"MEU ENERGIA VITAL": *LESBICAS NEGRAS'* THERAPEUTIC ETHICS AND CONTESTATION OF BRAZILIAN GYNECOLOGY

Nessette Falu[1]

Resumo: Based on 2011 preliminary research in Salvador-Bahia, New York City, and Houton-Texas, this paper is a prospective discussion of the conceptualization and critical tenets of my dissertation research to be sited in Salvador-Bahia, 2012-2013. This anthropological investigation of therapeutic ethics will focus upon Afro-Brazilian lesbians, or *lesbicas negras.* It utilizes medical and personal narratives of sexual health and encounters with the biomedical apparatus as sources to understand the racialized, sexualized, and gendered dynamics of women's care of the self. Through the lens of a Houston methodological project during the Fall 2011, I share some salient implications of the interview process for my fieldwork. One of the main objectives of this presentation is to invite Brazilian dialogue partners into my fieldwork process.

Palavras-chave: Sexual Health, Theraupetic Ethics, Lesbicas.

Lucy[2] never comes out to her gynecologists though she is out in all other facets of her life. Even if she has questions that are directly related to her gay sexual practices, she will not come discuss those issues neither does she receive interest or concerns about her sexual life from her gynecologists.

Lucy is a 40 year old self-identified black lesbian, employed and partnered with a woman, who lives in Houston, Texas in the United States. Many self-identified black lesbians in Houston like Lucy, are uncomfortable with the ways in which their sexuality is silenced during their gynecological visit. In preliminary research I have conducted to date in New York, Houston, and Salvador-Bahia, Brazil, most of my informants attributed their disgruntlement primarily to the quality of medical conversation and interaction with their gynecologist. Their reported conversational challenges, which I will briefly discuss here, suggest that excess anxiety and anguish are produced between the patient and provider. This is particularly the case when both parties want to and/or attempt (or not) to openly speak about gay sexuality as it might relate to sexual health concerns. In Lucy's case, she would often have questions about risks of sexually

[1] Rice University. Email: nfalu@rice.edu; nefalu@gmail.com
[2] All of my informants have pseudonym names.

transmitted diseases via using sex toys but was afraid to ask her gynecologist. Such unaddressed concerns is one of many reasons I am interested in discovering whether such ambivalence is tied to sexualized or racialized ways of dealing with sexuality as taboo, in particular. As I conducted the Houston interviews during the Fall of 2011, I identified the need to focus upon a methodological approach to adequately collect data about the particularities of such gynecological challenges for black lesbians. Particularly as it pertains to how physicians might neutralize or disregard patient gender and sexual experiences without recognizing racial dynamics, and as a result adequate medical conversation about sexuality and sexual health can become more difficult to elicit. Furthermore, I argue that such medical challenges inform black lesbians' perceptions of sexual health and their relationships to their bodies. In other words, if these women negate and silence their non-normative ways of creating healthier sexual perceptions and practices inside and outside of the clinic, they ways they practice sexual health will be radically changed. Such changes are what I sought to discover during this Fall 2011 project and in more depth in my broader dissertation project in Salvador.

Although I interviewed about 16 black lesbians between New York City and Salvador-Bahia during the Summer 2011, the Houston project raised significant methodological concerns and pertinents for my dissertation fieldwork. Indeed, the study Houston results reinforced the need and significance for an anthropological study with a focus on black lesbian sexual health and self-care and its intersection with gynecology. My conclusions led to a few salient observations. First, my black lesbian informants managed both desire and anguish in order to experience a more affirming gynecological experience that often compelled their gynecologists to show concern for how they might describe their health concerns tied to their sexuality. However, many showed difficulty in clearly articulating this entanglement of feelings and desires. Second, I noted that their much of their sexual health perceptions are associated with normative gynecological ideas about heterosexual women's body care and health. Yet, some of their normative ways of thinking about women's bodily care conflicted with the ways in which they eventually translated their personal needs and practices toward themselves and with their sexual partners. Third, the major observation was a significant lack of awareness about how they perceive about their sexual health as gay women of color. And yet my interlocutors were, in their daily lives, advocates for themselves and were committed to holistic sexual healthcare. This last conclusion raised a need to pay closer attention to the potential disconnections between black queer female subjectivities and

practices. In other words, what are the ways in which black lesbians acknowledge their embodied sexual desire and transform it into sexual health, or a practice of sexual health?

This short study of six Houston-based black lesbians and three health care providers[3] impacted broadly my dissertation research trajectory by demonstrating how such research can draw attention to the specific challenges of gynecological care and render them relevant, even critical, public information and research data. Also, it can help foster and bridge effective community among black gay women, gynecologists, and public health allies. The ways in which black gay women contest and react against such silencing experiences remain unrecognized in research and public discourse. Consequently, this project convinced me of the critical importance to focus upon the interview process in order to explore and analyze some of the above issues and propose an interviewing methodology that can facilitate effective access to qualitative data for my dissertation research. As an anthropology student, I particularly recognize the value of a unique reflexive ethnographic field experience that exchanges ideas, sensory affect, emotions, and language (bodily and linguistic) across informants and interviewer. Since the interview process for me was riveting and playful yet intense, quirky, and often very awkward, this reflexive experience and exchange of information through conversation, body language, and even silence is worth interrogating and spotlighting to assess its anthropological value. In this vain, I draw upon the arguments in Fictions of Feminist Ethnography by Kamala Visweswaran who acknowledges that "feminist anthropology cannot assume the willingness of women to talk, and that one avenue open to its is an investigation of when and why women talk - assessing what strictures are placed on their speech, what avenues of creativity they have appropriated, what degrees of freedom they possess" (Visweswaran 1994).

Theoretically, I further argue that sexual health for black gay women is significantly shaped by their gynecological medical encounters. However, I also argue that the ways in which they further interpret and practice sexual health are doubly constituted by their everyday modes of survival and self-affirmation through socio-cultural practices and knowledge. The latter phenomena is infused into the gynecological experience by women who self-advocate for affirmation and legitimacy

[3] The healthcare providers represent a black heterosexual gynecologist, white heterosexual nurse practitioner who works with LGBT HIV population at the Legacy clinic in Montrose and at a Planned Parenthood clinic in a rural area, and a black lesbian physician who works in emergency services care or E.R.

as ethical subjects (Faubion 2010). Although this presentation focuses upon methodology and not solely on theory, it is noteworthy to highlight the theoretical leanings informing my methodological inquiries. If lesbian sexual health studies can be anthropologically explicated with anti-normative methods (Browne and Nash 2010), then gynecological management and medical health training can be influenced by the voices of marginal patients such as lesbians, particularly women of color. Hopefully the barriers blocking quality and affirming medical interaction and practice can be ameliorated. Herein, I will briefly share two abridged sections of my methodological major paper for Ph.D. Candidacy: gynecological experience and sexual health.

Gynecological experiences: Medical Subjects or Medical Agents

Given the complexity of the intersubjective experiences of black lesbians with gynecologists, in general, that fuse racial, gender, and sexual normative language and overlooks their non-normative experiences, this research (and dissertation) requires significant strategic focus to analyze the conversations between the patient and doctor. This Houston project's interview information that signaled informants' concerns regarding their gynecological exams and treatment strongly suggested that there exist silent challenges to receive health-related affirming interactions and personally tailored medical feedback from their physicians. For example, they were far less concerned or disgruntled with how they were physically handled than with the conversation content and interaction approach. In *Freeing Ourselves*, a 2011 book about black masculine identified females, most of all its illustrations and essays show concern for how many masculine-identified women are physically handled with speculums by the GYN, for example. To the contrary, my interviewees, who identify as females with either feminine or greater masculine gender expression than their partners, showed more concern for the challenges of the medical conversation than the physical exam.

> *The doctor's way of assuming that I am gay is by asking whether I use birth control and sex protection. If I say no, then nothing else is asked and the exam moves forward as though there is nothing else to discuss since I don't need to use protection or must not be at risk. -Carla*[4]

These medical behaviors that discourage discussion about sexuality was a shared experience and sentiment among all my interviewees. It is an indication of how medical

[4] Carla: a 34 year old from Louisiana who moved to Houston. She has been partnered with Mary for 4 years. They live together. She is a high school teacher. She has had a lot of encounters with her GYN doctors because she has been undergoing treatment for HPV for few years.

conversation can inhibit or prohibit other pertinent conversational content between the physician and patient by merely shutting down an opportunity to discuss lesbian sexual issues. In fact, my informants also shared similar experiences with their doctors who never asked about their desires for conception if suspected or identified as lesbians. Neither would they initiate discussions about sexual health medical risks involving sexual practices, exposure to, or education of diseases such as Herpes, Human Papilloma Virus (HPV), HIV, or even self-breast exams. For example, Akya preferred for the doctor to initiate educating and screening her for STD risks. When I told there that there is very little research documenting such risks among lesbians, she said, "Well, the doctor should volunteer that information too!" Furthermore, Petra[5] said that her questions about how fingernail hygiene might impact vaginal-finger penetration between two female partners could cause recurrent yeast or bacterial vaginal infections was ignored by her white GYN female doctor. Petra said that when she asked such questions, her doctor first looked at her with a blank and frozen facial expression, looked the other way as though distracted, and never addressed the question.

As a healthcare provider, it is very disturbing to learn how many Houston-based gynecologists do not respond to these patient demands in the clinical setting even if their behavior can be attributed to lack of preparedness to deliver a "proper" answer. In The Cancer Journals, Audre Lorde said, "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 depersonalization of racism and homophobia and ask for what they need" (Lorde 1980:20-21). Lorde battled cancer for many years after her mastectomy in the early 1980's. Right after her mastectomy she wondered, "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?" (Lorde 1980:43). Lorde's affect toward her body changes that her breast cancer can be paralleled with the unspoken affect that many black lesbians might experience today when talking about sexual health, reproductive health and gynecological disease with doctors who depersonalize them. If the physician is white, male, and not identified as gay, my interviewee felt more distanced than receiving exams from black female physician. On the other hand, Mary experienced significant homophobia from a black

[5] Petra: a 30-year-old black gay woman who dates Lovie. She is taller than her partner and older. They have been in a relationship for 5 years. She works as a dance teacher part-time. She is native to Houston.

female physician, which signals that sharing racial identity does not ensure the provision of a gay sexual safe space. How can these women receive 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?

In 1976, Adrienne Rich declared that "we need to imagine a world in which every woman is the presiding genius of her own body. In such a world, women will truly create new life, bringing forth not only children (if and as we choose) but the visions, and the thinking necessary to sustain, console, and alter human existence – a new relationship to the universe" (Kline 2010:2). Rich's statement illuminates a possible solution to the disjointed or nonexisting gynecological conversations with many black lesbians. If physicians followed the leading ways in which black lesbians openly pose their inner questions, concerns, and experiences that respond to their sexual health needs and feelings, then such physicians who even lack an orientation to lesbian life could foster safer discussions in the clinical setting. The dilemma for many women is that they do not feel safe enough to even come out to their physicians. Lucy, who is her late thirties and has seen several physicians in her lifetime, has never come out to her GYN doctors. Her current GYN doctor, a black heterosexual female, knows she is gay but only because her partner is now her patient as well. Lucy has been out as a gay woman to her family for 15 years and is out at work and most social settings, except to her doctors. When I asked her why the discrepancy in how she chooses to not come out to her doctors, she says "I don't trust that they will not judge me and ultimate provide less quality healthcare to me. I am not taking that risk with my health and body." Although Lucy was the most opinionated of all interviewees about her perceptions of sexual risks (with sex toys for example), her longing to have an affirming discussion with her GYN doctors is desensitized by her fears and self-guarded closeting.

Sexual Health & Politics of Vulnerability

The impact of stigma against body parts surfaced during my Houston interviews. For example, some of the women believed that fingers and lips are stigmatized sexual body parts for lesbians. Mary[6] said that when she identifies as a lesbian to someone, her lips are usually immediately stared. According to several of my informants, the size of

[6] Mary: a 33 year old who works for a insurance company. Born and raised in Houston. Likes to wear her hair in an Afro like Petra. Her partner, Carla wears dreads and so does Akya.

hands among lesbians influences attraction. Some reported that unlike men who use their penis as the primary body part to insert for pleasure, hands are often used for vaginal and clitoral stimulation and/or insertion among lesbians. Mary describes all of this in the context of choosing partners. Petra and Lovie[7] also spoke about the importance of hands hygiene as comprising sexual health.

These narratives of sexual health are tied to underexplored ideas of sexuality in many ways. This project (and dissertation project) seeks to engage how sexual health is constituted within associated medical risks and surveillance. It also seeks draw greater attention to how sexual health is a fluid or holistic desire for a healthy sexuality, socially and medically. To speak of sexual health in terms of diet, hygiene of fingers, and non-normative sexual body parts such as lips (as associated with oral sex) calls for non-normative ways of engaging sexual health. However, World Health Organization (2012) defines sexual health in a way that invites a more comprehensive approach to sexual health for healthcare providers.

> Sexual health is a state of physical, mental, and social well being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

The ways in which WHO defines sexual health offer multi-dimensional perspective for interrogating black lesbian health, in particular. Black lesbian health experiences are silenced but rupture the medical space by challenging it in different ways. The ways in which black lesbians challenge the medical setting toward comprehensive sexual health evaluation will differ from region to region and transnationally. What constitutes as "state of being" according to WHO's definition will differ geographically. During my interviews, it was difficult to access what is a "state of being" physically, mentally and socially. However, this exploration can be more accessible with my dissertation long-term project. Methodologically, how to interpret and read "state of being" during an interview process is difficult since there is such a focus upon exchange of language. In *The Woman in the Body*, Emily Martin writes about "how women represent themselves as fragmented - lacking a sense of autonomy

[7]Lovie: a 23 year old who identifies as a stud. She had sex with a boy at 16 year old and her grandmother forced her to get a GYN exam. She says she was traumatized by the speculum experience. She has not received a GYN exam since mainly because she has not had health insurance. She works full-time for a cable company.

in the world and feeling carried along by forces beyond their control" (Martin 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" (Martin 1987:194). Though her focus is on difference between heterosexual men and women, the approaches her study through a lens of "embodiment of opposition" where women seek to become more aware of the fragmentations, or "fragmented images" they internalize via male dominance that influenced medical dominance (Martin 1987:194). Gregg's work falls within this similar analysis about sexuality of women. I point to Martin's work because she enforced the importance of paying attention to such fragmented images ("such as 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"). My interviews compelled me to consider how much of their self-perceptions and desires for self-fulfillment are stifled by medical images and demands that fragment their self-perceptions and practices. Beyond the interviews, evaluating how black lesbians transition their gynecological experiences into lived experiences outside of the clinic will be salient for my project. This methodological approach can further open analysis around Martin's arguments of the impact of embodied fragmented images.

Salvador-Bahia Dissertation Research Plan and Methods

I have travelled to Salvador-Bahia five times since 2007. During these 2-3 week to a month stays, I emerged deeply into some of the lesbian and gay circles and learned much about general and specific social concerns perculating in these circles and beyond. In September 2011, I decided to focus my anthropology dissertation research solely on Salvador (not a comparative of NYC and Salvador) in order to (1) develop with narrowed focus my ethnographic skills outside of my social and medical context, (2) integrate within the social and academic movements that address ameliorating social justice issues impacting black lesbians in Salvador, including health, and (3) to specifically work with Candomblé gay women on issues of sexual health. Earlier I argued that gynecological challenges inform black lesbians' perceptions of sexual health and their relationships to their bodies, and thus, I am very invested in research that hones upon how stigma is shaped, deconstructed, and drawn upon to emerge practices of freedom contesting structural violence, like silent and invisible discrimination. In other words, the ways in which women negate and silence their non-normative ways of

creating healthier sexual perceptions and practices inside and outside of the clinic must be brought to the forefront of public discourse.

Dissertation Fieldwork

Brazil is undertaking a significant healthcare reform project designed to eradicate discriminatory practices against the Lesbian, Gay, Bisexual and Transsexual (LGBT) population, on the grounds that these undermine their health and welfare. However, Salvador, an urban city in the northeast of Bahia (the poorest national region), heavily populated with Afro-Brazilians, is unlikely to experience the substantive benefits promised by such a national reform. Although there is a national push to make lesbians more "visible" in healthcare, many politicians and activists are concerned that Brazil's structural racism, homophobia, and gender inequality represent triple barriers to the improvement of Afro-Brazilian lesbian sexual health and access to healthcare. This anticipation rests upon studies showing that heterosexual black women continue to experience double barriers through race and gender inequities (dos Santos 2009; Caldwell 2007) and the literature suggesting that biomedical gynecological care is experienced as particularly violent by lesbian women (Knauth 2009). It is in this context of bureaucratic neglect and entrenched discrimination that this study examines how Afro-Brazilian lesbians, or *lesbicas negras,* forge and carry out an "ordinary ethics" of sexual health (Lambek 2010). These women have defined their sexual health broadly and non-normatively, contesting the boundaries of gynecology. Preliminary research suggests that "*lesbica negra*" has become an identity contesting discriminatory racial, gendered, and homophobic practices within professional and home settings (dos Santos 2009).

This project focuses upon both the invisibility and the endurance of *lesbicas negras'* lives in the face of current national LGBT healthcare reforms, which do not hold forth the promise of relieving structural barriers to their access to traditional biomedical care. In 2010, in response to indications that discrimination against LGBT Brazilians led them to avoid government healthcare treatment, the Brazilian Ministry of Health instituted its first comprehensive plan to eradicate "discrimination and exclusion" and "to improve LGBT health access, services, education about HPV, HIV, reproductive cancers, and sex surgery reassignments" (Ministerio Da Saude, Brasilia-DF 2010). The policy, "Politica Nacional De Saude Integral De Lesbicas, Gays, Bissexuais, Travestis E Transexuais," calls for better medical training on sexuality and mandates that private healthcare providers, as well as those within the Unified Health

System (UHS), implement transparent measures to ensure access to healthcare for Brazil's LGBT population. Given UHS's shortcomings to ameliorate healthcare inequities in socio-economically challenged states such as Bahia, as of September 2011, President Dilma Rousseff planed to invest R$12.8 million into Bahia's UHS to generate improved "basic healthcare like more clinics, medical machinery, drugs, and education" (Portal da Saude 2011).

The anticipated practical outcomes are, however, unclear. Health discrimination and alienation are critical issues for Brazilian gay activists; only 73 out of 5534 municipalities have laws against discrimination based on sexual orientation. Recent anthropological research in Porto Alegre, for example, found entrenched homophobic biases and pathologizing views among physicians which alienated LGBT patients, particularly lesbians (Knauth 2009). In Brazil, it is estimated that 83% of lesbians would rather never have a PAP smear done to test for cervical cancer or HPV (LBLRS Blog), because in this climate they feel the procedure renders their gynecological experiences medically violent (Knauth 2009; SIES 2009). In 2009, black lesbian activists in Salvador said that the invisibility of lesbicas negras within healthcare has made it difficult to address the perception of these tests as violent experiences (SIES, 2009). Although gay men in Brazil have historically received substantial national health attention because of the HIV/AIDS crisis (Parker 1987; SexPolitics Watch 2006), lesbians' medical needs are only slowly gaining visibility in Brazilian research and public discourse.

This research seeks to better understand how standards of care, service provisions, and patients' experiences are being transformed, or not, by the confluence of these concerns with the implementation Brazil's new policy mandate. It aims to identify and understand how *lesbicas negras* draw upon resources from their sexual, familial, political, and religious worlds to re-imagine sexual health broadly and engage in ethical action during their gynecological visits. Through a study of the ethical domain (Faubion 2011) inhabited by *lesbicas negras*, this project substantively revises the anthropological approach to the study of biocultural therapeutics. To this end, I will focus on examining gynecological practices and their effect upon *lesbicas negras*. My central research question is, thus: How have *lesbicas negras* developed and engaged in an ethics of the biomedical and biosocial care of the self? Does this ethics hold the potential to positively influence and improve their access to healthcare and engagement with the physicians who treat them?

Literature: To the extent that lesbicas negras are able to enact voluntary practices, viewed as legitimate expressions of self and self-making, they are engaging in "ethical acts" (Lambek 2010), and often in "radical ethics" (Dave 2010). My work will contribute a novel, biocultural study of practices of the ethical in spaces of subjectivation, wherein subordinate individuals are constituted as dominated subjects (e.g. *lesbicas negras* within the biomedical gynecological system). This anthropological literature suggests a reading of lesbicas negras as "ethical subjects." The "ethical" is a conceptual lens through which to understand the liberating, healing, self-making practices shared by similarly-positioned subjects (Faubion 2011; Foucault 1985). For this project, it is critical to study women who are "out" in their lives. This population offers particular information about the challenges and benefits of gynecological experience, as compared to closeted lesbicas negras. *Lesbicas negras,* as public sexual subjects, experience a myriad of "insults" both in and out of the medical care system (Eribon 2004), and they bring these experiences into the examination room. Studying the dynamics of agency and responsibility therein means reflecting upon the nature of ethical practice, as well as reformulating how care, e.g. of our bodies, relates to our ethical "acts" (Laidlaw 2010; Lambek 2010).

The literature on therapeutics provides a lens into the production of diverse patient knowledge about therapeutic markets; healthcare settings; related medical, political, and social interventions; and medical language and interactions (Csordas and Kleinman 1990; Petryna et al. 2006; Petryna 2002; Nguyen 2010; Behague 2009; Race 2009; Lakoff 2005). In Brazil, women in the Northeast have been studied as cultural agents in their own healthcare and healing (McCallum & dos Reis 2005; Gregg 2003) as well as "agents of change" with respect to the gendered construction of issues such as cervical cancer, fertility, sterilization, and alternative health protocols (Gregg 2003; Dalsgaard 2004; Rebhun 1993, 1994, 2004). The medical and biocultural anthropological literature offers a large body of research on therapeutic processes that connects medical, political, and spiritual power and offers a broad analysis at the intersection of patient interactions, healthcare policy, and therapeutic interventions (Sargent and Johnson 1990; Behague 2009; Wiley and Allen 2009; Nichter 2002). This study is a novel contribution to this literature by examining the ways in which *lesbicas negras* negotiate those of their experiences and needs not shared with white lesbians or heterosexual black women (Cohen 2005).

This study also draws upon anthropological studies on lesbian sexuality, responding to an emerging call for research in medical anthropology that focuses on lesbians and female masculinities (Inhorn 2006, 2007). Queer anthropology promotes an analysis of gender non-conformity that takes seriously "intersectionality, inclusion and difference" (Boellstorff 2006), and in particular engages "female non-normative sexualities" (Weston 1991; Lewin 1993), and "the interplay of categories and identities that represent gender and sexuality" (Valentine 2006; Kulick 1998). Richard Parker (1991) has conducted exemplary research on the transformation of Brazilian sexual health that does not disconnect processes of "sexual life and sexual universe" in Brazil from the influences of medical and scientific systems. This project builds upon Parker's research by contributing to the cross-cultural work in queer anthropology and offering insight into how black gay females relate to their bodies and institutional marginalization (Blackwood and Wieringa 1999). This study will make a significant contribution by highlighting the importance of women's intersecting experiences of healthcare, sexuality, medical interventions, and sexual politics (Inhorn 2006; McCallum and dos Reis 2005; Martin 1987; Kline 2010; Georges 2008; Dalsgaard 2004; Gregg 2003).

Methods and Analysis: From July 2012 - June 2013 in Salvador-Bahia, the primary fields of data collection will be: (1) patient-gynecologist dialogue and interactions, particularly with respect to prevention of sexually transmitted diseases and conception, which are highly stigmatized topics, (3) embodied perceptions and the expressions of what constitutes sexual health and sexual liberty, (4) evaluation of medical controls which particularly impact black lesbians, and (5) the practices by which *lesbicas negras* enact their sexual health and contest gynecological marginalization. These fields of inquiry will be explored through participant-observation in the daily lives of my informants, approximately 70 semi-structured interviews of primarily black lesbians and some gynecologists, escorting as many women as possible to their visits with gynecologists. The qualitative data gathered will be analyzed using: (1) feminist epistemological theory (to understand sexual health perceptions), (2) materialist approaches to the interpretation of medical and sexual language and objects (as they contribute to an understanding of sexual health), and (3) theories of ethical practice (to understand the contestation of medical and sexual subjugation). I am also planning a short visit to Porto Alegre and Brasilia (its policy making capital city) to interview activists and healthcare politicians. Lastly, I am a Physician Assistant with 10 years of experience. My clinical experience, particularly in

HIV/AIDS care, has given me the lens by which to recognize many socio-cultural issues affecting patient health, sexual health in particular, as well as ways in which patients negotiate, or not, the healthcare setting and provider interactions.

In conclusion, based on 2011 preliminary research in Salvador-Bahia, New York City, and Houton-Texas, I anticipate conducting a critical research agenda for my dissertation research sited in Salvador-Bahia during July 2012 - June 2013. Centrally, this fieldwork is an anthropological investigation of therapeutic ethics focusing upon Afro-Brazilian lesbians, or *lesbicas negras,* in Salvador-Bahia. I utilize medical and personal narratives of sexual health and encounters with the biomedical apparatus as sources to understand the racialized, sexualized, and gendered dynamics of women's care of the self. Through an evaluation of various forms of medical control and *lesbicas negras'* invisibility within the medical and social domain, I aim to explore ideas of patient self-advocacy and self-care that contest the subjugation of black lesbians within both local and global discourses. One limitation this project poses at this time is an adequate approach to analyzing race, racial perception, and racism. My intentions is to focus upon this aspect of this social element while in the field and develop critical strategies along the way. Through the lens of my medical practice and anthropological queries, I project that this data will eventually serve as a catalyst to spark and bridge transnational agenda and movements that address the specific lives of black gay women who are silenced, or not, within the medical domain both in U.S. and Brazil.

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