

Discussion Summary: Round Table on TB and HIV Trials & Research Infrastructure At-Risk in South Africa

15 May 2025

Treatment Action Group (TAG), Médecins Sans Frontières Southern Africa (MSF), and the South African Medical Research Council (SAMRC) hosted a round table discussion for donors and media to share information about tuberculosis (TB) and HIV trials and research infrastructure put at risk by United States government (USG) executive orders, funding suspensions, and grant terminations.

The round table was moderated by Dr. Marcus Low, the editor of Spotlight, and featured a presentation from Lindsay McKenna, TB Project Co-Director at TAG and remarks from Prof. Ntobeko Ntusi, President and CEO of the SAMRC, Prof. Linda-Gail Bekker, Director of the Desmond Tutu HIV Centre and Principal Investigator of the University of Cape Town Clinical Trials Unit, Prof. Ian Sanne, Co-Principal Investigator of the Wits HIV Research Group Clinical Trials Unit, and Dr. Tom Ellman, Director of the Southern Africa Medical Unit of MSF.

Opening remarks

Dr. Marcus Low opened the round table by describing the variety of ways in which NIH funding has been withdrawn from South Africa, noting that the mechanisms and pace of these losses have differed from the loss of funding from USAID and other USG agencies earlier this year. Low underscored the pivotal role NIH funding has played in advancing scientific progress and South African research institutions' success in winning competitive awards because of the country's TB and HIV disease burden, research and regulatory infrastructure, and scientific talent. He flagged that \$150 million USD per year (2.7 billion ZAR) is at risk, roughly half of all medical research spending in South Africa. In addition to the cancellation of several direct NIH grants to South African research institutions, Low noted a new [NIH policy pausing foreign subawards](#) which has implications for research in South Africa and beyond. *"The big picture is clear: there's been a fundamental shift in US policy. There's no going back to how things were [...] we've reached the point where the writing is on the wall and it's up to us to find the way forward."*

Analysis of TB and HIV Trials at Risk

Lindsay McKenna presented an analysis of TB and HIV studies sponsored by the HIV/AIDS Clinical Trials Networks funded under the Division of AIDS (DAIDS) at the NIH - the ACTG, HVTN, HPTN, and IMPAACT networks. Limiting the analysis to DAIDS-funded trials and sites, there are 12 TB trials, 24 HIV trials, and 29 South African clinical research sites at risk. Expanding the analysis to include a non-comprehensive list of other USG-funded or -proposed TB trials and sites, there are 20 TB trials and 39 South African clinical research sites at risk. McKenna noted the proportion of participants in DAIDS-funded trials from South Africa (30-50%), and the TB and HIV innovations that will be affected if South African sites are not supported to continue to contribute to these studies. Finally, McKenna raised potential indirect impacts of USG funding withdrawals on trials sponsored by pharma, philanthropies, and other

governments which rely and build on top of core and other funding provided to clinical trials units and research sites through NIH awards. *“In addition to imperiling specific studies and innovations, USG funding cuts threaten research infrastructure, staff/talent, training for the next generation of scientists, community engagement programs, trust, and willingness to participate in future research, data sharing initiatives, and biorepositories.”*

Panel discussion

Prof. Ntobeko Ntusi starting by pointing out that South African clinical trials units and research sites are the result of over two decades of investments in core facilities and the research infrastructure and skilled personnel necessary to lead complex clinical trials and implementation research. Ntusi underscored the major impact of the USG funding withdrawals on livelihoods, noting that universities have begun retrenchments at scale putting hundreds of scientists, students, post-docs into positions of inordinate precarity and threatening the ability of South Africa’s national research enterprise to sustain its work. Ntusi also raised the impact of the USG funding withdrawals on the individuals who participate in these studies as participants and the communities they come from. *“Over decades, the South African research enterprise has built trust and a formidable relationship with community. In some communities, 2 or sometimes even 3 generations in a family have participated in trials and have come to understand the value of supporting trials because they've seen the direct benefits to the health of their own communities.”* Ntusi warned of the importance of preventing the development of a narrative of an exploitative health research enterprise that recruits the most vulnerable and can drop them on a whim, and of pushing back against fundamental assaults on academic freedom.

Ntusi ended his remarks with an overview of what the SAMRC is doing to address the funding crisis, *“We assumed leadership of coordinating the strategy for a national response and raising funds given our statutory role as custodians of health research for the country.”* The SAMRC started by trying to understand exposure to USG grants, the amounts, staff employed, students being trained, and infrastructure supported through these mechanisms, and tracking terminations as they started trickling in. The SAMRC is also lobbying the national treasury through the National Department of Health and working closely with other government departments to make the case to decisionmakers of the fundamental importance of support for research. The SAMRC has also reached out to global research funders and hosted a very successful extraordinary funders forum at the end of April that opened dialogue with local corporates and local philanthropy. Ntusi ended by remarking on what is needed to safeguard key operations and infrastructure, *“It goes without saying that we need funding. One of the key lessons of the current crisis is the risk of over-reliance on a single source. We need diversification of funding. It's also spoken to the importance of local contributions. Support of health research needs to be seen as key strategic national imperative to drive development, knowledge economy, reduce poverty, reduce inequality, reduce unemployment.”*

Prof. Linda-Gail Bekker started with an overview of the University of Cape Town Clinical Trials Unit's work on some of the very earliest ARV studies. Bekker noted that the CTU currently employs 400 people at six sites across the Western and Eastern Capes. As one of the six CTUs in the country, Bekker highlighted UCT's history of collaboration with communities hardest hit by TB and HIV and ability through research to share new information and inform guidelines and policies in South Africa and globally. She mentioned "when-to-start" guidance for pediatric HIV that came out of the famous SHOW trial, research that supported task shifting distribution of ARVs to nurses, and more recent contributions to the approval of cabotegravir as long-acting PrEP. Bekker reflected on her own career and the importance of USG funding and collaborations with US universities and scientists. UCT was first funded by the USG as a CTU in 2004 and has been contributing to the DAIDS-funded clinical trials network studies ever since. She noted that many of these studies are done under investigational new drug (IND) applications overseen by the stringent regulatory authorities and feed into WHO guidance. The existence of this infrastructure and experience proved critical for responding to new pandemics, including COVID-19 and mpox.

Bekker underscored that it's not just UCT's contributions to the DAIDS-funded network trials – UCT investigators compete for NIH R01s and R21s, and benefit from Fogarty training grants. UCT's new East London site is entirely NIH funded and is currently being "disemboweled" -- there are 6 new young PhDs there whose futures are at risk. More recently, UCT has won grants from the USG that were cooperative agreements, including a \$45 million-dollar, five-year HIV vaccine research consortium that was funded by USAID but was terminated in February. *"Today: we are under threat. The Desmond Tutu HIV Center (DTHC) receives an annual average of US\$10 million from NIH alone. We stand to lose \$6.9M of that this year based on the new NIH policy. DTHC faces the need to retrench a significant number of expert trained staff as a result of these cuts along with many other research groups in the country."* Bekker explained that notices of awards have not been renewed so although trials have not been terminated, DTHC will have to bring their involvement in trials to an end because they can't pay for staff without knowing whether these costs will be reimbursed. She underscored her remarks by pointing out that South African research creates a lot of the world's knowledge, *"A study published in 2019 – HIV/AIDS Research Insights, Trainings, Opportunities. Between 2014–2018: in that report South Africa followed the US and the UK as the third biggest producer of relevant research in the field."*

Prof. Ian Sanne shared some of the history behind how the Wits HIV Research Group Clinical Trials Unit was founded. The CTU at Wits was initially supported by pharma funding until it became one of first NIH exploratory international sites in 2003. Fast forward to the 21st of March, the Wits CTU grant was among the first to be terminated by NIH. Sanne remarked that this termination turned out to be a canary in the mineshaft – it's not just South African CTUs and CRSs affected; it's an international crisis. Turning his attention back on South Africa, Sanne pointed out that *"The NIH investment in South Africa in TB/HIV work amounts to almost \$2 billion over a period of 20 years. The funding crisis we're experiencing now is estimated by Wits to be between \$150–200M at Wits alone, 70% of which is for TB and HIV."* Sanne noted that while Wits has had to

retrench staff already, the real crisis is that NIH funding to Wits ended on the 21st of March, creating both a regulatory and ethics nightmare. *“We saw this train coming and started to ask all of our NIH researchers for their contingency plans, focused on participants. What is the ethical way to continue to monitor participants?”*

Sanne provided one example of a study of microbicide rings that was terminated and reported on in the New York Times before research participants were informed. *“It’s extremely difficult to contemplate how to safely look after participants when there’s zero funding. Are you going to follow the protocol? Stop early? If one-third of participants were enrolled in South Africa, do these studies become underpowered and start falling apart?”* Sanne pointed out all of the additional outstanding external costs such as laboratory testing, and how the approach to closing down studies without funding is even more complicated when they are being conducted under IND where input from the regulators is then required. Sanne expressed his concern for international sites that might have less funding reserves than are available to South African sites. He wrapped up his comments with a reflection on the impacts of USG funding withdrawal on the laboratory infrastructure in South Africa, noting that other sponsors rely on this for their trials, including EDTCP and the Gates Medical Research Institute. Other sponsors have come to rely on a laboratory infrastructure, including virology, immunology, and pharmacology labs in South Africa that are already externally quality assured. *“These specialty labs host basic scientists – it’s not just the clinical research infrastructure but also basic sciences; it’s the entire infrastructure. \$2 billion invested over 20 years is at risk.”*

Dr. Tom Ellman opened his remarks by acknowledging how incredibly dependent the work of MSF is on partners at the front lines of providing treatment for TB and HIV – but also on research, and specifically on research from South Africa. Ellman underscored South African researchers focus on pragmatic interventions and innovations that are fit for purpose, *“What can work in the settings where we work. Literally every single MSF project I look at is reliant on research that has been carried out in South Africa.”* Ellman reflected on the incredible number of innovations dependent on partnerships with South African researchers – innovations now being used in countries throughout the region including in Kivu and Kinshasa in the DRC. Ellman mentioned more specifically, dolutegravir, a simple, incredibly effective drug that’s low cost and wide use as first line treatment for nearly all populations, including children, TB co-infected PLHIV, and pregnant and breastfeeding women was enabled by research in South Africa; diagnostics critical for addressing advanced HIV disease that were validated by South African researchers, followed by LAM and GeneXpert tests; and shorter, all-oral treatments for drug-resistant TB studied in South Africa and now in use across the region. He also touched on other diseases that South African research has already or is poised to continue to contribute to in the future, including for cryptococcal meningitis, sepsis, AMR, and Mpox.

“The best science leads to impact in most difficult settings. There’s no question South African science is transforming responses to TB and HIV across Africa and the world: our programs are a testament to that.” Ellman ended his comments by pointing out how

particularly awful it is that this is happening at this moment in time when we are closer than ever to finding ways out of the HIV and TB pandemics. *“Vaccines are there to be found but won't if this attack on science continues. Protecting science from these harms is of self-interest: for Africa, for Europe, for America. Not even enlightened self-interest: it is obvious these research endeavors are essential to the globe.”*

Highlights from the Question & Answer Session

Prof. Sanne: it hasn't been touch on yet but there is a health economics argument to be made. Return from research is in multiples in terms of health and economic outcome – the return is 15-fold the investment made. Investments in science affect mortality and morbidity and economic output.

Prof. Bekker: Why the CTUs in South Africa? What's so special about them? With the burden of disease and research sites next door, there is the opportunity for translation. You're able to move quite easily from the bench to the bed and back to the bench. This leads to the pragmatic response and solutions that Tom (MSF) emphasized. The multidisciplinary work. Out of a single study will come the cost, cost-effectiveness, and affordability and all the way through to the social science to engage with individuals who have to use these products. And finally, the variety of settings and populations we have to do this research in.

Kerry Cullinan, Health Policy Watch: Has anyone stepped up to fund the trials? Which would be the priority trials to be saved if you could?

Gavin Churchyard, Aurum Institute: From our perspective coming from Aurum Institute, not under any academic institution, these cuts pose additional risks to us without an academic big brother institution. There are constraints and challenges we face as an independent NGO that are unique. There's support for research core, laboratories, investigators. But then there's also the priority studies that are ongoing. For priority studies, we need to find specific funding for the completion of those studies.

Christophe Perrin, MSF: it seems we need ongoing tracking to follow the evolving situation and a mechanism to help donors find studies that match their agenda (e.g., pediatrics).

Prof Ntusi: Quite a number of groups have stepped forward to offer solidarity and to match funding to what the South African government will put on the table. Many have asked to remain anonymous for now until we're able to understand what support from the South African government will be. My hope is that will be announced on May 21st and we'll be in a position to make those contributions formal and public. Continued systematic tracking of cuts — what Christophe suggested — would be helpful. If there's capacity to lead a coordinated, systemic way of doing this I'd strongly support that.

Prof. Sanne: On prioritization, the list that Lindsay presented is what the networks consider as highest priority. My sense is each network is rapidly going through process of re-prioritizing. But it's difficult: grants and projects are so intertwined. It will end up

being a composite of funding opportunities that emerge. My unit, on the 31st of May lose 40% of staff. Without clarity, another round of staff cuts will hit months later. The laboratories we work with, the PPD monitors, are all terminating staff. There needs to be a sense of urgency because those people are not going to hang around. It will be very difficult to restart the endeavor.

Prof. Bekker: There's the acute, people in study, under investigation now. Maybe we can quickly come together and agree on that. Then we need to gather exactly what trials were ready to run or very well developed and create thematic groups. We can start to organize these opportunities, so they can be packaged toward alternative funders.

Closing Remarks

In the past 20 years, many of the people on this call collectively built something incredible, showing that you can do world class research at the tip of Africa and that it can be done by people from South Africa. The issue brief published by TAG, MSF, and the SAMRC contains specific actions that donor agencies, governments, and philanthropies can take. In addition to the science, donors need to continue to finance engagement and empowerment of treatment literate communities in South Africa and beyond – these investments support continued partnerships between scientists and communities willing to engage with, promote participation in, and advocate for research – activities critical for innovations to have an impact.

An issue brief, [South Africa's TB and HIV Research at Risk: A Call to Catalyze Urgent Action by Funders](#), launched during the round table provides additional information about TB and HIV clinical trials and research programs impacted USG funding disruptions, and proposes urgent actions that donor agencies, governments, and philanthropies can take to preserve scientific advances underway and prevent the collapse of TB and HIV medical research in South Africa.

List of Participants

Children's Investment Fund Foundation	Zack Panos - Senior Manager, HIV
Gates Foundation	Ann Ginsberg - Deputy Director, TB Vaccines
	David Hermann - Deputy Director, Global Health
UNITAID	Jessica Burry - Technical officer
	Carmen Perez Casas - Senior Strategy Lead & Pandemic Preparedness Head
	Cherise Scott - Senior Technical Manager, Strategy
	Anne-Isabelle Cameron - Technical Officer, Strategy
Wellcome Trust	Zaichen Mallace-Lu - Senior Funding and Partnerships Manager, Community Engagement
	Antonia Lombardi. Senior Policy Officer
Spotlight	Catherine Tomlinson
Health Policy Watch	Kerry Cullinan

ProPublica	Anna Barry Jester
Reuters	Nellie Peyton
PE Express/News24	Danielle Saayman
Guardian	Rachel Savage
KZN CTU	Quarraisha Abdool Karim
Wits CTU	Helen Rees
	Ian Sanne
Aurum CTU	Gavin Churchyard
University of Cape Town CTU	Linda Gail Bekker
ACTG Leadership	Judith Currier
	Joseph Eron
ACTG TB TSG	Kelly Dooley
	Kogie Naidoo
Treatment Action Group	Mark Harrington, Executive Director
	Lindsay McKenna, TB Project Co-Director
	Mike Frick, TB Project Co-Director
	Richard Jefferys, Basic Science, Vaccines, and Cure Project Director
	Elizabeth Lovinger, U.S. and Global Health Policy Director
	Cheriko Boone, HIV Project Director
Médecins Sans Frontières	Christophe Perrin
	Shailly GUPTA,
	Candice Sehoma
	Claire Waterhouse
	Kübra Yalcin
	Tom Ellman
South Africa Medical Research Council	Ntobeko Ntusi, President and CEO
	Liesl Zuhlke, Vice President
	Fareed Abdullah, Director of the Office of AIDS & TB Research
	Tendani Tsedu, Head of Corporate and Marketing Communications