Chlamydia: Prevention & Risk Reduction

Consistent Barrier Protection, Routine Multi-Site Screening, Partner Treatment, and Doxy-PEP Context

Chlamydia is one of the most commonly reported bacterial sexually transmitted infections worldwide, caused by the obligate intracellular bacterium *Chlamydia trachomatis*. It infects the mucous membranes of the urogenital tract, rectum, and pharynx. Because up to **70% to 90% of infections are completely asymptomatic**, silent transmission occurs frequently. Left untreated, chlamydia can ascend and cause pelvic inflammatory disease (PID), tubal scarring, ectopic pregnancy, and chronic pelvic pain.

> **Core Prevention Principle:** Because chlamydia produces few or no warning signs in most individuals, primary prevention relies on consistent barrier use combined with routine, proactive screening rather than waiting for physical symptoms to appear.

1. Primary Prevention: Barrier & Behavioral Protection

Blocking direct contact with infectious urogenital, rectal, or pharyngeal secretions is the primary method for preventing chlamydia transmission.

Preventive Layer	Transmission Context	Actionable Implementation
External & Internal Condoms	Vaginal and anal intercourse transmit *C. trachomatis* efficiently via mucosal secretions.	Use latex or polyurethane condoms consistently from start to finish of every vaginal or anal sex act, paired with water- or silicone-based lubricants.
Oral Sex Barriers	Pharyngeal chlamydia can occur through unprotected oral intercourse, serving as a reservoir for mucosal contact.	Use unlubricated condoms for fellatio and dental dams (or cut-open condoms) for cunnilingus or anilingus with new or non-monogamous partners.
Mutual Monogamy & Pre-Intimacy Testing	Multiple or concurrent sexual partners increase cumulative exposure probability over time.	Maintain mutual monogamy with a partner who has tested negative across all relevant anatomical sites, and confirm recent STI screening prior to intimate contact.

2. Secondary Prevention: Routine Screening & Multi-Site Testing

Because most infections are silent, routine screening catches cases early before reproductive complications or onward transmission occur.

- **Annual Screening for Sexually Active Young Adults:** Public health guidelines recommend annual chlamydia screening for all sexually active women aged 25 and younger, as well as older women with risk factors (such as new or multiple sexual partners).
- **Multi-Site Testing (Urogenital, Rectal, Pharyngeal):** Urine tests alone miss rectal and pharyngeal chlamydia in individuals practicing anal or oral sex. Ensure clinicians collect site-specific swabs based on reported sexual practices.
- **High-Frequency Screening for At-Risk Populations:** Gay, bisexual, and other men who have sex with men (MSM), individuals taking HIV PrEP, and people living with HIV should undergo multi-site screening every 3 to 6 months.
- **Prenatal Screening:** Screening pregnant individuals during the first prenatal visit prevents vertical transmission during childbirth, which can cause neonatal conjunctivitis or pneumonia.

3. Interrupting Reinfection & Emerging Prophylaxis

Halting transmission chains requires treating partners simultaneously and utilizing emerging biomedical tools where appropriate.

- **Simultaneous Partner Treatment & Abstinence:** All sexual partners from the past 60 days must be treated simultaneously. Both partners must complete their full medication course and abstain from sexual contact for 7 days post-treatment to prevent ping-pong reinfection.
- **Mandatory 3-Month Retesting:** Due to high rates of reinfection, all individuals treated for chlamydia should be retested approximately **3 months after treatment completion** to confirm cure.
- **Doxycycline Post-Exposure Prophylaxis (Doxy-PEP):** Clinical studies demonstrate that taking doxycycline 200 mg within 72 hours after condomless sex significantly reduces bacterial STI acquisition (including chlamydia and syphilis) in eligible high-risk populations; discuss eligibility with your clinician.