



GESTATIONAL AND CONGENITAL SYPHILIS AND PRIMARY HEALTH CARE IN THE FEDERAL DISTRICT FROM 2012 TO 2019

SÍFILIS GESTACIONAL E CONGÊNITA E ATENÇÃO PRIMÁRIA À SAÚDE DO DISTRITO FEDERAL NO PERÍODO DE 2012 A 2019

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ABSTRACT: Objective: To analyze the rates of gestational and congenital syphilis in the Federal District and explore, from the perspective of healthcare professionals, the role of Primary Health Care in managing these cases. **Methods:** This study combines a descriptive ecological analysis of syphilis cases and congenital syphilis-related deaths reported between 2012 and 2019 with a qualitative analysis conducted in 2021 through semi-structured interviews with Primary Health Care professionals. **Results:** There was a notable increase in both the detection of gestational syphilis and the prevalence of congenital syphilis during the study period. Coverage of the Family Health Strategy grew between 2017 and 2018, exceeding 50%. Content analysis revealed valuable insights from healthcare workers regarding the gestational and congenital syphilis surveillance model and Primary Health Care practices in the Federal District. **Conclusion:** The study highlighted both the challenges and opportunities for improving syphilis care, providing valuable information to enhance the quality of services.

KEYWORDS: Primary Health Care; Family Health Strategy; Syphilis; Health Surveillance.

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RESUMO: Objetivo: Descrever as taxas de sífilis gestacional e congênita no Distrito Federal e compreender, na percepção dos profissionais, o papel da Atenção Primária no cuidado às usuárias. **Métodos:** Foi realizado um estudo epidemiológico ecológico descritivo dos casos notificados de sífilis e dos óbitos por sífilis congênita entre 2012 e 2019 e um estudo qualitativo, em 2021, utilizando entrevistas semiestruturadas com profissionais da Atenção Primária. **Resultados:** Houve aumento na taxa de detecção de sífilis gestacional e da prevalência de sífilis congênita nos anos estudados. A cobertura da estratégia saúde da família elevou-se no período de 2017 a 2018, atingindo mais de 50% de cobertura. A partir da análise de conteúdo, os servidores trouxeram elementos a respeito do Modelo de Vigilância da Sífilis Gestacional e Congênita e da Atenção Primária no Distrito Federal. **Conclusão:** O estudo destacou as dificuldades e potencialidades para a atenção à sífilis, contribuindo para a qualidade dos serviços.

PALAVRAS-CHAVE: Atenção Primária à Saúde; Estratégia de Saúde da Família; Sífilis; Vigilância em Saúde.

INTRODUCTION

Syphilis remains a challenge for public health policies in Brazil, particularly in its gestational and congenital forms, which account for a significant portion of the cases reported in the country¹. Syphilis is a persistent sexually transmitted infection (STI), with the etiological agent *Treponema pallidum* having been identified millennia ago. In 2016, the World Health Organization (WHO) estimated 6.3 million new cases of this syphilis worldwide, with a prevalence of 0.5% among men and women. This rate varies regionally, ranging from 0.1% to 1.6%².

The challenges to its elimination mirror the broader public health challenges at a global level³. The negative outcomes of untreated syphilis during pregnancy include stillbirth, low birth weight, and congenital infection. Although vertical transmission can be prevented through penicillin treatment administered at least 30 days before delivery, congenital syphilis remains a significant public health issue in the 21st century⁴.

This disease is subject to regular mandatory reporting (within seven days) in all its forms and conditions throughout the entire national territory⁴. The main objectives of the surveillance model concerning gestational and congenital syphilis include developing actions to reduce morbidity and mortality, defining and implementing transmission control measures, and interrupting the chain of transmission⁵.

In the case of congenital syphilis, surveillance objectives focus on monitoring the epidemiological profile and its trends, identifying cases to support prevention and control actions—intensifying these during prenatal care—and following up on and evaluating actions aimed at its elimination.

In the Federal District (FD), the 2020–2024 District Plan for Syphilis Surveillance and Control follows the guidelines of the Ministry of Health, with Basic Health Units (BHUs) serving as the primary reporting centers for gestational syphilis and maternity hospitals reporting congenital syphilis. The primary information system used is the online Notifiable Diseases Information System (*Sistema de Informação de Agravos de Notificação – SINAN*)⁶.

The FD mirrors the nationwide increase in reported cases of acquired, gestational, and congenital syphilis. Between 2012 and 2017, 1,454 cases of syphilis in pregnant women were reported in the FD. During this period, there was an increase in both the number of cases and detection rates, which reached 8.7 per 1,000 live births in 2017, representing a 0.7% rise compared to 2016. Regarding congenital syphilis, 1,158 cases were reported in the FD between 2012 and 2017. The analysis of congenital syphilis notifications shows an upward trend in both the number of cases and the prevalence rate. In 2012, 130 cases were recorded, increasing to 225 cases in 2016. The prevalence rate for these years was 3.0 and 5.2 per 1,000 live births, respectively⁷.

In the FD, public health developments followed national trends, with the federal capital pioneering in providing universal healthcare to its resident population. Since its creation in 1960, the FD implemented a healthcare system with no official discrimination, until the establishment of the Decentralized Unified Health System (*Sistema Unificado Descentralizado de Saúde – SUDS*) in 1988—followed by the creation of the Unified Health System (*Sistema Único de Saúde – SUS*)—when universality was established throughout the country for all residents by the 1988 Federal Constitution and Laws 8,080 and 8,142 of 1990⁸. In 2016, the Family Health Strategy (FHS) coverage was only 28.17%, which contradicted the prioritized organization of Brazil's Primary Healthcare (PHC) system. As a result, the need for reorganizing the public health model in the FD was identified. By the end of 2018, FHS coverage had exceeded 50%⁹.

This study aimed to describe the behavior of the syphilis detection rate during pregnancy, the prevalence rate of congenital syphilis, and the congenital syphilis mortality rate from 2012 to 2019. Additionally, it sought to understand, from the professionals' perspective, the role of PHC in caring for users with gestational and congenital syphilis.

METHODOLOGY

Two studies were conducted in the FD. The first was a descriptive ecological epidemiological analysis of the syphilis detection rate during pregnancy, the prevalence of congenital syphilis, and the congenital syphilis mortality rate from 2012 to 2019. The second qualitative analysis was conducted in 2021, involving semi-structured interviews with healthcare professionals who provided care and surveillance for users in the prenatal care pathway at PHC in the FD Eastern Health Region.

The study period is justified by the analysis of notifications from five years prior to the change in the diagnostic concept of congenital and gestational syphilis, as well as the changes occurring in the organization of PHC during this period in the FD.

The epidemiological analysis included women and children who were notified for gestational and congenital syphilis, respectively, in the FD between 2012 and 2019.

Variables from the SINAN notification form and the Mortality Information System (MIS) were selected, including the month and year of notification, healthcare facilities responsible for the notification, distribution of syphilis cases by sex, age, race/color, education level, place of residence, treponemal test results, treatment administered, partner treatment, and case progression.

The data on gestational syphilis and congenital syphilis were detailed using the following epidemiological indicators:

- a) Gestational syphilis detection rate, calculated by dividing the number of reported cases each year by the number of live births in the same year and location, then multiplied by 1,000.
- b) Congenital syphilis prevalence rate, calculated by dividing the number of congenital syphilis cases among residents of a given municipality by the number of live births to mothers residing in the same municipality during the study period.
- c) Congenital syphilis mortality rate, calculated as the ratio of deaths due to congenital syphilis per 100,000 live births.

The data on gestational and congenital syphilis were extracted from SINAN and provided by the Sexually Transmitted Infections Surveillance Unit (*Gerência de Vigilância das Infecções Sexualmente Transmissíveis* – GEVIST) of the Health Department of the Federal District (*Secretaria de Saúde do Distrito Federal* – SES-DF). Mortality data were extracted from the MIS and classified by underlying and/or associated causes, with codes varying from A50.0 to A50.9 of the International Statistical Classification of Diseases (ICD-10). Population data, including live births, were accessed from the SES-DF situation room¹⁰, which contains the database of the Directorate of Epidemiological Surveillance, Health Surveillance Subdivision of the FD, sourced from the Brazilian Institute of Geography and Statistics (*Instituto Brasileiro de Geografia e Estatística* – IBGE).

The data on coverage of the FHS teams were extracted from the e-Gestor AB⁹ information system, which uses data from the National Health Establishment Registry (*Sistema do Cadastro Nacional de Estabelecimentos de Saúde* – SCNES) and the IBGE.

For the qualitative analysis, BHUs located in the FD Eastern Health Region were included, covering both urban BHUs with up to three FHS (Type 1) and those with more than three FHS (Type 2), as well as BHUs with FHS in rural areas. Additionally, those with the fewest and most notifications of gestational and congenital syphilis during the study period were selected, excluding those teams that worked in the prison system. Four BHUs were included, one from the rural area and three from the urban area.

The analysis included doctors, nurses, nursing assistants and technicians, and community health agents (CHAs) who provided direct care to users at the selected BHUs, totaling 16 staff members. Professionals who had been away from their duties for more than six months in the past two years were excluded.

Empirical data were collected through semi-structured interviews, using a guide with key questions to assess professionals' perceptions of the PHC role in caring for users in the management of congenital and gestational syphilis. The interviews were recorded and transcribed, maintaining the literal content, with fictitious identifiers for the BHUs (stars), FHS teams (plants), and professionals (initial letter of each professional category). The data were then subjected to content analysis according to Bardin¹¹.

The research was approved by the Ethics Committee in Research of the Foundation for Education and Research in Health Sciences – Health Department of the Federal District (*Fundação de Ensino e Pesquisa em Ciências da Saúde – Secretaria de Saúde do Distrito Federal – FEPECS-SES/DF*), under Certificate of Presentation for Ethical Consideration *Certificado de Apresentação para Apreciação Ética – CAAE*) No. 30890620.5.0000.5650.

RESULTS

The SINAN database for the epidemiological analysis consisted of 3,347 cases of gestational syphilis and 3,341 records of congenital syphilis—of which 3,056 cases were deemed valid for the study after a consistency analysis—and 22 death cases recorded in the MIS from 2012 to 2019.

The detection rate of gestational syphilis in the FD showed an upward trend, peaking in 2019 at 22.83 per 1,000 live births. The most significant increase occurred between 2017 and 2018, with an 81% rise in 2018 compared to 2017, reflecting the impact of the change in the case definition for gestational syphilis in 2017, as illustrated in Figure 1.

Regarding congenital syphilis cases, the prevalence rate in children under one-year-old, a direct indicator of prenatal care quality, also showed an upward trend, reaching its highest value in 2019 at 14.85 per 1,000 live births (Figure 2). Notably, more than 95% of congenital syphilis cases in the FD were diagnosed in children under one year old.

Regarding the mortality rate from congenital syphilis, the highest number of deaths was recorded in 2016, with five deaths, followed by a decrease to three deaths in 2017 and 2018 and four deaths in 2019. These data resulted in a different trend for the mortality rate compared to the previously presented data. The highest value was reached in 2016—11.54 per 100,000 live births—followed by a decline in 2017 and 2018, with a new increase in 2019 to 9.44 per 100,000 live births (Figure 3).

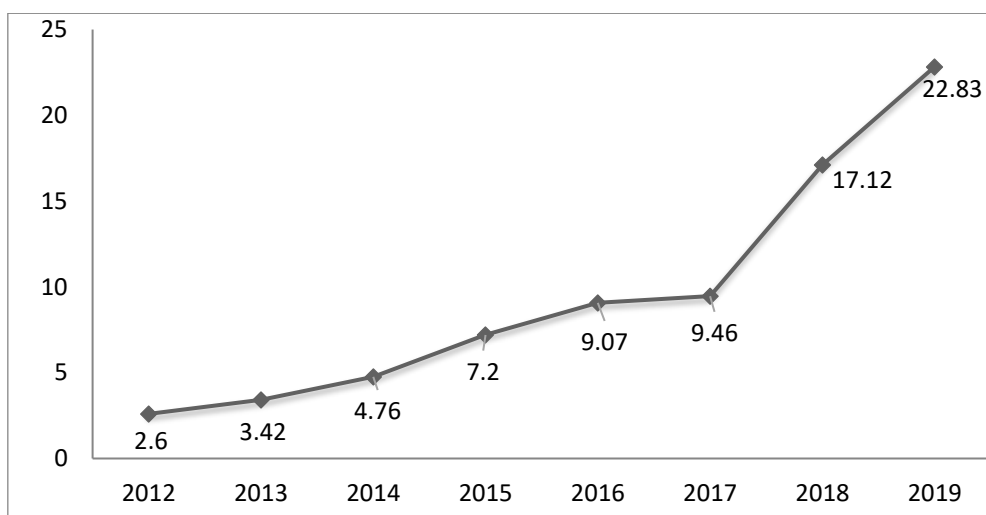


Figure 1 – Detection rate of gestational syphilis per 1,000 live births in the Federal District, 2012–2019.
Source: GEVIST/DIVEP/SVS/SES

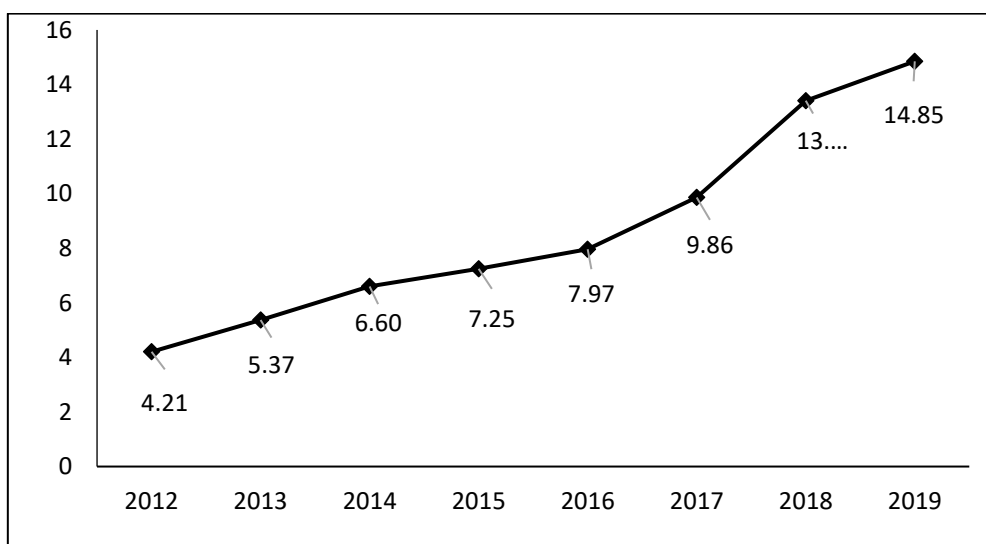


Figure 2 – Prevalence rate of congenital syphilis in children under one year of age per 1,000 live births. Federal District, 2012–2019.
Source: GEVIST/DIVEP/SVS/SES

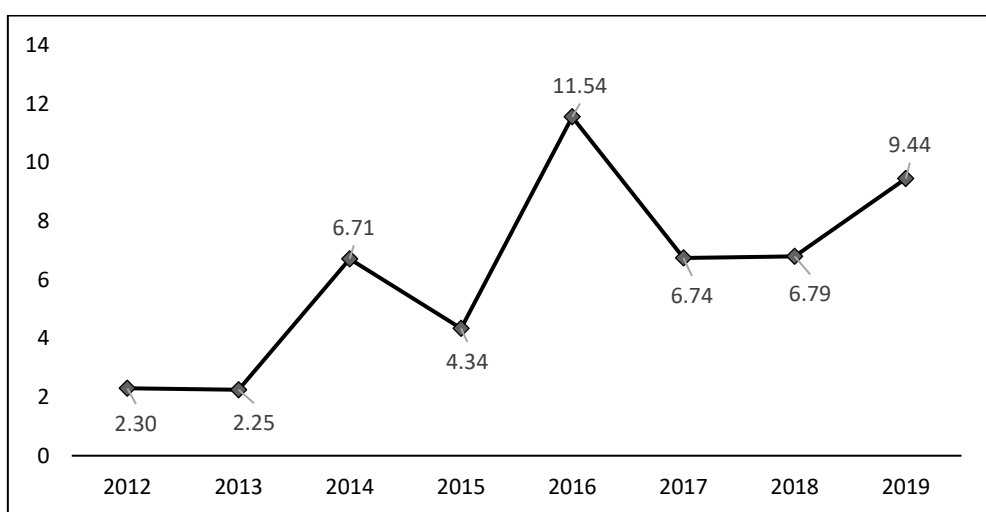


Figure 3 – Congenital syphilis mortality rate per 100,000 live births. Federal District, 2012–2019.
Source: GEVIST/DIVEP/SVS/SES

During the same period under analysis, the PHC organization in the FD also changed and varied in its mode of operation. The number of FHS teams fluctuated throughout the study's evaluation period, and consequently, this variation could have impacted the records of gestational and congenital syphilis. Figure 4 presents this variation in the percentage of coverage by FHS teams accredited by the Ministry of Health.

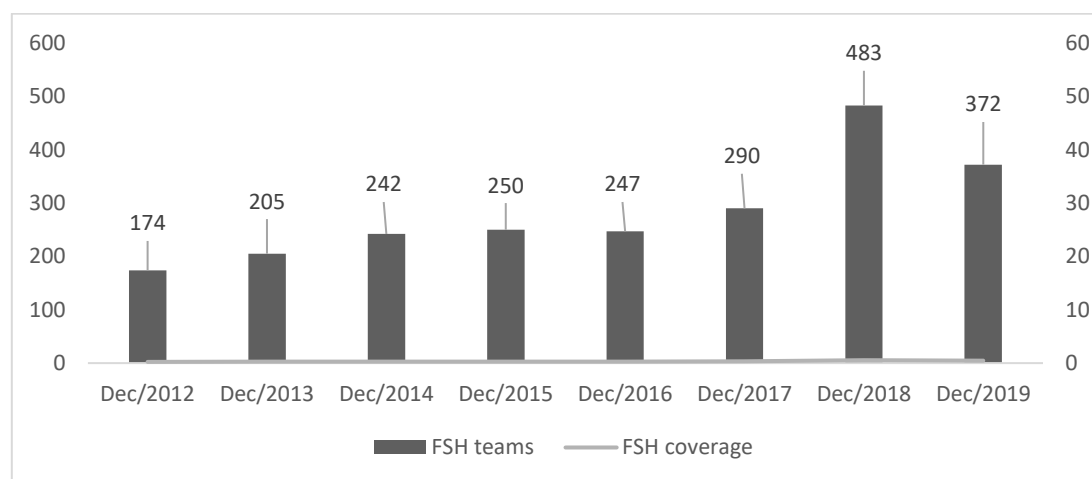


Figure 4 – Absolute number of Family Health Strategy (FHS) teams and coverage (%) in the Federal District, 2012–2019. Source: SAPS/Ministério da Saúde.

Sixteen interviews were conducted in the qualitative analysis, involving four family and community doctors, four nurses, four nursing technicians (one male and three female), and four female CHAs. These participants work in BHUs with specific characteristics, such as rural and urban areas, Types 1 and 2, and varying numbers of notifications. Furthermore, all the units involved are composed of FHS teams. Two BHUs participated in the expansion process of FHS teams in the FD, with some teams transitioning from traditional primary care to FHS teams. Table 1 outlines the characteristics of each unit involved.

Table 1 – Primary health units selected for the study, according to characteristics used for inclusion. Federal District, 2021.

Basic Health Unit (BHU)	Characteristics
BHU 8 Paranoá	Rural; Type 1; Assigned population of 3,500 people; Operating as an FHS team since inception; Lower number of reported cases of gestational and congenital syphilis.
BHU 2 São Sebastião	Urban; Type 1; Assigned population of 8,000 people; Operating as an FHS team since inception; Lower number of reported cases of gestational and congenital syphilis
BHU 1 Paranoá	Urban; Type 1; Assigned population of 8,000 people; Operating as an FHS team since inception; Lower number of reported cases of gestational and congenital syphilis
BHU 1 São Sebastião	Urban; Type II; Assigned population of 40,000 people; Initially operated with traditional teams, transitioning to FHS teams across all units after 2017.

Source: The authors.

The interviewees demonstrated a clear understanding of the topics discussed. Of the 16 participants, 11 (68.7%) have over 10 years of experience in PHC in the Eastern Region, while five have been working in this level of care and region for less than 10 years.

Regarding training, 11 participants reported attending events focused on the FHS model. Of these, eight (50%) attended training specifically addressing gestational and congenital syphilis in 2019. All CHAs reported training in both topics, while all nursing technicians stated they had not received training in either gestational or congenital syphilis. Only one medical professional reported receiving training in syphilis, and two nurses received training in both topics.

After transcribing and reviewing the interviews, two categories emerged: "gestational and congenital syphilis surveillance model" and "PHC in the FD." These categories were further divided into four subcategories, as shown in Figure 5.

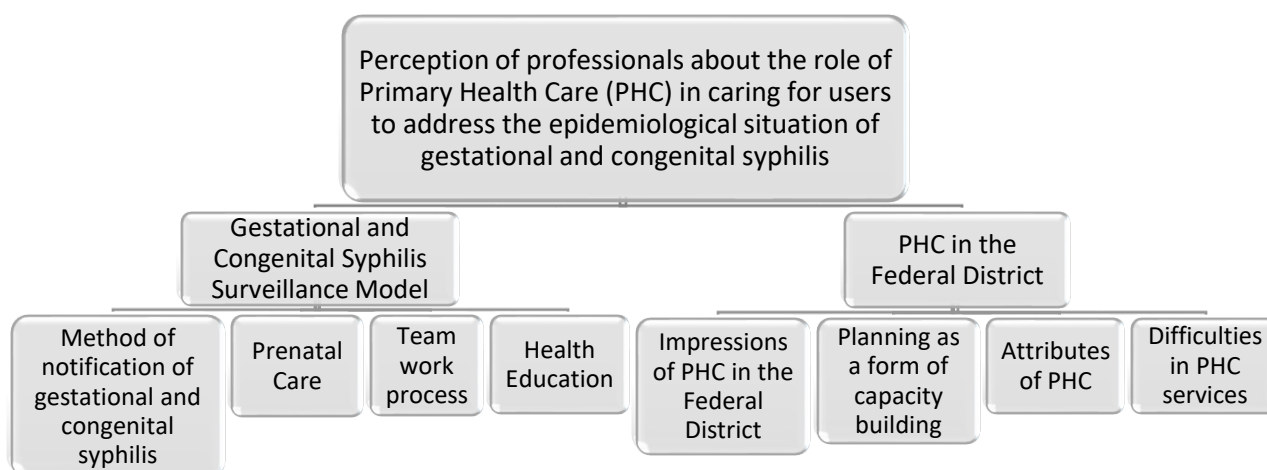


Figure 5 – Diagram of thematic categories and subcategories.

Source: The authors.

In the "gestational and congenital syphilis surveillance model" category, it was clear that 14 participants identified the notification process primarily as the responsibility of the FHS nurse. Three of the four nurses mentioned difficulties in completing the notification form using the current SINAN online system:

"...Now, for me, it's more of a hassle with SINANNET, because before, it was just on paper... we used to notify on paper and send it to epidemiological surveillance, but now you have to enter a lot of information, and sometimes it doesn't go through. What I do... I write it down on paper, note all the patient's details on paper, and then I type it into the system..."

(E1 from the Sun team at BHU Earth)

In the "prenatal" subcategory, 14 participants also mentioned the use of rapid testing as a diagnostic tool and disease management strategy, emphasizing it as the primary approach for early identification and treatment opportunities. M1 from the Sun team at BHU Earth, the unit with the highest number of cases during the study period, provides an example of the importance of this strategy in their statement:

"I think we have a lot of ease because we have access to rapid tests. As soon as it's detected, we start treatment right away. The rapid test puts (the result) in our hands, right? A tool for early detection."

(M1 from the Sun team at BHU Earth)

Concerning the subcategories "teamwork process" and "health education," there was unanimity regarding the satisfactory communication among team members, as expressed in the speech of TE 2 from the Mimosa team at the BHU Mars:

"All good... since the nurse goes first, she already schedules the first consultation, performs the tests, and tells us, right?"

– Ah! This pregnant woman needs to be very careful!

It's all good, the girls in the team are also very calm!"

(TE2 from the Mimosa team at the BHU Mars)

The challenge of communicating with the community was also detected, along with the difficulty of addressing sexual partners:

"We haven't been able to carry out this type of work anymore, the kind we used to do. In our community, there are many worker accommodations. We used to give talks about this, about syphilis, but we can't do it anymore..."

(TE1 from the Messier team at BHU Mercury)

Regarding the subcategories related to "PHC in the FD," impressions about PHC ranged from praise such as "good," "improving," "many resources," "interesting," "organized," and "diverse," to criticism such as "complicated," "a beautiful design but dysfunctional," and "unstructured," as illustrated below:

"...So, I think the design of primary care is beautiful, it's wonderful! But I find it a bit dysfunctional at times. Sometimes it's the small things that could be fixed, but for that to happen, those of us at the grassroots need to be heard. I feel like we're not being listened to."

(E4 from the Alpha team at BHU Jupiter)

Regarding the subcategories "planning as a form of training" and "attributes of PHC," the interviews highlighted the importance of planning in the training process to shift the PHC model in the FD. They also emphasized access as a significant attribute, discussed in terms of its expansion through the growth of FHS teams, as well as the impact of this increased access on the rise in diagnoses of gestational syphilis cases:

"...when a patient comes to the unit, they can access a variety of services, right?"

It's not just about a consultation; here, they can receive different types of care,

including tests and medication, right?"

(TE4 from the Alpha team at BHU Jupiter)

"In my opinion, the number of gestational and congenital syphilis cases increased... I think it's because, like, when a pregnant woman comes here for her first appointment, we already run all the tests. If we provide

access for them, of course, we're going to find out whether they have syphilis or not, right?"

(E1 from the Sun team at BHU Earth)

In the statements regarding the subcategory "challenges in PHC services," eight participants identified PHC as facing challenges related to infrastructure and human resources. Additionally, five members of the study reported an overload in PHC due to the broad scope of service portfolios:

"We notice that there has been a decentralization of some services that were transferred to primary healthcare, but there isn't enough staff, so primary healthcare ends up overloaded."

(TE4 from the Alpha team at BHU Jupiter).

DISCUSSION

Gestational and congenital syphilis are major public health concerns. The data from FD followed the national trend, showing the highest rates in the last two years of the study period, as indicated in the Ministry of Health's 2018 epidemiological bulletin³.

The year 2017 is pivotal in the present study, as it marks the change in the diagnostic criteria for gestational and congenital syphilis introduced by the Ministry of Health. It was also the year when the PHC model in the FD underwent modifications, with the implementation of ordinances 77 and 78, which prioritized the FHS team model in the federal capital¹², resulting in a significant increase in the coverage percentage of FHS teams in 2018¹³.

The historical series on the detection rates of gestational syphilis and the prevalence of congenital syphilis showed similar trends, with worsening outcomes over the last three years. This aligns with the Ministry of Health's 2018 epidemiological bulletin, which linked the rise in cases to the change in case definition criteria for the conditions studied⁴. However, unlike the national trend, both rates increased in 2019 in the FD, reaching their highest levels that year, while nationally, there was a 3.3% reduction compared to the previous year¹³.

An ascending trend was also observed in data from other federative units, such as the state of Bahia, where 15,050 cases of gestational syphilis and 7,812 cases of congenital syphilis were confirmed between 2007 and 2017. During the analyzed period, the incidence rate of gestational syphilis in the state rose from 1.29 to 15.09 cases in pregnant women per 1,000 live births, while the prevalence rate of congenital syphilis increased from 0.50 to 6.68 cases in children under one year of age per 1,000 live births¹⁴.

It is worth noting that the annual rates of congenital syphilis in Brazil increased from 4.0 cases per 1,000 live births in 2012 to 4.8 in 2013, 5.4 in 2014, and 6.5 in 2015¹⁵. For this country, this increase is attributed to several factors, including the shortage of benzathine penicillin, the drug recommended to prevent the transmission of syphilis from mother to child, and misconceptions about the adverse results of benzathine penicillin. In addition to the benzathine penicillin shortage, data from the second cycle of the National Program for Improving Access and the Quality of Primary Health Care (*Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica – PMAQ-AB*) in 2013/2014 indicate that 55% of FHS teams participating in this cycle use benzathine penicillin as the primary treatment in PHC, which may contribute to the increased vertical transmission of syphilis¹⁶.

As mentioned earlier, it is important to highlight that in 2017, the FD underwent the expansion of the FHS team model within PHC, which may also have contributed to the increase in case detection.

Congenital syphilis mortality reflects the performance of healthcare services at all levels of care, starting with the identification and monitoring of the condition during prenatal care in PHC and continuing through the management of delivery in a hospital setting. In the present study, the congenital syphilis mortality rate was lower than the national rate, ranging from 2.30 to 11.54 deaths per 100,000 live births in the analyzed series. Similar data were observed in other studies, highlighting congenital syphilis as a significant factor contributing to infant mortality¹⁷. However, it remains an avoidable cause with effective prevention strategies¹⁸.

The results from the interviews align with the historical overview of the shift in the PHC model in the FD, transitioning from the traditional model to the FHS teams. Previously, teams operated in a "traditional" format, with specialists such as general practitioners, gynecologists, and pediatricians providing care, while nursing teams worked in specific areas like the "children's room," "women's room," and "surveillance room." These teams shared both physical and political space with those adopting an integrated approach based on the territory's needs. A study on PHC policy in the Federal District from 1979 to 2009 clearly outlines the political events that influenced the development of this healthcare model¹⁸. This historical journey of PHC in the FD was reflected in the experiences of more than 10 participants who had been working in PHC in the region for over a decade.

By distinguishing the two categories in the content analysis of the interviews, it was possible to identify how the healthcare providers are aware that the surveillance model for gestational and congenital syphilis is influenced by the PHC structure. With the predominance of discussions focused on gestational syphilis and only a few mentions of the identification and management of congenital syphilis, the reality of the organization of the surveillance model for this condition in the FD becomes clear. This is outlined in the 2020/2024 District Plan for the Surveillance and Control of Syphilis by the SES/DF, which is still in the implementation phase within this State Health Department. The plan highlights PHC as the leading actor in the management and reporting of gestational syphilis, while maternity hospitals and birthing centers are seen as key players in the identification of congenital syphilis and the shared monitoring of identified cases with PHC⁷.

Qualitative analysis highlighted how the public health services of PHC in the FD operate using the surveillance model for gestational and congenital syphilis. Healthcare providers shared essential factors in their statements, such as the need to expand human resources, enhance training, and increase access to PHC services. These improvements are crucial for qualifying prenatal care actions, which could directly influence the reduction of gestational and congenital syphilis cases.

The year 2017 was significant in both stages of the research, as it marked the change in the diagnostic criteria for gestational and congenital syphilis at the national level. It also stood out in the timeline of health service organization in the federal capital with the shift in the PHC model, establishing the FHS as the model for organizing PHC that same year.

The literature provides few references regarding the direct association between the increase in the number of FHS teams and the reduction in the number of cases of gestational and congenital syphilis. In their study on the relationship between FHS coverage and gestational and congenital syphilis from 2007 to 2014 in the state of Goiás, Nunes et al. found a positive correlation between the percentage of FHS coverage and the number of cases of gestational and congenital syphilis in most of the years studied¹⁹. However, they did not identify a reduction in congenital syphilis in municipalities with higher FHS coverage.

This study has some limitations, including the use of secondary data in the quantitative analysis, which may result in the underreporting of cases. Furthermore, no linkage between databases was

conducted to allow for additional analyses of gestational and congenital syphilis records, which could have broadened the scope of the study.

CONCLUSION

The analysis of gestational syphilis detection rates and congenital syphilis prevalence rates reveals the upward trend of these conditions in the FD. The descriptive time series of these rates, combined with the insights of healthcare professionals directly involved in the practical care of individuals with gestational and congenital syphilis, constitutes a distinctive feature of this study.

Discussing the importance of improving PHC services based on indicators such as congenital syphilis—recognized as a sentinel indicator of prenatal care quality—through the perspectives of SES/DF staff and specific data from the FD offers an opportunity to expand discussions on targeted improvements for FD services.

The challenges of addressing gestational syphilis control and eradicating congenital syphilis are substantial, extending beyond the healthcare service model to include the sociodemographic characteristics of the affected population.

The potential of the FHS to operate within its designated territory stands out as a crucial element in organizing the healthcare network, fostering intersectoral communication with the social care network, and integrating with the community. Strengthening PHC strategies, as implemented in the FD—notably during 2017 and 2018—offers promising avenues for addressing this disease, which significantly impacts public health. Leveraging health promotion, prevention, and control strategies for syphilis based on the data presented in this study could lead to transformative changes in the disease's trajectory in the FD.

PHC is the cornerstone of the SUS for initiatives that encourage self-care and an understanding of SIT transmission. Therefore, monitoring the increase in cases of gestational and congenital syphilis, alongside evaluating FHS team coverage, can support informed decision-making to improve public health indicators.

This study provides an opportunity to highlight challenges and strengths identified by the own healthcare professionals, emphasizing their active role in shaping processes to enhance healthcare delivery.

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