clinic, a clinic in Kampala for women at high-risk of HIV-infection. We included HIV positive women ≥ 18 years who initiated ART at GHWP between August 2014 and October 2017. We defined LTFU as not taking an ART refill for ≥ 3 months from the last clinic appointment and not classified as dead or transferred to another clinic. We used the Kaplan-Meier technique to estimate time to LTFU after ART initiation. Predictors of LTFU were assessed using a multivariable Cox proportional hazards model.

Results Of the 293 enrolled participants, 16% of the women were LTFU within the first year of ART initiation. The mean ($\pm$ SD) age of study participants was 30.3 (± 6.5) years, with 274(94%) reporting paid sex while 38(13%) had never tested for HIV before enrolment into GHWP. LTFU in the cohort was estimated at 12.5 per 100 person-years (95%CI 9.8–16.0). In multivariable analysis, participants who reported sex work as their main job at ART initiation (Adjusted Hazards Ratio [aHR] = 1.98, 95%CI 1.12–3.52), having baseline WHO clinical stage III or IV (aHR = 2.65, 95% CI 1.26–5.60) were more likely to be LTFU.

Conclusion LTFU in this cohort is high. Follow up strategies are required to support women on Test and Treat to remain on treatment, especially those who engage in sex work and those who initiate ART at a later stage of disease.

Disclosure No significant relationships.

P038

COMPARISON OF ANYPLEX™II STI-7E V1.1 TO ALLPLEX™ CT/NG/MG/TV FOR THE DETECTION OF STI FROM URINE COLLECTED WITH URISPONGE™

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Background Sexual transmitted infections are playing an important role in genital infections. *Chlamydia trachomatis* (CT), *Neisseria gonorrhoeae* (NG), *Mycoplasma genitalium* (MG) and *Trichomonas vaginalis* (TV), have been associated to vaginal infections, cervicitis and urethritis and complications like pelvic inflammatory diseases. Pathogens like *Mycoplasma hominis* (MH), *Ureaplasma urealyticum* (UU) and *Ureaplasma parvum* (UP), residing in the genital tracts, are not always associated to active infections. Seegene introduced the Allplex™ CT/NG/MG/TV (STI-4) Assay. This study objective was to compare the performance of the Anyplex™II STI-7e v1.1 (STI-7) that detects CT, NG, TV, MG, MH, UU, and UP, to the Allplex™ CT/NG/MG/TV for the detection of STI from urines.

Methods Urines collected with UriSponge™ (Copan Italia, Brescia Italy) were tested with the STI-7: UriSponge™ samples were centrifuged 5min at 2500 RPM, tubes de-capped, sponges discarded, vortexed and loaded samples on the Nimbus for nucleic acids extraction. Extracted samples were analyzed with the STI-7 on the CFX96 system. Nucleic acids from 142 urine, already defined negative and positive, were analyzed with the Allplex™ CT/NG/MG/TV on the CFX96 system. Both assays were compared, concordant results

were considered negative or positive, discordant results were retested in duplicate.

Results In the 142 urines tested with STI-7 and STI-4 assays, concordant results were detected, 29 CT, 16 NG, 11 MG positives, 29 negatives and 5 discordant results, 2 STI-7 negative/STI4 positive (1MG and 1CT) and 3 STI-7 positive/STI-4 negative (1NG, 1CT,1TV). Results were not statistically significant ($P > 0.05$). Anyplex II STI-7 detected 22 MH, 25 UU and 45 UP.

Conclusion In this study an excellent agreement was demonstrated by the Seegene Anyplex™II STI-7e v1.1 and by Allplex™ CT/NG/MG/TV assays for the detection of *Chlamydia trachomatis*, *Neisseria gonorrhoeae*, *Mycoplasma genitalium* (MG) from urine collected with Copan UriSponge™. The Allplex™ CT/NG/MG/TV assays eliminate the detection of MH, UU, and UP.

Disclosure No significant relationships.

P039

A CENTRAL REFERENCE LABORATORY FOR ANTIMICROBIAL RESISTANT *NEISSERIA GONORRHOEAE* IN THE US DEPARTMENT OF DEFENSE

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Background Antimicrobial resistant (AMR) *Neisseria gonorrhoeae* has emerged as a global public health concern. Widespread resistance to all known antibiotics prescribed for treatment greatly hinders prevention, control, and management of gonorrhea. Misuse of antibiotics and substandard antibiotic quality and dosing have contributed to the threat of untreatable gonorrhea. As a globally deployed force, the U.S. military is vulnerable to diminished operational capability and readiness as this threat looms overhead.

Methods The need for rapid, timely, and actionable information for force health protection precipitated the establishment of the Department of Defense (DoD) Gonococcal (GC) Reference Laboratory and Repository in 2011. The aims of the Reference Laboratory are to monitor trends in AMR GC through confirmatory identification, antimicrobial susceptibility testing (AST) and advanced molecular characterization, and to improve *N. gonorrhoeae* culture capability at international DoD surveillance sites. To our knowledge, this is the only global AMR GC surveillance program led by a military organization.

Results Gonococcal surveillance at international DoD sites is conducted at partner military medical centers, private medical clinics, and U.S. government-sponsored care clinics. Laboratories currently submitting isolates include: AFRIMS (Bangkok, Thailand); NAMRU-3 (Accra, Ghana); NAMRU-6 (Lima, Peru); USAMRD-G (Tbilisi, Republic of Georgia); and USAMRD-A (Nairobi, Kenya). To date, 436 presumptive isolates have been shipped, from which 247 isolates were confirmed as *N. gonorrhoeae*. Resistance is commonly observed in these isolates, particularly with respect to tetracycline, penicillin, and ciprofloxacin. Of greater concern, reduced susceptibility to azithromycin (MIC ≥ 0.125 μ g/mL) and cefixime (MIC ≥ 0.06 μ g/mL) have been observed.