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Reframing Syphilis in an Extreme Climate Event

Tensions Between Epidemiological Surveillance and Primary Care

***Fig. 1** Flooded city in Rio Grande do Sul, Brazil. **Source:** São Leopoldo City Hall/Disclosure.*

This post looks at how primary care and epidemiological surveillance pull together, or pull apart, in Brazil's syphilis-control efforts. Primary care works with a logic of care focused on patients; surveillance works with a logic of control focused on monitoring disease. I trace when and how these logics are coordinated and when they break down along the care pathway.

We draw on the Brazilian Collective Health tradition of Institutional Analysis, especially as developed by Solange L'Abbate (2003; 2012). It treats "the institution" as a dynamic formation produced by the tension between instituted dimensions, the inherited, established order, and instituting dimensions, innovations that disrupt and rework that order. In this frame, I examine how epidemiological surveillance and primary care are constituted as institutions through their practices of syphilis care and control.

Syphilis notifications in Brazil have shown a persistent upward trend. Between 2019 and 2023, reported cases of acquired syphilis rose from 164,830 to 242,826; syphilis in pregnancy from 64,619 to 86,111; and congenital syphilis from 25,392 to 26,513 (Brasil 2024). In 2014, amid a national penicillin shortage, the first-line treatment, the disease was widely framed as an epidemic in Brazil, gaining prominence in public health debates.

Fieldwork was conducted in a city within the metropolitan region of Porto Alegre, capital of Rio Grande do Sul, Brazil's southernmost state. The city has ~200,000 inhabitants and sits within a wider urban area of roughly 4 million. Its health network comprises 24 primary care units, one general hospital, and one specialized care service. It also maintains a municipal health surveillance service that houses the epidemiological surveillance department for syphilis, alongside laboratories contracted to provide diagnostic services. Fieldwork took place between January and December 2024. I conducted observations, interviews, and focus groups with health professionals on practices of syphilis care and control.

In 2024, this city—like most municipalities in Rio Grande do Sul—experienced a severe flood that devastated infrastructure, including health services. After outlining the main issues that surfaced in fieldwork, I show how this extreme climatic event disrupted the health network and reframed syphilis through a collectivist, public-good lens (Das 2023). This shift contrasts with the hegemonic post-penicillin framing, which has treated syphilis as a private good tied to individual lifestyle choices since the mid-twentieth century.

Dilemmas and syphilis routines

A central theme that emerged in fieldwork was adherence to treatment in syphilis care. When invited to reflect on drivers of rising incidence, participants detailed numerous barriers to completing the full course of benzathine penicillin G. This long-standing issue becomes especially vivid when narrated from the vantage point of day-to-day work with the disease.

Among the barriers to administering penicillin, clinicians repeatedly emphasized the considerable pain of the injection. This is due to its dense, viscous suspension and the mode of administration: a deep intramuscular injection that penetrates muscle tissue and releases the drug slowly. As a result, they reported that many patients—especially men, in their accounts—do not return after the first dose to complete the standard three-dose regimen for infections of ≥1 year.

In routine meetings and in joint trainings that bring together Primary Care and Health Surveillance teams, the latter typically stress that patients who refuse penicillin should be offered an alternative regimen, even if it is longer, more costly, and less effective. Alternatives cited include doxycycline or ceftriaxone, whose schedules require periodic laboratory follow-up given the higher risk of therapeutic failure. As one recurring message put it: “If the patient won’t take the injection, there’s another way, ‘the drops’, but you must warn them it takes longer to achieve cure.”

For frontline clinicians, however, offering an alternative regimen was a last resort. Their first strategy with patients reluctant to be treated was what they informally called “punch theory”: emphasizing, at times in exaggerated or misleading ways, the risks and dangers of syphilis to elicit adherence through fear. According to accounts, this was directed primarily at pregnant women, with prompts such as: “Do you want your baby to be born sick, covered in red spots?”; “If your baby is born with syphilis, he’ll stay in the hospital for ten days and you won’t be with him in the first days of life”; and even, in one surreal example, “Do you want your baby to be born without an arm?” The underlying view was that one must “tell it like it is” and “show the truth about the disease,” otherwise people “won’t take treatment seriously.”

Beyond painful injections and patient reluctance, interlocutors pointed to factors spanning everyday constraints in low-income Brazilian settings and the organization of services, what we might read as “local theories of collective health.” At the level of living conditions, frequent changes in mobile phone numbers quickly obsolete patient records, undermining follow-up for those who do not return for remaining benzathine penicillin G doses or the VDRL (Venereal Disease Research Laboratory) test. As one put it: “These days poorer people all have mobile phones, but they change the number and provider all the time. What’s more, nobody answers calls anymore, and I don’t think it’s a good idea to leave a message when the subject is an STI.”

At the level of service organization, the most frequent comment concerned clinic hours: most primary care units close at 5 p.m. This not only limits access for working people but is also frequently cited as a reason for not seeking care. Added to this, professionals described a “natural resistance” among men to engaging with health services, a combination they identified as a key driver of reinfection in pregnant women. Professionals also noted difficulties with the VDRL test, which is performed not in primary care but in municipality-contracted laboratories. Patients must travel to these labs and later deliver results to the provider in charge of follow-up, adding an extra step in the therapeutic itinerary and another opportunity for drop-off.

In addition to these problems, Health Surveillance professionals reported errors in completing treatment documents: the antenatal booklet, medical records, and case-notification forms. Failures in recording this information are a central source of tension between the two sectors and a recurrent topic in trainings, meetings, and routine encounters. Not infrequently, during trainings, Surveillance staff showed Primary Care colleagues photos of incorrectly completed documents to underscore that concerns about data quality were not exaggerated and to highlight the impacts such errors have on continuity and effectiveness of treatment.

Accurate record-keeping proved especially important given a feature of workforce management in the municipal network—linked to the outsourcing of health services in peripheral capitalist countries (Druck 2016). Health workers were connected to services through multiple employment arrangements; in the case studied, three modalities prevailed: contracts via a foundation, a health institute, or the municipal government. This contractual diversity produced high staff turnover, weakening relationships not only between professionals and patients but also between Primary Care teams and Health Surveillance.

This scenario demanded new training sessions as well as the continual reconfiguration and renegotiation of work processes: “It is very common for new nurses to join the health network, become the reference professionals in Health Units, and then leave before we’ve even had a chance to learn who they are.” In this high-turnover context, accurate records became crucial, serving as the instituted means for information to circulate between these two sectors of the health system.

The flood

These difficulties crystallized a set of tensions between Primary Care and Health Surveillance around the theme of treatment adherence in syphilis control. Against this backdrop, in May 2024, an extreme climatic event struck Rio Grande do Sul. The floods constituted the most severe climate disaster in the state’s history, with massive material and human losses: transport infrastructure was destroyed; hundreds of thousands of homes were flooded; service networks and commerce suffered widespread losses; harvests were compromised; and at least 183 deaths were recorded. The study city was severely affected: 80% of its territory inundated and half of its population displaced. The health network was also badly hit: 64% (16) of Primary Health Care Units were affected, and 32% (8) became completely inoperable.

An immediate consequence was a sharp surge in demand that redirected nearly all efforts toward mitigating the disaster’s effects, addressing both physical damage and an intense burden of mental distress. Multiple services (surveillance, laboratories, hospitals, primary care units, and the Specialized Care Service) pivoted to disaster needs, reducing attention to other conditions, including syphilis. Many professionals could not work because facilities were destroyed or inaccessible. Thousands were left homeless and displaced, loosening ties with health services. In this setting, conditions such as syphilis receded in self-care practices, eclipsed by the urgency of material survival.

One key response was to adopt open, walk-in access to health units, regardless of catchment area. While essential during the public health emergency, given widespread displacement and reduced service capacity, this measure further weakened follow-up for syphilis. Patients might be seen at one unit, test at another, deliver results at a third, and receive treatment at a fourth. In this context, errors in notifications and records had an even greater impact on information flows and loss to follow-up.

The potential effects of this decoupling between users and services were partially mitigated by “Zap da Saúde,” a municipal service delivered via WhatsApp. The channel enables prescription renewals, offers initial mental-health support, disseminates information on services and activities, and provides dedicated assistance for people affected by the floods.

Finally, the floods also produced shortages of penicillin and alternative syphilis medications, as well as shortages of diagnostic and treatment-monitoring tests.

Climate disasters as abstract of life

The problems identified here, based on health professionals' accounts, reflect the instituted dimensions of both Epidemiological Surveillance and Primary Care. They are general features of work processes that condition how these institutions operate and are widely recognised by professionals in these settings. Errors in completing notification forms, demand that exceeds installed capacity, precarious employment relations, outsourcing of public services, patient resistance to treatment, and shortages of supplies are longstanding, everyday factors that shape the operational logics of Health Surveillance and Primary Care.

I argue that the flood aggravated this instituted scenario. Demand on the health network intensified, the workforce contracted, and fewer services remained operational. Errors and inconsistencies in documentation had broader effects, and ties between users and services, as well as among services, were weakened. Syphilis, already neglected, slipped further down municipal priorities. None of this was new in the setting; the event catalysed the instituted dimensions that make up the established order. One may say the disaster works like an abstract of life: over a short period and with heightened intensity, it compresses processes that ordinarily unfold under normal conditions, making visible connections that routine practice obscures. In this sense, the disaster neither inaugurates emergent processes nor introduces insurgent novelties; like an abstract, it contains nothing not already present in the main text.

Where, then, is the instituting dimension, the one that inflects institutions' traditional mechanisms and propels the dialectical movement through which they are produced? I argue it appears in a new framing of syphilis precipitated by the climate disaster: a perspective that revives the collectivist tradition of public health and breaks with hegemonic views of health as a private good, reduced to individual choice and liberal values.

The framing of syphilis as a public vs. private good

In the eighteenth and nineteenth centuries, the public–private divide intensified. The domestic sphere increasingly crystallized as the domain of the nuclear family and the feminine, while the public sphere was linked to men's activities, social interaction, and political life. Law codified this separation, distinguishing the public—of the state and the collective—from the private—of individuality and particular interests.

This divide was also projected onto disease (Das 2023). Communicable diseases were treated as public goods because their externalities affected collectives, making them objects of state intervention, via environmental measures, water supply and sanitation, mass vaccination, and the like. By contrast, non-communicable diseases were framed as belonging to the private sphere, thought to depend on lifestyle choices. They were seen as outcomes of individual decisions about health practices (e.g., physical activity, smoking, alcohol use) and thus as conditions to be personally borne, not proper targets of state intervention.

Within this dichotomy, in the eighteenth and nineteenth centuries syphilis was conceived as a public-good disease. Regarded as the venereal disease par excellence, it inspired widespread fear of contagion because it threatened family, state, and nation. Syphilis was said to degenerate body and soul and to corrupt the moral order of public life (Carrara 1996), thereby demanding wide-ranging control measures. Physicians, public health authorities, religious leaders, scientists, and rulers all sought to interrupt transmission (Accorsi 2025; Carrara 1996). Public spaces were regulated, with a pronounced focus on the control of prostitution. Cast as principal culprits of diffusion, sex workers, accused of sexual excess, were counted and monitored, required to undergo testing, and quarantined when infected; brothels became targets of sanitary inspection, and public campaigns promoting celibacy circulated widely. In short, syphilis functioned as a catalyst for the nineteenth-century dispositif of sexuality (Foucault 1985), activating state interference in sexual practices in the name of public health.

With the post–Second World War diffusion of penicillin, syphilis finally had an effective curative therapy (Bud 2007). The disease then receded from national public-health priorities, losing its public-good framing. In the following decades, campaign materials were no longer produced, sanitary decrees were repealed, and sexuality came to be regulated through other diseases, especially AIDS, which, from the 1980s onward, took up the position of the venereal disease par excellence.

Syphilis thus came to be framed as a private good, tied to personal choices about sexual life. Responsibility is individualized: each person must seek testing, adhere to treatment, and practise safer sex. The state's role is to enable self-care, for example, distributing free condoms in health services and, in case of infection, ensuring diagnostic access and treatment. The state is no longer implicated in containing transmission through broader social measures, and there is no collective mobilisation to intervene in private sexual life.

This private-good framing remains hegemonic and is evident in the accounts presented here. Patients are expected to complete treatment, if necessary, through fear-based persuasion, to seek diagnostic testing, attend laboratories for follow-up, and return results to providers. They may choose between a painful but effective regimen and a more comfortable option with higher risk of failure. All of this must occur within clinic opening hours; it is the patient who adapts to service routines, not the services that extend hours for syphilis care. Patients are also responsible for keeping their telephone contacts current in clinic records. In short, care is individualised: each person is expected to look after themselves.

I argue that, in the context of the floods that struck Rio Grande do Sul, syphilis was reframed as a public good. Not in the nineteenth-century biopolitical sense that fuelled the dispositif of sexuality or invoked fears of familial and national degeneration.

What the climate disaster makes visible is that sustaining syphilis as a private good, tied to individual choices and responsibilities, presupposes an underlying public-good perspective, now materialised as health-service infrastructure. Without accessible testing and diagnosis, personnel to deliver care, and functioning clinics and laboratories, syphilis cannot plausibly be maintained as a “private good.” In other words, to treat syphilis as a private matter, one must first secure the public-good conditions that enable care.

The floods make this plain: health as a private good cannot exist without health as a public good. When life enters an “abstract mode”—when the ties that weave social life are laid bare in a short, intense period—the public/private dichotomy loses force. This is an instituting moment that invites us to rethink the conditions under which Health Surveillance and Primary Care operate.

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