APRIL 2026

BIG IDEAS

Embracing Innovation in Sexual Health for Men Who Have Sex with Men and Transgender Women

Adapting clinical guidelines and practice for a new era

Sexual health is the ability to embrace and enjoy one's sexuality throughout their lifetime and it is a critical component of physical and emotional health. Sexual health is intertwined with HIV and STI prevention and care. Too often, however, the focus has been on preventing disease to the exclusion of enabling people to experience pleasure and have agency over the intimate parts of their lives. For more than a decade, highly effective drug regimens have been available to prevent HIV acquisition, but limited uptake has meant that the population-level prevention potential of PrEP has not been fully realized.[1] Men who have sex with men (MSM, including transgender men who have sex with men) and transgender women always have been among the most heavily impacted by HIV and have had higher rates of common STIs than other populations. They also have unique needs that must be met to achieve population health.

A growing array of longer-acting PrEP options that require dosing as little as a couple of times a year, as well as new STI prevention tools (i.e. doxycycline as post-exposure prophylaxis, known as DoxyPEP), are raising questions about

NEW CLINICAL TOOLS TO SCREEN, PREVENT AND TREAT HIV AND STIS CAN IMPROVE COMMUNITY HEALTH

Innovative HIV and STI prevention and treatment options and new diagnostic supports demand new approaches:

SCREENING GUIDELINES AND CLINICAL PRACTICE

Research is needed to better inform practice in terms of who needs to be screened and treated for HIV and STIs, and how often

There is a need for simplified screening guidelines that adapt to differing needs of MSM and trans women compared to lower incidence populations

When adjusting screening intervals, providers should prioritize frequent syphilis and HIV screening for MSM not on PrEP and others in higher-incidence sexual networks

PRIORITIZING COMMUNITIES WITH THE GREATEST HIV AND STI UNMET NEEDS

Meaningful community engagement must drive the ongoing refinement and evolution of HIV and STI services delivery models to increase population-level impact

Greater policy focus is needed on addressing the needs of uninsured and under-insured individuals

Existing technologies such as telehealth and at home self-collection/over-the-counter (OTC) self-testing need to be deployed at greater scale to overcome barriers such as stigma and transportation

COMMUNICATING COMPLEX SEXUAL HEALTH MESSAGES

Health departments and medical societies need to partner with communities to develop simple and effective sexual health communications. This is essential to build trust and confidence in messaging, at a time when trust in public health is fading

Community partners must be broadened to include influencers, party/event hosts, and public figures, as well as other corporate partners such as app developers and others

Sexual health messaging must emphasize pleasure, self-agency and not exclusively focus on disease prevention

EVIDENCE IS NEEDED TO INFORM CLINICAL PRACTICE—PRIORITY RESEARCH TOPICS

Screening is testing a patient without symptoms and is conducted as means to decrease illness and disease transmission at a population level. Empirical evidence supporting this rationale, however, is often lacking. Critical questions include:

- Is screening more useful for identifying MSM and transgender women who could benefit from PrEP than relying on behaviors self-reported to a clinician?
- Does asymptomatic gonorrhea and chlamydia (GC/CT) in MSM and transgender women on PrEP lead to increased rates of HIV transmission in MSM not on PrEP?
- What impact might reduced screening among MSM who also have sex with women have on women's rates of STIs including syphilis?
- How will reduced screening impact engagement in preventive services and outcomes for transgender women and men?
- How will reduced screening for GC/CT affect uptake of DoxyPEP?
- Would reduced asymptomatic screening of GC/CT screening among MSM and transgender women have a differential impact on populations based on access to care?

the importance of regular screening for gonorrhea and chlamydia among MSM and transgender women and, more broadly, about how current clinical guidelines and practice should evolve and stay relevant to the lives of people during this period of expanding HIV and STI prevention and treatment options.[2,3]

Important policy work is needed in key areas:

1. SCREENING GUIDELINES AND CLINICAL PRACTICE

Regular periodic screening may help to meaningfully reduce HIV and STI rates among MSM and transgender women.[4] Routine screening for gonorrhea and chlamydia in MSM has been justified partly by the idea that diagnosing and treating asymptomatic STIs reduces risk of HIV acquisition and transmission.[5] In the PrEP era, however, that logic needs to be re-examined since PrEP largely eliminates HIV acquisition risk, with modest clinical benefits of detecting asymptomatic extragenital gonorrhea and chlamydia in many individuals.[3] Evidence from clinics in some European countries, including Belgium and Netherlands, that have already implemented reduced screening frequency for MSM on PrEP show a moderate impact on STI rates from reduced screening.[3,6] Furthermore, in many cases extra-genital gonorrhea and chlamydia can resolve without treatment.[7] Current testing models, also can overestimate the burden of active infections, particularly for asymptomatic and extragenital infections.[8] In Seattle/King County sexual health clinics, evidence of infections resolving without treatment, the absence of disease and long-term impacts with asymptomatic infections, and the uncertain impact on population level STI incidence has led to changed recommendations for MSM and transgender persons. Routine screening for asymptomatic gonorrhea and chlamydia is no longer recommended in MSM and transgender persons on a stable oral PrEP regimen for greater than 6 months.[9] Lower clinic-visit PrEP delivery options, including tele-PrEP and pharmacy-based PrEP, provide further opportunities for reduced screening frequency; frequent required visits and lab testing can feel like "overmedicalization" and be a barrier to continuation.[10]

Studies that included syphilis, however, tell a different story. Syphilis can progress to more serious complications (including neurologic and ocular disease) and, through sexual networks, can increase incidence of congenital syphilis (CDC's data show congenital syphilis is now about seven times more prevalent than it was a decade ago, with nearly 4,000 cases reported in 2024[11]).[12] Missing or delaying diagnosis has higher downstream consequences than many asymptomatic extragenital gonorrhea and chlamydia infections. Studies show a significant decrease in the amount of symptomatic syphilis with every 3-month screening compared with yearly screening.[13] Extragenital STIs and syphilis are still strong markers of near-term HIV risk.[14,15] While reduced screening frequency for gonorrhea and chlamydia for people on PrEP might not increase risks, for people not on PrEP, more frequent screening can matter in higher-incidence MSM networks. MSM not on PrEP may still need to be screened quarterly or every 6 months, even if stable PrEP users are moved to longer intervals.

POLICY ACTION:

Research is needed to better inform practice in terms of who needs to be screened and treated for HIV and STIs, and how often.

Screening frequency can be pushed and pulled in different directions. On the one hand, if one screens more, they will likely find more infections. At the

same time, health resources, especially public health resources, are scarce. Lengthening the interval between screening can conserve resources and make it easier for individuals to remain engaged in care by lowering the burden on individuals. While some studies guide current practice, there is a need for additional research to better inform clinical practice regarding these trade-offs, including differences in recommendations for different pathogens and in populations with differing prevalences of infection. For example, available evidence may make some providers comfortable reducing the frequency of chlamydia and gonorrhea screening in MSM and transgender women, but not enough is known about the implications of reduced screening for syphilis from every three months to twice a year or annually as current CDC guidelines recommend, with more frequent testing recommended for those at higher risk. Such research, however, should take into account unique factors of MSM and transgender populations such as higher prevalence of many STIs and more interconnected sexual networks. Further, policymakers need to be clear that this is a dialogue about asymptomatic screening. Diagnostic testing should be made available whenever clinical symptoms are present. Insurance coverage and public health programs must be required to facilitate rapid diagnosis and treatment for symptomatic individuals. Further, if states or counties adopt reduced STI frequency models, it is important to ensure a continuation of robust STI surveillance. Moreover, reduced frequency of screening should be considered as part of a package of changes that includes improved and more robust tele-PrEP and pharmacy-based PrEP models, and PrEP and DoxyPEP counseling. Furthermore, given lack of access and poorer outcomes, particular attention should be placed on ensuring that transgender persons are not left behind.

POLICY ACTION:

There is a need for simplified screening guidelines that adapt to differing needs of MSM and trans women compared to lower incidence populations.

Deciding when and whom to screen requires a lot of nuance, and is further complicated by the increasing number of PrEP interventions and the availability of DoxyPEP and other current or future STI interventions. Therefore, there is a need for clinically grounded guidelines that account for sufficient difference across populations and that are simple and intelligible to primary care providers who may not specialize in HIV/STI prevention and care, as well as to heavily impacted communities who need to be assured that all guidelines value and respect their lives, preferences, and behaviors. Nuance is needed because the relevance of testing depends on the type of infection, the anatomy of exposure and objective of prevention (e.g., preventing illness vs. transmission vs. HIV risk). For gonorrhea and chlamydia, three-site testing (urine/urethral, rectal, and pharyngeal) is still a clinically meaningful approach since extragenital infections are commonly asymptomatic and will be missed with urine-only testing.[16] Importantly, evidence and current guidelines do not recommend screening for pharyngeal chlamydia, which explains why “three-site” is not automatically

ASYMPTOMATIC SCREENING FOR GONORRHEA AND CHLAMYDIA—IS IT WORTH IT IN AN ERA OF PrEP?

There are reasonable arguments for and against reducing the frequency of asymptomatic screening for STIs:

PROS:

Clinics in the US and Europe that have already implemented reduced screening frequency for MSM on PrEP provide evidence that show a moderate impact on STI rates.

The current body of evidence indicates that extra-genital gonorrhea and chlamydia can resolve without treatment.[7]

Frequent required visits and lab testing can feel like “overmedicalization” and be a barrier to continuation.[10]

Current STI testing models can overestimate the burden of active infections, particularly for asymptomatic and extragenital infections.[8]

CONS:

While reduced screening frequency for gonorrhea and chlamydia for people on PrEP might not increase risks, for people not on PrEP, more frequent screening can matter in higher-incidence MSM networks.

Trans people experience higher STI rates largely due to discrimination and stigma leading to reduced preventive care utilization. Reduced screening policies could exacerbate inequities for trans populations.

Sexual network analyses have documented links between syphilis-positive MSM and heterosexual women, underscoring that shifts in MSM screening and treatment could affect women’s STI burden.[12]

Extragenital STIs and syphilis are still strong markers of near-term HIV risk.[14,15] MSM not on PrEP may still need to be screened quarterly or every 6 months, even if stable PrEP users are moved to longer intervals.

appropriate for every pathogen at every site.[17] STI screening guidelines need not differ for people living with HIV compared to those on prevention medications, but adherence to these recommendations may be higher among persons using PrEP.

An important policy question is whether changing screening frequency improves health outcomes without widening gaps in access or shifting risk to other populations. When access to respectful and supportive sexual health services is absent, reducing screening frequency could exacerbate inequities for some populations. For example, trans people experience higher STI rates largely due to discriminatory practices including outdated assessment of risks, resulting in underutilization of health services and limited uptake of newer tools like DoxyPEP.[18,19] This is consistent with other research showing discrimination and stigma reduce preventive care utilization among transgender people and that many transgender respondents report low lifetime HIV/STI testing despite willingness to use at-home STI tests.[20,21,22,23] Any move to lengthen screening intervals should be paired with gender-affirming low-barrier alternatives, including at home testing options, telehealth or pharmacy pathways for rapid treatment and DoxyPEP counseling, and routine monitoring to ensure that gaps do not widen.

POLICY ACTION:

When adjusting screening intervals, providers should prioritize frequent syphilis and HIV screening for MSM not on PrEP and others in higher-incidence sexual networks.

The individual and public health consequences of STIs vary dramatically depending on the pathogen. The risk of transmission also is greatly influenced by the specific sexual networks in which individuals engage and the HIV and prevention status of individuals. Therefore, screening recommendations and screening intervals must be flexible enough to account for these variations. Changes in screening guidelines also can have spillover risks. Sexual network analyses have documented links between syphilis-positive MSM and heterosexual women, underscoring that shifts in MSM screening and treatment could affect women's STI burden.[13] Furthermore, since rectal STIs in MSM are linked to substantially higher subsequent HIV risk, any approach that requires less screening frequency for MSM on PrEP needs a parallel plan for MSM not on PrEP, to avoid increases in STI rates among the latter.[24] At the same time, reducing gonorrhea and chlamydia testing may not reduce clinic touchpoints if PrEP care still requires relatively frequent syphilis screening, or may call for alternative syphilis screening arrangements. Thus, savings may accrue in labs tests, not necessarily in visits, unless delivery models change to incorporate more at home-testing.

2. PRIORITIZING COMMUNITIES WITH THE GREATEST HIV AND STI UNMET NEEDS

Given the inequities in the impact of HIV and other STIs across populations, equity must be a core guiding value in the design and implementation of HIV and STI prevention and care programs. This means taking deliberate steps to identify barriers to access and working to ensure that the people with the greatest need for services have access to services to support their sexual health. To achieve greater reductions in HIV and STI rates and to improve HIV and STI care, particularly among MSM and transgender women, delivery systems must offer services in ways that are tailored to the specific needs of communities experiencing disproportionate HIV and STI rates. In addition, potential changes to STI screening recommendations must also consider how proposed changes could impact access to services for specific populations. For example, Black MSM already experience lower rates of insurance, low PrEP uptake, high background STI rates, and low durable HIV viral suppression rates. Thus, a recommendation for reduced frequency of screening could have the unintended consequence of contributing to widening racial inequities in STI rates for Black MSM and other groups. This means that deliberate actions must be taken to avoid this potential outcome. At a time when public health messaging is increasingly distrusted by marginalized communities, ensuring that community members have a say in tailoring how HIV and STI services are delivered is vital to rebuilding trust and community confidence in public health and healthcare delivery systems.

POLICY ACTION:

Meaningful community engagement must drive the ongoing refinement and evolution of HIV and STI services delivery models to increase population-level impact.

HIV and STI service providers, many of which have continued operating COVID-era service models that reduced community outreach, should re-prioritize engagement with their local communities. Fostering partnerships with community-based organizations that serve and have earned the trust of MSM and transgender women within their local jurisdictions through actions such as regular Town Hall-style listening sessions or virtual focus groups, to the (re)establishment of community advisory boards comprised of HIV and STI services users from the

most impacted communities, are just a couple of examples of strategies that providers can implement to gather feedback on an ongoing basis. Through ongoing, meaningful engagement of the most impacted communities, HIV and STI delivery systems can obtain the relevant data needed to adapt their services to accommodate different user preferences. By flexibly tailoring services and avoiding one-size-fits all approaches and choice around PrEP modalities and HIV/STI testing frequency, HIV and STI service providers can better meet the needs of their local communities. For example, at the Alabama Department of Public Health (DPH), community engagement informed the creation of a Fast Track Program in which patients seeking HIV testing can schedule their own 15-minute appointments either over the phone or online. Alabama DPH also worked extensively with its network of community-based organization partners to advertise the availability of DoxyPEP.[25]

POLICY ACTION:

Greater policy focus is needed on addressing the needs of uninsured and under-insured individuals.

In the country's expensive, highly fragmented health care system, provisions in the Affordable Care Act (ACA) that mandate coverage of evidence-based preventive services for most persons with private insurance (about two-thirds of Americans have private coverage) means that HIV and STI screening and PrEP typically must be covered without cost-sharing. While this policy does not cover every needed service, it does overcome significant access barriers to HIV and STI preventive services for persons with insurance. There are different, but separate protections in both Medicaid and Medicare that require or encourage access to critical preventive services without cost-sharing. Therefore, this calls for a much greater focus on ensuring access to HIV and STI prevention and care services to people who are uninsured and to filling gaps that can limit access to persons who may be under-insured. MSM and transgender women with the greatest needs for these types of sexual health services are disproportionately uninsured or face financial or other access barriers.[26]

Reductions in federal HIV/STI grants and threats to the 340B Drug Pricing Program that frequently support reimbursement for HIV and STI services to uninsured and underinsured persons demands a policy on expanding stable funding for an HIV and STI safety net. As part of the Ending the HIV Epidemic Initiative (EHE) launched by President Trump during his first Administration, there were significant positive efforts to take a syndemic approach to HIV and STIs and these efforts must be continued and expanded.[27] In addition to HIV prevention funding provided to health departments by the CDC, there are other essential funding sources including CDC Section 318 grants, the Title X Program, as well as funding from Medicaid and the Health Centers Program. It is important that advocates for HIV and STI programs help policymakers understand how this patchwork of funding sources fits together, how impactful it is, yet also how fragile it is and how it must be strengthened and sustained.

State and local leaders also have critical roles in expanding the safety net to ensure access to services for the uninsured. This includes supporting the ongoing transformation of longstanding STD clinics into affirming Sexual Health Clinics. It also calls for state legislators and local governments to re-invest in these clinics and community services by dedicating general fund revenues and collaborating with corporate and private funders to prioritize this often, overlooked part of a community health infrastructure.

POLICY ACTION:

Existing technologies such as telehealth and at-home self-collection/over-the-counter (OTC) self-testing need to be deployed at greater scale to overcome barriers such as stigma and transportation.

One of the challenges in improving sexual health for MSM and transgender women, indeed for all populations, is that researchers and clinicians have developed effective interventions to improve access to and engagement in sexual health services, but many of these innovations are not available at sufficient scale. Even during this period of rapidly developing new diagnostic, prevention, and treatment interventions, we have important validated tools to strengthen engagement that are not being sufficiently offered.

Offering people choices about where and how to access HIV and STI prevention and care services is a vital component of a system that centers the needs of priority communities including MSM and transgender women. The popularity of both telehealth services offered by brick-and-mortar HIV and STI clinics and fully online, telehealth sexual health platforms such as MISTR and QCare+ is a testament to the importance of offering flexible sexual health services to reaching communities experiencing access barriers such as stigma and transportation. The success of free mail order at-home/self-HIV and STI home specimen collection testing programs like *TogetherTakeMeHome* in reaching marginalized communities is also a testament to the importance of offering flexible testing options. Telehealth services and at-home/self-testing services need to be deployed at greater scale. This may call for federal guidance or best practices for scaling

up such interventions or defining how to establish productive collaborations between health departments and private sector or community partners. Alternatively, it could call for national organizations such as NASTAD, NCSD, NACCHO, ASTHO, or the American Sexual Health Association to develop learning collaboratives with the specific goal of scaling up access to interventions that offer individuals greater choice in where or how to access services.

3. COMMUNICATING COMPLEX SEXUAL HEALTH MESSAGES

For MSM and transgender women, stigma and discrimination undermine trust and decrease engagement with healthcare. KFF polling has shown that LGBT adults are twice as likely as other adults to report negative experiences with a health care provider.[28] The experience of MSM and transgender women engaging with healthcare must be supported by competent healthcare providers that proactively reduce stigma, and local and state health departments must ensure MSM and transgender women can access services without discrimination. At the same time, we also must empower MSM and transgender women with information about sexual health and STIs so they can effectively advocate for themselves and receive necessary standards of care in instances where their providers do not have training or the most up-to-date information.

Over the past few years, there has been an onslaught of attacks on public health. Disruptions at the federal level come as Americans are questioning public health messaging and faith and trust in public health authorities declines. The COVID pandemic exposed how fragile trust in public health is and how mixed-messages or incomplete information about the prevention of COVID can confuse the public and undermine trust. Additionally, the outbreak of mpox in the U.S. in 2022 posed a serious health threat for MSM and transgender women, while heightening stigma and fear. The initial response to the global outbreak of mpox in 2022 by the U.S. government was insufficient and public health messaging often promoted abstinence from not only sex, but social gatherings. In response, community-based public health advocates and epidemiologists collaborated to share information, identify drivers of the spread of mpox, and empower communities with culturally tailored knowledge.[29] This response was one of many at the community level across the country. Eventually, federal officials, specifically in the White House, partnered with community-based public health leaders, which in turn increased trust in public health institutions at a critical time.

POLICY ACTION:

Health departments and medical societies need to partner with communities to develop simple and effective sexual health communications. This is essential to build trust and confidence in messaging, at a time when trust in public health is fading.

Local and state health departments are more important than ever. These institutions will play a critical role in communicating changes to STI screening, prevention and care for MSM and transgender women. Both community members and health care providers who are not infectious disease specialists can be confused or intimidated by the complexity needed in communicating about sexual health, and this is complicated by the degree of innovation and change

STI SCREENING RECOMMENDATIONS—PROVIDERS AND PEOPLE NEED SIMPLE AND USABLE GUIDANCE

Move from “category-based” to “risk-based” screening guidance: Updated guidelines should clarify that some people on PrEP may warrant less frequent gonorrhea and chlamydia screening, while some MSM not on PrEP may warrant more frequent screening due to sexual network risks. Current CDC STI guidelines that, for example, place MSM on PrEP as high risk may not appropriately capture individual risk profiles.

Create tailored guidance for MSM who have sex with women: MSM who also have sex with women may need more screening, depending on risk factors and sexual networks. Guidance that bridges across networks has implications for partners, especially with regard to congenital syphilis risk. CDC guidance should explicitly address MSM who have sex with women as a subgroup where syphilis screening and partner services need heightened attention.

Align screening guidance with DoxyPEP implementation: Since DoxyPEP eligibility is commonly triggered by a documented bacterial STI, CDC should anticipate that reducing gonorrhea and chlamydia screening can limit who is prescribed DoxyPEP. Guidance should include alternative routes including risk-based counseling, self-report, and pharmacy/tele-PrEP models. Current CDC guidelines for patients on DoxyPEP that require STI testing every 3 - 6 months should also be reevaluated per the latest evidence of reduced chlamydia incidence among people on DoxyPEP.

*While there is insufficient evidence on the impact of screening on MSW, CDC should also provide practical, risk-based screening pathways for heterosexual men who are at higher risk due to sexual networks or substance use.

we are experiencing with the development of new tools and interventions. Local and state health departments need to ensure providers are updated on screening guidelines and have technical capacity to serve populations most impacted. To do this effectively, health departments should work with community providers and advocates to develop updated screening guidelines and best practices for dissemination to providers, using primary care associations and trusted community-based partners to tailor messaging and engagement strategies to the communities they serve.

POLICY ACTION:

Community partners must be broadened to include influencers, party/event hosts, other public figures, as well as corporate partners such as app developers and others.

While community-based organizations play a vital role in engaging communities as these organizations currently provide linkage to STI prevention and treatment services, other institutions have a significant role to play. Cultural leaders such as celebrities and social media influencers are also important; UNAIDS and Mac AIDS Fund have historically partnered with celebrities for HIV prevention campaigns. Additionally, industries focused on pleasure, including dating and hookup apps, but also nightlife events, and queer-identified spaces, should be engaged. PrEP providers such as MISTR who engage MSM communities through social media, dating apps and local events can also serve as partners. Adult entertainment studios and actors, such as those on OnlyFans, also have a unique reach into the communities most impacted by STIs, and partnerships should be developed with them to discuss the importance of STI screening and promote new guidelines among their networks and increase demand for sexual health services.

POLICY ACTION:

Sexual health messaging must emphasize pleasure and self-agency and not exclusively focus on disease prevention

MSM and transgender women on PrEP or those currently on HIV treatment have access to providers and are thus less likely to face barriers to services. The majority of people who could benefit from PrEP do not currently take it and existing STI screening guidelines may not be well known by populations not currently receiving sexual health services. This calls for enhanced efforts to reach individuals with sexual health messaging outside of traditional clinical services. A key way to do this is to emphasize pleasure and giving people tools that can improve their lives with this information. The source of this messaging should not come from someone in a white lab coat in an ad or article, but through people the community is more likely to trust. This can include strategies that include but are not limited to engaging social media influencers, local community leaders, and creatives and cultural workers that are uniquely positioned to address stigma and knowledge gaps, reducing barriers for new users of PrEP and STI prevention and treatment services. PrEP4Love, a PrEP messaging and prevention-advocacy campaign led by AIDS Foundation of Chicago and the Illinois PrEP Working Group (IPWG) used sex-positive messaging, prioritizing intimacy, pleasure and peace of mind in sexual encounters.[30] It used messages such as “spread tingle” or “transmit love,” transforming negative language about disease transmission into something positive.

New guidelines should be developed to be simple and effective, and messaging should target both providers and MSM and transgender communities, regardless of engagement with health services, and with sex-positive framing. PrEP, PEP, DoxyPEP, Telehealth and at-home or over-the-counter testing provide communities with more options for sexual health than ever before, but these options cannot be limited by outdated and ineffective strategies rooted in stigma and shame.

THE TIME IS NOW

The advent of longer-acting HIV treatment and PrEP, improved STI diagnostics, DoxyPEP and other novel technologies give us a range of new biomedical solutions that support sexual health. This new biomedical toolkit to treat and prevent HIV and STIs also affords an opportunity to break with the fear- and risk-based sexual health communication of the past, and embrace sexual health messaging that centers pleasure, connection, and overall well-being. Our current efforts must ensure that we adapt our clinical programs to expand options while remaining grounded in evidence, and we must prioritize the parts of our communities with the greatest barriers to engagement and good health outcomes.

ENDNOTES

1. Centers for Disease Control and Prevention, Expanding PrEP Coverage in the United States to Achieve EHE Goals (Oct. 17, 2023).
2. Centers for Disease Control and Prevention, Doxy PEP for Bacterial STI Prevention (Dec. 5, 2024).
3. Thibaut Vanbaelen et al., Effect of Decreasing the Frequency of Screening for Neisseria Gonorrhoeae and Chlamydia Trachomatis on the Incidence of These Infections and Antimicrobial Use Among Men Who Have Sex with Men Using HIV PrEP in Belgium: A Retrospective Cohort Study, 6 Lancet Microbe 101214 (2025).
4. Jeb Jones et al., Effect of Screening and Treatment for Gonorrhea and Chlamydia on HIV Incidence Among Men Who Have Sex With Men in the United States: A Modeling Analysis, 49 Sexually Transmitted Diseases 669 (2022).
5. Jeb Jones et al., Proportion of Incident HIV Cases Among Men Who Have Sex with Men Attributable to Gonorrhea and Chlamydia: A Modeling Analysis, 46 Sexually Transmitted Diseases 357 (2019).
6. Lotte Werner et al., Estimated Effect of Reduced Asymptomatic Testing on Missed Chlamydia Trachomatis Detections Among Women and Heterosexual Men in the Netherlands: A Retrospective Observational Study, 58 Lancet Regional Health Europe 101468 (2025).
7. Genevieve A.F.S. van Liere et al., Spontaneous Clearance of Urogenital, Anorectal and Oropharyngeal Chlamydia Trachomatis and Neisseria Gonorrhoeae in Women, MSM and Heterosexual Men Visiting the STI Clinic: A Prospective Cohort Study, 95 Sexually Transmitted Infections 505 (2019).
8. Kevin J.H. Janssen et al., Viability-PCR Shows That NAAT Detects a High Proportion of DNA From Non-Viable Chlamydia Trachomatis, 11 PLOS One e0165920 (2016).
9. Public Health–Seattle & King County, PHSKC HIV and Sexually Transmitted Infection (STI) Screening Recommendations for Men Who Have Sex with Men (MSM) and Transgender and Non-Binary (TNB) Persons Who Have Sex with Men (Jan. 2026).
10. Aaron J. Siegler et al., Developing and Assessing the Feasibility of a Home-Based Preexposure Prophylaxis Monitoring and Support Program, 68 Clinical Infectious Diseases 501 (2019).
11. Centers for Disease Control and Prevention, Sexually Transmitted Infections Surveillance, 2024 (Provisional) (Sept. 24, 2025).
12. Shayna D. Cunningham et al., Evidence of Heterosexual Bridging Among Syphilis-Positive Men Who Have Sex with Men, 82 Sexually Transmitted Infections 444 (2006).
13. Kristin Carr et al., Earlier Detection of Latent Syphilis: Every 3 Month Screening with MSM and HIV, 4 Open Forum Infectious Diseases S668 (2017).
14. Preeti Pathela et al., HIV Incidence Among Men With and Those Without Sexually Transmitted Rectal Infections: Estimates from Matching Against an HIV Case Registry, 57 Clinical Infectious Diseases 1203 (2013).
15. Vita W. Jongen et al., Can We Screen Less Frequently for STI Among PrEP Users? Assessing the Effect of Biannual STI Screening on Timing of Diagnosis and Transmission Risk in the AMPrEP Study, 99 Sexually Transmitted Infections 149 (2023)
16. Centers for Disease Control and Prevention, Clinic-Based Testing for Rectal and Pharyngeal Neisseria Gonorrhoeae and Chlamydia Trachomatis Infections by Community-Based Organizations—Five Cities, United States, 2007, 58 Morbidity & Mortality Weekly Report 716 (2009).
17. Centers for Disease Control and Prevention, Chlamydial Infections, Sexually Transmitted Infections Treatment Guidelines, 2021.
18. Laura H. Bachmann et al., CDC Clinical Guidelines on the Use of Doxycycline Postexposure Prophylaxis for Bacterial Sexually Transmitted Infection Prevention, United States, 2024, 73 Morbidity & Mortality Weekly Report: Recommendations & Reports 1 (2024).
19. Mackenzie Stewart et al., Cisnormativity as a Structural Barrier to STI Testing for Trans Masculine, Two-Spirit, and Non-Binary People Who Are Gay, Bisexual, or Have Sex with Men, 17 PLOS ONE e0277315 (2022)
20. Kristie L. Seelman et al., Transgender Noninclusive Healthcare and Delaying Care Because of Fear: Connections to General Health and Mental Health Among Transgender Adults, 2 Transgender Health 17 (2017).
21. Annie-Laurie McRee et al., Preventive Healthcare Services Use Among Transgender Young Adults, 19 International Journal of Transgenderism 417 (2018).
22. Rachel Brandão Raskin et al., Doxycycline Post-exposure Prophylaxis Awareness and Use Among Transgender Women in San Francisco, 2023-2024: Assessment One Year After Release of Health Department Guidance, AIDS & Behav. (published online Oct. 11, 2025)
23. Pedro B. Carneiro et al., PrEP Use in a US National Sample of Trans Men and Other Transmasculine People Who Have Sex With Men: A Longitudinal Analysis, 97 J. Acquired Immune Deficiency Syndromes 357 (2024)
24. Lindley A. Barbee et al., New HIV Diagnosis Independently Associated with Rectal Gonorrhea and Chlamydia in Men Who Have Sex with Men, 44 Sexually Transmitted Diseases 385 (2017).
25. Fast Track Testing, Ala. Dep't of Pub. Health, https://www.alabamapublichealth.gov/montgomery/fast-track.html (last updated Feb. 19, 2026).
26. Jae Downing, Kendall A. Lawley & Alex McDowell, Prevalence of Private and Public Health Insurance Among Transgender and Gender Diverse Adults, 60 Med. Care 311 (2022),
27. Moving Beyond HIV: Targeted Resources Spark Momentum in STI Clinic Services, Ctrs. for Disease Control & Prevention (Jan. 22, 2025).
28. Alex Montero, Liz Hamel, Samantha Artiga & Lindsey Dawson, LGBT Adults' Experiences with Discrimination and Health Care Disparities: Findings from the KFF Survey of Racism, Discrimination, and Health, KFF (Apr. 2, 2024)
29. Keletso Makofane et al., Community and Connection: A Study on Social Connection Among LGBTQ+ New Yorkers, Ctrl+F on behalf of RESPND-MI (2025)
30. Jessica M. Dehlin et al., #PrEP4Love: An Evaluation of a Sex-Positive HIV Prevention Campaign JMIR Public Health Surveill 2019;5(2):e12822

CENTER FOR HIV & INFECTIOUS DISEASE POLICY

APRIL 2026

This brief is a product of the **Center for HIV and Infectious Disease Policy (CHIDP)** of the **O'Neill Institute for National and Global Health Law** and is supported by a grant from ***Gilead Sciences, Inc.*** It was informed by a stakeholder consultation held in November 2025. Gilead Sciences, Inc. has had no input into the development or content of this brief.

Prepared by **Kirk Grisham**, **Vishakh Unnikrishnan**, and **Jeffrey S. Crowley** of **CHIDP** and **Justin C. Smith** of the **Harvard T.H. Chan School of Public Health**. The views expressed are solely those of the authors.

http://bit.ly/USHIVpolicyproject