

Impact Evidence Package

Dual HIV/Syphilis Testing and Benzathine Penicillin G

How to Use This Package

This package is organized around the key elements of a Global Fund GC8 proposal. Each section presents the relevant evidence and where to use it in the GC8 application. The package draws on published peer-reviewed studies and WHO-affiliated modeling.

Sections in this package:

- **Section 1:** Why Dual Testing Fits GC8 – the strategic case
- **Section 2:** The Evidence Base – burden, diagnostics, treatment efficacy, and cost-effectiveness
- **Section 3:** Country Adoption Examples – Cameroon, Liberia, and Zambia
- **Section 4:** Ready-to-Adapt Narrative Templates for GC8 proposals
- **Section 5:** Quick Reference Evidence Summary
- **Annex:** Evidence Brief – a one-page companion for country dialogues and CCM meetings

Section 1: The Strategic Case for Dual Testing in GC8

Value for money, integration, and affordability

1.1 The Case for Priority: Value for Money and Global Evidence

Antenatal syphilis screening and treatment ranks among the most cost-effective interventions available to Global Fund-eligible countries – and the published evidence is unambiguous.

The cost-effectiveness literature is consistent across geographies:

Study	Finding
Silke et al. 2024	Antenatal syphilis screening had the lowest ICER of 14 Global Fund-eligible interventions in 81 of 128 countries (63%).
Rodriguez et al. 2021	Cost-saving in all four countries modeled: Kenya –\$26, South Africa –\$559, Colombia –\$844, Ukraine –\$454 per pregnancy.
Kuznik et al. 2013	\$2–\$48 per DALY averted (average \$11) in 43 sub-Saharan African countries. Universal SSA screening costs ~\$20.8M/year and would prevent ~64,000 stillbirths and 25,000 neonatal deaths annually.
Bristow et al. 2016	In Malawi, dual HIV/syphilis testing produced the lowest total costs and fewest DALYs of four ANC screening algorithms among 100,000 ANC patients. Cost-saving versus HIV-only testing in almost all Monte Carlo simulations.

The economic burden of inaction is measurable. WHO estimated 700,000 congenital syphilis cases and **390,000 adverse birth outcomes** globally in 2022, including 150,000 early fetal deaths and stillbirths, 70,000 neonatal deaths, 115,000 infants with a clinical diagnosis of congenital syphilis, and 55,000 preterm or low-birthweight births. Of these, **53% occurred in women who attended ANC but were never tested** – not failures of access, but failures to test at the point of care where women were already present.

Against [~\\$309 million](#) in annual global medical costs from untreated maternal syphilis, universal SSA screening costs approximately \$20.8M/year – a return of approximately **15 to 1 on investment**. At **\$0.84 per dual test** – only \$0.04 more than the single HIV test countries already procure – and benzathine penicillin G available at [\\$0.39–\\$3.19](#) per dose, the commodity cost of detecting and treating a syphilis-positive pregnant woman is among the lowest of any maternal health intervention.

1.2 Feasibility: Integration into Existing HIV and ANC Platforms

The HIV/syphilis dual rapid diagnostic test integrates into existing HIV testing workflows without requiring new infrastructure, additional specialized cadres, or changes to antenatal service delivery.

- The dual test replaces the single HIV rapid diagnostic test already in use at ANC, detecting both HIV and syphilis from the same blood sample in the same 20-minute window, administered by the same nurse or community health worker already providing antenatal HIV testing.
- No laboratory equipment is required. No additional patient visit is needed.
- Nurses and community health workers administer the test – no specialized cadre is required, and no major investment beyond the commodity itself.
- Multiple WHO-prequalified brands are available from competing suppliers, ensuring countries are not dependent on a single source and that pricing remains stable as procurement volumes grow.

[WHO](#) recommends the dual test as the mechanism to immediately close the gap between HIV and syphilis testing coverage among pregnant women and positions it as a core tool for achieving the [WHO Triple Elimination Initiative](#) targets – eliminating mother-to-child transmission of HIV, syphilis, and hepatitis B by 2030. **The GC8 cycle is the last full Global Fund cycle before the 2030 target year. Countries that secure dual test and BPG procurement through GC8 will be positioned to demonstrate the coverage trajectories required for WHO validation.**

There is also a direct HIV program rationale for addressing syphilis within the HIV PMTCT encounter. Women co-infected with HIV and syphilis are **2.7 times more likely to transmit HIV to their children** than women without syphilis. Dual testing closes this gap within the existing HIV encounter at no additional visit or infrastructure cost.

Real-world evidence from sub-Saharan Africa confirms that introduction of rapid syphilis testing alongside HIV testing or adoption of the HIV/syphilis dual test consistently achieves high, simultaneous coverage of both HIV and syphilis screening:

Study	Finding	p-value	Use in proposal
Betrán et al. 2018 Stepped-wedge RCT Mozambique	Syphilis screening: 65.7% → 95.5% after dual test provision (aOR: 23.50, 99% CI 20.56–26.86). Treatment: 60.8% → 86.2% . (aOR: 2.49, 99% CI 1.38–4.51). HIV testing maintained throughout.	Screening: p<0.0001 Treatment: p<0.024	Narrative justification; intervention approach
Althabe et al. 2019 Cluster RCT DRC & Zambia	Screening: 99.9% (IQR 99.0–100.0) with behavioral support + supplies vs. 93.8% (IQR 85.0–98.9) with supplies only (absolute difference 6.1%, 95% CI 1.1–14.1). Treatment among syphilis-positive women: 100% (IQR 99.7–100.0) in intervention clinics vs. 43.2% (IQR 2.6–83.2) in control clinics (absolute difference 56.8%, 95% CI 12.8–99.0).	Screening: p=0.00092 Treatment: p=0.0028	Scalability; SSA implementation evidence

Study	Finding	p-value	Use in proposal
Bahemuka et al. 2025 Before-and-after study Uganda	Syphilis testing: 49.1% → 84.0% (RR 1.71, 95% CI 1.64–1.78) following dual test introduction.	p<0.001	Most recent real-world evidence; scalability argument
MedAccess / CHAI 2026 Global market data	By end of 2024: 31 million pregnant women accessed dual testing across 60+ LMICs ; HIV testing rates maintained or improving in documented settings; >90,000 stillbirths averted.	N/A	Global adoption; market stability argument

1.3 Affordability: The Cost Profile of the Intervention

At **\$0.04 more per test** than the single HIV rapid diagnostic test countries currently procure for antenatal care, the commodity cost of adding syphilis detection at ANC is effectively marginal.

- Dual HIV/syphilis test: **\$0.84/test** ex-works (available to all eligible LMICs)
- Single HIV rapid diagnostic test: ~\$0.80/test. The marginal cost of syphilis detection: **\$0.04**
- Benzathine penicillin G 2.4 MIU (first-line treatment): **\$0.39–\$3.19 per dose**
- Direct savings to procurers from reduced market pricing already exceeded **\$11.3 million globally** by end of 2024

Preventing one stillbirth through antenatal care packages costs an estimated **\$4,781–\$10,571** in LMIC settings. Against a commodity cost of \$0.84 per dual test and \$0.39–\$3.19 per BPG dose, the value-for-money case is straightforward.

Countries that build dual test procurement into their GC8 applications establish the quantification, ordering, and distribution infrastructure required for ongoing procurement – whether funded through Global Fund, USG bilateral agreements, UNICEF, or domestic health budgets. The marginal budget requirement to sustain dual testing after scale-up is achievable within routine national health spending in most focal country contexts.¹

Section 2: The Evidence Base

Burden, diagnostics, treatment efficacy, and cost-effectiveness

2.1 Global Burden and the Screening Gap

Use this evidence in the Programmatic Gap Table and the gap analysis narrative. It establishes why syphilis demands priority attention and why dual or triple testing is the right response at ANC.

Finding	Key Statistic	Source	Use in Proposal
Global adverse birth outcomes from congenital syphilis	390,000 per year: - 150,000 stillbirths/fetal deaths - 70,000 neonatal deaths - 115,000 congenital syphilis cases - 55,000 preterm/low birthweight births	WHO, 2024	Programmatic gap table; narrative introduction
Worsening trend	Babies born today are 11% more likely to be exposed to congenital syphilis	WHO, 2024	Urgency framing; investment case

¹ HIV/syphilis/hepatitis B triple rapid diagnostic tests are also entering the market at a unit price of \$2.60. Countries with significant antenatal hepatitis B screening gaps may wish to evaluate triple test options against country epidemiology and available budget. For market information, see: [CHAI Integrated Screening Market Memo, March 2026](#).

Finding	Key Statistic	Source	Use in Proposal
	than eight years ago (473 → 523 cases per 100,000 live births)		
The missed opportunity at ANC	53% of adverse outcomes occur in women who attended ANC but were never tested for syphilis	WHO, 2024	Gap analysis; justification for intervention at ANC point-of-care
Economic cost of inaction	~\$309M in annual global medical costs from untreated maternal syphilis; universal SSA screening (\$20.8M/year) yields a 15:1 return on investment	Kahn et al., 2014	Value for money; budget justification
Cost of preventable stillbirths	\$4,781–\$10,571 per stillbirth averted in LMIC settings	Heazell et al., 2016	ROI argument; comparison with commodity cost (\$0.84)
HIV/syphilis co-infection and HIV MTCT risk	Women co-infected with HIV and syphilis are 2.7x more likely to transmit HIV to their child	Mwapasa et al., 2006	HIV program completeness argument; integration rationale

2.2 Diagnostic Evidence: Dual Rapid Testing Works

Use this evidence in the funding narrative to justify the specific intervention approach. These are the strongest available studies on the introduction of rapid syphilis testing alongside HIV testing and adoption of the HIV/syphilis dual test in sub-Saharan Africa and comparable LMIC settings.

Study & Design	Key Findings	p-value	Use in Proposal
Betrán et al. 2018 Stepped-wedge RCT Mozambique	Syphilis screening: 65.7% → 95.5% after rapid syphilis test provision (aOR: 23.50, 99% CI 20.56–26.86). Treatment: 60.8% → 86.2% . (aOR: 2.49, 99% CI 1.38–4.51). HIV testing maintained throughout.	Screening: p<0.0001 Treatment: p<0.024	Primary justification for intervention approach; strong SSA RCT evidence for rapid scale-up via commodity provision
Althabe et al. 2019 Cluster RCT DRC & Zambia	Screening: 99.9% (IQR 99.0–100.0) with behavioral support + supplies vs. 93.8% (IQR 85.0–98.9) with supplies only (absolute difference 6.1%, 95% CI 1.1–14.1). Treatment among syphilis-positive women: 100% (IQR 99.7–100.0) in intervention clinics vs. 43.2% (IQR 2.6–83.2) in control clinics (absolute difference 56.8%, 95% CI 12.8–99.0).	Screening: p=0.00092 Treatment: p=0.0028	Replication and scalability evidence; demonstrates that near-universal coverage is achievable in SSA settings with existing health system infrastructure
Bahemuka et al. 2025 Before-and-after study Uganda	Syphilis testing: 49.1% → 84.0% (RR 1.71, 95% CI 1.64–1.78, p<0.001)	p<0.001	Most recent real-world SSA evidence; strengthens the case that trial findings replicate in routine settings

2.3 Treatment Efficacy: Benzathine Penicillin G

Use this evidence in your technical narrative and budget justification. It answers the question: what does treating a syphilis-positive pregnant woman actually achieve?

Core treatment requirement: A single intramuscular injection of benzathine penicillin G 2.4 million units, administered **at least four weeks before delivery**, produces the reductions below. BPG is the only antibiotic proven effective for preventing MTCT of syphilis.

Adverse Outcome Prevented	Reduction	95% CI	Source	Studies
Stillbirths and early fetal deaths	82%	67–90%	Blencowe et al., 2011	8 studies
Neonatal deaths	80%	68–87%	Blencowe et al., 2011	Multiple
Congenital syphilis cases	97%	93–98%	Blencowe et al., 2011	3 studies
Preterm delivery	64%	53–73%	Blencowe et al., 2011	Multiple

2.4 Cost-Effectiveness: Published Literature

Use the table below in your budget justification and value-for-money section.

Study	Setting	Key Finding
Silke et al. 2024	128 GF-eligible countries; meta-regression of published CE analyses	Antenatal syphilis screening had the lowest median ICER of 14 GF-eligible interventions in 81 countries (63% of 128). Median ICERs range from \$3/DALY (Equatorial Guinea) to \$3,473/DALY (Ukraine). Country-specific ICERs available in Figure 4 of the paper.
Rodriguez et al. 2021	Kenya, South Africa, Colombia, Ukraine	Cost-saving in all four countries : Kenya –\$26, SA –\$559, Colombia –\$844, Ukraine –\$454 per pregnancy versus no screening.
Kuznik et al. 2013	43 sub-Saharan African countries	\$2–\$48/DALY averted (average \$11). Universal SSA screening (~\$20.8M/year) would prevent ~64,000 stillbirths, 25,000 neonatal deaths, and 32,000 congenital syphilis cases annually.
Bristow et al. 2016	Malawi – 100,000 ANC patients (cohort decision model)	Dual HIV/syphilis testing had the lowest total costs (\$21.5M) and fewest DALYs lost (108,693) of four ANC screening algorithms. Almost always cost-saving versus HIV-only testing across Monte Carlo simulations.
Kahn et al. 2014	Global modeling; high-prevalence LMIC settings	Net savings of up to \$12.3M per million pregnancies in high-prevalence settings. Against ~\$309M in annual global medical costs from untreated maternal syphilis, universal SSA screening (\$20.8M/year) returns approximately 15 to 1 on investment .

Section 3: Country Adoption Examples

Cameroon, Liberia, and Zambia

How to use this section: These examples illustrate how countries have integrated dual testing into existing HIV and ANC platforms. They support CCM discussions and MOH advocacy – for example, as reference points during Country Dialogue or when justifying dual or triple test inclusion in a GC8 programmatic gap table.

Cameroon

Before Dual Test Adoption	
HIV screening	Approximately 85% of ANC-attending pregnant women tested for HIV
Syphilis testing	Estimated that approximately 50% of pregnant women were screened, but only through lab-based testing which minimized the ability to test and treat on the same day. National guidelines did not reference syphilis screening.
After Dual Test Adoption: Policy and System Integration	
National guidelines	HIV/syphilis dual testing and ANC algorithm validated in national HIV/AIDS Prevention and Treatment Guidelines (August 2023). National STI guidelines revised and validated (August 2023).
Strategic plan	Syphilis included in National HIV Strategic Plan under priority area 4: triple elimination of HIV, syphilis, and hepatitis B in the context of MTCT.
Coordination	Monthly dual test task force constituted and meeting since August 2023.
Universal health coverage	Syphilis screening and treatment added to national UHC package for pregnant women (October 2025). First dose of BPG now covered for all enrolled women.
Training scale-up	1,700 health facilities and 17,000+ healthcare providers trained. Among trained facilities, 79% syphilis testing coverage compared to 83% for HIV.

Liberia

Before Dual Test Adoption	
HIV screening	Approximately 80% of ANC-attending pregnant women tested for HIV
Syphilis testing	<8% of ANC-attending pregnant women. Lab-based testing only – no rapid test available.
After Dual Test Adoption: Coverage	
Syphilis screening coverage	National syphilis screening coverage rose from <8% to approximately 88% nationally.
Syphilis treatment coverage	Approximately 94%.
After Dual Test Adoption: Policy and System Integration	
National guidelines	HIV testing algorithm updated to incorporate dual HIV/syphilis testing for ANC populations (2020). Syphilis testing and treatment added to the revised HIV Testing and Counseling register.
National scale-up	All 566 ANC health facilities in Liberia trained across all 15 counties. Training cascade completed nationally.

DHIS2 integration	Syphilis screening and treatment indicators integrated into DHIS2 national health information system.
--------------------------	---

Zambia

Before Dual Test Adoption	
HIV screening	Approximately 93% of ANC-attending pregnant women tested for HIV
Syphilis testing	Approximately 44% of ANC-attending pregnant women. No national standard for dual testing.
After Dual Test Adoption: Coverage	
Syphilis screening coverage	Approximately 75% and climbing as more facilities are trained in dual testing.
Syphilis treatment coverage	Approximately 90%.
After Dual Test Adoption: Policy and System Integration	
Training scale-up	3,000+ health facilities trained; 24,00+ healthcare providers trained
Dual test curriculum integration	Dual testing integrated into the National Curriculum for the HIV Rapid Test Continuous Quality Improvement Program — ensuring all newly certified HIV testing staff are trained on the dual test going forward.

Section 4: Ready-to-Adapt Narrative Templates

GC8 proposal-ready language — replace bracketed placeholders with country-specific data

These templates follow the structure that has been used successfully to include dual testing in GC7 proposals. The language is calibrated for GC8 Technical Review Panel reviewers — formal, evidence-grounded, and concise. All placeholders are marked in brackets; adapt them to your country's specific data and program context.

Template A: Programmatic Gap Table Narrative

Use in: *Programmatic Gap Table narrative section*

[COUNTRY]'s National [HIV Strategic Plan / Triple EMTCT Operational Plan] explicitly identifies syphilis under the elimination of mother-to-child transmission framework, alongside HIV and hepatitis B, as a national priority. Syphilis screening and treatment for pregnant women is included in [Module 4 / PMTCT module] of this funding request as an integrated continuation of [COUNTRY]'s PMTCT programming.

Despite [X%] HIV testing coverage among pregnant women attending antenatal care, syphilis testing coverage stands at [X%] — a gap of approximately [X] untested pregnant women annually. With an active syphilis prevalence of [X%] among pregnant women, this gap translates to approximately [X] syphilis-infected pregnancies each year where infection goes undetected and untreated.

Burden calculation: With an annual cohort of approximately [XX] pregnant women attending ANC and an active syphilis prevalence of [XX%], there may be as many as [XX] adverse pregnancy outcomes due to congenital syphilis in [COUNTRY] annually. Globally, 53% of adverse outcomes from syphilis occur among women who attend ANC but are never tested (WHO, 2024). Without action, this gap will worsen: babies born today are 11% more likely to be exposed to congenital syphilis than eight years ago (WHO, 2024).

The HIV/syphilis dual rapid diagnostic test addresses this gap through [COUNTRY]'s existing PMTCT platform. It replaces the single HIV rapid diagnostic test currently in use at ANC — using the same test encounter, the same health worker, and the same national algorithm. Results are available in 20 minutes. Treatment with benzathine penicillin G, administered at least four weeks before delivery and available at \$0.39–\$3.19 per dose (UNICEF

Supply Catalog), prevents over 80% of congenital syphilis adverse outcomes (Blencowe et al., 2011). Service delivery will be strengthened through: (i) adequate commodity stock; (ii) capacity building of providers and community health workers; and (iii) validated training tools already in use in [COUNTRY / comparable settings].

[COUNTRY] targets [X%] syphilis screening coverage and [X%] syphilis treatment coverage by [year], aligned with WHO Triple Elimination Initiative benchmarks of 95% coverage in both indicators by 2030. Other partners contributing to this module include [partner names, commodities, and timeframes]. Global Fund funding covers [X%] of total commodity costs for this module over [grant period].

[INSERT country-specific data: current screening rate, ANC attendance, syphilis prevalence, estimated annual adverse outcomes. Data sources: WHO Global Health Observatory, UNAIDS AIDsinfo, national HMIS/DHIS2, WHO CS Estimation Tool.]

Template B: Budget Justification (Value for Money)

Use in: *Budget justification and value-for-money section*

The marginal cost of integrating HIV/syphilis dual testing into [COUNTRY]'s PMTCT program is \$0.04 per test – from approximately \$0.80 for the single HIV test currently procured to \$0.84 for the HIV/syphilis dual rapid diagnostic test (MedAccess and CHAI, 2026). Benzathine penicillin G 2.4 MIU is available at \$0.39–\$3.19 per dose through the UNICEF Supply Catalog.

For [COUNTRY], with [X] pregnant women attending ANC annually and an active syphilis prevalence of [X%], the estimated annual commodity cost of full dual testing and treatment coverage is approximately \$[X]. The total commodity budget for dual tests and BPG over the GC8 grant period (2027–2029) is \$[X], representing [X%] of this module's total cost.

Published cost-effectiveness analyses consistently identify antenatal syphilis screening as among the highest-value interventions available for Global Fund investment:

- Lowest ICER of 14 GF-eligible interventions in 81 of 128 countries analyzed (Silke et al., 2024)
- \$2–\$48 per DALY averted across 43 sub-Saharan African countries, at an average of \$11 (Kuznik et al., 2013)
- Cost-saving versus no screening in all four countries modeled, including Kenya (–\$26/pregnancy) (Rodriguez et al., 2021)

WHO classifies interventions below 1x GDP per capita as highly cost-effective. Based on published modeling, antenatal syphilis screening falls well below that threshold in all GC8 focal country contexts.

[INSERT: name of other partners contributing to commodity procurement, with amounts and years. Confirm that partner contributions and GF ask are clearly differentiated and do not overlap.]

Template C: Strategic Alignment and Integration Rationale

Use in: *Main funding narrative, strategic alignment section*

Integrating HIV/syphilis dual testing into [COUNTRY]'s PMTCT program directly advances WHO's Triple Elimination Initiative, which calls for 95% testing and 95% treatment coverage for syphilis among pregnant women by 2030 – alongside equivalent targets for HIV and hepatitis B. [COUNTRY's National HIV Strategic Plan / Triple EMTCT Operational Plan] positions syphilis screening and treatment as a national priority within the PMTCT framework, under [specific plan reference and priority number].

The GC8 HIV Prioritization Guidance and Modular Framework Handbook explicitly endorses HIV/syphilis dual rapid diagnostic tests as the recommended first-line test in ANC settings, positioning this investment within GC8's framework for integrated service delivery and health system strengthening.

The case for integration goes beyond epidemiology. Women co-infected with HIV and syphilis are 2.7 times more likely to transmit HIV to their child than women without syphilis (Mwapasa et al., 2006). A comprehensive PMTCT program that does not address syphilis leaves a measurable gap in HIV program outcomes. The dual test closes this gap within the existing HIV testing encounter – no new infrastructure, no new cadre, no additional visit.

The dual HIV/syphilis rapid diagnostic test replaces the single HIV test already in use at ANC. It uses the same fingerstick, the same ANC infrastructure, and the same trained health worker already conducting HIV screening.

The competitive market of WHO-prequalified brands – with more than 31 million tests procured across 60+ countries by end of 2024 – ensures stable pricing and supply continuity (MedAccess, 2026).

The intervention's commodity cost profile – \$0.84 per dual test and \$0.39–\$3.19 per BPG dose – makes ongoing procurement achievable within national health budgets beyond the GC8 grant period. Countries that embed dual test and BPG procurement in their GC8 applications establish the quantification, ordering, and distribution infrastructure required for continued procurement through any financing stream: Global Fund, UNICEF, or domestic budget.

Section 5: Quick Reference Evidence Summary

Topic	Key Figure	Source
Annual adverse birth outcomes from congenital syphilis	390,000+ total: 150,000 stillbirths/fetal deaths; 70,000 neonatal deaths; 115,000 congenital syphilis cases; 55,000 preterm births	WHO, 2024
Worsening trend	11% increase in congenital syphilis exposure risk over 8 years	WHO, 2024
Missed at ANC	53% of adverse outcomes occur in women who attend ANC but are never tested	WHO, 2024
HIV/syphilis co-infection risk	2.7x increased HIV MTCT risk for women co-infected with syphilis	Mwapasa et al., 2006
Global economic cost of inaction	~\$309M annual global medical costs from untreated maternal syphilis	Kahn et al., 2014
Dual test cost	\$0.84/test – only \$0.04 more than the single HIV test	MedAccess, 2026
BPG cost	\$0.39–\$3.19 per dose (2.4 MIU)	UNICEF Supply Catalog
CE ranking	Lowest ICER of 14 GF-eligible interventions in 81 of 128 countries (63%)	Silke et al., 2024
CE range (SSA)	\$2–\$48/DALY averted (average \$11) across 43 SSA countries	Kuznik et al., 2013
CE (Malawi modeled)	Dual testing: lowest cost and fewest DALYs of 4 ANC screening algorithms; cost-saving vs HIV-only in nearly all Monte Carlo runs	Bristow et al., 2016
ROI of universal SSA screening	~15:1 return: \$20.8M/year cost vs ~\$309M prevented in medical costs	Kahn et al., 2014
Stillbirth reduction with BPG	82% (95% CI: 67–90%)	Blencowe et al., 2011

Topic	Key Figure	Source
Neonatal death reduction with BPG	80% (95% CI: 68–87%)	Blencowe et al., 2011
Congenital syphilis reduction with BPG	97% (95% CI: 93–98%)	Blencowe et al., 2011
Preterm birth reduction with BPG	64% (95% CI: 53–73%)	Blencowe et al., 2011
Screening RCT – Mozambique	Syphilis screening: 65.7%→95.5% (p<0.0001); treatment: 60.8%→86.2% (p<0.024)	Betrán et al., 2018
Screening RCT – DRC & Zambia	99.9% syphilis screening and 100% treatment achieved with behavioral support (p=0.0028)	Althabe et al., 2019
Real-world adoption – Uganda	Syphilis testing: 49.1%→84.0% (RR 1.71, 95% CI 1.64–1.78, p<0.001)	Bahemuka et al., 2025
Global market scale	31M+ pregnant women tested; 60+ LMICs; >90,000 stillbirths averted by end of 2024	MedAccess, 2026

Annex: Evidence Brief

The [Syphilis Evidence Brief](#) is a companion to this package, designed for use in country dialogues, CCM meetings, and direct discussions with Ministry of Health officials and donors. It presents the core evidence for dual HIV/syphilis testing and BPG in a concise one-page format suitable for sharing with stakeholders.