Andrew Gibbs is a Researcher at the Health Economics and HIV/AIDS Research Division (HEARD), University of KwaZulu-Natal, Durban, South Africa.

Mildred Mushinga is a Junior Researcher at HEARD, University of KwaZulu-Natal, Durban, South Africa.

E. Tyler Crone is Coordinating Director of the ATHENA Network, a global women's rights and HIV network.

Samantha Willan is the Gender Equality and HIV Prevention Programme Manager at HEARD, University of KwaZulu-Natal, Durban, South Africa.

Jenevieve Mannell is a doctoral candidate at the Gender Institute, London School of Economics and Political Science, London, UK.

Please address correspondence to the authors c/o Andrew Gibbs, University of KwaZulu-Natal, Durban, South Africa, email: gibbs@ukzn.ac.za.

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How do national strategic plans for HIV and AIDS in Southern and Eastern Africa address gender-based violence? A women's rights perspective

Andrew Gibbs, Mildred Mushinga, E. Tyler Crone, Samantha Willan, Jenevieve Mannell

Abstract

Gender-based violence (GBV) is a significant human rights violation and a key driver of the HIV epidemic in southern and eastern Africa. We frame GBV from a broad human rights approach that includes intimate partner violence and structural violence. We use this broader definition to review how National Strategic Plans for HIV and AIDS (NSPs) in southern and eastern Africa address GBV. NSPs for HIV and AIDS provide the national-level framework that shapes government, business, donor, and non-governmental responses to HIV within a country. Our review of these plans for HIV and AIDS suggests that attention to GBV is poorly integrated; few recognize GBV and program around GBV. The programming, policies, and interventions that do exist privilege responses that support survivors of violence, rather than seeking to prevent it. Furthermore, the subject who is targeted is narrowly constructed as a heterosexual woman in a monogamous relationship. There is little consideration of GBV targeting women who have non-conforming sexual or gender identities, or of the need to tackle structural violence in the response to HIV and AIDS. We suggest that NSPs are not sufficiently addressing the human rights challenge of tackling GBV in the response to HIV and AIDS in southern and eastern Africa. It is critical that they do so.

Introduction

Gender-based violence (GBV) is one of the key human rights violations that contributes to the high levels of HIV and AIDS in southern and eastern Africa.[1,2,3] In this paper, we build on a broad understanding of a human rights approach to GBV that moves beyond narrow understandings of GBV as intimate partner violence or other forms of direct violence, to encompass structural GBV, particularly for women living with HIV and women with non-confirming sexual identities. We then use this to reflect upon how National Strategic Plans for HIV and AIDS (NSPs) in southern and eastern Africa integrate policy and programmatic interventions that seek to prevent GBV and mitigate its impact. Within national responses to HIV and AIDS, NSPs provide a broad framework and guiding tool, as such how they conceptualize and program for GBV is critical to the HIV response as a whole.

Gender-based violence as a human rights issue

Understandings of GBV and its relationship to human rights are widening to include the multiple forms that this violence can take. Initially, human rights frameworks were quite narrow, excluding GBV and violence against women as private acts not covered in a human rights

framework.[4] This, however, has been changing; since the Beijing Declaration and Platform for Action (1995), GBV has been seen as a critical human rights issue and a central component of women's human rights.[5] This view has increasingly become codified in international legislation, including the Protocol of the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (referred to as the African Women's Protocol), which provides a strong perspective on the relationship between violence against women and human rights.[6] These broader human rights frameworks typically build on definitions like that outlined in the United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which defines "gender-based abuse" as "any act of gender based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life."[7]

Definitions of GBV have further expanded in two important ways. The first expansion provides for a broader understanding of gender violence as any form of violence perpetrated against an individual or a group because of gender, rather than the typical focus of male violence against a female intimate partner, with the assumption of a heterosexual relationship. This expansion makes it possible for a human rights framework to be applied to gender violence against people because of their non-confirming sexual identities. Such an expansion has enabled issues such as the "corrective rape" of lesbians to be framed from a human rights perspective and used to hold states accountable for their ineffective responses.[8,9] Furthermore, it means that gender-specific work, such as female sex work, can be framed within human rights language and can highlight the high levels of violence that clients and police inflict on female sex workers.[10]

The second expansion of the GBV framework moves away from focusing on direct forms of violence by recognizable actors (typically physical, emotional, and economic forms of violence), to include indirect forms of violence ingrained in social arrangements and institutions. Paul Farmer's seminal work on structural violence emphasizes how broad social forces, including gender, race, and class, shape health outcomes and access to specific forms of health care.[11] In this way, broad social arrangements, including economic forces of neoliberalism, legal frameworks, policing systems, and health care systems that perpetuate unequal social relationships, are all capable of causing violence, even though they are not autonomous actors. In terms of GBV, this helps us recognize the significance of the criminalization of non-conforming sexual identities, coercive sterilization of women, and the criminalization of sex work as forms of systematic structural violence with a gendered dimension. This expansion of the GBV framework allows for inclusion of violence that undermines women's human rights and that would not have been included in early conceptualizations of GBV.

Gender-based violence and HIV

The HIV/AIDS epidemic has created a focus on the role of violence and human rights violations in undermining health.[12] There are multiple potential pathways between GBV and HIV. Evidence clearly shows that GBV is a cause of HIV transmission. A range of cross-sectional studies showed that women who experience intimate partner violence are more likely to be HIV-positive.[13,14] However, these studies have been criticized as not being able to show the temporal relationship between HIV and violence. More recent work by Jewkes et al., using a cohort sample, showed that women who experienced intimate partner violence were more likely to contract HIV than those who did not.[15]

In addition, there is growing evidence that women who are HIV-positive experience high levels of intimate partner violence because of the intersection between their gender and their HIV-positive status.[16] A study by Gielen et al. maps women's lives following an HIV-positive diagnosis, showing the multiple risks and forms of intimate partner violence the women faced, including emotional, physical, and sexual abuse.[17] Furthermore, there is increasing evidence that women living with HIV are subjected to a wide range of structural violence because of the intersection between their gender and HIV status. Forms of documented violations include the coerced and forced sterilization of women living with HIV, poor treatment in antenatal clinics and during delivery, and the criminalization of HIV transmission.[18-22] All these factors undermine HIV-positive women's access to effective treatment and care services, and expose them, directly and indirectly, to institutional

violence.

Structural forms of GBV are also implicated in facilitating HIV transmission and undermining access to prevention, treatment, care and support. For instance, a significant body of work shows that the criminalization of sex work undermines sex workers' access to HIV prevention and care; this has led to a high rate of HIV among this population.[23] Similarly, the criminalization of people based on their sexual identity, and the subsequent forms of direct violence against criminalized groups, are also potential modes of transmission. In South Africa, for instance, there is an increase in the number of women who report being raped for self-identifying as lesbian.[24] Furthermore, formal institutions such as the police and health care facilities often exclude or give poor treatment to women with non-conforming sexualities.

Economic forms of structural violence and their intersection with gender inequalities are a key factor in understanding HIV transmission and high levels of direct violence against women.[25,26,27] In southern and eastern Africa, this relationship has primarily focused on transactional relationships, whereby women's exclusion from the formal economy makes them financially dependent on male partners. Women's economic dependency on men, places them at higher risk of intimate partner violence as well as unable to negotiate sexual relationships, factors that place them at increased risk of HIV acquisition.[28]

Responding to GBV

Responses to GBV have increasingly emphasized a holistic approach to tackling the relationship between GBV and HIV. The World Health Organization (WHO), for instance, has developed and applied an ecological approach to GBV. An ecological approach recognizes that the causes of violence range from individual psychological factors, through to community, social, policy, and structural factors. As such, they argue that any comprehensive response to prevent violence needs interventions targeted at all of these levels.[29] There has also been an emphasis on providing support for survivors of violence. In particular, in the context of HIV, providing post-exposure prophylaxis has been a central response.

National Strategic Plans for HIV and AIDS

National Strategic Plans for HIV and AIDS emerged to provide a holistic and coordinated response to HIV and AIDS that moved beyond HIV being seen as a health issue alone.[30,31] For many countries, including all of those in southern and eastern Africa, NSPs are a key guiding document that outline a national framework and approach to the HIV/AIDS response.[32] As such, NSPs include the broad principles guiding the approach, as well as clearly identified policies, programs, and interventions to effectively manage HIV and AIDS. Furthermore, they allocate roles and responsibilities to government agencies, as well as to civil society and the business sector.[33]

As NSPs have a central role in setting the parameters of a national response to HIV and AIDS, ensuring that a comprehensive response to women's equality, and specifically GBV, is included in NSPs is critical if we are to address both GBV and HIV. Indeed, the current UNAIDS strategy Getting to Zero explicitly recognizes the importance of including effective responses to GBV and women in NSPs.[34] Yet little is known about how NSPs in southern and eastern Africa specifically address GBV. Our study seeks to fill this gap.

METHODS

As part of a wider process around strengthening the response to women, girls, and gender equality in NSPs in southern and eastern Africa, the Gender Programme at HEARD and the ATHENA Network developed a policy framework of strategies, interventions, and programs that should be included if NSPs are to meaningfully integrate the response to women, girls, and gender equality. To develop this framework, we undertook a multilevel process of consultation and review, which included the following steps:

1. We reviewed evidence on good practice and effective strategies in academic and grey literature looking at the intersection of gender, human rights, sexual and reproductive health and rights, and HIV;

2. We reviewed key international and African protocols, platforms for action, and legal frameworks and commitments such as the African Women's Protocol, CEDAW, and the Maputo

Plan of Action;

3. We sought input from regional and global actors, ranging from HIV-positive women's groups, organizations working to involve men and boys in women's rights, women's groups, human rights groups, the UN family, and academics.

Through this process, we developed nine key strategic areas for the framework.[35] These nine areas are:

1. *Enabling environment*: Focuses on the wider legal and policy contexts that support women's rights

2. *Meaningful involvement of and leadership by women living with and affected by HIV*: Focuses on ensuring that women living with and affected by HIV are included in policy and programmatic decisions affecting their lives

3. *Utilizing a sexual and reproductive health and rights approach*: Recognizes and outlines policies and programmatic responses that locate HIV within the broader needs of women and girls' sexual and reproductive health and rights

4. *Preventing HIV transmission among women and girls*: Includes a focus on preventing vertical transmission and horizontal transmission of HIV

5. *Eliminating GBV and discrimination*: Focuses on strategies to prevent GBV and support survivors of GBV

6. *Increasing access to and uptake of treatment for women and girls*: Emphasizes policies and programs that can support access to anti-retroviral treatment

7. *Strengthening care and support by and for women and girls*: Focuses on ensuring support for women and girls undertaking caregiving

8. *Accountability*: Creates mechanisms to monitor and hold government to account

9. *Inclusion of key stakeholders*: Ensures women in all their diversity are included

In each of the strategic areas of the framework, we developed specific policy language and interventions to support the strengthening of the NSP's ability to meaningfully respond to these key issues. The intention was that many stakeholders, from civil society to governments to UN agencies, could evaluate their NSP against this framework and adopt policy language and programs into the new generation of NSPs. UN agencies and civil society organizations have indeed used the framework as they move to strengthen NSPs globally, and in particular across southern and eastern Africa.[36]

This paper draws exclusively on the fifth strategic area of the framework: eliminating GBV and discrimination. We report on the full findings of how countries in southern and eastern Africa compare to the framework elsewhere.[37] Within the fifth strategic area, we identified 15 approaches to GBV and HIV. These ranged from the need for NSPs to identify GBV as both a cause and consequence of HIV to the provision of a broad definition of GBV (as economic, physical, and psychological violence to many survivors, rather than only as violence against women), to legal responses for violence prevention and ensuring justice to survivors. The approaches also included primary prevention interventions–interventions aimed at working with men and boys and women and girls to prevent violence. Further, the strategic area included interventions to support the immediate and longer-term needs of violence survivors, particularly in the context of HIV. This included strategies such as access to post-exposure prophylaxis (PEP). Table 1 provides the comprehensive review of all interventions and policies outlined in the framework.

We then reviewed NSPs for HIV and AIDS for 20 countries in southern and eastern Africa against the framework and its recommendations. The countries are, Angola, Botswana, Comoros, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe, against the framework and its recommendations.[38] In reviewing the 20 NSPs, we assessed whether they included interventions, policies, or programs that resonated with the specific components of the framework. In this paper, we report only on

Table 1. How do NSPs integrate gender-based violence?

	Angola	Botswana	Comoros	Eritrea	Ethiopia	Kenya	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Rwanda	Seychelles	South Africa	Swaziland	Tanzania	Uganda	Zambia	Zimbabwe
NSPs must recognize gender inequality as a fundamental driver of GBV with attention to addressing GBV as both a cause and a consequence of HIV transmission.				x			x		x		x	x	x		x	x	x			
Attention must also be paid to addressing GBV in all its forms, such as intimate partner violence, sexual violence, and psychological violence as well as systemic, structural violence in peace, conflict, and post-conflict settings. Specific interventions and approaches should include the following:				x									x		x		x			
Interventions to create supportive legal and policy frameworks to prevent and redress all forms of violence against women, including in intimate partner settings							x				x		x	x	x		x		x	x
Legal reform to criminalize marital rape																	x			
Interventions that build the capacity of the police, health care workers, social workers, and the judiciary to respond more effectively and sensitively to GBV				x		x							x	x	x	x				
Interventions to alleviate stigma and discrimination on the basis of HIV status, gender, and sexual orientation in the police, health care sector, social services, and judiciary	x												x	x						
Interventions to support violence survivors' access to justice and remedies	x			x			x		x				x		x		x			
Legal and other responses to end cultural and traditional practices that are harmful to the health and rights of women and girls							x		x						x		x			
The decriminalization of sex work													x		x		x	x		
The decriminalization of consensual adult same-sex sexual conduct													x		x		x			

Continued on next page

Table 1. How do NSPs integrate gender-based violence? (cont'd.)

	Angola	Botswana	Comoros	Eritrea	Ethiopia	Kenya	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Rwanda	Seychelles	South Africa	Swaziland	Tanzania	Uganda	Zambia	Zimbabwe
Comprehensive post-rape care protocols for HIV prevention, including:				x		x								x	x	x	x			
Post-exposure prophylaxis available within 72 hours	x	x		x		x			x	x		x	x	x	x	x	x		x	x
Psycho-social support				x		x									x		x			
Emergency contraception				x		x									x		x			
Access to voluntary, safe, and comprehensive termination of pregnancy care and services			x												x					
Primary prevention strategies around GBV need to include:																				
Comprehensive sexuality education for all women, men, girls, and boys (both in and out of school) that includes factual information on knowing one's body and a focus on gender equality, human rights, and transforming social norms										x			x		x		x		x	x
Women's economic empowerment and gender equality interventions to reduce GBV											x		x		x					
Interventions to halt intimate partner violence, including marital rape													x	x		x				
Interventions to halt and address violence and discrimination against sex workers													x							
Interventions to halt and address violence and discrimination against lesbian, bisexual, and transgender women																				
Interventions working with men and boys to challenge notions of violence, transform gender norms, and address harmful masculinities											x				x		x			
Management of drug and alcohol substance use for individuals, including harm reduction for women who use drugs and specific interventions for women who are partners of injecting drug users										x			x	x	x				x	

the fifth strategic area of the framework. Rather than exploring and comparing individual countries directly, we seek to provide a broad regional overview of NSP trends regarding inclusion of GBV.

Results and Discussion: How do National Strategic Plans for HIV and AIDS integrate responses to GBV?

Definitions of gender-based violence in NSPs

Despite evidence showing the strong links between GBV and HIV across southern and eastern Africa, our analysis shows that the majority of NSPs (11 out of 20) failed to explicitly recognize this relationship. Countries that did recognize an important relationship between GBV and HIV, tended to focus on narrow definitions of GBV, specifically intimate partner violence and physical violence, rather than approaching GBV more holistically as encompassing economic and psychological violence. Four countries did include this broader definition of GBV: Eritrea, Rwanda, South Africa, and Tanzania. No countries explicitly included structural violence as an issue that required discussion.

Primary prevention responses

Primary prevention programmatic responses are interventions that seek to prevent direct physical, psychological, and economic violence. The evidence base on effective interventions in the context of HIV is relatively limited, but there is emerging evidence on broader strategies that are effective and have the potential to reduce GBV.[39,40] Our analysis suggests that few NSPs included primary prevention interventions: Only five countries out of 20 included any primary prevention interventions in their NSPs, while only three countries included more than one primary prevention intervention. Three countries included comprehensive sexuality education interventions, which have been shown to reduce violence perpetration (such interventions include the Stepping Stones program).[41] Furthermore, three countries included interventions working with men and boys to challenge notions of violence, transform gender norms, and address harmful masculinities. Evaluations from across the globe show important positive outcomes of working with men and boys.[42,43] Similarly, only five countries included interventions to manage drug and alcohol use, despite the strong relationship between alcohol use and violence.[44] Other interventions to prevent violence against women included interventions to halt intimate partner violence, including marital rape (three countries) and interventions to build women's economic empowerment (three countries).

NSPs across southern and eastern Africa took a narrow view of the forms of direct violence that they sought to prevent through primary interventions. No NSP explicitly mentioned interventions to halt and address violence against lesbian, bisexual, and transgender women, despite countries such as South Africa reporting increasing levels.[45] Only one country, Rwanda, mentioned primary prevention interventions to halt and address violence and discrimination against sex workers, even though evidence suggests that in generalized epidemics, sex workers face a higher-than-average HIV burden, and that sex workers are at a high risk of violence from society and police.[46,47]

Policies and programs for survivors of violence

A central response to GBV has been to ensure survivors of violence have access to services and programs to provide immediate support, relief, and care. These services often focus on access to health care, psychological trauma counseling, and, increasingly, access to justice. The majority of the NSPs we reviewed included post-trauma interventions. One particular focus was on the provision of access to post-exposure prophylaxis (PEP) in the case of rape, with 14 out of 20 NSPs including this as a critical intervention. Half the NSPs (10 out of 20) expanded this to a more comprehensive response to post-rape care, including interventions such as psychosocial support and access to voluntary, safe, and comprehensive pregnancy termination services.

While the NSPs included plans for strong immediate response to post-rape and post-violence, few included policies or programs focused on building institutional capacity to support survivors of violence. Only five NSPs included interventions to strengthen health care workers, social workers, and the judiciary's response to GBV and HIV, despite the emphasis on ensuring a comprehensive and holistic response to violence, and especially immediate post-violence care. As such, the focus of NSPs on survivors of violence was limited to immediate post-rape care and support, without building wider structures to support

access to justice and a supportive environment.

Structural forms of violence

In our framework, we included interventions that tackled structural forms of violence experienced by men and women because of their gender identities and practices. Many of the NSPs included interventions that sought to create a stronger legal environment for preventing GBV, but these were often narrowly focused on strengthening the criminalization of intimate partner violence. Seven countries included legal strategies to criminalize intimate partner violence, but did not include broader legal reforms were lacking. For instance, only South Africa included a policy that sought to fully decriminalize sex work, while three others included steps that would support the decriminalization of sex work and three included legal reform in relation to the decriminalization of consensual adult same-sex sexual conduct. The criminalization of these issues contributes to direct forms of violence that sex workers and same-sex men and women experience; it also limits access to HIV prevention, treatment, care and support.[48]

Only three NSPs included interventions to alleviate stigma and discrimination on the basis of HIV status, gender, and sexual orientation in the police, health care sector, social services, and judiciary, even though these groups are often the face of structural forms of violence.

Discussion and Conclusion

GBV is a fundamental human rights violation and a key driver of HIV globally, and particularly in southern and eastern Africa.[49] Typically, GBV is conceptualized narrowly as intimate partner violence or direct physical, economic, or emotional violence. In this paper, we sought to expand this definition outwards in two ways. The first was to recognize the centrality of structural forms of violence in the definition of GBV. The second was to include a broad conceptualization of how gender intersects with different issues, primarily, in this case, non-conforming sexualities (focused on lesbian and transgendered women) and women living with HIV. These two groups of women face very specific forms of GBV.

Our review of NSPs for HIV and AIDS across southern and eastern Africa suggests that in general, GBV is poorly integrated into them. At a very basic level, this includes a lack of recognition of the role of GBV as a key driver of the epidemic and a narrow conceptualization of what constitutes GBV. Our data suggest that the failure to identify GBV as a major driver of the epidemic means that this has been translated into few programs and policies that seek to respond to it. There are few primary prevention interventions aimed at preventing GBV and even fewer policies that seek to reduce the structural dimensions of GBV. Where there is some focus within NSPs on GBV, it centers on the provision of care and support to those already subjected to violence, in particular, the provision of PEP in the case of rape.

Where interventions and policies do exist, especially around structural forms of violence, they are primarily targeted at heterosexual relationships, with a narrow focus on intimate partner violence. There are no NSPs that include interventions to halt and address violence and discrimination against lesbian, bisexual, and transgender women, and only three that include the decriminalization of same-sex sexual conduct – this is despite the fact that in southern and eastern Africa, 17 countries currently criminalize consenting same-sex conduct.[50] The women constructed in the NSP policies are almost all heterosexual. Such a narrow framing of women denies the radical diversity of women's sexualities and identities in Africa and further entrenches forms of violence against women who do not conform to mainstream sexual identities.

Our review has suggested that NSPs have some significant weaknesses in their response to GBV; we now look at the possible reasons. Buse and colleagues suggest that we should understand HIV policymaking processes as occurring at the intersection of three factors: 1) ideas and ideology (the way issues are constructed), 2) institutions (the structures that shape decisions and the ways decisions are made) and 3) interests (who potentially gains and loses through different policies). [51] They also suggest that the history of HIV policymaking is too often located in ideology

rather than evidence.

We suggest that two dominant ideologies have shaped the ways in which NSPs have constructed GBV in eastern and southern Africa. The first is the assumption of a heterosexual HIV/AIDS epidemic in Africa.[52,53] This assumption, as Eppercht points out, emerged from colonial writings and has deeply impacted HIV and AIDS research, creating a context in which homosexuality has, until recently, been excluded from the discourse surrounding HIV in Africa.[54] This exclusion of homosexuality from HIV discourse in Africa, intersects neatly with many African states' reification of heterosexuality and overtly conservative positioning on homosexuality, which Connell has referred to as a product of the patriarchal state.[55] State policies and programs typically reinforce narrow definitions of sexuality and identities, even if, as in the case of South Africa, constitutions provide broader guarantees. Furthermore, at a global level, such an approach was implicitly supported by the Bush administration in the United States.[56] NSPs and how they integrate GBV can be seen as a product of patriarchal bureaucracies and an assumption of African heterosexuality that are reproducing rather than challenging existing social and gender norms. As such within NSPs women's relationships are assumed to be monogamous and heterosexual, denying the rights of lesbian, bisexual, and transgender women, and female sex workers who do not conform to narrow stereotypes.

The second ideological factor that has shaped NSPs is the biomedical dominance of much HIV research and practice.[57] Within NSPs in southern and eastern Africa we have previously noted the tendency to prioritize biomedical approaches to HIV, particularly in the form of antiretroviral treatment.[58] This discourse and emphasis is also apparent in the way GBV is framed within NSPs, specifically around the focus on the response to GBV in terms of post-rape protocols and access to PEP, all components that focus on a medicalized response. In an era where there is movement toward evidence-based approaches to HIV and health more widely, those developing policies and programs may feel that there is not enough clear evidence on interventions that work to reduce GBV, particularly at the time when these NSPs were being written.[59] Such questions get to the heart of what is good evidence in the response to HIV, particularly in times when funding for HIV and development is shrinking. Providing support to survivors of violence is a critical component of responding to GBV, but stops short of challenging the underlying causes of violence and supports a relatively biomedical approach. Preventing GBV requires the creation of a strong evidence base to support clear strategies of what works in the context of HIV.

NSPs provide a critical platform for ensuring that GBV is meaningfully included in national responses to HIV. Our review draws on a broad human rights approach to GBV that includes structural forms of violence. It suggests that although NSPs provide a useful opportunity to address a key human rights violation and driver of HIV, they are not doing so in their current form. As organizations develop the next generation of NSPs, there must be a concerted effort to ensure the inclusion of policies and programs that respond meaningfully to GBV. The broad spectrum of actors that are drawn together in the development and implementation of NSPs offers new opportunities to hold states accountable and push the boundaries of state responses to HIV and AIDS. Strengthening the response to GBV in new NSPs is a critical opportunity for supporting human and women's rights.

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References

1. R. Jewkes, K. Dunkle, M. Nduna, and N. Shai, "Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study," *Lancet* 376/9734 (2010), pp. 41-48.

2. L. Gerntholtz, A. Gibbs, and S. Willan, "The African women's protocol: Bringing attention to reproductive rights and the MDGs," *PLoS Medicine*, 8/4 (2011). Available at http://www.ncbi.nlm.nih.gov/pubmed/21483715.

3. Human Rights Watch, *Policy paralysis: A call for action on HIV/AIDS-related human rights abuses against women and girls in Africa* (New York: Human Rights Watch, 2003).

4. D. Thomas, and M. Beasley, "Domestic violence

as a human rights issue," *Human Rights Quarterly* 15 (1993), pp. 36-62.

5. United Nations General Assembly, Report of the Fourth World Conference on Women, UN Doc. No. A/Conf.177/20/Rev.1 (1995).

6. Gerntholtz (2011) (see note 2).

7. United Nations General Assembly, Convention on the Elimination of All Forms of Discrimination against Women, UN Resolution No. 34/180 (1979).

8. N. Mkhize, J. Bennet, V. Reddy, and R. Moletsane, *The country we want to live in: Hate crimes and homophobia in the lives of black lesbian South Africans* (Cape Town: HSRC Press, 2010).

9. Human Rights Watch, *"We'll show you you're a woman": Violence and discrimination against black lesbians and transgender women in South Africa* (New York: Human Rights Watch, 2011).

10. A. L. Crago, *Arrest the violence: Human rights abuses against sex workers in Central and Eastern Europe and Central Asia* (New York: Sex Workers' Rights Advocacy Network, 2009).

11. P. Farmer, *Pathologies of power: Health, human rights, and the new war on the poor* (Berkeley, CA: University of California Press, 2005).

12. J. Mann and D. Tarantola, "Responding to HIV/AIDS: A historical perspective," *Health and Human Rights* 2/4 (1998), pp. 5-8.

13. K. L. Dunkle, R. K. Jewkes, H. C. Brown, et al., "Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa," *Lancet* 363/9419 (2004), pp. 1415-21.

14. F. Hale, and M. Vazquez, *Violence against women living with HIV/AIDS: A background paper* (Geneva: ICW Global, 2011).

15. Jewkes (see note 1).

16. Hale and Vazquez (see note 14).

17. A. Gielen, K. McDonnell, J. Burke, and P. O'Campo, "Women's lives after an HIV-positive diagnosis: Disclosure and violence," *Maternal and Child Health Journal* 4/ 2 (2000), pp. 111-20.

18. J. Mallet and V. Kalambi, "Coerced and forced sterilization of HIV-positive women in Namibia," *HIV AIDS Policy Law Review* 13/2-3 (2008), pp. 77-78.

19. Z. Essack, and A. Strode, "'I feel like half a woman all the time,' The impacts of coerced and forced sterilisations on HIV-positive women in South Africa," *Agenda* 26/2 (2012), pp. 24-34.

20. M. O'Reilly, and L. Washington, "Young women from informal settlements report on their experiences of accessing sexual and reproductive and other health services from clinics," *Agenda* 26/2 (2012), pp. 126-38.

21. Human Rights Watch, "Stop making excuses:" Accountability for maternal health care in South Africa (New York: Human Rights Watch, 2011).

22. ATHENA Network and AIDS Legal Network, *10 reasons why criminalization of HIV exposure or transmission harms women* (Seattle, WA: ATHENA Network, 2010).

23. World Health Organization, *Violence against sex workers and HIV prevention* (Geneva: WHO, 2005).

24. Mkhize (see note 8).

25. C. Campbell and A. Gibbs, "Poverty, AIDS and gender," in S. Chant (ed), *International handbook on poverty and gender* (Cheltenam: Edward Elgar, 2010), pp. 327-332.

26. P. Farmer, M. Connors, and J. Simmons, *Women, poverty, and AIDS: Sex, drugs, and structural violence* (Monroe: Common Courage Press, 1996).

27. L. Thomas, J. Vearey, and P. Mahlangu, "Making a difference to health in slums: An HIV and African perspective," *Lancet* 377/9777 (2011), pp. 1571-1572.

28. R. Jewkes, K. Dunkle, M. Nduna, and N. Shai, "Transactional sex and HIV incidence in a cohort of young women in the Stepping Stones Trial," *Journal of AIDS and Clinical Research* 3/5 (2012), pp. 1-8.

29. E. Krug, J. Mercy, L. Dahlberg, and A. Zwi, "The world report on violence and health," *Lancet* 360/9339 (2002), pp. 1083-1088.

30. E. Morah and M. Ihalainen, "National AIDS

commissions in Africa: Performance and emerging challenges," *Development Policy Review* 27/2 (2009), pp. 185-214

31. UNAIDS, *"Three Ones" key principles: "Coordination of national responses to HIV/AIDS": Guiding principles for national authorities and their partners* (Geneva: UNAIDS, 2004).

32. UNAIDS, *Getting to zero: UNAIDS 2011-2015 strategy* (Geneva: UNAIDS, 2012).

33. Ibid.

34. Ibid.

35. The full framework is available at: www.heard.org.za/gender/nsp.

36. For further details on this programmatic work see: www.heard.org.za/gender/nsp.

37. A. Gibbs, E. T. Crone, S. Willan, and J. Mannell, "The inclusion of women, girls and gender equality in national strategic plans for HIV and AIDS," *Global Public Health* (forthcoming).

38. As defined by the UNAIDS Regional Support Team for Eastern and Southern Africa.

39. WHO and UNAIDS, *Preventing intimate partner and sexual violence against women: Taking action and generating evidence* (Geneva: WHO, 2010).

40. WHO and UNAIDS, *Addressing violence against women and HIV/AIDS: What works?* (Geneva: WHO, 2010).

41. R. Jewkes, M. Nduna, J. Levin, et al., "Impact of Stepping Stones on incidence of HIVand HSV-2 and sexual behaviour in rural South Africa: Cluster randomised controlled trial," *British Medical Journal* 337/7666 (2008).

42. G. R. Gupta, J. Ogden, and A. Warner, "Moving forward on women's gender-related HIV vulnerability: The good news, the bad news and what to do about it," *Global Public Health* 6/3 (2011), pp. S370-S382.

43. G. Barker, C. Ricardo, and M. Nascimento, *Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions* (Geneva: WHO, 2007).

44. S. Kalichman, L. Simbayi, M. Kaufmann, et al., "Alcohol use and sexual risks for HIV/AIDS in sub-Saharan Africa: Systematic review of empirical findings," *Prevention Science* 8/2 (2007), pp. 141-151.

45. Mkhize (see note 8)

46. L. Chen, J. Prahbat, B. Stirling, et al., "Sexual risk factors for HIV infection in early and advanced HIV epidemics in sub-Saharan Africa: Systematic overview of 68 epidemiological studies," *PLoS One* 2/10 (2007).

47. K. Shanon, T. Kerr, S. Strathdee, et al., "Prevalence and structural correlates of gender based violence among a prospective cohort of female sex workers," *British Medical Journal* 339 (2009), pp. b2939.

48. L. Itaborahy, *State-sponsored homophobia: A world survey of laws criminalising same-sex sexual acts between consenting adults* (New York: The International Lesbian, Gay, Bisexual, Trans and Intersex Association, 2012).

49. Gerntholtz (see note 2).

50. Itaborahy (see note 48).

51. K. Buse, C. Dickinson, and M. Sidibe,"HIV: Know your epidemic, act on its politics," *Journal of the Royal Society of Medicine* 101(2008), pp. 572-573.

52. Epperecht, M. *Heterosexual Africa*, (Pitermaritzberg: UKZN Press, 2009).

53. A. de Waal, *AIDS and power: Why there is no political crisis - yet* (London: Zed Press, 2006).

54. Epperecht (see note 52).

55. R. Connell, *Gender: In world perspective* (London: Polity Press, 2009).

56. De Waal (see note 53).

57. V. K. Nguyen, *The republic of therapy: Triage and sovereignty in West Africa's time of AIDS* (New York: Duke University Press, 2010).

58. Gibbs (see note 37).

59. D. Marks, *Perspectives on evidence-based practice* (London: Health Development Agency, 2002).