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ORIGINAL ARTICLE

HEALTHCARE IN THE FACE OF SYPHILIS DIAGNOSIS DURING PREGNANCY: YOUNG WOMEN'S PERCEPTIONS

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ABSTRACT

Objective: to understand the perceptions of young women diagnosed with syphilis during pregnancy regarding the disease and healthcare. **Methodology:** an exploratory, cross-sectional study with a qualitative approach, supported by Symbolic Interactionism. Developed in the maternity ward of a city in the countryside of the state of São Paulo. Data collection took place between July 2023 and April 2024. Sixteen women, in the postpartum period, aged between 15 and 24 years, diagnosed with syphilis during pregnancy, were interviewed. Data analysis was guided by thematic analysis and occurred concomitantly with data collection, ending in June 2024. The study was approved by the Research Ethics Committee. **Results:** the social stigma of syphilis reverberated in relationships with healthcare professionals and negatively interfered with care. The topics "Healthcare professionals: interactions and (mis)information", "Treatment of pregnant women and their partners" and "Family and partnership: interactions and (lack of) support" portray perceptions about syphilis and healthcare. **Final considerations:** it is urgent to revisit the care approach in the context of gestational syphilis, valuing women as individuals and considering the social determination of their lives and health. The internet has emerged as an informational resource, with indications that it should be considered in health education actions.

Keywords: Syphilis. Adolescent Health. Public Health. Pregnancy In Adolescence. Maternal Behavior.

INTRODUCTION

Syphilis is an infection caused by the bacterium *Treponema pallidum*. Its main form of transmission is sexual, but it can occur vertically when the disease is diagnosed during pregnancy (gestational syphilis (GS)) and is not treated or treated inadequately. When the bacteria is transmitted to the fetus, it is known as congenital syphilis (CS)(1).

A large proportion of people with syphilis are asymptomatic. If left untreated, the disease can progress to more severe forms, with consequences for the nervous and cardiovascular systems. Vertical transmission can occur at any stage of pregnancy or the mother's disease, and can have severe consequences for the fetus. Among women with untreated syphilis, 40% of pregnancies result in spontaneous abortion, in those without effective treatment; 11% of pregnancies will result in fetal death at term; and 13% will result in preterm birth or low birth weight(1). Approximately 20% of newborns will present signs suggestive of CS(1).

Syphilis is a health problem in Brazil and worldwide, and reporting has been mandatory since 2005. The fact is that our country was already facing difficulties in controlling the disease; however, these difficulties were aggravated during and after the COVID-19 pandemic, largely due to underreporting and incomplete monitoring of cases, especially of GS and CS(2). However, it is known that reporting cases is essential for decision-making, health surveillance, care management, trinomial screening (father, mother and newborn) and appropriate treatment.

The Epidemiological Bulletin revealed, between January and June 2022, the occurrence of

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31,090 cases of GS and 12,014 of CS in Brazil(3), highlighting them as public health problems that require longitudinal healthcare and surveillance actions, constituting a challenge to the Brazilian Healthcare system (In Portuguese, *Sistema Único de Saúde* - SUS)(4).

In 2021, according to the Ministry of Health (MoH), 74,095 cases of syphilis were reported in pregnant women in Brazil (incidence rate of 27.1 per 100,000 inhabitants)(3). For this reason, the World Health Organization (WHO) has made syphilis a priority for implementing actions. In fact, the 2030 Agenda for Sustainable Development has made commitments to reduce the incidence of this disease by 90%(4).

The WHO and the Brazilian MoH chronologically consider adolescents to be individuals between 10 and 19 years old, and young people to be those between 15 and 24 years old(5). In 2022, young people and adolescents accounted for approximately 22% of the Brazilian population(6). During this phase, sexuality manifests itself in unique ways. It is common for there to be curiosity and desires to have romantic relationships and sexual experimentation, an aspect that predisposes this population segment to acquiring sexually transmitted infections (STIs)(1,7).

Adolescence pregnancy is a situation of considerable incidence in Brazil as well as being one of the main causes of morbidity and mortality among women in this age group(5). Regarding syphilis, an exponential increase in incidence among young people and adolescents has been identified in recent times(8). Thus, preventing the transmission of syphilis in this population involves informational support and empowerment for changes in sexual behavior(9).

In the meantime, the urgency of intervention to reduce the rate of GS and CS is highlighted through the availability and quality of prenatal care, the right to routine serological tests to detect the disease during prenatal care and childbirth, and above all the monitoring of these women and their children(10). Therefore, it becomes evident that women, from the time they are diagnosed with syphilis during pregnancy, must be monitored and treated, including after childbirth, with indications for quarterly follow-up until the 12th month postpartum(2). In this regard, one cannot fail to acknowledge the suffering and concerns arising from the diagnosis of syphilis, especially when it occurs in adolescence and youth. The strategic role of nurses in prenatal care, in GS treatment and in vertical transmission prevention, is highlighted(11).

Therefore, this study is justified by seeking to expand and deepen knowledge regarding healthcare in the face of GS in youth, relevance aligned with the reemergence of the disease with increasing rates in adolescence. Therefore, the question was: how do young women diagnosed with syphilis during pregnancy conceive and experience the disease and healthcare? The objective was to understand the perceptions of young women diagnosed with syphilis during pregnancy about the disease and healthcare.

METHODOLOGY

This is an exploratory study with a qualitative approach, given the intention of accessing specific experience, with attention to meanings and perceptions(12). Symbolic Interactionism was used as theoretical framework, since it understands meanings as the result of social interactions. Its focus is to understand the way in which people perceive the facts around them and how they act in relation to them. Furthermore, the way in which human beings interpret facts and behave towards someone or something depends on the meaning given to the elements present in this context. Meanings result from interactional processes and are modifiable(13). This study was structured according to the COnsolidated criteria for REporting Qualitative research (COREQ)(14).

The research was developed together with the maternity hospital of *Santa Casa de Misericórdia* in a city in the center-east of the countryside of the state of São Paulo, Brazil, which has an estimated population of 254,857 inhabitants(15). This location was chosen because it is the only public service for childbirth in the city, and, therefore, has a better chance of identifying women with the potential to participate in the study.

Participants were selected by convenience and had to meet the following inclusion criteria: having been diagnosed with syphilis during pregnancy; having been diagnosed between the ages of 15 and 24; and having conditions to engage in comprehensible dialogue. Exclusion criteria were not being emancipated or under 18 years of age on the date of data collection. Participants were recruited at the rooming-in sector of the maternity hospital of *Santa Casa de Misericórdia* in the city. A nurse from the sector consulted women about their interest in learning about the study. When the study was conducted, the second author of the article, who had experience in qualitative studies, went to the location and explained the research to the women in detail and, upon acceptance, scheduled the interview for after hospital discharge, with a telephone call being made the day before to confirm the interview.

Twenty-three women were invited to participate in the study, three of whom declined to participate, claiming they were not interested in discussing the subject. Four of them, despite accepting the invitation, did not respond to subsequent attempts to contact them. It is worth noting that a maximum of three attempts were made to contact each woman. In total, 16 participants were interviewed, all in the postpartum period. It is worth noting that prior to the interviews, the Informed Consent Form was read together in order to clarify doubts, and then, if they agreed, they were signed. The interviews were semi-structured(16) and, therefore, developed based on a set of previously formulated questions, but which allowed for the exploration of other elements put forward for discussion. They took place in person, at the interviewees' homes, from July 2023 to April 2024, and were scheduled on days and times agreed with participants. All were conducted by the second author, a nursing undergraduate with experience in qualitative studies, supervised by the first author.

No pilot interviews or repeat interviews were conducted. It is important to note that no type of relationship was established with participants by the interviewer before the study. During the interviews, there was no one else present in the home environment, except for the interviewee's child. In relation to the number of participants, the sufficiency criterion was adopted, based on the understanding achieved about the phenomenon of interest(19).

Participant characterization data were collected as the first stage of the interview, including age, race, number of pregnancies, number of living children, number of prenatal consultations, treatment received, history of reinfection, who they live with and provider(s) of the family income. This information was analyzed based on frequency distribution.

The initial trigger for the second stage of the interview was the following question: remember when you were diagnosed with syphilis and tell me how you received care. Then, in conjunction with the above, the following questions were asked throughout the interview: (1) Did you have knowledge about the disease? How did you obtain this knowledge? (2) Did the professionals try to clarify things about syphilis for you? Did the explanation you received expand your knowledge? (3) How did you feel when you received the diagnosis, what came to your mind? What actions were taken? (4) Was your partner/father of the child approached by the professionals? (5) Did you and your partner/father of the child talk about the situation? How was the conversation? (6) What concerns arose with the diagnosis? How did you deal with these concerns? (7) How did you perceive the health team's work during your prenatal care? (8) And now in your postpartum period?

The interviews lasted about 35 minutes. All were audio-recorded, with participants' authorization, and later transcribed using Transcriptor® software. Immediately afterwards, the material was double-checked to ensure its validation.

Data analysis occurred concurrently with data collection, ending in June 2024, and was supported by thematic analysis(17). This analytical process involved familiarizing the data through repeated readings of transcripts as well as exporting them to the MAXQDA® software, a tool that assisted in data coding, exploration and organization(18). With this support, excerpts were selected with the aim of generating codes, which later composed the topics, from which the results were reported. To establish consensus and validate these, the other authors of the article contributed by reviewing the coding, discussing divergences and establishing consensus.

The study was approved by the Research Ethics Committee, under Opinion 6,200,614 and Certificate of Presentation for Ethical Consideration 69634923.1.0000.5504. All ethical precepts were respected, following the Brazilian National Health Council standards. Participants' identities were preserved, and excerpts were identified with the letter "W", alluding to the word "woman", followed by the Arabic number representing the order of their participation in the study.

RESULTS AND DISCUSSION

Sixteen pregnant women who had a positive Venereal Disease Research Laboratory (VDRL) test during prenatal care and/or delivery were interviewed. At the time of interviews, all of them were already in the postpartum period. Participants' mean age was approximately 18 years. Of these, 11 reported having attended more than six prenatal consultations in Primary Health Care units. On the other hand, for five of them, the number of visits to the service was below the recommended number, with two being the lowest number. Moreover, three of them had a history of reinfection with *Treponema pallidum*, and two of them had received inadequate treatment. All of the women in this study were black or brown. Additional data characterizing participants are presented in Chart 1.

Chart 1. Characterization of study participants regarding age, number of children, who they live with and source of income. São Carlos, São Paulo, Brazil, 2024

Woman	Gestation	Age	Children	Who do you live with?	Income
Woman 1	1	18	1	Partner	Partner's income
Woman 2	4	24	4	With children	Social benefits
Woman 3	1	17	1	With parents	Parents' income
Woman 4	2	21	2	Mother and children	Mother's income and social benefits
Woman 5	1	17	1	Partner	Partner's income
Woman 6	3	21	2	Partner	Own and partner's income
Woman 7	2	23	2	Mother and children	Mother's income and social benefits
Woman 8	2	18	2	Partner and children	Partner's income
Woman 9	4	24	4	Mother and children	Mother's income and social benefits
Woman 10	2	22	2	Partner and children	Partner's income
Woman 11	3	23	3	Mother and children	Mother's income and social benefits
Woman 12	2	19	2	Partner and children	Partner's income
Woman 13	1	16	1	Parents and sisters	Mother's income and social benefits
Woman 14	2	20	2	Partner and children	Partner's income
Woman 15	3	23	3	Mother, brother and children	Parents' income
Woman 16	3	24	3	With children	Partner's income

Source: own authorship.

In this scenario, a study from Ceará, focused on the outcomes of CS in children of infected mothers, pointed to the high incidence of CS in children of adolescents, highlighting that this may be associated with gaps in prenatal care(20).

In this article, the prevalence of matriarchal families became evident as well as the predominance of social benefits as important sources of income for the women participating in this study. Based on this last data, it can be inferred that the socioeconomic conditions of the women interviewed are borderline. According to literature, income transfer programs are one of the strategies to guarantee basic living conditions, but social policies that are articulated with health policies are urgent, considering specific groups(21). Furthermore, low pay is a determining factor in the context of GS (22).

Epidemiological analysis of GS in the Southeast region associated the predominance of the disease in black and brown people in situations of economic and social vulnerability(23), a fact that is in line with information collected in the present study.

The results obtained indicate that women perceived prejudice on the part of the vast majority of professionals regarding their condition, an aspect that hindered the establishment of a relationship between them, with consequences for the scope of healthcare. There is truncated communication and informational support and women felt helpless, alone and guilty. The topics "Healthcare professionals: interactions and (mis)information", "Treatment of pregnant women and their partners" and "Family and partnership: interactions and (lack of) support" represent the analysis of the data obtained, the first of which is subdivided into "Diagnosis and understanding of syphilis" and "Prenatal consultations".

Topic: Healthcare professionals: interactions and (mis)information

Subtopic: Diagnosis and understanding of syphilis

The women in this study understood syphilis as a socially stigmatized disease, a concept that acted as a determinant in restricting their interaction with professionals and people in their family, including their sexual partner(s).

When faced with the diagnosis of GS, the first symbol that came to participants' minds was that related to the labels of the disease. They perceived it as an infection linked to sex, promiscuity and/or marital betrayal. Thus, they reported feeling ashamed and uncomfortable upon hearing the news that they had syphilis, and that it had the potential to cause harm to the child, which made them sad and worried.

> Oh, when he said syphilis, it was a shock. I knew it was from sex, that it was transmitted through sex. Then, when the doctor talked about the baby, I got nervous, my heart sank. I just listened, I felt like crying, I wanted to understand, so I just listened. (W5)

> I felt embarrassed, as I can say, awkward, disjointed. I felt embarrassed even to look at her face (the nurse). You know something about "doing something wrong, huh?". And look, I'm not like that, no. I had about three boyfriends and now I live with his father. Syphilis is a sexual disease, right? (W8)

> They (professionals) had that look of a "woman with syphilis" at me, I was always embarrassed. Then I would say "uh-huh", "yes", "ok". I think that since it was my 4th (pregnancy) they thought I already knew everything. Second time with syphilis, but it's like that again, you know? (W9)

> It's a disease that's frowned upon. People just think, "Oh my God, what's this?" "Oh, that one over there has it", and it's not a urinary tract infection, right? So it's viewed with prejudice, because there's a lot of prejudice against it, you can feel it in the conversation. They look at it like it's syphilis and that's it. (W12)

> It's embarrassing, right? It is, because sometimes what will happen to someone? Do you understand? So, it's embarrassing. They'll start talking and it's something like that [...]. It's not that it's embarrassing, it's annoying for other people to find out, even if you're a professional, you feel, you know, that look, syphilis. (W15)

It is undeniable that stigma is an important aspect in the fabric of care in the context of syphilis. Thus, women cried out for emotional support, which permeated the way professionals and others behaved when interacting with pregnant women diagnosed with "syphilis"(8). Therefore, breaking the stigma barrier surrounding syphilis to promote resignifications and behavioral changes(14) is a challenge to healthcare.

In this scenario, a project developed in the state of Rio Grande do Norte, Brazil, provided professionals and managers with the opportunity to experience being tested and receiving advice as a strategy to change thoughts and practices(24). In this study, the project team recognized, as did participants, the urgency of "removing the veil of stigma", demystifying and deconstructing both taboos and prejudices(1). This attitude is of great importance, because by sharing a different vision from the previous one, new meanings and social behaviors were established(14).

Another study showed that the symbolic meaning given by pregnant women to having syphilis was reconstructed(14) as they acquired more knowledge about the disease, maternal treatment, cure and vertical transmission prevention 25). This fact was also evident in our study.

Subtopic: Prenatal consultations

According to interviewees, prenatal care was limited to consultations, during which interactions with nurses and/or doctors were seen as superficial and limited to requesting tests and monitoring the gestational/child's development.

Concerning syphilis, the reactive result of the rapid test led to professionals requesting a blood test for confirmation, as well as a prompt explanation about the disease, with emphasis on the consequences for children. According to participants, this information built the meaning of being able to be the woman and mother who could cause harm to her child, a symbol that she reflected on intensely and was constantly revisited during pregnancy.

> The idea of him (his son) going blind remains in my mind. I thought, oh my, what now, because my doctor already said, "If you don't take care of him, he could be born blind, he could be born disabled, retarded", then I felt, you know, very, very bad, I

> even went to see a psychologist. (W7)

> So, I thought about what they were saying, that he could go blind, deaf, have a head problem, that he would have to have his back examined, and then I got worried and thought, “Poor thing if all this happens to him”. So, I took the painful injections, but I thought, “it’s so that he doesn’t pass it on to him so that he doesn’t suffer and he doesn’t become retarded”. (W4)

> Ah, when he said that the baby could be born with a problem, I got worried. (W10)

> Prenatal care was like that, you go in, ask how you are, just to ask, weigh yourself, check your blood pressure, measure your belly and ask if there are any tests for that month, always like that. They only mentioned syphilis when you discovered it and then they asked if you had the injection and if your husband had been treated. Oh, and they always talked about the baby, about what could happen, about going blind, having a head problem, always like that. (W14)

Women also described that the guidance on syphilis provided by professionals was provided without any type of relational comfort, and that there was no space in which they could express their doubts and concerns. According to literature, active listening and the promotion of an environment that is conducive to dialogue should be part of healthcare services’ routine, since such an approach enables the establishment and strengthening of bonds(1) as well as encouraging the ability to take over the role of the other(14).

Furthermore, given the previous knowledge that syphilis is a sexually transmitted disease, and now considering the risk to children, participants commented on the need to obtain more information, associated with the question of how they became infected. This occurred in a movement to find out who was the “transmitter” of the disease and the guilt of causing harm to children. To this end, they reported turning to the internet and certain family members, with whom they feel confident and comfortable talking, motivated by feelings of misinformation and helplessness in relationships with professionals.

> Then I left and ran to tell (partner’s name) let’s look it up on the internet, you can’t pass it on to him (pregnant child). He didn’t care much, he just looked it up with me, read it with me. I’m still worried, I keep watching videos, reading and thinking that it can’t happen to him. (W5)

> I went online and started looking at my exams. There we have it, it shows the amount that is normal or not, reactive or not. And then there it was, VDRL reactive. I went to look up what VDRL was, and it said syphilis. Then a bunch of things started to appear. At that moment, I even left work, I cried, I cried, I was shaking, I was desperate, I went home. And then I cried, I cried and I cried, alone, with my little things. (W6)

> As soon as I found out, I looked on my phone to see what it was. I was worried, I thought, “How could I pass it on to the baby?” I cried, I read things and cried, I was like, oh, lost. I started to learn more with my sister and I realized that getting treatment at the beginning is good. The nurse talked to me, explained it in her own words, but I only understood half of it. It was my sister who really helped, we kept looking and looking. (W13)

A study carried out with young mothers of children diagnosed with CS highlighted that healthcare professionals act as a support network, creating heterogeneous bonds and providing social support both after diagnosis and during the gestational and puerperal periods(26). In the case of our research, there was no mention of a close and trusting relationship with any professional, and no welcoming dialogue was reached about their needs in the field of syphilis and its management. However, it is known that it is essential that professionals assist users, providing guidance in a clear, objective and accessible manner, clarifying possible doubts resulting from excess of information provided.

In the field of communication, women categorically mentioned how incomplete the information provided by professionals is, with the need for progress and changes in this area. The internet has proven to be a resource that is popular and accessed by young people and that can be mobilized by professionals. In this case, the importance of projects that reflect on the issue of communication with young people is highlighted, with the aim of raising awareness of the need to build new strategies for introducing practices to prevent STIs, including syphilis, into the cultural fabric related to youth(25).

According to literature, pregnant women have some knowledge about syphilis; however, there are still doubts and uncertainties regarding the subject(20). The prenatal period is an opportune time for health education actions, and the way in which professionals relate to women influence the scope of these actions. However, participants in this study reported weaknesses in the interventions aimed at health education/informational support. This situation makes it clear that meanings are open and changing at all times, depending on what is experienced in social interactions(14).

It is important to highlight that reproductive and sexual health education is an essential topic to be addressed and worked on with adolescents and young people(1). In this regard, in a study carried out focusing on the contraceptive experiences of adolescents and young people, the internet emerged, once again, as the main resource for obtaining information(27). It is a space for accessing various content, but most of the time it occurs without mediation so that there is not always understanding and/or translation of the post there to the particular situation. This occurred with the participants of this study, who despite using the internet to broaden their understanding of what was said by professionals, still had doubts, especially those particular to their situation.

The reception and informational support in healthcare is weakened in the face of relationships with professionals, being intercepted by stigmas, with negative effects on attendance at healthcare services, which contributes to misinformation and inequities(28). Our interviewees associated professional behavior with social stigma related to syphilis; however, it may be that this is added to the conceptual and philosophical structures that guide professionals in healthcare.

Topic: Treatment of pregnant women and their partnership(s)

The interviewees, when reflecting and symbolizing the power of syphilis to cause harm to the unborn children, described efforts to comply with treatment, especially primiparous women. However, one of them commented that she had previously had GS, but that this time she was unable to complete the treatment regimen, revealing efforts to understand what it means to be a "scar".

> I did (treatment), everything was fine, right? It was new to me, I didn't know what it was, but later they explained it to me. I didn't know about the syndromes that babies get, that they're born blind, there are all these things, right? (W12)

> The first pregnancy is a unique moment. And then a disease like that! Oh my God, oh my God, it was okay. But I did the treatment, all the tests, I did the tests nicely, we can't let it go, right? We can't let it go, it's our health, not only our health but also the baby's. (W13)

> This is what I think about the most, but I did all the treatment correctly, all the injections correctly, everything correctly. I had it in the other pregnancy, so I already knew about treatment, I just don't understand how it came back if he and I treated it. (W14)

> Look, I was going to do treatment, but since I was traveling from São Carlos to Jaboticabal, and then from Jaboticabal to here, and I missed my appointment, I ended up only getting one (injection). But I didn't understand the scar, what is that? Is there any point in treating it if I have a scar? (W15)

These women, as social actors, took on the role of mothers and made efforts to protect their children. As in the study carried out, this effort is a portrait of their attitudes, during treatment, permeated by concern, guilt and responsibility for the well-being of their babies(25). Therefore, it was evident that the diagnosis of GS determined the change in behaviors(14).

The issue of treatment for their partner(s) is always raised in professionals' interactions with them, but there is no room for an open conversation about individual issues. The symbolism of syphilis as a sexually transmitted disease has led some women to inform their partners about their diagnosis and the importance of finding out about their condition. Others have not made the diagnosis public for fear of its consequences.

> They keep telling us to think about everyone we have sex with, to tell them and bring them, but it's not simple. For them, it's just go there, tell them and bring them. Why don't they go? If I tell everyone, will they go? (W2)

> I did the treatment, my father is the same, he did the other one (treatment) too. He said he wouldn't go for this one, if it didn't work, he wouldn't take the injections again. I didn't say anything to them (professionals), I just said that I already told him (partner) to come. This thing is also tense, they make us keep calling the man. Men know how difficult it is, even more so with this thing about sexual diseases. (W9)

According to literature, the professionals who identify and monitor cases of GS are making efforts to provide adequate treatment for women and their sexual partner(s). Furthermore, simultaneous, timely and complete treatment is a strategy for minimizing vertical transmission of syphilis and controlling the disease(1).

Currently, it is known that the lack of knowledge of serological status for syphilis of sexual partners of young women diagnosed with GS is a challenge(29). Therefore, the presence of a partner in prenatal care is indicated as a differentiated measure for the approach and timely treatment of this condition(1). However, this view considers a single type of family arrangement, which does not reflect the majority of participants in this study. Thus, it is urgent to think of a range of strategies to list, based on information specific to each pregnant woman, the most strategic one to reach women's sexual partner(s). It is also worth highlighting that they are collaborators in this process, but it is not appropriate to delegate to them, even implicitly, the recruitment and arrival of sexual partner(s) for screening and treatment of syphilis(1).

Topic: Family and partnership: interactions and (lack of) support

Some of the participants commented that conversations with family members took place in an uncomfortable environment, reflecting the social construction of syphilis as a disease linked to sex and "promiscuity". Thus, in some cases, prejudice and sexism were the grounds on which family support was outlined. Moreover, the lack of opportunity to openly express concerns and suffering resulted, for many of them, in emotional overload in the face of a process that was open and undefined. Single mothers revealed that they did not have family members to even covertly share the situation.

> And who do we talk to about this? There's no one, it's just you and you. (W2)

> I didn't tell him, not even to him (partner) or to my parents. [...] they're already on the fence about this sexual relationship. My parents barely talk about it and that's it, if they talk about a disease like that that has to do with sex, gosh, I'll hear about it until tomorrow. And, he (partner), I don't know, I'm afraid he'll talk about cheating and there's nothing like that, just like that, I don't know. (W3)

> Your head is spinning and you have no one to talk to, I only told her father. (W8)

> My parents know, they don't bring it up, they don't like me to talk about it. It's almost forbidden. They tell me to take care of everything, but they don't even say the word "syphilis"; they talk about the "problem". Has the "problem" gotten better? Have you had another test for the "problem"? You know, forbidden. Even though he (the child's father) is close, and my sisters are friends, I feel like I'm all alone. I don't know, it seems like I only think about the "problem" (syphilis) and it seems like it's all mine, all mine. Let's see how it goes. (W13)

> I felt like crap, incapable, you know? Like, I didn't trust (people). Then it stuck in my head that it wasn't my problem, it was the other person's, right? (W16)

It is known that parents/guardians and the health team tend not to address determining aspects of adolescents' sexual health, due to the denial of the young person's sexual desire and the encouragement of prolonging childhood(1), as observed in one of the reports in this research. However, it is essential to emphasize that sexual practice is part of this phase of life, and that it can be desired and experienced without guilt, with information, communication, prevention and the exercise of free will(1).

A study showed that there were weaknesses in establishing dialogue and sharing the events experienced with those close to them, due to not having the habit of talking about certain subjects, such as the diagnosis of syphilis, or not feeling comfortable sharing the situation of illness with family members, for fear of their reaction(26). This can also be observed in this article.

In this scenario, some of the interviewees reported fear about their partners' reaction to the syphilis diagnosis, and some revealed that he did not accept taking the test and/or treatment. Among the justifications, they presented the understanding that there was no need to discover the disease and/or need to address the discovery of a possible betrayal. However, there were those who felt revolt against their partner and were sure that they were the one to blame for transmitting the disease.

> I told him that he had syphilis, that it could be from him or me, that it could be transmitted through sexual intercourse, and that he had to go and get tested. He didn't want to, he said he was taking the medicine, but not taking the test, it was better not for both of us. It's difficult, there's the whole cheating thing, but neither of us are each other's first

> boyfriends. There's that feeling, but he's going to get treatment and I'm also getting treatment. (W1).
>
> It's because his (the son's) father isn't around. If he wasn't, I told everyone that I would ruin his (the son's father) life, just like he ruined mine. My biggest fear was catching this stuff (syphilis). (W4)
>
> We (her and her partner) were on the same page. He's from the other city. But he knows where she was born. But I still have a grudge against him. I've really grown a grudge against him up until now. But I don't know. I caught it. I don't know what he's going to look like now. But I haven't even told him about this stuff (syphilis) yet. I'm thinking about what's going to happen to him with this thing (syphilis). (W11)

According to the literature, some pregnant women diagnosed with syphilis find confidentiality about the disease as a way to protect themselves from prejudice and judgment(24), as was observed during our research.

Furthermore, a study showed that reporting the infection to the partner provoked a variety of feelings, such as concern, insecurity, sadness, failure, impotence, fear of death and incurability, betrayal, and fear of prejudice and obtaining support in the face of the possibility of living with a stigmatizing disease(29). Such reactions were also reported by the interviewees when telling their partners about the diagnosis.

As in another Brazilian study, the possibility of conflicts and relational distrust arising in the face of a syphilis diagnosis was identified. In these cases, it is difficult to establish dialogue and share the situation with people close to them for fear of how the stigma will manifest itself(26), which is in line with the results obtained in this study.

Therefore, it is clear how much prejudices and beliefs intersect with experience, with a tendency to determine prescriptive practices and negative repercussions on women's coping with the situation. Furthermore, it is possible to see how much meanings remain open and are transformed according to what is experienced during social interactions(14).

This study has the limitation of being carried out only with SUS users, who live in a scenario of social vulnerability, all of whom are black or brown.

FINAL CONSIDERATIONS

Based on the results obtained, it is possible to understand the perceptions of young women diagnosed with GS regarding the disease and the healthcare they received. It was noted that the social stigma of syphilis reverberated in relationships with healthcare professionals and negatively interfered with their care, restricting opportunities to meet each woman's particular needs. Weaknesses in informational and emotional support were highlighted, in addition to the insinuation of women's responsibility for attracting their sexual partners. Furthermore, the symbol of her being the one to cause harm to the child acted as a driver for women's involvement in appropriate treatment, but also caused them to suffer.

It is urgent to revisit the approach to care in the context of GS, valuing women as individuals and considering the social determination of their lives and health. Furthermore, the use of the internet as a resource for information was confirmed, with indications of its incorporation into health education actions mediated by open and welcoming dialogue. To this end, the focus on relationships is urgent and confirms that healthcare is built and implemented in and from the encounter between a person(s) seeking healthcare and professionals. A positioning based on this approach would help to reach people who are significant to the woman and act in the family dynamics, expanding women's social support network.

Finally, this study has the potential to contribute to transformations in healthcare professionals' practices in the development of healthcare for adolescent and young women diagnosed with GS, their sexual partner(s) and family members. Furthermore, there is a need to renew the ways of interacting with these women, with the aim of providing relational comfort and establishing relationships that inspire security that are permeated by respect and dignity for their health.

CUIDADO EM SAÚDE DIANTE DO DIAGNÓSTICO DE SÍFILIS NA GESTAÇÃO: PERCEPÇÕES DE MULHERES JOVENS

RESUMO

Objetivo: conhecer as percepções de mulheres jovens diagnosticadas com sífilis no período gestacional acerca da doença e do cuidado em saúde. **Metodologia:** estudo exploratório, transversal, de abordagem qualitativa, apoiado no Interacionismo Simbólico. Desenvolveu-se na maternidade de um município no interior do estado de São Paulo. A coleta de dados ocorreu entre julho/2023 e abril/2024. Foram entrevistadas 16 mulheres, no período puerperal, com idades entre 15 e 24 anos, diagnosticadas com sífilis durante a gestação. A análise dos dados foi direcionada pela análise temática e aconteceu concomitantemente à coleta, encerrando-se em junho de 2024. O estudo recebeu aprovação do Comitê de Ética em Pesquisa. **Resultados:** o estigma social da sífilis reverberou nas relações com o profissional de saúde e interferiu negativamente no cuidado. Os temas “Profissionais de saúde: interações e (des)informações”, “Tratamento da gestante e sua(s) parcerias(s)” e “Família e parceria: interações e (des)amparos” retratam as percepções sobre a sífilis e o cuidado em saúde. **Considerações finais:** é premente a revisitação da abordagem de cuidado no contexto da sífilis gestacional, valorizando a mulher enquanto pessoa e considerando a determinação social de sua vida e saúde. A internet surge como recurso informacional, com indicativas de ponderá-la nas ações de educação em saúde.

Palavras-chave: Sífilis. Saúde da Mulher. Saúde Pública. Gravidez. Comportamento Materno.

CUIDADO DE LA SALUD ANTE EL DIAGNÓSTICO DE SÍFILIS EN EL EMBARAZO: PERCEPCIONES DE MUJERES JÓVENES

RESUMEN

Objetivo: conocer las percepciones de mujeres jóvenes, diagnosticadas con sífilis en el período del embarazo, sobre la enfermedad y el cuidado de la salud. **Metodología**: estudio exploratorio, transversal, de enfoque cualitativo, basado en el Interaccionismo Simbólico. Se desarrolló en la maternidad de un municipio del interior del estado de São Paulo/Brasil. La recolección de datos ocurrió entre julio/2023 y abril/2024. Se entrevistaron a 16 mujeres, en el período puerperal, con edades entre 15 y 24 años, diagnosticadas con sífilis durante la gestación. El análisis de los datos fue dirigido por el análisis temático y ocurrió concomitantemente a la recogida, finalizando en junio de 2024. El estudio recibió la aprobación del Comité de Ética en Investigación. **Resultados**: el estigma social de la sífilis repercutió en las relaciones con el profesional de la salud e interfirió negativamente en la atención. Los temas "Profesionales de salud: interacciones y (des)informaciones", "Tratamiento de la gestante y su(s) alianza(es)" y "Familia y colaboración: interacciones y (des)amparos" retratan las percepciones sobre la sífilis y el cuidado en salud. **Consideraciones finales**: es apremiante revisitar el enfoque de cuidado en el contexto de la sífilis gestacional, valorando a la mujer como persona y considerando la determinación social de su vida y salud. Internet surge como recurso informativo, con indicaciones para reflexionar sobre las acciones de educación sanitaria.

Palabras clave: Sífilis. Salud de la Mujer. Salud Pública. Embarazo. Comportamiento Materno.

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