

24-03

STATEMENT OF POLICY

Congenital Syphilis

Policy

The National Association of County and City Health Officials (NACCHO) calls for increased efforts from public health professionals, medical providers, and policymakers to prevent and treat congenital syphilis, of which there were 3,755 reported cases in the U.S in 2022.¹ From 2012 to 2021, congenital syphilis cases increased by 755%.² To prevent congenital syphilis, pregnant and birthing people should receive support in accessing proper prenatal care and support services to address their syphilis infection and have a healthy pregnancy. According to the Centers for Disease Control and Prevention (CDC), 88% of congenital syphilis cases in 2022 could have been prevented with timely screening and treatment.³ Concerted public health measures must be implemented to address congenital syphilis and the barriers to care. NACCHO supports federal, state, and local actions and policies that advance the role of local health departments in the prevention and elimination of congenital syphilis and urges the provision of sufficient funding to strengthen prevention efforts. The prevention and treatment of syphilis in the population as a whole is crucial to preventing congenital syphilis. To address the growing issue of congenital syphilis, NACCHO calls on stakeholders to do the following:

Public Health Professionals

- Perform a syphilis test in all settings where HIV tests are being performed, with expanded outreach to those who are pregnant, birthing, of reproductive age, or with childbearing capacity.
- Develop and implement comprehensive interventions that specifically address healthcare disparities—including racial/ethnic and economic as well as those related to incarceration and houselessness. These measures should aim to mitigate the health effects that may arise from gaps in care and inadequate syphilis treatment, while also promoting overall health and well-being for impacted communities.
- Address barriers to completing syphilis treatment to ensure the effectiveness of healthcare interventions. Efforts should be made to identify and mitigate factors such as financial constraints, transportation issues, limited access to health care, childcare services, and social stigma that may prevent patients from completing their prescribed treatments.

- Expand access to STI point-of-care, self-collected, and mail-order testing options for syphilis testing integration into diverse services and non-traditional settings (e.g., harm reduction/syringe service programs, jail/prison intake, emergency rooms, pharmacies, retail health clinics, the Women, Infants, and Children program (WIC), HIV offices, HIV care/prevention centers, etc.).
- Provide patients unlikely to be seen again treatment presumptively, where and when possible, to avoid a lack of treatment for likely cases of syphilis and the prevention of congenital syphilis.
- Apply a syndemic lens with integrated STI and harm-reduction approaches to prevent congenital syphilis for pregnant people who use or inject drugs or those who exchange sex for money. Substance use and sex work should not be criminalized in the context of pregnancy, as access to prenatal care must be prioritized. Offering substance use treatment options to support recovery among pregnant people could increase patient engagement and reduce stigma.
- Implement measures to reduce stigma experienced by pregnant people, which is essential for promoting equitable access to healthcare and support services. These measures should include public awareness campaigns, continuous education, and training for both health care providers and other health professionals to promote inclusive and non-judgmental environments. By addressing and alleviating stigma, we can empower pregnant people to seek timely care and treatment, contributing to improved maternal and infant health outcomes.
- Strengthen access to resources and support for healthcare providers to ensure the effective delivery of penicillin or in the case of allergies, alternatives for patients with penicillin allergies. Empowering providers with the necessary tools and knowledge allows for improved patient care that meets patient needs and leads to reduced incidence of congenital syphilis and other preventable diseases.
- Work with state professional licensing board/healthcare professional associations to train and raise awareness for healthcare providers to identify, treat, and follow up with patients with syphilis and their partners to prevent and control the spread of the disease, specifically focusing on cultural humility and addressing disparities. Additionally, the importance of addressing the social and structural factors contributing to the transmission of congenital syphilis, including missed opportunities for testing, should be recognized, and addressed in policies and programs.
- Coordinate a Fetal Infant Morbidity Review and Congenital Syphilis Morbidity Mortality Review Board with providers and partners to review congenital syphilis cases and identify missed opportunities, prevention efforts, and to develop interventions to address the issue.
- Establish collaboration with Disease Intervention Specialists (DIS), community health workers (CHW), doulas, pharmacists, midwives, and other public health professionals to offer partner services, testing, and treatment delivery to pregnant people, partner(s) or

contact(s) and to coordinate with regional hospitals and healthcare facilities for desensitization for patients experiencing penicillin allergy, testing, and treatment of the baby.

- Ensure correct and complete treatment of individuals who test positive for syphilis, especially when pregnant or able to become pregnant. When necessary, use providers or health care professionals outside the usual clinic setting to confirm complete treatment.
- Ensure connectivity and data sharing between STD surveillance units at local health departments and tribal health departments/organizations such as having access to Electronic Medical Record (EMR) systems or vital statistics databases to ensure testing, adequate treatment, and to obtain valuable health information to support disease investigation or contact tracing.

Medical Providers

- Utilize screening guidelines for **all** people of reproductive age or childbearing capacity across all care settings to ensure early detection and intervention, contributing to improved health outcomes and prevention of congenital syphilis.
- Screen all pregnant people for syphilis at the first prenatal visit (first trimester) and at 28-32 weeks (about 7 and a half months or third trimester) of pregnancy and upon labor and delivery to ensure identification and timely treatment of syphilis in accordance with the CDC STI Treatment Guidelines.⁴ Ideally this will be done using dual HIV/syphilis rapid diagnostic tests.
- Give patients who are unlikely to return to care presumptive treatment for likely cases of syphilis.
- Confirm complete and correct treatment of syphilis in pregnant people—including using the Health Department to engage DIS and/or CHW or individuals in similar roles to confirm successful treatment.
- Talk to patients about the need to have partners tested and treated to not be reinfected with syphilis, especially during pregnancy.
- Provide culturally and linguistically responsive education and inclusive resources to people with childbearing capacity and their partners about the importance of congenital syphilis prevention, sharing healthy sexual behaviors and congenital syphilis prevention measures.
- Offer expanded access to STI point-of-care and self-collected syphilis testing options.
- Integrate conversations about syphilis within annual preventive care visits with primary care providers, including discussions about pregnancy intention for both the individual and their sexual partners in the coming year. Providers should address the individual's life situations that might affect the risk of congenital syphilis if they or their partner(s) want to become pregnant and discuss how to avoid or terminate pregnancy if that is their intention. Similarly, all medical visits related to pregnancy (including getting a pregnancy test) should include a conversation about syphilis and congenital syphilis to ensure that

individuals are aware of how to avoid syphilis during pregnancy, the risks of syphilis during pregnancy, and the need to be tested multiple times during pregnancy for syphilis.

Policy Makers

- Ensure availability of all treatment options for syphilis and congenital syphilis with special consideration for solutions that will allow health care practitioners to reach marginalized populations. This must especially include Bicillin L-A, currently the only treatment option for pregnant people, which has been in short supply.⁴
- Increase funding from federal, state, and local governments to support local congenital syphilis prevention and control programs, activities, and services, with a specific focus on addressing social determinants of health and reducing disparities in historically marginalized communities. Adequate funding and resources should be provided to support efforts to prevent and manage congenital syphilis, including increasing resources for missed opportunity testing to reach those individuals who have not been adequately screened for syphilis.
- Inform stakeholders of the economic burden of the hospital cost of infants with congenital syphilis. The unadjusted mean cost and the median cost are more than three times larger for infants with congenital syphilis than for those without syphilis.⁵
- Create policy, laws, and/or regulations that ensure protected data sharing across the surveillance systems of state, local, and tribal health departments as well as with tribal councils, epidemiology centers, and Indian Health Services. This should include access to EMR systems and/or vital statistics databases to ensure testing and adequate treatment, and to support disease investigation or contact tracing.
- Partner with state professional licensing board/healthcare professional associations to raise awareness for healthcare providers to identify, treat, and follow up with patients with syphilis and their partners to prevent and control the spread of the disease, specifically focusing on addressing disparities.
- Address the social and structural factors that contribute to the transmission of congenital syphilis, including missed opportunities for testing, by taking measures to allow for testing and treatment outside of a medical setting, such as supporting reimbursement for pharmacists who test and treat.

Justification

The CDC's *2022 STI Surveillance Report* revealed over 2.5 million reported cases of chlamydia, gonorrhea, and syphilis, representing a 1.9% increase from 2018.¹ This increase was largely driven by the ongoing surge in reported syphilis cases in the U.S, a 78.9% increase in syphilis cases in 2022 over 2018.¹

Congenital syphilis is a serious but preventable public health concern connected to the surge in syphilis cases. Congenital syphilis is contracted when a pregnant person with untreated or

inadequately treated syphilis passes the infection to their fetus. The consequences of congenital syphilis can include miscarriage, stillbirth, early infant death, and lifelong physical and neurologic problems for the infected infant.⁷ According to the March of Dimes, nationally as many as 2 in 5 babies born to mothers with untreated syphilis are stillborn or die from the infection as a newborn.⁸

Congenital syphilis cases in the United States are skyrocketing at an alarming rate. The CDC's *2022 STI Surveillance Report* found that congenital syphilis cases in the US increased 183% between 2018 and 2022.¹ States located in the South and Southwest experienced the highest rates of reported congenital syphilis cases.¹

Both timely testing and treatment of syphilis, especially in pregnant people, are essential to prevention of congenital syphilis. A lack of adequate testing and treatment during pregnancy was found to contribute to 88% of congenital syphilis cases in 2022. This highlights a clear need for increased public health, medical, and policy supports that connect pregnant people with the appropriate testing and treatment.⁷ Prenatal care with syphilis testing is also essential to combating the rise in congenital syphilis. Structural factors such as insecure housing, difficulty accessing care based on geography or cost, and drug-use make it harder for individuals to engage in prenatal care.⁹ Parental concerns about social services agency involvement (such as Child Protective Services) and the possibility of removal of the child from the home, along with criminalization based on substance use, sex work, and immigration status may contribute to reluctance in seeking prenatal care, further exacerbating the risk of congenital syphilis transmission.¹⁰ Historically and currently underserved communities experience an inequitably high prevalence of congenital syphilis, including American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and African American/Black populations.¹ Systemic racism, health inequity, poverty, discrimination, bias, lack of transportation, and lack of access to affordable and quality prenatal care, play significant roles in congenital syphilis disparities by race. Prevention efforts must be made with a specific focus on those communities to prevent further perpetuating historical and medical neglect that minoritized communities have been subjected to.

References

- 1. Centers for Disease Control and Prevention. *Sexually Transmitted Infections Surveillance 2022*. Atlanta: US Department of Health and Human Services; 2024.
- Centers for Disease Control and Prevention. Vital signs: syphilis in babies reflects health system failures. CDC; 2023. Available at: <u>https://www.cdc.gov/vitalsigns/newborn-syphilis/index.html</u>. Accessed April 12, 2024.
- 3. Centers for Disease Control and Prevention. (n.d.). *Syphilis in babies reflects health system failures*. Centers for Disease Control and Prevention. <u>https://www.cdc.gov/vitalsigns/newborn-syphilis/index.html</u>
- Workowski KA, Bachmann LH, Chan PA, et al. Sexually Transmitted Infections Treatment Guidelines, 2021. MMWR Recomm Rep 2021;70(No. RR-4):1–187. DOI: http://dx.doi.org/10.15585/mmwr.rr7004a1
- 5. Bateman, D. A., Phibbs, C. S., Joyce, T., & Heagarty, M. C. (1997). The hospital cost of congenital syphilis. *The Journal of Pediatrics*, *130*(5), 752–758. https://doi.org/10.1016/s0022-3476(97)80018-2

- 6. Centers for Disease Control and Prevention. (2023, April 11). *Detailed std facts syphilis*. Centers for Disease Control and Prevention. <u>https://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.htm</u>
- McDonald R, O'Callaghan K, Torrone E, et al. *Vital Signs*: Missed Opportunities for Preventing Congenital Syphilis — United States, 2022. MMWR Morb Mortal Wkly Rep 2023;72:1269–1274. DOI: http://dx.doi.org/10.15585/mmwr.mm7246e1
- 8. Congenital syphilis. March of Dimes. Accessed January 26, 2024. https://www.marchofdimes.org/find-support/topics/planning-baby/congenital-syphilis.
- Bellerose, M., Rodriguez, M., & Vivier, P. M. (2022). A systematic review of the qualitative literature on barriers to high-quality prenatal and postpartum care among low-income women. *Health services research*, 57(4), 775–785. <u>https://doi.org/10.1111/1475-6773.14008</u>
- 10. Stone, R. Pregnant women and substance use: fear, stigma, and barriers to care. *Health Justice* **3**, 2 (2015). https://doi.org/10.1186/s40352-015-0015-5

Record of Action

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