Partner Investigator meeting at the 11th International Congress on Drug Therapy in HIV Infection Glasgow, 12 November 2012

1. **Welcome (Andrew Phillips)**
2. **Brief update on status of the Partner Study (Andrew Phillips)**
    a. Recruitment

    Enrollment by month since inception-November 2012

    Recruitment isn't as high as earlier, maintaining a stable level 20-25 per month (844 pairs enrolled, or 63% of projected total). Variation among the countries, but some is getting closer to their enrolment goals. 35% MSM is slowly increasing, very important to have as many enrolled as possible

    b. Amount of PYFU that Partner is accruing

    Total eligible person-time for primary analyses is at the moment 360 year and we are aiming for 2000 PYFU. There are several reasons why we don't have the level of eligible PYFU preferred - e.g. all HIV negative individuals must come in for their follow up test; partner break ups: please note that at least it's important to get the negative test before they are lost; ensure you have the best contact numbers.

    In the event of a seroconversion, it is critical to get the bio sample from the seroconverter and the HIV+ partner to see if their infections are from same/different sources (phylogenetic analyses). Once we approach 1,000 PYs, we will conduct phylogenetic analyses.
3. **Feedback on recruitment and Follow up visit/retention rates (Tina Bruun)**
    a. Primary contact are the nurses: thank you for all you do
    b. Recruitment

    More difficult to enroll, but please keep in mind that partner status can change and it's important to re-enquire on willingness/eligibility to enroll.

    The complete month follow up visit: Tina reminded the attendees about what constitutes a PYFU eligible visit (2eCRFs, 2 questionnaires (1 from HIV+, 1 from HIV negative), 1 viral load, and a minimum of 1 HIV test per year). We need to receive all the documentation required to assess your country's retention rate. Each month, Tina will send you reminders about documentation needed: please ensure that all documentation is sent in.

    You can probably recruit about 3% of the HIV population in your clinic. Currently, great variability among the sites, with room for improvement at some sites.

4. **Nurses' panel: Nicky Perry, (UK), Bente Baadegaard (DK), Maarit Maliniemi (Sweden)**

    Nicky: Works in Brighton, Demographic: over 80% MSM. Clinic is saturated with study information. Twice a week, teams meet to review cases, physician knows who is eligible, Notepad alerts prompt nurses and physicians for Partner—the medical staff refers them to the research nurses who follow up on eligibility; off clinic hours-availability helps; will help with STI screening at the same time. Monthly recruitment letters, list who has recruited the most to their studies on a board. They visit community organizations, etc. Best that worked was competitiveness within the clinic! Follow up visits: helps to have off hours before/after work. Barriers: HIV – partners are not as keen on the study as the HIV+s

    Bente: works in the outpatient clinic for infectious diseases-2 research nurses. Clinic staff tells them about the Partner study and then if interested, they are referred to research nurses. Sometimes they receive external calls-they often come unsolicited. Flexible hours.

Patients seem to like the office: because they take the time to talk with them. They never miss a questionnaire because the negative partner fills out the questionnaire while the rapid test is processing

Maarit: Study coordinator from Stockholm; outpatient ward for MSM. They do a lot of prescreening. She feels her couples are happy to be in the study, esp in the first year when they are coming together. The second year, it is harder to get the negative partner in. It would be helpful to have a nurse on site that is responsible for the study.

5. **Newest data from Partner (Pietro Vernazza)**

Continued high levels of condomless sex. Please see the presentation for further details.

Thank you!