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Ministry of Health, Welfare and Sport

Sexually transmitted infections in the Netherlands in 2025

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RIVM report 2026-0047

Colophon

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This study was commissioned by the Ministry of Health, Welfare and Sport (VWS) as part of the annual STI surveillance programme.

Synopsis

Sexually transmitted infections in the Netherlands in 2025

The number of people tested for a sexually transmitted infection (STI) at a Sexual Health Centre (SHC) decreased by 8 per cent in 2025 compared with 2024. This decrease was mainly seen among men who have sex with women (MSW) and women. The overall percentage testing positive for an STI (17 per cent) was slightly lower than the percentage in 2024 (20 per cent). These decreases are partly due to a changed chlamydia testing policy.

In this overview, RIVM describes the development of STIs in the Netherlands, including the number of tests and diagnoses per STI at the SHCs. SHCs offer free STI testing for people at increased risk of acquiring an STI. In 2025, there were a total of 146,982 consultations at the SHCs, slightly fewer than in 2024 (159,252). Since 2019, the SHCs have also offered care to men who have sex with men (MSM) who are using PrEP, the medicine that prevents HIV. These consultations are referred to as MSM-PrEP. Regular STI consultations for MSM are referred to as MSM-STI.

Chlamydia

Chlamydia is the most reported STI among MSW and women. Since January 2025, only people with STI symptoms or with a partner who has STI-related symptoms are routinely tested for chlamydia. Due to this new policy, far fewer chlamydia tests (56,288) and diagnoses (10,731) were registered at the SHCs in 2025 compared to 2024. Therefore, the 2025 figures are not directly comparable to previous years.

Gonorrhoea

Gonorrhoea is the most common STI diagnosed at the SHCs. The number of diagnoses increased slightly, from 13,952 in 2024 to 14,297 in 2025. The percentage of women with gonorrhoea remained high at 4.3 per cent (4.2 per cent in 2024), the highest since measurements began in 2003. Among MSW, the percentage increased to 4.4 per cent (3.7 per cent in 2024). The percentages among MSM-STI and MSM-PrEP also increased slightly. Furthermore, in 2025, for the first time, resistance was observed to the antibiotic used to treat gonorrhoea in the Netherlands (ceftriaxone).

Syphilis

There were more syphilis diagnoses in 2025 than in 2024 (1,927 versus 1,798). The percentage of MSM-STI with syphilis remained about the same as in 2024, at 2.5 per cent (2.4 per cent in 2024). Among MSM-PrEP, this percentage increased slightly to 2.2 per cent (1.8 per cent in 2024). The number of syphilis diagnoses among women increased from 43 in 2024 to 60 in 2025. Among MSW, the number rose from 56 in 2024 to 64 in 2025.

HIV

In 2025, 440 people were newly diagnosed with HIV. This number may increase due to reporting delays. The total number of new diagnoses increased slightly by 6 per cent, but among MSM there was a decrease of 9 per cent. In total, 979 people with HIV visited an HIV treatment centre in the Netherlands for the first time ('enrolled in care'); about the same as in 2024 (1,013). This also includes people who had already been living with HIV for some time.

Keywords: STI, chlamydia, gonorrhoea, syphilis, HIV, PrEP, antimicrobial resistance, young people, MSM, monitoring, Sexual Health Centre.

Publiekssamenvatting

Seksueel overdraagbare aandoeningen in Nederland in 2025

In 2025 lieten 8 procent minder mensen zich bij een Centrum voor Seksuele Gezondheid (CSG) testen op seksueel overdraagbare aandoeningen (soa) dan in 2024. Vooral mannen die seks hebben met vrouwen (MSV) en vrouwen deden dat minder vaak. Ook was het totale percentage mensen met een soa (17 procent) iets lager dan in 2024 (20 procent). De dalingen hebben onder andere te maken met een veranderd testbeleid voor chlamydia.

Dit blijkt uit het overzicht van de ontwikkelingen van soa in Nederland, dat het RIVM elk jaar maakt. Bij de CSG's kunnen mensen met een groter risico op soa zich gratis laten testen. In 2025 waren er in totaal 146.982 consulten bij de CSG's, iets minder dan in 2024 (159.252). Sinds 2019 bieden de CSG's zorg aan mannen die seks hebben met mannen (MSM) en een medicijn krijgen dat hiv voorkomt (PrEP). Hun consulten worden MSM-PrEP genoemd. De gewone consulten bij MSM heten MSM-SOA.

Chlamydia

Chlamydia is de meest gerapporteerde soa onder MSV en vrouwen. Sinds januari 2025 worden alleen mensen met soa-klachten of met een partner die klachten heeft die bij soa horen, standaard getest op deze soa. Door dit nieuwe beleid zijn er in 2025 veel minder chlamydia-testen geregistreerd bij de CSG's (56.288) dan in 2024, net als het aantal diagnoses (10.731). De cijfers van 2025 zijn daarom niet goed te vergelijken met de jaren ervoor.

Gonorroe

Gonorroe komt het meest voor bij de CSG's. Het aantal diagnoses nam iets toe, van 13.952 in 2024 naar 14.297 in 2025. Het percentage vrouwen met gonorroe bleef hoog op 4,3 procent (4,2 procent in 2024), het hoogste sinds het begin van de metingen in 2003. Onder MSV steeg het percentage naar 4,4 procent (3,7 procent in 2024). Ook onder MSM-SOA en MSM-PrEP stegen de percentages iets. Verder is in 2025 voor het eerst opgemerkt dat iemand resistent was tegen het antibioticum dat in Nederland wordt voorgeschreven bij gonorroe (ceftriaxon).

Syfilis

Er zijn meer syfilis-diagnoses gesteld in 2025 dan in 2024 (1.927 versus 1.798). Het percentage MSM-SOA met syfilis bleef ongeveer hetzelfde als in 2024, op 2,5 procent (2,4 procent in 2024). Onder MSM-PrEP steeg dit percentage licht naar 2,2 procent (1,8 procent in 2024). Het aantal syfilis-diagnoses onder vrouwen steeg van 43 in 2024 naar 60 in 2025. Onder MSV steeg het aantal van 56 in 2024 naar 64 in 2025.

Hiv

In 2025 kregen 440 mensen te horen dat ze hiv hebben. Dat kunnen er meer worden omdat meldingen later kunnen binnenkomen. Het totaal aantal nieuwe diagnoses steeg licht met 6 procent, maar daalde onder MSM met 9 procent. In totaal gingen 979 mensen met hiv voor het eerst in Nederland naar een hiv-behandelcentrum ('in zorg'); ongeveer evenveel als in 2024 (1.013). Hier zitten ook mensen bij die al langer hiv hebben.

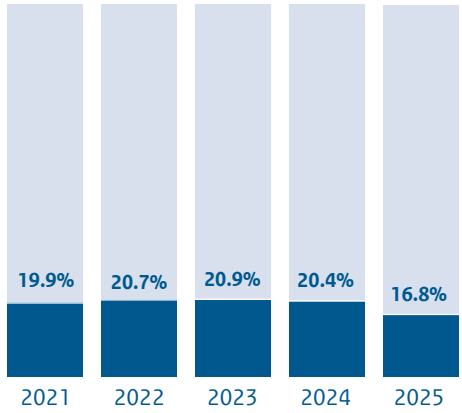
Kernwoorden: soa, chlamydia, gonorroe, syfilis, hiv, PrEP, antibioticaresistentie, jongeren, MSM, monitoring, Centrum voor Seksuele Gezondheid.

General

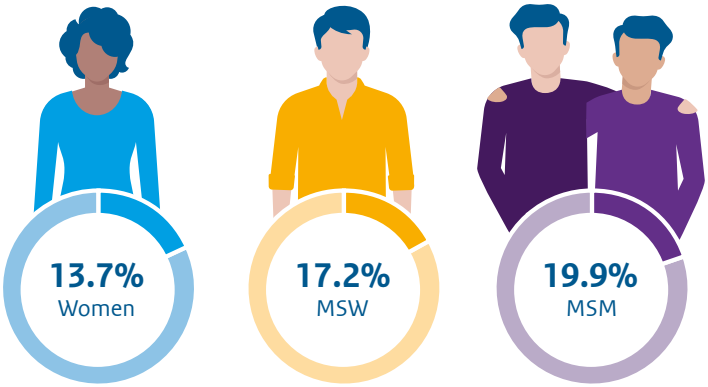
Number of SHC-consultations

Number of GP-consultations

One or more STI



One or more STI in 2025



Chlamydia

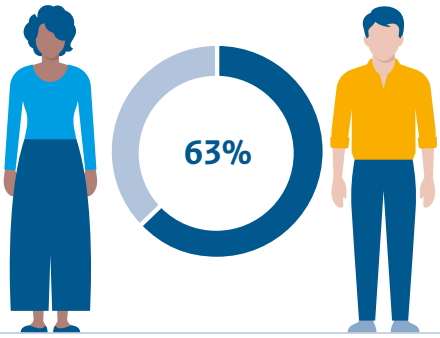
SHC

10,731
Diagnoses **at SHC**

47% decrease *compared with last year*

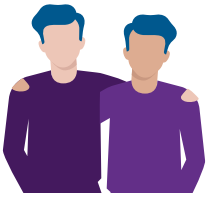
33,400
Diagnoses **at GP**

Proportion of diagnoses among women and MSW <25 years



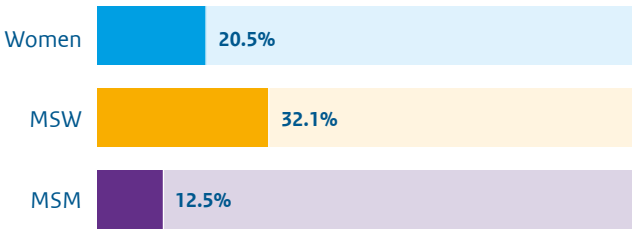
Number of LGV diagnoses among MSM

Lymphogranuloma venereum



440

Positivity



Gonorrhoea

SHC

14,297

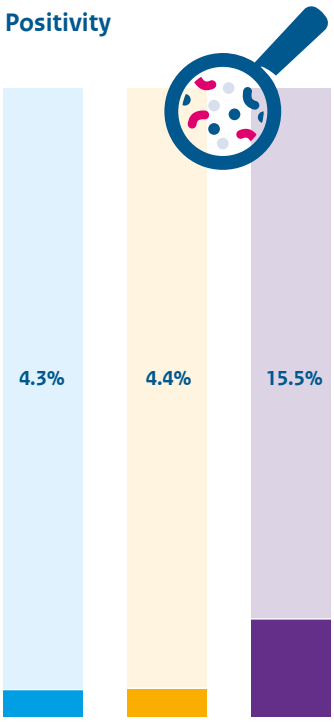
Diagnoses **at SHC**

2% increase *compared with last year*

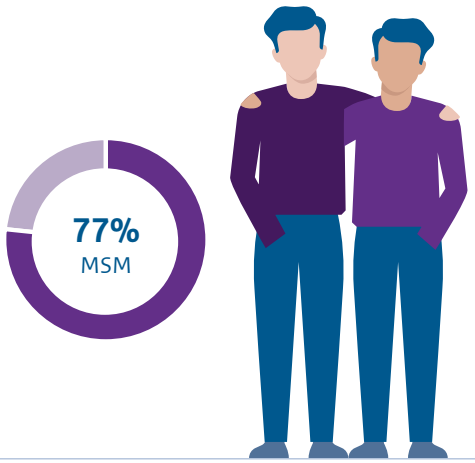
19,700

Diagnoses **at GP**

Positivity



Proportion of diagnoses among MSM



One case of cetriaxone resistance reported

Infectious syphilis

SHC

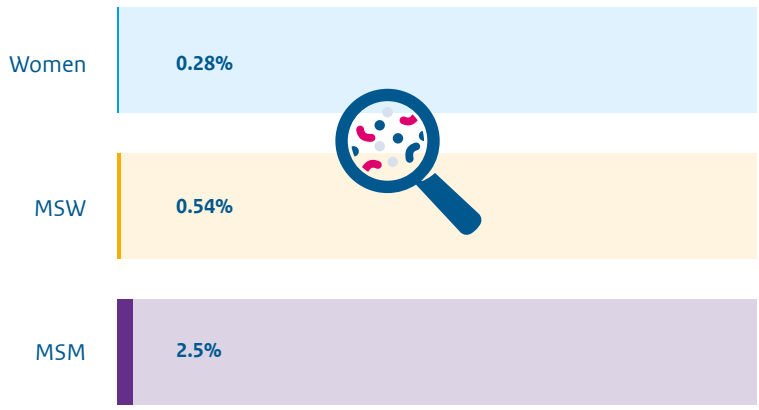
1,927

Diagnoses **at SHC**

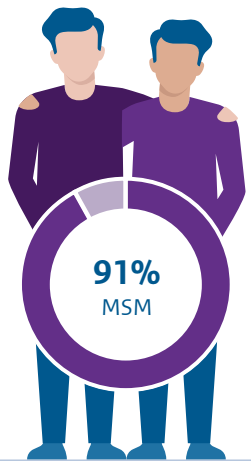
7% increase *compared with last year*

Positivity increased with age

Positivity



Proportion of diagnoses among MSM



HIV

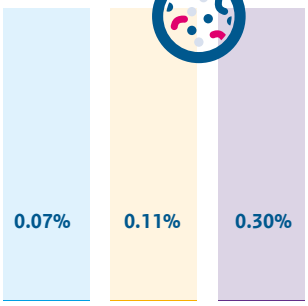
SHC

191

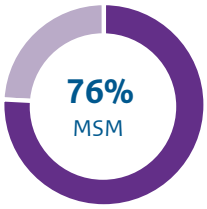
Diagnoses **at SHC**

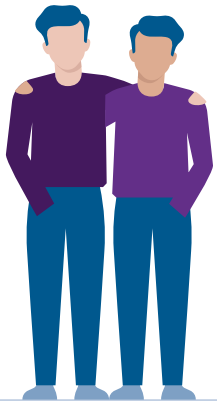
7% increase *compared with last year*

Positivity



Proportion of diagnoses among MSM





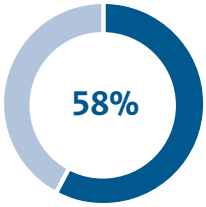
Acute hepatitis B

100

Notifications

14% increase *compared with last year*

Proportion of diagnoses that had sexual contact as transmission route



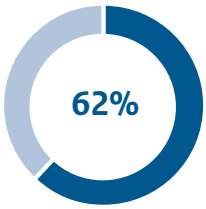
Acute hepatitis C

45

Notifications

22% increase *compared with last year*

Proportion of diagnoses that had sexual contact as transmission route

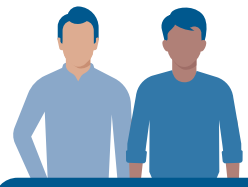


PrEP programme

Total number of participants in the PrEP programme

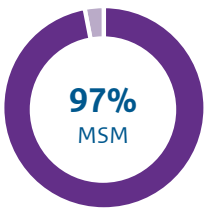
21,044

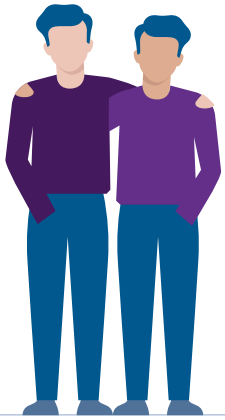
Number of new participants in 2025



3,674

Proportion of participants who are MSM



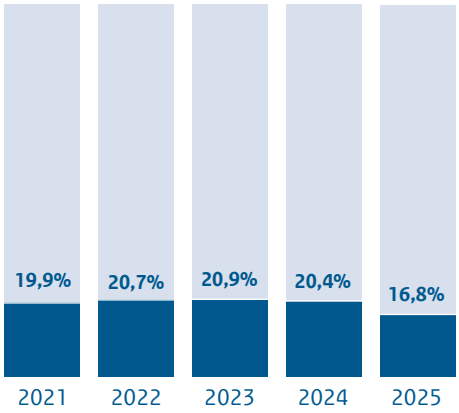


Algemeen

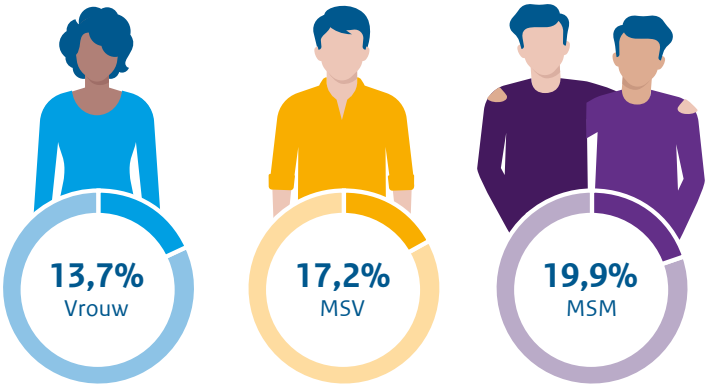
Aantal SHC-consulten

Aantal huisartsen-consulten

Eén of meer soa



Eén of meer soa in 2025



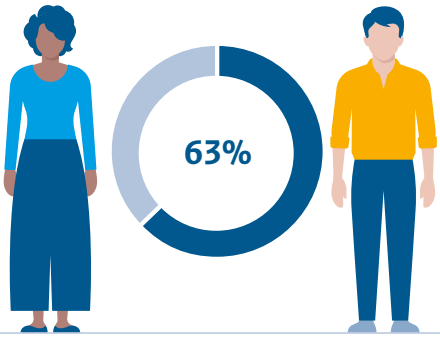
Chlamydia

10.731
Diagnoses **bij CSG**

47% daling
ten opzichte van vorig jaar

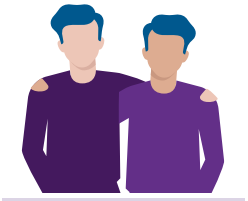
33.400
Diagnoses **bij huisarts**

Aandeel diagnoses onder vrouwen en MSV <25 jaar



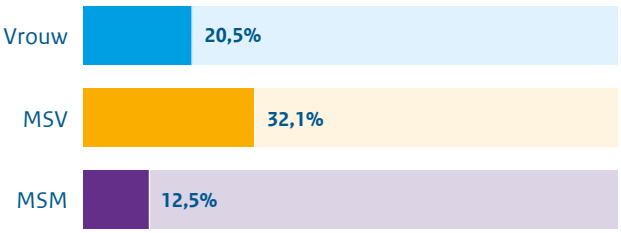
Aantal diagnoses LGV bij MSM

Lymphogranuloma venereum



440

Vindpercentage



Gonorroe

SHC

14.297

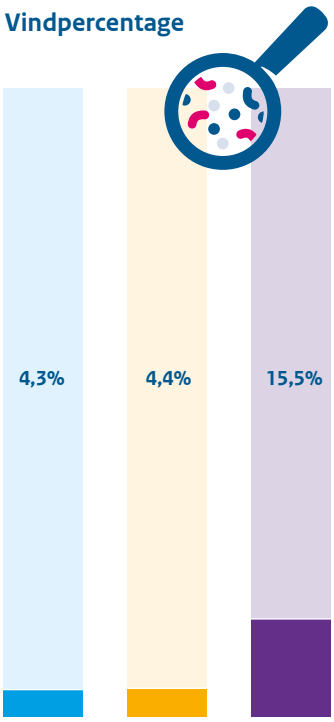
Diagnoses **bij CSG**

2% stijging *ten opzichte van vorig jaar*

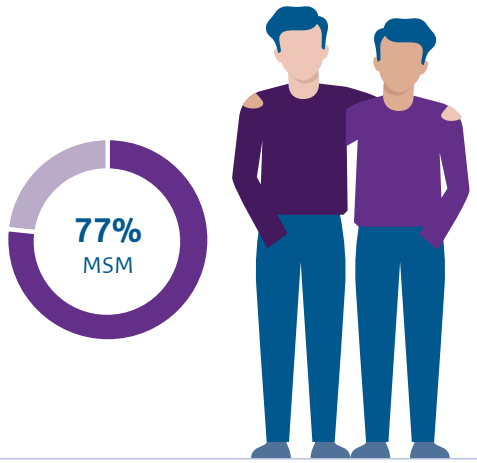
19.700

Diagnoses **bij huisarts**

Vindpercentage



Aandeel diagnoses onder MSM



Een ceftriaxon resistentie gerapporteerd

Infectieuze syfilis

SHC

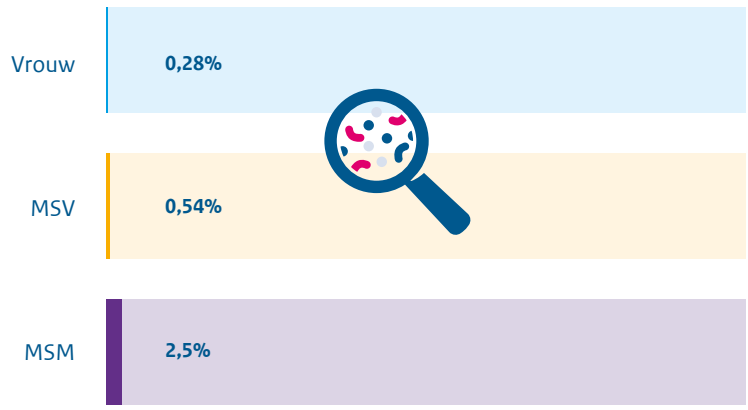
1.927

Diagnoses **bij CSG**

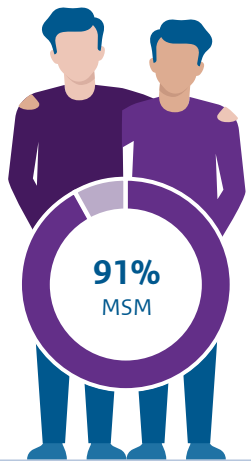
7% stijging *ten opzichte van vorig jaar*

Vindpercentage neemt toe met leeftijd

Vindpercentage



Aandeel diagnoses onder MSM



HIV

SHC

191

Diagnoses **bij CSG**

7% stijging
ten opzichte van vorig jaar

Vindpercentage

Aandeel diagnoses onder MSM

Acute hepatitis B

100

Notificaties

14% stijging
ten opzichte van vorig jaar

Percentage diagnoses dat transmissieroute seksueel contact had

Acute hepatitis C

45

Notificaties

22% stijging
ten opzichte van vorig jaar

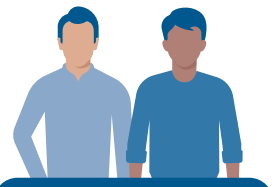
Percentage diagnoses dat transmissieroute seksueel contact had

PrEP programma

Totaal aantal deelnemers in het PrEP-programma

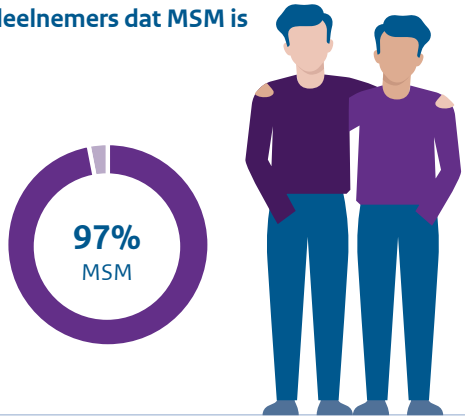
21.044

Aantal nieuwe deelnemers in 2025



3.674

Aandeel nieuwe deelnemers dat MSM is



Preface

This annual report provides an overview of the epidemiology of sexually transmitted infections (STIs), including HIV, in the Netherlands in 2025. The data presented are derived from the national STI surveillance database as well as other data sources registering STI and HIV in the Netherlands. These sources include the general practitioners, the antenatal screening programme, HIV treatment centres, and notification data. We present a summary of recent trends ('key points') for each STI, followed by tables and figures relating to STIs analysed in relation to a range of relevant characteristics. Finally, an overview of the main conclusions and recommendations is given. We hope this report will contribute to further awareness of the distribution and causes of STI, including HIV, in the Netherlands, supporting the development and targeting of (preventive) interventions, and enabling assessment of the effectiveness of control activities on STI transmission. The information aims to support policy makers and researchers in the STI field and related subjects, as well as others interested in STI trends in the Netherlands. More information on STI and HIV trends in the Netherlands is available at rivm.nl/soa and hiv-monitoring.nl. This report can be downloaded in PDF format from rivm.nl/soa.

Acknowledgements

We gratefully acknowledge the cooperation of a large number of physicians, public health doctors and nurses, microbiologists, epidemiologists, dermatologists, behavioural scientists, prevention workers and other professionals working in the field of STI and HIV. We would like to thank the following organisations for their support and continuous collaboration in data collection: the Sexual Health Centres (STI clinics and public health services) and stichting hiv monitoring (shm, HIV Monitoring Foundation. We also thank Soa Aids Nederland, Rutgers, HIV association, Nivel, Netherlands Institute for Health Services Research, general practitioners participating in the Nivel Primary Care Database (Nivel-PCD), the Dutch Working Group on Clinical Virology from the Dutch Society for Clinical Microbiology (NVMM), Soapoli-Online, SoapoliNoord, SoaStudentArts, and all participating laboratories providing the virological data from the weekly Sentinel Surveillance system, as well as the other units at the Centre for Infectious Diseases Research, Diagnostics and Laboratory Surveillance (CIb/IDS), and finally, the National Coordination Centre for Communicable Disease Control (CIb/LCI). Special thanks go to Silke David, policy advisor and programme leader STI, HIV and sexual health at the RIVM. Furthermore, we would like to thank Kitty van der Ploeg from TNO, and Frithjofna Abbink, Alexander Ernst, and Marlies van Lent (RIVM) for the data on pregnant women (Praeventis), Eric Doppenberg (RIVM) for data on congenital syphilis, Yvette Weesie and Joost Vanhommerig for Nivel-PCD data and analysis, Thijs van de Laar and Ed Slot from Sanquin for the blood donor data, and Renate van den Broek (RIVM) for the HBV vaccination programme data. We thank Sonia Boender from the Public Health Service of Amsterdam (GGD Amsterdam) for HIV incidence data from the Amsterdam Cohort Studies (ACS) on HIV/AIDS. Finally, we thank Britt de Wit, Manon Haverkate and Tom Woudenberg (CIb/EPI), and Marieke Hiemstra (VPZ) for their contributions.

Comments

Please send any comments or suggestions to soap@rivm.nl.

Contents

Summary

In 2025, a total of 146,982 STI and PrEP consultations took place at Dutch Sexual Health Centres (SHCs), which is 8% less than the number of consultations in 2024 and 3% less than in 2019. This marks the first year in which the number of consultations has dipped below the pre-COVID years.

In 2025, an adjustment to the chlamydia testing policy was implemented at the SHCs: only individuals with STI symptoms or persons who currently have a partner with symptomatic chlamydia are tested for chlamydia. Therefore, 2025 numbers are not directly comparable to previous years. The large decrease in numbers of chlamydia tests performed, and the selective testing of mostly symptomatic persons has led to increases in chlamydia positivity rates. Testing policies for other STIs have remained unchanged. Consultations of men who have sex with men (MSM) in the PrEP programme are referred to as MSM-PrEP (consultations). Regular STI consultations among MSM are referred to as MSM-STI (consultations).

Of all SHC consultations in 2025, 31% were among women (44,997 consultations), 16% among MSW (23,572), 35% were MSM-STI (50,636), and 17% MSM-PrEP (24,522). A total of 3255 consultations (2%) involved gender diverse clients, of whom 13% identified as trans men, 50% as trans women, and 37% as other gender diverse persons. Gender diverse persons are only included in the total number of diagnoses and excluded from further breakdowns, due to relatively small numbers. Compared with 2024, the number of consultations in 2025 decreased by 17% among women, by 8% among MSW, and by 7% among MSM-PrEP, while it remained relatively stable among MSM-STI. In 31% of the consultations, individuals had STI symptoms, and in 18%, they had received a partner notification for an STI.

The proportion of consultations involving one or more positive STI tests (chlamydia, gonorrhoea, infectious syphilis, HIV, or infectious hepatitis B) was 17% in 2025. STI positivity was 13.7% among women in 2025, and 17.2% among MSW. The positivity among MSM-STI was 19.9%, and among MSM-PrEP, it was 16.2%. Among both women and MSW, the most reported triage indication was age ≤ 25 years, having symptoms, or having a partner in a risk group. For women and MSW, the proportion of consultations involving reported symptoms were 45% and 43%, respectively. In both MSM-STI and MSM-PrEP, the most reported triage indication, in addition to being MSM, was having a partner from a risk group (43%). Among women and MSW tested at SHCs in 2025, 14% of women and 9% of MSW visited the SHC more than once (both decreasing slightly compared to 2024). Among MSM-STI, the proportion with more than one consultation remained stable at 33% in both years.

The total number of STI-related episodes registered with a general practitioner in 2024 (2025 data is not yet available) was estimated at 323,000 (including 141,100 STI diagnoses and 181,900 'fear of STI' episodes, among the Dutch population aged 15-64 years). This was a decrease from 2023 (345,200 episodes). Between 2023 and 2024, the reporting rate for STI-related episodes at GPs decreased from 31.1 to 28.1 per 1000 women, and from 28.8 to 27.7 per 1000 men. Between 2015 and 2023, the incidence of ectopic pregnancy, infertility, and pelvic inflammatory disease among women remained relatively stable in general practices, with rates in 2023 of 15 per 1000 live births, 760 per 100,000 women, and 131 per 100,000 women, respectively. Hospital rates were lower and also relatively stable.

PrEP

The PrEP programme at SHCs continued to grow in 2025, with 13,669 participants in care in 2025 (a 15% increase compared to 2024), of whom 3674 were new participants. The majority of participants were MSM (95%). The proportion of gender diverse participants gradually increased to 4%. Event-driven PrEP use became more common than daily use. The follow-up intervals were extended from three to six months for most participants, in accordance with the PrEP care guidelines. The most common indication for joining the PrEP programme was having condomless anal sex, which was registered at 82% of PrEP start consultations. In 2025, 2693 participants exited the programme or were lost to follow-up, mainly due to reduced HIV risk. Out of the 615 participants who reported leaving the PrEP programme, 136 continued PrEP via another provider, 302 stopped using PrEP, while for 177 participants it was unknown whether they continued using PrEP. STI positivity (chlamydia, and gonorrhoea) among PrEP users slightly increased over time, with chlamydia and gonorrhoea positivity at 13.0% and 15.2%, respectively, in 2025, while syphilis positivity remained stable around 2%. HIV positivity among PrEP users remained very low (≤0.10%).

Bacterial STI

In 2025, chlamydia was diagnosed 10,731 times at SHCs, which was a 47% decrease compared to 2024 (20,174). This sharp decline represents a trend break resulting from the new chlamydia testing policy introduced at SHCs in 2025 (see introduction); therefore, 2025 figures are not directly comparable to previous years. Chlamydia remained the most reported STI among women and MSW. In 2025, chlamydia positivity was 20.5% among women, 32.1% among MSW, 12.5% among MSM-STI, and 11.7% among MSM-PrEP. Of all unique MSM-PrEP participants tested in 2025, 13.9% tested positive for chlamydia in at least one consultation. When focusing only on persons with a test indication (defined here as STI symptoms or a partner notification for symptomatic chlamydia), chlamydia positivity was stable around 23% for women between 2016 and 2025. Among MSW, it slowly increased from 26.0% in 2016 to 29.1% in 2024, and to 33.5% in 2025. In the past years, positivity fluctuated around 17% among MSM-STI, and around 20% among MSM-PrEP. The highest positivity was found among persons notified of chlamydia: 45.5% among women, 47.0% among MSW, 26.4% among MSM-STI, and 27.6% among MSM-PrEP. Chlamydia positivity used to be lower among those with university/HBO education level but became more similar to those with other education levels in 2025 among women and MSW.

The estimated number of chlamydia episodes among women reported at GPs decreased from 24,700 in 2023 to 18,900 in 2024. Among men, this number decreased from 18,300 in 2023 to 14,500 in 2024. For both women and men, reporting rates of chlamydia episodes per 1000 individuals aged 15-64 years decreased in 2024 to 3.3 and 2.5, respectively, compared to 4.3 and 3.1, respectively, in 2023. The reporting rate in 2024 was highest among women aged 15-24 years (8.4). While MSM are no longer routinely tested for chlamydia either, all MSM are still screened for lymphogranuloma venereum (LGV, an infection caused by an invasive strain of chlamydia). These tests are reported to RIVM as LGV tests, not as chlamydia tests. However, implementation difficulties led to a large part of LGV tests being incorrectly reported as both an LGV and a chlamydia test. This artificially increased the number of (anorectal) chlamydia tests reported among MSM in 2025. The number of LGV diagnoses at SHCs decreased from 512 in 2024 to 454 in 2025. Out of the diagnoses in 2025, 440 were among MSM. The proportion of HIV-negative MSM (both in STI and PrEP consultations) among LGV-positive MSM increased from 45% in 2016 to 74% in 2025.

The number of gonorrhoea diagnoses at SHCs increased in 2025 (14,297 diagnoses) compared to 2024 (13,952 diagnoses). In 2025, gonorrhoea positivity was 4.3% among women and 4.4% among MSW. For both groups, this is the highest gonorrhoea positivity since 2014 and a substantial increase compared to 2022 (women: 2.3%, MSW: 2.4%). The increase in gonorrhoea positivity among women and MSW in 2023 was most prominent among those under the age of 25 years. In 2025, gonorrhoea positivity remained high in these groups compared to previous years and increased further among those aged ≤20 years. Among MSM, positivity was also highest in those under the age of 25 years. Gonorrhoea positivity in MSM-STI increased from 12.4% in 2021 to 15.5% in 2025. Among MSM-PrEP, gonorrhoea positivity increased from 11.7% in 2023 to 13.5% in 2024. Of all unique MSM-PrEP participants in 2025, 21.6% was gonorrhoea-positive in at least one consultation. Among MSM-STI this was 19.4%. Highest gonorrhoea positivity was reported among persons notified for gonorrhoea (31.0% among women, 16.5% among MSW, 35.4% among MSM-STI, and 41.1% among MSM-PrEP in 2025). Due to these developments, gonorrhoea has now become the most frequently diagnosed STI at SHCs. The number of estimated gonorrhoea episodes reported at GPs increased from 18,800 in 2023 to 19,800 in 2024. In 2024, the reporting rate for gonorrhoea at GPs was 1.7 episodes per 1000 individuals aged 15-64 years. This amounted to 1.0 per 1000 for women and 2.4 per 1000 for men. These rates mainly increased in young individuals. Antimicrobial resistance to ceftriaxone, the first-choice treatment for gonorrhoea in the Netherlands, was reported for the first time in 2025. This person acquired the infection in South-east Asia and was diagnosed upon return to the Netherlands. The strain was resistant to ceftriaxone (MIC 0.19 mg/L), cefotaxime (MIC 0.38 mg/L), azithromycin (MIC >256 mg/L), tetracycline (MIC 6 mg/L), and ciprofloxacin (MIC 2 mg/L). Treatment with ceftriaxone was successful, no further sexual contact was reported in the Netherlands.

In 2025, 1927 infectious syphilis infections were diagnosed at SHCs, which is more than in 2024 (1798 diagnoses). Of all infectious syphilis infections in 2025, 64% were diagnosed among MSM-STI and 27% among MSM-PrEP. Infectious syphilis positivity among MSM-STI remained stable from 2021 to 2025. Among MSM-PrEP, infectious syphilis positivity was 2.2% in 2025, which is an increase compared to 2024 (1.8%). Within MSM-STI, positivity increased among the age groups 26-30, 41-50, and >50 years, while positivity declined in other age groups. The highest positivity was found among MSM-STI notified of syphilis (13.8%). Other groups with high positivity were MSM-STI with symptoms (5.7%).

Women and MSW are not routinely tested for syphilis. In 2025, a syphilis test was performed in 48% of STI consultations among women and 50% among MSW. Among

women, 21,802 tests and 60 diagnoses were reported, compared to 44 diagnoses in 2024 (positivity 0.28%, up from 0.19% in 2024). Among MSW, 11,895 tests and 64 diagnoses were reported, an increase from 54 diagnoses in 2024 (positivity 0.54%, 0.53% in 2024). While the absolute numbers remain low, there was a clear increase in diagnoses in both groups compared to the previous year. An estimate of the number of syphilis episodes at GPs is not available due to the small number of cases.

Viral STI

In 2025, 979 persons were newly registered in care at HIV treatment centres according to Stichting hiv monitoring (SHM) (1013 in 2024 at the same data extraction date). Among these persons, 440 were newly diagnosed with HIV in 2025, although this number may still increase due to reporting delays. The total number of new diagnoses slightly increased by 6%, while diagnoses among MSM declined by 9%. HIV diagnoses increased, however, by 34% among MSW and by 16% among women compared to 2024, but numbers are relatively small. The proportion of MSM among new HIV diagnoses was 63% in 2025 (62% in 2024). Of MSM newly diagnosed with HIV and entering care in 2025, 29% were diagnosed at GPs, 49% at SHCs, and 16% at hospitals. Overall, up until 30 March, 40% of newly diagnosed patients in 2025 presented late for care (CD4 <350/mm3 or AIDS). In 2024, an estimated 94% of those living with HIV in the Netherlands had been diagnosed and linked to care; of these patients, 95% had started treatment and 96% had a suppressed viral load.

At SHCs, 191 new HIV infections were diagnosed in 2025, which is higher than in 2024 (178 diagnoses). 70% of these diagnoses were among MSM-STI, 6% among MSM-PrEP, 9% among gender diverse persons, 8% among women, and 7% among MSW. Out of the nineteen HIV diagnoses reported in the PrEP programme in 2025, fourteen persons received their diagnosis during participation, while five were diagnosed at their first PrEP consultation before starting the programme. HIV positivity among MSM-STI decreased from 0.8% in 2016 to 0.3% in 2025. Positivity remained low and stable among MSM-PrEP (0.05% in 2025), and among women and MSW (around 0.1%). Among gender diverse persons, HIV positivity was 0.6% in 2025.

The number of acute hepatitis B cases reported in the registration of notifiable diseases increased to 100 in 2025 compared to 88 in 2024. Sexual contact was the most frequently reported transmission route (60%). Acute hepatitis C cases also increased to 45 in 2025 compared to 37 in 2024, with sexual transmission among MSM accounting for the majority of cases (58%).

The mpox outbreak in the Netherlands started in May 2022 and peaked in July 2022, followed by a rapid decline in reported cases. In October 2025, the first mpox clade 1b case was identified in the Netherlands, and a total of nine clade 1b cases were reported that year, mainly through local (autochthonous) transmission. Since 2022, a total of 1579 mpox infections have been reported to RIVM, of which 149 occurred in 2025. Of all cases reported since May 2022, 89% occurred among MSM, and sexual contact was reported as the route of transmission for 86% of cases.

In 2025, a total of 6307 mpox vaccinations were administered, of which 3635 (58%) were first doses and 2672 (42%) were second doses. Notably, the proportion of persons with mpox who were fully vaccinated increased from 1% in 2022-2023 to 23% in 2025, suggesting ongoing transmission despite vaccination efforts.

Most cases of genital warts and genital herpes are registered at GPs. In 2024, an estimated 46,900 diagnoses of genital warts (48,600 in 2023) and 30,000 diagnoses of genital herpes (28,600 in 2023) were made. At GPs, genital warts were more often reported among men (around 62% of all cases) than among women, while genital herpes was more often diagnosed among women (around 73%). At SHCs in 2025, the number of diagnoses of genital warts and genital herpes were 845 and 557, respectively (806 and 616 in 2024).

Conclusion

In 2025, the total number of consultations at SHCs declined further compared to previous years, with the decrease particularly notable among women and MSW. The most notable development was the implementation of a new chlamydia testing policy, restricting testing to individuals with STI symptoms or who currently have a partner with symptomatic chlamydia. This policy led to a sharp decline in chlamydia tests and diagnoses, resulting in a clear trend break and making the 2025 data for both the number of diagnoses and positivity rates not directly comparable to previous years. It is important to note that, in principle, this policy was intended to affect only chlamydia testing; the overall number of STI consultations would be expected to remain stable, as individuals should still be able to access testing for other STIs. However, the overall decrease in consultations may also be related to rising costs per consultation and capacity limitations due to the ASG regulation.

Although chlamydia remains the most frequently diagnosed STI among women and MSW, the higher positivity rates observed in 2025 are a result of the more selective triage and testing policy. Overall, however,

gonorrhoea has now become the most reported STI at SHCs. Gonorrhoea diagnoses and positivity continued to rise in 2025, especially among young women, MSW, and MSM. Infectious syphilis diagnoses also increased, mainly among MSM, with a concurrent increase in positivity. After years of decline, data from the national registry of HIV treatment centres (Stichting hiv monitoring) showed that the number of new HIV diagnoses increased again, but diagnoses among MSM stabilised. This upward trend is even more pronounced when adjusted for reporting delays through extrapolation. Despite progress in PrEP rollout, the number of new HIV diagnoses remains elevated, with a substantial proportion of people still being diagnosed late.

These findings underscore the importance of continued efforts to improve early HIV testing and linkage to care, while maintaining broad access to STI prevention, testing, and treatment for all groups at higher risk. In addition, ongoing surveillance, attention to partner notification, and targeted prevention campaigns, such as the planned national condom campaign, remain crucial for effective infection control and transmission prevention.

Samenvatting

In 2025 vonden in totaal 146.982 soa- en PrEP-consulten plaats bij de Centra Seksuele Gezondheid (CSG's), wat 8% minder is dan in 2024 en 3% lager dan in 2019. Dit is het eerste jaar dat het aantal consulten onder het niveau van vóór de COVID-pandemie uitkomt. In 2025 werd het chlamydia-testbeleid bij de CSG's aangepast: alleen mensen met soa-klachten, of met een partner die klachten heeft van chlamydia, worden getest op chlamydia. Hierdoor zijn de cijfers uit 2025 niet direct vergelijkbaar met voorgaande jaren. Door het sterk gedaalde aantal chlamydiatesten en de meer selectieve teststrategie (vooral gericht op mensen met klachten) is het chlamydia-vindpercentage gestegen. Het testbeleid voor andere soa's bleef ongewijzigd. Consulten van mannen die seks hebben met mannen (MSM) in het PrEP-programma worden aangeduid als MSM-PrEP-consulten. Reguliere soa-consulten bij MSM worden aangeduid als MSM-SOA-consulten.

Van alle CSG-consulten in 2025 was 31% onder vrouwen (44.997 consulten), 16% onder mannen die seks hebben met vrouwen (MSV, 23.572), 35% MSM-SOA (50.636) en 17% MSM-PrEP (24.522). In totaal vonden er 3.255 consulten (2%) plaats onder genderdiverse personen, waarvan 13% zich identificeerde als transman, 50% als transvrouw en 37% als anders genderdivers. Gender-diverse personen zijn alleen opgenomen in de totale diagnosetellingen en uitgesloten van verdere uitsplitsingen vanwege de relatief kleine aantallen. Ten opzichte van 2024 daalde het aantal consulten in 2025 met 17% onder vrouwen, met 8% onder MSV en met 7% onder MSM-PrEP, terwijl het aantal MSM-SOA-consulten stabiel bleef. Bij 31% van de consulten had de persoon soa-klachten en bij 18% was er sprake van een partnernotificatie voor een soa.

Het percentage consulten waarbij één of meer positieve soa-testen (chlamydia, gonorroe, infectieuze syfilis, hiv of infectieuze hepatitis B) werd gevonden, was 17% in 2025. Het vindpercentage onder vrouwen was 13,7%, onder MSV 17,2%, onder MSM-SOA 19,9% en onder MSM-PrEP 16,2%. Bij vrouwen en MSV was de meest voorkomende triage-indicatie leeftijd ≤25 jaar, klachten, of een partner in een risicogroep. Bij vrouwen en MSV werd in respectievelijk 45% en 43% van de consulten melding gemaakt van klachten. Bij MSM-SOA en MSM-PrEP was de meest voorkomende triage-indicatie, naast MSM, het hebben van een partner uit een risicogroep (43%). Van de vrouwen en MSV die in 2025 bij het CSG werden getest, bezocht 14% van de vrouwen en 9% van de MSV het CSG meer dan eens (beide licht gedaald ten opzichte van 2024). Onder MSM-SOA bleef het aandeel met meer dan één consult stabiel op 33%.

Het totale aantal soa-gerelateerde episodes geregistreerd bij de huisarts in 2024 (data over 2025 zijn nog niet beschikbaar) werd geschat op 323.000 (waarvan 141.100 soa-diagnoses en 181.900 episodes 'angst voor soa', onder de Nederlandse bevolking van 15-64 jaar). Dit was een daling ten opzichte van 2023 (345.200 episodes). Het rapportagecijfer voor soa-gerelateerde episodes bij huisartsen daalde voor vrouwen van 31,1 naar 28,1 per 1.000 vrouwen en voor mannen van 28,8 naar 27,7 per 1.000 mannen tussen 2023 en 2024. Tussen 2015 en 2023 bleef de incidentie van buitenbaarmoederlijke zwangerschap, infertiliteit en PID onder vrouwen in de huisartsenpraktijk relatief stabiel, met respectievelijk 15 per 1.000 levendgeborenen, 760 per 100.000 vrouwen en 131 per 100.000 vrouwen in 2023. De ziekenhuiscijfers waren lager en ook stabiel.

PrEP

Het PrEP-programma bij de CSG's bleef in 2025 groeien, met 13.669 deelnemers in zorg (een stijging van 15% ten opzichte van 2024), waarvan 3.674 nieuwe deelnemers. De overgrote meerderheid van de deelnemers was MSM (95%). Het aandeel genderdiverse deelnemers steeg geleidelijk naar 4%. Gebruiksafhankelijke PrEP (event-driven PrEP) werd vaker gebruikt dan dagelijks gebruik. De controlemomenten werden voor de meeste deelnemers verlengd van drie naar zes maanden, in lijn met de PrEP-zorgstandaard. De meest voorkomende reden voor deelname aan het PrEP-programma was het hebben van condoomloze anale seks, wat bij 82% van de PrEP-start-consulten werd geregistreerd. In 2025 verlieten 2.693 deelnemers het programma of gingen verloren uit de follow-up, vooral vanwege verminderd hiv-risico. Van de 615 deelnemers die hun deelname beëindigden, vervolgden 136 hun PrEP-zorg bij een andere aanbieder, stopten 302 met PrEP en was bij 177 onbekend of zij PrEP bleven gebruiken. Het vindpercentage voor soa's (chlamydia en gonorroe) onder PrEP-gebruikers nam licht toe: in 2025 was het vindpercentage voor chlamydia 13,0% en voor gonorroe 15,2%, terwijl het voor syfilis stabiel bleef rond 2%. Het vindpercentage voor hiv bleef zeer laag (≤0,10%).

Bacteriële soa

In 2025 werd chlamydia 10.731 keer vastgesteld bij de CSG's, een daling van 47% ten opzichte van 2024 (20.174). Deze scherpe daling is het gevolg van het nieuwe chlamydia-testbeleid in 2025; cijfers zijn daarom niet direct vergelijkbaar met voorgaande jaren. Chlamydia bleef de meest gerapporteerde soa onder vrouwen en MSV. Het chlamydia-vindpercentage was in 2025 20,5% bij vrouwen, 32,1% bij MSV, 12,5% bij MSM-SOA en 11,7% bij MSM-PrEP. Van alle unieke MSM-PrEP-deelnemers die in 2025 getest werden, testte 13,9% in minimaal één consult positief op chlamydia. Als alleen wordt gekeken naar personen met een testindicatie (klachten of een partnernotificatie), bleef het chlamydia-vindpercentage stabiel rond 23% voor vrouwen tussen 2016 en 2025. Onder MSV steeg dit van 26,0% in 2016 naar 29,1% in 2024 en 33,5% in 2025. Bij MSM-SOA schommelde het vindpercentage rond 17% en bij MSM-PrEP rond 20% in de afgelopen jaren. Het hoogste vindpercentage werd gezien bij personen die gewaarschuwd werden voor chlamydia: 45,5% onder vrouwen, 47,0% onder MSV, 26,4% onder MSM-SOA en 27,6% onder MSM-PrEP. Het vindpercentage was voorheen lager bij hoger opgeleiden, maar in 2025 is het verschil tussen opleidingsniveaus kleiner geworden onder vrouwen en MSV. Het geschatte aantal chlamydia-episodes bij de huisarts daalde bij vrouwen van 24.700 in 2023 naar 18.900 in 2024 en bij mannen van 18.300 in 2023 naar 14.500 in 2024. Voor beide groepen daalde het aantal gerapporteerde chlamydia-episodes per 1.000 personen (15-64 jaar) in 2024 naar respectievelijk 3,3 (vrouwen) en 2,5 (mannen), vergeleken met 4,3 en 3,1 in 2023. Het rapportagecijfer was het hoogst onder vrouwen van 15-24 jaar (8,4). MSM worden ook niet meer standaard getest op chlamydia, maar alle MSM worden nog wel getest op LGV (lymfogranuloma venereum, een invasieve chlamydia-variant). Deze testen worden bij het RIVM als LGV-tests geregistreerd, niet als chlamydia-tests. Door implementatieproblemen werd een deel van de LGV-tests ten onrechte als zowel LGV- als chlamydia-test gerapporteerd, waardoor het aantal (anorectale) chlamydia-tests bij MSM in 2025 kunstmatig werd verhoogd. Het aantal LGV-diagnoses bij de CSG's daalde van 512 in 2024 naar 454 in 2025; 440 daarvan waren bij MSM. Het aandeel hiv-negatieve MSM (SOA en PrEP) onder de LGV-diagnoses steeg van 45% in 2016 naar 74% in 2025.

Het aantal gonorroe-diagnoses bij de CSG's steeg in 2025 naar 14.297 (13.952 in 2024). In 2025 was het gonorroe-vindpercentage 4,3% onder vrouwen en 4,4% onder MSV, het hoogste sinds 2014 en een flinke stijging ten opzichte van 2022 (vrouwen: 2,3%, MSV: 2,4%). De stijging in 2023 was vooral zichtbaar bij jongeren onder de 25 jaar. In 2025 bleef het vindpercentage in deze groepen hoog en steeg verder bij jongeren tot en met 20 jaar. Onder MSM was de positiviteit het hoogst onder MSM onder de 25 jaar. Gonorroe-vindpercentage onder MSM-SOA steeg van 12,4% in 2021 naar 15,5% in 2025. Bij MSM-PrEP steeg het van 11,7% in 2023 naar 13,5% in 2024. Van alle unieke MSM-PrEP-deelnemers in 2025 testte 21,6% in minimaal één consult positief op gonorroe, bij MSM-SOA was dit 19,4%. Het hoogste vindpercentage werd gevonden bij personen die gewaarschuwd waren voor gonorroe (31,0% bij vrouwen, 16,5% bij MSV, 35,4% bij MSM-SOA en 41,1% bij MSM-PrEP in 2025). Door deze ontwikkelingen is gonorroe nu de meest gediagnosticeerde soa bij de CSG's. Het geschatte aantal gonorroe-episodes bij huisartsen steeg van 18.800 in 2023 naar 19.800 in 2024. In 2024 was het rapportagecijfer voor gonorroe bij huisartsen 1,7 per 1.000 personen (15-64 jaar): 1,0 per 1.000 voor vrouwen en 2,4 per 1.000 voor mannen. Deze stijging werd vooral gezien bij jongeren. In 2025 werd voor het eerst resistentie tegen ceftriaxon, het voorkeursantibioticum voor gonorroe in Nederland, vastgesteld. De betreffende persoon raakte besmet in Zuidoost-Azië en werd bij terugkomst in Nederland gediagnosticeerd. De bacteriestam was resistent tegen ceftriaxon (MIC 0,19 mg/L), cefotaxim (MIC 0,38 mg/L), azitromycine (MIC >256 mg/L), tetracycline (MIC 6 mg/L) en ciprofloxacine (MIC 2 mg/L). Behandeling met ceftriaxon was succesvol, en er was geen verder seksueel contact in Nederland.

In 2025 werden bij de CSG's 1.927 infectieuze syfilis-infecties vastgesteld, meer dan in 2024 (1.798). Van alle infectieuze syfilis-infecties in 2025 werd 64% vastgesteld bij MSM-SOA en 27% bij MSM-PrEP. Het vindpercentage onder MSM-SOA bleef stabiel tussen 2021 en 2025. Bij MSM-PrEP steeg het vindpercentage naar 2,2% in 2025 (1,8% in 2024). Bij MSM-SOA steeg het vindpercentage in de leeftijdsgroepen 26-30, 41-50 en >50 jaar, en daalde het in andere leeftijdsgroepen. Het hoogste vindpercentage werd gevonden bij MSM-SOA die gewaarschuwd waren voor syfilis (13,8%). Andere groepen met een hoog vindpercentage waren MSM-SOA met klachten (5,7%). Vrouwen en MSV worden niet standaard getest op syfilis. In 2025 werd bij 48% van de soa-consulten bij vrouwen en bij 50% van de consulten bij MSV een syfilistest uitgevoerd. Bij vrouwen werden 21.802 tests en 60 diagnoses geregistreerd (vergelijk 44 diagnoses in 2024; vindpercentage 0,28%, 0,19% in 2024). Bij MSV werden 11.895 tests en 64 diagnoses geregistreerd (54 diagnoses in 2024; vindpercentage 0,54%, 0,53% in 2024). Hoewel de absolute aantallen laag zijn, is er een duidelijke stijging van diagnoses in beide groepen ten opzichte van vorig jaar. Een schatting van het aantal syfilis-episodes bij huisartsen is niet beschikbaar vanwege het lage aantal gevallen.

Virale soa

In 2025 werden volgens Stichting hiv monitoring (SHM) 979 personen nieuw aangemeld voor zorg bij hiv-behandelcentra (1.013 in 2024). Hiervan werden 440 personen nieuw gediagnosticeerd met hiv in 2025, maar dit aantal kan nog oplopen door rapportagevertraging. In totaal steeg het aantal nieuwe diagnoses licht met 6%. Onder MSM daalde het aantal diagnoses met 9%, maar onder MSV steeg het met 34% en onder vrouwen met 16% ten opzichte van 2024, al blijven de absolute aantallen in deze groepen relatief laag. Het aandeel MSM onder nieuwe hiv-diagnoses was 63% in 2025 (62% in 2024). Van de MSM met een nieuwe hiv-diagnose en instroom in zorg in 2025 werd 29% gediagnosticeerd bij huisartsen, 49% bij CSG's en 16% in ziekenhuizen. Tot en met 30 maart kwam 40% van de nieuw gediagnosticeerden in 2025 laat in zorg (CD4 <350/mm3 of AIDS). In 2024 was naar schatting 94% van de mensen met hiv in Nederland gediagnosticeerd en gekoppeld aan zorg; van hen was 95% gestart met behandeling en 96% daarvan had een onderdrukte viral load. Bij de CSG's werden in 2025 191 nieuwe hiv-infecties gediagnosticeerd, meer dan in 2024 (178). Hiervan was 70% bij MSM-SOA, 6% bij MSM-PrEP, 9% bij genderdiverse personen, 8% bij vrouwen en 7% bij MSV. Van de 19 hiv-diagnoses binnen het PrEP-programma in 2025 werden 14 personen gediagnosticeerd tijdens deelname aan het programma en 5 bij het eerste PrEP-consult voor de start van PrEP. Het vindpercentage voor hiv bij MSM-SOA daalde van 0,8% in 2016 naar 0,3% in 2025. Het vindpercentage bleef laag bij MSM-PrEP (0,05% in 2025), vrouwen en MSV (beide rond 0,1%). Bij genderdiverse personen was de hiv-positiviteit 0,6% in 2025.

Het aantal gemelde acute hepatitis B-gevallen steeg naar 100 in 2025 (88 in 2024), waarbij seksueel contact de meest gemelde transmissieroute was (60%). Het aantal gemelde acute hepatitis C-gevallen steeg naar 45 in 2025 (37 in 2024), met seksueel contact tussen MSM als belangrijkste transmissieroute (58%).

De mpox-uitbraak in Nederland begon in mei 2022 en piekte in juli 2022, waarna het aantal meldingen snel daalde. In oktober 2025 werd het eerste mpox clade 1b-geval vastgesteld in Nederland, en in totaal werden dat jaar negen clade 1b-gevallen gemeld, voornamelijk door lokale transmissie. Sinds 2022 zijn in totaal 1.579 mpox-infecties gemeld bij het RIVM, waarvan 149 in 2025. Van alle gevallen sinds mei 2022 betrof 89% MSM en was bij 86% seksueel contact de transmissieroute. In 2025 werden in totaal 6.307 mpox-vaccinaties gegeven, waarvan 3.635 (58%) eerste doses en 2.672 (42%) tweede doses. Het aandeel personen met mpox dat volledig gevaccineerd was, steeg van 1% in 2022-2023 naar 23% in 2025, wat wijst op aanhoudende transmissie ondanks vaccinatie.

De meeste gevallen van genitale wratten en herpes genitalis worden bij de huisarts geregistreerd. In 2024 werden naar schatting 46.900 diagnoses van genitale wratten (48.600 in 2023) en 30.000 diagnoses van herpes genitalis (28.600 in 2023) gesteld. Bij huisartsen werden genitale wratten vaker bij mannen (62% van de gevallen) dan bij vrouwen geregistreerd, terwijl herpes genitalis juist vaker bij vrouwen werd vastgesteld (73%). Bij de CSG's werden in 2025 respectievelijk 845 en 557 diagnoses van genitale wratten en herpes genitalis gesteld (806 en 616 in 2024).

Conclusie

In 2025 is het totale aantal consulten bij de CSG's verder gedaald ten opzichte van voorgaande jaren, met name onder vrouwen en mannen die seks hebben met vrouwen (MSV). De belangrijkste ontwikkeling was de invoering van een nieuw chlamydia-testbeleid, waarbij alleen mensen met soa-klachten of met een partner die klachten heeft van chlamydia worden getest. Dit leidde tot een scherpe daling in het aantal chlamydiatesten en -diagnoses, wat een duidelijke trendbreuk veroorzaakt. Hierdoor zijn de gegevens over het aantal diagnoses en vindpercentages in 2025 niet direct te vergelijken met voorgaande jaren. Belangrijk is dat dit beleid in principe alleen van toepassing was op chlamydia; het aantal soa-consulten zou daarmee stabiel moeten blijven, omdat mensen nog steeds voor andere soa's getest kunnen worden. De algehele daling in consulten kan echter ook samenhangen met stijgende kosten per consult en capaciteitsbeperkingen door de ASG-regeling.

Hoewel chlamydia onder vrouwen en MSV de meest gediagnosticeerde soa blijft, zijn de hogere vindpercentages in 2025 vooral het gevolg van het selectieve triage- en testbeleid. Gonorroe is inmiddels de meest gerapporteerde soa bij de CSG's. Het aantal gonorroediagnoses en het vindpercentage namen in 2025 verder toe, met name onder jonge vrouwen, MSV en MSM. Ook het aantal infectieuze syfilisdiagnoses steeg, vooral onder MSM, evenals het vindpercentage. Na jaren van daling liet de landelijke hiv-registratie (Stichting hiv monitoring) in 2024 en 2025 weer een toename zien van het aantal nieuwe diagnoses, maar het aantal bij MSM stabiliseerde. Deze stijging is nog duidelijker als er gecorrigeerd wordt voor rapportagevertraging. Ondanks de verdere uitrol van PrEP blijft het aantal nieuwe hiv-diagnoses relatief hoog en wordt een aanzienlijk deel nog steeds laat gediagnosticeerd.

Deze ontwikkelingen onderstrepen het belang van blijvende inzet op vroege hiv-diagnostiek en snelle koppeling aan zorg, én op laagdrempelige toegang tot soa-preventie, testen en behandeling voor alle risicogroepen. Ook voortdurende surveillance, aandacht voor partnerwaarschuwing en gerichte preventiecampagnes, zoals de geplande landelijke condoomcampagne, blijven essentieel voor effectieve infectiecontrole en het voorkomen van verdere verspreiding.

1 Methodology of STI and HIV surveillance

The tables and figures in this report are based on a variety of data sources and provide a current overview of STI and HIV in the Netherlands. This overview is based on the systematic surveillance conducted among populations at increased risk of STI embodied in the nationwide system of Sexual Health Centres (SHCs). Data from general practitioners (GPs), who perform the bulk of STI consultations, was extrapolated from the Nivel Primary Care Database. We included data from the HIV treatment centres (Stichting hiv monitoring) to gain insight into trends in new HIV diagnoses and people living with HIV. Other data sources include the national Health Survey, weekly virological laboratory reports, the Gonococcal Resistance to Antimicrobials Surveillance (GRAS) programme, antenatal screening, mandatory reporting on hepatitis B, hepatitis C, and mpox, the hepatitis B vaccination programme for key populations, the mpox vaccination programme, and the blood donor registry.

1.1 National surveillance at Sexual Health Centres

From 1995 onwards, STI diagnoses have been registered in an STI database at RIVM in the Netherlands. In 2003, an STI sentinel surveillance system was implemented, which achieved national coverage in 2004. Since 2006, reporting to the national STI surveillance system has been organised in eight regions. In each region, one SHC is responsible for the coordination of STI surveillance (Figure 1.1). A total of 23 SHCs, mostly within the Public Health Services (PHSs), provide low-threshold, free-of-charge STI/HIV testing and care targeting high-risk groups, which falls under the 'Additional Sexual Healthcare' regulation or ASG (in Dutch). Inclusion criteria relate to those who: (1) report STI related symptoms, (2) are notified of STI exposure, (3) are men who have sex with men (MSM) or transgender persons, (4) are migrants from a region of origin specified in the triage criteria, (5) report a partner who originates from these regions of origin or who is MSM, (6) are under the age of 25 years, (7) report sex work, or (8) are a victim of sexual violence. In 2015, a financial ceiling was implemented. Since then, SHCs have had more strongly prioritised populations at the highest risk of STIs, such as clients who are notified of an STI or report symptoms relating to STIs. This change should be considered when interpreting trends, as stricter triage can result in higher STI positivity.

Until 2011, attendees were routinely tested for chlamydia, gonorrhoea, and syphilis, with an opt-out policy for HIV testing. Between 2012 and 2014, attendees aged under 25 years who did not meet other indication criteria were tested exclusively for chlamydia. If the chlamydia test result was positive, clients were subsequently tested for gonorrhoea, syphilis, and HIV. From 2015 to 2024, attendees aged under 25 years have been tested for chlamydia and gonorrhoea, with additional testing for syphilis, HIV and/or Hepatitis B Virus (HBV) when indicated. In short, indications for additional STI testing relate to those who (1) are notified of syphilis, HIV, LGV, HBV, or HCV infection, (2) have symptoms relating to syphilis or HIV, (3) have reported performing sex work, (4) are clients of sex workers, (5) are MSM, (6) are migrants from a region of origin that is included in triage,[1] (7) report a partner from these regions of origin or who is MSM, or (8) are victims of sexual violence. The testing policy for attendees aged over 25 years remained unchanged: routine testing for chlamydia, gonorrhoea, and syphilis, and an opt-out HIV testing.[2] Hepatitis B and C, genital herpes, trichomonas, and LGV are tested on an indication basis only. As of January 2024, the testing policy for chlamydia no longer includes oral tests, resulting in a trend break.

In 2025, a new chlamydia testing policy was implemented at the SHCs. Under this new policy, chlamydia is no longer part of routine testing. Instead, a chlamydia test is only conducted when a person has STI symptoms affiliated with chlamydia or currently has a partner with a known (symptomatic) chlamydia infection. Two SHCs piloted this new testing policy in November and December 2024, and the other regions implemented the new policy at the beginning of 2025. Although MSM are no longer routinely tested for chlamydia, all MSM continue to receive LGV screening. These LGV tests are supposed to be reported to RIVM only as LGV tests, not as chlamydia tests. However, due to implementation challenges, a significant number of LGV tests in 2025 were mistakenly registered as both LGV

[1] Regions of origin as indicated by triage include Turkey, Africa, Latin America including Suriname and the former Netherlands Antilles, Asia, and Eastern Europe.

[2] See 'Draaiboek': lci.rivm.nl/draaiboeken/consult-seksuele-gezondheid

and chlamydia tests, resulting in an artificial increase in the reported number of (anorectal) chlamydia tests among MSM. Changes in testing policy need to be considered when interpreting trend data, as they may influence trends.

All consultations conducted at SHCs, and corresponding diagnoses, are reported online to RIVM for surveillance purposes, through a web-based application (SOAP). The unit of analysis is a 'new STI consultation' with reports including epidemiological, behavioural, clinical, and microbiological data on a variety of STIs. In 2014, an identification number was added to the data collection, which allows for the identification of clients who were repeatedly tested at the same clinic. We discuss the number of repeat visits and STI positivity by number of consultations in Chapter 2.

Most data in this report is presented separately for women, men who have sex with women (MSW), MSM, and gender diverse persons. The definition of an MSW is a cis-gendered man who only has sex with a person with a (neo)vagina. The group of gender diverse persons comprises all persons who are not cis gender and includes, but is not limited to, trans men, trans women, and non-binary persons. The region of origin is based on the client's and the client's parents' country of birth, according to the classification of Statistics Netherlands.[3] The classification distinguishes between persons born in the Netherlands with parents who were born in the Netherlands, migrants, and children of migrants. Migrants are persons who were born abroad. Children of migrants are persons who were born in the Netherlands and have at least one parent who was born abroad.

Between August 2019 and August 2024, a national Pre-Exposure Prophylaxis (PrEP) pilot programme was implemented at SHCs in the Netherlands. SHCs provided PrEP for a maximum of 8500 MSM and transgender people at increased risk of acquiring HIV. Before providing PrEP, the SHCs assessed eligibility criteria and contra indications, including STI and HIV testing. Three-monthly follow-up consultations included STI and HIV tests, medical monitoring, including kidney function, and counselling.[4] PrEP consultations and STI tests were provided free of charge (publicly funded), while participants paid a reduced fee for PrEP (€7.50 for 30 tablets).

Since August 2024, PrEP care at SHCs has been structurally embedded into the ASG regulation. PrEP care includes eligibility assessment, regular follow-up consultations, HIV and STI testing, medical monitoring, counselling, and prescription of PrEP medication. This transition from pilot to structural programme introduced several changes:

- The limitation on the number of individuals receiving PrEP care has been removed
- Anyone who meets the criteria specified in the PrEP guideline is eligible for PrEP care, which is no longer exclusively limited to MSM and transgender people.
- SHCs focus on the guidance of patients who start using PrEP and on persons who are most likely to drop out of care as well as the persons most vulnerable to non-adherence.
- Clients with good adherence to PrEP use and accessing PrEP care are encouraged to transition their PrEP care to their GP.
- Medication is prescribed by SHC physicians and provided by pharmacies, with clients covering the costs of the medication. PrEP care at SHCs is still free of charge.
- The budget for PrEP care has been increased.

Before July 2024, the PrEP guideline recommended follow-up consultations every three months. Since July 2024, the PrEP guideline also allows four-monthly or six-monthly follow-up, depending on the individual situation. Therefore, persons in PrEP care at SHCs visit SHCs more frequently and for different reasons than MSM who visit SHCs for STI testing only. As a result, persons in PrEP care and persons who have STI consultations only are not directly comparable in terms of the number of consultations and STI positivity. In this report, we therefore divided consultations among MSM into (1) STI consultations that come under the ASG regulation (MSM-STI consultations), and (2) PrEP consultations that come under the national PrEP pilot (MSM-PrEP consultations).

Several SHCs offered additional PrEP care outside the PrEP pilot programme, funded through municipal reimbursements or other means. These PrEP consultations are included under MSM-PrEP in this report, unless stated otherwise. It should be noted that MSM in PrEP care can also visit SHCs for an STI-only consultation between PrEP follow-up consultations.

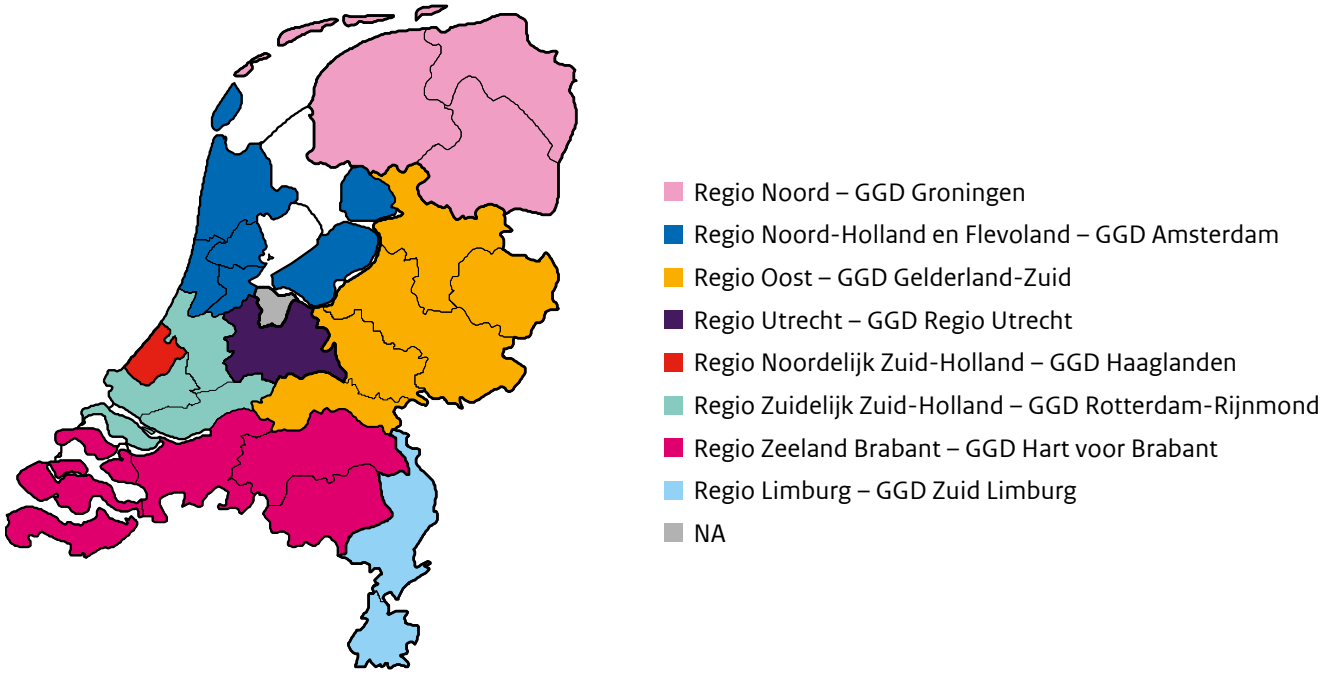
This report presents the results of national surveillance at SHCs, focusing on the number and characteristics of new consultations and diagnoses. Our focus is on the major bacterial and viral STIs, including HIV. Trends in positivity by risk profile (derived from demographic and behavioural indicators) are based on data collected from SHCs under

[3] Statistics Netherlands: www.cbs.nl/en-gb/our-services/methods/definitions/migration-background
[4] See Draaiboek: lci.rivm.nl/draaiboeken/consult-seksuele-gezondheid

national surveillance between 2014 and 2025. In May 2018, the General Data Protection Regulation (GDPR; AVG in Dutch) was implemented in the Netherlands. Initially, the interpretation of the GDPR led to a shift from an opt-out to opt-in approach. This means that, since May 2018, all SHC attendees had to give consent to share their consultation data with RIVM for surveillance purposes. The switch resulted in high numbers of non-consenting attendees in some regions, compromising the interpretability of the data and threatening the continuation of regional and national STI/HIV surveillance. This posed a risk to effective STI and HIV control – a task of general interest. For this reason, SHCs reverted to the opt-out system from July 2019 onwards. Between May 2018 and December 2019, aggregated data from non-registered consultations was obtained from SHCs on the total number of chlamydia, LGV, gonorrhoea, syphilis, and HIV tests and diagnoses. Data was stratified by sex and sexual contact. Aggregated data of non-registered consultations was added to data on registered consultations to calculate the total number of consultations and the positivity. Apart from information on sex and sexual contact, no demographic and behavioural indicators were available for non-registered consultations. Therefore, all the tables and figures regarding positivity by risk profiles are based on registered consultations only. It is indicated where aggregated data on non-registered consultations has been included to registered consultations.

The Netherlands experienced several waves of the COVID-19 pandemic in 2020 and 2021. In 2020, and to a lesser extent in 2021, sexual health care services at SHCs were scaled down. This involved a stricter prioritisation of clients with (severe) STI-related symptoms, those who received STI notifications (for syphilis, HIV, hepatitis, and symptomatic gonorrhoea), and victims of sexual violence. Also, PrEP clients were allowed medication and essential PrEP care (i.e. creatinine, HIV and STI tests). This resulted in a lower number of consultations and higher positivity in 2020 and 2021. Positivity rates from 2020 and 2021 should be interpreted with caution. In 2022, SHCs returned to their regular prioritisation.

Figure 1.1 Eight regions with coordinating SHC indicated



Footnote: GGD Gooi & Vechtstreek (grey region) does not have an SHC, persons from this area can be tested at an SHC in surrounding regions.

1.2 Sense

To improve primary prevention and promote sexual health among young people (<25 years), SHCs offer free, anonymous consultations (Sense consultations) on a broad range of subjects relating to sexual health, including (problems with) sexual intercourse, unintended pregnancy, birth control, STIs, sexuality, sexual identity, and sexual violence. Data on the number and demographics of Sense consultation visitors is presented. Since 2014, demographic information and the subject of Sense consultations have been included in the national STI/HIV surveillance system. However, interpreting the results is challenging due to inconsistencies in the registration of Sense consultations across SHCs.

1.3 Sexual health in the Health Survey/Lifestyle Monitor

Since 2014, Statistics Netherlands (CBS), in collaboration with RIVM, Rutgers, and Soa Aids Nederland, has collected data on various aspects of lifestyle from a representative sample of the Dutch population in the national Health Survey (Health Survey/Lifestyle Monitor). The survey covers lifestyle themes such as substance use, physical activity, nutrition, accidents, and sexual health. For each of these topics, a standard set of indicators is collected annually. This report presents a selection of the 2025 results to highlight characteristics relating to sexual health and STI healthcare in the general population of the Netherlands. The data was weighted for demographic characteristics to account for differences between the survey sample and the overall Dutch population.

1.4 STIs at general practices

Data on STI incidence reported by GPs was obtained through the primary care network maintained at Nivel, the Netherlands Institute for Health Services Research. This study has been approved according to the governance code of Nivel Primary Care Database, under number NZR-00325.046. The use of electronic health records for research purposes is allowed under certain conditions. When these conditions are fulfilled, neither obtaining informed consent from patients nor approval by a medical ethics committee is obligatory for this type of observational studies, which contain no directly identifiable data (art. 24 GDPR Implementation Act jo art. 9.2 sub j GDPR).

Nivel's primary care network is based on electronic health records in a network of over 500 GPs, the Nivel Primary Care Database (Nivel-PCD).[5] The network uses data routinely collected from GPs to monitor health and the utilisation of health services at GPs in a representative sample of approximately 10% of the Dutch population. All symptoms and diagnoses are recorded using the International Classification of Primary Care (ICPC-1) codes.[6] Data on the incidence of STI episodes in the population covered by this network from 2013 to 2024 has been included in this report. This is restricted to data from GPs with high-quality morbidity data, which amounted to 384 practices in 2024. Incidence rates were calculated on the basis of the number of episodes of illness per 1000 population aged 15-64 years.[7] Annual estimates of the total number of episodes at GPs in the Netherlands were made by extrapolating the reporting rates at these practices to the total number of Dutch residents aged 15-64 years, as obtained from Statistics Netherlands (CBS) and reported by sex and age group (15-24 years and 25-64 years). For syphilis and HIV, the number of incident cases reported was too small for reliable incidence estimates. For HIV, the total number of episodes and the prevalence rates are based on the entire Dutch population (all ages), the reported prevalence rates are based on estimates by Nivel-PCD. HIV prevalence estimates in 2015 to 2024 have been standardised for urbanisation in this report.

For chlamydia, which does not have a main ICPC code, we used the 'chlamydia-related' ICPC codes in combination with prescription data and laboratory data. The chlamydia-related ICPC codes include vaginitis (X84), cervicitis (X85), and Pelvic Inflammatory Disease (PID; X74) in women, and orchitis/epididymitis (Y74) and other genital diseases (Y99) in men.[8] The percentage of chlamydia episodes was estimated for each chlamydia-related ICPC main code. The chlamydia incidence rate was calculated by combining these percentages with the incidence rates of the separate

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5 Vanhommerig JW, Verheij RA, Hek K, Ramerman L, Hooiveld M, Veldhuijzen NJ, et al. Data Resource Profile: Nivel Primary Care Database (Nivel-PCD), The Netherlands. Int J Epidemiol. 2025 Apr;54(2):dyaf017. doi.org/10.1093/ije/dyaf017

6 Lamberts H, Wood MR. ICPC: International Classification of Primary Care. Oxford: Oxford University Press, 1987.

7 Nielen MMJ, Spronk I, Davids R, Korevaar JC, Poos R, Hoeymans N, Opstelten W, van der Sande MAB, Biermans MCJ, Schellevis FG, Verheij RA. Estimating Morbidity Rates Based on Routine Electronic Health Records in Primary Care: Observational Study. JMIR Med Inform. 2019 Jul 26;7(3):e11929. doi: 10.2196/11929. PMID: 31350839.

8 Van den Broek IVF, Verheij RA, van Dijk CE, Koedijk FDH, van der Sande MAB, van Bergen JEAM. Trends in sexually transmitted infections in the Netherlands, combining surveillance data from general practices and sexually transmitted infection centres. BMC Family Practice, 2010, 11:39.

chlamydia-related ICPC codes. The percentage of chlamydia episodes per ICPC was based on the proportion of the chlamydia-related ICPC codes with a chlamydia-related prescription, i.e. azithromycin or doxycycline, or a positive chlamydia laboratory result.

1.5 Laboratory surveillance

National laboratory surveillance data is not available for STIs, except for data taken from the weekly virological reports. This includes the total number of *Chlamydia trachomatis*-positive tests from up to twenty participating laboratories. The coverage of these laboratories and the extent to which they represent the Dutch population are not exactly known, but the laboratories are spread evenly across the country and the coverage is sufficient to provide accurate and timely trends for (virological) infections and chlamydia.[9] There is an overlap between laboratories reporting in this system and the laboratories connected to SHCs.

1.6 Antimicrobial resistance of gonococci

Concerns about increasing resistance to quinolones at the (inter)national level resulted in an RIVM laboratory survey of gonococci resistance in 2002.[10] Because the results demonstrated the need for systematic nationwide surveillance of gonococcal antimicrobial resistance, the Gonococcal Resistance to Antimicrobials Surveillance (GRAS) was implemented in the Netherlands in 2006. This survey consisted of the systematic collection of data on gonorrhoea and resistance patterns, linked to epidemiological data. Gonorrhoea is usually diagnosed using Polymerase Chain Reaction (PCR). Within GRAS, additional culture and susceptibility testing of isolates is performed using E-tests. Resistance levels are calculated through breakpoints for resistance by the European Committee on Antimicrobial Susceptibility Testing (EUCAST).[11]

1.7 Antenatal screening

In the Netherlands, pregnant women are screened for syphilis, HBV, and HIV. A blood sample is taken during the first midwife appointment before the thirteenth week of pregnancy. The screening is conducted following to the opt-out principle, where pregnant women are tested after receiving information unless they explicitly decline to participate. Almost all pregnant women in the Netherlands participate in this screening programme, with only 0.02% declining HIV testing and 0.00% declining hepatitis B and syphilis testing in 2023.[12] The screening programme is coordinated by the Centre for Population Screening at RIVM.

1.8 Congenital syphilis

RIVM-IDS (Centre for Infectious Diseases Research, Diagnostics and Screening) provides Immunoglobulin M (IgM) diagnostics for neonates and young infants (<1 year) who may have been exposed to syphilis.

1.9 National registration of individuals registered at HIV treatment centres

In January 2002, an HIV reporting system for individuals entering care was implemented in the Netherlands. Pseudonymised longitudinal data for nearly all newly registered individuals with HIV is collected by Stichting HIV Monitoring (SHM).[13] The goal of SHM is to monitor people living with HIV who are registered at any of the 23 recognised HIV treatment centres and 4 children's HIV centres in the Netherlands. This monitoring aims to study changes in the epidemic, assess the effects of treatment, and evaluate the quality of HIV care. All individuals diagnosed with HIV and registered in this national cohort are followed prospectively from the time they enter care. Those diagnosed before the start of SHM were retrospectively included in the cohort. Individuals diagnosed with HIV before 1996 mainly include people who survived up to the start of the AIDS Therapy Evaluation

[9] See website: www.rivm.nl/virologische-weekstaten
[10] Van Loo IH, Spaargaren J, van de Laar MJW. Resistance of Gonococci in the Netherlands; Results of a survey of Medical Microbiology Laboratories. Ned Tijdschr Geneeskd. 2005;149(22):1217-1222.
[11] The European Committee on Antimicrobial Susceptibility Testing. Breakpoint tables for interpretation of MICs and zone diameters. Version 16.0, 2026. www.eucast.org/clinical_breakpoints
[12] Van der Ploeg CPB, Schönbeck Y, Odijk JAM, van Lent M. PSIE. Procesmonitor 2023. Belangrijkste resultaten Prenatale Screening Infectieziekten en Erytrocytenimmunisatie (PSIE) over 2023. TNO/RIVM 2025. Available from: www.pns.nl/documenten/proces-monitor-psie-2023
[13] See website: www.hiv-monitoring.nl

in the Netherlands (ATHENA) national observational HIV cohort in 1996, SHM's predecessor.[14] The epidemiological data on newly reported HIV diagnoses, as well as trends in new AIDS diagnoses from 2000 onwards are reported in collaboration with RIVM.[15] For this annual report, the lock date of the SHM database for RIVM was 2 February 2026. The number of people living with HIV in the Netherlands in 2024, including the undiagnosed, was estimated using the European Centre for Disease Prevention and Control (ECDC) HIV Modelling Platform.[16]

1.10 HIV incidence data

HIV incidence data is obtained from the Amsterdam Cohort Studies (ACS) on HIV/AIDS and blood donations. In 1984, the Amsterdam Cohort Studies on HIV and AIDS started registering MSM. The initial goal was to study the epidemiology, psychosocial determinants, natural history, and pathogenesis of HIV-1 infection and AIDS, as well as to evaluate the effect of interventions in both MSM diagnosed with HIV and those without a diagnosis. Over the past decade, the scope of the ACS has expanded to include epidemiology and natural history of blood-borne and sexually transmitted infections other than HIV. The collaborating institutes within the ACS framework are Sanquin Blood Supply Foundation, the PHS of Amsterdam (GGD Amsterdam), Amsterdam University Medical Centres (Amsterdam UMC), Jan van Goyen Medical Centre, DC Klinieken Amsterdam, and SHM.

1.11 Notification of hepatitis B and C

The mandatory notification includes epidemiological data on newly diagnosed acute and chronic hepatitis B virus (HBV) and hepatitis C (HCV) infections, with chronic HCV infections becoming notifiable in 2019. Since 2002, all PHSs have reported notifications of HBV and HCV infections using the web-based application OSIRIS.

1.12 Hepatitis B vaccination programme for risk groups

As a low-endemic country, the Netherlands implemented a targeted vaccination programme for high-risk behavioural groups. The programme provides free vaccination for MSM and persons who report engaging in sex work. MSW with an STI indication were also considered a risk group until October 2007, and drug users until January 2012. PHSs and SHCs offer complimentary vaccination following the six-month schedule. During the first vaccination consultation, participants are serologically tested for markers of previous or current HBV infection. Data is recorded in a registration system specifically developed for the vaccination programme. Although universal childhood vaccination was introduced in 2011, the current targeted risk group vaccination programme needs to be continued in the coming years. Since June 2025, MSM and MSM sex workers are also eligible for free Hepatitis A and B vaccination (Twinrix), whereas previously the A-component was not covered.

1.13 Blood donors

Since 1985, all blood donations from new and regular donors have been screened for HIV, hepatitis B and C, and syphilis. Volunteers are screened according to quality and safety guidelines and people who report specific risk factors for blood-transmitted infections are not accepted as donors.[17] Records are kept in the national donor registry of Sanquin, which provides representative information on the prevalence and incidence of these infections in a low-risk population. Data from the 2016-2025 period is reported.

[14] Boender TS, Smit C, Sighem A, et al. AIDS Therapy Evaluation in the Netherlands (ATHENA) national observational HIV cohort: cohort profile. BMJ Open 2018;8:e022516. doi:10.1136/ bmjopen-2018-022516.

[15] Van Sighem AI, Wit FWNM, Boyd A, Smit C, Jongen V, Koole J. HIV Monitoring Report 2023, Human Immunodeficiency Virus (HIV) Infection in the Netherlands. Amsterdam: Stichting hiv monitoring, 2023. Available online at www.hiv-monitoring.nl

[16] European Centre for Disease Prevention and Control. HIV platform tool [Internet, software application]. Stockholm: ECDC; 2021. Available from: www.ecdc.europa.eu/en/publications-data/hiv-platform-tool

[17] Information on risk factors is available (in Dutch only) at: www.sanquin.nl/bloed-doneren/mag-ik-bloed-geven

1.14 Mpox

Data on mpox diagnoses is reported by the PHSs to RIVM through the web-based application Osiris. Outbreak control measures for mpox included contact tracing and monitoring, case identification and (self-)isolation, and targeted vaccination including post-exposure prophylaxis (PEP) vaccination with Imvanex for high-risk contacts, and primary preventive vaccination (PPV) with Imvanex for MSM and transgender persons with high-risk behaviour (e.g. HIV-PrEP users or persons who are on a waiting list for HIV-PrEP, living with HIV, having multiple sexual contacts or visiting sex venues, and/or engaging in group sex). National data on PEP vaccinations is not available. However, data on PrEP vaccinations, and the number of MSM and transgender persons invited for these vaccinations were reported to RIVM through iMPeX/Osiris. A new PrEP vaccination campaign targeting the same groups occurred between April and December 2025.

1.15 STI complications

Chlamydia and gonorrhoea infections in women can lead to pelvic inflammatory disease (PID), which may result in infertility and ectopic pregnancy (EP). To assess trends in the incidence of these complications and to monitor the effect of the chlamydia testing policy, the annual number of women with a primary diagnosis of PID (ICD-10 codes: N70, N71, N72, N73, A56.1+N74.4), infertility (N97), and EP (O00) was obtained from Dutch Hospital Data (DHD) for the years 2015-2023. Additionally, incidence data from general practices was collected through the Nivel Primary Care Database, using ICPC codes for PID (X74), infertility (W15), and ectopic pregnancy (W80) for the same period. These outcomes are not specific to chlamydia, but reflect all-cause PID, infertility, and EP.

1.16 Private test providers

Data from three private test providers for STI home tests have been included in this report. On the basis of internal quality assessments by Soa Aids Nederland (SANL), Soapoli-Online, SoapoliNoord, and SoaStudentArts are recommended. Data from these providers for 2024 and 2025 were incorporated to monitor the use and outcomes of home-based STI testing in the Netherlands. The data is presented in aggregated form.

2 Sexual health, STI and Sense consultations

2.1 Key points

2.1.1 Sexual Health Centres

Consultations

- In 2025, the total number of consultations at Sexual Health Centres (SHCs) amounted to 146,982 (Figure 2.1). 31% concerned women (44,997), 16% MSW (23,572), 35% MSM-STI consultations (50,636), 17% MSM-PrEP consultations (24,522) and 2% gender diverse persons (3255) (Table 2.1, Table 2.2).
- Out of 3255 consultations in gender diverse persons, 1630 (50%) concerned trans women, 407 (13%) trans men, and 1218 (37%) other gender diverse persons (Table 2.1, Table 2.2). Due to the low number of consultations among gender diverse persons, the characteristics of gender diverse persons are not included in all the tables or figures.
- The total number of consultations in 2025 decreased by 8% compared to 2024 and by 3% compared to 2019. Compared to 2024, the number of consultations decreased by 17% among women, by 8% among MSW, and by 7% among MSM-PrEP; among gender diverse persons, consultations increased by 16%. Among MSM-STI, the number of consultations remained relatively stable, with a 1% increase in 2025 (Figure 2.1, Figure 2.2).
- In 2025, one or more STI were diagnosed at 24,736 consultations (17%). Of these diagnoses, 25% concerned women, 16% MSW, 41% MSM-STI, 16% MSM-PrEP, and 2% gender diverse persons (Figure 2.2). The number of consultations in which one or more STIs were diagnosed decreased by 24% compared to 2024, but was comparable to 2019, showing a 3% increase (Figure 2.1).
- STI positivity in 2025 was 13.7% among women, 17.2% among MSW, 19.9% among MSM-STI, 16.2% among MSM-PrEP and 14.6% among gender diverse persons (Figure 2.2).
- At around 99% of all SHC consultations involving an STI test, gonorrhoea was tested. Around 50% of women and 43% of MSW were tested for chlamydia, compared to 34% of MSM-STI and 23% of MSM-PrEP. Around 48% of women and 50% of MSW were tested for syphilis and HIV. Of MSM-STI, around 98% and 89% were tested for syphilis and HIV, respectively. Around 98% of MSM-PrEP were tested for syphilis and HIV. Around 27%, 96%, and 91% of gender diverse persons were tested for chlamydia, syphilis, and HIV, respectively (Table 2.3).
- Among women and MSW, the highest STI positivity was found for chlamydia, 20.5% and 32.1%, respectively, followed by gonorrhoea (Table 2.4). Among MSM-STI, MSM-PrEP, and gender diverse persons, the highest STI positivity was found for gonorrhoea, 15.5%, 13.5%, and 12.1%, respectively, followed by chlamydia.

Repeat testing

- Of 38,414 women and 21,306 MSW who visited SHCs in 2025, 14% and 9% had multiple consultations, respectively (Table 2.6). Of 32,791 MSM-STI, 33% had multiple consultations. Of 2021 gender diverse persons, 37% had multiple consultations.
- Among unique women and MSW, 15% and 18% were diagnosed with one or more STI, respectively (Table 2.7a).
- Among unique MSM, 25% of MSM-STI and 25% of MSM-PrEP were diagnosed with one or more STIs (Table 2.7b).

Characteristics of SHC attendees

- Among women and MSW, the most reported triage indications were being under 25 years, having symptoms, or having a partner in a risk group (Table 2.8). For MSW, being notified was also frequently reported. Being an MSM is a triage indication in itself. Among MSM-STI and MSM-PrEP, the most frequently reported additional indication was having a partner in a risk group.
- Around 45% of women and 53% of MSW reported 3 or more partners in the past 6 months, compared to 80% and 86% of MSM-STI and MSM-PrEP, respectively (Table 2.9). Across all groups and types of sex, high levels of inconsistent or no condom use were reported.
- The majority of MSM-STI and MSM-PrEP reported having both insertive and receptive anal sex, around 55% and 69%, respectively. Around 23% of MSM-STI and 33% of MSM-PrEP reported drug use in relation to sex. The most used drugs included poppers, 3-MMC, XTC/MDMA, erection stimulants, GHB/GBL, and cannabis/hashish. 4% of MSM reported use of doxycycline as antibiotic prophylaxis (DoxyP(r)EP) in the past three months (Table 2.10).
- Of women and MSW who attended the SHCs, the majority was aged under 25 years, whereas MSM-STI and MSM-PrEP were generally older (Figure 2.3).

Trends in characteristics of SHC attendees

- Among both women (Figure 2.4a) and MSW (Figure 2.4b), the most reported triage indication in all past years was being aged ≤ 25 years.
- For women and MSW, the proportion of consultations during which symptoms were reported has been decreasing since 2020 to 30% for women and to 31% for MSW in 2023. However, it increased to 45% for women and to 43% for MSW in 2025 (Figure 2.4a).
- Among MSM-STI (Figure 2.4c), the most reported additional indication was having a partner from a risk group (43%). For MSM-PrEP (Figure 2.4d), having a partner from a risk group was also frequently reported (43%), followed by being a migrant from a triage region (35%) and having had an STI in the past year (34%).
- Among gender diverse persons (Figure 2.4e), the most reported indication was having a partner from a risk group (59%), followed by being a migrant from a triage region (53%).
- The proportion of STIs detected trough partner notification has been decreasing since 2021 for women, MSW, and MSM-STI. However, for women, an increasing trend was observed in 2025. Among MSM-PrEP, the proportion detected through partner notification decreased between 2020 and 2022, but has increased again since 2022 (Figure 2.5).
- For both women and MSW, the proportion of consultations among persons with university education levels (HBO/university) has decreased since 2022, while the proportion of consultations among persons with other education levels has increased since 2022 (Figures 2.6a and 2.6b).
- For both MSM-STI (Figure 2.6c) and MSM-PrEP (Figure 2.6d), the proportions of consultations by education level have remained relatively stable since 2022.

Regional comparisons

- In 2025, the number of STI consultations per 1000 inhabitants aged 15-65 years ranged from 2.4 in Drenthe to 13.5 in Flevoland, with Amsterdam reporting the highest rate at 37.6 consultations per 1000 inhabitants (Figure 2.7).
- In most regions, the highest number of consultations was among MSM-STI, whereas in Zeeland/Brabant, Noord-Nederland, and Limburg, the highest number was among women (Figure 2.8).

2.1.2 Sense

- In 2025, 7173 Sense consultations were registered among women, 2589 among men, and 662 among gender diverse persons (Figure 2.9).
- The number of Sense consultations in 2025 decreased by 10% among women, by 20% among men, and by 12% among gender diverse persons as compared to 2024 (Figure 2.9).
- Just over 50% of the consultations among women and men were among persons from a different region of origin than the Netherlands. Among gender diverse persons, around 83% of consultations were among persons from a different region of origin than the Netherlands (Table 2.11).
- The most frequently discussed topic at Sense consultations for women was birth control (35%), followed by sexuality (22%), and unwanted sexual behaviour/sexual violence (17%). For men, the most frequently discussed topic was sexuality (56%), followed by STI (14%), and unwanted sexual behaviour/sexual violence (13%) (Table 2.12).

2.1.3 General practices

- Among women aged 15-24 years, the estimated number of episodes of 'fear of STI/HIV' at GPs decreased by 13%, from 29,200 in 2023 to 25,500 in 2024. Among women aged 25-64 years, the number decreased by 7%, from 74,400 in 2023 to 69,000 in 2024 (Figure 2.10a).
- The estimated number of registered STI-positive episodes decreased by 18% from 27,100 in 2023 to 22,300 in 2024 among women aged 15-24 years, and by 6% from 47,900 in 2023 to 45,300 in 2024 among women aged 25-64 years (Figure 2.10a).
- Among men aged 15-24 years, the estimated number of episodes of 'fear of STI/HIV' at GPs decreased by 12% from 20,400 in 2023 to 17,900 in 2024. By contrast, among men aged 25-64 years, there was a slight decrease by 1%, from 70,100 in 2023 to 69,500 in 2024 (Figure 2.10b).
- The estimated number of registered STI-positive episodes decreased by 11% from 18,100 in 2023 to 16,100 in 2024 among men aged 15-24 years, and by 1% from 58,000 in 2023 to 57,400 in 2024 among men aged 25-64 years (Figure 2.10b).
- The reporting rate for STI-related episodes at GPs in 2024 was 44.2 and 24.5 per 1000 population among women aged 15-24 years and 25-64 years, respectively. For men, the rates were 30.3 and 27.0 per 1000 population for those aged 15-24 years and 25-64 years, respectively (Table 2.13).

2.1.4 Health Survey

- In 2024, 4116 (53%) women, 3508 (45%) men attracted to women only (MSW), and 159 (2%) men attracted to men (MSM) participated in the national Health Survey/ Lifestyle Monitor (Table 2.14).
- Among women aged between 16 and 29 years, 11% reported having been tested for STI in the previous year and 4% for HIV. For MSW aged 16-29 years, these rates amounted to 5% for STI tests and 4% for HIV tests. These percentages have remained relatively stable since 2021 (Figure 2.11, Figure 2.12). There is a slightly increasing trend for all women and MSW aged 30 years or over who reported being tested for an STI in the previous year.
- The majority of STI and HIV tests were among MSM (all ages): 19% tested for STI and 17% for HIV (Figure 2.12). These percentages were lower than in 2023.

2.1.5 STI-related complications

- The incidence of ectopic pregnancy in women aged 15-49 years diagnosed in general practices fluctuated slightly between 2015 and 2023, and was 15 per 1000 live births in 2023 (Figure 2.13). The incidence diagnosed in hospitals remained relatively stable at around 10 per 1000 live births during this period.
- For infertility, the incidence at general practices remained relatively stable until 2020, after which it fluctuated, at 760 per 100,000 women in 2023 (Figure 2.14). In hospitals, the incidence decreased between 2015 and 2018, after which it stabilised, amounting to 38 per 100,000 women in 2023.
- For pelvic inflammatory disease, the incidence at general practices has remained relatively stable since 2019, at 131 per 100,000 women in 2023 (Figure 2.15). In hospitals, the incidence remained relatively stable between 2015 and 2023, with 23 per 100,000 women in 2023.

2.1.6 Private home testing providers

- The number of chlamydia tests registered by SANL-recommended private home testing providers decreased from 31,961 in 2024 to 23,952 in 2025, while positivity increased from 9.5% to 10.2%.
- For gonorrhoea, the number of tests decreased from 24,813 in 2024 to 19,187 in 2025. A similar trend was observed for HIV, with the number of tests dropping from 7050 to 6078, respectively. The positivity rates remained similar throughout the years, at approximately 2.7% for gonorrhoea and 0.0% for HIV.

2.2 Consultations, tests, and diagnoses at Sexual Health Centres

Figure 2.1 Number of consultations and STI positivity in Sexual Health Centres, 2005-2025

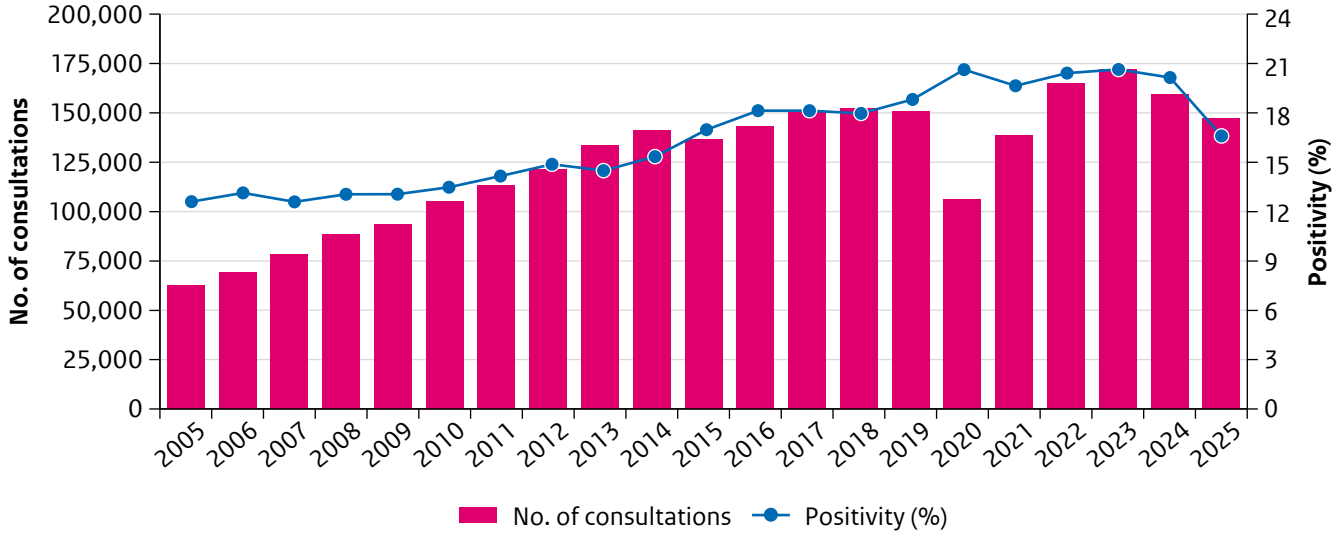


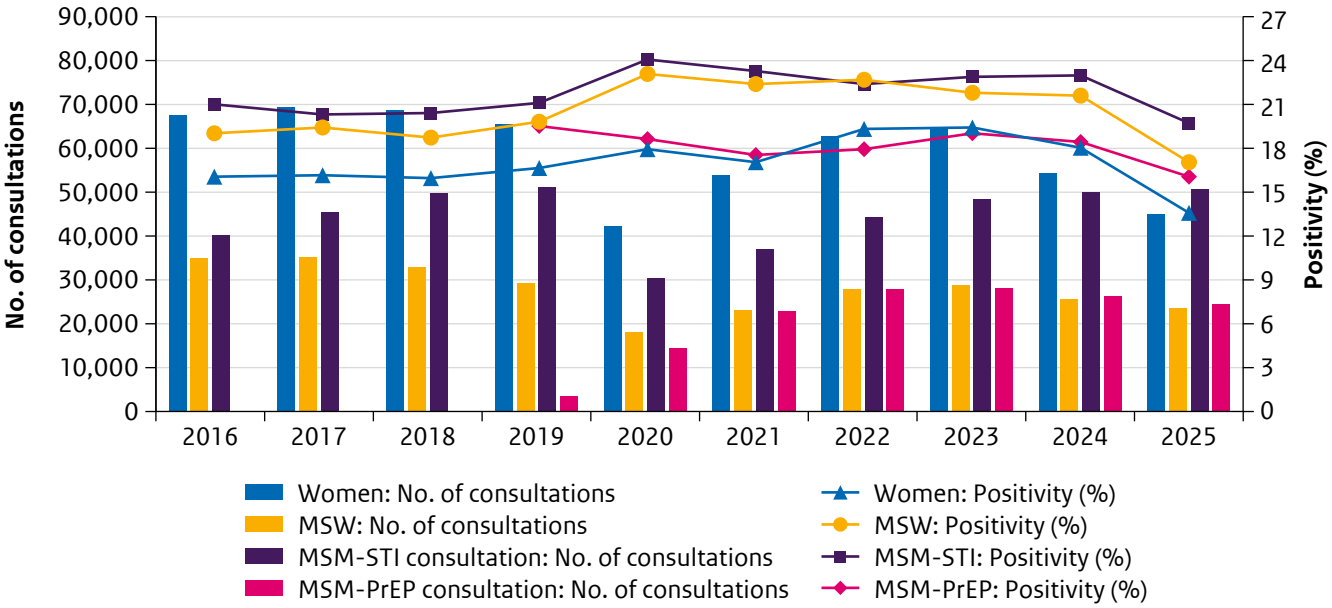
Table 2.1 STI consultations: number and proportion of consultations by sex and type of sexual contact, 2021-2025

Sex and type of sexual contact	2021	2022	2023	2024	2025
	n (%)	n (%)	n (%)	n (%)	n (%)
Women	53,941 (46.9)	62,845 (46.2)	64,319 (45.0)	54,306 (41.2)	44,900 (37.0)
MSW	23,198 (20.2)	27,947 (20.5)	28,825 (20.2)	25,738 (19.5)	23,556 (19.4)
MSM-STI consultation	37,067 (32.2)	44,318 (32.6)	48,440 (33.9)	50,056 (37.9)	50,636 (41.8)
Gender diverse persons	788 (0.7)	997 (0.7)	1,441 (1.0)	1,830 (1.4)	2,187 (1.8)
Trans men	148 (18.8)	157 (15.7)	174 (12.1)	221 (12.1)	328 (15.0)
Trans women	380 (48.2)	454 (45.5)	628 (43.6)	739 (40.4)	922 (42.2)
Other gender diverse persons	260 (33.0)	386 (38.7)	639 (44.3)	870 (47.5)	937 (42.8)
Total	**114,994**	**136,107**	**143,025**	**131,930**	**121,279**

Table 2.2 PrEP consultations: number and proportion of consultations by sex and type of sexual contact, 2021-2025

Sex and type of sexual contact	2021	2022	2023	2024	2025
	n (%)	n (%)	n (%)	n (%)	n (%)
Women	37 (0.2)	38 (0.1)	53 (0.2)	61 (0.2)	97 (0.4)
MSW	3 (0.0)	5 (0.0)	9 (0.0)	14 (0.1)	16 (0.1)
MSM-PrEP consultation	22,927 (97.8)	27,887 (97.5)	28,231 (97.1)	26,268 (96.1)	24,522 (95.4)
Gender diverse persons	474 (2.0)	678 (2.4)	795 (2.7)	979 (3.6)	1,068 (4.2)
Trans men	63 (13.3)	56 (8.3)	61 (7.7)	59 (6.0)	79 (7.4)
Trans women	308 (65.0)	452 (66.7)	493 (62.0)	629 (64.2)	708 (66.3)
Other gender diverse persons	103 (21.7)	170 (25.1)	241 (30.3)	291 (29.7)	281 (26.3)
Total	**23,441**	**28,608**	**29,088**	**27,322**	**25,703**

Figure 2.2 Number of consultations and STI positivity by sex and type of sexual contact, 2016-2025



Footnote 1: STI include chlamydia, gonorrhoea, infectious syphilis, HIV and infectious hepatitis B.
Footnote 2: Aggregated data of non-registered consultations are included in the number of consultations for 2018 and 2019. The STI positivity in 2019 was calculated based on consultations registered in SOAP only; for 2018 aggregated numbers of non-registered consultations were also included.
Footnote 3: Among gender diverse persons, STI positivity was 14.6% in 2025.

Table 2.3 STI tests: Number and proportion of consultations with STI test by sex and type of sexual contact, 2025

Test	Women	MSW	MSM-STI consultation	MSM-PrEP consultation	Gender diverse persons
	n (% tested)	n (% tested)	n (% tested)	n (% tested)	n (% tested)
Chlamydia	22,346 (49.7)	10,110 (42.9)	17,436 (34.4)	5,530 (22.6)	866 (26.6)
Gonorrhoea	44,363 (98.6)	23,237 (98.6)	49,998 (98.7)	23,741 (96.8)	3,135 (96.3)
Syphilis	21,802 (48.5)	11,895 (50.5)	49,559 (97.9)	23,983 (97.8)	3,122 (95.9)
HIV	21,723 (48.3)	11,798 (50.1)	45,187 (89.2)	24,162 (98.5)	2,947 (90.5)
Hepatitis B	5,763 (12.8)	3,219 (13.7)	11,524 (22.8)	3,141 (12.8)	1,155 (35.5)
Hepatitis C	521 (1.2)	307 (1.3)	2,538 (5.0)	13,376 (54.5)	709 (21.8)
LGV	51 (0.1)	66 (0.3)	33,843 (66.8)	17,641 (71.9)	1,949 (59.9)
Mpox	35 (0.1)	40 (0.2)	1,087 (2.1)	249 (1.0)	56 (1.7)

Table 2.4 STI diagnoses: Number of consultations with STI diagnosis and positivity by sex and type of sexual contact, 2025

Diagnosis	Women	MSW	MSM-STI consultation	MSM-PrEP consultation	Gender diverse persons
	n (% positivity)	n (% positivity)	n (% positivity)	n (% positivity)	n (% positivity)
Chlamydia	4,584 (20.5)	3,245 (32.1)	2,184 (12.5)	645 (11.7)	73 (8.4)
Gonorrhoea	1,914 (4.3)	1,034 (4.4)	7,755 (15.5)	3,216 (13.5)	378 (12.1)
Syphilis, infectious*	60 (0.3)	64 (0.5)	1,242 (2.5)	518 (2.2)	43 (1.4)
HIV	16 (0.1)	13 (0.1)	134 (0.3)	11 (0.0)	17 (0.6)
Hepatitis B, infectious	9 (0.2)	14 (0.4)	19 (0.2)	2 (0.1)	2 (0.2)
Hepatitis C, infectious	1 (0.2)	2 (0.7)	8 (0.3)	12 (0.1)	1 (0.1)
LGV	1 (2.0)	0 (0.0)	334 (1.0)	106 (0.6)	13 (0.7)
Mpox	0 (0.0)	0 (0.0)	80 (7.4)	11 (4.4)	2 (3.6)

* *Infectious syphilis includes primary infection, secondary infection and latens recens.*

Table 2.5 Other STI diagnoses: Number of consultations with STI diagnosis and positivity (in case of laboratory-confirmed diagnoses) by sex and type of sexual contact, 2025

Diagnosis	Women	MSW	MSM-STI consultation	MSM-PrEP consultation	Gender diverse persons
	n (% positivity)	n (% positivity)	n (% positivity)	n (% positivity)	n (% positivity)
Laboratory-confirmed diagnoses					
Syphilis, non infectious or not specified					
latens tarda	16 (0.1)	14 (0.1)	118 (0.2)	15 (0.1)	15 (0.5)
not specified	20 (0.1)	13 (0.1)	178 (0.4)	26 (0.1)	9 (0.3)
Hepatitis B, recovered	131 (2.3)	95 (3.0)	285 (2.5)	53 (1.7)	38 (3.3)
Hepatitis C, all types	4 (0.8)	4 (1.3)	37 (1.5)	52 (0.4)	8 (1.1)
Rectal LGV	0 (0.0)	0 (0.0)	329 (1.0)	105 (0.6)	13 (0.7)
Urogenital LGV	1 (2.0)	0 (0.0)	4 (0.0)	0 (0.0)	0 (0.0)
Oral LGV	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
LGV ulcer	0 (0.0)	0 (0.0)	8 (0.0)	2 (0.0)	1 (0.1)
Other syndromes/clinical diagnoses					
Trichomoniasis[1]	41	8	1	0	1
Genital herpes					
primary: HSV1[2]	99	54	88	20	4
primary: HSV2[2]	84	76	95	28	2
primary: type unknown	8	3	1	1	0
recurrent	4	2	10	4	0
Genital warts	254	362	180	38	11
Urethritis	0	245	380	66	14
Proctitis	1	0	166	27	6
Candidiasis	243	37	24	1	7
Bacterial vaginosis	728	0	0	0	7
Scabies	6	37	18	1	1
Pubic lice	0	0	13	2	1
PID	44	0	0	0	1
Epididymitis	0	5	14	1	1
Mycoplasma genitalium	19	31	19	6	3
Ulcus e.c.i.	19	14	72	13	1

1 *Trichomoniasis tests are usually performed on clinical indication (e.g. women with bacterial vaginosis), and in persons notified for trichomoniasis.*
2 *Laboratory-confirmed.*

2.3 Repeated testing at Sexual Health Centres

Table 2.6 Persons with multiple SHC visits: number and proportion of consultations and STI positivity at each visit by sex and type of sexual contact, 2025

No. of consultation	Women		MSW		MSM-STI		Gender diverse persons	
	n (%)	STI	n (%)	STI	n (%)	STI	n (%)	STI
1	38,414 (100.0)	13.5	21,306 (100.0)	16.8	32,791 (100.0)	18.2	2,021 (100.0)	14.3
2	5,258 (13.7)	14.7	1,904 (8.9)	21.2	10,948 (33.4)	21.2	752 (37.2)	13.4
3	1,023 (2.7)	15.0	272 (1.3)	18.8	4,196 (12.8)	24.9	325 (16.1)	17.8
4	228 (0.6)	10.5	63 (0.3)	19.0	1,617 (4.9)	27.5	113 (5.6)	17.7

Footnote 1: Number of visits reach up to 13 in MSM-STI consultations, 7 in women and gender diverse persons, and 9 in MSW. 4th-13th consultation not shown because of low numbers.
Footnote 2: Characteristics of persons with repeat visits are shown in supplementary table 13.1.

Table 2.7a Total number of tests, STI diagnoses and STI positivity on consultation and person level among women and MSW, 2025

Diagnosis	Women			MSW		
	Positive (N)	Tests (N)	Positivity (%)	Positive (N)	Tests (N)	Positivity (%)
One or more STI						
Consultations	6,151	44,997	13.7	4,060	23,572	17.2
Persons	5,834	38,419	15.2	3,871	21,395	18.1
Chlamydia						
Consultations	4,584	22,346	20.5	3,245	10,110	32.1
Persons	4,398	20,137	21.8	3,127	9,379	33.3
Gonorrhoea						
Consultations	1,914	44,363	4.3	1,034	23,237	4.4
Persons	1,861	38,049	4.9	992	21,145	4.7
Infectious syphilis						
Consultations	60	21,802	0.3	64	11,895	0.5
Persons	59	18,663	0.3	64	10,949	0.6
HIV						
Consultations	16	21,719	0.1	13	11,795	0.1
Persons	16	18,597	0.1	13	10,862	0.1

Footnote: Consultation level depicts all registered STI consultations with an STI diagnosis and STI test. Person level depicts the total number of unique persons with an STI diagnosis (at least once) and the number of unique persons tested (at least once) for each STI in 2025. Positivity is calculated as n diagnoses/n tests for both levels.

Table 2.7b Total number of tests, STI diagnoses and STI positivity on consultation and person level among MSM-STI consultations and MSM-PrEP consultations, 2025

Diagnosis	MSM-STI consultation			MSM-PrEP consultation		
	Positive (N)	Tests (N)	Positivity (%)	Positive (N)	Tests (N)	Positivity (%)
One or more STI						
Consultations	10,081	50,636	19.9	3,969	24,522	16.2
Persons	8,521	34,737	24.5	3,292	13,022	25.3
Chlamydia						
Consultations	2,184	17,436	12.5	645	5,530	11.7
Persons	2,027	14,538	13.9	582	4,173	13.9
Gonorrhoea						
Consultations	7,755	49,998	15.5	3,216	23,741	13.5
Persons	6,663	34,433	19.4	2,744	12,690	21.6
Infectious syphilis						
Consultations	1,242	49,559	2.5	518	23,983	2.2
Persons	1,222	34,231	3.6	511	12,857	4
HIV						
Consultations	134	45,127	0.3	11	24,162	0
Persons	134	31,682	0.4	11	12,933	0.1

Footnote: Consultation level depicts all registered STI consultations with an STI diagnosis and STI test. Person level depicts the total number of unique persons with an STI diagnosis (at least once) and the number of unique persons tested (at least once) for each STI in 2025. Positivity is calculated as n diagnoses/n tests for both levels.

2.4 Characteristics of Sexual Health Centre attendees in 2025

Table 2.8 Reported triage indication: number and proportion of consultations by sex and type of sexual contact, 2025

Triage indication	Women	MSW	MSM-STI consultation	MSM-PrEP consultation
	n (%)	n (%)	n (%)	n (%)
Notified				
No	37,369 (83.0)	17,888 (75.9)	40,442 (79.9)	22,482 (91.7)
Yes	7,533 (16.7)	5,667 (24.0)	10,150 (20.0)	2,029 (8.3)
Unknown	95 (0.2)	17 (0.1)	44 (0.1)	11 (0.0)
Symptoms				
No	23,288 (51.8)	12,780 (54.2)	37,552 (74.2)	21,639 (88.2)
Yes	20,402 (45.3)	10,035 (42.6)	12,058 (23.8)	2,716 (11.1)
Unknown	1,307 (2.9)	757 (3.2)	1,026 (2.0)	167 (0.7)

Triage indication	Women	MSW	MSM-STI consultation	MSM-PrEP consultation
	n (%)	n (%)	n (%)	n (%)
Region of origin included in triage[1]				
Dutch	27,487 (61.1)	12,763 (54.1)	28,544 (56.4)	13,412 (54.7)
Migrant from triage region	6,539 (14.5)	3,462 (14.7)	11,375 (22.5)	6,553 (26.7)
Child of migrant from triage region	7,068 (15.7)	5,488 (23.3)	4,476 (8.8)	2,016 (8.2)
(Child of) migrant, not from triage region	3,801 (8.4)	1,805 (7.7)	6,193 (12.2)	2,474 (10.1)
Unknown	102 (0.2)	54 (0.2)	48 (0.1)	67 (0.3)
Age				
≤25	32,472 (72.2)	16,752 (71.1)	8,746 (17.3)	2,829 (11.5)
>25	12,525 (27.8)	6,820 (28.9)	41,890 (82.7)	21,693 (88.5)
Partner in risk group[2]				
No	29,631 (65.9)	15,622 (66.3)	27,989 (55.3)	13,407 (54.7)
Yes	14,435 (32.1)	7,782 (33.0)	21,764 (43.0)	10,609 (43.3)
Unknown	931 (2.1)	168 (0.7)	883 (1.7)	506 (2.1)
Sex work in the past 6 months				
No	40,059 (89.0)	23,257 (98.7)	49,059 (96.9)	23,344 (95.2)
Yes	4,645 (10.3)	190 (0.8)	1,154 (2.3)	802 (3.3)
Unknown	293 (0.7)	125 (0.5)	423 (0.8)	376 (1.5)
Gonorrhoea/chlamydia/syphilis in the past year				
Not tested	26,812 (59.6)	16,956 (71.9)	16,210 (32.0)	2,461 (10.0)
Tested, negative	10,888 (24.2)	3,585 (15.2)	18,791 (37.1)	12,067 (49.2)
Tested, positive	4,891 (10.9)	1,942 (8.2)	13,589 (26.8)	8,295 (33.8)
Tested, unknown result	61 (0.1)	21 (0.1)	186 (0.4)	139 (0.6)
Unknown	2,345 (5.2)	1,068 (4.5)	1,860 (3.7)	1,560 (6.4)
Victim of sexual violence				
No	41,548 (92.3)	22,995 (97.6)	48,017 (94.8)	23,421 (95.5)
Yes	2,539 (5.6)	161 (0.7)	774 (1.5)	271 (1.1)
Unknown	910 (2.0)	416 (1.8)	1,845 (3.6)	830 (3.4)
At least one indication (including MSM)				
No	349 (0.8)	286 (1.2)		
Yes	44,648 (99.2)	23,286 (98.8)	50,636 (100.0)	24,522 (100.0)

1 *Region of origin with triage indication includes Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.*

2 *For MSW and MSM: partner originating from a region of origin as indicated by triage criteria. For women: partner originating from a region of origin as indicated by triage criteria or a male partner who had sex with men.*

Footnote: Characteristics of gender diverse persons are shown in supplementary table 13.2.

Table 2.9 Demographics and (sexual) behavioural characteristics: number and proportion of consultations by sex and type of sexual contact, 2025

Characteristic	Women	MSW	MSM-STI consultation	MSM-PrEP consultation
	n (%)	n (%)	n (%)	n (%)
Number of partners in the past 6 months				
0 partners	552 (1.2)	324 (1.4)	608 (1.2)	298 (1.2)
1 partner	11,986 (26.6)	5,369 (22.8)	3,795 (7.5)	1,173 (4.8)
2 partners	10,793 (24.0)	5,329 (22.6)	5,445 (10.8)	1,665 (6.8)
3 or more partners	20,125 (44.7)	12,457 (52.8)	40,442 (79.9)	21,173 (86.3)
Unknown	1,541 (3.4)	93 (0.4)	346 (0.7)	213 (0.9)
Receptive anal sex, in the past 6 months				
No receptive anal sex	35,495 (78.9)		14,835 (29.3)	4,387 (17.9)
Yes, consistently with a condom	1,148 (2.6)		5,138 (10.1)	1,184 (4.8)
Yes, not consistently with a condom	1,705 (3.8)		15,657 (30.9)	8,660 (35.3)
Yes, never with a condom	5,589 (12.4)		14,243 (28.1)	10,132 (41.3)
Unknown	1,060 (2.4)		763 (1.5)	159 (0.6)
Insertive anal sex, in the past 6 months				
No insertive anal sex		20,170 (85.6)	11,015 (21.8)	3,712 (15.1)
Yes, consistently with a condom		461 (2.0)	5,989 (11.8)	1,205 (4.9)
Yes, not consistently with a condom		829 (3.5)	17,058 (33.7)	8,821 (36.0)
Yes, never with a condom		1,669 (7.1)	15,930 (31.5)	10,626 (43.3)
Unknown		443 (1.9)	644 (1.3)	158 (0.6)
Vaginal sex, in the past 6 months*				
No vaginal sex	620 (1.4)	408 (1.7)	1,003 (10.9)	331 (15.7)
Yes, consistently with a condom	3,420 (7.6)	1,651 (7.0)	1,207 (13.1)	294 (14.0)
Yes, not consistently with a condom	15,898 (35.3)	9,825 (41.7)	2,623 (28.4)	583 (27.7)
Yes, never with a condom	24,511 (54.5)	11,465 (48.6)	3,288 (35.6)	839 (39.8)
Unknown	548 (1.2)	223 (0.9)	1,114 (12.1)	60 (2.8)
Receptive oral sex, in the past 6 months				
No receptive oral sex	4,582 (10.2)		2,856 (5.6)	643 (2.6)
Yes, consistently with a condom	1,041 (2.3)		352 (0.7)	92 (0.4)
Yes, not consistently with a condom	3,524 (7.8)		4,620 (9.1)	1,279 (5.2)
Yes, never with a condom	34,662 (77.0)		42,053 (83.0)	22,338 (91.1)
Unknown	1,188 (2.6)		755 (1.5)	170 (0.7)

Characteristic	Women	MSW	MSM-STI consultation	MSM-PrEP consultation
	n (%)	n (%)	n (%)	n (%)
Previous HIV test				
No	29,297 (65.1)	17,566 (74.5)	5,917 (11.7)	445 (1.8)
Yes, positive	40 (0.1)	27 (0.1)	4,113 (8.1)	
Yes, negative	14,195 (31.5)	5,277 (22.4)	40,180 (79.4)	24,031 (98.0)
Yes, result unknown	85 (0.2)	54 (0.2)	106 (0.2)	34 (0.1)
Unknown	1,380 (3.1)	648 (2.7)	320 (0.6)	12 (0.0)

* *For MSM: numbers are reported for men who had sex with both men and women. Men who had sex with men only are excluded.*

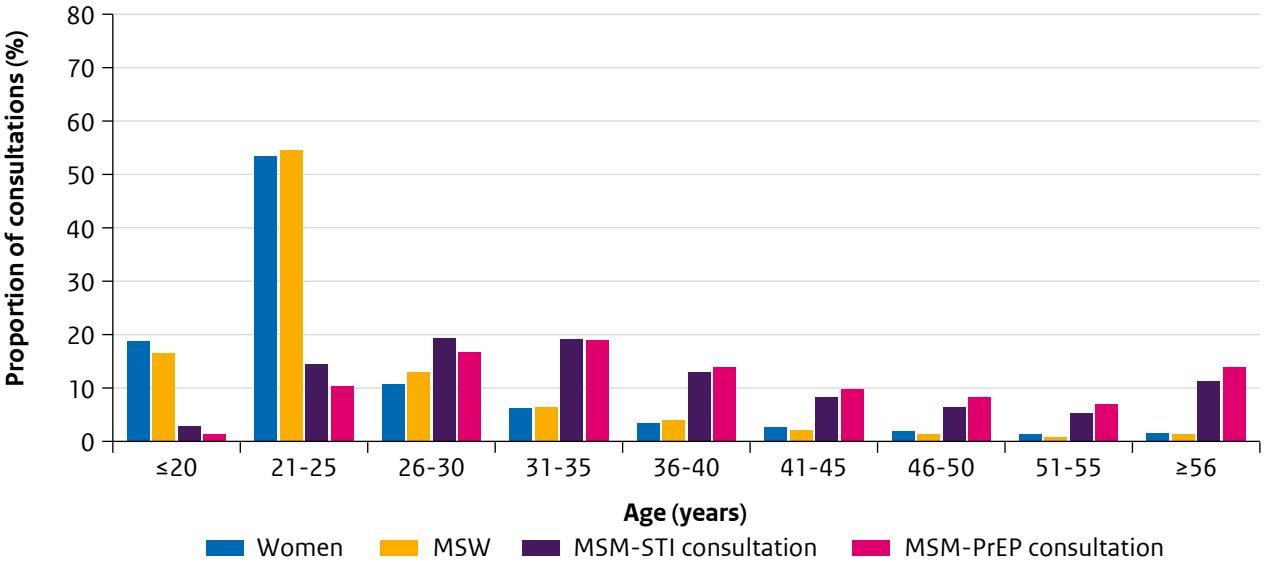
Table 2.10 Sexual behavioural characteristics among MSM: number and proportion of consultations and STI positivity by sex and type of sexual contact, 2025

Characteristic	MSM-STI consultation		MSM-PrEP consultation	
	n (%)	% STI	n (%)	% STI
Anal sex, in the past 6 months				
No	4,011 (7.9)	8.8	625 (2.5)	5.0
Receptive anal sex only	7,030 (13.9)	17.6	3,102 (12.6)	13.1
Insertive anal sex only	10,969 (21.7)	15.6	3,778 (15.4)	10.1
Both insertive and receptive	28,008 (55.3)	23.8	16,874 (68.8)	18.6
Unknown	618 (1.2)	18.0	143 (0.6)	5.6
Group sex				
Yes	16,832 (33.2)	26.3	10,984 (44.8)	20.8
No	31,719 (62.6)	17.0	13,299 (54.2)	12.4
Unknown	2,085 (4.1)	12.7	239 (1.0)	16.7
Injected/slammed drugs, in the past 6 months[1]				
No	15,180 (30.0)	26.7	10,385 (42.3)	20.4
Yes	410 (0.8)	35.6	355 (1.4)	27.9
Missing	27,701 (54.7)	16.4	10,763 (43.9)	12.4
Drug use in relation to sex, in the past 6 months[2]				
No	38,623 (76.3)	17.1	16,196 (66.0)	12.8
Yes	11,571 (22.9)	29.2	8,139 (33.2)	23.1
Unknown	442 (0.9)	20.1	187 (0.8)	13.4

Characteristic	MSM-STI consultation		MSM-PrEP consultation	
	n (%)	% STI	n (%)	% STI
Drugs type				
Alcohol	15,891 (31.4)	22.1	7,591 (31.0)	18.0
Erection stimulants	4,610 (9.1)	27.0	3,691 (15.1)	18.7
Cocaine	3,370 (6.7)	24.7	1,893 (7.7)	21.2
XTC/MDMA	4,991 (9.9)	25.1	3,671 (15.0)	19.5
Speed	1,598 (3.2)	28.4	970 (4.0)	24.2
Heroin	11 (0.0)	45.5	9 (0.0)	11.1
Crystal Meth	565 (1.1)	34.0	444 (1.8)	28.4
Mephedrone	544 (1.1)	32.9	367 (1.5)	27.0
3-MMC	6,257 (12.4)	35.5	4,675 (19.1)	27.5
4-MEC	125 (0.2)	28.0	110 (0.4)	20.9
4-FA	50 (0.1)	32.0	42 (0.2)	21.4
GHB/GBL	4,548 (9.0)	33.0	4,007 (16.3)	24.8
Ketamine	2,273 (4.5)	29.5	1,639 (6.7)	24.2
Poppers	7,827 (15.5)	26.9	5,234 (21.3)	20.1
Cannabis/hashish	4,636 (9.2)	24.0	2,475 (10.1)	17.9
Other	152 (0.3)	27.0	201 (0.8)	20.9
Recent PrEP use				
Yes	15,395 (30.4)	25.1	20,701 (84.4)	16.9
No	31,103 (61.4)	16.0	3,821 (15.6)	12.2
Known HIV-positive, not eligible	4,112 (8.1)	29.6		
Antibiotic prophylaxis use				
No	46,241 (91.3)	19.9	23,083 (94.1)	16.0
Yes, Doxycycline (DoxyP(r)EP)	2,065 (4.1)	20.4	865 (3.5)	21.0
Yes, another antibiotic	377 (0.7)	24.4	161 (0.7)	16.1
Unknown	1,928 (3.8)	18.7	410 (1.7)	17.3

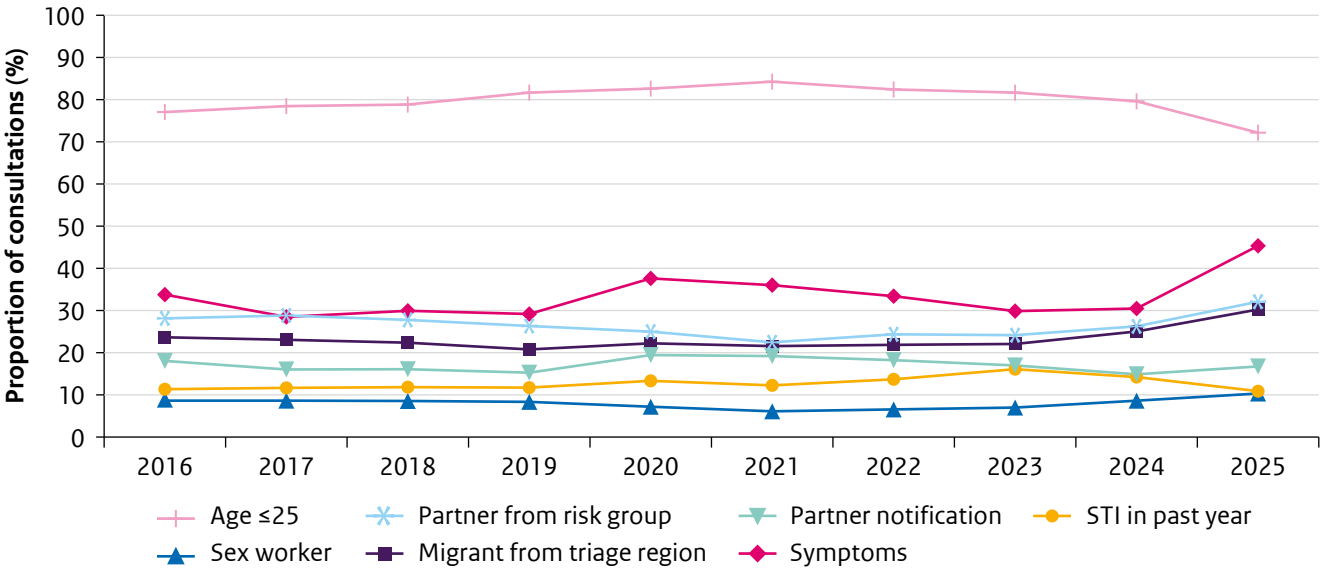
1 *Data not obligatory to collect.*
2 *Included drugs are cocaine, XTC/MDMA/Speed, Heroin, Crystal Meth, Mephedrone, 3-MMC, 4-MEC, 4-FA, GHB/GBL and ketamine.*
Footnote: STI include chlamydia, gonorrhoea, infectious syphilis, HIV and infectious hepatitis B.

Figure 2.3 Age: proportion of consultations by age group, sex, and type of sexual contact, 2025



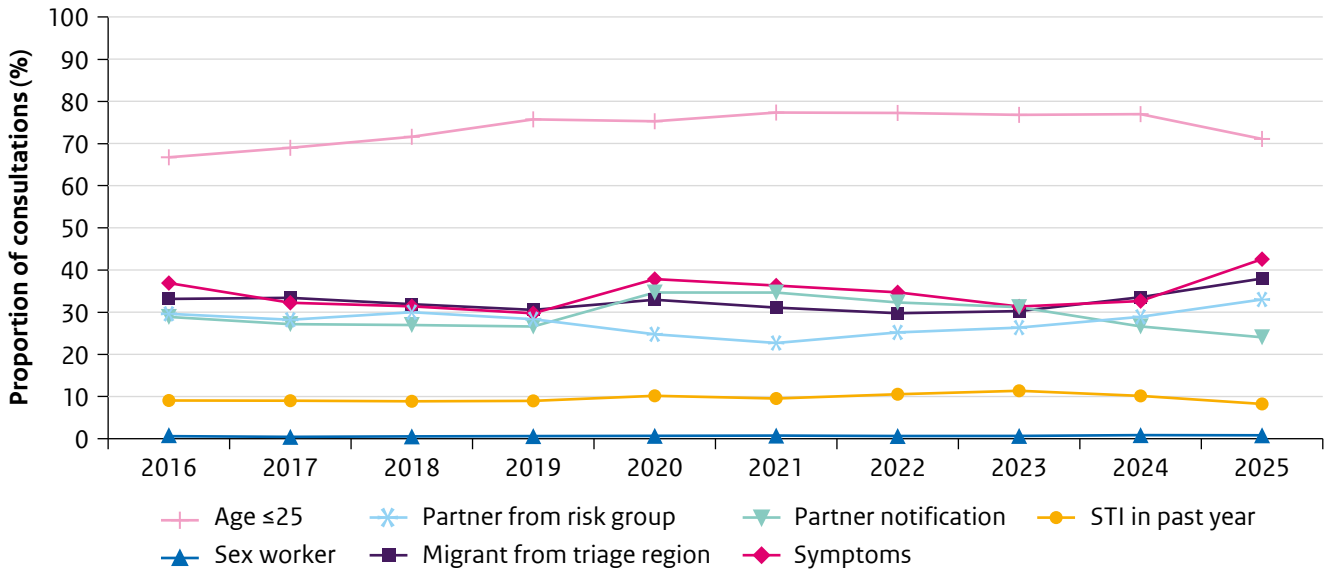
2.5 Trends in characteristics of Sexual Health Centre attendees

Figure 2.4a Reported triage indication: proportion of consultations with triage indication, women, 2016-2025



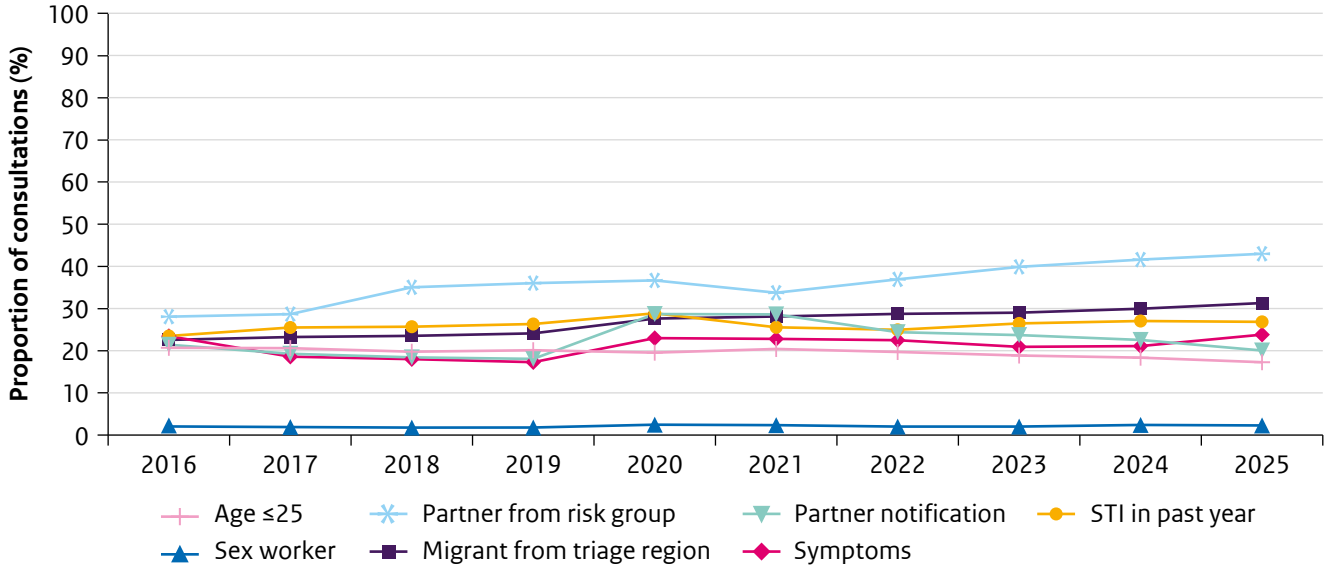
Footnote 1: Migrant from triage region includes migrants and children of migrants from Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.
Footnote 2: Partner from risk group: partner originating from a region of origin as indicated by triage criteria or a male partner who had sex with men.
Footnote 3: Multiple triage indications can be registered in one consultation. Therefore, the proportions do not add up to 100%.

Figure 2.4b Reported triage indication: proportion of consultations with triage indication, MSW, 2016-2025



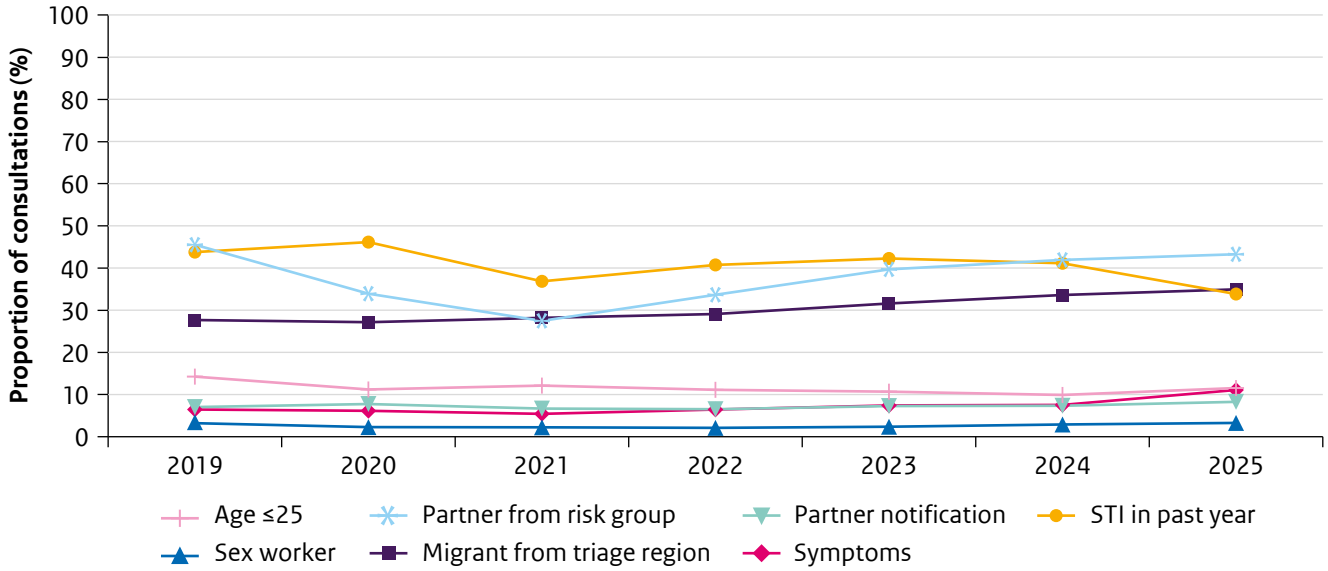
Footnote 1: Migrant from triage region includes migrants and children of migrants from Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.
Footnote 2: Partner from risk group: partner originating from a region of origin as indicated by triage criteria.
Footnote 3: Multiple triage indications can be registered in one consultation. Therefore, the proportions do not add up to 100%.

Figure 2.4c Reported triage indication: proportion of consultations with triage indication, MSM-STI consultations, 2016-2025



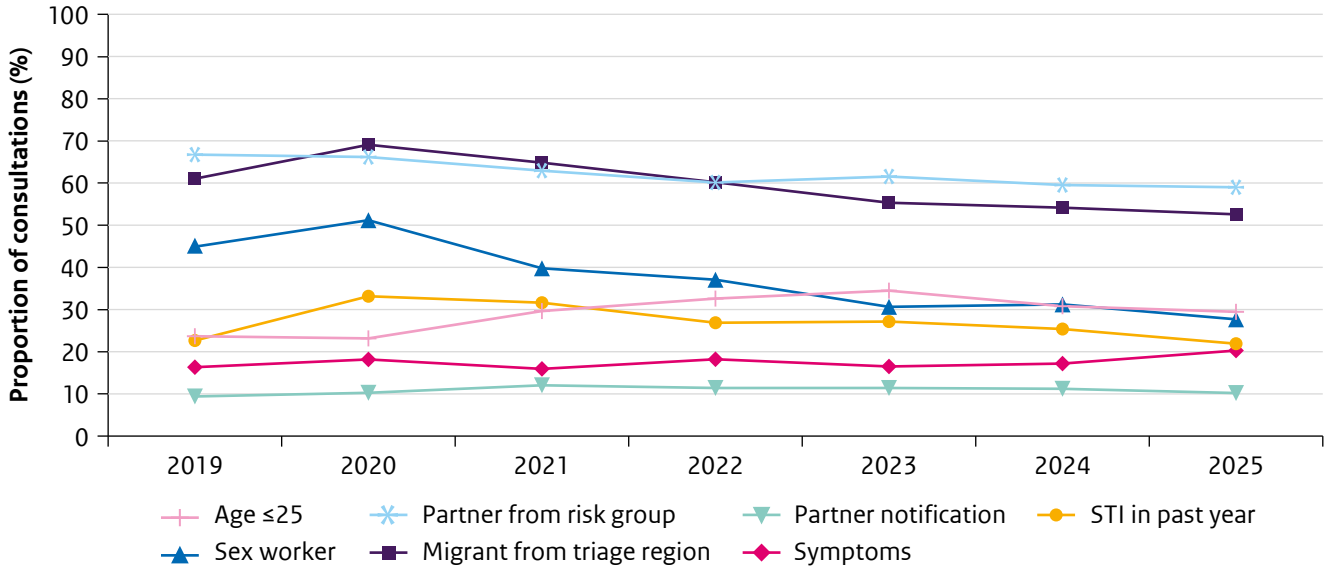
Footnote 1: Migrant from triage region includes migrants and children of migrants from Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.
Footnote 2: Partner from risk group: partner originating from a region of origin as indicated by triage criteria.
Footnote 3: Multiple triage indications can be registered in one consultation. Therefore, the proportions do not add up to 100%.

Figure 2.4d Reported triage indication: proportion of consultations with triage indication, MSM-PrEP consultations, 2019-2025



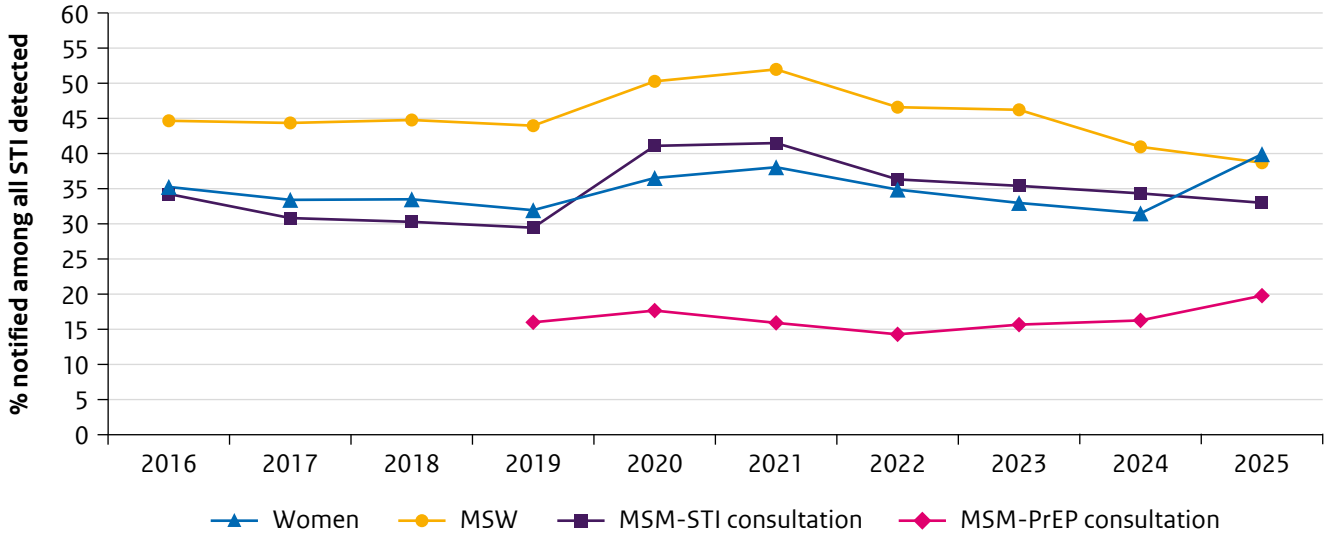
Footnote 1: Migrant from triage region includes migrants and children of migrants from Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.
Footnote 2: Partner from risk group: partner originating from a region of origin as indicated by triage criteria.
Footnote 3: Multiple triage indications can be registered in one consultation. Therefore, the proportions do not add up to 100%.

Figure 2.4e Reported triage indication: proportion of consultations with triage indication, gender diverse persons, 2019-2025



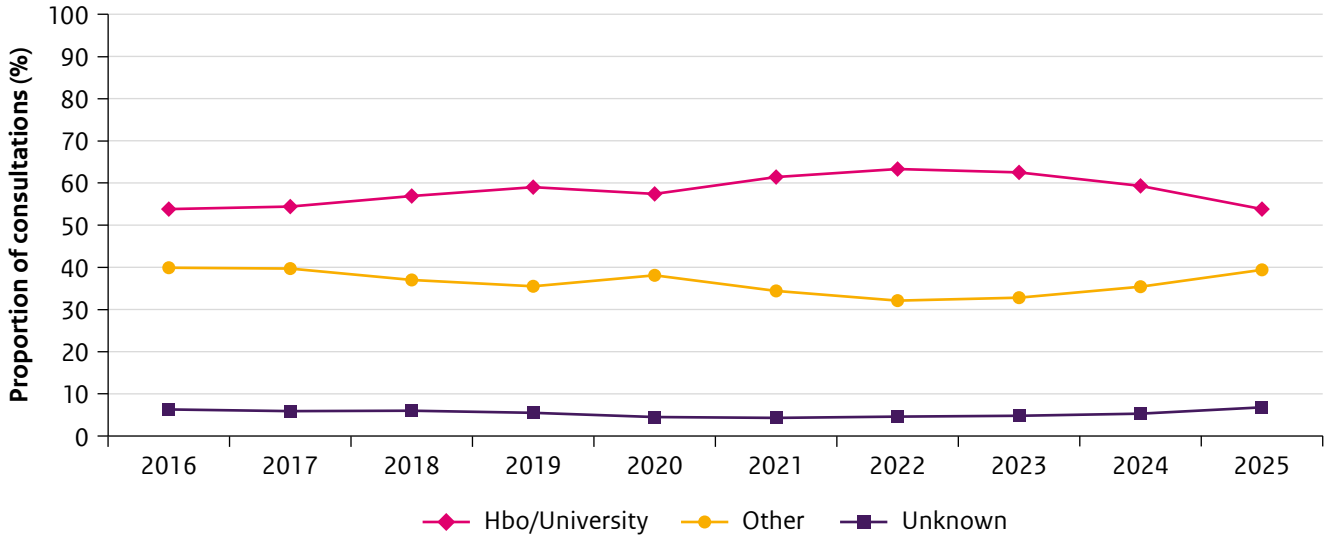
Footnote 1: Migrant from triage region includes migrants and children of migrants from Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.
Footnote 2: Partner from risk group: partner originating from a region of origin as indicated by triage criteria.
Footnote 3: Multiple triage indications can be registered in one consultation. Therefore, the proportions do not add up to 100%.

Figure 2.5 Partner notification: proportion of STI detected through partner notification by sex and sexual contact, 2016-2025



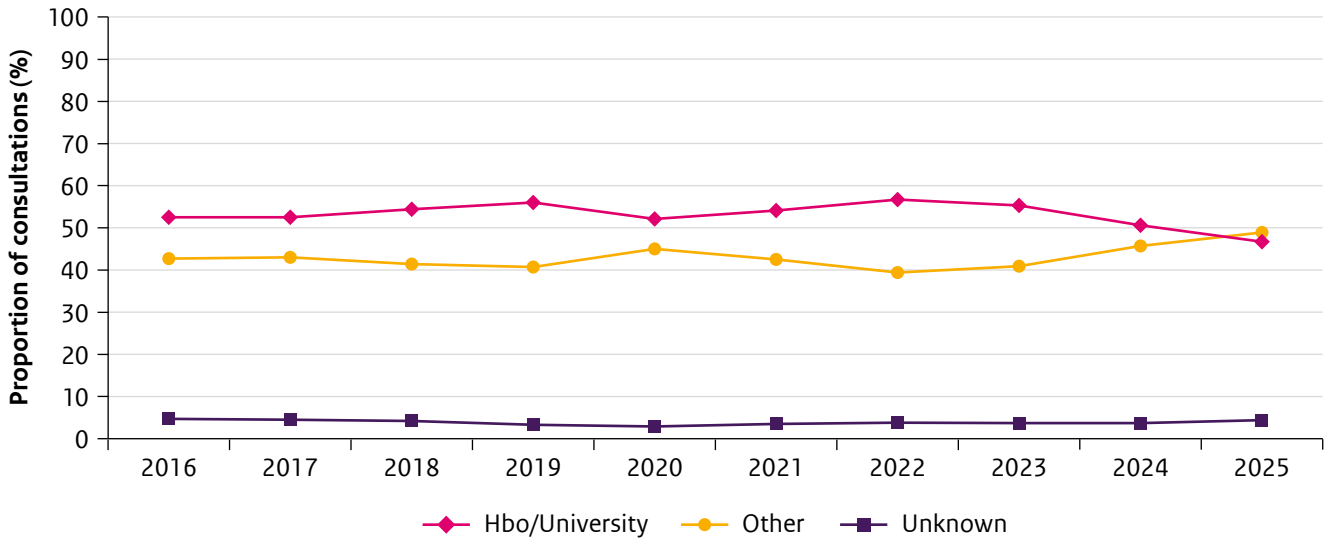
Footnote: STI include chlamydia, gonorrhoea, infectious syphilis, HIV and infectious hepatitis B.

Figure 2.6a Education level: proportion of consultations by education level, women, 2016-2025



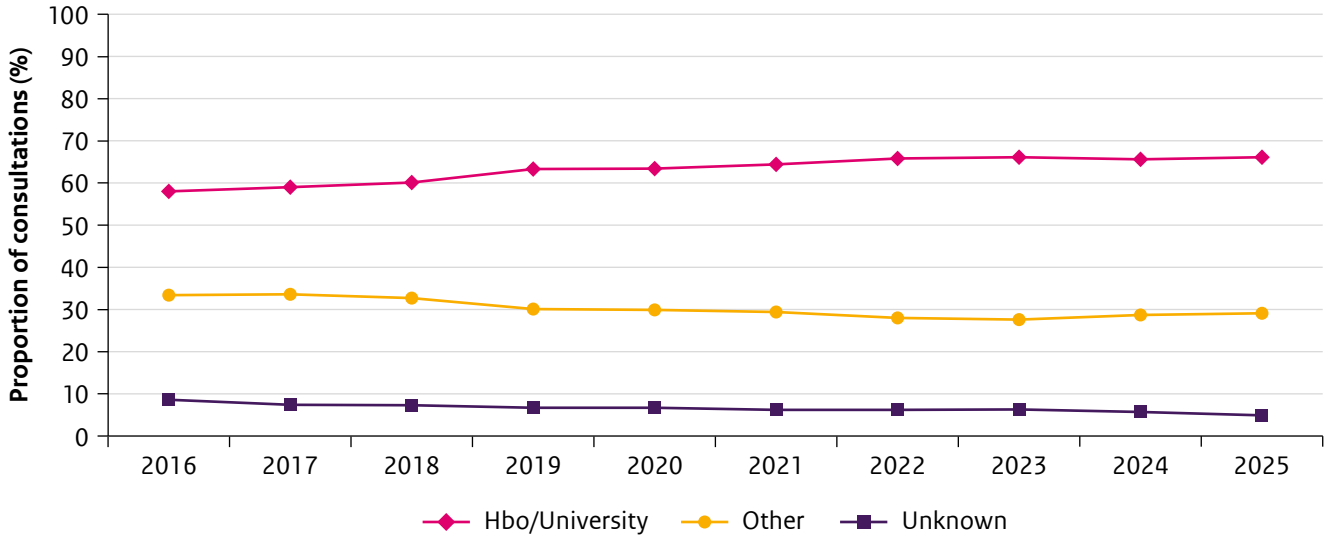
Footnote 1: Other education includes: no education, elementary school, lbo, mavo, vmbo, mbo, havo, vwo.
Footnote 2: Additional information on STI positivity and education level is shown in supplementary table 13.3.

Figure 2.6b Education level: proportion of consultations by education level, MSW, 2016-2025



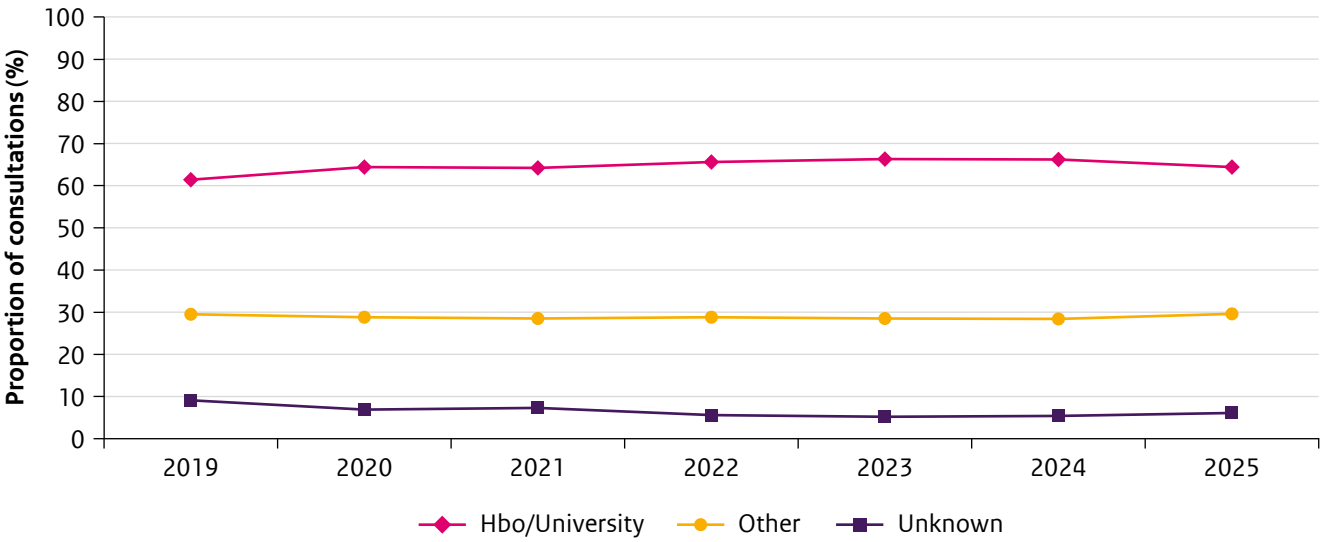
Footnote 1: Other education includes: no education, elementary school, lbo, mavo, vmbo, mbo, havo, vwo.
Footnote 2: Additional information on STI positivity and education level is shown in supplementary table 13.3.

Figure 2.6c Education level: proportion of consultations by education level, MSM-STI consultations, 2016-2025



Footnote 1: Other education includes: no education, elementary school, lbo, mavo, vmbo, mbo, havo, vwo.
Footnote 2: Additional information on STI positivity and education level is shown in supplementary table 13.3.

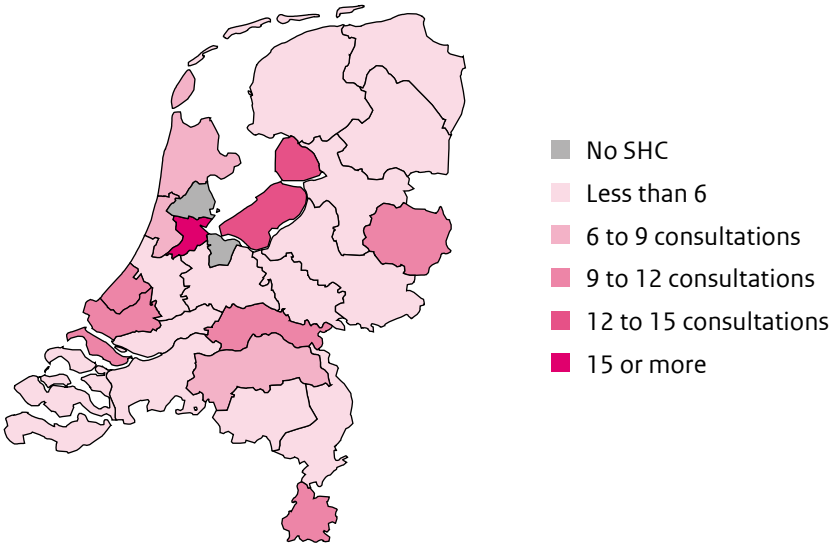
Figure 2.6d Education level: proportion of consultations by education level, MSM-PrEP consultations, 2019-2025



Footnote 1: Other education includes: no education, elementary school, lbo, mavo, vmbo, mbo, havo, vwo.
Footnote 2: Additional information on STI positivity and education level is shown in supplementary table 13.3.

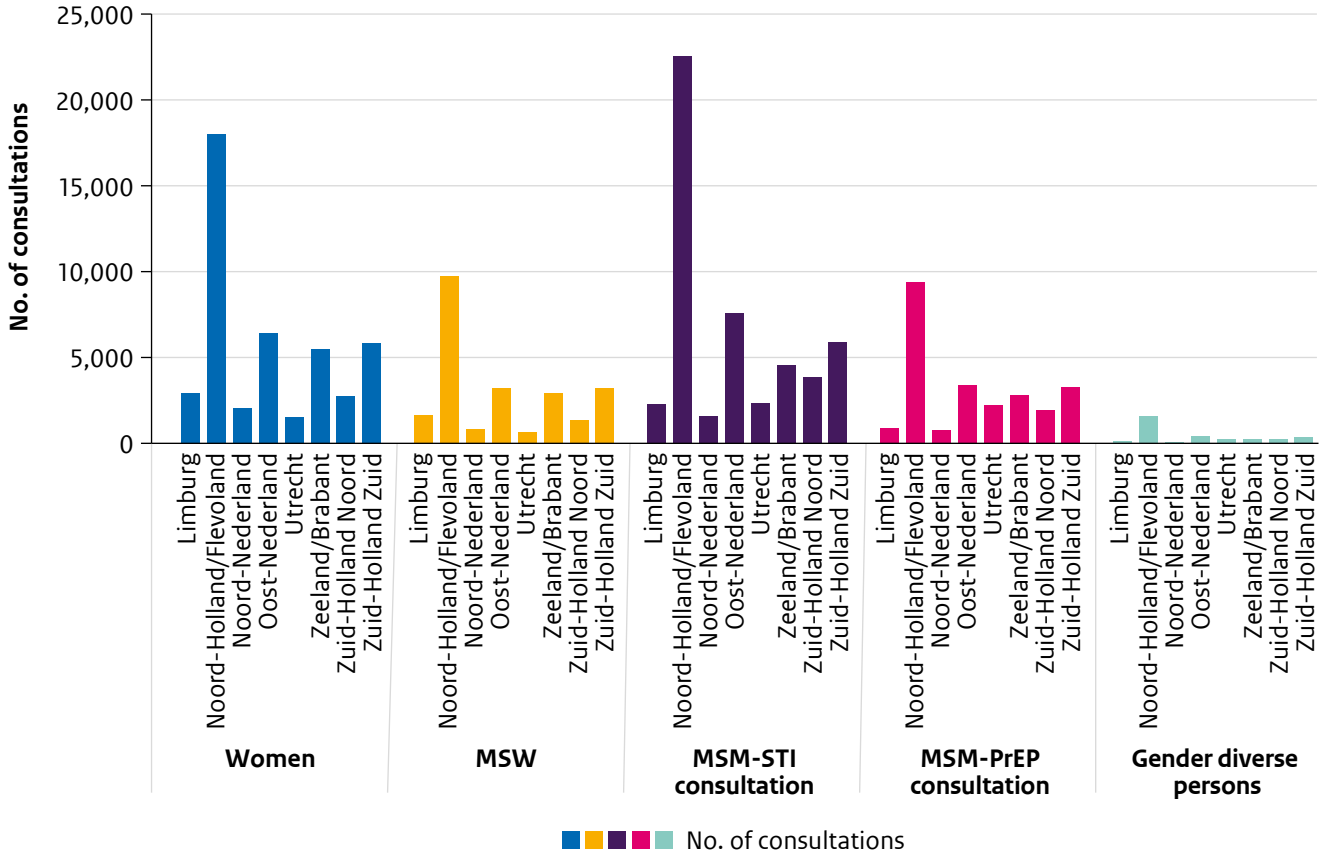
2.6 Consultations and characteristics at Sexual Health Centres by region

Figure 2.7 Number of persons with at least one SHC consultation per 1000 inhabitants aged 15-65 years by region, 2025



Footnote 1: GGD Amsterdam = 37.6 per 1000 inhabitants.
Footnote 2: GGD Gooi & Vechtstreek does not have an SHC, persons from this area can be tested at an SHC in surrounding regions.
Footnote 3: Consultations from GGD Zaanstreek-Waterland are registered at GGD Amsterdam.

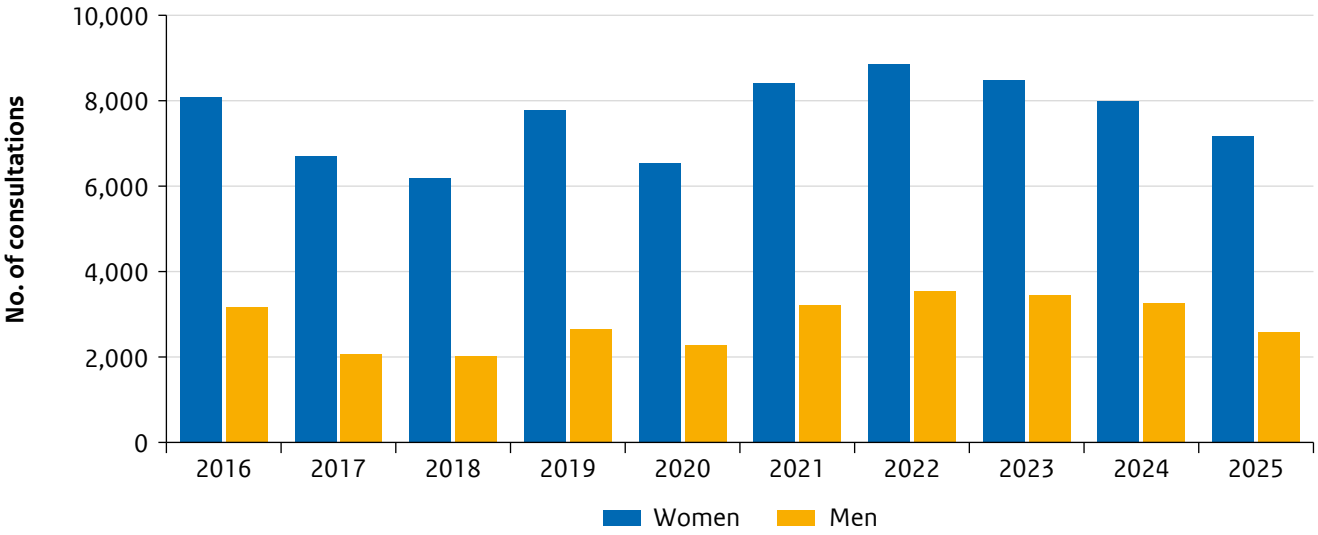
Figure 2.8 Region: number of consultations by region, sex and type of sexual contact, 2025



Footnote: Characteristics of SHC visitors by region are shown in supplementary figures 13.1 through 13.3.

2.7 Sense consultations at Sexual Health Centres

Figure 2.9 Sense: number of consultations by sex, 2016-2025



Footnote: Consultations in gender diverse persons were excluded from the figure. There were 662 consultations in 2025, which is a 12% decrease compared to 2024 (n=754).

Table 2.11 Sense: number and proportion of consultations by demographic and sex, 2025

Demographic	Women	Men	Gender diverse persons
	n (%)	n (%)	n (%)
Total	**7173**	**2589**	**662**
Age			
≤15	132 (1.8)	18 (0.7)	
16-20	1,778 (24.8)	452 (17.5)	55 (8.3)
21-25	3,290 (45.9)	1,085 (41.9)	189 (28.5)
≥26	1,972 (27.5)	1,033 (39.9)	418 (63.1)
Region of origin			
The Netherlands	3,419 (47.7)	1,155 (44.6)	111 (16.8)
Turkey	193 (2.7)	97 (3.7)	23 (3.5)
Morocco	206 (2.9)	105 (4.1)	10 (1.5)
Suriname	468 (6.5)	166 (6.4)	49 (7.4)
CAS-BES islands	281 (3.9)	68 (2.6)	32 (4.8)
Indonesia	50 (0.7)	32 (1.2)	14 (2.1)
Eastern Europe	561 (7.8)	143 (5.5)	82 (12.4)
Europe other	548 (7.6)	237 (9.2)	65 (9.8)
Africa other	446 (6.2)	140 (5.4)	26 (3.9)
Asia other	360 (5.0)	261 (10.1)	129 (19.5)
Latin America other	487 (6.8)	139 (5.4)	99 (15.0)
North-America/Oceania	97 (1.4)	34 (1.3)	18 (2.7)
Unknown	57 (0.8)	12 (0.5)	4 (0.6)

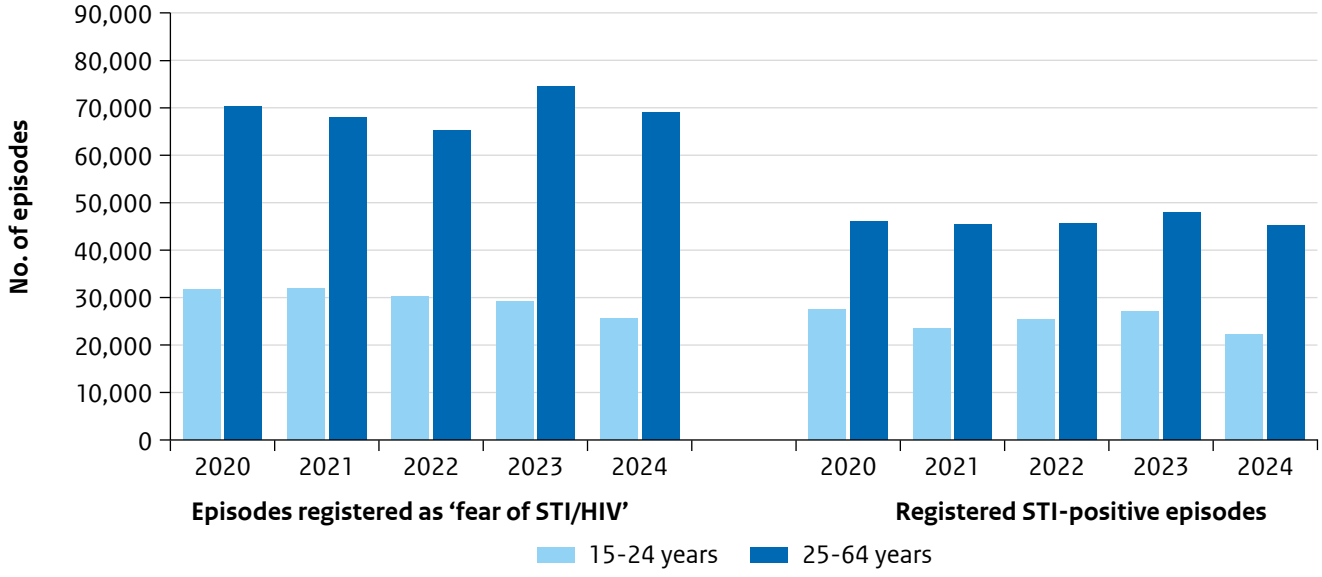
Table 2.12 Sense: subjects discussed during consultations by sex, 2025

Subject	Women	Men	Gender diverse persons
	n (%)	n (%)	n (%)
Total	**8,056**	**2,776**	**717**
STI	374 (4.6)	393 (14.2)	20 (2.8)
Sexuality	1,773 (22.0)	1,560 (56.2)	105 (14.6)
Human body	372 (21.0)	94 (6.0)	5 (4.8)
Sexual dysfunction	768 (43.3)	645 (41.3)	39 (37.1)
Sexual orientation	23 (1.3)	174 (11.2)	7 (6.7)
Sexual behaviour/sex techniques	286 (16.1)	320 (20.5)	39 (37.1)
Unknown/other	380 (21.4)	368 (23.6)	20 (19.0)
Birth control	2,816 (35.0)	35 (1.3)	29 (4.0)
Unwanted sexual behaviour/sexual violence	1,404 (17.4)	365 (13.1)	80 (11.2)
Unintended pregnancy	815 (10.1)	9 (0.3)	3 (0.4)
Gender	3 (0.0)	22 (0.8)	420 (58.6)
Other	871 (10.8)	392 (14.1)	60 (8.4)

Footnote: Number of topics does not add up to the total number of consultations, as for some consultations multiple topics were registered.

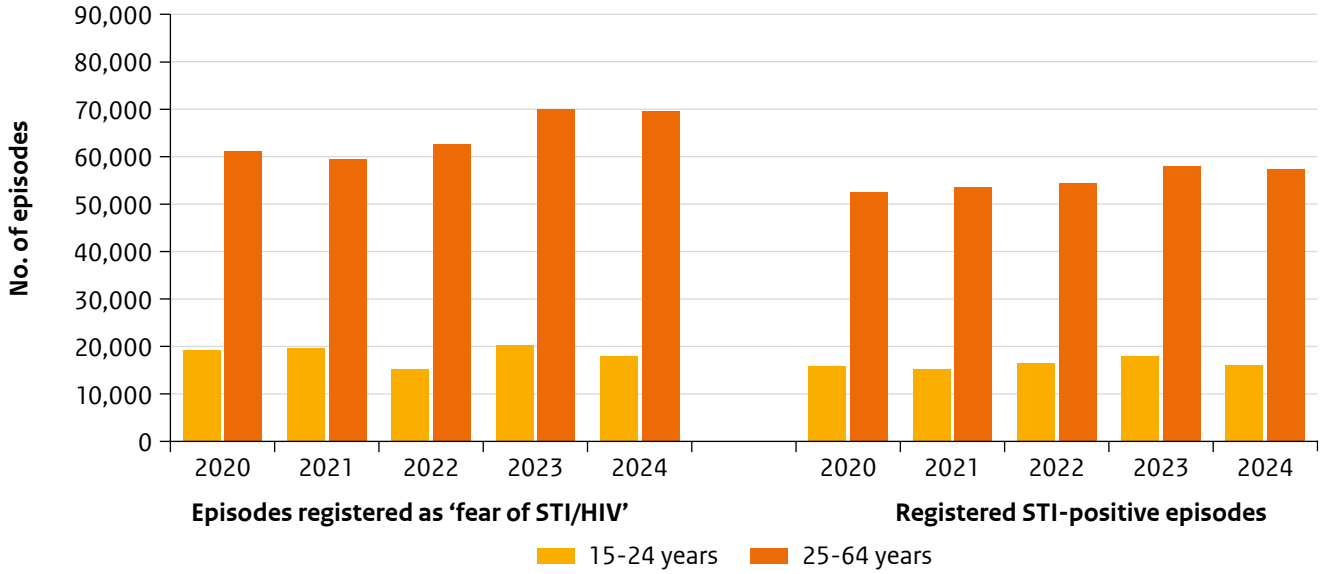
2.8 General practices

Figure 2.10a Estimated number of episodes of fear of STI/HIV and positive STI diagnoses among women in general practices by age group, based on general practices in Nivel-PCD, 2020-2024



Footnote 1: Diagnoses included are chlamydia, gonorrhoea, syphilis, HIV, trichomonas, genital herpes, genital warts, non-specific urethritis.
Footnote 2: About 50% of the total Dutch population consists of persons aged 25-64 years and about 10% consists of persons aged 15-24 years.

Figure 2.10b Estimated number of episodes of fear of STI/HIV and positive STI diagnoses among men in general practices by age group, based on general practices in Nivel-PCD, 2020-2024



Footnote 1: Diagnoses included are chlamydia, gonorrhoea, syphilis, HIV, trichomonas, genital herpes, genital warts, non-specific urethritis.
Footnote 2: About 50% of the total Dutch population consists of persons aged 25-64 years and about 10% consists of persons aged 15-24 years.

Table 2.13 Reporting rate (number of STI-related episodes per 1000 persons aged 15-64 years) of STI-diagnoses and fear of STI/HIV at general practices in the Netherlands by sex and age group, based on general practices in Nivel-PCD, 2020-2024

Year	Women n/1,000			Men n/1,000			Total n/1,000		
	All	15-24	25-64	All	15-24	25-64	All	15-24	25-64
2020	**31.1**	56.4	25.5	**26.2**	32.1	24.8	**28.7**	44.3	25.1
2021	**29.9**	52.9	24.8	**26.0**	32.0	24.6	**28.0**	42.5	24.7
2022	**29.4**	52.6	24.2	**26.8**	33.0	25.4	**28.1**	42.8	24.8
2023	**31.1**	52.3	26.4	**28.8**	34.5	27.5	**29.9**	43.4	26.9
2024	**28.1**	44.2	24.5	**27.7**	30.3	27.0	**27.9**	37.3	25.8

Footnote: Diagnoses included are chlamydia, gonorrhoea, syphilis, HIV, trichomonas, genital herpes, genital warts, non-specific urethritis.

2.9 Sexual health in the Health Survey

Table 2.14 Sexual behavioural characteristics of respondents to the national Health Survey by sex and sexual orientation, 2024

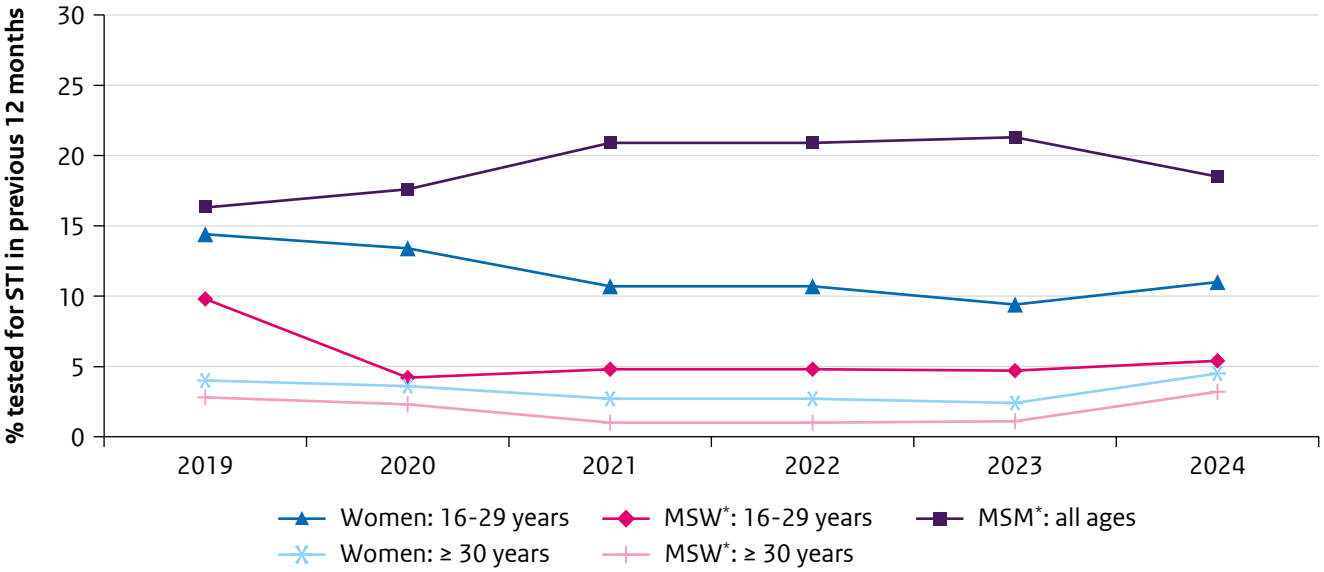
Characteristic	Women (%)	MSW (%)	MSM[1] (%)
Total	**4,116**	**3,508**	**159**
Two or more sex partners in the past 12 months			
Total	**4.0**	**4.3**	**22.6**
16-29 years	14.0	11.9	
30-44 years	4.3	6.3	
45-59 years	2.0	2.5	
60 years and older	0.3	1.0	
Sexual contact with a casual partner in the past 12 months			
Total	**4.9**	**6.0**	**26.4**
16-29 years	15.7	16.6	
30-44 years	5.8	8.1	
45-59 years	2.6	4.1	
60 years and older	0.6	1.2	
Sexual contact with a steady partner in the past 12 months			
Total	**53.0**	**58.5**	**31.4**
16-29 years	49.7	39.6	
30-44 years	76.3	75.7	
45-59 years	62.9	73.6	
60 years and older	35.3	48.5	
Condom use with a casual partner in the past 12 months[2]			
Total	**32.5**	**38.3**	

Source: Health Survey/Lifestyle Monitor, CBS in collaboration with RIVM, Rutgers and Soa Aids Nederland, 2024.

1 *The questionnaire scored respondents' sexual attraction as own sex, opposite sex or both; we included men attracted to women only in the category 'MSW', and men attracted to men or men attracted to both sexes in the category 'MSM'. No subcategories are shown for MSM due to low numbers (n≤50).*

2 *No subcategories are shown for the characteristic 'Condom use with a casual partner in the past 12 months' due to low numbers in women and MSW (n≤50). No percentage is shown for MSM due to low numbers (n≤50).*

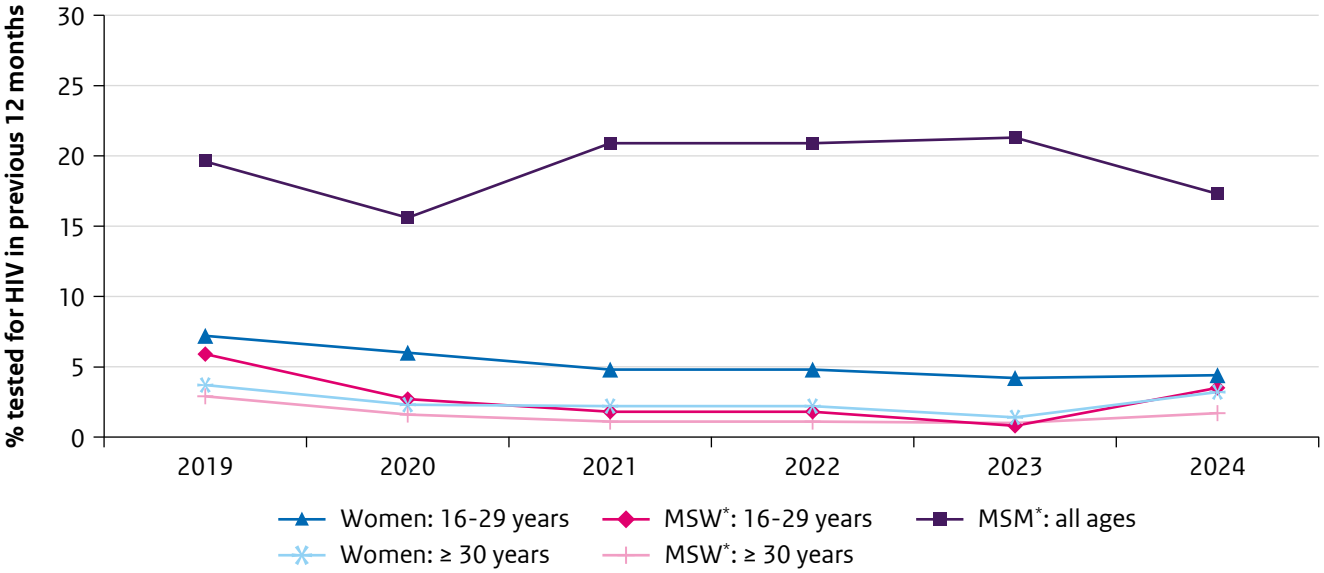
Figure 2.11 Proportion tested for STI in the previous year in the Health Survey, by age group, sex and sexual orientation, 2019-2024



Source: Health Survey/Lifestyle Monitor, CBS in collaboration with RIVM, Rutgers and Soa Aids Nederland.

* *The questionnaire scored respondents' sexual attraction as own sex, opposite sex or both; we included men attracted to women only in the category 'MSW', and we included men attracted to men or men attracted to both sexes in the category 'MSM'. No age groups are shown for MSM due to low numbers.*

Figure 2.12 Proportion tested for HIV in the previous year in the Health Survey, by age group, sex and sexual orientation, 2019-2024

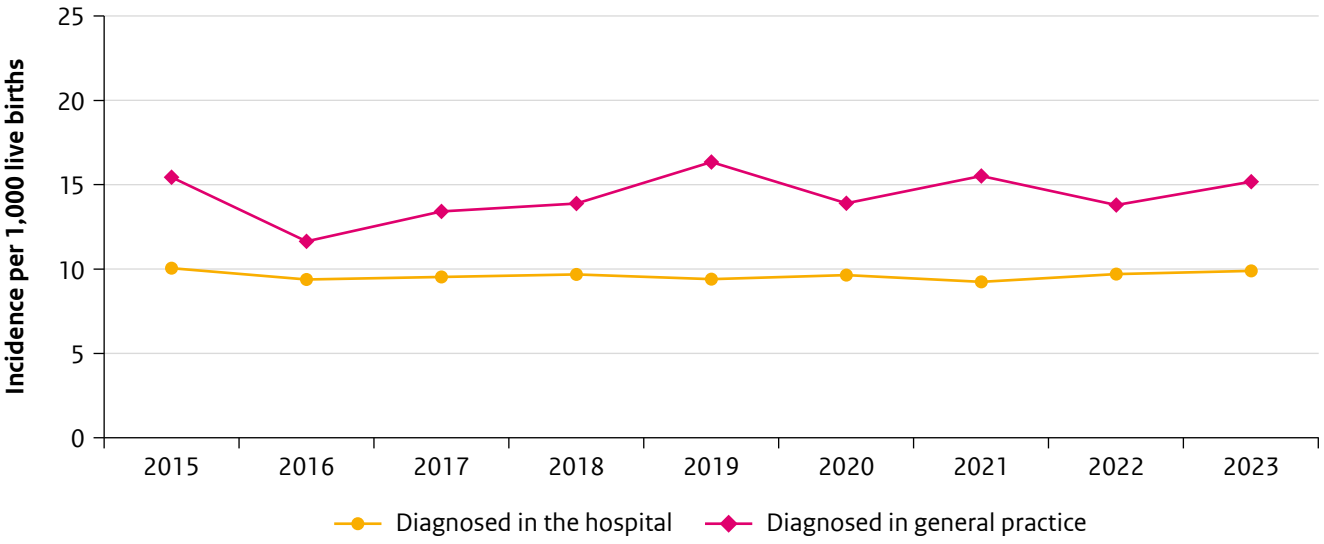


Source: Health Survey/Lifestyle Monitor, CBS in collaboration with RIVM, Rutgers and Soa Aids Nederland.

* *The questionnaire scored respondents' sexual attraction as own sex, opposite sex or both; we included men attracted to women only in the category 'MSW', and we included men attracted to men or men attracted to both sexes in the category 'MSM'. No age groups are shown for MSM due to low numbers.*

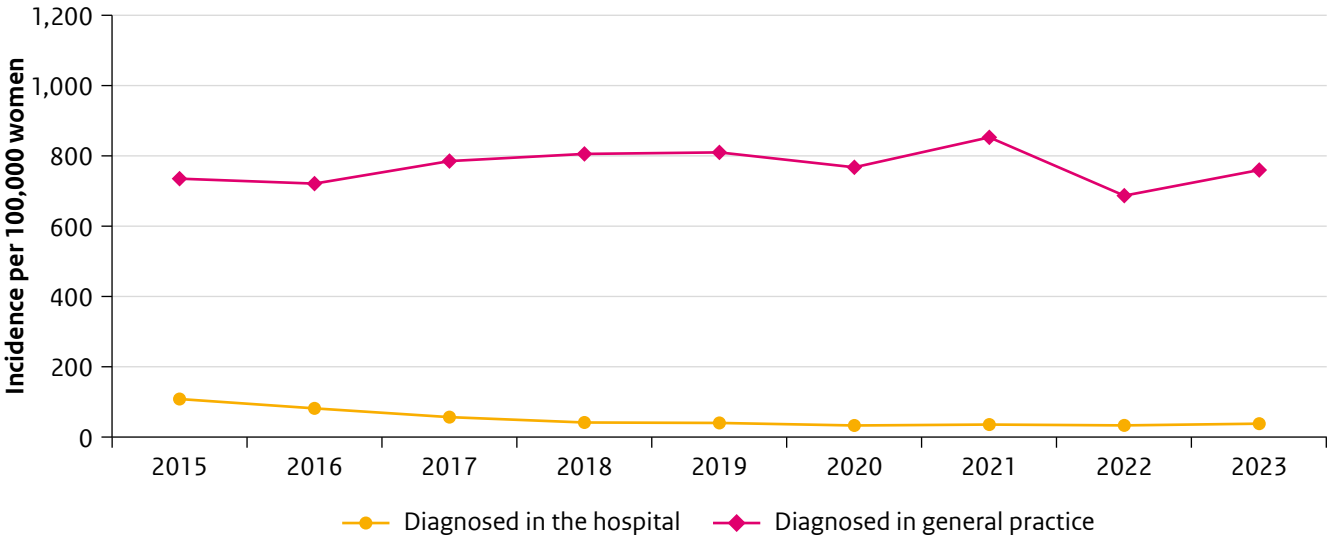
2.10 STI related complications

Figure 2.13 Incidence of ectopic pregnancy in women aged 15-49 years, by location, 2015-2023



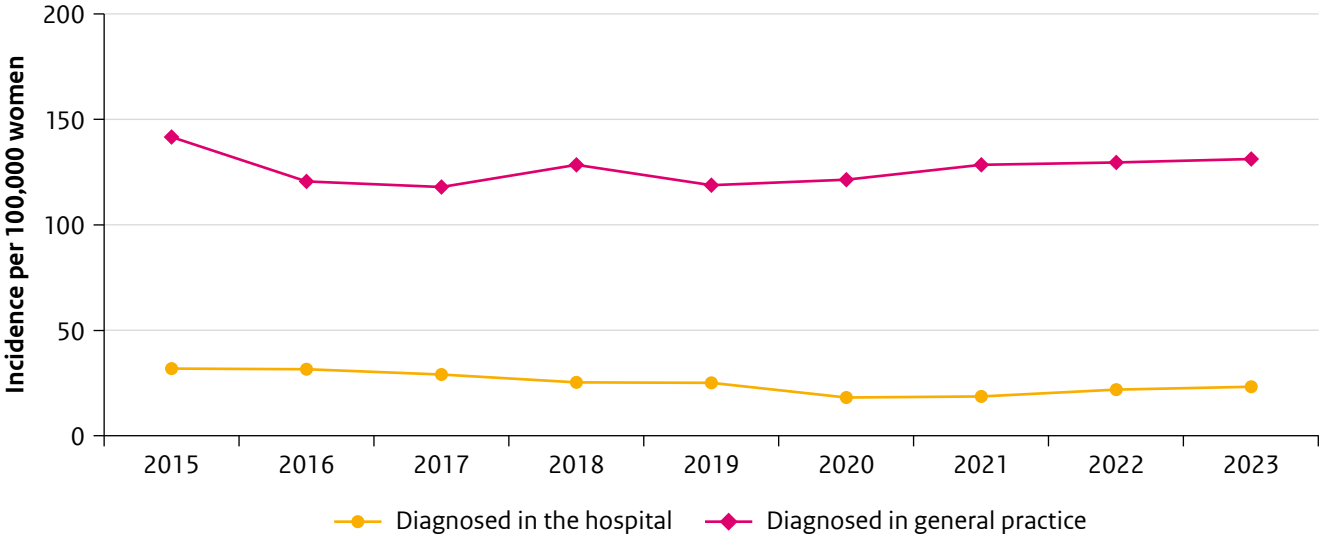
Source: Nivel-PCD and DHD
Footnote: All-cause ectopic pregnancy in women aged 15-49 years old.

Figure 2.14 Incidence of infertility in women aged 15-49 years, by location, 2015-2023



Source: Nivel-PCD and DHD
Footnote: All-cause infertility in women aged 15-49 years old.

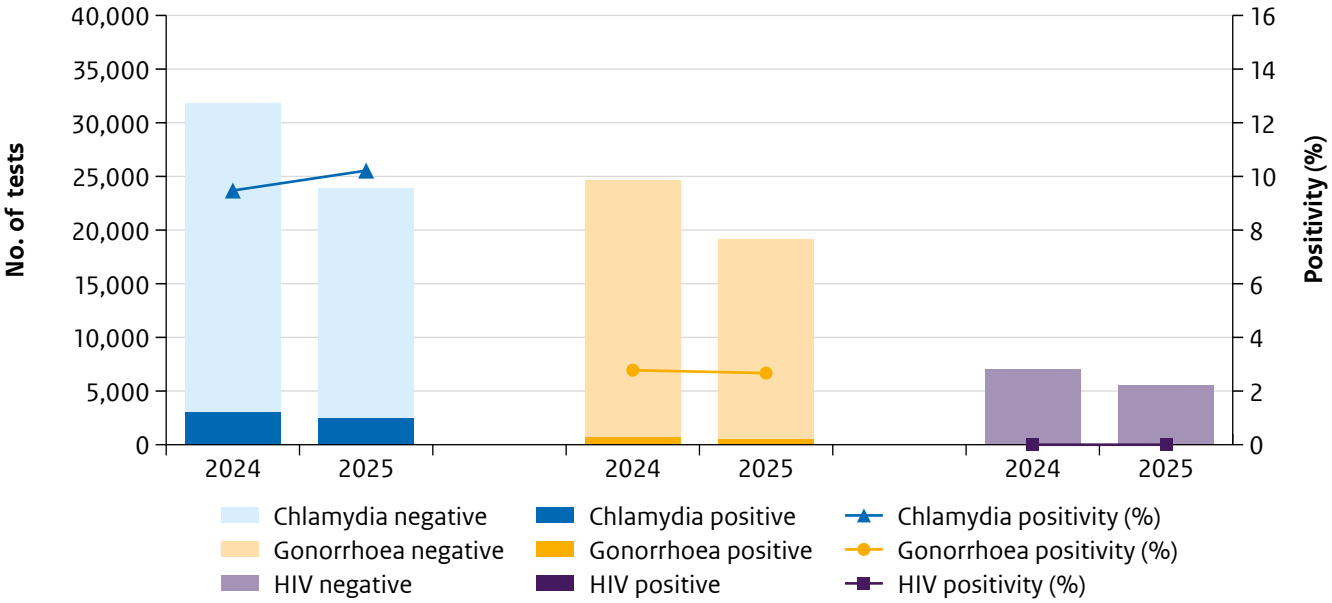
Figure 2.15 Incidence of pelvic inflammatory disease in women aged 15-49 years, by location, 2015-2023



Source: Nivel-PCD and DHD
Footnote: All-cause PID in women aged 15-49 years old.

2.11 Private home testing providers

Figure 2.16 Number of tests registered by the SANL recommended private home testing providers, by STI, 2024-2025



Source: SoaPoli Noord, SoaPoli Online, and SoaStudentArts
Footnote: HIV diagnoses lower than five were not disclosed, which leads to no diagnoses in the figure.

3 PrEP

3.1 Key points

3.1.1 Sexual Health Centres

- The PrEP pilot was conducted at SHCs from August 2019 to July 2024, after which it transitioned to a continuing PrEP programme on 1 August 2024. The current PrEP programme has no participation limit, and PrEP medication is no longer provided at reduced cost. For more information, see Chapter 1.
- In this chapter, 'PrEP programme' refers to all PrEP care offered at SHCs. This includes PrEP consultations conducted at SHCs as part of the PrEP pilot and the ongoing PrEP programme, as well as additional PrEP consultations offered by a number of SHCs outside of these programmes. Consultations for clients who obtained PrEP from other healthcare providers are not included due to limited information in SOAP. In Chapters 4-7, MSM-STI consultations or Testlab consultations among MSM participating in the PrEP programme are reported separately, and consultations among gender diverse participants are excluded due to low numbers.

3.1.2 Consultations

- In 2025, persons receiving PrEP care at SHCs had a total of 29,225 consultations (Figure 3.1). This includes 358 PrEP consultations at SHCs that offered additional PrEP care outside of the PrEP programme. The number of consultations in 2025 was 7% lower than in 2024 (n=31,277).
- In 2025, 14% (n=3952) of all PrEP consultations were PrEP start consultations, while 73% (n=21,393) were PrEP follow-up consultations (Figure 3.1). In addition to their PrEP consultations, PrEP programme participants can undergo STI testing at their SHC between PrEP consultations, for instance following an STI notification from a partner or STI-related symptoms. These consultations are registered as MSM-STI or Testlab consultations. In 2025, PrEP programme participants had 3522 MSM-STI or Testlab consultations (12% of all participant consultations), an 11% decrease from 2024 (n=3955).
- Throughout the PrEP programme, the proportion of consultations in which participants reported recent PrEP use in the past 3 months remained consistently high in 2025, at 95% (Figure 3.2).
- In 2025, event-driven PrEP was the most common mode (50%) among those reporting recent use (Figure 3.3). Daily PrEP use decreased from 63% in 2019 to 43% in 2025. Combined use, for example switching between daily and event-driven, was reported at 7% of consultations in 2025.
- Following updates to PrEP care guidelines, the interval between PrEP follow-up consultations has increased in recent years. The proportion of PrEP follow-up consultations scheduled at 3-month intervals was 5% in 2025, a decline from 77% in 2021 (Figure 3.4), while 6-month intervals became more common (81%).

3.1.3 Participants

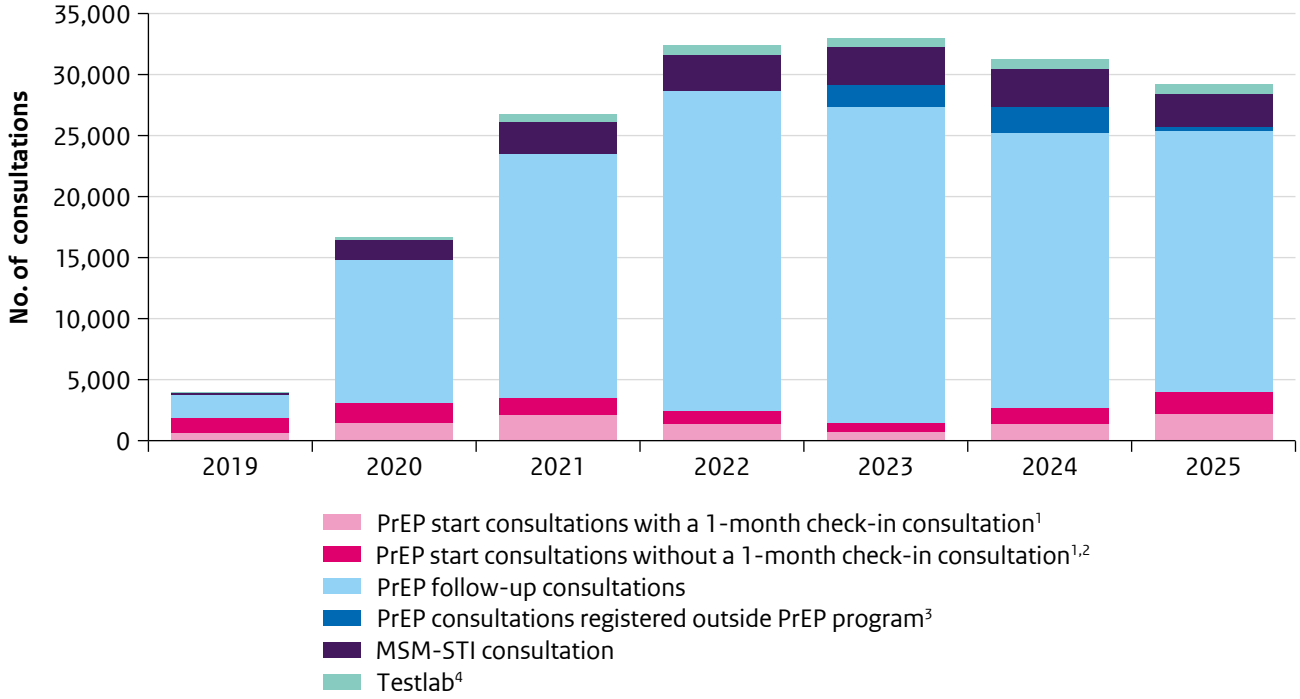
- A total of 13,669 persons participated in the PrEP programme in 2025, each having at least one PrEP consultation (Figure 3.5).
- In 2025, 3674 new participants joined the PrEP programme, a 20% increase compared to 2024 (n=2944) (Figure 3.5). MSM made up 93% of all new participants, while 6% were gender diverse (Table 3.1).
- MSM consistently made up about 97% of participants each year, with 13,012 MSM (95%) in 2025 (Figure 3.6). The proportion of gender diverse participants gradually increased from 2% (n=50) in 2019 to 4% (n=589) in 2025.
- The most common indication for joining the PrEP programme was having condomless anal sex, which was registered at approximately 80% of PrEP start consultations each year (82%; n=2875 in 2025) (Figure 3.7). A recent STI diagnosis was registered as an indication for PrEP use at 13% of PrEP start consultations in 2025, a slight decrease from 15% in 2024.
- In 2025, 2693 participants exited the PrEP programme: 615 stopped participating in the PrEP programme at their SHC and 2078 were lost to follow-up (Figure 3.8). Loss to follow-up is defined as no PrEP consultations for ≥7 months until June 2024, and ≥8 months from August 2024 onwards due to the PrEP programme transition. As a result, the number of persons lost to follow-up in 2025 may be underestimated.
- Out of the 615 participants who stopped in 2025, 136 continued PrEP via another provider, 302 stopped using PrEP, and for 177 it was unknown whether they continued PrEP (Figure 3.9).
- Among those who stopped using PrEP in 2025, a reduced risk for HIV was the most frequently cited reason for stopping by 62%, while 6% (n=19) stopped due to an HIV diagnosis (Figure 3.10).

3.1.4 STI

- STI positivity remains relatively constant during participation in the PrEP programme (Figure 3.11). Of the 18,928 persons with a first PrEP consultation between 2019 and 2025, 17% were diagnosed with an STI at their first PrEP consultation.
- In 2025, chlamydia and gonorrhoea were diagnosed at 13.0% and 15.2% of consultations among PrEP programme participants, an increase from 11.8% and 12.0% in 2019, respectively (Figure 3.12). Syphilis positivity remained constant at around 2% (Figure 3.13).
- HIV positivity has remained consistently low (≤0.10%) among PrEP programme participants (Figure 3.13).
- Out of the nineteen HIV diagnoses reported in the PrEP programme in 2025, fourteen persons received their diagnosis during participation, while five were diagnosed at their first PrEP consultation, prior to starting the programme (Figure 3.14).
- Out of the nineteen HIV diagnoses reported in the PrEP programme in 2025, thirteen were among MSM (Table 3.4), eleven during PrEP consultations and two during an MSM-STI consultation (see Chapter 7). Six gender diverse persons received an HIV diagnosis in 2025, five during a PrEP consultation and one during an MSM-STI consultation.

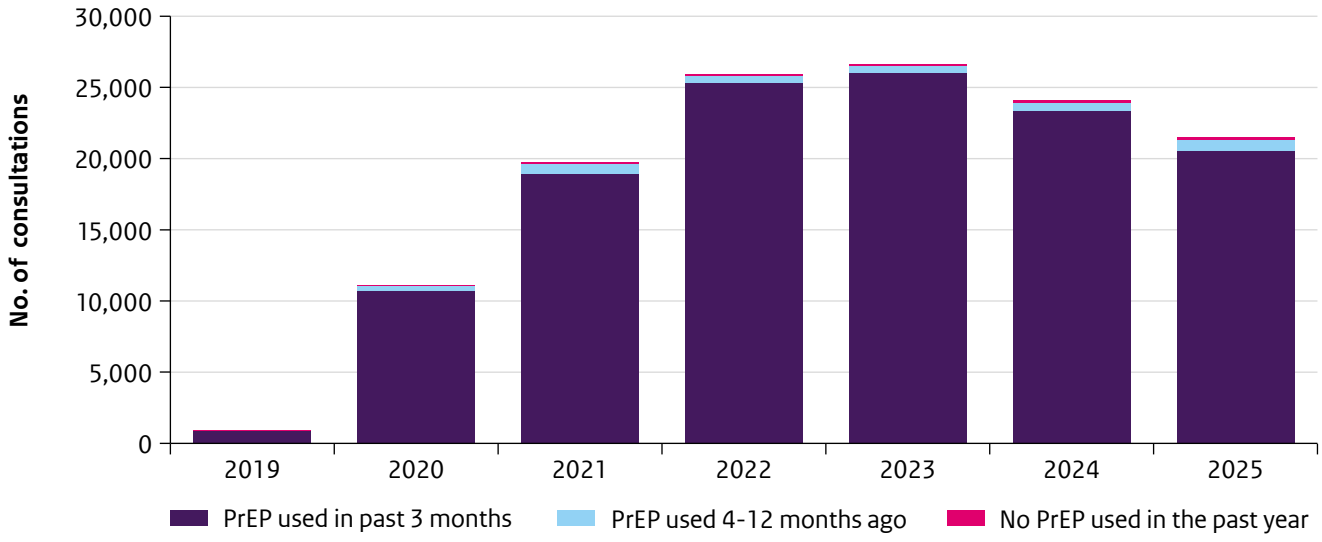
3.2 Consultations

Figure 3.1 Number of consultations by consultation type in PrEP programme participants, 2019-2025



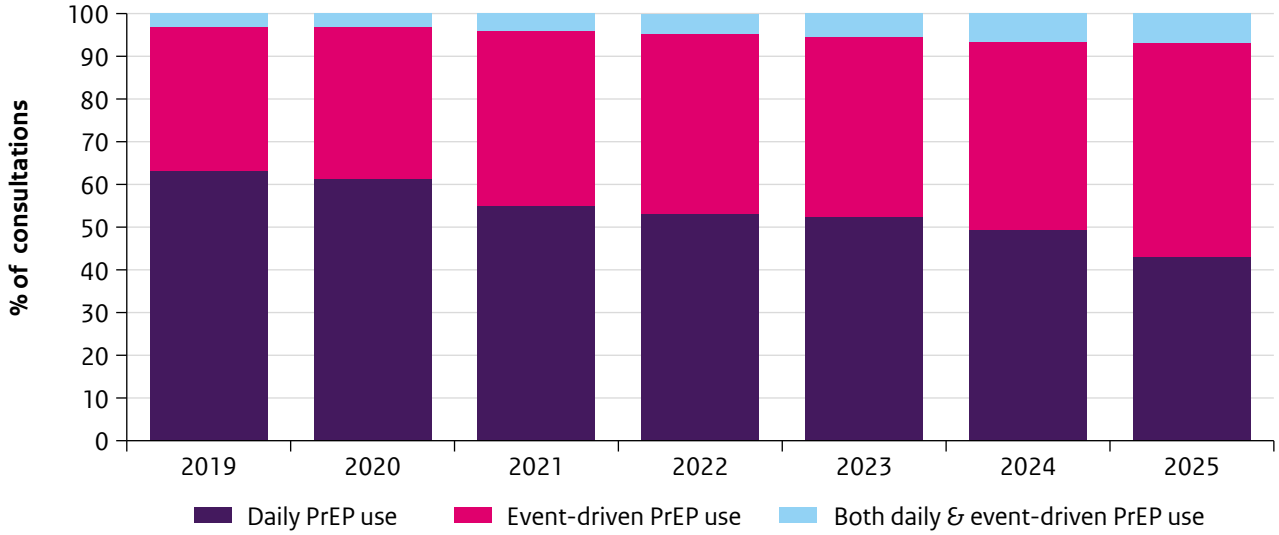
1 *Some participants have more than one PrEP start consultation registered, therefore the number of PrEP start consultations differs from the number of new PrEP participants in Figure 3.5.*
2 *One month check-in consultations may not be carried out for clients who were already familiar with PrEP use before joining the programme.*
3 *In 2023-2025, a number of SHCs provided PrEP consultations through additional municipal funding (Amsterdam, Rotterdam, Utrecht, Arnhem) or through their ASG funds (Zuid-Limburg, Limburg-Noord, Noord- en Oost-Gelderland). These consultations are not part of the national PrEP programme and are excluded from further figures.*
4 *This figure includes only testlab (Man-tot-man) consultations that were not registered anonymously and could be linked to PrEP programme participants' person ID.*

Figure 3.2 Number of PrEP follow-up consultations by PrEP use, 2019-2025



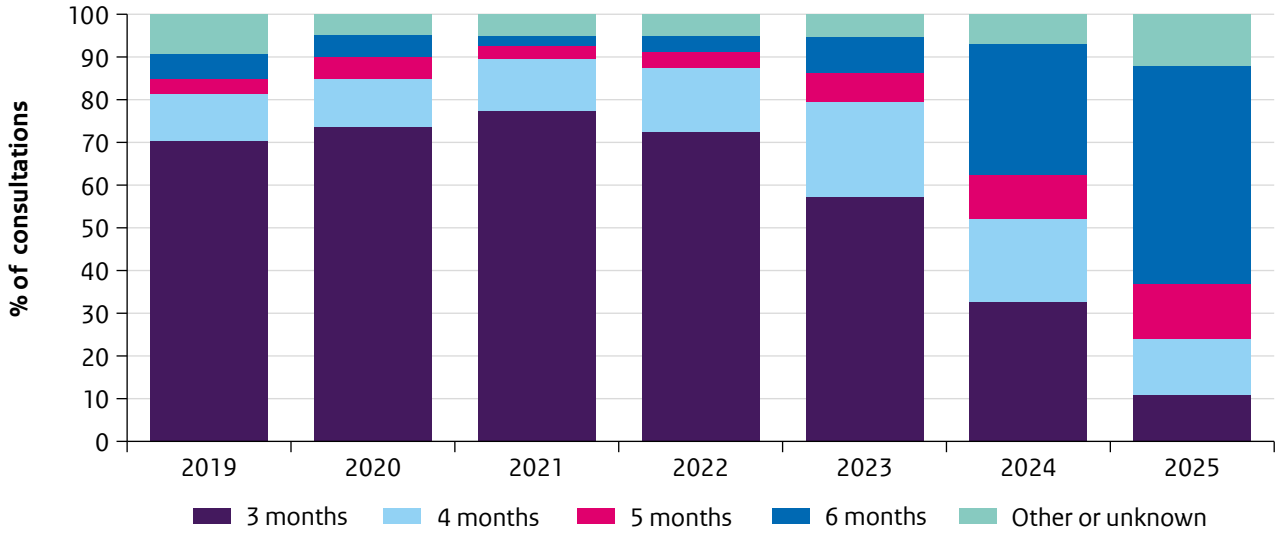
Footnote: This figure shows only PrEP use during PrEP programme participation. Any PrEP follow-up consultations that were a participant's first PrEP consultation were excluded.

Figure 3.3 Proportion of PrEP consultations by PrEP use in the past 3 months, 2019-2025



Footnote: This figure includes PrEP follow-up consultations in which recent PrEP use (in the last three months) was reported). Any PrEP follow-up consultations that were a participant's first PrEP consultation were excluded.

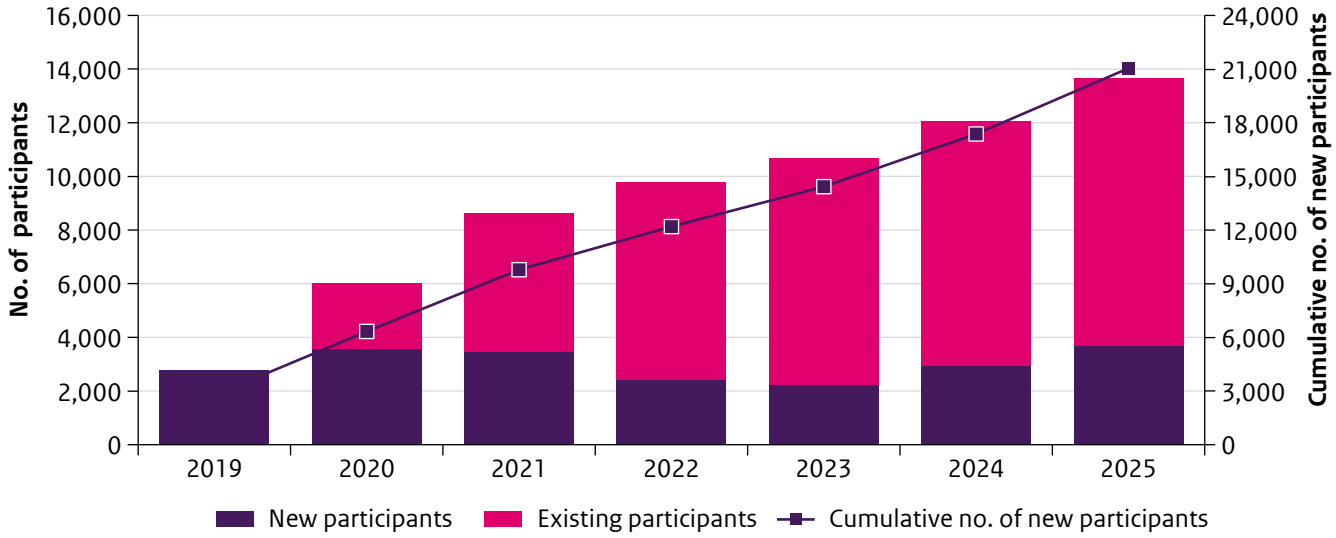
Figure 3.4 Proportion of PrEP consultations by time until next PrEP consultation, 2019-2025



Footnote: This figure excludes PrEP follow-up consultations that were a participant's last PrEP consultation.

3.2 Participants

Figure 3.5 Number of PrEP programme participants, 2019-2025



Footnote: This figure includes all persons with at least one PrEP consultation. Participants can join and leave the programme during the year, so the total number of persons who participated in a given year can exceed the maximum number of places in the PrEP pilot.

Figure 3.6 Sex and sexual orientation of PrEP programme participants, 2019-2025

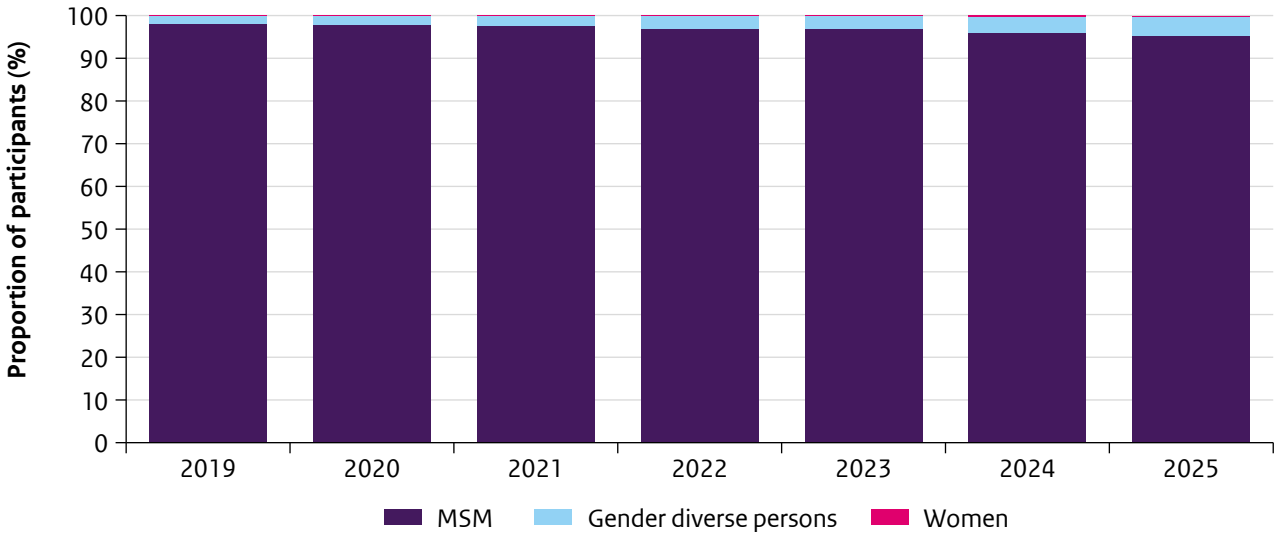
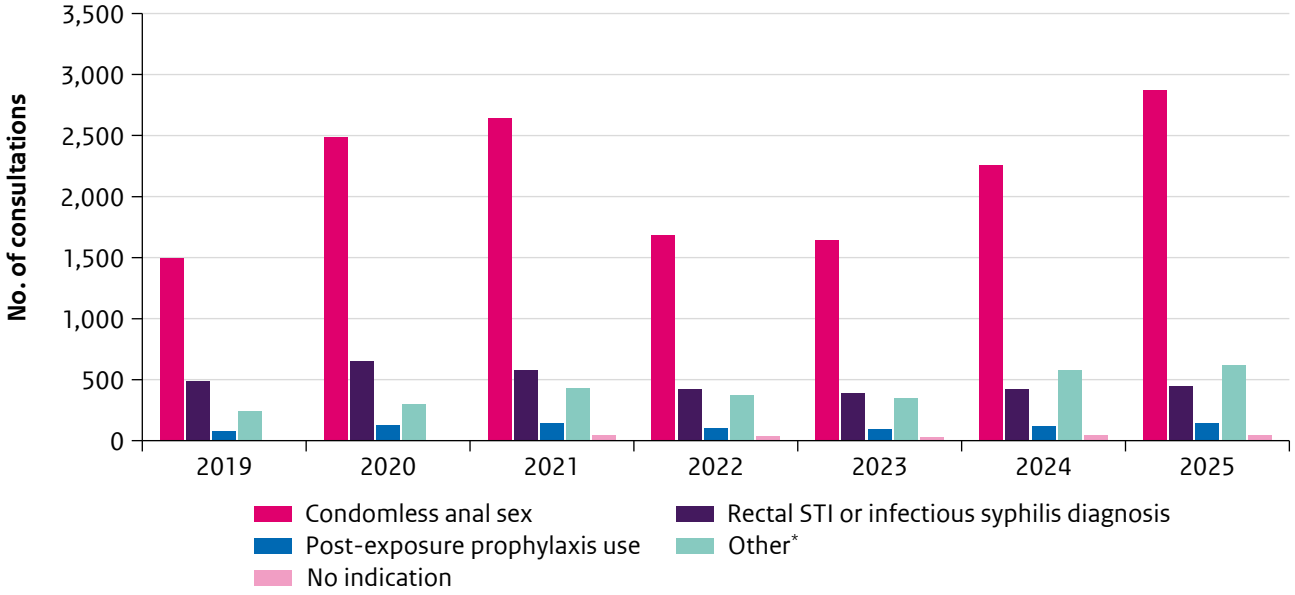


Figure 3.7 Indications for PrEP use among new participants in the the PrEP programme, 2019-2025



* *Other reasons for PrEP use include fear of HIV, not wanting to go to GP or GP does not prescribe PrEP, financial reasons, being vulnerable (including migrants, aged under 25 years, sex work, or transgender persons), and wanting optimal protection against HIV.*

Footnote: participants can cite multiple reasons for starting PrEP use.

Table 3.1 Demographic characteristics of new participants in the PrEP programme, 2025

Characteristic	MSM	Gender diverse persons	Total
	n (%)	n (%)	n (%)[1]
Sex and sexual preference			
MSM			3,397 (92.5)
Gender diverse persons			229 (6.2)
Women			40 (1.1)
Other men[2]			8 (0.2)
Age group			
≤20	156 (4.6)	6 (2.6)	162 (4.4)
21-25	767 (22.6)	49 (21.4)	818 (22.3)
26-30	792 (23.3)	64 (27.9)	863 (23.5)
31-35	591 (17.4)	41 (17.9)	646 (17.6)
36-40	350 (10.3)	20 (8.7)	376 (10.2)
41-45	212 (6.2)	20 (8.7)	236 (6.4)
46-50	163 (4.8)	12 (5.2)	182 (5.0)
51-55	123 (3.6)	9 (3.9)	138 (3.8)
≥56	243 (7.2)	8 (3.5)	253 (6.9)
Education level			
Hbo, university	2,030 (59.8)	84 (36.7)	2,136 (58.1)
Mbo 2-4, havo, vwo	707 (20.8)	42 (18.3)	763 (20.8)
No secondary education, vmbo, mbo 1	356 (10.5)	32 (14.0)	392 (10.7)
Unknown	304 (8.9)	71 (31.0)	383 (10.4)
Region of origin[3]			
Dutch	1,647 (48.5)	60 (26.2)	1,734 (47.2)
Migrant from triage region	1,058 (31.1)	125 (54.6)	1,197 (32.6)
Child of migrant from triage region	281 (8.3)	19 (8.3)	303 (8.2)
(Child of) migrant, not from triage region	380 (11.2)	24 (10.5)	407 (11.1)
Unknown	31 (0.9)	1 (0.4)	33 (0.9)
SHC region			
Limburg	126 (3.7)	8 (3.5)	137 (3.7)
Noord-Holland/Flevoland	1,260 (37.1)	119 (52.0)	1,395 (38.0)
Noord-Nederland	141 (4.2)	10 (4.4)	154 (4.2)
Oost-Nederland	333 (9.8)	13 (5.7)	351 (9.6)
Utrecht	418 (12.3)	22 (9.6)	445 (12.1)
Zeeland/Brabant	494 (14.5)	11 (4.8)	507 (13.8)
Zuid-Holland Noord	280 (8.2)	25 (10.9)	311 (8.5)
Zuid-Holland Zuid	345 (10.2)	21 (9.2)	374 (10.2)

1 *Total column includes women and other men.*
2 *Other men are cis-gender men for whom sex of sex partners in the past six months is unknown or who only had female sex partners in the past six months.*
3 *Region of origin with triage indication includes Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.*

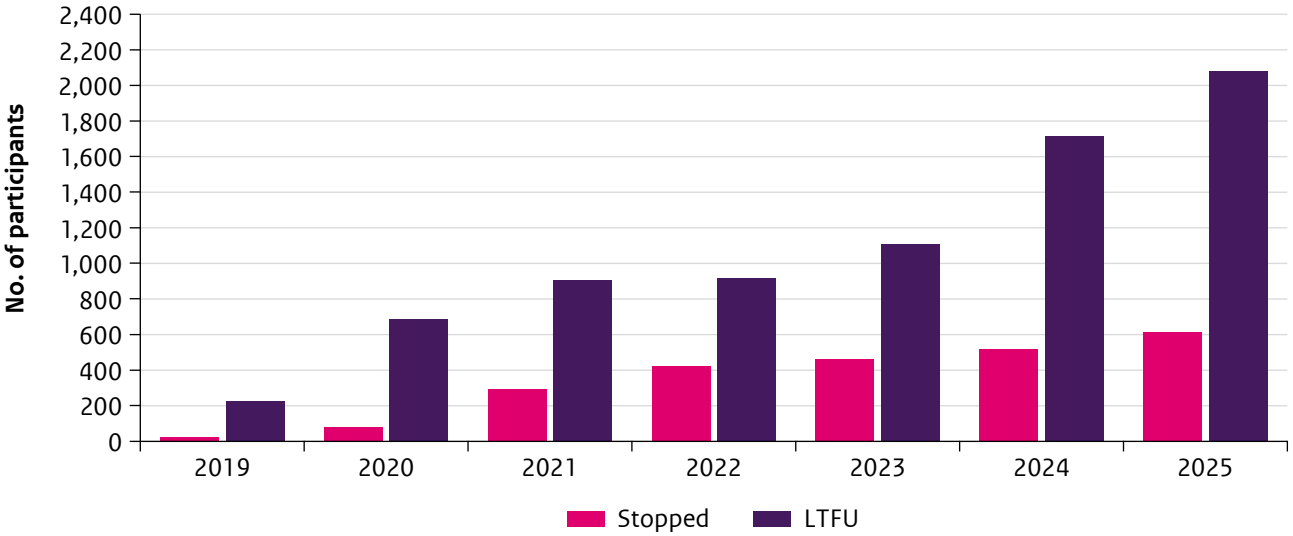
Table 3.2 Behavioral characteristics of new participants in the PrEP programme, 2025

Characteristic	MSM	Gender diverse persons	Total
	n (%)	n (%)	n (%)[1]
Type of first PrEP consultation			
PrEP start consultation	3,226 (95.0)	220 (96.1)	3,494 (95.1)
PrEP follow-up consultation	171 (5.0)	9 (3.9)	180 (4.9)
Previous PrEP use			
No, not in the past year	2,472 (72.8)	176 (76.9)	2,689 (73.2)
Yes, 4-12 months ago	124 (3.7)	14 (6.1)	141 (3.8)
Yes, in the past 3 months	801 (23.6)	39 (17.0)	844 (23.0)
Previous PrEP provider[2,3]			
SHC	253 (27.4)	21 (39.6)	276 (32.4)
GP	83 (9.0)	2 (3.8)	87 (10.2)
HIV physician	8 (0.9)	0 (0.0)	9 (1.1)
Other specialist physician	112 (12.1)	9 (17.0)	122 (14.3)
Informal	167 (18.1)	10 (18.9)	177 (20.8)
Other	176 (19.0)	5 (9.4)	182 (21.3)
Previous HIV test			
No	297 (8.7)	26 (11.4)	330 (9.0)
Yes, negative	3,082 (90.7)	201 (87.8)	3,322 (90.4)
Yes, result unknown	11 (0.3)	2 (0.9)	13 (0.4)
Unknown	7 (0.2)	0 (0.0)	9 (0.2)
Receptive anal sex in the past 6 months			
No receptive anal sex	628 (18.5)	40 (17.5)	676 (18.4)
Yes, consistently with a condom	351 (10.3)	29 (12.7)	381 (10.4)
Yes, not consistently with a condom	1,357 (39.9)	99 (43.2)	1,473 (40.1)
Yes, never with a condom	1,022 (30.1)	53 (23.1)	1,088 (29.6)
Unknown	39 (1.1)	8 (3.5)	56 (1.5)
Insertive anal sex in the past 6 months			
No insertive anal sex	640 (18.8)	67 (29.3)	711 (19.4)
Yes, consistently with a condom	333 (9.8)	25 (10.9)	359 (9.8)
Yes, not consistently with a condom	1,350 (39.7)	66 (28.8)	1,416 (38.5)
Yes, never with a condom	1,030 (30.3)	22 (9.6)	1,055 (28.7)
Unknown	44 (1.3)	49 (21.4)	133 (3.6)

Characteristic	MSM	Gender diverse persons	Total
	n (%)	n (%)	n (%)[1]
Number of partners in the past 6 months			
0 partners	81 (2.4)	14 (6.1)	95 (2.6)
1-5 partners	1,443 (42.5)	75 (32.8)	1,531 (41.7)
6-9 partners	587 (17.3)	25 (10.9)	616 (16.8)
10 or more partners	1,250 (36.8)	111 (48.5)	1,390 (37.8)
Unknown	36 (1.1)	4 (1.7)	42 (1.1)
Group sex in the past 6 months			
No	2,038 (60.0)	116 (50.7)	2,154 (58.6)
Yes	1,309 (38.5)	61 (26.6)	1,370 (37.3)
Unknown	50 (1.5)	52 (22.7)	150 (4.1)
Sex work in the past 6 months			
No sex worker	3,189 (93.9)	146 (63.8)	3,356 (91.3)
Sex worker	143 (4.2)	73 (31.9)	243 (6.6)
Unknown	65 (1.9)	10 (4.4)	75 (2.0)
Drug use before or during sex in the past 6 months[4]			
No	2,463 (72.5)	151 (65.9)	2,647 (72.0)
Yes	894 (26.3)	74 (32.3)	982 (26.7)
Unknown	40 (1.2)	4 (1.7)	45 (1.2)

1 *Total column includes women and other men.*
2 *Among those who report using PrEP in the past year.*
3 *Persons can receive PrEP through more than one provider.*
4 *Included drugs are cocaine, XTC/MDMA/Speed, Heroin, Crystal Meth, Mephedrone, 3-MMC, 4-MEC, 4-FA, GHB/GBL and ketamine.*

Figure 3.8 Number of participants who stopped participating in the PrEP programme or were lost to follow-up (LTFU), 2019-2025



Footnote: Loss to follow-up is defined as a person not having any PrEP consultations for >=7 months until June 2024. From August 2024 onwards the definition was changed to >=8 months due to the switch from PrEP pilot to program. The number of persons lost to follow-up in 2025 is therefore underestimated.

Figure 3.9 Reasons for stopping participation in the PrEP programme, 2019-2025

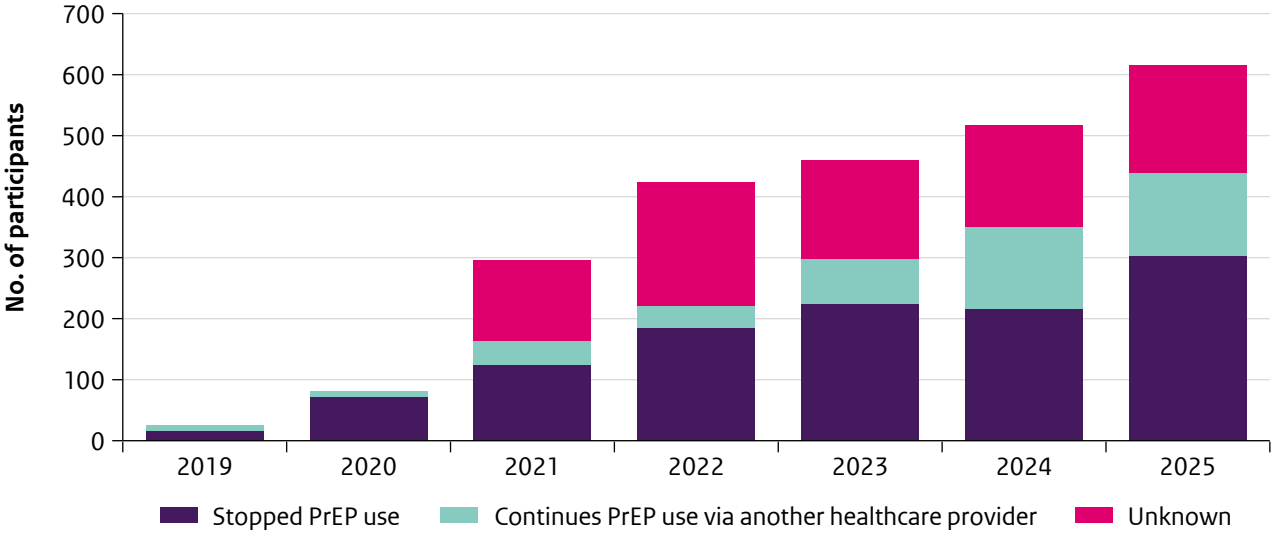
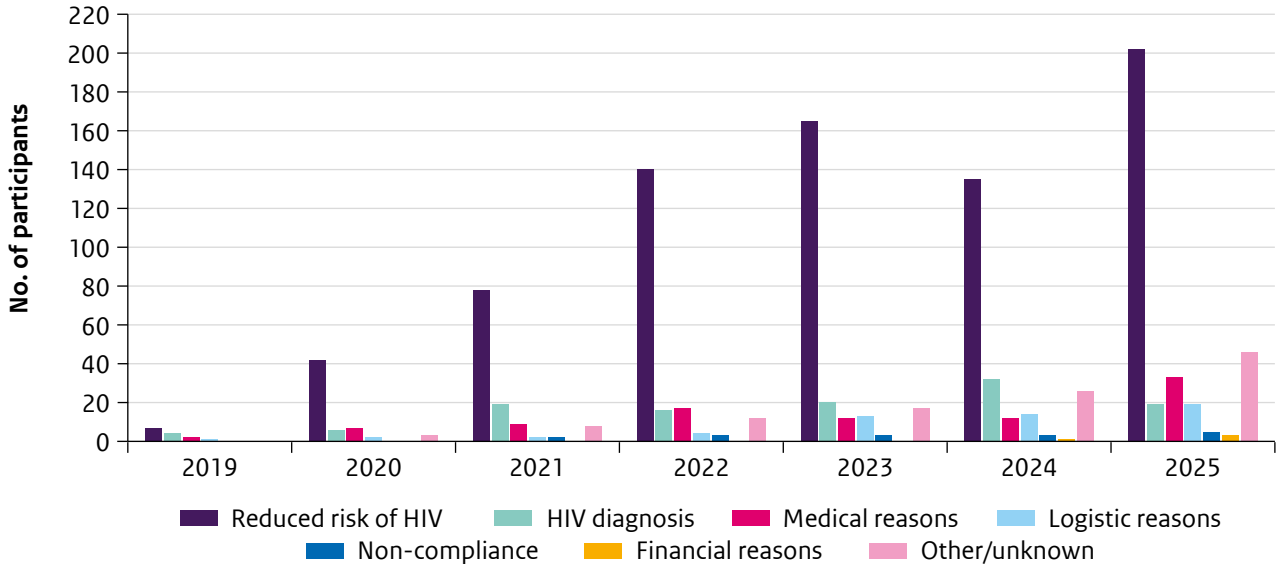


Figure 3.10 Reasons for stopping among participants who stopped using PrEP, 2019-2025



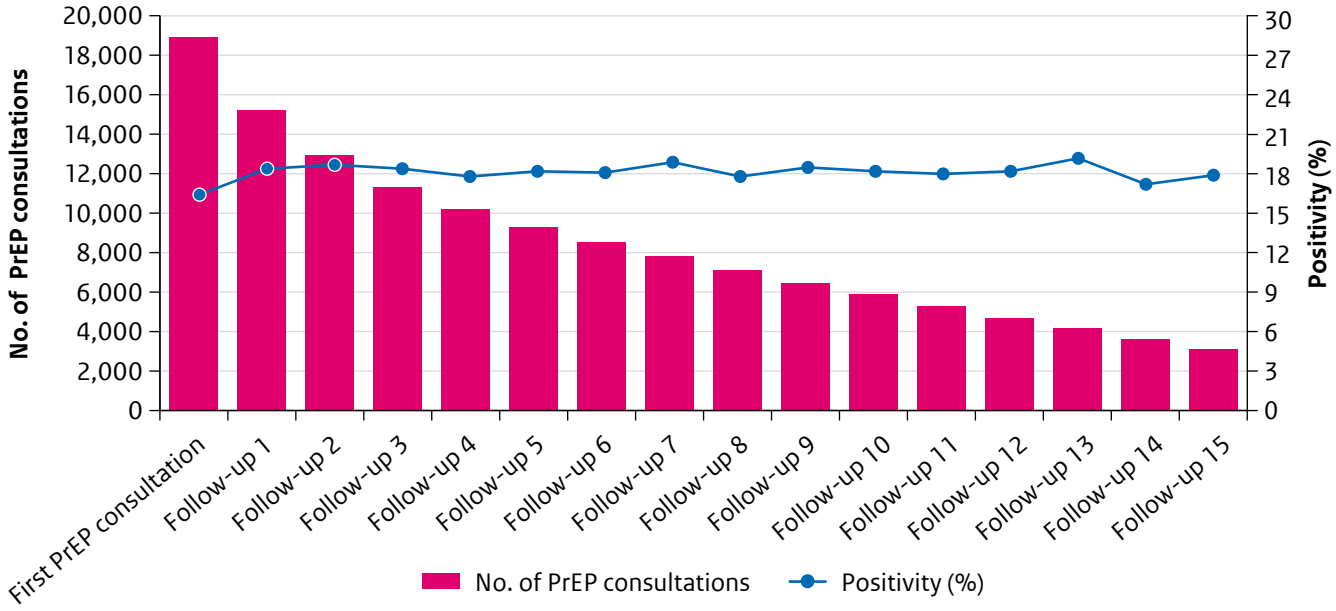
Footnote 1: Participants can cite multiple reasons for stopping PrEP use.
Footnote 2: Medical reasons include medical interactions, renal impairment, and other side effects.

Table 3.3 Characteristics of participants who stopped participating in the PrEP programme or were LTFU, 2025.

Characteristic	Stopped	LTFU
	n (%)	n (%)
Sex		
MSM	579 (94.1)	1950 (93.8)
Other men	1 (0.2)	1 (0.0)
Women	8 (1.3)	10 (0.5)
Gender diverse persons	27 (4.4)	117 (5.6)
Age group		
≤24	80 (13.0)	287 (13.8)
25-34	263 (42.8)	839 (40.4)
35-44	140 (22.8)	481 (23.1)
≥45	132 (21.5)	471 (22.7)
PrEP use		
Daily	150 (24.4)	518 (24.9)
Event-driven	302 (49.1)	898 (43.2)
Both	30 (4.9)	107 (5.1)
Unknown	133 (21.6)	555 (26.7)

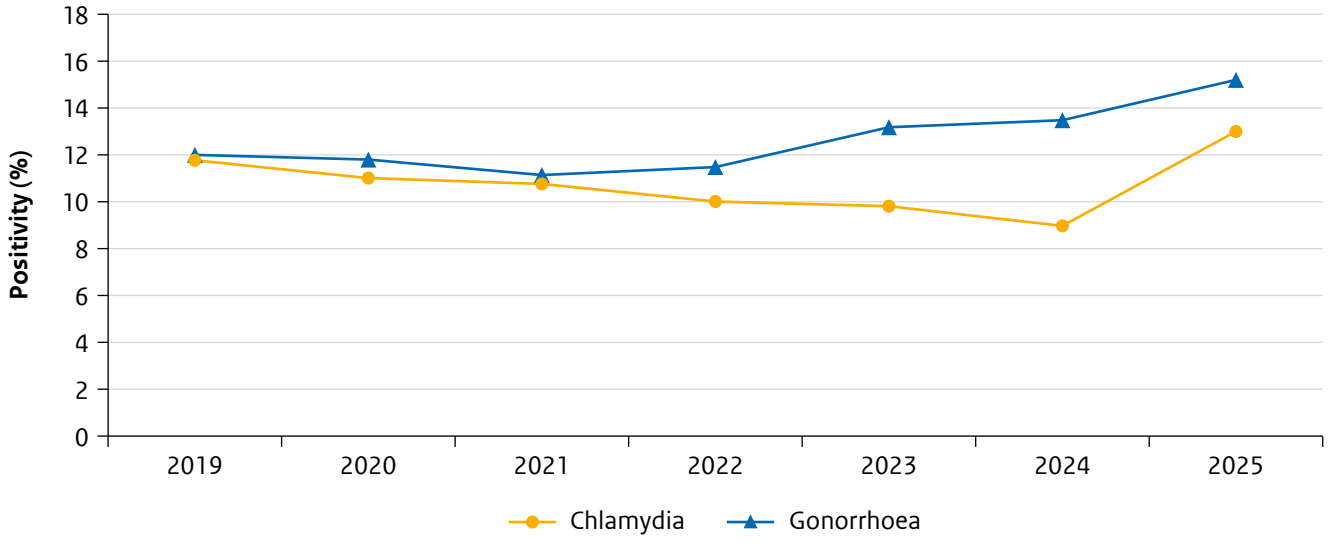
3.2 STI

Figure 3.11 Number of PrEP consultations with an STI test and STI positivity by PrEP consultation number, 2019-2025



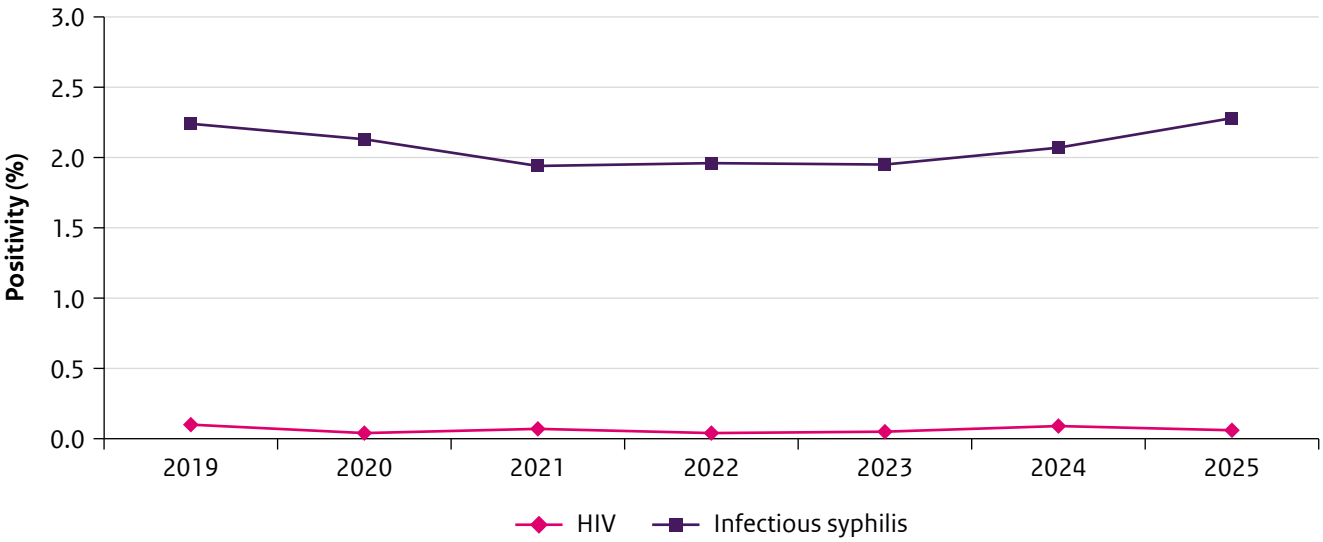
Footnote: STI include chlamydia, gonorrhoea, infectious syphilis, HIV and infectious hepatitis B.

Figure 3.12 Chlamydia and gonorrhoea positivity among PrEP programme participants, 2019-2025



Footnote: This figure includes all consultations (both MSM-PrEP and MSM-STI consultations) among persons participating in the PrEP programme.

Figure 3.13 HIV and infectious syphilis positivity among PrEP programme participants, 2019-2025



Footnote: This figure includes all consultations (both MSM-PrEP and MSM-STI consultations) among persons participating in the PrEP programme.

Figure 3.14 Number of new HIV-diagnoses in PrEP programme consultations, 2019-2025

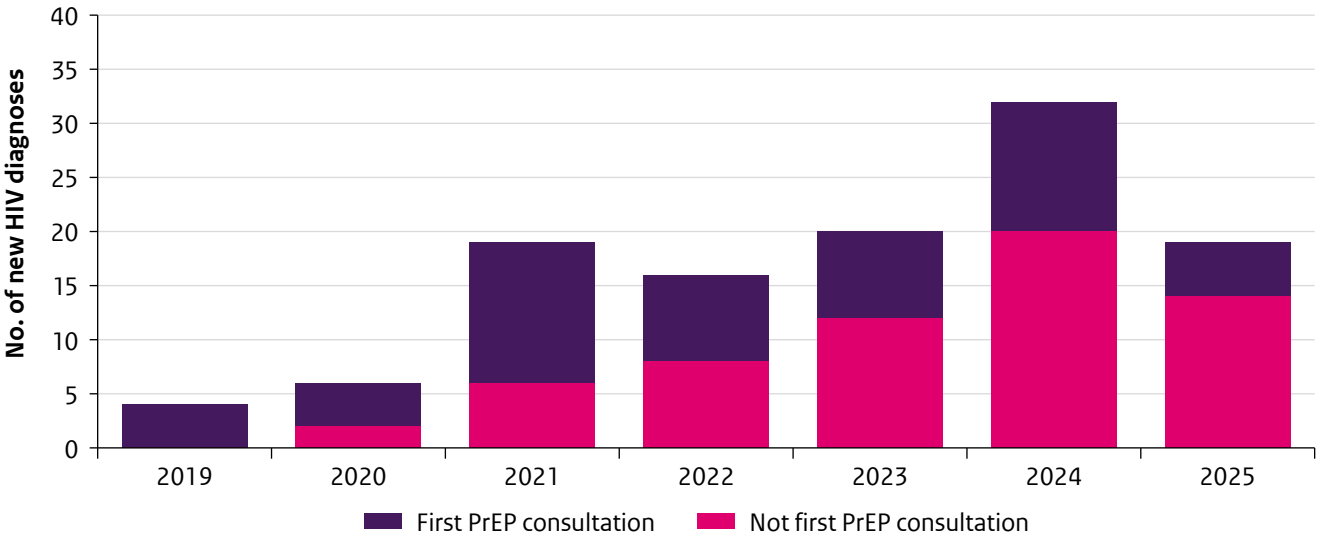


Table 3.4 HIV diagnoses among PrEP programme participants by type of PrEP consultation and sexual preference, 2025

Consultation	MSM	Gender diverse persons	Women	Other men
1st PrEP consultation	2	3	0	0
≥2nd PrEP consultation	9	2	0	0
STI consultation	2	1	0	0
Total	**13**	**6**	**0**	**0**

BACTERIAL STI

4 Chlamydia, including Lymphogranuloma venereum

4.1 Key points

4.1.1 Sexual Health Centres

In 2025, a new chlamydia testing policy was implemented at the SHCs: only individuals with STI symptoms or persons who currently have a partner with symptomatic chlamydia are tested for chlamydia. Therefore, 2025 numbers are not comparable to previous years. The large decrease in number of tests performed, and the selection of testing mostly symptomatic persons has led to increases in positivity rates.

While MSM are no longer routinely tested for chlamydia either, all MSM are still screened for LGV. These tests are reported as LGV tests to RIVM, not as chlamydia tests. However, implementation difficulties led to a large part of LGV tests being incorrectly registered as both LGV and chlamydia tests. This artificially increased the number of (anorectal) chlamydia tests reported among MSM in 2025.

- In 2025, 10,731 chlamydia infections were diagnosed at SHCs (43% in women, 30% in MSW, 20% in MSM-STI consultations, 6% in MSM-PrEP consultations, and 0.7% in gender diverse persons). This is a decrease by 47% compared to 2024 (20,174 diagnoses) (Figure 4.1a-e).
- The 10,731 chlamydia diagnoses were made among 10,140 individuals (Table 2.7). There were 544 persons (5%) with more than one chlamydia diagnosis in 2025.
- In 2025, 56,288 chlamydia tests were registered at SHCs. The number of tests decreased by 58% among women (2024: 53,821; 2025: 22,346), by 60% among MSW (2024: 25,503; 2025: 10,110), by 65% among MSM-STI consultations (2024: 49,619; 2025: 17,436), by 78% among MSM-PrEP consultations (2024: 25,689; 2025: 5530), and by 69% among gender diverse persons (2024: 2754; 2025: 866) (Figure 4.1a-e).
- In 2025, chlamydia positivity amounted to 20.5% for women, 32.1% for MSW, 12.5% for MSM-STI consultations, 11.7% for MSM-PrEP consultations, and 8.4% for gender diverse persons (Figure 4.1a-e).
- As the number of gender diverse persons is relatively low, they are not included in all the tables and figures.
- When only looking at persons with a test indication (here operationalised as STI symptoms or a partner notification for chlamydia), chlamydia positivity was stable around 23% for women between 2016 and 2025. Among MSW, it slowly increased from 26.0% in 2016 to 29.1% in 2024 and then to 33.5% in 2025. Among MSM-STI consultations, it fluctuated around 17% and among MSM-PrEP, around 20% in the past years (Figure 4.2a–d).
- The highest chlamydia positivity was seen among persons who were notified for chlamydia (45.5% among women, 47.0% among MSW, 26.4% among MSM-STI and 27.6% among MSM-PrEP consultations in 2025) (Figure 4.3a–d, Table 13.4).
- High chlamydia positivity was seen among women and MSW aged 20 years and under (35.2%) and aged between 21 and 25 years (26.9%) as compared to other age groups (Figure 4.4).
- Chlamydia positivity used to be lower among those with university/HBO education levels, but became more similar to those with other education levels in 2025 among women and MSW (Figure 4.5a).
- Most chlamydia tests in 2025 were performed at the urogenital site among women, and anorectal testing decreased more than urogenital testing in 2025. Among MSM, anorectal tests were performed more often than urogenital tests in 2025, but this is likely due to faulty registration of anorectal tests that were performed in the light of LGV screening (Table 4.1).
- Co-infection with gonorrhoea was found among 9% of women and 9% of MSW who were diagnosed with chlamydia (Table 4.3).
- In 40% of MSM-STI consultations and 44% of MSM-PrEP consultations involving a chlamydia diagnosis, a gonorrhoea co-infection was found. A syphilis co-infection was found in 5% of MSM-STI and 6% of MSM-PrEP, while 1% of MSM-STI and 0.3% of MSM-PrEP were also newly diagnosed with HIV (Table 4.3).

4.1.2 General practices

- The estimated number of chlamydia episodes at GPs decreased among women aged 15–24 years, from 12,600 episodes in 2023 to 9000 in 2024. Among women aged 25–64 years, the number of episodes decreased from 12,100 to 9900 (Figure 4.7).
- For men aged 15–24 years, the episodes decreased slightly from 6400 in 2023 to 4900 in 2024. For men aged 25–64 years, the number of episodes decreased from 11,900 in 2023 to 9600 in 2024 (Figure 4.7).

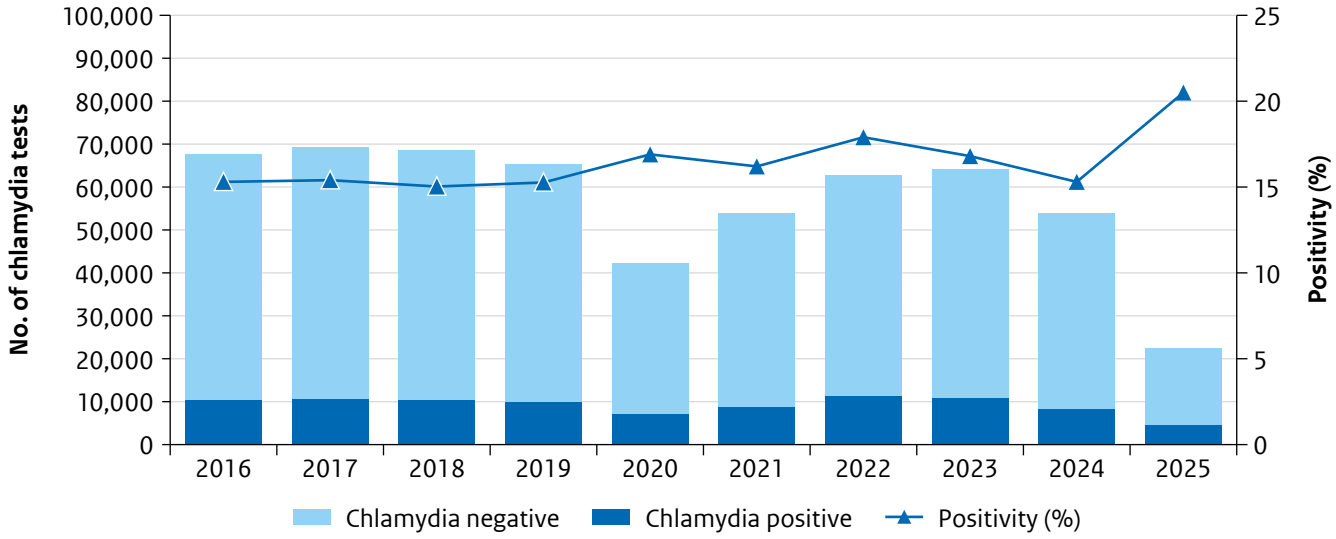
- In 2024, the reporting rate for chlamydia at GPs was 2.9 episodes per 1000 persons aged 15-64 years. The reporting rates are higher for women and men aged 15-24 years than for women and men aged 25-64 years (Table 4.4).

4.1.3 Lymphogranuloma venereum at Sexual Health Centres

- While MSM are no longer routinely tested for chlamydia, all MSM are still screened for LGV.
- In 2025 there were 454 lymphogranuloma venereum (LGV) diagnoses. Out of these, 334 diagnoses were among MSM-STI consultations, 106 among MSM-PrEP consultations, 13 were among gender diverse persons, while 1 woman was diagnosed with LGV.
- The number of LGV diagnoses in MSM increased from 243 in 2016 to 572 in 2023, but then decreased to 440 in 2025 (Figure 4.9).
- The proportion of HIV-negative MSM (both in STI and PrEP consultations) among LGV-positives increased from 45% in 2016 to 74% in 2025 (Figure 4.9).
- LGV positivity was highest among MSM with HIV (2.7% in 2025) (Figure 4.10).
- Of all LGV infections among MSM, 50% were asymptomatic.

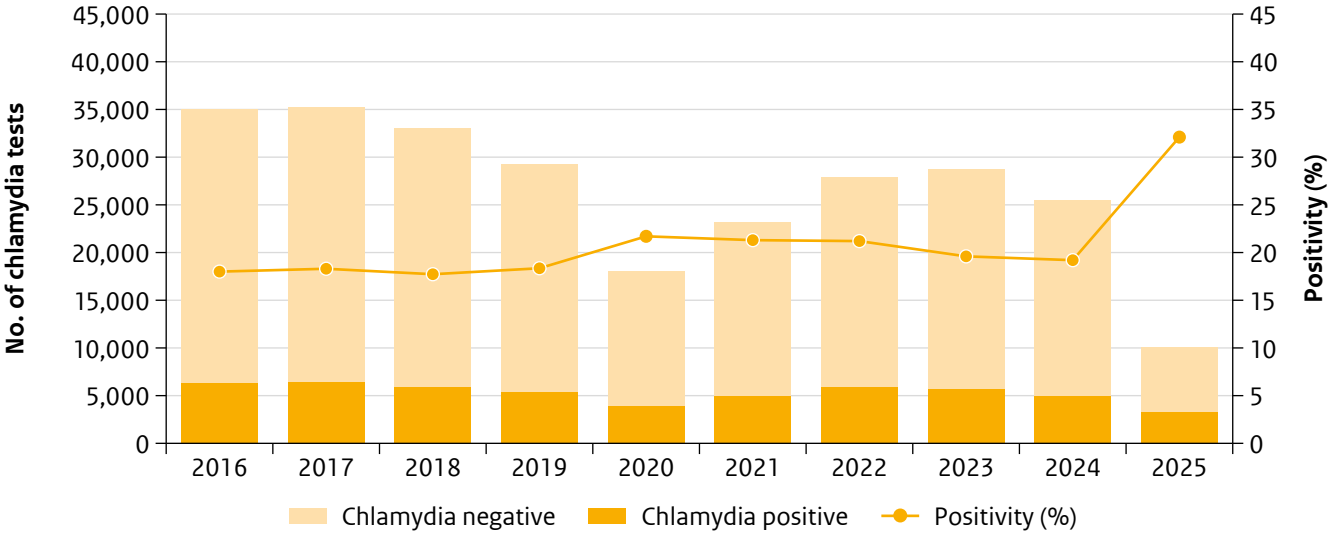
4.2 Sexual Health Centres: characteristics, risk groups and trends

Figure 4.1a Number of chlamydia positive and negative tests and chlamydia positivity in women, 2016-2025



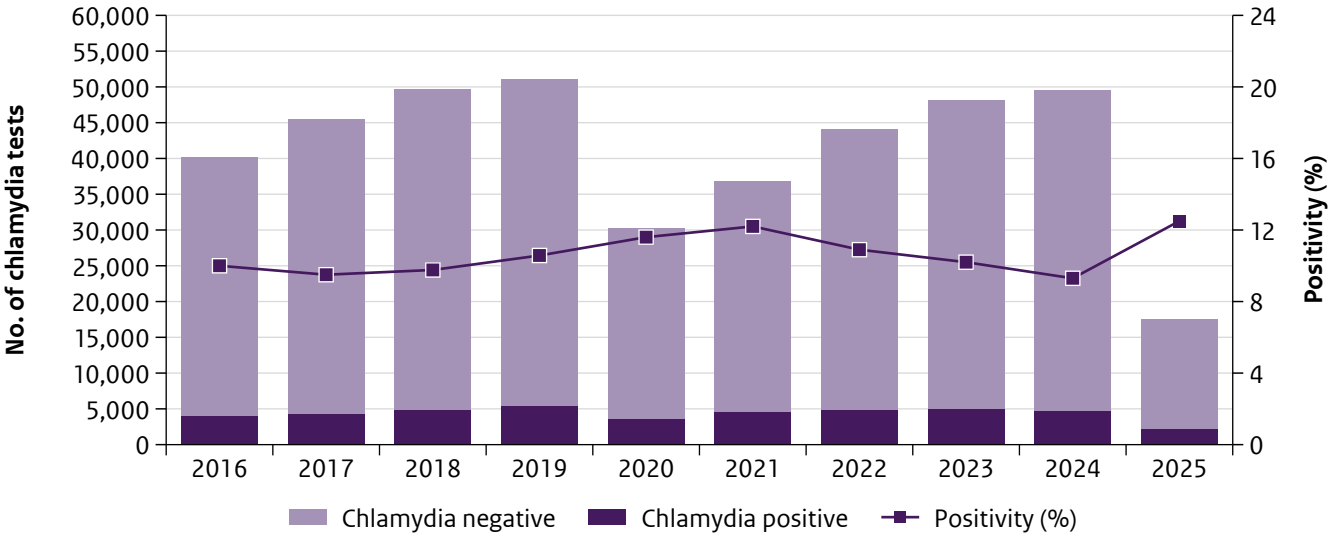
Footnote: Aggregated data of non-registered consultations included for 2018 and 2019.

Figure 4.1b Number of chlamydia positive and negative tests and chlamydia positivity in MSW, 2016-2025



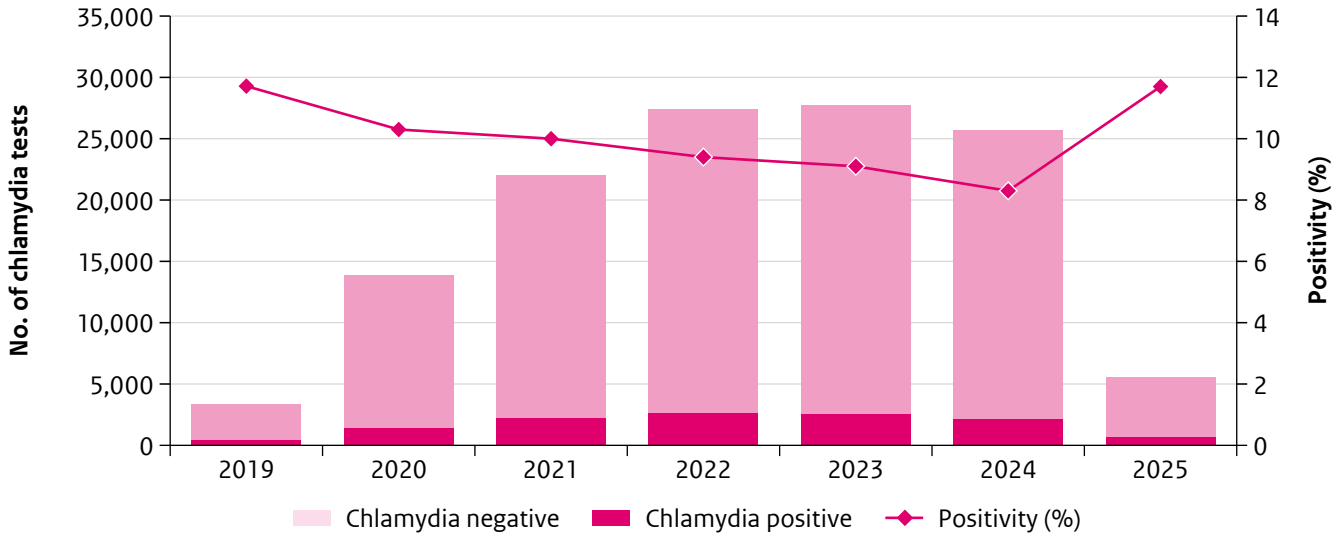
Footnote: Aggregated data of non-registered consultations included for 2018 and 2019.

Figure 4.1c Number of chlamydia positive and negative tests and chlamydia positivity in MSM-STI consultations, 2016-2025



Footnote: Aggregated data of non-registered consultations included for 2018 and 2019.

Figure 4.1d Number of chlamydia positive and negative tests and chlamydia positivity in MSM-PrEP consultations, 2019-2025



Footnote: Aggregated data of non-registered consultations included for 2019.

Figure 4.1e Number of chlamydia positive and negative tests and chlamydia positivity in gender diverse persons, 2020-2025

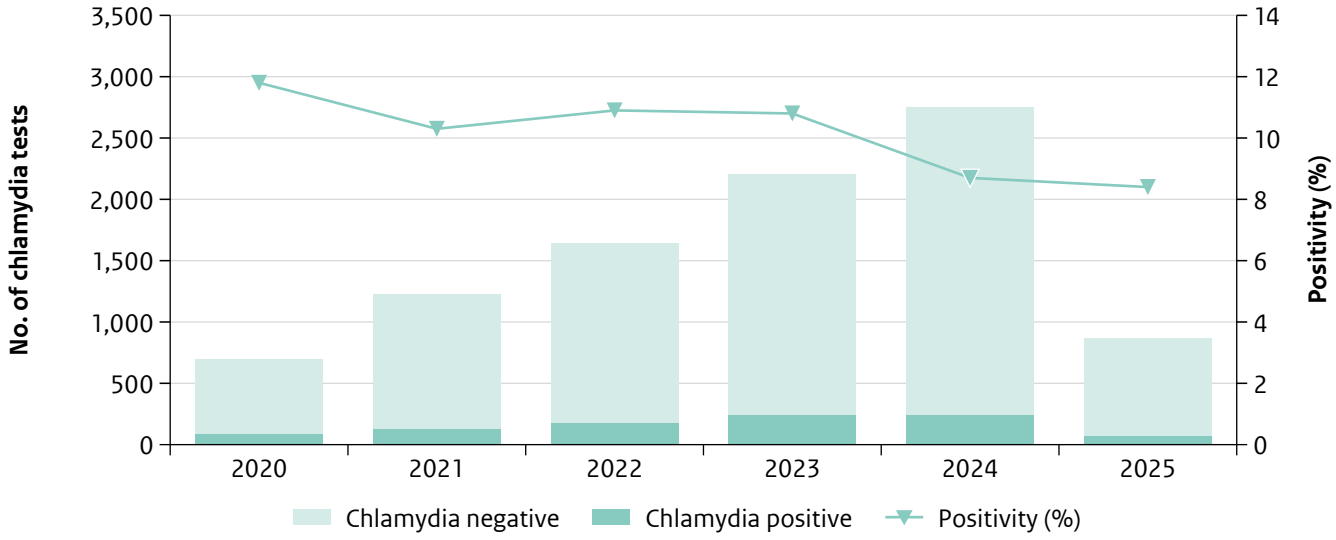


Figure 4.2a Number of chlamydia positive and negative tests and chlamydia positivity in women with STI symptoms or a partner notification for chlamydia, 2016-2025

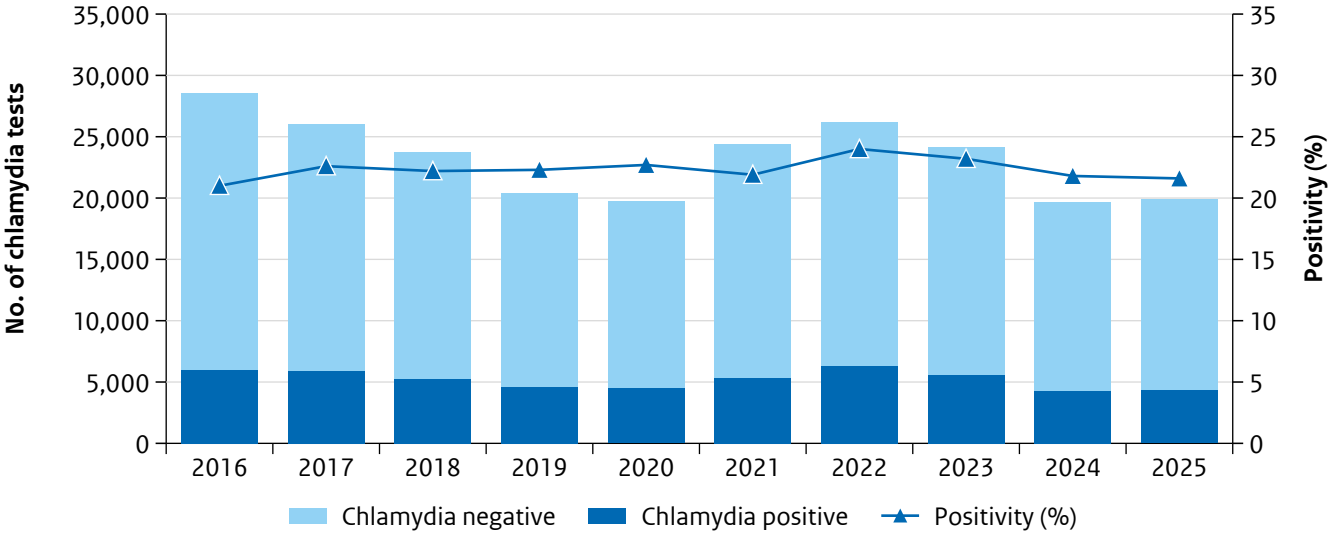


Figure 4.2b Number of chlamydia positive and negative tests and chlamydia positivity in MSW with STI symptoms or a partner notification for chlamydia, 2016-2025

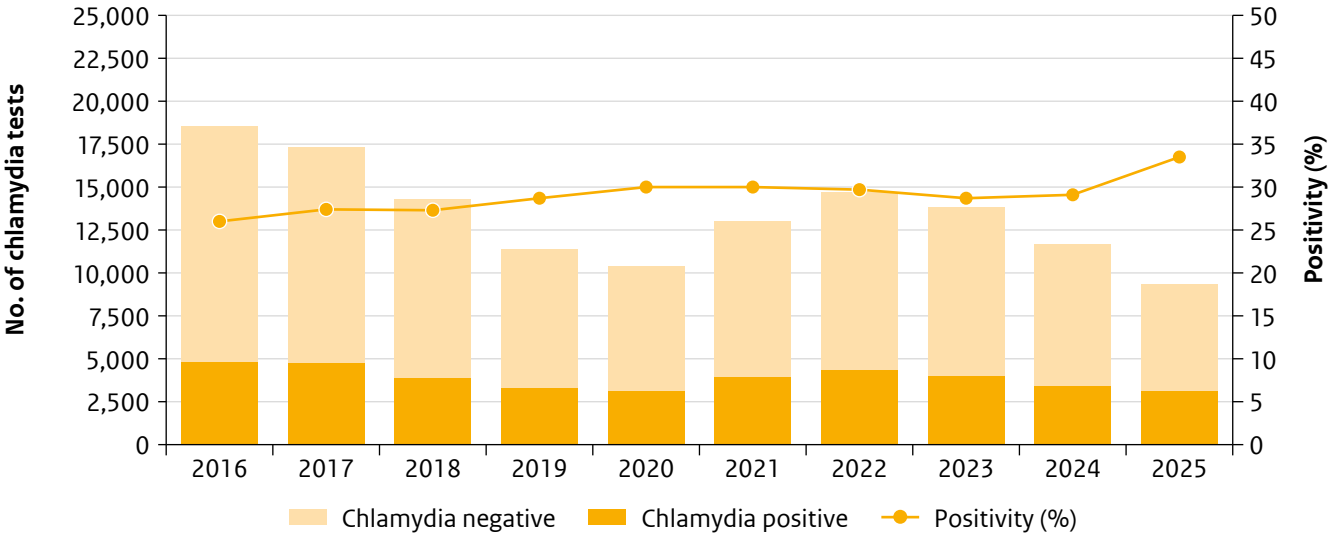


Figure 4.2c Number of chlamydia positive and negative tests and chlamydia positivity in MSM-STI consultations with STI symptoms or a partner notification for chlamydia, 2016-2025

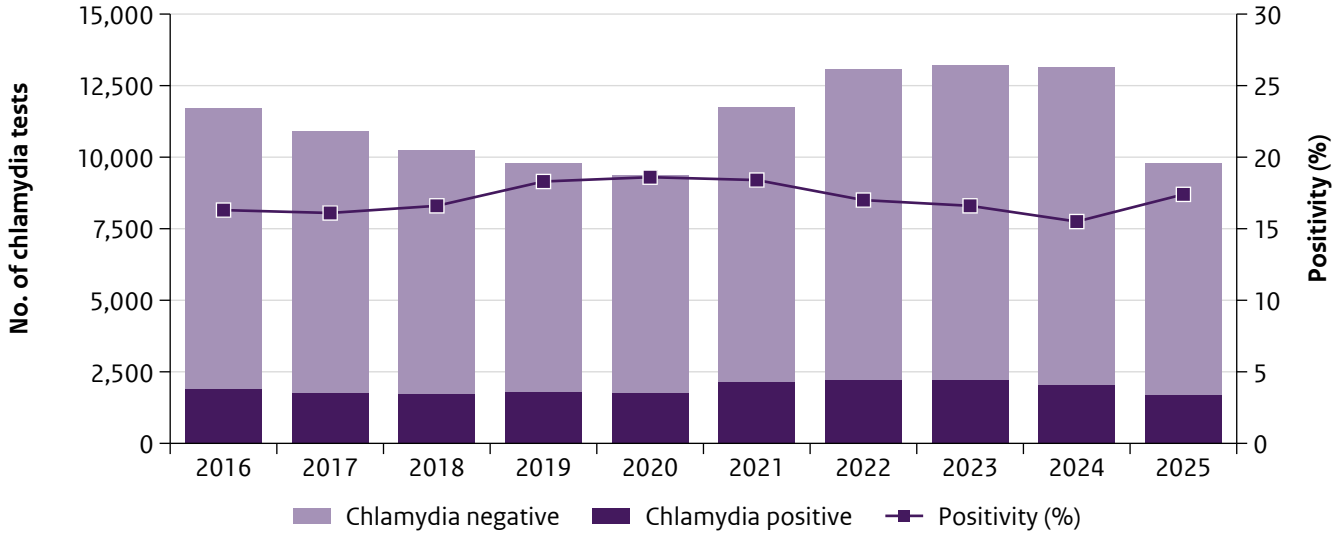


Figure 4.2d Number of chlamydia positive and negative tests and chlamydia positivity in MSM-PrEP consultations with STI symptoms or a partner notification for chlamydia, 2019-2025

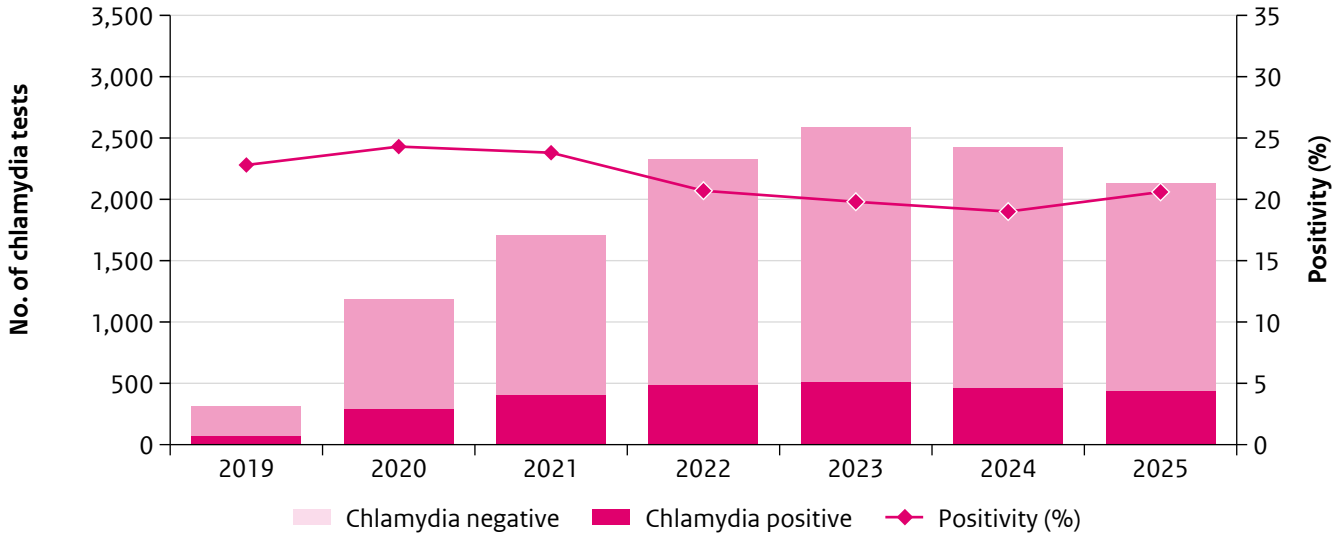
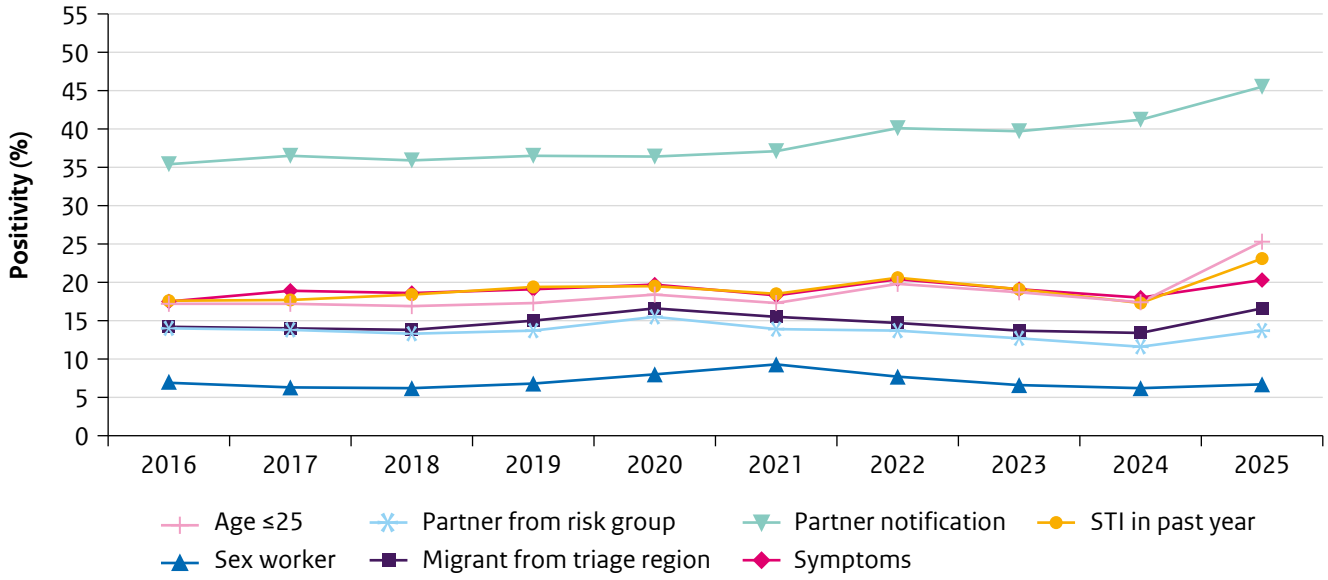
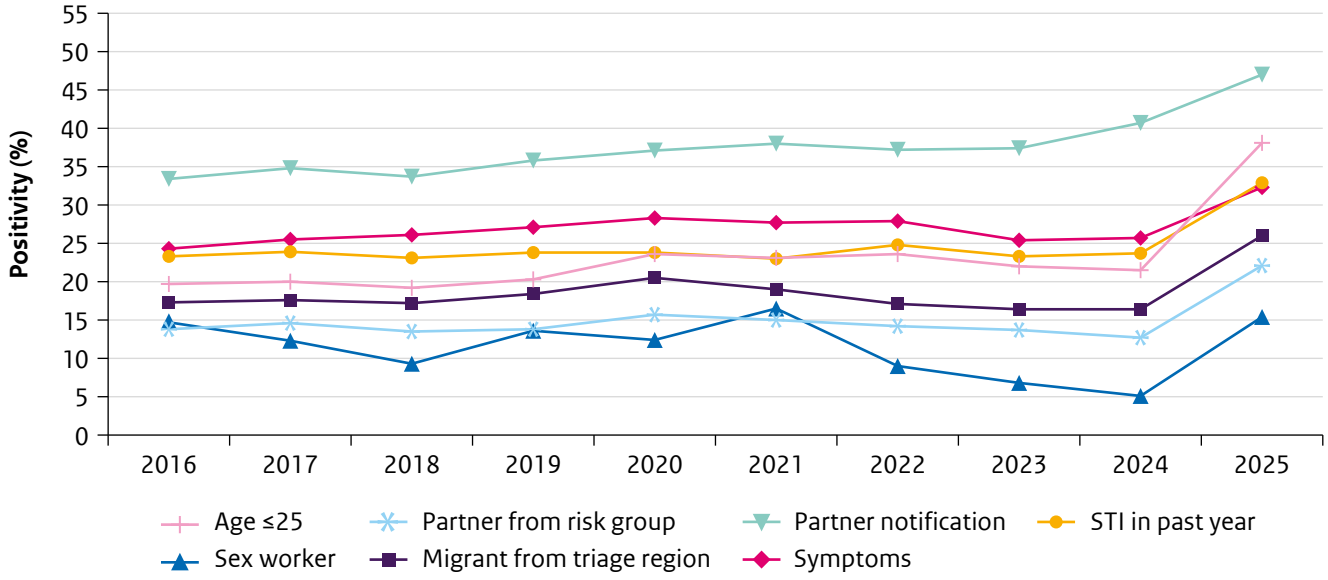


Figure 4.3a Reported triage indication: chlamydia positivity by triage indication in women, 2016-2025



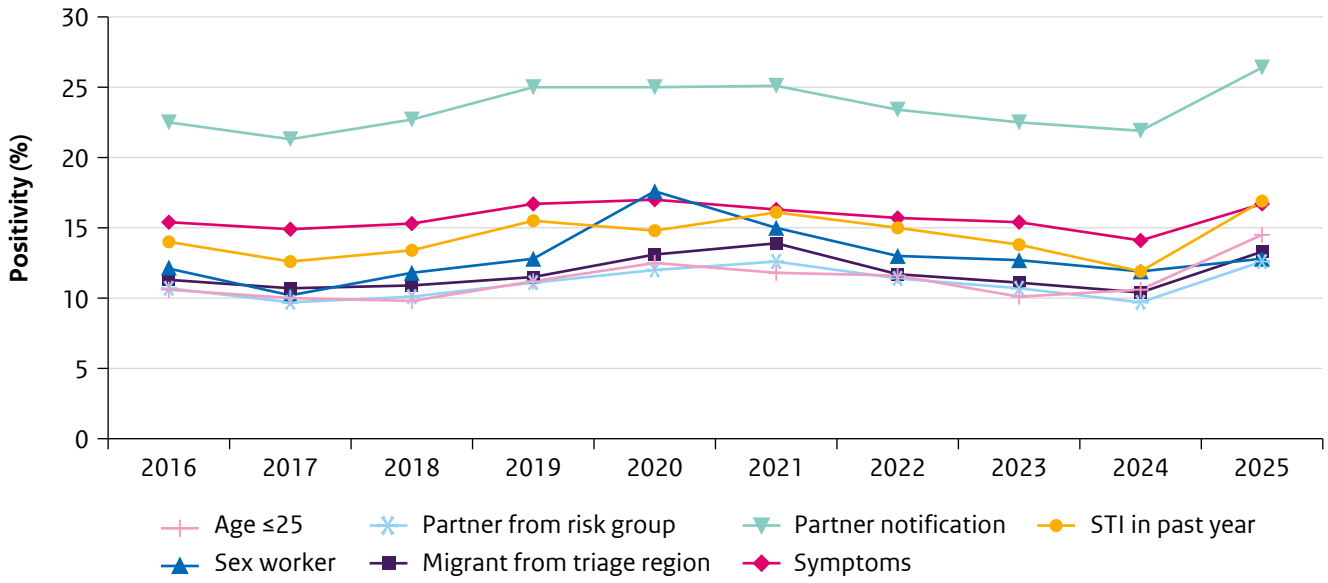
Footnote 1: Migrant from triage region includes migrants and children of migrants from Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.
Footnote 2: Partner from risk group: partner originating from a region of origin as indicated by triage criteria or a male partner who had sex with men.
Footnote 3: Exact numbers of diagnoses, tests and positivity by triage criteria in 2025 are shown in supplementary table 13.4.

Figure 4.3b Reported triage indication: chlamydia positivity by triage indication in MSW, 2016-2025



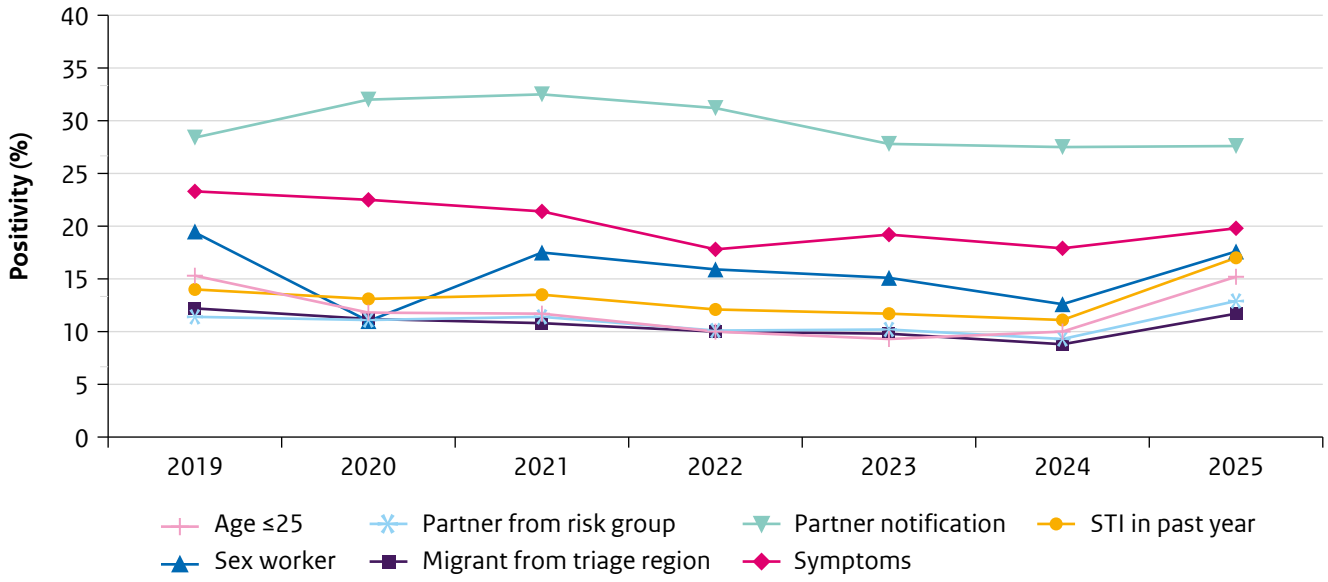
Footnote 1: Migrant from triage region includes migrants and children of migrants from Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.
Footnote 2: Partner from risk group: partner originating from a region of origin as indicated by triage criteria.
Footnote 3: Exact numbers of diagnoses, tests and positivity by triage criteria in 2025 are shown in supplementary table 13.4.

Figure 4.3c Reported triage indication: chlamydia positivity by triage indication in MSM-STI consultations, 2016-2025



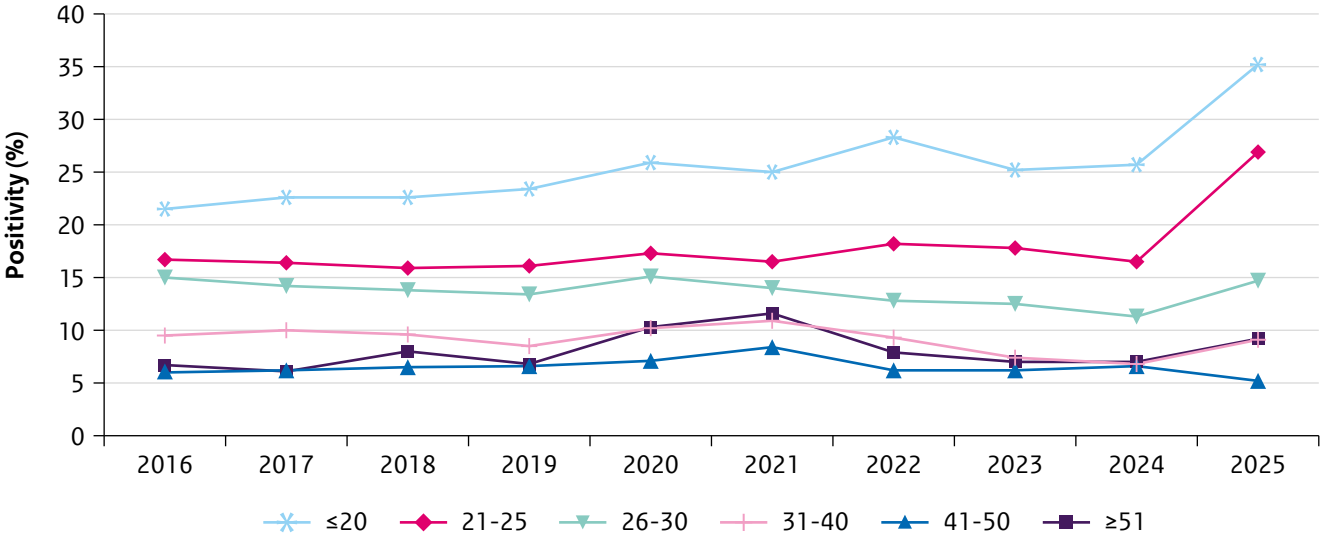
Footnote 1: Migrant from triage region includes migrants and children of migrants from Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.
Footnote 2: Partner from risk group: partner originating from a region of origin as indicated by triage criteria.
Footnote 3: Exact numbers of diagnoses, tests and positivity by triage criteria in 2025 are shown in supplementary table 13.4.

Figure 4.3d Reported triage indication: chlamydia positivity by triage indication in MSM-PrEP consultations, 2019-2025



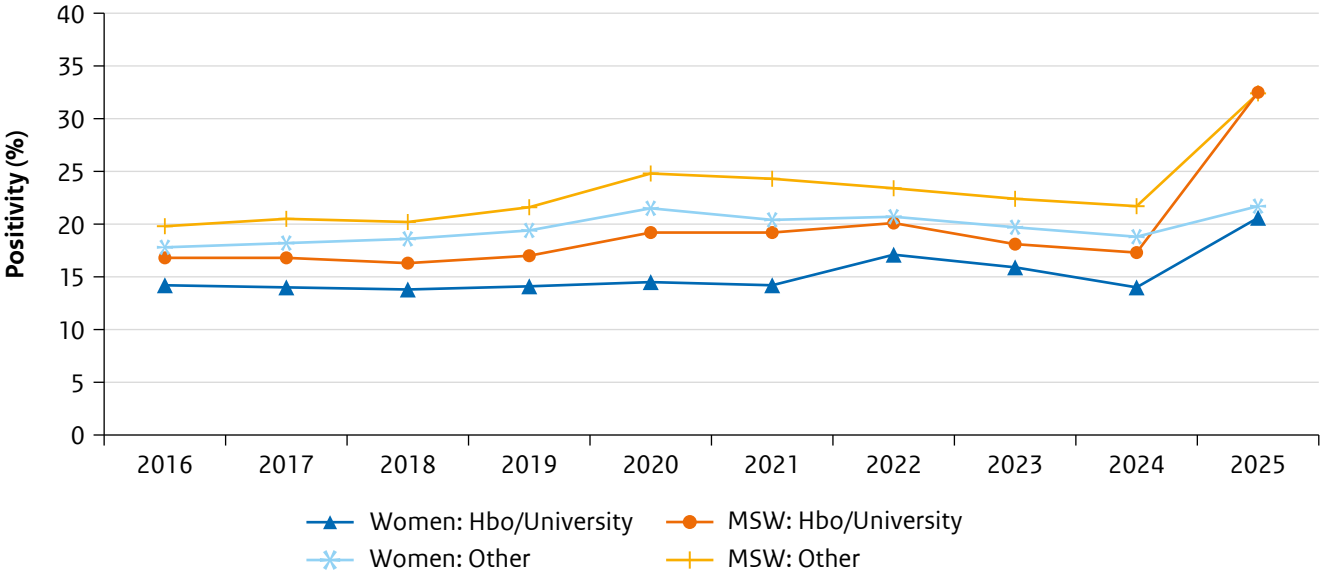
Footnote 1: Migrant from triage region includes migrants and children of migrants from Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.
Footnote 2: Partner from risk group: partner originating from a region of origin as indicated by triage criteria.
Footnote 3: Exact numbers of diagnoses, tests and positivity by triage criteria in 2025 are shown in supplementary table 13.4.

Figure 4.4 Age: trends in chlamydia positivity by age group in women and MSW, 2016-2025



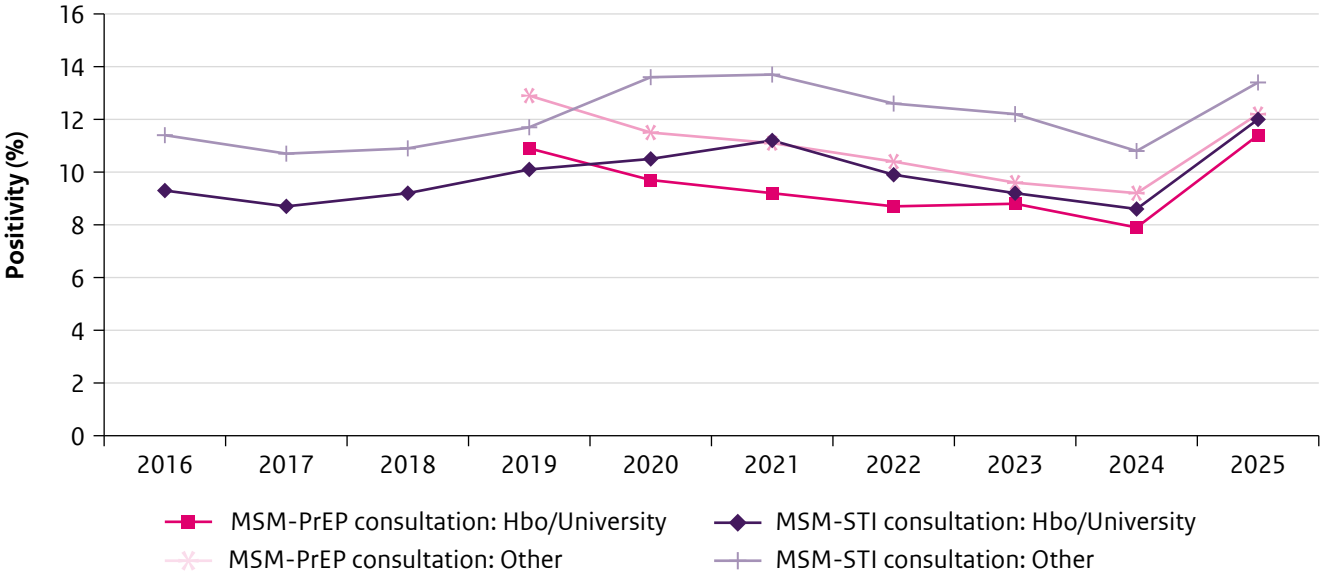
Footnote: Exact numbers of diagnoses, tests and positivity by age group in 2025 are shown in supplementary table 13.6.

Figure 4.5a Education level: trends in chlamydia positivity by education level in women and MSW, 2016-2025



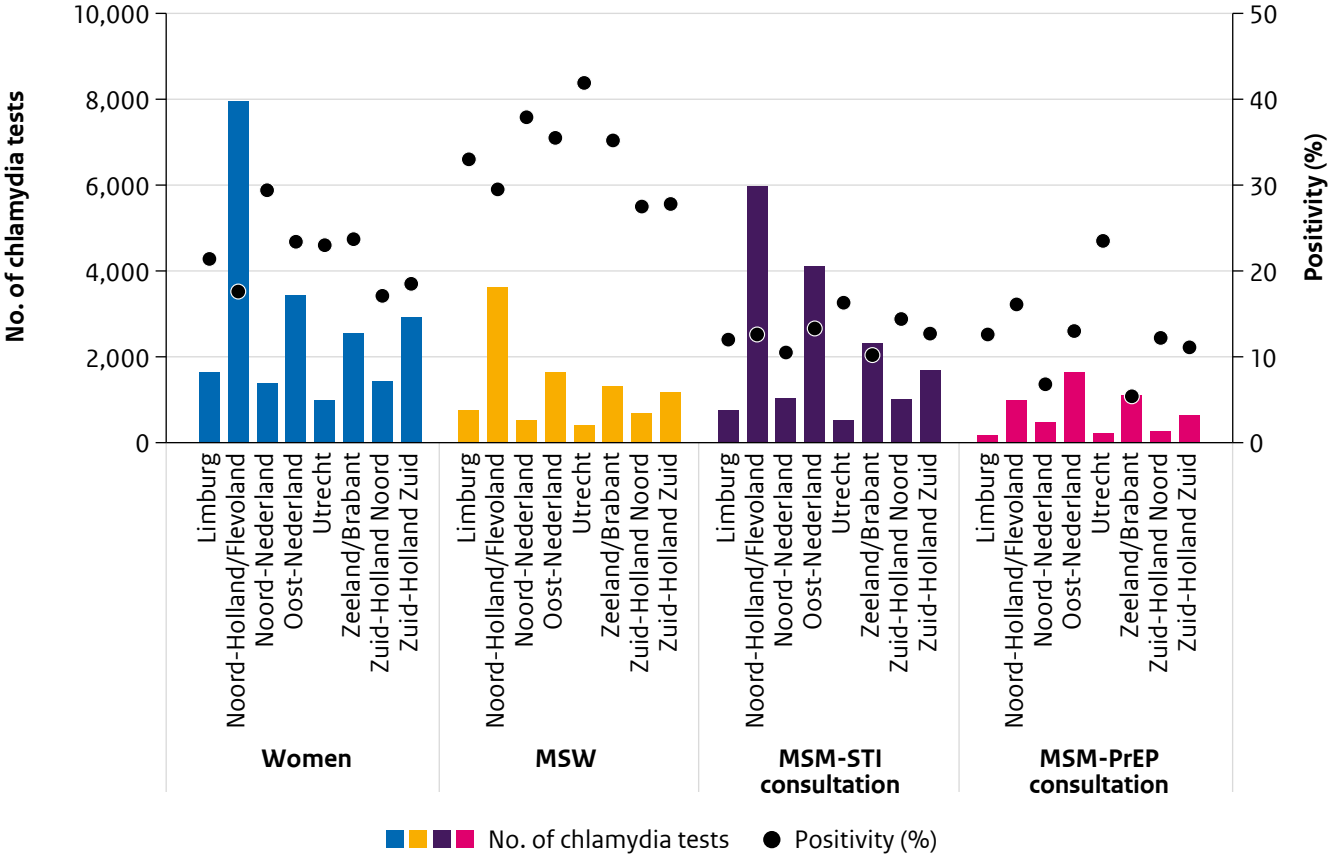
Footnote: Other education includes: no education, elementary school, lbo, mavo, vmbo, mbo, havo, vwo.

Figure 4.5b Education level: trends in chlamydia positivity by education level in MSM, 2016-2025



Footnote: Other education includes: no education, elementary school, lbo, mavo, vmbo, mbo, havo, vwo.

Figure 4.6 Region: number of chlamydia tests and chlamydia positivity by region, sex and type of sexual contact, 2025



Footnote: Trends in chlamydia positivity by region are shown in supplementary figures 13.4a and 13.4b.

Table 4.1 Anatomical site: number of chlamydia tests and chlamydia positivity by anatomical site, sex and type of sexual contact, 2021-2025

Location	2021	2022	2023	2024	2025
Women					
Urogenital					
N tested	53,815	62,664	64,026	53,764	22,045
Positivity (%)	14.9	16.5	15.6	14.6	20.5
Anorectal					
N tested	20,676	24,884	23,856	19,065	2,623
Positivity (%)	13.9	15.7	14.1	12.1	17.8
Oral					
N tested	18,720	22,627	23,355	4,303	209
Positivity (%)	5.4	5.5	5.4	4.8	1.9
MSM-STI consultation					
Urogenital					
N tested	36,770	43,886	47,994	49,018	9,610
Positivity (%)	3.7	3.3	3.2	3.1	9.4
Anorectal					
N tested	36,101	43,038	46,904	48,357	12,757
Positivity (%)	9.3	8.2	7.6	7.4	11.0
Oral					
N tested	36,425	43,540	46,150	7,846	193
Positivity (%)	1.9	1.8	1.6	1.5	2.6
MSM-PrEP consultation					
Urogenital					
N tested	22,022	27,376	27,723	25,326	1,850
Positivity (%)	2.3	2.0	2.1	2.0	10.6
Anorectal					
N tested	21,945	27,272	27,617	25,512	4,588
Positivity (%)	8.0	7.5	7.3	6.9	10.4
Oral					
N tested	22,016	27,382	26,492	4,230	41
Positivity (%)	1.4	1.4	1.2	1.8	0.0

Footnote 1 MSW are usually only tested urogenital, while women are tested on indication for anorectal or oral chlamydia; indications vary by region. MSM were usually tested at all three sites until 2023. Since 2024, oral chlamydia is only tested on indication.
Footnote 2: Please note that people can test positive at multiple anatomical sites.

Table 4.2 Anatomical site of infection: number and proportion of chlamydia diagnoses by anatomical site, sex and type of sexual contact, 2025

Location	Women	MSM-STI consultation	MSM-PrEP consultation
	n (%)	n (%)	n (%)
Any location, total	**4,584 (100.0)**	**2,184 (100.0)**	**645 (100.0)**
Urogenital only	4,113 (89.7)	777 (35.6)	168 (26.0)
Anorectal only	63 (1.4)	1,268 (58.1)	447 (69.3)
Oral only	2 (0.0)	3 (0.1)	0 (0.0)
Urogenital and anorectal	404 (8.8)	131 (6.0)	29 (4.5)
Urogenital and oral	1 (0.0)	0 (0.0)	0 (0.0)
Anorectal and oral	0 (0.0)	2 (0.1)	0 (0.0)
Urogenital and anorectal and oral	1 (0.0)	0 (0.0)	0 (0.0)

Footnote 1: MSW are usually only tested urogenital. Women and MSM are tested at different anatomical sites on indication.
Footnote 2: For 1 MSW, 3 MSM-STI and 1 MSM-PrEP consultations, the anatomic site of infection was unknown because of pooled testing.

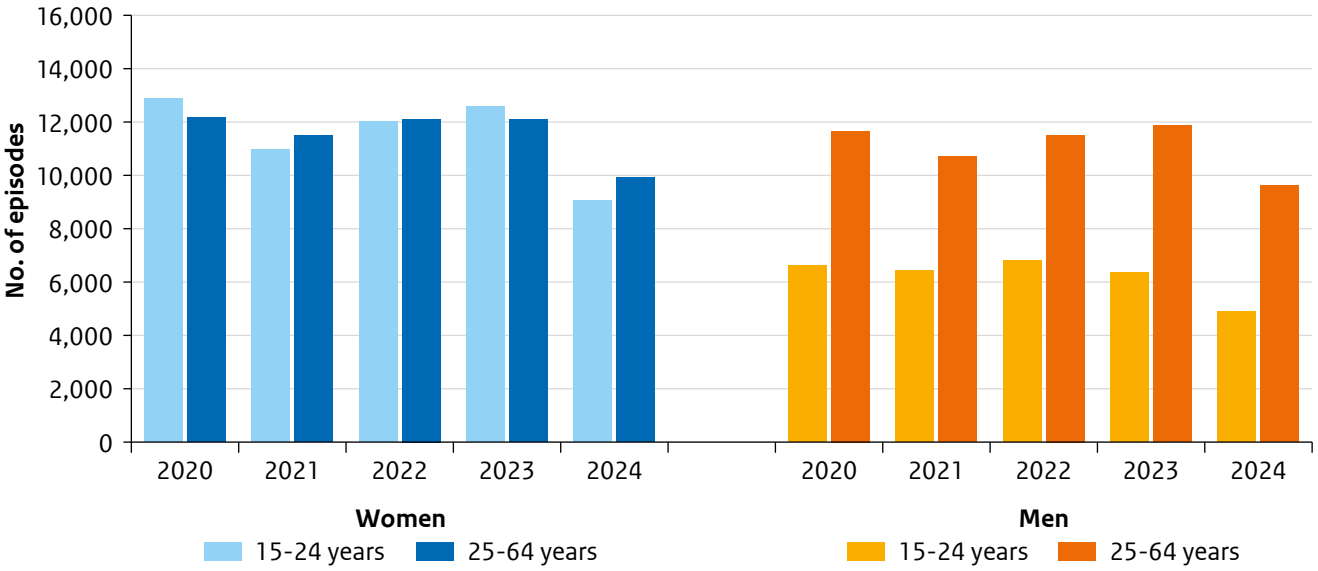
Table 4.3 Concurrent STI: Proportion of consultations with concurrent chlamydia and other STI diagnoses by sex and type of sexual contact, 2025

Concurrent infection	Women	MSW	MSM-STI consultation	MSM-PrEP consultation
	n (%)	n (%)	n (%)	n (%)
Chlamydia, total	4,584 (100.0)	3,245 (100.0)	2,184 (100.0)	645 (100.0)
Gonorrhoea	420 (9.2)	302 (9.3)	869 (39.8)	284 (44.0)
Syphilis, infectious	4 (0.1)	3 (0.1)	107 (4.9)	37 (5.7)
HIV newly diagnosed	1 (0.0)	0 (0.0)	21 (1.0)	2 (0.3)
Other STI*	46 (1.0)	48 (1.5)	31 (1.4)	8 (1.2)

**Other STI includes genital herpes, genital warts, hepatitis B (infectious), and hepatitis C. SHCs check for genital herpes and genital warts on indication only. In addition, clients are not routinely tested for hepatitis C.*

4.3 General practices

Figure 4.7 Estimated number of chlamydia episodes in general practices by sex and age group, based on general practices in Nivel-PCD, 2020-2024



Footnote: About 50% of the total Dutch population consists of persons aged 25-64 years and about 10% consists of persons aged 15-24 years.

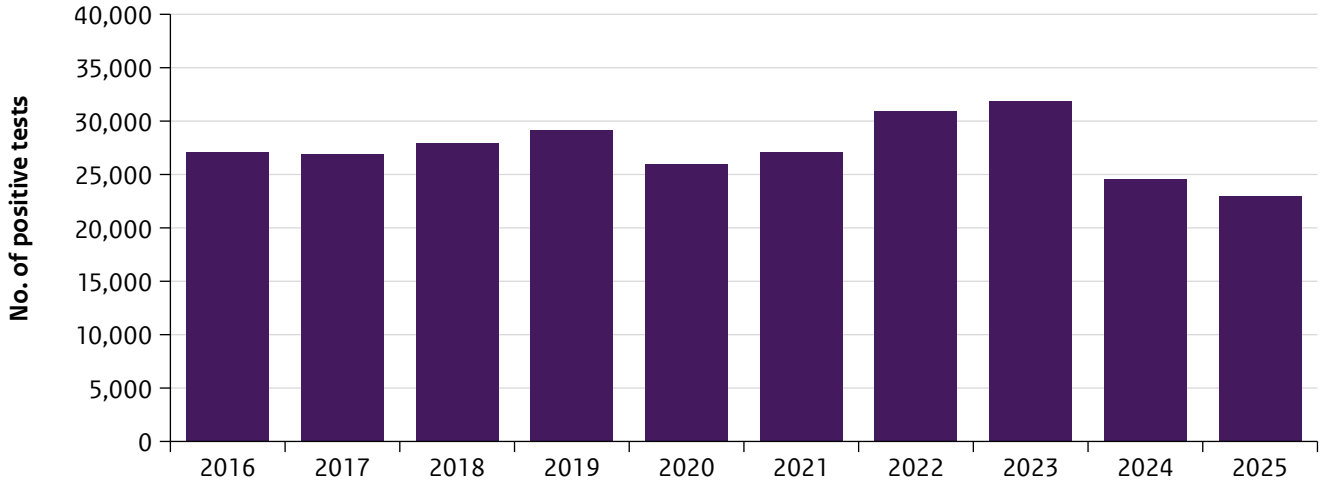
Table 4.4 Reporting rate (number of episodes per 1000 persons aged 15-64 years) of chlamydia in general practices by sex and age group, based on general practices in Nivel-PCD, 2020-2024

Year	Women n/1,000			Men n/1,000			Total n/1,000		
	All	15-24	25-64	All	15-24	25-64	All	15-24	25-64
2020	**4.4**	12.3	2.7	**3.2**	6.1	2.5	**3.8**	9.2	2.6
2021	**4.0**	10.5	2.5	**3.0**	5.9	2.3	**3.5**	8.2	2.4
2022	**4.2**	11.3	2.6	**3.2**	6.2	2.5	**3.7**	8.8	2.6
2023	**4.3**	11.7	2.6	**3.1**	5.7	2.5	**3.7**	8.7	2.6
2024	**3.3**	8.4	2.1	**2.5**	4.4	2.1	**2.9**	6.4	2.1

4.4 Other sources

4.4.1 Laboratory surveillance

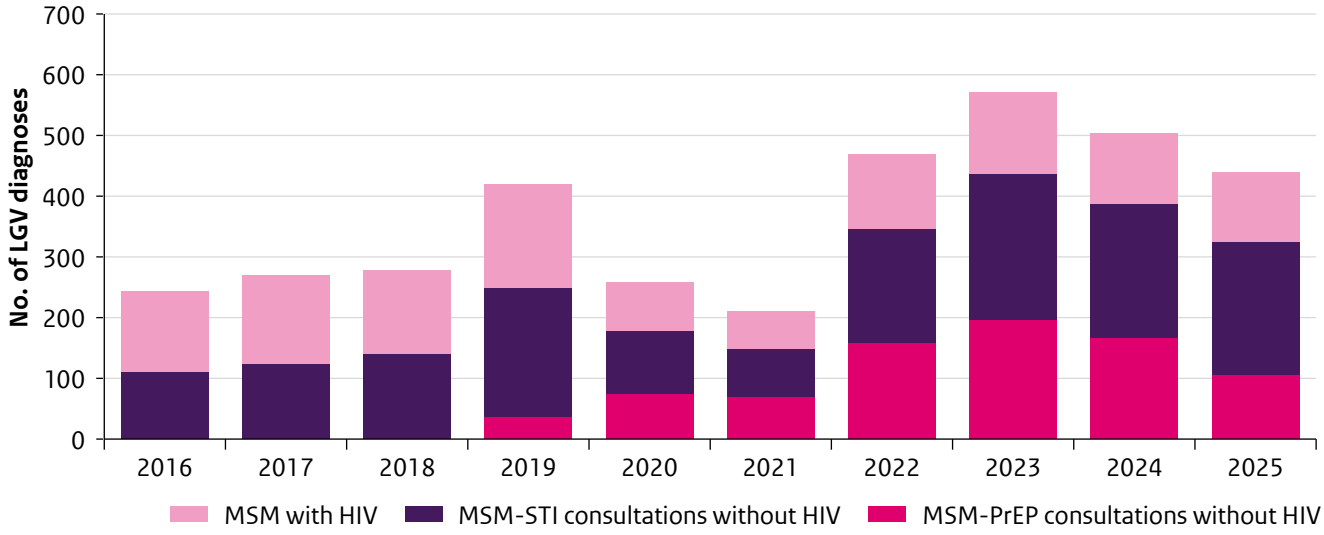
Figure 4.8 Number of positive tests for Chlamydia trachomatis from up to 21 medical microbiology laboratories, 2016-2025



Source: Virologische weekstaten
Footnote: 20 medical microbiology laboratories in 2025.

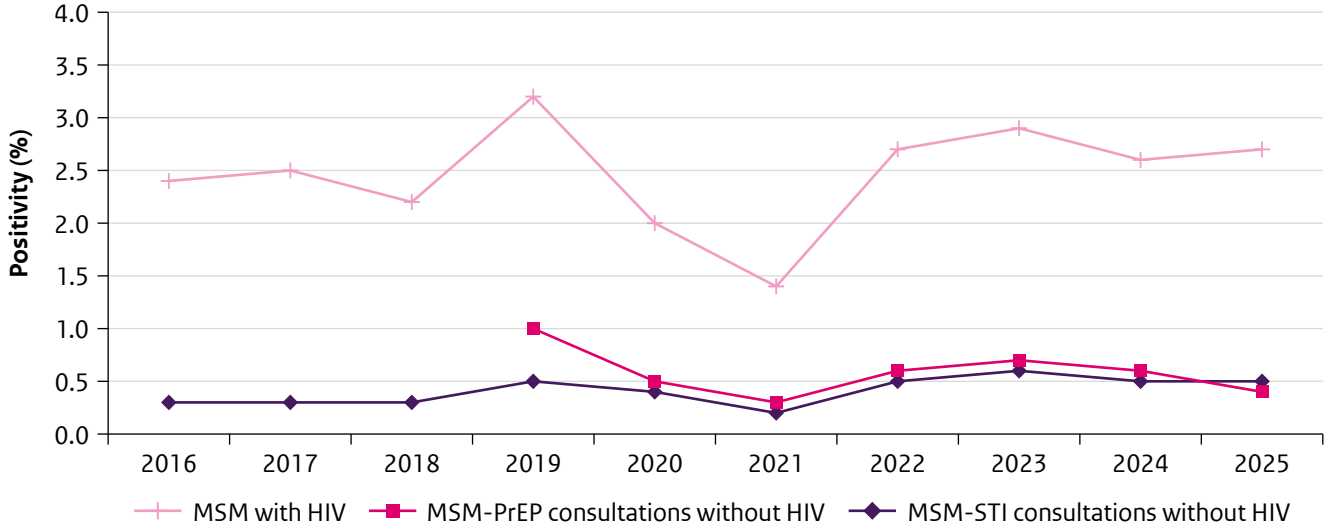
4.5 Lymphogranuloma venereum at Sexual Health Centres

Figure 4.9 Number of LGV diagnoses among MSM by HIV-status, 2016-2025



Footnote: Aggregated data of non-registered consultations included for 2018 and 2019.

Figure 4.10 LGV positivity among MSM by HIV status, 2016-2025



5 Gonorrhoea

5.1 Key points

5.1.1 Sexual Health Centres

- In 2025, 14,297 gonorrhoea infections were diagnosed at SHCs (13% in women, 7% in MSW, 54% in MSM-STI, 23% in MSM-PrEP, and 3% in gender diverse persons). This was a 2.5% increase compared to 2023 (13,952 diagnoses) (Figure 5.1a-e).
- The 14,297 gonorrhoea diagnoses were made among 12,086 individuals. There were 1754 persons (15%) with more than one gonorrhoea diagnosis in 2025.
- In 2024, 157,862 gonorrhoea tests (2025: 144,474) were registered at SHCs. The number of tests decreased by 18% among women (2024: 54,068; 2025: 44,363), and by 9% among MSW (2024: 25,643; 2025: 23,237). The number of tests was similar among MSM-STI (2024: 49,675; 2025: 49,998) and MSM-PrEP consultations (2024: 25,713; 2025: 23,741) and increased by 13% among gender diverse persons (2024: 2763; 2025: 3135) (Figure 5.1a-e).
- In 2022 and 2023, gonorrhoea positivity increased sharply among women and MSW. Since then, positivity stabilised among women, amounting to 4.3% in 2025, and continued to increase among MSW to 4.4% in 2025 (Figure 5.1a-b).
- Gonorrhoea positivity in MSM-STI consultations has been increasing from 12.4% in 2021 to 15.5% in 2025. Among MSM-PrEP consultations, gonorrhoea positivity increased in 2025 compared to 2024 (from 11.7% to 13.5%) (Figure 5.1d). Of all unique persons who were tested among MSM-PrEP in 2025, 21.6% was gonorrhoea-positive in at least one consultation. Among MSM-STI this proportion was 19.4%. (Table 2.7b).
- Gonorrhoea positivity in gender diverse persons has been around 10% in the past years and increased to 12.1% in 2025 (Figure 5.1e). As the number of gender diverse persons is relatively low, they are not included in all the tables and figures.
- Highest gonorrhoea positivity was seen among persons who were notified for gonorrhoea (31.0% among women, 16.5% among MSW, 35.4% among MSM-STI, and 41.1% among MSM-PrEP consultations in 2025). High positivity was also seen among those with symptoms, an STI in the past year, and sex workers (Figure 5.2a-d, Table 13.8).
- The gonorrhoea increase among women and MSW in 2023 was most prominent among those under the age of 25 years. In 2025, gonorrhoea positivity remained high in these groups compared to previous years and increased further among those aged ≤20. Among MSM, positivity was also highest in those under the age of 25 years (Figure 5.3a-b).
- The gonorrhoea increase among women and MSW in 2023 was most prominent among those with university education level (HBO/university). In 2024 and 2025, gonorrhoea positivity stabilised in these groups but further increased among women and MSW with other education levels. Among MSM, no differences in trends were seen between education levels (Figure 5.4a-b).

5.1.2 General practices

- Compared to 2023, the estimated number of gonorrhoea episodes at GPs slightly decreased among women in 2024, from around 6300 to 6000 and increased among men, from around 12,500 to 13,800 (Figure 5.6).
- In 2024, the reporting rate for gonorrhoea at GPs was 1.7 episodes per 1000 individuals aged 15-64 years. The reporting rates were higher for women and men aged 15-24 years and decreased in these groups. Among women and men aged 25-64 years, the reporting rate increased (Table 5.4).

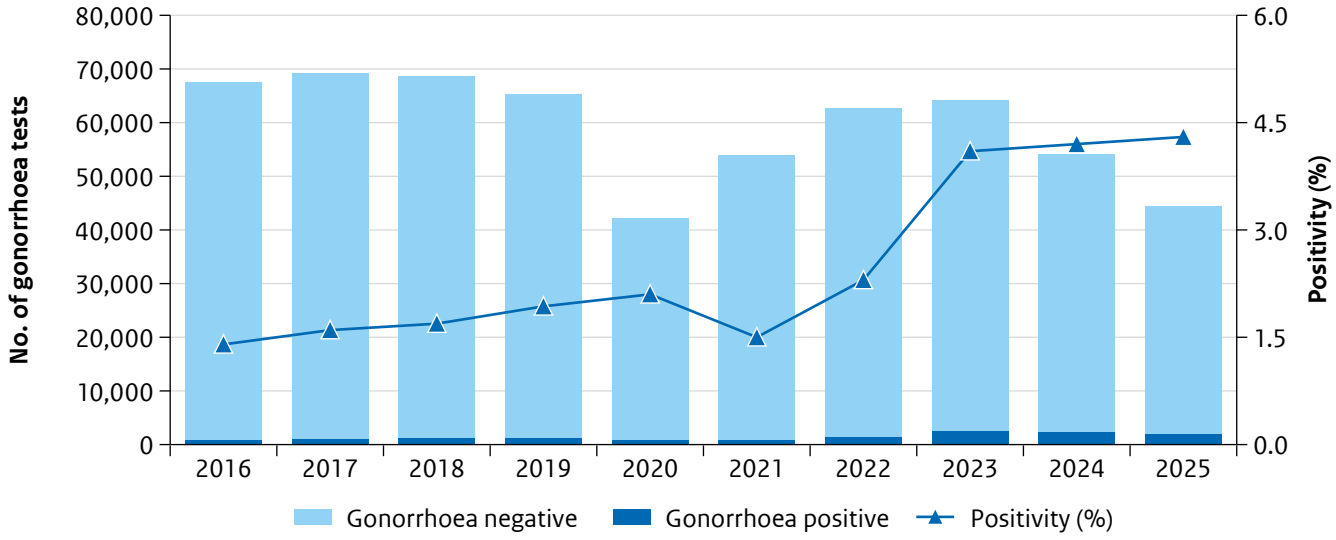
5.1.3 Antimicrobial resistance of gonococci in the Netherlands

- In 2025, 15 out of 24 SHCs reported susceptibility test results in the Gonococcal Resistance to Antimicrobials Surveillance (GRAS) programme. Together, these SHCs represented 82% of all gonorrhoea infections diagnosed at SHCs in the Netherlands.
- Within participating SHCs, cultures were performed for 73% of consultations involving a gonorrhoea diagnosis. Due to negative or failed cultures, susceptibility test results were available for 41% of diagnosed infections (n=4768) within participating SHCs (Figure 5.8). At national level, susceptibility test results were reported for 33% of gonorrhoea diagnoses at SHCs. This proportion has been stable at around 33% since 2014 (Figure 5.7).
- Antimicrobial resistance to ceftriaxone, the first-choice treatment in the Netherlands, was reported for the first time in 2025. This person contracted gonorrhoea in South-east Asia and was diagnosed upon return to the Netherlands. The strain was resistant to ceftriaxone (MIC 0.19 mg/L), cefotaxime (MIC 0.38 mg/L), azithromycin (MIC >256 mg/L), tetracycline (MIC 6 mg/L), and ciprofloxacin (MIC 2 mg/L). Treatment with

ceftriaxone was successful, and no further sexual contact was reported in the Netherlands.
- Since 2021, there has been an increase in isolates with slightly reduced susceptibility to ceftriaxone (MIC >0.008) and a decrease in the most susceptible isolates (MIC ≤ 0.002 mg/L). In 2025, two isolates were reported with an MIC-value of 0.125 mg/L, just below the cut-off for resistance (Figure 5.12a).
- Resistance to azithromycin increased between 2016 and 2023, up to 30.6% in 2023, but decreased in 2025 to 21.9% (Figure 5.10). This trend was similar for MSM, women, and MSW (Figure 5.11a).
- Resistance to ciprofloxacin has been over 50% since 2019 and amounted to 59.7% in 2025. (Figure 5.10). For women and MSW, ciprofloxacin resistance was much lower in 2019, but since then it has increased to over 50% in 2025 (Figure 5.11b).
- Resistance to cefotaxime has been under 1% since 2020 and was 0.2% in 2025 (Figure 5.10).
- In 2025, tetracycline was temporarily added to the GRAS panel. 14 SHCs performed tetracycline susceptibility testing, and tetracycline resistance was 57.1%.

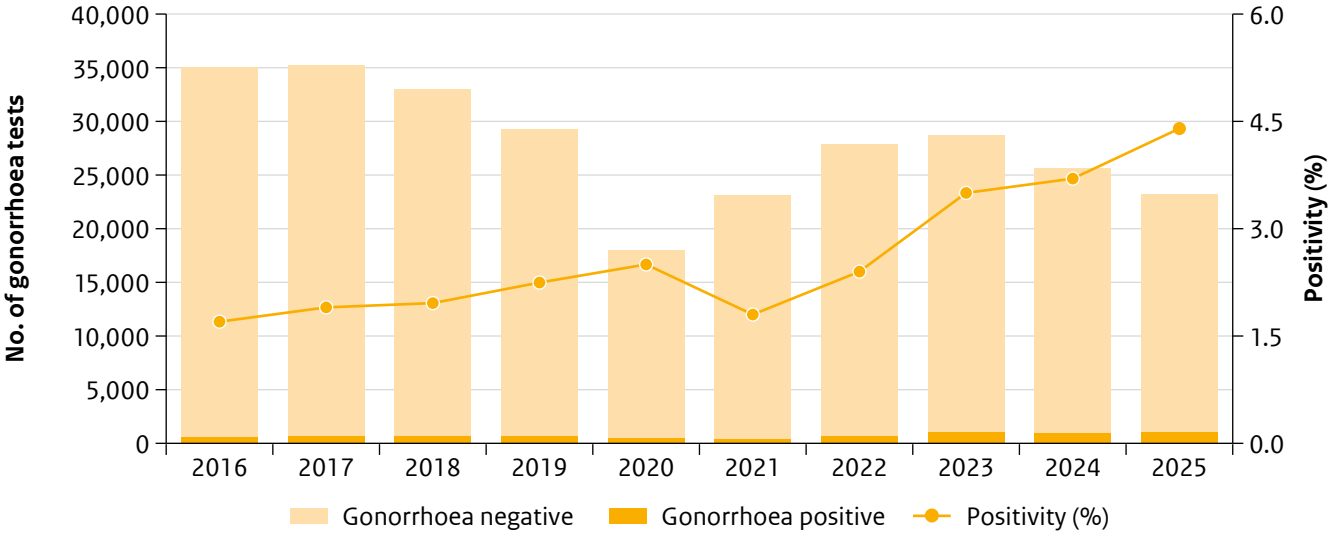
5.2 Sexual Health Centres: characteristics, risk groups and trends

Figure 5.1a Number of gonorrhoea positive and negative tests and gonorrhoea positivity in women, 2016-2025



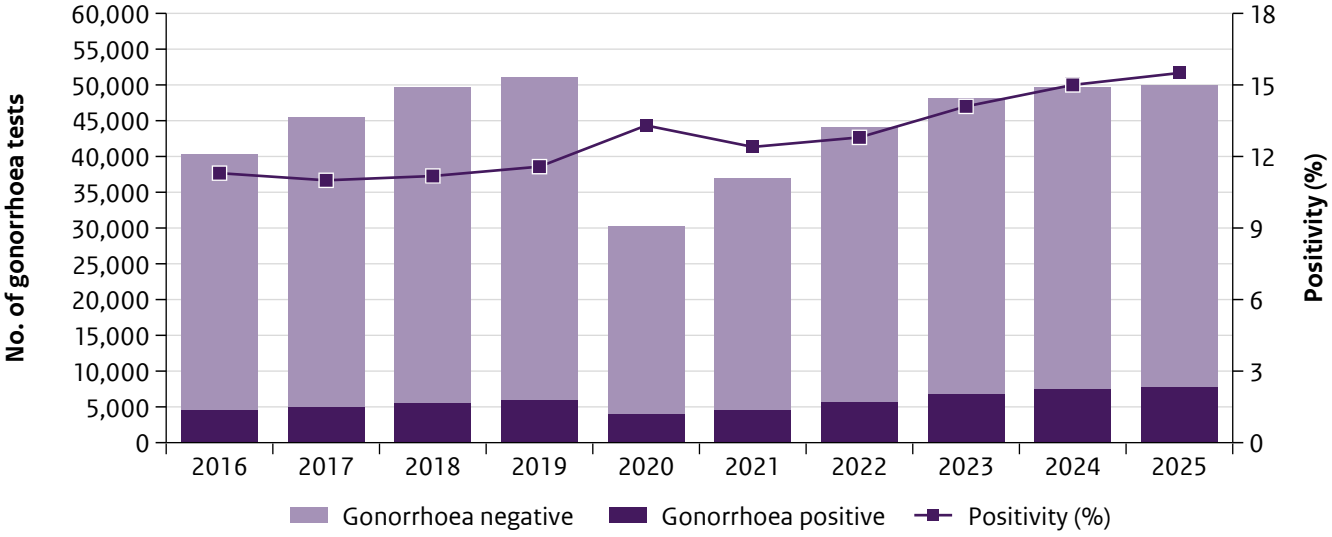
Footnote: Aggregated data of non-registered consultations included for 2018 and 2019.

Figure 5.1b Number of gonorrhoea positive and negative tests and gonorrhoea positivity in MSW, 2016-2025



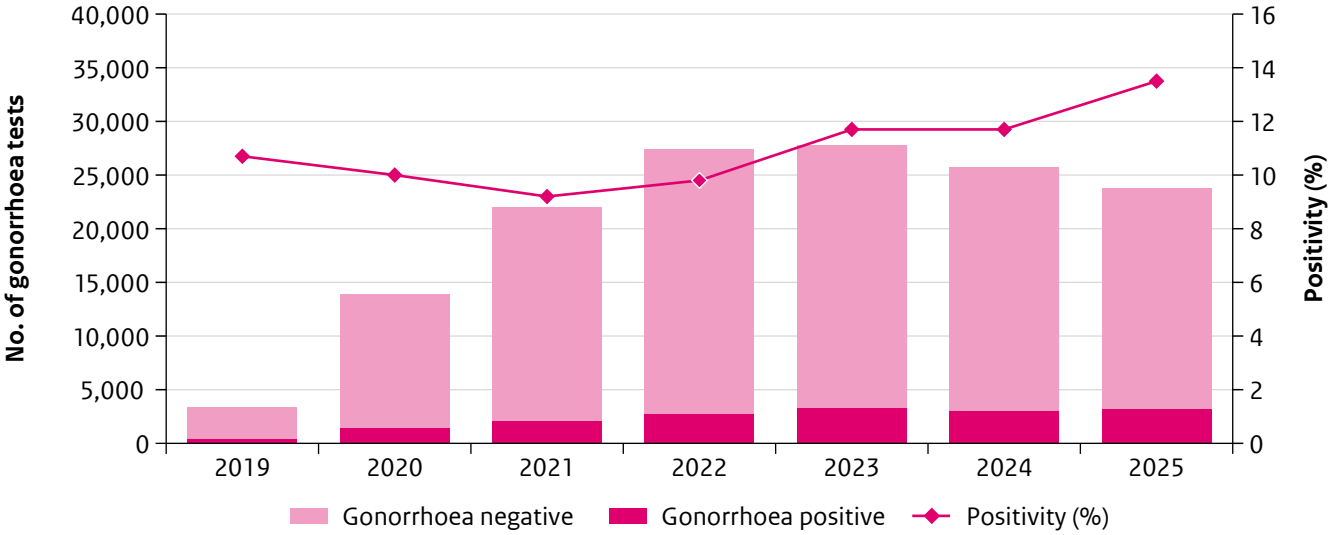
Footnote: Aggregated data of non-registered consultations included for 2018 and 2019.

Figure 5.1c Number of gonorrhoea positive and negative tests and gonorrhoea positivity in MSM-STI consultations, 2016-2025



Footnote: Aggregated data of non-registered consultations included for 2018 and 2019.

Figure 5.1d Number of gonorrhoea positive and negative tests and gonorrhoea positivity in MSM-PrEP consultations, 2019-2025



Footnote: Aggregated data of non-registered consultations included for 2019.

Figure 5.1e Number of gonorrhoea positive and negative tests and gonorrhoea positivity in gender diverse persons, 2020-2025

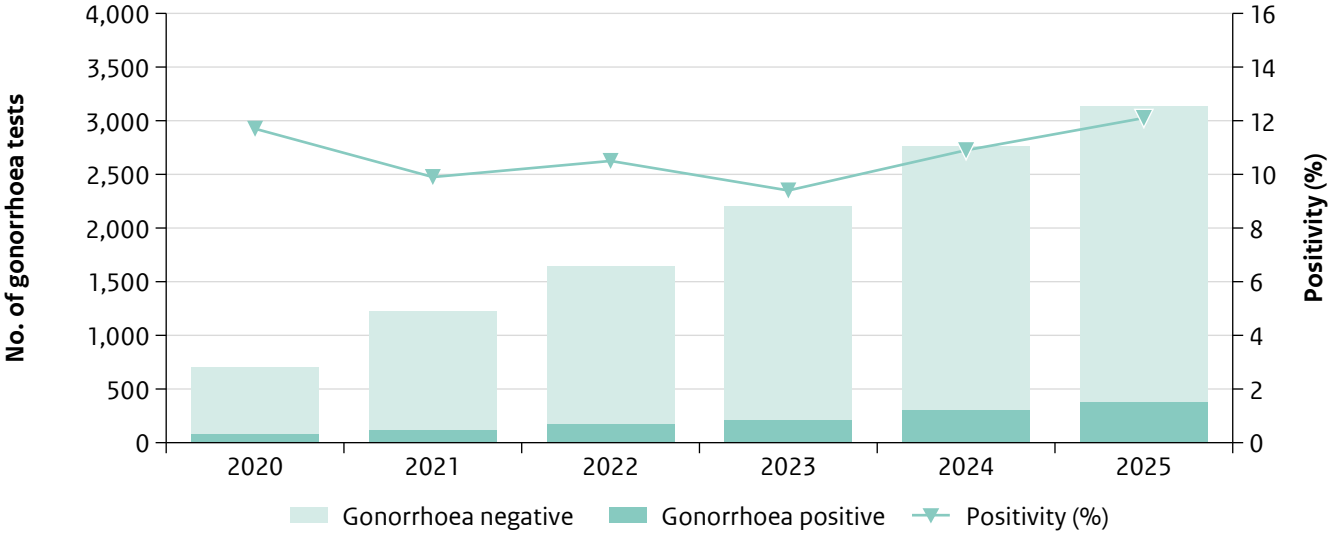
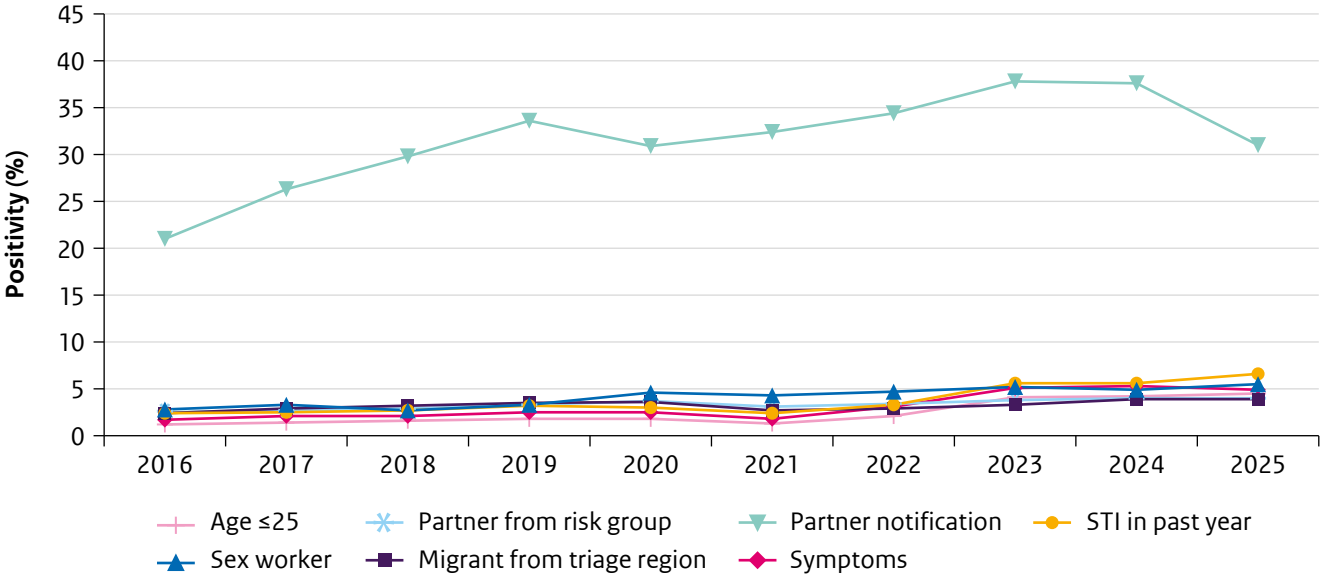
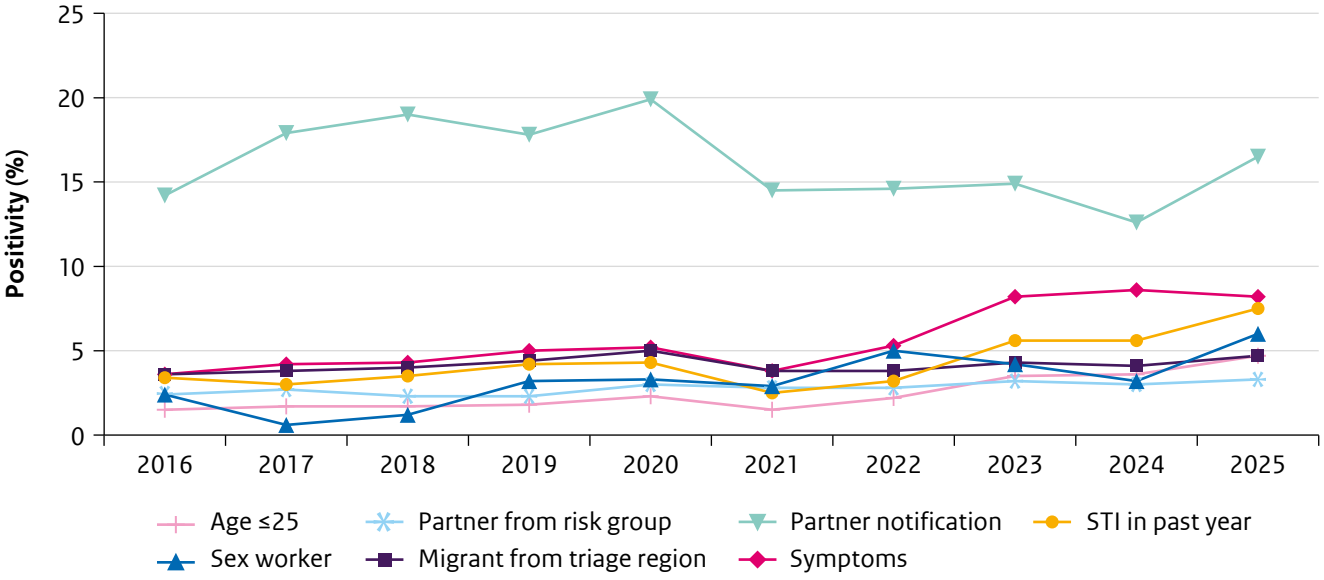


Figure 5.2a Reported triage indication: gonorrhoea positivity by triage indication in women, 2016-2025



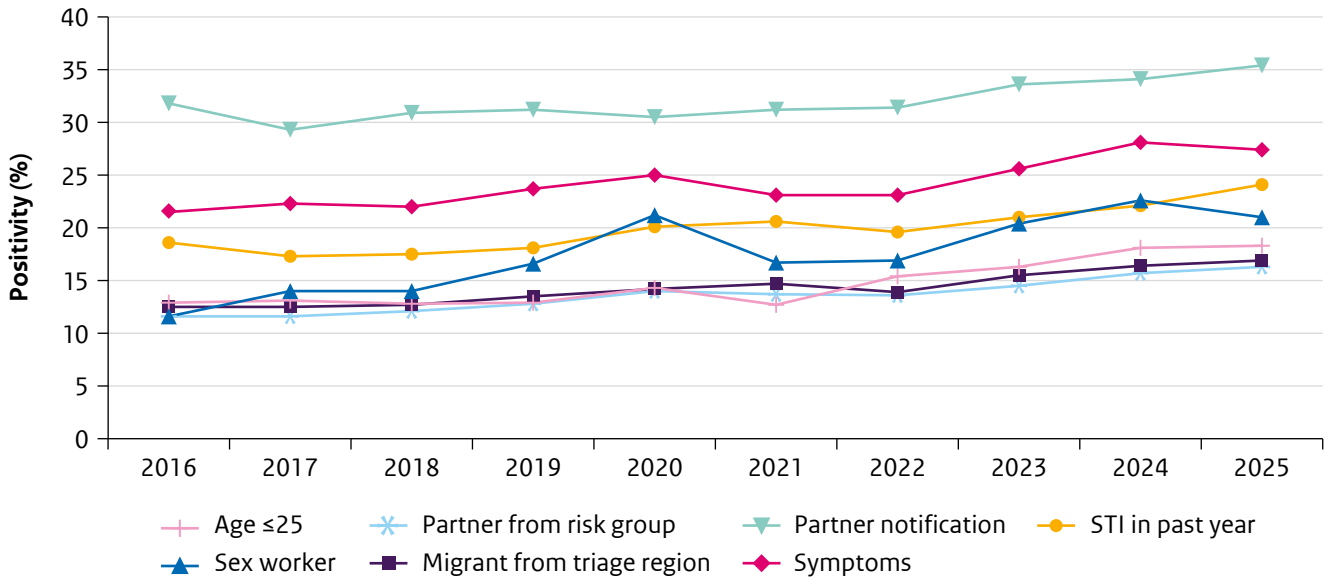
Footnote 1: Migrant from triage region includes migrants and children of migrants from Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.
Footnote 2: Partner from risk group: partner originating from a region of origin as indicated by triage criteria or a male partner who had sex with men.
Footnote 3: Exact numbers of diagnoses, tests and positivity by triage criteria in 2025 are shown in supplementary table 13.8.

Figure 5.2b Reported triage indication: gonorrhoea positivity by triage indication in MSW, 2016-2025



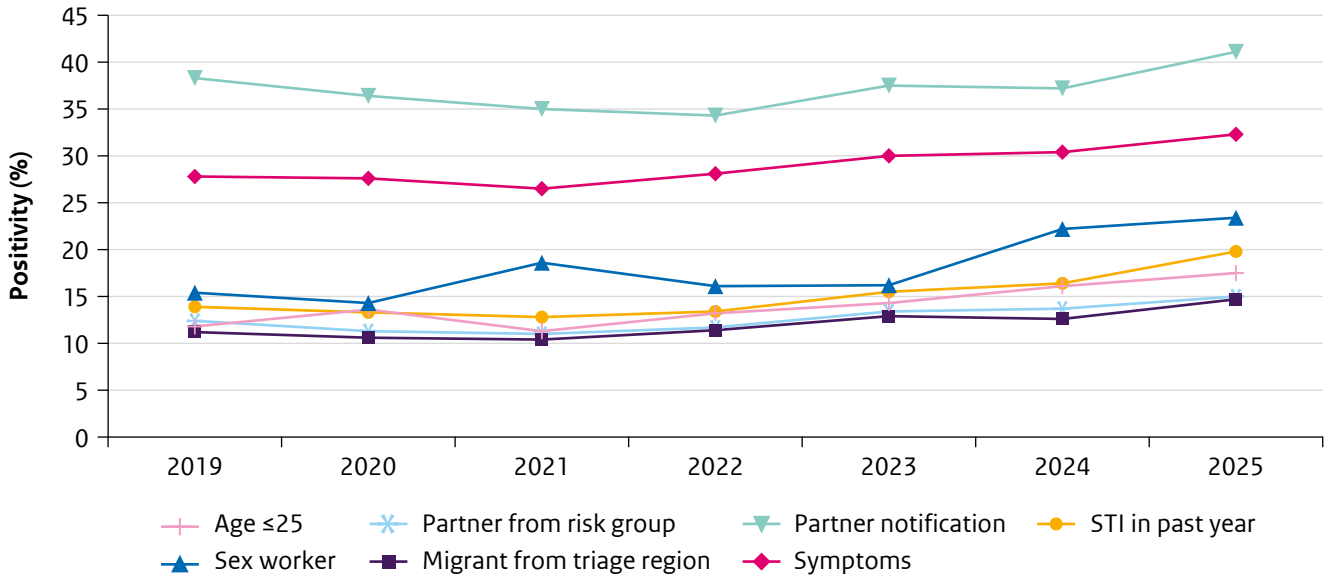
Footnote 1: Migrant from triage region includes migrants and children of migrants from Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.
Footnote 2: Partner from risk group: partner originating from a region of origin as indicated by triage criteria. Footnote 3: Exact numbers of diagnoses, tests and positivity by triage criteria in 2025 are shown in supplementary table 13.8.

Figure 5.2c Reported triage indication: gonorrhoea positivity by triage indication in MSM-STI consultations, 2016-2025



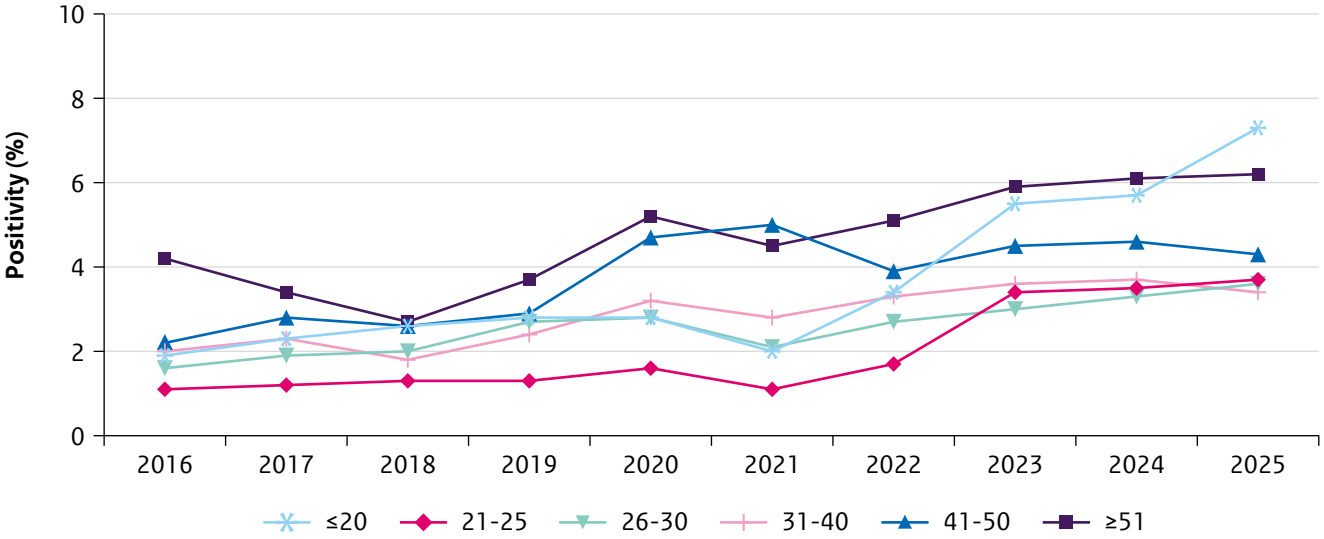
Footnote 1: Migrant from triage region includes migrants and children of migrants from Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.
Footnote 2: Partner from risk group: partner originating from a region of origin as indicated by triage criteria.
Footnote 3: Exact numbers of diagnoses, tests and positivity by triage criteria in 2025 are shown in supplementary table 13.8.

Figure 5.2d Reported triage indication: gonorrhoea positivity by triage indication in MSM-PrEP consultations, 2019-2025



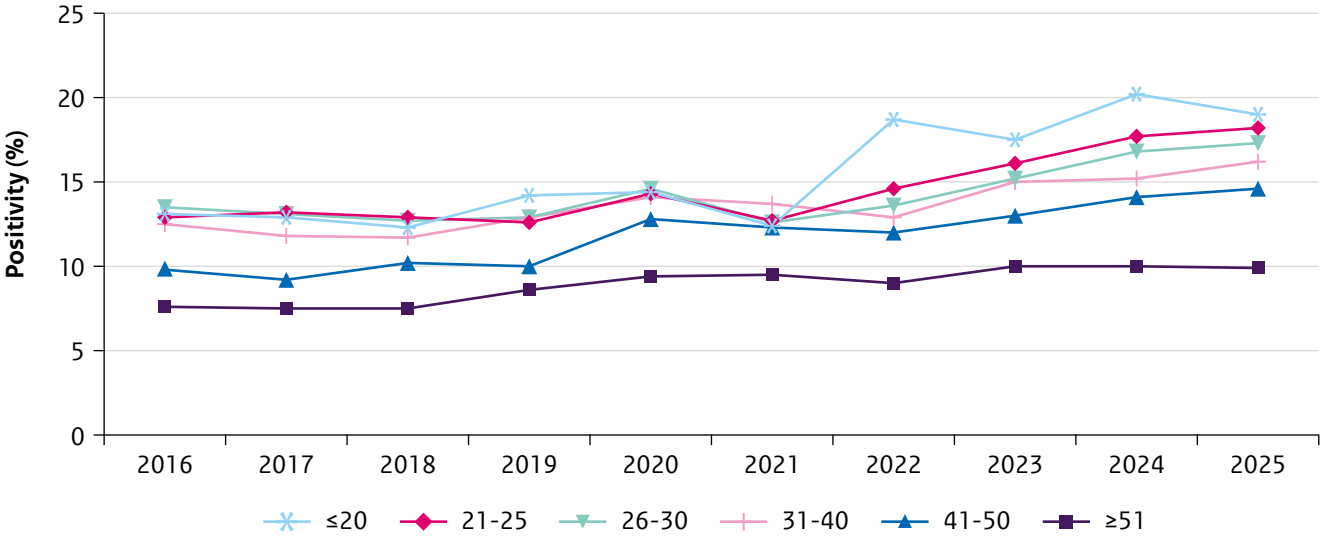
Footnote 1: Migrant from triage region includes migrants and children of migrants from Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.
Footnote 2: Partner from risk group: partner originating from a region of origin as indicated by triage criteria.
Footnote 3: Exact numbers of diagnoses, tests and positivity by triage criteria in 2025 are shown in supplementary table 13.8.

Figure 5.3a Age: trends in gonorrhoea positivity by age group in women and MSW, 2016-2025



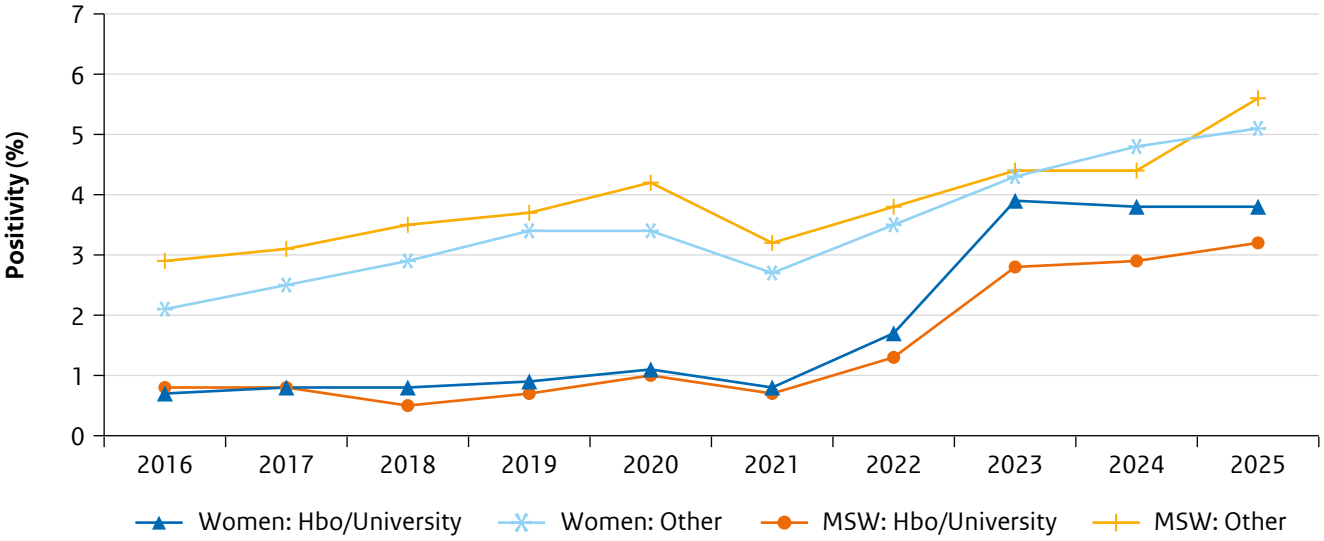
Footnote: Exact numbers of diagnoses, tests and positivity by age group in 2025 are shown in supplementary table 13.10.

Figure 5.3b Age: trends in gonorrhoea positivity by age group in MSM-STI consultations, 2016-2025



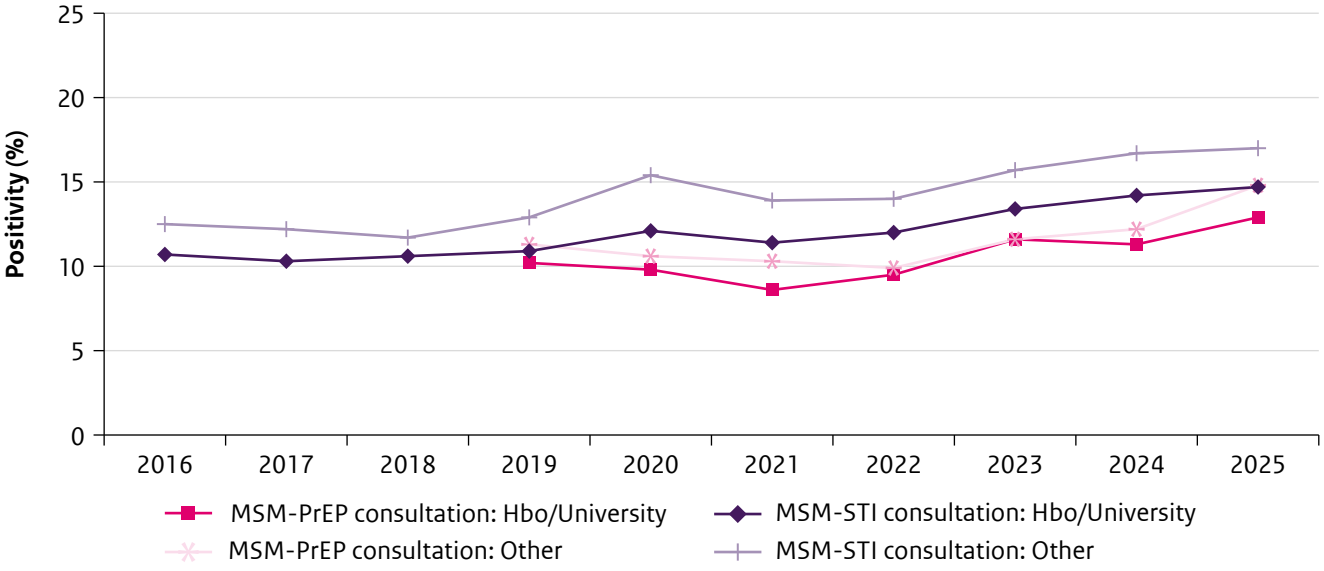
Footnote: Exact numbers of diagnoses, tests and positivity by age group in 2025 are shown in supplementary table 13.10.

Figure 5.4a Education level: trends in gonorrhoea positivity by education level in women and MSW, 2016-2025



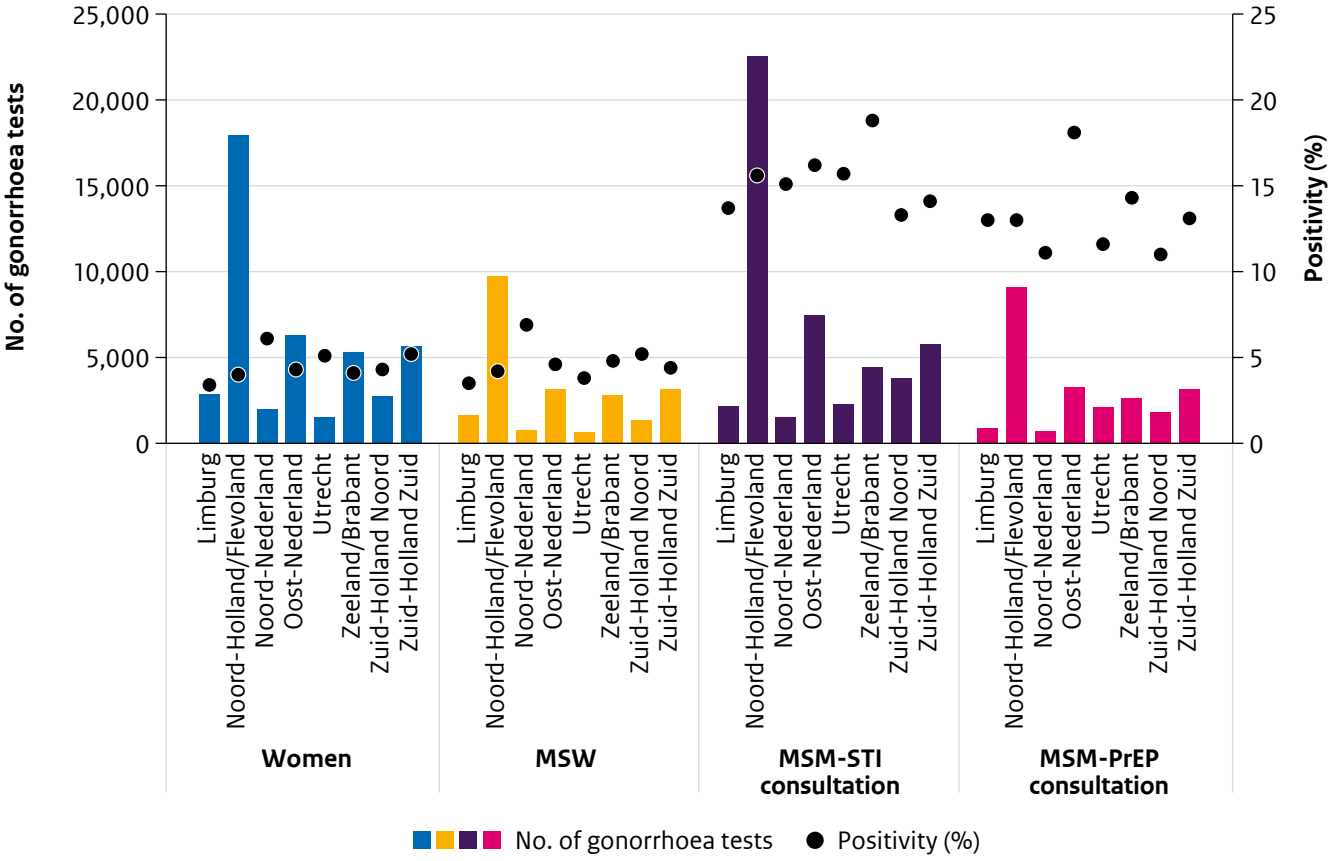
Footnote: Other education includes: no education, elementary school, lbo, mavo, vmbo, mbo, havo, vwo.

Figure 5.4b Education level: trends in gonorrhoea positivity by education level in MSM, 2016-2025



Footnote: Other education includes: no education, elementary school, lbo, mavo, vmbo, mbo, havo, vwo.

Figure 5.5 Region: number of gonorrhoea tests and gonorrhoea positivity by region, sex and type of sexual contact, 2025



Footnote: Trends in gonorrhoea positivity by region are shown in supplementary figures 13.6a and 13.6b.

Table 5.1 Anatomical site: number of gonorrhoea tests and gonorrhoea positivity by anatomical site, sex and type of sexual contact, 2021-2025

Location	2021	2022	2023	2024	2025
Women					
Urogenital					
N tested	53,781	62,652	64,034	54,018	44,287
Positivity (%)	1.2	1.8	2.9	3.0	3.2
Anorectal					
N tested	20,633	24,862	23,857	19,146	15,568
Positivity (%)	1.4	2.0	3.3	3.2	3.3
Oral					
N tested	18,712	22,637	24,751	21,197	19,777
Positivity (%)	1.7	2.6	4.5	4.3	4.1
MSM-STI consultation					
Urogenital					
N tested	36,776	43,887	47,994	49,536	49,802
Positivity (%)	3.4	3.2	3.4	3.7	4.0
Anorectal					
N tested	36,103	43,018	46,894	48,375	48,416
Positivity (%)	8.7	8.4	9.3	10.3	10.9
Oral					
N tested	36,442	43,530	47,514	49,067	49,314
Positivity (%)	7.4	8.2	9.3	9.5	9.6
MSM-PrEP consultation					
Urogenital					
N tested	22,018	27,369	27,725	25,673	23,675
Positivity (%)	1.2	1.1	1.5	1.4	2.1
Anorectal					
N tested	21,945	27,258	27,609	25,532	23,513
Positivity (%)	6.1	6.4	7.8	7.8	9.4
Oral					
N tested	22,012	27,377	27,717	25,648	23,666
Positivity (%)	5.5	6.0	7.2	7.0	8.0

Footnote 1: MSW are usually only tested urogenital, while women are tested on indication for anorectal or oral gonorrhoea; indications vary by region. MSM are usually tested at all three sites.
Footnote 2: Please note that people can test positive at multiple anatomical sites.

Table 5.2 Anatomical site of infection: number and proportion of gonorrhoea diagnoses by anatomical site, sex and type of sexual contact, 2025

Location	Women	MSM-STI consultation	MSM-PrEP consultation
	n (%)	n (%)	n (%)
Any location, total	**1,914 (100.0)**	**7,755 (100.0)**	**3,216 (100.0)**
Urogenital only	805 (42.1)	344 (4.4)	98 (3.0)
Anorectal only	89 (4.6)	2,165 (27.9)	1,128 (35.1)
Oral only	396 (20.7)	1,927 (24.8)	863 (26.8)
Urogenital and anorectal	210 (11.0)	496 (6.4)	98 (3.0)
Urogenital and oral	207 (10.8)	184 (2.4)	43 (1.3)
Anorectal and oral	26 (1.4)	1,682 (21.7)	736 (22.9)
Urogenital and anorectal and oral	181 (9.5)	957 (12.3)	250 (7.8)

Footnote 1: MSW are usually only tested urogenital, while women are tested on indication for anorectal or oral gonorrhoea; indications vary by region. MSM are usually tested in all three locations.
Footnote 2: Please note that people can test positive at multiple locations.

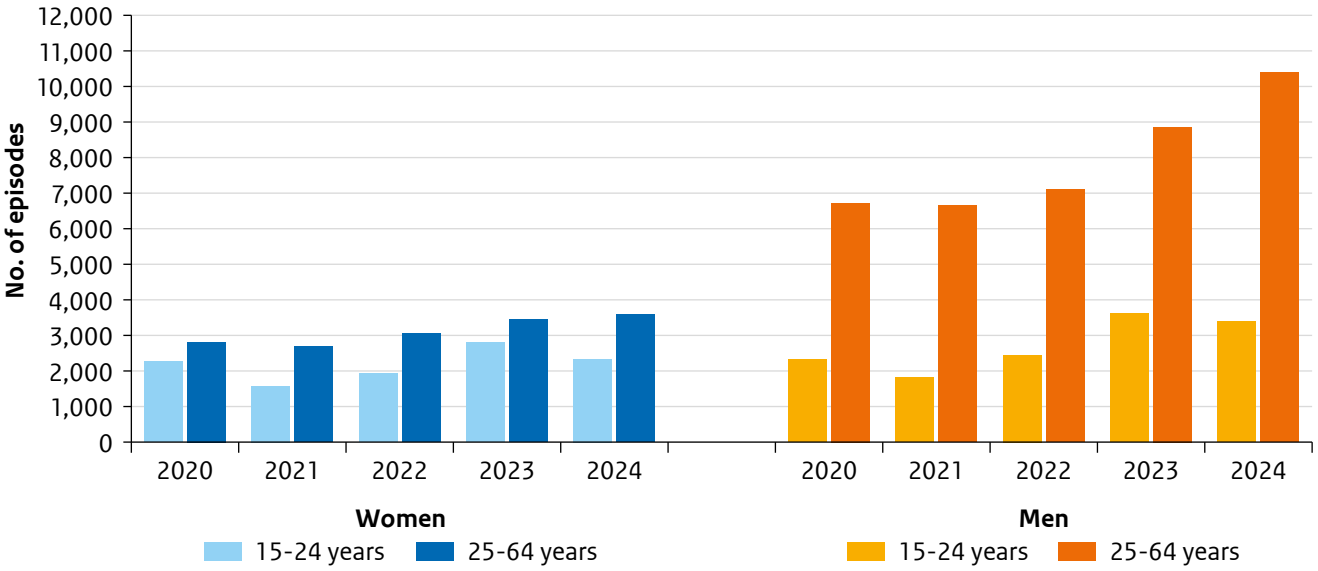
Table 5.3 Concurrent STI: Proportion of consultations with concurrent gonorrhoea and other STI diagnoses by sex and type of sexual contact, 2025

Concurrent infection	Women	MSW	MSM-STI consultation	MSM-PrEP consultation
	n (%)	n (%)	n (%)	n (%)
Gonorrhoea, total	1,914 (100.0)	1,034 (100.0)	7,755 (100.0)	3,216 (100.0)
Chlamydia	420 (21.9)	302 (29.2)	869 (11.2)	284 (8.8)
Syphilis, infectious	6 (0.3)	2 (0.2)	261 (3.4)	113 (3.5)
HIV newly diagnosed	3 (0.2)	1 (0.1)	44 (0.6)	6 (0.2)
Other STI*	17 (0.9)	13 (1.3)	70 (0.9)	23 (0.7)

* *Other STI includes genital herpes, genital warts, hepatitis B (infectious), and hepatitis C. SHCs check for genital herpes and genital warts on indication only. In addition, clients are not routinely tested for hepatitis C.*

5.3 General practices

Figure 5.6 Estimated number of gonorrhoea episodes in general practices by sex and age group, based on general practices in Nivel-PCD, 2020-2024



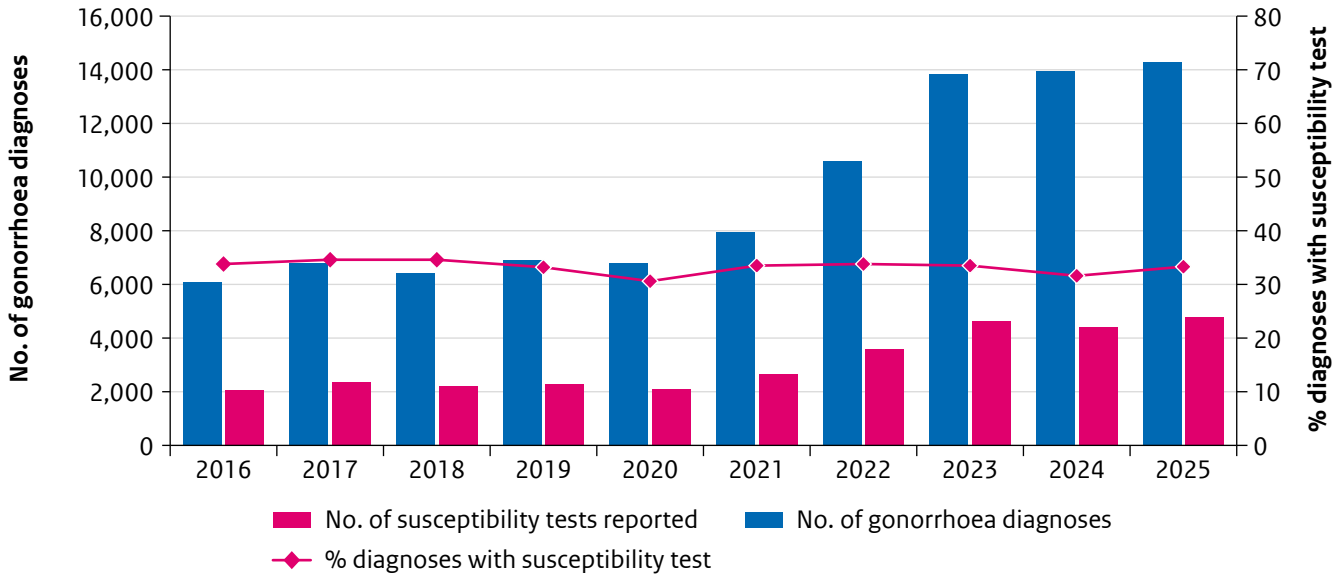
Footnote: About 50% of the total Dutch population consists of persons aged 25-64 years and about 10% consists of persons aged 15-24 years.

Table 5.4 Reporting rate (number of episodes per 1000 persons aged 15-64 years) of gonorrhoea in general practices by sex and age group, based on general practices in Nivel-PCD, 2020-2024

Year	Women n/1,000			Men n/1,000			Total n/1,000		
	All	15-24	25-64	All	15-24	25-64	All	15-24	25-64
2020	**0.9**	2.2	0.6	**1.6**	2.1	1.5	**1.2**	2.1	1.0
2021	**0.8**	1.5	0.6	**1.5**	1.7	1.4	**1.1**	1.6	1.0
2022	**0.9**	1.8	0.7	**1.7**	2.2	1.5	**1.3**	2.0	1.1
2023	**1.1**	2.6	0.7	**2.2**	3.3	1.9	**1.6**	2.9	1.3
2024	**1.0**	2.2	0.8	**2.4**	3.0	2.2	**1.7**	2.6	1.5

5.4 Antimicrobial resistance of gonococci

Figure 5.7 Number of gonorrhoea diagnoses and number and proportion of diagnoses with an antimicrobial susceptibility test, 2016-2025



Footnote: In less than half of all gonorrhoea diagnoses at SHCs antimicrobial susceptibility was measured by culture. This is due to the fact that not all SHCs participate in GRAS, not all patients are cultured, and cultures sometimes remain negative, making measurement of resistance levels impossible.

Figure 5.8 Number of diagnoses, performed cultures and susceptibility testing results reported in GRAS, 2025

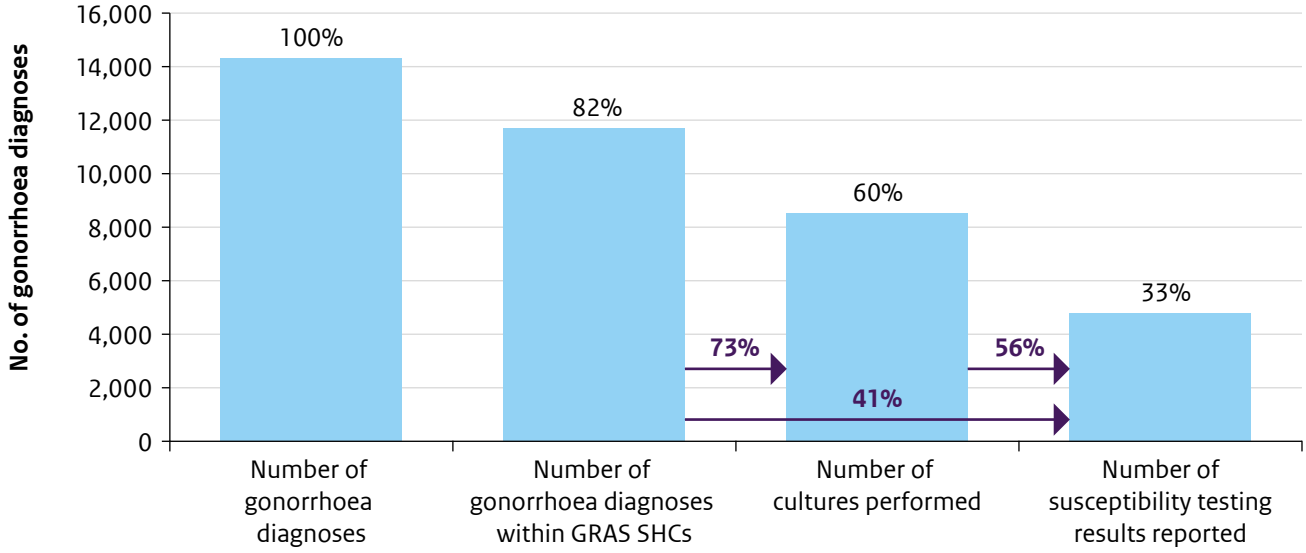


Figure 5.9 Distribution of performed cultures – negative, positive and failed – per anatomical site of gonorrhoea infection, 2025

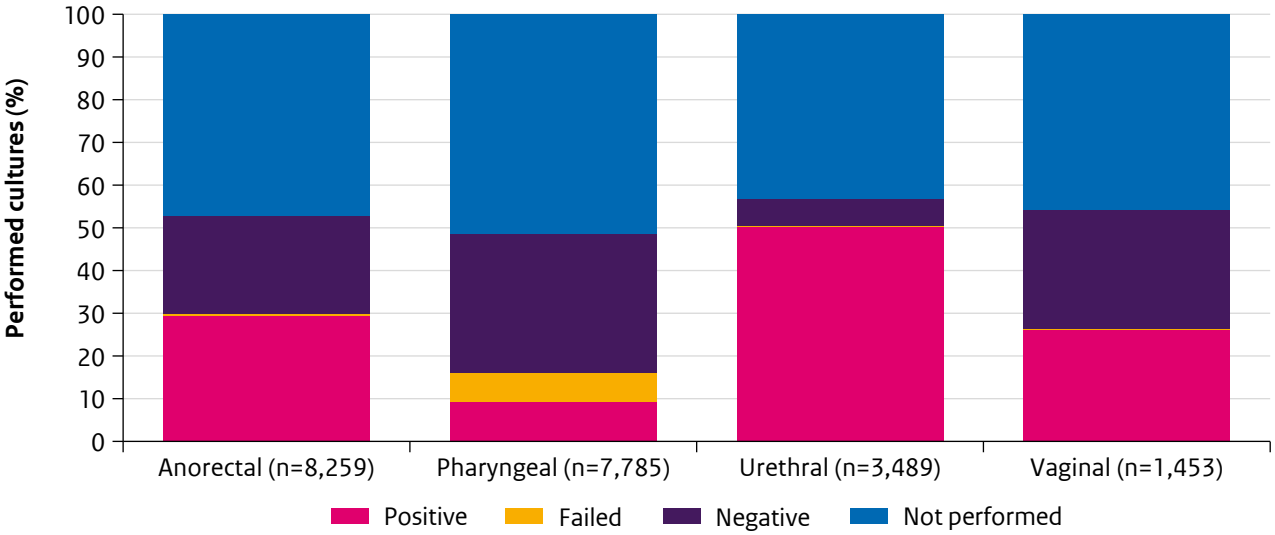
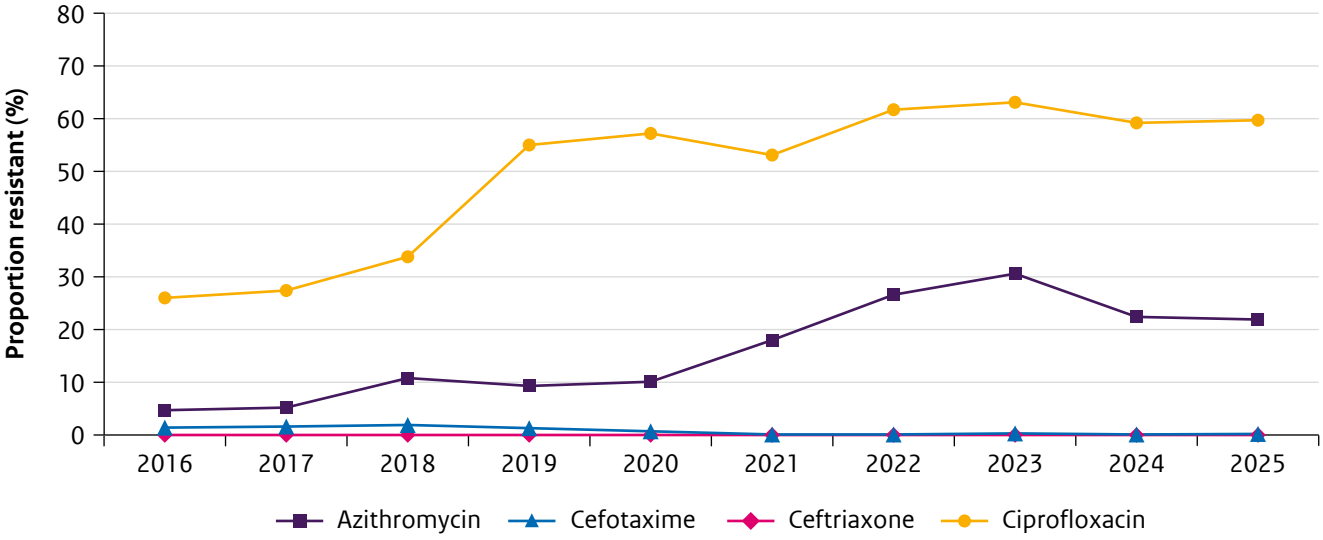
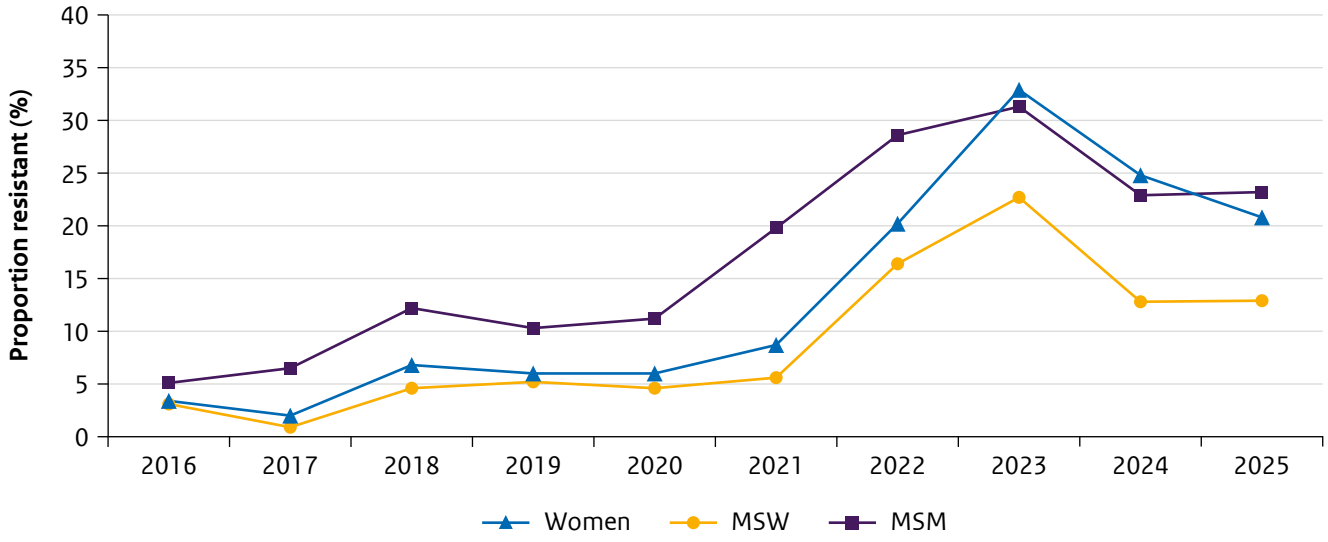


Figure 5.10 Gonococcal resistance (following EUCAST breakpoints): proportion of resistant cases by antibiotic, 2016-2025



Footnote 1: In 2025: one case of ceftriaxone resistance was reported.
Footnote 2: Following EUCAST breakpoints, no clinical breakpoint for azithromycin is available. An MIC >1.0 mg/L is considered the epidemiological cut-off value for resistance.

Figure 5.11a Azithromycin resistance (following EUCAST breakpoints): proportion of resistant cases by sex and sexual contact, 2016-2025



Footnote: Following EUCAST breakpoints, no clinical breakpoint for azithromycin is available. An MIC >1.0 mg/L is considered the epidemiological cut-off value for resistance.

Figure 5.11b Ciprofloxacin resistance (following EUCAST breakpoints): proportion of resistant cases by sex and sexual contact, 2016-2025

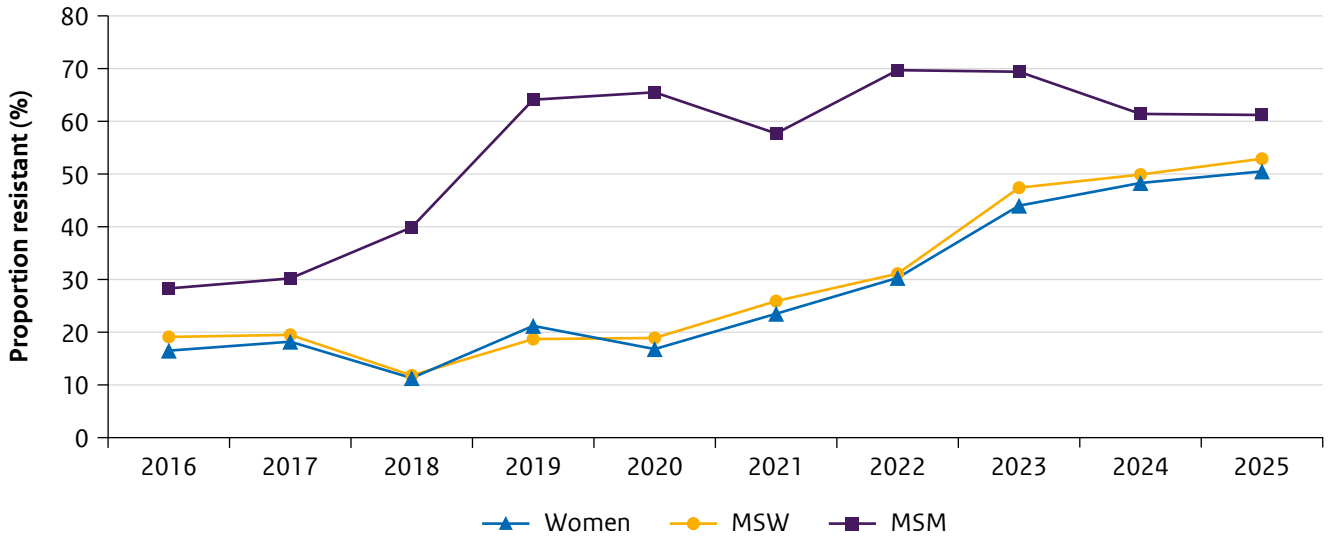
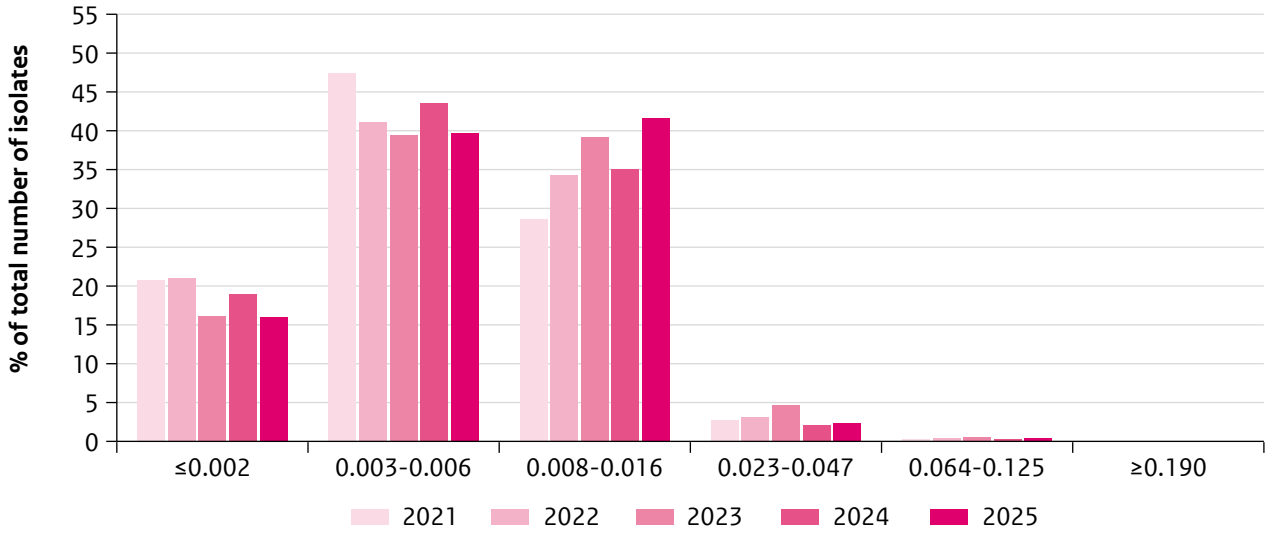
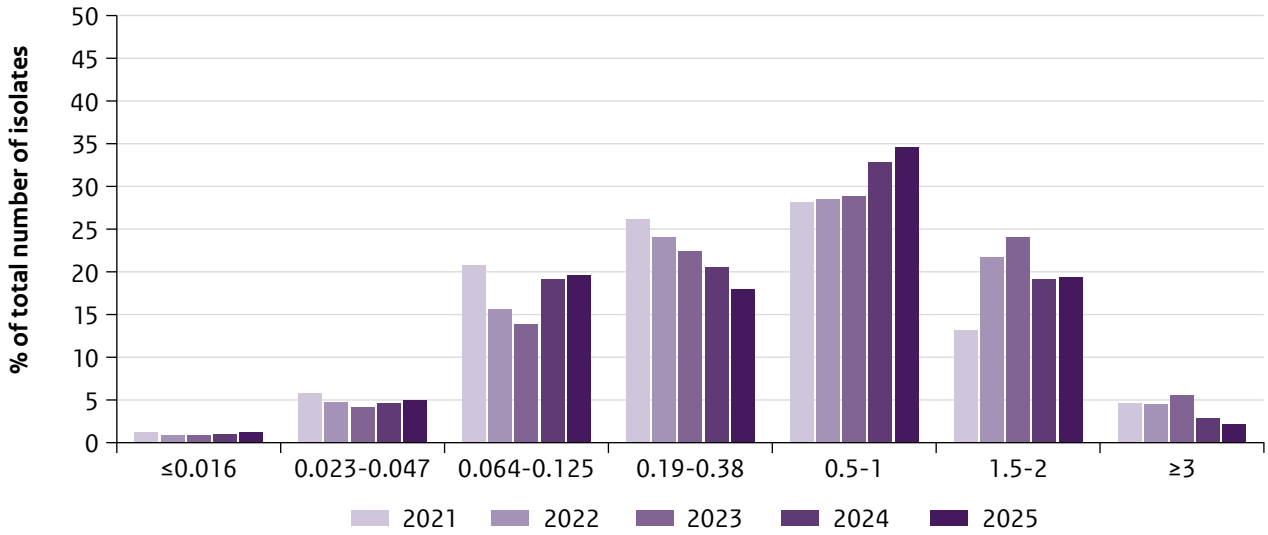


Figure 5.12a MIC (= minimum inhibitory concentration) distribution for ceftriaxone, 2021-2025



Footnote: Following EUCAST breakpoints, an MIC of >0.125 mg/L is considered resistant.

Figure 5.12b MIC (= minimum inhibitory concentration) distribution for azithromycin, 2021-2025



Footnote: Following EUCAST breakpoints, no clinical breakpoint for azithromycin is available. An MIC >1.0 mg/L is considered the epidemiological cut-off value for resistance.

6 Syphilis

6.1 Key points

6.1.1 Sexual Health Centres

- In 2025, 2351 syphilis infections were diagnosed at SHCs, of which, 1927 (82%) were infectious syphilis. Between 2016 and 2025, the proportion of syphilis diagnoses that were infectious among women and MSW increased from 50% to 66%. In contrast, among MSM, this proportion remained stable around 83 to 84% (Figure 6.1).
- Out of the 1927 infectious syphilis diagnoses in 2025, 60 (3%) were among women, 64 (3%) among MSW, 1242 (64%) among MSM-STI consultations, 518 (27%) among MSM-PrEP consultations, and 43 (2%) among gender diverse persons (Figure 6.2a-e).
- The 1927 infectious syphilis diagnoses were among 1892 individuals; 34 persons (2%) had more than one syphilis diagnosis in 2025, of whom 32 (94%) were MSM.
- In 2025, 110,361 syphilis tests were registered at SHCs, out of which out of which 33,697 were registered among women and MSW and 73,542 among MSM (Figure 6.2a-e).
- In 2025, the total number of syphilis tests increased for women (21,802) and MSW (11,895) as compared to 2024 (women: 20,756, MSW: 11,082) (Figure 6.2a-b). Heterosexuals aged <25 years are not routinely tested for syphilis. In 2025, a syphilis test was performed at 48% of all STI consultations among women and 50% of all STI consultations among MSW.
- For MSM-STI consultations, the number of syphilis tests increased from 49,189 in 2024 to 49,559 in 2025, while for MSM-PrEP consultations, the number of syphilis tests decreased from 25,917 in 2024 to 23,983 in 2025 (Figure 6.2c-d).
- The number of syphilis tests among gender diverse persons increased from 2722 in 2024 to 3122 in 2025. The infectious syphilis positivity in this group was 1.4% in 2025 (Figure 6.2e).
- As the number of gender diverse persons was relatively low, they are not shown in all the tables and figures.
- In 2025, infectious syphilis positivity among women (0.28%) was higher than in 2024 (0.19%), while for MSW, infectious syphilis positivity was stable at 0.54% compared to the previous year. For women, positivity has been increasing since 2019, whereas positivity among MSW has been increasing since 2022 (Figure 6.2a-b).
- Infectious syphilis positivity among MSM-STI consultations remained stable from 2021 to 2025 (Figure 6.2c). Among MSM-PrEP consultations, infectious syphilis positivity was 2.2% in 2025, which is an increase compared to 2024 (1.8%) (Figure 6.2d).
- Among MSM-STI consultations, the highest positivity was found among those notified for syphilis (13.8% in 2025). Positivity was also high among MSM with symptoms (5.7% in 2025) (Figure 6.3).
- Infectious syphilis positivity among MSM-STI consultations increased in the age groups 26-30, 41-50, and >50 years, while there was a decrease in the remaining age groups. The highest positivity was found among those aged 41-50 years (3.4% in 2025) (Figure 6.4).
- Among MSM consultations involving a reported infectious syphilis diagnosis in 2025, chlamydia co-infection was found in 9% of MSM-STI consultations and 7% of MSM-PrEP consultations; a large decline compared to 2024 (15% and 18%, respectively). This decline is likely caused by the reduction in chlamydia testing following the implementation of new chlamydia testing guidelines. Co-infections with gonorrhoea occurred in 21% of MSM-STI consultations and in 22% of MSM-PrEP consultations involving a reported infectious syphilis diagnosis, which is comparable to 2024 (Table 6.1).
- Infectious syphilis positivity among MSM with HIV remained stable at 6.6% in 2025. Among MSM-PrEP consultations and HIV-negative MSM-STI consultations without recent PrEP use, positivity slightly increased from 1.7% in 2024 to 2% in 2025. Among MSM-STI consultations reporting recent PrEP use, infectious syphilis positivity decreased from 2.8% in 2024 to 2.5% in 2025 (Figure 13.9).

6.1.2 Congenital syphilis

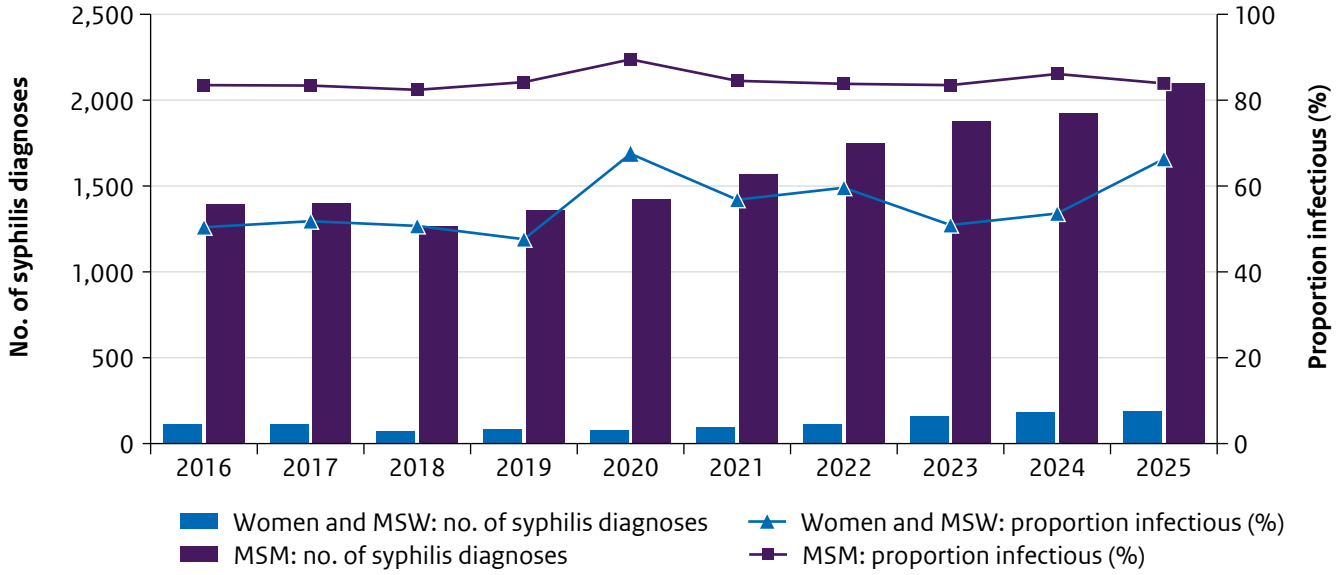
- In 2024, 30 women (0.02%) tested positive for syphilis in the antenatal screening programme, with prevalence remaining fairly stable over the past decade (Table 6.2).
- Since 2016, the number of infections of congenital syphilis found in neonates has remained very low, at zero to three per year. In 2025, there was one positive test (Figure 6.7).

6.1.3 Blood donors

- Between 2016 and 2025, the syphilis incidence among regular blood donors increased, with some fluctuations, from 0.8 per 100,000 donor years in 2016 to 6.7 per 100,000 donor years in 2025 (Figure 6.8).
- A similar trend was seen among new blood donors, where syphilis prevalence increased from 27.3 per 100,000 new donors in 2016 to 52.6 in 2025 (Figure 6.9).

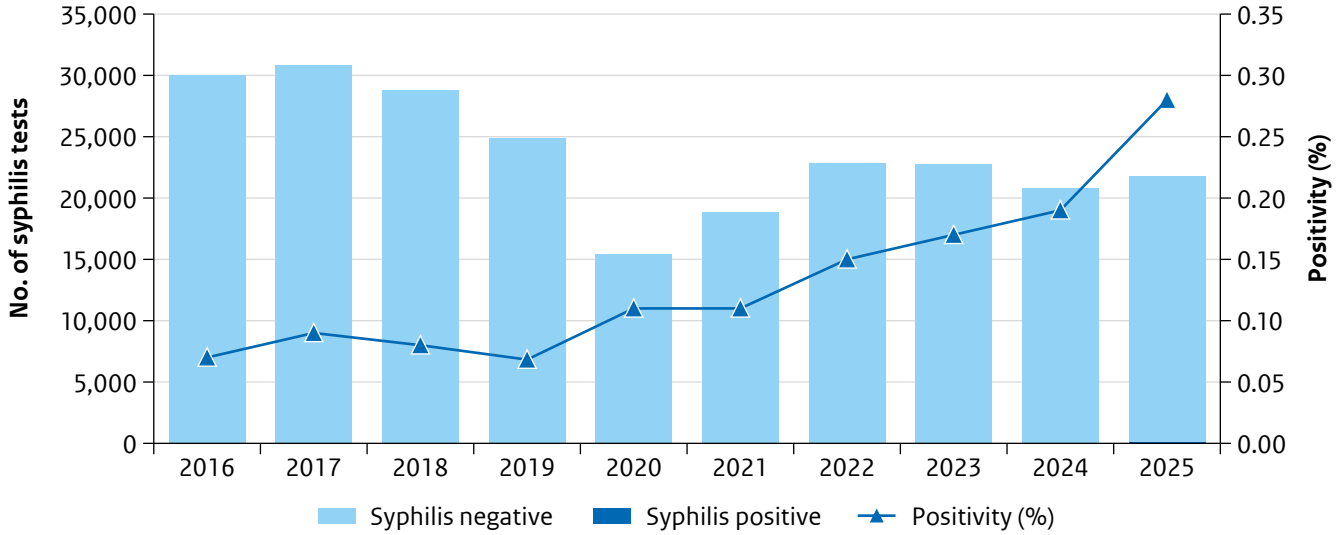
6.2 Sexual Health Centres: characteristics, risk groups and trends

Figure 6.1 Number of syphilis diagnoses and proportion of diagnoses that is infectious by sex and type of sexual contact, 2016-2025



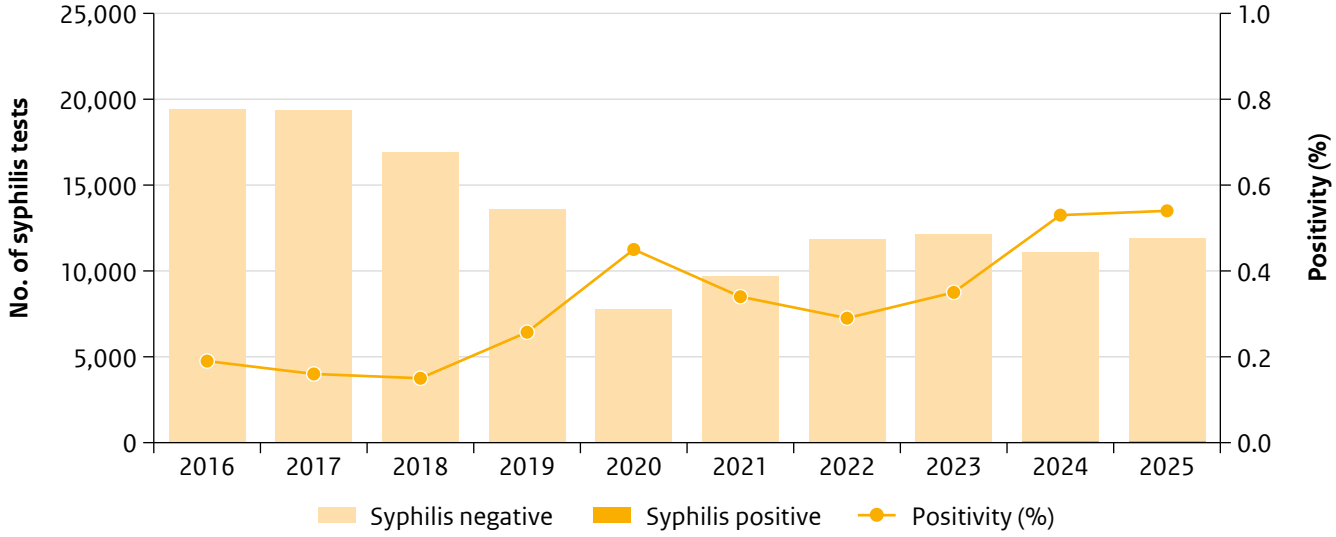
Footnote: Aggregated data of non-registered consultations included for 2018 and 2019.

Figure 6.2a Number of infectious syphilis positive and negative tests and infectious syphilis positivity in women, 2016-2025



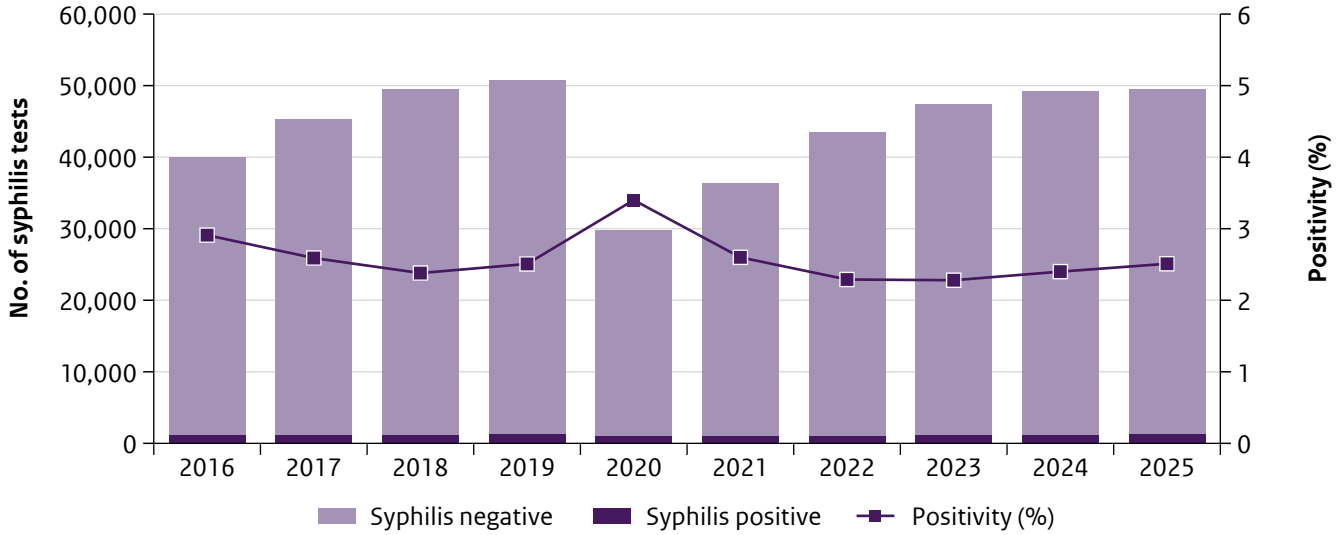
Footnote: Aggregated data of non-registered consultations included for 2018 and 2019.

Figure 6.2b Number of infectious syphilis positive and negative tests and infectious syphilis positivity in MSW, 2016-2025



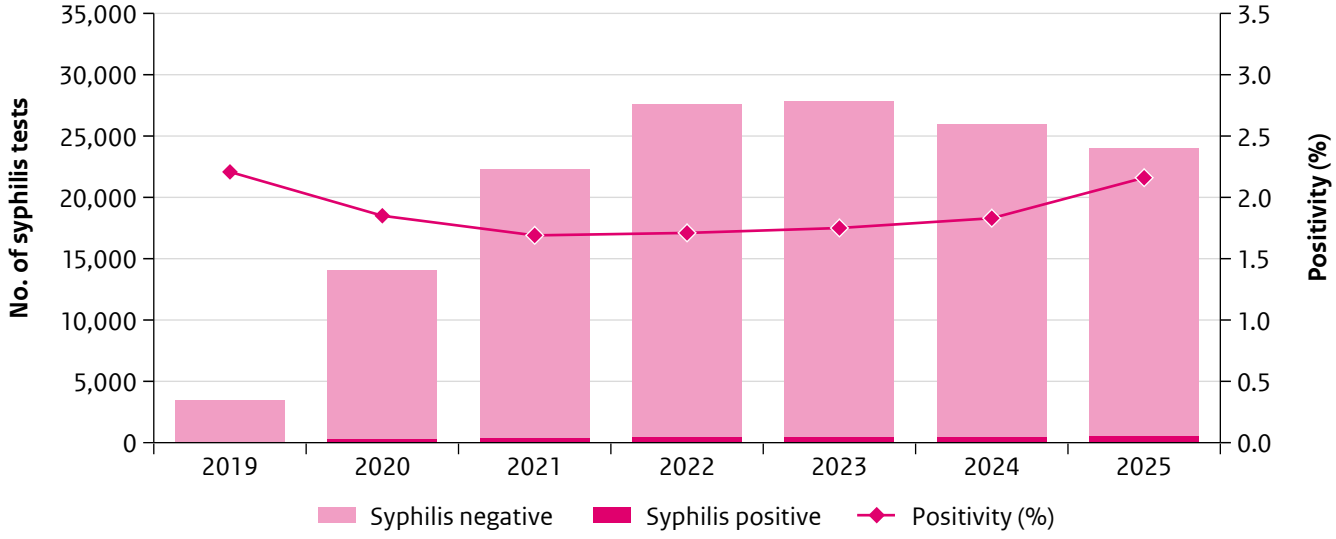
Footnote: Aggregated data of non-registered consultations included for 2018 and 2019.

Figure 6.2c Number of infectious syphilis positive and negative tests and infectious syphilis positivity in MSM-STI consultations, 2016-2025



Footnote: Aggregated data of non-registered consultations included for 2018 and 2019.

Figure 6.2d Number of infectious syphilis positive and negative tests and infectious syphilis positivity in MSM-PrEP consultations, 2019-2025



Footnote: Aggregated data of non-registered consultations included for 2019.

Figure 6.2e Number of infectious syphilis positive and negative tests and infectious syphilis positivity in gender diverse persons, 2020-2025

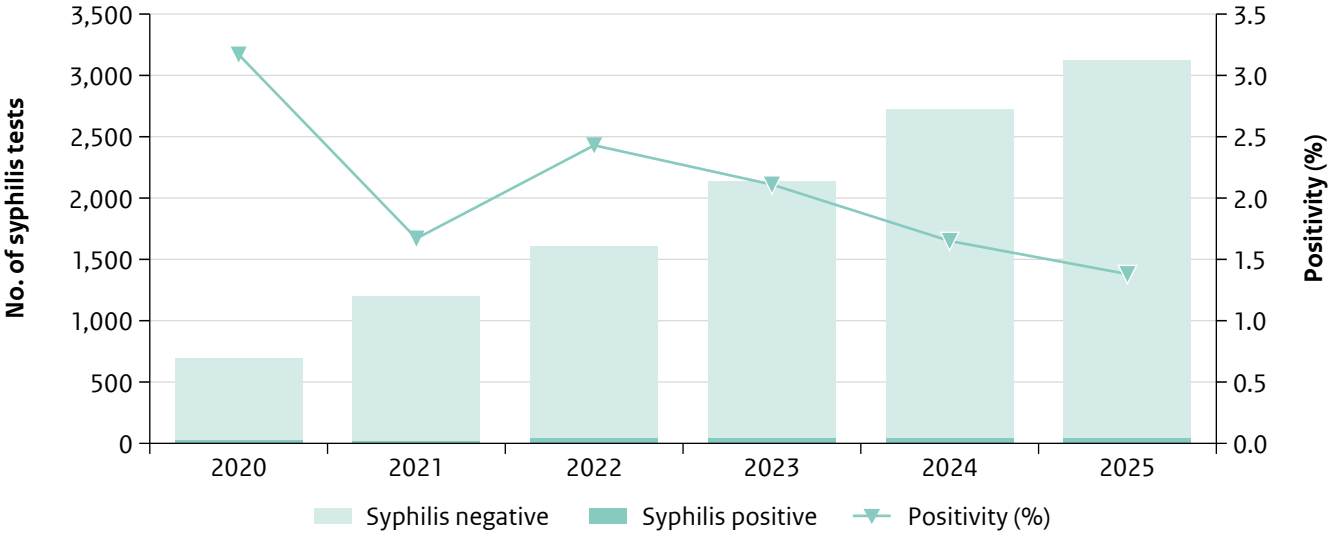
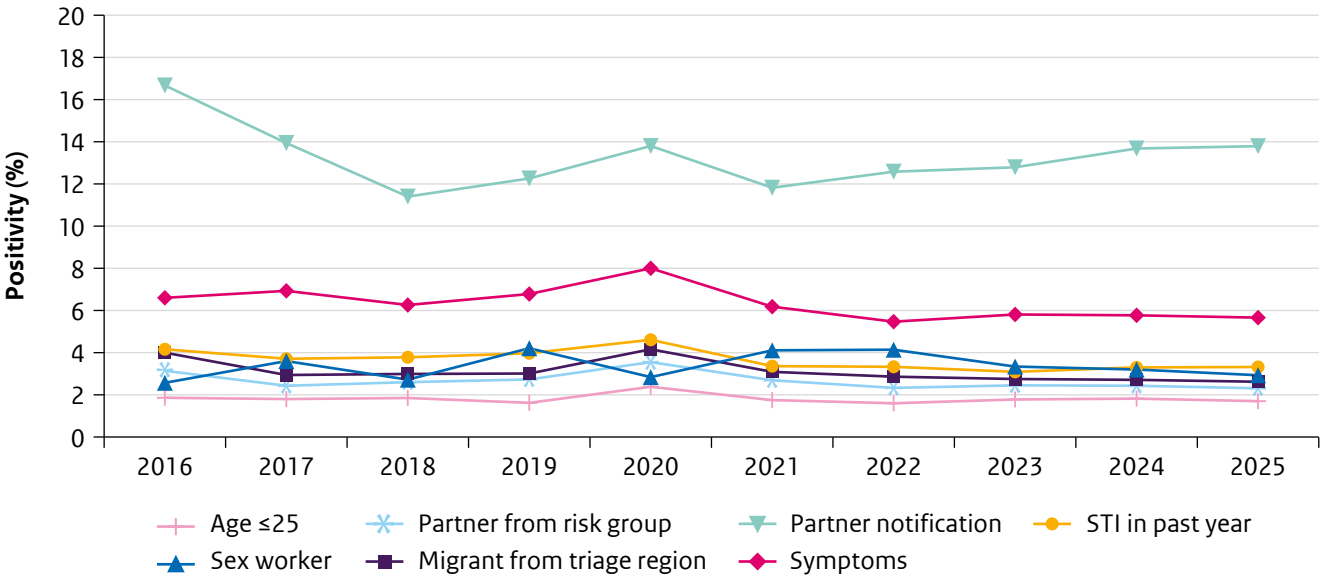
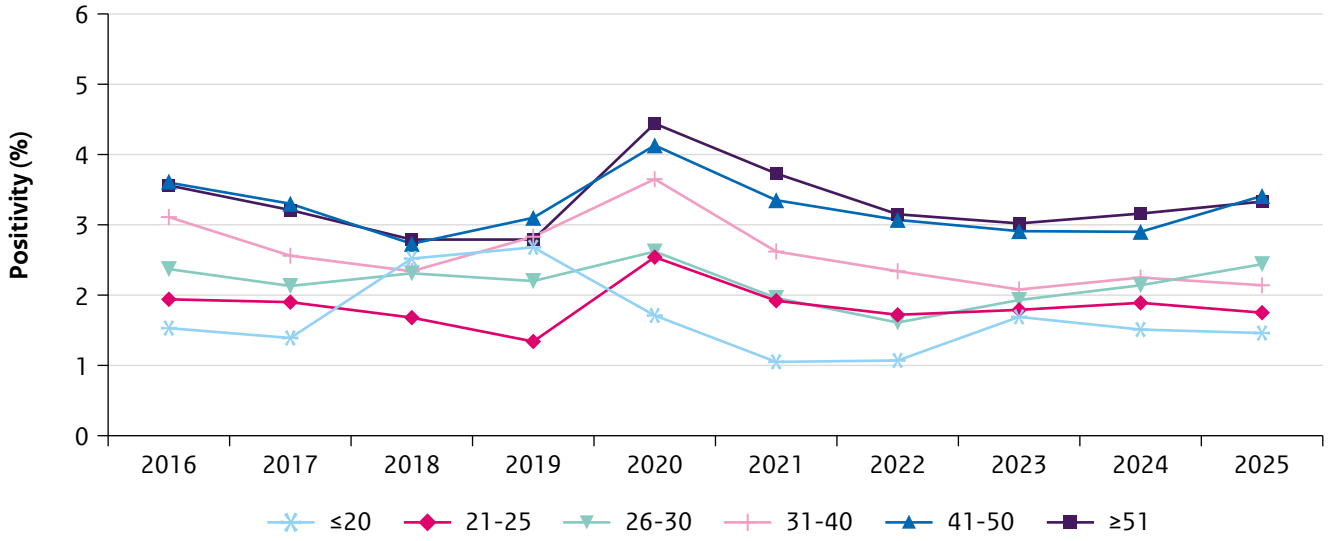


Figure 6.3 Reported triage indication: infectious syphilis positivity by triage indication in MSM-STI consultations, 2016-2025



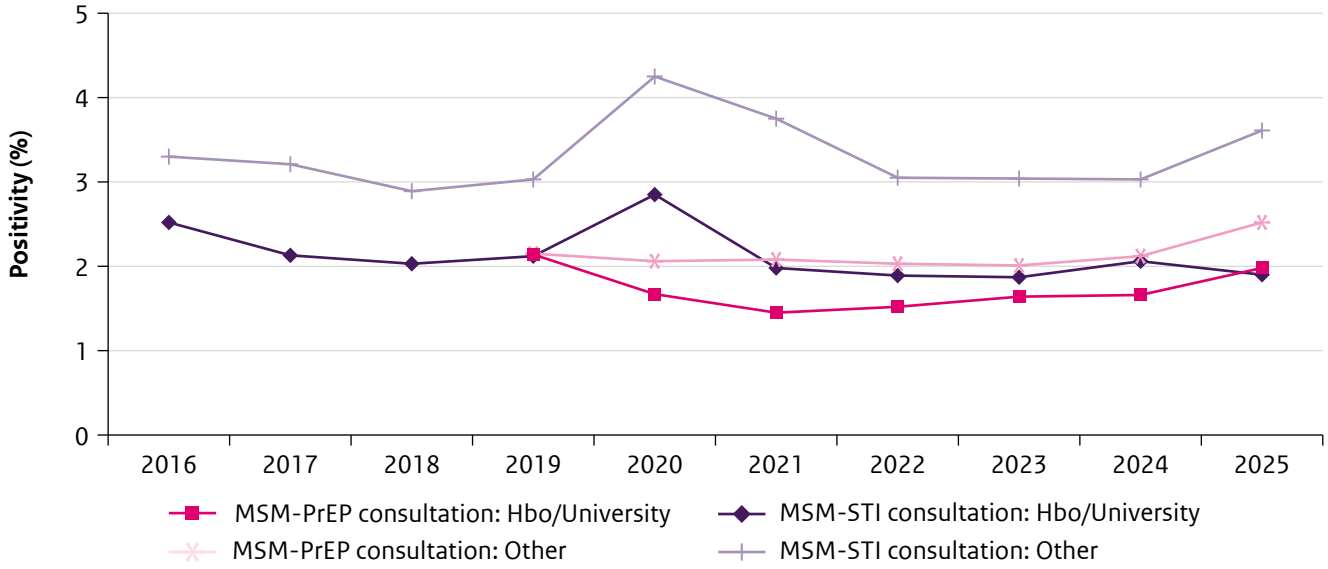
Footnote 1: Migrant from triage region includes migrants and children of migrants from Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.
Footnote 2: Partner from risk group: partner originating from a region of origin as indicated by triage criteria.
Footnote 3: Exact numbers of diagnoses, tests and positivity by triage criteria in 2025 are shown in supplementary table 13.12.

Figure 6.4 Age: trends in infectious syphilis positivity by age group in MSM-STI consultations, 2016-2025



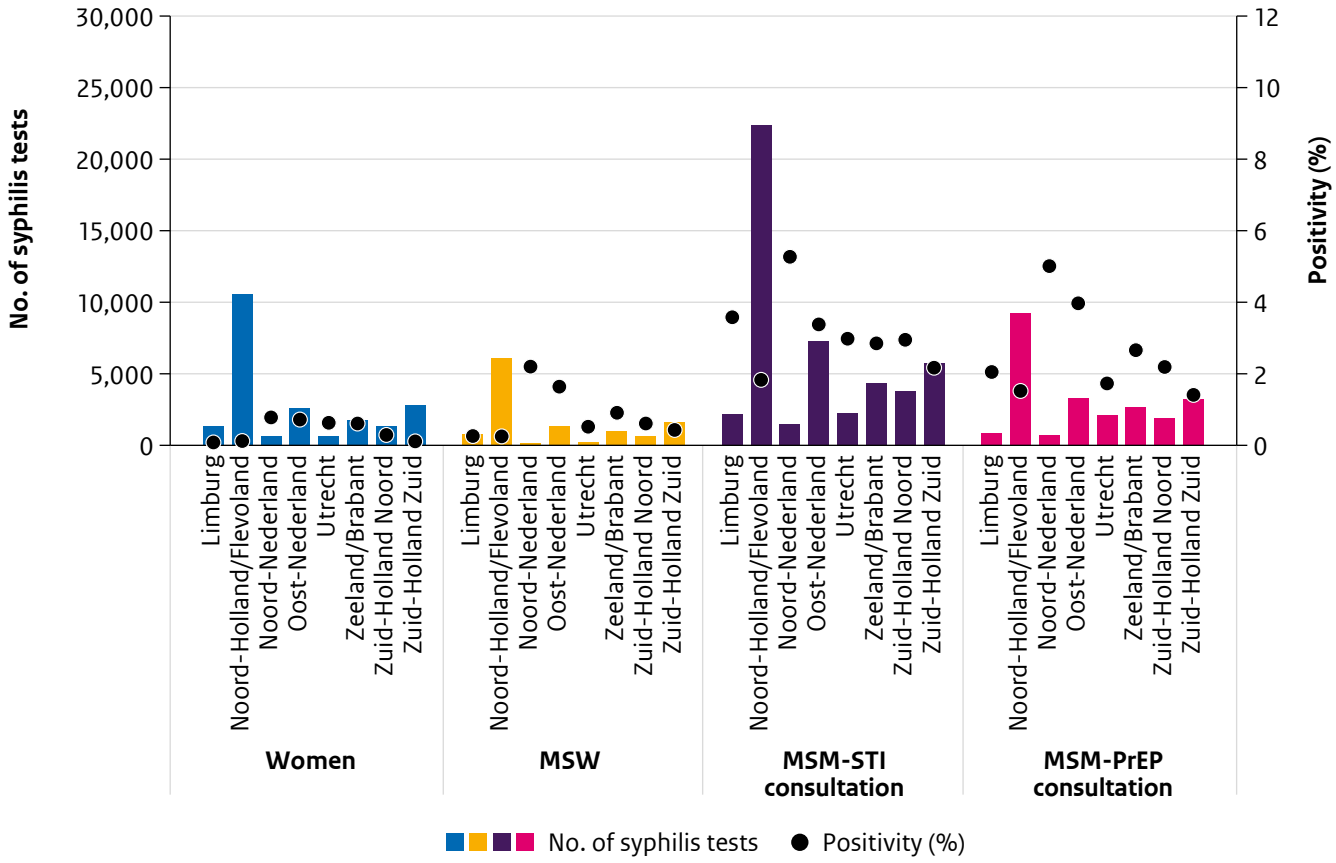
Footnote: Exact numbers of diagnoses, tests and positivity by age group in 2025 are shown in supplementary table 13.14.

Figure 6.5 Education level: trends in infectious syphilis positivity by education level in MSM, 2016-2025



Footnote: Other education includes: no education, elementary school, lbo, mavo, vmbo, mbo, havo, vwo.

Figure 6.6 Region: number of syphilis tests and infectious syphilis positivity by region, sex and type of sexual contact, 2025



Footnote: Trends in infectious syphilis positivity by region are shown in supplementary figure 13.8.

Table 6.1 Concurrent STI: Proportion of consultations with concurrent infectious syphilis and other STI diagnoses in MSM, 2025

Concurrent infection	MSM-STI consultation	MSM-PrEP consultation
	n (%)	n (%)
Syphilis, infectious total	1,242 (100)	518 (100)
Chlamydia	107 (8.6)	37 (7.1)
Gonorrhoea	261 (21)	113 (21.8)
HIV newly diagnosed	13 (1)	1 (0.2)
Other STI*	26 (2.1)	6 (1.2)

* *Other STI includes genital herpes, genital warts, hepatitis B (infectious), and hepatitis C. SHCs check for genital herpes and genital warts on indication only. In addition, clients are not routinely tested for hepatitis C.*

6.3 Other sources

6.3.1 Antenatal screening

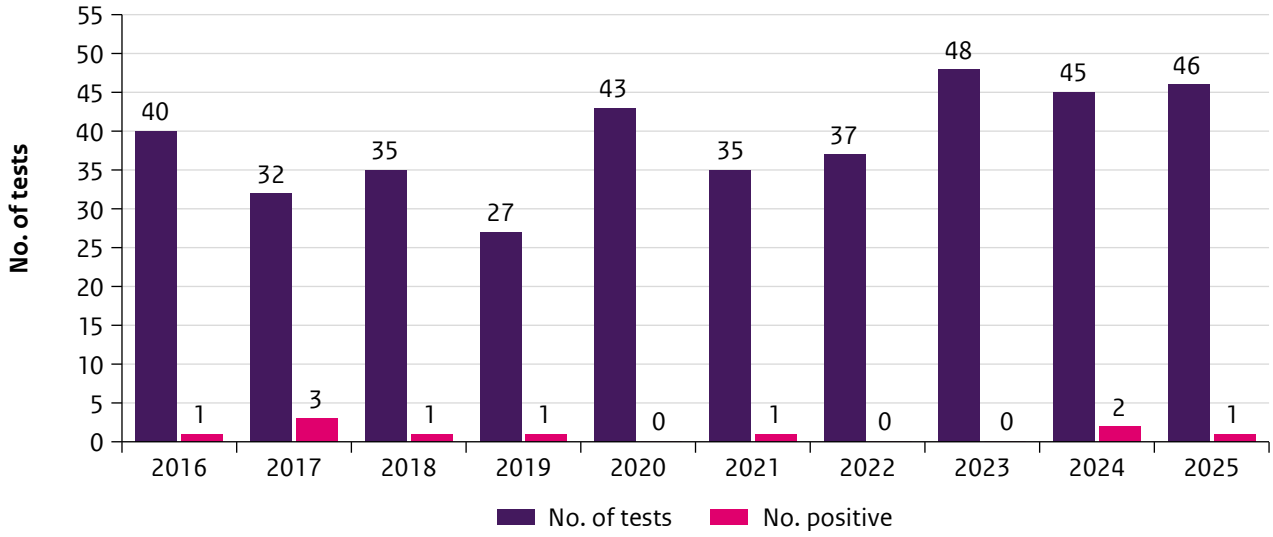
Table 6.2 Syphilis prevalence estimates in pregnant women, based on test results of antenatal screening, 2015-2024

Year	n positive/N women screened	Prevalence estimate
2015	98/176,219	0.06
2016	36/172,785	0.02
2017	25/170,453	0.01
2018	18/171,228	0.01
2019	12/171,480	0.01
2020	21/176,218	0.01
2021	24/176,460	0.01
2022	14/168,329	0.01
2023	24/167,751	0.01
2024	30/170,198	0.02

Source: C.P.B. van der Ploeg (TNO), L. Vonk (TNO), J.A.M. Odijk (RIVM), M. van Lent (RIVM). Prenatale Screening Infectieziekten en Erytrocytenimmunisatie (PSIE). Procesmonitor 2024. TNO/RIVM 2026; and earlier monitors.
Footnote: Improvements in registration in 2016 and 2017 resulted in fewer confirmed positive test results than in previous years.

6.3.2 Congenital syphilis

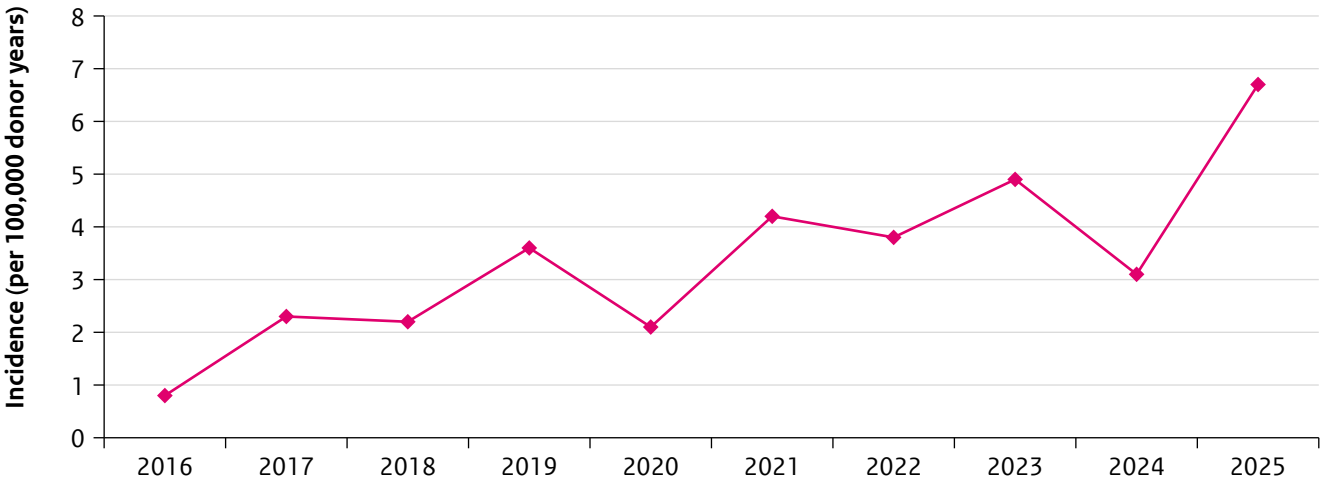
Figure 6.7 Number of tests among neonates and young infants (<1 year) suspected of having congenital syphilis and the number of IgM positives, 2016-2025



Source: RIVM/CIb/IDS.

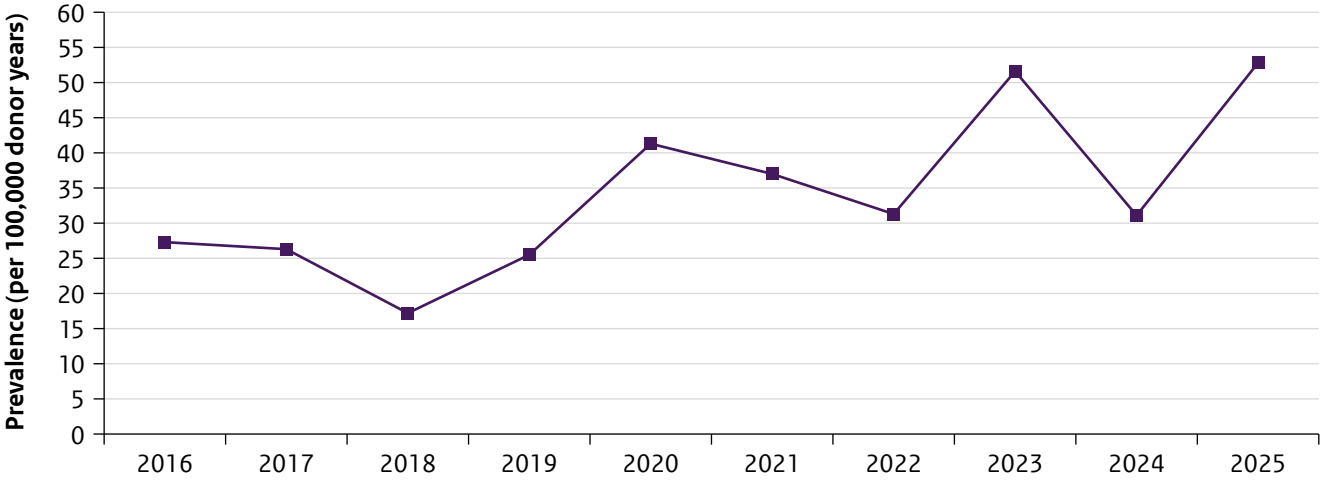
6.3.3 Blood donors

Figure 6.8 Incidence of syphilis per 100,000 donor years among blood- and plasma donors, 2016-2025



Source: Sanquin.
Footnote: The syphilis screening for plasma donors has been discontinued in 2024. Therefore, the denominator for syphilis among repeat donors is lower than in previous years and lower than for the other infections (HIV, HBV, HCV).

Figure 6.9 Prevalence of syphilis per 100,000 new donors among blood- and plasma donors, 2016-2025



Source: Sanquin.

VIRAL STI

7 HIV and AIDS

7.1 Key points

7.1.1 HIV treatment centres

- In total, 23,547 people living with HIV (PLWH) were reported to be in clinical care as of December 2025. In 2025, 979 PLWH were newly registered in care. Among them, 440 were newly diagnosed with HIV in 2025 (Figure 7.1). Data collection is still incomplete due to reporting delays.
- In 2025, the total number of new HIV diagnoses slightly increased by 6% to 440 compared to 413 in 2024 (using the same database lock date as in the previous report). New diagnoses among MSM declined by 9% (234 vs 256), following an earlier increase since 2022. By contrast, diagnoses among men who have sex with women (MSW) increased by 34% (75 vs 56) and by 16% among women (73 vs 63), although these involve relatively small numbers. Gender diverse individuals accounted for 4% of new diagnoses in 2025.
- Among newly diagnosed MSM in 2025, 49% were diagnosed at SHCs, an increase compared to 42% in 2024. Diagnoses at GPs accounted for 29% (compared to 36% in 2024), and in hospitals for 16% (18% in 2024). Among MSW, 12% were diagnosed at SHCs (5% in 2024), 45% at GPs (43% in 2024), and 37% in hospitals (43% in 2024). Among women, 12% were diagnosed at SHCs (10% in 2024), 45% at GPs (41% in 2024), 33% in hospitals (40% in 2024), and 7% through pregnancy screening (9% in 2024). Among gender diverse individuals, 71% were diagnosed at SHCs, 18% at GPs, and 12% in hospitals (Table 7.6).
- In 2025, 26% of newly diagnosed individuals had acquired HIV within the past 12 months (recent infection), compared to 31% in 2024. Recent infection was identified in 39% of MSM (40% in 2024), 9% of MSW (16% in 2024), 8% of women (11% in 2024), and 41% of gender diverse individuals (33% in 2024), although numbers in the last group are small (Figure 7.2).
- In 2025, 40% of individuals newly diagnosed with HIV were classified as presenting late (CD4<350/mm3, or AIDS-defining event regardless of CD4 count), similar to 39% in 2024. Late presentation occurred in 25% of MSM (29% in 2024), 52% of MSW (57% in 2024), 55% of women (50% in 2024), and 19% of gender diverse individuals (25% in 2024), although numbers in the last group are small (Figure 7.3).
- In 2024, an estimated 94% of PLWH were diagnosed and linked to care; 95% of these diagnoses had started combination antiretroviral therapy (cART), and 96% of those on cART achieved viral suppression (Figure 7.4). Among MSM, 95% were diagnosed and linked to care, 96% were on cART, and 97% had viral suppression. For MSW, the proportions were lower at 89%, 92%, and 95%, respectively. For women, all three indicators were 95% (Figure 13.11a-c).

7.1.2 Sexual Health Centres

- In 2025, 191 new HIV infections were diagnosed at SHCs, an increase compared to 178 in 2024, and 138-144 cases annually during 2021-2023.
- Of the 191 new diagnoses in 2025, 70% (134) were in MSM-STI consultations, 6% (11) in MSM-PrEP consultations, 9% (17) in gender diverse persons, 8% (16) in women, and 7% (13) in MSW (Figure 7.5a-e).
- In 2025, a total of 105,739 HIV tests were registered at SHCs. Compared to 2024, testing increased by 5% among women (21,719 vs 20,688), by 7% among MSW (11,795 vs 11,001), and by 14% among gender diverse persons (2936 vs 2576). Among MSM-STI consultations, the number of HIV tests remained stable (45,127 vs 44,550), while it decreased by 7% among MSM-PrEP consultations (24,162 vs 26,052). (Figure 7.5a-e.)
- In 2024, HIV positivity was highest among gender diverse persons (0.6%), followed by MSM-STI consultations (0.3%). Positivity among gender diverse persons has decreased since 2020. Among MSM-STI consultations, positivity has steadily decreased since 2016 and stabilised since 2021 (Figure 7.5c-e).
- In 2025, positivity rates remained at or below 0.1% for women, MSW, and MSM-PrEP consultations (Figure 7.5 a-d). Among MSM-STI consultations, positivity was highest in those notified for HIV by a partner (6%), followed by persons with symptoms (0.6%) and migrants from regions with a triage indication (0.5%) (Figure 7.6). Among MSM-STI consultations, age trends were generally stable, except for a small increase in 2025 in those aged 20 years or under (small numbers) (Figure 7.7).

7.1.3 General practices

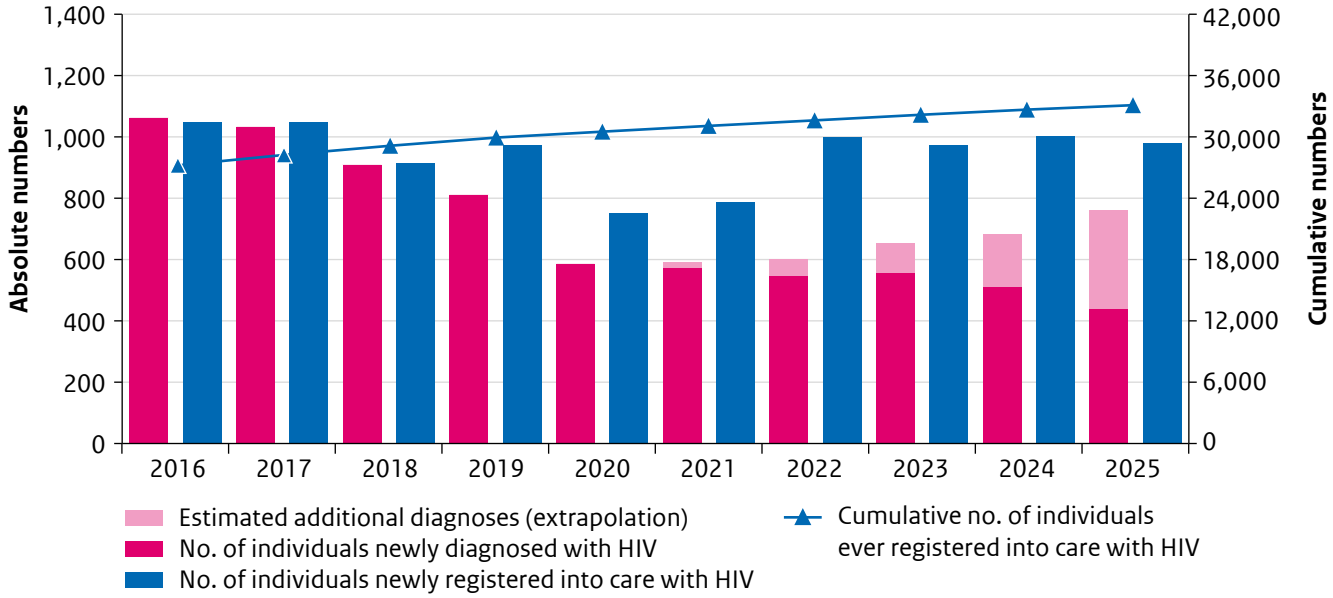
- At GPs, an estimated total of 24,100 prevalent HIV cases were reported in 2024, corresponding to a reporting rate of 1.4 per 1000 population. Prevalence rates were higher among men than among women at 2.1 and 0.6 per 1000, respectively (Figure 7.9).

7.1.4 Other data sources

- In 2024, 78 women (0.05%) tested positive for HIV in the antenatal screening programme, with prevalence having remained fairly stable over the past decade (Table 7.10).
- Between 2015 and 2025, HIV incidence among regular blood donors ranged between 0.0 to 1.0 per 100,000 donor years, with an incidence of 0.7 per 100,000 donor years in 2025 (Figure 7.10). Among new blood donors, HIV prevalence fluctuated between 0.0 and 4.8 per 100,000 new donors between 2015 and 2025 (Figure 7.11).

7.2 HIV treatment centres

Figure 7.1 Number of individuals newly diagnosed and newly registered into care with HIV by year, 2016-2025



Source: Stichting hiv monitoring, 2025 incomplete.
Footnote: Extrapolation based on the average reporting delay over the past five years to estimate the expected annual increase in newly diagnosed individuals. It includes all diagnoses–both made in the Netherlands and abroad among migrants to the Netherlands–and may be influenced by migration effects and/or improved timeliness of data collection in the past two years.

Table 7.1 Number and proportion of individuals newly diagnosed with HIV, and number of individuals with HIV in care, by sex and transmission category, as of 31 December 2025

Transmission group	Women		Men		Total	
	n (%)	Total in care (%)	n (%)	Total in care (%)	n (%)	Total in care (%)
MSM	0 (0.0)	0 (0.0)	234 (68.6)	14,373 (77.2)	249 (56.6)	14,725 (62.5)
Heterosexual contact	73 (89.0)	3,937 (87.1)	75 (22.0)	2,753 (14.8)	149 (33.9)	6,701 (28.5)
Injecting drug use	0 (0.0)	81 (1.8)	2 (0.6)	205 (1.1)	2 (0.5)	287 (1.2)
Blood or blood products	0 (0.0)	101 (2.2)	4 (1.2)	194 (1.0)	4 (0.9)	299 (1.3)
Mother to child	0 (0.0)	181 (4.0)	0 (0.0)	171 (0.9)	0 (0.0)	358 (1.5)
Other/unknown	9 (11.0)	222 (4.9)	26 (7.6)	933 (5.0)	36 (8.2)	1,177 (5.0)
Total	**82 (100.0)**	**4,522 (100.0)**	**341 (100.0)**	**18,629 (100.0)**	**440 (100.0)**	**23,547 (100.0)**

Source: Stichting hiv monitoring, 2025 incomplete.
Footnote: gender diverse persons are included in the total but not shown separately due to low numbers.

Table 7.2 Number and proportion of individuals newly diagnosed with HIV, by age at diagnosis and transmission category, as of 31 December 2025

Age (years)	Sexual transmission			Other/unknown transmission*
	Women n (%)	MSW n (%)	MSM n (%)	n (%)
0-14	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
15-19	2 (2.7)	1 (1.3)	1 (0.4)	0 (0.0)
20-24	11 (15.1)	4 (5.3)	27 (11.5)	2 (4.8)
25-29	8 (11.0)	6 (8.0)	50 (21.4)	2 (4.8)
30-39	19 (26.0)	24 (32.0)	68 (29.1)	14 (33.3)
40-49	11 (15.1)	17 (22.7)	38 (16.2)	12 (28.6)
50-59	15 (20.5)	15 (20.0)	25 (10.7)	6 (14.3)
60-69	7 (9.6)	7 (9.3)	21 (9.0)	6 (14.3)
70-79	0 (0.0)	1 (1.3)	4 (1.7)	0 (0.0)
≥80	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Total	**73 (100.0)**	**75 (100.0)**	**234 (100.0)**	**42 (100.0)**

Source: Stichting hiv monitoring, 2025 incomplete.
* *Gender diverse persons, injecting drug use, blood and blood contacts, mother-to-child transmission, other, unknown.*

Table 7.3 Number and proportion of individuals with HIV in care by age at diagnosis and transmission category, as of 31 December 2025

Age (years)	Sexual transmission			Other/unknown transmission*
	Women Total in care (%)	MSW Total in care (%)	MSM Total in care (%)	Total in care (%)
0-14	6 (0.2)	0 (0.0)	7 (0.0)	364 (17.2)
15-19	184 (4.7)	36 (1.3)	283 (2.0)	59 (2.8)
20-24	569 (14.5)	189 (6.9)	1,476 (10.3)	206 (9.7)
25-29	821 (20.9)	354 (12.9)	2,475 (17.2)	285 (13.4)
30-39	1,322 (33.6)	940 (34.1)	4,817 (33.5)	546 (25.7)
40-49	583 (14.8)	722 (26.2)	3,339 (23.2)	354 (16.7)
50-59	315 (8.0)	364 (13.2)	1,489 (10.4)	191 (9.0)
60-69	90 (2.3)	119 (4.3)	404 (2.8)	70 (3.3)
70-79	19 (0.5)	23 (0.8)	56 (0.4)	10 (0.5)
≥80	1 (0.0)	0 (0.0)	1 (0.0)	1 (0.0)
Unknown	27 (0.7)	6 (0.2)	26 (0.2)	35 (1.7)
Total	**3,937 (100.0)**	**2,753 (100.0)**	**14,373 (100.0)**	**2,121 (100.0)**

Source: Stichting hiv monitoring, 2025 incomplete.
* *Gender diverse persons, injecting drug use, blood and blood contacts, mother-to-child transmission, other, unknown.*

Table 7.4 Number and proportion of individuals newly diagnosed with HIV by region of origin and transmission category, as of 31 December 2025

Region of origin	Sexual transmission			Other/unknown transmission*
	Women n (%)	MSW n (%)	MSM n (%)	n (%)
The Netherlands	22 (30.1)	40 (53.3)	126 (53.8)	18 (42.9)
Europe, other	9 (12.3)	10 (13.3)	38 (16.2)	10 (23.8)
Caribbean & Latin America	13 (17.8)	7 (9.3)	27 (11.5)	3 (7.1)
Sub-Saharan Africa	24 (32.9)	12 (16.0)	12 (5.1)	5 (11.9)
Other	3 (4.1)	6 (8.0)	28 (12.0)	6 (14.3)
Unknown	2 (2.7)	0 (0.0)	3 (1.3)	0 (0.0)
Total	**73 (100.0)**	**75 (100.0)**	**234 (100.0)**	**42 (100.0)**

Source: Stichting hiv monitoring, 2025 incomplete.
* *Gender diverse persons, injecting drug use, blood and blood contacts, mother-to-child transmission, other, unknown.*

Table 7.5 Number and proportion of individuals with HIV in care by region of origin and transmission category, as of 31 December 2025

Region of origin	Sexual transmission			Other/unknown transmission*
	Women Total in care (%)	MSW Total in care (%)	MSM Total in care (%)	Total in care (%)
The Netherlands	1,079 (27.4)	1,257 (45.7)	9,267 (64.5)	779 (36.7)
Europe, other	331 (8.4)	245 (8.9)	1,763 (12.3)	481 (22.7)
Caribbean & Latin America	589 (15.0)	377 (13.7)	1,836 (12.8)	178 (8.4)
Sub-Saharan Africa	1,608 (40.8)	693 (25.2)	268 (1.9)	453 (21.4)
Other	319 (8.1)	168 (6.1)	1,152 (8.0)	212 (10.0)
Unknown	11 (0.3)	13 (0.5)	87 (0.6)	18 (0.8)
Total	**3,937 (100.0)**	**2,753 (100.0)**	**14,373 (100.0)**	**2,121 (100.0)**

Source: Stichting hiv monitoring, 2025 incomplete.

* *Gender diverse persons, injecting drug use, blood and blood contacts, mother-to-child transmission, other, unknown.*

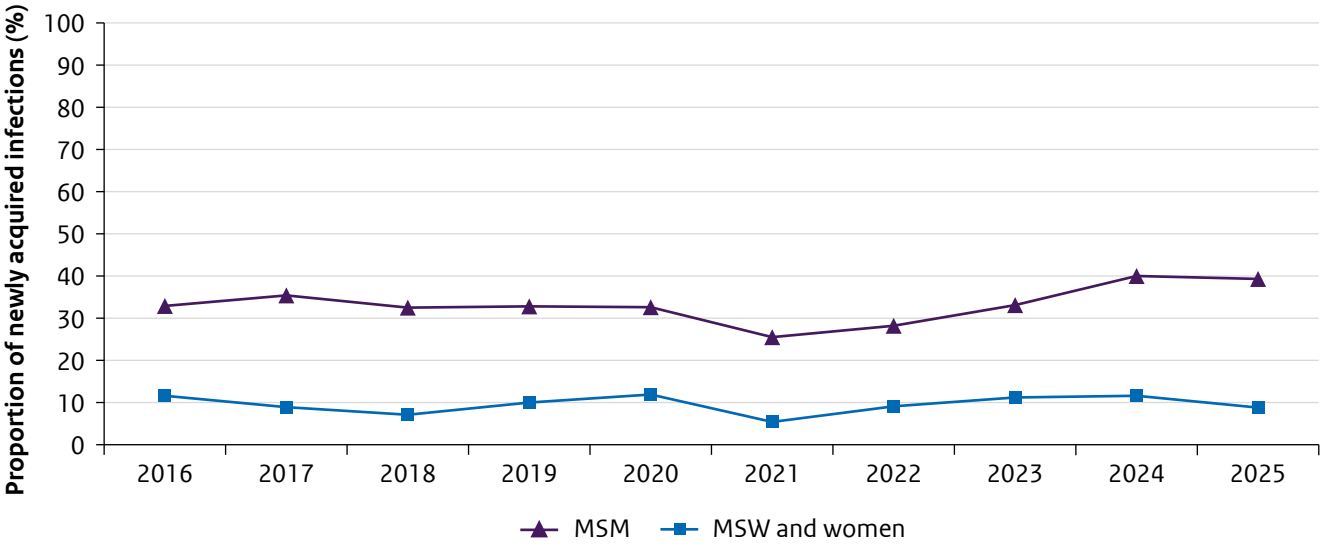
Table 7.6 Number and proportion of individuals newly diagnosed with HIV by test location and transmission category, as of 31 December 2025

Test location	Sexual transmission			Other/unknown transmission*
	Women n (%)	MSW n (%)	MSM n (%)	n (%)
Public Health Service/ Sexual Health Centre	9 (12.3)	9 (12.0)	115 (49.1)	5 (11.9)
Hospital	24 (32.9)	28 (37.3)	38 (16.2)	28 (66.7)
General practice	33 (45.2)	34 (45.3)	68 (29.1)	5 (11.9)
Pregnancy screening	5 (6.8)	0 (0.0)	0 (0.0)	1 (2.4)
Other/Unknown	2 (2.7)	4 (5.3)	13 (5.6)	3 (7.1)
Total	**73 (100.0)**	**75 (100.0)**	**234 (100.0)**	**42 (100.0)**

Source: Stichting hiv monitoring, 2025 incomplete.

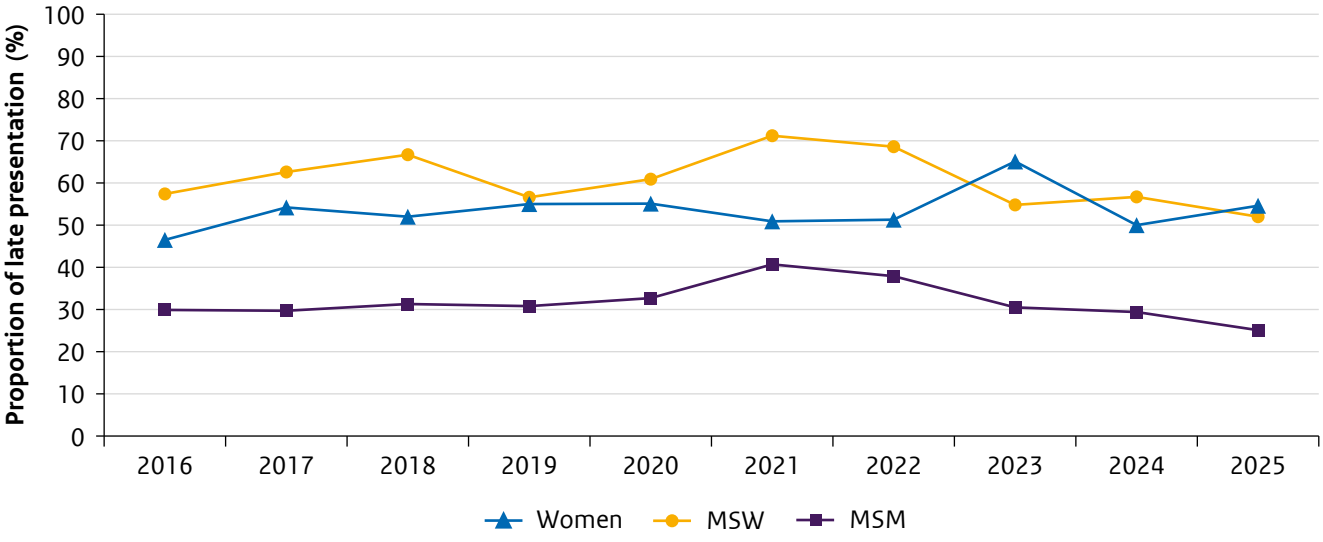
* *Gender diverse persons, injecting drug use, blood and blood contacts, mother-to-child transmission, other, unknown.*

Figure 7.2 Proportion of newly acquired HIV infections (< 12 months*) by sexual transmission group, 2016-2025



Source: Stichting hiv monitoring, 2025 incomplete.
** A recent infection is defined as either having had a negative test within the year prior to diagnosis or having a blottest indicating a recent infection.*

Figure 7.3 Proportion of late presentation (CD4 count <350/mm³ or AIDS at diagnosis) by sexual transmission group, 2016-2025



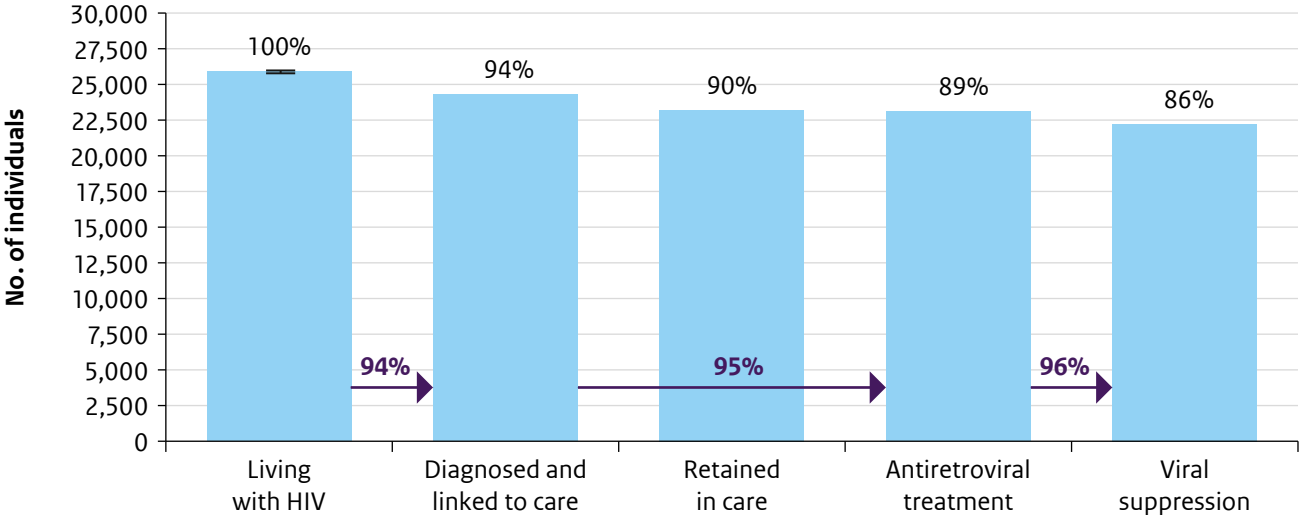
Source: Stichting hiv monitoring, 2025 incomplete.
Footnote: People with CD4 counts at diagnosis < 350 or <200, who were also identified as having a recent infection, are not categorized as having late or advanced disease.

Table 7.7 Number of AIDS patients by year of AIDS diagnosis and transmission category, 2016-2025

Year of diagnosis	Sexual transmission			Other/unknown transmission*
	Women n (%)	MSW n (%)	MSM n (%)	n (%)
2016	39 (17.5)	41 (18.4)	105 (47.1)	38 (17.0)
2017	36 (16.5)	43 (19.7)	101 (46.3)	38 (17.4)
2018	29 (14.0)	39 (18.8)	91 (44.0)	48 (23.2)
2019	29 (15.4)	32 (17.0)	89 (47.3)	38 (20.2)
2020	31 (17.9)	34 (19.6)	78 (45.1)	30 (17.3)
2021	17 (11.4)	23 (15.4)	81 (54.4)	28 (18.8)
2022	28 (17.3)	30 (18.5)	68 (42.0)	36 (22.2)
2023	25 (14.3)	33 (18.9)	82 (46.9)	35 (20.0)
2024	23 (13.3)	34 (19.6)	88 (50.9)	28 (16.2)
2025	15 12.9)	17 (14.7)	58 (50.0)	26 (22.4)

Source: Stichting hiv monitoring, 2025 incomplete.
* *Injecting drug use, blood and blood contacts, mother-to-child transmission, other, unknown.*

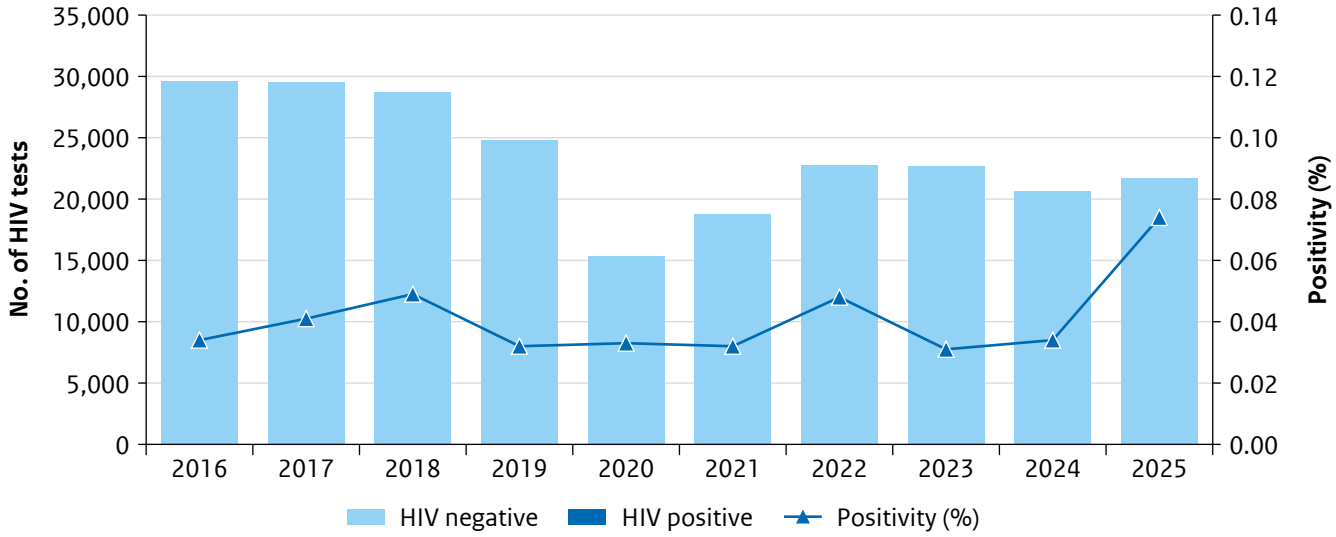
Figure 7.4 Continuum of care for HIV in 2024, total population, Stichting hiv monitoring



Source: Stichting hiv monitoring, Monitoring Report 2025 SHM: Monitoring of Human Immunodeficiency Virus (HIV) Infection in the Netherlands. For details: www.hiv-monitoring.nl

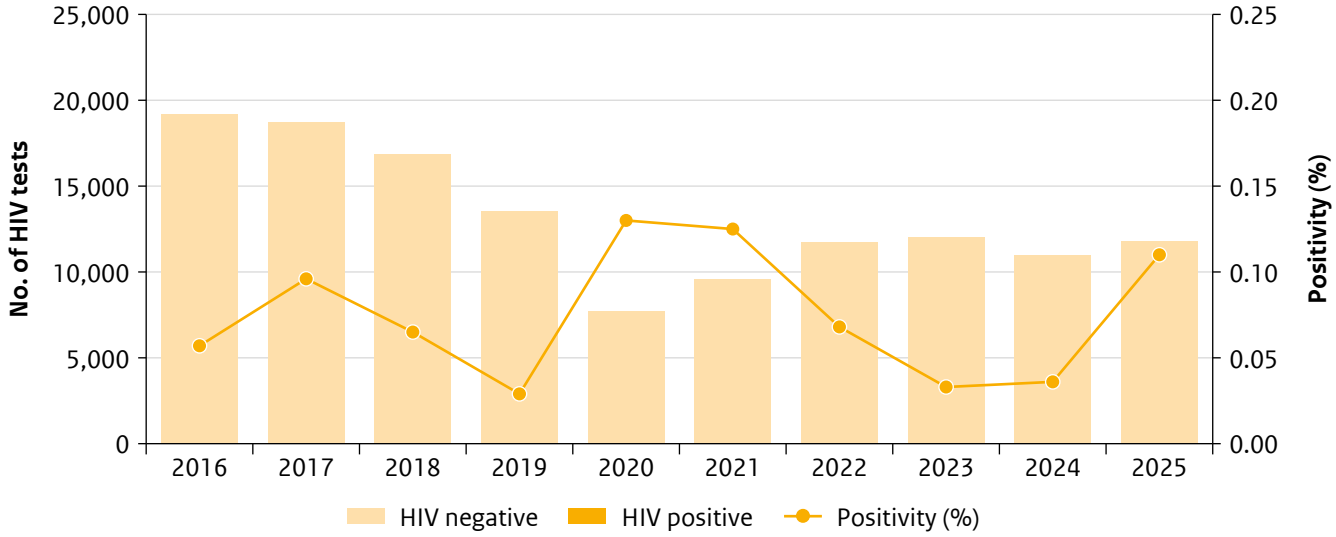
7.3 Sexual Health Centres: characteristics, risk groups and trends

Figure 7.5a Number of HIV positive and negative tests and HIV positivity in women, 2016-2025



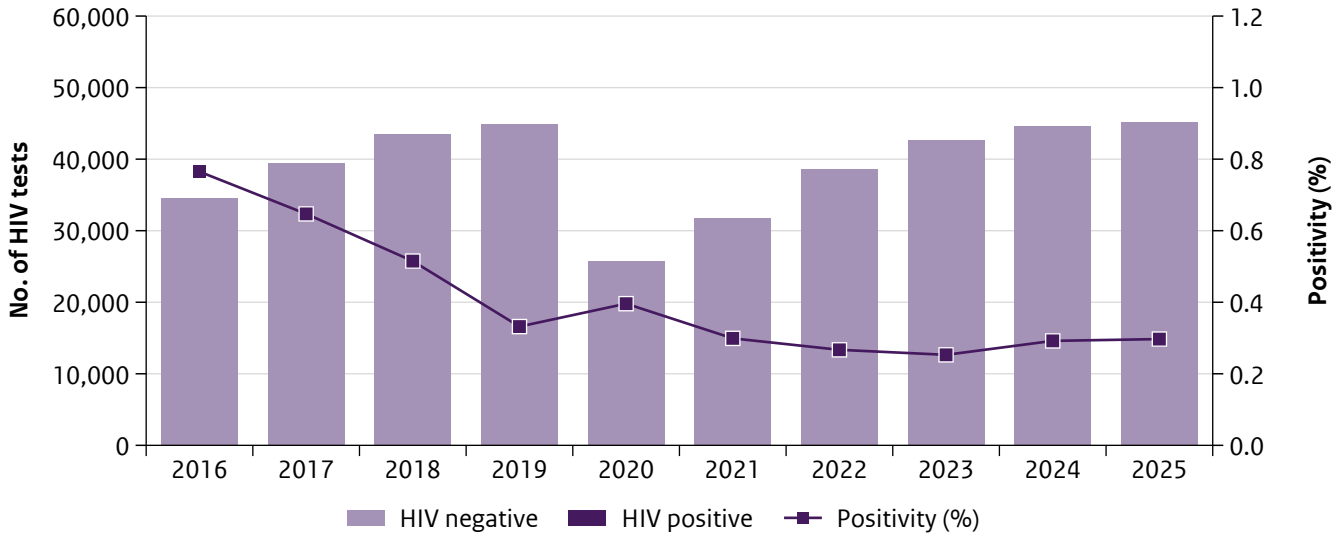
Footnote: Aggregated data of non-registered consultations included for 2018 and 2019.

Figure 7.5b Number of HIV positive and negative tests and HIV positivity in MSW, 2016-2025



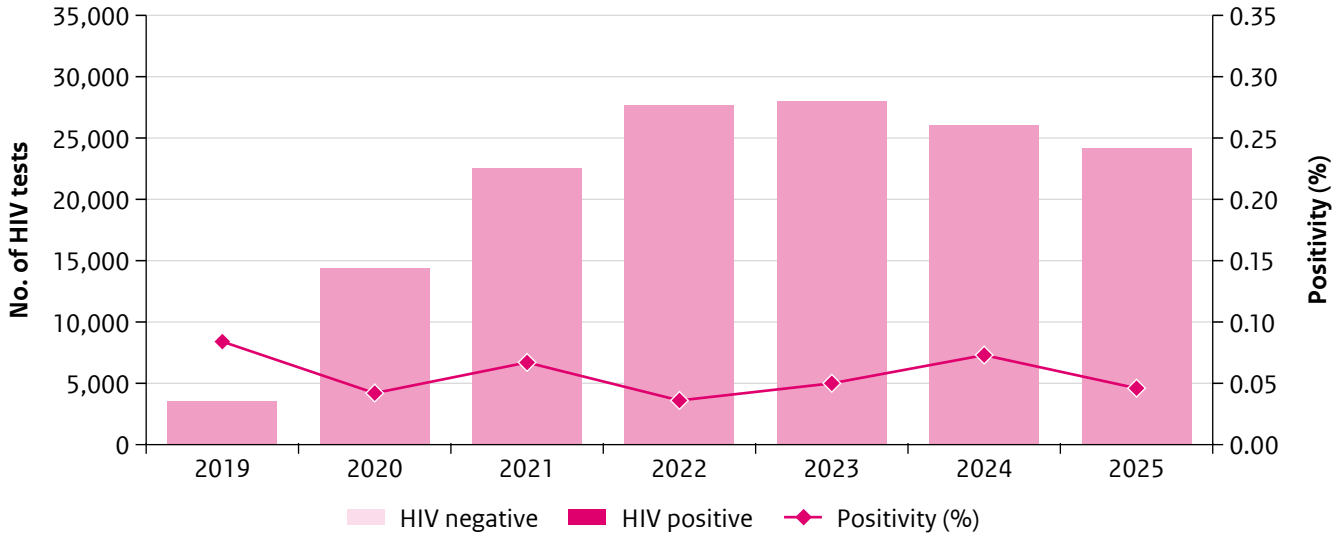
Footnote: Aggregated data of non-registered consultations included for 2018 and 2019.

Figure 7.5c Number of HIV positive and negative tests and HIV positivity in MSM-STI consultations, 2016-2025



Footnote: Aggregated data of non-registered consultations included for 2018 and 2019.

Figure 7.5d Number of HIV positive and negative tests and HIV positivity in MSM-PrEP consultations, 2019-2025



Footnote: Aggregated data of non-registered consultations included for 2019.

Figure 7.5e Number of HIV positive and negative tests and HIV positivity in gender diverse persons, 2020-2025

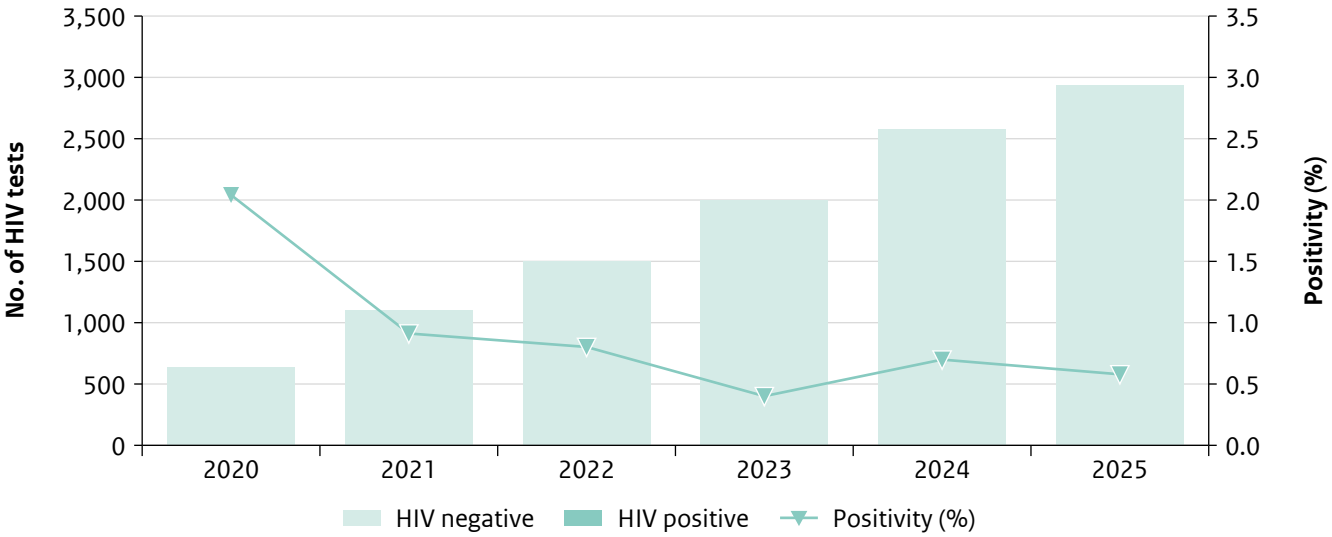


Figure 7.6 Reported triage indication: HIV positivity by triage indication in MSM-STI consultations, 2016-2025

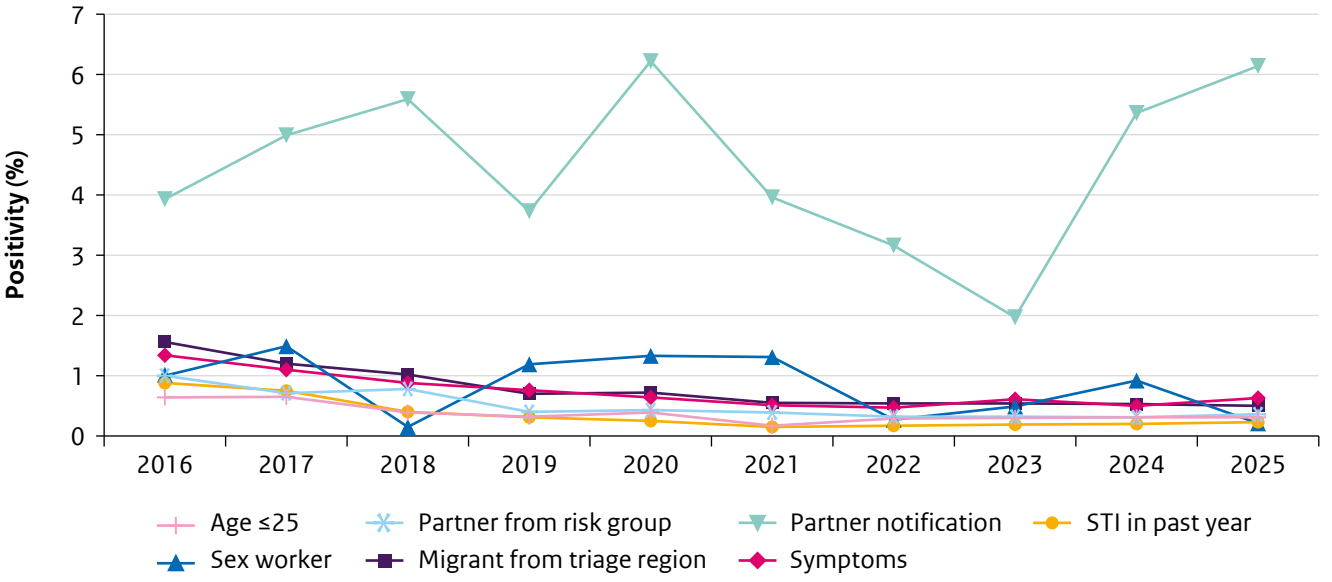
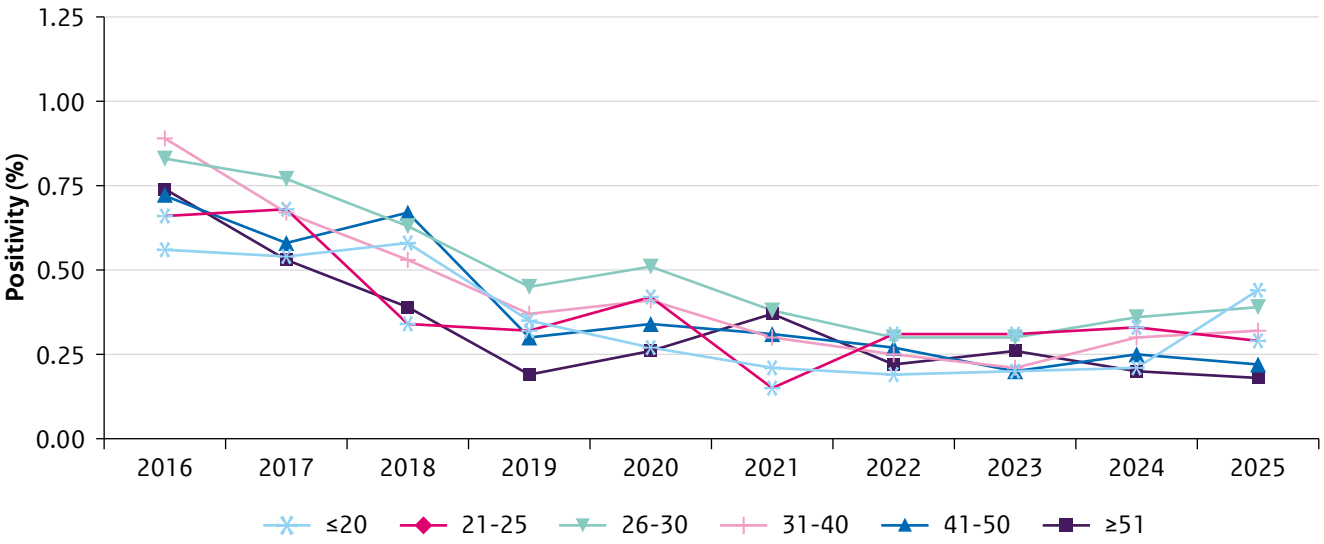
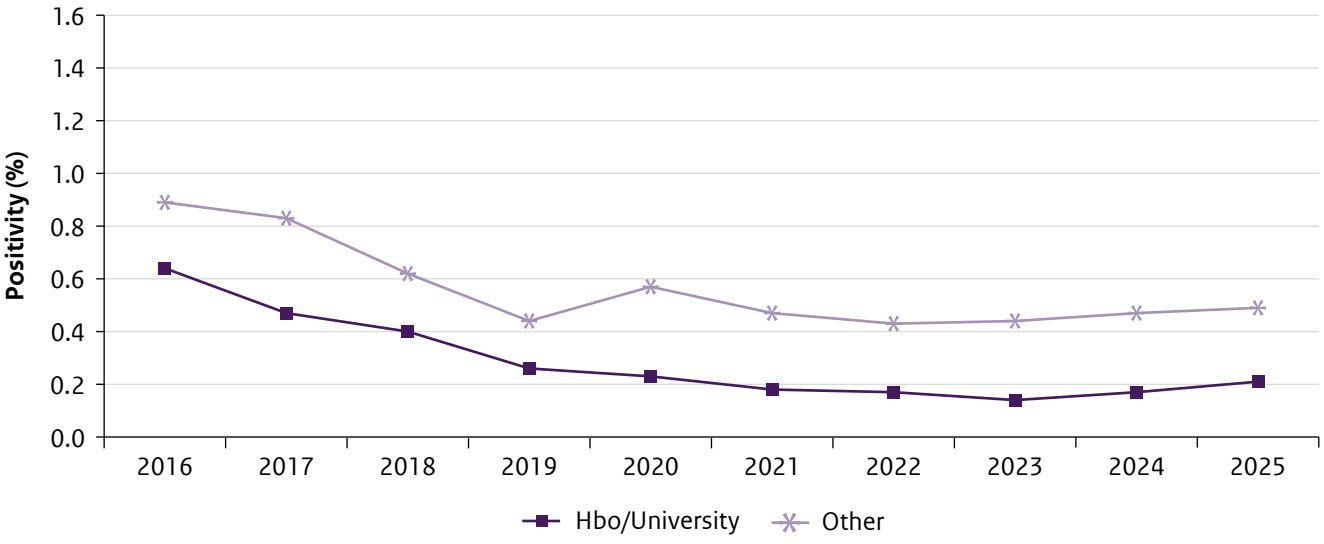


Figure 7.7 Age: trends in HIV positivity by age group in MSM-STI consultations, 2016-2025



Footnote: Exact numbers of diagnoses, tests and positivity by age group in 2025 are shown in supplementary table 13.18.

Figure 7.8 Education level: trends in HIV positivity by education level in MSM-STI consultations, 2016-2025



Footnote: Other education includes: no education, elementary school, lbo, mavo, vmbo, mbo, havo, vwo.

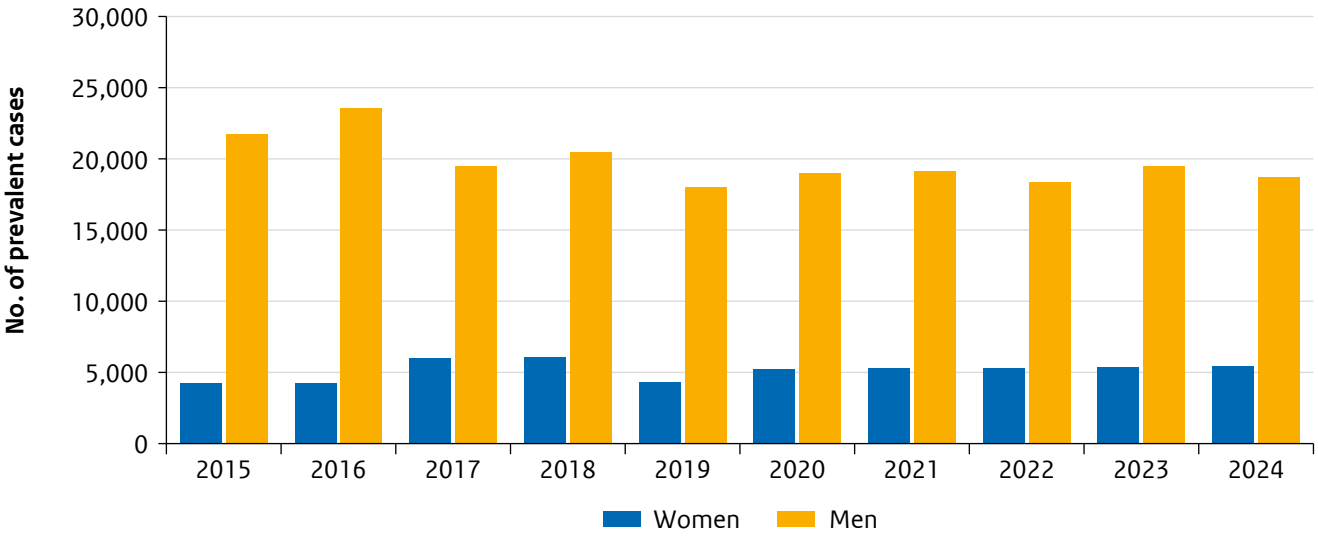
Table 7.8 Concurrent STI: Proportion of consultations with concurrent HIV and other STI diagnoses in MSM-STI consultations, 2024

Concurrent infection	MSM-STI consultation n (%)
HIV, total	134 (100.0)
Chlamydia	21 (15.7)
Gonorrhoea	44 (32.8)
Syphilis, infectious	13 (9.7)
Other STI*	4 (3.0)

* *Other STI includes genital herpes, genital warts, hepatitis B (infectious), and hepatitis C. SHCs check for genital herpes and genital warts on indication only. In addition, clients are not routinely tested for hepatitis C.*

7.4 General practices

Figure 7.9 Estimated number of prevalent HIV-cases in general practices by sex, based on general practices in Nivel-PCD, 2015-2024



Footnote: HIV prevalence estimates have been standardised for sex, age, and urbanisation.

Table 7.9 Estimated prevalence of HIV (rate per 1000 population) in general practices by sex, based on general practices in Nivel-PCD, 2015-2024

Year	Women	Men	Total
2015	0.5	2.6	1.5
2016	0.5	2.8	1.7
2017	0.7	2.3	1.5
2018	0.7	2.4	1.5
2019	0.5	2.1	1.3
2020	0.6	2.2	1.4
2021	0.6	2.2	1.4
2022	0.6	2.1	1.3
2023	0.6	2.2	1.4
2024	0.6	2.1	1.4

Footnote: HIV prevalence estimates have been standardised for sex, age, and urbanisation.

7.5 Other sources

7.5.1 Antenatal screening

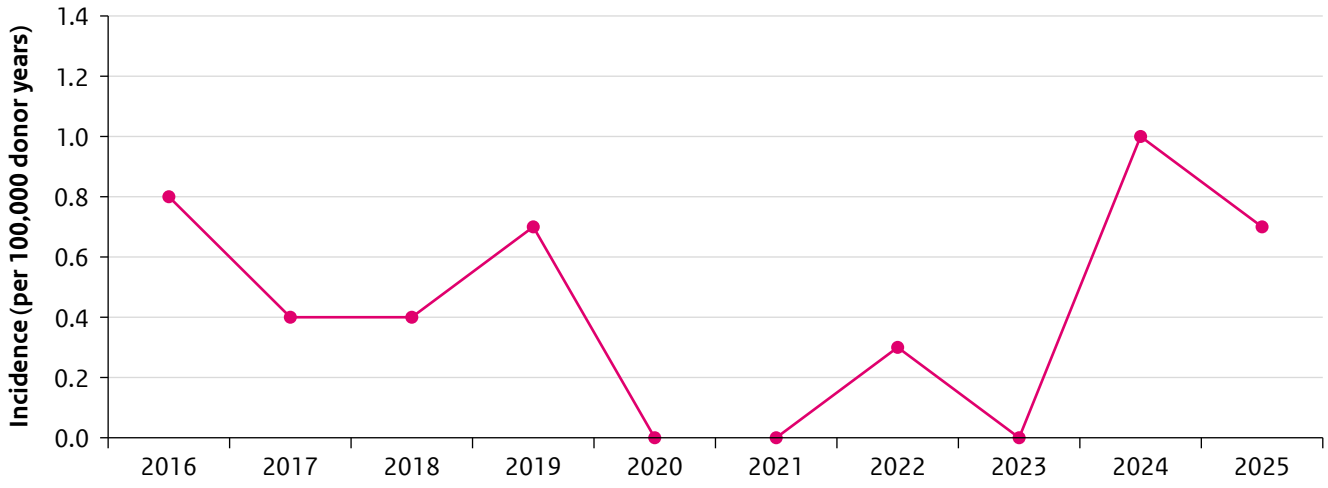
Table 7.10 HIV prevalence estimates in pregnant women, based on test results of antenatal screening, 2016-2024

Year	n positive / N women screened	Prevalence estimate
2016	88/172,694	0.05
2017	112/170,390	0.07
2018	91/171,149	0.05
2019	96/171,480	0.06
2020	89/176,103	0.05
2021	86/176,400	0.05
2022	82/168,258	0.05
2023	90/167,711	0.05
2024	78/170,189	0.05

Source: C.P.B. van der Ploeg (TNO), L. Vonk (TNO), J.A.M. Odijk (RIVM), M. van Lent (RIVM). Prenatale Screening Infectieziekten en Erytrocytenimmunisatie (PSIE). Procesmonitor 2024. TNO/RIVM 2026; and earlier monitors.

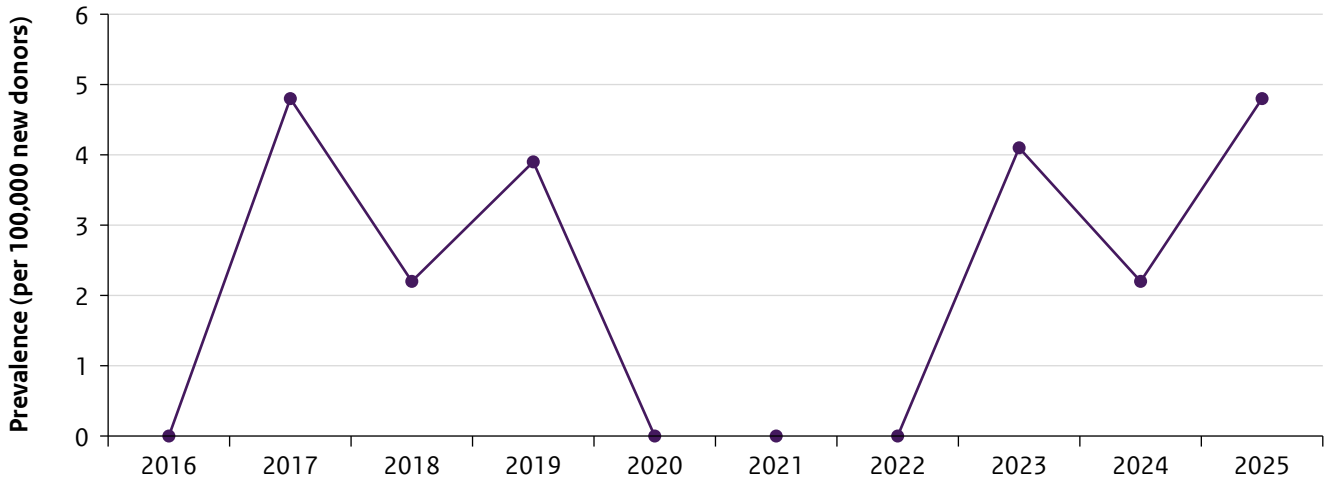
7.5.2 Blood donors

Figure 7.10 Incidence of HIV per 100,000 donor years, among blood- and plasma donors in the Netherlands, 2016-2025



Source: Sanquin.

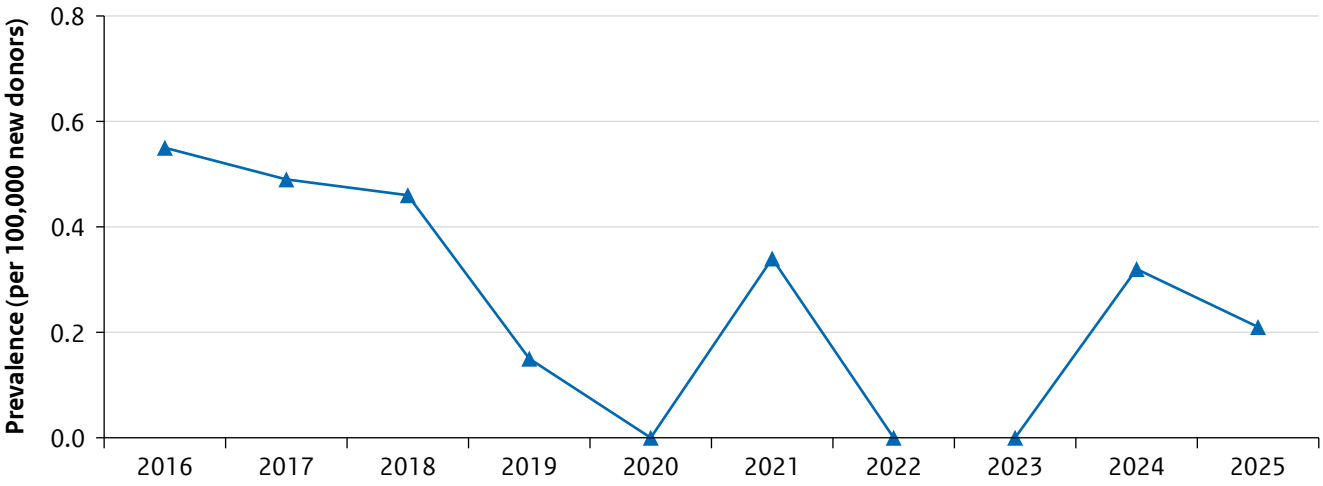
Figure 7.11 Prevalence of HIV per 100,000 new donors, among blood- and plasma donors in the Netherlands, 2016-2025



Source: Sanquin.

7.5.3 Amsterdam Cohort Studies

Figure 7.12 Yearly HIV incidence among MSM in the Amsterdam Cohort Studies, 2016-2025



Source: Amsterdam Cohort Studies among MSM, Public Health Service of Amsterdam.

8 Hepatitis B

8.1 Key points

8.1.1 Notification data

- In 2025, 891 hepatitis B infections were reported to RIVM, of which 791 (89%) were identified as chronic or of unknown status, and 100 (11%) as acute infections. Compared to 2024, the number of chronic/unknown infections decreased by 2.9% (from 918 to 891 cases), while acute infections increased by 13.6% (from 88 to 100 cases).
- The incidence of acute hepatitis B declined steadily between 2003 and 2021, but has since then stabilised at around 0.2 cases per 100,000 population among women and 0.9 cases per 100,000 among men.
- Sexual contact remained the most reported transmission route for acute hepatitis B (58%) in 2025. For 33% of the cases, the route of transmission was unknown (Figure 8.2).
- Of the chronic/unknown HBV infections in 2025 with a reported route of transmission, 312 (69%) were cases by vertical transmission, 55 (12%) by sexual contact (23 heterosexual, 22 MSM, and ten without sexual orientation), 7 (2%) among IDU, 10 (2%) by occupational accident, and 71 (16%) through other routes. For 336 cases, the route of transmission was unknown or not reported.

8.1.2 Sexual Health Centres

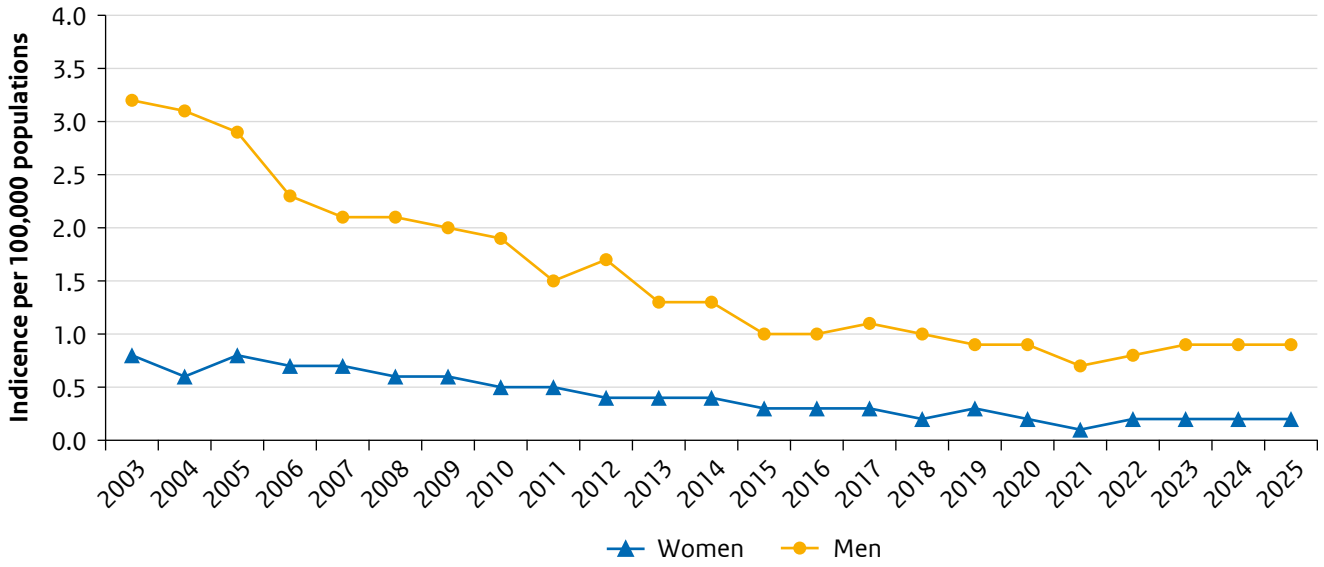
- In 2025, 24,802 hepatitis B tests were conducted at SHCs, out of which 5763 (23%) were among women, 3219 (13%) among MSW, 11,524 (47%) among MSM-STI consultations, 3141 (13%) among MSM-PrEP consultations, and 1155 (5%) among gender diverse persons (Table 2.3). Overall, this was a 1% decrease compared to 2024 (25,120 tests).
- In 2025, 46 infectious hepatitis B diagnoses (both acute and chronic) were reported at SHCs, a decrease from 56 diagnoses in 2024. Of the 46 diagnoses in 2025, 41% were among MSM-STI consultations, 30% among MSW, 20% among women, 4% among MSM-PrEP consultations and 4% among gender diverse persons (Table 2.4).
- Most infectious hepatitis B cases were among migrants from a region of origin with a triage indication: 100% of cases among MSW and gender diverse persons, and between 50% and 65% of cases among women, MSM-STI consultations, and MSM-PrEP consultations.

8.1.3 Other data sources

- In 2024, 321 women (0.2%) tested positive for hepatitis B in the antenatal screening programme. The prevalence has remained stable over the past decade (Table 8.1).
- The incidence of hepatitis B among blood and plasma donors remained unchanged in 2025 compared to 2024. Among new donors, the prevalence decreased between 2019 and 2024, but showed an increase in 2025 (Figures 8.3 and 8.4).
- In 2025, 3933 MSM and 603 sex workers entered the hepatitis B vaccination programme for risk groups. Although the number of new entries dropped sharply in 2020 due to the COVID-19 pandemic, participation has gradually increased since 2021. However, numbers have not yet returned to pre-pandemic levels, especially among sex workers (Figure 8.5).

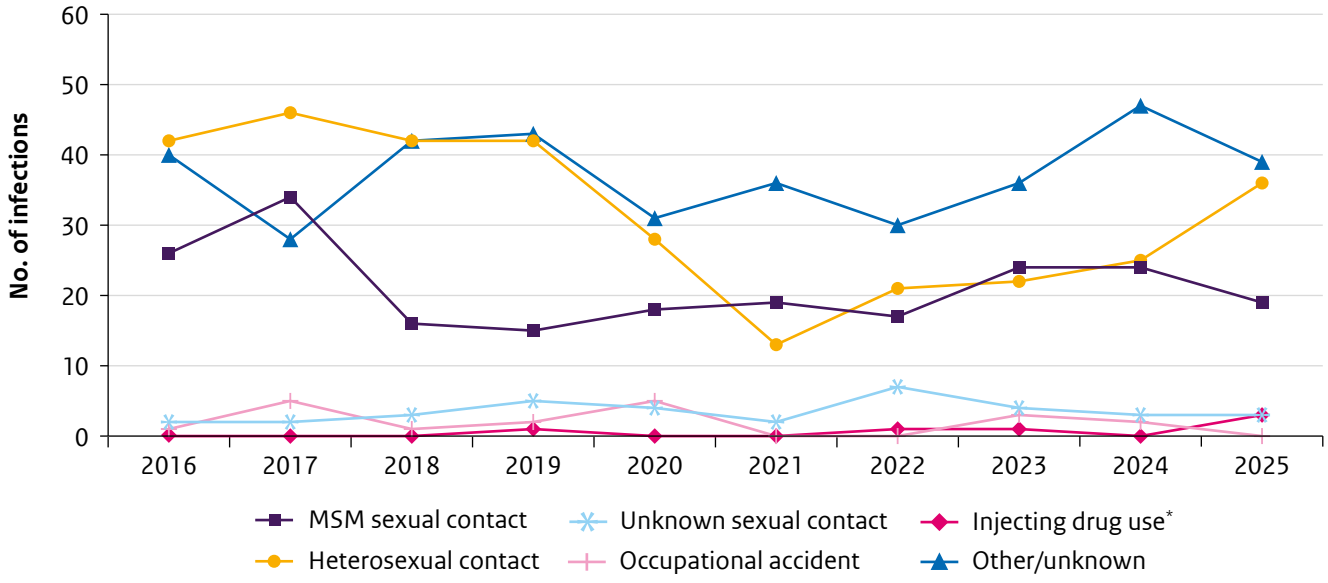
8.2 Notification data: trends and characteristics

Figure 8.1 Incidence of acute hepatitis B per 100,000 population by sex, 2003-2025



Source: RIVM-OSIRIS, notification data.
Footnote: Data from 2025 might be incomplete due to reporting delay (data were collected on February 25, 2026).

Figure 8.2 Number of acute hepatitis B infections by route of transmission, 2016-2025



Source: RIVM-OSIRIS, notification data.
Footnote 1: Data from 2025 might be incomplete due to reporting delay (data were collected on February 25, 2026).
Footnote 2: Other/unknown can include medical transmission, mother to child transmission, and other routes of transmission.

8.3 Other sources

8.3.1 Antenatal screening

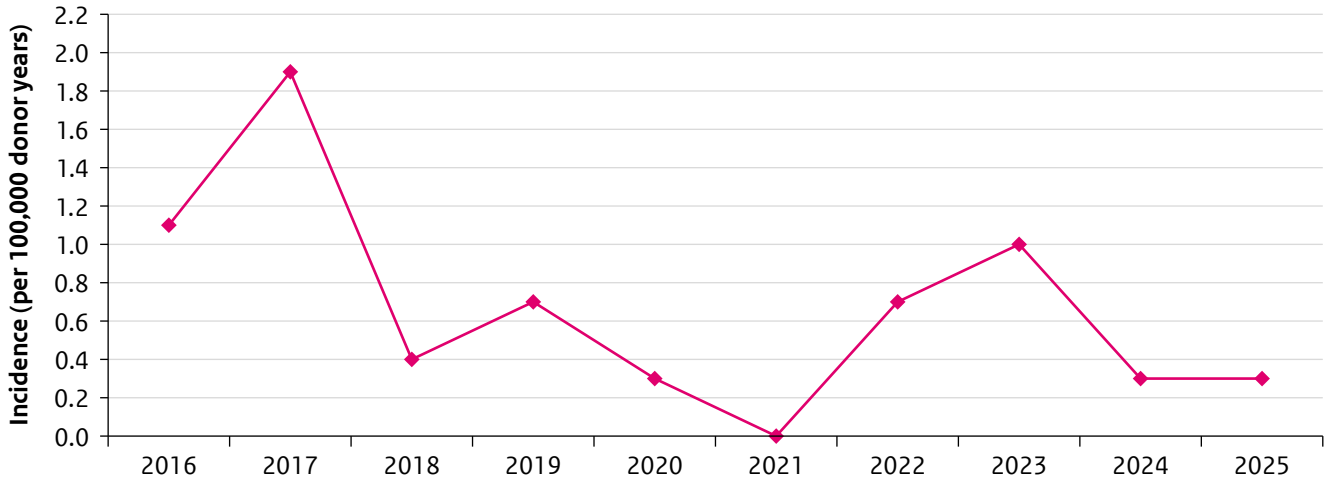
Table 8.1 Hepatitis B prevalence estimates in pregnant women, based on test results of antenatal screening, 2015-2024

Year	n positive / N women screened	Prevalence estimate
2015	506/176,238	0.29
2016	507/172,799	0.29
2017	480/170,461	0.28
2018	453/171,242	0.26
2019	437/171,609	0.26
2020	394/176,235	0.22
2021	334/176,464	0.19
2022	323/168,333	0.19
2023	319/167,762	0.19
2024	321/170,218	0.19

Source: C.P.B. van der Ploeg (TNO), L. Vonk (TNO), J.A.M. Odijk (RIVM), M. van Lent (RIVM). Prenatale Screening Infectieziekten en Erytrocytenimmunisatie (PSIE). Procesmonitor 2024. TNO/RIVM 2026; and earlier monitors.

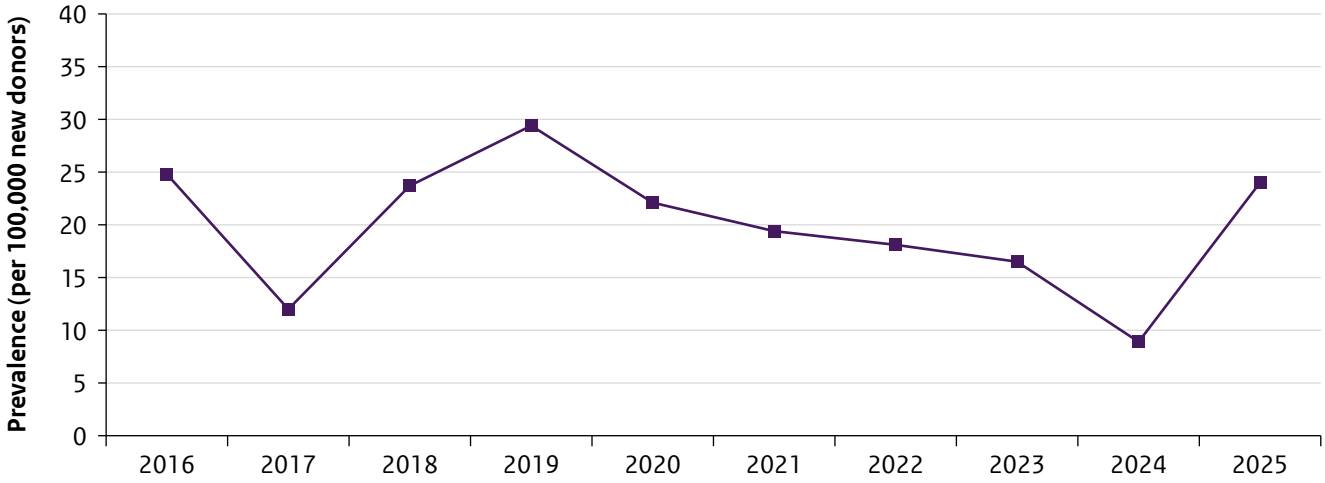
8.3.2 Blood donors

Figure 8.3 Incidence of hepatitis B virus per 100,000 donor years among blood- and plasma donors, 2016-2025



Source: Sanquin.

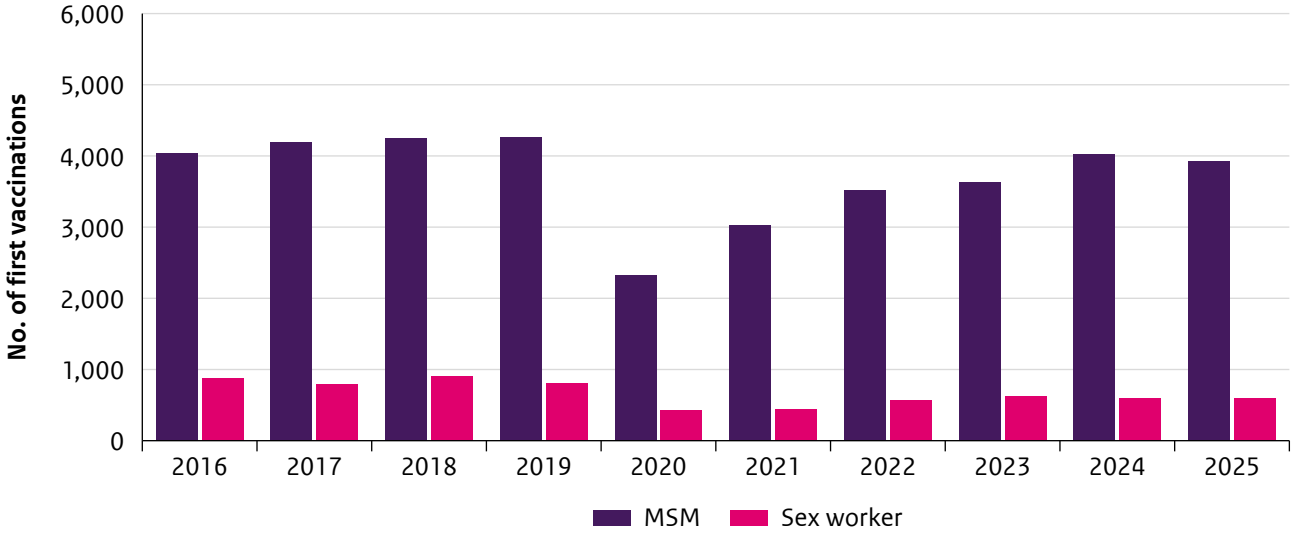
Figure 8.4 Prevalence of hepatitis B virus per 100,000 new donors among blood- and plasma donors, 2016-2025



Source: Sanquin.

8.3.3 Hepatitis B vaccination programme

Figure 8.5 Number of MSM and sex workers entering the hepatitis B vaccination programme, 2016-2025



Source: RIVM, HBV vaccination programme among MSM and sex workers.

9 Hepatitis C

9.1 Key points

9.1.1 Notification data

- In 2025, 414 hepatitis C infections were reported, out of which 369 (89%) were identified as chronic infections or of unknown status, and 45 (11%) as acute infections (Figure 9.1).
- Sexual contact among MSM remained the most frequently reported transmission route for acute hepatitis C, accounting for 58% of all cases in 2025. The proportion of hepatitis C infections relating to injected drug use increased from 13% in 2022 to 18% in 2025 (Figure 9.2).
- Acute hepatitis C infections among MSM increased from 14 cases in 2022 (47% of all acute infections) to 26 cases in 2025 (58% of all acute infections). A growing proportion of these acute infections was observed among MSM without HIV, rising from 13% in 2022 to 24% in 2025 (Figure 9.3).
- Among the 369 chronic/unknown infections reported in 2025, the majority (53%) were associated with other or unknown risk factors. Injecting drug use accounted for 29% of cases, sex between men for 7%, mother-to-child transmission for 5%, while 3% involved unknown sexual risk factors.

9.1.2 Sexual Health Centres

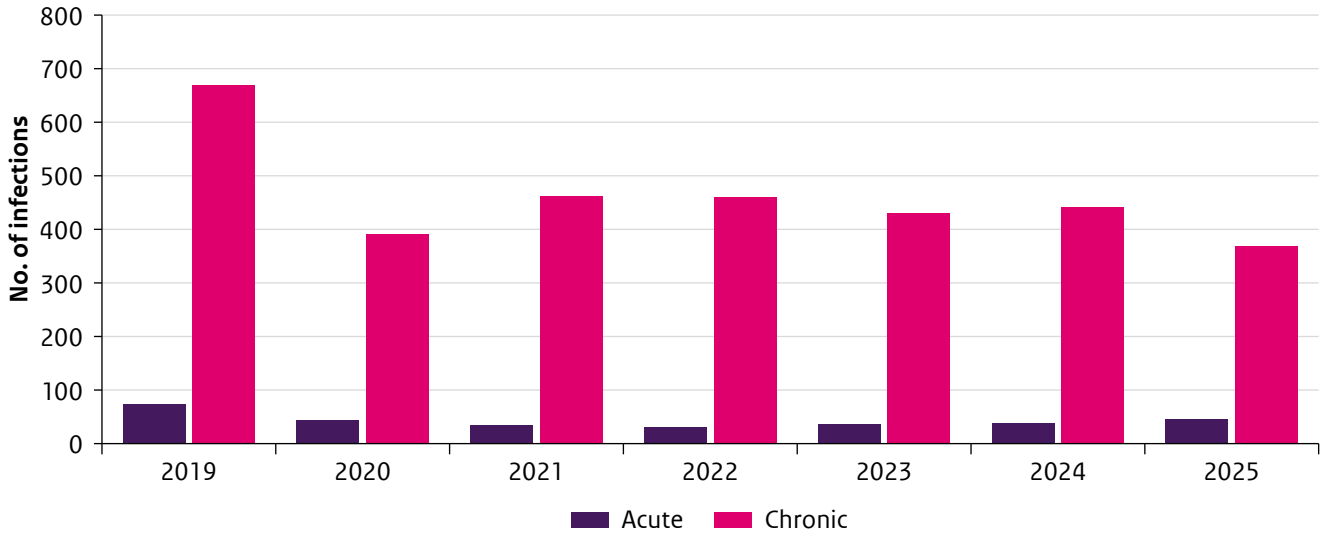
- In 2025, 17,451 hepatitis C tests were conducted at SHCs – a 16% increase from 15,052 tests in 2024. Out of these, 521 (3%) were among women, 307 (2%) among MSW, 2538 (15%) among MSM-STI consultations, 13,376 (77%) among MSM-PrEP consultations, and 709 (4%) among gender diverse persons (Table 2.3).
- Among MSM-STI tested for hepatitis C, 782 (31%) were living with or newly diagnosed with HIV, while 1756 (69%) were HIV-negative. Of the HIV-negative group, 46% had used PrEP in the past 3 months.
- There were 25 infectious hepatitis C diagnoses at SHCs in 2025, out of which 12 were among MSM-PrEP, 8 among MSM-STI, 1 among women, and 1 among gender diverse persons (Table 2.4).

9.1.3 Other data sources

- The prevalence of hepatitis C among new blood- and plasma donors increased in 2025 compared to 2024, from 8.9 to 12.0 per 100,000 new donors. The incidence among regular donors remained 0 (Figure 9.4).

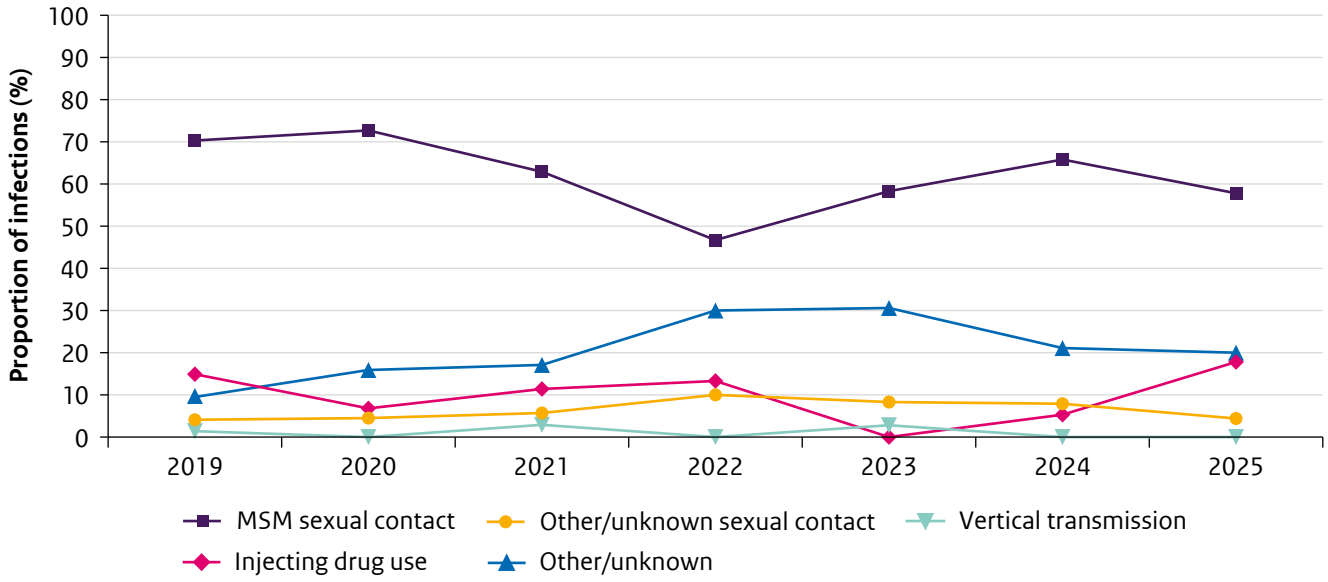
9.2 Notification data: trends and characteristics

Figure 9.1 Number of acute and chronic hepatitis C infections, 2019-2025



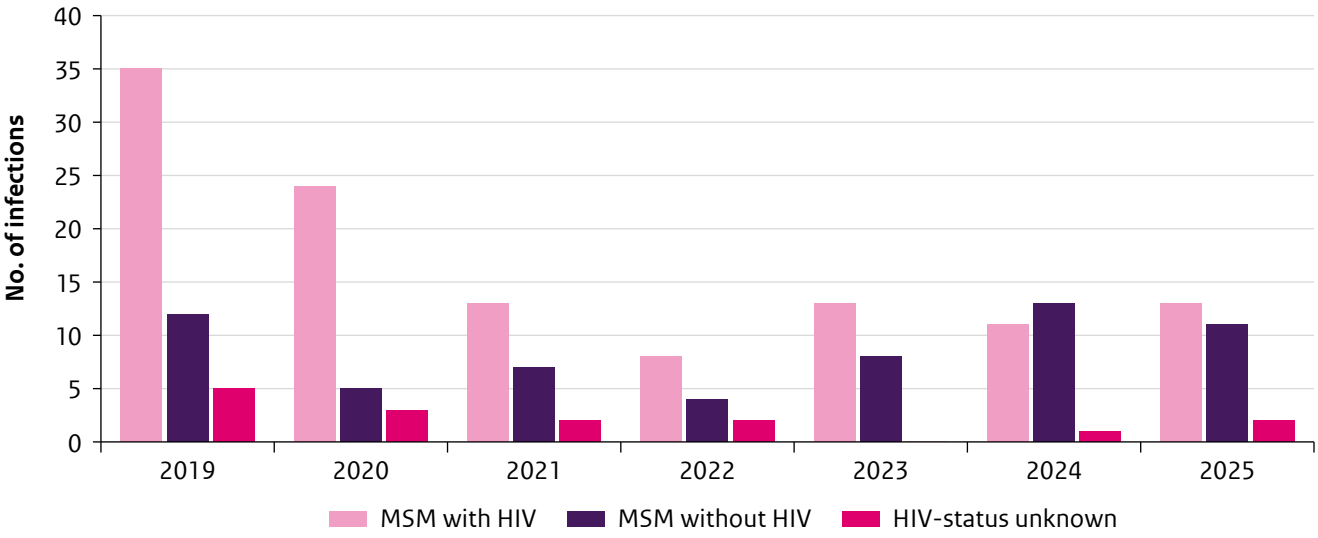
Source: RIVM-OSIRIS, notification data.
Footnote: Data from 2025 might be incomplete due to reporting delay (data collected on February 17, 2026).

Figure 9.2 Proportion of acute hepatitis C infections by route of transmission, 2019-2025



Source: RIVM-OSIRIS, notification data
Footnote 1: Data from 2025 might be incomplete due to reporting delay (data collected on February 17, 2026).
Footnote 2: Other/unknown transmission contains occupational accidents and all other transmission routes that were not included in RIVM-OSIRIS.

Figure 9.3 Number of acute hepatitis C infections in MSM by HIV status, 2019-2025

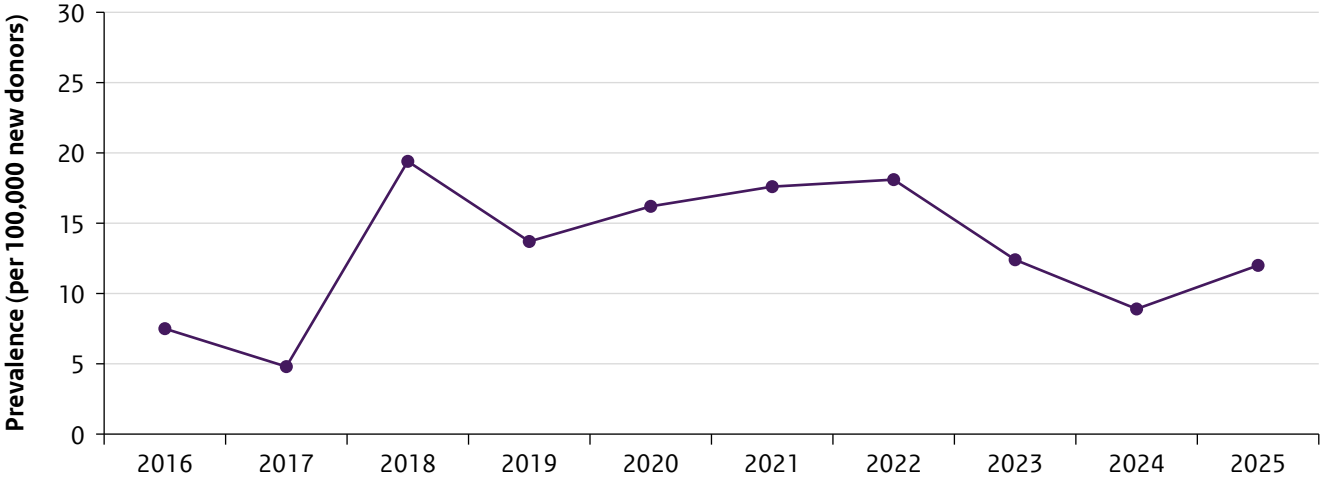


Source: RIVM-OSIRIS, notification data.
Footnote: Data from 2025 might be incomplete due to reporting delay (data collected on February 27, 2026).

9.3 Other sources

9.3.1 Blood donors

Figure 9.4 Prevalence of hepatitis C virus per 100,000 new donors among blood- and plasma donors, 2016-2025



Source: Sanquin.
Footnote: In the past 10 years the HCV incidence among regular blood donors was 0/100,000 donor-years, with the exception of 2020 and 2025 (0.3/100,000).

10 Mpox

10.1 Key points

10.1.1 Notification data

- The mpox outbreak in the Netherlands started in May 2022 and peaked in July 2022, after which a rapid decrease of reported mpox cases was observed (Figure 10.1).
- Since 2022, a total of 1579 mpox infections have been reported to RIVM. Out of these, 149 were reported in 2025 and 137 in 2024.
- In October 2025, the first mpox clade 1b case was identified in the Netherlands. A total of nine clade 1b cases were reported that year, mainly through autochthonous transmission (Figure 10.2).
- The characteristics of persons with an mpox infection in 2025 were similar to those since the beginning of the outbreak (Table 10.1). Out of the mpox cases reported in 2025, 133 (89%) were among MSM, 57 (38%) were among persons aged 25-34 years, and 28 (19%) were among people living with HIV.
- The proportion of persons with mpox who were fully vaccinated increased from 1% during the 2022-2023 period to 23% in 2025.
- Sexual contact, including close skin and mucosal contact, remained the most reported transmission route for mpox infections, with 85.9% of cases in 2025 having this route of transmission.

10.1.2 Sexual Health Centres

- In 2025, a total of 1467 mpox tests were conducted at Sexual Health Centres. Out of these tests, 1087 (74%) were among MSM-STI consultations, 249 (17%) among MSM-PrEP consultations, 56 (4%) among gender diverse persons, 40 (3%) among MSW, and 35 (2%) among women.
- There were 93 mpox diagnoses at Sexual Health Centres. Out of these diagnoses, 80 (86%) were among MSM-STI, 11 (12%) among MSM-PrEP, and 2 (2%) among gender diverse persons.

10.1.3 Mpox vaccinations

- In 2025, a total of 6307 mpox vaccinations were administered, out of which 3635 (58%) were first doses and 2672 (42%) were second doses (Figure 10.3).

10.2 Notification data: trends and characteristics

Figure 10.1 Number and cumulative number of reported mpox cases per quarter, 2022-2025

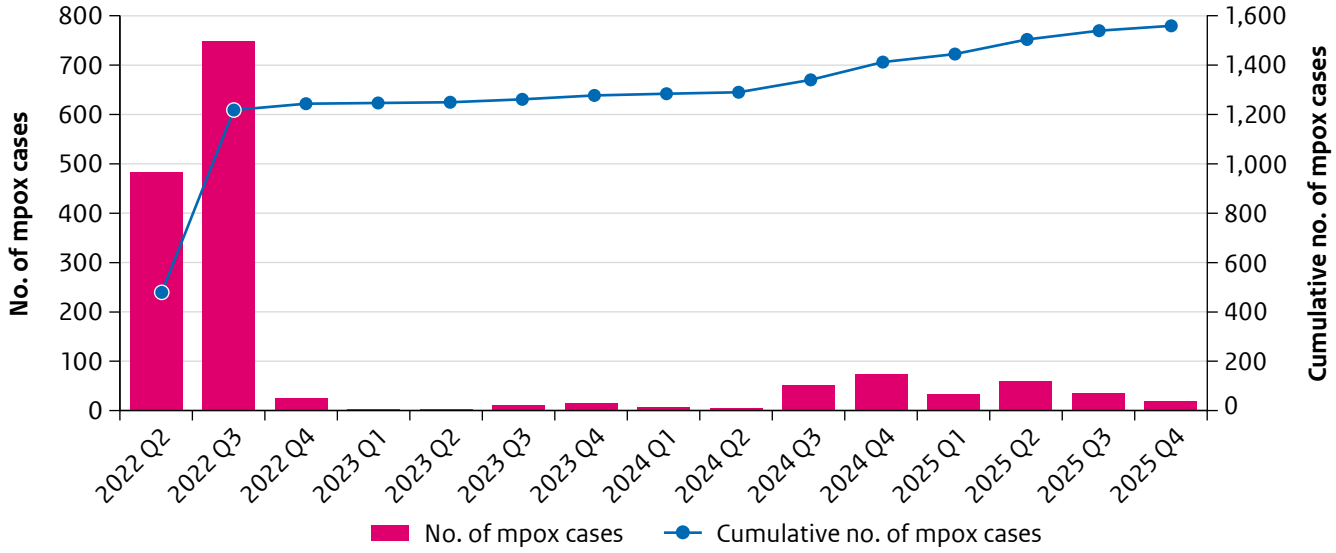


Figure 10.2 Number of reported mpox cases per month by clade, 2025

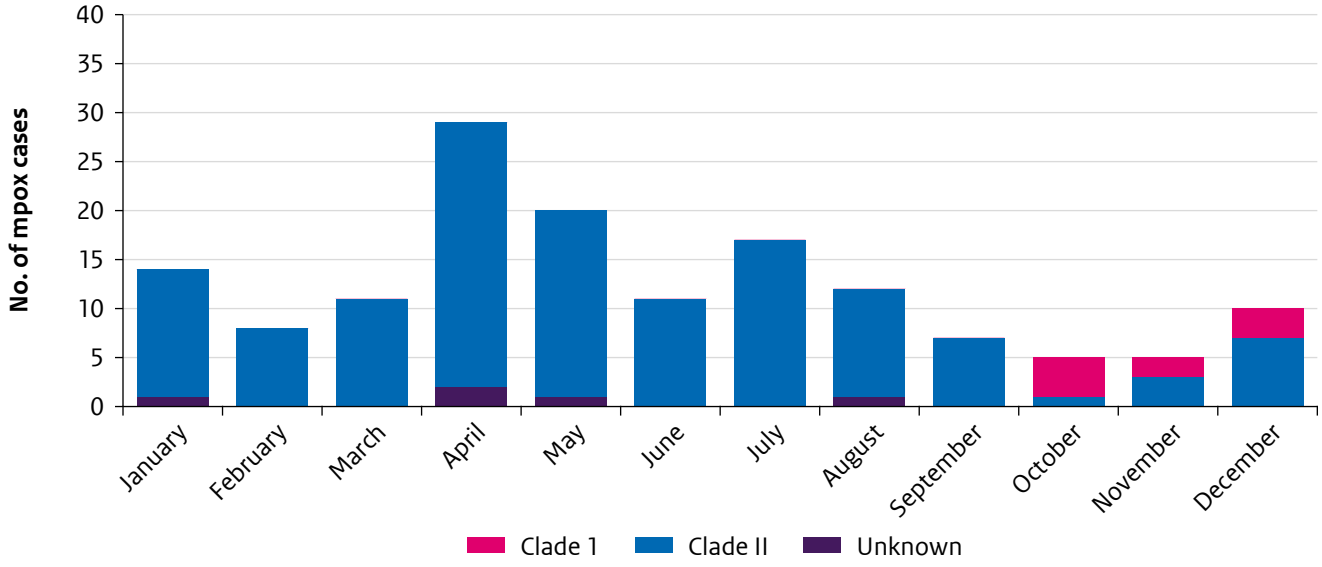


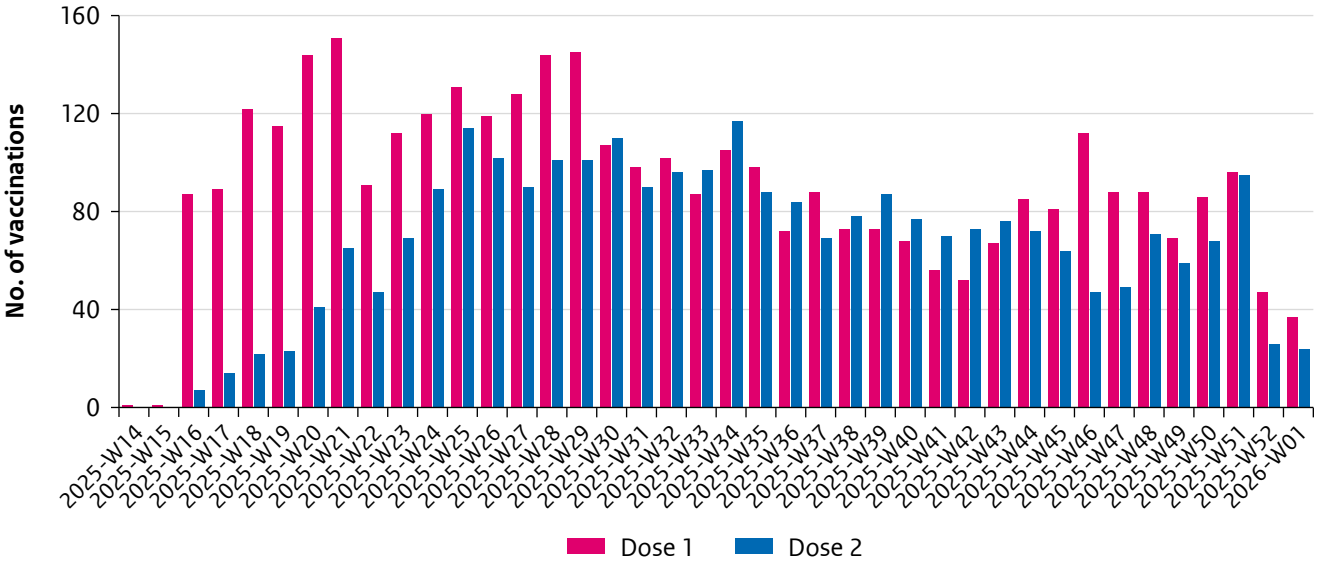
Table 10.1 Demographics and (sexual) behavioural characteristics: number and proportion of mpox cases, 2022-2025

Characteristic	Total	2024
	n (%)	n (%)
Total	**1,579 (100.0)**	**149 (100.0)**
Clade		
I	9 (0.6)	9 (6.0)
II	224 (14.2)	135 (90.6)
Unknown	1,346 (85.2)	5 (3.4)
Sex and type of sexual contact		
Woman	20 (1.3)	1 (0.7)
MSW	36 (2.3)	4 (2.7)
MSM	1,450 (91.8)	133 (89.3)
Gender diverse	10 (0.6)	1 (0.7)
Unknown	63 (4.0)	10 (6.7)
Age		
≤24	100 (6.3)	7 (4.7)
25-34	552 (35.0)	57 (38.3)
35-44	536 (33.9)	58 (38.9)
≥45	389 (24.6)	26 (17.4)
Unknown	2 (0.1)	1 (0.7)
Country of birth		
The Netherlands	833 (52.8)	65 (43.6)
Abroad	717 (45.4)	80 (53.7)
Unknown	29 (1.8)	4 (2.7)
Travel history abroad		
Yes	565 (35.8)	48 (32.2)
No	916 (58.0)	91 (61.1)
Unknown	98 (6.2)	10 (6.7)
Vaccination status (Imvanex)		
Vaccinated, 2 doses	77 (4.9)	34 (22.8)
Vaccinated, 1 dose	131 (8.3)	17 (11.4)
Vaccinated, dose unknown	17 (1.1)	4 (2.7)
Not vaccinated	854 (54.1)	84 (56.4)
Unknown	500 (31.7)	10 (6.7)

Characteristic	Total	2024
	n (%)	n (%)
HIV status and PrEP use, in the past 6 months		
HIV negative and PrEP use	458 (29.0)	63 (42.3)
HIV negative and no PrEP use	551 (34.9)	39 (26.2)
Living with HIV	346 (21.9)	28 (18.8)
Unknown	224 (14.2)	19 (12.8)
Route of transmission		
Sexual contact (including close skin and mucosal contact)	1,326 (84.0)	128 (85.9)
Other/unknown	253 (16.0)	21 (14.1)

Source: RIVM-OSIRIS, notification data.
Footnote: Data from 2025 might be incomplete due to reporting delay (data collected on February 20, 2026).

Figure 10.3 Number of reported mpox vaccinations per week by dose, 2025



Source: RIVM-OSIRIS, notification data.
Footnote: The last vaccinations administered in 2025 (on 29–31 December) are officially recorded in week 1 of 2026.

11 Genital warts

11.1 Key points

11.1.1 General practices

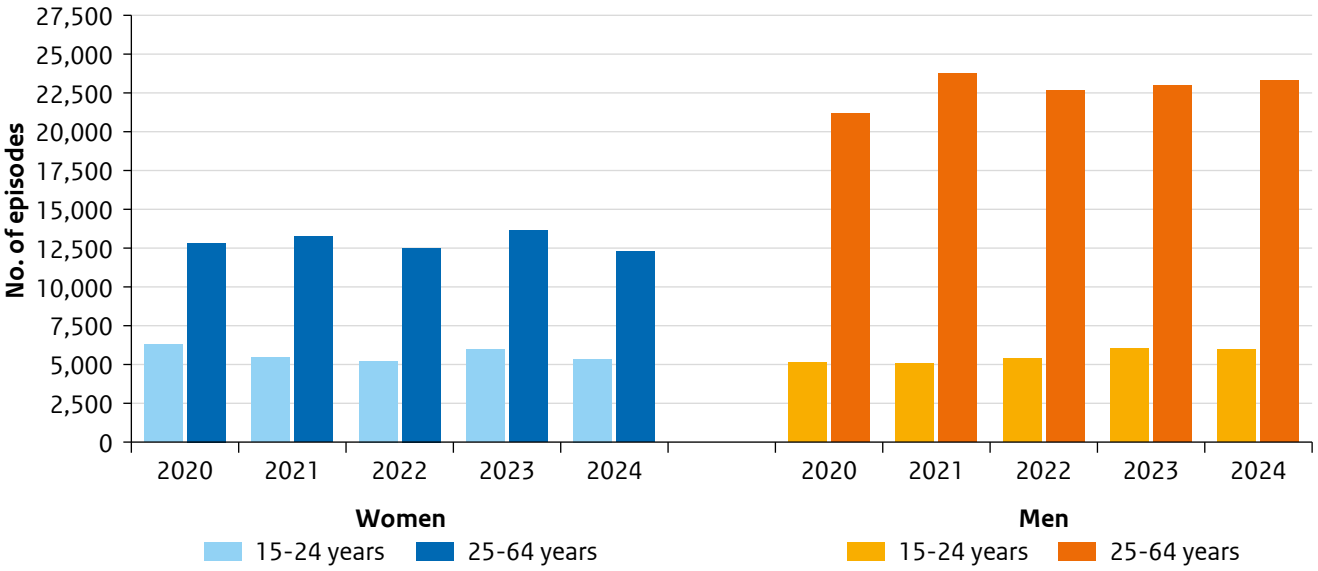
- At GPs, the total number of genital warts episodes, estimated on the basis of Nivel-PCD data, was 46,900 in 2024. This was lower than in 2023 (48,600) (Figure 11.1).
- In 2024, the reporting rate for genital warts at general practices was 4.0 episodes per 1000 aged 15-64 years. This was 3.1 per 1000 population for women and 5.0 per 1000 for men (Table 11.1).
- The reporting rate for men was higher among men aged 15-24 years (5.3 per 1000) than among men aged 25-64 years (5.0 per 1000) (Table 11.1).
- Among women, the rate was higher among women aged 15-24 years (5.0 per 1000) than among women aged 25-64 years (2.6 per 1000) (Table 11.1).

11.1.2 Sexual Health Centres

- In 2025, the number of genital warts diagnoses at SHCs amounted to 845, which was an increase compared to 2024 (806). Of the genital warts diagnoses in 2025, 30% were among women, 43% among MSW, 21% among MSM-STI consultations, 5% among MSM-PrEP consultations, and 1% among gender diverse persons.
- In 2025, the number of genital warts diagnoses among persons aged ≤ 25 years was 519. Among women diagnosed with genital warts, 80% was aged ≤ 25 years. Among MSW this was 68%, among MSM-STI 32% and among MSM-PrEP 18%.

11.2 General practices

Figure 11.1 Estimated number of episodes of genital warts in general practices by sex and age group, based on general practices in Nivel-PCD, 2020-2024



Footnote: About 50% of the total Dutch population consists of persons aged 25-64 years and about 10% consists of persons aged 15-24 years.

Table 11.1 Reporting rate (number of episodes per 1000 persons aged 15-64 years) of genital warts in general practices by sex and age group, based on general practices in Nivel-PCD, 2020-2024

Year	Women n/1,000			Men n/1,000			Total n/1,000		
	All	15-24	25-64	All	15-24	25-64	All	15-24	25-64
2020	**3.4**	6.0	2.8	**4.6**	4.7	4.6	**4.0**	5.3	3.7
2021	**3.3**	5.2	2.9	**5.1**	4.6	5.2	**4.2**	4.9	4.0
2022	**3.1**	4.9	2.7	**4.9**	4.9	4.9	**4.0**	4.9	3.8
2023	**3.4**	5.5	2.9	**5.0**	5.4	4.9	**4.2**	5.5	3.9
2024	**3.1**	5.0	2.6	**5.0**	5.3	5.0	**4.0**	5.1	3.8

12 Genital herpes

12.1 Key points

12.1.1 General practices

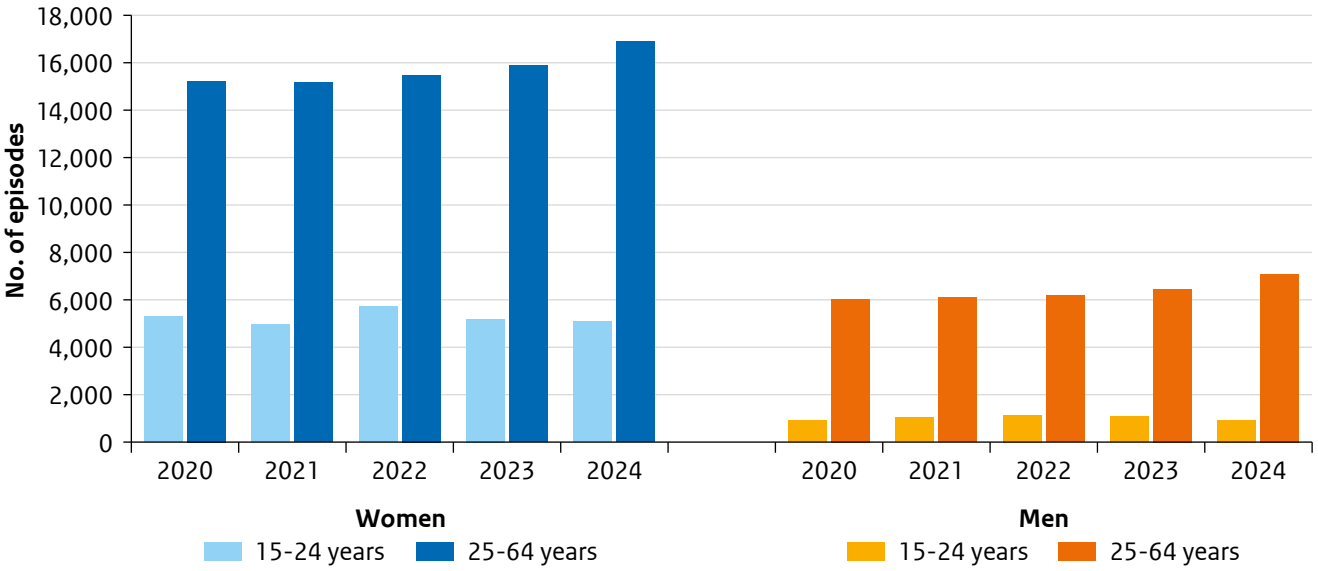
- At GPs, the number of genital herpes episodes in 2024, estimated using Nivel-PCD data, was 30,000, compared to 28,600 in 2023 (Figure 12.1).
- In 2024, the total reporting rate for genital herpes diagnoses at GPs was 2.6 per 1000 population.
- The reporting rate was 2.8 per 1000 population aged 15-24 years. This was 4.7 per 1000 for women and 0.8 per 1000 for men. The reporting rate was 2.6 per 1000 population aged 25-64 years. This was 3.6 per 1000 for women and 1.5 per 1000 for men (Table 12.1).
- The reporting rate for women was higher in the population aged 15-24 years, while for men this was higher in the population aged 25-64 years (Table 12.1).

12.1.2 Sexual Health Centres

- In 2025, the number of persons with a genital herpes diagnosis at SHCs in the Netherlands amounted to 557, which was lower than in 2024 (616). Of the diagnoses in 2025, 34% were among women, 24% among MSW, 32% among MSM-STI consultations, 9% among MSM-PrEP consultations, and 1% among gender diverse persons.
- The number of genital herpes diagnoses in 2025 among persons aged ≤ 25 years was 247. Among women diagnosed with genital herpes, 71% was aged ≤ 25 years. Among MSW this was 62%, among MSM-STI 14%, and among MSM-PrEP 6%.
- Among women, 51% of the diagnoses was herpes simplex virus 1 (HSV1) and 43% herpes simplex virus 2 (HSV2). Among MSW, 40% was HSV1 and 57% was HSV2. For MSM-STI, this was 46% and 50%, respectively. For MSM-PrEP, this was 39% and 54%, respectively.
- The proportion of HSV1, HSV2, and primary genital herpes with an unknown type of all primary genital herpes diagnoses has ranged between 2% and 8% from 2016 to 2025.

12.2 General practices

Figure 12.1 Estimated number of genital herpes episodes in general practices by sex and age group, based on general practices in Nivel-PCD, 2020-2024



Footnote: About 50% of the total Dutch population consists of persons aged 25-64 years and about 10% consists of persons aged 15-24 years.

Table 12.1 Reporting rate (number of episodes per 1000 persons aged 15-64 years) of genital herpes in general practices by sex and age group, based on general practices in Nivel-PCD, 2020-2024

Year	Women n/1,000			Men n/1,000			Total n/1,000		
	All	15-24	25-64	All	15-24	25-64	All	15-24	25-64
2020	**3.7**	5.1	3.3	**1.2**	0.8	1.3	**2.4**	2.9	2.3
2021	**3.6**	4.7	3.3	**1.3**	1.0	1.3	**2.4**	2.9	2.3
2022	**3.7**	5.4	3.4	**1.3**	1.0	1.3	**2.5**	3.2	2.4
2023	**3.7**	4.8	3.4	**1.3**	1.0	1.4	**2.5**	2.9	2.4
2024	**3.8**	4.7	3.6	**1.4**	0.8	1.5	**2.6**	2.8	2.6

13 Supplementary tables and figures

13.1 STI

Table 13.1 Characteristics of clients at repeat consultations: number and proportion of consultations by sex and type of sexual contact, 2025

No. of consultation & characteristic	Women	MSW	MSM-STI consultation	Gender diverse persons
	n (%)	n (%)	n (%)	n (%)
Notified for STI/HIV				
1	6,404 (16.7)	5,140 (24.0)	6,983 (20.1)	216 (10.4)
2	954 (18.2)	446 (24.3)	2,139 (20.2)	74 (10.2)
3	148 (14.5)	61 (23.6)	686 (20.0)	32 (10.6)
Symptoms				
1	17,289 (45.0)	8,894 (41.6)	8,346 (24.0)	419 (20.1)
2	2,527 (48.1)	956 (52.2)	2,469 (23.3)	135 (18.7)
3	467 (45.7)	137 (52.9)	817 (23.8)	67 (22.2)
Region of origin with triage indication[1]				
1	11,341 (29.5)	7,885 (36.9)	10,694 (30.8)	1,001 (48.1)
2	1,747 (33.2)	853 (46.6)	3,333 (31.5)	424 (58.7)
3	400 (39.1)	151 (58.3)	1,153 (33.6)	191 (63.2)
Age ≤25 years				
1	28,174 (73.3)	15,082 (70.5)	6,616 (19.0)	714 (34.3)
2	3,553 (67.6)	1,407 (76.8)	1,553 (14.7)	159 (22.0)
3	597 (58.4)	191 (73.7)	412 (12.0)	56 (18.5)
Partner in risk group[2]				
1	11,915 (31.0)	7,000 (32.7)	14,635 (42.1)	1,161 (55.7)
2	1,930 (36.7)	645 (35.2)	4,605 (43.5)	438 (60.7)
3	438 (42.9)	94 (36.3)	1,631 (47.6)	213 (70.5)
Sex work				
1	3,118 (8.1)	145 (0.7)	756 (2.2)	464 (22.3)
2	1,042 (19.8)	30 (1.6)	240 (2.3)	234 (32.4)
3	348 (34.1)	11 (4.2)	100 (2.9)	127 (42.1)
GO/CT/syphilis in the past year				
1	3,170 (8.3)	1,272 (5.9)	6,761 (19.5)	299 (14.4)
2	1,270 (24.2)	525 (28.7)	3,845 (36.3)	211 (29.2)
3	339 (33.2)	104 (40.2)	1,736 (50.7)	125 (41.4)

No. of consultation & characteristic	Women	MSW	MSM-STI consultation	Gender diverse persons
	n (%)	n (%)	n (%)	n (%)
≥3 sexual contacts in the past 6 months				
1	16,483 (42.9)	11,077 (51.8)	26,803 (77.2)	1,444 (69.3)
2	2,875 (54.7)	1,156 (63.1)	8,866 (83.8)	576 (79.8)
3	559 (54.7)	171 (66.0)	3,040 (88.7)	258 (85.4)
Living with HIV				
1	32 (0.1)	19 (0.1)	2,440 (7.0)	118 (5.7)
2	7 (0.1)	5 (0.3)	1,005 (9.5)	47 (6.5)
3	1 (0.1)	2 (0.8)	427 (12.5)	22 (7.3)
Education: No secondary education, vmbo, mbo 1				
1	3,381 (8.8)	2,771 (13.0)	2,926 (8.4)	258 (12.4)
2	627 (11.9)	305 (16.6)	828 (7.8)	97 (13.4)
3	144 (14.1)	52 (20.1)	247 (7.2)	45 (14.9)

1 *Region of origin with triage indication includes Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.*
2 *For MSW and MSM–STI consultations: partner originating from a region of origin with triage indication. For women: partner originating from a region of origin with triage indication or a male partner who had sex with men.*

Footnote: Number of visits reach up to 13 in MSM-STI consultations, 9 in MSW, and 7 in women and in gender diverse persons. 4th-13th consultation not shown because of low numbers.

Table 13.2 Reported triage indication in gender diverse persons: number and proportion of STI consultations by gender, 2025

Triage indication	Trans men	Trans women	Other gender diverse persons
	n (%)	n (%)	n (%)
Notified			
No	277 (84.5)	837 (90.8)	778 (83.0)
Yes	51 (15.5)	82 (8.9)	159 (17.0)
Unknown		3 (0.3)	
Symptoms			
No	218 (66.5)	691 (74.9)	688 (73.4)
Yes	100 (30.5)	214 (23.2)	216 (23.1)
Unknown	10 (3.0)	17 (1.8)	33 (3.5)
Sex worker			
No	295 (89.9)	559 (60.6)	849 (90.6)
Yes	22 (6.7)	341 (37.0)	78 (8.3)
Unknown	11 (3.4)	22 (2.4)	10 (1.1)
GO/CT/syphilis in the past year			
Not tested	163 (49.7)	337 (36.6)	422 (45.0)
Tested, negative	92 (28.0)	345 (37.4)	337 (36.0)
Tested, positive	48 (14.6)	193 (20.9)	146 (15.6)
Tested, unknown	1 (0.3)	2 (0.2)	3 (0.3)
Unknown	24 (7.3)	45 (4.9)	29 (3.1)
Living with HIV			
No	321 (97.9)	791 (85.8)	872 (93.1)
Yes	7 (2.1)	131 (14.2)	65 (6.9)

Table 13.3 Age group and education level: number of consultations and STI positivity by sex and type of sexual contact, 2025

Education level	Age group				
	≤20 n (% positivity)	21-25 n (% positivity)	26-35 n (% positivity)	≥36 n (% positivity)	Total n (% positivity)
Women					
Hbo, university	2,976 (23.1)	15,463 (13.1)	4,126 (6.9)	1,657 (6.2)	24,222 (12.8)
Mbo 2-4, havo, vwo	3,734 (21.0)	6,545 (14.3)	1,988 (11.3)	1,254 (8.4)	13,521 (15.1)
No secondary education, vmbo, mbo 1	1,431 (25.4)	1,478 (17.3)	627 (8.8)	658 (9.6)	4,194 (17.6)
MSW					
Hbo, university	1,135 (27.9)	6,626 (16.6)	2,306 (10.4)	950 (7.3)	11,017 (15.7)
Mbo 2-4, havo, vwo	1,873 (22.8)	4,441 (18.2)	1,435 (14.9)	628 (13.4)	8,377 (18.3)
No secondary education, vmbo, mbo 1	774 (25.8)	1,428 (20.9)	511 (18.4)	428 (9.8)	3,141 (20.2)
MSM-STI consultation					
Hbo, university	529 (21.9)	4,720 (20.8)	13,697 (19.8)	14,500 (16.2)	33,446 (18.4)
Mbo 2-4, havo, vwo	647 (24.4)	1,750 (23.7)	3,662 (24.7)	4,542 (20.1)	10,601 (22.5)
No secondary education, vmbo, mbo 1	185 (20.5)	569 (27.4)	1,262 (25.4)	2,115 (21.1)	4,131 (23.3)
MSM-PrEP consultation					
Hbo, university	112 (11.6)	1,559 (18.0)	5,908 (17.5)	8,201 (13.1)	15,780 (15.2)
Mbo 2-4, havo, vwo	126 (18.3)	658 (23.3)	1,622 (20.7)	2,659 (16.1)	5,065 (18.6)
No secondary education, vmbo, mbo 1	48 (18.8)	195 (20.0)	622 (20.4)	1,319 (14.6)	2,184 (16.8)
Gender diverse persons					
Hbo, university	54 (5.6)	397 (11.3)	738 (11.4)	324 (10.8)	1,513 (11.0)
Mbo 2-4, havo, vwo	77 (13.0)	218 (15.1)	274 (19.7)	156 (16.0)	725 (16.8)
No secondary education, vmbo, mbo 1	40 (15.0)	109 (22.9)	147 (16.3)	126 (12.7)	422 (16.8)

Figure 13.1 Age: Proportion of STI consultations in women and MSW by region, 2025

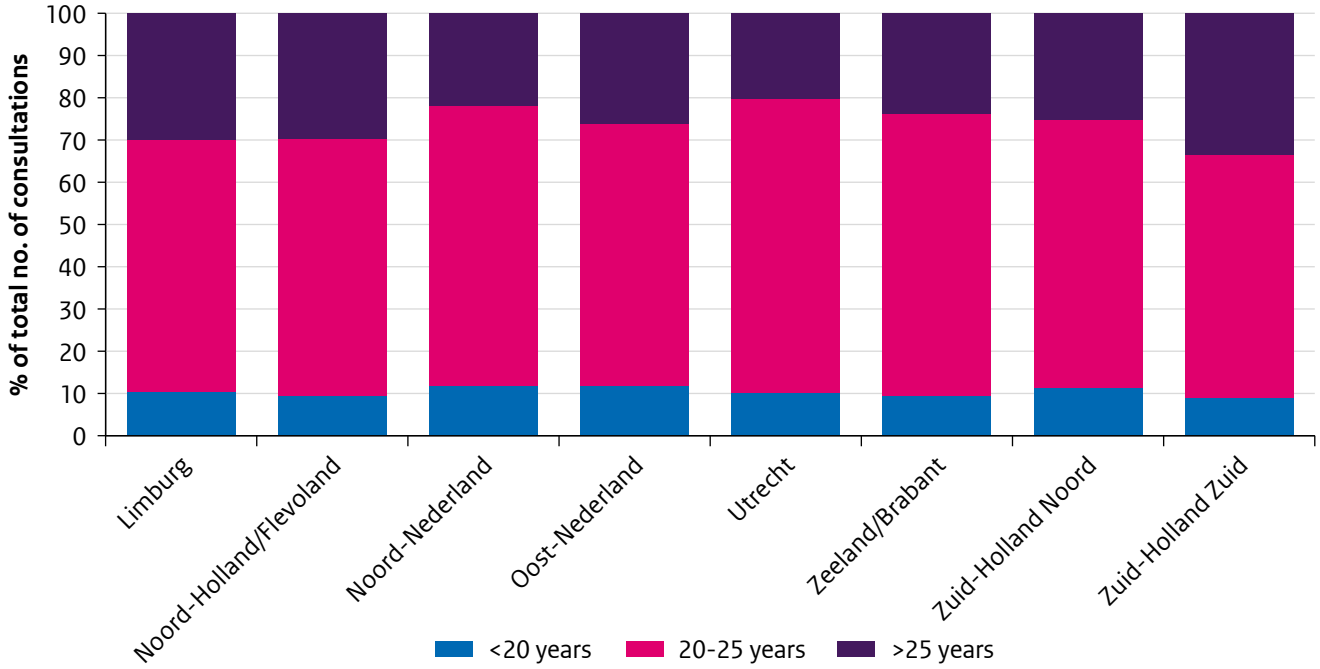


Figure 13.2 STI symptoms and/or notification: proportion of STI consultations in women and MSW aged >25 years by region, 2025

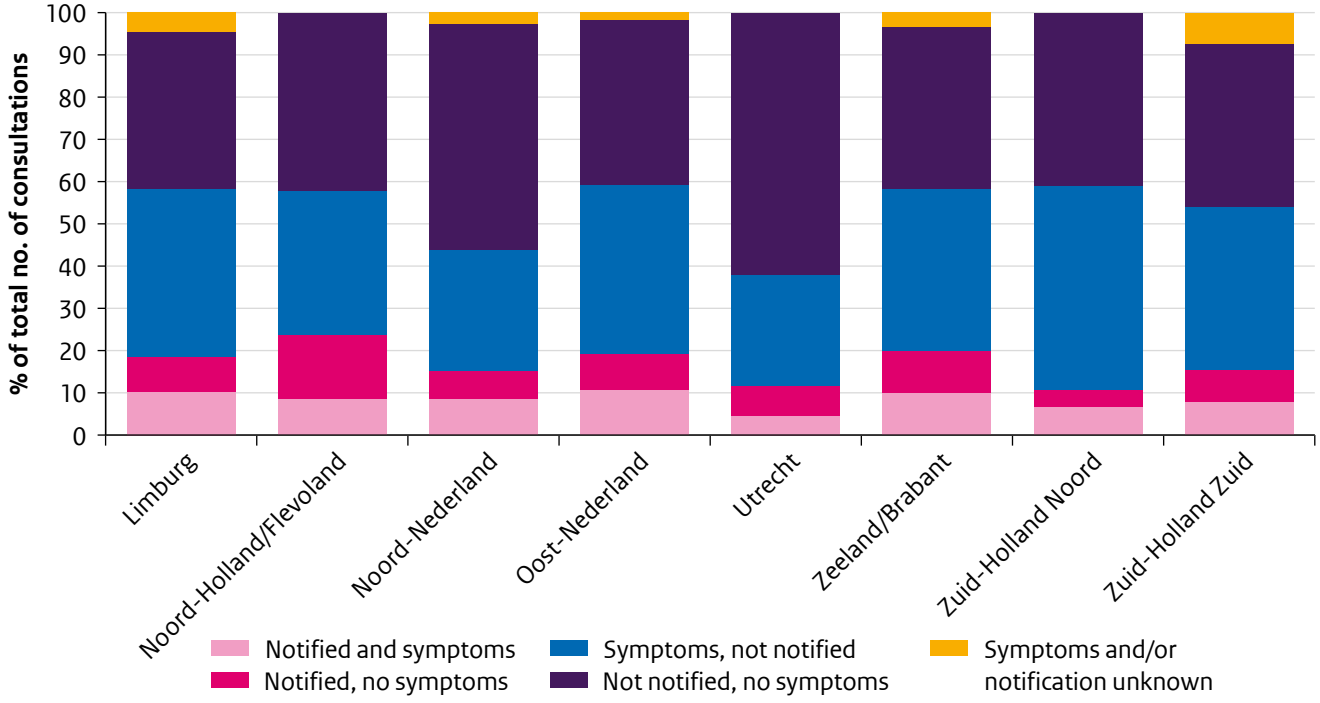
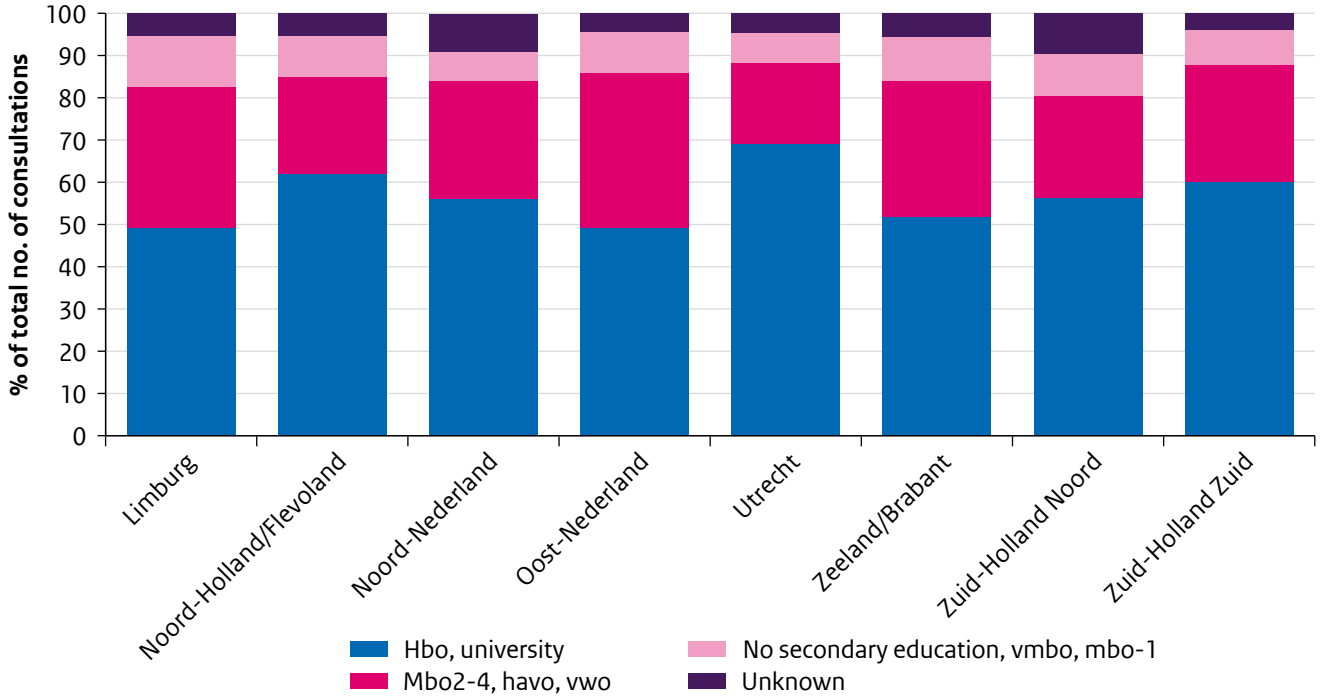


Figure 13.3 Education level: proportion of STI consultations in women, MSW, and MSM by region, 2025



13.2 Chlamydia

Figure 13.4a Trends in chlamydia positivity in women and MSW by region, 2016-2025

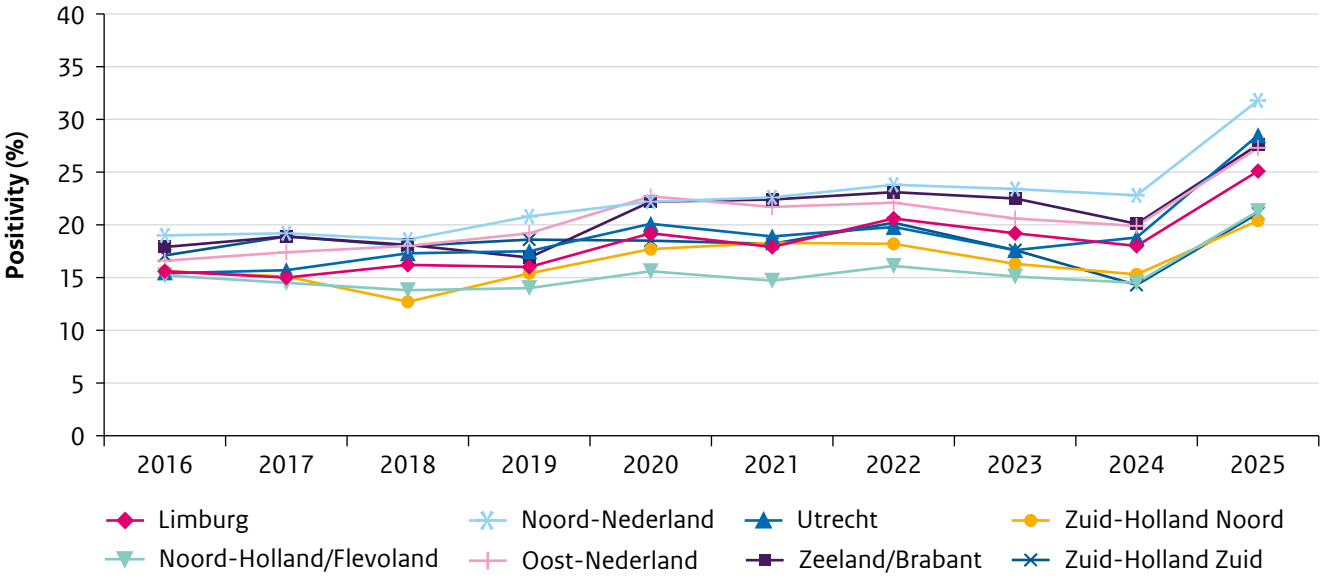


Figure 13.4b Trends in chlamydia positivity in MSM by region, 2016-2025

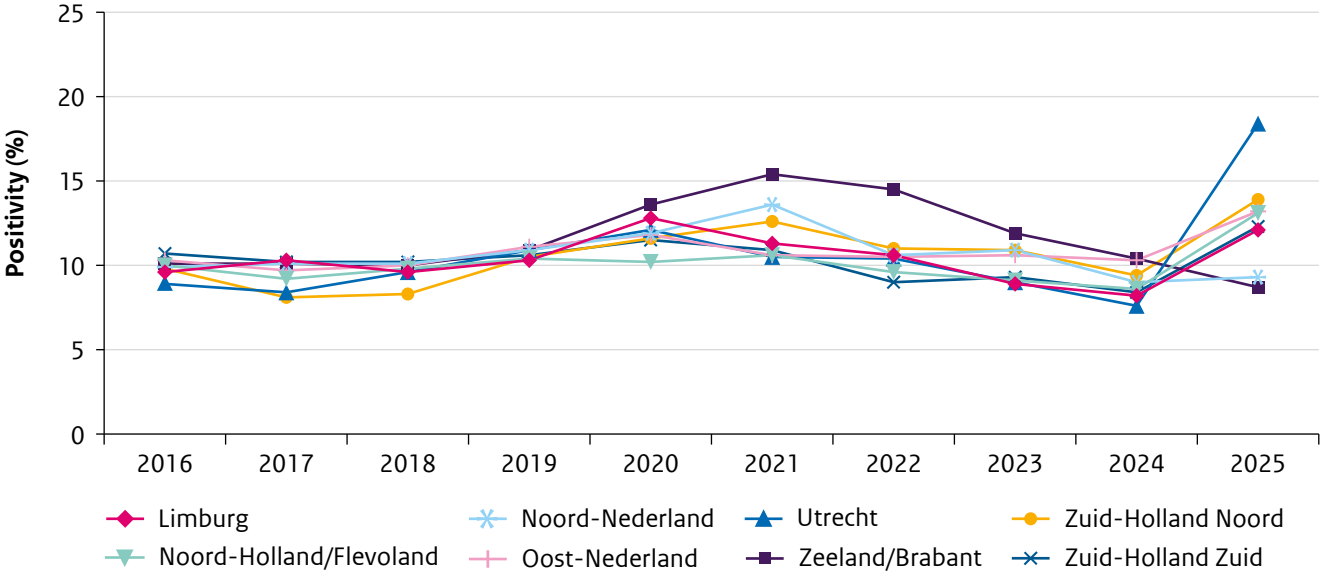


Table 13.4 Reported triage indication: number of chlamydia diagnoses, tests, and positivity by sex and type of sexual contact, 2025

Triage indication	Women		MSW		MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%	n positive/N	%	n positive/N	%
Notified								
Not notified	2,686/17,296	15.5	1,867/6,790	27.5	1,379/12,962	10.6	446/4,630	9.6
Notified for chlamydia	1,625/3,568	45.5	1,246/2,649	47.0	424/1,605	26.4	96/348	27.6
Notified for other STI/HIV	266/1,438	18.5	129/665	19.4	380/2,854	13.3	102/547	18.6
Unknown	7/44	15.9	3/6	50.0	1/15	6.7	1/5	20.0
Symptoms								
No	705/3,235	21.8	564/1,791	31.5	645/8,078	8.0	251/3,523	7.1
Yes	3,832/18,881	20.3	2,650/8,214	32.3	1,523/9,093	16.7	391/1,973	19.8
Unknown	47/230	20.4	31/105	29.5	16/265	6.0	3/34	8.8
Region of origin included in triage[1]								
Dutch	3,246/14,036	23.1	2,091/5,762	36.3	1,248/10,040	12.4	405/3,458	11.7
Migrant from triage region	353/2,782	12.7	306/1,337	22.9	503/3,885	12.9	147/1,261	11.7
Child of migrant from triage region	740/3,807	19.4	658/2,374	27.7	234/1,660	14.1	46/395	11.6
(Child of) migrant, not from triage region	245/1,687	14.5	185/621	29.8	198/1,837	10.8	46/411	11.2
Unknown	0/34	0.0	5/16	31.2	1/14	7.1	1/5	20.0
Age								
≤25	4,088/16,186	25.3	2,723/7,138	38.1	464/3,194	14.5	92/605	15.2
>25	496/6,160	8.1	522/2,972	17.6	1,720/14,242	12.1	553/4,925	11.2
Partner in risk group[2]								
No	3,550/14,758	24.1	2,570/7,067	36.4	1,236/9,912	12.5	347/3,200	10.8
Yes	1,001/7,286	13.7	658/2,974	22.1	902/7,156	12.6	274/2,126	12.9
Unknown	33/302	10.9	17/69	24.6	46/368	12.5	24/204	11.8
Sex work in the past 6 months								
No	4,459/20,650	21.6	3,227/9,997	32.3	2,104/16,814	12.5	607/5,303	11.4
Yes	107/1,588	6.7	12/78	15.4	59/460	12.8	34/193	17.6
Unknown	18/108	16.7	6/35	17.1	21/162	13.0	4/34	11.8
Gonorrhoea/chlamydia/syphilis in the past year								
Not tested	2,797/13,269	21.1	2,229/6,893	32.3	615/5,920	10.4	53/575	9.2
Tested, negative	836/4,977	16.8	434/1,508	28.8	590/5,734	10.3	224/2,775	8.1
Tested, positive	659/2,850	23.1	373/1,134	32.9	860/5,097	16.9	331/1,950	17.0
Tested, unknown result	8/27	29.6	2/9	22.2	18/79	22.8	3/49	6.1
Unknown	284/1,223	23.2	207/566	36.6	101/606	16.7	34/181	18.8

1 *Region of origin with triage indication includes Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.*
2 *For MSW and MSM: partner originating from a region of origin as indicated by triage criteria. For women: partner originating from a region of origin as indicated by triage criteria or a male partner who had sex with men.*

Table 13.5 Demographics and (sexual) behavioural characteristics: number of chlamydia diagnoses, tests, and positivity by sex and type of sexual contact, 2025

Characteristic	Women		MSW		MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%	n positive/N	%	n positive/N	%
Education								
Hbo, university	2,374/11,514	20.6	1,451/4,465	32.5	1,256/10,463	12.0	359/3,144	11.4
Mbo2-4, havo, vwo	1,565/7,246	21.6	1,218/3,694	33.0	604/4,318	14.0	168/1,441	11.7
No secondary education, vmbo, mbo-1	522/2,380	21.9	463/1,496	30.9	204/1,726	11.8	78/577	13.5
Unknown	122/1,205	10.1	112/454	24.7	120/929	12.9	40/368	10.9
Number of partners, in the past 6 months								
0 partners	20/178	11.2	7/67	10.4	8/125	6.4	3/29	10.3
1 partner	1,043/6,324	16.5	624/2,186	28.5	120/1,286	9.3	15/207	7.2
2 partners	1,212/5,658	21.4	705/2,303	30.6	182/1,903	9.6	27/334	8.1
3 or more partners	2,271/9,786	23.2	1,898/5,515	34.4	1,843/13,991	13.2	590/4,900	12.0
Unknown	38/400	9.5	11/39	28.2	31/131	23.7	10/60	16.7
Receptive anal sex, in the past 6 months								
No receptive anal sex	3,870/17,666	21.9			453/4,932	9.2	64/817	7.8
Yes, consistently with a condom	36/433	8.3			146/1,620	9.0	14/230	6.1
Yes, not consistently with a condom	121/845	14.3			763/5,215	14.6	266/1,864	14.3
Yes, never with a condom	501/2,966	16.9			791/5,426	14.6	301/2,609	11.5
Unknown	56/436	12.8			31/243	12.8	0/10	0.0
Insertive anal sex, in the past 6 months								
No insertive anal sex			2,909/8,728	33.3	309/3,416	9.0	61/706	8.6
Yes, consistently with a condom			29/141	20.6	162/1,898	8.5	16/234	6.8
Yes, not consistently with a condom			69/336	20.5	823/5,851	14.1	255/1,867	13.7
Yes, never with a condom			178/714	24.9	866/6,071	14.3	313/2,706	11.6
Unknown			60/191	31.4	24/200	12.0	0/17	0.0
Vaginal sex, in the past 6 months[1]								
No vaginal sex	20/181	11.0	20/112	17.9	57/437	13.0	5/90	5.6
Yes, consistently with a condom	91/1,101	8.3	64/471	13.6	43/471	9.1	12/83	14.5
Yes, not consistently with a condom	1,512/7,793	19.4	1,290/4,008	32.2	133/1,015	13.1	9/130	6.9
Yes, never with a condom	2,941/13,063	22.5	1,858/5,452	34.1	168/1,482	11.3	40/238	16.8
Unknown	20/208	9.6	13/67	19.4	26/252	10.3	2/13	15.4

Characteristic	Women		MSW		MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%	n positive/N	%	n positive/N	%
Receptive oral sex, in the past 6 months								
No receptive oral sex	486/2,137	22.7			104/1,028	10.1	18/115	15.7
Yes, consistently with a condom	25/287	8.7			9/108	8.3	1/8	12.5
Yes, not consistently with a condom	198/1,495	13.2			167/1,304	12.8	32/219	14.6
Yes, never with a condom	3,768/17,827	21.1			1,871/14,730	12.7	593/5,173	11.5
Unknown	107/600	17.8			33/266	12.4	1/15	6.7
Previous HIV test								
No	3,634/15,056	24.1	2,682/7,601	35.3	238/2,200	10.8	13/103	12.6
Yes, positive	3/16	18.8	5/8	62.5	244/1,641	14.9		
Yes, negative	809/6,568	12.3	494/2,227	22.2	1,685/13,412	12.6	629/5,413	11.6
Yes, result unknown	5/49	10.2	1/23	4.3	5/46	10.9	2/8	25.0
Unknown	133/657	20.2	63/251	25.1	12/137	8.8	1/6	16.7
Drug use before or during sex, in the past 6 months[2,3]								
No					1,485/12,983	11.4	336/3,425	9.8
Yes					682/4,316	15.8	303/2,038	14.9
Unknown					17/137	12.4	6/67	9.0
Group sex, in the past 6 months[3]								
No					1,214/11,125	10.9	255/2,705	9.4
Yes					927/5,945	15.6	382/2,759	13.8
Unknown					43/366	11.7	8/66	12.1
Antibiotic prophylaxis use, in the past 3 months[3]								
No					2,039/15,978	12.8	619/5,244	11.8
Yes, Doxycycline (DoxyP(r)EP)					44/540	8.1	14/169	8.3
Yes, another antibiotic					20/159	12.6	4/39	10.3
Unknown					79/749	10.5	8/78	10.3

Characteristic	Women		MSW		MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%	n positive/N	%	n positive/N	%
PrEP use, in the past 3 months[3,4]								
Known HIV-positive, not eligible					244/1,641	14.9		
No					1,141/10,763	10.6	70/901	7.8
Yes					797/5,022	15.9	575/4,629	12.4
via SHC					400/2,187	18.3		
via GP					266/2,000	13.3		
via HIV practitioner					2/16	12.5		
via other physician					100/608	16.4		
via informal routes					46/249	18.5		
other					39/285	13.7		

1 *For MSM: numbers are reported of men who had sex with both men and women. Men who had sex with men only are excluded.*
2 *Included drugs are cocaine, XTC/MDMA/Speed, Heroin, Crystal Meth, Mephedrone, 3-MMC, 4-MEC, 4-FA, GHB/GBL and ketamine.*
3 *Data not obligatory to collect for women and MSW; results are therefore not shown.*
4 *Persons can receive PrEP through more than one provider.*

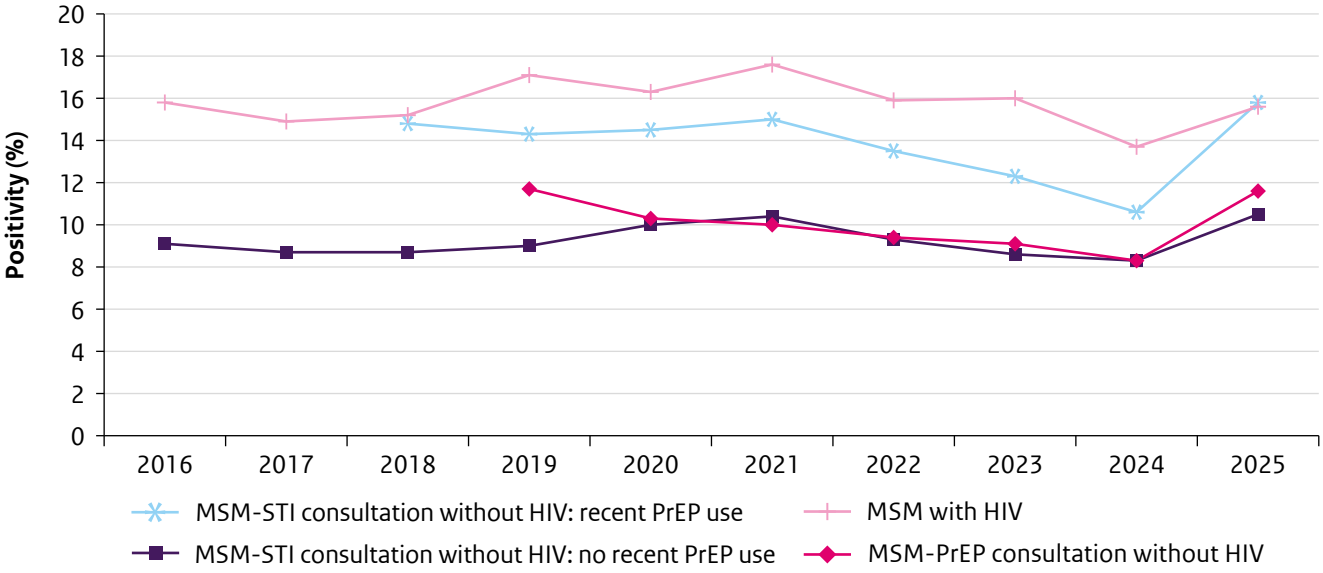
Table 13.6 Age: number of chlamydia diagnoses, tests, and positivity by sex and type of sexual contact, 2025

Age (years)	Women		MSW		MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%	n positive/N	%	n positive/N	%
≤20	1,468/4,640	31.6	795/1,795	44.3	75/526	14.3	7/70	10.0
21-25	2,620/11,546	22.7	1,928/5,343	36.1	389/2,668	14.6	85/535	15.9
26-30	286/2,779	10.3	325/1,389	23.4	450/3,375	13.3	121/941	12.9
31-35	90/1,434	6.3	108/658	16.4	440/3,237	13.6	130/977	13.3
36-40	44/725	6.1	50/394	12.7	245/2,177	11.3	89/770	11.6
41-45	17/508	3.3	16/193	8.3	137/1,372	10.0	60/544	11.0
46-50	20/327	6.1	7/126	5.6	135/1,130	11.9	46/489	9.4
51-55	15/199	7.5	8/79	10.1	122/916	13.3	44/395	11.1
≥56	24/188	12.8	8/133	6.0	191/2,035	9.4	63/809	7.8

Table 13.7 Region of origin: number of chlamydia diagnoses, tests, and positivity by sex and type of sexual contact, 2025

Region of origin	Women		MSW		MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%	n positive/N	%	n positive/N	%
The Netherlands	**3,246/14,036**	**23.1**	**2,091/5,762**	**36.3**	**1,248/10,040**	**12.4**	**405/3,458**	**11.7**
Turkey	**83/448**	**18.5**	**95/359**	**26.5**	**69/514**	**13.4**	**23/150**	**15.3**
Migrant	7/65	10.8	15/75	20.0	16/179	8.9	5/55	9.1
Child of migrant	76/383	19.8	80/284	28.2	53/335	15.8	18/95	18.9
Morocco	**86/461**	**18.7**	**104/456**	**22.8**	**46/313**	**14.7**	**4/59**	**6.8**
Migrant	4/53	7.5	6/47	12.8	14/66	21.2	2/25	8.0
Child of migrant	82/408	20.1	98/409	24.0	32/247	13.0	2/34	5.9
Suriname	**210/1,231**	**17.1**	**215/780**	**27.6**	**60/444**	**13.5**	**12/110**	**10.9**
Migrant	31/230	13.5	45/166	27.1	15/152	9.9	6/39	15.4
Child of migrant	179/1,001	17.9	170/614	27.7	45/292	15.4	6/71	8.5
CAS-BES islands	**139/719**	**19.3**	**126/420**	**30.0**	**77/425**	**18.1**	**13/107**	**12.1**
Migrant	37/282	13.1	59/187	31.6	57/317	18.0	9/75	12.0
Child of migrant	102/437	23.3	67/233	28.8	20/108	18.5	4/32	12.5
Indonesia	**36/174**	**20.7**	**15/44**	**34.1**	**27/252**	**10.7**	**8/80**	**10.0**
Migrant	6/33	18.2	1/5	20.0	10/84	11.9	4/28	14.3
Child of migrant	30/141	21.3	14/39	35.9	17/168	10.1	4/52	7.7
Eastern Europe	**154/1,020**	**15.1**	**87/304**	**28.6**	**123/1,003**	**12.3**	**41/288**	**14.2**
Migrant	90/759	11.9	45/189	23.8	113/906	12.5	40/272	14.7
Child of migrant	64/261	24.5	42/115	36.5	10/97	10.3	1/16	6.2
Europe other	**214/1,413**	**15.1**	**161/535**	**30.1**	**167/1,565**	**10.7**	**38/355**	**10.7**
Migrant	119/904	13.2	91/331	27.5	146/1,291	11.3	34/266	12.8
Child of migrant	95/509	18.7	70/204	34.3	21/274	7.7	4/89	4.5
Africa other	**135/774**	**17.4**	**151/594**	**25.4**	**70/515**	**13.6**	**11/130**	**8.5**
Migrant	48/289	16.6	51/240	21.2	47/366	12.8	9/107	8.4
Child of migrant	87/485	17.9	100/354	28.2	23/149	15.4	2/23	8.7
Asia other	**168/948**	**17.7**	**110/525**	**21.0**	**150/1,183**	**12.7**	**54/481**	**11.2**
Migrant	86/500	17.2	51/305	16.7	129/1,001	12.9	48/425	11.3
Child of migrant	82/448	18.3	59/220	26.8	21/182	11.5	6/56	10.7
Central/South America other	**82/814**	**10.1**	**61/229**	**26.6**	**115/896**	**12.8**	**27/251**	**10.8**
Migrant	44/571	7.7	33/123	26.8	102/814	12.5	24/235	10.2
Child of migrant	38/243	15.6	28/106	26.4	13/82	15.9	3/16	18.8
North America/ Oceania	**31/274**	**11.3**	**24/86**	**27.9**	**31/272**	**11.4**	**8/56**	**14.3**
Migrant	14/177	7.9	14/45	31.1	20/211	9.5	6/38	15.8
Child of migrant	17/97	17.5	10/41	24.4	11/61	18.0	2/18	11.1
Unknown	**0/34**	**0.0**	**5/16**	**31.2**	**1/14**	**7.1**	**1/5**	**20.0**

Figure 13.5 Trends in chlamydia positivity in MSM by HIV-status and PrEP use, 2016-2025



Footnote: Information on PrEP use has been collected since 2018. In 2018, recent PrEP use was defined as use in the past 6 months. Since 2019, recent PrEP use has been defined as use in the past 3 months.

13.3 Gonorrhoea

Figure 13.6a Trends in gonorrhoea positivity in women and MSW by region, 2016-2025

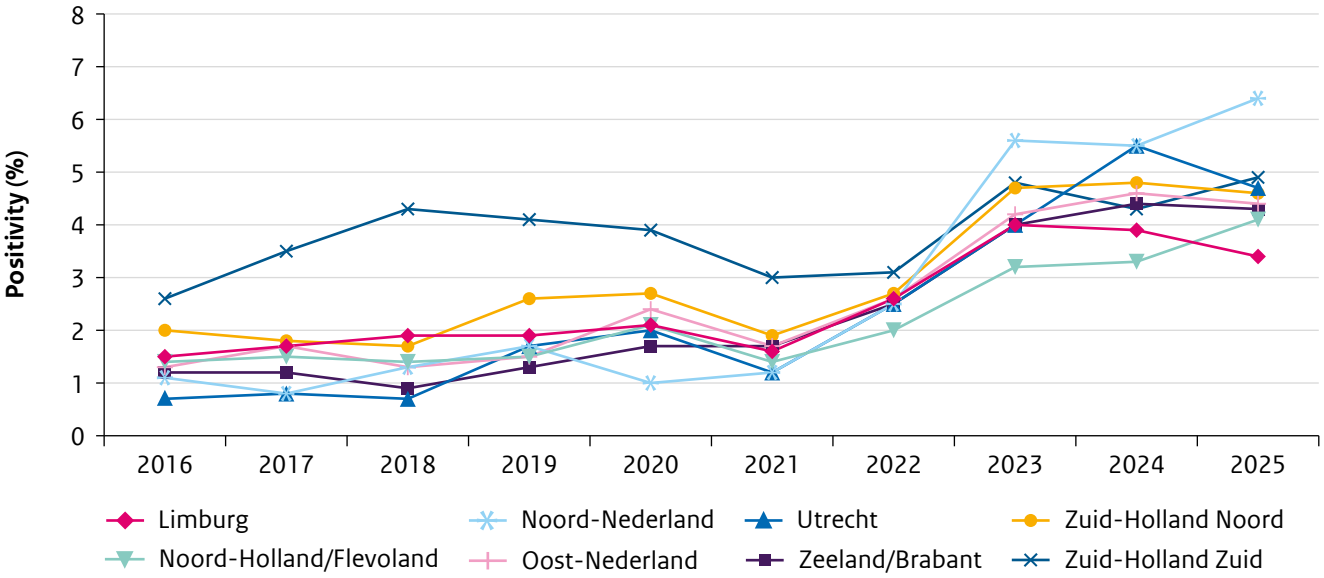


Figure 13.6b Trends in gonorrhoea positivity in MSM by region, 2016-2025

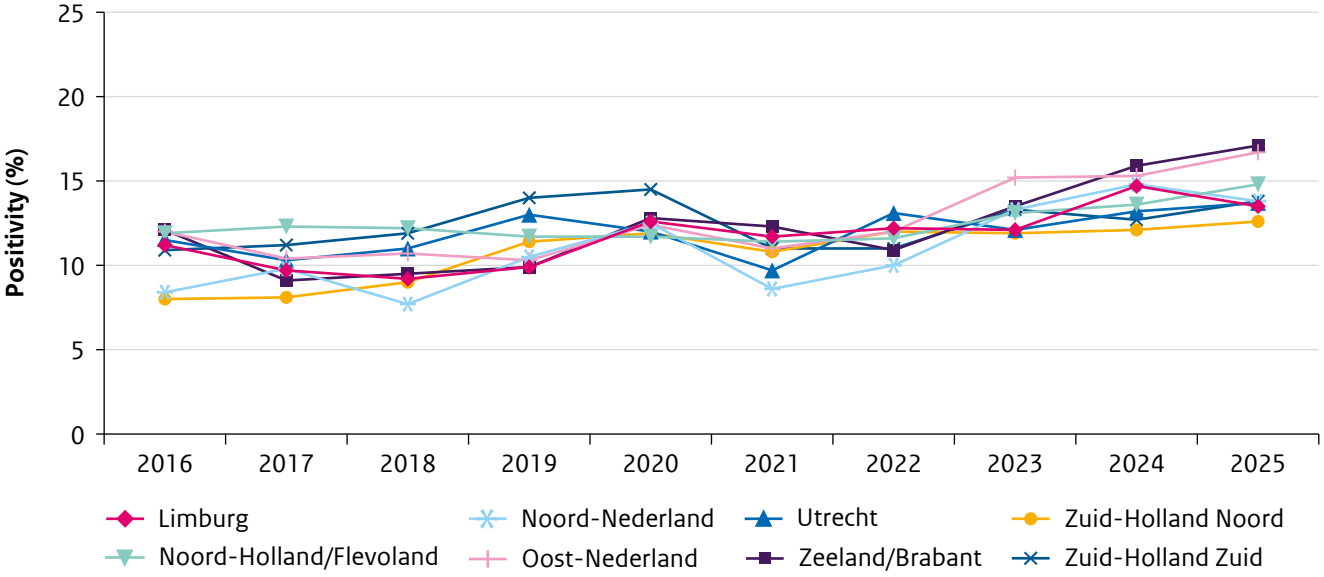


Table 13.8 Reported triage indication: number of gonorrhoea diagnoses, tests, and positivity by sex and type of sexual contact, 2025

Triage indication	Women		MSW		MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%	n positive/N	%	n positive/N	%
Notified								
Not notified	1,162/36,873	3.2	780/17,641	4.4	5,178/39,993	12.9	2,584/21,756	11.9
Notified for gonorrhoea	519/1,675	31.0	180/1,091	16.5	1,946/5,503	35.4	491/1,195	41.1
Notified for other STI/HIV	225/5,730	3.9	73/4,488	1.6	626/4,472	14.0	139/781	17.8
Unknown	8/85	9.4	1/17	5.9	5/30	16.7	2/9	22.2
Symptoms								
No	880/22,869	3.8	201/12,597	1.6	4,391/37,154	11.8	2,321/20,908	11.1
Yes	992/20,268	4.9	816/9,921	8.2	3,252/11,884	27.4	864/2,677	32.3
Unknown	42/1,226	3.4	17/719	2.4	112/960	11.7	31/156	19.9
Region of origin[1]								
Dutch	1,275/27,093	4.7	568/12,552	4.5	4,190/28,133	14.9	1,720/13,026	13.2
Migrant from triage region	213/6,440	3.3	142/3,411	4.2	1,926/11,260	17.1	925/6,320	14.6
Child of migrant from triage region	311/6,983	4.5	274/5,441	5.0	729/4,439	16.4	289/1,945	14.9
(Child of) migrant, not from triage region	108/3,754	2.9	49/1,782	2.7	904/6,122	14.8	277/2,388	11.6
Unknown	7/93	7.5	1/51	2.0	6/44	13.6	5/62	8.1
Age								
≤25	1,436/32,059	4.5	779/16,541	4.7	1,578/8,612	18.3	462/2,634	17.5
>25	478/12,304	3.9	255/6,696	3.8	6,177/41,386	14.9	2,754/21,107	13.0
Partner in risk group[2]								
No	1,307/29,212	4.5	772/15,387	5.0	4,120/27,606	14.9	1,608/12,974	12.4
Yes	572/14,309	4.0	254/7,695	3.3	3,510/21,557	16.3	1,548/10,297	15.0
Unknown	35/842	4.2	8/155	5.2	125/835	15.0	60/470	12.8
Sex work in the past 6 months								
No	1,647/39,521	4.2	1,021/22,937	4.5	7,459/48,461	15.4	2,986/22,620	13.2
Yes	253/4,592	5.5	11/183	6.0	240/1,144	21.0	183/782	23.4
Unknown	14/250	5.6	2/117	1.7	56/393	14.2	47/339	13.9

Triage indication	Women		MSW		MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%	n positive/N	%	n positive/N	%
Gonorrhoea/chlamydia/syphilis in the past year								
Not tested	1,050/26,493	4.0	691/16,733	4.1	1,903/15,998	11.9	278/2,358	11.8
Tested, negative	439/10,742	4.1	137/3,526	3.9	2,318/18,594	12.5	1,147/11,772	9.7
Tested, positive	316/4,798	6.6	142/1,902	7.5	3,227/13,416	24.1	1,587/8,033	19.8
Tested, unknown result	4/52	7.7	3/18	16.7	28/179	15.6	17/132	12.9
Unknown	105/2,278	4.6	61/1,058	5.8	279/1,811	15.4	187/1,446	12.9

1 *Region of origin with triage indication includes Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.*
2 *For MSW and MSM: partner originating from a region of origin as indicated by triage criteria. For women: partner originating from a region of origin as indicated by triage criteria or a male partner who had sex with men.*

Table 13.9 Demographics and (sexual) behavioural characteristics: number of gonorrhoea diagnoses, tests, and positivity by sex and type of sexual contact, 2025

Characteristic	Women		MSW		MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%	n positive/N	%	n positive/N	%
Education								
Hbo, university	899/23,970	3.8	344/10,886	3.2	4,879/33,095	14.7	1,975/15,317	12.9
Mbo2-4, havo, vwo	608/13,342	4.6	418/8,259	5.1	1,732/10,432	16.6	746/4,904	15.2
No secondary education, vmbo, mbo-1	278/4,125	6.7	217/3,093	7.0	728/4,076	17.9	287/2,087	13.8
Unknown	129/2,925	4.4	55/997	5.5	416/2,395	17.4	208/1,433	14.5
Number of partners, in the past 6 months								
0 partners	13/522	2.5	3/297	1.0	48/558	8.6	18/209	8.6
1 partner	336/11,764	2.9	178/5,262	3.4	354/3,697	9.6	57/1,100	5.2
2 partners	401/10,664	3.8	230/5,258	4.4	621/5,375	11.6	121/1,613	7.5
3 or more partners	1,093/19,975	5.5	620/12,335	5.0	6,665/40,045	16.6	2,971/20,613	14.4
Unknown	71/1,438	4.9	3/85	3.5	67/323	20.7	49/206	23.8
Receptive anal sex, in the past 6 months								
No receptive anal sex	1,465/35,046	4.2			1,525/14,668	10.4	340/4,223	8.1
Yes, consistently with a condom	44/1,139	3.9			509/5,088	10.0	115/1,140	10.1
Yes, not consistently with a condom	95/1,692	5.6			2,913/15,502	18.8	1,350/8,374	16.1
Yes, never with a condom	285/5,511	5.2			2,709/14,049	19.3	1,405/9,893	14.2
Unknown	25/975	2.6			99/691	14.3	6/111	5.4

Characteristic	Women		MSW		MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%	n positive/N	%	n positive/N	%
Insertive anal sex, in the past 6 months								
No insertive anal sex			902/19,915	4.5	1,190/10,860	11.0	346/3,562	9.7
Yes, consistently with a condom			9/455	2.0	568/5,940	9.6	119/1,160	10.3
Yes, not consistently with a condom			37/819	4.5	3,025/16,906	17.9	1,322/8,539	15.5
Yes, never with a condom			70/1,632	4.3	2,887/15,717	18.4	1,420/10,369	13.7
Unknown			16/416	3.8	85/575	14.8	9/111	8.1
Vaginal sex, in the past 6 months[1]								
No vaginal sex	13/589	2.2	14/389	3.6	158/977	16.2	51/312	16.3
Yes, consistently with a condom	106/3,373	3.1	52/1,620	3.2	156/1,189	13.1	46/284	16.2
Yes, not consistently with a condom	705/15,742	4.5	385/9,723	4.0	299/2,596	11.5	85/554	15.3
Yes, never with a condom	1,079/24,158	4.5	576/11,304	5.1	354/3,231	11.0	103/809	12.7
Unknown	11/501	2.2	7/201	3.5	112/1,103	10.2	11/54	20.4
Receptive oral sex, in the past 6 months								
No receptive oral sex	162/4,473	3.6			292/2,804	10.4	65/584	11.1
Yes, consistently with a condom	39/1,021	3.8			32/347	9.2	8/89	9.0
Yes, not consistently with a condom	170/3,493	4.9			696/4,579	15.2	210/1,237	17.0
Yes, never with a condom	1,515/34,261	4.4			6,637/41,587	16.0	2,923/21,707	13.5
Unknown	28/1,115	2.5			98/681	14.4	10/124	8.1
Previous HIV test								
No	1,306/28,936	4.5	805/17,339	4.6	681/5,816	11.7	54/393	13.7
Yes, positive	1/38	2.6	2/26	7.7	879/4,072	21.6		
Yes, negative	539/14,006	3.8	196/5,188	3.8	6,135/39,710	15.4	3,153/23,305	13.5
Yes, result unknown	4/78	5.1	2/53	3.8	14/105	13.3	6/31	19.4
Unknown	64/1,305	4.9	29/631	4.6	46/295	15.6	3/12	25.0
Drug use before or during sex, in the past 6 months[2,3]								
No					4,917/38,131	12.9	1,621/15,659	10.4
Yes					2,785/11,467	24.3	1,579/7,912	20.0
Unknown					53/400	13.2	16/170	9.4
Group sex, in the past 6 months[3]								
No					3,984/31,298	12.7	1,288/12,815	10.1
Yes					3,575/16,685	21.4	1,895/10,707	17.7
Unknown					196/2,015	9.7	33/219	15.1

Characteristic	Women		MSW		MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%	n positive/N	%	n positive/N	%
Antibiotic prophylaxis use, in the past 3 months[3]								
No					7,033/45,776	15.4	2,972/22,364	13.3
Yes, Doxycycline (DoxyP(r)EP)					379/2,048	18.5	165/840	19.6
Yes, another antibiotic					72/365	19.7	21/157	13.4
Unknown					269/1,786	15.1	58/377	15.4
PrEP use, in the past 3 months[3,4]								
Known HIV-positive, not eligible					879/4,071	21.6		
No					3,717/30,669	12.1	361/3,378	10.7
Yes					3,157/15,234	20.7	2,855/20,363	14.0
via SHC					1,396/5,293	26.4		
via GP					1,248/7,401	16.9		
via HIV practitioner					7/48	14.6		
via other physician					447/2,254	19.8		
via informal routes					160/735	21.8		
other					171/695	24.6		

1 *For MSM: numbers are reported of men who had sex with both men and women. Men who had sex with men only are excluded.*
2 *Included drugs are cocaine, XTC/MDMA/Speed, Heroin, Crystal Meth, Mephedrone, 3-MMC, 4-MEC, 4-FA, GHB/GBL and ketamine.*
3 *Data not obligatory to collect for women and MSW; results are therefore not shown.*
4 *Persons can receive PrEP through more than one provider.*

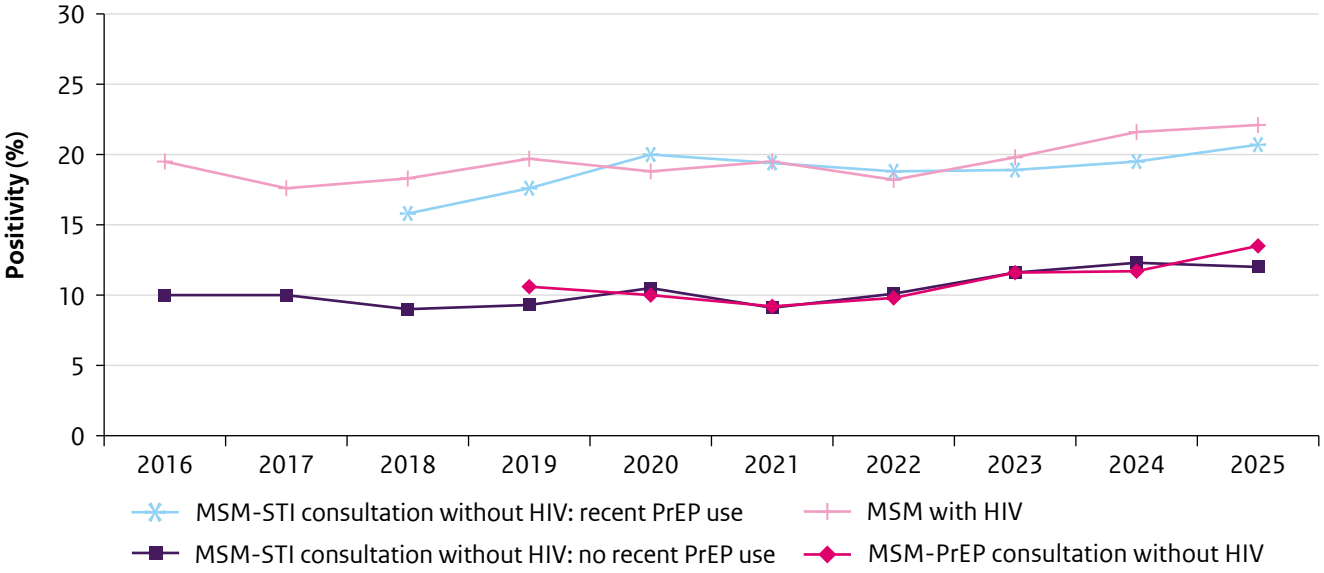
Table 13.10 Age: number of gonorrhoea diagnoses, tests, and positivity by sex and type of sexual contact, 2025

Age (years)	Women		MSW		MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%	n positive/N	%	n positive/N	%
≤20	595/8,271	7.2	286/3,829	7.5	264/1,390	19.0	40/281	14.2
21-25	841/23,788	3.5	493/12,712	3.9	1,314/7,222	18.2	422/2,353	17.9
26-30	163/4,801	3.4	114/2,993	3.8	1,680/9,685	17.3	702/3,924	17.9
31-35	101/2,730	3.7	51/1,471	3.5	1,615/9,608	16.8	659/4,489	14.7
36-40	50/1,524	3.3	25/928	2.7	999/6,495	15.4	450/3,345	13.5
41-45	52/1,152	4.5	19/478	4.0	620/4,104	15.1	278/2,333	11.9
46-50	31/819	3.8	17/327	5.2	443/3,187	13.9	242/1,997	12.1
51-55	37/618	6.0	8/186	4.3	281/2,676	10.5	145/1,679	8.6
≥56	44/660	6.7	21/313	6.7	539/5,631	9.6	278/3,340	8.3

Table 13.11 Region of origin: number of gonorrhoea diagnoses, tests, and positivity by sex and type of sexual contact, 2025

Region of origin	Women		MSW		MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%	n positive/N	%	n positive/N	%
The Netherlands	**1,275/27,093**	**4.7**	**568/12,552**	**4.5**	**4,190/28,133**	**14.9**	**1,720/13,026**	**13.2**
Turkey	**32/755**	**4.2**	**36/776**	**4.6**	**209/1,180**	**17.7**	**100/597**	**16.8**
Migrant	1/150	0.7	5/196	2.6	73/488	15.0	40/259	15.4
Child of migrant	31/605	5.1	31/580	5.3	136/692	19.7	60/338	17.8
Morocco	**36/779**	**4.6**	**42/1,048**	**4.0**	**142/788**	**18.0**	**39/275**	**14.2**
Migrant	5/94	5.3	8/129	6.2	28/194	14.4	14/112	12.5
Child of migrant	31/685	4.5	34/919	3.7	114/594	19.2	25/163	15.3
Suriname	**106/2,369**	**4.5**	**119/1,772**	**6.7**	**219/1,353**	**16.2**	**90/682**	**13.2**
Migrant	13/457	2.8	33/372	8.9	81/454	17.8	35/244	14.3
Child of migrant	93/1,912	4.9	86/1,400	6.1	138/899	15.4	55/438	12.6
CAS-BES islands	**65/1,324**	**4.9**	**60/874**	**6.9**	**203/1,130**	**18.0**	**80/534**	**15.0**
Migrant	18/522	3.4	25/392	6.4	154/835	18.4	55/407	13.5
Child of migrant	47/802	5.9	35/482	7.3	49/295	16.6	25/127	19.7
Indonesia	**13/343**	**3.8**	**5/137**	**3.6**	**101/760**	**13.3**	**59/439**	**13.4**
Migrant	4/74	5.4	0/18	0.0	37/240	15.4	23/176	13.1
Child of migrant	9/269	3.3	5/119	4.2	64/520	12.3	36/263	13.7
Eastern Europe	**83/2,495**	**3.3**	**32/814**	**3.9**	**534/3,015**	**17.7**	**223/1,422**	**15.7**
Migrant	61/2,009	3.0	22/553	4.0	494/2,790	17.7	209/1,336	15.6
Child of migrant	22/486	4.5	10/261	3.8	40/225	17.8	14/86	16.3
Europe other	**89/3,126**	**2.8**	**42/1,512**	**2.8**	**778/5,191**	**15.0**	**233/2,080**	**11.2**
Migrant	47/2,112	2.2	23/970	2.4	660/4,360	15.1	202/1,702	11.9
Child of migrant	42/1,014	4.1	19/542	3.5	118/831	14.2	31/378	8.2
Africa other	**58/1,562**	**3.7**	**61/1,469**	**4.2**	**228/1,386**	**16.5**	**88/680**	**12.9**
Migrant	22/616	3.6	22/621	3.5	154/950	16.2	66/548	12.0
Child of migrant	36/946	3.8	39/848	4.6	74/436	17.0	22/132	16.7
Asia other	**58/1,918**	**3.0**	**46/1,310**	**3.5**	**500/3,404**	**14.7**	**315/2,286**	**13.8**
Migrant	29/1,110	2.6	20/771	2.6	426/2,857	14.9	274/1,983	13.8
Child of migrant	29/808	3.6	26/539	4.8	74/547	13.5	41/303	13.5
Central/South America other	**73/1,878**	**3.9**	**15/652**	**2.3**	**519/2,683**	**19.3**	**220/1,350**	**16.3**
Migrant	60/1,408	4.3	7/359	1.9	479/2,452	19.5	209/1,255	16.7
Child of migrant	13/470	2.8	8/293	2.7	40/231	17.3	11/95	11.6
North America/Oceania	**19/628**	**3.0**	**7/270**	**2.6**	**126/931**	**13.5**	**44/308**	**14.3**
Migrant	13/417	3.1	4/170	2.4	101/786	12.8	30/241	12.4
Child of migrant	6/211	2.8	3/100	3.0	25/145	17.2	14/67	20.9
Unknown	**7/93**	**7.5**	**1/51**	**2.0**	**6/44**	**13.6**	**5/62**	**8.1**

Figure 13.7 Trends in gonorrhoea positivity in MSM by HIV-status and PrEP use, 2016-2025



Footnote: Information on PrEP use has been collected since 2018. In 2018, recent PrEP use was defined as use in the past 6 months. Since 2019, recent PrEP use has been defined as use in the past 3 months.

13.4 Syphilis

Figure 13.8 Trends in syphilis positivity in MSM by region, 2016-2025

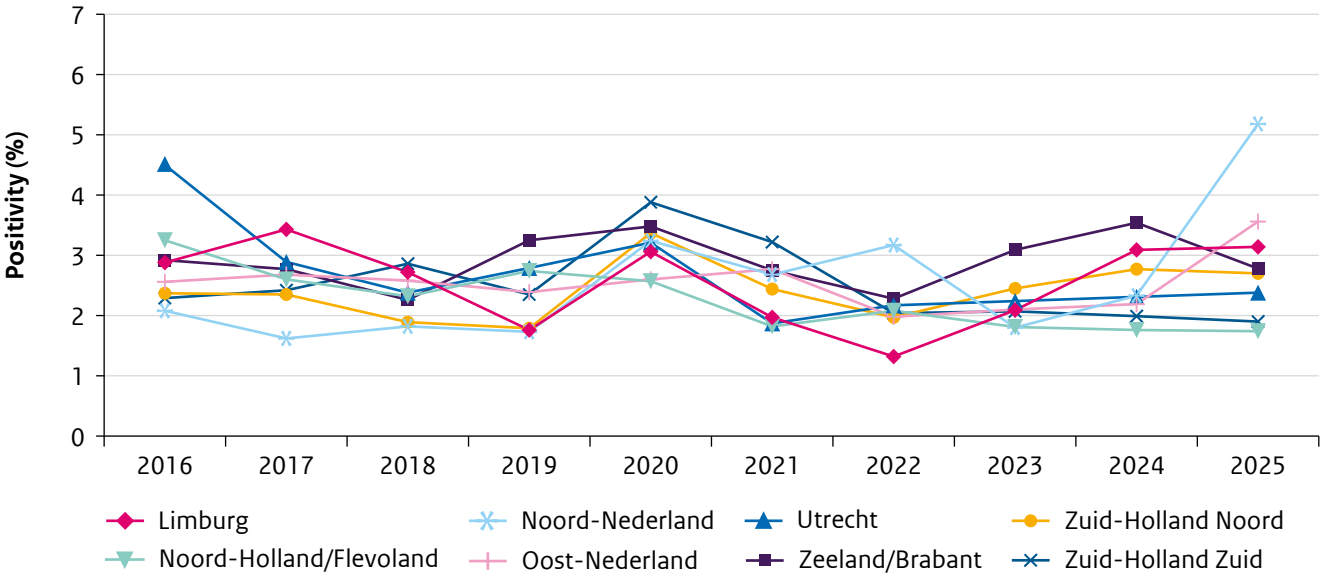


Table 13.12 Reported triage indication: number of infectious syphilis diagnoses, tests, and positivity in MSM, 2025

Triage indication	MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	(%)	n positive/N	(%)
Notified				
Not notified	1,036/39,700	2.6	466/22,019	2.1
Notified for syphilis	272/1,661	16.4	52/374	13.9
Notified for other STI/HIV	228/8,165	2.8	41/1,581	2.6
Unknown	2/33	6.1	0/9	0.0
Symptoms				
No	757/36,949	2.0	376/21,179	1.8
Yes	751/11,652	6.4	178/2,645	6.7
Unknown	30/958	3.1	5/159	3.1
Region of origin[1]				
Dutch	861/27,815	3.1	324/13,120	2.5
Migrant from triage region	418/11,200	3.7	148/6,413	2.3
Child of migrant from triage region	115/4,405	2.6	55/1,963	2.8
(Child of) migrant, not from triage region	140/6,095	2.3	31/2,423	1.3
Unknown	4/44	9.1	1/64	1.6
Age				
≤25	183/8,509	2.2	49/2,727	1.8
>25	1,355/41,050	3.3	510/21,256	2.4
Partner in risk group[2]				
No	886/27,286	3.2	305/13,108	2.3
Yes	615/21,459	2.9	236/10,390	2.3
Unknown	37/814	4.5	18/485	3.7
Sex work, in the past 6 months				
No	1,483/48,062	3.1	524/22,850	2.3
Yes	40/1,127	3.5	32/785	4.1
Unknown	15/370	4.1	3/348	0.9
Gonorrhoea/chlamydia/syphilis, in the past year				
Not tested	540/15,899	3.4	69/2,388	2.9
Tested, negative	441/18,469	2.4	229/11,855	1.9
Tested, positive	488/13,265	3.7	226/8,115	2.8
Tested, unknown result	11/175	6.3	3/133	2.3
Unknown	58/1,751	3.3	32/1,492	2.1

1 *Region of origin with triage indication includes Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.*
2 *Partner originating from a region of origin as indicated by triage criteria.*

Table 13.13 Demographics and (sexual) behavioural characteristics: number of infectious syphilis diagnoses, tests, and positivity in MSM, 2025

Characteristic	MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	(%)	n positive/N	(%)
Education				
Hbo, university	757/32,878	2.3	320/15,482	2.1
Mbo2-4, havo, vwo	427/10,293	4.1	143/4,937	2.9
No secondary education, vmbo, mbo-1	223/4,033	5.5	52/2,120	2.5
Unknown	131/2,355	5.6	44/1,444	3.0
Number of partners, in the past 6 months				
0 partners	24/567	4.2	2/261	0.8
1 partner	113/3,660	3.1	17/1,130	1.5
2 partners	169/5,306	3.2	28/1,635	1.7
3 or more partners	1,207/39,737	3.0	502/20,752	2.4
Unknown	25/289	8.7	10/205	4.9
Receptive anal sex, in the past 6 months				
No receptive anal sex	291/14,550	2.0	53/4,287	1.2
Yes, consistently with a condom	80/5,079	1.6	20/1,160	1.7
Yes, not consistently with a condom	575/15,386	3.7	213/8,480	2.5
Yes, never with a condom	570/13,876	4.1	271/9,925	2.7
Unknown	22/668	3.3	2/131	1.5
Insertive anal sex, in the past 6 months				
No insertive anal sex	281/10,771	2.6	69/3,626	1.9
Yes, consistently with a condom	99/5,907	1.7	21/1,177	1.8
Yes, not consistently with a condom	546/16,782	3.3	195/8,640	2.3
Yes, never with a condom	591/15,539	3.8	272/10,411	2.6
Unknown	21/560	3.8	2/129	1.6
Vaginal sex, in the past 6 months[1]				
No vaginal sex	46/965	4.8	7/322	2.2
Yes, consistently with a condom	28/1,181	2.4	6/287	2.1
Yes, not consistently with a condom	60/2,554	2.3	17/565	3.0
Yes, never with a condom	96/3,193	3.0	23/815	2.8
Unknown	20/1,096	1.8	1/55	1.8
Receptive oral sex, in the past 6 months				
No receptive oral sex	76/2,783	2.7	9/615	1.5
Yes, consistently with a condom	11/344	3.2	6/90	6.7
Yes, not consistently with a condom	161/4,536	3.5	36/1,253	2.9
Yes, never with a condom	1,269/41,236	3.1	507/21,883	2.3
Unknown	21/660	3.2	1/142	0.7

Characteristic	MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	(%)	n positive/N	(%)
Previous HIV test				
No	175/5,760	3.0	17/413	4.1
Yes, positive	283/4,011	7.1		
Yes, negative	1,060/39,386	2.7	541/23,526	2.3
Yes, result unknown	6/102	5.9	0/32	0.0
Unknown	14/300	4.7	1/12	8.3
Drug use before or during sex, in the past 6 months[2]				
No	1,065/37,846	2.8	310/15,830	2.0
Yes	444/11,326	3.9	243/7,980	3.0
Unknown	29/387	7.5	6/173	3.5
Group sex, in the past 6 months				
No	902/31,044	2.9	268/12,991	2.1
Yes	581/16,532	3.5	286/10,770	2.7
Unknown	55/1,983	2.8	5/222	2.3
Antibiotic prophylaxis use, in the past 3 months				
No	1,434/45,379	3.2	529/22,582	2.3
Yes, Doxycycline (DoxyP(r)EP)	34/2,033	1.7	14/853	1.6
Yes, another antibiotic	13/367	3.5	4/159	2.5
Unknown	57/1,758	3.2	12/386	3.1
PrEP use, in the past 3 months[3]				
Known HIV-positive, not eligible	283/4,010	7.1		
No	842/30,497	2.8	97/3,591	2.7
Yes	413/15,029	2.7	462/20,392	2.3
via SHC	189/5,129	3.7		
via GP	138/7,373	1.9		
via HIV practitioner	1/47	2.1		
via other physician	61/2,242	2.7		
via informal routes	28/734	3.8		
other	25/692	3.6		

1 *Numbers are reported of men who had sex with both men and women. Men who had sex with men only are excluded.*
2 *Included drugs are cocaine, XTC/MDMA/Speed, Heroin, Crystal Meth, Mephedrone, 3-MMC, 4-MEC, 4-FA, GHB/GBL and ketamine.*
3 *Persons can receive PrEP through more than one provider.*

Table 13.14 Age: number of infectious syphilis diagnoses, tests, and positivity in MSM, 2025

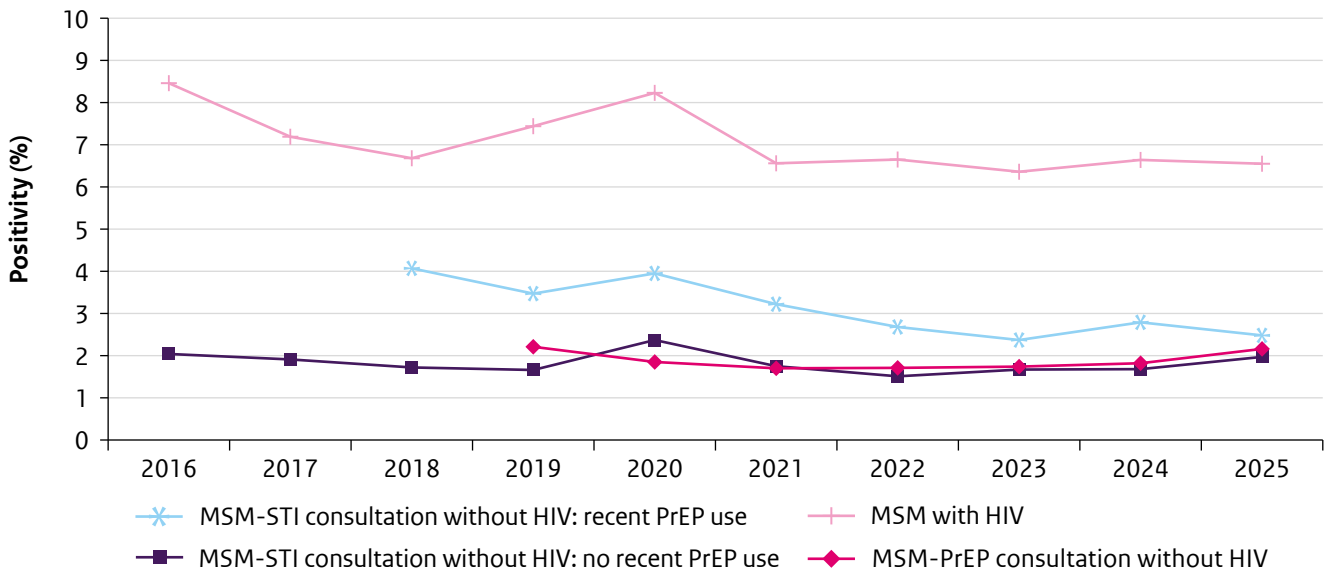
Age (years)	MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%
≤20	20/1,366	1.5	3/295	1.0
21-25	125/7,143	1.7	35/2,432	1.4
26-30	234/9,603	2.4	96/3,978	2.4
31-35	204/9,545	2.1	89/4,533	2.0
36-40	138/6,427	2.1	87/3,363	2.6
41-45	147/4,076	3.6	47/2,349	2.0
46-50	99/3,143	3.1	39/2,004	1.9
51-55	83/2,646	3.1	44/1,684	2.6
≥56	192/5,610	3.4	78/3,345	2.3

Table 13.15 Region of origin: number of infectious syphilis diagnoses, tests, and positivity in MSM, 2025

Region of origin	MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%
The Netherlands	**720/27,815**	**2.6**	**304/13,120**	**2.3**
Turkey	**34/1,172**	**2.9**	**9/601**	**1.5**
Migrant	16/485	3.3	4/263	1.5
Child of migrant	18/687	2.6	5/338	1.5
Morocco	**15/784**	**1.9**	**7/281**	**2.5**
Migrant	6/194	3.1	5/116	4.3
Child of migrant	9/590	1.5	2/165	1.2
Suriname	**34/1,343**	**2.5**	**12/691**	**1.7**
Migrant	14/451	3.1	5/248	2.0
Child of migrant	20/892	2.2	7/443	1.6
CAS-BES islands	**38/1,127**	**3.4**	**17/541**	**3.1**
Migrant	30/834	3.6	12/413	2.9
Child of migrant	8/293	2.7	5/128	3.9
Indonesia	**25/755**	**3.3**	**9/438**	**2.1**
Migrant	10/241	4.1	4/174	2.3
Child of migrant	15/514	2.9	5/264	1.9
Eastern Europe	**75/3,003**	**2.5**	**36/1,452**	**2.5**
Migrant	69/2,782	2.5	31/1,366	2.3
Child of migrant	6/221	2.7	5/86	5.8
Europe other	**100/5,168**	**1.9**	**26/2,107**	**1.2**
Migrant	76/4,336	1.8	22/1,723	1.3
Child of migrant	24/832	2.9	4/384	1.0

Region of origin	MSM-STI consultation		MSM-PrEP consultation	
	n positive/N	%	n positive/N	%
Africa other	**31/1,377**	**2.3**	**14/688**	**2.0**
Migrant	21/942	2.2	9/553	1.6
Child of migrant	10/435	2.3	5/135	3.7
Asia other	**75/3,386**	**2.2**	**51/2,309**	**2.2**
Migrant	64/2,843	2.3	39/2,001	1.9
Child of migrant	11/543	2.0	12/308	3.9
Central/South America other	**82/2,658**	**3.1**	**31/1,375**	**2.3**
Migrant	81/2,428	3.3	27/1,279	2.1
Child of migrant	1/230	0.4	4/96	4.2
North America/Oceania	**12/927**	**1.3**	**2/316**	**0.6**
Migrant	7/781	0.9	2/247	0.8
Child of migrant	5/146	3.4	0/69	0.0
Unknown	**1/44**	**2.3**	**0/64**	**0.0**

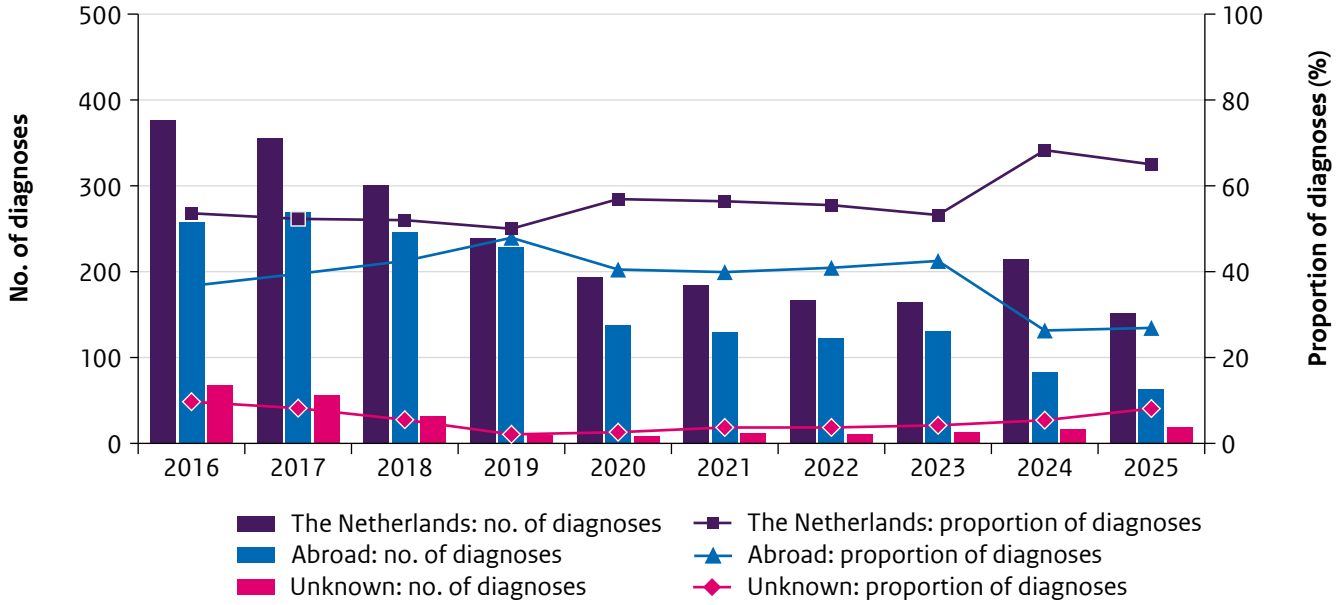
Figure 13.9 Trends in infectious syphilis positivity in MSM by HIV-status and PrEP use, 2016-2025



Footnote: Information o has been collected since 2018. In 2018, recent PrEP use was defined as use in the past 6 months. Since 2019, recent PrEP use has been defined as use in the past 3 months.

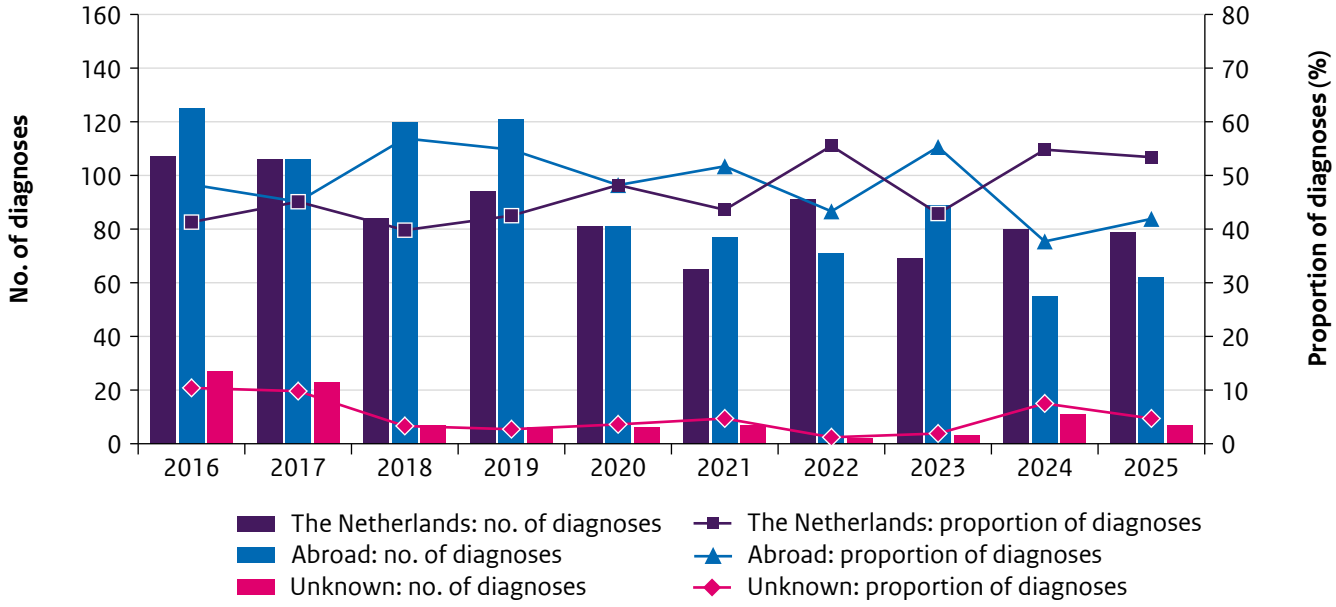
13.5 HIV

Figure 13.10a Reported country of acquiring the HIV infection in newly diagnosed HIV-positive MSM by year of diagnosis, 2016-2025



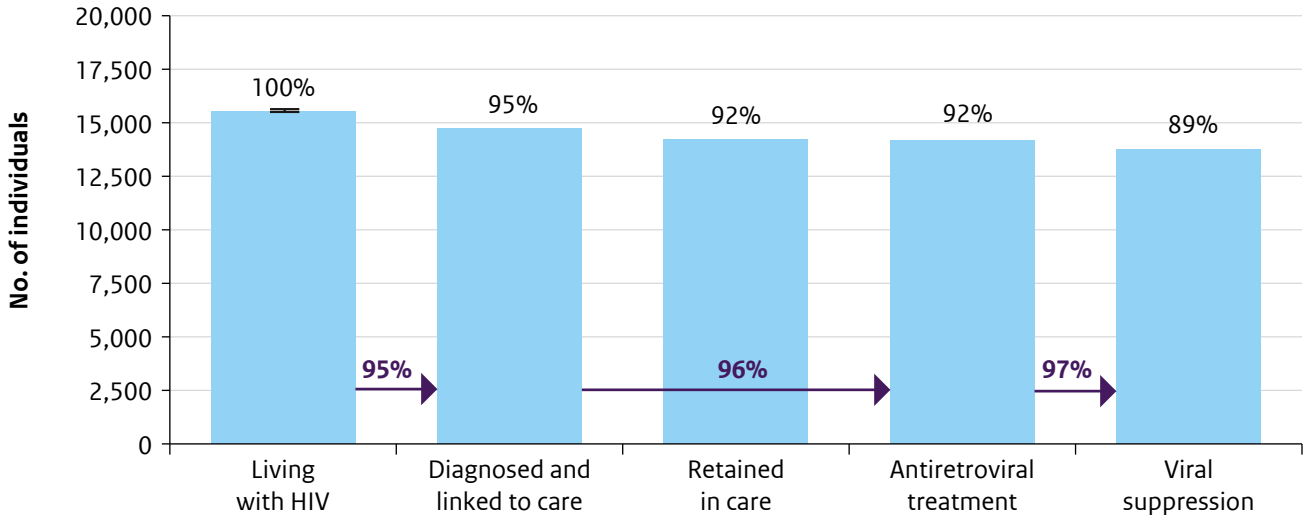
Source: Stichting hiv monitoring, 2025 incomplete.

Figure 13.10b Reported country of acquiring the HIV infection in newly diagnosed HIV-positive MSW and women by year of diagnosis, 2016-2025



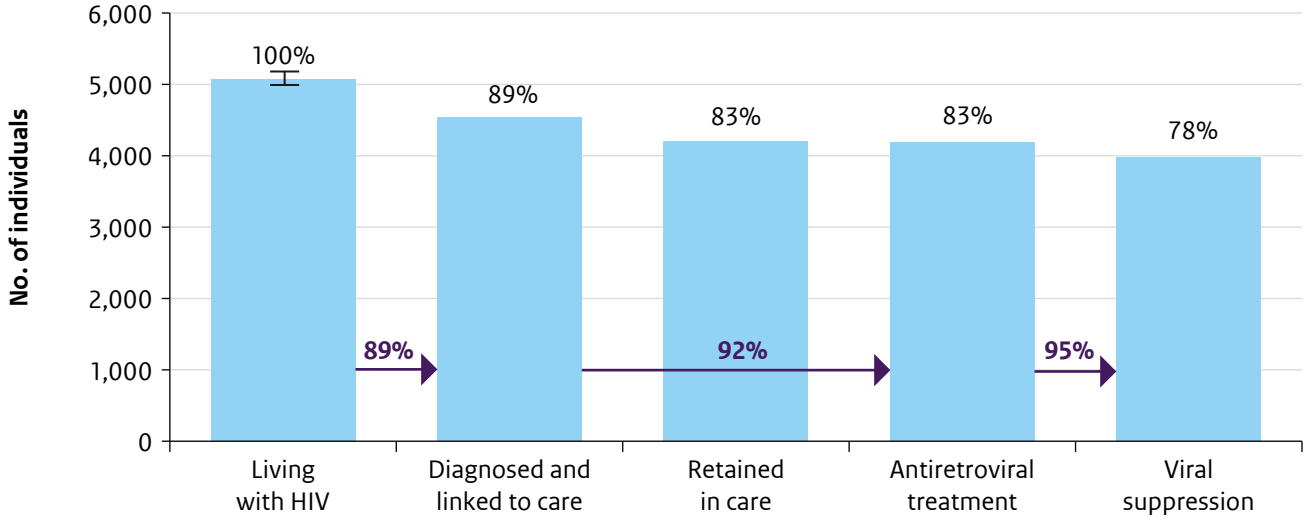
Source: Stichting hiv monitoring, 2025 incomplete.

Figure 13.11a Continuum of care for HIV in 2024, MSM, Stichting hiv monitoring



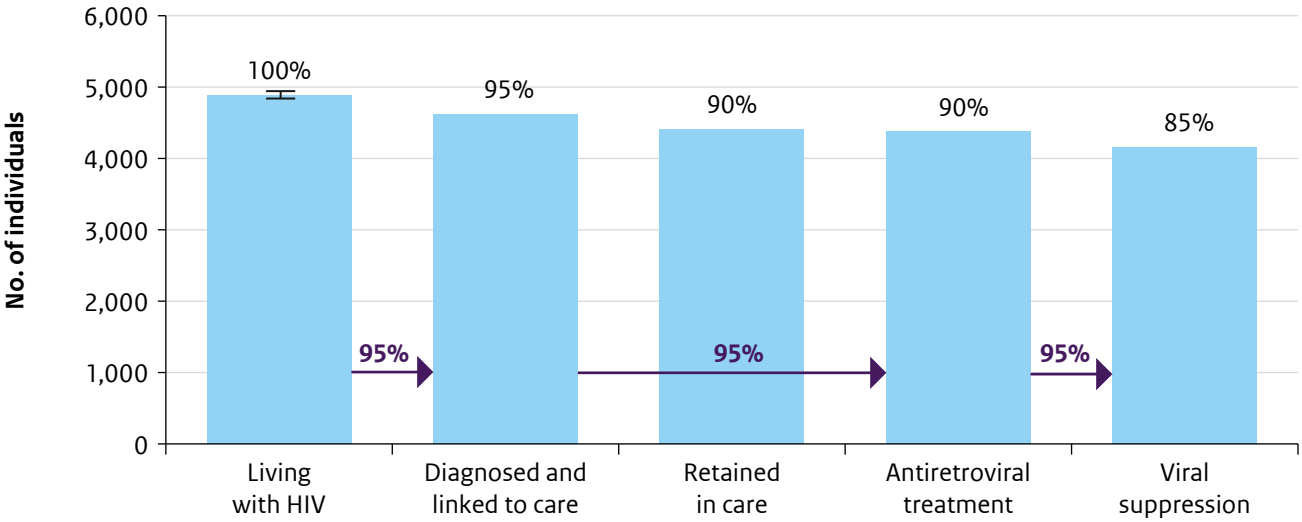
Source: Stichting hiv monitoring, Monitoring Report 2025 SHM: Monitoring of Human Immunodeficiency Virus (HIV) Infection in the Netherlands. For details: www.hiv-monitoring.nl

Figure 13.11b Continuum of care for HIV in 2024, other men, Stichting hiv monitoring



Source: Stichting hiv monitoring, Monitoring Report 2025 SHM: Monitoring of Human Immunodeficiency Virus (HIV) Infection in the Netherlands. For details: www.hiv-monitoring.nl

Figure 13.11c Continuum of care for HIV in 2024, women, Stichting hiv monitoring



Source: Stichting hiv monitoring, Monitoring Report 2025 SHM: Monitoring of Human Immunodeficiency Virus (HIV) Infection in the Netherlands. For details: www.hiv-monitoring.nl

Figure 13.12 Trends in HIV positivity in MSM-STI consultations by region, 2016-2025

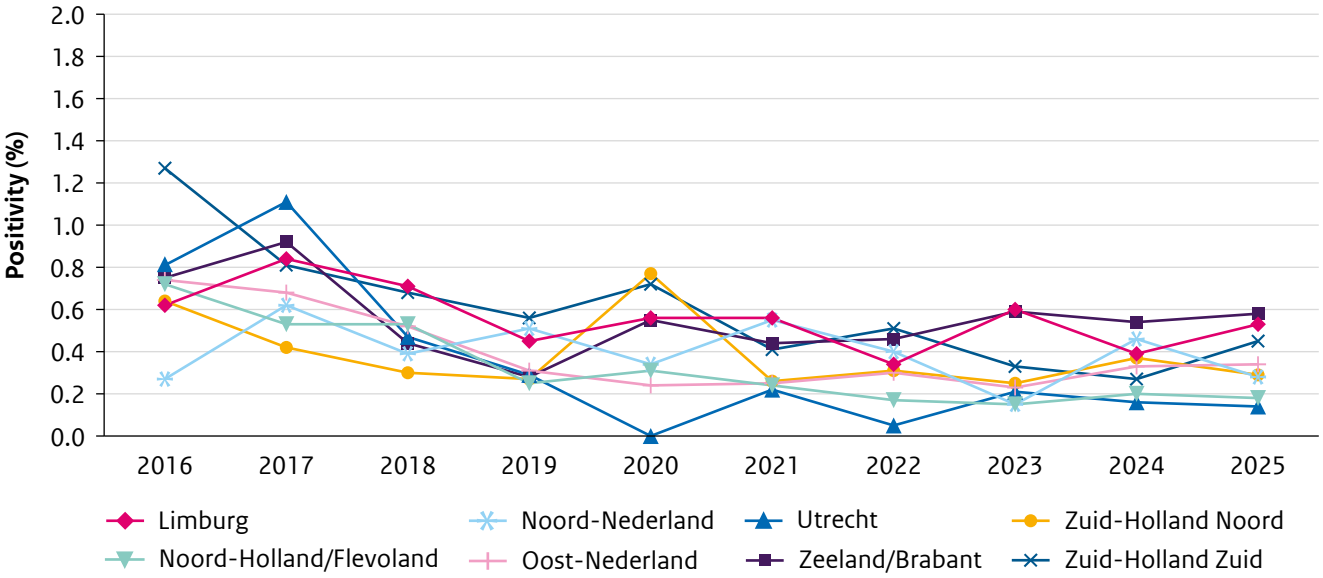


Table 13.16 Reported triage indication: number of HIV diagnoses, tests, and positivity in MSM-STI consultations, 2025

Triage indication	MSM-STI consultation	
	n positive/N	(%)
Notified		
Not notified	84/36,523	0.2
Notified for HIV	17/277	6.1
Notified for other STI	33/8,296	0.4
Unknown	0/31	0.0
Symptoms		
No	65/33,961	0.2
Yes	65/10,275	0.6
Unknown	4/891	0.4
Region of origin[1]		
Dutch	53/25,726	0.2
Migrant from triage region	58/9,523	0.6
Child of migrant from triage region	11/4,143	0.3
(Child of) migrant, not from triage region	12/5,695	0.2
Unknown	0/40	0.0
Age		
≤25	26/8,367	0.3
>25	108/36,760	0.3
Partner in risk group[2]		
No	63/24,974	0.3
Yes	69/19,431	0.4
Unknown	2/722	0.3
Sex work, in the past 6 months		
No	129/43,830	0.3
Yes	2/950	0.2
Unknown	3/347	0.9
Gonorrhoea/chlamydia/syphilis, in the past year		
Not tested	73/14,910	0.5
Tested, negative	32/17,028	0.2
Tested, positive	26/11,431	0.2
Tested, unknown result	0/148	0.0
Unknown	3/1,610	0.2

1 *Region of origin with triage indication includes Turkey, Morocco, Suriname, CAS-BES islands, Indonesia, Eastern Europe, Africa other, Latin America other, and Asia other.*
2 *Partner originating from a region of origin as indicated by triage criteria.*

Table 13.17 Demographics and (sexual) behavioural characteristics: number of HIV diagnoses, tests, and positivity in MSM-STI consultations, 2025

Characteristic	MSM-STI consultation	
	n positive/N	(%)
Education		
Hbo, university	65/30,412	0.2
Mbo 2-4, havo, vwo	41/9,303	0.4
No secondary education, vmbo, mbo 1	22/3,446	0.6
Unknown	6/1,966	0.3
Number of partners, in the past 6 months		
0 partners	0/496	0.0
1 partner	16/3,399	0.5
2 partners	20/4,887	0.4
3 or more partners	97/36,117	0.3
Unknown	1/228	0.4
Receptive anal sex, in the past 6 months		
No receptive anal sex	15/13,970	0.1
Yes, consistently with a condom	8/4,893	0.2
Yes, not consistently with a condom	60/13,647	0.4
Yes, never with a condom	51/12,013	0.4
Unknown	0/604	0.0
Insertive anal sex, in the past 6 months		
No insertive anal sex	31/10,032	0.3
Yes, consistently with a condom	13/5,691	0.2
Yes, not consistently with a condom	40/15,190	0.3
Yes, never with a condom	50/13,713	0.4
Unknown	0/501	0.0
Vaginal sex, in the past 6 months[1]		
No vaginal sex	3/915	0.3
Yes, consistently with a condom	6/1,151	0.5
Yes, not consistently with a condom	10/2,486	0.4
Yes, never with a condom	6/3,086	0.2
Unknown	1/1,041	0.1
Receptive oral sex, in the past 6 months		
No receptive oral sex	5/2,603	0.2
Yes, consistently with a condom	0/327	0.0
Yes, not consistently with a condom	9/3,997	0.2
Yes, never with a condom	120/37,603	0.3
Unknown	0/597	0.0

Characteristic	MSM-STI consultation	
	n positive/N	(%)
Previous HIV test		
No	29/5,717	0.5
Yes, negative	100/39,028	0.3
Yes, result unknown	2/91	2.2
Unknown	2/290	0.7
Yes, positive	1/1	100.0
Drug use before or during sex, in the past 6 months[2]		
No	86/34,894	0.2
Yes	45/9,916	0.5
Unknown	3/317	0.9
Group sex, in the past 6 months		
No	83/28,727	0.3
Yes	48/14,585	0.3
Unknown	3/1,815	0.2
Antibiotic prophylaxis use, in the past 3 months		
No	130/41,405	0.3
Yes, Doxycycline (DoxyP(r)EP)	1/1,808	0.1
Yes, another antibiotic	0/313	0.0
Unknown	3/1,579	0.2
PrEP use, in the past 3 months[3]		
No	118/30,282	0.4
Yes	15/14,822	0.1
via SHC	6/5,016	0.1
via GP	3/7,316	0.0
via HIV practicioner	0/43	0.0
via other physician	3/2,220	0.1
via informal routes	2/727	0.3
other	2/685	0.3

1 *Numbers are reported of men who had sex with both men and women. Men who had sex with men only are excluded.*
2 *Included drugs are cocaine, XTC/MDMA/Speed, Heroin, Crystal Meth, Mephedrone, 3-MMC, 4-MEC, 4-FA, GHB/GBL and ketamine.*
3 *Persons can receive PrEP through more than one provider.*

Table 13.18 Age: number of HIV diagnoses, tests, and positivity in MSM-STI consultations, 2025

Age (years)	MSM-STI consultation	
	n positive/N	(%)
≤20	6/1,355	0.4
21-25	20/7,012	0.3
26-30	36/9,174	0.4
31-35	30/8,821	0.3
36-40	16/5,705	0.3
41-45	9/3,500	0.3
46-50	5/2,738	0.2
51-55	4/2,205	0.2
≥56	8/4,617	0.2

Table 13.19 Region of origin: number of HIV diagnoses, tests, and positivity in MSM-STI consultations, 2025

Region of origin	MSM-STI consultation	
	n positive/N	(%)
The Netherlands	53/25,726	0.2
Turkey	5/1,086	0.5
Morocco	3/732	0.4
Suriname	5/1,192	0.4
CAS-BES islands	10/950	1.1
Indonesia	4/658	0.6
Eastern Europe	14/2,618	0.5
Europe other	11/4,817	0.2
Africa other	9/1,244	0.7
Asia other	12/3,098	0.4
Central/South America other	7/2,088	0.3
North America/Oceania	1/878	0.1
Unknown	0/40	0.0

Footnote: Region of origin: migrant or child of migrant.

14 Conclusions and recommendations

In 2025, the total number of consultations (146,982) at SHCs decreased by 8% compared to 2024 (159,252 consultations). For the first time, this number was lower than the number of consultations prior to the COVID-19 pandemic (-3% compared to 2019). The number of consultations in 2025 particularly decreased among women (-17%) and MSW (-8%). The number of MSM-PrEP consultations also decreased (-7%), while the number of MSM-STI consultations remained stable (+1%). The overall decrease in consultations could be attributed to several factors: 1) rising costs per consultation and the financial ceiling of the ASG regulation resulted in less capacity for consultations, and 2) a change in STI testing behaviour relating to the revised chlamydia policy in January 2025, especially among young women and young MSW, which was also reflected in the higher proportion of women with symptoms. The decrease in PrEP consultations could possibly be attributed to changes in the test frequency. According to new guidelines, the test frequency is lower than previous, with a minimum of two consultations yearly. Among both women and MSW, the most reported triage indication in all past years was being aged ≤25 years. Among MSM-STI consultations and MSM-PrEP consultations, the most reported triage indication was having a partner from a risk group since MSM is a triage indication in itself. The proportion of STIs detected through partner notification has been decreasing since 2021 for women, MSW, and MSM-STI consultations. However, for women this proportion increased in 2025. While the proportion of STIs detected through partner notification among MSM-PrEP consultations had decreased between 2020 and 2022, it increased from 2022 until 2025, probably as a result of the new chlamydia and PrEP testing policy.

At 17% of all consultations, one or more STIs were diagnosed, which was a lower proportion than in previous years and could be explained by the change in chlamydia testing. Before 2025, chlamydia tests were performed at all consultations at the SHCs, chlamydia was the most diagnosed STI and therefore the most important component in the overall percentage positive. As of 2025, a chlamydia test is only performed if a person is having symptoms or is currently having a partner with symptomatic chlamydia.[1] Therefore, the absolute number of chlamydia diagnoses decreased and subsequently, so did the overall number of STI diagnoses and the percentage of consultations in which an STI was diagnosed. At general practices, the estimated number of episodes of 'fear of STI' and STI-positive episodes decreased between 2023 and 2024 in both men and women and in both age groups (15-24 years and 25-64 years). This trend is comparable to the trend in SHC consultations in 2024 compared to 2023, probably relating to a temporal scale-up of testing in 2023 following the COVID-19 pandemic. Unfortunately, GP data from 2025 is not yet available. Therefore, we could not determine if people went to their GP instead of an SHC for their chlamydia test, since general practitioners did not change their chlamydia testing guidelines, as was suggested by a vignette study.[2] On the other hand, this is the first time we published data from the three private STI home-sampling test providers that are recommended by STI AIDS the Netherlands. In their data, the number of STI tests also decreased between 2024 and 2025 suggesting that people did not switch from an SHC to these test providers in 2025.

Data from the annual National Health Survey showed that testing rates among women and heterosexual men have been decreasing since 2019 with a slight increase in 2024. In 2024, 11% of women aged 16-29 years reported being tested for STIs in the past year, while this proportion was 5% for heterosexual men in the same age group. Among MSM aged 16-44 years, reported STI and HIV testing increased from 16 % in 2019 to 21% in 2023, and then decreased to 19% in 2024.

The trends in numbers of consultations observed at SHCs, GPs, and in the National Health survey, the consistently low STI testing rates among young MSW, and the decreasing testing rate among young women, in combination with decreased condom use raise[3] concerns about effective infection control and transmission prevention. This calls for targeted action to reach these groups to encourage STI testing (for gonorrhoea) and promote safe sex practices. In this context, the Ministry of Health, Welfare and Sports will launch a national condom campaign aimed at STI prevention at the end of 2026.[4]

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1 Consult seksuele gezondheid | LCI-draaiboek | LCI-richtlijnen

2 Impact of reduced chlamydia testing on STI testing and provider preferences in the Netherlands: an experimental vignette study. van Bergen IJW, Heijne JCM, de Bruin M, van Wees DA. Sex Transm Infect. 2025 Dec 11:sextrans-2025-056703. doi: 10.1136/sextrans-2025-056703.

3 Mannen hebben vaker risicovolle seks, vrouwen doen vaker soa test | RIVM

4 Kamerbrief over voortgang beleid seksuele gezondheid | Kamerstuk | Rijksoverheid.nl

In 2025, a total of 13,669 persons participated in the PrEP programme, of whom 95% were MSM and 3674 were new participants. On the other hand, 2693 persons exited the programme, 2078 of whom were lost to follow-up (no PrEP consultations for more than seven months). Dropout of PrEP care seemed to be related health care barriers.[5] Event-driven PrEP was the most common mode (50%) among those reporting recent use. Daily PrEP use decreased from 63% in 2019 to 43% in 2025, possibly since medication has no longer been provided at reduced cost from August 2024 onwards. Following updates to PrEP care guidelines, the interval between PrEP follow-up consultations has increased from three- to six-monthly visits in recent years. Despite these changes in PrEP use and consultation intervals, the number of new HIV infections diagnosed among PrEP participants decreased in 2025 compared to 2024 (30 in 2024 and 19 in 2025). Out of the nineteen new HIV infections diagnosed among PrEP participants, five were diagnosed at a PrEP start consultation and fourteen at a PrEP follow-up consultation.

Due to the change in testing policy in 2025, chlamydia is no longer the most diagnosed STI at SHCs (20,174 in 2024 and 10,731 in 2025). Of the 10,731 chlamydia diagnoses, 43% were among women, 30% among MSW, 20% among MSM-STI consultations, 6% among MSM-PrEP consultations, and 1% among gender diverse persons. Among women and MSW, chlamydia positivity used to be lower among those with university/HBO education level but became more similar to those with other education levels in 2025. When only looking at persons with STI symptoms or a partner notification for chlamydia, chlamydia positivity was stable around 23% for women between 2016 and 2025. Among MSW, it slowly increased from 26% in 2016 to 29% in 2024, and then to 34% in 2025. Among MSM-STI consultations, it fluctuated around 17% and among MSM-PrEP around 20% in the past years. Since lymphogranuloma venereum (LGV), caused by the L2 strain of chlamydia, can lead to more severe symptoms, SHCs continue testing MSM for LGV regardless of symptoms. The number of LGV cases among MSM increased until 2023, followed by a decline in 2024 and 2025 (440 diagnoses). The proportion of MSM without HIV among LGV positives increased from 45% in 2016 to 74% in 2025. The estimated number of chlamydia episodes at GPs decreased among both women and men and in both age groups (15-24 years and 25-64 years) in 2024, which is comparable to the decrease in number of chlamydia diagnoses and performed tests seen at SHCs in 2024. To monitor changes in chlamydia testing policy, we added surveillance of long-term STI complications to this report and continue to monitor testing behaviour using various data sources.

As of 2025, gonorrhoea is the most diagnosed STI at SHCs. In 2022 and 2023, gonorrhoea positivity increased sharply among women and MSW. Since then, positivity stabilised but remained high among women, amounting to 4.3% in 2025, and continued to increase among MSW, amounting to 4.4% in 2025. The gonorrhoea increase among women and MSW in 2023 was most prominent among those with university education level (HBO/university). In 2024 and 2025, gonorrhoea positivity stabilised in these groups but further increased among women and MSW with other education levels. Among MSM, no differences in trends were seen between education levels. Gonorrhoea positivity among MSM-STI consultations likewise increased from 12% in 2016 to 16% in 2025. The increase in gonorrhoea was also seen at the GPs in 2023 and continued in 2024 among men and women aged 25-65 years, whereas in younger men and women it slightly decreased compared to 2023. The cause of this strong increase in gonorrhoea cases in recent years remains unknown but is not related to a single strain or to antimicrobial resistance.[6] It might be a result of increased transmission following the release of social distancing measures during the COVID-19 pandemic, catchup testing, decreasing condom use, other behavioural changes, or a combination of these factors. These findings underline the importance of low threshold access to STI testing services in combination with motivational interviewing to increase condom use and partner notification to break transmission chains.

Antimicrobial resistance to ceftriaxone, the first-choice treatment, was reported for the first time in 2025 in the Netherlands by one person who contracted gonorrhoea in South-east Asia and was diagnosed upon return to the Netherlands. Treatment with ceftriaxone was successful, and no further sexual contact was reported in the Netherlands. Resistance to azithromycin has decreased from 31% in 2023 to 22% in 2025. A possible reason for the decrease in azithromycin resistance might be the change in the chlamydia treatment guidelines from azithromycin to doxycycline. In 2025, tetracycline was temporarily added to resistance testing panel at SHCs, and tetracycline resistance

[5] Subpopulations with frequent healthcare barriers have increased risk of sexually transmitted infections and dropping out from HIV preexposure prophylaxis care. Wijstma ES, Jongen VW, Boyd A, De Vries HJC, Van Der Loeff MFS, Prins M, Hoornenborg E. AIDS. 2025 Sep 1;39(11):1610-1620. doi: 10.1097/QAD.0000000000004224.

[6] Neisseria gonorrhoeae Sequence Types During an Increase of Gonorrhea Among Young Women in 2022 and 2023 in the Netherlands. Visser M, Zondag HCA, van Benthem BHB, Klaassen CHW, Bruisten SM, Twisk DE, van Veen SQ, de Vries HJC, Wolffs PFG, van Dam AP. Open Forum Infect Dis. 2025 Dec 15;13(1):ofaf767. doi: 10.1093/ofid/ofaf767.

was 57%. This high resistance is one of the reasons why doxycycline is not recommended as post exposition prophylaxis (doxyPEP) in the Netherlands.[7] Despite that, in 4% of the MSM consultations the use of doxyPEP was reported.

In 2024, 2351 syphilis infections were diagnosed at SHCs, out of which 1927 (82%) were classified as infectious syphilis. Of the infectious syphilis diagnoses, 94% were among MSM. Infectious syphilis positivity has fluctuated around 2.5% among MSM-STI consultations in the past ten years, and increased from 1.8% in 2024 to 2.2% among MSM-PrEP consultations in 2025. Although absolute numbers are low among women, positivity increased from 0.07% in 2016 to 0.28% in 2025, corresponding with an increase in diagnoses from 21 in 2016 to 60 in 2025. Among MSW, the number of diagnoses increased from 37 in 2016 to 64 in 2025. Additional analyses showed that the increase could not be explained by demographic factors and that living with HIV was an important determinant for increased risk of syphilis[8]. Also, among blood and plasma donors, increases in syphilis incidence and prevalence have been seen in the past ten years. This rise, however, is mainly but not entirely associated with an increased number of syphilis infections transmitted via male-to-male sex, with heterosexual transmission playing a smaller role. Over time, the stepwise implementation of less stringent donor deferral criteria for MSM - from life-long deferral (until December 2015) to no specific MSM deferral (January 2024) - has led to a gradual influx of MSM into the Dutch donor population.

As syphilis infection during pregnancy can have devastating consequences, these trends highlight the need to carefully monitor syphilis cases among heterosexuals, actively support partner notification, and maintain effective screening for pregnant women. The Dutch antenatal screening programme remains effective, with 0.00% of pregnant women refusing hepatitis B and syphilis testing in 2024. One case of congenital syphilis was reported in 2025, still within the range of 0-3 cases observed since 2016.

Data from the national registry of HIV treatment centres (Stichting hiv monitoring) showed that, after years of decline, the number of new HIV diagnoses have started to rise slowly since 2021. While diagnoses among MSM declined, among MSW and women an increase was seen, although absolute numbers in these groups remain small. The overall upward trend in new diagnoses becomes more apparent after adjusting the numbers for reporting delays. The extrapolation, based on the average reporting delay over the past five years, was used to estimate the expected annual increase in newly diagnosed individuals. This estimate however includes all diagnoses – both made in the Netherlands and abroad among migrants to the Netherlands – and may be influenced by migration and improved timeliness of data collection in recent years.

The earlier decline in new HIV diagnoses could be explained by several factors, including early diagnosis and treatment efforts, the broader implementation and improved access to PrEP, as well as the impact of the COVID-19 pandemic. However, the slower decrease and the recent increase in new diagnoses may be partly explained by recovery of health services and testing rates following the COVID-19 pandemic, as well as increased mobility and travel. Other contributing factors include suboptimal access to PrEP, limited awareness of PrEP, adherence to the PrEP regimen among certain groups at higher risk, declining condom use among young people, and demographic shifts in the MSM population with HIV toward a younger age. The overall increase in new HIV diagnoses was also visible at SHCs, where the number of HIV diagnoses increased from 178 in 2024 to 191 in 2025; with rises observed among both women and MSW, although the numbers in these groups remain small and numbers among MSM remained stable. Proportions of recent HIV infections has remained relatively stable among both MSM and heterosexuals in recent years; the proportion is higher among MSM compared to women and MSW. Among all individuals diagnosed with HIV in 2025, 40% presented late (CD4 <350/mm3, or AIDS-defining event regardless of CD4 count). This proportion is lower for MSM than for women and MSW. In 2024, 78 women (0.05%) tested positive for HIV (including both new and known diagnoses) through the antenatal screening programme. Over the past decade, the prevalence in pregnant women has remained low and stable, ranging from 0.05% to 0.07%.

The number of both acute and chronic hepatitis B infections remained stable in 2025 compared to 2023 and 2024. Since 2021, the number of MSM and sex workers entering the hepatitis B vaccination programme for risk groups has gradually increased, although it remains below the 2019 levels. Similarly, the number of acute hepatitis C infections was stable in 2025 compared to the previous two years.

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[7] www.soaaids.nl/files/2026-01/Nederlandse%20stellingname%20doxyPEP%20definitief%20dec%202025-%20red%20.pdf

[8] Spatiotemporal trends and determinants of syphilis among heterosexual males and females in the Netherlands, 2011 to 2023. Kayaert L, Kampman CJ, Driessen-Hulshof HC, van Benthem BH. Euro Surveill. 2025 Dec;30(49):2500364. doi: 10.2807/1560-7917.ES.2025.30.49.2500364.

However, among MSM, there has been a slight increase in acute cases since 2022.

Since 2022, a total of 1579 mpox infections have been reported to RIVM. Out of these, 149 were reported in 2025 and 137 in 2024. In October 2025, the first mpox clade 1b case was identified in the Netherlands. A total of nine clade 1b cases were reported in 2025, mainly through autochthonous transmission. In 2025, a total of 6307 mpox vaccinations were administered, out of which 3635 (58%) were first doses and 2672 (42%) were second doses. Ongoing mpox transmission underscores the need for continuing the mpox vaccination programme, which, according to modelling studies, could diminish future outbreaks.[9]

At RIVM, infectious disease signals from the Netherlands and abroad are discussed at the early warning meeting. These signals may include outbreaks, emerging infectious diseases, or unusual trends. In 2025, several national STI-related signals were discussed. These national signals included an increase in HIV diagnoses at one SHC, rising gonorrhoea diagnoses in young men at GPs, transmission of integrase inhibitor-resistant HIV-1 in the Netherlands, and the first case and cluster of mpox clade Ib in the Netherlands as well as the first case of ceftriaxone-resistant gonorrhoea in the Netherlands.

On the basis of the figures and trends outlined in this report, we recommend the following actions:

- Maintain effective and efficient STI control by ensuring:
  1. Accessible and low-threshold sexual health care and STI testing for groups at increased risk of acquiring and transmitting STI and HIV,
  2. rapid and reliable testing results, and
  3. effective and timely treatment to break transmission chains.
- Maintain effective STI prevention, especially by strengthening primary prevention efforts, including a structural national condom promotion campaign targeting young people and other populations with increased rates of condomless sex. And by expanding awareness about PrEP and other preventive measures, especially among groups with lower uptake, and responding to recent increases in HIV, including targeted HIV testing and outreach
- Optimise (integrated) surveillance systems and early detection of STI, HIV, and viral hepatitis infections, as well as sexual behaviour among key populations, including PrEP users, to detect possible changes early, enabling timely responses;
- Continue mpox and HAV/HBV vaccination among groups at higher risk, and address barriers to uptake to reach pre-pandemic levels;
- Continue outreach testing, and follow-up for viral hepatitis, especially among migrant populations from high prevalence areas, and where possible, integrate this with HIV and TB care;
- Stimulate the systematic culturing of Neisseria gonorrhoeae to enable early detection and prevention of resistant strain transmission at all SHCs;
- Maintain surveillance of long-term STI complications to monitor the impact of the chlamydia testing policy.

[9] Combining mpox vaccination and behavioural changes to control possible future mpox resurgence among men who have sex with men: a mathematical modelling study. Xiridou M, van Wees DA, Adam P, Miura F, Op de Coul E, Reitsema M, de Wit J, van Benthem B, Wallinga J. BMJ Public Health. 2025 Jul 31;3(2):e002682. doi: 10.1136/bmjph-2025-002682.

APPENDICES

Appendix A List of abbreviations

ACS	Amsterdam Cohort Studies
AIDS	Acquired Immune Deficiency Syndrome
ASG	Aanvullende Seksuele Gezondheidszorg regeling, Additional Sexual Healthcare regulation
ATHENA	AIDS Therapy Evaluation in the Netherlands
CBS	Centraal Bureau voor de Statistiek, Statistics Netherlands
CIb	Centrum Infectieziektebestrijding, Centre for Infectious Disease Control
COVID-19	Ziekte veroorzaakt door het coronavirus 2019, Coronavirus disease 2019
CSG	Centrum Seksuele Gezondheid
ECDC	European Centre for Disease Prevention and Control
EUCAST	European Committee on Antimicrobial Susceptibility Testing
GDPR	General Data Protection Regulation
GGD	Gemeentelijke Geneeskundige Dienst, Public Health Service
GP	General Practitioner
GRAS	Gonococcal Resistance to Antimicrobials Surveillance programme
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HSV	Herpes Simplex Virus
ICPC	International Classification of Primary Care
IDU	Injecting Drug User
IgM	Immunoglobulin M
IDS	Laboratory for Infectious Disease and Screening
LCI	Landelijke Coördinatie Infectieziektebestrijding, National Coordination Centre for Communicable Disease Control
LGV	Lymfogranuloma venereum, Lymphogranuloma venereum
MIC	Minimum Inhibitory Concentration
MSM	Men who have Sex with Men
NAAT	Nucleic Acid Amplification Test
Nivel-PCD	Nivel Primary Care Database
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PHS	Public Health Service
PID	Pelvic Inflammatory Disease
PrEP	Pre-Expositie Profylaxe, Pre-Exposure Prophylaxis
PSIE	Prenatale Screening Infectieziekten en Erytrocytenimmunisatie, Prenatal Screening for Infectious Diseases and Erythrocyte Immunisation
RIVM	Rijksinstituut voor Volksgezondheid en Milieu, National Institute for Public Health and the Environment
SHC	Sexual Health Centre
SHM	Stichting HIV Monitoring, HIV Monitoring Foundation
soa	Seksueel Overdraagbare Aandoening
SOAP	Seksueel Overdraagbare Aandoeningen Peilstation, Online STI registration system
STI	Sexually Transmitted Infection
TNO	Nederlandse Organisatie voor toegepast-natuurwetenschappelijk onderzoek

Appendix B STI case-definitions of Sexual Health Centres

Chlamydia
Chlamydia diagnosis is based on positive nucleic acid amplification test (NAAT) on genital (vagina/urine) material or on indication extragenital (anus, oropharynx) material collected either by a professional or self-collected by patients. A person is defined as chlamydia-positive when the NAAT is positive at one or more anatomical sites.

Lymphogranuloma venereum
LGV is diagnosed based on a positive PCR for *Chlamydia trachomatis* species, followed by genotyping assessing Ct serotype L1, L2 or L3.

Gonorrhoea
Gonorrhoea diagnosis is based on positive nucleic acid amplification test (NAAT) on genital (vagina/urine) material or on indication extragenital (anus, oropharynx) material collected either by a professional or self-collected by patients. A person is defined as gonorrhoea-positive when the NAAT is positive at one or more anatomical sites.

Syphilis
Syphilis diagnosis is based on a serological screening by Treponemal tests (Treponemal tests: TPHA/TPPA or EIA) followed by IgG or IgM-westernblot. Activity of the infection is assessed by non-treponemal tests like RPR/VDRL. NAAT is indicated in primary infection.

The stage of syphilis is defined by clinicians according to symptoms: Lues stage I, II, latens recens (infection acquired in the last 12 months). These three stages are defined as infectious syphilis. Both lues latens tarda and lues stage unknown are grouped together for the purposes of surveillance. The public health response to these cases can differ when there is uncertainty about the duration of the infection.

HIV
HIV is diagnosed based on a positive 4th generation HIV combotest (anti-HIV and p24 Antigen), followed by an immunoblot on the same serological sample to confirm presence of antibodies and to distinguish between HIV-1 and HIV-2. On indication, HIV PCR is performed to confirm an (early) infection or to determine the viral load.

Genital warts
Genital warts is a clinical diagnosis based on symptoms.

Genital herpes
Genital herpes diagnostic is primarily based on clinical symptoms, and sometimes confirmed by herpes NAAT from lesions to confirm the diagnosis and differentiate Herpes Simplex Virus 1 (HSV1) and HSV2.

Hepatitis B
Hepatitis B screening is performed by detection of Anti-HBcore antibodies, sometimes combined with HBs-antigen. In case of positive screening-test, HBs-antigen and (sometimes) other hepatitis B-markers are tested to diagnose infectious hepatitis B.

Hepatitis C
Hepatitis C is diagnosed by either serological testing (anti-HCV and immunoblot) or molecular testing (HCV-RNA). A chronic hepatitis C-infection is usually determined by serological testing. In some cases molecular testing is warranted, for example when a partner notification for hepatitis C is received and sexual contact was recent (over 7 to 10 days ago).

Mpox
Mpox is diagnosed based on a positive PCR of a skin lesion or of an anorectal or orofaryngeal swab. There are several PCR protocols for diagnosis, which are either orthopox-specific with subsequent identification by sequence analysis, or mpox-specific. When using an orthopox-specific PCR, and in case of a positive test, one of the positive materials (preferably the one with the lowest Ct value) should be sent to the RIVM or Erasmus MC for confirmation of mpox. Subsequently, clade-determination can be performed to gain more insight into the epidemiology of mpox and to add to the knowledge on mpox.

Appendix C National surveillance of Sexual Health Centres

Coordinating SHCs

GGD Amsterdam	E. Hoornenborg
GGD Haaglanden	M. Suijker
GGD Groningen	M. de Bruin
GGD Hart voor Brabant	F. Lagendijk en R. Hermens
GGD Gelderland-Zuid	T. de Glee
GGD Rotterdam-Rijnmond	S.M. Rovers
GGD regio Utrecht	L. van Neer & M. van den Elshout
GGD Zuid Limburg	M. Bosman

Regional SHCs

GGD Brabant-Zuidoost	GGD Hollands-Midden	GGD Zaanstreek-Waterland
GGD Drenthe	GGD Hollands Noorden	GGD Zeeland
GGD Flevoland	GGD Kennemerland	GGD Zuid-Holland Zuid
GGD Fryslân	GGD Twente	GGD Zuid Limburg
GGD Noord- en Oost-Gelderland	GGD West-Brabant	Veiligheidsregio Limburg Noord
GGD Gelderland-Midden	GGD IJsselland	

Laboratories

Certe Medische diagnostiek & advies
Clinical Diagnostics Gelre
Erasmus MC Rotterdam
Haaglanden Medisch Centrum
Labmicta, Laboratorium Microbiologie Twente Achterhoek
Laboratorium voor Medische Microbiologie en Infectieziekten, Isala Klinieken
MUMC Maastricht
Star SHL Rotterdam
Streeklaboratorium Haarlem
Streeklaboratorium voor de Volksgezondheid Amsterdam
Radboud Universitair Medisch Centrum
Ziekenhuis Rivierenland

Appendix D Stichting HIV Monitoring

Clinical centres
* *denotes site coordinating physician*

Amsterdam UMC, Amsterdam:
HIV treating physicians: F.J.B. Nellen*, M.A. van Agtmael, M. Bomers, G.J. de Bree, S.E. Geerlings, A. Goorhuis, V.C. Harris, J.W. Hovius, B. Lemkes, E.J.G. Peters, T. van der Poll, K.C.E. Sigaloff, V. Spoorenberg, M. van der Valk, M. van Vugt, W.J. Wiersinga, F.W.M.N. Wit.
HIV nurse consultants: C. Bruins, E. Donkor, J. van Eden, I.J. Hylkema-van den Bout, L.M. Laan, F.J.J. Pijnappel, A.M. Weijsenfeld.
HIV clinical virologists/chemists: N.K.T. Back, S. Jurriaans, F. van someren Gréve, M.R.A. Welkers, K.C. Wolthers.

Emma Kinderziekenhuis (Amsterdam UMC), Amsterdam:
HIV treating physicians: M. van der Kuip, D. Pajkrt.
HIV nurse consultants: F.M. Hessing, A.M. Weijsenfeld.

Admiraal De Ruyter Ziekenhuis, Goes:
HIV treating physicians: M. van den Berge*, A. Stegeman.
HIV nurse consultants: S. Baas, L. Hage de Looff.
HIV clinical virologists/chemists: A. van Arkel, J. Stohr, B. Wintermans.

Catharina Ziekenhuis, Eindhoven:
HIV treating physicians: M.J.H. Pronk*, H.S.M. Ammerlaan.
HIV nurse consultants: E.S. de Munnik, S. Phaf.
HIV clinical virologists/chemists: B. Deiman, V. Scharnhorst, M.C.A. Wegdam.

DC Klinieken Lairesse – Hiv Focus Centrum, Amsterdam:
HIV treating physicians: J. Nellen*, A. van Eeden, E. Hoornenborg, S. de Stoppelaar.
HIV nurse consultants: H. Berends, L.J.M. Elsenburg, H. Nobel.
HIV clinical virologists/chemists: N. Back, S. Jurriaans, F. van Someren Gréve, M. Welkers, K.C. Wolthers.

ETZ (Elisabeth-TweeSteden Ziekenhuis), Tilburg:
HIV treating physicians: M.E.E. van Kasteren*, M.A.H. Berrevoets, A.E. Brouwer.
HIV nurse specialist: A. Adams, B.A.F.M. de Kruijf-van de Wiel.
HIV nurse consultants: M. Pauwels-van Rijkevoorsel.
HIV data collection: B.A.F.M. de Kruijf-van de Wiel.
HIV clinical virologists/chemists: J.L. Murck.

Erasmus MC, Rotterdam:
HIV treating physicians: C. Rokx*, A.A. Anas, H.I. Bax, E.C.M. van Gorp, M. de Mendonça Melo, E. van Nood, J.L. Nouwen, B.J.A. Rijnders, C.A.M. Schurink, L. Slobbe, T.E.M.S. de Vries-Sluijs.
HIV nurse consultants: N. Bassant, J.E.A. van Beek, M. Vriesde, L.M. van Zonneveld. *HIV data collection*: J. de Groot.
HIV clinical virologists/chemists: J.J.A. van Kampen.

Erasmus MC Sophia Kinderziekenhuis, Rotterdam:
HIV treating physicians: P.L.A. Fraaij, A.M.C. van Rossum, C.L. Vermont.
HIV nurse consultants: L.C. van der Knaap.

Flevoziekenhuis, Almere:
HIV treating physicians: J. Branger*, R.A. Douma.
HIV nurse consultant: A.S. Cents-Bosma, M.A. Mulder.

HagaZiekenhuis, Den Haag:
HIV treating physicians: C. de Bree*, C. van Nieuwkoop, E.F. Schippers.
HIV nurse consultants: J. Geilings, A. van Overeem.
HIV data collection: G. van der Hut.
HIV clinical virologists/chemists: N.D. van Burgel.

HMC (Haaglanden Medisch Centrum), Den Haag:
HIV treating physicians: E.M.S. Leyten*, L.B.S. Gelinck, F. Mollema.
HIV nurse consultants: M. Langbein, G.S. Wildenbeest.
HIV clinical virologists/chemists: T. Nguyen, A. Pettersson.

Isala, Zwolle:
HIV treating physicians: B. Hafkamp*, J.W. Bouwhuis, A.J.J. Lammers.
HIV nurse consultants: A.G.W. van Hulzen, S. Kraan.
HIV clinical virologists/chemists: S.B. Debast, H, Gremmels.

Leids Universitair Medisch Centrum, Leiden:
HIV treating physicians: A.H.E. Roukens*, M.G.J. de Boer, H. Jolink, M.M.C. Lambregts, H. Scheper.
HIV nurse consultants: A. Metselaar, D. van der Sluis.
HIV clinical virologists/chemists: S.A. Boers, E.C.J.Claas, E. Wessels.

Maasstad Ziekenhuis, Rotterdam:
HIV treating physicians: J.G. den Hollander*, R. El Moussaoui, K. Pogany.
HIV nurse consultants: C.J. Brouwer, E. Mulder, J.V. Smit, D. Struik-Kalkman.
HIV data collection: T. van Niekerk.
HIV clinical virologists/chemists: C. van Tienen.

Maastricht UMC+, Maastricht:
HIV treating physicians: S.H. Lowe*, A.M.L. Oude Lashof, D. Posthouwer, A. Stoop, M.E. van Wolfswinkel.
HIV nurse consultants: R.P. Ackens, M. Elasri, K. Pintaric, J. Schippers.
HIV clinical virologists/chemists: T.R.A. Havenith, I.H.M. van Loo, M. van Loo.

Frisius MC, Leeuwarden:
HIV treating physicians: M.G.A. van Vonderen*, L.M. Kampschreur, S.E. van Roeden.
HIV nurse consultants: M.C. van Broekhuizen, S. Faber
HIV clinical virologists/chemists: A. Al Moujahid.

Medisch Spectrum Twente, Enschede:
HIV treating physicians: G.J. Kootstra*, M. van den Boomgaard, C.E. Delsing.
HIV nurse consultants: M. van der Burg-van de Plas, L. Scheiberlich.

Noordwest Ziekenhuisgroep, Alkmaar:
HIV treating physicians: W. Kortmann*, G. van Twillert*, M. Klouwens, R. Renckens, J. Wagenaar.

HIV nurse consultants & HIV data collection: D. Ruiter-Pronk, B. Stander.

HIV clinical virologists/chemists: J.W.T. Cohen Stuart, M. Hoogewerf, W. Rozemeijer, J.C. Sinnige.

OLVG, Amsterdam:
HIV treating physicians: K. Brinkman*, G.E.L. van den Berk, K.D. Lettinga, M. de Regt, W.E.M. Schouten, J.E. Stalenhoef, S.M.E. Vrouenraets.
HIV nurse consultants: H. Blaauw, G.F. Geerders, M.J. Kleene, M. Knapen, M. Kok, I.B. van der Meché, A.J.M. Toonen, E. Wttewaal.
HIV clinical virologists: D. Kwa, T.J.W. van de Laar.

Radboudumc, Nijmegen:
HIV treating physicians: R. van Crevel*, K. van Aerde, R.J.W. Arts, S.S.V. Henriet, H.J.M. ter Hofstede, J. Hoogerwerf, O. Richel, K. Stol.
HIV nurse consultants: K.J.T. Grintjes-Huisman, M. de Haan, S. Hendriks Franssen, M. Marneef.
HIV clinical virologists/chemists: M. McCall, J. Rahamat-Langendoen, E. Ruizendaal. HIV clinical pharmacology consultant: R. Bruggemann, D. Burger.

Rijnstate, Arnhem:
HIV treating physicians: E.H. Gisolf*, M. Claassen, R.J. Hassing.
HIV nurse consultants: G. ter Beest, P.H.M. van Bentum, Y. Neijland, M. Valette.
HIV clinical virologists/chemists: C.M.A. Swanink.

Spaarne Gasthuis, Haarlem:
HIV treating physicians: S.F.L. van Lelyveld*, R. Soetekouw.
HIV nurse consultants: L.M.M. van der Prijt, J. van der Swaluw.
HIV clinical virologists/chemists: J.S. Kalpoe, A. Wagemakers, A. Vahidnia.

Medisch Centrum Jan van Goyen, Amsterdam:
HIV treating physicians: F.N. Lauw, D.W.M. Verhagen.
HIV nurse consultants: M. van Wijk.

Universitair Medisch Centrum Groningen, Groningen:
HIV treating physicians: W.F.W. Bierman*, M. Bakker, J. Kleinnijenhuis, E. Kloeze, A. Middel, D.F. Postma, Y. Stienstra, M. Wouthuyzen-Bakker.
HIV nurse consultants: A. Boonstra, M.M.M. Maerman, D.A. de Weerd.
HIV clinical virologists/chemists: M. Knoester, C.C. van Leer-Buter, H.G.M. Niesters, X.W. Zhou.

Beatrix Kinderziekenhuis (Universitair Medisch Centrum Groningen), Groningen:
HIV treating physicians: B.R. Brandsema, A.R. Verhage.
HIV nurse consultants: N. van der Woude.
HIV clinical virologists/chemists: M. Knoester, C.C. van Leer-Buter, H.G.M. Niesters, X.W. Zhou.

Universitair Medisch Centrum Utrecht, Utrecht:
HIV treating physicians: T. Mudrikova*, R.E. Barth, A.H.W. Bruns, P.M. Ellerbroek, M.P.M. Hensgens, J.J. Oosterheert, E.M. Schadd, A. Verbon, B.J. van Welzen.
HIV nurse consultants: B.M.G. Griffioen-van Santen, L. van de Koolwijk, I. de Kroon.
HIV clinical virologists/chemists: F.M. Verduyn Lunel, A.M.J. Wensing.

Wilhelmina Kinderziekenhuis, UMC Utrecht, Utrecht:
HIV treating physicians: Y.G.T. Loeffen, T.F.W. Wolfs.
HIV nurse consultants: M. Kok.
HIV clinical virologists/chemists: F.M. Verduyn Lunel, A.M.J. Wensing.

Curaçao Medical Center, Willemstad (Curaçao):
HIV treating physicians: E.O.W. Rooijakkers, D. van de Wetering.
HIV nurse consultants: A. Alberto.
Data collection: I. der Meer.

Coordinating center
Board of directors: M. van der Valk, S. Zaheri.

HIV data analysis: D.O. Bezemer, V.W. Jongen, A.I. van Sighem, N. Shalev, C. Smit, F.W.M.N. Wit.

Data HIV data management and quality control: M.M.J. Hillebregt, T.J. Woudstra, T. Rutkens

HIV data monitoring: D. Bergsma, J.M. Grolleman, L.E. Koster, S.T. van Loenen, M.J.C. Schoorl.

HIV data collection: K.J. Lelivelt, K.M. Visser, M. van den Akker, O.M. Akpomukai, R. Alexander, L. Bastos Sales, A. el Berkaoui, M. Bezemer-Goedhart, C.B.J. Bon, E.A. Djoechro, I. el Hammoud, M.R. Khouw, L.M. Kotzebue, C.R.E. Lodewijk, E.G.A. Lucas, M. van Marrewijk, S. van Meerveld-Derks, M.A. van Montfoort, L. Munjishvili, C.M.J. Ree, R. Regtop, A.F. van Rijk, Y.M.C. Ruijs-Tiggelman, P.P. Schnörr, R. van Veen, W.H.G. van Vliet-Klein Gunnewiek, E.C.M Witte.

Patiënt registration: D. Bergsma, Y.M.C. Ruijs-Tiggelman.

Appendix E Nivel Primary Care Database (Nivel-PCD)

Data collection and processing
Drs. Yvette Weesie

Researchers
Dr. Joost Vanhommerig

Project management
Dr. Lucy Overbeek

Appendix F STI publications (co-)authored by RIVM employees 2025

Barriers and missed opportunities in PrEP uptake, use and care among men who have sex with men with recent HIV infection in the Netherlands. JCD Koole, MRD Bedert, F de la Court, I Bais, F Wit, B van Benthem, et al. PLoS One 2025; 20(1):e310621; pubmed: 39761269; doi: 10.1371/journal.pone.0310621

Effects of behavior change techniques in interventions promoting condom use among youth in the Global North. A de Vries, JCM Heijne, JBF de Wit, C den Daas. PLoS One 2025; 20(9):e0328467; pubmed: 40986614; doi: 10.1371/journal.pone.0328467

Effects of improved partner notification on the transmission of HIV and N. gonorrhoea among men who have sex with men: a modelling study. M Reitsema, J Wallinga, BHB van Benthem, ELM Op de Coul, A van Sighem, M Schim van der Loeff, M Xiridou. Sex Transm Infect 2025; 101(4):236-241; pubmed: 39832950; doi: 10.1136/sextrans-2023-055772

Integrating hepatitis B virus, hepatitis C virus and human immunodeficiency virus screening for migrants from endemic countries into travel-related and sexual health care in Amsterdam, the Netherlands. E Generaal, Y Bachour, S Klijzing, E Op de Coul, N Hamdiui, A Meiberg, et al. Front Public Health 2025; 13:1636918; pubmed: 40963655; doi: 10.3389/fpubh.2025.1636918

Investigating the influence of partner attitudes, norms and risk behavior on condom use decision-making during penile-vaginal sex with casual partners: a vignette study among Dutch young people. A de Vries, JCM Heijne, JBF de Wit, C den Daas. BMC Public Health 2025; 25(1):3388; pubmed: 41062995; doi: 10.1186/s12889-025-24741-6

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Neisseria gonorrhoeae Sequence Types During an Increase of Gonorrhea Among Young Women in 2022 and 2023 in the Netherlands. M Visser, HCA Zondag, BHB van Benthem, CHW Klaassen, SM Bruisten, DE Twisk, et al. Open Forum Infect Dis 2025; 13(1):ofaf767; pubmed: 41488694; doi: 10.1093/ofid/ofaf767

Prevalence and risk factors for *Chlamydia trachomatis* seropositivity and seropersistence among women: A prospective cohort study. ZW Alexiou, BM Hoenderboom, CJPA Hoebe, I Scholte, R Sheombarsing, NHTM Dukers-Muijrers, BHB van Benthem, et al. PLoS One 2025; 20(8):e0328449; pubmed: 40763133; doi: 10.1371/journal.pone.0328449

Prevalence of genital and anorectal chlamydia trachomatis in Kenya by risk groups: a systematic review and meta-analysis. A Sohaili, Z Alexiou, F Mogaka, V Ocholla Omollo, SA Morré, PPM Thomas. BMC Infect Dis 2025; 25(1):1622; pubmed: 41266987; doi: 10.1186/s12879-025-11813-6

Self-sampling and self-testing for HIV at a commercial and community-based test provider in the Netherlands: user preferences and usability. IJM Willemstein, O Shobowale, AM Żakowicz, H Bos, ELM Op de Coul. BMC Health Serv Res 2025; 25(1):141; pubmed: 39863901; doi: 10.1186/s12913-025-12252-4

Spatiotemporal trends and determinants of syphilis among heterosexual males and females in the Netherlands, 2011 to 2023. L Kayaert, CJG Kampman, HCM Driessen-Hulshof, BHB van Benthem. Euro Surveill 2025; 30(49):2500364; pubmed: 41383174; doi: 10.2807/1560-7917.ES.2025.30.49.2500364

Steeds meer jongeren met gonorroe. P Bloem, B Mourik, R Joosten, A Randag, M Visser, S de Stoppelaar. Ned Tijdschr Geneeskd 2025; 169:D8369; pubmed: 40063288

Combining mpox vaccination and behavioural changes to control possible future mpox resurgence among men who have sex with men: a mathematical modelling study. M Xiridou, DA van Wees, P Adam, F Miura, E Op de Coul, M Reitsema, J de Wit, B van Benthem, J Wallinga. BMJ Public Health 2025; pubmed: 40756169; doi: 10.1136/bmjph-2025-002682

Changes in Genital Human Papillomavirus (HPV) Prevalence During 12 Years of Girls-Only Bivalent HPV Vaccination: Results From a Biennial Repeated Cross-sectional Study. JMA Kusters, MF Schim van der Loeff, JCM Heijne, AJ King, HE de Melker, T Heijman, JA Bogaards, BHB van Benthem; Papillomavirus Surveillance Among STI Clinic Youngsters in the Netherlands (PASSYON) Study Group. J Infect Dis 2025 Feb 4;231(1):e165-e176; doi: 10.1093/infdis/jiae455

Global hepatitis C elimination: Updates, challenges, and opportunities from real-world experiences in Europe and North America. Săndulescu O, Dutman SG, Op de Coul E, et al. Hepatology 2025; 00:000-000; pubmed: 41003584; doi: 10.1097/HEP.0000000000001548

The effect of bivalent HPV vaccination against invasive cervical cancer and cervical intraepithelial neoplasia grade 3 (CIN3+) in the Netherlands: a population-based linkage study. M Middeldorp, JGM Brouwer, JW Duijster, MJ Knol, FJ van Kemenade, AG Siebers, J Berkhof, HE de Melker. The Lancet Regional Health – Europe 2025; 54; pubmed: 40503392; doi: 10.1016/j.lanepe.2025.101327

The indirect effect of the bivalent human papillomavirus vaccination program: an observational cohort study. M Middeldorp, JW Duijster, MJ Knol, BHB van Benthem, J Berkhof, AJ King, HE de Melker. BMC Medicine 2025; pubmed: 40481488; doi: 10.1186/s12916-025-04155-2

R. El-Jobouri | M. Visser | M. Middeldorp |
E.L.M. Op de Coul | D. van Wees | I. van Bergen |
C.G.I. van Straten | S. van Iersel | K. Kampman |
J.W. Vanhommerig | A.I. van Sighem | M. van der Valk |
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