Table 2. Self-Reported Current Sexual Behaviors

Recent Sexual Activity	(N=30)
Any sex in last 30 days	22 (73%)
No sex reported in last 30 days	8 (27%)
Recent Condom Use	(N=22)
No condomless sex in last 30 days	1 (5%)
Some condomless sex in last 30 days	1 (5%)
Only condomless sex in last 30 days	20 (91%)
Recent Sexual Partners	(N=30)
0	8 (27%)
1	21 (70%)
2	1 (0.3%)

Conclusions: Future outbreaks will benefit from intervention programs to address knowledge gaps among women and their male survivor partner regarding the risk of sexual transmission of Ebola and clear communication about effective strategies to reduce this risk.

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775. The Burden of Arboviral Infection in the Military Health System, 2011-2019

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Session: P-31. Global Health

Background: Travel-related arboviral infections are important preventable, emerging infectious diseases, with an estimated annual global toll of US$950 million. We investigated the burden of arboviral infections in the military health system (MHS).

Methods: KAPOS (Deployment and Travel Health: Knowledge, Attitudes, Practices, and Outcomes Study) is a multi-cohort study evaluating the burden of travel-associated diseases in the MHS. The MHS Data Repository was searched for International Classification of Diseases (ICD)-9/10 codes for arboviral infection in military beneficiaries receiving care in military treatment facilities (direct care) or civilian centers (purchased care) for fiscal years 2011-2019. Diagnostic codes were classified as Dengue, Chikungunya, Zika, or other arboviral infection. 755 outpatient charts in the direct-care system were randomly selected for diagnostic validation using Armed Forces Health Surveillance Center case definitions, and review of travel history, medical comorbidities, and pre-travel counseling.

Results: 11,066 unique-patient ICD codes for arboviral infections were identified; 6356 (57.4%) were direct care; 4710 (42.6%) were purchased care; 889 (8.0%) were inpatient. Median age was 31 years; 5110 (46.2%) were active duty. The most frequent ICD codes for arboviral infection were Japanese encephalitis virus (JEV) (n=4483), dengue (DENV) (n=1786), yellow fever (YF) (n=230), Zika virus (ZIKV) (n=217), West Nile virus (WNV) (n=171), and chikungunya virus (CHIKV) (n=91). DENV codes were confirmed in 166/249 (66.7%) charts; CHIKV in 23/41 (56.1%), and ZIKV in 15/129 (11.6%). No cases of JEV were confirmed in 171 encounters; all codes referred to JEV vaccine administration. 173/204 (84.8%) of confirmed arboviral cases did not undergo pre-travel counseling.

Conclusion: Arboviral infections constitute a substantial burden of preventable infections within the MHS. Dengue contributed the largest burden of arboviral infection when corrected for accuracy. Coding for ZIKV and JEV likely overestimated the burden of these diseases in the MHS. Low rates of pre-travel counseling among patients with confirmed, non-endemic arboviral infections represent an opportunity for increased emphasis on travel counseling and insect-avoidance precautions.

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776. The prevalence of HIV among hospitalized persons with acute febrile illness in rural Uganda, August 2019-June 2020

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Background: In Uganda, in the early PEPFAR era, HIV coinfections were responsible for most hospitalizations with febrile illness (as high as 85% in 2006). Currently, national guidelines recommend universal antiretroviral therapy ideally before the development of AIDS. We evaluated the prevalence of HIV among patients admitted to two regional referral hospitals with febrile illness in the era of 'Treat All.'

Methods: Participants admitted to two regional referral hospitals in Uganda were enrolled at emergency departments or medical wards. Participants uniformly received blood cultures, malaria (rapid diagnostic test), and tuberculosis (Xpert MTB/RIF Ultra), hepatitis A IgM, hepatitis B sAg, and HIV fourth generation testing were performed. Among participants with HIV, cryptococcal antigen testing and urine lipoarabinomannan (LAM) were performed.

Results: From August 2019-June 2020, 95 participants (58% female) with an average age of 36.2 (SD 14.1) years, presented from 11 districts in Uganda. Participants presented at facilities 4.9 days (SD: 2.5) after onset of symptoms. Additionally, 16.1% of participants had a qSOFA (quick Sepsis Related Organ Failure Assessment) severity score of 2 or greater. By 28 days, 11.0% (n=7) died and 10.8% were lost to follow-up. On admission, 25.3% (n=24) of participants had a known history of HIV, the majority (87.5%) were on ART on hospital presentation. Of the 9.5% (n=9) who were newly diagnosed with HIV during the admission 6 were started on ART during hospitalization or within a month after hospitalization. Microbiologic and rapid diagnostic test results included positive results for tuberculosis (2.1%, 2/95 PCR; 3/16 urine LAM), malaria (29.5%, 28/95), cryptococcal antigen positive (12.5%; 2/15), hepatitis A (1.1%, 1/95), and hepatitis B (5.3%, 5/95). Blood cultures were positive in 11.1% of patients (10/90) with *S. pneumoniae* being most common isolate (N=4).

Conclusion: In the universal ART era, the proportion of hospitalized febrile patients with HIV has decreased. Overall, 10% have newly diagnosed infection emphasizing the importance of continuing to test all hospitalized febrile patients. Diagnostic evaluations are needed to assess the burden of other causes of febrile illness in order to reprioritize potential differential diagnoses.

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777. Travel Destination, Demographics, and Underlying Medical Conditions Among Travelers Seeking Yellow Fever Vaccination at a Large Academic Medical Center in the U.S.

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Session: P-31. Global Health

Background: Yellow fever (YF) vaccine has the potential to cause viscerotropic and neurotropic disease in at-risk individuals. Screening patients is necessary to prevent vaccine-related life-threatening complications. We lack data on the clinical features of patients seeking YF vaccination. We aim to describe the characteristics of a cohort of patients receiving the YF vaccine before travel.

Methods: A retrospective analysis of 964 patients receiving the YF vaccine (Stamaril®) from Oct 2016 to Jul 2019 was performed at the University of Colorado Hospital in the United States. Percentages, means, and standard deviations were calculated. A multivariate logistic regression model was built to evaluate the association between receiving YF vaccination less than 10 days before departure and visiting friends and relatives (VFR).

Results: The average age of patients was 39 ± 18 years with a range of 9 months to 83 years. Patients who were 60 years of age and older represented 17%. Women consisted of 52%, and most of the patients were Caucasians (64%). Patients reported traveling to Africa (57%) or South America (40%). The primary destination for patients overall was Kenya (19%), Uganda (11%), and Tanzania (11%) in Africa; and Peru (14%) and Brazil (13%) in South America. The most common reasons for travel included leisure (44%), VFR (18%), and mission trips (10%). Comorbidities included a history of hematologic disorders (4%), HIV infection (2%), and diabetes mellitus (3%). The average duration between vaccine administration and travel was 43 days. Those visiting friends and relatives were 2 times more likely to receive the YF vaccination less than 10 days before departure.

Table 1. A cohort of patients receiving the Yellow Fever vaccine at the University of Colorado Hospital.