Syphilis in Pregnancy and Newborns

Summary This Policy Directive outlines the minimum standards for syphilis screening of pregnant women in New South Wales, and the establishment of Local Health District pathways that enable appropriate referrals for assessment and management of syphilis in pregnancy and newborns.

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Secretary, NSW Health

NSW Health

POLICY DIRECTIVE

Syphilis in Pregnancy and Newborns

POLICY STATEMENT

NSW Health is committed to addressing concerning increases in the number of women diagnosed with syphilis in pregnancy (maternal syphilis) and mother-to-child transmission of syphilis (congenital syphilis) resulting in adverse outcomes including preterm birth, low birth weight, congenital anomalies, fetal loss or stillbirth, and neonatal death. Congenital syphilis is an entirely preventable disease and its occurrence reflects a failure of delivery systems for antenatal care and syphilis control programs.

SUMMARY OF POLICY REQUIREMENTS

This Policy Directive introduces new antenatal syphilis screening intervals for all pregnant women, and outlines Local Health Districts (Districts), Specialty Health Networks (Networks) and service level responsibilities to ensure appropriate referrals, assessment and management of syphilis in pregnancy and neonates.

This Policy Directive must be read as a supplement to existing gold-standard clinical guidance outlined in the current edition of the Australasian Society for Infectious Diseases (ASID) guidelines *Management of Perinatal Infections*.

Assessment, diagnosis, and treatment of maternal and congenital syphilis is multifaceted and requires a multidisciplinary response. Leadership at Districts and Networks must ensure that local processes are in place to enable effective implementation of this Policy Directive including identified referral pathways and responsibilities for follow-up of women at risk of syphilis in pregnancy, and pregnant women diagnosed with syphilis in pregnancy.

All pregnant women in NSW must be offered syphilis screening as part of their first antenatal visit blood screen and again at 26-28 weeks gestation. Pregnant women who have received minimal or no antenatal care, or are at risk of missing an appointment, should be opportunistically screened for syphilis and blood-borne viruses Hepatitis B and HIV at the service they present at, regardless of gestation. Documentation of all antenatal syphilis screening must be entered into the relevant District maternity database and medical records.

All positive syphilis results in pregnancy should be discussed with a clinician who has expertise in managing and treating syphilis. Local pathways must be developed to ensure pregnant women are referred to maternity services, and all relevant services are informed including sexual health services, the local public health unit and primary care services to facilitate appropriate contact tracing and treatment where relevant.

Timely assessment and initiation of treatment is essential for all cases of maternal syphilis per the Australasian Society for Infectious Diseases (ASID) guidelines *Management of Perinatal Infections*. All pregnant women diagnosed and treated for syphilis in pregnancy need the details of their investigations and management, and recommendations for future

testing requirements clearly documented in their medical records. Local pathways must be developed to ensure maternal and neonatal assessment is clearly documented in the patient's medical record in a manner that ensures this is flagged at the time the pregnant women presents for birth.

Responsibility for neonatal follow-up must be clearly defined on discharge identifying the most appropriate service as relevant to the local context and woman's needs (such as paediatric outpatient clinic or outreach service). Auditing processes must be developed to monitor and review follow-up care and clinical outcomes.

All cases of congenital syphilis are to be investigated as a clinical incident and entered into the Incident Management System (ims+) with a harm score relevant to the case. NSW Health employees must be aware of the importance of reporting incidents and near misses to ensure timely investigation and ensure lessons are learnt to facilitate the elimination of congenital syphilis in NSW.

REVISION HISTORY

Version	Approved By	Amendment Notes
PD2023_029 October 2023	Director General	New policy directive

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1. BACKGROUND

Syphilis is a highly infectious bacterial infection caused by *Treponema pallidum*. Syphilis can affect anyone and cause serious health issues when left untreated. Syphilis can be transmitted sexually and acquired during pregnancy (maternal syphilis) leading to mother-to-child transmission (congenital syphilis) with devastating impacts on the fetus. With timely screening and treatment during pregnancy, congenital syphilis can be prevented [1, 2, 3, 4, 5].

A meta-analysis found over half of pregnancies affected by syphilis, where treatment did not occur, resulted in adverse outcomes, including stillbirth and second or third trimester fetal loss (21%), neonatal death (9%), premature and low birth-weight infants (6%), and infants with clinical syphilis infection (16%)[6]. This demonstrates the importance of robust screening and management pathways for syphilis in pregnancy.

Since 2017, infectious syphilis has increased in the general population including women of childbearing age. This has led to an increase in congenital syphilis cases in NSW and nationally. Between 2017 and 2022, NSW reported 12 cases of congenital syphilis[7]. A review of these cases identified that not all of these pregnancies would have been considered 'high-risk' according to the Australian Government Department of Health and Aged Care *Clinical Practice Guidelines Pregnancy Care* (2020).

Syphilis screening involves a blood test to detect antibodies against *Treponema pallidum*. It may take up to three months following exposure to develop syphilis antibodies. Swabbing of a syphilis lesion (chancre) for polymerase chain reaction (PCR) testing may also be performed if present[8].

1.1. About this document

This Policy Directive establishes the minimum requirements for NSW Health services and outlines the roles and responsibilities of clinicians and NSW Health staff when screening and managing syphilis in pregnancy and managing neonates at risk of congenital syphilis, with the overall aim to eliminate congenital syphilis. This Policy Directive must be read as a supplement to existing gold-standard clinical guidance outlined in the current edition of the Australasian Society for Infectious Diseases (ASID) guidelines *Management of Perinatal Infections.*

Syphilis screening must be offered to all pregnant women **at least twice** during pregnancy (serology at first antenatal visit and again at 26–28 weeks' gestation)[9]. Additional screening should be offered when a woman has an increased risk of syphilis infection (See Appendix 2). Pregnant women who have received minimal or no antenatal care, or are at risk of missing an appointment, should be offered opportunistic screening at the service they present at, regardless of gestation.

The principles of informed decision making must be adhered to by all healthcare staff when discussing the benefits and risks of syphilis screening. Assessment for congenital syphilis is to be performed for all neonates born to women diagnosed with syphilis during the current pregnancy (See Section 5.2).

This Policy Directive aligns with other key clinical guidelines and documents, including:

- Australian Government Department of Health and Aged Care *Clinical Practice Guidelines Pregnancy Care* (2020)
- NSW Health *Syphilis Control Guideline*
- Clinical Excellence Commission Safety Information *Increased universal screening for syphilis infection in pregnancy* (SI:009/22)
- *The Child Safe Standards and NSW Health Child Safe Action Plan*
- NSW Health *Integrated Trauma-Informed Care Framework: My story, my health, my future*
- *NSW Sexually Transmissible Infections Strategy 2022-2026*
- Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) – Bloodborne Virus and Sexually Transmissible Infections in Antenatal Care

1.2. Key definitions

Aboriginal people	In this Policy Directive, Aboriginal and Torres Strait Islander people are referred to as Aboriginal people in recognition that Aboriginal people are the original custodians of NSW.
Health visit	A health visit in the context of this Policy Directive refers to any visit with a health service (including but not limited to general practice, mental health, antenatal, alcohol and drug, preconception, emergency departments).
Incident Management System (ims+)	A NSW Health state-wide system that records all health care incidents for follow-up by the relevant manager to minimise the clinical risks in health services through the management of health care incidents as they occur.
Informed decision-making	Informed decision-making is a two-way communication process between a woman and one or more health professionals and reflects the ethical principle that a woman has the right to decide what is appropriate for her, considering her personal circumstances, beliefs and priorities. This includes the right to accept or to decline the offer of certain health care.
Integrated trauma-informed care	Integrated trauma-informed care brings together the elements of trauma-informed care and integrated care to improve the experiences of clients and staff. Trauma-informed care considers people's symptoms, responses and behaviours in the context of their past experiences, and emphasises physical, emotional and psychological safety for clients and staff. 'Integrated care' is the provision of seamless, effective and efficient care that responds to

	all of a person's health needs, across physical and mental health in partnership with the individual, their carers and family[10].
Neonate	A live newborn infant from birth to 28-days old.
Women	In this Policy Directive, the terms 'woman' and 'women' are used. The use of these terms is not meant to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care.

1.3 Related NSW Health documents

Reference	Title
PD2010_016	*SAFE START Strategic Policy*
PD2020_032	*Nursing and Midwifery Management of Drug and Alcohol use in the Delivery of Health Care*
PD2020_047	*Incident Management*

This Policy Directive is also to be read in conjunction with:

- The NSW Health *Syphilis Control Guideline*, which details the public health case and contact management, data management and treatment following positive serology notification.
- NSW Health *Clinical Guidelines for the Management of Substance Use in Pregnancy, Birth and the Postnatal Period*.

2. LOCAL HEALTH DISTRICT AND SPECIALTY HEALTH NETWORK RESPONSIBILITIES

Leadership at Local Health Districts (Districts) and Specialty Health Networks (Networks) must ensure that local processes are in place which enable the effective implementation of this Policy Directive.

Districts and Networks are to monitor compliance with this Policy Directive using the *Implementation checklist and compliance self-assessment* (see Appendix 1).

3. SERVICE LEVEL RESPONSIBILITIES

3.1. Local protocols

All NSW Health staff who engage with pregnant women and neonates have a role to play in preventing and managing congenital syphilis. Refer to the *Implementation checklist and compliance self-assessment* (see Appendix 1).

3.2. Education

All clinicians working with pregnant women should understand their role in the assessment and pathways for management of syphilis in pregnancy and neonates. For clinicians involved in antenatal care, detailed syphilis training and education is available via the ASHM *NSW Introduction to Syphilis for Midwives and Clinicians Providing Antenatal Care* online learning module.

Clinicians are to be aware of local resources and training, including any provided by Districts or Networks.

4. SYPHILIS SCREENING IN PREGNANCY

Given the increased incidence of congenital syphilis in NSW, and the finding that many women were not considered high-risk during pregnancy, the following screening regime is now the expected standard of care. Documentation of all syphilis screening, treatment and management plans must be recorded into the relevant Local Health District (District) maternity database and medical records.

The principles of informed decision making must be adhered to by all healthcare staff when discussing the benefits and risks of syphilis screening. If a service does not have appropriate workforce or facilities to undertake testing, women are to be referred to a suitable service. Refer to the antenatal syphilis screening risk assessment (see Appendix 2).

4.1. Universal first syphilis screening at booking

All pregnant women in NSW must be offered syphilis screening as part of their first antenatal visit blood screen.

4.2. Universal second screening at 26-28 weeks

All pregnant women in NSW must be offered a second syphilis screening at 26-28 weeks gestation. The Clinical Excellence Commission Safety Information notification introduced the second universal antenatal screen as part of routine care at 26-28 weeks[9].

4.3. Additional screening for pregnant women at higher risk of infection

Additional syphilis screening at 36 weeks and birth should be offered to pregnant women deemed as having an identified risk of infection (see Appendix 2) despite already being screened at the recommended intervals[9].

4.4. Opportunistic screening for pregnant women who present outside of maternity services

Pregnant women who have received minimal or no antenatal care, or are at risk of missing an appointment, should be offered opportunistic screening for syphilis and blood-borne viruses Hepatitis B and HIV at the service they present at, regardless of gestation. Districts must develop processes for how other services (such as Drug and Alcohol, Mental Health,

Emergency Department, Aboriginal Medical Services, GP services, Custodial Settings) can provide opportunistic antenatal screening which includes information on the blood tests required.

Pregnant women who are not regularly engaged with antenatal care may face challenges accessing antenatal care and have complex care needs including psychosocial issues, trauma, mental health conditions, and drug and alcohol related health issues. Clinicians are to refer to support services that are culturally appropriate, safe, respectful and provide integrated trauma-informed care. Local processes and responsibilities to focus on enabling engagement with health services are to be explored.

5. MANAGEMENT AND FOLLOW-UP OF SYPHILIS IN PREGNANCY AND NEONATES

The assessment, diagnosis, and treatment of syphilis in pregnancy is multifaceted and requires a multidisciplinary approach. The risk of fetal transmission and adverse pregnancy outcomes increases the longer maternal syphilis remains untreated; therefore, all women should be treated as soon as possible unless there is documented evidence of previous adequate treatment and no reason to suspect re-infection[11, 12]. Consideration must be given to the appropriate supply, storage, and access to Benzathine penicillin.

Local Health Districts (Districts) must establish local referral pathways, that are culturally appropriate, to support access to care for women diagnosed with syphilis in pregnancy. Local pathways should be developed to facilitate and ensure timely treatment occurs for all women and consider issues that may impact on attendance for treatment; where necessary commence active follow up such as home visits.

5.1. Assessment, management and follow-up of women with a positive syphilis result in pregnancy

Syphilis serology can be a challenge to interpret. If assistance in interpretation is needed, contact a sexual health physician, microbiology registrar or another expert practitioner. All cases of syphilis in pregnancy should be discussed with a clinician with expertise in managing and treating syphilis, and timely treatment initiation is essential.

- Refer to Algorithm 2 in the Australasian Society for Infectious Diseases (ASID) guidelines *Management of Perinatal Infections* that outlines appropriate antibiotic management and follow-up serology.
- All pregnant women diagnosed and treated for syphilis in pregnancy need the details of their investigations and management, and recommendations for future testing requirements clearly documented in the medical records.
- Local protocols must ensure all relevant services are informed – this includes maternity, sexual health, public health units and primary care services.
- Local protocols must ensure pregnant women are referred to maternity services, and for additional ultrasound scans as appropriate.
- Local protocols must ensure appropriate contact tracing and treatment where relevant.

- Local pathways must be developed to ensure maternal and neonatal assessment is clearly documented in the patient's medical record in a manner that ensures this is flagged at the time the pregnant women presents for birth.

5.2. Assessment and management for neonates at risk of congenital syphilis at birth

All neonates born to women diagnosed with syphilis in the current pregnancy, regardless of maternal treatment, require assessment by a senior medical officer for clinical signs of congenital syphilis.

- Refer to Algorithm 3 in Australasian Society for Infectious Diseases (ASID) guidelines *Management of Perinatal Infections* to guide the assessment and management.
- As indicated, prepare a plan to ensure that the necessary samples for the investigations for congenital syphilis are taken at birth from both the woman and neonate. These include blood, placental and/ or umbilical cord samples.

5.3. Follow-up of babies at risk of congenital syphilis after discharge

Responsibility for neonatal follow-up must be clearly defined on discharge. This includes:

- identifying the most appropriate service as relevant to the local context and woman's needs (such as paediatric outpatient clinic or outreach service)
- establishing a local process for initiating and ensuring follow-up occurs, including if a baby is discharged prior to pathology result availability
- using audit processes to monitor and review follow-up care and clinical outcomes.

5.4. Treatment and follow-up of neonates with congenital syphilis

All suspected cases of congenital syphilis must be discussed with a clinician with expertise in managing and treating syphilis. Refer to Algorithm 3 in Australasian Society for Infectious Diseases (ASID) guidelines *Management of Perinatal Infections* for medical management.

6. SUPPORT FOR ABORIGINAL WOMEN AND FAMILIES

Clinicians are to provide all pregnant women with care that is culturally appropriate, safe, respectful and trauma informed. Clinicians should offer and engage Aboriginal support services at the commencement of care for all pregnant Aboriginal women, and women pregnant with an Aboriginal baby. All pregnant women must be asked if they identify as Aboriginal, or if they are pregnant with an Aboriginal baby, from the outset of care as this can help to overcome barriers in accessing culturally appropriate care/ support. Refer to the Aboriginal Health Worker/ Practitioner nominated for all follow-up of Aboriginal women.

Where available, offer referral to Aboriginal Maternal Infant Health Services (AMIHS) or other maternity services for Aboriginal families.

7. RECOGNISING AND RESPONDING TO SPECIFIC NEEDS

Cases of congenital syphilis often occur where women are experiencing significant social disadvantage. This may involve drug and alcohol use, mental health disorders, transience, and disconnection from health services. Clinicians are to consider referral to specialist or support services via local pathways.

Where applicable, clinicians should refer to the following documents:

- NSW Health *Clinical guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period*
- NSW Health Policy Directive *SAFE START Strategic Policy* (PD2010_016)
- NSW Health Policy Directive *Nursing and Midwifery Management of Drug and Alcohol use in the Delivery of Health Care* (PD2020_032).

8. INCIDENT MANAGEMENT SYSTEM (IMS+) REPORTING OF CONGENITAL SYPHILIS

All cases of maternal syphilis are to be monitored and reviewed by the maternity service to ensure appropriate processes are followed. Any occurrence of congenital syphilis represents missed opportunities for prevention in the public health, antenatal and primary health care system.

All cases of congenital syphilis are to be investigated as a clinical incident and entered into ims+ or other incident management system with a harm score relevant to the case (see NSW Health Policy Directive *Incident Management* (PD2020_047).

NSW Health employees must be aware of the importance of reporting incidents and near misses to ensure timely investigation and ensure lessons are learnt to facilitate the elimination of congenital syphilis in NSW.

9. REFERENCES

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10. APPENDICES

1. Appendix 1: Implementation checklist and compliance self-assessment
2. Appendix 2: Antenatal syphilis screening risk assessment

10.1. Appendix 1: Implementation checklist and compliance self-assessment

Organisation / Facility:	
Assessed by:	Date of Assessment:

Key Policy Requirements	Not commenced	Partial compliance	Full compliance
Leadership and coordination Local processes are in place that enable the effective implementation of this Policy Directive. This may include appointing an Implementation Sponsor, Project Lead, and local Steering Committee. Consideration is given to include local Aboriginal and culturally and linguistically diverse community representation in planning and coordinating the implementation of the policy.	❑	❑	❑
	Notes:		
Identify staff, train staff, support staff Staff are appropriately educated to implement this Policy Directive. Consideration is given to role appropriate levels of training and support. Managers have a process in place to monitor training needs and attendance. Clinical (and other staff) staff attend education as needed.	❑	❑	❑
	Notes:		
Coordinate referral pathways for screening and management Ensure local processes are in place so that all women can have access to screening and management of syphilis in pregnancy. Ensure that all staff are aware of this Policy Directive. Consideration is given to routine communication between executives, managers, clinicians, and patient representatives on the implementation of this Policy Directive. Managers will ensure that the progress and issues identified in the implementation of this Policy Directive are reported via local governance channels. Clinical staff will document assessments, support and interventions provided, and outcomes associated with this Policy Directive.	❑	❑	❑
	Notes:		

Key Policy Requirements	Not commenced	Partial compliance	Full compliance
	❑	❑	❑
Communication Communicate with the multidisciplinary teams the identified referral pathways and responsibility for follow-up. Inform health care providers who may encounter women with syphilis in pregnancy (such as in emergency departments, general practitioners) about the referral pathways. Collaborate and coordinate with local clinical and community services (such as Aboriginal and/ or Torres Strait Islander medical services, community organisations and programs, mental health services, drug and alcohol programs, young parent programs, women's groups, criminal justice systems.	Notes:		
Establish accountability mechanisms Local processes are in place to ensure that the implementation of this Policy Directive is monitored. Managers will monitor staff training, syphilis surveillance and case demographics, interventions, impacts and outcomes. Consideration will be given on how this data will inform service delivery, clinical practice and patient experience in the implementation of this Policy Directive and how data can inform NSW Health syphilis surveillance objectives.	❑	❑	❑
	Notes:		

10.2. Appendix 2: Antenatal syphilis screening risk assessment