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Self-Care Practices and Associated Sexual Health Risks Among Cisgender Women Sex Workers in Colombia

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Abstract

Introduction *Sex work* is a social phenomenon characterized by exchanging sexual services for money or goods. In Colombia, it generally occurs in clandestine and unsafe environments due to social exclusion related to stigma, discrimination, and criminalization of the occupation. Sex workers may experience health risks due to the ineffectiveness of some self-care measures in exercising sexual practices.

Methods This qualitative, constructivist, hermeneutic phenomenological study explored the sexual health self-care practices of 34 cisgender women sex workers over 18 years of age in Colombia from the analytical lens of intersectionality. Data were obtained through in-depth interviews face-to-face and discussion groups between July 2021 and March 2022.

Results After reflective thematic analysis with an inductive approach to the data, five general themes emerged: meaning of self-care promoting practices, relationship with the healthcare system, empowerment and personal autonomy, vulnerability of cisgender women sex workers, and low-risk perception.

Conclusions and Policy Implications The findings show the need to promote and provide humanized, friendly, and self-sustainable sexual health care with educational strategies that favor the intersectional cooperation of preventive care linked to the body, conceptual, and cultural memory of sex workers, providing them with the necessary tools to manage sexual health risks from their situated and contextual reality with a perspective of rights, social justice, and gender equity.

Keywords Cisgender women sex workers · Sex work · Self-care practices · Sexual health · Intersectionality

Introduction

Sex work (SW) is a social, complex, controversial, and long-standing phenomenon in human history; it is characterized by the exchange of sexual services for money or goods and can occur frequently or occasionally (McMillan et al., 2018).

For some feminist movements, prostitution is viewed from an abolitionist perspective, and SW is conceived as an alienation of women and, therefore, should be abolished. In contrast, from other more liberal viewpoints, SW is interpreted starting from the labor and economic implication of the sale of sexual services, being seen as a paid activity like any other occupation (Di Nucci, 2019; Moran & Farley, 2019; Vanwesenbeeck, 2017). On the other hand, the polymorphic perspective interprets SW as a complex phenomenon due to diversification in time, place, type of SW, and legal approach, which cannot be reduced to either exploitation or empowerment because variations and combinations of both can be experienced (Weitzer, 2009). In this sense, sex workers can live diverse experiences such as coercion, exploitation, resistance, and agency (Benoit et al., 2019).

SW is often framed socially in unfavorable environments for the empowerment of self-care behaviors in Sexual Health (SH) among Cisgender Women Sex Workers (CWSWs) due to the work circumstances where the occupation is exercised, commonly clandestine and unsafe spaces, where social problems such as crime, the sale and consumption

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of psychoactive substances, human trafficking and the lack of police protection can develop; however, SW itself is not prone to the development of these problems (McBride et al., 2021; Platt et al., 2018; Strega et al., 2021; Tanaka, 2022). In addition, the unmet needs of CWSWs, the knowledge required to identify and address the risks of SW in unsafe environments, and the propensity of people to associate SW with crime and immorality negatively impact their enjoyment of and struggle for their labor and human rights (Chow et al., 2015; Goldenberg et al., 2015; Ong et al., 2022).

On the other hand, there are barriers to the promotion of preventive care for the maintenance of the health of CWSWs related to the adverse characteristics of the environment where SW is exercised and the stigmatizing social, cultural, political, and institutional discourse surrounding it, as well as by the lack of interventions culturally compatible with the embodied reality of sex workers (Bailey & Figueroa, 2018; Benoit et al., 2017; H. Ma & Loke, 2021; Okafor et al., 2017). Consequently, there are increased morbidity associated with sexually transmitted infections (STIs), sexual and gender-based violence, and mental health harms among socially disadvantaged sex workers (Beattie et al., 2020; Ediomo-Ubong, 2020; Love, 2015; Shannon et al., 2015).

From the intersectionality lens (Carbado et al., 2013), SH self-care among CWSWs can be considered an individual and collective identity encompassing the set of preventive measures conceived and accepted to protect SH from the risks and dangers of sexual practices with clients. These ways of self-care for people's SH are part of social construction, resulting from the intersection of multiple personal identities (related to sex, gender, ethnicity, race, occupational and economic status) and their interaction with social institutions (Abrams et al., 2020; Ruiz et al., 2021; Strega et al., 2021; Tanaka, 2022; Winker & Degele, 2011). Thus, the contents of preventive SH practices are supported and validated according to the place and social circumstances where women engage in SW and interact with their clients. In contrast to the scientific literature, it is evident that due to the punitive, discriminatory, and stigmatizing nature of laws, public policies, and SH promotion programs aimed at people in SW, the elaboration and empowerment of self-care practices for SH are relegated to chance and common sense, increasing vulnerability and disparity to SH among people related to the occupation (Andrade et al., 2019; Ediomo-Ubong, 2020; Ediomo-Ubong Ekpo, 2020).

Barriers in communication and lack of cross-cultural transferability of preventive SH care available to CWSWs have been associated with the lack of public policies and models of SH care with an intercultural approach involving participatory strategies and methodologies in the analysis and approach to preventive care from the lived reality of those involved (Ferguson et al., 2017; Huschke & Coetzee, 2020; Luchenski et al., 2018; Ma et al., 2017).

In Colombia, SW is not illegal when performed by a person over 18 years of age of his or her own free will, without any coercion. Inducement to SW and pimping are criminalized. In general terms, there is a legal deficit that causes deep conflicts, with gaps in applicability and inoperability, and a lack of protection of labor rights; since, although it is mentioned as SW, there is no political and legal corpus that includes it as an autonomous labor activity, with labor guarantees and Social Security coverage (Delgado-Beltran, 2019). On the other hand, public policy on sexual and reproductive health refers to the people involved as people who perform paid sexual activities and not as sex workers, and the occupation is referred to as prostitution. The accurate characterization of the population immersed in the occupation is unknown due to the lack of operational information systems adapted to the dynamic demands of this crucial group, the concealment of the occupation, and the lack of absolute acceptance of SW.

Therefore, the question arises: What are the self-care practices in SH among CWSWs in Colombia? It is considered of socio-health and public policy relevance to explore the self-care constructions of CWSWs due to the scarcity of a body of knowledge that has addressed the phenomenon from the embodied experience of this collective as a result of the interaction between the care needs in the exercise of sexual practices, the demands and behavior of clients (Davis et al., 2020; Orchard et al., 2021), the vulnerability of the environment where SW is framed, and the overlapping intersection of multiple identities, such as being a woman and selling sexual services, using streets and parks to seek and negotiate with clients, living in precarious economic situations, having unmet needs, and facing the consequences of stigma, discrimination, and social criminalization from the micro to the macro-structural level (Abrams et al., 2020; Benoit et al., 2018; Mutola et al., 2022; Ruiz et al., 2021).

Exploring SH self-care practices among CWSWs from their lived reality can be helpful insofar as it encourages health professionals and SH policymakers to rethink how SH self-care is conceived and promoted in a socially vulnerable population. It requires a reflective and intersectional evaluation and analysis for a holistic-humanized understanding, with approaches free of stigma, discrimination, and criminalization, promoting cooperation and negotiation of culturally and socially competent preventive SH care.

Method

Design

A qualitative study was conducted with a paradigmatic constructivist perspective, whose method of approach to the object of knowledge was aligned with the Hermeneutic

Phenomenology of Martin Heidegger, given that the construction and interpretation of self-care practices for SH emerged from the empirical-conceptual reality of CWSWs (Neubauer et al., 2019). The participants' narratives were interpreted from the intersectional analytical approach, allowing the exploration of the constructions and meaning of self-care practices in the maintenance of SH as an identity grounded in lived experience, resulting from the intersection of the diverse personal identities of cisgender women with the practice of SW (Abrams et al., 2020; Carbado et al., 2013; Ruiz et al., 2021).

Context of the Study

The study was conducted from July 2021 to March 2022 in the Republic of Colombia, located in the northwestern region of South America, bordered to the east by Venezuela and Brazil, to the south by Peru and Ecuador, and the west by Panama; it has an area of 1,141,748 km^2 and a population of 51,516,562 people (2021) for a population density of 45 inhabitants per km^2; politically organized into 32 departments and five districts. It is a unitary, social, and democratic state under the rule of law, and its form of government is presidential. Currently, the country is affected by social inequality, with a Gini coefficient of 54.2 for 2020, with negative repercussions on the self-perceived health status of its inhabitants (Góngora-Salazar et al., 2022; The World Bank, 2021).

The fieldwork included qualitative face-to-face interviews and discussion groups conducted in the city center of Bogotá, the Capital District of Colombia, and in the city center of Barranquilla, the capital of the Department of Atlántico in Colombia, also officially known as the Special, Industrial, and Port District of Barranquilla.

These two cities are enormous in size and population, and the study focuses on specific areas within them: the Santa Fe neighborhood in Bogotá and El Parque de Los Enamorados in Barranquilla. The Santa Fe neighborhood, also known as La Zona de Tolerancia, was the first place in the city where SW was publicly accepted. It is a complex area where internally displaced individuals, migrants, and marginalized groups often seek "paga-diarios"—places where they can pay per day to spend the night. Additionally, it is a hub for informal and stigmatized income-earning activities, including SW, hairdressing, recycling stores, food vending, and others.

The District Secretary of Women of Bogotá alludes that the exchange of sex for money is an activity mainly feminized due to the number of women who exercise this occupation compared to men, as the district council of Barranquilla suggests in its draft law and public policy approach on SW.

The Santa Fe neighborhood was designated in 2002 by the land use plan of the city of Bogotá as the Tolerance Zone or Special High Impact Zone, where brothels and establishments offering services of high socio-psychological impact related to SW and similar activities are demarcated and allowed, in order to protect residential, hospital, and educational areas. However, this place has become a front for illegal activities unrelated to SW, such as selling and consuming psychoactive substances, illegally carrying weapons, theft, organized crime, and extortion.

On the other hand, the Santa Fe neighborhood is where migrants, internally displaced persons, indigenous people, and socially marginalized groups tend to arrive in search of a source of economic income to cover their housing and food needs and thus survive in the city.

In Barranquilla, the fieldwork was conducted in the Parque de Los Enamorados, formerly called Parque de Los Locutores, which, similar to the Santa Fe neighborhood in Bogotá, is a place where bars and discotheques offering entertainment services for adults are concentrated, combining music, dancing, alcoholic beverage consumption, and the hidden sale of psychoactive substances. Additionally, the environment is characterized by the concentration of CWSWs contacting their clients in the streets, discos, and bars to then provide sexual services in brothels, hotels, motels, and residences where they can pay only for the use of the room (usually 15 min for each sexual encounter). It is also a space where illegal activities unrelated to SW, such as theft, sale of narcotics, organized crime, extortion, and problems related to addiction to psychoactive substances are present.

These tolerance zones are socially conceived as marginalized and unsafe places due to the lack of police surveillance and continuous social interventions that provide accurate answers to the problems related to the sale and consumption of psychoactive substances and the economic precariousness of the floating population, who are often forced to get involved in criminal activities such as theft, organized crime, extortion, and the sale of psychoactive substances.

Strategies for Inviting Participants

Purposive sampling (Campbell et al., 2020) was used to select the 34 CWSWs, of which 16 were interviewed individually face-to-face and 18 in discussion groups. Data saturation was achieved in the individual interview 16, and as a strategy to enrich and validate the analysis regarding SH self-care practices, two discussion groups were conducted (Jayasekara, 2012). The recruitment and fieldwork period was 9 months, from July 2021 to March 2022. Considering the barriers to contacting CWSWs and the social insecurity of the tolerance zones where they work, the first author used four strategies to invite participants, as detailed in Fig. 1.

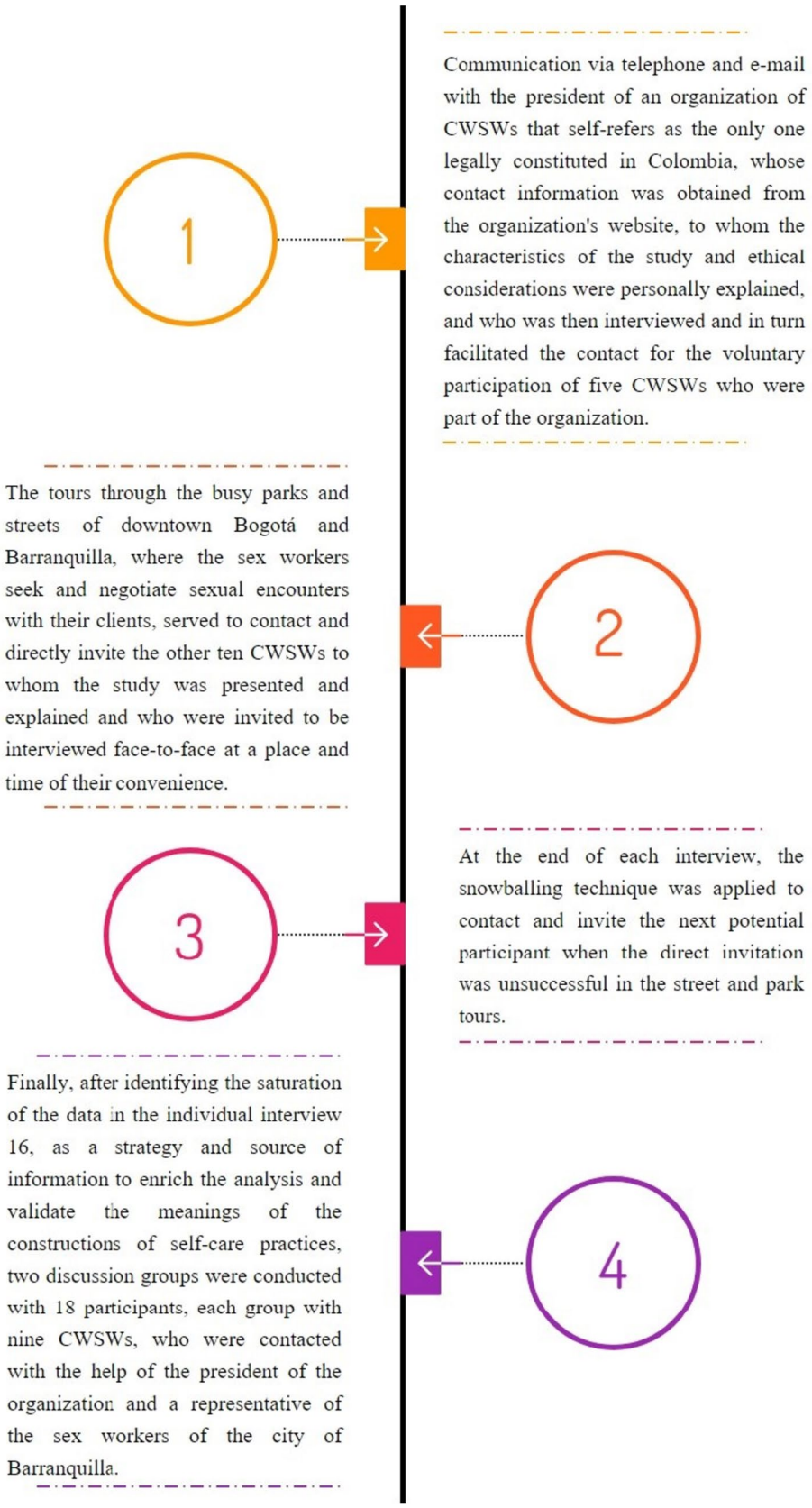

Fig. 1 Strategies for inviting participants

Selection and Characteristics of Participants

Participants had to identify as cisgender women, be at least 18 years old, self-identify as sex workers during the interview, and be willing to share their lived experiences voluntarily and honestly. Children, transgender women, cisgender or transgender men, and non-current sex workers were excluded from the study.

Cisgender women were selected because of the social and gender inequality that many have historically experienced due to the ideologies assigned to sex and gender in androcentric contexts. Also, when they choose to engage in SW, they are often undervalued, silenced, and labeled as immoral and impure because their behaviors fall outside the norms and roles socially assigned to cisgender women's sexuality. Many CWSWs with a life course marked by the consequences of economic poverty, the lack of opportunities in Colombia, and added to the lack of legislation and inclusive public policies friendly to the needs of this group (Delgado-Beltran, 2019), leads them to practice SW usually in marginalized social circumstances with various limitations for preventive self-care of SH. In Colombia, there is a lack of studies that specifically report on SH self-care practices among CWSWs, essential information to guide individual and collective interventions aimed at strengthening the SH of this group. For all these reasons, this research gives a voice to CWSWs and, in a way, adds to the international call for sustainable development in its goal 5, which alludes to the importance of ensuring women's full and effective participation to achieve gender equality and empower all women (United Nations, 2023).

A total of 34 CWSWs participated, 16 in the individual interviews and 18 in the two discussion groups, with diverse sociodemographic characteristics, as detailed in Table 1.

Table 1 Sociodemographic characteristics

Characterization	Participants
In-depth interviews	16
Discussion group one	9
Discussion group two	9
Total	34
Age	
18 to 43 years old	13
> 43 years old	21
Sexual orientation	
Heterosexual	30
Homosexual	1
Bisexual	3
Education	
Completed primary school	1
Incomplete primary school	15
Completed high school	4
Incomplete high school	9
Technologist	1
Professional	1
Illiterate	3
Religion	
Catholic	24
Christianity	9
Atheist	1
Age at onset of SW	
12 to 36 years old	30
> 36 years old	4
Length of time in SW	
1 to 22 years	18
> 22 years	16
Marital status	
Single	25
Married	1
Divorced	3
Unmarried/cohabiting	5
Migrant status	
No	21
Yes	13

Data Collection

Of the in-depth interviews, eleven were conducted in the city of Bogotá and five in the city of Barranquilla. These were guided by the first author (a native Spanish speaker with full knowledge of the linguistic nuances of Colombian Spanish) in a flexible schedule for the CWSWs, with an average duration of 65 min (single encounter), in a space facilitated by the president of the organization or in the residence where the CWSWs provided their sexual services.

The two discussion groups were held on the dance floor of a brothel in downtown Barranquilla and lasted 90 min each. The owner of the brothel provided the dance floor during non-business hours for SW.

The interviews and discussion groups were recorded in MP3 audio format on a digital smartphone recorder with the participants' prior consent; in parallel, contextual records and non-verbal expressions were made in the field diary. These data collection strategies facilitated interaction and exploration of self-care practices among CWSWs by encouraging open and spontaneous conversation about lived experiences (Jayasekara, 2012; Jimenez et al., 2019).

The in-depth interviews and discussion groups were guided by a thematic script constructed through the following phases: (1) review of the scientific literature, (2) familiarization with the environment and dynamics of SW, (3) construction of the first draft of the question script, (4) review and readjustment of the stimulus-questions, (5) the review of the stimulus questions by a group of seven CWSWs who participated voluntarily and were not part of the final number

of participants, and (6) the final refinement of the interview script incorporating the comments and suggestions of both the authors and the group of CWSW volunteers.

Modifications suggested by the seven CWSWs consisted of replacing the word "prostitution" with "sex work" (SW), as the former term carried stigma and social aversion toward the occupation. Additionally, they proposed rephrasing two initial questions that had generated confusion regarding preventive self-care during sexual encounters with clients. They also emphasized the need to replace specific technical terms with more colloquial language to give the interviews a more natural and contextual tone. All these suggestions were accepted in order to achieve better understanding and participation.

Indeed, the guiding instrument contained open-ended questions with a flexible nature that allowed for rephrasing, reordering, and clarifying the questions, encouraging participants to talk openly about self-care practices linked to SW (see Table 2).

Methodological Criteria

We applied Stenfors et al. (2020) criteria of quality and methodological rigor for qualitative research, which include: (1) credibility, characterized by the trustworthiness and plausibility of the findings with the theoretical perspective, question, methodological orientation, analytic perspective, and reporting of results; (2) trustworthiness, the possibility of replicating the study in similar contexts, because detailed information is provided to follow the same methodological sequence, even if different conclusions are reached; (3) conformability, which relates the findings and the empirical reality studied, supported with textual quotations from CWSWs; (4) transferability, the possibility of transferring these findings to other groups because the relationship of the context with the structure and meaning of the results is detailed; and (5) reflexivity, the researchers' training in the health care discipline may have influenced the construction of the study phenomenon.

The standards for reporting qualitative research by O'Brien et al. (2014) were considered for elaborating the manuscript.

Data Analysis

The first author transcribed verbatim in Microsoft Word the audio recordings derived from the interviews and discussion groups. The second and third authors verified the quality of the transcripts by comparing the transcribed information with the audio recordings and their consistency with the proposed interview script. Then, the transcripts and field notes facilitated a contextual interpretation of the meanings of self-care practices as part of the sociocultural context (Fetters & Rubinstein, 2019).

The first two authors participated in the data analysis phase, and the third author settled discrepancies. For this purpose, the reflective thematic analysis was approached, with an inductive approach in the thematic construction of the phenomenon, following six phases: (1) the familiarization with the data through the transcription of the recordings,

Table 2 Interview script

Stimulus questions
• From your experience, what self-care practices do you do to protect your SH in SW?
• Who agrees on the conditions of care during sexual practices?
• When does the client pay for a sexual service, and who exercises control over the sexual practices?
• What aspects do you analyze in the client before providing sexual services?
• What do you do when you identify a risky situation in your SW?
• How do you deal with the situation when the customer has asked you to do something that you consider dangerous to your health in exchange for a better offer?
• Have you ever felt compelled to do something risky in your work?
• Have you ever had a STI? Which one? What did you learn from that experience?
• What care do you know about the prevention of STIs?
• When you require health care, do you identify yourself as a sex worker?
• What is the type of customer that gives you the most security?
• How do you feel your clients treat you?
• In the time you have been practicing SW, what have been the riskiest sexual practices that the client has asked you to do?
• Do you use any psychoactive substances when having sex with your clients?
• Do you consider your sexual practices to be safe from a health point of view?
• What is a risky sexual practice for you? Do you consider that some sexual practices can be dangerous for your health?
• Have you ever been attracted to a client?
• How do you prevent STIs?
• How do you feel about condom use?
• When do you consider condom use essential, and when not?
• Have you ever been forced by circumstances to make risky decisions for your health during SW?
• What factors have contributed to adopting any risky behavior in your job?
• Has anyone motivated you to engage in risky behavior at work? Who?

the verification of the authenticity, and rereading of the data; (2) the generation of initial codes, recovering the text units on the constructs of self-care in SH; (3) the search for potential themes with a broad meaning by exploring, combining, and comparing the coded text units; (4) the refinement of the thematic schema, the annotated text excerpts were thoroughly reviewed, looking for a shared pattern of meaning for each theme, and when they did not describe the pattern of the data succinctly, they were renamed, or new themes were created; (5) the definition and description of each theme, the essential aspects were identified, selecting representative text excerpts for each theme; (6) finally, the report's writing from an analytical narrative told through the essential themes and verbatim of CWSWs' perceptions (Braun & Clarke, 2006, 2019).

ATLAS.ti version 22 software for Windows was employed as an assistive technology tool for storing, organizing, coding, and synthesis of qualitative data.

Ethical Considerations

The ethical principles for medical research involving human subjects established in the Declaration of Helsinki were followed. The participants were invited and informed orally, and in writing in simple language about the details of the study, information management, and ethical considerations (Dewey & Zheng, 2013); after clarifying doubts, they signed an informed consent document, and each CWSW was given a copy of it and an information sheet. This research is part of the doctoral thesis of the first author, which is being developed in the Program in Nursing and Health at the University of Barcelona, Spain, thesis directed by the third author, and whose research project was approved by the Bioethics Commission of the same university with number IRB00003099 of June 14, 2021.

Results

Thirty-four CWSWs participated in the study, 16 in the in-depth interviews and 18 in the two discussion groups. The participants ranged in age from 18 to 62 years, most of them in a precarious economic situation, heterosexual, single, with incomplete primary and secondary education, and with a length of service in SW between 6 months and 37 years.

Our findings reveal the self-care practices for SH among Colombian CWSWs, conceived as a social and subjective construction that emerges from the intersectionality of the empirical evolution of their occupational, cultural, family, sociohealth, political, and legal interaction in the environments where SW is framed. Therefore, self-care practices in SH are continuous activities derived from experience to maintain SH and prevent disease, with or without the support of information or health education. From the reflective and inductive thematic analysis of the data, five general themes emerged, three related to SH self-care practices and two related to unfavorable circumstances for SH self-care (see Fig. 2).

Theme 1. Meaning of Self-Care Promoting Practices

The self-care practices performed by CWSWs to avoid or mitigate risks and safeguard their sexual well-being in providing sexual services acquire meaning and importance according to the interpretation of the experience of sexual interaction with their clients. Thus, participants' acceptance of barrier methods is conceived as follows:

Subtheme 1.1. The Male Condom is a Preventive and Hygienic Method

The most recurrent self-care practice among CWSWs is the use of condoms; they agree that it is essential to prevent STIs; however, they indicated having experienced symptoms that they attribute to STIs such as vaginal itching, foul odor, or vaginal discharge after unprotected sex. The majority of CWSWs stated that they would not provide sexual services if they had not ensured condom use:

> I first establish what the client is asking for and what services I can offer. But, if there is no condom, no! If he demands that it must be without a care method during the relationship, no! (P-6)
> I do it with a condom because some clients say: "without a condom, I'll spill my milk (semen) outside" no, sir, put on a condom. After all, you're not going to harm me. Stop being silly! (P-17)

For some participants, condoms are simply a hygienic measure to avoid contact with semen during vaginal or oral sex:

> I demand they use a condom for hygiene, not contraception because I can no longer get pregnant. It is essential hygiene for me; the condom is vital! (P-2)
> Some men want oral sex, but I do it with a condom because some tell them that, without a condom, I tell them: to stop being a pig! (P-7)

Subtheme 1.2. The Female Condom is an Alternative Protection

Some CWSWs stated that when they suspect or identify the risk of unprotected sex because the client claims to feel less pleasure with a condom, is under the influence of alcohol, or because there are environments where male condoms are not available, they opt for the use of the female condom as an alternative protection strategy, and many of them use both condoms simultaneously because of the belief of

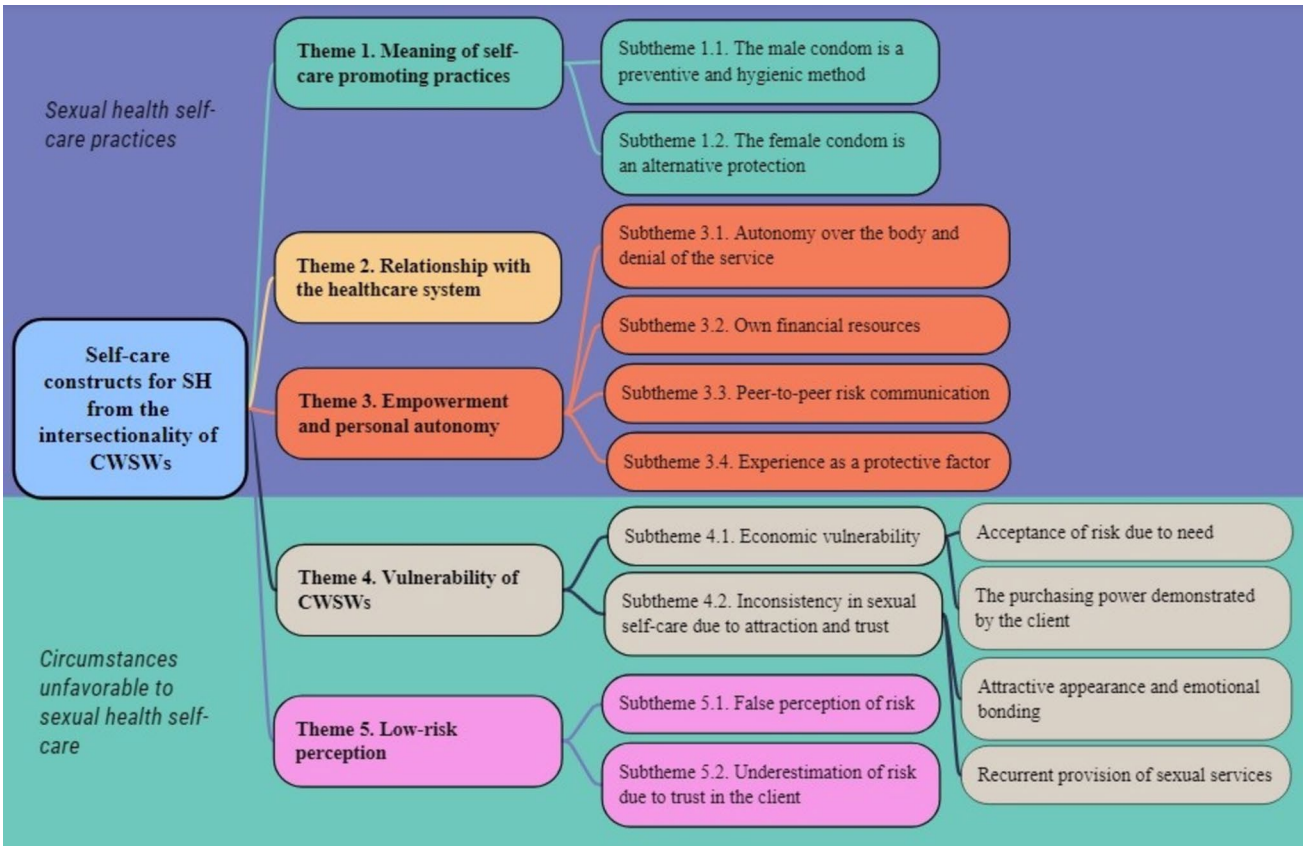

Fig. 2 Self-care constructs for SH from the intersectionality of CWSWs

double protection without considering the risk of breakage due to friction:

> [...] nowadays there are ways to solve it, and that is by using the female condom; but before we thought we could not take care of ourselves, I am telling you this because I was in areas where the male condom was not used. (P-1)
> [...] it would also be good to use a female condom. It is good because you put it inside and outside you have a ring, and it protects you because if the male condom bursts, the semen does not fall inside (vagina). (P-19)

Theme 2. Relationship with the Healthcare System

The denial of occupational identity in health care for fear of rejection is expected, even though CWSWs consider it necessary to assess their health for the risks associated with SW. In addition, some agree that they require Human Immunodeficiency Virus (HIV) testing, cervical cytology, serological tests, vaginal swab, and other tests, which are essential in assessing their SH. Only two of the CWSWs interviewed have communicated their occupational identity to the treating physician so that they can explore their health situation and initiate an appropriate therapeutic plan. When CWSWs openly acknowledge their work to the health professional, they tend to be more demanding of the health system:

> It's not just being a sex worker. It also means taking care of yourself and protecting yourself because it's not just coming and getting tested for HIV. No! One has to have cytology, vaginal discharge smears, and serology, which are essential when one is a sex worker, to have everything that has to do with physical and mental health. (P-18)
> I told the doctor: look, doctor, I'm a sex worker because if you go to the doctor to tell lies, how will he investigate more about you? If you're not telling the truth, and I'm worried about something about my health, and I want it to be emphasized, you better not go! (P-9)

Theme 3. Empowerment and Personal Autonomy

Individual experiences and socialization among peers have generated in some CWSWs the ability to act independently of the client's wishes, forging the acquisition of

decision-making power over their bodies in adverse situations for their SH, incorporating self-care practices such as avoiding risky clients and allocating their economic resources for the acquisition of condoms.

Subtheme 3.1. Autonomy Over the Body and Denial of the Service

Some CWSWs indicated that the fact of providing a sexual service did not oblige them to do everything the client demanded, either because the client did not provide them with sufficient security or simply because they did not want to provide the service, they decided not to do so, because for them it was linked to self-respect and the decision, they had over their bodies:

> Some clients have sought me out for me to provide the service, but I have seen things that I have not liked, and I say no because not even the owner of the brothel can force me because I am in charge of my body, and it is my job, and I decide with whom. From then on, whatever I choose, even if they pay me. (P-6)
> I go with a client, and when providing sexual service, I may not like him. When I feel this, I give them back the money and leave. You don't know why or what will happen, but I can sense there is a risk. (P-4)

The denial of the service is also interpreted by some CWSWs as a practice of self-care in SH in the face of insecurity generated by some clients, for example, when they insist on the provision of sexual services without a condom, even increasing the fee, or by the identification of abnormal manifestations in the previous evaluation of the penis, causing them to deny the service out of distrust and fear of possible contagion:

> Sometimes, many clients offer things to you. They say: "I will pay you more, and you have sex without a condom," and I say: no! I prefer to earn less but always take care of myself. (P-3)
> As soon as I saw him, I told him: you are sick, I won't give you back the money because you wanted to make me ill, let's go to the police! He said, "no, let's leave it at that." I told him: well, you must go to the doctor to have all that cauterized because you have the Human Papilloma Virus. (P-12)

Subtheme 3.2. Own Financial Resources

Most CWSWs indicate that the only method of protection against STIs is a condom. For this reason, several ensure a personal reserve with their resources, foreseeing that the place where the sexual service is agreed upon lacks equipment, the client asks to be served more than once, the condom breaks during intercourse, or the client tears it:

> I always keep a box of condoms in my purse because I don't know if I will have sex more than once with the client or if the condom will break. So, I have much experience with condoms. (P-5)
> One has to be aware of carrying a stock of condoms just in case; in the hotel or the residence where I provide sexual services, they give me condoms, but I always have my condoms because some clients break the condom on the sly, and I can change it. (P-14)

Subtheme 3.3. Peer-To-Peer Risk Communication

A pooled self-care practice among CWSWs is the communication and disclosure of clients perceived as risky for SH because of the appearance of illness or because they have tried to coerce the provision of unprotected service, as they refer to it:

> [...] there are clients we have already identified, at least where I work. I tell my colleagues: he is asking me without a condom, he asked me without a condom! Then we spread the word, and the guys don't return there so that they learn to be serious about using condoms. (P-7)
> For example, a client here was a carrier of HIV and wanted to come and infect the sex workers; I told them: be careful, don't go to be with that man because he is a carrier of HIV. I tell all of them not to go without a condom for anything in the world and that if they are going to have oral sex, they should use a condom. (P-12)

Subtheme 3.4. Experience as a Protective Factor

The CWSWs agree that the fact of having suffered from STIs throughout their SW due to little or no use of condoms has made them more cautious with their clients, regardless of their physical appearance:

> I came to provide sexual services without a condom because I was inexperienced. Let's put it this way: I did not consider the precautions for preventing sexual diseases. In my case, I didn't use a condom at that time because I didn't know enough, and now that I know more about protection, I take more care of myself. When I use a condom, I am protected. (P-6)
> [...] when you start to do SW, some men are very handsome, so I used to have sex without a condom, but

now I have become more aware, and I say: I can't have sex with everyone without a condom! After having an infection, I said: no more! (P-11)

Theme 4. Vulnerability of CWSWs

The narratives of CWSWs showed a susceptibility to engage in risky sexual behaviors with their clients when scarcity of economic resources makes it difficult to meet essential life needs or when emotions and feelings of attraction and trust toward clients prevail over-sensitivity to risk identification and the purpose of SH self-care. Thus, negotiation and even avoidance of condom use in SW may be linked to CWSWs' economic vulnerability and attraction and trust toward clients:

Subtheme 4.1. Economic Vulnerability

Acceptance of Risk due to Need. Considering that the participants in this study are women of low socioeconomic status, most of them think that primary personal and family needs such as food, lack of shelter, payment of debts, and child support become a priority in the face of the uncertainty of the presence of STIs in the client, accepting the risk of providing an unprotected sexual service to make a profit and subsist daily when the client influences the decision to have a sexual relationship without the use of a condom:

I have colleagues who, because of the number of children they have, often prefer to expose themselves to the risks of having unprotected sex to bring a plate of food to those little boys they have at home. (P-7)
No one knows how thirsty someone else is! I prefer to earn 10,000 COP without a condom instead of crying in the streets, homeless, hungry, and cold. Sometimes, we accept the client's proposal to go without condoms. (P-34)

The Purchasing Power Demonstrated by the Client. On the other hand, several participants stated that getting a reasonable payment for the sexual service exempts the client from having to use a condom if they wish to do so:

The dog dances for money! Moreover, if the client I go with is to my liking and pays well, I do it without protection. (P-4)
If the client tells them: "let us go for 100,000 COP," and they answer: "let us go without a condom." (P-15)

Subtheme 4.2. Inconsistency in Sexual Self-Care due to Attraction and Trust

Attractive Appearance and Emotional Bonding. There is a common belief among some CWSWs that attractive clients are associated with sexual well-being, generating security and confidence in the acceptance of sexual practice without condoms; likewise, on other occasions, physical taste transcends, and affective bonds are forged with clients that result in the possibility of avoiding condom use:

I don't use a condom with him, not with my fool, no, but he's a little thing! I do love him. I do love him, and I feel love for him... That is better said; he is cute, tall, and with curly hair! (P-4)
He was the son of the owner of a brothel, he was handsome, I liked him that time, and he had already been with another woman, and then he was with me. The next day, I had the medical exams, and when I took a vaginal swab, I came out infected with gonorrhea because I did it with him without a condom, believing that he was a healthy guy because he was not with women. (P-12)

Recurrent Provision of Sexual Services. Another factor that generates trust with the client is the recurrent provision of sexual services. Thus, some CWSWs consider regular clients who have been with them multiple times without having acquired STIs to be reliable clients, making condom use unnecessary:

My regular clients give me more security and peace of mind for not using a condom. (P-7)
I felt safe with him because I had known him for four years, and he was up and down with me. I did not doubt that he was with other women, so there was no need for a condom. (P-14)

Theme 5. Low-Risk Perception

The subjective judgment of CWSWs for the interpretation and detection of threats to SH in the provision of sexual services could be biased or underestimated by the simultaneous consumption of psychoactive substances as an alternative to solve negative emotional states when SW is performed out of necessity or also when there is trust with the client. As a result, CWSWs who experienced it dismissed preventive measures for risk mitigation in sexual practices:

Subtheme 5.1. False Perception of Risk

In the provision of sexual services, some CWSWs opt for the simultaneous use of psychoactive substances or alcohol to counteract the negative perception of the sexual encounter with the client, preferring not to overload themselves with harmful emotions that arise from being with men they do not know or because it is the only alternative that disinhibits them, calms them, or makes them more docile to cope with these unpleasant effects; however, they may be at the mercy

of incurring in high-risk sexual behaviors. Similarly, some CWSWs encourage their clients to get drunk to avoid providing sexual services:

> Some women like to make the client spend more on drinks, to get drunk with the client, and then the drunk client will not have sex, but the woman also ends up drunk. (P-6)
> Once, I tried cocaine, it puts you in a state of alertness, and you are more docile, fluid, and lighter. It is like an inhibitor. It's as if you take off the mask you usually wear, and it's like alcohol. There you sing, dance, and insinuate yourself. But there comes a moment when you may be unable to control the situation, and the client takes off the condom. There comes a moment when you see yourself and don't have a condom, and neither does the other person. (P-9)

Subtheme 5.2. Underestimation of Risk due to Trust in the Client

> I almost always analyze the client, and if a person inspires me to have a bit of security for my health, protection, and life, then I do it without a condom. That may count for me because of how he is, how he expresses himself, his build, and his presentation. (P-6)

Discussion

Half of the participants in this study considered condom use as a self-care practice to prevent STIs and as a hygienic habit to avoid contact with semen during vaginal or oral sex with their clients. This self-care practice is commonly observed among more experienced Commercial Sex Workers (CWSWs) who have been in the profession for an extended period. They often develop this practice after experiencing symptoms associated with STIs, such as foul-smelling vaginal discharge, itching, or discomfort in the vaginal area following unprotected sexual encounters. These CWSWs face challenges in managing these symptoms due to the marginalization they encounter when clients refuse their sexual services or the embarrassment they feel when considering consulting a healthcare professional for treatment. They fear being judged for not using condoms during intercourse. However, this experience helps them recognize the crucial role of condoms in STI prevention.

Furthermore, CWSWs who are less economically vulnerable take proactive measures by purchasing condoms themselves. They do this to prepare for potential emergencies, such as condom breakage or a lack of condoms at the location of a sexual encounter with a client. This attitude of self-care is related to previous studies that show the association of SH care, through the prevention of STIs, with condom use (Huschke & Coetzee, 2020); however, their adherence and correct use in SW may be disrupted by client-specific factors, such as the perception of decreased sexual pleasure, a violent sexual act that causes the penis to slip out of the condom or break, and acceptance of unprotected sexual practice by CWSWs due to the risk of lack of economic gain during the workday (Gore et al., 2020; McBride et al., 2021).

CWSWs with more experience in SW, higher levels of literacy, and better economic circumstances often consider the female condom as an alternative form of protection when clients insist on engaging in sexual practices without a condom or when there is no condom available at the location of the sexual encounter. Their experience with female condoms has led to a sense of convenience, comfort, both external and internal protection of the vagina, and a feeling of security, as they perceive female condoms as more durable than male condoms. These findings align with a study by Van Dijk et al. (2013), where sex workers reported feeling empowered when using female condoms as they had the autonomy to use them when clients refused male condoms. They also adopted strategies for discreetly inserting female condoms, such as excusing themselves to go to the bathroom or dimming the lights. This suggests that female condoms can be viewed as an acceptable alternative for protecting against STIs and unwanted pregnancies, giving women control in SW. However, some participants in our study who accept the use of female condoms believe that using both male and female condoms simultaneously provides double protection during vaginal intercourse. This is an unsafe practice because the friction between both condoms during intercourse can lead to breakage, increasing the risk of exposure to semen (Centers for Disease Control and Prevention, 2022) and, consequently, the risk of STIs and unplanned pregnancies.

CWSWs who entered SW at a young age were more vulnerable to STIs due to engaging in unprotected sexual practices. This vulnerability was linked to their underestimation of the infection risk, driven by the attractive appearance of some clients and their consumption of psychoactive substances and alcohol during work, which impaired their judgment and preventive behaviors. In contrast, older participants with more experience in SW became more cautious about infection risks after experiencing, observing, or hearing about STIs from their peers. They became more aware of the importance of self-care practices to prevent STIs while providing sexual services. Therefore, it is crucial to promote SH self-care empowerment among CWSWs at the early stages of their involvement in SW. This can be achieved through timely education, guidance, and sensitization regarding risk assessment

and preventive self-care measures to mitigate STI risks. These efforts should consider the specific contextual circumstances of SW (Ediomo-Ubong Ekpo, 2020; Footer et al., 2020; Khezri et al., 2020; Ong et al., 2022).

When clients insist on unprotected sex, they often display suspicious behavior, an unpleasant physical appearance, and aggressive communication with CWSWs. Some CWSWs perceive these clients as risky for their safety and health. As a preventive measure, they may refuse to provide sexual services or even threaten to report such clients to the authorities for engaging in unsafe sexual practices. However, CWSWs may underestimate the perceived risks and hazards to their SH due to various factors or circumstances that can arise in the course of SW. These factors may include unmet needs, providing sexual services to regular clients, sexual desire, trust, and physical attraction to the client's appearance (including hygiene and the condition of the client's genitals). They may base their assessment of risk on visible aspects or even the client's character and behavior. These findings underscore the importance of addressing cultural constructs related to pleasure, sexual desire, attraction, and collective knowledge about STIs. It is essential to develop a contextual and cross-cultural framework that facilitates the identification and management of risks within the SW practice (Bailey & Figueroa, 2018; Coetzee et al., 2022; Khezri et al., 2022; Pitpitan et al., 2017).

Healthcare-seeking behavior is more prevalent among non-migrant Commercial Sex Workers (CWSWs) who are affiliated with health-promoting institutions, while migrant CWSWs often encounter challenges in connecting with and accessing healthcare programs. For non-migrant CWSWs who have had access to health information and care, seeking healthcare is considered a vital step in understanding their health status in light of the risks associated with SW. They view healthcare as a means to enhance their self-care practices through health counseling. Consequently, this group of CWSWs actively seeks medical check-ups and specific tests, such as cervical cytology, vaginal flow smears, and blood tests, to enable early disease detection. This self-care practice can be linked to what was found by Gore et al. (2020), who revealed that fear of infection with the HIV favors the use of condoms and taking the test for virus detection and early initiation of antiretroviral treatment in diagnosed CWSWs; this fear is accentuated in situations of risk due to condom breakage. However, participants avoid identifying themselves as sex workers to health personnel for fear of being rejected, stigmatized, and discriminated against, which is consistent with the results of several studies (Benoit et al., 2018; Ma & Loke, 2021; Tomko et al., 2021).

The difficulty and avoidance in seeking health care among some CWSWs have encouraged the adoption of ineffective self-care practices for the maintenance of SH, such as consulting pharmacies, friends, acquaintances, or the same family to treat symptoms associated with the alteration of their SH; weakening the therapeutic communication and cooperation of preventive care in SH between health personnel and CWSWs (Huber et al., 2019; Huschke & Coetzee, 2020; Ma et al., 2017; Platt et al., 2018). This implies addressing the occupational concealment of CWSWs related to internalized and public stigma (Tomko et al., 2021), societal discrimination, and the lack of public policies and models of preventive SH care that match the intersectional realities of CWSWs (Ferguson et al., 2017; Mishra et al., 2016).

The communication of perceived risks in the exercise of SW among CWSWs is a prevention measure against harm to SH related to STIs, violence (sexual, physical, and emotional), theft, and even the risk of death. This risk disclosure strategy among CWSWs is used when they experience negative experiences with clients, such as non-compliance with sexual encounter agreements, suspicion of illness in the client (determined by behavior, general hygiene, appearance, and hygiene of the penis), and suffering from STIs following the provision of sexual services without a condom. These results reveal the role of CWSWs as agents of knowledge and promoters of SH knowledge linked to lived experience and contextual reality, fundamental to constructing and promoting culturally competent and self-sustainable SH care with the dynamics of SW. As in other studies, attitude is highlighted as a strength that can favor the empowerment of SH self-care among CWSWs through peer socialization processes, considering that the bonds of friendship and life in common favor the exchange of stories, experiences, and advice for the avoidance, control, and mitigation of alterations in SH (Hendry et al., 2017; Kerrigan et al., 2013; Leddy et al., 2020).

For CWSWs with more experience in the occupation and less economic hardship, autonomy, and decision-making capacity over their bodies means a practice of self-care of SH, incorporating strategies to identify risks and determine to whom and when to provide sexual services. Also, the adverse experience of their relationship with the work environment and clients has served to make them aware that being a woman and satisfying the client's sexual desires for money does not prevent them from refusing to provide the sexual service and setting limits to the client's demands, as well as demanding protective methods during intercourse to safeguard their bodies when they feel in imminent danger. Segovia et al. (2021) propose a sexual education that favors empowerment as a strategy to protect oneself from violence, domination, and discrimination that favors the prevention of STIs; that is, SH education with a perspective of rights and gender equity among the interpersonal relationships of the socially disadvantaged, that enhances autonomy, respect, and the capacity to make decisions about the body. This approach in Colombia from the socio-political and health

sphere is still fragile due to the adoption of public health policies and conventional and standardized pedagogical models in promoting SH, leaving the SH of less favored people like the participants of this study to chance.

Finally, the narratives of CWSWs reflected greater sensitivity in the identification of risks and initiative to take care of their SH during SW. While clients appear to be less responsible since they are willing to coerce a risky sexual practice in order to satisfy their sexual desires by increasing the payment for unprotected sexual services, removing or altering the integrity of the condom during intercourse, and clients with clinical manifestations suggestive of STIs or living with the HIV motivate the provision of sexual services without a condom (Chow et al., 2015; Huschke & Coetzee, 2020). Like other studies, CWSWs with less socioeconomic vulnerability were found to have more choices in adopting preventive self-care measures for SH in this power relationship and adverse client behavior. However, CWSWs with greater socioeconomic vulnerability have fewer opportunities to negotiate self-care, overriding hunger and homelessness for themselves and their children over the risks of accepting unprotected sex (Ediomo-Ubong, 2020; Hao et al., 2015; Strega et al., 2021; Wulandari et al., 2020).

Limitations

There are practically no studies in the Colombian context about the SH self-care of cisgender women. This study gives a voice to sex workers who, in the face of the need to earn income to cover their basic personal and family needs, must confront sexual demands from clients, live with the consequences of social inequality stemming from stigma and discrimination towards SW, and experience the vulnerability of their work environment, along with the lack of opportunities for literacy and consistent SH care. Therefore, these women have had to develop their sexual self-care practices and routines based on their experiences, information, and available resources to mitigate the risks associated with SW and preserve and maintain their SH.

However, the results of this study should be interpreted and considered in light of the following limitations: First, the difficulty in accessing the population of CWSWs due to the public risk associated with the areas where they practice SW, and because this is a group that generally employs mechanisms to avoid individuals who come to scrutinize their personal and private information due to the consequences of the occupational stigma they experience. Second, it should be noted that participants at times hesitated to speak openly about their sexual behavior and the preventive measures they incorporate due to their distrust, modesty, and doubts arising from the same stigmatization they have received from healthcare professionals regarding their sexual lives. However, they gradually improved the spontaneity of their discourse thanks to friendly and empathetic interaction with the participants. Third, the fact that some participants were members of a sex worker organization may have affected their access to and type of SH information received, influencing both the identification and interpretation of SH risks and the construction of sexual self-care practices compared to participants who were not part of the organization. Fourth, the participation of only cisgender women who primarily work in socially vulnerable settings limits the applicability of the data to other sex workers with different gender identities and who experience less adverse work circumstances. Finally, due to the qualitative methodological nature of the study and the lack of a representative sample of Colombian sex workers, the results lack statistical significance to be generalized to the rest of CWSWs.

Conclusions and Policy Implications

In conclusion, this study shows that CWSWs construct their SH self-care practices to address the perceived risks of SW. The identity and sense of self-care arise from the intersection of multiple overlapping experiences, such as being a woman linked to SW; experiencing and incorporating in their identity the consequences of stigma, discrimination, and social criminalization; the gender inequality experienced by women in patriarchal societies; and the coercive attitudes and hostile behavior of the client for the adoption of preventive self-care measures during the agreed sexual practices.

In this sense, it is imperative to promote health education strategies that promote the empowerment of the agency of SH self-care, based on self-respect and commitment to care among CWSWs and their clients; that is, a universal education in which each person is recognized as an agent of knowledge and manager of their self-care, with actions that favor intersectional cooperation in preventive SH care, consistent with the conceptual and cultural memory of this crucial group. Likewise, it is necessary for a humanized, friendly, and self-sustainable SH promotion and care, which eliminates the physical and psychological barriers to accessing health services to manage the SH risks of the women involved from the situated and contextual reality of SW, with a perspective of rights, social justice, and gender equity.

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Availability of Data and Material The study's data are available upon request to the lead author but are not made public for reasons of safeguarding the participants' privacy.

Code Availability Not applicable.

Declarations

Ethics Approval This research is part of the doctoral thesis of the first author, which is being developed in the Doctoral Program in Nursing and Health at the University of Barcelona, Spain, thesis directed by the third author, and whose research project was approved by the Bioethics Commission of the same university with number IRB00003099 of June 14, 2021. The ethical principles for medical research involving human subjects established in the Declaration of Helsinki were followed. The participants were invited and informed orally and in writing in simple language about the details of the study, information management, and ethical considerations; after clarifying doubts, they signed an informed consent document, and each cisgender woman sex worker was given a copy of it and an information sheet. During the research, the confidentiality of the data and the anonymity of the participants were guaranteed by assigning codes ranging from P-1 to P-34.

Consent to Participate Informed consent was obtained from all individual participants included in the study.

Competing Interests The authors declare no competing interests.

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