



Eliminating mother-to-child transmission of syphilis: the need for more consistent political commitment

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Wijesooriya and colleagues (1) recently reported an approximately 40% decrease in the global burden of both syphilis in pregnancy and syphilis-associated adverse pregnancy outcomes over the period from 2008 to 2012. The determinants of the welcome decrease are manifold, but chief among them are (I) the reduction in overall adult syphilis prevalence levels, and (II) some improvement in the coverage of interventions for screening and treatment of pregnant women. The findings of the report illustrate the importance of establishing and maintaining support for policies and programmes which are effective in controlling this preventable condition which, nonetheless, still afflicts hundreds of thousands of infants and their parents worldwide, as well as the importance of robust surveillance systems to monitor progress (or not) over time.

The control of mother-to-child transmission (MTCT) of infection relies not just upon the availability of effective and affordable interventions, but also on the ‘political will’ to ensure that these interventions are incorporated into policies and that programme coverage is equitable and universal. Data from the 2008–2012 global analysis show that we still have a long way to go. The World Health Organization (WHO) launched the global initiative for the elimination of MTCT of syphilis in 2007 (2). A reduction in MTCT of syphilis incidence was reframed as a “winnable battle” for which major progress could be made with a sustained and coordinated effort (3).

In recent years, there has been an upsurge in global and national interest in controlling MTCT of syphilis, closely aligned with the global goal for eliminating MTCT of HIV (4–6). The similarity of the interventions, for

example, prevention of adult infection through combined interventions to reduce transmission, along with promotion of early antenatal screening and treatment, suggested the feasibility of an integrated approach to eliminate both infections simultaneously (7). Integrating MTCT of syphilis and HIV interventions is not only more cost-effective than controlling MTCT of HIV alone (8), but will also help improve a broad range of maternal and child health outcomes and therefore directly contribute to achievement of global health goals (7), including SDG 3 and 5.

In 2008, WHO and global partners (including UNAIDS and UNICEF) introduced surveillance of syphilis in pregnancy within the Global AIDS Response Progress Reporting (GARPR) System to monitor progress through three core indicators (i.e., syphilis testing, seropositivity, and treatment) (9). A global monitoring system, such as GARPR, may act to enhance accountability for MTCT of syphilis if national governments deem the global commitment as legitimate and comply with it (10). From 2008 onwards, global and regional goals were set, screening methods such as dual rapid syphilis and HIV tests on a single device were introduced (11), and countries have been encouraged to scale up programmes towards the goal of dual elimination (12–14). In 2015 and 2016, a small number of countries (including Thailand, Cuba, Armenia, Belarus and Moldova) have been validated by WHO for eliminating MTCT of both syphilis and HIV (15,16).

Nonetheless, the global picture shows that progress is patchy, and in some regions of the world the picture for MTCT of syphilis screening was worse in 2012 than in 2008. While the number of countries that are now

complying with the GARPR reporting requirements has increased by almost 40% from 88 to 122, the actual ability to deliver interventions has shown less promising progress. The 2008–2012 data show that around 64% of pregnant women with syphilis never receive any syphilis-screening during pregnancy (of whom, 16% do not receive any antenatal care at all), and in sub-Saharan Africa (where 63% of all pregnant women who are syphilis seropositive live), the proportion of women not screened for syphilis in pregnancy actually increased during the period 2008–2012.

In contrast, over a similar time frame, prevention of mother-to-child transmission (PMTCT) of HIV became a flagship activity for many governments and external funding agencies across sub-Saharan Africa. UNAIDS and PEPFAR recently [2016] launched a “Start Free, Stay Free, AIDS Free” campaign which, among other initiatives, calls for the ‘fast-track’ of PMTCT and an end to AIDS among children, adolescents and young women by 2020. Progress on scaling up access to HIV screening for all pregnant women is rapid, and in 21 priority countries in sub-Saharan Africa, 50% of women are now receiving full HIV counselling, screening and their test results, with 77% of HIV positive women on antiretrovirals (ARVs) to reduce MTCT and 65% of HIV positive pregnant women receiving ARVs as part of long-term care. These numbers are in sharp contrast to the picture of MTCT of syphilis in the same region where, as noted, the proportion of women not screened for syphilis during pregnancy increased by 49% from 2008 to 2012.

What accounts for this dramatic discrepancy between the resources afforded to PMTCT of HIV and PMTCT of syphilis in the worst-affected and highest burden region (Sub-Saharan Africa). In their paper, Wijesooriya and colleagues revealed a significant variance in provision of MTCT of syphilis interventions, as well as compliance with the global monitoring system. Some of these differences may be due to variations in the level of national political attention paid to the issue. A study of six Sub-Saharan Africa countries found that despite the existence of global and regional strategies and plans proposing dual elimination, there are currently insufficient political and financial resources to ensure scaling up of maternal syphilis screening and antenatal care strengthening (5).

Lack of political support can be due to many factors, and some scholars have interpreted the difficulty in controlling MTCT of syphilis as a consequence of a lack of “champions”—persons either from the political field or civil society who are explicitly responsible for achieving the goals of universal coverage of screening and treatment

for maternal syphilis (17,18). Others attribute inefficient responses to a popular perception among public health experts, programme managers, and policymakers that syphilis has been eliminated already (19).

We believe that lessons may be learnt from the case of China. A recent study comparing the policy processes of PMTCT of syphilis and PMTCT of HIV revealed that epidemiological and technical evidence was not necessarily translated into political priority and resource allocation (20). In the 1990s and 2000s, the lower political salience afforded to MTCT of syphilis, compared to lower incidence MTCT of HIV, could be explained by a number of factors, including: relative neglect of MTCT of syphilis at a global level; insufficient international financial and technical support; weakly unified domestic initiatives; poor accountability mechanisms; decision-makers’ lack of clarity around the issue and the availability of solutions; as well as a prevailing negative framing of syphilis leading to serious stigmatization. It was not until 2010 that the political salience of and resources allocated to, MTCT of syphilis significantly increased, particularly when the Ministry of Health set a goal to eliminate MTCT of syphilis by 2020. Our own work has shown that the largely enhanced national commitment to combating MTCT of syphilis could be attributed to joint efforts from the national PMTCT of syphilis and PMTCT of HIV policy communities (20). Since the late 2000s, these two communities actively transferred global norms regarding the urgent need for dual elimination into influence on national decision-makers, reframed the two infections together as “threatening the physical and mental health of a large number of women” (21), and developed working guidelines to integrate HIV and syphilis screening into routine antenatal care across the country (4).

In 2016 the global goal for dual elimination received a welcome boost from the United Nations (UN) General Assembly High-Level Meeting (HLM) on Ending AIDS where all Member States of the UN committed to “taking all appropriate steps to eliminate new HIV infections among children... (and) dual elimination with congenital syphilis” (22). This is the first global commitment to dual elimination and can provide the impetus for countries and development partners to tackle these two infections simultaneously. As the experience of China showed, political will is imperative to the success of health initiatives. The global commitment from the HLM provides a unique opportunity for countries and development partners to mobilise resources and ensure that the entirely preventable burdens of MTCT syphilis and HIV are eliminated, together, once and for all.

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References

1. Wijesooriya NS, Rochat RW, Kamb ML, et al. Global burden of maternal and congenital syphilis in 2008 and 2012: a health systems modelling study. *Lancet Glob Health* 2016;4:e525-33.
2. World Health Organization, Department of Reproductive Health and Research. The global elimination of congenital syphilis: rationale and strategy for action. Geneva: World Health Organization, 2007.
3. De Cock KM, Centers for Disease Control and Prevention (CDC). Trends in global health and CDC's international role, 1961-2011. *MMWR Suppl* 2011;60:104-11.
4. Wang AL, Qiao YP, Wang LH, et al. Integrated prevention of mother-to-child transmission for human immunodeficiency virus, syphilis and hepatitis B virus in China. *Bull World Health Organ* 2015;93:52-6.
5. Newman Owiredun M, Newman L, Nzomo T, et al. Elimination of mother-to-child transmission of HIV and syphilis: A dual approach in the African Region to improve quality of antenatal care and integrated disease control. *Int J Gynaecol Obstet* 2015;130 Suppl 1:S27-31.
6. Hossain M, Broutet N, Hawkes S. The elimination of congenital syphilis: a comparison of the proposed World Health Organization action plan for the elimination of congenital syphilis with existing national maternal and congenital syphilis policies. *Sex Transm Dis* 2007;34:S22-30.
7. WHO. Elimination of mother-to-child transmission (EMTCT) of HIV and syphilis: Global guidance on criteria and processes for validation. Geneva: World Health Organization, 2014.
8. Owusu-Eduesei K Jr, Tao G, Gift TL, et al. Cost-effectiveness of integrated routine offering of prenatal HIV and syphilis screening in China. *Sex Transm Dis* 2014;41:103-10.
9. World Health Organization, Department of Reproductive Health and Research. Methods for surveillance and monitoring of congenital syphilis elimination within existing systems. Geneva: World Health Organization, 2011.
10. Taylor A, Alfoén T, Hougendobler D, et al. Nonbinding Legal Instruments in Governance for Global Health: Lessons from the Global AIDS Reporting Mechanism. *J Law Med Ethics* 2014;42:72-87.
11. Yin YP, Ngige E, Anyaike C, et al. Laboratory evaluation of three dual rapid diagnostic tests for HIV and syphilis in China and Nigeria. *Int J Gynaecol Obstet* 2015;130 Suppl 1:S22-6.
12. Pan American Health Organization. Regional Initiative for Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis in Latin America and the Caribbean: Concept Document for the Caribbean. Washington, DC: Pan American Health Organization, 2010.
13. Srikanthiah P. Elimination of New Paediatric HIV Infections and Congenital Syphilis in Asia-Pacific, 2011-2015. Conceptual Framework, Monitoring and Evaluation Guide. Bangkok, Thailand: UNICEF East Asia and Pacific Regional Office, 2011.
14. World Health Organization, Regional Office for Africa. Strategic framework for the elimination of new HIV infections among children in Africa by 2015. Brazzaville: WHO Regional Office for Africa, 2013.
15. World Health Organization. WHO validates elimination of mother-to-child transmission of HIV and syphilis in Cuba. World Health Organization 2015. Available online:

- <http://www.who.int/mediacentre/news/releases/2015/mtct-hiv-cuba/en/> (accessed March 7, 2016).
16. World Health Organization. WHO validates countries' elimination of mother-to-child transmission of HIV and syphilis. WHO 2016. Available online: <http://www.who.int/mediacentre/news/statements/2016/mother-child-hiv-syphilis/en/> (accessed September 26, 2016).
 17. Hawkes S. Eliminating congenital syphilis--if not now then when? *Sex Transm Dis* 2009;36:721-3.
 18. Buse K, Martin-Hilber A, Widyantoro N, et al. Management of the politics of evidence-based sexual and reproductive health policy. *Lancet* 2006;368:2101-3.
 19. Mabey D, Peeling RW. Syphilis, still a major cause of infant mortality. *Lancet Infect Dis* 2011;11:654-5.
 20. Wu D, Hawkes S, Buse K. Prevention of mother-to-child transmission of syphilis and HIV in China: What drives political prioritization and what can this tell us about promoting dual elimination? *Int J Gynaecol Obstet* 2015;130 Suppl 1:S32-6.
 21. Ministry of Health of the People's Republic of China. Report on Women and Children's Health Development in China (2011). Beijing: Ministry of Health of the People's Republic of China, 2011.
 22. United Nations General Assembly. Political Declaration on HIV and AIDS: On the Fast - Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030. 08 June 2016.

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