

Partner Notification and Retesting After an STI

Why Treating Only One Person Is Often Not Enough: Partner Care, Test of Cure, Retesting, Reinfection, Fertility Protection and the Supportive Role of Unani Medicine

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A Message From Dr. Nizamuddin Qasmi

When I diagnose a sexually transmitted infection in a patient, I do not consider the treatment complete simply because:

“I have prescribed the medicine.”

There are several additional questions that may be just as important:

Does the sexual partner know that exposure may have occurred?

Does the partner need testing?

Does the partner need treatment even without symptoms?

When can the couple safely resume sexual intercourse?

Does the patient need a test of cure?

Does the patient need to be retested after three months?

If a test becomes positive again, is this treatment failure or reinfection?

These questions are fundamental to good sexual medicine.

Many patients are treated successfully for:

chlamydia,

gonorrhoea,



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trichomoniasis,

another STI,

but then become infected again because their sexual partner was never assessed or treated.

The patient may then conclude:

“The medicine did not work.”

But in many cases, the real problem is:

reinfection.

CDC specifically notes that most repeat chlamydia and gonorrhoea infections detected after treatment are related to reinfection—often because a partner was not treated or because sexual contact occurred with a newly infected partner—rather than true failure of the original antibiotic regimen.

This is why I explain to patients:

Treating the infection is only one part of STI care.

The complete process may include:

Diagnosis → Treatment → Partner Notification → Partner Testing or Treatment → Temporary Sexual Precautions → Appropriate Follow-Up → Retesting When Indicated.

The World Health Organization now formally recommends that STI partner services be offered as part of a comprehensive, **voluntary** package of STI testing, treatment and prevention. WHO emphasizes that these services must protect privacy and confidentiality and should never involve forced disclosure or mandatory testing.

India's updated **2024 National Technical Guidelines on STI and RTI** similarly place increased emphasis on partner notification and partner management and recognize the usefulness of newer communication methods, including web-based notification systems where appropriate.

For me, the most important principle is:

Partner notification should protect health—not destroy trust, privacy or safety.

What Is Partner Notification?

Partner notification means informing a sexual partner that:

they may have been exposed to a sexually transmitted infection.

It does not necessarily mean revealing:

who transmitted the infection,
when the infection was acquired,
which partner had it first.

The purpose is medical.

It allows the exposed partner to:

receive counselling,
undergo appropriate testing,
receive treatment when necessary,
avoid transmitting the infection to another person,
protect future reproductive health.

WHO defines STI partner services as voluntary processes in which a healthcare worker helps a person diagnosed with an STI identify effective ways of notifying partners and linking those partners with testing, treatment and prevention services.

Partner Notification Is Not About Blame

One of the most damaging mistakes in sexual-health care is turning a laboratory result into an accusation.

A positive STI result does not always tell us:

exactly when infection occurred,
who acquired the infection first,
whether infection was recent.

Several sexually transmitted infections can remain:

asymptomatic,
undiagnosed
for significant periods.

Examples include:

chlamydia,
herpes,



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HIV,

hepatitis B,

latent syphilis,

Mycoplasma genitalium.

Therefore:

a positive STI test is a medical finding—not automatically proof of recent infidelity.

My role as a physician is to help the patient and partner protect their health rather than use diagnostic testing to make unsupported relationship conclusions.

Why Partner Notification Is So Important

There are three major reasons.

1. The partner may already be infected

Many STIs cause no symptoms.

A partner may therefore say:

“I am completely fine.”

But absence of:

discharge,

pain,

sores

does not prove absence of infection.

2. The untreated partner may reinfect the patient

This is especially important with infections such as:

chlamydia,

gonorrhoea,

trichomoniasis.

Successful treatment does not create permanent immunity.

Therefore, if one partner is treated while the other remains infected:



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the infection can return.

3. The partner may develop complications

An asymptomatic infection can still affect reproductive health.

For example, untreated chlamydia in a woman can progress to:

pelvic inflammatory disease.

Repeated chlamydial infection increases a woman's risk of:

PID,

reproductive complications.

Therefore:

partner management is also fertility protection.

What Are “Partner Services”?

Partner notification is only one part of a broader concept called:

Partner Services.

CDC describes partner services as a continuum involving:

counselling,

diagnostic testing,

clinical evaluation,

treatment,

linkage to prevention and additional care.

The partner may require more than an antibiotic.

For example, partner assessment can also lead to:

HIV testing,

syphilis testing,

hepatitis vaccination,

HIV PrEP,

HIV PEP,



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reproductive counselling.

This is one reason modern partner services are much broader than simply saying:

“Tell your partner to take these tablets.”

How Can a Partner Be Notified?

WHO recognizes several approaches.

The exact method depends on:

patient preference,

available health services,

confidentiality,

relationship safety,

local regulations.

Approaches may include:

Patient Referral

The diagnosed person informs the partner directly.

Enhanced Patient Referral

The patient receives:

written information,

referral materials,

counselling

to help communicate the exposure.

Provider-Assisted Notification

With the patient's consent, a trained healthcare or public-health professional contacts the partner.

Provider–Patient or Dual Referral

The healthcare provider and patient participate together in the notification.

Delayed Provider Referral

The patient initially agrees to notify the partner, but if this has not occurred by an agreed time, the provider assists.



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WHO recommends offering options according to patient preferences rather than imposing one method on everyone.

Can Partners Be Notified by Phone, Text or Online Message?

Yes, modern partner services increasingly use:

telephone,

SMS,

secure messaging,

email,

internet tools.

India's updated national STI recommendations specifically recognize innovative communication technologies, including web-based partner-notification approaches.

CDC also recognizes technology-supported partner notification when conventional contact is difficult.

However, communication should remain:

discreet, confidential and respectful.

A message should generally say that the person:

may have been exposed to an STI and should seek testing or treatment.

It is not necessary to use insulting or accusatory language.

Partner Notification Must Remain Voluntary

WHO makes an extremely important human-rights distinction:

STI partner services should be voluntary.

They should not involve:

coercion,

forced testing,

public disclosure,

humiliation.

Privacy and confidentiality must be protected.



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This principle is particularly important in:

marriage,

adolescent care,

socially sensitive settings.

Good sexual-health care should encourage responsible notification while respecting human dignity.

What If Telling a Partner Could Cause Violence?

This is a critical exception.

If telling a partner could realistically lead to:

physical violence,

coercion,

sexual violence,

severe intimidation

the patient should not be casually instructed:

“Just go home and tell the partner.”

CDC and WHO both emphasize assessment of intimate-partner-violence risk before partner-notification strategies are used. WHO states that partner services may not be appropriate where there is significant violence risk.

In such cases, the safest option may involve:

specialist counselling,

provider-assisted notification,

public-health support,

violence-support services.

Patient safety comes before routine notification.

What Does “Index Patient” Mean?

The person who has been diagnosed and whose partners are being considered for notification is sometimes called the:



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index patient

or:

index case.

This terminology does **not** mean that the index patient was necessarily the first person in the relationship to become infected.

It simply identifies the person through whom the current healthcare investigation began.

Does Every Partner Need Exactly the Same Management?

No.

Management depends on the infection.

This is extremely important.

For some infections:

the partner may receive presumptive treatment.

For others:

testing comes first.

For some viral infections:

there is no partner treatment at all, but vaccination or prevention may be available.

Therefore, partner management should be:

infection-specific.

Partner Management and Follow-Up at a Glance

Infection	Partner approach	Test of cure?	Routine retesting/follow-up
Chlamydia	Partners during previous 60 days generally evaluated/tested and presumptively treated	Usually no in nonpregnant people; pregnancy: about 4 weeks	Retest about 3 months



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Gonorrhoea	Partners during previous 60 days evaluated/tested and presumptively treated	Usually no for uncomplicated genital/rectal infection; throat: 7–14 days	Retest about 3 months
Trichomoniasis	Current partners should receive presumptive treatment	Selected persistent/recurrent cases	Women: retest about 3 months
Syphilis	Partner window depends on stage; some recent partners receive presumptive treatment even with negative early blood test	Follow quantitative RPR/VDRL rather than simple “negative/positive” cure test	Early syphilis: usually 6 and 12 months; latent: 6, 12 and 24 months
M. genitalium	Symptomatic patient's partners can be tested and positives treated	Not routine after recommended therapy if asymptomatic	Persistent symptoms require reassessment
Genital herpes	Partners counselled/evaluated; selected asymptomatic partners may receive type-specific HSV-2 testing	No—herpes remains in the body	No routine “cure” retest
HIV	Confidential partner services, testing, PEP/PrEP where appropriate	Not applicable as an STI cure test	Follow exposure-testing or HIV-care schedules
Hepatitis B	Partners should be tested and susceptible partners vaccinated	Not a standard STI test-of-cure model	Follow HBV/vaccine plan and immunity assessment where indicated

The exact plan should always account for:
 pregnancy,

symptoms,
treatment used,
local guidelines,
ongoing exposure.

Test of Cure and Retesting Are Not the Same Thing

This is one of the most important sections of the article.

Patients often use these terms interchangeably.

They are completely different questions.

Test of Cure

asks:

“Did the treatment eliminate the original infection?”

It is usually performed relatively soon after treatment when medically indicated.

Retesting

often asks:

“Has this person become infected again?”

It may be performed several months later.

Therefore:

a person may not need a test of cure but may still need retesting after three months.

Chlamydia is one of the best examples.

Why Retesting Matters Even When Treatment Worked

Suppose a patient has chlamydia.

They receive the correct treatment.

The infection is eradicated.

But their partner was not treated.

The couple has sex again.



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Three months later:

the patient is positive again.

This is not necessarily failure of doxycycline or another treatment.

It may be:

a completely new episode caused by reinfection.

CDC therefore recommends retesting after treatment for:

chlamydia,

gonorrhoea,

trichomoniasis in women

because repeat infection is sufficiently common to matter clinically.

Chlamydia — Partner Notification

For chlamydia, CDC recommends evaluation, testing and presumptive treatment of sexual partners who had contact with the diagnosed person during:

the 60 days before symptom onset or diagnosis.

If no sexual contact occurred in that period:

the most recent sexual partner should still be evaluated and treated.

This is important because a partner can be:

completely asymptomatic.

Chlamydia — When Can Sex Resume?

CDC advises a patient treated for chlamydia to avoid sexual intercourse:

for seven days after a single-dose treatment, or

until a seven-day regimen has been completed,

and until:

symptoms have resolved where applicable,

all relevant partners have been treated.

This is not simply to avoid transmitting infection outward.



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It also protects the patient from:

immediate reinfection.

Does Chlamydia Require a Test of Cure?

For most:

nonpregnant patients,

routine test of cure is **not recommended** after appropriate treatment.

Exceptions include situations where:

adherence is uncertain,

symptoms continue,

reinfection is suspected.

Why not simply test everyone immediately?

Because molecular tests can remain positive from:

nonviable bacterial material.

CDC advises against using chlamydia NAAT less than approximately:

four weeks after treatment,

because residual organisms can produce misleading positive results.

Chlamydia During Pregnancy

Pregnancy is different.

CDC recommends:

a test of cure approximately four weeks after treatment

for chlamydia during pregnancy.

The woman should also be:

retested approximately three months after treatment.

Women who remain at increased risk may also need additional testing later in pregnancy.

The stricter follow-up is justified because persistent maternal infection can affect:



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mother,
newborn.

Chlamydia — Why Three-Month Retesting Matters

CDC recommends retesting both women and men approximately:

three months after treatment,

regardless of whether they believe their partners were treated.

If three-month testing cannot be performed:

retest at the next healthcare visit within 12 months.

Repeat chlamydial infection in women is particularly concerning because it increases the risk of:

PID,

reproductive complications.

From a fertility perspective:

preventing recurrent chlamydia is more valuable than repeatedly treating the consequences of pelvic damage later.

Gonorrhoea — Partner Notification

For gonorrhoea, partners who had sexual contact with the infected person during approximately:

the previous 60 days

should be:

evaluated,

tested,

presumptively treated.

If the most recent sexual contact occurred more than 60 days before diagnosis:

the most recent partner should still be treated.

Gonorrhoea — Is Test of Cure Required?

For uncomplicated gonorrhoea affecting:

urethra/genitals,

rectum,

routine test of cure is generally **not required** after a recommended treatment regimen.

But:

throat gonorrhoea is different.

CDC recommends that patients with:

pharyngeal gonorrhoea

return approximately:

7–14 days after treatment

for a test of cure using:

culture,

NAAT.

Testing at exactly seven days can occasionally produce a false-positive molecular result, which is one reason culture may become important if an early NAAT remains positive.

Why the Throat Is Different

Pharyngeal gonorrhoea can be:

more difficult to eradicate,

important in antimicrobial resistance.

Therefore:

a negative urine test does not replace throat follow-up.

The anatomical site matters both at diagnosis and follow-up.

Gonorrhoea — Retesting at Three Months

Both men and women treated for gonorrhoea should generally be:

retested approximately three months after treatment,

even when they believe their sexual partners received treatment.



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Again, the purpose is mainly to detect:

repeat infection.

Persistent Gonorrhoea Symptoms

If symptoms continue despite appropriate treatment, the next step should not simply be:

“repeat the same antibiotic.”

CDC recommends obtaining:

gonorrhoea culture,

antimicrobial-susceptibility testing

when treatment failure is suspected.

Antibiotic resistance has made this increasingly important.

What Is Expedited Partner Therapy?

Expedited Partner Therapy—EPT—is a partner-management strategy in which treatment or a prescription is provided for an exposed partner without the clinician first examining that partner.

CDC supports EPT particularly for:

chlamydia,

selected gonorrhoea circumstances

when partners are unlikely to obtain timely clinical care and when local law permits it.

US clinical trials found that EPT increased partner treatment and was associated with reductions in repeat infection; pooled evidence cited by CDC found follow-up reductions of approximately:

20% for chlamydia,

50% for gonorrhoea

compared with standard patient referral in studied settings.

However:

EPT does not mean sharing leftover antibiotics.



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The correct medicine and dose depend upon:

infection,

pregnancy,

allergy,

local antimicrobial guidance.

In India, partner management should follow current:

NACO recommendations,

local clinical protocols.

Trichomoniasis — Partner Treatment Is Essential

Trichomoniasis is one of the clearest examples of why treating both partners matters.

CDC states:

concurrent treatment of all sex partners is vital for preventing reinfection.

Current partners should generally receive:

presumptive treatment.

The couple should avoid sexual intercourse until:

both have been treated,

treatment has been completed,

symptoms have resolved.

This remains important when one partner has:

no symptoms.

Trichomoniasis — Retesting

Because reinfection is common, CDC recommends that:

sexually active women

be retested approximately:

three months after treatment,

regardless of whether they believe the sexual partner was treated.



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If three-month retesting is impossible:

retest at the next medical visit within 12 months.

For men:

current evidence is insufficient to recommend routine universal retesting after treatment.

Why Trichomoniasis Seems to “Come Back”

The major possibilities are:

reinfection from an untreated partner,

incomplete adherence,

less commonly antimicrobial resistance.

Therefore, before telling a patient:

“The metronidazole failed,”

I ask:

“Was your partner treated?”

That question can completely change management.

Syphilis Requires a Different Partner Strategy

Syphilis partner management is more complicated because:

the infectious period depends upon the stage.

The major stages include:

primary syphilis,

secondary syphilis,

early latent syphilis,

late latent syphilis.

Partner evaluation therefore uses different look-back periods.

Syphilis — Which Partners Should Be Notified?

CDC currently considers the following partners at risk and appropriate for confidential notification:

Primary syphilis

Sexual partners from approximately:

three months plus the duration of symptoms.

Secondary syphilis

Partners from:

six months plus the duration of symptoms.

Early latent syphilis

Partners from:

the preceding one year.

Long-term partners of a person with:

late latent syphilis

should also be clinically and serologically evaluated.

Recent Syphilis Exposure May Require Treatment Even if the Test Is Negative

This is an extremely important concept.

A sexual partner who had exposure to someone diagnosed with:

primary,

secondary,

early latent syphilis

within the previous:

90 days

should generally receive:

presumptive treatment for early syphilis,

even if their serology is currently negative.

Why?

Because early in infection:



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antibodies may not yet be detectable.

Waiting for the blood test to become positive may therefore delay necessary treatment.

Syphilis Does Not Have a Simple “Negative Test of Cure”

After syphilis treatment, we usually do not expect every antibody test to become negative.

Treponemal antibodies can remain reactive for many years or permanently.

Follow-up therefore focuses mainly on:

quantitative nontreponemal titres

such as:

RPR,

VDRL.

We compare the post-treatment titre with:

the titre at treatment.

Syphilis — Follow-Up Timing

For:

primary and secondary syphilis,

CDC recommends clinical and serological follow-up at:

6 months and 12 months.

For:

latent syphilis,

quantitative nontreponemal testing is generally repeated at:

6, 12 and 24 months.

Follow-up may need to be more frequent in selected situations.

What Suggests Syphilis Reinfection or Treatment Failure?

A sustained:



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fourfold rise in the RPR or VDRL titre

after treatment can indicate:

reinfection,

treatment failure,

especially when accompanied by new symptoms.

This illustrates why looking only at:

“positive versus negative”

is not enough in syphilis follow-up.

Mycoplasma genitalium — Partner Management

M. genitalium requires another distinct approach.

CDC notes high infection concordance between sexual partners, although research has not yet definitively established how much partner treatment reduces reinfection.

For patients with:

symptomatic *M. genitalium*,

sexual partners can be:

tested,

treated if positive.

When partner testing is not possible, the clinician may consider providing the same antimicrobial regimen used for the diagnosed patient.

Because antimicrobial resistance is common:

partner treatment should not mean random azithromycin use.

M. genitalium — Test of Cure

CDC does **not** recommend routine test of cure for an:

asymptomatic patient

who received a recommended treatment regimen.

However, reassessment is appropriate when:

symptoms persist,



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cervicitis persists,

urethritis persists,

PID symptoms continue.

Alternative regimens used in special circumstances may specifically require a test of cure.

When Can Sex Resume After Mgen?

CDC advises patients to wait until:

they,

their sexual partner or partners

have completed treatment and:

symptoms have resolved

before resuming intercourse.

This reduces immediate transmission and reinfection.

Genital Herpes Is Different Because It Is Not Eradicated by Treatment

Genital herpes is usually caused by:

HSV-1,

HSV-2.

Antiviral medicines can:

shorten outbreaks,

reduce recurrences,

reduce transmission risk in selected patients.

But treatment does not remove the virus permanently from the body.

Therefore:

there is no ordinary “test of cure” after genital herpes treatment.

Genital Herpes — Partner Notification



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CDC recommends that people with symptomatic genital herpes:

inform current sexual partners

and discuss the condition with future partners before beginning a sexual relationship.

Partners who have symptoms should be:

clinically evaluated,

tested appropriately.

Asymptomatic partners of someone with symptomatic HSV-2 genital herpes may be offered:

type-specific HSV-2 serological testing.

Herpes — Why Repeat Testing May Occasionally Be Needed

Herpes antibody tests can be:

negative early after acquisition.

CDC states that when recent HSV-2 acquisition is suspected, repeating type-specific antibody testing around:

12 weeks after the suspected exposure

may be appropriate.

But routine repeated herpes testing is not recommended simply because a person has already been correctly diagnosed.

HIV Partner Notification

HIV partner notification deserves particularly careful, confidential handling.

Current CDC partner-services guidance states that people newly diagnosed with HIV can receive assistance notifying:

sexual partners,

injection-equipment-sharing partners

who may have been exposed.

The partner can then receive:

HIV testing,



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counselling,

preventive services.

WHO also recommends provider-assisted HIV partner services as part of a voluntary comprehensive package of:

testing,

care,

prevention.

HIV — Why Partner Notification Can Be Time-Critical

If a partner had a possible HIV exposure less than:

72 hours ago,

they may still qualify for:

PEP — Post-Exposure Prophylaxis.

CDC notes that partner services can provide an opportunity to offer PEP after very recent exposure and PrEP to partners with continuing risk.

Therefore:

timely notification can sometimes prevent HIV infection.

HIV — What About Retesting After PEP?

A person who receives HIV PEP follows a special HIV-testing schedule because antiretroviral drugs can temporarily influence detection.

CDC's updated **2025 PEP guidance** recommends follow-up using sensitive testing, including:

laboratory antigen/antibody testing,

HIV NAT.

Interim testing is generally performed approximately:

4–6 weeks after exposure,

with final testing approximately:

12 weeks after exposure.



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The exact schedule should be provided by the clinician supervising PEP.

A Person Already Diagnosed With HIV Does Not Need an HIV “Test of Cure”

HIV is managed through:

antiretroviral therapy

and:

viral-load monitoring.

The important treatment goal is:

sustained viral suppression.

A standard HIV antibody test remaining positive after treatment does not indicate treatment failure.

Modern HIV care therefore uses:

viral load,

treatment response,

rather than trying to make an HIV antibody test negative.

Hepatitis B — Partner Notification Is Particularly Important Because Vaccination Can Protect the Partner

A person with hepatitis B surface antigen—HBsAg—should inform:

sexual partners,

household contacts

so that they can receive appropriate hepatitis B testing.

CDC recommends that susceptible partners complete hepatitis B vaccination.

For the sexual partner of an HBsAg-positive patient, testing can determine whether the person is:

infected,

previously infected,

vaccinated/immune,

susceptible.



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Hepatitis B — Condoms Until Immunity Is Established

CDC advises susceptible sexual partners of an HBsAg-positive person to use condoms until:

vaccination is completed,

immunity is documented where appropriate.

An anti-HBs concentration of at least:

10 mIU/mL

after vaccination is considered evidence of protective immune response when post-vaccination testing is indicated.

This is different from infections where repeated antibiotics are needed.

With hepatitis B:

vaccination can transform partner risk.

Recent Hepatitis B Exposure

If an unvaccinated susceptible person has a significant recent sexual exposure to someone known to be HBsAg positive:

do not simply wait for follow-up blood tests.

Prompt medical evaluation may identify a need for:

hepatitis B vaccination,

hepatitis B immune globulin — HBIG.

This is one of the situations where partner notification provides an opportunity for:

actual post-exposure prevention.

Hepatitis C and Partner Notification

Hepatitis C is transmitted mainly through:

blood.

Sexual transmission is generally much less efficient in long-term heterosexual monogamous couples than transmission of infections such as:

HIV,

hepatitis B.

CDC states that people with hepatitis C who have one long-term steady sexual partner do not ordinarily need to change their sexual practices solely because of HCV, but they should discuss:

transmission risk,

whether the partner should be tested.

Higher sexual HCV transmission risks have been documented in certain other populations and circumstances.

Partner advice should therefore be individualized.

Retesting After an STI Does Not Mean the First Treatment Was Poor

Some patients feel insulted when advised:

“Please return after three months.”

They ask:

“Doctor, do you not trust the medicine?”

I explain:

retesting is often looking for reinfection—not questioning whether the antibiotic worked.

This distinction is especially important with:

chlamydia,

gonorrhoea,

trichomoniasis.

Why Reinfection Is So Common

Reinfection usually occurs because of one of the following:

Untreated partner

The patient received treatment, but the partner did not.

Sex too early



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Intercourse resumed before:

treatment completion,

partner treatment.

New infected partner

The patient later had exposure to another infected partner.

Continuing sexual network transmission

Several interconnected partners may carry the infection.

Therefore, preventing reinfection requires:

more than medication.

Does Treatment Give Permanent Immunity?

For most bacterial and protozoal STIs:

No.

A person can be cured of:

chlamydia,

gonorrhoea,

trichomoniasis,

Mgen

and become infected again after a new exposure.

Treatment clears:

the current infection.

It does not usually create:

lifelong immunity.

Why Repeated Infection Matters to Fertility

This is particularly important in my practice.

Repeated infections can produce:

repeated inflammation.



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In women, repeated chlamydial infection can increase risk of:

PID,

tubal damage,

ectopic pregnancy,

infertility.

CDC specifically notes an elevated risk of PID and other complications among women with repeat chlamydial infection.

Therefore:

a three-month chlamydia retest is also a fertility-preservation strategy.

Partner Notification After Pelvic Inflammatory Disease

PID is not always caused by one identified STI.

Nevertheless, when a woman is diagnosed with PID, CDC recommends that sexual partners from approximately:

the preceding 60 days

be:

evaluated,

tested,

presumptively treated for chlamydia and gonorrhoea,

regardless of which specific organism was isolated.

This is particularly important because partners of women with chlamydial or gonococcal PID are frequently:

asymptomatic.

PID — Retesting

Women with:

chlamydial PID,

gonococcal PID

should generally be retested:



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three months after treatment.

Preventing recurrent PID is extremely important because:

repeated pelvic infection can produce cumulative reproductive damage.

Partner Notification Does Not Automatically Mean Partner Treatment for Every STI

This deserves emphasis.

Partner notification can lead to:

testing only,

testing and treatment,

presumptive treatment,

vaccination,

counselling,

PEP,

PrEP.

For example:

Chlamydia

Partner treatment is generally needed.

Syphilis

Recent partners may need presumptive treatment.

Hepatitis B

A susceptible partner may primarily need:

vaccination.

HIV

The partner may need:

testing,

PEP or PrEP,

depending on the situation.

Herpes

The partner generally receives:

counselling,

evaluation,

selected testing

rather than “curative partner treatment.”

This is why partner management must be:

organism-specific.

Should the Patient Give Their Own Medicines to the Partner?

Generally:

No.

Do not simply divide your prescription in half.

Partner treatment should follow:

clinician guidance,

an approved EPT pathway where applicable,

local guidelines.

Why?

Because the partner may have:

pregnancy,

allergy,

a different infection,

significant symptoms,

another STI.

Sharing half of one person's medicine may result in:

two undertreated patients.

Should Partners Be Tested for Other STIs?

Often:

yes.

Someone diagnosed with one STI may have been exposed to others.

For example:

chlamydia diagnosis often prompts HIV, gonorrhoea and syphilis testing;

trichomoniasis evaluation includes consideration of HIV, syphilis, gonorrhoea and chlamydia.

India's current STI programme similarly integrates STI management with:

HIV,

syphilis screening.

Why Partner Treatment May Protect Pregnancy

Several STIs can have important pregnancy consequences.

Examples include:

syphilis,

HIV,

hepatitis B,

chlamydia,

gonorrhoea,

trichomoniasis.

Partner management can reduce the risk that a successfully treated pregnant woman becomes:

reinfected later in pregnancy.

This is one reason partner services are especially important in antenatal sexual health.

WHO specifically notes that STI partner services may deserve prioritization in situations such as:

a pregnant woman diagnosed with syphilis,

because untreated infection can cause severe adverse pregnancy outcomes.

Pregnancy and Chlamydia Retesting



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A pregnant woman treated for chlamydia should generally have:

test of cure at approximately four weeks

and:

repeat testing about three months later.

If she remains at increased risk:

third-trimester retesting

may also be indicated.

Her sexual partner must also be appropriately:

tested,

treated.

Otherwise:

reinfection can occur during pregnancy.

Partner Notification Before Fertility Treatment

When a couple is preparing for:

IUI,

IVF,

ICSI,

an active STI should ideally be identified and managed before treatment where clinically appropriate.

This protects:

the patient,

partner,

pregnancy,

fertility laboratory.

But a previous STI does not automatically mean:

infertility.

Once active infection is controlled, fertility evaluation should focus on:



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Female factors

ovulation,
ovarian reserve where appropriate,
uterus,
fallopian tubes.

Male factors

semen concentration,
motility,
morphology,
reproductive examination.

Repeated Antibiotics Are Not a Substitute for Fertility Evaluation

A patient may have had:

chlamydia,
PID
years earlier.

She is now infertile.

If the active infection has been eradicated:

repeatedly giving antibiotics will not reopen a permanently scarred fallopian tube.

At that stage, evaluation should consider:

HSG,
HyCoSy,
hydrosalpinx,
other reproductive factors.

This is a central principle in my fertility practice.

The Psychological Side of Partner Notification

STI diagnosis can provoke:

fear,
guilt,
anger,
embarrassment,
suspicion,
relationship conflict.

India's 2024 national STI guidance specifically recognizes that STIs can substantially affect:

mental health and wellbeing

and recommends appropriate psychosocial support where required.

The physician should therefore communicate in a way that is:

factual,
nonjudgmental,
confidential.

What Should a Patient Say to a Partner?

The goal is not to prove fault.

A simple health-focused message is often best:

“I was diagnosed with an infection that can be sexually transmitted. Because we have had sexual contact, the doctor advised that you should also be tested or treated. It does not necessarily tell us when the infection was acquired, but both of us should take care of our health.”

This approach is much safer than beginning the conversation with accusations.

Is Anonymous Notification Acceptable?

Sometimes.

When direct contact is not feasible, technology-supported or provider-assisted notification can help.

CDC notes that anonymous electronic notification is:



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better than no notification at all,

although direct or healthcare-assisted communication may allow better linkage to care.

WHO similarly supports multiple patient- and provider-led options rather than one rigid notification method.

Confidentiality Is Essential

A person should be able to seek STI care without fear that their diagnosis will be:

publicly disclosed,

discussed casually,

used to shame them.

WHO explicitly requires that partner-services programmes protect:

privacy and confidentiality.

In healthcare systems where certain infections are legally reportable, reporting requirements should still be handled according to:

applicable law,

confidentiality safeguards.

What If the Partner Refuses to Test?

The patient cannot physically force another competent adult to undergo:

testing,

treatment.

The treating clinician can:

explain the health risk,

provide referral information,

offer provider-assisted notification when available,

advise appropriate sexual precautions.

If the infection is:

legally reportable,

relevant to public-health partner services,



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local systems may have additional procedures.

But in ordinary clinical care:

coercion is not an acceptable substitute for counselling.

What If the Partner Says, “I Have No Symptoms”?

This is one of the most common responses.

My answer is:

symptoms are not required for many STIs.

A person can have:

chlamydia,

gonorrhoea at some sites,

trichomoniasis,

Mgen,

HIV,

hepatitis B,

syphilis

without realizing it.

Partner evaluation is recommended because:

exposure—not symptoms—is the reason for assessment.

What If the Partner's Initial Test Is Negative?

The meaning depends upon:

the infection,

timing,

type of test.

Examples:

Syphilis



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A very recent exposed partner may have negative serology and still require presumptive treatment when exposure occurred within 90 days of an early syphilis diagnosis.

HIV

A very recent negative test may still fall inside the diagnostic window.

Herpes

Antibody testing may take weeks to become positive.

Therefore:

an early negative result cannot always end the evaluation.

Test of Cure Should Not Be Performed Too Early

Modern molecular tests are extremely sensitive.

That is helpful—but it can also create confusion.

After successful antimicrobial treatment, molecular tests may detect:

genetic material from dead organisms.

For chlamydia, CDC specifically recommends avoiding routine NAAT less than four weeks after treatment because residual nonviable organisms can produce false-positive results.

Therefore:

earlier testing is not always better testing.

Positive Again: Reinfection or Treatment Failure?

The clinician should consider:

Did the patient complete treatment?

Was the partner treated?

Was sex resumed too early?

Was there a new sexual partner?

Was the correct medicine used?

Is antimicrobial resistance possible?

Was repeat testing performed too soon?



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This structured assessment is far more useful than simply telling the patient:

“Your infection is resistant.”

How Does Antimicrobial Resistance Change Follow-Up?

Resistance is especially important for:

gonorrhoea,

Mgen.

Persistent gonorrhoea after recommended treatment may require:

culture and susceptibility testing.

Mgen increasingly requires:

resistance-aware sequential antimicrobial treatment.

Therefore:

persistent infection should be investigated—not treated by repeatedly changing antibiotics at random.

Partner Notification and Sexual Abstinence

Temporary abstinence is often part of STI treatment.

The reason is simple:

antibiotics do not instantly eliminate every organism the moment the first tablet is swallowed.

Sexual contact before treatment is completed can lead to:

onward transmission,

reinfection.

The exact duration varies by infection.

Patients should follow:

infection-specific advice.

Do Condoms Replace Partner Treatment?

No.



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Condoms reduce transmission risk for many STIs.

But if a partner already has:

chlamydia,

gonorrhoea,

trichomoniasis,

Mgen,

the infection still requires appropriate management.

Condoms are:

prevention.

They are not:

eradication treatment.

What About Oral and Anal Partners?

Partner assessment should consider the:

anatomical sites involved.

If the exposure involved:

oral sex,

anal sex,

testing may need to include:

throat,

rectal specimens

for infections such as gonorrhoea or chlamydia.

A negative urine test does not automatically mean that every anatomical site is infection-free.

The Unani Perspective on Partner Care and Post-STI Recovery

As a physician trained in **Unani medicine**, I approach sexual and reproductive health as more than the elimination of one microorganism.

Traditional Unani care places importance on:



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Mizaj or constitutional wellbeing,
nutrition,
digestion,
sleep,
physical strength,
urinary health,
reproductive wellbeing,
sexual confidence.

These areas can be useful after a patient has undergone appropriate treatment for an STI.

For example, some patients continue to experience:

weakness,
disturbed digestion,
anxiety,
reduced sexual confidence,
nonspecific urinary or genital discomfort
after the infection itself has been treated.

In such patients, carefully selected Unani supportive care may contribute to:

whole-person recovery.

Unani Research on Genital Symptoms

CCRUM continues to investigate Unani formulations for reproductive symptoms such as:

Sayalān al-Raḥīm — excessive abnormal vaginal discharge.

Its 2024–2025 annual report describes ongoing multicentre clinical validation of a Unani pharmacopoeial formulation for abnormal vaginal discharge, while earlier CCRUM research also reported symptom improvement in women treated for leucorrhoea.

This research is useful for understanding the potential supportive role of Unani medicine in selected genital symptoms.



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But:

vaginal discharge is not the same thing as a laboratory-confirmed STI.

Improvement in discharge does not prove elimination of:

chlamydia,

gonorrhoea,

trichomoniasis,

Mgen.

Can Unani Medicine Replace Partner Treatment?

No.

If a sexual partner has a transmissible bacterial or protozoal infection:

appropriate infection-specific treatment is necessary.

Giving only the diagnosed patient a Unani formulation while leaving an infected partner untreated can allow:

reinfection.

That defeats the purpose of treatment.

Can Unani Medicine Replace Retesting?

No.

If current guidelines recommend a:

chlamydia retest,

gonorrhoea retest,

syphilis RPR follow-up,

HIV follow-up test,

there is no Unani symptom assessment that can replace that objective laboratory information.

The role of Unani medicine is:

complementary—not diagnostic substitution.



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Where Unani Medicine Can Add Value

In my practice, useful supportive areas may include:

nutritional strengthening,

digestive wellbeing,

general recovery,

urinary comfort after active infection has been treated,

sleep,

stress management,

sexual confidence,

reproductive wellbeing.

This can be particularly valuable when a patient is medically cured but continues to feel:

weak,

fearful,

sexually avoidant.

Special Follow-Up Approach by Dr. Nizamuddin Qasmi

When a patient returns after STI treatment, I do not simply ask:

“Are you feeling better?”

I ask:

Was the correct infection treated?

Was treatment completed?

Was the sexual partner notified?

Was the partner tested or treated?

Did intercourse occur before treatment was complete?

Does this STI require a test of cure?

Does it require three-month retesting?

Does the patient have new symptoms?



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Has another STI been excluded?

Is pregnancy or infertility relevant?

Has sexual confidence returned?

These questions turn a prescription into:

complete sexual-health care.

What “Special Treatment” Means at Saira Health Care

At **Saira Health Care**, specialized STI follow-up does not mean giving everyone the same medicine.

It means:

infection-specific care.

A patient treated for chlamydia needs a different follow-up plan from someone with:

syphilis,

herpes,

hepatitis B.

The treatment plan may include:

medication,

partner referral,

vaccination,

repeat NAAT,

quantitative RPR,

HIV testing,

fertility assessment,

sexual-health counselling.

This is the value of a structured clinical approach.

Patient Example — Chlamydia

A woman was treated correctly.



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Her symptoms disappeared.

Her husband had no symptoms and took no treatment.

The couple resumed sex.

Three months later:

she is chlamydia-positive again.

The first question is not:

“Which stronger antibiotic do we need?”

The most likely issue may be:

reinfection from an untreated partner.

This is exactly why CDC recommends:

partner treatment,

three-month retesting.

Patient Example — Gonorrhoea in the Throat

A patient had:

pharyngeal gonorrhoea.

The symptoms disappear after treatment.

Unlike uncomplicated urethral gonorrhoea:

throat infection needs a test of cure approximately 7–14 days later.

A general rule such as:

“No gonorrhoea needs a test of cure”

would therefore be inaccurate.

Patient Example — Syphilis

A man completes treatment and asks:

“Doctor, my treponemal test is still positive. Does this mean treatment failed?”

Not necessarily.

Treponemal antibodies may remain positive.



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We follow:

quantitative RPR or VDRL titres

over time.

This is why syphilis follow-up requires:

correct interpretation rather than repeatedly ordering random tests.

Patient Example — Trichomoniasis

A woman completes treatment.

Her husband feels completely well and takes nothing.

The woman's infection returns.

Again:

reinfection should be considered before drug resistance.

Treating current partners simultaneously is central to trichomoniasis care.

Patient Example — Mycoplasma genitalium

A man has confirmed Mgen and is appropriately treated.

His partner is asymptomatic.

Because partner concordance is high, the partner can be:

tested,

treated if positive.

But random single-dose azithromycin should not be used casually because:

Mgen resistance is a major clinical problem.

Patient Example — HIV Exposure

A person receives a new HIV diagnosis and informs a recent partner.

If that partner's latest potential exposure was within:

72 hours,

notification may give the partner enough time to begin:



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HIV PEP.

In this situation:

partner notification can literally prevent another infection.

Patient Example — Hepatitis B

A husband is HBsAg positive.

His wife is uninfected but unvaccinated.

She does not necessarily need medicine for hepatitis B.

She needs:

testing,

vaccination,

possibly post-exposure prophylaxis depending upon timing.

This demonstrates why:

partner care is not synonymous with partner antibiotics.

Patient Example — Infertility After Recurrent Chlamydia

A woman has been treated repeatedly in the past and now cannot conceive.

If she currently tests negative:

repeated antibiotics may not help.

Now I want to evaluate:

fallopian tubes,

ovulation,

ovarian reserve where appropriate,

uterus,

male partner's semen.

This is the point where:

STI treatment becomes fertility evaluation.



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Partner Notification and Male Infertility

STIs can occasionally affect:

epididymis,
prostate,
reproductive tract.

But a previous STI should not automatically be blamed for:

low sperm count,
poor motility,
abnormal morphology.

A complete male evaluation may still need to assess:

varicocele,
hormones,
genetic factors,
testicular history,
lifestyle.

Partner Notification and Female Infertility

In women, repeated ascending infections—especially chlamydia and gonorrhoea—are particularly relevant because they can cause:

PID.

PID may eventually result in:

tubal scarring,
hydrosalpinx,
ectopic pregnancy,
infertility.

Therefore:

partner treatment today may prevent infertility years later.

That is one reason I consider partner management part of reproductive medicine.



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When Should Couples Resume Trying for Pregnancy?

When an active curable STI has been diagnosed, I generally advise completing:
the patient's treatment,
relevant partner management
before deliberately trying to conceive.

The exact waiting period depends upon:
infection,
treatment regimen,
pregnancy considerations.

Once infection is appropriately managed:

natural conception can usually resume unless another fertility problem exists.

An STI diagnosis does not automatically mean IVF is needed.

Does Retesting Mean You Need Another Treatment Automatically?

No.

Retesting first determines whether infection is present.

If negative:

no additional antimicrobial treatment may be necessary.

If positive:

the clinician should assess whether this represents:

reinfection,

treatment failure,

testing too early,

antimicrobial resistance.

Then treatment is selected appropriately.

Why Not Give Preventive Antibiotics to Every Partner?

Because indiscriminate antibiotic use contributes to:

antimicrobial resistance.

This is particularly concerning with:

gonorrhoea,

Mgen.

Partner treatment should therefore follow:

evidence-based recommendations,

specific organism,

local clinical guidance.

This does not mean withholding treatment when presumptive treatment is recommended.

It means avoiding:

unnecessary antibiotics without a clinical rationale.

India-Specific Partner Notification — 2024 NACO Update

India's updated STI/RTI guidance emphasizes:

partner notification and partner management

as essential components of STI care.

The guidance acknowledges that partner notification can be difficult and supports the use of:

newer communication technologies,

web-based notification approaches

while balancing:

patient confidentiality,

partner protection.

The same national guidance emphasizes:

sexual-health education,

risk-reduction counselling,

attention to psychological wellbeing.



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This is particularly important in India, where social stigma can sometimes prevent:
testing,
partner treatment,
timely follow-up.

WHO 2026 Direction: Partner Services as Part of the STI Care Cascade

WHO's **2026 Consolidated Operational Handbook on STIs** places partner management within the broader STI prevention and care pathway together with:
diagnostics,
treatment,
service delivery,
surveillance,
primary care integration.

This reflects an important change in how modern STI medicine is understood.

Successful STI treatment is no longer simply:

“Give medicine to the person in front of us.”

Instead, modern care considers:

the patient + partner + sexual network + prevention + follow-up.

Current Medical Understanding — 2026 Update

Several conclusions are now especially important.

Partner services should be offered—not forced

WHO recommends voluntary STI partner services with protected:
privacy,
confidentiality.

Provider support can improve partner management

WHO includes patient-led, provider-assisted and combined models, with provider-supported approaches especially useful where feasible.

Intimate-partner violence must be considered

Notification should not be pursued in a way that creates serious risk to the patient.

Digital notification can be useful

Both India and international partner-service frameworks increasingly recognize technology-based approaches.

Chlamydia requires three-month retesting

This applies to treated women and men because reinfection is common.

Gonorrhoea also requires three-month retesting

And pharyngeal gonorrhoea requires a 7–14-day test of cure.

Trichomoniasis requires concurrent partner treatment

Sexually active women should generally be retested at around three months.

Syphilis requires titre-based follow-up

Early syphilis is generally reassessed at six and 12 months, while latent infection usually receives serologic follow-up at six, 12 and 24 months.

Mgen treatment is becoming resistance-aware

Partner testing is useful, but routine universal test of cure is not required after recommended treatment in an asymptomatic patient.

HIV partner notification can open an urgent prevention window

Partners with very recent exposure may qualify for PEP, while those with continuing risk may benefit from PrEP.

Hepatitis B partner management focuses heavily on vaccination

Susceptible partners should be vaccinated and protected until immunity is established.

Frequently Asked Questions

Why do I need to tell my partner if I already took treatment?

Because the partner may be infected without symptoms and can reinfect you.

Does partner notification mean I am accusing my partner?

No.

Partner notification is a healthcare intervention.



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It usually cannot establish who acquired the infection first.

Does my partner need treatment even without symptoms?

For some STIs:

yes.

Examples include exposed partners in:

chlamydia,

gonorrhoea,

trichomoniasis,

selected recent syphilis exposures.

The exact approach depends upon the infection.

How far back should I notify partners for chlamydia?

Generally partners from the:

preceding 60 days.

If there was no sexual partner during that period, the most recent partner should still be evaluated.

What about gonorrhoea?

The same general:

60-day partner period

is used.

How far back should partners be notified for syphilis?

It depends on the stage.

CDC uses approximately:

primary syphilis: three months plus symptom duration;

secondary syphilis: six months plus symptom duration;

early latent: one year.

Can my partner's syphilis test be negative even though treatment is still needed?

Yes.

Recent partners exposed within 90 days to early syphilis may require presumptive treatment even if initial serology is negative.

Do both partners need trichomoniasis treatment?

Yes.

Concurrent partner treatment is a central part of preventing recurrence.

Does a sexual partner need testing for Mgen?

Partners of patients with symptomatic Mgen can be tested and positive partners treated.

Can I just give my partner half of my tablets?

No.

This may result in:

inadequate treatment for both people.

Partner treatment should follow proper medical guidance.

What is a test of cure?

A test performed after treatment to confirm that the original infection has been eradicated.

What is retesting?

Testing later to identify:

reinfection.



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Are they the same?

No.

Do I need a chlamydia test of cure?

Usually not if you are nonpregnant, correctly treated and asymptomatic.

Pregnant women should generally have a test of cure approximately four weeks after treatment.

Why should I not test for chlamydia one week after treatment?

NAAT can detect genetic material from dead organisms and potentially create a false-positive interpretation.

CDC advises against routine testing before approximately four weeks.

Should chlamydia be retested later?

Yes.

Approximately:

three months after treatment.

Does gonorrhoea require a test of cure?

Usually not for uncomplicated:

genital,

rectal

gonorrhoea treated correctly.

Pharyngeal gonorrhoea does require a test of cure approximately 7–14 days after treatment.

Should gonorrhoea be retested at three months?

Yes.



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Should women treated for trichomoniasis be retested?

Yes.

Approximately:

three months later.

Should men with trichomoniasis always be routinely retested at three months?

Current CDC evidence is insufficient to make that universal recommendation.

Does syphilis treatment make my blood tests immediately negative?

No.

Treponemal antibodies may remain positive.

Follow-up generally uses:

RPR,

VDRL titres.

When is early syphilis followed after treatment?

Usually around:

6 and 12 months.

When is latent syphilis followed?

Usually:

6, 12 and 24 months.

Does genital herpes require retesting after treatment?

Not as a test of cure.

Herpes remains in the body after infection.

Should my partner know I have genital herpes?

Yes.

CDC recommends informing current partners and future partners before starting sexual relationships.

Can my asymptomatic partner be tested for herpes?

In selected circumstances, particularly when the diagnosed patient has symptomatic HSV-2 infection, type-specific partner testing can be offered.

If I have HIV, should I tell previous partners?

Confidential partner services should be offered so people with possible exposure can receive:

HIV testing,
prevention,
care.

Why is HIV notification urgent?

If the most recent exposure was less than:

72 hours ago,

the partner may still qualify for:

HIV PEP.

What HIV testing is needed after PEP?

Current CDC guidance generally includes sensitive follow-up testing around:

4–6 weeks after exposure,

final testing at about 12 weeks.

My partner has hepatitis B. What should I do?

You should be appropriately tested for:

infection,



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immunity.

If susceptible:

vaccination is important.

Do we need condoms if my partner has hepatitis B?

CDC advises condoms for susceptible partners until:

vaccination is completed,

immunity is demonstrated where appropriate.

Is hepatitis C sexually transmitted?

It can be, but the risk is relatively low in many stable heterosexual relationships.

A partner should discuss:

testing,

individual risk

with a healthcare professional.

If all my symptoms are gone, why retest?

Because many repeat infections are:

asymptomatic.

Retesting looks for infection before complications or onward transmission occur.

If I test positive again, does that mean my antibiotic failed?

Not necessarily.

Reinfection is extremely common.

Partner treatment and new sexual exposures need to be reviewed first.

Can I have sex immediately after the last antibiotic tablet?

The answer depends on the infection.



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For several common curable STIs, both the patient and partner need to:

complete therapy,

follow the recommended abstinence interval,

allow symptoms to resolve.

Follow the specific advice for your infection.

Can condoms alone prevent reinfection from an infected partner?

Condoms reduce risk substantially, but an infected partner still needs appropriate treatment.

What if I cannot contact my previous partner?

Discuss:

provider-assisted notification,

public-health partner services,

secure digital notification

where available.

Can I notify a partner anonymously?

In some partner-services programmes this is possible.

Technology-supported notification can be used when appropriate, although direct or professional-assisted communication may improve linkage to care.

What if notifying my partner may be dangerous?

Tell your healthcare provider.

Do not put yourself at risk of violence.

WHO and CDC recommend considering intimate-partner-violence risk before partner notification.

Can an STI come back even if both partners were treated?



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Yes.

A new exposure can result in:

a new infection.

Treatment usually does not create lifelong immunity.

Does recurrent chlamydia increase infertility risk?

Repeated infection increases the risk of:

PID,

reproductive complications

in women.

If I had PID, should my partner be treated?

Sex partners from approximately the previous 60 days should generally be evaluated, tested and presumptively treated for:

chlamydia,

gonorrhoea.

Does partner treatment restore already damaged fallopian tubes?

No.

Partner treatment prevents:

reinfection,

additional injury.

It does not reverse established tubal fibrosis.

Can Unani medicine prevent STI reinfection?

It cannot replace:

partner diagnosis,

effective antimicrobial treatment,



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vaccination,

follow-up testing.

Reinfection prevention requires dealing with the actual infection in all relevant partners.

Can Unani medicine still help after STI treatment?

Yes, in selected patients it can be integrated supportively for:

nutrition,

digestion,

general recovery,

urinary wellbeing,

sexual health,

reproductive wellbeing.

Can symptom improvement with Unani medicine prove that the infection is cured?

No.

For laboratory-confirmed STIs, cure or follow-up should be assessed using the appropriate modern clinical and laboratory criteria.

A Message From Dr. Nizamuddin Qasmi to Patients

If you have been treated for an STI, I want you to remember:

Do not stop thinking about the infection the moment you swallow the last tablet.

Ask:

Does my partner need testing or treatment?

When can we safely resume sex?

Do I need a test of cure?

Do I need retesting after three months?

These questions can prevent the same infection from returning.



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A Message to Couples

I encourage couples not to use an STI diagnosis as:

a weapon.

Use it as:

a healthcare opportunity.

The responsible approach is:

both people get the correct information, both people receive the necessary care, and both people protect their future reproductive health.

A Message to Patients With Repeat Positive Tests

If an infection returns, do not immediately assume:

“My body is weak.”

or:

“The medicine was useless.”

We first ask:

Was the partner treated?

Was sex resumed too early?

Was there another exposure?

Was the repeat test performed at the correct time?

Could antimicrobial resistance be present?

These questions usually lead us much closer to the real answer.

A Message to Infertility Patients

A history of STI is important.

But infertility should still be evaluated systematically.

For women, we may need to evaluate:

ovulation,

fallopian tubes,



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ovarian reserve,

uterus.

For men:

semen concentration,

motility,

morphology,

reproductive factors.

Partner notification and STI treatment prevent:

future damage.

Fertility evaluation identifies:

damage or other infertility factors that already exist.

These are different clinical tasks.

A Message About Unani Medicine

As a physician trained in Unani medicine, I believe that treatment should address:

physical recovery,

nutrition,

digestion,

sexual confidence,

reproductive wellbeing.

These are important.

But responsible integrative medicine also requires clear boundaries.

If an STI requires:

antibiotics,

antivirals,

vaccination,

partner treatment,

repeat laboratory testing,



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these interventions should be used.

Unani medicine can complement:

recovery and whole-person care.

It should not replace:

microbiological cure or public-health prevention.

Saira Health Care's Contribution to Sexual Disorders & Infertility

At **Saira Health Care**, STI follow-up is particularly relevant because untreated or repeatedly acquired infections can affect:

sexual health

and:

fertility.

Our approach therefore goes beyond simply handing the patient a prescription.

Depending upon the situation, follow-up may include:

infection-specific partner counselling,

testing of relevant partners,

assessment of treatment adherence,

planning the appropriate retesting interval,

pregnancy counselling,

evaluation for PID,

evaluation of urethritis,

assessment of sexual pain,

male and female fertility assessment,

sexual-confidence counselling,

evidence-aware supportive Unani care.

The objective is not only:

cure today's infection.

It is also:



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prevent tomorrow's reinfection and protect future reproductive health.

Dr. Nizamuddin Qasmi's Specialized Clinical Approach

My approach can be summarized as:

Identify the infection → Treat correctly → Explain transmission → Notify partners safely → Test or treat partners appropriately → Avoid premature sex → Perform test of cure only when indicated → Retest at the correct interval → Investigate recurrent infection properly → Protect fertility → Support sexual recovery.

That sequence is especially important in my specialist-focused clinical practice in:

Sexual Disorders & Infertility.

Current Medical Understanding — 2026

WHO's modern partner-services model is clear:

partner notification should be offered as part of STI care.

It should be:

voluntary,

confidential,

adapted to patient preferences,

sensitive to intimate-partner-violence risk.

India's updated 2024 national STI/RTI framework likewise emphasizes:

partner notification,

partner management,

risk-reduction counselling,

digital communication options,

mental-health awareness.

CDC's currently applicable STI clinical guidance continues to recommend routine three-month retesting after:

chlamydia,

gonorrhoea,



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trichomoniasis in women.

The most important modern distinction is:

Retesting is often looking for reinfection.

It is not proof that clinicians expect the original treatment to fail.

This distinction helps patients understand why follow-up is an essential component of treatment rather than an unnecessary extra appointment.

Conclusion

Partner notification and retesting are essential parts of modern STI treatment.

An infection should not be viewed only as:

patient + medicine.

Instead, the complete clinical picture may involve:

patient + sexual partner + treatment + prevention + follow-up.

Partner notification helps exposed people obtain:

testing,

treatment,

vaccination,

HIV PEP or PrEP where appropriate,

reproductive counselling.

WHO recommends voluntary partner services as part of comprehensive STI care while emphasizing:

confidentiality,

informed participation,

protection from coercion,

consideration of intimate-partner violence.

The exact partner-management plan differs according to the infection.

For:

chlamydia and gonorrhoea,



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partners from the preceding approximately 60 days usually require evaluation and presumptive treatment. Both infections generally require patient retesting approximately three months after treatment.

For:

trichomoniasis,

concurrent treatment of current partners is essential, and sexually active women should generally be retested approximately three months later.

For:

syphilis,

partner look-back periods depend upon disease stage, and recent partners may require presumptive treatment even with an initially negative test. Follow-up depends on quantitative RPR/VDRL titres rather than simply waiting for all antibody tests to become negative.

For:

Mycoplasma genitalium,

partners of symptomatic patients can be tested and positive partners treated, while follow-up should account for increasing antimicrobial resistance.

For:

genital herpes,

partner counselling and disclosure are important, but there is no test of cure because HSV remains in the body.

For:

HIV,

confidential partner services can identify exposed people who need testing and may offer an urgent opportunity for PEP if exposure occurred within 72 hours.

For:

hepatitis B,

partner management can prevent infection through:

vaccination.

Susceptible sexual partners should be tested and vaccinated, with condoms used until immunity is established where appropriate.

From the reproductive perspective, this work is extremely important.

Repeated STIs—particularly infections that can ascend into the female reproductive tract—can increase the risk of:

PID,

tubal damage,

ectopic pregnancy,

infertility.

Therefore:

partner treatment and appropriate retesting are forms of fertility preservation.

From the **Unani perspective**, individualized traditional care may make a useful contribution to:

nutrition,

digestion,

urinary wellbeing,

sexual wellbeing,

recovery,

reproductive health.

CCRUM continues to study Unani formulations for reproductive symptoms such as abnormal vaginal discharge.

But:

supportive Unani treatment cannot substitute for partner notification, organism-specific antimicrobial treatment, vaccination or guideline-recommended laboratory retesting.

At **Saira Health Care**, my approach is therefore comprehensive:

treat the infection correctly, protect and appropriately manage the partner, retest at the correct time, prevent repeated infection, investigate fertility when required, address the sexual and psychological consequences of the diagnosis, and integrate responsible Unani supportive care where clinically useful.

The most important message I want patients to remember is:

If only one partner is treated, the treatment may be medically incomplete.



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And:

A three-month retest is often not checking whether the medicine failed—it is checking whether the infection came back.

Understanding that difference can protect:

sexual health,

the relationship,

future fertility.

About the Author

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Qualifications & Professional Training

BUMS — Hamdard University, Delhi

MD

CGO

Certificate in Infertility — MGBIMS, Delhi

Certificate in Urology — London, UK

Masters in Male Infertility — MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health — ISRH, UNFPA

Dr. Nizamuddin Qasmi is a well-qualified physician with a **specialized clinical focus on Sexual Disorders & Infertility** at Saira Health Care.

His clinical approach recognizes that STI management is closely connected with:

partner health,

sexual confidence,

pregnancy planning,

male fertility,

female fertility.

Depending upon the individual patient, assessment may include:

STI test interpretation,

treatment-history review,



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partner-management counselling,
assessment for reinfection,
test-of-cure planning,
three-month retesting,
HIV and viral-hepatitis risk assessment,
evaluation of persistent urethritis or cervicitis,
pelvic inflammatory disease assessment,
semen analysis where fertility is affected,
female tubal and reproductive evaluation,
sexual-function counselling.

Where medically appropriate, individualized Unani principles may also be used to support:

nutritional wellbeing,
digestion,
general recovery,
urinary health,
sexual wellbeing,
reproductive health.

At **Saira Health Care**, the objective is not simply:

“Give medicine and close the case.”

The objective is to determine:

Has the infection been correctly treated?

Is the partner protected?

Is reinfection likely?

Is follow-up testing required?

Has reproductive health been affected?

and:

How can normal sexual and fertility health be restored safely?



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Medical Disclaimer

This article is intended for professional education and public awareness. It does not provide an individual prescription or replace examination and advice from an appropriately qualified physician, sexual-health clinician, dermatologist/venereologist, gynecologist, urologist, infectious-disease specialist or fertility professional.

Partner-management recommendations differ according to the specific STI and may vary by:

pregnancy,

anatomy,

symptoms,

local antimicrobial resistance,

national guidelines.

Patients should not share leftover antibiotics or divide their own prescribed course with a partner.

Anyone who may have been exposed to HIV within the previous 72 hours should seek urgent medical evaluation for PEP rather than waiting for routine partner testing.

People recently exposed to hepatitis B who are not known to be immune should seek prompt medical advice regarding vaccination and, where indicated, hepatitis B immune globulin.

Partner notification should not be pursued in a way that puts a patient at risk of intimate-partner violence. Patients who fear violence or serious retaliation should inform their healthcare provider so that safer notification options can be considered.

Unani medicine may be incorporated as supportive integrative care where appropriate, but it should not replace:

proven antimicrobial treatment,

antiviral treatment where indicated,

vaccination,

partner management,

laboratory follow-up.

Persistent or recurrent symptoms after STI treatment require proper reassessment rather than repeated self-medication.



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Patients experiencing infertility following a previous STI should receive a complete couple-based fertility evaluation rather than repeated antibiotic treatment when active infection is no longer present.