RESULTS: HIV-infected women described various reasons for enrolling in a Prevention of Mother to Child Transmission and HIV treatment trial while pregnant, including a desire for access to enhanced health care such as supplementary laboratory tests, and a desire to protect their infant from HIV. Women described disappointment at losing study benefits in subsequent pregnancies. Some at-risk women who were denied enrollment into a HIV preventive study while pregnant, or who were taken off of the investigational product when a pregnancy was detected at a study visit, accepted these restrictions as they might protect the fetus from unknown harm from the study drug. Others indicated that they would have enrolled/stayed on the study product during pregnancy for HIV prevention if allowed.

CONCLUSIONS: While the HIV research agenda is increasingly responsive to the needs of pregnant women, many continue to experience exclusionary research practices. Some participants expressed a desire to enroll and/or remain on studies of products to prevent or treat HIV that were denied them due to pregnancy. Further consideration of women's views, in the context of meaningful informed consent, should inform efforts to advance a more inclusive approach.

4 Surgical site infection after cesarean delivery: incidence and risk factors at an academic institution

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OBJECTIVES: To identify the rate of surgical site infection (SSI) after Cesarean delivery (CD) within a modern cohort of patients receiving prophylactic antibiotics and determine risk factors predictive for infection at a large academic institution.

METHODS: This was a retrospective cohort study in women undergoing CD during 2013. SSIs were defined by CDC NHSN criteria. Chi square and t-tests were used for bivariate analysis and multivariate logistic regression was used to identify SSI risk factors.

RESULTS: In 2419 patients, the rate of SSI was 5.5% (n=133) with cellulitis in 4.9% (n=118), deep incisional infection in 0.6% (n=15) and intra-abdominal infection in 0.3% (n=7). On multivariate analysis, SSI was higher among CD for labor arrest (OR 2.4; 95% CI 1.6-3.5; p <0.001). Preterm labor (OR 2.8; 95% CI 1.3-6.0; p=0.01) and general anesthesia (OR 4.4; 95% CI 2.0-9.8; p=0.003) were predictive for SSI. Increasing BMI (OR 1.1; 95% CI 1.05-1.09; p=0.02), asthma (OR 1.9; 95% CI 1.1-3.2; p=0.02) and smoking (OR 1.9; 95% CI 1.1-3.2; p=0.02) were associated with increased SSI.

CONCLUSIONS: Several patient and surgical variables are associated with increased rate of SSI after CD. Identification of risk factors for SSI after CD is important for targeted implementation of quality improvement measures and infection control interventions.

5 Post-discharge infections and healthcare contact in ugandan women hospitalized for delivery

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OBJECTIVES: Postpartum infection is a common cause of pregnancy-related morbidity. Data are lacking from resource-limited settings on post-discharge febrile morbidity and healthcare contact in women with in-hospital postpartum fever. We hypothesized that women febrile postpartum were more likely to report post-discharge fever and infection, seek healthcare, receive antibiotics, and report ill health within 6 weeks postpartum than women normothermic postpartum.

METHODS: 4,231 largely rural-dwelling women presenting to Mbarara Regional Referral Hospital for delivery or postpartum care were prospectively enrolled. Vital signs were monitored every 8 hours after delivery. Febrile women were evaluated clinically and microbiologically for fever source. All febrile and 1,574 randomly selected normothermic women underwent interview and chart review to collect demographic, health, obstetric, and outcomes data; and were followed by telephone until 6 weeks postpartum. Categorical variables were analyzed using Chi squared and Fisher's exact tests, and multivariable logistic regression was used to determine whether in-hospital postpartum fever was an independent predictor of new postpartum infection and health care contact.

RESULTS: Temperature was measured for 4,176 women (99%); 121 (2.9%) developed in-hospital postpartum fever. Febrile women were significantly more likely to report new post-discharge antibiotic prescription (n=64, 9.9 vs. 3.8%, P=0.002), readmission (4.5 vs. 1.5%, P=0.02), infection diagnosis (endometritis, wound, and urinary tract infections, n=51, 7.2 vs. 3.0%, P=0.02), wound infection (n=29, 6.1 vs. 1.5%, P<0.001), and poor health (n=58, 8.1 vs. 3.4%, P=0.01) within 6 weeks postpartum than normothermic women. Of 51 new post-discharge infections, 39 (76%) occurred after cesarean delivery (4.6% of cesarean vs. 1.6% of vaginal deliveries, P=0.001), 36 (71%) within 2 weeks of discharge, and 8 (15.7%) in women with in-hospital postpartum fever, of whom 6 (75%) had endometritis in-hospital. When controlling for potential confounders, in-hospital postpartum fever was associated with increased odds of new post-discharge infection (aOR 2.5, 95% CI 1.1-5.7, P=0.03), but not healthcare contact (aOR 1.0, 95% CI 0.4-2.4, P=0.96).

CONCLUSIONS: In Uganda, in-hospital postpartum fever was associated with post-discharge hospitalization, infection diagnosis, and poor health. In-hospital postpartum fever should be evaluated and treated more thoroughly to prevent post-discharge febrile morbidity.

6 Prevalence of candida africana among women with Vulvovaginal Candidiasis (VVC) and/or Bacterial Vaginosis (BV) in the United States

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OBJECTIVES: Candida africana, an emerging pathogen, is a species or biovar closely related to C. albicans that produces germ tubes. However, C africana lacks the capacity to produce chlamydospores, assimilate N-acetylglucosamine (NAG) and glucosamine (GLN), and has a lower adherence to human epithelial cells and production of biofilms than C albicans. Our objective was to assess the prevalence of C. africana in women diagnosed with VVC and/or BV.

METHODS: Women were enrolled in a multicenter trial to test the safety and efficacy of investigational products for treatment of BV and/or VVC. BV was diagnosed based on 4 Amsel criteria and Nugent score >3. VVC was diagnosed using a composite signs and symptoms score, and the budding yeast on wet mount. A vaginal swab sent to a central lab for yeast culture was inoculated onto