Does Intimate Partner Violence Affect the Acceptability of Expedited Partner Therapy?

Suzanne Beck, BS[1], Robert Bednarczyk, PhD[2], Louise-Anne McNutt, PhD[3]

(1) New York State Department of Health, Bureau of STD Prevention and Epidemiology; (2) Hubert Department of Global Health, Emory University; (3) University at Albany, SUNY School of Public Health

Background

- In 2010, over 99,000 cases of Chlamydia were reported in New York State (NYS) and 1.3 million cases were reported nationally[1,2]. Women are disproportionately affected by Chlamydia.
- Nearly 25% of US women have experienced intimate partner violence (IPV) in their lifetime, with an estimated 1.5 million women assaulted annually[3]. Studies have shown associations exist between IPV and risk factors for sexually transmitted diseases (STD)[4-8].
- Resources to prevent the spread of STDs are limited, and may be further complicated by the high prevalence of IPV among women.
- Expedited Partner Therapy (EPT) is the practice of treating the sex partners of STD-infected patients by providing the infected patient with a prescription or medication to give to his or her partner(s), without the partner(s) receiving a medical evaluation.
- In 2009, NYS passed legislation to legalize EPT for chlamydial infections.
- Guidance on the use of EPT when IPV is a concern is not available.

Methods

- Study participants consisted of women receiving services at an urban community health center in Upstate NYS; participants completed a self administered questionnaire.
- An assessment of respondents' general and sexual health, opinions on health policy, exposure to IPV and patient demographics were collected. Participants were told the survey was voluntary and anonymous and assured that refusal would not affect the healthcare received. The study was approved by the University at Albany's Institutional Review Board.
- Clinic confidentiality policy would not allow us to know the number of women eligible for the study. The survey was completed by 294 women; respondents reporting no lifetime (n=24) or same sex only intimate partners (n=10) were excluded. Thus, 260 respondents (88%) were included in the analysis.
- IPV was measured using the composite abuse scale (CAS), a validated series of 31 questions intended to comprehensively evaluate IPV[11].

  A cumulative CAS score was used to assign three levels of IPV:

  - ten or greater is considered high level IPV,
  - four though nine is considered lower level IPV, and
  - three or less is considered no or lowest level IPV.

- The acceptability of EPT was assessed by questions with five-level Likert scale response options: "Strongly agree," "Agree," "Neither agree nor disagree," "Disagree," or "Strongly disagree."
- Bivariate measures of association were tested using Chi-square and Fisher's exact test. Adjusted prevalence ratios were obtained using multivariate log binomial models.
- Patient demographics found to be associated with unfavorable opinions of EPT in stratified analysis ($p \leq 0.05$) were included in multivariate models.
- Data were analyzed using SAS version 9.1 (SAS Institute, Carey, NC).

Results

Characteristics of Study Participants

Age		**Marital Status**		**General Health**	
18-25 years:	31%	Married:	17%	Excellent:	17%
26-35 years:	33%	Divorced:	18%	Very Good:	29%
36-45 years:	36%	Widowed:	1%	Good:	39%
		Never Married:	47%	Fair:	13%
		Unmarried Couple:	17%	Poor:	2%
Race and Ethnicity		**Education**		**Health Care Coverage**	
White, non-Hispanic:	15%	Less than High School:	31%	Yes:	84%
Black, non-Hispanic:	69%	Grade 12 or GED:	33%	No:	16%
Other, non-Hispanic:	6%	Some college:	29%		
Hispanic:	10%	College graduate:	7%		

Number of Current Intimate Partners*

One:	40%
Greater than one:	60%

* Women exposed to recent IPV were more likely to report >1 current intimate sex partner compared to women not recently exposed to IPV ($p<0.001$).

Results, cont'd

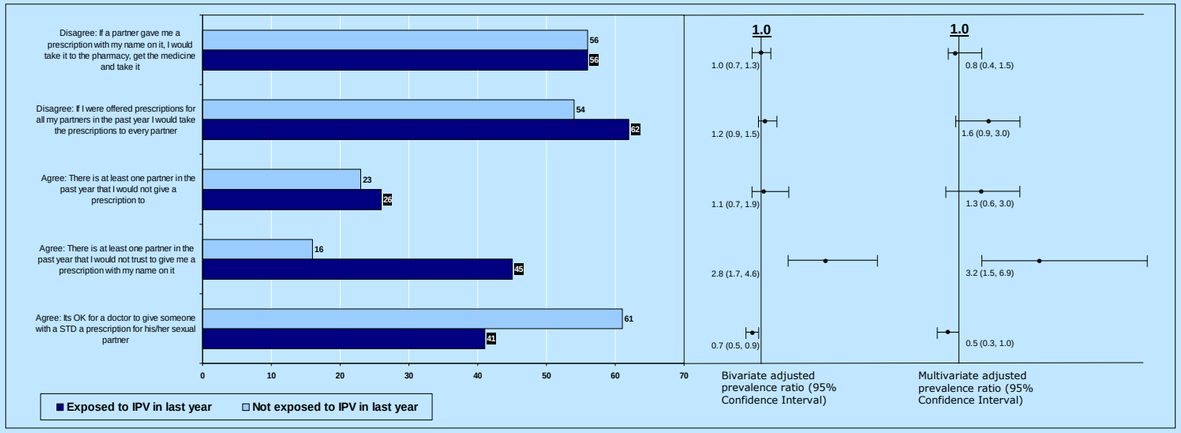
Respondents' Exposure to Intimate Partner Violence (IPV) in Last 12 Months§

High level of IPV (CAS score ≥10):	31%
Low level of IPV (CAS score 4 – 9):	19%
Lowest level or no IPV (CAS score 0 - 3):	50%

§ Statistically significant differences of EPT opinions were not seen between those with a high level and low level of IPV exposure so the two groups were combined to create one category of exposed to IPV (data not shown).

- Bivariate analysis revealed women exposed to IPV in the last year were **less likely** than women not exposed to **agree** with the opinion that "it is okay for a doctor to give someone with a STD a written prescription for his or her sexual partner (with the partners name on it)" (Figure 1).
- Bivariate and multivariate analysis revealed women exposed to IPV in the last year were **more likely** than women not exposed to **agree** with the opinion that "there is at least one partner in the past year that I would not trust to give me a prescription with my name on it" (Figure 1).

Figure 1. Study Respondents' Expedited Partner Therapy Opinions by Recent Exposure to Intimate Partner Violence



Discussion

To date, this study is the first to evaluate how IPV affects the acceptability of EPT among women.

Findings from this study show:

- Less than half of respondents find it acceptable for a doctor to give someone with a STD a prescription for his or her sexual partner with the partner's name on it.

  Women recently exposed to IPV were significantly **less** likely to find this practice acceptable compared to women not recently exposed.

- One quarter of women believe there is at least one former partner that would not give her the prescription.

  Women recently exposed to IPV were significantly **more** likely to have this opinion compared to women not recently exposed.

- The large majority of women surveyed would see a physician for evaluation and treatment if presented with a patient delivered prescription.

Conclusions:

- Important differences in the acceptability of EPT exist between women recently exposed to IPV and women not abused.
- This study suggests that abused women may be less likely to benefit from EPT.
- In situations where the index patient is a perpetrator of IPV, EPT could provide the perpetrator with a mechanism to coerce his partner and enhance the level of control held over the partner.
- Prevention programs should take IPV into account when developing EPT policies and regulations.

Limitations:

- Limited generalizability: due to the use of a NYS urban community health center patient population of predominantly non-married African American women.
- Social desirability and recall biases: recent IPV was determined from self-reporting of events that occurred over the past year.
- Temporality: it could not be determined if respondents' opinions related to EPT were formed prior to experiences of IPV.

Bibliography

1. New York State Department of Health, Bureau of Sexually Transmitted Disease Prevention and Epidemiology.
2. Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2010. Atlanta, GA: U.S. Department of Health and Human Services; November 2011.
3. Black, M.C., Basile, K.C., Breiding, M.J., et al (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
4. Wu E., El-Bassel N., Witte S.S., et al. Intimate Partner Violence and HIV Risk Among Urban Minority Women in Primary Health Care Settings. AIDS Behav. 2003 Sep;7(3):291-301.
5. Bauer H.M., Gibson P., Hernandez M., et al. Intimate Partner Violence and High-Risk Sexual Behaviors Among Female Patients with Sexually Transmitted Diseases. Sex Transm Dis. 2002 Jul;29(7):411-6.
7. Seth P., Raiford J.L., Robinson L.S., et al. Intimate partner violence and other partner-related factors: correlates of sexually transmissible infections and risky sexual behaviours among young adult African American women. Sex Health. 2010 Mar;7(1):25-30.
8. Raj A., Reed E., Welles S.L., et al. Intimate Partner Violence Perpetration, Risky Sexual Behavior, and STI/HIV Diagnosis Among Heterosexual African American Men. Am J Mens Health. 2008 Sep;2(3):291-5.
9. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2010. MMWR 2010;59(No. RR-12):2.
10. Centers for Disease Control and Prevention. Expedited partner therapy in the management of sexually transmitted diseases. Atlanta, GA: US Department of Health and Human Services, 2006.
11. Hegarty K, Sheehan M, Schonfeld C. A multidimensional Definition of Partner Abuse: Development and Preliminary Validation of the Composite Abuse Scale. J Fam Violence. 1999; 14: 399-415.