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Telehealth resources and utilization interest among women who sell sex: An explanatory sequential mixed methods study☆

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ABSTRACT

Objective: Among a sample of women who sell sex (WSS), we examined unmet health needs, resources for telehealth, utilization interest, and attributes associated with interest in using telehealth.
Study design: Explanatory sequential mixed methods.
Methods: WSS (N = 52) completed a fixed choice survey and focus group (N = 6, 26 individuals) from drop-in centers serving WSS. Chi-square/t-tests and results from the survey data informed the semi-structured focus group interview guide. Thematic analysis of focus group data was conducted to identify themes.
Results: Over half (58 %) of participants expressed interest in using telehealth; however, some lack the necessary resources for use. While 60 % of participants own mobile phones and 46 % have access to a computer, only 35 % have a secure, private space for telehealth appointments. Interest in telehealth was higher among participants who self-identified as having high risk for HIV compared to low risk for HIV (79 % versus 46 %, p = 0.024), and among those considering PrEP for HIV prevention versus not considering PrEP (68 % versus 32 %, p = 0.046). Focus group participants preferred face-to-face encounters for complex medical concerns but expressed interest in telehealth for improved access to healthcare providers for routine care and mental health.
Conclusion: Incorporating telehealth into community organizations could be one strategy to address health inequities experienced by WSS. Access to resources, including technology and safe spaces may be well-accepted if offered at trusted community organizations. Such accessibility addresses a gap in care for WSS and paves the way for new avenues for HIV prevention, mental health support, and research related to unmet health needs among WSS.

1. Introduction

Women who trade sex for something of value (i.e., women who sell sex (WSS)) experience increased vulnerability to interpersonal violence, substance use, HIV, and mental illness [1–4]. A highly marginalized and stigmatized population, street-based WSS who meet or solicit clients outdoors, often experience additional structural barriers to essential resources such as healthcare, transportation, or a safe place to live [5,6]. These structural barriers to healthcare subsequently impact WSS's harm reduction and health promotion needs [7]. The rapid expansion of telehealth and the provision of medical care over video or phone provides unique opportunities to provide healthcare services to underserved, resource-constrained populations. However, research focused on understanding the utilization interest, feasibility, and acceptability of telehealth for marginalized populations such as WSS is limited.

Telehealth grew significantly during the COVID-19 pandemic and continues to expand [8]. In the past 12 months, 37 % of patients across the United States have used telehealth to get help for mental health symptoms, urgent care, and sexual and reproductive health among others [9–12]. The rapid expansion and incorporation of telehealth into

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routine healthcare services during the pandemic highlights the potential for a digital divide [13]. Those within marginalized populations may have limited access to privacy and other resources necessary for telehealth visits, such as cell phones, computer technology, and broadband internet access. WSS in particular, may lack a safe, private place to engage in health visits, due to barriers such as unstable and/or unsafe housing [5,13]. Failure to consider barriers preventing access to telehealth may result in deepened health inequities for marginalized populations. Telehealth interventions must address digital and space inequities to improve care access and reduce health disparities [8,11,13].

This study aimed to understand the ways in which telehealth may fill a health services utilization gap for WSS. We examined unmet health needs and examined resources for telehealth (i.e., phones, internet, privacy), utilization interest, and attributes associated with interest in using telehealth. We employed an explanatory sequential mixed method study design gathering quantitative data initially followed by qualitative data. Initially, we administered a fixed-choice survey to 52 participants. Next, we conducted 6 focus groups (26 participants) to explore WSS's interest in and resources for utilizing telehealth services and to examine how telehealth may address the unique sexual, mental, and physical health needs of this patient population.

1.1. Theoretical framework

A syndemics framework was used to guide this study. Applicable to WSS [14,15], the syndemics framework guides conceptualization of health conditions among populations with overlapping social, economic, and environmental circumstances [14–16]. These vulnerabilities can cause a syndemic effect in which their overlapping nature increases the vulnerability to health outcomes such as HIV, mental illness, and sexually transmitted infections [15,17].

2. Methods

2.1. Study design

We used an explanatory sequential mixed methods design (see Fig. 1) [18,19]. First, we conducted a quantitative fixed-choice survey to examine unmet health needs and telehealth utilization, feasibility, and

Phase	Procedures	Products or Results
Quantitative data collection	Cross-sectional survey (N=52)	Numeric data guided by theoretical framework
Quantitative data analsyis	Descriptive statistics, chi-square, t-test. SPSS version 28.0.0.0.25	Descriptive statistics and univariate analyses
Qualitative interview guide development	Developed interview questions guided by theory and significant quantitative findings	Interview guide
Qualitative data collection	Focus groups N=6; 26 Total participants	Interview transcripts
Qualitative data analsyis	Codebook developed a priori and invivo coding, thematic analysis NVivo software 12	3 Themes

Fig. 1. Explanatory Sequential Mixed Methods Study Design

interest. We analyzed the quantitative data to inform the semi-structured focus group interview guide. Using this WSS-informed guide, we then conducted 6 focus groups with (n = 26) WSS to expand understanding of our quantitative findings. Institutional Review Board Approval was obtained from Marquette University Office of Research Compliance. (Insert Fig. 1 here).

2.2. Study population

Participants were recruited from two community-based drop-in centers for street-based WSS. The inclusion criteria were women who spoke English, and reported exchanging sex for food, drugs, money, or shelter at least once in the previous 3 months.

2.3. Sampling and methods

All participants were recruited from two drop-in centers within community partner sites in a mid-sized Midwestern city in the United States located in areas known for street-based sex trade. In addition to sharing recruitment materials with the community partner site, researchers promoted the study and recruited participants by attending drop-in hours on various days and times. Quantitative data collection occurred March 2022–June 2022. Subsequent focus groups occurred in November 2022–January 2023. The focus group recruitment procedures, inclusion, and exclusion criteria were the same as those used for the quantitative survey. WSS were not required to complete the quantitative survey to participate in the focus group. Semi-structured focus groups sessions were comprised of 4–5 WSS and lasted 60–90 minutes.

2.4. Data collection

We used a convenience sampling approach for both quantitative and qualitative recruitment. Quantitative and qualitative data collection occurred in person, utilizing private rooms at the two drop-in centers. After being screened for eligibility and completing the informed consent process, WSS who were both interested and eligible provided verbal consent to participate in the study.

2.4.1. Quantitative data collection

To avoid participation barriers regarding literacy, researchers read fixed choice survey questions aloud, immediately inputting participant answers on an iPAD. Surveys took approximately 45–60 minutes, and each participant received a $50 gift card for their time and involvement.

2.4.2. Qualitative data collection

Qualitative focus groups occurred later, as the interview guide was developed using data from the quantitative findings. After being screened for eligibility, WSS were required to provide verbal consent before focus group participation. During the consent process, women selected their pseudonyms and were given a name tag with the pseudonym to wear during focus group sessions. Audio recorded, semi-structured focus group interviews were facilitated by the study PI and one research assistant. Focus groups occurred in a private room at the drop-in center. Refreshments were readily available to all focus group participants after each session. Participants were received a $50 gift card after participating in one (60–90 minutes) focus group session.

2.5. Study instruments

2.5.1. Quantitative survey

2.5.1.1. Independent variables. We used a syndemics theoretical framework to guide development of our quantitative survey instrument. We included demographic variables (age, race, gender, education, sexual identity orientation), structural variables (health insurance, past year homelessness), and emergency department visits. Syndemic constructs were included and measured with validated instruments when available. We measured violence by clients (people who pay for sex) and regular partners (non-paying sexual partners) using a modified Conflicts Tactics Scale [4,20]. Mental health symptoms were measured using validated instruments including depression with PHQ-9 and post-traumatic stress disorder with the PCL-5 [21–23]. We used Likert scale variables to assess participant access to technology and privacy needed for telehealth visits.

2.5.1.2. Dependent variable. Our dichotomous outcome variable was interest in telehealth. Participants were asked, "Would you like to be able to see a doctor with telehealth (over the phone or video)? Women who responded "maybe interested" or "definitely interested" were coded as 'interested in telehealth' and those who responded "not interested" were coded as 'not interested in telehealth.' We dichotomized our outcome variable as only six participants indicated "maybe interested" in telehealth. Those six participants were coded as "interested in telehealth" as they expressed some interest in use of telehealth.

2.5.2. Qualitative semi-structured interview guide

The qualitative interview guide developed was based on the quantitative survey results to deepen our understanding of telehealth feasibility, acceptability, and utilization interest (see Table 1 for sample of semi-structured interview guide).

2.6. Analysis

2.6.1. Quantitative analysis

Categorical variables were compared across binary outcomes using chi-square or Fisher's exact tests, as appropriate. For continuous numerical variables, means were compared using independent t-tests to assess the differences between women who were interested and those not interested in telehealth. All analyses were performed using SPSS version 28.0.0.0.25 [24]. All statistical analysis was done using two-tailed tests with an alpha level of 0.05.

2.6.2. Qualitative analysis

Focus groups were audio recorded and professionally transcribed verbatim. Transcripts were checked against the audio recordings for accuracy. Research team members (J.Z., A.B., J.B., H.R.) utilized a thematic analysis approach and applied deductive and in vivo coding using NVivo 12. The PI of the study developed a codebook based, guided by the study's theoretical framework. The research team utilized the deductive codebook to code transcripts, identifying new in vivo codes that emerged through the coding process. When new codes were identified, the team members discussed them, defined them, added them to the codebook, and applied them throughout the transcripts. We kept memos while we coded to reflect our experiences with the data and consider any patterns in the data. During weekly meetings, team members would discuss patterns and identify potential themes. We also used data visualization techniques such as word clouds to as another approach to identify possible themes in our data. Saturation was established when findings from 4 focus groups offered no new insights [25,26]. We completed two additional focus groups to ensure saturation was reached.

3. Results

The baseline characteristics of the participants in our quantitative sample (N = 52) were divided by their interest in telehealth (see Table 2). The average age of the participants was 38.7 +- 11.3 years. Most participants identified as Black/African American (67.4 %), had a high school or greater education (55.8 %), and possessed health insurance (90.4 %). Over half of the sample (57.6 %) indicated they were either 'maybe' or 'definitely interested' in using telehealth in the future.

Table 1
Sample questions and prompts from semi-structured focus group interview guide.

Rapport building

1. This drop-in center is interested in ways they can better help and support you.
   - What types of health services do think are needed?

Healthcare utilization

1. Tell us about your experiences accessing healthcare.
   - How did you find your doctor or provider?
   - What has been your experience seeing doctors or providers?
   - How has your experience been in the emergency room?

Telehealth

1. Telehealth is seeing a doctor over video or phone.
   How do you feel about using telehealth?
   Have you used it in the past? When? What did you like and dislike?
2. What would make you want to use telehealth? Or not want to see a doctor in this way?
   - Is privacy an issue? Why or why not?
   - How would you feel about using telehealth here in the drop-in center?
   - What would be a benefit of having telehealth at the drop in? What might be a challenge?
   - What kind of medical services would you like to receive over telehealth? For example, mental health? Sexual and reproductive health? Others?

HIV/STI Risk

1. We want to learn more about how you feel about HIV risk.
   - What might make someone who is in the life say they are high or low risk for HIV?
   - How would you describe your risk for HIV?
   - What do you think makes someone high risk? What about low risk?
2. PrEP is a daily medication you can take to prevent getting HIV infection. Would you be interested in taking PrEP? Why or why not?
   - How would you feel about receiving PrEP care over telehealth?

Structural Vulnerability

1. Many women reported experiencing homelessness in the past year. By this we mean living in places like the street, car, a vacant house, or someone's couch. What are some ways experiencing homelessness affects you?

Closing
Is there anything else you think we should know about your thoughts about telehealth or women's health?

Being interested in telehealth was associated with identifying as LGBTQ+ (gay, lesbian, bisexual, queer versus heterosexual (74 % vs 45 % $p \leq 0.04$); self-identifying as having moderate or high risk versus low risk for HIV (79 % vs 46 % $p < 0.024$); and being interested in Pre-Exposure Prophylaxis (PrEP) for HIV prevention (68 % vs 39 % $p < 0.046$). Fewer than half (39 %) of participants used telehealth in the past, and among those with past use, 80 % were interested in using telehealth in the future. While many WSS reported having the technology necessary for telehealth visits such as access to cell phones (59.6 %) or access to a computer/tablet (46.2 %), fewer women had access to a safe, private place for a telehealth visit (35.3 %). WSS who identified as Black/African American versus White/Asian/Native American/Biracial were less likely to be interested in telehealth (45.7 % vs 82 % $p \leq 0.017$). (Insert Table 2 here).

These quantitative results guided our focus group interviews with women in which we explored telehealth interest, feasibility, and acceptability. We explored healthcare utilization experiences and attributes significantly associated with interest in telehealth (i.e., past telehealth use experiences, HIV risk, and PrEP interest). 26 women participated in one of 6 focus groups (See Table 3). The mean age of participants was 43.3 ($\pm$ 11.1). Most women identified as Black/African American (69.2 %) and as cisgender female (96 %). Nearly a one-third (31 %) of focus group participants completed the quantitative survey. (Insert Table 3 here).

We identified three themes related to telehealth feasibility, acceptability, and utilization interest: 1) "I'd rather be seen in person," 2) "Keep their business private,", and 3) "Telehealth could work." (see Table 4 for exemplar quotes).

3.1. *"I'd rather be seen in person."*

Some women described resistance or disinterest in using telehealth for healthcare services. These participants indicated a preference for face-to-face visits if there was a need for a physical examination or if there was a possibility of hearing bad news during the visit. Women felt adequate care could only be delivered if a physical examination was provided.

3.2. *"Keep their business private"*

Privacy was a concern for many women interested in using telehealth. Women described potential challenges of securing private places for visits and protecting personal information. Women discussed the high visibility of living lives on the street and the need to guard personal information. Privacy was often possible only in areas such as bathrooms, which was undesirable when participating in telehealth visits. Additionally, experiences of violence by both clients and intimate partners perpetrators were pervasive among our participants. Discussing health information with violent partners nearby may pose threats to women's safety and an additional challenge in engaging in telehealth visits among WSS.

3.3. *"Telehealth could work."*

Other women expressed an interest in using telehealth, particularly for visits that do not require physical examinations such as mental health visits. Some women described having a previous experience with telehealth visits with mental health providers, particularly during earlier phases of the COVID-19 pandemic. These were described as helpful because of easier access to care and were desirable because of reduced requirements for physical exams during these types of visits. Improved access to care was identified as a potential benefit of telehealth mainly if services were offered in a walk-in model within a community site like the sex worker drop-in center. In these models, women could access the technology (i.e. devices such as a tablet or computer), wireless internet service, and have private spaces visits. Housing insecurity and the unpredictability of life in the street-based sex trade made accessing traditional medical visits challenging and having a

Table 2
Demographic characteristics of quantitative survey participants (N = 52).

Quantitative Sample Characteristics (N = 52)	Total Sample (N/%)	Interested in telehealth N (%) (N = 30)	Not interested in telehealth N (%) (N = 22)	p Value*
Age (mean, standard deviation)	38.71 (11.3)	38.6 (12.0)	38.86 (10.4)	0.935
Race (N, %)				0.017*
Black/African American	35 (67.4)	16 (45.7 %)	19 (54.3 %)	
White/Asian/Native American/Biracial	17 (32.7 %)	14 (82.4 %)	3 (13.6 %)	
Education level				0.473
Some high school or less	23 (44.2 %)	12 (52.2 %)	11 (47.8 %)	
Graduated high school/GED or greater	29 (55.8 %)	18 (62.1 %)	11 (47.8 %)	
Sexual Identity				0.035*
Heterosexual	29 (55.8 %)	13 (44.8 %)	16 (55.2 %)	
Gay/Lesbian/ Bisexual/Queer	23 (44.2 %)	17 (73.9 %)	6 (26.1 %)	
Relationship Status				0.476
Single	35 (67.3 %)	19 (54.3 %)	16 (45.7 %)	
Married/in a relationship	17 (32.7 %)	11 (64.7 %)	6 (35.5 %)	
Structural Factors				
Have health insurance	47 (90.4 %)	25 (53.2 %)	22 (46.8 %)	0.132
Homelessness in past year	41 (78.8 %)	23 (56.1 %)	18 (43.9 %)	0.653
Number of Emergency Room Visits in the past year				0.043*
4 or less	26 (61.9 %)	13 (50 %)	13 (50 %)	
5 or more	16 (38.1 %)	13 (81.3 %)	3 (18.8 %)	
Sex Work				
Age first sold sex				
17 or younger	17 (32.7 %)	7 (41.2 %)	10 (58.8 %)	0.093
18 or older	35 (67.3 %)	23 (65.7 %)	12 (34.3 %)	
Lifetime experiences of violence by clients				
Physical violence by client	39 (75 %)	25 (64.1 %)	14 (35.9 %)	0.289
Forced sex by client	16 (31 %)	6 (37.5 %)	10 (62.5 %)	0.027*
Lifetime experiences of violence by regular partners				
Physical violence by regular partner	27 (60.0 %)	19 (70.4 %)	8 (29.6 %)	0.082
Forced sex by regular partner	11 (25 %)	9 (81.8 %)	2 (18.2 %)	0.108
Mental Health				
Previous diagnosis of mental health disorder	39 (75 %)	24 (61.50 %)	15 (38.50 %)	0.331
PHQ-9 greater than or equal to 10 (mean, standard deviation)	12.96 (7.5)	13.5 (8.1)	12.29 (6.6)	0.592
PCL-5 greater than or equal to 33 (mean, standard deviation)	44.54 (17.2)	46.03 (15.3)	42.48 (19.7)	0.477
HIV Risk and PrEP				
Self-assessment of risk for HIV				0.024*
Not at risk/small risk	32 (62.7 %)	15 (45.5 %)	17 (54.5 %)	
Moderate or high risk	19 (37.3 %)	15 (78.9 %)	4 (21.1 %)	
Interest in PrEP				0.046*
Not interested	18 (34.6 %)	7 (38.9 %)	11 (61.1 %)	
Maybe or definitely interested	34 (65.4 %)	23 (67.5 %)	11 (32.4 %)	
Technology Access/ Telehealth Feasibility				
Ever previously used telehealth	20 (38.5 %)	20 (80 %)	4 (20 %)	0.020*
Access to cell phone most of the time or always	31 (59.6 %)	16 (51.6 %)	15 (48.4 %)	0.281
Access to a smart phone with data or WIFI most of the time or always	24 (46.2 %)	12 (50.0 %)	12 (50.0 %)	0.299
Access to computer or tablet most of the time or always	24 (46.2 %)	13 (54.2 %)	11 (45.8 %)	0.634
Access to private place for telehealth most of the time or always	18 (35.3 %)	13 (72.2 %)	5 (27.8 %)	0.151

* = p value ≤ 0.05.

Table 3
Demographic characteristics of focus group participants N = 26, 6 groups.

Variable	N (%)
Age (mean/standard deviation)	43.3 (11.1)
Race	
Black/African American	18 (69.2 %)
White	2 (7.7 %)
More than one race	3 (11.5 %)
American Indian/Alaska Native	2 (7.7 %)
Sex at birth	
Female	25 (92.2 %)
Male	1 (3.8 %)
Gender identity	
Female	22 (84.6 %)
Non-binary	2 (7.7 %)
Transgender woman	1 (3.8 %)
Time working in sex work/sex trade	
1 year or less	4 (15.4 %)
1–5 years	3 (11.5 %)
5–10 years	2 (7.7 %)
10–15 years	2 (7.7 %)
15–20 years	8 (30.8 %)
20 or more years	7 (26.9 %)
Completed Quantitative Survey	9 (32 %)

telehealth option at a site they already visit would be beneficial.

4. Discussion

This research provides valuable insights into the interest and feasibility of telehealth usage among a marginalized population of WSS. More than half of the participants were interested in using telehealth highlighting the potential of technology to enhance healthcare access. While nearly all WSS had health insurance (90.4 %) and some possessed the technology needed for a telehealth visit, most identified privacy concerns as a potential barrier for telehealth visits. Notably, the association seen with women who self-identified as high risk for HIV and

Table 4
Qualitative themes and exemplar quotes.[a]

Theme	Exemplar quotes
"I'd rather be seen in person."	• "I don't want no bad news (over telehealth). Somebody telling me I got 3 months to live." Nea, age 26 • "I think that (telehealth) needs to be crossed out. How can the doctor really know what's wrong without unless he checks you out himself? I'd rather be seen in person than via screen" Succubus, age 38 • "I don't like video. I like it (health care visits) in person more because I like to be checked." Sadie, age 37
"Keep their business private"	• "If it was in a private place, yeah. I don't want to make my appointment and go to the bathroom and do a video call." Nea, age 26 • "When you are talking your business, you don't want no one to hear it." Gwen, age 48 • "Maybe they have health problems that they wouldn't want out there. Some people aren't in houses. They are in the streets, they need to keep their business to themselves in private." Becky, age 44
"Telehealth could work"	• "That (telehealth) would be a really good idea, having more resources to get ahold of somebody. It's the way the world is." Cat, age 38 • "I think we need to use video because a lot of time we can't make it to an appointment and we could just snap right on." Cynt, age 52 • "A positive thing about telehealth would be the fact that because the drop in center is like spur of the moment, we just come in here and if we could to that telehealth and have it like already set up on a certain day. That would be something because people do not keep appointments on the street." Becky, age 44 • "That (mental health visits) is where something like telehealth could work. Most of the time for a psychologist or psychiatrist there is not so much physical." Succubus, age 38

[a] All names are pseudonyms.

interested in PrEP also correlated with interest in telehealth. This association highlights how telehealth may be an essential avenue for addressing critical health disparities among WSS given the potential for access to mental health services and HIV prevention.

WSS voiced a preference for co-location (locating health services within the community where women live and work) which can include telehealth services [27,28]. Co-location models address structural barriers to care, such as access and transportation. Additionally, care located in sex work communities is often seen by WSS as a safe, non-stigmatizing place to address the unique sexual risks associated with selling sex with healthcare providers [28,29]. Typical co-location models include the use of mobile vans to bring harm reduction services such as clean needles, condoms, and contraceptive services to areas where street-based sex trade occurs [27]. Mobile vans are an excellent option but are costly to initiate and maintain [30]. Telehealth services embedded into community sites are a cost-effective option for co-location services.

Telehealth offers a unique opportunity to co-locate by embedding health services within trusted community partner sites frequented by WSS. Such a partnership may be one way to provide low-barrier physical and mental healthcare [31]. Telehealth co-location models that include the provision of private spaces for visits and the technology needed for engagement in telehealth visits (computer/tablet and internet connection) may improve access to these services. Focus group participants acknowledged that embedding telehealth services into a community site that women already feel safe attending may improve access to high-quality care.

WSS experience overlapping risk factors for poor health, including mental health, violence, and substance use. To tackle mental health disparities associated with trauma and substance use [2,32], mental healthcare services delivered through telehealth emerged as a trusted access point for WSS seeking mental healthcare. This could serve as a crucial pathway to enhance access to critical health services, given that more than over half of WSS have symptoms of Post-Traumatic Stress disorder [2]. Furthermore, over 80 % of street-based sex workers reportedly use cocaine or opioids daily [2]. A recent scoping review found that using telehealth for opioid medication-assisted treatment is associated with higher patient satisfaction, reduction in healthcare costs, and improved access and adherence to treatment [10]. Increasing the use of telehealth among WSS may improve access to mental health care and substance use treatment.

The Centers for Disease Control has specified the use of telehealth as part of a solution to achieve a goal of 90 % reduction in new HIV infections by 2030 [33,34]. In our quantitative survey interest in telehealth was significantly associated with WSS who self-identified as high-risk for HIV and those interested in PrEP for HIV prevention. Telehealth for HIV prevention services may be an effective and community-responsive strategy to increase access and close care gaps among populations such as WSS, who continue to have high rates of HIV infections [35]. Telehealth use for PrEP care among other marginalized populations such as young men of color who have sex with men was shown to reduce barriers to health care and was described as fast, convenient, and easy to use [36]. Telehealth visits for PrEP care may be acceptable to WSS because these visits do not often require extensive physical examinations [37]. HIV prevention via telehealth is another avenue to improve WSS healthcare access.

WSS often have complex, overlapping identities that must be considered in healthcare delivery. Black/African American women in our quantitative survey were less interested in telehealth than other women. This finding may suggest a need for culturally specific, tailored approaches to care among this population. WSS who identified as LGBTQ+ (gay, lesbian, bisexual, or queer) were more likely to be interested in telehealth, indicating that for some marginalized women with intersecting identities such as sex workers and people who identify as LGBTQ+, telehealth may be an acceptable care delivery model. Although we explored questions to prompt discussion around preferences for care in focus group questions, data did not reach the level of theme development to provide sufficient understanding of these nuanced differences among intersecting identities of WSS. Additional research examining telehealth through an intersectional lens is warranted.

Limitations should be considered for this study. The quantitative sample size (N = 52) limited the ability to have statistical power for more analyses controlling for confounders. In the quantitative survey, we identified the age participants entered sex trade but did not obtain a value of total number of years engaged in sex work. This may limit quantitative understanding of the complex role of entry and exit from sex work on telehealth resources or utilization interest. Participants were recruited at community drop-in centers from one urban area in the United States, limiting generalizability to other geographic regions or to WSS who do not attend drop-in centers.

5. Conclusion

WSS are interested in receiving telehealth services but lack safe, private places for medical visits. Innovative approaches to co-locating or embedding telehealth services into trusted community sites serving WSS can address digital health equity issues and health disparities. Future research should focus on mental and physical health disparities of WSS by examining the feasibility and acceptability of embedding telehealth services within a trusted community-based organization.

Declaration of competing interest

The authors have no conflicts of interest to declare.

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