Cogitare Enfermagem

ORIGINAL ARTICLE

Barriers to comprehensive care for women who engage in sex work

HIGHLIGHTS

1. Women who engage in sex work face stigmatization and prejudice.
2. Sex work exposes women to physical violence.
3. Women who engage in sex work have limited access to healthcare.
4. Healthcare professionals need to be trained.

Victoria Cardoso Alves[1]
Raíssa Stephanie Rodrigues da Silva[1]
Samyra Giarola Cecílio[2]
Rafaela Siqueira Costa Schreck[3]
Elen Cristiane Gandra[3]
Sumaya Giarola Cecilio[3]

ABSTRACT

Objective: Identify barriers to comprehensive care for women who engage in sex work in Belo Horizonte, Minas Gerais, Brazil. **Method:** Qualitative study conducted with seven sex workers from October to December 2023. The data were collected through semi-structured interviews and submitted to content analysis, according to the framework proposed by Bardin. **Results:** Social inequality, the context of violence in which these women live, the stigma and prejudice surrounding sex work, and the lack of training among health professionals are factors that act as significant barriers to these women's access to health care and comprehensive care. **Conclusion:** Strategies for training health professionals and implementing public policies to mitigate the social vulnerability of female sex workers are necessary.

KEYWORDS: Sex Workers; Social Vulnerability; Health Vulnerability; Integrality in Health; Stereotyping.

HOW TO REFERENCE THIS ARTICLE:
Alves VC, da Silva RSR, Cecílio SG, Schreck RSC, Gandra EC, Cecilio SG. Barriers to comprehensive care for women who engage in sex work. Cogitare Enferm [Internet]. 2025 [cited "insert year, month and day"];30:e96291en. Available from: https://doi.org/10.1590/ce.v30i0.96291en

[1]Faculdade de Ciências Médicas de Minas Gerais, Curso de Medicina, Belo Horizonte, Minas Gerais, Brasil.
[2]Centro Universitário Presidente Tancredo de Almeida Neves, Curso de Medicina, São João del Rei, Minas Gerais, Brasil.
[3]Universidade Federal de Minas Gerais, Escola de Enfermagem, Belo Horizonte, Minas Gerais, Brasil.

INTRODUCTION

The term sex work refers to a variety of situations and behaviors in which sexual services are exchanged for monetary compensation or goods. This concept acknowledges the agency of women working in the sex industry, while taking into account the intricate web of socioeconomic, legal, and cultural influences in their lives[1].

This study understands sex work as a precarious working condition, aggravated by intersectional inequalities, such as class and race of female workers, which places this population group in a context of social and health vulnerability. In Brazil, most women who engage in sex work are black and have low levels of education[2-3].

Social determinants are often related to entry into sex work, especially the fragility of social and community networks, the absence of maternal affection, care, or family abandonment, along with low levels of education, violence, and illicit drug use[4]. Social vulnerability, defined here as a set of factors that can increase or decrease the risks to which individuals are exposed in all situations, encompasses broad social and political aspects[5].

In turn, vulnerability in health is defined as the concept of social vulnerability with a focus on health care,[6] characterized, in the context of this study, by the effects of inequality in healthcare services provided to women who engage in sex work.

There are no reports in the literature of programs focused on comprehensive health care for women working in the sex industry, including educational strategies on proper nutrition, integrative health practices, and relaxation activities in the workplace. This lack of attention reinforces the invisibility of these women as citizens and workers, exacerbating their social and health vulnerability.

As a principle of the Unified Health System (SUS), comprehensive care aims to offer assistance that goes beyond healing, covering all levels of care for the individual. The Federal Constitution of 1988[7-8] guarantees health as a universal right for all Brazilian citizens, and it is the responsibility of the SUS to ensure democratic access to health, respecting the principles of universality, comprehensiveness, and equity. Violation of these principles may result in unconstitutional practices and raise questions about the fulfillment of the SUS's responsibilities.

In this context, it is crucial to recognize that comprehensive care for women working in the sex industry faces barriers that need to be understood, studied, and discussed. This is essential to reduce the discrepancy between health policies and the effective practice of care for this population[9]. Understanding the obstacles to comprehensive care helps identify critical issues and generate discussions about new approaches to caring for women working in the sex industry, as well as influencing health care provision and public policy.

Therefore, this study aimed to identify barriers to comprehensive health care for women who engage in sex work in Belo Horizonte, Minas Gerais, Brazil.

METHOD

This is a study based on qualitative research[10], exploratory and cross-sectional in nature, based on the theoretical assumptions of sociology, particularly in the analysis

of social structures that produce and reproduce situations of social vulnerability and inequalities. Thus, the starting point is the understanding that inequalities in access to essential rights and services are socially constructed and historically determined, resulting in different levels of exposure to risks and capacity to respond to them11. The research is also anchored in analytical reflection on the data, based on the guiding principle of the SUS, which is comprehensive care[8].

The participants in this study were women who engage in sex work at a hotel in the Guaicurus Region hotel chain in Belo Horizonte, Minas Gerais, Brazil. The study setting was intentionally limited, considering the presence of participants with characteristics relevant to the study. The criteria for inclusion in the study were: being a sex worker for at least twelve months, being over 18 years of age, regardless of gender, being able to understand and answer questions, and agreeing to be interviewed.

With regard to the number of study participants, the sample for information collection was constructed using the saturation criterion, which ceased when no new information emerged and the research objective was achieved. Ten women who engage in sex work were selected, but only seven were interviewed, as the sample reached saturation. There were no refusals to participate in the survey.

Data collection took place between October and December 2023. For data collection, an interview time was scheduled using Google Meet®, taking into account the participants' availability. The interviews were conducted by two researchers, previously trained in qualitative data collection, in safe, quiet, and comfortable environments for the participants, with a good internet connection. Each interview lasted an average of 30 minutes. Data collection was guided by a semi-structured questionnaire containing the following questions: i) What does health mean to you? ii) How do you think we take care of our health? iii) How do you think the SUS takes care of the population's health? And what about the health of female sex workers? Describe an experience that helps justify your answer.

Sociodemographic data were collected using a structured questionnaire designed by the authors for the purposes of this study at a specific time. The questionnaire investigated the following issues: a) age, b) education/length of schooling, c) gender, d) religion, e) marital status, f) length of time working as a sex worker, g) remuneration per client, h) estimated number of clients per day, i) monthly family income.

In order for the study to contain elements that satisfactorily met scientific criteria and enhanced the presentation of results, the International Consolidated Guidelines for Reporting Qualitative Research (COREQ) were used as a reliability parameter for the preparation and evaluation of health research.

All interviews were recorded using audio/video equipment and subsequently transcribed, with the data collected in the interviews being checked against the transcribed data. The interviewees were coded using randomly chosen flower names. For data analysis, we used Bardin's theoretical and methodological framework[12], through a thematic content analysis of the transcribed materials. The process of forming categories was achieved through coding, which was carried out according to semantic criteria, as this was deemed most appropriate for thematic analysis. Once triangulated with the observed results, these were organized into units of record, allowing for progressive categorization. The thematic categorization was defined in light of the theoretical framework of comprehensive care as a guiding principle of the SUS[8].

The research was submitted for review by the Research Ethics Committee under opinion number 5,573,323. All participants read and signed the Free and Informed Consent Form (FICF). CAAE: 58070422.2.0000.5134.

RESULTS

Seven women who work as sex workers, aged between 37 and 53, with between two and 20 years of experience in the Guaicurus region, participated in the study. They run an estimated 5 to 20 programs per day, earning between R$1,000 and R$3,500 per month. The need to generate income to support themselves is the main reason they give for starting work as sex workers. In terms of gender, all women interviewed identified themselves as cisgender.

In analyzing the participants' statements, two thematic categories emerged: 1) The stigmatization of women who engage in sex work as a barrier to comprehensive health care, and 2) The living conditions of women who engage in sex work as a factor in maintaining barriers to comprehensive health care.

The stigmatization of women who engage in sex work as a barrier to comprehensive health care

The results indicate that women who engage in sex work are exposed to approaches that are far from comprehensive health care, the most apparent cause being the stigmatization of their work in society. When they present themselves as women who engage in sex work, there is a reaction from health professionals that reduces these women to bodies that can spread disease.

[...] once, a church brought a bunch of people to hold an event on Pink October Day. They brought a bus with some dentists to clean [our teeth]. When I sat down, he [the dentist] asked if my HIV test was up to date. I thought that was absurd, so I got up and left. (Flor de Laranjeira)

This prejudiced way of categorizing them limits the approach to healthcare, physical well-being, and life in general for these women. In addition, there are reports of inadequate management in health services, which expose these women to prejudice and neglect.

[...] When I contracted gonorrhea and they didn't know I was a sex worker, I was treated one way, and another day when I needed to return to the health service for treatment related to a sexual situation [the condom broke with a client], I was treated completely differently, I was treated as if it were something of minor importance, you understand? (Dália)

But São Paulo is totally different from Belo Horizonte, do you know? In São Paulo [...] I don't go a month without getting tested for HIV and syphilis. No way. Anywhere there's prostitution ,they [health services] are all over it [...] They come and pick you up and take you to get tested [...]. In Belo Horizonte, it's really hard to get one. Like when my condom broke, I spent the whole day trying to get tested. I got there at 10 a.m. and didn't get tested until 6 p.m. I was desperate until I finally got to talk to the psychologist. (Dália)

I fight hard so that when I go to a gynecologist and identify myself [as a sex worker], that gynecologist understands that it's not just to ask for an HIV [test]. I fight so that

when she looks at my uterus, she knows that it doesn't belong to a woman who has sex three times a week, but to a woman who has sex 30 or 40 times a day. Got it? Because that's what a worker in the Guaicurus region does. And we need another form of care. Some women use cotton during their menstrual period in order to have sexual intercourse. It hurts even more. Another thing, it's not right for a woman who has sex 30 times a day to have an IUD fitted and for the doctor to think that she's safe because she has an IUD. Got it? (Flor de Laranjeira)

Participants report that some health professionals, due to lack of training or other factors, stray from ethical practice, disrespecting patients' autonomy and values. Instead of maintaining a respectful approach, these professionals adopt fundamentalist and ideological discourse during consultations.

[...] Yesterday, the trans [transgender sex workers] went to get vaccinated, and there was a [health professional] who was religious [and said], "Oh, Jesus have the power, find Jesus." She was giving a vaccine and saying that to a transgender woman. I reported her, and she [the sex worker] went there to get the vaccine. The nurse who was there was preaching, wanting to pray for trans people. It's such an invasion! (Flor de Laranjeira)

As a consequence of the stigmatization and prejudice suffered during health care visits, some women who engage in sex work choose not to attend appointments or, when they do, choose not to identify themselves as sex workers— thus yielding to the oppressive logic of the professionals who work there.

Sometimes I prefer not to look for the clinic. I am left without assistance or I seek private assistance and do not speak to my supervisor. They already know me at the station, so there's always a look, a snide remark [...]. (Margarida)

According to Flor de Laranjeira, not seeking health services puts these women at risk, since, according to reports, *many are behind on their vaccinations* and do not receive follow-up care for other conditions such as high blood pressure, diabetes, rheumatic diseases, anxiety, and depression. Furthermore, according to their statements, sex workers report not engaging in other activities that promote health or well-being, suffering from an exhausting routine and isolation from other sectors of society.

[...] Nobody comes here to talk about health, to talk about care. No one cares if we take care of our mental health [...] or exercise. Nothing. They only want to talk about the diseases that prostitutes may have or already have [...]. I stay here for days, weeks, I come from Rio [de Janeiro]. I leave my husband, family, and children there and come to work day after day. I don't leave here for anything, like a lunchbox, when it's time, I don't even see the light of day, whether it's day or night. (Tulipa)

There are many women here with high blood pressure, diabetes [...]. The service doesn't worry about them. It's more about STIs, always STIs. That puts everyone at risk, doesn't it? Why is the issue of health as a whole being overlooked? (Flor de Laranjeira)

Not to mention that [our work] strains our spine [due to repetitive effort]. So, it's not just HIV that the doctor has to worry about, you understand? Yes, there are many things. It is our overall psychological health, just like psychological or psychiatric illness. It is promoting our health [...]. (Margarida)

Life situations of women who engage in sex work as a factor maintaining barriers to comprehensive health care

The life situations of women who engage in sex work reflect vulnerability and inequality, given the disadvantages they face in terms of social mobility *"due to the*

low value of the program" (Tulipa, Dália, Flor de Laranjeira), frequent *"exposure to situations of violence"* (Dália), as well as social exclusion — all of which are factors that contribute to maintaining barriers to comprehensive health care. Amidst the participants' comments, the difficulty they face in achieving better standards of quality of life and citizenship emerges.

We hide, we hide from our families, we are afraid of losing custody of our children, of being kicked out of our homes, of our families finding out, if we are in a relationship, we are afraid of our husbands finding out [...]. (Flor de Laranjeira)

When you discover the value of the program, you say, "My God, to make a R$ 1.000,00, I'm going to have to have a lot of sex," and you get scared! (Dália)

The cost of the program (which varies between R$ 50.00 and R$ 150.00, depending on the time and type of service provided), mentioned in particular by participant Dália, is the source of another problem, which is the number of programs/services provided per day. The more programs carried out, the worse the factors for maintaining quality of life, such as longer working hours and no breaks for adequate food, rest, or distraction.

In the "ups and downs" of Guaicurus, according to some participants, there are certain patterns that organize women's roles. Depending on the client, the service offered varies: some clients seek them out just for conversation, others for physical and intimate contact, and still others seek acts of violence and illicit drug use. However, according to another participant, Margarida, negotiation does not always take place— in some situations, when refusing an activity, sex workers have to deal with clients who, upon entering the hotel room, feel like they own their bodies and force them to consume substances against their will or engage in violent sexual activity.

Sometimes I feel afraid. The man enters the room and feels like he owns the place. He's paying [...]. There have been situations where one threw me on the bed and raped me [...]. I was afraid, I was afraid of dying [...]. Close the door [to the bedroom], now what? There are men who force us to use drugs with them, cocaine, marijuana [...], if we say no, we are at risk. (Margarida)

Without adequate means to exercise their citizenship, women who engage in sex work are kept in a permanent state of social and health vulnerability. There is also the fact that many women are from other cities and states and stay in hotels in Guaicurus for only a few days a month for work. This fact contributes to maintaining their state of vulnerability and social exclusion, since, according to the participants' reports, health services refuse to treat them because they do not have a permanent residence.

[...] Why did you come from another state, then you have to start from scratch here, only to stay here for 20 days and go back home [to another state]. How are you going to control your diabetes and blood pressure with so little time here? [...] Here we have reports of girls who had to be monitoring their high blood pressure and weren't doing so because they had to stay between here and there [places] and couldn't monitor it. He died because he had a stroke. (Tulipa)

[...] To be seen at the clinic, you need to have an address [...], and women can't go because they're from out of town and have to pay for a hotel room [...]. I also bumped into someone once who said at the health center, "Oh, but the women aren't from here, they're from other states, they have to go to their own states." They say, "Hey, but they're not from here, they'll just spend money where they live, or do they want to burden the municipality?" (Flor de Laranjeira)

There are women who haven't had a preventive checkup in five years [...] women don't do it because they stay here for two months, three months. When they return home, do they go to the doctor? No. They will see their family resolve something and return. So, they have to have access to this, women have to take care of themselves. Why? Because her financial advisor is here. Their workplace is here, so the municipality has to take care of them here, yes! (Flor de Laranjeira)

Regarding the daily rates mentioned by participant Flor de Laranjeira, this refers to the fact that women who engage in sex work have to pay a fixed daily rate for the use of a room at the Guaicurus hotel. The daily rate depends on the room facilities and the hotel's location, ranging from one hundred to two hundred and fifty reais. The data collected in the interview reveal the precariousness and fragility of the rights of women who engage in sex work, since they are not entitled to remuneration upon presentation of a medical certificate for attending appointments at the health center.

[...] If a woman leaves during the day to go to the clinic, spending a lot of time away from home, it's a loss for her. The daily rate will still be charged. Certificate? Who will she give the certificate to? For the hotel owner? No, there isn't. It's her own fault, she doesn't have equal rights, she should have found another job. That is our daily struggle. (Flor de Laranjeira)

Flor de Laranjeira presents the struggle of sex workers for their rights as workers, including the right to health, safety, and public policies.

Because sex work is there, it happens. We have a CBO [Brazilian Classification of Occupations]. This CBO is a term we use to say that we are supported by the Ministry of Labor. [...] From me, you will always hear sex workers. Do you know why? We are fighting for legislation [...] to guarantee labor rights [...] for women who do work, that work, which supports their families [...]. And there's more, because it's not just about health. It is comprehensive healthcare, safety, public policies [...]. (Flor de Laranjeira)

According to Flor de Laranjeira, recognizing sex workers as workers can help guarantee their rights as citizens and their access to public policies.

When she goes to CRAS, she says she is a single mother, but that she works as a prostitute, that she pays R$120,00 a day [...], and she is immediately disqualified. Yes, because who pays R$ 120,00 a day for accommodation? How much does this woman earn per month? So, she doesn't qualify for assistance or benefits. (Flor de Laranjeira)

Another thing that is part of our struggle is women's safety. If she is a recognized professional, a hard worker, she will have rights, including the right to safety. If he suffers violence inside the room, who will she call? Are you going to call the police in Guaicurus, an area known for drug use and prostitution? It will drive away other customers, which is the girls' livelihood. It won't. (Flor de Laranjeira)

DISCUSSION

Women who engage in sex work face oppression and struggle daily for freedom, autonomy, and respect, both in health services and in society at large. Recognizing this vulnerability as an obstacle to comprehensive care is crucial for awareness of otherness, collectivity, and social participation. In the present study, the two categories found refer to the situations of vulnerability to which women who engage in sex work are exposed—whether due to the stigma imposed by health professionals or the living and

working conditions of these women—and expose how these conditions distance them from what we understand as comprehensive health care.

Women who engage in sex work face oppression and struggle daily for freedom, autonomy, and respect, both in health services and in society at large. Recognizing this vulnerability as an obstacle to comprehensive care is crucial for awareness of otherness, collectivity, and social participation. In the present study, the two categories found refer to situations of vulnerability to which women who engage in sex work are exposed, either due to stigma perpetrated by health professionals or due to these women's life and work situations. Furthermore, they expose how these conditions distance them from what we understand as comprehensive health care.

With regard to the stigma suffered by women who engage in sex work, it is worth considering how necessary it is to reflect on the place of women in society, before considering the place of women who engage in this work[13]. It is worth highlighting the social construct that, even when women work in other occupations, they continue to occupy hierarchically inferior positions and are victims of violence simply because they are women. Thus, women and sex workers are intersectionally affected by prejudice, social exclusion, gender inequality, and stigmatization.

This overlap of oppressions suffered by these women reveals the intersections of social markers of inequality in the field of sex work: sociocultural markers, which are products of machismo, sexism, and control over female sexuality, and structural markers, which result from the context of poverty, marginalization, and social inequality to which these women are exposed and which often lead them into prostitution[14].

With regard to stigma[15], this is a characteristic of the individual that, when socially transformed into a negative attribute, disqualifies them and creates obstacles to their access to goods, whether material or symbolic. Thus, it is possible to observe how the stigmatization of women in prostitution resonates in frequent situations of exclusion.

In the first category, the main findings reflect feelings of inadequacy, shame, and anger caused by the oppressive attitude of healthcare professionals. These professionals not only provide inadequate care, but also fail to promote the overall health of women who engage in sex work, often expressing fundamentalist views and imposing their beliefs during consultations. As a result of all these factors, there has been a reduction in health care for the distribution of condoms and the exclusion of these women from health services and spaces[9].

Despite concerns and risks related to sexually transmitted infections, the health of women who engage in sex work cannot be reduced to such problems. There is little open discussion and exploration of alternatives, not limited to protection during sexual intercourse, to promote the expression of care among this population. In addition, healthcare professionals find it difficult to recognize the existence of a sexual intimacy between this woman and a partner outside of her work. Even though they know that assessing sexuality is a key part of care, for a bunch of reasons, a lot of healthcare pros don't bring it up when they're helping people[16-18]. Thus, the lack of preparation of health professionals to address the sexuality of these women deprives them of adequate care, even leading to iatrogenic action.

Health care focuses solely on disease prevention, and there is no incentive for health promotion, leisure, sports, or cultural activities, reducing the health care scenario for female sex workers to a minimalist approach.[19]. In addition to the danger of a reductionist approach, there is also the danger of inadequate care, permeated by discrimination or mistreatment. A study[19] that looked into how sex workers use primary

healthcare services in Brazil through an integrated review found reports of mistreatment or discrimination by healthcare professionals in 85.7% of the studies analyzed.

In addition, there are other barriers to full access to healthcare, such as limited opening hours of healthcare services, namely: long waiting times for appointments and tests, delays in care, lack of reception and links between basic healthcare units and sex workers[19-20].

Authors[20] point out that women, when seeking health services, do not always claim to be sex workers, preferring to omit this information for fear of discrimination. This information converges with the data from the present study, which showed that women, when they go to health centers, do not feel comfortable saying that they are sex workers, whether in other regions of Belo Horizonte or in their hometown.

In the second category, feelings of inadequacy reappear in the statements, but now with a focus on social relationships beyond those with health professionals — which greatly hinders the achievement of decent social standards and the maintenance of citizenship.

In this context of loss of rights and abuse, these professionals remain silent and develop strategies to protect themselves from the social suffering imposed on those who choose this form of work[14]. Most women create "war names" so as not to lose their socially accepted roles, as well as their rights as mothers. Thus, their identity becomes divided between the hotel environment and their circle of friends and family[21-22].

In our society, historically, states have responded to sex work in three main ways: abolitionism, regulation, and prohibition. The abolitionist view considers women who engage in sex work to be victims of coercion by intermediaries, while regulation proposes that prostitution be legalized and subject to specific rules. Prohibitionism, on the other hand, advocates criminalizing not only sex workers, but also brothel owners and their clients[14].

Within feminist movements, there are significant differences of opinion on this issue. Radical feminism, over the last few centuries, has viewed prostitution as a violation of human rights and a manifestation of gender inequality. However, during the 1980s and 1990s, with the rise of liberal feminism, sex work began to be considered a profession like any other. With these positions in mind, two opposing camps emerged: one that sees sex as a form of oppression for women and another that defends it as a source of pleasure and power for them[14].

Another example of this is the position of the Pantokrator Catholic Community, which gathered testimonies from women who had been involved in prostitution, who argue that prostitution is not work, but paid rape, and that the use of this term (women who engage in sex work) only undermines efforts to stop it[23].

In any case, even though there is no consensus on whether or not to regulate the profession, it is known that non-regulation exacerbates the vulnerability of women who engage in sex work, contributing to experiences of suffering — since there are no public policies aimed at working conditions, rest hours, safety in the workplace, or any initiative to control alcohol and drug use and promote health.

As sex workers place themselves at the service of their clients, a hierarchical relationship is established, placing them in a vulnerable position and exposing them to violence. This is important to note, since during the interviews for this study, women

mentioned the fear they feel when they "close the bedroom door" to start work. They bring to light and reinforce the idea that a hierarchical relationship is indeed established in which the client can commit a violent act at any time[21].

Although the reports in this study on alcohol and drug use are not significant, other studies show that this is another problem present in the daily lives of women who engage in sex work. The use of alcohol and drugs is present in these women's work practices, serving as strategies to encourage them to carry out the program and, in some situations, to please the client[21].

This study, by recognizing the barriers to comprehensive health care for women who engage in sex work, raises questions about the importance of educational, assistance, and, above all, promotional practices — anchored in public policies—as instruments for promoting social transformation in the context of prostitution.

The limitations of this study relate to the limited number of interviews conducted and the intentional data collection, which may have affected the understanding of the data investigated. However, even so, the data collected and analyzed revealed the reality of women who engage in sex work and the extent of the inequalities to which they are exposed, which limit their access to comprehensive healthcare.

CONCLUSION

The two categories found in this study refer to the vulnerable situations of women who engage in sex work: the stigma imposed by health professionals, the living and working conditions of these women, and structural inequalities — and expose how these conditions distance them from what we understand as comprehensive health care.

By identifying barriers to comprehensive care, this study hopes to contribute to discussions about how far we are from providing comprehensive care to women who engage in sex work and how much needs to be invested in public policies capable of mitigating the social inequalities to which these women are exposed. Furthermore, there is an urgent need for investment in training health professionals with the skills to tackle these inequalities through training practices such as continuing education and training in health care services.

ACKNOWLEDGEMENTS

This study was conducted with support from the Research and Extension Department of the Faculdade de Ciências Médicas de Minas Gerais, through a Scientific Initiation scholarship, PROBIC/01-2022.

REFERENCES

1.Wulifan JK. Female transactional sex workers' experiences and health-seeking behavior in low-middle

income countries: a scoping review. BMC Public Health [Internet]. 2024 [cited 2024 Jul 23];24(1):2749. Available from: https://doi.org/doi:10.1186/s12889-024-20211-7

2. de Góes JM. Corpo, autonomia e associativismo: a participação das prostitutas da Guaicurus [thesis]. Belo Horizonte: Faculdade de Filosofia e Ciências Humanas, Universidade Federal de Minas Gerais; 2017 [cited 2024 Jul 23]. 144 p. Available from: https://repositorio.ufmg.br/bitstream/1843/BUOS-AQFQ8A/1/disserta__o_final.pdf

3. Figueiredo R, Peixoto M. Profissionais do sexo e vulnerabilidade. BIS [Internet]. 2010 [cited 2024 Jul 23];12(2):196-201. Available from: https://periodicos.saude.sp.gov.br/bis/article/view/33790

4. de Souza MD, Ferraz DLS, de Melo JMPV. Prostituição: para além do "ser ou não ser profissão". Germinal (Salvador) [Internet]. 2023 [cited 2024 Jul 23];15(3):156-76. Available from: https://periodicos.ufba.br/index.php/revistagerminal/article/view/56819

5. Salmeron N A, Pessoa TAM. Sex workers: socioepidemiologic profile and measurements of harm reduction. Acta Paul Enferm [Internet]. 2012 [cited 2024 Jul 23];25(4):549-54. Available from: http://dx.doi.org/10.1590/s0103-21002012000400011

6. do Carmo ME, Guizardi FL. O conceito de vulnerabilidade e seus sentidos para as políticas públicas de saúde e assistência social. Cad Saúde Pública [Internet]. 2018 [cited 2024 Jul 23];34(3):e00101417. Available from: http://dx.doi.org/10.1590/0102-311x00101417

7. Brasil. [Constituição (1988)]. Constituição da República Federativa do Brasil [Internet]. Brasília, DF: Senado Federal; 1988 [cited 2024 Jul 23]. 496 p. Available from: https://www2.senado.leg.br/bdsf/bitstream/handle/id/518231/CF88_Livro_EC91_2016.pdf

8. Ministério da Saúde (BR). Sistema Único de Saúde (SUS): princípios e conquistas [Internet]. Brasília: Ministério da Saúde; 2000 [cited 2024 Jul 23]. 44 p. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/sus_principios.pdf

9. de Freitas METP de, Ribeiro LS, Guimaraes SSS, Martins LF, Chinelato RSC. Fatores biopsicossociais na história de vida de mulheres profissionais do sexo. Psicol Pesq [Internet]. 2020 [cited 2024 Jul 23];14(2):152-78. Available from: https://doi.org/10.34019/1982-1247.2020.v14.27385

10. Taquette SR, Villela WV. The authors respond. Ciên Saúde Colet [Internet]. 2017 [cited 2024 Jul 23];22(1):20-1. Available from: http://dx.doi.org/10.1590/1413-81232017221.28572016

11. Marmot, M. The status syndrome: how your social standing directly affects your health and life expectancy. Londres: Bloomsbury, 2004. 320 p.

12. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011. 288 p.

13. Elias ARR, Junqueira MAB, de Noronha IC, Pereira J, Giuliani CD, Ferreira MCM. Vulnerabilidades e marginalização no mundo do trabalho da prostituição. Cad Espaço Fem [Internet]. 2019 [cited 2024 Jul 23];31(2):301-331. Available from: http://dx.doi.org/10.14393/cef-v31n2-2018-15

14. da Silva AP, Santos CRC, Carvalho, MG. Entre prazeres e sofrimentos: vivências subjetivas de trabalhadoras sexuais em São Paulo. Cad Psicol Soc Trab [Internet]. 2018 [cited 2024 Jul 23];21(2):181-95. Available from: http://dx.doi.org/10.11606/issn.1981-0490.v21i2p181-195

15. Villela WV, Monteiro S. Gênero, estigma e saúde: reflexões a partir da prostituição, do aborto e do HIV/aids entre mulheres. Epidemiol Serv Saude [Internet]. 2015 [cited 2024 Jul 23];24(3):531-40. Available from: http://dx.doi.org/10.5123/s1679-49742015000300019

16. Sousa RMRB, Frota MMA, Castro C, Kendall BC, Kerr LRFS. Perceptions of female sex workers about access to HIV testing: incentives and barriers. Saúde Debate [Internet]. 2017 [cited 2024 Jul 23];41(113):513-25. Available from: http://dx.doi.org/10.1590/0103-1104201711313

17. da Silva SB. Para além de uma concepção biomédica: o corpo e o trabalho das profissionais do sexo [undergraduate thesis on the Internet]. Santos: Universidade Federal de São Paulo; 2020 [cited 2024 Jul

23]. 49 p. Available from: https://repositorio.unifesp.br/handle/11600/58011

18. Brito NS, Belém JM, de Oliveira TM, Albuquerque GA, Quirino GS. Daily work and access to health services of female sex workers. Rev Rene [Internet]. 2019 [cited 2024 Jul 23];20:e33841. Available from: http://dx.doi.org/10.15253/2175-6783.20192033841

19. de Oliveira RR, Silva KH, Tavares SS, Gonzaga MFN, de Almeida CG, Contini ICP. Acesso à saúde pelas profissionais do sexo na atenção primária: uma revisão integrativa. Scire Salut [Internet]. 2021 [cited 2024 Jul 23];11(3):100-7. Available from: http://dx.doi.org/10.6008/cbpc2236-9600.2021.003.0013

20. dos Santos PS, Ferreira PG, de Figueredo RC, Silva LS, Amorim RCCS. Atenção à saúde dos profissionais do sexo: a ótica da equipe de enfermagem da estratégia saúde da família. Scire Salut [Internet]. 2021 [cited 2024 Jul 23];11(3):90-9. Available from: http://dx.doi.org/10.6008/cbpc2236-9600.2021.003.0012

21. Gehlen RGS, da Costa CM, Arboit J, da Silva EB. Situações de vulnerabilidade a violência vivenciadas por mulheres profissionais do sexo: estudo de caso. Cienc Enferm [Internet]. 2018 [cited 2024 Jul 23];24:8. Available from: http://dx.doi.org/10.4067/s0717-95532018000100208

22. Pereira JF, de Paiva KCM, dos Santos JVP, Sousa CV. "O show tem que continuar": encalços e percalços do ser/estar prostituta. Contextus [Internet]. 2018 [cited 2024 Jul 23];16(3):151-80. Available from: http://dx.doi.org/10.19094/contextus.v16i3.32642

23. Oliveira A. Prostituição em Portugal: uma atividade marginalizada num país que tolera mais do que persegue. Bagoas [Internet]. 2017 [cited 2024 Jul 23];17:201-24. Available from: https://repositorio-aberto.up.pt/handle/10216/111356

Received: 30/07/2024
Approved: 05/06/2025
Associate editor: Dra. Tatiane Herreira Trigueiro

Corresponding author:
Sumaya Giarola Cecilio
Universidade Federal de Minas Gerais
Avenida Professor Alfredo Balena, 190, Belo Horizonte, Minas Gerais, Brasil.
E-mail: sumayagc@ufmg.br

Role of Authors:
Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - **Alves VC, da Silva RSR, Cecílio SG, Schreck RSC, Gandra EC, Cecilio SG.** Drafting the work or revising it critically for important intellectual content - **Alves VC, da Silva RSR, Cecílio SG, Schreck RSC, Gandra EC, Cecilio SG.** Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - **Alves VC, da Silva RSR, Cecílio SG, Schreck RSC, Gandra EC, Cecilio SG.** All authors approved the final version of the text.

Conflicts of interest:
The authors have no conflicts of interest to declare.

ISSN 2176-9133