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GENDER, SEXUAL VIOLENCE, AND OPERATIONAL BARRIERS TO POST- EXPOSURE PROPHYLAXIS FOR HIV IN MEXICO

AUGUST 2010

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EXECUTIVE SUMMARY

While international standards recommend provision of post-exposure prophylaxis (PEP) to prevent HIV transmission following potential exposure through sexual violence (SV), few policies exist to operationalize this recommendation. Task Order 1 of the USAID | Health Policy Initiative conducted a policy review and situational analysis to explore operational barriers to PEP for those who have experienced sexual violence in Mexico and designed materials to increase demand for PEP services and improve their delivery through existing channels. The project focused on supporting gender-sensitive PEP services that facilitate access to PEP for most-at-risk populations (MARPs), such as men who have sex with men (MSM), transgenders (TGs), and at-risk women.

The Health Policy Initiative worked with healthcare providers and local- and national-level decisionmakers to identify barriers to PEP. In Mexico, SV survivors often do not report or seek treatment for sexual violence, and many are unaware that PEP exists. Fear of experiencing stigma and discrimination and the cumbersome nature of the current reporting, referral, and treatment systems also deter SV survivors from seeking care, especially MSM and TGs. In addition, healthcare providers often have little knowledge of PEP and lack protocols to implement it. Providers are also resistant to providing PEP for non-occupational exposures when PEP is often not available for their own potential occupational exposure to HIV. According to stakeholders, PEP is not a priority for high-level decisionmakers who control resources for health, and antiretrovirals (ARVs) for PEP are often not available.

In collaboration with stakeholders, including the national AIDS program (CENSIDA), the Health Policy Initiative designed materials to support more effective implementation of gender-sensitive PEP in Mexico, including a procedural flowchart on PEP protocol for service providers; a pamphlet for service providers on PEP, gender, and sexuality; and a training module on PEP, gender, sexuality, and violence. Unfortunately, due to political and budgetary limitations imposed by Mexico's response to the H1N1 epidemic, these materials were not piloted or disseminated as originally planned because ARVs for PEP were not available. However, the Ministry of Health plans to roll out the new materials as soon as resources are available to provide uninterrupted access to ARVs for PEP.

While the Health Policy Initiative was unable to implement all its planned activities, the participatory process used during the barriers assessment and design of PEP materials spurred an active dialogue among stakeholders on gender-sensitive PEP for sexual violence. This dialogue inspired advancements in providing PEP for SV at the three sites: Mexico City, the state of Mexico, and Puerto Vallarta. The dialogue also raised the profile of PEP for SV, especially among MARPs, and increased collaboration among actors to provide services for these vulnerable groups.

To overcome the barriers identified, it is imperative that providers, decisionmakers, and civil society continue to work together to explore the operationalization of PEP through evidence-based policy dialogue and existing international gold standard policies and protocols. Civil society groups, healthcare professionals, and Mexican authorities should demand that national policies, protocols, and norms on PEP, gender-based violence, and HIV reflect a gender perspective and recognize sexual violence as an emergent health issue with treatable sequelae. Efforts to increase awareness of PEP among MARPs and healthcare providers are essential to increase demand for and access to services by these vulnerable groups. Finally, PEP should be recognized as an essential HIV prevention strategy that can save the lives of people exposed to sexual violence because of their expressions of gender and sexuality.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ARV	antiretroviral
ART	antiretroviral treatment
BBC	British Broadcasting Corporation
CAPASITS	AIDS & STI Ambulatory Care and Prevention Clinic
CENSIDA	Mexican National AIDS Program (Center for Prevention and Control of HIV/AIDS)
CNEGySR	Mexican National Center for Gender Equity and Reproductive Health
CONASIDA	Mexican National Council for the Prevention and Control of HIV
FGD	focus group discussion
FSW	female sex worker
GBV	gender-based violence
H1N1	Influenza A virus, subtype H1N1 (popularly known as Swine Flu)
HIV	human immunodeficiency virus
IASC	Inter-Agency Standing Committee
IDU	injecting drug user
IGLHRC	International Gay and Lesbian Human Rights Commission
IGWG	Interagency Gender Working Group
ILO	International Labor Organization
MARP	most-at-risk population
MP	Ministerio Público/Attorney General
MSM	men who have sex with men
MSW	male sex worker
NGO	nongovernmental organization
NOM	Official Mexican Norm
PEP	post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PrEP	pre-exposure prophylaxis
RH	reproductive health
SAI	Comprehensive Care Service for PLHIV
SALVAR	Logistic and Tracking System for Antiretrovirals
STI	sexually transmitted infection
SV	sexual violence
SW	sex worker
TA	technical assistance
TG	transgender
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	U.S. Agency for International Development
WHO	World Health Organization

I. BACKGROUND

While international standards recommend provision of post-exposure prophylaxis (PEP) to prevent HIV transmission following potential exposure through sexual violence (SV), worldwide, few policies exist to operationalize this recommendation. Where policies are in place, a variety of barriers to effective implementation remain. SV is a form of gender-based violence (GBV). Women, who are marginalized and disempowered in some cultures because of their gender, are often victims of SV. Those whose sexuality is not aligned with cultural gender norms—such as men who have sex with men (MSM) and transgenders (TGs)—are also vulnerable to sexual and other violence. Moreover, barriers based on gender and sexuality often discourage SV survivors from seeking care and treatment, including PEP. To ensure equitable access to PEP for all SV survivors, PEP policies and implementation efforts should take such gender barriers¹ into account.

Through this activity, Task Order 1 of the USAID | Health Policy Initiative reviewed current international PEP policies with a gender lens and conducted pilot activities to identify and overcome barriers to full implementation of gender-sensitive PEP policies. The project chose to focus on Mexico because it offered an opportunity to explore the unique gender considerations that arise in a concentrated epidemic where certain vulnerable groups (including MSM and TGs) experience high rates of HIV prevalence and sexual violence, coupled with limited access to health services. Mexico also has national- and state-level antiretroviral treatment (ART) programs and a favorable policy environment in terms of HIV and homosexuality. The choice of Mexico, moreover, complemented previous project work on GBV and most-at-risk populations (MARPs) carried out in the country.

Unfortunately, the outbreak of the H1N1 epidemic in Mexico prevented the Health Policy Initiative from fully implementing activities as planned. This paper describes the completed activities, their impact, and recommendations for future action.

What Is PEP?

Post-exposure prophylaxis for HIV² is a shortened treatment regimen of antiretrovirals (ARVs) given to reduce the risk of transmission after a person is potentially exposed to HIV. The World Health Organization (WHO) and International Labor Organization (ILO) define PEP as “the medical response given to prevent the transmission of blood-borne pathogens following a potential exposure to HIV” (WHO and ILO, 2007, p.1). Evidence from several studies on PEP suggests that it greatly reduces HIV transmission, including in cases of sexual exposure (Cardo et al., 1997; Smith et al., 2005).

Literature on PEP generally divides exposure to HIV into two categories: occupational and non-occupational. The former refers to exposure to infected blood or bodily fluids in the workplace—generally among medical professionals, but sometimes among emergency responders, police, and sanitation professionals. The latter refers to exposure to HIV through sexual contact—a significant subset of which is sexual violence³—or injecting drug use. While PEP policies and protocols for occupational exposure are relatively extensive, much less information exists regarding PEP for SV (Herstad, 2009). Treatment for sexual violence is a complex topic, in part due to gender inequalities that often drive SV and affect survivors’ access to services.

¹ In this report, the term *gender barriers* refers to a broad spectrum of barriers related to gender, including those that arise from expressions of gender and sexuality that fall outside dominant gender norms.

² Hereafter in this report, PEP will be understood to refer to PEP for HIV.

³ Non-occupational exposure through sexual contact also includes accidents, such as a condom breaking, as well as consensual unprotected sex.

Gender, Sexual Violence, and HIV

GBV is a widespread public health problem that can increase vulnerability to HIV. It stems from unequal power relationships based on social and cultural norms around gender. The United Nations Inter-Agency Standing Committee (IASC)⁴ defines GBV as “any harmful act that is perpetrated against a person’s will, and that is based on socially ascribed (gender) differences between males and females” (IASC, 2005, p.7). Forms of GBV may include the following (IGWG, 2008):

- Physical, sexual, and psychological/emotional violence within the family
- Child sexual abuse
- Dowry-related violence
- Rape and sexual abuse
- Marital rape
- Sexual harassment in the workplace and educational institutions
- Forced prostitution
- Trafficking of girls and women
- Female genital cutting

Gender refers to the economic, social, political, and cultural attributes and opportunities associated with being women and men. The social definitions of what it means to be a woman or a man vary among cultures and change over time. Gender is a socio-cultural expression of particular characteristics and roles that are associated with certain groups of people with reference to their sex and sexuality.

*Interagency Gender Working Group
(IGWG)*

Sexual violence, a subset of GBV, can take many different forms.⁵ For the purposes of this paper, however, the term will be used to refer to coerced sexual acts that could result in exposure to HIV (also sometimes called sexual assault or rape). Sexual violence is pervasive worldwide and can have both indirect and direct consequences for sexual health and HIV transmission. It has many versions and manifestations and can be perpetrated by strangers, neighbors, or family members. As an example of the magnitude of SV, a multicountry study by the WHO found that between 6 and 69 percent of ever-partnered women reported experiencing some form of sexual violence by their partner (WHO, 2005).

It is important to note that women are not the only targets of GBV and SV and that some men and vulnerable populations routinely face violence as a result of their expressions of gender and sexuality. Research has shown that MARPs, such as MSM and TGs, experience high levels of violence, often sexual in nature (Jenkins, 2006; Betron, 2009).

GBV increases survivors’ risk for other physical and mental health problems, including HIV (WHO, 2005). The act of SV itself can directly increase the risk of HIV transmission, due to physical trauma and lacerations from the use of force, as compared with consensual sex. Studies have shown this to be true for both forced vaginal and anal sex (Jansen et al., 2002; Republic of Kenya, 2004).

GBV also affects survivors’ health through indirect, psychosocial mechanisms. Power imbalances resulting from GBV limit the ability of women and MARPs (such as MSM, TGs, and sex workers [SWs]) to negotiate condom use or to choose when and with whom to have sex, which in turn increases their risk for acquiring HIV and other sexually transmitted infections (STIs) (IGWG, 2008). Fear of further violence may also lead these populations to avoid testing for HIV, disclosing their serostatus, or seeking treatment for HIV. Additionally, the subordinate social status of women, MSM, TGs, and SWs in many cultures limits their access to resources such as money and transportation, which in turn hinders their

⁴ The IASC, which involves key United Nations (UN) and non-UN humanitarian partners, is the primary mechanism for inter-agency coordination of humanitarian assistance.

⁵ For further discussion of the forms of SV and terminology, see pages 15 and 16 of the WHO’s *Guidelines for Medico-Legal Care for Victims of SV* (2003).

ability to seek care and treatment for GBV and/or HIV. Moreover, many recent studies have outlined the relationship between a history of violence and vulnerability to HIV in diverse communities (Gupta et al., 2008; Ravi et al., 2007; Dunkle et al., 2004; Manfrin-Ledet and Porche, 2003; Niang et al., 2003; Wyatt et al., 2002; El-Bassel et al., 2001; Carballo-Diéguez and Dolezal, 1995).

PEP for SV Survivors

In most occupational exposures to HIV, the response is limited to risk assessment, treatment, and counseling for the medical consequences of the exposure. In cases of exposure to HIV caused by sexual violence, a multisectoral treatment approach should be adopted, which addresses the broader potential psychological, legal, and long-term health consequences for the survivor (see WHO and ILO 2007 PEP guidelines). Providing this type of comprehensive care can be challenging. It requires integration of post-sexual violence care with HIV prevention and legal services, which involves multiple sectors (e.g., law enforcement, sexual assault specialists, emergency departments, HIV clinics, social workers, community support systems, etc.) working together through efficient referral and communication systems. Clear, detailed, and well-disseminated operational procedures are vital to overcoming potential operational barriers.

Personnel involved in administering PEP for SV survivors may come from widely different sectors. Training them on PEP, sexual violence, gender, and referral procedures is essential to enable them to help survivors move through the system and access timely and appropriate care. Training on sexual violence and gender can help mitigate stigma and discrimination often experienced by SV survivors and MARPs in healthcare and law enforcement settings. Reducing such stigma and discrimination can increase access to PEP for those who need it most, as well as contribute to creating a more supportive environment for ensuring improved access to high-quality prevention, care, and treatment services.

Patients must initiate the PEP ARV regimen within 72 hours of exposure for it to be effective. Therefore, an efficiently functioning referral system and prioritization of PEP as a time-sensitive intervention are vitally important (WHO, 2005). Having a protocol in place to provide access to ARVs and counseling for SV survivors at all times is also crucial, as violence often occurs after hours and on weekends. This protocol should include consideration of alternative points of entry for SV survivors outside of normal business hours—such as the emergency departments of major hospitals, community organizations, or the Red Cross. Other important factors to consider when drafting PEP policies for SV survivors are testing protocols, risk assessment, and counseling, which can differ substantially from those offered for occupational exposure⁶ (WHO, 2003).

Mexican Context

HIV in Mexico

Adult HIV prevalence in Mexico is relatively low at 0.3 percent,⁷ while prevalence rates among MARPs are high, reaching 15 percent among male SWs (MSWs), 11 percent among other MSM, 5 percent among injecting drug users (IDUs), and 2 percent among female SWs (FSWs) (CENSIDA, 2009a).

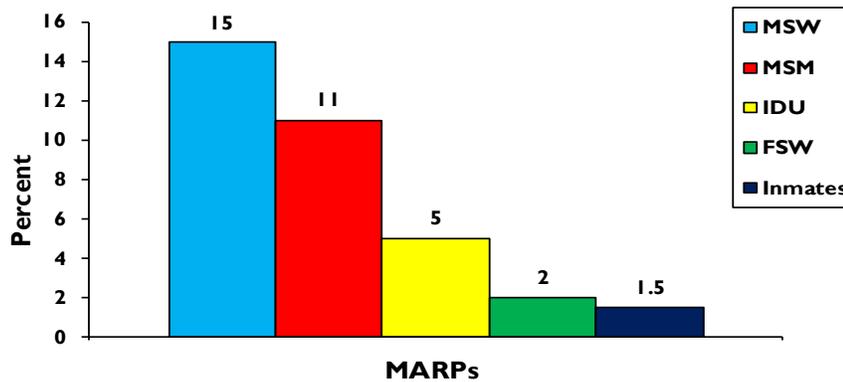
Mexico has an active national AIDS program, which includes specialized public HIV clinics called CAPASITS (AIDS and STI Ambulatory Care and Prevention Clinics), which provide testing, treatment, care, and support, as well as community outreach and prevention activities. The national program

⁶ For more detail on these considerations, see Herstad, 2009, and WHO and ILO, 2007.

⁷ Mexico's National Center for HIV Prevention and Control (CENSIDA). 2009

includes free, widely available ART for HIV and recognizes that prevention and treatment efforts in a concentrated epidemic must include a focus on MSM, TGs, SWs, and other most-at-risk groups.

Figure 1: Estimated HIV Prevalence among MARPs in Mexico, CENSIDA 2009



GBV and MARPs in Mexico

Partially in response to widely publicized cases of violence against MSM and TGs in the 1990s, Mexico adopted several progressive laws and policies outlawing discrimination. These laws include an amendment to the Mexican Constitution prohibiting discrimination based on sexual preference (2001) and a 2003 federal law to prevent and eliminate discrimination, which includes “appearance, mannerism, and expression of one’s sexual preference or gender” as a discrimination category (IGLHRC, 2004). Mexico City has progressive sexual identity policies that include recognizing official gender and name changes for TGs. Same-sex civil unions are recognized in Mexico City and Coahuila. Same-sex marriage and adoption by same-sex couples have been legal in Mexico City since early March 2010 (IGLHRC, 2004; BBC, 2009).

Despite this positive trend in Mexican policies on discrimination, MSM and TGs continue to experience high levels of stigma and discrimination, often manifested as violence, because they do not fit into traditional gender categories. The Joint United Nations Program on HIV/AIDS (UNAIDS) reports that two people a week are killed in Mexico because of their sexuality (UNAIDS, 2009). Other data on violence against MARPs are scarce, but anecdotal evidence suggests these populations experience high rates of violence, and recent Health Policy Initiative work on gender and violence in Mexico supports this finding (Betron, 2009).

Recent health policy initiative work on gender, violence, and health services in Mexico

From August 2007 to December 2008, the project conducted a pilot activity on screening for violence against MSM and TGs in Thailand and Mexico (Betron, 2009). Through a literature review and field assessments, the project developed a screening tool and protocol to detect GBV among MSM and TGs, which was implemented in CAPASITS in Puerto Vallarta and the state of Mexico, as well as at sites in Thailand. The results after six weeks of implementation showed that, in Mexico, of those screened, 50 percent of MSM and 65 percent of TGs had experienced violence in the last year (Betron, 2009). The majority of MSM and TGs having experienced any type of violence, experienced sexual violence (Betron, 2009). Furthermore, the research indicated that only 2 in 5 MSM and only 1 in 5 TGs who experienced

violence had sought help (Betron, 2009). This pilot activity demonstrated a high level of sexual violence among MARPs in Mexico and a low likelihood of these groups seeking care after the assaults.

Table 1. Levels of Violence Detected among MSM and TGs in Mexico (Betron, 2009)

Persons screened	#, % that experienced violence within past year	Type of violence, #, % of those screened				If experienced violence, previously sought help? #, %
		Emotional	Physical	Sexual	All Types	
	Yes					Yes
Mexico-MSM (n=142)	71 50%	42 30%	22 16%	67 47%	16 23%	29 41%
Mexico-TGs (n=51)	33 65%	29 57%	28 55%	33 65%	26 51%	10 20%

II. METHODOLOGY

The Health Policy Initiative’s activities in Mexico were designed to identify and mediate operational policy barriers⁸ to PEP, particularly those based on gender. The project completed a policy review, situational assessment, materials development, follow-up assessment, and provision of technical assistance (TA) to local partners. Due to political and budgetary complications brought on by the H1N1 virus epidemic in Mexico, the project was unable to fully implement activities as planned. More details on this issue are included in the section “Piloting of Materials.”

The Health Policy Initiative selected Mexico as the site for this work on PEP and sexual violence because of its national- and state-level ART programs, favorable policy environment in terms of HIV and rights related to sexual diversity, and its high rates of sexual assault among MARPs. Mexico also offered the opportunity to build on previous project work on GBV and MARPs carried out there. This activity focused on three pilot sites: Mexico City, the state of Mexico, and Puerto Vallarta. All three sites have high HIV prevalence and concentrated populations of MSM and TGs, as well as ART programs (CENSIDA, 2009a; CENSIDA, 2009b). The state of Mexico and Puerto Vallarta were both included in the Health Policy Initiative’s previous GBV/MARPs project, which identified high levels of sexual violence and low levels of access to healthcare in these areas. Returning to these sites allowed the project to capitalize on previous work and foster continuity of involvement on the topic—thus increasing the potential for impact.

The Health Policy Initiative first reviewed all national HIV and GBV policies related to PEP. The project’s participatory approach provided opportunities for collaboration with local partners and encouraged their input and feedback during each phase of activity implementation. The Health Policy Initiative gathered participants’ views on the current state of GBV and programs and policies on PEP for sexual violence and their suggestions for project interventions to address operational barriers to successful

⁸ The Health Policy Initiative defines operational policies as “the rules, regulations, codes, guidelines, and administrative norms that governments use to translate national laws and policies into programs and services” (Cross et al., 2001).

PEP implementation. This input informed the project’s activities and was shared with other stakeholders to stimulate enhanced dialogue on issues of sexual violence and PEP. Prior to commencing the Mexico-based activities, the project conducted an assessment of current international policies on PEP following sexual assault (Herstad, 2009).

Between June and October 2008, the Health Policy Initiative conducted a situational assessment. The assessment included nine interviews with national and regional decisionmakers in HIV and reproductive health (RH) and focus group discussions (FGDs) and structured interviews with 26 healthcare providers in three sites (see Table 2).⁹ Participating providers included doctors, nurses, social workers, and psychologists working at HIV treatment clinics. Interviewers questioned participants about their knowledge of PEP policies, current PEP procedures at their site, and training and materials for PEP; and asked participants to share their recommendations for improving operationalization of PEP. In each category, interviewers probed about PEP for sexual violence, as well as for any additional issues affecting women, MSM, and TGs.

Table 2. Situational Assessment Details

Site	HIV treatment facility	Type of data collection	N	Total n per site
Mexico City	Clínica Condesa	Individual interviews	4	4
Mexico State				14
• Ecatepec	CAPASITS	Focus group	7	
• Cuatitlán	Servicio de Atención Integral (SAI)	Focus group	7	
Puerto Vallarta	Regional hospital/ CAPASITS	Focus group, Group interview	6 2	8
			Total	26

Between October and December 2009, the Health Policy Initiative held follow-up interviews with 13 assessment participants to document the impact of project activities and collect further information on challenges and future considerations for PEP in Mexico. The loosely structured qualitative interviews asked participants to reflect on any gender-related changes to services or the environment that occurred as primary or secondary responses to the project’s activities and the related dialogue that emerged among stakeholders. To enhance impartiality, all but one of these interviews in Mexico City and the state of Mexico were conducted by Fundación Entornos, a Mexican health research nongovernmental organization (NGO). Health Policy Initiative technical staff conducted the remaining interview in Mexico City, as well as the interviews in Puerto Vallarta.

⁹ Providers in Mexico City were unable to come together for a focus group without disrupting service provision, thus they requested structured individual interviews instead. In Puerto Vallarta, providers participated in a focus group as well as a small group interview.

III. PROJECT ACTIVITIES AND FINDINGS

Phase I—Policy Review and Situational Assessment

Review of international PEP policies in PEPFAR (President’s Emergency Plan for AIDS Relief) countries

The project’s gender review of PEP policies for sexual violence in PEPFAR countries found that while almost all PEP policies include guidelines for PEP for sexual assault, most lack the appropriate detail to address gender barriers that hinder implementation of the policies (Herstad, 2009). The review also identified criteria for access to PEP following a sexual assault, suggested elements of service provision, and outlined key components of a gender-sensitive PEP policy for sexual assault. To complete that review, the Health Policy Initiative developed a framework for gender analysis of PEP guidelines for sexual violence (see Figure 2), which the author then applied to the guidelines for PEPFAR countries¹⁰ (Herstad, 2009). In the framework, the Health Policy Initiative identifies several areas where gender barriers might arise, such as criteria for access to PEP, access to PEP services and quality of PEP care for SV survivors—as well as whether the guidelines explicitly talk about PEP for sexual violence at all. While Mexico is not a PEPFAR country, the information gathered through the review provides a broad policy overview that informs this paper.

Review of PEP policies in Mexico

Mexico has several progressive policies regarding HIV and sexual orientation, particularly in Mexico City. The policy review found that several federal health policies include PEP, both in HIV and RH policies. Highlights from the policy review follow.

The Official Mexican Norm (NOM) NOM-10-SSA2-199311, for prevention and control of HIV, establishes federal standards for prevention, care, and treatment of HIV. A subsequent modification to this NOM (2000) states that PEP should be carried out according to the latest edition of the *Guía para la atención médica de pacientes con Infección por VIH/SIDA en Consulta Externa y Hospitales* (Guidelines for Medical Care of Patients Infected with HIV/AIDS), approved by the Ministry of Health (CONASIDA, 1997). In these guidelines, there is a dedicated chapter on PEP for occupational exposure by healthcare workers, as well as a very brief mention of non-occupational exposure—referring to sexual exposure.¹²

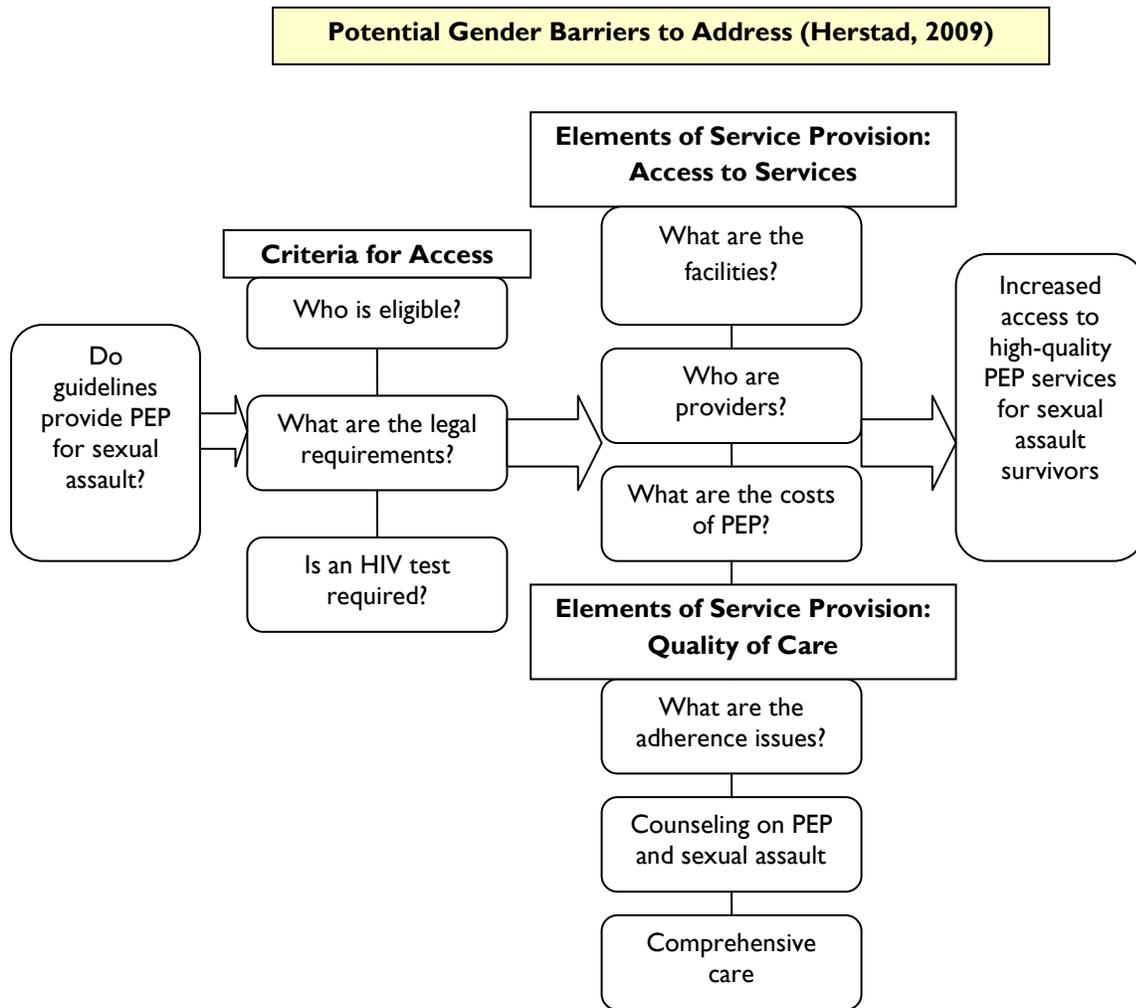
The *Guide to Antiretroviral Care in Persons with HIV* (third edition, CENSIDA, 2007, p.45) mentions preventing HIV transmission, particularly in cases where sex acts were carried out in a “violent manner and by multiple perpetrators who practiced vaginal or rectal penetration, with or without ejaculation.” The guide outlines which ART regimens to use in specific situations, details appropriate measures to avoid STIs, and makes specific recommendations about PEP for pregnant women. It recommends against using PEP in cases where patients exhibit “high-risk sexual behavior” with multiple partners whose HIV status is unknown or if the exposure was on intact skin, just mucous membranes, or exclusively through oral sex. Finally, the guide recommends offering treatment to serodiscordant couples who experience contraceptive failure or for family members of people living with HIV (PLHIV) if they are accidentally pricked with a potentially infected needle.

¹⁰ PEPFAR focus countries included in this analysis were Botswana, Côte D’Ivoire, Ethiopia, Guyana, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia. At the time of publication, Haitian guidelines could not be accessed and Vietnamese guidelines did not include PEP for sexual violence in their guidelines (Herstad, 2009).

¹¹ Available at <http://www.salud.gob.mx/unidades/cdi/nom/010ssa23.html>.

¹² In 2000, the Secretary of Health, through CENSIDA, published a second-edition technical guide on “Prevention and Treatment for Occupational Exposure in HIV,” which has not been updated since and has instead been replaced by this chapter in the guidelines for care of patients with HIV/AIDS.

Figure 2. Framework: Gender Analysis of PEP Guidelines for Sexual Assault



PEP is also mentioned in *An Integrated Model for the Prevention and Care of Domestic and SV*, an operating manual published by the National Center for Gender Equity and Reproductive Health (CNEGySR, part of the MOH). This manual contains more information on PEP for sexual exposure than any other national-level policy or guideline. It contains a chapter on the legal responsibilities of healthcare personnel when caring for survivors of domestic violence, which includes guidelines for medical care for sexual violence, such as emergency contraception and prophylaxis for STIs, including PEP for HIV.

While PEP was included in national-level policy documents, from an operational standpoint, these documents provide insufficient detail on how to successfully implement PEP. References to PEP are cursory in general, and mention of non-occupational exposure is even more limited. In addition, these policies do not discuss gender issues, and there is no explicit mention of using PEP with MARPs, despite elevated rates of HIV and sexual violence among these groups.

Situational assessment of barriers to PEP

As mentioned in the Methodology section, the Health Policy Initiative conducted a situational analysis through FGDs and interviews with healthcare personnel and decisionmakers. The follow-up interviews conducted from October–December 2009 yielded additional information on barriers faced by MARPs

when accessing PEP and challenges that PEP will face in the future. This section presents barriers identified during both rounds of interviews as well as those identified during activity rollout.

ARV availability and funding

According to stakeholders, PEP is not a national healthcare priority—particularly for non-occupational exposures. Existing policies have had little implementation. The government does not provide ARVs for PEP for sexual violence to CAPASITS and, due to budget restrictions brought on by the H1N1 virus outbreak, the government is unable to pay for ARVs that are not destined for treatment of identified PLHIV. Clinics that offer PEP for sexual violence are able to do so only because they have leftover ARVs from current patients who change ART courses—which is not a reliable or sustainable source of medication. While some states have allocated state money to pay for PEP, most states have not. Several providers and decisionmakers also pointed to the lack of a dedicated budget line item for PEP within their institutions as a barrier to reliable supplies of ARVs for PEP.

ARVs must be securely financed and distributed before promoting PEP, so as not to create a demand that cannot be met by existing services. This is of particular concern for cases of sexual violence, where seeking hard-to-obtain services can increase the visibility of an SV survivor and potentially put the person at risk for further violence. If such individuals are encouraged to come forward only to find that treatment is unavailable, they are unlikely to seek treatment in the future and may share their negative experience, thereby discouraging others from seeking treatment. As a result, promoting PEP before services are consistently available could ultimately decrease demand for PEP. To avoid this situation, the Health Policy Initiative and the government of Mexico decided not to disseminate the PEP materials developed by the project, as there was concern that they could increase demand for PEP services at a time when ARVs were unavailable in part due to resource limitations brought on by the H1N1 epidemic.

Operational barriers

The interviews revealed a variety of operational barriers that impede provision of PEP throughout the system, from reporting sexual violence to provision of services.

Stakeholders mentioned that even the initial process of reporting sexual violence through the Attorney General's office, the Ministerio Público (MP), presents several barriers. To report SV to the police, a forensic physician at the MP must examine the survivor. The process of reporting sexual violence through the MP is lengthy and can delay referral to a healthcare facility and cause survivors to miss the window of opportunity to receive PEP. To receive care, an SV survivor might have to undergo multiple examinations, both at the MP and then at a health center. In addition to being potentially traumatic for the survivor, this can delay treatment. Poor communication between the MP and healthcare facilities can also result in problems with referrals, further complicating individuals' ability to receive PEP in a timely manner.

Several stakeholders highlighted an additional logistical barrier—the SALVAR (Logistic and Tracking System for Antiretrovirals) computer system used by CENSIDA and clinics to monitor and order ARVs. Every ARV ordered through SALVAR must be assigned to an HIV-positive person (with proof of a positive HIV test), and there is a delay of several weeks between entering a person in the system and receiving the ARVs. This tracking system was established to avoid waste and potential corruption; however, it poses a challenge to operationalizing PEP. This barrier could be overcome with adjustments to the database or the protocol. However, it is indicative of the tight control exercised by the federal government over ARVs and its reluctance to finance PEP due to budgetary constraints and the high cost of ARVs.

Furthermore, CENSIDA currently does not collect data on PEP for sexual violence, and the federal entity that deals with GBV from a health perspective—the National Center for Gender Equity and Reproductive

Health—does not systematically collect data from health centers on the prevalence of sexual violence. As a result, limited data exist to assess the magnitude of SV—particularly among MSM and TGs. Such data could help document the need for PEP for sexual assault and allow accurate projections of the potential budgetary impact of systematic provision of PEP for SV.

Many stakeholders mentioned the federal government’s existing policies for HIV and stigma and discrimination as progress. However, they went on to point out the lack of attention to PEP and the need for standardized clinical protocols. They expressed concern for how providers could operationalize and implement PEP, particularly for sexual violence. One specific concern, for example, was the need for an explicit protocol to assess risk in a potentially exposed person to determine whether the exposure risk warranted a PEP regimen. Stakeholders recommended piloting the materials developed by CENSIDA and the Health Policy Initiative on an operational protocol for PEP, disseminating them to key actors across sectors, and training these actors on their use.

Finally, many stakeholders expressed concern about the potential magnitude of PEP treatment in Mexico and the resulting burden on the health system. One specific concern cited was that, if PEP were made more widely available, the health system would be unable to meet the demand without sacrificing other essential health services. The lack of information on magnitude of need for PEP is another part of the problem.

Healthcare provider attitudes and knowledge

One key finding from interviews with healthcare providers is that, when asked to discuss PEP, providers’ primary concern was related to occupational exposure and ensuring their own personal safety. Providers viewed establishing PEP for occupational exposure as a prerequisite for offering it to patients exposed in non-occupational settings. They reported a lot of ignorance among general hospital/clinic staff about risk evaluation (i.e., what constitutes real risk for exposure to the virus), as well as dramatic under-reporting and therein treatment of occupational accidents.

In terms of their ability to provide PEP services to others, providers felt they lacked the preparation, training, and information needed to manage the topic of PEP with their patients. While national policies and protocols on PEP do exist, they are not well disseminated to healthcare providers. Providers, moreover, lack protocols and materials to help them operationalize provision of PEP in healthcare settings. The interviews revealed that providers largely were unaware of the following:

- National or regional policies on PEP
- The existence of operational guidance for PEP or any other tools/guidelines with clear procedures and reference systems for PEP risk evaluation and treatment (pertaining to either occupational or non-occupational exposure)
- The existence of institutional strategies for PEP, including standard operating procedures (which did not exist in most sites)

Some stakeholders also expressed concern about the efficacy of PEP for sexual assault, as compared with occupational exposure, and pointed to the lack of SV-specific literature on PEP efficacy.¹³ In addition, stakeholders expressed concern about how to deal with the subjectivity of risk assessment after sexual violence, especially when the serostatus of the perpetrator is unknown. As many of these concerns are addressed in international literature and programming, evidence-based dialogue with stakeholders highlighting PEP literature and best practices could help assuage these concerns and inform policies and programs.

¹³ Most literature on PEP efficacy deals with occupational exposures; however, the Centers for Disease Control and Prevention have conducted research that points to the efficacy of PEP for sexual exposure as well. See <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm>.

Finally, several interviewees expressed concern about the potential of PEP for non-occupational exposure to encourage high-risk behavior (i.e., would more people engage in unprotected sex, knowing that they could take PEP afterwards?). Providers wondered whether they should offer PEP to anyone exposed sexually (including accidents and consensual unprotected intercourse) or only to those who experienced sexual violence and how that distinction would be made. These discussions also raised the issue of pre-exposure prophylaxis for HIV (PrEP)—when a person who knows he/she will be exposed to HIV through sexual contact or injecting drug use begins a preventive regimen before the exposure.

Stigma and discrimination

Interviewees explained that traditional gender norms in Mexico marginalize MSM, TGs, and SWs, because providers may not consider them to be susceptible to sexual violence, may not believe that sexual exposure was not consensual, may interpret SV as part of sexual deviance, and/or may feel that MSM, TGs, and SWs who experience sexual violence are “getting what they deserve.” Providers mentioned that many actors, such as emergency responders, the MP, and the police are also not familiar with the particular needs of MARPs or are unsure how to treat them or where to refer them to for services. Interviewees mentioned that MSM, TGs, and SWs are much less likely to seek treatment for sexual violence at a hospital or report the incident through the MP as a result of personal experiences with homophobia, machismo, and discrimination in healthcare settings or with authorities such as the police. These individuals often fear discrimination or further violence. Additionally, according to providers, even when MSM, TGs, and SWs seek care after experiencing sexual violence, they usually seek treatment only if severe physical injuries were incurred in the assault. Many patients do not mention the sexual component of the assault. Nor are they regularly screened for SV at the emergency department due, at least in part, to ignorance or prejudice on the part of the providers. Reluctance to self-identify as a survivor of sexual violence can lead to a delay in reporting SV until days or weeks after the attack, which leaves survivors outside of the window of efficacy to begin a PEP regimen.

Several stakeholders voiced the need to change norms on how the healthcare community and the general public perceive sexual violence. They suggested that SV should be acknowledged as a medical emergency for which a person should go to a health center to receive immediate care and treatment that can help them avoid major negative health consequences. The low reporting levels of SV suggest that this is currently not the case. The dramatic underreporting of sexual violence is a barrier to PEP, as potential PEP candidates cannot be identified and appropriately referred if they do not go to the police or a health center to seek care.

Phase II—Development of Intervention Activities

After completing Phase I, the Health Policy Initiative shared its findings with providers, decisionmakers, and other local partners. At a December 2008 stakeholder meeting, project staff presented interventions to overcome operational barriers to PEP proposed by stakeholders in assessment interviews, as well as their own suggestions. The meeting included assessment participants, as well as additional high-level local and national decisionmakers. Project staff worked with the 20 participants to collectively devise a set of interventions to be implemented by the Health Policy Initiative. The meeting yielded consensus on the following interventions:

- Developing modules for trainings on gender and PEP for actors involved in responding to sexual violence (healthcare workers, MP, NGOs) to increase knowledge of PEP and SV and raise awareness of the needs of MARPs
- Developing materials on standard operating procedures for PEP for occupational and non-occupational exposure
- Providing TA to facilitate the integration of PEP into existing healthcare services provided to MARPs

- Providing TA to promote coordination among institutions involved in PEP for SV response (development of a directory and flowchart for referring potential PEP cases)
- Providing TA in advocacy to support efforts to create a national budget line item for PEP

After the stakeholders meeting, the Health Policy Initiative worked with CENSIDA and healthcare providers to develop the proposed PEP training and educational materials. The content of these materials drew on responses from the assessment, as well as on international standards for PEP and sexual violence.

Creation of PEP training and educational materials with CENSIDA

Training module for healthcare providers on PEP for SV

In collaboration with CENSIDA, the project created a training module for healthcare providers on PEP for sexual violence. This training module includes discussions of gender, GBV, and SV and their implications in different risk populations (see Box 1 for an outline of module's content).

Box 1. Training Module Outline on PEP for SV in Mexico

1. Introduction
 - Gender, sexuality, stigma and discrimination
 - GBV
 - SV
 - Implications of HIV in women, men, and TGs
 - Non-occupational PEP
2. Modes of HIV transmission
 - Considerations for sexual transmission
3. GBV and HIV in MARPs
4. Current policies on non-occupational PEP
5. PEP for
 - Pregnancy prevention (emergency contraceptives)
 - Healthcare workers
 - Unprotected sex
 - SV
6. Course of action for healthcare providers when a person has experienced SV
 - Flowchart for care of SV
7. Preventable consequences of SV
 - Pregnancy
 - STIs, including HIV
8. Recommendations for administering PEP
 - Risk evaluation
 - Importance of antibody testing for HIV
 - Pregnancy testing
 - Serological testing for STIs (Gonorrhea, Chlamydia, Syphilis, Hepatitis B)
9. Psychological support for SV survivors:
 - Counseling on PEP and SV
10. Human resources requirements and materials to implement PEP for non-occupational exposure
 - Access to facilities
 - Healthcare providers
 - Follow-up for SV cases

During the drafting process, portions of the module were included in non-project trainings to solicit feedback and test effectiveness. The complete module was not pilot tested prior to completion of the project's work.

Procedural flowchart on PEP for healthcare personnel

In collaboration with CENSIDA, the project designed a chart illustrating how to evaluate risk in occupational exposure and what ARV prophylaxis to use based on the source patient's serology. This chart was designed to be posted in healthcare facilities as a reference for providers. The chart is intended to help address providers' concerns about occupational safety, as expressed in the assessment.

Pamphlet on PEP for SV in Mexico

The Health Policy Initiative and CENSIDA also produced a pamphlet on PEP for sexual violence in Mexico—targeted at healthcare providers, based on the Policy Brief on PEP in Mexico. The pamphlet presents a definition for GBV and gives background on exposure to HIV through sexual violence, including how GBV puts women, MSM, and TGs at risk for HIV. It explains that both men and women can experience sexual violence, details what PEP is and what PEP for SV is, and explains that there are gender barriers to implementing PEP. The pamphlet is designed to raise awareness and increase knowledge among healthcare providers of PEP for sexual violence and the influence of gender issues in the exposure and treatment processes.

Piloting of materials

Situational factors related to the H1N1 virus epidemic prevented the Health Policy Initiative from fully implementing some planned project activities. The H1N1 epidemic cost the government 4,300 million Mexican pesos (more than US\$325 million), absorbed a large chunk of the 2009 health budget, and dramatically affected health services for several months¹⁴ (Guerrero, 2009). The epidemic hit just as the project was preparing to pilot its intervention materials and begin drafting a reference directory for responders to sexual violence in each site. In such a time of medical crisis, preventive health measures, such as PEP, were sidelined in order to deal with more urgent issues. Several months later, once the epidemic was more controlled and health services began to return to pre-outbreak status, the Mexican government's H1N1 expenditures caused crippling cuts across the health budget. These budget cuts dramatically affected CENSIDA and other federal health institutions. As a result, decisionmakers faced difficult choices about which services were essential, and there was limited support for pilot projects, such as the PEP project. Under the restricted budgets, federal financing for ARVs for PEP was not available, and the Health Policy Initiative could not ethically proceed with a full pilot of the training and materials as originally planned without available treatment. Portions of the training module were piloted in the materials development phase.

Phase III—Impact of Implemented Project Activities

Although piloting and dissemination of the PEP training and education materials was not possible, the stakeholder dialogue and creation of the key materials had a positive impact on program areas and local partners.

Project outcomes

During the follow-up interviews, respondents reported several important outcomes of the implemented activities.

¹⁴ Using an exchange rate of 13.2 pesos to the dollar on the date the article was published
<http://www2.esmas.com/noticierostelevisa/mexico/nacional/105651/ssa-influenza-ah1n1-costado-4-mil-300-mdp>.

Availability of reference and training materials on PEP protocol, gender, and sexuality

Prior to this activity, little information on PEP protocols, gender, and sexuality existed in Mexico. Key materials were developed in collaboration with stakeholders, including CENSIDA:

- Policy brief on PEP in Mexico
- Procedural flowchart on PEP protocol for service providers
- Pamphlet for service providers on PEP, gender, and sexuality
- Training module on PEP, gender, and sexuality

These materials are ready for piloting and implementation as soon as ARV funding issues are resolved.

Increased awareness, understanding, and interest in PEP for SV among stakeholders and providers

Through both formal and informal project discussions, many institutions, stakeholders, and providers who participated in the activity gained greater awareness about SV, MARPs, stigma and discrimination, as well as PEP for sexual violence, how it can be implemented, and gender considerations related to PEP for SV. At the beginning of the activity, some participants were unaware that PEP existed for sexual violence, and many had not thought about the implications for MSM and TGs. Through pre- and post-assessments, stakeholder meetings, and creation of new materials, the project raised the profile of issues related to PEP for SV and engaged national and local decisionmakers and healthcare providers in an active dialogue about the issue.

Improved institutional collaboration

Stakeholders reported increased institutional collaboration resulting from participation in both the previous Health Policy Initiative activity on screening for GBV among MARPs and the current activity on PEP, especially in Puerto Vallarta. Both projects repeatedly brought stakeholders together from different sectors involved with HIV, GBV, and MARPs in Puerto Vallarta to discuss the issue. As a result, stakeholders described increased dialogue, information exchange, and collaboration outside of project-supported activities.

Successes with PEP and SV in the three sites

The project's participatory approach and its efforts to raise awareness and generate dialogue among key stakeholders led to advances related to gender-sensitive provision of PEP for sexual assault in all three project sites. In many cases, the project provided TA to the sites to support their efforts to improve access to PEP for sexual violence.

Mexico State. The state of Mexico's HIV program had proposed making ARVs for PEP available in a few major hospitals in case of possible sexual violence and purchased ARVs for this use. Unfortunately, lack of awareness and some medical personnel's refusal to participate posed challenges to implementation. Conflict also arose over whether responsibility for providing PEP would fall to the preventive medicine service or the emergency department because PEP is both a prevention strategy and a response to a medical emergency. Such challenges and a lack of clear operational protocols prevented the program from being fully implemented and the medicines expired.

In December 2008, with TA from the Health Policy Initiative, the state of Mexico began implementing a pilot program for PEP for sexual violence at CAPASITS in Ecatepec and Cuautitlán. In conjunction with CENSIDA and the Health Policy Initiative, the state program trained and educated staff from all CAPASITS in the state on PEP for sexual violence, as well as MP staff and other healthcare workers. This training generated a lot of interest and the desire to create a referral system to effectively manage PEP services. The pilot project in Ecatepec and Cuautitlán is multidisciplinary, offering survivors both medical treatment and psychosocial assistance. It includes risk assessment based on case history and patient follow-up over time. Between December 2008 and October 2009, the program treated five SV

survivors referred to the CAPASITS by the MP. However, the program suffers from limited resources, low demand for services, and a need for increased technical support from the state government.

Puerto Vallarta. In Puerto Vallarta, stakeholders saw the PEP activity as a natural extension of the Health Policy Initiative's previous work on GBV and MARPs. In 2009, the project collaborated with CENSIDA to pilot portions of the training modules on PEP and MARPs for healthcare providers, which informed the final PEP training module designed by the project (see Box 1).

As a result of increased awareness of GBV among MARPs, the Mesón—which began as a temporary shelter for those who come from less populated areas to seek care for HIV—opened to survivors of GBV as well. Mesón offers direct links with healthcare services for MSM and TGs in the state of Jalisco, where Puerto Vallarta is located, including referrals to local CAPASITS and Red Cross clinics. While the establishment of Mesón was not directly spurred by the project's PEP-related activities, stakeholders report that increased interest in access to GBV services for MSM and TGs increased the number of stakeholders wanting to be involved in the center's creation. In addition to the changes at Mesón, key informants reported that the gay community center in Puerto Vallarta plans to help raise awareness of PEP for sexual violence among MSM and TGs and the center for survivors of violence, which previously offered services only to women and children, changed their policies to offer access to MSM and TGs.

Mexico City. The Condesa Clinic in Mexico City—the largest specialized HIV clinic in Latin America and the Caribbean—began implementing a post-SV care program in December 2008. The Health Policy Initiative trained clinic staff and MP personnel on gender-sensitive PEP services for SV survivors. Following the trainings, the clinic developed its own PEP policy and operational guidelines, including PEP for SV survivors. The project's ongoing TA supports the clinic's impressive comprehensive approach to SV care, which includes counseling, psychological care, and medical services such as prophylaxis for HIV, STIs, pregnancy, and follow-up care and testing. The clinic serves many MSM and TGs, and the project's training on gender-sensitive PEP service provision has benefitted both clinic staff and patients.

Lessons Learned

Participatory processes ensure stakeholder buy-in

One major lesson learned from this activity is the importance of using participatory approaches. The project worked with various stakeholders to identify operational barriers to PEP, with a gender focus, and design corresponding intervention materials. At every stage, there was a feedback loop or direct collaboration with decisionmakers and providers. This participatory process was vital to understanding the Mexican context—both from decisionmaker and provider perspectives. The participatory approach allowed for ongoing learning and awareness of changes in the policy context. The project's participatory approach also encouraged buy-in and ownership of the process by decisionmakers and key stakeholders. Regardless of other countries' differing policy, HIV, and SV contexts, the process followed in this activity is replicable and can help reveal the intricacies of gender-related barriers to PEP.

PEP for occupational exposure is a necessary precursor to successful PEP for SV

The project's assessment in Mexico revealed the importance of ensuring that healthcare providers have access to PEP for occupational exposure as a precursor to providing PEP for SV. The project found that many healthcare providers lacked knowledge about PEP for occupational exposure and were highly concerned about protecting themselves at work. Because most providers came from sites that did not regularly provide PEP, they were primarily concerned about how to operationalize PEP in cases of occupational exposure. This made it more difficult to explore the gender intricacies in PEP services for non-occupational exposure. If PEP for occupational exposure is not in place, it may be difficult to ensure provider buy-in for PEP for SV.

The general SV response mechanism must be strengthened before PEP can reach MARPs

While, in theory, SV care and PEP are currently available, in reality, those with the greatest need for these services are not accessing them. Heterosexual women, as well as MARPs, are underutilizing SV care and PEP due to providers' lack of knowledge of PEP for SV and patients' hesitance to seek out PEP for fear of discrimination. To facilitate patients' access to PEP for SV, it is important to ensure that points of entry to SV services address gender and that in countries with concentrated HIV epidemics, like Mexico, providers and emergency responders are aware of the high prevalence of sexual violence and HIV among MSM, TGs, and SWs and screen accordingly. Stakeholders noted that demand for PEP for SV is generally quite low and is even lower among MARPs. They recognized the need for civil society groups to engage in promoting awareness of PEP for special circumstances such as SV and addressing operational policies that impede provision of PEP for all who need it.

Interventions that help providers better identify SV survivors when they visit the emergency department for other assault-related injuries increases the opportunity to detect sexual violence and provide PEP, especially for MARPs. This is often a missed opportunity to detect sexual violence and offer timely treatment in populations that rarely access traditional healthcare facilities for fear of discrimination and rarely self-identify as having experienced SV. That said, there are many careful considerations around who, when, how, and where to screen for GBV,¹⁵ and there are issues of confidentiality and the ability to refer patients for adequate treatment and care—all of which require thoughtful preparation and training of staff administering the screening, as well as gender sensitivity.

A smooth referral network is key to moving SV survivors through the system

In Mexico, some pieces of the system were in place to provide PEP, but without clear communication among the actors and agencies involved in moving patients through the system, especially MARPs, victims will not receive the comprehensive care they require. To accomplish smooth referrals, healthcare providers, MPs, and other social and legal service providers need to be aware of PEP, protocols for PEP, and which other agencies need to be involved. Training for all actors not only on their role in the process but on the roles of others can help ensure comprehensive treatment.

Shifting priorities require continuous advocacy

Ensuring uninterrupted and equal access to PEP is on a long list of priorities for decisionmakers in Mexico. As demonstrated by the shift of attention and resources to the H1N1 virus during the activity, competing priorities can drop PEP to the bottom of the list at any time. Steps, such as creating a dedicated budget line item for ARVs for PEP and implementing interventions that increase providers' understanding of and patients' demand for PEP can help maintain services when priorities shift, but ongoing advocacy is required to keep PEP high on the list of policy priorities.

Facilitating dialogue helps reduce barriers to operationalizing PEP

While the project was unable to fully pilot and disseminate the materials created to support operationalization of PEP, the dialogue generated among stakeholders fueled some positive changes to the system. While some policy changes needed to increase access to PEP require high-level, coordinated efforts, access can also be improved when individual clinics and service providers make changes and share information and ideas.

Recommendations/Next Steps

Through a participatory process involving key decisionmakers and providers, this activity identified operational barriers to PEP provision in Mexico. Through the resulting situational analysis and

¹⁵ For further considerations of screening for GBV, see IGWG of USAID, 2008. For further discussion of screening for MSM and TGs for GBV in Mexico, see Betron, 2009.

intervention development, the Health Policy Initiative recommends the following actions to help achieve gender-sensitive and sexual orientation-sensitive PEP provision for SV survivors in Mexico.

1. Increase awareness of PEP among MARPs and PLHIV groups and increase civil society demand for gender-sensitive PEP for sexual violence

The Health Policy Initiative recommends undertaking advocacy and awareness-raising strategies with civil society groups about PEP for SV, particularly PLHIV, MSM, TGs, and SV and GBV survivor groups. This will require collaboration among groups from traditionally different backgrounds, such as women's and HIV groups. As such collaboration is currently limited, this may require thoughtful and creative approaches to overcome obstacles to such joint efforts. Advocacy strategies should include information about sexual violence as a medical emergency, PEP as a prevention strategy, and how stigma and discrimination around sexual violence and gender increases certain population groups' HIV risk. Without an active civil society demand for gender-sensitive PEP services for SV survivors, it is likely that government officials will continue to see PEP as an expendable service instead of an essential HIV prevention strategy.

2. Use evidence and advocacy to build support and secure financing for ARVs for PEP

Before taking other steps to implement PEP, it is imperative that the financing issues for ARVs for PEP be resolved, so that the medicines are consistently available at sites that will offer PEP. Ideally, ARVs for PEP should be financed through a separate budget line item—a secure and sustainable mechanism for ensuring the availability of funds. To achieve this goal, civil society and other stakeholders should engage in evidence-based policy dialogue with state and federal health programs. To help inform these arguments, further research on gender, SV, and HIV may be necessary to determine the likely number of SV survivors requiring PEP and the potential burden of disease averted. If possible, such research should be carried out concurrently with implementation to avoid delaying access to PEP. PEP should be recognized as an essential HIV prevention strategy that can save the lives of people who are discriminated against and exposed to violence because of their expressions of gender and sexuality. Demonstrating that a small investment in PEP would prevent more costly treatment in the future (if those exposed subsequently seroconverted), may assuage decisionmakers' concerns about financing PEP. Advocates should also present existing recommendations from internationally recognized bodies, such as the WHO and ILO.

3. Create and roll out gender-sensitive operational protocols

Once financing has been secured and availability of ARVs ensured, federal and state health programs should implement operational protocols for PEP for both occupational and non-occupational exposure, including a focus on gender and MARPs. While national health policies include PEP, providers need standardized operating procedures to dispense it, particularly in cases of sexual violence. The protocols should include protocols for risk assessment, after-hours access to PEP, referrals, counseling, testing, and patient follow-up—all the gold standard components recommended by the ILO and WHO (2005).

Once protocols are developed, dissemination strategies to roll out the operational protocols to all actors involved in providing PEP for SV (MP, law enforcement, call centers, emergency responders, etc.) should be implemented. To ensure understanding of the materials, dissemination should be accompanied by training for all actors involved in PEP provision. This training should be comprehensive, up-to-date, and repeated for new personnel. To help make services more accessible to MARPs, the training should involve strong stigma and discrimination reduction and gender and sexuality components. Disseminating the materials designed in partnership with stakeholders during this activity could be a first step in operationalizing PEP. Developing a monitoring system will be the final step to ensure continued availability of high-quality PEP services.

4. Strengthen referral networks and access points for PEP for all SV survivors

Linking points of entry and treatment services through an efficient, well-organized referral system is imperative if SV survivors are to receive timely access to PEP and other medical treatment. While this research specifically examined HIV services, it is important that GBV services also work to ensure that they are gender-sensitive for all GBV survivors—not just heterosexual women—as this will increase access to PEP for other vulnerable populations. GBV-specific services and clinics should be examined for gender-sensitivity and any lessons that might be shared with HIV services. The Health Policy Initiative recommends that involved actors work together to develop a referral directory and protocol and that this be implemented once recommendations two and three are in place.

This referral system should take into account hours of operation (and how referrals should change after hours), points of entry where MARPs are likely to seek care, and components of comprehensive care for SV survivors. In particular, law enforcement and the MP should be a key part of this system. As stated in recommendation three, all members of the referral network should receive training on PEP protocols, including gender, sexuality, and stigma components. All actors should be trained on their specific role within the SV response but also have knowledge of what a comprehensive response looks like and who is involved so they are able to facilitate survivors' access to services.

5. Build community response capacities for peer-supported work related to identifying and preventing SV in marginalized communities

To build community resilience to GBV and SV, it is necessary to work with vulnerable groups who are marginalized in society and therefore often lack the necessary capacities to build a sustained community response. This can be the case for MSM, TGs, SWs, and poor urban youth (especially girls), who are often more vulnerable to sexual and other forms of violence. To build a stronger community, it is necessary to work with community members to increase their understanding of health services and build their communication and advocacy skills to ensure that they can access health, social, and legal services. This process can also help reduce stigma and discrimination.

Building the social capital of marginalized groups helps ensure their representation in policy discussions about health and social services. Building social capital entails increasing awareness, fostering group cohesion, and developing competencies—all of which helps increase collective ability to respond to needs. This process should also build resilience to help promote dialogue with public authorities and emergency care professionals to ensure better access to services and contribute to a community that is better equipped to prevent sexual violence.

IV. CONCLUSION

In conclusion, many barriers to implementing PEP for HIV exist in Mexico, particularly for SV survivors. Many people do not view sexual violence as a medical emergency, and survivors often do not seek out care and treatment because of stigma and discrimination, fear of further violence, or lack of high-quality services. Screening, referrals, and care for SV could be improved and made more comprehensive, and healthcare providers need more guidance and training on operationalizing PEP for SV. The populations most-at-risk for sexual violence and resulting HIV transmission (MSM, TGs, SWs) are unaware that PEP is available. Many decisionmakers and clinicians have not fully capitalized on PEP's potential to prevent new HIV infections and further concentration of the epidemic among MARPs. Finally, the irregular supply of ARVs for PEP complicates both the provision of high-quality care and the ethics of increasing demand for services that may not be available.

To overcome these barriers, it is imperative that providers, decisionmakers, and civil society continue to work together to explore the operationalization of PEP through evidence-based policy dialogue and

existing international gold standard policies and protocols. Civil society groups, healthcare professionals, and Mexican authorities should demand that national policies, protocols, and norms on PEP, GBV, and HIV reflect a gender perspective and recognize sexual violence as an emergent health issue with treatable sequelae. Finally, PEP should be recognized as an essential HIV prevention strategy that can save the lives of people exposed to sexual violence because of their expressions of gender and sexuality.

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