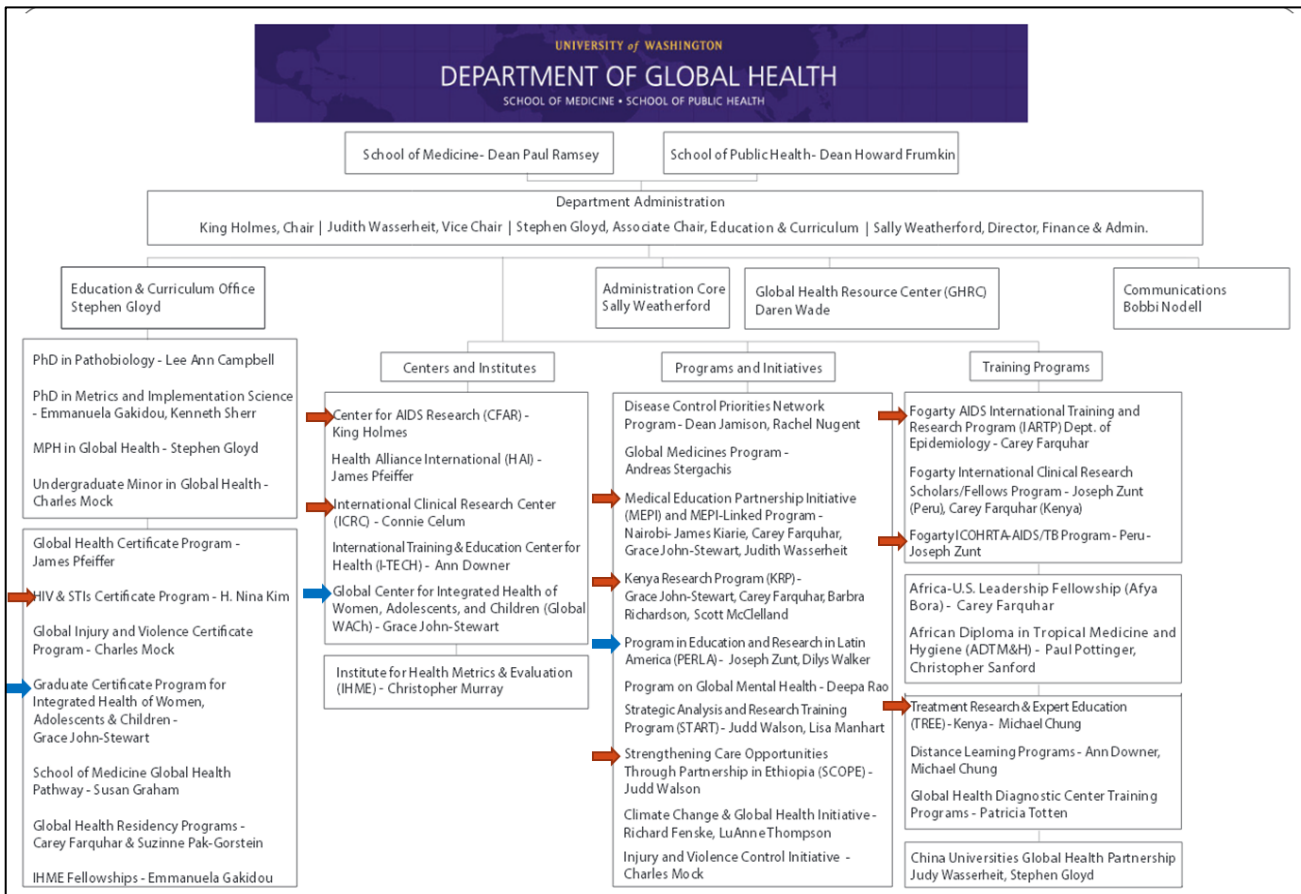
Evidence suggests the leadership of the UW DGH sees departmental work on HIV/AIDS as one of the core strengths of the department, while other aspects of sexual health and social justice receive much less attention. Almost half of the faculty in the department, including the founding chairperson Dr. King Holmes, are trained in infectious diseases and specialize in HIV/AIDS. Figure 2 portrays the number of core faculty in the UW DGH that specialize in each of the topics listed. There are 62 core faculty in the UW DGH; of these core faculty, 27 specialize in HIV/AIDS.¹⁰ In fact, more core faculty specialize in HIV/AIDS than in any other health topic. Ten core faculty specialize in STDs other than HIV, and ten core faculty specialize in infectious diseases other than STDs. (Most of the 62 core faculty specialize in more than one health topic.) The only other health topic listed on the UW DGH website that refers to sexuality or sexual health is “Maternal and Child Health (incl. Reproductive Health).” Altogether, sixteen core faculty list Maternal and Child Health (incl. Reproductive Health) as a health topic on which they focus – not an insignificant number, although it is revealing (and disappointing) that no other health topics explicitly relate to global sexual health. Only four core faculty specifically note in their profiles that they specialize in “Social Justice and Human Rights.”

One of the implicit frames employed by many of the CPIs, courses, projects, and faculty within the UW DGH suggests sexuality is a largely dangerous enterprise, because it is associated with the spread of disease (HIV and other STIs). The unfortunate implication of this framing is that disease must be controlled and contained in the homosexual and sex worker populations so that it does not infect the straight population. According to this framework for understanding global sexual health, the public health community must control and contain the disease by controlling the behaviors of individuals in the “at-risk” populations. This framing is evident in the ways that LGBTIQ individuals are represented in global health – rarely as a population with strengths, resilience, and dynamic health needs, but much more often in the context of being “at-risk” of acquiring and/or transmitting HIV.

A good example of the consequences of narrow framing of sexual health is the “ABC” approach to HIV prevention. ABC, which stands for “**a**bstinence, **b**e faithful, use condoms,” is an approach to HIV prevention that was promoted by the Bush administration during the launch of PEPFAR in 2003. Bush, himself a born-again Christian, allowed PEPFAR to be partially shaped by the demands of evangelical Christian groups in the US.¹¹ The conservative activist and self-proclaimed antifeminist Phyllis Schlafly herself wrote to Bush to urge that PEPFAR prevention funds be based on the ABC approach. In fact, Schlafly urged for a greater emphasis of “A and B” and the minimization of “C.” The emphasis on controlling sexual behavior as prevention, at the expense of addressing systemic issues like poverty, weak health systems, health care workforce or access to ARVs, reflects a conservative ideology that conflates sexuality with immorality. Someone who abstains from sex is deemed moral and good, and as a reward this person will not acquire HIV. Conversely, someone who has sex with one or multiple partners and does not use condoms is immoral and bad; if this person acquires HIV, it is a punishment for the immoral behavior.

The above framework is only one of many that are employed by public health professionals such as faculty and professors, researchers, and practitioners implementing public health interventions, both in the UW DGH and in other domestic and global public health agencies. It is important to note that many people in the public health field do more holistic, contextualized community-based work (often termed “harm reduction”), while others are engaged in important biomedical research related to treatment and prevention of HIV/AIDS. However, the framing of sexuality as something that is ultimately dangerous and risky is quite widespread, particularly in global health. While this framing also exists in domestic public health in the United States, it is less prominent, and domestic public health communities and organizations such as the American Public Health Association (APHA) also draw on much more complex, nuanced, and holistic frameworks for understanding sexual health.

The varied frameworks that domestic public health practitioners draw upon can be seen in the APHA Annual Meeting and Exposition. This conference draws thousands of



attendees each year, and boasts thousands of sessions on a very wide variety of public health issues, including some global health issues.¹² I examined the titles of sessions offered at the 142nd Annual Meeting and Exposition in November 2014. The diversity of session titles related to sexuality and sexual health is reflective of the multiple, overlapping framings that are employed by professionals in domestic public health. Some sessions reflect a narrow and/or biomedical framing of sexuality, focusing mainly on the biology and pathogenesis of HIV or other STIs. Other sessions suggest broader framings of sexuality that include social, economic, and political aspects of sexual health and disease. The wealth of different types of sessions offered on sexual health at the 2014 APHA Annual Meeting and Exposition, and the multiple framings employed in the various sessions stands in contrast to the UW DGH, which most often employs a biomedical framing and much less frequently draws on other, more nuanced framings of sexual health.

Figure 1: Organizational Chart of the University of Washington Department of Global Health

Source: University of Washington Department of Global Health [Internet]. Cited 2014 Apr 25. Available from: <http://globalhealth.washington.edu/>

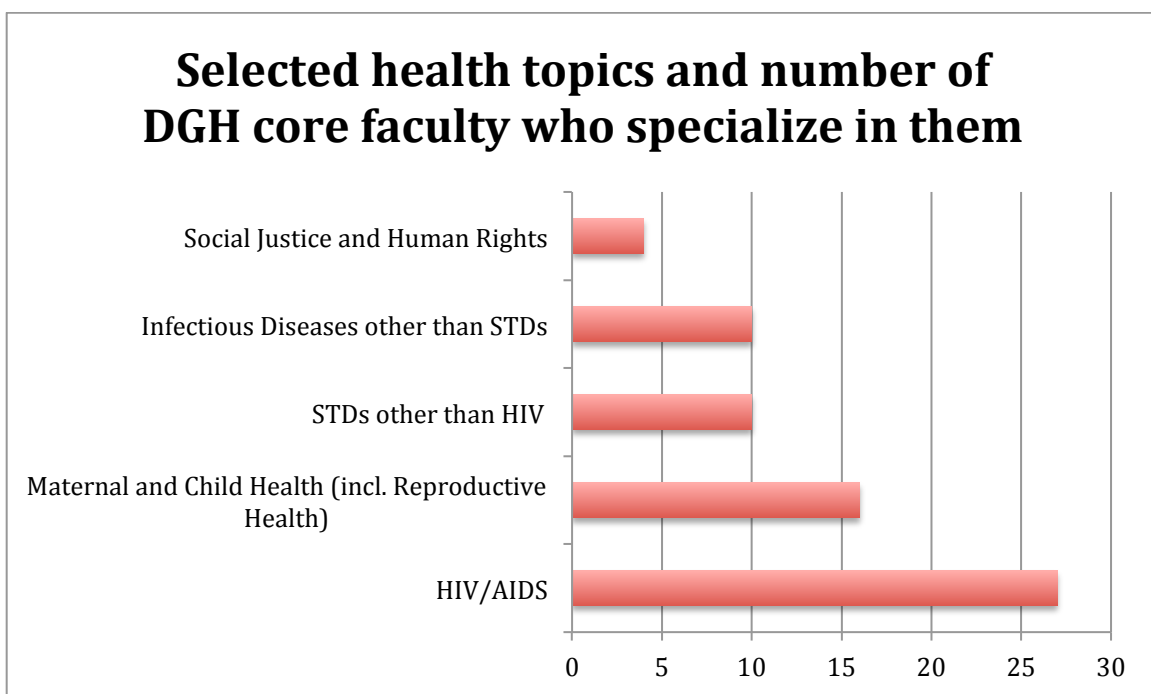


Figure 2: Selected health topics and number of core faculty in the UW DGH who specialize in them

Source: University of Washington Department of Global Health [Internet]. Cited 2014 Apr 25. Available from: <http://globalhealth.washington.edu/>

I identified 137 sessions offered at the 2014 APHA Annual Meeting and Exposition that are somehow related to gender and/or sexuality. Many of these sessions employ a similar biomedical framing that is often employed in global health, such as session 3152.0 “Biomedical HIV Prevention and Treatment in International Settings,” and session 3257.0 “HIV Treatment: Successes and Challenges.” However, many other sessions

employ a much broader, more inclusive, and contextualized framing of sexuality that includes an intersectional analysis of gender, race, and/or place; incorporates positive aspects of sexuality and sexual health; and includes a broad range of genders and sexualities in ways that challenge traditional binary constructions. For instance, this conference includes topics such as session 3161.0 “Social contexts and social determinants of LGBT health,” session 3165.0 “Pushing public health to the margins: Critical approaches to aggressive policing, aging in prison, and gender-based criminalization,” session 3174.0 “Affirmative models for sexual health,” and session 3264.0 “Sexual minority and women’s health (including lesbians, bisexuals, and WSW/WSWM).”

A number of factors contribute to the narrow focus on HIV/AIDS as one of the primary ways in which global sexual health is addressed in the UW DGH. Funding often drives priorities in global health, and the UW DGH was established in 2007 with a gift and endowment from the Bill and Melinda Gates Foundation (BMGF). Since its establishment the department has been housed in both the School of Public Health and the School of Medicine¹⁰ The Bill and Melinda Gates Foundation and the UW School of Medicine both employ a more narrow biomedical approach to health issues in comparison to the School of Public Health, which utilizes a much broader and more contextualized understanding of public health issues. I operationalize the focus and approach of these institutions using information available on their websites.

BMGF is comprised of four divisions: global health, global development, U.S. program, and global policy and advocacy. On its website, BMGF provides a brief description of the global health division:

“Our Global Health Division aims to harness advances in science and technology to save lives in developing countries. We work with partners to deliver proven tools – including vaccines, drugs, and diagnostics – as well as discover pathbreaking new solutions that are affordable and reliable. Equally important is innovation in how we bring health interventions to those who need them most. We invest heavily in vaccines to prevent infectious diseases – including HIV, polio, and malaria – and support the development of integrated health solutions for family planning, nutrition, and maternal and child health.”¹³

Vaccines, drugs, and diagnostics are, indeed, critical for public health, and innovation in delivering health interventions can sometimes yield impressive results – but almost every initiative mentioned even in this short description relies on a narrow biomedical framing of public health.

Not surprisingly, the UW School of Medicine also draws on a framing of health that is largely biomedical. Like the BMGF, the UW School of Medicine website includes a brief description of the school. In this description it is stated: “[UW School of Medicine] is recognized for excellence in training primary-care physicians and for advancing medical knowledge through scientific research.”¹⁴ The website also lists the areas in which *U.S. News & World Report* has ranked the school among the top 10 medical schools in the country. Among these is AIDS, but not any other aspects of sexual or reproductive health. The site also states that:

“Research scientists at the UW School of Medicine explore every aspect of health and disease, from the molecular mechanisms of gene action to population studies of global illnesses. UW research scientists’ work has contributed to improved understanding of the cause of diseases and to better treatments and prevention of many disorders.”¹³

This brief description actually does incorporate some broad framing of health, but as we would expect for a medical school, the biomedical approach is prioritized. Throughout the UW School of Medicine website, in fact, “scientific research,” “medical knowledge,” and “biomedical education, research, and health care” are highlighted most prominently. This is not surprising for a medical school, but it is important to note that this kind of framing shapes priorities in the UW DGH because it is jointly housed in the School of Medicine and School of Public Health.

The UW School of Public Health draws on a broader framing of public health that includes, but extends beyond, the biomedical model. The School of Public Health’s stated vision is “Healthy people in sustainable communities – locally, nationally, and globally.”¹⁵ Embedded in this vision is the idea that individual health is inextricably linked to the community and to the local and global environments. The School of Public Health has nine stated values, including diversity (“embrace and build on diverse perspectives, beliefs, and cultures to promote public health”) and equity (“promote equity and social justice in defining and addressing health and health care”).¹⁵ The School of Public Health employs a contextualized framing of public health that is interdisciplinary and nuanced.

The size and resources of the Gates Foundation and School of Medicine result in these entities having greater influence on the UW DGH than does the School of Public Health. In FY 2013, the University of Washington fully implemented activity-based budgeting (ABB) for the first time. That year, the total ABB budget for the UW School of Public Health was \$18.3 million, compared to \$119.1 million budgeted for the UW School of Medicine.¹⁶ The Gates Foundation has several funding areas, of which global health is one; in 2012, the Gates Foundation budgeted \$892.7 million for Global Health.¹⁷ In addition to funding from the Bill and Melinda Gates Foundation, the UW DGH brings in millions of federal dollars through research grants. US federal funding for HIV/AIDS has been increasing steadily and significantly, and in 2014 alone the US allotted \$6.5 billion for the global HIV epidemic, including international research, through PEPFAR, USAID, and the CDC.¹⁸

The 2014 WRIHC conference suggested a different way to frame global sexual health, by prioritizing the voices of women and gender non-conforming and LGBTIQ individuals and communities. The conference drew 600 attendees and provided a forum for discussion and opportunities to meaningfully critique the ways in which our department has engaged in the topic of sexuality in global health. The success of the conference pointed to the ability of a group of dedicated students and a few core staff and faculty members to subvert the status quo and change the framing of sexuality in global health.

While the UW DGH does little to address the health of LGBTIQ populations in the US or abroad in regards to issues other than HIV/AIDS, the WRIHC prioritized these issues by highlighting topics, perspectives, and speakers that are traditionally relegated to the margins. The WRIHC posed a new frame for understanding global sexual health, in which sexual health is contextualized in the wider social, economic, and political environment. The WRIHC engaged a comprehensive approach to sexual health that included freedom from oppression and discrimination, the right to determine one's own gender identity and sexuality, and the right to have safe and pleasurable sexual experiences. The conference engaged a rights-based approach to sexual health, including access to comprehensive sex education, reproductive health including abortion, and access to lifesaving medicines. Perhaps most importantly, this framing did not pathologize sexual minorities or gender non-conforming individuals.

The conference featured a Ugandan activist as our keynote speaker; it featured multiple LGBTIQ-identified speakers, and attracted many more LGBTIQ-identified attendees; and it featured a broad, contextualized framing of global sexual health front and center—not as a stand-alone breakout session, but as one of the central themes of the conference. We covered topics such as feminist and queer movements in the Global South; national, international, and transnational perspectives on health and gender violence; successful interventions and organizing across social movements; critiques of research labels (such as “MSM”) in sexual health; trans* identities and specific health needs; global reproductive rights and access to abortion; comprehensive sex education in developing countries; masculinity and health; LGBT human rights and advocacy; and sexuality and sexual health in indigenous communities around the world. These topics could become part of the core curriculum and research agenda at the UW DGH, if we employed a more comprehensive approach to sexuality. The WRIHC also tackled some of the underlying issues that result in some of the existing narrow frames for global sexual health in the UW DGH. For instance, in November 2013 the WRIHC planning committee sponsored a screening of *God Loves Uganda*, a film that explores many of the issues that shape prescriptive behavioral approach to addressing HIV/AIDS, such as the role that American evangelical Christians continue to play in promoting anti-homosexuality fervor in Uganda.

Fifty-eight attendees completed the WRIHC follow-up survey. Results indicated the conference was successful in inspiring at least a temporary reframing of global sexual health. Many attendees came to the conference because they already possessed a broad, contextualized frame for understanding global sexual health, but felt frustrated by the narrow frames posed by the institutions where they work. One participant described his approach to global sexual health before attending the conference as an “open, inquisitive approach of trying to understand both root causes as well as daily realities in this spectrum for a variety of cultures/contexts.” This participant described his approach to this topic after the conference as the “same, just with added knowledge/awareness.” Another participant, who indicated his primary work was associated with the UW DGH, wrote, “My office is metrics-based, while my personal approach is more interpersonal, so this conference really validated many of the ways I would like to engage in global health in the future.” Another respondent indicated her approach to global sexual health before

the conference was “well-informed,” and she chose to describe her approach the same way – “well informed” – after the conference.

For other attendees, the conference played a critical role in reframing their approach to global sexual health. One attendee wrote that before the conference, global sexual health “was a topic that was of interest to me, but I did not realize how big the topic really is. When I would think about global sexual health, I mainly had focused on family planning and STI/STD prevention.” After the conference, the attendee reported being “much more aware of the language I use. I really enjoyed the conversations about transgender and never realized how often people assign genders to various activities, etc.” Another individual reported that before the conference, he was “uninformed,” but after the conference, he described his approach to global sexual health as “open, informed, respectful, and uncensored. [The conference] opened me up to conversations that I would have never had and gave me the right vocabulary, history, and background to have these conversations.”

Discussion

The close relationships between the DGH and the Gates Foundation as well as the School of Medicine indicate that each of these entities plays a significant role in shaping the priorities of the department. The values, priorities, and culture of the School of Medicine and the Gates Foundation differ significantly from those of the School of Public Health, particularly in the ways that they prioritize a narrow biomedical model and emphasize technological solutions and clinical practice to address public health problems. Many definitions of culture vary across time and place; to understand the different cultures in the UW School of Public Health, UW School of Medicine, and the Gates Foundation, I drew on Susie Jolly’s work. Jolly understands culture to be:

“diverse and dynamic; formed by internal and external influences; and structured by representations and power. According to this understanding, cultures are the products of history, place, politics, and people and change over time.”¹⁹

Culture shapes identities of individuals, and these individuals in turn shape their cultural environments by conforming to or resisting cultural norms.¹⁹ In the UW School of Public Health, culture and practice emphasize the various environmental, economic, political, and social factors that influence individual and community health.²⁰

The role of PEPFAR in setting global health priorities in regards to HIV/AIDS (and in establishing the dominant framing of global sexual health) cannot be overstated. Between 2004 and 2013, the U.S. government committed more than \$52 billion for PEPFAR projects.²¹ Many of PEPFAR’s strategies involve vertical programs that do not adequately contextualize the HIV/AIDS epidemic in the complex environments in which it exists. I use the term “vertical” to describe an approach defined by Gonzalez as one that “calls for the solution of a given health problem through the application of specific measures through a single-purpose machinery.”²² The alternative to a vertical approach is a horizontal approach, which “seeks to tackle the over-all health problems on a wide

front and on a long-term basis through the creation of a system of permanent institutions commonly known as ‘general health services.’”²²

PEPFAR does have a stated commitment to health systems strengthening, and designates some resources to addressing health care workforce issues. However, even this broader initiative is understood by PEPFAR as a response primarily to “constraints to HIV service delivery.” Furthermore, the majority of PEPFAR funds are used more narrowly to address treatment and prevention of HIV, rather than the underlying causes of high burden of disease. PEPFAR funds are used to provide ART to more than 6.7 million HIV-infected people in developing countries. In FY 2013, PEPFAR funded HIV counseling and testing (HCT) for more than 12.8 million pregnant women, and provided ARVs to prevent mother-to-child transmission of HIV for hundreds of thousands of women who tested positive for the virus.²³ Access to ART is critical for the survival and health of people living with HIV/AIDS (PLWHA), and there is no doubt PEPFAR funding provides treatment and prevention to save lives. At the same time, interventions based on limited definitions of sexuality ignore the rich social determinants and contexts of sexual health and sexually transmitted infections. These limited, narrow frames are often less relevant, less effective, and less appropriate than interventions that are complex and nuanced. As Stella Nyanzi writes:

“HIV prevention interventions that target sexuality must of necessity embrace its inherent ambivalence and depth of scope to be effective. Interventions driven, designed and implemented by the participation of targeted communities have warranted some success because of local input into conceptualizations, process and outcome.”²⁴

To execute one of PEPFAR’s central tactics of changing sexual practices and behaviors, PEPFAR partners with faith-based organizations (FBOs) in developing countries, many of which share the conservative ideology behind many of PEPFAR’s programs and strategies.¹¹ Jappah notes the polemical nature of PEPFAR politics when he writes:

“Evangelical Christians in the USA and their counterparts in Africa, the Catholic Church and other FBOs, gender-based advocacy groups, human rights organizations, social movements, health experts and politicians have vied to tilt the pendulum of PEPFAR in their direction. American national politics of social conservatism versus progressivism over morality and sexuality have been brought to the global stage, engaging both supporters and dissenters.”¹¹

Indeed, Jappah reminds us, the very creation of PEPFAR is moored in religious conservative ideology, which can be traced back to the Adolescent Family Life Act (1981), a Reagan-era federal law that aimed to prevent teen pregnancy by promoting abstinence.

Postcolonial and antiracist feminists from across the globe have highlighted the importance of centering feminist theory and scholarship in development and global health work. In her book *Feminism Without Borders: Decolonizing Theory, Practicing Solidarity*, the Indian American feminist scholar Chandra Talpade Mohanty advocates for “expansive and inclusive” antiracist feminism that is “attentive to borders while learning to transcend them.”²⁵ She emphasizes solidarity between Global North and Global South

feminists, “as opposed to vague assumptions of sisterhood or images of complete identification with the other.” In her book, Mohanty outlines her own feminist vision:

“This is a vision of the world that is pro-sex and –woman, a world where women and men are free to live creative lives, in security and with bodily health and integrity, where they are free to choose whom they love, and whom they set up home with and whether they want to have or not have children; a world where pleasure rather than just duty and drudgery determine choices, where free and imaginative exploration of the mind is a fundamental right; a vision in which economic stability, ecological sustainability, racial equality, and the redistribution of wealth form the material basis of people’s well-being. Finally, my vision is one in which democratic and socialist practices and institutions provide the conditions for public participation and decision making for people regardless of economic and social locations.”

Focusing on “women’s health” or exploring differences in men’s and women’s health issues can be important and even lifesaving work, but it is not the same as centering feminist and gender theory in public health research and practice. In fact, the type of women’s health that is often prioritized and funded in global health may reinforce the binary constructions of sex and gender that are critiqued and deconstructed in feminist scholarship. Incorporating feminist perspectives in global public health requires us to emphasize gender as a relational, intersectional, and biosocial construct that shapes health. According to Springer, et al., feminist global health “disrupt[s] persistent essentializing tendencies in much gender and health research, underscore[s] new ways of thinking about gender complexities, and highlight[s] the ongoing need for capturing intersections of biological factors and other forms of social difference – including but not limited to gender and sex.”²⁶

Global WACH and the two global health courses that the UW DGH offers on women’s health all provide essential instruction, scholarship, and research, but they are not centered in feminist and gender theory as described above. Feminist perspectives in global health must include perspectives from the Global South as well as the Global North, and the UW DGH does a poor job of this; most of the instructors, lecturers, and researchers are American, and articles and other readings assigned are largely written by American authors. By contrast, the Gender, Women, and Sexuality Studies (GWSS) department at the University of Washington offers such courses as *Feminism in an International Context*; *Global Feminisms: International and Indigenous Communities*; *Critical and Interdisciplinary Approaches to Women’s Health*; and *White Privilege and Racism in Health and Human Services*.²⁷

Restricting sexual health to a strictly biomedical definition results not only in a narrow and inadequate discourse; a number of scholars have noted that this type of narrow framing may also explain some of the lack of success in improving the aspects of sexual health that are prioritized, such as HIV/AIDS. Stella Nyanzi suggests that while some progress has been made in the areas of HIV/AIDS and other STIs; unintended pregnancies; child marriages and teenage pregnancies; and sexual abuse and domestic violence, progress in all of these areas has been hampered by a narrow view of sexuality

and sexual health.²⁴ Eileen Stillwaggon, a professor of Economics at Gettysburg College who has conducted research throughout the Global South, writes that focusing on the behavioral paradigm to explain higher rates of HIV in African countries ignores other factors – such as cultural and social aspects – that are typically considered in epidemiological studies.²⁸ Stillwaggon writes:

“What distinguishes most Africans, Asians, and Latin Americans from most Europeans and North Americans is not extraordinary behavior but poverty. Effective prevention depends on recognizing the real commonalities among people, as well as the real differences. The behavioral paradigm and its assumption of African exceptionalism largely determine the questions that can be asked and the solutions that can be proposed in AIDS research and AIDS-prevention policy for Africa and other profoundly poor populations [...] By accepting the wrong paradigm, the AIDS discourse has failed to ask the right questions, and we have lost well over a decade in understanding the complexity of AIDS, especially among poor, malnourished people.”²⁸

Alternate models do exist for doing public health work in sexuality and sexual health. Students and practitioners who are trained outside of or beyond the narrow biomedical framing of sexual health, or who employ an alternative framing, use a more holistic approach to sexual public health; and feminist scholars from Africa and throughout the Global South have been writing about anti-colonialist feminist approaches to public health issues for decades. Sylvia Tamale, for example, deconstructs the “universalism vs. cultural relativism” debate on women’s sexual rights, whereby many Western feminists and some first-world African feminists understand African culture(s) as antithetical to women’s rights, and a top-down legal/constitutional framework is viewed as the only legitimate way to achieve these rights.²⁹ Tamale advocates instead for an anti-colonial feminist approach to improving women’s sexual rights, in which “we surface the positive, egalitarian aspects of African culture and use it to our advantage”; and in which we “(re)-interpret the underlying values within our culture with the changing socio-economic circumstances.” Numerous other African scholars such as Stella Nyanzi, Beth Maina Ahlberg, and Zethu Matebeni have contributed to a rich discourse on broad framings of sexual health that are nuanced and contextualized.^{30 31 32}

In 2012, a student in the University of Washington’s Community Oriented Public Health Practice (COPHP) Program did a six-month practicum with the HIV/STD Program of Public Health-Seattle & King County, which culminated in a report entitled “Developing a sexual health approach to HIV prevention in men who have sex with men.” The student, Genya Shimkin, created a new definition of sexual health that was based on an extensive literature review and interviews with professionals in sexual health and HIV prevention.³³ Shimkin defines sexual health as:

“a state of well-being that supports one’s decisions about how and when to explore, practice, accept and nurture one’s sexuality.”

The new definition crafted by Shimkin is one of a few definitions that the county’s health department HIV/STD Program draws on to develop projects and programs to improve sexual health. Shimkin’s definition was used to shape the We Are 1 project, a tri-county health education campaign promoting health and wellness among gay men, bi men, trans

people and straight men who love men. The project website offers resources on a variety of topics including diet and exercise, drugs and alcohol, health care and health insurance, mental health, stigma and discrimination, tobacco, and violence.³⁴ It also offers resource on HIV/AIDS and other STIs, but the broad framing of sexual health employed in this project results in contextualized, nuanced, and inclusive messaging that includes, but is far from limited to, sexual infections and diseases.

The COPHP program differs in significant ways from any program housed in the UW DGH. Problem-based learning (PBL) and service learning are used to help students integrate academic training and practice, and students are taught to recognize and work within the complexities of real-world public health issues.³⁵ A community-based approach to public health practice emphasizes a very different set of skills and values than the traditional model employed by the UW DGH, where the power, decision-making, and funding typically flow from academic and government institutions in the Global North to tackle diseases in the Global South.

A number of feminist and social change theorists posit that change comes from the ground up, and indeed originates in activist action in marginal spaces. For instance, writing about the resistance to development, Gustavo Esteva posits that the struggle is:

“a creative reconstitution of the basic forms of social interaction, in order to liberate themselves from their economic chains. They have thus created, in their neighborhoods, villages, and barrios, new commons which allow them to live on their own terms [...]

“For people on the margins, disengaging from the economic logic of the market or the plan has become the very condition for survival. [The spaces] where they organize their own modes of living [...] were their last refuge during the development era. After experiencing what survival means in economic society, they are now counting the blessings they find in such refuges, while working actively to regenerate them.”³⁶

In other words, resistance can take place in the commons and the margins; grassroots activism can produce change and does not require approval from authority.

The American lesbian feminist Adrienne Rich, writing about compulsory heterosexuality, suggests that our society’s dominant narrative, which insists in overt and subtle ways that women are innately heterosexual, serves not only to marginalize, but to erase a lesbian existence. Rich writes that

“Lesbians have historically been deprived of a political existence through ‘inclusion’ as female versions of homosexuality[...]Just as the term *parenting* serves to conceal the particular and significant reality of being a parent who is actually a mother, the term *gay* may serve the purpose of blurring the very outlines we need to discern.”³⁷

Like Esteva, Rich insists that real and authentic change can only happen within the very margins that are created by the dominant discourse itself.

Similarly, the black lesbian feminist Audre Lorde asked the question: “What does it mean when the tools of a racist patriarchy are used to examine the fruits of that same patriarchy?”³⁸ Lorde answers her own question:

“It means that only the most narrow parameters of change are possible and allowable [...] For the master’s tools will never dismantle the master’s house. They may allow us temporarily to beat him at his own game, but they will never enable us to bring about genuine change [...] Women of today are still being called upon to stretch across the gap of male ignorance and to educate men as to our existence and our needs. This is an old and primary tool of all oppressors to keep the oppressed occupied with the master’s concerns.”³⁷

Changing the framing of global sexual health at the UW DGH will require those of us who are marginalized by the current framing to resist *in the margins*. The 2014 WRIHC was planned by a group of students from across fifteen departments at the University of Washington; many of us were dissatisfied with the current framing of global sexual health at the UW DGH, and many of us self-identify as lesbian, gay, bisexual, or queer. Many speakers and attendees of the conference were LGBTIQ individuals. In many ways, the 2014 WRIHC was a way to resist – and thus, begin to change – the dominant discourse in the UW DGH around global sexual health, by engaging a new discourse *in the margins*.

Staging a conference can be an effective strategy to shape or reframe issues in public health, and in influencing a professional community’s stance on a particular issue. Conferences provide an opportunity for debate and discussion, as well as a physical convergence of academics and professionals with a shared interest and shared goals. The 10th Conference on Retroviruses and Opportunistic Infections, which took place in Boston, MA in February 2003, was instrumental in creating the policy and practice shifts that later led to much greater availability of antiretroviral treatment in low-income countries.³⁹ The 2010 Western Regional International Health Conference, hosted at the University of Washington, aimed to reframe war as a global health issue. The conference organizers found the conference to be successful in developing new student leaders in medicine and public health who are committed to conflict prevention, management and reduction; and that the conference enabled students to connect with experts and build departmental support for including war in the public health curriculum.⁴⁰ Ultimately, the conference led to a building momentum for understanding war as a public health problem in APHA, public health journals, and in public health classrooms across the country.

There remains the question of what will happen at the UW DGH and in the field of global health now that the 2014 WRIHC is over. How can we advocate for the UW DGH to take up the reframing of global sexual health offered by the WRIHC? At a short presentation of my thesis in front of DGH faculty, staff, and students, I began the process of engaging our global health community in some of the issues discussed in this paper. There seems to be a lot of interest and potential for change. To further the conversation and provide guidance for developing a praxis of feminist, antiracist, anticolonial global sexual health, I have developed a “report card” we can use to monitor progress towards a broader, more nuanced framing of global sexual health (see Figure 3). Based on these

tracking indicators and my evaluation of the UW DGH, I am awarding the department a “C” for academic year 2013-2014.

The narrow framing of global sexual health employed by the UW DGH does not capture the multitude and diversity of sexualities around the world, the breadth and complexity of global sexual health, or the various ways in which sexuality impacts individual and population-level health directly and indirectly. I hope this thesis has outlined the importance of a broader framing of global sexual health, and that UW DGH students, staff, and faculty will begin working toward changing the framing of global sexualities in our department.

WHAT ABOUT THE NEW MISSION STATEMENT

| Numerical Grade | Interpretive Statement |
|-----------------|--|
| A | The UW DGH engages a broad, nuanced, and contextualized framing of global sexual health. An understanding of sexual health as more than the absence of HIV and STIs is incorporated into multiple aspects of teaching, research, and practice. Feminist theory informs working definitions of gender and sexuality as complex, fluid identities. Courses are offered that reflect antiracist, postcolonial feminist scholarship, and students are assigned readings by feminist scholars from the Global South. Students, faculty, and staff are engaged in critical discussions of gender and development, including critiques of funding streams within global health and the role of the UW DGH. Real efforts are made to recruit and admit more American students of color and more LGBTIQ students, and to hire more faculty of color and LGBTIQ faculty. |
| B | Sexuality in global health is addressed as a core topic and incorporated into various other aspects of global health work. Sexual health includes maternal and reproductive health, gender based violence and intimate partner violence, and it incorporates a range of sexualities, not just two or three. LGBTIQ individuals, sexual minorities, and gender nonconforming individuals are discussed as dynamic individuals and communities with a variety of strengths and health needs. The |

| | |
|---|---|
| | Department of Global Health Diversity and Inclusion Committee includes at least one LGBTIQ individual, as well as individuals of color. |
| C | Sexuality is seen as an important topic mainly because of its relevance to core subject areas. For example, MSM (men who have sex with men) and sex workers are discussed in relation to the HIV/AIDS epidemic, because they have a higher burden of disease than other populations. Women's health issues are addressed in courses, research, and public health practice, but feminist, antiracist, and postcolonial theories are not incorporated. Gender and sexuality are presented as binary and immutable categories. There is little critical discussion of development work or funding streams and priority setting in global health. |
| F | There is little or no discussion of gender and sexuality as determinants of individual and community health and resilience. If gender and sexuality are discussed at all, they are presented as binary and immutable categories. Course readings and syllabi do not reflect scholarship from the Global South, and feminist and antiracist scholarship is not incorporated into global health curricula. There is no discussion about funding or power and decision making dynamics between actors in the Global North and Global South. |

Figure 3: Report card with proposed tracking indicators to measure framing of global sexual health

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