Strengthening STD Prevention and Control for Health Departments

Technical Assistance Note # 7 | Disease investigation and intervention for pregnant women and other women of reproductive age with syphilis

From Strategy Area II: Conduct Disease Investigation and Intervention

7. Conduct health department disease investigation for pregnant women with syphilis and other reproductive-age women with syphilis
    a. Prioritize for investigation all reported females of reproductive age with reactive serology, including provider follow-up to confirm stage, treatment, and pregnancy status
    b. Regardless of pregnancy status, conduct follow-up on new syphilis cases among women of reproductive age, to obtain more information, if needed, on treatment and other information needed to ensure linkage to related STD, MCH, HIV prevention and other services. For those who are pregnant, investigation should also include follow-up with the pregnant female, prenatal care providers, birthing centers, and neonatal care providers as needed to ensure adequate maternal follow up and stillbirth and neonatal evaluations per clinical guidelines
    c. Provide timely partner services to all pregnant women who are diagnosed with syphilis and all other women of reproductive age who are diagnosed with early syphilis

Why DSTDP included these strategies

Disease investigation and intervention are fundamental to the public health response to many infectious diseases, including STDs. The goal of these activities is to interrupt disease transmission networks by diagnosing and treating individuals in those networks and preventing various potential adverse outcomes of syphilis in women, particularly pregnant women. Taken to scale, disease intervention, including partner services, can slow and even stop transmission at a population-level. Additionally, disease intervention can also help link persons to much needed services if appropriate, including HIV re-engagement in care and PrEP. Health department STD programs have unique authority and responsibility to conduct disease investigation and intervention.

After more than a decade of extremely low case rates, primary and secondary syphilis among women, and congenital syphilis among pregnant women, have steadily increased since 2012. The prevention and control of congenital syphilis is the strategic priority for DSTDP and should also be considered a priority for all DSTDP funded programs.

Why prioritize women of reproductive age

- Women of reproductive age (WRA) are generally defined as women between 15-44 years old, but STD programs may opt to define this as women under age 50
- Disease investigation for all pregnant women who test positive for syphilis, regardless of stage, is important because treatment of a pregnant woman with syphilis may prevent congenital syphilis. Partner services for pregnant women with syphilis (or those who have been recently treated for syphilis) can reduce the chance that the individual is re-infected with syphilis during pregnancy

- Intervention and partner services for other women of reproductive age with early syphilis is highlighted because case and laboratory reports for syphilis often do not include information on pregnancy status, and therefore the woman may be pregnant or could become pregnant

STD programs should ensure that their follow up for these groups is as strong as possible, before designating other groups of STD cases eligible for health department investigation.

Considerations for implementation

Prioritizing reactive lab and provider reports

- Record search all lab and provider reports on WRA within 48 hours of receipt to determine history of testing or treatment. Prioritize all lab and provider reports for additional follow-up if there is no documented history that confirms that the case is a former or "old" case not in need of any follow-up. If there is any doubt, err on the side of caution and proceed with follow-up
- Prioritize reactive lab and provider reports among women for physician outreach to determine pregnancy status, reason for testing, symptom history, treatment information, and patient locating information. Determining pregnancy status is paramount at this stage of investigation and should not wait for a patient interview
- Prioritize reactive lab and provider reports from prenatal care providers for immediate follow-up to ensure timely treatment. Consider other facilities that aren't traditional medical providers that might be a priority for review: for example prisons/jails and drug treatment facilities that serve women
- Create program standards for the timely follow-up of reactive lab reports on pregnant women and other females of reproductive age. Monitor timeliness and completeness of laboratory and provider reporting
- Don't wait for confirmatory test results before initiating provider follow-up for a pregnant woman with a reactive syphilis serology. If communication between the provider and the health department is stalled, initiate health department follow-up with the patient immediately. However, do wait for a confirmatory test before recommending treatment, in most cases
- Beyond cost barriers, explore whether there are other barriers that may prevent a WRA from receiving care or engaging with the health department, including transportation, child care, inability to take leave from work, etc.
- Regularly inventory the available resources needed by staff that routinely manage of WRA with syphilis, such as sites providing no/low cost prenatal and reproductive health services, high-risk maternity services, penicillin desensitization, case management resources, etc.
- Consider identifying a liaison to carry out active surveillance with delivery hospitals, OB/GYNs, and other key providers in high-morbidity areas and/or that serve large populations of women at-risk for syphilis. Perinatal hepatitis B or perinatal HIV coordinators may be particularly helpful in making connections and navigating systems
- Consider the environmental context. For example, during times of an opioid outbreak, you may consider provider outreach to facilities who may see at risk women to discuss symptoms and the need for testing among certain populations, like those who exchange sex for money or drugs.

Following up on cases

- First priority should be given to pregnant women, then to pregnant contacts to active syphilis cases, then to women of reproductive age with positive syphilis tests, and then to women of reproductive age who are contacts to active cases
- Consider whether there may be cost barriers to treatment (among uninsured and under insured women) and consider health department support/coverage for the treatment of those for whom treatment or treatment cost is a barrier.
- Consider a daily debriefing on these female cases once assigned to ensure prioritization by DIS, front line supervisors, and field operations managers. Frequently monitor the status of cases and provide a forum for DIS to discuss case management (e.g. chalk talks, case conferences) in a timely way, so that the discussions can benefit active follow-up/ investigation efforts. All congenital syphilis cases will merit special review (see STD PCHD Strategy and **TA Note #4**)
- Don't hesitate to have health department staff visit the hospital to talk to a patient or provider related to a congenital syphilis case. Infection Control Nurses at hospitals are often an excellent resource
- Pursue public-private partnerships and/or collaborations with maternal and child health organizations to enhance provider awareness of congenital syphilis and to conduct social marketing efforts to promote prenatal care and ensure timely referral of pregnant women to case management

Conducting partner services

- Ensure that high morbidity providers regularly inform their patients that the health department may be contacting them for interview and partner elicitation. Because provider buy-in is essential to successful partner services, consider creating a brief script that providers can use to talk about health department follow-up for partner services
- Partner services is essential for all women reported as index cases. In addition, pregnant female contacts and associates, and other women of reproductive age named as partners or associates to male syphilis cases, should also be prioritized for follow-up
- Offer partner services as quickly as possible after a case is diagnosed. This is particularly important in pregnant females to reduce the chance of reinfection by an untreated partner. Ensure DIS have appropriate access to records and resources that could assist them in locating and referring partners (e.g. eHARS, Accurint, Facebook, etc.)
- During every interview of a diagnosed case of syphilis, ask the person if they have partners who are or who may be pregnant, as well as any other women they know who may be pregnant. Assist with linking any women who are not yet in prenatal care into care, and assist with linking women who are not pregnant and want to use contraception to family planning services. HIV prevention services, including education about and linkage to PrEP, should also be a part of this assessment and assistance to both cases and partners, as appropriate.

Recommended follow-up on congenital syphilis cases is described in a separate strategy of STD PCHD and in a separate **TA Note #4**. Please reference those alongside this document.

Other resources

- IPS tool kit: https://www.cdc.gov/std/program/ips/default.htm
- PS evaluation field guide: https://effectiveinterventions.cdc.gov/docs/default-source/partner-services-materials/Partner_Services_Evaluation_Field_Guide_041610.pdf?sfvrsn=0
- DIS training centers: http://distc.org/
- Recent review paper on partner services: http://journals.lww.com/stdjournal/Fulltext/2016/02001/Partner_Services_in_Sexually_Transmitted_Disease.8.aspx
- CDC Call to Action: Let's Work Together to Stem the Tide of Rising Syphilis in the United States: https://www.cdc.gov/std/syphilis/syphiliscalltoactioapril2017.pdf
- 2018 revised syphilis case definitions: https://wwwn.cdc.gov/nndss/conditions/syphilis/case-definition/2018/

For more information or feedback on this document, contact your DSTDP Prevention Specialist or email STD_PCHD@cdc.gov. CDC's Division of STD Prevention, Program Development and Quality Improvement Branch, developed this document for recipients of PS19-1901 STD PCHD to provide additional clarification of strategies outlined in that NOFO and to support program implementation. The content here does not represent additional NOFO requirements nor official CDC recommendations. Issue date: April 2019