CENTER for HEALTH and GENDER EQUITY

Policy Brief

A Woman-Centered Approach to the U.S. Global Health Initiative

February 2010

INTRODUCTION

Investing in the health of women, adolescents and girls is not only the right thing to do; it is also the smart thing to do. That is why we are integrating women's issues as key elements of our foreign policy agenda and in, especially, our Global Health Initiative…

- Secretary of State Hillary Rodham Clinton, Remarks on the 15th Anniversary of the International Conference on Population and Development, January 8, 2010

In May 2009, President Obama announced a new global health initiative (GHI) as a critical component of U.S. foreign policy. The initiative builds on the successes of the President's Emergency Plan for AIDS Relief (PEPFAR), while adopting a comprehensive and integrated approach to global health that links HIV and AIDS, family planning, maternal and child health, malaria, TB, and neglected tropical diseases. Recognizing that the marginalization of women negatively affects women's access to health care and the protection of their health and rights, the administration is committed to developing a woman-centered approach to the GHI.

The purpose of this background paper is to define what a woman-centered approach is by identifying its key elements, providing examples of what it looks like, and demonstrating its importance for the success of the GHI.

WHAT IS A "WOMAN-CENTERED" APPROACH?

A woman-centered approach to health is a human rights-based approach that seeks to ensure that every individual has access to basic health, education, and other social services, including sexual and reproductive health. It provides a framework for prevention, care, and treatment that recognizes the roles women play in their communities, as well as the risks and obstacles each woman faces in accessing her own health care.[1] A woman-centered approach does not ignore or diminish the health needs of men and boys, but rather recognizes and addresses the disparate needs and conditions of women. With women at its center, it provides a plan for ensuring that every member of society has equal access to basic health services.

Creating an environment for women to reach the highest attainable standards of physical and mental health will require the GHI to not only provide basic health services, but to recognize and address the economic, cultural, social, and legal barriers for women and girls accessing those services.[2] This requires reducing gender inequities, while at the same time looking at each woman as an individual. Every woman

KEY ELEMENTS TO A WOMAN-CENTERED APPROACH IN THE GHI

1. Support of a right to health for all women, men, children, and youth
2. Meaningful participation of women in planning, decision-making, monitoring, and evaluation
3. Comprehensive, integrated care
4. Meaningful and robust referral systems
5. Continuum of care through the life cycle
6. Multisectoral approach to health and rights
7. Access for *all* women

This brief was written by Maeve McKean, legal fellow with the Center for Health and Gender Equity (CHANGE) and the International Community of Women Living with HIV and AIDS (ICW), through the Women's Law and Public Policy Fellowship program at Georgetown University.

must have access to the wide range of information and services she needs to make her own choices about her health and to care not only for her needs, but the needs of her children and family members.[3] Meeting women's biological and social needs requires health services, as well as the resources needed to access those services.

GLOBAL CONSENSUS FOR A WOMAN-CENTERED APPROACH

At the 1994 International Conference on Population and Development (ICPD), the U.S. helped forge a global consensus around a 20-year plan of action that placed empowering women and girls, protecting human rights, and promoting the sexual and reproductive health of men, women, and young people at the core of efforts to achieve sustainable development.[4] The ICPD acknowledged that achieving the goal of gender equity requires, among other things, empowering women in all aspects of their lives, as "the power relations that impede women's attainment of healthy and fulfilling lives operate at many levels of society, from the most personal to the highly public."[5]

This notion that gender equity is a precondition for health and development has been reaffirmed by the global community numerous times since the ICPD. In 1995, at the United Nations Fourth World Conference on Women in Beijing, governments and the UN reaffirmed the central principles of the ICPD in the Beijing Platform for Action and agreed to promote gender mainstreaming in future policies and programs.[6] Since then, many national governments have adopted these goals and incorporated them into their health policies.[7]

Building on these national and international agreements, 188 governments came together in September 2000 to create the Millennium Development Goals (MDGs) with the aim of cutting poverty in half by 2015.[8] The eight MDGs both explicitly and implicitly acknowledge that gender equality is critical, and four of the MDGs directly address women's health and rights.[9] In fact, the success of many of these goals depends on the success of Goal 3: "To Promote Gender Equality and Empower Women."[10]

WHY A WOMAN-CENTERED APPROACH?

Because power is distributed unequally in most societies, women typically have less access to and control over health information, care, and services, and resources to protect their health.[11]

—The Global Fund to Fight AIDS, Tuberculosis, and Malaria

Findings from a recent World Health Organization report on women and health demonstrate a need for a woman-centered approach to global health[12]:

- For women in their reproductive years (15-44), **HIV/AIDS is the leading cause of death,** and **unsafe sex** is the main risk factor in developing countries.
- **Nearly all of the half-million maternal deaths that occur each year are in developing countries.** Despite increases in contraceptive use over the past 30 years, **significant contraceptive needs remain unmet in all regions.**
- **Violence against women is widespread throughout the world.** Women who have been physically abused have higher rates of unintended pregnancies, abortions, and miscarriages than women who have not been abused.

High rates of illness and death related to sex and reproduction are rooted in the stark gender disparity and inequality that characterize women's lives throughout much of the world. These include lack of access to education, income, and property, as well as social, legal, and cultural norms that limit women's control over sex and reproduction, and contribute to high rates of violence against women and girls.

Women's legal status, as demonstrated by unequal laws concerning property rights, marriage, and sexual exploitation and abuse, as well as lack of enforcement, leaves women and girls vulnerable to economic dependency and diminishes their decision-making power.

Economic hardship and lack of access to and control over income can compel women to engage in sexual behavior that may put them at risk of preventable

illness and death, including intimate partner violence and intergenerational and transactional sex. Particularly in sub-Saharan Africa, young women may engage in transactional sexual relationships with older men in order to pay for school fees or to help support their families. Engaging in sex with older men increases risks of HIV infection among young women and girls.

Cultural practices such as wife inheritance, early child marriage, and female genital mutilation put women at risk of HIV infection.

Education plays a critical role in reducing HIV infection and unintended pregnancies, yet universal education for girls is still a challenge globally. A tendency towards son preference means that daughters are less likely to receive education when families can only afford to send one child to school. Additionally, girls are expected to care for sick parents, and when parents die, daughters are often responsible for caring for siblings and unable to stay in school.

Because women and girls commonly encounter these and other economic, social and cultural barriers to basic health care, it is critical that the GHI aggressively confronts these barriers not as a side component, but as a central element of the entire initiative. In particular, the GHI must ensure that it meets the needs of women and girls who exist on the margins of society such as sex workers, injecting drug users, and the incarcerated.

WOMEN AND THE U.S. GLOBAL HEALTH INITIATIVE

For the GHI to most effectively improve the health of women, program designers must take into account those issues that limit women's status in societies, their biological risk of disease, and accessibility and quality of care. Women and girls comprise the largest disadvantaged groups in a population. They suffer multiple and compounding forms of health-related discrimination throughout the course of their lives, both because of social disadvantages and because of biological factors. Creating a political and social environment where women have the autonomy to make decisions about their own health and health care is an important and necessary step to reducing gender inequity.

Improving a woman's health has a direct positive impact on the community and her household. Where women are healthy and can generate an income, it has been found that they tend to invest a higher percentage of their earnings on children's education and health care than men.[13] Likewise, the United Nations Population Fund has documented that women who use contraceptives have an increased personal self-esteem and status in the household, and "are more likely than non-users to join their husbands in making household decisions."[14] For women, improving their health and being able to have fewer, further spaced, and healthier children is essential to closing the gender gap.[15] It will not only improve their health and quality of life, but positively affect other challenges that women face in their communities.

It is critical that the GHI aggressively confronts economic, social, and cultural barriers not as a side component, but as a central element of the entire initiative.

The following are seven key elements that should be included in the GHI's woman-centered approach:

1. Support of a right to health for all women, men, children, and youth

The right to the highest attainable standard of physical and mental health is internationally recognized.[16] It is defined as the right for every individual to have access to those goods, services, and conditions needed to be able to live a healthy life.[17] Health encompasses both timely and appropriate health care and other determinants on which health depends, such as access to water and food, freedom from violence, and a healthy environment. Thus it cannot be realized separate from many other rights protected by national and international law.[18]

This right guarantees access to quality health services regardless of condition or status, mental or physical disability, race, ethnicity, religion, nationality, gender, marital status, primary language, sexual orientation, or immigration status.

2. Meaningful participation in decision making

A woman-centered approach that is based in human rights ensures that groups representing diverse sectors of society participate in the development of programs which directly effect them. Women and girls, especially those living with HIV, must be given a voice in defining and prioritizing their own health needs. Women's health needs cannot be adequately assessed if looked at from the top-down viewpoint of donors, providers, or trainers. Instead, women must be meaningfully involved in major decision making relating to the conceptualization, design, implementation, monitoring and evaluation of policies and programs on global health matters.[19]

In order to ensure there is input from local women, the GHI should actively seek partnerships with local community-based women's organizations. Women's groups are critical partners to any health or development intervention, but too often they do not have relationships with international NGOs or access to international donors. Just as individual women often work in the informal sector, women's organizations often function outside of mainstream NGO communities. A woman-centered approach recognizes the barriers that local women's organizations have in receiving funding and participating in national and international planning processes, and includes mechanisms for receiving health program funding other than through large international NGOs or private contractors.

Moreover, individuals should be ensured decision-making power in their health care. GHI programs should provide the information necessary for individuals to make informed decisions, ensure accessibility of as many treatment or prevention options as possible, and respect the autonomy and agency of program beneficiaries—particularly women, whose decision-making power is frequently undermined and undervalued.

The Beijing Platform for Action listed the following as one of the actions that must be taken by governments in collaboration with NGOs, and with the support of international institutions:

> Design and implement, *in cooperation with women and community-based organizations*, gender-sensitive health programs, including decentralized health services, that address the needs of women throughout their lives and take into account their multiple roles and responsibilities, the demands on their time, the special needs of rural women and women with disabilities and the diversity of women's needs arising from age and socio-economic and cultural differences, among others; include women, *especially local and indigenous women*, in the identification and planning of health-care priorities and programs; remove all barriers to women's health services and provide a broad range of health-care services.[20] [emphasis added]

Hence, a woman-centered approach should concentrate on quantity and quality of care, along with women's control over their health decisions. This approach considers women's education, illness, parenting, aging, and heavy work burden throughout the life cycle.[21] Women's role in decision making related to their own health, both formal and informal, should be at the core of any health strategy that puts them at the center.

GHI programs should provide the information necessary for individuals to make informed decisions and respect the autonomy and agency of program beneficiaries—particularly women.

3. Comprehensive, integrated care

Integrating health care services so that clients have access to a wide range of information and services at one location is a cost-effective, client-centered, and successful way to reach those who may not otherwise seek care.[22] The need for co-located care is particularly important for women, as some services that are critical components of comprehensive reproductive health, such as family planning, sexual health, and maternal health, work best when they are offered at the same

location, or can be seamlessly offered at another accessible location.[23] Integrating reproductive health and HIV/AIDS is also essential to ensuring that development goals are reached and that the reproductive health needs of those living with HIV are met.[24] Moreover, it makes "people sense" that a woman would be more likely to actually obtain family planning, maternal health, and HIV prevention or treatment services if they are co-located or seamlessly linked.

Integrating services is also a successful way to reach people with information about their health and rights. This is especially true for those whose needs are great, such as low-income or rural women, women in need of postpartum or post-abortion care services, and people living with HIV/AIDS.[25] By increasing the use of health care as an opportunity to meet patients' other non-health issues, there is greater continuity of care, and clients have the sense that services are responsive to and respectful of their needs. *Integration Revisited*, the UN Millennium Project's exploration of the integration of sexual and reproductive health services in primary care, gives the following example: "A pregnant woman who goes for HIV testing at the district hospital could be referred for antenatal care to her local clinic, where counselors could discuss her nutrition, ask her about partner violence, or give her information about postpartum family planning methods."[26]

4. Meaningful and robust referral systems

While co-location of services facilitates users' seamless transition among them, this does not imply that every health facility must provide every health service. As *Integration Revisited* clarifies, in "a 'continuum of care' model, different levels of integrated services are provided at different levels (e.g., FP [family planning], ANC [antenatal care], STI/HIV education, counseling and maybe testing at primary health clinic, surgical contraception, STI diagnosis, HIV treatment, abortion etc. at a hospital), *but the staff are able to assess an individual's needs and refer the same individual across different levels of the systems as needed* [emphasis added]."[27] The services provided at each health facility will depend greatly on the country's infrastructure, health priorities, and cultural considerations.

No organization or clinic can provide all services to all people. Where problems cannot be addressed or immediately addressed, there should be a system whereby staff refers patients to other facilities that offer these services.[28] This way, a client is provided a continuum of services appropriate to his or her needs. Health clinics that provide seamless referral to other services and facilities reduce or eliminate gaps in coverage that can result in unaddressed health problems.[29] These gaps are costly both in terms of lives and financial resources. For example, a woman who can get HIV testing, postpartum care, and family planning in one provider visit does not have to spend more resources and time away from her family and work traveling to different providers.[30]

5. Continuum of care through the life cycle

> "Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men."[32]
>
> *- Beijing Platform for Action, 1995*

Health services and programs must address health for the duration of a person's life cycle by providing services and programming appropriate to each stage of life. This is particularly important for women, as many of their health concerns have to do with reproduction, which unlike diseases such as the flu, are not time-limited but occur throughout their life cycle.[31] Both ICPD and the Beijing Platform for Action affirm the life cycle approach to women's health. The Beijing Platform for Action states that, "Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men."[32]

Adopting a life cycle approach for sexual and reproductive health means program planners and implementers should understand the particular needs of individuals change over time. This requires access to different services at different stages of one's life: comprehensive sex education and youth-friendly sexual and reproductive health services for young

people, family planning and maternal health care for those in their reproductive years, and care for post-menopausal women.[33] This approach must be implemented not just at the community level, but *most importantly* at the level of the individual. Planners must also understand, and accept without judgment, that the same individual who seeks family planning at one moment in life often seeks maternal health care at another moment.

6. Multisectoral approach to health and rights

The right to health cannot be met through medical care services alone. Poverty alleviation, education promotion, food provision, housing support, job creation and training, and environmental protection all contribute positively and substantively to health outcomes. Also, just as the right to health encompasses more than the prevention and treatment of disease, health education and health services must also be provided outside the traditional health sector, for example, through schools and workplaces. Mainstreaming health and rights information requires partnerships with the health sector, as well as leadership by the government, civil society organizations, and private sector.

Adult women, adolescent girls, sex workers, lesbians and transsexuals, those who are incarcerated, women with disabilities, and those living with HIV and AIDS are all women who share basic health needs, but whose particular situation puts them at different levels of risk for ill health.

7. Access for all women

Making the GHI woman-centered not only means that health services are available to women, but also that they are accessible to all. For too many women, discrimination, poverty, education level, and stigma create barriers for women accessing basic health services.[34] It is important in the GHI that women are treated as a diverse group within populations, with varying needs and life circumstances, so that every woman's and girl's health needs are met, without stigma or discrimination. Adult women, adolescent girls, sex workers, lesbians and transsexuals, those who are incarcerated, women with disabilities, and those living with HIV and AIDS are all women who share basic health needs, but whose particular situation puts them at different levels of risk for ill health.

EXAMPLES OF A WOMAN-CENTERED APPROACH TO HEALTH INTERVENTIONS

Colectiva Mujer y Salud (Women's Health Collective), Dominican Republic

The Colectiva Mujer y Salud health center in the Dominican Republic provides high-quality comprehensive health care to local women. This includes family planning, antenatal care, counseling and testing, antiretrovirals, and sexual education for ages 10 and up, in addition to community outreach that incorporates gender violence screening and focuses on women's rights and gender equity. When women enter the clinics, not only are their immediate health needs addressed, but staff uses the visit as an opportunity to provide a wide range of other services. All patients are questioned about their need for contraceptives, provided information about their rights, and asked about violence in the home. The organization also works directly with municipal authorities teaching them about the linkages between gender-based violence and HIV. Their programs are based on extensive consultation with the community.[35]

Intervention for Microfinance and Gender Equality (IMAGE), South Africa

In a recent article in *Health Affairs*, Judith Auerbach describes IMAGE, a community-based program based in Limpopo, South Africa that addresses HIV prevention by focusing on the central roles that poverty, gender-based inequalities, and violence play in fueling the epidemic.[36] It uses an existing microfinance institution as a strategic entry point to deliver gender and HIV education to women in the community. Partnering with a microfinance organization, loans are made contingent on recipients attending specific education sessions. The weekly sessions address issues such as gender roles, gender inequality and cultural beliefs, the body, sexuality and relationships, and domestic violence, as well as more conventional topics relating to HIV prevention.

Throughout the sessions, women are encouraged to identify both obstacles and opportunities for engaging men and youth in their communities.

A number of positive quantitative and qualitative impacts have been observed in the IMAGE program. Among other benefits, women who participated reported greater self confidence, autonomy in decision making and communication with partners about sex and HIV, as well as increased comfort challenging gender norms. The past year's physical and/or sexual risk from an intimate partner was reduced by more than 50 percent.[37]

CONCLUSION

The Global Health Initiative is an ambitious plan for improving the health and lives of individuals across the globe. Placing at its core the health and rights of women creates a tremendous opportunity to continue to expand the concept of health strategies beyond disease treatment, and to confront broader social barriers to health and rights. Ensuring that quality health care is accessible and available to women should not be seen as a bold and ambitious target, but as an indispensable and achievable objective, a vital human right, and a prerequisite for reaching U.S. foreign policy goals.

[1] IPAS. *Women-Centered Approach Transforms Abortion Care in Europe*. IPAS, May 2, 2005. http://www.ipas.org/Library/News/News_Items/Woman-centered_approach_transforms_abortion_care_in_Europe.aspx.

[2] This approach must look at women through both a sex and gender lens. Sex refers to biologically determined characteristics while gender refers to those characteristics that are socially constructed. This two tiered lens is extremely important when looking at women's health because a woman's ability to be healthy and access health care is different than a man's both biologically and socially. See e.g. Family Health International. *Through a Gender Lens: Resources for Population, Health and Nutrition Projects*. FHI, March 1998. http://www.fhi.org/en/rh/pubs/wsp/genderlens.htm.

[3] Ibid.

[4] United Nations. *Program of Action of the International Conference on Population and Development*. Program of Action. Cairo, Egypt: United Nations Conference on Population and Development. 1994. http://www.un.org/popin/icpd/conference/offeng/poa.html.

[5] Ibid.

[6] UN. *Beijing Declaration and Platform for Action*. Beijing, Fourth World Conference on Women. Beijing, China, 4-15 September 1995. http://www.un.org/womenwatch/confer/beijing/reports/. (hereinafter Beijing).

[7] See e.g., *Australia Adopting a National Women's Health Policy*, http://www.mcwh.com.au/downloads/cons-dis-paper2009.pdf; India, http://wcd.nic.in/empwomen.htm.

[8] UN General Assembly, Eighth Plenary Meeting. *United Nations Millennium Declaration, Resolution 55/2.* New York, September 8, 2000. http://www.un.org/millennium/declaration/ares552e.htm.

[9] UN General Assembly, *Millennium Development Goals*, New York, September 2000. http://www.un.org/millenniumgoals/. MDG 4: Child Health; MDG 5: Improve Maternal Health, with Target B being universal access to reproductive health, and MDG 6: Combat HIV/AIDS.

[10] See Center for Health and Gender Equity. *Making Foreign Assistance Work: Sexual and Reproductive Health and Rights as Key to Global Development*. Oct. 2008, 3. http://www.genderhealth.org/pubs/foreignassistancereform.pdf.

[11] The Global Fund to Fight AIDS, Tuberculosis and Malaria. *Fact sheet: Ensuring a Gender Sensitive Approach*. http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_FactSheet_1_Gender_en.pdf.

[12] World Health Organization. *Women and Health: Today's Evidence Tomorrow's Agenda*. WHO, November 2009, 76. http://www.who.int/gender/documents/9789241563857/en/index.html.

[13] UN Observance of International Women's Day. *Investing in Women in the Right Thing to Do*. March 6, 2008. http://www.un.org/News/Press/docs/2008/obv684.doc.htm.

[14] UNFPA and the Alan Guttmacher Institute. *Adding it up: The Benefits of Investing in Sexual and Reproductive Health Care*. 2004, 23. http://www.guttmacher.org/pubs/addingitup.pdf.

[15] UNFPA. *Healthy Expectations: Celebrating Achievements of the Cairo Consensus and Highlighting the Urgency for Action*. 2009, 14-15. http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/chartbook.pdf.

[16] See International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200 (XXI), art. 12, U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (Dec. 16, 1966); Convention on the Elimination of All Forms of Discrimination Against Women,

art. 12, G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46; Universal Declaration of Human Rights, art. 25, G.A. Res. 217A (III), at 71, U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948); United Nations. *Program of Action of the International Conference on Population and Development*. Program of Action. Cairo, Egypt: United Nations International Conference on Population and Development. 1994.

[17] Committee on Social, Economic and Cultural Rights, *General Comment 14, The right to the highest attainable standard of health* (22nd Sess., 2000), para 11, U.N. Doc. E/C.12/2000/4 (2000), available at http://www.publichealthlaw.net/Reader/docs/GenCom14.pdf (explaining the right to health "[is] an inclusive right extending to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels).

[18] IPAS. *The Human Right to Health and Women's Reproductive Health Policy*. 2009. http://www.ipas.org/Publications/asset_upload_file925_4202.pdf.

[19] Ibid., 12.

[20] UN. Beijing, 106(c).

[21] Rosalia Rodriguez-Garcia. *Women's Health: What is it? Approaches to women's health, training and services*. Unpublished manuscript. (as cited in May Cohen and Chris Sinding. Canada-U.S.A. *Women's Health Forum: Changing Concepts of Women's Health -- Advocating for Change*. July, 1996. http://www.hc-sc.gc.ca/hl-vs/pubs/women-femmes/can-usa/back-promo_a-eng.php.

[22] USAID. *Family Planning Integration.* May 2006. http://www.esdproj.org/site/DocServer/FAMILY_PLANNING_INTEGRATION_5.24.06.pdf?docID=122.

[23] See "Countdown to 2015 for maternal, newborn, and child survival: the 2008 report on tracking coverage of interventions." *The Lancet*, Vol. 371, Is. 9620: 1247 - 1258, (April 12, 2008), http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2808%2960559-0/fulltext (explaining the "three priority gaps in the continuum of care: contraceptive prevalence, skilled attendance at birth, and clinical case management of newborn and child illnesses").

[24] See USAID and WHO. *Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AIDS Policies, Programs, and Services: A Tool for Planning and Implementation*. USAID and WHO. 2009. (citing reports by the following six international organizations on the importance of linking reproductive health and HIV/AIDS policies and programs Interact World, World Health Organization (WHO), United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations General Assembly Special Session on HIV/AIDS (UNGASS), African Union).

[25] USAID, Family Planning Integration.

[26] Marc Mitchell, Susannah Mayhew and Irina Haivas *Integration Revisited* [Background paper to the report "Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals"]. United Nations Millennium Project. October 11 2004, 8. http://www.unmillenniumproject.org/documents/Mitchell_Mayhew_and_Haivas-final.pdf.

[27] Ibid., 8.

[28] Integrated Care, 41.

[29] Center for Health and Gender Equity. *Investing in Reproductive Justice For All: Towards a U.S. Foreign Policy on Comprehensive Sexual and Reproductive Health Rights*. 2009, 18. http://www.genderhealth.org/pubs/rjforallweb.pdf.

[30] Ibid.

[31] Marc Mitchell, *Integration Revisited*, 16.

[32] Beijing, para. 92.

[33] CHANGE. *Investing in Reproductive Justice*, 19.

[34] Ibid.

[35] Ibid., 30.

[36] Judith Auerbach. "Transforming Social Structures And Environments To Help In HIV Prevention." *Health Affairs* 28 (2009): 1659.

[37] Ibid.