POLICY BRIEF

Strengthening HIV Prevention in Estonia: Expert Recommendations on Pre-Exposure Prophylaxis, Post-Exposure Prophylaxis, and Doxycycline Post-Exposure Prophylaxis

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This brief was developed collaboratively, drawing on contributions from Estonian Network of People Living with HIV (EHPV), academic researchers, physicians and public health specialists, representatives of community-based organizations, and members of the affected communities themselves, including people with lived experience. It reflects the perspectives of both public health institutions and the communities the recommendations are intended to serve.

Key Messages

- Estonia's national PrEP/PEP clinical guideline is based on evidence reviewed through 2019 and has not been revised since. The National HIV Action Plan it sits alongside expired in 2025 with no successor yet in place, creating a natural window to update both together.
- PrEP eligibility in Estonia still relies on a structured pre-visit risk questionnaire rather than the client-request-based, same-day access model now recommended internationally, and does not name gender-diverse people as a distinct risk group, unlike current EACS criteria.
- Estonia offers only daily oral PrEP. It has no event-based dosing option, including the version long recommended for MSM before EACS extended it to all populations in 2025, and no long-acting injectable products.
- PEP is clinically available for any substantial-risk exposure, but state funding covers only occupational exposure and sexual assault. Other non-occupational exposures meet the same clinical criteria yet require the

patient to pay for treatment directly, a gap first documented in 2017 and never revisited.

- Two of Estonia's three recommended PEP regimens fall short of current international preference for INSTI-based, simplified once-daily dosing, and bictegravir, the drug in CDC's current preferred single-tablet regimen, does not appear in the guideline at all.
- Doxycycline PEP is entirely absent from Estonian guidance. Because Estonia reports into the same EU/EEA resistance surveillance system underpinning ECDC's cautious position on gonorrhoea, any future national guidance should follow that evidence base rather than the more permissive US framing.
- Both PrEP and PEP service delivery remain fully centralized around infectious disease specialists and a small number of hospitals, with no role for primary care, community-based organizations, or civil society, despite WHO's explicit recommendation for task-sharing and international evidence linking community-embedded delivery to measurable reductions in new HIV diagnoses.

BACKGROUND

HIV epidemiology in Estonia

Despite substantial progress in HIV control over the past two decades, HIV remains an important public health challenge in Estonia. According to the latest national surveillance data, 133 new HIV diagnoses were reported in 2024, corresponding to 9.7 cases per 100,000 population. Although this represents a marked decline compared with previous years, the notification rate remains substantially higher than the EU/EEA average of 5.3 cases per 100,000 population, indicating that HIV transmission continues to pose an important public health concern in Estonia [1,2].

CURRENT BIOMEDICAL PREVENTION

Estonia has progressively incorporated biomedical HIV prevention into routine healthcare. The National HIV Action Plan 2017–2025 identified HIV prevention, testing and treatment as strategic priorities and supported the implementation of both pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) within the national healthcare system [3]. These recommendations were subsequently incorporated into the national clinical guideline on HIV treatment, PrEP and PEP, published through the Estonian clinical guideline programme (Ravijuhend) in 2019 [4]. Currently, oral PrEP is available through specialist-led services, restricted to infectious disease specialists for initiation, and partially reimbursed through the national health insurance system. PEP is available under the national guideline, but access differs by exposure type: employer-funded for occupational exposure, state-funded for sexual assault, and self-paid for other non-occupational exposures. Doxycycline post-exposure prophylaxis (doxy-PEP) has not yet been incorporated into national clinical guidance [4].

GOVERNANCE

HIV prevention in Estonia is implemented through a multi-institutional framework. The Ministry of Social Affairs is responsible for national health policy and strategic planning, Terviseamet conducts epidemiological surveillance and notification, the National Institute for Health Development (TAI) coordinates research and prevention programming, Tervisekassa finances healthcare services and pharmaceutical reimbursement, while national clinical recommendations are developed through the Estonian clinical guideline programme (Ravijuhend). Community-based organizations working with key populations currently sit outside this framework, providing outreach and testing but with no formal role in service delivery. Consequently, modernization of HIV prevention requires coordinated action across health policy, financing, public health implementation, clinical guideline development, and the integration of community-based organizations into service delivery itself.

POLICY WINDOW

The current policy framework is in a natural period for revision. The National HIV Action Plan concluded in 2025 with no successor plan yet adopted, while the evidence review underpinning the current national PrEP and PEP guideline was completed in 2019. Since then, international recommendations have evolved substantially across all three areas this brief addresses. WHO and ECDC now recommend simplified PrEP delivery models, broader prescribing practices, differentiated service delivery and long-acting PrEP formulations. WHO has also issued its first major update to PEP guidance in years. More recently, both agencies have issued recommendations on doxy-PEP for selected populations at increased risk of bacterial sexually transmitted infections. These developments create a policy opportunity to update Estonia's HIV prevention framework and align national policy with current international evidence and best practices.

This policy brief reviews recent developments in HIV pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) and doxycycline post-exposure prophylaxis (doxy-PEP), evaluates their relevance for the Estonian healthcare system, and proposes evidence-informed recommendations to support the revision of national clinical guidance, strengthen service delivery and improve equitable access to biomedical HIV prevention.

Pre-exposure prophylaxis (PrEP)

ELIGIBILITY CRITERIA

Current international recommendations define PrEP as a routine component of combination HIV prevention and recommend offering it to individuals at substantial risk of HIV acquisition using a person-centred approach [5]. Rather than limiting access to predefined population groups, WHO recommends individualized risk assessment and shared decision-making, allowing PrEP to be initiated whenever an individual perceives themselves to be at ongoing or anticipated risk of HIV infection [5,6]. The EACS guidelines provide more specific clinical criteria, recommending PrEP for men who have sex with men (MSM), transgender and gender-diverse people, heterosexual individuals with ongoing HIV exposure, people who inject drugs, people involved in prostitution and serodifferent couples, while also considering behavioural indicators such as recurrent sexually transmitted infections (STIs), repeated use of post-exposure prophylaxis (PEP), condomless sex with multiple partners and chemsex [7].

The current Estonian clinical guideline recommends PrEP for key populations at increased risk of HIV infection, including MSM, people who inject drugs, people involved in prostitution and serodifferent couples. Notably, gender-diverse people are not identified as a distinct risk group anywhere in the guideline, unlike in the EACS criteria above [4]. The guideline is therefore aligned with WHO and EACS recommendations in scope but not in approach, since eligibility still rests on a structured risk questionnaire completed before initiation rather than the self-perceived, request-based assessment now recommended internationally. Future updates of the Estonian guideline could both close this population gap and shift toward flexible eligibility criteria, shared decision-making and patient self-perceived HIV risk to improve timely access to PrEP.

WOMEN AND INTERSECTING RISK

Women are not a single risk category but face HIV risk through several different, sometimes overlapping pathways. EACS criteria include heterosexual women with ongoing HIV exposure and women in serodifferent couples among the populations for whom PrEP should be offered [7], and the Estonian guideline already reflects part of this through its recognition of serodifferent couples [4]. Women involved in prostitution meet the same eligibility criteria as other key populations under both EACS and the Estonian guideline [4,7]. Dosing options have also been extended specifically with women in mind: EACS's 2-7 event-based regimen was developed as an alternative to the MSM-focused 2-1-1 schedule precisely because pharmacokinetic evidence differs by tissue type [7]. Doxy-PEP is a clear exception to this pattern of inclusion. Neither CDC nor WHO recommends it for cisgender women, citing insufficient trial data, a gap that

should be stated explicitly in any future Estonian guidance rather than left ambiguous [8,15,16]. Migrant women and women whose only point of contact with the health system is through a partner from a key population may face additional access barriers that clinical eligibility criteria alone do not capture, and future guidance should address these barriers directly rather than assume that meeting clinical criteria is sufficient for actual access.

PRESCRIBING PRACTICES

WHO recommends decentralizing PrEP delivery wherever appropriate by expanding prescribing beyond specialist HIV services to trained primary care physicians, nurses and community-based providers [6,8]. This differentiated service delivery model aims to improve accessibility, reduce waiting times and facilitate earlier PrEP initiation while maintaining appropriate clinical oversight.

Several countries have already incorporated these approaches into national programmes. In France, prescribing authority has been expanded to trained general practitioners, contributing to improved geographical access and sustained growth in PrEP uptake [9]. Community-based PrEP programmes implemented in Kazakhstan have similarly demonstrated improved engagement of key populations and reductions in HIV test positivity among MSM [10].

In Estonia, PrEP prescribing remains primarily specialist-led under the current national clinical guideline [4]. Although this model ensures appropriate clinical expertise, expanding prescribing capacity through trained primary care providers or community-based organizations could improve accessibility, particularly outside major urban centres.

DOSING REGIMENS

International guidelines now recommend multiple evidence-based PrEP regimens to accommodate different patterns of HIV exposure and patient preferences. Daily oral tenofovir disoproxil fumarate/emtricitabine (TDF/FTC) remains the preferred regimen for most individuals at substantial HIV risk [5,7]. Event-driven PrEP, historically described as "2-1-1" dosing and validated first in MSM, has been broadened in the most recent EACS guidelines, which now recommend event-based dosing for all populations, using 2-1-1 dosing primarily for MSM and an alternative 2-7 regimen for cisgender women and transgender and non-binary people [7]. WHO implementation guidance additionally supports long-acting injectable cabotegravir (CAB-LA) as an alternative for individuals who prefer less frequent dosing or experience challenges with adherence to daily oral medication [8]. In 2025, WHO further expanded available prevention options by recommending twice-yearly injectable lenacapavir as a new long-acting PrEP modality [11].

The current Estonian guideline includes daily oral PrEP but does not incorporate event-driven PrEP in any form, including the MSM-only version recommended prior to 2025, or long-acting injectable formulations [4]. As additional PrEP modalities and dosing options become available in Europe, future revisions of the national guideline should consider whether broader regimen options, including the recently expanded event-based approach, could improve patient choice, adherence and programme coverage.

LABORATORY MONITORING AND FOLLOW-UP

WHO's approach to monitoring balances patient safety with minimizing barriers to PrEP initiation and continuation, keeping the baseline package deliberately narrow: confirmation of HIV-negative status, renal function, hepatitis B screening and STI testing where appropriate [5,6,8]. During follow-up, this same principle extends to the format of monitoring, not only its frequency. WHO's 2024 implementation guidance permits HIV self-testing (HIVST) between or instead of provider-administered tests for oral PrEP and the vaginal ring, supports remote or telehealth follow-up visits, and recommends differentiated intervals for clinically stable, PrEP-experienced users rather than a uniform schedule for everyone [6,8].

The current Estonian guideline's baseline testing package is broadly consistent with these international standards [4]. Follow-up, however, is not: the guideline requires in-person visits at a fixed three-month interval for all users, with no provision for HIVST, telehealth follow-up, or reduced-intensity monitoring for stable, long-term users. Incorporating these options would bring Estonia's follow-up model in line with current WHO guidance and could reduce the visit burden on PrEP users without compromising safety.

Post-exposure prophylaxis (PEP)

ELIGIBILITY CRITERIA AND INDICATIONS

Post-exposure prophylaxis (PEP) remains an essential component of comprehensive HIV prevention and should be considered a medical emergency following potential HIV exposure. The updated WHO guidelines recommend initiating PEP after occupational and non-occupational exposures that present a substantial risk of HIV transmission and emphasize that treatment should begin as soon as possible, ideally within 24 hours and no later than 72 hours after exposure [9]. Risk assessment should consider the type of exposure, the HIV status of the source individual where known, and the likelihood of HIV transmission. The decision to initiate PEP should be based on an individualized assessment while avoiding unnecessary delays in access to treatment.

The current Estonian clinical guideline defines PEP eligibility by exposure type rather than by context, and its clinical criteria are broadly consistent with WHO recommendations [4]. Access, however, is not. The guideline itself notes that Estonia has no national PEP programme, and funding is guaranteed only for occupational exposure, covered by the employer, and sexual assault, covered through state-purchased reserves. Other non-occupational exposures meet the same clinical eligibility criteria but have no guaranteed funding pathway, leaving the patient to pay for treatment directly. Updated international guidance places growing emphasis on rapid, low-barrier access to treatment, and this funding gap runs counter to that principle even where the clinical criteria themselves are aligned.

TREATMENT REGIMENS

WHO currently recommends a three-drug antiretroviral regimen administered for 28 days as the standard PEP regimen for adults and adolescents [12]. Integrase strand transfer inhibitor (INSTI)-based regimens are preferred because of their favourable safety profile, tolerability and high completion rates. Similar recommendations are reflected in the latest CDC guidance, which names bictegravir/emtricitabine/tenofovir alafenamide as the preferred single-tablet regimen and also supports dolutegravir-based combinations, emphasizing modern antiretroviral options with fewer adverse effects and simplified, once-daily dosing [13].

The Estonian clinical guideline recommends three regimen options, one of which, TDF/FTC plus dolutegravir, is INSTI-based and consistent with current preferred practice [4]. The other two, however, are not: one is protease-inhibitor-based rather than INSTI-based, and the raltegravir-containing option does not offer the simplified, once-daily dosing now prioritized internationally. Bictegravir, the drug in CDC's current preferred single-tablet regimen, does not appear in the Estonian guideline at all. Future updates

should narrow the recommended regimens toward INSTI-based, simplified-dosing options and evaluate whether bictegravir-based combinations are available and appropriate for the national context.

CLINICAL ASSESSMENT, FOLLOW-UP AND COUNSELLING

Baseline assessment for PEP should include rapid HIV testing, hepatitis B and C screening, pregnancy assessment where appropriate, and STI testing following potential sexual exposure [12]. The current Estonian guideline's baseline package is consistent with this. Follow-up testing, however, is not: the guideline's testing schedule is adapted from 2016 CDC guidance and extends selected tests out to six months post-exposure, whereas CDC's 2025 update shortened this to a final evaluation at 12 weeks using a combined antigen/antibody and nucleic acid test, reducing both the duration of follow-up and the number of visits required [4,13]. Counselling on transition to PrEP for clients with ongoing HIV risk is not addressed in the Estonian guideline's PEP section, unlike the explicit WHO recommendation that this discussion take place as a routine part of PEP follow-up [12].

SERVICE DELIVERY

Recent international guidance treats PEP as part of a continuous, decentralized HIV prevention pathway rather than an isolated emergency intervention delivered only by specialists. WHO's 2024 guidance explicitly recommends task-sharing PEP provision, distribution and monitoring to community-based organizations and non-specialist providers, alongside access through emergency departments [12]. The Estonian guideline follows a fully centralized model: initiation leads directly to urgent referral to an infectious disease specialist, and ongoing care is delivered through the same small set of hospitals that manage HIV treatment nationally, with no emergency-department pathway, community-based organization route, or civil society option described [4]. This centralization is consistent with the guideline's equally restrictive approach to PrEP prescribing, and the case for broadening it, discussed in detail in the PrEP section of this brief, applies here with the same force.

Doxycycline post-exposure prophylaxis (doxy-PEP)

CURRENT EVIDENCE AND INTERNATIONAL RECOMMENDATIONS

Doxycycline post-exposure prophylaxis (doxy-PEP) has recently emerged as an additional biomedical intervention aimed at preventing bacterial sexually transmitted infections (STIs), particularly syphilis and chlamydia, among populations at increased risk of recurrent STIs. Clinical trials have demonstrated that a single 200 mg dose of doxycycline taken within 72 hours after condomless sexual exposure can substantially reduce the incidence of syphilis and chlamydia, while evidence for gonorrhoea prevention is contested between international bodies [14–16].

The US Centers for Disease Control and Prevention (CDC) issued the first formal guidance on doxy-PEP in June 2024, recommending it for MSM and transgender women with a bacterial STI diagnosed in the past 12 months, following shared decision-making, and reporting reductions in gonorrhoea incidence of approximately 50% alongside larger reductions for syphilis and chlamydia [16]. The European Centre for Disease Prevention and Control (ECDC) subsequently issued its own guidance in January 2026, targeting the same population but reaching a more cautious conclusion specific to the European context: with tetracycline resistance in circulating Neisseria gonorrhoeae strains in the EU/EEA at 58.4% in 2023, ECDC concludes that doxy-PEP is unlikely to meaningfully reduce gonorrhoea in most European settings, does not recommend it as a population-level intervention, and frames its use as an individual clinical decision focused primarily on syphilis prevention among the highest-risk individuals [14]. WHO issued its own first recommendation in May 2026, targeting MSM and transgender women as well, taking a position between the two, acknowledging a possible gonorrhoea benefit in some settings while stopping short of a general recommendation and encouraging countries to consult WHO before national introduction [15].

CURRENT SITUATION IN ESTONIA

Doxy-PEP is not currently included in the Estonian national clinical guideline on HIV prevention, and no national recommendations have been issued regarding eligibility criteria, prescribing practices or clinical monitoring [4]. This reflects timing rather than an active decision: the current Ravijuhend predates all three international recommendations discussed above.

The publication of CDC, ECDC and WHO guidance between 2024 and 2026 represents a significant development in biomedical STI prevention and an opportunity to assess doxy-PEP's role in Estonia. Because Estonia reports into the same EU/EEA resistance surveillance system that underpins ECDC's more cautious position, that guidance,

rather than the more permissive US framing, is the more directly applicable evidence base for any future national protocol. Any future consideration of doxy-PEP should be based on local epidemiology, antimicrobial resistance surveillance, feasibility of implementation and alignment with broader sexual health services.

RECOMMENDATIONS

Policy recommendations

Based on the comparison of current international recommendations with the existing Estonian clinical guideline, the following actions are recommended to strengthen and modernize biomedical HIV prevention in Estonia.

MINISTRY OF SOCIAL AFFAIRS (SOTSIAALMINISTEERIUM)

- Update the national HIV prevention framework following the conclusion of the National HIV Action Plan (2017–2025), ensuring that biomedical HIV prevention remains a strategic public health priority.
- Establish a mechanism for regular review and updating of national HIV prevention policies and clinical guidance to facilitate timely incorporation of new scientific evidence and international recommendations.
- Promote integrated, person-centred HIV and STI prevention services through coordinated collaboration between government agencies, healthcare institutions, research organizations, community-based organizations, organizations of people living with HIV, and other organizations working directly with target populations.

ESTONIAN CLINICAL GUIDELINE PROGRAMME (RAVIJUHEND)

Revise the national clinical guideline on HIV prevention to reflect current WHO, EACS, ECDC and CDC recommendations by:

- adopting a more individualized, person-centred approach to PrEP eligibility based on risk assessment and shared decision-making;
- expanding PrEP prescribing to appropriately trained healthcare providers, including primary care physicians and community-based organizations, where feasible;
- incorporating additional PrEP modalities, including event-driven PrEP and long-acting injectable formulations, as they become available in Estonia;
- simplifying laboratory monitoring and follow-up through differentiated service delivery, including consideration of telemedicine and HIV self-testing where appropriate;
- updating preferred PEP regimens and follow-up recommendations in line with current WHO and CDC guidance;
- strengthening recommendations on transition from PEP to PrEP for individuals with ongoing HIV risk;
- evaluating the incorporation of doxycycline post-exposure prophylaxis (doxy-PEP) into national guidance, taking into account local STI epidemiology, antimicrobial resistance surveillance and international recommendations.

ESTONIAN HEALTH INSURANCE FUND (TERVISEKASSA)

- Review reimbursement mechanisms to ensure equitable access to biomedical HIV prevention services.
- Evaluate financing models that support expanded PrEP delivery, differentiated service models and future implementation of additional prevention modalities.
- Consider reimbursement of community-based prevention services where these contribute to improved access, linkage to care and retention in prevention programmes.

NATIONAL INSTITUTE FOR HEALTH DEVELOPMENT (TAI)

- Strengthen surveillance of PrEP uptake, PEP utilization and bacterial STI epidemiology.
- Monitor antimicrobial resistance trends relevant to future doxy-PEP implementation.
- Support implementation research evaluating the effectiveness, accessibility and equity of biomedical HIV prevention services.
- Develop educational materials and national awareness campaigns for healthcare professionals and populations at increased risk of HIV and STIs.

COMMUNITY-BASED ORGANIZATIONS (CBOS)

Community-based organizations play an important role in reaching populations disproportionately affected by HIV and other STIs and are recognized by WHO as essential partners in differentiated, person-centred service delivery. To strengthen the national HIV prevention system, community organizations should be supported to:

- provide evidence-based information on PrEP, PEP and doxy-PEP and improve health literacy among key populations;
- deliver peer-led prevention counselling, adherence support and risk-reduction education;
- facilitate timely referral and linkage to HIV testing, PrEP, PEP, STI services and ongoing clinical care;
- contribute to community outreach and engagement of underserved populations who may experience barriers to accessing healthcare services;
- participate in implementation research, programme evaluation and development of future national HIV prevention policies and clinical guidelines.

References

[1] European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2025 – 2024 data. Stockholm: ECDC; 2025. https://www.ecdc.europa.eu/en/publications-data/hivaids-surveillance-europe-2025-2024-data

[2] Statistics Estonia. Sustainable Development: 3. Good Health and Well-Being, indicator 3.7.1, New cases of HIV per 100,000 inhabitants (source: Health Board, National Institute for Health Development). Statistics Estonia; accessed 27 July 2026. https://www.stat.ee/en/avasta-statistikat/valdkonnad/saastev-areng/3-good-health-and-well-being

[3] Ministry of Social Affairs, National Institute for Health Development (TAI). Riiklik HIV tegevuskava aastateks 2017–2025 [National HIV Action Plan 2017–2025]. Tallinn: Sotsiaalministeerium; 2017. https://www.sm.ee/sites/default/files/content-editors/Tervishoid/rahvatervis/hiv_riiklik_tegevuskava_2017_2025.pdf

[4] Ravijuhend.ee. HIV-infektsiooni kokkupuute-eelne ja -järgne profülaktika ning HIV-positiivsete isikute ravi. Töörühma juht Kai Zilmer. Ravijuhendite Nõukoda, Tartu Ülikool; 2019. https://www.ravijuhend.ee/tervishoiuvarav/juhendid/195/hiv-infektsiooni-kokkupuute-eelne-ja-jargne-profulaktika-ning-hiv-positiivsete-isikute-ravi

[5] World Health Organization. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring. Geneva: WHO; 2021. https://www.who.int/publications/i/item/9789240031593

[6] World Health Organization. Differentiated and simplified pre-exposure prophylaxis for HIV prevention: update to WHO implementation guidance. Technical brief. Geneva: WHO; 2022. https://www.who.int/publications/i/item/9789240053694

[7] European AIDS Clinical Society (EACS). EACS Guidelines, version 13.0. 2025. https://www.eacsociety.org/guidelines/eacs-guidelines/

[8] World Health Organization. WHO implementation tool for pre-exposure prophylaxis of HIV infection: provider module for oral and long-acting PrEP. Geneva: WHO; 11 July 2024. https://www.who.int/publications/i/item/9789240097230

[9] ANSM / EPI-PHARE (France). Suivi de l'utilisation de Truvada ou génériques pour une prophylaxie pré-exposition (PrEP) au VIH à partir du SNDS. 2023. https://ansm.sante.fr/actualites/suivi-de-lutilisation-de-truvada-ou-generiques-pour-une-prophylaxie-pre-exposition-prep-au-vih-a-partir-du-systeme-national-des-donnees-de-sante-snds-1

[10] Karibayeva I, Turdaliyeva B, Shah G, et al. Pre-Exposure Prophylaxis Reduces HIV Test Positivity Among Men Who Have Sex with Men in Kazakhstan: An Interrupted Time Series Analysis. Research Square. 2026 (preprint).

[11] World Health Organization. Guidelines on lenacapavir for HIV prevention and testing strategies for long-acting injectable pre-exposure prophylaxis. Geneva: WHO; 14 Jul

y 2025.
https://www.who.int/news/item/14-07-2025-who-recommends-injectable-lenacapavir-for-hiv-prevention

[12] World Health Organization. Guidelines for HIV post-exposure prophylaxis. Geneva: WHO; 22 July 2024.
https://www.who.int/publications/i/item/9789240095137

[13] Tanner MR, O'Shea JG, Byrd KM, et al. Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV, CDC Recommendations, United States, 2025. MMWR Recomm Rep. 2025;74(RR-1):1-56.
https://www.cdc.gov/mmwr/volumes/74/rr/pdfs/rr7401a1-H.pdf

[14] European Centre for Disease Prevention and Control (ECDC). Public health considerations on the use of doxycycline for post-exposure prophylaxis for bacterial sexually transmitted infections in the EU/EEA. Stockholm: ECDC; 19 January 2026.
https://www.ecdc.europa.eu/en/publications-data/public-health-considerations-use-doxycycline-post-exposure-prophylaxis-bacterial

[15] World Health Organization. WHO issues first recommendation on doxycycline post-exposure prophylaxis to help prevent sexually transmitted infections. Geneva: WHO; 28 May 2026.
https://www.who.int/news/item/28-05-2026-who-issues-first-recommendation-on-doxycycline-post-exposure-prophylaxis-to-help-prevent-sexually-transmitted-infections

[16] Centers for Disease Control and Prevention (CDC). Clinical Guidelines on the Use of Doxycycline Postexposure Prophylaxis for Bacterial Sexually Transmitted Infection Prevention, United States, 2024.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11166373/