Governance and Empowerment in Clinical Encounters:
An Ethnography of Toronto's Sexual Health Landscape

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Abstract

This dissertation is an ethnography of the clinic. My fieldsite was a sexual health organization, comprised of what I call The Centre and The Mobile. Created in the 1970s, The Centre was a pioneering force in the history of sexual health care and the women's health movement in Toronto, Ontario, Canada. This organization was created by and for immigrant women with the goal of providing free and accessible sexual health care. However, providing sexual health care to these populations in Canada's public health care system needs to be understood in terms of the increasing emphasis placed on the managerial tasks of reporting as a form of accountability.

I use the conceptual framework of sexual health governance to examine the delivery of sexual health care in Toronto. Sexual health governance is an assemblage of institutions, social actors, and expert knowledge, which regulates, counts, and fosters sexual health via technologies of care, surveillance, and metrics. In this dissertation, I ask: How is the sexual health landscape organized, and how does the sexual health governance shape everyday practices and experiences of care? I carried out participant observation in The Mobile and The Centre. I interviewed an array of sexual health social actors, including counsellors, physicians, administrative staff, executive directors, volunteers, sexual health promoters, and clients.

In this dissertation, I argue that both The Centre and The Mobile were a part of, and were shaped by, sexual health governance. While their funding requirements meant they had to carefully manage their metric data (counting clients and services), they also remained productive spaces for meaningful forms of care. I argue that sexual health social actors were invested in biomedicine while also seeking to do it *differently* via valuing choice, bodily autonomy, and agency. Clients, too, exercised agency-within-compliance as they accessed sexual health care, both desiring biomedical information and care while also challenging it, revealing nuance in the operations of neoliberal disciplinary power. This is a dissertation about entanglements—highlighting the tension between care and surveillance, empowerment and governance—through an ethnographic study of sexual health clinical encounters and the meaning this held for the landscape's social actors.

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Prologue

The first time I attend a mobile clinic in the spring of 2018, I meet the team on site. I take the subway to a large and long brown building, a combination of a high school and adult learning centre. I walk around the building to try to figure out where they will park the bus. In the teachers' parking lot, I spot a set of orange pylons sectioning off a few spaces; I correctly guess this is where the mobile clinic will be held. When I see The Mobile pull into the parking lot, with Donna at the wheel and another woman in the passenger seat, I am struck by its size.[1] Large black and pink writing covers the side with the name of the organization and Toronto Public Health's logo. In fact, the bus is so big that I wonder how they will park it among the other vehicles. Donna opens her window and calls out to me, "We're going to go around the building to turn around; can you move the parking cones for us?" I oblige and watch her expertly manoeuvre the bus, disappearing around a corner only to reappear less than a minute later.

Once The Mobile is parked, Donna waves at me and offers a broad smile. A door located halfway down the side of the bus opens, and a small set of stairs emerges from under the large Winnebago, where Donna and Aaliyah exit the bus a few moments later. While I have met Donna previously at The Centre (once during an initial meeting with the administrative coordinator and once during an interview), I am meeting Aaliyah for the first time. She greets me warmly. Instead of climbing aboard the bus, we all go inside the school to let the office (and Donna's contact) know we have arrived and to remind them about the morning announcements. It is clear to me, even on this first day, that the school and The Mobile have a close, ongoing relationship.

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[1] In the interest of clarity, I will be referring to the mobile clinic bus as The Mobile. I will also be using the descriptor The Centre when referring to the main sexual health clinic.

After heading back to The Mobile, I meet the volunteer physician for the day, a Canadian-born South Asian woman Dr. Shereen. It is one of her first mobile clinics, so we are in the unique position of taking in the space and place of The Mobile together. The energy aboard the bus is frenzied at first, with everyone setting up their area: pulling out files, setting up label makers, stocking swabs, and handing out pens. This energy is amplified the first couple of trips because I am not familiar enough with the operations of the bus. What looks rushed at first glance is a fine-tuned dance. Everyone knows what their role is—counsellor, doctor, sample tech/coordinator—and they are setting up in a way that holds logic for them. They want to get everything ready before students start to come aboard the bus. Dr. Shereen heads into the back end of the bus, which has been retrofitted to include a separate examination room. I peer around the corner and see a long countertop, cupboards, and an exam table with stirrups. Meanwhile, Aaliyah moves to the front of the bus and sits down in the passenger seat (which can be turned 180 degrees so that it faces a small table and the second-row seat). I sit across from her while Donna is moving around the bus, preparing for the day's clinic. A few minutes later there is a knock at the door, and Donna lets in a young woman. She is passed a clipboard with a few forms to fill out; then, another woman enters Aaliyah's improvised counselling space. Just as a third woman comes aboard, the first woman finishes her forms and hands them back to Donna. I soon learn the importance of being aware of the space you are occupying when The Mobile is open for business.

As I stand in the bus, I learn there is a delicate choreography the team must perform to keep things moving, to see the clients, to perform the tests and safeguard the specimens, and to ensure they meet their quota. Once the forms are filled out, clients enter the front of the bus to be counselled by Aaliyah; this includes reviewing their patient history and their reason for coming aboard (such as a Pap smear, testing, or birth control). After they are finished talking, the client exits the room through a sliding door to sit on one of the booth-like seats until the doctor is ready. Dr. Shereen calls them to the examination room through another set of sliding doors on the opposite side of the bus. With every new patient, I move from seat to seat to accommodate them. I watch Donna carefully as she organizes the long laminate counter with equipment for the day, ticking off the services that have been performed on a tracking form securely fastened to a clipboard.

Aaliyah understands the mobile clinic and outreach work done through The Centre as valuable, having given numerous workshops and displays at multiple locations. In order to illustrate the legitimacy of The Mobile, she cites a decrease in both sexually transmitted infections (STIs) and teen pregnancies among The Mobile's clients. This conversation continues later in the shift to include Donna and Dr. Shereen. I learn The Mobile has a quota. They need to see at least ten clients to make the trip with the large Winnebago worth its expense, although 15 is preferred. From our conversation, it is clear that The Mobile team understands their purpose as providing sexual health care to immigrant and marginalized communities. What is also clear is the role that funding and counting also play aboard The Mobile, as their funding comes with specific requirements.

These first few mobiles, I sit on one of the bucket seats, trying to take the whole space in. Behind me hangs a blown-up newspaper story from a decade ago, fastened to the wall of the bus between the top of the seat and the cupboard. All areas of The Mobile (partitioned into three distinct areas: exam room, counsellor's office, and waiting area/admin) hold materials, objects, and technologies that are easily recognizable as being there to support the provision of sexual health care (Pap smear kits, swabs, sample bags, clipboard, printer, label maker, lube packets, condoms, varying sizes of plastic speculums), but there are other things which draw my attention over the coming months: a sticky note with the pronunciation of a translator's name; a calendar several months behind; weathered sexual health posters; a piece of paper with the names and numbers of physicians (some from past years, and some pencilled in to reflect new doctors). Even the style of the furnishings speaks to how long The Mobile had been in circulation, in a way that gives the space character.

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I offer this opening vignette to give the reader a sense of what it was like to be aboard The Mobile, how the staff were invested in biomedical sexual health care, while also desiring to see it done differently by remaining committed to their feminist roots. As I spent almost 14 months travelling with The Mobile (March 2018–May 2019), through space and time, its origins and history were omnipresent. If I were to chart the locations we went to, it would show the bus zig-zagging across the Greater Toronto Area (GTA) to churches, shelters, schools, and settlement organizations. At each location, Donna would introduce me as a "York University anthropology student doing her PhD," who wanted to learn more about The Mobile and sexual health services in Toronto. In turn, she would introduce her contacts, their names, and their occupations, while also hinting at the history of their relationships: "We've been coming here for years" or "They have been supportive of the work we do for a long time."

Being on The Mobile provided a real and tangible sense of its history—how it operated, and how it had operated in the past—and for this reason, I understand it as a travelling symbol of the women's health movement in Canada. While modern in its current design to provide sexual health care services, it was also a time capsule of the past. The Mobile had been created by and for immigrant women in the 1980s in an effort to make sexual health care portable, and as such, it was a part of the larger feminist health movement, which demanded equitable and accessible care for women. I noted not only the physicality of the bus but also the relations aboard it. Donna and Aaliyah would frequently engage in storytelling practices about The Mobile's history. Often, the clients coming aboard had heard of The Mobile or had attended it in the past. The spaces and places we went aboard the large bus served as a reminder of its origins. The Mobile—a service and space created *by* a collective of immigrant women and *for* immigrant women—continued that legacy of work by heading to spaces where people may not have access to free, private sexual health care or could not make the trip to the main clinic, as The Centre's high demand often meant wait times. Additionally, it was the *kind of* care provided aboard the bus that drew in its clients: language translation, confidentiality, encouragement from the community, and culturally sensitive care.

In addition to being a space for storytelling and care, the bus was also rife with documentary practices of (ac)counting. Organizing a mobile clinic for a given community is not simply the act of travelling to the location and giving free services; it requires planning, coordination, safety measures, networking, and record-keeping. I saw in practice the contingencies involved in providing and accessing sexual health care, while at the same time not fully understanding how they fit within the larger system. It was not until I began looking at the sexual health care system of Toronto through the lens of care and surveillance that I understood the crucial role of the label maker, the sign-up sheet, the specimen cooler, or the counting of clients to meet the quota, but it was something I learned over the course of 14 months of fieldwork. Through ethnographic research, I would not only become familiar with these objects and processes but would also come to actively participate in their maintenance as my role shifted from that of observer to team member.

Introduction

"Ethnographic sitting, and the mindful perception and listening it fosters, is part of anthropological practice. Ethnography is both a mode of attentiveness and openness to being taken off course" (Pigg 2013, 132)

Introduction

This is an ethnography of a clinic. The sexual health care system of Toronto, Ontario, was my ethnographic fieldsite, and the mobile clinic I have just described in the prologue was one its nodes; its permanent counterpart was a home base sexual health clinic, I call The Centre. During my fieldwork, over the course of 14 months, I was interested in the vital role of both care and surveillance in a single sexual health organization. My dissertation offers an analysis of the sexual health care system through fieldwork centred on a community-based organization, comprised of The Centre and The Mobile, an organization which was created by immigrant women, and with their needs in mind. In this dissertation, I talk about health care and the concept of care as distinct but also overlapping. Health care includes the clinical services provided within institutional sites, the practices present in my fieldwork which include counselling, STI testing, pap smear exams, and contraceptive sales. I am also thinking about the provision of care through a theoretical lens; care as a concept refers to ideas and practices that are intended as interventions into how health care is organized and delivered, encompassing a particular logic and ethic that is intended to impact not just biomedical bodies but to intervene upon health care itself. My ethnography of a clinic understands both The Centre and The Mobile to be cultural sites, ones in which biomedical truths had been constructed alongside a commitment to the feminist health movement and its values since the 1970s. By spending time with counsellors, physicians, executive directors who staffed the clinic, and the clients who attended it, my goal was to create a narrative which does not shy away from the empowering, regulating, joyful, contradictory, and distressing aspects of providing and receiving sexual health care.

I began my fieldwork in October, 2017. This project was born out of my lasting interest in women's sexual health as well as my past experiences conducting ethnographic research with newcomer communities. It was the frequent and ever-present tensions within sexual health that captured and held my attention, tensions that medical anthropology and ethnography are in a unique position to attend to with nuanced care. While I was doing fieldwork "at home," this did not mean that the spaces I was able to access were readily intelligible. In fact, the further along I got with fieldwork, the more I realized how little I knew about the health care system and how sexual health care services were positioned within it. I had planned to conduct participant observation at multiple organizations that offered a range of clinical services and educational programming. The first space I was granted access to, after several months of failed attempts, was The Mobile. The Mobile, first launched in the 1980s was a mobile health unit, a retrofitted Winnebago that offered sexual health services, such as cervical cancer screening, birth control counselling, and testing for sexually transmitted infections among other things. It was a key service of a long-standing sexual health organization in Toronto, which sought to serve immigrant women in the community. Even as I pursued building relationships with other organizations, conducting an ethnography of a single organization, focusing on the women who worked there and the women who used its services, became a rich fieldsite. Many of the stories I heard from both those working in the field and those accessing the services of The Mobile brought to the foreground the complexities of what I was trying to capture as the "field of sexual health."

I set out to study immigrant women's experiences of sexual health care in Toronto, and therefore selected a clinic that specialized in this field. The Centre, established in the 1970s, and The Mobile, established in the 1980s, were by a group of immigrant women, who identified specific barriers and a gap in access to sexual health care experienced by other immigrant women living in downtown Toronto. When The Centre was created, it included immigrant women from several regions, including Europe, Africa, South America, and Asia. It was a grassroots collective, which sought to meet the needs of its clients by not only offering language translation, free services to those without OHIP, culturally sensitive care, and low-cost contraception, but also by founding a mobile clinic bus that could reach immigrant women at their job sites. Over the next four decades, their clientele and operations changed. While immigrant and refugee women still made up a large percentage of the clients who came to The Centre and The Mobile, so too did Canadian-born women, international students, and even men. As I began my research, I was drawn to the narrative of this organization, the women who worked towards honouring their commitment to its feminist roots to provide care for immigrant women, and how such a clinic fit with the Canadian universal health care system in Toronto.

Immigration and migration have been the subject of anthropological work which seeks to examine its empowering (challenging the meaning of borders and nation-states) and restricting (historical and contextual power inequities) effects (Castañeda 2010, 6–7). However, even though "immigration" and "migration" are often used interchangeably (Horevitz 2009), they each have their own broad definitions. A "migrant" is generally understood to refer to anyone who has migrated to a new place; this categorization is not dependent on length of time spent, and therefore leaves the definition open in order to capture its dynamic nature (Castañeda 2010).

With the term “immigrant,” there is a sense of permanency and the status indicates that the host nation is the final destination, or in other words the migration is linear (Horevitz 2009, 748).

Within the Canadian context, and specifically in Toronto, immigration has become racialized. This racialization of the immigrant has been addressed in other contexts as well, such as Europe (see Silverstein 2005), understanding the ways in which the category of immigrant has become a racialized category denoting “Otherness.” Therefore, the immigrant has become a racialized subject of the state and healthcare, with race being tied to cultural difference and mobility (Silverstein 2005, 366). Racialization also features in health news coverage in Canada, where the immigrant is described as a racialized Other who poses a threat to public health; this is tied to a long history of racist ideologies which frame racialized communities as the “unhealth Other” (Reitmanova, Gustafson, and Ahmed, 2015). Canada and Toronto present a particularly unique context, where multiculturalism is an official federal policy, popularly understood to encourage and promote cultural diversity. However, anthropologist Eva Mackey (1998) has analyzed multiculturalism as a policy and strategy for managing difference; multiculturalism can be understood as a particular project of nation-building which outwardly promotes inclusion yet works to create racial hierarchies of difference (16). Mackey draws our attention to entanglement of race and culture, how culture has become the “new racism” (21), within a context which divides people into those who have culture and those who do not, with the latter being tied to whiteness. Within my fieldsite, immigration, race, and culture were conflated producing an Othering effect, and racialized immigrants who sought sexual health care both faced barriers to access and experienced increased surveillance as a result when accessing care.

This dissertation provides insights into the relationship between a feminist sexual health organization and the Canadian universal health care system. It also goes beyond the walls of the clinic to examine how those who work within sexual health care, education, and promotion and those who use the services provided by such a system have a complicated and nuanced understanding of their role within the sexual health care landscape. The field is peopled by two groups of interlocutors: sexual health social actors,[1] who either perform paid work or volunteer in the field of sexual health care in Toronto, and clients. These social actors differ greatly in terms of their educational backgrounds, formal expertise and training in sexual health, institutional power connected to their status as paid health care providers, and privilege. In some ways, I draw inspiration from the call by Laura Nader (1972) to "study up," which draws our attention to the importance and potential of conducting ethnographic research with those in a position of power (i.e., experts). And yet there is a reason why I refer to those working in sexual health care as social actors and not experts. While I do envision my project as one of studying those in a position of authority, at the same time, I wish to complicate a rigid binary between the clients who attended the clinic for services and those women (who were also predominantly immigrants or second generation) who worked within the clinic's walls. By attending to a wide variety of sexual health social actors, those who hold post-secondary degrees and other credentials (who performed paid work), as well as those who are beginning their journey of working in the sexual health care landscape by volunteering their time to gain experience, this category seeks to address how their backgrounds and positionings shape their approach to providing this kind of care and education in Toronto.

The sexual health landscape is comprised of social actors, clients, care services, and sexual health care objects and spaces. Such a landscape allows us to think about the ways in

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[1] Sexual health clinic staff were not required to have any specific education related to sexual health but were expected to complete training on-site; the same went for volunteers.

which sexual health care and surveillance are organized both conceptually and spatially. Meanwhile, I use the term "sexual health governance" to refer to an assemblage of institutions, social actors, and expert knowledge, which regulates, counts, and fosters sexual health through technologies of care, surveillance, and metrics. Here, governance operates through this assemblage within the sexual health landscape with the goal of optimizing sexual health. I will argue that both care and surveillance are integral and inseparable within the space of the clinic. In a Foucauldian sense (1984, 2003), care and surveillance can be understood to be the same thing—they are part and parcel of each other, wherein to care is to surveil and to surveil is to care. Conceptualizing them as inseparable enables an analysis of the operations of disciplinary power via sexual health governance. However, there are points in this dissertation where I separate the two, and this is done for two reasons: to explain the nuances in their multiple forms, and to describe the practicalities of providing care and conducting surveillance activities in the clinic.

In the remainder of this chapter, I will introduce two central tensions and substantive claims I make in this dissertation, along with my research questions and key findings. This will be followed by detailing my research focus and the key concepts I utilize in my analysis: care, surveillance, metrics, and sexual health. Finally, I provide an outline of how the dissertation will unfold by detailing the focus of each subsequent chapter and emphasizing this dissertation's contributions to the field of medical anthropology and studies of sexual health.

Research Questions

Two central tensions were identified in conducting ethnographic research within the field of sexual health care, and I will introduce them via my first two key research questions. My first question is: How does sexual health governance shape everyday practices and experiences of care? There is the relationship between numbers and stories, the tension between care and metrics. The purpose of The Centre and The Mobile was to provide sexual health care services. These spaces were a part of the legacy of the women's health movement in Canada, demanding accessible, equitable, and respectful care. As such, these clinics were spaces of storytelling, where sexual health social actors negotiated the subtleties of requesting and providing care beyond biomedical diagnosis, prevention, and treatment. However, to maintain funding for such a clinic, attending to metrics was a requirement. Numbers and stories have historically been placed in opposition, understanding the stories of health being obscured via their translation into numbers. However, numbers also tell stories, and their construction is a social process which shapes the practices of the clinic.

In this dissertation, I use sexual health governance as a concept to analyze how sexual health care is organized and governed in Toronto, including the ways in which it shaped the everyday practices of The Centre and The Mobile, and the way it acted on the bodies of clients who sought the services of The Centre and The Mobile. Sexual health governance can be understood as an assemblage of institutions, social actors, and expert knowledge, which regulates, counts, and fosters sexual health via technologies of care, surveillance, and metrics. This theoretical framework draws on two concepts of governmentality (Foucault 1991; Li 2007) and biopower (Foucault 1990), which should be understood not as separate but representative of the evolution of Foucault's analytical thinking about life and the ways in which it is governed. I will use them to analyze the "how" of governance, the diverse set of techniques, social actors, and institutions which seek to govern the welfare of the population. The governance of sexual health operates through disciplinary power, inciting the desire to self-manage one's sexual health in accordance with expert knowledge as well as the fostering of the population's sexual health.

The second tension emerges through my second question: What is the relationship between a working model of sexual health and the sexual health landscape? The sexual health landscape is a figurative metaphor for analyzing the assemblage of social actors, institutions, and expert knowledge, which aim to foster, optimize, and/or regulate sexual health in Toronto. In Chapter 4, I address how the circulation of information and values identified by such an assemblage are both invested in the project of biomedicine, while also striving to do it *differently* (see Murphy 2012). This working model of sexual health values biomedically informed sex education and access to biomedical technologies, while also desiring it to be done in alignment with feminist values of choice, empowerment, and equity. This working model is malleable, revealing how community-based organizations grapple with taking them up; they also operate via sexual health governance to produce particular kinds of subjects: those who are educated, self-managing, and responsible choice-makers. However, I reveal how clients exercised agency even as they navigated and embraced such subjectivities.

My final research question is: How do sexual health social actors comply with, resist, and strategically take up technologies of care, surveillance, and metrics? In Chapters 5 and 6, I develop the concepts of protocol care and exceptional care to analyze and contextualize the practices of sexual health care within The Centre and aboard The Mobile. Protocol care includes routine sexual health care services, such as annual Pap smear exams, refilling of contraceptive prescriptions, or regular STI testing. At the same time, protocol care is about the routine administrative protocols of the clinic to make care "count" in the eyes of regulators and funders by carefully filling out paperwork, reviewing client files, and accessing reports. Exceptional care refers to the kinds of care performed by staff in response to clients' emergent sexual health issues, such as STI testing after unprotected sex, or investigating troubling symptoms. While exceptional care almost always entails some form of protocol care (as, in order to perform sexual health services, clinical protocols must be followed), staff also engage in practices of active listening, creative problem-solving, and other forms of caring, which take time and skills but which are not easily counted in official reports. In my formulation of these concepts, protocol care and exceptional care are not opposites but contain the ambiguity of care. In Chapter 6, I attend to the ways in which protocol and exceptional care operated similarly yet uniquely aboard the large Winnebago by framing both as central to the staff's efforts to cultivate capacity, by which I mean to ensure their ability to continue providing biomedically informed and accessible services across the GTA.

Research Focus and Key Concepts

For the purposes of my fieldwork "the clinic" represents a bounded and boundless space,[2] an institution, and an ideology. What does anthropology have to offer when critically engaging with spaces where biomedicine is practiced and public health advice is dispensed? Emily Martin asked over two decades ago, "[w]hat might a cultural anthropological study of Western science look like?" (1998, 24). Using the metaphor of the citadel, Martin describes how science has been portrayed as ahistorical, wherein scientists "claim to construct reality but not to be themselves constructed" (26). I follow her critique of science into the realm of sexual health services as they are delivered and made meaningful by the social actors who staff these organizations and the clients who receive their services. By starting from a place where sexual health social actors and clients are situated humans and not simply neutral ahistorical workers and "rational" subjects respectively, I am in a better position to analyze the sociality of the clinic.

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[2] By this I mean the clinic can be defined in terms of the services performed, supplies required, and staff knowledge, while also pointing to the ways in which the clinic is an idea, a site which extends beyond the physical space and follows clients and staff in their daily lives. It is both a health care setting and a locus of politics and morality.

As Sameena Mulla points out in the introduction to her ethnography on sexual assault intervention in the United States, anthropology does not claim to have all the answers. By arguing "[h]uman life is too complex and varied to be easily reduced, and thus the most effective ethnographies recognize these complexities by leaving some things unanalyzed" (2014, 16), Mulla highlights how anthropology is not about finding final solutions. I choose to foray into the "empirical mess" of ethnography (Krebbekx 2019, 4). In doing so, I will attend not only to the tensions I found in analyzing the provision of sexual health care but also to how sexual health social actors and clients believed in the project of sexual health, envisioning it done in a way that made sense in their lives. There are no simple or easy answers, but the stakes are high. In this dissertation, I will analyze The Centre, The Mobile, and the operations of the sexual health landscape, highlighting conflicting narratives and zooming in on how my interlocutors discussed and experienced sexual health care by attending to their storied realities (Madden 2010). In doing so, in examining the subtle nuances of their stories as they made sense of their role in the sexual health landscape, I seek to illustrate how ethnographic research methods offer something different for projects of health care.

Surveillance goes wherever care goes, collecting and compiling statistical information in the form of metrics; this was done within The Centre and forwarded to Toronto Public Health on a quarterly basis as a part of their funding requirements. I understand care to not only be the clinical services performed aboard The Mobile or in The Centre, things that are transformed into numbers via practices of (ac)counting, but also as a theoretical concept. The concept of care will require unpacking, for what it meant to those working in this field, and for its significance to the clients who were seeking to engage in self-care to support their sexual health. To define care, we must look at care in context. Care is multiple, it is a practice, a process, and a moral object (see

Garcia 2010; Mulla 2014; Yates-Doerr 2012; Ticktin 2011; Mol, Moser and Pols 2010; Livingston 2012; McKay 2018; Tronto 1993). Caring can "be viewed as a *species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible.* That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web" (Tronto 1993, 103). Thinking theoretically about care includes recognizing the ways in which care work has been historically marginalized, emphasizing its multiplicities as personal and universal, as political and personal.

I understand the provision of sexual health care services, such as routine Pap smears, STI testing, and writing birth control prescriptions, to be twofold: the engagement of sexual health social actors in biomedical practices (performing testing, recording client symptoms, diagnosing, and recommending treatment options) and caring practices (showing empathy for difficult situations, listening to client stories, offering resources, and alternative problem-solving). However, I understand these kinds of care as not mutually exclusive but rather existing in the same space and often overlapping. The clinic clerk can withdraw blood (a part of performing testing for HIV or gonorrhea), while also offering comfort. A physician can perform a Pap smear while also being sensitive to a client's past trauma. Building on this framing of sexual health care in the clinic, the provision of care necessitates particular documentary practices of surveillance, monitoring, and recording. Through conducting participant observation via volunteering in both The Centre and aboard The Mobile, I saw how carefully translating the care services provided into countable numbers (how many clients were seen, how many first-time Pap smears were performed, how many IUDs and IUSs were inserted) was crucial to complying with the requirement of their funder (Toronto Public Health) and maintaining their ability to continue providing care services in the future.

Finally, before I outline the organization of the dissertation, I must unpack the term "sexual health"; this will include an official definition, how my interlocutors understood it, and my own understanding of sexual health as a medical anthropologist. Sexual health has been defined by the World Health Organization (WHO) as

> a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO 2006, 5)

I present this official definition as a baseline for thinking about how a global, biomedically oriented organization in a position of authority defines sexual health. Many of the people I met in the field (including counsellors, physicians, executive directors, volunteers, and clients) expressed a similar definition, emphasizing the need to undergo regular tests for STIs and routine Pap smears, but also being confident in one's body and sexuality. Toronto Public Health (TPH) understands sexual health within a health promotion framework, as a form of health which requires access to correct or "expert" information. As an institution, TPH envisions sexual health as something to be addressed at the individual, community, and population level; value is placed on the circulation and accessibility of information, which can take multiple formats, such as workshops, pamphlets, consultations, and training sessions (see Toronto Public Health 2021a, 2021b, 2021c). However, regardless of the form, TPH's definition of sexual health can be understood as invested in the production of particular kinds of subjects who (a) seek out resources, (b) educate themselves using said resources, and (c) incorporate the knowledge they gain into their sexual health beliefs and practices. The expert knowledge provided by TPH touches on the biomedical (STI/HIV prevention, birth control, reproductive health) and the interpersonal (gender, sexuality, pleasure, and relationships). Additionally, TPH has historically been committed to providing sexual health promotion for ethno-cultural-linguistic communities; for example, the Raising Sexually Healthy Children program has been operational since 1998, working through community partnerships and addressing the challenges of sex education between parents and youth.

The Centre and The Mobile also understood the provision of sexual health information to their clients as important and placed value on empowerment, compassion, choice, safety, cultural sensitivity, and accessibility in the provision of care. Sexual health was also understood as being embedded in health care and the space of the clinic, as both biomedical and feminist, and as specialized. In this dissertation, I understand sexual health as a feminist clinical project, one that understands sex as a moral object (Pigg and Adams 2005). It is politicized as a form of empowerment, and yet it is firmly embedded in biomedical authority. Sexual health demands clinical practices (testing, treatment, prevention) in fostering sexual health in the general population, yet it is also squarely positioned as a personal, embodied experience. To build on this point, feminist sexual health models promote bodily autonomy and liberation through knowledge, while at the same time seeking to produce particular kinds of subjects, those who are responsibilized and self-managing choice-makers. Insofar as sexual health is both technical and liberating, I have observed how it is emblematic of Rose, O'Malley, and Valverde's statement that even though governance operates in our daily lives, this doesn't mean that it operates to control completely. Therefore, I define sexual health as a flexible project, which constantly shifts between poles of governance and liberation, reflecting the continuous negotiations between empowerment and expert authority that are taken up by clients, counsellors, executive directors, physicians, and volunteers.

Sexual health care responds to crises, following protocols, providing outreach, and engaging in practices of (ac)counting, involving the provision of health care services but also *caring* for women's sexual health. Here, to understand the kind of work done by the clinic where I conducted fieldwork, I draw on Murphy's (2012) metaphor of *seizing* the means of reproduction, wherein feminist self-help clinics in the 1970s took up the kinds of technoscience involved in providing reproductive health care and engaged in the sharing of knowledge and care practices. I argue The Mobile actively engaged in what I call *cultivating capacity*, wherein a group of women formed a community, based on the Boston Women's Collective, to provide sexual health care by and primarily for immigrant women (although they did not turn away Canadian-born women). To do so, they worked with the health care system of Toronto in order to garner funding, effectively cultivating their own capacity to provide foster women's sexual health via biomedical services, education related to patient's rights, and feminist acts of caring.

The Mobile and The Centre were originally created to fill what they saw as a care gap by providing access to sexual health care for immigrant women in downtown Toronto. It began as a collective of immigrant women *caring for* immigrant women, focusing on the provision of Pap smears, breast exams, and education. Over the following years, The Centre's (and therefore The Mobile's) operations shifted; many of the team members attribute this shift to funding mandates, which directed where they should focus their energy in terms of service provision. Therefore, the way in which The Centre and The Mobile received funded through Public Health has impacted how they provided care and involved a set of accounting practices. The production of metrics have taken on greater importance in the daily working of the clinic; such metrics are produced through practices of (ac)counting and serve to demonstrate where their core funding is going and legitimize their operations within a universal health care system. I draw on Tichenor's definition of metrics, as a "numeric representation that translates assumed realities into numbers" (2020, 1), as it draws attention not only to the multiple forms metrics can take (numbers, indicators, and statistics) but also to how their authority is tied to their ability to be comparable, universal, and replicable. Additionally, metrics do work, they communicate evidence, offer a means of evaluation, and involve practices of both accounting and accountability (see Adams 2016). In my fieldsite, when I refer to metrics, I am speaking about how the women working at The Centre and aboard The Mobile carefully recorded how many clients were seen, how many different types of services were provided, how many birth control packages were bought, and how many IUDs were inserted. This list is not exhaustive, but I want to give a sense of the kinds of metrics that were documented and monitored. Metrics count, indicate, prove, and illustrate within the space of the clinic and Toronto's sexual health landscape.

Outline of Chapters

In the first chapter, *Care, Surveillance, and Metrics: Sexual Health Governance in the Clinic*, I craft a theoretical framework that understands sexual health governance as an assemblage of institutions, social actors, and expert knowledge to regulate, count, and foster sexual health. Drawing upon the concepts of governmentality and biopower, I analyze care, surveillance, and metrics as technologies that support the government of sexual health. Using anthropology, science and technology studies, and feminist literature, I first define each of these concepts in a way that acknowledges their nuanced ambiguity and places them in conversation with one another as being important to the larger project of sexual health governance. I then trace the history of clinical medical anthropology and critical medical anthropology, situating my project as informed by each in how I attend to the daily practices of care, surveillance, and metrics within the clinic, and how they are embedded in larger socio-economic and political concerns. Finally, I use care, surveillance, and metrics to analyze contemporary clinical encounters in key ethnographic texts. In these texts, I identify how the organization and practices of clinics (including multiple sites, interests, and actors) require and result in complex negotiations, as well as interpersonal relationships between care providers and patients.

In the second chapter, *Methods: An Ethnography of the Clinic and the Sexual Health Landscape*, I describe my entry into the fieldsite, providing an account of the research methods I employed as well as some reflections on the process of doing fieldwork. I describe the ethical dilemma I faced in seeking to conduct ethnographic research with immigrant women and how this ultimately resulted in me having to reorient my project. In reflecting on my experience, I also tie this methodological challenge to my central themes of care and surveillance. I then describe how my data was produced through participant observation, ethnographic interviews, and social media tracking. Over the course of 18 months, in both downtown Toronto and the GTA, I spent, on average, two to four days a week conducting participant observation through volunteer work at a sexual health organization, in both their base centre and mobile clinic. The data I produced comes from this volunteer work (i.e., the doing of the work and learning how their system operated); long conversations and short updates with those who worked in the clinic; and ethnographic interviews with individuals, whom I will refer to throughout this dissertation as sexual health social actors. These individuals included counsellors and physicians who provided care in sexual health clinics, executive directors of organizations which provided sexual health care and/or sexual education, sexual health promoters who worked for TPH, volunteers who worked in clinics and in outreach efforts, and clients. I connect my reflections on where my fieldwork “failed” to feminist anthropological literature to examine how positionality is not merely recognizing a set of identities, but is continually interrogating the position from which we conduct research.

In the third chapter, *Health Care and the Women’s Health Movement in Canada,* I set the stage for the reader by introducing my fieldsite: a sexual health clinic in Toronto, Ontario. I begin by providing the mandate of The Centre and The Mobile, how they were formed, and the kind of sexual health care they provided for immigrant women. This historical overview is contextualized by describing the women’s health movement in Canada. I lay out the ways in which health care is organized and funded at the national, provincial, and municipal levels. I then move to define and unpack the complexities of access in relation to health care, acknowledging the overlapping factors that pose barriers, and the ways in which the structure of health care systems is intimately entangled in demonstrating to the reader how the women’s health movement was concerned with women’s access to sexual health care. It is only once I have laid the groundwork for an understanding of the health care system that I can situate sexual health care broadly and temporally, and that I can identify where both The Centre and The Mobile fits within this landscape.

The fourth chapter, *Models of Sexual Health*, focuses on the institutions, social actors, and circulation of expert knowledge across the GTA, which operate to both regulate and foster sexual health through the figurative metaphor of the sexual health landscape. Here, I attend to the organization and careful planning of the landscape and its governance through models of sexual health, which simultaneously value biomedical and empowering approaches to maintaining sexual health. I account for the ways in which sexual health promoters, counsellors, physicians, volunteers, and clients were invested in biomedicine while also challenging it, wanting to imagine how it could be done differently via feminist values of choice, empowerment, and equity. I illustrate how disciplinary power operates through sexual health education to incite clients' desire to self-manage their sexual health, not only in accordance with expert knowledge but in a way that supports a universal health care system. Within this context, I observe the ways in which it mattered to my interlocutors both *how* information was provided and by *whom*. Finally, I examine choice as a neoliberal discourse and a feminist value, which actively support sexual health governance.

The fifth chapter, *Metrification and Feminist Acts of Caring in the Clinic*, focuses on The Centre. I argue that the purpose of The Centre was to provide free, accessible sexual health care, but that due to The Centre's funding relationship with TPH, sexual health social actors and the operations of the clinic also depended on the metrification of care: the translation of care practices into numbers which demonstrated to TPH the legitimacy of the work of the clinic, and which were required to secure continued funding. After I define metrification, I analyze the space and place of The Centre before concentrating on the client files; I argue that the way in which The Centre was structurally organized and the meticulous work of maintaining client files supported the metrification of care. At the same time, by attending to the counselling sessions I sat in on with Aaliyah, I show how not everything that the clinic did can be captured by metrics. Finally, I introduce two original concepts: protocol care and exceptional care. Protocol care entails an analysis of the routine reasons clients came to The Centre and the processes done to support the metrification of care, such as filling out waivers, ticking off services provided, and tracking testing results. Exceptional care allows for a different kind of analysis of the same site. I define exceptional care as care that is provided in response to a client's request for care which is not routine, such as wanting STI testing after learning of an unfaithful partner or recurring bacterial vaginosis. Exceptional care also demonstrates that which is not readily translatable into numbers: the client’s experience and the problem-solving done by the counsellor.

The sixth chapter, *Cultivating Capacity Aboard The Mobile*, ends with where my fieldwork began, as it exclusively focuses on the mobile clinic—a space where I first learned about the provision of sexual health care and The Centre’s feminist history. I understand The Mobile to be a travelling symbol of the women’s health movement, and I argue that its history continues to play a vital role aboard the large bus, as The Mobile team continue to cultivate their capacity to provide free, accessible care within a context that demands evidence of their legitimacy. Given the high operating cost of The Mobile, practices of (ac)counting care were taken seriously. Thus, there was increased pressure to demonstrate how The Mobile *performed* via numbers, and therefore meeting the predetermined quota was on the minds of The Mobile team. I demonstrate the role of metrification aboard The Mobile by first describing the operations of the mobile displays and sign-up sheets. Through fieldwork I learned how such processes and documentation were performed to ensure mobile success. However, I also pay careful attention to other forms of caring aboard the mobile clinic, specifically, how outreach was not only central to its continued operations, built upon long-standing relationships, but encompassing feminist acts of caring in the counsellor and examination rooms. Finally, this chapter understands practices of (ac)counting to be a social process, and outlines how moments aboard The Mobile that could not be turned into numbers were equally important to the continued success of mobile clinics.

The final chapter offers a brief ethnographic vignette, which details the retirement of The Mobile after I left the field. I follow this with a summary of my key research findings, analyses, and arguments. I then outline the theoretical contributions this dissertation makes to medical anthropology, governmentality studies, and feminist scholarship. Finally, I examine the tension between metrics and stories in thinking about future research applications.

Prelude of Dissertation Contributions

My dissertation makes several contributions to medical anthropology, the study of sexual health, biomedicine, and public health as cultural systems. First, I have written an ethnography of a sexual health clinic in Toronto, which is uniquely situated. The Centre and The Mobile were created by a grassroots feminist collective with the goal of providing free, accessible sexual health care to immigrant women. My project details how these clinics' practices, despite their continued commitment to a radical form of sexual health care, had changed over time, and how fostering clients' sexual health had become increasingly institutionalized within a universal health care system. Therefore, I show how sexual health care, both its models and in practice, cannot be divorced from its social and historical context. Through analyzing the role of metrics in relation to funding, I zoom in on the practices of one organization to illustrate the seemingly conflicting qualities of sexual health—empowerment, regulation, autonomy, governance—making room for an analysis which does not seek to pin down a universal understanding of sexual health but rather shows how all these pieces fit together within the same frame.

Throughout this dissertation, I use the terms feminist and feminism in multiple and entangled ways. I recount the history of the women's health movement in order to provide context for the inception of The Centre and The Mobile, which was created by a group of immigrant women determined to create equitable access to sexual health care and information. Therefore I understand the early days of the Centre to have been inspired by feminism. I use the term feminist as an analytic category to critically engage with how feminist values are taken up in the neoliberal project of sexual health care and education; this is done to examine how care becomes individualized and an emphasis is placed on personal choice rather than addressing systemic issues which pose access to barriers to care and information. Finally, I use the term feminist care to describe and analyze the importance of *how* care was provided in The Centre and The Mobile, to explain the presence of a care ethic and commitment to care through the narratives of staff and clients. I use the term feminist care to characterize sexual health social actors' understanding of their work as feminist, as committed to the values of equity, informed choice, bodily autonomy, accessibility, and compassion. Therefore, feminist care also captures their care ethic (Tronto 1993) in their attentiveness to the experiential, women's stories, in the space of the clinic; a commitment which is part of a longer legacy in relation to the women's health movement and the demand for equitable and accessible sexual and reproductive health care. By working within these tensions between different understandings and uses of feminism, I understand this dissertation to be acknowledging the ways in which the work of examining such nuances is never complete. Therefore, my work contributes to anthropological scholarship which attends to the multiplicities of the feminist and feminisms, how it is used by our interlocutors, how we use it as an analytic tool, and as a means to historicize our fieldwork.

This ethnography also contributes to the anthropological study and critique of metrics by examining their importance within a Canadian universal health care system. While collecting metrics was not the focus of The Centre and The Mobile's work in sexual health care, these activities shaped their daily practices within the space of the clinic. Therefore, I attend to the social production of metrics, their contentious place in the clinic, and how they were used strategically. Additionally, while metrics have been criticized for not being able to capture the stories of patients, physicians, clients, and care, I build upon this work to show how metrics can also tell stories of their own. Finally, the figurative metaphor of the landscape allows me to zoom in and out on how sexual health was modelled in Toronto, both spatializing its governance and highlighting the perspectives of sexual health social actors. Here, I contribute to the long legacy of medical anthropologists entering the spaces of the clinic and seeking to understand how social actors actively negotiate care subjectively.

Chapter 1

Care, Surveillance, and Metrics: Sexual Health Governance in the Clinic

In this chapter, I describe my overarching theoretical framework for analyzing the provision of sexual health care, The Centre and The Mobile as sites of sociality and counting, and the concern with fostering sexual health at the individual and population level. Informed by the work of Morgan and Roberts (2012), I use the term "sexual health governance" to capture how an assemblage of institutions, social actors, and expert knowledge aim to regulate and cultivate sexual health via technologies of governance: care, surveillance, and metrics.[1] After defining each of these technologies[2] and how I will use them to analyze the data produced from my ethnographic fieldwork, I move to locate my project within the history of clinical and critical medical anthropology. Finally, I attend to contemporary ethnographies of clinical encounters, drawing connections across multiple sites (the hospital, a detoxification clinic, sexual assault examination rooms, and community programs of maternal activism). In doing so, I use these texts to build an understanding of the clinic as permeable and deeply embedded in socio-economic and political contexts, and to call attention to the complex and emergent relationships between caregivers and their patients.

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[1] While access is an important concept that I draw attention to throughout this dissertation, I understand access to be more than a theoretical concept. As a piece of the story, access is central to contextualizing the creation, operations, and funding of The Centre and The Mobile. Therefore, I will unpack access as an ethnographic object in Chapter 3 by explaining what it meant to my interlocutors as well as the meaning it holds within the feminist health movement in Canada.

[2] Here, I refer to care, surveillance, and metrics as technologies in a Foucauldian sense. Such technologies are central to the relations of power invested in fostering, and regulating sexual health, as they monitor, count, and operate via disciplinary power. Integral to my understanding of neoliberal approaches to sexual health, technologies of the self (see Foucault 1988) involve processes of responsibilization and individualization required in the operations of care, surveillance, and metrics. In Chapter 6, I deepen my analysis of technologies by thinking about The Mobile's sign-up sheet as a technology of metrification.

Sexual Health Governance

This is fundamentally a dissertation about governance, specifically, the governance of sexual health, governance of the clinic, and self-governance. In this section, I use a feminist Foucauldian framework to describe how the governance of women's sexual health will be analyzed by paying close attention to how it is cared for, how it is regulated, how it is surveilled, and how it is operationalized through discourses of desire and empowerment. Here, I turn to the concept of governmentality (Foucault 1991; Dean 2009; Li 2007; Ferguson and Gupta 2002). Governmentality is concerned with the "art of government" or the "conduct of conduct," evoking a sense of both flourish and calculation, with the effect of directing. This kind of governing at a distance entails a particular conceptualization of power, one that is not vertical (held by those at "the top" and exercised upon those below) but rather as an encompassing assemblage (Li 2007, 276; see also Gupta and Ferguson 2002).

According to Foucault, this kind of power, which is interested in directing the conduct of populations, requires institutions, social actors, and social norms; it also requires both an administrative apparatus and expert knowledge (1991, 96). In this case, expert knowledge was described as the "science of the state," which took the form of statistics. In recognizing governance as an assemblage, we are in a better position to understand it not as a monolith but as requiring a diverse set of social actors and techniques across multiple institutions. Therefore, governmentality involves the directing, shaping, and configuring of people's desires, beliefs, and practices. Crucially, this kind of power is productive—that is, it does not operate via repression or prohibition but rather through using expert knowledge to define norms, which individuals aspire to take up in self-managing their sexual health—as it is interested in the fostering and optimization of life (Ayo 2012; Gastaldo 1997; Li 2007).

Governmentality has "as its purpose not the act of government itself, but the *welfare* of the population, the improvement of its condition, the increase of its wealth, longevity, [and] health" (Foucault 1991, 100, emphasis added). I understand this interest in ensuring the welfare and health of the population to be directly tied to what is now conceptualized as the field of sexual health. Since sexual health is concerned with such things as contraception, family planning, preventative cervical cancer screenings, and testing for sexually transmitted infections, those institutions, and social actors, through specific rationalities, practices, and expert knowledge, attempt to govern the welfare of the population as it pertains to sex. In these discourses of concern for the welfare of the population, we see a direct link to an earlier (and related) Foucauldian concept, biopower,[3] which operates through placing value on health discursively in such a way as to inspire individuals to want to become self-regulating and responsible subjects. In conceptualizing biopower, Foucault draws our attention to a shift from coercive power ("to *take* life or *let* live") to disciplinary power ("to *foster* life or *disallow* it") (1990, 138), and I understand the latter to be fundamental to my analysis of the operations of sexual health governance in Toronto's sexual health landscape during my fieldwork. Biopower is emergent with and in the fostering and optimizing of the welfare of the population through inciting a desire to conform to norms based on expert knowledge. A key point, one which is particularly important for analyzing sexual health care, is the ways in which biopower operates via consent, which in turn can effectively obfuscate the relations of power at work in governing health. However, biopower has two poles around which it operates: anatomo-politics and bio-politics. The former focuses on the individual, the body as machine, and practices of self-regulation in accordance with expert knowledge, while the latter operates at the level of

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[3] In 1978, Foucault shifted his attention from the language of biopower to that of governmentality (Cisney and Morar 2016, 7).

population, where technologies of calculation and predication are used to manage and care for its welfare (Cisney and Morar 2016; Foucault 1990).

Bio-politics has been described as representing a historical shift in the 17th century from counting *hearths* to counting *bodies* (Hacking 2016, 67). This means that in the state's attempt to assess the population for demographic and tax purposes, they went from counting the number of dwellings to counting the number of people who lived within those dwellings, something that was previously thought to be impossible. In attending to the proliferation of numbers that accompanied such a shift, Hacking uses the metaphor of an avalanche to help the reader visualize the degree and impact of such practices of enumeration at the level of population(76). This description was originally offered in the 1980s, and I would argue that it continues to be apt today in the realm of sexual and reproductive health, as continued "statistical enthusiasm" (Hacking 2016, 67) plays a central role in that sector. Attending to the historical context of enumeration (the *who*, *what*, *when*, *where*, and *why* of counting) reveals the contingency and sociality of numbers and their construction, which in effect illustrates how numbers are not merely objective and neutral representations of reality. Additionally, historicizing the operations of bio-politics draws attention to shifting matters of concern and the object/subject of power relations. In the case of sexual health governance, counting Pap smear exams, IUD insertions, and STI test results is a part of a larger state project to care for the welfare of the individual and the population, and more specifically the medicalization of sexual health, but also to produce governable subjects (see Sokhi-Bulley 2014), who will self-manage their sexual health through requesting such practices. Medicalization refers to the ways in which medicine has increasingly expanded into other areas of life which were previously not considered medical issues. Importantly, for the project of sexual health governance, with medicalization comes standardization, where “medicine was gradually integrated into an extensive network of formal practices whose function was to regulate the health and moral behaviour of entire populations” (Lock and Nguyen 2018, 61).

Drawing on the work of Foucault (1990) and as developed by Lynn M. Morgan and Elizabeth F. S. Roberts (2012), reproductive governance is useful for analyzing the ways in which women’ reproductive lives are managed, promoted, and intervened upon. According to the authors, reproductive governance refers to

> the mechanism through which different historical configurations of actors – such as state, religious, and international financial institutions, NGOs, and social movements – use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviours and population practices. (Morgan and Roberts, 2012, 241)

Within this concept, Morgan and Roberts explain how shifting socio-economic and political contexts (local and global) shape the ways in which reproductive policies and practices are played out on the ground. In some instances, such as the case of abortion, the same discourses were co-opted by opposing groups; the concept of human rights, for example, was simultaneously utilized to defend women’s bodily autonomy and choices, and to allow those who are against abortion to claim rights on behalf of foetuses (2012, 243). Elyse Ona Singer (2016) analyzes the ways in which legislative changes, while welcomed by feminist activists, can be understood as reflecting agendas of reproductive governance. In attending to how the legalization of abortion in Mexico can be understood as empowering women and supporting their reproductive choices, but also as opening a new site for their bodies and reproduction to be governed, Singer argues that increased bodily autonomy did not represent a clear break from older agendas but rather resulted in a *continued* emphasis being placed on producing self-managing subjects (2016, 446).

While Dána-Ain Davis (2019) does not utilize reproductive governance in her analysis of African American women's experiences of giving birth prematurely, I have identified a common thread. Both Singer's (2016) and Davis' (2019) analyses reflect the ways in which sexual and reproductive health care can alternatively involve challenging, calling upon, resisting, or appropriating technologies of governance to foster sexual and reproductive health. For example, Davis offers insight into how biomedical racism has impacted the experiences of African American women giving birth prematurely and subsequently being cared for in NICUs. While some women experienced explicit forms of racism, including a woman whose husband (who had a darker skin than his wife) was treated poorly by staff during their stay in the NICU, other women did not explicitly identify any instances of racism. By drawing on and extending the concept of the "afterlife of slavery," Davis understands the pervasiveness of biomedical racism as not only occurring in the past but as having a strong presence in the present, as this history cannot be easily detangled from health care as an institution in the United States. In this sense, Davis makes theoretical space for her interlocutors to express that they did not experience explicit forms of governance, racism, or sexism, while still acknowledging the pervasiveness of these features of health care systems. Similarly, Singer's approach makes room for celebratory discourses related to the legalization of abortion, while also recognizing the ways in which legalization entails participation in a continued system of reproductive governance. I use the term "sexual health governance," building upon the work of Morgan and Roberts, as it aids my ability to analyze the ways in which sexual health entails both (self-)governance and empowerment. The tension identified in the work of Singer and Davis is central to my analysis of sexual health governance, as clients can feel empowered by their ability to make sexual health choices, while at the same time utilizing a system which enacts disciplinary power via technologies of care and surveillance, to encourage them to self-manage their sexual health by making the "right" choices.

Women's ability to make sexual and reproductive health choices has been a central value in the feminist health movement, which advocates for the ability to participate in biomedical health care systems in ways that respect their bodily autonomy. However, choice has also been taken up within the practice of biomedicine in clinical settings. The concept of strategic alignments allows for a nuanced and contextualized understanding of how key concepts and values emerged and were operationalized in the name of progress. For example, in her writing on the professionalization of midwifery in Canada, Margaret MacDonald is critical of historical tracings that do not acknowledge the women's health movement as fundamental to the concept of choice and patient empowerment being championed within the biomedical community (2016). By stating, "[m]idwifery legislation in Canada did not come about because politicians and policy makers cared about women's embodied knowledge and dismantling the doctor–patient hierarchy, but because it fit with an emerging culture of health consumerism in the late 20th century" (2016, 46), MacDonald reveals how particular values are co-opted and re-packaged to serve governmental, biomedical, and public health institutions.

Within this context, I understand sexual health empowerment and choice to be acts of governance, in much the same way that I understand care and surveillance to be inseparable. However, sexual health care and surveillance are both acts of governance and are both essential to the provision of health services. In putting the work of Singer (2016), Davis (2019), and MacDonald (2016) into conversation, I want to draw attention to how ethnographic research can make space for seemingly contradictory concepts to be analyzed as interconnected, and how these can even be considered as part and parcel of each other. Morgan and Roberts' reproductive governance informs my usage of "sexual health governance," specifically in its focus on the ways in which social actors, policies, and institutions converge to manage and direct women's health and bodies. However, I diverge from its focus on family planning and population control to think about the ways in which sexual health outside pregnancy is regulated within a universal health care system. Additionally, I use the term "sexual health governance" as the spaces in which I conducted research (The Centre, The Mobile, the larger sexual health landscape) and the social actors I spoke with consistently framed their work in terms of *sexual* health, not *reproductive* health. I use the term "sexual health governance" to refer to an assemblage of institutions, social actors, and expert knowledge which regulates, counts, and fosters sexual health through technologies of care, surveillance, and metrics. Both poles of biopower, anatomo-politics and bio-politics, are central to sexual health care and, in turn, to sexual health governance. The provision of care is enacted and managed at the level of the individual within the walls of clinics, and at the same time is monitored and governed through the institution of municipal public health, concerned with sexual health trends, needs, and problems at the level of population. To grapple with the *how* questions[4] provoked by a governmentality and biopower analysis, I offer what I term sexual health technologies of governance:[5] care, surveillance, and

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[4] According to Dean (2009), an analytics of government provokes questions pertaining to *how* we govern and *how* we ourselves are governed which include: "characteristic forms of visibility, ways of seeing and perceiving[,]…distinctive ways of thinking and questioning, relying on definite vocabularies and procedures for the production of truth[,]…specific ways of acting, intervening and directing, made up of particular types of practical rationality ('expertise' and 'know-how'), and relying upon definite mechanisms, techniques and technologies[,]…[and] characteristic ways of forming subjects, selves, persons, actors or agents" (33).

[5] I follow Manderson's definition of technologies as "do[ing] things…and include objects and processes; practices, institutions and regulations; ideologies and their encodings that shape and sanction social actions and relations" (2012, 1).

metrics. As I show in the following sections, these technologies are central for analyzing the provision and regulation of sexual health within my fieldsite.

Care

Care is not singular; it is multifaceted and eludes easy definition. Anthropologists have explicitly engaged with the concept of care through ethnography (Garcia 2010; Mulla 2014; Yates-Doerr 2012; Ticktin 2011; Mol et al. 2010; Livingston 2012; McKay 2018; see also Tronto 1993). As such, I draw upon their work to construct a flexible and particularized definition of care for the purposes of analyzing the work it does to support sexual health governance, and understanding it as a technology of governance. My project examines the sexual health care system of Toronto, conducting fieldwork in a clinical setting where care was provided to clients. This section will help to expand our understanding of care beyond simply a service to be given or received by engaging with theoretical debates that analyze the rationale of care, the work it does, and its affective power within the context of governance. Carolyn Smith-Morris (2018) has described the second decade of the 21st century as "medical anthropology's decade on "care"" (426). However, scholarly engagement with care can be traced back to its roots in the 1970s with the work of Carol Gilligan, who offered an understanding of care as a moral virtue and as context-dependent (Smith-Morris 2018, 426). Historically, there has been a divide between the professional work of care (e.g., nursing) and care within the home (i.e., parenting), but critiques of this constructed dichotomy argue that all care has value and all care does work (Van Esterik 1995). An analysis of care as a technology of governance will attend to the ways in which care should be understood as relational and embedded in interactions instead of transactional or individual (see Yates-Doer 2012; Mol et al. 2010). Health care services can be described as those provided by a caregiver (e.g., a counsellor or physician) providing care to a care-receiver (a patient or client), and which also often fit into a calculative frame, which relies on quantifying care via bureaucratic practices or documentation and reporting. However, in following calls to think about the relational nature of care (Yates-Doerr 2012; Mol et al. 2010), I understand the agentive capacity of the client to call upon care—to seek out and request care in an effort to become a self-managing subject.

Van Esterik (1995) describes care in terms of its practices (what care does); its rationale (why we care); and its emotional component (care's capacity to be affective). Relatedly, Mol, Moser, and Pols (2010) use the term "logic of care" to attend to what care *is* and what care *does* (7). These understandings of care are central to my analysis of the provision of sexual health care in Toronto and the space of the clinic. While care can be understood in terms of the provision of health care services, it also means thinking about these practices as interpersonal, affective, and embedded in a system of governance that aims to foster sexual health. In understanding care as a technology of governance, care does *work*—care supports, fosters, treats, assures, resolves, and responds. Therefore, care is both a practice and a process, something that is alternatively funded, provided, and measured in the context of health care, while at the same time being imbued with emotional investment and feminist values.

Building on these understandings, care is affectively charged (Martin, Myers, and Viseu 2015) and rife with contradictions. In attending to the multiplicity of care (its practices, its rationale, its affective dimensions, its logic) I want to make it clear that I do not understand care to be inherently or singularly "good" or "bad." However, anthropologists and science and technology scholars have argued that the very enactment of care, while necessary in some cases, does not mean it is free from criticism. Care is "notorious for the problems it raises when it is defined, legislated, measured and evaluated" (Martin et al. 2015, 625) and the "fact that care can be a well integrated process should not distract us from the fact that care involves conflict" (Tronto 1993, 109). Care has been analyzed for its institutionalized practices and harmful effects in terms of colonialism, and Yates-Doerr reminds us that an analysis of care is also an analysis of power, as all actions (even care) are power (2012, 138). Therefore, in thinking about care as a technology of sexual health governance, I use Foucault's understandings of governmentality and biopower to take seriously care work in a clinical setting. In doing so, I want to think about how care is managed through the use of protocol and surveillance, how it is meticulously provided and (ac)counted[6] for in the clinic, while also revealing how counsellors and physicians take part in feminist practices of caring, such as listening to clients' stories, using creative problem-solving, showing cultural sensitivity, and creating a space where free sexual health services and information, low-cost contraception, and follow-up procedures are accessible. In describing 20th century theorizing of care, Mol, Moser, and Pols (2010) illustrate how care has historically been placed in opposition to technology: care is described as nourishing, warm, and impossible to calculate, while technology is assumed to be instrumental, cold, and efficient (14). However, in their work on care as "tinkering," they move away from this socially constructed binary to consider mixtures and specificity, for care is not the same in all contexts or at all times.

A politics of reproduction entails looking at what is happening locally, in the fieldsite, while also considering the larger socio-political and economic processes, as the policies and practices put into place locally depend on larger processes in their expression (Ginsburg and Rapp 1995, 313). Therefore, as sexual and reproductive health is raced, gendered, and classed,

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[6] Here, the term "(ac)counted" refers to the act of counting in producing metrics while also pointing out the ways in which such numbers are used to demonstrate accountability for the fiscal responsibility of providing health care in a universal system.

reproduction has been an ethnographic site where anthropologists have analyzed the multiplicity of experiences and their politicization, and this includes the provision of care. In Chapter 6, where I will discuss The Mobile as a mobile symbol of the women's health movement in Toronto, I grapple with understanding its role in the large health care system through the idea of *cultivating capacity* in care. This understanding of care is contextual and serves to avoid naturalizing care, as this would threaten "to take the heart out of care…its effectiveness, its tenacity, and its strength" (Mol, Moser, and Pols, 2010, 7). In following Ginsburg and Rapp's call to localize care, I actively engage in the politics of sexual health in this dissertation, and I understand the care work and surveillance I saw in the field as being deeply embedded in such politics of governance.

Surveillance

Surveillance often goes where care is provided. Within the field of health research, surveillance has a long and sometimes fraught history. Contraception usage in family planning projects is tracked, maternal mortality statistics are carefully recorded and reported to shape future policy directions, and HIV infection rates are monitored globally via tools of surveillance. If governmentality can be defined and utilized as both a rationale and a strategy of governing at a distance, involving expert knowledge and the production of the subject via an operationalization of norms (Lupton 2013, 115–116), surveillance can be analyzed as a technology of governance that supports the fostering of health, requiring "an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations" (Foucault 1990, 140). Within this context, surveilling the population is done through record-keeping and compiling statistics, which tell those in a position of power about the state of the population's health; within this context, surveillance can be understood as the monitoring of a population, recording with the intent of using the information gathered to inform policies and practices which will improve and foster health. Experts use the knowledge garnered through these practices of surveillance to incite a desire on the part of the population to self-manage or engage in responsibilization as a form of disciplinary and not coercive power (Bridges 2011; Lock and Nguyen 2018; Pylpa 1998; Scheper-Hughes and Lock 1987).

I understand surveillance to be a technology of governance, operating within the spheres of public health and health care to monitor, record, trace, collect, and inform. According to the Public Health Agency of Canada, surveillance involves the "tracking and forecasting [of] health events and determinants through the collection, analysis, and reporting of data" (PHAC 2017), understood to be the foundation of public health efforts. Health surveillance is a critical component of public health at the population level, as it allows agencies to monitor trends, respond to outbreaks with guidelines, and put policies into place. In this instance, surveillance is seen as serving the "greater good" by collecting health data in the form of statistics to inform prevention efforts and policy. However, as I saw in the field, surveillance also takes on a particular salience for sexual health clinics, which receive funding from TPH, as they are required to provide quarterly reports based on an accounting of their operations. Additionally, STI infection results are placed into a database, and a positive report result sets off a chain reaction, where TPH's sexual health case workers work collaboratively with The Centre staff to ensure proper notification and treatment protocols are followed. Therefore, similar to my conceptualization of care, I understand surveillance to do *work*. Requirements tied to health care provision and surveillance (entailing practices of documentation) intimately shaped the daily operations of The Centre and The Mobile. The women who worked in the clinic engaged in particular forms of surveillance: recording positive test results, coordinating follow-up visits, and monitoring clients with emergent sexual health issues. In order for the clinic to continue providing free sexual health care services (and low-cost contraception) to those without OHIP, status, or private coverage, The Centre and The Mobile had to engage in meticulous forms of accounting.

Anthropologists and social science scholars have contributed to a discussion of the operations of disciplinary power by drawing attention to how surveillance and the regulations of health cannot be examined apart from race and gender (Stoler 1995, 2002; Sawicki 1991; McNay 1992; Pigg and Adams 2005; Hunt 1997), as Foucault's initial vision did not explicitly consider how biopower operates on *particular* bodies. For example, Bridges (2011) analyzes a New York prenatal program that offers free care to pregnant women; Medicaid (within a predominantly private health care system) is understood as an apparatus which "attracts poor, [racialized,] pregnant subjects onto the carceral archipelago" (71). For the pregnant women who use this program's services, their ability to access care means they must become objects of disciplinary power to a degree which exceeds that of pregnant women who can afford private health care. While all operations of health care in Toronto are subjected to practices of (ac)counting and therefore require protocols of surveillance, both The Centre and The Mobile were under a higher level of scrutiny. Sex is a moral object (Pigg and Adams 2005); therefore, it is unsurprising that the caring and fostering of sexual health entails increased regulation and reporting compared to family doctors or walk-in clinics. Bridges' ethnography, for example, demonstrates how surveillance operates within a New York hospital, targeting impoverished and racialized women. While all care provision entails surveillance, surveillance of the body and at the institutional level, Bridges' usage of the idea of maternity care as part of the 'carceral archipelago' allows for an analysis of the ways in which particular women are subjected to increased surveillance; in order to receive free prenatal care, they must submit themselves to various forms of surveillance as a condition of participating in the program which requires their physical and emotional labour along with the collection of their data.

Foucault's notion of *the gaze* within the context of a biomedical clinic allows for a relationship to be established between the visible and invisible (2003: xiii) and is useful for thinking about public health and clinical surveillance. For Foucault, the gaze is vital to the inner workings of the clinic and speaks to the authority imbued in the physician to see the patient, to see illness, and to diagnose it. He argues there are three facets of the gaze that make it distinct: it imbues the physician with power, it allows the physician to see completely (patterns and variations), and finally, the gaze "was not content to observe what was self-evident; it must make it possible to outline chances and risks; it was calculating" (2003, 109). However, anthropologists such as Diana Gibson (2004) have also noted the ways in which the gaze is not omnipotent. In her ethnography of a South African hospital, Gibson illustrates how some patients become "invisible" due to economic, policy, and shortage issues (2004, 2023). For example, a patient named Mr. Mbatha was unable to receive the kind of care and attention he requested because he had slipped through the cracks of practices of surveillance and bureaucracy. Mr. Mbatha was not "listed," and therefore, he was not seen to be as sick as other patients in the hospital ward; the intern had attended to other patients who were made visible by particular practices of surveillance (2004, 2020).

Outside the clinic and hospital, the metaphor of seeing has been used by anthropologists (see Biruk 2012; Ferguson 2005; Scott 1998) to examine how the state employs particular techniques (such as surveying) in an effort to *know* the population; processes of "legibility, simplification, and magnification are necessary to the state's ability to *see* its subjects" (Biruk

2012, 352, emphasis added) and, therefore, work to enable and support governance. In writing an ethnography on a demography research project in Malawi, Crystal Biruk sought to reveal how practices of surveying local communities to produce knowledge related to AIDS was a social enterprise and reflected the state's concern with making the population visible in order to shape policy in the future. Here, I draw a connection between the emphasis placed on "seeing" and "making visible" within Biruk's fieldsite, Foucault's use of the medical gaze in the clinic, and the role of sexual health care surveillance in my own fieldsite clinic and health care system. Biruk, utilizing the metaphor of "seeing like a research project," allows for a reflection of the ways in which the collection of villagers' lived experiences is translated into ticked boxes on a form as a part of the demography project's goal to render them numerically legible. Through compiling and aggregating survey data, villagers' lives become simplified and visible to the project team, who can then identify issues and recommend policy changes to address them (Biruk 2012). I draw a connection between this search to capture "objective" data, involving processes of molding narratives into neat responses, and the medical gaze (see Foucault 2003). In historicizing the emergence of the clinic, Foucault asks us to think about seeing as perceiving through his concept of the gaze which is productive in how it creates the object it perceives (xv). It is within this new context, a distinct and corporeal space, where two things occur: its social construction via discourse, which structures the possibilities for what could be said and understood about the body and disease (xx), and how patients become abstracted from their bodies, become sites of investigation (xvi). Here, knowledge is collected *through* the gaze (65).

In connecting Biruk's work on "seeing" like a research project (2012) and Foucault's theoretical insights from examining the clinic as a site where the power of the medical gaze constructs the object to be known, I draw a connection to my own fieldwork in relation to care and surveillance. According to Foucault (2003), seeing the "truth" when diagnosing a patient is not about individual patients but in how signs structure diseases wholly (119); each case is not "new" but rather represents a new combination of symptoms and signs (121). It is only through rigorous attention to case numbers where patterns emerge and conclusions can be drawn that some degree of certainty can be established (124). The entanglement of care and surveillance in sexual health care reflects these themes insofar as services provided and results rendered can be aggregated to form a larger picture, one in which the state can *see* the condition of sexual health in the city.

Within my own fieldsite, surveillance can be understood as a similar although distinct form of *seeing*, operating under a particular logic: that public health institutions cannot act on what they do not know. While surveillance can be enacted within the space of the clinic and directed towards bodies (bodies who are meant to be inspired with a desire to self-manage their sexual health in accordance with expert knowledge), I am also interested in forms of surveillance that are part of the systemic nature of health care. For example, STI reporting requires careful monitoring of positive cases and infection rates, data which is collected in databases and forwarded to members of TPH's sexual health team to ensure partner notification and the following of proper treatment schedules. Public health institutions require such data to *see* the population's sexual health needs and issues, so that they can better address them. The metaphors of sight and the gaze are equally useful for examining the funding requirements of The Centre and The Mobile, as quarterly reports detailing the clinic's activities (such as the number of clients seen, IUDs inserted, and Pap smear exams performed) can also be thought of as a way for TPH to *see* care services and therefore the active fostering of sexual health in the community. Within this context, the ability to see is discursively structured in how the object (sexual health) is rendered intelligible via discourses of health and illness; while such discourses do make mention of autonomy, choice, and mental and physical well-being, they also tend to frame sexual health in terms of preventing and/or detecting infection, cancer, or unintended pregnancy, and therefore, value is placed on *seeing* such values numerically. In the following section, I will expand upon this understanding of how the ability to *see* is a prominent feature of health care by examining anthropologists' engagement with the concept of metrics, ultimately building to my own use of the metrification of care to encompass how care practices were translated into numbers via practices of (ac)counting and surveillance in my fieldsite.

Metrics

I now move to introduce the third interrelated sexual health technology of governance, as care and surveillance are critical components of creating, measuring, and responding to metrics. Anthropologically, we must ask, what kinds of work do numbers do and what do they signal to the social actors involved? Metrics can be understood alternatively as numbers, indicators, or statistics which enumerate, quantify, and come to represent "assumed realities" (Tichenor 2020, 1). According to Vincanne Adams, metrics are also a form of storytelling, as they tell us something about "what those who produce them and what those who rely on them care about most" (2016, 9). In relation to the other two technologies of governance, the proliferation of metrics in global health and health care reflects the importance placed on quantification for "good" governance. While metric creators acknowledge the subjectivity of numbers, statistics, and indicators, these metrics still hold immense power (Tichenor 2020, 2) to influence the provision of care.

In the fields of global health and international health development, statistical and numerical data (metrics) produced through quantitative methods[7] are increasingly relied on to frame global health interventions and local health care protocols; social actors and institutions rely on metrics need to be able to "see"[8] the problem before they can propose the best course of management. In this respect, metrics are part of a longer history of placing value on numerical, objective data, specifically evidence-based medicine (EBM) and care (see Adams 2016; Brunson and Suh 2019; Storeng and Béhague 2014; Brives, Le Marcis, and Sanabria 2016; Lambert 2006). In the mid-1980s, EBM was created in response to the rising demand for quantitative, scientific, and objective measurements of effectiveness in the production of evidence (Lambert 2006, 2633); in this sense, EBM reflected a "push for better ways of counting and better indices of accountability" (Adams 2016, 7).

In attending to this increased pressure to perform via metrics, anthropologists have addressed how metric requirements shape local health care practices, enrolling staff in practices of counting and reporting. In attending to metrics via ethnographic research, medical anthropologists can demonstrate how metrics "flatten messy events, render [particular] narratives legible, and make unlike situations comparable" (Wendland 2016, 63). For example, in a case study of a young Malawian girl who experienced several seizures after giving birth, resulting in her death, Wendland describes physicians' discussion of how they would categorize the death: was it due to eclampsia (as suggested by one of the nurses at the health centre), or could it have

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[7] In the context of The Centre, quantitative data refers to the compiling of numbers (how many IUDs were sold in a month, how many clients received their first Pap smear, the number of positive STI test results). This kind of data serves two purposes: to legitimize The Centre's work and maintain funding, but also to inform public health guidelines and mandates.

[8] My use of "seeing" as a metaphor follow Adams' use of James Scott's work, which understood "the degree to which modern governments succeed or fail depends in part on their ability to create systems of quantification that render complex social phenomena comparable and countable" (Adams 2016, 7).

been cerebral malaria? (2016, 63–64). According to Wendland (2016), the second determination is important because it reflects how health care workers have been pressured to decrease maternal mortality rates, and if it were determined the young woman had died of cerebral malaria, she would not count towards the health centre's maternal mortality statistics.

Within this context, where the demand for metrics (numbers of clients seen, number and type of services provided, number of contraceptives sold) has resulted in increased pressure to perform well via "good" numbers, care providers must carefully consider how the data they produce will "count" in relation to clinic protocols and governmental policy agendas. In Adeola Oni-Orison's (2016) ethnographic accounting of a pregnant woman who sought care after a coughing fit severely ruptured her Caesarian sutures, we can see the profound impact of metric demands that placed an emphasis on following reporting protocols. When the woman was not immediately attended to by the hospital staff, and after discovering the severity of her injury, the chief medical director, Dr. Olamide, yelled, "Why was this patient not seen? This is an emergency!" (Oni-Orison 2016, 95). In her analysis of the situation, Oni-Orison argues that the emphasis placed on maintaining good metrics resulted in increased pressure placed on staff to follow strict protocols for patient record-keeping (wherein patients must register with their card and casebook before being seen by a doctor), and prioritizing these procedures meant a woman with severe trauma was missed. The work of Wendland and Oni-Orison reveals how ethnographic research plays a vital role in capturing such stories, not only demonstrating how metric demands affect day-to-day practices of health care but also presenting the stories that are rendered invisible in this process.

Metrics are "technologies of counting that form global knowledge" (Adams 2016, 6), and this knowledge production is dependent on the standardization of data. However, the assumed neutrality and objectivity of metrics obscures the socially constructed authority they are imbued with and privileges the roles of science and biomedicine. Within The Centre and aboard The Mobile, I delineate the number of clients seen and the number of services provided as the metrics used to indicate how sexual health operated within these spaces. I understand metrics to be an important element of the clinical space of the sexual health care system in Toronto, in which such indicators are collected, tracked, and operationalized[9] within a Canadian context at both the provincial and municipal level. In Chapter 5, I argue metrics are an integral part of how The Centre was funded and played an increasingly prominent role in the day-to-day operations of the clinic; the numerical reports (containing such things as the number of patients seen, the number of IUDs inserted, the number of Pap smear exams performed, and the number of Depo-Provera shots injected) were sent to TPH on a quarterly basis and were a requirement of their funding. The women who sought the services of The Centre and The Mobile were both cared for and surveilled by metrics. But what stories do numbers tell in The Centre and aboard The Mobile, and what stories are obscured? Using the concept of metrics allows for a deeper analysis of how the legitimacy of sexual health care services is tied to performing through metrics while at the same time being useful for grappling with which stories get told through the filter of numbers.

At The Centre and on The Mobile, sexual health social actors were engaged in the *metrification of* care, which in turn, served to foster sexual health. As part of their work, they translated care practices within the clinic walls into numbers; a central part of this process is acknowledging the relationship between funding and numerical data. As discussed in the first chapter, Toronto Public Health provided most of The Centre and The Mobile's funding, and in

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[9] By operationalize, I mean to drawn attention to how metrics are used to inform budgetary spending, budget cuts, and public health guidelines.

return, the clinic provided quarterly reports on the provided services, number of clients, and testing results. Therefore, the metrification of care not only involved the translation of care practices into numbers and quotas for reporting and legitimizing funding but also worked to define which care counted: Pap smears, HIV tests, birth control prescriptions, and IUD insertions. In the coming chapters, I will examine the impact of the pressure placed by metrification on The Centre and especially The Mobile, but I will also look at what kinds of care did not get counted in these final reports. Using metrics as an analytic object through an anthropological lens helps us not only understand the social construction of numbers, removing their assumed inherent privilege, but to explore what gives them such power by contextualizing and historicizing their production and circulation via ethnography. In my dissertation, I seek to capture how life inside the clinic cannot always be contained within a report’s rows and columns.

Anthropology of the Contemporary Clinical Encounter: A Site of Governance

Early clinical anthropology was a proponent of analyzing “western” systems of health care as it would any other system of healing, disrupting the socially constructed divide between the two, while also working against discourses which position biomedicine as a monolith. Over three decades ago, Lynn M. Morgan (1990) historicized medical anthropology, focusing on the fractures between clinical anthropology and critical medical anthropology, wherein tensions arose between these frameworks in the 1970s and 1980s. Clinical anthropologists (see Kleinman 1978; Kleinman, Eisenberg, and Good 1978; Good 1977) most often worked within a clinic or hospital setting to assess the micro-practices of patient care. In her description, Morgan argues that while critical medical anthropology focused on macro-level theoretical engagements, historicizing and contextualizing the object of their analysis, clinical medical anthropologists are concerned with the micro-level, seeking to understand the space of the clinic, investigating dynamics between doctors and patients, and seeking practical applications from their findings. However, critical and clinical medical anthropology are not adverse approaches, as clinical anthropologists have “acknowledge[d] material constraints, and critical anthropologists recognize the meta-messages encapsulated in the briefest clinical encounter” (Morgan 1990, 949). Contemporary medical anthropologists who conduct fieldwork in clinical spaces draw from both sides of the debate in exploring interpersonal dynamics and clinical practices, while also holding the larger context and history in their analysis.

I understand my work to be informed by both clinical and critical medical anthropology (see Lock 2001; Morgan 1990; Kleinman 1978; Singer and Baer 2018), as I attend to the daily practices involved in the provision of sexual health care services, while at the same time addressing the social, political, and financial contexts in which such care exists. I also recognize the ways in which clinical anthropologists were constrained by their work within the space of the clinic. In my fieldwork, I did not have to “answer” to The Centre or The Mobile; however, my positionality as a researcher and volunteer necessitated my engagement in supporting practices of care and surveillance, while maintaining a critical lens. Finally, critical medical anthropology informed how I was able to contextualize the clinic’s mandate, to provide free sexual health care and low-cost contraception through a commitment to client choice and empowerment, via the feminist sexual and reproductive health movement in Canada and the universal health care system, which requires careful practices of (ac)counting in the governance of the clinic. Both clinical anthropology and critical medical anthropology have argued that biomedicine is a social and cultural system, with the former focusing on its daily practices and meanings, and the latter recognizing the ways in which the political economy of health and relations of power impacted such clinical encounters.

My ethnography of the clinic utilizes the insights medical anthropology has produced in studying health, sickness, and systems of healing and care. Placing an emphasis on carefully attending to the production of knowledge within the space of the clinic through questioning the taken-for-granted (and sometimes even mundane) aspects of care provision was vital to my fieldwork and my analysis of the data produced through being a participant-observer within The Centre and aboard The Mobile. By following these medical anthropologists' line of thought, I was able to think about the clinic as a social site, one which both informed and was informed by values and practices which went beyond its walls, such as the universal health care system, ebbs and flows of funding filtered via various governmental approaches to health and care, and the clinic's feminist history. A wealth of literature in medical anthropology informed my ethnography of the clinic, and the anthropologists' work featured below represents a continuation of medical anthropology's interest in the sociality of biomedicine, the socio-political and economic factors which influence its governance, and the careful attention paid to practices that flesh out the clinic as culturally constructed with particular (and moral) goals.

An anthropology of the contemporary clinical encounter draws on foundational debates and approaches to the clinic and clinical care, as outlined in the previous section. Key texts that locate "the clinic" in a variety of locales—hospitals, clinics, emergency rooms, midwifery centres, detoxification clinics, daily-rent hotels, and maternity wards—have been selected to demonstrate how the clinic is not a solid, clearly demarcated space. I argue that the contemporary clinic is a site of governance, an institutional setting home to various social actors and governmental technologies that work together to foster life. The clinic has continued to be constructed as an objective site, which can be planned, intervened upon, and regulated in popular discourse; this construction does not leave room for the unexpected, nor does it account for *how* care in the clinic takes on different forms. In this section I will analyze how contemporary ethnographic research into the clinic understands biomedicine to be a cultural system, how the clinic is always embedded in a particular socio-political and economic space which shapes its operations via specific regulations, and finally how anthropologists have examined the complex relationships between care providers and patients. I will trace how care, surveillance, and metrics can be found within the space of the clinic and their role in supporting the governance of health. The realities of the contemporary clinic reveal it to be a subjective and cultural space, one where the relationships between care providers and patients are complicated, and where health care is embedded in larger institutional matrices of law, biomedicine, and public health.

Early hospital ethnographies, such as Coser's *Life in the Ward* (1962), argued hospitals could be understood as "islands," separated from all other social life (Long, Hunter, and van der Geest 2008 71). However, more contemporary hospital ethnographies (see Zaman 2005) depart from this conceptualization, arguing instead that hospitals reflect the society in which they run and must be contextualized (Long, Hunter, and van der Geest 2008 72). Medical anthropologists and ethnographers have written about the hospital and the clinic as cultural spaces, specifically analyzing how "*biomedicine, and the hospital as its foremost institution, is a domain where core values and beliefs of a culture come into view"* (van der Geest and Finkler 2004, 1996, original emphasis included). According to Wendland (2010), the assumption that biomedicine is neutral works to support its appearance as cultureless and easily transferable to different locales. I follow this line of thought in analyzing how governmental technologies, the provision of care, practices of surveillance, and the production of metrics have also become naturalized as simply a part of the contemporary clinic. Wendland draws on the rich history of anthropological engagement with biomedicine, including the work of Jean Comaroff (1982, 1993), wherein all systems of healing are cultural in their attempt to provide care, using hegemony (Gramsci 1971) to make visible for the reader the ways in which biomedicine's authority is assumed to be "common sense" and therefore is taken for granted (Wendland 2010, 12). In doing so, she argues the hospital and biomedicine are deeply cultural institutions imbued with relations of power.

The following ethnographies help to answer the question: Where does the clinic begin and end? Anthropologists have attended to various clinical encounters, capturing how the clinic has permeable boundaries and cannot be contained within the walls of a hospital or detoxification centre. Wherever we locate the clinic, it is clear that multiple systems of governance (health care, public health, and law) overlap in the provision of care and practices of surveillance. As discussed at the beginning of this chapter, I understand care and surveillance to be entangled and not reducible to a dichotomous relationship with one being labelled as "good" and the other "bad." In recognizing the ways in which care and surveillance work in tandem, I see the following ethnographic texts as fleshing out their subtleties, how care and surveillance alternatively target/intervene/require, resist/take up/call upon, and support/foster. Finally, these pieces illustrate how caring and care practices are relational and imaginative, whereby investment by the social actors involved often make space within sites of shortage. Here, we see one of ethnography's contributions in its ability to capture intimate and systemic forms of care and surveillance.

Knight's (2015) ethnography of pregnancy and addiction in San Francisco is useful for thinking about how clinical encounters extend beyond the space of the hospital or doctor's office; she illustrates the ways in which social services, programming, and public health become extensions of the clinic and its gaze. For Knight, who conducted ethnographic research with pregnant women who resided in daily-rent hotels and struggled with addiction, intervening upon them represented an attempt to manage these women's lives as a public health issue. At the intersection of science, politics, and social services, her interlocutors' narratives illustrate the dire consequences such networks have for addicted and pregnant women, how social workers, child protective custody workers, health care providers, and public health programming monitored and even pre-monitored the lives of these women. While such surveillance operated with the goal of preventing addiction-related health complications, it often worked to pathologize the pregnant women in Knight's project, extending the space of the clinic into numerous sites (hotels, hospitals, and programs). Here, the realities of the clinic and its values become a part of addicted and pregnant women's everyday lives, with the scope of public health and the clinic extending beyond formal clinical settings. Similarly, in analyzing the health care system and clinic as a part of the sexual health landscape, I am interested in analyzing how multiple social actors and institutions work together towards the same goal, to foster and monitor sexual health, and in the process, to promote a particular model: one which prizes the self-managing, choosing subject.

In her analysis of New York City's Alpha Hospital, a publicly funded institution in a country with a predominantly privatized health care system, Khiara Bridges (2011) describes the ways in which pregnant women are incentivized to not only be surveilled by the hospital's maternity care program's requirements but also to engage in practices of self-surveillance. Bridges puts forth two theories as to why the state is interested in the health of its citizens (and why it is interested in them as self-regulating subjects): from a Marxist perspective, individuals are a source of labour, and therefore, their health is paramount to the economic success of the nation, while from a Foucauldian perspective, an individual's health is representative of the health of a nation (2011, 177). Those who wish to be a part of the prenatal program are required to engage with multiple social actors, including a nurse/health educator, an HIV counsellor, a social worker, and a Medicaid financial officer, before they can even begin to receive prenatal care; within this context, women who do not have access to or cannot afford private insurance must "make themselves vulnerable to the state by divulging both intimate and banal details of their lives" (2011, 43). Therefore, Bridges argues that this constructs pregnancy as a site of surveillance and regulation, one which is particularly homed in on the bodies of racialized women. Utilizing the work of Foucault, Bridges connects the production of docile bodies within the prison, the panopticon, and "carceral circles" in her analysis of how particular women are targeted for *more* surveillance than those with the means to seek care outside of a public hospital (2011, 69). Specifically, she uses the term "carceral nets" to visualize how discipline and self-discipline expand beyond the space of the hospital. She argues the kinds of bodies caught in these carceral nets are raced, classed, and gendered, and therefore there "might be an intentionality to power and discipline that would allow them to be directed toward certain subjects thought *worth* of discipline" (2011, 71).

Importantly, in analyzing how the Medicaid apparatus operating at Alpha Hospital required pregnant women to submit themselves to increased surveillance through multiple meetings, tests, and the completion of lengthy paperwork, an often extractive process, Bridges also makes space for those patients who thought such meetings and resources were useful. Similar to the work of Singer (2016) and Davis (2019) who also identified tensions between systemic issues and participant perspectives, Bridges acknowledges the nuanced and heterogeneous feelings of her interlocutors of going through this process, while also reminding the reader of the ways in which these pregnant women were within a system of carceral nets. In my own fieldsite, the process of receiving free sexual health care services meant entering systems of surveillance: the tracking of test results, their compilation in databases, the performance of particular tests. Within The Centre and The Mobile, the multiple forms of surveillance need to be understood within the context of how an independent sexual health clinic (which made a name for themselves by providing accessible and free care to immigrant women) must record their data to justify and illustrate where their funding is going in the provision of care. This kind of surveillance could be analyzed as part of the larger project of sexual health governance and disciplinary power which targets marginalized populations. However, clients often regarded such processes as either a mundane part of receiving health care or a clear indicator that they were being cared for. Therefore, Bridges' piece is useful for thinking about how surveillance is neither universally "good" nor "bad," and how the anthropologist's job is to reveal under which circumstances care and surveillance are enacted and who the recipients/targets of such practices are.

In Bridges' ethnography, the Medicaid apparatus operated within Alpha Hospital to require pregnant women in the program to submit to onerous testing, meetings, and paperwork, which made them visible to the clinic via practices of surveillance. Alice Street (2012) illustrates how patients who called upon the state for care made themselves visible. In Madang Hospital, patients cared for and regularly used their health cards in an attempt to get the Indonesian state to perform their obligation to care for the well-being of its population; here, the health card operated not as a technology to govern and surveil patients, but rather as a technology for patients to compel care (2012, 2). Street argues that an analysis of governance (and, in turn, the technologies which support, operationalize, and regulate governance) is highly context-dependant. In a health care system where hospitals have been historically underfunded, Madang Hospital patients used the health card as a tangible way to both engage with doctors and be *recognized* as patients. Street's analysis offers a productive way to think about how social actors work within existing systems, sometimes of scarcity, to enact the kind of future they want. Within my own fieldsite, while practices of reporting and counting were required with in a universal health care system to distribute funding, social actors in The Centre and The Mobile were, in a way, cultivating their own capacity to care. For example, the importance placed on the sign-up sheet reflects their careful attendance to managerial tasks of metrification in order to secure a future which would enable them to continue providing care and fostering clients' sexual health.

With Street's (2012) work, we see how the government's post-war promises of development and their failure to enact changes resulted in a strong "desire for the state" on the part of citizens as patients. While patients making themselves visible and welcoming surveillance within a context where care was lacking or non-existent was prominent in Street's fieldwork, other anthropologists have shown how the state's legal frameworks have resulted in an interventionist approach under the guise of care. Garcia (2010), through her work as an attendant in a detoxification clinic, explores how the intersection of public health and the law both classify and respond to addiction within and outside the clinic walls. The moral values that underpin the workings of a detoxification clinic are obscured by other legal and public health frameworks, which position detox as a form of rehabilitation. It is critical to note here that those who are sent to the detoxification centre as a part of their legal sentence are transformed into both patients and prisoners. While state-mandated care involves protocols related to dispensing medication and managing withdrawal symptoms in the clinic, Garcia uses the concept of pastoral care to analyze the ways in which treatment cannot be reduced to detoxification, that it must recognize the historical legacy of suffering and loss in New Mexico's Española Valley.

In another example, Mulla's (2014) work adds nuance to our understanding of the clinic by making sense of how the intersection of the law and biomedicine are clearly embedded in a particular set of moral values, which in the case of sexual assault intervention, works to dictate what happens in the intimate space of the examination room. In this context, "the clinic" is an emergency room sexual assault exam, whose operations are shaped by the American legal and biomedical system. In analyzing the interactions between those who work in the clinic and those who come as the victims of sexual assault, she describes a case where Sierra, a young African American woman, refuses emergency contraception during her exam, which in turn results in the forensic nurse acting brusquer and more distant with her. Mulla both analyzes and contextualizes the reaction of the forensic nurse, revealing how nurses not only determine whether an assault happened, but to what degree. Legally, the refusal of emergency contraception can be interpreted as consent to the assault, and the forensic nurse knows that this refusal may affect Sierra's legal case against the perpetrator. Both Mulla and Sierra noticed a change in the nurse's demeanor after Sierra revealed she showered after the assault (perceived by the nurse as washing away evidence) and refused emergency contraception; the nurse saw these actions as reasons to doubt the veracity of Sierra's claim because, in her mind, a victim would not want to have the perpetrator's child. Sierra understood this poor treatment she received as a racist act, asking Mulla, "She hates me because I'm black, right?" (2014, 88). Mulla acknowledges this exchange could be based in racial prejudice in relation to pathologizing discourses of Black single mothers (89). Mulla also understands the nurse's reaction as a reflection of the training provided on forensic professionalism and expertise, which encourages nurses to focus on veracity: Is the account true? Sierra expresses a desire to become a mother, and Mulla understands this as being her rationale for refusing emergency contraception; however, this explanation does not fit into the nurse's (or the legal system's) understanding of the proper narrative of events, as refusing contraception can be legally construed as consent. Mulla's ethnographic vignette, which focuses on Sierra's experience with a nurse, help us move away from assumptions regarding the neutrality and objectivity of biomedicine and its discrete separability from society, instead painting a nuanced picture of the clinic as a complicated space. Additionally, the ethnographic example discussed above demonstrates how the clinic is a site wherein truths and belief systems are not equally weighted, with the nurse's perception of the events diminishing the autonomy and lived experiences of Sierra. Both Garcia's (2010) and Mulla's (2014) work reflects the ways in which care, intentionality, and larger systems operate within the contemporary clinic; care and surveillance are processual, and the clinic becomes a space where patients/clients alternatively take up, call upon, resist, strategically use, and submit to systems of care and surveillance.

These insights helped to inform my analysis of my fieldsite, where requesting sexual health care could sometimes entail processes of self-management, and yet unexpectedly, also meant clients were subject to increasing systems of governance. These ethnographic texts encourage anthropologists to capture these kinds of complex negotiations of care and surveillance, attending to their entanglement within systems of health care, protocol, and evidence. While legal and public health systems may enact, require, or provide care with the goal of fostering health and welfare, it is also important to attend to how the recipients of such care understand this exchange.

Finally, in analyzing contemporary clinical encounters as sites of governance, the relationships between care providers and their patients/clients played a prominent role. While sexual health governance can be understood as assembling institutions, social actors, and expert knowledge to foster and regulate sexual health, this does not mean these were the only things that happened at the clinic. In considering the cultural background of care providers, Wendland observed how those who work within the field of biomedicine and health care do not simply dispose of their own cultural values and experiences upon entering the hospital walls, as medical students "bring their own histories and cultures to the places in which they are supposed to learn a transnational medicine and sometimes they craft something out of that encounter" (Wendland 2010, 4). I saw how the women who worked in The Centre and aboard The Mobile also brought with them their own intersectional experiences.

The relationships between those who provide care and those who receive care are complex and cannot be universally captured. As Mulla's (2014) work on sexual assault intervention shows, the nature of this kind of care is complicated and messy; even with procedures and guidelines for how providers should present themselves, the provision of care often breaks free from the clinic and the clinical gaze. As a part of her fieldwork, Mulla attended a week-long forensic nurse examiner training series, where the participants had to listen to a brutal and upsetting 911 call; the purpose of playing this call was to demonstrate the kinds of emotions and narratives these nurses would have to attend to in the space of the sexual assault examination room (89–90). Mulla points to the ways in which forensic nurses must simultaneously engage in "emotional labour," both in assessing their patient's mental state and in controlling their own reactions during the examination process and shifting their focus to the legal legibility of sexual assault victim's statements.

While forensic nurses are offered training to prepare them for performing examinations for sexual assault victims, Garcia's (2010) description of her first graveyard shift illustrates not only the pain and suffering detoxification patients face, but also how the clinic did not prepare her for the things she would experience that night. Arriving for her first shift, Garcia was given minimal instructions, which mostly pertained to administering medications and being told not to fall asleep. The next several hours included a power outage, dispensing pills, having to relieve a young man's physical pain by massaging his legs, hands, and feet, and accompanying him while he sat outside the clinic, waiting for the pain to lessen. At the end of the shift, Garcia had to complete the paperwork she had not had time to attend to during the blackout, and while the notes she wrote were "sufficient for the purposes of clinical record-keeping, it was a woefully inadequate representation of the complexity of that night" (2010, 49).

Garcia's ethnographic analysis of her first night in the detoxification clinic speaks to the ways in which the lines between the clinic as a professional space and the clinic as a personal place collided (61), and I follow how she creates an understanding of the clinic as complicated, contingent, and often contradictory. Here, emphasis is placed on how the process of recording what happened at the detoxification clinic overnight, through quantifying pain and the administering of medications, does not adequately capture what else was happening in the clinic. In Garcia's writing, being with a patient who was experiencing the agonizing pains of withdrawal was clearly a profound moment and offers an understanding of what it means to be confined within the walls of the detoxification clinic. However, the shift notes are not constructed in a way which would allow her to reflect on such a moment. By understanding the clinic as an institution which did not operate "rationally or coherently, but symptomatically" (2010, 62), it becomes a space where even the best-laid plans often do not align with what happens in practice. Both Mulla's (2014) and Garcia's (2010) ethnographies offer a substantial contribution to an anthropology of the clinic. First, they are able to capture via ethnographic methods and writing the relational aspects of caring and being cared for within the clinic. Second, they are useful for thinking about the ways in which stories count. In Chapter 6, I utilize such insights to analyze how The Mobile, as both a feminist symbol and a clinic operating with particularized protocols of (ac)countability, became a space where meeting quotas and client stories both counted.

The clinic, as a site of governance, evident in the various technologies of care-giving and receiving, sometimes leads to the creation of other sites, ones which exceed and contest *how* care is provided. In her ethnography on Black women's experiences of premature birth in the space of the hospital, Dána-Ain Davis (2019) describes the creation and role of "radical Black birth workers" (169), who engage in practices of care to support pregnant Black women. This kind of support is deemed necessary because the state has proved itself to be both unreliable and uncaring when it comes to Black women's reproductive health (170–171). Within this context, planning to give birth is described as an empowering experience, one which seeks to support Black women's bodily autonomy (183), an experience which is beyond the regulation and surveillance of an overly medicalized birth. While The Centre and The Mobile did not operate outside the public health care system of Toronto, the staff had worked towards what I term cultivating capacity,[10] recognizing their ability to provide free sexual health care and low-cost contraceptives to all women. By using part of their core funding to run a mobile clinic, which operates in spaces outside of The Centre (such as adult learning centres, churches, settlement organizations, and shelters), they are engaged in imagining a different future through practices of care. Davis' account of Black birth workers' role in maternal activism, not only filling a gap in

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[10] Cultivating capacity encompasses the strategies and social practices undertaken by The Mobile team to ensure they can continue to provide free and accessible sexual health care across the GTA; this is the focus of Chapter 6.

care but also working towards providing the *kind* of care their patients want, will inform my analysis of The Mobile's operations across the GTA, including how they negotiate their feminist roots amid increasing calls to quantify the work they do.

In tracing an anthropology of the contemporary clinical encounter, a site of governance, I have tied together several anthropological accounts of doing ethnography in hospitals, a detoxification clinic, sexual assault examination rooms, daily-rent motels, and a community maternal activism program. Each space is different from the next, including that of my own research aboard a mobile clinic and within a sexual health centre in Toronto. In following anthropological engagement, which analyzes the contemporary clinic not as a neutral and ahistorical institution but rather as one embedded in a particular socio-political and economic context, ethnographic research plays a critical role in telling a story that cannot be captured in charts, reports, or policies. At the same time, I also use the insights garnered from these ethnographic texts to analyze how numbers tell stories. Finally, I illustrate how anthropological attention to the relationships between those who provide care and those who receive it results in a deeper understanding of the clinic as a subjective, messy, and complicated space.

Conclusion

In this chapter I have introduced the theoretical framework of sexual health governance, informed by the work of Morgan and Roberts (2012) and Foucault (1990, 1991) to analyze the ways in which sexual health has been fostered by an assemblage of institutions, social actors, and expert knowledge. These practices of monitoring and regulating sexual health are supported via care, surveillance, and metrics, and I have conceptualized them as specific technologies of governance. I have engaged with the history of medical anthropology, the division between clinic and critical medical anthropology, situating my projects as taking up aspects of both approaches; I pay careful attention to the daily practices of the clinic (both within The Centre and aboard The Mobile) and how a particular understanding of sexual health was enacted while also keeping in mind the larger systemic forces which shape the provision of care. Finally, I have selected key anthropological and ethnographic texts that help me to capture how attending to contemporary clinical encounters means expanding our definition of what the clinic is, its flexibility and permeable boundaries. In analyzing these texts in relation to the technologies of governance I outlined at the beginning of this chapter, I examine how care, surveillance, and metrics were explicitly and implicitly a part of the clinic as a site of governance. However, ethnography's attention to the nuances and subtleties of the contemporary clinic also reveal how governance does not result in an entirely programmed world.

Chapter 2

Methods: An Ethnography of the Clinic and the Sexual Health Landscape

Ebbs and Flows of Volunteering in a Clinical Setting

It is Wednesday morning, and I arrive at The Centre just before 10 a.m. After climbing three flights of stairs, I walk down a short hallway towards the office door. Even though the clinic hours begin at 1 p.m., it is not unusual to see women sitting on the floor or leaning against the wall outside The Centre, waiting for the doors to open. They are there to get one of the early spots. Rose—an Asian woman who is both a counsellor and part of the administrative staff—is already sitting at the front desk, speaking to someone on the phone; I overhear part of the conversation where she reiterates, "There are no appointments; the clinic is walk-in only" before hanging up. I put away my things and come to the reception area for instructions on what work needs to be done. Wednesdays provide the staff with extra time to catch up on all the administrative and practical tasks that come with operating a sexual health clinic.

Today, I spend most of my time shadowing Rose. Training comes in the form of short instructions: use the leftover report envelopes to make packages of condoms for easy disbursement; open the incoming mail and stamp the documents with the current date; or put the previous day's client files in the correct filing office. Through these simple administrative tasks, I am able to piece together the practices and protocols that support the clinic. We often sit in the reception area together while we work, as this allows us to drink coffee and catch up while also keeping an eye on the front door. The door is open, but clients are not allowed to wait inside until noon, so we hand out spare chairs for them to use in the outside hallway. Occasionally clients will come to the front desk, not realizing the hours are different on Wednesdays. Unfortunately, we cannot check them in early or speed up the process.

However, as with all things, there are always exceptions to the rule. There is no doctor, but there is always a counsellor[1] at this time; clients who have an existing contraceptive prescription, or who have a medication prescription on file, can purchase it. Today the counsellor on site is Ines, who speaks Portuguese and is a member of the management team. One young woman, approximately in her late 20s, enters through the doors and pleads with us to see Ines. I head down the long hallway to knock on her door and see if she can speak with the woman. After I explain the situation, Ines agrees to see her; they speak in her office for what seems like an unusually long period of time. The young woman leaves, and I hover in the hallway, waiting for a good time to ask another question. Ines looks exasperated, so I invite her to sit in the reception area and discuss what is bothering her. She is annoyed with the Brazilian health care system. At first, I do not know what she means. As I probe further, she clarifies that the young woman she has just spoken to was terrified she had cervical cancer. The woman had started menstruating when she was 11 years old, and her doctor had immediately placed her on a regimen of continuous oral contraceptive pills because he deemed her “too young” to have a period.[2] After a decade of taking them consistently, she recently went off them, but then received an abnormal Pap smear test result. The young woman came to Ines because she thought there might be a connection between the result and her birth control usage. According to Ines, doctors in Brazil tend to over medicalize women’s bodies and encourage unnecessary testing for profit. She

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[1] Counsellors are not required to have any prior education specific to sexual health; incoming counsellors are trained on-site as to the protocols The Centre’s staff must follow. One counsellor who had been hired fairly recently (within a year of when I first met her) explained the training process. First, the trainee will sit in on counselling lessons with a more senior staff member to see how counselling is performed at the clinic. The second part involves the trainee doing the counselling with the more senior staff member present to oversee them. The trainer and the management staff will decide when the trainee is ready to counsel on their own.

[2] Emilia Sanabria’s ethnography *Plastic Bodies* (2016) speaks to the complicated ways in which menstruation is conceptualized and managed in Brazil.

gestures to the room where current client files are kept, saying, “Have you seen some of their files? They are huge.”

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Introduction

> When I described the range of sites at which my research was taking place (an immunology lab, various clinical HIV settings, AIDS activist volunteer organizations, several urban neighborhoods, and corporate workplaces), a science studies colleague was dismayed. Coming from a tradition of studying science in great detail inside the laboratory, she asked me, “Don’t you know how to stay put?” (Martin 1998, 32)

Much like Martin’s quote, my research methodology was not easily understood by my interlocutors. I did not begin with a clear-cut problem that needed to be solved, nor did I have an end goal of producing knowledge that would improve sexual health care. Rather, I sought to understand how the sexual health care system was structured and envisioned to operate by sexual health social actors, and also to see and experience what was happening in practice. As illustrated in this chapter’s opening vignette, I spent a large portion of my fieldwork in the space of the clinic, familiarizing myself with both the routines and also the women who provided sexual health care services. Being in those spaces—the reception area, the filing room, the counselling offices, the break room, the clinic clerk’s alcove, and the examination rooms—allowed me to see *how* sexual health care was provided and what it took to operate a municipally funded clinic. I wanted the mundane details of what was needed to provide sexual health care, including the administrative tasks, reporting and charting protocols, and supplies. By making The Centre and The Mobile my primary fieldsites, I sought to become knowledgeable about not only the kinds of services provided but also the challenges the staff faced on a daily basis, and how in practice, some routines and protocols became flexible. In allowing me to spend time with the counsellors, physicians, volunteers, clinic clerks, and managers, fieldwork offered a space to capture knowledge about The Centre and The Mobile in a way that was different from during an interview, and included chance encounters, emergent issues, and spontaneous questions I would not have known to ask without this level of intimacy and engagement with my interlocutors in their space.

Ethnography systematically and carefully grapples with difficult subjects. It does not shy away from contradictions but instead embraces them. Anthropologists "take their time, celebrate messy or dirty data, and see questions not as conclusively answerable (especially with numerical data alone) but as provocative of new questions" (Biruk 2018, 203). Ethnography can be thought of as a "storied reality," wherein the qualitative data and the personal engagement of the researcher within a community produces an ethnographic narrative (Madden 2010; see also Hammersley and Atkinson 2007; DeWalt and DeWalt 2011). As such, the immersion of the anthropologist in the fieldsite, combined with sustained interaction with interlocutors, results in a rich ethnographic narrative, one which is not considered definitive but rather nuanced and contextual.

This chapter will first introduce my fieldsite, the sexual health care landscape of Toronto, paying close attention to the two spaces where I spent most of my time: The Mobile and The Centre. While I have identified care and surveillance as key themes in my dissertation, they were also central to my methodology. Shortly, I will provide a reflexive accounting of how my research project shifted from a focus on the experiences of im/migrant women to the clinic and clients themselves. After describing this delicate ethical dilemma, I will move to providing a robust description of my research methods, including participant observation aboard The Mobile and The Centre as well as conducting ethnographic interviews. Since the women I spoke to play an integral role in my analysis, and ultimately my ethnography of the clinic, I dedicate two sections to introducing my interlocutors. First, I define "sexual health social actors," explaining why I use this over other terms such as "expert" or "professional." After introducing the sexual health social actors, I turn to the clients who participated in my project. While I use the term "im/migrant" to capture their multiple and complex migration trajectories and various statuses, I also understand them as offering a unique perspective in terms of The Centre's broader clientele. Once my interlocutors have been introduced, I will pay close attention to the spaces and practices of The Mobile and The Centre, illustrating how my positionality as a volunteer resulted in my participation in both care and surveillance. Finally, I will end this chapter by reflecting on my positionality, my desire to both avoid Othering the clients I spoke with and not wanting to exclude their perspectives. I will also discuss the challenges of interviewing sexual health social actors.

I began my fieldwork by interviewing executive directors working in sexual health clinics or sexual education centres in downtown Toronto and meeting with various sexual health organizations across the GTA. Several months later, I found my primary research sites aboard The Mobile and in The Centre of a sexual health organization that primarily served immigrant women. I utilized multiple methods in the field, including participant observation in these clinical spaces, interviewing sexual health social actors (executive directors, sexual health promoters, physicians, counsellors, program coordinators, and volunteers) and clients who were navigating Toronto's sexual health care system. In doing so, I followed Nader's (1972) call to not only "study up" but also to study down and across. However, while Nader uses this approach to create a “vertical slice” (1972, 292), I understand studying up, down, and across within the context of the sexual health care system to be best captured by the figurative image of the landscape. The sexual health landscape works to capture the ways in which institutions and sexual health social actors operate separately but are interconnected across Toronto. Nader’s call is useful in that it draws attention to how, even though such actors and institutions are differently situated and contain different degrees of expert knowledge, they all play a central role within the landscape and the governance of sexual health. Both being in spaces of care and surveillance and speaking with the women who occupied those spaces was integral to an ethnographic exploration of the field of sexual health in Toronto; my dissertation seeks to address how such a system is envisioned to work in theory, its protocols and governance, but also to examine how what happened at the level of everyday practice did not always neatly align. After every volunteer shift, I wrote a series of jot notes in a small notebook, which would later be translated into a fieldwork narrative.

I obtained written and oral informed consent from The Centre’s management team to conduct fieldwork in their organization at the beginning of my time in these spaces. However, informed consent was continuous. I had numerous conversations with various staff members about the kinds of things I was looking at, writing about, and thinking through over the course of 14 months. These discussions proved to be central to the development of a meaningful relationship of trust with the women aboard The Mobile and in The Centre. Throughout the fieldwork process, members of the management team would express how they wished they could pay me for my work at the organization, even though my role was that of volunteer. It was important to them to ensure I was “getting something out of it.” In addition to conducting ethnographic research in these sites, I wanted to be useful and assured them that no payment was necessary. During my time as a volunteer, I helped to run the reception desk (answering phone calls, locating client files, registering new clients in the electronic database, and sorting incoming reports); I organized and filled out the client chart[3] aboard The Mobile; and I helped Aaliyah run mobile displays across the GTA.

When I decided to begin recruiting interlocutors from The Centre, I asked Donna and Aaliyah if I could sit in on counselling sessions, with the consent of the client. Attending these sessions served two purposes: it allowed me to see first-hand the process of sexual health counselling, and it provided an opportunity to hand out my business cards[4] to potential interlocutors in a setting that offered more discretion than aboard The Mobile. Initially, I attended im/migrant women's counselling sessions exclusively, but after the first couple of days, I decided to sit in on all women's sessions, attending approximately 25 counselling sessions in total. As Aaliyah would leave the room to call for the client, she would indicate whether the file listed a country of origin other than Canada. Before they entered the room, I would identify myself as a PhD candidate conducting a research project on sexual health care and immigrant women and ask the client if I could sit in on their session. I assured them all information would be kept confidential and anonymous. If they agreed and they were an im/migrant, I would hand them one of my business cards and explain my project; this left the decision to participate in their hands.

When one of them did reach out, either via email or text message, we would set up a place to meet that was convenient for them, usually a coffee shop. At the beginning of each

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[3] The client chart involved placing their client label (name, birth date, and OHIP status) onto a form and ticking off boxes that indicated which services they had received.

[4] I designed and printed business cards with the name and particulars of my study, as well as my contact information.

interview, I distinguished myself from The Centre, as I did not want them to assume I was acting as their agent and that I would report back what we discussed. All but one of my interviews came from these interactions during counselling sessions, and I believe this resulted from a degree of self-selection on the part of the clients. All of them were either international students or permanent residents, and in taking my card and making prompt contact, they understood themselves to be "good" research subjects.[5]

I began my fieldwork by interviewing sexual health social actors (SHSAs) as I wanted to gain a better understanding of the sexual health care system of Toronto before I began interviewing the immigrant women who were manoeuvring through it. Additionally, after several months in the field, I decided to make an amendment to my ethics protocol, adding an honorarium for some of my interlocutors as a way to express my gratitude and compensate them for their time and expertise. The 25 interviews I conducted with sexual health social actors and clients were semi-structured and ethnographic in nature[6]; seven were clients, five were sexual health promoters who worked for Toronto Public Health, and the remainder were other sexual health social actors (executive directors, physicians, counsellors, and volunteers). An ethnographic interview "is not as simple as asking a series of direct questions and getting unproblematic answers [and] is a complicated exchange that while obviously instrumental in character, still relies on many conversational norms and patterns to help it to flow and be productive" (Madden 2010, 69). While I prepared interview schedules with specific questions, I was also responsive to the stories my interlocutors chose to tell. Often, we would begin by

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[5] In Chapter 4, I expand on my understanding of these clients' narratives as valuable despite not being representative of The Centre or The Mobile's clientele as a whole and what I learned from their sexual health experiences and perspectives.

[6] I conducted 25 interviews with 24 interlocutors, as I interviewed one of the counsellors twice.

discussing a recent news event. For example, when I met with one of my interlocutors who worked in sexual health, the hearing where Dr. Christine Blasey Ford testified about her alleged sexual assault by nominated Supreme Court Justice Brett Kavanaugh had aired recently, and it was weighing heavily on our minds. While there were specific questions I asked every SHSA and immigrant woman, and specific subjects I broached, being flexible helped me to garner insights into how my interlocutors understood the sexual health care system of Toronto. For SHSAs, I focused on why they had chosen sexual health, and I asked them about their professional roles (including what their day-to-day work lives looked like); I also asked them to reflect on the organizations they worked for; every interview ended with them describing a rewarding and a challenging moment in the field of sexual health (see Appendix A: Sexual Health Social Actor Interview Schedule). Interviews with immigrant women traced their experience in coming to live in Toronto, how they navigated the sexual health care system, and their beliefs and practices regarding sexual health (see Appendix B: Immigrant Women Interview Schedule). I followed Madden's assertion that a good ethnographic interview "will give the ethnographer insight into how a participant sees the world in analytical, typological, and relational ways, and such information helps to create insight into the participant's worldview" (2010, 73). All interviews were recorded using the app Voice Memo on an iPhone designated for research activities. As many interviews took place in public spaces, such as coffee shops, I brought with me an attachable microphone, which could drown out ambient noise. Even though I was recording all interviews, I did take notes; noting preliminary details and particular quotes or questions they provoked. After each interview I translated my notes into an ethnographic narrative in a Word document.

Before introducing the category of sexual health social actors and my interlocutors in the sexual health landscape, I want to address the issue of their background in terms of race, ethnicity, and nationality. While each client was asked about their country of origin, other sexual health social actors who worked across Toronto's sexual health landscape were not asked this question. Some of my interlocutors freely offered this information, typically to contextualize their perspective or to situate themselves within a particular story from their work. I do not wish to make assumptions about their race, ethnicity, or nationality when this information was not offered. Additionally, The Centre, The Mobile, the Toronto Public Health sexual health promotion team, and organization typically form smaller communities where interlocutors could be more easily identified. Therefore, I have chosen to anonymize mentions of their nationality, ethnicity, and race by generalizing their background to maintain their anonymity and. I will also anonymize the backgrounds of clients in the same way to maintain uniformity in the dissertation.

Sexual Health Social Actors

Over the course of 18 months of fieldwork, I interviewed 17 sexual health social actors who were situated across various educational, occupational, ethnic, and religious backgrounds. I created two categories of interlocutors: sexual health social actors,[7] who either worked or volunteered in the field of sexual health care in Toronto, and clients. I use the term "sexual health social actor" over other terms such as "sexual health expert" or "sexual health professional" for three reasons. First, while they do possess varying degrees of expertise and hold authoritative knowledge relating to sexual health, I wanted to move away from a distinction that would frame them as the experts and the clients as non-experts. While the clients were not

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[7] At The Centre where I did my fieldwork, counsellors were not required to have any specific education related to sexual health but were expected to complete training on-site; the same went for volunteers.

trained in sexual health care, health promotion, or managing a sexual health clinic, they too were experts in their own sexual health. Clients held experience in the sexual health care system, often in multiple countries, and were aware of their sexual health needs. Additionally, a crucial component of the relationship between sexual health social actors and clients is the information the latter possess, as counselling or examinations cannot be performed without patient histories and context. However, while I seek to critique the label of "experts," I also recognize the ways in which expertise is central to models of sexual health and their governance, and this is something which will be addressed in Chapter 4. Secondly, I use the term "social actor" to encompass all persons who work, volunteer, or operate within the sexual health landscape, to capture the heterogeneity of positions which carry out and support sexual health care and sexual health governance. Sexual health social actors include physicians, counsellors, volunteers, management, executive directors, administrative staff, clinic clerks, and sexual health promoters. While these positions vary in terms of education, skills, and expert knowledge, they all play an integral role in keeping the operations of sexual health care running smoothly and supporting the governance of sexual health in Toronto. Thirdly, and finally, I use the term "sexual health social actor" to recognize my interlocutors as professionals acting in the landscape of sexual health, but also to acknowledge them as individual people whose experiences, perspectives, and skills need to be particularized. In labelling them social actors, I am also reiterating how I understand the clinic (and the health care system) as a cultural site, one where its staff do not represent an entirely neutral, asocial monolith.

The executive directors were responsible for overseeing their respective sexual health clinics, ensuring proper care was provided and working in a management capacity. The physicians I spoke with and interviewed all worked either aboard The Mobile or in The Centre;

while some also took on shifts at hospitals and CHCs, they all expressed an explicit interest in sexual health care. The administrative staff who worked in The Centre were responsible for greeting clients and collecting their files, managing incoming mail and test results, and ensuring the flow of care meant clients saw counsellors in the order they arrived at the clinic. The sexual health promoters who worked for TPH came with vastly different backgrounds and had been working in this capacity for periods of time ranging from months to decades; their jobs entailed community outreach and the circulation of sexual health information and resources, including facilitating workshops in high schools, women's shelters, parenting classes, and with community organizations. When I spoke with Jenny, who was new to being a sexual health promoter, she explained how she assumed one needed to be a nurse in order to get this kind of job; to her surprise, an applicant only needed a history of experience in sexual health, preferably in a community and social justice capacity. I interviewed volunteers from a sexual health clinic and post-secondary sexual education centre, young women who were passionate about young people's sexual health. Some of the sexual health social actors I interviewed not only worked within the sexual health system but also had an educational background in sexual and reproductive health. I met one young woman, Elise, at a youth sexual health symposium held at the University of Toronto, who was completing her M.A. and had conducted research in Black communities in relation to HIV/AIDS prevention. Another young woman, who was second generation, had co-created a blog that highlighted the voices of immigrant and second-generation youth in Toronto, featuring poetry, art, and articles on sexual health.

As much of my time spent in the field was within the walls of The Centre and aboard The Mobile, I think it is important to introduce the key sexual health social actors who worked in these spaces. From the beginning of my fieldwork, all the counsellors, administrative staff, and physicians in these locations were supportive and interested in my project. For example, Rose, a Filipino woman who had previously worked in childcare before coming to The Centre, was a calming force at the reception desk, offering advice and reassurance as I learned the clinic's practices and protocols. Both Ines and Katherine expressed their concern over whether I was getting what I "needed" out of volunteering in The Centre, as they appreciated my presence as a volunteer. Ines, who had immigrated from Portugal and had been with The Centre and The Mobile for many years, offered insight into how the organization had changed over the years through storytelling. In the span of my fieldwork, Catalina had shifted roles from being the clinic clerk (with duties including drawing blood and managing samples for testing) to counsellor; as someone who spoke Spanish, she was an invaluable addition to the team. Catalina was driven in the ways she supported The Centre and The Mobile, taking it upon herself to update intake forms and prepare testing forms for mobile clinics in advance. Kwan, a South Korean practicum student who arrived shortly after I began volunteering at The Centre, was someone who radiated positivity and was keen to get into the field of sexual health. Irene, the member of the team with the most experience at The Centre, was inquisitive, asking questions about my project, and quick to make a joke to ease tensions. Aboard The Mobile, I met and became close with three physicians, Dr. Shereen, Dr. Morena, and Dr. Priyanka. Dr. Shereen was a recent medical graduate who had been hired to work at mobile clinics on a regular basis; she was enthusiastic about my project (specifically my use of ethnographic research methods) and offered nuanced reflections on working in rural communities during her residency. Dr. Morena, after several years of practicing medicine abroad, had returned to Toronto to complete a fellowship, picking up hours both aboard The Mobile and within The Centre. I can clearly remember the ways in which Dr. Morena persevered through her first mobile clinic, one which was scheduled on a sweltering day in May and during Ramadan. Dr. Priyanka was a long-term member of The Centre and The Mobile, having recently returned from maternity leave when we first met. She was known for her efficiency in the number of clients she could successfully see during mobile clinics and the care she took in performing first-time Pap smears.

Finally, there were Donna and Aaliyah, with whom I spent the most time during my fieldwork, first aboard The Mobile and then in The Centre. Donna, a European woman who had immigrated to Canada during her childhood, grew up in downtown Toronto. As we drove to and from mobile clinic locations, she would point to a building or across an overpass before telling a story from her experiences in the city. She remained close with her parents and had an extended family network living in the area. Donna was not only enthusiastic about the work she did but was generous with her time, always willing to discuss any aspect of sexual health care, The Centre, and The Mobile. Aaliyah was equally generous with her time, as I spent many mornings sitting in her office, discussing the latest developments in the clinic and strategizing for upcoming mobile clinics. She had completed her Master of Science in Nursing and had spent a few years teaching at a local university before coming to work at The Centre. Through our conversations, I would learn that family meant everything to her, and she had a close relationship with her parents, sister, and son. Aaliyah took both a practical and empathetic approach to providing sexual health care for her clients.[8]

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[8] Instead of providing biographical details for each client in this chapter, as I have done for other sexual health social actors, I have decided to leave include this information in Chapter 4. As my focus shifted from immigrant women to the sexual health care system itself (and the social actors within it), I will introduce the clients I interviewed as their narratives appear in Chapter 4 to contextualize their position within the sexual health landscape.

Accessing the Field of Sexual Health Care in Toronto

Anthropologists are no longer required to travel to faraway locations or to study people and cultural belief systems that were exoticized in the past. However, conducting fieldwork "at home" comes with its own set of considerations and challenges, and requires "looking and listening in particular anthropological ways, rather than being in particular kinds of places" (MacDonald 2007, 12). While I had some idea of how difficult it would be to get into some of the spaces I needed to access for my research, I woefully underestimated how long and how tedious this process would be at times. After making a series of cold calls, sending emails, and contacting various sexual health organizations across the GTA, the response was lukewarm. Some organizations encouraged going through their own ethics and research review, as this was needed before I would be able to speak to someone at their organization: others never responded. As I look back on the first meeting I had with Katherine (the administrative coordinator) and Donna, the amount of work needed to make my project intelligible to those working in the sexual health care was substantial. Ethnographic research was not readily translatable to an area where quantitative studies were the norm. I did not want them to envision me as someone who would come into the space and sit on the sidelines while continuously taking notes; I wanted to be an active participant, creating a mutually beneficial relationship with The Centre.

While The Centre and The Mobile were my main fieldsites, I was also interested in entering public health spaces and speaking with SHSAs who worked within them. Sexual Health Promotion is one department of Toronto Public Health. I wanted to talk to sexual health promoters (SHPs) so that I could understand how the sexual health of immigrant women would be understood by those responsible for providing sexual health workshops in the community in an effort to promote and improve residents' sexual health. While I had many questions, I would have to wait for over a year to get any meaningful answers. The process of going through a city-level ethics review was an exercise in patience, but it also provided insight into what kinds of information those who seek such clearance typically include in their studies. For example, there was a long matrix of “types” of data that could be collected, and the applicant was instructed to tick off whichever applied and provide a justification as to why that kind of data would be necessary. As a medical anthropologist, many of the boxes I checked off spoke to the kinds of questions I would be asking, and the rationale I gave for all was “contextualization.” There were several back-and-forth emails from the ethics coordinator at TPH; it seemed that the type of project I was undertaking and what I was seeking from them (to interview sexual health promoters) did not readily fit into their understanding of health research. The application form was largely geared to quantitative research, a theme which will be explored in the following chapter, and therefore an ethnographic approach to interviewing required further explanation. However, this process was equally frustrating for those working within the system, as one sexual health promoter, an Asian woman named Sandra who had worked in the field of sexual health for three decades after immigrating to Toronto, lamented with me before our interview. At the time, she had just received clearance for an internal project after six months of review.

Once I received ethics approval from the Toronto Public Health Research Ethics Review Board, I contacted the head of sexual health promotion via phone, and we created a plan for recruiting sexual health promoters for interviews. At first, she suggested instructing staff to contact me, emphasizing that it was “their job” to support research projects. I was not comfortable with this and felt that it would compromise informed consent, and therefore asked if I could send her an email containing a call for participants that she could circulate with a blinded email address. At the same time, it is significant that participating in research is conceived as a part of their position as municipal public health employees Ultimately, after over a year of trying to obtain ethics clearance with them (which included creating a new informed consent document and submitting such changes as an amendment to York University's Office of Research Ethics), I was able to send out a call for participants, and five sexual health promoters responded.

The Mobile Clinic

Looking back through my fieldnotes, I can pinpoint the moment in which I got my foot in the door of the sexual health care system of Toronto. It came when I interviewed Donna. We had an instant rapport with each other, and I think she could sense my enthusiasm for learning more about the work the organization did; before I could even ask, she had invited me onto the mobile clinic. During the first few mobiles, I felt slightly out of place; not knowing any of the protocols or routines, I spent most of my time observing and not participating. However, while the mobile clinic could get quite busy, it also afforded time for more intimate conversation; being in that space allowed me to attend to *what* matters and *why* it matters (Pigg 2013, 133). Travelling across the GTA with The Mobile's team gave me a sense of who the organization was serving, and in some ways offered a window into the past. Almost every location where we were scheduled to run a mobile clinic had a long-standing relationship with The Centre. Donna would frequently introduce me to the main contact at each organization (adult learning centre, settlement organization, church, or women's shelter), while emphasizing how many years they had been partnered; in some cases, The Mobile had been working with agencies for over a decade. The clientele of The Mobile, those who sought care during these clinics, depended on that day's site. For example, when we went to Adult Learning Centres, clients were a mix of recent immigrants or refugees and Canadian-born students. A large proportion of all three categories were racialized. At settlement organizations, almost all clients were immigrants or refugees. Overall, the proportion of immigrants and racialized clients (with these two categories not being mutually exclusive) aboard The Mobile was high. This is not to say that immigrants, refugees, and racialized clients were not seen at The Centre but there was also a growing population of Canadian-born and white clients seeking services at the home base clinic. While men were allowed to seek services at The Centre and The Mobile, they typically made up a much smaller percentage of clients seen.

The bus was demarcated into three spaces: the front of the Winnebago (where the driver's and passengers' seats were located) was the primary location for counselling clients, while the middle section contained bucket seats for the women coming aboard The Mobile and a long countertop, where Donna worked to organize the testing and samples, while keeping track of client information. The back of the bus was where the examination room was located; it included a small desk and seat, as well as a table with stirrups. Through volunteering aboard The Mobile, I gained a clear understanding of what was expected in terms of protocol, while also experiencing when things went "wrong" in practice. When there was a lull in foot traffic, I would sit in any of these sections and chat with the counsellor, the coordinator, or the physician. As Wendland puts it, "[m]edicine is full of stories" (2010, 6), something I found to be the case while conducting fieldwork aboard The Mobile and at The Centre. However, it was not only doctors who shared stories, but also counsellors, management, support staff, and volunteers. Since I was in the space of the mobile clinic approximately twice a week for several months, these narratives allowed me, as a medical anthropologist, to ask questions about issues that I would not have thought about prior to entering the field. Whether it was an official poster from the government outlining types of contraception and provoking disagreement among staff, or a counsellor re-telling a client's story to work through the best way to help them, this kind of storytelling was prominent in the field.

While I had learned a little about the mobile clinic's operations during my interview with Donna, being in the space was something entirely different. The description she offered, experiencing The Mobile as more "dynamic" than the main centre, was highlighted every time I attended them. Depending on the location of that day's mobile clinic, I would meet the team (Donna and Aaliyah), either on site or at the main centre in downtown Toronto. The physicians almost always met us on site. I would arrive at The Centre at approximately 8:15 in the morning and help Aaliyah collect everything we would need for the day; sometimes this included stocking supplies (Pap smear specimen jars, plastic speculums, condoms, and occasionally the files of returning clients who had signed up for the day). Once Donna arrived, we all piled into her vehicle with the numerous bags, a briefcase, and a cooler before heading to the parking lot where The Mobile was held;[9] this could be a high school, a settlement organization, a church, an apartment building, or a shelter.

Over time, my role with the mobile clinic shifted. When I was new to how the team operated, it felt odd to sit on one of the bucket seats in the centre section of the bus, shuffling from area to area to accommodate clients coming aboard and the movement of staff. I truly wanted to participate in what was happening and to be a help rather than a hindrance. I was primarily responsible for greeting clients when they climbed the stairs onto the old Winnebago, offering them a green folder with blank forms inside, attached to a clipboard with a pen. Each

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[9] A discussion of how the travelling to a given mobile location offered insights will be featured in Chapter 4.

client had to fill out the first page[10] with their background information, including their name, address, whether they had an OHIP card, their emergency contact, and a signature agreeing to the terms of The Centre, indicating they understood their rights and how the information would be used. When they had completed the form, I took the file and used the label maker to create a sticker for several things: the clipboard where Donna could tick off which tests were done for that particular client, the sample containers and swabs, as well as all of the documents in the file. As I spent more time aboard The Mobile and came to learn the protocols, services, and even information about the tests themselves, I answered client questions to the best of my ability. However, The Mobile was just one piece of the puzzle for this organization, as all the testing specimens (Pap smear jars, urine samples, and swabs) and information gathered had to be transported to The Centre.

The Centre

As the summer approached, Donna and Aaliyah explained that the number of mobile clinics would dwindle over the next few months. It was Donna who suggested I come and volunteer at The Centre. It took several months to begin to grasp how everything was interconnected: counselling services, record-keeping, filing reports, examination visits with doctors, public health guidelines and check-ins, and running the reception desk. Ethnography drives theory (McGranahan 2018), and being in the space of The Centre through volunteering offered a unique window into understanding what was needed to run an independent sexual health clinic, how care was imagined and enacted in practice, and the role of surveillance. I engaged in administrative and practical practices (pulling/creating new files, updating client information,

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[10] I will provide a more in-depth accounting of the various forms of documentation used and required by The Centre in Chapter 5.

handing out cases for counsellors, opening the mail, answering questions, etc.). On occasion, these administrative practices and routines were punctuated by “incidents” and “special cases,” for example, doctors calling in sick and the clinic being short-staffed, low supplies, and technological issues. Frequently, working in a sexual health clinic involved handling difficult and delicate issues; this usually entailed pulling another team member aside to figure out a solution. Often a counsellor, an administrative staff member, or a physician would recount these cases when we were away from the reception area. One of the advantages of conducting ethnographic research in this clinical space was the way in which it allowed me to see the day-to-day negotiation of such issues, to see how sexual health care as a job was fraught with difficult conversations, challenging interactions, and bureaucratic constraints. Through writing fieldnote narratives about all these practices, interactions, and conversations, my analysis attends to how The Centre was structured in theory in contrast to what happened on an everyday basis.

While volunteering at The Centre, approximately two to three days a week for four to five hours a day, I was responsible for helping Rose, the administrative support staffer, run the reception desk. This included answering phone calls, attending to client questions, keeping track of the order clients came into the clinic through small squares of paper with numbers written in black permanent marker, and checking in clients. If someone was new to The Centre, much like aboard The Mobile, a new file needed to be created, both in the form of a physical copy and by entering their information into the computer database. If they were a returning client, I would ask for their file number or name and date of birth in order to pull their existing file from one of the various rooms where documents were stored. The Centre kept client records on site for five years, after which they were transferred to an off-site centre before being destroyed. After learning these skills, I was shown how to organize and record incoming reports in the form of public health lab results; I highlighted the client's name, stamped the date received, and found a binder for the month in which testing took place in order to tick off when the report had arrived. Afterwards, the client's file needed to be located, and the report would be attached with a paperclip and left in the attending physician's basket for their review. Spending time in The Centre allowed me to form closer relationships with the management team, the counsellors, and Rose, as well as with the clinic staff and physicians. By being immersed in the daily tasks and routines, I was able to ask questions in response to things that were happening in the clinic in real time.

Conducting Research in the Sexual Health Landscape: Reflexivity and Ethnographic Tensions

For this PhD research, I had initially proposed to study why the sexual health of African newcomer young women is an object of intervention in Toronto, and how sexual health experts define and describe this problem in the field of sexual health. This proposal was built upon previous research conducted during my master's degree, where I was a part of a community-based participatory project. My piece of this larger project had been focused on interviewing African teen girls and young women; in coming to Toronto, I wanted to continue such work in a city with a more substantial sexual health care and education infrastructure as well as numerous immigrant communities living in the downtown core. When I began my doctoral fieldwork, it quickly became clear that I wanted to be in the space of a sexual health clinic, as I understood this to be an important site, where sexual health care and education was provided and received. Gaining access to the types of spaces I needed to be in for my project proved to be difficult, and part of this, I believe, was largely due to the fact that I needed to make participant observation legible to the women running The Centre. I explained how anonymity and confidentiality would work in writing my fieldnotes and later my dissertation, emphasizing how I was not there to conduct an “exposé” of what happened in the clinic, but rather to try to understand how it operated, their experiences of working there, and the process of meaning-making in sexual health care.

In some ways, the label of being a “graduate student” or “PhD candidate” led to open conversations about what anthropological research looked like and how the information would be disseminated afterwards. The women I worked with at The Centre and aboard The Mobile were curious about the nature of ethnographic work, and so I explained the value of participant observation to them; this kind of research contrasted with other studies they were familiar with, which had drawn upon large sample sizes and statistical findings. In this regard, I understood myself as a student of the sexual health landscape, and the social actors I interacted with were the experts in this field.

In carrying out ethnographic research within Toronto’s sexual health care system, I found myself both actively participating in and supporting sexual health governance, while simultaneously critiquing it. Care and surveillance were embedded in the practices of sexual health social actors in the space of the clinic, which is reflected in The Centre and The Mobile’s commitment to their grassroots feminist roots, while simultaneously engaging in practices of (ac)counting to produce the required metrics, which would allow them to maintain their core funding. As a medical anthropologist who has conducted sexual health research and has made sexual health the focus of two degrees, in the field I saw a clear tension between discourses of empowerment and choice, and discourses of governance and (ac)countability. Anthropologists such as Singer (2016) have argued that increased reproductive rights inevitably entail increased governance. In her ethnographic accounting of the legalization of abortion in Mexico, Singer draws attention to the ways in which championing a woman’s right to choose an abortion directly opened a space for increased control and regulation over women’s bodies. In reflecting on my fieldwork, I follow Singer’s (2016) work to think critically about how sexual health is both enabling and constraining, is both empowering and subject to governance, to account for how it can be performed with the intention of supporting clients through accessing care while also being a part of a system that places constraints on said care. In Biruk’s reflections on their positionality in the field, particularly in terms of how the goals of both demography and anthropology differ, they state, “I recognized myself as a sympathetic outsider to practitioners and from a discipline whose goals were at odds with the tenets anthropologists hold dear” (2018, 15). Within my own fieldsite, I can relate to Biruk’s statement. I understand the value of making sexual health care accessible to clients and learning the proper protocols for providing and recording care. At the same time, I also recognize that volunteering aboard The Mobile and in The Centre required my participation in systems of surveillance and governance, which I have critiqued—and continue to critique—anthropologically. Biruk’s words remind us to hold the tension between our own critical gaze as medical anthropologists and the perspectives of our interlocutors, for even when there is tension between the two, this also does work in revealing why something we problematize is so easily taken up in our fieldsites.

I will also admit that my position as a volunteer aboard The Mobile and at The Centre helped with the negotiation of access by organization leaders and high school principals; by conducting participant observation in a volunteer capacity aboard The Mobile, I was able to enter spaces which, under other circumstances, would not be available to me; such spaces included high schools, churches, shelters, settlement organizations, and apartment complexes. I also would not have been allowed to volunteer at The Centre or aboard The Mobile if I had been a man, as the organization hired only women. In other ways my positionality, namely my educational background, stood as a barrier when at first the administrative coordinator felt that I would be “bored” with the mundane tasks a volunteer would have to complete at The Centre.

I had conversations with sexual health social actors and clients about why I had chosen this kind of project; the implicit question being why a white woman was interested in writing about a sexual health clinic which primarily served im/migrant women. This led to honest and open discussions about the feminist movement, anthropological projects of ethnography, and positionality. In these discussions, I would emphasize how I did not want to focus my project on the experiences of white, middle-class women, as much had already been written about them to the exclusion of racialized women and im/migrant women. The unspoken double-edged sword which underpinned these reflections was my desire to also not Other the women whom I was seeking to make the focus of my doctoral research, to not exoticize their experiences in this singular focus on the category of “im/migrant women.”

The original focus of my research shifted after entering the field, from examining the experiences of immigrant women in Toronto’s sexual health care system to researching the system itself, specifically within The Centre and aboard The Mobile. After several months of fieldwork, I began seeking out clients to interview, a process which I had put off, as I felt uncomfortable with the recruitment process. I spent a few months debating the best approach to recruiting immigrant women who came to the clinic for interviews. During one shift on The Mobile, I handed out business cards to clients I had identified as falling under the category of “immigrant,” by checking their country of origin listed in the file. While I handed out several cards, I was apprehensive about this undertaking; there was little privacy on the bus, and I could not help but wonder whether other clients were questioning why I was handing out small pieces of paper to some of the women and not to others. In my fieldnotes about this particular day, I reflected on how deciding when and whom to invite to participate in my project left me with a feeling of uneasiness.

The majority of The Mobile's clients were racialized in addition to being immigrants or refugees. Racialized women face significant barriers to sexual and reproductive health care while also being the target of public health and state policies, labelled as either "at-risk" or "risky" (see Bridges 2011; Davis 2019). In effect, health care systems can operate as "perpetuating racial and social inequalities" (Bridges 2011, 15) even as clinics try to address these issue by providing accessible care. Again, I return to Bridges' use of the image of the carceral archipelago, where racialized women at Alpha Hospital were able to access free prenatal care under the condition that they submit themselves to increased scrutiny by the state. The Mobile strove to provide free, culturally sensitive, and accessible care to their clients across the Greater-Toronto-Area, yet these services still exist within a system which targets and surveilled racialized women.

As both a researcher and a volunteer aboard The Mobile, I was obligated to participate in the workings of sexual health governance by collecting client information and managing client files, along with the order the women were seen by the counsellor and physician. At the same time, I did not want to add to the surveillance of clients who were already experiencing various forms of categorization. I did not want them to feel that they were being "put on the spot" in front of others on the bus, or that they felt obliged to accept my card to receive The Mobile's services. I felt strongly about not wanting to single out or marginalize the im/migrant women aboard The Mobile in attempting to find interlocutors who would be willing to participate in my project.

This delicate ethical dilemma is something I struggled with throughout my research and ultimately resulted in my feeling defeated on several occasions. Here, I turn to Visweswaran's reflections on "feminist ethnography as failure" (1994) to analyze where I felt my own project had gone awry. Visweswaran describes a fieldwork encounter wherein she travelled to a woman's house to request an interview. Visweswaran was greeted with a host of issues: re-scheduling the interview upon realizing the woman was prepared to conduct one on the spot; the presence of the family; their expectations of a televised setup and not two women from a university; and the woman's eldest son continually interrupting the flow of conversation, shifting the focus from his mother to the experiences of his father in the Indian nationalist movement. Ultimately, Viswesaran left with her friend Geetha, feeling defeated about the entire meeting. This story is important, but equally important is Visweswaran's reflection on the "failures" of feminist fieldwork. She outlines how others have written about such disastrous encounters during fieldwork, but she notes that they frame these incidents as learning opportunities and provide lists of recommendations or strategies to ensure they will not be repeated (see De Vita 1992; Anderson and Jack 1991; Minister 1991). Instead, Visweswaran argues we should be writing about when feminist intentions "fail" (1994, 97), and what this says about our assumptions and practices of representation in the field. While my choice to not continue attempting to locate participants aboard The Mobile felt like a failure in the moment, ultimately it also reflected my analysis and concerns with the nature of sexual health care—the inseparability of care and surveillance—which led to my ethical reflections on what it meant to be an anthropologist embedded in the provision of care. By the time I was finishing interview the self-selected clients and wrapping up my fieldwork, it was clear that even those women did not necessarily fit within the scope of the clinic's clientele or my search to speak with immigrant women, as the majority were international students. This realization came surprisingly late, as I came to grips with the fact that my project was no longer focused on immigrant women but instead on The Centre and The Mobile, an organization with a care ethic dedicated to serving immigrant women. I believe this realization came at such a late stage in my research due to the fact that by situating myself in The Centre and The Mobile, it still felt as if my research was about immigrant women. Providing free and accessible care played such a substantial role in the creation of these clinics and the commitment of the staff to continue doing such work; this ethos was still ever-present even as the demographics of their clientele changed over time. My research was centered on the work of the clinic, the space and place of the clinic, and how it fit into the broader sexual health landscape of Toronto.

In a recent chapter, Dána-Ain Davis and Christa Craven (2020) reflect on such calls within the legacy of feminist ethnography. While feminist ethnography does not have a singular definition or focus, the authors describe it as an "enterprise where method of data collection, analysis and politics merge" (2020, 282). Since the 1980s, feminist ethnography has long contended with questions of how to avoid the exploitation of women as objects of research inquiry, as well as how and when to centre ethnography on particular communities of women. In particular, Davis and Craven highlight the work of Chandra Mohanty (1984), whose *Under Western Eyes: Feminist Scholarship and Colonial Discourses* criticizes the social construction of the "Third World" woman, arguing that feminist ethnography is not about "collecting" their stories but also about these women's everyday lived experiences (1984, 285). In reflecting on my feelings of uneasiness with identifying and approaching im/migrant women aboard The Mobile, I now understand this as a reaction against wanting to simply "collect stories" without getting to know the women's everyday lives and relations of power, and as a desire to avoid Othering practices. In this way, I actively take up Craven and Davis' definition of reflexivity in my analysis, not just as listing a set of axes of identity (see Narayan 2012) but as "interrogating the position from which one researches and writes" (2020, 286).

In taking a reflexive approach to ethnographic interviewing, I quickly learned how my positionality as a researcher sometimes resulted in particular interactions with sexual health social actors. For example, many of the physicians, counsellors, and coordinators I interviewed would consistently check whether they were giving me the kinds of "data" I needed or encouraged me to ask all the questions on my interview schedule. I found two themes occurring with frequency while interviewing sexual health social actors: performing expertise and apologizing for going "off script." To illustrate what I mean by "performing expertise," I noticed that while interviewing executive directors, sexual health promoters, and physicians, there was a tendency for them to want to reiterate the "facts" and highlight the organization's point of view, thus leaving little room in some cases for anything deemed "subjective." I found myself having to do the work of gently encouraging them to expand on these official narratives, which involved re-formulating my questions, sometimes bringing up recent news events, and expressing my own views on a subject that were more critical, as this sometimes signalled to them that they could also express a viewpoint that did not necessarily align with their job. At times they would reiterate what the TPH policy would have them do, while at other times they reflected on personal experiences in their work as sexual health promoters. Additionally, I felt the need to share parts of myself, my own views and experiences, in ethnographic interviews as a form of reciprocity.

One of my interviewees, Dr. Morena, a second-generation South Asian woman in her mid-30s, worked in The Centre and occasionally came aboard The Mobile. When I met her in the spring of 2018, I learned that her career trajectory after graduating from medical school in Alberta had been vast. She completed a family medicine residency at St Michael’s hospital in Toronto and specialized in inner city populations. She then moved to New Zealand, where she practiced family medicine, urgent care, and sport medicine for a rugby team. Dr. Morena then focused on travel and tropical medicine. Through her interest in contraception, she became a part of a collaborative group that worked to create a map of medicine, which she explained as the process of standardizing guidelines for medicine. Her working group explicitly focused on reproductive health and standardizing care for contraception. She spent time in Nepal as a part of a gynecological and midwifery group from the United States and, at the time of my research, was completing a fellowship in Toronto in an infectious disease unit. At the beginning of our conversation, Dr. Morena joked about her husband’s reaction to my scheduling an interview with her, saying, “Why would someone want to interview you?” This teasing speaks to a larger issue when interviewing experts in the field of healthcare, that of questioning why an anthropologist would be interested in speaking with a group of people, as the women I spoke with traditionally did not think of themselves as being key interlocutors. I understood Dr. Morena’s experience with sexual and reproductive health in multiple contexts in addition to working at The Centre as important to understanding sexual health care from a biomedical perspective. In my interview with her, I saw the ways in which she would reiterate guidelines and expert knowledge in her responses to my questions. At the same time, when I pushed further or revealed a differing perspective I held, it was almost as if this gave her permission to veer away from more standardized answers.

I saw the ways in which sexual health social actors not only felt out of place being interviewed, but also how they dealt with these feelings by needing to stay on task and not do what they considered to be straying from the interview. A young Canadian-born woman of West-African and Caribbean ancestry, Winners, who worked as a research coordinator at a large health organization for women of colour in Toronto, apologized for "going off script" after telling a beautiful story about how her grandmother's work as a nurse and midwife in Jamaica inspired her to focus on the issue of sexual health in her research career. The apology signified how she viewed such a narrative as out of place in an interview, and as something that sharply contrasted with how she had prepared for our meeting; she brought a folder which contained a stapled printout of her organization's PowerPoint.[11]

Clients

The category of "immigrant", not unlike the category of "woman," is simultaneously complicated and homogenizing. It fails to capture the intersectional complexity of the women I interviewed and had informal conversations with at The Centre and aboard The Mobile. Migrants occupy "multiple subject positions, some of which they define for themselves and some of which are defined for them" (Brettell and Sargent 2006, 4). We can begin to unpack this category by first looking at the ways "immigrant" is used by the Canadian government. If we look at the Government of Canada's (2020c) website on how to "Immigrate to Canada," we can see that immigrants are broken down into several categories including those eligible for family sponsorship, skilled workers, caregivers, start-up visa holders, and refugees. What is not included in this list is international students, who are considered temporary residents (Ontario Council of Agencies Serving Immigrants 2020) but also "prospective immigrants" (Neiterman et al 2018, 396); This is important because the majority of clients with whom I conducted formal

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[11] When I contacted Winners later that week for a copy of the PowerPoint slides, she explained that her supervisors did not want her to circulate it.

interviews had come to Canada to either attend university or college, and thus they occupied a particular status with regard to their ability to access to health care services, including sexual health care. Specifically, they were not eligible for OHIP but rather obtained health insurance through either their respective postgraduate institutions, purchasing private coverage, or through being identified as a dependant on their partner's insurance.

I use the term "im/migration" to leave its definition open and fluid, to contend with not only how my interlocutors understood their own subject position but how they were understood and categorized by public health and The Centre. Many of the im/migrant women I interviewed had come as international students, which I learned was one of the easier ways to immigrate to Canada. Selena, who had left South America amid political strife and widespread civil unrest, specifically came to Canada to study English because it was the quickest path for her to leave her country. Nina, who had come from South America after completing a bachelor's degree in journalism, attended college in Toronto before applying for a work permit. Many of the women who came as international students saw this status as not only a way to leave their country but also a path forward to eventually obtaining a work permit, which would allow them to stay in Toronto. Their experiences as international students are a part of the im/migrant experience, as all but two came by themselves in the hopes of staying permanently. Two were married, but none of the interlocutors had children. I met all the immigrant women I interviewed through sitting in on counselling sessions, except for Dayana, who saw one of my recruitment posters in a sexual education centre. These women ranged in age from 19 to 35 years old. The term "immigrant women" is a broad category, which has room for their heterogeneous perspectives and lived experiences, but I would like to dedicate space to describing the particular circumstances of the women who generously shared their time with me as research participants.

While the women I interviewed are not representative of the full range of clients who came to The Centre and The Mobile, their narratives provided insight into the workings of sexual health care in Toronto and their experiences of seeking care to self-manage their sexual health. Therefore, while the findings of this research could have benefited from the richness of The Mobile clients' narratives, reorienting my project to focus on The Centre, The Mobile, and the landscape allowed for critical engagement with the enabling and constraining elements of health care provision more deeply. In particular, it also allowed for an analysis of multiple sexual health social actors as being invested in the project of sexual health, while wanting to see it done differently. Even though most of these women had some form of private insurance or OHIP, they still came to The Centre for free sexual health services; while cost was a factor, they also came to the clinic because it provided specialized, tailored sexual health care, which offered a different experience from simply going to a walk-in clinic or family doctor. They expressed their frustrations in accessing care and being in clinical encounters, but all praised The Centre as providing them a different kind of care, which they had not received at other walk-in clinics. Additionally, their narratives revealed the complex negotiations involved in accessing clinical care and their desire to be educated, self-managing sexual health choice-makers while also being challenged by biomedical and institutional authority.

Conclusion

From late 2014 until mid-2015, I conducted ethnographic research in Winnipeg, Manitoba, on a Canadian Institute of Health Research (CIHR)-funded community-based research project for my master's degree. The goal of this project was to engage critically with the idea that African newcomer youth were "at risk" for HIV/AIDS, and my M.A. thesis focused on sexual health messaging. While the scale of that research was far smaller than what I envisioned for my doctoral project, what remained the same was my interest in what ethnographic fieldwork could bring to the study of a subject that is fraught with contestation—sexual health empowerment and health care governance, biomedical embrace, and feminist critique. How did the sexual health care system of a large metropolitan, multicultural city operate? How were various social actors, across space and time, connecting within this field? In undertaking methods that would garner answers to these questions, and thinking about sexual health, health care, and sexual education as a complex landscape of interrelations, I took an anthropological, reflexive, and feminist approach to research, which enabled drawing parallels between the ethical quandaries I grappled with in the field and the issues of need, intervention, surveillance, and care. Practices of meaning-making, circulating discourses, and nuanced embodied accountings were critical to better understanding my fieldsite: the sexual health care system of Toronto. I follow McGranham's definition and usage of the term "ethnographic sensibility," as a "sense of the ethnographic as the lived expectations, complexities, possibilities, and grounds" which animate anthropology (2018, 1). Conducting participant observation both at The Centre and aboard The Mobile provided insights into how sexual healthcare services are imagined, provided, planned, and recorded, while also offering spaces where intimate conversations flowed freely. In this chapter, I defined my term "sexual health social actors" and revealed why I am invested in capturing their complicated experiences of participating in, providing, and receiving sexual health care. Events often unfolded during fieldwork in unanticipated ways, and I had to learn to seize on the relevant opportunities that came my way. Ethnographic interviews yielded discussions that were interesting and at times comical, but that also revealed how the context in which we are currently living is rife with frustration. Finally, I analyzed my goal of conducting and writing a feminist ethnography by connecting it to feminist anthropological literature, wanting to seek out the voices of im/migrant women, yet not wanting to Other their narratives in a methodological reflection which was central to analyzing my data and writing this dissertation. Sexual health care has a long, nuanced, and contentious history—one that continues to affect the lives of those who seek to provide free and accessible care. In the next chapter, I contextualize my ethnography of a clinic by laying out the history of The Centre, The Mobile, and the women's health movement and its relationship to the Canadian universal health care system.

Chapter 3

Health Care and the Women's Health Movement in Canada

Introduction

The Centre and The Mobile were created by and for immigrant women in the 1970s, with the understanding that the provision of sexual health care in Toronto at the time was not accessible enough for clients; in response to this gap in care, a feminist collective decided to create an organization that addressed community concerns and their care needs. Therefore, The Centre and The Mobile have long been engaged in "seizing the means" (Murphy 2012) of sexual health care, taking the provision of care into their own hands where they felt the larger system had failed. However, as I will address in this chapter, this organization has also experienced being "seized" by the health care systems of governance. This chapter will both contextualize and historicize a single sexual health organization by first describing its mandate and explaining how universal health care operates in Canada. The role of Toronto Public Health (TPH), as The Centre's source of core funding, will be highlighted to show how it enables the team to uphold their mandate. I will then show the ways in which the creation of The Centre and The Mobile need to be understood within the context of the women's health movement in Canada and the United States, including the movement's radical history of demanding that sexual health care must be made financially and culturally accessible by carving out a space of their own to provide care that saw choice, patient rights, and bodily autonomy as central values. The following section unpacks the concept of access as theorized and researched by critical social science scholars and medical anthropologists. I then move to examine what accessing care looked like in practice; here, I demonstrate the role of The Centre in addressing existing health care access inequities. Finally, I tie my discussion of accessible care back to The Centre's mandate and the issue of funding, revealing how their operations and budget have evolved over several decades.

The Centre: Canadian Health Care, Public Health, and Funding

The Centre and The Mobile had a clear mandate: to provide free and accessible sexual health care to their clients. In doing so, the team upheld a feminist approach to sexual health by empowering clients through the provision of accessible services and information via a choice- and rights-based framework. The Centre had been operating out of its current building and neighbourhood for decades. While The Centre had never excluded Canadian-born women, its focus had always been on providing care to other immigrant women who experienced barriers to access; many of these women continued coming to The Centre, as their client files indicated a decades-long history of requesting care. The Centre provided a variety of sexual health services, including contraceptive prescriptions; Pap smear examinations; testing for sexually transmitted infections (urine, blood, and swab tests were performed in identifying particular STIs, including gonorrhea, chlamydia, syphilis, hepatitis, herpes, and HIV); pregnancy testing; bacterial vaginosis screening; IUD insertion/removal; and counselling. In operating a sexual health clinic which provided free sexual services, regardless of whether clients held provincial coverage or private insurance, securing and maintaining funding was central.

Health care in Canada is universal but decentralized. Each province and territory is responsible for "the management, organization and delivery of health care services for their residents" (Government of Canada 2016). Health care coverage can be divided into three categories: public services (primary care and hospitals); mixed services (prescription drugs); and private services (dental and eye care) (Martin et al 2018, 1719). In Ontario, a resident can obtain an OHIP (Ontario Health Insurance Plan) card, which covers health costs for family doctor visits,

visits to a Community Health Centre (CHC) or the emergency room, and surgery (Ontario 2020a). To qualify for an OHIP card there are numerous requirements. A person must make Ontario their primary home, spend the first 153 of 183 days physically in Ontario, and spend a minimum of 153 days in Ontario within a twelve-month period. Once they have met these requirements, a person must fall under one of the following categories: a Canadian citizen; a registered Indigenous person; a permanent resident; a person who has applied for permanent residency, has met the requirements for eligibility, and has not been denied at the time of application for OHIP; someone who has a valid work permit and works full-time in Ontario for an Ontario employer; someone who holds a valid work permit as a federally approved live-in caregiver; a convention refugee; or a legal clergy member who has been ministering full-time for at least six months (Ontario 2020a). Based on conversations with clients and sexual health social actors, I learned that a single doctor's visit at a walk-in clinic for a client without an OHIP card or private insurance can range from $50 to $150. According to the OHIP eligibility guidelines I have just listed, permanent residents are able to obtain a health card if they qualify, but Ontario is one of the only provinces (aside from B.C. and Quebec) that imposes a mandatory three-month waiting period between when someone arrives in Ontario and when they can get OHIP (see Bobadilla et al. 2017), often forcing permanent residents to purchase private health insurance or go without coverage.

In 2006, the Ontario government created Local Health Integration Networks (also known as LHINs) (MacLeod 2015, 242). Such regionalization was introduced to address systemic issues in health care administration with an emphasis on both cutting costs and community participation (Barker and Church 2017, 333). Regional health authorities were involved in decentralizing administrative responsibility and centralizing authority over operations (Barker and Church

2017, 334). The regional body was responsible for making financial decisions as they pertained to day-to-day operations, while the central governing body focused on evaluations and planning related to health care and health promotion. LIHNs are non-profit organizing bodies; each one has a merit-selected Board of Governors that is responsible for the coordination of healthcare and health promotion services. To be listed as a provider within a particular LIHN (which operate based upon catchment areas), an organization needs to be defined as a Community Health Centre (CHC). The Centre and The Mobile were not categorized as CHCs and, therefore, were not slotted into a particular LHIN. However, Toronto Public Health (TPH) is connected to the Toronto Central LHIN (Ontario 2020c). In this sense, Public Health Units work alongside LHINs to ensure policy direction is being followed, the health care system is functioning as it should, and close attention is paid to both the cost of care and potential barriers (Moloughney 2007). The Centre (and by extension The Mobile) received their operating budget from TPH in order to provide free and accessible sexual health care as an independent sexual health clinic.

Public health is constitutionally provincial (see Sutcliffe, Deber, and Pasut 1997) and regionalized into distinct but interconnected Public Health Units. Toronto Public Health is the largest Public Health Unit (interchangeably referred to as a local public health agency) in Canada, providing public health programming to nearly three million people (City of Toronto 2020d). According to Ontario's Ministry of Health website, a Public Health Unit is "an official health agency established by a group of urban and rural municipalities to provide a more efficient community health program, carried out by full-time, specially qualified staff" (2018); these units are responsible for carrying out health promotion programs that focus on improving the health of citizens and preventing the spread of communicable disease. Historically, the field of public health in Canada emerged in response to crisis, as colonialism brought with it disease and infection. During the late 19th century, changes were made in terms of how people understood the spread of disease and disease causation, which led to the provinces adopting public health measures based on the 1875 United Kingdom Health Act (Kozyrskyj 1996, 10). Over several decades, public health was professionalized as an institution and evolved to meet the context in which Canadians were living, including a focus on maternal and infant health post-WWI and increasing social services during the Depression; this shift also represents increased attention to not only decreasing the spread of communicable disease but fostering (in a Foucauldian sense of the word) the health of Canadian citizens.

In TPH's 2015–2019 Strategic Plan, their mission statement broadly addresses the desire to reduce health inequities while improving the health of Toronto residents—being both accountable and transparent with the work the agency does, and fostering diversity and inclusion. The priority area direction for the identified years was "[s]erv[ing] the public health needs of Toronto's diverse communities." TPH has a direct reporting relationship with Ontario's provincial Ministers of Health and the Ontario provincial government (Martin et al 2018, 1719). According to TPH's operating budget, for at least the last decade, 75% of their funding came from the province, with the municipality covering the remaining 25% for their cost-shared funded programs[1](City of Toronto 2019). In terms of core public health functions (their key areas and strategies), there is provincial variation. For example, in a survey of six provinces (Newfoundland, New Brunswick, Ontario, Manitoba, Saskatchewan, and Alberta), disease surveillance and epidemiology are mandatoryin all six, while health promotion is only categorized as mandatory in Newfoundland and Ontario (Sutcliffe, Deber, and Pasut 1997, 247).

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[1] A select number of programs are completely funded by the provincial government which focus on nutrition, dental, and Indigenous health.

As an independent sexual health clinic which relied on public funds, The Centre and The Mobile were under increased scrutiny to report and adhere to documentation requirements (such as waivers). The Centre and The Mobile[2] received their core funding through Toronto Public Health and, therefore, must provide operations reports on a quarterly basis. These reports were collectively prepared by the management team (three long-standing counsellors) and Katherine, a South Asian woman and the administrative coordinator. These reports detailed how many clients they had served, how many and what types of services had been performed, and the nature of their test results (percentage positive). The report was sent to their contact in TPH's Sexual Health[3] division; the city is sectioned off into quadrants, with a different TPH sexual health manager responsible for monitoring each section.

Origins of The Centre and The Mobile: The Story of the Women's Health Movement

At the time of my research, The Centre and The Mobile continued to provide free sexual health care services, funded by Toronto Public Health. However, the scope of their services had narrowed over the years; according to Donna, it had been a "very long haul." The organization had a decades-long and rich history in the Greater Toronto Area (GTA) beginning in the 1970s. Whether I was eating lunch in the makeshift conference room at The Centre or printing out client labels aboard The Mobile, I saw physical reminders of how long the organization had been providing care. A large black-and-white photo taken decades earlier hung in the break room, plaques thanking The Centre and The Mobile for their services were dated in the mid-2000s, and a laminated poster board featuring a newspaper article about The Mobile from over a decade earlier was fastened to one of its walls. The impetus for creating The Centre was grassroots; in

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[2] They are a registered charity and do accept donations as well.

[3] In the past, The Centre and The Mobile were funded by TPH's family planning division.

1975, a collective of immigrant women organized under the common goal of providing sexual health care for immigrant women. According to Donna, who was not only the current mobile clinic coordinator but who had been working in sexual health for approximately 33 years at the time of our interview, the women in this founding collective were pioneers in the field of sexual health care.

The founding members understood the creation of such an organization as playing a vital role in their communities' ability to access sexual health care. Translation for clients, information on OHIP and other insurance coverage, educational resources, and sexual health services, all free of charge, were prioritized by the collective. After several years, they realized that a substantial number of immigrant women were still unable to access their free services. During this time, the physical landscape of downtown Toronto included factories that lined a major street, where many immigrant women found employment. They typically worked long hours in addition to being responsible for taking care of their families, and therefore, sexual and reproductive health was not, or could not be, a priority. The team decided sexual health need to be *portable*, in order to address the community's needs and make sexual health care more accessible. After applying for more funding, they launched The Mobile in 1983 through a pilot project; if the women did not have the time or resources to come to the clinic, The Centre would come to them via the newly purchased mobile health unit. The Mobile team went into factories, negotiating consent from employers to come onto the factory floor and speak with their workers over the lunch break. By providing sexual health care services and education during the workday, The Mobile sought to overcome barriers which would prevent these women from accessing care. Performing workshops during their lunch period meant they did not have to take time off from work or pay for childcare after their shift ended to come to The Centre. However, the process of performing mobile clinics at the beginning of their operations was often fraught.

First, businesses were reluctant to dedicate time to women's sexual health issues. Second, the subject matter of the presentations and interactions was hotly debated. Donna plainly stated, "Mind you, it's very difficult. Because there is stigma attached to sexual health." Within this context, sexual health issues were only considered safe to talk about if they were not strongly associated with sex or sexuality, and if they were medicalized, such as Pap smear examinations and breast exams for the prevention and identification of cancer. Other topics, such as oral contraceptive pills or HIV, were initially not well received. There was pushback on the part of factory managers, who wanted a say in which subjects were covered during mobile workshops. Donna argued it was a "package deal," explaining they could not talk about one without the other if they wanted to offer comprehensive information about sexual health issues and the services they provided.

Additionally, the focus of The Centre and The Mobile was education and sexual health care in the form of services, with an emphasis on patient rights and teaching women how to navigate health care coverage during this time. When I asked Donna about the kinds of topics they discussed, Donna said they "would put on workshops on what a vaginal infection would be. What are some of the symptoms? What is the Pap smear? What are the doctors checking? These are the speculums that they use to insert in your vagina, so [an emphasis on] the education." In performing such education workshops alongside services,[4] The Mobile team was working to

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[4] Since its inception, this organization had exclusively focused on what they term "sexual health." While initially they were able to offer ultrasounds and breast exams, as these services were deemed to fall under the umbrella of sexual health, in later years due to budget cuts, services would be scaled back. They did not provide prenatal, pregnancy, or postnatal care. According to Donna, their main focus (upon creating The Centre) was testing (for cervical cancer, breast cancer, and STIs) and contraception.

ensure these women were comfortable and understood the process of requesting care, how examinations and testing would proceed, and what their rights were in terms of the circulation of information and treatment.

The creation of such an organization, one which identified a problem within its own community, was based on an understanding of how immigrant women were frequently unable to access free sexual health care and education. Additionally, when women were able to see a doctor or get an appointment at a clinic, the care itself was lacking. Therefore, the work of The Mobile and The Centre should be understood within the context of a larger movement, the women's health movement in Canada and the United States. The women's movement in both the United States and Canada has long grappled with questions of access, doctor–patient power dynamics, bodily autonomy, abortion, contraception, and choice (see The Boston Women's Health Book Collective 1976, 2008; Morrow, Hankivsky, and Varcoe 2007; Sherwin et al. 1998; Armstrong 2010; Nelson 2003, 2015; Backhouse and Flaherty 1992; Boscoe et al. 2004; MacDonald 2016, 2018; Murphy 2012; Seaman and Eldridge 2012). Beginning in the 1960s, a growing demand was made by women for better care, care which respected their bodily autonomy and supported their ability to make choices about their health (Armstrong 2010). As the population in Canada is small relative to its large geographic size, women had to form connections across the country. Their approaches, while interconnected, alternatively emphasized agency, systemic issues which impact women, gender-based analysis, and the development of women's health centres (Armstrong 2010, 371). The Canadian women's health movement must be understood in relation to Canada's universal health care system. The post-WWII period saw an expansion of the state's power along with increased social services; Armstrong argues one of the main motivating factors for early women's movements at the time was gaining *access* to care (2010, 372). However, universal health care, while praised for supporting health as a human right, led to another issue. At the time, Canadian "Medicare" was focused on the funding of hospitals and doctors, which still posed a problem for women trying to access care through a patriarchal system, as this meant the decision as to what was medically necessary required a physician's final approval.

A lack of systemic government support led to the creation of the Royal Commission on the Status of Women, which resulted in minimal but impactful recommendations on Canadian women's health (2010, 373). Subsequently, monies were made available to working groups committed to improving women's health, with some collectives taking a more radical approach. In 1968, McGill University's Student Council created and circulated a pamphlet (which predates the germinal *Our Bodies, Ourselves*), designed to provide information about birth control and offer a critique of population control through family planning projects; until 1969, it was illegal to distribute information about contraception (Armstrong 2010, 373). Given the fact that circulating information about contraception was not legalized until 1969, the wariness of factory managers and clients during mobile clinics illustrates the radical work of The Mobile and The Centre as a grassroots collective, reflecting the wants and needs of the women's health movement.

Access to sexual health care, information, and technologies was a cornerstone of the movement. With the publication and circulation of *Our Bodies, Ourselves*, women were encouraged to take an active role in their sexual and reproductive health. This included educating themselves on how services were performed (such as Pap smear examinations, abortions, and IUD insertions); learning how to address physicians who practiced gatekeeping; and knowing how to navigate sexuality in the health care system. According to Murphy (2012), women were organizing self-help groups during this time to *seize the means of reproduction*—in other words, harnessing the power of biomedicine and sexual health technologies to perform sexual and reproductive care in a space outside the clinic, one which held a sense of community and safety. In this sense, biomedicine and biomedical technologies were re-imagined and adapted within the feminist women's health movement to serve their needs.

Both the women's movement and the women's health movement were "concerned with challenging dominant paradigms while at the same time building a body of theory and practice to influence policy and responses to women's concerns" (Morrow 2007, 33). Historically, women's health has either been ignored or exclusively analyzed in terms of reproduction, wherein women's bodies are constructed as being in need of regulation (Morrow 2007, 34). Additionally, it was important to consider which women's voices were heard in imagining a new sexual and reproductive health future. As addressed by Morrow (2007), the women's health movement transformed over time to address the concerns of women of colour and the queer community. Immigrant women and women of colour[5] have faced unique challenges in the field of sexual and reproductive health care. Furthermore, women of colour in the United States have grappled with a legacy of population control campaigns of enforced contraception and forced sterilization (see Davis 2012; Nelson 2003). For example, some communities saw abortion as a form of genocide for African American and Latin American women (tied to a history of population control campaigns, forced sterilization, and forced contraception); other women were concerned with their right to both terminate a pregnancy *or* to have a family on their own timeline (Nelson 2003,

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[5] The two are not mutually exclusive, but I wanted to reiterate that Canadian-born women of colour also face serious discrimination and barriers in healthcare. For an example of such marginalization, see Dána-Ain Davis' *Reproductive Injustice: Racism, Pregnancy, and Premature Birth* (2019) for an accounting of how Black women in the United States face reproductive health challenges deeply tied to racist and sexist ideologies.

2–4). Here we can see how an intersectional approach to sexual and reproductive health involves embracing biomedical information, care, and its technologies, while also remaining skeptical, embedded in a long history of marginalization and violence. Women both desired access to sexual and reproductive health care and were governed by it, with the two not being mutually exclusive.

In women's desire for comprehensive, accessible, and respectful care—building upon first- and second-wave feminists' legacy of work within the movement—third-wave feminists were increasingly becoming social actors within the arena of policy and programming (Morrow 2007, 48; see also Armstrong 2010). While feminist women's groups remained critical of governmental agencies and politicians, some also received financial support from them. In the 1980s, conservative governance at the federal level brought with it cuts to their funding, and while some networks were able to withstand such cuts, others were not as lucky (Armstrong 2010, 374). However, for the groups that continued to receive funding, this increased participation in the public health and health care system has been recognized as a double-edged sword. On the one hand, many women felt they were working within the system to disrupt hierarchies and work towards correcting power imbalances. At the same time, they also had to be increasingly involved in bureaucratic institutions, which meant managing governmental expectations and requirements, and therefore had an impact on their ability to engage in radical feminist work (Morrow 2007, 48–49).

The idea that women needed to work within biomedical and bureaucratic institutions to effect change was something put into practice on a regular basis in the field. The women who formed The Centre decades ago in response to the growing immigrant community in downtown Toronto originally operated as a collective. Donna frequently described the organization's roots as “pioneering” in the field of women’s sexual health care. However, the grassroots and revolutionary framework utilized in the creation of the organization was also embedded within the context of governmental partnerships to ensure (through funding) their ability to continue doing the work they saw as vital for the community. According to Donna, The Centre and The Mobile were initially funded by the provincial government but were “downloaded” to municipal funding with the election of Premier Mike Harris (Progressive Conservative) in the 1990s. Since the City of Toronto’s budget was smaller than that of the province, this meant there was less funding for The Centre and The Mobile; reflecting on the situation, Donna described how the women who worked there felt “dismissed” by the change. Even with their budget being decreased, ensuring their clients continued to have access to free sexual health care remained a priority, with the team understanding that a feminist conceptualization of access meant more than just coverage. As I stated in Chapter 1, while access is indeed a theoretical concept which was key in my fieldwork, it is also a part of the larger story of sexual health care in Canada. I include a discussion of access in this chapter to contextualize the creation of The Centre and The Mobile, to better understand how such a clinic operated within a universal health care system, and to delineate how access is historically meaningful to the women’s health movement, shaping the role and continued existence of The Centre and The Mobile.

Access: A Multidimensional Concept

Health and health care are entrenched in socio-economic and political systems, as well as moral understandings of personhood, “ways in which we conceptualize and speak and write about health are never just about health” (Robertson 1998, 155). The sociality of health and health values work to shape how a health care system is structured, and we are reminded that health care is not neutral, reflecting the dominant ideologies of a given nation (see Doyal 1979; Farmer

2003; Dean and Ellis 1999; Mitchell 1999; Robertson 1998; Anderson 2000; Sherwin et al. 1998).

Access is multidimensional. Access is an integral characteristic of a “good” health care system, an issue to be addressed where barriers (economic, social, and institutional) to health care persist, a human right, an object of political debate, and a deeply personal experience. From a global perspective, the World Health Organization (2021) understands universal health coverage and universal health access[6] to be intertwined. To access health care, there are various dimensions: physical (availability and delivery of services); financial (direct and indirect costs of seeking health care); and related to acceptability (whether care is culturally appropriate and its impact on seeking out and using services) (Evans, Hsu, and Boerma 2013).

Before unpacking the relationship between access and health care coverage, I will attend to other barriers which impact a person’s ability to access health care. I want to make two points clear. Firstly, the barriers I will describe, such as discrimination, racism, transportation, culturally sensitive care, language translation, and clinic availability, are not singular issues, as they often overlap and compound one another in the experiences of those who are seeking health care. Secondly, the issue of access does not resolve itself once a person arrives at the clinic and receives health care services; accessibility issues can occur during appointments and impede future care interactions, sometimes resulting in the avoidance of the health care system altogether.

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[6] Here, universal health coverage relates to the cost of health care in which services are free of charge while universal health access points to the ways in which other barriers may still impede accessing health care beyond the cost of services.

Within a Canadian context, accessibility is one of the five funding criteria in the Canada Health Act of 1984, understood in the provincial health care insurance plans' responsibility to "not impeded or preclude, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to insured health services" (Marchildon 2013, 27). Scholars across disciplines (including but not limited to sociology, midwifery, human geography, nursing, equity studies, and health sciences) have worked towards identifying barriers to accessing health care in Canada, recognizing many of their systemic and institutional factors (see Newbold and Cho 2013; Johnson et al. 2004; McConkey 2017; Socías, Koehoorn, and Shoveller 2016; Higginbottom et al. 2016; Burton and Bennett 2013; Nestel 2012).

Canada rarely collects race-based data, and this has been identified as an issue when assessing health care and patient experience (Nestel 2012). Discrimination based on race not only impacts a racialized person's ability to access care but can result in them discontinuing care through fear of being discriminated against in future interactions. For example, in a London, Ontario, study, physicians revealed their lack of knowledge about traditional Indigenous practices, which impacted their ability to provide accessible care (McConkey 2017, 7). Additionally, assumptions were made about Indigenous patients based on racist stereotypes of addiction, which led to physicians avoiding prescribing pain medication. In another study, South Asian immigrant women recounted their experiences of discrimination in health care in Canada (Johnson et al. 2004), where they were culturally essentialized and racialized by providers. The authors analyze the ways in which the Othering of South Asian immigrant women is a direct barrier to accessing health care services. While physicians homogenized patients' cultural beliefs and positioned *their culture* as a barrier to accessing biomedical care, we should instead focus on how care, on the part of the physicians, is being *made inaccessible* (2004, 255). In a 2012 report published by the Wellesley Institute (Nestel 2012, 20; see also Lingard, Tallett, and Rosenfield 2002), evidence has shown that physicians in Canada understand themselves to be “fact bearers” and their patients to be “cultural bearers,” highlighting how they are “unwilling to consider the cultural frameworks that underlie medicine.”

In addition to health care access being impacted by racism and practices of Othering, health coverage status is another critically factor that impacts whether a person can access health care services. Newbold and Cho (2013) examined the experiences of refugee and refugee claimant women who were seeking health care in Hamilton, Ontario. The authors emphasized the interrelated vulnerabilities and obstacles they faced, including mental and physical health disparities, social isolation from community networks, and fear of stigma and legal consequences (2013, 433). While it can be argued that Canada’s health care system has “essentially removed income barriers to care,” other financial costs which can occur during this process will compound refugee and refugee claimant women’s ability to access care, including the expense of private insurance, language translation where not provided, and transportation to and from clinical settings (2013, 434). Newbold and Cho importantly note that access issues did not stop once their participants received services, accessibility also means taking into consideration institutional factors which might impact accessing care in the future, such as lack of continuity of care, waiting room times, and rushed appointments (2013, 440).

The issue of health insurance coverage not only impacts whether a patient can access care without incurring costly fees but has come into direct conflict with the value of choice in reproductive health care (Burton and Bennett 2013). In Ontario, Canada, midwives are able to provide care for all women, regardless of whether they have provincial coverage or not; this uninsured population can include immigrants, undocumented persons, members of minority religious groups who have opted out of OHIP for cultural reasons, and those who have lost OHIP (2013, 24). These patients are expected to either purchase private insurance or pay for services out of pocket. While midwives can provide care to pregnant women regardless of whether they are insured or uninsured, there are still expenses which can occur, such as lab tests, physician consultations, and hospital fees (if hospitalization is required). Burton and Bennett's analysis reveals how the choice to give birth in a way that the patient wishes is constrained by her status as an uninsured person.

Anthropologists have utilized ethnographic research methods to understand how access (and denying access) to health care is made in practice (see Kierans et al. 2013; Bridges 2011; Willen, Mulligan, and Castañeda 2011). For example, in conducting fieldwork on the Prenatal Care Assistance Program (PCAP) in a New York hospital, Khiara Bridges reveals the ways in which Alpha Hospital was able to provide universal health care within a private system. However, and most importantly, this care came with strict guidelines and onerous protocols. In Alpha, the PCAP enabled all pregnant uninsured women access to reproductive health care but only for the duration of their pregnancy and until eight weeks after birth (2011, 12). As part of their acceptance into this program, all pregnant women had to become Medicaid patients and complete a strict set of services, including a pregnancy test, HIV test, and meetings with a health educator, nutritionist, social worker, and Medicaid financial officer. In turn, these various tests and meetings serve to exacerbate existing inequities for the majority racialized patient population by requiring multiple and time-consuming visits and excessive documentation. It is within this context that Bridges argues these women's ability to access free care meant making themselves available for increased scrutiny and surveillance compared to women with private insurance.

Other medical anthropologists have also examined how the ways in which health care systems are structured shape not only the ability to access care but the experience of receiving life-saving care services. In Mexico, a fragmented health care system results from insurance coverage only being provided to those who work in the formal economy through social security, while the remainder of the population (approximately 18%) is uncovered and has to rely on institutions that provide subsidized services and programs (Kierans et al. 2013, 2). Through tracing the trajectories of patients with chronic kidney disease (CKD) and the availability of Renal Replacement Therapy (RRT) in a Jalisco hospital, we see how patients are forced to piece together resources and engage in creative problem-solving in order to access emergency and life-saving care (3). With the work of Kierans et al., access is not only about the coverage status but how that status is tied to notions of productivity (in terms of participating in the formal labour economy) and embedded in existing inequalities for CKD patients at the Hospital Civil de Guadalajara.

Building on the issue of who is afforded health care coverage (an integral component of access) and who is denied it, Willen, Mulligan, and Castañeda (2011) call for medical anthropologists to practically engage with the issue of unauthorized im/migrants lack of access to care services. While unauthorized im/migrants represent a heterogeneous group, the authors point out two commonalities: “all have health needs, or will in the future, and all are excluded, either in part, or in full, from the systems of health care” (2011, 331). Unauthorized im/migrants being denied health care coverages and therefore access to care can be understood through the concept of “deservingness,” which Willen, Mulligan, and Castañeda argue is reflective of governmental and dominant rhetoric in the United States (2011, 332). Within this context, being “unauthorized” can be seen as a direct barrier to accessing care in a private health care system, but also as having a direct impact on health itself (2011, 333). In comparison to other country's health care systems, such as Spain, where providers are legally able to provide free and anonymous care to unauthorized immigrants (2011, 336), in the United States, access is complicated by contradictory or non-existent policies and the fact that a large segment of the "authorized" population lack coverage and therefore access as well. Through thinking about access to health care services through the lens of "deservingness," this text draws our attention to the ways in which the ethos of health care systems is an integral part to understanding not only who has access to coverage but how this access is compounded by other inequities, similar to the work of Bridges (2011) and Kierans et al. (2013).

Through critical social science and anthropological scholarship, access is understood to be multifaceted. Even in a nation with universal health care, this does not translate to universal access for all. The financial cost of care (transportation, time off work, and childcare), alongside the time required to attend appointments, reveals inequities in access. Additionally, accessibility issues do not resolve themselves upon reaching the clinic, as women from racialized and immigrant communities experience Othering and a lack of culturally sensitive care in requesting services. Finally, ethnographic work has demonstrated how systems of health care are entangled in ideas of deservingness tied to citizenship status. As I will show in the following section, Canada's health care system, while valuing and recognizing health as a human right, does not mean all accessibility issues have been resolved.

Accessing Health Care in Canada: Taking a Closer Look

I began this chapter by describing the mandate of The Centre and The Mobile—to provide, free, accessible sexual health care to their clients—and by explaining the organization's creation in relation to the women's health movement in Canada. In their commitment to accessible care (free services, low-cost contraception, translation, culturally informed care, portable, choice-informed, and respectful), The Centre and The Mobile were engaged in providing specialized sexual health care to predominantly marginalized communities in an effort to address gaps in the accessibility of health care in Toronto; in doing so, they were required to engage in particular practices of accountability to demonstrate the legitimacy of their funding.

Universal health care is both a way to structure access to health care services and a value. The Mobile and The Centre operated not only through a grassroots movement, relying on community relationships and feminist values, but within an institutionalized health care system. The latter requires a clear description of Canada's health care system's structure and public health operations in Toronto in order to understand the role of funding, the provision of services, the accessibility of prescriptions, and The Centre's ability to provide care for all women (including those without insurance coverage). The Canadian health care system has been lauded globally for placing the health *needs* of citizens above their ability to afford care (Martin et al. 2018). Pride in a universal health care system is something scholars have positioned as embedded in our national identity (Flood and Choudhry 2004; see also Deber 2018; Morgan and Boothe 2016) and it is one of the stories Canadians tell about themselves, that we live in a "progressive"[7] nation that understands health care as a universal right. However, upon closer

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[7] Here, quotation marks are meant to indicate that I recognize the idea of being progressive is culturally constructed and needs to be historically and contextually situated.

inspection, the Canadian health care system is far more complicated than it is often presented, and how it is envisioned as operating often comes into conflict with what happens in practice. At the federal level, the Canadian Health Act (CHA) is the legislation intended to support and ensure all residents of Canada are able to maintain both their physical and mental health through access to health care services (Government of Canada 2020b). There are five major criteria which must be met in the CHA: public administration, comprehensiveness, universality, portability, and accessibility. The Federal Government is responsible for creating and ensuring health care standards are met, administering funding to the provinces and territories, and providing care for refugees and Indigenous communities (Government of Canada 2016).[8]

There is a mandatory three-month waiting period for OHIP eligibility in Ontario for permanent residents (Bobadilla et al. 2017). For new permanent residents, the cost of purchasing private health insurance, pre-existing conditions, and the quality of care they receive are all impacted by not having OHIP coverage. For example, pregnancy is considered a pre-existing condition and therefore private insurance does not cover any costs related to hospital care. According to the Association of Ontario Midwives, this lack of coverage results in immigrant women who choose to or are required to give birth in a hospital setting to pay out of pocket for costs associated with a hospital stay (2017, 398–399), which can range from five hundred to one thousand dollars a night (Association of Ontario Midwives 2021). By providing free sexual health services and not requiring clients to have an OHIP card or private insurance, The Centre and The Mobile were actively committed to their mandate to provide accessible care. This

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[8] There are specific groups of eligible Canadians (First Nations, Inuit, Canadian Forces, Federal inmates, eligible veterans, and some refugees) whose health care is covered by the Federal government through Health Canada (Martin et al 2018: 1719). In The Centre and aboard The Mobile, it was critical that refugees with "federal papers" presented them for their file, as the federal government would reimburse the cost of services.

provision was essential for newcomers and international students, who were either waiting for their OHIP or who had minimal insurance through their post-secondary institutions.

While Canadian provinces and territories offer health cards, which grant access to free health care services, Canada does not have a “broad public pharmaceutical program” (Boothe 2014, vii). In fact, Canada is the only “developed” nation with a universal health care system that does not cover the cost of prescription drugs (Morgan and Boothe 2016, 247). While medication administered during a hospital stay is free of charge, medications prescribed by a physician require entering a messy matrix of private insurance plans with drug coverage and provincial drug plans, which either cover a portion of the cost or propose a cap-based system (where the individual spends a specific amount on prescription drugs with the province covering anything beyond that amount); such a system results in many Canadians not having access to their medications (see Morgan and Boothe 2016, 248). In Ontario, a Drug Benefit Program operates through the enforcement of strict guidelines which determine whether or not the cost of the over-the-counter medications (not prescribed by a physician) or prescription drugs may be covered in full or in part (Ontario 2020b). Provinces across Canada, including Ontario, have been calling for a universal pharma care program for over a decade (Morgan and Boothe 2016, 252), and as of 2020 such a system has yet to be realized. However, Ontario has made strides towards this goal.

Former Premier Kathleen Wynne (Liberal) instated the OHIP+: Children and Youth Pharmacare program, the first of its kind in Canada, offering free prescription drugs to all people under the age of 25[9] as of January 1, 2018 (Office of the Premier 2018) regardless of access to private coverage. I draw attention to the lack of a comprehensive pharma care in Ontario because

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[9] Coverage is in effect until the day they turn 25.

it speaks to the limitations on the universal health coverage in practice. While The Centre offered low-cost contraception, addressing an accessibility issues with the high profit margins for birth control at local pharmacies, younger clients sometimes struggled with having enough cash to pay for them. As such, staff members were enthusiastic about the recently instated policy, citing the ways in which it offered young women the option of getting access to contraceptives without having to go through their parent's insurance.[10] In the minds of sexual health social actors, this rationale supported the concept of patient autonomy, as clients would not have to answer questions from family members about their sexual and reproductive health choices. However, even with the creation of the OHIP+ program, which covers the cost of prescriptions, it does not cover all forms of contraception. According to Teen Health Source's website[11] (2020), OHIP+ covers most combined oral contraceptive pills, emergency contraceptive pills, the Depo-Provera injection, and two brands of the hormonal IUD (Kyleena and Mirena). OHIP+ does not cover the contraceptive patch, the copper IUD, the NuvaRing, and new brands of oral contraceptives. Additionally, there is a list of oral contraceptive brands (such as Alesse 28 and Tri-Cyclen Low 21) which may or may not be covered, with the website stating, "it's complicated." This last category can cover some of the listed contraceptives (such as Alesse 28 or Marvelon 21) under special circumstances; the list includes brand name contraceptives, which typically are not covered by OHIP+. However, if the prescribing doctor states the brand name contraceptive is

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[10] While the women who worked at The Centre supported the OHIP+ program because it allowed immigrant young women access to free contraceptives without having to consult with their families, the Canadian medical community's rationale is different. According to Di Meglo and York (2019), the reasoning behind physician's support has more to do with the correlation they draw between access to free contraceptives and preventing pregnancy.

[11] Teen Health Source is Planned Parenthood Toronto's "confidential sexual health information service by and for teens." It offers self-assessment quizzes, resources for accessing sexual health care, and anonymous communication for teens to ask questions about sexual health via phone and web chat.

required due to allergy or previous negative reaction to other formulations, OHIP+ can cover the cost.

While the OHIP+ program was lauded publicly, it would soon be scaled back by the subsequent Premier of Ontario (a Progressive Conservative). In the early months of 2019, it was announced that the Ford government would be introducing broad budget cuts to health care (Dhanraj 2019). This included an election campaign promise of cutting one billion dollars from Toronto Public Health over the course of a decade. The move prompted the Mayor of Toronto to comment that "[i]t is impossible to not to see this as a targeted attack on the health of our entire city and, in particular, the health of Toronto's most vulnerable people" (Gray 2019). In addition, the OHIP+ program was narrowed to only include children and youth who did not have extended health benefits (which would cover all or some portion of prescription costs) through their employer or their parents' employer; women I spoke with at The Centre believed this made it more difficult for young women to access contraceptives without going through their parents' insurance. These changes had a direct impact on The Centre's clients. During a counselling session, not long after the new restrictions applied to the OHIP+ program went into effect, a young woman wanted to go on the patch.[12] When she asked about coverage, Aaliyah called the local Shoppers Drug Mart to ask if the client would still qualify for the program, given that she was also on her parent's insurance plan. When the employee explained the contraception would not be covered, the young woman was disappointed because this meant she either would have to go through her parent's insurance (something she was hesitant about doing in anticipation of being questioned on her sexual activity) or pay out of her own pocket. Shortly before this visit,

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[12] The Evra Patch is a form of contraception which works through affixing an adhesive patch to either the arm, back, buttocks, or stomach where hormones will be absorbed through the skin in order to prevent pregnancy.

we had a meeting where staff were informed of the changes to the OHIP+ program, and within hours we were seeing its effects. Accessible care, therefore, is not limited to free services such as STI testing or contraception counselling, as the cost of contraception and treatments must also be taken into consideration.

Over several decades, The Centre and The Mobile had remained committed to their goal of providing free and accessible sexual health care to their clients. Here, I return to the matter of funding (which was introduced at the beginning of this chapter) as in order to continue providing free Pap smears, counselling, and testing, The Centre had to engage in the production of particular forms of evidence—which became even more vital as their budget decreased over the years. From the mid-90s until 2002, the Premier of Ontario was Progressive Conservative politician Mike Harris. The Centre and The Mobile had previously been funded by the provincial government, and in Donna's words, had since been "downgraded" to municipal public health funding by Harris; she argued The Mobile should be covered by the province, given the areas they travel across the Greater Toronto Area. After receiving their funding from TPH for several years, The Centre and The Mobile were once again on the "chopping block." Reflecting on her memory of this time period, Donna explained how The Centre's staff successfully lobbied the municipal government to continue funding their operations through the use of numbers and stories. They attended a City Hall deposition and made both an affective and pragmatic appeal, advocating on behalf of the clinic. They emphasized how even though they may not see as many clients as other sexual health clinics, their numbers had been increasing in recent years, and in providing culturally sensitive and accessible care, they were addressing an important community need.

Sexual health is categorized as a mandatory core public health function in Ontario (Sutcliffe, Deber, and Pasut 1997, 247). Toronto Public Health has a vested interest in health promotion, improving the communities it serves, and preventing the spread of communicable disease. While The Centre and The Mobile accepted donations, the majority of their operating budget was provided by TPH, which required quarterly reporting of the clinics' operations. Such reports included the number of clients seen, as well as the number and types of services provided. In doing so, TPH was upholding its commitment to *excellence* "through the use of evidence in service and policy decisions, continuous measurement and improvement of performance, fostering a culture of innovation, and supporting staff learning" (City of Toronto 2020a). Within the context of my fieldsite, TPH provided funding for sexual health clinics that operated within and beyond the Ontario health care system, supporting The Centre and The Mobile's ability to provide care to their clients regardless of their coverage status.

While The Centre and The Mobile continued to provide free sexual health care services, the scope of their services had narrowed over the years; For the mobile clinic, their initial focus included not only contraceptive counselling and STI testing but also preventative testing in the form of cancer screening through breast exams as well as pelvic ultrasounds. They also placed a strong emphasis on education by offering workshops to various immigrant communities. Unfortunately, they were no longer able to provide breast exams or ultrasounds due to budgetary and funding restraints. Education had been a major feature of The Mobile when it was first created, and in subsequent years the number of workshops had decreased, with an emphasis placed on providing countable sexual health services.

Conclusion

The Centre and The Mobile's mandate to provide free and accessible sexual health care was deeply embedded in the context of Canadian universal health care and the women's health movement. By carefully examining their origins, we see how even with universal coverage for Canadian citizens, there were other accessibility gaps which the team was committed to addressing. With a collective of women who sought to provide care by and tailored for immigrant women, The Centre and The Mobile allow us to think about access beyond whether one can book an appointment with a care provider or whether one has a provincial health card. The team's operations reveal the barriers clients faced in not only accessing care but accessing the right *kind* of care; embracing and demanding biomedical information and technologies in a way which was feminist. Honouring their roots in the feminist women's health movement, The Centre and The Mobile provided care in a way which was unique by addressing financial barriers and tailoring their services to their diverse clientele via translation services, low-cost contraceptives, and culturally sensitive practice. However, with this chapter we can also see the beginnings of how having a publicly funded clinic means they are responsible for showing where that money is going—via metric reports which counted clients and services—and ultimately resulting in the scaling back of their operations over the years. The funding and provision of care in Toronto requires an assemblage of social actors, expert knowledge, and institutions. While The Centre and The Mobile's operations had been pared down over the years, their team remained committed to the historical feminist imagining of accessible sexual health care. In the following chapter, I examine the models of sexual health I found in Toronto's landscape, models which grappled with how to do sexual health "differently" (see Murphy 2012) by embracing biomedicine and exceeding it.

Chapter 4

The Working Model of Sexual Health

On a cold Wednesday morning in early February, 2019, I make my way to The Centre. It has been a little under a year since I first met Donna in her office for an interview, ultimately resulting in an invitation to come aboard The Mobile. As I follow my normal routine of exiting the streetcar and grabbing a coffee before entering the large brick building where The Centre is located, I reflect on how it has taken several months of volunteering in the clinic to begin to grasp its routines and protocols.

On Wednesdays, I arrive approximately two hours before the clinic begins seeing clients; during this time period I work alongside the scheduled staff to ensure we are fully stocked for the day, while also catching up on any of the previous days' paperwork. For example, I retrieve several strips of condoms from the floor-to-ceiling cupboards in the breakroom and sit on the couch in the reception area, tearing them into individual items and refilling several large bowls which are strategically located throughout the clinic. I enter the two examination rooms and open the accordion-style folder which contains all the forms physicians might need during a visit with a client. On other days, I work my way through incoming test reports by highlighting the client's name in yellow, stamping the pages with the date received, and ticking off their receipt in a long, skinny black binder before they are placed in the appropriate physician mail basket for them to review.

On this particular day, I receive a phone call from a Toronto Public Health (TPH) nurse. I can hear the concern in her voice when she asks me to check on the status of one of our clients who has recently tested positive for an STI. The TPH nurse has tried to call the client several times to no avail, and she needs to know whether the client has been treated after their positive result. She gives me the client’s name and date of birth, and I proceed to search our client database, which will show the last time they came to The Centre and the nature of their visit. I am able to locate the client in our system and see they have already come to clinic and picked up their prescription. Upon hearing this, the TPH nurse sounds relieved. She thanks me for my time, and we say goodbye.

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Introduction

Sexual health governance is a landscape, an assemblage of institutions, social actors, and expert knowledge, which works to regulate and foster sexual health via technologies of care, surveillance, and metrics. By paying close ethnographic attention to the people and places which make up this landscape, I came to understand the particular model of sexual health by which it is constituted. Sexual health discourses reflect how we “perceived and understand the social, cultural, and material worlds in which we move” (Lupton 2013, 23); they both structure and limit the possibilities for what sexual health and sexual health care can look like in practice.

In attending to the sexual health landscape as an *assemblage* of social actors, institutions, and expert knowledge, I draw on the work of anthropologists (Collier and Ong 2005; Nguyen 2005) and other social scientists (Leahy 2014; Rose 2000) to account for how the landscape’s individual components (clinics, hospitals, TPH, physicians, counsellors, volunteers, and health promoters) are collectively engaged in the process of both *making* sexual health via a model and *fostering* it via practices of care and surveillance. Using sexual health governance as a framework for analyzing this landscape and the narratives of clients, I observe how a working sexual health model can be understood as an “analytic of governmental assemblages” (Leahy 2014, 173). I understand this working model of sexual health as reflecting a biomedically rigorous and feminist-oriented approach to sexual health, which attempts to balance a biomedical understanding for managing one's sexual health and feminist values, such as bodily autonomy, choice, and intersectionality. By characterizing this as a "working model," my intent is to reveal how, in practice, this model of sexual health is malleable, and how this malleability enables it to be used in different contexts according to the sensibilities of the social actor. This working model allows for a deeper understanding of the ways in which sexual health social actors approached, understood, performed, and requested sexual health care and information. Therefore, this model is an amalgamation of ideas and discourses which construct what sexual health care is and what sexual health care should be within the landscape. The landscape is a metaphor for thinking about how social actors, institutions, and expert knowledge work together, albeit in different ways and capacities, to foster sexual health in Toronto. While I am not arguing this model is exclusive to Toronto and this landscape, I am using the working model to attend to the specificities of my interlocutor's accounts, how they drew upon this model, an assemblage, within this landscape to perform care and circulate information. I will elaborate on this working model in the coming pages and specifically address how the work of sexual health social actors benefited from using it. From an anthropological perspective, assemblages can involve multiple logics and are simultaneously "heterogenous, contingent, unstable, partial, and situated" (Colllier and Ong 2005, 12).

The opening ethnographic vignette provides a snapshot of how The Centre worked in tandem with other institutions and social actors. It took several months to understand how all the social actors[13] inside the clinic (the physicians, the counsellors, the administrative staff, the clinic

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[13] As addressed in Chapter 2, I use the term "sexual health social actors" to encompass all people working within the sexual health landscape. While physicians, executive directors, counsellors, administrative coordinators, and volunteers have varying degrees of expertise and levels of formal education, I group them together under this label

clerk, and the volunteers) worked in tandem and alongside other institutions (hospitals, Toronto Public Health, laboratories) to provide care to clients. In doing so, they were representative not only of particular protocols and processes which managed and monitored sexual health, but also of the values which underpinned them. While The Mobile's practices can be particularized to their clinical sites, they can also be understood as only a partial picture of the larger sexual health care landscape's operations, where separate yet connected people, places, and practices make up a whole with the goal of fostering and regulating sexual health in Toronto.

The figurative metaphor of the landscape is useful for describing the key social actors and institutions which support sexual health in Toronto; it can serve to orient the reader to the operations of sexual health care in the city, to visualize the people, places, and practices which make up such a system. The vignette introduces us to a TPH employee who worked in the Sexual Health department, whose phone call can be understood as not only illustrating investment in a biomedical understanding of sexual health (and the bureaucracies which govern it) but how such a social actor communicated concern about the welfare of a client who had tested positive for an infection. The elements in this landscape are deeply revealing of the dominant models of sexual health—its commitment to biomedicine, choice, empowerment, and diversity—which seek to create a particular kind of sexually healthy subject, one who is self-managing, responsible, a chooser, and invested in their sexual health through heeding the authority of biomedicine and expert knowledge to help them to maintain it. In this chapter, I argue the landscape tells us something about how sexual health is conceptualized in Toronto and the implications this has for

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because I understand them *all* to be an integral to sexual health governance in their contributions to its regulation and fostering.

clients' health care experiences and perspectives on what it means to be "sexually healthy," reflecting an emphasis placed on biomedical care and empowerment via client choice.

The first section of this chapter will bring the landscape into focus by describing the sexual health institutions and social actors I encountered during fieldwork. In effect, I will be peopling sexual health governance. Here, I will describe their day-to-day operations (what they did to support and monitor the sexual health of communities in Toronto) and the sexual health models I see reflected in these practices, emphasizing how they contributed to a particular envisioning of sexual health and investment in biomedicine and feminist empowerment. Building on this analysis, in the following section, I will zoom in on the narratives and experiences of counsellors, physicians, sexual health promoters, and clients. In identifying the ways in which expert knowledge was communicated and circulated via sex education, I analyze how in practice the operations of disciplinary power were programmed but never programmatic. Additionally, I observe how clients' understanding of sexual health information largely reflected the models of sexual health analyzed in this chapter, taking up and resisting medicalized understandings of sexual health.

In this chapter, I explore the experiences of clients (sex talk, how they took up models) but also how counsellors, physicians, and promoters had to engage in a variety of practices to support disciplinary power (building relationships, being humble, changing strategies). Within this context, I understand sexual education as operating through disciplinary power to foster particular kinds of sexually healthy subjects, ones who are self-regulating, responsible, and educated choosers. In the final section, I analyze clinical encounters in which clients negotiated care and reflected on the subtleties of feminist biomedical practices. In their narratives, I observe how clients were educated not only on how to maintain their sexual health via care services but also on how to *use* the health care system in a responsible way.

Governance does not operate in a top-down fashion (see Foucault 1990; Ferguson and Gupta 2002; Li 2007), and therefore, the figurative metaphor of the landscape is useful for envisioning and spatializing sexual health governance's assemblage of institutions, social actors, and expert knowledge as working together to regulate and foster sexual health across the city. This chapter reveals how social actors and institutions are not only engaged in operations which support a particular model of sexual health but are *invested* in these models. However, as I will show in the coming pages, the physicians, sexual health promoters, counsellors, coordinators, executive directors, and clients I spoke with did not represent a monolith; their narratives reflect the nuanced and subtle ways they believed in the work they did, but also left room for questioning of particular approaches and operations.

The working model of sexual health analyzed in this chapter is flexible. I define the model of sexual health discussed here as representative of an investment in biomedical understandings of sexual health (which places value on objective/factual information and access to education that is scientifically rigorous), while at the same time envisioning how biomedicine can be done *differently*. Therefore, the working model of sexual health I analyze in my interlocutors' narratives—those of TPH sexual health promoters, executive directors, counsellors, and clients—also includes valuing bodily autonomy, choice, empowerment, inclusion, and diversity. By delineating how the working model of sexual health in this chapter contains all these values, I want to draw the reader's attention to the subtleties and complexities of sexual health in theory and practice. This malleable model of sexual health aims to produce responsibilized, self-regulating subjects, while also taking into account the relations of power in which sexual health education and care are embedded historically, specifically, the role of institutions such as public health and medicine. Effectively, this model of sexual health can be considered an assemblage, one that is constantly changing over time, and which sexual health social actors draw upon as they move through the landscape. The last chapter contextualized the operations of The Centre and The Mobile by attending to the history of health care in Canada, the questions of access, and the role of such a clinic in addressing these issues. This chapter zooms in on the sexual health landscape of Toronto, analyzing the ways in which institutions and sexual health social actors operate within this landscape, and how their narratives reveal the complexities when believing in and engaging with a model of sexual health which is rarely straightforward.

The Sexual Health Landscape of Toronto: Key Social Actors and Institutions

While I made The Centre and The Mobile my primary fieldsite, it was also important to meet with sexual health social actors outside of these clinical settings. I interviewed executive directors, sexual health promoters, program coordinators, and researchers who worked in the field of sexual health. In this section, I describe the operations of Toronto Public Health's (TPH) sexual health promotion division, sexual health clinics, a university centre for sexual education, and a sexual health blog written by and for newcomers in Toronto. I analyze their practices and mandates to reveal how they drew upon a working model of sexual health, which resulted in the fostering of particular sexually healthy subjectivities.

I was fortunate enough to speak with five sexual health promoters who worked for TPH, each with a different level of experience in the position. Two (Sandra and Leah) had been with the health promotion team for a substantial amount of time, while the three other health promoters (Jo, Anu, and Jenny) had been hired within the last couple of years. These promoters' experiences both provided a historical overview of sexual health promotion in Toronto by describing how the job had changed over time, and also offered a fresh perspective on how promotion currently operated in the city and on work expectations of those who may not have had long-term experience in public health. Sexual health promoters' duties include going out into the community and engaging in activities that foster the circulation of sexual health information. Such activities include holding workshops at schools, shelters, settlement organizations, or libraries, during which promoters cover a wide variety of topics; issues are contextually tailored to their audience and can include a discussion of birth control, STIs, Pap smear exams, consent, sexuality, relationships, and parenting. Some of the topics broached are clearly done through a biomedical lens, encouraging safe sex practices, using contraception, and getting tested regularly. At the same time, other topics, such as consent, sexuality, and relationships, represent feminist values. Therefore, I understand these workshops as reflecting a working model of sexual health, as they included not only a biomedically informed approach to protecting and managing one's sexual health but a sex-positive approach, which challenges stigmatizing cultural norms around sex and sexuality and promotes open and honest conversations. Yet this working model, which reflects an investment in wanting to do biomedicine *differently*, does not exist outside neoliberal sexual health governance, which promotes self-regulation and responsibilization. Neoliberal ideologies operate through disciplinary forms of power, aiming to produce "rational, calculating creatures whose moral autonomy is measured by their capacity to 'self-care'" (Mann 2016, 332, citing Brown 2003).

Jenny, a Canadian-born woman with European and Asian ancestry, was a personable, enthusiastic, and relatively new promoter. She contextualized her interest in sexual education in relation to her upbringing; a number of her cousins had become pregnant at a young age, and she reflected on how they had all come to her parents for a safe and judgement-free space. While unplanned pregnancy is dominated by discourses of risk and harm, Jenny saw how most of her family members flourished with the right kind of support. After high school, she had volunteered as a peer-educator and had worked in family support for several years before coming into public health. According to her, sexual health promoters are encouraged to work with agencies and groups of people rather than individuals, which supports public health's population based-approach. For example, sexual health promoters are often invited into school settings, to either deliver a content-specific workshop, provide support for teachers who have been tasked with teaching sexual education, or address a recent issue. Anu, second-generation South Asian promoter who worked primarily with newcomer communities and had a background in youth mental health research, described the circumstances under which she might be asked into a school:

> If it's a new teacher, we will go in to help support them by just facilitating a session so that they can watch us and learn, [to] be able to model that the next time around. That's one of the things that we offer. But in a recent situation I was called into a [middle] school… as a result of an incident that took place in the school. A lot of boys who felt that they can just go and grab girls' bums. A lot of [the girls] started reporting it to the principals and the teachers, they weren't comfortable with it. We were called in as a result to talk about consent and body boundaries. And from there, we also find out that um… within the school there was also some incidents around sharing of nudes and pictures that went around.

In this case, sexual health promoters can be asked to facilitate sexual education with teachers who are new to teaching the subject, offering them resources, and teaching them skills to engage with students. Anu emphasized that these resources are often published on the TPH website, and teachers are directed to look for them there because TPH and the school division have a different understanding of appropriate sexual education, particularly when it comes to inclusivity. In 2015, Ontario implemented a revised sexual education curriculum for the first time in 17 years. However, these changes (which included talking to students about gender identity, sexual orientation, consent, masturbation, contraception, pregnancy, and STIs) sparked a mixed reception from the public, with some communities claiming the curriculum was not progressive enough, and others arguing these topics were inappropriate for children. In 2018, Progressive Conservative Party politician Doug Ford was elected as Ontario's Premier, vowing to dismantle the 2015 curriculum changes. When I asked sexual health promoters about this curriculum's journey over the past few years, I was met with long sighs and exasperated looks, with several of them mentioning the creation of a hotline where teachers who continued teaching the updated curriculum could be reported. In addition to helping teachers, sexual health promoters can also be called in to mediate an ongoing issue in the school, such as inappropriate touching or the circulation of underage nude pictures. Anu was called in to speak to a particular class of students where such behaviour had been prevalent, and in this case the workshop was tailored to discussing consent but also to emphasizing the legal consequences of sexual harassment and circulating what would be considered child pornography. Anu, also a relatively new member of the sexual health promotion team, had extensive experience working with youth and believed she offered a cultural lens to communicate with the largely immigrant demographics of the schools she worked in, supporting her ability to link biomedical facts about sexual health through a nuanced approach based on their shared experiences.

As education via the circulation of information and resources is a central component of sexual health promotion, I observed the ways in which such conversations revealed the politicized nature of sexual health. Both the biomedical components (how infection is transmitted, how to choose contraception, how to get tested) and values which can be described as feminist and/or progressive (consent, sexuality, and relationships) are representative of TPH's approach to sexual health. In this sense, the narratives of the sexual health promoters I interviewed reflect a working model of sexual health, one which is flexible in practice, as their descriptions included messages not only about the correct (or clinical) ways to maintain one's sexual health but also about how being "sexually healthy" is about more than getting tested or using contraception. Giving students the resources and skills to navigate sex, sexuality, and sexual health as they get older also works to produce particular sexual subjectivities that prize agency and responsibility (see Mann 2016; Bay-Cheng 2015). However, this approach to sexual health manifests the operations of disciplinary power, as students, teachers, and organization members are *trained* with the "correct" information, while at the same time they are inspired to take up other forms of knowledge in their understanding of sexual health via this working model.

In addition to being asked to facilitate workshops in schools, sexual health promoters are also engaged in larger projects enacted across the GTA. Sandra, a senior TPH employee who had worked in a sexual health clinic for a decade before becoming a promoter, described her current role as "doing capacity building within ethnic communities… I actually collaborate with ethno-specific agencies, settlement agencies that have a specific kind of language… I am doing my approach called 'raising sexually healthy children'. We call it peer leader training." Sandra took a candid and determined attitude to promoting sexual health, drawing on her experiences abroad and within the GTA. Sandra did not meet directly with participants in the peer leader training program; instead, she met with organization members who would be running the peer training. Therefore, peer leader training represented a form of community-based (and run) sexual health promotion. Sandra worked with different organizations to create a manual for this program, which allows peer leaders to *train* community members, and to improve communication between parents and children on issues related to sexual health and sexuality. Sandra was instrumental in the program's creation of manuals that could be translated into multiple languages and used in different communities. Within this context, capacity building refers to the skills and resources transferred from Sandra and her team to local organizations, who then can take what they learned and pass along such expert knowledge to community members. Subsequently, building capacity can be understood as not only discursively communicating a particular model of sexual health, but also of encouraging its incorporation into people's everyday lives.

I spoke with Leah, a sexual health promotion specialist and a long-term employee of TPH, about how the sexual health division had changed over the years. Leah was generous with her time, providing a nuanced and reflexive accounting of TPH's role as an institution and the field of health promotion. Leah's job title had changed from promotion consultant to promotion specialist, a change which she described as reflecting "the weight of history. Terms like specialist within a traditional institution." Leah's job title was not the only thing to change over the years. Sexual health promoters used to be called "sexual health educators," a difference which was commented on by my interlocutors. Jenny said, "From what I understand, I think there is a history of that on the team where this role used to be called a sexual health educator. Cause you would be teaching… [but] in the last couple of years we're promoters, not educators. We're not teaching, we're trying to *engage*." She added that the term "promoter" sounds better than “educator” in terms of the public’s perception of their work, that it would be easier to get into the kinds of spaces they need access to foster the sexual health of communities.

While the work sexual health promoters do is largely engagement based, such as delivering workshops, based on their narratives I still understand them as largely reflecting a model of sexual health that prizes access to expert information via educational modes of interaction. Their work as facilitators and trainers places them in a position of power in relation to the communities they work with, which presents issues upon which some of the sexual health promoters reflected. For example, Jenny believed she had to reflect on this positionality of expertise, stating, “I don’t know your life. You know your life. And I don’t want to pretend to know your life. And that’s it. If I go into any space, if I come off like I’m an expert... give me a break. I kind of said that right at beginning. I know a little bit, I don’t know everything.” This comment speaks to how the work of sexual health promotion requires navigating complex relationships with their intended audience and fits within the working model of sexual health. In Jenny’s narrative, while it is important to provide workshop participants with biomedically sound and “correct” information, the type of approach the promoter takes to communicate this information is equally important. Within this context, acknowledging the expertise and autonomy of her audience is incorporated into how Jenny promoted sexual health.

The work sexual health promoters do, the literal promotion of sexual health, has them going into a variety of spaces (schools, community centres, settlement organizations) and working with different kinds of social actors (teachers, school boards, community members, and agency employees). Based on my conversations with sexual health promoters, while they were generally optimistic and enthusiastic about the work they were doing, they also did it reflexively. Leah, who was Canadian-born and specifically drew attention to her whiteness in her role, made the important point that all promoters are “agents of the state… Even within the context of sexual health. And it’s easy when you’re in sexual health to forget it, but public health is not a friend of a lot of communities.” In addressing Leah’s statement, which points to the broader issue of public health’s history of intervening upon marginalized populations in the name of promoting health, I understand the working sexual health model taken up by promoters and other sexual health social actors as not only acknowledging this history but also trying to figure out a different path forward. During the interview, Leah alternatively drew on academic literature and theories, as well as her experience in public health, advocating for evidence-based interventions which were rooted in consultation and centring the community. Leah grappled with her previous work in HIV case management, a position which she felt had a “policing” role, and shared how it took her a while to come to terms with this. As a queer woman, Leah carefully considered the work done by TPH through an intersectional lens; she simultaneously believed in the goal of health promotion and public health, while keeping in tension its colonial history.

Thus far, the working model of sexual health described among sexual health promoters reflects a blend of biomedical, feminist, and sex-positive values. However, drawing on the work of Singer (2016), I will now address the ways in which sexual health empowerment is also embedded in forms of neoliberal governance. Anu’s workshops in school settings and Sandra’s capacity-building peer-leadership programs are reflective of the state’s interest in fostering and managing the sexual health of its population. Through the circulation and promotion of expert knowledge, sexual health promoters are put in the position of supporting sexual health via disciplinary power, while also critiquing its operations within communities. Sexual health promotion, through the circulation of information and resources, works to produce particular kinds of “sexually healthy” subjects: the educated chooser who seeks to self-manage their sexual health by seeking clinical care. There are multiple clinics in Toronto which specialize in sexual health care services and programming, and I spoke with variously positioned sexual health social actors (an executive director, a director of research and programs, volunteers, and program coordinators) in these locales. Two of the clinics operated as community health centres (CHCs), as they provided primary care services and offered programming that explicitly focused on a particular community or issue. These clinics tailored their services towards youth, women of colour, and the transgender community.

In addition to providing care services, such as HIV testing, Pap smear exams, and contraception counselling, these clinics were committed to sexual health programming and workshops. For example, one CHC offered a peer-to-peer model of programming for newcomer youth, which involved going out into the community to different sites (such as settlement organizations) to give sexual health workshops, and creating resources and campaigns for newcomers. Programming was community based and depended on the work of staff and volunteers, who would work within their own community, operating with the goal of addressing inequities in access to health care and sexual health information. Take for example, a CHC that provided primary and sexual health care for women of colour. I interviewed two women, Winners and Nia Renee, who had taken on leadership roles in such community-based programming. Volunteers would act as sexual health advocates, going into their communities to provide information about HIV and HIV testing; networking was done between agencies and faith groups, with the goal of running sexual health workshops with an emphasis on HIV. Eventually, they began a peer-led project, modelled after an American study, which saw community members hosting gatherings to provide information and rapid testing in the comfort of their own homes. Nia Renee had a background in biotechnology before working in the field of sexual health after being diagnosed with an STI; she described how this experience had revealed the embodied stigma people with STIs experience, particularly in the Black community. Nia Renee's decision to take on a leadership role in community-based programming stemmed from her confidence that sharing her experiences could alleviate community members' fears around getting tested and diagnosed. She also emphasized how part of the success of such programs could be attributed to them being more relatable, with the information coming from "someone who looks like you," from another community member. Here, disciplinary power operates through the community in lieu of a top-down assemblage of power; representatives are directed to recruit other community members and network, with the goal of increasing HIV testing. However, the specific context of such a program is complex, as women of colour work to destigmatize HIV testing and HIV-positive people in their communities, while at the same time participating in sexual health governance.

These clinics in the sexual health landscape of Toronto, which offer care services and programming, participate in sexual health governance. In terms of the working sexual health model, they envision sexual health as something to be maintained via regular and preventative visits, as well as responding to emergent issues. At the same time, they rely on frameworks which promote patient empowerment, choice, diversity, and inclusion, values which are the focus of their sexual health programs. This requires, and ultimately works to produce, a client who is educated via expert knowledge; and such a model of sexual health works to produce clients who are not only informed but who put their education into practice by being responsible, choosing, self-managing subjects.

In addition to the work of sexual health promoters (who rely on community engagement and the circulation of expert knowledge) and sexual health clinics (which provide not only health care services but also opportunities for community engagement on issues related to sexual health), there are other efforts to foster sexual health in Toronto via education. I met Dani in the fall of 2018. She was the executive director of a university centre for sexual education with almost four years of experience working as a sex information hotline volunteer and an inclusive sexual education advocate. She described the *vital* role their organization played in providing free sexual health supplies and making sexual health literature accessible to their local community. External condoms, internal condoms, pregnancy tests, lube, and menstrual products were all provided free of charge. The centre was staffed by university students, who sought to provide information and supplies to their peers, allowing its staff and clients to both work and access resources completely anonymously to encourage participation, whether this meant picking up a bag of condoms or taking out a queer novel. Here, I turn to the work of Nikolas Rose's "vital politics" (2008). Rose delineates vital politics temporally, shifting from a concern about health (in terms of birth, death, and disease) to the 21st-century concern with our "growing capacity to control, manage engineer, reshape, and modulate the very vital capacities of human beings" (2008, 3). Dani's understanding of the centre's work as vital to the community can be understood in two senses. First, and more literally, the centre provided necessary information and supplies to those who requested them. Second, and following Rose's line of thought, the educational materials, library, and supplies operated to optimize the sexual health of students.

When I interviewed Dani, she proudly gestured towards their small library, which held information documents, erotica, and LGBTQ literature. As a university student-run centre for sexual education, the centre's mandate was to provide information and resources that were both factual and inclusive—valuing expertise and storytelling. This approach to sexual health was representative of the malleable and mobilized model I encountered across the sexual health landscape; both clinics and sexual health promoters negotiated biomedical understandings of sexual health (preventative care, safe sex, testing, and treatment) while upholding a commitment to diversity, inclusivity, empowerment, and choice. What was different about this sex education centre was how it was developed *within* the community, where those who would use their resources were the same people working in the centre. Here, the relations of power were diffuse and reflected the ways in which power operates outside of top-down conceptualizations; the university did not demand students form a centre for sexual education. Instead, students understood becoming “sexually healthy” as requiring access to information and resources, taking this up in their creation of the university-funded centre. I observed in my interview with Dani a tension between truly believing in biomedical understandings of sexual education, while also valuing a more holistic approach to sexual health that took seriously its subjective realities as sexual health became a morally loaded object, which meant navigating the fissures between the two approaches. I saw the working model of sexual health in action when speaking with Dani, as she and the organization grappled with how to do biomedicine *differently*, in a way which was respectful and worked against approaches that dismiss individual autonomy and experiences.

Another organization also struggled with imagining a model of sexual health that could both be biomedically informed and reflect people’s lived experiences of sex, sexuality, and sexual health through a blog format. Through one of my contacts at a local sexual health clinic, I was introduced to Loren. After completing a master’s degree in public health, she had become disillusioned with the field she was working in and its singular focus on statistics and risk. Through a contact at a Toronto sexual health clinic, Loren and her co-founder sought to conduct a mini-community-based research project; they applied for (and were denied) funding multiple times. However, they were accepted into a program that offered structure and guidance in lieu of financial support. Subsequently, they created a needs assessment for their target population, newcomer, and second-generation youth, initially believing there was a lack of access to sexual and reproductive health information. However, their project findings revealed newcomer and second-generation youth had access to sexual health information, and they knew where to go to find a clinic or contraception; the issue was the kinds of voices and perspectives highlighted in sexual health literature. The participants wanted to see themselves in the sexual health information being circulated—their identities, their stories, and their challenges.

After receiving funding from the Ontario Trillium Foundation, Loren co-founded a blog, which featured the voices and artwork of newcomer and second-generation youth in Toronto. These stories reflected personal experiences but also challenged systemic forms of discrimination. Loren described the purpose of the blog as providing a platform where their contributors (all newcomers or second-generation youth living in Toronto) could "say what they want to say" on the subject of sexual health without being vetted by an institution (submissions were still proofread for accuracy). This tension reveals the challenges which come with enacting and negotiating the working model of sexual health. In examining the provision of a platform created by and for second-generation and newcomer youth, we can see how the model of sexual health was entangled in and reflected the value of both biomedical and intersectional feminist understandings of sex, sexuality, and health. The blog simultaneously sought to allow newcomers and second-generation youth to see themselves in the stories told, while at the same time, dealing with the issue of "factual" sexual health information. Blog posts frequently grappled with cultural norms, familial relationships, and the "truth" about sexual health. Therefore, while *educating* oneself with expert knowledge is understood as important, so too are complicated, messy stories of experiencing menstruation, identifying as queer, and getting tested for STIs.

Finally, Toronto's sexual health landscape would not work without the people who receive sexual health care, take part in sexual health programs, and participate in sexual health education—the clients. Clients are a central social actor in the sexual health landscape and an essential part of the operations of sexual health governance in Toronto. As I stated at the beginning of this chapter, sexual health governance includes an assemblage of social actors, institutions, and expert knowledge, which aims to foster, regulate, and monitor sexual health via technologies of care, surveillance, and metrics. It is the clients' sexual health that is being fostered, regulated, and monitored, including practices of self-regulation and self-monitoring. The clients I interviewed came to The Centre for sexual health care services and information, whether that meant requesting a Pap smear, undergoing STI testing, or having an IUD inserted. Through sitting in on over two dozen counselling sessions, I observed how clients requested services, negotiated care and surveillance, and understood Aaliyah and the physician as a resource for information that would help them to maintain their sexual health.

Before I explain how the women I interviewed represented outliers among the clinic's predominant clientele, I want to address the language being used here. When I began volunteering aboard The Mobile, I was struck by the team's use of the term "client" instead of "patient." I attribute this to three reasons. First, client-centred language and care was popularized at the beginning of the women's health movement and was found in settings such as women's health centres (see Norsigian et al. 2021); its usage worked to address power imbalances between care providers and clients (MacDonald 1999, 29). Second, the term "client" edges away from assumptions about illness or sickness associated with the term "patient." While testing can reveal a case of gonorrhea or cervical cancer, the term "client" seems to reorient the seeking of sexual health care as related not only to infection or disease, but also to preventative and routine care, such as requesting a prescription for contraception or picking up a package of condoms. Third, sex is a moral object (see Pigg and Adams 2005), and while all health care involves moral norms and evaluations (see Crawford 1980, 1994), the term "client" can be understood as framing sexual health care in terms of neoliberal ideologies of empowerment and choice (see Esposito and Perez 2014). Framing the women who came to The Centre as their clientele evokes particular ideas of what kind of subjects these clients would be—rational, educated, self-managing, and responsible—and the women I interviewed both took up and resisted such ideals. We also cannot discount the attractiveness of neoliberal discourses, as the term "client" also reflects the ways in which care aboard The Mobile or in The Centre was understood as specialized or personalized, as offering something different from a walk-in clinic or family doctor's office. The clients I spoke with felt that when they came to The Centre, they would not only receive biomedical care, but it would be performed in a way that did not feel rushed and that treated them respectfully.

In contacting me after counselling sessions where I handed out my project cards, the seven clients I interviewed self-selected themselves for my research, and in turn, identified with the term immigrant; they did not feel the need to adhere to official (i.e., governmental) categorizations. Most of these women were international students,[14] who understood coming to Canada to study as the easiest and quickest way to leave their country of origin. Additionally,

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[14] International students, while considered temporary residents, do have the opportunity to either obtain a work permit to continue living in Canada after they graduate (Government of Canada 2019). Additionally, Ontario has three programs which international students can apply to try and secure permanent residency. For example, the Ontario Immigrant Nominee Program is available for those with a job offer to work in Ontario (Ontario Council of Agencies for Serving Immigrants 2019).

one client was a permanent resident, having moved to Toronto with her family during childhood, and another had recently obtained a work permit after completing post-secondary education in the city.

While these clients were not representative of the majority of clientele who came to The Centre (sponsored immigrants and refugees), their experiences and narratives are still valuable. For example, I learned from them that although Toronto had a well-established and funded industry of settlement organizations and resources, many of these women still faced challenges in accessing sexual health care. Additionally, in discussing their experiences of sexual health care in Toronto, including their care critiques, their narratives revealed taken-for-granted aspects of the universal health care system, such as limited services, referral systems, and the cost of prescriptions. Finally, they both took up and resisted the discourses of sexual health which encouraged the medicalization of care and feminist values of empowerment and choice. In seeing how the understood their role as clients in the sexual health landscape of Toronto, I observed how their manoeuvring through the health care system also reflected the working model of sexual health described thus far in this chapter, as simultaneously desiring biomedical and expert knowledge while emphasizing the need for diversity, equity, and sensitive care.

The sexual health landscape provides insight into how an assemblage of institutions, social actors, and knowledge both exist and operate in Toronto to foster sexual health. However, importantly, empowerment and choice within this context are understood as embedded in neoliberal values (self-management, responsibilization, and individualization). Yet at the same time, through ethnographic interviews with counsellors, physicians, sexual health promoters, coordinators, and clients, I understood how a working model, while reflecting an official approach to health care and public health, meant negotiating the realities of putting them into practice in relation to my interlocutors' positionalities and sensibilities.

Putting a Sexual Health Model into Practice: Educating Minds, Bodies, and Desires

In the sexual health landscape of Toronto, it is clear that sexual education, the circulation and exchange of knowledge, was central to fostering sexual health. Sexual health promoters, physicians, counsellors, executive directors, volunteers, coordinators, and clients operate as an assemblage, contributing to the construction of sexual health as something that requires not only expert biomedical knowledge but also those who will take up said knowledge in becoming responsible, self-managing subjects. In this section, I observe how sexual education operated via disciplinary power, informing and inciting the desire to take up such approaches in the fostering and managing of sexual health. However, as I analyze in this section, the provision and circulation of sexual health information was anything but simple and cannot be reduced to a question of access alone. Sexual health consequences (such as STIs or unintended pregnancy) are often presented as a result of lacking the correct information (see Davis, Gahagan, and George 2013). However, I will show how the practice of promoting sexual education was contingent, complicated, and contradictory, challenging the assumption that access to information will result in the desired outcome of acceptance and incorporation—the production of "sexually healthy" subjects.

Sexual health education plays an important role in the operations of disciplinary power. Later in this chapter, I offer an analysis of biopower, a diffuse, constant, and subtle form of power, which is concerned with the management and regulation of life at the levels of individuals and populations (Foucault 1990; Pylypa 1998; Gastaldo 1997), by contextualizing its operation in a universal public health care system in Toronto. Foucault's concept of biopower

(1990) is useful for thinking about how the regulation of individuals and populations operates not only through institutional power but also by inciting a *desire* in the individual to self-regulate and become responsible in accordance with *expert knowledge* (Pylypa 1998, 21). In my analysis of sexual health promotion discourses and practices—such as clinic operations, sexual education workshops, and client narratives—I show how sexual education requires paying careful attention to both *how* information is provided and *who* is providing the information, specifically attending to the ways in which such social actors' approach to sexual health sometimes conflicts with official (Public Health) stances on the matter. The sexual health social actors responsible for circulating such information and the audiences receiving it reveal how the reality of sex education can result in something different through stories of exception, loopholes, and negotiations; thereby demonstrating the complicated and diffuse workings of biopower.

The provision of sexual education was taken seriously by sexual health promoters, physicians, and counsellors. For example, Anu described her experience working with newcomer communities in downtown Toronto in the following exchange:

> Specifically newcomer populations, wherever they're coming from, you can't expect that they've gotten that education. Sometimes that's where our assumption is. Um, it was interesting because I was working with the newcomer mothers' program a while back, I went in to discuss birth control options. When I started talking about birth control options, they started asking me questions about periods. And how to make a baby, how to stop a baby. Their questions were how do twins get made, how come some are identical, how come some aren't identical. Then we got into the whole conversation of having periods, making babies, how do the egg and the sperm meet, where do they grow. All of that… I went in for one session and ended up doing a completely different session. And I

> was fascinated because this was newcomer mothers who wanted to get this information to also share with their children. I went home to my mom and I was like, I wanna know how much you know about this—so I had the same conversation with her. *My* mom also had no clue about how the period sheds, what is it actually coming down. I asked about her background. We're coming from a war-torn country, you were given a pad, deal with it. And that was it, that's your education… It was eye-opening for me as well, going through that learning curve. Sometimes we go into groups thinking that they already have that basic information. Majority of the time they don't because of the situations they're in.

This description of Anu's experience providing sexual education reveals the ways in which it requires attuning to the needs of her audience. I want to highlight in her story how the mothers' group she was working with cannot be imagined as a blank slate, nor can we assume what knowledge they have access to in immigrating to Canada. Anu soon realized that the lesson plan she had gone into the workshop with needed to be changed to accommodate the group she worked with, and this kind of flexibility reflects the operations of biopower. It is not simply the circulation of correct information which counts, but how social actors in the landscape of sexual health must be adaptable in fostering their audience's desire to conform to sexual health norms in Toronto. If she had proceeded with her original lesson plan, not only would there have been confusion due to unfamiliarity with the information, but ultimately this would have hindered whether the mothers' group would accept and take up such information in managing their own sexual health.

The need to consider how sexual health information was circulated in workshops was also highlighted in Jenny's narrative. Jenny was adamant that she could not go into a women's shelter or a school with the attitude of "I'm the expert, and you have to listen to me." When she delivered a workshop, whatever the setting, she could not pretend to know everything about her audience's life; she came into the space with a sense of humility. In this sense, sexual education can be understood as a form of relational care. If one of the objectives of providing sexual health information is to work towards producing a self-regulating subject, we must recognize that this requires more than an individual. In her analysis of the relationship between nutritionists and patients, Yates-Doerr argues that the subject's sense of self requires relations and a sense of community (2012, 147). Jenny's decision to approach the success of a sexual health promotion workshops as one built on relationships reflects an understanding of such care as interactional and not transactional (2012, 151). Within the context of sexual health promotion, Jenny illustrates how the approach a promoter takes when trying to circulate sexual health information can matter just as much as the information given:

> You have to relate on some level. In my workshops, I always give people, depending on the thing, people are nervous. They don't want to talk. And so I say, "I am not going to make you talk, you do not have to say a word. If we're going to do an activity, you have the right to pass. I understand some people process information differently. I know you're probably going to be listening so it's okay." Every time I say that, people are more likely to engage and to share.

By running workshops in a manner that respected the participants' choice to engage or not engage in the activities, Jenny's approach worked to incite their desire to participate by making them feel safe. This approach makes sense on two accounts, and I understand it to be a form of disciplinary power. First, it allowed Jenny to circulate sexual health information via a gentler and more subtle form of power and caring, one which was more likely to be well received by her audience. Jenny did not make direct demands or threats that would impede their participation, and therefore, her approach worked to actively cultivate her audience’s desire to take up a model of sexual health in their daily practice, one which emphasizes having biomedically correct information, while making space for the role of choice and empowerment via such knowledge. Secondly, it demonstrates the fact that more coercive methods were not necessary and could impede her goal of fostering sexual health. In analyzing Jenny’s approach, we can see how making demands of the clients she worked with or mandating participation would most likely result in an unsuccessful workshop, one which would not shape the desires of its participants to engage in practices which could foster their sexual health. Therefore, by taking a more unpresuming and reflexive approach to circulating information, Jenny’s practices can be understood as engaging in the subtle operations of biopower. While taking a gentler approach could be seen as a strategic, I also argue that Jenny’s choice to approach sexual health promotion in such a way not only increased her chances of success, but also respected her audience’s autonomy. We can also analyze Jenny’s understanding of audience autonomy as operating to individualize the people she worked with, another symptom of biopower’s operations.

A counsellor at The Centre, Riri (a Canadian-born woman with South American ancestry), also explored the role of a trusting and caring relationship in supporting her clients’ sexual health. At the time of our interview, there had been a recent positive HIV case, and I was surprised to learn through The Mobile’s team that there was no set protocol in terms of how counselling proceeded when notifying a client of their positive HIV result or Pap smear. Riri said:

> When we were doing all of this stuff, the [clients] don’t like a script. You know what I mean? Don’t speak to me like in a script. Speak to me like you know this is serious. I’ve had a lot of people with positive high grades [pap smear results] that turn into cancer;

> I've had a lot of those conversations. And their main takeaway that they always tell me is like I loved how you just had a real conversation with me. It wasn't like you were a doctor talking at me… You weren't like a health professional just talking at me and giving me information. I tell them in small parts, "Are you okay? Do you want me to still continue?" That kind of stuff. Cause sometimes they hear it and they're like listen... go home, have a sleep on it, and come back tomorrow. So, I don't think scripts work. You know what I mean? In this sense, where like it's based on trust and it's about something super sensitive… But it's like how would I want to be talked to? That's just how I base it.

From Riri's perspective, like Jenny's, *how* sexual health education and information is provided matters. If she had gone into a counselling session and read from a script, the client may have stopped listening to her or felt disconnected. During our interview, Riri revealed why she decided to work at a sexual health clinic. After experiencing a sexual assault, she had felt the kind of care she was looking for—the provision of fact-based information, community resources, and compassion—was severely lacking. Riri drew on her experiences and incorporated them to form her approach to providing sexual health care, which, like Jenny, came from a place of wanting to be respectful while also ensuring the right kinds of information were being given to clients. In this sense, being relatable and caring for the client, and caring for how the information is given, can be understood as supporting the government of sexual health.

In addition to attending to the ways in which sexual health social actors approached the provision of sexual health information—in their capacities as health promoters running workshops and as counsellors providing care for clients—and how they foster sexual health via disciplinary power, I also want to share my observations on how TPH and care organizations work within communities. I want to discuss how they actively recruit members, promote the circulation of sexual health information, and encourage testing. Both Davis (2019) and Gurr (2015) have analyzed the role of community organizations in relation to reproductive health care. For Davis, The Birthing Project[15] organized a space where Black women in the United States could receive support and represented a form of maternal activism (2019, 178-179). This project included their "Big Sister" pairings, where a pregnant woman would work with another Black woman in the community in support of her pregnancy. Meanwhile, Gurr (2015) describes the role of recently developed (and funded) prenatal groups for Native American women titled Centering Pregnancy; this project was dedicated to providing culturally appropriate care through community participation and was supported through the connections of its community members (2015, 96). Both projects were created to provide a space that exists outside clinical settings that tend to overmedicalize birth. Social actors in the sexual health landscape of Toronto also participated in projects, which had the goal of community-based research and participatory-action, but which operated to support sexual health governance.

Sandra discussed the role of research and projects in TPH's repertoire of promoting sexual health in a variety of ways; one of these ways is their peer-leadership programs. Working with a particular settlement agency or ethno-specific organization, Sandra's role was to train community members, who would then be in a position to provide sexual education to other community members. An important part of the peer-leadership project was creating sexual health training manuals, and each of these manuals must be translated depending upon the group. For example, if Sandra was working with a Somali group, the manual would be translated so that

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[15] The Birthing Project was created in California and has expanded to over 100 communities globally (Davis 2019, 181).

group could understand it and use it to inform others about sexual health. However, this did not always go according to plan, as Sandra indicates:

> Because the training manual is in different languages, for example, I got trained and I speak Chinese so I will get the Chinese manual. We have somebody who does the translation and everything. For Somali, when you translate it, I have someone whose English is very good. But I didn't know that her Somali is not that great… She translates the whole thing. I give it to somebody to do the proofread, and the person said its fine. So I think it's fine. Until I went into a Somali group. I start to do the training. The first day after the introduction I give them the manual. I want you after the session to go home and read some of the information. Their facial express, I said, is something wrong? You can tell, right? They said, who translated this? I told them somebody who is very educated. Our program is called raising sexually healthy children… In Somali, everything "sex" — this word is translated into meaning intercourse.

In this case, simply translating the words was not sufficient; the manuals had to be made culturally relevant for their audience. The very fact that this project depends on soliciting the participation of community members works to support its acceptance in the community, that the information is made to be relevant to their members—which, in turn, increases the likeliness that they will desire to conform to the norms described in support of their sexual health. Another organization, one which was discussed earlier in this chapter and serves women of colour, also has programs that depend on the participation of the community. This program employed community members as sexual health representatives whose job was to run workshops that would provide sexual health information, with an emphasis on HIV, to community groups via workshops. Eventually, after conducting a literature review, Winners explained how they came to run their “girlfriends’ education workshops,” which provided not only sexual health information but also on-site rapid HIV testing; these workshops were done in spaces where existing women’s groups congregated, such as settlement agencies, churches, or mosques. This strategy meant that the women who attended, through a collective ethos of solidarity and community, would participate in supporting their sexual health through testing; they were also encouraged to share their experiences in the hope that this would encourage other women to participate in the future.

In addition to *how* the information is provided, interlocutors pointed out that *who* is providing the information can also have an impact on how the intended audience negotiates it. Dr. Morena, a second-generation Pakistani woman and physician at The Centre, described the ways in which sexual health had not been talked about within her home growing up, and how this had shaped the way she now provided sexual health information as a physician. For Morena, providing sexual health information was about more than simply transferring knowledge, as shown in the following exchange:

> M: How do you broach that subject? So yeah, I think kind of finding it, making it culturally okay, right? For me, if I go back and say to someone in my community or the mosque. And they say, oh, where do you work? And I say I’m working at a sexual health clinic for immigrant women. And they might be like, oh I’m an immigrant woman. Oh okay. And then it becomes okay.
>
> A: Normalizing it.
>
> M: It’s normalized, it becomes a normal thing. You’re not hush about it. You’re not saying you’re working at a clinic, you’re saying you’re working at a sexual health clinic.

> It becomes a medical thing. It does become a normalized thing and people become a little more comfortable discussing it. I found that one of the reasons is, I feel like I'm in a position where I can help normalize it.

In this exchange, Dr. Morena connected the normalization of talking about sexual education with an understanding of how the source of sexual health information was also important in this process of normalizing talking about sex and health. From her perspective, having a second-generation Muslim woman speak openly about sexual health would help to de-stigmatize such conversations. However, Dr. Morena's perspective also draws attention to the medicalization of sexual health, as she argues making sexual health a matter of biomedicine and health care serves to sanitize it, to make it more palatable.

If it is not a cultural matter, it becomes a medical matter, which reinforces the importance placed on biomedical understandings of sexual health in the state's project of fostering it. Therefore, in her efforts to normalize talking about sex and sexual health, Dr. Morena supports an analysis of attending to how the provider of sexual health information can impact the ways in which a model is accepted or taken up by their audience. Here, the process of normalization in relation to her intersectionality works to encourage clients and community members to see biomedical understandings of sexual health as valuable and communicates the importance of self-managing one's sexual health in accordance with such understandings.

I now turn to Yolanda, a counsellor at a local sexual health clinic, who reflected on her experience of providing education and advice that deviated from such biomedical norms:

> Y: Vaginitis is [when] you have yeast symptoms and they don't go away. They do smears and testing, and there's nothing there. And so I spent a little bit of extra time with her

> because I was like, “Okay there’s a few number of things you can do.” I made notes for her, these are different strategies. We can choose to try out, when it comes to our bodies we really are our own scientists and we can try different things. See what works for us. Nobody has the answer, right? The doctor is not going to be like, oh yes this is what it is, do x, y, z, you’ll be fine.
>
> A: I’m sure that is a really great thing for them to hear. This disparity between expert knowledge and lay knowledge.
>
> Y: I think that’s really important. I do that kind of education piece of like, well, you know if even the doctor say x, y, z, she’s not saying it’s not this. Trust your experience. so with this particular client I was like, okay, you can try probiotics, you can try switching out menstrual products, you can try, um, I mentioned a couple of other things that are for symptoms that you can get over the counter and try on your own

For Yolanda, providing sexual health information that supported her client’s concerns and well-being meant offering her multiple strategies and reaffirming the client’s embodied experiences, and this was described as a rewarding clinical experience. In working at a sexual health clinic as a counsellor, her role necessitated upholding a biomedical understanding of sexual health care issues and treatments. However, she also exercised agency in providing advice which relied on the client’s embodied experience of vaginitis. Additionally, Yolanda was a proponent of natural family planning (which can involve taking one’s temperature and tracking one’s menstrual cycle to identify periods of time where sex would not likely lead to pregnancy); while she would have liked to counsel clients on such methods in addition to other forms of contraception, natural family planning was regarded as either not effective enough or requiring too much of clients to ensure the prevention of pregnancy. Therefore, Yolanda struggled to reconcile her own approach to sexual health with the officially sanctioned one, which acknowledged alternative methods but ultimately supported biomedical ones.

Sexual health social actors, such as counsellors, physicians, and health promoters, can be understood as upholding a model of sexual health, which, while placing an emphasis on biomedicine, continually grappled with how to make room for other understandings. These narratives serve to show not only how sexual education and the circulation of sexual health information was often complicated and contingent in practice, but also how their individual positionalities and intersectionality shaped their practices in the ways in which they approached fostering sexual health. For Jenny, even though she had authority as a "TPH sexual health promoter," she chose to include humility and care in providing workshops. For Riri, informing a client of their positive HIV test result meant avoiding overly technical language, and instead, speaking to them as a person and not merely a "client." And yet, regardless of whether the information is biomedical or rooted in the experiential, I argue the goal remains the same: to care for the sexual health of individuals and foster the desire to care for one's sexual health in ways which make sense to them.

In analyzing technoscience, Murphy (2012) does not focus on whether it is good or bad but instead on *how* it has been taken up, which can entail coercion and management but also empowerment and enthusiastic participation. For the women's health movement and self-help clinics, performing Pap smears on themselves and each other can be understood as doing technoscience *differently* (4–5). Here, I draw a connection to MacDonald's work on midwifery and the role of choice as a "feminist experiment in care" (2018). Each of these texts serves to inform how we can unpack the morphing model of sexual health in Toronto's sexual health landscape which both embraces biomedical sexual education while also recognizing how it seeks to deliver and adapt it *differently.* The women's health movement fought for accessible, respectful, and equitable care, and the working model of sexual health outlined in this chapter captures how such demands shifted from radical to expected or required aspects of health promotion and care. However, this does not mean these issues are no longer contentious or political. While the sexual health social actors I spoke with can be understood as agents of the states, wielding disciplinary power in their efforts to foster and monitor sexual health, they all seemed to have in common the fact that they believed in the values of the women's health movement and kept in mind the ways in which sexual health cannot be abstracted from its history or the relations of power in which it circulates. In this way, while they complied with the guidelines and rules laid out by TPH—to promote sexual health across the GTA with biomedical accuracy—they also found space to make their work community-centred, reflexive, and respectful of their audience's autonomy in how they delivered workshops and circulated information.

Finally, as I understand sexual education and the circulation of sexual health information to be a relational process, I want to focus on the experiences of clinic clients. Just as we have seen how the provision of sexual education is not monolithic in its execution, neither is its audience. Similar to the previously described narratives of other sexual health social actors, clients also drew upon a malleable assemblage of sexual health information. Therefore, clients also negotiated a working model of sexual health characterized by their expressed desire for biomedically accurate information, which could be requested and tailored to their circumstances and values of bodily autonomy and choice.

According to Donna, having access to the right kind of sexual health information is central to not only their ability to self-regulate their sexual health but also to manoeuvre through the sexual health care system of Toronto. I want to begin with my interlocutors' past experiences with sexual health information before moving to their understanding of sex education as it pertained to their ability to access sexual health care in Toronto. Clients understood having "the talk" about sex with their parents as alternatively embarrassing, unnecessary, impossible, and vital. I understand this "sex talk" as the kind of practice that illustrates how biopower operates not only through institutions, but also through families and friendships; these circulations of sexual health information worked to shape their later experiences in managing and caring for their sexual health. Additionally, just because women were having a "sex talk" does not mean that sexual education based on expert knowledge was being circulated in identical ways, and family members also drew on their own experiences and values. What is clear from the following narratives is the fact that sexual health, while often portrayed in sexual education as a matter of having access to information, is morally fraught and requires a complex network of relations between clients, the health care system, and their families. Yet I will also show how the clients I interviewed took up the model of sexual health described at the beginning of the chapter, in seeking to be self-managing, responsible choosers, who cared about their sexual health via biomedical practices.

Each woman I spoke with had a different experience in broaching the subject of sexual health with family members. While some women spoke explicitly with their parents about using contraceptives, others did not broach the subject; Selena's mother never spoke to her about sex or sexual health but did take her to the doctor for her Pap smear test. According to Selena, her mother's ability to take her to the gynecologist rested on the fact that a Pap smear test could be framed medically, as a preventative measure to detect cancer, and therefore, was not about being sexually active. Here, I see a connection between Selena's story and Dr. Morena's sanitizing of sexual health by framing it in biomedical terms.

For both Nina and Cynthia, their mothers communicated the dangers of having sex, with the primary concern being pregnancy, but in vastly different ways. Nina was 28 years old when we met in a coffee shop in East York. She described her childhood as traditional and tumultuous, citing emotional and verbal abuse from her family. She made a promise to herself that she would leave the country by the time she was 26. After obtaining a B.A. in Journalism, she undertook studies in Early Childhood Education in Toronto and, at the time of our meeting, worked with young children. According to Nina, her mother had married at a young age and therefore felt she had "missed out" on having sexual experiences with more than one man. Nina's mother encouraged her to have multiple sexual partners while strongly emphasizing the need to be on some form of contraception to avoid becoming pregnant. Nina was not only confused by this but also questioned what her mother would do about the situation if she chose not to take on multiple partners. However, Nina was not discouraged by these conversations, as she had always been interested in learning more about her sexual health. Nina set a timeline for when she would leave and remove herself from what she described as a toxic relationship with her family. When she came to Canada, Nina dedicated herself to researching contraception and finding the kind of doctor who would serve her needs best. In placing importance on educating herself via sexual health expert knowledge, Nina was taking up a key aspect of Toronto's sexual health model by becoming an informed, responsible chooser, who understood contraception as a means to self-manage her sexual health. However, in the last section I will describe how Nina's perspective, while still valuing biomedical information, shifted over time after using an IUD for several years; ultimately, Nina came to the understanding that it was important to question such expert knowledge and to be informed about alternative forms of contraception.

Selena was a 24-year-old Venezuelan woman who was completing her master's degree in Environmental Sciences at a post-secondary institution. Selena had been living in Toronto since she was 17 years old, immigrating to Canada for educational and political reasons. As an international student, she did not qualify for OHIP. Through her job as a teaching assistant at the university, she did have access to their international student health plan, but this did not cover prescriptions and required her to go to one of the insurance provider–approved clinics. Selena was another interlocutor who craved biomedical sexual health information, asking for resources during our interview and wanting to locate expert knowledge in Toronto. Here, I draw a parallel to Yates-Doerr's (2012) description of patients' relationship with their nutritionists, patients who were both active and receptive to nutritional advice and who had a strong *desire* to be trained. Nina and Selena's desire to be informed with the "right" kind of information could be analyzed as accepting dominant and biomedical norms of sexual health. However, as Yates-Doerr points out, this does not mean they lacks agency; agency can also be exercised through compliance.

At the time of our interview, Cynthia was 27 years old and had been living in Toronto for 15 months, but this was not the first time she had lived in Canada. She had attended a private boarding school in Windsor, Ontario for part of her high school education. After working in graphic design and fashion in Mexico, she desired a career change; she now attended culinary school in Toronto. As an international student, she did not have access to OHIP, and while she had insurance through her post-secondary institution, it was both mandatory and came at an additional cost. For Cynthia, having a talk about sex or sexual health with her mother was not only uncomfortable but also caused her to feel ashamed about sex and her sexuality. She described the lack of information around contraception when she lived in Mexico, specifically how she had not become educated about contraceptives until she was approximately 24 years old. Cynthia associated coming to Canada with an ability to become sexually educated and seek out care without shame; she regularly talked with her friends and boyfriend about Pap smears, contraception, and testing. However, while this speaks to Dr. Morena's approach of normalizing talking about sex and sexual health, Cynthia quickly pointed out that she still would not have these kinds of conversations with her family.

For other women, having the "sex talk" with their parents and reflecting on this conversation led them to the conclusion that while it may have been embarrassing, it was ultimately useful. Yara was a 24-year-old South American woman who had been living in Toronto for less than a year. She held both a bachelor's and a master's degree but had found it difficult to find a job in her line of work. Yara's parents were not religious, and this is how she made sense of her relatively open relationship with them regarding sex and sexual health. She described how her parents encouraged her to "be safe" when engaging in sexual relationships, explaining:

> My parents, they are not Catholic so I think that is the reason why I could talk to them about it. They are more open. They were not following some rules. They were worried about telling me, "Okay you're ready, read about it, get to know your body," and my mother went with me when I got my first period. She took me to the doctor every year. Telling me this is a normal thing. When I had my first sexual relation, I told her because it was an open conversation. But I know a lot of families aren't like that. Pretending that their daughter is a virgin, she doesn't have sex. Like, no, that's not true.

Yara’s relationship with her parents facilitated her understanding of sexual health as something that was normal but as also requiring a degree of care; she was encouraged to seek out information and regular sexual health services.

For Beatriz, talking about sex and sexual health with her mother was also complicated. She recognized how her mother was making an effort, trying to communicate about such things, but the execution was not always what Beatriz hoped for, describing it as “definitely not a soothing conversation.” Beatriz had moved from Europe with her immediate family several years earlier. She had other family who lived in the city, and at the time of her family’s migration, her father was coming to Toronto for work. Beatriz had Canadian citizenship, explaining that her parents could not apply for citizenship because they did not speak English or French. She had an OHIP card and utilized her parent’s insurance for prescription purchases. After she was diagnosed with vaginismus, a condition which makes penetrative sex very difficult (if not impossible) and began going to pelvic floor therapy, her mother would ask questions such as “Have you been able to do anything yet?” This question was trying to ascertain whether Beatriz was able to have penetrative sex. Beatriz wished her mother could be more empathetic. For her, these conversations were rooted in heteronormative ideas of sex and her mother’s fears around her daughter getting pregnant, in addition to not showing empathy for Beatriz’ experience with vaginismus and how it impacted both her sexuality and sexual health. Beatriz was the only participant I interviewed who had grown up in Toronto, having moved to the city with her family at the age of nine. She had attended Catholic school in a Portuguese neighbourhood and remembered her sexual education fondly. While I had been told by various sexual health social actors that having a public Catholic school system complicated the provision of sexual health in terms of what they were and were not allowed to discuss, Beatriz emphasized how she had a teacher who openly had conversations about sex, sexual health, and sexuality via an anonymous question box. Beatriz's accounting of her positive experience in participating in Catholic sexual education classes could be attributed to the individual teacher's approach. However, I also understand her experience as complicating universalizing discourses that reinforce the idea that religion stood in opposition to sexual health and sexual education.

The circulation of sexual health information, and in turn, the dissemination of a biomedical feminist model of sexual health, required flexibility, negotiations, and reflexivity in practice. Within TPH, the educating of its subjects' desires to foster their own sexual health was done in schools and communities. However, the ways in which this occurred in practice required promoters to be flexible in their approach and responsive to their audiences, reflecting the non-monolithic nature of the state's attempts to foster sexual health. Therefore, how sexual health information was provided and promoted, as well as who was doing the work of circulating such information, mattered to the project of sexual health governance. Schools and clinic programs were not the only sites of sexual education, as other forms of relationships also shaped clients' understandings of sexual health and the role of the health care system in assisting their practices of self-care and self-management. Clients' experiences with sexual education and obtaining sexual health information illustrate how sex was a morally fraught topic, and yet all the women I spoke with understood education as vital to their ability to be "sexually healthy." I understand these divergent sites where sexual health information was circulated to be central to my understanding of sexual education as relational, contextual, and historical; they are both shaped by and challenge the government of sexual health in Toronto.

Clients' Clinical Encounters: The Politics of Choice in Toronto's Sexual Health Care Landscape

Choice, as both a discourse and a practical matter, was prominent in clients' narratives. As I observed in the last section, sexual education plays a central role in sexual health governance and the landscape it supports. Through the education of minds, bodies, and desires, clients are taught through a diverse set of social actors and institutions how to self-manage and care for their sexual health in accordance with a particular model of sexual health, one which places an emphasis on the role of biomedicine (testing, preventative care, hormonal, and barrier contraception) while also committing to inclusion and empowerment via choice-making.

In this section, I focus on the stories of two clients, Selena and Nina, to illustrate how such a model of sexual health was readily taken up, negotiated, and resisted in practice. Both clients valued and sought out biomedical sexual health care, yet they both confronted different issues during clinical encounters. For Selena, the limiting of services and the inability to directly see a gynecologist reflected the ways in which it not only this working model of sexual health care which disciplines clients, but the nature of providing sexual health services in a universal health care system. For Nina, painstakingly researching contraception and selecting an intrauterine system (IUS) based on biomedical information and authority was initially experienced as empowering in that she was able to make such a choice, but it ultimately left her feeling conflicted about the effectiveness of hormonal contraception in relation to the side effects she suffered.

The language of choice is prominent in the working model of sexual health, reflecting the historical commitment of the women's sexual and reproductive health movement's values, evoking both discourses of rights and responsibilizaition. Feminist scholars have addressed the complexities of patient autonomy, pointing to the ways its conceptualization (celebrated as a form of empowerment) often comes into conflict with how it can be enacted in practice. In defining patient autonomy as the "recognition that patients have the authority to make decisions about their own health care" (Sherwin 1998, 19), I want to draw the readers' attention to how this must be negotiated within a clinical context, where power dynamics between patients and doctors, as well as funding restraints, shape clinical encounters and place autonomy in a precarious position. Health care has a long history of paternalism, which often results in the dismissal of the woman's experiential knowledge in favour of privileging the doctor's expertise (Sherwin 1998, 21). However, the privileging of the doctor's expert knowledge and authority is not the only thing which impacts a patient's ability to exercise their autonomy. Government policies governing the provision of care, funding requirements aimed at cost containment, and gatekeeping all influence a patient's ability to make informed decisions about their care (Sherwin 1998, 22).

Clinics and spaces where doctors and patients interact inevitably involve the negotiation of power dynamics, as the doctor holds biomedical authority via their use of expert knowledge as well as the authority they possess as a regulated health care provider. However, women, and especially women of colour, often must negotiate further barriers to accessing care in these situations. For example, a West African sexual health researcher named Elise explained how she went to a walk-in clinic with flu symptoms (nausea, fever, and stomach pain). However, the first question the doctor asked was, "Are you pregnant?" When Elise explained that she was not having sex, the doctor pressed her further by asking if she had a boyfriend, and did not believe her when she said she was not sexually active. As a Black woman, Elise felt that the doctor was making assumptions about both her sexuality (first assuming her to be heterosexual) and her sexual health based on her race. If she had needed a referral, would this doctor have believed her and granted her request?

Several of the clients I interviewed participated in the sexual health care system of Toronto in ways which embodied a model of sexual health care that prized individualism and responsibilizaition. While on the one hand, we can analyze the universal health care system and clinical social actors as limiting clients' choices, on the other hand, we can consider how within the Toronto sexual health landscape, choice was conceived of under particular terms and conditions. As choice is also valued in a neoliberal framework, I follow Bay-Cheng in her assertion that "neoliberal ideology is not an affirmative celebration of agency; instead, it is the hegemonic institution of agency, deviation from which brings social sanction" (2015, 284). Within this context, neoliberalism works to shape individual desires, precisely because it is experienced as agency. Such a celebration of rights and bodily autonomy can also be looked at more closely, as systems which promote bodily autonomy in the realm of reproductive care also seek to expand governance (see Singer 2016). Therefore, choice and agency are entangled in the operations of a universal health care system and a model of sexual health, which are committed to a biomedical feminist understanding of sexual health care.

Bodily autonomy and patient choice have been identified as values in women's health care (Sherwin 1998; Murphy 2012; MacDonald 2018) and are a part of the guidelines for proper practice by Ontario physicians (The College of Physicians and Surgeons 2020b) However, I have learned through fieldwork that there are limits to the concepts of choice and autonomy. According to Dean, a "useful way for thinking about liberalism as a regime of government… is to consider the multiple ways it works through and attempts to construct a world of autonomous individuals, of 'free subjects'" (2009, 192–193); this regime fosters agency and empowerment, while at the same time producing norms and standards, which are monitored in order to measure their performance. The politics of choice are directly tied to the presence of a universal health care system which requires the metrification of care in an effort to be (ac)countable; therefore, Canadian residents cannot have every service they request. I understand this to be part of a larger project of sexual health governance, which seeks to discipline its subjects. However, as will be discussed shortly, client narratives also illustrate how such operations of disciplinary power are resisted and questioned.

While a client can request a service to be performed by a specialist, it is ultimately the physician's judgement (and their clinic's protocols) which determines whether the referral (or even if care) is warranted. Canada's universal health care system is founded on the idea that the provision of health care should be based upon need and not the financial ability of residents to pay for care (Martin et al. 2018, 1718), and the World Health Organization has defined health as a fundamental human right (2017). However, in a universal health care system, this does not mean unlimited access to care, or that the right to demand services is not constrained. The ways in which health care systems offer care and coverage is tied to how their respective nations govern,[16] and Canada, as a state predicated on the welfare system, operates through the principal of social solidarity (Dao and Mulligan 2016, 7; see also Fierlbeck 2011). As such, while the well-being of the population is respected in the system's quest to not require patients to go into debt to be able to afford care, it also means care must be *rationed* in a way which is assumed to

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[16] Both Livingston (2012) and McKay (2018) provide robust ethnographic accountings of how the provision of health care is deeply embedded not only in national ideals but also in socio-historical and economic contexts. In Botswana, the health care system is shaped by a collective commitment to equity and debt avoidance, entangling both state and hospital bureaucracy (Livingston 2012, 102). Livingston describes this process as "caring for the national cake," and therefore caring practices come to include practices of bureaucratic counting. Meanwhile, in Mozambique, McKay draws our attention to the ways in which public health, non-governmental projects, and transnational funding work together to shape not only the provision of care but also how it is accounted for. Both Livingston and McKay illustrate how local understandings of care and healthcare have been shaped by global forces.

be fair and evenly distributed. The purpose of the Canada Health Act (1985) is to "protect, promote and restore the physical and mental wellbeing of residents of Canada and to facilitate *reasonable* access to health services without financial or other barriers" (Minister of Justice 2017, 5, emphasis added). This purpose guides the Canadian system's organization and governance.

In analyzing my participants' narratives, I understand public administration and accessibility to represent a larger issue in Canadian health care; to ensure that continuation of health care for all, this public system is governed in a way that is fundamentally different from a private system, where services are provided on demand for the right price. In the Canada Health Act, public administration represents how health care is funded and how that funding is made (ac)countable, while accessibility is defined as "*reasonable* access to insured hospital, medical, and surgical-dental services" (Health Canada 2015, 4, emphasis added). In Canada's universal health care system, care must be *reasonably* accessible, and it is the job of physicians, clinics, and Public Health Units to determine when care is reasonable. Therefore, health care providers must balance the provision of reasonably accessible care while also being tasked with containing health care costs, and this requires a particular kind of participation on the part of its patients and clients. A universal health care system that mandates care be made reasonably accessible and accountable requires a degree of collective responsibility—being responsible to the system in terms of not causing undue strain by requesting excessive services. While this has a practical rationale, it is also modelled as a core value of being part of a collectivity that understands health as a human right for everyone.

I observed that while health care providers are responsible for ensuring reasonable care is provided in a way that does not put undue burden on the health care system, clients are also made to be responsible, both for their own health and for the protection of the health care system. Nations with universal health care systems tend to operate on the assumption that this kind of system is done in the best interest of its citizens, and therefore promotes a sense of collective solidarity and responsibility for maintaining it (Fierlbeck 2001, 5). Neoliberalism, as an ideology which calls for limited government intervention, individualization, and choice (see Ayo 2012; Crawford 2006) has become a feature of the Canadian health care system and has shaped how it is governed (Mykhalovskiy et al. 2020). Within this context, encouraging individual clients/patients/health care users to use the system responsibly is "not only a matter of economic efficiency, but it is also highly-value laden and situated as a code of ethics, an obligatory duty of citizenship" (Ayo 2012, 103). Here, I turn to the stories of two clients, Selena and Nina, to examine how feminist values of choice and bodily autonomy operated in the same space as their desire for biomedical sexual health care.

The clinic is not static. As we saw with the shift from family planning and population control to human rights within the women's health movement at the global level, the clinic (as a social space) has taken up values which have been promoted during the women's movement for decades: choice, agency, and bodily autonomy. Clients experienced a tension when they wanted to assert their rights in the context of sexual health care in Toronto; services could be denied, questions which could be perceived as invasive were asked, and experiential knowledge was often downplayed or discounted entirely. Selena expressed her frustration with the Canadian health care system, as her requests were either refused or required seeing multiple doctors.

Selena was enthusiastic about sexual health, and during our interview, she asked for a list of resources and organizations in Toronto which would provide her with further information about how to take care of her sexual health and where she could go to learn more. In her narrative, I clearly observed how her approach to sexual health reflected the predominant model circulating within Toronto's sexual health landscape; she understood biomedical care as essential and sought out the care of a specialist. While I want to acknowledge Selena's frustration with a system that appeared to be needlessly bogged down with bureaucratic rules and regulations, I also want to analyze what this says about the Canadian health care system. Selena attempted to book an appointment with a gynecologist only to find out that she must first go through a family doctor; this often meant that without a personal family doctor, these requests had to be made through either sexual health clinics or walk-in clinics.

The rationing of care in support of a universal health care system occurs at all levels and for all patients to some degree. However, it is also important not to become complacent in accepting this rationing without questions. Bridges (2011), in analyzing how prenatal care was provided to women in New York (those without health insurance in a predominantly private health care system), draws our attention to how this "charity" care comes with an excessive Medicaid apparatus, one that disproportionately impacts racialized and impoverished women. Therefore, even though the rationing of health care in Toronto can be explained based upon a discourse of equitable distribution and fiscal accountability, this explanation also draws our attention away from the ways in which racism, sexism, homophobia, and ableism also play a role in this rationing.

While not specific to The Centre or The Mobile, the following ethnographic example speaks to a larger issue I saw when clients were manoeuvring through the Canadian health care system. Many of the clients I spoke with desired medicalization; they wanted biomedical tests, services, and results in their own quest to self-manage their sexual health. While medicalization has been rightfully critiqued, it is not just repressive but also productive (Bridges 2011, 175). In analyzing women's birth choices, along the continuum of non-medical to medicalized, Bridges flags the debate over which is better (citing Davis-Floyd and Fraser) and emphasizes that we should not naturalize either choice (2011, 194). Sexual health governance in Toronto works to discipline clients by encouraging their desire to seek biomedical answers, but in a way which is responsible to the health care system. Selena had a history of having high cholesterol as a child, and while this is not unheard of, it is quite rare. Since that diagnosis, which she managed with dietary restrictions and other treatments, she liked to get her blood levels checked on a regular basis, as she describes in the following exchange:

> S: One time [the doctor] didn't let me check my [blood] levels. They told me, "No, that's not necessary," and I was like, yeah, but I want to check it. It's my body and my health, and I want to know how I am doing. "No that's not necessary; only people over 50 have high cholesterol."
>
> A: There's a lot of restrictions.
>
> S: And I'm like, no, I had it. I have a history of high cholesterol. "Well in your country you must have different regulations. Here we have more, we have a different system." And then [they] didn't let me [get blood testing]. Another time, I asked for b12. Cause if you have low iron, most likely b12 also goes with it. But b12 takes a long time to deplete. So the levels were good from the last test, but I asked them to check it. I want to make sure it's okay. "No you don't need it." Well, why don't I need it? I'm going to the lab anyways, why can't you just click that... I couldn't understand. What was she going to lose? Let me do what I want to do for my body. And she's like, "No, this is a waste of resources." She literally said that. It was a waste of resources. If I wanted to check my

> b12, back home you don’t even need a prescription. You will go into the lab and if you have someone in your family who is a doctor or a friend, they’ll read it for you.

Selena felt this interaction was dismissive. Her request for bloodwork was based on her experiential knowledge of her own body and past diagnoses. The doctor’s choice of wording requires further unpacking, as to say that someone getting testing done is a “waste of resources” is a strong statement to make. The concept of patient autonomy, and by extension the protection of choice, is ripe for a feminist analysis when writing about marginalized communities. By thinking about autonomy as relational (Sherwin 1998, 35), we are in a better position to not only critique idealized imagining of autonomy but also how individuals are never completely autonomous, as they are embedded in multiple relationships and institutions (each with their own forms of governance). Selena was frustrated with the doctor and her inability to exercise both patient autonomy and choice. She understood requesting blood work, based on her medical history, as taking care of her health and her body.

Interactions between doctors and patients can be understood as “sites of political negotiation and contestation, often serving as microcosms of large-scale social, political, and economic relationships” (Cooper 2015, 260). The physician’s comments, while harsh, speak to how health care providers in Canada have a responsibility to limit services which are not deemed reasonable (or deemed excessive); this responsibility is tied to the above-mentioned public administration of the Canadian health care system, evidence-based care, and the metrification of care. From Selena’s perspective, a private health care system is more responsive to patients; however, I would add the caveat that this is only true for patients who can afford such care. By denying her request and stating, “[W]ell in your country you must have different regulations.

Here we have more, we have a different system," the physician was enacting a form of disciplinary power meant to remind her of her responsibility to the health care system.

Selena was adamant in her desire for biomedical testing, which would provide answers on the issues she had with her cholesterol. However, she was not relying on these tests alone, as her experiential knowledge of living with high cholesterol was also important. There were other areas of care where she expressed a desire for biomedicine, while also critiquing it. Selena was one of many clients who sought out contraceptive methods which would limit the number of hormones she put in her body, which she deemed "unnatural" and potentially harmful. Nearing the end of our interview, she pulled out her smartphone to show me an Instagram account of an influencer, explaining how this is where she had learned about a contraceptive methods which was both effective and did not require hormones or barriers.

While some may find Selena's narrative contradictory, I understand it as reflective of the working model of sexual health in action. Selena desired biomedical sexual health care, yet this does not mean the authority of biomedicine communicated via a sexual health model in Toronto was accepted wholesale. Testing that required specialized care was valued, as she sought out information and clinics after arriving in the city. While Selena's acceptance of such a biomedical model can be understood as simply part of the process of producing *docile bodies*, acceptance does not automatically translate into clients not exercising agency and "expressions of docility and willing subordination do not necessarily imply an abandonment of agency" (Yates-Doerr 2012, 148); for Yates-Doerr, a framework of "agency-within-compliance" is relational and shared. Selena actively engaged in processes which would ensure she could become a rational, self-managing, and responsible subject via expert sexual health information; while this complies with the model of sexual health described at the beginning of this chapter, Selena was also asserting agency in compliance by seeking care on her own terms. She valued regular cervical cancer screenings by requesting annual Pap smears (a biomedical process within sexual health care), while at the same time worrying about the long-term consequences of taking hormones to prevent pregnancy, leading her to seek information outside the clinical health care system. Here, I turn to Nina's story, a client who initially was enthusiastic and determined to manager her sexual health via biomedical technology, but who later felt conflicted about the embodied process of having an IUS.

Nina left her family in Brazil to come to Canada when she was 25 years old. When I asked about her experience in the sexual health care system here, she explained how she had not engaged in sexual activity until she arrived in Toronto. Nina and her mother had a difficult and complicated relationship; Nina was constantly told that if she had sex, she would become pregnant, while at the same time her mother, who regretted never having sex with anyone besides her husband before marriage, was adamant that her daughter would not make the same "mistake." Unsurprisingly, given the constant pressure and surveillance by her mother, Nina waited until she came to Canada before having sex; having sex in Canada did not stop those kinds of conversations between the two women, but Nina felt it was easier to navigate when she was in another country. Once she was in Toronto, Nina dedicated herself to researching sexual health care services and options, as her priority was selecting a form of contraception, as she had recently become sexually active. Unsurprisingly, her parents' background as physicians left Nina with a strong respect for biomedicine, and she understood accessing biomedical care as a vital aspect of maintaining her sexual health. The Centre had a variety of resources available to clients, including a two-sided infographic created by The Society of Obstetricians and

Gynecologists of Canada.[17] One side features various contraceptive methods listed in order of effectiveness, which respectively reads as: hormonal intrauterine contraceptive, copper intrauterine contraceptive, injectable contraception, oral contraception pill, contraceptive patch, vaginal ring, male condom, female condom, withdrawal (pulling out), fertility awareness methods, no method (2015). The effectiveness of each method is split into two categories, perfect use and typical use, with each column containing a small cartoon outline of a pregnant woman to indicate how many pregnancies occur per thousand women during the first year of using that method. On the opposite side is what I call a choice-based infographic, which is meant to help women decide whether they should go with a short-acting reversible contraception (SARC) or long-acting reversible contraception (LARC); the deciding factor shown on this flowchart is whether or not the woman wants to become pregnant and how important it is to her to not be pregnant. This is clearly a counselling aid that is meant to help those who work in sexual health care guide the decision-making process, and yet the contraceptive narratives Nina and Yara told cannot be captured by a simplistic choice-based flow chart.

While I do not know whether Nina saw the specific infographic I discuss above, she did conduct her own research before choosing an IUS. When Nina was deciding on a method of contraception, she had no desire to become pregnant in the near future and from her perspective, the hormonal IUS was the best choice, effectiveness-wise, for ensuring she would not become pregnant. However, the issues began when she came to The Centre for insertion. When she recounted the story, she said:

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[17] Mann and Grzanka (2018) have specifically looked at advertising and visual representation of contraceptive choice in relation to the IUD. They assert the IUD is often presented as a choice, but also as the *only* choice due to its empowering reproductive benefits.

> And to me it’s like, if you look on the Mirena information website, all of these things are not saying that these side effects can happen. The side effects that they give are very broad. Insertion is just going to be a pinch. I don’t know if you’ve ever had an IUD inserted, but I fainted.

From working at The Centre, I have learned that the reactions to the IUS (hormonal) or IUD (copper) insertion are polarized. Either women barely have any discomfort and can leave shortly after the procedure is completed, or they find the procedure to be immensely painful and must lie down before leaving The Centre. However, nearly fainting after getting her IUS would not be the last time it caused Nina pain or discomfort. In describing all the side effects, she experienced during the three years she had the Mirena, Nina and I had the following exchange:

> N: And yes it’s very unlikely you’ll get pregnant, but your libido is gone. So you’re not even having sex. Might be TMI [too much information], but my libido. I got worried that it was too high. And now... am I just burnt out? I had other issues. I had several UTIs [urinary tract infections], several yeast infections, several vaginosis. It was reoccurring.
>
> A: In the paper work it says you might be more susceptible to this, but it’s a single line.
>
> N: It’s made to sound as if you might get one once every three months. I had one of those one every five weeks.

In sharing this, Nina highlighted how the information given before choosing a form of contraception mentions the possibility of side effects while having an IUS, but their magnitude and frequency is left understated. When agreeing to get a hormonal IUS from The Centre, a waiver must be signed that lists potential risks and side effects. However, it is difficult to get a complete sense of all the potential side effects of having the Mirena; medical and pharmaceutical websites provide different answers. Nina expressed her desire to learn more about how this hormonal IUD was affecting her body and mental health; she was not only interested in reading studies but wanted to know what other women were *feeling*:

> It wasn't until I talked with this chiropractor, that it clicked to me that my pain could be from my IUD.[18] She said, I have a lot of patients with the IUD, the inflammatory reaction it causes in your body, it causes a lot of pain. Your body is reacting to that strange thing. It makes sense. I started doing research and watching videos. Looking at forums, what are people feeling. I don't want to read a study that was funded by Bayer.[19]

Nina experienced many of the side effects which can happen when you are using an IUS and yet it was also difficult for her to definitively attribute her pain to a single source. The IUD has been described as being simultaneously a source of empowerment and oppression (Gomez, Mann, and Torres 2017); many women have reported feeling like having the IUD decreased the control they had over their reproductive health, emphasizing, "I feel like it would have control over me instead of me having control" (2017, 6).

When I met Nina, she had just had her Mirena removed ten days prior; she said she felt like a brand-new person. The process of experiencing multiple symptoms and side effects over the course of three years before having the IUS removed also speaks to the difficulty of making such decisions. Some might question why she did not have it removed earlier if it caused her discomfort, but the answer is never that simple. There are three factors that may have shaped

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[18] Here, Nina uses a colloquial reference. While the IUS (hormonal) and the IUD (copper) are two different forms contraception which work in very different ways, staff and clients frequently use the catch all term of IUD to refer to them interchangeably.

[19] In this last sentence, Nina makes it clear that she does not want to read a study written by the parent company of the product. Instead, she chose to focus on YouTube videos and blogs where women could share their stories.

why Nina decided to keep the IUS in for the full three years. First, when she described her symptoms to various doctors, she felt pressured to not remove the device early, as she sought (and ultimately did not find) definitive answers to the various side effects she experienced; none of the doctors could directly attribute her symptoms to having a hormonal IUD. Second, she was very firm in her stance that she did not want to become pregnant during this time and felt pressure from her family not to become pregnant. Third, the day I interviewed Nina was less than two weeks after she came to The Centre to have her IUS removed; I had sat in on her counselling session and watched as Aaliyah went through all of the necessary paperwork to have the device removed. She was there first thing in the morning and was still there several hours later. During the interview, she explained that she had to take time off from her job at a daycare to come to The Centre. The time and cost of having to go to a sexual health clinic to have the IUS removed was also a factor. Therefore, choosing contraception is not as simple as looking at an infographic and selecting one.

Contraception was one site where clients negotiated the politics of choice. While choosing a contraceptive method could be an empowering experience, it also opened them up to increased biomedicalization and governance. Generally speaking, physicians exercising their judgement in making recommendations, potential side effects, following protocols in clinical settings, and technologies of surveillance which record client data can all be part of the process of seeking contraception. Clients are asked to take care of their bodies in accordance with predetermined values, which in this case are individualization, responsibilization, and empowerment through educated choice-making. The malleable and morphing model of sexual health described in this chapter form a central component of sexual health governance, and Nina’s story can be understood as reflecting her desire to be a “health-conscious citizen” (Ayo

2012, 100) by adhering to these values. However, this subjectivity is not static, as her participation in neoliberal sexual health practices resulted in mixed emotions about the authority of biomedicine in relation to Nina's embodied experience of contraception.

After having her IUS removed, Nina searched for forms of contraception which would not "hijack" her anatomy; she explained a recently developed product, which would track her basal temperature and allow her to predict which days were safe for her to have sex. While this new form of contraception could be placed in opposition to a biomedical technology like an IUS, Nina's insistence on researching the replacement reflects the ways in which she continued to place importance on evidence. However, by selecting a method of contraception which placed herself and her embodied experience in a position of authority, Nina's story also reflects her ability to exercise agency in fostering her sexual health while complying with a model which places importance on self-management and empowerment via choice.

Through paying close attention to the clinical encounters of two clients, I have observed how the model of sexual health detailed in this chapter was taken up, negotiated, and resisted in my interlocutor's narratives. Many of the clients I spoke with desired biomedical sexual health care, feeling it was important to get regular Pap smears, contraceptive counselling and prescriptions, and STI testing. At the same time, their desire to be "sexually healthy" —a self-managing, responsible, choosing social actor—was complicated in practice. For Selena, her desire to see a gynecologist directly was hindered by a universal health care's referral system. Additionally, while she emphasized the importance of biomedical testing (such as preventative cervical cancer screenings), she was wary of using hormonal contraception and the potential effect this may have on her body and well-being. In Nina's case, after researching contraceptive choices and selecting the IUS (based on efficacy and long-term goals) her story can be understood as an illustration of how she accepted the model of sexual health described at the beginning of this chapter; she educated herself on available options, compared them, and selected the one which would work best for her. However, her experience of having an IUS for several years and the relief she felt after its removal left Nina feeling conflicted about the biomedical authority of sexual health care. As demonstrated in this section, the politics of choice are directly tied to the governance of Toronto's sexual health landscape, and therefore, choice can be understood as both empowering and subject to governance, particularly in the fostering of sexual health.

I understand the clients I interviewed as engaging in both agency-within-compliance and seizing the means of sexual health via the politics of choice. Both Nina and Selena were invested in biomedical knowledge and technologies, which would help them to self-manage their sexual health, such as regular Pap smears and STI testing. And in their compliance with a biomedically informed sexual health care system, they were also active agents in how they sought out accessible services which provided the right *kind* of care—biomedically rigorous, culturally informed, and respectful—in essence, committed to the biomedical project of sexual health while at the same time doing it differently. In some ways, Nina and Selena became neoliberal subjects—educated, responsible, choice-makers—seemingly complying with a sexual health model outlined in this chapter. However, they also exercised nuanced agency in how they took up, questioned, and resisted biomedicine. Selena craved proper and medicalized information about sexual health, taking an active role in locating and requesting care. At the same time, she was worried about long-term hormonal side effects of putting "chemicals" into her body, navigating a nuanced way of self-managing her sexual health, which was true to her experiences. For Nina, she saw utility in biomedicine but also actively questioned it, conducting her own research, and searching for alternative forms of care. Additionally, she valued finding not just any physician, but one who would listen to her concerns and take them seriously in how she would take up a biomedical model of sexual health.

Conclusion

In this chapter, I have focused on a model of sexual health, and its centrality in sexual health governance through the figurative metaphor of the landscape. In detailing the operations of key institutions and social actors, I have drawn attention to the ways in which they promoted a particular model of sexual health, one which frames a "sexually healthy" person as an educated, self-managing, and responsible chooser. While such models value biomedical understandings of sexual health by placing an emphasis on seeking health care services (such as Pap smears, contraception, and STI testing), they also demonstrate a commitment to feminist values of diversity, inclusion, and empowerment. Sexual education, and the circulation of sexual health information is embedded in the operations of biopower, working to discipline and incite the desires of clients to self-manage their sexual health in accordance with expert knowledge and norms of care. In this section, I have observed the importance of both *how* information was provided in practice and *who* was providing it; this served to complicate straightforward understandings of sexual education, wherein information is provided and immediately accepted. Finally, I have examined the concept of choice in sexual and reproductive health, its role in the women's health movement, and its limitations in a Canadian universal health care system. Here, I have presented choice as a multifaceted concept, a feminist value which has also been taken up in neoliberal discourse. By focusing on the stories of two clients, I illustrated how while they took up the models of sexual health described in this chapter, they also had to negotiate them in practice during clinical encounters. In this final section, I analyze how clients were responsibilized through their interactions with the health care system while at the same time exercising their own form of agency.

Chapter 5

Metrification and Feminist Acts of Caring in the Clinic

Approximately once a month, a staff meeting is held before the clinic opens and clients can be seen by staff. I push open the door and greet Rose with a hug before heading down the long hallway to Aaliyah's room, where I drop off my jacket and backpack. After chatting in her office for a few minutes, we head to the lunchroom (and for today, the makeshift conference room) together to help the other team members set up. Katherine and Donna enter through a side door carrying several grocery bags filled with food. Unprompted, everyone begins unpacking the bags, cutting up vegetables, setting out plates and cups, and placing the food across the long table. Once everything is set up and everyone has arrived, we all find a place to sit; I have forgotten my notebook, so I quickly head to the reception desk to grab a few pieces of scrap paper.

People pass food to each other, wanting to ensure everyone gets a bit of everything. The whispers of staff conversations begin to fade as Katherine begins the meeting. After saying a few words, we launch into the normal routine, with a member of each "department" providing a report; these reports often contain a form of accounting (how many clients were seen, how many services were provided, etc.) but also detail successes, challenges, and recommendations faced by each area of The Centre. Administration/reception goes first, with Rose providing an update on the number of volunteers currently signed up, with one returning from the previous year. Additionally, she brings up a technical issue, as two client's charts were misfiled, and misfiling is not only distressing for the client but impedes many of the documentation requirements for testing, reporting, purchasing contraception, and copying file information to personal physicians. Next, Donna details the number of mobile clinics offered over the last month and the locations they visited. Additionally, she provides the number of first-time Pap smears performed, something which is considered particularly important and which can be used to demonstrate the success of The Mobile's outreach work. Next, the clinic clerk reports on how many IUDs and IUSs were inserted over the last month, and the running totals since the beginning of the last quarter—numbers which give the staff a sense of whether they are increasing or decreasing, with the goal being the former. While the clinic clerk provides such numbers, they also point out other matters of concern, such as clients filling the specimen jar with too much urine; she reminds the counsellors to stress to the clients about the fill line. Aaliyah goes next, with a reporting of contraceptive sales, detailing the total number sold in dollar form. One IUD purchase was provided a refund due to the device "failing."

Finally, management goes over several ongoing issues in the clinic, two of which I want to highlight. First, they discuss limiting services per client to three; the rationale behind such a rule is if a client comes and requests an excessive number of services, this could increase the wait time for clients and ultimately result in fewer clients being seen in a day. They do note that some services can be bundled, such as a Pap smear exam and vaginal swabs, as they are seen as requiring similar procedures and protocols. The second issue is what was termed "stand-bys." As each client checks in with reception, their file is given a number. One of the jobs for staff and volunteers who work at the front desk is to perform the mental math of calculating how many clients can be seen in a day. For example, if there are two clinic hours left and four clients waiting to see the physician, this means one or two more clients can be accepted, as each will have to see the counsellor, and we average 15 minutes per visit with the physician. Stand-bys refer to clients who come after the cut-off number has been established, but there is still a chance they may be seen. As one can imagine, this sometimes leads to issues, as physician visits take shorter or longer depending on the client's needs. Management reminds us to check in with everyone who is wishing to be put on stand-by and let them know as soon as possible whether they will be seen or not seen. The complicating factor is that there is no set number of stand-bys, as every day is different. What remains the same is The Centre's desire to have a full day of clients being seen and to provide care in a timely fashion.

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Introduction

In the above opening vignette, describing one of the monthly meetings I attended during fieldwork, we can begin to see how The Centre's operations were multifaceted. When I attended staff meetings, it was immediately clear how a sense of community was woven into the fabric of its operations. At times it felt less like a staff meeting and more like a gathering of women sharing stories of success and challenges. Many of the team members had been with The Centre for over a decade, with some being there since the beginning in the 1970s. What was also clear was that one of the goals of these monthly staff meetings was to inform the team how they were "doing" in providing free and accessible sexual health care to their clients. Departmental reports revealed trends in the number of clients seen and the number of services provided, frequently contextualized in terms of whether these numbers were increasing or decreasing. The two issues I highlighted from management—service limits and stand-bys—also speak to another looming issue: metrics and funding in a community-based and independent sexual health clinic. The rationale behind limiting services was meant to expedite care, so everyone would be seen in a timely manner. This supported The Centre's feminist commitment to accessibility in providing sexual health care. However, it also worked to support a metric system which valued trying to see as many clients as possible in a clinic shift. Stand-by numbers were equally complex, understood as ensuring as many clients as possible could be seen in the allotted time, keeping track of the order in which clients arrived, and also trying to respond to client needs. The staff meeting illustrates how sexual health social actors (management, counsellors, volunteers, clinic clerks) were invested in both protocol care—guidelines and routines—and exceptional care—emergent concerns, storytelling, and empathy—when discussing the operations of The Centre in the three months preceding the meeting. These practices and discourses occasionally came into conflict and at other times overlapped; the practices involved in what I define as protocol care and exceptional care were valued and understood to be a part of the larger project of providing sexual health care within The Centre, by both honouring its feminist roots and attending to the increasing demand to enumerate their operations.

In this chapter, I observe how the metrification of care played a central role in The Centre's daily practices. I use the term *metrification* to evoke a sense of process, that metrics are indeed made and do not exist in the world as neutral and objective facts in the form of numbers. Metrification generates practices of surveillance, which monitor, record, and report on care work in the clinic. While care work in The Centre was aggregated into reports—which counted the number of clients seen and how many services were provided—such metrification often obscured the complexities of providing sexual health care by reducing a counselling visit or examination to a single number (see Biruk 2012; Wendland 2016; Adams 2016; Suh 2019; Tichenor 2020). In the space of The Centre, staff took these counting tasks seriously in an effort to maintain their funding by carefully filling out the required paperwork and reviewing clinic reports. The numbers produced through these processes of metrification were persuasive in their ability to communicate the scope of the sexual health care provided in The Centre. Counting in The Centre was both central to its operations and often less visible than aboard The Mobile.

Since the main clinic was consistently busy, often resulting in all spots filling up two or three hours before the shift closed, there was no set daily quota they had to reach. However, counting could be seen in other ways. Pinning numbered cards to files functioned to keep track of the order in which clients would be seen, and let us know how busy the day would be; monthly staff meetings revealed how many clients were seen and how many services were provided by type; and the mundane but vital work of filling out proper documentation would ultimately result in an accounting to their Toronto Public Health contact in the Sexual Health department of how many people were receiving services and what kinds of services were provided.

In this chapter, I argue the metrification of care is central to the work of sexual health governance. Surveillance of sexual health care, counting the numbers of clients seen, and quantifying the services provided, contribute to the monitoring and regulating of sexual health in Toronto. Foucault's governmentality helps us to account for the connection between governance and metrics. Since governance operates through multiple sites with multiple goals, in this case, a sexual health clinic and a public health agency, in order to govern, one must *know* who and what they are governing (Rose, O'Malley, and Valverde 2006, 84). Within this context, the provision of care, surveillance of care practices, and production of metrics all contribute to The Centre and TPH's ability to foster and manage sexual health. In my analysis of metrification in The Centre and the requirement of such metrics by TPH, I am "seeing like sexual health governance,"[1] which draws attention to two points. First, sexual health care is quantified, and therefore rendered as a technical object to be monitored, regulated, and intervened upon. Second, this

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[1] Here, Biruk's phrasing draws on the work of James Scott (1998).

focus on metrics in such reporting, while supporting the governance of sexual health, drew my attention to what was *not* getting counted in those reports.

Here, I am gesturing to how metrics provided a partial picture, a *numeric representation* of care within the clinic, and how they were made to speak in particular ways. Here, numbers could be understood as communicating the maintenance of routine guidelines but also successes (increasing the number if IUD/IUS insertions) or challenges (seeing fewer clients than in a previous quarter). The increasing emphasis on quantification meant that these clinic metrics were *made* to matter. In this chapter, I will pay attention to how this emphasis meant other practices fell outside of the scope of those numbers, as reports did not always capture the complex negotiations between clients, counsellors, physicians, administrative staff, and the clinic clerk which I will attend to in this chapter. In analyzing the kinds of practices which often fell outside the metric gaze, I make a connection to the purpose of The Centre: to provide free, accessible sexual health care for its clients; this often involved listening to client stories, working towards collective solutions, and advocating for client care and empowerment. These actions are representative of what I term feminist acts of caring, and demonstrate the staff's responsiveness to client concerns. In addition to meeting clients' needs, feminist acts of caring reflect the commitment of The Centre to its feminist roots, providing culturally sensitive and supportive care. A key distinguishing feature of feminist acts of caring is the fact that they not only include providing health care services but also *how* those services are provided, the manner in which the care is provided to clients. In this chapter, I demonstrate how feminist acts of caring not only involved forms of caring that were not officially recorded but that reflected the working model of sexual health analyzed in the previous chapter, operating as a technology of sexual health governance while also trying to see sexual health care provided differently from other clinics.

I begin this chapter by defining metrics through care and surveillance as concepts and practices, ultimately building to my concept of metrification of sexual health. I follow this by fleshing out what I mean by feminist acts of caring in the clinic. I then examine how the space and place of The Centre supported the metrification of care but also allowed for practices which could not be transformed into numbers. I then shift my focus to zoom in on the client files and their role in allowing us to see the care performed in The Centre, albeit a partial view. Here, I discuss how client files worked to facilitate the provision of care, but also how they could not capture everything that happened in the counsellor's office or examination room. Finally, in the last section, I introduce two key concepts: protocol care and exceptional care. These concepts help me to analyze counsellor–client interactions and how care and surveillance operated in the clinic to make the argument that care in the clinic occurred in complex ways. Protocol care allows for a discussion of how regulations and guidelines aid the metrification of care, and exceptional care draws our attention to the caring practices that are not readily translatable to metrics but that still count in other ways.

Anthropology of Metrics and Feminist Acts of Caring

As numeric representations of social realities, sexual health metrics in The Centre operated as indicators, quantifying care services and making sexual health care legible to TPH in a way that was comparable to other clinics. Metrics are often used as proof of success or failure in public health interventions. Suh, for example, describes how post-abortion care metrics in Senegal "conveyed a public health success story of the introduction of a new set of life-saving obstetric services and technologies" (2019, 157). As anthropologists have analyzed, the demand for metrics tends to flatten the sociality of providing care (see Adams 2016; Wendland 2016; Oni-Orison 2016; Suh 2019; Brunson and Suh 2019). While being able to engage in surveillance of sexual health care and provide metrics to make care practices legible to funding bodies was important to their operations, it rendered sexual health to be a technical object, to be monitored, regulated, and calculated to foster the sexual health of clients. The role of metrics in governance through practices of accounting has been well documented in global health interventions (Adams 2016; Tichenor 2020). This process necessitates, and is reflected in, the entanglement of care and surveillance I saw in the space and place of the clinic. Metrics are frequently relied on to measure success and offer evidence of efficacy, efficiency, and fiscal responsibility in health systems. Anthropologists of global health, in particular, have provided nuanced understandings of not only the rationale of producing metrics but also how the work of metrics "creates" (Adams 2016, 1), questioning whether metrics simply measure the world, counting and recording factual information, or whether metrics create the world they measure (Suh 2019, 154; see also Merry 2016).

The metrics collected and recorded in The Centre counted clients and services, and in doing so, worked to produce a picture of reality for Toronto Public Health, making numbers meaningful in the process by showing what the provision of sexual health care looked like in the clinic, drawing our attention to the ways in which sexual health is transformed into a calculable object. Take, for example, the ways in which the clinic clerk reported on the number of IUD/IUS insertions during a monthly staff meeting in this chapter's opening vignette. The number of insertions is a metric, an indicator which counts as evidence, and in this instance, the higher the number of insertions, the better. I understand the number of IUD/IUS insertions as an indicator that The Centre was increasingly engaged in providing long-acting reversible contraception (LARC), which is perceived by TPH and The Society of Obstetricians and Gynecologists as one of the most effective ways to prevent pregnancy. Many of The Centre's clients chose to have an

IUD or IUS for multiple reasons, including the relatively lower cost (in comparison to local pharmacies), which was particularly valuable for women without insurance coverage. However, The Centre's practices of tracking IUD/IUS insertions was not done to provide TPH with qualitative data explaining the experience of IUD insertion. The metric rationale was to count how many IUDs were inserted, which then allowed TPH as a funder to see the value of providing support so that The Centre could continue to offer low-cost contraception.[2]

In the above example, the number of IUD/IUS insertions represent a metric that works to communicate success, in the sense that providing increasing numbers of this form of LARC supports the goals of sexual health governance by using a form of contraception with a high degree of efficacy in regulating sexual health by preventing unintended pregnancy. Since the primary purpose of such devices is to prevent unintended pregnancy, increasing the number of IUD insertions was understood to be positive in fostering sexual health by TPH, The Centre, and clients. By virtue of having a decentralized system made up of federal, provincial, and municipal agencies, the *need* for accounting is greater. Those who make decisions about funding and proposed budgets want to *see* where the money is going and see the evidence of its impact on sexual health care. In this sense, the process of metrification works to legitimize the provision of care through various processes of surveillance and (ac)counting to *create* evidence in the form of metrics. The metrification of care involved the translation of care practices (i.e., the provision of services such as birth control counselling, IUD insertion, and Pap smear exams) into metrics. In turn, these metrics were communicated during staff meetings and in The Centre's quarterly reporting to TPH; this report made sexual health care legible to their municipal Public Health

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[2] While The Centre charged just above cost for IUDs, pharmacies can increase the price tag in order to increase their profit margins.

Unit. The manager who received their metric reports could *see* how the core funding provided to the clinic was being used by accounting for how many clients had been seen and how many services had been provided in a finite time.

However, the picture presented in these staff meetings and reports was partial. I draw on the work of Biruk (2012), who argues numbers are one of the primary ways we learn and come to know about global health issues and how they are created via socio-cultural processes, in order to examine the rationale for metrification. Biruk, who conducted research in Malawi with demographers, argues numbers are the main way we learn and understand the HIV epidemic; the production and recording of such numbers requires surveillance, which provides (ac)countability through allowing governments, NGOs, and health care systems to *see* the problem of HIV. As stated earlier in this chapter, in order for health governance to operate and work towards its goal of fostering health, it requires knowing the population and the issue, which in this case is done through metrics; once those numbers are produced, a solution can be created to address how they can be ameliorated. What institutions want to *see* tells us something about what is valued (or understood to be valuable) and also tells us something about what falls out of view. Biruk's analysis involves "seeing like a research project," to understand how information about HIV is produced via community-level surveys, reflecting a desire to simplify data in a form that is comparable.

While metrics attempt to quantify sexual health care to foster sexual health and produce "sexually healthy" subjects, we do not live in a "programmed world" (Rose, O'Malley, and Valverde 2006, 86). Therefore, this chapter will also pay careful attention to feminist acts of care provided, which were not readily translated numerically within the context of a demand for metrics. Here, I use the term "feminist acts of caring" to characterize the social practices undertaken by staff in The Centre while providing sexual health care services: empathy, creative problem-solving, the provision of meaningful resources, and making exceptions to protocols. Sex is a moral object (see Pigg and Adams, 2005), and care is a moral practice (see Tronto 1993), one that is simultaneously political, professional, and feminist. In the 20th century, specific attributes (caring, nurturing, etc.) were categorized under the umbrella of "women's morality" in a strategic effort to gain political power and social status (Tronto 1993, 1). Tronto draws our attention to how thinking about caring and nurturing could be beneficial, not as women's morality, but as a care ethic. By theorizing care in relation to morality, Tronto offers a theoretical tool, which takes into account emotion and lived experience in an effort to take multiple forms of care seriously (10); in thinking about shifting from women's morality to an ethic of care, Tronto is not arguing such attributes are inherent to women but rather is acknowledging the ways in which women have chosen to care, the circumstances under which caring and morality were made (particularly within the context of feminist movements and equity work). Here, an ethic of care (care work, feminist acts of caring) seeks to (a) show how moral and political theoretical frameworks marginalize care to legitimize the status quo, while also (b) envisioning a different type of future (1993, 101). To build on this latter point, I understand the staff's performance of exceptional care to provide insight into both their radical roots as a feminist organization and also how they want sexual health care to be undertaken in the future, a future which addresses the concerns of clients in a way that is meaningful to them and not just simply a part of a bureaucratic health care system.

In this chapter, I draw upon Tronto's explanation of acts of care (caring about, taking care of, care-giving, and care-receiving) and the four ethical elements of care (attentiveness, responsibility, competence, and responsiveness) to analyze how feminist acts of caring operated as a form of exceptional care within The Centre. For Tronto, care is intimately bound up with the concept of burden, as caring must involve more than a passing interest; it requires action (103). In describing the care work of an oncology ward in Botswana, Livingston (2012) understands care in crisis to be profoundly interpersonal, wherein the weight of care-giving and care-receiving is often glossed over in North American and European contexts in favour of focusing on the technological and bureaucratic (6). It is here that understanding the practice of biomedicine as an "incomplete solution" (2012, 7) is useful. In the previous chapter, I analyzed how sexual health social actors were invested in biomedicine while also wishing to see it done differently, and therefore this kind of caring was aspirational in nature. In this chapter, I use exceptional care to better understand how feminist acts of caring illustrate the ways in which staff members took up the working model of sexual health.

Space and Place in the Field of Sexual Health Care

In building on my analysis of The Centre as a site where metrification—the translation of care into metrics via practices of surveillance and counting—took place, I will first examine how the clinic was physically organized to do and support the work of metrification. In this section, I describe the clinic itself, including who worked in The Centre, who volunteered there, and who came there for care. By using anthropological theory on space and place, as well as Foucault's notions of visibility, I will do two things. First, I will analyze how the clinic was intentionally designed and organized to facilitate seeing care and performing surveillance through *space*, both central practices to the metrification of care and, therefore, the fostering of sexual health. Second, I will engage with The Centre as having a sense a *place*, intimately tied to its history within the women's health movement and advocacy for immigrant women's sexual health care, which also contributed to the fostering of sexual health through caring in a way which made The

Centre stand out from other clinics. I observed how this sense of space and place, the physicality of the clinic and the meaning-making which actively happened inside their walls,[3] can be understood as contributing to both the metrification of care and feminist acts of caring. While the metrification of care may mean that those who reviewed those metrics (how many IUDs were inserted, how many STI tests were administered, or how many first-time Pap smears were performed) did not get to see how the sense of place contributed to the fostering of sexual health, this does not mean that it was any less meaningful to The Centre's clients.

The Centre was laid out into six areas: the reception area, which was home to a large U-shaped sectional; private counselling rooms, which lined a long hallway; the main filing room, where client files were housed alphabetically along with incoming assessed reports;[4] the examination rooms, where clients met with physicians; the "clinic," where the clinic clerk received the day's specimens (as they were taken) to be sent off for testing, as well as a space for drawing clients' blood; and the break room adjacent to the kitchenette, where meals were prepared and eaten and staff meetings were held. These areas were clearly demarcated, and staff and volunteers easily moved between them. While there were no signs forbidding clients from going into these spaces, there seemed to be an understanding that they were only allowed to leave the reception area to enter other spaces with staff permission. Individual counsellor offices, examination rooms, and the clinic clerk's desk were off-limits to clients unless a service was being provided by a staff member. The main filing room was a space that clients were never

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[3] The following chapter will explore what this looked like beyond The Centre's walls by following The Mobile across the GTA.

[4] When reports were faxed to The Centre, we would stamp them with the current date, highlight their name, and sort them according to the physician they saw for testing. If they were positive, they would be placed in a bright pink folder. After recording their presence in a black binder, we placed them in their corresponding physician's inbox for them to review and sign off on the next steps.

allowed to enter, as it contained both private and sensitive information. When thinking about The Centre as a place, I see the space as doing two kinds of work: conveying clinical authority and professionalism, while also providing a sense of welcoming intimacy. The Centre was a place where free sexual health services were provided to clients, and a part of what made it an attractive site for this kind of care is its long-term commitment to accessibility, diversity, and empowerment. At the same time, it was also a place where sexual health social actors identified, recorded, and reported sexual health care metrics. The following vignette demonstrates how the clinic was organized to provide a judgement-free and welcoming environment for care, while also supporting the work of metrification.

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I arrive at The Centre just before 10 a.m. On Wednesdays, The Centre doors open at noon and the clinic begins seeing clients at 1 p.m. Given the extra time before The Centre is officially open, Rose and I spend the morning playing catch-up by filing reports, stocking up examination rooms, refilling the condom bowls and packets, and addressing any existing issues. On most days when I arrive early in the morning, I see a secured box hanging on the front door of The Centre, where specimens and reports will be placed interchangeably. I am in the last months of my project and feel as though I finally have a grasp on the space of The Centre and how information, people, and documents flow through it. Rose and I sit in the reception area, making ourselves comfortable with freshly brewed coffee and stacks of folders, reports, binders, a rubber date stamp, paperclips, and a highlighter. However, this day is different. A young woman, approximately in her late 20s, arrives and introduces herself as a new volunteer. I sit on the large U-shaped couch, organizing reports for filing, while Rose begins explaining the kinds of administrative duties volunteers undertake while at The Centre. After Rose spells out a couple of the clinic's routines, she turns to me and asks if I have anything to add; we laugh nervously, as it is difficult to explain the operations of The Centre in a single sitting. When discussing health coverage, Rose explains how The Centre does not require a health card from clients (if they don't have one), but if they do have one, they must provide the card details. We ask these clients to provide this information, as The Centre will be reimbursed differently depending on whether a client has OHIP or federal refugee papers, or no documentation at all.

Another task frequently done on Wednesdays is making sure the examination rooms are fully stocked in terms of the necessary forms for client services; each room has an accordion-style file organizer (labelled with tabs) with all the potential forms a physician may need during a visit with a client. If one of the tab's folder is running low on a particular form, we make photocopies and hole-punch them for later placement in client files. As we open the doors for the day, I show the new volunteer how we keep track of clients as they approach the desk. Every client is asked to provide their client card,[5] write their name and date of birth on a piece of scrap paper, or fill out a background document to create a new file. We attach a coloured square of construction paper, which has a number written in black permanent marker. Throughout the day, Rose and I guide the new volunteer through the process of registering new clients in the database, how and where to pull client files from their various storage spaces across the office, and how to distribute them. We explain who works in each office, making our way down a long hallway, pointing to different spaces and identifying the counsellor's name and which languages they speak. When we get to Donna's room, we can see newspaper clippings and media from

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[5] A client card was given to every new client who came to The Centre. It was a business card for the clinic with their client label attached; the label stated their client number, their first and last name, their OHIP number, as well as their date of birth. The client card allowed staff to quickly access their file by typing in their client number and searching the electronic database.

different events she has attended over the years, supporting the women's health movement. When someone approaches the reception desk, querying how much longer it will be before it is their turn to see the doctor, I show the new volunteer how to "count" the files hanging near the examination rooms; we allot 15 minutes for each file, so if there are four files before the woman who is asking when she will be seen, they have approximately an hour to wait. In addition to the U-shaped couch in the main reception area, there is a small room with a futon for more privacy, which also has toys as some women will bring their children with them to their appointment. I show her where we keep the bundles of condoms, discretely packaged in blank report envelopes; if someone comes, we can hand them the package without announcing to the room what is inside. In helping Rose to train the new volunteer, I am suddenly aware of how all that I have learned about The Centre, its operations, and its organization. The spatialization of The Centre is purposeful, and everything has its place for the smooth provision of care (and surveillance).

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This vignette serves not only to evoke the physical space of The Centre, but also to show how the structuring of space was intentional. To engage in the metrification of care, which sexual health social actors in the clinic understood to be a part of their daily routines, the clinic was set up to facilitate the storage, transportation, and safeguarding of client information, specimens, and reports. A client file moved from the reception desk, where Rose pulled it from one of the filing rooms, to be hung outside the appropriate counsellor's door. The counsellor would briefly review the file before calling the client to their office, which provided a private space to discuss their concerns. Once the counselling session was completed, the client would return to the reception area and wait to be called by one of the physicians working that day, and the file would then travel to a small alcove between the examination rooms and the clinic clerk's office; the file was hung, with its brightly coloured piece of construction paper that signalled their position in line, on one of the walls. After seeing the physician, if there was no need for the client to remain (such as waiting for their birth control prescription or the results of a pregnancy test), they could leave; if they had testing done, they would be asked to call The Centre within a specified time frame (which was determined by the kind of test performed). The physician would finish writing any final notes they had in the client file, and specimens would be placed on a metal tray which sat upon a ledge; this is where the clinic clerk would process testing specimens, by cataloguing them for transport to a laboratory. All incoming reports for testing results were received in reception and required pulling client files and placing them in the incoming boxes of physicians to be reviewed before the client received their results or was contacted about treatment, if necessary.

I used the word “evoke” purposefully in the previous section when describing the vignette because the process of a client entering The Centre up until the time they left is laid out to include all the details of where and how information, specimens, and reports travelled. Additionally, we can see how counting—counting clients, counting office supplies, counting timeslots, counting clients’ OHIP cards—were organized to support the operations of the clinic, reflecting how its physical organization supported the team’s goal of (ac)counting for the care, services, and supplies provided. Foucault’s description of hierarchical observation, how the physical structure of an institution can assert control via constant surveillance to shape a subject’s behaviour, is useful here, as it relies on the metaphor of sight and seeing as a form of disciplinary power (1984, 189). Through the example of literal architecture, Foucault draws our attention to the vital role space plays in surveillance, specifically how the design of a building, such as the panopticon, is done so purposefully to support observation and therefore shape behaviour within it. The spatial layout of The Centre was organized to support the smooth transfer of information, people, and objects, which in turn allowed for the provision of care to be counted and seen by TPH.

The counsellors, volunteers, physicians, administrative staff, and management team were all women (as men were not allowed to work in The Centre); most of the various staff positions were held by immigrants and second-generation immigrants. Several of the staff members, including Donna, Ines, and Irene, had been working within the organization for decades, close to its inception, when a group of immigrant women had formed a collective to provide sexual health care by and for immigrant women. The Centre, as a politicized place, was rooted in its history as an organization which had been created with the sole purpose of providing sexual health care for immigrant women. While the clients who came to The Centre were originally exclusively immigrant women, in recent years their demographics had shifted (in part, due to opening their mandate to serve non-immigrant women and men as well). Since The Centre offered free sexual health care services and low-cost contraception, it was particularly attractive for those who did not have OHIP or private insurance; while I observed many clients who came for this reason were international students and immigrants to Canada, we also saw Americans coming for short trips to receive free care. Additionally, Canadian-born clients would come to The Centre to receive care they did not feel their family doctor or a family medicine walk-in clinic could provide. For example, a Canadian-born woman came to The Centre because she and her partner had decided to become polyamorous, and she did not believe her family physician would be supportive of this choice.

Through conducting ethnographic research in The Centre, spending months within the main clinic, and getting to know both the space and place intimately via volunteering, I want to now pay careful attention to how The Centre was made meaningful for the staff and clients. The Centre was a place where *feminist acts of caring* were practiced, including offering resources, assuaging client concerns, and providing a safe space for many women. Feminist acts of caring involve moral care work, and this work is frequently intimate and personal. Additionally, as stated earlier in this chapter, such acts of caring can be understood via Chapter 4's working model of sexual health by both being invested in biomedicine and want to see it done differently. Within this context, the kinds of feminist acts of caring described in the above vignette illustrate what it means to be invested in routines and guidelines, while also doing so though a particular moral and ethical framework.

In this sense, I am using the term "caring" to evoke clients' perception of The Centre's staff as offering sexual health services in a way that was different from their family doctors or other walk-in clinics; the space was at once clinical and inviting, where counsellors often built relationships of trust and community with clients. The Centre operated as a unique space and place within the sexual health landscape of Toronto. Anthropologists have written on the ways in which reproductive care is provided, and how these reflect their given contexts. Davis (2019) illustrates how communities work together towards a future which exceeds the clinical space of the hospital. In terms of the latter, The Birthing Project operated through volunteers to provide support for pregnant Black women as a form of maternal activism, one that relied on notions of family and community (2019, 178–179). This kind of activism was born out of understanding the health care system as inadequate to protect the lives of Black pregnant women and their children, as well as the state being both unreliable and *uncaring* (2019, 169).

While The Centre itself did not operate outside Toronto's health care system or sexual health landscape, it is productive to think about it as a *place* where feminist acts of caring occurred, nonetheless. I follow the work of Yates-Doerr (2012) in understanding care as a relational and affective process. I observed how care in practice was not simply transactional—a client coming to see the counsellors, requesting a service, and the physician providing the service to the client—but rather represented an interpersonal process. The kinds of caring I saw in The Centre—reassuring clients, consoling women after a positive result, or actively listening to their stories without judgement—were tied to this clinic as a place firmly connected to its feminist histories. Feminist acts of care are aspirational in nature (see MacDonald 2018), insofar as social actors within The Centre attempted to foster sexual health not only by providing services but also by caring for the well-being of clients.

According to Nina, the kind of care she received at The Centre was invaluable. In describing her experience of getting her IUS removed, she stated:

> I know that at the clinic it has to be quick because there is a lot of people waiting. But I never got like someone saying, "Okay, you have to go." They ask "Do you have any more questions? Are you comfortable?" It's a very safe space. I've had to go to that clinic after sexual violence. That's especially a situation that you need to be made to feel like the world's not going to end… When I got the IUD out, I don't know if it was something with my vagina, cuts or scrapes. When the doctor put the speculum in with the lube, the lube burned. And she was like, "Do you want me to take it out?" And I was like, "No, let's just do it." The fact that she's asking if I want to take it out. I know doctors back home who would have either taken it out or not even paused. The small thing of asking you, "Do you want me to stop? Do you want to pause?" And those two procedures, the removal and the insertion, were very painful. But I had someone guiding me through the whole process. "You're going to feel this now." I believe that people work in places like

> that clinic have extra training. There's a lot of sensitivity training as well, I think… The experience as a patient, leads me to believe yes, that's how they do it. I always thought that I wanted to volunteer or work at the clinic. Because it has been so positive to me.

On paper, Nina's visit to The Centre could simply look like ticking off a box for the removal of her IUS, a service which was then tallied into monthly and quarterly reports. However, in her narrative of this process, we come to learn about more than just a care service but her experience of being *cared for*. The Centre's physician who performed the IUS removal not only completed a health care service but fostered Nina's sexual health in a way that was respectful of her bodily autonomy and agency, something that is not readily translatable into a metric. As I understand care to be a technology of sexual health governance, the way in which her IUS was removed—the ways in which the physician responded to her client's discomfort—ultimately left Nina feeling good about her clinical experience. In describing her experiences with The Centre, Nina emphasized how part of the reason she would continue going there to receive sexual health care, even though she had recently obtained an OHIP card and found a family doctor, was due to how she was *cared for* by the staff; caring, in this instance, worked to not only monitor Nina's sexual health but also to incite her desire to continue seeking out sexual health care in the future. In interviewing Nina and witnessing one of her counselling sessions, I was able to learn about her experiences with the IUS and its removal, and to contextualize how she understood sexual health care. In contrast, if I had looked at her client file, I would have only seen the fact that she had an IUS inserted on a particular date and removed on another. However, this does not mean client files do not provide valuable insights into the clinic's operations, as I will now show the role they played in The Centre.

Client Files

It is Tuesday, and The Centre has finally calmed down after the morning rush. I take the opportunity to go into the main filing room, which holds all the files for the current and previous years[6] (2017–2018), where I see a black box filled with client files that need to be slotted back into their correct position. It is a small room, perhaps ten by ten feet, and the walls are lined with floor-to-ceiling shelves, apart from one wall that has a giant grey filing cabinet. The wall facing the window has a shorter bureau, where incoming reports can be sorted, and complete files can be placed back on the shelves. After I have finished ticking, attaching, and filing incoming reports, I turn my attention to the files that are no longer needed and can be put away. As I pull files and scan the shelves for the correct position—there are tabs made from construction paper that indicate where each letter begins—Aaliyah walks in to chat. She says in a teasing manner, “They’ve got you in here filing. What are you going to learn from that?”

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I would come to learn a great deal about The Centre through the process of filing. Client files (and their contents) played a central role in supporting the governance of sexual health provided in the clinic through practices of surveillance and documenting care. In analyzing the role and function of client files, I understand them to be tangible, material objects with a relationship to care (see Cogburn 2020), as well as bureaucratic (see Street 2012) sexual health technologies. Client files are critical to the metrification of care in a universal system which relies on the accountability of its social actors, including the actual translation process of recording care services as countable and knowable numbers. By volunteering in The Centre, I saw the ways in

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[6] The Centre held files for five years before they were moved through a company off site and eventually destroyed. The files from five, four, and three years have a home in various filing cabinets scattered throughout The Centre.

which staff created, managed, and cared for client files, which provided insights into metrification as a social process. Metrics are not natural facts existing outside of human agency and politics; rather, they were as part of the daily routine in the clinic.

During every volunteer shift at the clinic, I completed administrative and practical tasks, such as filing and organizing incoming reports containing clients' test results. As I familiarized myself with the routines, I often found myself sitting at the reception desk and managing incoming clients. After greeting them, I would either ask them for their client card (which had their name, date of birth, and OHIP number affixed via a label to one of The Centre's business cards), or I would ask them to write down their name and birth date so I could search for them in the system.[7] The client file required a mix of technology and practicality. If they were not a returning client, a client file would have to be made; they were given a blank background information form with a square of construction paper with a number written in black Sharpie[8] attached to a clipboard. The form asked for their name, date of birth, address, emergency contact, country of origin, languages spoken, and OHIP number (if they had one). Once they had completed the form, I would input the information into the computer database; The Centre kept track of client information digitally in addition to safeguarding a physical copy. Entering the information would be followed by printing out their labels (which contained their client number, first name, last name, date of birth, and OHIP number) and placing two on the outside of the physical folder so they could be clearly seen. The remaining would be used for identification purposes on other forms, so I scotch taped them to the inside of the folder. I then used a

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[7] This was done to identify where I should be looking for their file. If it had been more than five years, a new file would be put together for them. Additionally, if they were returning after a recent visit, their file may be in one of the Doctor's baskets or incoming report bins.

[8] These squares indicated their numerical position in line and allowed staff to track the order in which clients should be seen.

paperclip to attach their number in line. I would glance inside the file and place it on the appropriate door; many of the counsellors spoke multiple languages, so it was our job at the front desk to match each client with the right person. However, this process could also be tricky. If a Spanish-speaking counsellor already had four files on her door, we would approach the next client to see if they wanted to wait or if they felt comfortable speaking with someone else. We wanted to ensure a good match between the client and counsellor, while also keeping the line moving.

The client files held several practical purposes. I did not examine these files to see what kinds of things had been written in them, as I saw this as a breach of privacy. However, throughout the course of my duties as a volunteer, I needed to access files to answer client questions or help a counsellor figure out an administrative issue. If a client came to the front desk or called The Centre to ask if they could purchase another package of oral contraceptives, I would locate their file and flip to the last page where counsellors kept track of birth control sales on a bright purple piece of paper. If a client called for the results of recent testing, I could access the database to see if their results were ready for them.[9] If a client came in for birth control but also wanted to know when they were due for their next Pap smear, we could look at their file and see the date of their last test results. These tasks enabled a deeper understanding of the client files' critical role in The Centre, specifically the ways in which they were essential to providing sexual health care.

Client files could facilitate the provision of care by allowing counsellors, doctors, and volunteers to refer to past visits to guide current decisions. For example, a young woman who

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[9] As a volunteer, I was not allowed to give results to clients, but I could tell them if the results were in the system and have a counsellor call them back. All test results could be given over the phone (after verification) except for HIV results. Whether the results were positive or negative, clients had to come in person to The Centre to hear them.

was taking one brand of oral contraceptives could come in to express dissatisfaction with side effects; the counsellor could look in the file to see how long the woman had been taking that particular brand and then suggest one that might be more suitable. These files also contained all client reports (Pap smear and STI test results, and prescription history), and housing them in a single file facilitated the transfer of such reports; information could be faxed to a specialist or family doctor when requested, which supported continuity of care.

During my fieldwork at The Centre, I sat in on approximately 25 counselling sessions and witnessed how these files were created and used in practice. I understand client files as objects of ethnographic interest, objects which are created and used in practices of storytelling, verification, problem-solving, and metrics. Anthropologists have argued for paying close attention to documents and the processes of documentation (see Hull 2012; Adams 2016; Biruk 2012), which are not neutral, but rather, which have productive power, and do work. It is within the context of health care that I understand client files as "promot[ing] control within organizations and beyond, not only through their links to the entities they document but through the coordination of perspectives and activities" (Hull 2012, 257). Client files recorded information, not only for The Centre's records but also to support the metrification of care; the information in the client files (i.e., services) was translated into numbers, which could be counted and which were forwarded to TPH by entering the information into an electronic database used by staff. As files played such a central role in the clinic's operations, all counsellors and physicians engaged in meticulous record-keeping *activities*. In this sense, client files as documentation not only coordinated the clinical activities of counting but aided the flow of information from the clinic to the level of public health. The governance of sexual health, through technologies of care, surveillance, and metrification, is supported through the *administration* of such knowledge; as Foucault (1991) argues, governmentality and the art of government requires both expert knowledge of the population and an apparatus to govern it. In thinking about statistics as the "science of the government" (1991, 99), the physical client files are a part of a documentary system which works with the electronic database. This information is aggregated in the form of quarterly reports.

Client files offered a way to *see* clients who come to The Centre. Client files can be thought of as providing a partial and curated picture, as they allowed us to see through the lens of metrics. The file provided detailed information in the form of ticked boxes and short answers (including but not limit to statements alongside which clients were meant to tick a box to indicate "yes" or "no," such as you use condoms sometimes, you engage in sexual activity with men and women, you only menstruate every second month, you are requesting a Pap smear). The physician would make a note of the client's symptoms and fill out the required paperwork for different kinds of exams (Pap smears, oral swabs for STI testing, bloodwork for a syphilis test). It is within this context that metrics "tell stories about what those who produce them and what those who rely on them care about most" (Adams 2016, 9), and by paying close attention to these files, we are also able to understand which stories do not get told. The client file was not only a repository for client information, their medical history, and the services they've accessed, but also allowed The Centre, its staff, and TPH to intervene through a blending of crisis and protocol care—terms that I will explain shortly.

Client files allowed the counsellor to *see* clients' country of origin, their primary language, and whether this was their first time at The Centre. The countable forms of information in client files, including Pap smears, STI testing, birth control counselling, birth control prescriptions, birth control purchases, and IUD insertions, could be translated into metrics. However, client files are unable to fully capture how staff *see* clients and their stories. The dynamic, relational nature of counselling sessions is not and cannot be accounted for in the notes section of the file; I will attend to such clinical encounters shortly through an ethnographic example. Therefore, the file does not readily account for the feminist acts of caring provided by staff, nor does it address the affective experience of seeking sexual health care for clients. Yates-Doerr argues that the nutritionists who counselled their patients on how to reduce weight-related chronic conditions through diet in her fieldsite not only provided them with information but also "carried their patients' lives and stories with them" (2012, 146). The weight of both caring and receiving care, as an interactional process and not a transactional one (see Mol et al. 2010), is not found in the file, as it is not readily translated into boxed to be ticked or client notes. However, while the file may not communicate all dimensions of providing sexual health counselling, as I will address shortly, client files can support staff's ability to engage in feminist acts of caring by providing a documentation of medical histories and past concerns which can be reviewed by the counsellor. In this sense, client files provide important details about a client, which when combined with listening to their sexual health narrative, allows staff to provide care in a way that is more responsive to their current needs.

While the counting and careful management of client files is required to maintain accurate reporting to public health institutions, I also follow Street's (2012) argument that making care within the clinic visible to those responsible for funding can also be strategic, as agency can still be invoked in compliance (see Yates-Doerr 2012). By the counsellors, administrative staff, and physicians engaging in bureaucratic processes of counting and caring for the client files maintenance, which they are called upon to do by institutions in the government of sexual health, they are also calling upon the state to continue funding their efforts to foster sexual health through the provision of feminist acts of caring. However, this process of metrification in a public health system can lead to missing the specificities of care (see Mol et al. 2010). Mol, Moser, and Pols question how care work is often broken up into “good” and “bad” care, that instead of reinforcing this dichotomy we must analyze the ambiguity of care (2010, 11), which is useful for acknowledging care in its multiple forms without assigning value. I pose a hypothetical example which demonstrates the role of the client file in aiding metrification of care, but which also tells us something about the ways in which TPH’s ability to *see* sexual health care is particular to what they aim to see.

When a client came to The Centre and had a vaginal swab for STIs, the test would be transported via a third-party company to an independent lab such as LifeLabs. The test results were sent to The Centre, and if they were positive, a series of clinical and bureaucratic activities were initiated. The positive results were automatically forward to TPH, and a caseworker sent a series of forms via fax that needed to be filled out by the notifying counsellor, as TPH wanted to know when the client had been notified, if and when they had sought treatment, and the status of partner notification. This positive test result was collected and compiled with other data from The Centre, which when aggregated and contained in the quarterly report, worked to create a numerical picture; in this case, such a metric provided one representation of STI infection. Leah, a sexual health promotion specialist, argued that the public health teams who reviewed STI infection rates data might see a spike in positive chlamydia results from a specific area and assume this meant an outbreak. Leah argued this could also signal an increase in testing, and therefore with more testing, the chance of identifying positive results also increased. The data provided through metrification can illustrate problem areas but also the state of sexual health in Toronto by assessing STI rates across the city. The state’s interest in its citizen’s sexual health (and in them becoming self-regulating subjects) relies on such processes of metrification. With the above example, I want to highlight two things. First, we see how the complexities of going to a clinic, receiving counselling, providing a sample for STI testing, waiting for the results, receiving a positive result, partner notification, and receiving treatment can be collapsed into a final (and metric) form. However, we can also see how for those providing care and who are familiar with clinic documentation—counsellors, physicians, administrative staff, and volunteers—information found in client files also tells a story. Therefore, ethnographic methods which attend to counselling visits was valuable for better understanding how the metrification of care—the complex translation of client's stories, concerns, and hopes—was done in practice.

While sitting in Aaliyah's office and being present for counselling sessions, I learned that not everything that was said made it into the official record. A Canadian woman in her mid-20s came to The Centre on a Tuesday morning, hoping to get one of the coveted IUD slots;[10] Aaliyah proceeded to methodically go through the intake paperwork with her and nearing the end of the process, handed her a form that listed specific things you can and cannot do while having an IUD, things which the client must acknowledge having read and provided a signature for the file. Users of the IUD are advised against using a menstrual cup, as the suction can change the position of the IUD. The young woman looked shocked and told us her friend had recently had an IUD inserted with her family doctor; the friend used a menstrual cup. When she asked Aaliyah why the friend's doctor did not warn her about the dangers of using both products, Aaliyah explained that sexual health clinics are under strict obligations in terms of informing clients of all risks and benefits with contraception, requiring a signature as directed by TPH,

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[10] On Tuesdays, there was one IUD insertion timeslot in the morning and one in the afternoon. When I asked why there were such limited spots, multiple staff members explained the extra time needed and higher chance of complications with this procedure (i.e., difficulty inserting the device).

whereas family doctors are not under the same scrutiny. Ultimately, the young woman decided against having the IUD inserted because she was committed to not using tampons and pads for environmental reasons. She opted instead for oral contraceptives.

While Aaliyah had taken the time to provide care to this client, that care did not get "counted." If the young woman had received an IUD, a box would have been ticked on the form in her file and recorded in the electronic client database. This data would have been compiled and reported at the monthly staff meeting when citing how many IUDs had been inserted at The Centre. Since the young woman had decided to go with an oral contraceptive, a different box would have been ticked and different waivers would have been filled out and signed; her decision to go with a different form of contraception would have been reflected in the counting of birth control prescriptions and birth control sales. I understand client files operate as a repository for metrics, for storing a client's contraceptive history. The act of ticking boxes on a form is both practical and clinical, as it is a part of the protocols counsellors must follow in performing counselling duties. However, the social process of getting that tick mark and the client's rationale for oral contraceptives is obscured by the desire for the final numbers only; the reports given to their TPH sexual health contact are strictly numerical and reflect an accounting of the care provided. Returning to the question Aaliyah asked in the vignette at the beginning of this section, I have learned how client files contain clear-cut and digestible facts that answer the following types of questions: How old is the client? What languages do they speak? What kinds of testing have they done? How much longer is their oral contraceptive prescription good for? However, I now also know how these files do not and cannot contain the entirety of providing sexual health care services, the problem-solving, the advice given, and the dialogue exchanged. Within a framework of metrics, the client file did not allow TPH to see how these kinds of conversations unfold, why a client ultimately chose one form of contraception over another, or how uncountable problems were addressed.

While client files and their diligent creation and maintenance support the translation of health care services into numbers, ethnographic data demonstrates how the clinic is also a place where immigrant women's care occurred in ways which were not (or could not) be translated into quantitative data. And yet this does not mean that this kind of care did not count, as I argue these kinds of caring practices (problem-solving, offering advice, listening to their stories[11]) mattered to the clients and mattered to the counsellors. Rather, it was not a part of the official metrics presented to TPH because it was difficult to *see* them. In trying to see a sexual health care system through analyzing client files, I want to draw attention to how care was simplified, made legible, and magnified (Biruk 2012, 351) through the filling of forms, ticking of boxes, and filing of reports. In this section I have moved back and forth between stories which demonstrate the ambiguity of care in relation to client files, showing the ways in which, they support metrification and feminist acts of caring, while also being unable to grasp the conditions of feminist caring. I do so to wade into and demonstrate the entanglement of care and surveillance, governance via numbers and empowerment via respectful and responsive care. I do not see these things as contradictory, but instead as overlapping pieces which all work towards the goal of providing accessible, biomedical, and feminist sexual health care. In the following section, I will continue to build my analysis of how care and caring was performed within the space and place of The Centre.

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[11] This kind of care will be expanded in a following section on exceptional care.

Protocol Care and Exceptional care

As discussed at the beginning of this chapter, analyzing the production, reliance on, and usage of metrics has predominantly been done in the field of global health (see Adams 2016). This analysis can also be useful for fieldwork done within a domestic context, where an independent sexual health clinic's funding relies on the metrification of care. Within a Canadian context, managerial tasks (such as filing paperwork, providing accurate reports of care, and surveillance activities) are on the rise as a neoliberal and universal health care system demands newer and more robust forms of accountability (see Choiniere 2011; Dale 2020). These tasks have been described by nurses as looking good on paper to those in an administrative position, but in practice they can have the effect of shifting time away from providing care to paperwork management (Choinere 2011, 335); here, efficiency in care is conceptualized by placing an emphasis on numbers and the production of numbers through surveillance (Dale 2020, 35).

In spending several months volunteering at The Centre and sitting in on counselling sessions, I paid attention not only to how sexual health care was provided but also to how care was sought out and requested by clients. Here I introduce two key concepts: *protocol care* and *exceptional care*. Both exceptional care and protocol care play a role in the metrification of care. However, the difference between the two can be explained by paying close attention to what kind of care can be easily quantified, and what kind of care cannot. Protocol care involves clients' routine requests for care, such as regular Pap smears, renewing of birth control prescriptions, follow-up visits, and periodic STI testing. Therefore, protocol care also entails the daily practices within the clinic that supported the routine provision of sexual health care. Exceptional care refers to clients' emergent requests for care, such as concerns about recently having unprotected sex, painful menstruation symptoms, or side effects after switching to a new form of contraception. I choose the term exceptional to capture both the kind of care sought and the kind of care provided in these situations; the term exceptional distinguishes crises, emergent concerns, and difficult decisions from routine care visits. Additionally, exceptional captures the mission of The Centre and The Mobile to provide responsive and respectful care. The kind of care needed and provided in these instances is what I term "feminist acts of caring," care which reflects The Centre's long-time commitment not only to providing sexual health care services to immigrant women but to caring *for* immigrant women via feminist values of empowerment, choice, and respect; such feminist acts of caring involved counsellors and physicians *caring* for their clients through problem-solving, listening, and empathy.

While I make a distinction between the two forms of care, it was also the case that exceptional care often led to protocol care, receiving any of the services The Centre offered (such as STI testing, emergency contraception, a swab to confirm bacterial vaginosis for a prescription) required forms to be filled out, the information provided by the client to be recorded, and waivers to be signed. While I have made a distinction between protocol care and exceptional care, this is not to say that it is only the latter that involves *caring* for clients and their concerns. Even in thinking about the perceived transactional nature of protocol care—wherein a client requested a routine service, the clinic paperwork was completed, and the service was counted as a part of The Centre's reporting purposes—these interactions were still often built upon a relationship of mutual trust and community. My purpose in distinguishing the two is to illustrate how exceptional care, in responding to pressing or distressing client requests, can helps us to unpack how it both relies on biomedicine and exceeds it in how it constructs its object (see Good 1994).

Protocol Care

Protocol is concerned with the *how of care*, how do practitioners at the clinic perform exams, prescribe contraception, and record results. Protocol can be defined as the "procedural script that strategically assembles technologies, exchange, epistemologies, [and] subjects" (Murphy 2012, 25), and this definition is apt for analyzing the kinds of protocol care enacted in the field. Protocols were firmly embedded in the space of the clinic, including the care and surveillance work done to aid metrification. However, this common definition of "protocol" has been fleshed out by Murphy, whose application of the term was created with the understanding that feminism and technoscience are deeply interconnected. A 1970s feminist self-help clinic was more than a physical location, as it was about the *experience* of the clinic rather than a demarcated space. Murphy introduces the concept of protocol feminism to speak to the mobility of the self-help clinic—mobile practices, mobile conversations, and mobile technologies reproduced outside of the hospital or doctor's office—and in doing so, argues protocol feminism to be a kind of counter-conduct, given the politicization of women's health and of technoscience (28–29). For my purposes, I use the term "protocol" to signal the clinical protocols, which in the space of The Centre became mundane and routine and comprised a large portion of the daily work within the clinic. I argue protocol care is both feminist and strategic. The counter-conduct described by Murphy relays how women were forming their own self-help clinics, performing the kinds of sexual and reproductive health care which otherwise would be performed in a biomedical clinic, and emphasizes how these women were quite literally *seizing the means of reproduction* for their own purposes. The Centre's creation by a collective of immigrant women, with the goal of providing free, accessible sexual health care to other immigrant women, offered a similar form of counter-conduct in that the team explicitly understood their care work as filling a gap, bringing down systemic and structural barriers (language translation, transportation, time off work, childcare, etc.) to provide information and care underserved groups of immigrant women. Therefore, protocol care, while on the surface appears to only reflect the mundane and routine care acts of a sexual health clinic, if put in context of The Centre’s origins and Murphy’s analysis of self-help clinics, is a continuation of the feminist histories and radical actions which demanded accessible and equitable care. To *continue* providing accessible and free services (along with low-cost contraception), The Centre had to adhere to protocols which outlined how to practice biomedicine and how to translate care into metrics for TPH; in doing so, they maintained their funding and were able to continue providing care for women who otherwise may not have been able to access it in a way that was suitable.

Protocol care refers to routine care practices that, when assembled, comprise a large part of The Centre’s operations. Protocol care can include filling out client files with the appropriate information, reviewing an ensuring all proper documentation has been provided, and labelling specimen jars with client labels. Practices of record-keeping and reporting are engaged in a form of surveillance, the purpose of which will be elaborated on in the coming pages. However, protocol care also refers to the client’s concerns and requests embedded in routine, such as obtaining a new birth control prescription, purchasing contraceptives, or having a routine Pap smear exam, as demonstrated in the following vignette.

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I arrive early to The Centre and immediately head to Aaliyah’s office; I am trying to increase the number of counselling sessions I am present for, so instead of staying at reception, I have spoken with Donna and Rose about spending the first part of my shift shadowing Aaliyah. There is a new volunteer training today, so Rose will still have help running reception. After placing my backpack and jacket on her filing cabinet, I sit in one of the chairs positioned to face Aaliyah's desk, so I will be sitting next to each client. Over the past few counselling sessions, I have noticed the frequency with which women come to The Centre for routine requests: refilling a birth control prescription, buying oral contraceptives, having a Pap smear performed, or undergoing a follow-up appointment.

On my way home from The Centre, I open a small notebook and write about the women whose counselling sessions I attended today. There was a young Irish[12] woman in her early 20s coming to The Centre to purchase oral contraceptives (for which she already had a prescription). I watched Aaliyah flip to the back of her file and write how many packages were being purchased, subtracting them from the running total on a bright pink piece of paper. A Filipino woman in her 30s came to the clinic to have the position of her IUD checked; upon inserting an IUD, the doctor recommends clients come back within a specific time frame to ensure the device is in the proper position. An Italian woman in her late 20s was also there to purchase contraception and chose the NuvaRing. This choice necessitates specific protocols, wherein paperwork must be filled out before the client can see the doctor and get the prescription. Aaliyah explained how to use the device, the risks involved, and asked the client to sign a form indicating she has understood the information presented.

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Each of the women in this vignette came to The Centre for sexual health care, whether that meant buying contraception, obtaining a prescription, or attending a follow-up visit. With each

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[12] In discussing the women who came to Aaliyah's office for counselling, the nationalities provided reflect their respective countries of origin, which were listed in their client file.

new woman who came through the office doors, there was paperwork to fill out: intake forms, waivers, and payment receipts. Each of them had to go through the process of intake paperwork, filling out service-specific forms, and indicating they understood the information they were being given. Instances where I saw what I now understand to be protocol care were a part of the daily routines and practices of the clinic, the ones that were recorded in client files and registered on intake forms. Whether it was an Albanian woman coming to The Centre for general STI testing shortly after immigrating or a Latvian woman requesting a new birth control prescription since she was on the last box of oral contraceptives, protocol care circulated through the women working and among various technologies.

A routine Pap smear (which occurs according to care recommendations) is a key example of how protocol care occurred in the clinic. When someone came to the clinic for their routine Pap smear, the counsellor would open their file and thumb through the reports section; here was where you would find all results secured with a metal fastener that is adhered to the fold. Each report was stamped with the date received, a physician’s signature, highlighted findings. After a client had a normal Pap smear result, they would wait three years before coming for their next one.[13] In this instance, the client was receiving protocol care by complying with Canadian care guidelines. In checking the date of the last Pap smear, the counsellor was ensuring both the client and The Centre were following proper protocol. After it was established, the client could have a Pap smear done that day, Aaliyah would fill out an intake form for the visit, documenting the service requested. After the counselling visit was complete, the client waited in the reception area until they could see one of the physicians working in the clinic on that day. The doctor had their own paperwork to fill out and place into the client file, as well as a form they needed to

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[13] In the past, Pap smears were administered annually.

sign. and added their physician number for the lab to process the sample. The Pap smear exam involved removal of clothing, wearing a gown, lying on the examination table and placing their feet in the stirrups. The doctor had a Pap smear testing kit, used a speculum to gain access to the cervix and swabbed the area before adding the specimen to the corresponding jar. One of the patient labels was affixed to the jar and the specimen was sent for testing.

The act of going to The Centre for a routine Pap smear involved multiple layers of protocol care. Both the counsellor and physician were required to follow the protocols laid out by The Centre and health care guidelines; this involved filling out paperwork, ensuring the correct label was attached to the specimen jar, and only providing a Pap smear when it was necessary to do so. However, protocol care is also about the client, who I understand to be engaging in a form of *protocol self-care.*[14] They came to the clinic for their scheduled Pap smear, actively participating in their sexual health within an appropriate timeframe. There were multiple instances where I saw women double-checking this timeframe in relation to their own care. When I sat at the reception desk, I would receive phone calls asking me to check the date of their last Pap smear; this was done in order for them to know when they needed to come in for another one. I saw first-hand in counselling sessions how women who came for another service would also ask Aaliyah to check the date while she had their file. In this sense, protocol self-care is a form of biopower and sexual health governance within the Toronto health care system.

As I stated earlier in this chapter, sex is a political object, and therefore biopower is centred upon it (Foucault 1990, 145); in identifying the proliferation of discourses which focused

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[14] Here, I draw inspiration from Murphy's analysis of self-care clinics in the feminist reproductive health movement. However, while Murphy describes the ways in which women formed their own sites of care and performed exams on each other outside of the clinical space, I am speaking to how clients sought out official biomedical sites for their services in caring for their sexual health.

their attention on sex, Foucault effectively illustrates how concern with birth, death, and life was realized via disciplinary power that sought to calculate and optimize sex. As discussed in the previous chapter, the operations of biopower are continuous, subtle, and work through multiple sites; biopower is evident in the standardization and creation of the norm. Upon coming to The Centre, clients learned the Canadian health care standards for when clients should get a Pap smear examination. For clients, the guidelines started from their first Pap smear *in Canada*; this means that even if they had a Pap smear six months ago in their home country, they were encouraged to get one in Canada as soon as possible. I had a conversation with Donna about one of her clients, who was concerned about receiving a letter from the Ontario government encouraging her to get a Pap smear exam. Donna tried to assuage her apprehension, but the woman believed the results could be used in a way that would impact her immigration status.

Based on these observations, protocol self-care can be understood as empowering, as taking control of one's sexual health. However, as I discuss in my definition of sexual health governance, this empowerment is often understood to come with increased regulation. For The Centre, protocol care was the routine clinical protocols followed by sexual health social actors. However, the carefully recording of services, which translated care practices into metrics, can also be understood as strategic, ensuring their ability to continue providing sexual health care by maintaining their funding. For clients, the continual referencing to the client's history of service can also serve to *discipline* them in their desire to receive services.

Exceptional care

While protocol care deals with the daily minutiae of clinical health care practices and practices of self-care for clients which involve responsibilizaition, *exceptional care* occurs when care is enacted in response to an emergent problem, issue, or event which the client could signal to various sexual health social actors at The Centre. Having unprotected sex, finding out a partner has been unfaithful, experiencing excessive or irregular bleeding during periods, or reoccurring UTIs can all be analyzed as a part of exceptional care. Therefore, exceptional care is not only a form of care that responds to crises, but a concept that allows me to attend to the feminist acts of caring I witnessed that are not readily translatable into numbers; the following vignette demonstrates how exceptional care operated in practice.

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As I walk down the hallway, Aaliyah motions me with her hand to follow her. She is holding a client file and calls out a first name in the reception area. A woman of colour in her early 20s rises from the soft sectional. We lead her down the hall to Aaliyah's office, and along the way I explain who I am and ask her if she would mind my being present during counselling. She smiles warmly and agrees, so I take a seat next to her across the desk so that we are both facing Aaliyah, who begins the session in her characteristic fashion: "What brings you to The Centre today?" The issue she wants to address is her irregular periods, as every third month she seems to be skipping it altogether—but even this has not been consistent. I listen as Aaliyah asks her a series of questions: Do you travel? Do you track your menstrual cycle? How long have you been living in Canada? The young woman is from the Bahamas and has been living in Toronto for close to three years. Aaliyah explains that travelling to and from different countries, particularly ones with different climates, can have an impact on one's menstrual cycle. She swivels in her office chair and points to a large diagram of a reproductive system to demonstrate another possible reason; an egg is released from one of the fallopian tubes, alternating monthly. Aaliyah suggests tracking her cycle to determine if one of the fallopian tubes is not releasing an egg and therefore may be the cause of the missing periods. This explanation makes sense to the young woman, and she agrees to track her periods more closely before leaving the counselling session.

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This short vignette offers insight into how exceptional care occurred within counselling sessions. The young woman was concerned about the irregularity of her periods, and Aaliyah engaged in a set of caring practices by asking her follow-up questions and problem-solving why the client might be experiencing this issue. Instead of offering a service which might solve the issue (such as taking oral contraceptives, which could potentially regulate her cycle), Aaliyah used her knowledge as a nurse and counsellor to empathize with the woman, contextualize her experiences, and subsequently create a path to move forward, one in which the client would have control. It is through her attentiveness to the issue brought up by the client, her competence as a sexual health social actor with years of experience in this field, and her own moral positioning which garners a type of care which one would hope to receive at a sexual health clinic but which one could not find on a form.

Through my time volunteering at the reception desk and sitting in on counselling sessions with Aaliyah, I saw first-hand in the field how different situations require different kinds of care and care practices. In the previous vignette, exceptional care involved Aaliyah problem-solving with the client to address her concerns. By asking questions about the client’s daily life and recent experiences, Aaliyah was able to offer a possible rationale for why irregular periods may be occurring. Aside from the initial intake form, there was no box to tick or report to file for providing care in the form of brainstorming possible answers and solutions. In this kind of clinical encounter, the counselling visit was counted and the woman was included in the counting of how many clients had come to The Centre, but the young woman’s experience of sharing and problem-solving her irregular periods was not (ac)counted for in a metric sense. There is no public health database that tracks the occurrence of women presenting with irregular menstrual cycles or how irregular periods impact these women’s lives; this means this meaningful interaction is not within the gaze of sexual health metrics. However, I want to emphasize that this does not mean that the care Aaliyah provided does not count; it is just not counted as a metric. What I am gesturing to here is the kinds of caring practices which were central to the work of The Centre and part of the reason so many women returned year after year for services. The im/migrant women I interviewed all expressed the sense of relief that came with finding The Centre, as a place which was created for im/migrant women and which provided its services to this community through the provision of free and accessible sexual health care.

In this section, I return to anthropological work, which has attempted to define and parse out care as a concept (see Van Esterik 1995, Garcia 2010; Mol et al. 2010). In analyzing exceptional care, I need to pay close attention to how care is constructed, its practices, the abstract emotional investment in care, and the rationale for caring (Van Esterik 1995). According to Van Esterik, it is easier to measure access to care than to measure care itself, and I have used the concept of metrification in an effort to explore how care *is being measured*, to examine how care practices are translated into a form (metrics) that is measurable and assessable. However, this leaves us with the kind of care work that is not easily measurable but that also worked to support the goal of the clinic to provide accessible sexual health care: a word of reassurance, an expression of empathy, or an act of problem-solving. An analysis of care should attend to specificities, otherwise the protocols which regulate them remain neutral in their appearance

(Mol et al. 2010, 7). Exceptional care allows for an analysis of how care provided to clients' emergent concerns both utilizes and exceeds biomedicine. Biomedical care seeks to record "natural" objective facts. Here, instead of reinforcing a divide between biomedicine and caring, I focus on how biomedicine is practiced in defining what exceptional care offers to adapt it, using Good's insights to reflect on how "assumptions authorize our systems of medical knowledge" (1994, 3). In this sense, I draw a parallel between how biomedicine constructs its object and Biruk's analysis (2012) of how to "see" like a research project—wherein simplification, legibility, and magnification can be connected to biomedicine's goal of identifying an issue via discretely categorized symptoms to "cure" or treat the patient. Exceptional care captures the complexities of sexual health as experiential and not just the transfer of facts from the client to the counsellor and physician to inform ordered testing, diagnosis, and treatment. In this sense, exceptional care is also responding to clients' feelings, stories, and experiences in a way that takes them seriously, and not just a means to get to the biomedical "truth" of the visit (see Kleinman 1978). Here, I understand the staff's efforts to address a client's sexual health concerns to be a moral commitment, a feminist care ethic, which is invested in biomedicine while recognizing other facets of the client's lived experience, which need to be taken into consideration when providing care.

Exceptional care often necessitated protocol care. I once sat in on a counselling session with a Chinese woman in her early 30s who came to The Centre after having unprotected sex with someone she did not know very well. The woman was concerned about the possibility of STIs and HIV, and therefore, came to request testing. While some testing was performed that day, Aaliyah had to delicately explain that other tests could not be done so close to the encounter; for example, the client would have to wait three months for an HIV test, as this is how long it would take before the test would be able to accurately diagnose her as positive for HIV. The woman was disappointed, as she believed coming to the clinic soon after the event was the right thing to do, not only in terms of caring for herself but also to ease her mind. Aaliyah assured her they could perform other tests, such as a urine G/C (testing for gonorrhea and chlamydia) and showed empathy by acknowledging the stress of having to wait to complete all testing. With this kind of exceptional care, I am reminded of Garcia’s (2010) detailing of her first night shift in a detoxification clinic. While she was responsible for ensuring medications were provided on a regimented schedule to patients and for recording any behavioural issues which occurred on her shift, Garcia reflects on how important it was for her to provide human contact for one resident who was experiencing painful withdrawals. While she was forced to write her shift notes in the early morning after a power outage, the lines she filled in did not seem to be able to accurately encompass the kind of care she provided for this particular patient. Similarly, exceptional care in The Centre required this kind of human touch, providing biomedically informed care which worked to centre the client—their needs and concerns—and this aspect of the caring provided is not readily seen in the notes of the client files or in the quarterly reports. The kind of sexual health care provision enacted in this example reflects the working model of sexual health analyzed in Chapter 4, specifically, by communicating the technical timeframes and protocols for testing, reflecting a biomedical approach to sexual health, and by spending several minutes listening to the client’s concerns and responding to their anxiety regarding the wait. While another doctor or counsellor at another clinic might have just told the client the final wait time, Aaliyah took a more empathetic approach, sympathizing with the client’s concerns and ensuring her we would do what we could regarding all other testing to ease her mind.

Exceptional care involves the ways in which health care providers are caring and empathetic, listening to a client's concerns and giving them all the information so that they can make an informed decision. In this sense, I understand exceptional care as opening a space for a different kind of caring, one that parallels the care performed in feminist self-help clinics (see Murphy 2012). Murphy describes the self-help clinics as a place where women can share intimate biomedically informed knowledge and experiences and do so in a comfortable environment (2012, 25–26). While fieldwork is located within the walls of a clinic, with all the protocols which go along with that experience, there is also room in the reception area, the examination rooms, and the counsellor's office to provide more nuanced and personal care, which is responsive to clients.

On another day, an Indigenous woman in her mid-20s came to Aaliyah regarding her experience of repeat bacterial vaginosis (BV) after having sexual relations with one partner. She explained that she only seemed to get BV without fail when being with this person. In this instance, exceptional care involved providing strategies for avoiding BV (aside from abstaining from sex with the partner), which included urinating after sexual intercourse, using vaginal wipes, and wearing cotton underwear. This was followed by forms of protocol care, including BV testing to secure a prescription for treatment. For this young Indigenous woman, Aaliyah was able to provide a form of care in addition to the routine testing and treatment by offering suggestions for preventing the BV, which in turn would save her from having to come back to The Centre for another dose of medicine and experiencing it in the first place. For this client, the kind of care she received was a result of Aaliyah listening to her narrative and asking questions to better understand how and why the BV was occurring. Her suggestions were a part of a problem-solving approach that did not rely on thinking about BV solely as a biological infection with a biomedical treatment. Additionally, this young woman had seen Aaliyah multiple times; she was a repeat client at The Centre and, therefore, a sense of rapport was built through this relationship. The kind of caring Aaliyah was able to offer even included an exchange of jokes between the two women, joking which did not shame the client but which instead worked to acknowledge the complexities of sexual relationships. The relationship of trust and the brainstorming which followed are form a exceptional care that was valuable to the client. By enacting a feminist ethic of caring, I understand Aaliyah's approach to be emblematic of Tronto's ethical elements of care (1993) by being attentive, responsive, competent, and responsible towards her client. She was attentive to the client's concerns and did not dismiss them or lecture the client on what she could be doing differently. Aaliyah listened to the client's experiences, the storytelling she engaged in during the counselling session, and responded by asking questions why which worked to clarify important details, which were incorporated into her final recommendations. She utilized the information provided from the client and combined this with her knowledge as a counsellor to come up with a responsible, biomedically informed, and realistic set of advice, which worked with the client's experiences

Another example of the kind of exceptional care that can be provided by counsellors involves ensuring clients fully understand the service they are requesting and providing information to avoid panic when the results are back from the testing facility. Pap smears are not always done on a routine basis, and therefore, both protocol and exceptional care can take place concurrently. Pap smear test results are tricky and sometimes elude protocol. After spending several weeks cataloguing and sorting such results, I found myself questioning why there were multiple categories of Pap smear results: normal, abnormal low-grade cells, and abnormal high-grade cells. A normal result meant a Pap was not required for three years, an abnormal low-grade result required the counsellor to ask the client to come back to The Centre for another exam in six months, and an abnormal high-grade result required an appointment for a colposcopy, which would be done at another clinic. While the various results each came with corresponding guidelines, I saw other forms of care Aaliyah performed in practice. Before any client left her office to have a Pap smear examination done by the physician, Aaliyah explained the various testing result grades. She did this in order to prepare them for results, and also to emphasize that abnormal results do not automatically mean they have cancer. Through my conversations with Aaliyah, I learned that her approach to providing sexual health care correlated with her ethical commitment to providing care in a way that was empathetic; she did not want clients to panic upon hearing the highly technical and clinical terms included in a Pap smear test report. Instead, she always took the time to explain what the report meant, ensuring the client understood this sometimes-new biomedical knowledge, while also easing their concerns by articulating the next steps. To Aaliyah, this kind of counselling was routine, and yet it was not recorded officially or aggregated for TPH as other forms of protocol care were. This kind of care shown to clients cannot be translated into a metric. The visit and the Pap smear can be counted, but the care taken to explain services and assuage concerns is not written up in a report to be evaluated. In this sense, there are aspects of care in the clinic that hold on to the feminist roots of The Centre and are not *seen* in TPH's assessment of the clinic's metrics.

The counselling session was not the only place where I saw exceptional care. While not frequent, there were a few cases where a young woman would get an IUD inserted (the protocol was for her to stay in The Centre for half an hour after insertion for monitoring) and suddenly felt dizzy afterwards. We were instructed to bring her to a small separate room with an area for her to lie down, as well as grab a juice box and bag of cookies for the client. All these cases involved forms of care that were either not readily translated into metrics or were simply the kinds of care metrics are not interested in collecting. As a result, the intimate conversations, concerns, and solutions which fell outside clinical care fell out of view. Even as I create these two concepts, exceptional care and protocol care, I want to leave room for them to be flexible, as the lived experiences of care and surveillance in the clinic are never straightforward. Metrics is engaged in care storytelling, but the stories being told are very particular to the interests and rationales of public health, and because of this, some stories do not get "counted" or told; this is where anthropology and ethnography are most valuable. The Centre was invested in biomedical care, committed to its feminist roots, and demanded equitable access to sexual health care services. At the same time, exceptional care sheds light on feminist acts of caring—invested in the clients' concerns and emergent care needs—which are often lost in the practices of metrification. There, the "success" of The Centre's operations was often defined by its ability to participate in the governance of sexual health, while continuing to provide the kind of care their clients expected.

Conclusion

The metrification of care plays a crucial role in how the work of The Centre was organized and how they monitored client and service information. While sexual health care services, such as Pap smears and STI testing, had to be counted and reported to TPH, other forms of care were not easily captured by a metric lens. In this chapter I have described The Centre as not only a site of sexual health governance, attending not only to how the space and place of the clinic contributed to practices of accounting and feminist acts of caring, but also to how the careful maintenance and management of client files worked to support the governance of sexual health. The counting of clients and services supported sexual health governance by allowing The Centre and TPH to *see* how sexual health care was being fostered, regulated, and self-managed within the clinic via technologies of care and surveillance. Additionally, the metrification of care was required in the reporting-funding agreement made by The Centre and Toronto Public Health, and translating care into metrics allowed The Centre to continue providing care for its clients. The last two sections of this chapter shed light on the kinds of care and care practices in The Centre which mattered in the space of the clinic, but which were not always accounted for in assessing the operations of The Centre by TPH. By using these concepts, I have followed anthropologists' call to wade into the ambiguity of care, to attend to its particularities, and to deconstruct how it is valued. I have used the concepts of protocol and exceptional care to analyze how a sexual health clinic with feminist roots can both follow institutional protocols and aid metrification while also making space for other forms of care—care which mattered to the staff and the clients.

Chapter 6

Cultivating Capacity Aboard The Mobile

On a Friday morning in the late fall of 2018, I make my way downtown to meet Donna at The Centre. While mobile clinics generally operate on Tuesdays and Thursdays, occasionally the team makes exceptions for community organizations to fit their scheduling needs. In this particular case, we have been asked to come to a women's shelter east of the downtown core on a Friday. Irene is scheduled as today's counsellor and will meet us on site, while a new physician will be meeting us at The Centre. At approximately 8:30 a.m., I arrive at The Centre to help Donna prepare for the mobile clinic. We pack supplies for the day, including extra condoms, gowns, disposable sheets for the exam table, and blank client files. The new doctor comes through the main entrance just as Donna is looking for her contact information. After introducing ourselves, we collectively grab the supplies and head downstairs to Donna's vehicle. As we head to the lot where The Mobile is parked, Donna and I provide Dr. Anne with a brief overview of mobile clinics, including the layout of the large Winnebago, how client visits proceed, and the quota we will need to reach in order to ensure a "successful" mobile clinic. When new physicians come aboard The Mobile, there is usually a bit of a learning curve, although they tend to pick up the protocols and rhythm of the clinic quickly. After transferring the supplies from Donna's vehicle to The Mobile, we head to the shelter.

It is a rainy day as we make our way to Scarborough. As we get on the Don Valley Parkway, Dr. Anne begins to ask questions about The Mobile, wanting to know more about its history. Every time someone new joins us for mobile clinics, I get to hear Donna re-tell the story of The Mobile's creation, how it operated in the "early days," how its services have been pared back, and emphasizing the importance of continuing to provide free, accessible health care across the Greater Toronto Area (GTA). This last point is particularly salient in her account, as many of the locations we visit include racialized, im/migrant, refugee, and precariously positioned communities. The Mobile's initial focus was broad, including breast exams and workshops on patient rights, but after a few years, these types of services and activities were dramatically cut. When I ask if there was a particular rationale behind such a move, Donna sighs, saying she believes it had to do with their shifting funding sources (from the provincial government to municipal public health) and "crunching the numbers." Every time Donna tells this story, it is clear how much she cares about The Mobile and its feminist roots. However, what is also clear is the uncertainty in her voice when she thinks about clinic's future – who will keep The Mobile going?

Introduction

The Mobile provided necessary care. It played a crucial role in providing a safe space for clients (predominantly immigrant women, racialized women, women in shelters, and students in adult learning centres) to access free sexual health care by travelling across the GTA. Donna's story reveals The Mobile's radical feminist roots—providing portable and accessible sexual health care by and for immigrant women—while also pointing out the ways in which The Mobile had been subject to bureaucratic budget cuts over the years. I draw attention to this fieldwork moment to illustrate two things: The Mobile's pioneering role in the women's health movement, their dedication to providing access to sexual health care, and its increasingly precarious existence. In this chapter, I argue the social actors aboard the bus are engaged in what I term "cultivating capacity" to provide care, which is both about honouring the creation of The Mobile—in their continued ability to provide accessible sexual health care services across the

GTA—while also navigating bureaucratic shifts and reporting rules which demand metric success by meeting quotas.

The Centre was created in the mid-1970s to provide free and accessible sexual health care to immigrant women. However, the founders soon identified another related and pressing issue. While they were able to offer free services, low-cost contraception, education, and translation for clients who could come to The Centre, these kinds of care were still largely inaccessible for a significant number of immigrant women in Toronto. During this time, many immigrant women worked in factories located in the downtown core, and going to The Centre could mean having to take time off work, finding suitable childcare, and financing transportation. According to Donna, these women worked long hours, and for many of them, what little time they did have from work was spent caring for their families; within this context, taking time out of one's day for sexual health was not feasible. Therefore, it was determined that The Centre's services needed to be *portable*, to mobilize their efforts and go out into the community to provide care. After applying for and receiving funding from the provincial government, the team transformed their first bus into a mobile clinic. During their initial launch in the 1980s, The Mobile primarily visited factories and other workplace settings where many immigrant women worked in downtown Toronto, thus enabling them to bring their main goal to fruition: to provide truly accessible sexual health care by meeting the needs of their clients in a way that worked with the client's schedule. The Mobile team did encounter some challenges in enacting this approach to providing portable sexual health care and education, as they had to work *with* employers to gain access to the immigrant women who worked in their facilities. These early mobile clinics provided both sexual health care and outreach in the form of education. On multiple occasions, Donna brought up the expansive services they offered, with a particular focus on prevention and patients' rights.

During this time, The Mobile provided Pap smear exams, STI testing, birth control counselling and prescriptions, and breast exams. They also put on workshops, which covered everything from sex education to navigating OHIP. The work being done by The Mobile was radical, and so was their goal of making sexual health care and education accessible. As The Mobile was created *by* immigrant women and *for* immigrant women, they intimately understood the barriers faced by their clients and the stakes of providing this kind of care for their community. I retell the story of The Mobile in greater detail at the beginning of this chapter to draw attention to the truly revolutionary history of The Mobile team's work; this chapter examines the contemporary work of The Mobile, attending to the nostalgia present aboard the large bus, and provides a refresher for thinking about how and why cultivating the capacity to continue providing accessible care remained a priority for these women.

While there were similarities between the operations of The Mobile and those of The Centre (which is the focus of the previous chapter), there were also subtle and nuanced differences. As of 2019, mobile clinics continued to provide accessible outreach predominantly to marginalized and underserved communities to address their diverse sexual health needs; this took place in adult learning centres, settlement organizations, shelters, and churches. While the clients who came directly to The Centre were also comprised of immigrants, refugees, and students, those clients reflected the women and men who were in a position to access The Centre's services. Without The Mobile's services, many of their clients would face several barriers to accessing care (paying for transportation, length of time to travel to The Centre, needing to find childcare, and finding time in their schedule). While there is overlap between the demographics of the clients seen by The Centre and The Mobile, I am paying attention here to

The Mobile's ability to bring care directly to their clients, and to how this mattered for these communities.

Mobile clinics offered many of the same services available at The Centre, including Pap smear examinations and contraceptive counselling with physician prescriptions. However, while STI testing was available aboard the large Winnebago, it was limited. Clients could provide a urine sample or have a swab test performed during examination, but there were no resources to perform blood tests during mobile clinics. If clients still needed bloodwork completed, the physician would provide them with a signed request form, which they could take to any local laboratory site, and the results would be forwarded to The Centre. In this way, even though bloodwork was not taken directly aboard The Mobile, clients circumvented having to go to a family doctor or walk-in clinic for the appropriate paperwork, which in the end, saved them time.

Finally, I want to point out how The Mobile differed in three areas, which have been addressed in the previous chapter with the work of The Centre: documentation, protocol care, and exceptional care. Each of these differences will be elaborated on in the remainder of this chapter. First, a sign-up sheet system was used specifically for The Mobile, to gauge interest at each site, to demonstrate the legitimacy of each mobile clinic to The Centre by showing how many potential clients had signed up to attend, and to give the staff a resource to call clients the day of the clinic as a reminder and to encourage attendance. The Centre did not have or need a sign-up sheet, as it was consistently busy; more times than not, The Centre had to turn away clients because they had reached full capacity given the operating hours of the clinic. For The Mobile, given its high operating cost and relatively short amount of clinic time compared to The Centre (4 to 5 hours with the former versus 6 to 8 hours with the latter), the sign-up sheet was a necessary form of documentation.

In attending mobile clinics, I observed how protocol care was practiced similarly to The Centre. However, the ways in which The Mobile was precariously funded necessitated unofficial protocols alongside the clinical protocols of counting services and clients in order to meet quotas. While it still involved responding to routine sexual health care requests from clients (annual Pap smears, refilling contraceptive prescriptions, and regular STI testing), which required staff to carefully record care and diligently fill out paperwork, the stakes of providing sexual health care aboard a large Winnebago across the GTA were different.

Exceptional care aboard The Mobile took on particular salience; given the precarious nature of the bus, there was more pressure to run successful clinics. This pressure also reflected The Mobile team's commitment to cultivating their capacity for providing sexual health in a way that was both invested in biomedicine, but it also highlighted their desire to see it done differently via feminist acts of caring. Here, the stakes of being able to engage in exceptional care were even more critical for communities who might otherwise not have been able to access the kind of care provided by The Mobile. The Centre received core funding from Toronto Public Health (TPH) on an annual basis, and the budget for The Mobile was drawn from the total funding provided to the organization. Relative to The Centre, The Mobile had a high operating budget, as they had to account for not only the staff's salaries, the price of gas, and supplies but other costs; while mobile clinics accounted for a full day of work for team members, the mobile clinic itself only ran for four hours. As discussed in Chapter 2, over the years, funding provided to The Centre, and therefore the Mobile, had decreased after being downgraded from Public Health Ontario to Toronto Public Health; the smaller operating budget of a municipal Public

Health Unit[1] meant a decreased budget for The Centre generally. In order to justify the operating budget of mobile clinics, increased pressure was placed on The Mobile team to demonstrate success via metrics by meeting their quota of clients and demonstrating community need through the provision of countable services.

The Mobile's team were acutely aware of the proportion of the budget running the clinics took up, and they worked hard to honour their decades-long commitment to providing biomedically rigorous, empowering, and equitable sexual health services. They worked hard to cultivate capacity to continue providing accessible care aboard The Mobile which attended to the needs of marginalized communities in a way that was more accessible than other options. In developing their capacity to care, The Mobile team members were doing two things. First, they were engaged in processes of metrification which demonstrates to The Centre and their funder the success and legitimacy of these mobile clinics. Second, in demonstrating their success, they cultivated their capacity to operationalize Chapter 4's working model of sexual health via feminist acts of caring. In defining the notion of cultivating capacity, I draw upon the work of scholars in health promotion. The term "capacity building" has become a buzzword in public health for over two decades (Narushima et al. 2013, 27). According to the World Health Organization, capacity building refers to "the development of knowledge, skills, commitment, structures, systems, and leadership to enable effective health promotion" at the individual, organizational, and community levels (Public Health Ontario 2018). In broadening this definition, Narushima and colleagues understand capacity building usage in practice to be relatively open-ended, including empowerment, self-determination, competence, and

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[1] While there used to be separate funds designated for The Mobile, Donna explained how the municipal institution opted instead to raise the core funding for The Centre (from which The Mobile could draw funds), the caveat being the amount the core budget was raised was less than what The Mobile was previously receiving from the province.

participation, representing both a goal and an ongoing process (2013). Building upon this understanding of capacity within public health theory and practice, I want to think about how The Mobile team worked towards building their own capacity to continue providing sexual health care and information across the GTA. Second, the term “cultivation” draws inspiration from Murphy’s analysis of self-help clinics within the context of the women’s health movement as *seizing* the means of reproduction. These self-help clinics were used by women to take control of their sexual and reproductive health in a way that valued biomedical knowledge and approaches, but in a way that also allowed them to control how this process unfolded in caring for their bodies.

Cultivating capacity for The Mobile team’s continued ability to provide mobile feminist sexual health care captures the liminality of the work done aboard The Mobile. Simply describing the work done by the team as capacity building would sanitize their radical beginnings and the ways in which they continued to provide care that honoured their feminist moral commitment to accessible sexual health; capacity building felt too formal, too mainstream, too firmly entrenched in the bureaucracy of public health. Murphy uses *seizing the means of* reproduction to capture how feminist self-help clinics, following the work of Cohen (2005), made “themselves available to biomedical manipulation for the sake of participation and recognition within… feminism” (2012, 35). Here, the literal seizing of biomedical knowledge and practices is politicized; however, this work does not exist outside of the patriarchal system of sexual and reproductive health care. In thinking about the politicized work of running a mobile sexual health clinic, which simultaneously operates within a health care system that relies on defining success via metrics, while also engaging in work that reflects the working model of sexual health (being both invested in biomedicine and wanting to see it done differently), I draw inspiration from Murphy’s term. I understand the process of cultivation to represent how The Mobile team engaged in social practices which ensured they could continue to provide care, both housed within the traditional, biomedical system of health care and exceeding it. Here, the act of cultivation operates similarly to the work of seizing reproductive knowledge and technologies, insofar as The Mobile was collectively committed to carving out an accessible space for their clients who otherwise might have faced barriers in accessing care. Both seizing and cultivating implies a degree of care and long-term attention, both working towards a goal which is somehow also never quite finished.

By becoming an independent sexual health clinic operating through public health funding, The Centre and The Mobile were required to engage in specific practices of counting and regulating sexual health via technologies of caring and surveillance within a system that has increasingly relied on metrics to prove efficiency and (ac)countability. According to Donna, The Centre and The Mobile were caught up in the excitement of initially getting funds and over the coming years would learn how those funds brought with them new requirements and sacrifices. While this funding allowed the sexual health care work they did to continue, it also limited the care they can provide. The Centre’s and The Mobile’s participation in metrification, the translation of care services and practices into numbers, worked to ensure funding so they could continue the work they wanted to do, caring for immigrant, racialized, and marginalized communities. While the sexual health governance is intent on fostering sexual health care, even optimizing it, The Mobile as an ethnographic site also offered an opportunity to see the ways in which the funding of care in this way opened space for other forms of caring for sexual health and clients, which reflected the working model of sexual health I analyzed in Chapter 4.

By drawing on the metaphor of cultivation, I will show how The Mobile team engaged in specific social practices to secure and maintain their funding, including performing mobile displays, filling the sign-up sheet, making phone calls to potential clients, making PA announcements, advertising through word of mouth, and checking/re-checking paperwork and client numbers. Within this context, cultivating capacity resulted in constant tending to and concern about meeting their quotas to ensure a successful mobile clinic. In effect, these practices supported The Mobile's capacity to *continue* providing care and information, meeting local communities' needs, and engage in their feminist project of health; here, I make a connection to the values of capacity building and the values of The Mobile team: empowerment, participation, and self-determination).

In this chapter, I will begin by explaining the role of "mobile displays" and will analyze them as sites which are designed to ensure a successful mobile clinic. In attending several displays with Aaliyah and Rose, I gained insight into The Mobile's relationships with adult learning centres and the importance of the sign-up sheets prepared by The Centre. These sheets demonstrated to The Centre and TPH that there was a community need for The Mobile's services, doing this by providing a list of interested potential clients. I will discuss the practical and symbolic nature of the sign-up sheets in the coming pages. Subsequently, I will show how both protocol and exceptional care operated uniquely aboard the large Winnebago. I will examine how practices and discourses of (ac)counting were highly visible in the confined spaces of Donna's vehicle and on the bus, maintaining a constant presence throughout the day. Protocol care aboard The Mobile meant practices of counting, re-counting, and tending to the kinds of metrics which were critical to running a smooth and successful mobile clinic. While the metrics collected and recorded aboard The Mobile were similar to The Centre (number of clients seen and number of services performed), I will address how the topic of quotas shaped The Mobile team’s practices. As I mentioned earlier in this chapter, due to the increased cost of running mobile clinics (price of gasoline, limited clinic hours, staff salaries, time spent travelling to the site), the number of services provided became paramount. Quotas were never needed in The Centre since, as the home base clinic, the clinic was always busy; this meant The Centre was consistently providing sexual health care services, which could be counted as illustrating their success as an independent sexual health clinic funded by public health. Meanwhile, The Mobile’s client numbers varied greatly due to several factors (location, time of year, weather, and community members’ availability), meaning at one clinic we might see 25 clients, while during another we may struggle to see eight.

Finally, I will analyze how exceptional care still attended to emergent sexual health issues and client concerns, which are both countable yet not readily translatable. However, aboard The Mobile, exceptional care also encompassed community outreach, built upon the historical relationships between the team, their organizational partnerships, and their clients. While The Centre routinely saw immigrant, newcomer, and international students as a part of their clientele, they also served quite a few Canadian-born women and men. The locations where mobile clinics were booked typically took us into marginalized communities, where accessing sexual health care at The Centre would be impeded by several barriers (financial, temporal, and childcare). Therefore, through this outreach, The Mobile became a productive space of possibilities in its ability to provide accessible sexual health care, which I analyze as reflecting the working model of sexual health insofar as the team engaged in practices of translation, active listening, and culturally sensitive care, built on the commitment to accessibility and development of trust between the team and their community partners in their commitment to do biomedicine differently.

Within this context, exceptional care and protocol care will be understood as entangled, as both are central to ensuring the success of mobile clinics, and as part of cultivating capacity, provide accessible sexual health care, which reflects their engagement in the working model of sexual health. Attending to the number of clients seen and the number of services provided, as well as providing the kind of care these communities have come to expect from The Mobile, are crucial to its survival. The cadence of the large Winnebago and the work done aboard it was simultaneously mundane and loaded. Julie Livingston (2012) describes Botswana's first oncology ward as simultaneously dramatic and boring (2012, 22) and this could also be said of the way care unfolded aboard The Mobile. Sometimes it was routine, focusing on completing paperwork and annual testing. Other times it was chaotic, triggered by too many clients or not enough clients. For example, I witnessed a mobile clinic where the physician saw close to 40 clients, who were all newcomers seeking bloodwork (required by their school), and another mobile clinic where most of the potential clients were of an older demographic and therefore had little need for a sexual health clinic's services (i.e., past the age of Pap smear examinations, post-menopause, and were not sexually active). The social practices required for cultivating capacity—double-checking paperwork, carrying out mobile displays, making PA announcements, reminding potential clients about the bus via phone calls, effectively communicating with community liaisons, helping mothers by minding their children, solving problems creatively, showing empathy by actively listening to their stories, providing free education resources, and bundling services—were not only a part of The Mobile's operations but were taken up by the team to support their ability to continue providing sexual health care. By performing mobile metrification via protocol care and community outreach via exceptional care, The Mobile sought to continue providing care that was feminist, moral, political, and professional. The team's goal of mobilizing care in a way that attempted to ameliorate barriers directly was done via the above-mentioned social practices needed to cultivate their capacity.

Mobile Displays

It is a particularly hot spring day as I head to an adult learning centre to help with a mobile display for the first time. A few weeks prior, Aaliyah mentioned being frustrated after a volunteer who was supposed to be at the display to help her cancelled at the last minute. The Centre (and Aaliyah, who does most mobile displays) prefers staff/volunteers to go in pairs, as this helps to facilitate answering questions and signing up students. A mobile display entails Aaliyah going to one of the adult learning centres to sign up clients for the mobile clinic; these displays typically occur the day before The Mobile will be travelling to that location. In addition to signing up potential clients, it also provides an opportunity to showcase both The Mobile and The Centre to students. Before we go, I asked Aaliyah if I would need any special training, as I do not have a background in sexual education or sexual health care. She explained my role as helping her ensure we reach out quota for "sign-ups" and handing out pamphlets and condoms, so no training was necessary.

The school sits atop a hill with a long winding driveway, surrounded by forest, industrial buildings, and ongoing construction of apartment buildings and condos. I meet Aaliyah just past the front entrance of the school, near a green space with a panoptic view. She is unsure whether there will be a mobile the following day, as a doctor has not been confirmed yet. Afterwards, we head into the cafeteria to grab a table/bench (a dual-purpose piece of furniture) and bring it back near the front doors. The building is humid, and when I comment on this, Aaliyah explains there is no air conditioning at this school. Aaliyah drops her bags off with me before heading to the school's office to let her contact know we have arrived. I peek in the recyclable bag and see several colourful information sheets and booklets. When she comes back, I help her to lay out a tablecloth before we strategically place all the pamphlets and condoms. As we spread out the condoms, making a pile on each side of the table, I begin to look closely at them. They are round, instead of the standard square package that can be ripped off one by one like tickets. They appear to be themed with colour cartoons and puns written on the front. Aaliyah tells me that Toronto holds a contest where people can submit their condom package designs; the winner is also asked to choose a sexual health clinic, which will get a large donation[2] of condoms. One year, The Centre was chosen by the designer, as she had frequently used their services and wanted a way to give back to them.

We spend approximately two hours greeting incoming students and handing out supplies. Running the display provides an opportunity for me to ask Aaliyah questions about The Mobile. For example, when she tells me a physician could not be booked in time for the following day's mobile clinic, I ask about the hiring process. I learn that hiring physicians to cover The Mobile shifts is sometimes challenging. Mobile clinics are typically held on Tuesdays and Thursdays. While some doctors have a set schedule (such as attending every Tuesday or every second Thursday), this means that for the remaining mobile clinic days, Donna has to hire doctors[3] for

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[2] Condoms were yet another thing that were rationed and determined via The Centre's (and by extension, Toronto Public Health's) budget. During a meeting in the spring of 2019, I learned that given Premier Ford's recent announcement of upcoming cuts to health care, condoms would also have to be rationed in the future.

[3] The scheduling of doctors was complicated. Some physicians, like Dr. Priyanka and Dr. Shereen, had set days (such as every Tuesday or every second Thursday), as they would also be working in other clinics. Dr. Morena had a regular shift at The Centre but would also come aboard The Mobile if a doctor was needed (or for the rare times a mobile was schedule on a Friday). As the mobile coordinator, Donna had a roster of doctors with different availabilities that she would call to book for particular dates. All doctors were paid an hourly wage from The Centre. The doctors predominantly chose to work aboard The Mobile because they were invested in sexual health care and providing that care to marginalized communities.

individual shifts. Since a doctor could not be booked in time for the following day's mobile clinic, we decide to focus on providing students with information about The Centre and handing out condoms to those who want them. We watch students walk to and from classes, head to the cafeteria, and get picked up at the front doors. At one point we hear an announcement being made over the PA system promoting the display and encouraging students to sign up for The Mobile. While we offer informational pamphlets, Aaliyah tells me an interesting story about a pair of friends who came for STI testing at a previous mobile clinic; the young man had close to 40 partners and tested negative, while the young woman, who had two partners, tested positive. From Aaliyah's perspective, this might lead the young man to continue having unprotected sex, as a negative test result could indicate to him that he did not need to use protection with his partners. Nearing the end of our time at the school, a couple of women approach the table and want to know why we are there if the clinic is located a considerable distance away. Aaliyah points to the picture of the mobile bus on the pamphlet and explains we will not be able to come back until the fall. Aaliyah is clearly disappointed, and remarks that she does not like to turn people away.

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This first experience with Aaliyah provides valuable insight into the purpose of mobile displays and the reality of running them within adult learning centres. As with most of my fieldwork, my first foray into clinical and care spaces felt like I was putting together a puzzle, learning bits of information as I went but only being able to piece everything together as time went on. I left my first display with many questions: Why was there no doctor? Why could we not come back until the fall? What role did the sign-up sheet play? These questions would be answered over the course of 14 months of fieldwork aboard The Mobile. I would learn the importance of the sign-up sheet and its relationship to surveillance, care, and metrics. I observed how this piece of paper was actively tended to in order to cultivate the capacity of The Mobile to continue performing sexual health care across the GTA. I would learn that The Mobile's limited number of services were often met with confusion or annoyance by potential clients. I would learn the importance of maintaining good relationships with our community partners. Finally, I would learn the mobile displays were sites where sexual health discourses of morality, agency, and responsibility took place, and one where we would become active players.

Although there were exceptions, mobile displays were generally scheduled the day before The Mobile would be coming to schools. While The Centre and The Mobile served all clients (im/migrant, non-im/migrant, women, and men) the adult learning centres were primarily comprised of racialized and im/migrant population.[4] Aaliyah and I would come to these schools first thing in the morning, just before classes would begin, and would set up our table. I also attended two mobile displays with Rose (who primarily worked at the front desk of The Centre). The next three to five hours would be spent trying to get the attention of students as they passed by; we needed to complete the sign-up sheet, hand out as many information pamphlets as we could, and make a dent in the large bag of condoms.

The sign-up sheet was an 8.5" x 11" piece of paper, seemingly innocuous and serving the purpose of getting students to commit to a "timeslot" aboard The Mobile. However, by this point, I knew there were no appointments at either The Centre or The Mobile, I wanted to learn more about this piece of paper which had been frequently talk about by the team. The sheet

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[4] In Ontario, adult learning centres provide courses for those who wish to improve reading, writing, and math skills, if they are 19 or older and are not currently attending college of university. It also allows students to work towards obtaining their high school diploma (Ontario 2020d). Adult learning centres may have specific programs for skilled immigrants or refugees who want to improve their English/French and/or continue working in their field.

asked for the student's name, phone number, and whether they had a health card, and the form was organized into blocks of time on the left side of the page (ranging from 10:00 a.m. to approximately 2:30 p.m). After speaking with a student and explaining what we did aboard The Mobile, I watched on many occasions the way they would take the sign-up sheet and look carefully at the timeslots (no doubt trying to take into consideration what time would work best given their course load) only for Aaliyah or Rose to explain the timeslots did not matter. The important part of the sign-up sheet was being able to demonstrate there was enough interest/commitment from students to proceed with The Mobile the following day.[5] At the end of every display, I would watch as Aaliyah carefully secured the sign-up sheet to be taken back to The Centre.

This single piece of paper can be understood in multiple ways: as a symbol of bureaucracy, as a documentary practice, as a practical tool to ensure a proper turnout rate aboard The Mobile, and finally, as a technology of metrification. By invoking the "politics of immediation," Hull (2012) asks us to think about *how* and *why* particular documents are made in order to resist simplistic reductions that obscure the work of documents (and their creators) as a social process. Anthropologists are interested in how documents that serve a bureaucratic function *work*. How is their bureaucratic presentation part and parcel of how they are effective? I understand the "sign-up sheet" to be a bureaucratic and practical document. The "sign-up sheet" performed the bureaucratic and metric function of counting potential clients to demonstrate interest and justify The Mobile heading to an adult learning centre or a church. This piece of paper also contained contact information which allowed The Mobile team to contact students if

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[5] Another key part of the sign-up sheet was the provision of phone numbers, as we would frequently call students the day-of to remind them of The Mobile when we were having a slow day.

we were having a slower day than usual. In practice, the sign-up sheet was more flexible than it would first appear. However, the design of this document complicated the mobile clinic's work and confused clients.

Ethnographic research which analyzes documents is also concerned with the construction of particular socialities (Hull 2012, 253; see also Harper 1998) examining not only how documents are created with purpose but how those documents come to shape the practices of those who use them. In her edited volume, Manderson understands the term "technologies" to be broad, encompassing "objects and processes; practices, institutions, and regulations; ideologies and their encodings that shape and sanction social actions and relations" (2012, 1). However, I want to be careful with how I discuss the sign-up sheet as a piece of documentation. I do not want to fetishize, naturalize, or personify such technologies, for it was the people in The Centre and The Mobile who had created, used, and engaged in social processes with them. I understand this sheet of paper, documenting interest in the following day's mobile clinic while also offering a way to contact potential clients, as being partially dependant on the long-term relationships built between Aaliyah, Rose, and Donna with potential clients and school's staff. In attending several mobile displays, the rapport between The Mobile team and students conveyed a sense of intimacy, wherein through returning clients and word of mouth, mobile clinics became known and understood by such potential clients as a space where they could receive free, accessible, and discrete sexual health care.

While they are material objects, I attend to them as technologies of metrification, as being a part of social processes and protocols aboard The Mobile and, in turn, working to ensure the purpose of The Mobile could continue: the provision of care. The "sign-up sheet" as a technology of metrification comes out of a particular history and context, one which understands the careful performance of (ac)counting as a way of measuring success and subsequently the fostering of sexual health. The "sign-up sheet" was multiple in its functions. Practically speaking, it recorded interest in The Mobile by potential clients writing their name and contact information; it was suggested that by "signing up" for the mobile clinic through this document, students would feel more obligated to attend the following day. Metrification involves the translation of care practices into numbers via surveillance and protocols. Therefore, as a technology of metrification, the "sign-up sheet" strategically supported the success of The Mobile by an explicit effort to meet metric requirements, such as the client quota. However, as I learned through attending multiple mobile displays and mobile clinics, the "sign-up sheet" did not guarantee success aboard The Mobile.

The students who quickly wrote down their name and phone number may not come to The Mobile at all. Some students were regulars and would come when they heard the school announcement over the loudspeaker the day of, as you did not have to sign the sheet to be seen. If ten students signed up, we were not limited to seeing ten students. This sign-up sheet instead served a larger, and more familiar, purpose as it demonstrated the legitimacy and community-need of The Mobile's operations. By having a piece of paper which contained anywhere from 15 to 25 names of students who had signed their interest in using the bus' services, the team was able to demonstrate to The Centre and its management team that there was enough potential client interest in attending the following day's mobile clinic. While the contents of these sign-up sheets were not forwarded to TPH, The Mobile's work became legible to public health via the quarterly reporting – detailing how many clients were seen and how many services were provided – which, in turn, allowed them to determine how successful these mobile clinics were metrically. Within this context, sign-up sheets became aspirational and therefore resulted in a form of self-surveillance, a social process which tended to and represented cultivating capacity. This seemingly mundane documentation came to represent the efforts of The Mobile team and their hopes for the next mobile clinic: that they had done everything possible to ensure they would meet their quota and hopefully exceed it. However, while it worked to increase interest, it did not guarantee participation by clients.

The sign-up sheet was not only used during mobile displays. Whenever The Mobile was booked at a location other than an adult learning centre, the organization's contact was forwarded a copy of the sign-up sheet, which they were required to fill out and provide to us on the day of the mobile clinic. Donna, as The Mobile coordinator, emphasized to her community contacts the need for at least ten clients for any given mobile clinic to justify to the management team of The Centre The Mobile's continued operations in different communities and The Mobile's continued funding. On many occasions I heard Donna tell us on our way to a mobile site that she "told them they need at least ten people," if not more.

Mobile displays were a space where I not only learned more about The Mobile itself, what services were offered, what could and could not be done. They also allowed for interactions with students who had varying opinions on sexual health care and the large Winnebago. The space and place of these mobile displays offered an environment which was not heavily monitored in terms of time, where we could interact with students, promote The Mobile, and answer their questions. Additionally, mobile displays offered a site where I saw reactions to sexual health care from potential clients (who were different from those people who came to The Centre to seek care), in a different setting (a high school). What was different about these interactions from some of those I had at The Centre was the immediate (and sometimes visceral) reactions to the mobile clinic and sexual health.

The most commonly requested services aboard The Mobile included urine G/Cs (a urine sample was collected and tested for gonorrhea and chlamydia); Pap smear exams; throat/vaginal/rectal swabs (for various STIs and bacterial vaginosis); UTI testing; and prescribing birth control. HIV, syphilis, and hepatitis required blood testing, so a requisition form was filled out by the doctor for the client to have their blood drawn and tested elsewhere. On one occasion, a man approached the table to ask what he could get done aboard the bus, and when we told him STI testing and referrals for bloodwork (as hepatitis testing and vaccination are commonly requested of immigrants by schools), he told us he "hadn't done anything bad" and therefore he would not need any testing. When a middle-aged woman approached the table and we offered her condoms with the pamphlet she picked up, she told us she was married and that she had no need for such things. Often the younger students would approach the table, giggling while picking up condoms to read the packaging; some would do this out of curiosity, not knowing what they were holding, only to quickly drop them when they found out it was a condom. We watched one young man exuberantly grab a handful of condoms and begin attempting to hand them out to other students.

This single piece of paper, as documentary technology of metrification, was used strategically to demonstrate interest in the upcoming mobile clinic; therefore, it helped to legitimize the expense of sending The Mobile out into the community and assuage The Centre's management team's concerns about its high operating cost. However, displays were also an event where I witnessed interactions between students, teachers, and ourselves; operating as a form of outreach, the display also afforded us the opportunity to promote The Mobile and The Centre, and the affordable and accessible care provided. In this sense, I observed how running mobile displays can be understood as a supporting sexual health governance. By creating a site where mobile staff could interact with students, provide educational materials and supplies, all the while reiterating the importance of choosing regular health care services (such as annual Pap smears and obtaining prescriptions for contraception), the mobile displays not only constructed interest and legitimacy via the sign-up sheet but participated in models of sexual health which cultivate particular sexual health subjects: responsible, educated, choice-makers. The sign-up sheet demonstrated success but also relied on practices of surveillance to foster, calculate, and manage sexual health for its clients.

Students approached our mobile display table for many reasons. Some came out of curiosity, wanting to know why we were there and what we had to offer. Aaliyah would frequently advertise the free contraception (male and female condoms), with students chatting for a few minutes and putting a handful in their backpacks or pockets. Additionally, we came with Mobile-specific flyers, which provided more information about mobile clinics and the free services we offered to them. Students were also interested in learning sexual health more generally, and so giving them further sex education materials proved valuable to them. For example, one of the reading materials we handed out was the *Safer Sex Guide*, a booklet created by CATIE (Canada’s source for HIV and hepatitis C information) and the Sex Information and Education Council of Canada. In effect, such resources provided students with the desired biomedically informed and inclusive sexual health information. Early on in running mobile displays with Aaliyah, I also learned they were a space for students to ask questions. For example, a young woman (in her early 20s) approached the table while pushing a stroller; she wanted to know about her contraceptive options and was particularly interested in which birth control pills could make her gain weight. Aaliyah explained how particular brands of birth control had been known to potentially cause weight gain and went through options with her.

Aaliyah addressed a potential client's concerns and offered her biomedically informed information, which responded to her question about weight gain. She did not chastise her or correct her desire to find a form of birth control which not only worked as contraception but would help her to gain the weight she had lost after giving birth. Instead, she answered the young woman's query respectfully and shared a moment of bonding through mutual trust. Here, I see mobile displays as a showcase for the kind of care The Mobile offered which could be perceived as different from a walk-in clinic or family doctor; these displays worked to not only help The Mobile meet their client quota but to *sell* potential clients on using a mobile clinic for their sexual health care needs. In this way, these displays can be analyzed as supporting sexual health governance by encouraging, through the provision of information and access, potential clients to self-manage and regulate their sexual health by communicating its importance in these exchanges.

Here, the social practices found at mobile displays demonstrate the ways in which the production of self-governing sexual health citizens is entangled with genuine concern for potential clients; the latter is reflected in the approach taken during displays. Mobile clinics have been analyzed in terms of the apprehension some patients may have before accessing services (see Carmack 2010), and mobile displays operated as a space where we could assuage their concerns, encourage them, explain the process of receiving care aboard a large Winnebago, and assure them confidentiality would be maintained. Both this concern and the investment in biomedical understandings of sexual health were present. Mobile clinics (in their capacity to provide accessible care by bringing the clinic to the clients) also promoted a particular idealized version of access. Through discussions with Aaliyah and students, I learned that for many of them, without the mobile clinic, the trip downtown to The Centre would be unlikely. While the provision of mobile sexual health care on site attended to barriers in terms of travel, time, and cost, it also encouraged clients and potential clients to act as self-regulating citizens, who sought out opportunities in their community to have sexual health care services performed for them.

Protocol Care and Mobile Metrification

We turn down a narrow residential street and park in front of a large duplex; if I did not know that it contained an organization that serves Asian immigrant women, I would not notice the building being different from any of the others. After we park, Donna, Irene, and I begin to set up for the mobile clinic by opening cabinets and unpacking boxes. While Aaliyah is the counsellor on most mobile clinics I attend, if we are going to an area or organization where the clients require translation services (and if we have a counsellor at The Centre who speaks those languages), that person comes along instead. Irene sets up the front section of the bus, where clients will be counselled before seeing the attending doctor; she pulls forms from a built-in filing cabinet, which non-Canadian resident clients must sign. Donna is working to prepare one side of the long counter which runs parallel to the door where people can enter and exit the bus. She sets up a metal filing rack, which contains the various and numerous forms which must be filled out by hand and stamped to be properly processed by the laboratories. I watch as Donna lines up small plastic containers with pylon-orange lids, jars containing individually wrapped swabs, and small plastic containers with white lids that already have a viscous liquid inside them. Finally, she places a stack of plastic bags, which have a read seal, and a box of gloves beside the rest of her equipment. On the other side of the long counter, I ready my own station by pulling out a stack of green[6] client folders and tucking them into a metal file organizer. I check to see if

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[6] The colour was important, as it helped to distinguish which files were created at The Centre and which were created aboard The Mobile. Mobile files were stored in a separate area of the office. As many of the clients who

the printer is on before pulling out a label maker and plugging it in; the label maker plays a crucial role aboard The Mobile, as we need a way to identify client files, forms, and testing samples. With every new client who comes aboard, I double and triple check that everything is correct on the label: first and last name, date of birth, and health card number (if they have one). I also prepare the tracking chart by writing the date, the names of today's mobile team, and the doctor's physician number (which I retrieve from a piece of paper that has been taped to the wall). As the shift progresses, Donna and I make sure to tick off (with a check mark) who has had which services as well as their country of origin, and at the end of the clinic, she will go through each sample and call out the correlating name while I scan the sheet to make sure all testing samples are accounted for before we head back to The Centre, where the samples will be stored for testing.

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The above vignette illustrates the kinds of practices performed and the protocols followed by the team to prepare for the day's clients and the care that will be provided for them. The purpose of these mobile clinics was simple: to provide sexual health care to communities who otherwise might face barriers of time and distance in seeking out such care. However, given the way in which funding from TPH required careful (ac)counting and the increased cost to operate The Mobile, an emphasis on quotas meant metrification also took place aboard the large Winnebago. The metrification of care, which I described in Chapter 5, was palpable aboard The Mobile. While The Centre rarely had to worry whether they were seeing enough clients, this was a constant topic of conversation aboard the bus, and in effect became omnipresent in conversations

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come aboard The Mobile may never come directly to The Centre, those files were kept in Donna's office in large filing cabinets. This was done to save space in the main filing rooms, which were already quite full.

between team members. Every time The Mobile went out into the community, there was no guarantee they would meet their quota, and this weighed heavy on their minds.

When I asked Donna whether TPH (as the provider of The Centre's core funding) ever made demands upon the clinic—either asking them to increase the number of clients they saw or work towards providing more services—she explained that while providing quarterly reports was a requirement of their funding agreement, TPH had not made direct requests to "increase" their client numbers or services provided. However, it was clear from our conversation that this was not entirely outside the realm of possibility. Donna understood careful (ac)counting of The Centre, but particularly The Mobile's services, to have potential for communicating the ways in which their team were "successfully" providing services to the community. Since The Mobile was in a precarious position, the team did not want to leave any room for budget cuts, and therefore, the importance of meeting quotas and providing multiple services came into focus. In this sense, how staff felt about funding was like operating in a panopticon, wherein The Mobile did not know when or if TPH or The Centre would have to cut its budget; this resulted in continuous efforts to cultivate their capacity through careful (ac)counting practices. However, as I have analyzed with the sexual health care choice-making of clients, there is agency in compliance.

Earlier in this chapter, I examined the mobile display's sign-up sheets as one of the social practices attended to by The Mobile team in an effort to cultivate their capacity to continue providing sexual health care beyond the walls of The Centre. Similarly, practices of counting, re-counting, checking, and re-checking paperwork can also be considered actions which do such cultivation work. Donna understood meeting quotas and encouraging services to hold strategic power for the future, in case they had to negotiate or legitimize the work they did aboard The

Mobile. Therefore, meeting pre-set quotas did not automatically equate with docile acceptance and compliance with such requirements, as it did not completely explain why The Mobile's team was invested in getting "good" numbers. Within this context, compliance was done strategically to cultivate their capacity to continue providing sexual health care, which was both biomedically informed and committed to an accessible, equitable, and empowering approach. A successful mobile clinic needs three things: interest, attendance, and good metrics.

In previous chapters, I have described metrification as a social process: that the production and counting of metrics is not entirely neutral nor objective. The conversations I had with The Mobile's team—whether this was during prep work at The Centre early in the morning, driving to pick up the large Winnebago in Donna's vehicle, or on site and sitting at the front of the bus—reflected their commitment to continuing to provide sexual health care in a free and accessible manner, which necessitated paying close attention to meeting our client quota and encouraging services that the clients otherwise may not have had access to in their neighbourhood. In doing so, I analyze their actions as actively cultivating their capacity to care for clients' sexual health through performing protocols which made metrics in practice and in turn, the intimate space of mobile clinics meant such metrification was highly visible and omnipresent.

There were two doors which separated the examination and counselling segments of the bus from the "lobby" and clinic area, where clients waited to be called. In this space, the sign-up sheet, clinic testing paperwork, client clipboard, and files were organized along a long stretch of counter. Throughout a shift, members of the team (myself included) would check and re-check such documentary evidence in the process of providing care. This differed from The Centre, which also required staff to engage in documentary practices, but did not involve constant re-checking. In effect, due to the confined quarters and increased stakes, making The Mobile "count" via metrics became a force of its own. The Mobile, through the women who worked at The Centre, had long-standing relationships with various community organizations and schools. For example, the adult learning centres would book a Mobile four times a year, twice in the fall and twice in the spring. Other organizations might coordinate when they booked The Mobile to have it coalesce with other activities or events, such as community health fairs. With schools, interest was demonstrated through the running of mobile displays, where the sign-up sheet was filled out. Organizations which combined multiple events also served to boost interest and attendance for The Mobile, while simultaneously being understood as doing so for the benefit of community members. If the mobile clinic ran concurrently with community events, women would not have to make multiple trips. In terms of attendance, Donna communicated with the organization's contact[7] regarding the quota, letting them know we needed there to be ten clients at a minimum who came aboard for sexual health care. However, I also want to make the caveat that attendance can be qualified metrically. While all clients "counted" towards reaching The Mobile's quota, it would look better on paper for the staff to provide services (Pap smears, urine G/Cs, prescribing birth control) as opposed to just counselling. Through conversations with The Mobile team, I learned providing care services strengthened the case for operating the expensive mobile clinic; the more services provided, the greater the need for The Mobile to go out into the community.

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[7] Of course, there were days when we did not meet this threshold. I will discuss the strategies team members deployed to increase our client numbers later in this chapter.

Therefore, practices of careful (ac)counting[8] are directly tied to the increasing emphasis the state has placed on numbers, placing *demands* (Hacking 1982, 280) on those who work in health care to dedicate at least part of their time to counting care. I have chosen to emphasize the *(ac)counting* aspect of protocol care purposefully, to link caring and counting, for two reasons. Firstly, The Mobile team actively cared about numbers aboard the bus, not because they had an affective relationship with quantification but rather because "good" numbers would support their ability to continue cultivating their capacity to provide sexual health care. Secondly, (ac)counting signals to the ways in which processes and practices of accounting have become increasingly relevant and prevalent in Canada's universal health care system (see Dale 2020; Choiniere 2011). Understanding health care in terms of economics has meant neoliberal reforms place increasing demands on care providers, including spending large amounts of time filing paperwork and attending to managerial tasks. Here, a neoliberal ethos has led to not only the cutting of funds but also to encouraging health care institutions, such as The Mobile and The Centre, to "diversify [their] funding"; according to Donna, other sexual health social actors suggested they apply for funding from places like United Way as means of shoring up monies for The Mobile. However, securing outside funding could jeopardize the core funding they received from TPH.

Therefore, the metrification of care, the process of translating sexual health care services into metrics involves the counting of clients, quotas, and services provided; these metrics had become a key part of the reporting requirements laid out by TPH and management discussions on the cost-effectiveness of The Mobile. To perform such metrification, surveillance tools were needed, such as charts, labels, and forms. However, the mere presence of these technologies of

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[8] Care practices of (ac)counting entailed asking the following types of questions: How many clients were seen on The Mobile? How many Pap smears were performed? How many of those Pap smears were the client's first time? How many HIV requisition forms were filled out? How many STI tests were performed?

metrification was not enough, as having them did not ensure accurate numbers, and so we checked the names, dates, forms, and labels multiple times. The sociality of (ac)counting in performing protocol care was palpable aboard the bus. Metrification may look like reporting we saw 17 clients aboard the bus, we performed 15 Pap smears (with half of them being first-time Paps), and having ten clients provide urine samples for gonorrhea and chlamydia testing. If we were three hours into a mobile clinic and had only seen six clients, the team would begin to worry, opting to brainstorm how they could reach the quota before the end of the physician's shift.

While these final numbers do tell a story about the work done aboard The Mobile, working to legitimize the care work done and justify its operating cost, the story these metrics tell is only a partial one, as the social process of getting those numbers is often obscured. Mobile metrification required technologies of surveillance: sign-up sheets, labels which allowed identification for files and specimens, and forms which allowed the staff to track the progress of the day's mobile clinic. For example, while aboard the bus, I would print out a test label and show it to the client, having them confirm whether the information was correct. This was done for two reasons. First, if the information was incorrect, the sample may not be tested, which in turn impacted The Mobile's numbers. Secondly (and more importantly in my perspective), if the information was incorrect and the testing was cancelled, that person would then have to come into The Centre and re-do the testing. In addition to making sure the client labels and information provided were correct, other routine tasks were done for similar reasons. At the end of each mobile clinic, I would help Donna to double check all the samples were accounted for. Generally, I would sit at the table in the front section of the bus, while Donna would lay out the sample bags on the counter in the reception area. She would call out each individual sample by client name and type, and I would cross-check this with the clinic sheet to ensure the correct boxes had been ticked off to indicate how many and what types of services each client had received. Having a test performed but not having the correct information written can impact whether that test would *count* for The Mobile.

There are multiple ways the team engaged in activities which promoted The Mobile, and such promotion was central to not only fostering sexual health but also to ensuring we met our quota. Therefore, it was not only the counting which mattered, but the practices performed by the team to ensure the counting would put that day's Mobile in a good position in relation to funding. When arriving at an adult learning centre, the first thing we did after parking the bus (which usually meant Donna navigating into a designated area where cones prevented other staff and students from parking) was head inside to meet with the school's contact. We chatted for a few minutes and reminded the administrative staff to make an announcement for students about the mobile clinic. On one occasion, we heard the announcement over the PA system, to which Donna exclaimed, "I've never heard it before in person!" I noticed the school used very specific language after reiterating the time and place of The Mobile, asking students to "honour" their appointment with us. This was a strategy to ensure a good turnout, but also might have confused students, as we did not have set appointment times. School announcements were also utilized to encourage attendance throughout the day. While The Mobile normally received a steady flow of clients, there were days where we only saw a couple of students in one hour, and in these cases Donna or Aaliyah would head into the office and request another announcement be made. In other instances, we would use the sign-up sheet, which contained all the students' cell phone numbers from the previous day's mobile display, to call them one by one. At times, students had forgotten that The Mobile was scheduled that day, or they may have arrived late to school. We would also encourage clients who came to The Mobile to remind any friends who would be interested in our services. All these strategies served to bolster The Mobile's numbers in an effort to continue providing care for these communities.

As The Mobile sought to serve areas and communities that otherwise would not be able access the free sexual health care services of The Centre, most of the time this meant leaving the downtown core and travelling to different locations. On the day of a mobile clinic, I would arrive at The Centre just before 8:30 in the morning and head upstairs to help Aaliyah with the supplies we needed for the day. Aaliyah would have already performed an accounting of what supplies needed to be replenished (such as Pap smear testing bottles, urine containers, swabs, condoms, birth control, and previous client files), and we would organize the supplies we needed to bring with us to the bus. We may have had to pack extra Pap smear testing containers if we noticed we were running low on the previous Mobile. We may have had to double check that we were bringing enough packages for women to buy oral contraceptives if several students had expressed interest during the mobile display. Once we had stocked up on supplies, we met Donna downstairs and she drove us from The Centre to the location where The Mobile was parked, as it was too large to keep on a residential street for an extended period of time. Once we get to the location where The Mobile was parked, Donna normally parked in the same lot. If there were no spaces available, we would go across the street and Donna would hand over her vehicle's keys to a man who managed another parking lot. After we found parking, we transferred all the supplies aboard The Mobile before Donna could carefully (yet expertly) navigate the large Winnebago out of the lot and onto the road. These trips from the parking location to the designated site of The Mobile were some of my favourite moments. As a team, we would discuss the upcoming shift, strategize what could (and often would) go wrong, and discuss how we could make sure we would see enough clients. Donna and Aaliyah would share family stories and update me on the latest news from The Centre. As we moved along one of Toronto's freeways, I often stared out the window from my seat behind Donna; during these long drives (sometimes up to an hour), I could not help but think about this same journey for clients who may have needed to take public transportation, take time off work, or make childcare arrangements.

The work I have thus far outlined how practices of (ac)counting contributed and supported protocol care, which in turn allowed The Mobile to continue providing sexual health services to marginalized communities. These communities were typically, although not always, located outside of downtown Toronto. As The Mobile offered free sexual health services and did not require an OHIP card, these services were vital for community members, who otherwise would not have been able to spend several hours travelling to and from the downtown, waiting for a spot to see a doctor (which was not guaranteed), or for those who could not take time off work or find suitable arrangements for childcare. By ensuring they met the minimum number of clients required and being cognizant of how many services were provided, the team could illustrate the *need* for The Mobile. However, collecting data, such as metrics, to evaluate efficiency requires and results in homogenization (Smith-Morris 2016), which works to flatten experiences.

In evaluating randomized control trial (RCT) data in the U.S. Veteran Health Administration, Smith-Morris offers an evocative picture of how such homogenization occurs in practice. Two veterans, one who is a 53-year-old computer programmer with a spinal cord injury and the other who is a 38-year-old roofer with a similar injury, look relatively the same in RCT data (2016: 181). Smith-Morris argues that the process of metric quantification strips away these men's individual stories as they are reduced to specific variables (181) and asks, "What happens to all the other evidence that falls outside the RCT model?" (197). Practices of (ac)counting and the production and circulation of metrics allowed TPH and, therefore, the state to *see* care aboard The Mobile, in terms of services provided and number of clients served; at the same time, protocol care and the attendance to metrics reveals its own story to those who have intimate knowledge of mobile clinics, the stakes of providing care, and funding. However, it is more difficult for those reading such reports to *know* the clients' stories, and the ways in which sexual health was fostered are not readily translated into numbers. The metrics produced via (ac)counting for the care aboard The Mobile both supported the clinic's ability to continue providing care while at the same time enabling the state's interest in its population's sexual health to regulate and foster it. However, such metrics also only provided a partial picture of The Mobile's teams work to cultivate capacity and clients' experiences seeking and receiving sexual health care.

Proper timing and planning were essential to supporting the long-standing relationships between The Centre, The Mobile, and community organizations (schools, churches, settlement agencies, shelters. Additionally, temporality, including pressures to perform well through metrics, also impacted the practices of The Mobile and its team. Throughout The Mobile shift, any one of the team could be heard asking, "So, where are we at?" which in turn prompted someone else to look at the tracking form attached to a clipboard and count how many clients we had seen up until that point. Keeping good time was essential for the metrification of care. However, as I will demonstrate below, keeping "good time" and ensuring we were meeting our quotas also came into conflict with other temporalities aboard The Mobile. Therefore, after setting up the importance of time to metrification, I will address how exceptional care (and the team’s commitment to exceptional care) operated despite temporal restraints. While counsellors and physicians who worked on The Mobile tried to maintain a decent pace, not spending too much or too little time with each client, there were inevitably cases where extra time was warranted. Sometimes this meant reassuring a client who was there for their first Pap smear or allowing them to ask all their questions when choosing a type of contraception. When we went to adult learning centres, we were not the only ones trying to maintain a schedule. Some students chose to come during lunch or a spare period while other students had to decide whether they would miss part of their class to come aboard the bus; multiple times a student would come to The Mobile, only to see multiple people waiting for care and ultimately deciding to go back inside. Even when Donna would remind them of the deal The Mobile made with the schools, excusing them from class if they wanted to come to the clinic, many students did not want to miss a large portion of class or come during a test.

Temporality and time-keeping was not only essential to the production of metrics, which reflected positively on The Mobile, but to how sexual health care was provided to clients. This time-keeping was distinct from the type which appeared in The Centre, where the clock was monitored to ensure as many clients as possible could be fit in during clinic hours. Aboard The Mobile, time-keeping was nervously watched, given the high stakes required to justify the expense of bus’s operations, and “slow time” was unwelcomed. In researching the fieldwork of demographers in Malawi, Biruk frames the issue of time by explaining the importance placed on circulating information in AIDS research projects *quickly* (2012, 356). However, the temporality of such projects did not always neatly align with that of its participants. In much the same way, since The Mobile only had limited time for a single trip, there was pressure to ensure time is used wisely to produce good numbers, such as meeting client quotas and providing enough services. Biruk's work encourages us to examine what happens when different temporalities collide; in their fieldsite, demographers are trained to take meticulous notes, have good penmanship, and ask all listed questions in a timely manner (358). In practice, the attempts by demographers to keep good time were disrupted by weather, villager's schedules, and even participants pushing back against such rigid structures. Therefore, the idea of keeping good time had to be adapted in the field, as they had to *make* time. In relation to my own fieldwork aboard The Mobile, strategies were undertaken to keep good time, which in turn supported (ac)counting care. At the same time, counsellors and physicians also understood that the provision of care sometimes necessitated taking more time. While time-keeping has been analyzed in terms of how time is managed by staff in order to meet client quotas and avoid lulls in time where we are not seeing any clients, the temporality I will be examining in this section addresses how The Mobile team resisted such metric time and in effect, took time back in the following section on exceptional care.

Exceptional care and Community Outreach: The Mobile's Vision

While the practice of translating mobile visits into metrics obviously focuses on practices which are countable, I also chose to pay close attention to other experiences aboard the bus, which are not easily captured by numbers. In this section, I turn to how exceptional care operated aboard The Mobile through a commitment to community outreach. The performance of exceptional care during mobile clinics, not unlike at The Centre, responded to emergent sexual health issues (such as symptoms of infection, worries about unprotected sex, and fears surrounding first-time Pap smears in Canada). However, I observed how exceptional care operated differently aboard the large Winnebago for two reasons. First, mobile clinics were constrained by time, as clinics only ran for four hours and, depending on the location, may only return to the site once every four or six months. The team was committed to providing sexual health care to clients in a way which addressed their concerns as completely as possible, given the accessibility barriers many of them faced. Second, and tied to the first reason for how exceptional care was shaped by its context on the bus, The Mobile's primary population of clients were im/migrants, refugees, and racialized and precariously positioned communities. Performing community outreach aboard mobile clinics has been described alternatively as "curbside care" (Carmack 2010, 1393) and a process of "meeting people where they're at" (1397). Community members who use the services of a mobile clinic may initially be feeling vulnerable, unsure, or embarrassed. Therefore, in attending to how outreach shaped the performance of exceptional care, I use this concept to analyze the impact of The Mobile team's practices and client experiences which were not easily captured by metrics, including cultivating capacity via community partnerships and feminist acts of caring. The space and place of The Mobile, going into communities which are typically underserved or for whom health care is inaccessible, can be seen in the practice of exceptional care aboard the bus. Sexual health governance requires technologies that work towards the goal of regulating and counting sexual health, and I understand exceptional care aboard The Mobile to be a necessary part of this process, as both are interested in fostering the sexual health of clients.

The Mobile team and their coordinator, Donna, in particular were responsible for maintaining mutually beneficial relationships with various communities. I saw in the field the ways in which Donna was attentive to and engaged in networking activities. During a mobile clinic at a community centre which offered ESL (English as a Second Language) classes, daycare, and afterschool programs for Black youth, two women came aboard the bus to not only become clients themselves but to also learn more about what The Mobile did for the community. After speaking with them for a few minutes about the types of services which are offered and who can attend a mobile clinic, one of the women asked Donna if they would be able to schedule the bus; the following year they were planning a community event and thought having The Mobile there at the same time would not only bring foot traffic to their event but would also be a productive space where women could access sexual health care. If we take this one example, we see that the planning of The Mobile was often done months in advance with a variety of communities, and this meant coordinating when The Mobile was available and finding an optimal time to hold a mobile clinic for each particular site. Adult learning centres would book a mobile for the beginning of the new school year, as many of their students may not have been able to access services over the summer break. In order to ensure The Mobile continued running on a regular basis, a great deal of behind-the-scenes work was done by The Mobile team; this form of care work was not readily translatable for a framework of metrics, but it was essential, nonetheless. Additionally, these relationships between The Centre and various communities were built on the long history of The Mobile's operations. A key part of these relationships and their ability to stand the test of time was their mutual goal of providing sexual health care to underserved and marginalized communities.

In this section I argue that even though providing feminist acts of care sometimes came into conflict with the pressure to keep good time, the caring practices performed aboard The Mobile, including listening, asking questions, and ensuring the client was comfortable and respected, played a central role in providing sexual health care to marginalized communities. This kind of caring work, while not immediately reflected in technologies of surveillance which produce metrics, can be attended to through ethnography to reveal the ways in which exceptional care was a part of the larger project of governance and fostering clients' sexual health.

I draw attention to the forms of care which played what I consider to be a pivotal role aboard The Mobile. The kinds of caring which occurred during the mobile clinic is central to the impetus of both The Centre and The Mobile: providing care for immigrant, refugee, racialized, and marginalized communities. As I spent the most time with Aaliyah aboard The Mobile, I was able to see how long an average counselling session lasted. While several factors influenced the length of a visit, including how many/what types of services were being requested, language barriers, and apprehension,[9] counselling sessions typically lasted between five and ten minutes. However, there were several occasions where a little bit of extra time was needed.

In the spring of 2019, we drove to an ESL high school in Scarborough, where many of the women we saw had either recently immigrated or were refugee claimants. Nearing the end of the day, the doctor remarked on the number of clients who had disclosed circumcision, either during counselling or just prior to the exam, and who had requested their first Pap smear test. In these cases, Dr. Priyanka had felt it necessary to also take more time before and during the procedure to ensure these women were comfortable.[10] The Centre would count the number of (first-time) Pap smears and keep track of those numbers for when it came time to report The Centre and The Mobile's numbers. Yet the care which was taken to speak with clients about their female circumcision and to perform a Pap smear was not included in such reports. I draw attention to this day aboard The Mobile to emphasize how these kinds of practices and stories are also a critical part of the operations of mobile clinics, as without the care shown by the attending

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[9] In an interview with Aaliyah, she explained that there were clients who came in requesting one service (a Pap smear, for example) only to disclose their real reason for coming to The Centre afterwards (which can include an unfaithful partner or sexual assault). Therefore, the length of a visit with a counsellor was impacted by how the client wished to navigate that process.

[10] When I spoke with Nina, she commended the doctor at The Centre who took out her IUD, explaining that by continually checking in with her about her pain and asking about the temperature of the lubricant, the doctor's approach demonstrated consent in practice.

doctors, care that is non-judgemental and attends to the needs of clients, women would be less likely to use their services. During my time in the field, there were numerous instances where we would be pulling green files before heading to a location, as the community contact or the sign-up sheet would tell us that we had a returning client. These returning clients came back not only because of the convenience and provision of free services but also because of the kind of care they received while aboard The Mobile. Within this context, by providing care that was accessible, tailored, and predicated on a relationship of trust, The Mobile was able to increase its client retention rate; having clients return to the clinic for their health care needs was not only reflected in their metric reporting but spoke to The Mobile's ability to cultivate its capacity as a historically feminist sexual health care clinic.

WA client who came aboard only for counselling, and who elected to not have any other services or speak with the doctor, still technically counted towards the number of clients seen in a single mobile shift. However, if all the clients came only came for counselling, this would impact the numbers in terms of demonstrating the need for The Mobile to go out into the community. However, these kinds of exchanges remain important, not only for the benefit of the client who may be seeking out sexual health (care) information, but also in thinking about the long term. Having a student come to speak with the counsellor and not proceed with any services happens for various reasons. In one case, a woman came aboard The Mobile and was interested in having a Pap smear, only to find out that not enough time had elapsed since her last Pap smear.[11] In another case, a young woman in her late teens/early 20s wanted information about what to expect the first time she had sex and about the use of condoms; she was planning to get

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[11] According to Ontario guidelines, Pap smear exams should be performed once every three years after a normal test result. However, I learned from staff that if the client had a Pap smear less than three years ago but outside Canada, they could have one performed in Ontario.

married within the next six months. In this case, while the young woman had minimal or no "countable" services beyond counselling, Aaliyah took time to provide sexual education because it mattered to her client. In this sense, having a mobile clinic which goes into school spaces acted as another site where students/clients could get sexual health information. Here, disciplinary power operated to incite a desire on the part of the young woman to seek out information to maintain her sexual health after she was married. While The Mobile's primary operations involved providing health care through the provision of services, clients also sought out information from The Mobile's team, something which can be understood as a "desire to be trained" (see Yates-Doerr 2012). While the authority of biomedical knowledge of sexual health and reproduction has been critiqued, it has also been recognized as playing a positive role in the sense that when chosen by patients (or clients), it can serve as a source of empowerment (see Bridges 2011). While there was a pressure to perform services such as Pap smears and urine G/Cs, I saw how each counsellor who came aboard The Mobile (and worked in The Centre) took counselling seriously, whether or not it led to the performing of those services. In analyzing the operations of a mobile clinic serving rural communities in the United States, scholars have noted the importance of creating a welcoming atmosphere for potential patients (Carmack et al. 2017, 426). I understand this sense of welcoming to be a key part of the exceptional care performed aboard The Mobile, as the team attempted to make clients feel at home and make the process less intimidating; while all forms of health care visits can be stressful, given the intimate nature of Pap smear examinations and STI testing, sexual health care services can feel particularly invasive. For team members, it was about listening to the client, assuaging their concerns, answering their questions; all these things had been historically important to The Centre and The

Mobile, as the staff were committed to not only providing care services by *caring* for their clients.

In the summer of 2018, we went to a community centre that provided services primarily to Muslim immigrants and refugees in a neighbourhood east of the downtown core. There had been a recent influx of Syrian refugees, and on this day, many of the women Aaliyah spoke to had come from Syria. In some of these instances, Aaliyah would spend more time with each client, as their stories were interconnected to the services they were seeking. One young woman explained her experiences of loss and pain; a woman in her mid-30s, whom I interviewed the following year, emphasized the importance of not only listening but of acknowledging these stories of migration and seeking refuge. One of the women I interviewed, Dayana (from South America), expressed how just the fact of being an immigrant while trying to access health care compounds all the difficulties of an already difficult system. Being able to tell your story "right" and from the beginning was something I frequently saw aboard The Mobile. As Wendland points out, "medicine is full of stories" (2010, 6) and The Mobile was no exception; counsellors and doctors alike frequently engaged in storytelling. But I also heard stories from clients. The practice of listening to these stories was implicitly and explicitly placed in opposition to the metrification of care. In the act of producing metrics, meeting client quotas, and counting services provided, the kinds of caring (actively listening to clients and assuring they received empathetic and comfortable care) which occurred aboard the bus were not officially counted for TPH. The pressure to produce good metrics came into conflict with spending extra time with clients; while counsellors and physicians did their best to listen to clients' stories in their entirety, there was a limit to how long they could spend with them. For example, if we had a bus filled with clients, with every available seat taken, and counselling was perceived as taking too long, Donna would check in with the counsellor or physician, as the bus was only at a given location for a set amount of time. The logic of metrification called for meeting client quotas and performing sexual health care services, which garnered funding and demonstrated the value of The Mobile. When a counsellor or a physician took a little more time with clients, in the logic of metrification, this may mean fewer clients could be seen during The Mobile's shift. Scholars have analyzed how universal (or public) health care systems operate under specific temporalities, wherein there is an increased pressure to see as many patients as possible, while at the same time budget cuts and lack of staff have resulted in longer wait times. Elise Andaya (2019) analyzed Black women's narratives in a New York City hospital, arguing their "experience[s] of waiting and the pressure on providers to speed up are temporal manifestations of the same histories of racism and racialized structures of inequality that constrain conditions of care" (2019, 652). Aboard The Mobile, I also observed the pressure to optimize the number of clients seen by making admittance, counselling, and exams more efficient (i.e., take less time); this can be understood as a part of their ability to cultivate capacity through meeting quotas but also to ensure everyone who wanted to be seen could be seen. However, I also saw the ways in which the team took extra time to provide reassuring care and properly translate during visits. Ultimately, while the logic of metrification aims to see as many clients as possible, the logic of exceptional care understands providing empathy and allowing clients to tell their story as vital to their ability to feel empowered in choosing sexual health care and to encourage them to continue to self-manage their sexual health in a responsible way.

In addition to actively listening to clients' stories and concerns, the issue of language translation also played a role in terms of how many clients were seen aboard The Mobile. In the fall of 2018, Donna, Dr. Shereen, Catalina, and I were invited to run a Mobile at a site of a governmental organization, which worked with immigrants who predominantly spoke Spanish. Catalina brought The Centre's background information sheets in Spanish, and also took some time to partially fill out the testing forms (stamping them with The Centre's information and printing the doctor's name and their physician number) to expedite our work. When most clients did not speak English, this could mean longer visit and wait times, as the counsellor would speak with them in their respective language before moving to the back of the bus to translate for the doctor. On this particular day, Catalina (who was new to working aboard The Mobile), expressed concern over how long she was taking with each client; she explained that it was difficult to keep up the "normal" pace for counselling visits, as she did not want to rush the women who were telling their stories. Listening to the women's stories was valuable for numerous reasons, with one being it would ultimately help the counsellor and physician provide the proper care for each individual client. Within this context, taking the time to listen to women's stories and ensure proper translation had led to understanding their reason for seeking sexual health care, and can be understood as hindering the imperative to keep good time. A demand for good metrics may have demanded shorter visits to ensure meeting the client quota, but it meant something that the counsellors who did such translation work continued, regardless of its impact on keeping good time. Listening to the women and their stories played a large role in the provision of *good care*, as I heard from nearly all the im/migrant women I interviewed say they had not felt heard when describing their experiences with the doctors in the Canadian health care system.

Through performing exceptional care, The Mobile was able to provide care which was empathetic, and which took the clients' stories seriously, building a relationship of trust which in turn encouraged clients to return to The Mobile in the future and share their experienced with their friend and family networks. In some ways, one can also understand this work as also contributing to The Mobile's continued capacity to provide accessible care. Mobile clinics can be thought of as an improvised setting, where care becomes moral work (see Livingston 2012), with the staff striving to ensure their clients receive empathetic and competent care despite their constrained circumstances. Here, Livingston's ability to differentiate between empathy and pity is critical (110), with one of the nurses understanding her ability to empathize with patients as one of the most important parts of working on the oncology ward. Aboard The Mobile, with the raised stakes, unfamiliar setting, weight of history, and community partnerships, I understand exceptional care to be paramount to the team's ability to cultivate capacity. The relationships between staff and clients were typically warm—clients remembered the women, and the women remembered the clients—and helped to facilitate not only the return of clients but through word of mouth bring new community members to the bus. Mobile metrification and community outreach via exceptional care played a central role in The Mobile team's ability to cultivate their capacity. The precariousness of running mobile clinics resulted in the need for specific social practices which supported their ability to (a) demonstrate their success via meeting quotas and performing via metrics, and (b) provide morally situated feminist care, which had come to be expected of them by clients.

Conclusion

In this chapter, I have attended to the precarious positioning of The Mobile as a symbol of The Centre's radical feminist beginnings and its transformation through Toronto's health care system, subject to its protocols and requirements. I have shown how the team who run the mobile clinics are actively participating in cultivating capacity to continue providing mobile sexual health care and information across the GTA. Put simply, cultivating capacity entailed demonstrating the legitimacy and value of the work performed aboard The Mobile via metrics, carefully recording how many clients we saw and which services were provided, while also engaging in activities (calling clients from the sign-up sheet and asking school staff to make announcements over the PA system) to ensure a successful mobile clinic. At the same time, I illustrated, through particularizing protocol and exceptional care aboard The Mobile, how both were a part of the larger project of sexual health governance across the GTA, while demonstrating the effect that making sexual health mobile had on the stakes of continuing to provide such care. Instead of placing them in a dichotomy, I have worked to show how both were central to the fostering of sexual health and The Mobile team's effort to cultivate their capacity to continue providing free and accessible care.

Conclusion

The End of an Era

In late 2019, approximately six months after I complete fieldwork, I receive a text message from Aaliyah. The message is shocking but also not entirely surprising: "The Mobile is retiring." She lets me know there will be a party held within the next month and a more formal invitation will be sent via email. In December, I make the journey downtown to The Centre for the festivities and upon opening the office door, I see a projector aimed at one of the walls, showing snapshots from The Mobile's history and travels across the Greater Toronto Area. Rose is sitting behind the reception desk, and gets up to greet me warmly while Aaliyah hurries to show me the t-shirts The Centre has made for the occasion. After selecting a size I think will fit and putting it in my purse, I head to the lunchroom where I spent so much time during my research, sharing food and stories with the staff, attending meetings, pulling boxes of condoms from the cupboards to refill containers in reception, and organizing photocopies of visit paperwork.

Tables of food have been set up, along with a makeshift drinks cart. Chairs are arranged on the edges of the room in a large circle so you can see everyone else. I spend most of the evening moving between different clusters of people, catching up with the staff and introducing myself to those with whom I am unfamiliar. The turnout is large, as The Centre has invited not only staff and volunteers but past staff, members of organizations with which The Mobile held partnerships over the 35 years it was running, and sexual health social actors who belong to other clinics in the city. One of the staff's family members has made a cardboard cut-out of The Mobile that you can hold in front of you to make it appear as if you are driving the large Winnebago—and everyone delights in taking pictures with it. Throughout the night there are several toasts to The Mobile and the work they have done, with Donna simply stating that The Mobile's retirement is a "sign of the times."

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I have chosen this final vignette to illustrate not only the fate of the beloved Mobile but to engage with Donna's words. I think Donna's comment could be interpreted as reflecting on how things had changed—including their funding, reporting, and the emphasis on quotas—over the life of the large Winnebago, things which had made it more difficult to continue operating it. The retirement party was less of a wake, and more of a celebration of life. While many of those who attended expressed sadness that mobile clinics would no longer be performing outreach, the tone of the event was also sentimental, honouring its legacy of work in the community. Interestingly, there was barely any talk about numbers or quotas at the party, something which had taken centre stage, almost a spectre-like presence, for most of my fieldwork aboard the bus. Instead, stories of mobile successes, challenges, and community were the focus of the evening. Such storytelling on the part of the team, past staff, and partner organization members, recounted its radical beginnings and described the work done as pioneering—making sexual health portable and accessible, by and for newcomer women. What remained unsaid was how they were imagining the future without The Mobile's presence and the vital work it did, as well as what precisely had led to its retirement.

Through conversations with Donna and the other staff members that evening, I surmised there was no single cause for shutting down The Mobile. Instead, a combination of factors had each played a role: the high cost of operating mobile clinics, the stress of not meeting quotas, the staff required to run the bus, and the fact that the previous year it had required substantial repairs and in effect put The Mobile out of commission for a few months. With The Mobile retiring, those funds could now be redirected towards supporting The Centre's growing operations, as the demand for their services was steadily increasing. Donna's comment about it being "a sign of the times" lingered with me long after the party. To me, this comment spoke to how doing radical feminist sexual health care work had been increasingly constrained by operating within a bureaucratic health care system.

In this dissertation I have sought to position The Centre and The Mobile within their vital historical context of the women's health movement, a history that continues to shape the operations and hopes of their team today: feminist-oriented sexual and reproductive health care focused on bodily autonomy, choice, and access. And yet in the practice of this vision, I have identified two major tensions. First, I have argued that care and surveillance (and their relationships to empowerment and governance) are entangled in the provision of care at The Centre and aboard The Mobile. In Chapters 5 and 6, I demonstrated how the more I tried to parse out different kinds of care and their relationships to surveillance, the more I needed to wade into their ambiguity. The social practices performed in The Centre and aboard The Mobile supported sexual health governance. Metrification was carefully attended to in order to maintain funding and contribute to the ability of the state to *see* the ways in which citizens were engaged in self-regulating their sexual health. At the same time, feminist acts of caring were performed in alignment with the purpose of this organization's work in providing accessible sexual health care. In Chapter 6, I argued that the social practices undertaken can be understood as a way of cultivating capacity to continue providing accessible care, firmly entangling both protocol and exceptional care. Second, I argued that sexual health social actors were engaged in what I call a *working model of sexual health*, which is both invested in biomedicine while also wanting to envision sexual health care done *differently*. This resulted in a flexible and malleable model, which was taken up by counsellors, physicians, sexual health promoters, volunteers, and clients. I understood this working model as useful for analyzing and exploring the ways in which sexual health care and education could embrace biomedicine while also recognizing and negotiating its sometimes fraught relationship with consent, choice, and empowerment.

Contributions

This dissertation contributes to medical anthropology literature, which examines the socio-political and economic factors shaping clinical encounters, analyzing the tension between desiring or participating in biomedical systems of care, while at the same time challenging and negotiating the ways in which those systems of care enroll their subjects into projects of surveillance and self-surveillance. My research contributes to anthropological calls to address the complexities and multiplicities of governance and disciplinary power, and how they operate in health care by making space for the multiples ways they are supported, taken up, resisted, and re-fashioned on the ground. In lieu of reinforcing dichotomies, such an approach reveals how sexual health social actors were simultaneously empowered and governed. Throughout this dissertation, I have argued that care and surveillance are inseparable as they play a central role in the governance of sexual health. By engaging with social science literature (Van Esterik 1995; Mol et al. 2010; Garcia 2010; Tronto 1993), which seriously grapples with care as a theoretical and practical object of inquiry, my dissertation contributes to a legacy of research which, while trying to define care, also leaves room for its ambiguity—its multiplicity and mutability. At the same time, I have also sought to carve out a space for posing the following question: Is there a possibility for care without surveillance? As I have argued in this dissertation, within the sexual health landscape, care and surveillance are firmly entangled. Following a Foucauldian approach, care does not exist outside of governance. However, I want to posit that the kind of work undertaken at The Centre and aboard The Mobile—an organization created by and for immigrant women—cannot be entirely reduced to the work of sexual health governance and surveillance. Within their capacity for community outreach, relationships built on trust and respect between staff and clients, is there not also room for feminist caring, which does not exist solely to serve governance?

By thinking about sexual health care and the circulation of sexual health information through the figurative metaphor of landscape, this dissertation contributes to anthropological governmentality studies. The concept of sexual health governance, which understands the project of fostering, optimizing, and regulating sexual health as requiring an assemblage of sexual health social actors and institutions, has enabled an analysis of how particular models of sexual health were created, valued, and critiqued in practice. One can both believe in the project of sexual health, fighting for equitable, biomedically rigorous, and liberating sexual health care while also leaving room to critically engage with its history, relations of power, and consequences. This dissertation contributes to Li's call for "ethnographies that examine constellations of power in particular times and places, and the overdetermined, messy situations in which creativity arises" (2007, 278). The production of particular subjects via modes of neoliberal governmentality within the sexual health landscape of Toronto revealed how becoming an educated, responsible, and choice-making individual was a complex process with heterogeneous outcomes in terms of how clients negotiated such subjectivities. This contributes to the legacy of anthropological work which has revealed the ways in which global health models—analyzed through governmentality—simplify, such as KAP (where once knowledge is circulated, attitudes will shift to align with said knowledge, and therefore practices will change); ethnographic research illustrates how this is rarely the case when focusing on people’s lived experiences of such projects (see Gupta 2001).

Sexual health governance is an assemblage of social institutions, social actors, and experts which regulates, counts, and fosters sexual health. This concept worked to demonstrate how metrics, care, and surveillance operated as technologies via operations of disciplinary power. In analyzing how numbers became important for a sexual health clinic in downtown Toronto, I contributed to the history of anthropologists’ engaging with, and analyzing the role of, metrics (see Adams 2016; Tichenor 2020; Merry 2011; Suh 2019). Through the concept of metrification, I have shown how care practices were translated into metrics (numerical indicators of success via counting and calculating how many clients were seen and how many services were provided), revealing how this represented a social practice and process within The Centre and The Mobile. Additionally, this dissertation situates the ways in which metrics became omnipresent in the space of the clinic and shaped how sexual health social actors came to measure the success of their operations. However, it should be made clear that metric success was not the only success which counted. Literature which grapples with the importance placed on metrics in relation to health care governance works to contextualize the interests of governance; my research reveals how the emphasis placed on having “good” numbers is intimately tied to the universal health care system, where transparency and accountability are intended to support its equitable and responsible provision. Additionally, through conducting ethnographic research within a clinic, I saw the ways in which such a metric approach to care held consequences, both in shaping the practices of sexual health social actors and in the experiences of clients who sought sexual health services. Part of the sociality of constructing metrics is how they are made to matter to those in positions of authority, and the staff at The

Centre were able to strategically utilize metrics to make their case for continued funding. My dissertation illustrates how numbers were made to matter—communicating successes and room for improvement—and yet, how they were unable to fully capture the space and place of the clinic.

Feminist studies of health, and particularly sexual and reproductive health, provide a nuanced accounting of how women have taken up, resisted, desired, and challenged biomedicine and technologies of health (see Murphy 2012; Armstrong 2010). Within the realm of women's sexual health, the personal remains the political and feminist ethnographic studies "produce forms of knowledge that resist reductionism, for better or worse" (Brunson and Suh 2019, 3) by centring their analysis on interlocutors' narratives. Returning to the work of Mulla (2014), who described the capacity of ethnography to sit with the messiness, contradictions, and avoiding claims of definitive knowledge, my description and analysis works to do the same by utilizing a feminist ethnographic lens. The work of Bridges (2011) and Singer (2016) highlights what it means to critically examine raced, classed, and gendered aspects of care in order to provide a nuanced and compelling "storied reality" (Madden 2010) of care. Both scholars shift our attention to how, even in cases which might appear celebratory or empowering, such as the legalization of abortion in Mexico or charity care in a New York public hospital, feminist ethnography interrogates the layers and entanglements of care and surveillance, empowerment and governance; this largely reflects the ability of feminist ethnography to reveal multiple truths.

By focusing on a sexual health centre and mobile clinic, invested in biomedicine and its collectivist roots to provide free and accessible care, this dissertation reflects Davis and Craven's description of feminist ethnography "as a practice, [which] has become organized around supporting the struggles of people whose lives are marked by structural inequalities making attention to power one of the most important aspects of feminist ethnography" (2020, 283). I chose to focus my fieldwork on The Centre and The Mobile as sites which offered insight into how the health care system operated in Toronto, but more importantly, into how an organization was created with the goal of providing accessible care in a context where this was not always taken seriously. My approach to describing and analyzing what I encountered in the field reflects Davis and Craven's description by paying attention to the ongoing inequities, complexities, and nuances of sexual health care. Feminist ethnography foregrounds lived experiences and their role in the production of knowledge, representing a theoretical orientation, a practice, and a commitment to addressing inequities in the field and the project. My work contributes the legacy of feminist ethnography in anthropology by attempting to capture what happened in the field in a way which is both theoretically rigorous while also reflexively responsive to my interlocutors.

Future Research and Applications

During a recent CASCA panel on the anthropology of health and care, where I presented a paper on cultivating capacity aboard The Mobile, one of the audience members asked if we could envision a way for our research, as anthropologists, to have a place in supporting the communities we work with in the field. In response, I told a story about how the women at The Centre testified at a municipal deposition to avoid budget cuts for The Centre (and therefore, The Mobile). The team decided to attend this deposition in order to plead their case for maintaining their funding. Part of the rationale for why their funding might be cut, according to the City, was the fact that they were not seeing as many clients as other local sexual health clinics in Toronto. In a post-fieldwork phone conversation, Donna explained their stance on the issues, passionately stating "They don't know who we are or what we do. What is being lost in translation?"

Several of the team members went to the deposition in person, as they felt this was the best way to plead their case and explain what they did as an organization, and why it was important to the community. In essence, they made an affective appeal which relied on both numbers and stories, explaining that even though they were seeing fewer clients than other clinics, their numbers were steady. Additionally, as a clinic which specialized in providing sexual health care for immigrant women, they argued this kind of care took more time; providing translation services, ensuring the care was culturally sensitive, and fostering a sense of safety meant overall they saw fewer clients than other clinics. Ultimately, their appeal was persuasive. The politicians listened, and their funding was safe for the time being. Donna ended this story by stating, “It was an emotional time.”

During this meeting, they utilized both numbers (metric indicators of success via how many clients they served and how many services they provided) and stories to demonstrate their value to the council. In essence, The Centre’s team were engaged in practices which mimic concerns in anthropology. Within anthropological scholarship, metrics have often been positioned in opposition to stories, and Tichenor (2020) argues this conflict is something anthropologists will have to reckon with, given how intertwined the two have become. According to Tichenor:

> Rather than arguing against metrics, which is a dangerous thing to do in our ‘post-truth’ world, anthropologists may want to argue for better metrics and the simultaneous use of multiple modes of evidence. Analysing the practices that create metrics, and interrogating their effects, does not stand in for an argument against their use. Instead, it indicates the importance of couching metrics and quantified data within other forms of evidence, in a

> way that ensures that the assumptions, data sources, and estimations that were used to create them remain clear. (2020, 12)

As health and health care increasingly rely on metrics, and as discourses and policies on sexual and reproductive health continues to impact women's lived experiences, there is still much room for anthropologists to analyze this field, wherein individuals and communities desire, comply, resist, and negotiate caring for their sexual health. In the years since completing fieldwork in the spring of 2019, several media stories have highlighted the contested world of sexual health governance. The only abortion clinic in Fredericton, New Brunswick, closed after the provincial government refused to cover the cost of out-of-hospital abortions (Kappler 2019). In May of 2021, we learned Indigenous girls as young as nine years old were forced to have IUDs inserted by social workers (Basu 2021; MacMahon and Steacy 2021). Breen Ouellette, a Métis lawyer based in Vancouver, who has worked with the National Inquiry into Missing and Murdered Indigenous Women and Girls, described how victims had come forward with their stories of forced contraception. Given the ongoing history of systemic racism in Canada, Ouellette expressed his lack of confidence in the B.C. Ministry of Health and Ministry of Children and Family Development to investigate the issue (Basu 2021). The COVID-19 pandemic has sparked new conversations about essential care and the value of access, revealing how care is made to matter to the public (Action Canada 2020a, 2020b; Couto 2020; Araneta 2021).

Finally, I return to the work of Singer (2016), whose analysis of reproductive governance encourages us to understand the celebratory aspects of sexual and reproductive health while also not becoming complacent about the ways in which increasing governance intimately shapes the lives of clients. The retirement party held in honour of The Mobile acknowledged both the team's long-term dedication to providing free and accessible sexual health to predominantly marginalized communities, and how increasing governance had ultimately contributed to its closure. In this context, ethnographic research offers a way of contextualizing how sexual health in increasingly governed by numbers through a focus on storytelling, examining which stories are obscured, but also the stories of how the production of numbers involves a social process; this approach allows for a deeper understanding of the subtleties of care, surveillance, and governance.

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Appendix A:

General Interview Schedule for Sexual Health Social Actors

<u>Experience, Education, and Position:</u>

- Establish a timeline
    - How long have you been working in the field of sexual health and/or education?
    - What is your current position? What does this entail?
- Gauge expertise
    - What kind of education and/or training have you had?
- Organization Information
    - What is your organization's goals (or mission statement)?
    - Can you tell me a little about the history of your organization?
- Assess motivations
    - Why did you choose to work in this field?
    - Were there any similarities and/or differences between the expectations you had coming into this field and what occurred in practice?
- Professional development
    - [probe: evolution of sexual health and experiences]
    - How often do you attend conferences/workshops?

<u>Sexual Health:</u>

- Definition/meaning
    - How would you define sexual health? Is there a difference between an official definition and how you conceptualize it?
- Being "sexually healthy"
    - [probe in relation to their work] What does this mean to you? Do you think it is important? Why or why not?
    - What kinds of beliefs and practices does this entail?
- Operationalization
    - [approach depending on position and knowledge]
    - What role do organizations play in promoting sexual health?
    - Can you tell me a bit about the process of creating programming/messaging/campaigns?
    - Can you tell me a little about the clinical operations and services offered at your organization?
    - Can you tell me anything about how the organization's operations/projects/programming/clinical services are funded? [probe re: responsibilities that come with this funding]
    - Does your organization have a relationship to other institutions (municipal, provincial, or federal level)?

Personal Perspectives and Reflections:

- Hot topics: I would like to work through some key concepts I have come across in my research and ask for your perspective on them
    - Sexual education in Ontario (recent changes and response)
    - Sex positivity (What does this mean to you? What does this look like in practice?)
    - Risk (practices and people)
    - Role of culture and community outreach (How do you think about the concept culture and community factoring into sexual health?
    - Healthy sexuality (What does it mean to have a “healthy sexuality”? What does it mean to have healthy as an adjective applied to other contexts?
    - Source of knowledge (dichotomy of expert vs. lay)
- Challenges and rewards
    - What are some of the challenges of doing this kind of work? Can you think of a specific example?
    - Can you describe a rewarding moment in your work?

Appendix B:

Interview Schedule for Clients

Background and Contextual Information:

- How old are you?
- Where were you born? Where did you grow up?
- Can you tell me a little bit about your family?
- Do you attend school and/or work?
- Do you consider yourself a religious person?

Settlement Experience:

- Can you tell me a bit about how you immigrated to Canada?
- What were you first impressions of Canada? Did anything surprise you
    - What were your first impressions? Did anything surprise you?
- What kinds of challenges did you have when you first arrived?
- What would you say your major concerns were?
- Were newcomer services important upon settling in Toronto? If yes, how so?

Everyday Life:

- Do you live with your family? Do you live alone or with roommates?
- How familiar is downtown Toronto to you? Have you explored a lot of the neighborhoods?

Dating, Marriage, and Sexuality:

- How would you describe your relationship status?
- Is dating and/or marriage important to you?
- Is your family involved is your relationships? If so, in what ways?

Sexual Health and Education:

- What first brought you to the centre? How did you hear about it?
- Are there other places you for sexual health needs?
- What do you look for in an organization?
- How would you define sexual health?
- First experience
    - Do you remember the first time you heard about sexual health?
    - If so, can you tell me about it?
    - How has your understanding of it changed over time?
- Can you tell me a bit about your experiences with sexual health messaging and/or education?
- What are some similarities and/or differences between your experiences growing up and in Canada?

- Has settling in Toronto impact how you think about your sexual health and sexuality?
- If you felt it was important, where would you seek out information about sexual health? (Internet, apps, clinics, organizations, non-profits, NGOs, campaigns, family, friends, etc.)
- What do you think about messaging/programming/campaigns in Toronto?
- What are your experiences with sexual health campaigns? Have you ever been approached by organizations?
    - Are you involved in any forms of activism related to sex, sexuality, or sexual health?
    - Have you attended/encountered sexual health events/displays?
    - What are your thoughts on social media and sexual health activism?
        - [probe: hashtags, women's march, planned parenthood, etc.]
        - Bring examples
- Have you heard of the term "culturally sensitive/appropriate" services/care? What are your thoughts on this?

Beliefs, Experiences, and Practices:

- Sex life
    - Can you tell me a little about the role sex plays in your life?
    - What does *sexually active* mean to you?
- Negotiations
    - Is being "sexually healthy" important to you?
        - [Probe what does this entail in practice]
    - Can you tell me a little about your experiences with:
        - Consent
        - Contraception
        - Menstruation and/or pregnancy
    - In your opinion, what are some of the benefits and concerns that come with sex?