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Health care and black women: notes on coloniality, re-existence, and gains

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Abstract *We reflect on Black women's health as part of a narrative produced by the exercise of coloniality and the forces that contribute toward defining and imposing the place of a subaltern since the objectified and racialized body notion informs it. Black women are represented in the worst health indicators. We propose to look at collective health from the perspective of care as a political, social, and intersubjective technology, in whose encounters with the aesthetic-political body of Black women are traversed by unique exclusion experiences. Moving beyond suffering, we also address agency, resistance, and the construction of an agenda of struggle based on the Black people's leading roles.*

Key words *Healthcare, Racism, Coloniality, Gender*

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Introduction - about coloniality, racism, and Black women

In this text, we speak from us, Black women, our place, the place of our mothers, our elders, our ancestors, who came from places about which we were not allowed to know for sure, whose concealment is only a part of the violence that founds us as objectified and silenced subjects in the forced diaspora. We also speak in unison with our sisters, Black in body, soul, and resistance, which is much more than resistance: it is the creation, reinvention, realization, and existence production in a daily life marked to be unfeasible since it is from a colonial place. We also want to start by discussing the exercise of power in coloniality, which systematically acts toward defining a subordinate place destined for us since the objectified and racialized notion of the body informs it.

We dialogue here with Quijano[1], for whom coloniality is defined as a global pattern of domination and exploitation within capitalist frameworks, which are based on the racial and ethnic classification of the world's population as an accumulation strategy, a powerful concept in shaping the imposing sociability and subjectivation processes of a modern Eurocentric hegemony over the several life areas, especially the notion of the body as a locus of the exercise of domination.

Materially and discursively inscribed health practices are marked by differential workmanship in the care encounters depending on body reading. Although narrated as the result of "general protocols", they are not neutral but situated, incarnated, and performed daily and differently, depending on the subject's place in the socially, colonially, and racially demarcated plot. For this reason, we start our writing by criticizing coloniality's domination project and the confrontation of "[...] forms of harassment that often undermine Black women's ability to convey the certainty of talent and intellectual mastery"[2](p.472), underscoring the repercussions of colonial expropriation policies on Black-women-lives:

The colonial demarcation of the world implies the hierarchization and vulnerability of human lives, through the racialization of their bodies, toward their objectification and consequent exploitation [...]. The globalized coloniality's socio-political plot [...] is expressed in the field of health not only in the modes of illness but also in its regulating bases and control and care strategies[3](p.31).

The permanently updated world racialization is one of the European colonial enterprise's important axes. It shapes political, economic, and social processes grounded on distinctions in diverse cleavages – of race, class, and gender – that benefit a specific population group to the detriment of others. The right of capitalist colonial expropriation is anchored in the assumption that the spaces of "gains" are human and legal voids, the so-called "non-being zones"[4], underpinning the "[...] imposed racial/ethnic classification of the world population as the cornerstone of said [...] [capitalist] power[...]"[5].

The end of the international trade of Africans raised the price of enslaved people, and, in response, the elite and the State organized themselves to prolong the lives of captives so that they could be exploited for a longer period. Improved living conditions are not related to well-being but economic issues. Fertile women became a specific target due to the reproductive potential of slaves[6]. The *Lei do Ventre Livre* (Free Womb Act)[7] directly attacks Black women, their reproductive capacity, and motherhood. The mother had no right over her offspring. It is a controversial law that grants freedom but provides the means for the enslaver to maintain possession of the individual until the age of 21[7].

The bases of coloniality hierarchize relationships at a global level from the North/South delimitation, supported by the triad of coloniality that operates the hierarchies: of power (capitalist concentrated in the North), the being (European white man as a universal reference), and knowledge (modern Eurocentric western science hegemony)[5,8]. Lugones[9] discusses the notion of the being's coloniality based on the racialized production of the other and its relationship with the demarcation of gender, which would be valid only for the reading of universal (white) bodies and emptying this notion regarding others, "othered" and objectified. The man/woman binomial is voided of meaning when referring to the colonized, emphasizing that "unlike colonization, gender coloniality is still with us; it is what remains at the intersection of gender/class/race as central constructs of the world capitalist power system"[9](p.939).

The notion given to Black bodies, denied the same human status as whites, makes sense of the grammar of violence as a key to the operation of State devices, which is veiled and explicit violence, intersected in different spheres, including health, performing in access barriers; hierarchy and differentiation in care practices; non-prioritization in health programs and policies, among other vulnerable dynamics of living conditions.

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As part of this plot, health policies and practices also reproduce the pattern of oppression, inequalities, and their naturalization. They produce different material and symbolic violence types, ranging from substandard living conditions to access barriers and differentiated forms of care.

Health has several expressions of this dynamic, and they must be part of the public health priority agenda. Black women are at greater risk of having prenatal care with fewer appointments than expected, less presence of a companion at delivery, and less access to labor analgesia[10]. The risk of maternal death in Black women in Rio de Janeiro state is fivefold higher than in white women[11]. Health indicators clearly show the problem, even if discussions about them are insufficient concerning the racial issue.

Likewise, the percentage of deaths from abortion in Black women is 45.21% compared to 17.81% in white women from January 2020 to February 2021[12]. Regarding maternal mortality, a sensitive indicator related to living conditions, access, and quality of prenatal care and childbirth, we can observe that the rate for Black women is almost 66% and just over 30%[12] for white women in Brazil. Analyses regarding lethal violence against women in Brazil indicate a decrease over the last decade. However, they have been preserved and increased in racial terms, given that the decrease is much more significant regarding non-Black than Black women[13].

The records of the ethnicity/skin color item, and consequently the epidemiological studies, represent a huge gap in health discussions and are one of the countless expressions of structural and institutional racism[14,15]. The high percentage of uninformed records concerning ethnicity/skin color (27.39%) stands out, reinforcing the criticism that academics and activists dedicated to the discussion of racism make of the relationship between the non-appreciation of this information and the myth of racial democracy, which a significant part of Brazilian social thought reinforces[16].

Coloniality regarding care makes explicit an absence in the history of Black women, where the construction of the Brazilian nation is marked by the perpetuated violations of these women's rights. The intention of a nation desired by supporters of the eugenics movement did not leave room for Blacks and indigenous peoples. With the scientific support of the medical community, the movement launches proposals for sterilization, marriage control, selection, racial segregation, and generation of "healthy offspring"[17](p.107). The entire universe of eugenics is a producer of Black women's suffering. Strategies designed for "improving the race" include inhibiting reproduction, affective isolation, separatism, and dehumanization.

Here we discuss health in its care dimension, looking at the relationship between racism, sexism, and classism, whose oppressive synergy converges, in the experience of Black women, in what Carneiro[18] designates as social asphyxia and the expressions in their health conditions, the care relationships, and the consequent urgency of an emancipatory reinvention. Inadmissible social asphyxiation, as it ontologically removes Black women from the place of being social and imprints a colonial-based care relationship[19]. A set of issues that traverses us as Black women – individually, collectively, and historically marked – are addressed here as an agenda that needs to be built collectively, enter through the front door of academic spaces and health care, and elevate the social practice level: the social production of the racialized body and the issue of care, sewn together by the affectations of these dynamics, and addressing the issue of suffering, agency, resistance, and gains.

However, as Rivera Cusicanqui[20] warns us, transposing into social practice implies imploding the legitimacy that agents of a thinking elite grant themselves in terms of powers, even those who say they are not aligned with colonial knowledge, but who often discursively appropriate the decolonial reflection as a strategy to maintain their role. These are conflicting statements since they are unrelated to the acts and the place they continue to hold in the world. The unveiling of this false 'contradiction', interested in preserving knowledge resources as an expression of power, can be transformed, as the author tells us, from a learning grounded on acts rather than words, and on social practices rather than conceptual frameworks, that, although important and necessary, are insufficient[20].

Notes on Healthcare and Practices

We are in the 21st century, but the lack of care for Black women had long been denounced by Sojourner Truth[21] in the 19th century, when she questioned, in the Ohio Women's Rights Convention, the category of a universal woman based on hegemonic feminism and neglecting racial guidelines since she did not receive the same "care" as the white woman[21](p.27).

On the contrary, she had been treated like a commodity, enslaved, without any sign of a pos-

sible feminine fragility characterizing her. Since then, there has been no lack of reports of worse health outcomes, care inequalities and the possibility of self-care, and narratives about sexism, racism, and *anti-Blackness*, "a logic that results in ontological and social denial of the Black person", affecting especially the Black woman[22](p.18).

By coining the term *anti-Blackness*, Vargas[22] points to the singular and systematic exclusion that non-white people go through, that is, living under the sign of the devaluation of non-whiteness due to global white supremacy. Although the oppression experienced by these people stems from the same source (and, therefore, likely to be shared), it translates into different experiences, as they hold different positions of privilege or disadvantage. Thus, "the modern being (who) is defined in opposition to not being Black"[22](p.18) finds in *anti-Blackness* the constitution and foundation of humanity, which excludes those who are considered *non-persons*, those who live *non-existence*. It is a perspective beyond racism, which defines the level of citizenship to be assigned to non-white people; it is about belonging or not to the human family, something that operates implicitly and unconsciously[22].

Suppose the Black presence in diasporic societies defines the non-Black being as a subject. In that case, when we think of Black women and the issue of gender as a historical-social construct, we must stretch the debate to the issue of Blackness and racism from an intersectional perspective that glimpses the differentiating grammar of the social interpretation of bodies, translated into various forms of oppression embodied in political operations and daily management of Black subjects. What place does society produce for Black women if the situation of Black women and men is that of a dominated caste facing the stereotypes created by the dominating caste in a white patriarchal system? Beauvoir[23] wonders, "How the fact that we are women has affected our lives, what possibilities were offered to us, and which were denied to us?". The author tells us that women were born on the "wrong side"; however, we inquire: on which side were Black, Afro-Latin American, and Caribbean women born?

Lugones[9] tells us about the relationship between race and colonialism, unraveling a possible reflection on intersectionality in modernity. This intersection abandons man-woman and white-Black binarism to delve into another logic that is not categorized to understand the intersection of race, gender, and sexuality. Man-woman dichotomy was centered on the European-bourgeois-colonial-modern man and his supposed opposite, the European-bourgeois woman. The idea of a homogeneous and updated categorization refers to the main subject of this dichotomy; therefore, reference is made to white women when talking about women from a fallaciously universalist perspective, and talking about Black people refers to Black men. Thus, Black women are the Other of Black men and the Other of the white women[24].

Spivak[25] draws attention to how women are included in subalternity to avoid a monolithic collectivity of "women" in the discourse on feminism: "If you are poor, Black, and female, you are involved in three ways"[25](p.110). Such involvement does not presuppose a social place that puts them in the role of the oppressor; in contrast, white women and Black men can simultaneously act as oppressors or oppressed. Understanding subalternity is a *sine qua non* condition for transcending the colonial difference and advancing towards decolonization, as this perspective of subalternity will come as a response to the colonial difference and could restore the knowledge and place of subalterns within a new epistemology[9].

When directing our gaze to Healthcare (with a capital letter because it is a proper noun in this conception and somewhat removed from the idea of *treating*, *healing*, or *controlling*), we see the Black population with less access to services, medication, and hospitalization; high syphilis and HIV rates in pregnant women, and maternal mortality[26], thus explaining the care-racism interface[27], which requires an accurate perspective on the provision of health practices vis-à-vis the legitimacy of the search for care, regardless of the body that will receive it[28].

Under the SUS principles, health care should consider equity, comprehensiveness, and humanization. However, such devices are activated differently depending on who the care is directed to. How public health policies organize lines of care rarely debates or considers the racial issue; on the contrary, they are formulated based on the notion of a single, universal body, without envisaging the historicized production of the place of colonial-racial-based bodies and subjects, which reveals a given social dynamic and translates into social values and racist practices[29].

Care presupposes a complex dynamic that requires attention, shared responsibility, autonomy, and zeal, not just a technical procedure meeting a specific demand. Healthcare is heavily thematized in collective health outputs, with significant

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criticism, for example, about the technical apprehension of work processes. However, the racial issue is made invisible or devoid of meaning.

Therefore, one wonders what the meaning of an inclusive, comprehensive encounter of care that offers positive, respectful interaction should be, since the feeling of helplessness and neglect produce exacerbated suffering. Black women's aesthetic-political bodies are marked by unique experiences of exclusion by a "stressful freedom"[30]. There is a need to consider the ethnicity/skin color of the historical body that enters the care environments! As Carneiro warns us, the struggle of Black women "[...] for access to dignified care [...] and respect for values and beliefs [...]"[30](p.22) and against the structural and institutional racism that excludes and segregates, should guide clinical decision-making, albeit subliminally[30].

When claiming the "[...] production and analysis of data with racial disaggregation", Borret *et al.*[31] propose an anti-racist healthcare, "[...] toward racial equity"[31](p.3). It means taking for oneself, as a healthcare professional-caregiver, an ethical horizon that considers racial difference as relevant to the ways of living, getting sick, and dying, as part of moral and political subjectivity that inscribes Black women in a place beyond their biological self, to perceive a "historical, relational, and transcendent I/us", since "[...] the body marks and recreates gestures and cultures that stem from afar [...]"[30](p.24).

Questioning the approaches on the subject, we dialogue with Muñoz and Bertolozzi[32](p.322) when they consider that "[...] vulnerability must consider dimension related to individuals and their social place", whose interpretation of the production of vulnerabilities dialogues with Ayres[33] when he warns about recognizing vulnerability as a practical concept to think about intervention, proposing to discuss a notion of care that permeates the interaction between health professionals and the subjects targeted by their actions.

It would be a care to achieve technical success in the context they originate and justify such procedures and that effectively constitute subjects and not just the agents or objects of success[34,35]. Ayres[35] also talks about the importance of building an identity between those who care and those cared for as fundamental for establishing the necessary bond for effective care. Given our colonial history of unequal production of subjects and bodies, we should underscore that, thinking about an "identity" construction in which both stakeholders in care encounters assume equal roles in the professional-user relationship, living a dialogical encounter, is unlikely to happen.

It reflects on the act of caring as an encounter in which the "reading" of the body of those who care and those who are cared for "arrives first" in the face of our process of sociability and subjectivation historically forged in colonial and racist bases, in which each of us, individually and collectively, ends up holding different places in the world that modulate care actions.

Kilomba[24] narrates the white doctor's impressions of the figure of the young Black patient who enters his office, placing her in the position of potential nanny of his children on vacation, which leaves him free to invite her to the role, the same reading, but symmetrically opposite, that white/male and female/Brazilian/doctors make of the place of Black/male and female/doctors who came to Brazil from Cuba, through the *Mais Médicos* (More Doctors) Program, when manifesting against their incorporation into the Family Health Strategy, arguing that they look like "maids"[36](n. p.). If the girl-patient was white, would the invitation to be a nanny be part of the subjective and relational repertoire of the German doctor? If foreign female doctors were white, would they be considered to have the face of "domestic servants"? This "face" is read "in the implementation of care in its different levels, [and there are] people with whom we establish the most primary relationships and decide to accept or reject, to dominate or cooperate with"[28](p.38).

Epidemiological knowledge that guides another type of care will only be possible through the formal identification of Blacks and browns. Resisting the collection of the ethnicity-skin color item and keeping silent about our racial dynamics are ways of embargoing and interdicting the discussion, as proposed by supporters of the new *color-blind* racism, which advocates silencing around "race-related" issues: "not see, speak, or act regarding race". That way, nobody sounds racist, and nothing seems racist"[29](p.128). It is a dynamic of racism similar to which our myth of racial democracy is based, perpetrating inequalities even recognizing the unequal conditions in which Blacks and non-Blacks live.

In this setting, the Black population, particularly Black women, receives fewer resources and less care. Besides being racist practices in health, recognizable as such, and the target of combat strategies already proposed, they are also a way of understanding and relating to each other. It is the very notion of humanity. It is *anti-Blackness*[29], operating in an implicit but no less effective way.

Suffering, agency, re-existence, and gains

We arrived here with one certainty: we must return this trauma to the world, as Lima[37] tells us in a dialogue with Kilomba[38]. The painful experiences of a racist and sexist societal logic help preserve Black women's subordinate position, perpetuating stereotypes such as colonial heritage: "good for hard work", "good in bed...".

According to the 2020 Public Security Yearbook, Black female bodies are the target of insistent attempts at removal through psychological, physical, and social coercion: 66% of femicide victims are Black women, and 75% of violence against children and adolescents was committed against Black women[39]. For these and other reasons, the agency of Black women, in their daily efforts to survive to face structural, institutional, and contingent barriers, boosted the movement of Black women from the 1980s onwards when they started "[...] to organize themselves politically per their specific condition of being a woman and Black [...]"[18](p.167). This militancy became threefold, as it included analyses of exclusion arising from race, sex, and class, manifesting itself in different national and international forums. Black women are creating their cosmogony through Black feminism, which offers a vision "of the self, the community, and society" where they live, a vision only they can describe[18](p.183). Black women play a leading role in spaces hitherto entirely dominated by whiteness, such as academic spaces, an important locus for producing and reproducing knowledge and what is considered science.

Black men and women's strength to re-exist stands as a "[...] positive inheritance for the struggle for their liberation or to express freedom and strength that are already theirs since their ancestry, since time immemorial"[40](p.232-233). This strength is renewed in groups because Black women also feel weakness and tiredness and need support. Healing processes need to be collective[37] and operate as an agent of collective change when confronting the patriarchal society[41]. Despite the historical dynamics of coloniality pushing Black women to the place of suffering, this does not summarize them. On the contrary, the Black women's agency is present in diverse social spaces and daily challenges the perverse plot that operates in the effort of their dis-subordination. The genocide of young Black men, a common practice in the Brazilian state, has resulted in many experiences of resistance and struggle by Black women – mothers, companions, sisters... Examples such as the path from "Mourning to Fighting" of the Mothers of Acari, the Mothers of Manguinhos, and the *Muleke* Movement[42] expose the daily effort not only to survive and overcome pain, mourning, and depression but also transform and build new meanings for Black existence, from a perspective of producing a future, which necessarily traverses the fight against racism.

As pointed out by Araújo *et al.*[43], "The resistance and how the Movement of Mothers act is close to the notion called Ubuntu – 'I am because we are' – in African philosophy"(p.1335). Facing the processes of illness in the face of racial violence, under which Black women are historically subjected, clearly outlines the power of re-existence in other bases of life, different from those imposed on us by the colonial plot to define the "Black men/women's place".

Health emergencies such as COVID-19 also make racial inequalities in health even more explicit[44]. There are countless initiatives for the survival and re-existence of Black people in the face of the (in)action of the State, in the form of perpetuating institutional racism that shapes policies to combat the pandemic (social distancing, remote work, and access to environment and hand´s hygiene). An example is the creation of the Complexo de Favelas do Alemão Crisis Office, emphasizing the work of the *Mulheres no Alemão* movement, under the leadership of Camila Moradia, in partnership with *Voz das Comunidades em Ação* and *Coletivo Papo Reto*[45], which act on several fronts such as civil health surveillance, distribution of staple food baskets and hygiene material, and the political struggle against State violence in the favelas, which culminated in the ADPF 635, known as "ADPF Favelas", which limited police actions to conduct operations in the favelas, sanctioned in June 2020 by the Federal Supreme Court[46] (STF). Similarly, the quilombola population also suffered and resisted. Examples such as the confrontation of COVID-19 by quilombola women from the Jequitinhonha Valley in Minas Gerais, as narrated by Maria Aparecida Machado Silva, from the quilombola community of Córrego do Rocha, in Chapada do Norte, Minas Gerais (MG):

They indirectly erased our smile, which is wonderful. However, even under the mask, we do not lose the joy of living, even with many challenges. I have heard it said, and I believe it, that being a woman is to be challenged tenfold; to be Black is tenfold more challenges; to be a quilombola is tenfold more. So, we are challenged thirty times over by being Black quilombola women. This pandemic

also brought this impediment. However, we also found much strength to struggle and resist because we are also a strong resistance symbol[47](p.178).

Black feminism warns us about the need to talk about the experience of Black women in the world, the possibility of a non-excluding discourse and to consider how oppression operates and shapes the experiences of those women. The role of Black women's movements, whose struggle agenda in health contributed decisively to the construction of the National Policy for Comprehensive Health of the Black Population, is a significant example of resistance, power, and production of life in colonial fracture spaces[9], where the debate on care has a prominent place. Thinking about health care in our context necessarily implies racializing the debate and, therefore, breaking visions given to us by coloniality.

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