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SURVEILLANCE & MONITORING

Monitoring of the responses to sexually-transmitted infection epidemics in EU/EEA countries, 2024

ECDC SURVEILLANCE & MONITORING REPORT

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This report by the European Centre for Disease Prevention and Control (ECDC) was coordinated by Lina Nerlander, with support from Otilia Mårdh and Teymur Noori.

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Abbreviations

AST	Antimicrobial susceptibility testing
CHIP	Center of Excellence for Health, Immunity and Infections
CT	*Chlamydia trachomatis*
Doxy-PEP	Doxycycline Post-Exposure Prophylaxis
EEA	European Economic Area
ECDC	European Centre for Disease Prevention and Control
EMIS	European Men-who-have-sex-with-men and trans people Internet Survey (EMIS-2024)
EU	European Union
Euro-GASP	European Gonococcal Antimicrobial Surveillance Programme
GAM	(UNAIDS) Global AIDS Monitoring
gbMSM	Gay, bisexual and other men who have sex with men
GHSS	Global Health Sector Strategies
GUD	Genital Ulcer Disease
HAV	Hepatitis A Virus
HIV	Human Immunodeficiency Virus
HPV	Human papillomavirus
IUSTI	International Union against Sexually Transmitted Infections
LGBT+	Lesbian, gay, bisexual and transgender and other sexual orientations and identities
M. genitalium	*Mycoplasma genitalium*
MDR/XDR	Multi-drug-resistant/extensively drug resistant
NAAT	Nucleic Acid Amplification Test
NG	*Neisseria gonorrhoeae*
NGO	Non-Governmental Organisation
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
REDCap	Research Electronic Data Capture
SDG	Sustainable Development Goal
STI	Sexually-transmitted infection
TESSy	The European Surveillance System
TP	*Treponema pallidum*
US CDC	United States Centers for Disease Control and Prevention
WHO	World Health Organization

Key findings

The European Centre for Disease Prevention and Control (ECDC) has developed a system to support countries in the European Union (EU) and European Economic Area (EEA) in monitoring responses to their sexually-transmitted infection (STI) epidemics. The newly developed monitoring system is centred around the key elements of national responses and aligned with targets of the Global Health Sector Strategy (GHSS) and the World Health Organization (WHO) European Regional Action Plan. In this report, we provide an overview of the data reported by EU/EEA countries in 2024, describing the state of play for STI prevention and control in the region. This includes measurement of progress towards the 2025 interim targets for ending the epidemics of STIs as major public health concerns, as outlined in the WHO European Regional Action Plan 2022–2030.

In 2024, 29/30 EU/EEA countries responded to the first ever ECDC online STI monitoring questionnaire related to four main thematic areas: enabling environment, prevention, testing and treatment. This report presents some key indicators from the STI monitoring data submitted by the EU/EEA countries and, where relevant, is supplemented with available information and data for STI indicators from existing data sources (e.g. Dublin Declaration monitoring for HIV in Europe and Central Asia, ECDC's mapping of sexual behavioural surveys, the European Gonococcal Antimicrobial Surveillance Programme (Euro-GASP) and the European Men-who-have-sex-with-men and trans people Internet Survey (EMIS-2024)).

- **Enabling environment**: Of the 29 EU/EEA countries that responded, most (24 countries) either already have, are currently developing, or plan to develop a national strategy, plan, or policy for the prevention and control of STIs within the next two years. Among the 18 EU/EEA countries with an existing national strategy, plan, or policy for the prevention and control of STIs, most (16 countries) focus specifically on gay, bisexual and other men who have sex with men (gbMSM), young people (aged 15–24 years) and people living with HIV. In the majority (eight countries) of the reporting countries, the legal age for being tested for STIs without parental consent was 16 years, but in seven countries it was 18 years.
- **Prevention**: A majority of countries had vaccination policies covering mpox (24 countries) and hepatitis A virus (HAV) (20 countries) for gbMSM, but less than half (12 countries) had policies covering human papillomavirus (HPV) for gbMSM. Using data from the 2024 European Men-who-have-sex-with-men and trans people Internet Survey (EMIS-2024), vaccination coverage in EU/EEA countries for all three vaccines is generally low, with a great deal of heterogeneity. Data on coverage of condom use among different populations is lacking, as is behavioural surveillance data over time, which is needed to understand sexual behavioural drivers of changing trends in STIs and tailor prevention interventions. The most recent data from ECDC's Dublin Declaration monitoring on Partnership to Fight HIV/AIDS in Europe and Central Asia show that policies to deliver comprehensive HIV and sexuality education in the EU/EEA exist in primary school settings for 15 countries, secondary school settings for 19 countries and university for seven countries.
- **Testing**: Many countries have a national STI testing strategy, guidance or recommendation in place (18 countries) or follow international recommendations (six countries). Asymptomatic screening on a regular basis is common among HIV Pre-Exposure Prophylaxis (PrEP) users, with screening for chlamydia in 18 countries, and gonorrhoea and syphilis in 19 countries. A substantial proportion of countries report routine testing at rectal (13 countries), oropharyngeal (12-13 countries), and urogenital (15 countries) sites for chlamydia and gonorrhoea and other countries report screening anatomical sites, depending on exposure. While 27 of 29 countries have a policy of screening women for syphilis in the first trimester, around half (15 countries) did not report a policy of repeat screening in the third trimester (whether routine or guided by risk) and only eleven countries reported a policy of testing at the time of delivery, if not done before.

  STI testing is available across a range of settings in 28 countries, with 23 reporting that testing is available in non-governmental organisation (NGO)/community settings. However, in many countries, service providers other than medical doctors were not able to independently carry out STI testing, and STI self-sampling was not available for chlamydia (14 countries), gonorrhoea (14 countries) or syphilis (19 countries). Furthermore, STI testing for all three bacterial STIs is still associated with a cost for the individual in 13 of 29 countries.

  Very few countries – between one and four – were able to submit available data on the proportion of priority populations screened for gonorrhoea or syphilis. Of particular note, while most countries had antenatal screening policies in place, only four countries were able to submit data on the proportion of pregnant women screened for syphilis. With regard to gonorrhoea, while 24 EU/EEA countries reported that a majority of clinics had access to antimicrobial susceptibility testing, a low proportion of cases received antimicrobial susceptibility testing.
- **Treatment**: A majority of countries follow national or international case management guidelines or recommendations for chlamydia, gonorrhoea, syphilis and *Mycoplasma genitalium*. All countries implement first line treatment for uncomplicated gonorrhoea in line with the International Union against Sexually Transmitted Infections (IUSTI) Europe recommendations, although only half were able to assess what proportion of cases received this treatment. STI treatment is available in a variety of settings, although generally not in NGO/community settings. Very few countries were able to submit data on treatment coverage, but data on gbMSM from the EMIS-2024 survey suggests that the vast majority of gbMSM diagnosed with gonorrhoea and syphilis had received treatment.

Data gaps

There are several areas for which very few countries were able to submit data, including coverage indicators related to condom use, testing and treatment. It should be noted that the limited data availability and completeness among EU/EEA countries for these indicators signals the need for improved data collection, rather than a lack of progress towards global health targets.

While results here should therefore be interpreted with caution, they constitute useful information, allowing experts to gain an overview of where efforts are required to improve prevention, testing, and treatment efforts and to ensure an enabling environment. The results also indicate areas where efforts are needed to fill information gaps. It is crucial that countries understand the local/national situation to assess the scale of the challenges that need to be addressed, and to effectively plan services to reduce morbidity and prevent onward STI transmission.

Priorities for action

- Countries should ensure that they have an up-to-date national STI strategy, plan or policy for the prevention and control of STIs that is informed by data, whether standalone or integrated within a broader strategy. For integrated strategies, it is recommended that a standalone STI action plan should be added to ensure enough specific focus on STIs [1].
- Legal environments should serve to enable people accessing STI testing – this includes removing punitive laws and the requirement for parental consent, which may be a barrier for young people to access testing.
- Good data on risk behaviour are key to guiding prevention messages. Therefore carrying out regular behavioural surveillance among groups at increased risk of STIs is a priority.
- Sexual health promotion should start in schools and ensuring that there are policies to deliver comprehensive HIV and sexuality education across educational settings should be a priority.
- Countries should ensure regular updates of vaccination polices on vaccination of gbMSM against HAV and mpox, taking into account epidemiological developments.
- Countries are recommended to have an updated national STI testing strategy, guidance or recommendations, and to ensure that populations at elevated risk of STI acquisition have adequate access to testing. Barriers to testing should be removed, including costs. Access and availability can be increased by ensuring that a variety of settings offer STI testing and that providers other than medical doctors can order testing. Data on the number of STI tests performed, including anatomical site of testing, can be crucial to understanding trends in STI notifications and being able to ensure adequate testing of groups at increased risk.
- Countries are recommended to monitor the coverage of syphilis testing for pregnant women and to ensure antenatal screening policies are in place for repeat testing of those at risk, or testing at the time of delivery, if not before.
- Countries are recommended to ensure that up-to-date treatment guidelines or recommendations are in place, with content guided by antimicrobial resistance (AMR) patterns, as well as response plans for managing the threat to multidrug-resistant gonorrhoea. Public health and clinical bodies should ensure that treatment guidelines are followed, work towards an increasing number of gonorrhoea isolates being tested for antimicrobial susceptibility, and offer patients a test of cure (repeat test after completion of treatment).
- Collaboration and partnerships across action areas are key to ensuring that policies are in place and being followed, while also helping to facilitate the collection of robust, up-to-date data. This includes collaboration between different stakeholders in the field of STIs, including public health authorities, laboratories, clinical bodies, and civil society and community-based organisations.

Introduction

1.1 Context

Sexually-transmitted infections in the EU/EEA

Within the EU and EEA, there have recently been considerable increases in the number of notified cases of bacterial STIs reported among gay, bisexual, and other men who have sex with men (gbMSM) as well as heterosexual men and women [2-4]. Between 2014 and 2023, notifications of gonorrhoea, syphilis, and chlamydia among gbMSM from EU/EEA countries to ECDC increased by nearly 300%, 90%, and 180% respectively [5]. Among heterosexual men and women, the largest increase has been observed in young women, where notification rates of gonorrhoea increased by almost 200% between 2021 and 2023 among those aged 20–24 years [2-5]. The reasons behind these increases are unclear, but could be related to a combination of changes in behaviour and increased testing in some groups, although data on these factors are very limited. In addition, several outbreaks of 'novel' STIs have been seen in recent years among gbMSM, most notably mpox where transmission of clade II peaked in 2022, with sporadic transmission still being reported each month, together with recent transmission of clade I in some countries [6]. Extensively drug resistant *Shigella* infection is also spreading among gbMSM [7].

The threat of antimicrobial resistance for *Neisseria gonorrhoeae* is also of concern and ECDC collects data on antimicrobial susceptibility rates in isolates of *N. gonorrhoeae* on an annual basis through the European Gonococcal Antimicrobial Surveillance Programme (Euro-GASP). Rates of resistance to azithromycin – a commonly used first-line antibiotic together with ceftriaxone – is increasing. Cases resistant to ceftriaxone are still rare, but systems are needed to identify these early to prevent further transmission [8].

Case notification data are limited in that this is highly dependent on national testing policies– leading to challenges in interpreting notification rates between countries. There may be differences in access to testing for different population groups, testing policies for asymptomatic screening and testing technology used. Data on presence of symptoms at the time of laboratory diagnosis are scarce, adding to the challenge of interpreting case notification data. Case notification data are collected on the main transmission groups, but limited demographic data are available for transgender and non-binary populations, for example. Prevalence data can give additional information and a recent systematic review of European studies on STI prevalence among different populations showed that chlamydia, gonorrhoea and syphilis prevalence was high among gbMSM living with HIV, gbMSM on PrEP, and gbMSM attending STI clinics, as well as among female and transgender sex workers. Chlamydia prevalence was also high among young people, although at lower levels [9]. It is clear that background data, such as testing rates, are needed to put STI case notification data in context and to ensure that vulnerable groups are adequately covered. In addition, data related to vaccination and behaviour are needed to evaluate and guide STI prevention programmes.

The Member States of the United Nations adopted the Sustainable Development Goals (SDGs) in 2015, including goal 3, to promote health and wellbeing, and target 3.3: 'End the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, waterborne and other communicable diseases' [10]. The adoption of the SDGs pushed control of STIs onto the global public health agenda. The EU is committed to implementing the 2030 Agenda for Sustainable Development and monitoring progress towards SDGs. In addition, the World Health Organization (WHO) Global Health Sector Strategy (GHSS) on HIV, viral hepatitis and STIs provides guidance on implementing strategically focused responses to achieve the goals of ending AIDS and the epidemics of viral hepatitis and STIs by 2030 [11]. Specific to STIs are the 2030 goals to reduce the number of new cases of syphilis, gonorrhoea, chlamydia and trichomoniasis in adults (aged 15–49 years) per year by 90% and eliminate congenital syphilis as a public health threat. Aligned with the 2030 SDG targets and GHSS guidance, the WHO European Regional Action Plans provide a framework for the strategic and integrated implementation of health responses to end AIDS and the epidemics of viral hepatitis and STIs by 2030 [12].

Understanding the complexity of STI epidemics and determining the effectiveness and efficiency of the programmatic responses to these infections requires robust data and information that can be provided by a sustainable and comprehensive monitoring and evaluation system, drawing on data from various sources. To date, there has been no formal system at the EU/EEA level to monitor and evaluate national and regional progress towards the STI targets related to the SDGs, the GHSS or the WHO European Regional Action Plans.

In 2024, ECDC developed a monitoring system for STIs in the EU/EEA, which was aligned with relevant GHSS and WHO European Regional Action Plan indicators and targets, but went further in terms of the number of indicators monitored in the areas deemed relevant to EU/EEA countries. The STI monitoring system is similar to the established systems for monitoring responses to hepatitis B and C epidemics in the EU/EEA countries [13] and implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia [14].

1.2 Aims and objectives of the monitoring system

For this first ever round of data collection, the main aims of the EU/EEA monitoring system for STIs were to:

- measure progress towards ending STI epidemics as major public health concerns in the context of regional STI incidence and prevalence trends; and
- measure progress in enabling environments, prevention, testing and treatment to identify where action is needed to achieve the goal of ending STI epidemics as major public health concerns.

This report presents the results of some key indicators from monitoring data submitted by EU/EEA countries on national responses to STI epidemics until the end of 2024. Indicators are presented regarding policies and programme coverage related to the four areas of enabling environment, prevention, testing and treatment of bacterial STIs.

Section 3.1 'Enabling environment' refers to indicators on the legal and policy environment, including what groups are covered by STI prevention policies.

Section 3.2 'Prevention' includes indicators on vaccination policies among gbMSM, sexuality education in educational settings and coverage of reported condom use among different population groups.

Section 3.3. 'Testing' includes indicators on STI testing policies for different populations. Additional indicators are included on total testing numbers and coverage of testing among certain relevant populations, such as young people (aged 15–24 years), gbMSM, pregnant women, people on HIV PrEP, migrants and sex workers. Indicators on STI testing access and availability are also included.

Section 3.4 'Treatment' refers to indicators on different policies with more detail on gonorrhoea – e.g. first-line treatment, antimicrobial susceptibility testing and policies on test of cure, as well as on STI treatment access and availability. Indicators on STI treatment coverage for relevant populations, such as gbMSM, pregnant women and young people (aged 15–24 years) are also included.

The purpose of this report is to provide public health decision-makers at national and European level with an overview of the situation in the EU/EEA in terms of responses to STI epidemics to inform action and policies. Furthermore, the monitoring data collection provides an overview of data gaps and areas where information is missing and focused efforts are needed to ensure adequate information is available for action. The report findings also inform ECDC's programme of work in technical and scientific advice and capacity building for the prevention and control of STIs in the EU/EEA.

2 Methods

2.1 Development of the monitoring system

ECDC has coordinated the monitoring of national responses to HIV under the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia since 2008 [14], and EU/EEA countries' responses to the epidemics of hepatitis B and C since 2016 [13]. For tuberculosis, monitoring has been done with data from the European Surveillance System and the WHO Global TB Database [15]. In 2023, under the framework service contract 'Monitoring progress towards the Sustainable Development Goals as they pertain to HIV, viral Hepatitis, STIs and TB in the EU/EEA and neighbouring countries', ECDC expanded monitoring activities in order to develop an enhanced monitoring system to supplement existing tuberculosis monitoring, and to develop a new system for data collection on national responses to ending the epidemics of STIs [16].

The ECDC STI Network Meeting in June 2023 served as a launch for developing the STI monitoring system. Meeting participants (EU/EEA National Focal Points, Operational Contact Points and representatives from key partner organisations) were asked to brainstorm topics freely, and rank in order of importance what should be included in an EU/EEA STI monitoring system in relation to one of four main areas: enabling environment, prevention, testing and treatment.

A mapping exercise was also carried out on relevant indicators currently being collected by other agencies or data collection processes, to identify key indicators that would complement existing data sources, while reducing any reporting burden for EU/EEA countries. A selection of relevant STI indicators from other sources have been included to supplement findings in this report (see list of supplementary indicators in Annex 1).

The further development of the monitoring system was supported by the ECDC Advisory Group for STI monitoring, consisting of experts from EU/EEA countries and partner organisations, such as the International Union Against Sexually Transmitted Infections (IUSTI) and representatives from civil society, as listed in the Acknowledgements section.

Key principles applied to the indicator selection process were, wherever feasible and relevant, to consider input from the 2023 STI Network Meeting brainstorming session on STI monitoring; to harmonise with ongoing ECDC HIV and hepatitis monitoring; and to align content with WHO European Regional Action Plan milestones and targets. Recent EU/EEA epidemiological trends also informed the focus on bacterial STIs and certain population groups, such as young people aged 15–24 years and gay, bisexual, and other men who have sex with men (gbMSM) [5].

The online questionnaire was developed using Research Electronic Data Capture (REDCap) tools [17,18] hosted at ECDC. STI monitoring Advisory Group members provided input on the final selection of indicators included in the STI monitoring questionnaire and pilot-tested the questionnaire before launching data collection.

Given the existing data gaps for STI incidence and surveillance data in the EU/EEA, it was expected that data completeness for the STI monitoring questionnaire would be low for a number of coverage indicators. This first STI monitoring round therefore also acted as a feasibility exercise to understand data availability in EU/EEA countries. Countries with no available data were presented with the option to specify the barriers related to reporting these data. Questionnaire indicators regarding population-specific data typically asked about young people, gbMSM and HIV PrEP users, but also other populations such as pregnant women, migrants or sex workers where particularly relevant. This selection of population groups was in part to keep the size of the questionnaire manageable. Nevertheless, countries were given the option to enter available data on other populations groups, and this may guide the population groups to be included in future rounds.

2.2 Collection of data from EU/EEA countries

ECDC invited current Member State National Focal Points (NFPs) for HIV/AIDS, STIs and hepatitis B/C to nominate one or more experts in their countries to report STI monitoring data. The online REDCap cross-sectional questionnaire was distributed to nominated experts in all 30 EU/EEA countries, with data collection taking place between October and December 2024. Deadline extensions were requested by some countries, with some late submissions made up until February 2025. Nominated experts were allowed to consult other experts in their country, but only those nominated could enter data.

In this first round of data collection, countries were requested to provide national level data for the most recent available year wherever possible, but were also encouraged to submit any data available and to provide details as to the date of the data, the source and the geographical coverage. This means that the data and information collected provide a current snapshot of national responses to STI epidemics in EU/EEA countries up until the end of 2024. When responding to coverage indicators on STI prevention, testing and treatment, countries had the option of only providing the numerator and/or percentage, depending on data availability.

Between March and June 2025, the information reported by each country was checked and returned for validation or clarification, as needed. In some of instances, country data was updated as a result.

Data was also collected separately in 2024 (for 2023) from all 30 EU/EEA countries to monitor indicators included in the Euro-GASP 'Response plan to control and manage the threat of multi- and extensively drug-resistant gonorrhoea in Europe'. Some data from this work is included in aggregated format in this report [8]. Relevant data already collected for some indicators through other systems, such as the Dublin Declaration monitoring for HIV in Europe and Central Asia [14], ECDC's mapping of sexual behavioural surveys [19] and the 2024 European MSM internet survey (EMIS-2024) [20,21] are also included in this report.

2.3 Main analyses

Following the data validation process, an exploratory analysis was performed to review completeness of country reporting on key indicators and document data gaps identified in the current round of STI monitoring.

The main analyses conducted on the STI monitoring data included a basic descriptive summary of the data at national and EU/EEA levels, an assessment of the status of progress towards the WHO European Regional Action Plan interim STI milestones and targets for 2025, and a summary of relevant indicators from existing data sources to supplement the STI monitoring data presented in this report.

The analyses in this report focused on a subsection of key national policy and programme coverage indicators related to STI prevention, testing and treatment. When presenting the 2024 status of progress towards WHO European Regional Action Plan targets [12], if fewer than five countries reported data, this was considered to be insufficient available data. While the STI monitoring questionnaire collected information on testing policies for multiple population groups, this report focuses on the findings specific to HIV Pre-Exposure Prophylaxis (PrEP) users, given the tailored testing approaches for this group across pathogens, and the disproportionately high prevalence of bacterial STIs.

3 Progress overview

In this first ever round of data collection, 29 of 30 EU/EEA countries responded to the STI monitoring questionnaire and provided data related to one or more of the questions. Data completeness among reporting countries was found to be high for questions related to information on strategies, plans, policies, guidelines and recommendations. However, only a small proportion of reporting countries were able to provide numerical data related to the coverage of STI prevention, testing and treatment (Annex 2).

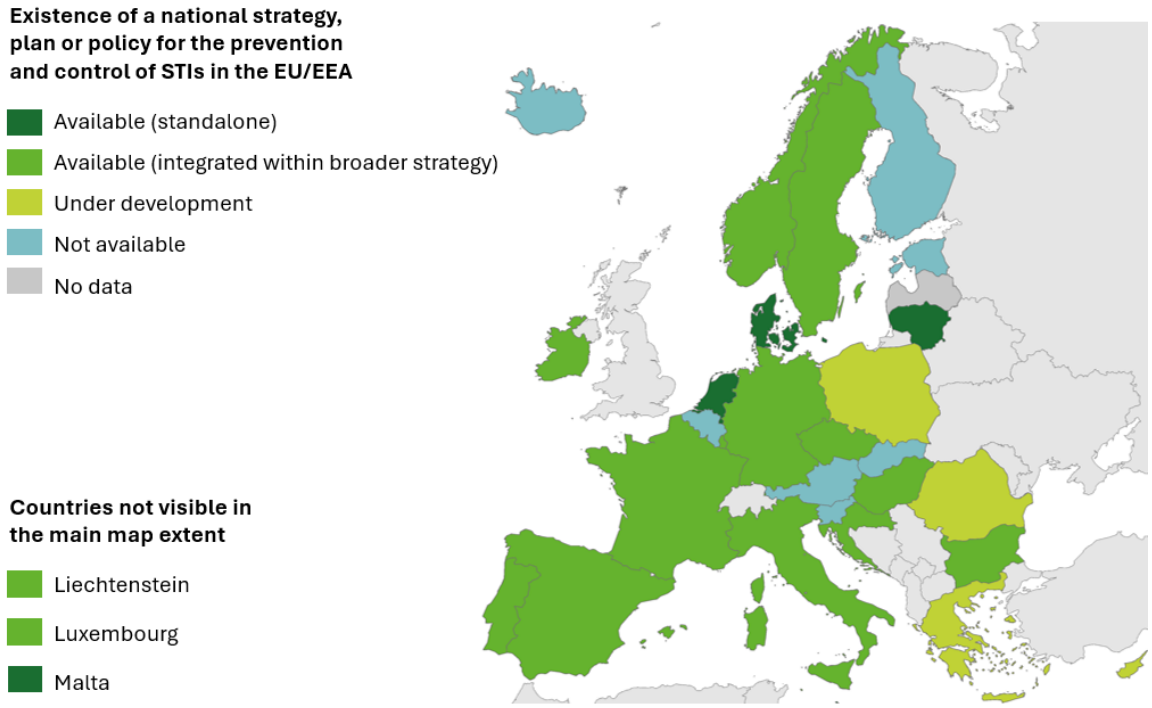
3.1 Enabling environment

ECDC encourages EU/EEA countries to develop coordinated national STI strategies that align clinical services, public health activities and national coordination mechanisms. These strategies should be evidence-based, tailored to national epidemiological data, and include stakeholder engagement [1]. By 2025, the WHO European Regional Action Plan interim milestone related to national STI plans aims for over 70% of countries to have national STI plans, updated within the past five years [12].

Policy environment

In the EU/EEA, 18 of the 29 reporting countries indicated that the country had either a stand-alone or integrated national strategy, plan or policy for the prevention and control of STIs (Figure 1). National strategies are currently under development in four countries[1] and of the seven countries without strategies, two[2] have plans to develop one within the next two years (Annex 3).

Figure 1. Existence of a national strategy, plan or policy for the prevention and control of STIs in the EU/EEA (n=29), 2024



However, the 2025 WHO European Regional milestone on national STI plans was not met, as only 10 EU/EEA countries had a national strategy, plan or policy for the prevention and control of STIs published within the past five years (Table 1).

[1] Cyprus, Greece, Poland, Romania.
[2] Belgium, Slovenia.

Table 1. Milestone and status of national strategy, plan or policy for the prevention and control of STIs, EU/EEA (2024)

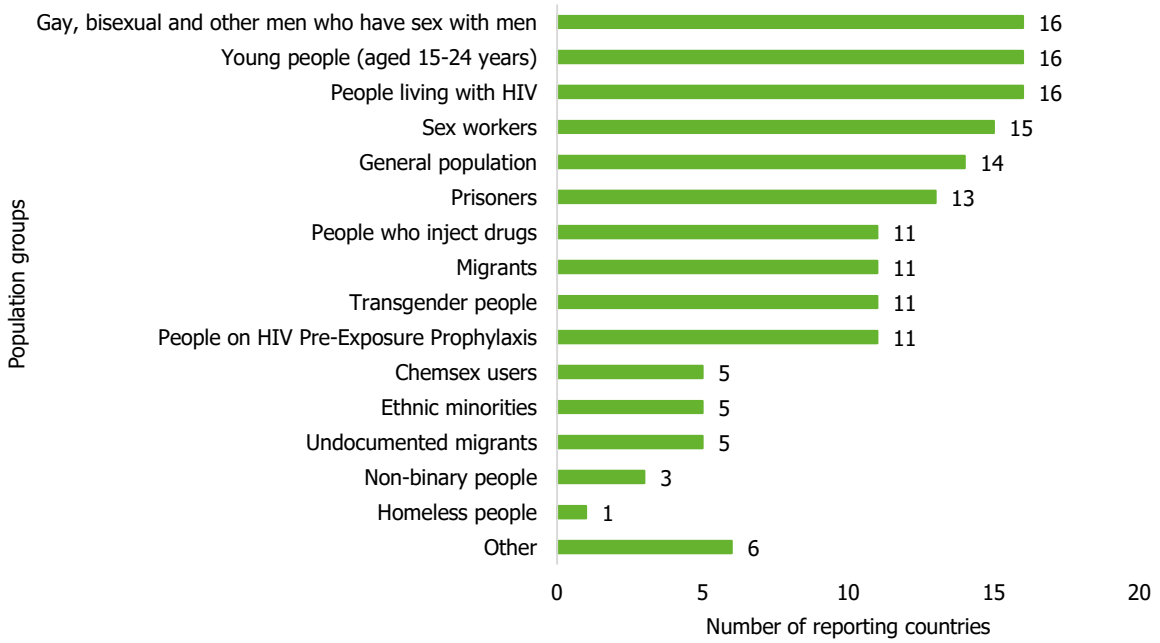
Milestone	2020 baseline	2025 target	2030 target	2024 status
Percentage of countries with national STI plans updated within the past 5 years [12]	38%	>70%	>90%	34% (10 countries) reached 2025 milestone[a]

[a] *In 29 EU/EEA countries that responded to the STI monitoring questionnaire.*

2025 milestone met or exceeded | 2025 milestone not met | No or insufficient data available

Most of the 18 countries with a national STI strategy, plan or policy for the prevention and control of STIs reported a specific focus on gbMSM, young people (aged 15–24 years), people living with HIV, sex workers and the general population (Figure 2). Six countries provided details on 'other' population groups[3] mentioned in a national STI strategy, plan or policy, even if only in the background narrative sections.

Figure 2. Specific focus on population groups among countries with stand-alone or integrated national strategies, plans or policies for prevention and control of STIs, in the EU/EEA (n=18*), 2024



** Countries were able to choose more than one response option.*

As part of their reporting to ECDC on the 'Response plan to control and manage the threat of multi- and extensively drug-resistant gonorrhoea in Europe', nine countries out of 30 (30%) reported having 'adopted a national plan to control multidrug resistant (MDR) or extensively drug resistant (XDR) gonorrhoea, or included MDR/XDR gonorrhoea in a larger gonorrhoea, STI, sexual health or other relevant strategy' [8].

[3] Lesbian, gay, bisexual and trans (LGBT+) people; gbMSM who may not identify as gay or bisexual; people with disabilities and/or chronic illnesses; people facing planned or unplanned pregnancy; older adults; early school-leavers; young people under the care of a local authority or agency; other identified as being 'at risk' and/or vulnerable populations during the lifetime of the strategy; and blood donors.

Legal environment

Legal age to receive STI testing without parental consent

Among the 29 EU/EEA countries with information available on the legal age for an individual to receive STI testing without parental consent, the most common age (in eight countries) was 16 years. In seven countries the legal age was 18 years (Table 2). Some countries provided additional details on case-by-case assessments and how the age for parental consent differs based on clinical setting.

Table 2. Legal age for an individual to receive STI testing, without parental consent, in the EU/EEA (n=29), 2024

Legal age for an individual to receive STI testing without parental consent	Number of countries	List of country names
14 years of age	5	Austria, Estonia, Germany, Malta, Norway
15 years of age	5	Czechia, Denmark, France, Liechtenstein, Slovenia
16 years of age	8	Bulgaria, Croatia, Iceland, Ireland, Lithuania, Netherlands[a], Portugal, Spain
18 years of age	7	Cyprus, Greece, Hungary, Italy, Poland, Romania, Slovakia
Case-by-case assessment	2	Belgium[b], Finland[c]
No legal age	2	Luxembourg, Sweden[d]

a Individuals aged 16 years may receive STI testing without parental consent in general practice settings, however in sexual health clinics, 13-year-olds may access STI testing without parental consent.

b In practice, individuals aged 14 years may be tested for STIs without parental consent.

c Individual assessment based on age, level of development and capacity to make an informed decision on STI testing.

d There is no legal age for STI testing; however, since the age of sexual consent is 15 years, parental notification may occur in some cases. Access to testing is therefore unrestricted, but a case-by-case assessment will be made for patients under the age of 15 years regarding notification of parents or guardians after the fact.

Criminalisation of STI transmission, non-disclosure or exposure

Legislation that criminalises the transmission, non-disclosure or exposure of communicable disease such as STIs may limit the provision and uptake of essential STI services among the most affected populations in the region and may therefore represent a barrier to effective responses to STI epidemics [22].

Seven countries[4] reported having laws criminalising the transmission of, non-disclosure of, or exposure to STI transmission (Annex 4). Germany reported only having specific laws in place for the transmission of, non-disclosure of, or exposure to HIV transmission.

3.2 Prevention

National STI strategies should include a coordinated, evidence-informed public health approach for primary prevention of STIs encompassing health promotion, behavioural interventions and vaccination strategies [1]. Where feasible, ECDC advises that STI prevention interventions within EU/EEA countries should prioritise population groups based on local epidemiological trends and ensure equitable access to comprehensive sexual health services through integrated care models and cross-sectoral collaboration.

EU/EEA country reporting on some of the prevention indicators from the STI monitoring data are presented below and supplemented with relevant information and data from ECDC's mapping of sexual behavioural surveys [19], the latest available data from the Dublin Declaration monitoring for HIV in Europe and Central Asia [23], and the ECDC vaccine scheduler [24].

The policy environment related to prevention

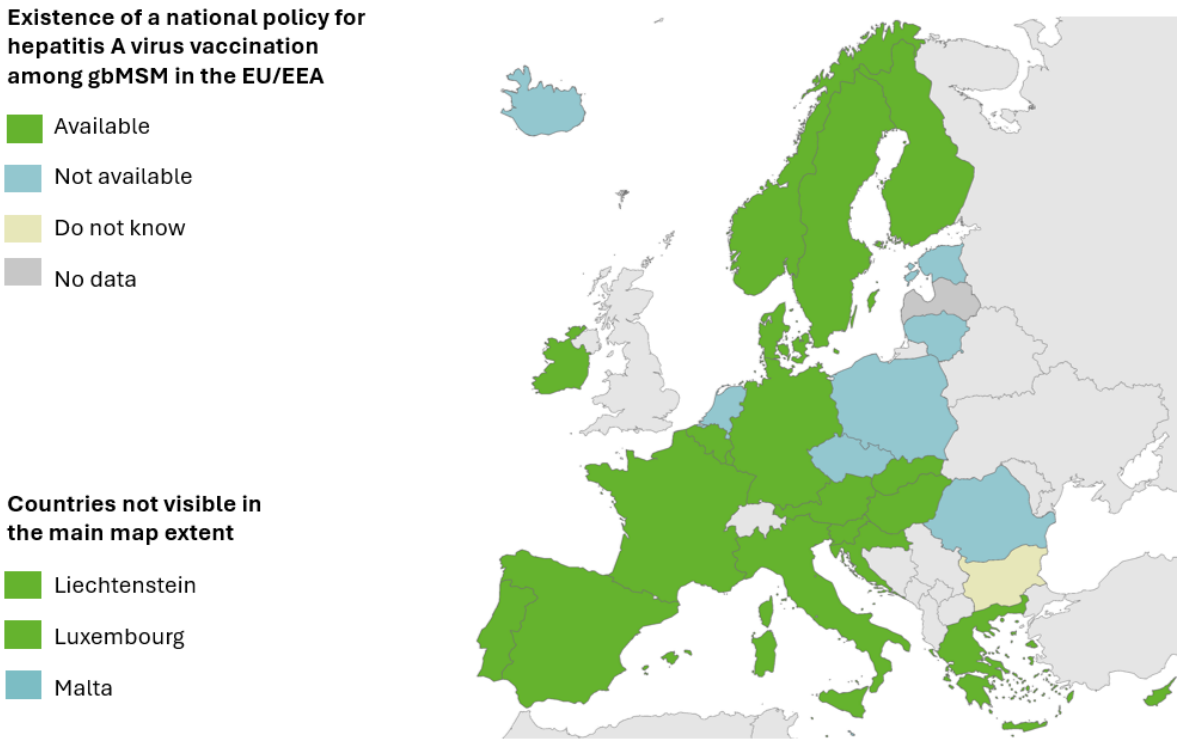
ECDC guidance on HIV and STI prevention among gbMSM suggests that countries consider promoting and delivering vaccination to protect against hepatitis A and B viruses and consider vaccination against human papillomavirus (HPV) [25-27]. For mpox, primary preventive vaccination strategies should prioritise gay, bisexual and other men who have sex with men and transgender people who have sex with men [28,29].

Countries were asked 'In your country, is there a national policy for the following STI vaccinations among gay, bisexual and other men who have sex with men (gbMSM)'. Among the 29 EU/EEA countries that provided information on national policies for vaccinations among gay, bisexual, and other men who have sex with men,

[4] Austria, Czechia, Greece, Iceland, Norway, Poland, Portugal.

20 reported having a policy in place for hepatitis A virus (HAV) (Figure 3), 12 for HPV (Figure 4), and 24 for mpox (Figure 5). Free (no cost) access to STI vaccinations was reported to be available to all gay, bisexual, and other men who have sex with men in seven countries[5] for HAV, four countries[6] for HPV and 17 countries[7] for mpox. As of 2025, all EU/EEA countries have implemented a gender-neutral funded vaccination programme for HPV [24] with many implementing catch-up programmes.

Figure 3. Existence of a national policy for hepatitis A virus (HAV) vaccination among gbMSM in the EU/EEA (n=29), 2024

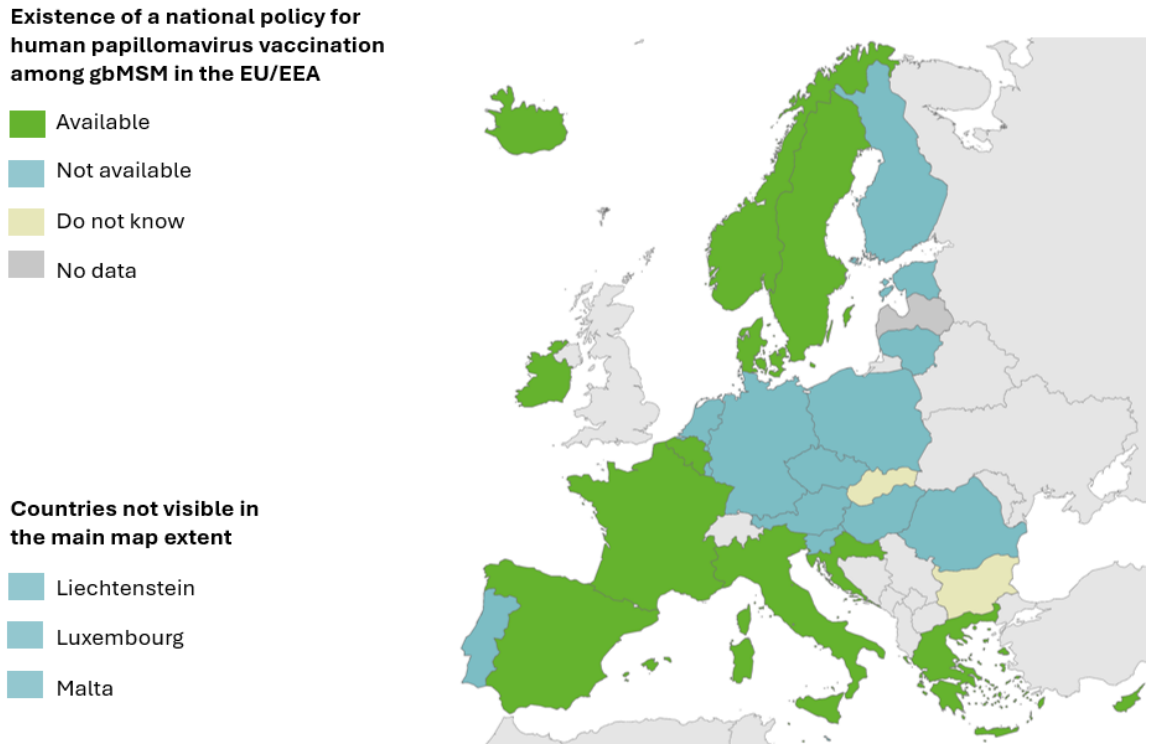


[5] Cyprus, Denmark, Finland, Germany, Greece, Italy, Spain. In addition, HAV vaccination is free in Croatia for persons exposed during an outbreak and through infectious disease specialist referral for HIV PrEP users and gbMSM living with HIV; Germany for gbMSM based on increased risk of sexual exposure; Ireland for all at public STI clinics, and Sweden in some regions.

[6] Denmark, France, Greece, Italy. In addition, HPV vaccination is free in Austria for anyone between nine and 21 years of age; Croatia as a catch-up vaccination for young people under 26years of age; and according to medical indication (HPV related cancers and other immunocompromised people); HIV positive MSM; Cyprus for gbMSM under 26 years of age; Ireland through public STI clinics for MSM up to age 45; Luxembourg for people aged 15–20 years who have not been vaccinated as catch-up vaccination; Malta for people born after the year 2000; Netherlands where children will be invited to receive vaccination when they turn 10 years through the national immunisation programme; Romania for young people aged 11–18 years; Slovenia for all boys aged approximately 11–12 years and through a catch-up programme for boys who attended grade 6 in the school year 2021/2022 or later; Spain for unvaccinated gbMSM under 46 years of age.

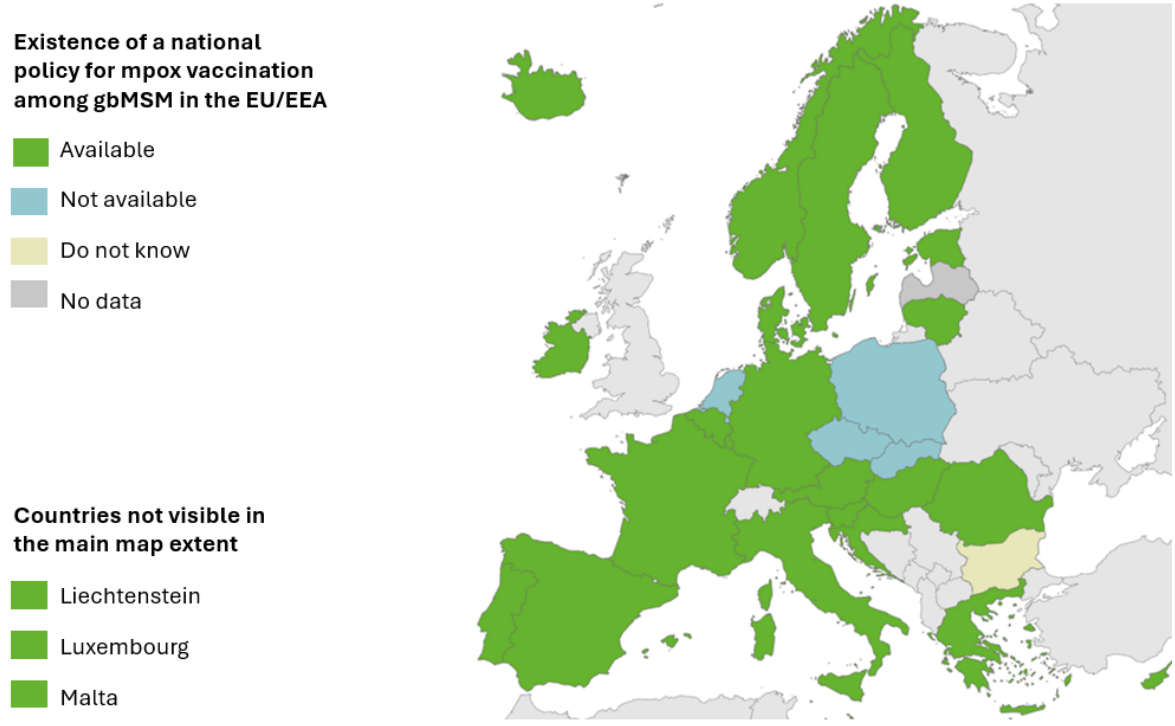
[7] Belgium, Cyprus, Czechia, Denmark, France, Germany, Greece, Iceland, Italy, Lithuania, Luxembourg, Malta, Norway, Portugal, Romania, Spain and Sweden. In addition, mpox vaccination is free in Austria at selected vaccination centres in the federal provinces for gbMSM with individual high-risk behaviour; Finland for gbMSM with multiple casual sex partners in the last six months and/or gbMSM taking or on the waiting list for HIV PrEP; Ireland provides free mpox vaccine in specific limited locations; and the Netherlands for gbMSM who are close contacts of mpox cases.

Figure 4. Existence of a national policy for human papillomavirus (HPV) vaccination among gbMSM in the EU/EEA (n=29), 2024*



** The policy in Norway does not state explicitly that vaccination should be offered to MSM but that, in addition to the main groups for whom vaccination is recommended, other people may be considered for vaccination on an individual basis and one group to consider are men who have sex with men who do not benefit from the herd immunity resulting from the vaccination programme that started in 2009, or from the catch up programme 2016–2018.*

Figure 5. Existence of a national policy for mpox vaccination among gbMSM in the EU/EEA (n=29), 2024



Vaccination coverage against STIs

While 20 EU/EEA countries reported having a national policy in place for HAV vaccination among gay, bisexual, and other men who have sex with men, only two countries were able to provide information on the proportion fully vaccinated against HAV[8]. France and Germany reported 26.1% and 62% of full vaccination coverage against HAV respectively.

Data from the EMIS−2024 survey[9] show that among gbMSM surveyed, the proportion who reported being fully vaccinated against HAV ranged from 10.9% to 69.4% across countries, with a mean of 43.5%. The proportion who reported being fully vaccinated against mpox ranged from 0.5% to 37.9% across countries, with a mean of 13.2%.

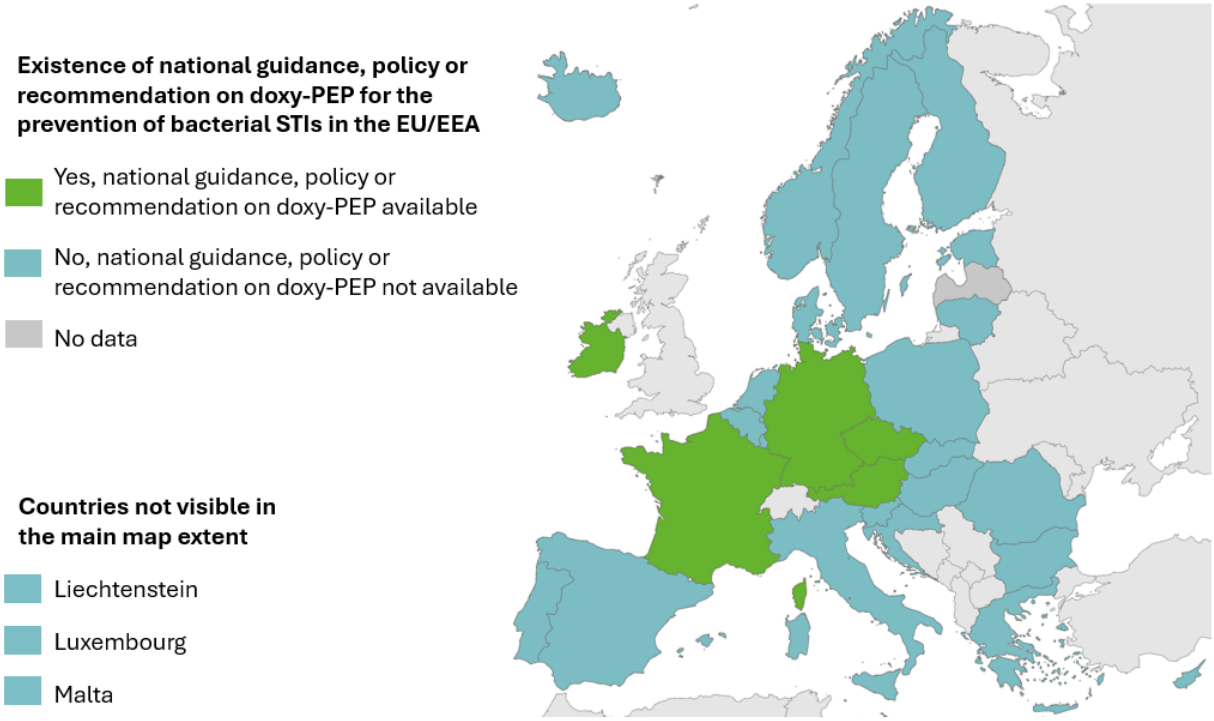
For HPV, the proportion of gbMSM EMIS−2024 respondents aged 25 years or older who reported that they had received at least one dose ranged from 3.6% to 41.1% across countries, with a mean of 14.4%. Among those aged under 25 years, in countries with sufficient sample size, the proportion who had received at least one dose ranged from 3.6% to 49.0%, with a mean of 22.1%.

Doxycycline post-exposure prophylaxis (doxy-PEP)

Amid concerns regarding potential pressure on antimicrobial resistance and possible effects on the human microbiome, there is evidence that doxycycline post-exposure prophylaxis (doxy-PEP) can substantially reduce bacterial STI acquisition (particularly incident syphilis and chlamydia) among gay, bisexual, and other men who have sex with men and trans women living with HIV or using PrEP. In 2023, ECDC indicated that, when prescribed for individuals at increased risk of acquiring bacterial STIs, doxy-PEP should be part of a comprehensive package of sexual health interventions, including regular screening and provision of treatment where needed, and regular reassessment of needs, along with monitoring for individual and population-level antimicrobial resistance [30].

Countries were asked about the existence of a national guidance, policy or recommendation on doxy-PEP for the prevention of bacterial STIs. Five[10] of the 29 EU/EEA countries reported having either clinical guidance or position statements issued by clinical societies on doxy-PEP (Figure 6) for specific population groups[11].

Figure 6. Existence of national guidance, policy or recommendation on doxycycline post-exposure prophylaxis (doxy-PEP) for prevention of bacterial STIs in the EU/EEA (n=29), 2024



[8] As countries may not have known the denominator of number of gbMSM in the country, the option was given to only report the number or percentage vaccinated.
[9] Data from 28 EU/EEA countries (sample size in Iceland too low, and data not separately reported for Liechtenstein)
[10] Austria, Czechia, France, Germany and Ireland.
[11] Cited population groups included gbMSM, trans women and/or people living with HIV (PLHIV) with a history of bacterial STIs in the past 12 months; gbMSM and/or trans women living with HIV; gbMSM, trans women and/or any individual using HIV PrEP, and individuals at increased risk of STI acquisition on a case-by-case basis.

Of the 24 countries without national guidance, nine[12] reported anecdotal, empirical or other evidence of doxy-PEP being prescribed by clinicians. In addition, informal use of doxy-PEP, without prescription or obtained by prescription for another purpose, was reported from 13 countries[13] based on findings from doxy-PEP studies or anecdotal evidence from community organisations and STI clinicians.

Sexual health education in schools

Delivery of life skills-based HIV and sexuality education[14], in school settings and according to international standards[15], is crucial for empowering young people to take control and make informed decisions about their sexuality and relationships freely and responsibly [31].

Within ECDC's Dublin Declaration HIV monitoring system, information is collected on national education policies that guide the delivery of comprehensive HIV and sexuality education in educational settings. According to the latest data reported by 26 EU/EEA countries in 2023, or most recent year with data available, such policies exist in primary school settings in 15 countries[16], in secondary school settings for 19 countries[17], at university for seven countries[18] and at teacher training institutes in 13 countries[19].

Condom use

Condoms, when used correctly and consistently, are among the most effective methods of primary prevention against STIs. The WHO European Regional Action Plan for ending AIDS and the epidemics of viral hepatitis and STIs does not have a specific target for condom use among the STI indicators, however the HIV prevention coverage interim 2025 target aims for 90% of key populations to have used a condom/lubricant the last time they had sex with a client or non-regular partner [12] (Table 3).

ECDC's Dublin Declaration HIV monitoring system routinely collects population survey data aligned with the Joint United Nations Programme on HIV/AIDS (UNAIDS) Global AIDS Monitoring (GAM) indicator on the proportion of key populations reporting to have used condoms the last time they had sexual intercourse. This GAM indicator further specifies condom use among gay, bisexual, and other men who have sex with men the last time they had anal sex with a male partner in the past six months; among people who inject drugs at last sexual intercourse in the past month; among sex workers with their most recent client in the past 12 months, and among trans people during their most recent sexual intercourse or anal sex in the past six months [32].

As young people are not included as a key population in the Dublin Declaration HIV monitoring questionnaire, countries were asked in this STI monitoring questionnaire to provide available data on the proportion of young people (aged 15–24 years) who reported using a condom the last time they had sexual intercourse in the past six months. Among the 12 countries[20] with available data, estimates ranged from 13–75%, which means that no country achieved the WHO European Regional Action Plan 2025 interim HIV prevention coverage target of 90% (Table 3).

The relatively low number of countries reporting on the indicator for condom use among young people in the STI monitoring questionnaire is consistent with the data available from EU/EEA countries on condom use among key populations during the last six months in ECDC's HIV monitoring of the implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia. According to the latest available data, as of 2024 or most recent year, estimates ranged from 25–75% among gbMSM (five countries[21]), 10–34% among people who inject drugs (PWID) (eight countries[22]), 11–55% among migrants (two countries[23]), 55–100% among sex workers (six countries[24]) and 62–85% among trans people (four countries[25]). Moreover, sex workers were the only key population to reportedly exceed the 2025 condom use target (Table 3).

It should be noted that methodological differences were specified in relation to behavioural survey respondent ages, question phrasing and reporting timeframes from over half of EU/EEA countries reporting condom use data

[12] Belgium, Bulgaria, Denmark, Italy, Lithuania, Malta, Netherlands, Norway, Spain.
[13] Austria, Belgium, Bulgaria, Croatia, Cyprus, Finland, Germany, Iceland, Ireland, Italy, Malta, Norway, Spain.
[14] An age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic and non-judgemental information (International technical guidance on sexuality education. Volume I. Paris: UNESCO; 2009).
[15] Standardised UNESCO benchmarks for the sexuality education curriculum to ensure quality, including teaching on (1) generic life skills (such as decision making, communication and negotiating skills); (2) sexual and reproductive health and sexuality education (such as human growth and development, relationships, reproductive health, sexual abuse and transmission of STIs); and (3) HIV transmission and prevention (International technical guidance on sexuality education. Volume I. Paris: UNESCO; 2009).
[16] Austria, Belgium, Cyprus, Czechia, Estonia, Finland, France, Ireland, Liechtenstein, Lithuania, Luxembourg, Netherlands, Norway, Portugal, Sweden.
[17] Austria, Belgium, Cyprus, Czechia, Estonia, Finland, France, Germany, Greece, Ireland, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Portugal, Romania, Sweden.
[18] Austria, Finland, Greece, Lithuania, Luxembourg, Romania, Sweden.
[19] Austria, Estonia, Finland, France, Greece, Ireland, Liechtenstein, Lithuania, Luxembourg, Norway, Portugal, Romania, Sweden.
[20] Austria, Belgium, France, Germany, Luxembourg, Malta, Netherlands, Norway, Portugal, Slovenia, Spain, Sweden.
[21] Cyprus, Estonia, France, Greece, Portugal.
[22] Croatia, Czechia, Estonia, Greece, Lithuania, Malta, Portugal, Romania.
[23] Greece, Portugal.
[24] Czechia, Estonia, Germany, Greece, Netherlands, Portugal.
[25] Cyprus, Germany, Greece, Portugal.

within the STI monitoring questionnaire, and from approximately one-third of EU/EEA countries that reported condom use data within the ECDC Dublin Declaration HIV monitoring questionnaire.

While this WHO European Regional Action Plan HIV prevention target is ambitious, the results from ECDC's respective HIV and STI monitoring systems demonstrate that very few countries have data to measure condom use coverage among priority population groups.

Table 3. Indicator, target and status for preventing new HIV infections in the EU/EEA (2024)

Indicator	2020 baseline	2025 target	2030 target	2024 status
Condom use at last sex*	No data	90% coverage	90% coverage	Young people aged 15–24 years: 13–75%; no country reached 2025 target[a] gbMSM: 25–75%; no country reached 2025 target[b]
				PWID: 10–34%; no country reached 2025 target[c]
				Migrants: 11-55%; no country reached 2025 target[d]
				Sex workers: 55–100%; two countries exceeded 2025 target[e]
				Trans people: 62–85%; no country reached 2025 target[f].

** The WHO European Regional Action Plan indicator on condom use specifies 'condom/lubricant use at last sex among sex workers with a client or among other key populations with a non-regular partner'. However, ECDC's HIV and STI monitoring questionnaire indicators ask about reported condom use at last sex among sex workers with a client or among other key populations with a partner.*

[a] In 12 countries with available data from the ECDC STI monitoring data collection round, as of 2024.
[b] In five countries with available data from the ECDC Dublin Declaration monitoring, as of 2024 or most recent year.
[c] In eight countries with available data from the ECDC Dublin Declaration monitoring, as of 2024 or most recent year.
[d] In two countries with available data from the ECDC Dublin Declaration monitoring, as of 2024 or most recent year.
[e] In six countries with available data from the ECDC Dublin Declaration monitoring, as of 2024 or most recent year.
[f] In four countries with available data from the ECDC Dublin Declaration monitoring, as of 2024 or most recent year.

2025 target met or exceeded | 2025 target not met | No or insufficient data available

Behavioural data

In 2024, ECDC conducted a mapping of surveys on sexual behaviour. The mapping was done in response to increases in STIs among young people following the COVID-19 pandemic and focused on finding representative surveys on sexual behaviour among the general population conducted in the EU/EEA during the period 2019–2024.

The mapping found 31 representative surveys carried out during the period 2019–2024 from 22 countries, with 27 of the surveys being a part of a repeated series. At the time of the mapping, the repeated surveys identified were from 19 countries[26] [19]. Eighteen of the 27 repeated surveys were from the Health Behaviour in School Children series, which covers a limited number of questions on sexual behaviour, the most relevant being self-reported condom use during most recent sexual intercourse.

This mapping highlights the limited availability of data on sexual behaviour, in particular over time. In addition, differences in methodological approaches, phrasing of indicators, and use of subjective and/outdated terms for sexual behaviour, particularly with regard to types of partners, means that it is difficult to make comparisons between such surveys. There is a need to update and better define standard terminology to capture sexual behaviour in surveys in order to facilitate comparisons of key indicators.

[26] Austria, Belgium, Cyprus, Denmark, Estonia, Finland, France, Iceland, Ireland, Italy, Latvia, Luxembourg, Netherlands, Norway, Portugal, Slovakia, Slovenia, Spain, and Sweden.

3.3 Testing

Testing interventions are central to the prevention and control of STIs. Integration of routine STI testing across a variety of service delivery settings, ensuring access to population groups at elevated risk of STI acquisition and supported by quality-assured testing technologies are essential elements to ensure early detection, timely linkage to care and access to partner management services. STI testing, combined with stigma-free counselling and awareness raising also provide opportunities for health promotion and behaviour modification [33].

EU/EEA country reporting on a selection of the testing indicators from the STI monitoring data are presented below, with a detailed summary on national STI policies, guidelines or recommendations pertaining to pregnant women and HIV PrEP users. This reporting is supplemented with relevant information and data collected by ECDC on the 'Response plan to control and manage the threat of multi- and extensively drug-resistant gonorrhoea in Europe' [8].

The policy environment related to testing

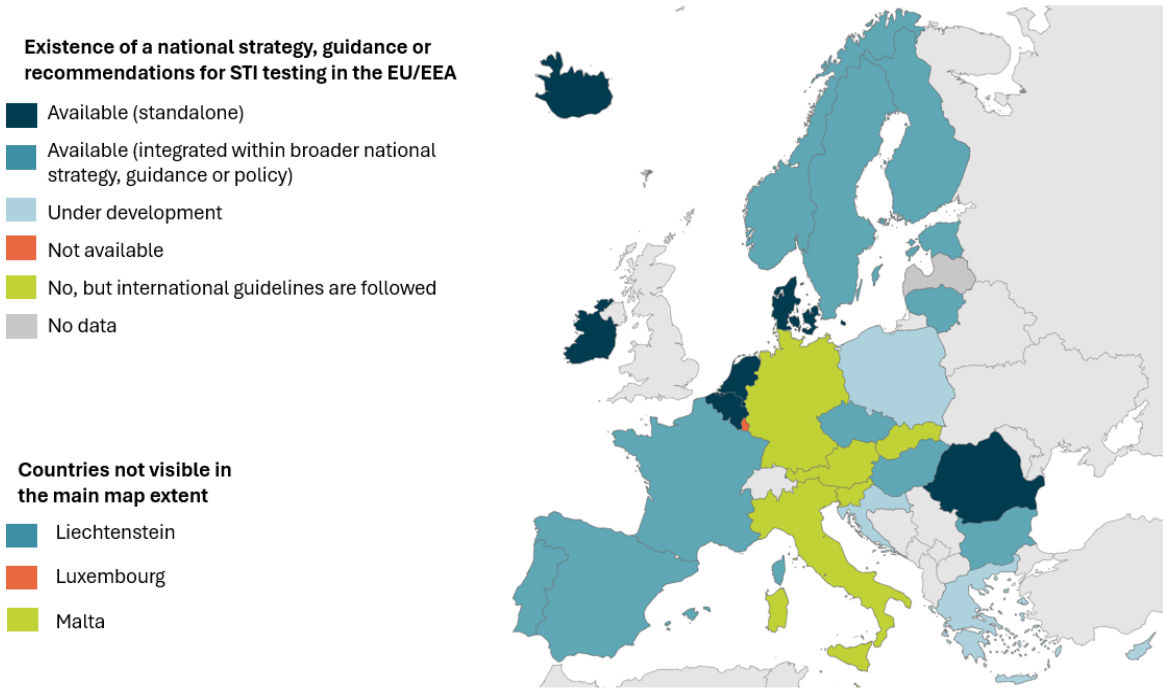
National strategies, guidance or recommendations for STI testing

STI testing strategies should be informed by local epidemiology and supported by frameworks that ensure equitable access to quality-assured and innovative testing technologies, establish clear treatment pathways and enable robust monitoring of testing services [1].

Among the 29 EU/EEA countries with available information, six countries[27] had a stand-alone national STI testing strategy, guidance or other recommendations and 12[28] had a strategy, guidance or other recommendations integrated within a broader national strategy, guidance or policy (Figure 7).

Six countries[29] without a national STI testing strategy, guidance or other recommendations reported following international recommendations from WHO, the International Union against Sexually Transmitted Infections (IUSTI) Europe or the United States Centers for Disease Control and Prevention (US CDC), while four countries[30] are currently developing a national STI testing strategy (Annex 5).

Figure 7. Existence of a national strategy, guidance or other recommendations for STI testing in the EU/EEA (n=29), 2024



[27] Belgium, Denmark, Iceland, Ireland, Netherlands, Romania
[28] Bulgaria, Czechia, Estonia, Finland, France, Hungary, Liechtenstein, Lithuania, Norway, Portugal, Spain, Sweden
[29] Austria, Germany, Italy, Malta, Slovakia, Slovenia
[30] Croatia, Cyprus, Greece, Poland[31] Austria, Czechia, Hungary, Poland.

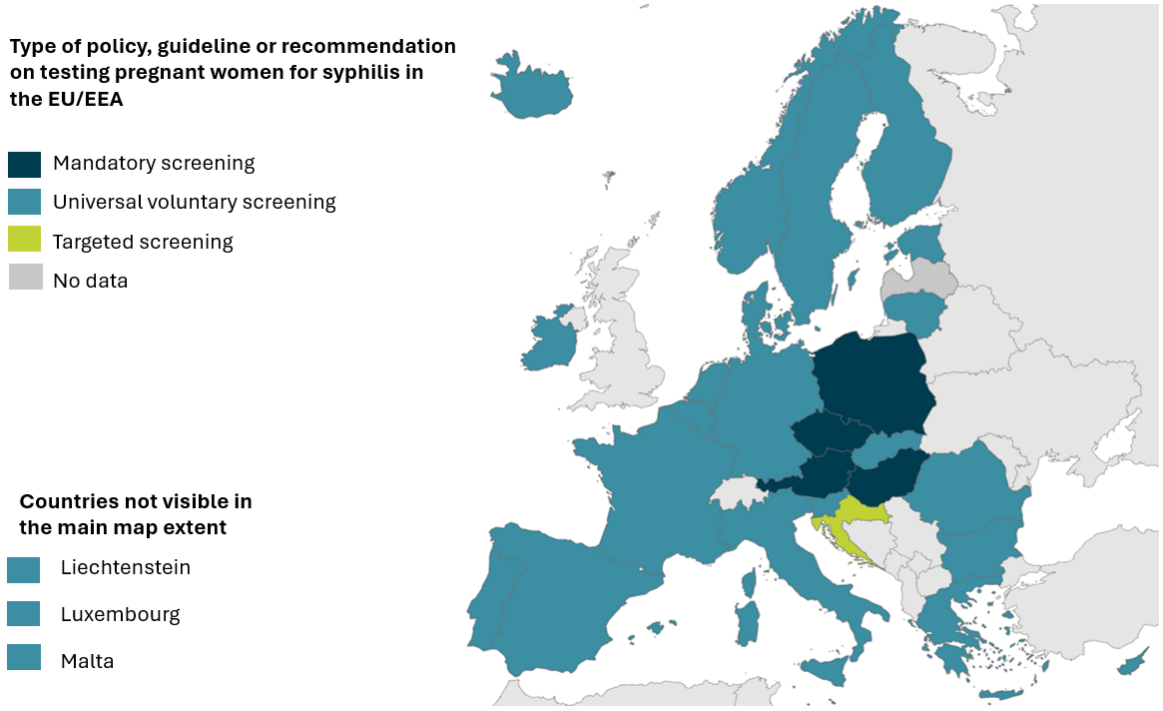
National policies, guidelines or recommendations on STI testing during pregnancy

Among the 29 countries that provided information on national policy, guidelines or recommendations on syphilis testing during pregnancy, 28 have a policy of screening all women. Twenty-four countries reported universal screening, which is the systematic voluntary testing offered to all pregnant women as part of routine care regardless of individual risk factors. Four countries[31] reported mandatory screening, where legislation enforces the screening of all pregnant women as part of antenatal care (Figure 8).

Twenty-seven EU/EEA countries reported a policy of screening women in the first trimester. One country reported screening women in week 16[32] and one country reported screening only on a case-by-case basis[33].

Five countries[34] reported a policy of repeat screening for all pregnant women in the third trimester, and nine countries[35] reported a policy of repeat screening in the third trimester for women with identified risk factors. Fifteen countries[36] did not report having a policy for repeat testing in the third trimester – whether routine or determined by risk factors. Eleven countries[37] reported a policy of testing pregnant women, irrespective of any risk factors, at the time of delivery, if not before.

Figure 8. Type of national policy, guideline or recommendations on syphilis testing during pregnancy in the EU/EEA (n=29), 2024



STI testing policy for HIV PrEP users

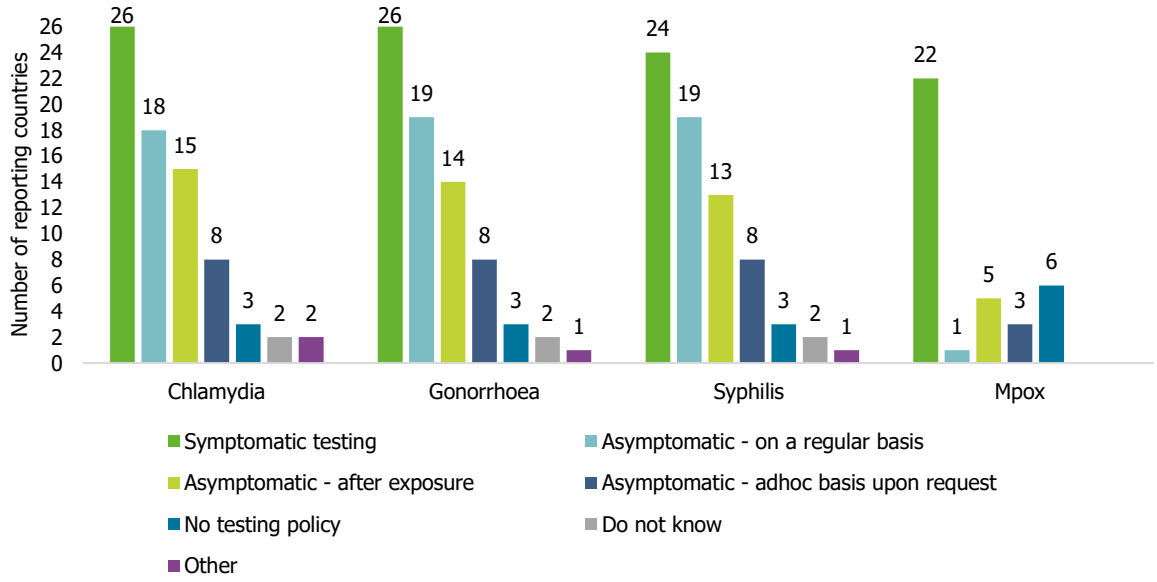
Countries were asked to provide information on testing policies for chlamydia, gonorrhoea, syphilis and mpox in different population groups, including HIV PrEP users, for which the results are presented here.

Of the 29 EU/EEA countries with information on testing policies for HIV PrEP users, regular asymptomatic testing is provided by 19 countries for gonorrhoea and syphilis and 18 countries for chlamydia (Figure 9). Asymptomatic testing on an ad-hoc basis was reported by eight countries for each of the bacterial STIs.

Most countries reported that symptomatic testing for chlamydia, gonorrhoea, syphilis and mpox is performed, irrespective of whether an official policy is in place. Among the few countries that report not having a testing policy, most confirmed that in practice STI testing would probably be provided, based on the presentation of symptoms, however there are no formal national guidelines stating this.

[31] Austria, Czechia, Hungary, Poland.
[32] Austria.
[33] Croatia.
[34] Czechia, Greece, Portugal, Romania, Slovakia.
[35] Belgium, Cyprus, Germany, Italy, Ireland, Lithuania, Luxembourg, Poland, Spain.
[36] Austria, Bulgaria, Croatia, Denmark, Estonia, Finland, France, Hungary, Iceland, Liechtenstein, Malta, Netherlands, Norway, Slovenia, Sweden.
[37] Bulgaria, Czechia, Estonia, France, Greece, Ireland, Lithuania, Malta, Netherlands, Portugal, Spain.

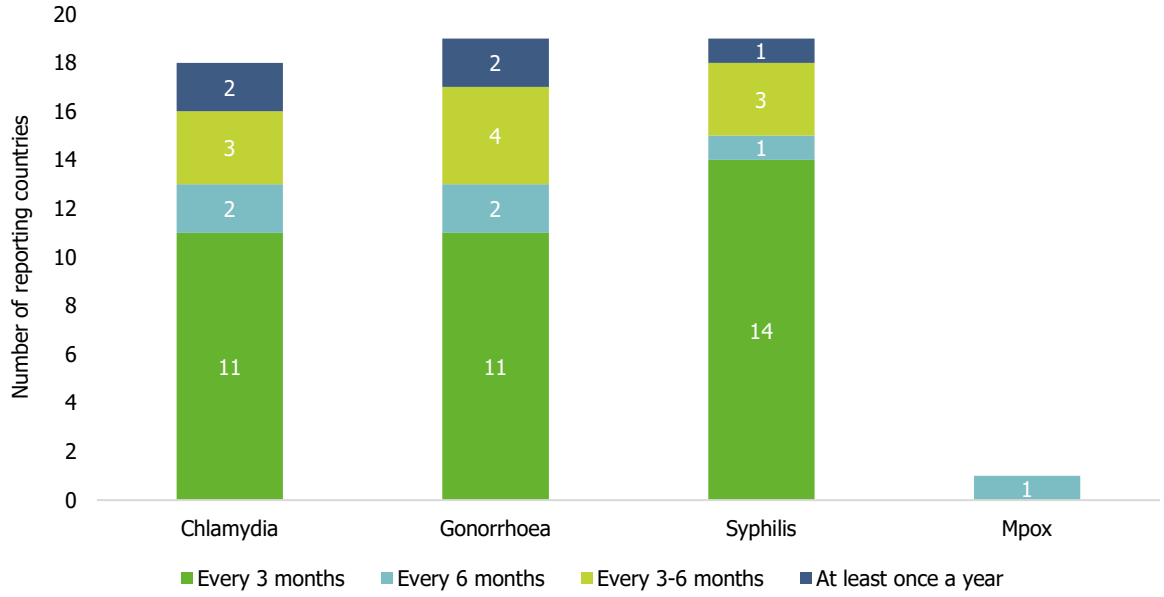
Figure 9. Number of countries with a reported policy, guidelines or recommendation for STI testing by infection among HIV PrEP users in the EU/EEA (n=29*), 2024



** Countries were able to choose more than one response option. Most countries reported that symptomatic testing is performed, irrespective of whether an official policy is in place.*

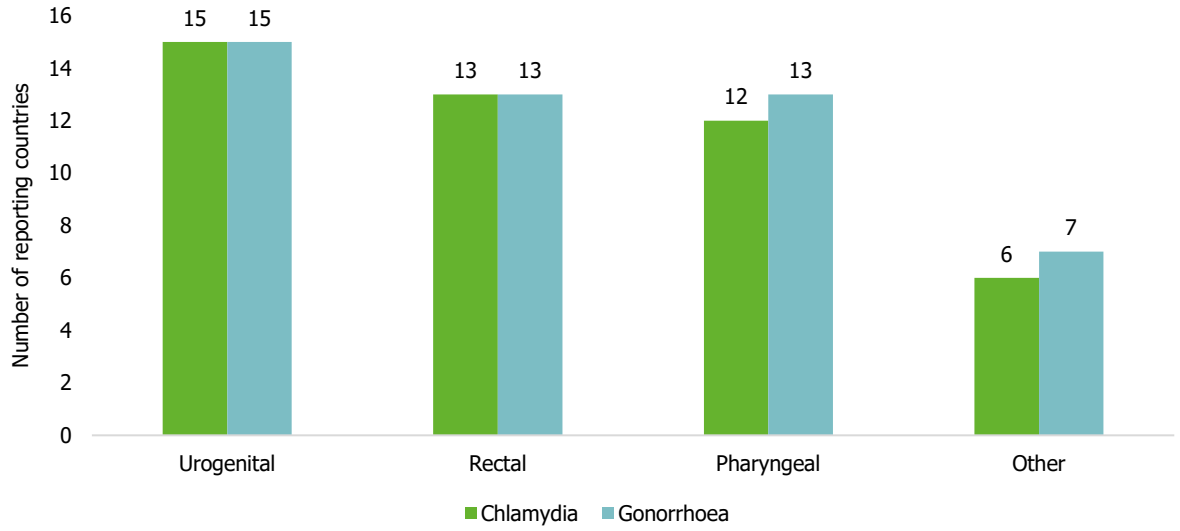
Of the 19 countries that had a policy of regular asymptomatic STI testing among HIV PrEP users, the most commonly reported frequency was every three months for chlamydia (11 countries), gonorrhoea (11 countries) and syphilis (14 countries) (Figure 10).

Figure 10. Number of countries with specific recommendations for the frequency of regular asymptomatic STI testing, by infection, among HIV PrEP users in the EU/EEA (n=19), 2024



The 19 countries with policies, guidelines or recommendations in place for asymptomatic STI testing on a regular basis were asked about the anatomical testing site for chlamydia and gonorrhoea among HIV PrEP users in this context. The most frequently cited anatomical site for asymptomatic testing of chlamydia and gonorrhoea among HIV PrEP users was urogenital, followed by rectal and pharyngeal sites (Figure 11). Twelve countries stated that all three sites are tested. Countries reporting 'other' anatomical site testing locations specified that this was dependent on individual sex practices and anatomy.

Figure 11. Number of countries with specific recommendations for anatomical site testing of HIV PrEP users during asymptomatic screening on a regular basis, by anatomical site, in the EU/EEA (n=19*), 2024

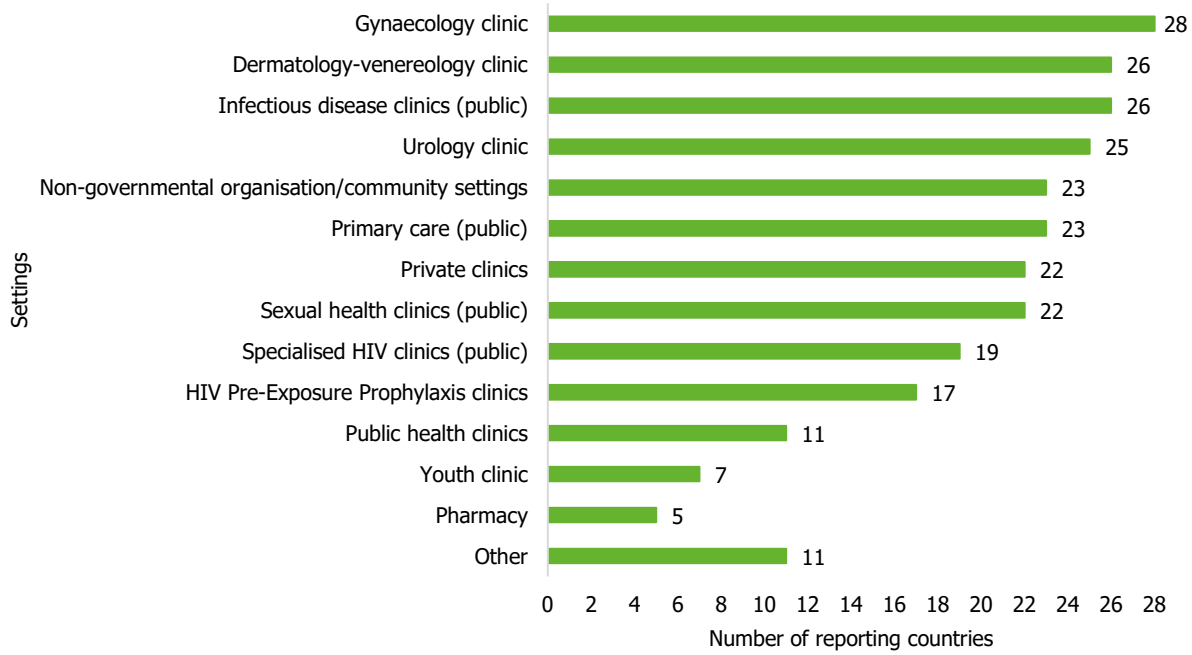


**Countries were able to choose more than one response option.*

STI testing access and availability

EU/EEA countries were asked to provide information on indicators related to STI testing access and availability, namely on the settings where STI testing is available and the cost to an individual for STI testing. Among the 29 reporting countries, 28 noted that STI testing is available at gynaecology clinic settings, and 26 noted that STI testing was available at dermatology-venerology and infectious disease clinic settings (Figure 12). Eleven countries provided details on 'other' settings[38] where STI testing was available.

Figure 12. Settings where STI testing is available, in the EU/EEA (n=29*), 2024



** Countries were able to choose more than one response option.*

[38] Hospital/emergency settings, medical biology laboratories, drug stores, outreach events, community organisations, home STI testing services and with midwives.

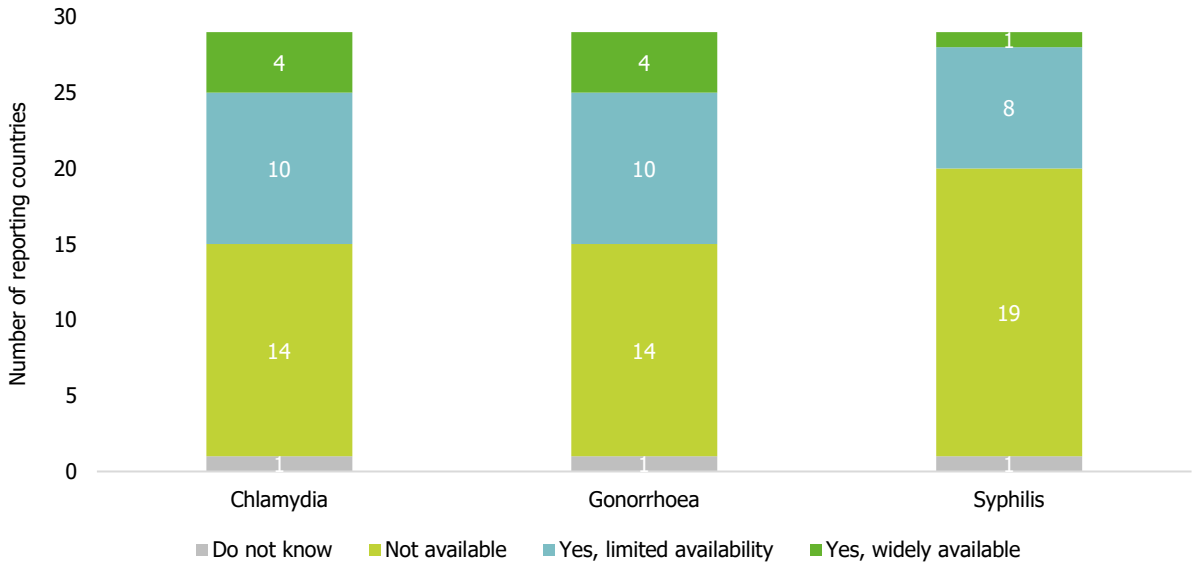
Out of 29 countries, eight reported having no restrictions on service providers who could legally carry out an STI test, while one country did not know. In all 20 countries that reported the presence of restrictions, medical doctors were able to carry out testing. In 11 of those 20 countries, nurses were able to carry out testing for chlamydia and gonorrhoea and in 14 countries for syphilis. Testing for chlamydia, gonorrhoea and syphilis could be legally performed by 'other' providers, such as midwives, in two countries[39]. Trained non-medical providers, such as community or social workers, were able to carry out testing for chlamydia and gonorrhoea in three countries[40], and testing for syphilis in five countries[41].

Availability of STI self-sampling

Self-sampling for STIs can be a complementary approach to strengthen STI testing delivery, particularly for population groups at elevated risk, who are in need of STI testing but face barriers to accessing traditional testing approaches and settings. Given the limited evidence on the effectiveness of linkage to care following STI self-sampling and self-testing, implementation of such approaches should include establishment of appropriate care pathways, and referral systems to ensure effective linkage to care for those who are newly diagnosed, including differentiated care pathways, as needed [33-36].

STI self-sampling at home was reported to be 'widely available' by only four countries for gonorrhoea and chlamydia, and one country for syphilis[42] (Figure 13). 'Limited availability' of STI self-sampling was reported by an additional 10 countries for chlamydia and gonorrhoea[43] and eight countries[44] for syphilis.

Figure 13. Availability of self-sampling* for STIs at home, by infection, in the EU/EEA (n=29), 2024



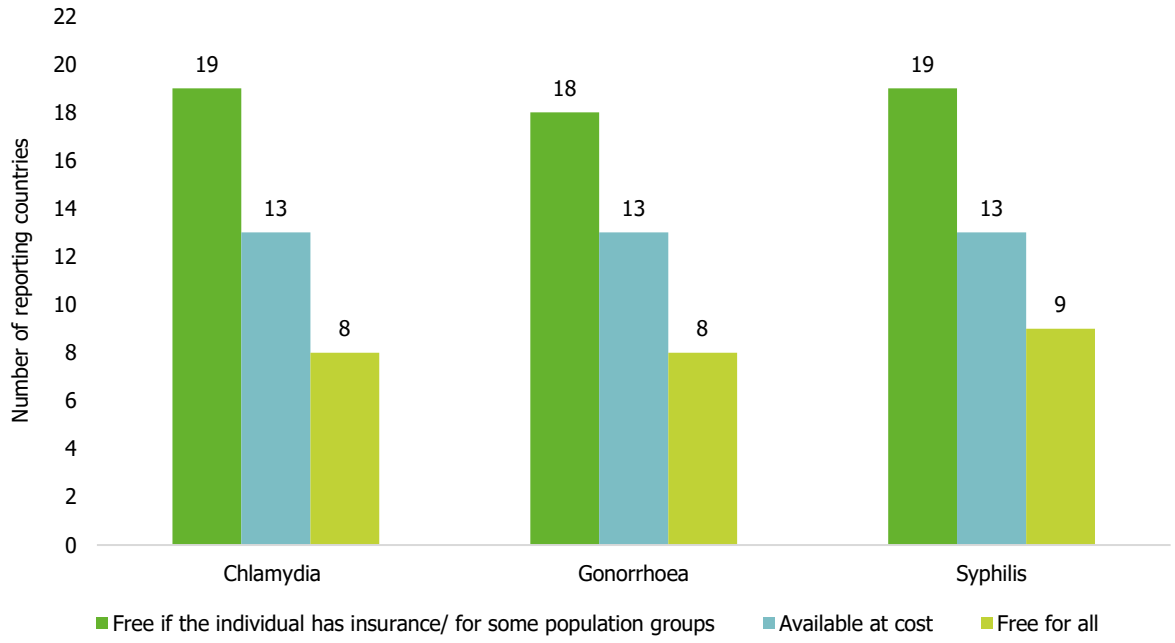
** Self-sampling: when the individual collects any of the following from themselves using a suitable kit: urine, finger-prick blood, vaginal, throat or rectal swab, typically outside of healthcare settings. The sample is then delivered to a designated laboratory for processing. Results are usually delivered by phone, text message or online, with referral mechanisms in place to ensure linkage to treatment and care, as appropriate.*

[39] Austria, Estonia.
[40] Croatia, Spain, Sweden.
[41] Belgium, Croatia, Cyprus, Luxembourg, Portugal.
[42] Chlamydia and gonorrhoea: Ireland, Netherlands, Norway and Sweden. Syphilis: Ireland only.
[43] Austria, Belgium, Bulgaria, Croatia, Denmark, Estonia, Finland, Germany, Poland, Romania.
[44] Austria, Belgium, Bulgaria, Germany, Netherlands, Norway, Poland, Romania.

Cost of STI testing

Approximately one-third of 29 EU/EEA countries reported that STI testing for chlamydia, gonorrhoea and syphilis was free to all individuals (Figure 14).

Figure 14. Cost to the individual of being tested for STIs, by infection, in the EU/EEA (n=29*), 2024



** Countries were able to choose more than one response option.*

Testing for gonorrhoea

As part of reporting to ECDC on the 'Response plan to control and manage the threat of multi- and extensively drug-resistant gonorrhoea in Europe' [8], with data from 2023, countries were asked to estimate the proportion of STI clinics that had access to gonococcal nucleic acid amplification tests (NAATs). Estimates ranged from 9% to 100% across 25 countries, with a mean of 88.8%. Multiple countries highlighted increased use of NAATs as the primary diagnostic method, which has decreased the availability of samples for culture and antimicrobial susceptibility testing (AST). The estimated proportion of STI clinics that had access to culture and antimicrobial susceptibility testing ranged from 0% to 100% across 24 countries reporting data with an average of 82.6%. The median was 100%, indicating that clinics in a subset of countries have little or no access to culture and AST.

The proportion of all reported gonorrhoea cases that were tested with culture and AST ranged from 0% to 80% across 21 countries that provided data, with an average of 29.5%. The median for this indicator was 30%, indicating that multiple countries estimated low proportions of cases were being tested with culture and AST.

STI testing numbers

Data on number of tests performed are crucial for putting STI notification rates in context. The data can facilitate comparison of notification rates across EU/EEA countries as these are partly related to testing volumes and which populations are tested. Having data on testing numbers over time facilitates the understanding of trends in STI case notification since observed increases or decreases may be related to changes in testing. Testing data on different population groups can also provide information on coverage and service delivery. By 2025, the WHO European Regional Action Plan interim targets for STI testing aim for over 20% of priority populations to be screened for gonorrhoea, 80% for syphilis and 95% of pregnant women for syphilis [12]. The WHO Regional Action Plan states that 'Priority populations should be defined by countries based on their epidemiological and social contexts'.

EU/EEA countries were asked to provide data on the total number of gonorrhoea and syphilis tests performed during a calendar year from routine programme or surveillance data. The most recent available data on the total number of tests performed were provided by 11 countries[45] for gonorrhoea and eight countries[46] for syphilis. As there were limitations with the availability and quality of different data sources at local and national levels, most countries used a combination of data sources (e.g. surveillance, programme, laboratory, insurance reimbursement) to report on the total number of STI tests.

Countries were also asked to provide available data on the proportion of different priority population groups tested for gonorrhoea and syphilis[47]. For the purposes of ECDC's STI monitoring data collection, countries were asked specifically about gbMSM and young people (aged 15–24 years) for gonorrhoea and gbMSM and pregnant women for syphilis. Countries were also given the option to add coverage data on any other population, if available, such as people living with HIV, sex workers, migrants or transgender people. Data availability and completeness were low for the proportion of any population group tested, with fewer than five countries able to report on any one population group. These data were therefore insufficient to measure progress towards the 2025 WHO European Regional Action Plan STI testing coverage targets (Table 4).

It is worth noting that only four countries (Denmark, France, Germany and Portugal) were able to provide data on the percentage of pregnant women screened for syphilis, which is of concern, given the increasing rates of syphilis among women and diagnosed cases of congenital syphilis in the EU/EEA [3, 37]. In these four countries, coverage of STI testing among pregnant women was >95%, except in Portugal where it was 50%.

Table 4. Indicators, programme coverage targets and status of STI testing in the EU/EEA (2024)

Indicator	2020 baseline	2025 target	2030 target	2024 status
Percentage of priority populations* screened for gonorrhoea	No data	>20%	>90%	gbMSM: 47%; one country exceeded 2025 target[a] Young people aged 15–24 years: 9–24%; two countries exceeded 2025 target[b] PLHIV: 87%; one country exceeded 2025 target[c]
Percentage of pregnant women attending antenatal care who were screened for syphilis	94%	>95%	>95%	50–99%; three countries exceeded 2025 target[d]
Percentage of priority populations* screened for syphilis	No data	>80%	>90%	gbMSM: 0–51%; no country reached 2025 target[e] Migrants: 2%; no country reached 2025 target[f] PLHIV: 5%; no country reached 2025 target[g].

** Priority populations should be defined by countries based on their epidemiological and social contexts.*

[a] *In one country with available data*
[b] *In four countries with available data*
[c] *In one country with available data*
[d] *In four countries with available data*
[e] *In two countries with available data*
[f] *In one country with available data.*

2025 target met or exceeded

2025 target not met

No or insufficient data available

[45] Belgium, Denmark, France, Greece, Iceland, Liechtenstein, Lithuania, Malta, Netherlands, Norway, Sweden.
[46] Belgium, France, Greece, Liechtenstein, Lithuania, Malta, Netherlands, Romania.
[47] Countries were given the option to only enter data on the proportion or number tested, if that was all that was available.

The STI monitoring questionnaire included open-text fields where countries could describe barriers to reporting total testing numbers. Common challenges included lacking surveillance data beyond the total number of laboratory-confirmed positive tests, information technology (IT) and data management issues, as well as insufficient resources or legal mandates to collect and analyse such testing data at national level.

While a limited number of countries could provide data on testing coverage, survey data from EMIS–2024 showed that the proportion of gbMSM with non-steady partners who received an STI test in the past 12 months ranged from 37.5% to 80% across countries. The proportion who reported that they had been tested for syphilis was much lower, ranging from <3% to 14.1%, with no country meeting the target of >80% for syphilis [12].

National policy or guidance for managing the partners of individuals with STIs

Partner management is the process of identifying the contacts of a person with an STI, and referring them to a healthcare provider for appropriate management [38]. Partner management delivery approaches are intended to facilitate early detection, timely intervention, and help curb further transmission in networks with greater exposure to STIs.

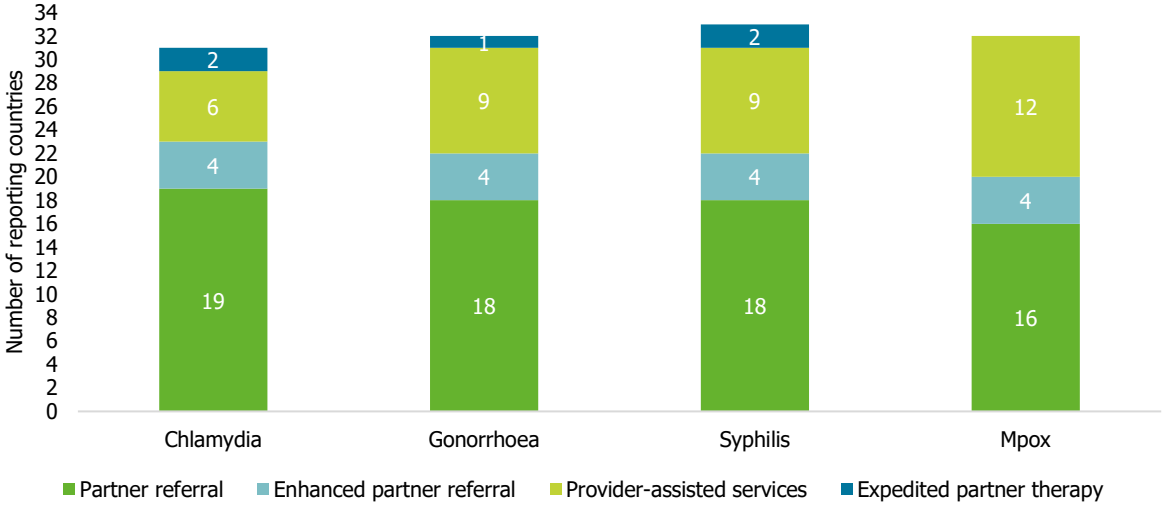
WHO methods for delivering partner services [36]

- **Partner referral:** Trained providers encourage clients to suggest testing to their partners, with or without disclosing their status. Providers advise clients on the need for partners to get tested, strategies for disclosing safely, and where and how partners can obtain testing, prevention services and treatment.
- **Enhanced partner referral:** Trained providers use various support tools (written information, referral slips, web-based messaging, provision of HIV self-testing kits) to facilitate the offer of testing clients to their partners, with or without disclosing their status.
- **Delayed assisted partner services:** Clients enter into an agreement with a trained provider to suggest testing to partners within an agreed period. If the partners do not access HIV testing services (HTS) or contact the provider within that period, the provider contacts the partners directly to offer voluntary HTS.
- **Provider-assisted services:** Trained providers ask clients about their partners and then, with the consent of the client, inform partners of their potential exposure. The provider then offers voluntary testing and additional services to partners.
- **Expedited partner therapy:** Clients diagnosed with one or more STIs are provided STI treatment, either prescriptions or medications, to deliver to their sex partners without requiring partners to receive examination by a health worker.

Twenty-one EU/EEA countries[48] reported having a national policy or guidance in place to manage the partners (sexual and/or drug injecting partners) of individuals with STIs. Countries were then asked if such strategies aligned with WHO methods for delivering partner services: partner referral, enhanced partner referral, delayed assisted partner services, provider-assisted services, or expedited partner therapy [36]. Partner referral and provider-assisted services were reported by most countries as the strategies used to deliver information to the partners of a client case with chlamydia, gonorrhoea, syphilis or mpox (Figure 15). No country reported delayed assisted partner services.

[48] Austria, Belgium, Croatia, Czechia, Denmark, Estonia, Finland, France, Greece, Hungary, Iceland, Ireland, Liechtenstein, Lithuania, Luxembourg, Netherlands, Norway, Romania, Slovenia, Spain and Sweden.

Figure 15. National policy or guidance for managing the partners* of individuals with STIs, by infection, in the EU/EEA (n=21)**



** Sexual and/or drug injecting partners*
*** Countries were able to choose more than one response option.*

3.4 Treatment

When left untreated, bacterial STIs such as chlamydia, gonorrhoea and syphilis can lead to serious health complications, including pelvic inflammatory disease or chronic pain. In addition, chlamydia and gonorrhoea can lead to infertility, while syphilis can cause neurological and cardiovascular issues. Untreated syphilis infection in a mother during pregnancy can lead to serious adverse outcomes affecting her child [2-4, 37].

By 2025, the WHO European Regional Action Plan interim milestones related to STI treatment aim for over 90% of countries having national STI case management guidelines updated within the past three years and reporting AMR in *N. gonorrhoeae* to the European Gonococcal Antimicrobial Surveillance Programme (Euro-GASP), while achieving treatment coverage targets of >90% of individuals within priority populations treated if positive for gonorrhoea and syphilis, and >95% of pregnant women treated if positive for syphilis [12].

EU/EEA country reporting on a selection of the treatment indicators from the STI monitoring data are presented below, with a detailed summary of national STI treatment guidelines or recommendations and treatment coverage data for gonorrhoea and syphilis among specific population groups. This reporting is supplemented with relevant information and 2023 data collected by ECDC on the 'Response plan to control and manage the threat of multi- and extensively drug-resistant gonorrhoea in Europe' as part of Euro-GASP, and from EMIS−2024 [8,21,39].

National STI treatment guidelines or recommendations

Countries were asked whether they had national treatment guidelines or recommendations for chlamydia, gonorrhoea, syphilis and *M. genitalium*, and the corresponding years of publication. Countries without national STI treatment guidelines that reported following international guidelines were asked to provide further details.

Based on country reporting, the 2025 WHO European Regional Action Plan target of >90% of countries with national STI treatment guidelines or recommendations updated in the past three years was not met for chlamydia (38%; 11 of 29 countries), gonorrhoea (45%; 13 of 29 countries), syphilis (41%; 12 of 29 countries) and *M. genitalium* (59%; 17 of 29 countries) (Table 5).

The policy environment related to treatment

Among the 29 EU/EEA countries with information on treatment guidelines or recommendations, most had stand-alone national treatment guidelines or recommendations for chlamydia, gonorrhoea and syphilis (10 countries), or integrated guidelines/recommendations (nine countries for chlamydia and gonorrhoea, and 10 countries for syphilis) whereas some countries followed international guidelines (Annex 6). The use of national guidelines was less common for *Mycoplasma genitalium*. (Figure 16). Treatment guidelines from IUSTI-Europe [40-43] and US CDC [44] were cited by most countries that stated they follow international recommendations, in addition to WHO STI treatment guidelines [45-47]. It is worthing noting that in the months following the end of ECDC STI monitoring data collection, IUSTI-Europe published updated chlamydia case management guidelines for 2025 [48].

Reporting of AMR in *N. gonorrhoeae* to Euro-GASP

According to the latest available information on the indicators in the 'Response to control and manage the threat of multi- and extensive drug-resistant gonorrhoea in Europe' [39], the >90% target of countries reporting AMR in *N. gonorrhoeae* to Euro-GASP was not met: only 23 of 30 (77%) EU/EEA countries participate in Euro-GASP reporting (Table 5).

Percentage of priority populations screened positive and treated for gonorrhoea and syphilis

The number of countries reporting the proportion of screen-positive population groups treated for gonorrhoea and syphilis was generally insufficient to measure progress against the respective WHO European Regional Action Plan interim targets for 2025 (Table 5). The only exception was for treatment coverage among young people (aged 15–24 years) for gonorrhoea where five countries[49] had data and three[50] reported exceeding the >90% target of screen-positive young people treated for gonorrhoea.

Table 5. Milestone, indicators, programme coverage targets and status for treatment of STIs in the EU/EEA (2024)

Indicator	2020 baseline	2025 target	2030 target	2024 status
Milestone: percentage of countries with national STI case management guidelines updated within the past three years	79%	>90%	>95%	Chlamydia: 38% (11 countries) reached 2025 milestone[a]
				Gonorrhoea: 45% (13 countries) reached 2025 milestone[a]
				Syphilis: 41% (12 countries) reached 2025 milestone[a]
				M. genitalium: 59% (17 countries) reached 2025 milestone[a]
Number of countries reporting AMR in *Neisseria gonorrhoeae* to Euro-GASP	82%	>90%	>95%	77% (23 countries) participating in Euro-GASP[b]
Percentage of priority populations* screened-positive for gonorrhoea and receive treatment	No data	>90%	>95%	Gay, bisexual, and other men who have sex with men: 81–98%; one country exceeded 2025 target[c]
				Young people aged 15–24 years: 7–100%; three countries exceeded 2025 target[d]
				Sex workers: 100%; one country exceeded 2025 target[e]
				Trans people: 82–100%; one country exceeded 2025 target[f]
				People living with HIV: 95–100%; two countries exceeded 2025 target[g]
Percentage of pregnant women attending antenatal care who screened positive for syphilis and were treated	94%	>95%	>95%	100%; one country exceeded 2025 target[h]
Percentage of priority populations* screened positive for syphilis and receiving treatment	No data	>90%	>95%	Gay, bisexual, and other men who have sex with men: 97–100%; two countries exceeded 2025 target[i]
				Migrants: 100%; one country exceeded 2025 target[j]
				People living with HIV: 17–100%; one country exceeded 2025 target[k]

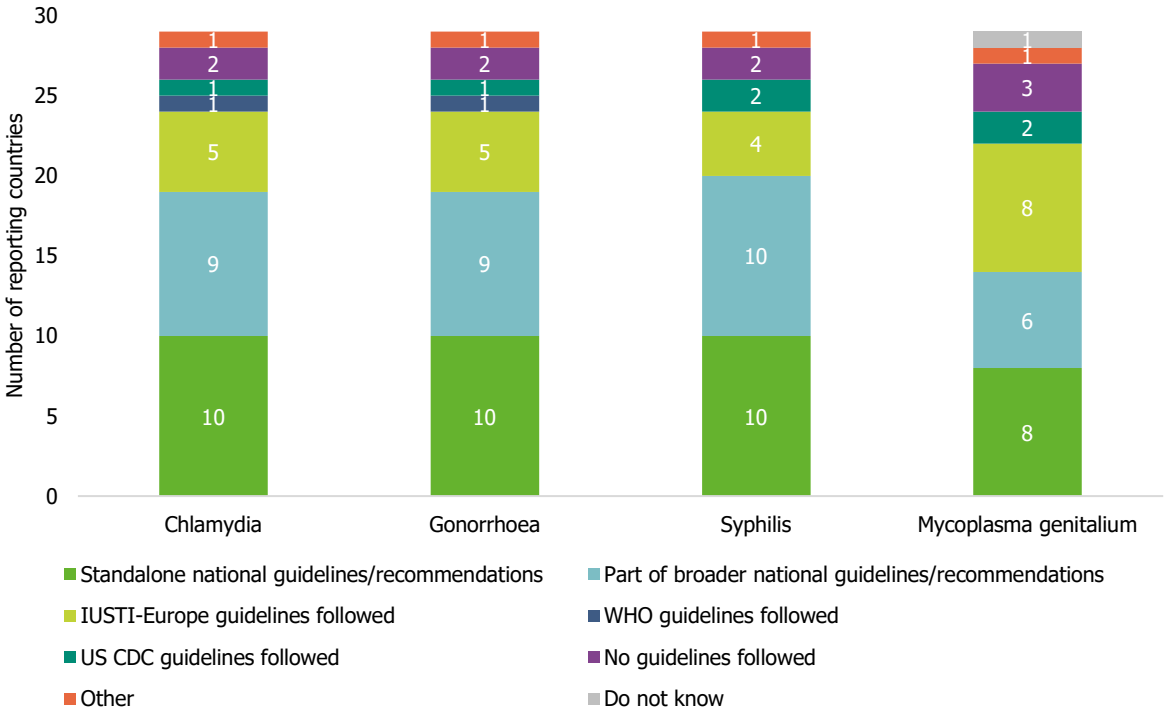
** Priority populations should be defined by countries based on their epidemiological and social contexts.*

[a] *In 29 EU/EEA countries that responded to the STI monitoring questionnaire*
[b] *In 30 EU/EEA countries*
[c] *In two countries with available data*
[d] *In five countries with available data*
[e] *In one country with available data*
[f] *In two countries with available data*
[g] *In two countries with available data*
[h] *In one country with available data*
[i] *In two countries with available data*
[j] *In one country with available data*
[k] *In two countries with available data.*

2025 target met or exceeded | 2025 target not met | No or insufficient data available

[49] Czechia, Denmark, Iceland, Malta, Romania.
[50] Czechia, Iceland, Malta.

Figure 16. National guidelines or recommendations for STI treatment, by infection, in the EU/EEA (n=29), 2024



Gonorrhoea treatment

Nineteen countries provided information on national guidelines or recommendations for the treatment of uncomplicated gonorrhoea cases. Eleven countries[51] reported that the guidelines include routine antimicrobial susceptibility testing, and ten countries[52] reported that the guidelines include a test of cure (repeat test after completion of treatment).

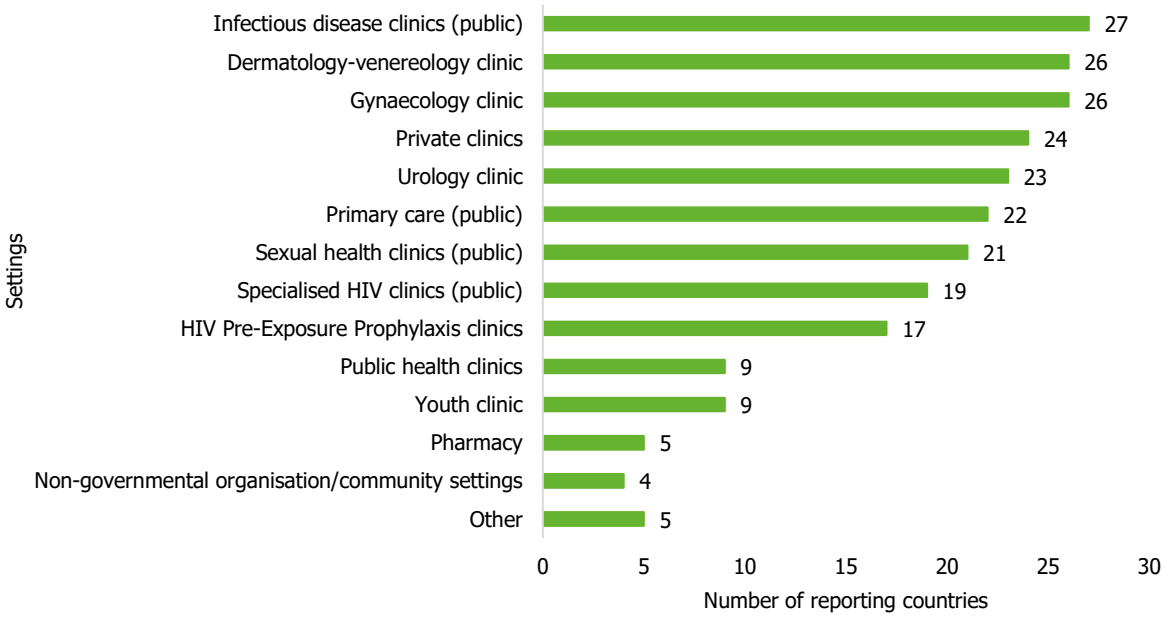
As part of 2023 reporting to ECDC on the 'Response plan to control and manage the threat of multi- and extensively drug-resistant gonorrhoea in Europe', 27/27 (100%) of countries with patient management guidelines recommended first-line antimicrobial agents for the treatment of uncomplicated gonorrhoea infections that were described in the 2020 EU/EEA treatment guidelines (ceftriaxone monotherapy or ceftriaxone and azithromycin dual therapy) [41]. Only 16/30 (53.3%) of countries were able to estimate the percentage of patients who received the recommended gonorrhoea treatment. The percentages of patients receiving recommended gonorrhoea treatment ranged from 8% to 100%, with an average of 78.1%. The median for this indicator was 90%, indicating relatively high adherence to treatment guidelines in most countries.

STI treatment access and availability

EU/EEA countries were asked to provide information on indicators related to STI treatment access and availability – i.e. on the settings where STI treatment is available and the cost to an individual to be treated for an STI. Among the 29 reporting countries, 27 noted that STI treatment is available in infectious disease clinics, followed by dermatology-venerology and gynaecology clinic settings in 26 countries (Figure 17). 'Other' settings where STI treatment is available, reported by five countries[53], included emergency/hospital settings, via home self-testing or self-sampling services, and specialised clinic settings. It is interesting to note that treatment was only available in NGO/community settings in four[54] countries. Just under one-third of 29 EU/EEA countries reported that STI treatment was free (no cost) to all individuals for chlamydia, gonorrhoea and syphilis.

[51] Austria, Czechia, Denmark, Estonia, Finland, Germany, Greece, Hungary, Iceland, Ireland, Netherlands.
[52] Austria, Czechia, Denmark, Finland, Germany, Greece, Hungary, Iceland, Ireland, Lithuania.
[53] France, Ireland, Liechtenstein, Norway, Portugal.
[54] Austria, Germany, Luxembourg, Slovenia.

Figure 17. Settings where STI treatment is available, in the EU/EEA (n=29*), 2024



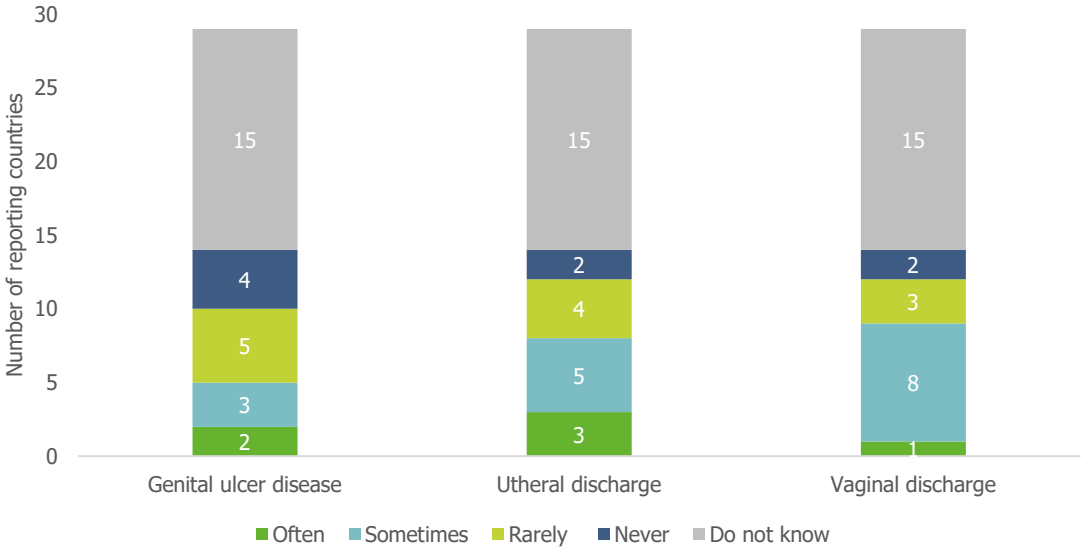
** Countries were able to choose more than one response option.*

Syndromic treatment of STIs

Syndromic STI treatment is a clinical approach that treats STIs based on symptoms without any testing. This is different from starting empirical treatment based on symptoms and then following with laboratory confirmation. Syndromic treatment is not recommended as it may lead to overuse or inappropriate use of antibiotics, potentially contributing to antimicrobial resistance.

Some EU/EEA countries reported that syndromic treatment was used 'sometimes' or 'often' (five countries for genital ulcer disease[55], eight for urethral discharge[56] and nine for vaginal discharge[57]). However, half of the 29 reporting EU/EEA countries reported not knowing about the frequency of syndromic treatment of STIs based on clinical indications such as genital ulcer disease, urethral discharge, or vaginal discharge (Figure 18).

Figure 18. Frequency of syndromic treatment* of STIs, by clinical indication, in the EU/EEA (n=29), 2024



** i.e. treated on the basis of symptoms only and without any testing. This does not apply to cases that are started on treatment while waiting for test results.*

[55] Austria, Bulgaria, Greece, Hungary, Ireland.
[56] Austria, Bulgaria, Cyprus, Czechia, Greece, Hungary, Ireland, Italy.
[57] Austria, Bulgaria, Cyprus, Czechia, Greece, Hungary, Ireland, Italy, Norway.

STI treatment numbers

In addition to the proportion of different population groups treated for gonorrhoea and syphilis, EU/EEA countries were asked to provide the total number of screen-positive people treated (Table 5). Data availability and completeness were low for the total STI treatment numbers, with only eight countries able to report information on the total number of screen-positive people treated for gonorrhoea[58] and four countries[59] on the total number of screen-positive people treated for syphilis infection.

The STI monitoring questionnaire included open-text fields where countries could describe barriers to reporting total treatment numbers for gonorrhoea and syphilis. Common challenges included lacking surveillance data beyond the total number of laboratory-confirmed positive tests, information technology and data management issues, and insufficient resources or legal mandates to collect and analyse such treatment data at national level. Additional treatment data barriers included a lack of centralised data systems and incomplete non-mandatory reporting.

Data from EMIS−2024 show that among gbMSM diagnosed with gonorrhoea, the proportion treated ranged from 87.2% to 100% across 20 countries with a sufficient sample size. Of these, 19 met the 2025 target of >90% treated. The proportion treated for syphilis ranged from 92.8% to 100% across 17 countries with a sufficient sample size, with all 17 exceeding the 2025 target of >90% of those diagnosed treated.

Shortages of antibiotics for STIs

Eight countries[60] reported experiencing shortages of benzathine penicillin for treatment of syphilis, however none reported or were aware of any evidence that this has affected treatment of syphilis among pregnant women. Eleven countries[61] reported shortages of other antibiotics for STI treatment, with most specifying shortages of spectinomycin. It should be noted that the question did not specify a specific timeframe for experiencing shortages of antibiotics for STIs, however those providing additional information noted that the shortages occurred in recent years (ranging from 2018 to 2024).

[58] Czechia, Denmark, France, Iceland, Ireland, Malta, Norway, Romania.
[59] Czechia, France, Iceland, Romania.
[60] Belgium, Bulgaria, Czechia, Greece, Italy, Luxembourg, Netherlands, Spain.
[61] Austria, Belgium, Czechia, Denmark, France, Germany, Hungary, Ireland, Italy, Netherlands, Norway.

4 Limitations

This first collection of STI monitoring data is subject to several limitations.

Data were entered by nominated focal points in each EU/EEA country. While focal points were able to consult with other experts in the countries, the extent to which this happened probably varied. It is possible that there are more data available than what the nominated focal points were able to access, for example in clinical databases or academic settings.

The low number of countries reporting available numerical data on coverage indicators (e.g. proportion of condom use, vaccinated, tested and treated) hindered the ability to draw conclusions on EU/EEA progress towards the WHO European Regional Action Plan 2025 STI targets. Furthermore, the numerical data provided by countries often varied in size, data source and timeframe and therefore could not be used to make any country comparisons. As a result, interpretation of findings on coverage indicators should be approached with caution as this may not reflect actual condom use behaviour or access to vaccination, testing and treatment.

As previously noted within this report, many countries face barriers to provide available national data on the total STI testing and treatment numbers for gonorrhoea and syphilis. Contributing factors, as reported by countries, included information technology (IT) and data management issues, insufficient resources or legal mandates to collect and analyse such data at national level, and lack of surveillance data beyond the total number of laboratory-confirmed positive tests. Additional barriers specific to STI treatment numbers included a lack of centralised data systems and incomplete non-mandatory reporting. A further challenge, specific to estimating testing coverage among priority populations, is the need to define the size of these populations [49,50].

This cross-sectional questionnaire presents what is known about relevant policies for respondent countries during the data collection period, and it is therefore possible that the policy situation has changed for some countries since the 2024 data collection took place. In addition, collected information does not include information on the quality of the prevention, testing and care offered in and between countries.

5 Conclusions

This report presents the key results from ECDC's first ever STI monitoring data collection with EU/EEA countries on policies and programme coverage related to enabling environments, prevention, testing and treatment of STIs.

Enabling environment: Eighteen EU/EEA countries had a national STI prevention and control strategy, plan or policy in place, whether stand-alone or integrated. Given the considerable increases in STI notifications among young people and gay, bisexual, and other men who have sex with men recently, it is encouraging that almost all of the reporting EU/EEA countries with national STI prevention and control plans include a focus on these populations. However, only ten national STI prevention and control strategies, plans or polices were recent enough to meet the 2025 WHO European Regional Action Plan interim milestone on national STI plans updated within the past five years. Only one-third of countries had a stand-alone or integrated national plan to control MDR/XDR gonorrhoea.

- Countries should ensure that they have an up-to-date national strategy, plan or policy for the prevention and control of STIs, whether standalone or integrated into another broader strategy. For integrated strategies, it is recommended that a stand-alone STI action plan should be added to ensure enough specific focus on STIs [1,12].
- STI prevention and control strategies, plans or policies should use up-to-date evidence from surveillance data, prevalence surveys and other available information to ensure that populations at increased risk of acquiring STIs are covered by prevention services and have access to testing and treatment.
- Countries should ensure that an action plan to control MDR/XDR gonorrhoea is adopted, either as a stand-alone plan or integrated into other strategies [8,12].

In some countries, there are legal restrictions in place to receive STI testing without parental consent that may limit access to testing for young people.

- It is recommended that the legal environment serves to enable people accessing STI testing – this includes removing punitive laws and the requirement for parental consent which may be a barrier for young people under 18 years of age to access STI testing.

Prevention: A majority of EU/EEA countries had policies for vaccination among gbMSM against mpox (24 countries) and HAV (20 countries), but less than half for HPV (12 countries). Using survey data from EMIS−2024, vaccination coverage across the EU/EEA for all three vaccines is generally low, with a great deal of heterogeneity.

- In the light of more frequent outbreaks of non-traditional STIs among gbMSM, it is important to ensure that those at increased risk of infection are vaccinated with the full course of HAV and mpox vaccines in particular. ECDC's guidance on HIV and STI prevention among gbMSM suggest that countries consider promoting and delivering vaccination to protect against hepatitis A and B viruses and consider vaccination against HPV [25]. Gender neutral HPV vaccination is now routinely recommended in the national vaccination programmes across the EU with gender neutral catch up programmes [51].

Only around half of EU/EEA countries reported having education policies that guide the delivery of comprehensive HIV and sexuality education at different levels of educational settings. Data on coverage of condom use among different populations are limited, as are behavioural surveillance data over time which are needed to understand drivers of changing trends and to guide prevention programmes [19].

- Countries should ensure that there are policies to deliver comprehensive HIV and sexuality education across educational settings [31].
- Good data on risk behaviour are key to help guide prevention messages. It should therefore be a priority to carry out regular behavioural surveillance among groups at increased risk for STIs [19].

Testing: Over half of countries had a national STI testing strategy, policy or other recommendations in place or follow international guidelines. With regard to access and availability, STI testing was available across a range of settings in many countries, with almost all reporting countries indicating that testing is available in gynaecology clinics, dermatology-venerology clinics and infectious disease clinics and, importantly, STI testing was available in NGO/community settings in 23 countries. This is encouraging for access to STI testing. However, in many countries, service providers other than medical doctors could not independently carry out STI testing, and there appears to be little or no availability of STI self-sampling. Furthermore, STI testing is still associated with a cost for the individual in many countries.

- Countries are recommended to have up-to-date national STI testing strategies, policies or recommendations and to ensure that population groups at increased risk for STIs have adequate access to testing [12].
- Removing barriers to testing, including cost of testing to the individual, ensuring that a variety of settings offer STI testing, and implementing policies so that service providers other than medical doctors can carry out testing could increase access and availability [33, 36, 52].

In light of increasing rates of syphilis and congenital syphilis in the EU/EEA [3, 37], implementation of national antenatal screening policies is of particular importance. Around half of EU/EEA countries did not indicate a policy of repeat testing for syphilis in the third trimester for pregnant women at risk, and only 11 countries reported having a policy of testing at the time of delivery, if not done before. It is particularly noteworthy that, while almost all countries had antenatal screening policies in place, only four were able to submit data on the proportion of pregnant women screened for syphilis.

- Countries are recommended to update their policy for syphilis testing in pregnancy to ensure repeat testing of women with risk factors and testing at the time of delivery, if not done before [42,53].
- Countries are encouraged to monitor the coverage of syphilis testing of pregnant women [12].

In two-thirds of reporting countries, regular asymptomatic screening every 3–6 months is common among HIV PrEP users for all three bacterial STIs, with a substantial proportion of countries reporting rectal and oropharyngeal testing in this population in addition to urogenital testing for chlamydia and gonorrhoea. The WHO guidelines for the management of asymptomatic STIs published in 2025, recommend offering testing, in particular for chlamydia and gonorrhoea, to individuals from priority populations that access healthcare facilities, depending on local epidemiology [54]. In the EU/EEA, research groups in several countries are reconsidering the benefits (and harms) of regular testing for chlamydia and gonorrhoea among gbMSM using pre-exposure prophylaxis for HIV [55], and of asymptomatic chlamydia among young people [56]. Planned work by ECDC on asymptomatic testing will collect evidence to support policy decision-making across EU/EEA countries.

Sufficient data on testing numbers and coverage would help provide context to STI notification numbers, however only around a third of countries were able to provide these data. Data on population coverage of testing are also needed to understand current testing practices and whether populations are optimally covered by testing efforts, including having data to inform considerations on asymptomatic testing. However, fewer than five countries were able to submit data on the proportion of priority populations screened for gonorrhoea or syphilis.

- Countries are encouraged to collect data on the number of STI tests performed, including information on the anatomical site of testing which can be vital for both understanding trends in STI notifications and ensuring adequate testing of groups at increased risk.

With regards to gonorrhoea, while most countries reported that a majority of clinics had access to antimicrobial susceptibility testing, a low proportion of cases received antimicrobial susceptibility testing, according to data collected by Euro-GASP. Around a third of countries had a policy of recommending a test of cure for gonorrhoea. Both antimicrobial susceptibility testing and test of cure are recommended by IUSTI [41] to monitor rates of AMR and detect treatment failures.

- Countries should work towards increasing the number of gonorrhoea isolates tested for antimicrobial susceptibility and offering patients a test of cure [8].

Treatment: While almost all EU/EEA countries have national or international case management guidelines in place for chlamydia, gonorrhoea, syphilis and *M. genitalium*, the WHO European Regional Action Plan interim milestone on national STI case management guidelines for 2025 was not achieved for several countries, as the plans and guidelines had not been updated within the three-year timeframe milestone at the time of data collection. It should be noted that IUSTI-Europe guidelines are often updated every five years, or any time that emerging evidence requires an update of clinical recommendations. In early 2025, IUSTI-Europe updated their guidelines for chlamydia [48] which will be taken into account in future rounds of monitoring data collection.

Twenty-nine EU/EEA countries recommended first line treatment for uncomplicated gonorrhoea in line with IUSTI-Europe recommendations, although only half were able to assess what proportion of cases received this treatment. The EU/EEA average of the proportion of cases tested with culture and antimicrobial susceptibility testing is low.

STI treatment is available in a variety of settings, although generally not in NGO/community settings, indicating a concern that those tested in these settings may not be able to access treatment as easily. Very few countries were able to submit data on treatment coverage, but data on gbMSM from EMIS–2024 is encouraging, with the majority of gbMSM surveyed having been treated, if diagnosed with gonorrhoea or syphilis.

- Countries should ensure that up-to-date national treatment guidelines or recommendations are in place, guided by AMR patterns, and to monitor the degree to which treatment guidelines are followed. Collaboration with clinical societies can serve both to promote the treatment guidelines and also to improve reporting channels and sharing of data on treatments used and treatment coverage.

Data gaps: Across areas, there are several indicators where very few countries were able to submit data, including on coverage indicators related to condom use, testing and treatment. While results here should be interpreted with caution, they constitute useful information allowing experts to gain an overview of where efforts are required to improve data collection methods in order to tailor and evaluate areas for public health information. It is therefore important to note that the lack of EU/EEA country data availability and completeness for indicators related to STI testing and treatment coverage targets signals the need for improved data collection, rather than just a lack of progress.

Across action areas, collaboration and partnerships are key to ensure policies are in place and followed, and to support the collection of robust, up-to-date data. This includes collaboration between different stakeholders in the field of STIs, including public health authorities, laboratories, clinical bodies, and civil society and community-based organisations. Working with clinical bodies in particular is important for improving practices concerning the use of correct treatment, antimicrobial susceptibility testing and test of cure.

ECDC will work to review and refine the STI monitoring indicators collected, including considering which of the STI targets in the WHO Regional Action Plan are priorities for EU/EEA countries. The wording of some items will need further refinement and indicators may in future be disaggregated by pathogen or population to more adequately reflect the complexity of some subjects. Other ECDC work in the near future may also contribute to improving data gaps – including work on new standards for surveillance data and on standards of care for antenatal screening,

The goal is that the current and future monitoring rounds will serve to provide data that can help countries, ECDC and other stakeholders work towards ending STIs as a public health concern.

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Annex 1. Supplementary STI indicators from existing sources

Data source	Indicator	Details
ECDC	• Presence of sexual health programmes in schools • Number and proportion of (gay, bisexual, and other men who have sex with men, sex workers, trans people, people who inject drugs, migrants) reporting using a condom the last time they had sexual intercourse.	Dublin Declaration monitoring
	Countries that have carried our behavioural surveillance surveys, and in which year(s).	Mapping and review: harnessing sexual behaviour survey data for the prevention of sexually-transmitted infections
ECDC-WHO Regional Office for Europe	Number of mpox infections among gay, bisexual, and other men who have sex with men.	Joint ECDC-WHO Regional Office for Europe Mpox Surveillance Bulletin
European Gonococcal Antimicrobial Surveillance Programme (Euro-GASP)	• Number and proportion of EU/EEA countries participating in Euro-GASP. • Presence of a national representative isolate collection • Number of countries offering national training modules (laboratory and/or clinical). • Proportion of all STI clinics (sentinel sites) that have access to culture and antimicrobial susceptibility testing. • Proportion of all (reported) gonorrhoea cases tested with culture and with antimicrobial susceptibility results available. • Proportion of patients who received recommended gonorrhoea treatment. • Online reporting template for probable and confirmed treatment failures developed. • Number of verified gonorrhoea treatment failures reported to ECDC. • Adoption of a national plan to control MDR/XDR NG or inclusion of MDR/XDR NG in gonorrhoea, STI, sexual health or other relevant strategy. • Number of peer-reviewed publications or other communications on antimicrobial-resistant NG from Euro-GASP.	Response plan to control and manage the threat of multi-and extensively drug-resistant gonorrhoea in Europe - Indicator monitoring 2019
European Men-Who-Have-Sex-With-Men and trans women Internet Survey (EMIS)	Coverage of self-reported vaccination among gbMSM for hepatitis A virus, human papillomavirus and mpox.	EMIS 2024

Annex 2. Data completeness

Below is a summary of how many EU/EEA countries were able to provide any information or data within the 2024 STI monitoring questionnaire related to the WHO European Regional Action Plan STI milestones, indicators and programme coverage targets [12]. These results have been presented in the tables within the corresponding STI monitoring report sections.

Enabling environment				
STI monitoring questionnaire indicator	**Number of countries eligible to respond**	**Total responses**	**Missing responses**	**Completeness (%)**
Q2.1 Percentage of countries with available information on a national STI strategy	30	29	1	97%

Enabling environment				
STI monitoring questionnaire indicator	**Number of countries eligible to respond**	**Total responses**	**Missing responses**	**Completeness (%)**
Q2.1 Percentage of countries with available information on a national STI strategy	30	29	1	97%

Testing				
STI monitoring questionnaire indicator	**Number of countries eligible to respond**	**Total responses**	**Missing responses**	**Completeness (%)**
Q4.1 Percentage of countries with a national strategy, guidance or other recommendations on STI testing	30	29	1	97%
Q4.25.3 Percentage of countries with available data on overall gonorrhoea testing numbers	30	11	19	37%
Q4.26.7 Percentage of countries with available data on proportion of young people (aged 15-24 years) screened for gonorrhoea	30	4	26	13%
Q4.27.7 Percentage of countries with available data on proportion of gbMSM screened for gonorrhoea	30	1	29	3%
Q4.31.3 Percentage of countries with available data on overall syphilis testing numbers	30	8	22	27%
Q4.32.7 Percentage of countries with available data on proportion of gbMSM screened for syphilis	30	2	28	7%
Q4.33.9 Percentage of countries with available data on proportion of pregnant women screened for syphilis	30	4	26	13%

Treatment				
STI monitoring questionnaire indicator	**Number of countries eligible to respond**	**Total responses**	**Missing responses**	**Completeness (%)**
Q5.1.1 Percentage of countries with available information on national STI treatment guidelines or recommendations for gonorrhoea	30	29	1	97%
Q5.1.2 Percentage of countries with available information on national STI treatment guidelines or recommendations for chlamydia	30	29	1	97%
Q5.1.3 Percentage of countries with available information on national STI treatment guidelines or recommendations for syphilis	30	29	1	97%
Q5.1.4 Percentage of countries with available information on national STI treatment guidelines or recommendations for *mycoplasma genitalium*	30	28	2	93%
Q5.8.4 Percentage of countries with available data on overall gonorrhoea treatment numbers	30	6	22	20%
Q5.9.7 Percentage of countries with available data on proportion of screen-positive young people (aged 15-24 years) treated for gonorrhoea	30	5	25	17%
Q5.10.7 Percentage of countries with available data on proportion of screen-positive gbMSM treated for gonorrhoea	30	2	28	7%
Q5.14.4 Percentage of countries with available data on overall syphilis treatment numbers	30	4	26	13%
Q5.15.8 Percentage of countries with available data on proportion of screen-positive gbMSM treated for syphilis	30	2	28	7%
Q5.16.8 Percentage of countries with available data on proportion of screen-positive pregnant women treated for syphilis	30	1	29	3%

Annex 3. National strategy, plan or policy for the prevention and control of STIs in the EU/EEA, reported in 2024

Country	National strategy, plan or policy for the prevention and control of STIs	Year published	If no strategy, plans within next two years
Austria	No	N/A	Other*
Belgium	No	N/A	Yes
Bulgaria	Yes, integrated within broader strategy	2021	N/A
Croatia	Yes, integrated within broader strategy	2023	N/A
Cyprus	Under development	N/A	
Czechia	Yes, integrated within broader strategy	2021	N/A
Denmark	Yes, standalone	2015	N/A
Estonia	No	N/A	No
Finland	No	N/A	No
France	Yes, integrated within broader strategy	2017	N/A
Germany	Yes, integrated within broader strategy	2016	N/A
Greece	Under development	N/A	N/A
Hungary	Yes, integrated within broader strategy	1998	N/A
Iceland	No	N/A	Other*
Ireland	Yes, integrated within broader strategy	2015	N/A
Italy	Yes, integrated within broader strategy	2020	N/A
Latvia			
Liechtenstein	Yes, integrated within broader strategy	2023	N/A
Lithuania	Yes, standalone	2023	N/A
Luxembourg	Yes, integrated within broader strategy	2018	N/A
Malta	Yes, standalone	2024	N/A
Netherlands	Yes, standalone	2022	N/A
Norway	Yes, integrated within broader strategy	2017	N/A
Poland	Under development	N/A	N/A
Portugal	Yes, integrated within broader strategy	2011	N/A
Romania	Under development	N/A	N/A
Slovakia	No	N/A	No
Slovenia	No	N/A	Yes
Spain	Yes, integrated within broader strategy	2021	N/A
Sweden	Yes, integrated within broader strategy	2024	N/A

**Both Austria and Iceland reported considering developing a national STI prevention and control strategy but have no formal plans.*

Annex 4. Countries with available information on laws criminalising the transmission of, non-disclosure of, or exposure to STI transmission in the EU/EEA, reported in 2024

Country	Laws criminalising the transmission of, non-disclosure of or exposure to STI transmission
Austria	Yes
Belgium	No, but prosecution occurs based on general criminal laws
Bulgaria	Do not know
Croatia	No, but prosecution occurs based on general criminal laws
Cyprus	No, but prosecution occurs based on general criminal laws
Czechia	Yes
Denmark	No
Estonia	No, but prosecution occurs based on general criminal laws
Finland	No, but prosecution occurs based on general criminal laws
France	No, but prosecution occurs based on general criminal laws
Germany	Yes
Greece	Yes
Hungary	No, but prosecution occurs based on general criminal laws
Iceland	Yes
Ireland	No, but prosecution occurs based on general criminal laws
Italy	No, but prosecution occurs based on general criminal laws
Latvia	
Liechtenstein	No, but prosecution occurs based on general criminal laws
Lithuania	No, but prosecution occurs based on general criminal laws
Luxembourg	No
Malta	Do not know
Netherlands	No
Norway	Yes
Poland	Yes
Portugal	Yes
Romania	No, but prosecution occurs based on general criminal laws
Slovakia	No, but prosecution occurs based on general criminal laws
Slovenia	No, but prosecution occurs based on general criminal laws
Spain	No
Sweden	No

Annex 5. National STI testing strategy, guidance or recommendations in the EU/EEA, reported in 2024

Country	STI testing strategy, guidance or recommendations	Year of publication	Plans to develop within next two years
Austria	No, international recommendations are followed (national, Association of Scientific Medical Societies in Germany, IUSTI, US CDC)	2021-2024	N/A
Belgium	Yes, standalone	2019	N/A
Bulgaria	Yes, part of national strategy, guidance or policy	2021	N/A
Croatia	Under development	N/A	N/A
Cyprus	Under development	N/A	N/A
Czechia	Yes, part of national strategy, guidance or policy	2021	N/A
Denmark	Yes, standalone	2015	N/A
Estonia	Yes, part of national strategy, guidance or policy	2021	N/A
Finland	Yes, part of national strategy, guidance or policy	2024	N/A
France	Yes, part of national strategy, guidance or policy	2017	N/A
Germany	No, international recommendations are followed (WHO)	2023	N/A
Greece	Under development	N/A	N/A
Hungary	Yes, part of national strategy, guidance or policy	1998	N/A
Iceland	Yes, standalone	2023	N/A
Ireland	Yes, standalone	2023	N/A
Italy	No, international recommendations are followed (WHO)	2023	N/A
Latvia			
Liechtenstein	Yes, part of national strategy, guidance or policy	2023	N/A
Lithuania	Yes, part of national strategy, guidance or policy	2013	N/A
Luxembourg	No	N/A	No
Malta	No, international recommendations are followed (WHO)	2023	N/A
Netherlands	Yes, standalone	2024	N/A
Norway	Yes, part of national strategy, guidance or policy	N/A*	N/A
Poland	Under development	N/A	N/A
Portugal	Yes, part of national strategy, guidance or policy	2011	N/A
Romania	Yes, standalone	1992	N/A
Slovakia	No, international recommendations are followed (WHO)	2023	N/A
Slovenia	No, international recommendations are followed (IUSTI-Europe and US CDC)	2018 and 2024	N/A
Spain	Yes, part of national strategy, guidance or policy	2024	N/A
Sweden	Yes, part of national strategy, guidance or policy	2024	N/A

** The year of publication for the Norwegian digital infection control handbook content differs between STIs.*

Annex 6. National STI treatment guidelines or recommendations in the EU/EEA, reported in 2024

Country	Chlamydia	Year of publication	Gonorrhoea	Year of publication	Syphilis	Year of publication
Austria	Yes, standalone	2018	Yes, standalone	2021	Yes, standalone	2018
Belgium	Yes, part of broader guidelines/recommendations	2023	Yes, part of broader guidelines/recommendations	2023	Yes, part of broader guidelines/recommendations	2019
Bulgaria	No, international guidelines followed (IUSTI-Europe)	2015*	No, international guidelines followed (IUSTI-Europe)	2020	Yes, part of broader guidelines/recommendations	2017
Croatia	No, international guidelines followed (US CDC)	2021	No, international guidelines followed (US CDC)	2022	No, international guidelines followed (US CDC)	2024
Cyprus	No	N/A	No	N/A	No	N/A
Czechia	Yes, part of broader guidelines/recommendations	2021	Yes, part of broader guidelines/recommendations	2021	Yes, part of broader guidelines/recommendations	2021
Denmark	Yes, part of broader guidelines/recommendations	2015	Yes, part of broader guidelines/recommendations	2015	Yes, part of broader guidelines/recommendations	2015
Estonia	Yes, part of broader guidelines/recommendations	2021	Yes, part of broader guidelines/recommendations	2021	Yes, part of broader guidelines/recommendations	2021
Finland	Yes, standalone	2024	Yes, standalone	2024	Yes, standalone	2024
France	Yes, standalone	2021	Yes, standalone	2021	Yes, standalone	2021
Germany	Yes, standalone	2016	Yes, standalone	2018	Yes, standalone	2020
Greece	Yes, part of broader guidelines/recommendations	2022	Yes, part of broader guidelines/recommendations	2023	Yes, part of broader guidelines/recommendations	2022
Hungary	Yes, part of broader guidelines/recommendations	2024	Yes, part of broader guidelines/recommendations	2024	Yes, part of broader guidelines/recommendations	2024
Iceland	Yes, part of broader guidelines/recommendations	2023	Yes, part of broader guidelines/recommendations	2023	Yes, part of broader guidelines/recommendations	2023
Ireland	Yes, standalone	2024	Yes, standalone	2024	Yes, standalone	2024
Italy	No, international guidelines followed (IUSTI-Europe)	2015*	No, international guidelines followed (IUSTI-Europe)	2020	No, international guidelines followed (IUSTI-Europe)	2020
Latvia						
Liechtenstein	Yes, standalone	2019	Yes, standalone	2019	Yes, standalone	2017
Lithuania	Yes, standalone	2010	Yes, standalone	2011	Yes, standalone	2011
Luxembourg	No	N/A	No	N/A	No	N/A
Malta	No, international guidelines followed (IUSTI-Europe)	2015*	No, international guidelines followed (IUSTI-Europe)	2020	No, international guidelines followed (IUSTI-Europe)	2020
Netherlands	Yes, standalone	2024	Yes, standalone	2024	Yes, standalone	2024

Country	Chlamydia	Year of publication	Gonorrhoea	Year of publication	Syphilis	Year of publication
Norway	Yes, part of broader guidelines/recommendations	2024	Yes, part of broader guidelines/recommendations	2024	Yes, part of broader guidelines/recommendations	2022
Poland	Other (combination of national and IUSTI-Europe guidelines)	2015*-2024	Other (combination of national and IUSTI-Europe guidelines)	2020-2024	Other (combination of national and IUSTI-Europe guidelines)	2018-2024
Portugal	No, international guidelines followed (IUSTI-Europe)	2015*	No, international guidelines followed (IUSTI-Europe)	2020	No, international guidelines followed (IUSTI-Europe)	2020
Romania	Yes, standalone	2023	Yes, standalone	2023	Yes, standalone	2023
Slovakia	No, international guidelines followed (WHO)	2016	No, international guidelines followed (WHO)	2024	No, international guidelines followed (US CDC)	2024
Slovenia	No, international guidelines followed (IUSTI-Europe)	2015*	No, international guidelines followed (IUSTI-Europe)	2020	No, international guidelines followed (IUSTI-Europe)	2020
Spain	Yes, part of broader guidelines/recommendations	2024	Yes, part of broader guidelines/recommendations	2024	Yes, part of broader guidelines/recommendations	2024
Sweden	Yes, standalone	2015	Yes, standalone	2015	Yes, standalone	2015

** IUSTI-Europe has since published 2025 chlamydia case management guidelines [48].*
IUSTI: International Union against Sexually Transmitted Infections
N/A: Not Applicable
US CDC: US Centers for Disease Control and Prevention
WHO: World Health Organization.

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