Beyond the Inflection Point: The Choices Before Us

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Three *HIV at an Inflection Point* briefs were published in July 2024 by the Center for HIV & Infectious Disease Policy in partnership with the Emory Global Health Institute and the Emory Rollins School of Public Health following a series of consultations with people living with HIV and leaders from community organizations, government, philanthropy, academia, and the private sector. Together, they advanced a central premise: after more than four decades of extraordinary scientific progress and community leadership, the HIV response had reached an inflection point. The choices made by policymakers, advocates, researchers, funders, and communities would determine whether the remarkable gains achieved over the past forty years could be sustained, or whether declining political commitment, growing complacency, and persistent inequities would undermine future progress.

The **first brief** called for renewed political leadership to sustain domestic and global momentum, including strengthening congressional engagement, reaffirming the central role of the White House in coordinating the national response, and maintaining HIV as a priority across the broader LGBTQ movement. The **second brief** argued that the HIV response derives its greatest strength from community leadership and emphasized the need to elevate Black leadership, strengthen accountability, invest in the workforce, and preserve meaningful community participation in planning and decision-making. The **third brief** looked ahead, calling for stronger Latino representation and leadership, greater attention to emerging populations, the application of a human rights framework, and a broader HIV agenda that addresses the social and structural conditions shaping health and well-being.

A. CORNELIUS BAKER: CARRYING THE VISION FORWARD

These reflections provide an opportunity to remember A. Cornelius Baker, one of the original authors of the *HIV at an Inflection Point* series, who passed away in November 2024. For decades, Cornelius helped shape the HIV response as an advocate, policymaker, service provider, mentor, and person living with HIV. His leadership stretched from the early years of the epidemic through the development of the institutions, policies, and partnerships that transformed what was possible for people living with and affected by HIV.

Cornelius understood that progress requires both remembering where we have been and being willing to imagine what must come next. He carried the lessons of the epidemic's earliest years into each new chapter: the importance of community leadership, the necessity of confronting stigma and inequity, the power of government action, and the responsibility to ensure that people living with HIV remain at the center of the response.

That legacy feels especially important today. Moving beyond an inflection point does not mean leaving the past behind. It means carrying forward the knowledge, relationships, courage, and hard-won lessons that made progress possible while adapting them to a changing world. At a moment when many of the institutions and commitments built over decades are again being tested, remembering that history is not an exercise in nostalgia. It is a source of guidance for what we protect, what we strengthen, and what we build next.

Cornelius helped ask the questions that launched this series. As we consider its next chapter, his life reminds us that progress is inherited, but never guaranteed. Each generation has a responsibility to learn from those who came before, build upon what they created, and prepare the way for those who will follow.

The choices before us are increasingly clear: whether to allow uncertainty and disruption to erode decades of progress, or to strengthen and adapt the systems that made that progress possible.

Collectively, these briefs argued that sustaining progress would require more than continued scientific innovation; it would require renewed commitment to the institutions, partnerships, and communities that have driven the HIV response since its earliest days.[1]

In the two years since those briefs were released, the environment surrounding the HIV response has changed dramatically. Political and financial uncertainty has disrupted long-standing domestic and global HIV programs, strained community organizations, reduced public health capacity, and challenged the stability of partnerships that have underpinned decades of progress. Proposed reductions in domestic HIV funding, restructuring of federal public health agencies, disruptions to HIV prevention and research programs, and significant changes to U.S. global health assistance have created uncertainty for governments, implementing partners, researchers, health care providers, and communities alike. At the same time, many organizations have faced workforce reductions, delayed funding, and growing concerns about their ability to sustain essential services.[2,3,4]

Globally, these changes have had immediate consequences. Recent analyses have documented substantial disruptions in HIV prevention, treatment, laboratory services, and community-based programming following changes in U.S. foreign assistance, while surveys of implementing organizations report widespread service interruptions, clinic closures, workforce losses, and reduced prevention activities. The President's Emergency Plan for AIDS Relief (PEPFAR) Pulse Study, which included 166 PEPFAR-funded organizations across 46 countries, documented at least 1,700 HIV service site closures following terminated or delayed payments, while more than one-quarter of implementing partners reported permanently discontinuing PrEP services.[5] New analyses from KFF and the Joint United Nations Programme on HIV/AIDS (UNAIDS) further show that donor government funding for HIV fell by $2.1 billion, or 25%, between 2024 and 2025—the largest annual decline since the global scale-up of the response began.[6]

Yet this moment is not solely defined by disruption. Scientific advances continue to expand what is possible in HIV treatment and prevention, creating a striking tension between unprecedented biomedical opportunity and growing uncertainty about the systems responsible for translating that progress into impact.

The original *Inflection Point* series asked whether the HIV response would continue to evolve in the face of changing political, financial, and social realities. Today, that question is no longer hypothetical. We are living through many of the pressures those briefs anticipated. The choices before us are increasingly clear: whether to allow uncertainty and disruption to erode decades of progress, or to strengthen and adapt the systems that made that progress possible. This brief argues that sustaining progress now depends not only on continuing scientific innovation, but on strengthening the political commitment, community infrastructure, public institutions, and cross-sector partnerships that have long made the HIV response one of the world's most successful public health movements.

A NEW ERA OF LONGER-ACTING HIV PREVENTION AND TREATMENT

Scientific innovation is rapidly expanding the choices available for HIV prevention and treatment. Longer-acting cabotegravir (Apretude), administered every two months, was the first injectable pre-exposure prophylaxis (PrEP) option and demonstrated greater efficacy than daily oral PrEP in two large clinical trials.[7] Twice-yearly lenacapavir (Yeztugo) has further expanded prevention options, demonstrating high efficacy in the PURPOSE trials and offering another longer-acting approach to HIV prevention.[8,9]

Longer-acting innovation is also reshaping treatment. Cabotegravir/rilpivirine (Cabenuva) provides an alternative to daily oral therapy, with real-world experience demonstrating its potential to help some people facing adherence challenges achieve and maintain viral suppression.[10] Additional longer-acting approaches are also in development. Alimatravir (MK-8527), for example, is being studied as a once-monthly oral PrEP option and has advanced to Phase 3 clinical trials.[11]

These advances create new opportunities to tailor prevention and treatment to people's lives. Their ultimate impact, however, will depend on whether health systems can make them accessible, affordable, and available to the people who could benefit most.

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SCIENTIFIC SUCCESS CANNOT SUSTAIN ITSELF

The HIV response stands at one of the most remarkable moments in its history. Four decades after the first reported cases of AIDS, scientific advances continue to redefine what is possible. Highly effective antiretroviral therapy has transformed HIV from a fatal diagnosis into a manageable chronic condition for millions of people. Longer-acting treatment and prevention options are expanding the choices available to people living with and at risk for HIV, while a growing pipeline of new modalities could further reshape how HIV prevention and treatment are delivered. At the same time, research toward an effective HIV vaccine, cure strategies, and implementation science continues to expand the possibilities for ending the epidemic.

Yet the history of the HIV response has repeatedly demonstrated that scientific discovery alone does not end epidemics. Every major breakthrough—from antiretroviral therapy to viral suppression, treatment as prevention, and PrEP—has required sustained investments in public health systems, community organizations, health care providers, implementation research, and other mechanisms to translate scientific possibility into population-level impact. Medicines do not deliver themselves. They depend on the people, institutions, and infrastructure that connect scientific innovation to the communities they are intended to serve.

Today, that delivery infrastructure is under increasing strain. Across the United States and globally, public health agencies, academic institutions, health care systems, and community-based organizations are confronting significant uncertainty.[12] Changes in federal priorities, funding instability, workforce reductions, and organizational restructuring have affected systems responsible for HIV prevention, surveillance, laboratory services, implementation research, and service delivery. Similar challenges have emerged globally as reductions in international HIV assistance have disrupted prevention, treatment, laboratory, and community-based programs in many countries.[13]

In the United States, HIV programs also depend on broader health care and insurance systems. Much of the progress of the past decade has occurred alongside expanded access to health coverage through Medicaid and the Affordable Care Act (ACA) marketplaces, which have expanded access to clinical care, medications, and other health services for people with HIV. In 2023, 46% of U.S. adults with diagnosed HIV had Medicaid coverage, underscoring the central role of broader health insurance programs in the HIV response.[14] Recent changes to these coverage pathways are now creating new pressures. The expiration of enhanced ACA Marketplace subsidies has increased affordability concerns, while new Medicaid eligibility and work requirements could put coverage at risk for some people with HIV.[15,16] Weakening these coverage pathways does not affect HIV care in isolation; it can shift greater responsibility to the Ryan White HIV/AIDS Program and its AIDS Drug Assistance Programs (ADAP), placing additional strain on systems designed to fill gaps in coverage rather than replace comprehensive health insurance.

This experience underscores a fundamental reality of the HIV response: innovation and implementation are inseparable. Longer-acting prevention therefore represents not only a biomedical breakthrough, but a test of the systems responsible for delivering it.

PROTECT THE INFRASTRUCTURE THAT DELIVERS INNOVATION—NOT JUST THE INNOVATION ITSELF.

Scientific breakthroughs alone cannot end the HIV epidemic. Sustaining progress requires comparable investments in the systems that make implementation possible. Policymakers, funders, and health leaders should:

- Sustain investments in HIV service infrastructure, including community-based organizations, public health departments, and clinical delivery systems.
- Reinforce and retain the public health and HIV workforce through recruitment, training, and long-term workforce stability.
- Protect implementation science, surveillance, laboratory capacity, and data systems needed to rapidly translate scientific advances into equitable population-level outcomes.
- Ensure that financing and delivery systems support equitable access to new prevention and treatment innovations, particularly among communities disproportionately affected by HIV.
- Protect access to Medicaid and affordable private insurance while sustaining HIV-specific safety-net programs, including the Ryan White HIV/AIDS Program and ADAPs, that ensure continuity of care for people who remain uninsured or underinsured.

A medicine that prevents HIV every six months cannot reduce infections if individuals cannot access care, if providers are unavailable to prescribe it, if insurance coverage creates barriers, or if community organizations lack the capacity to reach populations most likely to benefit. Likewise, scientific advances cannot achieve their full potential if surveillance systems cannot rapidly identify emerging trends, if laboratory networks are weakened, or if implementation science is unable to determine how best to integrate new tools into real-world settings. Emerging analyses of longer-acting PrEP have already highlighted that insurance coverage, affordability, and delivery systems will largely determine whether these innovations narrow or widen existing disparities in HIV prevention.[17]

The central challenge of this scientific moment is therefore one of translation. The pace of biomedical innovation is increasingly testing whether systems of financing, coverage, service delivery, and community engagement can keep pace. The measure of success will not simply be whether new prevention and treatment technologies are developed, but whether they can be delivered rapidly, equitably, and at scale. As the science becomes more powerful, implementation becomes more consequential.

STRENGTHEN THE INSTITUTIONS AND PARTNERSHIPS THAT MAKE PROGRESS DURABLE.

Long-term progress against HIV depends on institutions that can endure changing political, financial, and epidemiologic conditions. Policymakers, funders, and organizational leaders should:

- Invest in the next generation of HIV leadership while preserving institutional memory through mentorship, succession planning, workforce retention, and knowledge transfer across organizations and sectors.
- Strengthen mechanisms for meaningful community governance and shared decision-making at the local, national, and global levels.
- Expand cross-sector partnerships among public health agencies, academia, philanthropy, industry, and community organizations.
- Reinforce accountability structures that promote transparency, community engagement, equity, and continuous improvement.
- Encourage long-term partnerships rather than short-term transactional relationships, recognizing that trust and collaboration take time to build and sustain.

DURABLE PROGRESS REQUIRES MORE THAN FUNDING

The HIV response has succeeded not only because of what it has built, but because of how it has worked. Over four decades, HIV pioneered a model of shared responsibility among people living with HIV, community-based organizations, clinicians, researchers, public health agencies, philanthropy, industry, and policymakers. These relationships reshaped clinical research, elevated community voices in decision-making, strengthened accountability, and created mechanisms for coordinating action across institutions and sectors. As the original Inflection Point briefs observed, this capacity for collective action has been an enduring strength of the HIV response.

These institutions and relationships did not emerge by chance. They were built over decades through sustained public investment, bipartisan political leadership, scientific collaboration, community activism, and philanthropic engagement. The Ryan White HIV/AIDS Program established a national model for coordinated, patient-centered care. In 2024, the program served 601,853 people—more than half of people with diagnosed HIV in the United States—and 91.4% of patients receiving Ryan White-funded medical care were virally suppressed, up from 69.5% in 2010.[18] The Centers for Disease Control and Prevention, the National Institutes of Health, and the Health Resources and Services Administration developed complementary roles in prevention, research, care, surveillance, and implementation. Community planning bodies, advisory councils, advocacy organizations, and networks of people living with HIV helped ensure that policies reflected lived experience and that governments remained accountable to the communities they served. Their role was not simply consultative; community participation helped shape priorities, policies, and decisions. No single institution has been responsible for the success of the HIV response. Its strength has come from the ability of different institutions to play distinct but complementary roles while remaining accountable to a shared mission.

The global HIV response offers a parallel lesson about the importance of sustained institutions and partnerships. PEPFAR and the Global Fund have demonstrated what long-term collaboration among governments, multilateral organizations, civil society, communities, philanthropy, and implementing partners can achieve, dramatically expanding access to HIV prevention and treatment over the past two decades. PEPFAR, in particular, has been credited with saving more than 26 million lives since its creation.[19] These investments have also produced benefits beyond HIV. A recent analysis found that PEPFAR-supported countries experienced a 23.4 percent reduction in all-cause mortality relative to the 2004 baseline, alongside significant reductions in maternal and child mortality.[19] Investments in HIV infrastructure can therefore strengthen broader health systems and contribute to global health security.

Across both domestic and global responses, the implications for the future are clear. Sustainability cannot be measured solely by annual appropriations or grant awards. Funding is essential, but financial resources alone cannot create trust, leadership, or effective institutions. Community organizations require years to build credibility with the populations they serve. That credibility has become even more consequential in an environment where misinformation, distrust of public institutions, and growing challenges to scientific and public health expertise can shape how health information is understood and whether it is trusted.[20] Trusted community leaders, providers, and institutions play an essential role in translating evidence, addressing uncertainty, and maintaining confidence in the HIV response.

Cross-sector partnerships are built through sustained collaboration and shared accountability rather than short-term transactions. Institutional memory—the accumulated knowledge, relationships, and experience developed through decades of responding to HIV—is itself a form of public health capacity. Preserving that capacity requires not only retaining knowledge, but intentionally transferring it across generations of leaders. Once diminished, these assets can be difficult and costly to rebuild.

Durable responses are built through relationships as much as resources. Funding can establish a program, but leadership, trust, governance, and accountability determine whether institutions can adapt when circumstances change. Preserving these less visible assets of the HIV response will be essential to sustaining progress through periods of political, financial, and organizational uncertainty.

THE HIV RESPONSE MUST CONTINUE TO EVOLVE

The HIV response has never remained static. Throughout its history, it has repeatedly adapted to new scientific discoveries, changing epidemiology, and evolving social realities. Advances in treatment and prevention transformed what it means to live with HIV and what is possible in preventing transmission, while community advocacy reshaped research, policy, and public health practice. At every stage of the epidemic, progress depended upon a willingness to rethink existing approaches rather than simply preserve them.

That same spirit of adaptation is needed today. The HIV epidemic in 2026 differs substantially from the one that shaped many of today's institutions. Nearly half of Ryan White HIV/AIDS Program clients are now age 50 or older,[18] bringing increasing attention to multimorbidity and the complex health needs associated with aging with HIV.[21] Yet the systems developed to respond to HIV were not necessarily designed for a population increasingly navigating aging, multiple chronic conditions, and more complex health and social needs.

At the same time, persistent disparities remain across populations and geography. In 2024, Black people represented approximately 12% of the U.S. population but 39% of HIV diagnoses, while the South accounted for 51% of all diagnoses. Among males older than 24 whose HIV was attributed to male-to-male sexual contact, Hispanic/Latino males accounted for the largest share of diagnoses, at 40%. [22]

These demographic changes are occurring alongside technological and societal shifts that are changing how people interact with health systems. Digital health, artificial intelligence, telehealth, new models of service delivery, and increasingly personalized approaches to prevention and care create opportunities to reach

MODERNIZE THE HIV RESPONSE TO MEET THE REALITIES OF THE NEXT GENERATION.

The HIV response must continue evolving alongside changing demographics, technologies, and community needs. Policymakers, researchers, providers, and community leaders should:

- Develop a comprehensive national strategy for healthy aging with HIV, integrating HIV care with primary care, behavioral health, chronic disease prevention, and long-term support services.
- Strengthen integrated, person-centered models of care that address housing, mental health, substance use, and other social and structural factors alongside HIV prevention and treatment.
- Leverage digital technologies and artificial intelligence responsibly to improve outreach, clinical decision-making, and program delivery while protecting privacy, equity, and community trust.
- Regularly reassess HIV strategies and models of service delivery to reflect changing epidemiology, demographics, technologies, and where and how people seek care.
- Co-design emerging models of prevention and care with people living with and affected by HIV, ensuring that new systems and technologies reflect community needs and lived experience.

Durable responses are built through relationships as much as resources. Funding can establish a program, but leadership, trust, governance, and accountability determine whether institutions can adapt when circumstances change.

The HIV response has always succeeded by anticipating the future rather than reacting to it. Today's challenge is not to replace the institutions that have served the response so well, but to ensure that they continue to evolve alongside the people and communities they exist to serve.

people differently. They also raise important questions about privacy, access, bias, trust, and the appropriate role of technology in public health. The task is not simply to adopt new tools, but to determine how they can strengthen rather than substitute for the relationships and services on which effective HIV prevention and care depend.

The boundaries between HIV and broader health and social issues also continue to narrow. Housing instability, behavioral health, substance use, economic security, stigma, and other social and structural conditions increasingly shape outcomes throughout the HIV care and prevention continuum. These realities reinforce that HIV cannot be addressed in isolation. As people with HIV live longer and their health needs become more complex, HIV systems will increasingly need to connect with primary care, aging services, behavioral health, chronic disease management, housing, and other health and social services.[23,24] The challenge is not to dilute the focus on HIV, but to build models of prevention and care that better reflect the lives of the people those systems are intended to serve.

The HIV response has always succeeded by anticipating the future rather than reacting to it. Today's challenge is not to replace the institutions that have served the response so well, but to ensure that they continue to evolve alongside the people and communities they exist to serve. That means embracing new approaches while protecting equity, expanding the reach of HIV systems while preserving community leadership, and designing institutions flexible enough to respond to demographic, technological, and societal change. It also requires periodically reassessing whether the strategies, structures, and models that guided earlier phases of the response remain suited to the realities of the epidemic today. The purpose of moving beyond the inflection point is not simply to preserve what has been built. It is to build upon those achievements in ways that prepare the HIV response for the scientific, demographic, and policy realities of the decades ahead.

THE NEXT CHAPTER BEGINS NOW

The HIV response has never been defined solely by the virus it confronts or the medicines it develops. It has been defined by people—the advocates who demanded action when governments remained silent, the researchers who challenged scientific boundaries, the clinicians who earned the trust of their patients, the community organizations that reached those left behind, and the policymakers and partners who recognized that ending the epidemic required sustained commitment across generations. Together, they transformed one of the greatest public health crises of our time into a defining example of scientific innovation, community leadership, and collective action.

Today, the HIV response once again stands at an important moment in its history. Scientific possibilities continue to expand even as political, financial, and institutional uncertainty reminds us that progress is never inevitable. The challenge is to ensure that the systems and relationships built over four decades are strong enough to sustain progress while flexible enough to meet what comes next.

The original *Inflection Point* series asked whether we would continue evolving to meet the challenges ahead. The choices before us now will help provide the answer. Choices about leadership, partnerships, community engagement, governance, and sustained public investment will determine whether future generations inherit a response that is more equitable, adaptable, and capable of meeting the realities of a changing epidemic.

Our history offers reason for optimism. Time and again, the HIV response has demonstrated an extraordinary capacity to adapt. It has repeatedly transformed crisis into innovation, exclusion into partnership, and uncertainty into progress. That same spirit remains one of our greatest strengths.

We inherit one of the most successful public health movements in history. We also inherit the responsibility to strengthen it for those who come next.

The future of the HIV response will not be defined solely by the technologies we invent or the challenges we face. It will be defined by the choices we make together to ensure that innovation, equity, and community continue to move forward hand in hand.

We inherit one of the most successful public health movements in history. We also inherit the responsibility to strengthen it for those who come next.

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