From partner notification to partner treatment

To the Editor: We read with interest the recent discussions about management of partners of STD patients, which raise important issues about partner notification strategies as a central tenet of STD control. We would like to encourage and support this discussion, and add to it some of our own findings that reinforce the importance of strategies to reach and treat asymptomatic carriers of STDs.

The findings from Alexandra Clinic are an important step toward a better understanding of the patient's perspective on the constraints on partner notification. Qualitative research in Hlabisa on partner networking and communication supports these findings, and also highlights some of the difficulties with partner notification strategies that rely on patient referral. For example, our preliminary analysis shows that: (i) most patients are likely to identify one particular partner as the source of infection and are often motivated to contact only that partner about the need for treatment; (ii) patients (both male and female) find it easier to notify 'regular' partners about their STD, partly because of a feeling of trust in and responsibility toward that partner; (iii) there is a gap between partner notification and partner treatment — most patients interviewed say that they inform their partners, but are rarely sure whether they have actually received treatment.

These findings highlight the importance of understanding the social context of partnering and communication when designing partner notification strategies.

This information has helped to redesign the partner notification strategy within Hlabisa. Improved counselling and the introduction of a partner card with information about STDs and their sequelae have led to a modest improvement in the number of contacts treated by the health service — in one clinic, from 4% of all STD patients to 12% (Hlabisa Hospital and Health Service — unpublished data, 1996). These cards are part of a 'syndrome packet' that also contains treatment, condoms and information for the patient. This is designed to improve compliance with treatment and efficiency within the health service.

Partner notification alone, however, cannot slow the STD epidemic. Data from studies in our family planning (unpublished data) and antenatal clinics' suggest that there is a large burden of unrecognised and asymptomatic STD infection in the community. Unless these people are reached, community prevalence of STDs is unlikely to decline.

Is it time, therefore, to move from partner notification to direct partner treatment? We plan to extend the use of 'syndrome packets' as a pilot programme for partner notification, in which index patients would give the syndrome packet to their sexual partners. This may begin to fill the gap between partner notification and partner treatment.

Several important issues must be considered carefully before direct partner treatment is implemented. Inappropriate use of drugs could potentially harm pregnant women or those with an adverse drug reaction, and contribute to drug resistance. There is also a danger that drugs might be sold or used for purposes other than STD treatment. Carefully designed pilot studies will need to consider these questions, and provide an assessment of the feasibility and efficacy of such a strategy. Such studies will require confidential and systematic follow-up, perhaps relying on index patients to report whether their partners have completed treatment.

In areas where the prevalence of STDs is high, however, the benefits of direct partner treatment are likely to outweigh the risks.

In conclusion, we support the comments of our colleagues on the importance of improving partner notification strategies within STD management, and call for new and innovative strategies to be developed that can improve rates of partner treatment and help to slow the STD epidemic.

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