

Evaluability of Preventive Actions for the Transmission of Congenital Syphilis With a Focus on Men's Participation

Avaliabilidade das Ações Preventivas da Transmissão da Sífilis Congênita com Foco na Participação do Homem

Evaluabilidadde las Acciones Preventivas de la Transmisión de la Sífilis Congénita con Enfoque en la Participación de los Hombres

RESUMO

Objetivo: Analisou-se a implementação das ações de prevenção da transmissão vertical da sífilis congênita, com foco no parceiro sexual em um município da Bahia. **Metodologia:** Estudo de avaliabilidade, com revisão de documentos oficiais, elaboração do modelo lógico do programa e entrevistas com gestantes, parceiros, profissionais de saúde e gestores (n=22). **Resultados:** A gestante é considerada pelas equipes de Atenção Primária à Saúde o principal elo para adesão do parceiro ao cuidado. Profissionais reconhecem a baixa presença dos parceiros no pré-natal e relatam investimento em estratégias de busca ativa. Além disso, relações de gênero marcadas por desigualdade, medo e insegurança na revelação do diagnóstico podem gerar conflitos afetivos e impactar a adesão ao tratamento. **Conclusão:** Recomendam-se abordagens criativas e voltadas ao parceiro sexual, capacitação profissional que aborde temas como sexualidade, relações de gênero e saúde, além de estudos que aprofundem a compreensão das desigualdades de gênero e seus impactos na saúde.

DESCRIPTORES: Sífilis Congênita; Infecções Sexualmente Transmissíveis; Pré-natal; Parceiro; Avaliação de Serviços de Saúde.

ABSTRACT

Objective: Analyzed implementation of actions to prevent vertical transmission of congenital syphilis, focusing on the sexual partner, in a municipality in Bahia, Brazil. **Methodology:** An evaluability study was conducted, including a review of official documents, development of a program logic model, and interviews with pregnant women, partners, healthcare professionals, and managers (n=22). **Results:** The pregnant woman is considered by Primary Health Care teams to be the main link for the partner's adherence to care. Professionals acknowledge the low presence of partners in prenatal care and report investing in active search strategies. Furthermore, gender relations marked by inequality, fear, and insecurity in disclosing the diagnosis can generate affective conflicts and impact adherence to treatment. **Conclusion:** Creative approaches focused on the sexual partner are recommended, as well as professional training addressing topics such as sexuality, gender relations, and health, studies that deepen the understanding of gender inequalities and their impacts on health.

DESCRIPTORS: Congenital Syphilis; Sexually Transmitted Infections; Prenatal Care; Partner; Health Services Assessment

RESUMEN

Objetivo: Analizar la implementación de acciones para prevenir la transmisión vertical de la sífilis congénita, con enfoque en las parejas sexuales, en un municipio de Bahía. **Metodología:** Estudio de evaluabilidad, que incluyó la revisión de documentos oficiales, el desarrollo del modelo lógico y entrevistas con 22 participantes (embarazadas, parejas, profesionales de la salud y gestores). **Resultados:** Las embarazadas son el principal vínculo para la adherencia de sus parejas a la atención. Sin embargo, las relaciones de género, marcadas por la desigualdad, el miedo y la inseguridad, pueden generar conflictos emocionales durante el embarazo. Los profesionales reconocen la baja presencia de parejas y reportaron poca inversión en estrategias activas de búsqueda de pareja. **Conclusión:** Se recomiendan enfoques creativos hacia las parejas sexuales, formación profesional que aborde la sexualidad, el género y la salud, y estudios adicionales que profundicen la comprensión de las desigualdades de género y sus impactos en la salud.

DESCRIPTORES: Sífilis Congénita; Infecciones de Transmisión Sexual; Atención Prenatal; Pareja; Evaluación de Servicios de Salud.

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**Carla Taiana Cointeiro Bressy**

Master's degree in Public Health, Institute of Public Health, Federal University of Bahia, Brazil.
ORCID: <https://orcid.org/0000-0002-5649-8368>

Federal University of Bahia – Brazil.

ORCID: <https://orcid.org/0000-0002-1476-8649>

**Sônia Cristina Lima Chaves**

PhD in Public Health. Institute of Public Health,

**Ana Paula dos Reis**

PhD in Social Sciences. Institute of Public Health, Federal University of Bahia – Brazil.

ORCID: <https://orcid.org/0000-0002-6750-0187>

INTRODUCTION

Syphilis is a sexually transmitted infection (STI) transmitted through unprotected sexual intercourse with infected individuals or, vertically, from a pregnant woman to the fetus or newborn during pregnancy and childbirth¹. Congenital syphilis (CS) results from the hematogenous spread of *Treponema pallidum* from infected pregnant women—who have not received adequate treatment or have not been treated at all—to the fetus via the placenta, at any stage of pregnancy or clinical phase of the disease². Prevention of the disease is possible, and the elimination of vertical transmission can be achieved through strategies for early diagnosis and timely treatment of syphilis in pregnant women and their partners^{3,4}.

Syphilis can be diagnosed using a treponemal screening test, typically the Rapid Test (RT) for Syphilis, which is free and easy to perform and available through the SUS healthcare network. Currently, this is one of the main screening methods for diagnosing syphilis. Although diagnosis and treatment are accessible and low-cost, congenital syphilis remains a public health problem, even with the implementation of preventive measures such as the decentralization of diagnosis via rapid tests, the provision of free treatment, and the development of therapeutic protocols and guidelines. Studies indicate an association between syphilis and HIV

infection, the incidence of which is also high, and inadequate treatment of sexual partners contributes to the maintenance of the transmission chain^{5,6}.

An international study in 153 countries linked gender equality to improved outcomes for vertically transmitted infections (Hepatitis, HIV, Syphilis)⁶. Greater gender equity improved syphilis screening coverage during pregnancy and awareness of the disease. Conversely, gender inequality and low national income were associated with higher maternal prevalence of syphilis, low screening and treatment coverage, and high rates of congenital syphilis⁶.

In Brazil, in 2021, the *Certification Guide and Seal of Good Practices for the Elimination of Vertical Transmission of HIV and Syphilis* was launched to support municipalities with more than 100,000 inhabitants in achieving impact targets, such as the incidence rate of congenital syphilis, and process indicators, such as the minimum coverage of four prenatal visits, coverage of pregnant women with at least one syphilis test during prenatal care, and coverage of pregnant women receiving appropriate treatment for syphilis⁷.

Despite the aforementioned syphilis prevention initiatives, between 2012 and 2022, 1,237,027 cases of acquired syphilis, 537,401 cases of syphilis in pregnant women, 238,387 cases of congenital syphilis, and 2,153 deaths from congenital syphilis. The incidence rate of congenital

syphilis rose by 19.1% between 2017 and 2022, corresponding to 10.3 cases per 1,000 live births in 2022⁸.

Between 2014 and 2022, Bahia recorded 55,227 cases of acquired syphilis, 31,920 in pregnant women, and 11,785 cases of congenital syphilis, with an increase in detection rates for acquired syphilis and syphilis in pregnant women. Congenital syphilis maintained a rate of 5.1 to 7.8 cases per 1,000 live births, indicating that, despite increased prenatal coverage, the quality of care may be unsatisfactory or other external factors may be involved⁹.

The persistence of congenital syphilis may be associated with inadequate management, missed opportunities for diagnosis and treatment, lack of counseling, absence of treatment, or incorrect treatment of the partner^{8,10}. Thus, low male participation and poor adherence to syphilis treatment may perpetuate the vertical transmission of congenital syphilis. Consequently, this study focuses on evaluating the approach to the sexual partners of women diagnosed with syphilis in Camaçari, Bahia, a municipality with a high rate of congenital syphilis (12.4 cases per 1,000 live births), exceeding the national and state averages¹¹.

METHODOLOGY

This is a qualitative *feasibility* study of actions to prevent vertical transmission in Camaçari, with a special focus on the

strategies adopted by health services to ensure that the partners of women with syphilis in prenatal care⁽¹¹⁾ adhere to the treatment recommended in national and international protocols. This type of study is also known as a pre-evaluation and analyzes whether a health program is sufficiently clear and implemented to be evaluated¹².

The methodology included a literature review, the development of a theoretical-logical model for partner care, and 22 interviews with pregnant women, sexual partners, healthcare professionals, and facility managers, conducted between November 2022 and May 2023. The logical model is a graphical representation of the program's theory¹¹. The interviews were recorded, transcribed, and categorized using NVivo software. There were difficulties in obtaining consent from the interviewees, especially from partners, which led to the expansion of the research field to the Camaçari Regional Maternity Hospital. The categories of analysis include: socioeconomic profile, types of emotional and sexual relationships, syphilis management, main feelings related to the diagnosis, and criticisms/suggestions regarding health services. Initially, the study was presented to the Transmission Investigation Committee

The municipal office, where district and regional representatives of health and maternity services, as well as coordinators of the technical areas of maternal and child health, primary care, and the municipal sexually transmitted infections program, are located. The research participants were contacted via telephone calls or in person by the health facility that serves them, in order to request consent to provide their contact information to the researcher. After obtaining this consent, contact was established, and the objective of this research was presented. Upon acceptance, some of the interviews took place in person at a location of the interviewee's choice, usually at the health facility itself. The remaining interviews took place virtually, via video or voice calls, with only the spoken words being recorded;

no video footage was captured.

In all interviews, the Informed Consent Form was provided, as it is considered fundamental in all stages that must be strictly observed so that the person invited to participate in the research can express their consent autonomously, consciously, freely, and with full understanding. This research was submitted to the Ethics Committee of the Institute of Collective Health at the Federal University of Bahia, since the protection of research participants constitutes the fundamental rationale of the Brazilian Standards and Guidelines governing research involving human subjects, including Resolutions No. 466/12 and 510/16 of the National Health Council (CNS), and was approved by the CEP-ISC/UFBA, pursuant to Opinion No. 5,672,698, dated September 29, 2022.

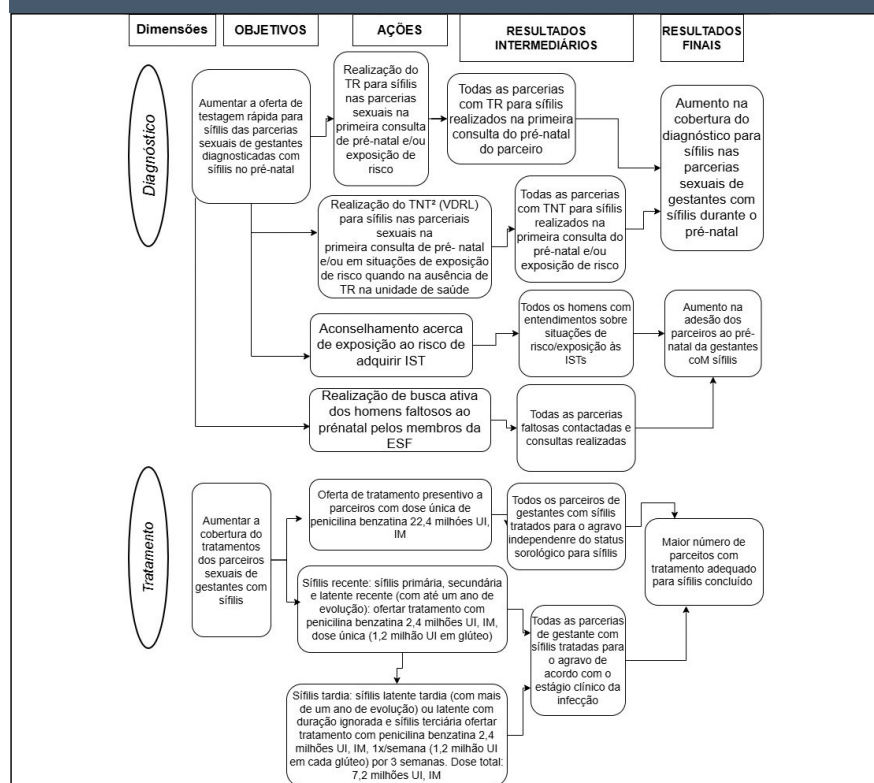
According to Resolution 466/12, it

is emphasized that the risks presented by the study were related to the possible discomfort participants might feel regarding the topic or a specific question, since these were private questions about their sexuality and sexual relationships, leaving them free to decide whether or not to continue participating in the study. Nevertheless, no participant withdrew from the study.

RESULTS

The logical model for reaching out to sexual partners of women diagnosed with syphilis during prenatal care was structured around six pillars: diagnosis, treatment, epidemiological surveillance, health education, and management. However, for the purposes of this study, which focuses on reaching out to partners, the first two pillars were analyzed (Figure 1).

Figure 1. Logical Model of the Plan for the Reduction of Congenital Syphilis focusing on sexual partners in the Diagnosis, Treatment, and Active Case Finding component. Brazil, 2024.



Source: Figure prepared by the author in 2023.

The initial stage, *diagnosis*, aims to expand rapid testing of sexual partners of pregnant women with syphilis. Interventions include conducting rapid tests, preferably during the first prenatal visit or in high-risk situations; ordering additional laboratory tests if rapid testing is unavailable; providing counseling on the risks of syphilis and sexual practices that increase STI risk; and actively seeking out partners who do not attend appointments¹². By the end of the *diagnostic* activities, it is expected that all partners will have undergone rapid or nontreponemal (VDRL) tests for syphilis (preferably early in prenatal care), understand the risks of exposure to STIs, and that users absent from the first visit will have their appointments scheduled. The

main objective is to increase diagnostic coverage for syphilis among sexual partners of women diagnosed during prenatal care and to increase male adherence to their partner's prenatal care.

In the *treatment component*, the focus is on increasing coverage of appropriate syphilis treatment for sexual partners. Activities include offering treatment with 2.4 million IU of benzathine penicillin, regardless of serological status, and prescribing treatment according to the clinical stage of the disease. The protocol recommends 2.4 million IU for early syphilis and 7.2 million IU for late syphilis or syphilis of unknown duration. The goal is for all partners to be treated for syphilis. An analysis of Ministry of Health documents indicates that the model

aims to expand diagnosis, prenatal care adherence, and treatment and monitoring. However, gaps in practice may prevent the achievement of the expected results.

Difficulty in Diagnosis

The municipality in question demonstrated success in early detection through syphilis screening, in line with national protocols. In the study population, thirteen pregnant women and two postpartum women were diagnosed with syphilis during prenatal care and childbirth, respectively (Table 1). Eight shared the diagnosis with their partners, despite fear of judgment or the end of the relationship, and two chose not to share it, fearing discrimination and prejudice.

Table 1. Characteristics of the women and partners in the program for the prevention of vertical transmission of congenital syphilis who were interviewed.

Person	Gender	Age	Relationship status	Race	Partner interviewed	Occupation	Attitude toward syphilis
GE 1	F	26	Stable	Brown	Yes	Receives Bolsa Família	Fear
GE 2	F	23	Occasional	Brown	No	No occupation	Concern
GE 3	F	33	Stable	White	Yes	Domestic	Fear
GE 4	F	31	Occasional	Brown	No	Receives Bolsa Família	Fear/guilt
GE 5	F	26	Separated	Brown	No	Manicure	Fear/guilt
GE 6	F	15	Occasional	Brown	No	No occupation	Fear
GE 7	F	24	Stable	Brown	Yes	Accountant/unemployed	Surprise
GE 8	F	19	Stable	Brown	Yes	Manicure	Shy
GE 9	F	26	Occasional	Black	No	Concierge	Concern
GE 10	F	24	Divorced	Brown	No	Event security	Scared
PS 1	M	30	Separated	Brown	No	Logistics	Anger, blames ex-partner
PS 2	M	32	Stable	Brown	Yes	Scaffolder	Surprise
PS 3	M	30	Stable	Brown	Yes	Construction	Indifference
PS 4	M	34	Stable	Black	Yes	Scaffolder	Fearless
PS 5	M	26	Stable	Brown	Yes	Pest controller	Surprise

Source: Table prepared by the author in 2023.

I took the test right away, early in the pregnancy. GE3 It was right at the beginning; I took the test and went straight away to get the shots. GE4 Man, I knew right from the start [...] my wife was already 4 months pregnant. PS3

Right at the beginning, I took the test and it came back positive, so it was right at the beginning of the pregnancy. PS4 Despite the successful reports, potential missed opportunities to diagnose the infection early, as seen in the reports below:

During the exam the doctor performed at the very end of my pregnancy [...] she said I should have had the exam done earlier and that I needed to undergo treatment. GE2 It was at the end of the pregnancy; I hadn't done it before [...] GE1

Test, treat, and cure

Pregnant women and some of their partners adhered well to treatment, which indicates that healthcare providers are attentive and aware of the recommendations regarding the appropriate treatment of syphilis.

Yes, I did. I took benzathacil [...] several times. GE2

Yes, I underwent treatment, and so did he! GE3

The nurse recommended that I take Benzetacil [...] I almost fainted after the last dose [...] excruciating pain [...] it hurts so much [...]. PS1

The partners, however, reported behaviors that indicated the treatment regimen was not completed, as well as inadequate management by healthcare professionals and failure to follow proper care protocols for the disease. It is known that treatment of the sexual partners of women diagnosed with syphilis is mandatory, regardless of the test result, a measure aimed at preventing reinfection of the pregnant woman and, consequently, reducing vertical

transmission of syphilis.

I took the test, but mine came back normal [...] then the doctor was upset because it was negative, so she ordered a lab test [...] but I haven't had time to get that one done yet [...] the doctor didn't prescribe anything for me, she just told me to repeat the blood test. PS4

Of course I don't have syphilis... but I wasn't upset with her, the doctor told me to get the lab blood test, but I haven't had time to do that one yet... honestly PS2

I went to the appointment, took the rapid test, but it came back negative. They didn't asked to undergo treatment. PS2

Partner's involvement in syphilis treatment

Men's ability to attend prenatal appointments and syphilis treatment is hindered primarily by the fact that their work schedules conflict with the health clinic's hours.

I went to prenatal appointments twice. Because they always fell during work hours, so I can't just keep leaving work all the time. PS 4

I didn't go with her to the appointments because of my work schedule. [...] I think there should be leave for men, so they can attend prenatal appointments without missing work... like, isn't there maternity leave? Can't a woman leave work to go to the doctor?

So, there should be a law that says x hours per month for the father to spend with the child. PS3

My biggest challenge is just my work schedule! I went to a appointment and an ultrasound. PS 2 Yes, I used to go when I had time off from work. PS 1

He only went to one appointment because he had to get tested to see if he had the problem too. But he works, so there's no way he can keep going all the time, so... I'm the only one who has to go by myself. GE3

Male participation in prenatal care

was found to be limited: five respondents reported that they did not participate in or accompany their partner to appointments; seven reported attending one or two appointments; and only two attended more than two appointments. Only one male respondent accompanied his partner to all prenatal appointments. On this occasion, he reported that his ability to accompany his partner to the health clinic was due to the flexibility of his work schedule.

Health professionals' perspective

Challenges in offering rapid tests and treatment to partners of pregnant women diagnosed with syphilis have been frequent in the experience of primary care health professionals in Camaçari. Despite knowledge of national protocols and local initiatives aimed at encouraging partner participation in prenatal care, the team reports that partners' response is occasional and/or unpredictable:

If the partner is accompanying the pregnant woman at the first appointment, or if he responds to the summons, the rapid test and treatment are performed. P3

At the first appointment, most pregnant women come alone, without their sexual partner. We send a summons—just a little note—asking the partner to come to the clinic for a medical consultation, but they almost never show up. PS 5

Unfortunately, there are some cases where the partners aren't treated, right? And then there's the risk to the child [...] the pregnant woman gets treated, but the partner doesn't. Unfortunately, there are still some cases like that. PS 5

Most of the professionals interviewed were familiar with the national guidelines for the appropriate management of women and their partners with syphilis during pregnancy. However, limitations were found in the active tracing of partners. As a result, the

presence of male partners at prenatal appointments was not guaranteed. The main barriers associated with the absence of partners at these appointments were the incompatibility of men's work schedules with the health center's operating hours and, consequently, the lack of systematic active outreach to these individuals by health centers. The excerpts below illustrate instances of active outreach and other strategies adopted:

We attempted to actively seek out partners through the pregnant women, empowering them with information to raise their partners' awareness. [...] P3

We explain to the pregnant woman the importance of treatment, the risks to the baby, and everything else to try to raise awareness. [...] there is a higher risk of serious illnesses or significant neurological sequelae; they become more aware and try to raise their partner's awareness as well. P1

We conduct active case finding, try to talk to the partner, and explain everything clearly. We ask them to come in for an appointment. We try to be flexible with work schedules and all that to see if it works out. Sometimes, I write the prescription and give it to the pregnant woman when he says there's no way he can go to the clinic. We give him the opportunity to get treated [...] We already treat both of them as if they were positive at that moment. P5

The interviewed professionals conducted monitoring in accordance with the developed logical model and emphasized the importance of including partners in syphilis monitoring, alternating internal strategies according to the dynamics of each health team. The narratives below provide examples of how monitoring is carried out in the surveyed units.

Monitoring is conducted using a spreadsheet created by the team that facilitates tracking of the VDRL for pregnant women and their partners. P4

Monitoring is done via VDRL,

monthly for pregnant women and every 3 months for partners. P2

We monitor the pregnant woman with monthly VDRL [...] We track both the pregnant woman's card and the partner's card. If they miss an appointment, we usually follow up by phone. P5

Despite the successful experiences in the municipality, and despite the difficulties already mentioned, health professionals report not having participated in training on syphilis in the past twelve months. The main reasons cited were the lack of such training in the municipality, the fact that they had not been invited to participate in training activities, or that they were unavailable to attend the session on the scheduled day. It is thus evident that the municipality of Camaçari needs to systematically implement training initiatives focused on syphilis prevention. The provision of educational activities at the health center, for example, appears to offer promising alternatives for professional development, aiming to reach all workers who work in primary health care.

DISCUSSION

This study indicates that measures to prevent vertical transmission of congenital syphilis are in place in the municipality of Camaçari and can be evaluated. The main areas requiring improvement concern the approach to the partners of pregnant women, who do not attend the health clinic and, in general, do not undergo the prescribed treatment, even when contacted by the team. From an organizational standpoint, it is necessary to ensure immediate treatment for men upon a positive diagnosis of the pregnant woman, as there are reports of non-adherence to the established protocol by some primary care teams in the municipality.

It is important to emphasize that our study showed that, underlying the

partners' failure to attend, there is a broader understanding—shared by women, partners, managers, and health professionals—that it is ultimately the woman's responsibility, to take responsibility for the pregnancy process and its outcome, including negative ones, such as congenital syphilis.

In this sense, training and continuing education initiatives must include opportunities for reflection, with the necessary discussion on the impact of structural gender inequalities, both in the organization of services—particularly in prenatal care—and in the practices and discourses of managers, professionals, and service users; and how to overcome them.

Improving access to screening and early treatment of syphilis during prenatal care, clinically monitoring all women diagnosed with syphilis and their infants, improving partner management, and reducing the prevalence of syphilis in the general population are recommendations found in the literature^{13,14}. In a study evaluating partner screening for syphilis, a low percentage of men were identified for concurrent treatment of the infection with the pregnant woman. This indicator demonstrated the weakness of the service regarding care directed at men, as well as the risk of ineffective treatment, leading to the perpetuation of vertical transmission¹⁵.

Our study revealed that women's social position, in a patriarchal and hierarchical society, can influence the hidden or explicit mechanisms of power relations exercised by partners over them¹⁶, including the perception of fear of abandonment, the normalization of men's reluctance to seek concurrent health care with their partners, and potential other sexual contacts. The difficulty in convincing sexual partners to participate in prenatal care and, consequently, to undergo serological testing for diagnosis and treatment monitoring, is a major obstacle to reducing vertical transmission. Thus, we

argue that the occurrence of CHC can be interpreted as the lack of treatment or inadequate treatment of sexual partners^{16,17,18}.

It is important to note, at this point, the criticism that health services—particularly prenatal care—have historically focused on women's care. Analyses adopting a feminist perspective on health have shown that this characteristic is not “neutral”; on the contrary, it reflects a broader and deeply rooted social understanding that women are the “natural” bearers of responsibility for phenomena such as pregnancy, childbirth, and the postpartum period, as well as for child-rearing and domestic work, for example. A direct consequence of this conception affects policy planning and the organization and management of health services¹⁹. Structured according to this underlying logic, services often exclude men from their facilities²⁰. This manifests itself, that is, as already

As pointed out in this article, this is due both to restrictions on office hours and to barriers to men's participation during childbirth, despite the Companion Law^{20,21}. In this sense, health facilities (and their professionals) reinforce men's lack of responsibility for monitoring their partners' health, which contributes to the failure of efforts to prevent the transmission of congenital syphilis. One aspect to consider concerns creative strategies for summoning partners. We have seen that women have been responsible for this communication between health services and men. However, beyond this practice, more modern methods of outreach are recommended, such as sending messages via cell phone (text messages, WhatsApp). From a programmatic perspective, health facilities are encouraged to organize extended hours for the partner's prenatal care, or to offer

Healthcare services for men on weekends.

It is crucial to understand that, in

addition to biomedical interventions, measures that promote reflection and behavioral change must be integrated into health care facilities. Specifically regarding the topic addressed here, health education initiatives are necessary, such as direct counseling of patients regarding their risk of contracting and transmitting syphilis and other STIs. In addition, discussion groups for women and men on the topic could be organized by the team as a way to encourage reflection on the sociocultural issues, especially regarding gender and sexuality, involved in this phenomenon²².

The term “active case finding” has come to be used to denote a policy approach to healthcare under the banner of comprehensive care, which involves addressing health needs beyond spontaneous demand²³. Various forms of active partner tracing were described by the professionals, such as telephone contact, involvement of community health workers for home visits, and summons notes and letters. However, it appears that these strategies are not proving very successful. The professionals reported that the greatest challenges in controlling congenital syphilis lie precisely in treatment adherence and partner monitoring. Furthermore, they believe that the best way to identify partners is through raising women's awareness. From the perspective of male dominance, the experiences of women living with syphilis during pregnancy reveal almost exclusive responsibility for prenatal care, without male participation. From the perspective of Bourdieu's theory, these experiences highlight the operation of a certain type of violence symbolic violence that manifests itself, in the context under study, through the acceptance and normalization of structures of domination reflected, for example, in the effective absence of partners during prenatal care or in women's fear of revealing a syphilis diagnosis to their partner. Thus, the inequality of responsibilities for reproductive work

is experienced as something natural and socially legitimate, rather than as the result of a form of symbolic violence. This process of “naturalization” affects not only women and their partners but also health managers, professionals, and planners.

A limitation of this study is the failure to address all dimensions of the constructed logical model; it is important to analyze the integrity of the program aimed at preventing vertical transmission of syphilis, as well as the focus solely on heterosexual relationships among SUS users from lower socioeconomic strata. As this is a preliminary study, the evidence presented here points to the need for more in-depth studies on interventions that incorporate health teams' understanding of affective-sexual relationships (whether asymmetrical or not, stable or temporary) between men and women. Incorporating sociological aspects into training may enable professionals to adopt more sensitive and assertive approaches for the successful control and/or elimination of congenital syphilis. We therefore recommend a creative and direct approach to sexual partners, improved professional training that includes discussions on sexuality, gender, and health, as well as new studies that deepen our understanding of gender inequalities and their impacts on health.

New studies focusing on power relations and gender inequalities, their effects on health, as well as those addressing other social strata and distinct forms of affective-sexual relationships outside of heteronormativity are equally encouraged. Finally, research that articulates the social markers of gender, class, and race from an intersectional perspective is fundamental to understanding the complex dynamics between affective-sexual relationships, gender inequalities, and their impact on the occurrence of sexually transmitted infections, particularly syphilis.

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