



THE PROFILE OF RISKY SEXUAL BEHAVIOR OF SEROPOSITIVE WOMEN FOR SYPHILIS

O PERFIL DO COMPORTAMENTO SEXUAL DE RISCO DE MULHERES SEROPOSITIVAS PARA SÍFILIS

EL PERFIL DE CONDUCTA SEXUAL RIESGOSA DE LAS MUJERES CON VIH A LA SÍFILIS

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ABSTRACT

Objectives: to identify the socioeconomic and demographic profile of seropositive women for syphilis and to describe their risky sexual behaviors. **Method:** descriptive, sectional, quantitative approach, using a secondary database. The data evaluation was performed with the Epi Info Program and the results, presented in tables. **Results:** the socioeconomic and demographic profile predominantly indicates women between 20 and 24 years of age; single women; race/brown color; with higher education; inserted in the labor market. Regarding sexual risk behavior, it points to exposure to syphilis from sex, heterosexual relationships, being a single partner, without condom use, or with an eventual partner, using a condom more than half of the time. **Conclusion:** the socioeconomic and demographic profile of the users can contribute to situations of vulnerability. However, the declared sexual behaviors of these women points to the risk situations in relation to the sexually transmitted infections. **Descriptors:** Adolescent Health; Postpartum Period; Family Planning; Contraception.

RESUMO

Objetivos: identificar o perfil socioeconômico e demográfico das mulheres soropositivas para sífilis e descrever seus comportamentos sexuais de risco. **Método:** estudo descritivo, seccional, de abordagem quantitativa, utilizando base de dados secundária. A avaliação dos dados foi realizada com o Programa Epi Info e os resultados, apresentados em tabelas. **Resultados:** o perfil socioeconômico e demográfico indica majoritariamente mulheres entre 20 a 24 anos; solteiras; da raça/cor parda; com ensino superior; inseridas no mercado de trabalho. Quanto ao comportamento sexual de risco, aponta para a exposição à sífilis advinda do sexo, relacionamentos heterossexuais, sendo parceiro fixo único, sem utilização de preservativo ou com parceiro eventual, utilizando condom mais da metade das vezes. **Conclusão:** o perfil socioeconômico e demográfico das usuárias pode contribuir para situações de vulnerabilidade. Entretanto, os comportamentos sexuais declarados destas apontam para as situações de risco em relação às infecções sexualmente transmissíveis. **Descritores:** Saúde do Adolescente; Período Pós-parto; Planejamento Familiar; Anticoncepção.

RESUMEN

Objetivos: identificar el perfil socio-económico y demográfico de las mujeres VIH-positivas para sífilis y describir sus comportamientos sexuales de riesgo. **Método:** estudio descriptivo, seccional, de enfoque cuantitativo, utilizando base de datos secundaria. La evaluación de los datos fue realizada utilizando el programa de Epi Info y los resultados, presentados en las tablas. **Resultados:** el perfil socio-económico y demográfico indica que majoritariamente mujeres entre 20 y 24 años; solteras; de raza/color parda; con educación superior; insertadas en el mercado laboral. Sobre el comportamiento sexual de riesgo, apunta para la exposición a la sífilis oriunda del sexo, relaciones heterosexuales, siendo pareja estable único, sin el uso de un preservativo, o con cualquier pareja, usando condón más de la mitad de las veces. **Conclusión:** el perfil socio-económico y demográfico de las usuarias puede contribuir a situaciones de vulnerabilidad. Sin embargo, los comportamientos sexuales de estas apuntan para las situaciones de riesgo en relación con las infecciones sexualmente transmisibles. **Descriptores:** Salud del Adolescente; Periodo Posparto; Planificación Familiar; Anticoncepción.

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INTRODUCTION

In the context of health challenges, Sexually Transmitted Infections (STIs) stand out for their ability to have a profound impact on the human species. In many countries, STIs have vast health, social and economic consequences. The difficulties of accessibility and the quality of health services offered to socially disadvantaged population groups are the major obstacles towards the elimination of these diseases.¹

STIs encompass all the diseases that can be acquired during sexual intercourse, both in actual intercourse and in the events surrounding it, with the most frequent being gonorrhea, soft cancer, donovanosis, Acquired Immunodeficiency Syndrome (AIDS), and syphilis.² Among STIs, syphilis is an infectious disease caused by the bacteria *Treponema pallidum*. Infection can be acquired through sexual contact, blood transfusion, organ transplantation or by congenital transmission.³

Syphilis may manifest temporarily in three stages. The major signs and symptoms occur in the first two stages, periods in which it is most contagious. At its third moment, it may not manifest and therefore give the false impression of healing, and, with the disappearance of its clues, the carrier may not seek the proper diagnosis and treatment. Without care and follow-up, the disease can compromise the skin, eyes, bones, cardiovascular and nervous system. And if left untreated, it can even lead to death.³ Chronic progression may show acute episodes of latency.⁴

The occurrence of syphilis in Brazil is so significant that it is the biggest concern for health authorities after AIDS. The highest incidence in the country is concentrated in the Southeastern and Northeastern regions.³ The state of Rio de Janeiro currently has, currently, a population of approximately 6,453,682 inhabitants, out of which, 3,360,629 are comprised by women,⁵ however, they are of childbearing age and infected by the syphilis virus.³

Epidemiological studies of the major epidemics during the second half of the twentieth century have identified how human behavior is the main risk factor for health.⁶ The existence of a pattern of human behavior at risk for sexual and reproductive health, in other words, varied behaviors towards sexuality, such as multiplicity of partners and / or irregular condom use, predispositions to sexually transmitted infections or unplanned pregnancies.⁷ The pattern of risk behavior in relation to sexual and reproductive health

may possibly relate to individual, family, social and cultural variables⁶, as well as to the vulnerability to which people are exposed.⁸

Vulnerability is understood as the possibility of exposing people to illness, resulting not only from a set of individual aspects, but from collective and contextual factors, which cause individuals greater susceptibility to the availability of resources to protect themselves.⁸

Thus, the increase in the number of women of childbearing age infected by syphilis and the serious consequences resulting from this pathology, especially when untreated, raised the need for questioning about the problem, since there are still gaps regarding the identification of risk behaviors in this group population in the face of this disease.

The study object was then outlined: the profile of the risky sexual behavior profile of seropositive women for Syphilis at a Testing and Counseling Center of a University Hospital in Rio de Janeiro was outlined as the object of study.

When considering that the woman, in any of its phases, is contemplated in the National Policy of Integral Attention to Women's Health, and that the number of those affected by STI, more specifically syphilis, is increasing, the hypothesis of this research indicates if: Testing and Counseling for syphilis of a University Hospital in Rio de Janeiro has, mostly, a risky sexual behavior.

This research is justified in order to intensify the scientific productions related to the subject of syphilis in women of childbearing age and their respective sexual behavior, allowing, in this way to give visibility to these questions, since they show factors pertaining to the vulnerability of gender. In this way, the objectives are: to identify the socioeconomic and demographic profile of seropositive women for syphilis; and describe their risky sexual behaviors.

METHOD

Descriptive, sectional, quantitative approach study. For the collection of the information, a secondary database was used, through documentary research, which were the electronic medical records of women included in the Information System-CTA (SI-CTA).

As a research scenario, the Center for Testing and Counseling (CTC) of the São Francisco de Assis Health Care Institute (HESFA), of the Federal University of Rio de Janeiro (UFRJ) was chosen as a reference and

free demand for accommodating for rapid testing and serology for Human Immunodeficiency Virus (HIV), Syphilis, Hepatitis B and C.

Testing and Counseling Centers fulfill the important role of intermediation between STI / AIDS prevention and care, promoting the reception and counseling by the health professional of the user in their decision to perform the tests.⁹

The participants of the study were investigated by means of the SI-CTC medical chart, and these were women who sought the industry on demand for the rapid test of diagnosis of HIV, Hepatitis B and C and Syphilis. The data collection period occurred between September and November 2015.

By means of the demand of care in the sector, from October 2013 to March 2015, and the identification of variables to be studied at that time such as, the quantitative total of examinations of the Venereal Disease Research Laboratory (VDRL) performed (2,138), quantitative Of VDRL tests performed on women (1,149), and positive VDRL exams in the female group (119), the sample calculation was used to know the presentation required for the investigation, with simple random sampling on the categorical variables.

The sample calculation formula pointed to a certain number of records to be analyzed. However, the system did not include the registry with the expected quantity, since the SI-CTC does not have *backup* and constant updates. In this way, the data collection work was done with eighty-six (86) charts available and that met the research requirements, thus, identifying a limitation in the study.

As the inclusion criteria, were used: medical records from October 2013 to March 2015; of women over 18 years of age; with positive diagnosis for syphilis, through VDRL examination; who were identified with syphilis⁸ at the first consultation of the CTC; and with the anamnesis totally filled in and, for exclusion: medical records with data lags or that were not identified in the system.

The study variables were determined based on the information available in the SI-CTC database. The data was collected using an instrument of their own, and analyzed through the Epi Info program.

Data collection took place after approval of the research project by the Research Ethics Committee of HESFA / UFRJ, on August 28, 2015, under CAAE: 2 46166015.1.0000.5238, and Opinion: 1,205,380.

RESULTS

The highest percentage of women who sought the CTC and who had a positive serology for syphilis were in the 20-24 age group (25.58%); single women (63.95%); race / brown color (38.37%) and higher level education (41.86%) (Table 1).

Table 1. Number, percentage and 95% CI of women with positive serology for syphilis, according to socio-demographic variables. CTC of the Institute of Health Care São Francisco de Assis (RJ), Brazil, 2015.

Variables	n	%	IC _{95%}
Age (years)			
18 to 19	7	8.14	(4.92 - 11.35)
20 to 24	22	25.58	(22.36 - 28.79)
25 to 29	15	17.44	(14.22 - 20.65)
30 to 34	11	12.79	(9.57 - 16.00)
35 to 39	6	6.98	(3.76 - 10.19)
40 to 44	9	10.47	(7.25 - 13.68)
45 to 49	9	10.47	(7.25 - 13.68)
50 to 54	3	3.49	(0.27 - 6.70)
55 to 59	1	1.16	(-2.05 - 4.37)
60 to 64	1	1.16	(-2.05 - 4.37)
65 to 69	2	2.33	(-0.88 - 5.54)
Total	86	100.00	
Marital Status			
Married/stable union	19	22.09	(18.87 - 25.30)
Single	55	63.95	(60.73 - 67.16)
Separated	10	11.63	(8.41 - 14.84)
Not informed	2	2.33	(-0.88 - 5.54)
Total	86	100.00	
Race/Color			
White	30	34.88	(31.66 - 38.09)
Black	16	18.60	(15.38 - 21.81)
Brown	33	38.37	(35.15 - 41.58)
Yellow	5	5.81	(2.59 - 9.02)
Ignored	2	2.33	(-0.88 - 5.54)
Total	86	100.00	
Education			
Basic education	15	17.44	(14.22 - 20.65)
Highschool	34	39.53	(36.31 - 42.74)
Higher Education	36	41.86	(38.64 - 45.07)
Ignored	1	1.16	(-2.05 - 4.37)
Total	86	100.00	

Regarding the employment situation, it was observed that 50% of the women reported being employed. However, this variable presented a high percentage without filling, identified as "Not applicable" (16.28%), and it is empirically attributed to these women being at school or retired.

The data on occupation in the work market were grouped according to the ten large groups of the Brazilian Classification of Occupations (BCO).¹⁰ In this way, the women of the household (unpaid activity within their own residence) and students, with 16.28% were considered unoccupied. So, the highest percentage identified, of women in employment, was that of service workers, store sellers and markets, with 18.60%.

In relation to the population cut, this CTC classifies the users who seek the service in: general population, sex workers, injecting drug users, people living with HIV / AIDS, among others. So, 88.37% of the women come from the population in general.

The participants were, in their majority, as place of residence, the capital Rio de Janeiro (75,58%). The neighborhoods were grouped according to the General Administrative Division of the city of Rio de Janeiro, which is composed of five Planning Areas (PA) ¹⁰. In

this way, the prevalence of women's housing was AP one (33.72%) and three (25.58%).

Among the women's charts, 43 (50%) indicated that they had information about the service offered by the CTC through friends / users of the service. For the others, the internet and the health service / professional were their main sources of knowledge, equivalent to 33.72%.

Regarding drug use (Table 2), licit, such as alcohol, 45.35% of the women reported that they use it "from time to time", 41.86% "are not users" and 4.65% use it "frequently". In relation to the illicit drugs, such as aspirated and injectable cocaine, crack and heroin, participants indicated that 58.14% "have used, but not anymore" and 41.86% "are not users." Regarding marijuana, 41.86% said that "have used it, but not anymore", for the same percentage that "is not a user", 4.65% and "uses from time to time."

Table 2. Distribution of women with positive serology for syphilis according to the type of drug used. CTC of the Institute of Health Care. São Francisco de Assis (RJ), Brazil, 2015.

Type of drugs	Alcohol		Marijuana		Aspirated cocain		Injectable cocain		Crack		Heroin	
	n	%	n	%	n	%	n	%	n	%	n	%
Is not a user	36	41.86	36	41.86	36	41.86	36	41.86	36	41.86	36	41.86
Has used it, but not anymore	-	-	36	41.86	50	58.14	50	58.14	50	58.14	50	58.14
Never used it	7	8.14	10	11.63	-	-	-	-	-	-	-	-
Uses it sometimes	39	45.35	4	4.65	-	-	-	-	-	-	-	-
Frequently	4	4.65	-	-	-	-	-	-	-	-	-	-
Total	86	100.00	86	100.00	86	100.00	86	100.00	86	100.00	86	100.00

The main reasons given by the women to look for the service offered by the CTC were: exposure to the risk situation (44.19%); immunological window (17.44%) and other reasons (13.95%) cited as: solving the test (04); coexistence with HIV / AIDS patients (02); sharing of objects, curiosity, routine, job application and intimate visit.

Thus, the socioeconomic and demographic profile of the women in this study is between 20 and 24 years of age (25.58%); single women (63.95%); of the race/brown color (38.37%); with higher education (41.86%); inserted in the labor market (50%) and coming from the general population (90%). Residents of the capital of Rio de Janeiro (75.58%), belonging to Planning Area 1 (33.72%); getting to know the CTC through friends / users of the service (50.0%); mostly cocaine, crack and heroin users (58.14%) and marijuana (41.86%), and alcohol users from time to time (45.35%); and that sought CTC (44.19%) for exposure to the risk of syphilis.

Regarding the type of exposure, 84, that is, 97.67% of the women in the study reported having had sexual intercourse, and only two (2.33%) corresponded to occupational

exposure (exposure to biological material, among others). Of the 86 women who took the HIV test, the result was negative for 46 (53.48%). However, 46.51% did not get the result.

Regarding the information in the medical records about the occurrence of some STIs of these users in the last 12 months, in only 7% of the documents had the positive information and in 93% they indicated the non-occurrence or lack of symptoms. The cases that were presented were treated at the health service, and the most prevalent were: herpes, leucorrhea and the human papilloma virus (HPV).

Regarding the types of partners in the last 12 months, almost all women reported sexual relations with men (90.7%), and less expressive portions indicated relationships with men and women (2.33%), with women only (3.49% %) and no relationship (3.49%).

The number of partners in the last 12 months was obtained by summing up the number of male and female partners informed. Thus, it was identified that 44.19% of the users had a single partner or between "2 to 4" (34.88%) (Table 3).

Table 3. Number and percentage of women according to number of partners. CTC of the Institute of Health Care. São Francisco de Assis (RJ), Brazil, 2015.

Amount	n	%
1	38	44.19
2 to 4	30	34.88
5 to 10	11	12.79
More than 10	1	1.16
None	3	3.49
Without information	3	3.49
Total	86	100.00

Most women (26.74%) did not use a condom with their (current) partner in the last 12 months and 20.93% used less than half the time; 13.95% used all of them at times (Table 4).

The alleged reason for not using the condom with the fixed partner, mostly with 19.76%, was trust, and 39.53% of the women reported not having used condoms in the latter relationship, also with a fixed partner.

However, regarding the risk that the fixed partner can present, a variable with low quality of information was identified,

denominated "other", representing 53.49% of the users' exposure, without further details in the medical record..

Table 4. N, percentage and 95% CI of women according to condom use and type of risk presented by fixed partner. CTC of the Institute of Health Care. São Francisco de Assis (RJ), Brazil, 2015.

Variables	n	%	IC _{95%}
Use of a condom with a fixed partner (current) in the last 12 months			
Not applicable	29	33.72	(30.50 - 36.93)
Did not use	23	26.74	(23.52 - 29.95)
Used more than half the time	4	4.65	(1.43 - 7.86)
Used less than half the time	18	20.93	(17.71 - 24.14)
Used it everytime	12	13.95	(10.73 - 17.16)
Total	86	100.00	
Reason for not using a condom with a fixed partner			
Did think you will not get it	1	1.16	(-2.05 - 4.37)
Thought the other had no HIV	5	5.81	(2.59 - 9.02)
Product allergy	2	2.33	(-0.88 - 5.54)
Trusts their partner	17	19.76	(16.54 - 22.97)
Cannot negotiate	1	1.16	(-2.05 - 4.37)
Not enough time / horny	3	3.49	(0.27 - 6.70)
Did not have one at the moment	2	2.33	(-0.88 - 5.54)
Do not like it	6	6.98	(3.76 - 10.19)
Not applicable	41	47.67	(44.45 - 50.88)
Negotiated not to use it	2	2.33	(-0.88 - 5.54)
Others	4	4.65	(1.43 - 7.86)
Partner does not accept it	2	2.33	(-0.88 - 5.54)
Total	86	100.00	
Used a condom in the last relationship with a fixed partner			
No	34	39.53	(36.31 - 42.74)
Not applicable	29	33.72	(30.50 - 36.93)
Yes	22	25.58	(22.36 - 28.79)
Yes, but it broke	1	1.16	(-2.05 - 4.37)
Total	86	100.00	
What risk can the fixed partner have			
Uninformed	3	3.49	(0.27 - 6.70)
Not applicable	29	33.72	(30.50 - 36.93)
Others	46	53.49	(50.27 - 56.70)
HIV positive	7	8.14	(4.92 - 11.35)
Injecting drug user	1	1.16	(-2.05 - 4.37)
Total	86	100.00	

Regarding the condom use of users who had relationships with a prospective partner in the last 12 months, 18.60% of the women said they used it more than half the time. The reason for no more justified use was confidence (17.44%) in the eventual partner. Of the users, 31.40% reported not having used the condom in the last sexual intercourse. (Table 5).

Table 5. N, percentage and 95% CI of women according to condom use with casual partner. CTC of the Institute of Health Care. São Francisco de Assis (RJ), Brazil, 2015.

Variables	n	%	IC _{95%}
Use of condom with possible partner (s) in the last 12 months			
Not applicable	40	46.51	(43.29 - 49.72)
Did not use	12	13.95	(10.73 - 17.16)
Used more than half the time	16	18.60	(15.38 - 21.81)
Used less than half the time	9	10.47	(7.25 - 13.68)
Used it everytime	9	10.47	(7.25 - 13.68)
Total	86	100.00	
Reason for not using condoms with an eventual partner			
Thought the other had no HIV	4	4.65	(1.43 - 7.86)
Trust their partner	15	17.44	(14.22 - 20.65)
Not enough time / horny	4	4.65	(1.43 - 7.86)
Did not have at the moment	3	3.49	(0.27 - 6.70)
Do not like it	2	2.33	(-0.88 - 5.54)
Not applicable	40	46.51	(43.29 - 49.72)
I had no information	1	1.16	(-2.05 - 4.37)
Negotiated not to use it	1	1.16	(-2.05 - 4.37)
Others	9	10.47	(7.25 - 13.68)
Partner does not accept	5	5.81	(2.59 - 9.02)
Under the influence of drugs / alcohol	2	2.33	(-0.88 - 5.54)
Total	86	100.00	
Condom use in the last relationship with an eventual partner			
No	27	31.40	(28.18 - 34.61)
Not applicable	40	46.51	(43.29 - 49.72)
Yes	19	22.09	(18.87 - 25.30)
Total	86	100.00	

Most users (45.35%) reported having received counseling from the health care provider to bring their partner to the CTC in order to accept counseling or testing for STIs. And on the disposition of these users to change the behavior, identified as risk, 31.40% of the medical records indicated that yes.

Thus, the analysis of the sexual risk behavior of CTC users presents with the majority of women exposed to syphilis (97.67%), without HIV co-infection (53.48%). Those who took the results, or by other STIs (93%). The sexual relationship identified with men (90.7%), and in a 12-month period, with a single partner (44.19%), without condom use with a fixed partner (26.74%), because of trust in the other 19.76%), or with an occasional partner, using a condom more than half the time (18.60%), also for believing in their partner (17.44%). They indicated that they received guidance from the health professional to bring the partner to the CTC (45.35%), in order to accept counseling or testing for STIs, as well as a behavioral change provision (31.40%), identified as risky.

DISCUSSION

The health of girls and women in each country is critically affected by social and economic factors, such as access to

education, family wealth, and place of residence. In almost all countries, these groups who live in richer households die less and use health services more than those living in poorer households. Such differences are not limited to developing countries, but are also found in the developed world.

The age between 20 and 24 years, considered as young adult,¹¹ indicates an age group where the woman, of fertile age, counts on the possibility of having a sexually active life and with the capacity and responsibility in making choices about the means of protection against STIs.¹²

The fact of being single, predisposing to not having a fixed partner, can increase the multiplicity of sexual partnerships and the risk of unprotected sex.

In this way, STI prevention should involve, above all, socio-cultural and psycho-affective issues, when prevention and care actions must take into account how men and women are socialized and how they exercise their sexuality.¹⁴

The brown race/color, identified as the majority of users, is the Epidemiological Bulletin of Syphilis, which also indicates that the mothers of children with congenital syphilis are the majority of browns, in relation to the total investigated.¹⁵

The race / color question is usually related to lower financial income, less information and precarious health services¹⁶ that may reflect or contribute to situations of vulnerability or risky behavior.⁷

As for schooling, data from the Brazilian Institute of Geography and Statistics (IBGE) 2010 indicate that there is a larger contingent of women among university students and people of complete higher education⁴, and as the school level broadens the horizons of knowledge, it is inferred That these people have more information about the causes, consequences and prevention of STIs.¹⁷

The women in the study are, predominantly employed, a fact that is reconciled with the IBGE data, which indicates that there was an increase from 43.2% to 54.8% in the total number of women employed between 2001 and 2011.⁵

The highest occupancy rate of users, who is a seller, has the average commercial salary in 2016, the value of one minimum wage, ¹⁸ which may reflect on health and quality of life issues.¹⁹

The users of the service come from the population in general, a point in harmony with one of the objectives established by the Ministry of Health for the CTC, which would be to increase access to the population in general, and especially, to the most vulnerable groups for counseling, diagnosis and treatment of HIV, syphilis, hepatitis B and C.⁹

Regarding the place of residence and neighborhoods of the users that seek the CTC, understanding that in the capital of Rio de Janeiro there are three CTCs linked to hospitals, ²⁰ and that the tests specifically offered have a connotation related to sexuality or that may give rise to prejudice, ²¹ the interested population can either seek the care close to their home or work, as well as distant from their areas of origin.

People, before seeking health care, often seek to interact with friends to obtain an indication of a place of service that meets their needs.

The use of licit or illicit drugs increases the likelihood of a person engaging with multiple sexual partners or non-use of the condom, ²³ and, thus, increasing the risk of STIs, unwanted pregnancies and other negative health consequences for the sexually transmitted infections.²⁴

The demand for services offered by the CTC is based on a spontaneous demand generally associated with exposure to risk situations such as unprotected sex,

immunological window monitoring or patient referral by other services.⁹

Sexual exposure to syphilis is the most frequent,²⁵ and, like any other STI, is a gateway to other sexually transmitted infections.³⁻¹³ and heterosexual contact has contributed significantly to the growth of the STI / AIDS epidemic in women in recent years.

A study carried out in the state of Ceará, developed in a reference unit in the treatment and diagnosis of STIs in women, syphilis was the second most frequent infection, and in relation to contamination, 80% of the patients thought that they contracted it from their current companion .²⁷

The low perception of risk for STI is usually related to the sense of protection, especially, when women are married or have a fixed and stable partner, as well as when they are no longer able to become pregnant.²⁸ In this way, individuals who do not feel vulnerable to diseases usually do not accept the recommended preventive measures for these diseases.²⁹

The trust placed in the fixed partner causes the woman to stop using the condom, since she does not identify possible risks arising from a stable relationship. ³⁰ The use of a condom with an occasional partner, which characterizes relationships without commitment, also indicated little adherence, since most of these partnerships were well-known, based on trust for not using the condom.³⁰ And yet, some individuals, although conscious of their vulnerability, persist in at-risk sexual practices, even with the possibility of becoming infected with STIs.²⁹

The health worker's approach to STIs has repercussions not only on the quality of care provided to women but also on other social actors involved, reflecting the promotion of sexual and reproductive health and disease prevention. The difficulty of coping with these actions may contribute to maintaining high rates of prevalence and incidence of different STIs in the country.³¹

Studies that applied the health beliefs model to the issue of STIs/AIDS revealed that when there is a greater perception of susceptibility to the associated disease, there is also a reduction in risk behaviors.²⁹

The reduction of sexual risk behaviors, ⁷ has, in the condom, a relatively limited prevention strategy, since, in addition to encouraging the use of this method, actions are needed to disseminate information about signs, symptoms and possible health consequences, as well as demystifying false beliefs, in order to guarantee the health

service's request in case of doubt or suspicion of infection.³¹

CONCLUSION

It was possible to identify that the women reflect a socioeconomic and demographic profile that can contribute to the condition of vulnerability. However, the declared sexual behaviors show the risk situations in relation to syphilis re-infection and the contamination by other STIs.

The answers found reinforce the importance of considering the context in which these women live to understand how they build their behaviors in relation to sexual health issues.

Given this scenario, the health professional should consider the need for preventive intervention, with a greater focus on educational actions, such as raising awareness of the importance of performing the rapid test, pre and post-test counseling, condom use with fixed or occasional partners, and self-care in health, clarifying also the associated vulnerability, Early diagnosis and treatment in order to break the chain of transmission without causing embarrassment among those affected by such diseases and their partners.

The study suggests the need for future research on syphilis in relation to women of childbearing age, for better monitoring and analysis of the factors associated with their sexual risk behaviors, in order to reduce this sexually transmitted infection.

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