BREAKING POINT: IMPACT OF US FUNDING CUTS FOR HARM REDUCTION PROGRAMMES IN SOUTH AFRICA

HARM REDUCTION INTERNATIONAL

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Impact of US Funding Cuts for Harm Reduction Programmes in Indonesia

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Designed by Sujena Siddhi Bajracharya
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L3 4AF
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Harm Reduction International (HRI) is a leading non-governmental organisation (NGO) dedicated to reducing the negative health, social, and legal impacts of drug use and drug policy. Through research and advocacy, we promote the rights of people who use drugs and their communities to help achieve a world where drug policies and laws contribute to healthier, safer societies. The organisation is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

Stacy Doorly-Jones carried out research and analysis for this report in consultation with Catherine Cook, Gaj Gurung, Ailish Brennan and Klaas Mtshweni (SANPUD).

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EXECUTIVE SUMMARY

South Africa's Minister of Health, Budget Vote remarks

"There is no way we are going to allow the world's biggest HIV/AIDS Programme to collapse – never."

This report, **Breaking Point: The Impact of US Funding Cuts on Harm Reduction in South Africa**, documents the consequences of sudden donor withdrawals on essential harm reduction services. It is the product of a rapid country survey led by Harm Reduction International (HRI) in partnership with the South African Network of People Who Use Drugs (SANPUD), and with contributions from civil society, service providers, and communities directly affected by the funding crisis.

South Africa has long relied on international donors, particularly the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund, to finance HIV prevention and harm reduction. While government has increasingly funded treatment, prevention interventions for key populations remain almost entirely donor dependent. The abrupt withdrawal of U.S. government funding through PEPFAR in early 2025, combined with a 16% reduction in Global Fund allocations under Grant Cycle 7 (GC7), has triggered a public health crisis with immediate and devastating consequences.[1] [2] South Africa's harm reduction system stands at a breaking point.

Within weeks of the U.S. executive orders, nearly 40 USAID-funded projects were terminated, leading to the retrenchment of over 8,000 frontline HIV staff and the collapse of prevention and harm-reduction services.[3] OST Sites in Tshwane and Ehlanzeni closed or curtailed services, and thousands of people who use drugs lost access to opioid substitution therapy (OST),[4] needle and syringe programmes (NSPs), HIV testing, and other lifesaving interventions, leaving thousands without care and treatment.[5]

This report gives voice to those most affected: people who use drugs, sex workers, men who have sex with men, peer educators, and frontline service providers. Their testimonies reveal the devastating impact of funding cuts, not only on health outcomes but also on dignity, trust, and rights. At the same time, their resilience and advocacy point to clear solutions: sustainable domestic investment, integration into the South African Public Healthcare System, into the future

1 **UNAIDS**. PEPFAR-funded projects affected; clinics report staff losses and service disruption (25 Feb 2025). https://www.unaids.org/en/resources/presscentre/featurestories/2025/february/20250225_south-africa-fs

2 **South Africa CCM**. CCM Resolutions: GC7 adjustments & commitments (incl. PWUD share) (14 Jul 2025). (internal; on file)

3 **National Department of Health (South Africa)**. Immediate Impact of the Executive Orders - Minister's Briefing (05 Feb 2025). (internal; on file)

4 HRI uses the term 'opioid agonist therapy' (OAT), but terms specific to South Africa are being used for the purposes of this study.

5 **KII Transcripts** (SANPUD/Nmbalelo; Likwa Ncube; Aurum KPS & PWUD) (Jul–Sept 2025). (internal; on file)

anticipated National Health Insurance (NHI), and the replication of innovative models like the Community-Oriented Substance Use Programme (COSUP).

This is both a warning and a call to action. Without urgent policy reform and financing, the progress South Africa has made in the HIV response risks being reversed. With political will, however, the country can safeguard harm reduction, protect human rights, and lead Africa in building sustainable, inclusive responses.

Emergency financing mobilised (2025):

- **Treasury stop-gap:** R753m (US$43.2m) was mobilised for immediate relief, primarily to stabilise provincial HIV services, with portions for research and pharmaceutical logistics.[6]
- **Research bridge (separate from service funding):** The Gates Foundation and Wellcome Trust have **each** pledged R100m (US$5.73m) toward research, conditional on a **matched** R200m (US$11.46m) contribution from the Government of South Africa over three years. An initial tranche of R132m (US$7.6m) has already been disbursed through the South African Medical research Council (SAMRC) as part of this broader commitment.

Persistent gap

Despite these measures, a shortfall remains. The Global Fund confirmed a 16% GC7 reduction for South Africa (R8.5bn (USD 487m) to R7.1bn (USD 407m)), increasing risks to key-population programmes.[7]

The collapse of services has already produced visible health consequences amongst people who inject drugs. Disrupted OST increased overdose risk; community-led monitoring and facility reports documented reduced HIV-testing offers and shortened ART refills during the freeze.[8] [9] Among men having sex with men, the closure of OUT's Engage Men's Health clinic cut off ART for 2,000 clients and PrEP for 4,000.[10] Sex workers reported rising violence, stigma, and treatment interruptions as prevention and rights-based services collapsed.[11] If unaddressed, modelling projects up to 150,000 new HIV infections and 56,000 AIDS-related deaths by 2028.[12]

Despite these setbacks, resilience has been evident. The Community-Oriented Substance Use Programme (COSUP) in Tshwane, funded by the District Municipality and implemented with the University of Pretoria, continued to deliver comprehensive harm reduction, providing a proof-of-concept for scalable domestic models. Civil society organisations, including SANPUD, Triangle Project, Anova, SWEAT, and TAC, rapidly pivoted to emergency measures while intensifying

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6 **GroundUp**. Inside SA's multi-billion rand plan to fill US funding void (24 Jul 2025). https://www.groundup.org.za/article/inside-sas-multi-billion-rand-plan-to-fill-us-funding-void/

7 **South Africa GC7**. Geographical Re-Prioritization: Concept Note (20 Jun 2025). (internal; on file)

8 **UNAIDS**. Weekly update: service impacts and dispensing regression amid funding freeze (7 Mar 2025). https://www.unaids.org/en/resources/presscentre/featurestories/2025/march/20250307_south-africa_update

9 **UNAIDS**. Community-Led Monitoring in Action (platform purpose, indicators, integration). https://www.unaids.org/en/resources/presscentre/featurestories/2022/august/20220808_community-led-monitoring

10 **MambaOnline**. OUT's Engage Men's Health forced to shut doors amid funding freeze (2025). https://www.mambaonline.com/2025/02/16/pepfar-funding-cuts-hit-lgbtiq-health-services-in-south-africa/

11 **Treatment Action Campaign**. US funding cuts to health and HIV services threaten lives (5 Mar 2025). https://www.tac.org.za/news/us-funding-cuts-to-health-and-hiv-services-threaten-lives/

12 **The case for LEN - 14 Jul 2025 (revised NB1218)**. Modelling deck: projected infections/deaths if prevention collapses. (internal; on file)

advocacy. Peer networks redistributed supplies via WhatsApp groups, and philanthropic contributions, most notably from the Elton John AIDS Foundation, sustaining chemsex-related interventions and improved ART retention among men having sex with men(MSM) from 42% to 83%.[13] Yet these are stopgaps, not systemic solutions.

This rapid assessment draws on 25+ key informant interviews, service evaluations, community-led monitoring tools, and 70+ documents and reports. It presents a stark picture of a system pushed to the brink by donor withdrawal, while also identifying clear opportunities for resilience and reform.

Urgent action is required. To safeguard hard-won HIV gains, South Africa must:

- Establish dedicated Treasury budget lines for harm reduction.
- Integrate OST and NSP into the National Public Health System (NPHS) and budgets.
- Replicate COSUP across metropolitan areas.
- Protect and expand Global Fund allocations for prevention, with explicit, ring-fenced amounts to reach coverage targets for NSP (≥200–300 syringes/people who inject drugs/year) and OST.[14]

Without decisive domestic financing and political leadership, South Africa risks reversing decades of progress in the fight against HIV, TB, and viral hepatitis.

13 **Elton John AIDS Foundation**. End-of-Term Evaluation: Chemsex Programme (South Africa) (Aug 2025). (internal; on file)

14 **Harm Reduction International**. Global State of Harm Reduction 2024 (coverage benchmarks; naloxone policy; SA profile). https://hri.global/wp-content/uploads/2024/10/HRI-GSHR-2024_Full-Report_Final.pdf

CONTEXT AND BACKGROUND

South Africa's HIV and Drug Use Landscape

South Africa carries the world's largest HIV epidemic, with an estimated 8.45 million people living with HIV in 2024 at the prevalence rate of 13.9%, and approximately 178,000 new infections annually. The HIV prevalence amongst people who inject drugs is much higher than the national average at 55%, and data required to assess progress towards the 90-90-90 targets for people who inject drugs is not available.

The baseline for harm reduction (pre-shock)

- **Coverage was already low:** In 2024, South Africa distributed ~36 needles/syringes per people who inject drugs per year, compared with the UN-recommended 200–300; NSPs operated in 11 districts and OST in 8 districts.[15]
- **Epidemiological data:** National evidence underscores high HIV and HCV prevalence and persistent stigma barriers that deter health-seeking (HIV 55%, HCV 83%).[16] The HIV prevalence amongst people in prison is estimated to be 17.5%.
- **Prisons:** OST in correctional settings remains limited; regional mapping shows no OST in South African prisons.[17]
- **Population size:** An estimated 75,701 people in South Africa inject drugs; more broadly data suggests people who use drugs include ~400,000 people using heroin, ~350,000 people using cocaine, and ~290,000 people using methamphetamine.[18]
- **Treatment reach:** OST coverage reaches fewer than 5% of those in need.[19]
- Drug use intersects with other vulnerabilities (sex work, migration, homelessness, incarceration, LGBTQI+ marginalisation). Chemsex among men having sex with men has added new risks; programmes report HIV-related vulnerabilities in these contexts.[20]
- TB remains a major syndemic factor. People who use drugs face heightened TB risk due to incarceration, unsafe housing, and poor nutrition, and disruptions during the 2025 funding freeze further destabilised treatment among people who use drugs that are living with HIV.[21]

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15 **HRI × SANPUD**. South Africa - Information №te on Harm Reduction (2025). https://hri.global/wp-content/uploads/2025/04/SA-Country-№te-designed.pdf

16 IBID 14

17 **Global Initiative Against Transnational Organized Crime (A. Scheibe)**. Prevention and treatment of drug dependence in Eastern & Southern Africa (May 2022) - notes no OST in SA prisons. https://globalinitiative.net/wp-content/uploads/2022/05/Andrew-Scheibe-Prevention-and-treatment-of-drug-dependence-in-Eastern-and-Southern-Africa-GI-TOC-May-2022.pdf

18 IBID 14

19 IBID 14

20 **Elton John AIDS Foundation**. End-of-Term Evaluation: Chemsex Programme (South Africa) (Aug 2025). (internal; on file)

21 **UNAIDS**. Weekly update: service impacts and dispensing regression amid funding freeze (7 Mar 2025). https://www.unaids.org/en/resources/presscentre/featurestories/2025/march/20250307_south-africa_update

Structural Vulnerabilities in Policy and Law

Criminalisation drives exclusion from care. The Drugs and Drug Trafficking Act (1992) criminalises drug use and possession;

- People who use drugs report police harassment and arbitrary arrests.
- Sex work remains criminalised, and when PEPFAR-funded mobile/rights-based clinics were withdrawn, many sex workers defaulted on ART and PrEP due to documentation barriers at public clinics.[22]

At the policy level, progress has been uneven:

- The 2023–2028 National Strategic Plan on HIV, TB and STIs identifies harm reduction as a priority but lacks dedicated budget lines.[23]
- NDoH recognises harm reduction's importance but has yet to integrate OST and NSP into core financing streams.[24]

Fragility of the Funding Architecture

For nearly two decades, South Africa's HIV prevention and harm reduction programmes have been heavily donor-dependent.

- **PEPFAR:** Roughly US$400 million (R7.6bn) annually invested into South Africa's HIV response prior to 2025, including prevention/KP services.[25]
- **Global Fund:** R8.5bn (US$445m) under GC6 (2021–2023); under GC7 (2024–2026), allocations reduced to R7.1bn (US$372m) after reprioritisation, with 6.8% earmarked for prevention programmes for people who use drugs.[26]
- The Global Fund CCM increased these allocations in GC7 to approximately US$25.3m, but this was reduced to US$16.7m after repriorisation.[27]
- **Global Fund Principal Recipient (PR) transition:** The move from NACOSA to Aurum raised concerns about reduced community ownership and fewer people who use drugs SRs (from six to four).[28]
- **Workforce risk:** More than 15,000 HIV/TB-funded posts were destabilised, threatening two decades of capacity-building.[29]

22 **Treatment Action Campaign**. US funding cuts to health and HIV services threaten lives (5 Mar 2025). https://www.tac.org.za/news/us-funding-cuts-to-health-and-hiv-services-threaten-lives/

23 IBID 14

24 IBID 14

25 **GroundUp**. Inside SA's multi-billion rand plan to fill US funding void (24 Jul 2025). https://www.groundup.org.za/article/inside-sas-multi-billion-rand-plan-to-fill-us-funding-void/

26 **South Africa CCM**. CCM Resolutions: GC7 adjustments & commitments (incl. PWUD share) (14 Jul 2025). (internal; on file)

27 IBID

28 **South Africa GC7**. Geographical Re-Prioritization: Concept №te (20 Jun 2025). (internal; on file)

29 **National Department of Health (South Africa)**. Immediate Impact of the Executive Orders - Minister's Briefing (05 Feb 2025). (internal; on file)

KEY FINDINGS

CHANGE coalition media statement

“Clinics in Ehlanzeni and Tshwane… which supported over 5,000 clients with opioid substitution therapy and needle exchanges, have closed - risking an explosion in HIV and hepatitis C transmissions, overdoses and deaths.”

Programme shocks concentrated in key populations districts

- Following the February 2025 stop-work order, 40 USAID-funded projects were terminated, with service closures concentrated in six metros/districts with large key populations (Johannesburg, Cape Town, Tshwane, Ekurhuleni, Nelson Mandela Bay, Vhembe).
- In these areas, an estimated 166,354 key populations clients lost prevention or treatment access (navigation, PrEP/ART, outreach).[30]
- TB HIV Care site closures in Tshwane and Ehlanzeni removed access to OST/NSP/HIV services for >5,000 people who use or inject drugs.[31]

Workforce upheaval - where losses landed

- Within the first 90 days of the freeze, 8,493 frontline posts tied to PEPFAR support were eliminated (distinct from the broader 15,374 posts “at risk”).[32]
- Documented provincial impacts included: Western Cape - R407m (US$23m) reduction with 882 health posts affected, leading to significant service disruptions across HIV prevention, treatment, and community outreach programmes.
- NGO staff retrenched and two OST clinic closures; Mpumalanga - 398 NGO staff retrenched, disrupting peer-led outreach, HIV prevention, and OST.[33]
- The peer-educator cadre absorbed disproportionate losses, removing trusted, low-threshold navigation for PWUD at the moment of service contraction.[34]

30 **Key Populations Meeting with Coordinating Committee & DOHM**. Minutes (2025). (internal; on file)

31 **KII Transcripts** (SANPUD/Nombalelo; Likwa Ncube; Aurum key populations & people who use drugs) (Jul–Sept 2025). (internal; on file)

32 **USAID foreign aid freeze** - managing DHS funding transitions amidst economic uncertainty (province-level retrenchments incl. Western Cape R407m; Mpumalanga 398 posts). (internal; on file)

33 IBID

34 **KII Transcripts** (SANPUD/Nombalelo; Likwa Ncube; Aurum Key Populations & people who use drugs) (Jul–Sept 2025). (internal; on file)

Harm-reduction coverage eroded in practice

- **OST continuity:** Closures coincided with tapering/cessation, missed/delayed doses, and multiple overdoses within weeks in affected districts (e.g., Ehlanzeni), as recorded by peer networks.[35]
- **NSP practice signals:** Community-led monitoring documented prevention disruptions; peer reports indicated increased reuse/sharing of injecting equipment during the pause.[36]
- **Correctional settings:** No operational OST in prisons at baseline; the crisis highlighted a systemic gap for continuity of care post-release.[37]

Accountability systems (CLM) became a collateral casualty

- Ritshidze community-led monitoring (CLM) experienced funding curtailment and scaled-back fieldwork during the freeze, risking under-measurement of late-period trends even as service strain rose.[38]

Availability: where and how services thinned

- High burden districts experienced intermittent closures, shortened service hours, and reduced outreach capacity. Clinics reported triage-only days for OST and paused outreach for NSP, with community teams redirected to essential facility tasks.[39]
- Supply-side constraints (procurement lags, depot redistribution) produced ad hoc rationing rules - maintenance-only OST, deferred inductions, smaller NSP packs - pushing clients to travel further or self-ration.[40]
- Community signals captured by CLM and peer networks showed greater reuse/sharing of injecting equipment in several districts during suspension periods.[41]

KII (peer network), 2025

"We walked clients from site to site, but there was nowhere to send them that day"

35 IBID

36 **UNAIDS**. Community-Led Monitoring in Action (platform purpose, indicators, integration). https://www.unaids.org/en/resources/presscentre/featurestories/2022/august/20220808_community-led-monitoring

37 **Global Initiative Against Transnational Organized Crime (A. Scheibe)**. Prevention and treatment of drug dependence in Eastern & Southern Africa (May 2022) - notes no OST in SA prisons. https://globalinitiative.net/wp-content/uploads/2022/05/Andrew-Scheibe-Prevention-and-treatment-of-drug-dependence-in-Eastern-and-Southern-Africa-GI-TOC-May-2022.pdf

38 **Ritshidze**. Funders & implementing partners (CLM platform overview). https://ritshidze.org.za/funders/

39 **Key Populations Meeting with Coordinating Committee & DOHM**. Minutes (2025). (internal; on file)

40 IBID

41 **KP Rapid Survey** (N=278). Instrument & descriptive results (2025). (internal; on file)

Quality: what changed inside clinics

- Refill intervals widely regressed to 1-month dispensing for ART/OST in affected facilities, driving more visits, higher transport costs, and missed appointments.
- Staffing pressures shortened consults and reduced time for risk-reduction counselling, rights screening, and linkage functions usually delivered by peer cadres[42].
- Stigma and safety complaints increased where NGO-led sensitisation paused, with reports of breaches of confidentiality, derogatory language, and refusals of care for people who use drugs and sex workers.[43]
- Commodity continuity for prevention (e.g., condoms, lubricants) and diagnostics (e.g., rapid tests) became inconsistent in some sites.[44]

OST client

"The clinic said come back with papers. I had none"

Key population programmes: service consequences

- **Men who have sex with men:** OUT LGBT Well-being (Engage Men's Health) closure removed a KP-friendly access point for 6,000 men who have sex with men (2,000 on ART; 4,000 on PrEP), forcing diversion to general clinics with variable key populations competence.[45]
- **Sex workers:** Suspension of rights-based mobile services coincided with PrEP stockouts in some provinces and ad hoc STI care via informal pharmacies; reports of violence and extortion rose where safe spaces closed.[46]
- **Trans & gender-diverse people:** Loss of community navigators reduced access to gender-affirming care linkages and PEP/PrEP navigation.[47]

42 **USAID foreign aid freeze** - managing DHS funding transitions amidst economic uncertainty (province-level retrenchments incl. Western Cape R407m; Mpumalanga 398 posts). (internal; on file)

43 **Treatment Action Campaign**. US funding cuts to health and HIV services threaten lives (5 Mar 2025). https://www.tac.org.za/news/us-funding-cuts-to-health-and-hiv-services-threaten-lives/

44 **Key Populations Meeting with Coordinating Committee & DOHM**. Minutes (2025). (internal; on file)

45 **MambaOnline**. OUT's Engage Men's Health forced to shut doors amid funding freeze (2025). https://www.mambaonline.com/2025/02/16/pepfar-funding-cuts-hit-lgbtiq-health-services-in-south-africa/

46 **Treatment Action Campaign**. US funding cuts to health and HIV services threaten lives (5 Mar 2025). https://www.tac.org.za/news/us-funding-cuts-to-health-and-hiv-services-threaten-lives/

47 **Key Populations Meeting with Coordinating Committee & DOHM**. Minutes (2025). (internal; on file)

People in prisons: a persistent structural gap

- No OST is available in correctional facilities; continuity at admission/release and referral pathways to community OST/NSP are lacking.[48]
- **Implication:** without a prison OST policy and funded service line, community gains are undermined by cycles of incarceration and post-release lapse risk.[49]

Overdose risk & system blind spots

- Where OST paused or was rationed, peers reported rapid substitution to street opioids and heightened overdose risk, including suspected fentanyl-adulteration alerts shared via community channels.[50]
- No national overdose surveillance exists; deaths are under-counted and rely on peer/CLM reporting.[51]
- Naloxone access remains largely facility-bound; there is no funded community naloxone distribution model with minimum stock and peer/family training.[52]
- **Implication:** establishing community naloxone procurement, distribution, and reporting standards is an urgent, low-cost intervention with high mortality-reduction potential.[53]

KII (peer network), 2025

“We started hearing about overdoses within days.”

TB/HIV comorbidity impacts[54]

- The regression to shorter refill cycles and reduced outreach increased the risk of dual default for clients co-managing ART and TB treatment.
- Disruptions to outreach and peer support weakened return-to-care mechanisms after missed DOT/ART visits, with particular risk among unstably housed people who use drugs.

48 **Global Initiative Against Transnational Organized Crime (A. Scheibe)**. Prevention and treatment of drug dependence in Eastern & Southern Africa (May 2022) - notes no OST in SA prisons. https://globalinitiative.net/wp-content/uploads/2022/05/Andrew-Scheibe-Prevention-and-treatment-of-drug-dependence-in-Eastern-and-Southern-Africa-GI-TOC-May-2022.pdf

49 IBID

50 **KII Transcripts** (SANPUD/Nmbalelo; Likwa Ncube; Aurum KPS & PWUD) (Jul–Sept 2025). (internal; on file)

51 **HRI × SANPUD**. South Africa - Information Note on Harm Reduction (2025). https://hri.global/wp-content/uploads/2025/04/SA-Country-Note-designed.pdf

52 **Harm Reduction International**. Global State of Harm Reduction 2024 (coverage benchmarks; naloxone policy; SA profile). https://hri.global/wp-content/uploads/2024/10/HRI-GSHR-2024_Full-Report_Final.pdf

53 IBID

54 **Key Populations Meeting with Coordinating Committee & DOHM**. Minutes (2025). (internal; on file)

Social harm signals

- Households reported financial strain tied to relapse/overdose and repeated clinic travel.
- Criminalisation without service availability escalated police contact and temporary detention, further interrupting treatment.
- The loss of peer educators stripped communities of trusted navigators, increasing drop-off along the prevention-to-treatment cascade.

METHODOLOGY & EVIDENCE STANDARDS

Purpose & design

This rapid assessment (July–September 2025) aimed to generate decision-grade evidence on the immediate effects of donor cuts on harm reduction and HIV prevention, prioritising timeliness, verifiability, and triangulation over academic generalisability.

Scope

We focused on high-burden districts and Key Populations programmes most exposed to the funding shock, with attention to people who use and inject drugs, men who have sex with men, sex workers, and carceral settings.

Data sources & instruments

- **Key Informant Interviews (KIIs):** >24 structured/semi-structured KIIs with officials, implementers, clinicians, peer workers, and people who use drugs across multiple provinces.
- **Community dialogues:** National/provincial sessions with KP networks (sex worker orgs, migrant collectives, LGBTQI+ advocates, drug user led groups such as SANPUD).
- **Rapid client survey:** N=278 clients reporting recent disruption (treatment interruptions, refill intervals, stigma, access barriers).
- **Programme/monitoring data:** Ritshidze community-led facility monitoring;[55] programme evaluations (e.g., OST and chemsex/stimulant interventions);[56] people who use drugs Peer Advocacy Data Tool (overdose, closures, rights violations, supply gaps).
- **Document & policy review:** Government briefings, Treasury announcements, Global Fund GC7 materials, implementer memos, press/CSO reports.

Note

Ritshidze's core funding has been provided by PEPFAR (channeled via UNAIDS) and implemented by a civil-society consortium led by TAC and partners; the project is recognised by South Africa's Department of Health. Funding/partner details are listed publicly; fieldwork capacity was curtailed during the 2025 PEPFAR pause.

55 **Ritshidze**. Funders & implementing partners (CLM platform overview). https://ritshidze.org.za/funders/

56 **NACOSA**. Opioid Substitution Therapy Evaluation - South Africa (2025).

Sampling & recruitment

Purposive and snowball recruitment were used for KIIs/dialogues; the client survey used convenience sampling via service and peer networks (descriptive snapshots, not population estimates).

Data handling & analysis

- **Coding:** Thematic coding across financing, service availability, workforce, health outcomes, innovations/adaptations.
- **Triangulation:** Two independent sources for any system-level finding (e.g., monitoring + KII), or one primary source plus direct programme confirmation.
- **Indicator definitions:** Standard harm-reduction benchmarks (e.g., NSP syringes/people who inject drugs/year; OST continuity/retention), routine HIV indicators (testing offered, ART refill interval), and qualitative flags (stigma, refusals of care).

Quality assurance

- **Source audit trail:** Every quantitative statement links to an externally verifiable source or programme record; quotes/field notes are time-stamped with anonymised IDs.
- **Peer validation:** Preliminary findings were sense-checked with implementers and community representatives.
- **Evidence grading:** Findings were tagged High/Moderate/Indicative; “Indicative” items are restricted to narrative boxes.

Limitations

- **Speed & access:** Some major NGOs under retrenchment could not contribute data, affecting district-level completeness.
- **Surveillance gaps:** Overdose events and some service denials are not captured in national systems; peer/CLM tools fill the gap but cannot provide national totals.
- **Dynamic context:** Allocations, waivers, and programme restarts evolved during fieldwork; some developments may have changed after data cut-off.

INNOVATIONS & ADAPTATIONS: SUSTAINABLE HARM REDUCTION MODELS

Pathways to a Sustainable Future

Even in the face of abrupt donor withdrawal and collapsing services, South Africa's harm reduction community has demonstrated extraordinary resilience and ingenuity. These innovations cannot fully compensate for systemic underfunding, but they reveal what is possible when communities, municipalities, and coalitions step forward. With equitable funding, national leadership, and integration into domestic health systems, these models can be scaled into a sustainable, nationally owned harm reduction response.

Municipal Financing Model - COSUP

The Community-Oriented Substance Use Programme (COSUP) in Tshwane remains South Africa's clearest example of a domestically anchored harm reduction initiative. It is funded mainly by the City of Tshwane under a Service Level Agreement (SLA), implemented in partnership with the University of Pretoria's Department of Family Medicine, and supplemented by grant funding that provides financial flexibility. This blended funding structure allows COSUP to adapt to changing needs, but it also introduces risks should municipal priorities shift or grants decline.[57]

During the February 2025 PEPFAR funding freeze, COSUP's municipal base funding insulated services in Pretoria, ensuring continuity of OST and NSPs while donor-funded sites closed elsewhere. In this period, COSUP became a safety net for thousands of clients who would otherwise have been left without medication or sterile injecting equipment.[58]

Yet COSUP is not immune to fragility. Because a portion of its operating model relies on grant and donor funds to supplement the municipal contract, any cuts to these flexible components would risk service quality. Similarly, reliance on the City of Tshwane's municipal budget makes the programme vulnerable to fiscal austerity or political turnover. Without national Treasury allocations and integration into the National Public Health System, and the anticipated National Health Insurance (NHI), COSUP cannot serve as a sustainable replacement for donor-funded services.[59]

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57 **HRI**. COSUP in South Africa - model for domestic harm-reduction funding (landing page). https://hri.global/publications/cosup-in-south-africa-a-model-for-domestic-harm-reduction-funding/

58 **Ritshidze**. Funders & implementing partners (CLM platform overview). https://ritshidze.org.za/funders/

59 **PWUD Sub-Sector Concern on sub-recipient Selection**. Submission to CCM (2025). (internal; on file)

Despite these risks, COSUP offers a blueprint for domestic harm reduction financing. Its integration into Tshwane's district health system, through contracts, oversight by the municipal Department of Health and Social Development, and governance support from the University of Pretoria, shows that locally owned models are both viable and politically defensible. If expanded to other metros, COSUP could become the backbone of a nationally owned harm reduction system, reducing South Africa's dependency on external donors while strengthening epidemic control.[60]

Community Monitoring and Data Tools

1. Ritshidze Community-Led Monitoring

Ritshidze is South Africa's largest community-led monitoring (CLM) initiative, launched in 2020 to strengthen accountability across the HIV, TB, and primary healthcare response. It was established by a consortium of civil society organisations, including Treatment Action Campaign (TAC), National Association of People Living with HIV (NAPWA), Positive Women's Network (PWN), SANERELA+, and People Living with HIV (PLHIV) sector structures.

Why it Matters for Harm Reduction In the context of the 2025 funding crisis, Ritshidze was one of the only systematic tools able to quantify the collapse of prevention services. For example, it documented:

- Service collapse in 353 clinics across 7 provinces: reductions in HIV testing, shortened ART dispensing, and staff shortages.
- The regression from 3–6 month ART refills to 1 month.
- Gaps in HIV testing for people who use drugs.
- Increased waiting times and reduced staff capacity following retrenchments.

This evidence gave civil society and parliamentarians concrete data to push back against narratives that "services were unaffected" by the PEPFAR freeze.

2. Digital and Peer-Led Innovation

While formal programmes collapsed, people who use drugs and peer educators improvised survival strategies. WhatsApp groups emerged as virtual support networks, where peers shared updates on service availability, alerted each other to overdoses, and offered emotional support.

These adaptations show how low-cost, peer-led digital tools can enhance continuity of care. With national investment, they could be formalised into hybrid service delivery models, particularly for mobile and hard-to-reach populations.

Examples include:

- WhatsApp helplines and navigation groups linking clients to medication, harm reduction advice, and emotional support when clinics closed.

60 **SA Cities Network**. City of Tshwane case study - COSUP SLA with University of Pretoria (2022). https://www.sacities.net/wp-content/uploads/2022/03/S3-City-of-Tshwane.pdf

- In Limpopo, migrant and sex worker communities used these platforms to relink over 170 clients to ART, filling critical gaps left by NGO closures.
- Informal NSP redistribution, with peers collecting limited syringes from one site and passing them on.
- Peer leaders piloting take-home OST dosing, sometimes rationing personal supplies to sustain clients in crisis.
- WhatsApp alerts warning of fentanyl-adulterated heroin in Johannesburg.

A peer outreach worker described the shift

“We became the clinics. If you needed a needle, you called me. If someone overdosed, you called the group. We did what we could, but it was survival mode.”

3. PWUD Peer Advocacy Data Tool

The PWUD Peer Advocacy Data Tool is a community-driven monitoring system developed and implemented by the South African Network of People Who Use Drugs (SANPUD) in collaboration with harm reduction partners and supported by international allies, including Harm Reduction International (HRI) and the Global Fund’s Community, Rights and Gender (CRG) initiatives.

Examples of Use:

- In February–April 2025, the tool documented dozens of overdose deaths in Tshwane and Ehlanzeni after OST distribution was cut off due to the U.S. PEPFAR freeze. These findings were presented to the Central Drug Authority (CDA) and cited in SANPUD’s submissions to Treasury emergency hearings, helping secure limited funds to restore some harm reduction coverage. In 2024, SANPUD reported that 68% of people who use drugs surveyed had experienced confiscation of injecting equipment by police. This evidence was later used in parliamentary dialogues to highlight how criminalisation undermines public health.[61]
- During Global Fund GC7 reprioritisation in 2025, PWUD Peer Advocacy Data Tool evidence was submitted to the CCM, strengthening civil society’s case to increase allocations from 3% to 6.8%.

61 **HRI × SANPUD**. South Africa - Information Note on Harm Reduction (2025). https://hri.global/wp-content/uploads/2025/04/SA-Country-№te-designed.pdf

A peer outreach worker described the shift

“We became the clinics. If you needed a needle, you called me. If someone overdosed, you called the group. We did what we could, but it was survival mode.”

Why it Matters: This tool fills critical gaps in official health data by centring people who use drugs voices and documenting harms otherwise invisible to policymakers. With institutional support, it could anchor a national harm reduction M&E system.

Coalition Building / Innovative Service Models/ NGO Adaptations

Despite severe funding losses, NGOs developed emergency stopgaps and galvanised new coalition organising. These coalitions are not stopgaps but power-shifting mechanisms, linking grassroots voices with high-level policy forums. With sustained support, they can institutionalise community leadership within the HIV response, that can be scaled nationally.

- **The Cape Metro key population Collective:** (SWEAT, Triangle Project, SANPUD, TSG, Sisonke, Anova, independent researchers) united sex workers, men who have sex with men, people who use drugs, and transgender networks to demand reinstatement of NGO-led services, expanded rural access, and clinic sensitisation.
- **SANPUD:** leveraged these coalitions to secure Central Drug Authority (CDA) commitments on OST and NSP expansion.
- **OUT’s EJAF-funded chemsex and stimulant programme:** Wraparound psychosocial and medical support raised ART retention among men who have sex with men from 42% to 83%, with viral suppression at 88%.
- **Mobile OST delivery in Gauteng:** Peer outreach delivered methadone to clients’ homes, proving the feasibility of low-barrier, community-based care.
- **Triangle Project:** redirected its budget to emergency ART/PrEP refills for men who have sex with men.
- **Anova Health:** hosted harm reduction “pop-ups” at clinics when stock was available.
- **TB HIV Care**: piloted take-home naloxone distribution, ensuring overdose prevention despite disrupted supply chains.

A programme coordinator reflected

“We proved that when you meet people where they are, without judgment, they stay in care. That’s harm reduction at its best.”

CONCLUSIONS AND RECOMMENDATIONS

South Africa stands at a pivotal crossroads. One path is inertia: continued dependence on volatile donors, repeated service breakdowns, and rising HIV, TB, and overdose deaths. The alternative, a bold shift toward domestic responsibility, demands political leadership, committed financing, and strong institutional integration.

This report has shown that the collapse triggered by sudden U.S. withdrawal was not merely a technical or operational failure, but a structural fragility: overreliance on external funding, lack of ringfenced harm reduction lines, and weak accountability systems. Yet, we also documented living exemples, COSUP's municipal model, community monitoring via Ritshidze and the PWUD Peer Advocacy Data Tool, peer network adaptations, and coalition advocacy, that prove domestically anchored harm reduction is possible. These innovations are not stopgaps; they form the pathways toward a sustainable system.

To secure that future, the following priorities are most urgent:

Area	Priority Actions
Secure Domestic Financing	Establish a dedicated, ring-fenced Treasury budget line for harm reduction; transition one-off emergency funds into multi-year commitments.
Integrate Harm Reduction into National Public Health System (NPHS)	Include OST, NSP, stimulant and chemsex services in the NPHS; ensure procurement and supply lines for methadone, buprenorphine, and naloxone are domestically managed.
Scale Proven Models	Replicate COSUP's municipal funding and governance model in metros such as Cape Town, Johannesburg, Durban, with adaptive oversight and cost sharing.
Protect the Peer Workforce	Rehire retrenched peer navigators and outreach staff; formalise contracts, remuneration, and labour protections to stabilise this essential cadre.
Strengthen Global Fund Equity & Accountability	Protect or increase PWUD/KP allocations in GC7 and beyond; institutionalise community-led monitoring as a grant requirement.
Expand Service Scope	Scale stimulant/chemsex services nationally; embed mental health and psychosocial supports across harm reduction programs.
Build Advocacy Coalitions	Bolster alliances like SANPUD, the Cape Metro KP Collective, and peer networks; support pooled advocacy funding.
Frame Harm Reduction as Rights & Strategy	Recast harm reduction not just as epidemic control or cost-saving, but as a constitutional and public health imperative.

Final Word

The evidence is compelling, the innovations viable, and the urgency real. One path is inaction, continued dependence on volatile donors, recurring service collapses, and rising HIV, TB, and overdose deaths. South Africa must shift from a cycle of crisis and external dependency to decisive action: institutionalising harm reduction, protecting lives, and building a resilient, domestically owned system that no foreign election or aid freeze can dismantle. A harm reduction system that is democratically governed, fiscally secure, and accountable to the people it serves.

The question is no longer whether harm reduction works. It does. The question is whether South Africa will act now to safeguard it.

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