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APHA

Wasted Investments, Looming Crisis:

The Impact of U.S. Global Health Funding Cuts on HIV in South Africa

Acknowledgements

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The oral histories used as the basis for this report were gathered as part of the Izwi Lam | My Voice project developed and implemented by Yvette Raphael, executive director of Advocates for the Prevention of HIV in South Africa (APHA); Nomfundo Eland, executive director of Emthonjeni Counseling & Training; and Emily Bass. Izwi Lam received the 2025 Emerging Crises Award from the Oral History Association, and all involved in the development of this report gratefully acknowledge this support. The publication benefited from input and review by PHR staff and partners, including Salim Abdool Karim, director, Centre for the AIDS Programme of Research in South Africa (CAPRISA); Safura Abdool Karim, senior scientist, CAPRISA; Philip Alston, professor of law at New York University Law School; Richard Goldstone, justice of the South African Constitutional Court, retired; Glenda Gray, distinguished professor and director, Infectious Disease and Oncology Research Institute, University of the Witwatersrand, Johannesburg; Brian Honermann, deputy director, Public Policy Office, amfAR; James McIntyre, honorary professor, School of Public Health & Family Medicine, University of Cape Town; and, Sam Zarifi, executive director, PHR.

PHR, Emthonjeni Counseling & Training, and APHA South Africa are grateful to Angel Buthelezi, Kasiefa Charles, Namhla Dlova, Miza Gazi, Sinentlantla Gogela, Naomi Hill, Franklin Houtzamer, Siyasanga Kilani, Ntombozuko Kraai, Andrew Lambert, Sibongile Magwentshu, Mandisa Mbatha, Sarah Mkhabela, Moipone Mokena, Lerato Morulane, Nombeko Mpongo, Ntombifikile Mtshali, Gabriel Ndlovu, Nomonde Ngema, Neliswa Nkwali, Lesley Odendal, Nomvuzo Pike, Katlego Rasabitse, Kevin Rebe, Llyod Rugara, Paulinah Sebenzi, Katlego Cataleya Serame, Yanela Sinqu, Lulama Sulupha, Wim Vandervelde, Mzwakhe Vilane, Busisiwe Zengele, and the South African clinicians, peer counselors, peer navigators, people living with HIV, young people, transgender men and women, men who have sex with men, government health workers, and others who shared their time and experiences with our team. Their commitment to the survival of their communities and people living with HIV is a much-needed sign of hope in an increasingly dire situation.

Cover: HIV testing is the entry point to appropriate treatment or prevention. Participants reported extended waits and missed opportunities to connect to care.

Photo: Emthonjeni Counseling and Training

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Executive Summary

Starting in 2025, the Trump administration abruptly slashed and disrupted funding for global health, jeopardizing hard won public health gains and irreplaceable investments in infrastructure and partnerships for disease response, health security, and research. As of late March 2026 – more than a year after the disruptions began – HIV, tuberculosis (TB), and malaria programs, along with basic health services and many other humanitarian programs, remain impaired in countries around the world, and particularly in the Africa region.[1] As this report went to press in April 2026, frameworks guided by the America First Global Health Strategy, the U.S. Department of State's new approach to U.S. foreign aid for global health focused on advancing American economic and security interests, and securing co-investments for funded countries, had not yet been funded or implemented. This strategy, published in September 2025, covers health areas including, HIV, malaria, TB, polio, and global health security. Available information on these secretive bilateral agreements or memoranda of understanding (MOUs) between the United States and countries receiving U.S. funding has raised concerns about the lack of evidence-based, epidemiologically sound programming, and the extractive terms set by the U.S. government.[2]

South Africa is unique among the many countries impacted by the Trump administration's actions, having experienced triple blows of cuts to HIV funding, research, and cooperative diplomatic relations. Prior to 2025, South Africa was the recipient of the largest amount of funding from the National Institutes of Health (NIH) outside of the United States, with additional investments from the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Agency for International Development (USAID). These investments supported a robust research infrastructure that linked American and South African research institutions in partnerships that produced groundbreaking findings. The country is also home to the largest HIV epidemic in the world, with persistently high incidence in cisgender woman, particularly adolescent girls and young women.[3][4][5] An upper-middle income country, South Africa's national health system and HIV program are predominantly supported with domestic resources, spending 16.8 percent of the annual budget on domestic health priorities.[6] While U.S. funding paid for 80 to 90 percent of some countries' HIV programs prior to 2025, U.S. funding only accounted for 17 percent of the South African HIV response in recent years.[7][8] However, these resources supported much and, in some instances, all tailored programming for specific populations including adolescent girls and young women at risk of acquiring HIV, sex workers and key populations.[9] It also resourced key elements such as pediatric HIV diagnosis, data collection and cleaning, and community-based services.[10]

The Trump administration has disrupted every aspect of these longstanding partnerships and programs both through the elimination of USAID-supported programs, elements of the President's Emergency Plan for AIDS Relief (PEPFAR), the United States' flagship foreign aid program to respond to the global HIV crisis, and through a Trump executive order banning all foreign aid and assistance and suspended all funding for research to South Africa based on spurious claims of white genocide.[11][12][13][14] As a likely result of the collapse of cooperative diplomatic relations, the U.S. government has not, to date, sought to develop an MOU with South Africa for continued health-related funding. While these agreements are extractive and centered on U.S. interests they can provide critical assistance and technical partnership to countries to support transition planning and programming that ensures U.S. investments through PEPFAR, USAID and other partners are not altogether wasted as the result of abrupt cuts to global health funding. As of April 2026, this option was not available to South Africa. Instead, the United States government was on track to abandon virtually all of its investments in research, programming, and longstanding collaboration with a country at the epicenter of the global HIV pandemic and at the forefront of scientific innovation.

With the trio of dismantling of HIV programs, research funding, and cooperative diplomatic relations, the Trump administration has made South Africa a proving ground for its "America First" foreign policy.[15] It is crucial to document the current and future impacts of this global health policy approach.

Over the past year, South African advocates, activists, clinicians, researchers, and people living with HIV have systematically documented the impacts of the abrupt funding cuts.[16] Advocates for the Prevention of HIV in South Africa (APHA), Emthonjeni Counseling & Training, and PHR co-created a project to document the harms, bear witness to the impacts, and highlight the implications of the Trump administration's actions. In September 2025, PHR and collaborators conducted 20 oral history interviews with 40 participants, including South African doctors, nurses, clinical officers, peer counselors, peer navigators, people living with HIV, young

people, transgender men and women, men who have sex with men, government health workers, and researchers, who shared their experiences of the immediate psychological, physical, and public health harms caused by these losses. All participants were contacted again in March 2026 to validate quotes and provide updates.

These accounts depict how the triple blows to U.S. funding for HIV programs, research infrastructure, and civil diplomatic relations with South Africa have diminished the quality of HIV treatment and prevention, strained the broader health system, and are wasting billions of dollars of U.S. investment in research infrastructure and health delivery platforms, particularly for primary prevention. With no relief in sight in the form of transitional funding or resumption of robust research collaborations, the United States has helped make a future surge in otherwise-preventable new HIV infections all but inevitable.

Community-based HIV testing that is fast and convenient is critical to preventing and slowing the spread of HIV. Emthonjeni Counseling and Training is one of many groups in South Africa that has halted most community-based services due to U.S. funding cuts, like this testing day at a community gathering to address gender-based violence. .
Photo: Emthonjeni Counseling and Training

Key Findings

A. In the Community: Diminished Community-Based Testing and Programming for Primary Preventive Health Care

"The only way to get tested for HIV now is to go inside the clinic and test. Whereas we had people that were working in the streets for the community doing just HIV testing. You didn't need to go to the clinic, you didn't need to wait in long queues. You just went in the tent and said, 'I'm here for HIV testing.' You get tested, if you're positive, they link you to care. It's no waiting, no... It gave dignity, in a sense. Now you need to imagine now, someone is going to have to wait for them to really get sick, so that they can say, 'No man, I'm really sick, I need to go to the clinic.'"
Young cisgender woman HIV prevention advocate and educator

Participants including government health workers, young peer educators, and people living with HIV described a significant reduction in the availability of community-based health services including HIV and sexually transmitted infection (STI) testing, linkage to pre-exposure prophylaxis (PrEP), a biomedical strategy in which people who are HIV-negative use antiretroviral medications to eliminate their risk of acquiring the virus, HIV treatment, and primary health services like blood pressure monitoring, immunization catch-up and body mass index testing to support management of non-communicable diseases. In some instances, the services have vanished because the U.S.-funded entity that provided them lost resources. In other instances, the government-supported community outreaches have scaled back due to staffing shortages at the physical clinic locations. This is one of many ways that the U.S. cuts to PEPFAR-funded programs have diminished the quality and accessibility of care for other non-HIV related health issues. The loss of HIV testing in the community puts timely linkage to testing and treatment in peril.

An HIV diagnosis is the entry point for effective services. People who are HIV positive should be linked to antiretroviral treatment and other services; those who are HIV negative but at risk of acquiring the virus should be linked to comprehensive HIV prevention, including PrEP. Structural barriers such as long wait times, travel costs, and lost income associated with obtaining an HIV test at a clinic may reduce testing uptake if inconvenient and community-based services are no longer available. Many participants reported extended wait times in clinics and predicted that people will delay testing until symptoms are unavoidable. One participant warned, *"If we do not take care of our health, we will be forced to take care of our illness."*

B. In the Clinic: Diminished Quality of Clinic-Based Primary Prevention and Treatment Services

"So I went in there, so I told her [the nurse] that I wanted to return to my PrEP, and I asked her, 'Why now there's no counselors? [...] Why are the processes not the same?' And then she's like, 'Sis we have a lot of work here. We only test you when you ask, as now you are asking me to test you. If you did not ask, then I was not going to test you.'"
Cisgender woman, PrEP user

PrEP, like antiretroviral therapy, continues to be available in South African government-funded health facilities, private clinics, and in programs run by local organizations with existing CDC-PEPFAR and other funding sources. However, participants in this study described extended wait times, over-burdened staff, abandonment of standard protocols for HIV testing prior to PrEP provision, the loss of health workers who followed up with clients newly diagnosed with HIV and TB to ensure they understood and remained on treatment, and with people with HIV returning to the clinic after missed appointments to ensure they are fully re-engaged in care. PrEP, HIV, and TB treatment all work when the medications are taken as prescribed, following an accurate diagnosis that the client understands. Many people living with HIV take antiretrovirals regularly and as prescribed, achieving the virologic suppression that preserves health and reduces risk of HIV transmission. However, some people including newly-diagnosed individuals, members of marginalized groups who encounter or expect stigma at the health facility, and people with income and housing precarity may struggle to start or stay on regular treatment. The loss of health workers to support these segments of the population puts hard-fought gains in the HIV response at risk.

C. In the Dark: Diminished Availability of Timely, Actionable Data

"I'm waiting for a big bomb to blow on our face at any time. Because people, the truth is people are not taking the treatment. And because we can't see that they're not taking it. And even when they come, we don't have time for them because we are overwhelmed. I'm here today for a meeting to look at why is this clinic not seeing the [same] number of patients."
Cisgender woman, government-employed data quality officer

Effective public health programs depend on timely, accurate, evidence-based, and actionable data. In the context of HIV, this includes data on the number of new HIV diagnoses in a given population over a period of time (incidence), the percentage of people returning for their refills of antiretroviral therapy or PrEP, the percentage of people on antiretroviral therapy who are virologically suppressed, and the percentage of people on antiretroviral therapy who have disengaged from care. These data can be used to trigger targeted problem-solving actions, from a home visit to a client who has missed a refill, to tailored engagements with communities where there are high rates of new infections. Data can support allocation of scarce resources and it can yield warning signs when programs are not performing. In this study, participants described data-entry backlogs related to U.S. foreign aid cuts that meant clinic staff had little real-time information about key metrics of HIV program success. They did not know whether clients recorded as "disengaged," meaning they had missed one more refill appointment, or had in fact come for their refill, without that visit being logged in the system that generates usable data reports. Taken together, disrupted community-based services, diminished quality of facility-based primary prevention, and degraded timeliness and quality of data create conditions in which surges of new HIV infections could occur without awareness and action by public health stakeholders including health workers, impacted communities, and leadership at local, subnational, and national levels.

D. Irretrievable Waste: Squandered Investments in Research Infrastructure

"The worst part is I'm currently recruiting for a study that requires clinic assistants. They are not there, the people in the clinics [formerly employed by PEPFAR]. The clinics are in crisis…I work with many clinics here. The [health workers] that I would go and know that they'll be there: data capturers, there will be counselors, I will be able to interact with this person and that person, they are not here."
Cisgender woman, staff member at a major research institution

Prior to 2025, South Africa received an estimated $100 to $150 million annually in direct grants from the NIH, for a total of approximately $400 million including sub-grants, in addition to PEPFAR funds.[17] Much of that funding was lost over the past year via the termination of research and grant funding by the NIH, non-renewal of awards for ongoing clinical trials, and an NIH directive banning foreign sub-award grants. South African researchers have described these cuts as catastrophic.

The United States was a direct beneficiary of these research collaborations, including products developed by U.S. private sector companies such as the injectable PrEP medication lenacapavir. South Africa has also played a major role in evaluating effective strategies for treating and preventing TB, including development of the diagnostic called Xpert MTB/RIF test, capable of detecting *Mycobacterium tuberculosis* and rifampicin resistance, genomic research revealing human genetic variations linked to increased TB susceptibility, and TB vaccine research.[18] Cost-effective, efficient development of new drugs and preventive measures requires trials in communities where there are high rates of new infections and/or a high prevalence of the disease in question. Without these conditions, clinical trials of, for example, a new HIV PrEP strategy would require huge enrollments, lengthy timeframes, and prohibitive cost. The persistently high rates of HIV, TB, and other infections in South Africa and its exceptional infrastructure make efficient, ethical research possible, with worldwide benefits, including for populations in the United States.

Overall, this report finds that The Trump administration's "America First" foreign policy approach as implemented in South Africa via cuts to HIV programs, research, and civil diplomatic relations wastes resources, undermines progress against HIV/AIDS, and diminishes U.S. national and global health security.

In this report, PHR and collaborators provide narrative evidence that the Trump administration's cuts to global health funding and halt of foreign aid and assistance to South Africa have:

- Wasted hundreds of millions of dollars of investments by abandoning primary prevention programs and technologies designed to support large-scale prevention efforts, including the new PrEP drug lenacapavir;
- Squandered hundreds of millions of dollars of investments by failing to continue engaging with a unique collaborative research infrastructure including laboratories, data systems, clinical trial platforms, and highly skilled personnel; and
- Recklessly disregarded the dramatic consequences of failing to maintain funding to reduce new HIV infections among infants, young people, and adults, and preventing unnecessary suffering and death among people living with HIV, ultimately leaving populations worldwide, including in the United States, less secure and more vulnerable to illness.

In short, the America First Global Health Strategy aims to reduce the perceived inefficiencies and waste in foreign assistance through mechanisms like the bilateral health agreements.[19] However, the abrupt cuts to global health aid themselves have created inefficiencies and risk waste, fraud, and abuse, directly contradicting the strategy's stated objectives. Disruptions and reductions in aid jeopardize decades of U.S. investment in HIV prevention and response infrastructure. Primary prevention initiatives and clinical trials and the broader research ecosystem, which were established in South Africa over many years through billions of dollars in funding, are particularly vulnerable. These cuts not only weaken the resilience and durability of local health systems but also dismantle the critical clinical research pipeline in South Africa on which the United States has relied for innovations in treatment, prevention, and disease management. The disruption of these programs threatens both ongoing research and the capacity to generate new scientific knowledge, undermining the long-term effectiveness of U.S. foreign assistance, U.S. national security, and the global fight against HIV.

Recommendations

This report demonstrates that eliminating crucial funding for prevention, treatment, and research systems has consequences far beyond the dollar amount removed. These findings underscore the urgent need to restore investments in prevention, rebuild community-based outreach, HIV research, and data tracking to prevent further damage to South Africa's and the global HIV response. The report also identifies crucial shifts undermining the availability, accessibility, acceptability, and quality of HIV prevention and treatment services, particularly for key populations, signaling clear backsliding in realizing the right to health and other human rights.[20]

Eliminating crucial funding for prevention, treatment, and research systems has consequences far beyond the dollar amount removed.

Demonstrators, some of them former PEPFAR and USAID employees, protest to demand that Congress stand up to President Donald Trump and Elon Musk's "Department of Government Efficiency" and reinstate lifesaving programs in the Cannon House Office Building on Capitol Hill on February 26, 2025 in Washington, DC. Photo: Chip Somodevilla/Getty Images

Key Recommendations

To the United States Government

- Mobilize, safeguard, and spend funding appropriations for HIV prevention, treatment, primary health care, and collaborative HIV and TB research.
  - Extend the Bridge Plan through the end of FY2026 at levels commensurate with appropriation, with options for countries to 'roll off' as memoranda of understanding with aid recipient countries are signed.
  - Ensure that appropriated funds necessary for programmatic implementation still being performed by the CDC and Department of Defense are transferred with sufficient buffer time and funding for budget reserve and planning.
  - Ensure that shifts in global health policy do not undermine decades of investment.
  - Ensure that global health engagements and aid agreements with partner countries are grounded in human rights, equity, and mutual accountability.
- Reinvest in funding for community health workers, peer educators, health ambassadors, and other community outreach professionals globally.
- Ensure sustained, rights-based funding and programming for key populations.
- Lift the restriction on U.S. federal funding for research in South Africa.
- Ensure transparency and data access by publicly releasing disaggregated programmatic and financial data on a regular basis.

To Other Donor Governments

- Increase funding to address prevention and primary care gaps by urgently increasing bilateral HIV and primary health care support in high-burden countries.
- Collaborate with recipient countries to gradually transition them from reliance on donor funding through carefully planned, phased reductions, ensuring continuity of essential health services and minimizing disruptions to care.

To the Government of South Africa and Other Governments Responding to HIV Epidemics in the Context of Diminished Donor Financing

- Prioritize prevention, treatment, and primary care as part of the HIV response in domestic budgets.
- Act on warning signs of stress placed on domestic HIV programs by collecting data to understand the full extent of the impact of the funding cuts.
- Reaffirm, fully implement, and surpass the Abuja Declaration commitment to allocate at least 15 percent of national budgets to health and adopt progressive increases beyond 15 percent to reflect current funding realities.
- Prioritize ring-fenced funding for HIV prevention, particularly for adolescent girls and young women and key populations.
- Reduce reliance on a single donor by expanding domestic resource mobilization.
- Explicitly fulfill constitutional duties by taking proactive steps to ensure equitable access to essential health services for all populations, particularly key populations.
- Insulate critical programs from external shocks by strengthening the resilience of HIV and key population programs to funding fluctuations.
- Ensure provincial accountability and oversight by holding provincial health departments accountable for delivering services, ensuring that their resource allocations meet minimum service levels and reflect the progressive realization of the right to health as required under the constitution.
- Integrate anti-discrimination and equity measures by implementing explicit protections to protect marginalized and vulnerable populations.
- Monitor and publicly report impact by requiring transparent, regular reporting on access gaps, service disruptions, and health outcomes for key populations.

To the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization, Africa CDC, the African Union, and Other Multilateral Entities

- Ensure that prevention remains a core funding priority and invest in community health workers and peer-led models.
- Strengthen global and regional surveillance and reporting systems to document impacts associated with funding disruptions.
- Sustain and expand funding for HIV research.
- Establish an Africa-wide HIV emergency coordination mechanism.
- Lead development of an African HIV financing transition framework.
- Coordinate pooled procurement and regional manufacturing of HIV commodities in Africa.

To International and Human Rights Mechanisms and Bodies, including the United Nations, African Union, and World Health Assembly

- Monitor the human rights impacts of global shifts in funding

Acronyms

ACTG	Advancing Clinical Therapeutics Globally for HIV/AIDS and Other Infections
AIDS	Acquired immunodeficiency syndrome
APHA	Advocates for the Prevention of HIV in South Africa
ART	Antiretroviral Therapy
CAPRISA	Centre for the AIDS Programme of Research in South Africa
CDC	Centers for Disease Control and Prevention
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DTG	Dolutegravir
ELISA	Enzyme-Linked Immunosorbent Assay
FOIA	Freedom of Information Act
FY	Fiscal Year
HIV	Human immunodeficiency virus
ICCPR	The International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social, and Cultural Rights
IMPACT	International Maternal, Pediatric, Adolescent AIDS Clinical Trials Network
KRISP	KwaZulu-Natal Research Innovation and Sequencing Platform
LEN	Lenacapavir
NIH	National Institute of Health
NOFO	Notice of Funding Opportunity
U.S.	United States
USAID	United States Agency for International Development
UNAIDS	The Joint United Nations Programme on HIV/AIDS
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHR	Physicians for Human Rights
PLHIV	People living with HIV
PrEP	Pre-exposure Prophylaxis
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TB	Tuberculosis

Introduction

The U.S.-South Africa Collaboration on HIV Programs

South Africa has the largest HIV epidemic in the world, with an estimated 7.7 to 8.5 million people living with HIV and 170,000 new infections per year.[21] Many new HIV infections occur in adolescent girls and young women, who make up 25 percent of new HIV infections despite accounting for only 10 percent of the population and in pregnant women who have an HIV prevalence rate of approximately 44 percent.[22 23 24]

South Africa and the United States have worked in partnership for decades to respond to the HIV epidemic. In 2003, working in close collaboration with South African activists and physicians, the President's Emergency Plan for AIDS Relief (PEPFAR), the United States' flagship foreign aid program to respond to the global HIV crisis, supported free antiretroviral treatment programs in South Africa at a moment when the South African government questioned the safety of the medications and whether HIV was the causative agent for AIDS.[25] In the years that followed, the South African national government moved into a leadership role in domestic HIV response.

By 2024, the South African government was providing more than 83 percent of the funding for its domestic HIV response, which included antiretroviral treatment for more than 6 million people living with HIV, and U.S. support to South Africa continued and evolved. Prior to the disruptions that began in 2025, PEPFAR's targeted support in South Africa centered on 27 priority districts, including those with the highest HIV disease burden—in which up to 50 percent of people with HIV are also coinfected with tuberculosis (TB).[26] PEPFAR also focused on programs to ensure prompt diagnosis of infants and children with HIV, drug and HIV test supply chain management, primary prevention, health workers and community-based and -led services for populations at the highest risk of HIV, including sex workers, gay men and other men who have sex with men, and transgender people.[27 28 29 30] PEPFAR funds covered large portions of PrEP for adolescent girls and young women and the DREAMS Partnership programming, as well as a substantial proportion of community-based and -led services including mobile testing sites.

Most U.S. support was channeled to PEPFAR implementing partners (non-governmental organizations) with limited government-to-government contributions. The United States also supports the Global Fund to Fight AIDS, Tuberculosis and Malaria, which provides resources to South Africa.

In FY2025, the last year in which PEPFAR countries generated full country operational plans under the Biden administration, South Africa received approximately $332.6 million.[31] Most of these resources were split between the Centers for Disease Control and Prevention (CDC) and the U.S. Agency for International Development (USAID). By the time the oral histories were collected for this report in September 2025, almost no USAID funding was active in South Africa, while CDC programs had experienced disruptions but continued to operate.

The impacts of the funding cuts to South Africa cannot be understood simply by examining the percentage of the overall South African HIV program budget that was stripped away overnight. While the United States provided a relatively small proportion of the total HIV response budget in South Africa, the targeted resources the United States covered most, and in some instances all, aspects of key services, many of which had not been replaced by the South African government at the time of publication. This includes community-based and -led services and primary prevention services that provide convenient HIV testing and linkage to PrEP that helps prevent HIV, and other prevention tools for HIV negative people at risk of acquiring HIV.[32]

U.S.-South Africa Research Collaborations

In this same period that the two countries collaborated on HIV programming, the United States and South Africa forged research partnerships that transformed global public health responses to HIV and TB, and advanced innovation in many other areas. Resourced by significant funding from the National Institutes of Health (NIH), CDC, and USAID and implemented by South African research institutions, clinical trial sites, and communities, this research informed global guidelines for treatment and prevention of HIV and TB.

Prior to 2025, South Africa received an estimated $100 to $150 million annually in direct grants from the NIH and additional funding from sub-grants, totaling approximately $400 million, making it the largest recipient of NIH funds outside of the United States.[33] These funds supported an array of clinical trials of biomedical and public health strategies for preventing and treating HIV, TB, and other diseases. NIH resources supported an estimated 70 percent of South African clinical trials focused on HIV and TB.[34 35 36] These U.S. resources and partnership contributed to an infrastructure that yielded globally beneficial breakthroughs, including collaboration with the U.S. company Cepheid to development of the diagnostic called Xpert MTB/RIF test, capable of detecting *Mycobacterium tuberculosis* and rifampicin resistant TB, a crucial tool for limiting the spread of multi-drug resistant strains of the virus.[37]

The investments in research and programs were deeply synergistic, with PEPFAR-supported health workers playing key roles in clinical trial recruitment, retention, and operations. These research investments yielded breakthroughs with substantial benefits for the American people and private sector companies. For example, South African cisgender women comprised a significant majority of participants in the landmark study that found lenacapavir, a twice-yearly injectable antiretroviral, to be completely protective against HIV in women, with global implications for scaling HIV prevention. [38]

Much of that funding was lost over the past year via the termination of research and grant funding by the NIH, non-renewal of awards for ongoing clinical trials, and an NIH directive banning foreign sub-award grants. South African researchers have described these cuts as catastrophic. Earlier this year, Glenda Gray, chief science officer and former head of the South Africa Medical Research Council, said of the cuts, *"If you take this away, you take away scientists, doctors, nurses, laboratories, fundamental science, basic science, clinical science, supervisors for PhDs and masters, and postdocs. You basically abolish medical research in South Africa. That's how serious this is."* [39]

These cuts to research funding and collaborations have directly and materially weaken both U.S. national health security and global health security. South Africa contributed to the evaluation of the Ad26 SARS CoV-2 vaccine in health workers, and the Ubuntu study that evaluated Moderna's mRNA vaccine in people living with HIV in East and southern Africa. Effective pandemic response requires countermeasures like vaccines that work in all impacted geographies and populations, as new variants emerging in one geography can quickly spread around the world. Indeed, it was the KwaZulu-Natal Research Innovation and Sequencing Platform (KRISP) that first sequenced the Omicron variant of SARS CoV-2 which rapidly became the dominate agent of a new wave of the global pandemic. KRISP was also supported by NIH funding.[40]

The cancellation, freeze and non-renewal of grants and subgrants has disrupted support for epidemiologists, genomic scientists, laboratory specialists, and bioinformatics teams embedded in institutions such as the National Institute for Communicable Diseases, University of the Witwatersrand, Stellenbosch University, and the Centre for the AIDS Programme of Research in South Africa, which form the backbone of South Africa's disease surveillance and sequencing capacity. U.S.-South Africa collaborative programs have explicitly supported emerging infectious disease research, genomic epidemiology training, and data science capacity that underpin early warning systems and outbreak intelligence.[41] Without this web of investments and partnerships linking South Africa and the United States, the United States loses a critical frontline node in global pathogen detection and genomic surveillance. This loss of collaborations is happening concurrently with the U.S. withdrawal from the World Health Organization (WHO), which further exacerbates U.S. isolation in pathogen detection and response.[42]

South Africa has been central to identifying and characterizing emerging variants and pathogens, enabled by sustained investment in sequencing infrastructure, workforce development, and international data sharing. Weakening this ecosystem reduces real-time visibility into viral evolution, delays detection of threats that can reach U.S. borders within days, and erodes the collaborative networks required for rapid response. Cuts to research grants in South Africa increase the risk that other countries in the region and the United States will face future outbreaks with less warning, less genomic intelligence, and diminished ability to coordinate internationally, thereby heightening the likelihood of faster spread, greater negative health impact, and higher domestic response costs.

Over the long term, South African researchers and research institutions will continue their groundbreaking work; however, the abrupt and unplanned withdrawal of U.S. resources will hinder the United States' ability to efficiently develop, scale, and deploy new vaccines, treatments, and diagnostic tests for HIV and other pathogens that pose global threats, with implications far beyond global health. This report draws on testimony from skilled health workers and research assistants on the front lines to document the deleterious impacts of the research cuts.

Wasted Potential, Unfinished Work: The Impact of U.S. Actions on Primary HIV Prevention Research and Implementation in South Africa

South Africa has played a pivotal role in HIV prevention research and implementation, including evaluation and delivery of PrEP strategies. South Africa was home to almost 90 percent of the sites involved in the PURPOSE trial of lenacapavir for PrEP that showed 100 percent protection.[43] Before this, South African communities and clinicians were pivotal in the evaluation of the vaginal dapivirine ring and other oral and injectable strategies. South Africa was also in the vanguard of successfully rolling out PrEP and supporting groups at high risk, such as adolescent girls and young women, to start and stay on the medication.

PrEP is a biomedical strategy in which people who are HIV-negative use antiretroviral medications to eliminate their risk of acquiring the virus. Cost-effective, efficient development of new drugs and preventive measures requires trials in communities where there are high rates of new infections and/or a high prevalence of the disease in question. Without these conditions, clinical trials of, for example, a new HIV PrEP strategy would require huge enrollments, lengthy timeframes, and prohibitive cost.The persistently high rates of HIV, TB, and other infections in South Africa and its exceptional infrastructure make it uniquely well-positioned for efficient, ethical research, with worldwide benefits.

Even before the aid cuts, there were an estimated 1.3 million new HIV infections globally in 2024 – much higher than the United Nations target figure of fewer than 500,000 per year.[44] Lack of progress on primary prevention reflects many challenges, including inadequate funding for prevention, poverty, harmful social and gender norms, and laws and policies that restrict access through age of consent or age of access limitations and by criminalizing same-sex sex, transgender and gender non-conforming identities, sex work, and drug use. Access to care has also been a significant issue: in 2023, prior to the foreign aid disruptions, dedicated combination prevention programs for adolescent girls and young women were operating in 61 percent of subnational areas globally with high HIV incidence, but only 36 percent of locations with moderately high HIV incidence.[45]

Primary HIV Prevention: Unfinished Work, Unrealized Potential

Primary HIV prevention aims to keep HIV negative individuals from acquiring the virus through a combination of interventions, including biomedical strategies such as PrEP, prevention of mother-to-child transmission, and the treatment of people living with HIV to sufficiently suppress viral loads and prevent transmission of HIV to others. Safer sex practices, regular testing, linkages to care, and education and other behavioral interventions can also help prevent new HIV infections. Finally, structural interventions to address stigma; barriers to accessing care, treatment, and prevention; and gender inequality can create an enabling environment for HIV prevention. This approach is reflected in the World Health Organization's 2021 *Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring: Recommendations for a Public Health Approach*, which defines combination prevention as using "a mix of evidence-based biomedical, behavioural and structural interventions to meet the current HIV prevention needs of individuals and communities to have the greatest possible impact on reducing the number of people newly infected."[46]

A nurse prepares a syringe filled with the drug lenacapavir (a drug taken twice a year that has been shown to reduce the risk of HIV transmission by more that 99.9%), which he prepares to administer to a patient at the Phedisong clinic in Ga-Rankuwa, north-west of Pretoria, South Africa, on December 2, 2025. Photo by Ihsaan Haffejee / AFP via Getty Images

These barriers have hindered successful rollout of PrEP. Oral and long-acting injectable and vaginal ring formulations of PrEP are currently available and long-acting oral formulations are in the late stage of development. The Joint United Nations Program on HIV/AIDS (UNAIDS) estimates that 25 to 35 percent of new HIV infections could be prevented over the next ten years with the scale-up of lenacapavir, a game-changing new form of PrEP approved by the U.S. Food and Drug Administration in June 2025. If lenacapavir is implemented at scale, particularly in locations and among populations with the highest HIV incidence, this twice-yearly injectable prevention initiative could significantly accelerate progress toward reducing new infections.[47]

At the start of 2025, U.S. funding to PEPFAR countries supported more than 90 percent of PrEP initiations worldwide, and a cumulative total of 2.5 million PrEP users.[48] USAID-supported PrEP initiations were highest among women of reproductive age and men who have sex with men.[49] Launched in 2014, the PEPFAR-supported DREAMS partnership offered tailored, multilayered prevention packages including providing life skills, economic and social empowerment, HIV prevention, and community interventions to adolescent girls and young women. DREAMS was a key platform for PrEP programming for adolescent girls and young women – and PrEP initiations among this group were 1.4 times higher in areas where DREAMS was operating compared to places where the program was not implemented.[50] Overall, approximately 70 percent of all PEPFAR-supported PrEP initiations among adolescent girls and young women occurred in DREAMS districts.[51]

PrEP works for as long as it is taken – and for many people, including adolescent girls and young women, adherence to a daily pill regimen is challenging, especially if it is for prevention. As of the end of 2024, many PrEP programs in sub-Saharan Africa had documented high rates of discontinuation among those who initiated PrEP, as well as core groups of people who restarted the treatment, often because of a self-assessed risk.[52] While PrEP had yet to show widespread population-level benefit, the investments made in comprehensive prevention programs and related community-based services had built a robust platform for progress based on continued analysis of information about why people stop and start PrEP and what other services can help reduce HIV risk, as well as through the introduction of innovative products like lenacapavir. The primary prevention platform developed through years of U.S. investments is critically important to support the rollout of lenacapavir, which is in danger due to the U.S. funding cuts and actions against South Africa. The loss of these investments highlights just how counterproductive the cuts to PrEP programs are: an extraordinary amount of U.S. foreign aid is being wasted.

At the precise moment that this platform could have been used to expand access to injectable PrEP, the U.S. government canceled all DREAMS funding and restricted PrEP funding to services for pregnant and breastfeeding women only.[53] Adolescent girls and young women face exacerbated HIV risk due to poverty and limited education opportunities, as well as the loss of mentorship, youth-friendly health services, and support resources for remaining in school and starting businesses. Overnight, a prevention platform constructed over years of community presence was severely damaged and, in some places, destroyed.

While the Trump administration has committed to continued provision of antiretrovirals for people living with HIV, it has drastically redefined its investments in primary prevention, abandoning evidence-based approaches and epidemiological evidence for a narrower, more ideologically driven scope of activities.[54] As a result, the U.S. government has withdrawn support from a service provision platform in which it had invested hundreds of millions of dollars, despite its essential role in reaching those at highest risk of new infections and preventing the spread of HIV, including through the use of new U.S.-funded innovations.

Snatching Defeat from the Jaws of Victory: The United States, Lenacapavir, and South Africa

Lenacapavir is an injectable antiretroviral that can be used, in combination with other medications, as a treatment for people living with HIV. Two lenacapavir injections per year also eliminated the risk of HIV among cisgender women at risk of HIV through sexual exposure in a landmark trial that led to the approval of lenacapavir for pre-exposure prophylaxis (PrEP). South Africa's young prevention advocates, educators, and PrEP users were laying the groundwork for lenacapavir to be added to PrEP programs as an additional option. Offering injectable PrEP alongside oral and vaginal ring options replicates the "method mix" approach used in family planning programs, where evidence shows that offering users a range of options increases the use of all options.[55]

No Relief in Sight: South Africa and the Trump Administration's America First Global Health Strategy

In September 2025, the U.S. Department of State published its America First Global Health Strategy, ushering in a new approach to U.S. foreign aid for global health centered on advancing American economic and security interests, and securing co-investments for funded countries in the health areas covered by the strategy including, HIV, malaria, TB, polio, and global health security.[56] The strategy was introduced nine months after a series of seismic shocks to U.S. foreign aid for global health and research, including the NIH cuts previously described, as well as stop-work orders, the shuttering of USAID, the issuance of a waiver for a limited set of PEPFAR activities that eliminated PrEP for all populations except pregnant and breastfeeding women, and the issuance of executive orders that undermine women's bodily autonomy and transgender identity.[57]

As of mid-April, the United States has signed upwards of 25 Memoranda of Understanding under the America Global Health Strategy, with the aim of providing additional funding for specified health programs to selected countries. The United States and co-signatory countries have largely withheld these agreements from public view. However analysis of those that are circulating, and of the memorandum template, shows that the United States has retreated from its historic focus on data-driven, evidence-based programming. There is no mention of PrEP or primary prevention for any population other than pregnant and breastfeeding women; the process and outcome metrics by which performance will be assessed are objectively difficult to measure or tie to impact, and members of impacted communities including people living with and at highest risk of HIV have been excluded from the planning processes. These agreements are also part of highly transactional and extractive negotiations for access to health data and genomic specimens (stipulated under annexes to the Memoranda) and to critical minerals and rare earths, which have not to date been included in signed MoUs, but which are central to ongoing controversies in Zambia and Zimbabwe[58] [59]

As problematic as these MoUs are, they are also the vehicle by which countries can continue to obtain U.S. resources for health programs after the end of the period covered by 'Bridge Plan' funding. This period began as an initial six-month interval on October 1, 2025; as delays for MoU implementation piled up, the period was extended through June 2026. South Africa received Bridge Plan funding for the initial 6-month period, and

has permission to continue programs through the end of June. It has not to date negotiated or entered into discussions about an MOU. While no definitive decision has been made, it appears possible, if not highly likely, that the Trump administration will cease to fund health programs and research in South Africa at the end of this fiscal year, as a direct result of its baseless accusations of white genocide and the collapse of cooperative diplomatic relations.

The America First Global Health Strategy aims to reduce the perceived inefficiencies and waste in foreign assistance through mechanisms like the bilateral health agreements.[60] However, the abrupt cuts to global health aid themselves have created inefficiencies and risk waste, fraud, and abuse, directly contradicting the strategy's stated objectives. Disruptions and reductions in aid jeopardize decades of U.S. investment in HIV prevention and response infrastructure. Primary prevention initiatives and clinical trials and the broader research ecosystem, which were established in South Africa over many years through billions of dollars in funding, are particularly vulnerable. These cuts not only weaken the resilience and durability of local health systems but also dismantle the critical clinical research pipeline in South Africa on which the United States has relied for innovations in treatment, prevention, and disease management. The disruption of these programs threatens both ongoing research and the capacity to generate new scientific knowledge, undermining the long-term effectiveness of U.S. foreign assistance, U.S. national security, and the global fight against HIV.

Methodology

This report is based on data collected as part of an oral history project developed by a multidisciplinary team of researchers with expertise in human rights, public health, implementation of PEPFAR projects, HIV/AIDS, and qualitative data, including oral history methodology. In September 2025, an expert in global health, HIV/AIDS, and PEPFAR, with regional expertise and oral history training, conducted interviews in South Africa to document the lived experiences of individuals impacted by the transitions in foreign aid, particularly U.S. government funding for HIV/AIDS services, that began in January 2025. All narrators were recontacted in March 2026 to validate quotes and provide updates.

Following oral history ethics, study participants were given explicit control over how their personal information would be linked to their stories. A tiered release form, adapted with input from oral history experts, was completed by each study participant. This approach allowed respondents to specify which types of personal information could be publicly shared, and a separate demographic information form was used to capture biographical information about study participants.

Before each interview, the interviewer and a local collaborator explained the purpose of the project and participants' rights to control what personal details are shared publicly. At minimum, respondents agreed to share their role and the region where they live (for example, "a nurse from South Africa"). Depending on the respondent's preference, the release and demographic forms were completed before or after the interview, specifying their selections for identifying information that could be associated with their narratives, including transcripts, recordings and excerpted quotations. The interviewer collected data from 20 oral history interviews, with 40 participants from Cape Town, Khayelitsha Township, Phillipi Township, Midrand, and Johannesburg. Participants included doctors, nurses, clinical officers, peer counselors, peer navigators, people living with HIV, young people, transgender men and women, men who have sex with men, and government health workers. To select people for interviews, the study team worked with local collaborators from two South African organizations and a public health expert who previously worked on USAID-funded projects to identify narrators with diverse touchpoints to and experience with the foreign aid transitions in South Africa.

The study team worked with Advocates for the Prevention of HIV and AIDS (APHA) and Emthonjeni Counseling & Training to identify people who have experience at the front lines of the foreign aid transitions for oral history interviews. Interviews were conducted in-person in English. All interviews were recorded, transcribed, and reviewed for accuracy. Each interview or group discussion was audio-recorded and uploaded to a secure shared folder. Audio files were then transcribed, edited, and cross-checked by the research team to produce finished transcripts, which were also stored in a secure shared folder. The study team conducted thematic analysis using both inductive and deductive coding. Initial themes emerged during interviews and were refined during team review. Codes were organized into a theme table of excerpts and discussed in data preview meetings, where thematic groupings were further refined based on team feedback. This study received an exemption from PHR's Ethics Review Board as part of a broader project to document the impacts of the disruption to foreign aid.

Findings

The following section shares narrators' experiences in the aftermath of the funding cuts. Their stories illustrate severe impacts (i) in the community, (ii) at the clinic, (iii) in capacities to track and detect surges in new infections or disengagement from care, and (iv) in a skilled workforce on the front lines of a unique research infrastructure. Together, these impacts have already caused psychological and physical harm to individuals as well as structural harm to health systems and prevention platforms. They are also a significant waste of billions of U.S. dollars in prevention, treatment, and research platforms, components of which may never be restored.

A. In the Community: Diminished Community-based Testing and Programming for Primary Preventive Health Care

"If we do not take care of our health, we will be forced to take care of our illness."

Participants in this study described a significant reduction in the availability of community-based testing and services, and a substantial increase in wait times at clinic facilities.

An HIV diagnosis is the entry point for effective services. People who are HIV positive should be linked to antiretroviral treatment and other services; those who are HIV negative but at risk of acquiring the virus should be linked to comprehensive HIV prevention, including PrEP.

Structural barriers such as long wait times, travel costs, and lost income associated with obtaining an HIV test at a clinic may reduce testing uptake if convenient, community-based services are no longer available.

In South Africa, as in many PEPFAR-supported countries, U.S. government investments supported nurses, counselors, peer educators, and data entry clerks who worked alongside government-employed counterparts at government-run facilities. As a government-employed counselor explained, the loss of U.S.-supported HIV-centered personnel leaves remaining staff facing impossible choices about which services to provide – and where.

> "The biggest change for me: as I have mentioned that most people don't like to go sit in the facilities. So my job is to go where the people are. It's for me to go to outreaches, you know, go into immunization, outreaches, have professional nurse from the [government health] facility go to the informal settlement [and say] that, 'All the child should come here, we are here, the nurses are here, we're going to give you D-WM [deworming medicine], we're going to give you vitamin A, you know, we're going to catch up with your immunization, nobody's going to shout you, come.' [...] and also to do awareness program, you know, with for young people to know about PrEP, to know when to go and get PrEP, you know, for them to delay sexual relationships, sexual intercourse, you know, use of condoms. So those are the information that we go into in the informal settlement. So for me now, I had less outreaches because there's no staff in the facilities."
> *Cisgender woman living with HIV. government-employed health promotion officer*

Community health workers reported striking changes in the availability of community-based services. One youth HIV prevention educator described the sharp drop in the number of community-based testing tents where people get tested to learn their HIV status, an important first step to link people to care and prevention.

> "[Th]is is where stigma also comes in. So in the clinic, in the social clinic, what happens is that when you want to go for HIV testing, they will send you to the green tent. There's this green tent outside, so you have to go to the green tent to get tested. If you are maybe a mother coming to get…[tested]…, you know, the breastfeeding mothers, you go to the green tent. So that's why I'm saying that I haven't seen the tent in a while. So it means the HIV testing has actually gone down…So right now people don't know if they have sexually transmitted infections, they have no idea if they should go to the clinic to get their treatment on high blood, and some of them don't know their HIV status."
> *Young cisgender woman, HIV prevention educator and advocate*

Another community health worker, a woman living with HIV, described how funding disruptions to South African organizations that distribute medication have undermined efforts to connect people at risk of HIV to PrEP by disrupting mobile clinic services that provide community-based access to this preventive medication.

> "Those that are interested, you know, to get PrEP, we tell them where to get PrEP, and then those are ANOVA trucks would stand, you know, in those communities, you know, with their trucks, with fridges, with everything, where they would like give medication, they know that only Wednesday, ANOVA truck is coming, and then we'll get our PrEP, my dose of PrEP, you know, they would like take the bloods and everything. So basically, that is no more. There's no more ANOVA trucks."
> *Cisgender woman, government-employed health promotion officer*

With community-based services, such as mobile clinics, being shut down, people living with HIV or at risk of HIV are forced to seek care and prevention in medical facilities and static clinics that may require travel and time to reach, rather than through more easily accessible community-based services. A youth HIV prevention educator described the impact of this shift in where people can access services:

> "The only way to get tested for HIV now is to go inside the clinic and test. Whereas we had people that were working in the streets for the community doing just HIV testing. You didn't need to go to the clinic, you didn't need to wait in long queues. You just went in the tent and said, 'I'm here for HIV testing.' You get tested, if you're positive, they link you to care. It's no waiting, no... It gave dignity, in a sense. Now you need to imagine now, someone is going to have to wait for them to really get sick, so that they can say, 'No man, I'm really sick, I need to go to the clinic.'"
> *Young cisgender woman, HIV prevention advocate and educator*

Community health workers and educators have been deeply impacted by the cuts. One community health educator described loss of community health workers who provide sensitive, patient-centered care that is both accessible and acceptable to those they serve.

> "Because most men believe SRHR [sexual and reproductive health and rights]is for women because they are the ones who predominantly access services and clinics. Most men don't go to clinics. They don't even test for HIV [...]. I've proven that. So it's inculcated in our [men's] minds: these are women's services. [...] Men don't even use those things. So I had a huge job..."

> "The cessation of funds when it comes to HIV programs, we are looking at drastic changes. Not only in unemployment, but in an increment of the significant number of young people who are affected. They will no longer have the convenience of accessing SRHR [sexual and reproductive health] services….It's a lot, that's been affected. It's a lot, it's a lot. But no one is taking that into consideration. Everyone is saying we should be independent, let's be resourceful on our own. It's really not about that, at this point. Because we are now moving to a point where if we do not take care of our health, we will be forced to take care of our illness."
> *Young cisgender male community health educator and activist who lost his role as a mobile health worker providing HIV testing, PrEP, and sexutally transmitted infection information for men*

The abrupt end to global health funding caused confusion in the community about what services were available. One former PrEP counselor who worked with the CDC and PEPFAR-supported DREAMS program told PHR about clients who no longer knew that they could access PrEP at health facilities after the program ended:

> "I recently went for my PrEP stock up recently. Now I posted about PrEP and tagged and another one [former mentee from DREAMS] texted me and said, 'Oh PrEP, is it still available at the clinics?' And I said, 'Yes, haven't you been taking your PrEP?' [She replied] 'After you stopped working at the clinic, after I've stopped seeing you and after what I heard in the news, I thought that PrEP is no longer there.'"
> *Cisgender woman, HIV prevention activist, and youth ambassador from PEPFAR-supported DREAMS program*

Children living with HIV were also impacted as community-based services that provided food parcels, counseling and support with the challenges of taking medication, disclosing HIV status and orphanhood lost funding.

> "I met [K.] when she was very young. So she grew in front of me. I introduced her to the program when, I think it was 2015, 2017, when she lost her mum. So I introduced her to the program. So we've been together until the 27th of January this year, when everything was cut. So I remember the time I told her, '[K] Mommy doesn't have a job anymore now.' 'What do you mean, mom? [K asked] 'You know what Trump did, what Trump said. 'Okay? So how are we going to live?' [K asked] 'Are we going to get food parcels at [organization name omitted] Are we going to get vouchers? Need everything stop? What about you, mama? How are you going to sustain yourself? You have four boys.'"
> *Cisgender woman, formerly employed at organization serving children living with HIV. At the time of this interview, the organization was unable to provide all children in need with monthly food parcels as it had in the past.*

For young people entering adolescence, access to information about sexual and reproductive health and HIV prevention is essential. However cuts to U.S. assistance for HIV prevention and research programs have reduced the options for South Africans to access HIV prevention information. A young woman who worked on HIV prevention education as part of a research program recounted how the loss of HIV prevention education in her marginalized community has left at-risk adolescent girls and young women with few avenues to understand the options to prevent HIV and how to connect with research studies to try new prevention and treatment options.

B. In the Clinic: Diminished Quality of Clinic-Based Primary Prevention and Treatment Services

PrEP, like antiretroviral therapy, is available in government-funded health facilities and in programs run by local organizations with independent funding sources. However, participants in this study described extended wait times, over-burdened staff, abandonment of standard protocols for HIV testing, PrEP provision and treatment, and other shifts in the affordability, accessibility, acceptability, and quality of clinic-based PrEP and antiretroviral therapy. Many participants also noted that the cuts had impacted the quality of non-HIV health services, with longer wait times, reduced community outreach to provide blood pressure testing, body mass index and diabetes counseling, immunizations and other routine preventive medicine. The withdrawal of HIV funding has therefore impacted both crucial HIV programs and the broader health system. These impacts may be particularly acute for people in need of preventive services, including PrEP. People experiencing symptoms and requiring medication may tolerate these structural barriers in order to obtain lifesaving treatment, but people who need primary prevention and preventive health care may be less likely to access services if faced with barriers.[61 62]

In a study of PrEP use among adolescent girls, ease of access, youth-friendly counseling services, and peer support were all associated with PrEP continuation for six months or longer.[63 64] Adolescents and young people who require youth-friendly services with hours compatible with school attendance also experience unique barriers in accessing PrEP at clinics that no longer have tailored services.[65] A meta-analysis of 988 studies examining patterns of PrEP use show that one in four people who discontinue PrEP restart it, with knowledge of a partner's HIV status and the removal of access barriers influencing the decision to resume.[66] At the point that PrEP services were disrupted in South Africa and other countries where PEPFAR was supporting programs in 2025, the optimal design of programs to support initiation and restarting was still underway. While not yet perfected, PrEP programs were invaluable for last mile prevention among those at highest risk.[67] U.S. government investments had built a platform for reaching those at highest risk of HIV infection, one that was primed for adapting to new information about user preferences and incorporating new innovations. Respondents including health workers, PrEP users, and prevention advocates shared lived experiences with the destruction of a platform needed to deliver effective primary prevention.

A HIV counselor in a South African informal settlement. Supporting people living with HIV and tuberculosis to start and stay on treatment is key for individual health and public health impact. Salaries for many of these critical roles were supported by the U.S. government, but funding cuts have led to mass layoffs and reduced services. Photo: Emthonjeni Counseling and Training

Prior to foreign aid disruptions, U.S. investments had supported peer-based education in HIV prevention, including PrEP options, that raised awareness and demand among adolescent girls and young women, who are at disproportionate risk of HIV. One PEPFAR-funded organization lost all of its support for PrEP as it was assembling a proposal for program expansion.

> "I think we've initiated 35,000 people on the PrEP. We were very hopeful, you know, that we would get another five years of funding. But unfortunately, because of the prioritizations now in the new administration, that NOFO [Notice of Funding Opportunity] was recalled. And that program is closing down. And so, you know, there are hundreds of our staff, including mostly youth who we employ as peer educators, ambassadors, you know, learner support agents with these great and intensified economic strengthening programs. So really, you know, behavioral and biomedical and structural HIV prevention interventions for youth, which make a huge difference. And so that is ending."
> *Executive director of PEPFAR-funded organization that retained support for antiretroviral treatment for people living with HIV but lost PrEP support*

One nurse described the impact of the loss of health educators focused on adolescent girls and young women, known as DREAMS ambassadors, on the number of HIV negative young women who come to the clinic for PrEP to prevent HIV.

> "And we also lost the ambassadors because they were employed on the USAID program, where we were pushing young people to initiate PrEP. So now PrEP is on different people now. [...] So our recruitment now on PrEP is slow, because we don't have a dedicated person that is counselling them and is putting them on [preventive] treatment."
> *Government-employed nurse*

The same nurse explained that overstretched staff often deprioritize primary prevention, triaging patients in immediate medical need, such as a severely dehydrated child, over potential PrEP users. While understandable and ethically necessary, this approach leaves people at risk of HIV without access to preventive services.

> "The sister is busy putting the drip on the child and whatever, rehydrating the child. And now there's a person that is sitting there for hours for PrEP and this person is not sick and now is not a priority. The patient leaves, the person is already recruited but now the patient leaves because he's tired of waiting. So we end up not registering [the potential PrEP client]. So our uptake is low and then on continuous visits when they [PrEP users] came with the ambassador, she seated the group and [explained the side effects] to shorten time that [PrEP users spend] with the clinician. Now that does not happen. They come straight to the clinician. So even the uptake, the adherence is not that much. So we are having people that are hopping in and out of the PrEP program."
> *Government nurse, township clinic*

Respondents report changes in the clinic experience for people living with HIV and those seeking HIV prevention services. A former HIV prevention educator and PrEP user described perceptions of shifts in standards of PrEP care and daylong waits to access PrEP.

> "So I went in there, so I told her [the nurse] that I wanted to return to my PrEP, and I asked her, 'Why now there's no counselors? [...] Why are the processes not the same?' And then she's like, 'Sis we have a lot of work here. We only test you when you ask, as now you are asking me to test you. If you did not ask, then I was not going to test you.' And then she tested me. Then I had to – because I have worked there as an HIV counselor – I know the process. I'm like, 'Can you also do me a ELISA?'[68] I see she's trying to skip the steps, because she wants to fast the process. I'm like, 'It's been long, and I'm thinking that maybe I've been exposed.' So which process that I'm supposed to... I'm trying to engage with her, should I take PEP [post-exposure prophylaxis] first, because I think maybe, you see, I wanted to check why they are not doing the work that they're supposed to do. I was not trying to challenge her, but I was trying to show them that, 'Do you guys see the need of this, because these steps that we are skipping, there are people who really were exposed last night, and then they are getting at the clinic. You are not testing them. You are not taking the blood. And you are not providing them proper information, as well, because of the workload. You just give them the PrEP. What if this person was exposed? PrEP is not going to stop [infection], because she's supposed to take PEP first, and then after that, so I was trying to show her, 'Do you see the carelessness and the risks that people that are in?' I arrived at 7 o'clock. The gate is opening at half past 7. But I was there at 7 o'clock. I remember that there I was the first person to be at the clinic. But I was there at 7 up until I think I went home around 4. The whole day I was there. And I was expecting that."
> *Cisgender woman, former HIV and AIDS counselor and youth ambassador, PrEP user*

Clinic staff supported by PEPFAR resources played roles that over-taxed health workers simply cannot fill, and that the South African National Department of Health has not consistently replaced.

> "I was doing health talks about HIV and TB. And also I was doing HIV tests. And also I was working as a club facilitator. And then I was also doing adherence [clubs] for newly-diagnosed [people] for both HIV and TB."
> *Cisgender woman, formerly employed by USAID-supported program. She had conducted four forty-person adherence clubs a day.*

Increases in wait times were reported by multiple health workers. Many respondents tied the wait times to excessive demands on facilities that both lost workforce after the U.S. aid transitions and absorbed additional clients from clinics shuttered by aid cuts. Respondents report that clinics are staffed by overburdened health workers who are struggling to cope with the massive influx of patients. One woman living with HIV speculated that this strain could drive health care workers to leave the country. Even more concerning, she compared current conditions in clinics to 2003, when South Africa's HIV epidemic was at a far more critical stage.

> "As much as we're pushing, go back to facilities, but they're not coping. We find a nurse dealing with everything. Do child's health, do women's health, do everything. […] They say, 'Yho, I can imagine what's going on. You don't want to know. We don't even have time to take lunch.' So it's overburdened to them. We're going to lose them. They're going to leave the country for somewhere else. So what's going to happen? People are going to die. Hence I was saying, this thing reminds me in 2003, when we were tested to say, 'Go and wait for a dying.' People are dying as we speak, as we're sitting here. We lost our life. We lost our life because of poverty, unemployment. You see now, we're unemployed. We can't eat healthy. We can't even take the treatment."
> *Cisgender woman living with HIV, activist*

One woman living with HIV and activist, whose work in community-led monitoring of health services lost PEPFAR funding, described how the cuts have affected HIV counseling, with many people now being lost to follow-up for care.

> "One of the crises that we were monitoring, as the sector was the HIV counseling. People were coming to the facilities very sick in 2025. When you test a person in 2025, HIV is still a taboo. People are still crying. People need counseling. We are not doing well in TB [tuberculosis]. We are not doing well when things are normal. It's worse now. Defaulting, of which now they are using a big word of treatment disengagement. They always encounter these names, and when you start understanding this defaulting, they will come and say, 'No, people are disengaged from care.' And I was like, Aybo, I mean, defaulting is defaulting. And when you look at the challenges that people are facing, it's huge, and it makes them want to take responsibility. But we are not there as the government."
> *Woman living with HIV and activist*

A former counselor employed by a USAID-funded project described her role, and the clients who are defaulting from care.

> "Now I [used to] have a relationship with other patients. Because it's not easy for them to accept that they are HIV positive. So when you counse them, you give them comfort. […] Sometimes the nurses, the ART [antiretroviral therapy] nurses, they are rude. So they [PLHIV] come to you and then you have to speak with them so that they cannot be mistreated. […] So some of them they defaulted because they say 'No, I can't go to there back.' Because the treatment is not the way they like."
> *Cisgender woman, formerly employed as an HIV counselor.*

Many participants described rapid response efforts they had mobilized or from which they received support. These rapid response efforts were designed to provide clients at clinics that would be closing, due to funding cuts, with referral letters for obtaining services at other facilities. Participants described the psychological and structural barriers to making these shifts. One transgender woman described being a peer educator at a clinic serving trans people that closed and then obtained reduced funding for former staff, including themself, to provide peer services at a general government facility. They described how the clinic provided clients with three months of antiretroviral therapy or PrEP, but when those supplies ran out, many clients chose to wait for the clinic to reopen rather than going to a new facility:

"[W]hen we started now, again, when we talked to our patients, mostly would say, no, I didn't go to that clinic. They just had to wait [for us to reopen] and they'd say, no, I didn't go there. I didn't want to go there. But for the ones that are taking ART, they were buying over the counter, which is a lot. They were buying. It's an arm and a leg. Yes. Some of them would be sharing with friends."
Transgender woman, linkage officer at a transgender clinic, describing how her clients opted to go without medication when their clinic was closed. In this instance, key staff were able to resume limited services at a local government clinic, and the clients returned.

The reduction in funding for services for key populations has forced people at heightened risk of HIV, including men who have sex with men and sex workers, to seek care in clinics that are not tailored to their unique needs. One bisexual man living with HIV described how government health services remain unadapted for key populations, driving him to use clinics for the general population after the closure of a clinic that served gay and transgender people. At the time his oral history was collected, he had not taken his medication for three weeks due to the stigma he experienced at government clinics.

"It's been probably about three weeks or more now that I ...haven't taken meds. And I know how stupid it is on the one hand. [...] The government, also have been doing…but they can't do everything, they [government health workers] have limited the resources in their jobs, so they don't understand, but yeah, so it's important that places like the Men's Health Clinic open again. [...] I mean, you go to the hospital, I'm thankful for the free medication when I do need it, whatever, but people just, they're too busy to look you in the eye, there's too many hundreds of [clients] .... and you can't blame them, they don't have time to have a, you know, no, no, that's like the next one, you know, and when you go to a place like Ivan Toms, where everybody's sort of, you know, everybody, and you can ask them anything..."
Bisexual cisgender man living with HIV, who received medication from a men's clinic providing tailored services to gay and transgender people that closed in January 2025.[69] After his last refill ran out, he did not go to the government facility to get another one.

Multiple members of marginalized populations reported feeling unease and discrimination when seeking services at government clinics after the closure of facilities specialized in serving key populations due to funding cuts. One advocate described similar experiences, recounting how people referred from a closed clinic, known among health care workers for serving sex workers, faced stigma at government facilities.

"W]hen I went eventually to the clinic, the public facility, now with that referral letter, the person who treated me said, 'Where do you guys get this referral letter? Are you guys different from everyone else?' And then I felt the stigma rising because that particular clinic is known that it services sex workers, and it's a sex worker friendly clinic. So he said to me, 'So all you people that went there are actually sex workers.'"
Cisgender woman sex worker and advocate

At the time that these interviews were being conducted, populist, nationalist, and anti-immigration groups, known as Operation Dudula, attempted to block non-South African citizens from accessing publicly funded medical care, demanding identification and preventing anyone unable to prove South African citizenship from entering public medical facilities where free medical services were available.[70] Some non-South African citizen

"It's been probably about three weeks or more now that I... haven't taken meds."

-Bisexual cisgender man living with HIV, who received medication from a men's clinic providing tailored services to gay and transgender people that closed in January 2025.

participants who had previously accessed care at PEPFAR-supported clinics experienced this persecution when seeking continued treatment at government facilities. A Zimbabwean sex worker described how she and her mother now obtained antiretrovirals from Zimbabwe, paying for their delivery by bus.

> "We couldn't get the medication due to the Dudula issue. So when we got to the clinic, we were not allowed to access the clinic because they were saying only South Africans [were allowed to have] the medication. So from that time until today, we're getting our medication from Zimbabwe. We have to pay a lot of money for us to get that medication."
> *Cisgender woman sex worker, Zimbabwean passport holder*

Researchers, private sector, civil society and government partners from the United States and South Africa played a crucial role in the pivotal trial of lenacapavir and in the development of a grassroots, community-based and-led HIV prevention platform that provided services, information and advocacy. This platform was primed and ready for the introduction of lenacapavir, which many hoped would boost uptake of all PrEP and help drive down persistently high rates of HIV infection among South African adolescent girls and young women and older women, as well as key populations. The collapse of community-based prevention services and resources for community-led activities came at the precise moment that many participants in this study were preparing for lenacapavir and its game-changing potential.

> "So now fortunately, [it is] very exciting to have lenacapavir on the scene, which is instead of every two months, every six months injections, and through Global Fund, there is a procurement of lenacapavir. So, it's just sad that the systems that we'd set up for youth to be able to access LEN are kind of being dismantled or being handed over to government that hopefully will be sustained to some extent by government."
> *Executive Director of program funded by PEPFAR through CDC*

Fear that lenacapavir's promise to transform HIV prevention may be undermined is also felt in the community. One HIV prevention advocate and educator expressed concern that the damage to the health system from the funding cuts may prevent it from meeting the demand for lenacapavir.

> "Oh my goodness. I genuinely hope that LEN [lenacapavir] is just accelerated in all possible ways, because we need it as young people. You know, we do need it. And I feel like young people don't get the theatrics around the whole funds, the access, they just want to get it in their hands. But now I'm scared that it's not going to be accessible widely to everyone. It's going to be in a particular clinic somewhere. It's going to be, Oh, you're going to arrive. There's only like 150 [doses]. It's finished. It's going to come back in the next two months. You know? And another thing about young people is that they don't like inconvenience. So can you imagine now going to a clinic? You've heard that your friend has LEN. And then you actually now want to also go and get LEN. And then you get that they don't have LEN. Do you think they're going to come back? Of course they're not, because LEN wasn't there the other day."
> *Young cisgender woman, HIV prevention advocate and educator*

"...it's just sad that the systems that we'd set up for youth to be able to access...[lenacapavir]...are kind of being dismantled or being handed over to government that hopefully will be sustained to some extent by government."

CDC-funded executive director

C. In the Dark: Diminished Availability of Timely, Actionable Data

Effective public health programs depend on timely, accurate, evidence-based, and actionable data. In the context of HIV, this includes data on the number of new HIV diagnoses in a given population over a period of time (incidence), the percentage of people returning for their refills of antiretroviral therapy or PrEP, the percentage of people on antiretroviral therapy who are virologically suppressed, and the percentage of people on antiretroviral therapy who have disengaged from care. These data can be used to trigger targeted problem-solving actions, from a home visit to a client who has missed a refill, to tailored engagements with communities where there are high rates of new infections. Data can support allocation of scarce resources and it can yield warning signs when programs are not performing. In this study, participants described data-entry backlogs related to U.S. foreign aid cuts that meant clinic staff had little real-time information about key metrics of HIV program success. They did not know whether clients recorded as "disengaged" – meaning they had missed a refill appointment – had in fact come for their refill, without that visit being logged in the system that generates usable data reports. Taken together, disrupted community-based services, diminished quality of facility-based primary prevention, and degraded timeliness and quality of data create conditions in which surges of new HIV infections could occur without awareness and action by public health stakeholders including health workers, impacted communities, and leadership at local, subnational, and national levels.

Government health workers described data systems that are "falling apart" – with major backlogs of data entry and extended clinic wait times as overstretched triage staff struggle to locate client files.

> "It's a struggle. Even the [data] capturing is falling apart. Because in order for us to know exactly how many people were HIV positive in this month, this must be captured. It should be in the system. The system is [supposed to be] telling us that from January to March these are the people that are tested positive. These are the people that were initiated on ARVs. These are the people that were started on their TB treatment, you know. So if there are no hands to assist us in that [data collection] and then the staff is burned out, they take leaves, they get sick you know. They are not coping. It's really bad. […] You find that people don't get their folders… No one [in the pharmacy] would care for the backlog of folders, maybe about 50 to 60 folders that didn't get medication because [according to the pharmacists], 'my time [at work] is half past seven til four o'clock.'"
> *Government-employed health promotion officer*

One nurse described the impact of the loss of health workers who supported "fast track" refills for people with HIV on antiretrovirals, and "handshakes" that welcomed back people with HIV who had disengaged from treatment and returned to care. In the absence of this workforce, overloaded clinic staff cannot keep up with whether newly diagnosed people have started antiretroviral therapy or not.

> "What we would do on weekly basis we would work on people that missed their appointments. So then [when they returned] we were calling it a handshake technique, where the person [the health worker supporting PLHIV returning to care] would go with the folder and the patient to the clinician directly. And the patient would be assisted immediately. But now they must wait around with the other patients, because now they are no longer that special or a priority. … a newly diagnosed … USAID-funded person [is triaged] immediately when the person is tested positive would walk the patient and do the handshake and the patient will be initiated simply. Now we sometimes have a gap where we must check now, where is that person that tested positive last week is the patient initiated or not? So previously, from the pharmacy, we would have a different box. So we'll have general folders for the facility, everyone who is not HIV positive would be kept on one side, and everyone that is HIV positive would be kept on one side. So the data capturers would take those folders and capture them immediately. Because we want to make sure that we don't have patients that are not appearing as lost to follow up while they came. So what is happening now, we have long lists of lost to follow up, because they go with the flow of every patient that enters the facility. For instance here, we see over 350 patients per day. So all those folders now are in one batch. So it takes

time now. So we will have the coordinators calling us that you have this number of disengaged patients, only to find out those patients are not disengaged, they are here."
Cisgender woman, government-employed nurse

A data quality officer responsible for district-wide performance described the impact of the data entry backlog on tracking people with HIV who have disengaged from care. One participant described concerns about the dynamics of HIV viral load, the amount of virus in the blood, among people living with HIV taking antiretroviral combinations that include dolutegravir (DTG), and HIV integrase inhibitor which is now the first-line recommended regimen. She noted that people who stop treatment often have a rapid rise in viral load. When viral load increases, an individual's health is at risk and the potential for transmitting the virus is higher.

"The way I see it, it's for me. I'm waiting for a big bomb to blow on our face at any time. Because people, the truth is people are not taking the treatment. And because we can't see that they're not taking it. And even when they come, we don't have time for them because we are overwhelmed. I'm here today for a meeting to look at why is this clinic not seeing the [same] number of patients."
Cisgender woman, government-employed data quality officer

PEPFAR also supported government units responsible for health information systems. One PEPFAR-funded executive director described delays and challenges in accessing official data, noting that information is now being shared through informal channels.

"[G]overnment controls the health information system. And I think that the PEPFAR support for the unit that does that was interrupted. And so now the government, the availability of the government data on HIV has decreased. So, and there are long delays in accessing the information. And that's difficult for us because we depend on that to report. But we're able to, I mean, of course, any data that we submit, we have all of our own data that's visible to us. And CDC does have, you know, partner meetings where they share data from all of the partners. But I guess, yeah, so it's, it's, it's not, we don't feel blacked out. We feel that CDC is updating us as they can. But there's challenges with the government health information system."
Executive Director of program funded by PEPFAR through CDC

Even when government units attempted to obtain routine data, disruptions to the programs feeding into those databases meant that some information could not be reported. One sex worker program manager described the immediate impact of the stop-work orders on their ability to submit routine information into databases used to track progress on HIV indicators.

"We didn't hand over properly, officially [speaking about the two-week period after the stop-work order and before programs resumed because of a temporary restraining order on CDC grants]. Who do we talk to? Who do we say, 'We don't exist anymore?' I remember even during that period, I received a phone call from somebody from within the district Department of Health asking about our database to say, oh, we can sort of help you guys. And I was like, but I don't even have any office equipment. I don't have the database that you are looking for. So I can even give you a list of those that are due for their treatment in this current week. I would love to help, but I don't have anything with me. So when we were brought back after the two weeks, priorities had to change. Of course, they had to shift a little bit. They had to prioritize our cohort that was already taking treatment on ART and PrEP as well. You will not believe how many service users within a period of two weeks were affected by the fact that we were not even working. We came to probably 568 that had missed appointments. It was a huge number."
Cisgender woman, Project Manager, CDC PEPFAR-funded program providing services to key populations. (CDC-funded programs paused after a stop work order in January 2025, then resumed, often with major disruptions,)

D. On the Front Lines of Wasted Research Infrastructure

Many participants in this project were frontline health workers with intersecting, complementary roles in supporting the South African research infrastructure. Skilled staff who retained their roles at research institutions reported huge barriers in continuing their work due to the absence, in clinics, of the U.S.-funded health workers who supported clinical trial activities. Those who had lost their roles expressed despair at finding employment in the field for which they had been trained, and were actively seeking roles as house cleaners, restaurant servers, and other jobs in the service sector – an outflux of skilled, experienced research assistants that is yet another instance of wasted investments.

People involved in the HIV response in South Africa report that funding shifts have not only undermined the ability to track the HIV epidemic in South Africa but have also disrupted the ability to conduct research into new treatments, prevention strategies, and innovations to address the HIV crisis in South Africa, and globally. These cuts have also forced specialized, skilled workers to seek employment elsewhere, further weakening the country's capacity to respond to the epidemic.

One research assistant and woman living with HIV described how the funding cuts to research have pushed her, an experienced research assistant, to seek work in other sectors, affecting her career and her ability to support herself as a person living with HIV.

> "I've been working as a research assistant for the past 10 years. So I do not have any other experience for other jobs. So chances for me to receive another job is like quite very, very, very, very slim, very, very, very slim, because now I don't have experience and then even if I can go maybe to a restaurant and ask for a job, which I'm about to do that […]I'm just hoping that maybe they will bear with me, teach me if maybe I will catch up, teach me and then I will also try my best to, because at least I'm a fast learner."
> *Cisgender woman living with HIV, former research assistant*

The same research assistant reflected on her understanding of how workloads had shifted after the closure of the USAID-funded PEPFAR program for which she and others had worked, providing tailored HIV clinical services and supporting clinical trial recruitment.

> "In the study we were doing, I was in to counseling. So and also, yeah, doing a little bit of interviewing, it depends. So yeah, because we no longer working there, we now, we are not part of the study anymore. So then [the research organization] had to take over."
> *Former research assistant and cisgender woman living with HIV*

In a separate interview, a staffer from the research organization in question described her experience of the loss of the research assistant and her colleagues.

> "The worst part is I'm currently recruiting for a study that requires clinic assistants. They are not there, people in the clinics [formerly supported by a USAID-funded PEPFAR implementing partner]. The clinics are in crisis. I felt like as the country, it's an embarrassment that we managed to lose people. I work with many clinics here. The things that I would go and know that they'll be there, data capturer, there will [be a] counselor, I will be able to interact with this person and that person, they are not here. The clinic staff are overwhelmed because they are now doing things that they never used to do they need to catch up at the backlog and then you go to the people who are administering medicines in different places. It's much of a backlog and the community does not understand the crisis that we are in. That's the worst part in my life. People are complaining about waiting in the long time. They are not there to make the process go. It's a sad story. I wish I could wake up seeing it go."
> *Research organization staff member*

Research sites supported staff who provided education and information to young people about current and future HIV prevention strategies. Funding cuts for research grants brought this education to a halt—even though the young people were eager to continue receiving the information.

> "[The young women] would call and say they are coming even if there's no sessions. We don't really have sessions anymore. […] Listen, I don't know what to do. There are girls who are here and they want to learn. But we don't have the resources to do anything. […] We [used to] usually educate young girls about the choices that they have, the HIV prevention choices, your ring, your PrEP, yeah, and the studies that are in the pipeline. […] We educated them that they do have choices. If one prevention doesn't work for you, you can try another. […] We live in a very marginalized community. Many people are very young women who are very uneducated about prevention methods. So there's huge stigma surrounding prevention methods. So we've tried very hard to destigmatize. And young women who had a safe space to say, 'I want to take my prevention,' […] or to speak about their sexual health – now all of that is gone."
> *Young cisgender woman, formerly providing HIV prevention education as part of a research project*

Legal and Policy Analysis

The impact of U.S. funding cuts on HIV service delivery in South Africa, compounded by a concurrent failure to collect and maintain data needed to monitor and track the implementation and impacts of PEPFAR, has not only disrupted HIV treatment and prevention – devastating the country's healthcare system and harming key populations – but has also endangered lives across the globe. Populations in the United States and elsewhere benefit from deep investments in and collaborations with South African researchers who uncover critical data to strengthen the global HIV response and, in turn, U.S. and global health security. Taken together, these harms to HIV treatment, prevention, and research infrastructure constitute violations of legal obligations and policy commitments by the governments of the United States and South Africa and necessitate action by these governments and the international community.

U.S. Legal and Policy Framework

U.S. federal agencies administering health policy and foreign assistance are subject to statutory requirements to incorporate evidence, ensure transparency, and support accountability in decision-making. These statutory frameworks establish how appropriated funds must be used, how data should be reported, and how programs should be evaluated, operating alongside longstanding U.S. commitments to national security and, where applicable, human rights objectives.

U.S. foreign assistance programs, including PEPFAR, are discretionary and subject to congressional appropriations. However, once Congress appropriates funds, federal agencies are legally required to obligate and expend those funds in accordance with congressional purposes and conditions, unless they follow the procedures outlined in the Impoundment Control Act.[71][72][73][74] Withholding or delaying the obligation of appropriated funds for policy reasons, without complying with the statutory procedures, may constitute unlawful impoundment.[75][76] This includes the termination of programs that results directly from the improper withholding of appropriated funds.

Congress has also established a statutory framework to ensure oversight of executive branch activities.[77] Within PEPFAR's authorizing legislation, Congress mandates that the administration submit annual reports detailing program outcomes, progress, the impacts of U.S.-funded programming, and funding levels from all sources for each partner country.[78] In addition, Congress routinely uses appropriations language and accompanying explanatory statements requiring the administration to provide updates through reports and briefings on funding and program implementation. For example, in its explanatory statement for FY2026 appropriations, Congress directed the administration to brief the appropriations committee on multilateral and bilateral frameworks for sharing global health data; submit a comprehensive PEPFAR transition strategy assessing the readiness of partner countries' public health systems; and provide copies of the data sharing agreements incorporated into the bilateral memoranda of understanding under the America First Global Health Strategy.[79]

These reporting requirements operate alongside broader statutory frameworks, including the Government Performance and Results Modernization Act of 2010,[80] Foreign Aid Transparency and Accountability Act of 2016,[81] Foundations for Evidence-Based Policymaking Act of 2018,[82] and Freedom of Information Act (FOIA),[83] which collectively seek to ensure the effectiveness of foreign assistance, promote transparency and accountability, and advance evidence-based programming and policymaking through data and information. As mentioned, Congress has already authorized and established specific requirements for agreements under PEPFAR, including baseline standards governing transparency and reporting. While more recent bilateral memoranda of understanding or related agreements negotiated pursuant to the America First Global Health Strategy may extend beyond the scope envisioned in the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003,[84] they do not displace these underlying statutory requirements. At a minimum, these provisions continue to require timely public disclosure, including publication in the Federal Register within 10 days of signature and availability on the Department of State website.

Despite these clear statutory obligations and longstanding practices of transparency, the administration has failed to provide access to data and information. In 2025, it did not submit a required annual PEPFAR report to Congress. And, after decades of consistently releasing PEPFAR data publicly, the administration has withheld key datasets and failed to respond to FOIA requests seeking access to data since 2024.[85][86] These failures undermine

both statutory oversight and the ability of Congress and the public to monitor the implementation and impact of U.S. foreign assistance programs.12 Effective oversight requires appropriate sharing of data with stakeholders beyond the executive branch to accurately document the on-the-ground effects of the aid cuts.[87][88][89] Without such transparency, Congress, implementing agencies, and the public cannot fully assess the impact of funding changes or ensure compliance with statutory obligations.

Data, reported directly to Congress and released publicly, is essential to monitoring the disruptions to global health funding; identifying potential waste, fraud, and abuse; and supporting evidence-based decisions to safeguard long-term investments in health care infrastructure. Restrictions on data access undermine statutory frameworks designed to enable effective congressional oversight, promote transparency and accountability, and ensure programmatic decisions are informed by evidence, as publicly released PEPFAR data sets have informed independent and academic modelling, analysis, and comparative analysis of data. In practice, withholding key datasets or failing to report information as required by law creates blind spots in program oversight, limiting the ability of Congress and agencies to respond to disruptions, prevent waste, and maintain the efficacy of U.S. foreign assistance programs.

The America First Global Health Strategy also frames global health assistance as a means of advancing U.S. bilateral interests by strengthening local health systems and enhancing data systems to monitor outbreaks and health outcomes. However, funding disruptions undermine these objectives, with direct consequences for global health, U.S. public health, and national security. Specifically, reduced service delivery increases the risk of drug-resistant strains, while setbacks in HIV response weaken the capacity to gather essential data on the spread of HIV and other infectious diseases, and prevent and treat HIV both in the United States and globally, further exacerbating these risks.[90]

South African Legal and Policy Framework

The South African Constitution guarantees the right of access to healthcare services and obligates the state to take reasonable measures within its available resources to achieve progressive realization of this right[91]; it further provides that no person may be denied emergency medical treatment.[92] Access to HIV treatment and care has been repeatedly recognized as a core part of this right, imposing corresponding obligations on the South African government. The Treatment Action Campaign case in 2002 is the seminal decision in this area, in which the Constitutional Court held that this right required the South African government to ensure that pregnant women had access to nevirapine, a drug used to prevent mother-to-child transmission of HIV.[93] Subsequent cases have confirmed the government's obligation to ensure access to antiretroviral therapy for incarcerated persons and to take reasonable steps to maintain existing levels of access to healthcare services.[94] Constitutional jurisprudence affirms that the state must take active and reasonable steps to ensure access to essential health services, including planning and implementing protective measures for vulnerable populations,[95] and progressively realize socio-economic rights while ensuring minimum levels of service.[96] Together, this jurisprudence establishes a clear, rights-based, and enforceable obligation on the South African government to sustain its existing HIV programs and HIV response. While U.S. foreign assistance has supplemented national HIV prevention and response programs in South Africa, it does not replace the government's constitutional duty to provide health care.[97][98]

More recently, the Gauteng High Court affirmed that the state must take concrete steps to ensure safe and unhindered access to healthcare for all populations.[99] Courts have held that while resource constraints may justify limitations on specific interventions, the state remains obligated to prevent foreseeable harm and provide equitable access to care.[100] The continued dependence of core HIV and key population programming and other critical elements of health care service delivery on external funding highlights systemic gaps in resource allocation and planning. The sudden reduction of U.S. HIV and key population support through PEPFAR has exposed these gaps, leaving essential services underfunded and key populations particularly vulnerable, illustrating the tangible consequences of limitations affecting the state's efforts to give full effect to its constitutional duties. Despite the state's substantial financial capacity and constitutional anti-discrimination guarantees,[101] key populations face inequitable access to essential health services, underscoring deficiencies in the discharge of constitutional responsibilities.

In the South African context, the national government has historically allocated substantial funding for HIV programs; however, the provincial health departments, responsible under the National Health Act and the Constitution's concurrent health care mandate, have not allocated sufficient resources to ensure these funds reach key populations effectively. Both the National Department of Health and provincial departments share responsibility for service delivery, yet essential programs for people living with HIV, adolescent girls and young women, and men who have sex with men remain heavily dependent on external donor support, including PEPFAR. Reliance on donor funding cannot absolve the state of its constitutional duties.

International and Regional Human Rights Legal Framework

The human rights crisis that has resulted from the abrupt cessation of aid additionally implicates the right to life and the right to health under international human rights law. The right to health comprises four interrelated elements: availability, meaning sufficient functioning health facilities, goods, services, and underlying determinants such as clean water and sanitation; accessibility, ensuring these are available to all without discrimination; acceptability, requiring that they respect medical ethics and are culturally appropriate; and quality, meaning they are scientifically and medically sound and of good standard.[102] The United States, South Africa, and high-income countries each have obligations to help ensure that HIV prevention and treatment services remain available in South Africa, particularly for at-risk populations. The abrupt cuts to foreign aid also touch on other protected rights, including the right to equality and nondiscrimination and rights of women and children.

The United States has ratified the International Covenant on Civil and Political Rights (ICCPR),[103] which codifies the right to life and obligates states to respect, protect, and fulfil this right on a nondiscriminatory basis and ensure its equal enjoyment.[104] [105] The right to life protects against foreseeable and preventable life-terminating harm or injury, including from activities that have a direct and reasonable foreseeability of death.[106]

The United States has additionally signed, but not ratified, the International Covenant on Economic, Social, and Cultural Rights (ICESCR),[107] which codifies the right to health and obligates states to respect, protect, and fulfil this right on a nondiscriminatory basis and ensure its equal enjoyment.[108] Obligations include preventing and treating HIV;[109] providing nondiscriminatory, equal, and timely access to necessary HIV prevention and treatment services;[110] and ensuring accessibility of information to inform HIV response,[111] with attention to the specific needs of vulnerable populations.[112] The United States is obligated under international law not to undermine the object and purpose of the treaty,[113] and obligations arise when U.S. actions have foreseeable effects on treaty rights in other states.[114]

The extent to which U.S. funding supported global HIV prevention and response indicates that aid cuts had a foreseeable impact on both the right to life and health in South Africa, an impact heightened by the lack of notice and resources needed to sustain HIV service delivery and mitigate harm to communities. In addition, the global health aid cuts violated the nondiscrimination and equality guarantees pursuant to both treaties given the disproportionate impact on at-risk communities, including adolescent girls and young women, sex workers, and men who have sex with men.

As for potential avenues for accountability, although no international judicial forum has clear jurisdiction over a state's discretionary decision to reduce or terminate foreign aid, it may nonetheless be possible to pursue the issue through a relatively untested avenue before a UN human rights body, which can review state conduct and issue authoritative, though nonbinding, findings.[115]

The ICESCR further affirms the duty of international economic assistance and cooperation in realizing treaty rights, with a focus on addressing health disparities between countries.[116] The ICESCR thereby underscores the responsibility of states with available resources to economically assist South Africa in meeting its core obligations under the right to health, inclusive of primary HIV prevention services.[117]

South Africa has ratified the ICCPR,[118] which obligates states to protect life and ensure a life with dignity, including addressing life-threatening diseases and ensuring access to essential health services.[119] When disruptions to HIV service delivery and response lead to premature or preventable loss of life, through act or omission, then the right to life is violated.[120] South Africa has additionally signed and ratified the ICESCR.[121] [122] Core obligations of the right to health still must be met during times of resource constraints, and these obligations include nondiscriminatory access to health services for at-risk populations.[123] South Africa is obligated to request international assistance if it does not have available resources to ensure the core obligations of the right to health are met.[124]

South Africa has further obligations to uphold the rights to life and health in the context of HIV interventions under additional regional and international commitments and treaties, as supported by leading principles and guidelines. This includes the Abuja Declaration,[125] the African Charter on Human and Peoples' Rights and its Maputo Protocol,[126] [127] [128] [129] the Convention on the Rights of the Child,[130] [131] [132] and the Convention on the Elimination of All Forms of Discrimination Against Women,[133] [134] [135] [136] each of which South Africa has ratified. These commitments and treaties further enshrine non-discriminatory and equality guarantees that are violated by the disproportionate impact of the devastation of the health care system on at-risk populations.

The situation in South Africa represents an ongoing threat to the enjoyment of human rights, particularly the right to life and the right to health, requiring increased assistance and cooperation to address the deleterious effects of decreased funding on HIV services, including by the United States, South Africa, and other states with resources.

Analysis

Physicians for Human Rights (PHR) and South African collaborators have collected narrative evidence that the Trump administration's actions:

- Wasted hundreds of millions of dollars of investments in primary prevention programs and technologies designed to support large-scale prevention efforts, including the new pre-exposure prophylaxis (PrEP) drug lenacapavir;
- Squandered hundreds of millions of dollars of investments in a unique collaborative research infrastructure including laboratories, data systems, clinical trial platforms, and highly-skilled personnel; and
- Recklessly disregarded the dramatic consequences of failing to maintain funding to reduce new HIV infections among infants, young people, and adults, and preventing unnecessary suffering and death among people living with HIV, ultimately leaving populations worldwide, including in the United States, less secure and more vulnerable to illness.

This report is among the first to address the impacts of transitions in U.S. foreign aid that takes into consideration the Trump administration's America First Global Health Strategy and its stated aim of extending foreign aid for global health, focused on specific health areas including HIV/AIDS, tuberculosis, malaria, maternal child health, polio, and global health security. The impacts identified in this report will not be remediated by the America First Global Health Strategy, which marks a significant departure from historic approaches to evidence-based, data-informed public health programming. Specifically:

- Gaps in primary prevention will not be quantified or filled under the America First Global Health Strategy, which has no process or outcome metrics for PrEP provision or reduction of new infections in high-incidence groups including adolescent girls and young women, and key populations.
- Community-based and -led services will not be resourced or reported under the America First Global Health Strategy, which focuses solely on facility-based services.
- Research collaborations to identify new innovations using established infrastructure are not a part of the America First Global Health Strategy, nor are these partnerships noted, elevated, and valued in signed memoranda of understanding to date, or in U.S.-South Africa diplomatic relations.

This report demonstrates that eliminating crucial funding for prevention, treatment, and research systems has consequences far beyond the dollar amount removed. These findings underscore the urgent need to mobilize investments in prevention and rebuild community-based outreach, HIV research, and data tracking to prevent further damage to South Africa's and the global HIV response. PHR also identified crucial shifts affecting the accessibility, availability, and quality of HIV prevention and treatment services, particularly for key populations, a clear warning sign of backward movement in realizing the right to health:[137]

- *Availability:* Community-based HIV services have been reduced or eliminated, including mobile clinics, outreach programs for key populations, and prevention and care delivered by community health workers, resulting in fewer entry points into the health system;
- *Accessibility:* The loss of mobile and community-based services, combined with reductions in community health workers and longer wait times at clinics, has made HIV prevention and treatment physically and economically harder to access, particularly for marginalized groups;
- *Acceptability:* The closure of tailored, community-based services for key populations has forced many individuals into general health facilities that are not equipped to provide stigma-free, culturally competent care, leading some to delay or avoid treatment altogether; and,
- *Quality:* Reductions in trained staff, including those supporting clinical trials and prevention initiatives, have strained service delivery. Overburdened providers face challenges initiating and maintaining patients on antiretroviral therapy, while weakened data systems undermine continuity of care and limit the ability to monitor outcomes and respond effectively.

Government health workers in South Africa report exhaustion, overload, and data entry backlogs nine months after the U.S. government funding cuts. Photo: Emthonjeni Counseling and Training

This report shows that cuts to assistance for HIV programming by the United States resulted in a significant loss of prevention services, including community health workers, peer navigators, mobile outreach teams, prevention programming for adolescent girls and young women, and linkages to testing and treatment. These prevention programs worked together as part of an ecosystem of care that has helped to make major inroads in the HIV epidemic in South Africa and saved lives. This report documents how removal of a relatively small proportion of funding can have major impacts in the community, in the clinic, and for public health efforts overall when those resources were the majority or entirety of support for crucial components of a program.

Follow-up consultations with participants in this study in March 2026 confirmed that no mitigation had occurred. If anything, the situation felt increasingly unstable both due to South Africa's exclusion from the America First Global Health Strategy and because of a near-complete lack of visibility into the broader implementation of this new Trump administration initiative.

At the time of publication, only five of 24 bilateral memoranda of understanding agreements known to have been signed are in public circulation and only one of those has been formally shared by a co-signatory government.[138] The U.S. government has offered little public information to support assessments of whether the America First Global Health Strategy is meeting its objectives. The U.S. Department of State Bureau of Global Health Security has neither published PEPFAR data for FY2025, nor has it submitted the annual report to Congress on program results, both key mechanisms for ensuring accountability, despite having shared these data regularly in prior years as part of the executive branch's PEPFAR reporting requirements.

The data challenges described in this report reflect a structural human resource crisis triggered by abrupt funding disruptions. Further research is needed to assess the accuracy of data in and functionality South Africa's Three Interlinked Electronic Register (TIER.Net), the national HIV patient database used to track antiretroviral therapy delivery and laboratory results,[139] particularly given the loss of trained data and program staff and the shift to short-term, insufficiently trained support cadres. These disruptions contributed to misfiled records, data entry backlogs, and inaccurate classification of patients as "lost to follow-up," while the sudden cessation of funding undermined the longer-term investments required to recruit, train, and supervise a stable health workforce to maintain data quality and system integrity. Comprehensive information on key public health outcomes – such as number of new HIV infections, percentage of people with HIV on antiretrovirals and virologically suppressed, new initiations of HIV PrEP, and malaria deaths in children under five – are essential for an assessment of impact on quality of life, survival, and health. PEPFAR program data from FY2025 and two quarters of the Bridge Plan are vital sources of information about the impacts of the aid transition and impact of abrupt aid cuts.

At the same time, United States has withdrawn from the World Health Organization (WHO), which risks weakening access to standardized, real time HIV surveillance data, and undermines the collective global disease surveillance frameworks that relay on standardize data reporting, analysis, and accountability, ultimately reducing visibility into epidemiological rends and limiting the data needed for evidence-based decision-making.

The U.S. government's failure to share data does not mean there is an absence of evidence. Non-state actors including PHR, civil society groups, and other crowd-sourced impact trackers have mobilized to shed light on harms, disruptions, and gaps that are hiding in plain sight.[140] [141] [142] Assessments that center the lived experiences of people on the front lines of the foreign aid transitions, as this report does, reveal multidimensional impacts and long-term implications that may not be clearly captured by quantitative data.

Analyses grounded in lived experiences hold crucial insights about how to structure future activities, partnerships, and U.S. global health investments. Available information about the focal areas of these plans can be triangulated with evidence gathered by PHR and other non-state actors to identify areas of urgent, imminent concern. For example, based on available information, the memoranda of understanding have no process metrics related to provision of primary prevention services; no age-, gender-, or population-specific milestones; and no explicit focus on community-based and -led services. The participants in PHR's research across contexts are clear: a world without these evidence-based approaches is a world with needless suffering, new HIV infections, and increased deaths. The lived experiences of those most impacted should be enough to prompt oversight and remedial action.

The amount of funding cut by the United States was approximately $272,764,187 and represented only 17 percent of the annual HIV response budget in South Africa.[143] Despite the amount of the cuts being relatively modest in terms of the percentage of the overall HIV response budget in South Africa, the impact on prevention programs was outsized, with the amount of funding cut representing almost the entirety of the funding for primary prevention. The impact on prevention programs was immediate and wide-ranging. The collapse of primary prevention programs and services and the potential for large increases in new HIV cases in South Africa should not only ring alarm bells in South Africa, but around the world. The South African government currently spends approximately 16.8 percent of the general annual budget on health priorities, a figure that must increase to mitigate against the concerning impacts of the U.S. global health funding cuts. If concerning impacts of the aid cuts are being seen in South Africa, a country with a robust health system, national HIV response program, and relatively wealthy government, the implications in other countries with fewer domestic health resources and less robust health systems could be devastating.

As the world attempts to navigate the reductions in U.S. foreign aid, the central question is not just how much foreign assistance must be made available for global health priorities, but how the funding should be allocated. South Africa's experience in navigating the funding reductions shows the importance of ensuring funds for primary prevention to help curb the HIV epidemic. Treatment as prevention, early diagnosis, differentiated service delivery, community-based outreach, and linkages are evidence-based tools proven to reduce new infections and maintain progress in fighting the HIV epidemic. Eliminating almost all funding for these proven

public health strategies is retrogressive and shifts the burden forward to likely increase future infections, strain treatment ecosystems, and allow national and global HIV targets to slip away.

The loss of routine, updated, and publicly available data on PEPFAR funding's impact and the disruption to systems for local data collection exacerbate an already dire situation. Robust public health surveillance and reporting were a hallmark of the HIV response, ensuring that data drove the response. Without timely data and reporting, policymakers, public health officials, clinicians, researchers, and affected communities lack the information needed to monitor, track, and react to the constantly evolving HIV epidemic – let alone try to understand the impact of the funding cuts. The cuts to U.S. foreign assistance impacted both the government databases meant to track HIV indicators, and the ability of programs to share data, suggesting that even the data that exist may not be complete. Data blackouts obscure whether infections are rising, whether prevention programs are collapsing, and whether hard-fought gains are reversing. Despite congressionally mandated obligations, the Trump administration has missed all deadlines for reporting PEPFAR's FY2025 and Q1 FY2026 Bridge Plan data on its public-facing platforms, keeping the world in the dark about the impact of the administration's abrupt funding cuts on HIV programing.[144] The loss of data is a serious governance issue and should alarm anyone concerned with tracking HIV response and investments to end HIV.

Cuts to funding supporting HIV-related research in South Africa pose significant threats to the pipeline of future studies into new and more effective HIV treatment, prevention, and response strategies. Continued disruptions to funding for HIV-related research risks losing momentum in identifying innovative ways of addressing the HIV epidemic globally if the South African HIV research engine is not adequately supported. Progress in addressing the global HIV epidemic has been driven by evidence- and science-based approaches to successfully connect people to care, treatment, prevention, and information to reduce HIV transmission in many places around the world.[145] Disruptions to research also pose significant ethical challenges for future studies. Researchers will no longer be able to commit to resourcing and completing trials within a defined and appropriate timeframe, so they will risk compromising the trust and ethical protections owed to participants. Given these ethical implications, people may be reluctant to engage as participants in research. The uncertainty around research funding has also threatened investments in human resources, threatening to push experienced researchers, many of whom are people living with HIV themselves, into other sectors due to the cuts to research funding. This not only contributes to an exodus of skilled professionals from the research sector, threatening the ability to staff future studies, but also threatens the care, treatment, and community identity of people living with HIV employed in the research sector whose health depends on income.

The findings presented in this report raise serious concerns about the preservation of over two decades of investment from the United States to end HIV, putting the legacy of PEPFAR, deemed the most successful foreign assistance program in history, at risk. Almost a quarter century of investment in health worker training, prevention and research infrastructure, data systems, non-governmental organizational capacity development, and community outreach programs are now at risk of being lost in South Africa and in other countries where the United States has made significant investments in HIV prevention. The result is an unprecedented waste of American investment in primary prevention and national security risk at a critical moment when the very primary prevention infrastructure, that was the direct result of 22 years of U.S. investment, was in place to scale lenacapavir, a game-changing twice-yearly injection to prevent HIV that could potentially end the HIV epidemic globally.

Conclusion

The global HIV response is at a moment of realignment. As the United States retreats, other governments, multilateral institutions, philanthropic actors, and the private sector must fill the gap not to simply resurrect a system that has been dismantled but rather to help recipient countries by weaning them off donor funds slowly and in a planned manner, to ensure that decades of investment in HIV prevention are not lost. The cuts come at a time when other donor countries have made large cuts to foreign assistance – including France, the United Kingdom, the Netherlands, and Belgium, among others – and multilateral institutions, such as the World Health Organization and other UN bodies, are struggling with funding crises of their own, leaving no natural leader to fill the void created by the retreat of the United States from the global fight against HIV. This crisis represents an opportunity to create new and more equitable, efficient, and integrated global health systems. Governments and stakeholders should move beyond historically unequal aid models and build systems that center national ownership, human rights, and equity in public health and service delivery. .

While this report shows a health system under severe strain, it is not too late to reverse course by restoring and prioritizing prevention funding, while ensuring transparency and public access to routine data about the HIV epidemic, and reaffirming international support for a global HIV response. Swift action now can ensure that new HIV infections are prevented and continue to decrease, people living with HIV know their status, and people living with HIV continue to receive treatment and ensure the next generation is AIDS-free.

Funding cuts for HIV affect access to preventive care. Mobile services offering tuberculosis (TB) screening and health services like hypertension, diabetes, and gender-based violence screening have scaled back or closed. Photo: Emthonjeni Counseling and Training

Recommendations

To the United States Government

- Mobilize, safeguard, and spend funding appropriations for HIV prevention, treatment, primary health care, and collaborative HIV and tuberculosis research, including commitment to comprehensive HIV programming, including biomedical prevention, testing, treatment as prevention, and community-based primary care systems. HIV prevention must be explicitly reinstated as a core pillar of U.S. global health policy, with clear targets and budget allocations.
  - Extend the Bridge Plan through the end of FY2026 at levels commensurate with appropriation and past levels, with options for countries to 'roll off' as memoranda of understanding with aid recipient countries are signed.
  - Ensure that appropriated funds necessary for programmatic implementation still being performed by the Centers for Disease Control and Prevention (CDC) and Department of Defense are transferred with sufficient buffer time and funding for budget reserve and planning.
  - Ensure that shifts in global health policy do not undermine decades of investment, but instead support a responsible, phased transition to sustainable, evidence-based, and country-led HIV and broader public health responses.
  - Ensure that global health engagements and aid agreements with partner countries are grounded in human rights, equity, and mutual accountability, and must not condition, restrict, or leverage funding, data, or access to essential health services in ways that are coercive or extractive and undermine the realization of the right to health
- Reinvest in funding for community health workers, peer educators, health ambassadors, and other community outreach professionals globally who form the backbone of prevention efforts, linkage to care, adherence support, and prevention.
- Ensure sustained, rights-based funding and programming for key populations, including but not limited to adolescent girls and young women, men who have sex with men, sex workers, transgender people, and people who use drugs. Targeted prevention, treatment, and community-led services for these groups are essential to an effective HIV response and must not be deprioritized or defunded.
- Lift the restriction on U.S. federal funding for research in South Africa, including funding through the National Institutes of Health, CDC, PEPFAR, and other funding streams.
- Ensure transparency and data access by publicly releasing disaggregated programmatic and financial data on a regular basis to allow independent monitoring of the real-world impact of funding decisions on HIV prevention and treatment outcomes. Prevention indicators, including coverage of pre-exposure prophylaxis, community-based testing, adolescent girls and young women programming, and community health worker deployment, should be integrated into U.S. global health strategies and publicly reported. Support outcome-based metrics for programming, such as lives saved and reductions in HIV incidence and independent data collection and validation. U.S. monitoring should continue after bilateral agreements expire.

To Other Donor Governments

- Increase funding to address prevention and primary care gaps by urgently increasing bilateral HIV and primary health care support in high-burden countries. Governments should substantially increase funding to the Global Fund to Fight AIDS, Tuberculosis and Malaria to ensure sustained investment in prevention, treatment, and health systems strengthening.
- Collaborate with recipient countries to gradually transition them from reliance on donor funding through carefully planned, phased reductions, ensuring continuity of essential health services and minimizing disruptions to care.To the Government of South Africa and other governments responding to HIV epidemics.

Advocates for the Prevention of HIV in Africa supports its "ground forces" to build HIV prevention literacy in South African communities. This club had to close due to the funding cuts, leaving young people without a mentor and vital health information.
Photo: Advocates for the Prevention of HIV in Africa

To the Government of South Africa and Other Governments Responding to HIV Epidemics

- Prioritize prevention, treatment, and primary care as part of the HIV response in domestic budgets by protecting and expanding domestic financing for prevention, testing, treatment, and community-based primary care, including community health worker programs and programs for key populations.
- Act on warning signs of stress placed on domestic HIV programs by collecting data to understand the full extent of the impact of the funding cuts.
- Reaffirm, fully implement, and surpass the Abuja Declaration commitment to allocate at least 15 percent of national budgets to health and adopt progressive increases beyond 15 percent to reflect current funding realities. Given that the Abuja Declaration was adopted over two decades ago in 2001, the 15 percent benchmark should be treated as a minimum floor rather than a ceiling in light of current health system demands.
- Prioritize ring-fenced funding for HIV prevention, particularly for adolescent girls and young women and key populations, who have been disproportionately affected by recent funding cuts, to prevent the collapse of primary prevention systems.
- Reduce reliance on a single donor by expanding domestic resource mobilization and potential new partnerships, such as private sector co-financing.

- Explicitly fulfill constitutional duties by taking proactive steps to ensure equitable access to essential health services for all populations, particularly key populations, as a matter of constitutional obligation. This includes developing and implementing enforceable plans to maintain uninterrupted HIV prevention, treatment, and care programs at both national and provincial levels.
- Insulate critical programs from external shocks by strengthening the resilience of HIV and key population programs to funding fluctuations, ensuring that essential services are not dependent on external donors like PEPFAR, and that domestic resource allocation protects against future gaps.
- Ensure provincial accountability and oversight by holding provincial health departments accountable for delivering services, ensuring that their resource allocations meet minimum service levels and reflect the progressive realization of the right to health as required under the Constitution.
- Integrate anti-discrimination and equity measures by implementing explicit protections to ensure that marginalized and vulnerable populations (including adolescent girls and young women, men who have sex with men, and sex workers) have unhindered access to prevention, treatment, and care, in line with constitutional anti-discrimination provisions (s. 9) and ethical obligations.
- Monitor and publicly report impact by requiring transparent, regular reporting on access gaps, service disruptions, and health outcomes for key populations to identify failures in progressive realization and guide corrective action.

To the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization, Africa CDC, the African Union, and Other Multilateral Entities

- Ensure that prevention remains a core funding priority, with clear metrics and dedicated budget lines. Invest in community health workers and peer-led models that sustain prevention and treatment outcomes.
- Strengthen global and regional surveillance and reporting systems to document impacts associated with funding disruptions by the United States and other donors, including prevention coverage, treatment interruptions, and health system disruptions.
- Sustain and expand funding for HIV research, including prevention science, implementation research, and health systems innovation to ensure that evidence guides policy and that prevention and treatment strategies continue to evolve to respond in increasingly effective ways to end the HIV epidemic.
- Establish an Africa-wide HIV emergency coordination mechanism to respond to disruptions in external financing and to track the impact the funding cuts across Africa.
- Lead development of an African HIV financing transition framework to support countries shifting from donor dependency to sustainable domestic financing.
- Coordinate pooled procurement and regional manufacturing of HIV commodities in Africa, including antiretrovirals, PrEP, and other health commodities, to reduce dependency on external donors and prevent shocks from external funding shifts.

To International and Human Rights Mechanisms and Bodies, including the United Nations, African Union, and World Health Assembly

- Monitor the human rights impacts of global shifts in funding and programming for public health initiatives, including in South Africa, the United States, and other affected countries.
- Create platforms to facilitate coordinated efforts to respond to gaps and rollbacks in enjoyment in human rights resulting from shifts in funding and programming for global health, with a specific eye towards mitigating the impacts on already marginalized groups such as people living with HIV, women, children, and LGBTQI+ persons.

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