



KNOWING (AND) UNDERSTANDING: REPORTS FROM PEOPLE CURED OF SYPHILIS

Conhecer (e) saber: relatos de pessoas curadas da Sífilis

Conocer (y) saber: relatos de personas curadas de la Sífilis

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ABSTRACT

Objective: To describe the experiences reported by people cured of syphilis on the contagion, diagnosis and information about the infection.

Methods: Descriptive research with a qualitative approach, which comprised eight collaborators at a Specialized Health Center in Sexually Transmitted Infections/Acquired Immunodeficiency Syndrome (STI/AIDS) in 2015, in the city of Bauru, São Paulo, Brazil. Data was collected by means of a semi-structured interview, from an initial question followed by content analysis. **Results:** Three thematic categories were unveiled: "The occurrence of syphilis transmission", "The search and emotional reactions to the diagnosis" and "The information on syphilis". The first category evidenced that the vulnerability of the collaborators was permeated by misinformation, confidence in the partner, risky sexual behaviors and late discovery. The second category demonstrated that the diagnosis is usually sought when symptoms manifest themselves and, when faced with that, there are emotional reactions of astonishment, self-blame or blaming on the partner. The third category made it clear that there was little previous knowledge and that the information received in the visits to the health professionals who embraced and guided them contributed to the acceptance of diagnosis, the decision and adherence to treatment. **Conclusion:** The study evidenced that the disease transmission occurred because of misinformation, confidence in the partner and risky sexual behaviors, with manifestation of symptoms and emotional reactions of the patients.

Descriptors: Self-care; Health Education; Diagnosis; Disease Prevention; Syphilis.

RESUMO

Objetivo: Descrever as vivências relatadas por pessoas curadas da sífilis sobre o contágio, o diagnóstico e as informações sobre a infecção.

Métodos: Pesquisa descritiva com abordagem qualitativa, na qual participaram oito colaboradores de um Centro de Saúde Especializado em Infecções Sexualmente Transmissíveis/Síndrome da imunodeficiência adquirida (IST/AIDS) em 2015, no município de Bauru, São Paulo, Brasil. Os dados foram coletados através de entrevista semiestruturada, a partir de uma questão inicial para posterior análise de conteúdo.

Resultados: Desvelaram-se três categorias temáticas: "A ocorrência do contágio da sífilis", "A busca e as reações emocionais diante do diagnóstico", "As informações sobre a sífilis". A primeira categoria evidenciou que a vulnerabilidade dos colaboradores era permeada por desinformação, confiança no parceiro, comportamentos sexuais de risco e descoberta tardia. A segunda categoria demonstrou que geralmente busca-se o diagnóstico quando há a manifestação de sintomas e, diante dele, há reações emocionais de espanto e culpa a si ou ao parceiro. A terceira categoria deixou claro que eram insuficientes os conhecimentos prévios e as informações recebidas nos atendimentos com profissionais de saúde que os acolheram e orientaram, e que contribuíram para a aceitação do diagnóstico, a decisão e a adesão ao tratamento. **Conclusão:** O estudo evidenciou que o contágio da doença ocorreu pela desinformação, confiança no parceiro e comportamentos sexuais de risco, havendo manifestação de sintomas e reações emocionais dos pacientes.

Descritores: Autocuidado; Educação em Saúde; Diagnóstico; Prevenção de Doenças; Sífilis.



RESUMEN

Objetivo: Describir las vivencias relatadas por personas que han sido curadas de la sífilis respecto el contagio, el diagnóstico y las informaciones de la infección. **Métodos:** Investigación descriptiva de abordaje cualitativo en la cual han participado ocho colaboradores de un Centro de Salud Especializado en Infecciones de Transmisión Sexual /Síndrome de Inmunodeficiencia Adquirida (ITS/SIDA) en 2015 en el municipio de Bauru, São Paulo, Brasil. Se recogieron los datos a través de entrevista semiestructurada a partir de una pregunta inicial para el análisis de contenido a posteriori. **Resultados:** Se han desvelado tres categorías temáticas: “La ocurrencia del contagio de la sífilis”, “La búsqueda y las reacciones emocionales ante el diagnóstico”, “Las informaciones sobre la sífilis”. La primera categoría ha evidenciado que la vulnerabilidad de los colaboradores era permeada por la desinformación, la confianza en el compañero, las actitudes sexuales de riesgo y el descubrimiento tardío. La segunda categoría ha demostrado que en general se busca el diagnóstico cuando hay la manifestación de los síntomas y que ante el diagnóstico hay reacciones emocionales de espanto y culpa de uno mismo o de su compañero. La tercera categoría ha dejado claro que los conocimientos previos no eran suficientes y que las informaciones recibidas en las consultas con los profesionales sanitarios que les han acogido y les han orientado han contribuido para la aceptación del diagnóstico, la decisión y la adhesión al tratamiento. **Conclusión:** El estudio ha evidenciado que el contagio de la enfermedad se dio por la desinformación, la confianza en el compañero y las actitudes sexuales de riesgo con la manifestación de los síntomas y las reacciones emocionales de los pacientes.

Descriptor: Autocuidado; Educación en Salud; Diagnóstico; Prevención de Enfermedades; Sífilis.

INTRODUCTION

Acquired syphilis is a sexually transmitted infection (STI) that can be prevented and cured. The epidemiological data, however, shows an increase in the number of cases registered in Brazil in recent years^(1,2), as well as in other countries, such as the United States, Portugal, France, Germany and the United Kingdom^(3,4). In Brazil, between 2010 and 2016, 227,663 cases of acquired syphilis were registered. Of these, 65,878 were reported in 2015, thus showing an increase of 32.7% in previous year's figures⁽¹⁾. Such increase in cases suggests the need for public policies and programmatic actions directed at the prevention of STIs and control of the acquired syphilis epidemic.

After sexual infection by the bacterium *Treponema pallidum*, syphilis manifests in the primary and secondary stages of its clinical evolution, respectively, an ulcerative lesion, at the site of bacterial inoculation, and skin lesions with high infectivity (about 60%). Nevertheless, symptoms are sometimes rare and/or usually regress spontaneously, even in the absence of treatment, and the infection progresses with asymptomatic periods of latency. In this situation, it is common for the person to be unaware of being infected and to involuntarily transmit the infection to their sexual contacts, with the serological test representing the means of obtaining the diagnosis⁽⁵⁾.

The detection and treatment of people with acquired syphilis is relevant because of the risk of aggravation in the long term. In the tertiary stage, two to forty years after the sexual contact, approximately 30% of untreated cases will manifest cutaneous, neurological, cardiac and bone lesions^(2,5).

Furthermore, the occurrence of syphilis, and other STIs as well, can cause psychological and social impacts on the health of people affected. In the case of contaminated pregnant women, when not being treated, congenital transmission may occur and lead to severe outcomes, such as abortion, prematurity, early or late congenital manifestations and/or death of the newborn⁽⁵⁾; therefore, it remains a serious public health issue^(6,7).

Duly trained health professionals are regarded as protagonists in coping with the congenital syphilis epidemic⁽⁶⁻⁹⁾. Nevertheless, for an adequate performance, it is necessary to ensure the embracement of the users' subjectivities and singularities, counseling strategies and health education programs⁽⁸⁻¹⁰⁾.

Cognitive, subjective and cultural aspects can become challenges to the prevention and diagnosis of syphilis, as well as to the confrontation of the condition by the affected ones. On the person-focused care, from the perspective of the comprehensive clinical practice⁽¹¹⁾, it is necessary to stimulate behaviors of health promotion, primary and secondary syphilis prevention, so that the users develop self-care skills aiming at the autonomy necessary for the preservation and reestablishment of their health.

Women undergoing treatment for syphilis have reported little knowledge of the disease. Moreover, they were not advised by health professionals or, when this occurred, they reported difficulties in assimilating the information received⁽¹²⁻¹⁶⁾. Before the diagnosis, they reported feelings of sadness, shame, guilt and also concern about the symptoms and healing, and the transmission to the baby^(12-14,16).

Given this problem, the study is justified by the need to know the experiences lived by people diagnosed with syphilis who have adhered to the treatment until the infection is cured, being relevant to the understanding of the subjective, educational and social aspects that could influence their trajectories. The study shows relevance for health promotion, as its actions should be directed toward the development of alternatives that stimulate or intensify the adoption of healthy behaviors, through the practice of health professionals, whose actions should be focused on promotion, prevention and health care.

Within this context, the research presents as a presupposition: Do people affected by syphilis and treated for it have any knowledge of the infection, the diagnosis and the information about the infection? To have this question answered, the study was aimed at describing the experiences reported by people cured of syphilis on the contagion, diagnosis and information about the infection.

METHODS

A descriptive research, with a qualitative approach, focusing on the subjective and social aspects of the health-disease process⁽¹⁷⁾, conducted at a STI/AIDS Specialized Health Center in the city of Bauru, São Paulo, Brazil, a reference service for testing, counseling and treatment of infections.

The sample selection was initiated based on the records (notifications and records of syphilis treatment control from the period 2013 to 2015) of this health center, seeking potential collaborators among those who had been discharged from the treatment after being cured of syphilis. Pre-established inclusion criteria were: age above 18 years; being legally capable of responding to their own actions; having experienced the diagnosis of syphilis and treatment with penicillin, followed by follow-up testing until being cured of the infection. And those of exclusion: a record of depression or other disorders (which would prevent the study questions from being answered) and the presence of syphilis and Human Immunodeficiency Virus (HIV) coinfection.

Thus, 35 people were selected and contacted by telephone or in person at the health center for the invitation to participate in the study, resulting in eight participants. The data collection was carried out between July and October 2015, by means of a semistructured interview comprising two parts. In the first stage, data on identification was collected, with the variables: age, sex, educational level, income and marital status. In the second stage, guiding questions: “Tell me how it was for you to find out that you had syphilis (the diagnosis?), about the contagion (whom did you get it from?), and the information on the infection?”, in order to achieve the proposed goals.

The reports were transcribed and submitted to content analysis, which consisted of a floating and exhaustive reading of the transcribed interviews, followed by the identification of the units of analysis and context for the definition of mutually exclusive categories⁽¹⁸⁾. With focus on the study objective, the analysis unveiled three thematic categories: The occurrence of syphilis contagion; The search and emotional reactions to the diagnosis; and The information on syphilis.

All the ethical precepts in human research were respected in the accomplishment of this study, previously approved by the Ethics Committee of São Paulo State University (UNESP) - Araraquara Campus (Approval no. 1.052.260) and the Ethics Commission of the Municipal Health Secretariat of Bauru, São Paulo, Brazil.

With the aim of identifying the participants, in the excerpts from their reports in the categories of analysis, the study used the letter “C” (collaborator) followed by a number corresponding to the chronological order of participation in the study, in addition to an indication of the sex (M - male or F - female) and age at the time of data collection.

RESULTS AND DISCUSSION

The identification data of the collaborators are presented next and, following that, the categories that emerged from the content analysis of the interviews are presented.

The participants' ages ranged from 18 to 51 years old, with four men and four women, with educational level from incomplete elementary school to complete higher education, with an average (individual) monthly income of R\$ 1,500.00. As for marital status, one participant was separated, other was in a stable union, and the others were single.

The occurrence of syphilis contagion

This category included the reports in which the participants described the factors associated with the lack of condom use in the sexual relations in which they suspected that the infection had occurred, having the stable relationship as the justification for not using it.

Other claim about the unprotected relationship was related to the desire to be loved, followed by trust in the partner, their own neglect with respect to safe sex practices, and acceptance of non-use of the condom, sometimes attributing to themselves the “guilt” over the contagion, as can be seen from the following statements:

“I thought this [sex] was a way to be loved, you see? Unaware, and then ... it ended up happening to have had the disease.” (C6, F, 30)

“Because I trusted my husband very much, I did not use condoms with him in our intercourses.” (C5, F, 18)

“Because there were all kinds of persons, they were girls, women, you see? (...) So, one is not careful, they [partners] didn't take care of themselves either.” (C3, M, 22)

"[I think I got it] because I had no stable relationship. (...) At the beginning, we use it. We started using the condom, she was the one who said "now we're already together, we're not using the condom ", then we didn't use the condom, we stopped." (C1, M, 51)

"She [ex-partner] said, "Look, it's the condom, I don't like that you wear it, so you don't need to, do you, to use it?!" Unaware, thoughtless, one jumps on the bandwagon. I think that was my mistake."(C4, M, 29)

At the moment after the diagnosis, it was recurrent the suspicion that the contagion had occurred in a previous, or current, stable relationship, sometimes with mention of partner's infidelity:

"Then, after a day, she was telling me that she had to see the gynecologist (...) I said "oh, so it was from her that I got it". " (C1, M, 51)

"She [ex-partner] had already said, "Look, yeah, I found out I had syphilis, and all that, you go there get tested and see, then, if you have it too." (C4, M, 29)

"But then comes the issue, did I get it from some boyfriend or did I get it from the ex-husband? Why? Because the ex-husband cheated on me. What if that other woman didn't wear the condom?" (C8, F, 32)

"Look, as far as I know, it was from my partner [that I got], because I've lived with him for four years, you see, I had no other person but him, and always without a condom with him, then I discovered his betrayal, everything, isn't it?" (C7, F, 36)

The reports made by the participants about the contagion suggest the lack of a prior perception of their own vulnerability to STIs in the representations of a sex with pleasure and/or love, as well as in a relationship of stable partnership.

In other studies, in addition to the trust deriving from the stable partnership, other reasons for not using condoms were the difficulty in negotiating its use with the partner, the belief that their use reduces pleasure, personal devaluation and the use of alcohol and drugs^(14,15,16,19).

In the study in question, the reports prove that the habit of predominantly safe and healthy sexual activity is still distant. One can see that the participant (C6, F, 30) has her self-esteem compromised when she says that she gives up the condom because she feels "the need to be loved". In such situation, health professionals should have a comprehensive view, seeking to identify the individual problems of the patient, with adoption of educational measures and activities.

It is important to emphasize that false beliefs, such as associating the risk of STI contagion only with a promiscuous individual behavior or with partners bearing signs and symptoms, may impair the perception of the need for protection^(19,20), the definition of the diagnosis, and possibly, the acceptance of it.

The search and emotional reactions to the diagnosis

This second category comprises the reports about triggering factors for the search and definition of the diagnosis, including reports on a variety of emotional reactions to the diagnosis, some of which generate the need for emotional support by the health professionals.

In some cases, the manifestation of the primary stage symptom appeared to have triggered the search for medical care. This association was evidenced in the speech of the participant (C4M) who had already been warned by the ex-partner, suggesting that he should get tested for syphilis and, even so, only sought to undergo the testing after the visible perception of the symptom.

Another patient (C2M) also manifested the presence of an ulcer and treated syphilis at an emergency service, but was not referred to or advised on the follow-up of the treatment for the cure, and only sought care again after manifesting a symptom of the secondary stage, which suggests that a therapeutic failure⁽²¹⁾ or a reinfection^(22,23) might have occurred.

"I discovered this syphilis when a sore appeared." (C1, M, 51)

"I did not take it so seriously [the ex-partner's warning], you see, because I saw nothing in me, from the time I began to see the patches, then I got worried, as I realized it all. The carelessness, and that she had warned me." (C4, M, 29)

"I began noticing diffuse red patches, very small round sores. And then I went to the dermatologist and she, very experienced, very clever, requested my VDRL test, and its titration was kind of high, and it was already secondary, you see, because I already had it. I think that one was not properly cured." (C2, M, 24)

The researchers reported the discovery of syphilis through the testing and, while some were tested for STI in result of perceived vulnerability (C3M and C8F), others (C6F and C7F) underwent the test for other reasons: meeting requirements for an admission examination or blood donating. Asymptomatic infection may render it difficult to diagnose syphilis⁽⁵⁾ and to accept treatment⁽⁹⁾.

Participant C6F reports that she had been tested for syphilis in the past but did not want to check the result. She had also undergone another testing for STD that had not included syphilis, which justified the feeling of shame to talk about sexuality with the health professional, especially because he was a male. Thus, she remained unknowingly with the disease for 10 years, until the diagnosis appeared while making a blood donation.

The difficulty she reported in exposing her sexual experiences and concerns to the male or female health professional, represented a barrier to performing specific testing for syphilis, as might happen to other people. This question must be considered in the relationship between the doctor or nurse and the patient, in order to facilitate a communication that involves the embracement and trust, attitudes necessary for effective educational actions aiming at learning preventive behaviors in relation to syphilis^(5,9).

“And in this one, that she got pregnant, I decided to be tested, because I was worried about my son, I worried about myself, about my son, and I said: “Oh, it’s about time, I’m already 20 years old, I’ve been dating since I was 14, I never got tested (...).” (C3, M, 22)

“And when I came back to the night [sex professional], I got tested... and I had such a fright, because I discovered I had syphilis.” (C8, F, 32)

“I started to be monitored by the gynecologist and asked him to request blood tests, but he did not order all the tests but, then again, I was not specific either, I mean, because I was ashamed, and my doctor was a man and that made things even worse, [laughs] so I was very ashamed. And that’s how things were for 10 years. Only last year I did the treatment, it took me 10 years with the disease and not being aware of it.” (C6, F, 30)

“And, at that time, I worked at the general store, I had a cleaning job, then, as I was going to another sector, so I had to take the tests, as it involved dealing with food.” (C7, F, 36)

Reports evidencing the attitude of persistence on the part of the respondents in the search for a resolute health care are noteworthy. Previously, or concurrently to attending the specialized public service, the respondents had sought other services (Basic Health Unit, Emergency Care Unit, Private Clinics etc.), which were not always effective. For example, collaborator C6F was notified of syphilis in a blood bank and was not referred for treatment. Despite that, she sought the specialized service to get tested again and clarify the result received. It seems important to highlight how necessary the healthcare network is, for coping with the syphilis epidemic. Thus, in the complexity of prevention, contagion and care for people with syphilis, individual and social issues coexist, along with the technical, managerial, political and pedagogical dimensions⁽²⁴⁾.

In the report made by C5F, it was emphasized the importance of receiving support from the health professional at the disclosure of diagnosis in the specialized service, by means of attentive and welcoming treatment, which contributed to the emotional strengthening, acceptance of diagnosis and adherence to treatment^(14,15):

“She [health professional] said: “Keep calm, everything will be all right”. Then she said, “Oh, you have syphilis, but we’ll take care of it, we’ll help you,” and when she said “we’ll help you,” I felt a relief inside my heart. It was so nice. It’s so nice when you feel protected (...). And it was then that I became even stronger to stand on my feet and undergo that treatment.” (C5, F, 18)

In the context of the diagnosis, emotional reactions were reported by the participants in the present study and were described in other studies⁽¹²⁻¹⁴⁾ as well: sadness, shame, guilt, concern about cure and transmission to the baby. This reinforces the need for further investment for extended and multiprofessional team in the health field, for example, and the performance of psychologists in the team, especially when subjective issues interfere with adherence to treatment, or generate suffering for the people involved.

Confronted with the finding that syphilis had treatment and cure, the participants reported dealing with the news in a “normal” way, demonstrating acceptance of the diagnosis and motivation to face the treatment.

“So, for me, it was something normal because, at the moment the lady said, “Look, you have syphilis”, I said “Do I?” But I said, “is there a cure?”, she said: “there is” (...) It’s no use, if it happens to us, knowing that one did it [unprotected sex], to go and try to blame others, isn’t it, then you have to be accountable, in a way, without violence, nothing, talking, through dialogue, because it’s a mistake, everybody makes mistakes, don’t we?! So, it’s something we couldn’t foresee.” (C1, M, 51)

“Then I heard about it [diagnosis and guidelines] not happy indeed, but in a very calm, quiet manner, as I was aware that it was still early, primary, and that there was a cure. So, I just needed to do things right, and I would get it, you know, to be cured, and that it would all have worked out.” (C4, M, 29)

Others reported discomfort, mainly due to the presence of a feeling of shame or guilt for understanding syphilis as a consequence of their own carelessness in intercourse without a condom, and of personal devaluation. In fact, having a STI was expressed as “feeling dirty”, which may be related to judging their own sexual behavior as immoral or incorrect:

“Of course, gosh, so they came to mind like that, like... reminding us, well, look what you’ve done, look at the consequence. I’m being honest with you, I prayed a lot, I thanked God so much, because there were no major consequences.” (C6, F, 30)

“I, for having a STD, with the two [gonorrhoea, syphilis] that I got, I already felt like crap, I already felt like a dirty person, got it? Because, when you get it, you find yourself at that stage “gosh, dude, I got a STD”, an illness, it means I’m not, I’m not valuing myself, I’m not taking care of myself, I’m living a trashy life.” (C3, M, 22)

The participants in the study in question reported an emotional impact when faced with the diagnosis: feelings of despair, shock, sadness and fear, which seemed to be associated with a lack of a prior perception of vulnerability to the STI. In the case of infection transmitted by a stable partner, there was a manifestation of sadness and anger⁽¹⁴⁾, not only due to the disease itself, but also due to the suspicion, or disclosure, of infidelity. It was also reported the recognition of the vulnerability to the Acquired Human Immunodeficiency Virus (HIV), regarded by many as a source of greater concern, for being incurable⁽¹⁵⁾.

In the report made by C5F, feelings of anger and denial, typical of the mourning process, were perceived. In order to adhere to the treatment, it was necessary to deal with feelings of indignation and guilt, and also to have the support of close associates^(14,15). The participant whose partner was pregnant reported he had become terrified by the risk of congenital transmission:

"I was very nervous myself, too. (...) I did not want to know what was happening to me. I couldn't believe it. (...) [then, says to herself] "You trusted to luck, so now you're going to have to deal with its consequences, because it's no use you go and say 'I'm not going to do the treatment', because it's going to be worse for you." (C5, F, 18)

"Oh, I was completely floored. Gosh, I cried so much, because one doesn't expect something like that, I don't know... (I've) been sharing life with a person for so long and, suddenly, I thought to myself, I said "wow, it could be worse, it could be AIDS", isn't it, that would ruin my life because, you know, I would have to live on treatment, on medicines, right?!" (C7, F, 36)

"And when I learned that I had syphilis, I was sure it was not from her, it was related to me. Then, automatically, it already enlightened me, I already knew that I had passed it to her and, meanwhile, she was already pregnant! So I was already terrified, I said "what now? What am I going to do?" (C3, M, 22)

In general, acceptance of the diagnosis was accompanied by accepting responsibility for undergoing the treatment. No reports of indifference, fatalism^(15,22) and denial of syphilis infection were found in the reports of the present study, even after receiving the diagnosis⁽⁹⁾.

It is important to emphasize the importance of the health professional when revealing the diagnosis of a disease, embracing the feelings derived from it, informing and clarifying treatment procedures and discussing future preventive attitudes^(5,8,9,10). Therefore, the relevance of training and permanent education of health professional for the work related to sexuality is evidenced^(6,10,24).

The information on syphilis

This category comprises the reports about the knowledge of syphilis, before and after the diagnosis, as well as the mode of acquisition. Some collaborators reported lack of knowledge of syphilis prior to experiencing the disease. There have been comments about the fact that there is little or no information material on syphilis and the lack of habit of seeking information when there is no suspicion or symptoms of any illness.

"Only those who go to the doctor's really know what syphilis is, because there is not a poster about syphilis in the very Emergency Care Unit, many people don't know about it (...). I've never heard of syphilis, ever. It's because, hardly ... I mean, I'm that kind of person... I hardly went to the doctor's and, then again, you see... I'm not used to reading the posters, things like that." (C1, M, 51)

"No, I had never learned of this disease. I did not even know that such disease existed, because I'm not really into reading things, I'm not very connected in the world." (C5, F, 18)

"But I did not know of syphilis, I came to know of it after undergoing everything [treatment]." (C8, F, 32)

Thus, according to the reports made by the participants, previous knowledge of syphilis was scarce; some of them were unaware of the disease and others only had some notion that it was a STI, which corroborates other studies^(12,13,16). Others also stated that, previously, they only had knowledge of HIV, and became aware of the need to update themselves on the other STIs. And there was still a perception that only those who acquire the STI have specific knowledge of it⁽¹⁹⁾.

"That, until then, I didn't even know what syphilis is, you see, well... I knew it was an illness, because I had a friend of mine, who had shown some sores on his body, things like that." (C7 F, 36)

"Not [knowing syphilis] thoroughly, so ... I knew it was a sexually transmitted disease." (C6, F, 30)

"That moment when the exam was disclosed and she [dermatologist] said "oh, you have syphilis", I said "what's this?", you see, brother, I already had some notion that it was a STD." (C2, M, 22)

"When we hear about sexually transmitted diseases, we only know about HIV, understand? One only gets to know that there is a hepatitis A, a hepatitis B, a syphilis, either when one seeks, or when one ends up being infected, because on the disease, in general, for everyone, there is only HIV, no one has such knowledge, nobody knows that other STDs exist." (C3, M, 22)

"Yes, I had already heard [about it] during adolescence but, since it was a long time ago, we are usually more concerned about AIDS today, aren't we? The other diseases that don't seem to be a big deal, but are dangerous too, we sometimes forget them. "Ah, what is this about? It's nothing!" We're only concerned about AIDS." (C4, M, 29)

The participants reported health education when they received specific information from the health professional and during treatment follow-up: the syphilis stages, the treatment, the risk of reinfection, vertical transmission and the serological scar and, to a certain extent, this information led to treatment-friendly actions, consistent with other studies^(9,10,14,16).

“At the beginning, I was kind of... I mean, not acting hotheadedly, I asked “is there a cure, tough?” I was, she [doctor] said “no, [name of the participant], this is curable, you’re going to take Benzetacil, you will follow the regimen [in the sense of sexual abstinence].” (C1, M, 51).

“She first explained to me, got it, what syphilis is, showed me photos, explained to me what an early stage means and that there were still chances of healing, as long as I could also help, collaborate. (...) So it’s better to have it treated right away, now that it’s primary; because, otherwise, it gets complicated.” (C4, M, 29).

“I remember the doctor [gynecologist at the health care unit] took it, said so “look, there’s some alteration, and syphilis is only detected by the blood test.” (...) And the doctor said, “look, your boyfriend, he needs to get treatment.” (C8, F, 32).

“She [doctor] said “look, [participant’s name], and you, what you should do, see, you have many partners, don’t you, so you should always be careful, use a condom, never stop using it, she explained this to me.” (C7, F, 36)

“Then I searched for information, then I went to the doctor, he explained that if I treated it as soon as possible, I would not pass it on to my son, that it would depend ... That she should treat it as soon as possible.” (C3, M, 22).

Some participants also reported having searched for additional information through reading, especially on the internet^(14,15). In today’s world, the internet has become a common source of information, including on STIs. This mode of acquiring information, however, may be superficial and inadequate.

“Then I went to read about it, and I saw what it was.” (C2, M, 22)

“But so, I had my doubts on syphilis cleared up on the internet, things like that, so I’ve seen a lot of things, that it can even cause death.” (C7, F, 36)

“I accessed the internet, I studied a lot about diseases, not only syphilis but also infections such as hepatitis and everything, HIV as well, so I read a lot, you know, so today I can say that I have a basic knowledge.” (C3, M, 22)

“I struggled to get to know, anyway, all about it. But here I was already given a good background on this, then, out there, I sought even more information. Since it’s available nowadays, one just needs to go there and get it. Google teaches everything.” (C4, M, 29)

Finally, it is observed that it was only after receiving the necessary information about the infection, its treatment, the complications of its absence and the possibility of reinfection, that the participants of the present study reported making the decision and taking favorable attitudes of adherence to the treatment. It is known that mere information is not able to guarantee preventive attitudes because of the existence of other individual, social and institutional vulnerability factors. Nevertheless, it was by means of the information obtained, besides the experience of the disease, which currently influence the behaviors of these people are.

It is therefore vital to promote health education, which guarantees access to information, accompanied by reflections, encouraging self-care attitudes to be assumed before and/or after the occurrence of infections⁽²⁴⁾. Health education through a participative, democratic and dialogical process, with appreciation of popular knowledge and a critical and reflexive analysis of the realities of life and health of the populations, aims at promoting autonomy in the self-care of individuals and collectivities⁽²⁵⁾.

Thus, it is emphasized the relevance of promoting public policies that promote sexual health and reproductive rights for the general population, with Sexual Education addressed in schools. Also with promotion of media campaigns, development and availability of educational materials^(9,10), group activities in Basic Health Units and in community spaces. In addition to training and continuing education directed at the health teams, according to the specifics and needs of their workplaces and population served^(24,25).

It is hoped that the results contribute to the promotion of health among the general population and its partners, proposing new models of care that bring a different look at sexual and reproductive health. With a vision of changing the focus on the disease into focus on the person experiencing the infection. Thus, rendering it possible to understand the challenges in coping with the acquired syphilis epidemic by means of the subjective and singular perspectives of the people affected, aiming at effective preventive actions and, in the case of contagion, adherence to treatment.

The limitations of this study refer to the small group of participants, as this restricts the analysis from singularities, which prevent generalizations of the data. The settings of their experiences are restricted and conditioned to the variables related to the identification data, in addition to the characteristics of the health center specialized in testing and counseling in which they received treatment, as well as those related to their locality, region of the state and country.

FINAL CONSIDERATIONS

The study showed that the disease transmission occurred because of misinformation, confidence in the partner and risky sexual behaviors. The diagnosis of the disease has sometimes occurred late, usually with the manifestation of symptoms and, faced with them, there are emotional reactions of astonishment and self- and partner blaming.

It was also observed that the participants had insufficient previous knowledge of the disease and the information was received during the consultations with the health professionals who embraced and guided them, contributing to the acceptance of the diagnosis, the decision and adherence to the treatment.

It is incumbent upon the entire health team to invest in health education, acting empathically, without judgments, reinforcing and teaching the use of condom as the only way to prevent STIs.

Therefore, the recognition and appreciation of the subjectivities and meanings attributed by the users to their health-disease processes are highlighted as competences to be developed and improved in the continuing education directed at health professionals.

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CONFLICTS OF INTEREST

The authors declare the absence of conflicts of interest.

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