



HIV/AIDS HEALTH PROFILE

Latin America and the Caribbean



Overall HIV Trends

The HIV epidemic in Latin America is stable, and the adult HIV prevalence, at 0.4 percent, has remained unchanged between 2001 and 2010. The epidemic in the Caribbean has slowed significantly since the mid-1990s¹. The adult HIV prevalence in the Caribbean declined from 1.0 in 2001 to 0.9 in 2010. In 2010, about 76,000 people in Latin America and the Caribbean (LAC) countries died of AIDS, and 112,000 were newly infected. Although the number of people newly infected with HIV is declining, the absolute number of people living with HIV/AIDS (PLWHA) is increasing as more people are tested and have access to antiretroviral therapy (ART). The number of PLWHA in LAC is estimated to be 1.7 million¹. Two-thirds of PLWHA reside in five countries: **Argentina, Brazil, Colombia, Haiti, and Mexico**. The Caribbean and Central American subregions have higher adult prevalence rates than South America, with countries such as **Haiti, the Bahamas, and Belize** having rates in 2009 as high as 1.9, 3.1, and 2.3 percent, respectively (see figure on page 2). With its large population, **Brazil** accounts for about one-third of PLWHA in Central and South America.

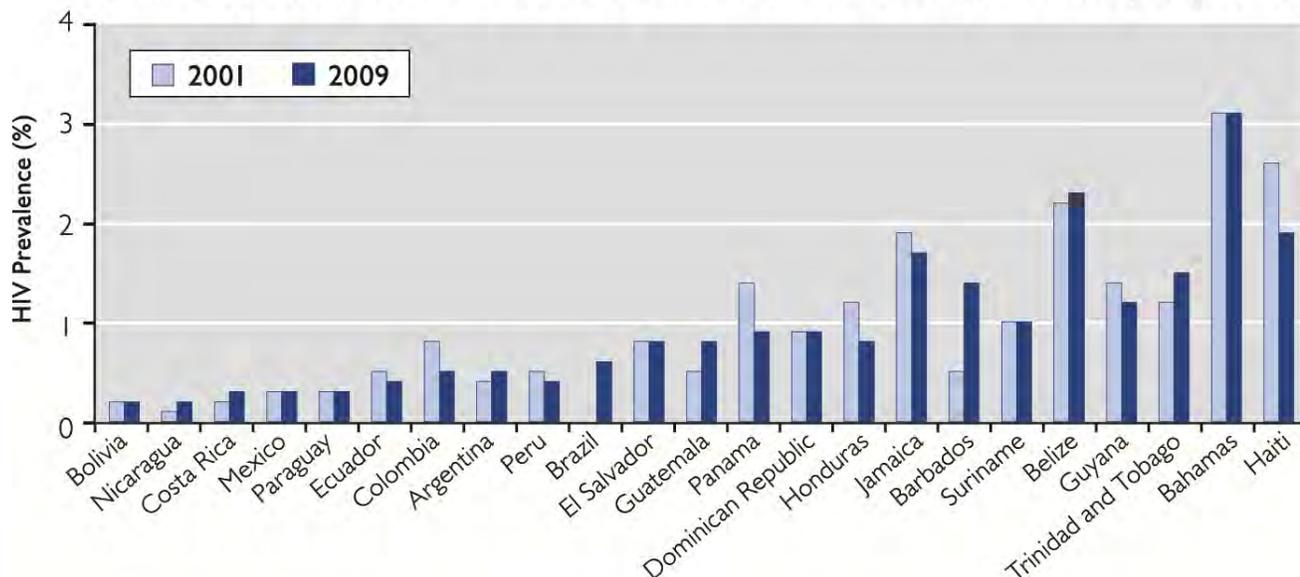
However, as a result of an early, well-coordinated response and protection of human rights among at-risk groups, Brazil's adult HIV prevalence never reached 1 percent².

Modes of Transmission. The epidemics in LAC are being fueled by unprotected sex between men. Surveys conducted over the last decade have found HIV prevalence of at least 10 percent among men who have sex with men (MSM) in 9 of 14 countries in the region (see infographic below). An earlier study found that MSM in South and Central America were 33 times more likely to be infected with HIV than the general population². Social stigma keeps these epidemics hidden, and many MSM also have sex with women. For example, one study in **Nicaragua** found that 40 percent of MSM in Managua and 57 percent in Chinandega said they had had sex with women in the previous year³. HIV prevalence among sex workers is relatively high in Central and South America, especially in **Guyana**⁴, **Honduras**⁵, **Guatemala**⁶, **El Salvador**⁷, and **Suriname**⁸. HIV incidence was 3 percent among female sex workers (FSWs) in a recent small study in Buenos Aires, Argentina⁹. Studies also reveal high levels of sexually transmitted infections (STIs), which are believed to increase the risk of acquiring HIV. In a 2009 study in Panama City, the prevalence of herpes simplex virus 2 was 77 percent among FSWs¹⁰. Injecting drug use is another significant source of transmission in the southern cone of South America and in parts of **Mexico**. The interplay of sex work and drug use in Mexico is an important factor in the epidemic along the border it shares with the United States. The HIV prevalence among FSWs who inject drugs was 12.3 percent in Tijuana and Ciudad Juarez in 2007².

HIV/AIDS Trends and Prevalence. The first figure (see next page) shows trends in HIV/AIDS adult prevalence in the LAC region between 2001 and 2009. In most countries, the prevalence rate was less than 1 percent and showed little change or was in decline, although in a few it continued to rise. Increases were particularly notable in **Barbados** and **Trinidad and Tobago**. The **Bahamas** remains one of the region's high-prevalence countries: 3.1 percent of the adult population is HIV-positive¹¹.

Outside sub-Saharan Africa, the Caribbean subregion has the highest HIV prevalence in the world. National estimated adult HIV burdens vary significantly, from an extremely low prevalence of 0.1 percent in **Cuba** to a relatively high prevalence of 3.1 percent in the **Bahamas**. Substantial differences also exist within countries. In **Jamaica**, HIV prevalence is highest in the parishes of St. James, Kingston, and St. Andrew. In the **Dominican Republic**, HIV prevalence in communities of sugar plantation workers is four times higher than the national average. Whether considered generalized or concentrated, HIV epidemics are disproportionately affecting the most vulnerable

Adult HIV Prevalence in Select Latin American and Caribbean Countries, 2001–2009



Source: UNAIDS Report on the Global AIDS Epidemic 2010. Data for Brazil are from the 2010 UNGASS report. No trend data are available for Brazil.

population groups across the region. The main route of HIV transmission in the Caribbean is reported to be unprotected sex between men and women and between men – including paid sex. Sex work, including sex tourism, is a primary source of transmission. The prevalence of HIV among sex workers varies considerably, from 2 percent in the Dominican Republic to 5 percent in Jamaica to 17 percent in regions of **Guyana** and 24 percent in parts of **Suriname**².

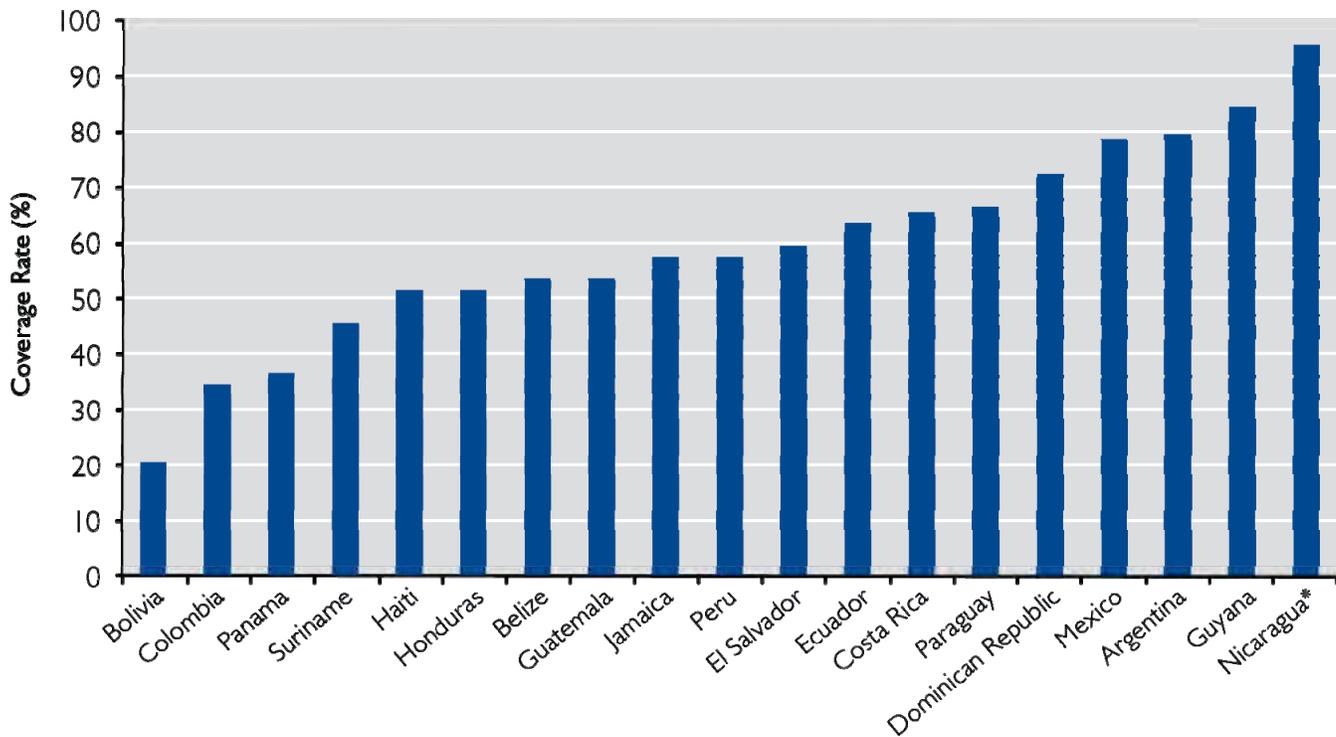
Most-at-Risk Populations. Although MSM behavior is seldom acknowledged as a factor in the Caribbean AIDS epidemic, research on most-at-risk populations (MARPs) demonstrates that MSM are another significant route of HIV transmission in this subregion (see *infographic below*). Many men who have sex with men also have sex with women. In the Jamaica study, one-third of MSM reported also having sex with women in the previous four weeks². Illegal drugs contribute to the HIV epidemics in **Puerto Rico**, **Jamaica**, and **St. Lucia**. In Puerto Rico, contaminated injection drug equipment accounted for 40 percent of men becoming newly infected and 27 percent of women in 2006. Crack cocaine users had a prevalence of 5 percent in Jamaica and 7.5 percent in St. Lucia. Crack users often sell sex to support their drug habit and are less likely to practice safe sex. HIV prevalence is also high in detention facilities in some countries. In Jamaica's largest correctional facility, prevalence is 3.3 percent, and it is close to 5 percent in detention centers in Belize and Guyana². Mobile and migrant populations and victims of gender-based violence (GBV) are also vulnerable groups, with higher HIV prevalence than the general population.

Prevention of Mother-to-Child Transmission. In Latin America and the Caribbean, access to prevention of mother-to-child transmission of HIV (PMTCT) services has increased. As a result, the number of children younger than 15 years living with HIV in Latin America has declined from 47,000 in 2001 to 42,000 in 2010. Over the same period, the number of children acquiring the disease in LAC decreased by 45 percent (from 9,200 to 5,100). In Latin America and the Caribbean, the number of children dying declined from 6,300 in 2001 to 3,700 in 2010².

Antiretroviral Therapy. The LAC region has made considerable progress in providing ART. The number of people receiving ART in LAC steadily increased from 210,000 in 2003 to 521,000 in 2010². ART coverage reached 63 percent – the highest level of any world region – in 2010. At the end of 2010, **Nicaragua** achieved universal access to ART (ART coverage over 80 percent of those who need it). **Argentina**, **Brazil**, the **Dominican Republic**, **Mexico**, and **Uruguay** had near universal coverage (between 70 percent and 79 percent²).

Tuberculosis and HIV Co-infection. HIV-tuberculosis-(TB) co-infection is a major concern in Latin America and the Caribbean, as TB is endemic in the region. According to the World Health Organization, TB-HIV co-infection in 2010 was high (between 20 percent and 47 percent) in **Bahamas**, **Belize**, **Brazil**, **Dominican Republic**, **Guyana**, **Haiti**, **Jamaica**, **Suriname**, and **Trinidad and Tobago**¹². HIV-TB co-infection complicates the care and treatment of both diseases, and multidrug-resistant strains of TB are a growing concern.

HIV-Infected People Receiving Treatment in Select Latin American and Caribbean Countries, 2010



Source: WHO/UNAIDS/UNICEF Global HIV/AIDS Response 2011. Coverage estimates are based on 2010 WHO guidelines.
*The ART coverage rate in Nicaragua is greater than 95 percent.

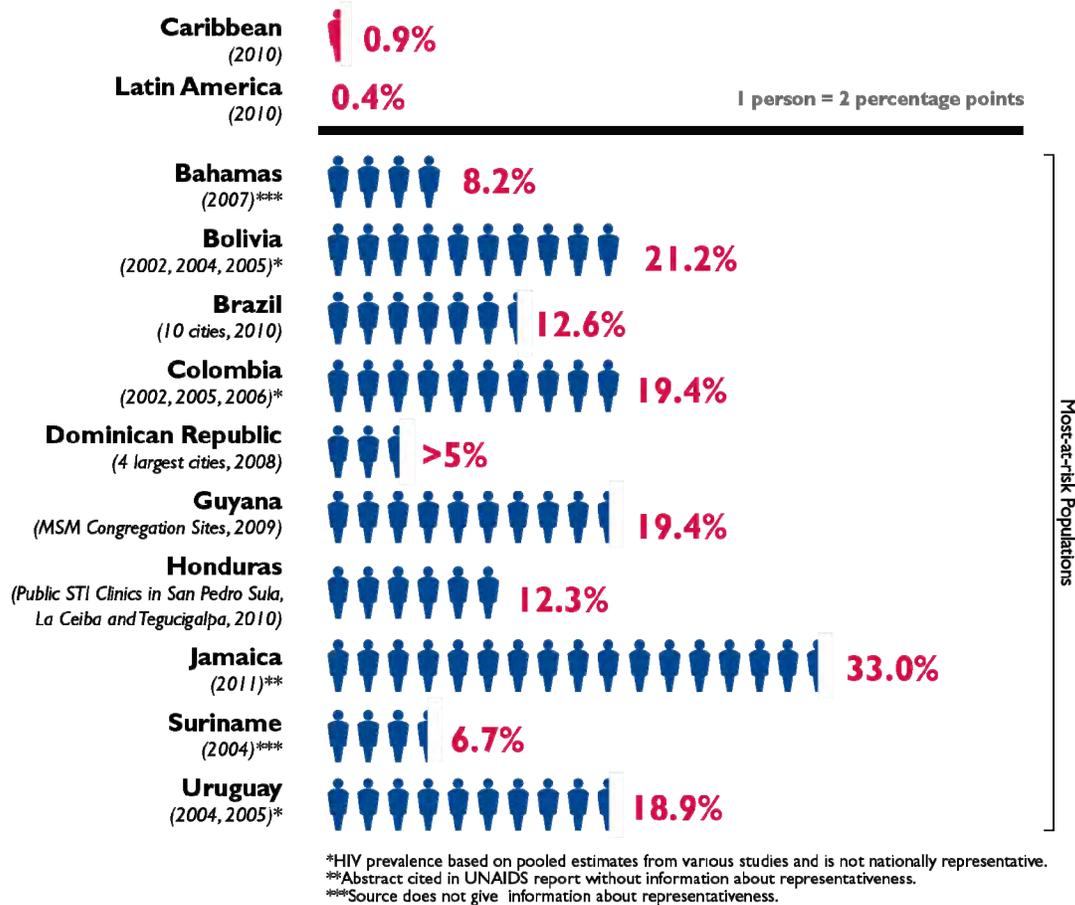
Economic and Social Impacts of HIV/AIDS in Latin America and the Caribbean

Illness, disability, and death associated with HIV/AIDS affect populations at multiple levels. The vast majority of people who have the disease are between the ages of 15 and 49, and often the under-30 age group is the most affected. This has an impact on the most economically active segment of the population, which could result in changes in the demographic structure that pose challenges to support systems for dependent populations, such as children and the elderly. In **Honduras**, 72 percent of HIV cases reported as of December 2011 occurred among people aged 15 to 39⁹. Also, the cost of addressing HIV can divert resources away from investments critical to national economic development. The potential loss of productive labor could threaten the economic growth of countries in the region that have more pronounced epidemics.

Although many LAC countries currently have low prevalence rates, this could change due to cross-border migration from higher-prevalence neighboring countries. Migration contributes to the HIV epidemic in the region in multiple ways. Since tourism drives the economies of many countries, workers migrate to tourist areas. In such areas, many workers engage in transactional sex, sex work, or other high-risk behaviors that increase their vulnerability to HIV¹³. Language and legal barriers make it difficult for migrants in many countries to gain access to services, particularly HIV testing and treatment services. In addition, outreach to migrant populations is difficult¹⁴.

Stigma and Discrimination. HIV/AIDS stigma and discrimination are widespread in the region. A predominant view is that HIV/AIDS is a punishment for immoral behavior. Many people avoid being tested or disclosing their HIV-positive status for fear of losing family, friends, jobs, housing, or social status. Although sex between men is fueling the epidemic in LAC, few national programs focus sufficiently on preventing and treating HIV infection among MSM². Therefore, accurate national data on prevalence and incidence among PLWHA such as MSM can be scarce due to the stigma associated with both HIV infection and behaviors within the MSM community. As such, concentrated epidemics among MSM have often been hidden. While some countries have attempted to pass laws to protect PLWHA, many still have provisions that reinforce prejudices, such as laws prohibiting sodomy and sex work². Countries that do have progressive policies are struggling to enforce human and civil rights protections, and many marginalized groups refuse to come forward when their rights are violated out of fear of retaliation or further discrimination. Stigma and discrimination directed toward PLWHA, especially those who belong to

HIV Prevalence among Adults 15–49 in the Latin America and Caribbean Region and among MSM by Country²



marginalized groups, can contribute to further spread of the virus when members of these groups are reluctant to access health services. Other forms of stigma may range from gossip and verbal abuse, to violence and physical abuse, to discrimination by employers, and create a challenge to the success of HIV programs targeting MSM and other MARPs. Fear of stigma may also drive MSM to seek out female partners to hide their sexual orientation, and this may be accelerating heterosexual transmission².

Gender and HIV. Gender discrimination also contributes to the spread of HIV. Traditional gender roles in many LAC countries imply that women should be submissive, allowing men to make decisions about such matters as engaging in sex. This limits women’s ability to negotiate condom use and makes them vulnerable to sexual assault. In Peru, 39 percent of women surveyed aged 15 to 49 had experienced physical or sexual violence¹⁵ in 2010. At the same time, young men are also pressured to prove their masculinity by engaging in sex at an early age, having multiple sex partners, and sometimes using physical force against women. In the **Dominican Republic**, 24 percent of men surveyed had more than one sexual partner in the last 12 months¹⁶. Higher rates of new infections are increasingly being reported among young women compared with men of the same age cohort. This may be due to strong PMTCT programs, which test pregnant women, and to particular high-risk behaviors among young women, such as unprotected transactional sex and cross-generational relationships.

Cost of Treatment. A persistent challenge in LAC is the hardship families and individuals face in purchasing antiretroviral drugs (ARVs). The high price of ARV combinations can deplete family resources for those caring for an HIV-positive family member or deter PLWHA from seeking treatment. While prices were cut nearly in half in 2003 (five major pharmaceutical companies committed to reducing the cost of ARVs in **Costa Rica, Guatemala, Honduras, El Salvador, Nicaragua, and Panama**), treatment often remains unaffordable for PLWHA in the region². Social security systems and health insurance coverage are limited in many LAC countries, including Guatemala, El Salvador, and Panama. Costa Rica is one of the few Central American countries with a public social welfare system that covers health costs for ART¹⁷. Even in those countries with stronger social welfare

programs, the systems currently in place are not strong enough to manage the burden of the disease. For example, the fact that second-line drugs are vastly more expensive means that, despite very few people taking them, they still account for a large proportion of the overall drug expenditure in some countries. According to a 2007 *AIDS* journal article titled “TRIPS Post-2005 and Access to New Antiretroviral Treatments in Southern Countries: Issues and Challenges,” the Brazilian Ministry of Health was spending 80 percent of its national budget expenditure for ART procurement on imported patented drugs¹⁸. Inadequate supply chain systems in many countries lead to stockouts of ARVs, resulting in the need for much more expensive second-line treatments.

Global Fund Investment in the Latin America and the Caribbean Region. The Global Fund to Fight AIDS, Tuberculosis and Malaria funds ART programs to increase coverage, fostering close collaboration between governments and civil society to work toward sustainability of ART programs. The U.S. Government provides nearly 30 percent of the Global Fund’s total contributions worldwide¹⁹.

USAID Regional and Bilateral Support

The U.S. Agency for International Development’s (USAID’s) HIV/AIDS programs in the LAC region are implemented as part of the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). Launched in 2003, PEPFAR is the U.S. Government initiative to support partner nations around the world in responding to HIV/AIDS. PEPFAR is the cornerstone of President Obama’s Global Health Initiative (GHI), which supports partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

Partnership Frameworks. In 2010, the U.S. Government signed Partnership Frameworks with regional and national governments and organizations in Central America and the Caribbean. Partnership Frameworks are designed as 5-year joint strategic frameworks to facilitate cooperation among the U.S. Government, the partner government, and other civil society partners to combat HIV/AIDS through service delivery, policy reform, and coordinated financial commitments. In March 2010, the U.S. Government and the Council of Ministers of Health of Central America signed a Partnership Framework that outlines a jointly developed strategy to support Central America’s regional response to HIV/AIDS. In June 2010, the U.S. Government signed a Partnership Framework with 12 Caribbean countries (**Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago**) and two regional organizations (Pan Caribbean Partnership Against HIV and AIDS and the Organization of Eastern Caribbean States/HIV/AIDS Project Unit). In November 2010, the U.S. Government signed a Partnership Framework with the Government of the **Dominican Republic** to support the implementation of the Dominican National Strategic Plan for the Prevention and Control of STIs, HIV, and AIDS, 2007–2015, which is part of the country’s HIV/AIDS national response, and the Health Sector Development Plan.

Addressing Prevention, Care, and Treatment Challenges. USAID regional support strengthens countries’ programs and services to prevent MARPs from transmitting or acquiring HIV/AIDS and to provide effective care and treatment for persons infected with HIV. The LAC Regional Program has funded an assessment of transgender access to HIV/AIDS treatment in the region. The assessment examined the perceptions of health providers regarding transgender people. The findings and recommendations will be used to improve provider capacity to offer quality services to diverse populations as well as to develop educational materials for transgender populations.

LAC regional funding supports fora to address specific issues. USAID and other partners held two meetings, one for the Caribbean and one for Central America, on HIV prevention for MARPs. These meetings led to improved comprehensive programming for these groups, including MSM, commercial sex workers, and PLWHA. In preparation for the Caribbean meeting, USAID commissioned a technical brief on hidden MSM in the Caribbean. As a result of the meeting in Central America, an integrated prevention program was designed using social media and private sector providers to target difficult-to-reach MARPs. In August 2011, USAID sponsored a meeting that focused on building public-private partnerships across the Pan Caribbean region between insurance companies and the health sector to enhance access to treatment by PLWHA and to reduce stigma and



discrimination associated with the disease. The workshop demonstrated how regional health insurance is meeting the needs of PLWHA. The meeting also identified how USAID could leverage its resources to expand coverage for PLWHA. In September 2012, USAID and other partners will sponsor a meeting on substance use and HIV/AIDS.

Workplace Initiatives. USAID bilateral support also increased private sector involvement. With seed money from USAID, a national business council known as CONAES (Consejo Nacional Empresarial sobre SIDA) was launched in 2004 in **Mexico** to reduce stigma and discrimination in the workplace. By using the media effectively and involving key business leaders and public officials, the project has dramatically raised the public profile of HIV-related stigma while giving credit to those companies that dedicate resources to reduce it. Since its inception, CONAES has had a direct impact on 150,000 Mexican workers and an indirect impact on an estimated 560,000 family members. In **Jamaica**, USAID addressed stigma and discrimination in the workplace through the Jamaica Business Council on HIV/AIDS and the Ministry of Labor and Social Security. The Ministry of Labor and Social Security has the mandate to lead the national response on HIV workforce issues and is finalizing the national HIV/AIDS workplace policy. Currently, the policy is being submitted to the Human Resource Committee of the Cabinet to be approved as a white paper. This is the final stage that will lead to the development of the legislation. A media campaign will be launched to aid in the public awareness and understanding of the importance of policies on HIV/AIDS and the importance of private sector companies developing policies on HIV/AIDS. In **Guatemala**, USAID entered an alliance with the Sugar Producers Association to pilot an integrated HIV and STI prevention project for sugar cane plantation and mill workers. A similar partnership has begun with the banana industry.

U.S. Government Coordination and Implementation. USAID regional and bilateral offices also play a lead role in coordinating activities with several U.S. Government agencies in the region, including the U.S. Centers for Disease Control and Prevention; the Peace Corps; and the Departments of Defense, Health and Human Services (i.e., Health Resources and Services Administration), and State. USAID also works with the Global Fund, the Pan American Health Organization, the Joint United Nations Programme on HIV/AIDS, the World Bank, and other donors and development banks, which have contributed crucial resources and technical capacity in fighting HIV/AIDS. In LAC, USAID and PEPFAR implement HIV/AIDS programs in **Belize, Brazil, the Dominican Republic, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Peru, and Panama**. In addition, USAID's Caribbean Regional Program, working with the other U.S. Government agencies, multilateral programs, and donors, covers the 12 Caribbean countries under the Partnership Framework.

Examples of recent USAID assistance include the following activities and interventions:

- In **Haiti**, 1 million people received HIV prevention messages through the National AIDS Communication Program. A national survey of high-risk groups identified 1,245 sites where people meet new sexual partners, enabling better targeting of prevention activities. Social marketing activities increased demand for condoms. In 2011, 2.2 million branded condoms were sold, and 39 million were distributed nationwide.
- In **Jamaica**, USAID addressed stigma and discrimination in the workplace through the Jamaica Business Council (50 members) on HIV/AIDS and the Ministry of Labor and Social Security. The Council has initiated a Foundation (JaBCHA National Foundation) to assist in the sustainability of the national HIV response in Jamaica. To date, they have received US\$70,848 million in corporate sponsorship.
- In **Guyana**, more than 45,300 people, including 9,700 pregnant women, received HIV counseling and testing (HCT) services and their results. Continued scale-up of ART programs provided more than 3,000 PLWHA with ART. An additional 7,200 HIV-positive individuals, including people with HIV-TB co-infection, and 1,600 orphans and vulnerable children received care and support services in fiscal year (FY) 2010.
- USAID's program in **Brazil** uses relationship sites, such as Facebook and Orkut, gay virtual meeting sites, mobile phone messaging, and pop-ups in a stigma- and discrimination-free environment to disseminate prevention messages and provide information on the availability of rapid HIV testing and counseling services. People interested in knowing more about testing options are referred to a USAID-funded blog that provides HIV/AIDS information and directions to testing sites. In addition, 2,239 gay men and MSM received individual prevention interventions. In Recife, Rio de Janeiro, Brasília, and São Paulo, USAID-supported mobile and nongovernmental organization-based units offered free, confidential, and reliable HCT to more than 4,000 MSM and transvestites in FY 2011.
- In FY 2011, USAID started working with eight networks in four regions in **Guatemala** to integrate care and treatment for PLWHA with community-based support. USAID expects that PLWHA will remain under treatment and that prevention activities will be integrated into care and support delivery, thus improving the continuum of care.
- Strengthening the capacity of Ministry of Health (MOH) personnel and other key stakeholders, USAID provided training on voluntary HCT to 700 counselors in **El Salvador**. In support of 2011 National HIV Testing Day,

USAID voluntary HCT counselors reached more than 4,000 people with HCT services. Among youth, USAID carried out prevention messages to 12,000 people from MARPs. HIV prevention messages emphasized prevention of GBV, life skills, and self-esteem.

- In **Honduras**, USAID supported the MOH in the development and launch of the National Strategy for Integrated Care of STI/HIV/AIDS in the context of health sector reform. This strategy lays the foundation for developing a basic package of HIV services that will increase the coverage and improve the quality and efficiency in providing prevention and treatment services at different levels of the health system (community, primary level, and hospital). Also in 2011, 12,633 MARPs received HCT, exceeding the target by 12 percent for women and 34 percent for men.
- To promote condom availability in **Mexico**, local commercial distribution partners work with USAID to distribute condoms in 147 high-risk, nontraditional condom outlet sites in seven target cities. A variety of behavior change communications strategies are employed with target groups in these cities to promote condom purchase and correct use. USAID also helped reduce stigma and discrimination through a training program for 124 health service providers and 69 media personnel.
- In the **Dominican Republic**, USAID promoted PMTCT by providing assistance to MOH sites to improve HIV testing among pregnant women. In 2011, 39,638 pregnant women were tested for HIV and 323 HIV-positive pregnant women received ARVs to reduce the risk of mother-to-child transmission of HIV.

Important Links and Contacts

Lindsay Stewart, Senior Advisor on HIV/AIDS
Latin America and the Caribbean Bureau/RSD-PHN, #5.9.101
USAID
1300 Pennsylvania Avenue NW
Washington, D.C. 20523-5900
Tel.: 202-712-4964
Fax: 202-216-3262
E-mail: lstewart@usaid.gov

USAID's HIV/AIDS website for Latin America and the Caribbean:

http://www.usaid.gov/our_work/global_health/aids/Countries/lacin.html

USAID's HIV/AIDS website for the Caribbean Region:

http://www.usaid.gov/our_work/global_health/aids/Countries/lac/caribbeanregion.html

USAID's HIV/AIDS website for the Central America Region:

http://www.usaid.gov/our_work/global_health/aids/Countries/lac/caregion.html

For more information, see USAID's HIV/AIDS website: http://www.usaid.gov/our_work/global_health/aids.

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