

IN PRACTICE

Patient preferences for partner notification

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Objective: To identify patient preferences for notification of sexual contacts when a sexually transmitted infection (STI) is diagnosed.

Methods: A questionnaire survey of 2544 patients attending three large genitourinary clinics at Derby, Birmingham, and Coventry in the United Kingdom.

Results: The median age of the respondents was 24 with 1474 (57.9%) women, 1835 (72.1%) white, 1826 (71.8%) single. The most favoured method of partner notification was patient referral, which was rated a "good" method by 65.8% when they had to be contacted because a sexual partner has an STI. Notifying contacts by letter as a method of provider partner notification is more acceptable than phoning, text messaging, or email. Respondents with access to mobile telephones, private emails, and private letters were more likely to rate a method of partner notification using that mode of communication as "good" compared to those without. With provider referral methods of partner notification respondents preferred to receive a letter, email, or text message asking them to contact the clinic rather than a letter, email or text message informing them that they may have an STI.

Conclusion: Most respondents think that being informed directly by a partner is the best method of being notified of the risk of an STI. Some of the newer methods may not be acceptable to all but a significant minority of respondents prefer these methods of partner notification. The wording of letters, emails, or text messages when used for partner notification has an influence on the acceptability of the method and may influence success of the partner notification method. Services should be flexible enough to utilise the patients' preferred method of partner notification.

Partner notification is the process whereby the sex partners of patients diagnosed with a sexually transmitted infection (STI) are informed of their potential exposure to infection, and thus the need to visit a health service for testing and treatment. Partner notification or contact tracing has been shown to be effective at detecting new STI.¹ Hennessy *et al* have showed that the gender and ethnicity of partner notification staff do not affect the partner notification procedure.²

Our study aimed to identify patient preferences for notification of sexual contacts and to determine the effect of access to a means of communication on acceptability of that method for partner notification. The increasing use of mobile telephones and electronic mail by the young people who are most at risk of an STI requires evaluation of these newer methods of communication.

METHODS

Ethics committee approval was obtained at the three participating sites, which were in Derby (A), Birmingham (B), and Coventry (C).

All new and follow up patients attending the genitourinary medicine clinics at the three participating sites during the study period were asked to fill in a questionnaire. Data were collected on demographic characteristics of the respondents, access to private letters, mobile phones and email, history of an STI, and number of partners in the last 3 months. Respondents were also asked to rate various methods of provider and patient partner notification on a five point Likert scale ranging from "not a good method" to "very good method." Respondents choosing the first two points on the scale (1 or 2) were judged to indicate that the method was "not good" while those choosing the last two points on the scale (4 or 5) were judged to indicate that the method in question was "good." Other responses were judged to be indeterminate.

Table 1 Characteristics of respondents

	Number (%)
Age	
12–24	1295 (50.9)
25–44	1007 (39.6)
≥45	118 (4.6)
Undocumented	124 (4.9)
Gender	
Males	1055 (41.5)
Females	1474 (57.9)
Undocumented	15 (0.6)
Ethnicity	
Asian	140 (5.5)
Black	351 (13.8)
Mixed	148 (5.8)
White	1835 (72.1)
Other	43 (1.7)
Undocumented	27 (1.1)
Marital status	
Co-habiting	334 (13.1)
Single	1826 (71.8)
Married	221 (8.7)
Other	122 (4.8)
Undocumented	41 (1.6)
Sexual orientation	
Homosexual	323 (12.7)
Heterosexual	2099 (82.5)
Bisexual	50 (2.0)
Undocumented	72 (2.8)
Reason for clinic visit	
Symptomatic	1067 (41.9)
Told to come in by partner	432 (17.0)
Follow up appointment	318 (12.5)
Asymptomatic (check-up)	880 (34.6)
Other	240 (9.4)
Access to methods of communication	
Private letters	1706 (67.1)
Mobile telephone	2205 (86.7)
Private email	1064 (41.8)

Table 2 Respondents rating of methods of partner notification

Method of being contacted if a sexual partner is found to have a sexually transmitted infection	Good method (%)	Bad method (%)	Number rating method of partner notification as a good method with access to communication method		
Being informed by your partner directly that you may have a sexually transmitted infection	1674 (65.8)	367 (14.7)	NA	NA	NA
Receiving a letter from the clinic informing you to contact the clinic	1247 (49.0)	558 (21.9)	Access to private letters	Yes	989 (79.3)
				No	258 (20.7)*
Receiving a letter from the clinic informing you that you may have a sexually transmitted infection	860 (33.8)	971 (38.2)	Access to private letters	Yes	694 (80.7)
				No	166 (19.3)*
Receiving a phone call from the clinic informing you that you may have a sexually transmitted infection	1013 (39.8)	816 (32.1)	Access to mobile telephone	Yes	911 (89.9)
				No	102 (10.1)*
Receiving a text message on your mobile phone informing you to contact the clinic	810 (31.8)	1075 (42.3)	Access to mobile telephone	Yes	761 (94.0)
				No	49 (6.0)*
Receiving a text message on your mobile phone informing you that you may have a sexually transmitted infection	433 (17.0)	1563 (61.4)	Access to mobile telephone	Yes	403 (93.1)
				No	30 (6.9)*
Receiving an email informing you that you may have a sexually transmitted infection	231 (9.1)	1706 (67.1)	Access to private email	Yes	142 (61.5)
				No	89 (38.5)*
Receiving an email informing you to contact the clinic	609 (23.9)	1153 (45.3)	Access to private email	Yes	368 (60.4)
				No	241 (39.6)*

Missing and "don't know" responses are not presented.

Analysis of the data was carried out using the statistical package SPSS. Logistic regression analysis was used for prediction with a binary outcome. A forward stepwise model was used with a significance level of 0.05 for retaining variables.

RESULTS

There were 2544 returned questionnaires with 963, 1075, and 506 from centres A, B, and C, respectively. The median age of the respondents was 24 with a range of 12–69 years. The median number of partners in the previous 3 months was one with a range of 0–30 partners (with three extreme values of 87, 118, and 150). There were 1027 (40.3%) respondents who had been diagnosed in the past with an STI. The other characteristics of the respondents are presented in table 1.

The demographic characteristics of the respondents reflect the demographic characteristics of the patient population attending the three centres where this study was carried out (data not presented). The respondents' rating of methods of partner notification including reported access to methods of communication and acceptability of the method for partner notification are presented in table 2. Further data on this are available in table A on the STI website (www.stijournal.com/supplemental).

An adjusted multivariate analysis of factors that predicted whether respondents chose to be notified using a particular method of partner notification is presented in table B on the STI website (www.stijournal.com/supplemental).

DISCUSSION

More respondents thought that self notification by contacts (patient referral) was a "good" method of partner notification than any of the provider referral partner notification strategies. US physicians also endorsed patient based referral more favourably than physician based referral.³ While the reasons for physicians preferring this strategy in the United States are complex and may be because of limited resources, both health providers and the recipients of care seem to prefer patients carrying out this important public health duty.

More people thought that the methods were good when being asked to contact the clinic than when informed of a risk of having acquired an STI. We would propose that clinics should consider changing the wording of the letters/text/emails they send out to reflect this. Another study has, however, shown that an infection specific contact slip was as equally acceptable to patients for patient referral partner notification as a standard coded contact slip.⁴

Quite a high proportion of the respondents had access to a mobile telephone, and we were surprised by the finding that more of the respondents had access to a mobile telephone than had access to private letters. Access to a method of communication and use of that method of communication for partner notification was significantly correlated. Collecting data from clinic attendees using a communication sheet (mini-questionnaire) that patients fill in when they attend clinic will help.

There was a gender bias with some methods of partner notification. Females were 30% more likely to accept that being informed directly by a partner or by a letter from a clinic were "good" methods of partner notification. Men were 30–40% more likely to accept a text message or email from the clinic about a risk of an STI as a "good" method of partner notification compared to women. This gender difference may require further studies.

There were also some ethnic differences, notably with Asians and black people more likely than those of white ethnicity to think being informed by text message to contact the clinic was a good method of partner notification. Some of the technological issues raised by the use of text messages and emails, such as confidentiality and anonymity, are discussed by Tomnay *et al.*⁵

Most respondents think that being informed directly by a partner is the best method of being notified of the risk of an STI. Some of the newer methods may not be acceptable to all but a significant minority of patients prefer these methods of partner notification. The wording of letters, emails, or text messages when used for partner notification has an influence on the acceptability of the method and may influence success

Key messages

- The most favoured method of partner notification was self notification (patient referral)
- Respondents with access to mobile telephones, private emails and private letters were more likely to rate a method of partner notification using that mode of communication as "good" compared to those without
- With provider referral methods of partner notification respondents preferred to receive a letter, email, or text message asking them to contact the clinic rather than a letter, email, or text message informing them that they may have a sexually transmitted infection

of the partner notification method. Services should be flexible enough to utilise the patients' preferred method of partner notification.

CONTRIBUTORS

AA initiated the study and performed the data analysis; AA, KW, and SD were principal investigators and participated in the management of the study; all authors were involved in data collection and contributed to the preparation of the manuscript.



Two further tables are available on the STI website (www.stijournal.com/supplemental)

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ECHO

More endoscopists improve outcome for upper GI cancer



Please visit the Quality and Safety in Health Care website [www.qshc.com] for a link to the full text of this article.

More endoscopists may be the answer to better outcomes for upper gastrointestinal (GI) cancer, as recent improvement seems to owe more to the introduction of nurse endoscopists than the UK government's two week wait scheme for a specialist consultation, according to doctors in one cancer unit.

True enough, the odds of curative resection increased significantly (odds ratio 1.48) in their unit in the two years after the scheme was introduced compared with the two years before, and curative resections for early (stage 1 and 2) cancers rose from 47 to 58. But only two patients (5%) of 38 diagnosed with the cancer out of 623 referred under the scheme had early stage disease compared with 56 (27%) outside it. Furthermore, just over a third of patients with early stage cancer had symptoms consistent with the referral criteria in the scheme, but only two of them were referred under it.

When the scheme was implemented at Norfolk and Norwich University Hospital, in September 2000, it coincided with appointment of two full time nurse endoscopists, which reduced routine waiting times for endoscopy—and probably accounted for the improvement.

Under the scheme guidelines for urgent referrals for upper GI cancer were issued to general practitioners to ensure timely specialist evaluation. Detecting the cancer early is key to curative treatment, but symptoms can be unreliable. This may be why reducing times for routine endoscopy may be the best option.

The UK government has been under pressure to improve its poor record on upper GI cancer outcome in western Europe.

▲ Spahos T, *et al.* *Postgraduate Medical Journal* 2005;**81**:723–730.