Conclusion

Love as a Pathway to Health Equity

In the years since I completed this project, I have driven through Tijuana on multiple occasions, only to feel unsettled. On these trips I've noticed how the numbers of people milling around in the Tijuana River Canal and sex workers lining the streets seem to be a permanent fixture of the cityscape. Despite Parejas and several other multimillion dollar NIH projects, implementation of national legislation to decriminalize drug use, and grassroots efforts to provide health care and harm reduction services, how much has substantively changed in the lives of socially vulnerable communities of sex workers and people who use drugs in Tijuana? In what can feel like an overwhelming impossibility for creating change, difficult questions arise in terms of why we do research, what impact we hope to make, and where we go from here.

Critical theories offer a powerful lens to help make sense of the injustices of the world. Integrating critical political and personal perspectives can unmask how structures of violence and oppression shape and constrain life possibilities and become embodied as health inequities. However, theory is also generated "*in order to act*" (Rhodes 2009, 194; emphasis in original). To this end I hope that my book has lent insight into an underappreciated topic of scholarship and inspires debate, dialogue, and fruitful interdisciplinary collaboration. I also want to push this further to suggest that love is not just a trendy scholarly topic, anodyne sentiment, or idealist but unreachable utopian version of society. Rather, I suggest that if we build on the work of revolutionaries before us and reframe our commitments in solidarity with the most vulnerable among us, *love can carve a pathway to health equity.*

One of the goals of my work is to offer suggestions for programming, policy, and research practice to improve the lives of female sex workers who use drugs, as well as their intimate male partners, families, and communities. The recommendations in this chapter are grounded in a political love and adopt a lens

of harm reduction—as a political philosophy and a set of practical strategies—to reenvision the work before us. I close out the book by offering a reflexive articulation of best practices and lessons learned through this research, including what we might do differently if our work were guided by love.

HARM REDUCTION AS BELOVED COMMUNITY

We already know much of what we need to do to create and implement better policies, programs, and research to improve the health and well-being of sex workers who use drugs, along with their loved ones. Yet we are still lagging in terms of achieving health equity for socially marginalized couples. In reviewing several recent comprehensive sources making recommendations to address sex worker health, I found that these publications either erased women's intimate partners completely or referenced their partners only in terms of the potential for intimate partner violence or the need to decriminalize partners' behaviors, such as drug use.[1] *Love and intimate relationships remain largely absent from global health interventions for sex workers.*

My thinking around interventions is guided by a multidimensional construct of love. Not only is interpersonal love a topic worthy of our attention in understanding and improving the human condition, but love can also guide our politics and help us reimagine our work. Revolutionary scholars understand love as a powerful political force that can transform unequal social relations and unjust material conditions. Embracing a *political love* means that our political commitments are guided by the ingredients of love—care, commitment, trust, respect, and the like—and that we take this up in concrete, collective actions to remake the world. In this sense, if a political love were to inform public policy, programming, and research, it would mean mapping out decisions and community-driven efforts that would affect the good for *everyone*, especially those who have been historically marginalized and left behind.

One way to channel the power of love and recenter our efforts toward transformative health and social justice is through the notion of the "beloved community," or what the late Reverend Dr. Martin Luther King Jr. envisioned as an inclusive, interconnected consciousness based in love and compassion ([1967] 2010). At its core the "beloved community" fits into a broader analytic of love as a mode of critical analysis and call to political action. The beloved community means recognizing how all lives are interconnected. Countering neoliberal logics and capitalist processes that exacerbate inequalities by valuing certain lives over others, the beloved community calls for efforts to shift "from a 'thing' oriented society to a 'person' oriented society" (186). Similarly, in outlining her call to build a political love as "concrete, revolutionary practice," Black feminist theologian Keri Day (2016, 105) advocates that love should inform how we organize and behave as communities. Without a political love we foreclose the possibilities of creating a caring

and just society, where we live together with respect, compassion, empathy, and the other "ingredients" of love in practice.

Engaging in such political commitments to love and changing harmful discourses and practices may seem abstract and difficult. However, there are multiple ways to enact change. Anthropologists are already integrating the social justice commitments of the beloved community into reenvisioning health care and training the next generation of physicians to practice humanistic medicine.[2] I take another perspective to suggest that *harm reduction* can anchor our political commitments and inform new research practices. My approach to harm reduction articulates with a political love that can compassionately address sex work and drug use in our world. As both a philosophy for thinking and a set of tools for doing, harm reduction links the political with the practical and always centers a love for people first. For many in the movement, harm reduction *is* the beloved community in action.

As a philosophy and movement for social justice, harm reduction is grounded in the belief that everyone has a right to health and should be treated with respect and compassion. As a practice, harm reduction is a set of practical strategies and ideas aimed at reducing the negative health and social consequences of drug use, which applies to meeting the needs of sex workers as well. Harm reduction thus holds transformative potential as a pathway to health equity because it is both a social theory of how we should operate in the world and a set of practices to counter the current harms the world offers us.[3]

Harm reduction (here forward encompassing both philosophy and practice) is premised on the notion that many (if not most) of the harms related to drug use and sex work do not emanate from those behaviors per se but rather are created by the systems that stigmatize, dehumanize, and punish individuals who engage in these behaviors. Harm reduction attempts to change dehumanizing discourses reducing people to "things" to be cast aside and ignored. Instead, harm reduction is a loving practice guided by the foundational principles of respect, acceptance, and dignity. It does not minimize or ignore the real harms associated with drug use and sex work but rather acknowledges that these behaviors are part of our world, and there are better ways to reduce these harms and keep people healthy and safe besides punishment.

Harm reduction services are noncoercive and nonjudgmental and "meet people where they're at" to empower their decision making. As a set of sensible and practical strategies, typical services include education about safer sex and drug behaviors (e.g., information need not be only abstinence-based); safer-sex supplies (e.g., condoms); safer drug use supplies (e.g., syringes, injection equipment, smoking supplies); naloxone (opioid overdose-reversal medication); HIV/HCV testing and linkages to care; referrals to drug treatment; and options for many other health, social, and legal resources. Importantly, harm reduction looks beyond sex and drugs to see people as whole beings who often have many unaddressed needs,

including access to preventative health care, mental health services, housing, food, and other basic needs.

Perhaps the most powerful offering of harm reduction lies in its potential to build a beloved community in which people respect and care for one another. In response to the violent systems of oppression that punish people who use drugs and engage in sex work, harm reduction offers a space of nonjudgmental care and compassion. Harm reduction organizations are often linked with other community-based empowering organizations, abolitionist and mutual aid groups, and other grassroots political-mobilizing efforts. Often harm reductionists actively organize at local levels to change legislation and policies. Some advocate outright breaking the law if those laws are not in the best interest of community health and well-being. Others adopt a spiritual orientation, which is particularly conducive to thinking about love as a concrete guide to action. Harm reductionist Reverend Erica Poellot describes the movement as a "revolution of love that resists the forces of death and destruction and is building a new world of life and creation" (2020, 12). In this sense, harm reduction offers a productive starting point for thinking through how love can change the way we address drug use and sex work and move toward health equity.

INTEGRATED HEALTH PROGRAMS FOR SEX WORKERS

Historically, interventions for sex workers have focused largely on sexual risk for HIV and other sexually transmitted infections (STIs) through a lens of biomedical individualism. While HIV/STI prevention remains a key area of concern for sex workers, we need to rethink approaches to programming that are more reflective of sex workers' lived realities and complex needs. As I have argued in this book, ideals of finding love and companionship are no different for women who engage in sex work and use drugs, and attention to women's intimate relationships should be integrated into programming. We should further recognize the experiences of *both* partners in relationships, including men's perspectives that remain largely ignored in health programming. Couples navigate competing health and social risks though the construction of dangerous safe havens that prioritize emotional security, intimacy, and support. Interventions need to acknowledge that "risk" has multiple meanings for couples and is always socially situated.

Findings from my work urge us to move away from biomedical concepts of sexual risk and toward a more loving discussion about sex in the context of subjectivity, emotional intimacy, and pleasure. A growing body of literature has consistently demonstrated that sex workers are less likely to use condoms with intimate partners with whom they share an emotional connection versus clients.[4] My book builds on these findings, providing ethnographic evidence of the emotional and material importance of sex workers' intimate relationships to *both* partners.

Increasingly, couples are considered as a social unit of intervention.[5] Such programs may leverage relationship characteristics, recognizing how love, emotional

intimacy, trust, conflict, and care profoundly shape relationship dynamics, and that any efforts to change health behaviors should consider the couples' dynamics in tailoring services. For example, partner communication is important and interconnected with multiple issues within relationships. As we have seen throughout this book, couples maintain forms of sexual silence that do not directly confront certain health issues, including sex work and HIV/STI risk. These silences serve as protection against hurting a partner's feelings and potentially generating conflict, but there may be better ways to promote healthy communication and coping strategies that do not threaten partners' emotional well-being. Motivational interviewing is a guided style of communication that empowers people to make changes based on how they make meaning and understand their particular situation. Assisted disclosure of HIV/STI test results could also be useful, in that providers could thoughtfully help couples discuss their results and negotiate safer-sex strategies.

Individuals in relationships create and adopt their own forms of harm reduction beyond formal services to keep themselves and their partners safe and healthy. Programs should build on the positive aspects of relationships, using strengths-based approaches rather than relying on standard risk-based discourses. Overall, integrating love and emotional intimacy with biomedical and epidemiological considerations of health could shift programming for sex workers in several key ways sketched out here.

Rethinking Program Content

Underlying all programmatic efforts is the imperative to rethink sexual "risk." This means taking sex workers' emotional connections and sexual pleasure seriously while adopting a more realistic harm reduction approach. Condom use to prevent disease transmission should be situated within relational contexts and consider the subjective importance of different types of sexual relationships. It makes sense to work within women's worldviews and encourage condom use with clients as a way to separate income-generating sexual partnerships from their emotionally meaningful partnerships.

Almost no couples in the entire Parejas study used condoms in their often years-long relationships, and trying to promote that now without raising suspicion and breaking trust makes little sense. Safer sex within intimate relationships could focus on negotiated safety approaches, such as agreeing to use condoms with outside partners but not within the primary relationship, engaging in regular HIV/STI testing, and accessing biomedical interventions, like preexposure prophylaxis (PrEP) to prevent infection among HIV-negative individuals.

As part of these broader efforts to accommodate realistic patterns of condom use and counter the threat of HIV/STIs, PrEP is an important intervention topic in which the technologies have quickly advanced and recommendations have changed since the time of this research.[6] Yet, as the medicalization of the HIV epidemic continues favoring technological and clinical interventions (e.g., medications),

it often comes at the cost of social considerations. Clearly, PrEP is a breakthrough, and everyone who wants to use it should have access, especially the sex workers in lower- and middle-income countries who are inexplicably disadvantaged in terms of accessing PrEP. However, we must still consider the importance of the social context in delivering biomedical interventions. Research has shown that PrEP can raise suspicion and trust issues and even instigate violence within relationship contexts, which may render individuals such as those who participated in Parejas as less likely to be adherent, reducing its effectiveness.[7]

Any such HIV/STI prevention and safer-sex programming should be offered as part of comprehensive sexual and reproductive health services that take sex workers' intimate relationships and childbearing preferences into account. However, programs rarely consider sex workers as parents or pay attention to the health and social outcomes of the children of sex workers, particularly sex workers who also use drugs. This remains a critical gap. As told through the story of Mildred and Ronaldo in chapter 3, the family had multiple challenges with health-care and child-welfare systems to navigate from the very moment their daughter, Zoe, was born. However, punitive approaches can exacerbate already difficult situations. Some scholars have called for the abolishment of "child welfare" systems altogether, arguing that current structures punish poor and racialized groups and expand police power rather than ensure familial welfare (Roberts 2022). More holistic approaches, including working with case managers and advocates trained in harm reduction, and granting families access to the economic, material, and social support they need, could lessen the likelihood of children being taken from homes while promoting family well-being. In many cases providing a supportive, encouraging, and loving environment for families rather than punitive threats of child removal could change familial dynamics and even motivate some families to reduce chaotic drug use or enter drug treatment. Programs for sex workers could play a key role in recognizing the importance of women's families, providing linkages to services, and advocating for broader policy changes that support rather than punish families.[8]

Overall, there is often a curious lack of attention to the overlap between sex work and drug use in health programming. Even though there is strong global evidence of drug use among sex workers, which is a particularly salient issue in cities with robust drug markets like Tijuana, little formal guidance exists on how to best deliver these services. Most of the time such services are offered separately and may be guided by aims of reducing drug use and promoting abstinence-based drug treatment (Iversen et al. 2021). As advocates from the Global Network of Sex Work Projects and the International Network of People Who Use Drugs rightly point out, sex workers who use drugs require regular access to all the services relevant to both sex workers and people who use drugs rather than our largely siloed approaches.[9]

Programs should be grounded in a harm reduction approach to drug use rather than focusing measures of program "success" in terms of abstinence. Some couples in Parejas showed interest in drug treatment and vacillated back and forth about pursuing it, except that humane, evidence-based programs designed for couples are largely absent in Tijuana. Other couples were not ready to quit or cut down. Following harm reduction principles compels us to accept these different realities and take a different approach. Drug use should be considered socially and relationally, moving from pejorative "codependency" models that emerge in programs based on individual self-recovery toward acknowledging an "interdependency" based on the social nature of drug use. As shown throughout this book, drug use is foundational to dangerous safe havens and embodied as practices of caretaking. In addition to working toward accessible and evidence-based treatment options, helping couples stay safer in their drug use means supporting the strategies they already use to protect themselves (e.g., not sharing syringes outside of the relationship, using at home rather than in public). Messaging around keeping partners (and others) safer in their drug use as practices of love, care, and trust would be effectively bolstered with regular access to the tools needed to reduce drug-related harms (e.g., sterile syringes, overdose-reversal medication).[10]

Building Relationships as a Key Intervention

While offering comprehensive health services to couples is critical, it is not just the *content* of programs that is important but also their *delivery* by trusted providers. At their foundation programs should be rooted in love: harm reduction principles of acceptance, nonjudgmental care, and compassion can create safer spaces to foster relationships and build the beloved community. The global literature shows that stigma, judgment, discrimination, lack of empathy, and provider insensitivity are widely reported among disadvantaged groups, including sex workers and people who use drugs.[11] These social barriers mean that individuals do not feel safe accessing care and may delay care until conditions become life-threatening. Individuals may also forgo vital social services and benefits to which they may be entitled if interactions are discriminatory or otherwise unhelpful. Personnel and approaches to service delivery matter.

The importance of building relationships is illustrated in a particularly frank conversation with Cindy and Beto about the Parejas study and what they desired in future programs. They both emphasized how important it was to have people with whom they could build a relationship and work up to discussing the difficult issues they faced in their lives. Cindy appreciated developing trust with project staff over time. Otherwise, she felt like she had to reopen wounds to strangers at subsequent visits. Here, she discussed her experiences in the Parejas research project, but her sentiments translate to other types of health programming. I think it is valuable to quote Cindy at length:

> I wasn't rude to [the other interviewer], but if I had been given the choice, if somebody had told me, "Are you comfortable with your interviewer? Or do you want somebody else?" I would have liked to at least have had another option. Like Beto was saying earlier, you know, during the first interview you may want to say something, but you kind of just touch the subject on the surface, and then you back off and you don't say it, and then when you go home you feel like, "Well, the interviewer was kind of nice, and I remember she didn't look like she was judging me." You know, you start thinking about all that, and then at home you're like, "Next time I'm going to tell her this, or I'm going to tell her that," and then the next time you share more. And another thing I like, when I talk about something, I'm like, "Remember Jen, when I told you this?" and then she remembers.
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> That feels good. That helps our self-esteem as well, and it helps us feel more confident with you guys. It's really hard to talk about all this stuff, especially your past; it's hard to talk about all that stuff. You know, it's weird to just be saying it to some stranger that you've really never met before, and just as you start feeling comfortable with them, then the next time you come, you're expecting to see them, and you see somebody new that you've never met before either, and you're like ahh. . . . You know, you go back into your shell, all over again, and it's a process, all over again. I mean, it's hard within ourselves; it was a battle for me within myself to bring myself to the point where I could share enough just during the one session that I had with someone, and so the next time it's like, I've gotten that out of the way already, and I don't need to go through that again. It was hard for me emotionally to go through all of that. And then when you get a new person, having to go through that all over again takes a lot out of the person.
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> Jen told us, "If anything is wrong, or if you don't like anything, or this and that, or if you have any suggestions, you would help me a lot." She made it feel more like she's not just using us to complete her paper or her work, or whatever, but she's also receiving help from us. You know, we're not just receiving help for her, but she's getting help from us, and that gives you more value as a person as well.
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> There's a lot of people who are not in the situation that Beto and I are in, and I feel that we're pretty confident with ourselves, but there's so many people who are not over their issues or maybe even need help. Maybe they're in a situation that's harmful for them, and they need someone they can trust and speak to, but they don't dare to do it. . . .
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> You never know what's in every person's life. And like I said, you don't just trust someone; you've got to earn their trust. So that's a job for you guys [as researchers or providers]; you are trying to earn our trust. . . . If you have the same person, and you're building trust with them, you can expect to think, "I think they're pretty comfortable with me. Next time I can probably go a little deeper."

Considering the lifetime of disadvantage that Cindy had embodied, it could be emotionally challenging to open up and discuss painful events. Tackling sensitive issues is best developed with trust over time and points to the need for trauma-informed care. Cindy also challenged us as providers and researchers to create opportunities for genuine participation in shaping programming.

Creating spaces to give people "value," as Cindy put it, also begins to cultivate a love of self that has been stripped away through lifetimes of trauma. The importance of self-love has a long history in Black feminisms, which emphasize the importance of loving oneself as an act of resistance in a world that doesn't want them to exist.[12] A healthy and positive self-love then enables individuals to find communion with others. In a loving state of being, individuals develop new subjectivities about the self and other and recognize that they are not individually morally deficient as they have been labeled and made to feel all their lives. Instead, self-love gets past individual blame to the recognition of repressive structures that call for transformation (e.g., stigma in health care, institutional barriers to services, the wars on drugs). Efforts to cultivate self-love through supportive, trusting relationships with program staff and others can begin to address the roots of addiction and raise consciousness toward social change and collective healing.

POLITICAL LOVE AS POLICY

Tailored, comprehensive, and compassionate programs for sex workers, like those outlined here, are vitally important. However, their effectiveness is also contingent on the political climate and broader social contexts that shape conditions of oppression and ill-health in the first place. Criminalization, stigma, and discrimination against sex workers who use drugs, as well as their intimate partners, reduces couples to their perceived disease risk and can keep them from accessing vital services. Discourses of deservingness question the value of investing in programs addressing sex work and drug use and feed into policies that surveil and punish rather than care for stigmatized groups who are already disadvantaged due to factors such as gender, race, class, migration status, and sexuality, among other lived experiences. As a counternarrative, drawing on political love as a guide reimagines the possibilities for policy.

No country in the world has completely decriminalized both sex work and drug use (Iversen et al. 2021), speaking to the globally pervasive lack of political love and imagination in addressing community health concerns. An increasing number of global organizations are calling for full decriminalization of sex work in parallel with an end to the global wars on drugs and a full shift toward harm reduction.[13] Mexico provides an interesting case study in terms of how decriminalization efforts form a backdrop for better understanding and addressing couples' unmet health needs. While Mexico's policies appear well intended to produce more progressive and public health–based outcomes, a critical reading reveals that such efforts remain grounded in largely punitive models of punishment, control, and political theater.

Policies regulating sex work through local ordinances in Tijuana seemed to have little direct impact on the women with whom I worked. Although sex workers are to register and get regular health checkups, the women in this book evaded the

system and did not benefit from it. The kind of sexual exchange that they practiced was less formal, public, and surveilled compared to the venue-based sex workers in Tijuana's world-famous clubs. But nondiscriminatory access to comprehensive and confidential health services for all sex workers—not simply surveillance systems based on perceived disease threats—is needed to address health inequities.

To be certain, sex worker rights and laws ensuring safe labor conditions are important. Empowerment approaches, wherein sex workers organize themselves into collectives, are also promising in many contexts to strengthen their political clout and rights.[14] However, the women in Parejas were largely not in the formal labor market, nor was sex work a marker of social identity, as they mostly avoided discussing sex work to preserve their intimate relationships. Research on sex worker empowerment in Tijuana has also found low levels of participation among sex workers who use drugs (Urada et al. 2021). Thus, it seems unlikely that organizing around sex work would be most beneficial to these particular women.

In terms of drug policy, Mexico's *narcomenudeo* reforms federally decriminalize possession of small amounts of drugs for personal use and mandate drug treatment instead of incarceration on the third apprehension on possession charges. These reforms were introduced in 2009 and were in the process of being implemented during the Parejas study. On the ground it was too early to see any effect of the policy shift on the couples' lives. However, their stories provide evidence of the need for large-scale changes in drug policy and law enforcement. What has happened since? And how might reading drug policy through a lens of political love shed light on what is happening now and what should happen next?

Drug policy reform is necessary but insufficient by itself to address a complex, multifaceted social and health issue like drug use. Political perceptions of and investment in public health infrastructure and harm reduction are corollary to policy reform efforts. Moreover, there have been unintended consequences related to public health and medicalized models of addiction. Among some politicians this approach justifies calls for involuntary drug treatment, which facilitates the containment of undesirable populations under a guise of medical care. However, involuntary drug treatment is largely ineffective, and, worse yet, what often counts for "treatment" across Mexico is based on punitive approaches using violence and humiliation.[15] Every couple in this book struggled with addiction, but access to evidence-based and humane drug treatment was virtually absent, as illustrated by Lazarus's experience in a rehabilitation center, described in chapter 3. Residential treatment programs also rarely account for how intimate relationship dynamics and families impact drug treatment outcomes, as programs are typically segregated by gender and often do not have support for couples with children. As such, these programs represent yet another form of structural violence enacted on people who use drugs, in which they are individually blamed for their "failure" to "succeed" rather than acknowledging a system unable to effectively support people who genuinely want help. In short, although drug treatment sounds like a

better alternative to incarceration, in practice the conditions in treatment centers in much of Mexico remain deplorable and counter to real change.

On-the-street police enforcement of drug policies is also a concern. Globally, there is a significant literature on the detrimental health and social effects of violent and arbitrary policing on people who use drugs and on sex workers.[16] In the wake of the 2020 transnational movement in solidarity with Black lives demanding attention to historically entrenched police violence, global calls to scrutinize the linkages between public health and policing have taken on an overdue sense of urgency.

At the time of this research, policing was a constant concern of couples, primarily related to their drug use. The stories throughout the chapters suggest the violence that policing enacted in couples' lives, including harassment for their appearance, obstacles for obtaining or carrying syringes, and threats of arrest, incarceration, and involuntary treatment. Not only do such police practices carry health consequences, but fear of the police also left social, psychological, and emotional imprints on individuals, who constantly worried about the safety of their partners. Male partners were often particularly targeted for harassment and arrest, leaving some of the women to take on more public roles—and risks—from engagement in sex work to support the couples' drug use to procuring drugs in the street-level drug economy. Mildred and Ronaldo were even targeted in their own home, where their daughter was removed into state custody because the police planted evidence and operated outside of their jurisdiction. In all, the negative effects of the policing system were a constant and clear threat to couples' well-being.

Since Parejas, police-education interventions have been developed and implemented in Tijuana, with a primary focus on promoting greater respect toward people who use drugs, an enhanced understanding of drug-law reform, and the health benefits of safe access to harm reduction services (Strathdee et al. 2015). These interventions have increased police knowledge (Arredondo et al. 2017), and researchers have also noted cases in which individual officers have changed their attitudes to become more supportive of people who use drugs. Despite this, researchers also found statistically significant increases in arrests preceding local political elections that likely reflected efforts to secure votes as tough-on-crime candidates (Arredondo et al. 2018). Furthermore, coordinated efforts among state and federal policing agencies, municipal judges, and drug center staff to "clean up" the canal through massive crackdowns have relocated individuals into drug rehabilitation centers against their will and otherwise displaced people under quality-of-life ordinances, such as loitering and other minor violations (Morales et al. 2020). As it stands, corruption, inadequate police knowledge and training, and an inefficient justice system undermine the effectiveness of Mexico's drug policies (Strathdee et al. 2015; Zedillo et al. 2019). Unless police training about public health issues is sustained and politically supported, along with options for

evidence-based, noncoerced drug treatment, Mexico's drug policy cannot reach its public health potential as it is currently conceived.

However, if we return to the idea of a political love as informing public policy, then we need a bolder critique of current political structures and the viability of the policing system as it currently operates, including questioning assumptions that armed agents of the state are necessarily effective public health champions and caregivers. One alternative approach is to engage in serious discussions about abolition. This means dismantling carceral systems that punish people who engage in sex work and use drugs (including those operating under the guise of "rehabilitation") in favor of building alternative systems better able to respond to community needs. Abolitionist approaches recognize the purposeful structural racism and systemic oppression encoded into the architecture of our institutions, which renders reform a futile task. This harkens back to June Jordan's question "Where is the love?" discussed in relation to the institutions of the drug war in chapter 3, including the child welfare and policing systems (2003, 269). Thinking about how the poor and most vulnerable in society are treated by those holding institutional power should reveal to us a lack of political love that requires urgent transformation. Ultimately, attempts at police reform do not broadly reduce community harms, and public health collaborations with police can end up amassing more resources for law enforcement than addressing health issues. Instead, at its core, abolition is about transformation and imagination. Alternative approaches favor building community services to provide care and resources in lieu of punitive state intervention. This means creating an infrastructure that situates sex work and drug use in the context of intersecting health and social needs in our communities, including addressing inequities in economic opportunities, education, housing, food security, and other basic needs. These alternative approaches necessitate shifting resources from carceral systems to communities themselves and are grounded in harm reduction principles to support rather than criminalize and punish people. While abolition may seem speculative and even unrealistic to some, police violence and human rights violations against sex workers and people who use drugs represent a global public health crisis that requires revolutionary acts of imagination. Abolition offers an alternative and aligns with the ideals of building the beloved community.[17]

In line with abolitionist imaginations, broader efforts are needed to expand access to harm reduction and build critical linkages across health and social services (that do not include the police). Harm reduction is politically permitted in Mexico and could keep people safer in their drug use and sex work, but the scope and coverage of services remains largely inadequate, as only a few harm reduction organizations are currently operating in all of Mexico. Despite its promise, there are also obstacles in expanding services in terms of political and financial support. Syringe services programs in lower- and middle-income countries are often supported by global health organizations, including the Global Fund, a major

organization dedicated to ending the epidemics of HIV/AIDS, tuberculosis, and malaria. From 2011 to 2013, which partially overlaps with the Parejas project, the Global Fund supported syringe services programs in Mexico. Even so, most of the couples in the Parejas project inconsistently accessed these services. Problems with funding have only exacerbated the conditions of scarcity that I witnessed during my work. Since Parejas the Global Fund withdrew its support, which has resulted in a significant decrease in provision of sterile syringes, less geographic coverage of services, less use of services, and increases in syringe sharing among people who inject drugs (Cepeda et al. 2019; Bórquez et al. 2019). Additionally, the federal government has since suspended funding for civil society organizations responsible for delivering HIV treatment and prevention services, representing a devastating blow to sustainable public health efforts across Mexico (Agren 2019a, 2019b).

Amid these challenges, harm reduction programming (e.g., access to sterile syringes, the opioid overdose-reversal medication naloxone) is offered in Tijuana in a drop-in center in the Zona Norte and by mobile services to expand the geographic reach. In addition, the Clínica de Heridas (Wound Clinic) is a volunteer-run mobile clinic, serving people who use drugs and suffer from injection-related wounds (abscesses), particularly migrants experiencing homelessness and US deportees who have been dispersed throughout Tijuana due to police victimization and violence (Mittal et al. 2016). This outreach was started by a local physician who saw a tremendous unmet need in the community and took action.

Another critical harm reduction strategy is overdose prevention programs, sometimes called safe injection facilities or safe consumption sites, where individuals have a safer place to use drugs, with access to sterile supplies and medical attention should they overdose. Such sites make public health sense but remain politically controversial. In the nearby border city of Mexicali, a local organization started the first such site in Latin America while offering other harm reduction services and support for women who use drugs (Agren 2019c). Evidence from chapter 3 shows that some couples extended their dangerous safe havens to friends and family, not only as safer sites to use drugs but also as spaces where other forms of mutual aid (e.g., a shower, clothes, temporary shelter) could be accessed. The concept of safe consumption sites could also work in Tijuana, if run by and for communities who use drugs and granted critical political and financial support.

Taken together, without broader political commitment, programs and policies are stymied in addressing health and social inequities among sex workers and people who use drugs. Thus, when the state cannot—or will not—take care of its most vulnerable, community organizing for harm reduction can fill in the gaps. Such efforts reflect abolitionist futures and require fundraising, volunteering, building mutual aid networks, and creating other grassroots caregiving efforts so that communities have access to the resources they need to take care of one another and

remain safe and healthy. These efforts are grounded in a political commitment to build the beloved community. Is there also a role for research?

TOWARD A MORE LOVING RESEARCH PRACTICE

As researchers who work with socially disadvantaged populations who engage in stigmatized and illegal behaviors, we must step back and reflect on our own roles in perpetuating oppression and how we might approach research from a more loving framework. Traditional academic practices have assumed an authoritative role for researchers who "collect" data from their "subjects" and publish these findings in prestigious venues for audiences of other academics. Although these ideas about research and associated practices exist on a continuum and are slowly shifting toward greater community engagement, the truth is that "research as usual" is more likely to advance careers than transform lives.[18]

In their contribution to the edited volume on activist research *Engaging Contradictions*, critical theorists Joy James and Edmund Gordon (2008) suggest that love offers a "counter-narrative" to the narcissism of typical academic procedures too often driven by self-absorption, competition, and career ambition. James and Gordon call for dismantling traditionally "apolitical" research values and maintain that a potent combination of "love and outrage" ought to sustain our efforts—that is, love for our communities and outrage over the social and health injustices they endure. Research is always guided by our politics and situated within broader power structures; we need not only acknowledge this but revolutionize our approaches by asking ourselves, Who are we as researchers? What are our political commitments? Even if we do not come from a similarly oppressed background as those with whom we work, are we willing to take on the cause? Are we just observers, liberal allies, or coconspirators for social and health justice?

Variously called activist, anti-oppressive, and community-engaged, among other labels, what I refer to under an umbrella term of "transformative research" (which goes beyond any singular discipline) calls for methodologies grounded in a political love. Transformative research is carried out in collaboration in all phases with communities not as the "subjects" of study but as cocurators of knowledge for action. Integrating love as a basis for transformative research practice compels us to rethink data itself in terms of how we how produce it, to what ends that data is used, and how research processes are always situated within unequal power relations that we can work to unmask and alter. This means bringing our work outside of the university system to produce solutions in collaboration with communities. In other words, shifting our research methodologies means that love can carve a pathway to health equity. We simply cannot achieve health equity through research as usual.

A critical part of reorienting our research practice means looking to communities themselves for guidance. Many activist groups have already thought deeply

about undoing extractive research conventions and recentering priorities. Excellent models are available for guiding principles of transformative research.[19] I am particularly drawn to the "Ethical Research Manifesto" of the North Carolina Survivors Union (NCSU), a community-based drug user union in the United States. They begin by acknowledging that researchers "need us more than we need them" and call for greater community participation "from planning to dissemination." They recognize that research, if aligned with community-driven values, can be beneficial for all those involved. The manifesto lays out a set of guiding principles that align with a political love; in fact, love itself is second on their list of research values:

> Love
> We know it is not a traditional research value, but love is at the core of all of NCSU's work. We love our community fiercely and compassionately. The research we do with you will be rooted in this love, and we invite you to open yourself up to it as well. It is not enough to engage in principles of nonmaleficence or beneficence; our research must care for our community and hold its interests at the forefront. Join us here—we have fun! (NCSU, n.d., 1)

While *love* and *fun* are not typical descriptors of academic research, is there any reason for them to be excluded? What might change if these principles were included?

Concretely, what does transformative research about sex work and drug use look like? To close out the chapter, I reflect on the entire research process that underlies this book to think through what was done well and where to improve. This section is by no means intended to criticize any other researchers or offer a proscriptive approach. The shortcomings detailed here are mine alone. My recommendations emerge from my own reflections, experiences, and particular interdisciplinary career trajectory. The reflections are applicable to multiple academic contexts, but research always needs to be appropriately adapted to the local context.

Research Design and Questions

Being in dialogue with communities to jointly arrive at a research topic and specific questions is foundational to transformative scholarship. The Parejas study successfully achieved this objective, as the investigators listened and responded to sex workers' concerns that their intimate partners were being left out of research and health services. My specific study focusing on love was at least partially grounded in this principle; the questions about the role of love in shaping HIV risk emerged from my early observations and conversations in the field, including interactions with Cindy. My focus on love came from a well-intended space of wanting to question prevailing discourses of disease and violence in sex work research, yet my study remained tethered to HIV to explore these concepts. Was this hopeful or still resigned to a paradigm of suffering?

Admittedly, genuine collaboration in designing research from the beginning of the process can be challenging for multiple reasons, none the least of which is that community members are busy with their lives and may not have the time, access, desire, or skills to prioritize research or conceptualize their needs within scientific paradigms. Furthermore, the power structures of the research enterprise often dictate which research priorities are "fundable" and who is able to ask particular kinds of questions. To access many forms of health-related funding, we must construct narratives of urgency and privilege notions of risk, but this can unintentionally marginalize communities in the process.

One key recommendation is to volunteer and work in other nonextractive capacities prior to initiating any new research project (and throughout the research process) so that researchers get to know the community, the salient issues, and their potential role (if any) to contribute in that context. Forming a Community Advisory Board (CAB) or similar entity composed of research participants and community members can also guide researchers in decision making throughout the entire research process. In my case I felt fortunate in that I joined an already established research group who had developed trust among sex workers and people using drugs in the Red Light District of Tijuana and were already learning about pressing health needs in the community, which led to the Parejas study. I felt more secure in my work knowing that the clinic gave back to the community in providing free health services and a space for engagement. I also worked hard to personally build relationships beyond the research protocols. But I could have taken a more transformative approach to foster dialogue and inclusion through a CAB and other forms of involvement in the community, including hiring and training participants to help conduct the research, as my current research orientation has shifted toward.

The Production of Data

Health-related research entails a process of documenting deeply private and sometimes life-threatening concerns, whether by manipulation of huge databases or intimate ethnography. Whether we anonymize data from private medical records or collect detailed life histories from key confidants, transformative research approaches respect that the word "data" derives from the Latin word for "gift." Data are gifts; they represent individual lives, and they deserve love and care. Conceptualizing data as gifts gestures to a reciprocal methodology, emphasizing how we treat people, develop trust, and collaboratively work toward change (Strega and Brown 2015).

One of anthropology's most redeeming qualities is its commitment to building relationships. But typical methods of participant observation—with an emphasis on observation and documentation—could be pushed even further to become *observant participation*, which places greater emphasis on active participation during the research process (Vargas 2008). While there is value in description, flip-

ping the emphasis toward participation opens up new ways of interacting in communities. It urges us to think beyond "data collection" to new modes of practice while being reflexive about our roles. While I tried to be open and develop caring relationships with couples in a traditional participant observation framework, I still wonder what pushing this further would have resulted in.

My use of photovoice and interviews with photographs as prompts was intended to invite greater input from couples and enable them to drive the conversations to topics I might not have known to ask about. Given the sensitive nature of the study, I kept my process more individually focused than traditional photovoice projects that engage community members to hold workshops and public exhibits to draw attention to specific issues. My visual approach was mostly successful and I think enjoyable for partners (except for Maria's partner, Geraldo, who told me he enrolled in the project only because she would want him to). Partners like Mildred found the process generative, commenting to her partner, Ronaldo, that it made her feel like someone finally paid attention to her life. If collaborative and directed by the community, photovoice with a public-engagement component could effectively catalyze social change.

I also advocate pushing creative methods even further, going deeper into the arts, health humanities, and experimental methodologies. From my work with the couples featured in this book, I see artistic methods as useful for exploring lived experiences of trauma, sharing stories, and potentially reducing stigma and generating empathy in the community. Many of the partners, especially the women, liked to produce art, draw, and write in journals to express their feelings. I could imagine the collective healing potential of art in lives that have long been silenced and oppressed. As Gloria Anzaldúa (2013) notes, such "creative acts" tap into something broader than the self—they form an embodied experience in which individuals connect with others who have similarly struggled. Through this experience they are able to foster a deeper kind of consciousness. Integrating creative expression into research could generate possibilities for consciousness raising as a means to articulate a political love working for transformation.[20]

Interpretation and Analysis of Data

Data analysis and interpretation are critical parts of the research process from which participants and community members are often excluded. Researchers may be concerned about introducing "bias" into the analysis process, but participants' insights can sharpen our analytical edge and lead to unexpected insights. Methodologies guided by love appreciate community members not as raw sources of data to be extracted but as experts in their own lives who can help us make sense of complex issues (Freire [1970] 2018; Hale 2008; Strega and Brown 2015).

There are a range of ways to facilitate collaborative analytical processes, and the Parejas project lends insight into one such approach. The design and analysis of our initial qualitative interviews from both field sites were based on a collaborative

model incorporating input from our transdisciplinary, binational team, whose members worked in multiple study capacities, from data collection to more conceptual roles. This model integrated multiple perspectives from the ground up, informing the questions we asked as well as processes of coding, analysis, and writing. In addition, in the one-year follow-up qualitative interviews, we implemented a process sometimes called "member checking," in which we went back to couples to assess our preliminary understanding of the data. Much of the backbone of this book is built on these foundational understandings of how couples valued their relationships, coped with outside sexual partners, and adopted communication styles and risk-reduction measures that prioritized the emotional intimacy of their relationship over physical health threats.

Member checking can provide valuable insights, but there are multiple ways for researchers to engage participants and even the broader community into analytical processes. Methods can range from participants reading and commenting on a researcher's writing to holding community events to generate actionable next steps. Whatever process is appropriate to the study, valuing different kinds of expertise and facilitating greater inclusion in analytical discussions shifts participants' roles to coproducers of knowledge. Coconstructed analytical processes could also lead to better solutions to health problems than researchers could devise on their own, thus strengthening the potential of research as a pathway to health equity and encouraging us to rethink the real impact of our work.

Rethinking Dissemination and Research "Impact"

Based on traditional academic measures, my project is a "success" in that you are reading this book, and there are more than thirty other publications in peer-reviewed journals about the Parejas study that contribute to the scholarly literature. To be clear, publications are important academic currencies and build systems of knowledge. However, if our research is multipurpose in that it is to be theoretically generative and crafted in order to act, shouldn't there be multiple ways of assessing our contributions? How does a methodology guided by love urge us to reprioritize sharing knowledge and evaluating the impacts of research?

Practically speaking, we can increase our impact if we disseminate our work in a mix of venues to reach multiple audiences. Experimental formats broaden the conversation, including a growing trend toward open-access publications, online formats, and public writing. In addition to publications, community-dissemination events, art exhibits, podcasts, digital storytelling, and other creative ways of producing and engaging with research materials can engage broader publics. An open-access book to share the stories of sex workers and their intimate partners and offer reflections and tools for others to improve on the research process is my modest contribution to these broader efforts. In all, creative and collaborative efforts that go beyond conversations in small disciplinary circles are the next horizon for academia.

Beyond measures of scholarly productivity, anthropologist Charles Hale (2008) asserts that capacity building and problem solving in communities should be key aspirations of research and evaluated accordingly. Working with structurally vulnerable communities requires us to go outside of academia and make connections in spaces where academic credentials mean little if action does not follow. In other words, we should also assess our impact by asking, *Did our research produce knowledge to address a problem or guide social transformation?* Key challenges remain in transforming incentive structures and valuing community engagement in the academy, but transformative research requires a sustained commitment to move beyond traditional measures of academic success to tangible action. As Gloria Anzaldúa reminds us, "Change requires more than words on a page—it takes perseverance, creative ingenuity, and acts of love" (2013, 574).

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I end my book by mapping out a more loving approach to programming, policies, and research to support sex workers who use drugs, along with their intimate partners, in the hope we can achieve real change. Of course, all of these issues could be explored with greater depth, and there are many other issues beyond the scope of this conclusion that impact sex workers' and their partners' health and quality of life. At their core these recommendations emphasize the need for meaningful participation by sex workers and people who use drugs, who are experts in their own lives and know best what they need. In addition, these recommendations call for the holistic provision of care, respectful programming and research that can engender trusting relationships, and meaningful collaboration between academia and communities, including research that goes beyond traditional boundaries of knowledge production. The success of any of these suggestions, however, requires us to move forward with a more revolutionary political commitment to love—a genuine desire to build the beloved community that engenders understanding and ensures the welfare of all.

In closing, I will always carry the memories of fieldwork in Tijuana with me, for better or worse. There is always room for improvement and more work to be done to address the historically entrenched health inequities along the border and elsewhere. Imperfect as this work may be and partial as the narratives are, I care deeply for the people in this book, who are not always granted that right. Sex workers and their intimate partners are capable and deserving of love, and their experiences should not be excluded from our efforts to pursue global health equity. I hope that these couples have contributed to such efforts through their stories of love and humanity. I also hope that other research participants, scholars, service providers, community members, coconspirators, and others take this work even further to harness the power of love's revolutionary potential.