

HIV: Testing, Prevention and Sexual Health

Understanding HIV and AIDS, Modern Testing, Window Periods, PEP, PrEP, U=U, Antiretroviral Therapy, Marriage, Pregnancy, Fertility and the Supportive Role of Unani Medicine

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A Message From Dr. Nizamuddin Qasmi

When a patient comes to me after a sexual exposure and says:

“Doctor, am I infected with HIV?”

I usually find that the greatest problem at that moment is not HIV itself.

It is:

uncertainty.

The patient may have spent several sleepless nights searching the internet.

They may ask:

“When should I test?”

“My test after seven days is negative—is that final?”

“Can I take medicine now to prevent HIV?”

“What is PEP?”

“What is PrEP?”

“If somebody has HIV, can he or she marry?”

“Can a person living with HIV have sex without infecting a partner?”

“Can we have a baby naturally?”



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“Can HIV cause infertility?”

These questions deserve calm, accurate and modern answers.

HIV medicine has changed dramatically.

A diagnosis that was once associated with severe illness and shortened life expectancy can now, with effective treatment, often be managed as a chronic medical condition.

The World Health Organization reported in July 2026 that approximately **41 million people were living with HIV worldwide at the end of 2025**. About **1.2 million people acquired HIV during 2025**, while approximately **570,000 people died from HIV-related causes**. WHO emphasizes that although there is not yet an established cure, effective prevention, testing and antiretroviral therapy allow people living with HIV to live long and healthy lives.

Perhaps the most transformative message in modern sexual medicine is:

U = U

Undetectable = Untransmittable.

A person living with HIV who takes effective antiretroviral therapy and maintains an undetectable viral load **does not sexually transmit HIV to their partner**.

This scientific fact has changed:

- marriage counselling,
- sexual-health counselling,
- pregnancy planning,
- fertility treatment,
- the social meaning of an HIV diagnosis.

My objective in this article is therefore not to create fear.

It is to explain:

how HIV is transmitted, how modern testing works, what to do immediately after an exposure, how HIV is prevented and treated, and how people living with HIV can maintain normal sexual and reproductive lives.

What Is HIV?

HIV stands for:

Human Immunodeficiency Virus.



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HIV primarily attacks important immune cells, especially:

CD4 T lymphocytes.

These cells help coordinate the body's defence against infections and some cancers.

Without effective treatment, HIV can progressively weaken the immune system.

A person may then become susceptible to illnesses that a healthy immune system would usually control more easily.

WHO identifies conditions associated with advanced HIV disease such as:

- tuberculosis,
- severe bacterial infections,
- cryptococcal meningitis,
- certain lymphomas,
- Kaposi sarcoma.

However:

HIV does not automatically mean AIDS.

What Is AIDS?

AIDS stands for:

Acquired Immunodeficiency Syndrome.

It describes the most advanced stage of HIV infection.

In modern clinical practice, advanced HIV disease may be identified when immunity is severely impaired or when particular serious opportunistic diseases occur.

WHO's current definition of **advanced HIV disease** in adults and adolescents includes:

- CD4 count below 200 cells/mm³,
- or a WHO stage 3 or stage 4 clinical event.

A person diagnosed early and maintained on effective antiretroviral treatment may:

never develop AIDS.

That is why:

HIV testing is so important.

Early diagnosis means early treatment.



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Early treatment protects:

- the immune system,
 - long-term health,
 - sexual partners,
 - future pregnancies.
-

HIV Infection Is Not the Same as AIDS

This distinction should be understood clearly.

A person can live with HIV for many years without having AIDS.

With effective modern treatment, HIV replication can be suppressed to extremely low levels.

The immune system can remain strong.

Therefore, I do not like patients thinking:

“My HIV test is positive, so I now have AIDS.”

That statement is medically incorrect.

The next step after confirmed diagnosis is:

linkage to HIV care and prompt antiretroviral treatment.

HIV in India — Current Situation

India has made substantial progress in reducing HIV transmission, although HIV remains an important public-health issue.

The **India HIV Estimation 2025 Technical Report**, presenting national estimates for 2024, estimated approximately:

25.61 lakh people living with HIV in India.

The estimated adult HIV prevalence among people aged 15–49 years was:

0.20%.

Approximately:

64,470 new HIV infections

were estimated during 2024.



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The report estimated that annual new HIV infections had declined by approximately:
48.7% since 2010.

These figures are encouraging.

But they also tell us that prevention, early testing and treatment remain essential.

HIV Testing and Treatment Services in India

India's National AIDS Control Organisation—NACO—operates HIV prevention, testing, care and treatment services through the National AIDS and STD Control Programme.

Integrated Counselling and Testing Centres—ICTCs—provide:

- HIV counselling,
- screening and diagnostic testing,
- prevention information,
- linkage to HIV treatment and care.

NACO describes HIV testing as being provided in a confidential and supportive environment, with people diagnosed with HIV linked to treatment and care services.

India also operates the:

NACO HIV/AIDS Helpline — 1097

which is toll-free and available **24 hours a day** for HIV-related information, counselling and information about ICTC and ART-centre locations.

HIV Testing Is Confidential

Confidentiality is extremely important in HIV medicine.

NACO identifies:

- informed consent,
- confidentiality,
- protection against discrimination

as important rights related to HIV testing and care.



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India's **HIV and AIDS (Prevention and Control) Act, 2017**, which came into force in September 2018, provides legal protection against HIV-related discrimination and establishes mechanisms for complaints and redress.

A person should never avoid testing because of fear that an HIV diagnosis removes their human dignity or basic rights.

How Is HIV Transmitted?

HIV can be transmitted through particular body fluids when sufficient virus is present.

Important routes include:

- blood,
- semen,
- vaginal secretions,
- breast milk.

Transmission can occur through:

- vaginal intercourse,
- anal intercourse,
- sharing contaminated injecting equipment,
- unsafe blood exposure,
- accidental occupational needle-stick exposure,
- pregnancy,
- childbirth,
- breastfeeding.

HIV transmission is not simply about:

“touching somebody who has HIV.”

The virus needs an appropriate route into the body.

Which Sexual Activity Carries HIV Risk?

Sexual HIV transmission is most relevant during:

- unprotected anal intercourse,



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- unprotected vaginal intercourse

when a partner has transmissible HIV.

Risk is influenced by several factors, including:

- whether the person living with HIV is receiving effective ART,
- viral load,
- presence of another STI,
- condom use,
- use of PrEP.

This is why HIV risk cannot be accurately judged from one sentence such as:

“I had sex with someone.”

We need to know:

- what kind of exposure occurred,
- when it occurred,
- whether protection was used,
- partner HIV status,
- viral suppression status.

HIV Is Not Spread by Ordinary Social Contact

HIV is **not transmitted** through ordinary daily contact such as:

- hugging,
- shaking hands,
- sharing food,
- sharing drinking glasses,
- sitting beside somebody,
- using the same toilet,
- living in the same house.

WHO clearly states that HIV is not transmitted through ordinary social contact such as:

- kissing,



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- hugging,
- shaking hands,
- sharing food or water.

A person living with HIV does not need to be socially isolated.

Can HIV Spread Through Saliva?

Ordinary saliva does not represent a meaningful route of HIV transmission.

Therefore, normal:

- talking,
- eating together,
- drinking together,
- casual kissing

should not be feared.

HIV is not spread like:

- influenza,
- COVID-19,
- tuberculosis.

It is not an airborne infection.

Can Mosquitoes Spread HIV?

No.

HIV is not transmitted by mosquitoes.

The virus does not reproduce inside mosquitoes in the manner required for mosquito-borne transmission.

Patients should not fear living in the same home as a person with HIV because mosquitoes are present.

Can HIV Be Transmitted Through a Toilet Seat?

No.



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Ordinary toilets are not a route of HIV transmission.

Neither are:

- swimming pools,
- ordinary bedding,
- shared utensils,
- routine household contact.

Why Other STIs Matter

Having another sexually transmitted infection can increase susceptibility to HIV.

WHO identifies STIs such as:

- syphilis,
- herpes,
- chlamydia,
- gonorrhoea

as factors that may increase HIV acquisition risk.

Genital inflammation or ulceration can make biological transmission easier.

Therefore:

HIV prevention and STI prevention belong together.

At Saira Health Care, if someone presents with:

- genital ulcer,
- urethral discharge,
- vaginal discharge,
- suspected syphilis,
- herpes,
- gonorrhoea,

I also consider whether HIV testing should be discussed.

What Happens After HIV Enters the Body?



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After infection, HIV begins replicating.

The earliest phase is often called:

Acute HIV Infection.

During this period:

- viral load may be very high,
- transmission risk can be high,
- routine antibody tests may still be negative.

This creates the important concept of the:

Window Period.

Symptoms of Early HIV Infection

Some people develop symptoms a few weeks after infection.

These can include:

- fever,
- sore throat,
- rash,
- headache,
- swollen lymph nodes,
- muscle aches,
- fatigue.

WHO notes that many people have no symptoms during the first weeks, while others experience a nonspecific influenza-like illness.

The problem is that these symptoms resemble many ordinary viral infections.

Therefore:

symptoms cannot diagnose HIV.

Only appropriate testing can do that.

Can Someone Have HIV Without Symptoms?



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Absolutely.

A person may feel completely healthy for:

- months,
- years

while HIV gradually affects the immune system.

This is why:

“I feel healthy” is not an HIV test.

Similarly:

“My partner looks healthy” tells us nothing reliable about HIV status.

Understanding HIV Tests

Modern HIV testing generally falls into several categories.

These include:

Antibody Tests

Antigen/Antibody Combination Tests

Nucleic Acid Tests — NAT

They detect different markers of infection and therefore become positive at different times after exposure.

This difference is crucial when interpreting an early negative test.

What Is the HIV Window Period?

The window period is the period after infection during which an HIV test may still be negative because the biological marker detected by that test has not yet reached detectable levels.

No HIV test becomes positive immediately after exposure.

CDC currently provides the following typical detection windows.

HIV NAT

Usually detects infection approximately:

10–33 days after exposure.



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Laboratory Antigen/Antibody Test

Using blood drawn from a vein:

approximately 18–45 days.

Rapid Antigen/Antibody Test

Usually finger-stick blood:

approximately 18–90 days.

Antibody-Only Test

Including many rapid and self-tests:

approximately 23–90 days.

These ranges explain why two patients tested on the same day with different tests may receive different levels of certainty.

Fourth-Generation HIV Test

A laboratory fourth-generation HIV test detects both:

- HIV antibodies,
- p24 antigen.

Because p24 antigen can appear before antibodies are fully developed, fourth-generation laboratory testing can detect infection earlier than conventional antibody-only tests.

CDC gives a typical window of:

18–45 days

for a laboratory antigen/antibody test using venous blood.

This is one of the most useful tests after a recent exposure.

HIV NAT or RNA Test

A nucleic-acid test detects:

HIV genetic material.

It can become positive earlier than standard antibody testing.

CDC estimates the typical window at:



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approximately 10–33 days.

NAT is especially useful in selected situations such as:

- suspected acute HIV,
- very recent high-risk exposure,
- compatible acute symptoms with negative or indeterminate screening.

It is not necessarily required for every routine HIV test.

Antibody Tests

Many rapid tests and self-tests primarily detect:

antibodies.

Antibodies take time to develop.

CDC gives a typical antibody-test window of:

approximately 23–90 days.

This is why an antibody test performed very soon after exposure cannot reliably exclude infection.

Is a Negative HIV Test at Seven Days Final?

Usually:

No.

A negative test one week after a recent exposure can be reassuring only in a limited sense.

It does not usually close the diagnostic window.

The appropriate repeat-testing schedule depends upon:

- type of test,
- timing of exposure,
- PEP use,
- ongoing exposures.

A clinician should interpret the result in that context.



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Is a Negative Fourth-Generation Test at Six Weeks Reassuring?

Yes, a laboratory fourth-generation antigen/antibody test at this interval is highly informative because its typical CDC window extends to approximately 45 days.

However, individual testing recommendations can vary with:

- laboratory assay,
- PEP or PrEP use,
- recent repeated exposure,
- clinical suspicion.

Therefore, the clinician or testing centre should advise when testing is considered final for that specific situation.

HIV Self-Testing

WHO supports HIV self-testing as a way to expand access to diagnosis and prevention.

A person can privately perform a self-test using an approved test kit.

However:

a reactive self-test is not the final diagnosis.

WHO states that no single self-test or screening test should by itself establish a complete HIV-positive diagnosis; confirmatory testing must follow the nationally approved testing algorithm.

Therefore:

Reactive self-test → confirmatory testing.

Not:

Reactive self-test → panic.

What Does “Reactive” Mean?

A screening test may be described as:

- reactive,
- non-reactive.



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Reactive means that the screening test has detected a signal requiring further evaluation.

It is not always synonymous with:

confirmed HIV infection.

NACO similarly distinguishes HIV:

- screening,
- confirmatory testing

to reduce false-positive diagnosis.

HIV Testing in Babies

Babies born to mothers living with HIV require a different testing approach.

Maternal HIV antibodies can remain in an infant's blood for many months.

Therefore, antibody testing alone cannot reliably diagnose HIV in children under approximately 18 months.

WHO recommends:

virological testing

for exposed infants rather than relying on ordinary antibody rapid testing.

Who Should Consider HIV Testing?

HIV testing is particularly important after possible exposure such as:

- sex without appropriate protection when partner HIV status is unknown or positive without confirmed suppression,
- shared injecting equipment,
- occupational needle-stick exposure,
- sexual assault,
- diagnosis of another STI,
- pregnancy,
- a partner newly diagnosed with HIV.



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WHO recommends testing for people who may be at risk and emphasizes linkage to either:

- prevention,
- treatment

depending upon the result.

What Should I Do Immediately After a Possible HIV Exposure?

If a potentially significant exposure occurred:

do not wait for symptoms.

And do not wait several weeks simply to see whether an HIV test becomes positive.

A preventive treatment called:

PEP

may be appropriate.

What Is PEP?

PEP stands for:

Post-Exposure Prophylaxis.

It means taking antiretroviral medicines **after a potential HIV exposure** to reduce the chance that infection becomes established.

PEP is an:

emergency HIV-prevention intervention.

WHO's current PEP guidance emphasizes that timing is critical.

How Soon Should PEP Be Started?

PEP should be started:

as soon as possible.

WHO states that it is most effective when started:

ideally within 24 hours,

and:



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no later than 72 hours

after potential exposure.

This is why a potentially significant exposure at:

- midnight,
- during travel,
- after sexual assault,
- after occupational needle injury

should not be left for several days if PEP evaluation is accessible.

How Long Is PEP Taken?

WHO recommends a:

28-day course.

Three antiretroviral drugs are preferred in current WHO guidance, although two-drug regimens can have preventive activity.

The exact regimen should be prescribed by an appropriate clinician according to:

- national guidelines,
 - kidney function,
 - pregnancy,
 - interacting medicines,
 - resistance considerations where relevant.
-

Who May Need PEP?

PEP assessment may be appropriate after:

- unprotected sexual exposure to potentially transmissible HIV,
- condom breakage in a relevant exposure,
- needle sharing,
- sexual assault,
- healthcare needle-stick or sharps injury,



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- blood exposure to non-intact skin or mucous membrane.

Not every exposure requires PEP.

Risk should be assessed based on:

- exposure route,
- source HIV status,
- source viral load where known,
- timing.

PEP After Sex With a Person Who Is Undetectable

An important modern distinction is:

if the partner living with HIV has confirmed durable viral suppression and therefore meets the principle of:

U = U,

there is no sexual HIV transmission risk from that suppressed partner.

WHO implementation guidance notes that PEP is not required for sex with a partner living with HIV who has a confirmed undetectable viral load.

Individual circumstances should still be reviewed if viral suppression status is uncertain.

What Is PrEP?

PrEP stands for:

Pre-Exposure Prophylaxis.

Unlike PEP—which is used after an exposure—PrEP is taken:

before future exposure

by a person who does not have HIV.

Its purpose is to prevent HIV acquisition.

WHO describes PrEP as a highly effective component of combination HIV prevention.

Who May Benefit From PrEP?



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PrEP may be appropriate for HIV-negative individuals with ongoing or anticipated HIV exposure risk.

Examples can include people who:

- have a sexual partner with HIV whose viral suppression is unknown or inconsistent,
- have repeated higher-risk sexual exposures,
- have recurrent STIs indicating ongoing HIV exposure risk,
- share injecting equipment,
- specifically request PrEP after informed assessment.

The decision should be patient-centred rather than based on stigma.

Current PrEP Options — 2026 Update

HIV prevention is changing rapidly.

WHO currently recommends several PrEP approaches, including:

- oral tenofovir-based PrEP,
- dapivirine vaginal ring in appropriate settings,
- long-acting injectable cabotegravir,
- long-acting injectable lenacapavir.

A major development occurred in **2025**, when WHO recommended:

long-acting injectable lenacapavir

as an additional PrEP choice.

Lenacapavir can be administered approximately:

twice yearly.

This represents an important advance for people who find daily tablets difficult.

Availability differs between countries and healthcare systems.

PrEP in India

NACO's current website lists national technical guidance for PrEP as part of India's HIV-prevention response.



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NACO training material describes daily oral PrEP using:

- tenofovir disoproxil fumarate—TDF,
- combined with emtricitabine—FTC,
- or lamivudine—3TC,

with HIV testing, kidney-function assessment where appropriate and continuing clinical follow-up.

Actual access to individual PrEP products can vary, so patients should obtain current information from NACO-linked services or an HIV specialist rather than purchasing medicines without medical supervision.

PEP Is Not the Same as PrEP

I explain it simply to patients:

PEP

Possible exposure happened → emergency prevention afterward.

PrEP

Future exposure may happen → prevention beforehand.

Repeated dependence upon emergency PEP when ongoing exposure continues may indicate that:

PrEP should be discussed.

Condoms and HIV Prevention

Correct and consistent condom use remains an important HIV and STI prevention method.

Condoms also reduce the risk of infections that ART or PrEP do not prevent, such as:

- gonorrhoea,
- chlamydia,
- syphilis,
- trichomoniasis.

PrEP is highly effective for HIV prevention but:



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PrEP does not prevent every STI.

Therefore, sexual-health counselling should not focus exclusively on HIV.

What Is U=U?

U=U means:

Undetectable = Untransmittable.

It is one of the most important discoveries in modern HIV medicine.

When a person living with HIV takes ART consistently and maintains an undetectable viral load:

they do not sexually transmit HIV.

WHO states this directly in its current 2026 guidance.

Large studies of couples with different HIV status found **no genetically linked HIV transmission** when the partner living with HIV had sustained viral suppression.

This is not a slogan created merely to reduce stigma.

It is based on strong scientific evidence.

What Is Viral Load?

Viral load measures the amount of HIV RNA in the blood.

Successful ART greatly reduces viral replication.

Over time, the viral load can become:

undetectable by the laboratory assay.

This does not mean HIV has been eradicated from every cell.

It means viral replication is so well controlled that the amount circulating in blood falls below the test's limit of detection.

Does Undetectable Mean Cured?

No.

A person whose viral load is undetectable:

- still has HIV,



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- still needs ART,
- should continue medical follow-up.

Stopping ART can allow viral replication to resume.

Therefore:

U=U means no sexual transmission while suppression is maintained.

It does **not** mean:

HIV has disappeared permanently.

What Viral Load Is Used for U=U?

The landmark sexual-transmission studies found no linked transmission when the partner living with HIV maintained viral load below approximately:

200 copies/mL.

Current NIH guidance states that people taking ART who maintain viral load below 200 copies/mL do not sexually transmit HIV.

In routine practice, the goal is usually:

laboratory-undetectable viral load.

Why ART Is Also HIV Prevention

Antiretroviral treatment benefits the person living with HIV by:

- protecting immunity,
- preventing opportunistic disease,
- allowing long healthy life.

But it also protects sexual partners.

This is called:

Treatment as Prevention.

WHO emphasizes early ART and sustained viral suppression as a major HIV prevention strategy.

What Is ART?



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ART stands for:

Antiretroviral Therapy.

ART uses combinations of medicines that interfere with different stages of the HIV life cycle.

The objective is to:

- stop HIV replication,
- suppress viral load,
- allow immune recovery,
- prevent HIV-related disease,
- prevent sexual transmission.

WHO recommends treatment for people diagnosed with HIV.

India's NACP-V incorporates the national:

- Test and Treat policy,
- universal viral-load testing,
- transition toward dolutegravir-based treatment.

Can HIV Be Cured?

At present:

there is no routinely available treatment that cures HIV infection.

WHO states this clearly.

Rare highly exceptional cases of apparent cure following complex stem-cell transplantation for life-threatening blood cancers have been scientifically important, but they are not an ordinary HIV treatment.

For the overwhelming majority of patients:

ART is lifelong treatment.

With adherence, it is extremely effective.

Can Someone Living With HIV Live a Normal Life?

Modern ART has transformed HIV.



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A person diagnosed early, linked promptly to treatment and maintaining viral suppression may live:

- for decades,
- work normally,
- marry,
- have sexual relationships,
- become a parent.

WHO now describes HIV as a manageable chronic health condition when effective treatment and care are available.

HIV and Marriage

An HIV diagnosis does not medically mean that a person cannot marry.

Modern sexual-health counselling focuses on:

- effective ART,
- sustained viral suppression,
- informed communication,
- prevention planning.

With sustained suppression:

sexual transmission does not occur.

Therefore, serodifferent couples—where one partner has HIV and the other does not—can maintain intimate relationships safely when HIV is appropriately managed.

Can a Person With HIV Have Sex?

Yes.

A diagnosis of HIV does not mean lifelong sexual abstinence.

The modern approach is:

- start and maintain ART,
- achieve sustained viral suppression,
- manage other STIs,



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- use additional prevention methods where desired or indicated.

Sexual-health counselling is important because many patients experience:

- fear,
- guilt,
- loss of confidence,
- erectile problems from anxiety,
- reduced libido,
- avoidance of intimacy.

These concerns deserve proper clinical attention.

HIV and Sexual Dysfunction

HIV does not automatically cause erectile dysfunction or loss of sexual desire.

However, sexual problems may arise through several pathways, including:

- anxiety after diagnosis,
- depression,
- relationship conflict,
- advanced illness,
- hormonal abnormalities,
- medication effects,
- other medical conditions.

A man with HIV and erectile dysfunction should not automatically be told:

“It is because of HIV.”

He deserves the same structured sexual-health assessment as any other patient.

HIV and Fertility

This is particularly important in my practice.

People living with HIV:

can have children.



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The presence of HIV does not automatically mean:

- infertility,
- compulsory IVF,
- donor sperm,
- permanent avoidance of pregnancy.

Reproductive planning depends upon:

- viral suppression,
- fertility of both partners,
- other medical factors.

HIV and Male Fertility

HIV infection—particularly uncontrolled or advanced infection—may be associated with abnormalities of:

- sperm concentration,
- motility,
- morphology,
- semen volume

in some men.

Current NIH reproductive guidance acknowledges that HIV and possibly some antiretroviral exposures have been associated with a higher prevalence of abnormal semen parameters in some studies.

However:

HIV does not automatically make a man infertile.

Many men living with HIV have normal fertility.

When infertility is present, a standard male evaluation remains necessary.

Male Infertility Should Not Be Blamed Automatically on HIV

Suppose a man living with well-controlled HIV has severe oligospermia.

I still investigate:



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- varicocele,
- hormonal disease,
- genetic abnormalities where indicated,
- previous testicular disease,
- smoking,
- obesity,
- heat exposure,
- medication effects,
- other reproductive infections.

HIV status should not become a shortcut that stops proper infertility investigation.

HIV and Female Fertility

Research regarding ovarian reserve in women living with HIV has produced mixed findings.

A systematic review including more than:

- 3,600 women living with HIV,
- 2,300 HIV-negative comparison participants

found lower unadjusted AMH levels in many studies, but associations became less consistent after accounting for confounding factors. Lower CD4 counts and higher viral loads were associated with lower AMH in some of the largest studies.

Therefore:

an HIV diagnosis does not automatically mean diminished ovarian reserve.

If fertility concerns exist, they should be evaluated objectively using:

- age,
 - menstrual history,
 - ovarian reserve testing when indicated,
 - tubal and uterine assessment,
 - male-partner fertility.
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Can a Couple With Different HIV Status Conceive Naturally?

Yes.

This is one of the most important advances in reproductive medicine.

If the partner living with HIV:

- takes ART reliably,
- has sustained viral suppression,

NIH guidance states that:

intercourse without a condom can be used for conception without sexual HIV transmission to the HIV-negative partner.

This is U=U applied to fertility care.

Does a Couple Need IVF Just Because One Partner Has HIV?

No.

Historically, assisted reproductive methods were sometimes used primarily to reduce HIV transmission.

Today, when the person living with HIV has durable viral suppression:

HIV alone is not automatically an indication for IVF.

If both partners otherwise have normal fertility, natural conception can be considered under appropriate medical guidance.

IVF or ICSI should be used because there is a genuine:

- female fertility problem,
 - male fertility problem,
 - another reproductive indication.
-

What if the Partner With HIV Is Not Undetectable?

If viral suppression has not yet been achieved or cannot be confirmed:

conception should ideally be postponed until effective ART produces sustained viral suppression.

The HIV-negative partner may also consider:



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PrEP

as an additional prevention method.

Can the HIV-Negative Partner Use PrEP While Trying to Conceive?

Yes.

Current reproductive HIV guidance recommends discussing PrEP with HIV-negative people who are:

- trying to conceive,
- pregnant,
- postpartum,
- breastfeeding

when prevention is appropriate.

PrEP may also be chosen as an additional layer of reassurance even when the partner living with HIV is already durably suppressed.

Both Partners Should Be Checked for Other STIs

Before attempting conception, current NIH guidance recommends screening and treating both partners for genital-tract infections.

This is important because STIs can affect:

- reproductive health,
- pregnancy,
- fertility.

Again:

HIV care and infertility care should be integrated.

When Should Infertility Be Investigated?

If conception does not occur despite appropriately timed attempts, infertility evaluation should proceed in the usual way.

That can include:

Female assessment

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

Male assessment

- semen analysis,
- examination,
- hormones or genetic testing when indicated.

Current NIH reproductive guidance specifically recommends ordinary infertility evaluation when conception does not occur.

HIV and Pregnancy

Women living with HIV can have:

successful pregnancies and HIV-negative children.

The cornerstone is:

effective ART and viral suppression.

Current NIH guidance states that when ART is started before pregnancy and an undetectable viral load is maintained through pregnancy and delivery, the risk of HIV transmission to the infant becomes:

less than 1%.

That represents one of the great successes of modern HIV medicine.

Pregnancy Should Be Planned Whenever Possible

Before conception, I want to know:

- Is ART effective?
- Is viral load suppressed?
- Are medicines appropriate for pregnancy?



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- Are other STIs present?
- Is general health stable?
- Are fertility factors present?

The HIV physician and obstetric team should coordinate care.

HIV Testing During Pregnancy

HIV testing should be part of antenatal care.

Current NIH guidance recommends HIV testing early during every pregnancy, with repeat testing when ongoing acquisition risk exists.

India's NACO programme similarly integrates HIV and syphilis testing into pregnancy care as part of its programme for eliminating vertical transmission.

Early diagnosis provides time to:

- start treatment,
 - suppress viral load,
 - protect maternal health,
 - dramatically reduce infant transmission.
-

Does U=U Apply to Breastfeeding?

This requires an important distinction.

U=U specifically describes sexual transmission.

HIV can be transmitted through:

breast milk.

Therefore, infant-feeding decisions for mothers living with HIV require:

- current national guidelines,
- maternal viral-load assessment,
- specialist counselling.

Patients should not assume:

“I am undetectable, therefore breast-milk transmission is automatically impossible.”



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Infant-feeding recommendations can differ between healthcare settings because they must balance:

- HIV transmission,
- nutritional safety,
- access to replacement feeding,
- maternal treatment.

In India, this should be managed with the treating HIV and obstetric/pediatric team under current NACO guidance.

HIV Does Not Mean a Baby Will Be HIV-Positive

This is one of the most damaging misconceptions.

With:

- maternal ART,
- viral suppression,
- appropriate obstetric management,
- infant preventive treatment and testing where indicated,

the likelihood of transmission can be reduced dramatically.

A woman living with HIV should therefore not automatically be told:

“You cannot have children.”

That statement is outdated and medically harmful.

HIV and Contraception

People living with HIV need the same reproductive autonomy as everyone else.

Some patients want pregnancy.

Others do not.

Contraceptive planning should consider:

- reproductive goals,
- ART interactions,
- other health conditions,



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- STI prevention.

Condoms remain useful because they prevent many STIs even when U=U has removed the sexual HIV transmission risk.

What About HIV After Sexual Assault?

Sexual assault requires urgent medical evaluation.

Depending on:

- type of exposure,
- time elapsed,
- source risk,

HIV PEP may be indicated.

Because PEP must begin no later than:

72 hours,

and preferably within:

24 hours,

medical care should be sought urgently.

Other needs can include:

- emergency contraception,
 - STI testing and prophylaxis,
 - hepatitis B prevention,
 - forensic and psychological support.
-

Occupational Needle-Stick Injury

Healthcare workers may experience occupational exposure through:

- needle-stick injury,
- sharps injury,
- blood exposure to mucous membranes.

The correct approach is:



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- immediate first aid,
- prompt exposure assessment,
- source evaluation where possible,
- PEP when indicated.

Again:

timing matters.

Do not wait several days before reporting the incident.

Why HIV Testing After PEP Is Different

PEP can influence the timing of detectable infection.

Patients completing PEP therefore need follow-up testing according to the PEP protocol rather than relying upon the ordinary window-period table alone.

The clinician prescribing PEP should provide a structured:

- baseline test,
 - follow-up testing plan.
-

HIV Prevention Is More Than Condoms

Modern combination HIV prevention includes:

- HIV testing,
- condoms,
- ART and U=U,
- PrEP,
- PEP,
- STI diagnosis and treatment,
- sterile injecting equipment,
- safe blood and medical procedures.

WHO emphasizes combination prevention rather than relying upon one single intervention.



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Injecting Drug Use and HIV

Sharing:

- needles,
- syringes,
- injecting equipment

can directly transfer infected blood.

Harm-reduction programmes using:

- sterile injecting equipment,
- opioid-substitution treatment where appropriate

are therefore important HIV prevention tools.

NACO's targeted interventions include provision of clean needles and syringes and linkage to HIV testing and care for people who inject drugs.

Blood Transfusions

Modern blood-screening systems have made transfusion-associated HIV dramatically less common where quality systems are functioning.

People should receive blood and blood products from:

- properly regulated,
- appropriately screened services.

Tattoos, Piercings and Medical Procedures

HIV transmission can theoretically occur if procedures involve contaminated blood and improperly sterilized equipment.

Therefore, choose centres using:

- single-use disposable needles where appropriate,
- validated sterilization,
- standard infection-control practices.

What Is the Best Way to Prevent HIV After Marriage?



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There is no one answer because couples have different situations.

For a couple where neither partner has HIV:

- testing when appropriate,
- STI prevention,
- condom use according to circumstances

may be sufficient.

For a serodifferent couple:

- effective ART,
- durable viral suppression,
- U=U

can eliminate sexual transmission risk.

PrEP may also be chosen by the HIV-negative partner.

Can Two People Living With HIV Have Sex Safely?

Yes.

Both partners should receive effective ART and maintain viral suppression.

Other STIs remain possible, so HIV suppression does not remove the value of:

- STI screening,
- appropriate condom use.

Current reproductive guidance notes that the risk of HIV superinfection or acquisition of resistant virus is negligible when both partners are fully suppressed on ART.

Why Adherence to ART Is So Important

ART only provides durable viral suppression when treatment is taken correctly.

Poor adherence can allow:

- viral load to rise,
- immune damage,
- drug resistance,



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- renewed transmission potential.

Therefore:

medication adherence is part of sexual-health protection.

Patients should not stop ART because:

- they feel healthy,
- their viral load is undetectable,
- a herbal practitioner says HIV is cured.

Undetectable viral load is evidence that:

the ART is working.

Not evidence that treatment is no longer necessary.

Viral Load Monitoring

Viral-load testing allows clinicians to determine whether ART is effectively suppressing HIV.

NACO's care programme includes universal viral-load monitoring as a central part of India's HIV response.

Monitoring helps identify:

- successful suppression,
 - adherence problems,
 - possible treatment failure.
-

CD4 Count and Viral Load Are Different

Patients frequently confuse these tests.

Viral load

tells us approximately:

how much HIV is replicating.

CD4 count

helps us understand:

the condition of the immune system.



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A good ART response usually produces:

- falling viral load,
- gradual immune recovery.

The Unani Perspective on HIV and Sexual Health

As a physician trained in **Unani medicine** and focused on **Sexual Disorders & Infertility**, I believe people living with HIV deserve care that addresses the whole person.

A patient may have successful viral suppression yet continue struggling with:

- fatigue,
- poor appetite,
- digestive problems,
- disturbed sleep,
- anxiety,
- sexual dysfunction,
- reproductive concerns,
- social stigma.

Traditional Unani medicine places importance on:

- **Mizaj** or constitutional temperament,
- balanced nutrition,
- digestion,
- sleep,
- physical wellbeing,
- psychological balance,
- sexual and reproductive health.

These areas may make individualized Unani care useful as:

supportive integrative care.

But there is an essential scientific boundary.



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Can Unani Medicine Cure HIV?

At present:

No high-quality evidence establishes Unani medicine as a cure for HIV.

No Unani formulation has been scientifically demonstrated to reliably:

- eradicate HIV from the body,
- produce permanent viral suppression without ART,
- replace antiretroviral treatment,
- prevent AIDS progression when ART is stopped.

WHO currently states:

there is no established cure for HIV infection.

This limitation applies not only to Unani medicine but to routine modern medicine as well.

What Does the Research on Traditional Medicines Show?

Traditional Indian medicines have been studied experimentally and in small clinical investigations for HIV-related:

- symptoms,
- immune effects,
- quality of life.

However, a review of traditional Indian medical systems—including Unani—found the evidence base limited and methodologically inconsistent.

A broader systematic review of herbal treatments for HIV concluded that available evidence was insufficient to support herbal medicine as treatment for HIV infection or AIDS.

Therefore:

Unani medicine should not be represented as an alternative to ART.

How Unani Medicine May Be Useful

The responsible role is supportive.



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Depending on the individual patient's needs, an integrative programme may focus on:

- nutritional health,
- appetite,
- digestion,
- sleep,
- general wellbeing,
- sexual confidence,
- stress and emotional wellbeing,
- reproductive counselling.

For example, if a patient on effective ART has:

- erectile dysfunction,
- reduced sexual confidence,
- infertility,
- digestive complaints,

these can be assessed and managed as their own clinical problems.

This is very different from claiming that treating those symptoms eradicates HIV.

Herbs and ART Can Interact

This is extremely important.

A person taking ART should tell their HIV physician about:

- Unani medicines,
- herbal formulations,
- vitamins,
- mineral products,
- supplements.

A review of complementary medicines used with antiretroviral therapy identified clinically important interactions with some herbal and nutritional products. Certain substances can:

- lower antiretroviral drug concentrations,



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- increase toxicity,
- interfere with absorption.

WHO also emphasizes that herbal medicines can interact with conventional drugs and that such interactions must be considered carefully.

Why Herb–ART Interactions Matter So Much

If an herbal product reduces the concentration of an antiretroviral drug, the consequence is potentially much more serious than simply:

“the herb did not work.”

Insufficient ART exposure can potentially lead to:

- viral rebound,
- loss of viral suppression,
- treatment resistance.

Therefore:

ART should never be interrupted or modified to accommodate an unverified herbal treatment.

Minerals Can Also Affect Some HIV Medicines

Patients often assume that:

- calcium,
- iron,
- magnesium

cannot interact with medication because they are “just minerals.”

Some integrase-inhibitor antiretroviral medicines can interact with polyvalent minerals through chelation and altered absorption.

Reviews of ART and complementary medicine interactions emphasize the importance of checking:

- supplements,
- mineral formulations,



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- traditional preparations

alongside prescription medication.

This is especially relevant in traditional formulations containing multiple ingredients.

My Approach to Integrative HIV Care

At Saira Health Care, if a person living with HIV wishes to use Unani medicine, my principle is:

ART remains the foundation.

Unani care, if used, should be:

- supportive,
- transparent,
- coordinated with HIV treatment,
- reviewed for interactions.

I would never advise a patient to stop ART because:

- CD4 count improved,
- viral load became undetectable,
- symptoms disappeared,
- an herbal product is being started.

Those improvements are exactly why ART should be continued.

Special Treatment Planning by Dr. Nizamuddin Qasmi

When a person consults me about HIV and sexual health, I first identify the actual clinical situation.

I ask:

Was there a confirmed exposure or only fear?

When did the exposure occur?

What type of sexual contact occurred?

Was a condom used?

Is PEP still possible?



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Which HIV test has already been performed?

How many days after exposure was it performed?

Was the test antibody-only or fourth-generation?

If the patient already has diagnosed HIV, I ask:

Are you taking ART?

What is your latest viral load?

Is it undetectable?

Are you married or planning marriage?

Is pregnancy desired?

Does your partner have HIV?

Are there sexual problems such as erectile dysfunction or painful intercourse?

Is infertility also present?

These questions determine what care is actually required.

What “Special Treatment” Means at Saira Health Care

Specialized treatment does not mean giving everyone the same medicine.

It means identifying the actual problem.

Consider some examples.

Patient One — Sexual Exposure 24 Hours Ago

This is not the time to prescribe a “sexual weakness” tonic.

The priority is:

urgent HIV PEP assessment.

PEP works best when started as quickly as possible and must begin within 72 hours if indicated.

Patient Two — Negative Antibody Test Seven Days After Exposure

The correct response is not:



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“You definitely do not have HIV.”

The patient is still inside the antibody-test window.

I explain:

- which test is appropriate,
- when it should be repeated,
- whether PEP was indicated.

Patient Three — Reactive HIV Self-Test

The correct response is not immediate panic.

A reactive self-test requires:

confirmatory diagnostic testing.

WHO specifically states that self-testing alone does not establish a final positive diagnosis.

Patient Four — Newly Diagnosed HIV

The priority is:

- confirmation according to the national algorithm,
- rapid linkage to HIV treatment,
- initiation of effective ART.

The objective is:

durable viral suppression.

Patient Five — Married Man With Undetectable HIV

He asks:

“Can I have sex with my HIV-negative wife?”

Current evidence allows a powerful answer:

when viral suppression is durably maintained, HIV is not sexually transmitted.

That is U=U.



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Patient Six — Serodifferent Couple Wanting Pregnancy

If the partner living with HIV:

- takes ART,
- has durable viral suppression,

natural conception through intercourse can be considered without sexual HIV transmission to the HIV-negative partner.

PrEP may be discussed as an additional choice for the HIV-negative partner.

Patient Seven — HIV and Infertility

Suppose the couple has tried for pregnancy for two years.

It would be incorrect to assume:

“The infertility is because of HIV.”

I assess:

Male factor

- semen analysis,
- reproductive examination,
- hormones where indicated.

Female factor

- ovulation,
- ovarian reserve where relevant,
- tubes,
- uterus.

HIV and infertility should be treated as overlapping but distinct clinical issues.

Patient Eight — HIV With Erectile Dysfunction

If viral load is controlled but sexual performance has deteriorated, I assess:

- anxiety,



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- depression,
- testosterone where indicated,
- diabetes,
- cardiovascular factors,
- relationship stress,
- medication interactions.

Treating sexual dysfunction can substantially improve quality of life.

Patient Nine — Patient Wants to Stop ART and Use Herbal Treatment

My advice is clear:

do not stop ART.

No herbal or Unani treatment has established evidence as a replacement for suppressive antiretroviral therapy.

Supportive Unani treatment may be considered only in a way that:

- preserves ART effectiveness,
 - avoids interactions,
 - keeps the HIV physician informed.
-

Saira Health Care's Contribution to Sexual Disorders & Infertility

At **Saira Health Care**, our contribution in this area is particularly focused on the intersection between:

HIV + sexual health + fertility.

Many patients receive excellent HIV treatment but still have unanswered questions such as:

“Can I have sex normally?”

“Can I marry?”

“Can we conceive naturally?”

“Do I need IVF?”

“Can my baby remain HIV-negative?”



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“Is my erectile dysfunction because of HIV?”

“Will ART damage my sperm?”

These are legitimate reproductive-health questions.

My approach is to combine:

- modern HIV science,
- sexual medicine,
- infertility assessment,
- responsible supportive Unani care.

Saira Health Care Does Not Treat HIV in Isolation From the Person

The laboratory report matters.

But so does:

- the relationship,
- sexual confidence,
- family planning,
- reproductive goals,
- emotional wellbeing.

Successful HIV care should ultimately help the patient return to:

health, intimacy, productivity and family life.

Stigma Can Be More Harmful Than the Virus

Modern ART can suppress HIV extremely effectively.

But stigma can continue damaging:

- relationships,
- employment,
- marriage prospects,
- mental health,
- willingness to seek testing.



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India's HIV and AIDS (Prevention and Control) Act specifically aims to protect people living with HIV against discrimination and to create an enabling environment for access to healthcare.

A person living with HIV should be treated with:

dignity.

What Patients Should Avoid

I advise patients not to:

- judge HIV status from symptoms;
 - assume a healthy-looking partner cannot have HIV;
 - consider a very early negative test automatically final;
 - delay PEP while waiting for symptoms;
 - use PEP casually instead of considering PrEP when exposures are repeated;
 - stop ART after achieving undetectable viral load;
 - believe “undetectable” means cured;
 - assume HIV automatically prevents marriage or parenthood;
 - assume HIV automatically causes infertility;
 - take herbal or Unani formulations without checking ART interactions;
 - accept claims of a guaranteed permanent herbal HIV cure;
 - avoid treatment because of stigma.
-

Frequently Asked Questions

What does HIV stand for?

Human Immunodeficiency Virus.

What is AIDS?

AIDS is the advanced stage of HIV infection when severe immune suppression or certain HIV-related illnesses occur.



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Does everyone with HIV develop AIDS?

No.

Effective ART can prevent progression to AIDS.

Is HIV curable?

There is currently no routinely available cure for HIV.

However, ART can suppress the virus extremely effectively and allow long, healthy life.

Is HIV treatable?

Yes.

Modern antiretroviral therapy is highly effective.

How many people currently live with HIV worldwide?

WHO estimated approximately **41 million people** were living with HIV at the end of 2025.

How common is HIV in India?

India's 2025 HIV-estimation report places 2024 adult prevalence at approximately **0.20%**, with about **25.61 lakh people living with HIV**.

Can HIV spread through vaginal sex?

Yes, when a person has transmissible HIV.

Effective ART with sustained undetectable viral load eliminates sexual transmission.

Can HIV spread through anal sex?

Yes.

Anal intercourse can be an important sexual transmission route in the absence of effective prevention.



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Can HIV spread through oral sex?

HIV transmission risk from oral sex is much lower than from anal or vaginal intercourse, although circumstances such as blood exposure and oral lesions can influence risk.

Risk assessment should consider the specific exposure rather than treating every oral-sex event identically.

Can HIV spread through kissing?

Ordinary kissing is not considered a route of HIV transmission.

Can HIV spread through food?

No.

Can I get HIV from sharing a toilet?

No.

Can mosquitoes spread HIV?

No.

Can HIV spread from mother to baby?

Yes, through pregnancy, delivery or breastfeeding.

Modern ART and perinatal care can dramatically reduce this risk.

What are the first symptoms of HIV?

Some people experience:

- fever,
- rash,
- sore throat,
- headache,
- swollen glands.



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Others have no symptoms.

Can symptoms confirm HIV?

No.

Only appropriate HIV testing can diagnose HIV.

What is the window period?

It is the interval after infection when a test may still be negative despite infection because the test's biological target is not yet detectable.

How early can NAT detect HIV?

CDC estimates approximately **10–33 days** after exposure.

What is the window period for a laboratory fourth-generation test?

Approximately **18–45 days** according to CDC.

What is the window period for an antibody test?

Approximately **23–90 days**, depending upon the test.

Is an HIV test negative at seven days final?

Usually not.

Is an HIV self-test accurate?

Approved tests can be useful screening tools, but a reactive self-test must be confirmed through an approved testing algorithm.

Does a reactive screening test mean confirmed HIV?

Not always.

Screening and confirmatory testing are separate steps.



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Where can someone get HIV testing in India?

NACO operates HIV counselling and testing services through Integrated Counselling and Testing Centres—ICTCs—and related programme facilities.

Is there an HIV helpline in India?

Yes.

NACO operates the toll-free:

1097

HIV/AIDS helpline, available 24×7.

What is PEP?

Post-Exposure Prophylaxis—antiretroviral medication taken after a potentially significant HIV exposure.

When should PEP start?

As soon as possible, ideally within 24 hours and no later than **72 hours** after exposure.

How long is PEP taken?

Usually **28 days**.

Is PEP 100% effective?

No medical intervention should be presented as an absolute guarantee.

Its effectiveness depends strongly on:

- rapid initiation,
 - adherence,
 - completing the regimen.
-

What is PrEP?

Pre-Exposure Prophylaxis—antiretroviral medication used by a person without HIV to prevent infection before anticipated exposure.

Is PrEP effective?

Yes.

Appropriately used PrEP is highly effective for HIV prevention.

What is the newest major PrEP development?

WHO recommended **long-acting injectable lenacapavir** in 2025 as an additional PrEP option, administered approximately twice yearly.

Is PrEP available as tablets?

Yes.

Tenofovir-based oral PrEP remains an established option.

Does India have PrEP guidance?

Yes.

NACO's current programme materials list national technical guidance for PrEP, including daily oral TDF-based regimens.

Does PrEP prevent syphilis or gonorrhoea?

No.

PrEP prevents HIV; it is not comprehensive protection against all STIs.

What does U=U mean?

Undetectable = Untransmittable.

A person taking effective ART who maintains an undetectable viral load does not sexually transmit HIV.



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Is U=U scientifically proven?

Yes.

Large studies found no linked sexual transmissions when the person living with HIV was durably virally suppressed.

Does undetectable mean HIV has disappeared?

No.

ART must continue.

Can a person with undetectable HIV stop medicine?

No.

Stopping ART can allow viral rebound.

Can a person living with HIV marry?

Yes.

HIV itself does not medically prevent marriage.

Can a person living with HIV have a normal sexual life?

Yes.

With effective ART and sustained viral suppression, sexual HIV transmission is eliminated.

Can a person living with HIV have children?

Yes.

Can an HIV-positive man and HIV-negative woman conceive naturally?

Yes.



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When the man is taking ART and has sustained viral suppression, current reproductive guidance states that intercourse can be used for conception without sexual HIV transmission to the HIV-negative partner.

Can an HIV-positive woman become pregnant?

Yes.

With appropriate ART and obstetric care, she can have a healthy pregnancy.

What is the risk of HIV transmission to a baby when maternal treatment is successful?

Current NIH guidance states that when effective ART is started before pregnancy and an undetectable viral load is maintained throughout pregnancy and delivery, transmission risk becomes **less than 1%**.

Does U=U mean breastfeeding has zero risk?

No.

U=U refers to sexual transmission.

HIV can be transmitted through breast milk, so infant-feeding decisions require specialist advice and current national guidance.

Does HIV cause male infertility?

Not automatically.

Uncontrolled or advanced HIV may be associated with semen abnormalities in some patients, but many men living with HIV remain fertile.

Does HIV lower sperm count?

It can be associated with abnormalities in some patients, particularly with more advanced illness, but an abnormal semen analysis requires a complete male infertility evaluation.

Does HIV cause female infertility?

Not automatically.

Evidence regarding ovarian reserve is mixed and influenced by factors such as:

- disease severity,
 - CD4 count,
 - viral load,
 - other health conditions.
-

Does an HIV-positive couple automatically require IVF?

No.

ART and sustained viral suppression have transformed reproductive planning.

IVF should be used when there is a true fertility indication.

Can the HIV-negative partner take PrEP during conception attempts?

Yes.

PrEP can be discussed and offered as an additional prevention choice where appropriate.

Can PrEP be used during pregnancy?

Current guidance allows appropriate PrEP use during pregnancy in people at HIV-acquisition risk, with selection of the regimen made by clinicians.

Does HIV cause erectile dysfunction?

Not necessarily.

Erectile dysfunction can arise from:

- anxiety,
- metabolic disease,
- hormonal factors,
- relationship stress,
- other medical conditions.



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These should be investigated normally.

Can ART cause sexual side effects?

Some medications or associated metabolic changes may contribute to sexual symptoms in selected patients.

Treatment should not be stopped without an HIV specialist.

Can Unani medicine cure HIV?

There is currently no high-quality evidence showing that Unani medicine can eradicate HIV or replace ART.

WHO states there is presently no established cure for HIV.

Can Unani medicine increase CD4 count?

Changes in CD4 count can have many causes.

There is insufficient reliable evidence to use Unani treatment as a substitute for ART for immune recovery.

The principal proven strategy is effective antiretroviral treatment and viral suppression.

Can Unani medicine reduce viral load to undetectable?

There is no adequate evidence demonstrating that a Unani formulation can reliably produce durable HIV viral suppression comparable with ART.

Can Unani medicine still be useful?

Yes, potentially as carefully coordinated **supportive care** for issues such as:

- nutrition,
- digestion,
- sleep,
- general wellbeing,
- sexual health,



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- stress.

It must not replace ART.

Can herbal medicines interact with ART?

Yes.

Clinically important herb–drug and supplement–drug interactions have been reported with antiretroviral medicines.

Should my HIV doctor know about my Unani medicines?

Absolutely.

The complete list of:

- medicines,
- herbs,
- minerals,
- supplements

should be disclosed.

A Message From Dr. Nizamuddin Qasmi to Patients After a Possible Exposure

If you have just had an exposure that worries you:

do not panic and do not wait for symptoms.

Ask two questions immediately:

1. Am I still within 72 hours?

If yes, seek urgent PEP assessment.

2. What testing schedule is appropriate?

Do not perform one test too early and then spend months repeatedly testing without understanding the test window.

Good counselling can prevent enormous anxiety.

A Message to Patients Who Receive an HIV Diagnosis

A confirmed HIV diagnosis changes your medical care.

It does not end your life.

Start appropriate treatment.

Take your ART regularly.

Monitor your viral load.

The objective is:

undetectable.

Once durable suppression is achieved, you gain two enormous benefits:

your immune system is protected,

and:

you do not sexually transmit HIV.

That is why ART is both:

treatment

and:

prevention.

A Message to Married and Serodifferent Couples

I want couples to understand that modern HIV science is very different from the situation 25 or 30 years ago.

If one partner lives with HIV and is:

- taking effective ART,
- durably undetectable,

current evidence tells us:

HIV will not be transmitted sexually to the HIV-negative partner.

This allows couples to discuss:

- intimacy,
- conception,
- pregnancy



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from a scientifically informed position rather than permanent fear.

A Message to Couples Concerned About Infertility

Do not automatically interpret HIV as the cause.

If pregnancy is not occurring, evaluate fertility in the same systematic manner we use for other couples.

For the man:

- semen analysis,
- hormones where appropriate,
- clinical reproductive assessment.

For the woman:

- age,
- ovulation,
- ovarian reserve where relevant,
- tubes,
- uterus.

Modern HIV medicine should remove HIV transmission as a barrier to fertility planning when viral suppression is maintained.

It should not stop us from diagnosing ordinary infertility correctly.

A Message About Unani Medicine

As a physician trained in Unani medicine, I believe strongly in treating the person as a whole.

A patient may need help with:

- nutrition,
- digestive health,
- sleep,
- physical strength,
- stress,



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- sexual wellbeing.

Unani medicine can have a supportive place in this broader care when appropriately selected.

But I also believe that responsible Unani medicine must respect established science.

For HIV:

ART should not be stopped.

An herbal product should never be presented as a proven substitute for viral suppression.

The purpose of integrative medicine is not to choose:

Unani or ART.

It is to use supportive care around:

effective HIV treatment.

Saira Health Care's Approach to HIV, Sexual Health and Fertility

At **Saira Health Care**, my clinical focus in this area includes:

- sexual-exposure counselling,
- interpretation of HIV testing and window periods,
- guidance regarding urgent PEP referral,
- education about PrEP,
- U=U counselling,
- sexual-health management for people living with HIV,
- assessment of erectile and ejaculatory disorders,
- preconception counselling,
- male and female infertility evaluation,
- coordination with HIV/ART and obstetric specialists,
- carefully selected supportive Unani care where appropriate.

For confirmed HIV infection, definitive HIV management should remain under an appropriate:

- HIV specialist,



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- ART centre,
- infectious-disease service

with viral-load monitoring and guideline-directed ART.

Our role in sexual and reproductive medicine is to help the patient understand that effective HIV control and a fulfilling sexual and family life can coexist.

Latest Medical Understanding — 2026 Update

HIV has become a manageable chronic condition

WHO's July 2026 update emphasizes that effective diagnosis, ART and care allow people living with HIV to lead long and healthy lives.

Global HIV burden remains substantial

Approximately **41 million people** were living with HIV at the end of 2025, with about **1.2 million new infections** and **570,000 HIV-related deaths** during that year.

India continues to reduce new infections

India's latest technical estimates place adult prevalence at approximately 0.20% and show a nearly 49% decline in new infections since 2010.

Modern testing can identify infection much earlier

A laboratory fourth-generation antigen/antibody test typically detects HIV within approximately **18–45 days**, while NAT can detect infection at approximately **10–33 days**.

HIV self-testing is an important access strategy

WHO supports self-testing but requires confirmatory testing after a reactive result.

PEP is an emergency

It should begin preferably within **24 hours** and no later than **72 hours** after a qualifying exposure and is generally taken for 28 days.

PrEP options are expanding

WHO now includes oral TDF-based PrEP, dapivirine ring, long-acting cabotegravir and twice-yearly long-acting lenacapavir among prevention options.

U=U is firmly established

A person maintaining undetectable HIV on effective ART does not transmit HIV through sex.



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Natural conception is possible in serodifferent couples

When the partner living with HIV has sustained viral suppression, intercourse for conception does not transmit HIV sexually to the HIV-negative partner.

Pregnancy outcomes have transformed

Effective ART before and throughout pregnancy can reduce mother-to-child transmission to **below 1%** when viral suppression is maintained.

Traditional medicines require interaction monitoring

Herbal medicines and supplements may interact with ART; their use should always be disclosed to the HIV-care team.

Conclusion

HIV: Testing, Prevention and Sexual Health is no longer a subject that should be discussed only through fear of AIDS.

Modern HIV medicine gives us several highly effective tools:

HIV testing

ART

U=U

PEP

PrEP

condoms

STI prevention

pregnancy and reproductive care.

No HIV test can diagnose infection immediately after exposure.

Different tests have different window periods.

Current CDC estimates indicate approximately:

- **10–33 days** for NAT,
- **18–45 days** for a laboratory fourth-generation antigen/antibody test,
- **18–90 days** for some rapid antigen/antibody tests,
- **23–90 days** for antibody tests.



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Therefore:

an early negative test must be interpreted according to the type and timing of the test.

When a significant exposure has just occurred:

do not wait for the window period if PEP may be appropriate.

WHO recommends starting PEP as rapidly as possible—ideally within 24 hours and no later than 72 hours—and continuing treatment for 28 days.

For people with continuing exposure risk:

PrEP can prevent HIV before exposure.

The range of available options continues to expand, with WHO now recommending long-acting cabotegravir and, since 2025, **twice-yearly injectable lenacapavir** in addition to established tenofovir-based oral PrEP.

For people already living with HIV:

antiretroviral therapy has transformed the disease.

The objective is sustained viral suppression.

And the most important modern sexual-health message is:

U = U — Undetectable = Untransmittable.

A person who maintains an undetectable viral load on effective ART does not sexually transmit HIV.

This means HIV does not automatically prevent:

- marriage,
- sexual intimacy,
- natural conception,
- parenthood.

Serodifferent couples can conceive naturally when sustained viral suppression has been achieved, and an HIV-negative partner may also choose PrEP as an additional preventive option.

Pregnancy outcomes have also changed dramatically.

When ART begins before pregnancy and viral suppression is maintained through pregnancy and delivery, current guidance places the risk of transmission to the infant at **below 1%**.



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Regarding fertility:

HIV should not automatically be diagnosed as the cause of infertility.

Some men living with HIV may have semen abnormalities, and studies of ovarian reserve in women living with HIV have produced mixed findings.

But infertility still requires:

complete couple-based evaluation.

A person living with HIV can simultaneously have:

- varicocele,
- low ovarian reserve,
- tubal blockage,
- endometriosis,
- hormonal disease,
- genetic infertility

just like any other patient.

From the **Unani perspective**, individualized supportive care may contribute to:

- nutrition,
- digestion,
- sleep,
- physical wellbeing,
- psychological health,
- sexual confidence,
- reproductive wellbeing.

These are important dimensions of whole-person medicine.

But the scientific boundary must remain clear:

Unani or herbal treatment has not been proven to eradicate HIV or replace ART.

Available systematic evidence remains insufficient to support herbal medicines as curative HIV treatment, and some traditional or nutritional products can interact with antiretroviral drugs.



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At **Saira Health Care**, my preferred approach is therefore integrative, sexual-health focused and evidence-based:

identify genuine HIV exposure, use appropriate modern testing, arrange PEP urgently when indicated, discuss PrEP for ongoing risk, link confirmed HIV promptly to ART, use U=U accurately to restore sexual confidence, support pregnancy and fertility planning, investigate infertility independently when present, and incorporate individualized Unani supportive care without interrupting effective antiretroviral treatment.

My most important message to patients is:

HIV is serious—but HIV is manageable.

A negative test must be interpreted at the correct time.

A recent exposure may require urgent PEP.

A person at continuing risk can consider PrEP.

And a person living with HIV who takes effective ART and remains undetectable can:

live, work, love, marry, have sex and build a family without sexually transmitting HIV.

That is one of the most important achievements of modern sexual and reproductive medicine.

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 whose clinical practice at **Saira Health Care** has a focused emphasis on:



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- sexual disorders,
- male infertility,
- female infertility,
- sexual and reproductive health.

His approach to HIV-related sexual and reproductive concerns emphasizes accurate modern HIV science combined with individualized sexual-health and infertility assessment.

Depending upon the clinical situation, evaluation may include:

- review of a recent sexual exposure,
- interpretation of HIV testing and window periods,
- urgent referral for PEP where indicated,
- counselling about PrEP,
- interpretation of U=U and viral suppression,
- male and female fertility evaluation,
- semen analysis,
- reproductive-hormone assessment when appropriate,
- preconception counselling,
- sexual-dysfunction assessment,
- coordination with HIV/ART, obstetric and fertility specialists.

Where clinically appropriate, individualized principles of Unani medicine may be used to support:

- nutrition,
- digestion,
- sleep,
- physical wellbeing,
- sexual health,
- psychological wellbeing

without replacing or interrupting evidence-based antiretroviral therapy.



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Useful HIV Services in India

People seeking confidential HIV information, testing or treatment can use India's NACO-supported services.

Integrated Counselling and Testing Centres — ICTCs provide HIV counselling, screening, confirmatory testing pathways and referral to treatment services.

The national HIV/AIDS helpline is:

1097 — Toll Free, 24×7

The helpline can provide:

- HIV information,
- counselling,
- information about nearby ICTCs,
- information about ART services.

Medical Disclaimer

This article is intended for public health education and awareness. It does not establish an individual HIV diagnosis and does not replace consultation with an appropriately qualified clinician, HIV specialist, ART centre, infectious-disease specialist or reproductive-medicine professional.

A person with a potentially significant HIV exposure within the previous **72 hours** should seek urgent medical evaluation for PEP rather than waiting for symptoms or for an HIV test to become positive.

HIV tests have different window periods. A negative test performed too soon after exposure cannot reliably exclude HIV infection.

A reactive rapid test or HIV self-test requires appropriate confirmatory testing before a final HIV diagnosis is established.

People with confirmed HIV should not stop or modify antiretroviral therapy without advice from their HIV-care team.

Undetectable viral load does not mean that HIV has been cured; ART must be continued to maintain suppression.

U=U refers specifically to **sexual HIV transmission during sustained viral suppression**. It should not be automatically extrapolated to breastfeeding or other exposure routes.



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People planning pregnancy where one or both partners live with HIV should obtain preconception counselling and ensure durable viral suppression before conception.

No Unani, herbal, supplement-based or alternative therapy has been scientifically established as a replacement for effective ART or as a method that reliably eradicates HIV from the human body.

Herbal medicines, minerals and supplements can interact with antiretroviral medicines. Patients should therefore disclose every complementary medicine or supplement to their HIV-care team.

Any person concerned about HIV in India can obtain confidential information through the NACO **1097 toll-free HIV/AIDS helpline** or an appropriate ICTC/ART service.



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