Uncovering Tensions and Capitalizing on Synergies in HIV/AIDS and Antiviolence Programs

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Research frequently points to the need to empower women to effectively combat the twin epidemics of HIV/AIDS and gender-based violence. Simultaneously, there has been increased attention given to working with men in gender equality efforts. The latter approach intervenes on masculinities as part of the fight against HIV/AIDS and violence. No research has considered these 2 lines of work side by side to address several important questions: What are the points of overlap, and the tensions and contradictions between these 2 approaches? What are the limitations and unintended consequences of each? We analyzed these 2 parallel research trends and made suggestions for how to capitalize on the synergies that come from bolstering each position with the strengths of the other. (*Am J Public Health.* 2011;101:995–1003. doi:10.2105/AJPH.2009.191106)

Research has never been more clear that sexual and reproductive health outcomes are shaped by broader gender inequalities within economic, social, interpersonal, and educational spheres.[1–11] It is now widely acknowledged that the twin epidemics of HIV/AIDS and gender-based violence (GBV) are driven in large part by inequitable relationships between men and women.[12–15] In light of these findings, a new generation of health programming is linking women's empowerment and health to reduce HIV and violence risks.[16–23] Simultaneously, there is increased recognition that masculinities (a socially constructed set of ideals and practices that define what it means to be male) can harm both women's and men's health.[24–34] Recent health interventions have, therefore, attempted to shape the norms and practices of masculinities that contribute to HIV/AIDS and GBV.[18,31–33]

In essence, 2 interconnected but distinct approaches within the HIV/AIDS and antiviolence fields have emerged—one that focuses on women's empowerment and another that seeks to work with men for gender equality. Both approaches view gender inequalities as drivers of HIV/AIDS and violence, and tend to take a "gender-transformative" approach[16,34] to shifting gender roles and promoting more equitable relationships between men and women. Yet, there are also differences in the 2 approaches, highlighting important questions for the field as it moves forward. Namely, what are the strengths and limitations of such programs, and to what extent does one approach, enhance, or inhibit the goals of the other? How can synergies between these 2 approaches be leveraged in a way that enhances gains in HIV/AIDS and violence outcomes?

We begin by examining the 2 approaches in depth. We then draw upon a number of programs in sub-Saharan Africa and Southeast Asia that fit 2 criteria: (1) they are gender-transformative in approach, and (2) they target the social construction of gender relations as an entry point for multiple health issues, such as reproductive health, HIV/AIDS or other sexually transmitted infections (STIs), and GBV. Next, we identify limitations and potential synergies across approaches that are focused on women's empowerment and work with men for gender equality in an effort to improve the efficacy of each.

WOMEN'S EMPOWERMENT

Much is known about the complex relationship between women's empowerment, HIV/AIDS, and violence, and research continues to demonstrate a clear association between GBV and women's HIV risk.[13,15,35–41] Interventions to reduce GBV are now regularly viewed as synergistic with the goals of HIV/AIDS prevention. Although there is a clear need and growing interest in biomedical interventions that offer female-initiated methods for HIV and STI protection (i.e., female condom, microbicides),[42–44] the efficacy of these interventions depends largely on the ability of women to employ these tools. Dunkle and Jewkes suggest cautious optimism because biomedical interventions may address the immediate realities of women's lives, but "they do not address the underlying social constructions of gender that create the constraints in the first place."[45(p174)] The literature suggests that women require increased knowledge and skills, access to and familiarity with technology, and greater agency in sexual negotiations to adequately protect themselves from HIV/AIDS.[16,46,47] Bolstering control over resources—such as income, land and property, food security, health services, and education—also helps to minimize HIV/AIDS risk.[8,17,48,49]

Interventions

We describe 2 interventions that use a gender-transformative approach to impact women's experience of violence, HIV, and reproductive health outcomes. The IMAGE (Intervention for Microfinance and Gender Equity) study in South Africa combined a curriculum on gender equity, violence prevention, and HIV prevention with group-based microfinance. After 10 sessions of a participatory curriculum called Sisters for Life, a smaller group of women received additional training to mobilize their community on issues such as intimate partner violence and HIV infection.[50] A randomized controlled trial showed that IMAGE shifted multiple dimensions of women's empowerment[20] and increased participant use of voluntary counseling and testing for HIV.[23] The effect of IMAGE on women's empowerment was significant when the program was later compared with groups receiving microfinance only,[51] suggesting that microfinance has

a synergistic effect alongside gender equity training. Similar mechanisms of change have been found in new ethnographic work on microcredit and gender equity in India.[52]

Notably, the IMAGE project resulted in a 55% reduction in intimate partner violence at 2-year follow-up for program participants compared with a control group.[22] What is less clear in the IMAGE example is how an intervention with women shifted the incidence of violence by male partners who did not directly participate in the intervention. Several factors may have influenced the reported decline in violence, although the causal pathways have yet to be examined systematically by the study's authors. Women participating in IMAGE reported higher levels of communication with both partners[23] and children,[53] potentially improving the way that conflict was resolved within the household setting. Additionally, access to microfinance significantly increased the value of assets in participant households,[22] and qualitative data revealed that women's improved financial contribution reduced marital stress and led to more harmonious intra-household relationships.[20] Last, the community mobilization element of IMAGE resulted in both individual and collective action around intimate partner violence in study communities,[54] which may have reduced violence by participants as well as those in the broader study communities.

Another gender-transformative program focused on women's empowerment and health is Shaping the Health of Adolescents in Zimbabwe (SHAZ!). This program was designed to test the potential of a combined life skills education and economic livelihoods intervention on reducing HIV risk and other reproductive health outcomes among adolescent female orphans in Zimbabwe.[9] After findings from a pilot study revealed that microcredit actually increased health risks for adolescent female orphans, a modified version of SHAZ! was developed to better meet the needs of participants and included (1) vocational training with a microgrant; (2) skills building on reproductive health, HIV/AIDS, violence, and interpersonal communication; (3) social support through peer networks, psychosocial services, and guidance counseling; and (4) reproductive health and HIV services.

A randomized controlled trial compared the effects of SHAZ! with a standard life skills intervention. Initial findings show improvements in economic factors and "relationship power" from baseline to endpoint among all participants. Intervention participants were significantly more likely to have equitable gender norms than were the standard life skills participants. Physical and sexual violence were reduced by more than half in the intervention group (odds ratio [OR]=0.42; 95% confidence interval [CI]=0.18, 0.99) over the 2-year period.[9] Although the study was not powered to detect measurable differences in HIV acquisition by intervention group (and no differences in HIV infection were noted), participation in SHAZ! improved many of the contextual and relationship factors associated with increased risk among girls and women in this age group, including economic insecurity, experiences of violence, and low relationship power.

Similar to the IMAGE project, what is less clear is exactly how participation in SHAZ! reduced participants' experiences of violence. SHAZ! programming did not involve male partners or efforts to directly change the attitudes or behaviors among the men in participants' lives, although its integrated social support component did include parent and guardian activities. The intervention and control groups received identical education about identifying and avoiding spaces where violence is likely to occur, as well as skills in communication, self-defense, and relationship negotiation. However, apparently some aspect of the combined intervention was more effective in reducing participants' experience of violence compared with the life skills intervention alone. Preliminary analysis into this question is underway, using both quantitative and qualitative data from the study. Addressing this question is a priority for ongoing research from this study.

Limitations

Despite the numerous promising aspects of women's empowerment programming, several limitations of this work require further elaboration. First, it is clear that focusing on the need to empower women and girls while not focusing attention on men and boys positions women as the arbiters of social change who must advocate their own improvements in health. This can be problematic. Research clearly shows that men often have control over decision-making and offer a strong degree of influence on women's sexual and reproductive health decisions.[32,55–57] Approaches that label women as disempowered and then ask women to take matters into their own hands—despite acknowledged structural inequities between women and men—may fall short of desired health outcomes over the long run.

Second, it is limiting to conflate the notion of "gender" solely with women. Many of the concepts and terminology that continue to frame the interactions between HIV/AIDS and human sexuality were developed in the mid-to-late 1980s and no longer offer sufficient precision to characterize the interactions, which may in fact exacerbate the confusion.[58] Select scholars have pressed toward what is termed a "relational analysis of gender," or the recognition of the ways in which not just women, but both women and men, are affected by gender inequality.[59,60] Indeed, both women's and men's health are harmed when men adhere to narrow and constraining aspects of masculine norms.[26–31,32–34,57] Even in examples of best-practice gender programming, such as IMAGE and SHAZ!, men are only marginally involved in intervention work.[9,50] Thus, while women are taught to re-envision the harmful aspects of gender relations within empowering health interventions, the very men who shape health risks in their lives (husbands, partners, fathers-in-law) may or may not be supportive of new gender norms.

Third, despite the positive examples we have provided of gender-transformative women's empowerment interventions, most programs globally do not focus on the structural drivers of behavior change. That is, the most common emphasis within the HIV/AIDS prevention science base is on building individual- or group-level agency to empower women and girls to negotiate safer sexual activity. However, scholars have effectively argued that social structures enable and constrain individual- and group-level choices from the outset.[61–64] Without reshaping the disempowering context in which individual decisions are made, there is less likelihood that behavior change can be enacted or maintained.[62,65] Indeed, the maintenance of preventive behaviors is one of the key problems in HIV/AIDS prevention programming, and there is some suggestion that structural and policy-level interventions can provide more lasting effects for behavior change.[62,63,65–67]

Fourth, although many men are supportive of changing masculinities and gender norms, some research has shown that some men respond negatively when they perceive that women are making societal and programmatic gains when they are not as often the recipients of these perceived or actual benefits.[68–70] Men's responses to women's perceived or actual gains can sometimes lead to masculinism (the bolstering of all-male realms and creating new formal or informal social practices of exclusion toward women) and backlash (violence or other negative reactions), both of which can harm women's empowerment and health.[71–73] For example, female condom initiatives have revealed that some men react negatively because initiating female condoms can lead to perceived improvements in women's decision-making power or perceived reversals of traditional gender norms. In a Zambian study, one man explained that, "By using a condom, my wife is demonstrating a liberation that I am uncomfortable with."[44(p2002)] Other female condom studies suggest that women's initiation leads to men feeling that women have too much power over sexual intercourse.[74,75]

Research outside the health realm shows similar responses by men facing rapid changes in gender relations on account of women's empowerment. For example, studies from Bangladesh revealed that domestic violence carried out by men against women worsened with female participation in a microcredit program.[76,77] Likewise, research in India found that married women who were unemployed at 1 study visit and began employment by the next visit had an 80% greater chance of experiencing violence (adjusted OR=1.8; 95% CI=1.3, 2.5) when compared with women who maintained their unemployed status.[10] Women whose husbands had stable employment at 1 visit and newly had difficulty with employment had 1.7 times the odds of experiencing violence (adjusted OR=1.7; 95% CI=1.1, 2.6) compared with women whose husbands maintained their stable employment.[10] As gender relations shift and women assume increased economic responsibilities and decision-making power, the added stress of a perceived reduction in familial power may lead to forms of masculinity that are intended to protect men's privileged familial or social status. Thus, in combination with the stressors associated with loss of income-generating power and entrenched poverty, this sense of destabilization can, at times, result in backlash in the form of intimate partner violence.[10]

Fifth, within women's empowerment approaches, the nature of empowerment itself remains somewhat unspecified. In the case of IMAGE and SHAZ!, it is unclear whether increases in women's access to and control over resources in the economic sphere (accomplished through microfinance or livelihood programs) translate to or facilitate increases in women's power in the sexual sphere.[8] The IMAGE analysis suggests that the gender equity training was of central importance, whereas SHAZ! showed improvements in these areas only when participants received the economic intervention and the life skills training. These examples suggest that it is the combined effect of economic opportunities and gender equity training that bolsters women's agency. However, new research in India reports that the microcredit programming in and of itself can stimulate women's collective action on gender equity and health-related issues.[52] Similarly, in an 8-country review of HIV-prevention interventions with a gender focus Weiss and Gupta[78] highlighted that small group-based initiatives can result in the mobilization that is critical to engendering social change, such as breaking the culture of silence around GBV and sexuality and fostering critical analysis, communication, and social support. Clearly, the findings are mixed in this area and more analysis is needed to fully understand the linkages between women's economic and sexual empowerment.

WORKING WITH MEN FOR GENDER EQUALITY AND HEALTH

In 1994, the International Population and Development conference in Cairo, Egypt, changed the face of women's reproductive health by shifting from strategies of population control to rights-based approaches to sexual and reproductive health.[79] Men were included in the new approach, not so much as agents who deserve their own sexual and reproductive health rights (e.g., lives free from sexual coercion and violence, the right to have children if HIV-positive, freedom from discrimination if HIV-positive, the right to control the fate of one's body), but as participants who can work to end gender inequities and work toward the empowerment of women in the name of improved health.[80] Since that time, men have been addressed directly in numerous international conferences,[81–83] United Nations meetings,[84–86] and white papers.[32,34,87]

Interventions

Programs that emphasize work with men toward gender equality have been underpinned by 2 frameworks concerning masculinity and health. First is the recognition that men play a role in the perpetuation of gender inequality, can be engaged to critically reflect on this within groups and communities, and can act more "responsibly" in terms of family life, antiviolence endeavors, and their own sexual and reproductive health behavior. We have also previously noted research that shows that men are frequently the decision-makers and arbiters of women's and men's sexual and reproductive health and should, therefore, be a point of intervention.[32,55–57,88] These efforts have been crucial for the empowerment of women and in showing that men can help women improve gender relations and health outcomes.

The second framing of this work recognizes that when men undergo gender norm transformation (including a focus on promoting safe spaces for men to critically reflect on and prompt the emergence of new definitions of what it means to be a man) and work for gender equality, this can dramatically change relationships and communities to positively shape both women's and men's health. Such transformation is clearly needed because research has shown that conformity to traditional masculine ideals can put men at risk for high-risk behavior and negative health outcomes.[11,29,89–91] In this paradigm, male vulnerability to poor health is emphasized to reconfigure masculinity and prompt new gender identities that are less harmful to men and women. Thus, there is recognition that negative health effects are associated with the costs of masculinity—narrowly conforming to the harmful aspects of masculinity (e.g., health-seeking behaviors are viewed as weakness, adventurous and risk-taking behaviors are viewed as bolstering masculinity). There is evidence that behavioral interventions carried out with the harmful aspects of masculinity in mind can improve the health practices

and attitudes of men and boys.[34,57] In essence, despite the fact that many men benefit from structures of gender inequality, this second discourse also expresses that many men care deeply about the women in their lives and can take a stand to fight for further gains in equality.[33,92]

Examples of HIV/AIDS and antiviolence programs attempting to reconstruct masculinities suggest that changes in gender attitudes and beliefs are possible. The Men as Partners (MAP) program of the nongovernmental organization, EngenderHealth, was designed to mobilize men to question the deep-seated patriarchal attitudes and beliefs that put the health of men, women, and children at risk. A longitudinal evaluation of MAP showed that participants were more likely than were nonparticipant counterparts to believe in equal rights for men and women and to express gender-equitable views about rape and intimate partner violence.[93] The evaluation found that adolescent males were more willing than were older men to accept alternative views challenging the prevailing norms of masculinity.

Stepping Stones, a randomized controlled trial on gender equity, HIV prevention, and antiviolence work showed significant changes in young men's attitudes and practices.[18,94] Although not originally designed as a program specifically for men, a modified version delivered in small single-sex groups used participatory learning approaches (as do most other gender-transformative programs) to promote reflection on gender roles, relationships, and sexual health and risks. At the end of 2 years, Stepping Stones fostered a 33% reduction in the incidence of herpes simplex virus-2 (incidence rate ratio=0.67; 95% CI=0.46, 0.97) and a 38% decline in men's reports of perpetrating intimate partner violence (adjusted OR=0.62; 95% CI=0.38, 1.01). Notably, the program did not lead to decreased HIV incidence among men and did not produce statistically significant improvements in women's sexual outcomes at 24 months.[18] Limitations of this work include the extent to which social desirability influences participant responses—especially in the intervention group—given that differential reporting by intervention group participants may account for at least some of the reported intervention effect.

Program H in Brazil and its Indian adaptation (Yaari Dosti) have also been successful in transforming masculinities and health. Each relies on promoting more gender-equitable norms among men to improve both men's and women's health. Gender-equitable men are defined as men that support relationships based on respect, equality, and intimacy (as opposed to inequitable attitudes and sexual conquest), are involved fathers (financially and in terms of care giving), take responsibility for sexual and reproductive health and disease prevention, and take a stand against violence. In Brazil, groups of young men aged 14 to 25 years were targeted, and the validated Gender Equitable Men scale was used to determine program impact. At baseline, young men reported significant HIV/AIDS risks and agreement with inequitable norms was associated with HIV/AIDS risks. At follow-up, significantly fewer men agreed with gender inequitable statements. In the intervention arm, there were significant improvements in condom use at last sexual intercourse with a primary partner. Additionally, in the intervention arm there was increased agreement with gender-equitable norms, and this was associated with reduced HIV/AIDS risks.[95]

Within the implementation of the Indian adaptation of Program H, Yaari Dosti, there were similar sexual risk trends and gender-inequitable attitudes among men at baseline. The program resulted in somewhat similar results as did Program H at follow-up, except there was a significant increase in condom use at last sexual intercourse with any type of partner among men participating in the Indian program. There were also significant reductions in self-reported violence against a female partner in the intervention arm in the Indian version of the program.[96]

Another program designed to intervene on gender equality, masculinity, and health is the One Man Can initiative developed by Sonke Gender Justice in South Africa. One Man Can is implemented in South Africa, Kenya, Burundi, Namibia, Uganda, and Mozambique. Delivered mainly to male-only groups, the program asks men to critically examine their views and practices of HIV testing, prevention, and sexual and domestic violence. Evaluation results showed that program participants at follow-up were more likely to access voluntary counseling and testing services and report GBV to the South African Police than at baseline.[97] Although these conclusions are limited because of the pre–post test evaluation design, academic collaborators plan to evaluate the program using a more rigorous study design in the near future.

Much work remains to be done in this field. However, emerging practices suggest that public health continues to move in the direction of successful gender-transformative work with men on masculinities, violence, and HIV/AIDS.[18,31–34]

Limitations

Several limitations of this approach also require further elaboration. First, some critics have suggested that focusing on work with men in the name of gender equality and health can position men as beneficiaries in a system of gender inequality where they are being viewed as personally responsible for women's poor sexual and reproductive health. At the same time, masculinities programming often distributes information, skills, or resources to men (and not women)—and may inadvertently exacerbate existing differentials between women and men. Furthermore, placing men at the center of interventions that shape both women's and men's health may reinvigorate male protectionism (that it is men's job to protect women), male-dominated decision-making, or male dominance overall.[44]

Second, researchers have found that men often respond positively to working with other men in HIV/AIDS and antiviolence prevention programming.[81,97] However, little work has examined how men who largely adhere to norms of masculinity that shape HIV/AIDS and violence outcomes respond to being asked to change in the direction of more gender equity in programs, particularly in contexts in which there are strict patriarchal norms.[69] Although there has been much historical and social research that underscores how men change over time in various contexts,[32,68,71–73,91,98–100] only a few studies have carefully delved into the social and cultural processes surrounding how masculine ideals actually get dislodged within HIV/AIDS and antiviolence interventions.[34,87,95,96,101] It is similarly unclear whether working with men alone does anything to dislodge gender ideals that shape women's disempowerment because women are not the focus of this approach. Even where men embrace new masculine roles, women can be resistant to changes in gender relations because of their beliefs that they should

handle household tasks or that men should retain authority in decision-making.[102,103] That is, little research to date has examined how "changing men" are received by women in relationships and communities.

Third, the main emphasis of working with men for gender equality is on individual or group-level attitudes about gender and how the costs of masculinity can harm women and men. Yet, community norms and structural processes surrounding gender relations, economics, and migration are some of the larger forces that shape men's health risks.[2,100,104–106] Despite the positive emphasis on HIV and antiviolence programming with men, the work has not yet intervened on structural disempowerment (globalization, poverty, migration) and has not yet targeted broader drivers of behavior change.

Fourth, privileging gender as the key axis for health interventions does not recognize that there are differences and inequalities among men that shape health outcomes as well.[11,60,99] Race- and class-marginalized men do not experience easy access to the structural benefits associated with masculinity (e.g., safe housing, good jobs) and are disproportionately at risk for acquiring HIV/AIDS and experiencing violence.[99,107,108] It is these very men who may have limited social and economic mobility through which to construct masculinity and who may seek to acquire it in the sexual realm.[25] By focusing on male vulnerability and the costs of masculinity to men rather than the relational nature of gender (examining masculinity and femininity simultaneously), researchers forgo the opportunity for women and men to work together toward positive health outcomes.

Fifth, although research shows that norms of providership are a key aspect of men's masculine identity, to our knowledge men have rarely been included in microfinance programs that aim to empower men toward economic stability and positive health outcomes. This is surprising if one considers that men, alongside women, have been economically destabilized on account of broader global trends, including structural adjustment, globalization, and privatization.[107] At minimum, this leaves the needs of men out and is unhelpful in pitting women and men against each other in terms of resources (when women are the sole recipients of microfinance and HIV/AIDS prevention integrations). At the most extreme end, these approaches can be perceived as blaming men for women's disempowerment and may elicit backlash. In essence, some men (and women) view power as a zero-sum game, and when women are viewed as gaining, men are viewed as losing.[10,16,71,72,109] Because we know that some men can perceive "losses" in power and reductions in male privilege when gender equality is a goal, it is unclear how programming that emphasizes men and health addresses the potential for masculinism and backlash that may result when one is seeking reductions in gender inequality among men.

CONSIDERATIONS FOR INTERVENTIONS AND RESEARCH

On the basis of our analysis, which describes the strengths and the potential limitations of these 2 approaches in the science base, we urge researchers to consider more synergistic approaches to gender equality with HIV/AIDS and violence prevention programs. Similar to the HIV-prevention field, which now views stand-alone prevention strategies as less impactful and durable than integrated, structural approaches to prevention,[62,63,67] we posit that gender-transformative work with men and women on violence and other health issues should not primarily remain within 2 stand-alone tracks. Gender-transformative programs should capitalize on the synergies between women's empowerment and working with men for gender equality.

Our suggestions for how to work toward synergistic approaches in HIV/AIDS and violence interventions can be found in Table 1. The early approaches to this work were often woman-centered and may not have adequately engaged the intersection between women's empowerment programming and work with men in gender equality efforts. Recently, promising approaches have advanced the field by tending to work with men. We strongly support the continued development of early and promising approaches, and recognize that "the value of all-male and all-female initiatives should not be discounted, because they fill a particular role in providing safe spaces for men and women to express worries, share their personal stories, and seek advice."[101(p290)] Simultaneously, we also press the HIV/AIDS and violence-prevention fields to increasingly consider synergistic and integrated approaches that simultaneously target men and women for gender-transformative work in the research, practice, and policy realms. As Pulerwitz et al. noted, "integrating both women and men as active partners in future interventions is likely to be a useful strategy for improving communication, collaboration, and mutual support between male and female participants."[101(p290)]

We offer the following recommendations for interventions and research:

- Women's empowerment approaches can engage men more through information sharing, soliciting interest and support, or offering empowerment strategies for less-empowered men. Women's empowerment approaches should also consider asking men about their responses to such programs before, during, and after implementation. Women's empowerment programs should also not assume that men will not change during the implementation of such programs, and should attempt to find out whether and how men change within these programs. All of these can assist with helping men to feel heard and seen—and to understand what they have to gain by participating in gender equality programming, minimizing perceptions of zero-sum game, and reducing backlash or violence.
- Program staff, research staff, and funders should be challenged to view work with men as central to the goals of gender equality and health, leading to better health outcomes for both women and men. Additionally, those who see resources as scarce and as being "taken away" from women when work is carried out with men should be challenged to consider some of the limitations of women's empowerment work, which underscore how the engagement of men can be crucial to its success.
- Further research is needed concerning how women and men actually wrestle with and use new notions of masculinity and femininity in their relationships and communities as a result of participation in antiviolence and HIV/AIDS prevention programming. We have little knowledge of how women or men who participate in such programming are met by their partners, peers, and communities when attempting to make changes in their lives, particularly at different income levels

TABLE 1—Key Questions for Moving HIV/AIDS and Violence Programming Toward Integrated and Synergistic Approaches Within Policy, Practice, and Research

Questions	Early Approaches	Promising Approaches	Synergistic/Integrated Gender Approaches
Who is/are the change agent(s)?	Individual as change agent	Small group as change agent	Institutional, structural, or community-level change
What is/are the desired outcome(s)?	Shift in individual knowledge and attitudes	Shift in social norms and behaviors	Shift in societal structures, communities, or couple dynamics
Who is responsible for social and health changes?	Women are trained to empower themselves; men are trained to protect women	Men are asked to contribute to gender equality and to critically reflect on gender norms and inequality with other men	Men and women work together for gender equality and health endeavors
Whose views are considered?	Attention to target groups: women-only or men-only	Explore how the uninvolved group responds to programs	Incorporate men's and women's views
How is gender incorporated and analyzed?	Gender inequality theories suggest men categorically oppress women	Theories of masculinity and women's empowerment inform research	Intersectionality or a relational analysis of gender: integrate work with men and women; simultaneous recognition of gender inequality and the costs of masculinity to men

and in different cultures. Such knowledge can help fine-tune programming to achieve the greatest results. Researchers can also seek greater understanding of how men weigh programmatic emphases on gender equality and reconfigurations of masculinity within antiviolence and HIV/AIDS programming.

- Young women and young men in particular should be targeted because gender ideologies and practices are developing and intimate relationships are forming at this point in the life course. The divergence between young men's and young women's freedoms and opportunities can become particularly salient at this time, and interventions on male vulnerabilities can be especially effective with consideration toward the broader pressures many men feel to adhere to masculine norms that shape violence and HIV risks.[101]
- Practitioners should also bolster work on gender relations and dyadic or couple-based programs in which these have been particularly successful. Research has demonstrated that couple-centered approaches to HIV testing and treatment are highly effective.[110–112]
- Men need more support, positive role models, and positive reinforcement for engaging in behaviors and practices that contribute to gender equality and health. At times, even when men show signs of change, these are not always visible or welcome in their relationships or communities.
- Programs should support broader gender-transformative interventions (with men, with women, and with both women and men), targeting schools, communities, and the structural level—and not solely individuals and small groups.[65,101,113] HIV and antiviolence interventions—with women and men—have shown success when they offer a combination of small group work and structural or community-level changes in gender norms.[51,101] If future research attempts structural interventions for men, these need to be coupled with a gender-transformative emphasis because "the status quo supports male dominance"[101(p291)] in some locales, and some argue that men may deploy new forms of structural power to disempower women. Mass media campaigns should also be bolstered because these can also play a powerful role in raising awareness and facilitating critical reflections on the linkages between gender norms, gender inequalities, and health.[101]
- There should be more support for the development of evidence-based prevention interventions with men that integrate behavior change with theories of masculinities.[11,60,71] Health research with women is often theoretically gender-specific or empowering, but when behavioral change is attempted with men, theories of masculinity do not play enough of a central role.[11]
- Another framework that can move gender-transformative work forward is that of intersectionality, or how the simultaneous intersection of race, class, gender, sexuality, and age influences health.[88,114-116] To be sure, the dialectic between women and men of a particular group and the resulting tensions (or opportunities) they experience are shaped by these complex and simultaneous intersections. An intersectional approach can offer the opportunity for women and men across races, religions, and classes to work together on issues common to them, as suggested by hooks and other multiracial feminists.[117–120]
- Relational analysis of gender should be built into public health decision-making. Whereas health policy often targets economic vulnerabilities and gender-specific health outcomes, the impact on power relations between men and women and the shaping of gender roles is typically absent.[121,122] Health policy simultaneously shapes and is shaped by masculinities and femininities as it responds to deleterious health outcomes.[123] Relational health policy would align health interventions with root causes—environmental determinants that emerge from public policy. Effective relational

analyses of gender would identify and distinguish more proximal policy-related influences, which are responsible for shaping masculinities, femininities, and resulting health outcomes (e.g., conditional cash transfers), from sociotemporal processes that are cumulative and occur over generations (e.g., generational poverty). This distinction would provide greater precision in locating sites of intervention. Ideally, relational public health policy would help to reconfigure existing social determinants to simultaneously ease broader gender inequalities and facilitate the gender norms, values, and networks that support gender equality and health.[64]

HIV/AIDS and violence prevention has taken several leaps forward in recent years. The World Health Organization endorses gender-transformative approaches to HIV and antiviolence as more effective than gender-neutral programming.[34] Programs globally have raised the bar through innovative approaches that link gender relations, antiviolence, and HIV research, but more resources are needed and this work remains severely underfunded.[113] No research to date has taken a careful inventory of the ways in which these separate tracks can increasingly work together—or against one another—depending on the program, funding structures, social and political histories, and local context. Reconciling these 2 approaches is challenging and, clearly, more work needs to be done to determine how to ensure that integrated programs are cost-effective. We hope that with research and further innovation, the public health field can increasingly move beyond zero-sum-game arguments about gender, assisting researchers and program planners to envision equality and health for both women and men. Wrestling with such challenges now may help to maximize success in the antiviolence and HIV/AIDS prevention realms as the public health field moves forward. ■

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Human Participant Protection

This research does not involve any primary data collection or contact with human participants.

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