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Original Article

PROSTITUTION AND HEALTH: SOCIAL REPRESENTATIONS OF NURSES IN THE FAMILY HEALTH STRATEGY

PROSTITUIÇÃO E SAÚDE: REPRESENTAÇÕES SOCIAIS DE ENFERMEIROS/AS DA ESTRATÉGIA SAÚDE DA FAMÍLIA

PROSTITUCIÓN Y SALUD: REPRESENTACIONES SOCIALES DE ENFERMEROS/AS DE LA ESTRATEGIA SALUD DE LA FAMILIA

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Objective: to identify nurses' social representations about the relationship among prostitution, health and the Family Health Strategy. Method: qualitative study supported by the Theory of Social Representations, carried out with 12 nurses from the Family Health Strategy. Data collection used the Free Words Association technique and structured interviews. The data were organized using an association of the lexical content and the Collective Subject Discourse, presented in a figure and tables, analyzed in a descriptive and interpretative way. Results: the social representations of the nurses influence the actions and behaviors offered insofar as they are restricted to the sexual and reproductive sphere, to the detriment of the contextual aspects of everyday life, work and health. Conclusion: nurses' social representations link sexual practices to the risk of catching sexually transmitted infections and lacks the articulation of health promotion and the principle of integrality.

Descriptors: Family health. Primary Health Care. Nursing care. Vulnerable populations. Sex work.

Objetivo: identificar representações sociais de enfermeiros/as sobre a relação entre prostituição, saúde e atuação da Estratégia Saúde da Família. Método: estudo com abordagem qualitativa subsidiado pela Teoria das Representações

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Sociais, realizado com 12 enfermeiros/as da Estratégia Saúde da Família. A coleta de dados utilizou a Técnica de Associação Livre de Palavras e entrevista estruturada. Os dados foram organizados utilizando-se associação do conteúdo léxico e o Discurso do Sujeito Coletivo, apresentados em figura e quadros, analisados de forma descritiva e interpretativa. Resultados: as representações sociais dos/as enfermeiros/as influenciam nas ações e condutas ofertadas à medida que se restringem à esfera sexual e reprodutiva em detrimento dos aspectos contextuais do cotidiano de vida, trabalho e saúde. Conclusão: representações sociais de enfermeiros/as vinculam as práticas sexuais ao risco de aquisição de infecções sexualmente transmissíveis e ressente-se da articulação da promoção da saúde e do princípio da integralidade.

Descritores: Saúde da família. Atenção Primária à Saúde. Cuidados de enfermagem. Populações vulneráveis. Trabalho sexual.

Objetivo: identificar las representaciones sociales de enfermeros/as sobre la relación entre prostitución, salud y actuación de la Estrategia Salud de la Familia. Método: estudio con enfoque cualitativo subsidiado por la Teoría de las Representaciones Sociales, realizado con 12 enfermeros/as de la Estrategia Salud de la Familia. La recolecta de datos utilizó la Técnica de Asociación Libre de Palabras y la entrevista estructurada. Los datos fueron organizados utilizándose la asociación de contenido léxico y el Discurso del Sujeto Colectivo, presentados en figuras y cuadros, analizados de forma descriptiva e interpretativa. Resultados: las representaciones sociales de los/las enfermeros/as influyen en las acciones y conductas ofrecidas a la medida y que se restringen a la esfera sexual y reproductiva en perjuicio de los aspectos contextuales del cotidiano de vida, trabajo y salud. Conclusión: las representaciones sociales de enfermeros/as vinculan las prácticas sexuales al riesgo de adquisición de infecciones sexualmente transmisibles y se resienten de la articulación de la promoción de la salud y del principio de la integralidad.

Descriptores: Salud de la familia. Atención Primaria a la Salud. Cuidados de enfermería. Poblaciones vulnerables. Trabajo sexual.

Introduction

Social representations regarding sexuality permeate moral values and meanings that have changed over time, influenced by rules, limits and behavior patterns that need to or should be respected and performed by men and women in a differentiated way, consolidated and socioculturally transmitted[1].

It is emphasized that sexuality was historically linked to reproductive need. Therefore, considering its practice as a way to obtain the pleasure and/or the commercialization of sexual practices in prostitution could be seen as something perverted and insulting to existing moral values[1].

Prostitution represents a comprehensive phenomenon, commonly found in many societies, whose genesis dates back to ancient civilizations. Although the practice continues today, it divides space with various sexual services, such as those found in brothels, nightclubs, bars, saunas, virtual and media environments, which are mostly marked by the commercialization of the erotic, but are not restricted to the act of prostitution[2].

Often, prostitution occurs in a marginalized and stigmatized manner by society, marked by exposure to risky situations such as physical, sexual and psychological violence, alcohol and drug use, Sexually Transmitted Infections (STIs), and individual, social and programmatic vulnerabilities in health[3-4]. This context hinders the development of conditions that favor the exercise of citizenship, making sex workers, in addition to suffering from prejudice and discrimination, coexist with the invisibility to society and difficulties to get access to health promotion actions and services[5].

Except for the attention paid to vulnerable populations regarding the prevention of STIs and Human Immunodeficiency Virus (HIV), the health system historically has not incorporated and offered the necessary attention to sex workers, characterized as difficult to access and with particular health needs[6].

Recognizing these people's difficulty to get access to health services[4,7], this study is part of a social health perspective, with the Theory of Social Representations[8] as theoretical support to understand the question: Which are the social representations of nurses about the relationship between prostitution, health and the activity of the Family Health Strategy (ESF)?

The choice to investigate the social representations of the nurse is justified by the insertion and coordination of care actions developed throughout the work process in the FHS, characterized as a universal care space focused on the promotion, protection, recovery and rehabilitation of individual and group health. In this sense, social representations in this care scenario can constitute characteristic elements of the health practices offered. Thus, the objective was to identify nurses' social representations about the relationship among prostitution, health and the family health strategy.

Method

An exploratory and descriptive study with a qualitative approach, supported by the theoretical contribution of the Social Representations. As a part of social psychology, this theory argues that groups and societies have shared knowledge about the reality that surrounds them and determine the elaboration of behaviors towards a certain phenomenon[8].

The study was carried out with nurses from the ESF in the city of Juazeiro do Norte, located in the metropolitan region of Cariri, southern mesoregion of the state of Ceará, from March to May 2014. Primary Health Care (PHC) in the city was divided into six health districts with 64 family health teams. Data collection was carried out in health districts II and V, which possessed a larger number of teams in the assigned area, respectively 11 and 13 teams. Together, they accounted for 37.5% of the PHC teams' coverage of the city.

Participants were nurses who had experience or contact with the local health situation over a period of more than 12 months in the team they worked in. Professionals who were away from work due to vacations and leave were excluded. Eligible nurses were informed about the research through telephone contact, invited to participate in the study and evaluated concerning the above criteria. After consent and signing of the Informed Consent Term (TCLE), the data was collected at the professional's availability. Thus, 12 nurses participated in the study.

We used the structured interview, containing open questions that were audio-recorded. While knowledge about the subject was explored, we confirmed the validity of the data for the research. The theoretical saturation of the statements was used as a criterion to close off the data collection, identified by the presence of repetitions and/or absence of new information[9]. In addition, the Free Words Association Technique (FWAT) was used during the interview, which granted access to the core, peripheral and latent contents about the research problem, through guiding questions in which the respondents were asked to provide representative words, terms or expressions on what was asked at that moment[10]. The resulting lexical content permitted the creation of thematic axes, in accordance with the occurrence, approach and recurrence of the words and/or expressions.

After the reliable transcription of the empirical data, the Collective Subject Discourse (CSD) was used as a method to organize the social representations about the participants' thoughts, attributed meanings and positions in relation to the subject addressed, preserving the individual dimension articulated with the collective dimension[11-12]. During this process, we sought to identify the key expressions (KE), central ideas (CI) and anchors (CA), allowing us to glimpse the development of the discourse and the social representation of the collective self[13].

To organize the data, the following steps were proposed for the elaboration of the CSD:

1) transcription and organization of the collected material, through the discourse

analysis instrument containing the KE, CI and/or CA;
2) identification of the excerpts from the discourse that grant CI or CA status:
3) identification of the linguistic expressions that emerged from the analysis of KE;
4) identification of ideas by means of codes and colors for each group of CIs that presented equivalent meaning;
5) designation of each group of CIs, giving it a unique CI synthesis representative of all the others, permitting the construction of the CSD;
6) construction of a synthesis discourse written in the first person singular and composed of KEs with similar CI or CAs[13].

After the data were organized, the results were analyzed in a descriptive and interpretive manner[14], discussing the findings in accordance with the relevant literature.

The study received approval from the Research Ethics Committee of the Leão Sampaio Institute for University Education (UNILEÃO), under Opinion 464.465/2013, in compliance with the principles of National Health Council Resolution 466/12.

Results

The investigation of the social representations based on the empirical data considered three aspects: characterization of the study participants, presentation of the data obtained in FWAT and Collective Subject Discourse.

Characterization of participants

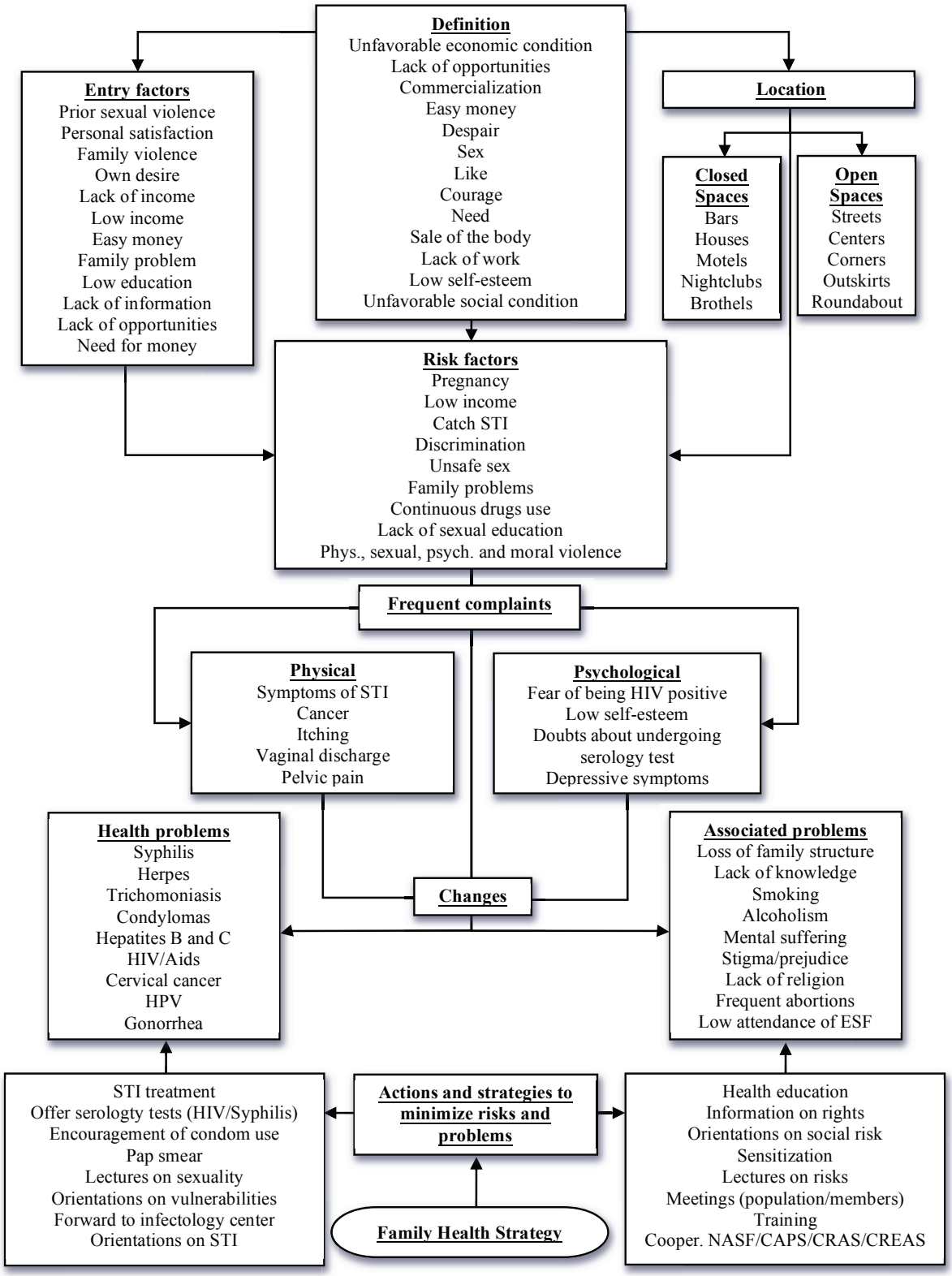
Twelve nurses in the age group from 22 to 40 years, with a mean age of 29.5 years, were matched for marital status (single and married), predominantly female[10] and monthly income between three and six minimum wages (considering the amount of R$ 724.00 in force at the time).

Regarding the professional characteristics, the length of professional experience ranged between two and five years. Regarding the care offered to people in situations of prostitution, all the participants stated that they had already attended to these clients at some point in their professional career. Regarding training and improvement, there was a predominance of specializations focused on the family health area. It is noteworthy that 11 nurses reported they had never participated in specific training on the subject.

Free Words Association Technique (FWAT)

Based on the data collected by the FWAT, through semantic approaches of the answers obtained, a conceptual structure was elaborated, divided into eight thematic axes: definition, insertion factors, risk factors, location, frequent complaints, health problems, associated problems and actions developed in the ESF. Chart 1 shows the lexical content the nurses evoked, which constituted subjective elements representing the prostitution phenomenon.

Figure 1 – Conceptual structure on prostitution resulting from words and expressions obtained in FWAT



Source: Created by the authors.

Legend: STI (Sexually Transmitted Infections), HIV (Human Immunodeficiency Virus), Aids (Acquired Immune Deficiency Syndrome), HPV (Human Papiloma Virus), ESF (Family Health Strategy), NASF (Family Health Support Center), CAPS (Psychosocial Care Center), CRAS (Social Service Referral Center), CREAS (Specialized Social Service Center).

In the FWAT, it was difficult for the nurses to conceptualize prostitution with terms and/or expressions, as the lexical content was diversified, referring to the defining characteristics of these people's insertion and/or motivation for the activity. Regarding the insertion factors, the professionals predominantly referred to the economic condition as determinant, but unfavorable factors were evidenced related to the family (within the scope of the problems and violence), social and educational contexts.

Linked to the insertion, we observed, in the social representations of location, variations in the type of space that determined forms of exposure in the different environments during the practice of prostitution. The risk factors were mainly related to the sexual behaviors adopted though. Consequently, the physical complaints these people reported in the health services were related to the symptoms of STIs which, as reported, constituted the health problems commonly observed in this population. The psychological complaints also involved fears about the possibility of catching STI (mainly HIV and diagnostic tests) and negative feelings related to prostitution.

Due to the complexity and association with multicausal factors, the actions and care strategies to respond to the physical and psychological complaints the sex workers reported to the nurses were related to the treatment and/or minimization of risks related to the sexual and reproductive aspects. Thus, they pointed out that the educational strategies could be effective and should be developed in partnership with other segments and sectors because they surpass the scope of action of the ESF.

Collective Subject Discourse (CSD)

The social representations about the concept of prostitution the nurses evoked depart from the principle of commodification, in which the individual, through his body, commercializes and trades sexual practices, as shown in Chart 1. This act occurs in four perspectives: amidst the personal motivation involved in interests, feelings and sensations to obtain and/or provide pleasure and sexual satisfaction; as a form of work and/or exploitation with pre-established formal and informal rules, in which the body is not only a commodity but also constitutes the main working instrument; due to the need for the activity to figure as the only available way some people have to get money to survive, constituting an immoral practice that occurs by illegal routes and with health risks; and as a practice associated with promiscuity.

Chart 1 – Central Ideas and Collective Subject Discourse on the concept of prostitution

(to be continued)

Central Idea	Collective Subject Discourse
Way to provide and/or gain satisfaction and pleasure	*It is the act of having sex with another person with financial interest, trying to profit in some way, receiving money or gifts. It is sexual intercourse in a conscious way, for money. It is a form of remuneration and negotiation of pleasure based on sexual practice and the commercialization of one's own body. Some do it for satisfaction, others to provide and/or have pleasure.*
Form of work and/or exploitation	*Today it is seen as a job, with labor rights, fixed remuneration and / or plus commission, and however deregulated it may be, professionals always attribute rules, such as the price. Sometimes there are a lot of people behind it, the big boss, who is making much more money than the person who's on the street, battling. It's a job that ends up being slave labor.*
Illegal, imoral and risky need for survival	*It means you acting for survival in an illegal way, which is a bit questioned, because her life is also at stake. It is not appropriate for you to sell your body, not for money, no matter for what, also because you are lying in bed with anyone who arrives, you do not know who it is, you are subject to any type of illness. It is very much linked to the use of drugs, it does not bring anything good, neither for the person who is often the biggest victim, nor for the family, let alone for society.*

Chart 1 – Central Ideas and Collective Subject Discourse on the concept of prostitution

(conclusion)

Central Idea	Collective Subject Discourse
Promiscuity	*Promiscuity is the constant relationship with diverse people in the same environment, who want to surrender the body to satisfy themselves, seek sexual practice for pleasure, of their own free will, even without the exchange of money or favors, because you like it and it's there and that's it. We can distinguish it by the issue of payment and the use of condoms, because there are those who really don't care; they go to bed with anyone without distinction. In one case, the main goal is profit and, in the other, it is fun or pleasure. To prostitute yourself, you do not necessarily need to be promiscuous; it will depend a lot on each person's conscience. In promiscuity, she has sex freely in a trivial way, without any interest, and then she may want to make money, make a profit. Promiscuity can lead to prostitution or vice-versa. Prostitution is more linked to illegal things; promiscuity, then, is linked to dirty things, lower, vulgar and that can not be done, but anyway they are interconnected.*

Source: Created by the authors.

In another aspect, the interviewees associated the insertion in prostitution to the lack of opportunities in the job market and conflicts of life, reporting aspects such as the low level of education and the disintegration of the core family with emphasis on physical and sexual violence. Others pointed to people's getting into prostitution to seek and/or maintain a standard of living, a status, or even a way for them to seek social acceptance. They also emphasized the feelings of choice and the individual right of sex workers to use their bodies in the way that suited them, regardless of the risks and/or benefits they need to weigh for themselves (Chart 2).

Chart 2 – Central Ideas and Collective Subject Discourse on the motives for engaging in prostitution

Central Idea	Collective Subject Discourse
Personal reasons	*A lot of people prostitute themselves because of the easy money, maybe to have more resources and maintain a standard of living they would not have in another profession. There are "n" motives that pass in these people's minds. Some do it because they want to, like it and feel pleasure, despite having other means of survival; others because they are obliged or do not see another way out. You need to be very courageous or desperate. The person was abandoned by the father or the mother, finds a friend who gives an opportunity for life and due to the fact that the person has low self-esteem, being a victim of past abuse and having failed to get out of this situation, (s)he ends up getting involved in prostitution.*
Structural reasons	*The reasons for starting this activity are the lack of opportunity, of insertion in the market and maintenance in decent jobs, loss of family structure, family violence in the form of beatings or abuse, lack of school preparation, employment or because of a low financial condition. There are a lot of people who prostitute themselves for survival, as well as social, cultural, economic and psychological problems.*
Individual autonomy	*Each person has his/her reasons to practice sex in the most suitable way, whether commercialized or not. It is difficult because, in our society, we live with impositions since we are in our mother's womb, but each person owns his/her body and turns it into what (s)he wants, whether legal or not. Some people prostitute themselves to evade preset rules.*

Source: Created by the authors.

In the discourse on nursing care for sex workers within the scope of the ESF, it was verified that the actions were aimed at minimizing the risks and health problems. The nurses pointed out the provision of guidelines through educational actions as appropriate intervention strategies for this public, particularly group lectures or even individual health education. Some of the interviewees mentioned that health education actions should be focused on sexual and reproductive health, with a focus on preventing STIs or clarifying the risks involved in sexual behaviors and practices. The lectures were pointed out as the commonly used and/or effective teaching-learning method. The active search was pointed out, through the Community Health Agents (CHA) as partners to approach people in prostitution to the actions of the ESF (Chart 3).

Chart 3 – Central Ideas and Collective Subject Discourse on health promotions actions for people in prostitution (to be continued)

Central Idea	Collective Subject Discourse
Educative strategy: lectures	*Health education commonly observed in public service occurs through lectures held in the waiting room. These sex workers who go to the unit consider it a waste of time to be there waiting for care though because, for them, time is money. The lecture, in a way, would help, but, because of the context, sometimes they end up without putting into practice what they know. That is why they become vulnerable. Knowledge, by itself, is not enough to raise awareness, for these people to take some care.*
Educative strategy: individual health education	*Using the presence of this sex professional in the consultation for individual health education, talk for her to come and pick up condoms, do the pap smear and clarify the disease transmission routes, such as identifying a vaginal lesion, ulcer, signs and symptoms related to some STI and visiting the health service when they feel threatened by any illness, work on ways to prevent STIs, use condoms, because people who see faces do not see diseases. These sexual life issues, sexual practices, number of partners, first sexual intercourse, time in prostitution, routine tests for hepatitis, syphilis, HIV, STIs, cervical and breast cancer prevention, pregnancy, gynecological and family planning should be addressed within the policy of comprehensive women's health care. As soon as the person identifies herself as a prostitute, some diseases can be associated. Then, we need to work on the history, diagnosis, conduct, treatment and classification, creating parameters related to vulnerability to these diseases. They are people who can be exposed to violence because they are exposing their own lives by constantly interacting with strangers on the street, nightclubs, motels and other places. Also, there are the psychological changes related to stigma, prejudice, self-image, self-esteem and STIs, HIV, use of crack, alcohol and drugs in environments that are sometimes meeting places for partners who smoke and drink.*
Search strategies by Community Health Agents (CHA)	*An active search of the environment or place of work can be carried out or invitations can be extended to attend the health service. But we do not have contact with this type of population. The CHAs have closer contact, who attend the house monthly, know who is more exposed to risky situations and we nurses do not. We only go when necessary, mainly prioritizing the bedridden. So, using this CHA for an active search of these people and, if necessary, removing them from the place, the street, prostitution, to have the possibility to rescue and insert them into society in a fairer, stable, balanced way.*

Chart 3 – Central Ideas and Collective Subject Discourse on health promotions actions for people in prostitution

(conclusion)

Central Idea	Collective Subject Discourse
Interdisciplinarity	*Everyone is entitled to health information. Thus, there should be a group in the coordination of women's health to visit sex workers and carry out continuous and problem-solving educational activities, through lectures or experience exchange focused on sexual, reproductive and psychological health in an integral perspective on women's health with a focus on risk factors; investigate forms of violence against women, the presence of STIs and the need to perform diagnostic tests. When necessary, these activities can be developed in other places, such as schools, auditoriums, community spaces, on a specific subject, in partnership with the NASF team, as they have social workers, psychologists, physiotherapists, physical educators, doctors and nurses and, depending on each case, we can even forward to psychological counseling.*

Source: Created by the authors.

Discourse related to the access and attendance of these clients to health services were also highlighted. In this regard, nurses stated that this population only visited the basic health services in case of complaints that compromised their work activities, irreversible conditions or with a high level of commitment, mostly related to STIs.

During the practice of prostitution, participants emphasized the constant risks of catching some STIs and, specifically regarding women, unwanted pregnancies and consecutive abortions, restricting themselves to sexual and reproductive aspects. They also linked prostitution to legal and illegal drug addiction, with the risk of these people becoming chemical addicts and potential targets for physical, sexual and psychological violence.

Due to the fact that care mainly occurred upon spontaneous demand, the nurses pointed out that the consultation should be the time to attend all the reported demands. Care tended to be centered on a curative logic and actions tended to become punctual and fragmented as a result of the difficulty to establish reliable bonds for the continuity and integrality of care. This process occurred because these people did not feel comfortable with the family health team or belonged to the community. Thus, they sought care in other health services, so as not to be identified, and also due to the incompatible times to attend the services (Chart 4).

Chart 4 – Central Ideas and Collective Subject Discourse on these people's access to health services

(to be continued)

Central Idea	Collective Subject Discourse
Search conditioned by the presence of health problems	*Women who engage in prostitution generally have that view and behavior of wanting to visit a service when they have a health problem, presenting signs and symptoms, mostly, of STIs in advanced degrees, when there is no possibility to revert without using procedures and medications. It is difficult to bring them to the public health service. They do not come because they are afraid and ashamed, but when they seek care they seek cure for the complaints that bother the body and affect work and profitability. They do not visit the service for health promotion, request consultations or advice on contraceptive methods and STIs. They come by chance, pick up condoms, contraceptive drugs or STI control. So our role is to try to cure what is affected at that moment. Visits are not performed because, during daytime hours, they are sleeping and the environment is closed. In addition, when invited, they do not show up because the service's opening hours are incompatible with their routine.*

Chart 4 – Central Ideas and Collective Subject Discourse on these people's access to health services

(conclusion)

Central Idea	Collective Subject Discourse
Bonding difficulty	*There is great difficulty to achieve a bond between this public and the ESF, especially when nurses are aware of their situation in prostitution, because sometimes they are embarrassed about how they will be received, what they will think of them and how they should come and ask. Often, however, they do not come to the ESF out of fear of repercussions, because the CHA or attendant will know. So they often prefer to visit the infectology center that is far from the community and are attended by people they do not know, with whom they do not have any bond. These professionals are accustomed to work with these people and diseases. When care takes place at the unit, they arrive with complaints and, despite the guidelines on prevention and treatment, they think they know everything and do not return to the service for follow-up. The greatest difficulty is the impossibility to terminate the care, because it is not up to the nurse to diagnose and treat, but to advise and forward. And in this referral to the doctor, many do not return. And when we visit them, we are not so well accepted. So one needs to establish a bond of trust, so that they can feel at ease and talk.*
Risk behaviors	*It is unacceptable for these people to be in a risk group and not visit the services because they are at risk of catching various curable and incurable STIs, such as gonorrhea, syphilis, HPV and AIDS, in addition to unwanted pregnancies, consecutive abortions and physical, psychological and sexual violence, cervical and penile cancers, pneumonia and skin cancer because of contact with foul clubs. These people are subject to aggression, as they are submissive to the will of the partners. Also, they can make continuous use of drugs and become users. They are at greater risk of death than we are. Although there are no specific groups and risk factors for sex workers today because everyone is exposed, anyway, it is a job that will directly lead to sexual activity with different partners in environments that may not offer proper working conditions. Not always taking preventive care, they may become more vulnerable to be exposed to and catch STIs, HIV and hepatitis C. This does not mean that other people are not vulnerable and exposed to risky situations and behaviors, provided that they are not aware of the preventive health care. The risk exists everywhere, even in the house itself, in a solid and stable marriage. When no condom is used, the risk is to catch sexual diseases.*

Source: Created by the authors.

Discussion

The association between prostitution and monetary gains was one of the structuring factors of the nurses' discourse, in which they seek to justify the unfavorable socioeconomic situation as responsible for the practice of prostitution[1]. The practice is socially tolerated, referring to structural factors that can be overome when the financial conditions improve and the activity can be ceased, however, that is not always observed in practice, as there are no suitable conditions for the insertion of sex workers in other occupations[15].

The social representation of prostitution as an act involved in desire and personal satisfaction contradicts the previous justification because, *a priori*, in a relationship of sale and negotiation, the possibility of the sex worker getting pleasure is not allowed. It contrasts with the generalized view of the exclusive sale of pleasure to third parties to obtain only money, which makes it impossible to construct a *sui generis* conception of prostitution as a series of socioeconomic,

cultural and personal factors surrounding its practice[1].

The strong association between prostitution and women, evidenced in the empirical data, represents an anchor explained by the gender stereotypes constructed and associated with the female image over time, due to the gender inequalities and the ways in which women should experience sexuality, considering that there are permanent aspects. On the other hand, male prostitution is seen in the social imaginary as something natural and inherent in masculinity[16].

This process stems from the association between sexual act and reproduction, which was socioculturally transmitted. Based on the imposed social rules, limits were established for women, who should respect the man, maintain the social order and be fit for the functions of reproduction and care for the home, while the full exercise of their sexuality is not their role[17]. Otherwise, the woman was seen as deviant and trespasser of moral and social standards of conduct, with all the negative effects on her life, such as the marginalization imposed on those who engage in prostitution. It is mainly among the social representations that gender asymmetries and power relations are reproduced[1,17].

In the practice of female prostitution, it is observed that promiscuity is a stereotype associated with sexual behaviors and practices socially marked by immorality, debauchery and libertinism[18]. Although there is no consensus in the literature about the concept of promiscuity, it cannot be affirmed that it is part of an individual's nature or essence, as it constitutes a historically determined cultural production[19], as a reflection of the patriarchal society and of inequalities in gender relations[18]. Thus, the practices of prostitutes are mistakenly interpreted. As a result, they have a devalued image, materialized in the form of prejudice, stigma and marginalization[18-19].

These social representations can be explained in the conception of sexuality as something given by nature, inherent in the human being, which is usually anchored in the body and in the assumption that all individuals share experiences or experience their bodies universally in the same way. Sexuality is not inscribed in the body though, but in the way the individual uses this sexualized body[20]. Departing from the premise that bodies gain social meaning, prostitution is a practice in which the body is seen as a working tool. The way in which sex workers use it can make them vulnerable to health problems.

As a result of the relationship between sexual activity and prostitution, it has been portrayed socio-historically as a practice marked by risks, due to the sexual behaviors adopted. This social representation was built more metaphorically than factually when related to STIs, because this population was configured as a risk group with the advent of AIDS which, in the social imaginary, had discriminatory connotations, as it ended up associating the disease to these populations, reinforcing the strong burden of prejudice linked to the idea of sexual transgression and/or promiscuity in the exercise of sexuality[1,21].

Social representations of the body and sexuality interfere in the care practices the health professionals offer[21], as they usually depart from the reductionist assumption that the demands of people in situations of prostitution are centered on sexual and reproductive aspects. As a result of the trade in sexual practices, there is a trend to portray the bodies of prostitutes as ill, which is reflected in welfare practices focused on hygiene and cure measures[22]. In this sense, the acquisition of STI would represent an occupational risk, as the body and the sexual practices are work instruments, which would make the use of condoms fundamental according to the health professionals[23].

Studies have pointed out that, although prostitutes know about contraceptive methods, the social representation of non-use in fixed relationships prevails, due to the trust placed in the partner and the assumption of fidelity in the affective-sexual involvement. In addition, sexual behaviors between sex workers and clients sometimes go beyond the dimension of the pursuit and supply of pleasure through regular problems or the power relations stemming from gender inequalities, as the program may impose the non-use of condoms[17,23].

The sex workers can internalize the association between prostitution and STI, influencing their perception about self care and the search for care in PHC[17]. A study identified that the access of women in prostitution to health services is related to the occurrence of unplanned pregnancies, undergoing the pap smear, picking up condoms and routine exams and their importance to comply with care for the body as a work instrument[22].

The perception that the search for health services occurs as a result of STI restricts the health professionals' care perspectives[17]. These processes impede or limit the communication and understanding of daily life, health and work based on an integral approach, as these populations are subject to individual, social and programmatic vulnerabilities in health that surpass the sexual dimension and the biological perspective.

Due to the complexity of the aspects involved in the practice of prostitution, it becomes imperative to understand the needs of the people involved in this activity, and then to list actions and strategies that include sexual, social and labor rights, awareness raising in health, valuation and bonding between professionals and users[24].

Thus, the challenge collective health faces, as a field of knowledge and practices, is to implement policies to promote equity and damage reduction strategies as possibilities to legitimize the right to health and reduce the associated inequities, inequalities and disparities. The need to re-adjust the structure and schedules of existing services is appointed, as well as to train and develop competencies in health professionals to provide comprehensive and continuous care, based on respect for the freedom of choice and the principle of non-discrimination[25] and mainly to legitimize the ESF as a gateway to the health care network, as a space capable of responding decisively to the health needs of sex workers through integrated and intersectoral actions.

It is pointed out that the restriction of the data collection to only two health districts can compromise the interpretation and generalization of the findings, which suggests the need for similar studies that may refute or corroborate the results of this study, as well as unveil developments of the theme as a result of the multi/inter/transdisciplinary approach the understanding of the prostitution phenomenon requires. The deepening of the discussion in question is relevant though, as it contributes to a better understanding of the relationship established between sex workers and health professionals within the scope of the ESF, the social representations and their implications in health care practices in this care scenario.

Conclusion

The social representations of nurses about prostitution converge to the paid practice of this activity, sometimes involved in personal desire and satisfaction, permeated by the stereotype that the execution of this practice is restricted to the female audience and is related with promiscuity, as a reflection of the patriarchal society and gender relations.

The imaginary of the nurse related to prostitution is built amidst hybrid references, that is, between socially shared, collective and individual knowledge, marked by gender relations. As a result of this articulation, professionals link the sexual practices and behaviors of prostitutes with the risk of catching STI. The discourse and prescriptions are directed at actions, programs and services restricted to sexual and reproductive health. As a result of the complexity involved in this phenomenon, the care actions cannot be solved in the ESF, but need articulation with other services in the health care network.

Nurses should investigate the bio-psycho-socio-economic-cultural aspects and health needs, be sensitive in their behaviors and attitudes and consider the work conditions of the people who carry out prostitution as determinants of health problems in order to overcome the biological and curative view in care, integrating the perspective of health promotion and the principle of integrality and equity.

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