

HIV/AIDS in Haiti: How Cultural Sensitivity
Can Combat The Epidemic

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Dedication

This thesis is dedicated to my mother, Auberte Plaisimon. Her sacrifices and support have enabled me to become the passionate woman I am today. Every milestone achieved in my life is fueled by the knowledge that my mother sacrificed so much in order to see me succeed. She is my rock and my strength. Without her, none of this would have ever been possible.

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ABSTRACT

HIV/AIDS in Haiti: How Cultural Sensitivity Can Combat The Epidemic

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The Caribbean has the world's second highest rate of prevalence of HIV/AIDS, second to sub-Saharan Africa. HIV/AIDS is an epidemic that has posed all types of health issues in this region of the world. Haiti, the country on the western side of the Hispaniola peninsula, has been particularly hard hit by the epidemic. Stigma, poverty, natural disasters, and several other factors have all contributed to the devastating statistics Haiti faces from HIV/AIDS. The purpose of this project is to bring forth the HIV/AIDS problem that is currently present in Haiti and to acknowledge what has already been done, through non-governmental organizations (NGOs) and foreign aid. Furthermore, a comparison will be drawn with the HIV/AIDS case in Cuba and suggestions will be made from this comparison. Ultimately this project will culminate in support of increased culturally sensitive education and treatment by NGOs and foreign aid here on out to successfully combat and reduce the devastating impacts of HIV/AIDS in Haiti.

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Chapter 1: Introduction

Introduction

Figure 1: Map of the Caribbean



“The global HIV/AIDS epidemic is an unprecedented crisis that requires an unprecedented response. In particular it requires solidarity—between the healthy and the sick, between rich and poor, and above all, between richer and poorer nations. We have 30 million orphans already. How many more do we have to get, to wake up?” Kofi Annan, a Ghanaian diplomat, expressed his views on the devastating epidemic that HIV/AIDS is becoming. When

HIV/AIDS first became recognized as a major epidemic no one could have predicted how bad the illness would become and how many lives it would alter. Since the emergence of HIV/AIDS in the Caribbean several decades ago, the epidemic has been driven by many factors.

HIV/AIDS Definition, Transmission, and Treatment

HIV, which stands for human immunodeficiency virus, is the cause of AIDS, acquired immune deficiency syndrome. This disease negatively affects the human immune system, which makes it rather difficult for someone's body to fight off infectious diseases. HIV causes AIDS in people by damaging and infecting the body's main defenses against foreign infections, which are the white blood cells. White blood cells serve the purpose of fighting off invading pathogens, microorganisms and bacteria, and are more commonly known as lymphocytes. The virus attacks the lymphocytes, more specifically the T-cells. It takes over the T-cells and multiplies. In this process HIV destroys the T-cells, which leads to disabling the body's ability to fight off foreign substances and can ultimately cause disease. T-cell levels in the body are normally regulated so that opportunistic infections can usually be fought off. However, individuals with HIV have lower levels of T-cells and when that level falls very low, these individuals are more susceptible to opportunistic infections and certain types of cancer than individuals who do not have HIV/AIDS would normally be able to fight off. When the T-cell level becomes very low the illness is classified as AIDS, disease that causes weakened immunity that can result in some types of cancer, life-threatening illnesses and infections, and a deterioration of the nervous system. Although AIDS results from HIV, not all people who have HIV have AIDS. People who have the HIV infection can live years before they get sick with AIDS.

HIV/AIDS usually does not manifest itself with obvious physical signs early on. Symptoms alone are not enough to adequately diagnose an individual with an HIV infection or AIDS, and the only way to know for certain that an individual is infected is with an HIV test. Individuals who have HIV can feel perfectly healthy, while their immune systems are being damaged. It is also of equal importance to note that although an individual may feel perfectly healthy with an HIV infection, they can pass on the virus. As previously stated, the HIV virus makes an individual more susceptible to opportunistic infections; these opportunistic infections caused by foreign substances can manifest in symptoms of illness, and these symptoms can be more severe than they would be in an individual free of HIV. Although people do not usually have immediate symptoms following the initial HIV infection, some individuals may suffer from a short flu-like illness within a couple weeks of being infected and they may also develop swollen glands and/or a rash. However, such symptoms are common to many different illnesses and, therefore, it is not reliable to say a person who exhibits these signs has HIV/AIDS (AVERT.org). Visible signs of the HIV infection also include poor weight gain, fungal infections in the mouth more commonly known as thrush, enlarged lymph nodes, livers, or spleen, pneumonia, multiple bacterial infections and neurological problems (AVERT.org). Symptoms of AIDS once they appear can include rapid weight loss, night sweats, persistent diarrhea, swollen lymph nodes, pneumonia, intense fatigue, and susceptibility to opportunistic infections (AVERT.org). Given that people often show no symptoms early in HIV infection and that symptoms of HIV infection are also symptoms of other diseases, one can never be certain of who has HIV/AIDS just by looking at them.

Although a cure to HIV/AIDS does not currently exist, there are treatments for the disease. Antiretroviral drug treatment is the main type of treatment for HIV or AIDS, but it

should not be confused with a cure. Antiretroviral drug treatment can stop individuals from becoming sick for a long time. The individual has to take the drugs for the rest of their lives. The main goal of antiretroviral drug treatments is to keep the amount of HIV in an individual's body at a low level, which, in turn, stops the weakening of the immune system and allows it to recover from damage caused by HIV already (AVERT.org). Combination therapy is when two or more antiretroviral drugs are taken at the same time, and when three or more are taken it is referred to as High Active Antiretroviral Therapy or HAART (AVERT.org). The reason why many individuals take more than one drug at a time is due to the fact that HIV can quickly become resistant to one drug, which would render the use of a single drug ineffective. Taking multiple drugs greatly reduces the rate at which the resistance develops (AVERT.org). There are currently more than 20 approved antiretroviral drugs; however, not all of them are licensed or available in all countries. Despite the absence of a cure to date for HIV/AIDS, there are treatments that help those who are infected with HIV lead longer and healthier lives.

Methodology

The primary method of research done for this project was online. Online research methods are becoming more and more sophisticated and are also becoming easier and easier to utilize and access. Through online research, I was able to collect data from primary sources. I utilized Brandeis University's extensive databases to obtain the majority of my primary and secondary sources. Once I obtained these sources I compiled the information and applied it to my thesis.

HIV/AIDS in the Caribbean is a topic that has been researched and written on quite extensively. Due to this, my methodology enabled me to produce an argument that was quite

straightforward. I will first lay out the basis of my argument to prove that there is a problem that exists in the Caribbean, with a special focus on Haiti, in terms of HIV/AIDS, and I will then suggest a viable solution.

Chapter 2: HIV/AIDS Epidemiology in Haiti

HIV/AIDS Epidemiology in Haiti

Figure 2: Map of Haiti



Haiti is the small Caribbean country on the western side of the island of Hispaniola, an island it shares with the Dominican Republic. By the early 1970s, tourism was critical to the Haitian economy, and by the 1980s it ranked as Haiti's second largest source of foreign income (Farmer, 2010). However, violence and economic woes were pushing the Haitian people to migrate to other countries around the world, including the United States. During this time Haiti was presumed to be the source of the HIV/AIDS epidemic and this hindered the tourism industry as well as foreign investments in the country (Buss, 2008). The growing fear and stigma associated with HIV/AIDS proved devastating to the country's tourism industry. Stigma in the United States was so prevalent that Haitians were banned from being blood donors. "But the effects of the 'AIDS scare' were dramatic and prompt: the Haitian Bureau of Tourism estimated

a decline from 75,000 visitors in the winter of 1981-82 to fewer than 10,000 the following year” (Farmer, 2010). HIV first came to national attention in 1981-1982, although it was not yet named. At that time Haitians were among the so called 4-Hs, the original risk groups determined by the CDC (homosexuals, hemophiliacs, heroin users, and Haitians). After Haiti’s former president Jean-Claude “Baby Doc” Duvalier fled the country, the economy in Haiti faced a hard hit because of political turmoil and chaos. To make matters worse, a military junta gained control in 1987, and this led to even more political turmoil and brutality that proved devastating to Haiti’s basic social services (Buss, 2008).

Thirteen years later in January of 2010 a crippling earthquake hit Haiti at a magnitude of 7.0. It hit hard after several natural disasters, including hurricanes, tropical storms and floods, struck in a short time span, and proved catastrophic (Malow, 2011). The earthquake killed approximately 217,000 Haitians, injured approximately 300,000, and left more than a million displaced. About 500,000 people were forced to leave the capital of Port-au-Prince and seek refuge in areas of the country not as hard hit (UNAIDS, 2010d). Over one million lost their homes and are spread across 700 camps or with other families. It is estimated that over 500,000 people have moved out of the earthquake devastated areas to other rural areas with poor services and infrastructure (UNAIDS, 2010d).

Some of the earliest cases of illness which may have been HIV in Haiti started appearing in 1978, and by 1980 a lot more cases started to appear. In the 1980s HIV/AIDS in Haiti began to draw a lot of attention on an international level because cases of HIV/AIDS were appearing in Haitian immigrants in the United States (Farmer, 1990). In 1982, The Haitian Study Group on Kaposi’s sarcoma and Opportunistic Infections (GHESIKO) was founded in Haiti (Malow, 2010). GHESIKO was instrumental in HIV/AIDS prevention strategies, clinical testing and

services, research, and training (Malow, 2010). By 1983, AIDS was dubbed the “4H disease” by the CDC because it came to be associated with homosexuals, Haitians, hemophiliacs, and heroin users (Cohen, 2006). Labeling the Haitian people as a “high-risk group” increased the stigmatization for those who were suffering from HIV/AIDS and, indeed, all Haitians because they were now labeled as HIV/AIDS carriers (Farmer, 2010).

Stigma as a result of Haitian people being a high-risk group for contracting HIV/AIDS continued. This stigma arose from the belief that Haitian voodoo practices, social chaos, and poverty, for instance, were all causes of HIV/AIDS (Farmer, 2010). Widespread prejudice against Haitian people contributed to social and economic effects because the tourism industry was devastated. The government responded by performing raids on gay bars and establishments to arrest gay men and started to get rid of foreign individuals who owned businesses that catered to gay people (Smallman, 2007). Haitian communities in the United States were also affected in a negative manner because of the association with HIV/AIDS. Haitian people found it hard to get work, and they dealt with discrimination constantly (Smallman, 2007).

At the beginning of the HIV/AIDS epidemic, HIV/AIDS was referred to as a “city sickness” among Haitian people because the disease was running rampant among the poor urban population in Haiti. The poor urban populations were at a very high risk as HIV infections became extremely widespread in urban areas and amongst people of low socioeconomic status (Schoepf, 1993). Poor and urban people were at a particularly high risk because with poverty there is lack of education and access to services that cater to prevention and treatment of HIV. Even though many of the earliest cases of HIV/AIDS were documented amongst gay men, HIV/AIDS quickly became a major problem amongst heterosexuals. “By 1986 homosexuals or bisexuals accounted for only 7% of male Haitian AIDS cases, and 40% of total cases were

women” (Sabatier, 1988). It is important to note that this was different from the epidemiology in the United States. The blindness on the part of healthcare and health policy professionals to HIV among women was sad and astonishing. Women in poor urban areas were hard hit with the epidemic. A study done in Cité Soleil, a slum city in Haiti near the capital of Port-au-Prince, showed that the HIV+ rate for pregnant women increased from 8.9% in 1986 to about 9.9% in 1987 and then to 10.3% in 1988 (Boulos, 1990). By the the early 1990s HIV/AIDS had infected many more women than men in Haiti and had penetrated into rural areas, since many women began to practice prostitution as a mode of survival (Farmer, 1990). In rural areas, poverty poses a huge problem as income is mainly generated through farming. Many women are heads of households without male providers and agriculture did not provide adequate means for families to live. Prostitution became increasingly popular, as women would travel to urban areas for sex work.

Very early on in the epidemic’s history, Haiti relied on foreign aid to cope with HIV/AIDS. The epidemic ravaged the country, which had almost no public health system, had a substandard ratio of doctors to patients in rural areas, was severely affected by tuberculosis, lacked government resources, and was under serious political chaos (Smallman, 2007). The progression of the disease in people living with HIV/AIDS in Haiti was about twice as rapid as people living in developed nations. Poor nutrition and high rates of community-acquired infections, diarrhea, and tuberculosis were several factors that led to the swift progression of the disease (Deschamps, 2000; Cayemittes, 2001). Hospitals became packed with HIV/AIDS patients. When indications surfaced supporting that HIV/AIDS was becoming a devastating epidemic, health officials in Haiti finally started to regard the disease as a huge public health problem and not simply a public relations matter (Farmer, 2010).

The national response to HIV/AIDS in Haiti has mostly been provided by non-governmental organizations (NGOs) like Partners in Health (PIH), GHESIKO, Doctors Without Borders, the Clinton Foundation, Institute Haitien de l'Enfance, Centre de Development et Santé, and Volontaires d'Haiti. Haiti has a very poor health care system. Health facilities are not equipped with the best technologies to treat their patients. There are also a lot more services available in the capital than in rural areas. As a result, Partners in Health, founded by Paul Farmer, has been attending to the health care needs of Haitians in the most poverty-stricken areas of the country since 1987. In 1988 PIH created the first program in the world to deliver comprehensive free HIV/AIDS treatment in rural Haiti (PIH, 2012). GHESIKO became the first clinic in the world to treat HIV/AIDS patients, and they now provide a program that diagnoses and treats people with HIV/AIDS, other sexually transmitted infections (STIs), and tuberculosis (Koenig, 2010). National efforts have been supported by the UNAIDS Secretariat, sponsors, and development partners, and these efforts have gotten a lot of financial support from the US President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (UNAIDS, 2010a). When thirteen million dollars was allocated to Haiti in 2004, when the PEPFAR was put into action under the United States Global HIV/AIDS Initiative, \$39.4 million was allocated in 2005 and \$47 million in 2006 (Buss, 2008). In 2006, Haitian authorities with the help of NGOs implemented nationwide goals for the prevention, care, and treatment of HIV/AIDS. As a result of these objectives, 68 different sites providing antiretroviral therapies and 117 sites designated for the prevention of mother to child transmission of HIV/AIDS were set up. A strong national network of individuals living with HIV/AIDS and a national HIV monitoring system were created as well (UNAIDS, 2010d).

Today Haiti is the most impoverished and most unstable country in the entire western hemisphere and one of the poorest in the world (UNDP, 2005). A majority of adult Haitians do not have jobs, and 70% of the population lives in extreme poverty, as defined by the United Nations. A lot of Haitian people do not have access to safe drinking water or proper sanitation facilities. Forty percent of Haitian household do not have adequate food or shelter (Gage and Hutchinson, 2006). Only approximately 20% of all Haitians have health care access and 3% of all Haitians have health insurance. NGOs provide 70% of the health care services that exist in rural areas of the country, and they are also providing about 80% of public services (Buss 2008). Approximately 2.1% of adults are HIV+, and Haiti has one of the highest prevalence rates of HIV/AIDS epidemic in the Caribbean (UNAIDS, 2011).

Like in many other Caribbean nations, there are a lot of differences in the burden that HIV/AIDS causes in Haiti. In 2010, The United Nations General Assembly Special Session (UNGASS) reported that the most affected age groups are women aged 30-34, with 4.1% prevalence, and men aged 40-44, with 4.4% prevalence, and that young women are becoming more at risk (USAID, 2010). Two reasons for the gender disparity that exists for young women are increases in sexual violence against women and gang rape (Devieux, 2009). This is in addition to greater bio-physiological vulnerability than in heterosexual intercourse. As a result, young women aged 15-24 are more than twice as likely to become infected with HIV than young men in the same age range, with rates of 1.4% and 0.6%, respectively. A majority of HIV cases in Haiti are the result of heterosexual transmission of the virus.

Based on information from the World Health Organization (WHO), Haiti has one of the highest rates of tuberculosis in the western hemisphere, with an estimated incidence rate of 250 new cases per 10,000 people in 2008. About 23% of new tuberculosis cases in 2008 were among

people who were HIV+. The high percentage of people infected with both HIV and tuberculosis presents significant challenges in providing treatment services and care for both diseases (USAID, 2010). The 2007 UNAID and WHO estimates showed that Haiti had 22% prevention of mother-to-child transmission coverage and that 41% coverage for antiretroviral therapies for those in need of them. This is unfortunate because individuals who are not getting the treatment they need and also because being on antiretrovirals is a form of AIDS prevention due to the fact that it reduces viral load, sometimes to undetectable levels, and, consequently, reduces the likelihood of transmission via unprotected sex. It was estimated that 13,000 people were on antiretroviral therapies in 2007 and an estimated 24,000 people were on antiretroviral therapies in 2009. Despite the fact that more people have gained access to antiretroviral therapies, the projected number of people HIV+ in need of antiretroviral therapies has grown to an estimated 32,000 (UNAIDS, 2010d).

The degree of burden HIV/AIDS prevalence causes in Haiti differs from region to region. The area with the highest prevalence rates is Nippes, with 3.8% for women infected, and in the southeast there is one of the lowest prevalence rates at 1.7% (USAID, 2010). A 2007 study reported in 2010 showed that 12% of pregnant women using antenatal facilities in one city tested positive for HIV, and less than 1% of women using antenatal facilities in the western part of the country tested positive for HIV. Due to the increasing trend of HIV in pregnant women, more children will be born to HIV+ mothers (UNAIDS, 2010d). This is unless and until prevention of mother to child transmission reaches more women.

Behavioral studies in Haiti have shown a resemblance between the HIV/AIDS epidemic in Haiti and those in other Caribbean nations in terms of being able to identify knowledge and risk behaviors. Even though evidence shows that there is an increase in knowledge about

HIV/AIDS, the percentage of young women and men between the ages of 15-24 who can both correctly identify ways to prevent HIV transmission and reject misconceptions about HIV transmission is about 35%. Also, knowledge about HIV does not always correlate with adopting and practicing safe sexual behavior and preventative measures (USAID, 2010). Even though there was a drop in the average number of sexual partners and an increase in the use of condoms, protective behaviors remain an exception rather than the norm (UNAIDS and World Health Organization, 2008). For instance, between the years of 1994 and 2006 the percentage of young women and men 15-24 years old who were sexually active before their 15th birthday increased from 9% to 15% among women and 17% to 43% among men. Also during this period, the proportion of young men who had more than one partner in the past 12 months stayed the same at about 30% (UNAIDS, 2008).

By the end of 2009 Haiti had begun to make good strides towards reducing the HIV/AIDS epidemic, but the earthquake in January of 2010 was not only traumatizing to the country but also devastating to the national response to HIV/AIDS (Horstmann, 2010). Huge populations of Haitians were displaced and, as a result, were exposed to a lot of vulnerabilities. Such vulnerabilities included sexual exploitation, gender-based violence, rape, prostitution, and unprotected sex. The Ministry of Public Health and Population building itself, the National AIDS Program building, and many hospital and health center facilities were completely or partially destroyed in the earthquake and aftershocks.

Chapter 3: Current Institutional Response to HIV/AIDS in Haiti

NGO Aid

The WHO estimates that nearly one third of the world's population does not have access to essential pharmaceutical drugs and more than fifty percent of people living in poverty-stricken countries in Asia, Africa, and the Caribbean lack access to basic essential pharmaceutical drugs (World Health Organization 2002: 16). Obtaining access to these drugs is dependent on several economic factors, including reliable supply systems, affordable prices, and sustainable financing (World Health Organization 2002: 16). Drug prices are in part influenced by World Trade Organization (WTO) agreements, some of which are leading towards a reduction of import taxes on pharmaceutical drugs. However, the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement is leading to an increase in pharmaceutical drug prices because of strict patent protections. Due to this, the TRIPS agreement does allow some safeguards such as compulsory licenses, which countries like Brazil have been utilizing. Compulsory licenses allow for the bypass of a patent so that non-patent holders can make the patented product. The high price of pharmaceutical drugs poses a serious problem for poor and underdeveloped countries that are in high need of these drugs. Haiti, being one of said countries, is in dire need of a solution to the difficulty in accessing pharmaceutical drugs for HIV/AIDS.

A highly controversial aspect of the WTO TRIPS agreement has to do with patent protection on pharmaceutical drugs. Those who are in support of these patents argue that they are essential to innovation. Those against the patents, such as NGOs, deem the patents more harmful than beneficial because they make the drugs too expensive for those in high need in developing countries.

Patents and WTO trade agreement laws kept production of pharmaceutical drugs limited and monopolized. The pharmaceutical industry views patents as vital to their business (Barton 2004: 146). With patents, an inventor is entitled to a monopoly for anywhere from 17-20 years. Because of the lengthy duration of patent protection, pharmaceutical drugs become exclusive and therefore lead to high prices for the patent's term. This, in turn, ultimately keeps the pharmaceutical company's competition out of the market. Such power can be abused and ultimately reduces the welfare of consumers. The high prices are argued to be incentives that "provide the basis for the pharmaceutical industry to invest in the very costly research and development process that is necessary to bring new drugs to the market" (Barton 2004: 146). This shows that funding for the pharmaceutical industry's research and development is very expensive. By keeping the prices high richer developed countries can benefit. This is because the country has monopoly on the drug. The sale of drugs in richer and developed countries allows the pharmaceutical companies to gain money for the cost of research and development. Therefore removing the patents would result in a low rate of return and discourage innovation.

Several major questions have come up from this situation. How can countries protect their health interests while expanding free trade at the same time? Do we keep patents that ensure research and development within the pharmaceutical industry or do we get rid of these patents and in turn increase the access to drugs for poor and developing countries? Obviously there are

no clear-cut answers to these questions that are at the center of the debate over TRIPS and patents. Ultimately the problem lies in finding a balance between incentives for patented innovations and the welfare of consumers, who have to pay higher prices because of the monopoly power that is created by a patent.

Finding a way to balance these incentives is very relevant to poorer countries. In the case of prescription drugs, the faster a patent is removed, the lower the price of drugs can become; and, ultimately, they become affordable for poorer developing nations. These poorer developing nations would benefit because they could better handle devastating diseases like malaria, tuberculosis, and HIV/AIDS. The price of producing prescription drugs would be a fraction of the cost that it is in rich and developed countries; therefore this would be a positive incentive for poor developing nations. Many developing countries deny patent protection on pharmaceutical drugs and instead allow protection to the processes for production of these drugs (Barton 2004: 147). The argument behind this is that pharmaceutical drugs are so important and essential that they should not be patented.

One provision that countries can utilize to bypass the protection of patents is a compulsory license. The compulsory license is a provision in international trade law that defines a legal process by which governments can authorize the use of a patented technology even over the objection of the patent holder (Barton 2004: 147). However these provisions have rarely been formally granted because governments have used the threat of granting such licenses as a way to negotiate for lower prices for the products and technology involved (Barton 2004: 147).

TRIPS responded to the issue of compulsory licenses as developed nations saw a threat.

The United States and other developed countries were determined to change these laws and achieved important extensions of patent protection in the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement, which entered into force 1 January 1995. This agreement requires the member nations of the World Trade Organization (WTO)—

which includes nearly all major trading nations—to live up to defined standards of intellectual property protection (Barton 2004: 147). Those in support of the terms of TRIPS were responding to the pressure on their pharmaceutical copyright content, and trademark-based industries. Said industries felt that the “illegal copying” in other world markets was victimizing them, and they sought more protection for their products and technologies (Barton 2004: 147). Developing nations accepted the agreement, which would in turn increase license and royalties costs “in return for developed-world concessions that would expand these countries’ exports of agriculture and textile products” (Barton 2004: 147). This of course can be seen as a “win” for the pharmaceutical industry. Article 27 of the Uruguay Round Agreement states:

Patents shall be available for any inventions, whether products or processes, in all fields of technology, provided that they are new, involve an inventive step and are capable of industrial application. Subject to paragraph 4 of Article 65, paragraph 8 or Article 70 and paragraph 3 of this Article, patents shall be available and patent rights enjoyable without discrimination as to the place of invention, the field of technology and whether products are imported or locally produced (World Trade Organization, 1994).

The intent of this article was to ban the exclusion of pharmaceutical drugs as done in the Indian Patent Law of 1970. Article 31 of the Uruguay Round Agreements further establishes procedures that limit when countries can grant compulsory licenses (World Trade Organization, 1994).

These patent laws were met with opposition. NGOs such as Oxfam and Doctors Without Borders argued that the requirements of patent laws, especially in sub-Saharan Africa and in poverty-stricken Caribbean countries like Haiti, would lead to exceptionally high prices of antiretrovirals used for treatment against HIV/AIDS.

HIV/AIDS is a global epidemic that plagues impoverished countries tremendously. The epidemic is exceptionally problematic in the Caribbean, which is the world’s second-most affected region, second only to Sub-Saharan Africa (doctorswithoutborders.org). The cost of HIV medication is very expensive and unaffordable for people in this region of the world. A lot

of aid has been delivered through organizations like Doctors without Borders. Due to generic medications, drugs can be supplied at lower costs. With the presence of generic medications from different producers in the market, the cost of generics can remain low due to competition.

Newer drugs must constantly be entering the market for treatment because HIV/AIDS can become resistant to certain drugs over time (doctorswithoutborders.org). The main issue with the new drugs is that their costs are exceptionally high. Many poor people in the Caribbean need these newer medications to be provided by NGOs like Doctors without Borders and other health care providers because they have exhausted all other treatment options. The reason why these newer medications are priced so high is the patents that do not allow generic producers to make the drugs and sell them at a fraction of the cost. The patents in essence halt the generic competition in the market, which, in turn, hurts the people living in the Caribbean and other parts of the world who cannot afford treatment.

There have also been court disputes for when “patents prevent access, compulsory license – which allow countries to override a company’s patents – should be issued in the interest of public health” (doctorswithoutborders.org). One dispute stems from a law in South Africa intended to import generic antiretroviral medications, even generics of those that were patented in South Africa (Barton 2004: 148). The import of these generic pharmaceutical drugs into South Africa goes against and infringes upon the South African patent law (Barton 2004: 148). The international pharmaceutical industry confronted this law in South African courts (Barton 2004: 148). The lawsuit turned into a public relations catastrophe for the pharmaceutical industry, and “after threats that the amount of public support for the development of the relevant drugs would be publicized in the hearings, the industry settled in April 2001” (Barton 2004: 148).

A notable country involved in getting around the patent laws is India. India excluded pharmaceutical drugs from protection by patents in its 1970 patent law (Barton 2004: 147). This ultimately meant that India was making the choice to provide pharmaceutical drugs at low costs for people by eliminating the incentive to create new drugs. This law was the reason why the Indian generic pharmaceutical drug industry was able to grow and make copies of patented drugs produced in wealthier countries (Barton 2004: 147). Since then, India has become a major supplier of pharmaceutical drugs around the world to countries where the drugs can be marketed legally since they are not patented locally (Barton 2004: 147). The compulsory licenses in India, which is a world leader in generic drug production, have enabled the prices of some HIV/AIDS pharmaceutical drugs to fall (doctorswithoutborders.org). There is also an increase in the number of countries producing generic versions of patented HIV/AIDS medication.

Another very important dispute involved Brazil, which began producing its own antiretroviral drugs because it had implemented a national campaign to attempt to treat all HIV patients that needed these vital drugs (Barton 2004: 148). At first, the Brazilian national campaign relied heavily on pharmaceutical drugs that were imported. However, these drugs eventually became too expensive as the value of Brazilian currency fell in the market (Barton 2004: 148). As a result, Brazil started to manufacture some off-patent drugs in local laboratories, which ultimately reduced costs significantly. In 2001, a threat arose when Brazil wanted to do the same for patented drugs through the use of what would have been a compulsory license (Barton 2004: 148). The threat led to a negotiation for lower costs of imported patented drugs. As a result, Brazil was threatened by the United States in front of the WTO. The United States argued that Brazil's laws were in violation of TRIPS, but in July of 2001 the dispute was put into bilateral discussions (Barton 2004: 148).

As a result of all of these disputes, international agreements were formed. These agreements sought a compromise to find incentives for both the pharmaceutical industry and developing countries. The compromise to this problem is differential pricing or price discrimination. Price discrimination in this context is a practice where prescription drugs were sold at high prices in richer countries of the developed world and at lower prices in poorer and underdeveloped countries (Barton 2004: 148). With this practice, the patent holders can maximize profits in the developed countries and at the same time allow low prices for poorer and underdeveloped countries. This compromise allowed pharmaceutical drug firms to still generate revenue for their research and development spending but still keep prices low and close to production cost for the poor developing countries (Barton 2004: 148). Price discrimination could be practiced when the elasticity of demand is different in the rich and poor countries and when the markets are separated. These characteristics are present in trade between rich and poor countries. “This approach is justified because the market in poor countries is so small that it provides only a minimal incentive—the total market of the poorest countries (for example, sub-Saharan Africa or the United Nations’ Least Developed Countries) is on the order of 1 percent of the global pharmaceutical market” (Barton 2004: 148).

Brazil is considered a middle-income country, but its government is able to provide antiretrovirals to its people at no charge (Galvao 1110). In order for this policy to be feasible Brazil has to produce some of its drugs domestically and import the rest through negotiations. Using Brazil’s HIV/AIDS model may not be as easily accomplished by other nations, especially developing nations where there are higher levels of HIV infection. The ability to produce some antiretrovirals domestically is a huge help to Brazil and is a major reason why they can provide antiretrovirals free of charge. Countries like Haiti and those in sub-Saharan Africa would need to

have the means to produce these drugs domestically. If people were trained in these countries to produce quality drugs, this would be able to cut significantly the costs of antiretrovirals and thereby increasing access. The director of Brazil's National AIDS Program, Paulo Teixeira, believed that "maintaining political will while fostering new international alliances for more favorable regulations on pharmaceutical-related trade and intellectual property will continue to be central" (Galvao 1111). By creating better relations with developing nations, countries like Haiti may be able to improve access to antiretroviral drugs that have to be imported. Having Haitians trained in skills needed to produce generic drugs domestically will, in the long run, prove to benefit the country. Not only will doing so increase jobs in the market and produce high skilled laborers, but it will also be able to cut the cost of accessing HIV/AIDS antiretroviral drugs.

It is unfair to expect poor individuals living in developing nation such as Haiti or a sub-Saharan African country to be able to provide the same contribution towards research and development costs as rich individuals living in developed nations. The cost of a single dose is the same for any market. Patents allow for higher prices that generate revenue for research and development. It is reasonable that these costs are placed on wealthier nations than poorer ones. The cost of research and development will benefit all of humanity. The pharmaceutical industry, which is research based, achieves differential pricing through donation programs or by charging different pricing. Critics of the pharmaceutical industry would prefer that the patent monopoly be made unavailable to raise prices in the developing world (Barton 2004: 149).

In November of 2001, Brazil, several African countries, and several NGOs brought the TRIPS issue and problem with access to pharmaceutical drugs to the global debates that preceded the Doha meeting.

The meeting led to the Doha “Declaration on the TRIPS Agreement and Public Health.” This declaration affirmed that TRIPS “should be interpreted and implemented in a manner supportive of WTO members’ rights to protect public health and, in particular, to promote access to medicines for all” (Barton 2004: 149).

This decision was particularly important because it supported compulsory licenses and other provisions that were exceptions to TRIPS as a right of all nations. This decision was designed to meet the needs of public health concerns and stated, “public health crises, including those related to HIV/AIDS, tuberculosis, malaria and other epidemics can represent a national emergency” therefore compulsory licenses usage has been encouraged (Barton 2004: 149).

One major problem the Doha Declaration posed is that the drugs were to be produced under compulsory licenses in countries that did not have the ability to manufacture the drugs themselves (Barton 2004: 149). This problem was solved with a waiver of Article 31(f) in 2002 to which all relevant countries agreed except the United States (Barton 2004: 149). The waiver was for a procedure that “covered products needed to meet the public health problems recognized in the Doha Declaration, but the United States feared that it would be expanded to a broad variety of products and thus was unwilling to accept it” (Barton 2004: 149). In 2003 a compromise was reached in which the United States accepted the 2002 document. The agreement was made on the basis that it would be used in “in good faith to protect public health” and not as “an instrument to pursue industrial or commercial policy objectives” (Barton 2004: 149).

This agreement is a step forward in access to medicine and definitely pressures the pharmaceutical industry to provide drugs at low prices to the developing world. Although patented drugs can be copied and produced under compulsory licenses, there is still an underlying economic problem. Only about 8% percent of those who need HIV/AIDS medications worldwide are receiving the antiretrovirals (Galvao1110). They are receiving them

from donations and purchases of generics and name brands. In order to provide treatment for HIV/AIDS and other global epidemics in the developing world, the amount of money needed is far beyond what is currently available in global funds. It is estimated by UNAIDS that six million people with HIV in developing countries need antiretroviral therapy.

Even at the reduced prices approaching \$300 a year for antiretroviral combination therapies, this would amount to \$1.8 billion and would use a very substantial portion of President George Bush's \$15 billion (over five years) HIV initiative (Barton 2004: 150)

The global solution almost necessarily requires an increase in funding coupled with lower costs for pharmaceuticals in developing nations. There are two solutions I find most beneficial. The first would be to produce pharmaceutical drugs with compulsory licenses in private-sector generic industries. These industries would need to have fixed costs distributed over a large market. The second solution would be to have a public-sector generic industry where the public pays for fixed costs. This would offer competition as a way to lower prices (Barton 2004: 150).

Accessing HIV/AIDS medication is also a major problem that has proven to make the HIV/AIDS crisis in Haiti difficult. Many HIV/AIDS medications are patented under WHO agreements, primarily TRIPS).

These patent laws were met with opposition. NGOs such as Oxfam and Doctors without Borders argued that the requirements of patent laws especially in sub-Saharan Africa and poverty-stricken Caribbean countries like Haiti, would lead to exceptionally high prices of antiretrovirals used for treatment against HIV/AIDS.

Haiti is a country that has been plagued with social, political, and economic instability. Chances to be prosperous were hampered by autocratic, corrupt, and brutal leaders. Any signs of growth and development in Haiti have shown to be deterred by the government and their lack of inclination or inability to successfully govern or alleviate the poverty. A virtually non-existent

health care system, extreme poverty, and HIV/AIDS stigma and discrimination all play roles in the social and economic effects of HIV/AIDS in Haiti. These social and economic effects have shown to be disproportionately high in Haiti as compared to other Caribbean nations. Efforts targeted at reducing the HIV/AIDS epidemic in Haiti have mostly been carried out by NGOs that provide HIV/AIDS prevention, care, treatment, and support rather than by Haitian authorities. After the January 2010 earthquake, Haiti not only faces the task of rebuilding itself but it also needs continued international support and the financial support of outside aid to rebuild itself, since weak infrastructure and poor living conditions are a huge problem.

achievements of the Cuban revolution. It is “recognized as such not only by Cuba themselves but also by governments, international organizations, and poor citizens around the world who have directly benefited from Cuba’s global health policies” (Sweig, 2009). Before the first diagnosed case of HIV/AIDS in Cuba, Fidel Castro and health officials had launched a national AIDS education program in 1983 and began to invest in HIV/AIDS awareness and prevention (Diaz, 2011). This became very important as the tourist industry was growing in Cuba and consequently the sex trade industry was growing as well (Sweig, 2009).

There is evidence of progress that has been made to reverse the HIV/AIDS epidemic in the Caribbean. However, there are huge gaps that continue to persist in how different Caribbean governments have taken action against HIV/AIDS. Haiti and Cuba are two countries in the Caribbean that provide extreme examples of the paradoxes that exist in this region of the world. With less than 50 miles separating the two islands, the current state of the HIV/AIDS epidemic in both countries show the disparities that exist throughout the region (Inter Press Service).

“Haiti’s prevalence represents 60 percent of all Caribbean infections, and if you add that to the Dominican Republic, which shares the same island, it’s about 80 percent of HIV in the entire region,” Evan Lyon, a doctor working with the group Partners in Health, which assists people living with HIV in Haiti, told IPS.

“On the other hand, Cuba has one of the lowest HIV incidences in the world,” he said – less than 5,000 people, or 0.1 percent of the population (Inter Press Service).

Currently 100 percent of the people in Cuba infected with HIV are on antiretroviral therapy. This is a stark contrast to the only 20 percent of people infected with HIV getting antiretrovirals in Haiti (Inter Press Service).

The HIV/AIDS policies in Cuba have proven to be a very successful model for the country. Indeed, the national AIDS program in Cuba has shown to be one of the most successful in the entire world based purely on statistics (Hoffman 208). Prior to the first case of AIDS in Cuba, the Cuban government established a National AIDS Commission in 1983 and proceeded

to destroy all foreign-derived blood products (Hoffman 208). This action allowed Cuba to avoid HIV transmission via hemophiliacs and other recipients of blood.

Once AIDS had reached Cuba, the government along with the Ministry of Public Health, created a national program that's was designed to control the spread of the disease (Hoffman 208). One regulation that existed in Cuba was the Decree-Law 54 of April 1982, which stated that,

“[F]or the exercise of prevention and control actions for communicable diseases, one or more of the following measures will be adopted, depending on the case: isolation of individuals suspected of suffering from a communicable disease, and of possible carriers of the casual germ, if necessary, as well as the suspension or limitation of these individuals activities when their realization poses a risk for the health of others” (Hoffman 208).

Moreover, Law 41 of July 1983 states:

“[T]he Ministry of Public Health will determine which diseases pose a risk for the community, will adopt diagnostic and preventative measures and will establish methods and procedures for mandatory treatment” (Hoffman 208).

These Cuban regulations were the stepping stones which led to the establishment of the Santiago de Las Vegas AIDS Sanatorium in Havana for HIV-positive individuals. Cuba had several other sanatoriums created in other parts of the country. Between the years of 1986, when the first documented case of HIV was found in Cuba, to 1994 the government in Cuba quarantined everyone who was found to be HIV positive (Hoffman 209).

These sanatoriums were effective for multiple reasons in controlling the spread of HIV in Cuba. While in a sanatorium, HIV-infected persons received education about HIV and AIDS in terms of how the virus was transmitted, how to prevent transmission, and safe sex practices (Hoffman 209). Essentials such as food, social services, privacy, medication, and other services were provided in the sanatoriums along with the educational and preventative program (Hoffman 209). After 1994 the obligatory quarantining of HIV positive people was loosened. Newly

infected HIV persons were only required to go to the sanatorium for eight weeks of comprehensive HIV and AIDS education. After this period patients were allowed to leave and reintegrate back into their communities and families and return to their jobs.

Cuba is also revolutionary in the fight against HIV/AIDS because its health care system puts a lot of effort into seriously combating the epidemic. All HIV-positive citizens receive free antiretrovirals that are produced in the country. The manufacturing of antiretrovirals in Cuba started in 2001 (Hoffman 209). Cuba produces stavudine, lamivudine, didanoside, indinavir, and zidovudine (Hoffman 209). It is mandatory that all pregnant mothers get tested for HIV, and if found HIV positive they undergo antiretroviral treatment and are required to undergo Cesarean section, which is known to reduce HIV transmission (Hoffman 209). Under Cuban regulations, those who are HIV positive must provide the names of all the people they have had sex with in the past 6 months and those individuals are required to be tested (Hoffman 209). Any individual with a sexually transmitted disease is required to get tested for HIV as well (Hoffman 209). All these strict regulations have been very effective in controlling the HIV virus.

Statistics on the incidence and prevalence of the disease and comparisons on HIV/AIDS rated with other countries demonstrate the regulations' effectiveness. Per person, there have been 35 times more deaths from AIDS in the United States than in Cuba⁵. Cuba has 3,969 HIV/AIDS cases, or 0.05 percent of the sexually active population (15-49 years) infected. Since the first case was discovered on the island in 1986, local sanitary authorities reported 5,146 HIV positive cases, and of the 2,247 who got AIDS, 1,177 have died as of December 2003. As of February 2003, the United States reported a rate about 10 times higher than that of Cuba, with about 0.3 percent of the population, or about one million American infected with HIV (Hoffman 209).

Why Cuba's Response Is Not a Viable Solution for Haiti

Haiti has not fared as well as Cuba. Infection rates are hundreds of times higher than those in Cuba. The strategies employed by Cuba are unparalleled by any other country in the

world. However, many ethical dilemmas arise from Cuba's tactics in combating HIV/AIDS. The mandatory quarantine of all HIV-positive persons for at least eight weeks is extremely controversial despite the legal policy that supports the practice. Although universal HIV education and prevention programs for HIV-positive persons and universal access to antiretrovirals would be very successful in Haiti, quarantine would not ever work as it has for Cuba. The stigma that would come from those in quarantine would be more detrimental than helpful in Haiti. As stigma is already a huge factor in Haiti's high HIV rates, the quarantine would only create additional and detrimental stigma.

Chapter 5: Recommendations

Culturally Sensitive Education and Treatment

In order to successfully manage the HIV/AIDS crisis in poverty-stricken countries like Haiti, culturally sensitive tactics have to be employed. Since a majority of the health care services provided for HIV/AIDS in Haiti are done through NGOs, NGOs would greatly benefit

from getting accustomed to Haitian culture. Aspects of Haitian culture that would help foreign aid providers deliver more effective services are eating habits as well as religions and taboos.

Learning about Haitian eating habits is very important if a health care provider wishes to deliver services to patients in Haiti. Grains are a staple food product in the Haitian diet. Haitian people eat rice with almost every meal, and it is common to eat it with beans and sauce (Dash 2001). Haitian people eat fried foods, stews, and soups and use many spices in their cooking. Weight is associated with health in Haitian culture (Dash 2001). It is common for people who are suffering from AIDS to lose weight and look malnourished and thin. This appearance is a highly stigmatized appearance in Haitian culture. It represents poor health and could be indicative of demons possessing the thin-looking person. Good nutrition to Haitian people means eating a lot. Haitian people commonly offer food to guests as a sign of respect. In the United States, for example, obesity is seen as a health risk and is not favored. In Haiti, overweight people are seen as having good health and wealth. It is a sign that the individual can afford food. With this knowledge of Haitian culture, health care providers can better educate the Haitian people on diets that would help in maintaining a healthy weight while an individual is receiving treatment.

Religion is arguably the most important aspect of Haitian culture that foreign aid workers should be sensitive to when delivering services. Religion is a very sensitive and complex topic in Haiti. Most people would describe themselves as very religious, and religion affects almost every aspect of Haitian society (Dash 2001). Ninety percent of the country's population is Catholic and ten percent is Protestant (Dash 2001). Despite these statistics, Haiti is most famous for voodoo. "Voodoo exists side by side with Christian faiths. Many Haitians see no contradiction in calling themselves Christians while engaging in voodoo practices" (Dash 2001). The history of voodoo in Haiti dates back to slavery. Slave uprisings used voodoo ceremonies (Dash 2001). "Many

Haitians, particularly in America, are sensitive to being seen as voodoo worshippers. Yet the practice continues in the United States” (Dash 2001). When people get extremely sick in Haiti, it is common to believe that they are the victim of some sort of voodoo rituals. Being sensitive to this common belief is critically important. In Haiti, AIDS is commonly referred to as “*ti bet la*,” which translates as the “little animal.” By educating Haitians on the origins of HIV while being sensitive to their beliefs, an effective delivery of prevention, treatment, and education can be employed through health services by foreign aid.

One particular NGO is utilizing a very successful tactic which caters to Haitian culture. A Partner in Health educates and employs Haitians to provide health services in Haiti. This tactic is an exemplary successful use of cultural sensitivity. What better way is there than to have health care providers deliver the most comprehensive and culturally sensitive treatment than to have health care providers who are members of the population that is seeking the services? There is also the added benefit that this tactic provides jobs for Haitians, a population that is hard hit by poverty. Culturally sensitive tactics for education and treatment are the best way to start tackling the current HIV/AIDS problem in Haiti.

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