Securing our HIV response: The PEPFAR crisis in South Africa

On 26 February 2025, 90% of the United States Agency for International Development (USAID)-funded co-operative agreements held by the US President's Emergency Plan for AIDS Relief (PEPFAR) implementing partners across the globe were cursorily terminated. These terminations followed a month-long period of anxious confusion and desperate hope following an executive order (EO) issued by President Donald Trump on the first day of his second term in office, 20 January 2025. The EO instated a 90-day pause on US foreign assistance under the guise of a review for alignment with US interests. Four days later, the US State Department issued a 'stop work order' directive, expanding the pause to include a freeze on all foreign aid programmes, including PEPFAR.[1]

First announced by President George W Bush in 2003, and re-authorised four times since with bipartisan support in Congress, PEPFAR has been critical in the global response to the HIV epidemic, and strengthening overall health systems in >50 countries worldwide.[2,3] It is the largest commitment to any single disease by any nation. In 2003, when PEPFAR started, South Africa (SA) was in the grips of an unfolding HIV epidemic that would grow into the largest national HIV epidemic globally, with nearly 8 million South Africans living with HIV today.[4] This was 3 years after hosting the International AIDS conference in Durban, where an 11-year-old boy, the late Nkosi Johnson, courageously called out then President Mbeki and his administration for their AIDS denialism and failure to provide South Africans with access to highly effective antiretroviral treatment (ART). At SA's lowest point, as many as 3 000 young women were acquiring HIV a week, one in three of their infants were born with the virus and dying within 2 years, tuberculosis (TB) rates had increased sixfold and the national life expectancy had decreased from 62 years in 1992 to 54 years in 2005. It was subsequently estimated that this denialism was responsible for the death of >300 000 South Africans.[5]

PEPFAR offered SA, and its neighbouring countries, a critical lifeline. With <USD8 billion invested in SA and USD120 billion worldwide since then, PEPFAR has supported >20 million people with HIV treatment in 55 countries, including half a million children. In addition, it has reached 2.3 million adolescent girls and young women with comprehensive HIV prevention services, prevented 5.5 million babies from being born with HIV, supported 6.6 million orphans, vulnerable children and caregivers, enrolled 2.5 million people on HIV pre-exposure prophylaxis (PrEP), provided 83.8 million people with HIV testing services, and directly supported 342 000 health workers.[2,3] In 2022, the USD460 million from PEPFAR represented 18% of SA's USD2.56 billion annual HIV budget.

Over PEPFAR's 22-year history, the global HIV epidemic has evolved, and significant progress has been made. HIV treatment is now very effective, and provided in a single, once-a-day pill. Life expectancy for people living with HIV who are on treatment is comparable with those without HIV. People living with HIV who are on treatment and have an undetectable viral load have zero risk of transmission to sexual partners, and minimal risk of transmission from mother to child. In addition, there have been huge strides made with primary HIV prevention. In the absence of an effective HIV vaccine, antiretroviral PrEP – where a single pill is taken regularly prior to HIV exposure – can effectively prevent HIV acquisition. Besides oral PrEP, we now have the capability to offer less-frequently dosed and longer-acting PrEP modalities, which add even more capability in reducing transmission.[7] Other well-established forms of prevention include condom use, voluntary medical male circumcision, regular testing and counselling and provision of clean needles and syringes for people using drugs. With >6 million people living with HIV in SA on treatment, the largest HIV treatment programme in the world, the national fiscus funds almost all HIV treatment and the majority of core public sector HIV services.[8]

With the new US administration, there is huge vulnerability in our HIV programmes, and an urgency to ensure that we do not lose the progress of the past two decades. A recent modelling study estimates that eliminating PEPFAR support in SA without transitioning the supported services will lead to 601 000 HIV-related deaths and 565 000 new HIV infections over the next 10 years alone. Additionally, population-level healthcare expenditure will increase by USD1.7 billion, owing to an increase in HIV prevalence and a less healthy population.[6]

SA, with financial support from PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), has made major strides towards overcoming its greatest public health challenge.[9] (Fig. 1A-C).[10] The 'last mile' efforts to reach global AIDS targets by 2030 are proving to be challenging and resource-intensive at a time when our national budget is strained, we are undergoing austerity measures and health systems across the country are in trouble. Of the 2 million people living with HIV not on treatment in SA, an estimated 400 000 have never been tested and do not know their HIV status.[11] Among the remaining 1.6 million who are not on treatment, some have been tested and know their status, but have never started treatment. A substantial number of people started treatment but later interrupted it owing to a combination of individual, interpersonal and structural vulnerabilities, along with life disruptions, such as unexpected travel, that affected their ability to remain in care.[12]

Finding and supporting those who need to start or restart treatment and remain on lifelong therapy is no simple task, but it is essential to significantly reduce the current annual 50 000 HIV-related deaths and 150 000 new infections. Actively offering quality HIV testing services annually to all public sector facility attendees is a massive undertaking. This must be supplemented with community-based testing for individuals who do not access public sector services due to concerns about stigma, discrimination, or logistical barriers. Additionally, tracing and reaching out to individuals who have interrupted treatment, guiding them back into public sector care and providing tailored clinical and psychosocial support are crucial steps in restoring their health and ensuring long-term retention on treatment. At the same time, the public health system must continue to support the 6 million people already on treatment, ensuring they remain in care despite the challenges faced by overstretched public sector facilities that struggle to provide comprehensive, high-quality services with reduced waiting times. The last mile will require strong government leadership, collaboration with civil society and investment in community-led solutions. While HIV science has made exciting headway in developing long-acting antiviral formulations for prevention and treatment, these can only be provided to those who stand to benefit most through reliable, robust health systems. All of this, and ensuring impact by 2030, is going to need more, not fewer, resources and collaboration. The reduced reliance on foreign aid for our HIV response is noteworthy, but the ~20% supported by PEPFAR has been critical.

PEPFAR-supported partners have in recent years played a crucial role in addressing these hard-to-reach gaps by integrating additional staff within public sector clinics and community health programmes. Working alongside government-employed healthcare workers, these

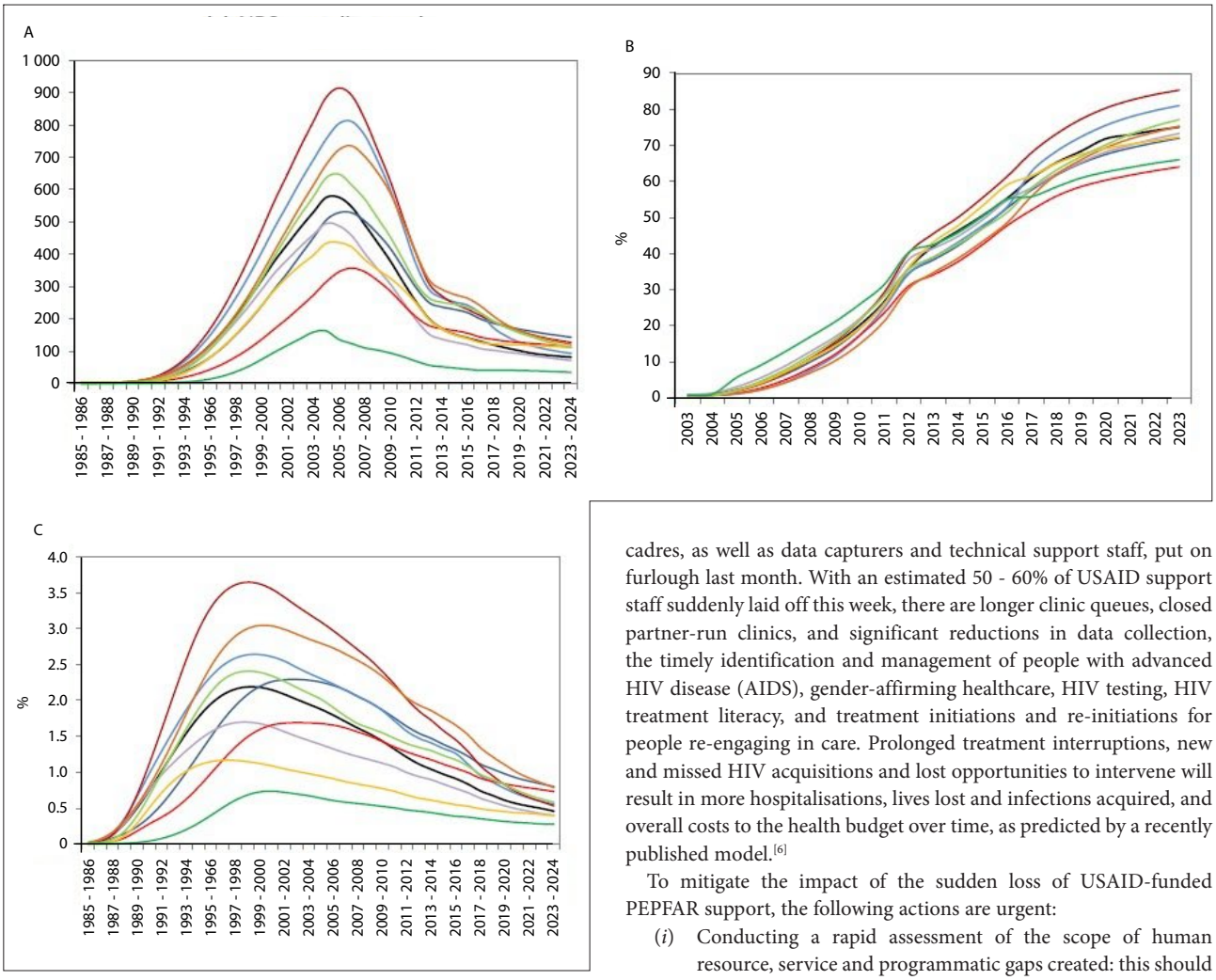

Fig. 1A-C. Trends in AIDS mortality, ART coverage and HIV incidence.[10] A: AIDS mortality trends. B: Antiretroviral therapy trends. C: HIV incidence trends.

teams have been instrumental in the tasks outlined above, providing essential client-facing service delivery functions. In addition to their direct roles in care, they have played a significant part in training and mentoring public sector staff to ensure the implementation of ever-evolving clinical and service delivery guidelines. In addition to direct service delivery, these funded partners have seconded staff to national and provincial health departments to strengthen essential systems that underpin public HIV services. Supporting supply chain management to prevent treatment stock-outs, maintaining patient-level monitoring and evaluation systems across 4 000 public sector health facilities and developing systems for data visualisation and use have all been done with PEPFAR-supported staff. Supported staff have also played a key role in sustaining critical service providers such the Central Chronic Medicine Dispensing and Distribution programme, which facilitates the distribution of pre-packed multi-month treatment refills at convenient facility and out-of-facility collection points – a system that serves ~50% of the 6 million people on HIV treatment in SA, as well as people with other chronic diseases. Notably, they have also funded the critical role of community-led monitoring of public sector HIV services, ensuring accountability and improving the quality of care provided by both government and PEPFAR-funded partners.

Immediate removal of these services has already left a major gap in programming, with >15 000 trained healthcare providers across all cadres, as well as data capturers and technical support staff, put on furlough last month. With an estimated 50 - 60% of USAID support staff suddenly laid off this week, there are longer clinic queues, closed partner-run clinics, and significant reductions in data collection, the timely identification and management of people with advanced HIV disease (AIDS), gender-affirming healthcare, HIV testing, HIV treatment literacy, and treatment initiations and re-initiations for people re-engaging in care. Prolonged treatment interruptions, new and missed HIV acquisitions and lost opportunities to intervene will result in more hospitalisations, lives lost and infections acquired, and overall costs to the health budget over time, as predicted by a recently published model.[6]

To mitigate the impact of the sudden loss of USAID-funded PEPFAR support, the following actions are urgent:

(*i*) Conducting a rapid assessment of the scope of human resource, service and programmatic gaps created: this should be done collaboratively and urgently by the national and provincial health departments with their respective PEPFAR-funded implementing partners.

(*ii*) Allocating funding in the 2025 public sector health budget to fill currently unfunded posts that are critical for delivering public sector health services.

(*iii*) Securing resources and implementing the most efficient mechanisms to deliver critical services, by:
- urgently mobilising acute 'bridging' funding
- reducing unnecessary burdens and improving efficiencies within the health system, such as enabling 6-monthly ART refills and annual clinical consultations and scripting for stable clients
- identifying the fastest service delivery mechanisms, including potentially continuing funding for existing implementing partners already set up to provide these services
- engaging the private and non-governmental sectors to supplement service delivery capacity.

(*iv*) Developing a long-term plan, with short-, medium- and long-term priorities, to restore the HIV programme and align with the 2030 goals by:
- mobilising funding through partnerships and collaboration, exploring innovative financing mechanisms, leveraging private sector and philanthropic support and ensuring cost-effectiveness and efficiency
- retaining, where possible, the expertise and experience of PEPFAR programmes

- closing data collection gaps to enable real-time impact measurement, evaluation and programme adjustments.

(*v*) Securing additional and/or reprogramming current GFATM funding, with an ongoing plan to gradually reduce dependency on these funds.

Home to the world's largest HIV epidemic, the SA government, in partnership with civil society, has the potential to turn this crisis into an opportunity – collectively reassessing urgent health system demands while urgently securing our HIV and TB response, and identifying strategies to enhance healthcare delivery for long-term sustainability.

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1. Tram KH, Ratevosian J, Beyrer C. By executive order: The likely deadly consequences associated with a 90-day pause in PEPFAR funding. J Int AIDS Soc 2025;28(3):e26431. https://doi.org/10.1002/jia2.26431
2. KFF. The US President's Emergency Plan for AIDS Relief (PEPFAR). KFF, 2024. https://www.kff.org/global-health-policy/fact-sheet/the-u-s-presidents-emergency-plan-for-aids-relief-pepfar (accessed 4 March 2025).
3. Ratevosian J, Millet G, Honermann B, Bennet S. PEPFAR under review: What's at stake for PEPFAR's future. Lancet 2025;405(10479)603-605.
4. Johnson L, Dorrington R. Thembisa version 4.7: A model for evaluating the impact of HIV/AIDS in South Africa. Thembisa Project, 2024. https://thembisa.org/content/downloadPage/Thembisa4_7report (accessed 4 March 2025).
5. Chigwedere P, Seage GR, Gruskin S, Lee TH, Essex M. Estimating the lost benefits of antiretroviral drug use in South Africa. J Acqu Immune Deficiency Syndr 2008;49(4):410-415. https://doi.org/10.1097/qai.0b013e31818a6cd5
6. Gandhi AR, Bekker L-G, Paltiel AD, et al. Potential clinical and economic impacts of cutbacks in the President's Emergency Plan for AIDS Relief Program in South Africa: A modeling analysis. Ann Intern Med 2025 (epub 11 February 2025). https://doi.org/10.7326/ANNALS-24-01104
7. Pike C, Bekker L-G. Interrogating the promise of long-acting HIV pre-exposure prophylaxis. Trends Mol Med 2023;29(2):93-98. https://doi.org/10.1016/j.molmed.2022.11.003
8. Hero. South African HIV investment case 2023. Hero, 2023. https://www.heroza.org/wp-content/uploads/2024/01/HIV-Investment-Case-2023-Full-Report-v1.2.pdf (accessed 3 March 2025).
9. Doan TM, Shin HB, Mehta NK. To what extent were life expectancy gains in South Africa attributable to declines in HIV/AIDS mortality? Demogr Res 2022;46(18):543-555.
10. Johnson LF, Dorrington RE. Modelling the impact of HIV in South Africa's provinces: 2024 update. Centre for Infectious Disease Epidemiology and Research, 2024. https://thembisa.org/content/downloadPage/Province2024 (accessed 4 March 2025).
11. Pillay Y. This is how South Africa can meet its targets. Spotlight, 15 January 2024. https://www.spotlightnsp.co.za/2024/01/15/opinion-yogan-pillay-this-is-how-sa-can-meet-its-hiv-targets (accessed 4 March 2025).
12. World Health Organization. Policy Brief: Supporting re-engagement in HIV treatment services. Geneva: WHO, 2024.

S Afr Med J 2025;115(3):e3216. https://doi.org/10.7196/SAMJ.2025.v115i3.3216