An analysis of how National Strategic Plans on HIV and AIDS in five global regions address the role of men and boys in achieving gender equality and reducing the spread and impact of HIV and AIDS

A scan conducted for UNFPA by Sonke Gender Justice Network in preparation for a global consultation on integrating strategies to address gender based violence and include gender equality work with men and boys into National Strategic Plans, November 2010
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Acronyms

ART – Anti-Retroviral Therapy
ARV – Anti-Retroviral
BCC – Behavior Change Communication
CSW – Commission on the Status of Women
FSW – Female Sex Worker
GBV – Gender Based Violence
HAART – Highly Active Anti-Retroviral Therapy
HBC – Home Based Care
IEC – Information Education Communication
IDPs – Internally Displaced Population
IDU – Injecting Drug User
LGBTI – Lesbian, Gay, Bisexual, Transgender and Intersexed
MARP – Most at Risk Population
MC – Male Circumcision
MMC – Medical Male Circumcision
MSM – Men who have Sex with Men
NSP – National Strategic Plan
NSF – National Strategic Framework
OVC – Orphaned and Vulnerable Children
PEP – Post-Exposure Prophylaxis
PNG – Papua New Guinea
PMTCT – Prevention of Mother to Child Transmission
STD – Sexually Transmitted Disease
STI – Sexually Transmitted Infection
VCT – Voluntary Counseling and Testing
WHO – World Health Organisation
The UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV calls on United Nations member states and on civil society to make concerted efforts to address the well-established link between gender inequalities, gender based violence and women’s increased vulnerabilities to HIV and AIDS. To address this, the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV includes clear language about the importance of engaging men and boys to achieve gender equality and prevent gender based violence, as one of many strategies. It also calls for strategies that encourage men to reduce their own risk taking, access HIV services as needed, and actively support their partners to do the same, as the following excerpt makes clear:

In response to the increasing acknowledgement of the importance of engaging men and boys within gender equality and HIV work, Sonke was commissioned by the United Nations Population Fund (UNFPA) to carry out a desk review of HIV and AIDS National Strategic Plans (NSPs), analyzing the extent to which they commit to working with men and boys for gender equality and in relation to HIV and AIDS. NSPs from the following 16 countries were analyzed: South Africa, Rwanda, Kenya, Papua New Guinea, Pakistan, Ukraine, Jamaica, Cambodia, Serbia, Liberia, Sudan, Nicaragua, Brazil, Cote D’Ivoire, Haiti, India, in terms of their engagement with key issues of gender equality, and especially the degree to which men and boys are incorporated within this engagement. As such, the National Strategic Plans were analyzed in the following ways:

• whether they include a focus on challenging negative gender norms and stereotypes related to men and masculinity and whether they promote gender equality;
• the degree to which they recognize the potential role men can play in supporting women’s access to HIV prevention, treatment and care services;
• the degree to which they articulate strategies to involve men in preventing gender based violence;
• whether they include a focus on reducing men’s HIV risk taking, increase men’s uptake of HIV services and support men to be active participants in the HIV response.

Thus the report aims to assess the extent to which the National Strategic Plans acknowledge the importance of engaging men and boys to reduce both women’s and men’s gender related vulnerabilities and to promote gender transformation, and the degree to which they have planned and outlined specific work to address these issues.

The analysis of these 16 NSPs reveals that most countries acknowledge the importance of a gender perspective within HIV and AIDS work and many commit to mainstreaming gender across all areas of their HIV and AIDS work.

However, while a few of the NSPs acknowledge the harmful effects of certain gender norms, very little is proposed in the way of detailed strategies to specifically challenge or attempt to transform them. The few strategies that are described need to be more substantive and specific, in order for it to be clear how such strategies propose to address harmful gender norms. There is also little engagement around the difficulties of gender norm transformation, and as such strategies are not developed or described to overcome the potential obstacles involved in this work. As these are complex issues, the NSPs should account for this complexity in order to ensure that interventions are as effective as possible. For many of the NSPs it is clear that gender is almost synonymous with women, and in the process the NSPs neglect an important opportunity to engage men and boys to reduce their own and women’s vulnerabilities to HIV and AIDS.

The majority of the NSPs focus their prevention strategies on how best to reach women and youth, while men often go unmentioned. However, a small number of countries have made important steps towards including men and boys, predominantly in the area of condom distribution, Prevention of Mother-to-Child Transmission (PMTCT), Medical Male Circumcision (MMC) and the needs of marginalized men. While these steps are encouraging, and are commended, much remains to be done.

Executive Summary

“The Operational Plan acknowledges that traditional and stereotypical views of women and men and girls and boys, and the relations between them, that cast females as subordinate and males as superordinate, hinder an effective HIV response. The engagement of men and boys in the implementation of this Operational Plan is therefore critical. Men must work with women for gender equality, question harmful definitions of masculinity and end all forms of violence against women and girls.”

In response to the increasing acknowledgement of the importance of engaging men and boys within gender equality and HIV work, Sonke was commissioned by the United Nations Population Fund (UNFPA) to carry out a desk review of HIV and AIDS National Strategic Plans (NSPs), analyzing the extent to which they commit to working with men and boys for gender equality and in relation to HIV and AIDS.
A few NSPs address the issue of male circumcision, but very few incorporate a focus on women’s health and safety in their MMC plans or recognise the roll-out of MMC as an opportunity to carry out gender equality education. It is important for those countries that have not included MMC to consider its benefits, and along with the countries that have already done this, embed into their MMC roll-out plans gender equality education and measures to ensure that men do not engage in risk compensation and in the process increase women’s risks for violence or HIV infection.

Condom promotion and distribution almost always play an important role within countries’ strategies to address HIV spread. However, almost all of the NSPs fail to focus efforts on ensuring men have access to condoms, and that their attitudes towards condoms are addressed accordingly. While it may seem that emphasis should be placed on providing women with negotiation skills, much benefit could be derived from focusing some attention on attempting to influence men’s attitudes towards the use of condoms, especially education regarding the need to establish consent. Condom promotion and distribution efforts should also be used as an opportunity to educate men about the importance of always establishing respecting women’s rights to negotiate whether and how sex takes place.

VCT similarly receives attention within most NSPs, but few plans address the need to increase men’s utilization of testing services. Efforts are required to create more male-friendly spaces where VCT services are offered, in order to increase men’s uptake, as well ensuring that such services can be accessed in alternative settings. NSPs should also acknowledge the importance of encouraging men to support women’s uptake of VCT services and addressing men’s attitudes and reactions to disclosure.

A small number of NSPs acknowledge the need to include men within PMTCT but only a few focus on the benefits that could be derived from acquiring men’s support of women’s involvement in PMTCT services. Evidence has shown that the involvement of men within PMTCT benefits both women and children. Failing to garner this support compromises the health of both women and children.

The needs of marginalized men, namely prisoners, men who have sex with men (MSM) and injecting drug users (IDUs), migrants and refugees are often addressed by NSPs but the potential to incorporate gender issues within interventions focusing on these populations is not considered. NSPs should ensure that the specific needs of marginalized groups are always accounted for.

The need to address men’s health-seeking behavior in terms of treatment is not addressed within NSPs, nor is the important need for men to support women’s uptake of treatment. Similarly to VCT, it is essential that the spaces in which treatment is accessed are made more male-friendly, as well as placed appropriately for increased male access.

The burden created by the need for home based care is acknowledged in many NSPs but it is rarely suggested that men could be encouraged to become involved in order to alleviate this burden.

It is important that men are not only engaged to speak about gender-based violence but are also encouraged to become involved in efforts to prevent GBV. While a number of NSPs thoroughly address the issue of GBV, and especially its links with the HIV epidemic, no NSPs describe work which will engage with men as potential partners in addressing GBV.

Thus while important steps have been taken, the supportive role that men can play in women’s lives; the importance of addressing negative masculine norms; and the need to increase men’s uptake of HIV services are generally ignored by the majority of National Strategic Plans. It is important for countries to collaborate and learn from each other in order to understand the benefits of incorporating work with men and boys into their NSPs. Such work should be evaluated and taken to scale accordingly for it to have a significant and sustained impact.

While the need to engage with men and boys in work to prevent HIV and AIDS work and promote gender equality is clear, and the steps that have been taken by a small number of countries to include men and boys within their HIV and AIDS National Strategic Plans are encouraging, much progress is still required. Strategies that have been outlined need to be strengthened; and work which interrogates and challenges negative masculine norms needs to be developed. The proposed work outlined within NSPs must be monitored and evaluated to gauge its effectiveness so that successful interventions can be taken to scale. Other countries need to be encouraged to recognise the importance of including men and boys within policy work and program design and implementation, not only for the benefits which will be derived from women but also to ensure that men are engaged in work to achieve gender equality. However, an important start has been made and increased dialogue and collaboration on such issues must be encouraged in order for work to progress in a constructive and positive direction.
Introduction
Introduction

Gender inequality continues to undermine democracy, impede development and compromise people’s lives. Across much of the world, rigid gender norms and damaging perceptions of what it means to be a man or a woman encourage men to condone violence against women and engage in a variety of high-risk behavior patterns, including multiple sexual partners and the need to control the timing and circumstances of sex, including condom use. Social expectations and pressures around masculinity also render men vulnerable in terms of their own health, often causing men to be excluded from prevention, treatment and support initiatives. It has become increasingly clear that it is vital to engage men and boys as these behavior patterns increase the vulnerability of both men and women to HIV infection and other sexually transmitted diseases. Thus addressing issues of gender inequality should be integral to addressing the health of both men and women; and work with men and boys should be integral to addressing gender inequalities.

The Johannesburg MenEngage Symposium Declaration and Call to Action asserts that:

“Gender inequalities make women more vulnerable to contracting HIV and leave women and children with an unfair and debilitating burden of care for those sick with HIV, and for orphans and vulnerable children… Rigid gender norms also increase men’s vulnerability to HIV by encouraging men to equate manhood with risk-taking and pursuit of multiple sexual partners … Significant efforts need to be made to increase the scale and impact of interventions that aim to transform gender norms in order to prevent the spread of HIV and address the gender imbalances in care and support.”

Although there remains a need for new innovative interventions, there is growing evidence that well-implemented programs can influence men’s attitudes, behaviors and their role as agents of change in the achievement of gender equality. However, for meaningful change to occur at a societal level it is important that systematic and large-scale policy efforts are undertaken:

“Only through public policies and engagement with the public sector can these social institutions begin to take into account gender and other social inequalities in their operations and set the stage for large-scale change.”

At a personal level men and women ‘perform’ gender through their identities, behavior and relations but wider social constraints and power relations also shape their conduct. Policy is one of the collective forces defining and sustaining gender in communities, institutions and culture.

A report published by the International Center for Research on Women, ‘What men have to do with it’, examined public policies in seven countries to promote gender equality. The report asserts that: “For the most part, however, public policies have yet to adequately engage men and boys in overcoming gender inequality or addressing their own gender-related vulnerabilities.” The report recommends that, “given our knowledge of the impact of gender transformative programs on the lives of men and their families and community members, it is time now to be more ambitious and to take this work to the policy level in a more systematic and structural way.” It further argues that there is “a strong need, therefore, for policies to change social norms and institutional cultures that continue to perpetuate inequalities and violence” and suggests that an understanding that ‘laws and policies affecting women also involve and affect men (and vice versa), whether by design or by omission, can lead to more effective social policies.’

Large-scale policy initiatives have increased potential to lead to larger-scale, faster and broader changes in men’s behaviors and attitudes relating to gender and health; in this regard interventions which are ‘gender transformative’ and promote the questioning of traditional norms are most likely to be effective.

While policies may reflect and reinforce societal values and norms, the omission of certain issues also constitutes a form of policy that similarly reflects and reinforces norms. The purpose of this policy scan is therefore to assess whether men and boys are accounted for within the HIV/AIDS National Strategic Plans of specific countries in order to determine the extent to which these plans attempt to enlist men in promoting gender equality and preventing gender based violence, while also recognising the variety of vulnerabilities men face. The report further explores whether any national plans also describe work or interventions to address these issues and transform gender norms.
3 Evidence that Work with Men and Boys can Effect Positive Change
Evidence that Work with Men and Boys can Effect Positive Change

As new programs engaging men and boys have been implemented, a body of effective evidence-based programming has emerged that confirms that men and boys are able, and often willing, to change their attitudes and practices and, in some instances, to take a stand for gender equality. A number of interventions and reports indicate the emerging promise of this work:

- In 2007, the World Health Organization (WHO) and Instituto Promundo released a report reviewing 57 interventions with men in the areas of sexual and reproductive health, maternal and child health, gender based violence, fatherhood and HIV/AIDS prevention, confirming that such programs, while generally of short duration, had brought about significant changes in men’s attitudes and behavior.

- A study of nearly 150 Nicaraguan male participants in workshops on masculinity and gender equity revealed significant positive attitudinal and behavioral change, according to both partner reports and self-evaluations as measured by a wide range of indicators, including use of psychological and physical violence, sexual relations, shared decision-making, paternal responsibility and domestic activities.

- In Brazil, Instituto Promundo’s intervention with young men to promote healthy relationships and prevent HIV/sexually transmitted infections (STIs) showed significant shifts in gender norms at six and 12 months. Young men with more equitable norms were between four and eight times less likely to report STI symptoms.

- An evaluation of the Stepping Stones initiative in the Eastern Cape by the South African Medical Research Council (MRC) showed significant changes in men’s attitudes and practices. With two years follow up, participants reported fewer partners, higher condom use, less transactional sex, less substance abuse and less intimate partner violence.

- During 2008, an impact assessment of Sonke’s One Man Can (OMC) program in seven of South Africa’s provinces concluded that: “Overall, the findings for the impact of the OMC Campaign are very positive... The phone survey indicated significant changes in short-term behavior in the weeks following Sonke workshops, with 25% having accessed VCT, 50% having reported acts of gender based violence and 61% having increased their own use of condoms. More than four of five participants ... also reported having subsequently talked with friends or family members about HIV and AIDS, gender and human rights.”

These studies confirm that men can change their gender-related attitudes and relations in relatively short periods of time, and offer an understanding of the most effective strategies and types of intervention.
4 International Commitments to Working with Men and Boys
There have been numerous international commitments to working with men and boys on issues relating to HIV and AIDS and gender equality. These commitments require policy-makers in signatory countries to develop policies and programs around work with men and boys, and also provide civil society with leverage to demand effective implementation.23

The 1994 International Conference on Population and Development affirms 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”.24

The Programme of Action of the World Summit on Social Development (1995) and its 2000 review address the role of men, in particular with regard to sharing family, household and employment responsibilities with women.25

The Beijing Platform for Action (1995) restated the principle of shared responsibility, that women’s concerns could only be addressed “in partnership with men”.26 In the ten-year review in 2005, member states emphasized that changing men’s attitudes and behaviors requires a range of strategies including: legislative and policy reform, the implementation of programs, the involvement of educational systems and the media, and partnerships with NGOs, the private sector and leaders from all segments of society, including religious leaders.

The 26th Special Session of the General Assembly on HIV/AIDS (2001), which recognised the need to challenge gender stereotypes, attitudes and inequalities in relation to HIV/AIDS through the active involvement of men and boys.27

An expert group meeting on the role of men and boys, convened in 2003 in Brasilia by the United Nations Division for the Advancement of Women (DAW/DESA), in cooperation with ILO and UNAIDS, to inform the 48th session of the UN CSW held in 2004.28

The 51st session of the Commission on the Status of Women (CSW) in 2007, reported that “Equality between women and men is a fundamental principle of international law established in the United Nations Charter”.29

The Global Symposium on Engaging Men and Boys on Achieving Gender Equality in 2009,30 and the release in the same year of UNAIDS’ Operational Plan for UNAIDS Action Framework: Addressing women, girls, gender equality and HIV, which states clearly the critical importance of engaging men and boys (and cooperating with organisations working with men and boys) in realising the rights of women and preventing infection in the context of HIV/AIDS.31

The 53rd Session of the Commission on the Status of Women in 2009 adopted as its priority theme, “The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS”.


At the 54th session, the UN CSW adopted agreed conclusions calling on Governments, entities of the UN system and other stakeholders to, inter alia:

• Intensify efforts to eliminate all forms of discrimination against women and girls in relation to HIV and AIDS, including through challenging gender stereotypes, stigmatization, discriminatory attitudes and gender inequalities, and to encourage the active involvement of men and boys in this regard;31

• Enhance efforts by all relevant actors to include a gender perspective in the development of HIV and AIDS programs and policies and in the training of personnel involved in implementing such programs, including by focusing on the role of men and boys in addressing HIV and AIDS;32

• Acknowledge the critical role of men and boys and the need to share responsibilities between women and men in reducing maternal mortality and morbidity and promoting the health of women and girls, and urges Member States, the UN and civil society to include in their
development priorities programs that support the critical role of men in supporting women’s access to safe conditions for pregnancy and childbirth, contributing to family planning, preventing STIs and HIV, and ending violence against women and girls.33

- Encourage men and boys to continue to take positive initiatives and to work in partnership with women and girls to combat violence and discriminatory practices against women and girls, in particular female genital mutilation, through networks, peer programs, information campaigns and training programs;34

- Encourage the design and implementation of programs, including awareness-raising programs, to encourage and enable men, including young men, to adopt safe, non-coercive and responsible sexual and reproductive behavior and to use effective methods to prevent the transmission of HIV and other STIs;35

- Welcome the call by the Joint United Nations Program on HIV/AIDS to eliminate mother-to-child transmission of HIV by 2015, and urge Governments to rapidly scale up access to prevention and treatment programs for PMTCT of HIV and to encourage men to participate with women in programs designed to prevent mother-to-child transmission, to encourage women and girls to participate in those programs and to provide sustained treatment and care for the mother after pregnancy, including care and support for the family.36
Analysis of National Strategic Plans on HIV and AIDS across Five UNFPA Regions

- Importance of Engaging Men and Boys for Gender Equality
- Prevention Strategies
- Treatment and Care
- Gender Based Violence (GBV)
Analysis of National Strategic Plans on HIV and AIDS across Five UNFPA Regions

Importance of Engaging Men and Boys for Gender Equality

In the light of this progress, and increasing acknowledgement of the importance of engaging men and boys within gender equality and HIV work, Sonke was commissioned by UNFPA to carry out a desk review of HIV and AIDS National Strategic Plans (NSPs) analyzing the extent to which they commit to working with men and boys for gender equality and in relation to HIV and AIDS. National Strategic Plans determine countries’ priorities and budget allocations on HIV and AIDS and provide the framework guiding all related policies and programs. If the government of a country acknowledges the impact of gender and the importance of gender equality in HIV and AIDS work, this should be reflected clearly within their NSP, along with concrete plans and strategies to ensure the implementation. Without this in place, it will be difficult to effect broad and large-scale societal impacts.

The following 19 countries were identified initially for review: South Africa, Rwanda, Kenya, Papua New Guinea, Pakistan, Ukraine, Jamaica, Cambodia, Serbia, Liberia, Sudan, Nicaragua, Brazil, Cote D’Ivoire, Haiti, India, Egypt, Occupied Palestinian Territories (OPT) and the Russian Federation. Unfortunately, we were not able to locate copies of the Egyptian and Russian NSPs in the available time frame, and we were not able to determine whether there is an NSP for OPT.

The National Strategic Plans of 16 countries were analyzed in terms of their engagement with key issues of gender equality through an evaluation of the extent to which they:

- challenge negative gender norms and stereotypes related to men and masculinity and whether they promote gender equality;
- engage with the potential role men can play in supporting women’s access to HIV prevention, treatment and care services;
- outline strategies to involve men in preventing gender based violence;
- reduce men’s HIV risk taking, increase men’s uptake of HIV services and support men to be active participants in the HIV response.

While it is important for plans to address men’s specific needs in order to afford men equal access to prevention services, treatment, care and support, engaging men and boys will also benefit women directly and contribute towards gender equality. Reduced levels of prevalence and increased awareness about HIV amongst men will affect transmission rates to women. Challenging damaging gender norms will address the harm these cause to both women and men. Recognizing the important role that men can play as partners in HIV and gender equality work will ultimately minimize the burden carried by women, as well as the risks and dangers that they face.

For the purposes of this review, it was decided to analyze a specific set of topics within the NSPs: prevention strategies (medical male circumcision, condoms, VCT, PMTCT, marginalized men and boys); treatment and care, and gender based violence. These topics are almost always covered within National Strategic Plans, and specific reasons for the inclusion of men and boys in work planned around each of these topics is outlined in the following section.

Prevention Strategies

There are various key prevention strategies within which the specific needs of men and boys should be considered. The omission of such considerations within a National Strategic Plan could seriously hamper the effectiveness of HIV prevention efforts.

Medical Male Circumcision

Compelling scientific evidence suggests that medical male circumcision (MMC) reduces HIV infection among men by approximately 60%. The implementation of MMC is now widely accepted as a key HIV prevention intervention, recommended in contexts of generalised HIV epidemics with low prevalence of male circumcision. However, it is extremely important that MMC be included as part of a comprehensive package comprising HIV testing and counselling; STI treatment; education and promotion of safer sex practices, including the reduction of multiple concurrent partners; and the provision of male and female condoms, and education about correct and consistent use.

Numerous concerns remain about the large-scale roll-out of MMC and its potential negative side effects on HIV spread; for example, the possibility of ‘disinhibition’ or ‘risk compensation’ whereby men may conclude that MMC allows them to engage in more risky sexual behavior – to resume sex before the wound has healed fully, to have multiple concurrent partners or to be less willing to use condoms. The latter is especially problematic in societies where women have limited power to negotiate condom use. Another concern is that funding might be diverted from other
HIV prevention and treatment programs to support circumcision rollout. It is important to note that women only receive indirect protection from MMC, and are therefore affected by men’s potential ‘risk compensation’.41 Another concern is a possible increase in gender-based violence if women insist on condom use. 42 Circumcision is known to desensitise the penis, and there is thus an increased chance of force during sexual intercourse, which could increase a woman’s risk of contracting HIV due to abrasions of the genitalia. Similarly, loss of sexual sensitivity due to circumcision can result in reduced use of condoms.43 It is thus imperative that a man choosing circumcision is made fully aware of these consequences.

It is vital that this broader picture of gender equality is not neglected as studies have shown that: “Making gender norms and masculinity part of interventions with men and boys – that is, engaging them in deliberate critical reflection about these norms either in group sessions, individual counselling sessions or campaigns – leads to greater change in behavior and attitudes than only focusing on a specific issue without this larger reflection.”44

**Condoms**

Research has shown that men with more patriarchal attitudes toward gender roles and relations are more likely to have negative attitudes toward condoms and are less likely to use condoms consistently.49 Qualitative research demonstrating that men are more likely to practice safer sex with casual sexual partners than with their regular partners is supported by findings showing that the longer partnerships progress, the less condom use will be sustained and consistent.50

While condom availability has improved in many countries, studies continue to find that condom usage is related to people’s attitudes; reasons cited by men for resisting usage include “reduced pleasure, perceived and real physical side-effects, myths, lack of information, status, financial reasons, distrust in the efficacy of condoms, family planning, cultural reasons, gender-related reasons and trust.”51

In many countries, it is very difficult for women to negotiate condom use with their partners and therefore it is imperative that condom promotion interventions target and focus on men. Unless men’s attitudes towards condoms and condom use is addressed and transformed, little can be done to ensure an increase in consistent condom use.

**Voluntary Counselling and Testing (VCT)**

HIV testing is a key component in prevention and treatment. People who know their HIV status are more likely to use condoms, and testing also serves as a gateway to a range of HIV services and treatment. A recent national study of VCT services in South Africa found that men accounted for only 21% of all clients.53

While women and men appear to be similarly knowledgeable about HIV testing services,54 women are more likely to be tested during uptake of antenatal care in public health clinics. It is easier for men to avoid testing because of their low utilization of public health facilities. It has been suggested that men’s low uptake of testing is an example of a more general problem – that men are less ready than women to seek health treatment due to “gendered norms which make it difficult for men to admit any health-related weakness and seek medical attention”.55, 56

Consequently, it is essential to consider why men may be reluctant to test – and develop strategies to address this – to ensure the success of VCT drives. Men should also be encouraged to support women, and other men, in taking an HIV test in order to create a more enabling environment for VCT.

**Prevention of Mother-To-Child Transmission (PMTCT)**

Prevention of mother-to-child transmission is critical to HIV prevention efforts. Research suggests that the fear and fact of men’s violence can deter women from taking an HIV test or disclosing a positive result. Men’s lack of involvement in PMTCT programming, and in antenatal and postnatal care more generally, is a barrier to the success of such efforts. Efforts to increase the involvement of men in PMTCT processes may also motivate more men to know their gender equality and to offer men (and their partners) comprehensive HIV education”

“The chance to engage men through the roll-out of MMC should be seized as an opportunity to raise issues around gender equality and to offer men (and their partners) comprehensive HIV education”

The involvement of traditional leaders in MMC campaigns is pivotal because it is likely that men will approach traditional circumcision providers in countries where the public health system cannot keep up with the demand for clinical circumcision.54 The chance to engage men through the roll-out of MMC should be seized as an opportunity to raise issues around gender equality and to offer men (and their partners) comprehensive HIV education, along with prevention, treatment and support services.45 It is also crucial that effective communication strategies are employed to ensure that men receive the clear, unambiguous and consistent message that the benefit derived from MMC is relative and partial.46 Such strategies should include broader discussions around gender, socioeconomic inequality and power imbalances to “ensure women’s access to, control over and participation in HIV prevention options that truly reduce women’s risks and vulnerabilities”. 47
own status. Thus, efforts to encourage the increased involvement of men in PMTCT processes should be addressed in National Strategic Plans.57

Marginalised Men and Boys
The needs of men and boys, within a marginalized group of people, should also be specifically accounted for as these may not be specifically covered by interventions aimed more generally at marginalized populations. Thus such interventions may not achieve their aims as effectively as planned. The needs of certain marginalized groups should not be ignored by NSPs due to the fact that their contribution to the country’s overall HIV prevalence levels may be low.

Prisoners

“Incarceration is a risk factor for HIV and is correlated with unprotected sex and injecting drug use in correctional facilities...Interventions for risk reduction include provision of voluntary testing and counselling, condom provision, addressing rape, and addressing intravenous drug use.”58

It is thus essential that HIV/AIDS National Strategic Plans take account of the specific needs of prisoners, given that their level of HIV prevalence is often higher than among the general population. It is especially important that prisoners are educated on HIV, that condoms and lubrication are widely available and that prison warders are educated on HIV so as not to undermine prevention efforts. Prisoners are an ‘ideal’ population for such interventions, but unfortunately the little research that has been conducted in prisons shows that HIV transmission and vulnerability are exacerbated due to inadequate condom provision, and little or no distribution of disinfectant products or condom lubrication.59,60

Refugees and migrant workers
The vulnerable position within which refugees and migrants exist causes them to be particularly at risk of HIV infection. This situation can carry pose difficulties for men as male refugees may be struggling with the constraints of being unable to provide for, or even protect, their families. This painful situation can lead them into risky behavior patterns that may not have occurred in more secure circumstances. Migrant workers often live far away from their partners or families, which can also lead to multiple or concurrent partners and make it more difficult to access health care services. Thus, special efforts need to be made to reach and care for this group, with particular strategies developed to reach men given that the difficulties in encouraging men to test or access treatment are exacerbated for refugees and migrant workers.

Men who have Sex with Men (MSM)
Given the stigma associated with homosexuality, men who have sex with men (MSM) may be particularly difficult to reach through HIV prevention and treatment interventions. National Strategic Plans need to take account of and address the specific needs of men who have sex with men, including the need for condom and lubrication distribution and awareness programs, highlighting the specific risks associated with anal sex and HIV infection.

Injecting Drug Users (IDUs)
It has been found that in many cases male IDUs are more likely to procure injecting equipment from a friend or a stranger, than female IDUs, who are often more likely to procure such equipment from a sexual partner. This means that male IDUs might be less likely to know the HIV status of this person. It has also been found that male IDUs are often more likely to have more concurrent sexual partners than female IDUs.61 While women may be more likely to also have a partner who is an IDU, men are less likely, which could also mean that they are more likely to have a partner who is unaware of their drug habit. This highlights the importance of programmes that engage with IDUs taking gender into account, and making a special effort to engage with men. Men are more likely to disregard the risk involved in drug use, as gender norms dictate that men should be fearless and be prepared to take risks. As such, programmes intending to either engage with IDUs or curb the use of injecting drugs, should attempt to address or highlight the potential damage of such gender norms.

Treatment and Care
The effects of male socialisation, in which health-seeking behavior is often viewed as a sign of weakness, are also evident in treatment uptake.62 Men are also likely to access antiretroviral therapy (ART) later in the disease progression than women, and consequently access care with more compromised immune systems.63 Men's low utilisation of HIV services mirrors men's low utilisation of all health services.64

Men's lower than expected use of ART also reflects the fact that many reproductive health services do not address men in relation to HIV, STIs and other sexual and reproductive health needs. For instance, most VCT services are offered in antenatal clinics that are neither welcoming nor equipped to deal with men.65 Antenatal clinics do not attempt to reach male partners with VCT services, which are the gateway into ARV treatment programs.66 The Lancet recently drew attention to this, in an article by Mills et al., who wrote: “Efforts to understand men’s health-seeking behaviour are poorly understood in the AIDS epidemic, and encouraging men to get tested and into treatment is a major challenge, but one that is poorly recognised. Emerging
In order to attract more men to ARV programs, concrete steps need to be taken to address the gender norms which equate health-seeking behavior as a sign of weakness. In addition, the health sector needs to improve and make more available services, including emphasising the provision of male-friendly services; men need to be encouraged to become more treatment literate, to support women’s involvement in treatment programs, and, importantly, to support each other’s adherence and exposure to treatment literacy.

Home based care (HBC) is an important aspect of HIV/AIDS work, especially within developing countries. Caring for those with the virus involves both physical care – feeding, cleaning and providing medicine to cure opportunistic infections – and emotional support. Many carers of AIDS patients find this to be a full-time occupation that imposes great stress on the body, mind and finances.68 The majority of home-based carers are women – as mothers, sisters, wives, daughters and grandmothers are expected to care for those who are sick – rather than boys and men.69

While there are a number of issues that National Strategic Plans should consider in addressing the burden of care, for the purposes of this policy scan NSPs will be assessed in terms of the extent to which they attempt to encourage men to become more involved in HBC. In order for this to happen, the underlying gender norms that expect women to bear the burden of caring, and cause many men to see caring as ‘women’s work’, must be addressed.

Men’s attitudes towards care and support need to be understood before progress can be made, and to date little research has been done in this regard.70 One survey in Soweto found that men lacked the knowledge and skills to take part in caring activities and that they worried that their consequent inadequacy might expose them to ridicule.71 This suggests that the barriers to men’s greater involvement in care need to be analysed. Ideally, the general separation of work and chores into masculine and feminine should also be engaged with in order for people to recognise the far-reaching effects of everyday habits. The impact of involving men in traditionally female caring roles will begin to challenge these deeply held beliefs about appropriate gender roles for women and men.72 Men should also be encouraged to support other men who are involved in care work. Experience shows that is possible to change men’s care-related attitudes and practices, and it has been demonstrated that men often know they should, and want to, become involved in caring but lack a sense of permission to act on their convictions.73

If a more enabling environment were created in which men felt that they would not be criticised or judged for carrying out certain chores, many more men may quickly take up the responsibility of caring. It is also important to note that recruiting men into stipend work in HBC services, especially in areas of high male unemployment, could provide men with a (very minimal) income and serve as a potential route back to employment.74

Gender Based Violence (GBV)

Gender based violence (GBV) impacts on the spread of HIV in several ways. Women who experience sexual assault are at greater risk of HIV/AIDS infection than other women.76 A study of over 1,350 women across South Africa found that the risk of HIV infection was significantly related to the degree of violent or controlling behavior of male partners (an important feature of the control related to non-condom use).77

Men who use violence against women are also more likely to be HIV infected.78 There is also evidence to suggest that the fear and fact of men’s violence affect women’s use of HIV testing and treatment services.79 Strategies to prevent gender based violence will be enhanced by engaging men. Often, though, discussions around GBV still portray all men as probable perpetrators, which can make it difficult for more progressive men to become involved in efforts to prevent GBV. Men are too often depicted as the enemy rather than recognised as a potential and key partner in challenging GBV. Men can play a valuable role as advocates for the prevention of GBV; they are in a powerful position to influence their peers and to protect women and children. This power needs to be harnessed and channelled in a positive and constructive way. Excluding men from work on preventing GBV is a missed opportunity as many men and women share a commitment to addressing the issue of GBV and can work together to bring about real change. It is thus important that NSPs encourage men to become advocates for the prevention of GBV and the promotion of gender equality.
6 HIV/AIDS National Strategic Plans
It is necessary for NSPs to recognize the role that men can play in supporting women’s uptake of prevention and treatment services; the role that men can play in home-based care, and the care of orphaned and vulnerable children; and the role that men can play as agents of change in the prevention of GBV. It is equally important that various prevention strategies, as well as work concerning treatment, consider the specific needs of men and boys in order to effectively engage them to become involved in positive steps towards gender equality and in the fight against HIV and AIDS. The omission of such considerations within a National Strategic Plan could seriously hamper the long-term progress and impacts of such prevention and treatment efforts.

This section of the report presents the key findings and recommendations. Table 1 provides a summary view of the ways in which men and boys have been engaged with in each country’s National Strategic Plan on HIV/AIDS. A detailed analysis of each country plan, provided as Appendix 1, offers a deeper analysis of how each country plan includes a gender perspective; commits to gender equality and the need for transformation of negative gender norms; encourages an increase in men’s uptake of HIV services; and recognizes and focuses on the role of men and boys in addressing HIV and AIDS and gender-based violence.

TABLE 1: SUMMARY FINDINGS ABOUT HIV/AIDS NATIONAL STRATEGIC PLANS IN FIVE GLOBAL
<table>
<thead>
<tr>
<th>DOCUMENT</th>
<th>HIV AND GENDER</th>
<th>ATTEMPTS TO CHALLENGE OR TRANSFORM GENDER NORMS</th>
<th>ENGAGING MEN FOR PREVENTION OF GBV</th>
<th>MEN’S SUPPORT OF PMTCT</th>
<th>MALE CIRCUMCISION</th>
<th>CONDOMS</th>
<th>MEN’S USE OF VCT</th>
<th>MARGINALIZED MEN &amp; BOYS?</th>
<th>TREATMENT HOME BASED CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya National AIDS Strategic Plan 2009/10 – 2012/13</td>
<td>The importance of gender within HIV work acknowledged</td>
<td>Gender norms identified as a root cause of vulnerability, and interventions outlined to address them - but details of such an intervention are not provided</td>
<td>Men not included</td>
<td>Men included</td>
<td>Included, but implications thereof not analyzed in full</td>
<td>Men not accounted for</td>
<td>Men not accounted for</td>
<td>Specific needs unaccounted for; homosexuality illegal in Kenya</td>
<td>Men not accounted for</td>
</tr>
<tr>
<td>Rwanda National Strategic Plan on HIV&amp;AIDS 2009 - 2012</td>
<td>The importance of gender within HIV work acknowledged</td>
<td>Possible negative effects of male gender norms acknowledged, but no plans to address or transform them</td>
<td>Men not included</td>
<td>Increase male uptake and family approach for PMTCT. A need for male involvement in reproductive health also highlighted</td>
<td>Included and implications thereof considered – could be expanded upon</td>
<td>Men not accounted for</td>
<td>Men not accounted for</td>
<td>Included and many needs accounted for, less so however with IDUs and refugees. Although the potential to increase a gender aspect to such programmes is not addressed.</td>
<td>Men not accounted for</td>
</tr>
<tr>
<td>HIV/AIDS and STI Strategic Plan for South Africa 2007 – 2011.</td>
<td>The importance of gender within HIV work acknowledged</td>
<td>Plans to develop programmes to address gender stereotypes are outlined, but insufficient detail is provided</td>
<td>Plans to develop programmes to address gender stereotypes which contribute towards GBV - but no plans which encourage men to become involved in preventing GBV</td>
<td>Men included</td>
<td>Mentioned in terms of research, but not reached the stage of roll out, implications thereof not analyzed in full. (Outdated)</td>
<td>Condoms to be distributed through non-traditional outlets, but men not specifically focused on</td>
<td>Men will be focused on, but no target provided or strategy outlined</td>
<td>Included and needs accounted for, (except for IDUs), but the potential to increase a gender aspect to such programmes is not addressed.</td>
<td>Men not accounted for</td>
</tr>
<tr>
<td>Country</td>
<td>National HIV/AIDS Strategic Framework - 2007 – 2011 (NSF - Two)</td>
<td>Issues of gender are not addressed sufficiently</td>
<td>No attempt to engage with the issue of gender norms</td>
<td>Not included</td>
<td>Not included</td>
<td>Not included</td>
<td>Men not accounted for</td>
<td>Men not accounted for</td>
<td>The needs of prisoners, MSM and IDUs relatively accounted for</td>
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<td>Pakistan</td>
<td>Nigeria</td>
<td>India</td>
<td>South Africa</td>
<td>Ukraine</td>
<td>The State Program to ensure HIV prevention, treatment, care, and support to HIV-positive people and patients with AIDS for years 2009-2013</td>
<td>Issues of gender are not addressed</td>
<td>No attempt to engage with the issue of gender norms</td>
<td>Not included</td>
<td>Men not included</td>
</tr>
<tr>
<td>Papua New Guinea National Strategic Plan on HIV/AIDS 2006 – 2010</td>
<td>The importance of gender within HIV work acknowledged</td>
<td>No plans to engage with the issue of gender norms</td>
<td>Not included</td>
<td>Men not included</td>
<td>Not included</td>
<td>Men not accounted for</td>
<td>Men not accounted for</td>
<td>Hardly mentioned and needs not accounted for</td>
<td>Men not accounted for</td>
</tr>
<tr>
<td>Royal Government of Cambodia National Strategic Plan for a Multisectoral response to HIV/AIDS 2006 – 2010</td>
<td>The importance of gender within HIV work acknowledged</td>
<td>No attempt to engage with the issue of gender norms</td>
<td>Not included</td>
<td>Men not included</td>
<td>Not included</td>
<td>Is acknowledged that condoms need to be normalized but men are not focused on to encourage attitude change</td>
<td>Married couples included in groups encouraged to test, but men not specifically accounted for</td>
<td>Only MSM's needs accounted for</td>
<td>Men not accounted for</td>
</tr>
<tr>
<td>Country</td>
<td>National Plan</td>
<td>Gender Importance Acknowledged</td>
<td>Possible Negative Effects of Male Gender Norms Acknowledged, but No Plans to Address or Transform Them</td>
<td>Not Included</td>
<td>Men not Included</td>
<td>Men not Included</td>
<td>Multimedia and Social Marketing Effort Aimed at Sexually Active Males 15-19 Years. Focus on Non-Regular Partners Needs to be Addressed.</td>
<td>Men not Accounted for</td>
<td>Only MSM's Needs Accounted for, Although Lubrication Is Not Mentioned and Homosexuality Is Illegal in Jamaica</td>
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<tr>
<td>Jamaica</td>
<td>HIV and AIDS in Jamaica: National Strategic Plan 2007 – 2012</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Possible negative effects of male gender norms acknowledged, but no plans to address or transform them.</td>
<td>No</td>
<td>Only MSM’s needs accounted for, although lubrication is not mentioned and homosexuality is illegal in Jamaica</td>
</tr>
<tr>
<td>Serbia</td>
<td>Serbia National Strategy for the Fight against HIV/AIDS 2005</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No attempt to engage with the issue of gender norms.</td>
<td>No</td>
<td>Needs of MSM relatively accounted for</td>
</tr>
<tr>
<td>Liberia</td>
<td>Liberia: National HIV Strategic Framework II 2010 - 2014</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Acknowledgment that prevailing gender and sexual norms and attitudes need to be changed, but no detailed plan of work to be implemented</td>
<td>No</td>
<td>Certain needs of marginalized groups acknowledged but no plans to address them</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>Cote D’Ivoire National AIDS Strategic Plan 2006-2010</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No attempt to engage with the issue of gender norms.</td>
<td>No</td>
<td>Specific needs not acknowledged. MSM not acknowledged.</td>
</tr>
<tr>
<td>National HIV and AIDS Strategic Plan 2010 – 2014: Sudan National AIDS Programme SNAP (Northern Sudan)</td>
<td>The importance of gender within HIV work acknowledged</td>
<td>Possible negative effects of male gender norms acknowledged, but no plans to address or transform them</td>
<td>Men not included</td>
<td>Men not included</td>
<td>Not addressed within planned work as it is acknowledged that men in Northern Sudan are almost universally circumcised. No plans to ensure awareness of limitations of protection.</td>
<td>Men not accounted for</td>
<td>Men not accounted for</td>
<td>Specific needs not accounted for</td>
<td>Specific target set, disaggregated by sex, for people on ARV treatment by 2014.</td>
</tr>
<tr>
<td>Indian NACP III, 2006 – 2011 &amp; India: Strategy and Implementation Plan - NACO Programme Phase III (2006-2011)</td>
<td>The importance of gender within HIV work acknowledged</td>
<td>No attempt to engage with the issue of gender norms</td>
<td>Men not included</td>
<td>Men not included</td>
<td>Not included</td>
<td>Men not accounted for</td>
<td>Men not accounted for</td>
<td>Needs of MSM and migrants relatively accounted for. IDUs and prisoners not.</td>
<td>Men not accounted for</td>
</tr>
<tr>
<td>Haiti: Plan Interimari VIH/ SIDA suite au seisme du 12 Janvier 2010</td>
<td>Issues of gender are not addressed</td>
<td>No attempt to engage with the issue of gender norms</td>
<td>Men not included</td>
<td>Men not included</td>
<td>Not included</td>
<td>Men not accounted for</td>
<td>Men not accounted for</td>
<td>Only the needs of people living in temporary shelters are accounted for</td>
<td>Men not accounted for</td>
</tr>
<tr>
<td>Nicaragua: Plan estrategico nacional de ITS, VIH y SIDA, 2006 - 2010</td>
<td>The importance of gender within HIV work acknowledged</td>
<td>Possible negative effects of male gender norms acknowledged, but no plans to address or transform them</td>
<td>Men not included</td>
<td>Men not included</td>
<td>Not included</td>
<td>Clients of Female Sex Workers included</td>
<td>Men included within target</td>
<td>Needs of MSM accounted for</td>
<td>Men not accounted for</td>
</tr>
<tr>
<td>Brazil Strategic Plan for the National Programme on Sexually Transmitted Infections and AIDS 2004-2007 &amp; Brazil Strategic Plan for the National Programme on Sexually Transmitted Infections and AIDS 2005</td>
<td>The issue of gender is not acknowledged sufficiently within the 2005 plan and not acknowledged in the 2004 - 2007 plan</td>
<td>No attempt to engage with the issue of gender norms</td>
<td>Men not included</td>
<td>Testing to be expanded to pregnant women’s partners, but the potential support that men can offer women during PMTCT not recognised</td>
<td>Not included</td>
<td>Men are not specifically targeted by the NSP but condom use is already very high in Brazil</td>
<td>Men not accounted for</td>
<td>Needs of MSM relatively accounted for</td>
<td>Men not accounted for</td>
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<tr>
<td><strong>Key</strong></td>
<td>Adequate</td>
<td>Adequate but there is room for improvement, or aspects that are problematic</td>
<td>Slightly less than adequate</td>
<td>Not completely inadequate</td>
<td>Inadequate</td>
<td></td>
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</tr>
</tbody>
</table>
Key Findings

- Prevention Strategies
- Treatment and Care
- Gender Based Violence
Prevention Strategies

Medical Male Circumcision

Male circumcision is only addressed in a small number of NSPs, namely Kenya, Rwanda and South Africa. Rwanda addresses the issue most comprehensively in that it acknowledges the possibility of disinhibition and stresses that MMC should only form part of a comprehensive prevention package (this could be attributed to its recent publication). While MMC is focused upon heavily within the Kenyan NSP, its possible negative side effects are not acknowledged. The Sudanese NSP notes that circumcision is almost universal in Sudan, but no plans are described to ensure that men are fully informed about the effects of MC on HIV transmission. Plans for a large-scale roll-out of MMC are not outlined by any other NSP.

Condoms

Condom promotion and distribution form an important part of most NSPs, with the exception of the Ukraine. Unfortunately, very few NSPs acknowledge the need to make condoms more easily available to men and even fewer address the need to increase men’s support for female condoms. South Africa commits to increasing condom distribution in formal and informal outlets, especially in high transmission sites such as truck stops, borders, mines and brothels. Liberia acknowledges that it is difficult to reach men through traditional health facilities and plans to make condoms accessible at the workplace. The Liberian NSP also acknowledges that it is often difficult for women to negotiate condom use due to their economic dependency on men or fear of violence, and plans to reach young women and unemployed men and boys through multi-purpose youth centres to facilitate peer outreach activities. Messages will emphasize delay of sexual debut, partner reduction, and consistent condom use. The Jamaican NSP describes work that focuses on men and condoms, such as the multimedia and social initiative, “Wrap It Up”, aimed at sexually active males aged between 15–19. It also describes other non-traditional condom distribution methods, such as partnerships with party promoters. Unfortunately, the NSP only commits to increasing the number of people using condoms with a non-regular partner. The neglect of promoting the use of condoms with regular partners could be damaging as it strengthens the idea that condoms are associated with distrust. The Cambodian NSP commits to promoting negotiation skills and safer sex behavior, including consistent and correct male or female condom use, among married couples, and “normalizing condoms and their use for dual protection”, setting a target of 5% of married women reporting consistent condom use by 2010. In measures to encourage married couples to use condoms consistently, the NSP does not specify whether it will focus on the male or female partner. The inclusion of negotiation skills may imply that women will be the focus for such interventions.

No other NSPs specifically focus condom promotion efforts on men, and even the Liberian and Jamaican NSPs do not engage with how to encourage men to use condoms and ways to transform men’s attitudes towards condoms.

Voluntary Counselling and Testing (VCT)

Very few NSPs discuss the need to encourage men to increase their uptake of VCT services. While the South African NSP states that there should be a focus on men in VCT drives, it does not set a target nor describe how to implement this. The Cambodian NSP aims to encourage married couples to test, which is encouraging. The Liberian NSP again notes the need for access to VCT services within the workplace and this may increase men’s access to such services. In Sudan it is noted that the majority of people testing for HIV are men, and thus it is perhaps understandable that no plans focus on men to encourage their uptake of VCT services. The plan instead emphasizes that women and men should have equal access to such services.

Again, no NSP acknowledges the need to transform men’s attitudes towards HIV testing, outlines plans to address men’s attitudes, or specific measures to make VCT sites more male-friendly.

Prevention of Mother-To-Child Transmission (PMTCT)

The role of men within PMTCT receives marginally more attention in a few NSPs. The Kenyan NSP notes that male involvement in PMTCT services should be increased. It proposes an
intervention incorporating couple-based HIV testing, supported by increased male involvement in PMTCT, in order to identify discordant couples and increase the proportion of pregnant women accessing PMTCT services. The Rwandan NSP notes that the male uptake of PMTCT should be increased. The South African NSP includes the involvement of men within the expansion of PMTCT services. The Liberian NSP explains that community mobilization and mass media campaigns will sensitize pregnant women and their partners to the availability of PMTCT. Plus services. The NSPs that do raise the need to involve men in PMTCT services do not describe how they will motivate men to become more involved. The need to involve men within PMTCT services is not raised by any other NSP under review.

**Marginalized Men and Boys**

**Prisoners** often receive specific attention within NSPs and are acknowledged as a vulnerable group, but the work proposed to engage with them varies. A few NSPs have gone so far as to recognize the need for condom and lubrication distribution, but many plans go no further than including prisoners within general programs targeting vulnerable or at-risk populations and therefore their particular set of needs are often not accounted for.

**Refugees, migrant workers and mobile or displaced populations** are often included within NSPs, but again plans for work to target these groups are vague. There is a need for more detailed plans to be developed, which address the specific situation of refugee and migrant people. Men are never specifically identified as a group within the refugee population that requires tailored attention, and thus the specific needs of male refugees are never considered.

Men are more often discussed with regard to mobile populations, with truck drivers identified as a vulnerable group in a number of NSPs. However, while certain at-risk populations identified often comprise men, for example truck drivers, migrant workers, long-distance bus drivers, soldiers, UN peacekeepers, businessmen, uniformed service personnel, programs designed to target such populations do not appear to take gender into account. Their needs as a vulnerable or at-risk population are acknowledged, but their gendered experiences and realities are not, and thus the exact needs of these groups of men remain unaccounted for. This omission may seriously hamper the effectiveness of such interventions.

**Men who have sex with men (MSM)** are almost always identified within NSPs as an important focus group in terms of HIV and AIDS work. Problematically, in certain countries homosexuality is illegal which makes work with MSM extremely difficult. Unfortunately, those NSPs do not outline plans to work for the legalization of homosexuality, but they do often commit to ensuring that work focused on MSM takes place. The need to distribute lubrication and condoms is recognized by only a few NSPs. NSPs also need to consider more detailed plans of how programs focused on MSM will reach their target population given the level to which MSM are stigmatized in some countries.

**Injecting Drug Users (IDUs)** are often acknowledged within NSPs, but as the issue of clean needle exchange programs remains controversial, this key element is not always factored into work plans with IDUs. IDUs are never discussed in a gendered way, and the idea that the risk-taking associated with drug use is often encouraged by certain masculine norms is never engaged with. IDUs can also be neglected within NSPs as in many countries they constitute a small percentage of the HIV-positive population.

**Treatment and Care**

The need to increase men’s uptake of treatment services is severely neglected in the group of NSPs reviewed. No plans are made to address the issue that notions of masculinity affect men’s health-seeking behavior, nor are there plans to make clinics, hospitals and other sources of treatment more male-friendly. The NSPs do not specifically encourage men to access VCT services, as has been discussed above, and as these provide the gateway to ARV treatment, it is unsurprising that men are also neglected in this regard.

The need to encourage men’s involvement in the care economy is overlooked by all the NSPs, barring South Africa. The South African NSP acknowledges the need to increase male involvement, and sets a target of 20% of men involved in home based care by 2012.

**Gender Based Violence**

Gender based violence is addressed within a number of NSPs, but is overlooked by a number of other plans. No NSP addresses the potential for involving men in efforts to prevent GBV, and the role they can play as advocates for change. This is a serious omission as discussions around GBV then tend to only portray men as perpetrators. The Liberian NSP acknowledges that sexual and gender based violence are not unique to conflict situations, “but deeply rooted in traditional thinking about gender roles by men and women alike”, but it provides no plans for work to challenge this. The South African NSP outlines plans for the development of programs and strategies to address stereotype gender identities that contribute to gender based violence, but further details are not provided.
Recommendations

- Prevention Strategies
- Treatment
- Care
- Gender Based Violence
- General Recommendations
Recommen dations

Traditional and stereotypical views of gender roles and relations that cast females as subordinate and males as superordinate hinder an effective response to HIV and AIDS. The engagement of men and boys in HIV and AIDS work is critical to addressing and challenging these stereotypes and gender norms. In order to ensure that such work takes place effectively, it is imperative that its importance is recognized within policy and specific plans are outlined to guarantee its realization. This will ensure that progress is made in engaging men in work alongside women for gender equality, ending violence against women and girls and encouraging men’s active involvement in the care economy. Changes in the attitudes and behaviors of men and boys, and in the unequal distribution of power between men and women, will contribute to gender equality, assist in the prevention of HIV and AIDS and alleviate some of the devastating effects of HIV and AIDS.

In terms of those NSPs that have outlined plans to conduct research that will inform future interventions, it is vital that this research takes place and its results are integrated into future national strategic plans. It is important that more detailed work plans are developed, and that continually postponed or attributed to a lack of information regarding specific populations or issues. Examples of such NSPs include Rwanda, South Africa, Papua New Guinea, Liberia and India.

It is also important that the issue of gender equality is not pushed aside within NSPs or treated as mere window dressing. It is not sufficient to merely acknowledge the importance of gender and its mainstreaming within plans. It is imperative that this recognition is translated into real work that aims to engage with men and boys; encourage their involvement in gender equality work; acknowledge their specific needs and contexts; and attempt to challenge as well as transform destructive masculine gender norms. It is recommended that the detail, aims and implementation of such work is integrated into and fully described within future NSPs. In addition, it is vital that the value of gender work is fully recognised and understood. For example, within South Africa’s NSP, it is stated that gender transformation shares part of a broader transformation agenda “that also seeks to reduce the gap between rich and poor and between historically disadvantaged black communities and white communities with many more resources.” It is possible that within such a broad agenda, the importance of gender equality may be lost or sidelined while other forms of transformation are prioritized.

Prevention Strategies

Medical Male Circumcision

The roll-out of MMC should be conducted carefully and all possible repercussions thereof considered. Firstly, it is recommended that a regulatory framework and a national task force be developed and established within any country planning large-scale roll-out of MMC. Policies and programs should adopt a gendered and rights-based framework for operationalizing MMC within HIV prevention. HIV testing should be recommended for all men seeking circumcision, but should not be mandatory. More investment in the health sector is required to strengthen capacity to increase the provision of safe MMC services. Further research should be conducted in order to guide implementation.

It is important that the roll-out of MMC is utilized as an opportunity for raising awareness and education. NSPs should ideally provide for gender education to be explicitly included in national MMC policies, containing holistic, clear, unambiguous and consistent messages. Communication strategies should address risk compensation, HIV, sexual and reproductive health, socioeconomic inequality, power imbalances, family planning, STIs, stigma, behaviour change communication, shared sexual decision-making, gender equality and the impact in improving the health of both women and men. MC programs should promote zero tolerance for sexual coercion and violence against girls and women and encourage men to respect and support the health rights and needs of their partners. All participants must have a clear understanding of post-surgery requirements and be fully aware of the only partial protection that MC provides against HIV infection.

The value of including women in MC processes should be recognised. Firstly, in-depth studies should be conducted to investigate the role of women in MC decision-making processes.

Women should participate in and be consulted during the development of MC policies and programs, to ensure that education and awareness campaigns are better equipped to address the realities, risks and potential benefits for women. Furthermore, civil society organisations (including women’s rights groups) need to monitor the impact of MC on HIV-positive and HIV-negative women.

It is important that the behavior patterns of men post-surgery are monitored. For example, rates of GBV as well as coercive sex, post surgery should be monitored, in order for such behavior
patterns to be addressed and minimised.

The support of traditional leaders should be enlisted in order to utilize existing cultural structures. However, these structures need to offer the same holistic educational package outlined, and, if carried out, traditional circumcisions need to be carried out with adequate levels of safety and hygiene, within a regulatory framework that ensures compliance with training and minimum standards, as is the case in South Africa. Commenting on South Africa’s Application of Health Standards in Traditional Circumcision Act, the British Medical Journal reported that the Act: “provides for the observation of health standards in traditional circumcisions with penalties of up to 10 000 rands [about £800; $1200] and 10 years in jail”. The article describes the ambit of the Act: “It provides for the regulation of people qualified to perform the ritual and regulates the circumcision ‘schools’. The law makes it compulsory for parents or guardians to give permission and requires that in all but exceptional circumstances the young men cannot be younger than 18. Only recognised traditional practitioners may perform the operation, and they must have the permission of a medical officer designated in the area who also has to give permission for each circumcision school.”

There may be considerable challenges to implementing such a process, but if it done successfully such an intervention could prove very powerful.

With regard to HIV-positive men, the following UNAIDS guidelines should be adhered to: MC should not be recommended as an intervention to reduce HIV transmission to women; however if an HIV-positive man requests circumcision following in-depth counselling on the known risks and benefits, it should not be withheld unless it is medically contraindicated.

Condoms
It is important that men and boys are taken into account during design and planning of condom promotion and distribution efforts. NSPs need to acknowledge that in order to increase condom use, men’s and women’s attitudes towards condoms need to be addressed. While the issue of negotiation skills for women is key, it is equally important to address men’s attitudes towards accepting their partners’ wish to use a condom and to understanding clearly the difference between coercion and consent.

NSPs should develop innovative strategies to ensure that condoms are easily accessible to men, women, young people and most-at-risk populations—especially where and when they need them. Access to condoms should be normalized and attitudes that link condoms with promiscuity should be challenged. Ensuring that condoms are more visible might help to achieve this goal. The use of non-traditional condom outlets should be scaled up, coupled with gender equity education. It is important that condom distributors in such outlets are trained and supported to provide basic information on correct condom usage, as well as basic education around gender equity.

Condom policy should be explicitly linked to gender equity, and initiatives and messages used to promote condoms must also promote equitable sexual relations between women and men and not reinforce negative images of women and female sexuality. Condom distribution and promotion should be linked with work on sexual violence and coercion. Condom distribution and promotion are potentially valuable opportunities to educate men about issues of communication and coercion within sexual relationships.

Further research is needed on men’s attitudes toward the use of the female condom. There is anecdotal evidence that some of the factors inhibiting men’s use of the male condom, such as anxieties about correct use and loss of spontaneity, could be addressed by the female condom, and thus more research in this area is imperative. Frank discussion regarding sexual intercourse and condom use are also needed. Open and honest dialogue has the potential to dispel myths and address personal issues around sexual spontaneity and pleasure. Thus educational programs which focus on condom application should go further to incorporate discussions around practical ways to incorporate condom use within sexual intercourse; and can address issues relating to the use of female condoms. Such discussions should include the use of lubricant as a method to enhance the enjoyment of sex with a condom, as well as education on forms of lubrication currently used that damage condoms and increase risk of infection.

It would be beneficial to develop condom promotion campaigns emphasizing family planning and dual protection. Re-framing condoms as a family planning method, and emphasizing their role in dual protection, is one way to minimize the associations of condoms with distrust at the same time as increasing men’s engagement in family planning.

It would also be advisable for future NSPs to review their policies regarding condom availability in schools; and for the attitudes of health workers who stigmatize young people asking for condoms to be addressed.

Voluntary Counselling and Testing (VCT)
Similarly, it is important for NSPs to recognize the need to include men in promotion of VCT. NSPs should acknowledge the difficulty that many men face in accessing VCT, in that health-seeking behavior is often viewed as a weakness in terms of hegemonic masculine norms. Clinics are also often regarded by men as areas which are utilized and staffed predominantly by women. NSPs also need to acknowledge that the awareness of one’s HIV status is one of the most important aspects of prevention and thus creating an enabling environment to encourage men to test is an important first step in promoting responsibility for sexual behavior.
Regular HIV testing also needs to be normalized in order to reduce the stigma associated. If this can be achieved, men’s attitudes towards broader health-seeking behaviour may be influenced. Therefore, it is imperative that public health clinics be made more male ‘friendly’, through extending opening times to accommodate working men, employing more male staff, and improving privacy within clinic settings. It is also important that alternative VCT sites are devised as evidence suggests that men are more willing to test when VCT is taken to where they are, through mobile testing sites or workplace testing programs. Evidence also shows that it is vital to include male leaders and opinion formers through investing in community preparedness work to ensure uptake of testing by men when services are made available.

All work with men and boys should promote the uptake of VCT services, which should also be linked to anti-violence work. Violence by men should be addressed in terms of the role it plays in deterring women’s use of HIV testing and treatment services. Hopefully, by addressing men’s attitudes towards testing, their attitudes towards their partners’ testing will also be influenced. VCT counselors could undergo training to equip them to address gender issues, particularly GBV. Counselors should be encouraged to provide care in a way that maximizes protection for women and assists in processes that encourage men to test, including couple counseling.

Research suggests that disclosure of an HIV-positive status remains a significant challenge for many men, for various reasons, some of which relate to masculine fears of weakness and anxieties over an inability to fulfil the male ‘provider’ role. This suggests a need not only for increased attention to masculinity issues in pre- and post-test counseling, but also to ensuring that men have access to appropriate male-sensitive support groups, whether single or mixed gender, to help them deal with issues like disclosure and healthy living, as well as providing treatment literacy to prepare them for treatment.

Prevention of Mother-To-Child Transmission (PMTCT)

The lack of male involvement in PMTCT programming is a missed opportunity, not only to engage men in HIV prevention and testing, but also as partners and fathers. It is important to increase men’s involvement by supporting women to talk to their partners about PMTCT and HIV testing, but men should also be specifically focused on within PMTCT strategies in order to encourage their involvement. This can greatly enhance women’s experiences of PMTCT services and the benefits thereof. Greater male involvement in PMTCT has also been a priority for PMTCT-plus programming, which aims to meet the needs of every family member infected or affected by HIV and AIDS in resource-limited settings by extending all HIV services, including ART, to each mother’s HIV-infected children, partners, and other family members. It is also important that men play a role in supporting HIV-positive pregnant women to visit clinics and/or hospitals, which increases their chances of a safe delivery. Recent reports suggest that the involvement of men within PMTCT is increasing in Kenya, and more work is being done to encourage this trend.

Post birth there are many opportunities for men to take an active and positive role in child rearing. It will be beneficial if men can support women to with regard to adherence to ARV treatment and exclusive breastfeeding for 6–12 months. While it can be difficult for women to breastfeed for this period of time, men and boys can play an active role in their households by assisting with bottle feeding of expressed breastmilk. For mothers who have been advised by health care workers to formula feed, men can and should play an important role in obtaining formula, ensuring that feeds are properly and safely prepared, and in gaining the support of other family members, especially elders who might be opposed to formula feeding. PMTCT services and ante-natal care services represent an opportunity to reach thousands of men with prevention, VCT, care and support activities.

Marginalized Men

It is important that NSPs provide for the specific needs of marginalized groups. Many countries may make the mistake of neglecting these groups because they account for a small number of the overall HIV-positive population, or because engagement with them is politically uncomfortable and controversial. Thus extra effort must be made within NSPs to reach these groups as they may have limited opportunities to advocate for their rights and needs. Their needs and context sometimes differ from that of the general population and therefore require strategies tailored to address their particular situations.

Prisoners as a group are often neglected due to denial of the existence of sex amongst male prisoners, and possibly due to smaller budgets allocated to prison populations and the fact that they are not prioritized generally. However, HIV prevalence levels are often at least as high in prisons as in the general population and their right to prevention services must be ensured.

“Workshops to address and interrogate gender norms and violent forms of masculine identity in prisons should be conducted, as well further research to understand the specific circumstances and dynamics at play within such institutions”
Indeed, international law places a special obligation on states to meet the needs of populations in the care or custody of the state. It is important that condoms and lubricant are widely distributed and easily accessible within prisons, along with education about how commonly used forms of lubrication can damage condoms and increase infection risk.97 The attitudes of staff within particular penal institutions should not be permitted to restrict the availability of condoms and lubricants. It is also important that education and awareness programs take place in prisons to create awareness of the risks associated with anal sex. Prisoners should also be provided with VCT and ARV treatment services, STI symptom recognition, access to PEP and STI treatment, as well access to clean needles. It must also be ensured that staff providing such services are appropriately trained and provide fair and non-judgemental service. This implies an urgent need to develop training and support for medical and correctional staff in basic sex health education, post-assault care, as well as protocols for defining consensual and non-consensual sexual contact and preventing and addressing the latter within correctional settings.

Public policy responses to male-on-male violence, and its links with the culture and economy of gangs, must also take account of violence within prisons, both of prisoners against each other and by prison staff.98 Prisons reinforce some of the most harmful notions and practices of oppressive masculinity and submissive femininity, such as when more powerful inmates take other inmates as their ‘wives’ and routinely rape them.99 Consequently the ability of prisons to engage positively with men is severely compromised, and many men leave prison victimized or with harmful practices reinforced rather than corrected. This suggests that alternatives to incarceration are urgently required, alongside the challenge of making prisons more humane. Whether in prison or communities, little is known about the extent of physical and sexual violence against men within lesbian, gay, bisexual, transgender and intersexed (LGBTI) communities. Workshops to address and interrogate gender norms and violent forms of masculine identity in prisons should be conducted, as well further research to understand the specific circumstances and dynamics at play within such institutions.

Refugees and migrant populations are not necessarily always marginalized, but they are often more vulnerable than the general population due to factors such as lack of food, employment and shelter, homelessness and overcrowding, and xenophobia. Strategies therefore need to be developed to reach these populations effectively as their access to traditional health care services is often limited or problematic. In the same way that men need to be encouraged to access HIV prevention services within the general population, special effort should be made to encourage male migrant workers or refugees to access health care services, as female migrants or refugees may more easily access such services through pre-natal care or more female friendly clinics.

The needs of MSM should be addressed through the provision of condoms and lubricant. Organizations representing gay men and other MSM have long called for increased investment in appropriate lubrication to accompany condom distribution targeted at MSM, together with education about the damage to condoms, and thus increased risk of infection, of commonly used forms of lubrication.100

The stigma associated with MSM needs to be acknowledged to inform interventions targeting this group, and strategies should be developed to ensure that MSM are able to access services, that also address homophobia and the associated stigma. Dialogue with gay rights groups should inform such planning. Further research is also required in order to better inform such interventions.

IDUs constitute the largest HIV-positive population in certain countries, and the smallest in others. Nonetheless, their specific needs should not be neglected within an NSP. It is important for NSPs to make provision for substitution therapy and ARV treatment for IDUs, syringe exchange programs and support groups. Specific interventions targeting IDUs and raising awareness around the specific risks associated with sharing needles should be developed, and should also focus on the risks associated with sex under the influence of drugs, which is often unprotected. Such education efforts should also address harmful masculine gender norms which encourage risk-taking behavior.

Treatment
It is essential that NSPs address men’s poor health-seeking behavior.101 The gendered stigma that deters men from seeking treatment must be an important focus of masculinities work with men, both intensive group work and extensive media work, as well as being integrated into community preparedness work for HIV testing and treatment services. The provision of male-sensitive support to engage and maintain men in treatment should be ensured by NSPs. In this way men’s own treatment needs will be better met, and men will also be better equipped to support women’s access to treatment services. It has been acknowledged that women’s fear of men’s reactions to their HIV-positive status could deter them from accessing treatment. If men’s own attitudes towards treatment are more positive, this may influence their reaction to disclosure. As part of the testing-treatment continuum, consideration should be given to the role that single-gender as well as mixed-gender treatment literacy/preparedness and support groups can play in helping men to access and stay on treatment. The value of such male-only spaces can be seen from the experience of support groups for HIV-positive men that offer advice on health matters, HIV testing and counseling, sexual dysfunction and other services in an all-male milieu.

Efforts need to be made to design more male-friendly clinics and hospitals, and other sites for accessing treatment and treatment literacy. It is important that in the appropriate countries, TB and AIDS treatment is integrated and
Health Departments partner with the private sector to expand treatment services for men. Awareness campaigns should also highlight the need to access treatment at the appropriate time. It must be emphasized that in order for HIV treatment to be effective, people must not wait until they are very ill. If men’s attitudes towards health-seeking behavior could be transformed, this issue could be better addressed. Furthermore, if men are made more aware of the benefits of treatment, this may affect their uptake of VCT services.

NSPs should address reproductive health issues in HIV treatment. Recent research highlights the need to better integrate reproductive health issues within HIV treatment services, and shows that the reproductive rights and interests of people living with HIV are poorly addressed. Within this, the role of men in supporting their female partners’ reproductive choices and decisions as well as articulating and addressing their own reproductive desires, in the context of both discordant and concordant relationships, needs increased attention.

**Care**

While the overwhelming burden of AIDS care continues to be borne by women, there are signs of increasing willingness and involvement by men. Efforts must continue to increase recruitment of men into HBC programs, especially in areas of high male unemployment. The impact of involving men in traditionally female caring roles will share the burden of care and begin to challenge deeply held beliefs about appropriate gender roles. Thus it is recommended that peer-based projects be used as a pathway to increasing the number of men in the caring professions.

Men in government should lead by example and use their status and influence to promote the importance of greater male involvement in the care economy through personal and professional actions. They should commit the resources necessary to care, support and treat those affected by HIV and AIDS, and use public platforms to speak out frequently about the importance of greater male involvement.

Governments should provide a mix of public services and cash transfers to carers of people with AIDS-related illnesses, and ensure that availability and eligibility for grants and services are well publicised to all who need them. Governments should ensure that those infected and affected by HIV/AIDS have access to essential health and household services such as treatment, housing, electricity and running water. Governments should develop and advocate for coordinated public, private and civil society initiatives aimed at increasing men’s support for gender equality.

Departments of Education should implement measures to ensure that children affected by HIV and AIDS have access to high quality psychosocial support at schools and establish strategies to prevent children having to drop out to care of sick relatives. Departments of Health and Education should develop training curricula for teachers’ training colleges, social work programs and nursing programs to encourage men’s greater involvement in care and support in both the formal and informal sector.

**Gender Based Violence**

Research suggests that a range of men’s controlling and violent behaviours, rather than just sexual violence itself, is responsible for women’s increased vulnerability to HIV, as well as a range of other health impacts. This highlights the need to improve the health sector response to forms of male violence against women, including protocols, training and monitoring systems for improved case detection, management and referral. Once again, male leaders within the health sector should play a critical role in this regard, alongside their female colleagues.

It is also important that NSPs acknowledge and respond to men’s own experiences of violence and sexual violence. Recent studies have highlighted disturbing levels of male-on-male sexual violence in prison and other detention facilities, and the extent to which this results from and reinforces male-on-female sexual violence in the community. Steps should be taken to address general levels of violence within a country, as violence amongst males can affect females in a variety of ways. The equation of masculinity and violence needs to be made explicit within NSPs and work planned to address this. The need for men to dominate must be interrogated so that when men are dominated by other men they will not feel the need to then dominate someone weaker than themselves to prove their manhood. In this way, masculinities work with men needs to be expanded to address the roots of violence.

It would be beneficial for a focus on GBV to be integrated into a range of other HIV interventions, such as condom education and distribution strategies, especially the issue of coercive sex. It is important for more research into violence and sexual abuse experienced by boys as a recent study has revealed unexpectedly high levels of sexual violence against boys and young men. More research on child sexual abuse and its complicated gendered dynamics is also needed to understand its impacts on boys’ and men’s sexual attitudes and behaviors later in life, and its effects on their own and women’s sexual health. The role of sexual trauma in men’s sexualities remains poorly understood. NSPs should acknowledge the need to improve the response of the criminal justice system; and concurrently plan multisectoral initiatives to challenge the broader culture of impunity and acceptance of such violence.

A recent study recommends targeted support to households of children who have committed violent crimes, including “sending public health nurses or equivalent professionals to visit the homes of high-risk families, such as low-income families, and those with teenage or unmarried first-time mothers.
to help them with parenting practices, mental-health problems and to address the use of tobacco and alcohol” and “providing adult mentors to provide a sustained caring relationship and role models to youths aged 6–18 who live in single-parent families below the poverty line.” Such targeted interventions are also required to address the nexus of masculinities and inequalities issues that surround young men’s involvement in gangs and the violence they perpetrate.

Research continues to highlight alarming levels of physical and sexual violence in schools. The health sector has an important role to play in partnering with the education sector to support safer schools initiatives, including more work with district education officials, principals and governing bodies to address complicity in tolerating and not reporting such violence.

Violence and the sexual disinhibition that contributes to the spread of HIV/AIDS have both been linked to alcohol use,109 and therefore governments have a role to play in expanding the availability and accessibility of alcohol treatment. Efforts should be made to support conventional and traditional health providers in making appropriate referrals to alcohol treatment services in health sector and community settings.

The importance of involving boys and men within work to prevent GBV must be stressed within NSPs. Their potential positive role as advocates, partners and agents of change within GBV prevention work must be recognised and strategies developed to engage with boys and men around this issue.

**General Recommendations**

The 2007 WHO report, ‘Engaging men and boys in changing gender-based inequity in health: evidence from programme interventions’, recommends inclusion of the following elements to improve the impact of interventions to engage with men and boys:

- Use positive and affirmative messages;
- Encourage men to reflect on the costs of hegemonic masculinity to men and women;
- Be evidence-based – use formative research, ongoing monitoring and evaluation;
- Recognize that men are not homogenous and develop interventions that reflect men’s different life experiences;
- Use an ecological approach that recognizes the range of factors shaping gender roles and relations;
- Use a range of social change strategies – community education, community mobilization, media, policy development and advocacy for implementation.110

**It further suggests that:**

- Policy efforts must be comprehensive and large-scale;
- Policy and programming with men should be framed within an agenda that promotes human rights, including women’s rights;
- The social and structural determinants of gender inequalities and health inequities should be addressed;
- The establishment or consolidation of policies and programmes promoting gender equality should be contributed to;
- The gendered character and impacts of policies and policy-making should be examined;
- Lessons should be learned from policies developed to promote women’s rights;
- Initiatives already being run by NGOs and other players in national policies should be scaled up;
- Men should be encouraged to take responsibility for advocating agendas of gender equality, including policy initiatives for women’s rights;
- Political will needs to be inspired and maintained;
- Affected communities should be involved and their demands acknowledged;
- Existing structures should be used for the implementation of policies;
- Partnerships should be built and work planned, and executed, collaboratively;
- Institutional capacity and expertise needs to be built;
- Civil society capacity to monitor policy compliance and implementation should be strengthened;

**Mainstreaming of men into gender and health policy by:**

- Integrating policies on men and masculinities into policy on gender equality and health equity
- Maintaining dedicated women’s units and measures
- Working with gender and health experts and women’s rights groups
- Integrating policies on men into national gender and health related plans, policies and legislation
- Finding homes for such policies in national departments
- Ensuring that personnel creating and implementing these policies have sufficient authority and resources to achieve desired goals.111
While the need to engage with men and boys in work to prevent HIV and AIDS work and promote gender equality is clear, and the steps that have been taken by a small number of countries to include men and boys within their HIV and AIDS National Strategic Plans are encouraging, progress is still required and work remains to be done.

Strategies that have been outlined need to be strengthened, and work that interrogates and challenges negative masculine norms needs to be developed. The proposed work that has been outlined within NSPs must be monitored and evaluated in order to gauge its effectiveness so that successful interventions can be taken to scale.

“Steps should be taken to address general levels of violence within a country, as violence amongst males can affect females in a variety of ways”

Other countries need to be encouraged to recognize the importance of including men and boys within policy work and program design and implementation, not only for the benefits which will be derived from women but also the need to engage with men in order for gender equality to be achieved. However, an important start has been made, and increased dialogue and collaboration on such issues must be encouraged in order for work to progress in a constructive and positive direction.
APPENDIX 1: ANALYSIS OF NATIONAL STRATEGIC PLANS

2. Rwandan National Strategic Plan 2009 – 2012
5. The Law of Ukraine: The State Program to ensure HIV prevention, treatment, care, and support to HIV-positive people and patients with AIDS for years 2009–2013
13. NACP III To Halt and Reverse the HIV Epidemic in India
15. Nicaragua National Strategic Plan 2006 – 2010
The NSP is within the Priority Areas, Implementation Pillars, specifically Pillar 3: Community based HIV programs. This states that: "Interventions at the community level will also ensure that the root causes of vulnerability are addressed at this level, such as gender relations, beliefs and values around masculinity and femininity." However, there is no further explanation of how this intervention should be structured or implemented or how it will address beliefs and values around masculinity and femininity.116

Prevention strategies
Male circumcision is the primary issue focused on in terms of the specific prevention needs of men and boys within the Kenyan NSP. Medical male circumcision (MMC) is identified as an important, cost-effective prevention tool, which needs to be scaled up to ensure safe and affordable access. While approximately 84% of adult men in Kenya are circumcised, the approximately 17% of men who are not circumcised live in areas with the highest prevalence rates.117 The NSP describes male circumcision as one of the two main determinants of HIV infection.114 The second determinant is identified as the social acceptance of concurrent relationships.

The NSP acknowledges that circumcision presents a serious challenge to health service delivery, with demand currently outstripping supply.119 The NSP commits to prioritising areas and populations with low levels of male circumcision, while nationally it commits to ensuring the practice is made safer.120 However, there is no acknowledgement or discussion around the possible negative effects of MMC, for example the possibility of disinhibition, nor evidence to show that accurate information and education would be provided to recipients.

The NSP’s Planned Interventions specify “Increased Condom Use”, but there is no mention of efforts to target men in order to ensure this takes place. Men’s roles, responsibilities and needs are almost entirely neglected in other sections of the NSP; for example, it is expressed that partner reduction, condom use and delayed sexual debut should be promoted, “particularly among young girls, and youth in general”.121

There is no discussion in the NSP of ways to target and reach men to increase their utilization of VCT services, nor how men can be encouraged to support one another in accessing these services.

PMTCT is the only area within the NSP where men are explicitly mentioned in the context of couples, and a planned intervention proposes: “Couple-based HIV testing, supported by increased male involvement/ couple counseling in PMTCT and by intensive counseling and support groups, to identify discordant couples and motivate them to use condoms”.122 This is intended to address the proportion of men and women aged 15–64 who know their HIV status and to increase the proportion of pregnant women accessing PMTCT services.123

With regard to marginalized men and boys, IDUs, MSM and prisoners are identified in potentially stigmatizing language as groups that “need to be recognized in Kenya as significantly contributing to HIV incidence”.124 While it is claimed that the NSP will strive to work with these groups, the specific ways in which they will be reached is not outlined. Intravenous drug users...
are discussed under the topic of ‘Most At Risk Populations’; it is acknowledged that IDUs will be worked with but it is also mentioned that they account for a small percentage of the population. Men are not identified within this group specifically to be focused on. Men who have sex with men and prisoners are addressed together as one group. The differing needs of these groups (for example, condoms, lubrication or clean injection equipment) are not addressed, but rather they are simply recognized as a group in need of attention given that in 2008 they constituted 15% of new infections.125

The NSP draws attention to the issue of the illegality of homosexuality in Kenya. While the NSP aims to systematically alleviate the constraints that programs working with these groups face,126 there is no mention of efforts to decriminalize homosexuality. Overall, the NSP asserts that all “Most At Risk Populations” are included in the plan and that innovative ways to reduce HIV transmission within these groups will be sought. Refugees are also identified as a vulnerable group, but again there is no discussion on how to address their needs.

**Treatment and care**

The NSP asserts that community knowledge on treatment literacy should be strengthened127 but, unlike women, men are not specifically accounted for and there is no discussion around how men could encourage each other to become more treatment literate.

There is no evidence within the NSP to show that men will be targeted to become more involved in home based care, or the care of orphans and vulnerable children (OVC).

**Gender based violence**

Gender based violence is addressed in the NSP but men’s role men in efforts to prevent GBV is not addressed. The proposed interventions to support populations in need of PEP services, including survivors of sexual and gender based violence, cover the procurement and distribution of PEP kits procurement and distribution; the development, dissemination and capacity building among partners to implement the GBV standard operating procedures; and the development of a GBV information system.128 However, the role that men can play in preventing GBV is not addressed and there is no commitment to reach or engage with men and boys around this key issue.

## 2. Rwandan National Strategic Plan 2009 – 2012

**HIV and gender**

The Rwandan National Strategic Plan for 2009–2012 acknowledges gender equity as integral within HIV and AIDS work,129 and highlights various issues relating to gender inequality, including the negative effects that gender norms can have on men:

> “There is evidence that men living with HIV fail to obtain the same level of support as women, and men are far less likely than women to be members of associations of people living with HIV. Strict gender norms are also the origin of stigmatizing attitudes to sexual minorities, such as men who have sex with men. Programs will address the range of impacts that gender inequality can have.”

However, no detail is provided for how programs will address this range of impacts and there is little discussion on how men can be engaged in work promoting gender equality, or included in efforts to challenge gender norms.130

The NSP asserts that the “empowerment of women is an essential condition to make progress”,131 but in terms of specific issues like gender based violence, negotiation of condom use and family planning, the plan does not address the importance of men’s inclusion in work to empower women or improve their own health outcomes.

**Prevention strategies**

The NSP acknowledges that women’s vulnerability to HIV is linked closely with the behavior and attitude of male partners, stating that:

> “Women will be supported to carry out participatory assessments with their peers in order to assess what puts them at risk for HIV infection and the obstacles they face when trying to protect themselves from HIV. These assessments will form the basis for developing a range of communication, education, skills building, as well as community advocacy activities aimed at challenging norms [including gender norms] that make young women more vulnerable... the findings of assessments carried out in this group will be used to inform and strengthen strategies targeting other relevant population groups [for instance, males in the general population and mobile populations].”

Thus, the only attention afforded to men within prevention efforts is as part of the general population,134 and there are no specifics provided for any interventions to provide for their needs.

In 2007/2008, the percentage of circumcised males aged 15–59 in Rwanda was estimated at 15%. The Rwandan NSP commits to increasing the level of male circumcision, setting a target by 2012 of 50% of men aged 10–19, and 30% of men aged over 20 years.135 In 2007 only 21% of health facilities had staff qualified to perform circumcision, and the NSP aims to increase this to 80% by 2012.136

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Significantly, the NSP acknowledges that while male circumcision is an important strategy in HIV prevention, “reduction in concurrent sexual partnerships and consistent condom use” continue to be important, even for circumcised men, and “that circumcision programs should address the potential for behavioral disinhibition” among men who accept circumcision. The NSP further states that: “Although circumcision will be available to all adult males, voluntary circumcision will be particularly promoted to men with higher risk factors for sexual transmission of HIV.”

While the NSP outlines the need for increased condom distribution and access, there is no mention of men being specifically encouraged to use condoms or of measures to improve men’s access to condoms. However, the NSP does contain plans to utilize mass media communication to encourage the general population to access and use condoms. The plan discusses the use of female condoms and the strengthening of initiatives to “empower women to make decisions about safer sex,” but there is no mention of including men in these initiatives to promote safer sex practices.

The NSP states that in 2006, only 11.3% of men aged 15 to 24 had ever taken an HIV test, but it does not provide plans for encouraging the uptake of VCT among men specifically. Given that 13.2% of men aged 15 to 24 had already had sex before the age of 15 in 2005, it is clear that ensuring VCT centres are male friendly and readily accessible to men and boys should be a high priority.

While men’s role in supporting their partners during PMTCT is acknowledged in passing in the NSP (“Increase male uptake and family approach for PMTCT”), men feature more significantly in discussion around reproductive health:

“Male partners also have an important role to play in ensuring women have autonomy in reproductive health decisions… Increased involvement of male partners of HIV-positive women will be achieved through community-level promotion, through outreach services for HIV-positive women and their families, and through the introduction of couple participation as a criterion for performance-based funding of health services.”

The NSP recognizes the importance of reaching marginalized groups through prevention programs, acknowledging that while “some groups require specially adapted services that respond to their needs…Very few such services are currently available.” As these groups are not “always systematically reached by the broader general population programs”, the NSP considers it important to work with marginalized groups, including MSM, prisoners, migrant workers, people with disabilities, people in uniform and refugees, stating that:

“These activities include measures to ensure active participation of the groups concerned in assessing the barriers and in explaining to decision makers and service providers why it is essential to improve their access to services. In addition, training will be provided to health care personnel and other service providers in order to ensure they have the correct skills and approach to working with these groups. Civil society organizations will be strengthened to carry out these strategies, as they are often better placed to reach out to marginalized groups, in particular when these groups do not trust officials or service providers.”

The Rwandan NSP has made a concerted effort to ensure that prisoners’ needs are accounted for within the country’s HIV and AIDS strategies, recognizing that “there is evidence of sexual activity within prisons, where condoms are unavailable and very rarely used.” The availability of condoms in prisons is limited “because prison authorities deny the existence of sexual intercourse between inmates”. The key strategies to address the needs of prisoners, outlined within Output 1.1.1.4, include: outreach work with prisoners and prison workers including HIV awareness campaigns and anti-AIDS clubs; advocacy with authorities to ensure a supportive environment for prevention with prisoners; extension of testing, HIV and sexual health services to prisoners; and mobile VCT. Within this context, the plan states:

“Addressing sex between men in general, and within prisons, is a new area of work. Operational research will be carried out, and an emphasis will be placed on ensuring MSM are active in the design and implementation of these programs, to ensure that they are carried out in the most appropriate way. A specific activity will be to ensure access to condoms and water-based lubricant for men who have sex with men.”

With regard to refugees, the NSP states that:

“HIV prevalence and risk behaviors are very low in refugee camps, possibly because they are well covered by programs for the most part. It is unlikely that refugees are a major factor in the spread of HIV in Rwanda.”

The NSP does not address the needs of refugees in more detail, but it does commit to maintaining HIV prevention programs for refugees and surrounding communities and plans outreach programs to migrant and mobile workers (such as truck drivers, Moto taxi drivers and fishermen).

The NSP emphasizes that work with MSM in Rwanda is new and that more research is required to improve and adapt the services they access and to determine the contribution of MSM to the national HIV prevalence figures.
The NSP aims to rectify neglect of the needs of this group in previous HIV and AIDS work. It points out that most MSM are not open about their sexuality due to strong cultural resistance, which has complicated research endeavors. It highlights the need for “a novel approach to recruitment and data collection that prioritizes safety, while raising community awareness of the existence of MSM,” and describes research programs aimed at developing comprehensive prevention programs targeting this group.

The NSP outlines a number of such strategies, including peer education programs with training about prevention, information on HIV and STIs, referral for HIV testing, condom promotion and STI diagnosis and provision of ‘friendly’ STI diagnosis and treatment services.

IDUs are mentioned briefly within the NSP. Men are not recognized as a group for specific focus within this category, although plans for a detailed study on youth and drug use to be conducted in 2009 are provided. Other groups of men are also accounted for, such as men in uniform.

**Treatment and care**

On treatment and care, the NSP states that:

“Although access to treatment appears to be fairly distributed between men and women, it is important to document also access to other services to ensure there is no sexual discrimination in service provision between men and women.”

Men are not mentioned in any other discussion of treatment, nor is their potential role in home based care or care for orphans and vulnerable children.

**Gender based violence**

The NSP acknowledges that violence against women is a significant problem in Rwanda, especially during and since the genocide.

“New legislation against gender-based violence is a precondition for ensuring access to justice for women, and will be accompanied by training of judicial personnel, police officers and prison staff on human rights, gender-based violence and the management of cases involving vulnerable and disadvantaged groups.”

The plan provides for ready access to PEP for victims of GBV. It also emphasizes the importance of community outreach efforts to encourage reporting of sexual and gender based violence and the integration of messages against GBV across HIV communication programs. However, there is no discussion of plans to incorporate men into these activities.


**HIV and gender**

The HIV and AIDS and STI Strategic Plan for South Africa acknowledges the importance of issues relating to gender, especially that of female empowerment. It highlights the progress achieved toward gender equity and identifies the challenges that remain:

“Although access to treatment appears to be fairly distributed between men and women, it is important to document also access to other services to ensure there is no sexual discrimination in service provision between men and women.”

“Acknowledging the fact that gender inequality hinders social and economic development, the current government has made great strides towards empowerment of women and gender equality is one of the critical elements of the transformation agenda in the country... Patriarchal attitudes are changing, with men participating in efforts to address challenges such as violence against women... However, the high levels of gender-based violence in the country indicate that a lot still needs to be done in this area... The HIV and AIDS epidemic is clearly feminized, pointing to gender vulnerability that demands urgent attention as part of the broader women empowerment and protection. In view of the high prevalence and incidence of HIV amongst women, it is critical that their strong involvement in and benefiting from the HIV and AIDS response becomes a priority... The fact that the burden of the epidemic falls more on women and girls than on men and boys remains a central challenge to the national response.”

The NSP thus acknowledges that the “deep rooted institutional problem” of the low status of women is a ‘fundamental driver’ of the South African epidemic. It points to the fact that gender inequalities inherent in most patriarchal societies constrain women’s abilities to enact certain decisions in their lives. It further acknowledges that certain “sex-related cultural beliefs and behavioral practices”, as well as certain “cultural attitudes and practices”, play a role in the spread of HIV infection.

However, the NSP does not elaborate on how to accelerate the change in patriarchal attitudes, nor address and transform these beliefs, attitudes and practices. Despite its emphasis on the importance of gender issues, the NSP focuses on work that needs to take place with women, rather than recognizing the importance and benefits of working with men and boys to address gender inequality. While the NSP mentions interventions focusing on the “causes of gender inequality”, work with men and boys is not described nor included within the NSP’s Goals or Priority Areas. In some instances in the NSP negative generalisations are used to describe men and their behavior:

“In particular, male partners either have sex with sex workers or engage in multiple relationships and their female partners or spouses are unable to insist on the use of condoms during sexual intercourse for fear of losing their main
source of livelihood.”

Furthermore, the NSP focuses continually on the “low status of women” as being one of the “deep rooted institutional problems” that drives the spread of HIV, rather than identifying patriarchy. This simple choice of language continues to place the focus on women as opposed to engaging with men. In this regard, it seems significant that gender was not included within the NSP’s primary aims.

**Prevention strategies**

Men are included within the NSP’s Key Priority Area of Prevention in commitments to “accelerate programs to empower women and educate men and women on women’s rights and human rights” and to “Develop and implement evidence based programmes including a communication strategy that provides clear messages on the non-acceptability of coercive sex, addresses gender stereotypes and addresses the stigmatisation of rape survivors.”

The NSP also commits to identifying, evaluating and rolling out “effective gender sensitive male intervention programmes in the workplace and in communities” in order to promote male sexual health and address gender and gender based violence. While this commitment is encouraging, it would be beneficial for further detail to be provided regarding how such programs will address gender stereotypes, or which particular gender norms will be addressed.

Within Key Priority Area 4 Human and Legal Rights, the NSP commits to identifying cultural beliefs and practices that undermine HIV prevention, but does not explain what kind of cultural beliefs these might be or what steps will be taken once they have been identified.

Within Key Priority Area 3: Research, Monitoring, and Surveillance, the NSP commits to supporting the development of prevention technologies, including male circumcision. As the NSP was published in 2007, South Africa now supports a more systematic roll-out of male circumcision and that this will receive more emphasis in the next NSP. This will require that the NSP also addresses the potential negative effects of MMC.

The NSP commits to increasing condom distribution and access, especially in high transmission areas such as truck stops, borders, mines and brothels. The inclusion of such areas will hopefully increase men’s access to condoms, although this is not explicitly stated. While the NSP aims to “increase access to male and female condoms through distribution in formal and informal outlets including the hospitality and entertainment venues” to 90% by 2011, no specific plans are provided for changing men’s attitudes towards condom use.

Within NSP’s Key Priority Area 2: Treatment, Care, and Support, the NSP commits to increasing the number of adults who have ever tested for HIV to 70% by 2011, ‘with a focus on men’, and to increase access to VCT services that recognise diversity of needs.

Within Key Priority Area 1: Prevention, the NSP stipulates the expansion of existing PMTCT services to include contraception fertility services, reducing unwanted pregnancies and involving men, as well as prevention services in uninfected pregnant women. Men are thus mentioned within plans for expanding PMTCT, but the specific ways in which they could be involved in supporting their partners are not encouraging.

The NSP acknowledges the importance of including marginalized groups within HIV and AIDS work as “all these groups have a right to equal access to interventions for HIV prevention, treatment and support.” Thus Priority Area 4 Human Rights, Access to Justice and Law Reform commits to “ensure non-discrimination in access to HIV prevention, treatment and support of marginalized groups”, and by 2008 to “develop and disseminate information on HIV prevention, treatment and support that responds to the special needs of:

- Sex workers
- Children and adults with disabilities
- Drug users
- Prisoners
- MSM, gay and lesbian people
- Orphans and vulnerable children (including children in self-care)
- Refugees, undocumented migrants and immigrants
- Older persons.”

While all prisoners are vulnerable to the risk of HIV infection, male prisoners are particularly so. The NSP provides for an “incremental roll-out of comprehensive customised prevention package in prisons, including access to VCT and access to male condoms.

“Targeted programs are necessary to ensure that refugees and asylum seekers have access to information and services – including prevention, care, support and treatment – as an integrated component of the national response to HIV and AIDS.”

described. The NSP also commits to “Implement responsible fatherhood programmes in health districts and in the community”, which is lubricants, STI symptom recognition and access to PEP and STI treatment” to reach 100% by 2010.
The needs of refugees are included broadly under the commitment to “ensure non-discrimination in access to HIV prevention, treatment and support of marginalized groups”, and the NSF specifically commits to “develop and disseminate information on HIV prevention, treatment and support that responds to the special needs of refugees by 2008.”

“Targeted programs are necessary to ensure that refugees and asylum seekers have access to information and services – including prevention, care, support and treatment – as an integrated component of the national response to HIV and AIDS.”

There is no provision for a focus on the specific needs of men within this group.

The NSF acknowledges clearly the importance of reaching MSM within HIV and AIDS work:

“Biologically, MSM who practice receptive anal intercourse have an elevated risk for HIV infection. MSM practices are also more likely to occur in particular institutional settings such as prisons, often underpinned by coercion and violence. MSM behaviors and sexualities are wide-ranging and include bisexuality, and the HIV epidemic amongst MSM and the heterosexual HIV epidemic are thus interconnected.”

The plan commits to an "Incremental roll-out of comprehensive customised prevention package for MSM and transsexuals including promotion of VCT and access to male and female condoms, and STI symptom recognition" to 100% of services by 2011. It may be difficult to monitor the implementation of this commitment as no details are provided about the services, and there is no information provided on how (outside of prisons) MSM will be reached.

Drug users are also mentioned within the NSF’s commitment to reach marginalized groups, and it is acknowledged that: “There are heroin detoxification programs available in the country, but no formal needle exchange programs exist”. It is also acknowledged that: “The extent of intravenous drug use in South Africa is under-researched, mainly because of the legal environment and stigma associated with this behavior.”

**Treatment and care**

Within the Priority Area of treatment, care and support, the NSF states one of its goals as to “address the special needs of women and children”. There is no specific focus on encouraging treatment literacy among men or interventions to encourage men to access treatment.

Within the Priority Areas and the goal outlined of mitigating the impact of HIV and AIDS and creating an enabling social environment for care, treatment and support, one of the aims is to “Recruit and train new community care givers, with emphasis on men”. The target for 2010 is 25,000 people trained of whom 20% should be men. Within the body of the NSF, however, men are not mentioned during discussions relating to home based care.

**Gender based violence**

Within the key priority area of Prevention the NSF commits to developing a "comprehensive package that promotes male sexual health and which addresses gender and gender-based violence", as well as introducing "programs and strategies to address stereotype gender identities that contribute to gender-based violence". The ways in which these gender stereotypes will be addressed is not described. More detail is needed in this respect to demonstrate which gender norms are being referred to, and how they will be engaged with. Gender based violence is mentioned on numerous occasions, but the role that men can play in preventing GBV is not raised or discussed.

**HIV and gender**

The Pakistan National Framework (NSF) does not address the issue of gender substantially, and there is no discussion of gender equality nor work with men and boys. The NSF identifies denial, socio-cultural barriers prohibiting discussion of sexual health matters and low levels of condom use as constraints to HIV and AIDS work in the country. While it does acknowledge that HIV/AIDS is a development issue requiring a broad, multi-sectoral response that addresses both the “dynamic web of underlying causal factors of HIV and AIDS as well as its equally complex consequences”, the NSF does not outline work to address these underlying causal factors.

HIV prevalence in Pakistan remains concentrated amongst the IDU, MSM, trans-gender and sex worker populations, although the NSF does acknowledge the potential for it to spread rapidly to a full-blown epidemic through bridging populations if key risk factors are not addressed. These include low levels of literacy, widespread myths and misconceptions, a large drug-using population, a well-organized and established sex industry, inadequate data on HIV and AIDS and inadequate blood screening facilities. With regard to HIV prevalence and gender, the NSF states that: “Pakistani women in general have lower socioeconomic status, less mobility and less decision-making power than do men, all of which contributes to their HIV vulnerability.”

However, there is little evidence within the NSF of efforts to address the issue of women’s lower status in society or of opportunities to include and engage men in working towards gender equality. In addition, assertions such as the following, “Research the types of social services that would complement health services and help extend the...
reach to more women, children and youth who are at risk” illustrate that men are unlikely to be targeted in work that addresses gender.

The NSF commits to “establish a cadre of professionals with the requisite skills in HIV and AIDS … through the preparation and implementation of a national training program [HRD Plan] for HIV and AIDS”, with the aim of developing in-country capacity through the “training of trainers”. This training is aimed at “upgrading the knowledge and skills required to deal with issues related to stigma and discrimination, gender, and empowerment”. In addition, the NSF commits to developing and implementing “a uniform national school curriculum with respect to sexual and reproductive health education including HIV and AIDS and STIs”. However, it is unclear if the interrogation of gender norms would be included within such a curriculum.

**Prevention strategies**

Male circumcision is not raised within the Pakistani NSF. With regard to condom use, it is acknowledged that work is needed to encourage this and the NSF commits to “mediate to resolve the differences between MOH [Ministry of Health] and MOPW [Ministry of Population Welfare] that have so far restricted condoms from being promoted as infection protection devices”. It is also acknowledged that promoting the use of condoms will require the increased availability of lubricants. There is no mention of any plans for encouraging condom use and access amongst men specifically. Men are not recognized as a group requiring specific focus in efforts to encourage uptake of VCT services, and PMTCT is not addressed within the NSF.

The NSF makes provision that all most-at-risk populations (MARP’s) will have access to a minimum package of health services. These include primary healthcare services, the syndromic management of STIs, condom provision and promotion, access to voluntary counseling and confidential testing (VCCT) services, referral for ARV therapy, care and support, behavior change communication (BCC) services, peer educator/outreach services, advocacy with major stakeholders, empowerment activities and life skills training. The NSF also commits to interventions to develop capacity to deliver quality services through the use of a standardized user-friendly curriculum to train NGO service providers and staff, peer educators and outreach workers, in the management of STIs, VCCT services, BCC techniques, advocacy and reproductive health issues.

With regard to marginalized groups, the needs of IDUs, MSM and prisoners are specifically addressed within the NSF, which commits to “examine and recommend to Government policies on controversial issues including... distribution of needles and condoms in prisons”; and to “include VCT, promotion of safer sexual practices including condom provision and implement harm reduction interventions in prisons”. The plans do not cover providing prisoners with lubricants, but this issue is addressed in other areas of the NSF. In addition to the generic list of services available to MARPs, MSM will also have access to water-based lubricants and drop-in centres.

The NSF commits to “examine and recommend to Government policies on controversial issues including... substitution therapy and ART for IDUs, thus committing both policy and resources to support NGOs that operate needle syringe exchange programs with IDUs. In addition to the generic list of services available, IDUs will also be able to access needle exchange services, substitution services and drop-in centres (static and mobile), and specific support group interventions will be designed for the wives of IDUs.

Refugees are not addressed within the NSF, and migrant workers are excluded from access to the services available to other MARPs. Instead, they are accorded a package of IEC materials and a brief two- to three-hour orientation session on transmission, protection, safer sex and STIs. Specific support group interventions will also be designed for the wives of migrant workers.

**Treatment and care**

Men are not identified with regard to treatment literacy or increasing the uptake of ARV treatment. Home based care is not addressed within the NSF.

**Gender based violence**

The NSF does not address the issue of gender based violence.

5. The Law of Ukraine: The State Program to ensure HIV prevention, treatment, care, and support to HIV-positive people and patients with AIDS for years 2009–2013

**HIV and gender**

Ukraine has a concentrated HIV epidemic, with IDUs considered the “main factor of HIV infection spread”. The State Program document attributes the growing number of AIDS patients to a “decline in public morals”; a mismatch between the pace of health and social infrastructure development and the rate of epidemic spread; inadequate financing of prevention and treatment activities; and an inadequate system for public information and awareness on HIV prevention. Gender inequality is not identified as an issue contributing to the spread of HIV spread in Ukraine, and neither gender equality nor work with men and boys are explicitly addressed within the Program.

**Prevention strategies**

In terms of prevention strategies, the Program states the importance of “information and awareness campaigns and public service advertising that: are based on respect to human rights and dignity; promote traditional, spiritual, moral, ethical, cultural values and
responsible behavior – with active use of mass media and web networks”. It is unclear what is meant by “prevention services” as condoms are not referred to at all; male circumcision is not addressed; and men are not focused on in terms of increased condom access, involvement in PMTCT, or increased uptake of VCT services. The Program appears to focus predominantly on ensuring that testing is accurate.

Although the program commits to training 42,900 teachers in “HIV and AIDS prevention and in healthy lifestyle promotion for general education institutions of all types” and “providing up-to-date information and methodological materials” by 2013, the content of such training is not spelled out.

Much of the work described within the State Program focuses on vulnerable groups including “IDUs; prisoners and those released from prison; persons selling sex; migrants; homeless and care-deprived citizens [in the first place, children], including those from socially disadvantaged families”. The Program commits to carrying out 12 behavioral surveys on vulnerable groups and HIV sentinel surveillance between 2009 and 2013.

The program commits to reaching 60% of prisoners with HIV “prevention services” by 2013, ensuring “free of charge access to HIV counselling and pay-free testing for prisoners”, ensuring laboratory support for ART, Substitution Maintenance Treatment, prevention, diagnostics and treatment of opportunistic infections in HIV-positive people imprisoned or in pre-trial detention; and to creating infectious disease departments for treating HIV-positive people and patients with AIDS in penitentiary settings. However, as there is no detailed explanation provided of what prevention activities involve it is difficult to ascertain the impact of such interventions in catering for the specific needs of prisoners. The Program also commits to carrying out “activities aimed at preventing spread of HIV infection among the military”. Migrants and refugees are included within the category of vulnerable groups and will therefore have access to “prevention services”, but there is no evidence to show how services will be tailored to meet their specific needs. Given that IDUs are regarded as the main source of HIV infection in the Ukraine, they are afforded a clear focus within the Program, with a commitment provided of ensuring “access to SMT and rehabilitation programs for no less than 20 thousand IDUs”. The Program also sets a target of providing social services to 60% of IDUs with “provision of sterile disposable medical supplies of domestic origin and means of personal protection” by 2013.

**Treatment and care**
Men are not specifically included in any discussion around treatment and home based care is not addressed.

**Gender based violence**
Gender based violence is not addressed within the Ukraine State Program.


**HIV and gender**
The National Strategic Plan (NSP) for Papua New Guinea raises gender equality explicitly and outlines various ways in which inequality contributes towards the spread of HIV:

“The generally low status of women and the special health risk they face as well as sexual violence places them at a higher risk of HIV infection…Common to the many cultural groups is gender inequality that is expressed through the dominance of men in family, clan and community decision-making…The churches have played a significant role in social change in Papua New Guinea …but have been unable to change entrenched gender relations.”

The NSP highlights various ways in which women are made more vulnerable to HIV, often as the victims of men’s violent aggression and coerced sex. PNG has one of the highest maternal mortality rates in the world; women have a lower literacy rate than men; women are generally infected at a younger age than men; they have limited employment opportunities; and may struggle to access information regarding medical services or support services. Due to economic difficulties, some women resort to trading sex for money, transactions which are on occasion even brokered by male relatives.

Unfortunately, the Plan does not focus on how the work proposed can engage with these issues and attempt to change gender norms, or how men and boys can be engaged within any of the stated strategies or goals. In assessing the work done around HIV and AIDS in Papua New Guinea between 2001 and 2003, the NSP claims that these campaigns “stimulated discussion of AIDS and the sensitive issues of sex and condom use as well as challenging the acceptance of gender roles and gender related violence”. However, without any further detail provided it is difficult to confirm this, and the current NSP contains no reference as to how to address gender roles and gender related violence.

The NSP commits to conducting research into social behavior in order to understand “local social and cultural dynamics that could be used to achieve positive changes in behaviors that
constitute a risk to HIV infection”,239 which could identify clearer ways to challenge gender norms.

The plan encourages politicians and leaders at all levels of society to give a high profile to HIV and commits to “Support strategic advocacy at all levels of leadership, including local, traditional leaders and women”.240 However, there is no mention of plans for engaging men to accept women moving into positions of leadership.

The NSP asserts that gender-based strategies need to be identified for reaching high risk populations and marginalized groups, including MSM,241 but details of such strategies are not spelled out.

“almost four times more likely than men to be among the newly infected; with 40% of new infections among monogamous women”.

Prevention strategies
In terms of plans to increase awareness about prevention among the general population, and to facilitate and sustain behavior change in specific populations, the NSP suggests the implementation of special advocacy and education programs targeted to particular groups, with men included as a specific group.242 Unfortunately, no details of such programs are provided and therefore it is unclear how men are to be targeted and reached.

Male circumcision is not addressed in the plan. The promotion of condoms is acknowledged as an integral part of prevention efforts and the NSP aims to make condoms widely available and accessible and to promote their appropriate use.243 However, ways to increase the use of condoms by men are not mentioned. The NSP acknowledges a severe lack of VCT services in the country at the time of publication, and commits to “establish at least two sites for VCT services in each province that are easily accessible to people by 2008”.244 There is no provision for reaching men specifically in plans to encourage an increased uptake in VCT services and the role of men in supporting their partners is not included in discussion of PMTCT services.

Marginalized groups are afforded scant attention within the NSP for Papua New Guinea. Despite general commitments to implementing special advocacy and education programs with particular groups (including sex workers, MSM and people living with HIV) that aim to reach all at-risk groups,245 specific relevant preventative services are not described and no specific targets are set. Prisoners, IDUs and refugees/migrants are not mentioned within discussion of marginalized groups.

Treatment and care
When the NSP was published ARV drugs were not widely available in Papua New Guinea, “other than at high cost to a few people treated by private practitioners”.246 The NSP set a target for access to ARV treatment for 25% of the population by 2008.247 There is no specific target set for reaching men but it is acknowledged that it would be beneficial to have gender-specific sexual health services.248 Men are not addressed in discussions related to home based care.

Gender based violence
While the NSP acknowledges that patterns of male sexual behavior are determinants of vulnerability, along with “a high incidence of rape, lineups or pack rape, sexual assault, and weak law enforcement”.249 there is no evidence of work specifically aimed at dealing with these issues.


HIV and gender
With one of the highest rates of HIV infection in its region, Cambodia is also one of the few countries in the world that has demonstrably reversed their HIV and AIDS epidemic: “Between 1997 and 2003 the prevalence of HIV in the adult population fell from 3.0% to 1.9%.”250 However, the epidemic is generalizing from populations associated with commercial sex workers to couples and their children, and women are currently “almost four times more likely than men to be among the newly infected; with 40% of new infections among monogamous women”.251

The Cambodian National Strategic Plan for a Multi-Sectoral Response acknowledges the importance of addressing gender inequalities within HIV and AIDS work:

“Gender, development, and the HIV and AIDS epidemic are inextricably connected and this connection is particularly apparent in Cambodia. Women and girls are more vulnerable to infection biologically and because of their lower status in the family and the society. Gender inequalities need to be addressed for the national response to be truly effective.”252

While gender is utilized to explain why women bear the brunt of the disease, it is not highlighted that work with men could contribute to addressing gender inequality. As a result work with men and boys is not incorporated into the NSP.

Prevention strategies
The NSP focuses on what are defined as vulnerable groups or high-transmission environments, such as MSM or commercial sex networks. It commits to addressing these populations, as
well as the general population, through health services including preventive counseling, PMTCT, STI management, blood safety and condom programming; along with the educational system, arts, media and other means. Notably, men are not mentioned as a target group in terms of prevention strategies. While the NSF acknowledges that “sexual networking is shifting towards casual sex with sweethearts, with whom condom use is much lower” and that “an increasing proportion of new infections occur in the partners of infected men and their children”, the potential to use work with men to address these issues is ignored.

Male circumcision does not receive attention in the NSP. However, the NSF does acknowledge the need to scale up condom distribution, along with addressing negative attitudes towards condom use. The plans sets targets for 2010 of selling 25 million condoms annually, and ensuring 5% of married women report consistent condom use. The Plan also commits to promoting “negotiation skills and safer sex behavior, including consistent and correct male or female condom use, among married couples” implying that women may be the chief focus of such interventions. The NSF also commits to “using the media and arts effectively to increase awareness and contribute to behavior change, including normalizing condoms and their use for dual protection”.

The NSF commits to promoting the uptake of VCT services amongst the general population, as well as among specific populations such as commercial sex workers and married couples, but again a focus on men as a group is not specified.

PMTCT is identified as a weakness within the national approach to HIV and AIDS in Cambodia. Although the NSF commits to improving this, there is no mention of encouraging men to support their partners through the PMTCT process.

Marginalized groups are addressed within the NSF, which commits to “increase coverage of targeted interventions” for such groups, and specifies that such services should be “non-judgmental and non-discriminatory”. It outlines plans to “develop effective prevention strategies for newly emerging vulnerable groups”, including the military and police personnel.

While prisoners are briefly addressed by the NSF through the scaling up of “prevention activities for people in institutional settings [e.g. prison, orphanage, rehabilitation centre etc.]”, their particular set of needs are not adequately provided for.

The NSF sets a target of reaching 60% of mobile and migrant populations with outreach interventions and scaling up of prevention activities aimed at these populations. However, the specific needs of men among these populations are not mentioned. The NSF commits to developing targeted materials and scaling up prevention activities for sex workers and clients, MSM and street children, through ensuring access to condoms and lubricants, promoting correct, consistent condom and lubricant use for all sexual encounters, encouraging uptake of VCCT (including child-centred VCCT services) and access to appropriate STI services, as well as establishing coordination mechanisms and networks among sex workers, MSM and street children. Interestingly, it is also stipulated that interventions with other high-risk men be identified and initiated. The NSF commits to scaling up prevention activities for substance users, and to ensuring that 60% of IDUs are exposed to HIV prevention interventions by 2010.

**Treatment and care**

Men are not included in any discussions of treatment or home based care.

**Gender based violence**

Gender based violence is not addressed within the NSF.
However, this language is not translated into sufficient concrete examples of work to be conducted specifically with men and boys to address these issues. While it outlines a few instances of plans for work focusing on men, or addressing men as a discrete group, none of these interventions explicitly challenge gender norms.

The plan recognizes that wider societal involvement is needed to reshape cultural norms relating to risky sexual behaviors and makes commitments to implement such interventions. Gender norms are acknowledged as a strong factor preventing people from adopting safer behavior patterns, and the “Behavior Change Communication (BCC) strategy is one of the National HIV/STI Program’s chief prevention tools.”

“Individuals who influence the cultural norms have to be engaged in creative and rewarding ways to use their influence to create a shift in the cultural norms”

Given the many influences that glamorize risky behavior patterns, including the mass media, the Internet and the entertainment industry, the NSP suggests that “Individuals who influence the cultural norms have to be engaged in creative and rewarding ways to use their influence to create a shift in the cultural norms.” Exact details of strategies to encourage behavior change in relation to gender roles are not provided. It is not explained how influential individuals will be persuaded to become involved, and there is no guarantee that people occupying such positions will agree with the messages required to transform gender roles.

Prevention strategies

The NSP identifies various challenges in terms of prevention and commits to ensuring that 65% of men and women are able to identify correct prevention methods by 2012.

Male circumcision is not addressed in the plan. With regard to condom use, the NSP sets a target of ensuring that 80% of men and 75% of women aged 15 – 24 years report the use of a condom at last sex with a non-regular partner by 2012. It is unclear why condom use with regular partners is not similarly emphasized. The plan also commits to increasing the rate of condom use amongst ‘at risk’ groups (MSM, sex workers and adolescents), although it sets a low target of an increase of only 10% in condom use amongst MSM by 2012.

Various strategies are described within the NSP to increase access to condoms and usage skills, including “partnerships with party promoters and condom marketers.” This should enable men to access condoms more readily, although men are not specifically mentioned in regard to this intervention.

The plan acknowledges a lack of support from “political and other high-level leaders for messages and interventions dealing with risk reduction and increased access to treatment and care targeted to certain at-risk groups” including MSM and male prisoners. “This translates to a political environment that offers minimal support for any policy position or law reform seeking to increase access to condom use and treatment for such at-risk groups”, despite higher HIV prevalence levels among such vulnerable groups than among the general population.

In 2005, there were 5,000 people incarcerated in Jamaica. Sodomy is illegal and thus prison authorities are not in a position to consider access to condoms for inmates, although they acknowledge the high risk of HIV. Warders and inmates are part of an ongoing education and health program using creative and cultural approaches to HIV and AIDS knowledge and skills building, including performing arts and peer education. The NSP aims to reach 3,000 inmates by 2012.

While the NSP asserts the rights of MSM to access prevention, treatment and care, it also acknowledges that the “intolerance of male same sex relations impedes prevention interventions” among MSM, increasing their vulnerability to HIV, while simultaneously impeding access to treatment and care. Stigma also contributes to the denial of risk and casts doubt on the accuracy of surveillance data. Work that is proposed to address these concerns includes peer education, condom negotiation skills, building self-efficacy, increasing condom access and surveillance of MSM to provide more information related to behavior patterns. To date it appears that NGOs have been responsible for...
catering for the needs of MSM. The NSP stipulates a target of 8,000 or 6,600 MSM to be reached by 2012, the meaning of the two different figures is unclear. Despite attempts to provide for the needs of MSM in the NSP, much progress is needed in terms of addressing discrimination. IDUs are addressed briefly within the NSP. It is claimed that interventions with this population should focus on addressing addiction as well as the immediate issues of practicing safer sex through improving access to prevention methods.

Treatment and care
During discussions about treatment of transmission, but guarantees privacy and confidentiality of all information during testing, treatment and care. The NSP notes that a sharp reduction in infection among IDUs, haemophiliacs and blood and blood derivatives recipients but “a sharp rising trend in the populations of heterosexuals and homo/bisexuals”. Despite this trend, the NSP does not address the issue of gender other than to mention that the “position of women in a transition society is very unfavourable and, due to the considerable number of factors [cultural, economic, legal], adversely affects the possibilities of protection against HIV”. 

Prevention strategies
Until 2005, no comprehensive HIV prevention program had been established within the Serbian health system. Male circumcision is not addressed within the 2005 Serbian NSP. The NSP cites the latest research on the sexual behavior of young people, showing that among 87% of young people who were sexually active, only 34% had used a condom. The NSP outlines plans to promote condom use through implementation of economic incentives for condom distribution and sale; support for the social marketing of condoms; and development of educational programs for responsible family planning, including the use of condoms. There are no plans specifically targeting men in condom promotion campaigns, besides plans to distribute condoms to the military and promote their use.

HIV testing in Serbia is extremely low. In 2005, the average figure for HIV testing was 2.7 per 1,000. The NSP recognizes that measures must be taken to improve uptake of VCT, but there is no mention of men in these discussions. Mother to child transmission is cited as the third leading mode of transmission in Serbia, but is described as extremely rare with “31 cases or 1.7% of the total number of HIV registered”. There is no provision for inclusion of men in PMTCT-related activities.

The NSF outlines plans to conduct seroprevalence surveys amongst vulnerable populations, including MSM and prisoners, but refugees are not specifically addressed within the plan. Prior to 2004, little was known about prison populations. It is acknowledged that prisoners are an especially vulnerable group in terms of the spread of HIV. There are plans for educational programs among prison staff and prisoners to raise awareness about the risks of transmission and the need for prevention measures of HIV and STIs. However, there are no plans outlined to cater for the needs of male prisoners, such as the distribution of condoms and lubrication.

Despite the fact that HIV has to be reported, along with the mode of transmission, there are cases where the mode of transmission is unknown. It is reported that the majority of this group are men, who are assumed to be MSM. The NSP therefore asserts that “it is necessary to make additional effort to have this group destigmatised and educated”; “information regarding MSM is very scarce due to high levels of stigmatization experienced”.


HIV and gender
HIV prevalence in Serbia is growing, and it is suspected that rates are in fact far higher than reported, with the number of women infected growing. In 1991, the ratio between male and female HIV-positive people was 5.7:1 and in 2005, the ratio was 2.5:1. The chief mode of transmission is through blood transmission, predominantly amongst intravenous drug users, although this seems to changing. The NSP stipulates that HIV infection has to be reported, along with the mode

literacy, ARV uptake or home based care in the Jamaican NSP, men are not addressed specifically.

Gender based violence
The NSP does not discuss if men can play a role in preventing gender based violence.

Appendix 1: Analysis of National Strategic Plans
National Strategic Plans on HIV and AIDS in five global regions

Appendix 1: Analysis of National Strategic Plans


HIV and gender
Liberia is experiencing a low-level and generalised epidemic, with an overall higher HIV rate among women (1.8%) than among men (1.2%). The National HIV Strategic Framework (NSF) states that: “The difference in HIV rates between women and men is particularly strong in the younger age groups, with HIV rates among women three times higher than among men in the 15–24 year age group,” but acknowledges the scarcity of reliable HIV data in the country.

While it is acknowledged that little research has been conducted into the drivers of the epidemic in Liberia, gender inequality is recognised as one of the underlying causes of HIV spread. While the NSF asserts that gender must be mainstreamed across all areas of HIV and AIDS work, it is evident that ‘gender’ often implies issues relating to women:

“Gender plays a cross-cutting role in all these factors, leaving women – in particular young women and girls – especially vulnerable, as is evidenced by HIV rates.”

The NSF focuses strongly on issues of gender and gender equality. It also includes extensive discussion around GBV and the levels of transactional sex which take place within Liberia. While women are the predominant focus within the NSF, there is an encouraging focus on the need to include men and boys. The role that masculine norms can play in the spread of HIV is raised, and the need to engage with men and boys around HIV issues is clearly recognised:

“The same social and cultural norms and expectations that result in women’s disempowerment and [economic and social] dependency on men, lead boys and young men to accept the [dominant] gender roles that they learn through traditional and ‘post-conflict’ socialisation processes... In this context, strengthening HIV-prevention efforts and protecting women from sexual and gender-based violence requires changing the prevailing gender and sexual norms and attitudes. This cannot be done by focusing on [young] women alone, but this requires the active involvement of men and boys in HIV-education efforts and vocational training in school and out-of-school settings.”

While women are overall more vulnerable to HIV, male clients of sex workers are also at high risk. [Potential] clients of sex workers include mobile men who often spend time away from their families, such as truck and long-distance bus drivers, soldiers and UN peacekeepers, businessmen, and small miners. They form a key bridge platform to engage with and challenge broader gender norms.

Men are addressed as a discrete group, as the clients of sex workers:

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According to the 2007 Liberian Demographic Health Survey, "women are far less likely than men to report having had two or more sexual partners in the last 12 months [7% for women and 21% for men]. Similarly, 33% of women against 52% of men who had had sexual intercourse in the previous 12 months reported having had higher-risk sex." The NSF also stresses the importance of addressing gender differences in programs and services for prevention, treatment and care, and of offering women and men services that are "tailored to their needs and situation". 
While it is encouraging that the NSF emphasizes the active involvement of men and boys in HIV-education efforts, and recognizes that men often form bridge populations and engage in riskier behavior patterns than women, very little specific work with men or boys is outlined. The development of innovative and effective strategies to address the needs of men and boys, and to encourage them to play a role in promoting gender equality, is required.

The NSF states that “workplace programs in Ministries and the private sector need to be reinforced to effectively reach men with higher HIV risk, such as military and border guards, truck drivers and other men with a regular income, who may engage in paid sex”. It is recognized that “workplace programs are particularly useful for reaching men who are more difficult to reach through reproductive health-care services”. Such programs need to be expanded due to the increased risk associated with mobile occupations and the fact that “a regular salary – which is rare for many Liberian men and women – as well as work-related status and power increase the chance of seeking sexual services in exchange for money or favours”. While these programs will provide condom dispensing units, and the promotion of know-your-status campaigns and mobile VCT, the specific messages to promote behavior change are unclear. However, it is encouraging that the NSF acknowledges the need to reach men through alternative strategies and routes.

**Prevention strategies**

Men in high-mobility occupations often buy sex from sex workers. According to the NSF, this group has not been reached effectively to educate them about the risk associated with this behavior:

“A negative effect of HIV educational campaigns is that they have resulted in men buying less sex from overt, professional sex workers – particularly those working in brothels or other sex work establishments – and more from less obvious sex workers, who are perceived as lower risk, but with whom condom use is much lower.”

“Effective IEC/BCC programs need to be tailored to the specific information needs of different groups, using a mix of mass media and interpersonal communication ... in addition to promoting individual knowledge and behaviors, IEC/BCC programs will also focus on community and social norms, e.g. to address sexual and gender-based violence”.

The NSF provides a detailed workplan, committing to training 3,500 male and female peer educators from public and private workplaces to provide IEC/BCC by 2014.

Male circumcision is not addressed within the NSF and condom use in Liberia is very low. Despite findings that show that many people are aware of where to access condoms, the NSF recognizes that: “The availability, accessibility and proper condom education still needs more attention”, especially within communities; and that condom distribution continues to lack coordination. It is also acknowledged that it is often difficult for women to negotiate condom use due to their economic dependency on men, or fear of violence.

“To reach these young women as well as unemployed young men and boys (9) multi-purpose youth centres will be established to facilitate peer outreach activities for out-of-school youth with life-skills-based education, counselling on sexual and reproductive health and livelihood skills, as well as condoms. Messages will emphasise delay of sexual debut, partner reduction, and consistent condom use.”

“Private companies will be encouraged to place condom-dispensing units in the workplace, and provide free condoms to mobile employees (e.g. drivers, military)”.

Peer educators from all MARP groups will be trained to distribute male and female condoms among their peers. The location of condom dispensing units at workplaces will increase access to condoms, and peer outreach activities will encourage young men to utilize condoms. There are no explicit plans to address the issue of condom negotiation.

The NSF found that knowledge on various aspects of HIV transmission is low to very low among different groups within Liberia, and emphasised that:

“The effectiveness of IEC/BCC [Information, Education and Communication/Behavior-Change Communication] interventions was hampered by the absence of a clear, coordinated BCC strategy, and the failure to tailor IEC messages and methods to the information needs of different population groups. Most messages focus on the most basic facts, while failing to take socio-cultural norms and practices into account.”

The NSF states that while behavioral studies have not taken place among vulnerable

Peer educators from all MARP groups will be trained to distribute male and female condoms among their peers.

The NSF will use community mobilization and mass media campaigns to “sensitize pregnant women and their partners on the availability of PMTCT-Plus services”, but beyond that it is not specified how men will be encouraged to become more involved in PMTCT and support their pregnant partners.

With regard to marginalized groups, vulnerable groups are addressed fairly thoroughly within the NSF, with most attention focused on sex workers. The NSF states that while behavioral studies have not taken place among vulnerable
groups, “Smaller qualitative studies and assessments among these groups have, however, allowed identifying their specific risks and vulnerabilities, and developing specific HIV interventions that meet their needs”. 364 However, none of the plans for such work address needs specific to men, although it is acknowledged that more research among specific groups is a priority and that the “results of these different studies and assessments will be used to tailor key HIV-prevention services to the specific needs of these different groups”.365

The NSF considers prisoners as an important target group for HIV and AIDS work, especially as “After their release from prison, former prisoners may transmit HIV to their wives and other female sexual partners”. 366 The difficulties of effective HIV prevention work with prisoners is recognized due to the “lack of access to HIV/STI education, condoms, and the strong stigma and social rejection surrounding MSM – especially since most prison inmates engaging in sex with men do not self-identify as homosexual”.367

While the NSF commits to conducting more research in this area,368 and to strengthening HIV prevention efforts in prisons, no specific plans are outlined.

The war in Liberia created hundreds of thousands of refugees and internally displaced persons (IDPs),369 and thus it is appropriate that refugees, internally displaced people and labour migrants are acknowledged as a vulnerable group within the NSF.370 Although no research has been conducted on HIV prevalence amongst refugees, IDPs and migrants workers within Liberia, various groups have implemented interventions with this group.371 The NSF commits to conducting research to identify the specific characteristics, risk and vulnerability of key MARP and vulnerable groups, including mobile populations.372 However, the specific needs of men within this grouping are not included.

There is limited data available on MSM in Liberia but research suggests that HIV rates could be as high as 25% among this group, who are described in the NSF as an “extremely marginalized population, who often marry and end up living ‘double’ lives as a result of social pressure”. 373 The NSF notes the needs for more research into the behavior patterns of certain at risk groups, including understanding the scope and nature of MSM culture in the country.374 The NSF notes the concern among MSM about their lack of fundamental rights, and affirms the importance of encouraging more openness on MSM and HIV, and legislation to protect their basic human rights.375

The NSF recognizes the difficulty in targeting and reaching MSM with interventions due to the degree to which they are ‘closeted’. The Framework recommends that: “research is also needed to provide more insight into the nature of sexual dynamics and networks among MSM, who constitute a potential bridge group, as they engage in high-risk [anal] sex with men, as well as with wives and other female sex partners”. The findings of such studies will reveal more effective ways to reach MSM with education, for example, “through anonymous and safe media such as internet-based services”.376

The NSF does not address the issue of IDUs at all.

Treatment and care
There is no specific attention paid to men as a group within discussions pertaining to treatment or home based care in the NSF.

Gender based violence
Gender based violence was widespread during the conflict377 and remains a major problem. The NSF recognizes that GBV is not unique to conflict situations, but is deeply rooted in traditional thinking about gender roles by men and women alike. This is illustrated in the following quotes from two participants in a focus group discussion on the topic [Barh, 2001]:

[man] ‘As heads of homes, men have the right to take decisions regarding when to sleep with their wives and the number of children to have.’
[woman] ‘Men make decisions and should have authority. Women are there to procreate, raise decent children and lend support to their husbands”378

The NSF commits to focusing on community and social norms in order to address issues such as sexual and gender-based violence, amongst others, through IEC/BCC programs. However, beyond this commitment the NSF does not offer concrete plans for engaging men in playing an active role in preventing nor reporting GBV.


HIV and gender
The Cote D’Ivoire National AIDS Strategic Plan 2006–2010 acknowledges the importance of gender equality within an approach to addressing HIV and AIDS, but contains little focus on how to engage men and boys and the role they can play in achieving gender equality, reducing the spread of HIV and AIDS and preventing GBV.

Prevention strategies
The NSF does not mention circumcision. With regard to condom usage, the NSF’s Planned Interventions specifies a targeted increase from 40% to 50% of men using male condoms correctly, and a target of 5% of sexually active women using female condoms correctly. There are plans to promote the use of both male and female condoms in various targeted groups to achieve these targets.380 Research from 2005 showed that only 12% of women and 30% of men used a condom during last sex.381 The target for 2010 was to reduce new infections to at least 25% by promoting and encouraging the correct, consistent use of condoms.382

With regard to VCT, there is no mention in the plan of how men can be targeted to increase their utilization of these services nor how men could be encouraged to support each other
in doing so. There is also no mention of how men can support their partners through PMTCT services.

Migrants and refugees are mentioned in the plan, but not in the category of marginalized groups. While the NSP reports that 26% of the national population are immigrants from Burkina Faso and Mali, it does not specify their gender. According to the plan, 34% of migrants from rural areas do not use condoms at all.

Intravenous drug users are acknowledged as a group that should be worked with, although it is mentioned that they constitute a small percentage of the population. Within this group, men are not identified for any particular focused work. There is no mention of MSM nor prisoners as marginalized groups, and thus no particular attention is paid to addressing their specific needs in terms of HIV prevention. The NSP does not bring attention to the issue of GBV.

“Male circumcision is almost universal in North Sudan, and is cited as one of the reasons why HIV prevalence remains low despite low levels of HIV knowledge and condom use. The NSP does not provide any plans to ensure that men who are circumcised understand that this does not mean they are immune to HIV infection”

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**Treatment and care**

The NSP does not contain any discussion around promoting treatment literacy or support among men, nor ways to promote men’s engagement in home based care or the care of orphans and vulnerable children.

**Gender based violence**

While the NSP acknowledges the importance of gender equality and raises the issue of GBV, it does not address the role of men and boys in reducing the spread of HIV and AIDS and preventing GBV.

(GoNU) was established, providing more autonomy to Southern Sudan as the Government of Southern Sudan (GoSS). This strategic plan guides the implementation of the national response to HIV and AIDS in Northern Sudan.

In 2009, Sudan’s HIV prevalence level was 1.12%, with 0.67% prevalence in Northern Sudan, estimated to be concentrated amongst high risk populations. The NSP includes female sex workers (FSWs), their clients and MSM within high risk populations; and considers uniformed service personnel, prisoners, truck drivers, tea sellers, internally displaced persons (IDPs), refugees, migrant/seasonal workers, cross border population and the youth as vulnerable groups.

The NSP notes that the conflict has contributed to the spread of HIV due to widespread displacement of large numbers of people; movement of military personnel to and from conflict zones; and the movement of returnees, traders and professionals from neighboring countries.

Gender is acknowledged within the NSP as a cross-cutting issue, and there are numerous instances where issues relating to gender are recognised. While the NSP acknowledges that the “context of gender roles and relations substantially influences how women and men will respond to initiatives designed to reduce risk or vulnerability or to alleviate the impact of AIDS”, there are not many specific examples of work that is structured in such a way as to address gender transformation.

The NSP cites research showing that “women living with HIV AIDS in particular face higher degree of stigma compared to men at family, and community levels” and that the majority of people accessing VCT are men. These may explain why work with men and boys is not prioritized, although the plan does assert the need for innovative activities to target boys and girls to promote “more equitable and mutually respectful attitudes and behavior”.

**Prevention strategies**

The Sudan Household Health Survey (SHHS) in 2006 revealed that only 4% of respondents knew all three ways to prevent the sexual transmission of HIV. The NSP prioritises prevention efforts amongst high risk and vulnerable populations, asserting that prevention programs “should seek to promote safe sexual behavior, including increased correct and consistent use of condoms, utilization of counselling and HIV testing services, STI treatment, while addressing structural inequalities that fuel vulnerabilities to HIV infection and deter access to services for these high-risk populations”. The precise ways in which structural inequalities are to be addressed is unclear.

Male circumcision is almost universal in North Sudan, and is cited as one of the reasons why HIV prevalence remains low despite low levels of HIV knowledge and condom use. The NSP does not...
provide any plans to ensure that men who are circumcised understand that this does not mean they are immune to HIV infection.

The NSP notes that condom use remains a key measure for HIV prevention but acknowledges the cultural sensitivity around condom distribution. It recognizes that “this sensitivity has limited the availability of condoms and created psycho-social barriers to using them. Even when condoms are available, many men are reluctant to use them due to the perceptions that condom use reduces sexual pleasure.” While the NSP aims to distribute 103 million condoms by 2014, there are no plans outlined for specifically targeting men to address these perceptions, nor for promoting consistent condom use.

According to the NSP, the majority of people who have tested for HIV are men, which is attributed to “the limited capacity of women to have access to information, socio-cultural norms that relatively restrict mobility of women for accessing HTC, stigma and the consequent discrimination associated with HIV, and economic difficulties.” This could explain the absence of plans targeting men to encourage increased uptake of VCT services; the plan emphasizes that women and men should have equal access to such services.

There are numerous problems in Sudan regarding the roll out of PMTCT services, with only 28 PMTCT sites operating in Northern Sudan. The NSP has set the target of increasing this to 167 sites by 2014. Men are not included in discussion of PMTCT.

Marginalized groups are focused on within the NSP. The plan sets a limited target of reaching 40% of MSM with VCT services by 2014. Other targets for 2014 include ensuring that 60% of Most at Risk Populations (MARPS) can correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions, and that 4.1 million MARPs are reached with behaviour change communication (BCC) interventions.

The plan acknowledges that many of the vulnerable populations identified consist primarily of men: MSM, clients of FSWs, truck drivers, migrant workers, prisoners, the police and the military. However, no plans are provided for structuring interventions to specifically addressing the needs of these men.

The NSP acknowledges that prisoners constitute an important group in terms of HIV and AIDS work. Thus all work planned to reach vulnerable groups should include prisoners, but their specific needs are not addressed.

The NSP asserts that: “Advocacy for HIV prevention will target policy makers and religious, political and community leaders at Federal and State levels to ensure they (i) support the mainstreaming of HIV activities in priority sectors, (ii) integrate BCC interventions through organisations providing assistance to refugees and IDPs, (iii) develop BCC messages targeting migrant workers specifically.”

The NSP does commit to ensuring HIV testing and counselling facilities are available in IDP and refugee camps and military and police facilities. It also commits to ensuring that the scale up of PMTCT sites will focus on IDP and refugee camps, amongst other locations. However, as Sudan is dealing with one of the “worst internal displacements of persons in the world”, the issue of catering to the needs of displaced people, given their increased vulnerability to HIV infection, could be focused upon in more depth. Reaching and engaging men is not specifically mentioned in any of these plans.

According to behavioral data cited in the NSP, as many as 50% of MSM in North Sudan have sex with women, thus constituting a significant bridging population. While much work within the NSP focuses on high risk populations, there is no work specifically addressing the particular needs of MSM. There is no mention of the situation with regard to IDUs.

**Treatment and care**

The NSP sets a 2014 target of 5,272 males and 4,887 women receiving ART, but includes no specific plans to encourage men to access ART. There is no discussion of the role of men in home based care within the NSP.

**Gender based violence**

While the NSP notes that sexual exploitation and GBV are a problem in Sudan, particularly affecting refugees and IDPs (especially in the Darfur region), plans to engage men in preventing GBV are not addressed.

13. NACP III To Halt and Reverse the HIV Epidemic in India

**HIV and gender**

The Indian NACPIII describes the HIV epidemic in India as moving from high risk groups to the general population, and from urban centres to rural areas, and notes an increase in infection among youth and women. The plan states that the “HIV epidemic in India is complex and heterogeneous, impacted by intricate and varied social structures.” The NSP addresses the issue of gender, although in the following citation it seems that gender applies only to women.

As the meaning of the word ‘gender’ is not clarified, the nature of the work it describes remains unclear, as illustrated in the following quote:

“This workforce will, not only, be trained...”
and capacitated for HIV and AIDS but also for issues of gender, sexuality, STIs.\footnote{423}

In the plan, men are engaged with predominantly as a ‘risk group’, as is described in What men have to do with it:

“With the possible exception of the national AIDS program, which has included men, although mostly acknowledging them as a specific ‘risk group’ rather than including a full discussion of how masculinities create and reinforce power inequities [between specific groups of men, and between men and women] and how they reinforce men’s limited health-seeking behavior [or encourage the use of unqualified ‘street’ doctors, also known as ‘quacks’]”.\footnote{424}

Prevention strategies

Men are included in plans for behavior change interventions,\footnote{425} and it is recognized that men should be reached through occupational settings.\footnote{426}

Male circumcision is not addressed. While the plan aims to sell 3.5 billion condoms per year,\footnote{427} men are not focused upon specifically in this area. However, the plan does stipulate that Integrated Counseling and Testing Centers (ICTCs) will provide entry points for both men and women requiring different services.\footnote{428} Men are not included in discussion of PMTCT services.

With regard to marginalized groups, the NSP acknowledges that during the last phase of their program IDUs and MSM were neglected.\footnote{429} The current NSP commits to reaching the partners of 1 million FSWs, 1.15 million MSM and 190,000 IDUs by 2012, with targeted interventions.\footnote{430}

With regard to MSM, the NSP commits to ensuring access to thicker condoms and lubricants,\footnote{431} treatment of anal STIs, and “special efforts ... to bring about behavior change through innovative communication strategies and materials. Operation research will be carried out to understand the sexual practices of bisexual men, and provide them access to preventive care, support and treatment”.\footnote{432} IDUs are addressed,\footnote{433} but the needs of men specifically are not accounted for in this regard. While prisoners are acknowledged as a group, the plans for work with this group remain vague.\footnote{434} “Amend jail rules so as to reduce the risk of HIV to prisoners”.\footnote{435} The plan aims to reach 3 million truckers\footnote{436} and 8.9 million migrants,\footnote{437} and commits to creating peer support groups and safe spaces at destination sites for migrants.\footnote{438}

Treatment and care

Men are not included in discussions regarding treatment or home based care.

Gender based violence

Gender based violence is not addressed.


HIV and gender

Approximately 220 000 people died in Haiti as a result of a massive earthquake in January 2010. The earthquake devastated the country, and certain government departments were particularly hard hit, making their work especially difficult. The Haiti Plan Interimaire VIH/SIDA Suite Au Seisme of 12 January 2010 is a temporary HIV and AIDS Plan for 18 months, and sets out government strategies for mitigating some of the damage.

The HIV prevalence rate in the population is 2.2%, with a higher infection rate among women than men. The key issues addressed in the plan are the problems of caring for HIV-positive people displaced by the earthquake and living in temporary shelters and controlling the further spread of HIV. The plan aims to restore services to vulnerable people living with HIV; reduce the risk of infection; include the HIV curriculum in all information; and develop maternity and reproductive services. The drop in numbers of antenatal clinics has reduced the number of women exposed to VCT services and increased the numbers of orphans and vulnerable children.

Prevention strategies

Male circumcision is not addressed within this plan. Condoms are distributed in all temporary shelters but there is no mention of measures to encourage men to use condoms. There is no focus on men in the plans for VCT or PMTCT. While MSM are identified as a vulnerable group, there is no provision for the specific needs of prisoners, migrants, MSM and IDUs.

Treatment and care

In terms of treatment, the document focuses on HIV-positive people displaced by the earthquake to ensure that they remain on treatment, and men as a group do not receive any specific attention. Men are not encouraged to become more involved in home based care.

Gender based violence

While the document acknowledges that people living under these conditions, especially women and children, are more vulnerable to rape, violence, sexually transmitted diseases, stigma, discrimination and HIV infection, there is no mention of plans to address gender based violence.

15. Nicaragua National Strategic Plan 2006 – 2010

HIV and gender

Nicaragua has an estimated population of 5.7 million and is the second-poorest country in Latin America. According to the latest data provided by UNAIDS, there are an estimated 7,300 people living with HIV.\footnote{439} The epidemic is concentrated as it affects less than 1% of the population, although there is a
prevalence rate of 9% among MSM.\textsuperscript{440} HIV is mostly transmitted through sexual relationships (92%). The NSP acknowledges that there is not sufficient and reliable data on HIV prevalence, and that prevention efforts might be hampered by lack of information on the behaviour of the most at-risk populations.\textsuperscript{441}

In 1996, Nicaragua passed legislation to address HIV and AIDS; Act 238 for the Promotion, Protection and Defence of Human Rights against HIV aims to enshrine a human rights approach in prevention and treatment.\textsuperscript{442} There is a general acknowledgement of the importance of family and community considerations and gender equality within the approach to sexually transmitted diseases, HIV and AIDS, along with human rights and intergenerational approaches.\textsuperscript{443} However, the NSP background section does not provide much rationale or information on the roles that men and boys can play in supporting gender equality. The NSP logical framework introduces some language that speaks more directly to men’s involvement in some of the proposed interventions, although there are no indicators attached to all the activities.

Specific issues related to gender identified include the strong correlation between HIV and GBV, social exclusion and the denial of agency within certain population groups, e.g., women.\textsuperscript{444} The risky sexual practices of men and boys are specifically referred to.

“The Nicaraguan society is characterized by a predominant patriarchal culture, which influences the development model adopted by the citizens”.\textsuperscript{445} Gender focus is one of the pillars of the NSP, and gender inequalities are once again acknowledged although with reference to women’s empowerment to promote respectful relationships between men and women.\textsuperscript{447}

The NSP background analysis raises the need to increase the number of sexual education programs to change sexual behaviour, and this is followed up with proposed activities such as continuing the review of the educational curriculum and including parents in prevention activities at schools.\textsuperscript{446} This strategy does not explicitly discuss the role of men and boys though, except by mentioning that peer educators – both men and women – will be run life skills programs.\textsuperscript{449} Strategies around prevention and treatment mention the role of families and communities, but many of the efforts in the NSP are focused on the agency of women. Some strategies explicitly mention men, particularly when they constitute part of at risk populations; so for example, counseling on STDs, HIV and AIDS should incorporate men, and ideally couples;\textsuperscript{450} strategies aimed at promoting VCT target MSM;\textsuperscript{451} strategies aimed at changing sexual behaviour target young men in the armed forces;\textsuperscript{452} and social media campaigns activities refer to messages attached to all the activities.

Priority populations identified by the NSP include prisoners, mobile populations and MSM.\textsuperscript{460} The NSP mentions access to services to HIV-positive prisoners, although no further detail is provided, and referral to

\textbf{Prevention strategies}

Male circumcision is not mentioned in the NSP. The plan highlights that promiscuity is an issue, particularly when condom usage is not generally practised among most at-risk populations. Men’s responsibility is also addressed in the section dealing with sexual workers (assumed to be females), where awareness activities targeting sexual workers’ clients (assumed to be males) are listed. The indicator for the activities is the use of condoms.\textsuperscript{456} The NSP also outlines the need for social marketing of condoms to secure its availability.\textsuperscript{457}

In more general terms, within the NSP’s Planned Interventions of Expanding Services on HIV and AIDS (particularly counseling), men are specifically mentioned as a target group. One

\textit{“Gender constructions are based on unequal power relations between men and women…This situation impacts directly on women, adolescent and children…The low levels of responsibility of men with regards to their own sexuality and reproductive health drives them to engage in frequent casual sexual relationships without protection.”}
appropriate institutions after their release.461

Mobile populations are identified as a ‘most at risk’ group,462 and are targeted for counseling services, as well as in social media campaigns (although in general terms).

The NSP does not include IDUs under priority populations, although the need to research HIV prevalence among this group, promote condoms and offer counseling services is outlined under mentioned as a target group in several planned prevention and treatment interventions,468 though special reference to male members is not explicit.

**Treatment and care**

Under the intervention aimed at providing holistic services to families and children affected by AIDS, training and support to families – especially HIV-positive children – is listed, although no special reference is made to men.469 In more general terms though, prevention programs, awareness programs targeted at women474 and VCT counseling and services for victims of sexual violence.475 However, the role men can play within efforts to prevent GBV is not addressed.


**HIV and gender**

Brazil has an estimated population of 180,654 million inhabitants. There are an estimated 660,000 people living with HIV.476 The HIV epidemic in Brazil presents a very large heterogeneity, with large variations among regions. Heterosexual transmission, sex between men and IDUs continue to be almost equally responsible for the burden of HIV infection.477

The 2005 NSP contains a dedicated joint state-civil society plan of action aimed at defending human rights and promoting a policy of social inclusion in the context of the HIV epidemic. This section provides objectives and strategies framed on concepts of equality and social justice.478

However, it is noticeable that the Brazilian NSPs do not address or provide a gender analysis as a background to the interventions. Consequently, most of the goals and action plans are gender blind, except for a focus on women and PMTCT, the promotion of female condoms as a prevention method, and the principle of respecting the right to sexual orientation. The 2005 NSP though states that factors related to gender, sexual orientation, race and ethnicity, age, and quality of life for HIV-positive people are considered across the plan.479

The principles that guide the 2004–2007 NSP are: guarantee quality of life for HIV-positive people and people living with AIDS, particularly vulnerable populations; promote the decentralization of services provided at the three tiers of government administration: federal, provincial and local; guarantee the universality and holistic nature of the interventions;
and promote equality. The NSP does not provide a socio-cultural analysis focusing on gender issues or inequalities. There is a specific focus though on women of fertile age and pregnant women. The intent and language does not improve in the 2005 NSP. Under the section on special prevention programs for the year 2005, the NSP is silent with regards to projects addressing gender inequality.

The NSP Intervention Strategy Three of the Prevention Section though acknowledges the need to address gender inequality, but it is silent on the role of men and boys. Specific issues related to gender are mentioned afterwards in the section dealing with youth.

**Prevention strategies**

Male circumcision is not mentioned in any of the Brazilian NSPs. However, Brazil has been extremely successful in promoting condom use as a prevention method, particularly among youth. The 2005 NSP highlights the fact that 96% of the sexually active population know that condoms protect against HIV.

The 2005 NSP Prevention Strategy Two outlines specific goals related to the availability and/or development of prevention methods, such as male condoms, HIV vaccines, microbicides, female condoms. Some of the indicators include increased number of male condoms purchased by government for distribution, increased social marketing of condoms and opening of a government-owned condom factory.

One of the key strategies contained in the NSPs is the expansion of access to VCT in the primary health system at local level, and the use of the ‘rapid HIV test’. The 2004–2007 NSP set a goal of 80% of vulnerable populations (IDUs, sexual workers, MSM, prisoners and transgender people) testing for HIV at least once. The 2005 NSP aimed at providing VCT at local level in 100% of all primary health facilities. Only MSM are accounted for.

Brazil’s NSPs have set ambitious targets for providing treatment. The 2004–2007 NSP set the goal of providing universal access to treatment for 100% of HIV-positive people as per the Ministry of Health guidelines, while the 2005 NSP also outlines comprehensive goals to guarantee universal access to treatment. Men are not specifically accounted for in these plans.

Priority populations identified by the Brasil NSPs include IDUs, sexual workers, MSM, prisoners and transgender people. One of the goals of the 2004–2007 NSP is to produce and disseminate accurate information about the epidemic, and one of the concrete actions is to update every second year the infection rate among the following vulnerable populations: MSM, sex workers (both men and women) and IDUs.

Mobile populations are not identified specifically as a vulnerable group.

Until the mid 1990s, IDUs were the vulnerable group most affected by the epidemic but the infection rate has progressively decreased. The 2004–2005 NSP outlines specific interventions aimed at decreasing risky behavior among this group, but men and boys are not accounted for as a specific group.

In terms of marginalized men and boys MSM are a vulnerable population specially targeted, as the infection rate has been particularly high among this group in Brazil. The NSPs systematically includes them as a target group in many planned interventions. MSM are among the vulnerable populations targeted under the VCT strategy, and they are targeted in all the prevention action plans that municipalities were required to implement by the end of 2007.

The 2004–2007 NSP contains a specific goal aimed at promoting the reduction of stigma and respect for sexual, ethnic and cultural diversity. Concrete actions include, for instance, having networks of people living with HIV and AIDS and vulnerable populations with advocacy representatives.

The 2005 NSP Prevention Strategy Two also outlines the acquisition and distribution of lubricant gel by government departments, although no particular reference to men is made.

**Treatment and care**

The 2004–2007 NSP aims to contribute to the social inclusion of HIV-positive people and vulnerable populations and it aims to provide support to 50% of the available places in registered assistance centres for people living with HIV.

The 2005 NSP outlines indicators related to access to services for people living with HIV including increased referral networks and establishment of referral centres and assistance programs for homeless people, but no reference is made to the men specifically in these programs.

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Men’s responsibility is also addressed in the section dealing with sexual workers (assumed to be females), where awareness activities targeting sexual workers’ clients (assumed to be males) are listed.

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The 2005 NSP acknowledges the feminization of HIV, with an increase in infection rates among women at fertile age and pregnant women. The NSP aims to expand the network of primary health care facilities providing family planning, testing and counseling for pregnant women and their partners.

The NSP also outlines family planning services to HIV-positive couples intending to use fertility treatments.

**Gender based violence**

The 2005 NSP makes reference to cooperation with civil society in areas of work and acknowledges that gender inequality, violence against women and homophobic violence are public health issues. However, there are no concrete actions linked to the analysis, or a specific role for men outlined.
Notes
National Strategic Plans on HIV and AIDS in five global regions


‘Johannesburg Declaration and Call to Action’, Sonke Gender Justice Network & the MenEngage Alliance, 9 (October 2009), p. 3.


Redpath at al. op cit, p. 19.


‘Johannesburg Declaration and Call to Action’, Sonke Gender Justice Network & the MenEngage Alliance, 9 (October 2009), p. 3.


Ibid, p. 28.

Ibid, p. 10.


Ibid, p. 3.


Ibid, p. 10.


Policy Approaches To Involving Men And Boys’, p. 11.


Policy Approaches To Involving Men And Boys’, p. 28.


See paragraphs 1, 3, 40, 72, 83b, 107c, 108e, 120 and 179 of the Beijing Platform for Action.


Policy Approaches to Involving Men And Boys’, p. 28.


UN Report on 54th CSW, p. 12.

UN Report on 54th CSW, p. 30.

UN Report on 54th CSW, p. 37.

UN Report on 54th CSW, p. 12.

UN Report on 54th CSW, p. 11.

Copies of these NSPs will be made available at www.genderjustice.org.za. Various efforts were made to attain the latest and correct versions of NSPs. However, it was often difficult to source these documents and in the limited time available, work was conducted on the documents which were accessible.


Ibid, p. 25.


46 Palitza, Peacock & Shand, op cit, p. 6.

47 Policy Approaches to Involving Men And Boys’, op cit, p. 25.

46 Ibid.

47 AIDS Legal Network (2010), op cit.


54 Shisana et al., op cit.


66 Text drawn from Redpath et al., p. 23.


70 Greig & Peacock, op cit, p. 29.

71 Peacock & Weston, op cit, p. 10.

72 Greig & Peacock, op cit, p. 29.

73 Peacock & Weston, op cit, p. 2.


77 Text drawn from Greig & Peacock, op cit, p. 35.


80 Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV: Operational plan for the UNAIDS action framework: addressing women, girls, gender equality and HIV, UNAIDS, p. 5.


83 The Northern Province Circumcision Schools Act No. 6 of 1996; Application of Health Standards in Traditional Circumcision Act No. 6 of 2001 (Eastern Cape); The Free State Initiation School Health Act No. 1 of 2004

84 BMU 2001; 323, p. 1090


86 ‘Men’s influences on women’s reproductive health: medical anthropological perspectives’, Matthew R Dudgeon and Marcia C Inhorn, Social Science & Medicine, 2004 vol. 59 pp. 1379-1395

87 Policy approaches to working with men to achieve gender equality: National Consultative Meeting, September 17-18, 2007, Birchwood Conference Centre, Gauteng
"The clinic as a gendered space: An exploratory study examining men's access to and uptake of voluntary counselling and testing services (VCT) in the context of a male-friendly health facility", Maria Faull, A minor dissertation submitted in partial fulfilment of the requirements for the award of the degree of Masters in HIV/AIDS and Society, Faculty of the Humanities, University of Cape Town, 2008


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Men for change health for all", p. 15.


Sasha Gear and Kindiza Ngubeni, Daai Ding: Sex, Sexual Violence and Coercion in Men's Prisons (Johannesburg, Centre for the Study of Violence and Reconciliation, 2002)

Sasha Gear, Behind the bars of masculinity: disappearing victims, disqualifying desire and prefiguring perpetrators in South African men's prisons, Sexualities, 10, 2, 2007.

Policy approaches to working with men to achieve gender equality: National Consultative Meeting, September 17-18, 2007, Birchwood Conference Centre, Gauteng


Greig & Peacock, 'Men for Change', p. 29.


Policy Approaches To Involving Men And Boys In Achieving Gender Equality And Health Equity, Paper prepared by Sonke Gender Justice Network for the Department of Gender, Women and Health, World Health Organization, June 2010, p. 11.


(KNASP III), pp. 9.

(KNASP III), pp. 8 & 9.

(KNASP III), p. 9.


(KNASP III), p. 11.

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(KNASP III), p. 9.

(KNASP III), p. 11.

(KNASP III), p. 18.


(KNASP III), p. 7.

(KNASP III), p. 7.

(KNASP III), p. 6.

(KNASP III), p. 20.


Rwandan NSP 2009 – 2012, p. 120


National Strategic Plans on HIV and AIDS in five global regions