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Title: What comes next? The Sustainability of Donor Funded HIV/AIDS Programmes Post Funding Cycle

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Research Report Submitted for the Degree: Master of Medicine in Bioethics and Health Law

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Abstract

In the world of donor funding, there are inevitable instances where funding for certain projects or interventions will be concluded and withdrawn. There is no sustainability of these projects. In the South African context, Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) projects and interventions are some of the most heavily funded disease areas in South Africa. With funding cuts or decreases or complete removal of funding, these projects are impacted resulting in millions of livelihoods being affected. This research report looks at the ethical responsibilities that lie with the state to ensure that HIV/AIDS programmes are sustained beyond the funding period. Using different moral theories such as the theory of justice and care ethics, I have been able to show that the state has the ethical obligation to ensure the sustainability of these programmes when funding decreases or is stopped.

Acronyms

AIDS – Acquired Immunodeficiency Syndrome

ART: Antiretroviral Therapy

ARV: Antiretroviral

AYWG: Adolescent Young Women and Girls

CDC: Centre for Disease Control and Prevention

HIV – Human Immunodeficiency Virus

ISESCR: The International Covenant on Economic, Social and Cultural Rights

NACOSA: Networking HIV and AIDS Community of Southern Africa

NSP: National Strategic Plan

OVCs: Orphan and Vulnerable Children

PEPFAR: U.S Presidents Emergency Plan for AIDS Relief

PLHIV: People living with HIV

PrEP: Pre-exposure prophylaxis

PMTCT: Prevention of Mother to Child Transmission

SANAC: South African National AIDS Council

SAMRC: South African Medical Research Council

STI: Sexually Transmitted Infection

UHC: Universal health coverage

USAID: United States Agency for International Development

VMMC: Voluntary Male Medical Circumcision

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CHAPTER ONE: INTRODUCTION

1. INTRODUCTION

a. BACKGROUND

In the world of donor funding, there are inevitable instances where funding for certain projects or interventions will be concluded and withdrawn and more often than not, these projects are not sustained. In the South African context, Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) projects and interventions are some of the most heavily funded disease areas in South Africa (Vermund, Sheldon, & Sidat, 2015). The sustainability of these interventions post funding cycle is often argued about by recipients of the interventions as well as those that are funding the interventions as well as the implementing partners that are recipients of the funds.

Sustainable HIV/AIDS projects and interventions are defined as "*the capacity to maintain programme services at a level that will provide ongoing prevention and treatment for a health problem after termination of major financial, managerial and technological assistance from an external donor*" (Torpev, Mwenda, Thompson, Mamuwi, & van Damme, 2010). In South Africa, the largest funding organisation is the United States Presidents Emergency Plan for AIDS Relief (PEPFAR) alongside the United States Agency for International Development (USAID). These two funding organisations fund numerous HIV and AIDS programmes across the country. This paper will look at the impact the ending of a funding cycle has on the sustainability of these interventions and further look at who actually is morally obliged to ensure that these interventions continue post funding. I will be looking at different moral theories such as the theory of justice and care ethics to further explore the moral obligations in

this situation. I will be looking at the context of South Africa and the HIV/AIDS programmes that have been funded through PEPFAR.

This project will specifically look at the HIV and AIDS projects and interventions under the care and treatment plan for the disease in South Africa. These interventions are considered to be life-saving interventions and when they are no longer implemented, it poses a threat on the lives of those that are burdened or affected by the disease. The project will mainly focus on the interventions that are funded by PEPFAR through the Centre for Disease Control and Prevention (CDC) and USAID.

The importance of ensuring that HIV programmes are made a priority by the state, can be traced back to the Treatment Action Campaign case (Minister of Health and Others v Treatment Action Campaign, 2002). Through this case, it was stated that a large portion of people living with HIV, at least, who are in need of the treatment do not have access to it (Heywood, 2009). This case had also highlighted that the death and disease that is a result of HIV and the burden of it, is a violation `of "*human rights*", "*equality*", "*dignity*" and a violation of "*access to healthcare services*" (Heywood, 2009). This case had established that healthcare, and in particular access to HIV medication is a human right (Heywood, 2009). This case relied on The Constitution under section 27 to argue "*that the state must take reasonable legislative and other measures within its available resources to achieve progressive realisation of the rights to access to health care*". Treatment Action Campaign further stated that the state is required and obligated to take steps to overcome the lack of access due to the cost of medicines, especially when they have the means to do so (Heywood, 2009).

It is with this background that I aim to show that when the state fails to ensure the continuation of these HIV programmes once a funder pulls out or the funding cycle ends, it is a moral violation. The state does have a moral obligation to ensure that these programmes continue, or it can be argued to be a moral failure based on the human rights of these patients that rely on these programmes for health services access. The government has a responsibility to ensure that these programmes are running and continue to run, as it is a way of ensuring and progressively realising the right to healthcare services for those that are in need. Even without the funding from donors, the state still had the obligation to ensure that there are various mechanisms in place to ensure that people living with HIV (PLHIV) stay in care and failure to do so is morally unjustifiable.

In the Treatment Action Campaign case, the courts stated that the state has "*a duty to plan effective comprehensive national programme to prevent or reduce the mother-to-child transmission of HIV, including the provision of voluntary counselling and testing and where appropriate, Nevirapine or other appropriate medicine… which programme must provide for its progressive implementation to the whole of the Republic, and to implement it in a reasonable manner*" (Minister of Health and Others v Treatment Action Campaign, 2009). The above ruling from the court shows that the state does have an obligation to provide such programmes – funding and funders are an addition to these programmes. These programmes are still to be provided by the state even if funding is withdrawn or decreased. The state still has the primary obligation to ensure the continuation of these services and programmes as it is moral and constitutional to do so.

b. OVERVIEW OF THE LITERATURE

Background on PEPFAR Investments

PEPFAR has made significant contributions towards the alleviation of a single disease worldwide (PEPFAR, 2022). PEPFAR has made sizeable contributions towards alleviating the burden of HIV/AIDS with focus on sub-Saharan African countries, which carries a huge HIV/AIDS burden (PEPFAR, 2022). The PEPFAR program has conducted an increased scale up of life-saving antiretroviral therapy (ART) over the past 10 years and has expanded treatment to nearly 11.5 million people living with HIV in the region (PEPFAR, 2022). This is a huge increase when compared to the 50 000 people when PEPFAR was first established in 2003 (PEPFAR, 2022). This investment into the country resulted in a 39% decline in HIV/AIDS death rates during the time of investment (PEPFAR, 2022).

When the funding cycle entered a new phase in 2008 (which was called PEPFAR 2.0), the response to the HIV/AIDS program shifted (PEPFAR, 2022). This resulted in a shift from an emergency response to one geared towards sustainability and programme ownership by the country (PEPFAR, 2022). The aim of this was to gradually pull back involvement from the funder and handover the responsibility to the local and national governments on the receiving end of the funding (PEPFAR, 2022). The funding in Southern Africa decreased rapidly due to this phase.

Literature on the effects of transitions or withdrawal of funding

A study was conducted in Uganda in 2019 in which a team looked at the impact of the PEPFAR transition at health facilities (Wilhelm, et al., 2019). The study argued that PEPFAR had played

a large part in Ugandas' response to the HIV/AIDS pandemic in the country. For the transition, PEPFAR had planned to withdraw from 29% of facilities they had previously supported between 2015-2017 (Wilhelm et al, 2019). A survey was conducted and showed the results on "availability, perceived quality and access to HIV services" prior and after the transition in comparison to facilities that were still being maintained by PEPFAR (Wilhelm et al, 2019). The results of the study show that the facilities that were in transition were more likely to end HIV outreach programmes following the transition period, which resulted in a decline in HIV care access and quality (Wilhelm et al, 2019). The abovementioned study shows that when funding cycles end and there is a transition period, there is a cause for concern in the implementation of HIV/AIDS services.

Another study was conducted in Nigeria looking at the impact of funding changes has on HIV service delivery large HIV Care and Treatment programs, similar results were seen (Banigbe et al, 2019). During the period of transition with PEPFAR 2.0 which had focused on the country taking ownership and included funding cuts, the service delivery of key interventions was disrupted (Banigbe, et al., 2019). Following the policy changes, service delivery was affected and services such as laboratory services were affected, which also resulted in wages and staff positions being reduced (Banigbe, et al, 2019). This further compromised the quality of care and also posed challenges in the provision of routine HIV services (Banigbe, et al, 2019). This study concluded that there is a need for sustainable HIV service funding models (Banigbe, et al, 2019).

This study further highlighted that the responsibility falls on the host government/local stakeholders during a transition period and this is a common theme in development interventions (Banigbe, et al, 2019). Ensuring that host governments/local stakeholders are able

to do this is considered a very important element of sustainability strategies (Banigbe, et al, 2019). In order to reduce donor dependency, the recipients of the donor funding need to be able to come up with alternative funding sources and models to ensure sustainability of these interventions. Otherwise people will die.

In the study that was conducted in Nigeria, the author provides an example of an alternative funding method that was implemented in Zimbabwe (Banigbe, et al, 2019). This model was a levy program which taxed formal sector income (Banigbe, et al, 2019).

In South Africa, due to the decline in the funding threshold, South Africa has struggled to supplement the funding with domestic funding which has also resulted in increased waiting times, overcrowding in clinics and a decrease in the quality of care (Banigbe, et al, 2019). When compared to Nigeria, the authors of the article argued that South Africa's economy is larger than Nigeria and South Africa have a higher capacity to mobilize domestic funding in order to continue the response to HIV (Banigbe, et al, 2019).

c. RESEARCH QUESTION

The research question for my project is: "Does the state have an ethical obligation to ensure that HIV/AIDS interventions and programmes are sustained beyond the funded cycle?".

d. RATIONALE OF THE STUDY

There have been many discussions and articles that have been produced regarding the sustainability of donor funded interventions. These discussions are often based on whether donor funding creates a dependency on the host that is receiving said funding. It also looks at the relationship between the donor and recipient and seeks to find ways of ensuring the

sustainability – looking at the HOW and WHY of ensuring that there is sustainability in these interventions.

There is a further issue in conversations regarding sustainability around who does the ethical obligation fall on to ensure that this sustainability of interventions occurs. This is the area that my study will address, and which aims to contribute to the existing literature in this particular area of study.

This study could assist in developing the literature further as well assist in policy making that is geared towards ensuring sustainability of interventions that are donor funded.

e. THESIS

My thesis argues that the state does have an ethical obligation to ensure that the HIV/AIDS programmes and interventions that are donor funded are sustained and continued beyond the funding cycle, as they have an obligation to protect the right to access healthcare services which sustain life, even when funding is no longer available.

f. RESEARCH AIMS

My aim is to defend my thesis by arguing the state does have an ethical obligation to ensure that HIV/AIDS programmes and interventions that are donor funded are sustained and continued beyond the funding cycle.

g. RESEARCH OBJECTIVES

- Chapter 2 of this research paper will show the literature that is available regarding HIV/AIDS programmes in South

- Chapter 3 will give an account of the ethical theories that can be used to defend my thesis
- Chapter 4 and Chapter 5 will thresh out the ethical arguments for and against (respectively) the thesis statement I have made
- The final chapter will draw a conclusion on the arguments in the previous chapter.

2. RESEARCH DESIGN

I will be conducting a type 1 project which is a defence of a thesis study. I will be doing a normative bioethical study. Normative ethics have been described as the following: "*the branch of philosophical or theological inquiry that sets out to give answers to the following questions: what ought to be done? What ought not to be done? What kinds of persons ought we strive to become? Normative ethics sets out to answer these questions in systematic, critical fashion, and to justify the answers that are offered"* (Sugarman and Sulmasy, 2010, 3-4). In medical ethics, normative ethics look at topics that are concerned with the morality of physician-assisted suicide or the morality of whether it is proper to clone human beings as examples (Sugarman and Sulmasy, 2010, 3-4). This type of study looks at how a person ought to behave when presented with an ethical situation and whether such a situation does require an ethical approach to it (Sugarman and Sulmasy, 2010). It looks at how people actually behave in these types of situations and how exactly they are supposed to behave (Sugarman and Sulmasy, 2010).

3. RESEARCH METHODS

The research method that I will be using a Type 1 project. This kind of project is based on a desktop and library-based research. This type of project does not engage human participants

and therefore I will not be needing ethics clearance. I will be discussing findings from literature which I will then ethically discuss.

4. RESEARCH OUTCOMES

The outcomes I have envisioned for this project is that it will published in a journal (African Journal of Bioethics). I also aim to be able to present it to my work colleagues through our accredited journal article. The outcome I envision is that I will be able to pass my research project.

5. LIMITATIONS

There are currently no limitations anticipated for my project.

6. OVERVIEW OF SECTIONS/CHAPTERS

These are the chapters that I will be incorporating in my research project:

CHAPTER 1: Introduction

CHAPTER 2: Overview of the Literature

CHAPTER 3: Applicable Ethical Theories and Law

CHAPTER 4: Arguments For

CHAPTER 5: Arguments Against

CHAPTER 6: Closing arguments and conclusion.

Chapter Two: In-depth Overview of the Literature

In this chapter I will look in depth at the literature around HIV/AIDS programmes and interventions throughout the years. I will also focus on outlining the history of the PEPFAR programme and the implementation of the programme through various country with a focus on South Africa. I will also particularly focus on the history of such interventions in South Africa and the development of the HIV programme in South Africa. The literature overview will also provide an insight as to the effects of funding cuts and withdrawal and how this affects the sustainability of such programs.

i. History of HIV Programmes and Interventions in South Africa

South Africa has made great efforts towards tacking the disease burden of HIV and Aids through various interventions and programmes throughout the years since HIV was first diagnosed in the country. To understand the current climate of HIV interventions in South Africa, I will outline the history of the various interventions targeted at alleviating the disease burden through various mechanisms with the aim of highlighting that the South African government has a history of taking accountability of the HIV epidemic and it's interventions in South Africa.

The first act towards combatting the HIV crisis in South Africa was a joint effort by civil society and the South African government through the new ruling party at the time (African National Congress) (Simelela Venter, Pillay and Barron, 2015). The National Advisory Group (NACOSA) was created in order to lobby and eventually create a draft for a national AIDS Plan (Simela, Venter, Pillay and Barron, 2015). The purpose of this national AIDS plan was to

focus on preventative measures to combat the increase in the infections however this was not enough to curb the rising infections rate (Simelela, Venter, Pillay and Barron, 2015). The prevention interventions went through various conceptualisation and implementation phases. Through communication interventions which included an approach for "home-based care" for the large number of people who had advanced AIDS and interventions for affected children (Coates, Richter, & Caceres, 2008). These strategies were not effective as there was still discrimination caused by stigma, fear and other behavioural and social factors that contributed (Coates, Richter, & Caceres, 2008).

With the establishment of NACOSA, the South African government took ownership of ensuring that the rate of infection in South Africa decreases. They (alongside civil society) were to ensure that the interventions proposed would be accessible to all who needed the HIV services. Here we can see that there was some understanding that the role of ensuring that HIV programmes are implemented and sustained, laid with the government.

Following the establishment of NACOSA, there was an additional push for HIV treatment for HIV positive women pregnant women. This led to a second phase of the response to the prevention of HIV infections ARV research and whether it was effective in pregnant women and their newborn babies – this program was called the Prevention of Mother to Child Transmission (PMTCT) (Simelela Venter, Pillay and Barron, 2015). The government realised that this would be a phased approach in piloting this intervention as there was enough scientific evidence that showed that this intervention does work (Simelela and Venter, 2014). However, there was operational challenges in realising this which delayed its implementation. Civil society intervened and took the case to the High Court and argued that the refusal to provide PMTCT violated the Constitution and the High Court agreed and argued that a countrywide

PMTCT programme was an “ineluctable obligation of the state”, (Simelela Venter, Pillay and Barron, 2015). This meant that the courts ruled that the government would have to find a way to institute this programme as they had the obligation to do so and an obligation that they could get around regardless of the operational challenges.

This led to an appeal which resulted in a report by the national department of health which argued that there was not any good reason for delaying the execution and expansion of the PMTCT services in all of the provinces in phases . This resulted in 70% of public health facilities in Gauteng offering PMTCT services in the facilities. During this period, the South African government was criticised by the international and national communities for lack of an HIV strategy (Simela & Venter, 2014). This pushed the government to implement a new strategy called the HIV&AIDS and STI Strategic Plan for South Africa (Simelela & Venter, 2014). This resulted in the government through the Department of Health to establish a rollout plan for PMTCT and included a protocol for a comprehensive package of care for survivors of sexual assault (Simela & Venter, 2014.

The case for PMTCT by civil society, was successful in that it showed that the South African government has responsibility of ensuring that the right to healthcare is accessible to all those who need it. The case was able to highlight that when the state intervenes in ensuring that those affected, have the necessary access to the care that they need – that despite perceived ‘operational challenges’, the state has a legal and moral obligation to ensure that these programmes are running.

By 2006, parliament approved a new *National Strategic Plan (NSP) for HIV and AIDS and STIs, 2007-2011*, which was put together by the South African National AIDS Council

(SANAC) (Gow, 2009). This resulted in the government being committed to providing ART to 80% of those who were meeting the criteria and were eligible to received HIV treatment. Over the next years, this programme continued to expand and grow into providing various services with the support of different development agencies and funders such as Global Fund and PEPFAR. PEPFAR is currently the largest funder for a single disease in South Africa. The next section will focus on PEPFAR and the interventions through funding that it has contributed to the HIV/AIDS landscape in South Africa.

ii. United States President's Emergency Plan for AIDS Relief (PEPFAR)

The United States President's Emergency Plan for AIDS Relief (will be referred to as PEPFAR going forward), has been identified as one of the largest commitments to aid by a single country aimed at targeting a single cause (PEPFAR Website). Since the implementation of PEPFAR, the United States government has invested $100 billion in the global fight against HIV and AIDS (PEPFAR Website). This has resulted in over 25 million people worldwide being saved and preventing millions of lives and have supported countries in their goals towards achieving epidemic control (PEPFAR Website).

Which each year of implementation, PEPFAR has issued a list of priorities they are focused namely:

1) Progress: When PEPFAR was first launched, HIV was seen as a death sentence and since then, people have been given hope through the interventions that are funded by PEPFAR;
2) Policies: To make that every dollar spent is largely focused on impact using data driven policies and required the implementing countries they partner with to do the same;

3) Populations: To ensure that populations that are most affected by HIV/AIDS will have access to the interventions that they need without restrictions;
4) Partnerships: this focuses on PEPFARs ability to use the power of partnerships across multiple sectors to increase the impact of PEPAR and also promote the sustainability.

(PEPFAR, https://www.state.gov/our-priorities-pepfar/).

The impact of PEPFAR has been significant. The results of their funding and programmes have resulted in epidemic control amongst many countries that were burdened with the disease. They have managed to supply life-saving treatment to those who need it. They have also been able to empower and equip young women and adolescent girls to stay HIV free through various interventions and programmes. They have also aided in decreasing the number of children being born with HIV and other providing support and services to orphaned and vulnerable children as a result of the disease (PEPFAR, https://www.state.gov/our-priorities-pepfar/). PEPFAR also has services that are targeted at preventing HIV infection in men and boys (PEPFAR, https://www.state.gov/our-priorities-pepfar/).

The impact of PEPFAR and its programmes as well as the effects the approach PEPFAR has towards global health issues has been analysed since its inception and implementation. The analysis has been mainly focused on PEPFAR as a neoliberal policy as a response to the global health issue. It has been argued that this neoliberal approach to health polices can contribute and further perpetuate the imbalance in power relations that continue to marginalise certain groups in society (Sastry & Dutta, 2013). Neoliberal ideology has influenced the manner in which health interventions are implemented in the context of global health.

A neoliberal approach assumes that health is a private responsibility that it up to the individual to manage, further that health issues are caused by allocative and technological inefficiencies and that they can be improved through examples such as "*reducing corruption and waste and supporting cost-effective interventions and increasing the operation of market forces in health-service delivery and financing*", (Sastry and Dutta, 2013). When it comes to the neoliberal approach to HIV and AIDS policies and interventions, it has been argued that these policies contribute to creating the sociological and economic conditions that perpetuate the disease further in the developing world by having a negative impact on local infrastructures and economies (Sastry and Dutta, 2013). This means that rather than contribute towards the control of this disease, the interventions end up impacting the local economies and infrastructure. In the case of PEPAR, they treat the interventions as a way of creating an environment in which the clients (those affected by HIV/AIDS) will in turn reap the benefits of the globalization of these interventions through economic policies and financial management that accompanies the PEPFAR policies (Sastry and Dutta, 2013).

The above neoliberal approach mentioned above shows that from the inception of these neoliberal polices, there is not sufficient talk on the sustainability of these interventions but rather focuses on the actions of an individual in managing this disease and the effects this can have on the local and global economy. Talks of sustainability and the ethics of this, can only happen when we look at global health as something that not only an individual has to manage or only those with resources are able to deal with. In order to work towards creating sustainable interventions from all parties involved, global health needs to be seen as a fundamental human right. By doing this, one is able to create policies that will ensure that both funders and implementing countries are able to sustain these interventions even when funding is decreased or lowered.

Looking at global health interventions through the lens of human rights ensures that policies are created by taking into account structural violence and poverty that plagues many countries in the developing world (Sastry and Dutta, 2013). When looking at the historical context of HIV/AIDS policies, they have been plagued with controversies due to the lack of taking into account the various social issues within a country the interventions are being implemented in (Barney, Buckingham, Judith , & Johnson, 2010). The need to include social justice component to these interventions is one that will speak towards determining whether the intervention is ethical or not.

Transitions from funders to the government or community that are disruptive or too fast, may negatively impact the program, data quality, access to services and will risk the long-term of sustainability of health programs (Gibbs, Campbell, & Maimane, 2015). A phased approach is often the best at ensuring that sustainable programmes are able to be continued once transition phases started.

It can be argued that community mobilization is the greatest push towards ensuring sustainability of programmes in HIV and AIDS. The rationale for this is that community engagement is a core of HIV/AIDS policy and interventions and is critical for sustainability due to the following reasons:

1) To take HIV/AIDS management approaches that come from external parties into locally made and appropriate interventions (Oberth and Whiteside, 2016);
2) Community engagement is important for establishing local capacity to sustain externally funded programmes once funding is withdrawn (Oberth and Whiteside, 2016);
3) Sociopsychology of health related behaviour change (Oberth and Whiteside, 2016).

Sustainability of Health Programmes

The literature on sustainability is often focused on what can drive the sustainability of these programs and not who bears the responsibility of ensuring there is sustainability. There has not been much literature on sustainability and ethics being applied in the same context. The below will outline what has been written about sustainability and in particular sustainability in a donor funded environment when the lifecycle of the funding ends. They key words that have been used in defining sustainability are as follows: '*maintenance', 'durability', 'adoption', 'embedding', 'incorporation', 'appropriation', 'continuance', 'integration', 'institutionalisation', 'routinisation', 'long term' and 'adherence',*' (Walugembe, Sibbald, Janzen Le Ber, & Kothari, 2019). The above shows that sustainability is seen as something that requires not only the success of the intervention or program but also the longevity of the program.

According to the United States Agency for International Development (USAID), sustainability is defined as "*the capacity to maintain program services at a level that will provide ongoing prevention and treatment for a health problem after termination of major financial, managerial, and technical assistance from an external donor*", (Ilesanmi and Afolabim, 2022). Scheirer and Dearing also define sustainability as "*the continued use of program components and activities for the continued achievement of desirable program and population outcomes*", (Ilesanmi and Afolabim, 2022). Schell et al define sustainability as the "*the ability to maintain programming and its benefits over time*", (Schell, et al., 2012). The above definitions give importance to the longevity of the interventions or programs in order for them to be sustainable. The above definitions focus on the how and not necessarily on "who". Who is the person accountable to ensure that the programs and interventions continue?

United States Executive Orders on Foreign Aid

The question raised in the previous section is regarding who would be the responsible party for ensuring the sustainability of HIV programmes should funding be withdrawn or comes to the end of the funding cycle. The model implemented by PEPFAR (through USAID and CDC), has always incorporated sustainability mechanisms in the funding model. The programmes are designed to include a transition period in which the activities under the programme would be handed over to the respective government entity. However, we have seen that this was not the case when Executive Orders were issued by the White House in the beginning of 2025.

At the beginning of the year there have been major developments regarding the PEPFAR funding – impacting the South African HIV/AIDS funding landscape. The Donald Trump administration in the United States issued an Executive Order that targeted foreign aid (The White House, 2025). The order premised that the United States foreign aid industry and bureaucracy are not aligned with American interests and in many instances are the opposite to American values (The White House, 2025). The order further stated that the policy of the United States would be that no foreign assistance shall be disbursed in a manner that is not fully aligned with the foreign policy of the President of the United States (The White House, 2025). These orders results in a 90 day pause on all US funding across the globe pending re-evaluation of the programmes that were running.

In the context of South Africa, this meant that a vast amount of NIH funded research studies would be affected as well as a large number of USAID and CDC funded HIV/TB and related areas were affected by the sudden Executive Orders. A study was conducted that showed the

potential effects that the withdrawal of PEPFAR funding could have on South Africa in the epidemiological context (Meyer-Rath, Jamieson, Mudimu, Imai-Eaton, & Johnson, 2025).

The study found that over the 2025-2028 period, discontinuing the activities funded by PEPFAR in South Africa without a strong plan by the South African government would result in 150 000 – 296 000 new infections (29% - 56% increase) and 56 000 – 65 000 additional AIDS-related deaths (33-38%) (Meyer-Rath, Jamieson, Mudimu, Imai-Eaton, & Johnson, 2025). With a permanent discontinuation of the current PEPFAR programmes over the next 20 years would result to an additional 1.1-1.12 million additional new HIV infections and 519 000 – 712 000 additional AIDS-related deaths (Meyer-Rath, Jamieson, Mudimu, Imai-Eaton, & Johnson, 2025). The study further outlined the additional costs that the South African government would need to have in order to sustain the activities that were running which would be an additional $620 million - $1.4 billion between 2025 and 2028 (Meyer-Rath, Jamieson, Mudimu, Imai-Eaton, & Johnson, 2025).

Another study further looked at the effects this policy change would have on the Sub-Saharan African region would have as this region accounts for about half of HIV infected population (Hontelez, et al., 2025). This study found that the initial 90 day freeze would result in 60 0000 excess deaths and would increase to 74 000 following the effect of the Executive Orders (Hontelez, et al, 2025). This was deemed higher than what would have been the results had the funding not been interrupted. This shows that withdrawing funding without warning poses a great to public health security and in particular the lives of those that were relying on the interventions that were PEPFAR funded.

The acts of the United States administration speaks to the issue at hand regarding the reliance on foreign funding to supplement the local HIV/AIDS programmes in South Africa. The issue of sustainability arises as this was something that was not foreseen happening this quickly but has largely affected how the HIV/AIDS programme runs in South Africa. ``

The next part of this paper will closely look at the applicable theories that will support the case that the government is ethically responsible for the sustainability of interventions and programs once the funding cycle has ended.

Chapter 3: Applicable Ethical Theories

This next chapter will focus on the ethical theories that I will use to support my claims that the state or the government is ethically responsible in ensuring the sustainability of HIV/AIDS programmes in South Africa. The first theory I will use as my argument is based on the principles found in care ethics and ultimately the application in the donor-funded health interventions, and how the state has a moral obligation to ensure the sustainability of these programmes after the funded has ended or decreased. I will then follow on with justice ethics theory to further examine my argument.

Care Ethics

The first theory that I will be focusing on is Care Ethics. Care Ethics looks at interpersonal relationships, empathy and responsiveness to the needs of others (Adhikari, Saha, & Sen, 2023). Noddings argued that relationships exist alongside basic humanity, where the identity of a human is defined by the set relationship that humans have with other humans (Adhikari, Saha, & Sen, 2023). Noddings argues that caring is a universal human trait and that caring for other humans is ethically basic to humans (Adhikari, Saha, & Sen, 2023). Ethics of care looks at the world as it is today whilst aiming for the transformation of the world (Greenswag, 2017). It can be used by different theoretical schools that have different goals but still remains as an important standard and basis for moral judgement whilst emphasising the importance of caring practices in our daily lives (Greenswag, 2017).

Care Ethics focuses on how institutional norms, and relations of power shape our relationships by either creating good forms of care instead of creating harmful ones (Greenswag, 2017).

Robinson states that "*care relies on existing and potential relations among moral agents and the capacity of those agents to learn how to listen and respond to the needs of others*" (Robinson, 1999, 40). Care Ethics allows us to understand centres of power (international, national, economic and socio-cultural) influence and impact the caring relationships we have with those around us (Collins, 2015). Care theorists argue that care theory should guide all of us in moral decision-making, regardless of our gender and the conflicts we face (Collins, 2015).

Care ethicists support an affiliated view of autonomy, in which independent plans, projects and purposes cannot be separated from and are hugely influenced by people that we surround ourselves with (Collins, 2015). In the context of donor funded programmes, this would mean that it would look at the relationship between the donor, the state and the recipient of the programmes. When considering care ethics in the space of donor funded programs and interventions, it becomes necessary to integrate and shape ethical considerations around the provision of healthcare and the consequences of decreasing or withdrawing financial support.

Care Ethics can help us understand how governments can be organized to contribute and support people better through their policies and services – especially in the healthcare space (Kwan, 2023). There is a duty of the government to provide these services in a manner that aligns with care ethics. Therefore, the scope of care ethics is broad enough to cover the relationship between the state, its custodians and the services it should be providing for their citizens.

Human Rights and Social Justice

The next ethical theory that I will be relying on, is the human rights and social justice ethics. Human rights ethics are very critical to the evaluation of moral implications of policies in the space of public health (Barugahare, Nakwagala, Sabakaki, Ochieng, & Sewankamno, 2020).

Modern international human rights are not a singular entity that can be described in one way (Greenswag, 2017). There is a vast variety of what is considered human rights and are divided into "*moral*" and "*political*" understanding of human rights (Greenswag, 2017). Human rights are there to provide certain shared standards for evaluating and criticizing various practices of political societies in relation to the individuals within the society (Greenswag, 2017). Human rights norms are key in guiding the actions of governments and ethics in the healthcare space it is broadly focused on specific actions, inspirations and the relationships of individual health works, researchers and organisations (Gruskin & Dickens, 2006).

These two concepts come together in various such as the establishment of codes of conduct, legal statutes and acts that further guide the public healthcare space in how to act. Some examples of these are the Helsinki Code which was established in 1964 (Gruskin & Dickens, 2006). This code was established to guide research that involve human subjects and how to conduct ethical research on such subjects.

Human rights are the standards in which we determine what is important to live a human life (Nampewo, Mike, & Wolff, 2022). Secondly human rights consists of a set of claims that can be acted upon (Marks, 2016). As set of standards, human rights can be perceived to have little meaning unless they have legal and political enforcement (Marks, 2016). This means that rights

come with duties and responsibilities which is enforced by individuals and institutions (Marks, 2016). For a right to have authority, it must be able to be held against someone or something – this means that there would be someone to be the recipient of the human right (Marks, 2016).The extent to which any claim is binding, varies. In the case of international human rights, the question of who holds the duties can be argued (Pogge, 2008). Thomas Pogge provides one answer, stating that: "*While the government may, then, be the primary guardian of human rights and the prime measure of official disrespect, the people are their ultimate guardian on whom their realization crucially depends* (2008)".

Respecting human rights is not sustained just by the country's constitution, its legal and political system, and the attitudes of its politicians, judges, and police, it is also sustained more deeply by the attitudes of the people in the country (Pogge, 2008). They are further shaped by the education system and the economic distribution (Pogge, 2008). Institutions have a duty to stop not harm people but the citizens on the receiving end also have a duty to change how these institutions function within the international context. (Pogge, 2008).

An example of this is the 1948 Universal Declaration of Human Rights which has been incorporated into many legal systems in various countries – South Africa is one of them. These legal norms have helped shape and define how the government ought to act towards its citizens across various sectors.

Rawls theory of justice is a theory that looks at the principles and values that are necessary to create a fair and equitable society (Dutta, 2017). It covers issues such as inequality, discrimination and the distribution of resources whilst placing emphasis on the need for systems and policies that uphold dignity and the rights of individuals (Dutta, 2017). The theory

of social justice is premised on theory of justice as established by John Rawls. Rawls stated that the are two principles of justice. First being that each person has the same unyielding claim to a fully adequate group of equal basic liberties which scheme is compatible with the same scheme liberties for all (Dutta, 2017). This means that each person has access to the same freedoms that other people have access to as well. The second principle is that these social and economic inequalities are open to all (fair equality of opportunity) and also and can bring the greatest benefit to the least advantaged members of society (Dutta, 2017).

The principles that form part of social justice ethics are equality, equity, liberty and solidarity (Heredia, 2011). Equality is treating individuals in a uniform manner (Heredia, 2011). It argues that all people deserve equal respect, rights and opportunities and opposes any form of discrimination based on race, gender, religion and socio-economic status. It requires that social systems and institutions that exists provide fair treatment and equal access to resources and opportunities (Heredia, 2011). Another principle is equity which emphasises the need for fairness and justice in the distribution of resources and opportunities (Heredia, 2011). It acknowledges that individuals have different needs and circumstances and seeks to provide what is necessary for everyone to achieve similar outcomes (Heredia, 2011).

The principle of liberty states that every individual should have the freedom to pursue their own goals and interest provided that they do not infringe on the rights of others (Heredia, 2011). Social justice ethics supports the protection of individual liberties, including freedom of speech, assembly and the right to privacy and ensuring that these rights are balanced with social responsibilities. The final principle is solidarity which is mutual support and cooperation among members of society. It emphasises the interconnectedness of individuals and the collective responsibility to work towards the common good. Solidarity involves standing with

and supporting marginalized and oppressed groups in their struggles for justice and equality (Heredia, 2011).

Human rights and social justice can also be linked to political obligation as an ethical theory. The themes found under social justice and human rights can also be found under political obligation. Political obligation looks at the fact that individuals might have the moral duty to obey the laws of the country they are in (Dagger, 2007). Political obligation theory looks at themes like consent theory which argues that individuals have a duty based on explicitly or implicit consent to a country's laws. Political obligation looks at varies ethical theories such as consent, social contract, fairness in sharing societal benefits or natural duty to uphold justice

The two abovementioned ethical theories form a foundation for public health and the implementation and provision of healthcare services by both the government and funders alike. These theories can be used to evaluate who bears the onus of ensuring that there is sustainability in HIV/AIDS programmes that are donor funded once the funding cycle concludes. These are theories that have been applied and used across various legislations and policies that are used in public health. Social justice demands that healthcare systems provide equitable access to medical services for individuals, regardless of their socio-economic status (Daniels, 2008). This serves as a way to address disparities in health outcomes and assists in ensuring that vulnerable populations receive adequate care and promotes policies that enhance public health (Daniels, 2008).

Chapter 4: Arguments For

This chapter will use the theories that have been explained in the previous chapter to examine whether and how the government has an ethical duty to ensure the sustainability of funded projects. I will firstly look at care ethics, followed by human rights ethics.

Care Ethics Argument:

Care ethics can be considered as a tool of assessment and a method of discovery to uncover what underlying forces have contributed to the production and perpetuation of injustices such as poverty, systematic violence and racial and gender discrimination (Greenswag 2019). Care ethics in its nature seeks to look at the world as it is with the intention of transforming it (Greenswag 2019). Care is meant to serve as a critical, universal standard for moral judgements and it also provides a much more flexible standard of judgement than human rights standards. The normative question does not only look at how I can fulfil my caring responsibilities but also looks at which aspects of our political and social lives impact the kinds of responsibilities and relationships I would have (Greenswag 2019).

When applying the theory of care ethics to donor funded health programmes, it is important to establish and nurture relationships between the donor and the recipient nations in order to ensure effective collaboration (Mpofu & Govender, 2022). This would also be crucial in ensuring the continuation of these health programmes in the event that there is decline in the funding. Another element that is key to care ethics, is empathy and understanding. These programmes that are established need to reflect the genuine concern for the well-being of the populations they serve or aim to serve (Mpofu & Govender, 2022). This would require that the

health interventions should be tailored to the needs of the communities that these programmes are running in.

When talking about care ethics in the context of donor funded health interventions, there needs to be a sense of responsiveness to the needs of the individuals and communities that are receiving these services (Brock & Wickler, 2006). This would require that the interventions are adapted taking into account the cultural, social and economic realities of the recipient nations, which helps to promote locally sensitive and sustainable healthcare solutions.

Decreased funding can strain the relationships between donors and recipients, which could potentially compromise the collaborative and empathetic aspects of care and ethics. Strained relationships may hinder effective communication and coordination, impacting the implementation and success of health interventions. Care ethics emphasises patient-centered care, tailoring healthcare services to individual needs. Funding reductions may lead to shift away from patient-centred approaches, with a focus on cost-cutting measures and standardised interventions that may not adequately address the diverse needs of communities (Hower, et al., 2019).

With the Executive Orders that were issued to halt funding for 90 days, the harm that was done to patients that were receiving life-saving care from this funding, was detrimental. The decision to stop the funding without warning meant that patients across the globe and in South Africa were not receiving treatment that they had been receiving prior. This moves away from the patient centered care approach that is advocated for under the umbrella of care ethics.

Reduced funding may limit the ability of donor-funded programmes to be responsive to the evolving needs of communities. This challenge may compromise the development of flexible and context-specific healthcare solutions, which could potentially compromise the effectiveness and sustainability of interventions (Hower, et al., 2019). The kind of relationships that arise from care ethics allows for greater flexibility when applied to situations as they arise (Hower et al 2019). In this instance, when the threat of funding decreasing, there is flexibility under care ethics that would argue for the continued sustenance of these interventions and programs regardless of what would be required under resource constraint policies for instance.

When looking at care ethics, there is an emphasis on maintaining strong relationships between the donors, the state and the recipients, regardless of the decrease in funding. This would be done through open communication, shared decision-making, and a commitment to collaboration, even in challenging financial circumstances. Care ethics also guides ethical resource allocation by prioritizing the well-being of individuals and communities. Donor-funded health programmes, facing financial declines, should aim to allocate resources in a way that maximizes positive health outcomes while minimizing harm, aligning with the principles of care ethics.

The relationship between South African government and the funder in this instance (PEPFAR), was compromised as there was a lack of effective communication and shared decision-making. As mentioned above, care ethics requires that resource allocation by prioritizing the well-being of individuals and communities, which was not the case with the executive orders. There is an ethical breakdown here as a result of the funders decisions and the South African government would be obliged to ensure that these cuts do not compromise the care relationship between the stage and its custodians.

The application of care ethics in South Africa can be seen through the policies and strategies around HIV/AIDS management mechanisms and principles. South Africa has a National Strategic Plan (NSP) which is focused on HIV, TB and STIs for the years 2023-2028. The NSP highlights the strategic objectives that am to reduce barriers to accessing health and social services (NSP). The guiding principles of the NSP are the following:

- *The objectives and interventions in this NSP have been designed to place people and communities at the centre, providing people-centred health and social services.*
- *Universal health coverage (UHC) and comprehensive responses that integrate prevention, treatment, care and support ensure that no one is left behind.*
- *A response that is inclusive and participatory*
- *A substantial proportion of measurable community led, and community-based interventions driven by empowered communities, including key and other priority populations,*
- *A multi-sectoral approach in addressing inequalities that drive epidemics;*
- *A commitment to protecting and promoting human rights and gender equality.*
- *Evidence-based innovation in the processes and tools*
- *To reduce HIV, TB and STIs*

(DOH NSP 2023-2028).

Any donor funded interventions and programmes are aligned with the NSP and also have the same objectives outlined in the NSP. They have the same goals in ensuring that South Africa has the HIV pandemic under control.

The guidelines above specifically mention that the goals and objectives have been designed to place people and communities at the centre, providing people-centred health and social

services. This guideline particularly emphasises that there is a relationship between the government and the communities in which they aim to service. It recognises that there is an important relationship at stake and in order to meet the goals and objectives, this relationship needs to be maintained and upheld. The failure to maintain this relationship would be considered to be unethical. In the instance where a donor-funder has taken on the role of implementing a programme or intervention in the community and has to withdraw from this particular community, the responsibility of state would be to ensure that this intervention does not stop. If these interventions and programs are not sustained, the state would be unethical.

In the face of reduced funding, care ethics calls for innovative approaches to ensure patient-centred care. This may involve leveraging technology, community engagement, and participatory methods to continue delivering healthcare services that prioritize individual needs. This is also mentioned in the guiding principles which emphases that the interventions and programs implemented should be community led and community-based interventions and that they should also be innovative (NSP 2020). In ensuring the sustainability of programmes and interventions that are donor funded, the state needs to ensure that the community continues to be engaged and that there are innovative ways of ensuring this. By ensuring this, the state would also be maintaining their duty under care ethics and therefore would be considered to be morally correct by ensuring sustainability of these programs and interventions.

Care Ethics places a strong emphasis on relationships. It recognises that interconnectedness of individuals and communities (Sander-Staudt, n.d.). When applying this theory to donor funded health programmes, it is important to establish and nurture relationships between the donor and the recipient nations in order to ensure effective collaboration (Mpofu & Govender, 2022). This would also be crucial in ensuring the continuation of these health programmes in the event that

there is decline in the funding. Another element that is key to care ethics, is empathy and understanding. These programmes that are established need to reflect the genuine concern for the well-being of the populations they serve or aim to serve (Mpofu & Govender, 2022). This would require that the health interventions should be tailored to the needs of the communities that these programmes are running in.

When compared to human rights ethics in comparison to care ethics, human rights ethics are not geared towards looking at the relations of power that are running in the background of the current political order (Greenswag 2019). Human rights ethics do not look at the power relations that are running in the background when HIV programs and intervention policies are being discussed. Human rights ethics are premised on a set of agreed standards that are meant to protect certain aspects of human life and their relations towards each other and the stage, they however fail to see the array of problems that arise when it comes to the enforcement of these rights. This is a particular problem that care ethics can address

The relationship that exists is between the state and its citizens. This is the relationship that needs to be prioritised and taken care of. When the funding cycle ends or is withdrawn, the states' ability to execute its role by providing access to life saving services, it stands to breach this duty of care. The funding mechanism is merely a tool that was provided in order to assist the state with its mandate, it was not meant to be the custodian of providing these services and interventions to the citizens.

PEPFAR in South Africa funds various interventions such as providing care and treatment for those that newly diagnosed with HIV and further provides funding for programmes and

interventions that assist in keeping those that are diagnosed with the virus on treatment. These adherence programmes and interventions cover a broad scope of patients such as children, mothers and key populations. The state through this funding mechanism, creates a relationship with the patients (who are considered clients) and they have a moral duty to care and nurture this relationship. Should the state fail, it compromises the right to life of these patients. They have a duty to ensure that these services continue to run, even when the funding is withdrawn or decreased.

Human Rights and Social Justice Ethics: Arguments For

The very idea of health as a human right is rooted in the ethical principles of dignity, equality and respect for individual autonomy. This respect for ethical principles of dignity, equality and respect for individual autonomy is rooted in the protection of fundamental rights and freedoms for all individuals (McCrudden, 2008). At the very centre of human rights ethics is the inherent dignity of every individual (McCrudden, 2008). In the context of this paper, the right to health which stems from the understanding that all individuals deserve a life of well-being and the freedom to make personal decisions related to their health is paramount. Denying or limiting individuals access to healthcare does not only endanger their physical health, but it also compromises their dignity by limiting their ability to live a fulfilling life.

When the US government Executive Orders were executed, the rights of millions of South Africans were compromised. Their inherent dignity was compromised as their access to healthcare services was abruptly ended. The implementing partners as well as the South African government was blindsided and their ability to deliver these services was compromised which compromised the recipients of the interventions that were running under PEPFAR.

Human rights ethics also promotes quality by arguing that everyone should have access to basic rights, including healthcare. Healthcare access should be universal, free of discrimination based on socioeconomic, ethnic or geographical differences (Williams, Walker, & Egede, 2016). When there is unfair access to healthcare, there are disadvantages to marginalized populations by limiting their options which is ethically problematic.

Human rights ethics are grounded in the emphasis on the inherent dignity and equality of all individuals (Valentine, 2017). Donor-funded programs and health interventions should be guided by human rights principles and should ensure that there is equitable distribution of healthcare resources (Valentini, 2017). This would result in ensuring that every individual has the right to the highest attainable standard of healthcare (in this context, once that would be upheld by the donor or funder and sustained by the state).

Further human rights principles require that there should be non-discrimination in healthcare access. The health interventions need to be designed in a way that they address the health differences and ensure that marginalized and vulnerable populations have equal access to essential health services, despite their socio-economic status or background (Valentini, 2017).

Human rights ethics also argue that individuals have a right to participate in the decision-making processes that are related to their health (Wicks, 2007). When implementing donor-funded programmes and interventions, there should be enough mechanisms that encourage community engagements, informed consent and the active involvement of affected populations in shaping and designing the health interventions that directly impact them (Wicks, 2007). When there are substantial decreases in funding or there is a complete halt in the funding, this

becomes a direct threat to the realization of the right to health. Using human rights ethics theory, the state would be required to progressively realise the right to adequate healthcare and the declines in funding and the lack of sustainability as a result thereof, infringes on the fulfilment of this obligation of the state. This affects the communities and individuals that were relying on this funding in managing their health issues and therefore infringes on their rights to healthcare.

In response to the funding cuts, the South African government made concessions in order to cover the gap that USG funding cuts would leave. The South African National Treasury allocated R753 million to the Department of Health to aid with the shortfall caused by the funding cuts (South African Government News Agency, 2025). These funds would administered to the different provinces through a grant mechanism structure (South African Government News Agency, 2025). The South African government further made R132 million available to the South African Medical Research Council (SAMRC) in collaboration with Bill and Melinda Gates Foundation and the Wellcome Trust (South African Government News Agency, 2025).

The above shows that the state was able to make concessions to supplement the funding gaps that was left by the funding cuts across different programmes. The state was able to progressively realise the right to healthcare for those affected by HIV by making funding available. The obligation to ensure that the programmes do not collapse was honoured and the programmes are able to continue as a result of the funding made possible by the South African government.

Human rights ethics also focuses on ensuring that there is no inequality in the public health space and the interventions and programmes that occur under it. The decrease in funding would directly affect this as it could possibly result in further inequalities existing in society by creating a bigger gap between those that can afford and have access to adequate healthcare and those that do not (Deghaye, 2014). Those in need would not be able to access these services if it were not the state or the donors implementing them. This results in those who are able to access these services in other ways being privileged over those who are unable to access the services. The ethical implications of this directly impacts the human rights of individuals and communities and further contributes to the existing inequalities in health.

Another area under human rights that is taken into account when considering what is ethical from the perspective of human rights, is that human rights are things that can aid in empowering individuals and communities . By reducing funding for certain programmes and interventions that are implemented at the community level, reduces the opportunity for meaningful community participation and engagement (Marks, 2016). This is deepened when there are no alternatives offered from the relevant governmental bodies. This compromises the ethical principles of autonomy and empowerment which are a factor in the human rights framework (Marks, 2016).

When looking at donor-funded health interventions, the principles of human rights ethics are important for assessing the ethical dimensions of programme design, implementation, and the impact of a reduction in the funding or ending of the funding (Brock & Wickler, 2006). When looking at the impact, it is important to look at the effect it would have on the human rights of those communities and individuals the health interventions was designed to assist. By upholding the human rights, the principles of social justice will also be advanced. The state

would be fulfilling its Constitutional obligations which are rooted in human rights ethics as defined above.

One of the arguments that have been made in order to understand progressive realisation by legal scholars and policy makers, is that the state needs to specifically address the disadvantaged and those that are affected by structural inequality and are vulnerable and marginalised in society (Chenwi, 2013). This argument stems from the political obligation which exists between the state and the citizens. This political obligation which is entrenched in human rights ethics gives rise to a social contract between the parties involved.

Social contract theory, as argued by thinkers like Rousseau and Hobbes, suggests that individuals agree to certain mutual obligations when living under a government's rule (Betram, 2010). In exchange for stability and protection, citizens agree to adhere to state laws and support governmental structures (Betram, 2010). This perspective implies that governments, in turn, have a reciprocal responsibility to provide essential services to their citizens which would include healthcare.

The state would then be obligated to provide adequate healthcare services for its' citizens. Under the social contract, healthcare can be seen as an essential public good, necessary for individual well-being and social stability. For society to function, individuals need to be healthy and capable of contributing to the workforce, participating in education, and engaging in civic life. When states invest in public healthcare, they uphold their end of the social contract, providing citizens with the means to live healthy, productive lives.

The state then has a moral responsibility to preserve public health. Public health is intrinsically tied to the social contract because infectious diseases, environmental health hazards, and other

health threats affect society collectively. Thus, the state has an ethical obligation to ensure not only individual access to healthcare but also broader public health initiatives, such as vaccination programs, disease prevention, and health education campaigns.
By fulfilling these responsibilities, the state protects the collective well-being and ensures the resilience of society.

HIV/AIDS is a disease that often affect the poor people in society and has an intersectional impact on those people in society. There are instances where children of parents that are living with HIV, are unable to provide for them and thus affecting their livelihoods in terms of education, nutrition and health. In order to achieve social justice, the state is obligated to ensure that access to HIV/AIDS interventions and programs is continuous and available.

Looking at the above ethical theoretical theories and law, on is able to see that there is an ethical breakdown when there are no mechanisms in place to ensure the sustainability of health programs and interventions when funding is reduced.

Chapter 5:

Counter Arguments: Care Ethics

The normative content of care ethics is rooted in the values and practices of caring. Care is meant to serve as a critical, universal standard for moral judgments, and importantly, care is a standard of judgment that is much more flexible than human rights standards. Moral judgment, for the ethics of care, is "based on the possibility of making evident, in particular contexts, what makes [relationships] healthy and nurturing, or oppressive and exploitative" (Robinson 2006, 15). The normative question is not solely aimed at how I fulfil my caring responsibilities, but what aspects of our political and social lives impact (for good or ill) the kinds of relationships and responsibilities I have. Certainly, this formulation is more ambiguous than theories of human rights, but its very ambiguity allows for a greater flexibility in applying care ethics to concrete situations as they arise. The habit of looking for rule-based answers, like those produced by international human rights discourses, is not always beneficial nor is it always necessarily going to produce the answer that will solve the problem. It is possible that such answers can obscure the deep complexity that underlies many problems, such as poverty and especially poverty that women face.

This leads to the second point, namely, that the benefit of applying care ethics to public policy is that it will illuminate moral contexts that human rights often overlook or do not even 'see' and thus cannot address, such as complex cases of difference and exclusion, both of which have profound impacts on other moral contexts such as gender and violence. The lens of care, then, can be used to expand the limits of moral and political thought (Benhabib 1992, 164). Thirdly, although there is no claim to a specific set of universalizable moral rules, care ethics rests on a universal idea: people do live within webs of relationships, and require a bare minimum of care

to at least survive. Because people already live in relationships with particular others, care ethics can have broad scope across political, economic, and cultural boundaries. Thus, a critical ethics of care is another tool, in addition to human rights discourses, by which to analyze and assess complex ethical and political situations.

Even though Care Ethics poses argument that the state has a moral obligation to ensure that HIV/AIDS interventions and programmes are sustained, there are some critics that show that care ethics may not be the applicable theory in this regard and may not be the suitable theory to argue that the state has a moral obligation to ensure the sustainability. Care Ethics has been criticised around its empirical accuracy and validity and that it is not theoretically distinct (Boylan, n.d).

The argument here is that it incorporates various other theories and concepts such as autonomy, equality and justice (Boylan, n.d). It has also been highlighted in other theories such as utilitarianism and deontology (Boylan, n.d.). It has also been argued that it might be better situated under virtue ethics and it being one of the virtues that form part of virtue ethics (Rachels, 199; Halwani, 2003). Care Theorists have argued that what makes care ethics distinct is that it places emphasis on social power, identity, relations and interdependency which is what makes this theory unique (Sander-Staudt, 2006).

Care Ethics as a theory is not distinct enough to stand alone and therefore would be need to be accompanied by another theory in order for it to be applicable. For instance, more care ethicists are making room to include justice concerns in order to evaluate morality issues (Sander Staudt, 2006). They argue that it would be beneficial to include care ethics as a right in the context of a liberal society that places value on human rights.

In this instance merely establishing that a relationship between the state and its custodians exists would not be enough to ascertain that the state has a moral obligation to ensure that the programs and interventions that have been implemented under donor funds, need to be sustained when the funding has come to an end or has been decreased. There has to be another principle attached to it in order for it to be valid.

Another critic of care ethics in this context is that it does not take into account the different dynamics that are at play in society – between individuals and well as institutions (Staudt, 2006). Care ethics also has a narrow interpretation of analysing societal moral obligations (Staudt, 2006). Another criticism of care ethics in this instance, is that it hides the larger social dynamics that are in play in society and it is also has a limited or narrow outlook or scope in terms of analysing moral obligations (Sander Staudt, 2006). The implication of this in the context of the determining the moral obligation of the state, is that care ethics does not take into account all the other social issues that exist with South Africa and the effects this has on the moral obligations. Merely recognising and protecting the relationship between the state and its citizens is not enough, there has to be more that can place the moral obligation on the state to ensure sustainability. The argument of care ethics alone is not sufficient.

Looking at the above, there is grounds in care ethics that can support the argument that the state as a moral obligation to sustain programmes and interventions when funding has been withdrawn or decreased. It needs to be accompanied by another theory for it be applicable and justifiable.

Counter-Arguments: Human Rights and social justice

Even though human rights and social justice ethics support the argument that the state has a moral obligation to ensure that the HIV/AIDS programs and interventions are sustained post funding cycle, there is room for counterargument as to why the state does not have a moral obligation to do so. This can be argued using human rights and social justice as well. This will be highlighted in the paragraphs that follow.

The Constitution subjects the socio-economic rights to a screening under the "availability of resources" and "progressive realisation" qualifications (Chenwi, Unpacking "progressive realisation", its relation to resources, minimum core and reasonableness, and some methodological considerations for assessing compliacce, 2013). The International Covenant on Economic, Social and Cultural Rights (ICESCR), 1996 and the Constitution, are some of the human rights mechanisms that recognises that socio-economic rights have to be realised over time and that the progress towards full realisation of these rights is dependent on the availability of the resources (Chenwi, 2013). This brings about the question of the degree of obligation and expectation that these rights need to be implemented in accordance with the human rights theory. The progressive realisation qualification requires a state to strive towards the fulfil and implementation of and improvement in the enjoyment of socio-economic rights to the maximum extent possible, even in the face of resource constraints (Chenwi, 2013). The performance of the state in realising these rights would thus depend on the rights that people are able to enjoy at any given point verses the capacity of the society to fulfil this (depending on state resources) (Chenwi, 2013).

A lack of resources is the biggest hinderance in a states' ability to provide adequate access to healthcare services. Development aid from various funders has often been an investment that is considered a necessity in South Africa across various sectors and not just healthcare. The support received from these funders, is part of the reason why these services have been able to be made available to people that need them. This can be argued to be part of the progressive realisation of the rights as required by human rights and social justice ethics. When funding is withdrawn or has come to an end, the state is not obligated to sustain the services to the same degree that it was conducted under whilst there was funding available. Further I would also argue that the state should also take into consideration other areas that are of concern in the country and that are in need of resources. These areas of concern are also areas that are protected by human rights ethics as they contain norms and standards that are protected by human rights.

With regards to the above, there are two particular problems that arise when it comes to the question of sustainability of health programs which results in a limitation when using the human rights theory. The first issue is premised on the fact that human rights look at what is deemed as normal and problems that can be seen in order to solve the problems (Greenswag, 2019). It does not take into account that some of the things that are considered the above (HIV health programs), do not fall into the scope of what would be considered politically relevant, nor do they consider the background of what is considered socially relevant (Greenswag, 2019). Thus, in the instance of an HIV program, human rights theory would argue that because the right to health is entrenched in The Constitution and that the state has a duty to ensure that it is progressively realised, this particular right should be upheld in order for state to be in an ethical position. However, the limitation comes in that human rights do not seem to address whether by ensuring these HIV programs are sustained, would be socially or politically relevant. I could

argue that in The Constitution does also argue for example that individuals have the right to education and that the state should also progressively realise this right.

The societal norms and politically relevant issue could be ensuring that children have access to adequate educational services and programs and therefore the state should be prioritising this and ensuring that this right is being met instead of providing funding for HIV programs that would only benefit a certain portion of the population whereas ensuring educational programs are sustained, would benefit a bigger population in the country. Human rights theory provides a base for arguing the ethical stance of ensuring the sustainability of the HIV programs but it does not take into account that HIV programs might not be the politically or socially relevant norm that society deems to be important. There would have to be an additional element or theory that would support the argument for the state ensuring that HIV programs are sustained.

The second problem for a human rights perspective is that the agenda-setting stage requires a fair degree of 'active citizenship. 'This active citizenship is where the right to participation and consultation in public matters "implies the active, documented participation of all persons who are interested in the formulation, application, and monitoring of public policies" (Vazquez and Delaplace 2011, 43). The problem with active citizenship is that those who do not have the time to participate in this way are often left out, excluded from the policy process even though their problems, often around gender and dependency, are not brought to the policy table. Such persons can be rendered invisible to the political process because they cannot participate through traditional means (Kittay 2001, 529).

Human rights are not geared to look at the relations of power that operate in the background of the current political background. The manner in which human rights are set up is that they are

a set of standards that are meant to protect individuals and a way of life and they are not necessarily set up to take into account the power relations that occur in the background. For this context, human rights does not account for the power relations or the politics that lie behind the implementation of health programmes in the country. They do not take into account how the financial aspects form a political perspective would impact on whether certain programmes are prioritised or not. This makes it difficult to argue that the state would have a moral obligation under human rights to ensure that programmes continue. There could be other factors that need to be taken into account as to why such programmes would not be feasible or prioritised by the state.

Human rights has its basis set in inequality and this can often be understood to mean that everyone should be viewed the same and there should have rights be applicable to them equally (Nanni, 2023). This kind of definition of equality can lead to assumptions that would ignore the racial and gendered relations of power that exist and that how we view our ethical lives is often influenced by these relations of power.

Another critique of human rights can be found in care ethics which argues that human rights discourses can only focus on the individual agent, and too closely circumscribe who counts as an agent in the first place (Robinson 1999). Which often results in political thought based on mainstream human rights discourses can lose sight of the importance of how we live in relation to other people (Robinson 1999). The language of rights cannot always adequately encompass certain goods such as "economic and social security, the fulfilment of basic human needs, and the cultural survival of groups" (Robinson 1999, 63) because such goods are predicated heavily on social responsibility and care. For the most part, human rights discourses are aimed at

protecting the rights of the individual, not necessarily disconnected from their wider social and political framework, but with the primary focus being the individual as a moral agent

When we focus on the individual, we tend to negate the communities in which these individuals live in. Which when looking at things such as HIV/AIDS programmes, it could seem that it is not necessarily an individual problem and there should not be prioritised over the individuals needs.

Looking at the above, the human rights discourse has its merits, but it also does have its limitations on how we are able to apply them ethically to the ensure that the state is able to sustain HIV/AIDS programmes in the evet of funding decreasing or being removed.

Chapter 6: Conclusion

It is difficult to ascertain moral obligation when referring to issues that are also dependant on resource availability and the ability of a state to execute certain services and interventions. For over 29 years, PEPFAR has provided support to the Department of Health in South Africa in an effort to combat the HIV/AIDS epidemic in South Africa. The support received has helped in reducing the number of PLHIV, ensuring those that are on treatment live a longer and healthier life as well assist in spreading safe sexual practices amongst the young people in South Africa.

Various programs have been established through these funds such as voluntary male medical circumcision (VMMC), Prevention of Mother-to-Child transmission (PMTCT), Orphan and Vulnerable Children (OVCs), Key Populations, Adolescent Young Women and Girls (AYWG), amongst many other interventions implemented. These services have ensured that everyone that is affected or is living with the disease has access to the necessary services that would ensure that they are healthy and are able to continue with their daily lives.

The sustainability of these interventions and programs is important in the continued efforts of realising the right to health for all that live in South Africa. The state is the custodian of these rights and therefore have the moral obligation to ensure that these services and interventions are sustained beyond a funding cycle or a decrease in funding. They have the obligation to ensure that these continue under human rights and social justice. These ethical theories holds that the state needs to progressively realise the right to healthcare – even in a resource constraint environment. The state has the obligation to continuously find ways of ensuring that even though there is funding available, they are also working alongside PEPFAR to ensure that they

are able to continue these services once PEPFAR funding is completely pulled out. The state has an obligation to ensure that the withdrawal or reduction in funding does not hinder the quality of life that the individual has been accustomed to by receiving support from the state through these services. PEPFAR is merely a tool that is available for the state to use in fulfilling its obligations, it is not meant to overtake state functions in a way that would harm people should the end or be reduced.

The above is also supported by other ethical theories such as care ethics and deontological theories. As mentioned above, care ethics speaks to the recognition that there is a relationship between the state and its citizens that must be upheld and maintained. That by maintaining this relationship, the state would be morally right.. By ensuring that people have continued access to lifesaving interventions and healthcare services, the state would be respecting the dignity of those in its care. The eventual transition away from donor reliance require that the state engage in proactive strategies such as the mobilisation of domestic resources, policy reformation and institutional strengthening to ensure that the progress that has been made in HIV/AIDS management is not halted or reversed.

This research report was complete at the time of the Executive Orders that were issued by The President of the United States in February 2025 (these are referenced earlier in the paper). The effects of these orders has been paramount to the HIV/AIDS programme in South Africa and the HIV/AIDS funding landscape in general. It is now more important than ever for the state to take moral responsibility overt the HIV/AIDS programmes in South Africa. The effect of the current Executive Orders from the President of The United States has left the HIV/AIDS implementation in the country in a vulnerable state. The impact of relying fully on the funding to run essential services such as providing healthcare services and programmes, has left not

only the state in a vulnerable position but the recipients of these services and programmes in a vulnerable position. The state needs to be even more committed to ensuring our public health is strengthened and has been built to be resilient and sustainable enough to endure beyond external financial assistance.

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