Improving syphilis outcomes in culturally and linguistically diverse (CALD) populations

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Background: In recent years, syphilis – a harmful but highly treatable communicable disease – has seen resurgence in several countries despite being previously well-controlled under public health measures of the last century.[1,2] This pattern has been observed in Western Australia, where the crude rate of infectious syphilis has increased from 3.42 to 30.5 per 100,000 population in 2013 and 2022, respectively.[3,4] As part of initiating an equitable epidemic response, the Western Australian Syphilis Outbreak Response Group identified culturally and linguistically diverse (CALD) communities as a priority group for engagement. This project uses notification and consultation data to highlight the challenges and opportunities faced by CALD groups in context of the syphilis outbreak.

Aims: To report on trends in syphilis notifications among CALD populations living in metropolitan Perth and provide recommendations on issues requiring public health attention.

Methods: CALD status was defined as having country of birth outside Australia and non-English home language. Data on syphilis notifications were extracted from the Western Australian Notifiable Infectious Diseases Database by date of receipt of notification from 1 January 2020 to 31 December 2021. These data were analysed to report on epidemiological trends, including incidence rates, demographic and geographic distribution, and case characteristics. Stakeholder consultation was conducted with sixteen individuals through semi-structured interviews, with notes reviewed to identify key themes relating to syphilis prevention, detection and management in CALD communities.

Results: In 2020-21, 209 syphilis cases were reported in CALD communities. A total of 33 (16%) were in females of child-bearing age (15-44 years), of whom 14 were pregnant. Despite representing <20% of the population, CALD groups comprised 40% of all non-infectious syphilis notifications in metropolitan Perth, with two-thirds of CALD cases being non-infectious at time of detection. Most (62%) reported no prior treatment for syphilis. Case burden was highest in the 25-to-34-year age bracket for both infectious and non-infectious syphilis. Only 7% of primary and secondary syphilis notifications were detected via screening in CALD communities, compared to 22% in non-CALD groups.

CALD cases were likelier to be acquired overseas in areas of higher syphilis endemicity. Post-migration to Australia, CALD patients faced barriers that decreased engagement with sexual health, particularly among Vietnamese, Mandarin, and Italian language groups. Interpreter services were inefficiently organised in the primary care setting where 56% of syphilis cases were detected. Concerns about Medicare ineligibility, fear of deportation, and cultural/familial backlash affected propensity to engage. Health promotion to working-age CALD groups was limited. Time and billing pressures, as well as low awareness, were barriers to effective syphilis counselling at point-of-care.

Conclusions: CALD communities are disproportionately burdened by later-stage syphilis, indicating longer time spent in infective phases, increased risk of community and vertical transmission, and greater risk of tertiary syphilis. Efforts should be made to 1) reduce migrants' time to first contact with a health provider; 2) increase bilateral sexual health information flows during consults; and 3) increase GP-led opportunistic syphilis testing among target groups. Multicultural models of care and health promotion should be used throughout to facilitate syphilis prevention and timely case detection.

References

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