HealthHIV

STATE OF HIV Prevention and Care™

Eighth National Survey

2026 Report on Findings

HealthHIV RESEARCH AND EVALUATION

HealthHIV State of HIV Prevention and Care™ Eighth National Survey

The HealthHIV State of HIV Prevention and Care Eighth National Survey measures HIV prevention, care, and treatment from the vantage of those who deliver it and those who live it. In 2026, 1,214 people participated across 47 states and territories: 627 providers spanning clinical and service roles, 461 people with HIV, and 119 prospective, current, and former PrEP users. Fielded eight times since 2009, the survey covers PrEP access, treatment and care integration, retention, workforce capacity, coverage and cost, and stigma, and its findings inform the needs, education, and tools in this program. Findings, organized by domain, are shared for each audience.

1,214
participants in 2026

47
states and territories reached

3,200+
participants since 2009

8
surveys fielded in 2009

Who the survey reaches

627
Providers
Half in clinical roles; half case managers, navigators, community health workers, and outreach workers

461
People with HIV
A majority long-term survivors; 94% on treatment and 97% virally suppressed

119
PrEP Users
Prospective, current, and former users; awareness universal and 96% of prescriptions filled

Topics covered

- **PrEP Awareness and Access**
- **Treatment and Care Integration**
- **Retention Across the Continuum**
- **Provider Burnout and Capacity**
- **Coverage and Cost**
- **Stigma and Discrimination**

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Executive Summary

The HealthHIV State of HIV Prevention and Care Eighth National Survey collects data from those delivering and accessing HIV prevention, treatment and care to inform advocacy, education, research, and training. Our subsequent report provides insight into systemic challenges and opportunities, covering issues such as PrEP awareness and access, provider burnout and workforce capacity, treatment and care integration, and retention across the HIV care continuum. Fielded annually, it builds a multi-year record of how these issues change and where services can improve.

Previously, the survey focused on HIV care providers. In 2026, we expanded the survey to encompass people with HIV (PWH) and prospective, current, and former PrEP users (PrEP Users). From May to July 2026, we recruited 1,214 participants: 627 providers, 461 PWH, and 119 PrEP Users. The following reports our analysis of this data and, where possible, contextualizes findings from previous State of HIV Care Surveys and the larger HIV landscape. (See Table A1 in the appendix for survey respondent demographics.) The report is organized to guide readers who want to learn in depth about the HIV prevention, treatment, and care in the U.S., or wish to focus on a specific aspect or population. To this end, we have organized the report as follows:

I. **Summary of Key Findings** details what we found across the five domains that emerged from the data (HIV Prevention, HIV Treatment/Comorbidities, Behavioral Health, Access, and Workforce) and gives the key findings from each.

II. **Theoretical Framework** positions the survey and its data within an overarching literature concerning the relationship between the social determinants of health and the uptake and delivery of HIV prevention, treatment, and care.

III. **Findings Across Five Domains** reports results for all participants together, then a detailed analysis of each population surveyed: Providers, PWH, and PrEP Users.

IV. **Implications of Our Findings** discusses what the results mean, mapped to one or more of the five domains.

V. **Strategic Approaches and Actions** reads the findings against the current state of HIV and details recommended next steps.

VI. **References** details the supporting sources used to produce this report.

VII. **Methods** describes how we collected and analyzed the data.

A complete set of question-level responses is available for download separately.

FIVE DOMAINS OF THE SURVEY

Figure 1. The 2026 survey organizes its findings into five domains: HIV prevention, HIV treatment and comorbidities, behavioral health, access, and workforce.

I. Summary of Key Findings

The 2026 survey organizes its findings into five domains: HIV prevention, HIV treatment and comorbidities, behavioral health, access, and workforce. Each is described below with its main findings.

HIV PREVENTION

Prevention spans two paths: keeping HIV-negative people negative through PrEP, and using treatment to stop transmission, since a person who is virally suppressed cannot pass HIV to others. The survey looked at PrEP awareness, access, and long-acting options, and at viral suppression among people in care.

HIV PREVENTION FINDINGS:

- Among people with HIV in care, 96.9% were virally suppressed and 94% were on antiretroviral therapy, so most people in care are both treated and unable to transmit HIV.[1]
- Everyone in the PrEP survey had heard of PrEP, 79% had been prescribed it, and nearly all who were prescribed it filled it, so awareness and pharmacies are not where prevention breaks down.
- The soft step is the conversation: only 76% of PrEP users had a provider ever raise PrEP, leaving about a quarter who never had that conversation.
- Newer options are spreading unevenly: 61% of providers offer long-acting injectable PrEP, 69% offer injectable ART, and 63% prescribe doxyPEP, and whether a site offers them depends on integrated care, an urban location, and Medicare billing rather than the individual clinician.
- HIV prevention and treatment availability varies by organization, not geography. About 49% of the variation in injectable ART availability is attributable to organization type compared about 7% between states, so two patients in the same city can face very different options.

HIV TREATMENT/COMORBIDITIES

This domain looks beyond viral suppression to the fuller health of people with HIV: how many medications they take, how they function day to day, and the co-occurring conditions that shape their care.

HIV TREATMENT/COMORBIDITIES FINDINGS:

- 44% of people with HIV took five or more medications, and about one in five (22%) reported difficulty with everyday activities.
- Among people in care, the clinical cascade holds: 86% were retained in care and 89% took at least 91% of their doses.
- 12% of people with HIV responding to the survey were in a high-needs group characterized by having multiple health conditions and structural burdens, and a low quality of life (self-reported well-being, comfort, and happiness), even while virally suppressed.
- With suppression at a ceiling, quality of life is the outcome that now matters: two-thirds rate it good, and what lowers it is discrimination, accumulating conditions, and material hardship, not anything clinical.

BEHAVIORAL HEALTH

Behavioral health covers the psychosocial conditions that shape whether people engage in care, including discrimination, stigma, and fear of systems outside the clinic.

BEHAVIORAL HEALTH FINDINGS:

- 61% of people with HIV reported everyday discrimination. In a mediation analysis, stress carried about 83% of its effect on quality of life (indirect effect -1.11 of a total -1.33), and higher discrimination independently lowered the odds of good quality of life (OR 0.74, 95% CI 0.58-0.94).
- 27% rated their mental health fair or poor, yet few name it as their most pressing need, so a good quality-of-life report can hide it.
- The climate is itself an exposure: 46% of people with HIV and 32% of PrEP users said political or social change increased their stress, and nearly 30% of PrEP users said legal or law-enforcement worries affected whether they sought services. Stress and quality of life were almost entirely individual-level (states explained about 2% of the variation), so this is a person-level burden, not a geographic one.
- Asked to describe the state of HIV care in one word, people with HIV and PrEP users most often chose “scary,” “uncertain,” and “concerning.”

ACCESS

Access covers how people pay for and reach HIV care: their sources of coverage, the gaps tied to income, and the services that disappear when funding is cut.

ACCESS FINDINGS:

- Medication coverage is a patchwork with no dominant payer: private insurance 31%, Medicare 21%, and Medicaid 11%. More than a quarter (28%) rely on Ryan White HIV/AIDS Program (RWHAP)/AIDS Drug Assistance Program (ADAP).
- Viral suppression was lower among respondents earning at or below $25,000 than among higher earners (92% vs. 99%, p=0.01), a gap that opened along income, not race or gender.
- Providers most often reported that funding disruptions cut gender-affirming care (59%), housing (55%), and transportation (47%) first, the services that keep care reachable for the most marginalized patients.
- The organizations closest to marginalized patients can bill the least: FQHCs accept about 4.5 payer types on average, against 3.0 for community organizations and 2.2 for government sites.
- Whether a person's primary care provider also treats their HIV is one of the few outcomes strongly shaped by geography: a multilevel model placed about 17% of the variation between states (ICC 0.17), while stress and quality of life were not.

WORKFORCE

Workforce covers the capacity and wellbeing of the people who deliver HIV care: the policy pressures they face, burnout, and whether they intend to stay.

WORKFORCE FINDINGS:

- Nearly 84% of providers said the policy environment affected their ability to provide or sustain services.
- 35% reported at least early burnout, and 26% expected to leave the HIV workforce within five years.
- Providers reported feeling emotionally drained at least monthly rose from 55% in 2024 to 63% in 2026.
- Strain tracked the environment more than the workload: it rose with organizational threats, harassment, and disrupted services, and younger providers had about 2.8 times the odds of reporting threats at their organization (OR 2.8, 95% CI 1.4-5.8).
- Readiness was not the constraint: about three in four providers rated themselves competent in LGBTQ+ and transgender care.

II. Theoretical Framework

Before reviewing the results of our survey, it is important to ground the work in an overarching theoretical model that captures the goals of our interconnected populations: for providers, sustained delivery of care; for people with HIV, viral suppression and improved quality of life (self-reported well-being, comfort, and happiness); and for PrEP users, learning more about, starting, and staying on PrEP. Our model integrates several frameworks: Meyer's minority stress theory, which describes how stigma and discrimination create chronic stress above and beyond ordinary life stress,[2,3] and Krieger's ecosocial theory, which details how social exposures become biologically embodied across the life course and across generations.[4,5] Slavich's social safety theory adds that the absence of trustworthy social ties amplifies the physiological stress response.[6]

The combined framework explains why repeated activation of the stress-response system, described as allostatic load, produces preventable wear on the body and worse health even when viral suppression is sustained.[7,8] Because the survey reaches both people and the care system, its model must describe what happens inside that system. The resulting care-system model appears below. From a shared policy and structural environment, two pathways run in parallel: one through the organizations and workforce that deliver care, and one through the material and social conditions of people's lives; they converge at the care encounter, where outcomes for all three groups emerge. Beneath it all sits the set of supports that keep the system running: RWHAP and ADAP, Medicaid, integrated care, care coordination, community organizations, and telehealth.

PREVENTION, TREATMENT, AND CARE MODEL ACROSS THE STATE OF HIV CARE IN THE U.S., 2026

Two pathways run from the same environment: one through the organizations that deliver care, one through the lives of the people seeking it.

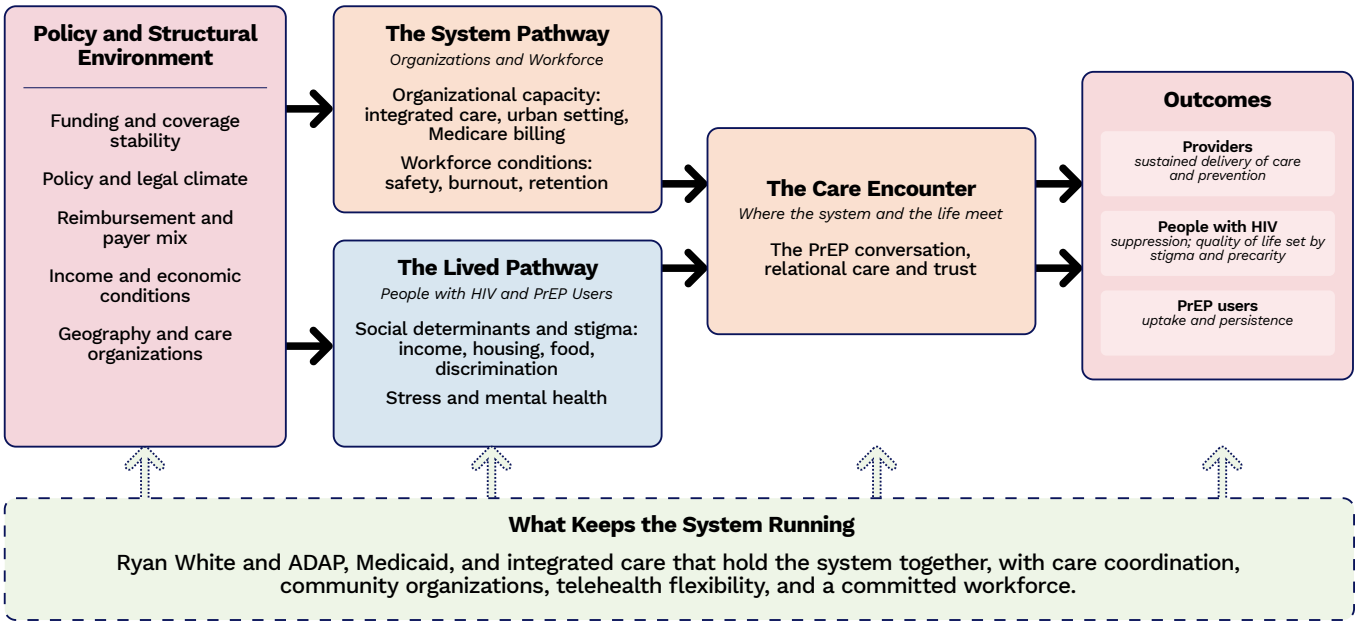


Figure 2. A care-system model of the state of HIV care, 2026. Two pathways run from the same policy and structural environment, one through organizations and the workforce, one through the conditions of daily life, and converge at the care encounter, where outcomes for all three groups emerge. Survey estimates annotate each pathway.

Together, these frameworks help explain a central quality-of-life finding: discrimination was associated with greater stress and, through stress, with lower quality of life. This pattern is consistent with research on stigma as a fundamental cause of health inequality and on weathering, which describes the cumulative health burden of long-term exposure to stress.[8–15] Social conditions rarely operate along only one dimension. Intersectionality and residential and economic segregation help explain how overlapping identities and living conditions are related to both exposure and access. Research on resilience also provides context for the survey's high-need latent class and for the resilience reported among Black respondents.[16–19]Across the survey, quality of life was more closely associated with income, housing, food, and social connection than with clinical status. Stable financing and care delivery through RWHAP and ADAP, Medicaid, telehealth, and integrated care support that pattern.[20–23] Access to newer options, including long-acting lenacapavir, may vary with the same conditions.[24–26]

The results of our 2026 survey data analyses align with this model, which we further align with each population throughout the report.

III. Findings Across Populations

Participants Overall

The survey began with a feeder form, in which participants were invited to describe HIV in one word and a single sentence. From there, they identified themselves as a provider, a PWH, or a PrEP user, which then directed them to the appropriate survey questions.

Collectively, participants overwhelmingly described the state of HIV care as "good," "evolving," "excellent," and "improving," although others said they found it "lacking," "uncertain," and "fragile." One participant shed light on this tension, writing: "We were making headway for years on ending the epidemic, but Federal government cuts have halted that progress." In their respective survey sections, participants were asked again to reflect on the state of HIV in a single word and sentence, revealing how one's experience changed their view on the state of HIV care.

Figure 3. Participants started the survey reflecting on the state of HIV prevention and care across the U.S. The overwhelming positive, most repeated words that dominate the word cloud (e.g., "good" and "excellent") speak to the positive health outcomes related to HIV prevention, treatment, and care over the past three decades. The slightly smaller, more negative words ("lacking" and "uncertain") likely speak to underlying concerns around funding and access that have emerged in the past year.

Providers

Who They Are

The provider survey reached N=627 healthcare providers delivering HIV prevention or treatment services across 47 states and territories, working in several organization types. This is a multidisciplinary workforce, with one-half occupying clinical roles, including physicians (MD/DO), nurse practitioners, and physician assistants. Non-clinical providers included case managers, care navigators, peer navigators, community health workers, and outreach workers, who help keep people in care. Providers described patient barriers and needs, workforce training needs, and strategies for HIV treatment and prevention.

- **About half of providers** (51%) are in a clinical role.
- **Three in five providers** (61%) offer long-acting injectable PrEP.
- **Most providers** (84%) say policy affects their services.
- **Nearly two-thirds of providers** (63%) are emotionally drained monthly or more.
- **One in four providers** (26%) expect to leave within five years.

Figure 4. Selected characteristics of the provider sample; full sample characteristics are in the Appendix.

Asked to describe the current state of HIV care in one word, positive and negative words were close (34% against 31%, respectively). The word "evolving" led among all responses, followed by the positive sentiments "improving" and "transformative," suggesting respondents saw progress. Other providers said they held a less positive outlook, describing it as "lacking," "uncertain," "underfunded," and "threatened."

WHAT IS THE STATE OF HIV PREVENTION AND CARE, IN 2026, ACCORDING TO PROVIDERS?

Figure 5. The word cloud recounts the state of HIV prevention and care according to providers responding to the survey. While the largest (most repeated) words ("improving" and "evolving") are positive, the slightly smaller words speak to underlying concerns around funding and challenges in the field of HIV and for their patients ("lacking" and "uncertain").

Several providers provided a sentence detailing their view of the HIV care landscape. Examples of what they shared included:

"It is hard to provide care and combat stigma for people that our nation is marginalizing, but those are the people that need these services most."

"In today's polarized society, it can be a challenge working with HIV patients."

"Making slow progress, but could do more."

Conceptual Model: Providers

Here, the relationship between providers and organizations and continuum outcomes is shaped by structural conditions, workplace strain, and care delivery and linkages.[27,28] Strain can include staffing shortages, limited time, prior authorization and paperwork, medically complex patients, burnout, and threats or harassment. Under those conditions, providers must still test, start ART and PrEP, offer long-acting options, connect patients with support, and keep people in care.[29,30] Beneath this model, we see the components that mitigate negative continuum outcomes at each stage.

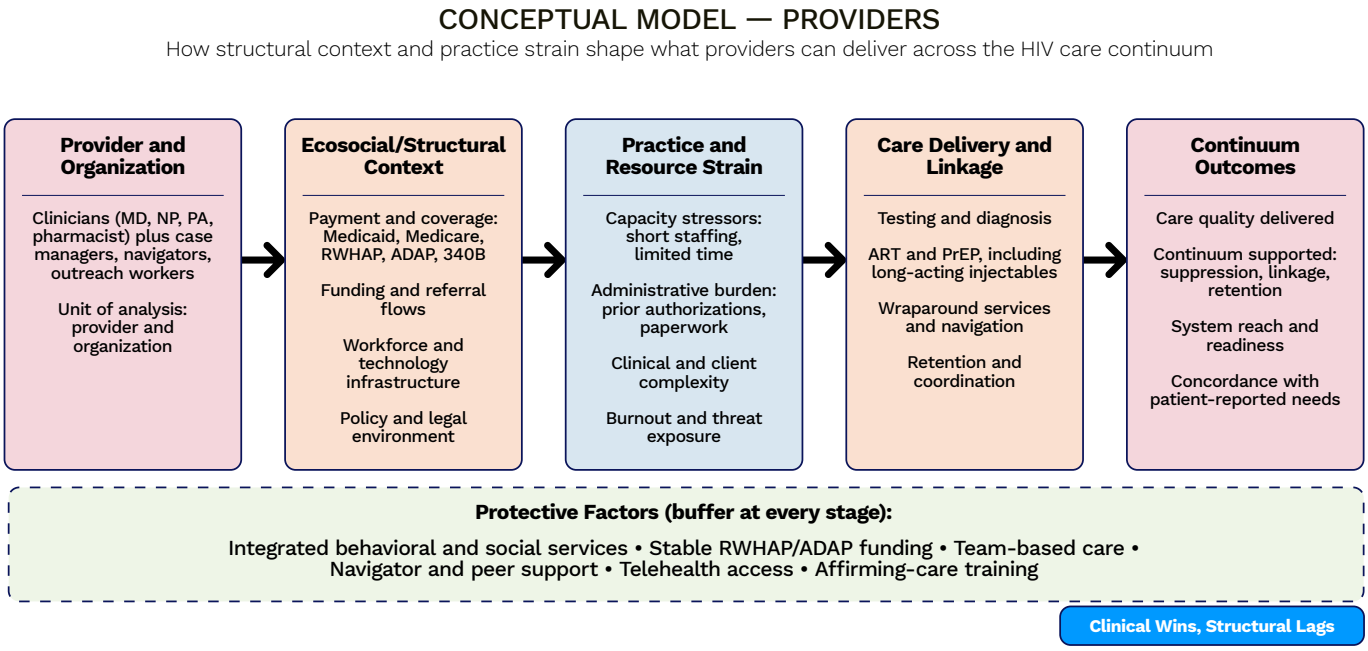


Figure 6. Conceptual model for providers: from the provider and organization, through structural context and practice strain, to care delivery and continuum outcomes. Built on the Andersen behavioral model, the social-ecological model, organizational-readiness theory, and the HIV care continuum.

Among providers, 92% rated at least one training topic as a moderate or high need, as shown in Figure 7. These training requirements primarily focused on resource development and funding, navigating insurance requirements, addressing clients' socioeconomic barriers and needs, setting up harm reduction services, and integrating mental health into HIV care.

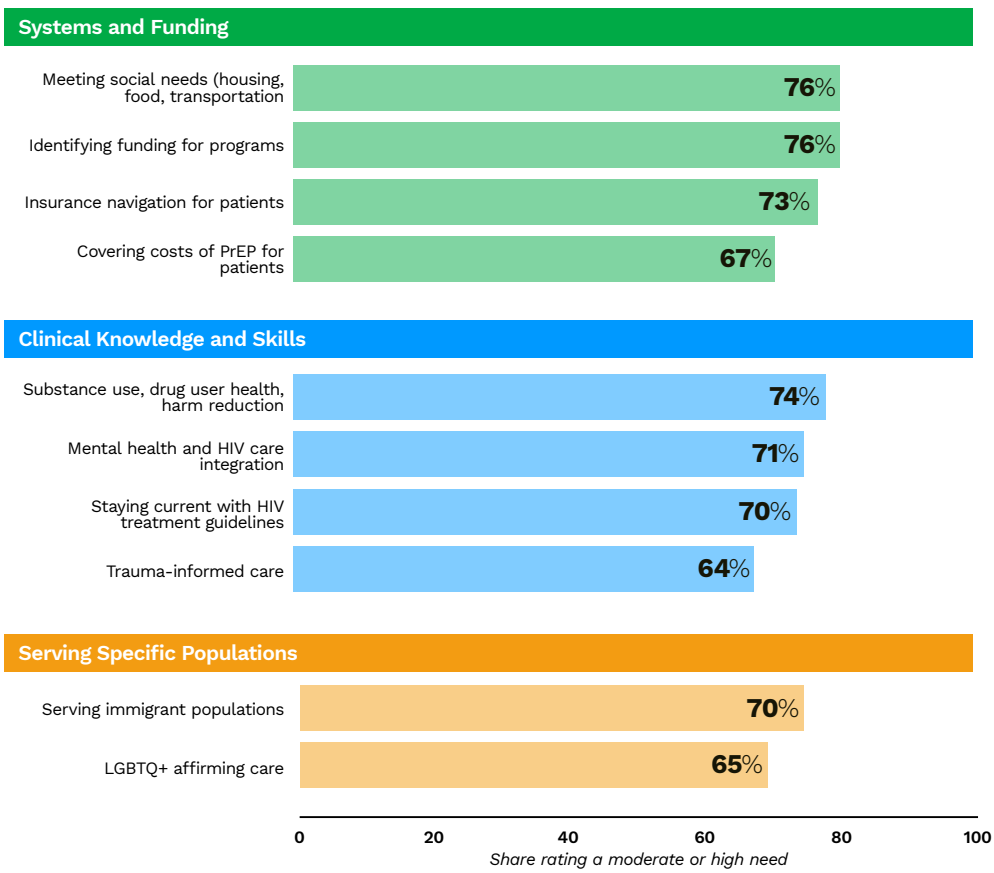


Figure 7. Provider training needs. The most-requested topics are about systems and funding.

Need Support Routinizing Screenings and PrEP Conversations

When asked about clients' barriers to HIV testing, providers name their clients' fear of stigma or discrimination first (50%) and fear of knowing their status second (42%), far ahead of limited funding (19%) or workforce shortage (13%). Barriers to testing reflect more psychosocial issues than logistical concerns, speaking to a need for status-neutral, stigma-free, routine testing. Screening for common HIV co-infections was far from universal. While 73% of providers said they routinely test their HIV patients for hepatitis C and 67% for hepatitis B, only 40% screen HIV patients for latent tuberculosis. Two-thirds of providers said they prescribed doxyPEP, which refers to the prophylactic use of the antibiotic doxycycline after sexual contact to prevent bacterial STIs,[31] primarily to men who have sex with men (MSM), people with recent or recurrent bacterial STIs, and transgender women. Three in ten providers, however, said they do not prescribe doxyPEP at all, due most often to the scope of their practice. Providers treated sexual-history-taking, standard STI screening, and PrEP conversations as optional rather than routine. Routine screening for sexually transmitted co-infections was far from universal, as the screening gaps above show, and the pattern carried over to patients: only 56% of PrEP users said their provider fully knew their sexual history, including partner genders and practices, and 18% said their provider knew it only in part. Providers also leaned conservative on prevention: given a choice of regimen, 33% named a daily oral pill as their preferred option and just 22% named any injectable form, while the plurality (39%) had no preference.

Long-Acting Prevention Availability Depends on the Clinic, Not the Provider

Even so, 61% of providers said they offered long-acting injectable PrEP, consistent with broad interest in emerging developments, notably cure and remission research (15%), long-acting cabotegravir and rilpivirine (14%), lenacapavir-based regimens (14%), and weekly oral combinations (10%), alongside preventive vaccines.[24,25,32]

Whether providers offered these options was associated with organizational affiliation and urban or rural setting. Among urban providers, 71% offered injectable PrEP, vs. 44% of rural providers; for injectable ART the gap was wider, 79% vs. 27%. In adjusted models (Figure 8), integrated primary and HIV care was independently associated with offering all three newer options, and urban location was associated with roughly three times the odds (or likelihood) of offering injectable PrEP (aOR 3.4, p=0.003) and more than six times the odds of offering injectable ART (aOR 6.6, p=0.003). Individual factors, such as provider race and gender, were not significant.

INTEGRATED CARE PREDICTS EVERY NEWER OPTION; PLACE AND PAYER SORT THE REST

Urban location and Medicare billing lift the injectables; Medicaid billing lifts doxyPEP. All four features adjusted together.

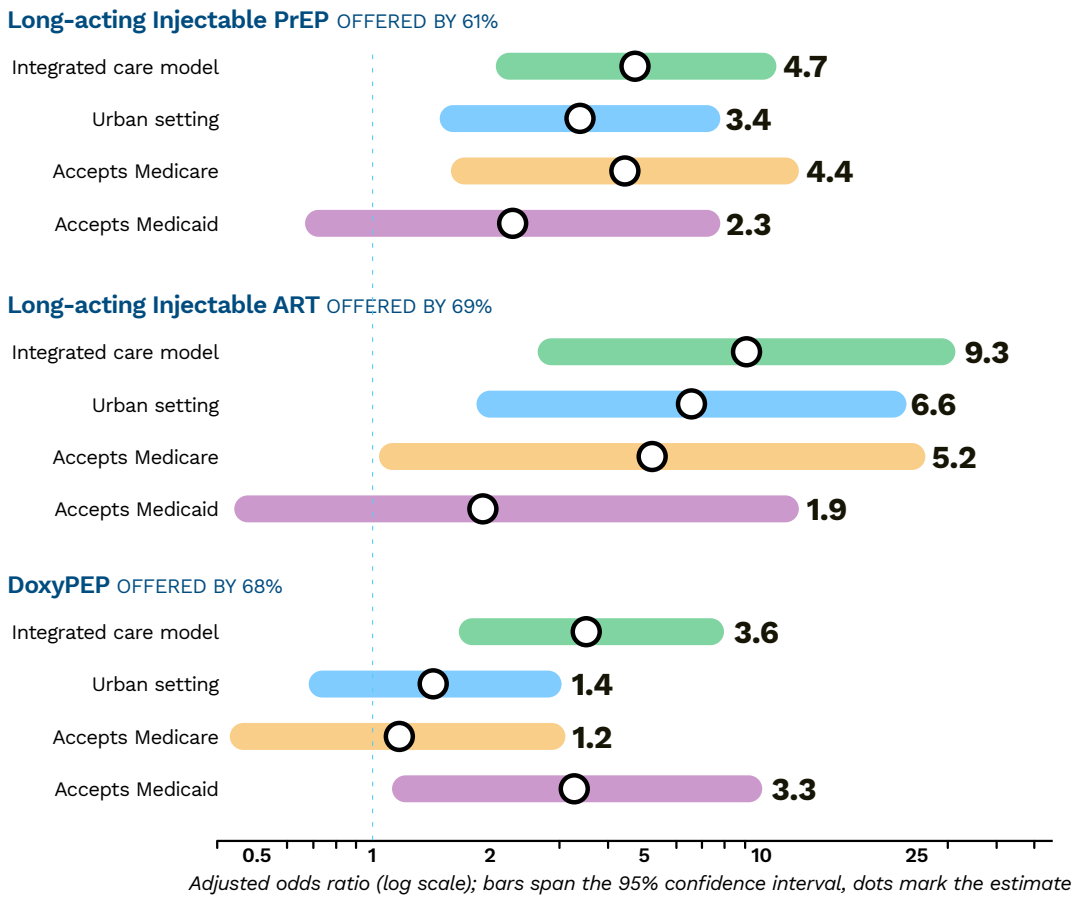


Figure 8. Adjusted odds of offering each newer option, by organizational feature. Each bar spans the 95% confidence interval and the dot marks the estimate, with all four features adjusted together. Integrated care is associated with all three options, urban location and Medicare with the injectables, and Medicaid with doxyPEP.

Long-Acting Availability Clusters by Organization Type, Not State or Region

We conducted additional multilevel analyses to examine whether providers' delivery of long-acting HIV prevention and treatment varied by state, census region, and organization type. Although geography is important to the HIV epidemic, organization type, including its funding and staffing, was more strongly associated with the services delivered. This association may reflect differences in staffing capacity, reimbursement mechanisms, clinical infrastructure, and access to pharmacy services that support implementation of long-acting prevention and treatment options. For long-acting injectable ART, 49% of the variation occurred between organization types, compared with 7% between states. Injectable PrEP and doxyPEP showed the same general pattern: 10% and 15% of the variation, respectively, occurred between organization types, while little occurred between states or regions. A clinic's urban or rural setting is an organizational characteristic, so setting may be associated with what is offered even when little variation occurs between states or regions.

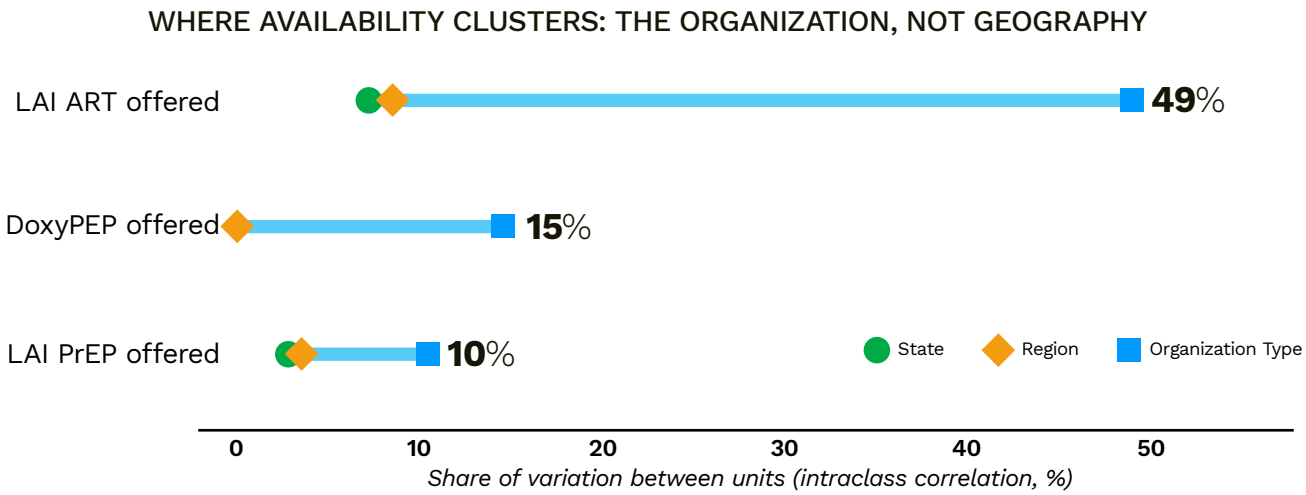


Figure 9. Share of the variation in offering each modality that sits between states, regions, and organization types. Markers show the share of variation explained by each level; organization type dominates every modality while state and region explain little.

Insurance and Structural Barriers Delay Linkage and Rapid Treatment Start

When asked what delayed PWH's timely linkage to care, providers focused on patient barriers and structural limitations, including clients' reluctance to pursue care (51%) and insurance coverage concerns (50%), as well as the indirect patient costs of setting up appointments, including transportation and records transfer (43%), and limited HIV care options in their region (28%). On the treatment side, rapid ART initiation, starting treatment at or near diagnosis, remains a recognized gap: 40% of providers name insurance barriers as the main challenge in starting patients on ART, ahead of adherence concerns (35%) and far ahead of side effects (15%). More than one-half of providers (54%) reported a moderate or high need for training on rapid ART initiation. In terms of patient adherence, approximately three-fourths (73%) of providers said that access to single-tablet regimens is extremely important, just ahead of bictegravir-based therapy (70%).

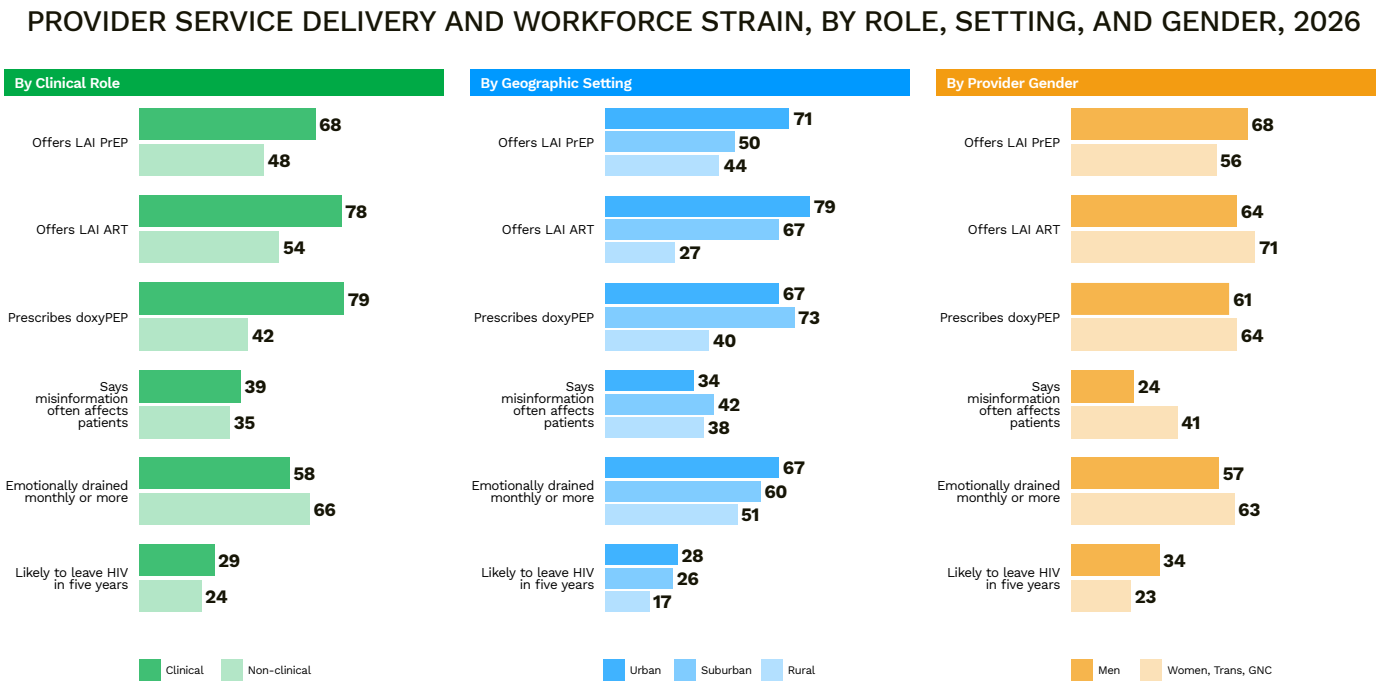


Figure 10. Provider service delivery and workforce strain, by role, setting, and gender. Each panel shows the share in each group; group sizes vary by measure, as noted in the legends.

The Coverage a Clinic Accepts Shapes the Options Its Patients Can Reach

The payer mix differed across organization types. Federally qualified health centers (FQHCs) and hospital or academic settings each accepted an average of 4.5 payer types, compared with 3.0 among community-based organizations and AIDS service organizations and 2.2 among government entities. FQHCs were also more likely than other organizations to accept Medicare (85% vs. 58%). Community-based organizations and AIDS service organizations reported fewer reimbursable payer types, and whether long-acting options were offered followed the same organizational pattern.[29] In adjusted models this payer pattern held (Figure 8): accepting Medicare was independently associated with offering injectable PrEP (aOR 4.4, p=0.004) and injectable ART (aOR 5.2, p=0.04), and accepting Medicaid with prescribing doxyPEP (aOR 3.3, p=0.03). Payer mix was not associated with provider burnout or intent to leave. What a clinic could bill was more strongly associated with what it offered than with how strained its staff felt.

Two-Thirds of Providers Report Substantial Unmet Training and Resource Needs

A latent class analysis, a method that groups respondents with similar response patterns, identified five provider capacity profiles based on 30 training-need indicators (Figure 11). They range from broad, high need across nearly every topic to little reported need:

- **Broad High Need (33%)**. Rates almost every topic a moderate or high need, from long-acting ART (99%) and injectable PrEP (95%) to social needs (96%) and substance use (96%).
- **Prevention-Modality Need (12%)**. Concentrated on newer prevention: injectable and lenacapavir PrEP (100%), on-demand PrEP (93%), and doxyPEP (90%), alongside substance use (100%) and trauma-informed care (90%).
- **Structural and Equity Need (22%)**. High on social needs (96%), mental-health integration (92%), racial disparities (85%), and cultural humility (81%), but already confident on long-acting options (6% to 17%).
- **Selective Modality Need (14%)**. Moderate overall, tilted toward long-acting lenacapavir (61%), injectable ART (55%), and injectable PrEP (52%).
- **Low Need (20%)**. Reports little training need on any topic; the most experienced or self-sufficient group.

Two-thirds of providers fall into a group with substantial unmet training and resource needs, including newer prevention tools and implementation of structural and equity supports.

> "Lack of housing; lack of treatment for mental health or SUD; lack of transportation (this is Michigan, after all); lack of trust of staff; lower priority than other issues."
>
> - PROVIDER, ON THE BARRIERS THAT MOST INTERFERE WITH PATIENTS STAYING IN CARE

> "If the budget cuts continue, we will lose our condom program … the first steps to HIV prevention."
>
> - PROVIDER, DESCRIBING THE STATE OF HIV CARE TODAY

> "The current administration is not responsive to the needs of persons living with HIV. Continued funding is uncertain."
>
> - PROVIDER, DESCRIBING THE STATE OF HIV CARE TODAY

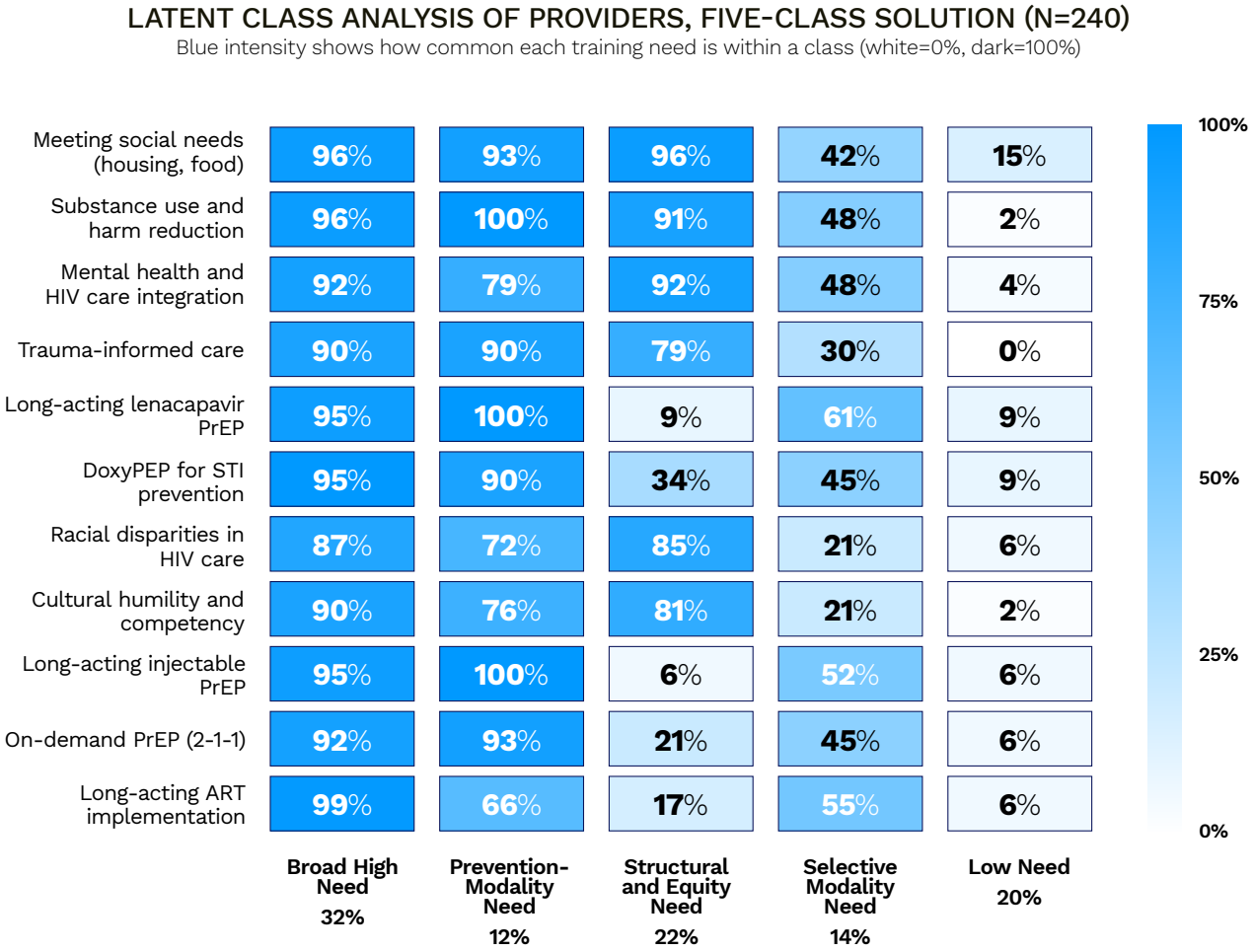


Figure 11. Provider latent class analysis, five capacity profiles. Each column is a profile, each row a training need; darker cells mean the need is more common in that profile.

Provider readiness is mixed as well, with 68% of providers offering telehealth for at least some visits.[23] Among those delivering LGBTQ+ care, 75% feel competent doing so. At the same time, 43% said misinformation often affects their patients' decisions about testing, PrEP, ART, or vaccines.[33,34]

Providers indicated that over the past year, they had experienced high rates of staffing reductions, hiring freezes, layoffs, and workflow changes, as well as disruptions in services supporting their most marginalized patients. Among patients hardest hit, they named low-income (20%) and Black and African-American (12%) persons, along with people experiencing homelessness (10%).

SERVICES CUT BY FUNDING DISRUPTIONS, 2026

Share of providers reporting each service was disrupted, among sites offering it. The biomedical core is protected; the services that reach the most marginalized patients are cut first.

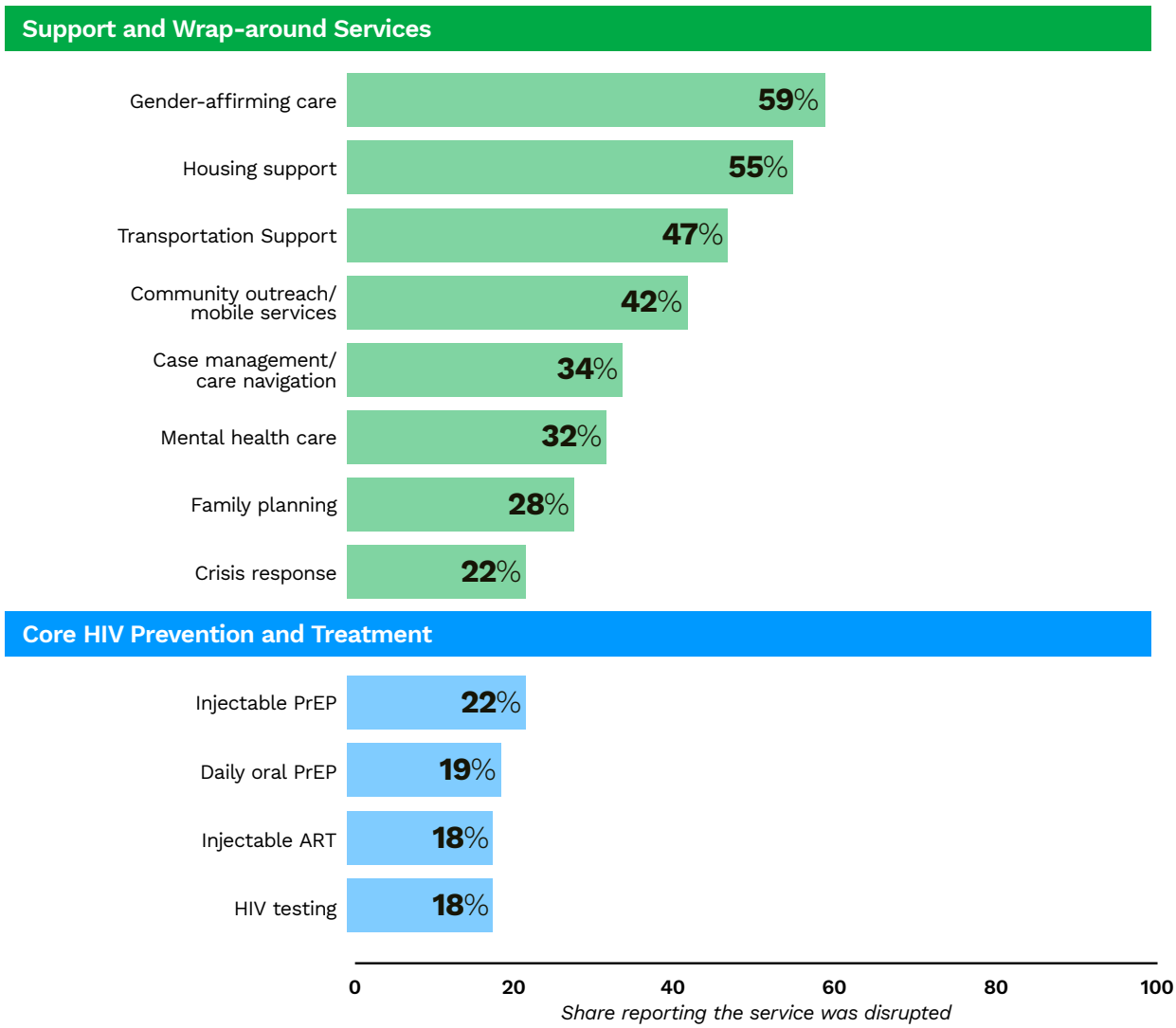


Figure 12. Services cut by funding disruptions, share of providers reporting each. The services cut first are the ones that reach the most marginalized patients.

Hostility and Strain, Not Workload Alone, Push Providers Toward Leaving

Most providers reported some symptoms of burnout, with 63% feeling drained at least a few times a month. About 35% placed themselves in at least the early stages of burnout, 26% said they were likely to leave the HIV workforce within five years, and another 33% were uncertain whether they would stay. Providers under age 30 were more likely than older providers to identify cost or insurance as the main barrier to viral suppression among their patients (53% vs. 16%). The workforce-strain index, which combines self-reported burnout and emotional exhaustion, was higher in organizations that had faced threats or harassment during the previous year. Provider strain was associated not only with clinical workload but also with the surrounding policy and funding environment.[33,34] In the mediation model, exposure to threats or harassment was associated with higher strain ($b=1.12$, $p<0.001$), and strain was associated with greater odds of intending to leave the HIV workforce (aOR 1.23, $p=0.047$). After accounting for strain, the direct association between threats and intent to leave was no longer statistically significant. This pattern suggests that strain may help explain much of the observed association between a hostile environment and intent to leave. Figure 14 illustrates the model. In the adjusted analysis of burnout, threats, clinical role, age, setting, integration, and provider race, emotional exhaustion was the only factor significantly associated with intent to leave (aOR 3.6, $p<0.01$, Figure 15).

Experiences with external threats vary across the workforce. Providers under 40 have roughly 2.8 times the odds of reporting that their organization faced threats, harassment, or safety concerns in the past year (OR 2.8, p=0.005). This pattern may reflect younger staff starting their careers in community and advocacy organizations, which are more exposed to external policies, though these trends remained the same even when adjusting for urban setting, clinical role, and community-organization employment (adjusted OR 2.6, p<0.05). These providers were also among the most trained and culturally supportive, especially for LGBTQ+ patients. Three-fourths rated themselves highly competent on all measures of our LGBTQ+ health competence index, which included serving LGBTQ+ patients and assessing their needs, as well as serving transgender patients. Figure 13 breaks the six provider measures out by race and provider age: delivery looks similar across racial groups, while younger providers report significantly more emotional exhaustion (76% vs. 58%).

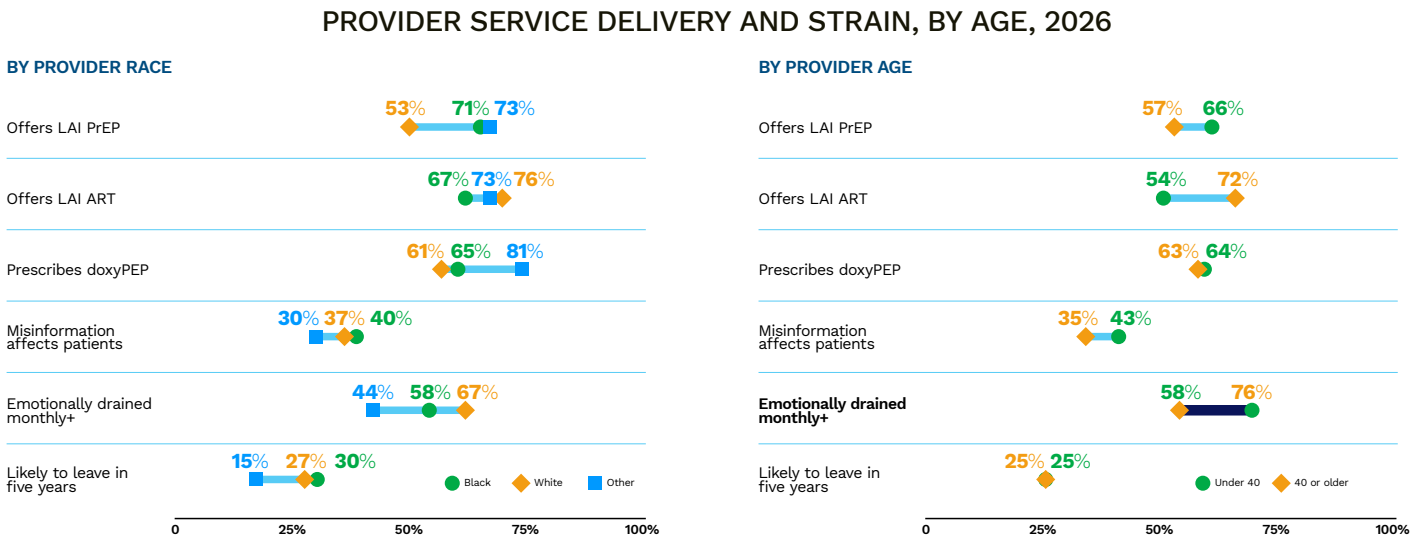


Figure 13. Provider service delivery and strain, by provider race and age, across six measures. Only monthly emotional drain was statistically significant. No statistically significant differences across these measures were found across racial groups.

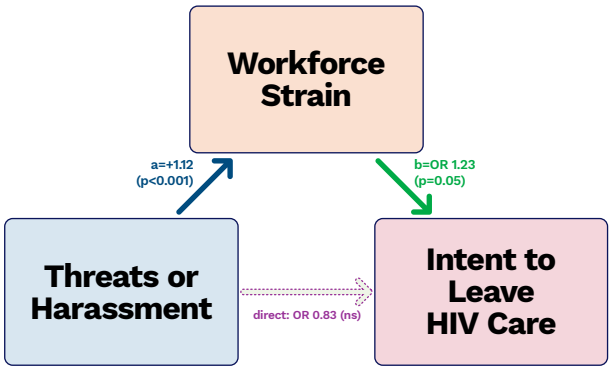


Figure 14. Provider mediation model: threats or harassment, workforce strain, and intent to leave. Threats or harassment were associated with greater strain, and strain was associated with intent to leave; threats showed no independent association with intent to leave after strain was included.

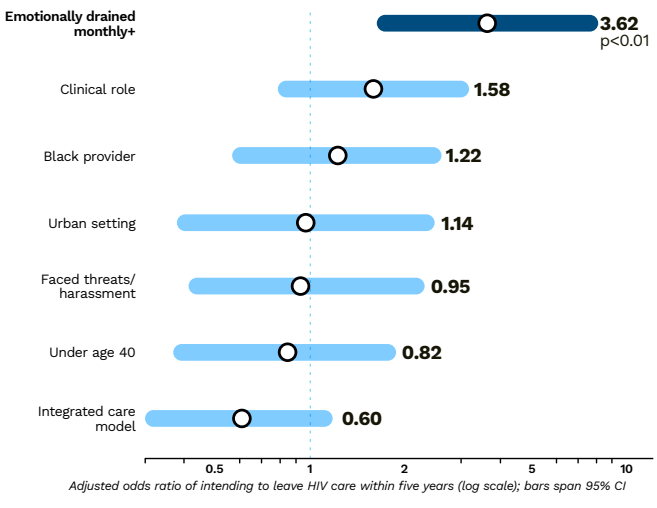


Figure 15. Factors associated with provider intent to leave HIV care within five years. Adjusted odds ratios with all factors considered together; only emotional exhaustion was statistically significant.

Client Barriers Shifted Toward Housing as Provider Strain Kept Rising

In the survey's early years (2009, 2011, 2013), participants said that the barriers PWH faced when seeking services encompassed community stigma (64% of answering providers in 2009), substance use (64%), and mental illness (62%), with housing close behind.

WHAT PROVIDERS SAID STOOD BETWEEN CLIENTS AND SERVICES, 2009 TO 2013

Same select-all battery in all three waves; substance use, mental illness, and stigma led every year

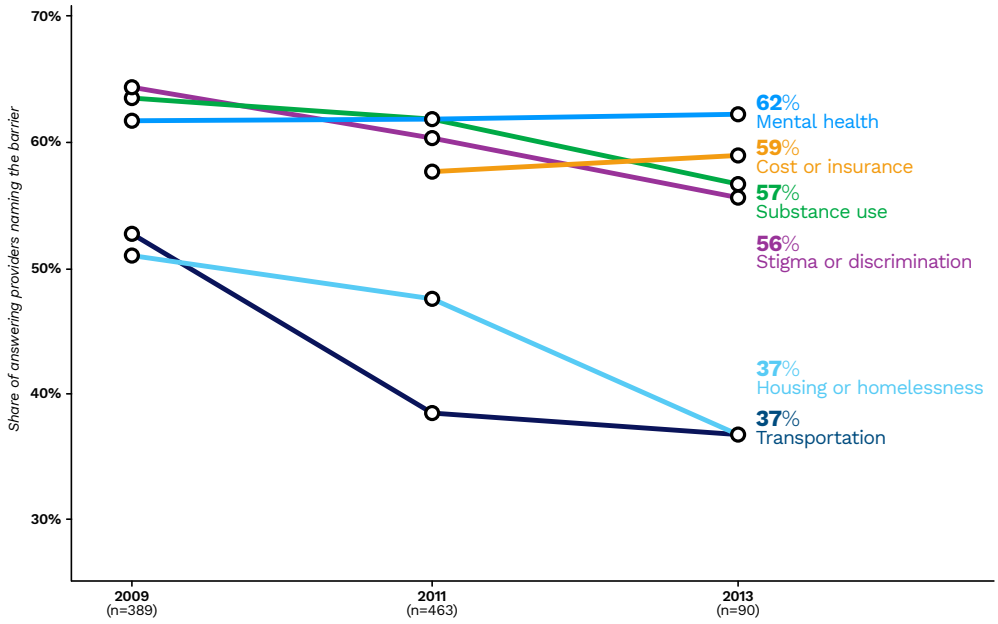
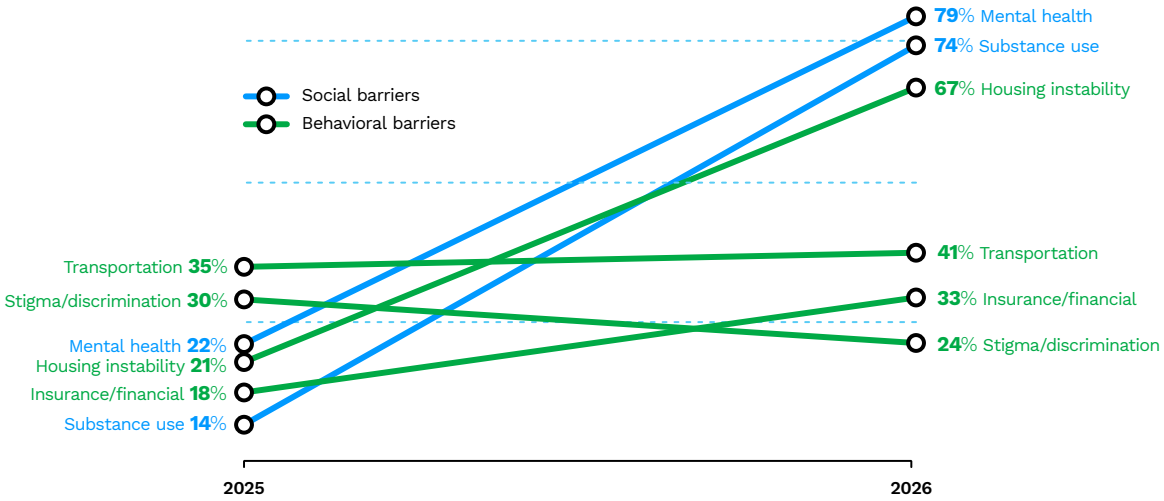


Figure 16. Client barriers named by providers, 2009 to 2013. Share of answering providers naming each barrier in the identical select-all battery fielded in all three early waves; the 2013 battery reached a smaller answering sample (n=90).

In recent years, housing instability has taken the lead, with 67% of participants placing it among their clients' top three challenges in 2026, followed by transportation (41%), insurance or financial barriers (33%), and stigma (a co-leader in 2009) (24%). On the behavioral side, mental health (79%) and substance use (74%) remain dominant.

HOW OFTEN PROVIDERS NAMED EACH CLIENT BARRIER, 2025 TO 2026



Behavioral barriers (mental health, substance use) climbed most. Selection caps rose from two picks in 2025 to three in 2026, so read direction more than exact level.

Figure 17. Client barriers named by providers, 2025 and 2026. Social and behavioral barriers are shown together; behavioral barriers (mental health, substance use) rose most. Selection caps rose from two picks in 2025 to three in 2026, so read direction more than exact level.

Among providers, feeling emotionally drained at least a few times a month rose from 55% in 2024 to 63% in 2026 on the identical item, the clearest quantitative marker of workforce strain. Telehealth delivery held roughly steady (72% of answering providers delivered some HIV service by telehealth in 2022; 68% offer telehealth visits in 2026), the pandemic-era gain that became infrastructure.

Burnout has also moved from an organizational frame to a personal one: in 2022, 62% of organizations named burnout a workforce challenge, while in 2026, 35% of providers place themselves in the burnout stages of the individual scale. The increase spanned groups. Provider gender and race were collected only in the 2024 and 2026 waves, and provider income was never collected, so a demographic comparison is limited to those two years. Within them, emotional exhaustion increased across every group: from 56% to 61% among women providers and from 48% to 57% among men, and from 43% to 58% among Black providers and from 61% to 67% among White providers (Figure 18).

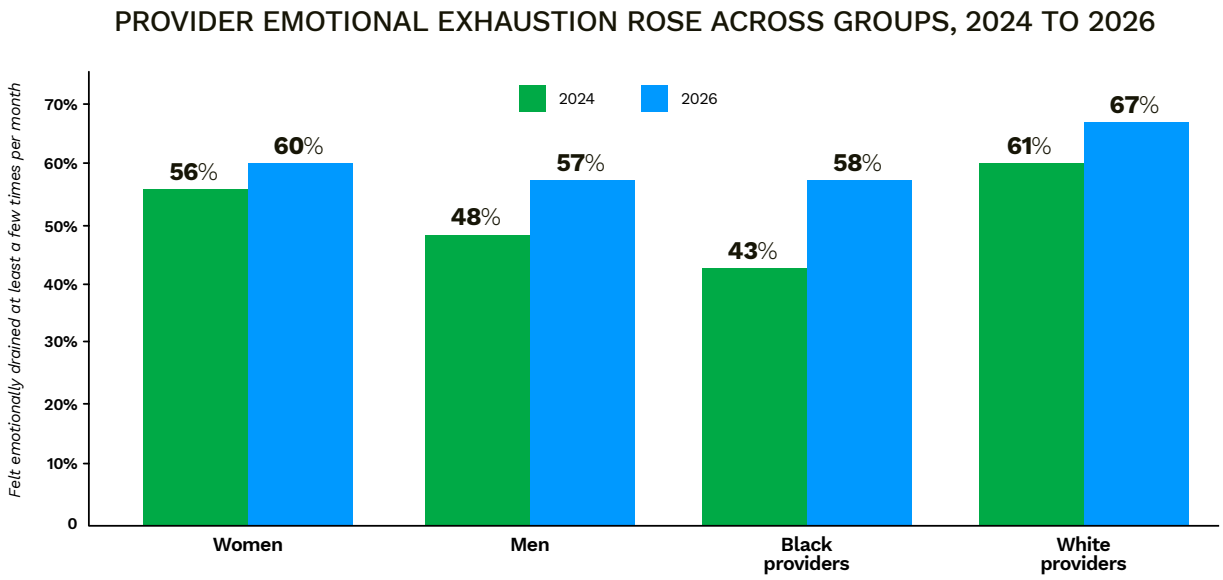


Figure 18. Providers feeling emotionally drained at least a few times a month, by gender and race, 2024 vs. 2026. Provider demographics are available only for these two waves.

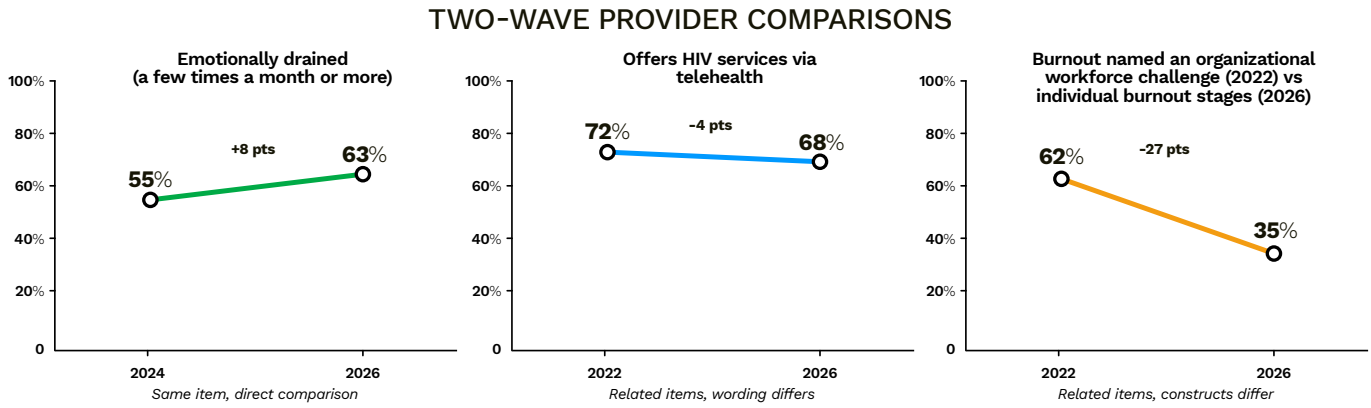


Figure 19. Two-wave provider comparisons. Emotionally drained is the identical item in 2024 and 2026; telehealth and burnout pair related items whose wording differs, as noted under each panel.

Figures 16 and 17 summarize the shift. The ordering has reversed since the early survey years. Substance use, mental illness, and stigma led every wave from 2009 to 2013; in 2026 housing instability leads the social list (67% of answering providers place it among their clients' top challenges), with transportation and insurance or financial barriers behind it and stigma at 24%, while mental health and substance use top the separate behavioral-health battery.

"Cooler heads may prevail and restore adequate funding to much-needed programs."

- PERSON WITH HIV, ON WHAT GIVES THEM HOPE

"Rural communities struggle with having adequate providers"

- PROVIDER, DESCRIBING THE STATE OF HIV CARE TODAY

People with HIV

Who They Are

Most of the N=461 PWH respondents are long-term survivors, with a median of 24 years since diagnosis, and 42% reporting an AIDS diagnosis at some point.35,36 Just over half were White and one-third were Black, with one-quarter reporting household incomes under $25,000. Nearly all were virally suppressed and taking antiretroviral therapy. Among survey participants, 86% had a visit within the past six months (indicating retention in care), with 89% taking at least 91% of prescribed medication as directed and 96.9% achieving viral suppression.

PEOPLE WITH HIV AT A GLANCE

461 respondents, a median of 24 years since diagnosis

- **Nearly all** people with HIV (PWH) who responded to the survey (97%) are virally suppressed.
- **Almost as many** PWH (94%) are on antiretroviral therapy.
- **More than three in five** PWH (61%) reported everyday discrimination.
- **More than two in five** PWH (44%) take five or more medications
- **About one in four** PWH (27%) rate their mental health as fair or poor.
- **Nearly one in five** PWH (19%) rely on Ryan White or ADAP.

Figure 20. Selected characteristics of the people-with-HIV sample; full sample characteristics are in the Appendix.

Nearly one in five people with HIV (19%) relied on the RWHAP or ADAP for their medications, within a mixed coverage landscape. Coverage sorts by income, race, and time since diagnosis: Medicaid covers 54% of people under $25,000, but only 9% of those above, and Medicare rises from 12% among people diagnosed less than 15 years ago to 41% among longer-term survivors. Care coordination also reached much of the cohort: 43% of people with HIV work with a case manager and 11% with a navigator (health, peer, or care).

HIV MEDICATION COVERAGE AMONG PEOPLE WITH HIV, 2026

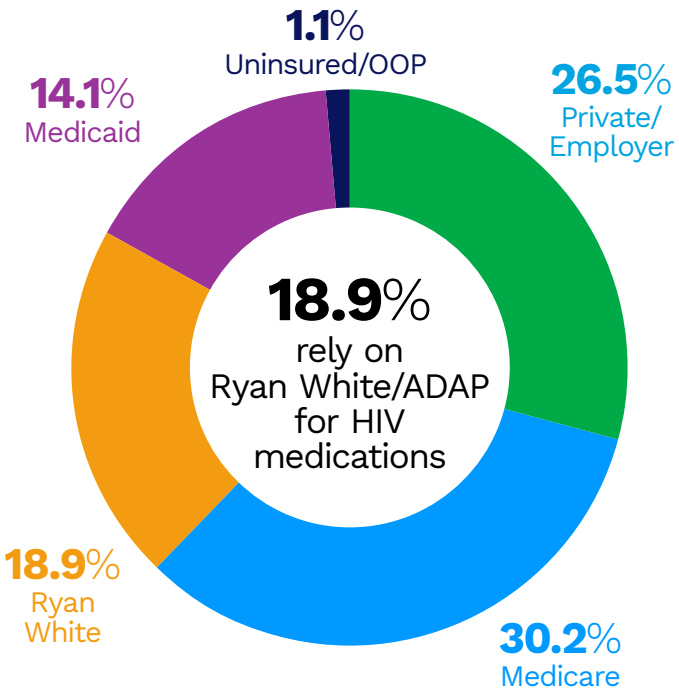


Figure 21. HIV medication coverage among people with HIV. No single payer dominates.

Respondents' positive clinical outcomes were reflected in the words they used to describe HIV care. "Good" led the responses, followed by "undetectable" and "excellent." Less common responses included "scary," "threatened," and "precarious," reflecting concern about rapid changes in health care provision.

WHAT IS THE STATE OF HIV PREVENTION AND CARE AMONG PEOPLE WITH HIV, IN 2026?

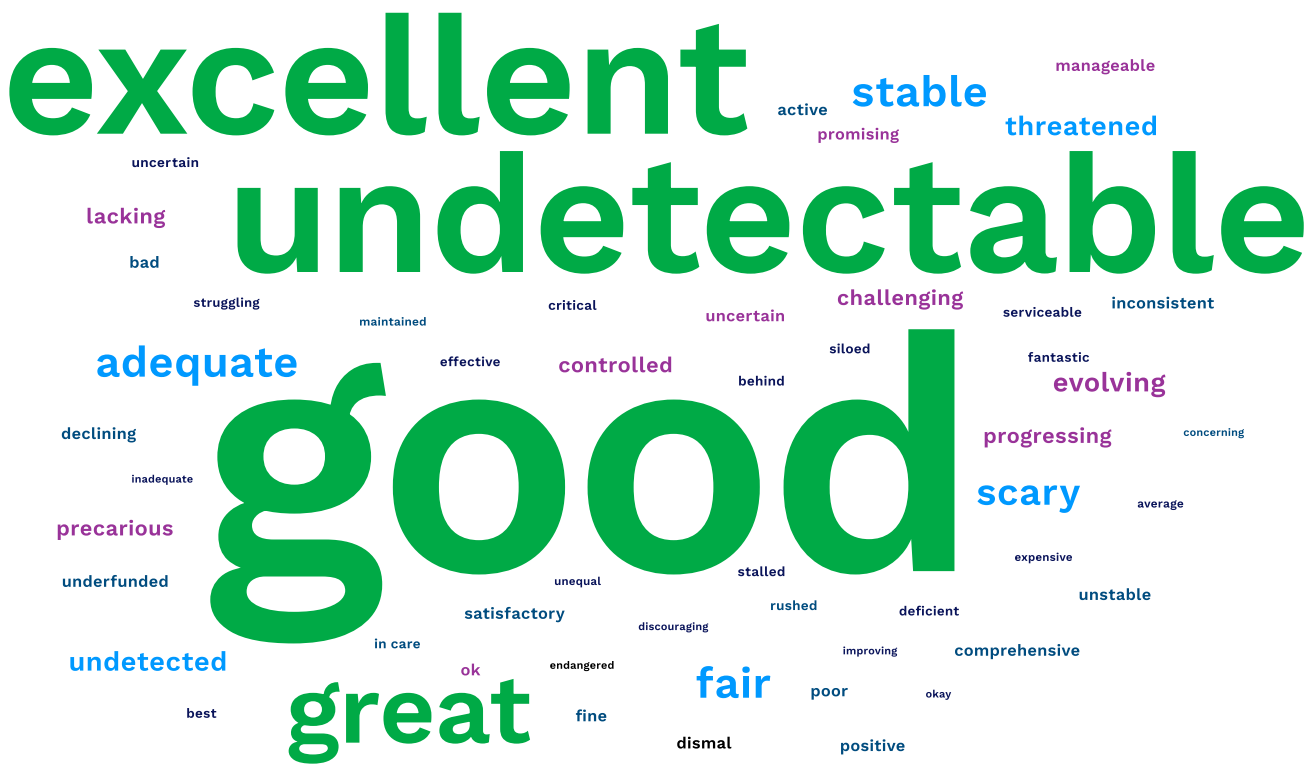


Figure 22. The word cloud recounts the state of HIV prevention and care according to PWH responding to the survey. Dominant positive sentiments are the most repeated words ("excellent" and "good") are positive, while the slightly smaller words speak to underlying concerns ("threatened" and "scary").

Participants illustrated this tension when asked to describe the landscape of HIV in one sentence:

> "Again, we are going backwards in HIV care instead of forward."

> "Depends on where you live is the level of care."

Most PWH Have Achieved Viral Suppression; Wellbeing Varies with Stress, Income, and Stigma

For people with HIV, their history and material conditions, income, housing, and food, along with access to coverage (RWHAP, ADAP, and Medicaid), and experiences of discrimination and stigma were associated with stress, which social support may buffer. Stress intersects with the health system at care engagement and was associated with three sets of outcomes: viral suppression and retention, quality of life and mental health, and how equally recovery is distributed. In this cohort, the virus was controlled almost universally while wellbeing varied with income, stigma, and accumulated illness.[2,4,6,29]

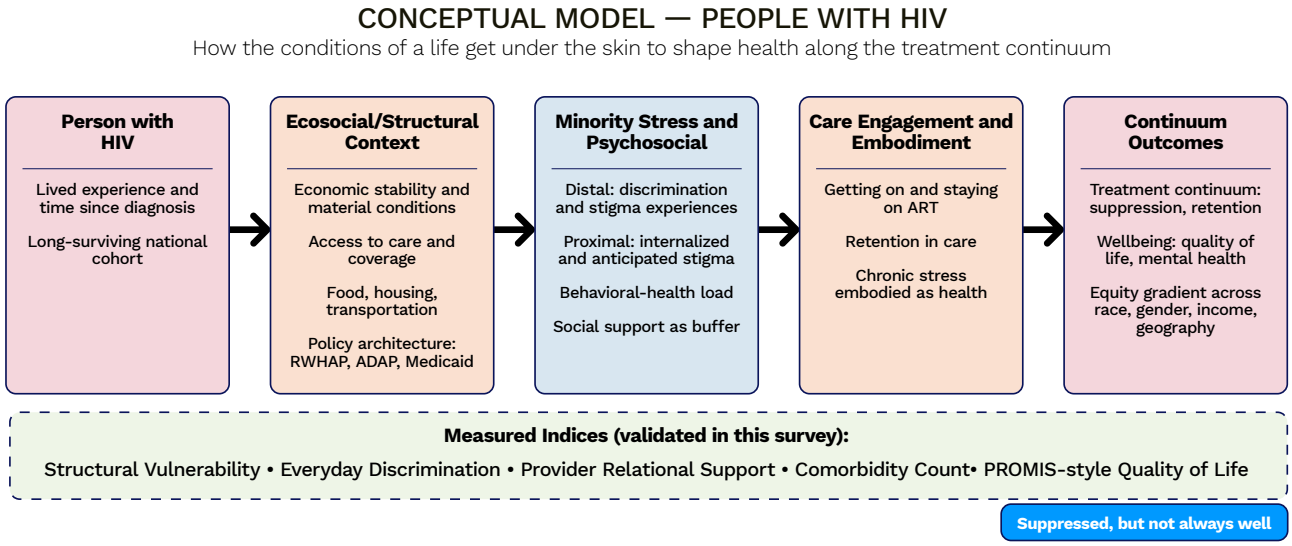


Figure 23. Conceptual model for people with HIV: from the person, through structural context and minority stress, to care engagement and continuum outcomes. The band lists the validated indices measured in this survey.

Positive Quality of Life Ratings Coexist With a Hidden Mental-Health Burden

This section's psychosocial and structural findings use multi-item indices drawn from established instruments: quality of life, everyday discrimination, provider relational support, structural vulnerability, and a comorbidity count (Table 1). (The methods describe their construction.)

TABLE 1. MULTI-ITEM INDICES USED IN THE PEOPLE-WITH-HIV ANALYSIS, WITH ITEM COUNTS, RELIABILITY, AND MEANS

INDEX	ITEMS	CRONBACH'S ALPHA	MEAN
Quality of Life (6 items, 6-30)	6 items	0.911	19.9
Everyday Discrimination (3 items, 1-6)	3 items	0.809	1.91
Provider Relational Support (5 items, 1-5)	5 items	0.973	4.22
Structural Vulnerability Index (6 domains, 0-6)	6 domains	n/a	1.87
Comorbidity count	13 conditions	n/a	2.25

Although 27% of PWH rated their mental health as fair or poor[37] and many reported moderate or high stress, few identified mental health as their most immediate need. At the same time, 84% reported good or better quality of life. Positive overall ratings can coexist with a substantial mental-health burden, and social connection may offer some protection.[38,39] Needs that do not appear as clinical complaints may be missed without direct screening.

HEALTH AND WELLBEING PROFILE AMONG PEOPLE WITH HIV, 2026 (N≈415)

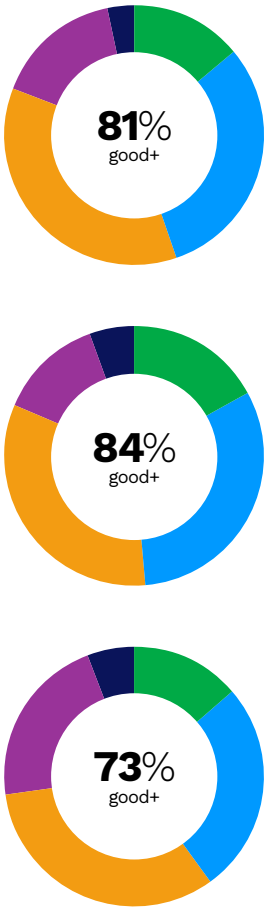


Figure 24. Health and well-being profile among people with HIV. Each ring shows the share reporting the outcome.

KEY OUTCOMES AMONG PEOPLE WITH HIV, 2026

Bold labels indicate priority concerns. Dashed line marks 50%.

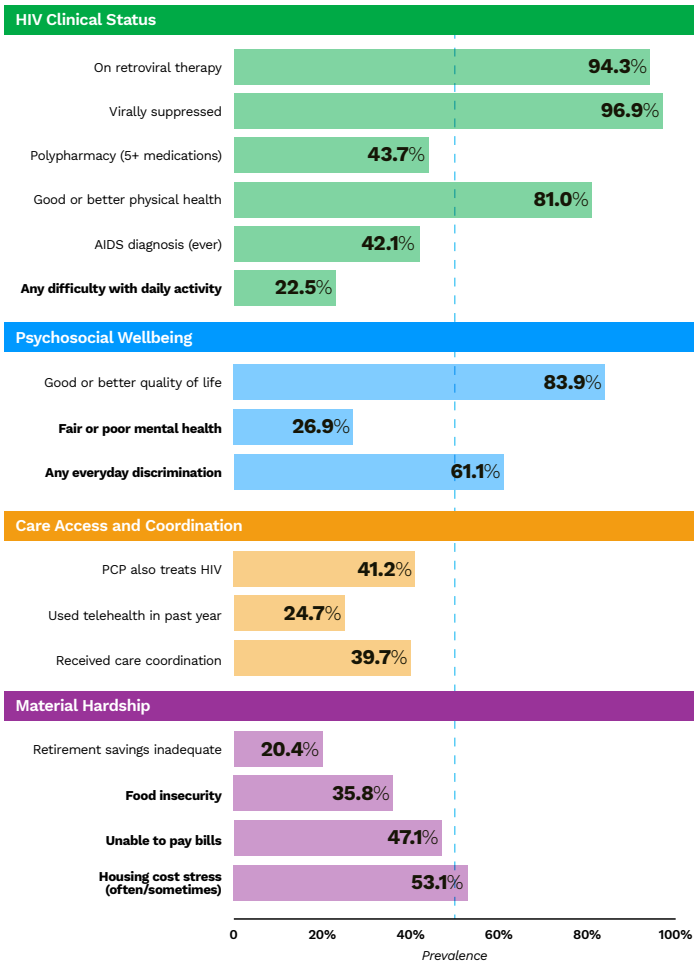


Figure 25. Key outcomes among people with HIV, by domain.

Quality of Life Tracks Discrimination, Stress, and Comorbidity, Not Viral Status

High reported quality of life coexisted with strains in other domains, including everyday discrimination (61%), polypharmacy (taking five or more medications, 44%), and having had an AIDS diagnosis at some point (42%), as shown in Figure 25.

We used a mediation analysis to examine how discrimination, stress, and quality of life were related (Figure 26). The model asked whether stress might help explain why greater discrimination was associated with lower quality of life.[10,11] Stress statistically accounted for approximately 83% of that observed association. This does not prove that discrimination caused stress or that stress caused lower quality of life. Discrimination was associated with greater stress (path a=+0.41, p<0.001), and greater stress was associated with lower quality of life (path b=-2.70, p<0.001). After stress was included in the model, the direct association between discrimination and quality of life was smaller and no longer statistically significant (c'=-0.22, p=0.38).

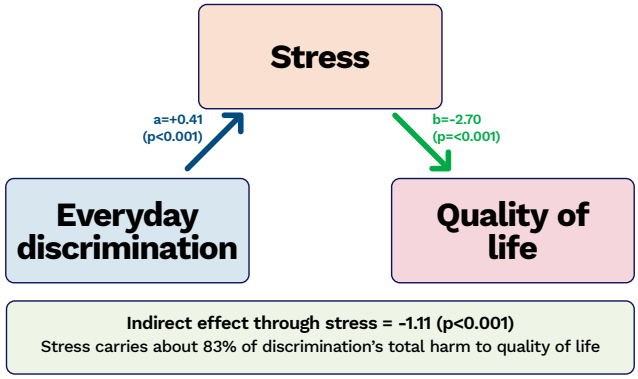


Figure 26. Mediation model for discrimination, stress, and quality of life. Solid arrows show statistically significant associations. The dashed arrow shows the smaller direct association after stress was included. The bottom box tests whether the pattern differed by income.

Figure 27 shows that respondents with more comorbid conditions had lower odds of reporting good quality of life. Respondents with three comorbid conditions, the average in this sample, had 56% lower odds than those with none. Structural vulnerability and number of health conditions had the strongest statistical associations with quality of life. Each additional area of structural vulnerability was associated with a 0.88-point lower quality-of-life score, and each additional health condition with a 0.82-point lower score.40,41 Viral suppression was not significantly associated with quality of life (p=0.06). Although respondents valued strong relationships with their providers, the association between discrimination and quality of life did not differ by level of provider support. It also remained similar across race and ethnicity, income, and gender.

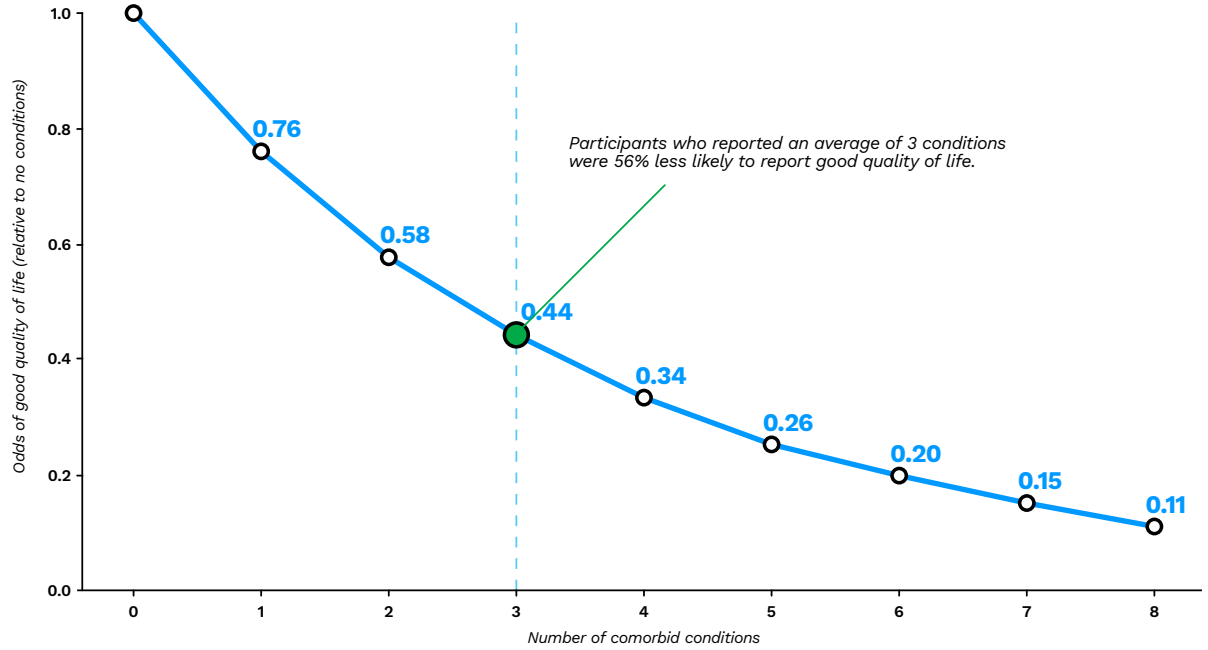


Figure 27. Association between comorbidity burden and good quality of life. A respondent with three comorbid conditions, the sample average, had 56% lower odds of reporting good quality of life than a respondent with none.

In Figure 28, the association between discrimination and quality of life is plotted for respondents grouped by years since diagnosis, and it stays firmly negative from the recently diagnosed to the longest-term survivors, suggesting that this association does not attenuate with time since diagnosis. Addressing the burden associated with discrimination may require providers to screen for stress and build anti-discrimination practices into their care routines.

> "Legally deployed physical, emotional, spiritual, and vocational stigma. Medical stigmas as well."
>
> - PERSON WITH HIV, ON THE SINGLE MOST IMPORTANT ISSUE THEY FACE

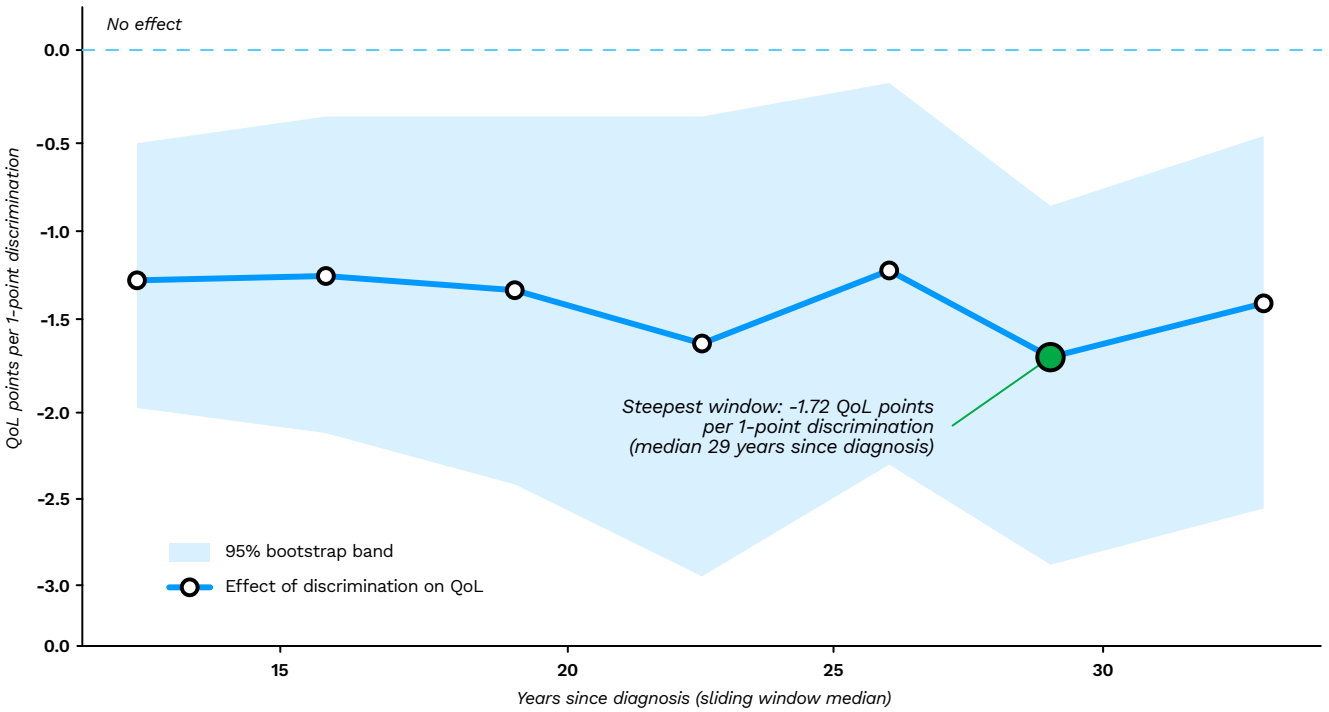


Figure 28. Discrimination is associated with lower quality of life at every stage after diagnosis, from the most recently diagnosed to the longest-term survivors; the association does not attenuate with time.

Structural vulnerability was associated with lower quality-of-life scores most steeply among transgender and gender-diverse respondents (-2.11 points per area, p=0.004) and men (-1.48, p<0.001), and least among women (-0.76, p=0.03). Higher everyday discrimination was associated with lower odds of good quality of life (odds ratio (OR) 0.74, p=0.02), as were each additional health condition (OR 0.76, p<0.001) and higher structural vulnerability (OR 0.78, p=0.02); all three remained after adjustment for income, race, and gender.[10,42]

Half of People With HIV Fall Into Higher-Burden Profiles Despite Viral Control

People with HIV fell into five distinct profiles that reflect their differing clinical, behavioral, and structural needs:

- **Lower Burden (41%)**. Defined most by polypharmacy (5+ meds) (24%), high mental-health stress (16%), difficulty w/ daily activity (13%).
- **Managed (10%)**. Defined most by housing cost stress (58%), low income (56%), retirement inadequate (56%).
- **Structural Strain (21%)**. Defined most by housing cost stress (100%), unable to pay bills (100%), retirement inadequate (79%).
- **High Discrimination (15%)**. Defined most by any discrimination (100%), retirement inadequate (57%), polypharmacy (5+ meds) (46%).
- **High Needs, Unmanaged (12%)**. Defined most by any discrimination (100%), difficulty with daily activity (86%), and retirement inadequate (74%). Lowest quality of life of the five.

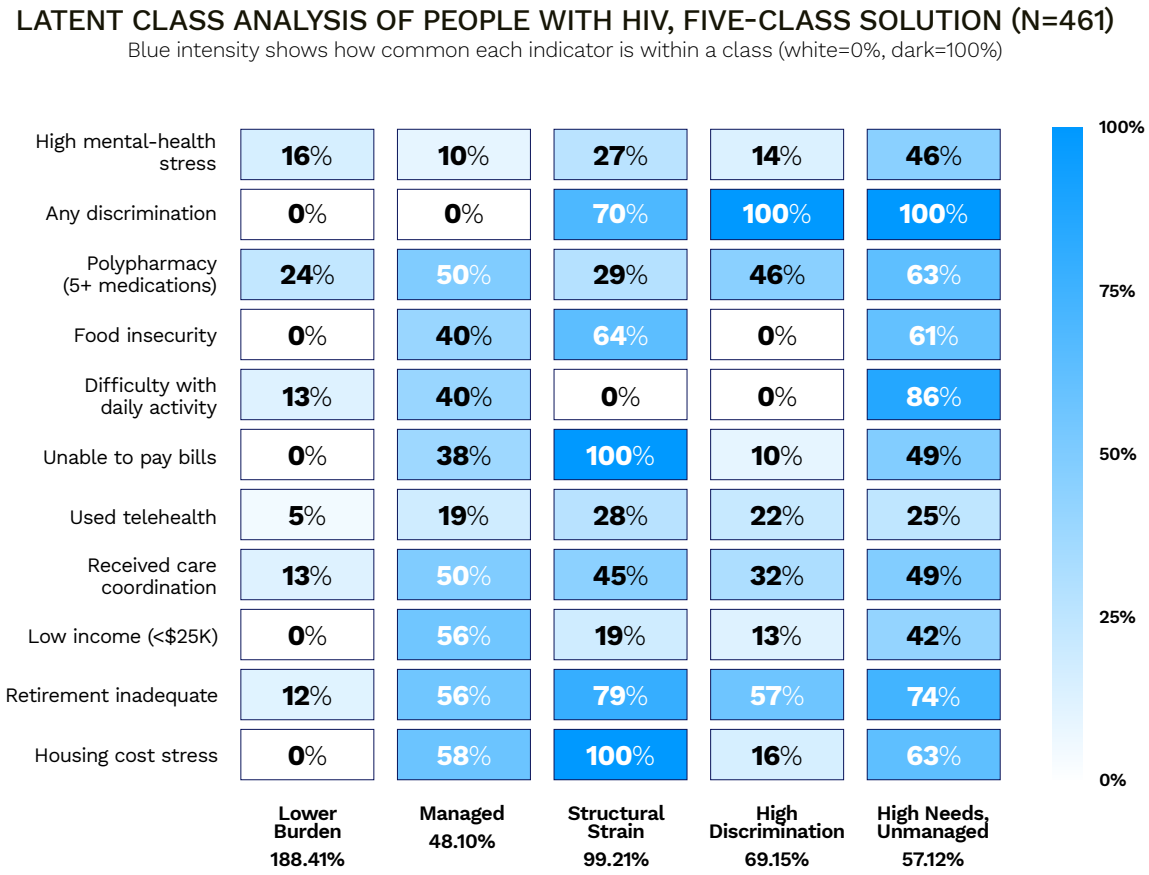


Figure 29. Latent class analysis of people with HIV, five-class solution. Each column is a profile, each row an indicator; darker cells mean the indicator is more common in that profile.

Income Divides Wellbeing More Sharply Than Race, Gender, or Geography

Subgroup comparisons showed the clearest and most frequent differences by income, followed by time since diagnosis, gender, race, and region. Income was the strongest dividing line in well-being and appeared repeatedly across the profiles above. While 51% belonged to low- or managed-burden groups, the other half are experiencing structural strain (21%), high discrimination (15%), or high, unmanaged needs (12%). These inequities vary when stratified by race, income, and gender. Black respondents report higher quality of life (85% vs. 81%) than White respondents even though they face far more food insecurity (48% vs. 27%, p<0.001). This may reflect, in part, Black respondents' greater likelihood of receiving care coordination (48% vs. 31%, p=0.006), consistent with RWHAP navigation reaching people with greater need. Figure 30 collects the four comparisons.

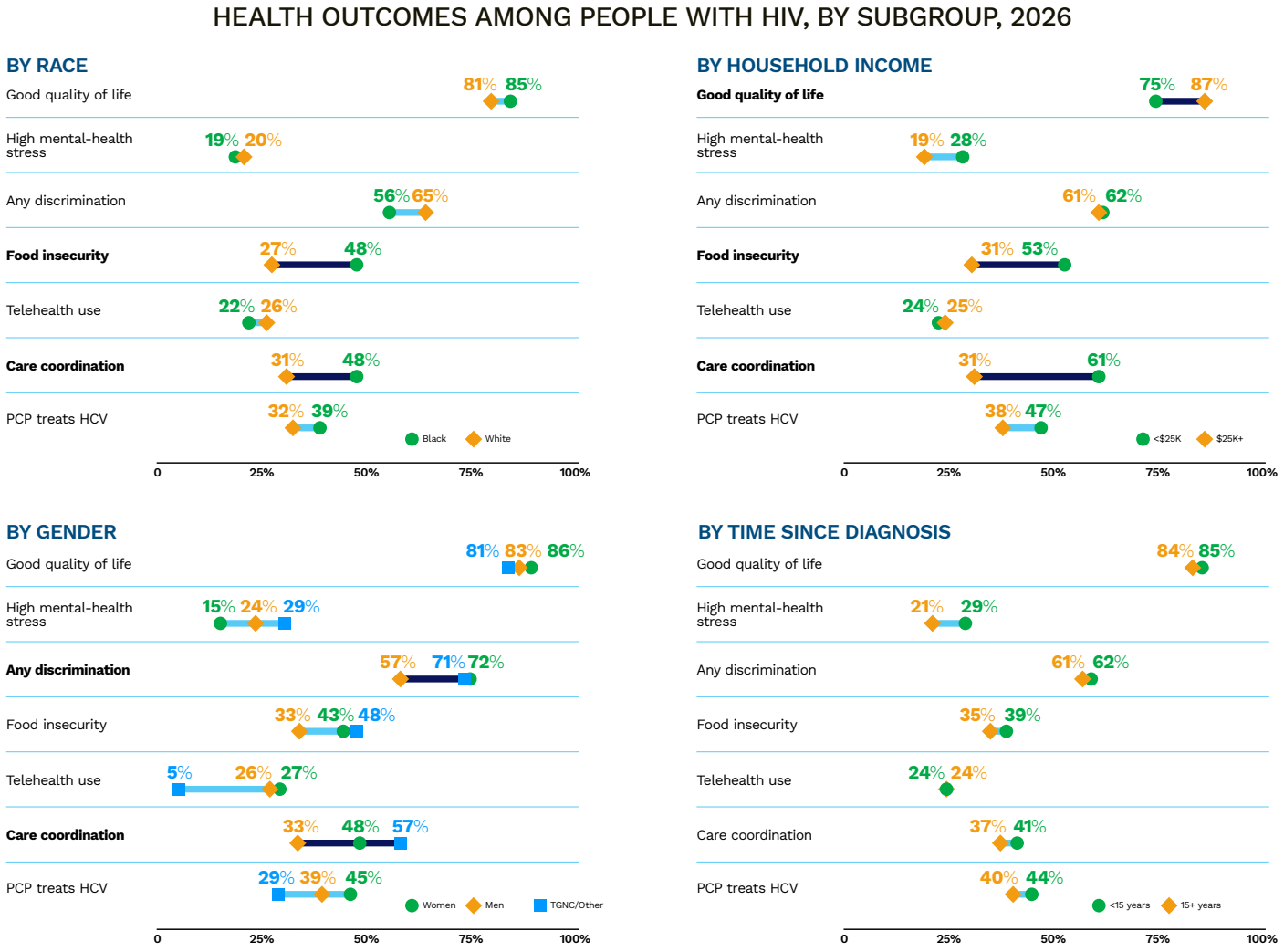


Figure 30. Health outcomes among people with HIV, by subgroup. Each panel compares the same seven outcomes across race, household income, gender, and time since diagnosis; a starred label marks a statistically significant difference.

The sharpest gaps appear by income. People with income under $25,000 report lower good quality of life (75% vs. 87%, p=0.02) and far more food insecurity (53% vs. 31%, p=0.001).[43] They also received care coordination roughly twice as often (61% vs. 31%, p<0.001), consistent with the safety net directing help toward greater need.

Women and transgender or gender-diverse respondents each reported everyday discrimination more often than men (72% and 71% vs. 57%, p=0.04), and received care coordination more often as well (48% and 57% vs. 33%, p=0.01). Transgender and gender-diverse respondents stood out in both system contact and system error: 48% are covered by Medicaid against 13% of men, with 62% having case-manager contact in the past six months compared to 37% of men; 38% reported being misidentified or misgendered across medical, insurance, or pharmacy records, compared to 7% of women and 3% of men. Viral suppression and quality of life did not differ significantly by gender.

Long-term survivors differed from more recently diagnosed respondents mainly in coverage and comorbidity rather than in quality of life, reflecting the aging of the cohort. Differences across this stratification were smaller than those by income or race.

Geographic location was associated with differences in some respondents' care experiences, with state residence playing a role in whether one's primary care provider treated their HIV (ICC=0.17), which points to infrastructure and integration policy rather than individual circumstances.[22] Experiences with care coordination (ICC=0.09) and telehealth use (ICC=0.06) also varied by state residence, while discrimination, food insecurity, quality of life, and stress were similar across individuals, regardless of residence. Regionally, participants were much more likely to report being treated for HIV in primary care settings in the Northeast (68%), West (64%), and Midwest (28%). Participants in the West were more likely to report experiencing stress (50%) and discrimination (85%) compared to participants in other regions.

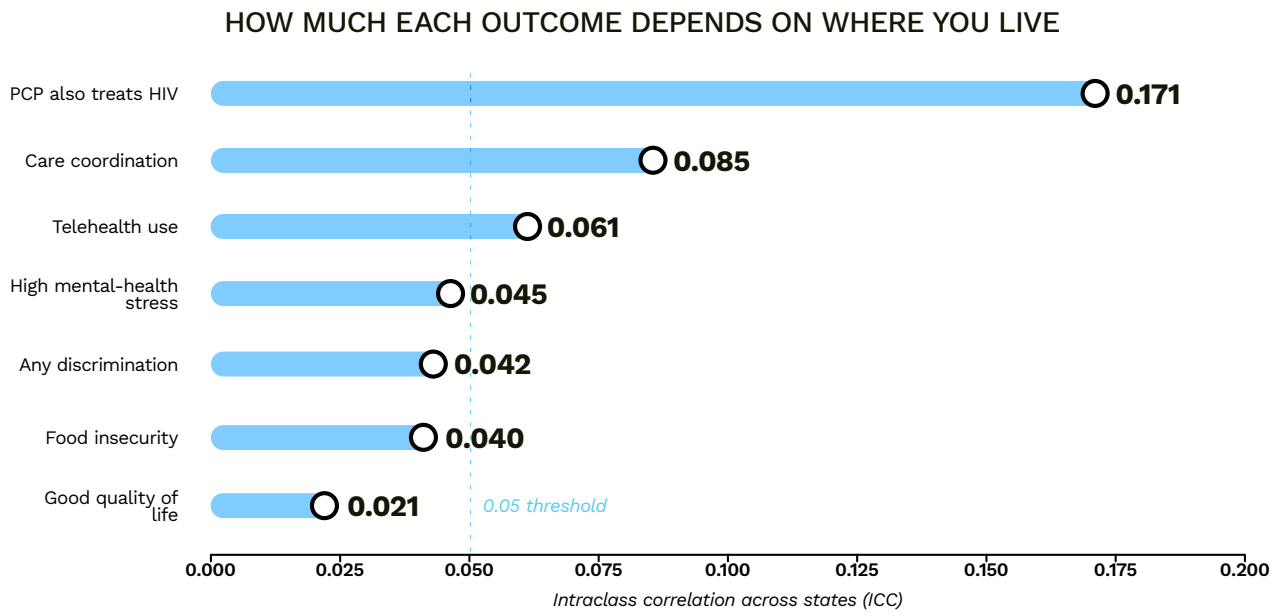


Figure 31. Share of variation in each outcome associated with state of residence.

Intersectional position, represented by combined strata of race, gender, and income, accounted for a similarly modest share of quality-of-life variation (about 2%).

> "One-half of my income was suspended and is causing hardship with keeping up with monthly financial obligations."
>
> - PERSON WITH HIV, ON THE SINGLE MOST IMPORTANT ISSUE THEY FACE

PrEP Users

Asked to describe the state of HIV and PrEP in one word, participants expressed more ambivalence than the other groups. Negative words slightly outnumbered positive ones (34% vs. 30%).

"Lacking" was the most common response, followed by "improving" and "transformative," a contrast reflected in respondents' own words:

> "HIV care is improving, and it must be of utmost importance in the USA as folks are still dying from HIV."

> "The uncertainty of HIV care proves it to be shaky."

> "I feel that I'm in good hands."

WHAT IS THE STATE OF HIV PREVENTION AND CARE, IN 2026, ACCORDING TO PREP USERS?

Figure 32. The word cloud recounts the state of HIV prevention and care according to PrEP responding to the survey. Comments are overall positive and focused on the promising science around PrEP ("transformative" and "evolving"), though PrEP uers are concerned by access issues ("chaos" and "limited").

Among the 119 PrEP-user respondents, all had heard of PrEP, and 75% said a provider had discussed PrEP with them. Nearly all respondents who received a prescription (96%) filled it. Most also reported active involvement in their care, shared decision-making with their care team, and a clear understanding of their care plan.

SNAPSHOT OF PrEP USERS

119 respondents

- **More than three in four** PrEP users who responded to the survey (76%) have ever had a provider discuss PrEP with them.
- **Nearly nine in ten** PrEP users (87%) would be very worried about HIV without PrEP.
- **Three in five** PrEP users (60%) worry about long-term side effects of PrEP use.
- **Two in five** PrEP users (40%) report a potential HIV exposure in the past year.
- **Nearly three in ten** PrEP users (29%) have discontinued PrEP at some point.
- **A similar share** of PrEP users (29%) say legal fears affected whether they sought services.

Figure 33. Selected characteristics of the PrEP-user sample; full sample characteristics are in the Appendix.

PrEP Users' Decisions Framed by Access and Stigma

The PrEP-user model follows a person from considering PrEP to using it consistently. Access can vary with awareness, whether a provider offers PrEP, cost and insurance, a regular source of care, and geography, including pharmacy-based services and tele-PrEP.[27] Decisions about starting and continuing PrEP may also be associated with discrimination, PrEP stigma, concerns about side effects and confidentiality, and social support.[2,44]

CONCEPTUAL MODEL — PREP USERS

From prevention candidate to sustained protection: where the path holds and where it leaks

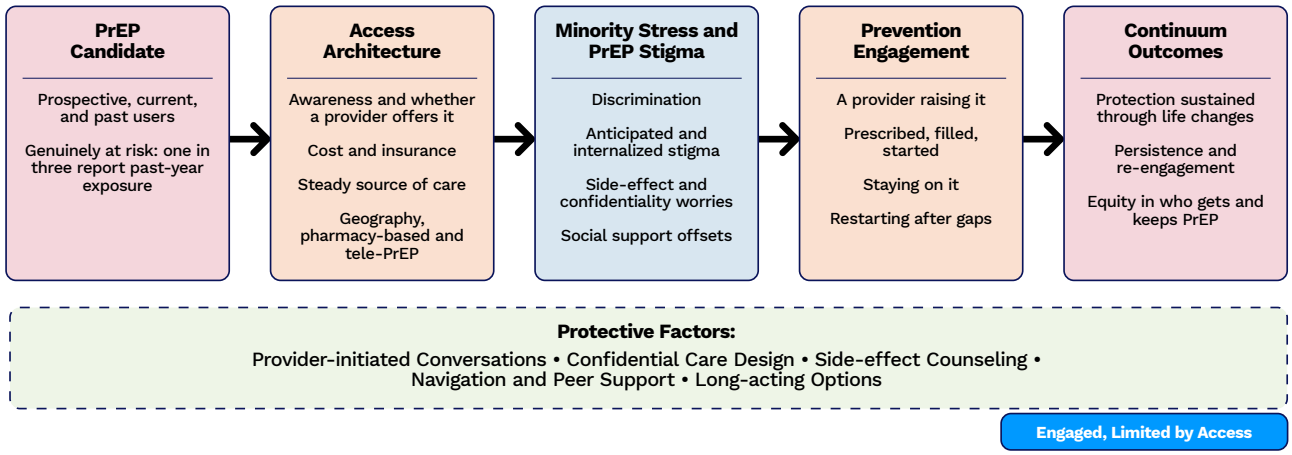


Figure 34. Conceptual model for PrEP users: from candidate through access architecture and stigma terrain to prevention engagement and sustained protection.

PrEP Users Confident in PrEP, Stymied by Privacy, Side-Effects, and Legal Concerns

Respondents expressed confidence in PrEP: 87% said they would be very worried about HIV without it, and 40% reported a potential HIV exposure during the previous year. They also reported concerns about long-term side effects (60%), the confidentiality of testing records (37%), and what others might think if they knew about their PrEP use (28%). Staying on PrEP remained a challenge, with 29% saying they had stopped at some point because of concerns about side effects or privacy. Unlike the income- and discrimination-driven gaps among people with HIV, these prevention experiences varied little by gender, race, or income; the sharpest subgroup difference was identity-based misgendering, described below, and the small PrEP sample limits subgroup power.

Twenty-nine percent of PrEP users said concerns about legal or law-enforcement systems affected their willingness to seek PrEP, HIV testing, harm reduction, or sexual-health services, and 32% said political or social change increased their stress. Asked to describe the climate in one word, they returned scary, dangerous, and negative alongside good and evolving. PrEP discussions occurred primarily with clinicians rather than other staff; few participants reported support from community health workers (10%), peer navigators (6%), and case managers (3%).

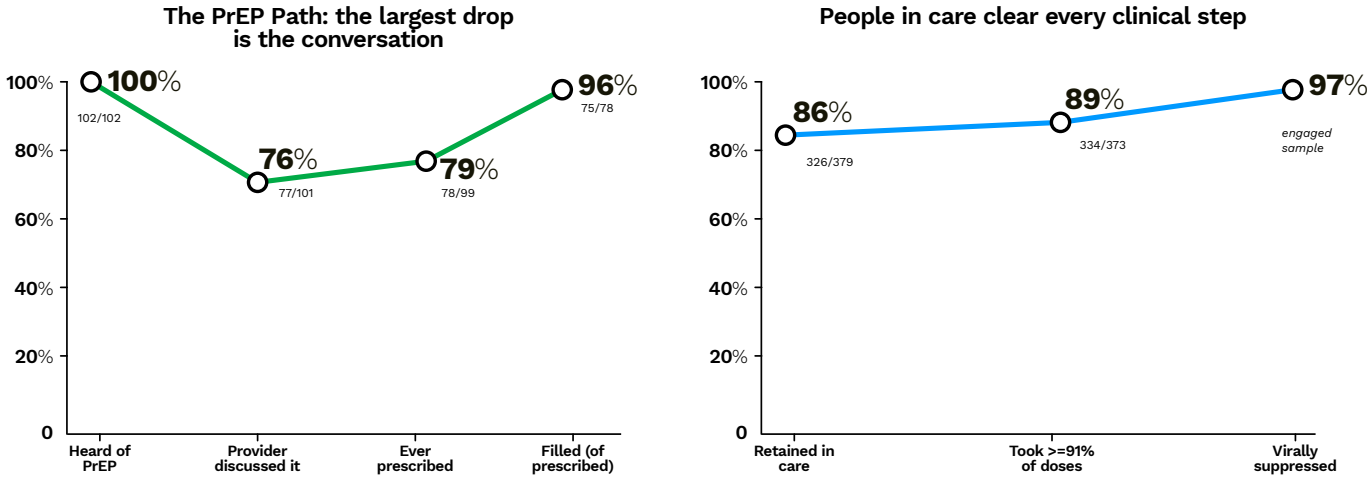


Figure 35. The PrEP path and the HIV treatment cascade, drawn as step charts.

PrEP Access and Persistence Varies Across Groups, Characterized by Insurance Gaps, Affordability, and Misgendering Fracture

Given the association between discrimination and care engagement,[10] a concerning number of transgender/gender-diverse PrEP participants (75%) were misidentified, misgendered, or had their sex or gender recorded incorrectly across medical, insurance, or pharmacy records, compared to just 8% of men and 6% of women. Affordability was the priority nearly everyone shared, named a top policy priority by roughly 90% of men and Black respondents, and by nearly 80% of women, White, and transgender/gender-diverse respondents. Only 16% of transgender/gender-diverse users maintained PrEP use over the past year without interruptions in insurance approval, prior authorization, or coverage (vs. 49% of men and 63% of women), and were the least likely to start PrEP within a week of prescription (29%, vs. 38% of women and 44% of men).

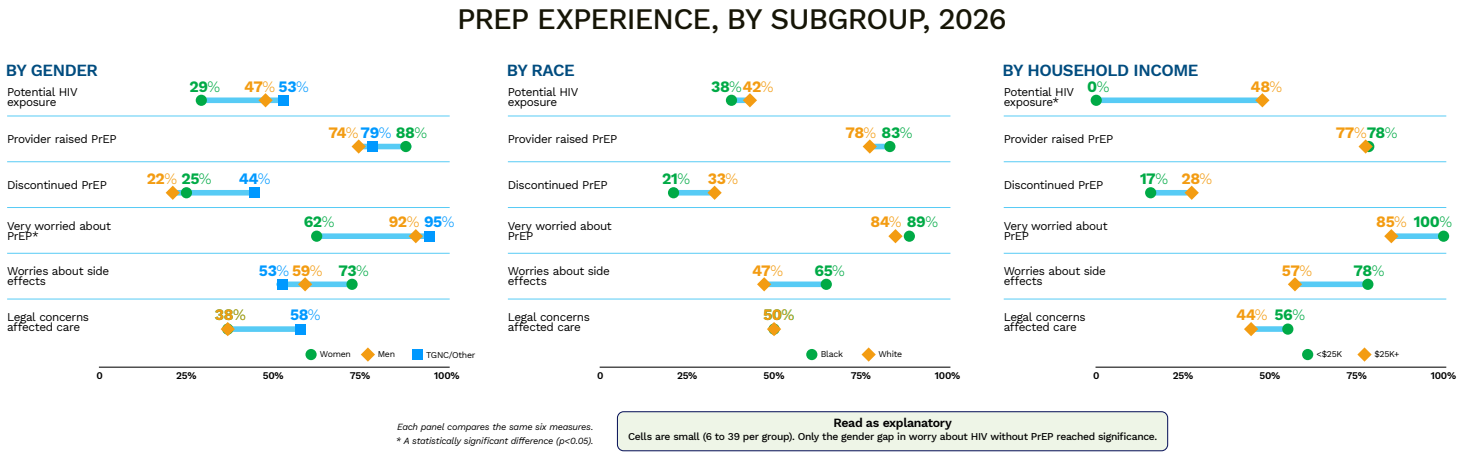


Figure 36. PrEP experience by subgroup, exploratory. Each panel compares the same six measures across gender, race, and household income. Cells are small (6 to 39 per group), so read these as exploratory.

Black respondents were far more likely than White respondents to have lost employment or work hours in the past year (56% vs. 19%), an economic shock that may make PrEP access harder. This matters because Black men who have sex with men continue to have the highest lifetime HIV risk and the lowest PrEP coverage nationally.[26,45]

> "Well researched, slightly underfunded and underutilized especially [by] Black MSM"
>
> - PrEP USER, DESCRIBING THE CURRENT STATE OF HIV CARE

> "Outside of the tight-knit HIV care community there is no compassion, education, or provider interest."
>
> - PrEP USER, DESCRIBING THE CURRENT STATE OF HIV CARE

Profiles of PrEP User Types Based on Survey Findings

We identified five distinct profiles of PrEP Users, based on their types of barriers they experienced related to access and engagement in PrEP. Within these groups, we found that confidentiality, cost, and fear of disclosure clustered together, while PrEP users concerned about side effects and food insecurity are halmarks of a small, high-burden group. Each profile had high rates of interruptions in PrEP use, as detailed in the heatmap (Fig 37).

- **High-Burden Users (8%)**. Bothered by side effects (100%) and food insecurity (75%), with frequent gaps in use and the highest telehealth use; half received care coordination.
- **Privacy and Cost Concerned (12%)**. Defined by worry over confidentiality (92%), cost of testing (92%), others learning their results (100%), and legal or law-enforcement contact (67%).
- **Interrupted Use (25%)**. Every member had gaps or stops in PrEP use; many used telehealth (60%) and carried some confidentiality concern (64%).
- **Disclosure-Anxious (14%)**. Marked mainly by fear that others learn their results (86%) and confidentiality worry (57%), with few other burdens.
- **Low-Concern (42%)**. The largest group, reporting little worry on any indicator, though a majority still had gaps in use.

Even among people motivated enough to start PrEP, staying on it is the exception rather than the rule for most profiles, and the barriers that separate the profiles are social and structural, confidentiality, cost, and disclosure, more than clinical.

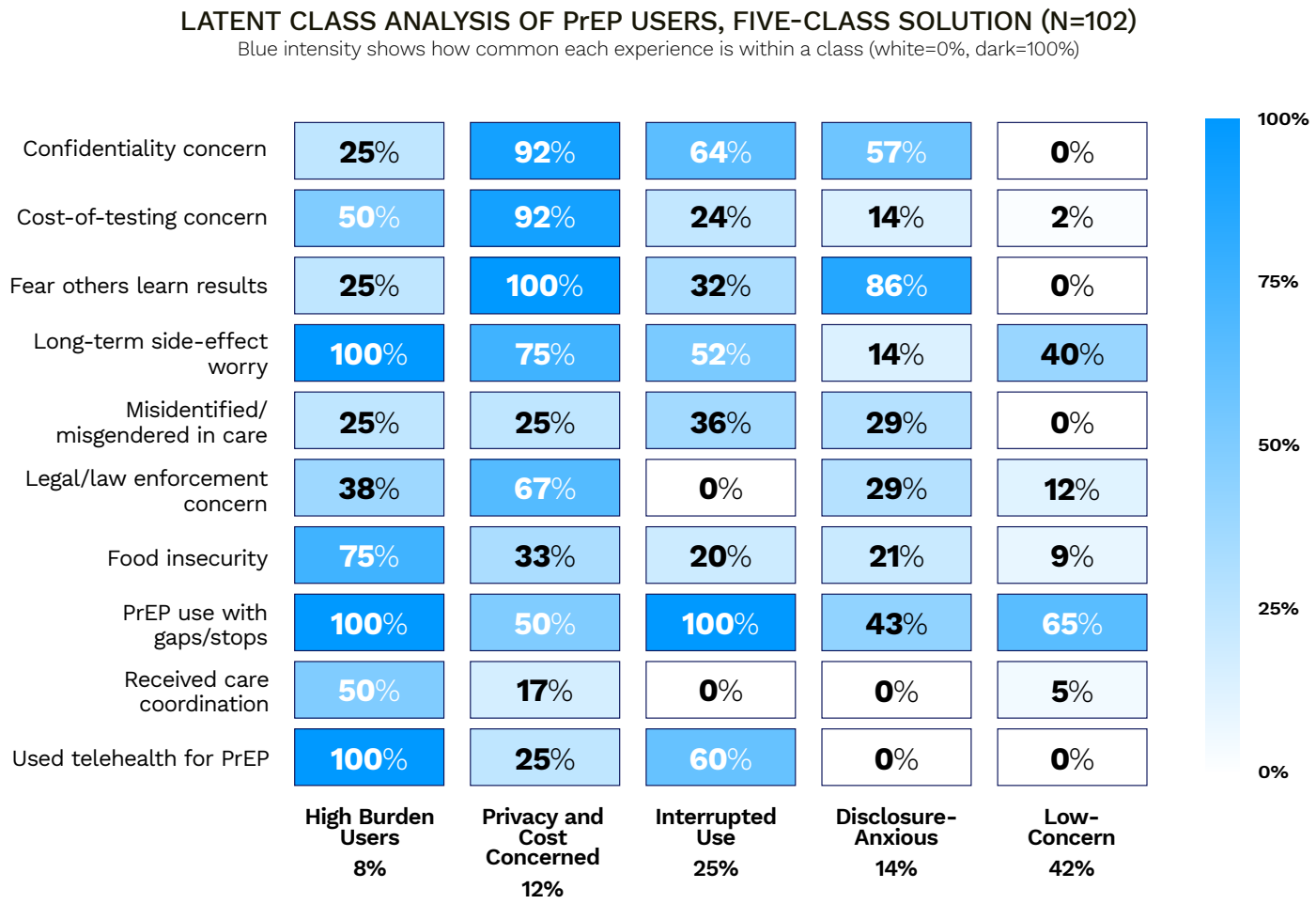


Figure 37. Latent class analysis of PrEP users, five-class solution. Each column is a profile, each row an experience indicator; darker cells mean the indicator is more common in that profile.

Key Findings Across Five Domains

The survey's key findings, summarized below across its five domains, show the pattern that runs through this year's results. Clinical outcomes among respondents remain strong, while the financing, services, and workforce that produce them come under mounting pressure.

DOMAIN	SNAPSHOT OF KEY FINDINGS
	▶ 97% of people with HIV in care who participated in the survey were virally suppressed, the foundation of treatment as prevention. ▶ PrEP awareness was universal, yet only 76% of PrEP users ever had a provider raise it. ▶ About 61% of providers offered long-acting injectable PrEP and 63% prescribed doxyPEP, though availability tracked organization type more than geography.
	▶ 44% of people with HIV took five or more medications. ▶ A high-need group (12%) reported the lowest quality of life despite viral suppression. ▶ Engagement was strong overall: 86% had a care visit within six months and 90% reported high adherence.
	▶ 61% of people with HIV reported everyday discrimination. ▶ Stress carried about 83% of discrimination's effect on quality of life. ▶ 27% rated their mental or emotional health as fair or poor. ▶ Discrimination, comorbidity, and material hardship each independently lowered the odds of a good quality of life; viral suppression did not.
	▶ The Ryan White HIV/AIDS Program, the payer of last resort, was disproportionately represented among payers; providers use it to cover care for people with HIV who are uninsured, underinsured, or cannot afford it, many at or near the federal poverty line. ▶ Viral suppression was lower at incomes at or below $25,000 (92% vs. 99%). ▶ Coverage was fragmented across private (31%), RWHAP/ADAP (28%), Medicare (21%), and Medicaid (11%), and long-acting availability tracked organization type more than state.
	▶ Nearly 84% of providers said the policy environment affected their ability to sustain services. ▶ 26% expect to leave HIV care within five years. ▶ Providers feeling drained by threats, harassment, and disrupted funding rose from 55% in 2024 to 63% in 2026, even as three in four rated themselves competent to deliver affirming care.

IV. Implications of Findings

Our findings speak to HIV prevention, treatment, and care landscape that is in a state of turmoil, perhaps more than ever since our first State of HIV Care report in 2009.

IMPLICATIONS OF THE FINDINGS

What the findings mean, across the survey

Providers Still Face Challenges Discussing PrEP, While PrEP Users Feel Pressured to Initiate HIV Prevention Conversations. Patients who know about PrEP, want it and will take it when it is offered: nearly all PrEP users surveyed who received a prescription filled it. But the current approach depends on potential PrEP users knowing they are at risk and having the wherewithal and skill to start the conversation. Access to newer options also depends on how a clinic is organized and located in an urban area.

Viral Suppression Is High, but at Risk for Those with the Greatest Need. The high rates of suppression reported by people with HIV who responded to the survey depend on income, housing, and food security as much as on medicine, and they slip first where those supports are weakest.

The Political Climate Is Increasing Stress for People with HIV and Deterring Testing, PrEP, and Care. Stress and discrimination are undermining quality of life among respondents, yet routine care rarely asks about them, so the harm accumulates behind good clinical numbers.

The First Services Cut Are the Ones That Get Patients Through the Door. Coverage, care coordination, transportation, and housing are what keep patients connected to treatment, and the providers surveyed report those services being cut first; losing them undoes outcomes the medicine alone cannot hold.

25% of HIV Providers Expect to Leave the Field Within Five Years. Among providers surveyed, the strain comes from threats, harassment, and disrupted funding more than from workload, which makes retention a policy problem before it is a staffing one.

A Transformed Epidemic, Persistent Barriers

Treatment has moved from early combination antiretroviral therapy to once-daily, single-tablet regimens and now to long-acting injectables.[46] In 2026, an estimated 1.2 million people in the U.S. are living with HIV,[47] many from historically marginalized communities: nearly two-thirds are racial or ethnic minorities (39% Black and 27% Hispanic or Latino), and more than half are 50 or older.[47]

The barriers have barely moved in two decades: poverty, distance to care in rural and underserved areas,[48] and limited access to food, transportation, and insurance.[49,50] Just under half of people with HIV (PWH) live at or below the federal poverty line,[51] and many qualify for the Ryan White HIV/AIDS Program (RWHAP), administered by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB), which serves as the payer of last resort for PWH with limited or no insurance.[52] In 2024, RWHAP served just over half of all PWH in the U.S. (602,000), 91.4% of whom were virally suppressed, against 67.2% of PWH nationally.[52]

PrEP: Uneven Access and Reach

Pre-exposure prophylaxis (PrEP) launched in 2012 and has moved from daily pills to long-acting injectables given twice a year.[53-56] Despite its proven role in lowering HIV incidence,[57] uptake still lags, especially in the groups who need it most. Only 591,000 people used PrEP in 2024, about half of those who could benefit. Black people were 15% of PrEP users that year but 39% of new HIV diagnoses; Hispanic people were 18% of users and 34% of diagnoses; and women were 10% of users and 20% of diagnoses.[58] The gap is starkest for Black women, who account for about half of new diagnoses among women yet represent just 1 to 2% of people taking PrEP.[47,58,59]

The Policy Shocks of 2025

This context matters more given the socioeconomic and policy changes affecting HIV services, PWH, and PrEP access since the new administration took office in January 2025. ADAPs faced cost-containment pressure, health agencies rolled back equity infrastructure, and limits were placed on HIV research and surveillance.[20,21,60,61] By the survey's close, the CDC had moved to end direct HIV prevention grants to 96 community-based organizations that support HIV testing, linkage to care, and PrEP and PEP referrals, redirecting the funding to state and local health departments and undermining the financial stability of the organizations closest to the communities most affected.[62,63]

What the 2026 Survey Shows

The 2026 State of HIV Care™ National Survey connects the experiences of providers, people with HIV, and PrEP users against this national picture. Treatment and prevention are working for the people who can reach them: viral suppression among the people with HIV who responded to the survey was near-universal, and most providers offered newer prevention options. What varied was access. The findings below run across five domains; the implications that follow state what those findings mean, and the priorities for action pair them with recommended courses of action.

Quality of Life Is the New Dividing Line

The clearest result of the 2026 survey is that HIV treatment and prevention work for the people who can reach them, and that the differences among people in care are rarely clinical. Because most respondents reported being virally suppressed, we focused on quality of life as the primary indicator of well-being in this sample. While overall high among survey respondents, quality of life , a self-report measure of individual well-being, comfort, and happiness, was dramatically lower among participants who experienced ongoing discrimination, comorbidities, and material hardship. Stress carried most of the effect of discrimination on quality of life, consistent with minority stress theory and with accounts of how social adversity is embodied over time.[2-8]

A Strong Clinical Core, Weakening Support

The same pattern runs through prevention and access. Awareness of PrEP was universal, yet a quarter of PrEP users were never asked about it, and whether a clinic offered long-acting options depended on how it was organized and paid. Coverage and cost shaped who stayed in care. The Ryan White HIV/AIDS Program, the payer of last resort, was disproportionately represented among payers because providers use it to cover care for people with HIV who are uninsured, underinsured, or cannot afford it, many at or near the federal poverty line, and viral suppression was lower at the lowest incomes. Set against the policy changes of 2025, ADAP under cost-containment pressure, equity infrastructure rolled back, and the CDC ending direct prevention grants to 96 community-based organizations, the survey shows a system whose clinical core is strong but whose support structures are being cut where need is greatest. The workforce sits in the same environment: strain rose with threats and disrupted funding rather than with workload, and a quarter of providers expect to leave within five years.

V. Strategic Priorities for Action

The findings point less toward new medicine than toward protecting and extending what already works.

Most of the priorities below are defensive: they protect the financing, workforce, and telehealth that produced near-universal viral suppression, each under pressure as of 2025. The rest extend reach at the points the survey identifies, the provider conversation, the organizations closest to patients, and the social conditions around care. Underlying all of them is one result the data support from several directions: the main constraint on the state of HIV care is no longer knowledge or medicine but money, organization, and policy. Our findings and implications point to the following priorities for action:

STRATEGIC ACTIONS TO ADDRESS THE FINDINGS

Seven priorities that follow from the findings.

Protect and stabilize RWHAP, ADAP, and Medicaid, the financing behind viral suppression. Nearly one in five people with HIV surveyed rely on Ryan White or ADAP, and no single payer covers a majority, so a change to any one program reaches patients with nowhere else to turn.

Pay community and safety-net organizations to offer long-acting options, so access does not depend on the clinic a patient reaches. In the survey, whether injectable PrEP or ART was available depended on organization type far more than on state or region, and the organizations closest to marginalized patients could bill the fewest payer types.

Fund care coordination, transportation, and housing as core care services. Providers surveyed reported these supports being cut first when funding is disrupted, even though they are what keep the most marginalized patients connected to testing and treatment.

Make mental-health screening and anti-discrimination practice routine, and treat quality of life as a core outcome. Among respondents with HIV, discrimination, stress, and accumulating conditions lowered quality of life while viral suppression did not, and more than one in four rated their mental health fair or poor without naming it a pressing need.

Invest in workforce retention, funding and insurance-navigation training, and protection from threats. One in four providers surveyed expect to leave the field within five years, and they asked for help with funding, insurance requirements, and patients' social needs ahead of clinical skills.

Protect telehealth flexibility and the integration of HIV into primary care. Whether a person's primary care provider also treats their HIV was one of the few outcomes that varied by state, which makes integration and telehealth flexibility gaps that policy can actually close.

Confront the policy and social conditions tied to greater stress and less willingness to seek testing and care. Nearly half of people with HIV surveyed and a third of PrEP users said political or social change increased their stress, and legal or law-enforcement worries deterred some respondents from seeking services at all.

The progress that providers, people with HIV, and PrEP users reported is real, and so is the strain around it. Investment in coverage, in the organizations nearest to patients, in the workforce, and in the conditions around care is where the next gains will come, and where inaction will cost the most for patients with the fewest resources.

> "For those able to access it, the current state of HIV care is very good."
>
> — PERSON WITH HIV, DESCRIBING THE CURRENT STATE OF HIV CARE

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VII. Methods

About the HealthHIV State of HIV Prevention and Care Eighth National Survey

HealthHIV fielded the 2026 State of HIV Prevention and Care National Survey through REDCap from May to July 2026. A single feeder question routed each respondent to one of three surveys: providers who deliver HIV prevention or treatment services, people with HIV, or people who use or are considering PrEP. Of N=1,214 participants, N=627 were routed to the provider survey, N=461 to the PWH survey, and N=119 to the PrEP survey; the remaining N=7 completed only the feeder question. Provider surveys were fielded in 2009 (the inaugural survey, branded 2008, was fielded from August 2009 to May 2010), 2011, 2013, 2022, 2023, 2024, 2025, and 2026; the PWH and PrEP surveys were fielded for the first time in 2026, establishing a baseline for future surveys.

ANALYSES AND DENOMINATORS

Percentages use the number of people who answered each question as the denominator, so a question skipped by branch logic or left blank does not count against it, and each figure and table reports the question-specific N where it differs. Group comparisons use chi-square tests. Item-level association screens test every checkbox option and single-select variable with enough respondents against race, ethnicity, gender, census region, provider age, income, HIV duration, and clinical role, controlled for multiple comparisons with the Benjamini-Hochberg false-discovery rate; only associations surviving that control are reported as findings, and results with p-values between 0.05 and 0.10 are treated as marginal signals rather than confirmed differences. Multivariable models adjust for a small set of demographic covariates (race, gender, and income or clinical role) rather than every available variable, to maintain stability at these sample sizes. Composite indices were assessed for internal consistency with Cronbach's α. Modeled analyses were fit on multiply imputed data, described under Data Management: Multiple Imputation below. Figure 38 collects the subgroup differences that survived this screen.

Statistical terms used throughout: a p-value describes the probability of observing a difference at least this large by chance alone if none existed, and by convention p below 0.05 is called statistically significant and values between 0.05 and 0.10 marginal. An odds ratio (OR) compares the odds of an outcome between one group and another (2.0 means twice the odds, below 1 means less likely), and an adjusted odds ratio (aOR) is the same figure after holding other measured factors constant. A 95% confidence interval is a plausible range for the true value; when it crosses 1 for an odds ratio, no effect cannot be ruled out. Cronbach's α, on a 0-to-1 scale, measures whether an index's items move together, with values above about 0.7 treated as reliable. A standardized coefficient expresses an association in standard-deviation units, allowing associations on different scales to be compared.

VARIABLE CODING

Categorical predictors are coded as indicator variables, with one category serving as the reference in regression models. Race is coded White, Black, and Other with White as the reference, and Hispanic ethnicity is kept as its own yes/no indicator rather than folded into race. Gender is coded as three groups: women, men, and transgender, nonbinary, or otherwise gender-diverse together; the three groups are used where cell sizes support them, which is every descriptive comparison and the association screen in all three samples, and are collapsed to men vs. women and gender-diverse respondents combined only inside multivariable models. Practice setting is coded urban (reference), rural, suburban, and tribal; clinical role is clinical vs. non-clinical. Provider age is reported in four bands: under 30, 30 to 49, 50 to 69, and 70 plus, the closest grouping the item's response bands support (cuts at 45 or 65 are not constructible); the under-40 indicator is retained in the threat-exposure models for comparability, and age is asked only on the provider instrument. Geography enters twice: the state, territory, or military postal code item for state-level models and frequency tables, and Census region (Northeast, Midwest, South, West, with territories tabulated separately) for subgroup comparisons, where state-level cells are too small. For select-all-

CONFIRMED SUBGROUP DIFFERENCES ACROSS THE THREE SURVEYS, 2026

Selected findings surviving false-discovery-rate control in the association screen, expressed as odds ratios between the named groups.

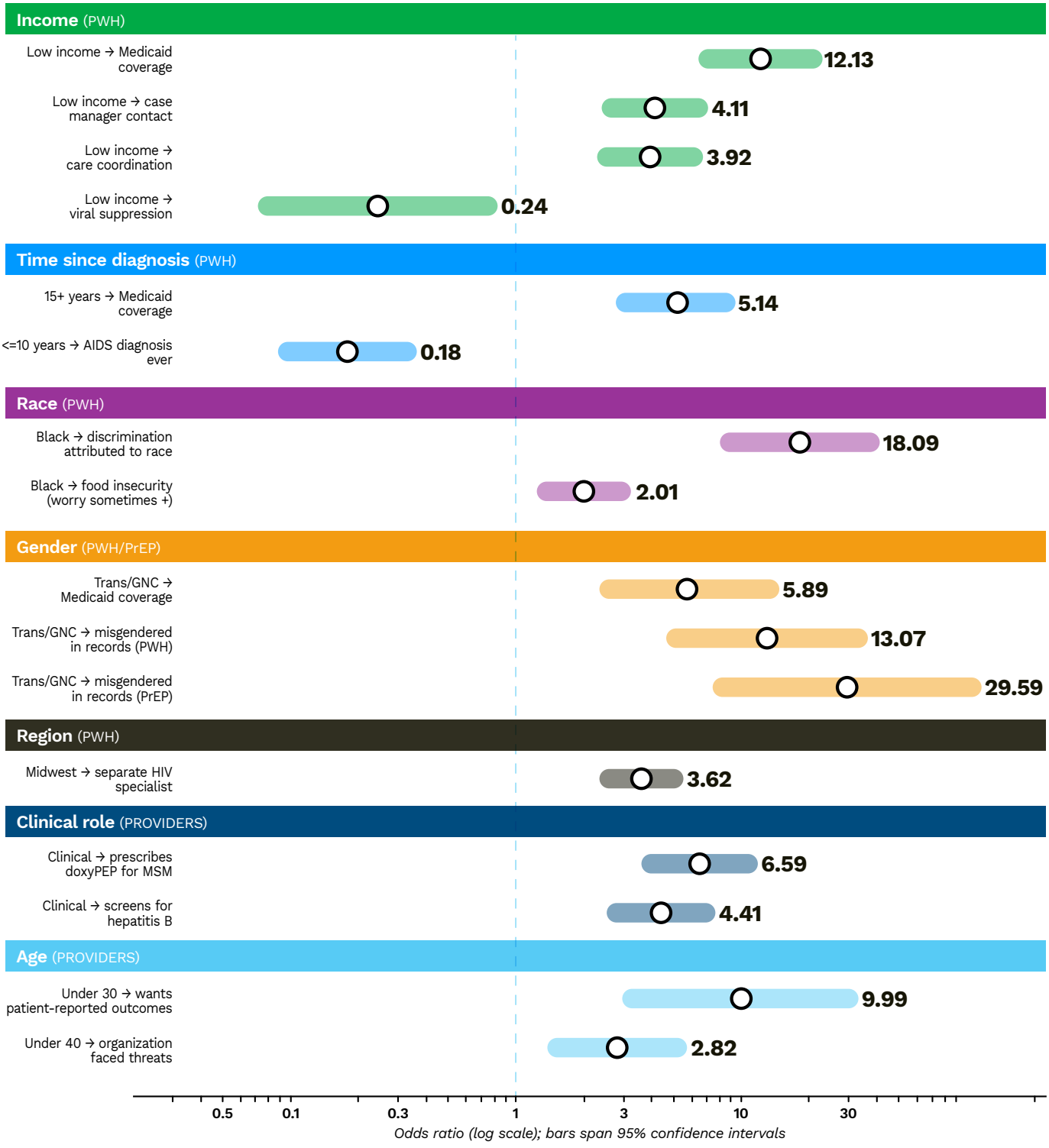

Figure 38. Forest plot of confirmed subgroup differences across the three surveys, 2026. Selected findings surviving false discovery rate control in the association screen, expressed as odds ratios between the named groups on a log scale; bars span 95% confidence intervals.

that-apply items, an unchecked box is treated as a true zero for the substantive items the survey required, but for the race and gender demographic items, a respondent who did not answer the demographics section is treated as missing rather than as a zero, so non-responders are never silently counted as not Black or not a woman; they are dropped from that specific comparison.

MEASURES AND INDEX CONSTRUCTION

The quality-of-life index averages six PROMIS-style self-ratings of physical health, quality of life, mental health, and social function, scored so that higher values mean better quality of life. The everyday discrimination index sums three items adapted from the Williams Everyday Discrimination Scale. The provider relational support index averages five items on whether the HIV provider knows the patient, listens, and involves them in decisions. The structural vulnerability index, following Bourgois, counts six binary material and institutional disadvantages: housing cost stress, food insecurity, difficulty paying bills, recent moves, income decline, and low household income; because it is a formative count rather than a reflective scale, it is summarized by its mean rather than by an α coefficient. The comorbidity count sums self-reported chronic conditions. Internal consistency (Cronbach's α) was 0.91 for quality of life, 0.81 for everyday discrimination, 0.97 for provider relational support, 0.93 for the cultural-competence index, and 0.62 for the workforce-strain index.

Multi-item indices were constructed for the two larger samples: for people with HIV, quality of life, everyday discrimination, provider relational support, structural vulnerability, and a comorbidity count; for providers, a workforce-strain index and a cultural-competence index. PrEP-user results are reported descriptively given the smaller sample.

DATA MANAGEMENT: MULTIPLE IMPUTATION

For modeled analyses, instead of dropping respondents with any missing value, missing data were filled in using multiple imputation by chained equations (MICE). Twenty imputed datasets were created with scikit-learn's IterativeImputer using Bayesian ridge estimation and posterior sampling, and results were combined across the twenty datasets using Rubin's rules.[64] Imputation was limited to respondents who began each survey and to the variables used in the models. Descriptive percentages throughout the report use observed data only. Mediation and moderated mediation were estimated with the product-of-coefficients method and bootstrap confidence intervals, in the PWH survey, where all three measures were available.[65,66] Latent classes were estimated with Gaussian-mixture models chosen by the Bayesian information criterion. The intersectional analysis used a multilevel model across strata defined by race, gender, and income, and the geographic analysis used a state random intercept. Analyses were conducted in Python 3 using the pandas, statsmodels, and scikit-learn libraries, with confirmatory models replicated in IBM SPSS Statistics; mediation and reliability estimates used 2,000 to 3,000 bootstrap resamples.[67,68]

LIMITATIONS

Several limitations frame these results. The survey is cross-sectional, a single time-point snapshot, so associations describe patterns rather than causes; it cannot say, for example, whether integrated organizations adopt long-acting options because they are integrated or because the organizations that integrate also tend to adopt early. Some models rely on small cells and have correspondingly wide confidence intervals, especially the organizational models for injectable ART, which run on fewer than a hundred sites, and the PrEP-user subgroup comparisons, which rest on as few as nine to nineteen respondents and are read as directional signals rather than precise estimates. In the trend analyses, question wording, answer options, and selection caps changed across survey waves, so levels are compared only within comparable spans and the emphasis falls on how providers rank client barriers rather than on raw percentages; in a capped battery a falling percentage can mean a problem eased or that others crowded it off a short list, so ranks are the safer reading, while the one identical two-wave item, providers feeling emotionally drained, carries no such ambiguity. The national sample is not fully representative: it reaches people with internet or mobile access and leans toward those already connected to care and to HealthHIV's networks.

Appendix

TABLE A1. SAMPLE CHARACTERISTICS

Percentages use the number who answered each item. Race, ethnicity, and gender allowed more than one response, so those categories can sum to more than 100%.

PEOPLE WITH HIV

Characteristic (N=461)	%	n
Years since diagnosis, median (IQR)		
24 (14 to 32)		416
Race and ethnicity (select all)		
White	35.1%	162
Black or African American	24.5%	113
Hispanic or Latino	6.5%	30
American Indian or Alaska Native	2.6%	12
Middle Eastern or North African	1.7%	8
Asian	1.5%	7
Prefer not to answer	1.3%	6
Native Hawaiian or Pacific Islander	0.2%	1
Gender Identity (select all)		
Man (including transgender man)	44.9%	207
Woman (including transgender woman)	16.1%	74
Nonbinary/genderqueer/genderfluid	2.6%	12
Prefer not to answer	1.3%	6
A gender not listed	1.3%	6
Transgender	0.7%	3
Two-spirit	0.7%	3
Sex Assigned at Birth		
Female	25.2%	78
Male	73.1%	226
Prefer to self-describe	0.3%	1
Prefer not to answer	1.3%	6
Sexual Orientation		
Lesbian or gay	46.3%	143
Straight, that is, not lesbian or gay	26.2%	81
Queer	8.7%	27
Bisexual	8.1%	25
Same-gender loving	2.6%	8
Asexual	2.3%	7

Characteristic (N=461)	%	n
Household Income		
Less than $15,000	13.3%	41
$15,000-$25,000	12.3%	38
$25,000-$35,000	14.6%	45
$35,000-$50,000	18.1%	56
$50,000-$75,000	19.1%	59
$75,000-$100,000	9.4%	29
$100,000-$150,000	5.8%	18
More than $150,000	3.2%	10
Prefer not to answer	1.3%	6
Education		
Less than high school	1.9%	6
High school diploma or GED	13.6%	42
Some college	28.2%	87
Associates degree	11.0%	34
Bachelor's degree	24.6%	76
Graduate or professional degree	20.1%	62
Prefer not to answer	1.3%	6
Employment		
Full-time	43.0%	133
Retired	23.3%	72
On disability	13.9%	43
Part-time	7.8%	24
Unemployed and looking	5.8%	18
Self-employed	2.9%	9
Prefer not to answer	1.3%	6
Area of Residence		
Urban	49.2%	152
Suburban	33.7%	104
Rural	14.9%	46
Don't Know	1.3%	4
Prefer not to answer	1.3%	6

Characteristic (N=461)	%	n
Relationship Status		
Single	54.7%	169
Married	17.2%	53
Partnered, living together	11.0%	34
Widowed	5.8%	18
Partnered, not living together	4.2%	13
Divorced	3.2%	10
Census Region		
Midwest	50.5%	230
South	27.9%	127
Northeast	13.0%	59
West	7.7%	35
Territory	0.9%	4

PROVIDERS

Characteristic (N=627)	%	n
Organization Type		
Non-profit organization	13.5%	32
Academic hospital/clinic setting	12.2%	29
Community Based Organization (CBO)	11.8%	28
Government entity (Local, State, Federal, Tribal)	11.8%	28
Federally Qualified Health Center (FQHC)	11.4%	27
Health department clinic/public health clinic	11.0%	26
AIDS Service Organization (ASO)	6.8%	16
Private hospital/clinic setting	5.9%	14
Clinical vs Non-Clinical		
Clinical	48.1%	114
Non-clinical	46.4%	110
Prefer not to answer	2.5%	6
Clinical Role		
Nurse Practitioner	25.4%	29
Registered Nurse	21.9%	25
Physician	13.2%	15
Other Provider / Clinical Professional	2.5%	6
Licensed Practical Nurse	4.4%	5
Nurse Manager	4.4%	5
Pharmacist	4.4%	5
Licensed Clinical Social Worker	3.5%	4

Characteristic (N=627)	%	n
Non-Clinical Role		
Case Manager / Medical Case Manager	33.6%	37
Administrator	14.5%	16
Health Education Specialist	10.0%	11
Community Health Worker	8.2%	9
Health Navigator	6.4%	7
Other Non-clinical Professional	2.5%	6
Disease Intervention Specialist	5.5%	6
Outreach Worker	3.6%	4
Practice Setting		
Rural	19.8%	47
Suburban	21.1%	50
Tribal	0.8%	2
Urban	55.3%	131
Prefer not to answer	2.5%	6
Time Spent on HIV Care		
0-25%	20.4%	98
26-50%	16.4%	79
51-75%	23.9%	115
76-100%	37.8%	182
Prefer not to answer	2.5%	6
People With HIV Served Per Month		
0-10	33.6%	161
11-50	29.2%	140
51-100	18.2%	87
100+	15.7%	75
Prefer not to answer	2.5%	6
Can Prescribe Medication		
No	53.5%	61
Yes	45.6%	52
Prefer not to answer	0.9%	1
Insurance/Funding Accepted (select all)		
Medicaid	28.1%	176
Medicare	23.0%	144
Other public insurance (e.g., RWHAP)	2.5%	6
Other private insurance (ACA, marketplace)	2.5%	6
Employer Sponsored Insurance	18.2%	114
Income dependent / sliding scale	14.4%	90
Other	2.5%	6
Prefer not to answer	2.5%	6
Age Range		
Under 30	6.5%	15
30-49	55.2%	128
50-69	34.5%	80
70+	3.9%	9

Characteristic (N=627)	%	n
Census Region (practice)		
South	45.6%	283
Northeast	21.8%	135
Midwest	18.5%	115
West	11.6%	72
Territory	2.3%	14
Military	0.2%	1

PrEP USERS

Characteristic (N=119)	%	n
Race and Ethnicity (select all)		
White	26.9%	32
Hispanic or Latino	18.5%	22
Black or African American	15.1%	18
Asian	4.2%	5
American Indian or Alaska Native	1.7%	2
Prefer not to answer	0.8%	1
Gender Identity (select all)		
Man (including transgender man)	38.7%	46
Woman (including transgender woman)	15.1%	18
Nonbinary/genderqueer/genderfluid	10.1%	12
Transgender	9.2%	11
Prefer not to answer	0.8%	1
Sex Assigned at Birth		
Female	40.8%	31
Male	57.9%	44
Prefer not to answer	0.8%	1
Sexual Orientation		
Lesbian or gay	40.8%	31
Straight, that is, not lesbian or gay	22.4%	17
Queer	15.8%	12
Bisexual	9.2%	7
Pansexual	6.6%	5
Same-gender loving	2.6%	2
Household Income		
Less than $15,000	6.6%	5
$15,000-$25,000	5.3%	4
$25,000-$35,000	5.3%	4
$35,000-$50,000	15.8%	12
$50,000-$75,000	21.1%	16
$75,000-$100,000	10.5%	8
$100,000-$150,000	19.7%	15
More than $150,000	9.2%	7
Prefer not to answer	0.8%	1

Characteristic (N=119)	%	n
Education		
Less than high school	1.3%	1
High school diploma or GED	6.6%	5
Some college	17.1%	13
Associates degree	11.8%	9
Bachelor's degree	26.3%	20
Graduate or professional degree	35.5%	27
Prefer not to answer	0.8%	1
Employment		
Full-time	69.7%	53
Part-time	7.9%	6
Self-employed	5.3%	4
Unemployed and looking	5.3%	4
Retired	3.9%	3
Other	2.6%	2
Unemployed and not looking	1.3%	1
Area of Residence		
Urban	61.8%	47
Suburban	22.4%	17
Rural	11.8%	9
Tribal land	1.3%	1
Don't know	1.3%	1
Prefer not to answer	0.8%	1
Census Region		
South	41.0%	48
Northeast	22.2%	26
Midwest	18.8%	22
West	17.9%	21

TABLE A2. SURVEY YEARS AND SAMPLE SIZES

Year	Instrument	Respondents (n)
2009	State of HIV Care (providers only)	N=461
2011	State of HIV Care (providers only)	N=699
2013	State of HIV Care (providers only)	N=288
2022	State of HIV Care (providers only, prevention and treatment)	N=1,364
2023	State of HIV Care (providers only)	N=768
2024	State of HIV Care (providers only)	N=966
2025	State of HIV Care (providers only)	N=601
2026	State of HIV Care (providers, PWH, PrEP users)	N=1,214 (Providers N=627 / PWH N=461 / PrEP N=119 / feeder only N=7)

HealthHIV RESEARCH AND EVALUATION

HealthHIV
STATE OF
Aging with HIV™
National Survey

HealthHIV
STATE OF
ASOs/CBOs™
National Survey

HealthHIV
STATE OF
Drug User Health™
National Survey

HealthHCV
STATE OF
HCV Care™
National Survey

HealthHIV
STATE OF
HIV Prevention and Care™
National Survey

National Coalition for LGBTQ Health
STATE OF
LGBTQ Health™
National Survey

HealthHIV Research and Evaluation conducts regular national surveys to better inform ongoing advocacy, education, research, and training activities. These “State Of” surveys provide unique insight into patient and provider issues in order to optimize primary and support services for diverse communities. The regular reports offer the ability to study multi-year trend analyses illustrating changes, challenges, and opportunities to address the needs of providers and patients. HealthHIV, HealthHCV and the National Coalition for LGBTQ Health conduct State of surveys addressing HIV prevention and care, HCV care, drug user health, ASOs/CBOs, LGBTQ healthcare, and aging with HIV.

HealthHIV.org/stateof

HealthHIV is a national non-profit working with healthcare organizations, communities, and providers to advance effective HIV, HCV, STI and LGBTQ health care, drug user health, and health equity through education and training, technical assistance and capacity building, advocacy, communications, and health services research and evaluation.

HealthHIV advances effective prevention, care, support, and health equity for people living with, or at risk for, HIV and hepatitis C—particularly with LGBTQ and other underserved communities—by providing education, capacity building, health services research, and advocacy to organizations, communities and professionals.

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