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Men, HIV/AIDS, and Human Rights

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Abstract

Though still limited in scale, work with men to achieve gender equality is occurring on every continent and in many countries. A rapidly expanding evidence base demonstrates that rigorously implemented initiatives targeting men can change social practices that affect the health of both sexes, particularly in the context of HIV and AIDS. Too often however, messages only address the harm that regressive masculinity norms cause women, while neglecting the damage done to men by these norms. This article calls for a more inclusive approach which recognizes that men, far from being a monolithic group, have unequal access to health and rights depending on other intersecting forms of discrimination based on race, class, sexuality, disability, nationality, and the like. Messages that target men only as holders of privilege miss men who are disempowered or who themselves challenge rigid gender roles. The article makes recommendations which move beyond treating men simply as "the problem", and instead lays a foundation for engaging men both as agents of change and holders of rights to the ultimate benefit of women and men. Human rights and other policy interventions must avoid regressive stereotyping, and successful local initiatives should be taken to scale nationally and internationally.

Keywords

empowerment; gender; HIV; HIV/AIDS; Human Rights; men; Middle East; North Africa

INTRODUCTION

Work with men to achieve gender equality is occurring on every continent and in many countries, but only by a handful of organizations. This approach represents a relatively new development, often traced to the 1994 International Conference on Population and Development (ICPD) held in Cairo. Alongside its call for a shift from an emphasis on population control to rights-based approaches to sexual and reproductive health, the ICPD

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Program of Action encouraged governments and civil society to involve men in efforts to achieve gender equality. In groundbreaking language, the ICPD Program of Action asserted:

> "Changes in both men's and women's knowledge, attitudes and behavior are necessary conditions for achieving the harmonious partnership of men and women. Men play a key role in bringing about gender equality because in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and program decisions taken at all levels of Government …. The objective is to promote gender equality in all spheres of life, including family and community life and to encourage and enable men to take responsibility for their sexual and reproductive behavior and their social and family roles."

Since ICPD, work with men for gender equality has gained widespread legitimacy and is increasingly seen as an indispensable means for achieving it. In addition to the push for equality in its own right, there is a growing recognition that dominant norms about manhood harm both women's and men's health. A rapidly expanding evidence base, described below, has demonstrated that rigorously implemented initiatives targeting men can lead to significant changes in social practices that affect the health of both sexes.

This article makes the case that patriarchy confers a range of privileges upon men that compromise the well-being, dignity, and human rights of women. In addition, however, the authors take issue with simplistic examinations of masculinity that focus only on the harms hegemonic masculinities visit upon women, while neglecting the damage done to men by these regressive norms. We further point to the emancipatory possibilities inherent in helping men to overcome the strictures imposed by rigid masculine norms.

We underscore the importance of work with men as a critical strategy for achieving gender equality and further argue that much has been learned since ICPD that can be applied to strengthen gender-transformative work with men. We urge a move beyond an exclusively "instrumentalist" approach that only engages men and boys vis-a-vis their impact on women and girls. We point to the limits of an instrumentalist approach for men and boys, particularly in the context of HIV prevention. Here, we call for a more complex and inclusive approach that recognizes that men, far from being a monolithic group, have unequal access to health and rights depending on other intersecting forms of discrimination based on race, class, sexuality, disability, nationality, and the like. We conclude with a set of recommendations which move beyond simply treating men as "the problem" and instead lay a foundation for engaging men and boys as agents of change and holders of rights to the ultimate benefit of women, men, girls, and boys.

Masculinity Norms and Health

Social constructions of gender shape men's and women's health outcomes in important ways across a range of heath issues. For example, the World Health Organization (WHO) recently published the results of a 10-country cross-sectional population-based study of 24,000 women, which found that between 15% and 71% experienced physical and/or sexual violence in their lifetimes. This violence was almost always committed by men and, more often than not, by men who hold traditional views about masculinity.[1] In sub-Saharan Africa, the AIDS epidemic disproportionately affects women both in terms of rates of infection and the burden of care and support they carry for those with AIDS-related illnesses. Gender norms have been found to play a critical role in creating these disparities.

A growing body of literature now provides strong evidence that men are also disadvantaged in sometimes dramatic ways by regressive masculinity norms. Studies repeatedly show that men who adhere to rigid notions of manhood, who equate masculinity with risk taking,

dominance, and sexual conquest, and who view health-seeking behaviors as a sign of weakness experience a range of poor health outcomes. We turn next to this evidence.

WHO reports that life expectancy for men is lower than that of women in every global region. [2] WHO estimates that males of all ages represent 80% of homicide victims worldwide.[3] Male deaths due to violence are approximately 2 times that of women.[4] Almost 3 times as many males die from road traffic injuries as females. These risks are especially high for males younger than 25 years of age.[5] In the United States, young men are more likely than women to drive recklessly, drive under the influence of alcohol, and fail to use seatbelts.[6]

Men who hold traditional views about masculinity are more likely to have contracted a sexually transmitted infection (STI).[1] They are more likely to view sexual relationships as adversarial, to have more negative attitudes toward condoms, and to use condoms less consistently.[7] In South Africa, men represent only one fifth of those who get tested for HIV[8] and only 30% of those accessing treatment.[9] Men in South Africa are likely to access antiretroviral therapy later in the disease progression than women and consequently access care with more compromised immune systems and at greater cost to the public health system.[10]

These gender discrepancies in HIV testing and anti-retroviral therapy uptake reflect both structural and attitudinal factors. Structurally, public health systems are generally weak in most countries with high HIV prevalence and do little to engage men. Women access health systems through prenatal services and are likely to be tested as part of prevention of mother to child transmission programs that generally make little effort to involve men, despite evidence that these programs can serve as a useful entry point for testing men. Attitudinally, many men believe that seeking health services shows weakness[11] and subsequently underutilize them. [12] When HIV and AIDS services fail men, they also put the health of their sexual partners at risk.

Global alcohol consumption provides another example of the ways in which norms about manhood harm both women's and men's health. Consistent with norms that equate masculinity with an ability to consume large amounts of alcohol and with an alcohol industry that targets men with advertisements that link drinking with success and sex, WHO found that men are likely to drink more heavily than women and are more likely to be habitual heavy drinkers. [13] A recent meta-analysis indicates that alcohol abuse is a risk factor for men's violence against their intimate partners[14] and for the sexual disinhibition that contributes to the spread of HIV. [15]

Working with Men for Gender Equality: The State of the Field

Because regressive masculinity norms jeopardize the health of women and men in a range of contexts, interventions that seek to challenge these norms are urgently needed.

In this section, we analyze contemporary gender-transformative work with men and describe the evidence base for its impact.

The years since ICPD have seen a range of initiatives aimed at engaging men. Early efforts did so to improve women's health, as called for in a 1999 United Nations Development Program publication, titled "*Men and the HIV Epidemic*" which reads, "failures in helping women to change sexual behavior and bringing about more equal gender roles demonstrate that boys and men too must be involved.[16]" Programs that emerged from ICPD work in 3 sometimes overlapping ways. They (1) serve men as clients, (2) involve men in improving women's health, and/or (3) work directly with men and boys to promote a positive shift away from regressive gender attitudes and behaviors.[17]

One of the most prominent initiatives was the "Men Make A Difference" campaign launched in 2000 by the United Nations to engage men in HIV prevention.[18] Other interventions of note include the international White Ribbon Campaign, the Family Violence Prevention Fund's Coaching Boys into Men Campaign, Instituto Promundo's Programme H Alliance in Latin America, Sonke Gender Justice Network's One Man Can Campaign in East and Southern Africa, and Men's Action to Stop Violence Against Women (MASVAW) in India.[19–22]

Empirical evidence demonstrates that behavioral interventions carried out with men and boys can work. For example, the Medical Research Council's evaluation of the Stepping Stones initiative implemented in the Eastern Cape showed significant changes in men's attitudes and practices. With 2 years follow-up, men who participated reported fewer partners, higher condom use, less transactional sex, less substance abuse, and less perpetration of intimate partner violence (Jewkes R, Wood K, Duvvury N. unpublished data).[23] In Brazil, Instituto Promundo's intervention with young men to promote healthy relationships and HIV/STI prevention showed significant shifts in gender norms at 6 and 12 months. Young men with more equitable norms were between 4 and 8 times less likely to report STI symptoms at 12 months postintervention.[24] Research conducted to determine the impact of Sonke Gender Justice's One Man Can Campaign in 3 rural communities in South Africa showed that amongst participants in community education activities and campaigns, 25% subsequently tested for HIV, nearly two-thirds increased their use of condoms, about 80% talked with friends or family about HIV and AIDS, gender equality, and human rights, and about half indicated that they responded to acts of gender-based violence they witnessed.[25] Based on findings such as these, WHO recently endorsed the efficacy of working with men to achieve gender equality and outlined the key aspects of successful interventions.[26]

International Mandates for Working With Men and the Instrumentalist Approach

Since the ICPD call for greater male involvement, a number of other international instruments have provided states with a clear mandate to develop gender-transformative programs and policies aimed at engaging men and boys. Women's rights nongovernmental organizations can largely be credited with advancing this groundbreaking language in international human rights instruments that has included men and boys in the context of family, reproductive health, and sexual violence. As important as the language about men and boys has been, a close examination of these instruments reveals a problematic, predominantly "instrumentalist" approach: one that only includes men and boys in the context of their responsibility to change to improve women's access to health and rights.[27]

It is certainly essential to recognize the important role men have to play in the realization of women's equality and health and such language should remain. But when men and boys are *only* included in rights instruments vis-a-vis their impact on women and girls, the approach is unduly limiting. Gender scholars and civil society activists have begun to move away from this narrow approach, but international documents that address gender equality, health and HIV/AIDS continue to rely on an exclusively instrumentalist approach to the inclusion of men and boys.

The instrumentalist approach is particularly unusual given the nature of human rights instruments. Formally speaking, human rights obligations are largely the responsibility of the state. Individuals are the holders of rights. Through various turns of phrase, these instruments obligate states to facilitate men's responsibility (not rights); an innovative and important addition, but one that is too limiting when used exclusively.

Below are examples of international instruments that outline the important mandate for male inclusion. Note also the instrumentalist approach, as italicized. When gender equality is

specifically invoked, the documents consistently fail to address the ways in which many men are harmed by regressive gender norms.

As noted, the **ICPD Program of Action (1994)** represented a significant milestone for male involvement. Both groundbreaking—and in retrospect, limited—the Program of Action affirmed the need to "promote gender equality in all spheres of life, including family and community life and to *encourage and enable men to take responsibility* for their sexual and reproductive behavior and their social and family roles.[28,29]" It further stated, "special efforts should be made to emphasize *men's shared responsibility and promote their active involvement in responsible parenthood. Male responsibilities* in family life must be included in the education of children from the earliest ages.[30]

The Program of Action of the World Summit on Social Development (1995) and its 2000 review also addressed male involvement.[31,32] For example, it stated:

> The obstacles that have limited the access of women to decision-making, education, health care services, and productive employment must be eliminated and an equitable partnership between men and women established, involving *men's full responsibility* in family life.[33]

The Declaration of Commitment on HIV/AIDS (2001) addressed neither the vulnerability of some men, such as gay men, to violence, stigma, discrimination, nor the urgent need to increase men's use of HIV/AIDS services. It did mention men in regard to their shared responsibility to practice safe sex:

> Bearing in mind the context and character of the epidemic and that, globally, women and girls are disproportionately affected by HIV/AIDS develop and accelerate the implementation of national strategies that promote the advancement of women and women's full enjoyment of all human rights; promote *shared responsibility of men and women* to ensure safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection.[34]

The Political Declaration on HIV/AIDS (2006) mentioned men and boys only once:

> States pledge to eliminate gender inequalities, gender-based abuse and violence; increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection and take all necessary measures to create an enabling environment for the empowerment of women and strengthen their economic independence; and in this context, reiterate the importance of the *role of men and boys in achieving gender equality*.[35]

The instrumentalist approach is particularly worrisome in the context of HIV/AIDS, to which, in some parts of the world, gay men have been disproportionately vulnerable. Governments' refusal to explicitly articulate the rights of men who have sex with men in the context of HIV/AIDS is discriminatory and dangerous. Silence in the HIV/AIDS instruments about the real vulnerabilities that some men face also risks embedding notions of men's invincibility.

New Perspectives: Including Men as Agents of Change and Subjects of Rights in the Gender and HIV/AIDS Paradigm

Encouraging men to "take responsibility" is a worthwhile goal; but in addition, failing to address the harms men experience themselves, the message could be interpreted negatively, alienating men who might otherwise be open to change. Messages do matter. The reproductive health movement underwent a transformative shift when it abandoned the state-sponsored "small happy family" campaigns that were viewed as patronizing propaganda aimed at

pressuring women to use birth control. The rights-based approach embraced at ICPD instead sent the powerful message that women were entitled, rather than obligated, to manage their fertility as a matter of human rights.

Might a similar paradigm shift be in order for men's involvement in reproductive and sexual health matters? Could a rights-based approach be more effective than male involvement messages that center around "should?" To give an example of such a framing, one might assert that men have the right to comprehensive sexuality education that challenges traditional notions of men as sexual risk takers. Such an approach might posit that men have the right to HIV/AIDS services that cater to their needs, the right to gender-transformative public health campaigns that challenge dominant alcohol industry advertisements and instead emphasize healthy alcohol use, or the right to be free of sexual violence when in the custody of the state. Unfortunately, the term "men's rights" is too closely associated with antifeminist backlash movements to be of any utility here. But, using other language that includes men's needs is an important first step to gender equality work that moves beyond the instrumentalist-only perspective. Further exploration of men's multiple anxieties, struggles, and fears may reveal empowerment strategies that would help men overturn societal pressures to be "real men"—to the ultimate benefit of both sexes.

In the following section, we offer recommendations that we believe would lead to a more complex, effective gender equality paradigm for HIV prevention efforts.

Engage Men as Proponents of Gender Equality and Health

Despite widespread pessimism about men being able or willing to participate actively in addressing the gender dimensions of AIDS, data indicates that, when given the opportunity, many men wish to be positively involved. A number of examples illustrate this point.

In Zimbabwe, calls from district councilors to men that they become more involved in caring for AIDS patients saw men take on the challenge. As Luckson Murungweni put it, "For years, we watched with bleeding hearts as our daughters and sons came home from the towns and cities to die after having contracted HIV…. As men, we never viewed ourselves as crucial in providing care to those being claimed by the AIDS pandemic …. But things changed last year when councilors in various districts of Goromonzi approached us and urged us to become involved.[36]"

In a pilot prevention of mother to child transmission program implemented by the Horizons project in Kenya that sought to increase partner involvement, the proportion of male partners who got tested for HIV as a result of being involved in the program doubled in one site and increased by 50% at another site.[37]

Significantly, WHO's analysis of 57 programs showed that the most effective campaigns and outreach programs "used positive, affirmative messages showing what men and boys could do to change, affirming that they could change and showing men changing or acting in positive ways. Other effective campaigns appealed to men's sense of justice or their preexisting desires to provide care and support for their partners and/or children.[38]"

Avoid Simplistic Gender Stereotyping

Over the last 4 decades, women's rights advocates, including those working more recently to address the growing feminization of AIDS, have worked tirelessly and effectively to draw attention to the damage done to women by gender inequalities. Much of this work has historically posited men as beneficiaries of the gender relations order and resistant to gender transformation. Efforts to draw attention to the many ways in which AIDS maps onto and reinforces women's subordination have been relatively successful—at least in terms of raising

awareness of the issues and securing national and international commitments. However, too often, to create a sense of urgency, these efforts have described men in broad brushstrokes as inevitably violent, irresponsible, and uncaring. Messages have often traded on stereotypes common in the global north about men and women in the global south.

Done to excess, stereotyping risks reinscribing the very norms gender equality activists seek to overturn. Recent feminist interventions have critiqued essentializing portrayals of women as victims and men as perpetrators as bad for both women and men. Scholars such as Ratna Kapur have critiqued the "victimization rhetoric" used to describe women in the developing world, arguing that there "is no space in this construction for … the articulation of a subject that is empowered.[39]"

Gender essentialism toward men is also problematic. Gary Barker warns that "giving so much attention to violence may give the impression that all or most low-income, urban-based young men *are* violent, have the potential to be violent or are gang-involved.[40]" Messages that most men are aggressors and never victims promote harmful perceptions about the "one" way in which to be a man. They may inadvertently serve to justify violent behavior as a normal manifestation of maleness, promoting a sense of inevitability about its continuation.

One recent news report described a Johannesburg clinic counselor's advice to HIV-positive women: "Don't hide it. Don't use the phone—tell him face to face. You use the phone, he will hunt you down. Try to prepare him. Some people are very violent. He will beat you.[41]" The counselor highlights an important concern about women's vulnerability to violence. However, the report obscures a more complex reality. WHO data from a 10-country study on HIV testing and disclosure reported that "the proportion of women reporting violence as a reaction to disclosure ranged from 3.5% to 14.6%.[42]" These numbers are alarmingly and unacceptably high. But at the same time, they reveal that between 96.5% and 83.4% of men were not violent. Worst-case scenario narratives about men's probable violence in response to their partners' diagnosis may actually discourage women from disclosing to or seeking support from a potentially compassionate male partner.

Similarly, advocacy that suggests that men will not play a role in the care economy inadvertently reinforces gender stereotypes and leaves women with the burden of care and support—especially in the context of HIV and AIDS. In South Africa, nearly 70% of AIDS-related care is carried out by women.[43]" This reflects a grossly disproportionate burden borne by women. Viewed differently, these figures show that one third of caregivers in South Africa are men. Making men's caregiving more visible has the potential to shift social norms about men's role in the care economy and increase men's involvement further. However, this happens very little. A qualitative study of households affected by HIV and AIDS in KwaZulu-Natal points out that although there is a "linguistic and conceptual locus for the discussion of 'deficient' men, no such language seems to exist to talk about men who are positively involved in their families.[44]"

A growing body of literature points to the fact that gender roles and relations are not fixed. Simplistic portrayals of men as probably violent, inevitably sexually irresponsible, callous, and uncaring impede rather than support efforts to change the gendered dimensions of vulnerability to HIV and AIDS. They undermine efforts to mobilize men around the solidarity they feel for women in their lives whom many men care deeply about. To be effective, work with men to achieve gender equality and improve both men's and women's health will need to recognize and support the efforts of growing numbers of men who want a more equitable world.

Recognize That Men Are Not Monolithic and Have Unequal Access to Health Care and Human Rights

Gender norms about manhood bring significant pressures to bear on men to act in socially prescribed ways. However, norms about masculinity do not determine the course of men's lives alone. Although gender roles certainly shape women's and men's health outcomes, the impact is both mitigated and exacerbated by other intersecting local and global social inequalities.

In the developing world, structural forces related to trade, aid, and debt often create barriers to health care services for all but the few who can afford private health care. A combination of unaccountable political leadership and the effects of structural adjustment plans and public sector spending caps have decimated health systems across the developing world, leaving them chronically short staffed and incapable of meeting the health needs of the majority of their citizens.[45]

In the United States, racial minorities experience poorer health outcomes than do white Americans; these health disparities are increasing.[46] In 2003, the uninsured rate amongst whites in the United States was 11.1% compared with 32.7% amongst Hispanics,[47] and 2006 data indicate that noncitizen immigrants were 3 times as likely to be uninsured as native-born citizens, causing serious inequities in access to health care.[48]

Across the world, poor and working-class men must often work in dangerous conditions that rely on risk taking and stoicism. Migrant workers face risks due to the long periods they are separated from their primary partners and the pressures they experience to have additional sexual relationships. In many countries, men who have sex with men often face state sanctioned harassment and violence and seldom have access to specialized health services. Men who are disproportionately incarcerated in prisons throughout the world face exposure to violence, STIs, and poor health services.[49]

Use Policy Approaches to Take Gender Transformative Work With Men and Boys to Scale

Globally, most interventions aimed at working with men and boys utilize community education approaches as their primary strategy, using workshops, street outreach, and community education events to change gender norms and practices. As such, they reach relatively small numbers of people and have a limited impact.

To truly transform gender inequalities, interventions with men must go beyond the small-scale interventions and often ad hoc efforts currently implemented. And comprehensive gender equality policy interventions, although they must certainly move beyond instrumentalist-only approaches, are a central means to transforming gender norms. These approaches are gradually receiving attention from the United Nation system, national governments, and key civil society organisations. A forthcoming WHO report on policy approaches to working with men asserts:

> "To address men's health and increase men's support for gender equality, we require systematic and substantial interventions; organizational and institutional changes; and local, national, and international policies, laws, and commitments. Policy commitments, processes, and mechanisms are necessary to scale up the scope of work with men; guide the conceptual and political agendas of such work; integrate policies on men, gender, and health into gender policy and address gender in policy-making in general; establish partnerships between policy-making bodies and other actors and constituencies; and build institutional capacity both within policy-making institutions and outside them.[50]"

As we have seen, the post-ICPD years have produced important international commitments to engaging men and boys. Reflecting this, new policies intended to transform men's gender and HIV-related attitudes and practices are emerging in many parts of the world, with the potential to achieve significant impact. In Malawi, for example, the Chitipa District AIDS Coordinating Committee requires community home-based care programs to ensure a minimum of 40% male volunteers.[51] Elsewhere, governments have acted on research demonstrating that male circumcision offers some protection against HIV infection and have developed policies to scale-up male circumcision.

Policies have also been implemented to address structural drivers shaping men's attitudes and practices. In South Africa, some mining houses have upgraded single-sex hostels to accommodate families, motivated in part by an awareness that forcing men to live away from their partners increases their involvement in sex work and contributes to high numbers of multiple concurrent partners. Similarly, taxes, alcohol outlet density regulations, and raising the minimum legal drinking age[52–54] have been used to decrease access to alcohol,[55,56] a well-established contributory factor to reduced risk perception and increased levels of violence and sexual risk taking.[57–62]

In many parts of the world, governments and civil society have developed policies aimed at embedding gender-transformative training and education into institutions that reach men and boys such as schools and universities, faith-based organizations, trade unions, and professional sports leagues. There is tremendous scope to expand this approach and ensure that Departments and Ministries of Health, Education, Social Welfare, Arts and Culture, Sports and Recreation, to name but a few, implement programs and activities aimed at transforming gender norms. Across the world, there are millions of community outreach workers, community health workers, and adult literacy practitioners, amongst many others, who could reach hundreds of millions of men and boys. Governments should mobilize them in the service of gender justice.

Finally, although a growing number of governments have made domestic and international commitments to address gender equality and health equity, many frequently fail to act on these commitments. Enforcement remains a major obstacle to the full realization of these important human rights.[63] A number of organizations working with men have begun to develop initiatives aimed at holding government accountable for their obligations. MASVAW based in Lucknow, India, provides a useful example. The 2005 Protection of Women from Domestic Violence Act (DVA) provides "protection against physical, verbal, and sexual abuse and the right to shelter and economic freedom.[64]" The government's failure to budget for the necessary enforcement officers or to educate the public about the provisions of the DVA left advocates concerned about implementation. In collaboration with women's rights organizations, MASVAW coordinated the 2007 *Ab To Jaago!* (wake up now!) Campaign in 41 districts across the state. It provided rights-based education about the provisions of the DVA and held tribunals to maintain pressure on the government for full implementation.[65]

CONCLUSION

Messages that only target men as holders of power and privilege miss the many men who do not to identify as such and who may in fact be committed to challenging rigid gender roles that negatively impact men and women. Simplistic portrayal of men as "advantaged" may not resonate those who are disadvantaged by intersecting forms of discrimination (race, ethnicity, nationality, class, sexuality, disability, and so on), and excessive stereotyping about men as violent oppressors may only reinforce regressive norms. In addition to avoiding these pitfalls, gender-transformative work must utilize broader policy approaches to ensure that local interventions are taken to scale nationally and internationally. Alongside this, advocacy efforts must seek to hold governments accountable for their human rights commitments.

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References

1. Courtenay WH. Focus on men's health. Blue Shield of California Positive Personal Health 1997;4(2): 1.
2. World Health Organization. World Health Statistics 2007. Geneva, Switzerland: World Health Organization; 2007. p. 88
3. World Health Organization. World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002. p. 274-275.
4. World Health Organization. World Report on Violence and Health: Summary. Geneva, Switzerland: World Health Organization; 2002.
5. World Health Organization. Gender and Road Traffic Injuries. Geneva, Switzerland: World Health Organization; 2002.
6. Courtenay WH. College Men's Health: An Overview and a Call to Action. J Am Coll Health 1998;46:279–290. [PubMed: 9609975]
7. Noar SM, Morokoff PJ. The relationship between masculinity ideology, condom attitudes, and condom use stage of change: a structural equation modeling approach. Int J Mens Health 2002;1:43–48.
8. Magongo, B.; Magwaza, S.; Mathambo, V., et al. National Report on the Assessment of the Public Sector's Voluntary Counselling and Testing programme. Durban, South Africa: Health Systems Trust; 2002.
9. Coetzee D, Hildebrand K, Boulle A, et al. Outcomes after two years of providing antiretroviral treatment in Khayelitsha, South Africa. AIDS 2004;18:887–895. [PubMed: 15060436]
10. Hudspeth J, Venter WDF, Van Rie A, et al. Access to and early outcomes of a public South African adult antiretroviral clinic. S Afr J Epidemiol Infect 2004;19:48–51.
11. Nachega J, Hislop M, Dowdy D, et al. Adherence to highly active antiretroviral therapy assessed by pharmacy claims predicts survival in HIV-infected South African adults. J Acquir Immune Defic Syndr 2006;43:78–84. [PubMed: 16878045]
12. Nattrass, N. AIDS, Science and Governance: The Battle Over Antiretroviral Therapy in Post-Apartheid South Africa. University of Cape Town; 2006 [Accessed May 21, 2009.]. Available at: http://aidstruth.org/nattrass.pdf
13. WHO. World Health Report 2002. Geneva, Switzerland: World Health Organization; 2002.
14. Stith SM, Smith DB, Penn CE, et al. Intimate partner physical abuse perpetration and victimization risk factors: A meta-analytic review. Aggress Violent Behav 2004;10:65–98.
15. Shisana, O.; Simbayi, L. Nelson Mandela/HSRC study of HIV/AIDS: South African national HIV prevalence, behavioral risks, and mass media household survey 2002. Cape Town, South Africa: Human Sciences Research Council; 2002.
16. Rivers, K.; Aggleton, P. Men and the HIV Epidemic, Gender and the HIV Epidemic. New York, NY: UNDP HIVand Development Programme; 1999.
17. Greene, M. Engaging Men and Boys: How Can We Build on What We Have Learned?. Proceedings from meeting; Washington DC. May 30, 2006; Washington, D.C: Rio de Janeiro, Brazil: International Women's Research Center; Instituto Promundo;
18. UNAIDS. Programme of Action of the World Summit for Social Development. Paragraph 7. 2000. Men and AIDS: A Gendered Approach.
19. Flood, M. Involving Men in Gender Practice and Policy. Critical Half, Special issue: Engaging Men in "Women's Issues": Inclusive approaches to gender and development. 2007a Winter. [Accessed May 21, 2009.]. Available at: http://doctorswithoutborders.org/publications/reports/2007/healthcare_worker_report_05-2007.pdf
20. Peacock, D. Working with Men. In: Flood, M.; Gardiner, JK.; Pease, B., et al., editors. Routledge International Encyclopedia of Men and Masculinities (RIEMM). Farmington Hills, MI: 2006.
21. White, V.; Greene, M.; Murphy, E. Men and Reproductive Health Programs: Influencing Gender Norms. Washington, DC: Synergy Project; 2003.

22. United Nations Population Fund (UNFPA). Technical Paper No. 3. New York, NY: UNFPA; Dec. 2000 Partnering: A New Approach to Sexual and Reproductive Health.
23. Jewkes R, Nduna M, Levin J, et al. Impact of stepping stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. BMJ 2008;337:a506. [PubMed: 18687720]
24. Pulerwitz, J.; Barker, G.; Segundo, M. Promoting Healthy Relationships and HIV/STI Prevention for Young Men: Positive Findings From an Intervention Study in Brazil. Horizons Research Update. Washington, DC: Population Council; 2004.
25. Colvin, CJ. Survey results from six South African provinces on the impact of the “One Man Can” campaign for gender equality, HIV/AIDS and human rights. Presented at: 4th South African AIDS Conference; April 1, 2009; Durban, South Africa: University of Cape Town;
26. World Health Organization. Engaging Men and Boys in Changing Gender-Based inequity in Health: Evidence From Programme Interventions. Geneva, Switzerland: World Health Organization; 2007.
27. Stemple L. Male rape and human rights. Hastings Law J 2009;60:622–625.
28. Cairo Programme of Action. Paragraphs: 4.11, 4.24, 4.25, 4.26, 4.27, 4.28, 4.29, 5.4, 7.8, 7.37, 7.41, 8.22, 11.16, 12.10, 12.13 and 12.14.
29. Outcome of the twenty-first special session of the General Assembly on Population and Development. Paragraphs 47, 50, 52, and 62.
30. Programme of Action. Presented at: United Nations International Conference on Population and Development; September 5–13, 1994; Cairo, Egypt. Para. 4.27, U.N. Doc. A/CONF.171/13 (October 18, 1994)
31. Programme of Action of the World Summit for Social Development. Paragraphs 7, 47 and 56.
32. Outcome of the twenty-fourth special session of the General Assembly on Further Initiatives for Social Development. Paragraphs 15, 49, 56, and 80.
33. Programme of Action of the World Summit for Social Development. Paragraph 7.
34. Declaration of Commitment on HIV/AIDS, G.A. Res. S-26/2. Paragraph 47, U.N. GAOR, 26th Special Session, U.N. Doc. A/RES/S-26/2. August 2, 2001.
35. U.N. General Assembly, June 2006. A/Res/60/262. Paragraph 30.
36. ZIMBABWE: men break with tradition to become AIDS caregivers. IRIN HIV/AIDS Weekly-182. May 212004 [Accessed May 20, 2009.]. Available at: http://www.plusnews.org/report.aspx?reportid=36999
37. Prevention of Mother to Child Transmission of HIV: Examining Feasibility, Acceptability and Impact. Washington, DC: USA Population Council, Horizons; May. 2002 Horizons Research Update.
38. World Health Organization. Engaging Men and Boys in Changing Gender-Based Inequity in Health: Evidence From Programme Interventions. Geneva, Switzerland: World Health Organization; 2007.
39. Kapur R. The tragedy of victimization rhetoric: resurrecting the “native” subject in international/post-colonial feminist legal politics. Harv Hum Rights J 2003;15:11–36.
40. Barker, GT. Dying to be Men. London, UK: Routledge; 2005. p. 59Emphasis in original
41. Rosenburg, T. New York Times. Aug 6. 2006 When a Pill is Not Enough.
42. Maman, S.; Medley, A. Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes. Geneva, Switzerland: World Health Organization; 2004.
43. Henry Kaiser Family Foundation. A Survery of Households Affected by HIV/AIDS in South Africa. Menlo Park, CA: The Henry Kaiser Family Foundation, Social Surveys, Moemory Box Project; 2002. Hitting Home, How Households Cope with the Impact of the HIV/AIDS Epidemic. These figures do not indicate the extent of men’s involvement.
44. Montgomery CM, Hosegood V, Busza J, et al. Men’s involvement in the South African family: engendering change in the AIDS era. Soc Sci Med 2006;62:2415.
45. Help Wanted: Confronting the Health Care Worker Crisis to Expand Access to HIV/AIDS Treatment: MSF Experience in Southern Africa. Johannesburg, South Africa: Medecins Sans Frontieres; May2007 [Accessed May 21, 2009.]. Available at: http://doctorswithoutborders.org/publications/reports/2007/healthcare_worker_report_05-2007.pdf

46. House, JS.; Williams, DR. Understanding and reducing socioeconomic and racial/ethnic disparities in health. In: Smedley, BD.; Syme, SL., editors. Promoting Health: Intervention Strategies from Social and Behavioral Research. Washington, D.C: National Academy Press; 2000. p. 81
47. Denavas-Walt, C.; Proctor, BD.; Mills, RJ. U.S. Department of Commerce Economics and Statistics Administration. Washington, DC: U.S. CENSUS BUREAU; Aug2004 [Accessed May 21, 2009.]. Income, Poverty, and Health Insurance Coverage in the United States: 2003. Available at: http://www.census.gov/prod/2004pubs/p60-226.pdf
48. Ku, L. Why Immigrants Lack Adequate Access to Health Care and Health Insurance. Washington, D.C: Center on Budget and Policy Priorities; Sep2006 [Accessed May 21, 2009.]. Available at: http://www.migrationinformation.org/Feature/display.cfm?id=417
49. UNAIDS. AIDS Epidemic Update. Geneva, Switzerland: UNAIDS; 2007.
50. Flood, M.; Peacock, D.; Barker, G., et al. Policy approaches to improving men's health and involving men and boys in achieving gender equality. Paper prepared by Sonke Gender Justice Network for the Department of Gender Women and Health, World Health Organization; Forthcoming
51. Gomo, E. Increasing male involvement in home based care to reduce the burden of care on women and girls in Southern Africa, VSO-RAISA in Caregiving in the context of HIV/AIDS, Joint United Nations Programme on HIV/AIDS (UNAIDS). paper presented at: Expert Group Meeting on "Equal sharing of responsibilities between women and men, including care-giving in the context of HIV/AIDS"; October 6–9, 2008; Geneva, Switzerland: United Nations Office;
52. Carpenter, CS.; O'Malley, P.; Kloska, DD.; Johnston, L. Alcohol control policies and youth alcohol consumption: evidence from 28 years of monitoring the future; BE J Econ Anal Policy. [Accessed May 21, 2009.]. p. 1-21.Article 25. Available at: http://www.rwjf.org/pr/product.jsp?id=20512
53. O'Malley P, Wagenaar A. Effects of minimum age drinking laws on alcohol use, related behaviors and traffic crash involvement among American youth: 1976–1987. J Stud Alcohol 1991;52:478–491. [PubMed: 1943105]
54. Voas, RB.; Tippetts, AS. The Relationship of Alcohol Safety Laws to Drinking Drivers in Fatal Crashes. Washington, DC: National Highway Traffic Safety Administration; 1999.
55. Center for Prevention Research and Development. Background Research: Development and Enforcement of Public Policy to Reduce Alcohol Use. Champaign, IL: CPRD, Institute of Government and Public Affairs, University of Illinois; 2005.
56. Babor, TF.; Caetano, S.; Casswell, G., et al. Alcohol: No Ordinary Commodity—A Consumer's Guide to Public Policy. Oxford, UK: Oxford University Press; 2003.
57. Abbey A, Zawacki T, Buck PO, et al. Sexual assault and alcohol consumption: what do we know about their relationship and what types of research are still needed? Aggress Violent Behav 2004;9:271–303.
58. Gil-Gonzalez D, Vives-Cases C, Alvarez-Dardet C, et al. Alcohol and intimate partner violence: do we have enough information to act? Eur J Public Health 2006;16:278–284.
59. Humphreys C, Regan L, River D, et al. Domestic violence and substance use: tackling complexity. Br J Soc Work 2005;35:1303–1320.
60. Riggs DS, Caulfield MB, Street AE. Risk for domestic violence: factors associated with perpetration and victimization. J Clin Psychol 2000;56:1289–1316. [PubMed: 11051060]
61. CADRE. Concurrent Sexual Partnerships Amongst Young Adults in South Africa: Challenges for HIV Prevention Communication. Johannesburg, South Africa: CADRE; 2007.
62. Stith SM, Smith DB, Penn CE, et al. Intimate partner physical abuse perpetration and victimization risk factors: a meta-analytic review. Aggress Violent Behav 2004;10:65–98.
63. Stemple L. Health and human rights in today's fight against HIV/AIDS. AIDS 2008;22:S113. [PubMed: 18641463]
64. Himanshi Dhawan, TNN. Act is alright, but will it be implemented?. The Times of India. Oct 272006 [Accessed May 21, 2009.]. Available at: http://timesofindia.indiatimes.com/articleshow/175011.cms
65. Domestic Violence Act U.P. Campaign. 2007 [Accessed May 21, 2009.]. Available at: http://dvactupcampaign2007.blogspot.com/2007/12/lucknow.html