

Perceptions of female sex workers about access to HIV testing: incentives and barriers

Percepções de mulheres profissionais do sexo sobre acesso do teste HIV: incentivos e barreiras

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ABSTRACT The objective of this paper is to discuss perceived barriers and incentives for female sex workers for HIV testing in services provided by the Unified Health System (SUS). Qualitative research was conducted through semistructured interviews in the city of Fortaleza from 2012 to 2014. Of the women who tested in primary care (30%), the majority (64%) were tested during prenatal care. Concerning testing, 17% had never tested, 69% had tested at least once in their lifetime and 14% tested regularly. Identified as barriers were the lack of on-demand testing, prejudice, and lack of confidentiality.

KEYWORDS HIV. Health vulnerability. Prostitution. Health services accessibility. Qualitative research.

RESUMO *Objetiva-se discutir as barreiras e os incentivos identificados pelas profissionais do sexo para a realização do teste HIV (Vírus da Imunodeficiência Humana) relacionados com a organização das ações e serviços no Sistema Único de Saúde. Pesquisa qualitativa realizada por entrevista semiestruturada na cidade de Fortaleza de 2012 a 2014. Das mulheres que fizeram o teste na atenção primária (30%), a maior parte (64%) teve acesso a ele pela assistência pré-natal. Sobre a sua realização, 17% nunca tinham feito, 69% já tinham feito alguma vez na vida e 14% realizavam-no constantemente. Foram identificadas como barreiras a falta de vagas por demanda espontânea, preconceito e falta de sigilo.*

PALAVRAS-CHAVE HIV. Vulnerabilidade em saúde. Prostituição. Acesso aos serviços de saúde. Pesquisa qualitativa.

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Introduction

According to Unaid (Joint United Nations Programme on HIV/Aids), in 2015, there were around the world 35 million people living with HIV/Aids (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome); among which, 15,8 million people had access to antiretroviral therapy, compared to 7,5 million people in 2010 and 2,2 million people in 2005 (UNAIDS, 2015).

Faced with this historical series, the 90-90-90 treatment goals proposed by Unaid say that by 2020 90% of people living with HIV are diagnosed; 90% of these people are being treated and 90% of them have an undetectable viral load. To reach this threshold, the same analyzes point to the need to focus on the work of prevention, diagnosis and treatment to the contexts of greater vulnerability to infection, among them, Sex Professionals women (SP) (UNAIDS, 2015).

In 2014, in Brazil, there were 734 thousand people living with HIV, the estimated HIV prevalence was between 0,4% and 0,7% of the population, there were 44 thousand new HIV infections, as well as the number of deaths related to Aids in Brazil was of 16 thousand in the same year (UNAIDS BRASIL, 2015).

Some populations are more affected than others. While it is estimated that between 0,4% and 0,7% of the general population are living with HIV; among SP women, for example, this estimate rises to 4,9% (UNAIDS BRASIL, 2015).

Brazil, in 2013, has adopted new strategies to curb the Aids epidemic, offering treatment to all people living with HIV, regardless of their immune status (CD4 count); simplifying and decentralizing antiretroviral treatment; increasing coverage of HIV testing in key populations, among which, women SP (WHO, 2014). However, the increase in the supply of HIV testing is insufficient due to the complexity of the process (SILVA ET AL., 2013).

As it enters the fourth decade of existence, Aids is a disease full of meanings that goes beyond the biomedical limit, triggering

diverse identifications that impart a social, cultural, religious and identity connotation to the transmission of a virus. This finding also poses major challenges: to promote universal access to prevention and care in a qualified manner and focused on the most vulnerable populations, development and improvement of medicines and the search for a possible vaccine, as well as a constant work on coping with stigma (DANTAS, 2015).

From this context, the search for the early diagnosis of HIV, mainly among the most vulnerable populations, represents nowadays one of the most important elements for Aids policy planning and implementation (BRASIL, 2010; WHO, 2014). The moment of the discovery of positive serology is associated with an impact on prevention, treatment and health expenditure. The realization of the test early in the infection allows for the rapid identification of those infected resulting in a higher survival rate, reduction of the hospitalization period and better compliance of the treatments.

However, in Brazil, the diagnosis of HIV still occurs late, with 43% of the Brazilian population arriving at the service already with clinical conditions related to Aids (GRANGEIRO ET AL., 2011; DOURADO ET AL., 2013).

The Aids epidemic is diverse and consists of a set of trends. Among them, feminization and concentration in certain populations, such as SP. Protecting regional diversities, the national HIV prevalence among women is 4,8%, while among women in general, the percentage falls to 0,4% (SZWARCOWALD ET AL., 2011).

This way, the inclusion of SP women in the health system has been configured as a challenge. According to data from the Ministry of Health (BRASIL, 2004; PASCOS ET AL., 2010), in the Brazilian northeast, the precariousness of access to the health service by SP women is higher than in other regions of the Country.

The prioritization of early diagnosis in the basic health units, systematically, occurs, even if precariously (LIMA ET AL., 2008), centered in the gestational period (ARAÚJO, 2014). Paradoxically, there are already national and international

recommendations (BRASIL, 2006; UNAIDS, 2009; WHO, 2014) that advocate the inclusion of SPs in these local health territories (primary care, for example) as a special way of containing HIV infection in the population generally.

In the same direction, according to recommendations of the Ministry of Health, HIV testing should be available as close as possible to people, expanded beyond the Centers for Testing and Counseling (CTA). It is also determined that basic health units should offer HIV testing beyond prenatal care and perform decentralized actions in social spaces that congregate more vulnerable populations, including areas of prostitution (BRASIL, 2006; BRASIL, 2010; WHO, 2014).

More specifically, the official documents suggest the implantation of integral care to SPs, which includes the recognition and mapping of spaces of sexual sociability in the territory, wide distribution of condoms, regular gynecological consultations, systematic testing for HIV, syphilis and hepatitis, and immediate treatment of some sexually transmitted disease (UNAIDS, 2009; BRASIL, 2004; UNAIDS BRASIL, 2015).

In practice, however, this issue occurs in another direction. The social and programmatic invisibility of prostitution, coupled with the prejudice associated with the idea of risk groups and HIV infection itself from these contexts, triggers a process of relative exclusion of the most vulnerable populations in the basic units (PEDROSA; CASTRO, 2009).

Faced with this scenario, this article intends to discuss the barriers and incentives identified by the SP in Fortaleza to perform the HIV test related to the organization of actions and health services in the various points of health care in the Unified Health System (SUS).

Methods

This is a qualitative research financed by three research promotion agencies: National

Council for Scientific and Technological Development (CNPq), Brazilian Ministry of Health and Agence Nationale de Recherches sur Le Sida et Les Hepatitis Virales (ANRS/France) (Public notice MCT/CNPq n° 14/2009 – Universal) through the Rapid Anthropological Assessment (RAA) methodology, a method proposed by Herman and Bentley (1993).

Among the main characteristics of the RAA, stand out: the use of mixed techniques, including, for example, semi-structured and open interviews with members of the affected community, besides field observation and interview with people involved with the surrounding population in question; analyzing the difference between a goal of the local health system and the reality of the community investigated (CHOPRA ET AL., 2006).

The RAA is a qualitative methodology focused on an assigned area, being performed in a short period of up to three months. For this study, interviews and participant observation were applied, focused on a specific theme in health. The involvement of workers from the own studied territory, with a bond and knowledge about the said space, is the most relevant feature of this methodology (KENALL ET AL., 2005; STIMSON ET AL., 2006).

The study was started from a training process conducted with a group of interviewers consisting of social educators from the Secretariat for Human Rights of the city of Fortaleza who worked in the prostitution zones with the SPs. The work of these educators was to inform and contribute to the inclusion of the SP in public social policies existing in the municipality. They were invited to integrate the research, conducting interviews and discussing the cases weekly with the researchers, considering the in-depth knowledge of these subjects on the territory and daily life of the SPs, as well as the ability to approach and interact with these women.

The research was performed in the city of Fortaleza, Ceará, in the period from

2012 to 2014, in four distinct territories: 1) Downtown Fortaleza (Square of the Promio Público and José de Alencar Square), historical squares in the configuration of prostitution in the center of the city, a primarily commercial area where commercial sex activities occur mainly during the day. 2) Port area in the Mucuripe neighborhood, a region where prostitution occurs during the day and night with port workers coming from different parts of Brazil and the world. 3) Neighborhood of Osório de Paiva Avenue – a route of truck drivers to one of the state highways (CE-095) that crosses the districts of Parangaba, Vila Pery, Siqueira and Canindezinho – suburban neighborhoods that concentrate several vulnerabilities associated with poverty, drug trafficking and violence. 4) Coastal zone of the periphery of the neighborhood of Barra do Ceará, an area of the periphery that concentrates diverse inequalities, trafficking and violence.

The data were collected through semi-structured interviews, carried out individually and concomitantly to the visits of recognition of the territory and observations in the field from the techniques of ethnography. These observations have been permanently constituted in places of prostitution – such as in the streets, bars and nightclubs, squares and gas stations during the period of three months –, where women were talked to when they were waiting for clients, observing their practices and relationships established in each territory. Through the techniques of ethnography, a field diary was constructed with these observations and reflections which integrates the analyzes presented here.

All interviews were recorded, coded, categorized, analyzed and systematized through comprehensive analysis. The criterion for finalizing the information collection phase was the theoretical saturation of the sample. This process occurs when one begins to identify the regularities in the speeches of the interviewees considering the discursive

aspects around the perception of reality. There is no exposure of identifications of the respondents so that fictitious names were used for writing this article.

The participating population of the research was 37 women aged between 18 and 50 years old. The inclusion criteria to be interviewed were: to be over 18 years old, to be practicing commercial sex in the areas described as a place of study, defined by the Secretariat for Human Rights of the city of Fortaleza as areas of greater social vulnerability.

The project was submitted to the Committee of Ethics and Research (Comepe) of the Federal University of Ceará, in accordance with Resolution nº 196/96 of the National Health Council on research involving human beings, being approved under protocol nº 263/09. Required ethical standards were followed, as all participants signed the Free and Informed Consent Form.

Results and discussion

Of the 37 women interviewed, 61% had completed primary education. Regarding the test, 17% had never done it, 69% had done it once in their lifetime, and 14% did it periodically. Regarding the main reasons for the realization of the test, the following stand out: 33% had prenatal care, 33% had experienced some situation considered by them as risk (punctual searches for HIV diagnosis) and 11% because of routine care with health (continuous realization). As for the place of realization of the test, 30% did in the 'health post' (primary health care unit), of which, 64% were in prenatal care. In relation to the other locations, 47% were carried out in specialized services for the treatment of Sexually Transmitted Diseases – STD/HIV/Aids.

These data are analyzed below by constructing contexts of greater or lesser protection, since a set of factors influences the constitution of the vulnerabilities (AYRES ET AL., 2008).

Invisibility of prostitution in primary care: incentives and barriers to HIV testing

Primary Health Care (PHC) has been considered essential for the effectiveness of health systems and for ensuring improvements in the health conditions of the Brazilian population. Research indicates that the service, if functioning effectively, contributes to the reduction of diseases and hospitalization rates and to premature mortality due to preventable diseases in addition to lower costs and greater equity in service provision (WHO, 2004). This parameter of effectiveness in primary care in relation to prostitution is still a major challenge due to the invisibility of this occupation in the different territories of basic health services (VILLELA, 2015).

In the present study, among women who tested in primary care (30%), most (64%) had access to anti-HIV testing for prenatal care. It has been reported greater difficult to get care at the 'health center' (primary care unit) closer to their home or in the prostitution zone; being identified as barriers to the test both the lack of vacancies by spontaneous demand that was not during the prenatal, as well as the prejudice and lack of confidentiality:

I've had tested for AIDS several times, but at the health post near my house I only had it when I was pregnant... because it's very difficult to get a record (attendance). When I was pregnant it was easier. If I go there to say that I want to have the test because I do sexual service I do not know what they are going to say... nor do I do prevention there, I do it at Bemfam [specialized clinic], I prefer a place far from home too, I do not want anybody taking care of my life here, not [prostitution], even more if something happens [HIV +]... the posts should be more sensitive to these issues, for me the call girls take care of themselves more than the housewife, but doctors do not think so, right... (Dejane, 25 years old, free translation).

It is noticed in this speech that the test associated with prenatal care is recurrent, which demonstrates the importance of this service. However, it also goes back to the discussion about the lack of preparation of the primary health care teams for the systematization of the anti-HIV test in the routine of women who are not pregnant, especially the SPs.

About this invisibility, one can think that female prostitution, as an urban social phenomenon, is inscribed in a specific economy of desire, characteristic of a society in which exchange relations predominate and a whole system of moral codifications. In this context, although the consumption of the service offered by the SPs is useful, moral values privilege monogamous sexual union, nuclear family, virginity, female fidelity and the reproductive role of women, assigning, consequently, a specific place, saturated with moralistic connotations and pejorative meanings for the woman who commercializes sex from her own body (VILLELA, 2015).

The social relations built from this referential also cross the health units, generating programmatic invisibility, and the woman is only seen as a priority of care when she occupies places of greater social acceptance, as, in the case, when they are pregnant (ARAUJO, 2014). The stigmatization of sex work challenges various social, commercial and affective interactions and constitutes an important obstacle to the 'empowerment' of these women. This is an aspect that requires a centrality not yet incorporated by public policies on STD/Aids and constitutes a fragility to be overcome (NEMES, 2004).

At the time of prenatal care, there is an appeal about the possibility of the vertical transmission of HIV that propels the decision to undergo the test, which is a demand of the service, not a necessity posed by the woman herself with reference to possible daily risks, such as work with sex (LIMA ET AL., 2008). Therefore, a considerable percentage of women accessed the prenatal test, as if it was a typical procedure of that period and of

protection for the child, not reverting itself to regularity of testing after the gestational period:

I was only tested when I was pregnant with my girl. I found it very important, the social worker said it was good to take the test to check the baby's health, to know if there was anything with her. (Eva, 32 years old, free translation).

I do not know any of this [HIV, test], but I already did it, once, when I was pregnant, the doctor requested because if I had HIV I could transmit it to my daughter, it proved negative, if it was not, it would harm her health. (Dária, 20 years old, free translation).

According to the women interviewed, many health professionals, at the time of prenatal care, do not even ask about their sex lives. It is noticed that the offer of the test at that moment is understood by the SP only as routine of care in the gestation. The difficulty of talking about this triad, sex, pleasure and prevention, as part of the daily life of women with active sexual life (being SP or not) constitutes a vulnerability to HIV related to the invisibility of female sexuality (VILLELA, 2015).

From another point of view, about 47% of those interviewed, when they felt themselves at risk, were tested in medium and high complexity services in the SUS (hospitals or specialized services) referring more preparedness and reception to their demands than in PHC:

I do prevention [gynecological] every 6 months, then I do the test, too, in the center's service [STD specialist referral service] because I'm used to it there, they're specialized. Due to our flow [sex work], the call girls are more susceptible, we always need care, at the health post near my house they don't always have it, only when the woman is pregnant. (Haída, 32 years old, free translation).

As indicated by Grangeiro *et al.*, (2009), this reference still follows the beginning of the epidemic in which HIV testing was initiated in blood centers and CTC, and treatment in Specialized Outpatient Services (SAE). In the state of Ceará, many people are still seeking specialized HIV/Aids services to also do the diagnostic test; which points to the need to rethink access to basic health services in relation to the search for HIV diagnosis.

HIV testing in primary care was implemented, in 2003, with the Family Health Strategy (FHS), as a prenatal care protocol, for people with tuberculosis, other sexually transmitted diseases and the most vulnerable populations, such as SPs, for example (BRASIL, 2006; BRASIL, 2007; CARNEIRO; COELHO, 2010; WHO, 2015).

Therefore, the fact that SPs mainly identify specialized services as locations conducive to the performance of the test when they feel they are at risk goes in the opposite direction of official policy, in which the Ministry of Health demands the expansion of the universal access in the PHC network. In addition, there is a need for investment in continuing education for professionals, appropriate knowledge about technical issues related to HIV infection, good working conditions and satisfactory infrastructure for the adequate care of these users (MAIA ET AL., 2015).

In this way, it is known that initially public policies on STD/HIV/Aids were in specialized services and focused on the conception of 'risk groups'. Subsequently, the concept of vulnerability has been modified and expanded to basic services, but, in practice, it still occurs with restrictions on universal access due to the restricted focus on maternal and child care (LIMA ET AL., 2008; ARAUJO, 2014).

This difference of identification with the test place has impact on the systematic accomplishment, as routine.

When I think there was some danger [the condom bursts for example], I look for São José [hospital of reference] to do the test because there I know that I will be taken care of, I will be

able to do the test and that's it. But at the health post? Not even in my thoughts, I think it's only for the pregnant woman and not all them end up doing it... (Amanda, 45 years old, free translation).

The proximity to the lived territory, the principles of linkage and longitudinality of the specific care of the FHS is that they could better qualify the systematization and regularity in the performance of the HIV test (CUNHA; COELHO, 2011).

However, what has occurred, according to the women involved in this study, is that this territorial proximity of the primary care unit with the workplace (prostitution house) and the environment where they live have not been built (their neighborhood, their home). What has been evaluated is that the way of organizing primary care has been constituted as a barrier to the test.

Lack of confidentiality and unpreparedness of professionals regarding issues related to sex and sexuality have been raised as points that keep people away from the decision to take the anti-HIV test at the nearest unit when they effectively feel at risk, that is, over and above the gestational period.

This feeling of breach of secrecy often hinders access to the units closest to home. The women in the study, generally, stated that it would be easier to conduct the test more often if prejudice and discrimination were not so prevalent in relation to services.

A lot of people are afraid to look for the service and say that they do the sexual service and not get care, or even have bad news [referring to the possibility of when they look for the service, they receive the news of a positive HIV test]. (Haída, 32 years old, free translation);

God forbid anyone of knowing that I do sexual service here, or even that I get to have the virus, it would be death for me, I would lose my job, my life... at the health post near here I still did not feel confidence, I do not know, I have never said anything. (Jane, 24 years old, free translation).

Sexual practices are few discussed in their essence within the health clinic, where preventive discourse is mostly unidirectional and little focused on the diverse contexts in which people may be inserted (DANTAS, 2015). Prescriptive standardization of the presupposed 'correct way' to exercise the sexual act renders the doctor-patient relationship dissonant in the discussion of effective prevention (SILVA, 2012).

One of the interviewees of the research follows her reasoning in this direction, pointing out ways to manage risk and expand this discussion with other women, while identifying fragilities in health care:

They [doctors] could have many ways to do it, when the person is there, they could talk to everyone, there are doctors who talk, there are doctors who don't talk, there are many ways to help, they should communicate with people, always talking, talking a lot about it, at some moment it will get into their heads [SP], this way people will know more and more about things... people are also afraid to speak and the doctor say something [about prostitution], it's embarrassing. (Marilena, 35 years old, free translation).

The regular access of the SPs to the health service is therefore compromised regarding the invisibility or even the non-acceptance of prostitution as a way of life and work. In this sense, it is necessary to invest in the deconstruction of the way of identifying the prostitution zones in many territories as something morally questionable and to strengthen the idea that each brothel should be registered and accompanied by its respective health agent linked to the mapping of the longitudinal care of the basic health unit.

In this sense, it is understood that it is necessary to discuss the prioritization of regular assistance to these groups in primary care, mainly because they are considered more vulnerable to HIV, as is the case of SPs; seeking, this way, an effective control of sexually transmitted diseases, from early

diagnosis to continuous treatment in an immediate time, reducing the chain of transmission of HIV and increasing health care.

Women know what they need: notes for the quality of health care in prostitution

During the research, women pointed to ways of reorganizing health care, describing how actions and services could be more accessible and inclusive in relation to prostitution.

In the case of the STD/HIV/Aids policy, what would be more productive and appropriate is that the test, as a priority, would be available closer to the most vulnerable populations, therefore, in primary care, in an easy and welcoming way, being widely disseminated and stimulated in diverse territories (BRASIL, 2006; WHO, 2014).

Not only does the Ministry of Health make this recommendation above but also some women from the study represented here:

I think the health post had to encourage us to do [the test]. There is a woman here [in the prostitution zone] who has and does not know, and still is afraid to do this test, of not to be welcomed... I think the doctor should stimulate, they should give a lot of guidance to us, nowadays people are not even seeing, they needed to have a work of the health post with constant campaigns, approaching people on the street, in the red-light district. (Rita, 27 years old, free translation).

As the interviewee points out, it is noticed that, in addition to the official recommendations, it is necessary to comprehend how the programmatic norms are experienced in the daily life of the organization of services and how the SPs understand that the health system could effectively incorporate them in the direction of the integral care.

Effective decentralization of care for

basic services (in accord with the previous category) appeared in the research as an incentive, one of the strategies to expand the early diagnosis of HIV, materialized in the idea that several points in the care network should offer the test:

I think it was supposed to have HIV testing in all posts, not only in a hospital here and another there [distant place], because it's very difficult people do not get interested, the right was that every hospital, every post could have it... (Evilane, 38 years, free translation).

This offer, however, besides being constant, should be qualified, with better conditions of care for the primary care units. The 'health posts', according to some women, needed to reduce bureaucracy and facilitate access, ensuring secrecy and quickness, resulting in greater resolve and reliability to increase the demand for the service:

In my point of view, I think we should go after doing this test, you know, and also in the attendance the doctor must ask if we want to do to encourage us, now our health posts have to improve a lot, because hail Mary, there are a lot of precarious health posts there, missing devices, things, it's a fight to get an appointment, we should arrive and that's is, do the test. (Ana Karine, 26 years old, free translation).

To improve the health post for us to take the test there it takes so much, so it's difficult, woman, we go to a health post at dawn, we get a record, not knowing if we are going to get it, it must be repaired, because it's a mess, we needed to come and get attended soon, it's just a test, woman, for us to do it every time, always, as you're saying there [questions from previous questions], only if it is easier. (Jaqueline, 32 years old, free translation).

The question about the delay in the delivery of the tests was reinforced as a barrier in the search for the HIV test in the public

service. One of the women states that, even looking for the unit to do gynecological prevention, she is not motivated to test because of the disbelief in the skillful return and highlights the search for private service to achieve greater efficiency:

I do my prevention at the health post [Primary Health Care unit], but the test they asked me in pregnancy I preferred to do privately, because in the health post takes too long, it's probably that I may have had the girl and not have had the result, in private is faster, useful. (Daniela, 23 years old, free translation).

Another issue raised is that it is not enough to know where to take the test. Because the intersection between Aids and prostitution is embedded in zones of stigma and discrimination, the lack of linking and welcoming at some of these known locations are factors that interfere with personal mobilization in taking the test. The implantation of the reception was highlighted as an important incentive tool, for providing approximation and inclusion. One of the women referred to this question, demonstrating that she holds the information of where to look for the test, but she lacks motivation for the representation of how the service is not very welcoming in this sense:

I know where I can do this test [HIV], but it's difficult for me to go to the health post [primary health care unit next to her home], I need to desire it, I know I need to do it, I need to take some time and do it, I'm lazy too, because it's not so easy, is bad to go alone, to talk about these things for a nurse, sometimes we do not even have time to talk, an attendance is difficult to get, and the time is short, there are some things we have to be confident to talk though... I think it's important to us, who live 'in this life' doing the sexual service, do it [the test]... (Marieta, 42 years old, free translation).

In this way, it is understood that when health professionals build bonds with people

and establishments in prostitution zones, with organizational charts that facilitate access, promoting referral to general and reference services, condom use rates, the performance of the test and the number of gynecological consultations increase (BRASIL, 2004, WHO, 2014). However, a study carried out in Porto Alegre highlights the difficulty of continuity of care by the high turnover of professionals in primary care, a factor not analyzed in this study (ROCHA ET AL., 2016).

Based on the above reports, it is noticed that one of the central attitudes for the preparation of the PHC teams to confront the Aids epidemic and other STDs in their territories would be the establishment of a strategic planning with direct involvement of women in each vivid context.

To establish an integral and systematic care program with SPs, it is necessary to invest in an upward manner in what women themselves understand about more adequate modes of intervention, connected with local potentialities and vulnerabilities (WHO, 2014).

Conclusions

According to the scenario outlined in this paper, the following points stand out: advancing early diagnosis of HIV is a necessity through the established achievements regarding the use of antiretroviral in the early stages of infection; even though the percentage of people tested has increased over the years, especially about women, the perception of the importance of an early diagnosis is still very low, and the test is focused on prenatal care.

In general, almost all women interviewed reported important issues that demonstrate their motivation to take the test; therefore, it was found that there is an intention to do so. The positive and spontaneous will to do so was present in many discourses. The main barrier, in this sense, was the form of organization of the services.

Different places were cited for the HIV test in Fortaleza, and the well-done reception in the health unit was the great incentive generally reported for the test to be consented to. However, the simple fact of knowing where to take the test was not enough to trigger the systematic need. Depending on the location and what it represents, as well as its modes of accessibility, there was more or less stimulation of continuous testing, incorporated as care inherent to occupation with sex and way of life.

Prejudice and lack of confidentiality in primary care (proximity to the place of living and work, demonstrating a contradiction in relation to the process of decentralization of the STD/Aids policy, focusing on the nearest territories and for the most vulnerable populations) are considered the main barriers.

This study points out the need to invest in research with a focus on the primary care services to incorporate the policy of comprehensive care to sexually transmitted diseases based on the potentialities and vulnerabilities of each territory. The integration of populations most vulnerable to HIV, such as SP women, in health services depends on the way the health system is organized considering their demands and needs, in a strategic and collective way with women themselves. This action will have significant impacts for the effective systematic realization of the HIV test in the SPs in each locality.

Collaborators

Renata Mota Rodrigues Bitu Sousa contributed substantially to the conception and planning or to the analysis and interpretation of the data; contributed significantly in the drafting or critical revision of the content and participated in the approval of the final version of the manuscript. Myrna Maria Arcanjo Frota contributed significantly in the drafting or critical revision of the content and participated in the approval of the final version of the manuscript. Camila Castro contributed substantially to the conception and planning or to the analysis and interpretation of the data; contributed significantly in the drafting or critical revision of the content and participated in the approval of the final version of the manuscript. Bernard Carl Kendall contributed substantially to the conception and planning or to the analysis and interpretation of the data; contributed significantly in the drafting or critical revision of the content and participated in the approval of the final version of the manuscript. Ligia Regina Franco Sansigolo Kerr contributed substantially to the conception and planning or to the analysis and interpretation of the data; contributed significantly in the drafting or critical revision of the content and participated in the approval of the final version of the manuscript. ■

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