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NOT LOST IN TRANSLATION: DEVELOPING A SEXUAL HEALTH COMMUNICATION TRAINING INTERVENTION FOR MEDICAL STUDENTS IN DAR ES SALAAM, TANZANIA

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Background Health professionals in Tanzania report a perceived need for sexual and reproductive health (SRH) communication training to meet patient needs and reduce disparities. Simulation optimizes the clinical performance and public entrustment. We describe the development and preliminary quality control results from an innovative, Afrocentric SRH simulation for later use within a large randomized controlled educational trial.

Methods Standardized patient (SP) simulation cases with embedded cultural, language, gender, age, sexuality, and legal complexity issues identified by stakeholders in Dar es Salaam were embedded in 1) adolescent health, 2) women's health, and 3) male health cases. Bilingual senior students were recruited and enrolled after informed consent to participate in a pilot trial. SP simulation interviews were conducted and via Zoom™ in Kiswahili. Each student completed the 3 simulations as a part of study procedures. We report the student characteristics and results of the translated and close-captioned [T-CC] fidelity and quality control analysis using the evaluation of both SP performance and student engagement using established patient-centered communications standards.

Results Twenty-four students mostly male (62.5%), year 5 (66.7%) students evenly split across nursery, midwifery, and medicine with a mean age (sd) of 25.1 (1.3) years were recruited for participation in the pilot. Review of the T-CC data was consistent across bilingual staff, demonstrated high student engagement, performances by SPs were true to the case context, and the quality of video data was consistent with other more expensive recording methods. There were no adverse events or unanticipated disruptions impacting the fidelity of the simulation component.

Conclusion Preliminary SRH simulation data using standardized patients demonstrate student engagement and trained SP fidelity to case and protocol. The use of translated, closed-captioned video data and input from bilingual staff ensures that the training materials meet international standards for patient-centered health communication without losing key information in translation.

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FOLLOW-UP ASSESSMENT OF PARTICIPANTS WITH URETHRAL DISCHARGE SYNDROME IN KAMPALA, UGANDA: LESSONS LEARNED FOR FUTURE STI CONTROL INTERVENTIONS

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Background After effective treatment, persons diagnosed with a sexually transmitted infections (STI) are encouraged to modify behavior and notify partners. In resource-limited settings (RLS), follow-up assessment is limited by a variety of factors, including access to knowledge, material resources, and reliable communication.

Methods A study conducted in 2019 within the existing WHO-based Enhanced Gonococcal Antimicrobial Surveillance Program (EGASP) collected urogenital samples and blood from men with urethral discharge syndrome (UDS). Samples were tested for *Neisseria gonorrhoeae* (NG), *Chlamydia trachomatis* (CT), *Trichomonas vaginalis* (TV) and *Mycoplasma genitalium* (MG), and HIV. Participants received treatment and were then followed up using phone calls on days 7, 14 and 21 post-enrolment.

Results Of the 250 participants recruited for this study, 66.7%, 20.5%, 11.6%, and 2.0% were positive for NG, CT, MG, TV, respectively, and 20% (50/250) were HIV-positive. Follow-up visits on days 7, 14, and 21 were completed by 98.8%, 96.0%, and 96.4% of participants, respectively. The majority (94.5%) of participants completed their prescribed treatment regimen. Resolution of symptoms (penile discharge and dysuria) was reported by 76.7% of participants 3–5 days post-treatment while 7.5% reported no resolution of symptoms. The majority (77.2%) reported sexual activity while on treatment; 31.6% of those reported condom use, and 15.1% reported multiple partners. PN was reported by 66.9% of participants; 16.8% of participants reported that they had no intention of notifying their partners.

Conclusions The prevalence of STIs was high in this group of men with UDS who also reported low condom use and multiple sex partners. While completion rate of follow-up visits was very high, innovative ways to follow-up patients to ensure response to treatment and to incentivize PN are necessary in future STI control interventions.

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DISRUPTED SEXUAL HEALTH CARE DURING THE CORONAVIRUS PANDEMIC IN 2020: THE IMPACT ON STI POSITIVITY AMONG SEXUAL HEALTH CLINIC ATTENDEES

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Background Dutch Sexual Health Clinics (SHCs) had to downscale services during the first coronavirus wave, but continued to provide essential STI/PrEP care including testing for persons at highest risk for (symptomatic) gonorrhoea, infectious syphilis (syphilis) and HIV. We describe STI positivity among SHC attendees between 2011–2020.

Methods National SHC surveillance data contained information on demographics, sexual behaviour, STI testing and diagnoses. We split 2020 into periods: 1 January–12 March (pre-lockdown), 13 March–31 May (lockdown) and 1 June–31 August (post-lockdown). Chlamydia, gonorrhoea, syphilis and HIV positivity (n positive/N tested) trends were explored by gender and sexual contact.

Results In 2020, weekly numbers of consultations varied between 2,803 and 3,515 pre-lockdown, 564 and 1,298 during lockdown and 1,084 and 1,976 post-lockdown. Relatively

more MSM, PrEP users and clients notified for or with symptoms of STI were seen during- and post-lockdown compared to pre-lockdown. Chlamydia positivity was around 18% among heterosexual men and 15% among women from 2016–2019, and increased to 21.1% and 16.6% respectively in 2020. Positivity increased during lockdown, up to 32% among heterosexual men, followed by decreases post-lockdown to pre-lockdown levels. Among MSM, the increase during lockdown was smaller, only slightly affecting overall positivity in 2020. Gonorrhoea positivity also increased during lockdown, causing further increasing trends among heterosexuals from 1.8% in 2011 to 2.2% in 2020 and among MSM from 9.0% to 12.1%. Syphilis positivity among MSM fluctuated between 2.0% and 2.9% in 2011–2020. Positivity peaked (6.7%) during lockdown, while the number of diagnoses was similar to pre-lockdown. In contrast, HIV positivity continued to decrease from 2.0% to 0.3% among MSM in 2011–2020.

Conclusion Prioritising persons at highest risk caused decreases in diagnoses, especially chlamydia and gonorrhoea, but increases in positivity. More information is needed to understand transmission dynamics, including testing at GPs, self-testing and sexual behaviour during coronavirus pandemic.

P265 VALUE OF CLIA SEROCONVERSION WITH NEGATIVE RPR AND IMMUNOBLOT FOR THE DIAGNOSIS OF EARLY SYPHILIS

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Introduction An isolated CLIA seroconversion (i.e. CLIA-reactive, immunoblot non-reactive, RPR non-reactive, with a previous negative CLIA) could indicate a false positive result or early incubating syphilis. To confirm early syphilis, follow-up appointments are often needed. We wanted to evaluate the diagnostic value of such seroconversions.

Methods We included every patient with a positive CLIA (Liaison) and a negative RPR and immunoblot visiting the STI clinic (To) between January 2014 to April 2020, and a preceding visit with a negative CLIA in the 6 months prior to the initial consultation (T-1). If available, a follow-up appointment in the 2 months after the initial consultation (T1) was included. If darkfield microscopy (DFM) or PCR for *Treponema pallidum* was positive at T0, diagnosis of syphilis was confirmed. This also applied to a positive RPR and/or immunoblot in the T1 consultation.

Results We included 91 participants with an isolated CLIA seroconversion. The value of the CLIA seroconversion in 19/91 (21%) of the study population could not be established, since they had no positive PCR or DFM ulcer sample at To and had no T1 consultation. Of the remaining 72 patients, 54 (75%) the CLIA seroconversion was confirmed. 28/54 persons (52%) had a PCR or DFM confirmation in the initial consultation and 26/54 persons (48%) had a serologic confirmation in the follow-up appointment. In 18/72 (25%) persons the CLIA seroconversion was regarded as false positive reaction since no seroconversion in RPR or immunoblot was seen at T1.

Conclusion Of the evaluable patients with a CLIA seroconversion, 75% had an early incubating syphilis infection. 48% of these patients would benefit from presumptive treatment, since they had no signs of primary syphilis at the moment of the CLIA seroconversion. However, 25% had a false positive result, thus would receive unnecessary presumptive treatment.

P267 DISCORDANT CURES ARE ASSOCIATED WITH MYCOPLASMA GENITALIUM INFECTION IN MEN TREATED WITH AZITHROMYCIN FOR NONGONOCOCCAL URETHRITIS

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Background In men with nongonococcal urethritis (NGU), clinicians and patients rely on the resolution of urethritis signs and symptoms to determine the need for additional testing/treatment and when to resume sexual activity, respectively. Whether clinical NGU cure correlates with microbiological clearance across sexually transmitted infections (STI) remains unknown.

Methods Within the Idiopathic Urethritis Men's Project (IUMP), we identified men with mono-infection NGU due to *Chlamydia trachomatis*, *Mycoplasma genitalium*, or *Ureaplasma urealyticum*. Men had presented to the Bell Flower Clinic in Indianapolis, Indiana, and were diagnosed with NGU and enrolled in IUMP. Men provided a urine specimen for STI testing by NAAT, received azithromycin 1gm and returned for a 1-month test-of-cure visit. At the test-of-cure visit, men were asked about interval antibiotic use, sexual activity, interval urethritis signs and symptoms, and repeat STI testing was performed. Clinical cure was defined as resolution of urethritis signs and symptoms. Microbiological cure was defined as clearance of STI at the test-of-cure visit. Significance was evaluated by Fisher's exact test.

Results Seventy-five men were included in this analysis, 52 with CT, 16 with MG, and 7 with UU. Clinical cure occurred in 50–100% and microbiological cure occurred in 31–100% of men. Discordant cures were more common in men with MG than CT (44% vs 15%, $p = 0.102$); no UU discordant cures occurred. Men with MG-NGU were significantly more likely to have a clinical cure with microbiological failure compared to CT-NGU (31% vs 4%, $p = 0.0042$). Clinical failure with microbiological cure occurred in approximately 10% of men.

Conclusions Discordant NGU cure outcomes do occur and are more common in men with MG-NGU. The most common discordant cure outcome was clinical cure with microbiological failure. In men treated with azithromycin for NGU, MG testing should be included and a test-of-cure considered to ensure STI clearance.

P268 CLINICAL PERFORMANCE ASSESSMENT OF THE ALINITY M STI ASSAY

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