Protecting Today's and Building Tomorrow's Domestic HIV Prevention System

Preventing HIV is a long game and there will always be a need to ensure access to durable and effective HIV prevention. Every day, thousands of young people reach the age of their sexual debut, and they need information, education and access to tools that enable them to experience pleasure while remaining free from HIV and other sexually transmitted infections (STIs). Our Nation's experience with HIV prevention and complex issues tied to poverty, substance use disorders (SUD) and communicable diseases, among other issues, shows that policies and programs must continuously evolve if we are to reduce the impact of these issues on the health of our communities.

The good news is that we have greater capacity than ever before to deliver effective HIV prevention services through bold agency-level federal leadership, high-functioning state and local health departments, well-trained clinical providers, and trusted networks of responsive and impactful community partners and advocates living with HIV.

In an era of unprecedented access to health information and rapidly evolving medical breakthroughs, a primary challenge today is to ensure that national leaders fully understand the complexity tied to preventing new HIV infections and the critical role that federal agencies play in protecting the health of our people. Policymakers must become invested in preserving the core public health infrastructure, capacity, and responsiveness of our HIV prevention system with the Centers for Disease Control and Prevention (CDC) as the cornerstone while it works in close partnership with other federal agencies, along with health departments and community-based organizations (CBOs) throughout the country. Policymakers also must support efforts to address the complex and changing needs of communities and prepare the HIV prevention system for the transformation that is coming as the fruits of our longstanding investments in prevention research, pharmaceutical innovation, and the development of other new technologies. There is a need to take action in three areas:

1. PROTECT CDC'S DOMESTIC HIV PROGRAM

Preventing HIV in the population is complicated because social conditions heavily influence whether people know, access or prioritize HIV prevention options. Each part of the system must operate efficiently at the national, state, local, and community levels. Federal agencies including the CDC, the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Indian Health Service (IHS) and the Centers for Medicare and Medicaid Services (CMS) must be seen as a network that is greater than the sum of its parts.

ENSURING THE SUSTAINABILITY OF OUR HIV PREVENTION SYSTEM

Ending HIV transmission in the U.S. is a never-ending challenge:

PROTECT CDC'S DOMESTIC HIV PROGRAM

Increase funding for the domestic HIV prevention portfolio and ensure adequate staffing levels

Modernize HIV surveillance systems and protect case surveillance, the Medical Monitoring Project (MMP), and the National HIV Behavioral Surveillance program (NHBS)

Safeguard local data and provide actionable data for local stakeholders

RE-IMAGINE THE ROLE OF COMMUNITY

Update mechanisms to give affected communities a real voice in setting services priorities

Restore and expand funding for community-led community-based organizations (CBOs)

Fund CBOs to take innovative and scientifically-proven prevention methods to scale

CHART A VISION FOR HIV PREVENTION THAT LEVERAGES CONTINUING INNOVATION

Maximize options for PrEP users that require fewer clinical visits

Support integrated syndemic approaches to HIV and other health threats

Continue supporting prevention research including basic science, vaccine development, microbicides, behavioral and social research, and implementation science

The CDC's domestic HIV program, housed within the Division of HIV Prevention (DHP), has primary responsibility for guiding and managing our domestic HIV prevention response. Its central leadership role directs HIV prevention programming, hosts a centralized surveillance system, disseminates best practices, and funds critical HIV prevention functions (e.g., technical assistance, capacity building, social marketing and research) that enable other parts of the Nation's HIV prevention response to function. Its success, however, depends on collaboration with other parts of the National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP). The communities most heavily impacted by HIV are also at elevated risk of other sexually transmitted infections (STIs), as well as other infectious diseases such as viral hepatitis, but also other social challenges such as poverty, SUD, and other barriers to good health. The concept of a syndemic—overlapping and synergistic epidemics—recognizes that conditions like HIV do not exist in isolation and the interactions with these other conditions often fuel their spread. No single agency or staff person can fully address all related conditions. Therefore, there is a need to maintain separate programs that ensure expertise is retained in HIV, STIs, hepatitis, other infectious diseases, as well as in monitoring and services delivery. The steady decline in HIV transmission in the U.S. and the reduction in disparities across many populations provide evidence that the complex structures and the networks of relationships established at the federal, state, local, and community levels are producing results.

HIV PREVENTION IS UNDER ATTACK

The complex, multi-faceted nationwide HIV prevention system that has been built and refined over four decades is being threatened:

- Proposed reductions in funding for CDC including its domestic HIV program
- Reductions in force (RIFs) and the loss of critical expertise at CDC and across the Department of Health and Human Services (HHS)
- Threats to the US Preventive Services Task Force (USPSTF) whose evidence-based recommendations provide no-cost access to PrEP, HIV testing, and other critical prevention services
- Government institutions spreading misinformation and actively undermining trust in science
- De-funding of programs that focus on the people and places with the greatest burden of HIV
- Weakening Medicaid and private insurance access, permitting or encouraging stigma and discrimination against groups heavily impacted by HIV including the LGBTQ community, people who use drugs, and racial and ethnic minorities

Notably, there has been a 12% decline in HIV incidence (i.e., new annual HIV infections) from 2018 to 2022.[1]

POLICY ACTION:

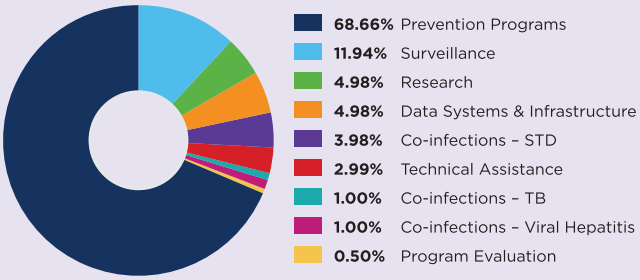
Increase funding for the domestic HIV prevention portfolio and ensure adequate staffing.

In 2019, the Trump Administration boldly launched the Ending the HIV Epidemic initiative (EHE) and directed additional resources from CDC, HRSA, IHS, and NIH to high burden jurisdictions across the U.S (48 high burden counties, Washington, DC, San Juan, Puerto Rico, and seven rural states).[2] EHE was designed as an add-on to core CDC HIV prevention activities and was not intended to substitute for the nationwide program of surveillance and prevention activities already supported by CDC's domestic HIV program. Although Congress has supported EHE during the Trump and Biden Administrations, it has never funded EHE at the level that both Administrations' projections said were needed to achieve its goals.

In 2025, in a reversal of the leadership witnessed six years prior, the Trump Administration proposed to eliminate the entire HIV prevention investment at CDC. If enacted, amfAR estimated it would have resulted in over 140,000 new HIV infections by 2030.[3] Some of these funds were to be shifted outside of CDC to a new agency, the Administration for a Healthy America, but the staffing expertise and the legal arrangements that enable CDC to collect HIV surveillance data voluntarily reported by state and local health departments would have been disrupted. Moreover, this move would have resulted in a wholesale elimination of critical expertise and historical memory at the CDC derived from more than four decades of HIV prevention efforts. Congress did not support the Administration's domestic HIV prevention request and funded the agency at $755.6 million for its core HIV prevention program, the same level as in FY 2025.[4] The Trump Administration proposed to continue to fund EHE at $220 million, the same level as in FY 2025, and Congress appropriated this amount. Over the past two years, a significant number of highly qualified personnel at NCHHSTP and throughout CDC (including the NCHHSTP director) either retired early or lost their jobs. Can CDC maintain a record of success in combatting HIV with this lost institutional knowledge and reduced staffing?

In 2026, the Trump Administration has again proposed to eliminate core prevention funding for CDC's domestic HIV program in its FY 2027 budget request.[5] **To protect the progress that has been achieved, Congress should not weaken our Nation's critical HIV prevention agency but instead increase funding for CDC's domestic HIV program to help preserve purchasing power eroded after years of flat funding**.[6,7] New biomedical HIV prevention options

FY 2026 BUDGET FOR CDC'S DOMESTIC HIV PROGRAM



Note: Includes $755 Million for Domestic HIV Prevention and $220 Million for the Ending the HIV Epidemic Initiative (EHE) at CDC

Source: Division of HIV Prevention Update, presented to the Federal AIDS Policy Partnership, June 24, 2026.

(e.g., longer-acting pre-exposure prophylaxis, i.e., PrEP) and advances in technology (such as self sample collection for HIV and STI screening) are creating new opportunities to more effectively prevent HIV. With more robust funding, CDC and its community and health department grantees stand to further accelerate HIV prevention progress. For FY 2027, the AIDS Budget and Advocacy Coalition (ABAC) is calling for an increase of $67.1 million for core prevention activities at CDC, to $822.7 million, and an increase of $175 million for EHE at CDC, to $395 million.[8]

POLICY ACTION:

Modernize HIV surveillance systems and protect case surveillance, the Medical Monitoring Project (MMP), and the National HIV Behavioral Surveillance program (NHBS).

States routinely and regularly report new HIV diagnoses and other critical data to CDC that then enables it to describe nationwide trends in HIV transmission, monitor viral suppression, and respond to outbreaks. The National HIV Surveillance System (NHSS) has been a model for other nations and provides actionable information for policymakers, providers, and community stakeholders nationwide.[9] More than $8 billion in federal funds annually are allocated based on the latest NHSS data to maximize the impact of federal investments by ensuring that they are directed to the places with the greatest need.[10] Technological advances and the wider use of electronic data systems are enabling more timely and accurate surveillance, but resources are needed to ensure that all jurisdictions can deploy these new tools.

The Medical Monitoring Project (MMP) is a separate surveillance system operated by CDC that provides a unique source of nationally representative data on the care experience of people living with HIV in the U.S.[11] Twenty-one project areas (15 state health departments, 5 local health departments, and the Puerto Rico Department of Health) conduct MMP and report data to CDC that enable it to offer nationally representative data related to clinical outcomes such as viral suppression, track behaviors and risk factors, and identify barriers to sustained engagement in care. Funding and staffing for this program should be retained, and CDC should be directed to preserve MMP program activities.

Created in 2003, CDC's National HIV Behavioral Surveillance (NHBS) program gathers critical biological and behavioral data about populations highly vulnerable to HIV.[12] Standard case reporting in the NHSS includes data only on people who have HIV and NHBS supplements this by providing insights into the groups

PREVENTING HIV REQUIRES MANY ACTIONS

A comprehensive HIV prevention system requires many functions and activities, including:

Surveillance: Systematic collection of data on HIV transmissions and other outcomes by health departments and subsequent reporting and analysis by CDC

Outbreak Response: Set of public health actions to curb widespread transmission to include targeted testing, provider alerts, public communication, and dissemination of various prevention interventions

Treatment as Prevention (TasP): Recognition that providing antiretroviral therapy (ART) to people with HIV to achieve viral suppression stops onward transmission

HIV testing and screening: Offering HIV tests to individuals based on risk behavior or routinely testing (i.e., screening) all people when they come in for clinical care without an indication of HIV exposure or risk

Pre-exposure prophylaxis (PrEP) and Post-exposure prophylaxis (PEP): Delivery of ART to prevent HIV transmission before exposure or a 28-day regimen following a possible exposure

Education/risk reduction: Dissemination of information about HIV transmission, living with HIV, and actions that can reduce the risk of HIV acquisition

Syringe Services Programs (SSPs) and Harm Reduction Services: Provide clean syringes and supplies to prevent needle sharing and reduce risk of HIV and Hepatitis transmission while injecting or smoking drugs

Condom Distribution: Provides free and easy access to condoms and lubricants

at greatest risk of acquiring HIV. Data from NHBS helps guide national and state HIV prevention efforts, but the program is under threat of elimination as part of the proposed budget reductions and restructuring.

POLICY ACTION:

Safeguard local data and provide actionable data for local stakeholders.

Through a combination of core HIV prevention and EHE funds, CDC's domestic HIV program awarded $485 million to state and local health departments in 2025.[13] To ensure a more robust HIV prevention response, state and local health departments must supplement federal funding with their own general fund revenue to maintain and strengthen their capacity to monitor trends in HIV transmissions, achieve better outcomes, identify resource needs and support services that have the greatest impact. Further, at a time of increasing infectious disease outbreaks across the Nation (e.g., measles, COVID-19, Cyclospora and other foodborne outbreaks, along with HIV, hepatitis, and STIs), there is an even greater need for robust and effective infectious disease monitoring at the state and local levels.

2. RE-IMAGINE THE ROLE OF COMMUNITY

CDC provides the infrastructure and state and local health departments fund and support critical prevention activities, including surveillance and outbreak response, but communities and CBOs are generally where positive impacts happen. The history of the HIV response always has been driven by people with HIV and the communities most heavily impacted. When resources tighten, however, it seems that investments in CBOs and funding for community-led activities are the first to be cut. In the face of fear and lack of information, community activists promoted safer sex practices even before there was scientific validation for behavioral risk reduction. People with HIV who are durably virally suppressed cannot transmit HIV sexually, known as U=U or undetectable equals untransmittable. This understanding was scientifically established and validated by critical research supported by the NIH, CDC and other agencies. While the acknowledgement of U=U by respected federal agencies and international bodies such as UNAIDS and the World Health Organization (WHO) is important, trusted community members often have far more credibility than the stamp of approval from a government agency.[14] Currently, many people and communities are fearful and under attack, and trust in government has fallen precipitously. At this precise moment, the power of communities to shape prevention programs continues to diminish. This retrenchment must be reversed.

POLICY ACTION:

Update mechanisms to give affected communities a real voice in setting services priorities.

Community engagement and input are critical to ensuring that prevention programming is effective and responsive. In the mid-1990s, CDC established HIV Prevention Community Planning. This requires jurisdictions that were receiving HIV prevention funds to establish community planning groups (comprised of affected communities, prevention services providers, epidemiologists, and clinical providers) to conduct an epidemiological assessment of HIV in their community and use it to establish local services priorities. This includes identifying underserved populations and setting priorities for funding specific prevention interventions. State and local health department grantees are required to invest federal resources consistent with the priorities set by the local community planning group. In some communities, especially larger jurisdictions with strong, organized coalitions of people with HIV or other advocacy groups, community planning has worked well. Unfortunately in others, health departments have sidelined critical community voices.

There is a need to retool community planning so that programs and services better meet community needs. This should include compensating community members for participating on advisory boards or in community consultations, and expanding the commitment of health departments and other public health agencies to hire, train, and nurture community members to formally work in public health, including but not limited to serving as community health workers (CHWs).[15]

POLICY ACTION:

Restore and expand funding for community-led community-based organizations (CBOs).

Currently, more than 85% of CDC's domestic HIV prevention funding is awarded to external groups including health departments, community-based organizations (CBOs), and other organizations.[16] The vast majority of this funding is awarded to state and local health departments for high-impact prevention and surveillance programs, but in FY 2024, CDC awarded $40 million in core CBO funding to 96 CBOs and their clinical partners throughout the nation, along with $14 million to 36 CBOs to conduct targeted prevention with disproportionately impacted communities.[17]

The Trump Administration has signaled its intent to phase out the funding mechanism that awards funding directly to CBOs (PS21-2102).[18] Concurrently, it is said

to be establishing a supplemental pool of funds that health departments could apply for that could be subsequently awarded to CBOs. The proposed new mechanism, however, would award fewer resources than the current CBO funding program, would result in fewer CBOs receiving funds, and would not require health departments receiving these supplemental funds to award the funds to CBOs. This new construct would weaken our nationwide HIV prevention response and should not be implemented.

POLICY ACTION:

Fund CBOs to take innovative and scientifically-proven prevention methods to scale.

The Nation has invested in biomedical and behavioral research that continues to yield more effective and durable prevention interventions, and we have sustained nationwide surveillance systems and public health efforts. Limited funding, however, has limited the impact of existing systems at the same time that we face an urgent challenge of delivering effective interventions at scale in communities all across the country. While much of the HIV discourse in Congress has been about maintaining flat funding for HIV prevention even in the face of increasing need, we cannot ignore the profound impact of health care inflation that results in diminished spending power. EHE is an important effort to increase the capacity of rural states and high-burden jurisdictions to offer prevention and care at scale. Despite insufficient funding and the disruptions caused by the COVID-19 pandemic, early evidence has shown that EHE is having an impact. An amfAR analysis found that reductions in the rate of new HIV diagnoses were higher in EHE counties than non-EHE counties with the next highest HIV prevalence.[19] Early evidence also suggests that PrEP uptake from 2016-2023 increased more rapidly in some EHE jurisdictions than non-EHE jurisdictions,[20] and an analysis of CDC HIV testing services in 2021 found that CDC-funded HIV testing services in EHE jurisdictions conducted more tests and diagnosed more people than non-EHE jurisdictions.[21] Increased funding for EHE and expanding beyond the phase one jurisdictions is an important component of taking proven prevention interventions and delivering them at scale in the communities with the greatest burden of HIV.

At the current moment of backlash against diversity, equity, and inclusion (DEI), it is important to understand that for prevention responses to be most effective at protecting all Americans from HIV, they should focus resources and attention on the people and places bearing the greatest burden of the epidemic. This means prioritizing the South and focusing intently on the communities most heavily impacted, including Black and Latino communities, as well as programs with the trust and capacity to serve gay, bisexual, and other men who have sex with men (MSM), transgender populations, cisgender Black women, and people who use drugs. The leadership of these organizations also should reflect the communities they are serving. Organizations for people who use drugs will be more impactful if the leadership and the staff consist of people in recovery who have their own lived experience with SUD.[22] Similarly, there is a place for all people who want to be part of the HIV response, but given the low uptake of PrEP among Black and Latino people, having strong organizations led and staffed by Black and Latino people is critical to their success.[23] Both nationally and in communities across the country, there are organized coalitions such as the US People Living with HIV Caucus, Positive Women's Network, PrEP in Black America, and the Latino Commission on AIDS, among hundreds of other such organizations, with the reach into communities unmatched by larger health centers, health departments, or health plans. We should reject the assertion that funding and staffing is based on ideology; it is based on effectiveness and impact.

HERE ARE THE RECEIPTS: CDC-FUNDED CBOs PRODUCE RESULTS

CBO HIV TESTING YIELDS MORE POSITIVE TESTS

A study of CDC-funded HIV tests from 2012-2017 found that CBOs conducted only 2.9% of all tests but **had a test positivity rate of 2.0% compared to 0.8% for health departments**. During this period, CBOs had 11,040 positive test results.

CBO HIV TESTING FINDS MORE NEWLY DIAGNOSED PEOPLE

Every positive test result is an opportunity to link people to HIV care, but not every positive test is a new diagnosis. Some people have tested positive before but were not retained in HIV care. **1.4% of all tests conduct by CBOs were people who had not been previously diagnosed, compared to 0.5% for health departments**. During this period, CBOs identified 7,625 new cases.

CBO HIV TESTING LINKS PEOPLE TO CARE SOONER AND MORE OFTEN

Getting people from a diagnosis quickly into care is important for establishing a stable ongoing relationship with a care system and it is critical to achieving viral suppression. A critical goal is to link all people to HIV care within 30 days of their diagnosis. **CBOs linked 86.7% of their clients to HIV care within 30 days compared to 73.7% for health departments**.

Note: These results are not an indictment of Health Departments. They have a larger and different role and CBOs could not replace them. BUT, CBOs are a critical part of an effective HIV testing and linkage to care program.

Source: amfAR infographic "CDC-funded community-based organizations are critical to ending HIV in the U.S.: Here is the proof", September 2026.

3. CHART A VISION FOR HIV PREVENTION THAT LEVERAGES CONTINUING INNOVATION

There is a need to articulate and work toward a new vision for what HIV prevention, delivered at scale, will look like. This will require giving people more options for which types of prevention services they receive, making it easier for sustained prevention engagement to fit into people's lives, and continuing to invest in a broad HIV prevention research agenda.

POLICY ACTION:

Maximize options for PrEP users that require fewer clinical visits.

The effectiveness of daily oral PrEP, first demonstrated in 2009 and approved by the Food and Drug Administration (FDA) in 2012, represented an important advance. There are now a growing number of daily and longer-acting PrEP options. Available research shows that PrEP is about 99% effective.[24] Therefore, supporting uptake and persistent use has important public health benefits. Too few people who could benefit from PrEP, however, are accessing it: the latest estimates suggest only about a third of people in the U.S. who would benefit from PrEP are taking it. Further, there are enormous gaps in who is not accessing PrEP. AIDSVu reports that Black people represented 39% of all new HIV diagnoses in 2024, the highest among all racial/ethnic groups, but only 15% of PrEP users in 2025. Latinos represented 34% of new HIV diagnoses, but only 18% of PrEP users in 2025. In contrast, white people represented 21% of new HIV diagnoses, but 63% of all PrEP users in 2025. By age, young people aged 13 to 24 made up only 10% of all PrEP users in 2025, but 18% of new HIV diagnoses in 2024. By sex, women accounted for 20% of new HIV diagnoses in 2024 but only 10% of PrEP users in 2025. The South is the region most underserved by PrEP. While 52% of new HIV diagnoses in 2024 were in the South, only 39% of PrEP users in 2025 were in that region.[25] More work is needed to increase uptake and persistence of PrEP use in the communities where the most HIV transmissions are occurring.

Access, affordability, and the logistics of the PrEP regimen (including required lab tests) all pose challenges. Beyond these, not everyone can consistently take a daily pill, and privacy concerns, transportation barriers, and limited provider capacity can make persistent use difficult. Today, we are experiencing a burst of innovation and expanded options for accessing effective PrEP. The FDA has approved a bimonthly injectable form of PrEP (also available for HIV treatment),[26] another form of twice-yearly injectable PrEP,[27] and there is an investigational new drug that holds out the promise of a monthly oral medication for PrEP.[28] This expansion of options, combined with new tools such as self-sample collection for HIV and STI screenings and the use of telehealth to minimize the need for in-person clinic visits, should foster an expansion in uptake of PrEP as different modalities can meet differing needs and preferences… But this will only happen if policies are enacted to ensure stable and affordable access to whichever PrEP option works for each individual. Policies are needed to accelerate the creation of a future where staying HIV free is easy and routine.

POLICY ACTION:

Support integrated syndemic approaches to HIV and other health threats.

We must integrate HIV prevention more deeply into other health care and other programs. Social and economic environments and policies affect health across the board. HIV infections are higher in lower-income versus higher-income communities.[29] Viral load is higher among people who are unhoused rather than stably housed;[30] higher for people living with HIV who have to travel more than 5 miles to access care;[31] and higher for people living with HIV who have experienced two or more recent stressful or traumatic events.[32] Communities that are burdened with high rates of poverty, SUD, crime, economic distress, and other infectious diseases need both greater access to health care including prevention services and legal and social environments that create safety. Thirty-two states criminalize people living with HIV and 28 states have harsh criminal penalty enhancements that elevate charges based on a person's knowledge of their HIV status for actions such as failure to disclose their HIV status before having sex or theoretically exposing a person to HIV, for transmitting HIV, or for donating blood products or organs.[33] These laws do not effectively change the behavior of people with HIV and do not protect individuals from exposure to HIV; however they do significant harm to people with HIV, and undermine public health efforts.[34] Therefore, eliminating these laws and removing law enforcement from the public health sphere are necessary components of strengthening HIV prevention for the future. Further, people with other unmet needs of everyday life, such as safe and stable housing, food and nutrition, or the ability to be safe in their person and in their community free from violence, are critical prerequisites of effective prevention.

POLICY ACTION:

Continue supporting prevention research including basic science, vaccine development, microbicides, behavioral and social research, and implementation science.

Our effective response to the HIV epidemic has been driven by scientific and community innovation.

THE U.S. CANNOT END HIV WITHOUT REDUCING RACIAL DISPARITIES

Black-white and Latino-white disparities in HIV incidence and prevalence in the U.S. have been documented over many decades and these are compounded by less access to health care and prevention services, poverty, and other social factors. Recently, researchers modeled the impact on HIV incidence of optimal prevention and care interventions in six cities (Atlanta, Baltimore, Los Angeles, Miami/Dade County, New York City, and Seattle/King County). These cities represent 24% of national HIV incidence. **The study demonstrated that simply implementing biomedical interventions without addressing social determinants such as poverty, stigma and racism will not eliminate current disparities in HIV incidence**. Increasing access to prevention and care services reduced incidence across all racial/ethnic groups, but it did not eliminate the large disparities. For example, the relative risk of HIV incidence for Black people declined in only three cities (Atlanta, Baltimore, and Los Angeles) and nowhere did it achieve parity with whites. Latinos approached parity in only three cities (Baltimore, Los Angeles, and Miami), but not in others.

The U.S. is undergoing several demographic shifts, each of which has implications for the future provision of HIV prevention services. Between 2014 and 2060, the U.S. population is projected to increase from 319 million to 417 million. Demographic trends suggest that there will be substantial growth in populations that have experienced syndemics of poverty, stigma, and HIV.

- The non-Hispanic White population is expected to decline from 199 million in 2020 to 179 million in 2060.
- By 2060, Latino people are projected to comprise 28% of the US population, up from 18% in 2017.
- By 2060, the Black population is projected to grow by 34%

Source: Nosyk, B. et al, "Ending the Epidemic" Will Not Happen Without Addressing Racial/Ethnic Disparities in the United States Human Immunodeficiency Virus Epidemic, CID, 2020 and PS Sullivan et al, Epidemiology of HIV in the USA: epidemic burden, inequities, contexts, and responses, Lancet, 2020.

There is a need, however, for continued discovery of biomedical agents to prevent and treat HIV and for a broader set of research priorities. More work is needed to test and evaluate new approaches to delivering prevention services and new ways to support sustained engagement with prevention for the most marginalized people and communities. This includes behavioral and social research to better understand how to engage marginalized communities in prevention, how and when to most effectively use self-testing (which can overcome barriers such as lack of transportation or stigma associated with coming into a clinic) and research into how to adopt a syndemic approach so that HIV prevention interventions improve health and well-being related to other challenges such as other STIs, SUD, and other social issues. Implementation science and translational research studies optimize how we deliver and implement proven interventions so that they can be used most effectively prevent HIV in different parts of the country and across populations. There is a need to re-invigorate and increase our long-term research investments across the NIH and in CDC DHP's Research Branch and to support expanded health services research through SAMHSA, Indian Health Service, and HRSA. Additionally, funding for demonstration projects supported by the Ryan White HIV/AIDS Program Special Projects of National Significance (SPNS) Program should be expanded.

THE TIME IS NOW

The future of HIV prevention and care can be bright, and we are on a trajectory to make HIV as a public health threat a thing of the past. This will require that we expand our investments in CDC's domestic HIV program, in HIV prevention and research programs across the Department of Health and Human Services, and in honoring the essential role of communities in leading the way.

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