

Balance, Capacity, and the Contingencies of Everyday Life: Narrative Etiologies of Health Among Women in Street-Based Sex Work

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Abstract

There is an abundance of health research with women in street-based sex work, but few studies examine what health means and how it is practiced by participants. We embrace these tasks by exploring how a convenience sample of sex workers ($n = 33$) think about and enact health in their lives. Findings reveal pluralistic notions of health that include neoliberal, biomedical, and lay knowledge. Health is operationalized through clinic/hospital visits and self-care practices, which emerge as pragmatic behaviors and ways to resist or compensate for exclusionary treatment in health care systems. Participants also use symbols of biomedical authority to substantiate their lay interpretations of certain conditions, revealing complex forms of moral reasoning in their health etiologies. We conclude that doing health and constructing rich narratives about it are constituent elements of the women's everyday praxis and subjectivities in relation to the broader socioeconomic and political worlds of which they are a part.

Keywords

therapeutic pluralism; street sex work; lay health knowledge; health narratives; subjectivity; qualitative; ethnographic; Canada

Introduction

Health is a ubiquitous term that refers to different states of embodied and mental well-being. Although the meanings of health and the ways it is resourced at structural, social, and interpersonal levels are diverse, mainstream discourse and scholarly research tend to privilege biomedical understandings of the body as well as the behaviors that are considered health-seeking (Mallee, 2017). Destabilizing homogeneous notions of health has long been an important task for health equity researchers, most of whom adopt qualitative approaches that examine how different health knowledge and practices are shaped by cultural, political, gendered, racialized, and sexual identities (Bourgois & Schonberg, 2009; Jackson & Mazzei, 2009; Knight, 2015; Scheper-Hughes, 1992). However, even some of these researchers use the term “health” as a concept and operationalized facet of life in an amorphous, unproblematic manner. Unpacking this key feature of life, well-being, and survival is central to ensuring that people's health needs are recognized, better understood, and responded to with quality care. This is particularly

important among those who experience profound forms of socioeconomic and political exclusion.

A case in point is women in street-based sex work, whose health experiences are approached through research and policy initiatives that often focus on health risks and other dangers to their safety and survival (Goldenberg, Silverman, Engstrom, Bojroquez-Chapela, & Strathdee, 2013; Krusi et al., 2014; Sanders, O'Neill, & Pitcher, 2017). These women have significantly greater unmet health needs compared with the general public stemming from precarious working conditions, poorer sociopolitical

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determinants of health, and complex personal histories (Benoit, Ouellet, & Jansson, 2016; Benoit, Ouellet, Jansson, Magnus, & Smith, 2017; Knight, 2015; Orchard, Vale, Macphail, Wender, & Oiamo, 2016; Shannon et al., 2015). Research also explores sex workers' reluctance to seek formal health services, causally linking this hesitancy to discrimination and other forms of structural violence they have experienced by providers and the health system (Bungay, 2013; Dewey & St. Germain, 2017; Dewey, Zhang, & Orchard, 2016; Mellor & Lovell, 2012). These critically oriented studies position health as a complex embodied experience that is mediated through political structures, social institutions, and the intimate contours of daily life. Yet, comparatively little attention has been paid to what health concretely means to sex workers and how it is operationalized in their daily lives.

Of the studies that do explore how women in sex work understand health as a concept and daily practice, most are set in the global south, particularly South East Asia. Researchers identify the sociocentric dimensions of health as a key finding (Basnyat, 2017; Yu Yeon, 2013). Participants often describe health in relational terms vis-à-vis sociofamilial obligations they are required to fulfill before attending to their own needs (Basnyat, 2015; Dasgupta, 2013; Kaufman, Harman, Menger, & Shrestha, 2016; Rivers-Moore, 2010). This extends to women's health practices, which often occur within informal networks and among their peers because of financial constraints as well as their poor treatment in formal health care settings (Basnyat, 2014; Scorgie et al., 2013; Yu Yeon, 2013). These studies also demonstrate that, while many women discuss health in ways that reflect dominant public health ideas, the narrow focus on sexual health and checkups within the biomedical system does not wholly align with their lived realities (Basu, 2010; Choudhury, 2010). Culturally specific models of health often include medical terms, but what they mean and how they are distinguished from one another in etiological terms can be vastly different. Downe (1997) illustrates this in her ethnographic research about violence and HIV/AIDS among Costa Rican sex workers. Her study participants identify infectious diseases as being caused by viruses or microbes and culturally classify violence itself as a contagious condition caused by germs that are passed between people.

Qualitative anthropological and sociological studies offer further insights into what health means and how it is practiced in people's everyday lives. Key to this research is the multivocality of health, which can refer to and mean living a good or virtuous life (Hunt, 1998; Jensen, 2013) and recalling the wisdom of ancestors (Balshem, 1991). Health can also symbolize economic change and gendered dispossession (Martin, 1987), and it can serve as a medium through which social anxieties are expressed (Kaiser et al., 2015; Rapp, 1999). Health is also enacted

in ways that help individuals make sense of their lived experiences, including fatalistic "talk" (Keeley, Wright, & Condit, 2009) and attitudes (Perfetti, 2018), which are employed to manage uncertainty and resist moralized judgments regarding disease etiology that can occur in mainstream health care systems. Such localized health behaviors are sometimes used to contest the imposition of biomedicine in people's lives (Balshem, 1991; Hunt & Mattingly, 1998; Marks, Reed, Colby, & Ibrahim, 2004; Scheper-Hughes, 1992). Other studies explore how individuals weave biomedical, complementary, and lay knowledge into their everyday health practices (Brodwin, 1996; Broom, Meurk, Adams, & Sibbritt, 2013; Popay, Williams, Thomas, & Gatrell, 1998). These examples of therapeutic pluralism demonstrate the complex and productive tensions between different health ideologies and activities, which are often employed in a selective, contextualized manner (Badone, 2008; Keeley et al., 2009).

We extend these bodies of research by examining how a convenience sample of women ($n = 33$) doing street-level sex work in the Canadian city of Kitchener-Waterloo, Ontario, construct and practice health. This is achieved by illuminating the diverse, experientially "thick" (Geertz, 1973) accounts of how health is described, practiced, and embodied in the lives of our participants. Rooted in an ethnographic approach that seeks to understand how people construct and move through their respective life worlds (Bourgois & Schonberg, 2009; Kirmayer, Mezzich, & Staden, 2017), we explore the range of cultural influences that constitute the women's emic or "insider" health ideas, also referred to as explanatory health models (Banks et al., 2016; Kleinman, 1980). Following other critically oriented feminist health scholars (Martin, 1987, 2007; Rapp, 1999; Scheper-Hughes, 1992), we are, in addition, interested in how the women experience different facets of power in their relationships with dominant health care systems and the various bodies of knowledge that inform their approaches to health. Although biomedicine and mainstream health practices can be deployed in oppressive ways that reproduce marginalization, this does not mean that all disenfranchised people experience these facets of life as strictly or always oppressive (Dewey & St. Germain, 2017; Foucault, 1977; Kaufert, 1998; Knight, 2015). Indeed, our participants' health models include neoliberal and biomedical ideologies alongside lay health knowledge, and they are used creatively, depending on the health issue at hand and their previous health care experiences. Their health narratives also reveal a cluster of experiential insights regarding how they think about their bodies, doing sex work, and the discursive forces that shape their lived realities as women.

We contend that the way women who engage in street-based sex work talk about and operationalize health

constitute a kind of performative praxis through which they are making themselves known, as women with valid health knowledge and the competency required to care for themselves. Performativity, in this sense, is a concept derived from speech act and gender theory that refers to how linguistic constructions and their embodied enactions create reality and constitute gendered subjectivity (Austin, 1962; Butler, 2010). Health, understood as performative praxis, is not merely an idea nor an ideal state of physical and mental well-being to be achieved, but rather takes place as a kind of *doing* that is also part of conversations whose meanings are under constant renegotiation. Our participants' accounts about health are thus rooted in and contingent upon intersubjective knowledge and everyday activities, what Schutz (1955) called "the world within reach" (p. 173). These rich narratives demonstrate how our participants care for themselves in relation to the broader socioeconomic, gendered, and political worlds of which they are a part. They also unearth compelling, rich insights into what health means and looks like in their daily lives.

Method

Study Setting

This project builds upon the first and last authors' formative research with women in street-based sex work in several Canadian cities. An interesting sociodemographic finding is that many women are originally from cities other than the ones in which they practice sex work (Orchard, Farr, Macphail, Wender, & Young, 2012), and within Southern Ontario, many women move regionally between smaller cities while taking part in the sex trade. Having conducted several studies in one key locale in the region, we were interested in determining how or whether women's experiences and the organization of sex work differed in nearby cities. The present study was developed to further understand these issues in Kitchener-Waterloo, Ontario, a medium-sized city that has received relatively little attention from sex work researchers.

Kitchener-Waterloo, known locally as "KW," is home to approximately 460,000 people and is a vital part of one of Canada's most productive manufacturing sectors. However, over the past 15 years, the technology market and start-up companies have begun to overshadow the industrial sector. This transition is a contested issue in KW, with some residents viewing it as revitalization and others seeing it as capital-driven gentrification (Macdonald, 2017). These changes overlap with amendments to the management of financial support programs, negatively referred to as "welfare" in Canada and some other countries. Under the auspices of removing barriers to employment and providing equal opportunities for

Ontarians to contribute to the economy, since 2013 the provincial government has dismantled tenets of the program that have made it difficult for marginalized groups to obtain the financial supports they rely upon to meet their basic needs. This includes the administration of exceedingly complex forms, which used to be completed primarily by government employees and social service providers. However, now such individual applicants are required to assume these arduous tasks largely on their own, which exemplifies how health is being reframed as a duty of citizenship and individual responsibility. Trends mirror similar developments occurring globally under neoliberalism (Polzer & Power, 2016). These changes have hit many residents hard, including our participants who often engage in sex work to supplement their shrinking income from government programs and other revenue-generating activities.

Data Collection

The primary objective of our qualitative, ethnographic study was to gather data about health care, social services, different kinds of violence, and how space shapes women's experiences of street-based sex work. We originally aimed to include transgender women, but their very small numbers in street-based settings and issues of stigma in a smaller community such as Kitchener-Waterloo precluded our recruitment of this population. Purposive sampling techniques were employed, and we placed recruitment posters at local agencies that serve women in street-based sex work. Staff members at these organizations helped spread the word about the study. Our inclusion criteria were intentionally broad to ensure a robust sample (i.e., 18–60 years of age, live in KW, and have been or are currently involved in street-based sex work).

Between March 2015 and May 2016, we conducted 33 in-person interviews with participants selected for the study. The interviews were semi-structured and included questions about the women's experiences in sex work, social and health service utilization, violence, health and health conditions, and different aspects of risk as well as resilience in their everyday lives. Our discussions included a social mapping component, whereby each participant was provided with a map of KW and asked questions about residency, health and social services, where street-based sex work occurs, and places in which they experienced violence. These data contributed unique insights about the spatialized nature of the women's everyday lives (Orchard et al., 2018; see also Orchard et al., 2016). The first two authors conducted the interviews and recorded observational field notes to supplement the interview data and social mapping exercises.

The interviews ranged from 30 to 90 minutes and took place at social service agencies who supported the project and other locales selected by participants. Prior to beginning our discussions, we described the study aims and our relative expertise in the fields of sex work research and service provision. Central to this is our shared belief that sex work constitutes a complex system of physical, sexual, emotional, and intimate labor that women (and others) become involved in for reasons related to early life experiences, socioeconomic need, racial and gendered vulnerabilities, survival, and a desire to live the way they choose. Voluntary participation, anonymity, and ongoing consent were also discussed, after which each participant signed informed consent documents.

This article features the experiences of 33 women with past and present experience in street-based sex work in Kitchener-Waterloo, which accounts for approximately one third of the total estimated number of women working in the area ($n = 100$). The women received CAD\$60 for their participation at the end of the interviews and were informed that they would receive this honorarium even if they were unable to complete our discussions. Before each interview, we discussed the potential for difficult issues or emotions to arise during the research process. We highlighted the importance of the women's well-being and let them know that they did not need to complete the interview, could stop at any time, and were welcome to spend time with us following the interview if they liked or needed to before transitioning back into their daily routines. Information about women- and sex work-friendly local services, including counseling, was made available to any participants who expressed a need for these supports. The project received ethics approval from Western University, the lead author's home institution.

Data Analysis

Data analysis was organized according to Braun and Clarke's (2006) six principles for thematic analysis, beginning with familiarization with the data by closely reading the interview transcripts. The interview data we focus on in this article correspond to the following questions: "What does health mean to you?" "How would you assess your own health?" and "What does health or being healthy look like in your daily life?" We posed these questions to better understand how our participants thought about health as a concept, experience, and technique of power often used by social institutions and health systems to exclude them in various ways. This line of inquiry was also driven by the recognition that cultural meanings of health are often absent from sex work studies, and the perspectives of sex workers are rarely, if ever, included in ethnographic studies of health. The first, fifth,

and last team members jointly coded several interviews to reach consensus about the thematic interpretation of the data, which were then organized into master files (i.e., Health, Risk, Resilience, Social Services) by the fourth author. These data were then reviewed using line-by-line coding and an iterative, constant comparative process to identify more nuanced themes relative to the master codes, interview transcripts, and study aims, tasks which were undertaken by the third author. Theoretical insights from critical feminism and medical anthropology were employed during our analysis of the women's ideas and practices related to health and the ways in which power, agency, and subjectivity intersected with and were produced through their performance of health (Butler, 2010; Martin, 1987; Scheper-Hughes & Lock, 1987).

Results

Sociodemographic Characteristics

Participants were between 18 and 55 years old, with an average age of 34 years. The majority identified as White, whereas a minority identified as Indigenous, and two participants identified as women of color. More than half of the participants finished high school, and some had taken college courses for nursing, accounting, and medical technician training. One third of the sample were originally from KW, and most grew up in nearby towns or small cities. Many women had experienced homelessness and at the time of the study, five participants lived in motels. These locales were also among the primary places where their work-related sexual encounters took place, along with cars, clients' homes, and parks. While our interviews were focused on street-based sex work, many participants took part in multiple forms of sex work over their careers and spoke of their experiences in other venues they have worked in, including hotels and massage parlors. The women had been in sex work for between 2 months and 20 years, with an average of 5.5 years. As in other studies (Benoit et al., 2017; Orchard et al., 2012), there were many complex issues that factored into their decisions to do sex work, including substance use, relationship break-up, poverty, and the excitement of making significant sums of money.

Own Health Status and Definitions of Health

When discussing their physical and mental health, participants often indicated that they felt unwell, and this mirrors findings from comparable studies that identify the unmet, complex health needs of street-based workers (Benoit et al., 2016; Benoit et al., 2017; Bungay, 2013; Dewey & St. Germain, 2017; Knight, 2015). Some women described their poor health in succinct terms

without any causal linkages: “My health is very bad . . . I’m sick all the time. Like I said, today I barely could get out of bed.” Others provided insights into the perceived cause of their compromised health status, which for this woman included not having consistent access to food: “My health isn’t that good considering, like, I don’t eat really . . . I get a real meal once every couple of days.” Some highlighted their mental health as particularly debilitating, including one participant who felt unable to disassociate from her traumatic past: “It’s just like, well, my past follows me everywhere.” A different woman provided a moving account of how her well-being fluctuates according to where she is at one day to the next, highlighting the fluid and context-dependent nature of health:

I don’t care about anything. I’m slowly giving a shit about myself. I’m at the point where I don’t want to harm myself, but if I don’t wake up some days I don’t care, you know what I mean? There is nothing else to lose, there’s nothing else to gain.

Despite having multiple morbidities (i.e., hepatitis C virus [HCV], cancer, diabetes, reproductive health issues), many women seemed to take their complex health conditions in stride. They did not downplay their severity or evade discussing the traumatic situations that precipitated them (i.e., addictions, poverty), but neither did they focus on these events or the painful outcomes associated with them as strictly debilitating. As one participant said when reflecting upon her deflated veins after years of intravenous drug use: “I have poor circulation, like I can hardly hit myself anymore. It must be my circulation, that’s about it. I’m pretty healthy though.” Similarly, while losing her teeth was clearly traumatic, this woman otherwise considered herself to be in fairly good health:

I got all my teeth fucken taken out because they were all just bad, you know from the drugs and what not . . . I just got dentures and they’re okay . . . For anything else for health, now I am pretty kind of healthy.

Many participants displayed considerable courage when talking about their health and had unique ways of telling us about it. Take this straightforward, darkly humorous account of what one woman was dealing with around the time of our interview: “The bipolar, the fibromyalgia. I have Hep C. I have major depression. Ah, what else? I died twice in the last three months, that was kind of interesting.” The women’s strength and resilience are remarkable and in stark contrast to notions of health as something fragile and in need of constant care that circulate in dominant social discourse (Polzer & Power, 2016).

When discussing what health meant to them, participants often framed it as a broad, complex issue: “Health is a lot, it’s big, very big.” Further probing about more

detailed meanings associated with health often generated confusion during the interviews, such that the women paused, looked quizzically at us, and asked, “Health, like my Doctor?” or “Like, do you mean STDs?” These awkward moments in the interviews reveal what the women thought we were interested in, namely, biomedical notions of health. They also reflect the obtuse nature of the word, which is used ubiquitously in social and research settings as though we all think about it in a similar fashion, particularly in the global north where it is often assumed biomedicine reigns exclusively.

Our participants thought about health in a variegated fashion that includes biomedical or neoliberal ideas about individual responsibility, along with holistic orientations of body-mind wellness, and political concerns regarding certain socioeconomic factors. Risk reduction and informed decision-making also occupied important roles in the women’s emic health model. As this woman relayed, “My definition of health is somebody taking complete care of themselves in one hundred percent of every aspect, every part of their being. Their physical health and their mental health.” Another participant said, “Health to me, is eating properly and healthfully, vegetables, meats, proteins, good fats. Health also is good balance in life.”

Many women in our study adhered to a holistic model of health, highlighting the importance of mental and emotional wellness along with physical health. One individual put it this way: “Mind, body and soul and how you feel on a daily basis.” Similarly, another woman said, “Health is as much physical as it is mental and emotional. It’s just about feeling good.” A strong sense of self was also identified as important, “Making sure that you’re not sick. Know who you are.” These two participants drew attention to the importance of sensory awareness and bodily freedom: “Feeling good with yourself, your ability in your movement, your everything” and “Content and able or the ability to do most of the things you want to do.” Another said, “A healthy life is just like getting out there enjoying like life, like life itself and enjoying the beauty of the earth.” Some participants commented on the political dimensions of health, noting how it is shaped by external factors, versus something that is strictly medical:

It’s anything, a number of factors that impact your life . . . your health. Like it doesn’t always have to be medical, it can be housing, your income, those kinds of things that really determine your social position basically.

Although the social determinants and political economy of health frameworks are regularly employed in health research among women in sex work, it is rare to see key tenets of these approaches featured in the words of our participants in such a definitive manner.

Operationalizing Health: Complementary Ideologies and Practices

In response to the question about what being healthy looked like in their lives, the women often discussed activities that align with neoliberal framings of health in terms of lifestyle: self-care, being active, mobility, and adhering to moral imperatives associated with “good” health (i.e., following their doctor’s advice, making better choices, managing that which is unruly). However, lay ideologies and practices also emerged and were positioned in three ways: (a) in resistance to dominant health systems, (b) as practical solutions to various ailments, and (c) as complex renderings of subjectivity, agency, and moral reasoning. Taken together, these pluralistic everyday practices reflect “the world within reach” (Schutz, 1955), and the ways in which health is taken up by the women in our study.

Lifestyle/Neoliberal Model

Many participants positioned being healthy as a set of embodied practices that inform what goes into the body (food, water) and what the body does (active, able, sleep): “Like how much you’re eating and sleeping . . . Like when you’re working you have to stay hydrated . . . and you also have to eat. You have to eat a lot of snacks.” The active management of the body also emerged as central, and participants often used expository terms that emphasized improvement and the necessity of having their healthy efforts assessed. To be “clean and active” is how another woman defined healthy. Others stressed the importance of verifying that one is, indeed, healthy through repeated references to “making sure”: “Making sure that you are good to go. Making sure that you, how would I describe it, making sure that you’re healthy.” Echoing key tenets of the neoliberal lifestyle discourse, being healthy was identified as a series of morally charged behaviors that should be performed in particular ways and are subject to social and self-surveillance.

To that end, several women discussed removing themselves from morally ambivalent “things” that could jeopardize their ability to be healthy and perform socially sanctioned health-related behaviors: “Staying away from, like, those other things.” They also raised the issue of making better decisions to improve their social and personal health landscape, including one participant, who said, “Making healthy choices, like making better choices for the environment, better food. Things that make you better.” Another woman described what she saw as the “right” way to engage in certain health-oriented behaviors: “eating properly and healthfully.” Visiting the doctor regularly was also cited as a valued activity, one that

some participants used to assess their health performance against that of their peers: “Keep going to the doctor, a lot of the women they don’t do that. They do not get those checkups . . . I think exercise and stuff at the doctor’s, [that] type of thing.” The need to take extra preventative measures to reduce the onset of certain conditions, including those that were genetic and largely beyond their control, was also mentioned. This woman described closely monitoring her health through the regular uptake of various medical procedures, which aligns with the responsible, risk-reducing subject featured in many neoliberal approaches to health promotion:

We [have] cancer in our family and unfortunately none of the parents lived past sixty. So, all us siblings have done a step up . . . I get a colonoscopy every three years, not five. I get a mammogram every two years. I get a pap smear once a year and I keep following that, I keep repeating it, repeating it.

Another participant shared her insights about food intake as well as sex and drugs, two behaviors most participants framed as necessary, not always enjoyable, and potentially harmful or linked with traumatic life events. However, instead of excluding these activities and marking them as strictly dangerous, they are folded into her full sphere of *doing* health, which challenges dogmatic notions of what *being* healthy can include “What you eat, um health and STDs, health and drug use, how you use your drugs, how you have sex, how you eat.” Morally questionable behaviors are reframed through her emphasis on enactment, which, in this instance, is not about wholesale consumption but a series of actions that is realized through expert knowledge and embodied performance. This renders sex, drugs, and food acceptable, while revealing how these contested activities fit within this woman’s life world. It also points to the limits of health models that interpret such behaviors through a moral or strictly biomedical lens.

Everyday/Lay Model

The women’s decisions to adopt lay health practices were influenced by the severity of the specific issue as well as the range of their health-related expertise. The ways they have been treated in health care settings also played a key role in structuring their health-related behaviors. Their encounters with health professionals were described as traumatic, stigmatizing events that sometimes involved being denied needed health care (Orchard et al., 2018). Determining how to reduce the prospect of these degrading experiences occupied a central place in the women’s everyday health practices. This was particularly true with injuries or infections stemming from intravenous drug use. As this participant relayed, “I don’t tell why or what

happened . . . They would not serve me. They would call me a junky and turn me away.” Another woman created a fictitious story about a drug-related infection when she had to seek medical attention, which was an attempt to deflect stigmatizing treatment and hide the fact that she had relapsed, which can amplify feelings of failure and guilt related to drug use:

I didn’t tell them I was a sex worker. I didn’t tell them that I took drugs from a needle . . . I administered my own health but did it wrong. It turned gangrene so when I went to the hospital . . . I told them that I was running and fell by the train tracks and a stick went into my hand . . . I didn’t want to [tell them it was a needle], cause my file said drug addiction. I didn’t want anybody to know I had had a fall out.

Other participants refused dominant care approaches altogether, particularly those that involved mental health and addictions. Having been failed in the past by such services or offered programs that fell short of what they needed, they chose to rely on their own resources to make sense of the trauma and pain they have experienced. Part of this involved saying “no” to counseling and addiction programs. For this participant, dredging up childhood abuse seemed futile because none of it can be changed, and she has devised her own way of dealing with it. From her perspective, she just needed a little extra time to heal:

Why go [to counselling]? I have never told one fucking person about my whole fucking life. The past is the past it can’t be changed, like, I can’t blame everything on because my mother was a drunk, I watched her. I watched her men when she was passed out, I can’t change none of that. You leave it alone. I know what happened to me and . . . I know what I gotta do . . . It’s just taken me a little longer to get past all that.

Another woman spoke about having the capacity to address her addictions and wanting to do so at a more comfortable pace than what is offered at outpatient programs: “I did the outpatient program . . . To this day I don’t want to go to no treatment place. I know what I need to do, I know what I have to do and I’m doing it slowly.” Although these acts of resistance could amplify their health challenges, they illuminate the women’s agential decisions to employ their own insights and expertise to take care of themselves.

Participants discussed other health management strategies that were informed by lived experiences, inherited knowledge, and pragmatic options for attending to what ailed them: “We [women on the street] fix our own boo-boos. We fix our own cuts and sores. We use tape or glue or whatever to seal up a cut or wound. You do it yourself.” This same woman shared a home remedy she and her friends use to treat abscesses: “We figure out how to do it. With tea bags . . . The tea bags, you put on the abscess and

it draws it out to the surface. It’s called a poultice.” A poultice is a moist mass of material pressed onto the body to relieve soreness and inflammation that has been employed throughout the world for centuries, and tea has been long used for wound care (Budd, 2011; Srivastata, Shankar & Gupta, 2010). Although the source of this knowledge is unknown, it is transmitted among the women (“we fix,” “we use,” “we figure out”) and may also be passed down through families. Such home remedies constituted a fascinating aspect of their self-care toolkit and reflect the breadth of their lay health knowledge.

Another woman in our study adopted a home-based approach to abscess care that involved using medical information gleaned from media sources in conjunction with her preexisting health knowledge. In this detailed discussion, she is positioned as a competent self-practitioner who hastened the healing time (i.e., overnight vs. up to 3 days) and cleared up the abscess without incident:

I heard doctors on tv saying if you have pus in your mouth you might want to look at it immediately . . . Instead of doing salt water, because that’s a process, you know: gargle, gargle, gargle . . . It can take up to three days. I sterilized a needle and went ‘boop’, and I popped it. God did it stink. I got pieces of rock salt, people use it now for a digestive. I took a piece of rock salt, I knew it was going to burn like a mother, but I did it anyway . . . I did that three times, in thirty second intervals. Next morning, I woke up and all that puss was gone. It was just a little small opening from the abscess.

In the quote below, another participant discussed doubling-up doses of food, water, and physical activity to mitigate the detrimental effects of crystal methamphetamine on her body, which she spoke about as something natural (i.e., “start to grow”), a concealed space (“in there”), and something that determines her survival (“on the health”):

The doctor said: “It doesn’t have to be the twenty hits of crack that you did, when that one decides to hit then you are gone.” She didn’t mean OD, drop dead, she meant on the health, because everything goes through the liver. So, when [I] put junk in my body I get so scared . . . I have put double to triple good stuff in there. Like I’ll drink eight to twelve glasses of water, I do two yogurts that day, I’ll do two apples, two oranges. And . . . I constantly go go go I walk walk walk, I make myself sweat, sweat sweat it out as fast I put it in there. I don’t want nothing to start to grow ‘cause poison loves poison. If you figure you put crystal meth in your body that’s straight up poison.

Unlike the woman above who reframed sex, drugs, and food as part of her health model by emphasizing how they are ingested and performed, this participant flagged drugs as a fertile poison that are in competition with the restorative effects of sanctioned health-promoting behaviors.

This narrative does not include self-judgment about doing drugs, yet it is intertwined with a moral sensibility in terms of highlighting evil versus good or healthy forces. Given her doctor's insights that it may not be an overdose that takes her life but the impact of drug use on her body or vital organs (i.e., the liver), her vigorous uptake of eating fruit, drinking water, and walking makes complete sense. In essence, this woman is taking care of "the health" by following prescribed biomedical advice while ensuring a place for the drugs she desires or needs in her everyday life.

This final example evokes a sense of mystery regarding one woman's acquisition of the HCV. It featured biomedicine, not as an exclusionary force but rather as a system of recognized technical expertise and social authority that was used to substantiate one participant's etiological narrative. Although the information about the root of her infection was somewhat implausible, it was part of the therapeutic pluralism she was enacting:

I said to myself "well you don't do needles," 'cause I did one needle when I was fifteen and they didn't find the hepatitis till eleven years ago . . . And I went "no way, there's no way I could have possibly caught it from that needle when I was fifteen." Doctor X did take eleven tubes of blood and goes to Toronto and it sits in a machine for two to three weeks. And they can tell you how long you have had the virus and what level it was at. I went back to see him, and he said, "So you have had that virus for over thirty years."

This participant strategically deployed the evidence of biomedical authority to evade moral judgments about an illness often associated with drug use in the street-based culture and sex work scene of which she is a part. The doctor's assessment of the temporality of her hepatitis C (contracted more than 30 years ago) is consistent with a personal narrative that resists blame for a stigmatized diagnosis.

Discussion

Women in street-based sex work in Canada and most other countries experience high levels of unmet health needs (Goldenberg et al., 2013; Knight, 2015; Krusi et al., 2014; Sanders et al., 2017; Shannon et al., 2015). Despite the abundant qualitative research conducted on this issue, few studies explore how these individuals think about and practice health. We addressed this research gap by examining how a convenience sample of women in street-based sex work in Kitchener-Waterloo, Ontario, constructed and operationalized health in their everyday lives. In this context, health is understood in pluralistic terms and includes biomedical, neoliberal, and lay knowledge. The conditions that determine which health model to employ oscillate according to participants' life histories, experiences

with the Canadian health care system, and their desires to take care of themselves. Health also emerged as a performative expression of agency, subjectivity, and localized knowledge, findings that contribute new insights to the growing field of sex work scholarship. The study results also enrich the anthropological and sociological research that explores lay or folk meanings of health, which rarely include the insights of women in sex work.

When discussing how they "do" health, participants described behaviors that reflect dominant neoliberal ideas about being active and partaking in individual pursuits that improve their physical condition, minimize risk, and avoid morally questionable activities. They also highlight the importance of following medical advice and surveilling their health to prevent disease. The women are affected by neoliberal notions of well-being and governance that are beyond their control to fully achieve, yet they often implied that they are responsible for their health (Ayo, 2012; Korp, 2010; Polzer & Power, 2016). This is a clear illustration of symbolic violence (Bourdieu, 1977) and the ways in which subordinated populations often "misrecognize" the structural inequities that shape their marginalization as the natural order of things and blame themselves for their compromised health and social status. This intimate form of violence is reproduced in the women's encounters with hospital and clinic staff, who have called them "junkies" or "drug-seeking" when they try to access drug use and mental health services (Bourgois & Schonberg, 2009; Dewey & St. Germain, 2017). These interactions made them feel ashamed, reinforced their mistrust of health care systems, and often compromised their health (Harris, Richardson, Frasso, & Anderson, 2018; Treloar & Rhodes, 2009). Such experiences also influenced our participants' decisions to employ lay practices to subvert or evade the inequitable power relations that structure health care settings and deprive them of their capacity to represent themselves with integrity (Beneduce, 2015; Bowen & Bungay, 2016; Ning, 2005). Using medical references, knowledge, and authoritative figures to substantiate their lay etiological narratives was another technique the women used to deflect stigma and blame associated with health conditions related to injection drug use and/or street-based sex work.

Although our participants' lay health practices were often used to avoid exclusionary treatment in health care settings, the agency and knowledge transmission among the women reflected in these acts of resistance are important to acknowledge. This recognition corresponds with Schutz's (1955) contention that although elements of daily life praxis are often oriented toward dominant ideologies and practices, they are not always dominated by them. These findings also align with feminist health research that demonstrates the subtleties involved in women's relationships with dominant medical systems and their own

experiential knowledge, which often exist in versus full opposition in relation with one another (Deveaux, 1994; Kaufert, 1998; Martin, 1987; Rapp, 1999).

Anthropological and sociological research into the meanings and functions of health among different socio-cultural groups reveals its multivocality as a symbol of life well-lived (Hunt, 1998; Jensen, 2013), socioeconomic change (Banks et al., 2016; Brodwin, 1996; Scheper-Hughes, 1992), and something created from multiple knowledge and healing systems (Badone, 2008; Broom et al., 2013). Our participants likewise viewed health in multivocal terms, including drug use, which was not always seen as a “bad” activity. Indeed, many women wove this facet of life into their emic health models, which makes sense because maintaining drug use can be an essential health-seeking strategy to avoid withdrawal symptoms and cope with life’s many challenges (Bourgois & Schonberg, 2009). Unlike comparative studies among sex workers in South Asia where health is described in relational terms (Basnyat, 2015; Dasgupta, 2013; Kaufman et al., 2016; Rivers-Moore, 2010; Yu Yeon, 2013), our participants did not position health as essential to the fulfillment of social or familial obligations.

In the women’s discussions of their complex emic health models, balance and capacity emerged as two particularly important attributes not previously highlighted together in the social science literature about health or sex work. Balance was repeatedly evoked in the women’s discussions about their use of biomedical and lay health systems, which did not exist necessarily in opposition to one another but were evaluated and used in tandem. Indeed, many participants employed aspects of biomedical authority to substantiate their experiential health knowledge. Balance was also reflected in the women’s emic reasoning about the relationship between their bodies and the outside world, restoring bodily equilibrium, and including competing approaches to well-being in their health behaviors (i.e., drug use *and* doubled-up doses of fruit). Capacity was demonstrated in their diverse health knowledge, decision-making processes, and performance of health. The way the women talked about health is part of their everyday praxis, which is also the medium through which their health narrative etiologies emerged. In telling us how they practiced health, our participants relayed not only how they do health, they were simultaneously engaged in the subjective work of making themselves known as women with valid health knowledge and the competency required to care for themselves (Turner, 1987).

Conclusion

Our findings add to the growing body of qualitative research that demonstrates how structural and everyday factors shape health experiences among women in

street-based sex work and highlight the need for health services that align with their lived realities. Incorporating the women’s pluralistic understandings of health into service delivery practices is essential to help make their health experiences more positive. Community services could offer courses about safer intravenous drug use practices and abscess care, which were key sites of the women’s degrading experiences with health care systems (Benoit, Jansson, Smith, & Flagg, 2018). Another recommendation is to support collaborations with hospital, clinical, outreach staff, and women in street settings in the design of nonstigmatizing health provision in mainstream health settings. Drug treatment programs could be longer than the prescribed 30 days, made available in community settings as well as treatment facilities, and offer peer-based employment options. Creating health education programs designed with and for sex workers is an additional suggestion. These initiatives can enhance community empowerment and provide transformative learning opportunities for women (and others) to reshape their personal health practices and help improve access to health and social services within the local community.

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