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Posted Date: 10 December 2025

doi: 10.20944/preprints202512.0915.v1

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Article

# Using the Candidacy Framework to Explore Access to NHS Healthcare for Street Sex Workers in Sheffield; an Ethnography and Art-Based Research Project

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### Highlights

#### What are the main findings?

Street sex workers face systematic barriers across all stages of healthcare access, including minimisation of health needs, administrative exclusion through digital systems, lack of consistent care, and stigma from professionals, rather than being disengaged from healthcare. Key enablers of healthcare access include supportive organisational staff, trusted relationships with consistent female healthcare providers, and trauma-informed care delivered through accessible third-sector partnerships.

#### What are the implications of the main findings?

Healthcare services must be redesigned through co-production with street sex workers to simplify registration processes, provide in-person and non-digital options, and prioritise continuity of care over utilisation metrics when evaluating service effectiveness. Service provision should recognise that street sex workers are systematically excluded rather than disengaged, requiring trauma-informed, gender-sensitive approaches with flexible appointment systems and training for healthcare professionals on the specific triggers and needs of this marginalised population.

### Abstract

**Background:** Street sex workers (SSWs) experience some of the highest levels of health inequality in the UK yet face persistent barriers to accessing NHS healthcare. These barriers are shaped by structural disadvantage, stigma, and the complex realities of their lives. Despite significant health needs, engagement with services remains low, and existing models of care often fail to accommodate the lived experiences of this population. **Aims:** This study explores how SSWs access, experience, and navigate NHS healthcare. It aims to understand the barriers and enablers of access, identify areas for improvement, and offer recommendations to inform the development of more inclusive service provision. **Methods:** An ethnographic approach was undertaken within a South Yorkshire charitable organisation. Data collection involved participant observation and an arts-based scrapbook intended to facilitate trauma-informed, flexible engagement. Thematic analysis was used to analyse the data, organised around a dynamic, processual access using the candidacy framework. **Findings:** Barriers to care were present across all stages of healthcare engagement, including minimisation of health needs, administrative exclusion, lack of continuity, and stigma from professionals. Participants frequently described systems as inaccessible. Key enablers included supportive organisational staff, and consistent, trusted relationships with specific providers. **Areas for Improvement and Recommendations:** Findings highlight the need to simplify registration processes, provide in-person options, and reduce reliance on digital communication. Greater continuity of care and gender-

sensitive, trauma-informed approaches were consistently requested. Services should not be evaluated solely by uptake but by how well they accommodate marginalised users. Healthcare settings that prioritise safety, trust, and consistency were shown to improve engagement. SW spoke of the work of access of care which for many way too hard to gain. **Conclusions:** SSWs are not disengaged from healthcare but are routinely excluded by systems that fail to meet their needs. Service redesign must begin from the realities of those most marginalised through co-production, to reduce health inequity and build meaningful access.

**Keywords:** healthcare access; health inequalities; stigma; marginalised populations; ethnography; primary care

1. Introduction

Sex work (SW) is a broad term for the exchange of sexual services for financial (or equivalent) return. Equivalent payments may include, but are not limited to, shelter, security from others, drugs/alcohol or food(1). Sex work encompasses a large variety of work types and thereby associated experiences [Table 1](1). In the UK, around 95% of SWs are cis or trans women and we focus on this group in our paper (2).

SWs are a highly marginalised group(3). The likelihood of becoming involved with SW, particularly forms of SW with greater risk, increases with disadvantage(4). Multiple disadvantage is prevalent in this community, and they often have a history of unstable or volatile home environment, homelessness, poverty, violence and trauma(5). Trafficking for sexual exploitation (the movement of someone to another place for the purposes of exploitation) is estimated to occur in 13% of females in the UK sex industry(2). Street Sex Workers (SSW) often face greater vulnerability than other SW groups, shaped by distinct experiences with many facing early life trauma, with high rates of domestic and sexual abuse(4,6). Entry into SSW frequently reflects these unstable beginnings, with an average starting age of 19(4). SSWs are at extremely high risk of abuse from clients - they report putting their lives at risk for every interaction(6). Violent experiences have been documented include being tied up, beaten, strangled, raped and attacked with weapons(4). This allows for a cycle of women with multiple disadvantage being vulnerable to further exclusion, which can marginalise them further(5).

Table 1. Summary of relevant sex work types, adapted from Hester et al. (1).

| Category                         | Definition                                                                   |
|----------------------------------|------------------------------------------------------------------------------|
| Parlour-based work, brothel work | Premises explicitly for providing sex, often more security than on street.   |
| Escort                           | Service pre-planned and provided for specific clients indoors.               |
| Online sex work                  | Sex work organised and provided online. Includes pornography and webcamming. |
| Street and outdoor               | Solicited or serviced on streets or other public areas.                      |

Health Needs of Street Sex Workers

SSWs are vulnerable to multiple health risks, yet their engagement with healthcare is low(7,8). Unscheduled and emergency care attendance and admission rates are higher amongst SWs than the general public(7). Presentations tend to be delayed leading to more severe and irreversible pathology(9). The prevalence of psychiatric health issues, including depression, post-traumatic stress, anxiety and suicidality, is higher in SWs than the general population(10). It is noted that pre-existing mental disorders are also associated with entry into SW(11,12).

SWs are more likely to use drugs and engage in high-risk drug behaviours such as intravenous use(14). A barrier to mental health services for SSWs is the frequency of dual diagnosis - coexisting mental illness and substance misuse - which often excludes them from mental health services until substance misuse is addressed(3). However, many rely on substances to self-manage existing mental health conditions, creating a cycle that is difficult to escape(13). Oftentimes, drugs and alcohol will be used to cope with and forget about the traumatic nature of the work(15). The use of drugs and alcohol as a coping mechanism can cause SSWs to become trapped in the ‘work-score-use’ cycle(4), perpetuating drug addiction and unsafe behaviours.

The sexual and reproductive health needs of SSWs are unique in that they are directly linked to occupational risk. Sexually transmitted infection (STI) is prevalent, due to high amounts of unprotected intercourse(16,17). Prevalence of lifetime pregnancy is high, as are abortion rates(19). SWs are more likely to have complications within pregnancy(8). Contraception use amongst SWs is complex. Whilst uptake can be low(17), many SWs are highly aware of STI and pregnancy risk(20). Menstrual periods are also a consideration within contraception choice, as they impact occupationally(20).

*The Candidacy Framework*

Dixon-Wood define Candidacy as ‘the ways in which people’s eligibility for medical attention and intervention is jointly negotiated between individuals and health services’(21). The candidacy framework helps us explore the varying stages of a patient’s healthcare journey, factoring in limitations to healthcare access(21). The framework consists of seven stages, which are dynamic and can overlap, reflective of the access process(22). The stages of the candidacy framework are outlined in **Table 2**.

**Table 2. Summary of the stages of the candidacy framework, adapted from Dixon-Woods et al. (21,22).**

| Stage of Candidacy Framework             | Dixon-Woods                                                                                                             | In practice                                          |
|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| Identification of candidacy              | How people recognise their symptoms and respond to them.                                                                | Do these symptoms require medical attention?         |
|                                          | Awareness of available services                                                                                         | Which service do I need?                             |
| Navigation of services                   | Ability to mobilise a range of practical resources                                                                      | How do I find it?                                    |
|                                          | The ease with which people can use services                                                                             | How do I get to it?                                  |
| Permeability of services                 | More porous - less qualifications, less mobilisation of resources                                                       | Am I eligible for an appointment?                    |
|                                          | Less porous - more qualifications, more mobilisation of resources                                                       | What needs to be done for me to book an appointment? |
| Appearing and asserting candidacy        | A person making a claim to candidacy for medical attention or intervention                                              | Do I know what my needs are?                         |
|                                          | The judgements and decisions made by healthcare professionals which influence a person’s progression through healthcare | How do I articulate and explain these?               |
| Adjudication by healthcare professionals |                                                                                                                         | What do healthcare professionals think of my claim?  |

|                                                        |                                                                   |                                                                             |
|--------------------------------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------------------|
| Offers of/resistance to healthcare services            | The choice of a person to refuse a service they have been offered | Do healthcare professionals think I deserve medical attention/intervention? |
|                                                        |                                                                   | Do I want to see this healthcare professional?                              |
|                                                        |                                                                   | Do I want this treatment?                                                   |
| Operating conditions and local production of candidacy | The influence of local services, resources and availability       | Do I feel judged by this offer?                                             |
|                                                        |                                                                   | Does this service have what I need?                                         |
|                                                        |                                                                   | Do I feel able to present myself to this service?                           |

2. Material and Methods

2.1. Study Setting

This study was a mixed methods qualitative study, which combined ethnography and art-based research (ABR). Participants of the study are all users of a project called Sheffield Working Women’s Opportunity Project (SWWOP) which is third sector organisation that offers support for SSWs, based in Yorkshire. The organisation interacts with approximately 150 women, not all of these women will have participated in this ethnographic study as it relied on whop was engaging with the service at the time of study. In line with ethnographic and participatory approaches, this study does not provide a definitive count of participants involved. We worked closely with charity members and organisational consent was obtained prior to beginning data collection. The organisation hosts a GP (LM) to provide primary care for women attending, this is funded by short term contracts with local authority and local funding streams.

Prior to the start of the research, we worked closely with staff and support workers at the charity to design a methodology that was appropriate for the situation. Many women attended are highly vulnerable, likely using illicit substances and at risk of coercion. We were keen that this should not impede their ability to share their voices, but we were mindful of maintaining safety and avoiding harm for researchers and participants.

- Inclusion criteria:
- Engages with or has engaged with the organisation.
- Aged 18+.
- Must have sufficient capacity to consent and participate in the study.
- Ethical approval was gained from The University of Sheffield Research Ethic Committee.

2.2. Study Design and Data Collection

The primary ethnographic method was participant observation by the lead researcher (CB). This included observations of and conversations with staff members of the organisation in the research. This was because they could offer a broader organisational understanding of the findings contributed by the individual SSWs themselves. Ethnographic data was collected from participant observation, conversations with participants, and conversations with staff, over a six-month period (October 2025 - April 2025). Participant observation was conducted once or twice a week over this time.

The Data were documented through field notes, which included informal writing and voice notes. Additionally, a list of guiding questions was prepared before starting data collection.



We used a scrapbook and craft materials to help engage women in discussion. The scrapbook data collection occurred over a two-month period (February 28th - April 30th 2025). The scrapbook was positioned on the main table in the drop-in centre.

The scrapbook was divided into:

1. Open questions exploring attitudes to and experiences of healthcare
2. Categories of healthcare need for specific feedback

Participants were invited to either write or draw in response to the prompts in the scrapbook.

### 2.3. Analysis

The data was initially analysed using Braun and Clarke's(23) thematic framework but despite careful reviewing and refinement, the emerging themes lacked coherence and clear boundaries. Many codes appeared to fit into multiple themes, which suggested that the thematic framework risked oversimplifying the complex, overlapping realities revealed in the data. Additionally, the thematic analysis alone did not adequately capture the dynamic and processual nature of healthcare access as a journey or negotiation.

To address the limitations identified in the thematic analysis, Dixon-Wood's (22) candidacy framework was applied as emerging themes. The application of the framework enabled clearer differentiation of overlapping codes and provided a structured means to account for the multifaceted nature of participants' experiences, thereby enhancing the coherence and depth of data interpretation.

The seven stages of the candidacy framework (identification of candidacy, navigation of services, permeability of services, appearing and asserting candidacy, adjudication by healthcare professionals, offers of/resistance to healthcare services, operating conditions and local production of candidacy) became the themes(22). The stages within the candidacy framework are overlapping and interact with one another.

The data was triangulated from the written scrapbook findings, arts-based scrapbook findings, ethnographic fieldnotes and answer to ethnographic questions to ensure comprehensiveness of findings. Thematic analysis was verified by RM and JR.

### *Reflexivity and Positionality*

CB's role was shaped by multiple intersecting identities as a medical student, a volunteer at the partner organisation, and an outsider to the lived experience of SSW could influence participant perceptions and my interpretation of interactions. Her medical education provided valuable insights into NHS service improvement areas but also aligned with a system many participants viewed suspiciously, requiring patience and honesty when building trust with research participants.

## 3. Results

The candidacy framework is used as an analytical lens to structure the data and explore how SSWs access and experience healthcare, findings from both the ethnography and the arts-based scrapbook are presented together. Whilst the results will be presented in the order of these stages, a SSWs journey through healthcare is rarely linear. Instead, their experiences often involve movement and hesitancy between stages as they navigate complex personal, social, and structural circumstances. The framework is therefore used not to impose a rigid pathway, but to illuminate the experiences through which candidacy is negotiated and realised.

### 3.1. Identification of Candidacy

Identification of candidacy refers to the recognition and interpretation of health symptoms and the decision to seek professional intervention (41). As the first stage of candidacy, identification is fundamental in receiving adequate care.

For many participants, fear played a significant role in delaying this process. SSWs expressed anxiety about what seeking care might reveal, with one commenting 'ignorance is bliss'. Some had lived with symptoms for so long they could no longer distinguish what 'healthy' felt like, and therefore could not compare that to how they felt on a daily basis. They felt as though once they acknowledged one aspect of their health, it would open the door to a series of other health complications that they had been unaware of. Or, they worried they might discover that health concerns may be more serious than they had realised. Two women described themselves as 'hypochondriacs', explaining that they felt they had to totally avoid thinking about health or they would not be able to stop. Another example of fear was that of test results. Participants described wanting routine STI testing, but being too scared of potential diagnoses.

Avoidance of health leads to minimisation of health needs. Women described a general attitude of having to 'just get on with it' and 'pushing through'. Generally, they stated having to be extremely worried about a health issue to consider seeking healthcare. One participant stated "as working women, we don't get sick pay...we just have to keep working", leading to routine de-prioritisation of health needs. For example, one woman, visibly unwell with flu, refused rest, saying she needed to collect a food parcel to eat that day.

Identification of candidacy involves both identifying a health need and identifying a health service to meet the health need. However, once the women had identified a health need, this was not necessarily viewed as requiring professional intervention. Many SSWs preferred to self-diagnose, rather than see an HCP. Internet searches were deemed to be quicker and easier, with the advantage of not having to talk to HCPs. Following on from self-diagnoses, they opted to self-treat. However, self-treat was often used to describe ignoring symptoms. As well as self-treating, women tended to have more trust for other women's healthcare recommendations than HCP's, particularly surrounding substance misuse and contraception. One SSW was advised by her GP that the coil would be the most appropriate contraception based on her needs, but she opted for the implant after receiving advice from another SSW.

### *3.2. Navigation of Services*

Navigation of services focuses on the idea that a patient has to work to use a service by a) being aware of the services on offer and b) having the resources to use the service (41).

Participants described difficulty identifying how to register with a service. Registration systems were cited as confusing and inconsistent, frequently changing formats between in-person, online, or mobile sign-ups. Many participants reported difficulties contacting healthcare services due to lack of consistent access to technology. When a phone is provided by an organisation, it is often stolen or sold. This makes appointment reminders impossible to receive.

To travel to an appointment one must know where it is and be able to get there. Without constant access to the internet, it can be difficult for the women to work out how to get there. Additionally, the cost of public transport is often too high. The organisation tries to provide bus passes to help with this.

### *3.3. Permeability of Services*

Permeability of services is concerned with the ease with which people can use services (41). Barriers to permeability can be administrative, or due to misalignment between a service and its user - essentially whether or not the patient feels comfortable using the service (41).

One barrier is the time it takes to register for some healthcare services. One participant was told by an external GP service that registration would take two weeks; she declined, believing she might no longer need care by then. In contrast, when offered immediate registration with the organisation's GP, she complied readily despite having no health concerns at that time.

Participants reported administrative constraints to accessing appointments. One participant detailed walking for forty minutes to her GP to try to make an appointment, but being told on arrival

that they only accept telephone appointment requests. Many women have no access to a smart phone so digital access is impossible.

Many participants experienced being barred from GP services. Reasons for this include missing previous appointments, and displaying triggered behaviours. This prevents the women from accessing further appointments and deters them from registering with alternate services.

### 3.4. *Appearing and Asserting Candidacy*

*Appearing and asserting candidacy* is the act of being able to formulate, articulate and seek help for an issue(21). This may be harder for vulnerable groups due to power imbalances, making it more difficult for them to ask for help.

Participants struggle with receptionists asking personal questions, feeling that this violates their privacy. One said “We already find it hard to tell the doctor personal things, we don’t want to be telling everyone”. This follows into the waiting room, where there are often men present. Women report feeling particularly vulnerable when seeking healthcare, and finding the presence of men triggering. Male HCPs can be an even greater trigger, due to traumatic past experiences with men, particularly those deemed to be in positions of authority. This compounds feelings of unsafety, making SSWs less likely to seek care.

It was clear that positive experiences with empathetic healthcare providers were transformative. This played a crucial role in appearing and asserting themselves to HCPs. The importance of having female HCPs was echoed here.

The participant’s gratitude for the organisation’s GP played a large role in their confidence to assert. The understanding that she was there for them, and had chosen to treat them because she specifically wanted to help SSWs allowed them to feel that they deserved treatment. One participant added “[love] yourself, we deserve it”, verbally explaining further that believing that they were worthy of love was the first step to asserting their needs.

When asked, “What do you think about when you hear the word healthcare?”, one participant responded, “[...] caring people, nice people, people who want to help [...]”. In response to the prompt ‘What would make you trust your doctor more?’, one participant drew a heart, verbally stating she just wanted to be treated with kindness.

The main consensus here was that the participants wanted to feel respected to trust a HCP enough to assert a claim. The value of friendly, consistent HCPs who showed they were really listening to the women was paramount to their ability to assert their claim to candidacy.

### 3.5. *Adjudication by Healthcare Professionals*

Adjudication is the influence that a HCPs judgements and decisions has on access and experience(22).

This is particularly important for SSWs as they experience negative feelings of judgement from HCPs often. Participants discussed feeling as though they were not deemed as deserving of care due to their identity as SSWs. Some argued that they felt as though they were viewed as making wrong decisions, and therefore incapable of making decisions about their own health. The issue of being asked personal questions by receptionists is also relevant here. This led SSWs to feel as though they were being stigmatised before they saw a HCP. The feeling of alienation also occurred from being barred from services. This demonstrates a decision from professionals surrounding the validity of a SSWs claim to candidacy.

Participants described having to fight for healthcare, whilst HCPs ultimately decide on the outcome. In response to the prompt, “What do you think about when you hear the word healthcare?”, one participant wrote, “That’s all I’ve heard for 15 years.” This response reflected a sense of persistent engagement with healthcare services, often initiated by professionals rather than the individual. Several participants described experiences where healthcare interventions, particularly types of contraception, were pursued or offered repeatedly, despite their own uncertainty or reluctance. In these instances, decisions about care appeared to be made primarily by professionals, with women



feeling that their preferences were secondary or disregarded. These accounts suggest that adjudication did not always follow a claim of candidacy from the individual; instead, candidacy was sometimes externally imposed, with professionals determining the need for care irrespective of the participant's own assessment.

### *3.6. Offers Of/resistance to Healthcare Services*

Patients can resist offers of healthcare, such as referrals or medication, directly affecting access(22).

Among SSWs, resistance was often shaped by prior negative experiences. This includes resisting healthcare experiences with male HCPs due to discomfort and safety concerns. This was particularly relevant for intimate health concerns, such as sexual health or mental health issues.

Resistance to substance misuse treatment was common. This was largely due to fear of bad side effects, particularly withdrawal. Many of the women had previously engaged with substance misuse programmes, using methadone tablets to treat opioid dependency. They explained that after having negative experiences with this treatment, when offered buprenorphine injections (an alternative treatment), they were hesitant and declined. However, once positive experiences with buprenorphine injections were shared within the community, more women opted in.

There were many reasons for this. Some participants did not want to commit to remembering to either collect prescriptions or take medication. Others felt that they had a difficult relationship with drugs, and did not trust themselves to use them safely. Others worried about side effects. Mental health medication was frequently declined.

Minimisation of need was a recurring theme. Many participants acknowledged that they felt their health was unimportant, which made it harder for them to assert a claim. Repeated experiences of social exclusion and trauma eroded their confidence to seek help.

There were examples of resistance to antenatal and perinatal care. A large reason for this was due to fear of child removal by social services. One woman explained that she refused skin to skin after birthing her child, as she did not want to develop a greater emotional attachment to a child that would shortly be removed from her care.

### *3.7. Operating Conditions and Local Production of Candidacy*

The operating conditions and local production of candidacy stage refers to the "perceived or actual availability and suitability of resources to address [...] candidacy" (22). This includes the local influence on patient and HCP relationships.

A clear theme from this study is the time it takes to get an appointment, particularly for mental health services. All participants stressed the importance of getting an appointment or assessment quickly. Long waiting lists for mental health services can feel like a total rejection from the service, leaving patients feeling alone. This prevents them from seeking further care.

Time constraints during appointments are also a barrier. SSWs are more likely to require more time and space to assert candidacy, due to trauma and fear of judgement. They are likely to have prior negative experiences which mean that building trust for an HCP takes longer. Being rushed through an appointment can make them feel dismissed, making them feel unworthy of care.

Lack of consistency is a barrier. This applies to inconsistent appointment booking systems. Navigating a new system can be more difficult for SSWs, so changing systems make it less likely for them to seek care. Consistency of HCP is also important, as it allows SSWs to build a rapport and trust with an HCP.

An example of this is the organisation's GP. The consistent time and care that she has offered the woman allows them to feel safe and trust her. Often, due to barriers discussed, SSWs miss their appointments with her. This means it is harder for the organisation to prove her necessity, as uptake is low. However, utilisation is not an appropriate measure of need and in this case the barriers which cause low uptake are the reasons why the GP is so essential for the women.

## 4. Discussion

There are significant barriers to access to healthcare for SSWs. Participants face personal barriers, such as fear of one's own health and hypochondria, and structural obstacles, such as consistent telephone access and time constraints.

### *SSWs Are Systematically Excluded, not Disengaged*

While barriers were widely reported, participants often placed culpability on systems rather than individual HCPs. The findings show that services are not structured towards the needs of SSWs. In contrast to some literature that portrays a uniformly negative relationship with healthcare, many respondents often expressed genuine gratitude for the positive experiences they had - particularly in settings where care was consistent, trauma-informed, and non-judgemental. This suggests that SSWs are not wholly disillusioned with healthcare but rather frustrated with inconsistencies in systems and practice. This optimism may reflect the specific context of their relationship with the organisation's GP, which provided a rare example of continuity, safety, and trust. Their perspective challenges narratives of disengagement and shows that meaningful, sustainable access is possible if systems are flexible enough to meet people where they are.

### *Healthcare Access for SSWs is a Process, not a Singular Event*

The process of accessing and experiencing healthcare for SSWs fits into the candidacy framework. This framework provides a clear structure for analysing healthcare access not as a singular event but as an evolving process. Traditional models often rely on a utilisation-based approach - measuring access by counting service use or attendance - which can overlook the many barriers, refusals, and informal attempts that occur before or instead of formal engagement. Using this approach has enabled a more nuanced analysis of healthcare experiences. This processual perspective reveals that the challenges SSWs face are not simply about their willingness or ability to use services but are embedded in systemic structures and attitudes that limit genuine access.

### *SSW Solutions*

A notable aspect of this research is its attention to participant voice. Many studies have focused solely on documenting barriers; here, participants also suggested solutions. SSWs are under-reached, and therefore many previous studies are produced with either healthcare providers or charity staff. This study has captured raw perspectives from SSWs themselves, allowing for the development of solutions that SSWs are comfortable with. This underlines the importance of moving away from top-down healthcare design and towards models that are co-produced with service users.

### *What SSWs Want in a HCP*

The SSWs in this study are clear about what is important to them in a HCP. Many SSWs expressed difficult experiences with male HCPs, and preferences for female HCPs. The importance of openness and friendliness in HCPs was expressed. SSWs are consistently judged and stigmatised in every area of life. Kindness from HCPs creates a uniquely safe environment where SSWs can be offered equal respect and care. SSWs want to be heard and listened to. This demonstrates an understanding from the HCP that SSWs are capable and worthy to make decisions about their lives and health. HCPs that actively listen, amplify the voices of SSWs, who are often unheard. This can create a special sense of empowerment in a routinely disempowered situation.

### *Digital Healthcare Does not Work for Everyone*

As healthcare becomes increasingly digital, the risk of excluding SSWs from healthcare grows. Whilst the digitisation of healthcare has potential to increase accessibility for certain patient groups, it is important for policy makers and HCPs alike to be aware of the potential inequalities it can

introduce. Greenhalgh suggests that patients who are disadvantaged by digital exclusion could receive a flag on their health record, reminding HCPs and staff to offer less digital, or non-digital options(24). Expanding on Greenhalgh's work on digital exclusion, SSWs could be offered healthcare services that consider their fast-changing access to telephones(24).

### *Comparison with Existing Literature*

The health needs and barriers to healthcare identified in this research are in line with previous studies investigating health needs for SSWs(3–5,7,18). This research has expanded on how these barriers emerge and persist, by examining the interplay between SSWs and services(5).

Much of the research directly engaging with SSWs was conducted prior to 2016 (4,5,7,26), with more recent studies tending to review literature(27), or interview professionals working around SSWs(3).. This study is distinct in that it engages HCPs, charity staff and SSWs, but crucially re-centres the voices of SSWs themselves. The NHS has changed considerably in the last decade, with particular focus on digitisation(24). As such, the study offers a timely and original contribution by foregrounding the lived experiences of SSWs navigating a rapidly evolving NHS.

As with this study, Mastrocola et al. carried out research with a specific third- sector organisation(7). Both Mastrocola et al. (7) and Jeal et al. (26) noted the advantage of harnessing the role of the voluntary sector in SSWs health. This study reinforces these findings, by demonstrating how the NHS can work with third sector organisations to maximise ease and efficiency for SSWs.

Unlike other studies which concluded that SSWs are disengaged from healthcare(5), this study found that many participants were engaged but excluded. This reframes the issue not as one of individual disengagement, but of systemic exclusion within the current healthcare landscape.

Mastrocola et al. (7) introduced the concept of candidacy to understand their results, particularly focusing on the permeability stage. This study expands on this idea by mapping and interpreting results within the candidacy framework. Being the first study to comprehensively analytically apply the candidacy framework to SSWs is significant because it opens new analytical ground and offers a novel perspective on how access issues are experienced and addressed within this marginalised population. This original application also provides a foundation for future research, allowing others to build on, adapt, or challenge the candidacy framework in relation to healthcare access for SSWs.

### *Strengths and Limitations*

#### *Strengths*

The sample of participants in this study offers strengths as an under-reached group, with SSWs directly engaged in the study design through varying perspectives including ethnographic, organisational staff, SSW-specific GP, and most importantly, the SSWs themselves, elevating voices that are often excluded from research. The use of ABR (Arts-Based Research) introduced multiple strengths by creating space for subjective healthcare experiences to be explored in a non-intimidating, relaxed setting that fostered honesty about care drawbacks and enabled SSWs to collaborate and exchange ideas. The scrapbook method may have enhanced participation by reducing perceived commitment and formality, while occasionally encouraging participants to make practical choices about their health and evolve into actions without waiting for formal data collection completion. A key strength is the use of the candidacy framework as an analytical tool, offering a robust and layered lens for analysis that makes it particularly well-suited to exploring healthcare access in SSWs.

#### *Limitations*

While this study offers valuable insights into healthcare access among sex workers (SSWs), several limitations should be acknowledged, including that the majority of participants were cis-female and results may not be applicable to transgender or cis-male SSWs, and the study's limited time frame constrained opportunities to build rapport with participants. Reliance on a single service for recruitment may have narrowed the sample, as different cities have different service delivery

models and organisational structures, and the research was embedded in a specific organisational environment that may not be replicable in other service settings. The scrapbook method, while receiving contributions, ultimately served as a conversation starter rather than producing visual results, indicating that the methodology of this study could be better edited to align with SSWs' needs, and participants were more responsive to general healthcare prompts than specific sexual health ones.

#### *Implications for Research*

This study suggests several avenues for future research to broaden the scope of sex workers (SWs) by including transgender SWs, male SWs, and those engaging in non-traditional sex work types to ensure results are generalisable to the larger SW population. Different access frameworks should be utilised to investigate healthcare access for SWs and other vulnerable groups, addressing low-barrier service provision. Healthcare research should explore specific areas like long-term physical health, mental health, substance use, sexual and reproductive health, and emergency care, while accounting for differences in financial access across these services.

#### *Implications for Practice*

Based on insights from this study, several recommendations can be made to improve NHS healthcare access and experience for sex workers (SWs), including designing health systems that avoid excluding groups before they reach services and shifting towards theoretical models that include interpersonal and systemic indicators of unmet need. SWs should be understood as disadvantaged in healthcare access rather than disengaged, with appointments made more readily available and emphasis on "walk in" options rather than being barred for exhibiting triggered behaviours. SSW-specific GPs should be considered to build trust through consistent care, and creating safe spaces for SWs to access healthcare is important since mainstream care settings can be triggering. There should be caution around increasing digitisation of healthcare, with no-digital or less-digital options provided for SWs who may face barriers, and appointment booking systems should allow for looser time constraints and more flexibility. Healthcare providers need proper training and understanding of triggers that affect SWs in medical settings.

## 5. Conclusion

This study aimed to build on existing research demonstrating unmet health needs for SSWs. SSWs are a highly marginalised group who experience multiple disadvantages. This causes SSWs to be at risk of vast health inequalities. The health needs of SSWs are interlinked and interdependent, meaning they cannot be solved on a case-by-case basis, but rather need a systemic overhaul. The barriers and enablers of access to adequate NHS healthcare provision for SSWs have been explored using the candidacy framework. These findings demonstrate the advantage of conceptualising NHS healthcare access and experience for SSWs through a model of candidacy. The importance of trauma informed, consistent care should not be overlooked. Future research should explore alternative care models for SSWs and should be co-produced with SSWs themselves.

**Author Contributions:** All authors had full access to the data in the study and took responsibility for the integrity of the data and the accuracy of the data analysis. Conceptualisation, RLM CB LM BW. Methodology, RLM CB JR. Investigation, CB. Formal Analysis and Coding, RLM CB JR. Resources, R.H.; Writing—Original Draft, RLM CB JR. Writing—Review and Editing, RLM CM JR LM BW. All authors have read and agreed to the published version of the manuscript.

**Funding:** Rebecca Mawson is funded by the UK National Institute for Health and Care Research as Academic Clinical Lecturer.

**Institutional Review Board Statement:** The proposed study outline was submitted to The University Of Sheffield Ethics. The project was approved on 10/12/2024. The reference number is 063995. Appendix 1 contains the ethics approval letter and details.

**Conflicts of Interest:** The authors declare no conflicts of interest.

List of abbreviations

|        |                                                                    |
|--------|--------------------------------------------------------------------|
| A&E    | Accident and Emergency                                             |
| ABM    | Arts-Based Method(s)                                               |
| ABR    | Arts-Based Research                                                |
| DERA   | Deep End Research Alliance                                         |
| GP     | General Practitioner                                               |
| HCP    | Healthcare Professional                                            |
| HIV    | Human Immunodeficiency Virus                                       |
| NHS    | National Health Service                                            |
| PRISMA | Preferred Reporting Items for Systematic Reviews and Meta-Analyses |
| STI    | Sexually Transmitted Infection                                     |
| SW     | Sex Work / Sex Worker                                              |
| SWs    | Sex Workers                                                        |
| SSW    | Street Sex Work / Street Sex Worker                                |
| SSWs   | Street Sex Workers                                                 |
| UK     | United Kingdom                                                     |

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