RICE UNIVERSITY

Lèsbicas Negras' Ethics and The Scales of Racialized Sexual Recognitions in Gynecology and Public Discourses in Salvador-Bahia

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF REQUIREMENTS FOR THE DEGREE Doctor of Philosophy

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HOUSTON, TEXAS
DECEMBER 2014
ABSTRACT

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This dissertation is an ethnographic investigation of the bio-cultural ethics of gynecological care among Afro-Brazilian lesbians, or lesbicas negras, in Salvador-Bahia. I argue that many lesbicas negras’ pursuit of what they believe is their human right to reveal their sexuality and integrate it into accessing quality gynecological care and health education from their physicians is informed by their ethical obligation to confront the wide social issue of “preconceito.” Preconceito, which literally translates to “prejudice,” represents a social phenomenon that signals how preconceived ideas can materialize micro-social inequities and the barriers to effective and affirming medical-patient interactions for these women. This project is an interpretation of the motivations and strategies to achieve social well-being in a context entrenched with preconceito toward skin color, homosexuality, poverty, and more. I contextualize particular strategies that help these women conceive themselves as agents of their well-being as black women, homosexuals, and as bodies historicized and continually marginalized as a population afflicted with economic, political, and health disparities. Theoretically, I demonstrate the ethical as a domain of relationships that my key interlocutors have toward themselves (also with others), and as a result, I pay attention to how such relationships inform a
particular set of ethical practices for the acquisition of well-being and human rights as openly black gay women. I interpret such relationships to the self to be composed of the understandings my interlocutors have about the impact that the freedom to speak about their sexuality, particularly as consumers of healthcare system, has upon their well-being. Analytically, I scale the social complexities of pursuing recognition of sexual liberty across public discourses, micro-social quotidian experiences, and social interactions. Thus, I argue that *lesbicas negras* become ethical subjects everyday as they strive toward well-being and such strivings can demonstrate the complicated relationships across sexual health, sexuality, racial formations, social well-being, citizenship, public discourses, and freedom (*libertade*).
ACKNOWLEDGMENTS

This dissertation has transformed me in unimaginable ways. What I have gained through the process has made this long-awaited moment profoundly worthy.

This dissertation is not possible without the trust and open hearts of the many women in Salvador-Bahia who embraced me as a friend, researcher, anthropologist, *medica*, and of course, as a *lésbica negra*. I owe them my sincere gratitude for sharing their intimate thoughts, fears, joys, and anguish. There is so much more to us that I dare to never share publically with anyone – not on paper, not in words. Our sacred shares.

To Lilian Marinho – thank you for your warm embrace and guidance in mapping out my topic, fieldwork, and journey in Salvador. Thank you for helping to open the door at MUSA-UFBA, accepting me as a visiting student and colleague, and connecting me to sharp feminist thinkers and to an amazing mentor, Cecilia McCallum. I also thank the researcher team at CEDAP for our brief time together – our work together is not finished.

My dissertation committee members were the strong roots of me as a growing tree keeping me steadily secured in the sprouting and enduring process. I have learned so much from each of you: James Faubion (chair), Cymene Howe, Nia Georges, Rosemary Hennessy and Elias Bongmba. I am forever grateful for your support through the process with your generous attention, being brutally honest, and unconditionally affirming.

This dissertation is not possible without you being you, James D. Faubion. Thank you for taking a risk on me. I am no longer a closeted anthropologist! You have gone beyond your call of duty over the years to participate in my intellectual, professional, and personal growth. I deeply appreciate you. A loving thanks to my responsive and communal anthropology department and to those who have supported me in their special
and critical ways: Nia Georges, Cymene Howe, Dominic Boyer, Altha Rodgers, the late Carol (the butterfly). To Ian Lowrie – thank you for moving me forward.

This dissertation is not possible if it were not for my first advisor at Rice, Anthony B. Pinn with whom I started my journey in African American Religious Studies and for Elias Bongmba who introduced me to Voek’s *The Sacred Leaves of Candomble*. I am forever grateful for your guidance.

This dissertation is not possible if I had not taken your class Fall 2008, Reading Material, where I learned to transform my thinking. Thank you, Rosemary Hennessy, for being a mentor, teacher, and friend. Thank you for the tough conversations about my writing and for your nurturing ways. I deeply thank Brian Riedel, Angela Wren Wall, and my cohort at the CWGGS for our transformative time with the Center.

This dissertation is not possible without my power playa: Monica. Thank you for always pulling me in your direction. And a deep thank you to special colleagues and friends at Rice, NYC and beyond who showed devoted care or caring moments along the way: Ezekiel, Brenda, Grace, Candace, Linda, Elizabeth F.S, Andrea A., Rachel V., Than, Shani, Chris, Terri, Margarita, Kevin, and to the staff at St. Hope Foundation – for making space for me to grow. To my mentors: Profs. Eleanor Moody-Shepherd (My Big Momma – what would I do without you), Janis Hutchison, Traci West, and Jenifer Bratter. My AKA sands – thank you for cheering and carrying me; and I especially want to acknowledge Julie and Stephanie for always showing up, unexpectedly.

This dissertation is definitely not possible without the generous Ruth Landes Memorial Foundation funding for fieldwork and the Sarah Pettit Dissertation Fellowship in LGBT Studies at Yale University. The Ruth Landes funds turned the impossible
possible as in facilitating my travels to various places, reaching many people, and collecting and creating materials in random ways and from hard to reach places. At Yale (2013-2014), my writing time there was invaluable. Thank you for sharing your precious time and support in all of your special ways: Inderpal, Katie, Karen N., Joe, Geeta, Margaret, Jill, Craig, and Linda and a special hug to Michelle Nearon (who I have known for 25 years), and to my new friend, Danya for our sisterly talks.

I also received fieldwork funding from the Center for Women, Gender and Sexuality Studies at Rice as well as SSRI fieldwork funding. I want to also acknowledge, Dale Irvin at NYTS for sponsoring my first and solo exploratory trip to Salvador in 2007. Thank you.

To Kim-Monique Johnson - our love sustained and changed me. I hope we are both transformed. To my family: my mom Ivonne, sisters Kalisha and Charika and their/my children: Destyn, Javan, Jania, and Amiya – the universe is waiting for all of you; love and triumph are the ladders into it.

My life is not possible without you. There is life at birth. Then, there is life. Thank you for coaching me for 30 years (1985-2015) on how to self-love, self-forgive, and self-affirm. Without you, not sure where this dissertation would be since my heart and mind are in this dissertation, and you help me take care of my heart and mind - to Merle Anslem and your/our girls.

Then, there is you - Erica Rocha (Salvador) to whom I entrusted my life. Thank you for keeping me safe in countless ways. This dissertation is not possible without you.

To RIP Valerie, my abuelos, and even Jayda – this dissertation is for you.

To anyone not mentioned. If you know me, you know where my heart is. Thank you.
CONTENTS

Acknowledgements iv

Contents vii

Introduction Windowing into Social Complexities 1

Field Site and Methodology

Thematic Evolution
Field Site
Interviews and Interlocutors
Participant Observation and Survey
Windowing as Method
The Film

Theoretical Underpinnings

Sexual Subjects and Bio-Culture in Brazil
The Ethical
Combating Racism, Protecting My Religion
The Medical as a Political and Discursive Realm

The Structure of the Dissertation

Chapter 1 Black (Homo)Sexuality and the Etico-Politico 32

Prelude
Window: Diverse Homosexual Liberal Subjects
Window: Blackness, Saude, and Ser Mulher
Window: LGBTT Healthcare Reform and Health Reforming Discourses
Window: Lesbian Health Discourses and Trickle-Down Effect
Window: Etica Racial, Etical Sexual and Recognition of Citizenship
Windowing Intimate Encounters:
A dor da cor, A cor da sexualidade
Windowing: Your Private Family Gynecologists and My SUS
Windowing: Working for No Pay, Working for Dignity
Windowing: On being “buffie-ledie” intellectual radicals
Windowing: Black Love, Black Sexuality, Etica Morada
Chapter 2  Manifesting the Ethical  
Sexual Health and Subjectivity  
Practices of Freedom and the Ethics of Self-Care  
Preconceito and Subjects  
Racialized Sexual Subjectivity: Mirela  
Lesbicas Negras as Ethical Subjects  
On History of Homosexuality and Race in Healthcare in Brazil  
Gineco-Etico Praticas

Chapter 3  Ginéco-Etico: A Window into the Ethical  
Prelude  
The Ethical and Ethical Subjects  
Ethical Telos: Well-Being  
Mode of Subjectivation: Accessing a Human Right to Well-Being  
Subjection and Subjugation, or Subjectivation  
Recognition of Interactions as Insult, Recognizing the Ethical Subject  
The Themitical: Human Right as a System of Values  
Negotiating Recognitions: Themitical’s Relative Stability  
Themitical: Dynamics of Recognition for Quality Social Interaction  
Themitical: The Speculum  
Gineco-Etico: An Ethical Framework

Chapter 4  Enquadramento: Framing the Ethical  
Prelude: Contextualizing the Window  
Writing Ethnography: Windowing and Making Data  
Windowing Social Accessibilities: Sexual Health and Preconceitos  
Barbara  
At the window with ultrasounds reports  
Beyond the window: Barbara’s Lesbian Sister  
Beyond the window: Barbara and Luci on Film  
Beyond the window: Gynecology in the streets  
Beyond the window: Santo Antonio Festival and a Gynecologist’s Son  
Beyond the window: Gynecologists’ interviews  
Gineco-Etico  
Access and Discourse: Materialisms  
The Ethical: Well-Being as Telos
Chapter 5  
*Minha Energia Vital: Scaling Social and Ethical Complexities*  
229

Prelude  
Social Complexities and Racialized Sexual Subjectivity  
Beyond the window: Interview with Dra. Rosa  
At the Window: Mirela  
At the window: Interview with Jandira  
Beyond the window: Visit with her Gynecologist  
Beyond the window: The Film  
Beyond the window: Dr. Manuel  
Beyond the window: Jandira and family on Good Friday  
Collective Ethical Subjects  
At the window: Isabelle  
Collective Moments  
*Novembro Negro* and Isabelle’s Birthday  
Nights at COBRE  
Collective Ethical Voices: The Film  
Scaling Social Complexities

Chapter 6  
The Last Window: A Conclusion  
304

Scaling  
Subject Formation and Subjectivation  
A Window into the Legacy of Ruth Landes: A final word on fieldwork  
A Window into Final Reflections of the Use of Ethnography  
Gynecology Talk with Elisangela and Marta at Mocambinho  
Future Considerations: The Next Window

Bibliography  
322
Introduction
Windowing into Social Complexities

This dissertation is a window.

In March 2013, the Brazilian singer Daniela Mercury, together with her lesbian partner and TV Globo journalist Malu Vercosa made headlines in many magazines, newspapers, and the television news when the couple (both natives of Bahia) publically announced their committed co-habitation and relationship. The media’s feverish reproduction of their detailed profession of love only gained momentum as stories placed their glamorous social and love life in relation to their family histories, past marriages with men, and children. Daniela (47) and Malu (36) were the new quintessential lesbian couple in Brazil. My friends and research interlocutors in Salvador chatted about them quite a bit. Indeed, Daniela and Malu’s mostly positive media attention took some of the edge off of the simmering resentment at the appointment of Deputy Marco Feliciano as the National Director of the Commission for Human Rights. Feliciano was widely criticized by citizens of all backgrounds (rich, poor, black, white, Christian, and otherwise) for his homophobia and racism (which I discuss in more detail in chapter two). Here, however, I want to draw attention to the figures of Daniela and Malu; how, as Bahiana white lesbians, the media was able to frame them as “financially independently, well-established professionally, from simple Catholic families who enjoy being married”\(^1\) (easily glossing over the fact that theirs was not a legal marriage, but a casamento, a folk version of common-law marriage).

\(^1\) As reported in the Brazilian magazine, Contigo! See Image 1
Daniela and Malu, both as women native to Bahia and as Brazilian citizens, showed me what it meant to be a homosexual couple, publically *casadas* without an official marriage. In *Contigo!* Magazine, Daniela said that she “used the word wife because we decided to live together and exchange alliances. So then, we are married. But not officially yet.” Many women and men of varying sexualities, gender expressions, racial, and class backgrounds understand themselves as “*casadas*” or “*casados.*” At first, I thought that it meant *actually* getting married, but experience taught me that it’s simply an idiom for an acceptable union. In other words, if you are going to live together (whether a in a committed sexual relationship or not), then, being *casadas* is an alternative, normative form of cohabitation, of being ethically together.

I open with Daniela and Malu because, while in fieldwork, I become most interested in the ways in which racial and sexual subjectivities intersect with issues of citizenship, human rights, and social well-being. After an interview with a woman named Arlete, I started to pay more attention to the nuances of the media discourses around Daniela and Malu. Arlete was a native of Salvador in her 30’s, and an initiate.
in Candomblé who self-identified as a black lesbian. As a Mãe Pequena (a priestess who helps oversee a terreiro, a Candomblé place of worship and sort of community center), she is particularly concerned for the social welfare of black women and lésbicas negras in particular. As we sat by my apartment window for an interview in March 2013, I was struck by her response to my question about this latter identity:

NF: O que é para você ser lésbica negra? (What does it mean to be a black lesbian for you?)

AF: I think a black woman is always disrespected. And so, society, especially men, they see a black woman as a sexual object - all the time, the body of a black woman, her butt, breasts (as object) ... If you're a black woman and have a relationship with a woman, you are a waste to society, the men see it that way. So, because it is easier for them to be violent, talk violently, use pejorative terms black women, when it comes to [homo]sexuality, they offend [us] even more. When a white woman has a relationship with another white woman, they can become friends and something even beautiful, perhaps they can [even] feel pleasure [together]. Daniela, the singer. It is beautiful to society ... (People might say:) "Oh, I wanted to see you [Daniela] have a relationship and it should be good and all." But when a black woman [wants a relationship with a woman], they [men or society] are more aggressive, "Oh, you bitches! You want to die? [as in it’s dangerous] Go find a man." This is what black women experience. If on a daily basis black women are already disrespected, then, a black lesbian woman is disrespect even greater. I think black women as lesbians experience a lot of this kind of marginalization. If a black woman is a lesbian, she suffers more than white women who are lesbians. And they can be in the same social context. Just for being black, you suffer more, and are disrespected more.²

Eu acho que a mulher negra ela é sempre desrespeitada. E assim, a sociedade, principalmente os homens, eles veem a mulher negra como um objeto sexual. Então o tempo todo, o corpo da mulher negra, a bunda, os seios... Se você é negra e tem uma relacionamento com mulher, é um desperdício para a sociedade, para os homens verem isso. Então como pra eles é mais fácil ser violento, falar, xingar, utilizar termos pejorativos com mulheres negras, quando se trata da sexualidade, pra eles também ofendem mais. Quando a mulher branca tem um relacionamento com outra mulher branca, é amiga, é algo mais, é algo até bonito, talvez sinta até prazer. Daniella the singer. Ate bonito para sociedade... “Ah, eu queria ver vocês tendo relacionamento, deve

² Translation is slightly modified and corrected a friend in Salvador (not someone in the study) whom corrected my English translations of the Portuguese text. My intentions are to preserve as much of the meaning as possible from the affective language, pauses, and conversational words and phrases. However, it was challenging to retranslate into a corrected paraphrase and maintain the integrity of the affect during the conversation, which contributes to what might otherwise seem as spoken Portuguese/English. Thoughout all the translations, the reader should consider content, meaning, linguistic relevance over grammatical precision in translation.
ser bom e tudo”. Mas quando é a mulher negra eles são mais agressivos: “Ah, suas putas! Vocês querem morrer? Vá procurar um homem!”’. Isso quando é mulher negra. Se no dia a dia já tem desrespeito, quando é mulher negra lésbica o desrespeito é maior. Eu acho que mulher negra, lésbica, está passando muito por essa marginalização. Se a mulher negra é lésbica sofre mais do que as mulheres brancas que são lésbicas. E podem estar no mesmo contexto social. Apenas por ser negra, acaba sofrendo mais, sendo mais desrespeitada.

Though I had not explicitly questioned Arlete about her opinion regarding white lésbicas, her strong differentiation between the two categories gestured to a very particular form of marginalization as a black lésbica. Though many lésbicas negras I spoke to were acutely aware of Daniela and Malu as white women, this difference was not driven home for me until another nationally-famous singer, Ellen Oleria, came out with her lesbian partner to a very different reality. Ellen, a dark-skin young woman from Brasilia, won the nation-wide Singer for the Stars competition. Having won R$500,000 and national acclaim, she had “made it.” Despite this acclaim, some months later, she appeared numerous times in the news again, this time accusing an apartment manager for discriminating against her and her partner and denying them housing. To Ellen, her experience screamed preconceito (prejudice) on the basis of her being black and gay, not just gay. The media coverage of these events, and the conversations that I had about them with my informants, open up onto several of the key questions of this dissertation. What does it really mean to be a lésbica negra, particularly in Salvador? What are the possible expressions of sexual freedom for black folks? In a context where blackness is held as dispensable and inferior, and yet homosexuals are readily accepted when engaged in normative practices such as marriage, how do lésbicas negras negotiate their homosexuality socially, specifically in the gynecological context?

3 Throughout the dissertation, I refer to my key interlocutors as lésbicas negras (black lesbians). It is the primary, often only, identity used by them and within public documents and discourses for categorizing combined racial and homosexual/gay identities. Queer is not a term that any of my interlocutors espoused.
This is a study of the social complexities (Law and Mol 2002; Mol 2002) that impact lésbicas negras’ quotidian lives in Salvador. By analyzing the formation of these women’s racialized sexual subjectivities, I seek to understand their struggles for existence and sexual freedom, struggles that are intimately tied to their social well-being as black women and Brazilian citizens. The lésbicas negras with whom I lived and worked strive for a holistic well-being in ways that produce unique forms of negotiation within the gynecological context. My central thesis is that these lésbicas negras pursue, first and foremost, recognition as ethical subjects (Davis 2012; Faubion 2010; Foucault 1985) by gynecologists. This dissertation, then, is centered on an ethnographic investigation of the bio-cultural ethics of lésbicas negras, an ethics that reveals itself sharply during gynecological consultations. However, while crystallized there, an investigation of their ethical practices must comprehensively investigate the social construction of their lives as marginalized racialized sexual subjects and citizens.

Therefore, I pose several supporting arguments in this dissertation. First, I argue that many lésbicas negras’ pursuit of what they believe is their human right to openly reveal their sexuality and integrate it into quality gynecological care and health education from their physicians is informed by their deep-felt ethical obligation to confront wider social issues of “preconceito.” Preconceito, which literally translates as “prejudice,” is a local Brazilian term for the ability of preconceived ideas to materialize micro-social inequalities, and, in this specific case, to create barriers to effective and affirming doctor-patient interactions. This project, then, offers a look at some strategies for achieving social well-being in a context saturated with preconceito toward skin color, homosexuality, poverty, and more. I contextualize particular strategies that help these women conceive themselves as agents of their well-being as
black women, homosexuals, and as bodies historically and continually marginalized, as a population afflicted with economic, political, and health disparities.\(^4\)

Theoretically, I understand the ethical here as a domain of relationships that my key interlocutors have primarily with themselves (although these relationships are always also intersubjective). I interpret such relationships to the self to turn on my interlocutors’ understandings of the impact that the freedom to speak about their sexuality, particularly as consumers of healthcare, has upon their well-being. Well-being is not just a catch-all term without a precise meaning, but takes on a particular, positive content in these women’s lives (cf. Veenhoven 2005:5). To understand this content, my project centers on the thick description of the lifeworlds of several key interlocutors, and on their striving towards recognition by their gynecologists as agents of their own well-being. The relevance of their sexuality to gynecological care becomes a central point of negotiation of their human rights in this context; they understand their holistic, social well-being as deeply and essentially involving their own care for their sexual health. Thus, I argue that lésbicas negras become ethical subjects in both gynecological and every day contexts where they strive toward this well-being. Their practices demonstrate complicated relationships between sexual health, sexuality, well-being, and freedom (libertade). These practices are part of a self-reflexive ethical strategy, and must be considered in the fullness of these women’s lives. As such, I investigate these women’s pursuit of recognition and sexual liberty at multiple scales: in public discourses, micro-social quotidian experiences, and social interactions. This ethnographic approach shows that lésbicas negras’ ethics are socially complex, cutting across issues of sexual health, medical best practices, sexuality, race, social well-being, citizenship, and freedom (libertade).

\(^4\) I have surveyed many printed materials, which document significant health, economic and political disparities in Salvador-Bahia and the Northeast discussed in Chapter 1.
In Brazil, the related medical structural norm and practice that guides and enforces what constitutes discussions of sexuality with the gynecologists are beholden to the normative use of sexologists, who by large, are gynecologists who further specialized in sexology. Gynecologists would not ordinarily have to discuss issues of sexual dysfunction, for example, that might compel gynecologists to discuss and engage sexuality and in these cases, female homosexuality (*homosexualidade feminina*). My interest lie less in how medical issues and pathologies such as sexual dysfunctions are directly impacted by the challenges or open opportunities to reveal one's homosexuality. Again, I am most interested in what constitutes the pursuit of such opportunities to be engaged with one's homosexuality in order to achieve affirming interaction. The questions I continue to pursue are whether ethical responsibility on behalf of the patients (*lésbicas negras*) are a dimension of mode of subjectivation that would invite and inflect a sense of sexual legitimation within the gynecological purview of practice and interaction. How does such dimensions of ethical responsibility toward the self and imposed by medical infrastructure help define mode of subjectivation(s) and depth of biopolitical norms and values that impact sexual expressions and identifications during such modes of experiences?

**Field Site and Methodology**

*Thematic Evolution*

My research questions substantively evolved over the course of both fieldwork and the writing process. Starting with questions of gynecological practices, sexuality, sexual health, and perceptions of identity among *lésbicas negras*, the research slowly took on a web of other, interrelated themes such as *preconceito* (prejudice), *bem-estar* (well-being), *condições* (social conditions), and citizenship. Throughout the project,
to produce data about these thematic interests, I focused on: (1) patient-gynecologist
dialogue and interactions, particularly with respect to the prevention of sexually
transmitted diseases and conception, which are highly stigmatized topics; (2)
edembodied perceptions and their relation to understandings of sexual health, sexual
liberty, race, and racism; (3) subjective evaluations of medical procedures that
particularly impact lésbicas negras; (4) the meaning and uses of preconceito; (5) the
social, cultural, and religious practices by which lésbicas negras enact their sexual
health and contest gynecological marginalization.

Field Site

My field site is Salvador-Bahia, Brazil. Before beginning major fieldwork, I
had been traveling to Salvador from 2007-2010. During these earlier trips, I became
very familiar with local social movements focusing on race, violence, women’s rights,
and lesbian issues. During summer 2011, I conducted preliminary dissertation
fieldwork to begin to explore the topic of gynecology and black lesbians, in light of
then-recent national government proposals to address Lesbian, Gay, Bisexual, and
Transsexual/Travesti (LGBT) healthcare issues. Salvador is Brazil’s Afro-cultural
center with the highest black/brown racial demographics (56% brown, 28% black, and
17% white) in the country (Kraay 1998). It is also the third largest city in Brazil, with
a population of nearly 3 million, situated in the poorest region of Brazil, the Northeast.
Despite this poverty and high rates of human trafficking, domestic violence, and
violence against LGBTT persons, Salvador still attracts significant tourism. Many
national social movements for the rights of blacks, women, and gays, and against

5 Lesbian, Gay, Bisexual and Transgender is only partial appropriate category of queer identities for
Brazil because transgender (or transgenero) is not near widely used or represented by individuals or in
public or academic documents. Whenever I refer to LGBTT, it stands for Lesbian, Gay, Bisexual and
Transsexual/Travesti (Lésbicas, Gays, Bissexuais, Travestis e Transexuais) representing the list of
identities most commonly used in Brazil. Travesti usually refers to persons who consider themselves
women but do not want a sex change while transsexuals refer to those who have had sex changes.
religious intolerance, originally emerged in Salvador (Matory 2005). Brazil’s oldest gay organization (1982), Grupo Gay da Bahia (GGB), was founded in Salvador. GGB ensured that Salvador became the first municipality to institute a law against discrimination on the basis of sexual orientation in 1997.

Salvador also has the largest population of black lesbians in the nation, and yet measuring or assessing this significant demographic quantitatively poses challenges, which are themselves worth exploring analytically. Most of these women are difficult to seek out publicly, because Salvador offers very few public spaces for them to congregate and openly express their sexual identities. However, exceptional social conditions allow for their abundant, albeit scattered, public presence arise during the summer months, when most residents enjoy Carnival (Salvador has its own Carnival featuring Afro-Brazilian and Bahiana music), out-door social fiestas (parties), and concerts. In addition, Candomblé houses offer some communal spaces for lésbicas negras to congregate, but even there, many will remain closeted to their senior members. There are far more spaces for white lesbians and black gay men to gather publicly. The hidden and scattered ways in which lésbicas negras do manage to create community makes Salvador a unique and significant field site. Because of these dynamics, my research also explores how lésbicas negras can at once confine themselves within semi-private/semi-public spaces, in order to personalize their social relations and engage in self-care, and yet be strongly impacted by public, gender-normative discourses of sexual health (Gregg 2003).

Porto Alegre: I visited Porto Alegre for a week in May 2013. It is located in the most Southern area of Brazil. I interviewed some of the lesbian health movement activists and researchers to assess the progress of the nation’s first 2011 municipal health policy and agenda promoting lesbian health (Prefeitura Municipal De Porto Alegre,
This trip provided a perspective on the racial and class divides affecting Salvador and lesbian health by assessing Porto Alegre’s local lesbian communities and the support they receive from the government, depth of financial stability compared to Salvador, and their available resources. In contrast to Salvador, Porto Alegre has already responded with its own 2011 lesbian municipal health policy. However, Porto Alegre has racial demographics of 79% white, 11% brown, 7% black, and also a high rate of employment, a surplus of doctors, and the nation’s greatest number of private insurance holders. Salvador’s strong history of gay activism, including LGBTT related health movements, is undermined by critical racial and class divides that leave lésbicas negra there at a disadvantage. Ultimately, my visit findings suggested that the municipal agenda was in fact paralyzed because many physicians resisted its purpose to define quality healthcare. The activists in the forefront of these efforts stated that many physicians argued that the agenda poses marked challenging ways to distinguish how to provide care to homosexual women in contrast to heterosexual women. The activist argued that the physicians could not adequately interpret that addressing homophobia and preconceito were at the heart of the municipal agenda. These findings helped me question to what extent a municipal agenda in Salvador would be more embraced than in Porto Alegre.

Interviews and Interlocutors

Women wanted to talk. However, I did not take for granted that almost all of the women who I interviewed openly shared, in an incredible amount of detail, their private lives. I interpreted their openness as a sign that the topic was extremely significant for them. I conducted over 60 interviews.
Lésbicas Negras: I interviewed 23 women, and spent a great deal of time with approximately 11-12 of those women. These women self-identified as lésbicas negras (black lesbians). Some of my criteria for selection included their being: (1) out with their sexuality in all realms of their lives, (2) aged 25 and above (ages ranged 25-51), (3) native to Salvador (though one was a transplant from Pernambuco, Recife). As a result, most of my interviews were obtained from snowballing process that started with women who I had met during prior trips. While I also attempted to solicit interviews independently from the snowballing sample, most of the time the interviews never took place, either because the women could not travel to meet with me or we simply lost communication (often due to the horribly unreliable cell phone systems in Salvador). Most of my key interlocutors have some level of formal education beyond high school. They also generally have private health insurance, are gainfully employed, and earning above the minimum wage. Most of my key interlocutors are what I would consider upwardly mobile women whom can acquire higher income well above the baseline monthly salaries in Salvador. Also, they may have a profession, significant political exposure compared to most black lesbians in Salvador, and educational training from college to doctoral studies. These areas of access enable them to maintain private healthcare, most or all of the time. However, most of these women come from poor and large families and participate in caring for their families in different ways. Others daughters of middle class black families whom might benefit from some level of resources but their desire and striving for independence pose many personal challenges and survival hustles. Their particular access in such varied ways sets them apart as key interlocutors in this research and deeply informs their life strategies, which I discuss in this dissertation.
Gynecologists: I interviewed 10 private physicians in Salvador: 7 gynecologists, 2 sexologists trained in gynecology, and the head of department of gynecology at Hospitais das Clinicas. Among these physicians, two were black women, two were white men, and 6 were white women.\(^6\)

Centro Estadual Especializado em Diagnostico, Assistencia (CEDAP) is a System Unico de Saúde (SUS)\(^7\) clinic in Salvador that provides health services for Sexually Transmitted Infections and HIV/AIDS. It is also a research center. During May-June 2013, I was able to get into the clinic through its research team, and interview approximately sixteen staff (physicians, nurses, and social workers). I was referred there by one of the private gynecologists who had worked in HIV care in the city. I considered it important to have an insider view of SUS, given the strong distaste of my interlocutors for SUS care. Also, all of the private gynecologists who I interviewed either currently work for SUS as well or have worked for SUS in the past. It was valuable to spend time at CEDAP, as I was able to take a closer look at the patient population profiles, the routine at the clinic, and gather varying perspectives from the staff on the lesbian population.

**Participant Observation**

While in the field, I often questioned whether I was actually doing ethnography. However, an anthropologist friend assured me that “ethnography is whatever you define it to be.” Being familiar with the range of approaches to ethnography and theory presented in *Queer Methods and Methodologies: Intersecting Queer Theories and Social Science Research* (Browne & Nash 2010), I was prepared to “follow the people and themes” (Marcus 1995) in order to gather as much

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\(^6\) Although most of my key gynecologist interlocutors chose to self-reveal their name, I have given all but one a fictitious name.

\(^7\) Sistema Unico de Saúde (SUS) also known as the Unified Health System is Brazil’s national government healthcare system created in 1990 after the nation’s 1988 constitution was created. It offers free healthcare to all citizens.
information and understanding of my inquiries contextually. If ethnographic methods are what we make them participation observation for me included every moment spent simply living with my interlocutors, my travels around the city, and attendance at as many events (academic, political, social) as possible, whether held in homes, public institutions, the streets, or other social spaces.

Survey

I conducted a survey of 20 young women who played soccer. Almost all of the women on the team were lesbians including their female coaches. Although I do not focus upon women and soccer in this project, it was particularly interesting to construct a survey instrument that inquired into identity name preferences, health and healthcare questions, and social backgrounds. Above all, I was able to interact with the young women on several occasions and enjoy the scene of Brazil’s most favorite sport played by young lesbians: soccer.

Windowing as Method

Methodologically, I craft my ethnographic writing through a technique that I refer to as windowing. Windowing is both a stylistic choice and an analytic approach designed to bring together the interviews, casual experiences, printed materials, floating discourses, and ephemeral social-political events that took place during my fieldwork. It is a compelling way to literally and metaphorically frame views of the complex experiences that arose during fieldwork, lésbicas negras’ lives within Salvador and its cultural and political climate, and the Brazilian social and medical contexts. In short, this framing (enquadramento) is a means to render visible the nuances of these women’s stories. Windowing is a written process by which to balance the weight and meanings of my different sources of my data (interviews
transcripts, demographic categories, circulating documents, institutions, ideas) in order to narrate an interpretation of what it means to become an ethical subject in the Brazilian context. In Chapter 4, I explain in more depth how this windowing process emerged for me in relationship to a concrete window in my apartment where many of my interviews took place.

The Film

My dissertation is also shaped by film footage that I produced while in the field. On camera, I conducted 16 interviews, which included re-interviews of several key interlocutors, a black female gynecologist, and Candomblé leaders. My intent was to address my research questions through film to elicit visually, more specifically, and in a more nuanced way how and why lésbicas negras draw upon their sexual, familial, political, and, critically, religious worlds for re-imagining their sexual health and well-being. The film project unveiled several particular forms of ethical striving. The process of filming turned into a project of appreciating how these women forge the ethical over time, through the moments in front of the camera. Telma, in particular, had a profound ethical relation to the camera, although not in the way that I had initially expected she might. In fact, I was shocked to hear Telma decline to be in the film, because she did not want to be recorded on film speaking as an out lesbian, given her pursuit of a career as a television actress. The news also took Erica, her casada partner by surprise; it was in contradiction with Telma’s stated commitment to sexual freedom, and with the ways in which she routinely confronted racism and heterosexism even as she strove to find work as an actress. As the months passed and Erica and I moved forward with the film plans, however, Telma’s relationship to the film project slowly evolved, in part due to her wrestling with some professional
disappointments. After several months, she approached me one day with tears of joy and release to tell me that she was ready to be free of her fears, to join the film project.

**Theoretical Underpinnings**

*Sexual Subjects and Bio-Culture in Brazil*

Jessica L. Gregg’s *Virtually Virgins: Sexual Strategies and Cervical Cancer in Recife, Brazil* (2003) has been central for me in thinking through subject formation in Brazil, particularly how it links female sexuality, medical institutions and practices, public and local discourses, and sociocultural norms and processes to produce particular forms of women’s agency. Gregg’s work focuses on “the conflict between cultural ideals of Brazilian women’s sexuality and the lived reality of sex for impoverished Brasileiras in the Brazilian Northeast,” examining the “interplay between sexual expectations, sexual reality, and disease in that same context” (Gregg 2003:3). Furthermore, she argues that “by focusing on women’s understandings and uses of their own sexuality, she claims that impoverished Brasilieiras are constrained by larger cultural expectations of female sexuality and manipulate those expectations to meet their own needs” (2003:4). Gregg’s ethnographic work reveals how women use strategies that draw upon the “dominant cultural constructions” of sexuality and gender to establish relationships to their own sexuality. As a medical anthropologist and physician, she demonstrates how her interlocutors interpret such dominant cultural views of female sexuality and in turn shape their “sense of agency,” even if sometimes in ways that have “deleterious ramifications for women’s health” (2003:4). My work takes inspiration from how Gregg’s ethnographically rich analysis of female sexual subjectivity establishes critical links between women’s lives, public discourses, and the medical setting. Through reflecting on Gregg’s methodology and her
analytical scaling between micro and macro issues, I developed critical ways to
demonstrate how racialized sexual subjects reinterpret the “dominant cultural
constructions” of female heterosexuality that overshadow female homosexuality in
the gynecological setting and beyond (2003). Like Gregg, I aim to tease out women’s
understandings of female homosexuality through their medical and social narratives,
seeking to understand how their “sense of agency” shapes their pursuit of social well-
being as black women.

Furthermore, Gregg focuses on how the medical establishment participates in
a “blame and risk” agenda, casting women’s sexuality as “dangerously excessive for
the spread of disease such as HPV which causes cervical cancer” (2003:43). While
my work does not explore female sexuality construed as a dangerous vector of disease,
a different notion of “blame and risk” repeatedly appeared in conversations with both
lésbicas negras and gynecologists. That is, most gynecologists hold lésbicas
responsible for disclosing their homosexuality or same-sex practices, if they are to be
treated with full recognition. I demonstrate that gynecologists either justify their
awkwardness or discomfort with engaging the homosexuality of their patients as
seeking to protect patients’ privacy. This might be an even exchange for some women
in Salvador, especially in the CEDAP SUS clinic where I spent some of my time.
However, for my lésbicas negras interlocutors, what mattered was being recognized
as patients having a legitimate sexuality, engaged in an open and appropriately
handled consultation and conversation, just as would be heterosexual women. Here,
the “blame and risk” game can be viewed as shifting the blame onto these women for
not receiving a properly affirming of even medically satisfactory consultation if they
do not immediately and voluntarily reveal their sexuality. However, this attitude by
physicians puts these women in a double-bind, as all of my interlocutors argue that
when they do reveal their sexuality, they are exposed to preconceito and put at a risk of psychic and physical trauma, or at least poor care. They emerge as ethical subjects, then, insofar as they actively negotiate the relationships of the gynecological space through a system of practices and values that turn on the notions of quality social interactions, affirmation of their bodies and self, and social well-being (bem-estar). Their ethical demand is for recognition as black lesbians deserving of their civic and right to quality healthcare (particularly when they are paying for it!). These are the negotiations that I highlight in this dissertation.

Throughout my fieldwork, many women stated that their homosexualidade ought to be respected and treated humanely. Indeed, understanding their demands became central to my research project. However, I constantly sought to understand why homosexuality was experienced by these black women as rendering them voiceless, invisible, and disposable in a city with vibrant, over-30-year-long history of LGBTT activism. Indeed, the national sexual political movements around the issue of homosexualidade (homosexuality) in Brazil are advancing, proliferating, and gaining more recognition than ever. Many of these movements began in the 1980’s, the era of the emergence of the HIV/AIDS crisis, which thrust the issue of male homosexuality and its visibility onto the national stage (Parker 1991). Richard Parker’s early research on “Brazilian sexual culture” made important strides toward understanding the links between cultural meaning and power as they relate to the study of sexuality and gender (1991). While I do not here follow Parker’s interest in studying “dangerous desires in modern medical and scientific thinking” (1991:4), I do take his lead in understanding gynecology as offering a complex window into Brazil’s “sexual universe,” offering us the opportunity to understand how homosexuality is permitted or prohibited within specific social hierarchies and imaginaries. In other words, by
taken a closer look at the interactions and exchanges between lésbicas negras and gynecologists, my research follows Don Kulick in studying how “gender is grounded not so much in sex as it is grounded in sexuality; and such grounding allows and even encourages the elaboration of cultural spaces” (1997:575). In this vein, I demonstrate that much of the dissatisfaction my lésbicas negras interlocutors reported is due to the highly porous nature of professional boundaries within clinical settings, with broader heteronormative structures impinging upon medical practices in ways that stigmatize their sexuality. However, my undertaking grounds gender in sexuality to the extent that I point to gynecology as an entrenched space and practice of desexualization, of removing the person from their body parts and sexuality until the consultation ends (Kapsalis 1997; Henslin and Biggs 1971). These palpable crevices in gynecology are the loci of negotiation for the ethical subjects described in this dissertation.

I began to pay greater attention to the “cultural meanings” (Parker 1991; Kulick 1997; Gregg 2003; Mol 2002) attached to homosexuality in myriad ways. My approach is similar to the strategies employed by David Valentine in Imagining Transgender: an Ethnography of a Category (2006). By being careful not to take for granted how the term homosexuality is deployed by Brazilian citizens, I began to learn a lot more about the political, ethical, and social implications of vivendo minha homosexualidade (living my homosexuality). Following Valentine, I approached homosexuality as an “analytic category” in order to assess its “partial connections” to other social categories and processes (Strathern 2004). Since I was also seeking to understand preconceito as a local theory, as a concept heavily associated with the materiality of social inequities, my ethnographic focus on lésbicas negras’ social well-being required an in-depth investigation of their how their lives as individuals and as parts of social collectives were shaped by their broader political-ethical context.
This focus shifted my ethnographic scrutiny to the ways in which “racial or class experiences can shape and reshape what gender and sexuality themselves can mean, as intersecting as they may be” (Valentine 2006). I set out to understand sexuality as something more than simply a tool of oppression (Valentine 2004; Rubin 1984).

The national and local efforts to eradicate (or at least lessen) homophobia were often disrupted by events that demonstrated just how deeply preconceito against homosexuality was entrenched in Brazil, despite efforts to eradicate it. Homophobia is understood by Brazilians as deeply and more-or-less openly entrenched in the medical and other professional settings; the national government instituted a national directive, titled Brasil Sem Homofobia (Brazil Without Homophobia), that would require all professionals “not treat homosexuals as abnormal or discriminate against them.”8 And yet, during my fieldwork, there was an attempt to pass a bill referred to as “Cura Gay” that would allow for psychotherapy to “reverse” homosexuality. As I made connections between the local and national arenas, I became more interested in interpreting the commitment to combating preconceito that was so evidently present in the discourse of both the government and human rights NGOs. In this vein, my research aims to chart the links between ethical practices and subjectivities (Davis, 2011) and these broader discourses. In Homophobias: Lust and Loathing across Time and Space, David A.B. Murray argues that “while homophobia has understood as a fear or hatred that resides in an individual’s psyche, anthropological research has demonstrated that homophobia is a socially produced form of discrimination located within relations of inequality as well as through a range of attitudes” (Murray 1999:3).

While anthropologists such as Murray rightly argued for a broadening our scope of investigation to include structural discrimination, my research shows that the

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8 This is a public document produced by the Ministerio de Saúde/Conselho Nacional de Combate a Discriminacao, 2004.
homophobia encountered by lésbicas negras at the gynecologist’s is based more concretely and specifically in preconceito (prejudice and biased attitudes) than discrimination itself. Gynecological consultations for these women are often experienced as very mechanical and indifferent, particularly when they have openly identified as lésbicas, despite their being compliant with gynecological best practices; the very routine character of this medical examination makes it challenging for these women to identify any actual discrimination in these settings, at least when services themselves are not being withheld.

I do not queer this dissertation nor apply queer as an analytic. Given the ways in which I have defined the use of categories such as “homosexuality,” I have chosen not to interpret my data through queer methodologies, per se. Instead, I explore “homosexual identity” (Wekker 1999) in ways that allow me to render visible local and national understandings of racialized sexual identities. My interlocutors do not identify with or use the word queer. I did, however, have the pleasure of meeting the queer theorist Jack Halberstam in Salvador in August 2012, when she was the plenary speaker for a conference at which I was presenting, the VI Congresso Internacional de Estudos Sobre a Diversidade Sexual e de Genero da ABEAH. Then, one day shortly after the conference, one of my interlocutors, asked me, out of the blue, “what is queer?” Given that Judith Butler will be the plenary speaker in 2015 for another conference in the region, I believe that queer in all its hegemonic contours will soon arrive into the sexual politics of Brazil. Until then, however, I have found the anthropology of LGBT issues more useful for understanding and interpreting my empirical data. That is not to say I have drawn no inspiration from a queer anthropology, which informs this work through reference to ethnographies that demonstrate how we might “clarify and distill” the invisible status of gendered and
sexual subjects (Kulick 1998). Queer anthropology promotes generating nonconforming gender analysis that takes seriously “the intersectionality, inclusion and difference” characteristic of “female non-normative sexualities” and “the interplay of categories that represent gender and sexuality” (Boellstorff 2006; Valentine 2006; Weston 1991; Lewin 1993). Even with the influence of a queer anthropology, then, a focus on the politics of women’s health and women’s subjectivities (Inhorn 2006) remains a viable intervention.

The Ethical

To the extent that lésbicas negras are able to engage in voluntary practices of self-formation, they are engaging in “ethical acts” (Lambek 2002). My study of lésbicas negras’ ethics highlights focuses on “why people do what they do,” and how through forms of “radical ethics” people ask reflexive questions of themselves about the conditions and limits they seek to surpass (Dave 2010). My work contributes to the growing body of anthropological investigations of ethics through a biocultural study of the how processes of reflexive self-formation and domination alike come together to mark and impact lésbicas negras within the Brazilian gynecological system. I draw upon the anthropology of ethics to understand how lésbicas negras emerge as “ethical subjects” within the specific domain of gynecological experience (Faubion 2011). A key component of their subject formation is engaging openly in liberating and healing practices in pursuit of their social well-being. This is one reason for focusing on women who are "out" in their lives. However, this investigation will mean reflecting upon the analytic use of the term of “agency,” as well as reformulating how responsibility (to our bodies, for example), mirrors ethical “acts” (Laidlaw 2010; Lambek 2010). Dealing with ethics is inevitable in my work
because the sexual subject, who but develop self-reflexive responses to a myriad of “insults” both inside and outside the medical care system (Eribon 2004), brings these cultivated responses along with them into the examination room.

Carefully articulating the outlines of these ethical subjects is important and tricky, as women shift back and forth from liminal spaces into more visible medical space where they forge authority over, or “ethical activity” (Lambek 2010) toward, their bodies. Thus, question of self-care and the conditions that enable some subjects to become public advocates of sexual freedom become critical. Assessing structural violence is challenging if “meaning and structure” or the “sexual subject” is not unraveled from its power relations (Farmer 2003; Dressler 2007; Parker, et al. 2000; Janes and Corbett 2009). The “ethical subject” provides a theoretical and conceptual groundwork for situating and studying the processes by which racialized sexual entrapments and subjugations can be actively negotiated both in the medical context and daily life through forms of ordinary ethics, or, more specifically to this study, therapeutic ethics (Faubion 2011; Lambek 2010; Foucault 1985). By drawing upon an anthropology of ethics to analyze social discourse and interactions in gynecology, I expand the field by looking at under-studied ethical aspects of healthcare. For many lesbians in Brazil, the notion and practice of coming out is intimately tied to their ability to access modes of freedom; avoiding or responding to the insults that preconceito(s) generate is a critical part of this coming out, and is never accomplished once-and-for-all, but becomes a part of daily life. The “themitical,” is the domain of the reproduction of system structure(s) and norms within the ethical field (Faubion 2010). As such, it is a crucial site for understanding how the social and medical domains are intertwined with and accountable to broader modes of social production and forms of ethical subjectivity. If the ethical needs to be understood as a domain of
relationships to self and other, then the dynamics of these relationships inform a particular set of ethical practices. In this case, these practices aim toward the acquisition of well-being and human rights as and by openly black gay women. I interpret these women’s relationships to their selves to be structured by understandings of the impact that the freedom to speak about their sexuality, particularly as consumers of healthcare, has upon their wellbeing. These reflexive relationships are tied to their approaches toward claiming recognition, human rights, and respect by the gynecologist. These approaches in turn produce feedback, perceptions, experiences, and interactions that are critical to recognize, anthropologically speaking, if we are to understand these women’s striving for well-being. I end this introduction by bringing together my overarching ethical framework with a materialist analysis of enabling conditions under an analytical concept I coin as the gineco-etico, or gyneco-ethical.

Combating Racism, Protecting My Religion

My interpretation of racialized sexual subjectivities has relied upon the study of racial identity and race relations in Brazil and the U.S. This research has been an ongoing challenge in Brazil due to the ways in which Brazil’s nationalist ideas of race continue to reflect a historically produced national vision “racial democracy” (Telles 2004; Sansone 2003; Heringer 1995; Daniel and Haddow 2010). Race scholars from both Brazil and the U.S. have documented the challenges and importance of researching how the “pervasive miscegenation and the lack of formal legal barriers to racial equality contributed to [Brazil’s] image as a ‘racial democracy’” (Daniel and Haddow 2010). Among the early U.S. scholars to contribute to this racial ideology was Charles Wagley, the first U.S. anthropologist to write about Brazil’s “racial
democracy” on the basis of his fieldwork in Bahia during the 1950’s (Wagley 1952). Wagley uncritically suggested that “Brazil … renowned in the world for its racial democracy … has no race problem. Brazilians have equal rights and advantages” (Wagley 1952:7). Anthropologist Ruth Landes agreed with Wagley that Brazil has “no race problems” (Landes 1947:xxxvi). Wagley and Landes, among others, shared what remains a problematic approach for scholars of today: explicitly comparing their Brazilian observations and conclusions about “race relations” to that of U.S. during their time; their analysis was also shaped by the ways in which U.S. scholars were beginning to critique contemporary domestic race relations (Pierson 1942).

Despite these claims, it is obvious that Brazil has a race problem. In the late 19th century, there were a series of campaigns designed to “erase Brazil’s past of slavery and pollution of a moral atmosphere” (Ramos 1939). Perhaps chief among these, Brazil’s 1891 constitution institutionalized a mandate for all national and local documents related to slavery, slave children names, and plantation records and more to be burned” (Ramos 1939). This was truly a catastrophic moment in Brazilian history, launching a neutralizing and sanitizing process of the historical and contemporary racial divisions across the nation. Unfortunately, the work of renowned Brazilian historian Gilberto Freyre further mobilized these ideological movements, cementing them with his praise of Brazil’s “racial democracy.” Although his efforts were meant to combat the many history of racism in the country, it instead forged a national and political color-blindness that prevented understanding racial difference as a root cause of social inequality (Daniel and Haddow 2010; Telles 2004; Sheriff 2001; Freyre 1986).

The scholarship on Brazilian race and racial inequalities is critical to my project as healthcare disparities, particularly in the Northeast of Brazil, continue to reflect not
just class or socioeconomic differences but racial lines, with large populations of black and brown Brazilians having limited access to healthcare and other social resources (McCallum and dos Reis 2005; Gregg 2003). Interrogation of how racialized attitudes within healthcare affect and alienate lésbicas negras, who also have to contend with the affects and effects of homophobia in medical care, is a central goal to this project. Since race and religion are intersecting categories for the many lésbicas negras in Bahia who practices Candomblé, I also offer an in-depth discussion of how Candomblé can offer a lens through which to understand racial, gender, and sexual categories and their role in shaping sexual health. My work builds on anthropological studies of race that examine how language and cultural meanings construct and allow people to inhabit “legitimate” racial identities, and to contest the racism that exists both in public places and at home (Sheriff 2001). This process is most obvious in how marginalized groups create territorial and epistemological communities for themselves as a consequence of their subordinate location within the bourgeois public sphere (Hanchard 2000). The Candomblé terreiro (temple) is one of those “alternative spaces of blackness” (Sansone 2003; Harding 2000) that “[prove] to white Brazilians that [black Brazilians] can organize in response to racism in a land of racial democracy” (Hanchard 2000; Guimaraes 1999). My investigation of the intersection of racial discrimination with gender and sexuality will contribute to the ongoing debate about and efforts to critique “racial democracy” and the desirability of a “color-blind” society.

The Medical as a Political and Discursive Realm

In Matters of Life and Longing: Female Sterilisation in Northeast Brazil, Anne Line Dalsgaard (2004) offers an extremely critical and compassionate analysis
of how socioeconomically women in Recife resort to practices of reproductive sterilization for myriad reasons, from politicization by the state as well by the lack of medical control of sterilization practices. The significant comparison that Dalsgaard offers me is here is with the analysis of her subjects’ desire for “recognition” (2004: 25) which turns on feelings of shame, desires to be happy, longings for control over one’s life, experiences of trauma and of exploitation by the medical system. The ways that lésbicas negras navigate the gynecological system in order to ensure recognition for their sexual subjectivities is a similar striving for recognition.

Hayes argues that “gendered norms of respectability function as constituent elements within a local moral topography that relates bodies and spaces and regulates their interactions” (Hayes 2011:96) L.A. Rebhun’s work confirms this insight in the Brazilian context, demonstrating the range of ways in which Northeastern Brazilian women manage, negotiate, and perform their different emotions in the face of normative, patriarchal control as well as class and racial difference in order to sustain everyday life with agency and even creativity (Rebhun 1993, 1994, 1995). Rebhun’s work, brought together with Brazilian medical anthropology, helps us to understand how Brazilian women mobilize gendered cultural meanings and agency in the face of inequality (2004).

Many black women activists are very clear about the “impact of racial discrimination and social exclusion on the health status of Afro-Brazilians; the concerns of the movement in the 1980’s focused on reproductive rights but as it progressed and developed an intersectional approach to advocating health justice for black women, topics about fibroid tumors, sterilization, and maternal mortality were placed to the forefront of discussions” (Caldwell 2009:118). My research builds on Caldwell’s analysis of black women’s lived experiences and processes of subject
formation (and activism) in Brazil as a way to treat race and gender as intersecting categories of identity and social experience (Caldwell 2007), although my work focuses specifically on the health issues and modes of agency related to same-sex sexual experiences and medical care. Caldwell’s work does not focus on the health issues that permeate the lives of black women; neither does it take into account the role of same-sex sexuality in dynamics of oppression and agency. However, Caldwell’s work establishes the importance through cultural and subjectivity formations the impact of racial identity and experiences for black women in Brazil (William 2013; Khan-Perry 2013; Allen 2011; Caldwell 2007).

I also give considerable attention to the ways in which “etico-politico” strategies are imbricated in governmental efforts to address both racial and homosexual preconceito, specifically in the amelioration of health and other social disparities. Since 2010, the Ministerio de Saúde based in Brasilia, where federal governance policies are made, put forth a national health reform to “eradicate homophobia and discrimination against its Lesbian, Gay, Bisexual and Transsexual/Travesti population,” with the specific goal of improving access to and the quality of healthcare for these vulnerable subjects. In Body of Knowledge, Wendy Kline (2010) surveys the history of women’s health in the United States in relation to gynecology and the pelvic exam. She states,

“Until recently, the pelvic has received little historical analysis-those who study the history of women’s health are more likely to investigate abortion or breast cancer, for example, than a routine gynecological procedure…The pelvic offers a fascinating window into the dynamics of the relationship between doctors and patients, as well as the blurred boundaries between sexuality and medicine. Though the procedure itself is routinely performed on healthy women in a supposedly sterile environment divorced from outside context, it is in reality loaded with context and meaning” (Klein 2010: 43-44).

The pelvic exam is a window into the social dilemmas entangled with interactions between lésbicas negras and gynecologists. Most women, but perhaps lésbicas in
particular, arrive at the gynecological clinic with already existing attitudes and perceptions that can shape the actual experience of the pelvic exam. These subjective webs are tied to an array of insecurities, desires for privacy, taboos, fears of intimate violence, hopes for sexual freedom, and other affective possibilities (Kline 2010; Martin 1987). For these reasons, I scale between micro and macro deployments of *preconceito* in order to reimagine formations of citizenship as they emerge in institutional, heteronormative medical environments, which in my research populations invokes particular ethical negotiations regarding racialized sexual subjectivities.

My research contributes to medical anthropology through an examination of the relationship between medical and social-cultural understandings of sexual health, particularly in terms of the meaning of “self-care.” I have drawn widely upon the medical anthropology literature to provide a lens through which to understand the production of diverse patient knowledge about therapeutic markets and healthcare settings (Csordas and Kleinman 1990; Petryna et al. 2006; Nguyen 2010; Behague 2009; Race 2009). This scholarship is especially salient to my project in its analysis of medical-patient reasoning and issues of selection and privilege (such as engaging in “triaging” to determine who will have access to care) (Lakoff 2005; Race 2009; Nguyen 2010). My project makes a new contribution to this body of theory with its analysis of the disconnections between gynecological and racialized lesbian medical subjects’ interpretations of sexual health. This links well with, but specifies in important ways, the scholarly recognition that black women in Salvador take an active, agential role in their own healthcare and healing (McCallum and dos Reis 2005, Gregg 2003). What is most important to capture for me here are the unique ways in which *lésbicas negras* navigate the gynecological context: it cannot be taken for
grant that they share the same experiences and demands as either white lesbians or heterosexual black women (Cohen 2005).

A consideration of the materiality of the power dynamics and understandings of sexual health (Hennessy 1993) that emerge through gynecological experiences for lésbicas negras allows us to understand whether and to what extent biomedicine – its knowledge practices, policies, equipment, and language – transform the lived realities of marginal medical subjects. Healthcare reformers too often fail to address whether the reforms they advocate might in fact reinforce difference and diminish agency. However, patients maneuver through the changing medical-political landscapes in ways that remain discoverable (Fainzang, et al. 2010). This is an opportunity to engage matters of “Brazilian sexual life” and the power of medical technologies (Parker 1991).

The Structure of the Dissertation

In Chapter 1, I discuss how national and local discourses about preconceito, homosexual subjects as citizens, and LGBTT access to healthcare might be scaled between the macro and micro to understand how national discourses might condition ethical striving for recognition and human rights. By exploring government policies and proclamations about black women’s health and healthcare, issues of justice for the black LGBTT, and related topics I demonstrate how the existing preconceito(s) circulating in Brazil pose a serious challenge for discourses and projects of citizenship. The ethical strivings of the government, which are shaped by activism and social movements, have implications for the lived experiences and ethical projects of lésbicas negras, who are close to these national discourses in many ways. I close with
an analysis of the lives of a casada couple drawing together many of the various threads that unfold elsewhere in the dissertation.

In Chapter 2, I conceptualize lésbicas negras’ ethical practices in gynecological care, in part from a historical perspective. I study their ethics to analyze and demonstrate how they forge sexual health confront heteronormative gynecological care’s silencing of their sexuality. More specifically, I discuss my interlocutors’ perceptions of racism and gender inequality, how they reveal their sexuality to their gynecologists, and their ethical motivations, demands, and outcomes. First, I trace how preconceito as a concept has been deployed historically, legally, and social-politically in significant ways. One goal of this discussion is to frame how preconceito shapes the decisions and practices of lésbicas negras in gynecological contexts. Many Brazilians believe preconceito contributes to both broad and intimate injustices and inequalities, holding it responsible for social conditions such as poverty, violence, and health disparities; therefore, I argue that it also holds broader implications for our understanding of these women’s racialized sexual subjectivities (Caldwell 2007). Specifically, I am interested in the connections between preconceito as an idiom or symbol, circulating in the public realm, and the socio-cultural and political shaping of these subjectivities. In later chapters, I return to preconceito to examine its more concrete, material existence as well.

In Chapter 3, I lay out the theoretical foundations for my anthropology of ethics. I develop a conceptual architecture that accounts for and frames lésbicas negras’ ethical teloi, modes of subjectivation, and relationships to the themitical, which lies within the ethical and allows for modes of subjectivation to operate (Faubion 2011). In so doing, I forge links between the anthropology of ethics and my
own work, as well as showing what the investigation of lésbicas negras’ lives can offer this emergent area of scholarship.

Chapters 4 and 5 are substantial ethnographic chapters in which I examine key interlocutors’ medical and personal narratives, draw connections between various aspects of their lives and their ethical projects. I window, or frame, some lésbicas negras’ narratives, collective experiences, and social worlds in relationship to their experiences of medical care and preconceito in the gynecological clinic.

In chapter 4, I center the ethnography upon one interlocutor and show how her medical and social narratives are structured by her friends, family and social and political life, all of which actively shape her formation as an ethical subject. For example, one of the issues introduced in this chapter is lesbian virginity and the concerns when faced with the gynecological consultation. Furthermore, I introduce my method of windowing in this chapter and introduce my analytic perspectives on the themes of virginity, enabling conditions, and social conditions.

In Chapter 5, I craft a more collective ethnography by focusing on a couple in their relations to some other Candomblé lésbica negras. The goal of this chapter is to demonstrate how individual and collective narratives reveal the enabling conditions that have allowed these women to navigate their ethical subjectivities. In this chapter, I develop a more in-depth definition and analysis of racialized sexual subjectivity, tracing how it interacts with the ethical projects surveyed in this project. This chapter also offers an in-depth discussion of how scaling social complexities (Mol 2002) can help us to create partial connections (Strathern 2004) between these themes, processes, and issues.
Chapter 1

Black (Homo)Sexuality and the Etico-Politico

“Mais cidadania para mais brasileiras”
(More citizenship for more Brazilian women)
Il Plan Nacional De Politicas Para As Mulheres, 2008

Prelude

Xire das Pretas was the most prominent space in Salvador for collective representations of what I regard as “negra homosexualidade feminina” (black female or feminine homosexuality). Xire das Pretas took place monthly in Pelourinho at Casa de Benin, a small museum with a beautiful large private event space, featuring large brick walls, cobblestone ground, live trees, and a partial roof. It was a new artistic and social space for all mulheres negras (black women). However, since most of the organizers were black lesbians, it attracted other black lesbians in particular. Xire das Pretas was put on by Amuleto, an organization addressing issues of violence facing black women, and featured an open mike for women’s artistic expressions. The performances included spoken word, dance, singing, instrument playing, and drama. The samba vocalist host and entertainer, Alice, performed with her band. Sometimes, they offered beer and acarajé; alternatively, there were food and alcohol beverages sold by street vendors and local bars right in the lower valley of.

Most of my interlocutors did not frequent Xire das Pretas, except for Barbara Alves and Isabel, who occasionally stopped in. In fact, I met Isabel there during my first visit in August 2012, when she approached me with an inquiry about the bklyn boihood calendars I had circulated in 2011. This social space represented fluid boundaries of space and lesbian out-ness, and was entangled with territorial political agendas. Rosy Almeida, as leading organizer of Xire das Pretas and Amuleto, also

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9 Acarajé is a dish made from peeled black-eyed peas formed into a ball and then deep-fried in dendê oil. It is a Candomblé food served in terreiros and sold by street vendors as well.
worked for the *Secretaria da Mulheres*, the state government agency for women’s issues. *Amuleto* hosted during the *Parada Gay* in September 2012 the parade float sponsored by *Secretaria da Mulheres*. I was on that parade float with a rainbow necktie and huge *caipirinha*¹⁰ in hand from a street vendor. Later, I had to justify my presence and the good time that I evidently had on the float to a few interlocutors because the tense role of the *Secretaria da Mulheres* office with local lesbian movements. However, most of my key interlocutors knew the organizers or heard of them. Their skepticism reminded me just how small a particular *lésbica negra* world could be within a broader political and social landscape.

*Xire das Pretas* generated invaluable ethnographic insight into socio-cultural meanings surrounding blackness, gender, and sexuality. On the one hand, it was both a social and *axé* space where women collectively and unapologetically identified as *lésbicas negras*. I witnessed modes of “*assumir-se*” [taking up] both black and lesbian identities, as participants engaged in discussion about social issues that impact them as *mulheres negras* (black women). How sexuality, gender, and racial identities were navigated by some *lésbicas negras* in that space reflected the disdain toward the broader normative gender systems in Salvador and Brazil (Williams 2013; Gregg 2003; Kulick 1997; Parker 1991). On the other hand, I appreciated how ethical formations are repeatedly reinforced in such a space through creative messages about social wellbeing and human rights. One of the main forces behind *Xire* was Rosy. When I finally interviewed her at *Amuletto’s* headquarters (a small house in Barrio Garcia) in May 2013, she told me, in front of a small group of her *lésbicas negras* friends, that she was a virgin. She strongly argued that gynecologists must learn to respectfully and appropriately interact with *lésbicas negras*.

¹⁰ Brazilian alcohol traditional cocktail made of crushed limes, sugar, cachaca and ice.
In this chapter, I examine how, as racialized sexual subjects, some lésbicas negras seek recognition of their human rights in ways that link them to formations of citizenship themselves connected to the reproduction of broader national and local structures and discourses. I argue that public forums in Brazil both generate and are produced by these structures, which present citizens such as lésbicas negras, with a variety of competing ways to overthrow racial and sexual preconceito. Furthermore, I window into these public discourses as a way to image how gynecology functions as a symbolic social space that for the enactment of racialized sexual subjectivities and the striving for social and civic well-being. Herein, I discuss how preconceito and other connected idioms are materialized across various interconnected government public platforms, to highlight the ethical implications of these public discourses and agenda. Finally, my ethnographic account of two key interlocutors, Erica and Telma, who as live-in partners provides a window into a couple’s intimate interactions as ethical and racialized sexual subjects. The formations that emerge in such an arrangement are intersubjectively tied to local forms of social. These threads are partial connections that help us to understand how scaling of complex social relations and systems can illuminate gaps between and within the various well-intentioned plans set forth by Brazil’s LGBTT Healthcare Reform for improving the social relations between physicians and patients, including lésbicas negras.

Window: Diverse Homosexual Liberal Subjects

The below image is the cover of a large pamphlet that circulated in May 2013 throughout major municipalities in Bahia, announcing approximately fifty-nine public discussions in various locals on topics such as health, religion (Candomblé in particular), issues facing LGBTT youth, and violence. The programming was spread
across seventeen municipalities in Bahia, including Salvador. In Salvador itself, seventeen events were scheduled in different locations, including the launching plenary held at the Secretaria da Justiça, Cidadania E Direitos Humanos, Maio da Diversidade LGBTT (See Image 2). As Bahia’s first effort to institute this form of justice or recognition, it placed homophobia at the center of discussions focusing the macro and micro scale violence and vulnerabilities for LGBTT population. I met Barbara Alves (you will meet her in chapter 2) at the plenary; she was very excited and proud of the agenda. I was pleasantly surprised to see Barbara and Rosy on the cover of the pamphlets and posters disseminated at the event.

Image 2: Barbara in second row and last square in right column; Rosy in third row and last square in right column.

These public images were compellingly aligned with the broader national movement and messages, just now trickling down into Salvador that focused on addressing homofobia, lesbofobia, and transfobia at the local level. The plenary was designed to honor and showcase the leaders of LGBTT activism in Bahia, to make their work visible. After the event, I was eager to interview Rosy about her perspective on the gynecological encounter issues raised by my interlocutors given her leadership with Xire das Pretas and the extensive public programming by Amuletto for Maio Da Diversidade LGBTT. Rosy’ interview in late May 2013, where
she revealed that she was a virgin, and like Barbara, that never had penetrative sex with a man and with a strong opinion about how *lésbicas negras*, in particular, experience gynecological exams, reminded me that “singular experiences” such as sexual or gynecological encounters “are derived of a multiplicity of positions and perspectives that are inter-subjectively embodied and circumscribed by socio-political, racial, national, and legal concerns” (Donnan and Magowan 2010: 1). The complexity of talking about sex elicits the “affective power of sexual experiences, … the most difficult aspects of engaging sexuality” (Donnan and Magowan 2010:2), which renders such complex interactions socio-politically charged negotiations. *Lésbicas negras* such as Rosy and Barbara (you will meet Barbara in Chapter 2), in their encounters with gynecologists, engage in ethical practices that are always linked to the broader forces seeking recognition for LGBTT humanity and for black women. Therefore, the ways in which women such as Barbara and Rosy shape their ethical subjectivities, in the sense that Elizabeth Davis argues as “truth, culture, and freedom that stand both as instruments and as sites of responsibility” (Davis 2011:17), expose how broader public discourses travel into micro-social spaces and interactions, serving to further and more intimately reinforce their subjective sense of social well-being. As an anthropologist, herein I think through the “cultural institutions and practices in ethical terms that reflect human relationships and ethics” (Schepers-Hughes 1992: 21) that reflect local and national discourses.
The social complexity of actively engaging *lésbicas negras* identities at the micro-social level further demonstrates the distinction of racializing sexuality and gender in ways that mirror public discourse. For example, the photo above (Image 3) is from a protest in support of a young white Brazilian woman in Salvador who was physically assaulted by a security guard at a well-known theater in an upper class area, *Corridor da Vitoria*. This incident provoked many women, including the founder and leader of *Grupo Gay da Bahia*, to make their discontent with violence and *lesbofobia* visible. The protest was followed by a mini-march to *Campo Grande* with shouts, “*Violencia Contra a Mulher!*” (*Violence Against Women*). Interestingly, the assault, though protested as *lesbofobia* as the woman assaulted was a lesbian, generated a somewhat different ethical discussion among my key interlocutors.

I was struck that only Isabel was present at the protest. In such moments, I strove to understand the forms of ethical engagement produced through these socio-political events. There were no other women present that I knew from other the lesbian movements, including *Lesbibahia*. Certainly, none of my key interlocutors were there, although Mirela (who you will meet in Chapter 2) and a male friend did make an appearance for a few minutes, but only as spectators. I did not really expect Erica, Telma, Jandira, Isabelle (Jandira and Isabelle to meet in Chapter 5), and others to get involved. After speaking with Barbara and Erica, I realized that their absence reflected their busy schedules and perceptions of a particular form of racial sexual subjectivity – *lésbicas brancas*. For example, Barbara strongly argued that the event misappropriated *lesbofobia*, when what was at issues was really gender violence. She felt that the victim, her lesbian partner, and others had seized upon the discourse opportunistically Barbara’s views gave me pause, given her strong involvement in the LGBTTT community and politics. I began to understand more, however, through
Erica’s opinion that the only reason such a public outcry was recognized was that the victim was a white, middle-class lesbian attending university.

Lesbian identities in Salvador, then, even amidst violence, unveil their racial dynamics, as recognition differentially depends upon race within both human rights discourse and experience of everyday social life. If the politics of identity are publically manipulated in such ways, it is read by some lésbicas negras as a threat to their ability to gain recognition on the ground in smaller spaces, such as in their interactions with gynecologists. As I will discuss in chapter 4, the gynecologist’s comment at the Marcha da Mulher Internacional that “they will come out for activism, but not to the doctor” is suggestive that these social-political connections are too often not disconnected. In other words, the medical community in Salvador might interpret lesbian identity in activism as a willingly mode of out-ness easily transferable into their medical spaces. I argue that some lésbicas negras are distinct ethical subjects given the complex ways in which they pursue recognition as part of a vulnerable population with racial and class struggles as black women. At the Marcha da Mulher Internacional, there were many local community groups of black women representing their economic, health, and social condições (conditions). Yet, a gynecologist participating within the marcha would make such a broad assumption. The partial connections between racialized lesbian identities, however, are not immediately evident in fieldwork, but instead can only be seen through tracing out the complexities of the ethical as it emerges through a range of interwoven social threads. Ethnographers must be attentive to the complexity of such identity politics, as “when investigators start to discover a variety of orders – modes of ordering, logics, frames, repertoires, discourses – then the dichotomy between simple and complex starts to
dissolve” (Mol and Law 2002:7). I argue that it is precisely within these partial, complex connections that lésbicas negras become ethical subjects.

Window: Blackness, Saúde, and Ser Mulher

Odara, Instituto da Mulher Negra, which organized the Vice-Prefeito candidate public debates discussed in chapter 5 and focuses on the social and physical well-being black women in Salvador, reminded me of the gendered implications of language for ethical subjects in Brazil. Odara’s office was located in Barrio Dois de Julho, the neighborhood where I lived. During my fieldwork, I spent time with the co-founder, Valdecir Nascimento, whom I had initially met in 2007. I also interviewed another co-founder, Emanuelle Goias, who has now started a PhD in Epidemiology at the Instituto da Saúde Collective-UFBA. Emanuelle shared their plans for Brazil’s 2015 million-women march; Emanuelle said that the goal was to publically promote the “bem-estar” of all black women. I further attended the meeting, in June 2013, where they began to plan launching Bahia’s first month dedicated to recognition of black women, Julho das Pretas (July of Black Women). Similarly to the agenda of Maio Da Diversidade LGBTT, there was to be a calendar of events, featuring local discussions on black women’s issues such as health, religious intolerance of Candomblé, and social violence.

I window into Odara to show how the launching of Julho das Pretas suggests profound, concerted efforts to acknowledge competing categories of identities in Salvador in their seeking recognition and social well-being as human rights. When Emanuelle emphasized the need to focus upon black women’s bem-estar, however, it suggested to me that the subjective ways in which ethical subjects in other arenas pursue recognition for social well-being as a human right continues to hold strong
ground on racialized gender subjectivities in Salvador. For example, in the flyer below in Image 4, it says “Julho das Pretas anuncia a March Nacional das Mulheres Negra Contra o Racismo e Pelo Bem Viver na Bahia” (July of Pretas announces a national march of black women against racism and for well living in Bahia). Their pursuit to promote “bem viver” (living wellness) is closely tied to the ethics of pursuing recognition of the condições of inequities created by racism and sexism.

The link between bem-estar and bem viver drawn here helps us to understand the processes of racialized sexual subject formation, those “symbolic processes informing the day-to-day racialization processes that distinct subjects experience as they move at different tempos across the city” (McCallum 2005:102), those partial connections between social well-being as a black woman and social well-being as a lésbica negra. Not all lésbicas negras engaged in socio-political work are ethical subjects who would openly and reflexively engage in negotiations about their social well-being with their gynecologists. However, it is important to remember that “racialization is the product of embodied experiences, occurring over time and through space” (McCallum 2005:100), and I argue that lésbicas negras are exposed to racializing discourses and institutions that racialize their gendered experiences, and that as openly black gay women they engage in specific practices of ethical self-formation regarding their sexuality. This means that their racialized homosexuality is the subjective identity that is most related to their well-being, rather than their gender, when they interact as black women with their gynecologists. In other words, these ethical subjects negotiate their homosexuality with their gynecologist with hyperawareness of their racial subjectivities.

The complex systems of gender norms in Salvador (Kulick 1997) have dramatic and sometime violent effects on all women, including white Brazilian
woman, as demonstrated by some of my interviews with white female gynecologists. But, as movements such as Odara and Amuletto serve to remind the public, black Brazilian women are much more profoundly affected. Much of the public discourse and readily available literature on black women’s health circulating in Salvador, Rio de Janeiro, or Porto Alegre argues clearly for a racialized understanding of differential health outcomes for women. I collected numerous printed materials on saúde da mulher negra (black women’s health) such as a pamphlet titled Saúde Da Mulher Negra: Guias para a defense dos direitos das mulheres negras, 2012) that fall under the auspices of social political visibility influenced by another national agenda and document titled Política Nacional de Saúde Integral da População Negra (2010, Brasilia). All of these materials share a common message about black women’s subjectivities and their health in relationship to social conditions reproduced by racism. I argue that these public discourses circulate notions of racialized gender that disrupt the desired visibility of homosexuality in settings of self-care and self-advocacy.

Image 4: ODARA’s Julho das Pretas
Window: LGBTT Healthcare Reform and Health Reforming Discourses

These competing public discourses about the vulnerabilities of some groups (LGBTT, black population, children, and women) aim on the one hand to eradicate discrimination, but on the other, and more urgently, to dismantle *preconceitos*. In this chapter, I want to explore a pattern of this public use of *preconceito* as an idiom to talk about the welfare of vulnerable groups and their relation to the nation state. *Preconceito* is a key symbol in Salvador, and is understood as such: many of my interlocutors, both *lésbicas negras* and physicians, have said that “it belongs to society.” In the context of my research, this commonly used phrase suggested that *preconceito* is a problem for and of all people, including those residing within the systems that produce it. One goal of this chapter is to make partial connections between embodied *preconceito* and the *preconceito* of *sociedade*. These partial connections point to the difficulties facing Brazil’s national LGBTT healthcare reform strategies as they aim to ameliorate the social tensions between black lesbians and gynecologists, for example.

I use an analytic of social complexity and scale to consider how public documents and government public health agendas situate *preconceito* as a human rights issue. By scaling the ways in which government efforts call for attention to the welfare of vulnerable groups at the level of the state down to the level at which *lésbicas negras* and their physician interlocutors place *preconceito*, it emerges that *preconceito* is, in part, a question of citizenship. In other words, if *preconceito* belongs to society, yet is believed by *lésbicas negras* to be expressed in the actions of those from the dominant side of racial, sexual, class, or gender hierarchies, then it is likely that the culpability for *preconceito* lies in particular forms of citizenship. This measure of civic culpability is evident in the government’s emphasis that *preconceito*
not only exists but functions alongside and supports discrimination. In a sense, the government and *lésbicas negras* agree that it is a *Brazilian* human right to not experience *preconceito*.

Given Brazil’s historical political decision in 1988 to institute the SUS explicitly in order to ensure the rights to health (*direito a saúde*) for all of its citizens, we must understand how *preconceito* as a socio-linguistic tool functions in public domains to materialize claims of accountability and to protest social barriers to belonging to society. For example, the Ministry of Health’s 2010 *Política Nacional De Saúde Integral De Lésbicas, Gays, Bissexuais, Travestis E Transexuais* purports to represent an “*ético-político*” (ethical-political) intervention on the part of SUS to combat the inequities that impact the LGBTT population and their health. By “*ético-político*,” I understand this national public policy to reinforce across the commitment of the SUS healthcare system to the elimination of discrimination against the LGBTT population. This strategic commitment via “*estratégias e metas sanitárias*” (strategies and health targets) is echoed by the country’s social movements and activists in their similarly “*ético-político*” understandings of the barriers to quality health and healthcare faced by the LGBTT population. As discussed in the introduction of this dissertation, this public policy agenda emerges on the heels of the country’s initiation of another socio-political agenda, *Brasil Sem Homofobia: Programa de Combate a Violência e a Discriminação contra GLTB e de Promoção da Cidadania Homosexual*, 2004, (Brazil Without Homophobia: Program for Combating Violence and Discrimination against LGBTT and for the Promotion of Homosexual Citizenship) which sought to recognize the various areas in which discrimination impacts homosexual citizenship, such as “racism and homophobia, health, women’s issues, etc.”
I interpret the *etico-político* commitment of SUS as fusing government and public discourses and agenda to reinforce the understanding that *preconceito* belongs to society because of its relationship to citizenship. Though this public policy focuses on various concrete health outcomes such as lesbians’ differential visibility in healthcare, HIV/AIDS in the LGBTT population, and even the rights of transsexuals to sexual reassignment surgery, the improvement of the health and healthcare of these populations is fundamentally grounded in ameliorating the negative social conditions that impact the LGBTT population. The reproduction of these social conditions is understood as *baseado* (grounded) in the perpetual reproduction of *preconceito*. The document\textsuperscript{11} itself highlights how *preconceito* is perceived to function:

Given the complexity of the health situation of the LGBTT population, and especially given the impact of sexual orientation and gender identity as evidenced by social and cultural determinants of health, the Ministry of Health has built this policy for SUS.

The condition of LGBT (population) is embodied within bodily habits or sexual practices that can impact, in some measure, the vulnerability of these people. However, the largest and deepest suffering is due to the discrimination and prejudice. The implications and the consequences of these prejudices compose the main objective of this policy.

The challenges in restructuring services, routines, and procedures in the public health system will be relatively easy to overcome. The deepest difficulty, however, is to overcome prejudice and discrimination that requires each person and the collective to change their values to reflect respect of differences.

The policy is based upon principles guaranteed in the Federal Constitution of 1988 (CF / 88), which guarantees citizenship and human dignity (Brazil, 1988, art. 1, inc. II and III), reinforced by the fundamental objective of Federative Republic of Brazil to "promote the good of everyone, regardless of origin, race, sex, color, age and any other forms of discrimination" (Brazil, 1988, art. 3 inc. IV).

The right to health comprises social rights and for its implementation, the Constitution devoted to health a well-engineered design to integrate it (heath)

\textsuperscript{11} Ministry of Health’s 2010 *Política Nacional De Saúde Integral De Lésbicas, Gays, Bissexuais, Travestis E Transexuais*, pgs13-14
into the Social Security System. Thus, social development is regarded as essential for the achievement of the health condition.

Diante da complexidade da situação de saúde do grupo LGBT e, especialmente, diante das evidências que a orientação sexual e a identidade de gênero têm na determinação social e cultural da saúde, o Ministério da Saúde construiu essa Política para o SUS.

A condição de LGBT incorre em hábitos corporais ou mesmo práticas sexuais que podem guardar alguma relação com o grau de vulnerabilidade destas pessoas. No entanto, o maior e mais profundo sofrimento é aquele decorrente da discriminação e preconceito. São as repercussões e as conseqüências destes preconceitos que compõe o principal objeto desta Política.

Os desafios na reestruturação de serviços, rotinas e procedimentos na rede do SUS serão relativamente fáceis de serem superados. Mais difícil, entretanto, será a superação do preconceito e da discriminação que requer, de cada um e do coletivo, mudanças de valores baseadas no respeito às diferenças.

A Política está embasada nos princípios assegurados na Constituição Federal de 1988 (CF/88), que garantem a cidadania e dignidade da pessoa humana (Brasil, 1988, art. 1.o, inc. II e III), reforçados no objetivo fundamental da República Federativa do Brasil de “promover o bem de todos, sem preconceitos de origem, raça, sexo, cor;

O direito à saúde compõe os direitos sociais e, para sua concretização, a Constituição dedicou à saúde um desenho bem arquitetado ao integrá-la ao Sistema de Seguridade Social. Desta forma, o desenvolvimento social passa a ser considerado como condição imprescindível para a conquista da saúde.

The etico-politico stance of the nation laid out here demonstrates the public, discursive investment that the nation has in promoting (promover) the bem-estar of its citizens. This etico-politico position is a relatively novel transformation, given earlier approaches towards health in past governments. In comparison to Dr. Manuel, Dra. Sandra, a white female gynecologist (both to meet in chapter 4), believes that “preconceito esta dentro da historia” of the nation and society, discursively reproducing embodied practices of (particularly racial) preconceito.

Moreover, the relationships between citizenship, health, and preconceito are further demonstrated in another the public document from the Ministry of Health
titled *Cadernos de Atencao Basica: Saúde Sexual E Saúde Reprodutiva*, 2010. I found this document online after being prompted by Erica to research sexual health as a public health concept in Brazil. I interviewed Erica on a relaxed afternoon in November 2012, both of us lounging on her bed in her apartment while Telma, her partner, hung out in the living room. Erica, though seemingly shy in public spaces, emerged here as a very blunt and animated person when speaking about social issues in Brazil. When I asked her on audio recorder about her perspective on sexual health, sexuality, and well-being, to my surprise she replied that “Nessette, the truth is that I was not aware about that idea of sexual health, in that way, until your research.” This was simply stunning to me, as Erica was highly active politically, staying abreast of a myriad of issues by reading newspapers, talking with close comrades in the movement, and was formerly involved with the lesbian movement *Palavra da Mulher* (in 2007, when I first met her).

Erica’s bewilderment was a trigger for me to rethink how Brazil pitched its national health education, even through obvious and normative ways such as discussing STDs and reproductive health. My searching on the internet that evening led me to discover that Brazil’s national platform to promote an idea of sexual health as a public health issue was a recent intervention in Brasilia. Most such public platforms begin in Brasilia and trickle down into the state (*secretaria*) and city/local (*municipal*) level; as Isabelle shared in chapter 5, discourses of sexual health and STD prevention were promoted on the ground through local discussions. I recognized in my key interlocutors’ understandings of sexual health, that is, as a form of social well-being, echoes of these ideas. The connection for me was made when I recognized that sexual health, as a concept, was linked to not just reproductive health but to Brazil’s historical notion of the “health of the family.” In other words, *saúde*
sexual was linked to the promotion and identity of family health, as another means to maintain the legacy relationship between citizenship, sanitation, and health (sanitaria as health) in the reproduction of the nation (Stepan 1991).\textsuperscript{12}

What is the implication for the LGBTTT population, and particularly for the black LGBTTT population, when the idea of this population forming “families” is only recently acknowledged in Brazil? More specifically, how do national and local ideas of gender and sexuality tied to notions of family, citizenship, and health influence the ways in which my key interlocutors seek to be recognized as ethical subjects, particularly in their negotiations over sexuality with their gynecologists? I argue that their mode of subjectivation is grounded in these national and local circulating ideas, but that their forms of quotidian sociality and ethical practices aim to transcend their social status, and the negative repercussions of these ideas for them as black women. In other words, as citizens, their pursuit for social well-being as a human right reflects how they recognize themselves as citizens within the periphery of the broader civic striving for social health. Much of this self-reflection is in turn reflected in national and local discourses. Here I turn to another public document and pamphlet titled Negros e Negras Lésbicas, Gays, Bisexuais, Travestis e Transexuais: construindo políticas para avançar na igualdade de direitos and Negra and Saúde?, produced by the Secretaria de Políticas de Promocao da Igualdade Racial (SEPPIR). In this pamphlet, we can see the intersection of racial and sexual identities and rights coming together in a slightly different way that reinforces the relationships between citizenship, social well-being, and preconceito. This excerpt depicts the necessity of

\textsuperscript{12} Nancy Leys Stepan in “The Hour of Eugenics”: Race, Gender, and Nation in Latin America (1991) reminds us of the complex history in Brazilian eugenics to promote sanitation laws for family enforced by physicians and other enforcement entities.
collaboration between SEPPIR and other government entities addressing LGBTT issues:

The debate about the intersection of discrimination based on racial belonging, sexual orientation and gender identities is still under construction [revision] throughout the Brazilian society and the government agencies responsible for public policy. We bring here some [concepts] and issues that we consider essential for advancing these discussions, in order to overcome the inequalities that affect citizens, and LGBT citizens in particular, in Brazil today, especially black men and women belonging to this subpopulation.

This debate has been fueled in recent years by strengthening political social movements of lesbians, gays, bisexuals, transvestites and transsexuals. In addition to demand public policies, these segments are organized to fight for their rights and full citizenship.

Being black or black LGBT does more than bring together afetivossexual orientation, gender identity, and race. It is an "attitude of life," a "transformative political proposal" that must be recognized by all people and also guaranteed to all people as a right. The diversity that humanizes us cannot be used to generate inequalities, oppression, and subalternities anymore.

Black and LGBT blacks have paved paths with their struggles, giving visibility to the contradictions in social relations and taking breaks with the standards and specifications of Eurocentric heteronormativity. Because they live their sexuality in self-determined manner different from "ordinary" were stigmatized historically and are still socially invisible, dispossessed of their rights and violated in their daily lives in various ways; they still remain resistant and fighting for their dignity.

O debate sobre a intersecção das discriminações baseadas no pertenci-mento racial, na orientação sexual e nas identidades de gênero ainda está em construção no conjunto da sociedade brasileira e também nos órgãos governa-mentais responsáveis por políticas públicas. Trazemos aqui alguns elementos e questões que consideramos essenciais para o avanço dessas discussões, com vistas à superação das desigualdades que atingem cidadãs e cidadãos LGBT no Brasil hoje, especialmente negras e negros pertencentes a este segmento.

Este debate tem sido impulsionado nos últimos anos pelo fortalecimento dos atores políticos dos movimentos sociais de lésbicas, gays, bissexuais, travestis e transexuais. Para além de demandar políticas públicas, estes segmentos se orga- nizam, lutam por seus direitos e pela cidadania plena.

Ser negra ou negro LGBT é mais que a junção de orientação afetivossexual e identidades de gênero e raça. É uma “atitude de vida”, uma “proposta política transformadora”, que precisa ser reconhecida por todas as pessoas e garantida também para todas as pessoas, enquanto um direito. A diversidade que nos hu- maniza não pode mais ser utilizada para geração de
desigualdades, opressões e subalternidades.

Negras e negros LGBT vêm abrindo caminhos com suas lutas, dando visibilidade às contradições nas relações sociais e assumindo rupturas com as normas e prescrições da heteronormatividade eurocêntrica. Por viverem sua sexualidade de forma autodeterminada, diferente do “comum”, foram estigmatizados historicamente e ainda são invisibilizados socialmente, expropriados de seus direitos e violados no cotidiano das mais diversas formas; ainda assim, permanecem resistindo e lutando por sua dignidade.

The above excerpt, from the second page of the pamphlet titled An invitation for a reflection: “What does it mean to be Negra(o) LGBT in Brazil today?”, is noteworthy for considering how black LGBTT folks in Brazil must be treated not just as equal citizens as but recognized for producing a unique form and quality of life grounded in their racial sexual identity. The pamphlet situates them as citizens; however, the third paragraph points to the pulse of this pamphlet, to their argument that be a black LGBTT person is to demonstrate a particular style of life. This attitude is multidimensional, with the capacity to transform the political climate of the country. Black LGBTT life is cast as a positive force and a representation of the “contradictions” of the nation’s goals for the welfare of its citizens in the face of their experiences of stigma and inequality.

The complex, national, socio-political discourses that produce these pamphlets are not disconnected from local dialogues. The person leading SEPPIR, Luiza Barrios, is from Salvador, and my key interlocutors all know her personally. I mention this to only emphasize that for many black women, social interaction and micro-social practices shape the ethical forms of social well-being in which they engage, by reinforcing communal language about the struggles of black community at large. Lésbicas negras’ racialized sexual subjectivities in part enact an “attitude of life,” by drawing upon both local and national forms of ethical discourse, reproduced here to recognize and change the social conditions of their racial community in particular.
In *The Virtual Speculum in the New World Order*, Donna Haraway observes that “a speculum does not have to be a literal physical tool for prying open tight orifices; it can be any instrument for rendering a part accessible to observation” (1997:197). Haraway is useful here for thinking through the ways in which the broader socio-political scene in Salvador considers “homosexualidade como tema político” (homosexuality as a political topic) in relationship to the racialization of self-image and social interactions. I am reminded of how Isabelle referred to saúde sexual as an instrument by which to shape our sexuality. Isabelle also reflected on the ways in which instruments can be physical, policy, or even educational tools, that can be used to render the humanity of others (patients) accessible and available for respect. Following Haraway and Isabelle, we can begin rethink how female homosexuality in Brazil functions as another speculum, symbolically speaking, with which we might recognize the dynamics of ethical citizenship that emerge between lésbicas negras and their gynecologists. Indeed, the federal public discourses discussed above function with the explicit expectation that their message will have a trickle down impact at the local level. However, such national and local efforts, in general, are often too disconnected to generate any efficient or quick changes (as I observed in 2006, with the slow impact of the new domestic violence law on local police and community attitudes).

Medical anthropologists have argued that Brazil’s complex ways of understanding the relationship between issues of gender, female sexuality, and health marginalize the vulnerable yet potentially transformative agency of women as belonging citizens striving to create meaning in their lives, particularly in the Northeast regions (Gregg 2003; Parker 1999; Dalgaard 2004; Caldwell 2007; Sheper-
Hughes 2003; Kulick 1998). Scholars have understood gender and sexuality as reflecting the strong normative associations of sexual practices and roles with gender roles in Brazil (Kulick 1998, 1997; Parker 1991; Gregg 2003; Hayes 2011). The notion of lésbicas as an identity functions as an instrument of social change, in part through its presence in academic research, making its way into government and local public discourses about sexual health in Brazil. The 2006 document published by Rede Feminista de Saúde titled Saúde Das Mulheres Lésbicas: Promocao da Equidade e da Integralidade is regarded as a pioneer publication in Brazil for its focus on the health of mulheres lésbicas (lesbian women). The research and propositions in this publication are a significant point of reference within national public policy agendas, facilitating awareness of the implications of health policy for this subpopulation. The dossier includes quantitative research on health and mulheres lésbicas, but for the most part, it is structured to situate “homosexualidade feminina” in public and local discourses, to understand its history, vulnerabilities, and social formations. Out of thirty-six large pages, only four are specifically dedicated to identifying health issues and concerns directly associated with mulheres lésbicas. I was given this document in Salvador by a friend who works for the Secretaria da Saúde office within a few weeks of arriving for fieldwork in August 2012. My continued perusal of this dossier led me to one place: the impact of preconceito upon lésbicas.

In this dossier, you can learn much about the history of homosexualidade feminine; that the term lésbicas, for instance, was first introduced into the national movement in 1993 despite lesbians being part of initiating the gay movement a

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13 The Ministry of Health’s 2010 Política Nacional De Saúde Integral De Lésbicas, Gays, Bissexuais, Travestis E Transexuais public document, Brasilia
14 The population profile of the first four studies is similar: mostly white women, middle socioeconomic strata and with 11 years or more of schooling. The latest study accounts that 53% of women ended at 11 years of schooling [11th grade of high school], of which 59% are black and brown.
decade earlier. It also briefly discusses SENALE, which on August 20, 1996 held its first meeting, leading to the *Dia Nacional de Visibilidade Lésbica*, still recognized in Brazil today (Barbara was also part of SENALE). Though the dossier lays out a comprehensive discussion about health and lesbians, as discussed above in the introduction, here I am more interested in its central focus on *preconceito* as the basis of the social conditions that negatively impact the health and health services of lesbians. The dossier brings social movements, understandings of health and body, and identity formations into public discourse, to promote a reflection about the fact that “*preconceito associa a homosexualidade implicam questões de saúde pública*” (prejudice associated with homosexuality implicate public health issues/questions).

There are two key points I want to draw attention to in this window. First, the first paragraph of the second chapter, “*Homosexualidade Feminina e Saúde: contextualizando*” states,

> The relationship between homo- and bisexuality and women's health is the theme pervaded by a number of factors involved: the invisibility of female homoeroticism; the invisibility of feminine sexuality in itself; and the degree of prejudice (*preconceito*) that we have, today, in relation to homosexuality.

> *A relação entre a homo e a bissexualidade feminina e a temática saúde está perpassada por uma série de fatores que envolvem: a invisibilidade do homoerotismo feminino; a invisibilidade da própria sexualidade feminina; e o grau de preconceito que temos, ainda hoje, em relação à homossexualidade.*

This opening paragraph signals that “*preconceito*” is the critical factor in the broader issues surrounding lesbians and health. The relationship between invisibility and *preconceito* is significant, pointing to the motivations with which *lésbicas negras* pursue recognition as ethical subjects. While my project does not negate the fact that other *lésbicas* are ethical subjects, I want to pause to examine and reflect on how and why racialized sexual subjects enter into these public discourses. Is it simply a matter

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15 Page 5 of the Dossier
of understanding the *homosexualidade feminina* of any Brazilian? What seems to be almost a disclaimer to give recognition to disadvantaged populations within the identity category of *homosexualidade feminina* appears in the final line of the dossier’s introduction:

However, we emphasize that the production of scientific or technical character should be considered that the "lesbian" category represents one possibility of formulating sexual identity, among several present in the population of women who have sexual practices with other women. We understand that the production of knowledge or policies must always take into account the diversity of lifestyles, generation, pertaining to racial / ethnic or class, among others, within the population.

Given the important above charge to recognize “racial/ethnic or class,” it seems to me strange that the dossier does not further discuss race and class in relation to health and *homosexualidade feminina*. Indeed, the studies discussed in the document focused mostly on white lesbians. Not only was this a first sign, which would later be confirmed by many others, that *lésbicas negras* are not visible in health policy (or, indeed, much other) research, but it also pointed to the challenges facing public discourses when it turns to explaining or even acknowledging with any specificity what constitutes racial and ethnic difference with respect to *preconceito*. While racism is the historically dominant manifestation of racial *preconceito* (race scholars), the dossier, like other public documents, demonstrated the challenges of *speaking for or on behalf of* black women and their social plights beyond the enveloping term of racism.
The preconceito that many lesbians, including whites, experience in Brazil is palpable and acknowledged in this dossier from 2006. Although there are more lesbians coming forward and speaking out on lesbian issues today, the plethora of materials and booklets addressing black women’s health is by far more prevalent and visible. Documents such as the 2010/Brasilia “Política National de Saúde Integral da Populacao Negra (PNSIPN),” 2008/Bahia “Saúde Da Mulher Negra: Guia para a defensa dos direitos das mulheres negras,” 2012/Porto Alegre “Saúde da Mulher Dialogando com a diversidade de genero e raca, and 2006/Salvador “Diagnostico de Saúde da Populacao Negra de Salvador (DSPNS)” evidence the commitment to differentially addressing the health of black populations in Brazil. All of these materials point not first to preconceito as the culprit for the health inequities of the black population, but rather socioeconomic status. For example, the opening line in the 2010 PNSIPN states,

The publication of the National Policy on Comprehensive Health of the Black Population (PNSIPN) is a response from the Ministry of Health on the social inequalities that affect this population. This response is the result of the recognition of the social, cultural, and economic processes that contributed and still create the living conditions of this population.

A publicação da Política Nacional de Saúde Integral da População Negra (PNSIPN) é uma resposta do Ministério da Saúde às desigualdades sociais que acometem essa população. Essa resposta é fruto do reconhecimento dos processos que construíram e ainda constroem as condições de vida dessa população.

The national and local emphasis on the black population’s health inequality as being primarily a result of their socioeconomic and cultural inequality is supplemented by the argument that they have not fully exercised their “direito político” to services. While many of these national and local platforms and documents refer to the quality of healthcare and access of SUS, they also demonstrate how claims to citizenship extend the SUS, as they attribute social and health inequities back to entrenched
societal and institutional *preconceito*. Therefore, *preconceito* is an issue of manifesting unjust citizenship status.

Although all of the physicians that I interviewed, even at CEDAP, had not read, seen, or even heard of the *Ministerio da Saúde* agenda discussed above, their lack of familiarity with this document does not reflect a direct impact upon them. In fact, it is precisely their unfamiliarity with these documents that signal how *preconceito* is a question of shaping citizenship values because the in between-ness of the scales of these social complexities that have allowed for ethical subjects to respond to its impact as a human right. Identifying, understanding, and engaging with *preconceito* are part of the social fabric of the country. Further, it is suggestive of a late modern symbolisms of highlight it as a social dilemma (Latour 2005). In other words, the relationship between *preconceito* and citizenship invites for understanding the ethical by interpreting Brazil’s “medicine as a site of complex social interaction” (Peard 1999).

The work of Jurema Werneck and *Criola*, her nationally wide-reaching organization based in Rio de Janeiro, has had a wide impact on national understandings of racism and citizenship. In her booklet, *Desigualdade racial em numeros: coletanea de indicadores das desigualdades raciais e de genero no Brasil* (Racial inequality in numbers: compilation of indicators of racial and gender inequalities in Brazil), she states,

> Racism has been the most effective magnet of ideologies of subordination in the production of different populations. An important facet of this [racism] ideology in our country is its ability to subterfuge, to produced itself [racism] as disguises, and the manipulation of reality resulting in concealment of its [racism] mechanisms.
Thinking through Werneck’s definition of how racism functions in Brazil, I return to my reflections of the lack of engagement with lésbicas negras, for example, in the dossier on homosexualidade feminina e saúde and my interviews with CEDAP physicians. To what extent can a nation such as Brazil dismantle preconceito through its various efforts and public discourses surrounding the issue, if part of its national agenda is to promote recognition of not its citizens but of the ways in which its systems and the conventional wisdom promote lack of recognition of the root of social dilemmas. In other words, the strivings for equal citizen status is as much a wide gap to bridge as recognizing the in-between matters that contributes to the gap in the first place. The large-scale drive for recognition on behalf of groups such as LGBTT, women, and black folks is part of a national, ethical-political program designed to improve the welfare of all citizens. I argue that these this national striving for recognition of the human rights of its citizens in their particularity functions to support or produce the proliferation of a wide range of novel forms of ethical subjectivity. These national and local socio-political strategies trickle down into the micro-spaces such as the quotidian lives of lésbicas negras. The question, then, is how to render this trickling down visible, particularly in the gynecologists’ office?

Here, I turn to a paper by Geisa Cristina dos Santos, which emerged from Salvador’s Enlacando Sexualidades (Untangling Sexualities) conference in 2009. I met Geisa, a lébica negra from Salvador, in 2008, when she was working on issues of homosexuality in the Catholic Church in Salvador (actually, I learned about Xire das Pretas from her Facebook page, which was advertising a schedule of activities for Lesbian Visibility Day on August 29th, 2012). Geisa had been one of the organizers of Amuleto until she moved to the rural interior of Bahia for a government job. However, we got to party together before her departure, on the Parada Gay float in 2012.
Geisa’s essay titled, “Rompendo o Silencio e a Invisibilidade Lesbianas Negras de Salvador,” which I read for the first time in 2011, was instrumental for my thinking about the ethical voices of some lésbicas negras in Salvador. Her first sentence was critical in shaping my initial approach to the question:

The work consists of analyzing the discourses of black lesbians from Salvador who experienced the process of breaking the silence and invisibility. Having as objectives: to identify the discourses of black lesbians in Salvador in the construction and experience of their identities; investigate the challenges and opportunities faced by black lesbians as coping mechanisms of prejudice, discrimination and violence; analyze the discourses of black lesbians who seek the transformation of silence and invisibility in language and action.

This essay is suggestive of the tension that even the most daring ethical subjects among lésbicas negras must work through to access legitimacy and respect in a variety of settings such as the workplace, with family, and even at the doctor’s office. One woman states,

“Look into your rights under the law, and demand recognition. And this recognition, it walks in the matter of public policy. Because there is no care, for example, when a woman goes to the gynecologist, she gets afraid of expressing what she feels or saying that she lives with another woman.”

“Buscar seus direitos perante a lei, e exigir o reconhecimento. E esse reconhecimento, ele entra pela questão de políticas públicas. Por que não se tem um cuidado, por exemplo, quando uma mulher vai para o ginecologista ela fica muito cheia de dedos para colocar que sente, ou vive com outra mulher.”

I discussed this statement with some interlocutors, who suggested that feeling “full of fingers” meant feeling too tense or scared to be yourself or speak about your same-sex partners. While this sentiment is shared by other white lesbians, I want to consider
that recognition takes on a different dynamic for lésbicas negras, given their personal involvement in processes of social transformation, as discussed in chapter 4 and 5. Below, Geisa offers concluding considerations that, in my opinion, expand upon this involvement by detailing the processes and formation of an “attitude of life”:

This [publication] seeks to rescue [render visible] the life stories of some black lesbians in Salvador who dared to speak and live their desire, their love, breaking the heteronormativity imposed upon the body and female sexuality, ultimately transgressing the space[s] of black women. They deconstruct and re-signify the possibilities of resistance and social transformation of themselves and their identities.

The experiences reported by respondents involved in the survey reflect the construction of their identity and commitment to the fight against racism, sexism, heterosexism and lesbophobia [that exist] in the many places they occupy where visibility of these issues is necessary. The act of coming out has personal and political dimensions and demonstrating its existence and demands as steps toward achievement of rights and respect [is critical]. The recognition and acceptance of the self promotes a sense of belonging as human beings, rights holders, encouraging increased self-esteem, appreciation, freedom and autonomy.

The speeches and actions of black lesbians show recognition and affirmation of these, and the confrontation with the existing order of sexist, racist, and lesbophobic society. These conditions favor the strengthening of their identity [identities] from the perspective of improving their lives, elevating their level of emancipation and empowerment through their participation, preparation and coordination of policies and activities in various social movements.

When we speak on rights we are affirming the exercise [enforcement] of each person’s citizenship, where everyone is involved, the community, families, institutions and the state in the promotion of respect and legitimacy of the diversity of affective and sexual orientation in the context of sexual rights, which are human rights based on freedom, dignity, fairness and equality for all. To ensure the rights of these humans, it is necessary for society to develop a new corporate design guarantees linked to human rights principles, embodied in the enjoyment of social and economic rights of coping with existing patterns of sexual and economic control.

*A produção busca resgatar as histórias de vida de algumas lésbicas negras de Salvador que ousaram falar e viver o seu desejo, o seu amor, rompendo a heteronormatividade imposta ao corpo e à sexualidade feminina, transgredindo o espaço determinado para as negras. Elas desconstroem e ressignficam as possibilidades de resistência e transformação própria e social por sua identidade.*
As experiências relatadas pelas entrevistadas envolvidas na pesquisa refletem a construção de sua identidade a partir do engajamento na luta contra o racismo, o sexismo, a lesbofobia e o heterossexismo nos diversos lugares que elas estão inseridas na perspectiva de visibilidade deste sujeito. Que o ato de assumir-se tem dimensões pessoais e políticas, e demonstram sua existência e demandas como passos na conquista de direitos e respeito. O reconhecimento e aceitação do eu promove o sentimento de pertença como seres humanos, sujeitos de direitos, estimulando o fortalecimento da auto-estima, da valorização, da liberdade e da autonomia.

Os discursos e ações das lésbicas negras demonstram o reconhecimento e afirmação destas, e o enfrentamento à ordem vigente da sociedade machista, racista, sexista e lesbofóbica. Estas condições favorecem o fortalecimento da sua identidade na perspectiva de melhoria de vida elevando seu patamar de emancipação e empoderamento, através de sua participação, elaboração e articulação de políticas públicas e na atuação nos diversos movimentos sociais.

Quando falamos de direitos estamos afirmando o exercício da cidadania de cada pessoa, onde todos estejam envolvidos, a comunidade, as famílias, as instituições e o Estado na promoção, respeito e legitimação à diversidade de orientação afetivo-sexual, no âmbito dos direitos sexuais que são direitos humanos baseados na liberdade, dignidade, equidade e igualdade para todos. Para assegurarmos os direitos destes seres humanos, faz-se necessário que a sociedade desenvolva um novo projeto societário de garantias, vinculados aos princípios dos direitos humanos, concretizados em usufruto dos direitos sociais e econômicos de enfrentamento dos padrões vigentes de controle sexual e econômico.

These reflections on citizenship, human rights, and resistance against the conditions that impede visibility and freedom are very specific nuances of social life in Salvador for many lésbicas negras as I have described in this dissertation.

Window: Etica Racial, Etica Sexual and Recognition of Citizenship

Fieldwork forced me to accept (well, almost accept) that I could not be in two places at once, though I hardly hesitated to pack my days with 2-4 events, meetings, and/or interviews. One particularly difficult choice was when I decided to attend Secretaria de Politicas de Promocao da Igualdade Racial da Precidencia da Republica’s (SEPPIR-PR) 10th anniversary celebration, featuring a day-long
scheduled of speakers, including Bahia’s Governor and the Ministra de Estado Chefe de SEPPIR-PR Luiza Barros, over attending the plenary and launching of the *Fios de Masculinidades* video and research project. I was torn since the women in the video were going to be there to speak about their experiences. Barbara had been constantly talking about it; I would miss discussions by some local scholars of gender and sexuality studies. However, I learned of SEPPIR’s event through Isabelle; I was with her when she posted the flyer in CEAO-UFBA in *Dois de Julho*. Then, a few days before the event, Jandira offered me her advice about my decision, speaking from her perspective on issues of masculinity and being *negra*. She urged me to go to SEPPIR because I would get exposed to a lot more events discussing gender and sexuality than about race and racism. I went to SEPPIR-PR’s event.

SEPPIR-PR was instituted on March 21, 2003 as a state level institution to address the “racial inequities of the Brazilian society, which have grave consequences in the political ambience and in accessing goods and rights.”16 I was eager to learn more about SEPPIR. In particular, I was curious how issues of racism and race would be addressed in the context of the event. It was crowded with lots of brown and black folks, some dressed in white, as it was a Friday, Day of Oxala.17 I was happy to see that Marta was present. We sat together at the event and had lunch together in Pelourhino. Then, after all the introductions and thank you remarks, the plenary speaker, Professor of Philosophy at the University of São Paulo (and native of Salvador), Dr. Marilena Chaui, began her lecture. As I listened, palpitations came over me as I heard her say: “etica, violencia, e racismo.” I could not get my recorder on fast enough! Fortunately, Erica was later able to find her transcribed lecture online.

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16 Taken from the SEPPIR pamphlet circulate on this day.
17 Candomble male highest diety recognized on Fridays by wearing white or light clothes.
Her talk was titled “Political Representation and Confrontation of Racism,” which she divided into 5 parts. I will window into the first section on ethics, violence and racism. I was astounded by the form in which Prof. Maui addressed the public: an academic lecture. It reminded me that in Salvador, in particular, many activists, organization leaders, and government agents might also be professors. The talk truly set the tone for the event; most of the speakers that followed her, representing the government and local organizations, referred directly back to Maui’s speech in making their own points. The public conversation generated at this event mirrored the ways in which the public documents mentioned above draw upon scholarly theory and activist discourse alike.

I found Maui’s talk on ethics instrumental for rethinking and articulating how the ethical subject formation of some lésbicas negras can be interpreted through their enactment of racialized sexual subjectivities in both social and private spaces. Maui’s talk laid out the following understanding of ethics:

Generally speaking, we can say that ethics defines the [formation] of the ethical agent and its actions and the set of ideas or values guiding the course of action [in order] for it to be considered ethical. The ethical agent is defined as an ethical subject, ie as a rational, conscious being who knows [aware of] what to do. As a free being [agent] who decides and chooses what he [she] does, and as a responsible being who is responsible for what he [she] does.

Ethical action, in turn, is buoyed by the ideas of good or evil, just or unjust, virtue and vice, that is, for values whose content may vary from one society to another, or the history of a society, but it always proposes an intrinsic difference between conducts based on good, justice and virtue. Thus, an action is ethical only if conscious, free and responsible. And the ethical action is virtuous only if it is free, and will only be free if it is autonomous, ie, if it is the result of an inner agent's own decision and does not come from obedience to an order, a command, or to an external pressure. Anyway, the action is only ethical conduct (if) rational, free and responsible nature of the agent, and if the agent observe rationality, freedom and responsibility of other staff, so that ethical subjectivity is always an intersubjectivity. Ethics is not a set of behaviors, but a praxis that exists only by the action of individual and social subjects and their action, defined by forms of sociability that are introduced by human action itself in certain material historical conditions.
Em uma perspectiva geral, nós podemos dizer que a ética define a figura do agente ético e das suas ações e o conjunto de noções ou de valores que balizam o campo de uma ação para que ela seja considerada ética. O agente ético é definido como um sujeito ético, isto é, como um ser racional, consciente, que sabe o que faz. Como um ser livre, que decide e escolhe o que faz, e como um ser responsável que responde por aquilo que faz.

A ação ética, por sua vez, é balizada pelas ideias de bom ou mal, justo ou injusto, virtude e vício, isto é, por valores cujo conteúdo pode variar de uma sociedade para outra ou na história de uma mesma sociedade, mas que propõe sempre uma diferença intrínseca entre condutas segundo o Bem, a Justiça e a Virtude. Assim, uma ação só será ética se for consciente, livre e responsável. Só será virtuosa se for realizada em conformidade com o bom e o justo. E a ação ética só é virtuosa se for livre, e só será livre se for autônoma, isto é, se resultar de uma decisão interior ao próprio agente e não vier da obediência a uma ordem, a um comando, ou a uma pressão externos. Enfim, a ação só ética se realizar a natureza racional, livre e responsável do agente, e se o agente respeitar a racionalidade, a liberdade e a responsabilidade dos outros agentes, de sorte que a subjetividade ética é sempre uma intersubjetividade. A ética não é um estoque de condutas, e sim uma praxis que só existe pela ação dos sujeitos individuais e sociais e na ação deles, definidos por formas de sociabilidade que são instituídas pela própria ação humana em condições históricas materiais determinadas.

This perspective is clearly firmly grounded in moral-philosophical understandings of the ethical realm, but is still very much in line with how I understand ethical subjects to be agents who put forth their ethical actions in intersubjectively negotiable terms. For Maui, ethics is only possible to the extent that ethical subjectivities are “always intersubjectivities.” This recalls Barbara’s sister Luci’s (to meet in Chapter 4) definition of black life as “classe mais baixa” in the sense that black folk are intersubjectively regarded and systemically treated as inferior. Further, Maui emphasized the myth that in Brazil violence because of racism does not exist. She attributed this myth to the “notion of (citizenship and class) representation in a racist class society that then legitimizes racism, oppression, exclusion and extermination.” I interpret her as arguing that only ethical subjects who enact their agency and freedom as citizens can overthrow this myth, through their pursuit of freedom from micro-violence as a human and civic right. Maui’s concluding recommendations included
3. Social reform, consolidating the State Social Welfare with a state policy and not a Government program. 4. And a policy of cultural citizenship that starts with education and the whole range of the arts in order to dismantle the authoritarian imagination, breaking the monopoly of the ruling class on the sphere of symbolic goods and their diffusion, and breaking their conservation through the middle class.

Maui’s final recommendations reinforce the idea that ethical negotiations are related to the welfare of citizenship and the nation state. However, they also call for national “etico-politico” discourses to be enacted more concretely in micro-social worlds of citizens who experience racism. Part of the disconnect between those Brazilians who understand racism and those who do not lies in their ability to grasp how it is experienced, not simply constructed. Those who can grasp this distinction, I want to suggest, can begin to perceive the different “attitude of life” characteristic of black LGBTT folks, and understand its relationship to their marginal place within the nation-state. In the balancing of their marginality through the construction of identity, building more satisfying forms of micro-sociality, or simply by striving toward a better life, lésbicas negras engage in ethical practices of both citizenship and racialized sexual subject formation.

These lésbicas negras are ethical voices in gynecology even when they are not faced with concrete medical problems, but are instead seeking recognition through routine exams. We need to consider the public discourses of citizenship in which they participate as entangled “relationships with sexuality and politics; between bodies and governments; and between forms of embodied power and national and transnational biopolitics” (Sheller 2012:242). As Mimi Sheller reminds us, “to think sex and citizenship together is to assert the insistently embodied corporeality of citizenship in
everyday practices, as against the disembodied, abstracted, juridical citizens of constitutional law who in fact are semantically and symbolically coded as white, male, propertied, and heterosexual” (242). Sheller’s work can help us to understand the ethical functions of particular subjects who are highly aware of their position in the contemporary world, that is, of their historically peripheral status as subjects of “colonialism, slavery, and exclusion” (1). Their racialized sexual subjectivities, then, represent examples of “citizenship from below, which look beneath conventional definitions of political agency and of citizenship and seek out the excavated field of embodied (material and spiritual) practices through which people exercise and envision freedom in a domain” (6). This is the domain of what Sheller calls “erotic agency.” (245) I want to suggest that my informants mobilize their “erotic agency” in their ethical negotiations within the gynecological setting.

We can understand the ethical here as how a form of morada, as a way of dwelling or occupying or creating a space, travels into the gynecological clinic. One day, Barbara Alves gave me an article in Portuguese on ethics that she said reminded her of my work. She had received it during a group discussion on planning the 2013 Enlacando Sexualidades. In the article, titled “Participative research and health researchers’ ethical formation,” Maria Luisa Sandoval Schmidt argues that “ethnographers in health research establish their own ethical subject position via an autonomy associated with self-reflection and the encounter with alterity typical of fieldwork” (2007:391). For Sandoval Schmidt (who also quotes Maui’s work), “a etica e morada, modo de habitar o mundo e lugar de atualizacao de valores e atitudes” (392). The idea that the ethical structures the ways in which we occupy places and spaces is consistent with the theoretical framework used this project. On the one hand, gynecologists’ offices are socially constructed places and spaces that
structure and produce particular forms of sexuality through instruments such as questions about sexual practices, the use of speculums, or other vaginal exams. *Lésbicas negras*’ ethical practices actively invoke the social dimensions of this experience and space in their attempts to expose and resist *preconceito*. On the other hand, some *lésbicas negras* attempt to reassemble the gynecological setting, identifying for themselves the spatial and social “ingredients” of their ethical dwelling in the gynecological setting (Latour 2005). The ethical, then, here offers a window onto the reassembly of social complexities.

*Windowing Intimate Encounters: A dor da cor, A cor da sexualidade*

In this last ethnographic look at my *lésbicas negras* interlocutors, I window into the life of Erica and Telma as a couple. The significant time that I spent with them as couple (including living with them during my first six weeks in the field) allows me to offer an intimate ethnographic view into the social complexities structuring their relationship. The title of this section, *A dor da cor, A cor da sexualidade* (the pain of color, the color of sexuality), borrows a phrase from Carneiro (2011: 63) to reflect upon the racial and sexual aspects of citizenship formation. It aims to demonstrate ethico-political aspects of these women’s forms of *morada* (Schmidt 2007). I hope to move between the politics of discourse and the politics of *lésbicas negras*’ lives, to envision partial connections between the ethical, broadly understood, and the particular racialized sexual subjectivities of these women.

Erica is 35 years old, native to Salvador, and self-identifies as a *lésbica negra*. I met Erica at *Palavra da Mulheres*[^1] in August 2007. Initially, I was struck by her attractive, butch-like appearance. Over subsequent years, I grew to appreciate her as a

[^1]: Palavra de Mulheres was one of the first organizations in Salvador to offer services and participate in activism on behalf of lesbian issues. It has since folded.
self-identified *lébica negra* with strong political, racial, and social views and intense community involvement, despite her middle-class background. Unlike Barbara, Jandira, and others, she does not have any gynecological health problems. Erica, as an ethical subject nevertheless, presents us with an alternative view into the formations of racialized sexual subjectivity in her negotiations with gynecologists and beyond. Here, I window into some of Erica’s joys and struggles as a young black woman in Salvador in order to better understand how particular enabling conditions within micro-social interactions are crucial for shaping ethical subjectivities.

My relationship with Erica, was often critical for my experience of the density of the ethical world inhabited by *lésbicas negras*. My key interlocutors spent a lot of time reflecting on and critiquing the social systems that contributed to the *condições* of their lives and of *negros/as* in general, and their political practices often brought them into contact with one another. I learned early on in my fieldwork, for example, that Erica knew Barbara from her younger days of *Partido de Trabalhadores* (PT) work, when she was eighteen years old. She said, “Sim, conheco a Barbara” (while nodding her head in her usual smiling gesture when she’s thinking about her past). Whenever I united her and Barbara, they would begin to reminisce about the past of the PT movement. I enjoyed seeing Erica during those moments, animated and opinionated. Erica also knew Jandira, who was her ex-girlfriend’s ex-girlfriend. In fact, I became friends with Jandira’s sister Ana Marcia in 2008 through Erica and her ex-partner, Fernanda. Erica, in many ways, introduced me to the black lesbian world in Salvador described in this dissertation.
Windowing: Your Private Family Gynecologist and My SUS

As ethical subjects without gynecological health issues, Erica’s and Telma’s negotiations with their gynecologists present somewhat different realities from those of my other interlocutors. Erica is privileged to remain under her mother’s health insurance until the age of 35. Her mother has very good health insurance because of her government job, which in Salvador means good pay, security, and benefits. This health insurance permits Erica to see a gynecologist who is a friend of her parents. When I formally interviewed Erica in November 2013, she told me that she never experienced *preconceito* from a gynecologist because she always sees her mother’s gynecologist. She believed that her gynecologist would never treat her poorly, as she is a friend of the family. For Erica, negotiations about her sexuality with her white female gynecologist involve a different set of tactics, given these familial ties. In our interview, Erica expressed fear of large speculums, and talked about how she suffers from strong *colica* (menstrual cramps), often requiring birth control pills to minimize her menses flow and menstrual pain. While these discussions do not necessarily involve overt discussions about her homosexuality, Erica believes that her doctor
treats her neutrally, with greater awareness of her sexuality, to avoid awkwardness. Of course, her top of line health insurance pays for that respect – literally.

Telma relies on SUS physicians (scouting out the “good ones”) more than Erica. When she worked for GLOBO television for 8 months in 2012, she had excellent health insurance. She said, “I must take advantage of my health insurance!” and maximized the benefits of her coverage by consulting a variety of private specialists (orthopedic, neurological, and gynecological). She even got dental braces. Once GLOBO health insurance ended, she returned to SUS. Telma, unlike Erica, had a strong opinion about how gynecologists treat women, and gay women in particular. Telma shared two different negative experiences with both private and SUS gynecologists during my fieldwork. One day I met up with Telma on the bus, eager to share her experience with her white female gynecologist from SUS. Sitting on the bus, wishing I had my recorder with me, Telma animatedly recounted the poor quality of her experience, presenting details that ranged from not using gloves and barely touching her legs during a pelvic exam to dismissive and rude responses to Telma’s concerns. Though she did not think that the treatment she received was related to her sexuality, we both agreed that it is hard to identify whether inappropriate treatment of patients is a reflection of their preconceito or simply neglectful. This quality of service is consistent with the general impression of care from SUS clinicians. What is interesting, however, is that many of these physicians also have private practices: are they treating their patients in those offices the same way? How is Telma to negotiate an “ética morada” with a gynecologist such as her? Telma told me she was not returning to the SUS doctor for her follow up, and Erica agreed with her decision. The negotiations of how she wanted to be treated were more accessible with the private male white gynecologist a few months back.
Windowing: Working for No Pay, Working for Dignity

Not even as a middle class daughter of parents holding upper level government jobs can Erica escape the obstacles that fractured employment and salary system present to her self-care and social progress. When I met Erica in 2007, she had just lost her job, from which she had earned $R500 per month. At the time, the mean monthly salary was around $R350. Erica preferred to work for social movement organizations, and to my surprise, Erica was not able to find work for over a year. She decided to return to college instead. As of 2011, she still struggled to find employment. Ultimately, she was able to find a place at a public lower school, in the administrative office. This work was sufficient until, in 2012 the “empresas” (the employment agencies contracted by the government) began to delay her pay for months at a time. Erica (and other workers) would have to continue going to work without pay each day, however, or she could lose her secured seat. Even once the pay began again, it would not come at once. It would trickle in slowly, from month to month. During my fieldwork, I saw Erica struggle to pay for food, rent, and her college books because her monthly pay was “frozen.” It was more common than I realized. Feeling chronically frustrated, she finally transferred to another school with the help of her father, where she would be paid through a different “empresa.”

Telma is an actress. Beginning at the age of 17, she worked for Bando de Teatro Olodum, a theater company that prides itself on excellence in Afro-Brazilian performing arts, located in the heart of downtown Salvador. If your carteira reflects work experience within a profession for significant time even without a college degree in a related area, the government accepts it as your profession. From a working class family, Telma’s strivings for a better life are somewhat different. Her work, as work, is important for maintaining her self-esteem and self-love. When I returned to
Brazil in 2012, Telma had left the *Bando* for a role in the *novelas* for GLOBO television. She was proud and excited, not just for the opportunity earn more money and travel to Rio de Janeiro, but for the possibility that she might transition into steady work on television as an actress. Her role in *Gabriela, the novella*, was as an “extra,” playing a domestic worker in scenes depicting white elite families and life in Brazil in the 1920s. She appeared on the novellas less frequently than she expected. She would sit at home collecting her pay and benefiting from her health insurance while waiting for her role to appear and travel to Rio for a few days at a time for production. If the *Bando* was Telma’s *ética morada*, where she enacted and embodied her racial and sexual worth, then, the tension caused by not returning to the *Bando* after not being recast by GLOBO after the novella ended produced or demonstrated changes in her ethical subjectivity. Erica, as her partner, was a key part part of this transformation.

*Windowing: On being “buffie-ledie” intellectual radicals*

Erica reminds me of a young black intellectual radical. The ways in which she debates and recounts politics, history, issues of oppression, and social violence in Brazil and Salvador over beer or coffee cannot but bring to mind a “collective” form of “black resistance inspired by an enduring cultural complex of historical apprehension” (Robinson 1983:5). In her engagements with and striving to participate in local social movements, Erica appears to be engaged not in “creating the idea” of the struggle for social justice in Salvador, so much as in “articulating” it (Robinson 1983:5). She is now completing her college degree in history, with a focus on Afro-Brazilian history and labor relations, as a direct result of her raised consciousness regarding the political situation and structural violence in Salvador. History, here, is
an important resource for the “attitude of life” of which Erica is an example. As a lesbian, she is out and proud, though she carries herself carefully; she is very aware of the extent of violence and assault upon LGBTT folks in Salvador. Erica is a buffie, a femme-butch, according to Telma. The term, amusingly, also cropped up after interviewing Sueli, a masculine female from Barrio Calabar, who out of nowhere asked me if I was a buffie or leide (lady). I had given her the opportunity to ask me any questions she might have (thinking they would be about my research), but I was not prepared to respond to her smirk, unapologetic shyness, and curiosity. My honest response was, “I am both.” Particularly given that she had just told me that “in her mind she is a man,” I was struck that she wondered on which side of the fence I fell; I knew she referred to my sexual roles. There is a distinction between a buffie on the street and a buffie in bed. I suppose the coding of my dress, given Brazilian gender norms, was difficult for Sueli to read. It was a fair question, as I was after all interviewing her about her personal sexual life.

When I shared that moment with Erica, though, she laughed with hysteria. These intimate queer moments for me were amusing, daunting, and illuminating. Erica, who never wears skirts, dresses, high heels, or makeup, would likely be considered as both a buffie and ledie by Sueli’s views on same-sex gender roles. Erica’s long hair-locks and serious face reads against Brazil’s femininity, and she often pays a price for it. Early on in our relationship, she told me she was likely not being called for a job she had applied for because of her being a negra with hair locks. Later, I learned about Brazil’s carteira de trabalho e previdencia social system, which is basically a citizen’s passport for applying for jobs, services, and much more; employers access your photograph on the carteira before hiring. That employers might discriminate on the basis of this photograph, however, does not deter women
such as Erica from maintaining their image of *negritude* associated with hair. As a *buffie*, neither does she stay single for long and values live-in (*casadas*) relationships. Her flirty, romantic appetite gravitates toward a particular type of person, such as Telma.

Telma, with her dark skin, full figure, big hair, big smile, and femme presentation was Erica’s love, pride and joy. Erica described Telma as complementing her intellectual appetite and commitment to issues of race and social justice. Telma once told me in front of Erica that she courted Erica at an outdoor social event. She said, “*Oh, gostei dessa buffinha.*” Erica eyes just glittered back at her in front of me.

Erica is shy. Telma is not. Still, they both have big hearts and intellectual minds. The extent to which couples can influence each other to reach new heights of well-being was evident in their relationship.

Telma took pride in how being part of the *Bando* taught her how to think critically about issues of race and even sexuality. She was an intellectual artist, and wanted to understand the world in ways that fostered self-love and love of the world. Telma wanted to be recognized as someone who understood herself in relationship to the world and to other people. After all, as an actress, singer, and theater performer in the Salvador black arts community, she embodied her ideas and work, envisioning herself as a free agent and an agent for change. However, she was acutely aware of the limitations that a black body such as hers was subjected to, aware of the obstacles to her striving. The navigations of their *condições* required of Erica and Telma in their work and passions were part of their shared reality as black citizens.
Windowing: Black Love, Black sexuality, Etica Morada

The term *casadas* was deployed in Salvador in a striking way. Being *casadas* means, simply, “being married” in everyday Portuguese. However, if an unmarried couple lives together or are in a committed relationship, you are referred to as *casadas* (*casados* for male couples). Throughout the period of my fieldwork, Barbara avoided being *casada*. She wanted no tied strings! Jandira and Isabelle, on the other hand, were veteran *casadas*. Methodologically, it was challenging for me to recognize Erica and Telma as *casadas*, given that I was so much part of their intimate lives. However, I strove to find a distance that would allow me to fully appreciate what it meant for them in their context. After all, as a researcher, in part, of intimate relations, I knew better than to assume that all *casada* black lesbian couples would live and move about the same way. I find the window onto their lives crucial, however, given the extensive role that partners play in each other’s lives both within and beyond their *casada* space. Luci and Luci’s girlfriend, Cristina, for example, leaned on each other to support Luci’s fear-filled encounters with the gynecologist. Jandira and Isabelle (who are partners for 8 years) supported each other through their hysterectomies and sharing
affirming gynecologists. As part of their striving for well-being, the members of these lesbian couples influence each other’s ethical projects. Put more specifically, the couples in this study influenced each other’s racialized sexual subjectivities.

How does being casadas, as an etica morada, an ethical being together, interact with the striving for saúde sexual? The intersubjective experiences of these women produce certain forms of citizens and subjects in the context of broader, circulating gender norms (Rosemary 1993) and arrangements by which love and relationships are represented in Brazil. The lives of lésbicas negras living casadas also functions to disrupts heteronormative understandings of familial and sexual health. If these women’s sexuality cannot be negotiated, made part of their ethical mode of being in the world, it would mean a kind of social death, at least within the most intimate spheres of their sociality. After all, not all lesbians may talk about their gynecological experiences collectively and publicly, but they will bring the affects that they produce home to their partners. As Cristina said, Luci often needed days to recover after visits to the gynecologist; less from the physical trauma than the emotional and psychological toll of the interaction. What is at stake for some lésbicas negras as ethical subjects and subjects of gynecological examination is more than fibroids and breast cancer, but a quality and form of often communal life and recognition that provides them with the resources to negotiate medical, intimate, and social interactions.

In the next chapter, I focus upon the concept of preconceito, its histico-political context, and its deployment by some of my interlocutors. This conceptual chapter serves as a foundation for introducing an anthropology of ethics framework for this research.
Chapter 2

Manifesting the Ethical

This chapter outlines the central arguments of the dissertation as a whole, delineating its key strands of inquiry. I have two main goals for this chapter. First, I discuss in detail the issue of *preconceito*, or prejudice.\textsuperscript{19} I show how *preconceito* shapes the decisions and practices of my principal interlocutors, *lésbicas negras*, in gynecological contexts. Many Brazilians believe *preconceito* contributes to broader and intimate injustices, inequities, and social conditions such as poverty, violence, and health disparities; in this dissertation, I demonstrate that it also holds broader implications for our understanding of the racialized sexual subjectivities (Caldwell 2007; Williams 2013; Khan-Perry 2013) of many *lésbicas negras*. Specifically, I am interested in the connections between *preconceito* as symbolic language, circulating in the public realm, and the socio-cultural and political shaping of these subjectivities. However, in later chapters I push my analysis of *preconceito* further, arguing that it serves as a material (social conditions and social reproduction) and cultural framework and discourse, through which some Brazilian citizens pursue particular modes of freedom from racism, sexism, or homophobia.

My second goal for this chapter is to introduce my conceptual and analytical framework, developed primarily in dialogue with contemporary work in the anthropology of ethics (Laidlaw 2013; Dave 2012; Davis 2012; Faubion 2010, 2001; Lambek 2010). Specifically, I focus on what I will call *gineco-etico praticas*; the ethical practices (Dave 2012; Faubion 2010), or “practices of freedom” (Foucault 1984), which my interlocutors developed in the context of their engagements with the

\textsuperscript{19} *preconceito*, a word in Portuguese can also mean bias, biased attitude, and preconceived ideas and opinions. It usually refers to negative attitudes formed by preconceived opinions.
gynecological establishment. They used a range of these *praticas* (practices) to realize themselves as ethical subjects (Faubion 2010; Davis 2012) through conversations about their sexuality, engaging in repetitive or renewed “self-realization” activity as lesbians (Eribon 2004) within the dialogic context established by the gynecologist. I introduce how these women interpret the ways in which gynecologists position them as sexual-medical subjects during their conversations. Later, in my more ethnographically-focused chapter 4, I draw out a number of ways in which a core group of my informants sought to establish themselves as ethical subjects through non-normative expressions of sexual health. My broader intention is illuminate their modes of expressing sexual health as social reproduction and as the bio-cultural means by which they seek social health. Ultimately, I argue that many *lésbicas negras* are robust ethical subjects, forging novel ethical practices through their engagements with the gynecological healthcare domain. These interactions might be considered as the focal points through which particular ethical subjectivities and practices emerge and shape underexplored intersubjective relationships that are racially, sexually, and gender-informed.

**Sexual Health and Subjectivity**

“*Saúde sexual e uma forma de liberdade*” (sexual health is a form of liberty) was how Jandira defined sexual health. I met Jandira, a 40 year-old *lésbica negra* and initiated member of Candomblé\(^{20}\) (a long-standing Afro-Brazilian religion), in 2008. We had our first official interview in 2011. Over the course of our developing friendship, as I returned for major fieldwork in 2012-2013, our conversations prompted me to take a close look at what would become the major focal issues of my

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\(^{20}\) Candomblé is an Afro-Brazilian religion native to Brazil. Most of my key interlocutors are initiated members of Candomblé or frequent the temples as non-initiated members in the community.
research into sexual health: (1) why is “sexual health” defined by my interlocutors as liberty and wellbeing; (2) under what conditions it is expressed and embodied (for example, sex, relationships, spirituality, forms of freedom); and (3) what are the dominant social structures in their lives subjugating or legitimating their experiences and desires, as these latter are thoroughly entangled with their personal projects of achieving sexual health? Moving forward, these densely interwoven lines of ethnographic inquiry helped me to identify the ethics of lésbicas negras’ lives and understand the material conditions undergirding or dominating their sexual subjectivities and sexual practices. In other words, I question how we might reinterpret the relationship between social and medical norms in relation to the emergence of medical subjects’ ethical practices. Reference to Naisargi Dave in *Queer Activism in India* (2012) is useful here when she says, “Norms, though, are not the other to ethics, nor is closure the other to potentiality: limitations as the very condition of possibility for once unthinkable social emergences” (2012:3). Here, I would like to introduce two interlocutors and parts of their related narratives. I point to these narratives not to privilege their experience as principal objects of analysis, but rather as points of entry into the private and intimate worlds of gynecology in Brazil.

Barbara is 39 years old. At age 18, she had her first sexual experience, with a woman. She has been out to and affirmed by her family since her early twenties (in fact, she has a lesbian sister who is “*masculinizada e casada*” [masculinized and married] who also helps take care of the family). Barbara has only slept with women, and has never been vaginally penetrated for sexual pleasure, including by fingers. She proudly and openly identifies as a virgin, and is considered a “virgin” by gynecologists as well. Barbara is a very “out and proud” lésbica negra who often
wears a rainbow-beaded necklace and is very active with political and social movements. Barbara had a very large single fibroid removed along with her uterus one year ago. Prior to this surgery, Barbara waited eight years to find a gynecologist who would affirm her virginity and lesbianism. It became a prerequisite for accepting medical treatment for her fibroid. Eventually, Barbara found a male gynecologist who with much affirmation said, “Yes, I treat virgins and lesbians.” Barbara underwent gynecological and pre-surgical evaluations without ever being vaginally penetrated by any instruments such as a speculum or wire camera. Barbara said she suffered with and would have continued to endure the pain, anemia, body distortion, and loss of sexual appetite in lieu of accepting medical attention by any gynecologist who would not have affirmed her need to not be penetrated, not just as a virgin, but as a lesbian virgin.

Lindinalva is a 34-year-old Candomblé initiate. Lindinalva has been alienated by her blood Christian family for a long time, because of both her sexuality and involvement with Candomblé. Lindinalva currently only sleeps with women, though she has slept with men in the past. She has a lot of lésbicas negras as friends, who she met initially through Candomblé. During Lindinalva’s first visit to her gynecologist, she stated that she does not feel attracted to men and prefers women. After her pelvic exam, the gynecologist told her that her uterus was ready to conceive and he would recommend that she takes a medication that would correct her “falto de apetito e stimulo para homens” (lack of sexual appetite or stimulus toward men). Lindinalva never told him she wanted children. In her conversation with me, she was adamant that “eles não sabem como respeitar a gente como pessoas. Não preciso ser um orientador sexual!” (They [gynecologists] don’t know how to respect us like people. He did not need to become my sexual advisor!).
The sexual subjectivities and practices of women such as Barbara and Lindinalva are present in much of their narratives; these women zealously exhibit how they are sometimes negatively affected and yet affirmed by their ongoing pursuit of sexual freedom. Through such social and medical narratives, I see the potential to interpret how these women perceive freedom either as the necessary condition of their ethical practices or as the value by which they secure and realize the possibilities for forging ethical practices in the gynecological setting. I argue that for some of my interlocutors, their ethical search for affirmation as lésbicas depends significantly upon their awareness of their ability to make alternative choices in how they represent themselves and to push gendered and sexual boundaries. Albeit often under challenging social circumstances, their sexual subjectivities signal a dimension of their quest for freedom; as Jandira poignantly said, “sexual health is a form of liberty.”

This notion is elaborated by Lindinalva’s claim that for her, “sexuality is equilibrium.” Equilibrium here meant taking care of oneself in all “sentidos” (ways), including health. However, it is important to keep in mind that “ascribing fixity to sexual terms is a notoriously slippery proposition” (Howe 2013:16). I agree with Cymene Howe in Intimate Activism: The Struggle for Sexual Rights in Postrevolutionary Nicaragua (2013) that “sexuality is a vast category that has been used to give name and voice to desires and practices, to codify political solidarity, and to define subjectivity and identity (2013:16). For many women I engaged in Salvador, notions of sexual health are not just associated with prevention of sexually transmitted diseases (STDs) or reproductive cancers, but with the expression and defense of their sexual subjectivities. For them, sexual health is a lived experience with high stakes and the potential for much gratification; given the extent to which Salvador can be a
complexly oppressive environment for the articulation of this relationship to sexual health can be enacted as a means of “self-governance and strategy of existence” (Biehl et al, 2007:5)

Furthermore, my interlocutors describe sexuality as being pleasure, sensation; it is both within the self and at the same time a dangerously public mode of being and subject to social violence. These subjective perspectives are also linked to the ways in which they seek their rights to “visibility by enunciating their homoerotic relations as a means to publicly define their sexuality” (Meinerz 2011:46; dos Santos 2009).21 Their self-interventions are active within the gynecologist’s office, particularly for women “assumidas” (not closeted with their sexuality) and seek to confront lesbofobia (lesbophobia). Many women are not solely interested in their sexual (or political) identity, such as “lésbica,” being recognized by their gynecologist; they want the fullness of their embodied experiences and practices outside of the clinic, their lived experiences as lésbicas negras, to be integrated within their medical conversation.

What this conversation looks like from a gynecologist’s point of view was confirmed for me during an interview with a very prominent and experienced gynecologist. This female physician (herein named Dra. Santos) confirmed the concerns of my informants without prompting.22 Dra. Santos said, “Sexuality in general is not given any significance. Most doctors treat women mechanically in Salvador and sometimes don’t even look into their eyes while speaking. Their first question is usually, what contraceptives do you use?” I chuckled while sitting with

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22 Dra. Santos chose to be anonymous though she signed an IRB form. This physician holds a high public position in the medical community in Salvador. I believe she chose to be anonymous, not just to protect her identity from the study, but to also feel at greater liberty to express her opinions. She has been in practice and part of public health arena in Salvador for several decades.
her, because most women I interviewed reported this as well. When I asked why discussing issues pertaining to sexuality was such a challenge, she suggested that it was a question of the “sexo masculino” (male/masculine sex) being and acting as superior. In these hypothetical male superior gynecologists’ view, “falar delas vidas sexual das lésbicas nao e um assunto importante, nao e atrativo, e nao e necesario” (it [lesbian sexuality] is not an important issue, not attractive, not necessary). After my interview with Dra. R., I began to pay attention to what medical control ought to not look like for my interlocutors. Her aggressive attitude towards medical preconceito and depth of insight made a huge impression upon me. Her stern frustration was palpable. It provided a stark insider’s perspective on how gynecological medical practices in Salvador-Bahia mirrored micro and macro modes of societal domination.

Gynecological clinics did not appear to be insulated private spaces for women’s social and health issues. Yet, women such as Barbara, Lindinalva, and Jandira seemed to be among the minority of women in contesting the medical control of their sexual subjectivities by gynecologists, and in their forging of ethical practices in response thereto. It is extremely difficult for lésbicas negras to disrupt the rigidity of heterosexist attitudes in Salvador among gynecologists, to demand the acolhimento (hospitality) and humanidade (humanity) that their lesbian subjectivities and practices deserve, unless they are in private care or their physicians are aware of the need to legitimize and affirm their demands. As Jandira says, for them, the “SUS nao existe!” (SUS does not exist!), SUS being the Brazilian Government Healthcare System, known as the Unified Health System, or Sistema Único de Saúde. Dr. R agreed with Jandira, stating that the conditions toward lesbians are worse in SUS.
There are deeper social structures, beyond mere individual callousness, that prevent an easy sense of belonging in the gynecologists’ office for lésbicas negras. Emily Martin, in *The Woman in the Body*, suggests that women often “represent themselves as fragmented - lacking a sense of autonomy in the world and feeling carried along by forces beyond their control” (1987:194). She attributes “this fragmentation to the affect of social hierarchy and the implicit scientific metaphors that assume women’s bodies are engaged in production” (1987: 194). I follow Martin in arguing that thinking about how an “embodiment of opposition” can lead us to a more sophisticated understanding of lésbicas negras’ ethical subjectivities; of how “fragmented images” of the self might arise through in efforts to resist internalizing the effects of the too often white, male, elite dominance typical of the medical domain. Furthermore, fragmentation of sexual subjectivity and embodied experience are ongoing, social processes within these women’s lives. Many lésbicas negras, for example, sleep and fall deeply in love with women married to men. The resulting, socially complex experiences leave many women torn and fragmented. Almost all women were disgruntled and anguished when describing their experiences with gynecologists. Their narratives invoke the rigid and alienating behaviors of gynecologists as reported by Dra. R, which are often not only dismissive of lésbicas’ sexuality, but racialized in troubling ways: 98% of the gynecological encounters I recorded during my fieldwork were between black or brown patients and white physicians. In short, the sexual practices and desires of lésbicas are not isolated from the racial, gendered, classed, and sexual structural violence of Salvador, and this violence is too often mirrored in the gynecological encounter.
Practices of Freedom and the Ethics of Self-Care

In this section, I begin my discussion of how my interlocutors not only confront preconceito, but how they seek to gain recognition for their racialized sexual subjectivities through gynecological interactions. I interviewed and spent time with lésbicas negras who sought to negotiate and not closet (or unwillingly conceal) their sexuality within home, school, religious space, friends, and work. These women spoke to me about how they felt the lack of sufficient acolhimento (hospitality or welcoming as a customer-patient) for them as black women by their gynecologists. My discussion of these women’s gineco-etico praticas, of their attempts to express their sexual health as liberdade (liberty or freedom), moves beyond the clinical encounter to the broader, encompassing social fields in which they are mostly articulated. These ethical practices open up onto underexplored, subtle, and complex modes of social reproduction within this medial domain. As we will see, the ethical field inhabited by lésbicas negras is maintained not primarily through gynecological interactions, but also by lived experience of sexual health in their daily lives. Their experience turn and shape their preconceptions of how the just gynecological interaction should unfold, as do, for that matter, gynecologists’ experiences in and of the complex structures of domination that structure their everyday experiences of “sexual health.” Any anthropology of ethics must come to terms with the realization that “sociocultural systems are in fact historical, messy, and definable only through analytical reification” (Faubion 2010:95).

In Toward an Anthropology of Ethics, James D. Faubion states that “Foucault distills the ethical into that rapport a soi or ‘relation of the self to itself’ that manifests itself as the ‘considered practice of freedom,’ a practice always analytically distinct from the moral principles and codes to which it has reference” (2001:85). I see my
interlocutors as ethical in this sense. In the absence of a just and nonviolent medical establishment, they hold themselves accountable for self-care with respect to their sexuality; this self-care permeates and shapes their inner selves, social practices, and personal routines with respect to their sexuality. It is a highly developed relationship of the self to itself; further, it is an awareness of responsibility to the self and others in the quest for modes of freedom (Davis, 2012). Many of my interlocutors defined sexual health as “cuidado de bem-estar” (care of well-being) and/or “uma forma de estar bem” (a form of being well). While there was often an explicit or implicit sense that sexual health is tied to the prevention of sexual transmitted diseases (STDs), or of caring for yourself by going to the doctor and treating such STDs, the conversations lead consistently too deeper, more robust and broad forms of self-reflection among the women I worked with.

Saúde sexual (sexual health), a recent concept in Brazilian public discourse, was understood as what I might interpret as social health, or the caring for the well-being of the self in the service of a happier and freer sexual life; or, more specifically, in the service of developing a self-relating attitude towards such a sexual self and life. It might not include, necessarily, having great sex, or the freedom to have sex with anyone desired, or any other more prosaic mode of sexual “liberation.” However, it always includes a sense of responsible access to modes of freedom; to modes of existence that allow one to be received by others in the world. This relationship to the sexual self was not divorced from how lésbicas negras see themselves in struggles and triumphs as black women, underlining the extent to which sexual health can only be accessed through an already racialized sexual subjectivity.

These women see themselves as part of a greater struggle against violent racial preconceitos. I focus on my interlocutors’ recollections of their interactions with
gynecologists because they are part of a broader blueprint by which their sexual health as liberty is negotiated. However, while some of the approaches that gynecologists take might be same for all women, heterosexual or gay, white lesbians or black lesbians, I am keen to distinguish how lésbicas negras evaluate their access to freer sexual subjectivity in this setting through the lenses of racialized “gay” sexual subjectivity in the first place. As Erica, one of my key lésbica negras interlocutors puts it,

“Contrary to what some might believe that we can change our sexuality, perhaps some can though I can’t, this is who I am, I can’t change my skin color. So, the violence that I experience through institutional racism is premised upon something that can’t be changed, the color of my skin is constant. But homophobia, on the other hand, can be fought with much more optimism because often times, you can’t see sexuality.”

While lésbicas might gain some of the benefits from the changes that these physicians have implemented in response to lesbian movements or white lesbian tactics, the greater task for me is to trace what does it mean to be a lésbica negra in this setting.

**Preconceito and Subjects**

In November 2012, a few months into fieldwork, I began to realize and pay more attention to the fact that preconceito was a huge buzzword among my interlocutors and in public discourse, used explicitly to resist racism, sexism, and homophobia. In the United States, the word “prejudice” was comparatively absent from public discourse or day-to-day conversations. Preconceito was described with far more palpable affect and disdain among mulheres negras heterosexuais e lésbicas negras than mulheres e lésbicas brancas during my time in Salvador. As I began to truly take greater notice of how virulently it circulated within the plethora of social
movement materials available in Salvador, I began to wonder: what function is served, in this Brazilian context, by maintaining the lifted idea of preconceito? Why should it be the catchall term for structural violence? What was it accomplishing for those who refer to it in order to make a point? Why was it such an obviously relevant and ever-present idiom in the context of my research?

Preconceito is not just an individual judgmental attitude or unconscious bias that privileged folks manifest far more frequently than marginalized folks (for example, to be a white Brazilian, upper or middle class folks, heterosexual white male or female is by large considered to have privilege and access to resources and, more importantly, respect as a citizen). Preconceito, rather, seems to be a huge social issue or problem (See Images 7 and 8). Among the many situations and varying spectrums through which I encountered this term, I want to highlight two incidences that connected its use across national and local levels.

The first was a dual national and local outcry against a federal official. This tremendous uproar was a significant signal to me that the millions of Brazilians were just as willing to speak against homophobia, sexism, religious intolerance, and racism—not only because of the discriminatory practices and inequities associated
with these forms of oppression, but also just as much for the thought, feeling, and affect processes behind related discriminations. In March 2013, Christian Pastor and Deputy Marco Feliciano was appointed as the head of the Federal Commission for Human Rights (Comissao de Direitos Humanos da Camara dos Deputados). His appointment opened a floodgates of public outcry and active resistance focused on a single individual and “verdadeiro preconceituoso, machista, racista e homofobico” (Mulheres em Luta, April 2013). This outcry would also expose the existing systematic efforts to condone and ignore not just discriminatory practices against negros/as, mulheres, religioes Africanos, e populacao LGBTT (as described by many activists in Salvador “the blacks, women, African religions and LGBTT population,”) but to affirm the rightful place of preconceito(s) to shape the country’s human rights policy at the federal level. The controversial appointment of Deputy Feliciano, who advocated a cura gay (cure for gays) and who was chastised for publicly stating that blacks were “heathens who needed to return to Africa,” made the newspaper and magazine headlines for months. Immediately, people responded with raging protests in numerous cities, even internationally (such as in Paris). As one of my key interlocutors, Barbara, told me, “it has been a long time since a national political issue brought people of all backgrounds of religion, sexual orientation, race, class, gender, and more together to protest.” It was startling to witness a nationwide social movement and response bringing together issues that tend to be advocated separately: to be black, to be gay, to be a woman, to be poor, and even to be Christian meant that Feliciano did not represent you. “Feliciano nao me representa!” (Feliciano does not represent me!) became a widespread public phrase and symbol. It feverishly circulated on Facebook attached to images of female faces, gay identity images and

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23 This quote was taken from a full-page article published by a local organization in Salvador called Mulheres Em Luta (Women in the Struggle) in April 2013. This one-page article was circulated and handed-out to the public in the streets of Salvador.
faces, black/brown faces, and much more. It prompted an explosion of individual and group acts and images about “outness,” whether from gay or straight-acting-as-gay folks in the media, on television, on Facebook, and everywhere. Globo television media celebrities circulated photos of two women or two men kissing with the caption “Feliciano nao me representa.” However, most of these faces were white and light Brazilians. To me, this seemed to suggest that the “proper,” empowered gay subject was held to be best represented by the face of a white Brazilian, while the struggle against racism was left mostly to black and brown faces.

This governmental appointment was a huge step back for civil rights movements, according to many folks. While I paced around my 10th floor apartment, overlooking a beautiful view of the Bahia bay water in the popular and central Barrio Dois de Julho, I thought furiously. How can the Ministério da Saúde keep pushing for its LGBT health and healthcare reform agenda with such humanitarian and political turmoil at the federal level? How does this entrenched, more or less explicit support
of preconceito affect the medical spaces occupied by my interlocutors? Deputy Feliciano represented not just the inability of the government infrastructure and many citizens to take seriously the implications of discriminatory practices, but of a deeper and indifferent complacency. It was a huge signal that the public was far more resistant to a wider social problem that of: preconceito mesmo (an expression to emphasize and to mean that it is just that: the real preconceito). This national and local controversy was especially intriguing (and alarming) to me because of its laying bare the social tug of war over what constituted as preconceito. At this juncture in fieldwork, the controversy only affirmed on a macro-scale my recent awareness of preconceito as a social problem in the gynecological realm.

I had further confirmation of the pervasiveness and often-unquestioned character of preconceito at the SOGIBA (Sociedade de Obstetricia e Ginecologista da Bahia) conference, an annual meeting for Gynecologists and Obstetricians in Bahia, held on October 25-27, 2012 at the exclusive Pestana Hotel in Barrio Rio Velmelho. I had eagerly registered as a student, interested in hearing gynecologists’ updates about gynecological health issues, interventions, dilemmas, and updates for women in Bahia or Salvador. I had also hoped for some physicians to mention something about homosexualidade feminino (female homosexuality) in their practice or as it related to any medical interventions. As it turned out, not entirely to my surprise, no physician mentioned homosexuality during the fibroids, gynecological cancer, or STDs panels. However, race (negro) was mentioned as a significant demographic risk factor during the uterine fibroid panel; further, unexpectedly but not-so-surprisingly, I myself became a subject of racial preconceito at this conference.
During the coffee break in the conference lobby, I was amazed at my view of the attendees socializing with coffee and sugar cookies. I overheard the president of SOGIBA say with much enthusiasm that there were over 600 people in attendance that morning. As I looked around the floor, there were only slightly fewer women than men, but a stark divide along color lines. Over both days, I saw only seven or eight brown and black women (and even fewer black men). The majority of the women were dressed in towering heels, and most often in evening formal wear. It was strikingly a high performance of femininity for a medical conference. As a Physician Assistant who has attended many medical conferences, this event struck me as very white elite Brazilian, especially as compared to other academic or social events in Salvador, where black folks made up a larger portion of the attendees. The femininity was a replica of a Brazilian novella (television daytime soap)! Still, I courageously pushed through my comfort zone and eventually secured interviews with the several gynecologists: Dr. Manuel, Dra. Rosa, a black female doctor who chose to remain anonymous, and Dra. Elizabeth. These initial contacts snowballed into the complete sample of the gynecologists I interviewed in Salvador. Dra. Elizabeth was the first one I reached out to; she had told me that “Sim, gosto de falar da essa coisa dos
Negros” (Yes, I like talking about that thing of Blacks). Not every meeting, however, was so felicitous.

A few days earlier, I had arranged by phone to meet a prominent physician during the conference. We had never met before, but decided to meet in the lobby during one of the coffee breaks. When I approached this physician at the designated area, however, I was greeted with a horrid face; it seemed as though I was disturbing the conversation he was engaged in with another physician. The rebuff was enough to cause me significant embarrassment; it was quite obvious to many of the others around us. I had my large SOGIBA identification around my neck and bag on my shoulders, and it was clear that I was there for the conference; had I done something, or forgotten to do something, to warrant such a greeting? When this physician realized I was the American student, however, not only did I receive an apology but his attitude changed drastically. To me, it was yet another reminder that many people who expected to receive an American visitor or academic also expected to see a white person. On this day, I was dressed in all black, with my hair in its usual curly afro. I knew I looked Bahiana. But when I realized that the servants putting out the coffee and replenishing the cookies, juice and water were all black and brown dressed in black, I realized this physician thought I was one of them. When I followed up on this with some of my friends and interlocutors, I discovered that the experience of being mistaken for the hired “help” was not unusual for black women in Brazil, especially in a “white,” elite setting. While I was not discriminated against by the physician, per se, I nevertheless experienced something of preconceito, of the sense of inferiority produced across power relations, even if in its mildest of form.
By the time I met with Dra. Elizabeth for our interview in March 2013, I was itching to speak with a physician who identified as a black woman. I met her at the Hospital da Familia Sagrada in Barrio Bom Fim. By the time I arrived, at 8:45am, she had finished discharging her patient. Her clinic was across the street, but she was not scheduled to be in clinic that day. She asked me if I would mind conducting the interview at her home, as she was in the middle of arranging funeral care for her dying nephew. She was warm and inviting in spite of her circumstances, so I went with the flow. It was worth it. We chatted long and deep in the car as it wove in and out of traffic. As it turned out, she lived only 15 minutes away from me on foot. In the car, she shared her thoughts about why my research was important for black lesbians and for black women in general. She lamented how healthcare is affected by racism, blaming it for the inadequate distribution of services and funding for public healthcare in regions predominately black.

At her home, we sat at her kitchen table in the kitchen for the interview. It was this part of the conversation that struck me about preconceito:

NF: How do you identify which patients are lesbians? (Como e que voce identifica qual pacientes sao lésbicas?)

Dra. Elizabeth: I tell them, you can talk to me, I don’t have preconceito. (Eu digo, pode falar, nao tenho preconceito).

It was that simple for her. However, Dra. Elizabeth was unique among physicians I interviewed in her belief that she does not have preconceito toward lesbians and their sexuality; among the sixteen+ interviews I conducted with gynecologists (and few

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24 Though Dra. Elizabeth might be considered lighter in complexion but not enough to be pardá (very light but not white) and definitely with cabello duro (what is conceived as kinky hair and black hair, basically). These racial and skin color categories such as preta, pardá, branca, amarella, and others are complex descriptive identities for skin color as discussed in the work of Edward Telles (2004), Kia Lilly Caldwell (2007), Sueli Carneiro 2011, and Carlos Moore (2012).
infectious disease physicians), this was an isolated response. Dra. Elizabeth’s statement she actually explicitly tells her patients that she does not have *preconceito* gave me much pause. My strong suspicion is that Dra. Elizabeth, as one of two black physicians interviewed, believes that she is incapable of *preconceito*, even about matters of sexuality, given her experience of the historical and political legacies of racial bias and racism in Brazil. In any event, I was captivated by how adamantly she believed to not have *preconceito*, if at least as a stepping-stone to building trust with her lesbian patients, to remove the fear of it as a barrier to their communication. At the end of the day, patients do not want to be received with the disapproving, or even disgusted, expressions reported as typical by many of my interlocutors. Black women, in particular, perceive such expressions of inferiority or disgust far more poignantly than white women, due to their particular place within the Brazilian economy of racial and sexual *preconceito*.

What then, is *preconceito*, such that one cannot “have” it? *Preconceito* translates into English as prejudice. While there is a distinct difference between *preconceito* and *discriminacao* (discrimination) similarly to how in the U.S. we might refer to prejudice and discrimination, I draw attention to *preconceito* because of its prevalence and the socio-cultural utility it seems to hold for many Brazilians. As I have begun to demonstrate, *preconceito* is believed to be the underlying substance or moving force responsible for unjust outcomes related to racism, sexism, homophobia, and other forms of social violence. As Jandira said in her interview for my documentary film project, “*Para com sua preconceito!*” (Stop with your *preconceito!*), as though it is something that can be willfully stopped. If *preconceito* is “the attitude and preconceived ideas and bias toward people or something,” as one of my informants put it, this sets it apart from discrimination, described as the act of
exclusion and violence *preceded* by *preconceito*. Why, then, is it so important for my interlocutors, for those involved with social movements, and for many ordinary people to not only verbally rant or complain about, but to endlessly materialize this idea of *preconceito* through pamphlets and other printed materials? What is the significance of *preconceito*? Many Brazilians are trying to hold responsible foundational culprits of injustice and inequality that ultimately lead to discrimination. For example, “The Time Has Arrived to Take Care of Your Health,” a small informational handbook for lesbians and bisexual women put out by the Ministério da Saúde in 2011, reminds the public and professionals that the Constitution of 1988 forbids its citizens from *preconceito*:

promote the welfare of all, irrespective of prejudice/bias of origin, race, sex, color, age and any other forms of discrimination.

*promover o bem de todos, sem preconceitos de origem, raca, sexo, cor, idade e quaisquer outras formas de discriminação*

Not only are their laws against racial discrimination, so too are there laws against the manifestation of *preconceito* as something separate from discrimination. On January 5, 1989, Lei No. 7.716 became a law, defining “*os crimes resultates de preconceito de raça ou de cor*” (crimes resulting from *preconceito* of race or color) and putting forth:

“Art. 1º Serão punidos, na forma desta Lei, os crimes resultantes de discriminação ou *preconceito* de raça, cor, etnia, religião ou procedência nacional. (Translation: Shall be punished in accordance with this Act, crimes resulting from discrimination or prejudice based on race, color, ethnicity, religion or national origin.) In Lei No. 9.459 of May 13, 1997, it is further revised to add a series of punishments including “If the

25 The original title of this small booklet in Portuguese is “Chegou A Hora De Cuidar da Saúde”
injury (harm) is to use elements referents to race, color, ethnicity, religion or origin: Penalty: imprisonment for one to three years and fine (Se a injuria consiste na utilizacao de elementos referents a raca, cor, etnia, religiao ou origem: pena: reclusao de um a tres anos e multa).”

*Preconceito* is prejudice and its outcome, or injury to another, produces a crime or isolated criminal event is punishable by law in Brazil. Brazilian scholars, such as Cristiano Jorge Santos in *Crimes de Preconceito e de Discriminação* (2001) have taken this to mean that there are *preconceito* crimes, what in the United States might be called hate crimes. This interpretation of *preconceito* crimes might lead to the conclusion that there is little difference between *preconceito* and *discriminação* (discrimination). However, I want to argue that *preconceito* is the social mechanism by which struggle and domination is transacted, and the idiom through which these are talked about in everyday life. It is certainly held that *preconceito* has a foundational role in producing discrimination (which may well be the case). However, in its historical and legal context, *preconceito* is itself the field of power by which domination is materialized during particular instances or circumstances. *Preconceito* is a system of ideas and beliefs that serves to establish difference across fields of people, behaviors, and values.

*Preconceito* represents the power of ideology as the force and substance of domination, subordination, and subjection of the Other. However, it appears here to have also become the language by which the Other can communicate that this domination exists. It might be the means by which to push back against or critique those who are subject to *preconceito*, part of the production of ethical subjects formed in response to systems of domination. Foucault’s analytic of power is helpful here:

“The target of these struggles is power effect(s) as such. For example, the medical profession is criticized not primarily because it is a profit-making
concern but because it exercises an uncontrolled power over people’s bodies, their health and their life and death. People do not look for the chief enemy but for the immediate enemy... This form of power that applies itself immediately everyday life categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him that he must recognize and others have to recognize in him. It is a form of power that makes individuals subjects. There are two meanings of the word “subject”: subject to someone else by control and dependence, and ties to his own identity by a conscience or self-knowledge. Both meanings suggest a form of power that subjugates and makes subject to” (1982:326).

I argue that preconceito cannot help but produce oppositional ethical subjects through quotidian, intersubjective experiences because its pervasiveness produces a regular power effect upon bodies. It is a power effect that predisposes the creation of boundaries of difference and Otherness while holding steady power relations and subjective struggles. An integral part of the counter-struggle is the individuals and collective struggle to wriggle out of certain subject positions.

In this dissertation, I focus on lésbicas negras and how they have developed ethics that contest various gynecological projects of “subjectivation” (Faubion 2010; Bielh et al. 2007; Eribon 2004). I develop the argument that preconceito is not just a descriptive way to link negative attitudes to behavior, but that in fact and more importantly, it is a systematic field of power relations which have produced a certain type of counter-struggle. It is in these terms that we must understand how preconceito is encountered and interpreted by my interlocutors. Race scholar and anthropologist Janis Hutchinson reminds us that prejudice is “a prejudgment, attitude, about a person or group without verification or examination of the merits of the judgment” (2005:8). Working from this definition, it would be extremely difficult to measure how and why preconceito happens. It would just be a back and forth, accusatory debate about what is said, what is meant, and what is intended. I heard many white

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26 Hutchison re-quoting Vander Zanden, 1983 in her definition of prejudice.
Brazilians, for example, say that Negros (Blacks) can also have preconceito against each other or against them with respect to racial preconceito. If we consider preconceito as a mechanism whereby subjects are produced, however, then we can understand discrimination a byproduct, rather than the core operation, of the power systems by which injustice and inequities are produced and instituted at every moment of daily life. On the other hand, focusing on preconceito allows people to be held accountable, responsible for seeing the broader, systematic ways of producing inequality.

In *Race in Another America: The Significance of Skin Color in Brazil*, Edward E. Telles argues that “particular mechanisms of racial discrimination in Brazilian society … ultimately lead to persistent racial inequity” (2004:150). He argues that, “the large majority of acts of discrimination are subtle and thus generally not recognized as discriminatory. These include a series of informal institutional mechanisms-which create barriers for nonwhite and privileges for white-and a web of individual causes- including slights, aggressions, and numerous other informal practices-both of which originate from a culture that naturalizes the racial hierarchy” (2004:151).

There is no question that informal institutional mechanisms give rise to the unrecognizable discriminatory practices mirrored in the wide disparities of economic, health, and living conditions for Negros (Blacks) in Brazil (Kahn-Perry 2013; Moore 2012; Caldwell 2007). A thoroughgoing qualitative analysis, however, must recognize the difference between “discriminatory practices” and practices that are “preconceituosos” or prejudicial. Praticas preconceituosas are often not yet discriminatory (in most cases), but rather are often subtle materializations of embodied experiences and ideological beliefs about difference. Differentiating a
discriminatory act from a *preconceituoso* act might be difficult for those with higher hierarchical power and particular privileges of class, race, gender, and sexuality-- but not for those who are made subjects of these mechanisms.

*Racialized Sexual Subjectivity: Mirela*

Mirela’s mother is a survivor: she was surgically treated for cervical cancer three years ago and was doing well when I met Mirela. Mirela, 32 years old and a college student, is certain that it was not a cancer related to HPV. She believes she is at risk for cervical cancer now, given her mother’s history, and must be screened routinely, once per year. Mirela detests the vaginal speculum exam just as much as the next person. However, she wants to be in charge of her own medical care, to actively identifying any potential cervical cancer in its early stages, so that she can live longer for her 2-year son; she knows that she needs routine PAP smear exams.

Mirela and I had many conversations about her lesbian love, relationships, friendships, and the struggles of being young and *Negra*, especially after her father separated from the family. The tension Mirela experiences between her race and sexuality when thinking of sexual health is an example of racialized sexual subjectivity. Mirela’s mom said to her, “*nao tenho preconceito mas…*” (I don’t have preconceito [toward your sexuality] but…); Mirela says to her, “*Mas na sua casa nao, ne om sua filna nao rola?*” (But, not in your house, not with any of your daughters this will happen?); her mom replies, “*E na minha casa não.*” (Not in my house). Mirela’s entangled feelings of empathy and resistance towards her family is grounded in her understanding of them as Negros. She is acutely aware of the struggle implied in being a black, that is to say, a dark skin family, and vacillating from middle class to working class since the departure of her father. Mirela is the only informant I followed who was in a coming
out process as opposed to already out with her family. This process was prompted by her close friendship with several of my other key informants, as well as her other sisters in Candomblé. As I spent time with Mirela and her family away from my other interlocutors, I learned much about the tensions implicit in seeing yourself as a dark woman in a dark family and learning to come out with your sexuality.

In *The Meaning of Freedom*, Angela Davis argues that “The inability to recognize the contemporary persistence of racisms within institutions and other social structures results in the attributions of responsibility for the effect of racisms to the individuals who are its casualties, thus further exacerbating the problem of failing to identify the economic, social, and ideological work of racism” (2012:171). I use Davis’ work to begin to think through how *preconceito* can be understood as the historically weighted language of racial power effect and domination yet seemingly invisible. In taking seriously what my interlocutors want as black gay women seeking respect and dignity, my experiences in the field led me to recognize that the expression of racialized sexual subjectivity is inevitable. It is the means by which my interlocutors feel, yearn, and resist domination, racially and sexually. It is through this lens that I hear and feel my interlocutors seek *respeito* (respect). It is through this lens that I narrate their stories and social-cultural lives.

If “subjectivity has become a mode of social organization and administration” (Mansfield 2000:64) then it explains why many of my *lésbicas negras* interlocutors think of *preconceito* as an idiom through which they frame undesired interactions with their gynecologists. They see themselves primarily as racially “*negras*” because of their brown and dark skins. Although most of my interlocutors could not recollect having experienced any explicit racially discriminatory practices by their

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27 Taken from her speech titled, “Recognizing Racism in the Era of Neoliberalism.” March 18, 2008.
gynecologists, they all believed that their white doctors always see race first, via their skin color (or other markers such as hair locks or Candomblé neck beads). To them, their skin color is most subject to *preconceito*; their sexual orientation is secondary, because of the heteronormative assumptions of most gynecologists. Their sexuality thereby rendered invisible, and subject to a socially layered *preconceito*. “*Sou negra, mulher, depois lésbica*” (I am black, woman, then lesbian) is the order of how *preconceito* is experienced, or as I frequently heard it described, “*ou como chega*” (or how it arrives). Later, I will discuss the interactive means by which gynecology establishes heteronormativity according to these women’s experiences and perspectives. In this section, I want to explain why I turn to the notion of *racialized sexual subjectivity* as a foundational way to understand the politics of *lésbica negras* as an identity and its connection with *preconceito* and subject formation. This provides the basis for what will follow at the end of this chapter, which is at the heart of this dissertation: *lésbicas negras*’ ethical acts as ethical subjects.

The genealogy of subjectivity as an analytic extends from Descartes, Rousseau, Kant, and Nietzsche, through Freud, Lacan, Foucault, Irigaray, Kristeva, Butler, and many others. This concept has persisted through modernity into postmodern thought due to its utility in our perpetual quest to understand the intertwined, seemingly indispensable notions self, being, individuality, and identity. Anthropologically, it serves a critical function in our interpretations of social context, power relations, and language, and has led me to question how the subjectivities of racialized subjects are in fact “modes of social organization and administration” and less about individuality as such. In Brazil, discussing sexual subjectivity in gynecological contexts is particularly challenging, given that most of my interlocutors, as well as many heterosexual women of various races, believe that sexuality is undermined and
rendered invisible in that setting. My argument is grounded in the notion that many lésbicas negras’ methods of coming out to the gynecologist, and their ways of confronting preconceitos against their sexuality, can function to strip away at the entrenched heteronormativity of gynecology. This study is an opportunity to speak of gynecology as not just a practice instantiating a “compulsory heteronormativity” (Rich 1986) but also a system that uses heteronormativity to presume gender subordination in extreme ways. In a country such as Brazil, where many white lesbians, or lésbicas brancas rally, confront, and fight against lesbofobia in healthcare, education, and all areas of life, the lésbicas negras who indeed speak out, whether in public or private spaces, are starkly differentiated as racialized sexual subjects within a marginalized realm of justice.

Lésbicas Negras as Ethical Subjects

Is the gynecological clinic an ethical domain for lésbicas negras? I draw inspiration from the Faubion’s insight that “if a subject is incapable of anything that could be identified as the exercise of his or her or its work or activity or agency or responsibility … then it falls … outside of the ethical domain.” He further reminds us that though freedom – needless to say – is not a sufficient condition of ethical action, it remains, on this Foucauldian reading, as necessary. This way of thinking about the ethical serves as a gateway to the analysis of the “field” of gynecological interaction and transaction (we cannot, after all, ignore that a clinical visit is a business transaction). My interlocutors believe that they have the right to speak, to exercise agency and responsibility over their self-care in seeking respect and recognition by their physicians, and act as free agents. The question here is not that the physicians are setting up blatant, public, or institutional rules to hold the lesbian patients from
being or acting as free agents to respond at their will. Rather, I am interested in how we might articulate what Foucault would call the “games of truth” being negotiated in the gynecological setting. Some of my key interlocutors are physicians -- medical subjects -- and as subjects they are free to speak, if in particular ways: they are held accountable to speaking the truth if they want to perform the roles entailed by their subject position. I want to place these subjects, with my other interlocutors, into the interactive space of the gynecological clinic considered as the container of “prima materia of subject-formation that would appear to be the social relations that any particular individual establishes and maintains with others” (Faubion 2001:90) in this case, the lésbica negra patient and the (usually white) physician.

I was led to my focus on how these women interpret saúde sexual as a practice of freedom by its presentation during our encounters and conversations as the idiom through which they personally measured and interpreted their existence as black female homosexuals (homosexuais femininos). This concept of saúde sexual served as a framework for perceptual self-care or caring, serving my interlocutors as a self-motivating way to forge justice, improve their lifestyles, and minimize stress from rigors of quotidian life such as disease, family issues, and poverty. For my interlocutors, saúde sexual has much to do with sharing the pleasures of a healthier sexual life with same-sex lovers. However, it has more to do with sexual conduct and self-care understood as socially engaged acts of freedom, viewed from a racially and socially conscious understanding of bem-estar (well-being). Lésbicas negras who come out and negotiate, not just discuss, their sexuality in the gynecological setting are ethical subjects because they find themselves there produced by “inter-subjective, social and cultural tissue” (Faubion 2010:120). As Faubion argues, the ethical practices emerging in such contexts
“are likely to condition the objective possibilities that a subject has available in its particularity as an occupant of a subject position in a certain environment, diminishing or enhancing those possibilities from one case to the next. They are also likely to lend to the subject’s experiential and ethical trajectory, a specificity – once again positive or negative – that exclusive attention to the habitus could fail to register. Finally, they are likely to serve as the stuff of the individualization of the ethical ‘personality,’ all the more so when individuality is itself a matter of either themitical obligation or ambition or ethical commitment or quest” (2010:120-121).

Of course, for lésbicas negras the negotiations do not begin and end with the gynecological visit. However, the clinical visit is an intensive site of subject formation, and one where both preconceito and the struggle against it are active. As ethical domains are neither fixed nor predictable, I argue that they generate more responsibility than agency.

On the History of Homosexuality and Race Issues in Healthcare in Brazil

This project maps the situatedness of homosexuality as a category of identity and experience as per pertains to black women, in particular, in ways that reminds us that the nationstate has facilitated in the promotion of LGBTT population’s concerns and dilemmas much earlier and wider than the issues and outcries by those who identify as Negros/as in Brazil. Richard Parker’s work reminds us of the alarms and wide attention given to gay men in Brazil in the 1980’s at the turn of its HIV/AIDS plight. However, race relations in Brazil was not given fuller and more legitimate attention by the government in spite of the country’s various social movements regarding social and health inequities until early twenty-first century when federal and local constituents such as SEPPIR and SEPROMI (which I discuss in this dissertation) were formulated to address racism and racial impact.

In chapter 1, I discussed some of the background of LGBTT movement that included lesbian movements in the 1980’s but more visibly not until the turn of the
twentieth century as well. Grupo Gay da Bahia initiated in Salvador-Bahia by historian and activist Luiz Mott extends from 1981-present. Mott documents in a 360-page book titled, *Boletim Do Grupo Gay da Bahia*, 2011, the numerous ways in which the LGBTT movement over decades has made its mark in Salvador and beyond. Given that it is the first group to initiate the lesbian and gay movement in Brazil, I was very surprised to discover that the lesbian movement in Porto Alegre had initiated a municipal agenda to address lesbian health issues on the heels of the national LGBTT healthcare agenda (2010), as I discussed in chapter 1. Therefore, one of the key reasons I focus upon preconceito as an analytic is because of this homosexual and racial entanglements, contradictions, disconnections, and complexities. One could argue that as wide-spread as the idea of *preconceito* has become to signify social inequities and injustice, the LGBTT movement has deployed if far more for its endeavours in political and social ways even if at the implicit exclusion of Negros/as LGBTT population. As a result, there are separate local and national discourses that recognize the precariousness of such exclusion.

Still, Brazil’s embarkment on addressing homosexuality as “abnormal” promoted by the medical domain is relatively recent compared to the U.S.. It was not until the turn of the twentieth century as well that the Association of Psychiatry removed it as pathological abnormal diagnosis. Since, the Ministry of Health has partnered with various other federal and local constituents to formulate discourses around homophobia as a problem impacting the welfare of its citizens and hold upholding the civil rights within the 1988 Reformed Constitution. However, one of the contributions this project makes is provoke conversation about not the latency of homosexuality in public discourses but the overshadowing of such latency of female homosexuality among black women in the country, which is extremely wrapped with
the historical and precariousness of black female sexuality in Brazil. Such historical work serves well to excavate in dialogue with this project given Brazil’s history of eugenics to maintain purity of its race by ensuring that black female bodies were free of disease (Stepan 1991; Peard 1999; Olivera 2012). The history of homosexuality, a word that is very much widely deployed by all citizens, cannot be revisited and interpreted without the historical and political courses of citizenship formation, broadly speaking.

*Gineco-Etico Praticas*

An “ethical field is a normative field but is often a field of ideals that actors are less obliged than encouraged to realize, rendering it a domain of obedience” (Faubion 2001:90), and the approaches of many gynecologists not only establish a particular domain of obedience to both the self and the power relations that attempt to shape individuals as ethical subjects. For example, the taking of medical histories, with its probing question of “what contraceptives do you use?” outraged all of my interlocutors with its heteronormative implications. This outrage seems to be common not just among *lésbicas negras*, but white *lésbicas* and even lesbians in the U.S. Through the conversation that proceeds from this question and this outrage, both actors (*lébica negra* and white physician) begin to construct an ethical domain. For example, what is the truth that will be revealed from each actor? Will the *lébica negra*, in her supposedly subordinate Otherness as a black woman, speak her truth? In turn, what will the physician say? Some physicians have said to me that many women do not reveal their sexuality to them in the office until the second, third, or fifth visits. The physicians might believe that they have always been gay because the women might identify as gay for sometime, at that point. The point is that physicians in their
minds welcome patients to reveal anything about themselves related to the purpose of their visit. Their reactions most times demonstrate heteronormative expectations, that is, surprise that their patients identify as sleeping with women.

*Lésbicas negras* who identify as such actively strive to not conform to the clearly sanctioned heteronormative and racialized patterns in the gynecological clinics. In *Subjectivity*, Mansfield argues that “complex and open-ended entanglements … condition our lives and … provide the context in which we have always lived and must continue to live” (2000:23-24). This insights helps further our interpretation of *lésbicas negras*’ subjectivity: in the gynecological setting, once they enter the doctor’s office and begin to speak with their white male or female doctor, preexisting power dynamics both specific to and extending beyond the clinic all too often stifle their desire to freely represent themselves. They become subjects of the power relations that hold health disparities in place. For example, if gynecologists hold that black women are more predisposed to uterine fibroids than white women, their medical training situates them to foreground the blackness of *lésbicas*’ bodies. However, when *lésbicas negras* speak out about their sexuality or situate themselves as self-caring agents, that is, see themselves as honoring their lives more than a system incapable of addressing their sexuality, these women seem to perceive their sexuality as an integral component of the fibroids or other medical problems they seek to have evaluated. They turn to a language of respect, hospitality, freedom, and dignity to express their ethical commitments and projects in this domain.

For many, this means a desire for more humane treatment. What does humane treatment have to do with getting direct healthcare for their fibroids or routine evaluations? When *lésbicas negras* speak out and say they are *lésbicas*, or “*fazo sexo com mulheres*, (have sex with women),” they experience an acute awareness of their
moral obligations, that is to say, of the gynecological mode of subjectivation. In the clinical setting, this process of subjectivation is complex and entangled with interactions and conversation as established and led by the gynecologists; for example, with the recurrent and common leading question of “do you use contraceptives?” Attempting to place all female bodies in a heteronormative subject position, gynecologists strive to produce the information that is, supposedly, most medically relevant. This is the question, the principle question that all interlocutors become resistant to but respond with, “no, sou lésbica.” When experienced by lésbicas negras, this question serves as an encounter with a compulsory heteronormativity, a preconceito, which can function to create a point of contestation around their racialized sexuality, not least because their sexual lives are rendered least significant in the social national context of Brazil.

In *Racismo & Sociedade*, Carlos Moore states, “Prejudices [preconceitos] are not necessarily manifestations of racism. On the contrary: and racism that generates the worst and most violent prejudices. Among them, the deeper and embracing and the notion of innate racial inferiority and superiority between humans” (2012:226). Moore recognizes that preconceitos are not necessarily manifestations of racism. On the contrary, he says “racism produces the most violent preconceitos.” Among these violent preconceitos are “the most profound ideas of racial inferiority and superiority among humans” (226). Moore wants to establish that preconceitos exist that do not necessarily emerge from racism, but from sexism and homophobia. In later chapters, I follow Moore in suggesting that this may be why preconceito, as an idiom within the public’s counter-struggle against domination, is so ubiquitous. However, Moore argues that the preconceito of a heterosexual white man regarding the homosexuality of a black woman, for example, is not divorced from racial preconceito.
In fact, it is racism that produces the most violent preconceito toward such a woman, even if it appears that only her sexuality is targeted. Moore persuasively argues that the homophobia and sexism experienced by the black gay woman is felt far more violently because it is filtered through the racial preconceito crystalized into a specific form of historical and individual odio (hate). Being subjected to preconceito does not always indicate that all such subjected persons are produced as subjects in the same way. The types of preconceito can vary in degrees of intensity and object. For example, my lésbicas negras interlocutors complain about the preconceitos against their sexuality, but most often do not disassociate this sexual preconceito from racial preconceito. For my interlocutors, you can’t be a lésbica negra without being subject to racial, gender, and sexual preconceito, even if one type is experienced more strongly than the other. In this case, even if racial preconceito is difficult to identify via any obvious language or action, the potential to be racially preconceituoso is far more probable than committing an actual discriminatory act. I use this insight to develop this line of inquiry aimed at understanding the inter-subjective medical interaction as experienced by lésbicas negras, the considerations of racialized sexual subjectivity in the setting of gynecological setting, and the ethical practices associated with these social constructions and processes of becoming (Caldwell 2007).

In conclusion, the analytical arguments about what constitutes the ethical domain in this project link the gynecological setting to a social-political world. The anthropological value in qualifying the knowledge production of my interlocutors is to measure to some degree how it functions within the gynecological space. The study of transaction of values, struggles, self-care, embodied knowing of worth, dignity, freedoms, violence, religiosity, care for the family, loving and seeking lovers, and sitting with friends, and social events, and so much more is central to this thesis. The
historical and cultural constituting of black bodies questing for modes of freedom stems from larger productions of selfhood that emerge and are provoked and resisted by a medical regime that predates them. This is the work to uncover and understand. This medical regime that continues to rely upon modern techniques and mechanisms for connecting with individuals and their histories continues to rely upon its complacency of normativity and domination. Yet, the medical regime in gynecology produces ethical subjects.

In the next chapter, I explore ethics as an analytical framework for differentiating subjection, subjugation, and subjectivation within this project. It is a careful attempt to analyze subject-formation and modes of subjectivation as they pertain to the intersubjective entanglements of race, gender, and sexual subjectivities in the medical setting. Differentiating how social and medical norms in the gynecological setting manifest or impact forms of subjection, subjugation, and subjectivation is work not yet undertaken. I believe that this is critical discussion to further explore why some of my key interlocutors are ethical subjects. It is foundational for the further undertaking within the dissertation to demonstrate how their ethical practices illuminate much more about the social reproduction in medical setting and beyond.
Chapter 3

Ginéco-Etico: A Window into the Ethical

Prelude

When the actress Angelina Jolie announced her double radical mastectomy consequently to being diagnosed with the BRCA genes for breast cancer, it hit the front pages of newspapers and magazines on newsstands all over Salvador. Widely-circulating national magazines such as Veja and EPOCA pitched this event as an opportunity to both teach the public: about breast cancer risks in Brazil and options such as mastectomies, but also to remind the public that the beautiful and famous actress had not abandoned her sexuality and femininity by undergoing the procedure. It was a life-saving decision. Simply, the story went, if Jolie could recover her image as an icon of beauty after having lost her breasts to save her life, so could anyone. In EPOCA, a white, female, thirty-one-year-old Brazilian, was also featured with her own short response to the broader Jolie article and issues. "A sexualidade e importante, max a vida e mais" (sexuality is important but life is more important), she explained. She shared how she agreed with Jolie that she would not feel less of a woman for having undergone such a procedure, and that her husband would support her in such a decision. Such extensive media coverage of a foreign celebrity’s double mastectomy raises the questions of what is counted as beauty in Brazil, and how this beauty might shape or define female sexuality? In other words, we might want to ask who can afford to lose their breast to save both life and sexuality or sexual appeal.

During this time, a heterosexual female friend of some of the lésbicas negras interlocutors was diagnosed with triple-negative breast lump. A couple of interlocutors asked me to step in and counsel her about treatment; she felt the
healthcare system was moving too slowly. On mammogram and ultrasound, she demonstrated a very suspicious lump, but her masteologist/gynecologist was not scheduled to see her for a month to read those results. In Brazil, patients pick up their results from the laboratories and imaging sites to then take results to the doctors. Most often, doctors do not know the results of these tests prior to the patients' delivery of them at their appointments. I was both fascinated and perturbed by this process. Ultimately, this friend, whose mother I know well, had to jump through many hoops to get a biopsy and eventually start treatment; in the end, it took a couple of months before treatment started. It even took over two weeks to get final results of biopsy. I asked about the seeming slowness of this process with one of my gynecologist interlocutors, and was informed that such was the norm in Brazil, especially Salvador. Not having any immediate family history of breast cancer did not put her at the least of risk as her not having a strong private health insurance. She was insured. Her particular insurance provided coverage almost as good as that offered by the government healthcare system. It was an awakening for me to see how the healthcare system worked in attending to reproductive and women's cancer. With all the hype about Angelina Jolie in the media (See Image 12), I wondered who can afford R$7000 (US$3500) for diagnosis of BRCA1 genes and an elective mastectomy, when black women in Salvador with triple-negative diagnosis cannot even begin treatment soon enough to minimize their risk for metastasis?

Image 12: EPOCA issue dated May 20, 2013
In *The Cancer Journals*, Audre Lorde writes that the “transformation of silence into language and action requires facing fears and uncertainties that divide the self from visibility; black women, lesbians in particular, must confront and claim the language needed to de-personalization of racism and homophobia and ask for what they need” (1980:20-21). Lorde battled cancer for many years after her mastectomy in the early 1980’s. Soon after her mastectomy, she found herself wondering “what is it like to be making love to a woman (who has both of her breasts) and have only one breast brushing against her? What will it be like to making love to me? Will she find my body delicious?” (1980:43). Lorde’s changing orientation toward her body during her cancer experience can be placed in parallel with the unspoken affect that many black lesbians might experience today when talking about sexual health, reproductive health and gynecological disease with doctors who de-personalize them. How can these women participate in affirming conversation about their sexual health as lesbians if physicians are not willing to transform their silence into the appropriate language and action to represent “quality” healthcare?

Jandira, one of the *lésbicas negras* interlocutors, showed much concern and empathy for Julia. Since Jandira’s sister was also diagnosed with breast cancer in 2011, Jandira must now have yearly mammograms to ensure early detection of familial breast cancer. For Jandira, sexuality is an important realm of experience that helps her exercise her rights and desires as a free agent. Her self-image of a black, locked hair, masculine-looking lesbian woman in her society is key to this ethical pursuit. In chapters 4 and 5, I demonstrate *lésbicas negras* already enter the gynecological consultation as ethical subjects. Their sexual strategies not only make visible the invisible but illuminate the practices that are already visible and but under-appreciated. Their ethical praxis, their self-orientation toward an ethical responsibility
(Davis 2012) to chart their liberty to speak and integrate their homosexuality in such a white, classed, gender, and heteronormative setting as gynecology, helps us understand the hows, whens, and whys of social change in these settings. In thinking through this problem, I draw on Naisargi Dave’s insight that “norms…are not the other to ethics, nor is closure the other to potentiality: limitations [are] the very condition of possibility for once unthinkable social emergences” (2012:3). In this chapter, I demonstrate how the theoretical frameworks and concepts provided by the anthropology of ethics shape and frame my arguments and observations.

I chart the ethical in this project through a conceptual architecture that accounts for and frames lésbicas negras’ ethical teloi, modes of subjectivation, and relationships to the themitical (Faubion 2011). The purpose of this chapter is to frame the ethical as subjectivation that explores the forging of new subject positions as well as old subject positions left behind by some lésbicas negras when negotiating their sexuality or sexual subject positions with the gynecologist. In this sense, the themitical is reframed herein and in the dissertation through possibilities of being altered as new subject positions are forged and old ones are left behind when confronting the gynecological encounter. In this sense, James Faubion (2010) refines Michel Foucault’s deployment of the ethical by “illuminating and elaborating the themitical in order to sharpen and broader its anthropological reach” (Faubion 2010:87). Therefore, I interpret such subject position shifts that are often nuanced and often blatantly pronounced by how some lésbicas negras participate in what I consider as enabling conditions (as well as inhibiting conditions) that allow for pursuit and realization of the telos as well-being. I end this chapter by pulling together my overarching ethical analysis and pointing to a materialist analysis of enabling conditions at work that is specific to the Brazilian context. This window into the
realm of the ethical is framed under an analytical concept I coin as the *ginéco-etico*, or gyneco-ethical.

**The Ethical and Ethical subjects**

In this section, I pose an “ethical turn” (Lambek 2010:5) and lay out some of the existing theoretical foundations that shape this project’s understanding of the ethical. I am interested in how “attending to the ethical provokes reconsideration of the basic terms in the anthropological tool kit – language, culture, politics, social structure, practice, agency, and the like…to deepen our understanding of social life more generally” (2010:7). In chapter one, I began to discuss the outlines of ethical subjectivation among *lésbicas negras*. In this section, I will chart more specifically the links between the existing theoretical arguments about the ethical and its connections to how I understand both my interlocutors, *lésbicas negras*, as ethical subjects, and my own work as part of the growing anthropology of ethics. The purpose of this project is to chart how particular ethical subjects seek recognition as openly *lésbicas negras* by negotiating their sexuality with the gynecologists in ways that seek to forge social well-being (telos) as a human right. I argue that via the self-(re)making through new subject positions via racialized sexual subjectivity reformulations beyond the gynecological encounter, these ethical subjects readjust the themitical realm of the ethical in ways that illuminate particular value systems that sustain their pursuit for social well-being, quality of life, and legitimation as consumers in gynecology.

Michel Foucault defines ethics as “the kind of relationship you ought to have with yourself, *rapport a soi*, which I call ethics, and which determines how the individual is supposed to constitute himself as a moral subject of his own actions.”
(Foucault 1983: 263). For Foucault, the ethical has four aspects: ethical substance, mode of subjectivation, self-forming activity, and telos (263-265). In this project, I am most interested in the latter three aspects. Here, I begin by discussing the realm of the ethical broadly, as it applies to my analytical goals.

By the ethical, I am referring to a domain of relationships that my key interlocutors have, primarily toward themselves as well as collectively and in relation to broader discourses that forge ethical strivings (Lambek 2010; Laidlaw 2010; Davis 2012; Dave 2010, 2012). I pay attention to how such relationships inform a particular set of ethical practices for the acquisition of well-being and the achievement of human rights as openly black gay women. I interpret such relationships to the self to be based upon the understandings my interlocutors have about how the freedom to speak about their sexuality, particularly as consumers of healthcare system, impacts their well-being. These self-relations and understandings are specifically tied to their practices of accountability vis-à-vis their human rights and due respect when interacting with their gynecologist. Such practices are the product of a schema of feedback, perceptions, experiences, social systems, and interactions that are critical to recognize if we are to understand these women’s striving toward well-being.

My work investigates the strategies lésbicas negras use to achieve well-being in a context entrenched with preconceito toward skin color, homosexuality, poverty, and more. I observed how these strategies enable them to conceive themselves as agents of their well-being as black women, homosexuals, and bodies historically and continually marginalized as belonging to a population afflicted with economic, political, and health disparities. My interlocutors strive to be recognized as ethical subjects by their gynecologists. Their sexuality becomes the point of negotiation for human rights claims in a healthcare arena. They understand sexual health as a critical
realm of their everyday well-being. Thus, *lésbicas negras* become ethical subjects every day as they strive toward well-being. This ethical striving demonstrates the complicated relationships between sexual health, sexuality, well-being, and freedom (*libertade*).

What are ethical subjects? In this study, the ethical subject emerges intersubjectively through *lésbicas negras* negotiations with their gynecologists in the context of medical and social reproduction. The ethical subject rotates and merges various modes of self-knowing and awareness of society as she negotiates several subject positions, ethical identities, and ideas of freedom inside of a sometimes seemingly futile and abstract ethical domain (Foucault 1985; Das, 2007; Lambek 2008; Faubion 2010; Dave 2012). Such intersubjective rotations compel, albeit via contradictions, particular medical subjects to seek their freedom towards modes of existing in such setting and moments. As James Faubion puts it,

“Neither methodologically nor ontologically does an anthropology of ethics have its ground in the individual. The population of its interpretive universe is instead one of subjects in or passing through positions in environments. It is thus a population not of atomic units but of complex relata. Its subjects are for their part already highly complex… Like the typical human being, the ethical subject, even when only an individual human being, is thus already always of intersubjective, social and cultural tissue. Its parts are never entirely its own. Ethical subject is not an abstraction” (2011: 119).

In other words, an anthropology of ethics must focus upon the inter-connective ways that ethical subjects are engaged, situated, and/or transformed by ethical practices, systems and norms (Lambek 2010; Faubion 2001, 2010). I understand this to mean
that ethical subjects are not merely produced by their sense of individuality in their becoming human but by both normative systems and their participation in sociality. The question becomes, then: what are the subject positions and modes of subject formation for lésbicas negras in the gynecological arena? I assert here that some lésbicas negras interlocutors are self-reflexive beings, who proceed “in the middle voice, actively and passively often at one and the same time” (Faubion 2011:50), bringing into the gynecological clinic particular ways of knowing the self in relation to modes of self-caring that interconnect with the ways they see themselves as black women and as black lesbians, in particular.

First, let me emphasize that I do not intend to argue that only lésbicas negras can be ethical subjects in these settings. Some brancas (white lesbians) or mulheres lésbicas negras heterosexual (black heterosexual women) can obviously be ethical subjects; this is simply not the domain of my own study. In fact, I do not even argue that all lésbicas negras fall as active agents (ethical subjects) within the ethical framework I build in this dissertation. Why, then, do I focus upon some lésbicas negras in Salvador? I am interested in articulating particular forms of freedom that can only be comprehended by considering the dimensional and inter-subjective experiences of women such as some of the lésbicas negras in Salvador. I want to analyze such relationships to the self a particular set of “qualitative features” (Faubion 2010) that distinguish the ethical as such and allows us to identify it as a dimension or inflection of practice in whatever institutional arena or specific place, such as the gynecologist’s office, that we (anthropologists) happen to be observing. The qualitative features of the intersectional identities I describe in this dissertation are connected to the ways in which these women enact their interests to be recognized as worthy of being respected and legitimized as gay women by the gynecologists. A
particular dynamic of recognition, for example, emerges as qualitative feature of the ethical domain that is the typical of engagements between lésbicas negras, the medical establishment, and their gynecologists. Since the chief complaint from most of my interlocutors is the quality of interaction with the gynecologists, of their (in)ability to integrate their sexuality and identity as lesbians, ethical practices of seeking recognition that work upon both self and relation become analytically foregrounded. This ethical engagement has specific implications for guiding or framing all aspects of the consultation is experienced; further, it has important impacts upon how these women relate to their own sexual subjectivities outside of the gynecological clinic. This analytical approach allows for deeper considerations of well-being as, for example, “anthropological invocations of agency as a concept that might be reformulated to accommodate proper recognition and facilitate perspicuous description of ethical life” (Laidlaw 2010:143).

The analytical framework offered by the anthropology of ethics provides a means to identify the anthropologically salient features of the processes whereby lésbicas negras become ethical subjects. Principally, I aim to demonstrate how and why some lésbicas negras are engaged as ethical subjects when confronting (or in seeking to avoid) preconceito at the gynecologist. I assert that the modes of freedom they deploy to negotiate norms and social systems emerge in dialogue with practices of historical knowledge production. I understand their emergence as intersubjective ethical subjects as the result in part of their negotiations of rights as citizens, as well as of their symbolically determined modes of self-care and striving towards well-being.
Ethical Telos: Well-Being

In this section, I focus on the ethical telos of lésbicas negras. James Faubion defines ethical telos as “the conditions that mark or define the consummation of any given subject position” (Faubion 2011:116). I explore ethical telos in my study as the conditions that inform some of the self-formation processes of my key interlocutors as ethical subjects. In particular, I refer to a set of enabling conditions that allow my key interlocutors in order to achieve what they describe as well-being. Herein, I draw upon the connections across well-being, sexual health, and sexuality as understood by my key interlocutors to interpret how might these interconnected understandings that shape the ethical telos, or enabling conditions.

There is a significant multidisciplinary literature on well-being (Dieher and Suh 2000; Gullone and Cummins 2002; McGillivray and Clarke 2006; Haworth and Hart 2007; Eid and Larsen 2008; Vernon 2008; Mathews and Izquierdo 2009; Kekes 2010; Scott 2012). Most of this literature draws primarily upon psychological approaches to acquisition and understanding of individual well-being as a state of physical health and being. However, this study contributes a novel, anthropological focus on the ways in which communities and individuals collectively develop and enact modes of striving towards or accumulating well-being as a paramount good. We do not often think of being well as a process of accumulation but rather a state health, happiness, or prosperity (Matthews and Izquiero 2009). Many disciplines have engaged in questions of how we might measure well-being and its degrees, again understood here as essentially a state of being (Phillips 2006). In particular, many anthropologists have argued for an understanding of well-being as happiness; that is, as fundamentally about “people’s own internal state of mind” (Matthews & Izquierdo 2009). While this work has been useful for me in beginning to approach well-being, I
am more interested here in reworking more explicitly the concept of well-being through a definition that points to modes of freedom; I understand freedom as essentially “possibility to choose” (Veenhoven 2000). For instance, lesbians who go to the gynecologists regardless of their skin color, race, and class, may recognize freedom as the possibility to choose to not identify as lesbians or as having same-sex sexual relations, identifying as women, or identifying as lesbians who have same-sex sexual relations. However, the participants in my research define their freedom as not just making the choice to self-identify as same-sex sexual beings, but also to choose to actively renegotiate the boundaries of their identities, holding this to be a human right. Their well-being is dependent upon their ability to make such choices not only in the clinic, but before they even arrive into the gynecologist. Therefore, I differentiate between “being in a state of well-being” and “being driven toward well-being.” The latter is what I consider as my interlocutors’ ethical telos, taken wholly together with its various components of sexuality, sexual health, race, and other social elements.

Some anthropologists have recently called for the study of well-being as a promising concept and field of ethnographic investigation, although noting that it is a term of valuation by professionals such as physicians, rather than an emic term, “given people themselves in describing their lives” (Mattews and Izquierdo 2009). Lésbicas negras, however, consistently and unprovokedly shared with me that their sexuality and sexual health were critical to their well-being. My own analytic focus on well-being has grown from the prevalence of their own focus on “well-being” as essential to their life projects. While there are obviously differences and in how my interlocutors perceive the relationship between sexuality and sexual health, these conjunction of these terms were universally typical of how they described their
broader pursuit of well-being. For many women whom I met in the field, well-being was a dominant framework for understanding social, bodily, financial, and mental health. Therefore, it is important to understand the discourse of well-being in these women’s narratives as a key feature of their self-formation as ethical subjects. In their pursuit of well-being, tied as it is to ideas of freedom, agency, struggle, and health, they are also pursuing their human rights as black gay women by openly negotiating their sexuality, particularly within the gynecological context. To this end, the ongoing process of striving towards or accumulating well-being represents their ethical telos, the object of their everyday strategies of existence (Biehl et al., 2007:5).

I would like here to return to two questions posed in chapter one: why do these women understand sexual health as about liberty and well-being? Further, under what conditions is this kind of sexual health expressed and embodied? In what follows, I want to consider these questions in relationship to the ethical. If “well-being depends on a feeling of being in a balanced relationship with our environment” (Pickering 2007), I would suggest that anthropologists might benefit from paying attention to how this feeling plays out in the particular context of subjects engaging their homosexuality in heteronormative, gendered, and classed institutions such as gynecology. While we might understand this engagement as a transcultural feature of the lives of all lesbians who move through the medical establishment across the globe, as anthropologists we must consider the ways in which unique contextual and historical meanings inform the value that individuals and collectives alike place upon particular modes of self-care.

An inquiry into “well-being” leads, inevitably, to the study of those enabling conditions that make ethical self-formation for some possible. The ethnographic particularities of the coming-into-being of these enabling conditions will be further
explored in chapters 4 and 5; I argue that such enabling conditions are ultimately best accounted for through a materialist, cultural analysis of these women’s lives. Here, I am more interested in laying out a theoretical framework that will render my later investigations sensible, but some ethnographic notes will be critical. By focusing on how the pursuit of the ethical telos of well-being, the field conditions that shape that striving come to the fore.

I explore ethnographically in upcoming chapters these ethical, or enabling, conditions that ultimately serve to accumulate well-being as describe and pursued by the key interlocutors. However, a conversation with Marta Alencar, a 44-year-old lésbica negra, about the connections between well-being, sexual health, and sexuality is illustrative. Marta has primarily been in love relationships with black lesbians, though is now has been in a relationship with a white, older Brazilian lesbian for the past seven years. Marta is a racially consciously black woman who advocates for her right to publically practice Candomblé religion, black women wearing natural hair, and the survival and progress of black communities at large. She works for an organization that promotes educational services for Negros (blacks). She also holds a Masters degree in education and teaches for Universidade Federal da Bahia outside of Salvador. I point to her current bi-racial relationship because in Marta’s case, it never seemed to destabilize her racial commitments and networks nor her values and actions toward uplifting the Brazilian black community.

I spent a good deal of time with Marta. For our formal interview in March 2013, we met at her workplace, FIEMA (Fundo Municipal para o Desenvolvimento Humano e Inclusão Educacional de Mulheres Afro-descendentes); the actual interview, however, was held across the hall in another quieter and cooler office. Our
conversation drew out some of the lively interconnections between sexuality, sexual health, and well-being:

MA: What is health? Health, I think, is well being. You know? You being well and the absence of disease, perhaps. I do not know if it’s just that, it is a question that I have never stopped to think about. We also have to pay attention to it. To being well (well-being)?

Then, when we think what it mean [is] to be well, not only about one issue, sexual health is not just you being well, meaning not having an illness, but you are also well regarding your sexuality, you know, I think it is that, it’s not enough to just be about one issue. But then how would that be? You know your body, you know your desires, you know where [what] gives you more pleasure, where you do feel (pleasure), I think that all of these things make up our sexual health. Because it bothers me a lot that when I go to the [children/teens] schools, I see that sex and sexual health education is only a discussion about the absence of disease but how about the absence of pleasure?

NF – Yes, yes.

MA: So then, how does it work? [how to have the discussion she means]? Sexual health also an awareness about the invisibility of the body. It’s not just about this [points to her body] body not having disease, I mean, but about this body [points again] becomes invisible as a sexual body, especially for us, women over 40 years old.

MA: O que é saúde, saúde eu acho que é um bem estar, né, você está bem, é a ausência de doença, talvez, não sei se é só isso, é uma pergunta que eu nunca parei pra pensar. Também tem que olhar isso – estar bem? Depois a gente pensa o que é estar bem, não só do campo, assim, saúde sexual não é só você estar bem, não ter doença nenhuma, mas você esta bem também com relação a sua sexualidade, né, eu acho que isso, não dá pra ser só um campo, mas como é? Você conhece seu corpo, você conhece seus desejos, você sabe onde é que te dá mais prazer, que não te dá, acho que isso tudo casa com saúde sexual, porque, me incomoda muito, é, e aí eu vou para o campo das escolas, quando vai falar sobre educação sexual, saúde sexual, só vai falar dessa ausência de doenças e a ausência de prazer?

NF - Sim, sim.

MA: Fica onde? Também é conhecimento, a invisibilidade desse corpo, não é só esse corpo não ter doença, digamos assim, mas esse corpo invisibilizado enquanto um corpo sexual, principalmente pra nos mulheres acima de 40 anos.
Here, Marta is grappling with what it means to be an invisible body in the context of biomedical engagements with her sexual health. Earlier, we had discussed what it meant to be a black lesbian, and how her links to the black experience are much like everyone else’s; to be black is to know struggle and to continually experience many disparities in financial, health, and educational opportunities and outcomes. However, when we discussed sexual health as well-being, she was explicit in wanting to acknowledge, but shift away from, medical pathologies associated with sexual health. Instead, she was quick to point out that well-being ought to be achieved through ways of knowing our desires, pleasures, bodies, though aware of the risks of those bodies being made invisible (corpo invisibilizado). According to Marta, it is more about recognizing that our bodies as lesbians (black lesbians in particular) are often rendered invisible in their contact with the biomedical establishment. While there may be sexual health education offered through the public health arena, its focus is generally on topics such as on STDs, and less about appreciating your body and right to be.

Given Marta’s preoccupation with sexual bodies that experience being made invisible, her description of her self-identification as a lesbian with the gynecologist was poignant:

First, what is important… first we (black lesbians) need to teach gynecologists that not all women are hetero. Why? The first question they ask us is, "Do you use contraceptives?" As if that was the only thing we go to the gynecologist to get. There is more to our physical health, you know, and we need to teach them that.. look, first ask about other issues, and don’t focus from that [hetero] [point of view]"

She [the gynecologist] will ask "have you already had an abortion? Have you already have a child? And whatever else" … And then she will ask you, "Are you sexually active? " [Then, I answer] Yes. Then she will ask, "What contraception do you use? " So that's the moment when I speak directly to this question [referring to identifying as a lesbian].
Some of them get scared, you know, like, "Oh shit, I could have asked you before [if you are a lesbian]" Others will write down the information [that I am a lesbian], but do not consider it as relevant, the problem also is that they don’t follow up or recognize it [their incapacities]

So my last gynecologist did not do that [ignore that I am a lesbian], and that is great, because she is a lesbian too [I think], but my other gynecologists, so few take it into account or take note there that you are a lesbian, you have homo-affective relationships with women, but for them, this information does not matter. They just fill in the questionnaires and the rest of the [medical] query is as if you were hetero, the standard treatment.

But their body language speaks, their body’s reaction [is evident]. Yeah, I remain comfortable during those moments. They are the ones that are uncomfortable... they look [uncomfortable].. I’ve been serviced by one that looked like she did not want to hear any of it, you know

Primeiro que é importante, primeiro que a gente precisa ensinar a essas ginecologistas que nem todas as mulheres são hetero, porque, a primeira pergunta que elas fazem é, "Você usa contraceptivos?" Como se isso fosse a única coisa que a gente vai buscar lá no ginecologista, essa saúde física apenas, né, então, assim e pra ensinar pra elas também "Olha, pergunta primeiro outras coisas, não parte desse princípio"

Ela vai perguntar " Já teve aborto, já fez aborto, já teve filho e não sei o que" E aí vai te perguntar " Tem vida sexual ativa?" Sim, " Qual o método contraceptivo que você utiliza?" Então, é nessa hora que eu particularmente falo, é nessa pergunta.

Umas se assustam, tipo assim "Ah falei merda, tipo, podia ter perguntado antes" Outras escrevem lá, mas tbm não leva em consideração isso, o problema também tá nisso, porque assim, essa minha última ginecologista não, essa é ótima, porque, ela é lésbica também, é, mas, as minha outras ginecologistas assim, umas levam em conta, anotam lá que você é lésbica, que você tem relações homo afetivas com mulheres, mas elas, esse dado não interessa pra nada, ela só registrou na ficha o restante da consulta é como se você fosse hetero, o tratamento.

O corpo delas falam, a reação do corpo. É, eu fico confortável, elas que ficam desconfortáveis, meio que parece, eu já tive uma que meio que parece que ela não queria ouvir, sabe.

Here, we see Marta grappling with the gynecological process of making sexual bodies invisible. However, her description of her conversations with gynecologists also suggests that they would have shaped their conversation differently if they had known of her sexual orientation sooner. The point here is that Marta
clearly wants to be understood as someone who is ready to negotiate the terms by which her sexuality is apprehended by the gynecologist during their consultation. For Marta (and others), the pursuit of her human right to be a lesbian and negotiate the terms through which her sexuality is understood is linked to her sexual health. She defines sexuality as “vivencia,” “como voce vive, ou como se relaciona sexual e cultural” (living; how we live, or how we relate sexually and culturally). Through our conversation, and after spending time with Marta and her lesbian daughter, partner and friends, in various settings of activism and political events, I came to understand that a chief facet of her self-formation as an ethical subject is to be found in her resisting preconceito, as both a black woman and lesbian. I argue that a focus on Marta’s ethical striving, that is, on her quest for well-being, can help us to understand the enabling conditions that allow Marta to claim her human right and resist preconceito.

Michel Foucault holds that

“an action is not only moral in itself, in its singularity; it is also moral in its circumstantial integration and by virtue of the place it occupies in a pattern of conduct. It is an element and as aspect of this conduct, and it marks a stage in life, a possible advance in its continuity. A moral action tends toward its own accomplishment; but it also aims beyond the latter, to the establishing of a moral conduct that commits an individual, not only to other actions always in conformity with values and rules, but to a certain mode of being, a mode of being characteristic of the ethical subject” (1985:27-28).

Foucault here argues that moral action informs patterns of moral conduct, both making a distinction and positing a relationship between action and conduct. This point is critical; I am not interested in diagnosing what constitutes as moral conduct, but instead identifying the conditions under which we might understand the practices of my key interlocutors within the gynecological setting and beyond as ethical. In Brazil, and Salvador in particular, there is an acute sense that black women’s health is
predicated upon a multidimensional set of structural conditions. The widely-circulated, *Saúde Da Mulher Negra: Guia para a defesa dos direitos das mulheres lésbicas negras*\(^{28}\) delineates the structural conditions and inequities affecting quality health: biology (individual factors and reproductive capacity), social and economic relations (impact of racism and patriarchy), environmental conditions, and the efficacy of *Sistema Unico da Saúde*.\(^{29}\) All of these areas that shape the modes of health – existence – of black women in Brazil are on the top of the minds of my key interlocutors, particularly as all of them have many kin affected by inequities in these domains. This catalogue also reminds the public that health in general is not about individual actions, but about a “complete well-being that is physical, mental, and social.”\(^{30}\) Again, we can see here a critical relationship between well-being and a particular understanding of the human condition, tied to survival, struggle, and overcoming.

I can appreciate, analytically, Foucault’s understanding of the ethical at the same time point out my contention with addressing the moral. In his discussion of the ethical telos, he argues that

> for an action to be “moral,” it must not be reducible to an act or a series of acts conforming to a rule, a law, or a value. Of course all moral action involves a relationship with the reality in which it is carried out, and a relationship with the self. The latter is not simply “self-awareness” but self-formation as an “ethical subject,” a process in which the individual delimits that part of himself that will form the object of his moral practice, defines his position relative to the precept he will follow, and decides on a certain mode of being that will serve as his moral goal” (1985:28).

While Foucault’s ethics turns to morality as the defining feature of ethical action and patterns of conduct, I draw upon Naisargi Dave’s understanding of ethics as primarily


\(^{29}\) *Saúde Da Mulher Negra*, p17-18

\(^{30}\) Ibid. p.11
“a commitment to philosophical exercise, to think differently, to ask new questions of oneself in order to analyze and surpass limits upon what can be said and done” (2012:8) I agree with Dave’s further assessment that “it is this aspect of ethical practice that Foucault refers to as ‘problematization,’ or as critical reflection upon norms” (8). As I elaborate in the next section, the norms and systems by which lésbicas negras, as ethical subjects, negotiate their human right within gynecology are quite complicated. Gynecology, as a discipline involved in the production and reproduction of the cultural norms and systems shaping categories of experience such as gender, sexuality, and even sexual health, continues to remain distant from anthropological critique. However, an investigation of the ways in which my interlocutors understand sexual health as well-being can serve as a pathway to imagining ethical subject formations beyond the gynecological setting, which in turn allows them to claim a set of human rights.

Self-care imagination and lived experience, or saúde sexual (sexual health) as bem-estar (well-being) as framing an ethical telos, supports the critical platform for this project about how their ethical ways of responding to themselves and then to others ultimately point to and reveal the norms and codes that are negotiated and even the conformity that is disrupted within normative settings.

**Mode of Subjectivation: Accessing a Human Right to Well-Being**

For Michel Foucault, the mode of subjectivation is the means whereby ethical subjects realize themselves as moral agents within a set of norms and systems (1983). I find his interpretation of mode of subjectivation in *The History of Sexuality, Volume II* to be most aligned with my analytical inquiry. There, the mode of subjectivation is glossed as “the way in which the individual establishes his relation to the rule and
recognizes himself as obliged to put it into practice” (Foucault 1985:27). In other words, ethical subjects are those who engage in practices of self-formation in relationship to particular norms and systems with a sense of obligation. For lésbicas negras, the mode of subjectivation is a process by which they relate to and negotiate the coded terms through which they come to occupy more than one subject position within the gynecologist office and beyond. However, Foucault’s analytic framework is lacking a concrete discussion of how might we discuss how bodies or persons engage with more than one subject position in the course of their ethical striving. How might the pursuit of well-being, as a fundamentally multi-positional experience, help us understand how particular ethical subjects demand access to a particular human right within a complexly gendered, classed, heteronormative, privileged domain such as gynecology? An analysis of the mode of subjectivation here would begin by looking at the ways in which lésbicas negras engage the themitical and influence discursive and practical adjustments within the ecological system of gynecology. Gynecology, considered as environment, is an arena in which norms and systems are (re)produced that both enable and constrain their practices.

In this section, I explore the ethics as subjectivation for lésbicas negras’ subjectivation. As the most dynamic element in my analytic framework, focus on these modes allows me to engage more specifically with my key interlocutors’ most active subject positions – as medical, sexual, and racial subjects in particular – within the gynecological regime. Moreover, it allows me to illuminate the ways in which they pursue well-being as self-reflexive ethical agents through deployment of human rights discourse. In short, I will discuss how processes of negotiation and recognition serve to engage human rights as an aspect of the themitical, which I explore further in
the next section. Here, I will focus on issues of access, interaction, and discourse as features of negotiation.

Subjection and Subjugation, or Subjectivation

At this point, it is appropriate to draw distinctions across the concepts of subjection, subjugation, and subjectivation in relation to women’s experiences within the gynecological setting. This course allows me to understand why and how particular ethical subjects come to claim particular human rights within the gynecological setting. Since studying social processes within gynecology is always complex and entangled (Martin 1987; Kapsalis 1997; Bordo 1993; Gregg 2003; Davis 2007; Kline 2010), it is imperative to not confound or collapse modes of subjectivation with processes of subjection and subjugation, though at times there can be a messy overlap.31 First, we ought to expose the gynecological environment (gynecological consultation and examination rooms) as a site of reproduction of compulsory heterosexuality (Rich 1981) where many female patients identifying as lesbians, or even many bisexuels, navigate such obscure frontiers with their gynecologist. As I have mentioned, compulsory heterosexuality manifests via a series of interpellating medico-social questions. Such presumptive questions suggest that the physician assumes from the outset that the patient’s sexual practices are those typical of a heterosexual lifestyle, and that, indeed, the patient is heterosexual.

One pervasive example of this described by my informants is the assumption that lesbians who have had penetrative sex with men at some point in their lives should tolerate the insertion of a vaginal speculum in the same way as most sexually

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31 This analytical approach is an attempt to address one of my long-time struggles as a Physician Assistant. I am very familiar with what an exam room as a space and patient-doctor interaction produce… making these distinctions are critical for this project and for moving the field in medical anthology and public health forward as lesbian health discourses proliferate in local and global ways.
active heterosexual women. These presumptive medical attitudes and approaches are a key feature of the reproduction of compulsory heterosexuality, which functions to uphold the patriarchal structure of medical practice generally, and control over women’s reproductive care and sexual practices specifically. Such reproduction of gender-normative approaches toward female-sexed bodies in turn subjects female patients to both social and medical discourses primarily concerned with the biopolitics of STD- and reproduction-focused sexual health. I consider these normative approaches part of the gendered and sexualized subjection of women in gynecological settings.

My intention here is not to render invisible the palpable fact that heterosexual women also experience processes of (social and medical) subjection. Indeed, many heterosexual women, and particularly black women, acknowledged to me that many gynecologists are *machista*; they often leave the clinics feeling hypersexualized, desexualized, or inferior. These feelings of subjection arose principally from these women’s conversations with their gynecologist. Further, medical conversations too often turn on physicians’ heteronormative medical practices and uses of technology and instruments (for example, the vaginal speculum). Both patients and (some) gynecologists felt that gynecologists do not often engage in “appropriate” conversation with patients during the transition to the pelvic examination. In these cases, women are thrust into a medical process that both subjects them to a dominating experience of vaginal instrumentation and subjugates, or subordinates, their sense of self to their body and body parts (Martin 1987; Karpalis 1997).

Both these examples and the wider scholarship on gynecology suggest that many women find much to abhor about sexist and insensitive medical encounters. However, such experiences reach beyond the unitary category of “women,” producing
many entangled struggles across different identities or subject position. Here, it is important to tease out the difference between subjection and subjugation in relation to power. As Foucault has it,

“This form of power that applies itself to immediate everyday life categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him that he must recognize and others have to recognize in him. It is a form of power that makes individuals subjects. These are two meaning of the word “subject”: subject to someone else by control and dependence, and tied to his own identity by a conscience or self-knowledge. Both meanings suggest a form of power that subjugates and makes subject to…

Generally, it can be said that there are three types of struggles: against forms of domination (ethnic, social, and religious); against forms of exploitation that separate individuals from what they produce; or against that which ties the individual to himself and submits him to others in this way (struggles against subjection [assujettissement], against forms of subjectivity and submission)” (1982:331)

Medical subjection in gynecology is too often shaped by the (re)production of broader forms of cultural or discursive domination, and is further reinforced through practical or conversational linkage to those forms of domination. Clearly, the gynecological examination is almost always an uncomfortable experience for most women. Here, however, I seek to understand the impact of such medical subjection in a historically and socio-culturally specific site that impinges upon modes of existence of particular female medical subjects such as black lesbians. That is to say, I believe that my research shows how gynecology as an institution draws upon and mobilized broader fields of social domination and inequality to produce gendered and sexualized meaning about its medical subjects. Consequently, many gynecologists show less capacity to move beyond their heteronormative leveling of varied modes of sexuality. In contemporary Brazil, gynecology continues to reflect medicine’s historically heteronormative and patriarchal. Various processes of domination and subordination are part of the biomedical institution’s reproduction of language, attitudes, and
interactions that subjugate and subject female patients to gender, racial, and sexual social inequities. When some *lésbicas negra* interlocutors complained of some gynecologists who belittled or mocked their sexual identities and lesbian practices (sexual lifestyle and desires), they are expressing their experience of subjugating processes, of their exposure to social micro-aggressions that I argue differentially target black lesbians.

In *The Psychic Life of Power: Theories of Subjection*, Judith Butler reminds us that “subjection is, literally, the making of a subject, the principle of regulation according to which a subject is formulated or produced” (Butler 1997:84). In this vein, I do not lose sight of the fact that processes of medical subjection in gynecology are inevitable; however, there are degrees by which medical subjection can be experienced. For example, all women are subjected to the presumptions of heterosexual relations that socially gender women as feminine (*feminina*). At times, most heterosexual women participate in reinforcing such heteronormative “sex/gender systems” by demanding (both as consumers and via different forms of distancing from with same-sex practices) to not be mistaken as gay women (Rubin 1987). This form of subjection “is a kind of power that not only unilaterally acts on a given individual as a form of domination, but also activates or forms the subject. Hence, subjection is neither simply the domination of a subject nor its production, but designates a certain kind of restriction in production, a restriction without which the production of the subject cannot take place, a restriction through which that production takes place” (Butler 1997:84). I argue that there is subjection to medical instrumentation and knowledge that produces modes of restriction, as Butler points out, that allows for the production of medical subjects. In this study, I focus on the heteronormative as the restrictive mode of sexual subject production. While all female
patients are subjected to the gender-normative codes of gynecology, lesbians are further subjected to heteronormative language and expectations. However, I want to suggest that a certain space or type of freedom can dialogically emerge as patients engage their gynecologists.

As ethical subjects, lésbicas negras develop and deploy quotidian strategies of existence (Biehl et al. 2007:5) to counter or even simply to recognize medical-social experiences that reproduce gendered and sexualized oppression. In analyzing these strategies, I ask, with Naisargi Dave, “how are cultural norms newly imagined, deployed, and inhabited in and through the politics of sexuality” (2012:17)? Dave’s question is particularly provocative when considering how some of my interlocutors perceive their sexuality in the broader context of simply living their lives. Barbara, Jandira and others used the expression “viver minha sexualidade” (live my sexuality) to describe their struggles with the norms that attempt to restrict their sexual freedom. Barbara, for example, said to me that she needed to get her house in order after her grandmother died, get her “concurso” (training and exam for a government job) completed, and start to “viver her sexualidade.” She continued to explain that by “viver her sexualidade” she meant to finding love or romance. She would giggle whenever I would add and say, “and sex?” She was adamant about remaining single for a while. Though Barbara was an out lesbian and very active within LGBTT politics, movements, and social activism, that did not seem enough to count, alone, as living her sexuality. Barbara at times felt a void in her life. Only finding a woman to love would truly mean that she was “vivendo minha sexualidade.” Finding love and romance through a relationship is culturally tied to how some lesbians express their sexual freedom; this even sometimes spills into the gynecological medical domain.
For women such as Barbara, to escape or derail the effects of female subjection and subjugation in the gynecological setting means actively pursuing recognition as women with agency and self-reflexive consciousness about their humanity and dignity. These women are aware of their personal obligation as medical subjects and as medical consumers to resist their any attempt to use their subject position as an opportunity to decrease their agency vis-à-vis access quality healthcare. Against these attempts, processes of subjectivation, unlike processes of subjection and subjugation, represent the myriad ways in which subjects hold, experience, and are constituted within any particular subject position (Eribon 2004; Faubion 2010). This is useful concept for this study, as it allows recognition of the many social and structural restrictions placed upon female bodies without sole recourse to the language of oppression. It also moves us beyond a focus on the normatively female status of my interlocutor’s bodies to a greater awareness of cross-cutting, intersectional identifications. After all, the more subject positions that any given ethical subject holds at the same time, the greater its intersubjective domain of being and “like the typical human being, the ethical subject, even when only an individual human being, is thus already always of intersubjective, social and cultural tissue” (Faubion 2011:120). As Faubion elaborates,

“The second aspect of the mode of the determination of subjectivation is without empirical exception, but all the more apparent as the number and complexity of subject positions increases. Call it that of the scope, structure and priority of subjectivation, or more precisely of any given subject position in its relation to others that might be available for occupancy” (2011:66).
Both the ways of making subject positions and the modalities of the actual occupations of those positions change when the modalities of relations to self and other multiply. One of the key advantages of the analytic I am arguing for here is that it allows one to discuss these proliferations, which are patently evident in the case of lésbicas negras’ ethical projects.

Indeed, the value in making distinctions between modes of subjection, subjugation, and subjectivation in the gynecological setting lies precisely in the isolation of subjectivation as the contextually-specific process of subject formation that is tied to not just the individual but to a collective of other beings, ideas, social issues, systems and norms. By interrogating the mode of subjectivation operative here, I can conceptualize modes of subject formation as well as focus on ethical subjects as both individuals and collectives that negotiate intersubjective modes of existence within particularly complex moments and systems. In other words, characterizing lésbicas negras’ mode of subjectivation allows me to take into account their subject positions and its realities while also pointing out the ways in which their ethical practices might intervene creatively into the reproductive social systems that crosscut the medical domain. The ethical subjects in question here are seeking to be recognized as humans and consumers with the freedom to negotiate their sexual subjectivities and intersubjective experiences. Admittedly, this is complicated to slice but I see digesting it as a critical starting point for isolating the particular social-cultural issues that thrive in the Brazilian medical setting.

Recognition of Interaction as Insult, Recognizing the Ethical Subject

In Insult and the Making of the Gay Self, Didier Eribon aims to “reconstruct the way in which gays are ‘subjugated’ by the sexual order, as well as the ways,
different in different moments, in which they resist domination through the production of way of life, spaces of freedom, a ‘gay world’” (2004:7). Here, Eribon makes distinction between gay subjects that are subjugated and gay subjects situated within processes of subjectivation. Eribon's work on the multi-dimensionality of insult is key here, particularly for thinking through distinctions between modes of subjection, subjugation and subjectivation. As Eribon says, “One of the consequences of insult is to shape the relation one has to others and to the world and thereby to shape the personality, the subjectivity, the very being of the individual in question” (2004:15). The demands of lésbicas negras as ethical subjects to not experience (or confront, enfrentar, as they would say to me) preconceito(s) toward their sexuality is about not having to respond to forms of sexual verbal insults. My interlocutors consistently describe how preconceito(s) feels like an insult directed at who they are trying to be, at their ability to live as proud and self-caring individuals. Marta, for example, shared with me how a young gay woman in Salvador was harassed by her gynecologist, who insisted that she (the patient) must be hiding some truth about having a boyfriend and having sex with men because women are “not just lesbians” who do not have sex with men too. Marta reported that the young woman was in frantic tears as she told the story to her. Marta, for her part, was utterly outraged. I consider Marta’s story as an example of overlapping social subjection and subjugation where medical female gay subjects are not free to be who they are even after they exercise their right to self-identify. Forms of subjugation and subjection indeed produce and reproduce a myriad of insults impinging upon the subjective experiences and modes of self-embracing during the medical exam. Patients do not expect to be addressed as “sapatonas” (a pejorative term, along the lines of “dykes”), the sort of pathological, stigmatizing, and often traumatic interpellation that some lésbicas
negras experience at home or in the streets. Precisely so, preconceitos are insults at the subjective level in this professional and sexualized setting. In this way, insult is a “mode of performative utterance” (Eribon 2004:17)

I use Eribon’s work to rethink the notion of insult as it applies to the medical setting in Salvador, how it functions to shape patients’ relations to their physicians, especially insofar as many do not openly identify as gay women or sleeping with women. In other words, Eribon helps me rethink preconceito as a performative insult, as an insult that pervades the gynecological encounter from the get-go. As ethical subjects, my informants arrive to their consultations prepared to claim their human right to not experience this (sexual, gendered, and even racial) insult during their visits. Women who chose to exercise their right to not identify as gay women will also not ask any health-related or medical questions suggestive of their homosexuality. Therefore, the social conditions within the gynecological setting that shape subjection and subjugation of sexual and gender issues emerge from the modes of insults upon their subjective modes of being have an impact that deters women from returning to any gynecologist. I argue that many Brazilian gynecologists in Salvador enforce compulsory heterosexuality through their semi-conscious enactment of preconceitos that produce insults directed towards the sexual experiences and practices of lésbica, and lésbicas negras in particular. As ethical subjects, however, lésbicas negras forge an intersubjective mode of being in order to enfrentar (confront) such preconceitos head-on, recognizing that such medical spaces ought to be domains of ethical action. Ironically, since most gynecologists themselves feel that ought to self-identify, that they only don’t come out because they are needlessly scared or ashamed, many physicians may actually be willing to intersubjectively negotiate this ethical field with their gay patients, despite the permeating, structural preconceitos cross-cutting the
Brazilian medical field as a whole. In this vain, lésbicas negras demand to be recognized as self-reflexive ethical subjects in pursuit of the human right to well-being, and to not experience insult.

In *Stigma: Notes on the Management of Spoiled Identity*, Erving Goffman argues that stigma usually falls upon an "attribute of a person that is deeply discrediting" (1963:9). Stigma, as an essentially linguistic or predicative phenomena, categorizes and selects certain characteristics as inferior with respect what is understood as normal (14). Stigmatized persons understand themselves as “naturally” possessing what is actually a socially-determined attribute that makes him or her feel “different” from others. Goffman’s analysis of stigma, however, aims to understand stigma as primarily about "social intercourse across individuals or among people. The social intercourse that Goffman suggests is at the heart of stigmatization is in fact produced through social exchanges and relations that reinforce the normal and acceptable. Against the naturalization of attributes, Goffman wants to develop an analytic “language of relationships, not attributes” (1963:3) to describe stigmatization. Goffman's attempt to articulate this "language of relationships," to describe the relations between the stigmatized attribute, the stigmatized person, and the intersubjective process of stigmatization is still unfinished work. Eribon's work continues some of Goffman's lines of inquiry in his analysis of insult. As he explains,

"One of the consequences of insult is to shape the relation one has to others and to the world and thereby to shape the personality, the subjectivity, the very being of the individual in question...In any case, insult is a performative utterance. Its function is to produce certain effects-notably, to establish or to renew the barrier between 'normal' people and those Goffman calls 'stigmatized' people and to cause the internalization of that barrier within the
individual being insulted. Insult tells me what I am to the extent that it makes me be what I am" (1963:16-17).

I highlight here the issue of stigma to call attention to its prevalence within the medical context, specifically the gynecological setting, and its manifestation in the *preconceitos* that ethical subjects seek to escape within such interactions. As Faubion argues, it is possible for ethical subjects, via particular processes of subjectivation, to experience the burden of stigma while also finding the "breathing room" in which to achieve the desired effects of their pursuit for affirmation. In the case of my interlocutors, this desired effect is achieved through their ability to gain respect for and affirmation of their sexuality, their understanding of their bodies and well-being, within the context of gynecological reproduction. It is the negotiated character of the emergence and repudiation of stigma that drives home the need for a “language for relationships, and not just attributes” (Goffman 1963:3). This will become particularly clear in later chapters.

The self-awareness of an ethical responsibility (Davis 2012) to the self and to one’s shared community means that recognition takes on a singular importance in this context. One commonly-held desire of my *lésbicas negras* interlocutors is that their homosexuality be “received and treated with a sense of welcoming” (*acolhimento*) during the clinical visit. Barbara Alves, a 39-year-old self-identified femme lesbian, first introduced the idea of hospitality as the appropriate attitude with which gynecologists ought to receive, respect, and integrate the ways in which seek to express their sexuality within the gynecological context. Only a few other *lésbicas negras* actually used the word “*acolhimento*” to describe what is missing from the approach that their gynecologists take toward their sexuality. However, it became
clearer to me over time, especially after interviewing many gynecologists in Salvador, that *acolhimento* was an essential component of successful acts of recognition. When *lésbicas negras* formulate a demand to be received with respect for and recognition of their sexuality, the measure of hospitality with which this demand is received is the measure of how successfully the clinician has avoided straightforward reproduction of social-medical *preconceitos*. As my key *lésbicas negras* interlocutors have above adequate private health insurance, they often articulated their demands in the register of their consumer right to be treated hospitably by the gynecologist.

I perceived a compelling, often agonizing, sense of commitment among *lésbicas negras* to attempting to occupy a particular mode of space and time with their gynecologists. Their continually tried to redirect their gynecological conversations, interactions, and outcomes toward their own understandings of their sexuality. Rosy Santos is an out *lésbica negra*, around 40 years old, with dark skin and her hair in locks. She is an initiated member of Candomblé and works for the *Secretaria da Mulheres* (Bahia state department for addressing women’s issues), also heading a social collective group for black women (both heterosexual and gay). She shared the following opinion about interacting with the gynecologist:

RS: "I would say that, first, we have to break that barrier. We [women] have to see that independent of being a professional, [they] are human beings, not gods! And not holding on to the belief: "Oh, it is a gynecologist!" You know? If I'm going to seek a professional to receive guidance from him, to see how I ought to take better care of myself, there has to be a dialogue, both of us breaking barriers. The gynecologist who is there, is there to attend to the patient, she may not know the patient’s [background], and too often he (or she) may not know what to say [lost for words], so he uses a questionnaire and asks for your name, address, what do you have [medical issues], or not. So I think that issue (silence about sexuality) should be broken (breaking a barrier) by both parties. [The silence] can be broken with a questionnaire that people fill out before talking with the doctor. The girl (nurse) should ask questions until you get to sexual orientation. There should be a video in the office with discussion of all kinds of sexuality, guidelines in which people could find themselves. It has to be a welcoming thing so that people feel comfortable talking... So
we should have videos that discuss issues such as “what is a gynecological examination? what is sexual orientation?” And the videos could show all the ways toward better relations [interactions], in order to spend time with patients and find ways of relating to people to help fill out such a questionnaire ... But not just have the person sit there and fill a questionnaire because people can skip some questions. The doctor himself can then go and do the normal (usual) questions, with more ease and not with that prejudice, but instead moving with a flowing dialogue ... So I think that [preceding] part is necessary to establish this part of the dialogue… the humanitarian aspect of the dialogue."

RS: “Eu diria primeiramente que a gente tem que quebrar essa barreira. A gente tem que ver ali que independente de ser um profissional, é um ser humano, não endeusar! Não ficar naquilo: “Oh, é ginecologista!”... sabe? Eu estou indo lá procurar um profissional para receber dele uma orientação, para ver como devo me cuidar. Então tem que haver aí um diálogo, quebrar ambas as barreiras. O ginecologista que está lá, está para atender a paciente, ela não sabe qual é o quadro dessa paciente, ele não sabe o que vai dizer, então ele está com aquele atendimento ali de praxe: nome, endereço, o que tem, o que não tem. Então eu acho que essa questão aí deve ser quebrada por ambas as partes. Pode ser quebrada com um questionário que a pessoa pode preencher antes, conversando, a menina fazendo pergunta até chegar à orientação sexual. Pode ter um vídeo no consultório onde fale de todos os tipos de sexualidade, de orientações com que a pessoa se identifique. Tem que ser uma coisa assim acolhedora, que as pessoas se sintam à vontade de falar.... Então a gente deveria ter vídeos passando ali com todas essas questões, o que é exame ginecológico, o que é orientação sexual. Passar lá todas as maneiras de se relacionar para que as pessoas ao preencher esse questionário... Mas não a pessoa sentar lá e preencher, porque as pessoas podem pular algumas perguntas. O próprio médico ir fazendo as perguntas normais, de forma tranquila e não com aquele preconceito, mas a coisa ir fluindo num diálogo...Então eu acho que é necessário essa parte, estabelecer essa parte do diálogo, essa coisa humanitaria.

Rosy describes and envisions, with considerable high expectations, a transformed clinic and a visit with the gynecologist that demonstrates more open access, a facilitated experience of human dignity, in relation to her sexuality. Rosy is not alone in holding this sentiment and expectation. Though other women did not use the word “dignity” during my interviews, they alluded to it in other ways. Jandira, Barbara, and most of my interlocutors feel strongly that gynecologists should be held accountable for showing a humane orientation toward their sexuality. On the one hand,
many lésbicas negras hold the gynecologist responsible for knowing how to initiate and guide the conversation, for knowing how to become partners in a dialogue about their sexual health, sexuality, and gynecological healthcare. On the other, many gynecologists I spoke with stated that they expect their patients to reveal their sexuality, that they (as physicians) did not feel comfortable encouraging them to reveal it. As a result of this tension, some gynecologists said that some patients did not identify as lesbians, gay women, or homosexuals until after a few visits.

The ethical emerges here precisely along these fault lines between lesbians and gynecologists. Most gynecologists do not want to inconvenience and make patients uncomfortable about their homosexuality. They behave accordingly, avoiding any interpretation of how their patients’ sexuality might be relevant to the practical aspects of their role as physicians (such as inserting instruments into their patients’ vagina). Patients are left to feel responsible for initiating such aspects of the conversation. Such shifts in responsibility ultimately generate moments of frustration for many women. They feel that they themselves must work to discover whether their gynecologist is preconceituoso (very prejudice), exposing themselves to the risk of experiencing the effects of biased attitudes or remarks; that they may as a consequence not experience a humane, dignified medical interaction; that, ultimately, they may not be recognized as medical subjects with particular needs associated with their sexuality. For example, Rosy considers herself a virgin who has never been penetrated, and does not want a penetrative examination by a vaginal speculum. lésbicas negras, such as Rosy and Barbara (both virgins), as well as Jandira and Barbara’s sister Luci, are generally extremely uncomfortable with the insertion of a vaginal speculum. They hope to maintain control over the gynecological engagement with their sexuality. Their expectation is that they should reveal their sexuality and
make it relevant to the discussion when necessary. This produces a disconnect between what *lésbicas negras* and gynecologists understand as the appropriate modes of relating to one another and vis-à-vis issues of sexuality, even if their aims are ultimately more or less congruent.

Given the barriers to self-reflexive, intersubjective becoming in such a setting, we may well be skeptical about the existence of intersubjective ethical subjects. Faubion’s analytic approach to questions of subjectivation, however, can move us beyond this deadlock towards a rich imagining the complexity of the ethical subjective experiences and practices I seek to expound, pointing out that

“We would unduly restrict the analysis of processes of subjectivation were we to take as an exclusive guide the presumption that subjectivation can have an ethical dimension only if the occupation of a given subject position is in some respect at least a ‘positive’ affair. We would be short-sighted were we further to presume that the valence - ethical or other - of any given position is fixed. Whether because they are stigmatized or because they come with what are experienced as excessive burdens, subject positions can be insufferable to the subjects who occupy them. This does not preclude their allowing ethical breathing room and objective ethical possibilities, psychic and practical. The stigmatized actor is not automatically a Foucauldian slave. Nor, as analysts from Goffman (1963) forward have shown, is stigma beyond manipulation or contextual retuning. Stigmatized minorities are remarkably adept at turning the terms of their detractors into positive signs of intimate community, even if such linguistic and rhetorical liberty is more compromised than some of those who take it appear to be aware.” (Faubion 2011:62)

Faubion reminds us that when ethical subjects are stigmatized by or marginalized with respect to normative domains of acceptance, even then, by suffering through and engaging with some form of insults (*preconceitos*), they can and often will gain traction to achieve an ethical sense of self.

Even in cases when they receive affirming, respectful, or cordial treatment from gynecologists, for example, many *lésbicas negras* report that their doctors demonstrate facial expression of amazement or puzzlement upon learning of their sexuality. The exhibition of such affects by gynecologists is illustrative of the
pervasiveness of the heteronormative structure of their profession, as well as perhaps personal imbrication with these structures. However, although these physicians might be stuck within both biographically and structurally-produced heteronormative frameworks of affect, many are committed to pushing the limits and boundaries of their practice. I recall interviewing a nurse at CEDAP, (Centro Estadual Especializado em Diagnóstico, Assistência e Pesquisa) an STD and HIV/AIDS clinic, who honestly shared that she was an evangelical and did not believe in homosexuality. She also modestly told me that in spite of her beliefs, she tries to treat all gay patients with dignity and equality and not allow her beliefs to affect treating gay patients with a smile and humane. Perhaps the social chaos and vulnerability of HIV/AIDS as a medical and social issue made her job easier in this regard.

This perception is tied to the recognition of the important role played by social forces in medicine, calling into question the physicians' ability to approach their patients not just from a biomedical perspective, but from a socially conscious, humane, ethical stance, understood in the context of their sexuality, are here invited to be who they are, but the question remains: will they receive the partnership in healthcare and promotion of well-being that their visit ought to off? In the gynecological interactions where this question is posed, I argue that an ethical field is created.

**The Themitical: Human Right as a System of Values**

In this section, I explore another component of my theoretical framework: the themitical (Faubion 2010, 2011). The themitical lies within the ethical; it is that realm of ethical engagement that draws a distinction between ethics and “morality” (Zigon, 2007) and represents a “homeostatic dimension of the ethical that by large belongs to
the order of reproduction” (Faubion 2010, 2011). An understanding of the themitical will be key for my interpretation of the more reproductive dimensions of “autopoiesis,” that is, of the processes of subject formation relevant to my study (Faubion 2001, 2010, 2011). As Faubion states, “the themitical belongs to and is among the constituents of social system-adjustment or the production of a social system that thenceforth will not be altogether the same, even the same thing, that it formerly was” (2011:104). In this vain, the themitical offers a conceptual approach by which to contemplate the social reproduction of human rights as a system of values and ideals for pursing social well-being for lésbicas negras as it pertains specifically to the Brazilian ethical, social, and political context. In other words, how might the shifts within the themitical, or order of reproduction, be reinterpreted as under the influence of the formulation and reformulation of new subject positions. In this project, I contemplate the gynecological consultation to reinterpret such themitical shifts via a micro-scale window by which to discuss how some lésbicas negras draw upon human rights as themitical. As an ethical resource representing a system of values and ideals that ultimately serve to enable the pursuit and realization of their well-being (telos), is the analytical endeavor herein. I explore gynecology and its many norms, systems, environments, technologies, and representatives (gynecologists in particular) as primarily pertaining to the “social system undergoing adjustment” (Faubion 2011, 2010). However, gynecology as a locus to hone on upon social reproduction is what marks the themitical particular useful as Faubion’s distinct deviation and contribution to Foucault’s ethical interpretation grounded in social production, or the becoming (Faubion 2010:86-87). My analytical focus is not upon the norms and systems within gynecology, albeit they must be acknowledged, but upon the issue of negotiating a system of values and ideals that represent the
themitical as human rights and thus, the central constituent that aims to readjust the social production terms within gynecology. Therefore, the themitical is the ethical realm by which such negotiation for recognition takes place as openly gay black women via what I ethnographically describe as both enabling conditions as well as a dance with inhibiting conditions deployed by ethical subjects.

The ethnographic chapters in this dissertation illuminate various micro-scale and macro-scale features and deployments of such a system of values and ideals about human rights for lésbicas negras. These value systems enable their self-(re)making formations and enactments via reinforcement of their racialized sexual subjectivities. It is via such dimensions of autopoiesis that intersections of race, sexuality, and class reformulate micro-systems of values and ideals about social well-being. In other words, I interpret these women’s strong claims that their human right to be treated with respect ought to be an integral realm of their interaction as openly lesbian patients is an ethical resource that guides their lives for well-being in the first place.

My goal is to demonstrate how some lésbicas negras, on the one hand, draw upon their quotidian lives to reformulate themselves as seekers of social well-being that encompasses their ideas of sexual health and self-care (health, mental, and social). In other words, the study of the themitical

The themitical discourse of human rights, even in its particular call for equality of access to healthcare, ought to have women’s health and reproductive rights at its center (Martin 1987; Gregg 2003; Inhorn 2003, 2009; Craven 2007; Georges 2008; Kline 2010). Indeed, my interlocutors are invested in accessing quality healthcare primarily for gynecological medical issues such as fibroids or for preventive treatment such as routine pelvic exams and mammograms. That said, their experiences enact the encounter between human rights and the medical encounter; at
their center, their practices produce the “problematization of social norms” (Dave 2012). In *The Body Multiple*, Anne Marie Mol posits that “medicine is as social as an endeavor as it could be,” and that “knowledge and power, science and society, are intertwined. That knowledge is material” (2002:62) *Lésbicas negras* claim that they should be received and treated with respect and humanity, particularly as regards their sexuality; many gynecologists, however, say that they are waiting for women to *self-identify*, holding this to be the precondition for their ability to provide such respect and humanity. The tension between these two understandings of the themitical is a key component of the ethical field developing in *lésbicas negras’* encounters with gynecology. Their reengaging with the norms and systems of social production within gynecology functions to remind us that “medical knowledge, medical perception itself, is as social in its origins as in its effect. And it is material as well: a discourse that structures buildings, instruments, gestures. That differentiates between normal and pathological organisms and thus mediates between the coherence of the body and the order of society” (Mol 2002:61). Mol’s view of the medical as (the) social helps me think through the social connections between sexuality, sexual health, and well-being (re)produced by my key interlocutors and in their making of human rights claims in the gynecological context. These claims are *precisely* about the problematization of social norms.

Moreover, it is *lésbicas negras’* promotion of enabling conditions and tango with inhibiting conditions of expressing sexuality and racialized understanding of self-care and self-advocacy that ground the readjustments within the themitical. As I will ethnographic demonstrate in upcoming chapters, I convey that modes of subjectivation, or self-(re)making via reformulated subject positions, for *lésbicas negras* are linked to micro and macro scales contextual understandings of human right
as an ethical pursuit. In other words, for them, it is the “right thing to do” in order to forge spaces that ought to affirm and recognize their openly sense of self as a lesbian.

Still, as Dave (2011:651) argues “incommensurability can transform affect into the commensurable to bring closure to potential, to normatively quality disruptive social intensity.” In other words, feminina homosexualidade (female homosexuality) was considered by random and interviewed same-sex loving women and even some interviewed gynecologists as “incommensurable” (Boellstorff 2005) to the gynecological encounter given the ineffective or disdained approaches to align female homosexuality with female heterosexuality. It is precisely these social complexities (Mol 2002) that I argue elicit significant affect and provocation of already existing racial and sexual subjectivities. These entanglements are markedly evident in my empirical work as both enabling and inhibiting conditions faced by my key interlocutors, who I consider as ethical subjects forging this ethical terrain.

In her recent annual review essay of the anthropology of human rights, Ellen Messer tells us that claims about “rights to a standard of living that include the rights to health and well-being was part of a second generation of socioeconomic and cultural rights” (Messer 1993:222). In Brazil, the pursuit of human and civil rights is generally a quite public affair. Brazilian citizens very often organize in large numbers at both the local and national level to make different human rights claims ranging from arenas as diverse as healthcare, anti-violence, housing, education, and the sexual, such as occurred during the manifestations of 2013. However, it is challenging to track the function of these claims as they move across the private and public domains. However, I understand my interlocutors’ self-identifications as a lésbica negra, and their insistence upon the relevance of their sexuality in the gynecological context as precisely about claims to respect and humanity. The ethical project of being
recognized as lésbicas negras is engaged with the themitical dimension of human rights discourse. This recognition is not primarily or only about the valorization of the category “lésbicas negras,” but about recognition as actually-existing women, marginalized within a broader social order, who are seeking to escape the inequities that plague both their communities and themselves personally. A key point here is that while many physicians might believe that the status quo quality of healthcare is in fact providing adequate testing, examinations, and management, my interlocutors, as patients, are arguing for a less quantitative, more robust notion of what might constitute the “quality” of healthcare. For them, “quality” healthcare must include the recognition of patients as entitled to mutual respect and affirmation as agents of their own lives in its their fullness; in their specific cases, as black women who are lesbians.

As should be clear from the analysis above, the themitical importance of (re)producing particular modalities of human rights is articulated largely through the idiom of “well-being.” Well-being has long been regarded as a human right (Messer 1993); however, within rights discourse, claims based upon well-being risk being vague or unintelligible. What, we might ask, does it mean to claim a right to well-being? In later chapters I delve directly and ethnographically into these particular human rights claims, arguing that an examination of such claims demands a materialist exploration of the enabling conditions that produce the possibilities that allow for them to become possibilities in the gynecological context. Nevertheless, I am here comfortable asserting that my interlocutors use human rights discourse to articulate their desire for well-being, understood as a particular harmonious relationship between sexual health and sexuality, in order to engage in a particular mode of freedom. My ethical subjects know that their gynecological consultation in
the private sector invites them to pursue such human rights more broadly; the pursuit of (the right to) well-being means for black women to be agents of anti-preconceito.

It remains to be seen what the norms and systems that structure the social (re)production of human rights in gynecology for black lesbians might be. In other words, what, concretely, are the dynamics of the themitical in this context? Or rather, what, within the gynecological setting and interaction, evokes claims for human rights? Here, I can point to at least three potential motivating factors outlined by both my lésbicas negras and biomedical interlocutors: (1) the gendered and heteronormative methods used by gynecologists to interview and assess provoke ethical subjects to strive for recognition; (2) the destabilization of the normative understanding of patient-physician interaction as a consumer transaction by the engagement with extra-medical discourses of sexuality; and (3) the disconnect between medical and lay understandings of the type of “self-care” of which both groups admit regular visits to the gynecologist are a part. A fuller discussion of these (and additional) factors is left to later chapters. The point to drive here is the significance of parsing out the enmeshed social and medical engagement that when in effect it reveals a process of readjustment. The readjustments through modes of negotiation (which I discuss in the next section) evidence the ethical in this project.

The focus on lésbicas negras’ engagement with the themitical discourse of human rights is crucial to the argument of my dissertation. However, as Faubion points out,

“The themitical dimension of the ethical field is hardly without its own dynamics, of course, but they belong largely to the order of reproduction. The broader ethical field, however, must always also have one foot at least in the dynamics of production, of becoming … the anthropologist of ethics slips into
yet another modality of the naturalistic fallacy should he or she mistake the normativity – the structural-functional principles - of the organization or autopoiesis for ethics itself, or even its themitical dimension” (2010:86-87).

The themitical, as a conceptual tool, facilitates my discussion of gynecology as belonging to a larger order of reproduction of social norms about gender and sexuality in particular, such as the notion that women with putatively reproductive bodies and heteronormative sexual relations must prioritize their health in order to sustain such reproductive capabilities. This analytic framework allows me to draw lines between that which is normative and that which is being adjusted for and by accommodating strategies of existence (Bielh 2007:5).

Negotiating Recognitions: Themitical’s Relative Stability

The silent, unsaid “now what’s next?” that inaugurates the ethical turns on the hope or demand for negotiation. Gynecological negotiation is a praxis and field of meaning that needs to be examined in order to understand the substantive particularities of my interlocutors’ lives and identities. I thread together an analytical discussion of their imagined, pursued, and enacted modes of freedom with their resistances against preconceito, focusing on how their striving toward sexual health as well-being builds a particular ethical framework. I understand their practices as negotiating a human right to an accumulation of well-being.

Negotiation is about belonging. I argue that to the extent that some lésbicas negras as ethical subjects negotiate in various ways their openness about their homosexuality as precarious racialized subject, they are further engaging in modes of recognition as ethical subjects. These negotiations constitute new subject positions, particularly in the ways in which local and national discourses are situating newer
emerging modes of ethically recognizing LGBTT, negros/as (blacks) in particular, citizens within healthcare. These modes of recognition represent the relative stability of the themitical within the ethical. In other words, when they advocate for their human right to be recognized as deserving greater recognition as openly gay women seeking treatment in humane and equal ways as their counterpart heterosexual and white lesbian patients, the themitical domain reestablishes in socially complex ways an order of reproduction toward female homosexuality and race relations. As lésbicas negras in gynecology reacting to and speaking out for themselves in gynecology and beyond repositions the ways in which their racial and sexual identities and bodies are situated in particular social relations. The mode of subjectivation of my lésbicas negras interlocutors can be illuminated through an examination of their sense of belonging particular to the gynecological setting and to a broader Brazilian biopolitical domain of norms and values regarding coming out as a lesbian. In other words, when lésbicas negras forge an ethical responsibility to be open with their sexuality, integrate it within their conversation, and to push the boundaries their sexual being with the gynecologist, they understand themselves to be participating in the emancipation and bringing-in of closeted lesbians, broadly, within the gynecological setting. I do not just refer to closeting of the homosexual self in the presence of the gynecologists, but to the occupying of an abstract space of sexual health and gynecological freedom. Too often, gynecologists are not prepared to affirm the sexualities of openly gay patients. These moments are analytically relevant for interpreting such social and medical complexities serve as the inhibiting conditions negotiated by many ethical subjects and in turn, serve to closet, challenge, or alienate them from the telos (well-being) in such settings.
Many lésbicas negras believe that as lesbians, their medical interaction with gynecologist ought to be different in many respects. They pursue recognition of their deserving and being entitled to speak from and identify with their sexual subject position within the social order that aims to organize their experiences as individuals at a given historical moment (Eribon 2004). The particular historical moment at issue in this project turns on a point of transition in the modality of interactions and conversation between lesbians and gynecologists toward the recognition, acceptance, or at least the tolerance of the homosexual female subject. Dr. Edson and other gynecologists reported that over the past five years they have been faced with more female patients who come out as lesbians, and that the discussions have become easier over time. While open engagement with homosexual identifications and negotiations within the gynecological setting for is a relatively recent phenomenon for many physicians and patients, such engagements contribute to an emerging field of ethical responsibility and, in turn, the emergence of a new class of ethical subjects. In this case, the strivings of black lesbians, as particular, historically constituted racial subjects, are of special interest.

**Themitical: Dynamics of Recognition for Quality Social Interactions**

Ethical as subjectivation is central to this project for examining the gynecological encounter as a locus for social reproduction of female homosexuality in Salvador. Although I have will further window into other ethical realms beyond the gynecological setting such as the lésbicas negras’ micro-social modes of interactions as well as how preconceito as discourse circulates within macro-scale realms yet reinforcing ethical strivings for such citizens, my intention is to point to the possible ways of visualizing homosexuality in Brazil as strivings for freedom, citizenship, and
“’erotic politics of agency, or erotic subjectivity’ (Allen 2011:97) grounded not just in the self-(re)making of racialized sexual subjects as individuals as a patient-doctor interaction might suggest but also in the collective concerns for others occupying similar subject positions. My assessments are informed by the ways in which these women hold themselves accountable to others and to the ways in which they embody such ethical strivings trickling down from the nation state. As Jafari Sinclaire Allen (2011) in his reformulations of self-making among LGBTT folks in Cuba argues, “’erotic subjectivity - deeper understandings and compulsions of the body and soul - simultaneously embodying and invoking sex and death-works toward not only transgressing but transcending and finally transforming hegemonies of global capital, the state, of bourgeois, limited and limiting notions of gender, sexuality, or blackness, for example” (2011:97).

The reformulation of subjectivation involves both negotiating inhibiting and enabling conditions albeit I draw more attention to the enabling conditions throughout the dissertation. The inhibiting conditions I point to encompass the challenges posed by the medical infrastructure and even by the ways they participate in creating their own marginalization. For example, some ethical subjects seem to respond in ways that reinforces the unwelcomed control of their ethical subjectivities by not seeking care when medically necessary, by enduring pain of the speculum exam and not speaking out about it, or by setting expectations of the gynecologist that never reach fruition. Such inhibiting conditions shifts them away from the telos (well-being) insofar as it gives license to collective disdain and stigmatization of same-sex relationships and gender non-conforming presentation of the self and of their skin color in a racial sense. My concerns for existing inhibiting conditions were repeatedly confirmed by the gynecologists interviewed in claiming that “lésbicas ought to come
but they don’t; they are too afraid or ashamed; they don’t come out in SUS.” These generalized medical attitudes, which I discuss in upcoming chapters, rub against the forging for the human right to well-being for openly lésbicas negras. Nonetheless, as Naisargi Dave (2012) argues, “sexual identities are partly constituted through the melancholy of loss and limitation. Perhaps it is this melancholy of subjection that is negotiated by reframing subjection as freedom” (69). In other words, it was clear me over time in the field via interviews, conversations, and the making of the film that such “melancholy” (Butler 1997) is a resource by my key interlocutors because they are transformed and retransformed by self-created or inevitable limitations. That ultimate produced well-being over time.

Nonetheless, this project focused upon the enabling conditions that influence the themitical. I emphasize that the themitical is a realm and influx of human rights for preserving such “erotic subjectivity” (Allen 2011), for example, that is influenced by both inhibiting and enabling conditions discussed within the next chapter. Through such influences that impact the ethical as subjectivation, or the establishing of new subject positions, lésbicas negras negotiate the enabling conditions travelled into the gynecological encounter. I am interested in studying and windowing into the enabling conditions as resources in the ethical reform or in other words, within the entrenched legitimacy of appeal to human rights, to dignity, to liberty and to equality. In this vain, my ethnographic chapters this empirical work. Dave is helpful in rethinking through how lésbicas negras argue that the medical establishment needs to change. Dave interprets her interlocutors to say, “If not by norms, how else might we give shape to our lives? How else might we live” (2012:96)? However, my work pushes this question in a different direction similarly to Jafari Allen’s work (2011) precisely because these women are black women contesting white establishments. In other
words, if I may rephrase Dave’s question as “If not by a system of values and ideals as black women, how else might we give shape to our lives? How else might we live?” These sort of questions I pursue in the reformulations of the self, the collective, and discursive agendas as means to this end.

Themitical: The Speculum

This section clarifies the implications of the speculum exam in this project. Throughout, I focus upon the negotiations of the speculum exams to show how in fact it is as a means by which to seek recognition as ethical subjects. It is precisely this relationship between material (speculum and their bodies) and power (medical establishment) that participates in invoking ethical subjects in particular ways. It is inaccurate to suggest that only lésbicas negras experience painful and inappropriate speculum exams. However, gynecological negotiation is also about defining access to a particular form or mode of social interaction. Lésbicas negras’ demands also include that their gynecologists are adequately informed about and willing to provide sexual health education appropriate for lesbians, and to consider the heteronormative implications of presumptive use of the speculum. Negotiations around these issues begin the moment the gynecological interaction, and its attendant modes of conversation, begin. In our conversations about these interactions, my interlocutors demonstrated deep self-reflection in articulating and recognizing that and how gynecology interacts with issues of sexuality, whether doctors want to embrace it or not. They feel that their sexuality should not be treated as invisible, irrelevant, and certainly not without dignity. One common and unfortunate consequence of visits that did not live up to this standard was their unwillingness to return to any gynecologist for long periods of time.
Women who demand to be recognized as ethical subjects in this setting know that they have the human right to embodying and expressing a whole, unfractured, sexual subjectivity, even when it does not seem directly relevant to their care. In *Woman in the Body*, Emily Martin (1987) describes how women feel “alienated or separated from themselves during gynecological and obstetrical procedures such as cesarean sections and other medical procedures and technologies that elicit the feeling of a self and body separation” (1987:82-85). Martin aims to show a “fair amount of fragmentation and alienation in women’s general conceptions of body and self in relationship to reproductive healthcare procedures” (89). Women’s perceptions of alienation are nearly universal with respect to vaginal speculum insertion, for example. During this procedure, there is a sense of alienation from the self and the body, as though the vagina is being wholly handed over, however briefly, to the gynecologist for an often uncomfortable and, in many cases, painful experience.

Luci, Barbara’s sister and a *lésbica negra*, is horrified by the vaginal speculum exam, but feels that she *must* undergo it, having has sex with men in her early 20’s. Now, in her late 30’s, she reports not having been penetrated sexually with anything bigger than a woman’s finger for a long while. Yet, she reports being treated by gynecologists with the presumption that her vagina will be supple and elastic enough to withstand any size or make of speculum, just because her medical history accounts for such past sexual relations with men. Luci had difficulty finding a gynecologist (either in private practice or SUS) who will discuss her sexuality with her in an affirmative manner. Luci’s experience serves as an unfortunate example of how gynecological experiences fragment women. I consider Luci as a committed, ethical subject, given the ways in which she self-reflexively engages her life and sexuality in general. Speaking of recent visits to the gynecologist, she told be that she
“just can’t keep letting doctors use any size speculum. They must respect my sexuality and listen to me.” Clearly, Luci wants to be heard. The way in which other interlocutors, such as Isabelle, describe their experiences also resonates with what Martin described as “women’s discourses about their body and self as active assertion alongside passive acceptance, clear perception of alternatives alongside confused discontent, wholeness and integration alongside separation and fragmentation.” She continues, noting that

“women’s general images of their selves are chronically fragmented, but … contain -alongside fragmented images - a rich mix of consciousness of alternative social and cultural worlds, together with resistance and protest against conditions perceived to be diminishing and denying of autonomy and fulfillment” (1987:194).

Martin’s interpretations of the women’s medical and personal narratives are still relevant today. Gynecology, as a medical regime, continues to construct, constitute, and disembodify the female body, and many women continue to associate the gynecological exam as an alienation from the self-experience (Martin 1987; Karpalis 1997; Gregg 2003; Kline 2010). It is far from clear that the solution to these problems is to be found in the use of advanced technologies designed to alleviate women’s gynecological experiences, such as transvaginal ultrasounds, vaginal speculums, or mammography. After all, as I have argued alongside Martin, the communicative, interactional, and intersubjective structures through which people become medical subjects in first a foremost a socially reproductive one, engaged with but not grounded in science and technology, nor in “objective” biomedical understandings of disease process and health outcomes. In this social-medical setting,
I am most concerned with the lésbica negra who sees herself not just as an individual with consumer rights but also as a whole person longing to contribute to building the conditions necessary for humane gynecological experiences for both herself and other women. In this vein, I argue that medical “access” needs to be understood in its connection with social access (a point I return to more thoroughly in chapter 4). Access becomes the means by which ethical subjects seek to be recognized as possessing a human right to wellbeing. Yet, physicians place much of the burden of such “access” upon their patients, provoking them to actively search for quality life during the medical examinations. This is the therapeutic collaboration (Davis 2012) they are seeking to establish, if only for the brief time of their clinical visit.

*Ginéco-Etico: An Ethical Framework*

An anthropological approach to the ethical opens a window into visualizing the relationships across medical objects such as speculums, circulating symbolic language loaded with meaning about social inequities such as *preconceito*, and the reformulations of new subject positions within the ethical. Without some degree of a materialist approach to my empirical work, the social relations that enable the readjustments of social reproduction would be challenging to tease out. After all, “the human person is never merely an individual but lives always in social relation” (Hennessy 2006:116). Moreover, Nancy Scheper-Hughes (1992) reminds us that “there is an exchange of meanings, images, representations, between the body personal and the collective and symbolic body social” (1992:169) Grounding her work in the Northeast of Brazil, Scheper-Hughes draws upon language as “metaphors used so often in the everyday conversations of Alto people that mimic the physiological symptoms of hunger” (169). I am interested in a materialist approach to
understanding what would be considered as immaterial: well-being (telos) (Miller 2005). Some anthropologists have argued for renewed ways for the study of materiality that does not beholds us to just objects (Miller). Rather, it is important to consider the “large compass of materiality, the ephemeral, the imaginary, the biological, and the theoretical as an approach to material culture within a large conceptualization of culture” (2005:4)

In the upcoming chapters, I demonstrate ethnographically the impact of circulating discourse(s) about sexuality and gynecology in Brazil, and their implications for the qualitative analysis of healthcare. The links, or partial connections, across a variety of ethnographic elements substantiate for me what the women would often consider as “not having the conditions by which to ascertain particular ways of living.” It did not always mean not having enough money but largely access to creating the conditions for what I study as well-being through their claims. At the micro-scale level, I noticed that the outcomes with speculum exam were secondary to having access with the gynecologists to the sexual freedom they always pursue beyond those medical walls. As I have argued, the ethical subjects at the center of this study place immense emphasis upon the quality of conversation and interaction. The issues of what is said, how it is said, and what ought to be said or unsaid during the consultation between the lesbian patient and gynecologist open onto a whole set of debates about language and discourse within the biomedical realm. By pursuing their human right to be as free as possible with their sexuality during these interactions, lésbicas negras are ultimately engaged in a project of thinking through homosexuality itself, engaging a particular form of liberal subjecthood (Puar 2007; Noonan 2014) that I discuss further in chapter 4.
Many gynecologists feel that they are not trained to adequately take into account issues of sexuality, in general, much less homosexuality in particular. Although no physician would likely admit that their intentions are to insult or treat insensitively women who identifies as lesbians, many have said that a good number of their colleagues are very homophobic. Nonetheless, there was a consistent perception among the gynecologists I interviewed that lesbians who are out and self-identify as such should take the lead on the conversation relating to their sexuality, even in the face of such homophobia. Many gynecologists perceive themselves to have an open door policy for patients to self-identify as a homosexual, but place a heavy responsibility onto the patient to self-identify. When, possibly due to their own awareness of the prevalence of homophobia among gynecologists, lesbians do not self-identify, doctors explained their behavior as the result of their (lesbians’) being “too ashamed to say, or too scared.” It was striking to me how most physicians do not offer any strategies to help homosexual patients feel at ease, even when they observe such putative shame or fear from their patients. Most of my physician interlocutors were aware that patients’ fear or shame about revealing their homosexuality is due to sexual and racial preconceito, yet they do not feel responsible to actively work to move beyond it.

It is important to engage the discourses circulating around sexuality among lésbicas negras and the general public to further trouble such attitudes and practices. I argue that medical discourses sustain medical authority over women’s sexual and reproductive health by neutralizing or insulting the sexual subjectivities of lesbian patients in particular. Most physicians seem to believe that it is unrealistic for them to broaden their professional orientation to sexuality, given their lack of training and expertise on sexuality in particular. In Brazil, there is an official subspecialty
sexology for gynecologists interested in receiving training. Despite this, many physicians told me that “we [gynecologists] are not trained to deal with sexuality.” However, it is not all so bleak. Several of the gynecologists and infectious disease specialist that I spoke to actively worked to be “lesbian allies” and affirming to their lesbian patients. More importantly, potentially, they were committed to holding their colleagues accountable for lacking a humane approach to sexuality, and for maintaining rigid “preconceitos” against homosexuals. These same physicians claim that rather than lack of formal training, an unwillingness to make what were for them intuitive connections between sexuality and gynecological practice was responsible for the inadequate discussions with and care for lesbian patients. In this vein, I am intrigued by the substantive and powerful ways that these clinicians and lésbicas negras alike can be understood as ethical subjects whose daily lives, but especially their interactions with clinicians, disrupt the reproduction of preconceito.

Furthermore, I set forth an ethnographic description of the social world of lésbicas negras, focusing on various themes, sites, people, and field situations that can help us imagine the formation of such ethical subjects. Throughout, my discussion of how modes of subjectivation come to engage the themitical (human rights) in gynecology is linked to the broader structures and intimate encounters of my ethical subjects. In so doing, I am interested in finding ways to highlight the creation of the “breathing room” in which these women enact their freedom. As such, I am also obliged to undertake a rich analysis of the social conditions in and through which black lesbians chart such modes of freedom. In the specific context of the gynecological, for example, I am interested how a rigidly normative field, permeated with preconceito, nevertheless allows for the intersubjective production of a sense of belonging. The ethical subject does this, I argue, in part by its ability to rotate and
merge various modes of self-knowing and an awareness of social forces, as it negotiates multiple subject positions, ethical identities, and ideas of freedom inside of a seemingly impossible ethical domain. Such intersubjective rotations compel, through the work of both contradictions and communication, particular medical subjects to seek their freedom through developing novel modes of existing in such settings and moments. The *gineco-etico*, in sum, is the name I have given to the realm where *lésbicas negras’* ethical practices navigate and intertwine with complex social and medical modes of reproduction in gynecology, seeking affirmation of their sexuality and sexual selves *in dialogue with* the biopolitical norms and values operative within broader Brazilian society.

“Life-Times of Becoming Human,” Neferti X. M. Tadiar proposes “the notion of ‘life-times’ as a concept for reckoning with the diverse array of acts, capacities, associations, aspirations in practice, and sensibilities that people engage in and draw upon in the effort to make and remake social life in situations of life-threatening hardship, deprivation, and precariousness” (2012:1) The “life-times” of the “*assumida*” or “out” subject position are grounded within intersubjective experience, and are informed by the precarious and singular project of making a human life as a black woman in Salvador. That is to say, being a black lesbian carries a triple weight: being black, a woman, and a homosexual; yet, it is a weight freely assumed by my interlocutors, whose carrying well becomes the way to a life full of happiness, freedom, self-love, and self-care. In large part, well-being for these women is about freedom to achieve a particular type of quality of life produced in time and space and through interaction (including, most saliently here, with the gynecologist).

My project makes several significant contributions to anthropological scholarship on gynecological medicine, sexuality, race, and ethics. Beyond
considering lésbicas negras as ethical subjects occupying multiple subject positions, a key component of my intervention is to develop a materialist analysis of the ways in which they create pathways to become visible, acknowledged, and respected as lesbian patients. My project aims to ask three main questions of the ginecoetico: (1) what are the enabling conditions by which such ethical subjects claim well-being as a human right in relation to their coming out practices with the gynecologists? (2) how can we understand the ethical telos of well-being through the social reproduction of sexuality, sexual health, and racial community? (3) how do such women’s strategies and intentions to be recognized as ethical subjects interact with their social, religious, and communal context in Salvador? Having established the theoretical groundwork with which I will be approaching these questions, I turn to their concrete investigation in the following chapters.
Chapter 4

*Enquadramento*: Framing the Ethical

*Prelude. Contextualizing the Window.*

My 10th-floor apartment in *Barrio Dois de Julho*, with its huge, wide windows overlooking the Bahia Bay and Itaparica Island, offered an escape to a paradisical landscape (See Image 13). The view included parts of the upper and lower cities of Salvador, the infamous touristy *Mercado Modelo* flea market, and of the historic Lacerda Elevator that connects the lower and upper cities over its 236-foot drop. These captivating windows provided ample compensation for the apartment’s very small size. I chose the apartment when, after a diligent three-week search, at our first viewing Telma and I realized that it was the perfect apartment for me. I would be within a short walk from her and Erica’s place; the windows extended horizontally
across an entire side of the apartment and vertically from the ceiling to more than midway down toward the floor.

The views were breathtaking and serene. I appreciated the windows even more in the context of the quite lively and rugged neighborhood. Barrio Dois de Julho was dynamic, filled with humanity, and centrally-located. I had access to over 100 city buses that branched out into Salvador and beyond. Indeed, my life there immersed me in the complexities and richness of daily life in Salvador. Dois de Julho was in the Centro of Salvador. By day, it was a busy commercial hub. By evening, it was a social plaza for beer-drinking and game-watching. Into the later night, it swarmed with homeless dogs and drug addicts. I was already familiar with the neighborhood, having lived in Dois de Julho with Erica in June 2011: it was perfect.

During my visits to Salvador between 2007 and 2010, going to Dois de Julho for drinks at Mocambinho Bar Restaurant or Lider Restaurant was the thing to do for gay folks; these two bar-restaurants remain the hot spots in downtown Salvador for late night beer drinking, caipirinhas, and food. Lider sits across from the Centro de Estudos Afro-Orientais (CEAO), a division of the Universidade Federal da Bahia, which offers Master’s and Ph.D. Programs; students can study in areas such as race, ethnicity, and religion with professors such as Dr. Livio Sansone, author of Blackness Without Ethnicity: Constructing Race in Brazil (which is well-read in the U.S.). Dois de Julho was an intellectual, academic, activist, and social hub. It was also the home of many social organizations such as ODARA, Bahia Street, and CEAFRO (which folded in November 2013). Located two blocks away from Avenida Sete de Setembro, with its stores, banks, street vendors and other quotidian businesses, Dois de Julho was a residential neighborhood as well. Though many “foreigners” rent apartments in Dois de Julho, it remains a barrio, with a combination of working and middle class
folk as residents. It was a lively plaza with freshly baked bread, hand-made juices, hardware stores, meat markets, and lunch restaurants that were mostly open 11-3 during the day. I loved browsing its daily farmers’ market, with its wide variety of fresh fruits and vegetables, cheeses, and seafood including lobsters, clams, red snappers, and octopuses. Though I only bought the red snapper, I was amazed at how the seafood managed to stayed fresh under the hot Brazilian sun.

In this chapter, I center on Barbara’s narrative (and the people and issues related to her life), highlighting her as an ethical subject. This chapter offers a conceptual and methodological model for framing ethical subjects ethnographically. My approach here, focusing on a single ethical subject, sets up a broader, collective framing of ethical subjects in chapter four, and of ethical subjects as part of institutional infrastructures and biopolitical/biocultural discourses in chapter five. I compose these texts in by windowing, a practice inspired by my experiences at the literal, concrete window in my apartment in Dois de Julho. As this window framed my view of the city, my textual windows frame a view into some lésbicas negras’ lives, into Salvador and its cultural and political climate, and into the social and medical structures of Brazil. In this dissertation, I have attempted to craft a writing method adequate to framing the perspectives gained through my research. I call the writing about my research process and perspectives alternatively “windowing” or framing (enquadramento), focusing my efforts to tease out the relevant nuances of women’s stories. This is a stylistic and conceptual effort to sequence my fieldwork information and “create a compelling story line that leads readers to an even fuller understanding of the people and issues addressed” (Emerson et al. 1995). The intent of the ethnographic windowing is: (1) to demonstrate the ethnographic material that
informed how I deployed the ethical structure discussed in chapter 3, and (2) to balance the weight of different and separate sources of data.

At (and beyond) the window

Image 14: Barbara and her grandmother, Sra. Donna

Donna Hilda is a part of Barbara’s narrative, shaping the enabling conditions for her ethical subjectivity. The seafood spoken of earlier reminds me of Barbara’s 107-year-old grandmother, Donna Hilda. Barbara and I would often sit at my windows and reminisce about how her grandmother almost tricked me into eating stewed stingray. I had gone to visit Barbara’s home down in the lower city for the first time to meet her grandmother (who was principally cared for by Barbara’s mother). Barbara’s butch sister and police-officer brother would also help from time to time, but Barbara was the only grandchild living there; she was the principal caregiver. I learned, over time, just how much Sra. Hilda was for Barbara a soul mate and source of strength. Like Barbara, Sra. Hilda had an infectious laugh. She would hold my hand really tight because she could not see well, though she was mostly coherent. On this day, Barbara’s mother had already prepared fried red snapper with rice and beans. However, Sra. Hilda asked me if I would eat “raya.”
Under her loving generational spell, I agreed to try it, though Barbara told me that Sra. Hilda was the only person other than her brother who ate raya. I had thought it was some sort of regular fish, until Barbara’s mom served me on a separate plate. From my first glance, I realized something might be amiss, and asked, “what sort of fish is this?” It began to dawn on me then that raya might translate into ray, and then realized – stingray! I began making gestures to the pointy tail of a stingray, as Barbara and her mom nodded in an affirmative and laughed at me. With very little shame, I could not eat it. I smiled as Sra. Hilda tried to coerce me to come back for raya as she chewed down on the heads of everyone’s small red snappers. She died on Thursday, July 6th 2013, and was buried the next day.

Writing Ethnography: Windowing and Making Data

Windows present views and give you a certain kind of access to something on the other side. I first heard the word “enquadramento” (framing a window or view) in my one-on-one photography class in Salvador. When Andre, my teacher, showed me photography techniques based upon framing windows or panes within larger frames, I began to think more deeply about how as anthropologists we access, use, and write about the often-challenging perspectives of others. Both conceptual and concrete windows are frames. Metaphorically, the term satisfies my need for a particular style of writing ethnography, offering a process through which arrange the dimensions of my fieldwork. This process, though remains tied to the literal window in my apartment where fully half of my lésbicas negras interlocutors were interviewed, and where many informal conversations took place with those who became my friends and key informants. Unexpectedly, this window revealed more about the complexity of the issues and processes I was studying, by showing me that most women preferred
to be interviewed in a domestic setting, even if not their own, and reminding me that I was to them not only a researcher but also a friend and fellow black lesbian. Their facial expressions, patterns of breaths, pauses, and efforts to retrieve old memories, and formation opinions all occurred in relationship to this window, as they looked out on the city. My apartment window became a material grounding for my narrative of interpretations of ethical subjects who are also tellers of their own stories – stories framed by the broad and intricate structures that they confronted and lived withing.

In *Ethnography in/of the World System: The Emergence of Multi-sited Ethnography* (1995), Marcus says, “when the thing traced is within the realm of discourse and modes of thought, then circulation of signs, symbols, and metaphors guides the design of ethnography. This mode involves trying to trace the social correlates and groundings of associations that are most clearly alive in language use and print or visual media” (108). Here, Marcus helps me reflect upon my research process and the partial connections I am attempting to make. I “traced” symbols or ideas such as *preconceito* in thinking about my *lésbicas negras* interlocutors as ethical subjects within both their personal and the broader Brazilian context. I agree with Marcus that ethnography must search for and follow the signs, symbols, and metaphors that partake in constructing both intimate and social narratives. In this project, a fresh way of writing ethnography has become necessary; not just to facilitate describing and accounting for the complexities of my research process, but also to frame what I consider as evidence. Windowing is a written process by which to balance the weight and meanings of my different sources of my data (interviews transcripts, demographic categories, circulating documents, institutions, ideas) in order to narrate an interpretation of what it means to become an ethical subject in the Brazilian context.
Here, I draw upon Marilyn Strathern’s distinction between “making data” and “proving the point with data.” As she states,

"The intensity of the perception of similarity and difference plays an equally significant part in the anthropologist's account whatever the scale. It also appears to play an equally significant part in the actors' orientations. Differentiation is not after all contained - it runs riot. Significance appears not to depend on order of detail but itself emerges as a constant background to the distinctions at each level. Should we then imagine the activity of comparison or differentiation as having a replicating, self-similar pattern of its own? To say as much would be to attract the scorn generally poured on the idea of ideas generating themselves. So rather than trying to prove the point with data, I shall make data with it." (2004:xxi-xxii)

Strathern’s project of making data with the points to be proven offers a me an approach toward arrange my evidence, encouraging me to do so through bringing together points and ideas that might otherwise seem disconnected. My presentation of evidence draws upon data that can only be shaped or revealed by carefully weaving together interpretations of key threads drawn from a disparate series of interviews, newspapers, materials, and metaphors that are did not seem not directly related when collected in the field. I follow Strathern (2004) in presenting this data as evidence, by recognizing the scalar and complex character of my data-gathering process, and of drawing out and interpreting partial connections between women, physicians, their activities, meaning, signs, and metaphors from that data.

In what follows, I shuttle between presenting my analysis in relation to the concrete window in my apartment and the abstract window(s) of anthropological thought. Both modes of windowing allow for describing, sequencing, and (meta)narrating the complex partial connections embedded within narratives as they are being told and lived. Qualifying my observations and determining the appropriate evidence to marshall in this project was challenging, as the narratives of my lésbicas negras interlocutors are based upon recollections of experiences and upon imaginaries
of freedom that are in the making even as they speak to me. Most of these women had
not spoken openly about such experiences and issues before our interview – at least
not in such depth. At the same time, I was not able to speak with any of the women’s
personal gynecologists. Early on, Jandira’s gynecologist, whom I met during one of
her visits, had agreed to give me an interview. She told me that she was only able to
confirm her appointment the morning thereof, and ultimately still cancelled three
times. While she might have initially had good intentions in agreeing to speak with
me, her cancellations raised huge red flags reminding me of patient privacy, the
afterlives of research that becomes public, and institutional policing. After all, she
worked for a private clinic, which she did not own. Her cancellations also raised an
important issue about my research topic itself: what does it mean for gynecologists to
speak about homosexuality, their practice, and their patients? My attention began to
shift to the lives of my lésbicas negras interlocutors and their ethical subjectivity.

What is ethnography if not the unique opportunity to engage the worlds of the
people you seek to follow, to develop an interior view of their dilemmas? In a project
such as this one, I was compelled to navigate and imagine two worlds: lésbicas
negras’ medical and social narratives, and the narratives of their physicians. In this
chapter, I present some of my research findings alongside a metamethodological
(Marcus 2009) discussion of my research process. I understand the practice I have
named windowing as metamethodological, as “while metamethod concerns the norms
of professional culture that share the actual form of research, there are other
metamethodological issues that define the conditions for research today that exceed
the discourse of fieldwork that exists” (Marcus 2009:4). Therefore, when I think
about the design of this research, I take seriously that my position is already complex
in its positionality and capacity to access information and interpret observations;
however, there is richness and depth to the experiences and events that I encountered that transcends this position; I approach my metamethodological reflections from a humble yet risky place.

Windowing transforms my data into a metanarrative. It is a metaphor for imagining how to arrange selected information and to craft a framework for understanding complex and sensitive narrative issues. For example, we can imagine how each of the windows of a house may offer a different view, and yet all frame one particular location or community. In this vein, each of the windows framed in this dissertation themselves frame the gynecological physician-patient interaction at the core of this research, which otherwise would be literally ethnographically inaccessible. My selection of data as evidence is sequenced in particular ways as to allow such a metaframing to show the ethical practices at the heart of this interaction. The idea is not to suggest that the selected information is as fixed and rigid as it might be an actual window. Neither do I suggest that we should manipulate information through imposing closed or limited views. However, there is much to gain from presenting particular or views on data, from different angles and through partial openings. The metaphor of windowing describes my attempts to hold together the variety of views, events, meanings, and contexts encountered in the field that inform my interpretations. I will alternate with short narratives situated “at the window,” with an analysis of interview content and experiences, and “beyond the window,” engaging fields and issues outside of my apartment. The weaving together of interview materials, moments shared with my interlocutors in their everyday lives, excerpts from interviews gynecologists, and discursive examples of gender, race, sexuality, and class categories to produce a metanarrative about how ethical subjects can be understood beyond the gynecological setting.
Barbara

At the window with ultrasound reports

Barbara was the first key interlocutor that I interviewed. I interviewed her at my place on Monday, September 10, 2012. I first met Barbara in June 2011; I was drawn to her, like many others, by her infectious smile and laugh. Even when she was crying (and she has cried deeply and privately with me), her smile was often like persistant sunshine in the background of a rain shower. Barbara also has an amazing, encyclopedic memory. She can talk for hours about everything from LGBTT history to the minute details of peoples’ lives. She is generally well-liked, by people from sorts of backgrounds; she participates in a huge range of activism and community activities that aim toward justice. She holds a few part-time and odd jobs to make ends meet, including working for a healthcare insurance company, at a bank as a teller, and on social “projetos” (movement and other political projects), in addition to caring for her 107-year-old grandmother. Through Barbara, I stayed connected to many relevant social, educational, and political events in Salvador.
Barbara set the precedent for framing interviews through their location at my apartment window. I had a semi-oval wooden wall-table mounted at the window, where I planned to write field notes with my coffee in the mornings or with wine at night. Here, uninvited visitors often challenged me: just about anything flew in through my window, including a small bird, a huge moth resembling a bat, colorful butterflies, and giant dragonflies, to name only some. Barbara was actually with me the night a large water bug flew into the apartment: after that particular incident came the screen! Besides allowing in these uninvited visitors, it was breathtaking and serene to sit at the window. I recall watching Barbara sitting while thinking about her responses to my questions. It was daytime, so the water was sky-blue and the boats were out. Barbara had already visited me with Raphaell and her (Rapha’s) now ex-girlfriend in late August to christen my unfurnished place with wine, food, gossip, and giggles. Interviewing Barbara at my place felt safe and easy for me; at that point, I was not anticipating that most of my key interlocutors would choose to be interviewed at the window (to be exact, twelve out of twenty-four).

On the day of the interview, I truly appreciated observing Barbara’s exhaling deeply while staring out the window, her smiling and pondering before her answers, her giggling with me, and even her becoming frustrated during some topics. The emotions and reactions triggered while reflecting upon my questions about sexuality, race and racism, being a lésbica negra, or even a woman, was much to contend with for over an hour for both of us. I can still remember Barbara sitting across me looking out of the window while she gathered her thoughts. While it was important to me to ask my interlocutors questions about their clinical experiences, I asked questions about how they defined sexuality, sexual health, race, gender, and similar concepts prior to discussing gynecology. I my ethnography here, with Barbara, not just because
she was my first interview with a very specific story about gynecology and sexuality, but because she had surprised me with her ultrasound reports. When she pulled out her reports of pre-surgery ultrasounds for her hysterectomy performed in 2011, just a year ago, I was deeply moved. As a Physician Assistant, I was trained to consider these documents as private. I felt as though she was showing me her medical records. When she invited me to make a copy for my research and began to explain how they fit into her story, I knew then Barbara was very committed to wanting to be recognized as patient, a lesbian, and someone who had undergone a hysterectomy. In Barbara’s case, her virginity played a huge role in this desire for recognition as a legitimate homosexual subject. Barbara offered an amazing story, which I began to discuss in chapter one. Here I want to window this story in more depth, detailing how her ethical project involves sexual health and social well-being.

As I mentioned in chapter 3, Barbara’s issues of virginity are noteworthy only for interpreting the ways in which she yearns and pursues to be recognized as a homosexual subject deserving appropriate “acolhimento” (welcoming) by the gynecologist. During the film project, on camera, Barbara stated, “Não e uma mulher realizada porque não tem penetração” (You are not a realized woman because you have not have penetration). Barbara was speaking about her virginity status. She acknowledged that there are heterosexual women who are virgins in need of similar special gynecological exam attention. However, Barbara is interested in her virginity identity to be associated with her homosexuality. In other words, while she might be considered “not a fully realized woman as a virgin” she also believes that she is at double risk for experiencing preconceito once she discloses her homosexuality. Here, it is useful to point to Jessica Gregg (2003) when she argues that “women’s sexual
health is considered dangerous and tossed within a ‘risk and blame’ discourses by the medical establishments” (41).

Barbara managed to protect her sexuality and mode of being as a lesbian in relation to her need for medical intervention for her growing and symptomatic uterine fibroids (which led to the hysterectomy in 2011). The ultrasound reports were part of this tangled narrative. During the interview, I learned that Barbara was a virgin. By virgin, she meant that she had never been vaginally penetrated by anything. Barbara sought to preserve her virginity by seeking a gynecologist who would not penetrate her for a vaginal exam or transvaginal ultrasound, which is typically done in Brazil as a routine test and as a pre-surgery test. Barbara spent more than eight years trying to find a gynecologist who would affirm her lesbian sexuality and virginity. In other words, Barbara not only wanted to be respected as a lesbian, but also accepted as a “virgin” despite having sex with other women. She too often had negative experiences with female gynecologists who did not accept her notion of virginity, stating that she could not be, as she was having sex with women:

BA: I prefer to do all of my self-care activities through [spiritual] baths, or via a [spiritual] cleansing. But I was going [refused to go] to the gynecologist, especially [gynecologist] women. I had several problems with female gynecologists. They [female gynecologists] do not listen, they are rude [grossas], they do not show concern [for my issues].

NF: You would tell them you are a lesbian?

[She nodded her head yes and kept speaking]
BA: The [medical] treatment received [called for] a lot of [vaginal] penetration, it was very conservative, and it violated me.

NF: I want to understand more what it was that you did not like. What did they talk about? What did they want to do?

32 I know it is done as a routine test whether you are symptomatic or not because many of my interlocutors said that a transvaginal ultrasound is done at least once a year. I escorted Raphaella to her transvaginal exam. One the way to the exam, she said to me, “vamps para que me estrupen!” (let’s go so they can rape me) she said with a cynical smile. In Salvador, there is a high production of performing transvaginal ultrasounds as a preventive measure of pathologies. Likely because of the high incidence of uterine fibroids even among women below age 30.
BA: Besides talking about how they wanted to examine me, as they would do ... One time it was just ridiculous. Then what happens: they act like, "ah, that nonsense." [pause in thinking] It was normal even to be a virgin.

NF: To use a speculum, are you talking about that?

BA: It was normal [easier/acceptable] during my twenties, twenty-one, twenty-two to be a virgin. It was a moment of [ ], everyone had to relate." How is it that I am still virgin, no man has had sex with? [She is referring to the biased attitudes of some gynecologists] Maybe you like a woman because you never slept with a man." So it was embarrassing for me.

NF: Because it was like being a virgin though you are not really a virgin. Is it because you are with women?

BA: It is.

NF: I understood.

BA: For them, [it is hard] to be understand [me] as a woman that is still a virgin.

NF: But did they still want to do the exam with the speculum?
[She nodded her head yes as she stared out of the window into the Bay water.]

BA: Women can be very [mean]... Had one that gave me the ugliest facial expression. What did I do? Girl, [told her] goodbye! I have always had lot of autonomy, in public or in private healthcare. I have always been very [self-caring] And then I found myself not wanting to go to ginecologista...

NF: Você falava que era lésbica?

BA: O tratamento era muito de penetração, era muito de conservadorismo e isso me violentava.

NF: Queria entender o que era que você não gostava. O que elas falavam? O que elas queriam fazer?

BA: Além de falar como elas queriam fazer o exame, como elas faziam... Uma vez chegou a ficar doído. Ai depois, o que é que acontece: “ah, que absurdo...”. De recriminar, porque era normal inclusive ser virgem.

NF: Para usar [spec] Você está falando sobre isso?
BA: Era normal na fase de vinte, vinte e um, vinte e dois ser virgem. Era um momento de [], todo mundo tinha que se relacionar. “Como você ser virgem ainda, não transou com homem? Talvez você goste de mulher porque você nunca transou com um homem.”. Então isso era vergonhoso pra mim.

NF: Porque era como ser virgem, mas não era virgem. É que você estava com mulheres.

BA: É.

NF: Compreendi.

BA: Para elas, compreendiam que estar com mulher, era ser virgem ainda.

NF: Mas elas queriam fazer o exame com o [spec]?

BA: As mulheres são muito... Teve uma que chegou a fazer cara feia para atender. Eu fiz: moça, tchau. Eu sempre tive muita autonomia, no público ou no privado, eu sempre fui muito... E ai eu me recolhi a não ir a ginecologista.

Barbara’s virginity shaped her unwillingness to be penetrated by a speculum. She understood being penetrated as an act of social violence that would negate her virginity as a lesbian, and negated her efforts to manage her own sexuality. For eight years, Barbara tried to find a gynecologist who would not completely disregard her need to be respected as a lesbian who is a virgin. Her virginity was a driving force in her mode of negotiation with her clinicians. Much of the disregard by gynecologists for Barbara’s unique orientation to her body and sense of being exposed the preconceitos toward lesbian sexuality held by many physicians in SUS, and even in private practice. Barbara’s interview recounted the shame (vergonha) and rage she felt when gynecologists would not believe that she had not had sex with men, despite her indicating that she was a lesbian and virgin.

As Barbara showed me her report of an ultrasound of the pelvis, which was ordered by a male surgeon, she proudly explained that Dr. Carlos had said “sim, eu atendo mulheres lésbicas e virgens” (yes, I attend lesbian women and virgins).” For Barbara, this response was enough to initiate a dialogue that respected her mode of
existence and was the ground for her request to not be penetrated by a transvaginal ultrasound. Her request was successful, and she was ultimately sent for a pelvis ultrasound to evaluate the miomas and her pelvic structures. An abdominal hysterectomy was performed in early August 2011. Barbara reported having suffered with fatigue, heavy bleeding that felt like hemorrhage, and distorted abdomen that made her feel very uncomfortable to the extent that she stopped dating and having sex. Despite her illness, she worked and maintained a good health insurance plan that would allow her to eventually secure the medical services of an affirming and accommodating gynecologist such as Dr. Carlos.

In *Performing Virginity and Testing Chastity in the Middle Ages* (2000), Kathleen Coyne Kelly “challenges the belief that virginity can be reliably and unambiguously defined and verified” (ix). Kelly’s work is useful here to consider the complexity of how women such as Barbara (and Rosy mentioned in Chapter 1 as well as Elaine whom I only interviewed and met once) regard their virginity relevant in particular ways within their gynecological consultation. In Brazil, female virginity generally represents many complex issues entangled as religiously conservatism or intentional chastity for social and economic gains (Gregg 2003). Some gynecologists whom I interviewed in Salvador attempt to be considerate and attentive to a virgin patient’s sexual and bodily needs by neither using a vaginal speculum nor even performing PAP smear exams. However, I recognize through the anguish of these women’s recount of their experiences, choices, and self-understandings that a social (less medical) mistranslation about the body politics negotiated during the medical encounter by some lesbian virgins. In other words, these women’s bodily understandings toward themselves and others are what I consider a nonnormative sexual and social freedom that emerges for recognition in the medical setting. For
example, the avoidance of “traumatic” penetrative medical instrumentation might be one goal to achieve. These women want to be recognized as active sexual bodies with unpressed sexuality that might be expressed not just through their sexual lives but also through their pursuit for human rights that legitimated them as viable citizens worthy of respect. These subjective negotiations challenge the normative purview of assuming that virginity can be “verifiable and definable” for an appropriate medical approach.

This anthropological research provokes questions such as: What is lesbian virginity? Can virginity be queered even when subjects do not identity with queer? How does the concept of virginity function, particularly in my research? “Virginity either is or is not, its meaning fully present in its status as a fact. If chastity is the articulation of social and sexual coherence, virginity is the physical location, the place of utterance, from which that articulation begins” (Schwartz 2002:13) However, Schwarz acknowledges the instability of such a patriarchal normative conceptual platform about sexual norms and virtues, even when female purity is most operative for its subjects. She quotes scholars Kelly & Leslie in Menacing Virgins (1999) and states that “the very instability of the designation virgin goes well beyond the social interrogation or technical verification of the virginal body to touch upon the grounds for the cultural construction of sex and gender. For example, the hymen being the ultimate site of technical verification is itself both elusive and disputed” (13). These scholarly perspectives on virginity help to grasp its conceptual social roots. My research findings tug at these perspectives in a different direction – as a socially functional identity and politics.

In Pure Resistance: Queer Virginity in Early Modern English Drama, Theodora Jankowski (2000) reminds us that “if you were not the expected type of
virgin: chaste, obedient, and silent... If a virgin (with unbroken hymen, untouched body) did not fit the social conceptions of its temporary premarital condition necessary for ensuring a woman, a future as wife and mother, and if rendered diabolic and associated with witchcraft, you were a monster. Worse, you were queer” (2000:4). While the dissertation does not take up queerness or queer subjects, it seems to me that queering virginity might be a return to strangeness, peculiar, and oddity. When female patients who self-identify to their gynecologists as both lesbians and virgins command a more humane medical approach, I argue that the possibility of virginity becomes more legible (precisely because it remains unreliably and ambiguously definable and verifiable) through the ethical domain that emerges their value systems as new subjects of the medical gaze. In other words, the ethical mode of racialized sexual subjectivation is an activation of the beliefs and values about human and social equity.

For Barbara and Rosy, being a “virgen” or virgin included sex, herein broadly construed. In other words, they described their virginity as representing social and sexual lifestyles not of celibacy or any intentional abstinence for religious purposes or to wait for marriage, normatively speaking. As time passed and shared moments, events, politics, and family matters, I recognized that the sexual politics entangled within their self-identifications as virgins forged sexual agency and sexual freedom aiming to conquer a multitude of sexual, erotic, and forms of bodily pleasure and experiences. Contextually, claims of virginity as a lesbian in Brazil are significant apertures. The “strangeness” was palpable as they relived memories of their encounters with gynecologists. Being a virgin for Barbara and Rosy, in their early 40’s, to me, suggests a ethical-political form of queer ontology that fuses their sexual politics and body politics (sexual and bodily not being synonymous) in the setting of
negotiating their sexual subjectivities, their *negritude* (blackness) in particular, invoking ethical politics – an ethical domain to legitimate their values systems about social well-being as a Brazilian human right. I question: What social status and social sanctioning yields from these bodily politics and social claims?

This project explores the navigation of embodied lesbian/gay/queer sexual practices and identity for some patients during the gynecological consultation that undoubtedly de-stabilizes the gender and sexual normativity of this medical discipline. I grapple with social complexity as partial connections and micro-macro scaling of ethical strivings. These analytical approaches enable me to situate the complexity of virginity within the encounter already designed to monster it. In part, social and financial access enables queerness. Such sexual and bodily politics that emerge ethical pursuits for such women provoke for me an interrogation of the racial and sexual implications of negotiating the gynecological encounter and the destabilization of what constitutes as sex. In other words, I argue that by deeply penetrating, via negations of bodily penetration, the heteronormative historical symbolisms of reproduction that, for example, the utility of the vaginal speculum represents for the public and in gynecology, anthropologically, we can re-imagine the queer-ness of [lesbian] virginity as practice, identity, and racial survival vis-à-vis negotiations of social well-being as a human right. Ultimately, I want to critically look at the complex ways of reinterpreting female subjectivity and the vaginal speculum as historical material that, through unconventional notions of queer-ness, subvert the discursiveness of such patient-gynecologist interactions, in Salvador-Bahia.

Ethnographically, Barbara’s issues of virginity are noteworthy for interpreting the ways in which she yearns and pursues to be recognized as a homosexual subject deserving appropriate “acolhimento” (welcoming) by the gynecologist. As I have
mentioned, Barbara stated, “You are not a realized woman because you have not have penetration.” Barbara was speaking about her virginity status. She acknowledged that there are heterosexual women who are virgins in need of similar special gynecological exam attention. However, Barbara yearns for her virginity identity to be associated with her homosexuality feminina. For Barbara and all my interlocutors, the frontier of preconceito (prejudice) once she discloses her homosexuality must become negotiable. I was very interested in how Barbara protected her sexuality and mode of being as a lesbian in relation to her need for medical intervention for her growing and symptomatic uterine fibroids (which led to the hysterectomy in 2011). During our first interview, I learned that Barbara was a virgin. By virgin, she meant that she had never been vaginally penetrated by anything. Barbara sought to preserve her virginity by seeking a gynecologist who would not penetrate her for a vaginal exam or transvaginal ultrasound, which is typically done in Brazil as a routine test. Barbara spent more than eight years trying to find a gynecologist who would affirm her lesbian sexuality and virginity. In other words, Barbara not only wanted to be respected as a lesbian, but also accepted as a “virgin” despite having sex with other women. She too often had negative experiences with female gynecologists who did not accept her notion of virginity, stating that she could not be, as she was having sex with women.

Barbara’s embodied notion of a lesbian virginity guarded her refusal to be penetrated by a speculum. She understood being penetrated was an act of social violence that would negate her virginity as a lesbian, and disrupt her balance in advocating for her sexuality. For eight years, Barbara tried to find a gynecologist who would not completely disregard her need to be respected as a lesbian who is a virgin. Her virginity was a driving force in negotiating with and discarding clinicians.
Barbara recounted the shame (*vergonha*) and rage she felt when gynecologists would not believe that she had not had sex with men, despite her indicating that she was a lesbian and virgin. As Barbara showed me her report of an ultrasound of the pelvis, she proudly explained that her new doctor had said “*sim, eu atendo mulheres lésbicas e virgens* (yes, I attend lesbian women and virgins).” For Barbara, this response was enough to signal respect toward her mode of existence, even through the strangeness across the encounter, and was the ground for her request to not be penetrated by a transvaginal ultrasound.

Here, I discuss again how Gregg (2003) has been central for me in thinking through subject formation in Brazil, particularly how it links female sexuality, medical institutions and practices, public and local discourses, and sociocultural norms and processes to produce particular forms of women’s agency. Gregg’s ethnographic work reveals how women use strategies that draw upon the “dominant cultural constructions” of sexuality and gender to establish relationships to their own sexuality. My work takes inspiration from how Gregg’s ethnographically rich analysis of female sexual subjectivity establishes critical links between women’s lives, public discourses, and the medical setting. Through reflecting on Gregg’s methodology and her analytical scaling between micro and macro issues, I developed critical ways to demonstrate how racialized sexual subjects reinterpret the “dominant cultural constructions” of female heterosexuality that overshadow female homosexuality in the gynecological setting and beyond. Like Gregg, I aim to tease out women’s understandings of female homosexuality through their medical and social narratives, seeking to understand how their “sense of agency” shapes their pursuit of social well-being as black women.
Again, I return to Richard Parker’s lead in understanding gynecology as offering a complex window into Brazil’s “sexual universe,” offering us the opportunity to understand how homosexuality is permitted or prohibited within specific social hierarchies and imaginaries. In other words, by taken a closer look at the interactions and exchanges between lésbicas negras and gynecologists, my research follows Don Kulick in studying how “gender is grounded not so much in sex as it is grounded in sexuality; and such grounding allows and even encourages the elaboration of cultural spaces” (1997:575). In this vein, I demonstrate that much of the dissatisfaction my lésbicas negras interlocutors reported is due to the highly porous nature of professional boundaries within clinical settings, with broader heteronormative structures impinging upon medical practices in ways that stigmatize their sexuality, likely more pronounced as black women. Therefore, thinking through lesbian virginity in its queerest form or process, if at all possible, points me to the “cultural meanings” (Parker 1991; Kulick 1997; Gregg 2003) attached to homosexuality by many Brazilian citizens are reinforced by micro and macro scale ethical strivings in pursuit of human rights. Via Barbara, I began to learn a lot more about the political, ethical, and social implications of vivendo minha homosexualidade (living my homosexuality). Following David Valentine (2007, 2004), I approached homosexuality as an “analytic category” in order to assess its “partial connections” (Strathern 2004) to other social categories and processes. However, my undertaking grounds gender in sexuality to the extent that I point to gynecology as an entrenched space and practice of desexualization, of removing the person from their body parts and sexuality until the consultation ends (Kapsalis 1997; Henslin and Biggs 1971). These palpable crevices in gynecology are the loci of negotiation for the ethical subjects described in my broader research.
Donna Haraway’s essay, *The Virtual Speculum in the New World Order* (1990), is very useful, as I have already mentions, when she asks: “what is the right speculum for the job of opening up observation into the orifices of the technoscientific body politic to address these kinds of questions about knowledge projects” (193)? My inquiry is about “considering that a speculum does not have to to be a literal physical tool for prying open tight orifices; it can be any instruments for rendering a part accessible to observation” (Haraway 1990:195). I am critically thinking of how unscaling of the body through female desexualization in the gynecological consultation open more questions about ways to interpret micro-scaling within the gynecological setting. Sex is informed by (and informs) the normative purview of the practice of gynecology that historically specializes in defining women, female health, and sexual practices. What happens when sex defies gynecology? How and when does such defiance take place? Even if gynecology is a performance of silence and shame for [all] women (Kapsalis 1997), my research explores what constitutes the silence, the unspoken, the variations and vibrations of what words cannot really say but mean to say about the multiplicity of sex, sexuality, and gender on the exam tables in gynecology. Anthropologically, I am interested in people who unsettle the gynecological settings and speak into the non-normativity of gender and sexuality. What happens when medically and socially fused heteronormative practices in gynecology are disrupted? When sexual politics function via language to designate sexual acts and body parts as normative and to validate gynecology, how might socio-cultural anthropological research turn the tables to validate those targeted bodies that invoke sudden awkwardness within gynecological consultations?
Beyond the window: Barbara’s Lesbian Sister

During one of our many moments spent drinking coffee while sitting at the window in my apartment, Barbara used the expression “viver a sexualidade” (to live your sexuality) to refer to how she must live as a lesbian, or rather, experience her sexuality. She used this expression when referring to her desires for a partner, though she denied dating or seeing anyone during the period my fieldwork. *Viver a sexualidade* was more than experiencing romance and companionship with another woman for Barbara: to be able to “live your sexuality” was also mode of experience that travelled into the gynecological setting. In fact, “living your sexuality” was a mode of existence that permeated all of her life, including the gynecological clinical encounter, particularly given her painful memories of symptomatic uterine fibroids. For Barbara, it was about well-being.

Barbara’s family life is a realm of experience that shapes her ideas of well-being and, in turn, ways of caring for her sexual health. For Barbara, while the notion of sexual health is closely associated with STDs, she also associates it with the idea of
“living her sexuality” as the well-being and self-care that makes sexual health as a broader scope of social health even possible such as romantic relationship. Barbara was fortunate to have a family that accepted her homosexuality during her teenage years. She came out to her family at 16 years old. She is the oldest daughter, with a sister and brother less than five or six years younger. Her mother was not so accepting initially, but her father and maternal grandmother (Sra. Hilda) were more embracing from the beginning. Unfortunately, her father was murdered during a robbery of his place of employment 20 years ago. Barbara still mourns him. Since his death, Barbara’s mom moved herself and the kids in with her mother and been caring for her since husband’s death. Barbara and her siblings grew quite close to “vohniha” (the grandmother). Donna Hilda was the rock of the family. She always respected Barbara and her sister’s homosexuality, and acted as the catalyst for helping everyone move on after Barbara’s father’s death.

Barbara is the only woman in this study with a gay sibling. I met Djanir (aka Luci) during Donna Hilda’s 107th birthday celebration in March 2012. Barbara did not talk much about Luci being a gay woman until a couple of months after our initial interview; I was intrigued by the news. Luci is a couple of years younger than Barbara, though she came out as a lesbian later than Barbara. My first interview of Luci was alongside her girlfriend, Cristina. I construed their eagerness to speak with me as a special courtesy, given on account participation in her grandmother’s birthday. To my surprise, Luci was very disgruntled about her experiences with the gynecological services in Salvador (both SUS and private). Her girlfriend, Cristina, wanted to be part of the interview, to speak to the importance of gynecologists developing better ways of approaching lesbians during a consultation and examination. I briefly mentioned Luci’s narrative in chapter 2 in relation to negotiating access to and social
interaction with gynecologists. Luci’s life was very different than Barbara’s. She worked full-time as a supervisor for a call center. Luci described her work as full of “sapatonas” (butch women), who chose the job because they could be “hidden” from the public while working. She was also trying to finish college, attending part-time. She was not as engaged in activism as Barbara. They led two different lifestyles. Luci also frequented terreiros, though she did not feel called to become initiated. In the past, she dated two Mãe Santos, and was with one of them for over 5 years; a lesbian openly dating a Mãe Santo is not common in Salvador.

During our interview, Luci associated her sexuality with sexual organs and sexual relations. She also associated it with desire and imagination of others, sexually, through conversation and fantasy. When I asked if sexual health could affect how sexuality was described, she and Cristiane both responded simultaneously, “vai” (it will). With respect to race, Luci also described the conditions of being black as “ser negro e ser discriminado como homosexual, e ser uma classe mais baixa” (to be black is to be discriminated like a homosexual, to be a lower class). When we began discussing her experiences with the gynecologist, Luci became just as charged as when discussing being a black woman.

L: Yeah I do not like, [shaking her head] do not like gynecologists. I go because I have to go, I could even go more often, but I will not because I do not feel right, because of the embarrassment, of it [exam] hurting me. I think the doctors are not prepared when it comes to homosexuals, they are not prepared. Yet I just go to the doctor because it is necessary ...

L: It is a difficult process for me. To talk with them is not so much an issue because I accept myself and when I get there, one of the first things that I say is: "I'm gay" to avoid some questions, but still seem that gynecologists do not listen, do not realize. I do not know if it's part [sexuality] and they have to ask their questions ... But well, if I have already said I'm gay, there are some questions that I think no longer apply to me, but they are still made [asked]. So for the initial conversation I stay calm, show myself, now I'm scared of the time of examination, the moment of touch because there is no delicacy. I do not know. There are no different treatment, there is a bias [prejudice] to say "I'm gay " and so the way they deal with women in general there is no
difference, not a different treatment [approach]. Sometimes the material [of the speculum] used hurts me. No, actually, it always hurt me. I always have vaginal pain when I get out of seeing a gynecologist, always when I go to the gynecologist, much like the fear that people have to go to the dentist, "Oh, no the dentist!" For me is: "Oh, no not the gynecologist!" I only go because there's no [other] way! Sometimes I ask Cristina to go with me because I get nervous, I get very nervous.

L: Sim. Não gosto, não gosto de ginecologista. Eu vou porque eu tenho que ir, poderia até ir mais vezes, mas eu não vou porque não me sinto bem pelo constrangimento, por me machucar. Eu acho que os médicos não estão preparados quanto se trata de homossexuais, eles não estão preparados e aí eu só vou mesmo porque é necessário...

L: Aí pra mim é um processo difícil. A conversa nem tanto porque eu me aceito e quando chego é uma das primeiras coisas que eu falo: “Sou homossexual”. Já para evitar algumas perguntas, mas mesmo assim os ginecologistas parecem que não ouvem, não percebem, não sei se faz parte e eles têm que fazer as perguntas... Mas assim, se eu já disse que sou homossexual tem algumas perguntas que eu acho que não cabem mais, mas mesmo assim são feitas. Então no papo inicial eu sou tranquila, me mostro, agora tenho muito medo do momento do exame, do momento do toque porque não há uma delicadeza. Não sei, há um preconceito de dizer “Sou homossexual” e por isso o trato que eles têm com as mulheres em geral não há uma diferença, não um trato diferente. Às vezes o material utilizado me machuca. Às vezes não, sempre me machuca. Eu sempre falo, quando saio do ginecologista sempre saio com dores, sempre quando vou ao ginecologista, o medo que as pessoas têm de ir ao dentista: “Ah, dentista não”. Comigo é: “Ah, ginecologista não!”. Eu só vou porque não tem jeito! Às vezes eu peço a ela pra ir comigo porque eu fico nervosa, fico muito nervosa.

When I learned the extent of Luci’s anguish during the vaginal speculum exam and the lack of recognition for her homosexuality, I began to rethink the importance that my ethical subjects were placing upon the conversation with their gynecologists. As Cristina pointed out to me during the interview, a gynecologist can chose a smaller and different speculum (if available) or mode of performing a PAP smear exam for women such as Luci. At times, gynecologists can chose different options to ease the discomfort of a vaginal exam, if necessary. As Luci mentioned, she intentionally self-identifies upfront as a homosexual to the gynecologist to avoid “unnecessary questions.” It seems that the juncture of Luci’s identifying as a
homosexual and the gynecologist’s unwillingness to associate Luci’s negative relationship towards exam with her homosexuality is where the themitical, as human right, becomes engaged by Luci as an ethical subject. (At times, though, Luci reports being too timid to speak up – especially with male gynecologists – and to this date, she had not returned for a repeat PAP).33 Luci’s narrative stands as a good example of the complexity of interaction between lesbians who self-identify and their gynecologists – especially when they need more than routine care. Luci underwent a hysterectomy a couple of years ago for a complicated cyst. She said that the cyst was filled with water and could have become “dangerous,” so her uterus was removed. She is certain that her ovaries were not removed but uncertain about her cervix. If her cervix was removed, she would not need to get exposed to a PAP smear as routinely recommended. Furthermore, Luci and Cristiane both reported that Luci’s anguish about going to the gynecologist affects their relationship. Cristiane reported having to calm her down for days prior to the appointments and for days afterwards.

Beyond the Window: Barbara and Luci on Film

I interviewed Barbara and Luci together for the film project in July 2013. They were mourning the death of their grandmother. Given their mourning, I viewed their continued enthusiastic willingness to be part of the film project as part of their pursuit for recognition. Like many siblings, Barbara and Luci disagree on many things and do not share the same social circles. However, their unity and loyalty were fused by the care given to them by their grandmother, and now for the caring needed

33I was unclear why Luci still needs PAPs. I interviewed her for a second time to clarify her hysterectomy. She does know whether her uterus with cervix was removed. Usually, in her case, she would not need a PAP yearly of both uterus and cervix are removed. If she does not have a cervix, it could be the reason her last PAP was non-conclusive. There is a break down in patient-doctor communication as well. A repeat vaginal exam would be unnessary to her given her anguish toward it. This I explained to her.
by their diabetic, mourning mother. Barbara, being the first college graduate in the family, and still living at home, did the bulk of care-giving and provided financial support for her grandmother and mother; Luci and their brother (a police officer, devout Christian, married with two children) did not take up an equal share. My film interview was intended to focus upon the impact of their grandmother upon their sisterhood and identity as lesbians. I filmed them sitting together on the bed where their grandmother used to sleep, and on the chair next to the bed where she would often sit. On film, they said they were blessed as two lesbian sisters who affirmed themselves and each other through their grandmother’s unconditional love, admiration, and acceptance of their homosexuality. Sra. Hilda was remembered as a “strong black woman.”

Part of that strength came from spiritual realms that sustained Sra. Hilda’s humanity: Catholicism and Candomblé. Sra. Hilda maintained an altar with over 100 figurines of Santa Barbara behind a curtain in her bedroom. Barbara, named after the saint by her grandmother, said that Sra. Hilda strongly believed that Santa Barbara came from Africa and represented the Yoruba deity, Iansa. Seven days after Sra. Hilda’s death, we attended a memorial service at her Catholic church of Santa Barbara. I had never stepped into a Catholic church with Santa Barbara at its center of worship and mass. Santa Barbara and the deity Iansã share the same color (red) and day of worship (Wednesdays). Almost everyone at the mass wore something red. Barbara, her mom, and Cristiane were there. Luci had lamented to me the day before that she could not attend because of her day job. They did not expect her brother to come, since he was a more orthodox Christian. Still, it was a beautiful experience. After the passing of Sra. Hilda, I could see with greater clarity how her faith in a better life influenced Barbara and Luci’s strivings toward self-affirmation. Sra. Hilda
loved being in the community; she cooked *caruru* every year during the Candomblé holidays. At her funeral, there were members of four different faiths in attendance: a Protestant pastor, a Catholic priest, Espiritistas, and a *Mãe Santo* of Candomblé. Such religious diversity did not go unnoticed by Barbara and Luci, who observed that “it takes a special person to be mourned by such an ecumenical circle.” Indeed, such personal resilience and abundance transmitted through Barbara’s daily smile and self-empowerment.

The shape of Barbara’s ethical subjectivity became more apparent during our filming. Since the start of fieldwork, I had suspected that Barbara was particularly driven by her lived experiences and the conditions of her life, fueling her pursuit of freedom as an openly gay woman. Barbara exuded a strong sense of lesbian pride. Yet, she was different than many other activists I had met. It was apparent that her college education was somewhat of a limitation, which did not open more doors for better work for her, as it did for many of those around her with Masters or doctoral degrees. Still, she remained a significant catalyst for many people’s political and social agendas in serving the community, especially the LGBTT community. Through Barbara, I was exposed to Bahia’s first venture of *Maio da Diversidade* (discussed in chapter 1). Barbara and I walked in marches, attended planning meetings for socio-political events, educational forums on gender violence, and often just sat at the beach or sat for coffee at the window or beyond the window.

I want to highlight two further scenes from the film: (1) an interview with a dear friend, Nildes, and (2) Barbara’s love for the water and the deity Yemanja. The interview with Nildes was profound. It was held at her apartment in *Barrio de Tororo*. Nildes was a dark-skinned, open lesbian who lived with her girlfriend. On occasions, I spent time with Nildes during her teaching of Capoeira or at social events such as
Xire das Pretas where she often dramatized socio-political issues. Nildes, after being initiated into Candomblé, had spent a year wearing all white. Like many other black women, and black lesbians in particular, Nildes was striving for a better life. She was accepted into a UNEB Master’s program located in the “interior” of Bahia, outside of Salvador. She would travel every week to the interior to study and then return to the city to be with her partner and family. Nildes was considered a guerrera (warrior) or militante (militant) by some activists and community organizers. She overcame many social obstacles and remained faithful to some black movements. Based upon Barbara’s friendship with her, I was not surprised that Barbara selected Nildes as the “friend” to create a conversation about her life on the film.

A great deal transpired during the 35-minute conversation. The purpose of this filmed conversation was to discuss Barbara’s grappling with waiting to see a gynecologist; we created a scenario where Nildes listens and advises her friend on those remembered issues. As it turned out, Nildes had not had much opportunity to talk to Barbara about those past experiences. While it was evident that Nildes knew of the tormenting fibroids, it emerged on film that she was not privy to the extent of Barbara’s connection between the endurance of her fibroids and her commitment to not go to just any gynecologist for evaluation. Their connection on film, through consideration of Barbara’s past issues and present laments, raised another common issue of the limited ways in which women, in general, share their disgruntlement with their gynecological experiences.

At times, some people may not be able to empathize with such layered decision-making processes such as in Barbara’s case. Barbara reminds us that it is not easy, even when there is a compelling reason for a visit, to choose a gynecologist as a lesbian in Salvador. However, such complexities often remain hidden by expectations
of privacy (on the topic of sex, identity, sexual body parts, etc). Therefore, when women such as Barbara are willing to speak on film about these matters or journey through seeking an ethical domain for recognition, it is important to contemplate the place of the social within such medical interactions, to illuminate such complexities. In making this claim, I am reminded of Foucault’s assertion that “Freedom is the ontological condition of ethics. But ethics is the considered form that freedom takes when it is informed by reflection. I am not saying that ethics is synonymous with the care of the self, but that, in antiquity, ethics as the conscious practice of freedom has revolved around this fundamental imperative: ‘Take care of yourself’” (Rabinow 1997: 284-285).

**Beyond the window: Gynecology in the streets**

On Friday, March 8, 2013, International Women’s Day (IWD) was recognized with a walk/parade, or *marcha*, Campo Grande’s plaza – a meeting ground where most parades, protests and marches kicked off in Salvador. Campo Grande plaza is also where I jogged; it’s a 12 minute-walk from *Dois de Julho*. The route followed the usual trail on *Avenida Sete* toward the Laderia de Jesus toward Pelourhino. Since most of my interlocutors were working at mid-day, I went alone. However, Isabel joined me toward the end of the *marcha*. When I arrived, I saw Marta and her daughter’s partner, Alex (formerly Sandra). I was happy to see Alex again. We walked and talked about my project; and he shared his transition into Alex and some of the challenges he experienced with people accepting the new name. Alex reported having never been to a gynecologist for fear of being penetrated by a speculum. At 26, Alex had not had a reason to see a gynecologist except recently for groin/pelvic pain. Alex said that an abdominal ultrasound recently showed an ovarian cyst, and that he
would now have to see a gynecologist. About a month later, by the window in my apartment, I interviewed Alex about his transitions and opinions on going to the gynecologist.

I was expecting a lot more women and men to participate in the IWD walk. Given that in Salvador there is a significant amount of social movements focused on women’s issues (domestic violence, trafficking, education, health, etc), I anticipated the participating numbers to be greater than the approximately two thousand who did attend, particularly compared to other marchas. I was, however, stricken by “who” was there. Indeed, there was a group representing LGBTT issues with a rainbow Pride banner led by the infamous activist and professor Luis Mott. To my surprise, I did not see any of the “regular” lesbian activists who are usually in the forefront of the broader lesbian movement (not to be confused with the lésbica negra movement, which does not quite exist yet!). More strikingly, I noticed that there were more working class women, particularly women of color (black and brown). There was a more age-diverse selection of women. It was a marcha of the inner city people. For the first time, I was at a public marcha substantiated by mostly working class and poor women of different generations. It was evident by their clothing and quality of banners and materials. There was nothing “fancy” about how they represented their issues and community programs on domestic violence, and education, for example. Then I realized that in this marcha, Salvador women were representing their struggle directly, rather than having it represented by middle-class movement professionals.

During the march, I chatted with a small group of physicians representing Salvador’s SUS maternity hospital strike. Brazil, and Bahia in particular, maintains its historic system with specialized hospitals for maternity and gynecological issues. They had been on strike for over 40 days as of this day in March 2013. Some of the
end goals of this maternity hospital strike were to improve wages, vacation time, and other benefits for SUS physicians in maternity hospitals. As all the groups gathered to kick off the *marcha*, I noticed a few people with t-shirts that read *Medicos em Greve* (Doctors on Strike) standing away from their own group. As expected, they would be considered white and very *parda* Brazilians. I approached them to inquire about the strike. I knew that many maternity hospitals also provided gynecological outpatient or surgery care, such as IPERBA, a popular Sistema Unico da Saúde maternity and gynecological hospital where I conducted a few interviews.

Among the three physicians were two obstetricians and a gynecologist. One of the obstetricians (female) reported working in Salvador for over twenty-six years. The gynecologist said that he was there to support his obstetrician colleagues. As usual, they wanted to know about my research. Once I began to explain my research topic, they became very intrigued and did not hesitate to comment on the topic and ask questions. This was ideal impromptu research-related conversation with random physicians, albeit at an unexpected place and time for a deep discussion! The unstructured setting and timing generated a “fluid” discussion. For example, the gynecologist (male and seemingly young) became eager to report that he had been working in Salvador for twelve years and had only witnessed four of his patients
come out as lesbians or as WSW (women who have sex with women). He claimed that he has suspected that many of his other patients were WSW, but that they never self-identified as such. Though that was quite telling to me given what many other doctors said to me, he further said that “I don’t understand gay people, they come out in public as activists or for public spaces but will not tell their doctors.” He was quite wound up in sharing his perspective. When I asked him if he had any strategies for helping his patients know they have an option to reveal their sexual orientation if they felt it necessary, however, he went on to say, that “no, it is the patients’ responsibility for telling me.” Neither could he remember what his interaction was like with the four who revealed their homosexuality.

I stood there in awe but engaged. I observed the gynecologist present his opinion about interactions between lesbian patients and gynecologists in a, frankly, very accusatory and defensive manner. When questioned directly, however, he agreed that gynecologists have a role in being more attentive to issues of sexuality. On balance, though, our conversation reminded me of the responsibility that gynecologists place upon their patients to reveal their homosexuality and practices. My encounter became even more complex; while the gynecologist was speaking, the female obstetrician among us fidgeted, listening to us. She remained engaged, injecting her commentaries and questions. Then, she said that though she does not practice gynecology, she was very curious about what it meant to be homosexual. She asked me several questions, such as, “How does someone become homosexual? What is the relevance of race for gynecologists?” This physician’s posture during her questions showed much curiosity, and certainly did not seem as though she was
concerned about my comfort level – not knowing I am a lesbian. I could not help but think that I was on display as an “expert” on how these issues work and matter.\textsuperscript{34}

I walked away with conflicting feelings, but definitely charged and ready to begin my arranged interviews with gynecologists about issues of women’s sexuality, homosexuality in particular. After all, these physicians at the march believed that they represented women’s health and reproductive rights. At this time, I began to ask myself about the human rights discourse located at the intersections of gynecology, lesbians, and women as ethical subjects.

\textit{Beyond the window: Santo Antonio Festival and a Gynecologist’s Son}

For the Santo Antonio (Saint Anthony) festival week, from June 1-13\textsuperscript{th} 2013, many people in Salvador practiced a 13-day prayer ritual to the Saint. It, in turn, led to the prelude celebrations for the upcoming festive Sao Joao (Saint John) holidays of the June 23-24 weekend. The centro of Salvador, especially Pelorihno, was quite festive, with elaborate decorations in the streets. Specially-prepared liquors and desserts permeated the city stores, homes, and streets. Many people would stop into Dois de Julho to buy these desserts and liquors. One of the most popular traditions is to cook peanuts in a pressure cooker with salt. I thank Erica and Telma for my fond memories of \textit{amendoins} (peanuts).

The most common ritual for Santo Antonio was to place a mini bread roll or mini croissant inside of a bag of rice for a year. These rituals promised abundance of food, to not go hungry, or to always have the means to care for yourself and family, according to Barbara. Barbara and I met for coffee at Bola Verde Bakery in Dois de Julho the evening of the Santo Antonio festival. We walked from Dois de Julho to

\textsuperscript{34} Though these physicians gave me their names, they will remain unanonomous.
Santo Antonio square, located in a barrio just above Pelourinho, which took us about 30 minutes. The streets were crowded. When we arrived, there were numerous food and alcohol vendors. The Santo Antonio Catholic Church had a mass service, which ended soon after we arrived. There were hundreds of people in front of the church listening to the service. Then suddenly, many people ran toward the side of the church, where something was being handed out. Barbara charged in that direction. As usual, she was thoughtful: she got me two of the mini bags with the mini rolls to put into a bag of rice. I asked her roll was, and she had told me that she already had one at home.

Then, we searched among the vendors for the best caipirinhas. With our caipirinhas, we sat at a table. I hoped that Erica and Telma would have joined us by now, but it turned out that they were too tired to come out. This was understandable, given that Erica attended college evening classes almost every weeknight. I did run into Ivana amidst the huge crowd, but we only exchanged a few words. Barbara and I decided to share a table with a random man drinking a few beers. It was the only table even partially available. The man (with light or white skin color, in his late 30’s to early 40’s in age) was quite friendly. We shared a few laughs about the public event. He inquired into what I was doing in Salvador. When I told him about my research in gynecology, he replied that his mom worked as a gynecologist and works for her. Barbara and I raised eyebrows and chuckled, especially after he said that his mom’s practice is located in Dois de Julho. Barbara got up to chat with someone she spotted nearby – being, as she was, such a popular person. I continued to chat with the gynecologist’s son. He was very curious about my research findings. He asked, “why does it matter that a lesbian comes out to the gynecologist?” He went on to answer his own question: “I don’t think it matters.”

35 I interviewed Ivana who Jandira’s friend, initiate of Candomble, a police officer and lésbica negra
It was another “gynecology” public moment as an anthropologist. Amidst the secular music, lots of alcohol, and sitting opposite a large and open Catholic church, I was once again being probed and probing through causal conversation about whether lesbian sexuality should matter or not to the gynecologist. I asked him whether any of his mother’s patients were openly gay women. While he replied that he believed there have been a few, he did not know of his mother’s strategies and relationship with them. As a manager of her practice, he also couldn’t tell me if those women were content or disgruntled about how they had been treated. He reported that his mother was in her 70’s, and would soon retire. Nonetheless, his questioning of whether coming out “matters” points to an issue central issue to both lésbicas negras and (some) gynecologists.

_Beyond the window: Gynecologists’ interviews._

The question “does it matter?”, of homosexuality’s visibility in the clinic, raises questions about issues of recognition and negotiation. It also pushes up against the social issues that are entangled within normative medical practices (Mol 2002). Even today, gynecology’s traditional heterosexist practices continue, often denying outright the possibility of some lesbian patients being openly gay (Kapsalis 1997). The denial manifests through the heteronormative assumption that gynecological patients are engaged in heterosexual practices (Kapsalis 1997). As part of my interviews with gynecologists, I wanted to assess the impact of heterosexism in gynecology (however impossible this task seemed). Joan W. Scott’s essay, “The Evidence of Experience” is useful here. She states,

They take as self-evident the identities of those whose experience is being documented as thus naturalize their difference. They locate resistance outside its discursive construction and reify agency as an inherent attribute of individuals, thus decontextualizing it. When experience is taken as the origin
of knowledge, the vision of the individual subject (the person who had the experience or the historian who recounts it) becomes the bedrock of evidence on which explanation is built. Questions about the constructed nature of experience, about how subjects are constituted as different in the first place, about how one’s vision is structured about language (or discourse) and history are left aside. The evidence of experience then becomes evidence for the fact of difference, rather than a way of exploring how difference is established, how it operates, how and in what ways it constitutes subjects who see and act in the world (1991:777).

Scott’s passage reminds me that gynecologists (or their agents) too often do not approach gender (or sexuality) as a social construction. As I consider gynecologists’ point of view, I keep in mind Scott’s argument about the use of experience as the ground of knowledge, rather than as an opportunity for exploring difference. In my interviews, I aimed to discover whether physicians thought that sexuality, and homosexuality in particular, mattered in their practice; what their strategies for accommodate any needs of lesbian patients were; their opinions on preconceito; and much more. While all of my medical interviewees were consistent in acknowledging that sexuality and the practice of gynecology are tied, and that preconceito exists in the Brazilian gynecological setting, I here will focus on two gynecologists: Dr. Manuel and Dra. Sandra.

I met Dr. Manuel at the SOGIBA (Associação De Obstetrícia E Ginecologia Da Bahia) conference. He has practiced for almost thirty years in Salvador. He graduated from Universidade Federal da Bahia (UFBA) in 1984. I solicited an interview from Dr. Manuel because he presented at SOBICA on surgical and medical implications of fibroids among women. He reported that fibroids primarily affect black women in Brazil, particularly in Salvador. His presentation was intriguing since he reported that many women believe that fibroids are “growing monsters or cancer or babies waiting to be delivered.” When I approached him, his willingness to be interviewed was a pleasant surprise. On the day of the interview, I discovered that he
was also trained in sexology. I interviewed him at this private practice. He squeezed my appointment in between his busy patient care schedule. Luckily, many patients did not turn up for their appointments, because of the rain. I learned that he also worked at IPERBA, a popular Sistema Unico da Saúde (SUS) maternity and gynecological hospital. My interview with Dr. Manuel convinced me that many gynecologists (and other specialists) commonly worked both in private and public (SUS) practice. In fact, only two of the gynecologists that I interviewed did not work for SUS and only worked in private sector. These two physicians reported getting out because of the inhumane treatment of and conditions for both patients and physicians. Ultimately, this realization led me to spend some time in CEDAP (SUS clinic for STDs and HIV/AIDS), which I discuss in chapter 5.

As part of my windowing process, I rely heavily upon Dr. Manuel’s interview, as he helps frame many of the themes in question in this dissertation. Here, I will refer to Dr. Manuel’s interview to provide examples of his perceptions of the implications of the sexuality and sexual health in gynecology. One of my first questions dealt with his interaction with openly gay women. First, when I questioned Dr. Manuel about any possible consequences to lesbian patients experiencing preconceito against their homosexuality, he stated,

If you [the gynecologist] behave heteronormative, then you will exclude the patient. The patient [might] omit information many times, you know, she may not come back. Then if she has no [medical] problems or her problem is resolved, sometimes the doctor, even unconsciously attends to a [gay] patient faster than another, neglecting the exam, you know. It creates challenges, or the doctor might even say something that will affect [the patient] psychologically, you know, and be harmful to the person [patient], which is something we call iatrogenesis. You know the term iatrogenic?

Se heteroniza né, vc pode afastar a paciente, a paciente lhe omite uma informação muitas vezes, né, ela não volta então ela não tem problema, o problema dela é resolvido, as vezes o médico, até de forma ela pode atender aquela paciente mais rápido do que outra, negligenciar no exame, né, criar uma
Iatrogenia means “of or relating to illness caused by medical examination or treatment.” Though I could barely remember the definition at the moment, I asked Dr. Manuel to explain further. He stated,

You might say something [to the patient], then what you say can be therapeutic or may be iatrogenic, right, to the patient. Then again, we learn about these consequences in our medical training and in medical psychology.

Dr. Manuel was the only physician to link any mishandling of patients, including of their sexuality, to the actual practice of medicine. I believe that many physicians are oblivious to such a medical correlation, with many simply telling me that they are “not trained to deal with issues of sexuality.” Dr. Manuel’s correlation raises the question of the difference between physicians seeing themselves as trained as sexologists, trained to think through their approaches to avoid any form of alienation or foster quality relational conditions during the consultation, as opposed to simply gynecologists. Nevertheless, I was intrigued by his insight and composed concern for creating an environment that invites women to be who they are – in other words, to be recognized as lesbians. Earlier in the interview, I questioned him about his strategies to facilitate women being comfortable with self-identifying as gay. He stated,

So, what I realize is that more recently, the number of women who report having [sexual] relations with women is increasing and they are coming forward more naturally, so ... Including the posture of the gynecologist toward it. How do I learn about it [sexual orientation] when I’m doing the AMNESE [history-taking questionnaire]. I would ask, ‘did you already have sexual intercourse?” ‘how old were you when you first had sex? How was your first sexual relation? How many partners have you had?’ ‘Now do you have a steady partner, your partner...?’ I
used to always question as though it was obvious [assumed] that their relationship was with a man. But it can not be like this anymore..

So, nowadays I ask: are you sexually active? Then, the person responds: “I do.” ...I’ll ask: ‘how is your relationship now?’ or, ‘What kind of relationship do you have?’ I ask a more open question. There are many patients who will then say, ‘I have a relationship with a woman.’ Yesterday I attended to a young, very young girl who told me about her [sexual orientation] in a very natural way. So, what I realize is that this information is becoming more accessible and the ease to disclose this information is improving. Before, people spoke in constrained ways, or did not speak at all [about their homosexual orientation]. At times, only after several consultations would they come forward with this information, you know. Or would say they had not had [homosexual] relations when in fact they had.

Então, o que eu percebo é que mais recentemente, o número de mulheres que informam que tem relações com mulheres vem aumentando e colocando isso com mais naturalidade, então... Inclusive a própria postura do ginecologista em relação a isso. Como é que eu aprendi, quando estou fazendo a AMNESE, perguntar, ‘vc já teve relação sexual?’ , ‘com que idade vc teve relação sexual?’ , ‘a primeira relação sexual’, ‘quantos parceiros vc já teve?’ , ‘atualmente vc tem parceiro fixo, o seu parceiro...?’; então, sempre perguntando como se fosse óbvio que a relação fosse com homem. Só que não pode mais ser assim. Então hoje em dia eu pergunto assim, ‘vc tem atividade sexual?’ a pessoa diz, ‘tenho’, ‘como é seu relacionamento atualmente?’

Ou então, ‘ que tipo de relação vc tem?’, faço uma pergunta mais aberta. Aí muitas falam, ‘eu tenho relação com mulher’. ontem mesmo eu atendi uma moça jovem, bem jovem, que me colocou de uma forma bem natural. Então, o que eu percebo é que essa informação tá sendo mais frequente e a naturalidade com que essa informação vem sendo dada tá sendo melhor também. Antes as pessoas falavam de uma forma constrangida, ou não falavam, ou depois de algumas consultas é que vinham dar essa informação, entendeu. Ou diziam que não tinham relação, quando na verdade tinham.

This strategy shows an awareness of how material instances of discourse, the use and order of language in the clinic, can allow women to reveal their sexuality while seemingly maintaining the integrity of heteronormativity. In other words, by asking patients their types of sexual relations, then, heterosexual, bisexual, and homosexual patients can interpret that such an ample question includes and applies to them. A question implying far less heteronormative intent might be, frankly, “do you have sexual relations with men, women, or both?” I do not argue that one or the other is the
more appropriate, since either question does not guarantee that lesbian patients will not experience *preconceito*. Rather, I point to the different ways in which ethical subjects recognize an ethical domain for striving towards their telos of well-being as a human right. What sort of questions and interactions most readily invoke ethical subjects into their modes of subjectivations?

Dr. Manuel spoke about alternative gynecological strategies for women who only have sex with women or are virgins. Given Barbara’s narrative about her virginity (shared by her sister and others), I paid closer attention to him, particularly since he made the association through a discussion of his own experiences, without my elicitation of his approaches to virgins. In response to my questioning how he might know whether his awareness of their sexuality and sexual practices would facilitate that the women take better care of their health, he stated,

Some women who have never had [sexual] relations with other men and have had a relationship with man or woman, have with men and women, is that right? So these women who never had a relationship with man, what happens is that some of them have an intact hymen, then some gynecological examinations will not able to be done, then [like] the vaginal ultrasound examination of vaginal examination, the collection of material of the cervix, but in practice those women who have never had vaginal intercourse, they are at minimal risk for cervical cancer. Even the Ministry of Health does not recommend the need for cervical PAP smear for these women. There are women who have only had relationships with women, but use [wear] prosthesis type artificial penis via vagina and have intact hymen, so to these patients I explain the exam and then ask if they would let me do the vaginal exam [via insertion]. So that makes a difference. Now, the rest of the medial service is the same [as others], asking about menstrual disorders, colic pain, and by having relations with a woman, you may contract some sexually transmitted infections, such as genital herpes, hpv on vulva, vaginosis, candidiasis, that sort of thing, regardless of the type of sexualrelationship. So the biggest difference [issue] in practice in relation to the research question of cancer of the cervix would be about those women who have never had a relationship with man. But if they have an intact hymen, I use a q-tip probe and either way I can do the cervical exam.

*A parte ginecológica. Tem algumas mulheres que nunca tiveram relação com homem e outras já tiveram relação com homem ou com mulher, tem com homens e mulheres, não é isso? Então, essas mulheres que nunca tiveram relação com homem, o que é que acontece, algumas delas tem o hímen*
íntegro, então alguns exames ginecológicos não vão poder ser feitos, então a ultrassom via vaginal, exame de toque vaginal, coleta de material do cólo do útero, mas na prática aquelas mulheres que nunca tiveram relação vaginal, a questão do câncer do cólo do útero a chance é muito pequena. O próprio Ministério da Saúde não recomenda a necessidade de colheita do papa nicolau do cólo do útero dessas mulheres. Então, tem mulheres que só tiveram relação com mulheres, mas que tem utilização de prótese tipo pênis artificial via vaginal que tem hímen íntegro, então essas pacientes eu explico e pergunto se elas permitem que faça o exame do canal vaginal também. Então, essa é uma diferença. Agora, no resto, o atendimento é igual, os distúrbios menstruais, se tem cólica e na relação com mulher vc pode ter algumas infecções de transmissão sexual, tipo herpes genital, hpv em vulva, vaginose, candidiase esse tipo de coisa independente do tipo de relação. Então, a maior diferença na prática seria naquelas mulheres que nunca tiveram relação com homem em relação a pesquisa na questão de câncer de cólo de útero. Mas, se elas tem hímen íntegro eu colho, de qualquer forma eu faço a avaliação do cólo do útero.

Here is another example of how Dr. Manuel engages lesbians who may experience penetration and might benefit, according to Dr. Manuel, from a vaginal speculum exam. There is a contradiction, however. If women having sex with women (WSW) who have never had sex with men would not need a PAP smear according to national health regulations, then why ask this of WSW penetrated with an artificial penis? This contradiction suggests the social and discursive complexities shaping how gynecologists are think through their approaches to WSW. If a patient, such as Mirela, does not report that her mother had uterine cancer, does that mean that she (if she was a virgin patient) would not need a speculum exam? On the other hand, does the medical anxiety about prevention by gynecologists justify their too-often-rushed performing of vaginal speculum exams on all women for the sake of prevention (or the collection of medical data collecting, or because of a pharmaceutical push)?

Such issues are aspects of the modes of negotiation and recognition for ethical subjects. Some doctors, such as Dr. Manuel, have nuanced techniques for inviting their patients to feel “vontade” (welcomed) to be who they are and help guide their examination. The labor that these strategies require offers an opportunity to
acknowledge the entanglement of social and medical domains. If gynecologists supposedly do not “learn” how to promote their environment as an ethical domain, how could it be done, if not by gynecologist being more conscientious about their preconceito or the social relations implicated in their practices? Here is another example from Dr. Manuel’s ways of managing the issue of sexuality:

That is why ... well, if the person does not disclose this information (sexuality), it [consultation] becomes tense, 'you ask how is their relationship', 'I do not have sexual relations with anyone,' she will say, or she might say, I have a relationship with man (too) and it is normal. Is normal how? I'm trying to fathom. When the person speaks, of course she feels more comfortable, even that may work, lessening the burden of not needing to be hide a secret, you know, keeping a secret, the strategy to not reveal. Because, for you to not reveal any information, you might have a strategy, you know, trying to disguise it there. My impression is that it improves. And I realize that people come forth [disclose] with more ease, right, more comfortably. And I have some patients who have children, have a lifetime relationship with man and from a certain point began to relate to women.

...Por que assim, se a pessoa não revela essa informação (sexuality), não é, fica sempre aquela, aquela coisa meio tensa, 'vc pergunta como é sua relação', 'não tenho relação sexual com ninguém', ela vai dizer, ou ela vai, vai dizer que tem relação com homem também, é normal, é normal como? eu vou tentando sondar. Quando a pessoa fala, claro que ela se sente mais a vontade, até aquilo ali funciona, aquela coisa de tirar um peso assim, ela não precisa ficar escondendo um segredo, né, ficar guardando um segredo, uma estratégia não revelar. Porque pra você não revelar uma informação você tem que ter uma estratégia, né, tentar disfarçar aquilo ali. A minha impressão é que melhora. E cada vez mais eu percebo que as pessoas colocam isso de forma mais tranquila, né, mais a vontade. e eu tenho algumas pacientes que tem filhos, tiveram a vida toda relação com homem e a partir de determinado momento passaram a se relacionar com mulher.”

Perhaps Dr. Manuel is willing to do this “tense” work because of his training in sexology. Perhaps all gynecologists in Brazil should be trained in sexology! Nevertheless, there exists a means by which to recognize women as same-sex loving women and negotiate their demands. Dr. Manuel’s perspectives offer a framing of what ethical subjects might, or not, contend with in negotiating their demands to be recognized. In forging such recognitions, a process of negotiation must subsequently
take place. *Lésbicas negras* who chose to only rely upon private healthcare know that gynecology reinforces gender and sexual norms, which they usually resist in striving for social well-being. In Barbara’s case, her physical well-being depends upon establishing a particular social well-being, upon a recognition that she strives to establish in her every-day life. Therefore, access to both healthcare/medical treatment and the human right to be affirmed as a WSW or “lesbian” virgin ought to be part of the “*acolhimento*” (welcoming) process within the gynecological system.

Whether sexuality matters can be an issue of medical interpretation, which implicates knowledge about the actual sexual relations of women; sexual relations involve social relations, however, and *lésbicas negras*, as ethical subjects, here engage the themitical (as human rights). When Dr. Manuel stated,

> Gynecological disease often leads to a change in sexuality, of course, you know, a person who has a fibroid and bleeding for 15 days per month, and has severe pain, hurts when she has sex and then, she begins to avoid having sexual relations...

> Muitas vezes a doença ginecológica leva a uma alteração na sexualidade, claro né, uma pessoa que tem um mioma, que tá sangrando 15 dias por mês, que tem dor forte, dói quando ela vai ter relação sexual, ela começa a evitar e não ter relação sexual...

Such a situation speaks to the experiences of Barbara, Luci, Jandira, and many other women (not just *lésbicas negras*). How do *lésbicas negras*, in particular, know that it is in their best interest to pursue such a form of the themitical? Why does well-being inform their pursuits? My interview with Dra. Sandra points us in that direction. Dra. Sandra chose to remain anonymous because she disclosed information about her lesbian daughter. Dra. Sandra’s position on these issues is particularly noteworthy, given her motherly commitments to her lesbian daughter’s affirmation. Dra. Sandra graduated from UFBA and has been practicing in Salvador for 26 years. I interviewed
Dra. Sandra about a week after Dr. Manuel’s, whose perspectives helped me strategize how to elicit more specific information in my interviews with gynecologists.

Dra. Sandra situated herself as not having the background, as a gynecologist, to “lidar com questões da sexualidade” (to lead with issues on sexuality), being instead mostly trained to deal with “physical” issues. When I questioned her about her views on the relationship between sexuality and gynecology, she stated,

Yes, the vast majority of women have this demand, to talk about sexuality. When they go to the gynecologist, they believe that they will be able to lead [come forth], speaking also of sexual issues. Often they are a bit disappointment [mislead], why, many gynecologists have not. We do not have many tools on how to talk about sex and to address many [sexual] issues.

Sim, as mulheres, tem essa, elas, a grande maioria das mulheres tem essa demanda, de falar da sexualidade, quando elas vão ao ginecologista elas vão acreditando que vão lidar, falar, também das questões sexuais, é, muitas vezes se decepção um pouco, porque, muitos ginecologistas não tem, não temos muito, é, ferramentas pra falar no assunto e pra abordar muitas questões sexuais.

She acknowledges that many women, regardless of their sexuality, pose questions to their gynecologists that elicit some form of advice about dealing with a lack of sexual desire. Sexual dysfunction seems to be a pervasive “problem” that gynecologists face, that they however often feel inadequate to manage, or to which they perhaps have difficulty relating. In general, issues of sexual dysfunction lead to other issues that need to be addressed. She separated “issues of desire” from sexual dysfunction, which can be a medical issue such as in the case of low libido caused by fibroids or hormonal imbalance as mentioned by Dr. Manuel. I do not argue for the validity of these biological determinants, but present them as common examples of the sexual issues managed between patients and doctors in this context. If women in Brazil, in general, perceive the gynecologist as the go-to professional for solving limitations with their sexual desires, are lesbians included within such medico-normative
demands? The answer is yes, albeit infrequently, according to a sexologist I spoke with at IPERBA.

Dra. Sandra’s connection of sexual health to well-being, without my prompting, stands out. When I asked Dra. Sandra early to define sexual health early in our interview, she stated that

Sexual health is health. I mean, it is linked to the question of well-being, eh, [a] well-being with their sexuality and their physical [body] too and with the physical sexual part. [If] You're good and feel good with their sexuality and physically, you know, well, and the genitals are also healthy, then so I believe that is right way to be [sexual health].

Saúde sexual é a saúde, assim, ligada a essa questão do bem estar, né, do bem estar com a sua sexualidade e com seu físico também, né, com a parte física sexual, você tá bem, se sentir bem, com a sua sexualidade e fisicamente, né, assim, os órgãos genitais também estarem saudáveis, isso, eu acredito, que seja por aí.

Dra. Sandra made an immediate connection to well-being. Her work on partos humanizado gives her insight into the significance of well-being from an obstetrical perspective. However, she was the only physician other than Dra. Rodriguez (from chapter 1) to discuss the preconceito against lesbians without my elicitation. She adamantly claimed that many gynecologists are not trained to lead on issues of sexuality. However, she made important arguments that patients’ comfortability with their sexuality is a salient establishing factor for sexual health and well-being, even when sexual disfunction is not present. In my interpretation, if the gynecologist’s office is a place to discuss sexual desires and dysfunctions, this points to particular liberties for women to discuss their sexual practices, albeit in a heteronormative register. This perspective frames a key argument for me. I argue that lésbicas negras’ pursuit of well-being in the gynecological office is also the pursuit of a particular
mode freedom; as Jandira told me, "sexualidade e uma libertade" (sexuality is a form of freedom).

On the other hand, Dra. Sandra’s strong opinions about preconceito are shaped by her concerns for her lesbian daughter. More specifically, Dra. Sandra was candid in sharing that her daughter’s homosexuality helped her to recognize her own preconceito as it emerged in her practice. Though she was neither the first and nor the last physician interviewed to acknowledge that many colleagues in gynecology have "preconceito," she captured her views about preconceito particularly forcefully:

Dra. S: So, yeah, my daughter said to me that the shock on the face made by the gynecologist when she disclosed her [sexual orientation]… her face was in shock, then she changed her face and looked so scared. So, my point of view is that to attend to lesbian women is part of the job, and even the gynecologist [should] deal with their own bias [preconceito]. They should deal with their worldview even to try to understand. I think it's something you have to be very careful. We can say that we have no prejudice, but it can just come out [show it] somehow.

NF - I know, and yet still comes out.

Dra. S: And - Oh, it [preconceito] shows for sure, I know colleagues who clearly have [preconceito] prejudice, that do not know how to handle it, do not know how to examine a woman [lesbian]. They are too embarrassed to wonder about how to examine a woman [lesbian], you know. I think many gynecologists, many of us, are not really prepared for it. Why, do we not learn? These things can not be learned in college, you know, is a matter of how to face the world even, you know, whether or not you are prejudice, to deal with your bias, work through or not your bias, it is a thing of a person, not only training, you know. I think you as a doctor, as a professional, you have a duty to deal with these things in a free and natural way, you have a duty. It is an official obligation, [right now you intrinsic?] to learn how to work toward wanting to deal and improve [yourself] as a human being. It is not a thing training, is a thing of the human being, then I think I, all these years, I had to work on it and question my prejudices. I had so many friends, so many gay and lesbian friends, I really thought I had no prejudice and then I saw that they [preconceito] often appear within me, understand? Even in the form of asking, in ways of speaking, understanding, and then I spent a lot of time even working on it inside of me, when my daughter came to me ...

Dra. S: Então, é, ela disse que o choque, a cara que a ginecologista fez quando ela falou, foi assim, uma a cara de choque, porque, mudou a cara e ficou assim, sabe, assustada e assim, eu vejo que atender mulheres lésbicas, é um, é um trabalho mesmo pra o ginecologista, de lidar com o seu próprio preconceito,
lidar com a sua visão de mundo mesmo, entendeu, eu acho que é uma coisa que você tem que tá muito atento mesmo, é assim, porque, a gente pode dizer que não tem preconceito, mas ele acaba saído de alguma forma, ele aparece

NF - Sei, e ainda até agora saí

Dra. S - Ah, saí, com certeza, eu conheço colegas, que tem assim, claramente o preconceito, que inclusive não sabe como lidar, não sabe como examinar, ficam assim constrangidos de como que vai examinar uma mulher, entendeu, aí, eu acho que é, o ginecologista, muitos, muitos de nós não estamos realmente preparados, pra, por que a gente não aprende? é, essas coisas não se aprende na faculdade, né, é uma questão de forma de encarar o mundo mesmo, né, ter ou não preconceito, de lidar com o seu preconceito, de trabalhar ou não seu preconceito, isso é uma coisa de pessoa, não é de formação só, né, eu acho que você como médico, como profissional, você tem o dever de lidar com essas coisa de uma forma isenta e natural, você tem o dever, isso é uma obrigação de ofício, né, agora você intrínseca, você aprender trabalhar, você querer realmente lidar e trabalhar e se melhorar como ser humano, não é uma coisa da formação, é uma coisa do ser humano, então, eu acho que eu nesses anos todos, eu tive que trabalhar mesmo, as minhas questões os meus preconceitos, porque eu dizia que eu tinha tantas amigas, tantos amigos gays e lésbicas, que eu achava que eu realmente eu não tinha preconceito e aí depois eu vi que não, que muitas vezes aparecia, e eu fui ao longo desse tempo, trabalhando mesmo isso dentro de mim, aí, quando minha filha veio me falar…

Dra. Sandra’s opinions raise questions about what it means to self-reflexively grapple with your preconceitos, both as a human and a professional. After encountering such views from Dra. Sandra and other professionals, I began to consider the impact of the gynecological setting, medically and professionally, upon women’s vulnerable subjectivities and relations to the self and to body parts, in particular (Martin 1987; Karpalis 1997). The challenge is to point out how the gynecological setting is designed to elicit sexual and gendered subjectivities. The way this works might seem obvious, but in practice it is complicated and messy. Dra. Sandra spoke of women being vulnerable in accessing affirmation and necessary advice about their sexual issues. For her, preconceito not only shapes the attitudes of gynecologists, but can also derail many women from experiencing humane treatment during interactions wherein they are exposed and vulnerable. She told me that she treats WSW patients
with vaginal and peri-anal Human Papilloma Virus (HPV) lesions who pose questions about how to protect their female partners. The point here, for me at least, is not whether gynecologists should be trained to provide medically adequate responses to such questions. They should be, and generally are. Rather, the issues I have been raising complicate the extent to which treatment that might be “medically adequate” for other types of subjects provokes for lésbicas negras ethical striving for recognition and human rights within such norms and systems within gynecology.

Dra. Sandra’s stated that recognition and respect is a “coisa de ser humano” (a thing of being human). It reminds me that the provocation of qualifying humanity in this project can be bidirectional during a medical encounter. Ultimately, what is consistent across the interviews that I conducted with medical professionals is that when a woman self-identifies as a WSW or lesbian, she is perceived as enacting a revealing, or “revelando” her sexuality. Such was the case for the disgruntled gynecology in Campo Grande, with his opinion that women don’t reveal their sexuality unless they are in the streets doing activism; we can also see it in Dr. Manuel’s report that women don’t reveal their sexuality in SUS clinics nearly as often as they do in private practice. In Epistemology of the Closet (1990), Eve Kosofsky Sedgwick claimed that “‘Closetedness’ itself is a performance initiated as such by the speech act of a silence - not a particular silence, but a silence that accrues particularity by fits and starts, in relation to the discourse that surrounds and differentially constitutes it” (3). Here, Sedgwick provokes thought about the possible ways in which closetedness can be read as speech acts of silence in relation to discourses. Specifically, thought of two possibilities: (1) of discourses that take place among gynecologists when not in the presence of patients about issues of homosexuality as negligent preconceito against gay women; as acts of silence that constitute gay
women’s closetedness from their point of view, and (2) of discourses beyond the
gynecologists’ office which such physicians might have access to if they so chose,
discourses that thrived at the IWD marcha and circulate widely in other political and
social venues.

My work draws attention to the invisible links between various social
discourses that inform the ways in which some ethical subjects pursue recognition by
their gynecologists. I claim that such invisible links participate in “assembling the
social” (Latour 2005), bringing together the various elements of medical interactions
to produce a coherent experience. The “laws” governing these interactions do not
“cover, nor encompass, nor gather, nor explain; they circulate, they format, they
standardize, they coordinate, they have to be explained” 2005:246). In *Reassembling
the Social*, Bruno Latour claims that “no face-to-face interaction is isotopic,
sychronic, synoptic, or homogenous.” In other words, face-to-face interactions: (1)
are influenced by discourses and processes originating in other places, (2) are not
always conducted with the “same ingredients with same age or time/space
configurations,” (3) have invisible features, with not all relevant thematics being
clearly present on center-stage, and (4) do not always have the same “material quality
or agency.” Latour’s analysis is particularly relevant to the discussion of medical
interactions, which may follow medical models, but do not produce identical
outcomes and effects. I point to these features of the clinical interaction to highlight
that while the interaction between ethical subjects and gynecologists needs to be
understood as having an impact on individuals, but that ethical striving more
generally is ultimately a collective process. While I have focused on Barbara’s
circumstances here to draw attention to the formation of an ethical subject, she strives,
as do the others discussed elsewhere in this dissertation, toward a common goal, that is, for the human rights of all lésbicas negras.

As an out lesbian, Barbara has spent most of her life engaged in some form of activism, community-building, social movement, or progressive political party. My friend (and key interlocutor) Erica, often reminded me of her knowing Barbara from long ago, when they worked together in the Workers’ Party, Partido de Trabalhadores (PT). Whenever I would bring Barbara and Erica together for coffee or beers, they would reminisce of their work with the PT and other social movements; they would also lament how different and less progressive the PT is today. I was always happy when Barbara and Erica would reconnect through me, because Erica would be buoyed by recounting her past work in the “moviment.” Such social interactions, particularly between these ethical subjects, actively foster social well-being, affirming and sustaining personal desires to be recognized as Brazilian citizens who pursue not just personal goals but collective human rights for women such as them and for the broader black Brazilian population.

What, then, are some of the invisible links between social interactions and discourses that tie together homosexuality, sexual health, and gynecology? I claim that access in gynecology often turns on the social conditions at play within the gynecological interaction. Medical-gynecological interactions are social interactions that are conditioned by and also produce these social conditions, which in turn shape the ethical claims lésbicas negras are capable of making. I argue that Mol’s notion of “enacting disease” (2002) can provide a framework for our understanding the ethical negotiations that occur within the gynecological space. I use Mol to highlight the embodied aspects of well-being: the body is both the vessel of well-being and potentially diseased. The body then, has different relationships towards well-being
that must be negotiated in the clinical encounter. This embodied character of well-being is the key to understanding how women such as Barbara pursue biomedical or physical wellness, even undergoing the adverse experiences typical of gynecological consultation and treatment. Therefore, the possibility of enacting sexuality is an embodied condition of the negotiations of the terms by which they are recognized as ethical subjects in this setting.

GINECO-ETICO

Access and Discourse

The analysis in this section focuses on the material conditions that shape ethical subjects such as lésbicas negras’ claims to human rights in particularly vulnerable spaces. The materialism I pursue turns on the notion of what I call “social accessibility.” As ethical subjects, lésbicas negras define “care” as not just medical diagnosis and treatment, but as an active engagement of their racialized sexual subjectivities and modes of self-care. In this section, I return to how these women employ symbolic language, such as the notion of condições (conditions), to describe the contexts for their ethical acts in the gynecological setting. In this section, I aim to investigate how these women’s actions materially reshape the conditions of this setting, with concrete social, political, and health implications for black gay women in Salvador.

Healthcare is an economically and socially ordered pathway to care of the body and prevention of disease, but also produces structural violence unrecognizable to those within the system, such as physicians and healthcare workers. It is both a literal economy and a social economy of norms, systems, values, personal and professional perspectives, all of which are historically, temporally, and spatially
produced. Within this economy, ethical subjects chart pathways that signal the gynecological setting to sit within boundaries of “individualized caring for the body” and “normative systems to adapt to gendered discipline.” As noted by Dr. Manuel and Dra. Sandra, physicians are biomedically trained, and must construct their practice strategically to ensure both medically successful and reasonably humane outcomes. The activities of lésbicas negras as ethical subjects, however, serve as a reminder of ever-present preconceito: not only contextual preconceito toward their sexuality, but to a historically and socially deep preconceito toward black women.

In 2010, The Brazilian Ministry of Health put out a pamphlet titled “The Time Has Arrived to Care for Your Health: A Special Book for Bisexual Women and Lesbians.” It was produced with intentions to promote a pilot healthcare program in large cities such as Salvador. I obtained a hard copy of the document from a woman who worked for the Secretaria de Saúde in Salvador for over twenty-seven years; she was a white lesbian, active in many social movement circles. According to her, this pamphlet did not arrive to Salvador in large enough numbers for distribution. Confirming her words, no gynecologist I interviewed had received copies of or even seen this pamphlet. If not widely circulating, however, the pamphlet is important as an example of the Ministry of Health’s discourse and practical understandings of sexuality. It asserts that “a free sexual orientation is a fundamental right of all citizens,” referring throughout to homosexuality as a legitimate way of being, with modes of self-relation that can empower and encourage access to the doctor, and to the gynecologist in particular. It argues that the norms and practices of gynecology need to be made adjustable, to accommodate black lesbians in particular: “as lésbicas negras também porque muitas vezes enfrentam uma discriminação muito mais violenta (black lesbians also because they often face a much more violent forms of
discrimination).” Most people I spoke to agreed that *lésbicas negras* experienced particularly virulent discrimination and inequality when contrasted with white lesbians.

*Preconceito* is based in a system of signs, meanings, and normative behaviors (Williams 1977). It also, however, is embedded in the material conditions of social life. It affects black, brown, and white Brazilians through the cross-cutting categories of class, gender, and sexuality. Given the historical importance of *preconceito* within the Brazilian discourse of inequality, as I describe in my earlier discussion of the Brazilian racial laws, I here would like to put forward materialist analysis of *preconceito*, understanding it as (1) linked to the idiomatic understandings of social (in)justice circulating among my interlocutors, and (2) having an impact upon the enabling conditions that shape the emergence of *lésbicas negras* ethical subjects.

Barbara referred to *condições* (conditions) during her interview in several contexts: discussing changes to her reproductive organs (segment #1), her attempts to create situations that would allow for her virginity as a lesbian to be honored by her gynecologist (segment #2), her striving acquiring the means to afford a healthcare plan that would give her access to gynecologists that would employ a particular mode of welcoming (*acolhimento*) of her sexuality (segment #3), and securing the education that she felt essential to financial and social stability (segment #4).

*At the window: segment #1:*

NF: But they left everything [during hystectomy]? Uterus, ovaries ...?
BA: The uterus. The uterus was not in any condition...
NF: But they left the ovaries?
BA: Left. And that's what I'll see how this process is be.

*NF: Mas deixaram tudo? Útero, ovários...?*  
*BA: O útero. O útero não tinha *condições*...*  
*NF: Mas deixaram os ovários?*
BA: Deixou. E é isso que eu vou ver como é que ta esse processo.

At the window: segment #2

NF: I wonder how are the consultations with gynecologists for virgins? Is it common to be a virgin patient?
BA: That was key for me in getting treatment [for fibroids]. It was essential. Otherwise I could not have done this surgery. I’d have worsened my situation. Why did I need to create those conditions? I needed to create concrete conditions.
NF: And you talk about how the doctor understands and accommodates all ...
BA: These specific conditions for the lesbian woman, in my point of view.
NF: How do you think it is for other women? Would you recommend your gynecologist to other lesbians?
BA: I recommended to Rafa, but the big problem is the issue of class because you must have a [healthcare] plan. They do not attend [women like me] in the SUS.

NF: Eu pergunto como são as consultas com ginecologistas? Ou como se é comum ficar virgem...
LN: Isso para mim foi fundamental no tratamento. Foi fundamental. Porque senão eu poderia nem ter feito essa cirurgia, ter piorado a minha situação. Por que eu precisava dessas condições? Eu precisava criar as condições concretas.
NF: E você fala de como o médico entende e acomoda tudo isso...?
LN: Essas condições concretas para a mulher lésbica no meu ponto de vista.
NF: Como você acha que isso para outras mulheres conseguir, mas você pode recomendar o seu ginecologista para outras pessoas...
LN: Eu recomendei para Rafa, mas o grande problema é a questão de classe que envolve. Porque você tem que ter um plano. Eles não atendem no SUS.

At the window: segment #3

BA: Actually, it's the dialogue. It is the possibility to choose. If you do not receive a welcoming treatment, you go out and look elsewhere until you find it. The big problem is that the public policy on health does not give you this range. You do not have to do as I did, I quit [the gynecologist]. I had problems but I was on the much-needed upward horizon to get out of this situation. I took responsibility for my choices. If I had acquired a cancer, I would be the culprit. It was not the state [SUS] that did not give me chance to use those doctors even without that ability to welcome me. Ultimately, it becomes an individual attitude. I took the risk. Besides the risk, I also abandoned my process to have sexual relations with other women during this period. Understand? So, I'll do the revision [surgery] now because I still have problems with the disease [fibroids]. But I preferred take care of this now rather than to make a harmful choice for myself, again. I may resolve my revision surgery. But when I have been silenced [my struggles] and then achieve my financial conditions to acquire my needs, I envisioned it would be
ideal that way than pay a price alone for my decisions. For lack of such assistance - We pay.

NF: Pay with mental, emotional?

BA: All different ways you pay [burdens, sacrifices]. It was an expensive investment including many taxês, to maintain this [healthcare] plan. Because as I am employed and earn a thousand and three-four hundred reais [monthly], and from the moment that I decided I had to decrease the amount of quality food and resources, could not broaden my studies or go back to school or start a Master’s degree because I could not create the necessary conditions. I had to make choices, as I told you yesterday. Today I ’m in a process that I have to make a choice to apply for a job in public sector.. And then lastly I come to a decision to make a way to get my Master’s so I may leave a legacy (financial money).

BA: Na realidade é o diálogo. É você ter a possibilidade de escolha. De que não ta tendo acolhimento e você sair e procurar até encontrar. O grande problema é que a política publica de saúde não lhe dá esse leque. Você não tem que fazer como eu que larguei de fazer, de ter coisa, porque eu tinha como horizonte que eu precisava para eu sair dessa situação. Porque eu passo a ser culpada pela minha escolha. Se eu adquirisse um câncer a culpada foi eu. Não foi o Estado que não me deu possibilidade de ter, que os médicos tivessem uma formação e tivesse esse acolhimento. Passa a ser uma atitude individual. Eu corri risco. Eu além de correr risco, eu deixei, provavelmente, o meu processo de interação sexual com outras mulheres durante esse período. Entendeu. Que isso, provavelmente, eu vou fazer a revisão agora, eu tenho problemas com a doença. Mas eu preferi essa escolha, a fazer essa escolha com esse prejuízo, que eu talvez resolve, ou eu vou querer resolver. Entendeu. Mas quando eu silenciei e que fui ter condições financeira pra adquirir esse acolhimento que eu idealizava e que eu tive, que seria o ideal, eu paguei um preço sozinha. Por falta dessa assistência. A gente paga.

NF: Paga com o mental, emocional?

BA: Todas as ordens você paga. Porque foi um investimento caro. Meu imposto de renda com esse plano. Porque como eu sou assalariada que ganha mil e trezentos, mil e quatrocentos reais e a partir do momento que eu decidi, eu tive que diminuir a quantidade da qualidade da minha alimentação, de ampliar meus estudos, de voltar a estudar, a fazer até um mestrado porque eu não pude adquirir as condições. Eu tive que fazer escolhas, como eu te falei ontem. Hoje eu estou num processo que eu tenho que fazer uma escolha para passar num concurso. E ai por ultimo eu vou para uma decisão de constituir um processo de mestrado para deixar um legado.
Barbara views changing the *condições* of her life as part of an accumulative pursuit of well-being. These conditions shape her life at various levels. *Preconceito*, then, is understood as part of *condições* that are antagonistic to the well-being of *lésbicas negras*. The language of *condições* and *preconceito* has a historical social relationship to particular (medical) subjects’ expectations of human rights. As a language or idiom, it reflects both an interpreted reality and a vision of the future (Williams 1977). It is involved in the ethical practices that these subjects use to “make sense of the world, or to interpret what counts as ‘reality’ through the assumptions it [reality] valorizes and the subjects it [reality] produces” (Hennessy 1993:xiii). Black women, and black lesbians in particular, reinterpret such language by creating, finding, or otherwise surrounding themselves with *condições* that elevate their consciousness of their realities, allowing them to enact their sexuality in the gynecological setting through the modes of subjectivation as framed in chapter 2.

I agree with Mark Graham in asserting that “Ethnography is best suited method to revealing the hidden sides of objects, or of things” (2010). Further, these “things constitute and are constituted in social relationships and are fundamental to their reproduction and change; things are personal and emotional; and things are treated well beyond signs and language through touch, taste, see, hear, and smell of things” (Graham 2010). In this project, there are several interconnected “things” to account for: gendered and sexualized body parts (Fausto-Sterling 2000), disease processes (Mol 2002), gynecological instruments (Martin 1987; Kapsalis 1997), and human needs (particularly in the ways in which Northeast Brazilians conceive of them; see Schepper-Hughes 1992). These interconnections have lead me to consider the “body as an accumulation of strategy” (Harvey 2000). In *Space of Hope*, David Harvey states that “to conceptualize the body (the individual and the self) as porous in
relation to the environment frames ‘self-other’ relations (including the relation to ‘nature’) in a particular way” (99). The question for me, then, becomes: what is the relation to the self that shapes an enactment of sexuality into an ethical striving toward human rights? In one of my field notebooks I wrote that “sexual health encapsulates such meanings regarding sexuality, the social construction, by which sexual freedom is sought after.” Sexual freedom is a condition for ethical subjects to invoke their ethical telos in the gynecological context. It points to the issue of “access,” foregrounding sexual health within both social acts and intimacies. In other words, there is access to pelvic exams and tests and surgeries; and then, there is access to affirmation and recognition: in Barbara’s words, to being received with acolhimento.

*The Ethical: Well-Being as Telos*

I have constructed an ethnographic narrative centered on Barbara to show how the themitical is engaged by modes of recognition and negotiation. Given that the interaction between physician and patient is both medical/consumer transaction and a complex ensemble of ideas, norms, codes, and behavior, the reproduction of such codes, norms and behaviors about lesbian sexuality cannot be taken as superficial processes. Barbara is an ethical subject insofar as she reveals the themitical that lies within a potential domain of self-relating practices: accessing human rights within the patient-physician interaction. As Faubion suggests, however,

“an apparatus that stipulates that the telos of the ethical domain is generally that of the occupation of a given subject position or the becoming of a certain subject surely must include more within the purview of the mode of subjectivation than the subject’s mode of recognizing
himself or herself or being recognized to be the subject of one or another moral obligation” (2011:52).

I aim to interpret *lesicas negras* mode of subjectivation as implicating broader forms of self-making than simply those typical of sexual subjects defined by their sexual orientation during such medical encounters.

On the one hand, we cannot escape the function and ideological structure of gynecology as it participates in the sexual order of society. Those with organs and bodies sexed as female by biomedicine are interpellated as “women,” whether they fit the prototype of Brazilian’s image of femininity or not, and have their bodies assigned to the gynecologist. Some patients and physicians alike agree that there should be the responsibility for lesbian patients to self-identify as such, so that they can be treated accordingly.

In our study of social constructions and the ways in which they manifest through the lived experiences of our subjects, how can we hope to account for complexities and weave partial connections without accounting for the historical and ever-changing knowledge production of our subjects themselves? Is writing anthropology today so diagnostic that in its effort to evoke that which deserves illumination would simultaneously reproduce difference and intersections dangerously othering our subjects? How is this fine line in research negotiated, and what are the assumptions unelaborated in such interactive exchanges?

Here Faubion is helpful, arguing that

“neither methodologically nor ontologically does an anthropology of ethics have its ground in the individual. The population of its interpretive universe is instead one of subjects in or passing through positions in environments. It is thus a population not of atomic units but of complex relata. Its subjects are for
their part already highly complex… Like the typical human being, the ethical subject, even when only an individual human being, is thus already always of intersubjective, social and cultural tissue. Its parts are never entirely its own.

The ethical subject is not an abstraction” (2010: 119).

In other words, Faubion suggests that an anthropology of ethics must focus upon the intersubjective ways that ethical subjects are engaged, situated, and/or transformed by their practices and (this being his revision of Foucault) by the themitical (Faubion, 2001, 2010). I understand this to mean that ethical subjects are not merely produced by their sense of individuality in their becoming human but by both the normative systems (norms) and by that which any named system produces. It is in fact the latter that is of most interest to me: the themitical. In taking on Faubion’s revisions to Foucault’s work in my discussion of ethical subjects and subjectivation, I am able to show how lésbicas negras’ narratives and desire for recognition same-sex loving women demonstrate their occupation of various subject positions. Their movements across these various subject positions in their interactions with others lead to the complex emergence of ethical intersubjectivity, eliciting a sense of ethical responsibility toward a their total environments: their selves; the medical professionals, contexts, and objects with which they interact; their experiences and feelings; their social identifications as as lesbians, black, women, working class, or Candomblé practitioners.

What analytic value is there in focusing on lésbicas negras’ subject formation? Why are they distinct and worthy of attention? I assert that my interlocutors, as self-reflexive beings, bring into the gynecological clinic particular ways of knowing the self and modes of self-caring that are inextricable from their subjectivity as black lesbians. In chapter 5, I go into more depth about their ways of
assuming their racial and sexual identity. Some of my interlocutors, for example, believe that as an “assumida” (out with your sexuality, non-closeted) black lesbian, you ought to pursue higher education and occupy a particular level of employment in order to be respected and recognized. In other words, they feel that in order to avoid being subjected to forms of violence, such as discrimination, dehumanization, and even simply verbal insults, you must be respected and recognized as a black woman who has achieved and elevated herself educationally and professionally. For them, it is the only way to counteract the social inequalities affecting black women, and black lesbians in particular. This project of “becoming human” and seeking a quality life (Tadiar 2012) does not occur only at the level of gynecological interaction. Many lésbicas negras in Salvador are engaged in raising consciousness of race, blackness, and social inequality, seeking to escape processes of dehumanization. They do not want to be treated as disposable humans. As black lesbians seeking to be “assumidas,” how they experience their humanity undergirds their ethical life. I develop this point of view on the meaning of racialized sexuality in chapter 5.
Chapter 5

Minha Energia Vital: Scaling Social and Ethical Complexities

Prelude

In the Fall of 2012 (that is, in Brazil’s Spring of 2012), Salvador’s elections for city Mayor, or Prefeito, had its residents on tenterhooks. Two out of the five leading candidates on the ballot were Nelson Pellegrino of the Partido de Trabalhadores (PT) party and A.C.M. Neto of the DEM, or Democratas, party. The strongest divide among voters was between those who wanted to elect Pellegrino, who represented a liberal progressive leadership despite being tainted with suspicions of political corruption, or A.C.M. Neto, from a conservative party and wealthy family, as well as being the grandson of a past mayor of Salvador, considered by many to have been a racist. The political debates over these candidates proliferated through Salvador in many ways, from spontaneous commentaries by taxi drivers to charged discussions in living rooms. However, I became most interested in another facet of the elections. The two leading mayoral candidates, Pellegrino and A.C.M. Neto, were running with a black woman as their vice prefeito: Olivia Santana for the PT and Celia Sacramento for the DEM. This was widely held to be history in the making, regardless of the outcome of this particular election. Not only had there never been a black – male or female – mayor, governor, or vice mayor elected, but now a black woman was likely to become vice mayor. As far as black community organizers were concerned, it carried a high price.

Evaluating their collective responses let to deeper scrutiny about their personal, professional, and political commitments by many black community leaders and

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36 There was a third less popular party with a woman of color as vice-prefeito candidate as well.
organizers. On September 5, 2012 – just six weeks into my fieldwork – ODARA, a recently launched organization addressing black women’s issues led by a veteran activist black woman in Salvador, Valdecir Nascimento, held a public forum at the city’s large library, Biblioteca da Barris, a common site for similar events. Titled “Mulher Negra: Nosso Tempo e Agora” (Black Woman: Our Time is Now), the forum spoke to not just the moment in which these black female candidates found themselves, but to the visibility that these candidates had given to the issues of all black women in Salvador. It was for the latter that the audience in this public forum showed most concern. In fact, the audience raised concerns that these candidates were only selected to manipulate the voters’ perceptions of the usual slate of white male candidates up for election. Yet, the possibility of having a black woman elected at this level nevertheless symbolized a moment of great pride and triumph for many in the black community.

Many folks there believed that Salvador deserved a black person in the prefeitura given the region’s rich history of black culture, religion, and slavery, as well as the many contemporary social inequities faced by the black community. Some folks in the audience asked personal questions about these candidates’ previous leadership ethics, community commitments, and even personal family issues. A major community leader and panelist was most concerned about what they would do after
election, and posed to the candidates the following questions: How will the elected candidate deal with the fact that Salvador has the highest rate of women’s death in the country, including of maternity deaths? How will they address issues of education, such as the low pay and training afforded to teachers? How will they deal with women’s issues such as mothers losing their children to violence? Ultimately, these candidates were reminded that as black women, they must demonstrate responsibility toward the issues of Salvador and its mostly black and brown population. At the forum, there were also openly gay black women. One of them raised the issue of the lack of political attention given to the recent homocide of two young black lesbians in August 2012 in Camacari, a metropolitan city just outside of Salvador. In Salvador, a black woman with power to effect change is held accountable to the social realities of all black women.

This chapter is a window into the ethical subject formation of openly gay black women in Salvador. Herein, I primarily focus upon Jandira and her immediate community. I explore their narratives and the broader structures contextualizing them in order to illuminate the social meaning of their racialized sexual subjectivities (Hammonds 1997; Caldwell 2007; Allen 2011; Williams 2013) as lésbicas negras. By considering them as ethical subjects, my intent is to foreground their claims to and pursuit of social well-being as a human right, with intimate and far-reaching impacts for their racialized sexual subjectivities. Ethnographically, I frame via Jandira’s narrative within a collective narrative that includes the other ethical subjects in her life. As in chapter 4, I also draw upon interviews with gynecologists and broader ethnographic data about the gynecological context in order to to articulate the lésbicas negras position as active ethical subjects within that context. One analytical goal is to make partial connections (Strathern 2004) between the perceptions of racism and
heterosexism within the gynecological setting and across the patient-physician interaction. These partial connections, or as I will refer to as scaling social complexities, help to “simplify the complexity enough to make it visible” (Strathern 2004) and reflect upon how social complexities intimately impact the ethical subjects herein. By scaling social complexities, I imagine a “hierchical value scale” (Voss and Schmidt 2000) that inter-connect human existence to notions of social and physical well-being, particularly within a “hierarchical system that pervades the treatment of sexuality within a heterosexual value scale (Voss and Schmidt 2000:4; see also Rubin, 1984). Finally, I discuss these lésbicas negras’ Candomblé religiosities in order broaden the window onto the formation of collective ethical subjectivities, particularly through film.

**Social complexities and racialized sexual subjectivity**

The complexity of social systems has been an important object of sociological theory since its inception, from the work of Simmel and Durkheim, through Irving Goffman and Pierre Bourdieu, to Bruno Latour and Niklas Luhmann. Anthropologically speaking, I am interested in how the notion of social complexity coming from this tradition might help us to understand some of the social entanglements and embodiments (Mol 2002) negotiated by lésbicas negras via social interactions through socially complex, materially-mediated encounters (Goffman 1963; Bruno 2005) with the gynecological establishment. In *The Body Multiple: Ontology in Medical Practice*, Annemarie Mol’s argument for “unscaling the body” is helpful here (2002:123). Mol argues that “to enact disease is also to enact norms and standards because the entity afflicted by the disease deviates - from some normality” (123). Mol’s conceptualization of enactment of disease and normality is relevant for
further imaging how and why gynecologists attempt to desexualize their biomedical practices and strategies for dealing with patients (Kapsalis 1997). Mol reminds us how the complexities of “doing medicine” are predicated upon producing knowledge about patients’ bodies from the outside and inside of the socially and biologically constructed female body (Mol 2002). Thus, I am interested in how dominant social and medical objectifications of the female body desexualize the body from subjective self-perceptions (Bordo 1993; Haraway 1999; Fausto-Sterling 2000; Davis 2007) of lésbicas negras. The unscaling of the body through female desexualization, through detaching the person from its sexual body parts until the end of the consultation and exam (Kapsalis 1997; Henslin and Biggs 1971), is of particular concern for lésbicas negras who feel that recognition of their homosexuality is in fact key to their recognition as ethical subjects during these encounters. Like Mol, my primary concern is not with identifying the “norms that signal where deviance begins” (Mol 2002) or how disease is measured, but rather with the social process whereby lésbicas negras become “afflicted” when gynecologists desexualize their female bodies thereby challenging their truths about sexuality and their bodies (Bordo 1993; Huffer 2010) in these settings.

As I have shown above, for lésbicas negras the gynecological interaction is shaped through the dialogic negotiation of more or less fluid, more or less rigid social discourses about health in its relation to race and sexuality. The social complexities shaping this dialogue cut across categories of identity such as race, gender, and sexuality that “require us to understand them simultaneously as discrete categories even as we recognize the interpenetration of experiences expressed through them” (Valentine 2004:215). That is to say, sexuality and health were not considered separate social and bodily conditions or experiences by most lésbicas negras. In fact,
the ways in which they associate their sexuality with health, both gynecological and otherwise, were self-consciously and frequently outlined in our conversations. These conversations helped me understand the urgency felt by these women to reveal and engage their same-sex sexuality with their gynecologists, especially given the risks of preconceito discussed in earlier chapters. Further, these women’s strong associations between human rights and wellness emerge from very racially coded interpretations of their own experiences, in a context both of compelling historical and structural reasons for racial identifications and of urgent claims by these women for social well-being as a human right. These subjective interpretations, which I refer to as racialized sexual subjectivities, strongly link their social-political, or “public” experiences with the gynecological context. They believe that the medical system and the strategies that gynecologists deploy to assess their reproductive and sexual health were more than heteronormative and sexist. They believe that a gynecological clinical visit that does not respect their same-sex sexuality from the start of the medical conversation counterfactually and disingenuously renders their same-sex desiring being irrelevant to the examination and clinical outcomes. Many of my lésbica negras interlocutors feel this social neglect keenly, as an insult upon their sexual subjectivity and a threat to their racial subjectivity. One key reason for this is that they perceive themselves and their experiences as part of a larger structural vulnerability to health disparities felt by black women more generally (Caldwell 2007; Wenerck), evidenced by disproportionate incidences and outcomes of such diseases as breast cancer (the

37 It is common to speak of “my” doctor or ecologist with possessive tone to convey that patients either have a close relationship or a sustained relationship with their doctor. It often suggests that patients have chosen to have this doctor with continuity. In the case of some women in the study, many women did not see their gynecologists but once or a few times.
leading cancer in Brazil) and cervical cancer (the third leading cancer among women).\textsuperscript{38}

A healthy attitude toward their same-sex sexuality is a critical component of these women’s self-understandings of bem-estar (or well-being). They rely upon such self-reflections to promote self-respect, self-care, self-love, and self-legitimizing. However, these women’s modes of self-reflections suggest a level of raised awareness about human rights and health outcomes, understood as being constantly negotiated either socially and physically. These women want to prevent, particularly given family histories of disease, reproductive health issues such as uterine fibroids, uterine cancer, and breast cancer. However, their self-perceptions and practices of prevention are informed by self-reflections upon their sexuality and well-being. Enactment of their self-perceptions shaped by “local moralities” (Inhorn 2006; Dave 2012) is a critical part of their ethical strategies of self-legitimization within medical settings.

For example, Jandira describes sexuality as freedom (libertade); not just because it symbolizes freedom to have sex and indulge sexual desire, but the freedom to live openly and healthily as someone who loves others of the same sex. She relates to her sexuality and orientacao sexual (sexual orientation) as “a conscious, engaged, and agentive state of being” (Howe 2013). Following Jandira’s nearly decade-long relationship with Isabelle (another of my interlocutors) offered me a window into these understandings of social bem-estar. As in many relationships, they periodically break up and make up, but ultimately bask in showing their pride for the longevity of their love and care for one another. They happily report being the oldest relationship among their circle of black lesbian friends. For Jandira and Isabelle, their love is held together by the ways in which they support each other through personal and family

\textsuperscript{38} Exame de Papanicolau em mulheres do Nordeste
issues, as well as by their religious obligations as Candomblé practitioners. For Jandira and Isabelle, the practice of the freedom that they experience in their sexuality is tied to their ability to gain recognition as legitimate citizens like white heterosexuals and even white lesbians albeit an “incommensurable” (Povinelli 2001; Boellstorff 2011) freedom as racialized sexual subjects.

Jandira, as an ethical voice, does not hesitate to provocatively express her opinions and interpretations. However, her dressing choices draw attention to the social contradictions that challenge her pursuit for social liberty as a masculine gendered lesbian. Jandira reminds me of how “gender is not an essence preceding social expression but an identity that is constructed and fluid” (Blackwood 2000). Jandira is one of the few of my interlocutors who proudly represented her masculinity through her boyish, less feminine, clothing, her aggressive and “lady’s man” demeanor, and through her physique, which would be considered “unfeminine” by the dominant standards of femininity in Brazil. For example, I remember being on the bus with her when a drunken man harrassed me with his flirtation. With an injured shoulder, Jandira quite effectively told the man to “back off”; I was reminded that Jandira’s
gender expression would be read as someone who threatens (or even intimidates) the dominant heterosexual masculinity in Brazil. Contradictions, however, emerge through her sartorial coding at work. While she does not 
closet herself at work (she is an educational coordinator and supervisor for a Catholic University), she does conform to a dress code that for her is quite uncomfortable. She detests wearing skirts and dresses, yet she wears them to work, as it upholds her workplace’s expectations that she represent womanhood. Though she considers herself a masculine woman, she believes that it is necessary to conform to the gender expectations of her occupation because “it’s the professionalism that her employer expects.” More importantly, it safeguards her health insurance and employment. Her enjoyment as an educator is offset her subjective discomfort in her workplace, although she holds that her work does not de
gelitimize her sexuality. However, as I got to know Jandira through our interviews, but perhaps especially through observing her and her friends, her relationship (casamento), family, religion, I understood the how she contended with such choices. For Jandira, being “out” as a lesbian may be at times disassociated with performing her gender as long as she can work to afford her health insurance. Being able to afford health insurance is critical for maintain her professional relationship with a gynecologist who affirms her sexuality. Ultimately, these are the sorts of choices confronted by many black women similar to Jandira, confronted by the difficulties of finding a decent paying and keeping your masculinity as an open lesbian.

In the recent short Brazilian documentary O Fio Das Masculinidades: Uma Reflexao das Masculinidades em Mulheres (2013), we are introduced to Natalicia, a dark-skinned female who does not deny being a woman and freely expresses her masculinity by dressing in pants and looser fitting shirts, flat shoes or sneakers,
wearing no make-up, and keeping her hair pulled back in a pony-tail. I had encountered Natalicia (and her flirty ways) a few times in lesbian social circles; female masculinities are a far from newly-emerged feature of social life in Salvador, but this film provided one of the first public, visual opportunities for these masculinities to rupture dominant gender and sexual views in Salvador. In the film, we see these stigmatized and marginal voices speak about their resistance to the normative workforce. Natalicia, for instance, says, “A friend told me that if I dressed this way on her job, she would fire me and certainly would never hire someone like me. I told her that I would then not mind being fired and would never choose to work where I can not be who I am. I am not a man but I will not allow a job to change the way I am.” Natalicia works as an administrator at a state university, where the environment is more tolerant of gender dress code and “gender transgressive” (Blackwood 2000) expressions.

As I watched Natalicia speak out in this film about the choices she would make about employment in order to not conform to heteronormative gender dress codes, I realized that Jandira was not the contradiction in her search for sexuality freedom. Jandira often said that the strikes against her were three-fold, as an openly black gay woman, and holding down a good job in Salvador was difficult and often impossible. Although some of the lésbicas negras interlocutors earned fairly above the low mean, with their monthly salaries ranging from R$1700-R$5000 per month (with minimum wage in Brazil is R$724 [US$ 310] per month), their jobs were mostly within education, activism and NGO’s, the arts, and government jobs in social politics and justice. In other words, there was a definite trend towards work in sectors and environments that tended to allow, even appreciate and encourage, the wearing of their natural hair (not permed or straightened) and being open lesbians. Yet, lesbians
such as Jandira and Natalicia compel us to “understand the ways our multiple identities work to limit the entitlement and status some receive from obeying a heterosexual imperative” (Cohen 1997:442).

Yet, in the short film I just discussed, a Brazilian white female gynecologist in a very brief appearance (less than a minute) says that while preconceito exists in the gynecological setting against female masculinities, there is also preconceito toward the doctors. Her comment suggested that these women potentially sour the patient-physician relationship from the start with their preconceito. In fact, the gynecologist did not take into account the depth of marginalization the women in the film attributed preconceito to have upon their social status. However, in the short film, the women did not even talk about any concerns with their gynecologists, allowing the presence of and response by this gynecologist to confirm the right of gynecologists to produce narratives about the gynecological experience. As we have seen elsewhere, however, some gynecologists are indeed quite passive in terms of their engagements with patients’ experiences of preconceito.

What else, then, is preconceito in this setting if not the “multiplicity of the body” (Mol 2002) through incomprehensible social interpretation? In other words, the multiplicity, or large variety of ways, of misrepresenting the self (Goffman 1959) via social interaction contributes to the social dilemma of existing hierarchies of preconceito. Yet again, “sexuality emerges as unknowable and unnameable” (Huffer 2010) through the entanglement of preconceito. By scaling these social complexities (in these women’s sacrifices to secure health insurance, for example), I hope to understand in my investigation of my interlocutor’s racialized subjectivities and interpretations of racial justice. In the words, I call for “a kind of ‘cultural physics’ in which sexuality operates as a vector that occasions multiple interactions among
groups of humans” (Roberston 2000:2). Still, seeking sexuality freedom in the gynecological setting is the scence of ethical encounter that remains most tangibly related to their sexuality, as gynecology remains the place where their sexual organs are exposed and observed as an object of medical inquiry (Kapsalis 1997), often with a high subjective price. And yet, for many in Salvador, it is the institutional place where sexuality is least regarded as relevant and worthy of humanizing. Scaling, or partial connections, of social complexities can rendered visible how the ethical travels from outside locals within intimate social relations, or “cultural physics” to interpret the ethical within the gynecological setting.

_Beyond the window: Interview with Dra. Rosa_

One of the gynecologists I interviewed was Dra. Rosa a black female gynecologist native to Salvador, who works both in the private and SUS (Systema Unico de Saúde) clinics. She has been practicing gynecology for over 18 years, and we met at the upscale OB/GYN clinic where she was working. Our conversation confirmed some of my findings from other physician interivews, such as there being far fewer women who openly self-identify as women who have sex with women (WSW) in SUS than in the private setting. Also, she reported that she approaches homosexual patients with affirmation by asking more appropriately specific questions about their sexual lives, after they have self-identified as WSW. She said it was her way to acknowledge WSW patients’ sexual relations and to help them relax. Dra. Rosa’s “more appropriate questions” seemed to attempt, generally, to neutralize sexuality: “are you having sexual relations?” “When was your last sexual relation?” She said these sorts of questions helped some WSW to self-identify. At the particular
(very upscale) clinic where we were meeting, she said that she had not treated any black women who have self-identified as WSW.

One of the several interesting points that Dra. Rosa raised during our 35-minute discussion was the issue of *diferenciada*, or differentiated, patients. When I asked for her about *preconceito* against skin color or black women in gynecology, she stated that her colleagues often referred (behind the scene) to some black female patients as *diferenciada*. This annoyed her because for these colleagues, *diferenciada* meant dressing or speaking in a more elite or socially acceptable way. Of *preconceito* and racism, she stated:

Dra Rosa. I think racism exists but I see racism much more concerned with economic class. I think it (class) is stronger, economic issues, than the color of skin, especially here in Bahia. I think the economic issue, how the patient dresses, sometimes I witness for certain prejudice from physician colleagues toward how the patient dresses, you know, more than toward the color [skin]. I think that here [Salvador] is very strong, very strong. There is one word that I think is ugly when people [her colleagues] call patients 'differentiated', you know, so sometimes it happens at the SUS, but so ‘differentiated patient’ is the patient better, sometimes in SUS I would realized that [my colleagues] would refer to this patient is differentiated, … [asking herself] Like so differentiated?

It's a word that bothers me [makes me uncomfortable] a lot, you know, to hear it.

NF: And speaking of differentiated in what other sense?

Dra Rosa. In a sense as in being culturally better, how she dresses and appear to be financially above the vast majority of the profile [of patients] that we serve. So that's the word I hear a lot compared to color reference, which I see very little, but of course, that most people that we serve and that are an economically disadvantaged population is more black people, and mestizo.

*Dra Rosa*: *Eu acho que existe, mas o racismo eu vejo que é muito mais em relação à classe econômica, eu acho que é mais forte, a questão econômica do que a de cor de pele, principalmente aqui na Bahia. Eu acho que a questão econômica, a forma como a paciente se veste isso às vezes eu vejo um certo preconceito do colega médico com a forma como o paciente se veste, né, mais do que com a cor. Eu acho que aqui isso é muito forte, muito forte, existe uma palavra que eu acho horrorosa que as pessoas chamam ' a paciente diferenciada', né, então às vezes chega na rede do SUS, mas é assim diferenciada é a paciente melhor, as vezes vc chega na rede SUS 'eu percebi*
Diferenciada, as she described, was connotative of a deep, elite, and entitled socio-cultural bias by her colleagues that ultimately stigmatize black patients of the working class. As I listened to Dra. Rosa, I remembered that Telma told me that she had to always “dress nicely” to go to the doctor so that she would be received and treated with respect. Telma’s idea of dressing well, however – or dressing appropriately – did not emulate the wealthy dress patterns of many middle-class and upper-class white Brazilians that I witnessed in the more upscale gynecology clinics. Furthermore, some black lesbians complained to me that reporting their upper level of education raises eyebrows of the intaker at doctors’ offices. This notion of diferenciada is an index of the social complexities I am describing here, and, frankly, a social symptom of racial and class preconceito (Moore 2012; Telles 2004; Sansone 2003) and of “racialidade das relações sociais (racialization of social relations) within spatialities of race relations” (Emerson dos Santos 2012:31). For example, Telma, who at 29 years old, started college after a 10-year career in theater, already experienced first-handedly the inferior treatment based upon her dress and presentation in medical clinics and so familiar to other lésbicas negras. I think these experiences must have been in the back of her mind when Isabelle would say to me that “as black lesbians, we must pursue education and good jobs because otherwise, we will not have options.” I heard this
At the window, Mirela stated,

MC: I think it's very important for you to be respected as a lesbian; you [must] have training, have schooling and graduate college. Because here, unfortunately, you are only respected – and I think this is for lesbians and gays in general – you are only respected when you have an education, you have money, a job and personality. You need to have those three things, I think. You need to be firm in whatever you chose to do without hesitation, because they will try to step on you, “velho” (old man [an expression of endearement])!

NF: But perhaps you will still experience prejudice?

MC: There will be [prejudice], of course! But it will not affect you directly! When they [whites] come talk to you, they will think, reconsider, think again until you get closer to them, especially given your [homo] sexuality! Within the academy we went through all this, yet there is still the question of affirmation and acceptance. I think that in my [college] class I am an a example [target]. I will not continue in this University because I think ... I want more. So, this is still not where I need to finish. But as long as I am there, I know I'm a differentiated (diferenciada) thing in the room. Maybe they already look at me with an issue for being lesbian, belonging to Candomblé, black, already different than when they entered the room, looking at me with another view. I do not know, I guess they think we are not people like, "Mirela, come here, oh look, she socializes too.” I think I'm already an odd factor in my room because of the color of my skin], I guess. Even without the masculine stereotype that’s already placed upon you, you know? ...It is assumed that because you are a lesbian that you have traits of masculinity because you like another woman...

MC: Eu acho que é muito importante para que você seja respeitada enquanto lésbica, você ter formação, ter escolaridade, graduação. Porque aqui, infelizmente, você só é respeitada – e eu acho que isso é para as lésbicas e para os homossexuais em geral. Você só é respeitado quando você tem uma formação, você tem dinheiro, emprego e personalidade. Você precisa ter essas três coisas, eu acho. Você precisa ser firme naquilo que você escolheu pra você sem titubear mesmo, se não eles pisam, velho!

NF: Mas talvez ainda vão ter preconceito.

MC: Vão ter, claro! Mas não vai chegar a você! Elas quando vierem falar com você, elas vão pensar, repensar, pensar novamente até chegar a você, principalmente com a questão da sua sexualidade! Sem saber que dentro da academia a gente passou por tudo isso, pela questão de afirmação, de
Similarly to Isabelle and Jandira, Mirela’s strong views on how to transcend inferior treatment and social stigma as a racialized population correlates with her pursuit of well-being as a human right. These women are not striving to conform to the white heterosexual norms and codes to be perceived as equal citizens, however. In fact, Jandira, Isabelle, and Mirela move against the social grain, accentuating their blackness with keeping their hair natural, adhering to their Candomblé dress codes and neck beads, and more or less often avoiding the extreme femininity and ideal image of Brazilian womanhood. As Mirela mentioned above, at times, many black lesbians are perceived as masculine if they do not dress in a very feminine manner. I argue that Mirela’s views suggest the prevalence of desexualizing black lesbians because they do not conform to heteronormative sexual codes (Cohen 1997; Wieringa and Blackwood 2000; Moore 2011). In such case, they are usually hypersexualized and desexualized as having viable gendered bodies. These societal perceptions toward non-normative sexualization challenge the strivings for recognition “as norm and as risk of destruction of a transformative process” (Butler 2004:133) for particular ethical subjects, particularly racialized female subjects (Williams 2013).

This chapter’s central question turns on the relationship between lésbicas negras’ racialized sexual subjectivities and their ethical striving. I investigate this relationship in part through windowing my analytical perspectives and ethnographic
data in order to understand the scaling effects of hierarchical values (Voss and Schmidt 2000). By scaling effect, I refer to the impact that some interpretations of race and sexuality produces as microscalar encounters with preconceito link up to and help sustain structural inequalities (Twine 1998; Sansone 2003; Telles 2004; Caldwell 2011). This form of writing, as an ethnographic method, helps me to recognize the blurred lines of racism and heterosexism that are connected to the multiplicity of preconceito, as in the notion of diferenciada. By windowing the ethical subjects’ narratives as a collective in relationship to their social and medical contexts, I intend to clarify how social complexities impact the interactions of these ethical subjects with their gynecologists via the enabling conditions in their lives beyond the clinical setting.

**At the window. Interview with Jandira**

10/4 After an interview with Jandira at my apartment, I wrote in my field notebook: “Doing the interviews at home offers a very interesting setting. J enjoyed sitting at the window and said that ‘everything could be breathed out onto the waters of Yemanjá (Candomblé diety of the ocean).’”

The moments before and after an audio-recorded interview were at times just as salient as the energy and content of the interview. Too often, I did not feel comfortable writing in my notebook before the interview. By the time the interview ended, we often established a mutual acknowledgement that jotting comments after the interview was just as important as during the interview. In fact, I often turned the audio recorder back on! Jandira’s comment above, for example, opened up onto her self-understanding as a concerned, self-caring citizen. The window view was
breathtaking to everyone who visited me. For Jandira, such a view framed well-being in a religious and social way, a mixture that I became increasingly aware of over time. This well-being included hope for change, healing, and justice for herself and her family, loved ones, religious community and beyond, resting on the energy of the Candomblé deity, Yemanjá, who oversees the ocean. It is customary to pay respect to Imenjá when you are upon the ocean waters.

I was excited to interview Jandira. She was my second interview in early October 2012. Prior to the interview, we met several times for drinks or coffee to chat about random stuff such as our lesbian partners, family, or politics in Salvador. She has been a devout Candomblé initiate for over 8 years and belongs to one of the oldest temples in Salvador, Terreiro do Bogum, in Barrio do Federacao. Jandira is dark-skinned with long locks, 40 years old, childless, and has a college education in pedagogy/education. She was raised in a working class family with five siblings. Her ethical voice becomes most pronounced in articulating her understandings of the ways that her sexual freedom is challenged by the institutions in which, as a consumer, her sexuality is most exposed and vulnerable. Jandira adamantly maintained throughout our encounters that gynecology must be a humane experience for all women, though recognized the subjective differences across women.

At the window

J: Alas, after I started working and [got] healthcare, I went back to the gynecologist. Alas, I found the gynecologist (pause): "you use a condom?" No. "Do you use birth control?" No. "Do you use that?" I answer: I do not use anything... I have not had sex with men, I'm a lesbian. Then you realized a change within the professionals [when you come out]. They become very harsh, very dry, or even brutal. Once, I got from from an exam table while getting a pelvic exam, asked her to stop, and got up from the table and walked away and never went back.

NF: How old were you then?
J: I was about 25 years ... And I delayed going back to the gynecologist.

NF: You waited 10 years to return?
J: Yes, because you are violated (violendada), you understand? You keep feeling like you’re a different thing because people do not treat you with respect, respect your humanity, throwing your [sexual] orientation [to the curb]. And then, I was too scared to go and be ... I dunno ... [pensive into the Bay]


NF: Quantos anos você tinha?
J: Eu tinha uns 25 anos... E demorei para voltar para o ginecologista.

NF: Você esperou 10 anos para voltar?
J: Sim, porque você fica violentada, entendeu? Você fica se sentindo como se fosse um negócio diferente porque as pessoas não lhe tratam com respeito, a sua humanidade, tirando a sua orientação. E ai eu tinha muito medo de ir e ser... sei lá... E aí o ao passado, lá na ‘Petrobrás’, uma colega minha, conversando com ela, e ela sabe da minha orientação e ela me disse: “Jandira, tem uma médica, ela é muito boa, marca lá que você vai gostar... quando chegar lá, fala com ela que foi eu quem lhe indiquei...” Ai tá, eu fui. Ai foi quando eu encontrei essa médica agora.

Similarly to Barbara, Jandira recollected part of her conversation with her gynecologist with much anguish. Women such as Jandira and Barbara remember the content of their conversations with a gynecologist and their impact upon their experiences both because of their self-conscious participation in those conversations as ethical subjects, but also because of the extent of emotional injury experienced during those conversations. Jandira, for example, once walked out of a gynecology clinic mid-exam, enraged by what she described as “brutal” treatment after the clinician learned of her homosexuality. However, for Jandira, that experience resulted in more than a spontaneous emotional reaction: she did not return to the gynecologist
for ten years. Jandira is an example of women who engage their ethical subjectivity through their refusal to submit to the subordination of their sexuality. When she says, “tirando a sua orientação” after describing the interaction as “lacking respect toward your humanity,” she refers to a violent lack of recognition of her sexuality as part of her humanity. While tirando means “throwing,” Jandira refers to a mode of discarding, of an aggressive disregard for worth. As I discussed in chapter 3, this is an example of how sexuality matters to these ethical subjects and how “antihomosexual prejudice is not always about [homo]sexuality but rather a phenomenon produced through a complex nexus of gendered, classed, and raced inequalities which are in turn tied to long term local and transnational political and economic relations of inequality” (Murray 2009:3). Women such as Jandira and Barbara remind us that when homosexuality becomes the object of an encounter in this setting, it functions both to shape the interaction in ways that negate their sexual subjectivities, but also to activate resistance and defense mechanisms from these women.

I interpret these women’s actions such as walking out of or avoiding gynecological visit for a long time as acts of resistance that do not immediately point to neglectful care of their bodies or health. In fact, quite the opposite: such responses instead point toward a particular ethical practice of care for the self, of a specific understanding of well-being as a human right and form of freedom. I argue that this form of well-being is a form of subjective homeostasis that lésbicas negras strive towards, turning, critically, upon the legitimatation of their sexuality (Faubion 2011). This subjective and ethical homeostasis, of human, social, medical, and sexual bem-estar, is not sustainable in the face of psychosocial violence. In other words, Jandira’s termination or avoidance of a gynecological interaction that devalues and demeans her sexuality is an act of resistance. It participates in her ethical striving toward
toward a form of self-care, in her formation as a subject capable of engaging in homeostatic processes, which foster a personal and social form of well-being.

During our interview, Jandira spoke of her new gynecologist’s commitment to accepting her sexuality and treating her with respect. Moreover, she described this gynecologist as a professional who actively engaged her sexuality in various ways, such as inquiring about relationship with Isabelle and being mindful of her discomfort with a speculum exam. Windowing into Jandira’s descriptions of her relationship with Dra. Marcia, I notice that Jandira considered her experiences with her as an ethical model for gynecologists who would respectfully recognize lesbians during their clinical interactions, conversations, and exam processes.

*Window 1:*

J: Dra. Marcia [my doctor] (a fictitious name). I scheduled with her and when I got there, she asked several questions. Then I spoke about my sexual orientation, and she responded, “ah, yes.” [with affirmation]. Then, she asked if I had a companion. She performed the job that could have been done [for me by others] long ago. She asked how was my relationship with my partner. Then I spoke [about it]. Isabelle, at the time, had had surgery. My doctors asked me if I had had surgery. And all this she noted down. She asked me about my family health history, and everything. She made a report and there began to order several tests. Ordered a battery of tests for me and I completed them. Thank god were all negative. And then she found the fibroid. She said it was already a bit large …

J: Dra. Marcia. Na clínica. Ai marquei com ela e quando eu cheguei lá ela fez várias perguntas e ai eu falei da minha orientação sexual, e ela, ah, tá... Ai perguntou se eu tinha companheira, fez um trabalho que já poderia ter feito há muito tempo. Perguntou como era a minha relação com minha companheira. Ai eu falei. Isabele, na época, tinha feito uma cirurgia, ela me perguntou que cirurgia. E tudo isso ela anotando. Perguntou de minha família, o histórico de saúde de minha família, tudo, fez um relatório e ai começou a passar vários exames. Passou uma bateria de exames pra mim, eu fiz. Graças a deus, deu tudo negativo. E constatou o mioma. Sim. Ai deu mioma e ela disse que já estava um pouco grande....
In window 1, Jandira’s suggests how a gynecologist ought to become informed about a patient through simultaneously engaging in both a humane connection and medical assessment. However, Jandira’s example presents only what I would consider to be micro-scale issues of complex social interactions between gynecologists and lesbian patients. The micro-scale issues in question here involve the subjective associations pertaining to the specific ways in which homosexuality was invoked during the interaction. I interpret Jandira’s claim as feeling invited to discuss her sexual orientation in a humane manner as leading to a subjective experience of value and respect. In this medical and ethical interaction, we can see the partial manifestation of the complex social structures that frame the issues of homosexuality. These micro-scale issues are negotiated and accessed not just in the objective content of an interaction, but through the process of deciphering what is best for the patient. What is best for the patient, here, is determined to be the recognition of what ought to be valued about them - their sexuality. The appearance of, but also the critical engagement with, these structural issues at a micro-scalar level are important, because they are all too often rendered invisible and negated as insignificant within the broader, institutional scale of heteronormative gynecological practice and discourse.

Window 2:

JS: What I think is essential for any professional and that is, they must treat the other as a human being in humane ways. And Dra. Marcia has that. Sometimes after I walk out of her office, she tends to her other clients, not clients, I mean patients in the same way. She treats me like them as a human person and as normal. She asks: "All good, Jandira? Are you feeling anything? [pausing] She investigates [inquires about] my life… my sexual life! Asks if I had relations with a man or relationship with women. How is it? How was it? At the time of the [vaginal] exam, she does preventive [tests] and she asks: "Look, I'll do it in a way not to hurt. It will bother you but it's not meant to hurt ..." And as she's doing it, she’ll ask: "is it bothering you?” During the exam she asks, “May I continue?” So you feel safe, you feel respected. Something I had not felt even with other professionals instead I felt violated.

In window 2, Jandira points out the discomfort exhibited by gynecologists when interacting with lesbians. Jandira suggests that for many lesbians, not feeling fully engaged by their gynecologists is often a result of the latter’s discomfort, which, when it leads to a lack of attentiveness, is experienced as preconceito. For Jandira, it is simply inhumane when gynecologists do not treat lesbian patients in the same comprehensive and appropriate manner during their exams and interviews as they would a heterosexual woman. When Jandira says, “Investigar minha vida toda. Assim, sexualmente,” we should not read into this comment a “total” investigation of her life without regard for professional and medical boundaries. Rather, in the context of a gynecological examination, she is referring to a clinician’s ability to inquire and connect with a lesbian patient’s sexuality without demonstrating reservation or rejecting the patient, without minimizing the sexualized components of the interaction to an extent that it leaves the patient feeling as though she was not appropriately engaged as a sexual and ethical subject. When Jandira says, “So you feel safe, you feel respected. Something I had not felt even with other professionals, because I felt violated.” I interpret her evaluation as part of her striving for a homeostatic social
well-being, linking the respect she experiences in a satisfying consultation to her broader experiences of health.

For Jandira, being respected as a homosexual does not mean that gynecologists should automatically assume that all lesbians would want to be treated as primarily lesbians, any more than they should automatically assume lesbians’ sexuality should not be a topic of gynecological inquiry. However, what Jandira argued is that to be respected as a homosexual by a gynecologist was to be recognized as a patient with legitimate questions, needs, concerns, and health issues that often touch upon sexuality, just as for heterosexual women. Here, the negotiation of these micro-scale interactions is especially complex, because the underlying supposition is that questions of gender should be separated from those of sexuality (Valentine 2009; Inhorn 2006; Gregg 2003). In other words, for Jandira, the freedom to openly participate in the gynecological encounter is tied to the gynecologist’s recognition that her claims to being treated as a woman and a patient are every bit as valid as a heterosexual woman’s. It seems to me that the heteronormative entanglement of particular, culturally-specific versions of femininity and heterosexual desire at the core of much gynecological practice is a key target of Jandira’s resistance. Most of the gynecologists I interviewed freely admitted that they do not know how to respond to lesbian patients or masculine females, and it seems to me that this un-knowing is based upon the fundamental assumption that their “proper” patient is a normatively heterosexual feminine woman (Sedgwick 1990).

Jandira is quite specific about how the quality of doctor-patient interaction influences the process of a gynecological exam. She relates that her previous gynecologists did not, generally, follow up her statement that she does not have sexual relations with men with pertinent questions about the actuality of her sexuality,
and her narrative here opens up onto the social dimensions of sexuality and gender
that saturate interaction.

Window 3

J: They [gynecologists] would not ask me many questions. When I would say
that I did not have relations with men, they would stop questioning me as if I
did not have an active sexual life. And at the time to do the [pelvic] exams, it
was total brutality. So, they would not ask anything ... And Dra. Marcia did
not do that. Dra. Marcia, on the other hand, will explain: "Look, I'm going to
use this device, I will pass a cream here.. it is for the better and is not supposed
to hurt. It will bother you but is not to hurt.” And when I went to do the
transvaginal [ultrasound] she asked me: "Jandira, I do not do transvaginal tests,
but when you go to get it done, you tell the doctor you do not have sex with
men, so that she would deal with your differently.” Tell her beforehand. Talk
to her about yourself. "

J: Não faziam tantas perguntas. Quando eu dizia que não tinha relação com
homens, elas paravam de perguntar como se eu não tivesse vida sexual ativa. E
na hora de fazer os exames era com muita brutalidade. Assim, não perguntava
nada e já ia... E Dra. Marcia não, Dra. Marcia, “olhe, vou usar esse aparelho,
vou passar um creme aqui que é para melhor, não é pra doer, vai incomodar,
mas não é pra doer. E quando eu fui fazer o transvaginal ela me perguntou:
“Jandira, eu não faço transvaginal, mas quando você for fazer você avise a
médica que você não tem relações sexuais com homens, para ela ter outro trato
com você. Avise antes a ela, diga, fale de você, fale com ela”.

In window 3, we can see Jandira’s desire for recognition as someone with an
active sexual life, having sex with same-sex partners, and for its incorporation in the
medical interaction. This is an ethical desire, as I have argued in Chapter 3. Patients
such as Jandira can perceive when physicians are not prepared or willing to
adequately engage such a non-normative patient. Through a whole series of
interactions, from the taking of medical histories to the performance of the
gynecological exam, this leads to an erasure of their sexuality, a foreclosure of their
ethical projects, and also to concrete physical and psychological medical
consequences. At its base, the point Jandira and I are trying to make here is that
difference in sexuality matters in the gynecological context, at the very least, to the
extent that its recognition would allow for a more appropriate and specifically tailored conversation and examination.

Window 4

J: For me, you should treat others with humanity and respect first the person independent of your color, your class, regardless of anything you.. treat each other with respect. This means dealing with the other. You allowing the other.. Giving voice to the other, you have to allow the other to have a voice so they can speak without fear, without restriction, as we are talking here and now. As I do that with Dra. Marcia. She asks questions and I talk with all tranquility. If you are feeling respected, then you’re receiving and being respected. It is about you having your spirituality, your body, you know? Your humanity must be respected.

J: Pra mim? Você tratar o outro com humanidade é você respeitar primeiro a pessoa como um ser independente de sua cor, de sua classe, independente de qualquer coisa você tratar o outro com respeito. É você tratar, é você permitir o outro, dar voz ao outro, você permitir que esse outro tenha voz, possa falar sem medo, sem restrição, como estamos conversando aqui e agora. Como eu faço com Dra. Marcia, ela pergunta e eu falo com tranquilidade de tudo. É você se sentir respeitada, ter seu corpo respeitado. É você ter sua espiritualidade, seu corpo... sabe? Sua humanidade respeitada.

Jandira’s reflections here show her in her complex ethical subjectivity in the gynecological setting. Jandira is adamant when she conveys that the humane treatment of a lesbian patient is tied to allowing that patient a voice and a role during the consultation. Further, to be respected means to “permit the patient to speak and feel freely, to not be restricted, so that the patient can speak with tranquilidade (tranquility) and to feel that they are within a ‘respected body,’” or self during the consultation. For Jandira, such a mode of being, if achieved, leads to feeling, among other things, spiritually balanced. She identifies the ways in which perceptions of skin color, or race, and presumptions of class factor into the production of negative, even violent interactions within the gynecological consultation, complicating questions of sexuality as a basic element of being human in ways that have a direct impact on the
quality of gynecological interaction for *lésbicas negras*. This chapter investigates such fundamental complexities at the micro-level of gynecological interaction, showing how their interactions with the ethical striving toward being “respected” and affirmed have a significant stake in the achievement and maintenance well-being for my interlocutors.

*Beyond the window: Visit to her Gynecologist*

A few weeks after Jandira’s interview, I met Dra. Marcia. I was very excited to accompany Jandira to her scheduled consultation, and Jandira was enthusiastic about it as well. She was confident that Dra. Marcia would give me an interview. Indeed, a brief visit with Dra. Marcia opened a window into two issues: (1) the possible challenge of interviewing my interlocutors’ personal gynecologists, and (2) Jandira’s status as an ethical subject. First, this *particular* (private insurance only) clinic was located in an affluent area in Barrio de Ondina. The clinic was located a block away from Salvador’s downtown ocean coastline with beachfronts, hotels, and highrise condominiums, within walking distance to the main campus of *Universidad Federal da Bahia* (UFBA). I arrived before Jandira and waited in the waiting room, near the front desk. There were several white Brazilian women waiting as well. After spending time in CEDAP (*Centro Estadual Especializado em Diagnostico, Assistencia e Pesquisa* - SUS’s Sexually Transmitted Diseases and HIV/AIDS clinic in Salvador), I could certainly attest to the fact that these women were *diferenciada* from the population at CEDAP, with their fancy high-heel shoes, clothing, and bags. When Jandira, with her animated manner, arrived dressed in all white casual clothing (it was a Friday, day of Oxala) – a button down shirt, baggy knee-length shorts, and loose long hair locks, her presence was palpable. Her arrival lifted the stiff silence in
the room, for me at least, which was a welcome change. She brought with her radiology films and other lab reports in hand. As I learned, patients were responsible for picking up their own medical reports (not just radiological films) and bringing them to their follow up consultations. In fact, after that very appointment we drove to another clinic, where Jandira picked up her sister’s blood laboratory results. Her sister had suffered a cerebral stroke in July 2012, which caused significant paralysis to entire one side of her body. I remember asking Dr. Manuel (male gynecologist discussed earlier) about this process of patients picking up their own reports. Specifically, I asked him about the risks of patients’ not picking up their reports limiting physicians’ awareness about critical results. He said that, unfortunately, “the Brazilian system is not prepared to financially sustain the amount of faxing and mailing all of the patients’ reports, especially if done in an outside facility.” Given the difficulty for many folks in Salvador of affording to even pay for bus transportation, I wondered whether shifting such accountability to patients resulted in higher rates of no-show clinical appointments.

In any event, after Jandira spent approximately twenty minutes with Dra. Marcia, she came out into the hallway and called me into the office. Before entering, she said that she had told Dra. Marcia about me and about the importance of this research. Dra. Marcia was a tall, white, very welcoming woman. Our initial meeting lasted less than 5 minutes, in which I introduced myself, the project, and asked to interview her. She agreed enthusiastically, and told me to call her two weeks later on a Friday, when the clinic was not as busy. Admittedly, I waited very excited to call her. Unfortunately, our interview never took place. After her third cancellation for personal reasons on the day of each scheduled appointment, I became far more wary about the reliability of my interlocutors’ physicians as informants. Whether or not Dra.
Marcia had in fact cancelled for personal reasons, as a researcher and medical clinician, I had to wonder if there were other factors at play: (1) patient confidentiality, (2) the clinician’s position as an employee of another physician’s owned practice, and (3) prohibitions or taboos attached to speaking about the homosexuality of their patients even if the patient consents such as Jandira did. These would become significant issues to anticipate as I charted fieldwork. Though I tried a few times to get other interlocutors to allow me to speak with their physicians, it ultimately proved unfruitful, and I chose to seek out physicians independent of my interlocutors. No other gynecologist interviewed cancelled appointments, thereafter.

Nonetheless, as Jandira introduced us, she eagerly shared her opinions about the research with Dra. Marcia. Jandira told her that the research was important for “all lésbicas negras.” At the same time, she showed her affection for and pride in Dra. Marcia as a clinician who affirmed and legitimized her sexuality by telling me, in front of her doctor, that “she is not like others.” Only later did I realize that the moment was a window into Jandira’s ways of pursuing recognition as an ethical subject. In other words, even as a patient that is satisfied with her personal relationship to Dra. Marcia as a gynecologist who affirms her sexuality, she still must remind that Dra. Marcia that her approach toward Jandira and her sexuality is very valuable. My observation of Jandira reminds me that the negotiation process as ethical subjects continues, and may even become more pronounced, when the gynecological relation is affirming. Still, Jandira’s reaction raises the question of what it means to become public with such ethical negotiations that might otherwise be considered private. In this moment, I briefly became exposed to and incorporated within Jandira’s mode of subjectivation.
Beyond the window: The film

I have to this point been focused primarily on sexuality, but it is important to remember that for lésbicas negras the issue is also always one of blackness as well. Jandira, being a very outspoken black gay woman, draws attention to what most physicians avoid discussing: that is, whether black Brazilian women receive inferior gynecological care and less respect from their clinicians than do white Brazilian women. While this question is under-researched quantitatively in Brazil, what is already clear from my research is a wide-spread inadequacy in the level professional acolhimento (hospitality) afforded lésbicas negras both as lesbians, but also, critically, as black women. On the one hand, an there is a wide-spread interest among highly conscientious and outspoken women such as Jandira in ameliorating gynecological health issues in the black community, such as the prevalence of reproductive cancer, uttering fibroids, and hysterectomies. Ultimately, however, I am here less focused on whether racist discrimination exists in gynecology, although it seems apparent that it does, than on the impact of racialized and (hetero-)sexualized preconceito on the everyday well-being of black gay women. In other words, preconceito offers a way into a conversation about the improvement of the social welfare of black folks and of the nation state. The complex tension between the racial, sexual, and indeed spiritual aspects of my interlocutors’ subject positions becomes particularly and materially visible within my filmed footage, such as in the following interview with Jandira in July of 2013:

“To be a black lesbian in Candomblé. (Paused to think) On a Friday you have a consultation, and you go to your consultation. You put on your beads for Oxala or (Oxaguian) and you go to hospital dressed in all white, giving respect to your higher diety. Then you arrive, and if the doctor is of a different religion, she immediately puts up a (paralal) as though you are demonized, and then you find yourself in a situation where you perceive that she can’t stop, you know, so then, how am I supposed to deal with all of that. Being covered with various prejudices and covered with various forms of violence.
When you are a professional, you don’t have to judge anyone. You are obliged to manage. The doctor must dismiss all prejudice, of everything, because they are receiving diversity in your office. Then when you arrive to the hospital and an attendant makes an ugly facial expression at you and says, “Hold on, Madam” and then someone else arrives and says, “Well no, Madam,” and then you immediately feel it. You walk into the doctor’s exam room and she says, “Hello,” you know, she becomes shocked and then you are shocked too, then you are left waiting to establish a relationship with her, and she is never able to establish a relationship with you. Then she does not directly examine you, and she does not ask pertinent questions for the consult, And you move along, pay for your visit, but leave dissatisfied.

Regarding the sexuality of lesbian women, I think, it is long overdue for us to start saying, ‘I am not obligated to deal with professionals that violate me, stop with the violence, stop, stop with your prejudice, and respect me because I am paying, understand.’”


Ser lesbica negra de Candomble, sexta feira tem uma consulta, e ahi voce vai para consulta, voce bota sua contas de Oxala ou de ( Oxaguian ) e ahi voce vai para hospital toda de branco, e respeita o pae major, ahi chega la, si a medica foi de alguma outra religio pronta, e ahi ela ja bota uma (paralal) como voce esta demonizada, voce esta, entao e um negocio que te, voce percebe ela ne consegue desfazer, sabe, entao assim, como eu vou lidar com tudo isso. E... Estando cuberta de varios preconceitos, estado cuberta de varios violencias, voce professional, voce nao tem que julgar ninguem, voce tem que conseguir, voce obrigada, se despide tudo preconceito, de tudo, por que voce esta recebendo uma diversidade em sua sala. Entao quando voce chega no hospital, e atendente que te olhe de cara fea, “aguarda um momento sehnora” Oi, chego outra pessoa, “ pues nao sehnora”, entao voce senti na hora, neh, como voce entre no consultorio, ela, “oi”, sabe, ela toma um choque e voce tambem, e ahi, voce fica esperando a relacao dela e ela ni consegue ter uma relacao. E ahi, nao te exama direito, e ahi nao faz perguntas que seja pertinentes a consulta, e ahi voce passa por ali, paga sua consulta, mas voce sae dali dissatisfeita, eu acho que para sexualidade, para das mulheres lesbianas, eu acho que a gente, ja passo la hora para a gente comenzar para os (jois), e os (jois) e parar e disser assim, eu nao sou obrigada a lidar com professional o que me violent e, pare, pare, com sua preconceito la, e me respete por que estou pagando, entendeo, mesmo quando voce esta no SUS, voce paga, entedeo...

Here, Jandira reflects upon preconceito and being a black lesbian who often wears Candomblé neck beads into a gynecologist’s office. In this two-hour film interview, I interview Jandira in her terreiro, wearing several heavy long neck beads placed on her by her Mãe Santo India. To my surprise, Jandira dressed in all white with a below-the-knee skirt as well. This presentation was very important for Jandira
because she is not just a devout Candomblé member, but takes pride in how her sexuality is accepted by her Mãe Santo and in her terreiro (Candomblé temple). Unfortunately, this is not a freedom that many women experience in Candomblé (Allen 2012). As most of my key interlocutors were members of Candomblé, or at least frequented terreiros, I spent time there with them. These women often reflect upon their self-understanding of themselves as descendents of Africans who brought their religion to Brazil. Unlike in other local Candomblé communities (Allen 2012) most of my interlocutors feel that their religion and gods “do not discriminate against gays and lesbian, like other religions,” that “Candomblé is open to everyone.” At first, such a welcoming attitude seemed like a contradiction to me, given the extent of homophobia by many Candomblé members and the religion’s leaders. Over time, however, it became clear to me that their own religious understandings of the traditional narratives of their gods did not cast homosexuality as sin. In fact, their gods were very sexual, and sexuality is part of the gods’ narratives, leading them to say that preconceito belongs to people and society (including the people in the religion) but not to their religion as such. They were echoed in this by some gynecologists’ feelings that preconceito belong to society. Dra. Morales reported that many physicians were afraid to touch patients dressed in all white clothing and wearing Candomblé beads, acknowledging that racist preconceito differentially targeted female patients of Candomblé.

On film, Jandira emphasizes that prejudice (preconceito) is a form of judgment that produces violence at the interactional level, often with sexuality as its trigger. However, Jandira in this film segment is not only speaking of her sexuality as a trigger of preconceito. Jandira, who presents as masculine female through her clothing and comportment, does not fit the typical representation of femininity in
Brazil (tied to make-up, high heels, and closely-fitted clothing). She is all too often marginalized based upon her physical appearance, she believes, as a dark-skinned, masculine, Candomblé woman. I argue that beyond merely troubling expectations of heterosexuality in the gynecological clinic, Jandira uncomfortably disrupts the fixed representations of woman-as-gender. I recall that among the physicians at CEDAP, there was a discussion on a transman patient with HPV on the cervix. One physician blurted out with humor, “how can that be?” That discussion was a quite stark view of how gender representation sets up expectations of modes of sexual activity and sexual health. The aesthetic features of gendered and racial modes of being in turn form relationships with how sexuality can be negotiated for patients and women like Jandira. The relationship between these categories of experiences and ways of existing impacts her differently than her counterpart white lesbian patients. Jandira and others (Isabelle [her partner], Mirela, Lindinalva, and Isabel) consistently conveyed the precarity of their efforts to be out gay women with the gynecologists as being inextricably tied to their being black women. Analytically, it is critical to understand the relationship between race and sexuality for subjects who feel targeted by their position within both sets of social categories.

As black women (Jandira, Isabelle, Lindinalva, and Mirela), they strive for a better life through pursing higher education and working jobs that pay 3-5 times higher than Brazil’s monthly minimum wage, often seeking to accumulate cultural capital via their social movement affiliations or work. Given their strivings, they take seriously forms of dehumanization that many black women endure. They recognize themselves as taking serious risks in their seeking recognition as gay women by their gynecologist, because they are black. Therefore, I want to draw a bit more attention to how racialized sexual subjectivities drive the ethical practices of these women. Their
racialized sexuality and the social conditions that their skin color represents (both health disparities and other social inequalities) shape their pursuit for a particular form of human rights, different from that sought by white or light-skinned Brazilian lesbians.

The racialized sexual subjectivities of these women shape their striving toward well-being as a human right in ways that are central to their action as ethical subjects outside of the clinical setting. On October 24, 2014 at the Are the Gods Afraid of Black Sexuality? Conference hosted by the Institute for Research African American Studies at Columbia University, Jafari Sinclair Allen, building upon the presentation and work of Mignon Moore, reminded us of the importance of studying “how the ethical moves from the inside into the outside and how ethics seek to serve those ‘who cannot be afforded grace.’” I am inspired by his comment because precisely this chapter will demonstrate how the ethical moves, or travels between the outside (social life) and the inside (gynecologist’s office). The medical discipline of gynecology is an ideal domain of service that mirrors how such ethical subjects’ pursuits are shaped by “social relations and social change on a micro-scale across interpersonal relationships” (Voss and Schmidt 2000:15). If there is an achievable homeostasis of well-being, characterized by the legitimation of their sexuality as a intersubjective variable, lésbicas negras who pursue and negotiate such ethical recognitions help us develop a more in-depth view of the social intricacies characterizing the social relations structuring such patient-physician interactions. That is, gynecology is a social system that reproduces normative practices and ideas about sex and gender on micro and macro scales (Martin 1987; Kapsalis 1997; Georges 2008; Kline 2010). Thus, the normativity of gynecology includes that all gynecology treatment is equal to all as well as any woman or female body can share similar or same complaints toward
the practice itself such as painful vaginal insertions of speculum or being subject to sexist behavior. However, it is historically, socially, and politically problematic to focus our investigation of gynecology upon issues of *preconceito* solely related to homosexuality. *Lésbicas negras* emerge as ethical subjects precisely through the subjective experience of *preconceito* against racialized sexual subjects.

**Beyond the window: Dr. Manuel**

I want to return here to Dr. Manuel’s interview, to consider his observations about his treatment of social class, race, and coming out as a gay women in his clinic. He said,

Sometimes we serve patients who present masculinized, right, then, I treat patients who have a shaved head, wear masculine clothes, a male chain [correntão] here, a cap, you look, it does not mean she is a lesbian, just because she is a masculine woman.. this form (presentation) already calls my attention, and I ask, 'how is your sexual activity currently, you have sex?', I try, you see, but at the SUS is much less frequent someone to show in that way or report that they relate [have sex] with women than here in the [private] office. I attend to a lot more patients in SUS, of course, the volume is greater in the clinic where I attend in SUS - 20 patients per day, here about 10 or so... it is now much more frequent to get that [lesbian identifications] information in the office than in the SUS. Because you will find out, huh. Whether it is more common among women of a higher social level, or if they feel more at ease, more security and a better environment. Also we know that the SUS privacy is less, has less privacy.

*As vezes a gente atende paciente que se apresentam masculinizadas, não é, então, eu atendo pacientes que tem a cabeça raspada, usa uma roupa masculina, um correntão aqui, um boné, você olha, não quer dizer que ela seja lésbica, por que ela é uma mulher masculinizada, dessa froma, já me chama atenção e eu pergunto, ' como é sua atividade sexual atualmente, vc tem relação sexual?', eu tento né, mas no SUS é muito menos frequente alguém se apresentar dessa forma ou informar que tem relação com mulher do que aqui no consultório. eu atendo muito mais paciente do SUS, claro né, que o volume é maior, no ambulatório do SUS eu atendo 20 pacientes, aqui eu atendo 10 então... agora é muito mais frequente essa informação ser no consultório do que no SUS. Por que vc vai descobrir, né. Se é mais frequente mesmo entre as mulheres de um nível social maior, ou se elas se sentem mais a vontade, maior segurança e um ambiente melhor. Também a gente sabe que no SUS a privacidade é menor, tem menos privacidade.*
This is a response to my questions about how he approaches women who may be lesbians but have not identified as such. I had not asked about women who present with masculine gendered features (clothing or otherwise). It is noteworthy to see how he described patients whom he might suspect as women who have sex with women. Given that Jandira presents as masculine to most people, she might fall under this gaze by physicians as well. Dr. Manuel conveys to me that he chooses words carefully and broadly to elicit the sexuality, that is, the gender of the sexual partners, of such patients. Given that Dr. Manuel is a sexologist as well, he has particular interests in using these broad approaches. Furthermore, Dr. Manuel makes the suggestion that more women reveal their sexuality in the private setting than in the public clinics of SUS. He also holds that speaking about your sexuality is a private issue. According to him, there is less privacy in SUS, and that therefore, it does not offer a suitable environment for revealing your homosexuality. In chapter 1, I briefly discussed some of my experiences in SUS’s clinic in Salvador. Now, however, I want to point out that women such as Jandira and Barbara are up against many variables when negotiating the ways in which they want to be legitimized by their gynecologists. One variable is precisely this perception by gynecologists of homosexuality as somehow “more private” than other forms of sexuality.

Here is another significant excerpt of Dr. Manuel’s interview touching on the intertwined issues of race, racism, and inequality.

You see, my tendency is to see the issue of race here in Salvador mainly related more to social inequality, right, clearly there is a race issue even for many people right, we see that. I’ve already worked at public hospitals, as an obstetrician then I saw patients who presented best dressed or white patients are better addressed not only by doctors but by everyone like the nursing assistant and so treated much differently. I saw it clearly, understood, I think there is this issue. Now, I think that actually, it is still more the issue of social inequality. Black women have less access to health insurance than white
women, it is not because she is black, the health plan does not deny them because she is black, because how they are financially disadvantaged reflects in the end, sometimes I think that certain things get mixed up and it seems like it is because of racism but it is lack of access. Black women earn less than white women if you see that 80% of black women have no level of higher education and 80% of white women have, so then... its not because to be black you then earn less, there no black bank manager who earn less than a white bank manager. You dont have black doctor who has the same job and earn less, no, the question is not about being black or white here, is about why you have greater difficulty in accessing education and those jobs, right, that comes with better level of education etc. but then I think there is some mixture of these things here, it is not always the issue of race is often a social, but then you can say, social reflects the racial, reflects because the Brazilian came out of slavery and was never [slavery] incorporated, that story is well known right there ... then this issue was perpetuated, but poor whites suffers as much as poor blacks.. they go to the same SUS and have the same story, have the same jobs with low salary, right, then ... I do not think this issue is much, at least here in Bahia in Salvador, the black population is very large, you go south of the country that there is another reality might be different.

Veja bem, a minha tendência é ver a questão da raça aqui em Salvador principalmente, mais ligada a desigualdade social, certo, claro que existe uma questão de raça mesmo para muitas pessoas, né, a gente ver isso. Eu já dei plantão em hospitais públicos, como obstetra então eu vi pacientes que se apresentaram mais bem vestidas ou pacientes brancas serem melhor tratadas não só pelos médicos mas, por todo mundo, a auxiliar de enfermagem e tal, de forma diferente. eu vi isso claramente, entendeu, eu acho que existe essa questão. Agora eu acho que atualmente ainda é mais a questão da desigualdade social. As mulheres negras têm menos acesso a planos de saúde do que as mulheres brancas, não é por que ela é negra, o plano de saúde não nega por que ela é negra, por que como financeiramente estão numa situação de desvantagem termina isso refletindo, as vezes eu acho que determinadas coisas se misturam e fica parecendo que o racismo é por causa, é falta de acesso. As mulheres negras ganham menos do que mulheres brancas se ver que 80% das mulheres negras não têm nível, ensino superior e que 80% das mulheres brancas tem então... não é por ser negra que ganha menos, não tem um gerente de banco negro que ganhe menos do que um gerente de banco branco. Você não tem médico negro que tem o mesmo emprego que ganhe menos, não, a questão não é porque é negro ou é branco nesse caso, é porque vc tem uma maior dificuldade de acesso a educação e aqueles empregos né, que vêm com melhor nível de educação etc. Mas, então, eu acho que existe um pouco de mistura nessas coisas aí, nem sempre é a questão racial muitas vezes é a social, mas aí você pode dizer, o social reflete o racial, reflete, porque o brasileiro saiu da escravidão e nunca foi incorporado, essa história aí é bem conhecida né... então se perpetuou essa questão, mas os brancos pobres sofrem tanto como os negros pobres eles vão para a mesma fila do SUS, tem a mesma história, tem os mesmos empregos com baixo salário né, então... não acho que essa questão seja muito, pelo menos aqui na Bahia, em Salvador, que a população negra é muito grande, você vai para o sul do país isso aí é outra realidade talvez seja diferente.
Dr. Manuel is not the only physician I interviewed with such perspectives on race and racism in relationship to access to quality health care or higher social class. The contradictions that his arguments about the primacy of class raise for me spring from the differential treatment of that substantial segment of light and white Brazilians who also share a lower class status with black and brown folk. Whether poverty and social inequities in Brazil ought to be attributed to primarily class or racial discrimination has been the focus of debate between many Brazilian and U.S. Scholars. However, Dr. Manuel, a white male gynecological surgeon, witnessed by his own account white Brazilian patients being treated more favorably by other physicians, not only due to their sartorial choices but because of their skin color, when compared to black female patients. It is difficult to reconcile this fact with his argument that black women (dressed “nicely” or not) are not discriminated against on the basis of their skin color or putative race. Erica (discussed in chapter 1) attends a quite distinctive (private) college in Salvador. She often said that UFBA’s free federal education sets standards too high for admissions. As a result, mostly light and white students attend state colleges for free, while more black and brown students must attend colleges for which they must pay tuition. Therefore, there are fewer black and brown students in college because either they are not admitted into UFBA or cannot afford the private colleges. On the one hand, Dr. Manuel recognizes that many black women are at a disadvantage in many ways. On the other hand, his lack of recognition of how systemic racism functions must be understood as furthering the continued reproduction of that systemic violence through uneven and distorted colorblind practices and beliefs. One only needs to think back to Natalicia’s experiences of
workplace prejudice earlier in this chapter, though these are by no means unique, to be reminded of this discrimination on the basis of skin color and gender presentation.

**Beyond the window: Jandira and family on Good Friday**

It was valuable to spend time with Jandira in various situations ranging from hanging out drinking beer with her partner or friends, or alone, or in her terreiro. However, perhaps the most important event for my purposes here was seeing her among her family on Good Friday. On March 29th, 2013, I rode the bus toward north of Salvador to her sister’s home where all of her family was gathering. I had received invitations to join other friends and their family, but chose Jandira’s family because I wanted to rekindle a relationship with two of her sisters whom I had known since 2007 (one of whom had recently suffered a large cerebral stroke). Also, I had not yet met her mother, and I was curious. As does Barbara, Jandira plays a significant role in taking care of her mother and siblings. Her family values are strong; though Jandira does not have any children, she is very close to her two-year niece, Abayome. Jandira has four sisters and a recently deceased brother. She is next to the youngest in age. Two of her sisters are also initiated members of her terreiro, thus being both blood sisters and initiated sisters in Candomblé (*irma de santos*). One of her blood sisters was diagnosed and treated for breast cancer in 2011. She is now cancer free and, of course, all sisters must get yearly mammograms. As I have mentioned, another sister suffered a cerebral stroke. When the family is challenged with health and social issues, Jandira acts as a *guerrera* on behalf of her family, according to friends who know her well. Jandira even shared with me how she aggressively confronted her father during her younger days when he was abusive toward her mother. These family dynamics are salient for our understanding of her as a *lésbica negra* and ethical subject.
After arriving in Itinga, a barrio in Laura de Freitas (a municipality next to Salvador), Jandira met me at a bus stop. When we arrived at her sister’s house, everyone was sitting in front of the house drinking beer, listening to music, and chatting. The beers flowed all day and night. Good Friday was treated like a holiday in Bahia. Banks and most businesses were closed; the bus schedule was limited. It is a Catholic holiday, and accordingly, fish was the main protein for the day in most homes. At Jandira’s family feast, fish was being served in two different ways: baked with bacalau (cod fish) and moqueca (fish stew). The other dishes included rice, vatapa, caruru, and stewed black eye peas. The intimate familial conversations and negotiations regarding household work such as cooking and cleaning were in themselves a valuable source of ethnographic detail; they allowed me to hear and see a side of my interlocutors that I might not have, otherwise, such as Jandira telling me on Good Friday that “she does not like doing domestic work like washing dishes but will do it anyway for her family.” While many women detest doing domestic work, Jandira’s family has history of domestic work in homes as a living. In 2007, her youngest sister told me that she was sent at a young age to perform domestic work and experienced significant violence by employers. Such social wounds too often
plague black families in Brazil and only a cohesive way of healing as a family promotes well-being, individually and collectively.

In any event, I felt welcomed and happy to be around her family. Her mother, seventy-four years old, was a tall, dark skinned woman who looked remarkably good and strong for her age. I noticed that she was wearing a t-shirt that said, “Diga nao a homofobia, Respeita as diferencias!” (Say No To Homophobia, Respect Differences). Jandira confided in me that she had “put it on” her mother. However, her mother did not wear the shirt on her way home, but instead changed into a grey blouse – which was understandable, as she was taking the bus home alone very late at night. Since Jandira did not voluntarily tell me why she put that t-shirt on her mother, I assumed that it was an affirmation of and welcoming gesture toward my visit and research. After all, it was Jesus and Oxala day, not the National Antihomophobia Day. I immediately photographed them. This seemingly incidental moment from my fieldwork stuck with me; as an ethnographer, I appreciate the interactive ways in which my interlocutors convey the significance of their lives, the details through which they construct their narratives, and the material ways in which they strive in facilitating their own social well-being. What is most significant for me in this story is that Jandira values being valued, and that such affirmations promote well-being at all levels, even when the self or family is challenged by health issues. The vulnerabilities and strengths within their lives, including those of their families, influence lésbicas negras’ pursuit of well-being as a human right.

**Collective Ethical Voices**

Many lesbian couples organize themselves around same-sex family ties in ways that foster belonging (Weston 1991; Moore 2011). I assert that such formations
of communal or collective belonging ensure well-being at the individual level and play a key role in ethical subject formation. In other words, the ways in which some *lésbicas negras* organize themselves as couples, mothers, biological sisters, Candomblé sisters and daughters, or simply friends can be understood as creating the enabling conditions for their pursuing social well-being. In this section, I window into the narratives of other key ethical subjects in this study that are connected to Jandira, such as her partner (Isabelle) and two Candomblé sisters (Mirela and Lindinalva). These women identify as *lésbicas negras* and have profound narratives regarding their experiences with gynecologists and their efforts to be recognized as ethical subjects. Though I have previously discussed these women, here I connect them as ethical voices, collectively, in their pursuit for social well-being.

Image 21: Photo by me of Isabelle: After the long walk together at the beach, November 2012

*At the window: Isabelle*

Isabelle Santana Perreira has been Jandira’s partner for over eight. The time spent with Isabelle was one of my most illuminating yet challenging experiences. One the one hand, I learned a lot about her perspectives on cultivating social well-being as
a black woman in Salvador. She was very outspoken in her opinions about injustices. She also was very sensitive to various human issues of life, which I got to know first hand. Such moments were illuminating, and as an ethnographer and friend, I did my best to balance listening to and observing her and other women. However, since their sexuality is central to my inquiry, same-sex couples obviously offered particular forms of insight into the construction of ethical sexual subjects. Following lesbian couples such as Jandira and Isabelle (and Erica and Thelma, as we will see in chapter 5) in particular allowed me to witness what might be regarded as forms of gender transgressions (Blackwood 2000) that inform their ethical subjectivity. In other words, these women were the clearest example in my fieldwork of female bodies who strove to balance their racial identities as black women first, and only then as black lesbians. I gained much more insight about their understanding of affirmation by sharing their spaces and reflecting on what was valuable to them as black lesbians. However, it was through my personal discomfort in balancing the dynamics among the couples and circles of friends that I spent time with that I learned to identify what I have come to understand as ethical subject formation and the enabling conditions that allow for pursuit of well-being as human right.

Unlike with Barbara and Jandira, I had spent a lot of time with Isabelle before we sat down for an audio-recorded interview at my place. By the time I interviewed her in March 2013, we already enjoyed many times together the beach, dancing, drinking caipirinhas at the local bars in Dois de Julho, celebrating her birthday in November 2012 (where I met her mother and siblings), drinking lots of coffee at my place and talking privately. She had even introduced me to her darling 15 year-old son, and invited me to visit her terreiro, where I saw her in her orixá, Oxum’s, clothing, under a trance. For our semi-structured interview, I had established a unique
relationship for our generative interview. For over an hour and a half in the evening, we sat at the window, looking over the bay and the evening lights over the boats reflecting across the still bay water, Itaparica Island in the distance, and the lower dark city. I generally scheduled interviews at the most convenient times for my interviewees. Though they often ran until quite late, the interviews conducted by the window rarely felt tiring. I believe the energy of these interviews was the result of these women’s interest in sharing their self-reflections and the experiences of discussing their quotidian lives.

One example of an illuminating interview moment was Isabelle’s drawing (literally) of how she perceived the relationship between sexuality and sexual health (saúde sexual). During our conversation, she picked up a pencil and began drawing a square and some arrows on my notebook. For Isabelle, sexuality was the square (walls and inner space) and sexual health was the pencil that drew the square.

NF: And sexual health and sexuality, what is the connection between the two?

IS: Sexual health is as if it were a brush, so to speak, and sexuality framework. I am the artist, say (She begins to draw)

NF: Ah, brush! Understand!

IS: So I spoke to handle. Then information help paint. Sexuality is my vital energy, and that sexual health is an instrument, perhaps

NF: Why does she care?

IS: Because it makes me able to take care of my sexuality. It makes me able to ... her understanding, access to information about it, makes me take care of my sexuality, my ... Then I'll have to think about this brush there.

NF: E saúde sexual e sexualidade, qual é a conexão entre as duas?

IS: A saúde sexual é como se ela fosse um pincel, digamos assim, e a sexualidade o quadro. Eu sou o artistas, digamos /

NF: Ah, pincel! Entendi!
**IS: Por isso que eu falava de manejar. Aí informações ajudam a pintar. A sexualidade é a minha energia vital, e essa saúde sexual é um instrumento, talvez**

**NF: Por que ela cuida?**

**IS: Porque ela me faz capaz de cuidar da minha sexualidade. Ela me faz capaz de... o entendimento dela, o acesso a informações sobre ela, me faz cuidar da minha sexualidade, de minha... Depois eu vou ter que pensar sobre esse pincel aí.**

Her illustration was unique and creative. In fact, it was on one level very intuitive, particularly in Isabelle’s reference to the pencil as an instrument representing *saúde sexual*. If *saúde sexual* were a pencil, it would draw one’s sexuality in terms of malleable features. In this drawing, she understands her sexuality as needing care; sexual health helps to take care of her sexuality. However, Isabelle is not speaking of just the prevention of STD’s or other medical problems. She refers to the social conditions that give meaning to sexuality through a variety of social meanings driving sexual health. Hence, sexual health as an instrument that shapes sexuality. She says above that “information helps paint and guide our sexuality.”

**IS: So, I heared more about sexuality when I first came in contact with feminism. Not before. Before we’d hear of sex education in school, but it was very attached to sexually transmitted diseases. You [feel like] you were working with the idea of health through a negative approach. If you talk about [sexual] health, you’d talk about illness… Why is everything so determined from the outside into the inside?.. You’re told: "Do not do it, do it. Who does this and this and this happens. Has such and such diseases.” Like that everything distant [from sexuality]. When I are put in the spot to talk [about sexuality] in that this aspect, folks are not prepared. I think sexual health needs more policy intervention, so to speak, to help understand [the issues]…**

**NF: But to understand what, information or something else?**

**IS: To understand, to manage all the information, I think. And to bring it closer to yourself and monitor your health. Because health seems.. so too, it seems that is comprimised, you take. As prevention is always one that says, "Do not do this and that." So what I do now, but then I may not be aware how this has to do with things like stress, for example. So thus my sexual health if I'm immersed in the world of stress, I'm not taking care of my sexual health. When I say political aspect, political aspect is to help people live better, to think like an independent woman. Because well, everything that is related to body, women always seem disconnected from their lives. As this body has**
always been handled by another, a man, a doctor, a lawyer ... I mean, A man: your father. A man: her husband. A man: the doctor. Another man, and then you decide to separate from your husband, another man lawyer, man judge. So sexual health for me is always connected to the possibility of acquiring subjective, emotional, financial independence and that is what I call politics. When I talked about politics, this is something to think about.


NF: Mas para entender as informações determinadas ou para entender outra coisa?

IS: Para entender, para manear essas informações, eu acho. E para trazer para perto de você mesmo e monitorar a sua saúde. Porque saúde parece também assim, parece que é comprimido, você toma. Como é sempre uma prevenção que fala: “Não faça isso e isso”. Assim, eu faço aquilo nesse momento, mas eu não estou atenta como isso tem a ver com aspectos como estresse, por exemplo. Então assim, minha saúde sexual se eu estou imersa no universo do estresse, eu não estou cuidando da minha saúde sexual. Quando eu digo aspecto político, é aspecto político que ajude a gente a viver melhor, a se pensar como uma mulher autônoma. Porque assim, tudo que é relacionado a corpo, para as mulheres sempre me parece desconectado da vida delas. Como esse corpo sempre foi manejado por outro, um homem, um médico, um advogado... Quer dizer, um homem: o pai. Um homem: o marido. Um homem: o médico. Um homem, e aí você decide se separar: o advogado, o juiz. Então saúde sexual pra mim está sempre muito ligada à possibilidade de adquirir autonomia subjetiva, afetiva, financeira e é isso que eu chamo de política. Quando eu falei de política, é essa coisa de se pensar.

Isabelle’s explanations of sexual health as more than biological health outcomes such as STD’s exemplifies what most of my key interlocutors describe as sexual health being a bem-estar. This bem-estar (well-being) is not just a physical wellness related to an absence of biomedical disease. Her perspective on sexual wellbeing deviates from typical Brazilian ideas that women’s sexuality is risky and to blame if afflicted with STD or reproductive cancer (Gregg 2003). As discussed in previous chapters,
Isabelle had a hysterectomy in 2011 as a result of a rare uterine-fibroid tumor. She always makes reference to her gynecological experiences in relation to the fear that she felt at the time of discovering that tumor, before she discovered that it was benign post-surgery. Still, Isabelle interprets the importance of managing and understanding the sexual self as a woman, a black gay woman in particular, through the social conditions that shape such markers of identity. When she says, “So sexual health for me is always connected to the possibility of acquiring subjective, emotional, financial independence and that is what I call politics. When I talked about politics, this is something to think about.” She refers to the importance of understanding how, as a woman, the possibilities for affirmation and legitimation in her social setting are dependent upon the realization of the socio-political effects upon her bem-estar.

Here, she speaks more specifically about self-identifying as a lesbian with the gynecologist:

IS: I think the biggest difficulty is to institutionalize it [how to treat a lesbian], so I think it would mean to institutionalize a humanized practice. So well, I guess the first thing is to create tools that these women [doctors] will have to use. I never think it’s the professional. The professionals obey the notion of a clinic, a hospital. She reproduces it. So well, I think this institution [gynecology], for example, a (ficha) that is more humane, more diverse, have to have an instrument [tool or questionnaire] for these questions. Like: "Are you a lesbian" ... I've got to think that maybe a gynecological care for adolescents should always be given alongside psychological care. But I think the training from the university [medical school] where they learn to think [medically] needs to change. In addition, a gynecologist has to have the capacity to see someone different from/than/or as her.

IS: Eu acho que a dificuldade maior é institucionalizar isso, então eu acho que seria institucionalizar uma prática humanizada. Então assim, acho que a primeira coisa é criar instrumentos que essas mulheres vão ter que usar. Eu nunca penso que é a profissional. Essa profissional obedece à noção de uma clínica, de um hospital, ela reproduz isso. Então assim, eu acho que essa instituição ela precisa ter uma ficha, por exemplo, que seja mais humana, mais diversa, tem que ter um instrumento que tenham essas perguntas. Tipo: “Você é lésbica?” ... Eu já cheguei a pensar que talvez um atendimento ginecológico para adolescentes sempre deveria vir acompanhado de um atendimento psicológico mais associado. Mas acho que uma formação diferenciada desde a universidade onde se pense já mudaria. Então uma
I interpret her here as specifying that women ought to create the “instruments” by which they negotiate their humanity and well-being even in settings such as the gynecological clinic. The institutionalization of such instruments refers to imagining sexual health as a socio-political instrument that reminds women, their gynecologists, and even the institutions that train the doctors about the factors that lead to recognizing and engaging sexuality as part of a transparent and non-threatening social interaction between the patient and gynecologist.

In recognizing herself as an ethical subject, Isabelle recognizes not just how preconceito looks and feels, but its implications for her more global well-being. In other words, if a gynecologist cannot affirm within the social and medical bounds of the consultation the humanity of all sexualities, then their overly narrow biomedical interpretations of sexual health are experienced as traumatic both in the gynecologist’s office and beyond.

Collective Moments

It was beneficial to spend individual time with my key interlocutors. At times, it was methodologically necessary, especially when dealing with couples and close friends. Too often I was implicitly reminded how private it was to talk about gynecological and sexual experiences. Though my key interlocutors abundantly shared their reflections on their personal experiences with the gynecologists, it was often challenging to get women as a group to discuss such issues. It was a reminder for me that many women (maybe most women) do not share stories about their gynecologist unless they are “shopping around” for one. Most of the time, social gatherings of three or more women were important opportunities to appreciate how
they reinforced or formed bonds as gay women with their friends, lovers, and family. However, whenever I spent time with couples such as Jandira and Isabelle or Erica and Thelma, I could access their individual reflections as well as learning how they leaned on each other for support (emotional and social) when discussing uncomfortable experiences. In this section, I will share some ethnographic moments that nicely demonstrate how I came to appreciate particular forms of ethical subjectivity that emerge when among friends, lovers, or religious sisters of Candomblé. Here, I window some of the dynamics between a few women, that is, ethical subjects, and the close ties they share in acquiring social well-being as openly gay women.

Image 22: November 2012 Month of Black Consciousness’s last day of festivities
I first met Mirella in Pelourinho on a Tuesday night. Tuesday nights are usually lively in Pelourinho with lots of tourists and locals, frequenting shops, bars, and generally enjoying themselves. Pelourinho is the heart of Salvador, where history, colonialism, modernism, religion, and tourism intersect. During the summer, there are free live performances outdoors and people cram the streets like sardines. Isabelle and Isabel took me to see a live performance to raise awareness about domestic violence against women. I was excited, since the performer was supposed to have been Lazaro, one of my favorite Afro-Brazilian samba singers. Lazaro did not perform, however; instead, an all female group of about twelve women performed, singing and playing instruments. Mirela met us there. I was drawn to her immediately: her personality was warm, her skin was very dark and full of glow, and she wore her hair natural, in an afro. In fact, most of my key interlocutors wore very natural hairstyles. By natural hairstyles, I mean no use of hair straightening products and hairstyles such as hair locs, afros, natural curls, or braids. It wasn’t a huge trend in
Salvador to wear natural hairstyles; on the contrary, wearing natural hairstyles was a sign of blackitude (black attitude) that meant black pride and self-love. According to my interlocutors, women often experienced negative consequences for expressing such freedom, not being accepted at their jobs or by their family members. I was among and emerged in blackitude for real…

Mirela was very close to Isabelle. Not just as friends, but as Candomblé sisters from the same terreiro, COBRE. Mirela was initiated just a few years ago and leaned on Isabelle for many reasons, including affirmation of her sexuality as a lesbian. As any trusted friend might offer, Isabelle served as a confidant, who listened to and supported Mirela through her troubles with her own family’s acceptance of her sexuality, or simply by having someone with whom to giggle about crushes and romance. They were also both mothers. Isabelle had a fifteen year-old son and Mirela had a 2 year-old son. They share much in common. I enjoyed being around them. After the dance, around one in the morning, we went out to eat in Dois de Julho. A very powerful and beloved older guerrera woman joined us. I was happy to see her. She knew me from prior travels to Salvador. She greeted me in her usual laughing manner and said, “Voce esta fazendo pesquisa das bucetas [you are doing research about pussies].” If there was any moment during fieldwork that embarrassed me most, it was then. I didn’t know what bucetas meant, but I already knew that anything this woman would say was to be taken lightheartedly. At that moment, Isabel laughed hard, then translated in my ear. I said to myself, “wow, an ethnographer of pussies… that’s a great look, I think.”

Mirela had eyes for Isabel. Indeed, Isabel was attractive. I would describe Isabel as a charismatic, flirty femme-stud. I call her a femme-stud because she and I would often talk about the clothes that she wore, which she believed confused
people about her gender and femininity. Isabel often wore a skirt or dress, but would claim those instances as “gender bending,” given her stud-like walk, tattoos, and mannerisms. Other times, she only wore baggy shorts and casual sneakers. Isabel and I conversed about many issues, from gynecologists’ behavior and sex toys to racism and Audre Lorde. Isabel was an Audre Lorde fan. She was not native to Salvador, but a transplant from Pernambuco in Recife, Northeast of Bahia, and she brought a different perspective about female same-sex sexuality as an outsider. If Bahian lésbicas felt that there were many women who had sex with women in Salvador, Isabel as a Pernabucan tested that notion, and she was happy to share her insights with me. Unfortunately, there were not any designated areas in Salvador for black gay women to congregate and find each other, according to my key interlocutors. My interlocutors were not interested in the few explicitly coded social areas for LGBTT folks, such as a small strip of bars by Teatro de Castro in Barrio de Garcia. What did women do to find each other? It seemed word of mouth, or “gay radar,” or, as some of the more masculine identified females would say to me, “gosto de conquistar as meninas heterosexuais [I like to conquer the heterosexual girls.]”

One of the most memorable nights out in Salvador was the last night of Novembro Negro. It was a most beautiful night, spent with Mirela, Isabell e, and Jandira. November Negro was intended to recognize black race and racial issues during the month of November. Unlike how February is rather tepidly recognized as “black history month” in the U.S., November Negro was about awareness of racial inequities and celebrating racial pride at all levels from communities to the government. The month was packed with daily activities within communities, social organizations, and government agencies. On the last night, November 30th, 2012, SEPROMI (Secretaria de Promoção da Igualdade Racial) had a party that was free
and open to the public in the Santo Antonio square above Pelourinho. Erica and I went to the party. The beer was flowing, the food was abundant, and the music was jamming. I was impressed, though my cynical friend Erica believed that the government should invest that party money into the communities. Nonetheless, Erica (among others) celebrated in the spirit of *Novembro Negro*. There were few other familiar faces; I thought I would see more, and Erica shared the same sentiment.

Isabel and I had stopped in earlier in the evening at a book signing for a book titled, *Mulheres Negras: A Historia* (check title) at (location). The irony of this night was that Isabel thought that there were going to be more *feministas negras* at this book signing. As it turned out, we barely recognized anyone there; neither were there many black or brown women. Once I learned that the book was priced at a whooping (R$90[US$45]), I understood that it was clearly not going to be accessible even to many scholars and activists. Further, the editors were white Brazilians. Out of 15 writers, only three were black/brown writers. The new Vice-Prefeito Celia Sacramento made an appearance. Nonetheless, it was very likely that the book signing ultimately appeared as a *contradiction* to what many hold *Novembro Negro* to represent: access and representation.

I was happy to be at *Novembro Negro*’s closing party, given how the book signing turned out for me. I was, however, waiting for Isabel to call me on my cell phone. It was Isabelle’s birthday that day. She had invited me, through Isabel, to come to her impromptu celebration in (location). It was far from where we were but we were going to be picked up by another friend in her car. I was really thrilled! The thought of spending time with Isabelle, her family, friends and Jandira for her birthday just seemed like a fascinating way to enter into her life. I felt welcomed, which made all of the difference. I could write for pages about this night. It was just
one night of many that I cannot fully capture in this dissertation, but it was the first
night that I understood these women not just as *individual* ethical subjects who
appeared at the gynecologist’s office and negotiated affirmation of their sexuality.
There was something profound about appreciating these women *collectively*. This was
an ethical understanding that I continued to look for throughout the rest of my
fieldwork, which culminated in the film production, with Mirela, Isabelle, and Jandira
in the film.

When I arrived, Isabelle was wearing a white dress and a big smile. I met her
mother, younger sister with her one-year-old daughter, and her two brothers. One
brother was visiting from Italy, where he works and lives now. Isabelle told me that
their father died a few years ago as she showed me his *maracas*, one of the Afro-
samba musical instruments that belonged to him. Jandira was dressed in white shorts
and loose white shirt. I was happy to see Jandira. They had recently separated and
managing the boundaries between Isabelle and Jandira often felt challenging for me,
as it could with other couples. Over time, however, I grew to trust that Isabelle and
Jandira were comfortable with how I spent time with them individually. I would
manage my relationship as a researcher by keeping them abreast of the study. At the
same time, I assured them by maintaining their individual privacy regarding what they
shared with me about each other.

At the gathering, Isabel and a few others were present. In addition, Mirela was
present with a couple of other *irmas de santos* from COBRE. I was thrilled to be
among Isabelle, Jandira, Mirella, and Isabel at this intimate festive event. Sharing
their social time was important to me as I learned to build trust and community as
both an ethnographer and friend. The night was beautiful at the beach, with the
darkness of the sky kissing the ocean on one side of us. On the other side of us were
tents, or barracas, serving beer and food. A small grill charred different meats throughout the night, and the beer flowed from the barraca serving us. The samba music played from an mp3 player. The night went on from just before midnight until after four in the morning.

I appreciated this night for the ways in which social well-being was created. I refer to social well-being for how the women affirmed each other. There was a moment during the night in which I paused in awe, captivated by the energy and solidarity across the friendships. The spontaneity of the collective moment did not feel as any routine night gathering for a birthday party. Instead, I regard the “collective” as a manifestation of collective unity that produces enabling conditions for the pursuit of social well-being. This collective moment I refer to as the dance. When the dance began, it almost seemed planned though it felt spontaneous. Only the Candomblé women (about 4-5 of them including Jandira and Mirela) participated in the dance. Suddenly, these women began to play the Afro-samba instruments (agogo bells, maracas, and a drum). They began singing some secular samba songs as well as axé music (Candomblé songs). Then, I watched as one by one danced into the middle of the semicircle to samba with a combination of axé moves (orixás dances). Each woman was initiated and knew the dances of their Orixás. For example, Mirela being of Ogum incorporated some of Ogum (male orixá) dance moves into her spotlight moment. Jandira was Xangô (male orixá). Isabelle was Oxum (female orixá). They tried to pull me into the circle but it was useless. Between my shyness and feeling very inadequate about my samba moves, I was unable to even fake it for the fun of the moment. They seemed disappointed by the “ahhhhh’s” sounds at me for being a party pooper. Admittedly, the force that I felt from watching to standing in the semi-circle was too powerful to bear. For the first time, I was a sole participant observant.
For me, the *dance* was not just about how the seemingly perfection of their dance moves or how well they played the instruments. Principally, it was about the spontaneity of how they manifested social tradition that intersected communal religiosity, sisterhood, and celebration of life. The *dance* represented symbolically the idea of seeking to be recognized and legitimized as thriving black women who live to love. What I mean by “live to love” are expressed moments with loved ones that invoke the best in you. During the moments of the *dance*, each woman took a turn to dance to the rhythms chosen by whomever led and sang the first beat. Each song invited one of them to come into the middle to dance. They celebrated each person who danced because of their love for something that would be unknown the other. While it was common in Salvador (a Brazilian tradition) to samba in ways that calls attention to yourself and centers your performance of samba in front of others, this *dance* invoked the women to be sambistas through communal love of accepting their religious roots, sharing their black pride, and creating a fun moment through *dance*. 

Image 24: Photo taken by me at Isabelle’s birthday. Mirela playing an instrument for the *dance*.
Why is this dance relevant to gynecology? I argue that being an ethical subject as a lesbica negra charts courageous paths intersecting several categories of identity (Cohen 1997). Ethnographically, I window moments that depict ethical subject formation are perceived as compelling pursuits to establish social well-being. These moments should not be taken for granted. They are not everyday manifestations of social well-being as a group, the collective moment for a dance. When black women in Salvador gather and recognize each other as prideful beings because of their skin color, it is a communal response of courage. Black women in Brazil, in general, are reminded that their skin color (black and brown) is least desirable, marketable, and worthy of representing inspiration unless it is used to represent overcoming poverty, literacy, and violence, as discussed in chapter 1. As an ethnographer, I want to show that women such as Jandira, Isabelle, and Mirela become ethical subjects over time in pursuit of well-being as a human right. They are not produced by mere isolated gynecological encounters. As lésbicas negras, their understanding of what is at stake for them as black gay women is not just experiencing the afflictions of isolated violent incidents but rather an accumulation of the affects of violence, struggles, and inequities that are experienced at the core of life, everyday. I witnessed over the course of fieldwork many women (these women) rant in rage in random places and times (including the night at Lider after the show at Baco de Teresa) about the injustices they experience because they are black women or Candomblé black women. The communal lamenting against racism is prevalent in Salvador.

The vulnerabilities are enraging for many black women who want to speak out and react against them. The emotional depth of their communal lamenting is palpable when you are among them hearing them detest personal circumstances and experiences. After spending enough time with particular lésbicas negras with their
friends, family, and communities that affirm their humanity, it is stark visual to imagine them within the gynecological setting pursing and negotiating their humanity as openly gay women in a healthcare system that produces the complaints and concerns these women have brought forward. In other words, how might we envision these women’s self-advocacy and pursuit for well-being (socially, politically, physically, spiritually) in a gynecological setting that premise medical strategies upon body parts and its functions? Yet such systems participate in the social constructions of these women’s sexual subjectivities and take for granted the extent of self-pride toward their sexuality and skin color?

_Nights at COBRE_

I window into these women’s religiosities of Candomblé because they recognize the social markers of structural racism upon their religion. Many initiated women [and men] in Candomblé including the interviewed initiated _lésbicas negras_ [Ivana, Arlette, Thelma, Mirela, Jandira, Isabelle, and Marta] have told me that their religion is not only a target of religious intolerance but also racism. Many believe that the religious intolerance toward their religion is rooted in the structural racism in Brazil. The racial stigma inflicted upon the religion of Candomblé in Brazil has been studied by scholars in Brazil and U.S. There is extensive resistance that many Candomblé members exert to reject the stigmas upon them. For example, a local politician, Vereador Marcell Moraes, attempted to pass a bill that would prohibit the use of animal sacrifices in Bahia. As a result, many members of the Candomblé community organized a large protest in front of the municipal building where such bills are debated upon by local politicians. In early June 2013, a few hundred folks mostly dressed in white gathered during the early afternoon and chanted against the
Drums and other were played. Then, a significant number of Candomblé religious leaders and supporting local politician lined up at the session long table and waited their turn to speak at the podium about the significance of throwing this bill out. The recurring message was that Candomblé is a religion *do povo negro* (of black folks) and the bill was not only an insult upon the religion and its members but a racist strategy to exert religious intolerance and demise of the thriving culture of *Candomblé* in Salvador.

The socio-cultural racial formations linked to African origins of their religion and people produce for many initiated members and others who are not initiated but frequent *terreiros* an enormous sense of self-pride and worthiness as a black community. For example, the deep pride toward blackness as a socio-cultural marker
within their religion is pronounced within protests, marches, and festive events held outside of the terreiros. The synergy in the protest is just one example of how many Candomblé members enact many forms of activism, political involvement, community organizing, and other micro and macro interventions to defend and protect their traditions and eradicate the religious intolerance against them. However, there has not been much attention through research or public discourse on the micro-affects of preconceito against Candomblé members. I refer specifically to not just individual stigmatized experiences but also to how even just person-to-person experiences and effects (Goffman 1959) are viewed as social injuries to the collective.

There was a sense in which Mirela, Isabelle, Lindinalva, and Jandira honored each other as irma santos (initiated sisters) who were same-sex loving women seeking support each other’s social well-being. The possibility to create social well-being as religious women became clearer to me the more I shared their terreiro space and its social life. The social life within terreiros is starkly different compared to the dominant Christian community of Catholics and Protestants. The first time Jandira took me to COBRE (when I met Lindinalva and finally saw Isabelle since my arrival), their Mãe Santo Val was celebrating her husband’s birthday with family, friends, and initiated members. Mãe Santo Val’s home was above the sacred sanctuary where the festas took place. My first visit to COBRE was actually in 2008 with Prof. Traci West. We were taken there to witness a burial ceremony of an elder of a terreiro. I remember getting on an empty city bus with other COBRE members and riding down to one of the beaches in Barrio de Rio Vermelho where the deity Imenja was recognized for her dominion of the ocean. It is traditional for many terreiros to send off reefs of flowers into the ocean when an initiated member dies.
Thus, when I return to COBRE with Jandira, I remembered the sanctuary. It is common, if not customary, for Mãe Santos and Pae Santos to live on the premises of their terreiros. When I returned to COBRE for several festas and social events, then realized that the sacred and profane constituted the social well-being of their religiosity. I visited COBRE for festas of Xangô, the coming out of a new initiated member as Oxum, and even Mãe Val’s Orixá festa. The details of these beautifully dressed women, the music, and food are details beyond this dissertation. My attending these festas was important in establishing appreciation for the women’s lives. They spent a lot of time in their terreiros throughout the year preparing for the festas, or other duties to the house. Their membership is indeed labor intensive. I recognized that while the festas were open to the public and my presence was read as the blessing of the orixás, their invitations were also about recognizing them as women who work and transform (via trance, clothing, etc) for their orixá. There were times when my absence generated some disappointment from them.

I really appreciated when I was more involved in their religious community at COBRE, particularly at the social events. At COBRE, I did get to see Lazaro perform and others as well at their fundraising night for which I paid R$70. However, the party for São João (Saint John) was the night that connected me most the collective dance during Isabelle’s birthday party. São João in Salvador is a festive holiday period with lots of special flavored liquors, steamed peanuts, and holiday cakes and desserts sold and consumed everywhere. The city, especially Pelhorinho, was decorated with street ornaments and pictures of Sao Joao and other saints such as Saint Peter and Saint Anthony. COBRE participated elaborately for São João on June 23 and 24. For the evening, the women wore tailored dresses made of the same fabric; the men were required the same for their shirts. The women wore pink plaid. Men
wore yellow plaid. I had a cute dress made as well for R$30 and wore boots in 80 degree weather, which was part of the dress code for Sao Joao. I was thrilled! I arrived to COBRE early and walked into Mãe Val and others praying to Santo Antonio. Shortly after, season cakes and liquors were arranged for self-serving. The night was long with lots of music, beer, liquor, and rodeo dancing.

Image 27: Left: Jandira, Right: Me at COBRE on night of São João

The magic began at 5am. Just when I thought with sleepy eyes that the night was ending, Mãe Val and others including Jandira gathered everyone there to head outside. Then, a few more men arrived with different instruments. Indeed another party different party took place. Everyone that was still there (about 30 people) walked the streets about a quarter of a mile away from the terreiro, singing, chanting, drinking some liquor, dancing, and giggling. Even an initiated elder member of 86 years old hung with us, widely awake, until it all ended at 6:30a.m. By the time I was driven home, it was fully daylight. I refer to this night as magic because of that communal social-cultural dimension of religious tradition for COBRE that manifested late into the night.
This event is one example of how their Candomblé religion contextualized for me the collective dance at Isabelle’s birthday celebration. In many ways, that collective dance was a micro-scale reproduction of how they embody and value their terreiro traditions and its social-cultural manifestations. It is common for Brazilians to perform create samba music in the street as part of having a good time. However, I argue that these women’s claiming of space and time through the social-cultural dimensions of their religion is an enabling condition by which to forge social well-being. In other words, I further argue that to understand some lésbicas negras as ethical subjects, their racialized sexual subjectivities must be interpreted through the accumulation of social well-being that affirms them as proud and communally loving black women. As black lesbians, these social well-being reproductions are saliently valuable to their individual thriving. As individuals, they thrive upon the collective
social well-being acquisition because as black women, they recognize the hardships
overcomed or to overcome.

I intended to spend some time viewing my interlocutors’ Candomblé festas for
two main reasons. First, Isabelle was consistent since our initial interview in 2011 in
referring to her sexuality as her vital energy (minha energia vital). It was important to
me to witness my key interlocutors within their religious space and learn more about
their communal relationships as openly gay women in Candomblé. For many same-
sex loving women or lesbians in Candomblé, it is not easy to feel comfortable as
openly gay women (Allen 2012). Yet, Isabelle as I have described makes a strong
connection to the importance of caring for her sexuality as in nurturing her energia
vital. Such sexual care has a direct association with caring for her relationship with
her orixá. Similarly to Jandira beliefs, caring for your sexuality is caring for your
body.

Second, when I interviewed Jandira in 2013, she said,

JS: When you touch someone’s body, if someone touches my body, is like
touching [connecting] my spirituality. I’m not alone [in the space with my
body]. Within me is my spirituality. So if you are violent to me, my
spirituality is also being violated. So when I respect a person, I respect her
spirituality too, regardless of what she [or I] believes. I like doing it
[respecting other’s bodies], I have practiced that a lot. I have learned so much.
I cannot invade the body of another without their permission, without a
dialogue on how I may access your body and your spirituality. So that, to me,
is sacred. So when I talk about our humanity, then any professional needs to
treat others as human in that way.

JS: Quando você toca o corpo de alguém, pra mim, se alguém toca em meu
corpo está tocando na minha espiritualidade. Eu não sou sozinha. Esta em
mim a minha espiritualidade. Então se você me violenta, eu to sendo
violentada também na minha espiritualidade. Então quando eu respeito uma
pessoa, eu respeito ela também na sua espiritualidade, independente do que
ele acredite. Eu gosto de fazer isso, eu tenho praticado muito isso. Tenho
aprendido muito isso. Eu não posso invadir o corpo de ninguém sem que o
outro permita, sem que haja um diálogo de como eu acessar o seu corpo e sua
espiritualidade. Então isso, pra mim, é sagrado. Então quando eu falo de
respeito à humanidade, é ser tratada por qualquer profissional como esse ser
que precisa ser tratado como humano.
Here I window Jandira’s concerns between her spirituality and the touching of her body even by a gynecologist. There is very little distinction between touching her body and the touching of her spirituality as in touching both her body and spirituality is touching her humanity. Jandira and other have told me that there is little connection, if at all, between spirituality and her religion. In other words, spirituality is constantly present within them outside the terreiro. The terreiro is merely a place by which their orixá is honored in various ways. However, the caring of their orixá, which principally governs the stability of their head, is an ongoing process outside of the terreiro. One key way to care for their orixá is by taking care of your body and mind. This is for them bem-estar (well-being) that are both physical and social.

Jandira’s response is significant in imaging her ethical subject formation as a lesbica negra. She does not separate her bem-estar from social and physical wellness. Racial formations that reinforce self-pride contribute to bem-estar. When Dra. Morales sharing with me in March 2013 that many of her colleagues have a lot of preconceito toward Candomblé female patients and often fear touching them, it was crucial for me to understand any connection between pursuing recognition of their sexuality as lesbians in the gynecological consultation and their pursuit for social well-being. One main connection is that the enabling condition by which they chart social well-being is a collective response, or know-how, to resisting racial and sexual injustice. Thus their black pride sustains their daily ambitions and transcends their struggles as well.

Collective Ethical Voices: The Film
The film footage is a compelling window in this research that materializes opportunities to convey the enabling conditions that forge their concerns as ethical subjects. Jandira, Isabelle, and Mirela were strong voices. They shared their perspectives on film in spite of (or because of) their deeper and sensitive circumstances. It is an understatement how much I appreciate their time and willingness to participate in the film. At the same time, their willingness is my opinion is part of their ethical subject formations as lésbicas negras. The interview scenes created were arranged to highlight areas of their lives relevant to their ethical subject formation as lésbicas negras. I interviewed Jandira alone and with her Mãe Santo, her blood and Candomblé sister, and with Isabelle. However, it was important to bring Jandira and Isabelle in conversation with Mirela because of the transformation that Mirela was undergoing as an open lesbian and mother.

One evening on July 21, 2013 with pizza, salad, and wine at Isabelle’s place, we filmed a short interview of Jandira and Isabelle followed by another table discussion with Jandira, Isabelle, and Mirela. Jandira was scheduled to have a hysterectomy in August 2013. They talked about how Isabelle was part of her support system as her partner and as having experienced the same surgery. To my surprise, Isabelle suddenly began to cry. I had never seen her cry and it was startling that she did it while the camera was rolling. I asked her if she wanted to stop but she refused. The moment that brought tears was during their discussion about the wonderful women who support them as a couple, which include their biological families and their Candomblé families, Mãe Val in particular. One of the take away messages from their film interview was their reliance as openly gay women in their terreiros. Their love and relationship struggles as a couple were dependent upon the strength of their spirituality and communal acceptance of their religious leaders and sisters. However,
Jandira and Isabelle were notorious for speaking out against homophobia in their terreiros, which was not a common thing. Therefore, the vulnerability of their relationship drew upon healthy bem-estar (social well-being) because they recognized with high regard that their social identities (black, woman, lesbian, Candomblé) played a significant role in establishing well-being as a human right. The loved ones who supported and nurtured them as a lesbian couple mattered as much as their sexuality mattered to them.

Isabelle and Mirela are lesbian mothers. They were the only key interlocutors who had children. As mothers, they always talked about their sons. Each had one son. Isabelle had a fifteen year-old teenage son. His father was active in his life and initiated in Candomblé at COBRE. I met him a few times. Mirela had a 2 year-old son. I visited Mirela’s home where she lived with her mother and niece to attend her son’s birthday party. Mirela had struggles with her mother accepting her sexuality. It was compelling to hear and witness Mirela transform over months into claiming her outness with her mother and family. Her mother was an initiated member of COBRE as well. Her mother was fond of Jandira and Isabelle but struggled with Mirela’s homosexuality. In the middle of these struggles were family questions about Mirela caring for her son.
By the time this film interview took place, Mirela was reporting that her mother was slowly embracing her sexuality and Diana, her new girlfriend. I remember when I first met Diana. Isabelle, Mirela and I went out to the Museum of Modern Art for live music performance. Mirela was glowing with sparkly eyes. Then she told me that someone was going to meet us. As she told me about her new romance, I felt palpitations for her. I was really happy for her. Most of all, I could see that nothing would stand between her and seeking love other than her son. While she did not want her family to manipulate her motherhood at the expense of her seeking an open love life that included her son, she still straddled these struggles across managing her family and her coming out process. When I interviewed Mirela in March, this discussion brought tears to her eyes. It was refreshing to see her with Diana as lovebirds as she claimed experiencing romance.

During the film interview, Isabelle, Mirela, and Jandira focused on being mothers and the related struggles as gay women. They also shared the rewards of being mothers and their sons having two mothers (their partner). The compelling
message that came across this film interview was that their sons would learn to not be homophobic and grow stronger in respecting women and the humanity of others. Furthermore, the film project offers a window into these lésbicas negras striving for their humanity to be recognized through their sentiments and deep concerns for claiming space as openly gay women. I believe that Mirela was able to take greater pride in participating in the film and sharing her voice to what was intended to a film to be viewed by many and anyone because she was in conversation with her trusted community – Jandira and Isabelle. While the collective support for well-being as friends and Candomblé sisters can happen any place and time, the film interview offered a different space. A collective way of being recognized for their humanity as lésbicas negras who are mothers and thriving citizens, particularly as medical consumers.

What is racialized sexual subjectivity if not the ways in which understandings of racial and sexual identities inform how they [lésbicas negras] chart their lives within these realms of social processes. One of the moments that heightened for me the extent of blackitude as a subjective issue took place in Jandira’s film interview with her Mãe Santo India. It was important to interview Jandira with her Mãe Santo because she was very proud that her Mãe Santo affirmed her sexuality. Jandira was very committed to her terreiro, Terreiro do Bogum. When we filmed Jandira with her Mãe Santo about the importance of affirming her sexuality and of nurturing her spirituality in preparation for her surgery, I was pleasantly surprised to hear that her Mãe Santo shared on camera that she had a hysterectomy as well over 5 years ago for fibroids. Her Mãe Santo shared this personal information as a way to convey that “as black women we must work harder to take care of ourselves given how society rejects us.” It was compelling that she was willing to be interviewed for the film with her
lesbian *filha de santo*. She led Terreiro do Bogum, a historic terreiro among the most historic terreiros in Salvador, founded in the late 1800’s. Thus, their nurtured relationship between them was evident during film process.

When I asked Mãe Santo India what does it mean to be a black woman in Salvador, she responded by saying, “that is based on whether you first assume yourself as a Black (assumer-se Negra).” This was a very provocative statement for the film and research from her. As a black woman herself, she suggested that many black women negate the social and historical blackness that the color of their skin represents in Salvador. Here, she further suggests that black women ought to want to be recognized as black women who are proud of their skin color and place in history as descendants of Africa.

Blackness as a process of racial formation undergirds *lésbicas negras* as ethical subjects in the gynecological setting because when they assume themselves as lesbians, they disrupt the racial boundaries that place them within an inferior social place by white physicians. Most of my gynecologist interlocutors have stated that black women are more often treated inferiorly than white female patients. While exuuality is at the forefront of these women’s narratives about interacting with the gynecologists as lesbians, as ethical subjects, the humanity they seek to be recognized is not just as lesbians but as black lesbians with human right to quality gynecological consultation in multifaceted way.

**Scaling Social Complexities**

In *Partial Connections*, Marilyn Strathern argues for the organizing data in relevant ways that help reflect upon, or window, the dynamics of interactive patient-physician context in this research. Through her work, I can reinterpret my fieldwork
to reimagine how the social and medical are interlinked by various social categories for lésbicas negras as ethical subjects. For example, when Strathern says, “So rather than trying to prove the point with data, I shall make data with it” (2004:xxii), I envision a multi-angle shaping of ethnographic conclusions as data. It is critical to make distinctions between what constitutes similarity and difference through what is revealed to us (the issues, ideas, practices, and identities) as anthropologists. For example, this research sparks questions about female gender similarity in relation to the speculum exam. I am often questioned if my research evidences significant difference of speculum exams for heterosexual and homosexual women. Such questions remind me of the difficulties for others to visualize the invisibility yet operative sexual meanings as my primary agenda. Thus, I emphasize that the speculum exam is a social sequelae, albeit mechanical experience, within the ethical pursuits. In other words, the size of the speculum falls within the negotiation process, if discussed, and reverses the desexualization process of women’s bodies in gynecology (Henslin and Biggs 1971; Kapsalis 1997). I argue that some lésbicas negras disrupt the historical desexualization of women’s bodies during the gynecological consultation as ethical subjects. They recognize that as medical subjects, their black female bodies are sexualized (socially, historically, and politically) in extreme ways, either socially desexualized or hypersexualized through heteronormative lens. Their homosexuality pushes the limits of established medical processes that desexualize female bodies for medical purposes. Such sexual engagements evidence how powerful the social and medical are enthralled in the interaction. As black women who reinforce their racial consciousness (individually and collectively), they are particularly cognizant of their vulnerable subjectivities yet
pursue the recognition of their sexuality as a necessary enabling condition for social and physical well-being.

By scaling social complexities, I can demonstrate the ways in which social categories such as race and sexuality participate in the formation for ethical subjects. It is very complex to evidence how racialize sexual subjectivities contribute to the formation of ethical subjectivities, particularly in Brazil where skin color is the primary marker for racial identity. Many Brazilians in general independent of their skin color cannot identity with forms of black constructions and structural racism as evident by the commentaries from the white gynecologists. Nonetheless, white Brazilians will acknowledge that black people have it worse and are more vulnerable population than white Brazilians. They can even label distinguished-seeming women as diferenciada. Therefore, scaling these social complexities of race and sexuality is an intervention for this research to illuminate the ways in which such identities are stratified given the linked social conditions. On the other hand, scaling allows for viewing into social well-being as a human right for these women. As a result, we can view further the relevant social implication of assumer-se Negra. By scaling, I draw some boundaries across racial and sexual life expressions to show how such expressions are regarded as producing social well-being. More specifically, lésbicas negras as ethical subjects engage in assumer-se Negra practices through activism, religion, community involvement, natural hair coding, and/or strong beliefs in themselves as black historical subjects. The pursuit for recognition by I negras as ethical subject is predicated upon the ethical pursuit of assumer-se I. The ways in which they see themselves as targets of preconceito through their different social identities, not just as lésbicas, is high suggestive of this ethical formation through racial and sexual identities. Strathern seeks to negotiate such realm of demarcations as
“scale(s)” worthy of recognizing its functions in fieldwork. Drawing upon Strathern, it is useful to scale these partial connections that represent social modes of pursuing social well-being as lésbicas negras via family, religion, friends, and through film. Windowing arranges such partial connections for me.

I apply a scaling approach to make partial connections across micro and macro social processes and not just move from small to large scales. These partial connections are important because complexities of gender, sexuality, race, and class manifested in gynecology are entangled. The social entanglements of such categories produce mechanisms that demarcate sameness and difference of all female bodies. I push the ethical boundaries to illuminate these complex entanglements as partial views into the social parts that invoke ethical subjects to negotiate their sexuality in the gynecology setting. After all, it is just a view or window that allow for the partial connections to become visible and intelligible. For example, Strathern further argues that “partiality only works as a connection: a part by itself is a whole” (2004: xxix). In other words, windowing in this research is necessary for recognizing that “partiality” is inevitably useful to visualize the anthropological meanings within the social and medical interpretation by physicians and patients. I understand Strathern’s idea of partiality to suggest the ability to recognize smaller scales in society (however presented to the ethnographer) and to tune into it for “addressing the question of unit of comparisons for examination” (2004:xxviii). For example, she challenges us to question and be keen to what we might see or identify as existing, or not. She says, “Should we not be thinking about what is implicit or explicit, or about what is hidden and what is made visible? What is then lost or hidden by moving one’s analytical position, for instance?” (2004:xxix). For Strathern, these series of questions probe into the relevance of “scaling” or what she refers to as “writing about relations through
partition, through cutting out obvious connecting material” (2004:xxix) For Strathern, writing anthropology is not fragmenting but making the unrecognizable recognizable partitioning that tells a broader or deeper story through what might otherwise be dismissed or regarded as meaningless.

Another dimension to the function of partiality for Strathern is the importance of understanding and accounting for complexity through recognition. She says,

“Complexity is intrinsic to both the ethnographic and comparative enterprise. Anthropologists are concerned to demonstrate the social and cultural entailments of phenomena, though they must in the demonstration simplify the complexity enough to make it visible. What appears to be the object of description – demonstrating complex linkages between elements – also makes description less easy” (2004:xiii).

Strathern’s perspective about the “ways to access description of complexity” will not guarantee simplification and visibility of complex phenomena. On the other hand, I interpret her compelling argument for the “partial linkages” as a means to avoid how “logic of enumeration” (Boellstroff) can produce ineffective analytical reflections about social categories of identities. Writing anthropology via windowing is an opportunity to make visible how the ethnographer makes the partial connections via narratives, materials, and issues. How can we determine what counts as complex or can be genuinely considered to have complexity? How can we avoid diluting, misrepresenting, or misinterpreting complex issues? Differentiating complex matters is critical to apprehend a multiplicity of issues in the field. To this end, Strathern makes a significant point that, “Complexity is culturally indicated in the ordering or composition of elements that can also be apprehended from the perspective of other
orders” (2004:xv). How can an approach to ethnographic differentiation (ordering through social relations) adjust our ethnographic view of the field?

In conclusion, normative practices of gender and sexuality that shape the gynecological interaction gives us a view into a social process of “differentiation” (Strathern 2004) through heteronormative racial relations. My partial connections in this chapter are intended to grapple with the complexity of racial and sexual differentiation as scaling social complexities. Lésbicas negras as ethical subjects seek recognition as open lesbians or same-sex loving women, might undergo process of sexual differentiation through their negotiation to claim a space to feel as agents of their sexuality. As I have argued, their ethical formations taking place in quotidian encounters travel into the gynecological encounters rendering the social complexities in gynecology more visible. These sexual self-identifications might look different among other lesbians but as ethical subjects, some push the boundaries deeper by claiming their racialized sexual subjectivities as operative in their social well-being. An investigation of the social as a domain of ideas, interpretations, and practices as having capacity for being disassembled (Latour 2005) calls for strategies of analytical "partiality" (Strathern 2004). However, I draw upon the themitical as wellbeing to tease out the reproduction of the norms and values that constitute a quality gynecological encounter for intersubjective ethical subjects such as lésbicas negras.
Chapter 6
The Last Window: A Conclusion

This dissertation is a window, a partial but sweeping view, into the ethical: a domain of social processes, interactions, and scales that point to the formation and enactment of subjectivities. To create this view, I have focused upon some openly gay black women in Salvador-Bahia. These lésbicas negras share common ground in their pursuit of well-being, in their striving towards their civic right to be respected and treated with humanity, particularly by their gynecologists. This enquadramento (framing) of their experiences with gynecologists, particularly when looking to sexuality as a locus of negotiation, would not be analytically possible without drawing partial connections between disparate areas of their lives, between each other’s lives, and between their lives and the socio-political context from which they cannot but draw their ethical attitudes. In my work as a Physician Assistant in the U.S., I recognize that patients do not leave who they are and how they know themselves at the clinic door. Because of this recognition, I have argued throughout the dissertation that in order to interpret these women’s gynecological concerns, dilemmas, and visions of change, we must acknowledge that their ethical subjectivities are the product of their movement through the variety of spaces, both abstract and concrete, that make up the social.

Gynecological medicine is an analytically rich site for an investigation of the ways in which sexuality, and homosexuality in particular, is enacted and reproduced in Brazil. Through my analysis of the heteronormative practices of gynecological care, I have demonstrated how lésbicas negras express their dissatisfaction with the level of respect and welcome that they received as gay women in the gynecological clinic.
Despite this maltreatment, however, most of these women also see possibilities for change. However, such change involves social transformation at the level of both the individual and the broader society, as *preconceito* is both an embodied enactment of prejudiced attitudes as well as a structurally embedded system of inequality. Given this dual existence, one of the main objectives of this project has been to grapple with how gynecological practices, *as social phenomena*, engage humanity at its core and in its nakedness. Understood in this light, and in this setting *lésbicas negras* emerge as agents in pursuit of social well-being as a human right, engaged in constructing and engaging a particular themitical realm. This domain that I call the themtical encompasses the norms and systems of the gynecological environment that engage in gendered, classed, racialized, and sexualized modes of engaging the female body as mediated through the medical apparatus and its instrumentation.

The partial connections that are not as obvious for interpretation comprise the features of social interaction are the problematic particularities, which I hone upon through the medical narratives in the dissertation. However, this project has attempted to push the boundaries of “the ethical” as an anthropological concept by also focusing upon the telos of social well-being, understood as enabling certain practices by particular ethical subjects, which travel into the gynecological space and are operative through micro-scalar interactions both within and without the gynecological setting. I argue that the ethical is achieved here through enactments of racialized sexual subjectivity by women who regard their homosexuality as a source of vulnerability, particularly in the gynecological setting, but also productively engage vulnerability in their self-making pursuits and quotidian negotiations of social space.

Furthermore, I argue that the concept of *preconceito* is a necessary tool for both analysts and citizens of Brazil. It helps us to articulate the roots of the social
inequalities that shape discourses and practices of citizenship and social justice. I have grappled with recognizing how the strong perceptions of lésbicas negras about race and skin color impact their understandings of social well-being as a human right, using an ethnographic and analytical strategy of windowing to understand their racialized sexual subjectivity formations. This practice of windowing (both while in the field and while writing) helped me to envision the partial connections that illuminate their racialized sexual subjectivities. By windowing collected material, interviews, events, and fieldwork experiences, I have attempted to address a dilemma in presenting my empirical qualitative data: namely, how to engage in an appropriate assessment of the complex, non-normative links between my own thematic interests, my interlocutors’ concerns, and the ethnographic material at hand. Ultimately, I decided upon a strategy that focuses on issues of ethics and subjectivity as much as on issues of discourse. A “cultural analysis of discourse” (Quinn 2005) became attractive to me during fieldwork, and even more so as I began analyzing my materials and writing my dissertation, as “the best available window into cultural understandings and the way that these are negotiated by individuals” (Quinn 2005: 3). Pursuing this strategy allowed me to trace how varying discourses cross scales to shape the ethical subjectivities of my lésbicas negras interlocutors. In so doing, I have aimed to reinterpret how qualitative empirical work such as anthropological investigation can open windows onto complex ethical processes such subjectivation (Faubion 2001; Foucault 1985) as they manifest within heteronormative spaces such as the gynecological clinic.
Scaling

Scaling between the micro and macro deployment of preconceito, race, and sexuality offered me an opportunity to engage in critically building “partial connections” (Strathern 2004). This aspect of the project unfolded into an interpretation of the complexity of social dynamics through an attempt to imagine the exchange and reproduction of cultural norms and demands that cut across the specialized, gendered, medical of gynecology. This was one of my central goals for this project, as gynecological visits shape the complexities and connections that stimulate and provoke the manifestation of the inter-subjective modes of responding to the self that in turn produce properly ethical subjectivity. Although my key interlocutors’ negotiations for recognition as ethical subjects obviously emerge as such, at other times these negotiations are not so transparent. However, while such areas of blurred purpose pose a challenge, particularly as I was not able to directly witnessing the interactions between women and their gynecologists (except in Jandira’s case), the dual strategies of windowing and scaling have proven uniquely able to transform this very uncertainty into an opportunity for analysis. Scaling between micro and macro discourses, events, social processes proved to be a critical source of insight into precisely those processes that I am most interested in, that is, into those interactions in which medical subjects act as ethical subjects, as agents, intervening directly into their sexual identities, lives, and practices. Their interactions in the gynecological setting only emerge in relationships to the broader world through which they move, both as individuals and collectively with others, to their social settings and the public discourses that influence their striving as citizens seeking human rights. In these interactions, they seek for physicians to receive and recognize
them precisely as ethical subjects, that is, as free agents of their sexuality, as black gay women. This project is a dance of scaling recognitions.

Subject Formation and Subjectivation

My interest in studying subject formation has culminated in a complex analytical path with multiple branches and connections to various bodies of theory. Luckily, anthropology provides a very flexible domain in which to intellectually engage the various threads I have aimed to connect in this project. My multidisciplinary background as a Physician Assistant and a scholar, and in particular the humanistic approach learned in my Women, Gender, and Sexuality Studies training, has helped me to understand the processes of subjectivation encountered in this investigation. Lésbicas negras’ medical concerns and their striving to be received as lesbians worthy of humane treatment are parallel negotiations, both understood as being fundamentally about human rights. I have linked their negotiations in each to their subject position as black gay women, which produces another element of fear of inferiority. In such socially complex interactions, focusing on subjectivation is a powerful way to consider the motivations and social threads that shape their intersubjective negotiations with gynecologists. It has suggested that we might be able to reimagine the sexual, gendered, and racialized subject positions that these lésbicas negras are occupy as being open to modes of ethical engagement, and, indeed, productive of certain types of freedom.

How are such ethical subjectivities to be recognized, however, within a medical regime that heteronormatively understands its work to be to shape female bodies as biologically and socially prepared for childbirth? Even uterine, cervical and ovarian cancers are approached as “reproductive” cancers by most gynecologists.
Indeed, many lesbians, and *lésbicas negras* no less, desire to be recognized as reproductive subjects or as mothers (Lewin 1993; Mammo 2007). However, the medical community in Salvador-Bahia does not encourage lesbians to feel comfortable broaching issues of childbirth and access to artificial insemination with their gynecologists. Lindinalva (one of my key *lésbicas negras* interlocutors), for example, reported that her white male gynecologist wanted to give her medication to improve her sexual appetite while her uterus was fertile, as she was getting old. As Lindinalva braided my hair one evening at my apartment, she shared her repulsion toward the sense of entitlement that some gynecologists show in directing and dominating their conversations with their lesbian patients. In part because of such aggressive heteronormativity, I have become interested in questions that probe how one might have sex *not* for the purposes of childbirth. The infamous leading question of “what type of birth control you use” does not explicitly turn around childbirth, but clearly confirms that gynecologists structure their conversations in ways that reinforce heteronormative and reproduction-centered understandings of sex and sexuality.

**A Window into the Legacy of Ruth Landes: A final word on fieldwork**

In November 2012, Isabelle and I took a long stroll on the beach near Barrio Itapua. We were spending quality time alone for the first time since my arrival to Salvador for fieldwork. We giggled together while walking on the beach, talking about relationships, same-sex loving women, family relations, and life more generally. I was surprised when, out of nowhere, she brought up Ruth Landes; I had some few months earlier been awarded a generous fieldwork grant from the Ruth Landes Memorial Foundation. This award made a great number of the experiences upon which this dissertation is based possible: allowing me the freedom to travel to
multiple events and interviews each day, to move easily through the city. It supported my attendance at expensive medical conferences, allowed me to visit Porto Alegre, and keep myself well-nourished and joyful. Now, I have the pleasure of concluding this dissertation by sharing this moment with Isabelle. Ruth Landes’ appearance in our intimate conversation as a resource for reflection was indicative of how I understand lésbicas negras’ ethical and political selves as in part shaped by their access to transnational feminist literature and dialogues with itinerant conversational partners such as myself.

Isabelle, reflecting upon Ruth Landes’ book, *The City of Women*, envisioned an imaginary history of Candomblé and its early, women-driven communities, filled with women who loved women, whether sexually or simply socially. She was not able to ground this imagined past upon any verifiable documents. In our discussion of this history, we yearned for the ability to explore oral histories from Candomblé’s earliest moments, texts that would be both sacred and rich, giving visibility to women’s practices of caring for each other that might speak to contemporary Candomblé. Though Landes’ text has been criticized by both Brazilian and U.S. scholars for lacking an adequate interpretation of race relations (rightly, I think), Isabelle still appreciated the nuances of Landes’ text, and its gestures toward the possibility of witnessing or hearing about same-sex loving women during her own fieldwork. We both imagined.

The fullness of the conversation with Isabelle reminded me of Alice Walker’s definition of Womanist from *In Search of our Mothers’ Gardens: Womanist Prose* (1983),

Womanist: A black feminist or feminist of color. From the black folk expression of mothers to female children, "you acting womanish: like a woman. Usually referring to outrageous, audacious, courageous or willful behavior. Wanting to know more and in greater depth than is considered
"good" for one. Interested in grown-up doings. Acting grown up. Being grown up. Interchangeable with another black folk expression: "You trying to be grown." Responsible. In charge. Serious. 2. Also, A woman who loves other women, sexually and/or nonsexually. Appreciates and prefers women's culture, women's emotional flexibility (values teas as natural counterbalance of laugher), and women's strength. Sometimes loves individual men, sexually and/or nonsexually. Committed to survival and wholeness of entire people, male and female. Not a separatist, except periodically, for health. Traditionally universalist, as in Mama, why are you brown, pink, and yellow, and our cousins are white, beige, and black? Answer: "Well, you know the colored race is just like a flower garden, with every color flower represented." Traditionally capable, as in: "Mama, I'm walking to Canada and I'm taking you and a bunch of slaves with me." Reply: "It wouldn't be the first time." 3. Loves music. Loves dance. Loves the moon. Loves the Spirit. Loves love and food and roundness. Loves struggle. Loves the folk. Loves herself regardless (xi).

Walker's definition turns on about the multiple and complex meanings of being a black woman. It speaks to many of the particularities of women such as Isabelle, who may not take up the identity of "Womanist," as do some women in the U.S., but nevertheless negotiate their lives in ways that similarly embody and be recognized as free agents of their social well-being. As ethical subjects, I have focused on lésbicas negras who not only seek to be out in their terreiros and within all realms of their lives but take this seriously for as part of a broad practice of self-reflective living, a practice that resonates with Walker's text. Landes' legacy in Salvador includes, of course, her white, privileged, and American interpretations of race relations, but also an important, reflexive contribution about gendered and sexual communal relations that focuses on emergent features of same-sex sexual expression in early Candomblé communities. Indeed, Landes' writings remind us explicitly about Candomblé's history of openness toward male homosexuality (Landes 1994, 1940). However, her lack of discussion about female homosexuality points to its long history of invisibility. Today, it is up to us, together with this initiate in her late 30s, to reimagine a history of women who love women by caring for each other in a whole host of ways – not
just to protect their religious community, but to build well-being, even if this must be
done in hiding.

Ruth Landes’ research has been duly recognized for its important
ethnographic contribution, for its work in teasing out the racial, sexual, and gendered
overtones of everyday life in Salvador (Cole 1994; Besse 2007). In *The City of
Women*, Landes puts forth much more than simply a rumination about Candomblé
religious life based upon her 1938-1939 fieldwork. She also illuminates and grapples
with gender relations and formations, male homosexuality in society, and
representations of Africanness beyond the walls of Candomblé, in local communities.
Landes’ unconventional narration of the material realities of Candomblé women and
men is indicative of her commitment to understanding the social conditions that shape
experiences of race, sexuality, and gender (Besse 2007; Landes 1940, 1953, 1994).
*The City of Women* must be appreciated for its deeply nuanced approach to describing
how gendered heterosexual expressions served to secure religious and social roles,
build personal relationships, and yet, often to reinforce stigmatized perceptions of
male homosexuality.

Furthermore, Landes’ *City of Women* was an ethnographic text that deviated
from the normative style of writing during her era in anthropology. I have taken
inspiration from Landes in my writing here, considering windowing as an opportunity
to craft a socio-cultural analysis of ethical-political discourses and micro-socialities in
ways that also deviate from the standards of contemporary anthropological writing. In
this vein, I hope that my project here advances the work of Ruth Landes by grappling
with the contemporary complexities of how race and sexuality impact the lives of
lésbicas negras in Salvador, particularly in Candomblé. During my visits to Salvador
over the past seven years, I have witnessed an abundant, albeit often culturally
invisible, form of gay life among women involved with Candomblé. During my major fieldwork, however, there seems to be a space within the religion emerging for women who openly self-identify as lésbicas. It was clear that this particular form of identification was tied to experiences and understandings of race, tied to a distinct history of Candomblé women nurturing and affirming themselves within their religious and shared social community. In memory of Landes, I am committed to an approach that engages the everyday lives of my informants in order to render them visible with care and sensitivity. Unequivocally, Landes recognized the marginal experiences of male homosexuals. My anthropological research advances this discussion by focusing on the marginalization of Candomblé lesbians in Salvador, revealing the fullness and quality of their sexual and cultural lives.

A Window into Final reflections of the Use of Ethnography

Any ethnographic writing project must select among the overwhelming number of ethnographically rich moments that take place during fieldwork, many of which simply cannot fit into the finished text. I can only trust that my readers can imagine the other richer experiences that informed this dissertation. As I mentioned in the introduction of the dissertation, ethnography called for generating moments, creating spaces, and soliciting opportunities. Above all, it was about building trust and friendships – even when I was reminded that I was “Americana.” During this process, despite my insider positionality as a black lesbian, my presence as a research fostered conversation around issues that might not be ordinarily discussed in everyday conversation.

Gynecology Talk with Elisangela and Marta at Mocambihno
When I first reconnected with Marta at FEMA (from chapter two) and shared my project, she said “A gente sabe como crear para pesquias!” (Folks know how to create research projects!). My time spent with her revealed how this comment in fact signaled a new and important terrain of research. One of the most spontaneous ethnographic moments during this period was a discussion with Marta, Elisangela (Erica’s friend), and Niara (Elisangela’s partner) who were both interviewed separately at another time. One evening in December 2012, I met Elisangela and Niara in Dois de Julho. Elisangela wanted to wish me well for my surgery; I was headed back to the states for six weeks to have a hysterectomy for what had turned out to be advancing endometriosis. I was symptomatic at this point, with monthly severe pain during my menses, heavy blood flow and fatigue, and new bladder incontinence. When we arrived to Mocambihno for drinks, I was a pleasantly surprised to see Elisangela sitting with Marta. On the occasion of my leaving for a hysterectomy, the discussion at the table, over many beers, turned into an outpouring of disgruntled experiences with their gynecologists. Ever the anthropologist, I was at first disappointed that I was not carrying an audio recorder! Instead of recording, however, I observed, listened, and took in the exchange of affect, body language, and commentaries. Ultimately, it served as a more valuable and memorable evening for having not been recorded.

I point to this generative outdoor discussion about gynecological exams, preconceitos, and racisms that poured from Marta, Elisangela, and Niara to reflect upon the question of ethnography itself. While “casual” and “spontaneous” conversations initiated as more or less routine methodological inquiries are often rendered as “unique” ethnographic moments, I truly believe that if it had not been for my upcoming, unexpected hysterectomy, this moment would not have occurred in
such a free, unplanned fashion. It is, likely, unusual for researchers to leave the field temporarily to have a surgery that many of their interlocutors themselves experienced and is part of the thematic of research topic, and it offered an advantage that could not be replicated, literally, as a methodological tool in other research settings. One the one hand, I could relate in various ways with some of the women who had hysterectomies; for example, through envisioning (and experiencing) a hysterectomy recovery process. On the other hand, many of my key interlocutors now considered me more legitimate – as both an insider and outsider. While I tried to not be more transparent than necessary, I also believed that my honesty and openness about my need to be affirmed and feel vulnerable was a key part of the trust building with all of my interlocutors. Indeed, upon my return, it generated much discussion about the similarities and difference between our forms of self-care, self-advocacy, and other related negotiations.

Doing the ethnography of complex relations and intimate topics such as negotiating same-sex sexuality with the gynecologist demands a lot from the ethnographer that is unexpected, asking that she be filled with humility, and often to understand her own defensive responses. Mapping much of our ethnographic experiences onto the written page, which is to say nothing of producing theoretical analyses of those experiences, is only possible through our self-recognition of our relationship to the material, linguistic, cultural – in a word, human – worlds that we, for a time, share with our informants.

_Future Considerations: The Next Window_

In “The Bubble, the Burn, and the Simmer: Locating Sexuality in Social Science,” Kath Weston reminds us that “If sexuality is already deeply embedded in
the topics and debates that constitute social science’s stock-in-trade, then more explicit attention to those aspect of social life marginalized as ‘just sex’ has the potential to reconfigure conventional analysis along more productive lines” (Weston 1998:8). Weston’s article situates this claim in the context of a survey of the impact that early works in anthropology, such as Mead (1961), Malinowski (1927, 1966, 1989), and Benedict (1939) made upon the social-scientific study of sexuality. She argues that later twentieth-century anthropologists in particular worked feverishly to divorce themselves from this early writing on the topic of sexuality, and its understandings of same-sex sexuality in particular, in order to develop theories adequate to the treatment of critical social issues such as queer and transgender identities, activism and international organizing (Weston 1991:8). However, this leap from early to more contemporary writings can discount how writing about sex, sexual life, and conditions marked as sexual, “looms large to the extent that it can overpower the rest of the writer’s points” (Weston 1991:17). In other words, she questions that what extent the social sciences continue to produce studies on sexuality that “speaks for itself without theory and interpretation” (18). Here, I draw on Weston to remind us of the work of twenty-first century anthropologists, primarily working in the U.S., who have reconfigured our understandings of sexuality, particularly as it relates to other intersecting categories such as race, gender, class, and citizenship. In this dissertation, I have turned to the work of Blackwood and Wieringa (1999), David Valentine (2004, 2007), Tom Boellstorff (2005, 2007), Gloria Wekker (1993, 2006), Stephen Murray (2009), Jafari Sinclaire Allen (2011), Naisargi Dave (2012), Cymene Howe (2013), and many others to theorize how we might draw upon U.S.-based perspectives to think through fieldwork experiences from elsewhere. On one hand, I wrestle with this part of my analytical work, with re-localizing the tools that I have
“already” been trained to use. On the other hand, I am reminded of its vital importance by moments such as Leandro Collins’ gentle suggestion to me that the use of “transgender” as a category is not currently useful in Brazil, given the rigid sexual norms, systems, and linguistic practices maintaining heterosexual gender dichotomies.

Moving forward, this dissertation has opened avenues for exploring other socio-cultural structures in Brazil, specifically in Salvador, that shape the intersections of race, gender, class, and sexuality for black gay women occupying other medical spaces such as cancer hospitals and fertility clinics. While I was not able to interview women and their actual doctors (in part because, for obvious reasons, many do not keep the same doctor after experiences of the preconceito that was a main focus of the current study), the study of same-sex sexuality in relationship to race and class raise particular questions about couple support as lesbian couples in the face of cancer. For example, I had hoped to interview a lesbian couple in Salvador who were faced with ovarian cancer secondary to HPV. During such a tender and challenging time, it became impossible to speak with the couple, or even to meet the supporting partner, but this remains a line of inquiry I am committed to following up. During fieldwork, I also had the unique opportunity to show support to one of Isabelle’s and Jandira’s heterosexual female friends who had been diagnosed with breast cancer. Hearing about her experiences introduced me to the bureaucratic healthcare procedures that result from Brazil’s health insurance system and SUS, as well as to the enormous amount of autonomy placed upon patients in managing their medical records. While I continue to be interested in how sexual categories cut across medical spaces and less interested in disease processes themselves, this dissertation offers a next step toward critically and directly engaging the socio-cultural negotiation of same-sex sexuality for black women in Salvador when faced with acute medical
dilemmas. As in the work of Gregg (2003), Kulick (1998), and Parker (1991), I continue to be interested in windowing into the dynamics of normativity within discourses of social justice in Brazil that have, to date, had limited reach into the entrenched systems of structural racism by many in Brazil.

Further, this research has implications for future research in African Diaspora Studies. There has been very little, if any, focused research situated at the intersection of diaspora, same-sex female sexuality, and race done in Latin America. Moving forward, one of the questions I would pose is: to what extent might black lesbians in Latin America understand themselves as agents of their sexual freedom through their symbolic and participation in an African Diaspora? How might we bring together ongoing conversations about the African Diaspora, race relations, and same-sex sexuality? How to put them into contact with studies of African history, forms of citizenship and access to healthcare and other social goods? How do these relations change in an era of moving bodies, ideas, practices, and media that interconnects women to women across transnational borders? Such inquiry would build upon the projects Deborah A. Thomas and Tina M. Campt put forward in their dialogue essay, “Diasporic Hegemonies: Slavery, Memory, and Genealogies of Diaspora,” where they argue for foregrounding diaspora as a lens through which to correct the disconnections in feminist transnationalism between gender, class, sexual and racial subjectivities (2006). In addition, Jafari Sinclair Allen’s understanding of “erotic self-making as entailing individual and collective (re)articulation of race, gender, and sexuality, and the creation of new social and political subject(ivities)” is consonant with the ways in my interlocutors express their sexuality in public, as well as with the structural, historico-political tensions encountered self-images (Allen 2011:14). Their pelo duro or “hard hair,” for example, is understood and recognized as a marker of
Africanness, and there is increasing attention paid by many black women to natural hair-styles, creating a movement toward a sense of racial freedom in the domain of beauty. Many lésbicas negras in Salvador occupy the center of these social and aesthetic movements, and there are ways to identify the “small practices of self-making through erotic subjectivity” (Allen 2011:14) as politically and even ethically transformative.

I reflect upon Diaspora Studies in particular given the ways in which my interlocutors embraced the bklyn boihood calendars that I gave away as gifts to participants in my research. These calendars exhibited masculine-featured women of color in queer ways unique to each individual model. These calendars were received by everyone, whether feminine, such as Isabelle or Elisangela, or masculine, such as Jandira and Sueli, with awe and admiration for the presentation of the models’ distinctly-gendered expressions. More surprisingly and importantly for this project, everyone read the calendar’s models as indicating that, as black bodies, “we all belong to the same place.” Moving forward, I hope to use moments like these to ask, along with Thomas and Campt: “how (and where) are diasporas, and particularly the African diaspora, produced? How have diasporas been politicized? How do they move and in what ways?” (2006).
I do have one deep regret about my fieldwork, which my apartment window did not help avoid. Sometimes, even with many windows or a magnified field of view, we can block our own paths toward self-discovery, toward seeing beyond the trees (both literally and figuratively). When Isabel finally moved from *Barrio Itapua* to *Dois de Julho*, she asked me several times to go to a small beach in the lower city, within walking distance of *Dois de Julho*. Whenever she would come to my apartment, she would point to a small beach from the window; the beach that I saw, and which I thought she was pointing to, was a very visible one, people by locals but partly deserted. Now, I love the beach. Occasionally, I would get on the bus for 45 minutes just to sit at a quiet small beach in *Barrio Rio de Vehmelho* with my notepad and lots of tanning oil. Yet, I repeatedly postponed Isabel’s invitation; the beach seemed inaccessible from my window. I also worried about how I spent my time – I always had more interviews to get to, events to attend, coffee to drink with someone or other, and of course, field notes to write. Isabel and I spent a lot of time together as it was, so brushing off her beach invitations did not seem consequential, until I finally did make it to the beach with her, just three days before my departure. It turns out, the beach that she was referring to was part of the Museum of Modern Art, just down the
hill from *Dois de Julho* and hidden from my window. From my window, I could see a beach beyond the tops of the trees, but not *that* beach, hidden by foliage. All that time, I had I thought that Isabel was speaking of the other, deserted beach. The MOMA beach was free, quaint, and clean – a perfect, nearby spot to relax, write notes, or meet with friends or interviewees. I will always regret not going to the beach with Isabel earlier, for not just taking her word and, in so doing, discovering *that* beach.

In the future, when I’m doing fieldwork, that beach will remind me to lift my head from the trenches, to question the view from my window, to look beyond the trees. The view from the ethnographer’s window is valuable, and we cannot have direct access to any other. However, we must not ignore the possibility of hidden symbols and meanings, visible to those surrounding us but blocked from our own analytic vantage. Otherwise, we can stop ourselves from following unseen paths into worthwhile discoveries.

![Image 32: A photo taken by Isabelle of some of our feet at the beach beyond the window two days before my departure - Until next time](image-url)
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