there are a number of commercial assays reporting various mutations linked to fluoroquinolone resistance. This talk will look at the evidence supporting the use of these assays and how these assays may contribute to patient management.

S03.3 MYCOPLASMA GENITALIUM: NEW TREATMENT APPROACHES

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Mycoplasma genitalium is an increasingly prominent STI notable for its limited susceptibility to antimicrobials and increasing acquisition of antimicrobial resistance. While AMR varies globally, rising rates significantly impacts on the efficacy of available antimicrobials and clinicians now commonly infections that challenging to treat. This talk will discuss the range of current and new treatment strategies including resistance-guided treatment strategies, combination treatment approaches, repurposed antimicrobials and new agents

S03.4 M. GENITALIUM: IS IT TIME FOR SURVEILLANCE?

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First identified in 1980, *Mycoplasma genitalium* is a recognized cause of male urethritis and is associated with increased risk of female upper reproductive tract disease and sequelae. Coinciding with the recognition of these disease associations is the emergence of significant antimicrobial resistance and potentially untreatable infections. Globally, from 2016–2017, half (51.4%) of *M. genitalium* infections were resistant to macrolides, ~9% contained fluoroquinolone resistance-associated mutations, and markers of dual class resistance were detected in ~4% (Machalek, 2020). Yet these estimates are derived largely from dedicated research studies, which are not always able to recruit and enroll representative samples of the population at risk. Surveillance systems overcome some of these limitations and are beginning to be implemented in several countries. In the US, a pilot sentinel surveillance system to monitor the prevalence of infection, and track changes in antimicrobial resistance was launched in 2020. Remnant specimens from patients tested for *Neisseria gonorrhoeae* and/or *Chlamydia trachomatis* attending eight sexual health clinics in four geographic regions of the US are tested for *M. genitalium* using the Aptima *Mycoplasma genitalium* assay (Hologic, Inc.). Each clinic submits 400 specimens: 200 from male sex at birth patients; 200 from female sex at birth patients (100 symptomatic and 100 asymptomatic for each sex) for a total of 1600 specimens per year. Macrolide and fluoroquinolone antibiotic resistance markers at positions 2058 and 2059 in *M. genitalium* 23S rRNA and in *parC* mRNA, respectively, will be assessed. The prevalence of *M. genitalium* infections, prevalence of antibiotic resistance, and characteristics associated with resistant infections from the 2020 surveillance cycle will be presented. These results will be discussed in the context of surveillance efforts in other settings.

S04.2 HOW SHOULD ANTIMICROBIAL RESISTANCE IN NEISSERIA GONORRHOEAE INFLUENCE PID TREATMENT

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Rising levels of antibiotic resistance in uncomplicated *N. gonorrhoeae* infection have led to changes in recommended treatment and suggestions for new management paradigms. It is, however, unclear how these new approaches to treatment should be reflected in managing gonococcal pelvic inflammatory disease (PID). *Gonorrhoea* remains an important but relatively uncommon cause of PID for which treatment is often commenced prior to identification of the causative organisms. Those at highest risk (severe symptoms, partner with *gonorrhoea*, gram negative diplococci on microscopy) should have therapy which includes cover for *N. gonorrhoeae*. Newer agents, such as lefamulin, gepotidacin and zoliflodacin have not been evaluated in women with pelvic infections but frequently have a wide spectrum of activity covering not just *gonorrhoea* but many of the other bacteria associated with PID, and achieve good tissue levels in the upper genital tract. However, optimal dosing regimens for PID to achieve clearance of infection but minimise the risk of developing future resistance need to be determined.

S04.4 EVIDENCE BASED APPROACHES TO PREVENTING PELVIC INFLAMMATORY DISEASE (PID) AND ITS SEQUELAE

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There are many challenges to preventing pelvic inflammatory disease (PID). The case definition is unclear: clinically diagnosed PID may not be confirmed by laparoscopy/endometrial biopsy/imaging. Both PID and its main cause *Chlamydia trachomatis* infection can be asymptomatic, and often no clear pathogen is identified. Most women (>85%) with *chlamydia* infection do not get PID. Finally, uptake of *chlamydia* screening is often low, and treatment of those infected and their sexual partners can be challenging.

A 2016 Cochrane review found four trials (in 21, 686 women) which examined the effect of *chlamydia* screening on PID: Scholes, Ostergaard, Oakeshott, Andersen. Overall, the risk of PID was lower in women in intervention than control groups: RR 0.68, 0.49 to 0.94. But in the two trials at low risk of detection bias (Oakeshott, Andersen) the RR was 0.8, 0.55 to 1.17, compatible with no effect. Thus, although detection and treatment of *chlamydia* infection can reduce the risk of PID in an individual woman, the size of the effect is uncertain. It is also unclear whether *chlamydia* screening to prevent PID reduces rates of infertility and ectopic pregnancy.

Our recent 'Test n Treat' trial of free rapid *chlamydia* tests and same day treatment in 500 sexually active, ethnically diverse teenagers, highlights the problems of persuading those at risk to get screened. Despite a 6.2% prevalence of *chlamydia* (and 0.6% *gonorrhoea*), test uptake was only 13%. Interviews suggested this was due to not feeling at risk, perceptions of stigma and little knowledge of STIs. However, £5 notes can be effective incentives, and enabled us to recruit

500 participants in 3-weeks. Cost analysis suggested incentives might be cost-effective for screening some high risk groups. We eagerly await results of the French i-Predict trial of 6-monthly chlamydia screening to reduce PID incidence over 2-years in 4000 female students.

S05.1 BEING ALHIV: SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS AND YOUNG PEOPLE LIVING WITH HIV IN SUB-SAHARAN AFRICA

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Background Over three quarters of all new HIV infections among 15–24 year old adolescents and young people globally take place in sub-Saharan Africa. As this growing cohort becomes older, understanding and meeting their sexual and reproductive health (SRH) needs is critical, particularly in light of COVID-19 healthcare and social disruptions. However, few studies have documented these outcomes among adolescents in resource-limited settings, with none reporting data from longitudinal cohorts.

Summary This talk summarises what we know about the sexual and reproductive health of adolescents living with HIV in sub-Saharan Africa, particularly experiences of pregnancy, motherhood and relationships. It draws from findings of a review of SRHR experiences of adolescents and young people living with HIV, complemented by analyses of two large community-traced cohort: the Mzantsi Wakho ('Your South Africa') and HEY BABY (Helping Empower Youth Brought up in Adversity with their Babies and Young children) studies in South Africa. The Mzantsi Wakho cohort conducted three waves of data collection with over 1,600 adolescents and young people living with HIV (93%–97% retained at each wave), 1,064 of whom were living with HIV since baseline. The HEY BABY study recruited over 1,000 adolescent and young women who had their first child <20 years old, 315 of whom were living with HIV. Qualitative data from COVID-19 related research with two Teen Advisory Groups in South Africa and Kenya will also be shared to highlight sexual and reproductive health service provision and access experiences of young people and their healthcare providers.

S05.4 AMPLIFYING THE VOICES OF YOUNG PEOPLE IN GLOBAL SOUTH TO ACCESSIBLE AND AFFORDABLE SEXUAL REPRODUCTIVE HEALTH AND RIGHTS SERVICES IN THE EFFORT TO CURB STIS

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10.1136/sextrans-2021-sti.33

Background Inaccessibility of SRHR services among young people has continued to impose a huge burden of morbidity and mortality in Africa by how STIs contribute to sexual transmission of HIV infections where the AGYW have continued to face disproportionate vulnerability to acquiring HIV.

Contributing factors:

- Africa lacks systematic and comprehensive STI surveillance yet it contains a large young population that is sexually

active. There is a lack of accurate Primary prevention information, education, and communication campaigns.

- The non-existence of youth-friendly SRHR programs at grass-roots levels lead to delayed diagnosis and treatment among young people resulting in high rates of infection complications
- SHRH care is, unfortunately, being provided by a variety of health care providers, lacking proper training in case management, and the quality of care is often compromised
- Delay in seeking care mostly a result of the asymptomatic nature of many STIs including HIV which is highly associated with low levels of awareness of sexual health and the stigma associated with genital symptoms, and HIV treatment

Recommendations:

- Programs promoting health education should be supported and adequately resourced to allow screening to be easily available and accessible thus early infection prevention, detection, improved management, and improved access to care.
- Prevention and control should be considered as an integral part of comprehensive sexuality and reproductive health services in order to help improve SHRH and access to SRHR services among the young people and stakeholders should identify barriers to the implementation of existing tools and devise possible strategies for ensuring that effective STI control programs are implemented

Conclusion There is urgency for an effective and efficient integrated approach that is not just problem-oriented but one that provides for mitigation of risk factors and puts in place a safety net for early detection and prevention of SRH challenges including screening, prevention, and treatment services.

S06.1 THE HEALTHCARE EXPERIENCES OF TRANSGENDER WOMEN LIVING WITH HIV IN THE BUFFALO CITY METRO MUNICIPALITY

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Transgender women bear a high burden of HIV in South Africa, and are not fully engaged in healthcare across the HIV continuum of care. The aim of this study was to gain an understanding of the healthcare experiences of transgender women living with HIV in the Buffalo City Metro Municipality. The study employed an interpretative phenomenological analysis design. Twelve participants were enrolled using a snowballing sampling technique. Data was collected using semi-structured interviews and analysed using an interpretative phenomenological analysis framework. Four super-ordinate themes emerged from the data: reaction to HIV positive diagnosis, disclosure of HIV status, adherence to ART, and experiences in utilising healthcare services. The findings reveal positive and negative healthcare experiences among transgender women living with HIV in Buffalo City Metro. Participants reported a number of factors that potentiate healthcare avoidance. These include stigma at various levels in transgender women's journey to access care, as well as healthcare worker insensitivity to their unique health needs. Healthcare