case, and $1127 per early syphilis case identified. ICE of identifying partner showed a decline with the increase in number of attempts but the ICE values of case detection through partner notification did not show any systematic pattern.

**Conclusion** This study demonstrates that adding partner notification with SS is more CE in syphilis detection in Louisiana compared to case detection by SS alone. In terms of intensity of partner notification, it was found that increasing the number of attempts to contact the partners remained cost effective but due to variability in the number of attempts to contact cases, it was not possible to determine the optimal number of attempts.

**Results** The models all have a baseline chlamydia prevalence of 3%. In the triple model, chains of contacts can be seen at cross-section, whereas there are, by definition, no ongoing partnerships in the instantaneous contact model. In all three models, we find that a substantial proportion of partners (>10%) from partnerships that ended as far back as 18 months is infected with C trachomatis. We then investigated the population level effect of PN (with 50% success) as a complementary strategy to screening (at a rate of 0.1 per year). Increasing both the number of notified partners and the PN period results in lower levels of C trachomatis. Under the most realistic assumptions of the sexual partnership dynamic, most of the effect of PN results from notifying the current partner.

**Conclusions** We found that extended PN periods can efficiently identify new chlamydia-infected cases. At low screening levels, the additional benefit of PN in decreasing chlamydia prevalence is minor and primarily derives from notifying the current partners in order to prevent re-infection. This study exemplifies the differences between individual and population level outcomes of PN as an intervention for the management of C trachomatis infections.

---

**ORAL SESSIONS**

**O5-S3.03**  **STI PARTNER NOTIFICATION: PATIENTS’ VIEWS AND EXPERIENCES OF NOTIFYING PARTNERS**

**Methods** We conducted a systematic search of 4 electronic databases for PN literature from 1990 to August 2009. Meta-ethnography was used to synthesise data from the 16 studies that met our inclusion criteria. We identified key metaphors and themes from individual studies and compared them and their explanations with other studies to enable further interpretations. We then examined the emerging concepts that have implications for STI/HIV PN policy and programs.

**Results** Our synthesis revealed that PN is influenced not only by type of partnership or infection but also by the socio-cultural, religious, and legal framework governing sex and sexuality. Paradoxically while PN is perceived as altruistic, and as a moral responsibility towards partners, it is also feared as ‘social suicide’. ‘Breaking the bad news’ is perceived as a difficult and potentially troublesome task; however, patient referral is preferred to provider referral. STI/HIV diagnosis invokes ‘embodied shame’ which can result in non-disclosure, or selective disclosure, or confronting and blaming the partner, especially a main current partner. While the experience of notifying partners is typically not as bad as expected, it occasionally results in violence against women. Injecting drug users felt less able to notify drug-using partners due to legal implications. Provider-led