

Intimate partner violence and partner notification of sexually transmitted infections among adolescent and young adult family planning clinic patients

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Summary: Patient-initiated partner notification of sexually transmitted infection (STI), i.e. patients informing their sexual partners of a diagnosis, is a cornerstone of STI prevention. Growing evidence suggests that women exposed to intimate partner violence (IPV) may fear such notification, or face negative consequences in response to STI disclosure. The current study assessed associations of IPV with fear of partner notification, and experiences of partner notification, among adolescent and young adult female family planning clinic patients. Women aged 16–29 years attending five family planning clinics in Northern California, USA ($n = 1282$) participated in a cross-sectional survey. A history of physical or sexual IPV was associated with fear of partner notification. Moreover, participants exposed to IPV were more likely to have partners say that it was not from them or otherwise accuse them of cheating in response to partner notification. Such partners were less likely to seek indicated STI treatment or testing. Current findings suggest that partner notification for STI may be compromised by IPV. Clinical practices and policies to support effective partner notification should include IPV assessment, and provide mechanisms to address related fears concerning partner notification.

Keywords: partner notification, sexually transmitted infection (STI), intimate partner violence, domestic violence

INTRODUCTION

Sexually transmitted infections (STIs) disproportionately affect youth. Young adults aged 15–24 years account for approximately half of new infections,¹ with an estimated one in four female adolescents infected.² Patient-initiated partner notification, whereby diagnosed patients inform their sexual partners, is a cornerstone of STI prevention and treatment recommendations³ and standard clinical practice.⁴ Intimate partner violence (IPV) is also prevalent within this age group, and women exposed to IPV suffer greater STI/HIV risk.^{5–10} In addition to posing unique STI/HIV risk, IPV may represent a significant barrier to partner STI notification. IPV may be inflicted in response to women's HIV disclosure,¹¹ and women may decide against notifying partners for fear of violence.^{11,12} Against this backdrop, the current study examines associations of IPV victimization with (1) fear of partner notification, (2) experiences of STI partner notification and (3) partner response to notification.

METHODS

Secondary analyses were conducted using cross-sectional survey data collected from English- and Spanish-speaking

women aged 16–29 years seeking care at five family planning clinics in California. Data were collected in 2008–2009 and served as baseline data for an intervention study. Patients who met age and linguistic eligibility completed informed consent procedures in a private area of the clinic. Given the confidential nature of family planning services, parental consent for participation was waived for minors. Participants completed an audio computer-assisted self-interview survey and subsequently received a US\$15 prepaid debit card and a list of local resources. All study procedures were reviewed and approved by Human Subjects Research Committees at the University of California Davis, Harvard School of Public Health, and Planned Parenthood Federation of America; the data were protected with a federal Certificate of Confidentiality. The final sample included 1319 participants (89% participation rate); further details regarding the parent study are available elsewhere.¹³

The current sample is limited to sexually active women who provided complete STI data ($n = 1282$). All participants were aged 16–29 years; approximately 22% of participants self-reported their race/ethnicity as white, 28% as black, 30% as Hispanic and 7% as multiracial, with the remaining 13% reported as other, including Asian.

All items were self-reported. Lifetime (i.e. ever) exposure to physical or sexual IPV victimization was assessed via items modified from the Conflict Tactics Scale¹⁴ and the Sexual

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Experiences Survey.¹⁵ Participants were classified as having been exposed to physical or sexual IPV if they endorsed at least one item. Partner STI notification experiences were assessed using investigator-developed items informed by qualitative research with adolescent dating violence victims and perpetrators. Fear of partner notification was assessed via the single item, 'if you had an STD or HIV would you be afraid to tell your partner?' Among those reporting STI history, partner STI notification was assessed via 'If you were ever told you had an STD, did you tell your partner?' Partner response to STI notification was assessed via three items: 'when you told a sexual partner you got an STD from them, did they ... seek treatment or testing?', 'tell you it wasn't from them or accuse you of cheating?', 'threaten to hurt you physically or actually hurt you physically?' Women who did not notify their partner were asked their reasons. Lifetime history of STI diagnosis was also self-reported via a single item. Descriptive statistics regarding fear of notification and all partner notification experiences (i.e. partner notification, consequences of and barriers to notification), and differences based on IPV exposure, were calculated. Models estimating adjusted risk ratios (ARRs) and 95% confidence intervals (CIs) for associations of IPV and STI partner notification experiences were constructed, adjusting for age, race/ethnicity and recruitment site.

RESULTS

Just over half (53.3%) of the sample reported a history of physical or sexual IPV. Those exposed to IPV were more likely to report being afraid to notify partners of an STI (ARR 1.46, 95% CI 1.20–1.77; Table 1). While IPV history was not related to partner STI notification itself, partners of women exposed to IPV were significantly less likely to seek STI testing or treatment on notification (84.8% versus 91.9%; ARR 0.93, 95% CI 0.86, 0.99). Partners of women exposed to IPV were significantly more likely to respond to STI notification by saying the STI was not from them or otherwise accusing her of cheating (ARR 1.56, 95% CI 1.24–1.98). A relatively small portion (5.4%) experienced threats of harm or actual harm in response to STI notification. Among women who did not notify their partner of their STI status, fear of partner response tended to

be more common among those exposed to IPV (43.8% versus 17.7%; $P < 0.1$).

DISCUSSION

Current findings illustrate that women with a history of IPV were more likely to report fear of future partner STI notification and face negative partner responses to notification (e.g. cheating accusations). Consistent with prior qualitative research,¹⁶ their partners were less likely to subsequently seek needed STI testing and treatment following notification. These data suggest that IPV may compromise effective patient-initiated partner notification efforts and threaten the safety of those involved.

Results should be considered in the light of several limitations. The cross-sectional nature of the investigation limits our ability to understand the temporality of IPV, STI diagnosis and partner notification. Sexual and romantic partnerships were likely subject to change over the period assessed. Undetected changes in partnerships may have influenced the associations observed, particularly as approximately one-third of those who did not notify their partners reported they were not together anymore. Further in-depth research into this topic will benefit from a finer assessment of relationship trajectories. For those infected, the STI source was not determinable. Further research should clarify differences in partner notification patterns and responses based on the source of STI, including those resulting from the sexual risk behaviour of abusive partners. All data were self-reported. While the partner STI notification assessments were informed by extensive qualitative research by the investigative team, these measures might not capture the full range of partner STI notification experiences and considerations.

Despite the limitations, findings offer distinct clinical and programmatic implications. Clinical practice and national STI prevention guidelines must incorporate provisions to address fears related to partner notification, particularly among those who have experienced IPV. The potential for threats of, and actual, physical harm in response to disclosure must also be considered. The potential consequences of STI notification should be discussed with all patients, particularly those with a history of IPV. Such discussions should include screening

Table 1 Partner notification for STI experiences and associations with IPV among women seeking family planning clinical care

	% Sample (n)	% Among IPV yes	% Among IPV no	ARR* (95% CI)
Fear of partner notification (n = 1282)	25.4 (325)	29.4	20.7 ^{†††}	1.46 (1.20, 1.77) ^{†††}
Partner STI notification (n = 499 with STI diagnosis)	89.8 (448)	89.4	90.5	0.99 (0.93, 1.05)
Partner response among those who did notify a partner** (n = 448 who notified partners)				
Sought treatment or testing	87.4 (443)	84.8	91.9 [†]	0.93 (0.86, 0.99) [†]
Said that it was not from them or accused you of cheating	47.7 (213)	54.7	35.2 ^{†††}	1.56 (1.24, 1.98) ^{†††}
Threatened to harm or actually harmed you physically	5.4 (24)	5.6	4.9	1.17 (0.51, 2.67)
Reasons for not notifying among those who did not notify partner** (n = 51 who did not notify partners)				
I was not sure as to whether they gave it to me	42.9 (21)	40.6	47.1	0.84 (0.34, 2.08)
I was afraid of their response	34.7 (17)	43.8	17.7 [§]	2.22 (0.72, 6.77)
We were not together anymore	30.6 (15)	31.3	29.4	1.01 (0.41, 2.47)
Other reasons	32.7 (16)	40.6	17.7	2.24 (0.74, 6.81)

IPV = intimate partner violence; STI = sexually transmitted infection; ARR = adjusted risk ratio; CI = confidence interval

*Adjusted for age, race/ethnicity and recruitment site

**Not mutually exclusive

§ $P < 0.1$ † $P < 0.05$ †† $P < 0.01$ ††† $P < 0.001$

and support for potential fears surrounding partner notification. Routine STI counselling and treatment should include discussion of safety strategies for partner STI notification (e.g. bringing the partner into the clinic, anonymous web-based partner notification), and the provision of local violence support resources to all patients in the event of violence victimization.

ACKNOWLEDGEMENTS

We gratefully acknowledge the staff and administrators of the Planned Parenthood Shasta Diablo Affiliate for their invaluable support with this study, specifically the clinics located in the Richmond, Vallejo, Antioch and Fairfield communities. National Institute of Child Health and Human Development (R21 HD057814-02 to Miller and Silverman); Harvard University Center for AIDS Research (HU CFAR NIH/NIAID fund P30-AI060354 to Decker); UC Davis Health System Research Award (Miller); and a Building Interdisciplinary Research Careers in Women's Health award (Miller, BIRCWH, K12 HD051958; National Institute of Child Health and Human Development, Office of Research on Women's Health, Office of Dietary Supplements, National Institute of Aging).

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(Accepted 20 January 2011)