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ARTICLES

EXPLORING DISPARITIES BETWEEN GLOBAL HIV/AIDS FUNDING AND RECENT TSUNAMI RELIEF EFFORTS: AN ETHICAL ANALYSIS

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ABSTRACT

Objective: To contrast relief efforts for the 26 December 2004 tsunami with current global HIV/AIDS relief efforts and analyse possible reasons for the disparity.

Methods: Literature review and ethical analysis.

Results: Just over 273,000 people died in the tsunami, resulting in relief efforts of more than US$10 bn, which is sufficient to achieve the United Nation's long-term recovery plan for South East Asia. In contrast, 14 times more people died from HIV/AIDS in 2004, with UNAIDS predicting a US$8 bn funding gap for HIV/AIDS in developing nations between now and 2007. This disparity raises two important ethical questions. First, what is it that motivates a more empathic response to the victims of the tsunami than to those affected by HIV/AIDS? Second, is there a morally relevant difference between the two tragedies that justifies the difference in the international response?

The principle of justice requires that two cases similarly situated be treated similarly. For the difference in the international response to the tsunami and HIV/AIDS to be justified, the tragedies have to be shown to be dissimilar in some relevant respect. Are the tragedies of the tsunami disaster and the HIV/AIDS pandemic sufficiently different, in relevant respects, to justify the difference in scope of the response by the international community?

Conclusion: We detected no morally relevant distinction between the tsunami and the HIV/AIDS pandemic that justifies the disparity. Therefore, we must conclude that the international response to HIV/AIDS violates the fundamental principles of justice and fairness.

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INTRODUCTION

The flow of humanitarian support for victims of the 26 December 2004 tsunami in South East Asia is appropriate and encouraging. It is reported that, in the aftermath of this natural disaster, international donors pledged over US$10 bn to tsunami relief efforts.[1] Of this US$10 bn, US$2.8 bn of funding was dispersed within the first six months after the disaster, and there is a concerted effort to ensure that donor countries live up to their funding promises.[2] The projection is that US$10 bn over the next five to ten years will be sufficient funding to complete the United Nations' long-term recovery plan for South East Asia.[3] Public generosity for tsunami relief has been so overwhelming that Médecins Sans Frontiéres has been compelled to decline further donations for this cause;[4] in addition, World Vision, Care USA, Oxfam America, and the American Red Cross also have stopped actively collecting for this cause.[5]

The magnitude and immediacy of the international response to the tsunami disaster compels us to ask why, paradoxically, other problems, most notably the HIV/AIDS pandemic, have failed to strike the same chord with the international community. In comparison to the ample amount of US$10 bn pledged to tsunami relief efforts and the US$2.8 bn actually dispersed so far, HIV funding pledged for 2005 is less than half of the US$12 bn required, and it is estimated that by 2007 the pledged HIV funding will be only a quarter of the US$20 bn that will be necessary at that time.[6] Between now and 2007 the Joint United Nations Programme on HIV/AIDS (UNAIDS) predicts a funding gap of US$18 bn for HIV/AIDS.[7]

In referring to the 'international community,' we realise that there is no universally recognised group of stakeholders that make up this association. However, in response to the tsunami, a coordinated international effort developed that is so extraordinary it almost defies description. For instance the United Nations have administered billions of dollars of pledges from more than 60 donor nations. The following is a quotation, which describes the extent of the international response for one city of the 12 tsunami-affected countries:

> The international community response has been extraordinary, involving 12 governments, 100 local governments, more than 150 NGOs and partner organizations with 5,000 international staff in Banda Aceh alone.[8]

The tsunami disaster demonstrates that stakeholders, such as governments, non-governmental organisations, religious organisations, individual members of the public, etc., have collaborated to orchestrate the world's largest humanitarian relief operation in history.[9] Therefore, it is fair to ponder why such collaboration has occurred in response to a natural disaster like the tsunami, but not the much larger HIV/AIDS pandemic.

Although it makes many of us uncomfortable to compare disasters, the fact remains that the tsunami death toll in 2004 of approximately 273,000 people is far less than the global death toll from HIV/AIDS in 2004, which was approximately 3.1 million people. In fact, some commentators have stated that the

[1] Reuters Foundation. 2005. Tsunami Pledges/Donations Top $10 Billion. *Reuters Foundation: Alert Net* 27 July. Available at: http://www.alertnet.org/thefacts/countryprofiles/218357.htm [Accessed 17 May 2006].

[2] B.S. Klapper. 2005. U.N.: Tsunami Relief Pledges Surpass $10B. *Associated Press* 22 June. Available at: http://www.wtopnews.com/index.php?nid=412&sid=393828 [Accessed 17 May 2006]; L. Cruz. 2005. *Governments must Make Good on Tsunami Relief Pledges.* Boston, MA: Oxfam America. Press Release, 7 January. Available at: http://www.oxfamamerica.org/newsandpublications/press_releases/press_release.2005-01-11.9987149063 [Accessed 17 May 2006].

[3] Klapper, *op. cit.* note 2.

[4] M. Thieren. Asian Tsunami: Death-toll Addiction and its Downside. *Bull World Health Organ* 2005; 83: 82.

[5] WWW Virtual Library-Sri Lanka. 2005. Tsunami charities enough already: U.S. Tsunami Donations Alone have Topped $1 Billion in Relief. *NewsMax.com* 1 March. Available at: http://www.lankalibrary.com/news/charities.htm [Accessed 17 May 2006].

[6] H.M. Coovadia & J. Hadingham. HIV/AIDS: Global Trends, Global Funds and Delivery Bottlenecks. *Global Health* 2005; 1: 13: doi:10.1186/1744-8603-1-13. Available at: http://www.globalizationandhealth.com/content/1/1/13 [Accessed 1 June 2006].

[7] C. Akukwe. 2005. HIV/AIDS: Looming Funding Crisis. *Worldpress.org* 27 July. Available at: http://www.worldpress.org/Africa/2123.cfm [Accessed 1 June 2006].

[8] E. Carll. United Nations Coordinated Tsunami Relief Efforts, Including Billions in Pledges. *International Society for Traumatic Stress Studies* Winter. Available at: http://www.istss.org/publications/TS/Spring05/tsunami.htm [Accessed 17 May 2006].

[9] B. Barber. 2005. Worldwide Tsunami Relief Pledges Top $6b. *USAID Frontlines* May. Available at: http://www.usaid.gov/press/frontlines/fl_may05/tsunamirelief.htm [Accessed 17 May 2006].

mortality rate from HIV/AIDS is equivalent to one tsunami a month.[10]

The intention of this paper is to compare the international response to the tsunami disaster with the international response to HIV/AIDS. We will explain some specifics about the disparity and offer an ethical analysis, which critically examines some of the fundamental differences between the two events. We will conclude that although there are differences between the tsunami and the HIV/AIDS pandemic, these differences do not justify the colossal difference in the response of the international community to these tragedies.

RESULTS

The Asian tsunami killed approximately 273,000 people in one afternoon, it affected 12 countries, resulted in more than 150,000 casualties, 24,000 missing persons reports, and more than one million displaced persons.[11] In response to this disaster, the international community pledged an incredible US$10 bn, of which US$2.8 bn has already been dispersed. It is expected that this funding will be sufficient to achieve the United Nations' long-term recovery plan for South East Asia. On the other hand, the annual death toll from tuberculosis is 2–3 times higher than the death toll from the tsunami,[12] and every month diarrhoea kills more than 140,000 people worldwide, while malaria and AIDS each kill an additional 250,000 people per month.[13] The tsunami orphaned approximately 100,000 children, whereas AIDS has orphaned more than 11 million children in Africa alone.[14]

The latest HIV/AIDS statistics report that the global prevalence of HIV is more than 39.4 million people and the incidence rate in 2004 was 4.9 million new infections. The death rate from HIV/AIDS related causes in 2004 was 3.1 million people. Sub-Saharan Africa, by itself, has over 60% (n = 25.4 million) of the world's population of people living with HIV/AIDS.[15] In 2002, the UNAIDS programme estimated that, without proper prevention efforts, there would be approximately 45 million new cases of HIV in Africa by 2010. They further argued that more than 64% (or 29 million) of these infections are avoidable via proper prevention efforts.[16] Regarding treatment of HIV, the '3 by 5 initiative' is a plan to provide three million people in low- and middle-income countries, with antiretroviral treatment by the end of 2005. The cost will be as little as US$17 per month/per patient, or US$0.56 per day/per patient, but will reach less than 50% of the people who need Highly Active Antiretroviral Therapy (HAART).[17]

A telling example of political inconsistency in response to these disasters is Canada's response. Within the first two weeks after the tsunami, Canada pledged over C$5 million without knowing exactly what was needed or what the strategic direction for relief efforts would be. On 10 January 2005, the Prime Minister announced that Canada would contribute C$425 million over the next five years for a comprehensive disaster relief package.[18] In fact, Canada has been applauded as one of the most generous countries in the world for its tsunami relief efforts.[19] In contrast, funding for the Canadian

[10] M. Wainberg. 2005. A Tsunami a Month: Canadians are Turning their Backs on the Global Fight against HIV/AIDS, Even though the Number of Dead and Orphaned Keeps Rising. *The Ottawa Citizen* 24 February: A15.

[11] Carll, *op. cit.* note 8.

[12] I. Bastian. The Tsunami of Tuberculosis. *Med J Aust* 2005; 182: 263–264.

[13] R. Deonandan. 2005. Why not (Cough Cough) Diarrhea? The West as a Whole seems to Prefer the Poor of Asia to the Poor of Africa. *rabble news* 19 January. Available at: http://rabble.ca/everyones_a_critic.shtml?x=36710 [Accessed 17 May 2006].

[14] Klapper, *op. cit.* note 2.

[15] Joint United Nations Programme on HIV/AIDS (UNAIDS). 2004. *2004 Global Summary of the HIV and AIDS Epidemic in 2004. Executive Summary.* Geneva: UNAIDS. Available at: http://www.unaids.org/bangkok2004/GAR2004_html/ExecSummary_en/ExecSumm_00_en.htm [Accessed 3 June 2006].

[16] R. Parker & P. Angleton. 2002. *HIV/AIDS-related Stigma and Discrimination: A Conceptual Framework and an Agenda for Action.* Washington, DC: The Population Council Inc. Available at: http://www.popcouncil.org/pdfs/horizons/sdcncptlfrmwrk.pdf. [Accessed 17 May 2006].

[17] D. Bangsberg. 2005. *HAART-felt or HAART-less: The Benefits and Harms of providing HAART to HIV Positive Persons in Low and Middle Income Countries.* Seminar Paper. Presented to the Canadian Association of HIV/AIDS Research, May.

[18] Canada: Office of the Prime Minister. 2005. *Canada Announces Comprehensive Tsunami Disaster Relief, Rehabilitation and Reconstruction Assistance.* Office of the Prime Minister: Ottawa, ON. New Release, 10 January. Available at: http://www.pco-bcp.gc.ca/default.asp?Language=E&Page=archivemartin&Sub=newscommuniques&Doc=news_release_20050110_381_e.htm [Accessed 3 June 2006].

[19] Wainberg, *op. cit.* note 10.

Strategy on HIV/AIDS will gradually increase from C$42.2 million to C$84.4 million over the next five years, which is still significantly below the C$106 million currently necessary to get ahead of the epidemic in Canada.[20] Furthermore, Canada's pledge of C$70 million for the Global Fund remains far below that deemed adequate by the Equitable Contribution Framework.[21]

DISCUSSION AND ETHICAL ANALYSIS

Unlike the international response to HIV/AIDS, the response to the tsunami disaster has demonstrated that rapid and massive resource mobilisation is possible if the international community is suitably motivated. In fact, resources allocated for the tsunami exceed what is required to deal with 100% of the demand; whereas the projected resource allocation for HIV/AIDS is expected to be deficient by US$18 bn between now and 2007. This comparison raises two ethically germane questions, which, furthermore, are importantly linked. First, what is it that motivates a more empathic response to the tsunami than to HIV/AIDS? Why is it that the international community has made such an extraordinary effort to address this need so completely? Second, is there a morally relevant difference between the two tragedies that justifies the difference in the international response?

The first of these questions is a matter of moral psychology, on which we will only speculate. The tsunami was a one-time event, whereas HIV/AIDS is an ongoing crisis. It is probably true that a sudden disaster generates a different visceral response than a slow ongoing horror such as the HIV/AIDS pandemic. Furthermore, the shock value of this event was definitely influenced by the media response and, quite possibly, the resultant empathy for victims of the tsunami was a 'knee jerk' response.

It is also possible that tsunami relief efforts are, in a sense, 'easier' and more concrete than what is needed to fight HIV/AIDS. Many health system constraints, in developing countries, create bottlenecks that prevent aid from being used efficiently where it is most needed.[22] Tsunami relief efforts largely went to tasks for which infrastructure and skills were readily available for use of resources, for example, providing food, shelter, rebuilding and re-equipping schools and clinics, rebuilding boats, desalinating rice paddies, etc.; whereas what is needed to confront HIV/AIDS is: education, changing attitudes, changing intimate behaviour, changing unequal gender relations and attitudes toward women, etc. These are much more involved projects that may be harder for people to conceptualise and difficult to achieve without adequate infrastructure support.

It is one thing to speculate whether the difference between a one-time event and an on-going crisis, or whether the lack of infrastructure supports, is actually the cause of the difference in the international response to the two events. However, it is quite another question to ask whether this difference is justified. In the first question we are simply trying to understand the phenomenon of the international community's reaction to the two events. But with the second question we are exploring whether any difference in response, whatever its actual cause, is justified. The principle of justice suggests that any two cases that are situated similarly ought to be treated in a similar fashion. For any difference in the international response to the tsunami and HIV/AIDS to be justified, the two tragedies have to be shown to be dissimilar in some relevant respect – in some way that is material to the purpose of the comparison. The general question from this ethical principle is; are the tragedies of the tsunami disaster and the HIV/AIDS pandemic sufficiently different, in relevant respects, to justify the difference in scope of the response by the international community?

One of the biggest differences between the tsunami and HIV/AIDS is the apparent morally neutral nature of the tsunami disaster. The tsunami was a natural disaster that did not involve human agency. HIV/AIDS, on the other hand, is a disease

[20] J. Boothroyd. 2004. How Ottawa has run down the Canadian Strategy on HIV/AIDS. *LIVING*+ July/August: 9–11. Available at: http://www.bcpwa.org/articles/issue_31_9-11_critical_care.pdf [Accessed 17 May 2006].

[21] KAIROS: Canadian Ecumenical Justice Initiatives. *Cultivating just Peace: KAIROS Education and Action Campaign 2004–2005. Factsheet on HIV/AIDS.* Toronto, ON: KAIROS. Available at: http://www.kairoscanada.org/e/action/CJPFactsheeHIV.pdf [Accessed 1 June 2006].

[22] Coovadia & Hadingham, *op cit.* note 6.

that is spread via human conduct, primarily through sex and/or injection drug use.[23] This, at a superficial level, may make it is easier to blame the victims, or at least to be less empathic. The following quotation from Stephanie Nolen's *Globe and Mail* piece describes the difference:

> It's not [for] people fighting each other all the time – and there is a moral judgment that people still make about HIV and AIDS, but there is no moral judgment about being hit by a wave. I feel a slight undercurrent – AIDS is connected with sex and sex is bad. But this is just a wave.[24]

The general point is that a major difference between the two tragedies is the role of human agency. That is, the victims of the tsunami did nothing to precipitate the event (the underwater earthquake) that led to the harms they ended up experiencing, but those affected by HIV/AIDS have had a causal role to play in the events that led to their being affected by the disease. This line of argument reasons that human agency justifies the difference in the way that the global community has responded to the two events.

The major problem with this argument is that it grossly overstates the roles of a great many individuals, particularly in developing countries, who end up with HIV/AIDS because they occupy relatively weak positions in the power relationships that govern the social order. For instance Dr Mark Wainberg explained the weakness in this argument as follows:

> It is incredible to hear some people still arguing that the victims of HIV are largely deserving of their fate because of injection drug use, promiscuity, prostitution or failure to use condoms – as though abject poverty, poor education and a too common sense of despair in AIDS-endemic countries had nothing to do with it. Not to mention that millions of women are the victims of sexual assault in any given year and are often not empowered to insist on condom use under the best of circumstances.[25]

Regardless of what one thinks about sex, injection drug use, prostitution, promiscuity, and/or any other HIV risk behaviour, evidence clearly indicates that the negative consequence of contracting HIV/AIDS and/or having untreated HIV are largely preventable and unnecessary. For example, the proper administration of HAART can significantly reduce the morbidity and mortality associated with HIV/AIDS and can extend, significantly, the lives of those infected with the HIV virus.[26] There is even evidence that providing effective HAART can reduce the heterosexual transmission of HIV by as much as 80%.[27] The correct use of condoms can reduce the risk of sexual transmission by more than 80%;[28] harm reduction strategies can significantly reduce the spread of HIV via injection drug use by more than one third;[29] and mother-to-infant transmission can be virtually eliminated with proper interventions.[30]

One consequence of the disparity that results from the human agency argument, is that if people behave in a way that precipitates holding individuals or groups responsible for their disease, it is then appropriate for that person (or group of people) to

[23] WWW Virtual Library-Sri Lanka, *op. cit.* note 5.

[24] S. Nolen. 2005. While we Mourn the Losses from the Tsunami . . . Federal Tsunami Aid hits $425 million . . . as Cash Woes Hurt African AIDS Fight. *The Globe and Mail* 11 January: A1. Available at: http://www.actupny.org/reports/tsunami.html [Accessed 17 May 2006].

[25] Wainberg, *op. cit.* note 10.

[26] World Health Organization (WHO). 2003. *Treating 3 Million by 2005: Making it Happen. The WHO Strategy.* Geneva: WHO. Available at: http://www.who.int/3by5/publications/documents/en/3by5StrategyMakingItHappen.pdf [Accessed 17 May 2006]; E.L. Murphy et al. Highly Active Antiretroviral Therapy Decreases Mortality and Morbidity in Patients with Advanced HIV Disease. *Ann Intern Med* 2001; 135: 17–26; J.T. King. Long-term HIV/AIDS Survival Estimation in the Highly Active Antiretroviral Therapy Era. *Med Decis Making* 2003; 23: 9–20; C. Laurent et al. Long-term Benefits of Highly Active Antiretroviral Therapy in Senegalese HIV-1 Infected Adults. *J Acquir Immune Defic Syndr* 2005; 38: 14–17.

[27] J. Castilla et al. Effectiveness of Highly Active Antiretroviral Therapy in Reducing Heterosexual Transmission of HIV. *J Acquir Immune Defic Syndr* 2005; 40: 96–101.

[28] S. Weller & K. Davis. Condom Effectiveness in Reducing Heterosexual HIV Transmission. *Cochrane Database Syst Rev* 2002; 1: CD003255.

[29] D. Vlahov & B. Junge. The Role of Needle Exchange Programs in HIV Prevention. *Public Health Rep* 1998; 113(Suppl 1): 75–80.

[30] Kwazulu Natal: Department of Health. Implementing Prevention of Mother to Child Transmission of HIV (PMTCT) in Kwazulu Natal. Unpublished data. October 24. Found in Coovadia & Hadingham, *op. cit.* note 6; M.L. Newell & C. Thorne. Antiretroviral Therapy and Mother-to-Child Transmission of HIV-1. *Expert Rev Anti Infect Ther* 2004; 2: 717–732.

suffer the consequent harms, no matter how severe or preventable. The principles of respect for human life and human dignity, however, suggest that the lives of those suffering preventable morbidity and/or mortality (e.g. HIV/AIDS) are not any less deserving than those who suffer morbidity and/or mortality from a natural disaster. Thus, we argue that focusing on the human agency argument misses the point. The question should not be whether or not we condone the risk behaviors that could lead to HIV, but whether we should tolerate avoidable negative consequences, simply because some may disapprove of certain human behaviors.

Because the negative consequences of HIV/AIDS are largely preventable, by employing the same type of supports and international collaboration as were provided to the tsunami victims, it is irrelevant whether or not we hold the victims of the HIV/AIDS pandemic responsible for their tragic fates. Yet, the way we have responded to the tsunami disaster, compared to the way we have responded to the HIV/AIDS pandemic, implies precisely this. Blameless victims have received unprecedented international support, whereas victims who are blamed for their own situations have received much less support. As Ian Culbert, Director of the Canadian HIV/AIDS Information Centre with the Canadian Public Health Association wrote: 'the global HIV/AIDS crisis is really two epidemics that fuel each other: an epidemic of disease ravaging countries and continents and an epidemic of stigma and discrimination.'[31]

As for the argument that the infrastructure for supporting those affected by the tsunami is in place, whereas it is missing in the cases of HIV/AIDS victims and the victims of other conditions; while the argument may have some explanatory merit, it lacks justificatory force. A recent example of how investing properly in health system infrastructure could help the more efficient use of resources is South Africa's programme for the prevention of mother to child transmission of HIV. This treatment regimen is relatively simple, a single dose of Nevirapine given to the mother during delivery and to the newborn. Prior to investing in infrastructure support, less than 10% of eligible women received this intervention, however, after improving the service delivery infrastructure, coverage increased to over 78% in South Africa.[32] The lack of infrastructure support in developing countries certainly is a barrier that would have to be addressed. If the international community collaborated to fight HIV in the way it came together in response to the tsunami, the lack of infrastructure in developing countries would be rectified. For instance, the tremendous efforts of the United Nations in coordinating tsunami relief required developing new infrastructure and this was done without delay.[33] This is not an insurmountable obstacle and, based on the above reasoning, there is an ethical imperative that it must be addressed.

Critics may reject our argument for why there is a disparity between tsunami relief efforts and HIV/AIDS relief efforts. Perhaps, stigma, discrimination, and/or blaming the victims are not the only reasons for the disparity. However, this does not mean that one is justified in accepting this disparity uncritically. We argue that there is no morally relevant difference between the two events that could lead to an ethically just distinction in response by the international community. Therefore, we must pose tough questions to the international community, and to ourselves, about how such injustice could occur and how it can be rectified.

CONCLUSION

What happened in South East Asia was basically unpreventable. Of course, an early warning system could have saved many lives, but the event itself could never have been prevented. Meanwhile, HIV/AIDS is an appalling example of a largely preventable disease with proven effective interventions. Responses to HIV/AIDS and the tsunami are examples of our inconsistency in responding to large-scale human tragedies. Regarding HIV/AIDS, we shrink behind rationalisations and fallacious

[31] I. Culbert. 2003. *The Fight Against HIV/AIDS Must Continue.* Toronto, ON. Canadian HIV/AIDS Legal Network. Press release, 28 November 2003. Available at: http://www.aidslaw.ca/Media/press-releases/e-press-nov0703.htm. [Accessed 3 June 2006].

[32] Vlahov & Junge, *op. cit.* note 29.

[33] Carll, *op. cit.* note 8.

reasoning, whereas in the case of the tsunami we simply did what needed to be done out of genuine empathy.

We can find no morally relevant distinction between the tsunami disaster and the HIV/AIDS pandemic that withstand critical examination. Therefore, we must conclude that the international response to HIV/AIDS (not the response to the tsunami) violates the fundamental principles of justice and fairness. Although it is very difficult to pinpoint exactly what is meant by the 'international response', the disparity between tsunami relief efforts and HIV/AIDS relief efforts is so grotesque that one cannot help but be morally outraged. If the tsunami disaster has taught us anything, it is that the public does have an enormous capacity for generosity in the face of human tragedy, and for pressuring governments to respond. In conclusion, our argument does not suggest that we should spend less money on tsunami relief. Rather, we should abandon fallacious rationalisations when it comes to dealing with the HIV/AIDS pandemic and do what needs to be done.

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