SEX PARTNER INTERPERSONAL COMMUNICATION ABOUT EXPEDITED PARTNER THERAPY (EPT) FOR THE TREATMENT OF *CHLAMYDIA TRACHOMATIS*

AN HONORS THESIS

SUBMITTED ON THE 15TH DAY OF APRIL, 2020

TO THE DEPARTMENT OF PUBLIC HEALTH

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

OF THE HONORS PROGRAM

OF NEWCOMB TULANE COLLEGE

TULANE UNIVERISTY

FOR THE DEGREE OF

BACHELOR OF SCIENCES

WITH HONORS IN PUBLIC HEALTH

BY

Grace Hindmarch

APPROVED:

Alyssa Lederer
Director of Thesis

Patricia Kissinger
Second Reader

Katherine Johnson
Third Reader

Abstract

Chlamydia is a highly prevalent sexually transmitted infection with high rates of reinfection. Expedited Partner Therapy (EPT), in which sex partners of a person diagnosed with chlamydia can be treated without visiting a healthcare provider, is an evidence-based strategy of reducing chlamydia transmission and reinfection. Although there are some studies about facilitators and barriers to accepting EPT from providers and giving EPT to partners, little is known about interpersonal interactions that take place once EPT is offered. In this study, we investigated young Southern Black men's interpersonal experiences with their female sex partners during notification of chlamydia infection and EPT. Eighteen men who took part in a community-based chlamydia screening and treatment program were interviewed. Interviews were transcribed and thematically analyzed in NVivo. Participants generally preferred to contact their partners about EPT via phone call. During notification, participants utilized different strategies to have a more positive interaction with their partners, most commonly emphasizing honesty. Often the EPT notification would lead to conflict between partners, with the most common argument centering around which partner caused the infection. While many partners accepted EPT, others sought confirmation of positive chlamydia status from their own healthcare providers. The interpersonal interactions during EPT notification prompted relationship changes between many partnerships, while other partnerships didn't change. While the findings of this study indicate that EPT notification transpires in diverse ways and affects partnerships differently, notable patterns were revealed. These results can be used to inform healthcare providers' communication about EPT with patients.

Acknowledgements

With thanks to Dr. Alyssa Lederer, Dr. Patricia Kissinger, Norine Schmidt, Gérard Gomes, Glenis Scott, Jr., Shannon Watson, and the rest of the Check It team. Without them, this project would not be possible. Special thanks to Dr. Alyssa Lederer, Dr. Patricia Kissinger, and Dr. Katherine Johnson for serving as my thesis committee and for all of their support and insight during this process. Finally, again to Dr. Alyssa Lederer for being my mentor, inspiring me as a researcher, and paving the way for my future success. My gratitude for her cannot be expressed nearly enough.

Table of Contents

List of Tables

List of Figures

Introduction

Chlamydia trachomatis is a highly prevalent public health concern, with 1.8 million cases reported to the Centers for Disease Control and Prevention (CDC) in 2018 (CDC, 2019a). Young people ages 15-24, African Americans, and Southerners are disproportionately burdened by chlamydia (CDC, 2019a; CDC, 2019b). Expedited Partner Therapy (EPT) is a method in which the sex partner(s) of an index patient (i.e., the patient who initially receives the positive diagnosis) can receive chlamydia treatment without needing a diagnosis from a healthcare provider. During EPT, the index patient is given one or more extra dose(s) of medication to deliver to their sex partner(s). The literature shows that EPT is an effective method of treating sexually transmitted infections (STIs). Specifically, EPT reduces the risk of repeated infection and increases rates of partner treatment (Kissinger, 2014; Kissinger & Hogben, 2011; Kissinger et al., 2005; Golden et al., 2005; Schillinger et al., 2002; Shiely et al., 2010; Mickiewicz, Al-Tayyib, Thrun, & Rietmeijer, 2012). Studies of EPT typically explore patient and provider perspectives on EPT as a treatment method (Coyne, Cohen, Smith, Mandalia, & Barton, 2007; Oliver, Rogers, & Schillinger, 2016; McBride, Goldsworthy, & Fortenberry, 2010; Temkin, Klassen, Mmari, & Gillespie, 2011; Ricks et al., 2015; Goldsworthy & Fortenberry, 2009; McBride, Goldsworthy, & Fortenberry, 2008; McBride, Goldsworthy, & Fortenberry, 2010). However, very little is known about the interpersonal interactions between sex partners during notification of EPT. As a result, this study aims to answer the question: What are the interpersonal dynamics that occur between young Southern Black men and their female sexual partners during notification of positive chlamydia diagnosis and the opportunity for EPT?

The study takes place in the context of a community-based chlamydia screening and treatment research project called Check It. In the Check It study, Black men in Orleans Parish aged 15-24 who have sex with women are offered free testing and treatment for chlamydia. Check It participants with a positive chlamydia diagnosis are offered EPT as a means to treat their sex partners. Using interview data from participants in the Check It project, this study sought to identify what kinds of interpersonal interactions occur between partners during the notification of EPT.

This study has public health significance because, although young Black men in the South are disproportionately affected by chlamydia, there is very little research about their experiences with EPT. Furthermore, there is minimal research generally on how sex partners communicate and interact about EPT. As a result, this study will fill major gaps in the research. The findings of this study should be used to inform how healthcare providers discuss EPT with their patients, especially within this priority population.

Literature Review

The purpose of this literature review is to provide background for the topics central to this thesis. The epidemiology, sequelae, and priority populations of *Chlamydia trachomatis* will be discussed. More specifically, the negative health issues that untreated chlamydia can lead to in women will be explained and the review will demonstrate that screening and treatment of men is an important avenue to reduce chlamydia rates in women. Then, the review will examine health disparities in young Black men, especially in the South, that set the stage for the focus of this thesis.

Next, the literature review will discuss the effectiveness of Expedited Partner Therapy (EPT) as an intervention for treatment of index patients and their partners. Because treatment of partners relies on patients notifying their partners of positive diagnosis, the literature review will summarize the research about general partner notification of STI diagnosis. Then, the review will focus specifically on EPT. The literature on the patient perspective of EPT focuses on facilitators and barriers to patients accepting EPT as a means to treating partners. The literature has very little information about how partners communicate about EPT as the chosen method for chlamydia treatment. As a result, the literature review demonstrates a hole in the literature that this thesis aims to address.

Epidemiology of *Chlamydia trachomatis*

Chlamydia is caused by infection with the bacterium *Chlamydia trachomatis*. It is the most common reportable STI in the United States and has made up the largest proportion of all STIs reported to the CDC since 1994 (CDC, 2019a). In 2018 alone, there were 1.8 million cases reported to the CDC. This is a rate of 539.9 cases per

100,000 people (CDC, 2019a). Since 2014, there has been a 19% increase in cases (CDC, 2019c).

In addition to the high prevalence of chlamydia, the sequelae of the infection are also a public health concern. Untreated chlamydia infections can have serious health complications, especially for young women. Untreated chlamydia increases the likelihood of a woman experiencing pelvic inflammatory disease (PID), which is the major cause of further complications like chronic pelvic pain, infertility, and ectopic pregnancy (Torrone & Weinstock, 2014). Multiple factors put women at higher risk for negative health consequences: chlamydia is most prevalent among young women, most genital chlamydia infections are asymptomatic, the aforementioned health consequences are more likely if a woman is re-infected with chlamydia, and re-infection is very common (Torrone & Weinstock, 2014; CDC, 2016). Chlamydia is asymptomatic for between 70 and 90% of women and over 50% of men (Lallemand et al., 2016). These asymptomatic cases of chlamydia, which often go untreated, serve as major reservoirs for the continuous spread of the infection (Lallemand et al., 2016). Unfortunately, reinfection of chlamydia is very common and women whose sex partners are not treated have a high risk of re-infection (CDC, 2016). For example, in one multi-site study, rates of reinfection of chlamydia among female adolescents ranged from 14.3% to 38.9% (Gaydos, et al., 2008).

Due to serious health complications for young women reinfected with chlamydia, young women are traditionally the main priority population focused on by public health, as evidenced by the CDC's recommendation for annual chlamydia screening of sexually active women under the age of 25 (CDC, 2019a). However, there are no

recommendations for the screening and treatment of men (CDC, 2016). This is an important issue because, as aforementioned, prevention of reinfection is hindered when sex partners are not treated (CDC, 2016). Additionally, men with untreated chlamydia infection can suffer from urethritis, scarring of the reproductive tract, epididymitis, and possible infertility (Jamison, Coleman, & Mmeje, 2019). Therefore, the treatment of partners is equally as important. Furthermore, screening and treatment of men has been shown not only to be cost effective, but more importantly, helpful in reducing rates in women (Gift et al., 2008).

There are also other populations that have specific challenges that should be addressed by public health efforts. To begin, the South has the highest rates of chlamydia infection in the United States. Next, young people are disproportionately affected, with people in the age range of 15-24 having the highest rates of chlamydia infection across the board (CDC, 2019d). Furthermore, Black men are facing a large health disparity when it comes to chlamydia rates. This health disparity is evidenced by the fact that Black men are 6.8 times more likely to report chlamydia infection than white men (CDC, 2019b). Given that young people are disproportionately affected and that Black men are the most impacted, young Black men have a particular burden. This is further demonstrated by the fact that the rate for Black men aged 15–19 years is 9.1 times the rate among white men of the same age range (CDC, 2019b). Similarly, the rates for Black men aged 20–24 years is 5.3 times the rate among white men of the same age group (CDC, 2019b). Black Americans are highly burdened by chlamydia because of issues such as disproportionate poverty rates and lack of health insurance. Inability to access and/or afford quality health care leads to a lack of sexual health services. In

circumstances where Black Americans can access good health care, additional barriers present themselves such as distrust of the health care system and provider bias (CDC, 2018). Additionally, Black Americans are more likely to participate in assortative mating, or choosing sex partners that are also Black, meaning that STIs stay within the Black population (Hamilton & Morris, 2015; Laumann & Youm, 1999).

Clearly, young Black Americans, especially in the South, are facing serious disparities when it comes to chlamydia. To help lessen these disparities, there needs to be a focus on screening and treatment of patients. But, as discussed earlier, it is also important to focus on the treatment of partners as well. One method of partner treatment is Expedited Partner Therapy.

Expedited Partner Therapy

Expedited Partner Therapy (EPT) is the practice of providing medication or prescriptions to sexual partners of persons diagnosed with *Chlamydia trachomatis* without the necessity of the partners having a medical examination. The purpose of EPT is to get partners treated in a rapid manner to reduce their chances of having serious health consequences and reinfecting their partner(s). EPT allows the diagnosed patient to receive extra prescriptions or medications to deliver to their sex partner(s), thereby allowing their sex partner(s) to receive treatment without ever going to a health care provider for testing and diagnosis of chlamydia (CDC, 2019d). In addition to reducing negative health outcomes and reducing the risk of reinfection, EPT is a useful practice because it helps address barriers to treatment by allowing low-income and/or uninsured partners to access treatment without needing expensive doctor appointments (National Coalition of STD Directors, 2019; Jamison, Coleman, & Mmeje, 2019). Furthermore,

EPT helps address lack of treatment caused by a partner avoiding care from a provider due to privacy and confidentiality concerns (Jamison, Coleman, & Mmeje, 2019).

Currently, EPT is legally permitted in 44 states, potentially allowable while subject to additional policies in 5 states (Alabama, Kansas, New Jersey, Oklahoma, and South Dakota), and prohibited in South Carolina (CDC, 2019e). One study indicated that providers from states where EPT is legal are much more likely to provide EPT to their patients than providers from states where EPT is potentially allowable and/or prohibited. However, this same study also showed that overall only 20% of providers in the study had ever provided EPT to their patients (Lee, Dowshen, Matone, & Mollen, 2015). Other studies also find that provider uptake of EPT is low (Kissinger, 2017; Rosenfeld et al., 2015). On the other hand, some studies show that EPT is much more frequently used by providers. For example, in one study 80% of health care sites provided EPT (Introcaso et al., 2013). Clearly, there is varied availability of EPT based on states and providers.

If prescribed, EPT is an effective method of STI treatment. EPT reduces the risk of repeated chlamydia infection (Kissinger, 2014; Shiely et al., 2010; Golden et al., 2005; Mickiewicz, Al-Tayyib, Thrun, & Rietmeijer, 2012); increases rates of partner treatment (Kissinger & Hogben, 2011; Shiely et al., 2010; Golden et al., 2005; Kissinger et al., 2005), and is a cost-effective method (Schillinger, et. al., 2016). As a result, the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American Academy of Pediatrics, the American Medical Association, the American Bar Association, the National Association of City and County Health Officials, the National Coalition of STD Directors, and the Society for Adolescent Health and Medicine have all recommended its

use in managing chlamydia infection (ACOG, 2018; CDC, 2006; Illinois Department of Public Health, 2019; Jamison, Coleman, & Mmeje, 2019). The effectiveness of EPT, however, hinges on the ability of the index patient to notify their partner(s) of their chlamydia diagnosis and EPT as their proposed method of treatment. As a result, the central issue to focus on is partner notification.

Partner Notification of Positive STI Diagnosis

Timely notification of STI exposure and treatment of sex partners is essential to reducing transmission and reinfection. However, only 20% of patients with chlamydia or gonorrhea receive notification from public health departments, meaning that treatment of partners strongly relies on partner notification from the index patient (Gursahaney, Jeong, Dixon, & Wiesenfeld, 2011). As a result, when addressing the public health issue of chlamydia, it is important to understand how to increase partner notification of chlamydia infection.

Research shows that partner notification increases with stronger interpersonal relationships. Index patients are more likely to notify the partners they are in a long term relationship with and main partners as opposed to casual or non-main partners (Gursahaney, Jeong, Dixon, & Wiesenfeld, 2011; Gorbach et al., 2000). In one study, main partners were four times more likely to be notified of a positive STI diagnosis than other types of partners (Gursahaney, Jeong, Dixon, & Wiesenfeld, 2011). Furthermore, notification of partners was associated with high levels of notification self-efficacy. In other words, if a patient believed they could successfully notify their partner, they were more likely to do so (Gursahaney, Jeong, Dixon, & Wiesenfeld, 2011; Hogben, 2007). Similarly, patients were more likely to notify their partners if they had notified any

partner in the past (Hogben, 2007). Patients were also more likely to notify partners based on the following conditions: they had sex with that partner within the past week, they had not used a condom with that partner, and they anticipated having sex with that partner again (Gursahaney, Jeong, Dixon, & Wiesenfeld, 2011).

There are also barriers to partner notification. In one study, researchers found that partners least likely to be notified were those perceived to be the source of the infection, partners who the patient engaged in sexual activity with prior to any onset of symptoms, one-time partners for men, and former partners of women (Gorbach et al., 2000). Additionally, fear and stigma complicate the process of notifying a partner, with different patient characteristics associated with having different fears related to partner notification. Researchers found that young heterosexual patients are more likely to fear gossip and violence, women are more likely to fear violence, and men who have sex with men (MSM) are more likely to fear rejection from partners (Gorbach et al., 2000).

Another study indicated that if medical providers directly involve the patient in the treatment process of their partner, partner notification increases. As a result, the study suggests EPT as an effective method to increase partner notification because EPT gives a patient the accountability for their partners' treatment (Trelle, Shang, Nartey, Cassell, Low, Mathews, & Coetzee, 2007).

Patient Perspective and EPT

There is a large range of how often patients accept EPT as a means to treat their partners, from as low as 30.5% of patients in one study to as high as 89.3% of patients in another (Oliver, Rogers, & Schillinger, 2016; Unger et al., 2015). This large range indicates that research on the reasoning behind patient's willingness to accept EPT is

needed. As a result, most studies on patient experience with EPT focus on facilitators and barriers to accepting EPT as a means of treatment. The most common factor associated with EPT acceptance was the type of partner. Many studies found that patients were more likely to accept EPT if they were treating romantic partners rather than non-romantic partners (Radovic et al., 2013; Taylor et al., 2013). Similarly, EPT acceptance was facilitated by the partner being a regular partner (Coyne, Cohen, Smith, Mandalia, & Barton, 2007; Oliver, Rogers, & Schillinger, 2016; McBride, Goldsworthy, & Fortenberry, 2010). Overall, regardless of relationship type, EPT acceptance is more likely when a patient has higher relationship satisfaction (Goldsworthy & Fortenberry, 2009). This finding is in line with the research on general partner notification of STIs that shows that notification is associated with stronger interpersonal partner relationships.

Another common factor associated with EPT acceptance was positive feelings about EPT. For example, EPT acceptance was facilitated by the patient thinking accepting EPT was the responsible thing to do and/or the good thing to do (Temkin, Klassen, Mmari, & Gillespie, 2011; Ricks et al., 2015). Additionally, the belief that EPT would generally reduce the spread of disease and reinfection influences patients to accept EPT (Goldsworthy & Fortenberry, 2009; Temkin, Klassen, Mmari, & Gillespie, 2011). Finally, EPT acceptance was facilitated by thinking EPT is convenient (McBride, Goldsworthy, & Fortenberry, 2008; McBride, Goldsworthy, & Fortenberry, 2010).

On the other hand, EPT refusal is associated with patients thinking, whether factual or not, that partners are already being treated (Temkin, Klassen, Mmari, & Gillespie, 2011; Vaidya, Johnson, Rogers, Nash, & Schillinger, 2014; Mickiewicz, Al-Tayyib, Thrun, & Rietmeijer, 2012; Cameron et al., 2010; Shim, Madrigal, Williams, &

Patel, 2019). The other most common reason for EPT refusal is a casual/discontinued relationship with the partner (Vaidya, Johnson, Rogers, Nash, & Schillinger, 2014; McBride, Goldsworthy, & Fortenberry, 2008; Radovic et al., 2013; Goldsworthy & Fortenberry, 2009; Coyne, Cohen, Smith, Mandalia, & Barton, 2007; Shim, Madrigal, Williams, & Patel, 2019; Ricks et al., 2015). Patients were likely to refuse EPT if they did not know how/were not able to locate or contact their partner (Temkin, Klassen, Mmari, & Gillespie, 2011; McBride, Goldsworthy, & Fortenberry, 2010; Cameron et al., 2010).

Although EPT acceptance may or may not occur in every case where EPT is offered to a patient, when a patient does accept EPT the actual interaction between partners during EPT notification is not widely studied. There are only a few studies that examined partner communication and interaction with EPT notification. For example, Kerani, et al. (2011) and Ricks, et al. (2015) explore how partners are notified. Kerani, et al. (2011) found that 38% of participants notify in person and 34% notify via telephone. Furthermore, one participant from Ricks and colleagues' (2015) study expressed that phone notification is preferred because that participant perceived that in-person notification would be threatening. The study led by Temkin (2011) has some data on the interaction between partners with partner notification. For example, 70% of patients watched their partners take the medication right after EPT notification. Unfortunately, the study also identified one instance of intimate partner violence following EPT notification. Overall, the research on patient experiences with EPT focuses on factors that facilitate or hinder EPT acceptance, but not the interaction or communication between partners during EPT notification.

Literature Review Synthesis

In summary, chlamydia is a serious public health problem that disproportionately affects Black youth in the South. EPT is an effective method to address this issue. Therefore, research on this topic is valuable. Yet, a gap in the literature is how patients communicate with their partners about EPT as a chosen treatment method. This study aims to learn about how partners communicate and interact during EPT notification, focusing on young Black men in the South. This research will aim to help formulate recommendations and interventions to help empower young Black men to utilize EPT to treat their partners.

Methods

This section will thoroughly describe the research process undertaken for this thesis. First, the thesis' parent studies will be described. Next, the specific procedure and analysis for this thesis will be outlined.

The Parent Studies

The Check It research study evaluates the feasibility of a community-based program that offers free testing and treatment for chlamydia to Black men aged 15-24 in Orleans Parish, Louisiana who have sex with women and its ability to reduce chlamydia rates in both male participants and their female partners. Check It participants are recruited in community venues such as barbershops, recreation centers, and local Historically Black Colleges and Universities (HBCUs). During enrollment, participants are offered a $25 incentive to participate in the program, which includes a consent form, a survey, and screening for chlamydia. For men who test positive, Check It provides free treatment for the participants and their sex partners either by mailing the participant the medication or having it available for pick up at a local pharmacy of the participant's choosing.

A complimentary qualitative study using semi-structured interviews was conducted to learn about participants' experiences with Check It and EPT as a treatment method for their partners (to view interview guide, see Appendix A). Previously enrolled Check It participants who agreed to be contacted for further studies on the original study consent form were incentivized with a $50 gift card to partake in an interview. Check It staff members called participants who agreed to be further contacted to ask if they would like to participate. All participants who expressed interest were invited to be interviewed,

but Check It staff members made efforts to diversify the sample based on age, college enrollment or not, and enrollment site. Interviews took place at private locations convenient for the participant, such as libraries for college-enrolled participants or the Check It office at Tulane's School of Public Health and Tropical Medicine. The interviews were conducted by Check It staff members who were present at the initial Check It recruitment, who were trained in interview best practices techniques, and had similar demographic characteristics as the participants. Specifically, the interviewers were typically young and African American, similar to the participants. This was because research on interviewer effect, or the impact that an interviewer's demographic characteristics have on the success of an interview, recommends that interviewers match the race of participants, particularly if the content of the interview surrounds sensitive topics (West & Blom, 2016). With the consent of participants, the interviews were digitally recorded and transcribed. Interviews continued until saturation was met, meaning that no new information was heard by the research team (Morse, 2015).

This Thesis

Both of the Check It research studies are approved by the Tulane University Institutional Review Board (IRB). To begin, I was granted IRB approval to be affiliated with the Check It project's qualitative study. After receiving approval, I was given access to interview recordings of Check It participants. For the scope of this thesis, I transcribed 20 interviews verbatim from recordings that had been de-identified. The interviews included in my thesis research needed to meet the following inclusion criteria: participants had to have tested positive for chlamydia, accepted EPT as a means to treat their partner(s), and attempted to notify their partner(s) of the opportunity for EPT.

Exclusion criteria for this study included the participant choosing not to accept EPT or being unable to contact their sex partner(s) regardless of their desire to notify about EPT or not. Due to the exclusion criteria, two interviews were removed from the study. The resulting 18 interviews that fit the criteria had an average length of 39 minutes and 24 seconds, with the shortest lasting 23 minutes and 40 seconds and the longest lasting 1 hour, 3 minutes and 56 seconds.

Transcriptions of each interview were uploaded into NVivo 12, a qualitative research data management software program (Edhlund & McDougall, 2019). Next, I read the interview transcriptions multiple times with my research question in mind in order to create a preliminary codebook based on initial patterns I noticed. The preliminary codebook was entered into NVivo and used to code a few transcriptions to check for usability and accuracy of the codebook (Edhlund & McDougall, 2019). Upon having preliminary results, I discussed the preliminary codebook with my qualitative research mentor, who is very familiar with the Check It interview content. Our discussion illuminated previously unconsidered codes and research themes. I returned to the interviews and my preliminary codebook to edit and inform the next version of the codebook. Again, I coded a few interviews to confirm the quality of the revised codebook. After another discussion with my research mentor, I did an additional round of edits, leading to the finalized version of the codebook (to view codebook, see Appendix B). In the codebook, codes were organized into chronological order of the notification process. Specifically, codes were categorized into: the initiation of the notification process, the participant's communication strategies during notification, the partner's

reaction to notification, the partner's next steps following notification, and the interpersonal dynamics following notification.

Interviews were coded thematically using conventional content analysis (Hsieh & Shannon, 2005). During the coding process, I closely read each transcription and highlighted sentences and paragraphs, categorizing them in NVivo based on the code that they represented (Edhlund & McDougall, 2019). During coding, I also paid attention to the number of partners each participant offered EPT to and noted what type of relationship the partner and participant shared. After the initial coding of all interviews was complete, I returned to each interview and reread to confirm that I didn't miss or incorrectly code anything. I repeated this process a few more times, until I was confident in the accuracy of my coding.

For the analysis stage, I used NVivo to determine which themes were most prevalent in the data (Edhlund & McDougall, 2019). In order to see which themes were most common, I looked at how many of the individual interviews contained the theme and also how many specific times the themes were mentioned in all of the interviews combined. Exemplar quotations were selected for each theme. Next, I categorized the results based on relationship type: casual sex partners, current relationship partners, ex partners, and one-night stands. Following the same process, I analyzed what themes were most common amongst relationship types to determine the most common notification pathway based on relationship type. I did not make conclusions about the pathways for ex-partnerships or for one-night stands because there were too few interviews for these categories to confidently identify patterns.

Results

Demographics

Eighteen participants offered EPT to a total of 27 partners. 11 participants offered EPT to one partner, five participants offered EPT to two partners, and two participants offered EPT to three partners. There were four categories of partners (in order of most common): casual sex partners, current relationship partners, ex-relationship partners, and one-night stands.

Casual sex partners were the most commonly categorized type of sex partner, with 14 partners labeled in this way by eight participants. Casual sex partners were partners that participants regularly or semi-regularly had sex with. Next, there were seven current relationships among seven participants. These partnerships were in dating relationships during notification of EPT. The third most common relationship was ex-relationship partners, with four partners labeled this way from four participants. These relationships ended before the participant received their positive diagnosis and notified their ex-partner of their positive chlamydia diagnosis and EPT. Finally, there were two one-night stands identified among two participants. One-night stands were partners that participants only had sex with one time.

Identified Themes

The results of this study illuminated a chronological model for categorizing the interpersonal interactions that accompany notification of positive chlamydia diagnosis and the opportunity for EPT. As shown in Figure A, first, the initiation of the notification process; second, the participant's communication strategies during notification; third, the partner's reaction to notification; fourth, the partner's next steps following notification,

and finally, the interpersonal dynamics following notification. The eight major themes and various subthemes will be presented in this order.

Figure A: Chronological model for categorizing interpersonal interactions during EPT notification.

Each theme will be supported by exemplar quotes. Within quotes, "P" represents "Participant," "I1" represents "Interviewer 1," and "I2" represents "Interviewer 2." Quotes will be attributed to participants' de-identified study ID numbers. Many themes also have "additional considerations," which are findings from the data that were not saturated enough to become themes, but that were interesting to note. Although explained in more detail below, Table A summarizes all of the themes identified.

Notification Stage	Identified Themes and Sub-Themes

Initiation of EPT notification process	• Immediate notification
	• Means of communication
	  ○ Phone call
	  ○ In-person
	  ○ Texting
	  ○ Social media

Participant's communication strategies during notification	• Participant approach
	  ○ Having an honest conversation
	  ○ Trying to help
	  ○ Emphasizing the convenience of EPT
	• Promising medicine

Partner's reaction to notification	• Conflict
	  ○ Debate about the source of infection
	  ○ Partner becomes upset
	  ○ Allegations of cheating
	• Conversation goes well

Partner's next steps following notification	• Partner's EPT decision-making
	  ○ Partner says yes to EPT
	  ○ Seek authority
	  ○ Ignore

Interpersonal dynamics following notification	• Change in relationship
	  ○ No change in relationship
	  ○ Relationship becomes distant
	  ○ Breakup

Table A: Identified themes categorized according to chronological model. Themes and sub-themes are listed from most prevalent in the data to least prevalent. Themes are represented with solid bullet-points and subthemes are represented with hallow bullet-points.

Initiation of EPT Notification Process

The first theme within the initiation of the notification process is *immediate notification.* This theme notes that almost every participant, regardless of relationship type, notified their partner(s) of their positive chlamydia status and the opportunity for EPT immediately following their positive diagnosis. Additionally, the theme reveals participants' motivation for immediate notification. For example, while explaining why he called immediately after receiving the diagnosis, one participant said it was important to him to:

"P: …let them know cuz I just can't be out here just doing day to day, thinking everything

is okay when it's not... I don't want that on my conscience." (2323)

Additionally, immediate notification resulted from concern for the partner's health. For example, a participant wanted to notify his partner immediately because:

"P: We just had sex like recently.

I2: And it was unprotected sex?

P: Yeah.

I2: Okay. So you were hyper concerned.

P: Yeah." (2201)

Additional considerations

The number of participants who didn't notify their partners immediately was negligible and therefore other time frames of diagnosis to notification were not themes in the data. However, it is interesting to note that the absolute longest a participant waited to notify their partner of EPT was three days.

The second theme within the initiation of the notification process is *means of communication.* This theme explores which method participants used to notify their partners of EPT. The most commonly utilized means of communication was a *phone call.* Participants presented phone conversations as the only type of notification that made sense for this type of conversation. For example: “That's a conversation you have on the phone,” (2273) and, “Those type conversations I don't text. I call.” (2274)

Additionally, the participants described calling as useful for explaining the complicated and multi-layered issues that come up during EPT notification such as explaining the infection and being able to fully describe the treatment process of EPT. For example:

> “P: I feel like I just need to be on the phone... so, you know, I can really explain cuz I couldn't really explain it in text about, you know, what was going on and everything so I feel like the phone call would have been best for, you know, explaining what it is and what's going on and like the treatment and everything like that.” (2323)

Next, *in-person* communication was a close second to notifying via phone call. In-person notification was especially common for participants notifying current relationship partners. In a similar manner to phone calls, participants presented in-person communication as the best way to have this type of conversation. For example, “P: I don't like doing stuff like that over the phone [laughs]. I gotta see your face.” (2716)

In-person notification was a response to perceived severity of the situation for some participants. For example, one participant explained:

> “I1: You- you like called her?

P: Nah I went over there.

I1: Yeah you talked to her face to face.

P: It was that serious to me. I was feel like...

I2: Yeah [laughs]

P: ...I was about to die so...

I2: Yeah.

I1: Mmm.

P: ...I gotta get this to you ASAP." (2376)

In-person communication was influenced by proximity to the partner. For example, one participant told their partner immediately in-person because the partner was there when they received the positive diagnosis phone call from Check It. As another example, one participant said:

"P: Yeah we had a serious talk.

I2: Wait a minute, okay. So when you called me you guys were in person?

P: We were face to face... we live together." (2201)

While phone calls and in-person communication were by far the primary means of communication, *texting* was another utilized method. Texting allowed participants to tell if their partners were actively ignoring messages. For example, one participant said, referencing the color of the text message on his phone [on iPhones, blue messages show that a message has been delivered through iMessage, whereas green messages show, among other things, that there is a chance the message has not been delivered]:

"P: That bitch was blue.

I1: I was gonna ask...

P: It wasn't green. You got that message.

I1: Yeah yeah yeah.

P: We got iPhones.

[Laughter]

P: It got delivered.

I2: Delivered.

P: You got that message bro." (2273)

Along the same lines of texting, private interactions on *social media* were utilized by a small number of participants to notify their partners. In fact, social media was often used in tandem with other methods such as texting. For example, a participant who was frustrated by a partner seemingly ignoring him via text attempted to have the conversation over social media as well. He explains:

"I1: Yeah. And [laughs] did you notice any confirmation that she's seen the text messaging? Like DM? [DM stands for direct message, which is a private message between people on social media, most commonly Twitter and Instagram].

P: Her read receipts are not on. But the DM...

I2: But- yeah I was gonna say DM you can.

P: I don't know if she just looked at the front of the message like I don't know how much showed in the box. [The beginning of a message, but not the whole thing, will appear on the notification box on a person's phone. The participant is indicating that he isn't sure if his partner read the beginning of his notification message or not. Either way, the partner never officially opened the DM message].

I1: Okay gotcha gotcha gotcha.

P: But no. No read DM.

I1: No read DM.” (2177)

Additional considerations

While not a theme in itself, it is interesting to note that one participant chose to use Facetime to notify his partner. He explained his choice saying, “P: You don't text that shit. You Facetime.” (2273)

Participant’s Communication Strategies During Notification

The first theme regarding participants’ communication strategies during notification is *participant approach*. This theme explores the many different strategies used by participants to help the notification process go as positively as possible. The primary subtheme in participant approach is *having an honest conversation*. By far, participants, regardless of relationship type, emphasized the importance of honesty during the notification process more than anything else. For example:

“I2: Um, so I call you with your results and how did that go for you?

P: Uh... my main concern was letting my partner know. Like, being honest. Telling her what was up.” (2201)

There was an emphasis on just telling it like it is: “P: Like I'm very blunt... Like I'm gonna let you know.” (2177) Being blunt often centered around disclosure of the diagnosis with statements like, “P: I told her I got tested positive for gonorrhea and chlamydia,” (2273) and “P: I told her, um, [partner name] you might have chlamydia...” (2565)

Participants discussed honesty as a characteristic that partners’ appreciated. For example,

"P: Like I said, I'm an open book.

I1: Mhmm.

P: I don't hide anything.

I1: Did that make her, you think that made her more, uh, calm as well. Her knowing...

P: Yeah." (2204)

The next most common participant approach was for participants to emphasize to their partners that they were simply *trying to help*, usually in regards to helping partners get cured. For example:

"P: I'm not judging, I'm not- I'm not coming at you. I'm not saying that you... I'm saying I don't know how long I have it and I had sex with you so I'm trying to help you, you know.

I1: Yeah

I2: Mhmm

P: Trying to get you this medicine. And if you don't want to take it that's fine. I told her that. I said if you don't want to take it that's fine." (2094)

Emphasizing that they were just trying to help was useful to participants when they were trying to get their partner to take medicine.

"P: We talked a couple more times. I'm- I keep reminding her that I'm like hey I'm trying to get you this medicine.

I1: Mhmm.

P: Because I can already get mine but I need you to be able to take yours too. So that you'll be better." (2404)

Next, during notification participants utilized the strategy of *emphasizing the convenience of EPT*. One of the main conveniences emphasized by the participants was that EPT allowed the partner to get treated for free. [It is important to note that this is unique to this study because the Check It program offered free EPT. EPT is not generally free]. For example:

"P: Right. And I'm telling her you know it's free medicine. Like you can do this like...

I2: Absolutely.

P: It's free. Like that was the first thing I said. It's free medicine. Don't nobody gotta know it's just me and you." (2094)

A more generalizable convenience mentioned by the participants was that their partner doesn't have to go get tested. One participant said, "I told you you ain't have to go get tested or nothing. You could save yourself the embarrassment." (2211) As the previous two quotes mention concepts like "nobody has to know," and "you could save yourself the embarrassment," another convenience of EPT emphasized by participants is that it helps deal with stigma associated with getting tested for STIs.

Finally, a key convenience of EPT highlighted by participants was that it allows the partner to be cured. For example:

"P: Like you could get the medicine, you could get cured for it and she was like okay cool let's just get the medicine.

I2: Mhmm.

P: And get cured for it, then we done with it.

I2: And you told her this...

P: Simple.” (2204)

Additional considerations

While in themselves not true themes of in the data, there were two other strategies used by participants. The first strategy was offering facts about chlamydia. Being able to explain to his partner that most people don’t show symptoms of chlamydia was helpful to one participant:

“P: And what was happening most people don't have symptoms so... that's what I just told the first partner...” (2323)

The other strategy was to encourage partners to take the medication just in case. For example:

“P: So... safety net... take it, if you don't have it, pills won't do nothing... if you do, clear it up, you know?” (2672)

The next theme within participants’ communication strategies during notification was *promising medicine.* This theme showed that the guarantee of medication for the partner granted by EPT was extremely useful to participants during notification. Having the promise of medication made the interpersonal interaction go more smoothly. For example:

“I2: And what made her calm down? Telling her you have the...

P: The medicine.

I2: ...the medicine. That changed her mood?

P: Yeah.” (2185)

Additionally, having the promise of medicine made it easier for participants to tell their partners in the first place. For example:

"I1: Did having the extra dose for her make it easier for you to let her know?

P: Yeah. Yeah. So instead of just like [laughs] bringing bad news... I did have some bad news but it's something to clean it with, you know." (2716)

Partner's Reaction to Notification

The first theme in partner's reaction to notification is *conflict***.** This theme represents types of conflict during the communication process. Conflict was notably most common for partners in a current relationship. Across all conflict, by far the most common point of conflict was the *debate about source of the infection.* This subtheme represents arguing about who brought the infection into the sexual relationship. For example:

"I2: Was there any type of argument or discussion of who infected who? Was there...?

P: Yeah.

I2: ...was that...

P: That was- that was, we were fussing bout that for like 30 minutes straight." (2185)

There was anger about accusations of blame. For example, one participant described: "P: She was like, 'well it's funny how you come to me, it's funny how you know like just cuz I'm doing this, just cuz I'm doing that don't mean it's me.' And I'm like, I'm not saying that." (2094)

This point of conflict also centered around feeling like partners were lying to each other. For example:

"P: I feel like she was lying.

I2: Mhmm.

P: But you know she swears to God she was telling the truth.

I2: Mhmm.

P: And she was like well since you feel like that, you know, break up [inaudible] that's how it happened.

I2: Mmm.

P: But she was like... she felt like I gave it to her.

I2: Okay. So she feels like you gave it to her and maybe you're thinking that she gave it to you or somebody lying in the situation.

P: Somebody lying." (2274)

The next subtheme under conflict is *partner becomes upset.* This type of conflict centered around the partner generally being upset. This could mean that a partner was angry: "P: I mean, she was, uh, not too happy. She was heated." (2201) A partner becoming upset could lead to behavioral outcomes, like cussing. For example: "P: Um [long pause] one of them cussed me out." (2211) A partner becoming upset could also mean that a partner panicked. For example, "I2: She kinda freaked out? P: Yeah," (2185) and, "P: Um one girl panicked but I was like... oh well. Oh well. You gonna take the medicine or you're not." (2672)

Less commonly, conflict centered around *allegations of cheating*. For example:

"P: Because she always accuses me she's like oh you're cheating on me, you're doing all this... I'm like no I'm not. I'm not. I never have in any relationship ever. And so I talked to her on the phone and she's- and then I tell her and she's like I

can't believe that you've done this to me, you know, how could you? I feel so hurt and betrayed. All this stuff, this is what she's saying on the phone.

I1: Mmm.

P: We talked a couple more times. I'm- I keep reminding her that I'm like hey I'm trying to get you this medicine." (2404)

On the other hand, the other theme within partner's reaction to notification was *conversation goes well.* This theme explores the interactions that were positive. The conversation going well was most common for casual sex partners. For many partnerships, the interaction was very casual. For example, "P: Like two of them were cool about it." (2712) During one notification, "I ended up laughing and playing with her." (2211)

Sometimes, partners would start out mildly upset but the conversation would eventually get better. For example, "P: Mmm I mean she was kinda upset but like as we kept talking- cuz like we have real good communication. We're working on that. So the more we talked it was just like okay." (2716)

Partner's Next Steps Following Notification

The theme regarding partner's next steps following notification is *partner's EPT decision-making.* This theme explores what choices a partner makes following notification of EPT. Most commonly, the *partner says yes to EPT.* Many of the partners accepted EPT, meaning that they used the medicine provided to them by the participants to cure themselves of chlamydia. For example, "P: The conversation, it was straight forward and she- she understood what was going on and she just took the medicine." (2323)

Some participants watched their partners take the medication. For example:

"I1: Cool. That's what's up bro. Um so you end up getting it all to them and...

P: Mhmm.

I1: ...um, did you- did they confirm with you that they took it or?

P: Oh yeah they took it. They all took it like literally right before me so…" (2712)

On the other hand, the next most common decision was for a partner to *seek authority.*

Slightly fewer participants than those that accepted EPT decided to seek an outside authority figure for testing and/or treatment of chlamydia. There were two authority figures that partners reached out to: health care providers and the Check It staff. More than half of the partners who wanted to seek out a different method of testing and/or treatment went to a health care provider. For example: "P: Mhmm, I was supposed to give it to my- my female companion but when I told her, you know, she ain't... she went and got tested by her doctor." (2274) Participants indicated that some of their partners didn't feel comfortable taking the medication without being sure that they were infected. For example: "P: you know, she said she had to get checked." (2323)

Alternatively, partners reached out to Check It. For example, speaking of a partner who called Check It:

"I2: You told her to call me which is good, which is rare, you know?

I1: Mhmm.

I2: Very rare so you're, you're a rare breed. Um, and she called me back to clarify the timing.

P: Mhmm.

I2: Why do you think that was important to her?

P: I think it was more of her having trusted me, like, because we are in a relationship now. So I think she wanted to see was I really lying or was I telling the truth about this but I was like really honest. I was like, I told her everything I told you, like... that was the time I did that shit. I wasn't hiding nothing. I wasn't lying but...

I2: Yeah.

P: You wanna hear it from them or do you wanna hear it from me?

I2: Yeah.

P: So I told her you want a second opinion, here's this number, call it." (2201)

In this case, the partner wanted to contact Check It to confirm that everything the participant had told her was true. Similarly to partners that looked for authority from a health care provider, partners looked to Check It to confirm the legitimacy of the notification.

Otherwise, the other subtheme under partner's EPT decision making was to *ignore.*

Some partners ignored the participants and never responded to the notification. This decision was most common in ex-relationship partnerships. A clear example of this comes from a participant who tried to notify his partner multiple times, to no avail:

"P: And like I got no response.

I1: Okay.

P: Going on social media she all over social media try to contact her, no response. [Laughs]

I1: So you contacted her via text?

P: Phone...

I1: Text?

P: And social media.

I1: Oh okay. So you called her, texted her, [inaudible]…

P: And sent the DM.

I1: And sent the DM. And you got no response?

P: No response." (2177)

Some partners continually ignored the discussion about chlamydia and EPT, regardless of the fact that they were communicating with the participant about other topics. For example:

"I2: Okay so you told her about the medication.

P: Yeah.

I2: Yeah. That made it easier or…?

P: I felt it- it's- I was uncomfortable because I didn't know what she would say but she didn't say anything so that's when I assumed she already got treated for herself.

I2: Oh she didn't respond at all? Wow. So like ghosted. Have you talked to her since or?

P: Every now and then but it's never about that. She- she tries to pretend the past didn't exist." (2565)

Interpersonal Dynamics Following Notification

The theme regarding interpersonal dynamics following notification is the *change in relationship.* This theme explores how or if the relationship dynamics between partners changed post-notification. The most common subtheme was *no change in relationship.* Most partners, regardless of relationship type, did not experience notable change in their relationships. For some participants, the lack of change was explicitly stated. For example:

> "I2: And if it did at all... how did your sexual relationship with her change or if it stayed the same or?
>
> P: Pretty much stayed the same.
>
> I1: Mmm.
>
> P: Yeah. [Laughter] Nothing's changed." (2716)

Partners were able to address interpersonal challenges resulting from the notification process and get their relationship back to normal. For example: "P: And I mean we still together now. We compromised." (2201)

However, for most relationships, the lack of change was coded based on the participant not actively discussing any changes during the interview. While interviewers did not always specifically ask whether EPT notification impacted the relationship, the topic almost always came up naturally. This is because the interviewers always asked generally about the relationships between participants and partners, and if a relationship changed, participants seemed to bring that up without direct prompting. As a result, no mention of the relationship changing implies that, in fact, there was no relationship change. However, it is important to recognize that there may be a chance that a small amount of participants did experience relationship changes and simply didn't mention it.

Of the relationships that changed, the most common change was that the *relationship becomes distant.* For example: “P: But like once she got cured of it she like she was distant for a while. Like me and her were like distant and I was like [pause] why? Like... and she told me like that's why were distant because I had this and I was upset and I didn't know how to tell you and I was like you know me... And like I said I'm not the average dude like if you- if you were cornered or something like I know you this long and I've been there for you...” (2094)

Becoming distant sometimes happened at the preference of the participant. For example: “P: And then I'm gonna just walk out, like I have nothing to say to you after that.” (2177)

A small but notable amount of relationships had a *breakup* because of the interaction. For example:

“I1: Oh you guys recently broke up.

P: Yes.

I1: Oh okay.

P: Yeah because of this.

I1: Cuz of this.

I2: Okay because of this situation.

P: Mhmm.” (2195)

Additional considerations

While not common enough to become themes in of themselves, there were additional impacts on relationships that were interesting to note. First, some partners agreed to use condoms more as a result of this process. EPT notification provided the

opportunity for participants to discuss using protection with their partners. For example: “P: I let her know that we should start using condoms more... More often. And I told her I had the medicine for her to get cured.” (2185) Alternatively, the desire to use condoms more was brought up by a partner in response to the notification: “P: She was just like um... maybe we should do condoms.” (2201)

Next, a few participants experienced their partner completely cutting off communication (often referred to as “ghosting”) after the notification. For example, “P: I'm just like well you ghosting me after that encounter and I'm sitting here trying to tell you. So either you knew you had it and you gave it to me or you just don't care. And then the fact that you- I'm telling you this and you still going around trying to do that [have sex with other men without getting treated for chlamydia] is kind of alarming to me.” (2177)

Finally, for one participant, the process actually made the relationship closer:

“I1: Mmm. What's the relationship like? With y'all.

P: I mean it's like we- we real close now but it's just like at the beginning...

I1: Mhmm.

P: ...kinda is- kinda rocky. That's why I'm saying like... I really don't know. I- I probably got the, that's what I'm saying, so... but- but it wasn't too bad. The conversation, it was straight forward and she- she understood what was going on and she just took the medicine.

I1: And she kind like trusted you enough...

P: Yeah she did.

I1: ...to believe that that was the medicine.

P: Yeah because I was coming straight forward and addressing it rather than like withholding information back from her." (2323)

This participant discussed how at the beginning their relationship was rocky but how the interaction about EPT fostered trust leading their relationship to become closer.

Conceptual Models

Based on the results, a clear EPT notification pathway emerged for the majority of participants. As shown in Figure B, most interpersonal interactions happened over phone calls, with the participants' approaches centering honesty. Most partnerships experienced conflicts, primarily about the source of the infection. Regardless, most partners accepted EPT and no changes in relationships occurred.

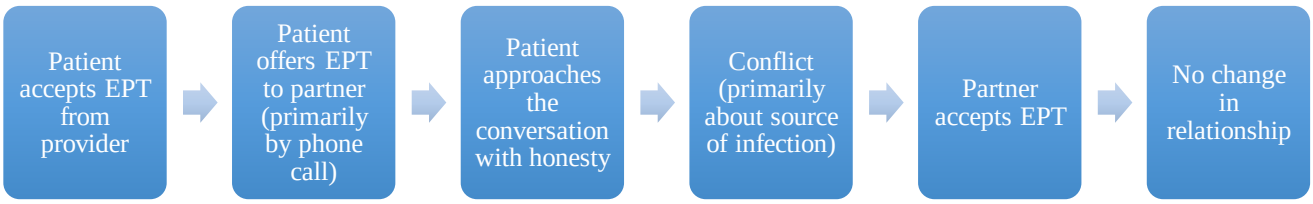

Figure B: Most common overall notification pathway regarding EPT.

Additionally, different common notification pathways based on relationship type emerged. There were noticeable differences among casual sex partnerships and current relationship partnerships. As Figure C shows, the pathway most common for casual sex partners was: phone notification, honest approach, conversation going well, partner accepting EPT, and no change in relationship. On the other hand, the pathway most common for current relationship partners was: in person notification, honest approach, conflict, partner accepting EPT, and no change in relationship. There were not enough ex-relationships or one-night stands for meaningful differences to be observed.

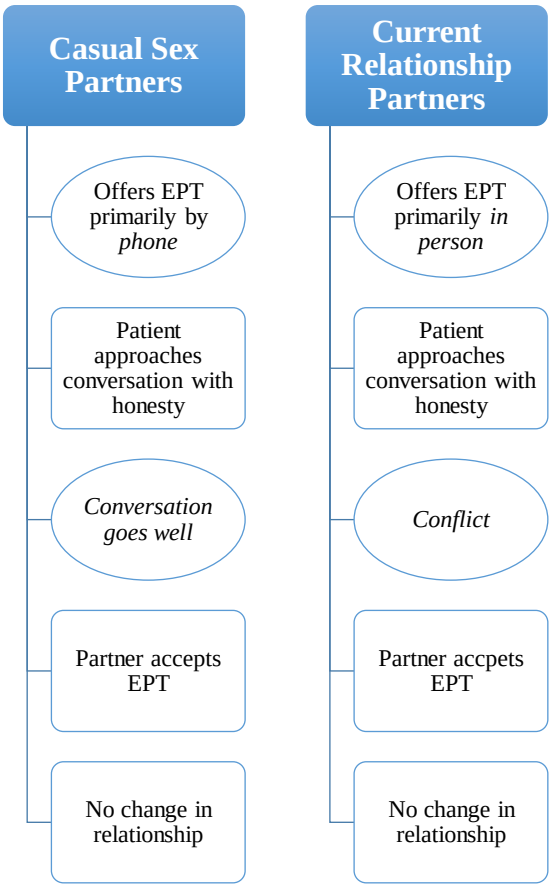

Figure C: Most common notification pathways regarding EPT notification based on relationship type (casual sex partners vs current relationship partners). Where differences emerge, aspects of the notification are represented in circles, rather than squares.

Discussion

To summarize the study's results, the interpersonal dynamics between partners during notification of EPT are categorized into: the initiation of the notification process, the participant's communication strategies during notification, the partner's reaction to notification, and the interpersonal dynamics following notification. Although there were differences among participants, in general, most participants notify their partners immediately and prefer notifying via phone call, followed closely by in-person notification. Participants primarily emphasize honesty in order to have a successful notification. Most partnerships experience conflict during notification, with most conflicts centering around the source of the infection. However, many notification conversations go well and are without conflict. Most partners decide to use EPT for treatment. Finally, most relationships do not change following the notification process.

While the results clearly indicate themes within each category there are differences that typically occur based on relationship type. For example, being in a current relationship changed several dynamics. Current relationships were the relationship type that utilized in-person communication and the relationship type that experienced conflict the most. On the other hand, the other types of relationships preferred phone call and didn't experience as much conflict. Most of the ex-relationships experienced a partner not responding to the notification at all, meaning that there was very little interpersonal interaction and no way of knowing if the partner was treated or not. However, across the board, participants notified their partners immediately and most relationships did not change following notification.

The findings of this research expand upon and are supported by the few studies that also look at aspects of communication during EPT notification. For example, the finding that most partners notify using phone calls, followed closely by in-person communication, is similar to Kerani, et al.'s (2011) findings that 38% of participants notify in person, 34% notify via telephone, followed by 22% by email, and 1% by text message. This study also finds that phone calls and in-person notification are the most commonly utilized methods with very close rates of use, although the most commonly used method was different between the studies. Interesting, Kerani, et al.'s (2011) study found texting to be a very infrequently used method and presented email to be a relatively frequent method, although email was not at all found in this study. This could be a result of the study occurring nine years ago, which could be a reflection of emerging communication technologies. Additionally, it is important to note that Kerani, et al.'s (2011) study had a very different sample demographically, with most participants being middle aged white men who have sex with men (MSM).

The fact that participants in this study notify their partners immediately and primarily over phone or in-person conversations, which is supported by Kerani, et al., indicates that EPT notification is seen as a serious conversation that prompts more personal communication methods. Phone call may be preferred because it meets the need for personal communication but can be less intimidating than in-person notification. For example, one participant from Ricks, et al.'s (2015) study expressed that they preferred phone because they perceived in-person notification to be threatening. Intimate partner violence is a possibility following EPT notification (Temkin, Kassen, Mmari, & Gillespie, 2011), which indicates that concerns about in-person communication are valid.

The case of the participant in this study who chose to notify over Facetime seemingly meets the needs of more personal communication for this serious conversation. It may be a good compromise between a phone call and in-person communication for someone who is nervous about in-person communication but feels like a phone call would be too impersonal.

Although this study does not look at why participants are choosing to use EPT to treat themselves and their partners, as every participant in this study had already made that decision, the existing research on reasons why patients choose to use EPT aligns with the communication strategies participants used in this study. To begin, the studies led by Temkin (2011) and Ricks (2015) found that patients accepting EPT was facilitated by the patient thinking that using EPT was the responsible and/or good thing to do. This finding parallels the emphasis during notification on honesty and trying to help by the participants in this study. It seems that perceptions of morality play a large role in not only the patient's acceptance of EPT but also the partner notification process. Furthermore, previous research shows that patients' acceptance of EPT is facilitated by patients thinking that EPT is convenient (McBride, Goldsworthy, & Fortenberry, 2008; McBride, Goldsworthy, & Fortenberry, 2010). Again, this is paralleled by the emphasis during notification on the convenience of EPT by the participants in this study. These parallels suggest that the factors that motivate patients to accept EPT become the aspects that patients emphasize to their partners during the notification for the opportunity for EPT.

This research generates many recommendations for practice. Providers should discuss the many aspects of interpersonal interactions with their patients. It may be

helpful for patients to be presented with many different options for how they can notify their partners so they can choose the option that is best for them. For example, a patient may never consider less commonly utilized methods like Facetime or social media as options for notification until they are suggested. Providers should supply their patients with all of the options for notification, all the way from in-person to social media, and emphasize that the important issue is to notify their partner, not which method they choose.

The findings present additional strategies that providers can use to motivate their patients to tell their partners about EPT. As discussed, it seems that the perception that notifying partners about EPT is the right thing to do plays a large part in participants' motivation to do so. Providers may be able to encourage their patients to notify their partners by telling them that it's the moral thing to do. Based on the findings of this research, providers can suggest honesty and helping the partner as moral aspects of notification. Furthermore, emphasizing convenience and having the promise of medicine helped participants tell their partners and ease the conversation. As a result, providers could motivate their patients to tell their partners about EPT by emphasizing these aspects.

Furthermore, providers should discuss the very real fear of conflict arising as a result of EPT notification. It is important to note that although conflict during notification is common, many notification interactions do not lead to conflict. Providers should be transparent with their patients about the fact that either situation is possible. In case of conflict, providers can warn patients about what types of conflicts they can expect. As debate about source of infection seems to be the most common type of conflict, providers

should let their patients know that regardless of which person introduced the infection into the partnership, it is important for both people to get treated.

The reality is that most partners were receptive to EPT regardless of partnership type. Additionally, partners are receptive to EPT regardless of if there is conflict or not. If a partner does not wish to take EPT, it is important to recognize that partners may be seeking their own treatment. Providers can tell their patients that even if they don't think their partners would accept EPT, that they should tell their partners about the diagnosis anyway so that the partner can seek their own screening and treatment.

Regardless of all of the complicated dynamics at play, it seems that generally relationships are not changing as a result of EPT notification. This is good motivation for patients to notify their partners of EPT. Even if there is conflict or if the notification generally is uncomfortable, many relationships will not change as a result. While it is important for a provider to recognize the patient's potential fear of a relationship changing, providers can encourage their patients that their relationships might not change at all.

Finally, providers should tailor how they talk to their patients based on the kind of relationship participants have with their partners. If their patient is in a casual sexual relationship, providers can discuss the notification process based on the most common pathway for casual sex partnerships found in this research: phone notification, honest approach, conversation going well, partner accepting EPT, and no change in relationship. On the other hand, if their patient has a current relationship, providers should discuss that the most common pathway found in the research was: in person notification, honest approach, conflict, partner accepting EPT, and no change in relationship. Specifically for

this type of relationship, providers can warn their patients that they perhaps should expect conflict, but that their partners are still likely to accept EPT and that they may not experience a change in their relationship.

Although the research generates many recommendations for providers about how to communicate with their patients about EPT notification, there must be a recognition that providers have a very limited amount of time to talk to their patients. As a way to deal with this constraint, an infographic or handout should be formulated detailing the different dynamics that are common during notification. This handout can be disseminated to health care providers so that they can logistically get this information to their patients during diagnosis of chlamydia and initial offering of EPT.

This research will generate applied changes to the Check It program and research study. The data from this thesis will be used to create videos for Check It participants that will be disseminated through Check It's various social media platforms. The videos will relay the information found in this study to past, current, and future Check It participants with the intention to motivate them to tell their partners about the opportunity for EPT in a way that is the best fit for them. The videos will use existing Check It marketing and cultural tailoring to appeal to participants like Check It's "A King Knows His Status" campaign (Check It Nola, 2020). For example, highlighting the major finding that participants in this thesis prioritize honesty, the Check It social media videos can use terminology like, "A king is honest with his partners."

In addition to recommendations for practice, this research also yields recommendations for future research. This research focused on a specific priority population of young Black men in New Orleans, LA and, as a result, the results may be

very specific to this population. As this is one of the first studies on the interpersonal interaction between partners during notification of EPT, there is little information on this topic. Future studies should examine the interpersonal dynamics during notification of EPT in other populations. Additionally, more research should be conducted specifically on ex-partnerships and one-night stand relationships. These partnership types were not common enough in this study to form conclusions about notification pathways for these specific relationships. Additionally, more research should focus on casual sex partners and current relationships to confirm the notification pathways identified in this study. Finally, this study was among patients who accepted EPT. With the recognition that many patients do not accept EPT, there should be studies focusing on if communicating the findings of this research to patients works as an effective intervention to motivate the acceptance of EPT.

There are limitations to this research. To begin, there may be a self-selection bias. Although many participants were asked to take part in the interview study, men had to self-select to be interviewed, meaning those who agreed may be different in some way than those who did not. Another limitation of this research is that there was not a second coder to confirm the reliability of the results. In the next step of this research, there will be a second coder to check for inter-coder reliability. Finally, this research came from secondary data. The interviews did not have a focus on communication between partners. If the interview guide had been constructed with the intention to collect data for a communication study, the questions may have been different and more targeted to the topic.

The findings of this study indicate that although EPT notification transpires in diverse ways and affects partnerships differently, there are notable patterns. This is important because although there are studies on how patients feel about EPT, until this study, there were no studies on how the notification process actually transpires for patients. By recognizing the patterns identified in this study, providers can have more intentional conversations with their patients about how to communicate with their partners about EPT. Providers can also let their patients know various outcomes that they can expect during notification, which may serve as motivation for the patient to follow through with notification and ease the communication process.

References

American College of Obstetricians and Gynecologists. (2018). Expedited partner therapy. ACOG Committee Opinion No. 737. Obstetrics and Gynecology, 131 (6), 190–193.

Cameron, S. T., Glasier, A., Muir, A., Scott, G., Johnstone, A., Quarrell, H., Oroz, C., McIntyre, M., Miranda, D., & Todd, G. (2010). Expedited partner therapy for Chlamydia trachomatis at the community pharmacy: Pharmacy treatment for chlamydia. BJOG: An International Journal of Obstetrics & Gynaecology, 117(9), 1074–1079. https://doi.org/10.1111/j.1471-0528.2010.02573.x

CDC, a. (2019). Sexually transmitted disease surveillance 2018. Chlamydia. Retrieved from: https://www.cdc.gov/std/stats18/chlamydia.htm

CDC, b. (2019). Sexually transmitted disease surveillance 2018. STDs in racial and ethnic minorities. Retrieved from: https://www.cdc.gov/std/stats18/minorities.htm

CDC, c. (2019). Sexually transmitted disease surveillance 2018. Retrieved from: https://www.cdc.gov/std/stats18/default.htm

CDC, d. (2019). Expedited partner therapy. Sexually transmitted diseases (STDs). Retrieved from: https://www.cdc.gov/std/ept/default.htm

CDC, e. (2019). Sexually transmitted diseases (STDs). Legal status of expedited partner therapy (EPT). Retrieved from: https://www.cdc.gov/std/ept/legal/default.htm

CDC. (2018). Sexually transmitted disease surveillance 2017. STDs in racial and ethnic minorities. Retrieved from: https://www.cdc.gov/std/stats17/minorities.htm

CDC. (2016). Chlamydia - CDC fact sheet (detailed). Chlamydia. Retrieved from: https://www.cdc.gov/std/chlamydia/stdfact-chlamydia-detailed.htm

CDC. (2006). Expedited partner therapy in the management of sexually transmitted diseases. Retrieved from: https://www.cdc.gov/std/treatment/eptfinalreport2006.pdf

Check It Nola. (2020). Kings know their status. Retrieved from: https://checkitnola.com/

Coyne, K. M., Cohen, C. E., Smith, N. A., Mandalia, S., & Barton, S. (2007). Patient-delivered partner medication in the UK: An unlawful but popular choice. International Journal of STD & AIDS, 18(12), 829–831. https://doi.org/10.1258/095646207782716956

Edhlund, B. & McDougall, A. (2019). *NVivo 12 essentials: Your guide to the leading qualitative data analysis software.* Form & Kunskap AB.

Gaydos, C. A., Wright, C., Wood, B. J., Waterfield, G., Hobson, S., & Quinn, T. C. (2008). Chlamydia trachomatis Reinfection Rates Among Female Adolescents Seeking Rescreening in School-Based Health Centers: *Sexually Transmitted Diseases*, *35*(3), 233–237. https://doi.org/10.1097/OLQ.0b013e31815c11fe

Gift, T. L., Gaydos, C. A., Kent, C. K., Marrazzo, J. M., Rietmeijer, C. A., Schillinger, J. A., & Dunne, E. F. (2008). The program cost and cost-effectiveness of screening men for chlamydia to prevent pelvic inflammatory disease in women. Sexually Transmitted Diseases, 35(Supplement), S66–S75. https://doi.org/10.1097/OLQ.0b013e31818b64ac

Golden, M. R., Whittington, W. L. H., Handsfield, H. H., Hughes, J. P., Stamm, W. E., Hogben, M., Clark, A., Malinski, C., Helmers, J. R. L., Thomas, K. K., & Holmes, K. K. (2005). Effect of expedited treatment of sex partners on recurrent

or persistent gonorrhea or chlamydial infection. New England Journal of Medicine, 352(7), 676–685. https://doi.org/10.1056/NEJMoa041681

Goldsworthy, R. C., & Fortenberry, D. J. (2009). Patterns and determinants of patient-delivered therapy uptake among healthcare consumers. Sexually Transmitted Diseases, 36(1), 25–32. https://doi.org/10.1097/OLQ.0b013e318186011d

Gorbach, P. M., Aral, S. O., Celum, C., Stoner, B. P., Whittington, W. L. H., Galea, J., Coronado, N., Connor, S., & Holmes, K. K. (2000). To notify or not to notify: STD patients' perspectives of partner notification in Seattle. Sexually Transmitted Diseases, 27(4), 193–200. https://doi.org/10.1097/00007435-200004000-00003

Gursahaney, P. R., Jeong, K., Dixon, B. W., & Wiesenfeld, H. C. (2011). Partner notification of sexually transmitted diseases: Practices and preferences. Sexually Transmitted Diseases, 38(9), 821–827. https://doi.org/10.1097/OLQ.0b013e31821c390b

Hamilton, D. T., & Morris, M. (2015). The racial disparities in STI in the U.S.: Concurrency, STI prevalence, and heterogeneity in partner selection. *Epidemics*, *11*, 56–61. https://doi.org/10.1016/j.epidem.2015.02.003

Hogben, M. (2007). Partner notification for sexually transmitted diseases. Clinical Infectious Diseases, 44(Supplement_3), S160–S174. https://doi.org/10.1086/511429

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. Qualitative Health Research, 15(9), 1277–1288. https://doi.org/10.1177/1049732305276687

Illinois Department of Public Health. (2019). Expedited partner therapy (EPT). Retrieved from: http://www.dph.illinois.gov/topics-services/diseases-and-conditions/stds/ept

Introcaso, C. E., Rogers, M. E., Abbott, S. A., Gorwitz, R. J., Markowitz, L. E., & Schillinger, J. A. (2013). Expedited partner therapy in Federally Qualified Health Centers—New York City, 2012. Sexually Transmitted Diseases, 40(11), 881–885. https://doi.org/10.1097/OLQ.0000000000000045

Jamison, C. D., Coleman, J. S., & Mmeje, O. (2019). Improving women's health and combatting sexually transmitted infections through expedited partner therapy. Obstetrics & Gynecology, 133(3), 416–422. https://doi.org/10.1097/AOG.0000000000003088

Kerani, R. P., Fleming, M., DeYoung, B., & Golden, M. R. (2011). A randomized, controlled trial of inSPOT and patient-delivered partner therapy for gonorrhea and chlamydial infection among men who have sex with men. Sexually Transmitted Diseases, 38(10), 941–946. https://doi.org/10.1097/OLQ.0b013e318223fcbc

Kissinger, P., Mohammed, H., Richardson-Alston, G., Leichliter, J. S., Taylor, S. N., Martin, D. H., & Farley, T. A. (2005). Patient-delivered partner treatment for male urethritis: A randomized, controlled trial. Clinical Infectious Diseases, 41(5), 623–629. https://doi.org/10.1086/432476

Kissinger, P., & Hogben, M. (2011). Expedited partner treatment for sexually transmitted infections: An update. Current Infectious Disease Reports, 13(2), 188–195. https://doi.org/10.1007/s11908-010-0159-3

Kissinger, P. J. (2014). Expedited partner therapy for sexually transmitted diseases—Are we there yet? Sexually Transmitted Diseases, 41(11), 695–697. https://doi.org/10.1097/OLQ.0000000000000207

Kissinger, P. J. (2017). The challenges of implementing and evaluating prescription expedited partner treatment. Sexually Transmitted Diseases, 44(2), 109–110. https://doi.org/10.1097/OLQ.0000000000000577

Lallemand, A., Bremer, V., Jansen, K., Nielsen, S., Münstermann, D., Lucht, A., & Tiemann, C. (2016). Prevalence of Chlamydia trachomatis infection in women, heterosexual men and MSM visiting HIV counselling institutions in North Rhine-Westphalia, Germany—Should chlamydia testing be scaled up? BMC Infectious Diseases, 16(1), 610. https://doi.org/10.1186/s12879-016-1915-2

Laumann, E. O., & Youm, Y. (1999). Racial/Ethnic Group Differences in the Prevalence of Sexually Transmitted Diseases in the United States: A Network Explanation: *Sexually Transmitted Diseases*, *26*(5), 250–261. https://doi.org/10.1097/00007435-199905000-00003

Lee, S., Dowshen, N., Matone, M., & Mollen, C. (2015). Variation in practice of expedited partner therapy for adolescents by state policy environment. Journal of Adolescent Health, 57(3), 348–350. https://doi.org/10.1016/j.jadohealth.2015.05.013

McBride, K., Goldsworthy, R. C., & Fortenberry, J. D. (2008). Formative design and evaluation of patient-delivered partner therapy informational materials and packaging. Sexually Transmitted Infections, 85(2), 150–155. https://doi.org/10.1136/sti.2008.033746

McBride, K. R., Goldsworthy, R. C., & Fortenberry, J. D. (2010). Patient and partner perspectives on patient-delivered partner screening: Acceptability, benefits, and barriers. AIDS Patient Care and STDs, 24(10), 631–637. https://doi.org/10.1089/apc.2010.0109

Mickiewicz, T., Al-Tayyib, A., Thrun, M., & Rietmeijer, C. (2012). Implementation and effectiveness of an expedited partner therapy program in an urban clinic. Sexually Transmitted Diseases, 39(12), 923–929. https://doi.org/10.1097/OLQ.0b013e3182756f20

Morse, J. M. (2015). "Data were saturated. . ." Qualitative Health Research, *25*(5), 587–588. https://doi.org/10.1177/1049732315576699

National Coalition of STD Directors. (2019). Expedited partner therapy: Reducing health care costs and creating healthy communities. Retrieved from: https://www.nationalfamilyplanning.org/file/documents---policy--communication-tools/EPT.pdf

Oliver, A., Rogers, M., & Schillinger, J. A. (2016). The impact of prescriptions on sex partner treatment using expedited partner therapy for Chlamydia trachomatis infection, New York City, 2014–2015. Sexually Transmitted Diseases, 43(11), 673–678. https://doi.org/10.1097/OLQ.0000000000000511

Radovic, A., Burstein, G. R., Marshal, M. P., Murray, P. J., Miller, E., & Sucato, G. S. (2013). Adolescents' Attitudes Toward Expedited Partner Therapy for Sexually Transmitted Infections. Sexually Transmitted Diseases, 40(11), 894. https://doi.org/10.1097/OLQ.0000000000000034

Ricks, J. M., Swartzendruber, A. L., Sales, J. M., Boyce, L. S., DiClemente, R. J., & Rose, E. (2015). Acceptance of and experiences utilising expedited partner therapy among African-American juvenile girls. Sexual Health, 12(4), 364. https://doi.org/10.1071/SH15050

Rosenfeld, E. A., Marx, J., Terry, M. A., Stall, R., Pallatino, C., & Miller, E. (2015). Healthcare providers' perspectives on expedited partner therapy for chlamydia: A qualitative study: Table 1. Sexually Transmitted Infections, 91(6), 407–411. https://doi.org/10.1136/sextrans-2014-051873

Schillinger, J. A., Kissinger, P., Calvet, H., Whittington, W. L. H., Ransom, R. L., Sternberg, M. R., Berman, S. M., Kent, C. K., Martin, D. H., Oh, M. K., Handsfield, H. H., Bolan, G., Markowitz, L. E., & Fortenberry, J. D. (2002). Patient-delivered partner treatment with Azithromycin to prevent repeated Chlamydia trachomatis infection among women: A randomized, controlled trial. Sexually Transmitted Diseases, 30(1). Retrieved from https://journals.lww.com/stdjournal/Fulltext/2003/01000/Patient_Delivered_Partner_Treatment_With.11.aspx

Schillinger, J. A., Gorwitz, R., Rietmeijer, C., & Golden, M. R. (2016). The expedited partner therapy continuum: A conceptual framework to guide programmatic efforts to increase partner treatment. Sexually Transmitted Diseases, 43, S63–S75. https://doi.org/10.1097/OLQ.0000000000000399

Shiely, F., Hayes, K., Thomas, K. K., Kerani, R. P., Hughes, J. P., Whittington, W. L. H., Holmes, K. K., Handsfield, H. H., Hogben, M., & Golden, M. R. (2010).

Expedited partner therapy: A robust intervention. Sexually Transmitted Diseases, 1. https://doi.org/10.1097/OLQ.0b013e3181e1a296

Shim, J., Madrigal, J., Williams, A., & Patel, A. (2019). 28. Acceptance of expedited partner therapy among adolescents in an urban reproductive health clinic. Journal of Pediatric and Adolescent Gynecology, 32(2), 205. https://doi.org/10.1016/j.jpag.2019.02.029

Taylor, M. M., Reilley, B., Yellowman, M., Anderson, L., de Ravello, L., & Tulloch, S. (2013). Use of expedited partner therapy among chlamydia cases diagnosed at an urban Indian health centre, Arizona. International Journal of STD & AIDS, 24(5), 371–374. https://doi.org/10.1177/0956462412472825

Temkin, E., Klassen, A. C., Mmari, K., & Gillespie, D. G. (2011). A qualitative study of patients' use of expedited partner therapy. Sexually Transmitted Diseases, 38(7). Retrieved from https://journals.lww.com/stdjournal/Fulltext/2011/07000/A_Qualitative_Study_of_Patients__Use_of_Expedited.14.aspx

Torrone E., Papp, J. & Weinstock H. (2014). Prevalence of Chlamydia trachomatis genital infection among persons aged 14-39 years-- United States, 2007-2012. CDC. Retrieved from: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6338a3.htm

Trelle, S., Shang, A., Nartey, L., Cassell, J., Low, N., Mathews, & Coetzee. (2007). Improved effectiveness of partner notification for patients with sexually transmitted infections: Systematic review. BMJ: British Medical Journal, 334(7589), 354-357. Retrieved from http://www.jstor.org/stable/20506410

Unger, J. A., Matemo, D., Pintye, J., Drake, A., Kinuthia, J., McClelland, R. S., & John-Stewart, G. (2015). Patient-delivered partner treatment for chlamydia, gonorrhea, and trichomonas infection among pregnant and postpartum women in Kenya. Sexually Transmitted Diseases, 42(11), 637–642. https://doi.org/10.1097/OLQ.0000000000000355

Vaidya, S., Johnson, K., Rogers, M., Nash, D., & Schillinger, J. A. (2014). Predictors of index patient acceptance of expedited partner therapy for Chlamydia trachomatis infection and reasons for refusal, sexually transmitted disease clinics, New York City, 2011 to 2012. Sexually Transmitted Diseases, 41(11). Retrieved from https://journals.lww.com/stdjournal/Fulltext/2014/11000/Predictors_of_Index_Patient_Acceptance_of.10.aspx

West, B. T., & Blom, A. G. (2016). Explaining interviewer effects: A research synthesis. Journal of Survey Statistics and Methodology, smw024. https://doi.org/10.1093/jssam/smw024

Appendix A: Interview Guide

Check It Phase 2: Individual interview guide v. 11/1/18

Objectives and notes on administration

This research is designed to provide the investigators an understanding of ways to improve results notification and facilitate treatment for participants who enrolled in the Check It study and their sexual partners by eliciting information on their experience in the study, barriers and facilitators to treatment and partner notification and treatment. Findings from these data will be used to improve services for participants and their partners.

Participation in the interviews will be entirely voluntary and confidential. The interview will be audio recorded (if the participant has provided consent for recording) and notes will be taken by study staff. Recordings will be summarized; names and any other identifying information will be removed in the summaries. The interviews are semi-structured. Questions asked and probing conducted during the interviews will reflect information given by each participant in the course of the interview. The outline provided is meant only to serve as a reminder to the interviewer and to assist in consistency.

Administrative section (data from Check It Phase 1):

Study ID: _____ Date of interview: _____

Chlamydia results: __ positive __ negative

Gonorrhea results: __ positive __ negative

Enrollment date: _____

Enrollment site: _____

Enrollment staff: _____

Results given date: _____

Elapsed time between results given and interview date: _____

For positives: Elapsed time between treatment outcome report and interview: _____

For men who were positive:

Contacted by LA OPH	☐ Yes ☐ No Comments:
Treatment plan	☐ Walgreens pick up ☐ Walgreens deliver ☐ Castellon mail ☐ Castellon pick up ☐ Castellon deliver ☐ Partner clinic ☐ Own Provider ☐ Other, _____
Treatment confirmed?	☐ Yes ☐ No
If treatment was different than the treatment plan checked above, explain what happened.	
Number of doses of medication requested for recent sex partners	
Number of doses of medication delivered to partners?	
Number of female partners at enrollment	
Number of female partners permitted to be contacted by LA OPH	
Partner medication requested for all of these partners?	☐ Yes ☐ No
If not, describe the notification/treatment plan for the partners that did not get medication	

A) Introduction/expectations

Hi. My name is _____ and this is _____. Thank you for agreeing do this interview today. We are talking to men who took part in the Check It study. We are interested in ways to improve the study so we are glad you are willing to talk to us today about your experience on Check It.
Everything you say to me is confidential and the researchers will not use your name or your partners' names on any documents we save.

FROM CONSENT FORM: Participant consented to be audio-recorded? ☐ Yes ☐ No
If YES, We will audio record the interview so that we can make sure we have written down everything you tell us. If any names are on the recordings we will remove them when we summarize the recording. After the recording is summarized and verified, we will destroy the audio recording.

We are interested in your opinions and ideas, so please speak freely. Remember, you do not need to talk about anything you don't feel comfortable with and you are free to leave at any time.

As a reminder. You enrolled in Check it on [date] at [location]. You spoke with [study staff]. Do you remember meeting with us, taking the survey and giving your urine to get tested for chlamydia and gonorrhea?
☐ Yes ☐ No

B) <u>SALIENT BELIEF ELICITATION</u>

Before you start your interview with _____ I'd like to ask you a series of short answer questions.

When I ask you these questions, I'd like you to tell me the first 3 answers that come to your mind. There are no right or wrong answers to the questions, I just want to know your first 3 thoughts.

Like if I say. What are your 3 favorite musicians? Who are the first 3 who come to mind?
1. _____
2. _____
3. _____

Great. Now for these next questions I'm going to explain a situation that you may or may not have experience with – that's ok. We are just interested to know what you think. Remember, just tell me the first 3 responses that come to your mind.
Let's say you got tested for chlamydia like you did with Check It. Afterwards you found out that your results were positive. You're told that you can pick up free medicine that will cure chlamydia for yourself AND your sexual partners so that you can deliver the medicine to your partners.

I want you to tell me the first three answers that come to your mind. There are no right or wrong answers.

a. What are 3 advantages or good things that might happen if you give the medicine to your sex partner(s)?

1. _____
2. _____
3. _____

b. What are 3 disadvantages or bad things that might happen if you give the medicine to your sex partner(s)?

1. _____
2. _____
3. _____

c. Who are three people or groups that might approve or support you if you give the medicine to your sex partner(s)?

1. _____
2. _____
3. _____

d. Who are three people or groups that might **not** approve or support you if you give the medicine to your sex partner(s)?

1. _____
2. _____
3. _____

e. What are 3 things that would make it easier for you to give the medicine to your sex partner(s)?

1. _____
2. _____
3. _____

f. What are 3 things that would make it harder for you to give the medicine to your sex partner(s)?

1. _____
2. _____
3. _____

Thank you. We're done with the short answer part of this interview. Now I'm going to ask for your thoughts and opinions about Check It.

C) <u>Overall thoughts on Check It</u>

1. **What did you think is the purpose of the project?**
   - Why do you think Check it is only enrolling African American men aged 15-24?
   - How important is chlamydia and gonorrhea to you and people you know?

D) <u>Check It – enrollment</u>

2. **How did you hear about the Check It program?**

3. **Tell us about your first interaction with the study team?**

4. **When you enrolled in the study, you were asked to take a survey. What did you think about the survey?**
   - Were there any questions that confused you?
   - What about the length?

5. **How was the testing?**
   - How were the facilities?
   - Were the instructions about peeing in the cup easy to understand? Was it awkward at all?

E) <u>Experience with Check It – results notification and treatment</u>

6. **I'd like to hear about when you got your results. Tell me about that experience that day. Start from the beginning.**
   IF THEY SAY THEY DID NOT EVER GET RESULTS, DO NOT ASK THIS SECTION – instead tell them that study staff will call them (confirm contact number) and go to Section F
   - How was the experience talking to the person who called you?
   - Did you have any questions for them?
   - Did they answer your questions?
   - What was your reaction about your results? How did getting the results make your feel?

7. **Once you got your results, did you tell anyone about them?**
   - Why did you choose to tell those people? How did you tell them?
   - Or if told no one, why didn't you tell anyone about your results?

8. **ONLY FOR POSITIVES: Once you were told about your positive results, what options for treatment did the person you spoke with tell you about?**
   - How did you feel about the options?
   - What option did you choose for you?
   - How did getting treatment work out? Ever get the medicine? Take the medicine?
   - What was your experience like at (talk about his treatment choice (e.g. pharmacy, clinic)

9. **ONLY FOR POSITIVES: Some guys who find out they are positive choose not to get treated. Why do you think that is?**

10. **ONLY FOR POSITIVES: We're interested in learning more about your feelings about telling sex partners about your results. How many recent sex partners did you have at the time you took part in Check It and were tested?**

11. **ONLY FOR POSITIVES: After you found out about your results, did you tell any of your sex partners about your results?**
    <u>If yes:</u> How did you tell them? Why did you decide to let them know of the results in that way?
    <u>If no:</u> Why did you decide not to tell them?
    - Told partner in person? On phone? Text message?
    - What are the good things about telling you partner?
    - What are the bad things about telling your partner?
    - How did your sexual relationship with each partner change?

12. **ONLY FOR POSITIVES: <u>If he told partner(s):</u> How was it talking to each partner(s) about their need to get medication or checked out?**
    <u>If yes:</u> What did you tell them? How did they respond? Did you give the medicine?
    <u>If no:</u> Why didn't you talk to them about treatment?
    - Follow up with partners?
    - Do you know if they took medicine or got checked out?

13. **ONLY FOR POSITIVES: <u>If he had more than 1 partner:</u> Did all of your partners get told the same way and given the same information? <u>If not:</u> Why not?**
    - How does the type of relationship you have with your partner(s) play into whether or not you tell them?
    - How does whether or not you think you will have sex with her play into your decision to tell her.

14. ONLY FOR POSITIVES: <u>If he chose to get medication to give to all of his partners and delivered it to their partners</u>: You chose to get doses of medication to deliver to your partners. Tell me about your experience getting your partner(s) the medication?
    - What was their reaction?
    - Did she take the medication?

15. ONLY FOR POSITIVES: <u>If he did not give the medication to all partners:</u> You chose to get doses of medication to deliver to your partners. Tell me about your experience getting your partner(s) the medication?
    - How did you choose which partner(s) to get the medication for?
    - What was their reaction?
    - How did you give information about your infection to your other partner(s) who did not get medication?

16. What are some things that may stop a guy from telling his sex partners about a positive STD result? What might be ways that we can get more young women notified and treated?

17. **One option that Check It offers is to have men who test positive, give the Check It staff number to his partner so that the staff can help get that partner treated. So far, most guys have not chosen to do that. Why do you think that is?**

18. **Now that you have been in Check It, what are ways you can think of that will help us improve it?**

19. **What might make it easier for guys and their partners to be tested and treated for STDs?**

F. Referral

20. **After you took part in Check It, did you tell any other guys about it?**
    - If so, how did you tell them how to get in touch with Check It staff (text message, word of mouth, flyer)? Why did you refer them?
    - If not, why didn't you refer anyone to the project?
    - Did staff ask you to tell other guys? How did they suggest you give other guys info about the project?

21. **We are hoping to get guys who have already taken part in Check It to refer other guys who might be eligible and interested into the program. What do you think is the best way for us to do that?**
    - What reasons might you not refer guys you know to the program?

22. **If you were sent a text message from Check It that you could send to guys that you know who might be interested in getting tested, would you use it? Why or why not?**

23. **What about referral cards that you could give other guys to let them know about Check It, would you give those out? Why or why not?**

24. **What other ideas do you have about ways to make it easier for guys to refer other guys?**

G. Website feedback

25. **Do you think that guys your age go online to look for information on STDs and other sexual health issues? ☐ Yes ☐ No**
    - If no, where do they go for this kind of information?
    - If yes, what sites?

26. **When a guy your age does go to a website to find out information on STDs, what do you think they will most likely be looking for information on?**

27. **Have you ever gone to the Check It website? ☐ Yes ☐ No [show him website if there is time]**

28. **If you have time to open up the website go to the landing page: What do you think of the landing page?**
    - Images? Text? Layout?

29. **If you have time to open up the website go to the landing page: If you have time to open up the website go to the landing page: There are 4 sections that the website focuses on: Why get tested, What to do if you find out your positive, How to talk to sex partners, and Frequently Asked Questions. How do you feel about those main topics? Any that are missing that are important to add?**

30. **We're are advertising the program more using social media. Do you think more guys would participate if we advertised heavily on social media?**
    - If yes-- Which platform would be best to use? What would you like to see?
    - If no—why not? What would work instead?

H) General feedback

31. **What is the first thing that comes to mind about a way that we can make Check It better?**
    a. What other things did you dislike? What are things we can improve on?

32. **What is the thing you liked most about Check it?**

33. **Any other things you can add to help us make things better on the project?**

34. **Is there anything else you would like to tell us about your overall experience with Check It?**

Thank you so much for helping us understand how we can make this a better program. Please let me know if you have any questions. Here is my contact information if you have any questions or ideas about Check it after you leave today. [Give contact card]

Appendix B: Codebook

Honors Thesis Codebook

Overarching research question: ***What kinds of interpersonal dynamics occur between young Black men and their female sexual partners during notification of EPT?***

Code	Description	Example	Notes
Immediate notification	This theme represents that most participants notified their partners about chlamydia diagnosis and the opportunity for EPT immediately.	"P: Soon as I got off the phone with you I called her." (2204)	The longest a participant waited to tell their partner was 3 days.
Means of Communication *(various sub-codes)*	How men choose to notify their partner of EPT.		
Phone call	Partners used a phone call to notify their partner.	"P: And then I just finally called. I was like, you know what let me call her and let's see what's going on." (2094)	
Texting	Partners texted their partner about opportunity for EPT.	"P: But so I was like but it's going to be okay cuz like I'm getting medicine before tomorrow and it will be here so I'll text you guys tomorrow and like check and see where you're at so I can give you the medicine." (2712)	
Social media	Partner used a form of social media to notify their partner.	"P: Going on social media she all over social media try to contact her, no response." (2177)	Notifying using DMs are included in social media code.
In-person	Partner notified their partner in a face to face discussion.	"p: I told her when I went by her house." (2185)	

Participant approach *(various sub-codes)*	This is the various methods that participants use to ease the conversation.		
Having an honest conversation	Participants emphasized the importance of honesty during the notification.	"P: My main concern was letting my partner know. Like, being honest. Telling her what was up." (2201)	
Trying to help	Participants emphasized to their partners that they were just trying to help them during notification.	"P: We talked a couple more times. I'm- I keep reminding her that I'm like hey I'm trying to get you this medicine." (2404)	
Emphasizing the convenience of EPT	Partner emphasize to their partners that EPT is convenient for them.	"P: It's free. Like that was the first thing I said. It's free medicine." (2094)	Two of the main conveniences emphasized are: free and avoiding the need to get tested.
Promising medicine	The guarantee of medication for the partner granted by EPT was extremely useful to participants during notification.	"I2: And what made her calm down? Telling her you have the... P: The medicine. I2: ...the medicine. That changed her mood? P: Yeah" (2185).	This code does not necessarily represent having the medicine physically on hand during notification. Rather, it is the promise of the medication that is coming that assists the participants in notifying their partners.
Conflict *(various sub-codes)*	Often times during notification there is conflict between partners.		
Partner becomes upset	Conflict during notification centered around the partner generally being upset.	"I1: Okay. How'd your- how'd your girlfriend take that news? P: I mean- she was kinda mad but she was like- she was just trying to ask me like how... I'm like I don't know girl." (2444)	Can include anger, anxiety, shock, behaviors like cussing, etc.
Allegations of cheating	Conflict could center around whether or not one of the partners cheated on the other.	"P: Because she always accuses me she's like oh you're cheating on me, you're doing all this... I'm like no I'm not. I'm not. I never have in any relationship ever." (2404)	

Debate about source of infection	Partners argued about who introduced the infection into the sexual relationship during notification.	"I2: Was there any type of argument or discussion of who infected who? Was there...? P: Yeah. I2: ...was that... P: That was- that was, we were fussing bout that for like 30 minutes straight." (2185)	
Conversation goes well	In contrast to the conflict code, this code explores how many of the notifications goes well.	"P: Like two of them were cool about it" (2712).	
Partner's EPT decision making *(various subcodes)*	This code explores what actions a partner chooses to take as a result of notification.		
Ignore	Some partners are notified of EPT but ignore it.	"P: And like I got no response." (2177)	
Partner says yes to EPT	Many partners agree to take the medicine provided through EPT.	"P: She was like okay cool let's just get the medicine." (2204)	
Seek authority *(various sub-sub-codes)*	Sometimes during notification, a partner desires authority on the subject.		
Contact HCP	Partner seeks out a health care provider.	"P: I was supposed to give it to my- my female companion but when I told her, you know, she ain't... she went and got tested by her doctor." (2274)	
Contact Check It	Partner seeks out the Check It staff.	"P: So I told her you want a second opinion, here's this number, call it." (2201)	
Change in relationship *(various sub-codes)*	The interaction during EPT notification changes some of the relationships.		
Becomes distant		"P: But like once she got cured of it she like she was distant for a while. Like me and her were like distant and I was like [pause] why? Like... and she told me like that's	

		why were distant because I had this and I was upset and I didn't know how to tell you and I was like you know me...” (2094)	
Break up		“I1: Oh you guys recently broke up. P: Yes. I1: Oh okay. P: Yeah because of this.” (2195)	
No change in relationship		“P: And I mean we still together now. We compromised.” (2201)	