availability of previously investigational drugs. Triclabendazole is now FDA approved for treatment of *Fasciola* infection in persons ≥6 years old and benznidazole is now FDA approved for treatment of Chagas disease in children 2–12 years old. Miltefosine has also been approved by FDA for treatment of certain leishmaniasis infections. CDC has successfully pursued expiry extensions of drugs with manufacturers, FDA, and other partners to ensure continued domestic availability of treatment options when there has been no or limited production of newer lots. CDC's Parasitic Diseases Branch can be reached by telephone: 404-718-4745 or email: parasites@cdc.gov.

[1] Pentostam* is made by GlaxoSmithKline

[2] WHO interim guidelines for treatment of gambiense HAT. Geneva: 2019.

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771. Prospective validation of the universal vital assessment (UVA) score to predict the in-hospital mortality of patients with acute illness admitted to a government district hospital in KwaZulu-Natal, South Africa

Amiya A. Ahmed, n/a[1]; Joseph B. Ladines-Lim, MD PhD[2]; Christopher Moore, MD[3]; Sipho Malinga, n/a[4]; Anthony Moll, MBChB[5]; Francois J. Eksteen, MD[5]; Sheela Shenoi, MD, MPH[6]; [1]University of Maryland School of Medicine, Silver Spring, Maryland; [2]University of Michigan Medical School, Ann Arbor, Michigan; [3]University of Virginia, Charlottesville, VA; [4]Philanjalo Care Center, Tugela Ferry, KwaZulu-Natal, South Africa; [5]Church of Scotland Hospital, Tugela Ferry, KwaZulu-Natal, South Africa; [6]Yale University, New Haven, Connecticut

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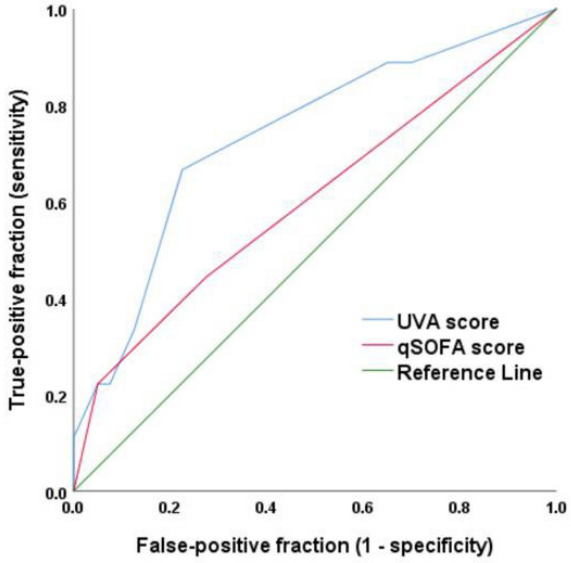
Background: Critical illness is a frequent cause of mortality in resource-limited settings. Improved triage on admission could improve mortality, but existing tools depend on variables that often are not available. We prospectively evaluated the universal vital assessment (UVA) score to predict mortality among patients admitted to a district hospital in rural, highly HIV-prevalent South Africa.

Figure 1. Receiver operator characteristic (ROC) curves for the UVA and qSOFA scoring tools.



	aROC	95% CI	P-value
UVA score	**0.74**	**0.55-0.93**	**0.03**
qSOFA score	**0.60**	**0.38-0.83**	**0.33**

Methods: In February-March 2020, adults admitted to the medical wards were enrolled, prior to interruption by covid19, and 30-day mortality assessed. Clinical parameters including temperature, heart and respiratory rates, systolic blood pressure, oxygen saturation, Glasgow Coma Scale score, and HIV status were collected within 24 hours of admission as part of routine care. Lower respiratory tract infections (LRTI) included pneumonia and suspected pulmonary tuberculosis. To evaluate the predictive ability of the UVA score, area under the receiver operating characteristic curve (aROC) and age-sex adjusted binary logistic regression models were generated, and compared to the sequential organ failure assessment (qSOFA).

Results: Sixty one patients were enrolled; outcomes were available for 56 patients. Patients had a mean age of 52 (SD+17), 51% were women, and 46% were HIV infected. The 30-day mortality was 16.1% (9/56) with infections and non-communicable diseases comprising 47% and 47% of admission diagnoses, respectively. The most common admitting diagnosis was LRTI (24.6%). The median (+IQR) UVA score was 2 (+3) accounting for 36% of participants. Medium-risk (2-4) and high-risk (>4) UVA groups were not associated with 30-day mortality, although the high-risk score trended towards significance (p=0.07). However, a UVA score > 3 was significantly associated with 30-day mortality, both alone and after adjusting for age and sex (aOR 6.2, 95% CI 1.2-33.1; p=0.03). The aROC (95% CI) for the UVA score was 0.74 (0.55 – 0.93), which performed better than qSOFA (aROC 0.59, 95% CI 0.37-0.81) and is shown in **Figure 1**.

Conclusion: In this resource-limited, HIV-prevalent setting, the UVA score predicted mortality better than the qSOFA score. A moderate-risk UVA score (>3) was predictive of 30-day mortality, though needs to be confirmed in larger studies.

Disclosures: **All Authors**: No reported disclosures

772. Respiratory Syncytial Virus Acute Respiratory Infections in Young Children in Jordan: A Prospective Surveillance Study

Zaid Haddadin, MD[1]; Danielle A. Rankin, MPH, CIC[1]; Ahmad Yanis, MD[1]; Yanal Shawareb, MD[1]; Olla Hamdan, BS[1]; Malek Saada, MD[2]; Sara Hilal, MD[2]; Ahmad Alhajajra, MD[2]; Basima Marar, MD[3]; Najwa Khuri-Bulos, MD[4]; [1]Vanderbilt University Medical Center; Division of Pediatric Infectious Diseases, Nashville, Tennessee; [2]Al Bashir Hospital, amman, 'Amman, Jordan; [3]Al-Bashir Hospital, Amman, Amman, Jordan; [4]University of Jordan, amman, 'Amman, Jordan

Session: P-31. Global Health

Background: Respiratory syncytial virus (RSV) is the leading cause of acute respiratory infections (ARI) hospitalizations in young children and is associated with increased severity compared to other viruses. The aim of this study was to evaluate the utilization of a rapid RSV diagnostic test and clinical characteristics and disease severity of children who were hospitalized during one respiratory season in Amman, Jordan.

Methods: Children less than two years hospitalized with fever and/or respiratory symptoms were recruited at Al-Bashir Government Hospital from January 8, 2020, to March 17, 2020. Nasal swabs were collected and tested by Sofia-2 RSV Fluorescent Immunoassay. Demographic information and clinical history were obtained through parental interviews. A validated severity score was used to assess disease severity, and the treating physician prospectively collected the necessary information to calculate the score at admission. Disease severity was categorized based on the total score into 0-5 mild, 6-9 moderate, and ≥ 10 severe. Molecular testing and medical chart reviews are still in process.

Results: A total of 532 subjects were enrolled, and nasal swabs were collected and tested from 458 (86%) of enrollees. The most common admission diagnoses were pneumonia (25%), bronchopneumonia (21%), bronchiolitis (19%) and sepsis (17%). Demographic and clinical characteristics are included in **Table 1.** Overall, 276 (60%) subjects were RSV-positive. The most common admission diagnoses were pneumonia (33%), sepsis (25%), bronchiolitis (24%) and bronchopneumonia (24%). Compared to RSV-negative children, RSV-positive children were younger **(Table 1),** and more likely to present with cough, nasal congestion, and appetite loss **(Figure 1).** There were no differences in severity score or direct intensive care unit admission between the two groups **(Table 1).**

Table 1. Demographic and Clinical Characteristics of the Study Cohort

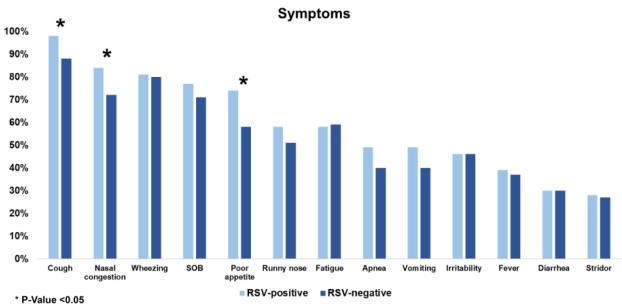
	Tested with Sofia n=458	RSV Positive n=276	RSV Negative n=182	P value
Demographic Characteristics				
Age, months, mean ± SD	**4.8± 4.6**	**4.3 ± 3.9**	**5.5 ± 5.4**	**0.02§**
Sex, male	255 (56%)	153 (55%)	102 (56%)	0.90†
Mother smoking during pregnancy	108 (24%)	72 (26%)	36 (20%)	0.12†
Prematurity	78 (17%)	50 (18%)	28 (15%)	0.45†
Current Breastfeeding	293 (64%)	185 (67%)	108 (59%)	0.09†
Household smoke exposure	357 (78%)	220 (80%)	137 (75%)	0.26†
UMCs	45 (10%)	24 (9%)	21 (12%)	0.32†
Clinical Characteristics and Disease Severity				
Illness Duration, days, mean ± SD	3.7 ± 2.1	3.6 ± 2.04	3.8 ± 2.3	0.5§
Maximum RR	48.4 ± 15.34	47.03 ± 15.70	49.28 ± 15.07	0.13§
Minimum O2 Sat.	94.47 ± 6.61	94.6 ± 5.33	94.24 ± 9.20	0.58§
Severity Score*				
Mild	328 (72%)	165 (72%)	113 (74%)	0.137
Moderate	105 (24%)	54 (23%)	38 (25%)	
Severe	14 (4%)	12 (5%)	2 (1%)	
Direct ICU admission	35/457 (8%)	16/275 (6%)	19/182 (10%)	0.07§

Categorial Data are in n (%), Continuous data are in mean ± SD, median [IQR]; ICU: Intensive care unit; IQR: interquartile range

*384 patients had complete data: 231 RSV-positive and 153 RSV-negative

§Pearson's Chi-Squared, † T-test

Figure 1. Symptom Distribution in RSV-Positive and RSV-Negative Subjects



Conclusion: Nearly 2/3 of children enrolled were RSV-positive via rapid diagnostic testing. The majority of RSV-ARI admissions were classified as mild. Further analysis of other clinical parameters, including oxygen use, intravenous fluids administration and length of stay, and molecular testing are needed to support these findings and further evaluate the utility of rapid diagnostic testing.

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773. Screening for Chagas disease in East Boston, Massachusetts from 2017 – 2020 reveals 0.9% prevalence

Jennifer Manne-Goehler, MD, ScD[1]; Jillian Davis, RN[2]; Juan Huanuco Perez, MD[2]; Jaime Gallegos Salazar, MD[2]; Jim Gomes, BA[3]; Alejandra Salazar, PharmD[4]; Ingrid Camelo, MD[4]; Katie Collins, BA[5]; Hong-Sun Park, LICSW[4]; Natasha Hochberg, MD, MPH[4]; Davidson Hamer, MD[4]; Elizabeth Barnett, MD[4]; Elizabeth Barnett, MD[4]; Julia Koehler, MD[3]; [1]Massachusetts General Hospital & Brigham and Women's Hospital, Boston, Massachusetts; [2]East Boston Neighborhood Health Center, Boston, MA; [3]Boston Children's Hospital, Boston, Massachusetts; [4]Boston Medical Center, Boston, MA; [5]University of Michigan, Ann Arbor, Michigan

Session: P-31. Global Health

Background: This study reports on the results of a screening program for Chagas disease in East Boston.

Methods: Based at the East Boston Neighborhood Health Center, the Strong Hearts Program offers continuing medical education sessions on Chagas disease to providers in Adult Medicine, Pediatrics, Family Medicine and Obstetrics. Providers are encouraged to offer one-time screening for Chagas disease for all patients who lived in Mexico, South or Central America for ≥6 months, at their discretion. A commercial lab performs the initial screening test using the Hemagen ELISA while confirmatory testing is performed at the US CDC. For each patient, completion of screening requires a multi-step process consisting of splitting the serum sample to save a frozen aliquot for send out to CDC if the ELISA is positive/indeterminate, monitoring screening results to send the saved aliquot to the CDC if indicated, filling out the CDC requisition, shipping the serum aliquot, and monitoring the result returning from the CDC. Patients diagnosed with confirmed Chagas disease are referred to Boston Medical Center for further evaluation and treatment if indicated.

Results: From 3/21/2017 – 5/18/2020, 8,142 patients were screened. 423 (5.2%) patients had an initial positive test, 7,669 (94.2%) initially tested negative and 50 were indeterminate (0.6%). Among those with a positive screening result, 76 were confirmed to have *T. cruzi* infection for an overall prevalence of 0.93% in this population. 293 (69.3%) patients with positive screening tests had a negative (discordant) confirmatory test, 18 (4.3%) had an indeterminate test, and 36 (8.5%) had results that were unavailable or pending as of this analysis. None of the indeterminate screening tests were positive upon confirmation.

Conclusion: Prevalence of infection with *T. cruzi* was nearly 1% among patients in East Boston who had lived in Latin America. Diagnosis of Chagas was challenging due to a large number of false positive screening tests. The resource burden imposed by current screening options is itself a barrier to addressing Chagas disease. Given the significant prevalence of Chagas disease in the US, increased access to tests (i.e., two-step screening conducted through commercial laboratories) and screening assays with improved specificity are needed.

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774. Sexual Behaviors and Attitudes of Intimate Partners of Ebola Survivors

Hannah M. Cunningham, n/a[1]; David Wohl, MD[2]; Sam Tozay, n/a[3]; Edwina Reeves, n/a[3]; Korto Pewu, n/a[3]; Harrieta Johnson, n/a[3]; Gerald Williams, n/a[3]; Tonia Conneh, n/a[3]; Jean DeMarco, PhD[3]; William Fischer, MD[4]; Jerry Brown, MD[5]; [1]Duke University, Durham, North Carolina; [2]UNC School of Medicine, Chapel Hill, NC; [3]UNC Liberia, monrovia, Montserrado, Liberia; [4]UNC Chapel Hill, Chapel Hill, North Carolina; [5]JFK Hospital, Monrovia, Montserrado, Liberia

Session: P-31. Global Health

Background: Sexual transmission of the Ebola virus (EBOV) from male survivors to their partners has been well-documented. While studies have characterized the sexual behaviors of male survivors of Ebola Virus Disease (EVD), there is little focus on their intimate partners. This study seeks to describe the attitudes and sexual behaviors of women who have had condomless sex with male survivors of the 2014-16 Ebola outbreak in Liberia, West Africa.

Methods: Participants were recruited through voluntary referral by their sexual partners, all of whom were participants in a longitudinal EVD survivor cohort. From February to March 2020, 30 women (age range: 19-53 years) were enrolled and surveyed regarding their sexual behaviors with a focus on perceptions of risk for acquisition of Ebola from their partners and the measures taken to address this risk. Mix method quantitative and qualitative assessment of survey responses was completed. Content analysis was used to consider open-ended questionnaire responses.

Results: Few women reported full compliance with the 2016 World Health Organization (WHO) recommendations for safer sex with EVD survivor partners, but 50% described utilization of a safer se x strategy to reduce risk of transmission. Major themes identified include: (1) an inaccurate perception of no or low risk of sexual transmission of Ebola virus, (2) negative attitudes towards condoms, (3) a preference for abstinence among those seeking to avoid infection, and (4) positive attitudes towards health care worker advice.

Table 1: Demographic characteristics and historical sexual behaviors of study participants **N=30**

	Number (%)
Age at study entry (years)	**Median age:** 30
18-25	12 (40%)
26-39	12 (40%)
40-59	6 (20%)
Cohabitation with EVD surviving partner	
Lived with spouse/partner during their initial symptom presentation	13 (43%)
Did not live with referring spouse/partner during initial symptom presentation	17 (57%)
Timing of initial Condomless Sex with EVD Survivor after their discharge from ETU	
Less than 3 months	4 (13%)
3 months to 6 months	12 (40%)
More than 6 months to less than 1 year	8 (27%)
1 to 2 years	2 (7%)
More than 2 years	4 (13%)
Frequency of condomless sex	
'Once'	0
'A few times'	1 (3%)
'Many times'	29 (97%)
Partner's Semen Testing Results	
At least 2 documented semen tests	30 (100%)
Positive semen testing results	3 (10%)