Improving HIV and STI Prevention and Care for Heterosexuals

Adopting a Sexual Health Framework and Expanding Services Capacity Offers an Opportunity to Improve Overall Health

Preventing HIV transmission and ending HIV as a public health threat entails not only identifying and focusing on the populations with the greatest burden of HIV, but also groups that could be overlooked by looking at case counts alone. For example, heterosexual women make up roughly half of the population and account for seventeen percent of new cases,[1] indicating that they are a significant source of new cases and must remain a priority. But this also masks the disproportionate impact of HIV on heterosexual Black and Latine women as they account for roughly 56% and 22.5% of cases, respectively, among heterosexual women in 2024.[2] Heterosexual men also make up close to half of the U.S. population but carry a much lower burden of HIV. Nonetheless, they accounted for roughly eight percent of all new HIV cases in the U.S. in 2024, with large disparities among Black and Latine men.[3] Despite this, heterosexual men receive very limited HIV messaging and services tailored to them. Addressing their prevention and care needs is critical both to protect their health and to interrupt a cycle of transmission with women.

HIV is a sexually transmitted infection (STI), but public health programs often have handled HIV separately and differently than other STIs, even though the behaviors and modes of transmission for HIV and other STIs overlap. The Centers for Disease Control and Prevention (CDC) estimates that at any given time, one in five U.S. adults has an STI.[4] Additionally, when one or both partners has an STI, it increases the likelihood of HIV transmission (see figure on page 2).

Effectively dealing with HIV and other STIs requires dealing with sex. American society, however, often struggles with forthright discussions about sex and sexuality. Public dialogues are often narrowly focused on what is appropriate to teach adolescents and young adults in the context of school-based sexuality education (i.e. sex ed). Too many adults across the lifespan,

MAKING SEXUAL HEALTH A GREATER PRIORITY WILL BENEFIT SOCIETY

Increased attention to HIV and STIs for heterosexuals can lead to improved overall health:

COMMUNITY ROLES FOR BOLSTERING SEXUAL HEALTH

New approaches are needed to increase sexual health literacy for parents, young people, and people across the lifespan

Culturally grounded interventions and programs that reach beyond clinical settings can improve sexual health for specific communities

Heterosexual men need to be deliberately brought into dialogues and policies about sexual health

REVISING GUIDELINES AND EMBRACING TECHNOLOGY

New HIV and STI reduction goals for heterosexual women, men, and newborns are needed

Updated guidelines are needed for screening for HIV and STIs for heterosexual men and women at different life stages and with differing exposure profiles

More implementation science research is needed to increase uptake of sexual health services and innovative technology

RE-INVESTING IN SEXUAL HEALTH CLINICS

Sexual health clinics can create an important entry point into primary prevention for heterosexual men

Sexual and reproductive health providers can create environments of trust for heterosexual women that facilitate whole-person health

Within the scope of their current practice and training, primary care providers can do more to screen and prevent HIV and STIs

Integrating Urgent Care and Emergency Departments with local health departments and STI clinics can strengthen engagement in care for heterosexual men

however, do not have a complete understanding of what it means to be sexually healthy and this can limit their enjoyment of a healthy sex life throughout adulthood and it can weaken interpersonal relationships.

In 2021, the National Academies of Sciences, Engineering, and Medicine (NASEM) released a consensus report commissioned by the CDC, *Sexually Transmitted Infections: Adopting a Sexual Health Paradigm*.[5] This report sought to review the latest evidence for addressing STIs. The report organized its recommendations around four action areas that also can be used to improve HIV and STI prevention and care for heterosexuals: 1) Adopt a holistic sexual health paradigm, i.e. we need to move away from a narrow focus on testing and treating infections and integrate HIV and STI prevention and care into a broader framework of increasing sexual health; 2) Broaden ownership and accountability for responding to STIs; 3) Bolster existing systems and programs for responding to STIs; and 4) Embrace innovation and policy change to improve sexual health.

Broadening ownership for sexual health means expanding responsibility beyond sexual health clinics and even beyond clinical settings. Indeed, if there is one single thing that has contributed to the success of the HIV movement, it is the central role of community leadership in advancing effective policies. In some cases, community stakeholders need to create avenues for engagement with women and men together and sometimes it requires approaches for men and women separately from each other.

Within clinical settings, **clinical practice offers very little for heterosexual men except for symptomatic testing and treatment**. There are no screening guidelines that call for regular or periodic screening of sexually active heterosexual men. Compounding this, the expansion of screening guidelines typically would require robust surveillance data which is currently under acute threat from federal funding cuts that have already eliminated key CDC STI surveillance capacity.[6] This reflects a broader gap in the health care system that fails to provide whole person care for males after adolescence when routine vaccinations and pediatric preventive care generally taper off. There are almost no routine preventive care touchpoints for men until much later in life when routine colorectal and prostate cancer screenings are recommended. As a result, many engage with the health system only when they have a sports injury, an acute concern or clear symptoms. This symptom-driven pattern of care is poorly suited to STI prevention because many infections in men are asymptomatic and can be transmitted without awareness.[7]

Among women, STIs are often much more likely to lead to serious and persistent harm, including negative impacts on fertility.[8] Moreover, there is a growing crisis of perinatal transmission of STIs to newborns. From 2015 to 2024, the annual number of congenital syphilis cases increased from 495 to nearly 4,000 [an increase of 700%].[9] Congenital syphilis is very serious and can lead to blindness, lifelong disability, and death of the newborn. Several interconnected failures drive this gap. Nationally, the most missed prevention opportunities were inadequate maternal treatment despite timely diagnosis (30.7%) and lack of timely prenatal care (28.2%).[10] Among pregnant people with timely syphilis identification, more than two-thirds were inadequately treated due to inappropriate antimicrobial selection, dosing errors, or insufficient interval before delivery, compounded by ongoing national shortages of benzathine penicillin G, the only recommended treatment.[11] Every case of congenital syphilis should be a sentinel event that results in concerted efforts to identify and address the system failures that led to it.

This may be an inopportune moment to describe new actions to improve the quality of HIV and STI services, given the significant funding pressures facing health systems and the decline in insurance coverage. A potential countervailing development, however, is that the fields of HIV and STI prevention and care are currently producing critical innovations in technology that are making progress more achievable. This

IMPACT OF STIs ON HIV ACQUISITION AMONG HETEROSEXUALS

Sexually transmitted infections (STIs) significantly increase HIV acquisition and transmission risk. The numbers below are derived from a meta-analysis of 32 studies and estimate how much the presence of an STI increases the likelihood of HIV acquisition in heterosexual adults.

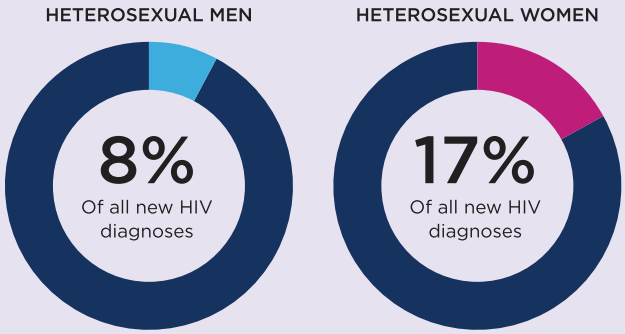
	HETEROSEXUAL MEN	HETEROSEXUAL WOMEN
CHLAMYDIA	**~0.8X** more likely to acquire HIV	**~1.5X** more likely to acquire HIV
GONORRHEA	**~3X** more likely to acquire HIV	**~3X** more likely to acquire HIV
SYPHILIS	**~1.8X** more likely to acquire HIV	**~1.7X** more likely to acquire HIV

Source: Wilkerson AM, Tao J, Chan PA. Sexually Transmitted Infections and Risk of Human Immunodeficiency Virus Transmission. Curr HIV/AIDS Rep. 2025;22:40 (Table 1), "Times more likely" = relative risk (RR).

SHARE OF HIV DIAGNOSES IN THE U.S.

HIV DIAGNOSES

Share of all new HIV diagnoses in the U.S. attributed to heterosexual contact, 2024.



Sources: CDC HIV Diagnoses, Deaths, and Prevalence: 2026 Update, released May 18, 2026.

includes longer-acting HIV prevention and treatment that can support durable adherence,[12] doxycycline as post-exposure prophylaxis (DoxyPEP) that has been shown to be effective among men who have sex with men (MSM) and for which researchers are examining its potential for reducing syphilis and chlamydia among heterosexuals,[13] as well as a range of home-collection, self-tests and point-of-care tests for syphilis and other STIs that can increase access to testing, give users more options for when and how to test themselves, and, in the case of accurate point-of-care diagnostics, facilitate faster and more targeted treatment while reducing unnecessary reliance on syndromic management.[14] Vaccines also offer expanding promise. HPV vaccination remains underutilized in the U.S. despite proven effectiveness, while investigational mRNA candidates for HSV-2 and a dedicated gonorrhea vaccine hold promise for the future. In this environment, there are three areas particularly ripe for policy attention.[15]

1. COMMUNITY ROLES FOR BOLSTERING SEXUAL HEALTH

Sexual health is an essential component of health, yet it is often overlooked in the way society and health systems define health. Too often, health is divided into physical health and mental health, while sexual health, which is deeply connected to both, is treated as a secondary concern or ignored altogether. Sexual health entails more than remaining free from STIs. It requires physical health to maximize the ability to engage and enjoy sex and mental health so that individuals can form emotional connections and have the ability to make sound, informed decisions that are often integral to positive sexual engagement. One's sexual needs and desires naturally evolve and change over one's lifetime, and sexual health requires helping individuals to safely and ethically seek to fulfill their needs. Additionally, there are facets of sexual health that have gained a newfound appreciation as society gains greater equality between men and women. The growing attention paid to sexual assault and sexual abuse call for integrating ideas and practices to ensure consent and respect among partners and to focus on sharing pleasure and satisfaction within a relationship and re-imagining sex as more than a transactional activity. The clinic cannot be the primary place where the language and understanding of sexual health among heterosexuals is defined and disseminated. Key actions by community stakeholders and institutions are essential to increasing sexual health for all populations including heterosexual men and women:

POLICY ACTION:

New approaches are needed to increase sexual health literacy for parents, young people, and people across the lifespan.

Greater attention and new resources are needed to increase sexual health literacy and give people more skills to adopt and promote healthy sexual behaviors. While there is an evidence-base that supports comprehensive, age-appropriate sexuality education, given the lack of consensus over teaching sex-ed to young people, a more productive additional focus could be giving parents greater knowledge and skills for guiding their children as they become sexually aware and progress into adulthood. It also has the benefit of helping these adults in their own lives. This could be operationalized in a variety of ways, including through new partnerships between health departments and parent-teacher associations.

Additionally, a variety of approaches and interventions are needed to increase sexual health literacy among adults. The NASEM report recommends 1) partnering with faith institutions, 2) engaging local businesses through community-based participatory research, 3) training and supporting lay health advisers and, 4) reaching minoritized and marginalized groups using street-based and alternative venue outreach. All of these areas merit deeper exploration. Sexual health messaging must extend across the lifespan. More than half of the 1.1 million people living with diagnosed HIV in the United States are over age 50, highlighting the importance of reaching older people.[16]

POLICY ACTION:

Culturally grounded interventions and programs that reach beyond clinical settings can improve sexual health for specific communities.

Given the cultural and other factors that make honest and open discussions about sex challenging, the most

meaningful opportunities for engaging with various groups of people to discuss sexual health are often deeply grounded in cultural practices and in places where shared history and experience have already built trust among group members. For people in recovery, it may be through members of Narcotics Anonymous (NA) or other approaches to recovery where common history has created an openness to discussing how sex fits into their lives and how to seek this in a way that maximizes health and mutual satisfaction. For others, it could be social groups, such as sororities and fraternities, membership in a labor union, or even in the workplace. Earlier in the HIV epidemic, CDC supported a program called Business Responds to AIDS (BRTA) that later expanded with a component called, Labor Responds to AIDS.[17] One aspect of the program was to develop toolkits that created forums for discussion of HIV prevention. This type of model could be adapted to expand knowledge about STIs, screening and treatment options, and to foster improved sexual health. It also can create opportunities for employers to integrate sexual health services in their employee assistance programs.

POLICY ACTION:

Heterosexual men need to be deliberately brought into dialogues and policies about sexual health.

One of the most important actions is to recognize the need to focus on sexual health for heterosexual men. Further, nearly half of all sexually-acquired cases of HIV among heterosexual men occur among Black men, yet Black men remain largely ignored in HIV programming, policy implementation, and research.[18] More attention should be paid to social media outreach. While this approach can be questioned in terms of reach and impact, when done right, it could be an important part of a broader engagement with men. Further, social media also creates more options for reaching a broader array of individuals with shared cultural and other connections without needing to broaden messages and dialogues to achieve mass appeal. In person engagement, however, is also critically important. For many men, Black men in particular, the barbershop is often a place where group members come together for social engagement as much as receiving a fresh cut. Again, experience with HIV has shown how this can be beneficial. Health departments or other public health entities recruited a network of barbers and provided them with basic HIV education and in some cases skills-based training on how to engage in HIV education.[19] The intention was not to create a script to follow, but to provide an already trusted community member with the information needed to provide factual information in a way that fosters dialogue about HIV testing, prevention and care. This type of model could be valuable with respect to sexual health. The same model also can be adapted to different social and civic groups ranging from sports leagues to faith-based men's groups to Elk and Moose lodges and other social clubs where men are accustomed to engaging primarily with other men. Additionally, community-based approaches such as "walk with your doctor" or information booths in malls and other public spaces can serve as informal ways of introduction and tools to build and strengthen trust in healthcare.[20]

SCREENING GUIDELINES ARE INADEQUATE FOR WOMEN AND ABSENT FOR HETEROSEXUAL MEN

Current U.S. screening guidelines for HIV and STIs are inadequate for heterosexual women and offer virtually no routine screening pathways for heterosexual men.

- CDC's STI Treatment Guidelines contain no screening recommendations for chlamydia or gonorrhea for heterosexual men.
- There is no universal or age-based pathway for syphilis screening.
- HIV screening for heterosexuals defaults to a one-time "opt-out" standard.
- Trichomoniasis has no routine screening recommendation for heterosexual men at all.

2. REVISING GUIDELINES AND EMBRACING TECHNOLOGY

The best medical care is often driven by standardization and evidence. Research examines which interventions are effective and the best way to use them in clinical care. Through a need to limit unnecessary health spending, to assist providers in focusing on the most urgent and relevant issues to promote health, and to keep patients engaged by not trying to do too much in a clinical visit, clinical practice guidelines and best practices are developed to standardize care. Health plans and clinics may be asked to report compliance with these guidelines, and this may cause them to organize the delivery of services around providing care consistent with these guidelines. Guidelines already prompt providers to routinely check vital signs and screen for critical health issues, asking about mood, depression, and other markers of well-being as a matter of course. The problem with practice guidelines for primary care is that they are wholly inadequate when it comes to STI prevention and care. And when providers have limited time for each individual patient encounter, sexual health and HIV and STI education and assessment are often given short shrift. The reluctance of many physicians and other providers to take a sexual history can inhibit what is often a foundational opportunity to address sexual health in the clinic by establishing a baseline of

information that can be supplemented and built upon over the course of a provider/patient relationship.

Even in sexual health clinics or with specialized providers who are knowledgeable and comfortable with delivering sexual health services, there are major gaps in the guidelines that shape practice. CDC guidelines call for persons 13-64 to be screened for HIV at least once over the course of their lifetime.[21] For syphilis, CDC guidelines focus on risk-based screening and some local jurisdictions recommend at least one lifetime screening for syphilis for heterosexual women and men.[22] Routine screening is recommended for persons considered to have high risk, such as individuals who have multiple partners or a history of STIs, MSM, people with HIV, and persons in high prevalence settings such as correctional institutions. There are no current chlamydia or gonorrhea screening recommendations for heterosexual men, except for those in high-risk settings such as correctional facilities or high prevalence clinics.[22] Even when heterosexual men and women access health care, providers do not always assess sexual behaviors, exposures, or STI/HIV risk in a consistent way. When these conversations do occur, they may be framed in ways that feel judgmental, rushed, or not culturally responsive. This can discourage disclosure and lead to missed opportunities for screening, prevention, and treatment.

For chlamydia and gonorrhea, CDC recommendations are aligned with USPSTF recommendations. USPSTF A and B graded recommendations have met a high evidence standard, and for most types of insurance, they must be provided without cost-sharing to the individual. USPSTF chlamydia and gonorrhea guidelines call for annual screening up to age 24 for sexually active heterosexual women and for women with higher risk age 25+ such as those with multiple partners or with a history of STIs.[23]

Additionally, USPSTF guidelines call for HIV, syphilis, gonorrhea, chlamydia and Hepatitis B and C screening during pregnancy at the first prenatal visit.[24] CDC further recommends third-trimester screening for syphilis and in some cases at delivery, as well as third-trimester screening for HIV and gonorrhea for persons with high-risk behaviors.

New tools and technological innovations are being introduced that can assist primary care in providing more and higher quality sexual health services:

POLICY ACTION:

New HIV and STI reduction goals for heterosexual women, men, and newborns are needed.

One of the successful elements of various iterations of the National HIV/AIDS Strategy and the Ending the HIV Epidemic (EHE) initiative was that they set measurable, time-phased targets for improvement along the HIV prevention and care continua. This approach is applicable at the national, state, local, and clinical levels. A component of the EHE was the development of the HIV AHEAD dashboard.[25] What is needed now are HIV and STI goals that can be used to motivate policy action and measure progress over time at each of these levels from the clinic to the nation.

POLICY ACTION:

Updated guidelines are needed for screening for HIV and STIs for heterosexual men and women at different life stages and with differing exposure profiles.

There are large variations in the prevalence of STIs in different populations and the differences in screening recommendations for different groups are not inherently problematic. Indeed, gay and bisexual men comprise roughly two percent of the population and account for two in three new HIV diagnoses and one in two primary and secondary syphilis cases.[26,27] Prevalence of both conditions in heterosexual men is much lower. Therefore, if guidelines appropriate for MSM were applied to all men, it would waste resources and divert provider and patient attention from what are more likely higher priority health issues. This illustrates that even good national guidelines must be supplemented with additional guidance and accountability standards for different populations and local needs, including differences in chlamydia, gonorrhea, syphilis, and other STI prevalence among various communities. Federal regulators, insurers, and professional societies of practicing providers need to come together and develop more informed guidance for individual providers and for practitioners in specific communities. For example, routine screening for syphilis, gonorrhea, and chlamydia may not be warranted for all heterosexual men, but in communities with high prevalence, it could be recommended, at a minimum, annually. Or, simple guidance could be developed to help primary care providers to ask questions about sexual history and sexual networks to indicate and document the need for more routine screening.

POLICY ACTION:

More implementation science research is needed to increase uptake of sexual health services and innovative technology.

One of the most important actions needed to better prevent and treat STIs is to invest more in implementation science research that is tailored to specific communities and populations, including subpopulations of heterosexual men and women. This need is especially acute as biomedical innovations, including user-controlled screening tests and longer-

acting prevention tools and treatments, offer the potential to improve outcomes. This depends, however, on developing interventions in a way that supports their sustained use.

3. RE-INVESTING IN SEXUAL HEALTH CLINICS

Adequate funding for a national network of public sexual health clinics is woefully lacking. This is part of a much larger problem of inadequate funding for public health overall. Whereas states have primary responsibility for public health under the Constitution, over time, the federal government has assumed a much greater responsibility for financing public health through insurance coverage through programs such as Medicaid, Medicare, CHIP, and subsidizing coverage in the Affordable Care Act's marketplaces, as well as through discretionary public health grants through the CDC and other federal agencies. A recent amfAR report found that in 2023, CDC funding made up between 18% of state public health funding in Oregon to 85% in Missouri.[28] In Texas and Florida (large states heavily burdened by HIV and STIs) CDC funding made up 71% and 61% of each state's public health funding, respectively. Nonetheless, federal funding has greatly eroded despite growing rates of STIs. Looking back twenty-five years and adjusting for inflation, today's federal investment in the CDC Division of STD Prevention (DSTDP) has fallen by 53% (See figure on page 7). Both state and federal funding for public health has been inadequate and has gone through boom-and-bust cycles. More recently, KFF reports that from 2010 to 2019, spending for state public health programs (supported with both state and federal funds) declined by 16% and funding for local public health (supported with a mix of local, state, and federal funds) declined by 18%.[29] State and local funding increased in response to the COVID-19 pandemic, but much of that funding has gone away.

A consequence of this is that many state and local publicly-funded clinics have closed or reduced their scope. This is happening at the same time that the field is seeking to transform prior STD clinics that were often poorly located and maintained into more welcoming sexual health clinics. This has transformative potential to increase the focus on STI screening and prevention and to integrate sexual health into broader health promotion efforts. By not only increasing funding for STI prevention efforts through the CDC, but ensuring that we stabilize and re-invigorate a national network of sexual health clinics and sites, we can improve the responsiveness to heterosexual men and women, as well as other parts of the community.

POLICY ACTION:

Sexual health clinics can create an important entry point into primary prevention for heterosexual men.

We have already acknowledged that our current health care system offers heterosexual men very little to promote and maintain their sexual health. Many of these men, however, access publicly-funded sexual health clinics when they suspect that they may have an STI. This shows that many men will access these services when available. More work is needed, however, to expand the number of these clinics and ensure that they have adequate funding. Moreover, CDC and states need to continue to support an ongoing transformation of traditional STD clinics into welcoming health promotion venues and to use these clinics as an entry point into more comprehensive primary care. This can include providing routine health screenings at every STI health visit and offering more comprehensive services when appropriate.

POLICY ACTION:

Sexual and reproductive health providers can create environments of trust for heterosexual women that facilitate whole-person health.

While STI prevention and care has been under resourced and underprioritized, when it has been funded, it has played a greater role in providing services to women than to men. A challenge has been not only underfunding, but attacks on the existence of many of these clinics themselves. In many places, women's reproductive health clinics are the primary provider of sexual health services. Indeed, the network of Planned Parenthood clinics across the U.S. forms a key part of the nation's capacity to deliver sexual health services.[30] It should be noted that after a Planned Parenthood clinic was forced to close which had been the only local source of HIV testing, a major outbreak of HIV in Scott County, Indiana occurred starting in 2014 in which 215 cases of HIV were identified among a network of people who inject drugs.[31] This was in a county that typically observed about five cases per year. Subsequent molecular surveillance analyses suggested that the initial transmission into this network may have been via sexual transmission[32] highlighting the need for integration of substance use disorder (SUD) and harm reduction services with primary care and STI services. Moving forward, greater attention is needed on maintaining and expanding the existing network of sexual health services providers.

POLICY ACTION:

Within the scope of their current practice and training, primary care providers can do more to screen and prevent HIV and STIs.

When individuals are asked how they want to receive health care services, a common refrain is that they want a one-stop shop. Except in cases where privacy and anonymity are important, they do not want to have to go to one place for primary care, another for HIV testing, and yet another for STI services or to receive a prescription. The most feasible way to operationalize this concept is to further expand the capacity of health centers and primary care clinics to serve as frontline sexual health providers. This may sound challenging and it is well documented that many clinicians are uncomfortable taking a sexual history,[33] but through a combination of task shifting to other clinical personnel, greater use of community health workers (CHWs), patient navigators, pharmacists, and the use of technology (i.e. providing questionnaires prior to meeting the provider often by giving patients a tablet in a waiting room), there are ways to better support primary care providers to deliver sexual health services. Further, sexual health visits also offer important opportunities to screen for routine and addressable health concerns such as hypertension, anxiety and depression, and other conditions that may otherwise go unaddressed.

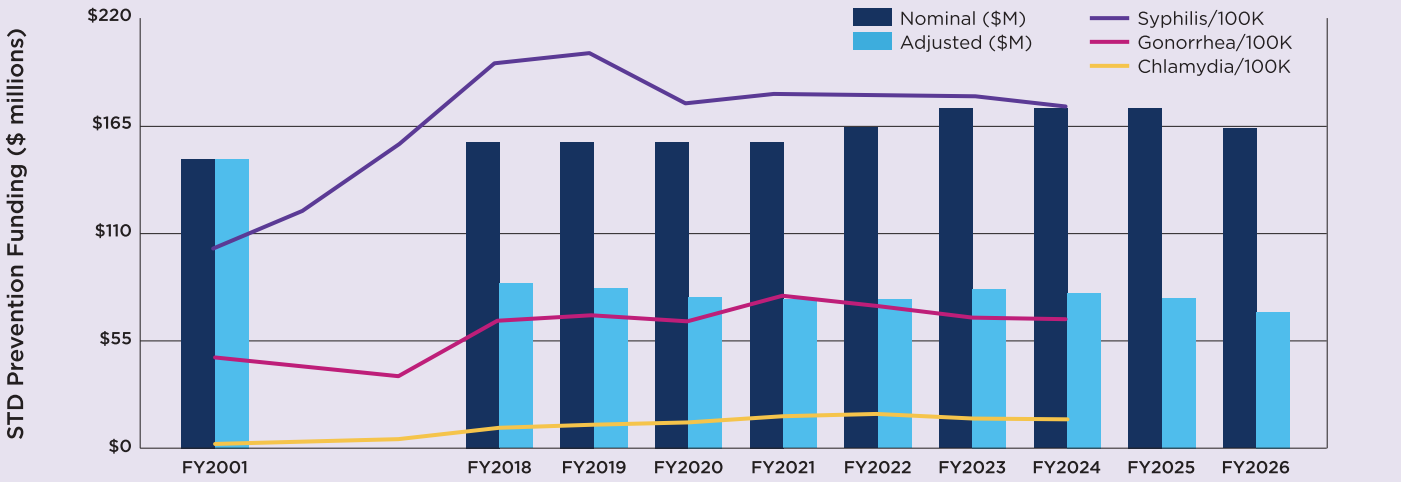
POLICY ACTION:

Integrating Urgent Care and Emergency Departments with local health departments and STI clinics can strengthen engagement in care for heterosexual men

Emergency departments and urgent care centers are increasingly sites for STI treatment and HIV testing.[34] Heterosexual men are less likely than other groups to have a primary care doctor or to be engaged in sexual health services and may rely on emergency departments and urgent care centers for these services.[35] Quality of care across urgent care centers varies greatly, including for linkage to care, partner notification etc. Follow-up services in emergency departments for people seeking STI treatment or receiving a positive HIV test also depend on community-based organizations and local and state health department programs. State and local health departments should establish formal referral and care coordination linkages between emergency departments and urgent care centers and sexual health clinics. Local and state health departments should develop greater engagement with emergency departments and urgent care centers to link heterosexual men and women to high quality sexual health services and to increase opportunities for care.

LONG-TERM DECLINE IN STI PREVENTION FUNDING

In real terms, federal STD prevention funding has declined 53% since FY2001, even as STI rates have reached historic highs



Source: NCSD Appropriations Budget Analysis Chart (ABAC) (FY2018–FY2026); CDC Financial Management Office FY2001 Appropriation Fact Sheet (FY2001). CDC Division of STD Prevention (DSTDP) annual appropriation, in millions of dollars.

Inflation adjustment: Nominal funding figures are adjusted for medical inflation using the Bureau of Labor Statistics Consumer Price Index for Medical Care Services (BLS series CUUR0000SAM2), annual average, with FY2001 as the base year (index = 100). Adjusted figures reflect the purchasing power of each year's appropriation in constant FY2001 dollars, calculated as: Adj = Nominal × (100 ÷ CPI_year). The FY2026 figure uses the January 2026 CPI value (236.0) as the full-year average is not yet available. Data retrieved via FRED (fred.stlouisfed.org/series/CUUR0000SAM2).

STI rates: National rates per 100,000 population for primary & secondary syphilis, gonorrhea, and chlamydia. Source: CDC STD Surveillance Report 2001; CDC STD Surveillance Report 2017; CDC STI Surveillance 2018–2024 (Provisional). Rates for FY2025–FY2026 not yet published.

Note: FY2001 is shown as a historical anchor point; data for FY2002–FY2017 are not shown. FY2001 serves as the base year for inflation adjustment.

THE TIME IS NOW

The Nation can improve its response to the crisis of STIs and it can keep driving down the rate of new HIV transmissions. To achieve this, the health system must refocus on tailored approaches that demonstrate to heterosexual men that their health, including their sexual health, is valued, while also assuring heterosexual women that they will receive the support, care, and resources needed to maintain their health and well-being. Improved sexual health will create a healthier America and move us much closer to ending HIV as an ongoing public health threat.

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CENTER FOR HIV & INFECTIOUS DISEASE POLICY

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