SURVEILLANCE & MONITORING

Priorities in the prevention of congenital syphilis in the EU/EEA

Monitoring of the responses to sexually transmitted infection epidemics in the European Union and European Economic Area – 2024 progress report

May 2026

Key facts

- Syphilis is a sexually transmitted bacterial infection, and congenital syphilis occurs when a foetus contracts syphilis during pregnancy. This can lead to severe negative consequences for the infant when they are born. Testing and treating pregnant women for syphilis prevents this from happening.
- Cases of congenital syphilis have increased by 243% in the past decade, from 37 cases in 2015 to 127 cases in 2024, among EU/EEA countries that consistently reported this data. Eleven countries reported rates above the WHO European Region 2030 elimination target of ≤1 case per 100 000 live births.
- Most EU/EEA countries have a policy of testing women for syphilis in early pregnancy, but few countries have data on how many are actually tested.
- Even if women test negative in early pregnancy, they can still contract the disease later in their pregnancy, and only about half of countries in the EU/EEA have a policy to re-test pregnant women.
- ECDC recommends that EU/EEA countries update their syphilis testing policy in pregnancy to ensure universal and voluntary syphilis screening in the first trimester, repeated testing of pregnant women with identified risk factors in the third trimester, and testing at delivery if it has not been done earlier. ECDC also recommends that countries have robust monitoring systems in place.

Background

Syphilis is a sexually transmitted infection (STI) caused by the bacterium *Treponema pallidum*. Congenital syphilis is an infection that occurs when *Treponema pallidum*, the bacterium causing syphilis, is passed from a pregnant woman who has syphilis to the foetus during pregnancy, primarily via transplacental transmission or, less commonly, through exposure to infectious lesions at delivery [1]. The term 'congenital' indicates that transmission has taken place in utero. Transmission can occur at any stage of maternal syphilis and at any stage of pregnancy; however, the risk is greatest in pregnant women with untreated early syphilis, in whom foetal infections occur in approximatively 70–100% of pregnancies, with stillbirths observed in up to one third of cases. Although transmission can occur at any time during pregnancy, it is most common after 28 weeks of gestation; timely treatment administered before this period and appropriate to the stage of infection is highly effective in preventing adverse foetal outcomes.

Erratum 22 May 2026: page 5: text suggesting that congenital syphilis can be easily cured deleted for clarity (complications that have already occurred at birth cannot be reversed but further complications can be prevented)

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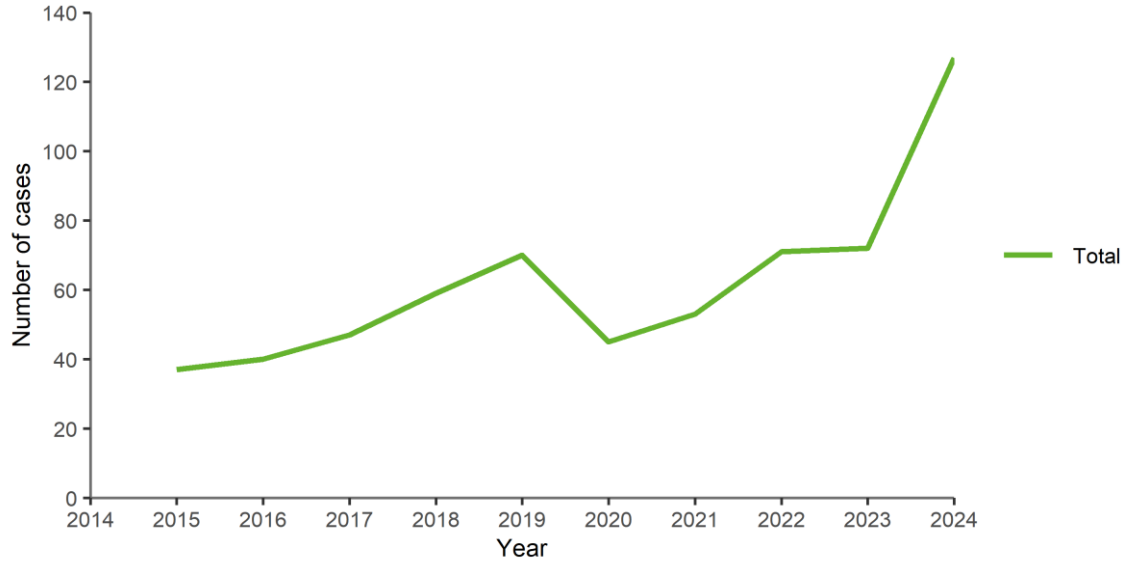
Congenital syphilis cases in infants that meet the laboratory criteria for case confirmation are under European Union epidemiological surveillance [1].

Congenital syphilis can be prevented through early and repeated screening during pregnancy and timely treatment for pregnant women who test positive with an active syphilis infection and treatment for their sex partner(s).

The WHO European Region 2030 target for eliminating congenital syphilis by 2030 are set at ≤1 case per 100 000 live births, <0.01% syphilis prevalence among women attending antenatal care, and ≥95% coverage of syphilis screening and treatment among pregnant women in antenatal care [2]. These targets are found within the WHO European Regional Action Plan for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections.

An increase in syphilis notification rates among women and heterosexual men was observed in 2022, 2023 and 2024 in several European Union (EU) and European Economic Area (EEA) countries. In parallel there has been an increase in the number of confirmed cases of congenital syphilis since 2020. In 2024, 14 countries reported 140 confirmed congenital syphilis cases, with a further 14 countries reporting no cases [3,4]., The number of cases of congenital syphilis increased by 243% from 37 cases in 2015 to 127 cases in 2024 (Figure 1) among countries which reported data consistently between 2015 and 2024

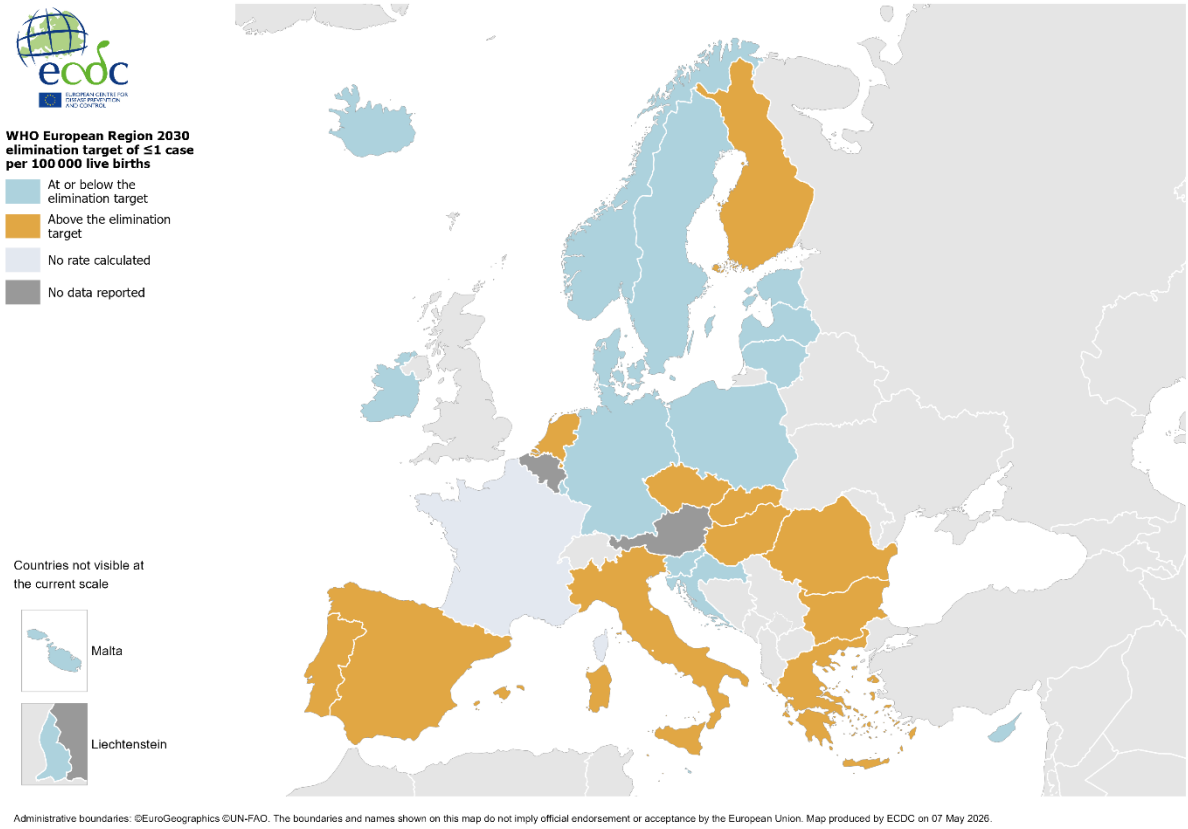
Figure 1. Number of confirmed congenital syphilis cases by year in EU/EEA countries with consistent reporting, 2015–2024



Source: Country reports from Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, France, Germany, Hungary, Iceland, Ireland, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden.

In 2024, 16 EU/EEA countries that provided data on congenital syphilis had national rates at or below the WHO European Region 2030 elimination target of ≤1 case per 100 000 live births. Eleven countries reported rates above one case per 100 000 live births, with the highest rates observed in Portugal (17.5), Hungary (47.9) and Bulgaria (52.5) (Figure 2).

Figure 2. Congenital syphilis rates in the EU/EEA in relation to the WHO European Region 2030 elimination target of ≤1 cases per 100 000 live births, 2024 data



Early detection and timely treatment of maternal infection through antenatal screening programmes, including universal screening for syphilis, are central to preventing congenital syphilis. Recent increases in congenital syphilis in the EU/EEA indicate missed prevention opportunities in antenatal care. Evidence from country reports and the literature shows that most cases occur among pregnant women with socio-economical vulnerabilities, and often in the context of them receiving suboptimal antenatal care. These socio-economic vulnerabilities can include being a minor, having low educational attainment, being unemployed, having a migrant background, or using substances [5]. Factors associated with receiving suboptimal antenatal care from healthcare providers include the absence of syphilis testing during antenatal visits, delayed or inadequate treatment following a positive test, and failure to detect infections acquired later in pregnancy after an initial negative screening. Improving prevention requires tailored approaches to increasing screening and screening uptake among these groups, ensuring effective follow-up and treatment, and strengthening antenatal care quality, including considering repeat testing where appropriate [6].

This evidence brief draws on data collected within the European Centre for Disease Prevention and Control (ECDC) 2024 STI monitoring questionnaire, which included questions to assess national antenatal screening policies for syphilis as well as testing and treatment coverage among EU/EEA countries.

National policies, guidelines and recommendations for syphilis screening during pregnancy

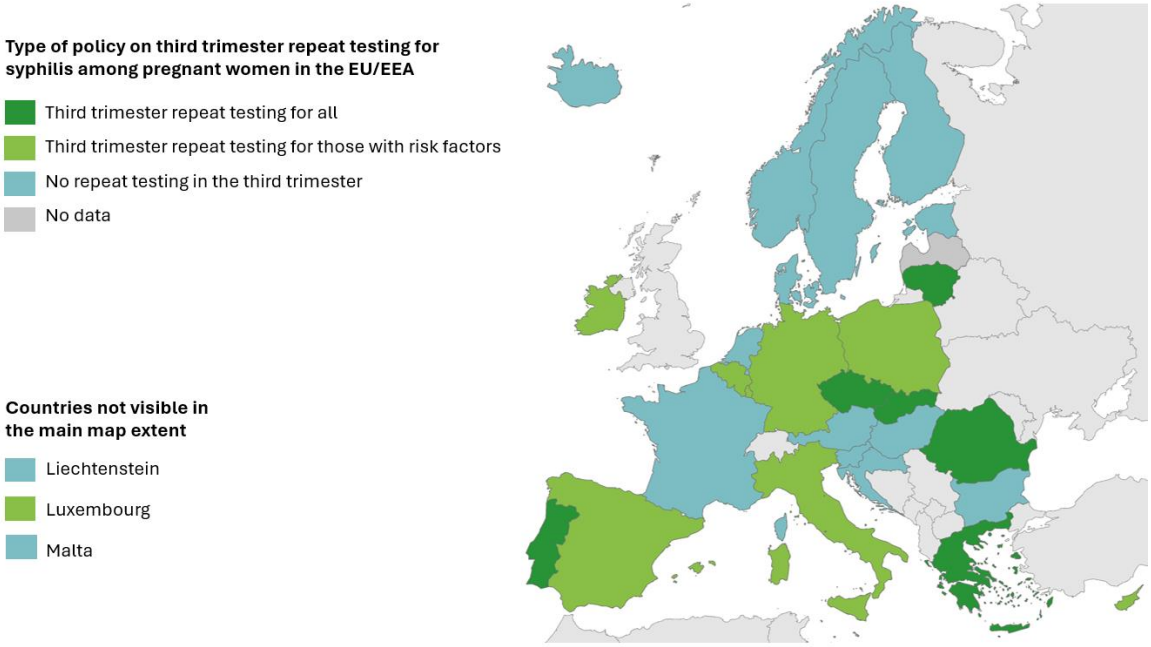
International recommendations promote universal[1], voluntary[2] and timely antenatal syphilis screening [7,8]. ECDC specifically recommends that syphilis screening is offered to all pregnant women during the first trimester alongside information on the rationale and benefits. Screening should be offered again during the third trimester for pregnant women at high risk of acquiring syphilis infection and for those who were not tested earlier, as well as at delivery to all women not previously screened [9].

In 2024, 29 EU/EEA countries reported information to ECDC on national policies, guidelines or recommendations on syphilis testing during pregnancy [10]. Twenty-four countries implemented a universal syphilis screening programme for pregnant women, while a mandatory[3] screening approach was followed in four countries (Austria, Czechia, Hungary and Poland). Croatia had a targeted screening approach, based on individual clinical indications and the local epidemiological situation.

Regarding the timing of syphilis screening during pregnancy, 28 EU/EEA countries reported syphilis testing policies for all pregnant women in the first trimester. National policies for the repeated screening of all pregnant women in the third trimester were reported by six countries (Czechia, Greece, Lithuania, Portugal, Romania, Slovakia), while in eight countries[4] this repeat testing is only offered to pregnant women with identified risk factors. Conversely, 15 EU/EEA countries with antenatal screening policies for syphilis do not systematically provide repeat testing in the third trimester (Figure 3).

Of note, only 11 counties[5] reported a policy that pregnant women, regardless of any risk factors, are tested at delivery if not before.

Figure 3. Type of national policy on third trimester repeat testing for syphilis during pregnancy in the EU/EEA (n=29), 2024



[1] Universal screening is the systematic voluntary testing offered to all pregnant women as part of routine care and regardless of individual risk factors. Consent may or may not be discussed.
[2] Testing systematically offered to the entire relevant population whereby refusal does not lead to immediate negative consequences, restrictions of civil rights or sanctions for the individual belonging to that population.
[3] Universal screening is where systematic voluntary testing is offered to all pregnant women as part of routine care regardless of individual risk factors. Consent may or may not be discussed. Mandatory screening is where legislation enforces syphilis screening of all pregnant women as part of antenatal care.
[4] Belgium, Cyprus, Germany, Ireland, Italy, Luxembourg, Poland, Spain.
[5] Bulgaria, Czechia, Estonia, France, Greece, Ireland, Lithuania, Malta, Netherlands, Portugal, Spain.

Figure 4. Overview of syphilis testing policies for pregnant women in the EU/EEA (n=29), 2024

Coverage of syphilis testing and treatment among pregnant women

While most EU/EEA countries had national antenatal screening policies in place, only five (Denmark, France, Germany, Netherlands and Portugal) had data on the proportion of pregnant women screened for syphilis which ranged from 50 to -100% [10]. Only Denmark provided data on the proportion of pregnant women who tested positive and were then treated for syphilis.

Conclusions and ECDC recommendations

Congenital syphilis is an easily preventable bacterial infection, yet many EU/EEA countries have recently reported an increase in the number of confirmed cases [4].

Within the EU/EEA, different implementation of European guidance on syphilis screening during pregnancy contributes to missed opportunities for timely detection, treatment, and follow-up among mothers and infants. In addition, substantial data gaps on antenatal syphilis testing and treatment coverage hinder countries' ability to monitor programme performance and assess progress towards the WHO 2030 elimination targets.

To enhance the efforts of EU/EEA countries towards the elimination of congenital syphilis transmission, the following recommendations should be considered:

Harmonise national policies in line with European guidance and recommendations

ECDC recommends EU/EEA countries update their policy for syphilis testing in pregnancy to ensure universal and voluntary syphilis screening in the first trimester, repeat testing of pregnant women with identified risk factors in the third trimester, and testing at delivery if not done before [7,8,11].

Strengthen national monitoring systems

ECDC encourages EU/EEA countries to improve reporting mechanisms to monitor screening practices and outcomes related to syphilis screening during pregnancy [4]. This can help to evaluate policy implementation, service gaps and support evidence-based decision-making. Such indicators should be aligned with the WHO 2030 elimination targets [12] and the WHO European Regional Action Plans [2].

Collecting surveillance data that link pregnant women who have syphilis to their birth outcomes can identify gaps in prevention to stop congenital syphilis and inform targeted interventions [6]. Countries can also investigate individual cases of congenital syphilis to understand where screening or treatment has failed and learn how future cases can be prevented.

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