When I began my career as an HIV activist in Botswana two decades ago, the thought of a vaccine seemed fanciful. Even after the country hosted vaccine trials in the mid-2000s, many of us on the frontlines of the fight against HIV doubted that such a breakthrough would ever happen.

But this month, research published in The Lancet upended our pessimism. Clinical trials involving 393 people in East Africa, South Africa, Thailand, and the United States have yielded encouraging immunogenic responses and a “favorable safety and tolerability” profile. While these findings are preliminary and the sample size small, it is nonetheless exciting to imagine that the world may be on the verge of a viable vaccine. To take advantage of the benefits, we must begin preparing for its arrival now.

These are challenging times in the global effort to end HIV. Though health-care workers have focused on containing the epidemic for nearly four decades, infection rates remain stubbornly high. In 2017, there were 1.8 million new cases, and some 15.2 million people were unable to access HIV treatment In West and Central Africa, only 2.1 million of the 6.1 million people living with HIV were receiving antiretroviral therapy.

This history suggests that even with a vaccine, many complex social, economic, and cultural issues will continue to complicate the war on HIV. We must think carefully about how to introduce a vaccine without unintentionally encouraging “rebound effects,” like the re-emergence of practices that expose people to HIV infection.

While an HIV vaccine would no doubt be a game changer, it would be only one of a diverse range of tools needed to contain one of mankind’s deadliest pandemics. For a vaccine to have the greatest impact, we must continue to promote other forms of prevention – such as condom use, medical male circumcision, and use of pre-exposure prophylactics for at-risk populations.

Vaccine-related rebound effects are guiding research on other diseases, particularly malaria. In Sub-Saharan Africa, for example, researchers are currently assessing how human behavior might change if a malaria vaccine became widespread. In ongoing pilot programs, scientists are trying to determine whether people will scale back their use of bed nets and insecticides to control exposure to mosquitoes. Such a response would be worrying, especially given that previous studies have shown that the efficacy of malaria vaccines can wane over time.

A similar behavioral shift in response to an HIV vaccine could be devastating. In many parts of the world, condom provision is in decline, while some individuals – like sex workers, drug users, and members of the LGBT community – have difficulty accessing HIV-prevention services, owing to legal restrictions or discriminatory practices. With scientists optimistic that a vaccine is forthcoming, there is no better time to ensure that traditional transmission interventions remain a priority for policymakers, politicians, and donors.

Just as important, activists must continue working to remove the structural barriers that stop people from using prevention services in the first place. After all, it is these same obstacles that will likely keep people from accessing a vaccine in the future.

Moreover, it is not too early to consider how an HIV vaccine would be paid for. In its recent report, UNAIDS warned that, given the absence of new donor commitments, the 8% increase in spending on HIV in 2017 is likely to be a one-off gain.

Around the world, donors are cutting development aid to middle-income countries while domestic health-care spending costs are increasing. These trends have coincided with a global reduction in funding for HIV prevention services and research. Given tight finances, we must consider how developing countries will balance funding for vaccines with other HIV prevention needs.

On a recent visit to Myanmar and Vietnam, I witnessed the progress that governments, donor agencies, and community activists are making in the fight against HIV. But I also heard many stories of how declining budgets are forcing organizations to make impossible choices about their prevention efforts. These are decisions no government should have to make, and the international community must marshal the political will to ensure that HIV prevention continues to be supported.

For now, I share the excitement of many that a new tool to tackle HIV may be on the horizon. This prospect will be a topic of much discussion when prevention strategists gather in Amsterdam this week for the 22nd International AIDS Conference. But, no matter what becomes of this latest vaccine-related discovery, the world will still have a long way to go before HIV is eradicated. To increase our chances of success, prevention programming must remain at the top of the agenda.

Christine Stegling is Executive Director of the International HIV/AIDS

Alliance.