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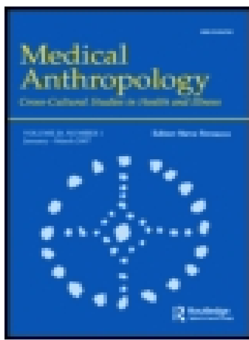

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Aesthetics Politics: Negotiations of Black Reproduction in Brazil

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ABSTRACT
This article explores the role of aesthetics in the construction and perception of what constitutes healthy reproduction and reproductive practices. I draw on women's reproductive experiences and navigations within a racialized gendered hierarchy. Processes and procedures related to the governance and measurements of reproduction and reproductive health shape these navigations. Focusing on Black women's experiences, I analyze the ways in which values, sensibilities, and affect connected to particular appearances and arrangements influence reproductive decision-making, reproductive health, and family constructions – what I refer to as aesthetics politics.

KEYWORDS
Brazil; Black women; aesthetics; racism; reproduction

> Beauty can be understood as a technology of biopower in Brazil, insofar as it produces, segregates and ranks populations within the national public sphere – providing some bodies more value than others according to a scale of racialized characteristics (Jarrin 2015:536).

I sat in the living room of Gabriella's apartment that she shared with her daughter and her mother. As was customary for my interviews, I asked Gabriella her age: 28. How did she identify racially? She identified as *parda*, the census category in Brazil that designates those who are mixed, neither Black nor white, and so includes people who identify as *moreno/a* (mixed race). I knew Gabriella prior to my research, and her identification as *parda* stood out because of a previous conversation with a mutual friend who insisted that Gabriella was *branca* (white). "Her mom is white, her dad is white, so she is white. There is no black or *moreno* there, though Gabriella would be happy to know that you thought she was *morena*. She wishes she was darker." Gabriella has light, tending toward white skin, a smallish nose and lips, thick thighs, a big butt and hips, a small waist (in comparison to her bust and butt/hip), and long dark curly hair – a combination of features common in Brazil and not easily classifiable into a racial category. On a different day, Gabriella had come to my house and described herself as *branca*.

Gabriella and I continued the interview. She had become pregnant while she was switching contraceptive methods. The previous method she was using made her too skinny – "*tava muito magra, emagrecendo muito. Aí a medica … me deu uma outra opção de anticoncepcional* – I was very skinny, losing a lot of weight. So the doctor … she gave me another contraceptive option." She did not plan on having another child because of the challenges in raising the one child she did have. In her words, "*Eu não me incomoda com a questão de estética, de ter outro filho. Isso não me incomoda. O que me preocupar, na realidade, é como que eu vou criar essa outra criança?* I don't mind the esthetic issue of having another child. This doesn't bother me. What bothers me is how I am going to rear this other child?" She was not interested in a tubal ligation because she wanted to leave open the possibility for future children in the event that her present relationship ended. Her particular statement about aesthetics struck me. The acknowledgment of an esthetic that informs and surrounds the number of children one had was an

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articulation of something that quietly colors the ways in which people engage or disengage reproduction, even if to differing degrees and in different ways.

The esthetic issue of having more than one child could be understood in many ways. There is the issue of her body and the changes it can potentially experience after having another child. Brazilian women's use of plastic surgery is associated with bodily changes that they attribute to multiple pregnancies, leaving one's body *acabado*/finished and *caido*/fallen (Edmonds 2010). As a partner in an interracial relationship, it could refer to the uncertainty of the appearance of another child. Brazilian families can have children ranging in skin color, eye color and hair texture, such that one could have children categorizable as black, white and *pardo* within the same family. It could refer to the fact that radical black activists in Salvador and a neighboring city have expressed their disappointment with Gabriella's partner, who is black, for choosing her as a girlfriend and mother of his child. Though Gabriella unstably teeters between *branca* and *parda*, they understood her as *branca* and too fair. It could refer to the actual appearance of the family in its various forms, as Gabriella lived with her daughter and mother: the mother with children; mother, father, children; mother, children, grandmother; father, mother, children, grandmother. By appearance I refer both to the appearance of each individual of the group and how that individual appearance contributes to the overall look of the grouping. Clearly, Gabriella's comment on aesthetics reveals not only its multiplicity, but also the way it colors social life and is in constant negotiation and contestation.

In this article, I explore the complex interplay of aesthetics, race and sexuality as it shapes black women's navigations of social life and reproductive norms. By exploring this interplay, I demonstrate the ways that esthetic systems and their interactions with health and biomedical systems literally and figuratively shape the meanings of one's health-related decisions and health outcomes. In what ways are Brazilian understandings and constructions of health, particularly reproductive health, aestheticized? In a context in which aesthetics are already racialized and race already aestheticized, how does that influence perceptions of health? I argue that recognition and interrogation of the esthetic underpinnings of health and biomedical systems will facilitate disrupting how these same systems contribute to the construction and perpetuation of notions of blackness and whiteness, and their relationships to disease, ugliness, death, health, beauty and life.

My argument encompasses two related claims. First, I contend that the influence of bodily aesthetics on decisions on contraception is entwined with conjuring value through their bodies. Second, what is deemed healthy and responsible reproduction maps onto a gendered and racialized aesthetics that devalues the reproduction of blackness, black lives and black bodies.

I take Gabriella's statement about the aesthetics of having another child as a provocation to engage differently with research on family planning. Researchers have tended to focus on the influence of gender inequalities in structuring women's contraceptive decision-making, while aesthetics, gender and race have attracted much less attention. Further, aesthetics is typically related to beauty in relation to plastic surgery or as an insignificant side effect of contraceptive use. Anthropologist Kia Caldwell, however, argues that body aesthetics need to be linked to larger issues of justice, and that "the relationship between physical bodies and citizenship merits close discussion since bodies form the material substance of citizen-subjects, and normative notions of acceptable and unacceptable bodies are used to determine who belongs to the nation" (2007:106). Anthropologists have pointed to the links between beauty and racism among Black Brazilians (Caldwell 2007; Hordge-Freeman 2015; Jarrin 2015), and its role in Brazilian social life (Edmonds 2010; Goldstein 1999; Gordon 2013; Rebhun 2004). Researchers have tackled the complicated relationship between racialization and the clinical encounter (Bridges 2011; Viruell-Fuentes 2011), and the importance of aesthetics in relation to health, health interventions, health outcomes and the ways in which race is also implicated (Graham et al. 2016; Hodzic 2013; Pearce 2012). Okezi Otovo (2016) draws upon archival research to reveal the infusion of cultural discourses of race, gender and class into Brazilian medical knowledge and public health theories and practice. In this article, I interrogate how race and aesthetics are already intertwined and inform each other. I illustrate the implications not just for reproductive health outcomes but also to interpret reproductive health-seeking behavior and the development of interventions.

Researchers have studied female sterilization in Brazil as elsewhere globally – by describing its prevalence and reasons for its use or predominance. Globally, tubal ligations are the most common method of contraception among people identifying as women, whereby the fallopian tubes are cut, tied, bound, clamped or otherwise blocked, via a small incision near the navel, to permanently obstruct passage of eggs to the uterus. In Brazil, by 1996, despite occupying a mostly illegal status and the lack of a national family planning program, tubal ligations were the most preferred method of contraception, with 40.1% of married women between the ages of 15–49 sterilized (DHS 1996). The trend was started by white elite women, but by 1996, Black, Brown and poor women were accessing tubal ligations in higher numbers. Black women activists led a campaign against the trend in sterilizations in the early 1990s and by 1996, the government established a national family planning program.[1] In 1997, the government legalized sterilization with criteria; for example, one must be a competent adult and above age 25 or have two living children. A person seeking sterilization must also agree to a 60 day wait after the declaration of desire for the procedure, spousal consent, and prohibition of coupling the procedure with birth, c-section, or abortion/ miscarriage. Tubal ligations rates have since dropped. Abortions remain illegal.

The establishment of a national family planning program in 1996 has translated into the availability of more contraceptive options (IUDs, injections, pills, implants, external and internal condoms), freely or at low-cost, through the Brazilian public health system known as SUS (*Sistema Unico de Saúde* or Unified Health System). However, access to contraceptives remains highly stratified. The practice of providing for the masses serves to cement their exclusion from civil society (Pagano 2012; Sanabria 2010). Brazil's language of citizenship and inclusion masks a hierarchical relationality that creates a distinction between *sub*- and *super*-citizens (DaMatta 1991; Sanabria 2010). The *sub*-citizens – poor, marginalized, black, and indigenous – are regulated by the law, which legitimates and reproduces inequality (Holston 2008). A two-tiered healthcare system "mandates governmental controls over poor women's access, while leaving free-market regulations for private healthcare" (O'Dougherty 2008:418). Black and poor women, with the least options for healthcare and higher risks for dying in childbirth and experiencing mistreatment in pregnancy and childbirth, come to rely on an inferior, underfunded, and under-resourced public health system that favors long-acting reversible contraceptives (LARCS) over tubal ligations (Edu 2018). Black women and their infants experience higher rates of maternal and infant mortality (De Zordo 2012). Black women are more likely to die during pregnancy than their white counterparts (Martins 2006), and they receive some of the worst treatments during hospital visits for prenatal care, delivery, and botched abortions (Edu 2015; dos Santos 2008). Within this reproductive health milieu, women are navigating and negotiating their reproduction and sexual lives. Below, after discussing my methods, I consider the concept of aesthetics, then discuss how aesthetics are racialized and race aestheticized. Finally, I explore the interpretations of health practices and proposed interventions through aesthetics.

Methods

I draw from 16 months of ethnographic research conducted in Brazil among Brazilian women, which explored the factors influencing women's decisions and experiences securing tubal ligations specifically and reproductive practices more generally. The research was conducted between June 2009 and July 2012, primarily in Salvador, the capital of the northeastern state Bahia, with additional research in Porto Alegre, Rio de Janeiro, and a smaller city in Bahia. I utilized participant observation and tape-recorded semi-structured interviews with women, black and health activists, and medical personnel. Between January and June 2012, I visited a nonprofit private reproductive clinic, Ramils,[2] where I attended contraception orientation lectures and interviewed two medical personnel. No women were recruited from the clinic. Other important sites of participant observation and informal interviews were in everyday activities such as parties, house gatherings, dinners, beach outings and more focused activities like health fairs, health lectures, social movement activities, and women's spaces (private and public).

Through snowball sampling within my previously established networks, I recruited 24 women aged 18 years or older, who had already gone through the procedure of tubal ligation or were interested in tubal ligation or alternative contraception. Race was not an inclusion factor. Many participants were employed and in relationships with men. I also interviewed seven black activists or NGO employees. In a few cases categories overlapped: for instance, a sterilized woman who worked as a nurse fell into both categories of woman and medical personnel. Participants predominantly identified as black, between lower to middle income, and had at least a high school level of education. Women participants with contraceptive or tubal ligation experiences or concerns ranged in age from 19–60. Interviews were carried out in locations chosen by the participants, often public spaces close to their homes, inside their homes, or at their place of work. I undertook all interviews, which lasted between an hour and an hour and a half, in Portuguese; I later transcribed and translated them into English. I relied on inductive, grounded analysis of interview transcripts and fieldnotes for analysis. In this context, I observed the worlds that women were navigating.

Aesthetics defined

My interest in aesthetics follows a trajectory in recent anthropological work that distinguishes it from art and pushes for more expansive thinking about its role in shaping life (Coote 1992; Hodzic 2013; Sharman 1997; Strathern 1991). Jeremy Coote has pointed out that "all human activity has an aesthetic aspect" and defines aesthetics as "something like the set of valued formal qualities of objects or valued formal qualities of perception" where perception is a phenomenon, shaped by cultural factors (1992:246–247). Russell Sharman defines esthetic perception as "the attachment of value to the sensory experience of objects or events," while esthetic expression "is the human re-creation of experience through which the values attached by means of aesthetic perception are reconstituted and/or transformed" (1997:178–183). For Sharman, "the process of socialization, the production of moral values, and the construction of identity all draw heavily on aspects of a cultural aesthetic" (1997:189). Marilyn Strathern describes aesthetics as "the persuasiveness of form, the elicitation of a sense of appropriateness" (1991:10).

Sharman (1997), drawing on Coote, points to the way that aesthetics and morality are conceptually connected. While morality is not sexuality, sexual arrangements and meanings come to be invested with moral significance (Pigg and Adams 2005). Sharman quotes Flores Fratto: "Aesthetics, like ideology, provides a culturally specific way of knowing the world, and as such, offers to the participants in a society a model upon which they may (and by implication should) base their beliefs, their behavior, and their characters" (1997:189, quoting Fratto 1986). This applies not only to morality but also identity. Drawing from Terry Eagleton's 1990 argument that "habits, pieties, sentiments, and affections" serve as the "ultimate binding force … of social order" (quoted in Sharman 1997), Sharman elaborates that these sources of binding for the social order can be produced through a "coercive apparatus like slavery." The coercive apparatus can color "the sensory perception of the world of a group of people who as a result recognize and express beauty in a similar way" (1997:190). The expressive process is one of inclusion and exclusion. The socially constructed nature of esthetic perception lends itself to anthropological inquiry as it "offers insights into socio-cultural processes that might otherwise remain invisible" (Sharman 1997:189). Bourdieu has demonstrated the way consumption patterns can announce one's taste and thus status in society, while naturalizing social difference, as Jarrin (2015) has shown when the body is inscribed with taste through cosmetic surgery. While I don't use the idea of taste, I am interested in the impossibility of value accruing to some bodies – when consumption and medicalization fail.

I draw on and expand on this literature by defining aesthetics as the cultural construction and prescription of tastes, sensibilities, values and affects to the appearance and arrangement of things, places and people. Aesthetics concerns what we deem beautiful, appropriate, normal and healthy, and what is deemed in contrast as ugly, grotesque, monstrous, diseased and deformed; it covers also the accompanying relations between the designations. Since the Enlightenment, a Western notion of aesthetics has concerned what to make of blackness and its appearances and arrangements.

Colonialism and the Trans-Atlantic Slave Trade left legacies in which “the black body became ever more specifically associated with degradation, contagion, and disease” (Comaroff 1993:305). Blackness and its appearances and arrangements have been overwhelmingly constructed as abnormal, diseased, excessive or deficient, unhealthy and inherent, defining the apprehension[3] of blackness. This particular formulation of aesthetics is antagonistic to blackness. Based on my fieldwork, I pay attention to the way aesthetics plays out in terms of reproductive health and family planning. In the next section, I illustrate how aesthetics is already racialized and race already aestheticized; this becomes important in thinking about the implications of a health system that is not only shaped by race and aesthetics, but is already racialized and aestheticized.

Aesthetics as racialized, race as aestheticized

The Negro is an animal, the Negro is bad, the Negro is wicked, the Negro is ugly (Fanon 2008:93).

The conceptualization and practice of race developed differently in Brazil to that in the United States. While the United States understood race through the “one-drop rule” or hypodescent – the idea that any black ancestry results in racial categorization as Black – Brazil’s racist mechanism has been disguised by ambiguity and myth (Davis 1991; Fry 1996; Telles 2006). Racial democracy is one of those myths, through which Brazil distinguishes itself from the United States and South Africa where racism and racial discrimination were legislated. Brazil presents itself as a more racially harmonious society. In part, Brazilians define their race based on their color and combination of features – aesthetics. Particular combinations of skin color, hair texture, size and shape of lips and noses, and so on, created categorizations of color categories such as *alva* (snowy white), *branca-queimada* (burnt white), *escurinha* (very dark), *puxa-para-branco* (somewhat toward white), *sarará* (yellow-haired negro), and *caboclo* (mix of indigenous and white) (Schwarcz 2003:27–30). While seemingly focused on skin color, these categories describe different couplings of features – for example, signaling a black person with naturally straight hair versus one with very kinky hair or a black person with green eyes. They also speak to scales of miscegenation and signal anxieties related to proximity to blackness or whiteness. Brazil’s 2010 census reduced the categories of racial categorization to *branco* (white), *preto* (black), *pardo* (brown), *amarela* (yellow, Asian-Brazilian) and *indigena* (indigenous). Because of the functioning of anti-black racism in Brazil, many people categorizable as *preto* identify as *pardo*. Gabriella’s movement between *parda* and *branca* signals the way race depends on context (Jarrin 2017). Within the state of Bahia, she can be read as white regardless of her parentage. In other parts of Brazil not characterized by their black population and despite a French last name, Gabriella’s features would produce doubt about her whiteness, such that *parda* or even *preta* or *negra* might be used to describe her.

Features of beauty were associated with whiteness (hair texture, skin color, shape and size of nose), while features associated with sex were those attributed to blackness – breasts, hips and buttocks (Caldwell 2007). Thus, while a corporeal ideal favors features associated with sensuality and blackness, a broader ideal of beauty favors whiteness and associated features. The intersection of race with gender meant that female gender identities and positioning were closely tied to women’s potential relationships with white men and racial patriarchy (Caldwell 2007). A hierarchy constructed white women as marriageable, *mulatas* for sex, and black women for labor.[4] Ugliness and labor are also associated with blackness; those not possessing desirable corporeal or beauty features are deemed suitable for labor, the margins, excess and death. This gendered and racialized hierarchy maps onto notions of beauty, sensuality and ugliness (see Figure 1). Despite the seeming rigidity of this hierarchy, there is flexibility, instability and ambiguity in its operation, allowing for different negotiations. Figure 1 illustrates the imaginings of racial categories and the ways that sensibilities and affect are prescribed to particular arrangements or appearances of people. It also illustrates how racialized aesthetics affect perceptions of reproduction. Within Brazil’s gendered hierarchy, white women are beautiful, marriageable and produce what is constructed as good reproduction; *pretas*, on

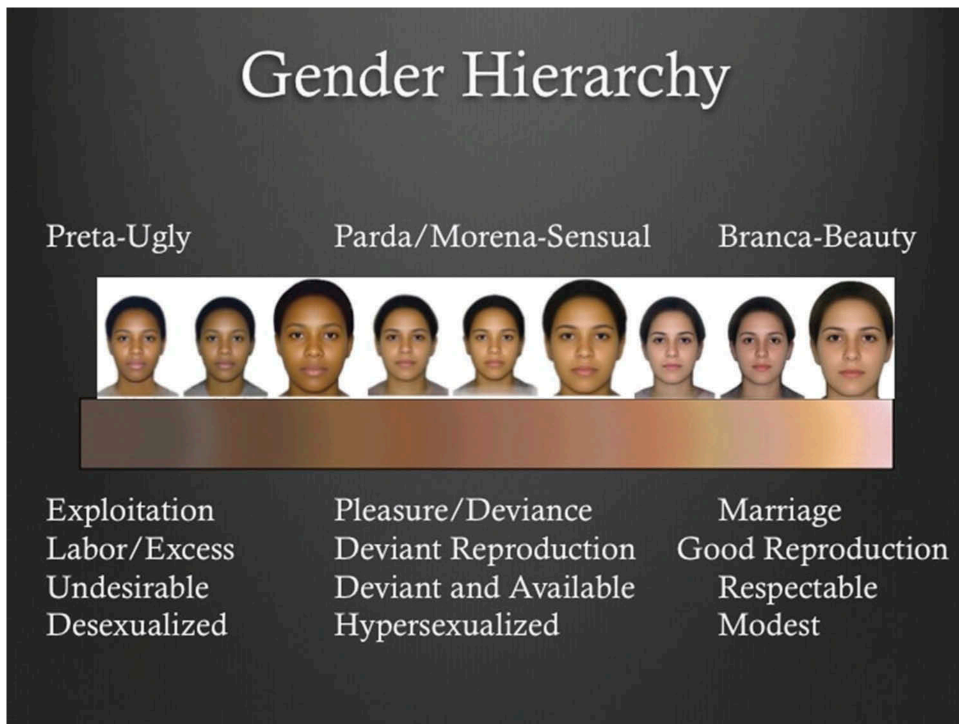

Figure 1. Racialized, aestheticized, and gendered hierarchy. (Continuum by author, source: Mendes, Arrais, and Fukusima 2009).

the other hand, are ugly, suited for labor, and produce what is constructed as undesirable and problematic.

I draw on a childcare experience to illustrate aestheticized race and racialized aesthetics at work, demonstrating how ideas about health as already aestheticized circulate in the everyday. Maria, over age 35, is a self-identified black married, stay-at-home mother of four children. At the time her story took place, she was the single mother of two children, a boy and a girl. This particular daughter of hers is significantly lighter and has less curly hair than Maria and the rest of her children. Maria tried to secure childcare for this daughter at an affordable daycare close to her house. But the woman in charge of the daycare, populated by predominantly black and brown children, surveyed both mother and child and questioned Maria's decision to enroll her daughter there. The woman characterized Maria's daughter as pretty and well-taken care of and insisted that Maria could not leave her daughter. Maria explained that her financial situation did not allow for a better place and that she was in desperate need of daycare so that she could work and provide for her daughter. Ultimately, the woman refused enrollment for her daughter. Referring to Maria's child as "pretty" and "well-taken care of" is an attribution of beauty and health to an appearance approximating whiteness.

The attribution of beauty, health and whiteness to the child of a black woman demonstrates the flexibility surrounding race, aesthetics and reproduction in Brazil, while mapping onto similar arrangements or appearances. It also reveals the differential value and affect that children, the result(s) of their parents' reproductive decision-making, garner. Maria's daughter's light skin was deemed valuable in comparison to her darker counterparts at the daycare, thus requiring a different kind of care that would continue to contribute to her beauty and health. This difference in treatment plays out in other areas more specific to health, most detrimentally to black women. Black women and their black children do not garner the same kind of life preserving interventions as their white counterparts, socially or medically.

Negotiating bodily aesthetics

I sat with Bruna, a 19-year-old unmarried black teen finishing high school, as she listed the different forms of reversible contraceptives available, including criteria for use, such as parity and prior health conditions. She was from a small city in the interior of Bahia, living in her neighborhood with her older brother. While she would later tell me that her preferred method would be the pill or the three-month injections, she was still a virgin and was not using any method when we spoke:

> The pill is good but if you forget to take it one day, you run the risk of getting pregnant. And the injection, you can take it and not worry except that it depends on the injection. It changes your body, you know. You can gain weight. So it depends on how my body reacts best.

She was worried about forgetting to consistently take the pill and was leaning toward injections, but she also expressed her unwillingness to compromise her body size for protection by hormonal methods. Within the few months between my first conversation with Bruna and my interview with her, she would start dating and lose her virginity to a man she identified to me as *branco*. She had not decided on a method before having sex with him, and she became pregnant, another statistic in the disparity between black and white women's rates of unplanned and early pregnancies in Brazil.

Bruna is slim, has dark brown skin, and a face that commands a sustained gaze. She would express to me her disappointment with the new categorization of race in Brazil, requiring that she self-categorize as *preta*. The term *preta* can be used pejoratively to mark a particular social position and, I argue, to mark one's ugliness. Although Bruna claimed to love her skin color, she rejected the term designated to describe it. In an initial group conversation, the lighter complexioned women admitted to preferring to reproduce children of their color or darker, while Bruna minimized the importance of such a consideration.

In a previous visit to Bruna's neighborhood, which she described as a favela, as I packed up my belongings following an interview, some of the younger neighborhood girls chided each other. One of them, with lighter skin complexion, talked about hair, specifically about her wavy hair and all its good qualities. She made an off-hand (color) comment about Bruna's wavy but coarser hair. To smooth over the hair comment, she called it a joke. Bruna was the darkest of the younger women and the comment was similar to other "jokes" that circulate about coarser, kinkier, "blacker/African" hair. Nothing changed between the young women but the comment made me reflect on Bruna's responses to questions about race and reproduction and the appearance-related social pressures she experiences.

I am not purporting to know why Bruna became pregnant nor to surmise that her pregnancy was simply due to her reluctance to use contraceptives that might change her body. That is just the point. We cannot know exactly why she became pregnant. I am interested in what will be mapped onto her pregnancy – what her pregnancy will be made to signify – and her presumed decisions. Bruna's skin tone, darker than the idealized white skin and eroticized brown skin of the *mulata/morena*, could necessitate careful consideration and negotiation of her inherited slimmer facial features and slim body. Her facial features allowed her some access to "beauty" often reserved for and associated with whiteness. Her bodily proportions meant she could still be sexualized in the manner reserved for brownness and some blackness. Her slimness is aligned with a whiter bodily esthetic and less the curvy, sexualized brown/black esthetic. The whiteness of her partner carries currency both for her and the appearance of her child. Despite her knowledge of contraceptive options and her desire to not reproduce, means for negotiating her social positioning vis-à-vis corporeal manipulations would narrow Its role in compromising her contraceptive usage should not be minimized.

Beauty functions as currency (Edmonds 2010). The possession of features of beauty and sex become currency by which black women can navigate and negotiate social life (or social death) and health. A context that values whiteness, prioritizes approximations toward it, and eroticizes brownness and bodily arrangements/proportions, can influence Bruna, who possesses a mix of beauty and sex features. Bruna's articulations of a preference for maintaining her body at the risk of pregnancy might be

characterized by public health discourse as irrational or uninformed – a behavior to change. Her decision to gamble with pregnancy to maintain her body, in part, is an attempt to distinguish herself from merely being black. Bruna did not like that she and others like her had to refer to themselves as *preta*, because she explained, she was not the color of a black shirt, *uma camisa preta*; she was not the color used to describe objects. Other women expressed concern and decisions against using the pill and/or injection for fear of weight gain. The difficulty navigating life with a body marked as black, female and poor (regardless of actual income level) is further complicated when also perceived as fat/overweight.

Sara, a lighter-complexioned friend and neighbor of Bruna, expressed similar hesitations around using contraceptives that could change her body. Sara was a19 years old, a self-identified middle-class and employed preta who hoped to have two or three children in the future. She was interested in hormonal injections administered once every three months:

> A lot of people take the injections. A lot of people's bodies change. Sometimes they were skinny and they become fat. Sometimes they were fat and become skinny. At times, they are totally deformed … you can see that they had children and they are using [contraceptives] you know … they have a big stomach … really very fat. If this happened to me, diet and gym immediately. If no [change], I'd go to the gynecologist and ask to change, explain my situation … explain that I want to change.

These negotiation and choice of contraception based on bodily changes must be situated within more nuanced contexts to better understand the circumstances impacting reproductive and sexual health in Brazil and the depth of racism's reach in structuring and interpreting behaviors. The cultivation and disciplining of bodily aesthetics can serve as a navigational tool for black women in an antiblack society to navigate away from the underbelly of society, even if also serving as a mechanism for health outcomes conceptualized as problems in need of intervention. The overemphasis on access, effectiveness and affordability as factors for contraceptive use obscure other factors that inform decisions. The public health and family planning logics, which justify labeling these sorts of negotiations and failures of contraceptive use as unhealthy and public health concerns, misconstrue and entrench an esthetic of unhealthiness or dis-health as black. Further, they obscure the consideration of unseen and unarticulated forces informing and structuring reproductive decision-making.

Cost, contraceptives and bodily aesthetics

Government contraceptives, provided through the public health system at "no cost" to patients, can cause drastic bodily modifications. As women, especially poor, young, brown and black women, attempt to discipline their individual bodies in accordance with societal disciplinary norms, governmental practices and policies serve to derail the disciplining process. In many cases they endanger health through the provision of contraceptives that increase blood pressure or result in other medical complications which then require cessation of the method. Women who do not run medical risks and choose to use these methods run the risk of bodily modification, as Camila, a 48-year-old separated mother of two, explained:

> If you were to go buy, there are contraceptives that are super expensive but you maintain your body cool. You won't gain weight. Your breast won't grow. Your butt won't grow. You won't have huge thighs and be awful. But what the government gives, it leaves women ugly and horrendous. Because they (the women) end up looking like a cake full of yeast … I got tired of seeing, because we would give every month, the one for three months, the injection for every three months. That one is poison. You give the injection to the girl, you see those girls all skinny. When they come back, just look at their breast, their thighs, their butts, horrible! All fat, all ugly, the body all messed up, because of the contraceptives given by the government … I work with men. I see what they say about women … 'What a fat woman!'

Camila, a nurse technician working in a government clinic, observes the esthetic effects of different contraceptives provided by the government. As Camila's male colleague indicated, women can be judged harshly for their commitment to attaining healthy reproductive decision-making, by delaying pregnancy through contraceptive use. And because black women are often only conceded beauty in and through their bodies, modifications to their bodies carry different consequences than for white women with similar changes. As anthropologist Jarrin has pointed out, "Blackness is only valued in

lower regions of the body if at all" (2015:537). Women and young girls, often poor, brown, and black, dependent on the Brazilian public health care system, have to navigate contraceptives that may prove inappropriate for them.

When women rely on non-modern contraceptive methods or methods that fail (such as copper IUDs in Brazil) to discipline their bodies, they further cement their construction as public health and civil society threats: over-reproductive, irrational, abusers of public resources, breeders of criminality and disease. They are targeted for public health campaigns to increase contraceptive education or empowerment. In overtly racist and eugenic terms, they are the targets of political and public health campaigns to legalize abortions to reduce the reproduction of criminals or of incomplete campaigns for implants that are not removed, as in Rio de Janeiro (Caldwell 2017) and Porto Alegre (REDE FEMINISTA DE SAÚDE 2006). Women able to access better contraceptives, with fewer esthetic modifications, enjoy an expendable income to cover expensive out-of-pocket costs. These women escape the kind of surveillance and governance deemed necessary to characterize and address the unhealthy/deviant reproductive and sexual health practices of black, brown and poor women that threaten the security of civil society. Stated differently, the construction of "vulnerable," "at-risk," or "unmet contraceptive need" populations of women that need surveillance and intervention is already racialized and based on a racialized esthetic, with effects on evaluations and delineations of health and the health services to serve these populations. Women negotiate their health and well-being with esthetic ideals that structure their lives. These ideals are often constructed by discourses about what health is and looks like, and why they do not achieve health.

Jarrin points to the biopolitically embedded racism in beauty to think about the "right to beauty" through plastic surgery in Brazil (2015:536). The particular provision of contraceptives in Brazil does several things anatomopolitically and biopolitically, further entrenching anti-black racist logics and aesthetics. The limited contraceptive options at no cost to the general population discursively puts the onus of discipline on women to access these options. If the contraceptives that do not result in poor health and esthetic modifications are not available for free, neoliberal logics blame poor women for their inability to sell their labor sufficiently to be able to purchase expensive and less disruptive contraceptive options. Women, then, despite their internalization of discourses and practices of individual discipline, appear undisciplined and uncontrollable. This reifies and reinforces discourses and constructions of female blackness and particularly female black reproduction as in need of institutional surveillance, control and intervention. Further, the aesthetics of blackness continue to be tied to poverty while those of wealth continue to be tied to whiteness. Maria, despite residence in a middle-class to wealthy bohemian neighborhood, ownership of a family car, and family excursions to different parts of the state for family vacations, insisted that she and her family were poor.

Women who approximate and inhabit whiteness can afford to escape surveillance and intervention through purchasing and using contraceptives with little to no health and esthetic consequences. This sustains a particular esthetic that positions Brazilian whiteness as moral, responsible, healthy and beautiful. Brazilian whiteness' reproduction and contraceptive practices are recognizable nationally and globally as part of progress (Jarrin 2015), while blackness remains antagonistic and in need of governance. The entanglement of class and race, such that whiteness connotes wealth and blackness connotes poverty, in conjunction with a particular practice and implementation of public health programming, produces material effects such as body modifications or more than two pregnancies. Women's unseen and unarticulated plans and intentions continue, invisible while discursive constructions are remapped, cementing constructions of black reproduction, white reproduction, and their relationships to health and otherwise.

The healthy family, the family planned

A racialized esthetic governs family planning, reproduction and motherhood with ramifications for bodily aesthetics. The aesthetics of a beautiful and healthy family is that of a heterosexual, two-parent, white middle class family with two children, preferably one male and one female. A healthy family is also

defined by an esthetic of plannedness, which not only imparts a notion of positive reproductive and sexual health outcomes, but also notions of female empowerment and modernity. It should be easily legible to a governing body. This esthetic takes into consideration the age difference of children, perceived age of the mother, and so on, as indicative of the “health” of the mother’s reproductive life. On one hand, Bruna and other black women are negotiating a bodily esthetic that always already oversexualizes their bodies, keeping them in particular social positions, while simultaneously serving as a means for navigation to a different social position – even if fugitively (Moten 2008). On the other hand, black women are also navigating an esthetic of responsible and healthy reproduction, to which they are constructed as antagonistic.

An example of this was illustrated in a day out with Maria, the black married mother of four children from earlier. Maria would have only had three children had her doctor honored her promise of a tubal ligation. Maria’s doctor did not, giving Maria contradicting reasons (Edu 2018), and she became pregnant again with her fourth child. She switched doctors and was finally able to secure her tubal ligation. While out enjoying Carnaval with her three youngest children, her husband, a mutual friend Bia and me, Maria would be subtly judged. Despite characterizing her family as poor, she, her husband, and four children lived in a middle-class neighborhood, owned a car, took family excursions, participated in extra-curricular activities, and Maria was able to stay at home by choice. Nonetheless, none of this was “read” or “recognizable” by white colleagues we encountered in the plaza when Bia and I pointed out the first two children. When Maria’s third child approached and we pointed her out, Bia called my attention to the wide-eyed shock of her friends: “Another child?!” Bia was particularly attentive as she worried that Maria was read as irresponsible or careless because of the number of children she had.

Although there is a rhetoric of contraceptive choice within the national family planning program, as I have described, for many black women, access to reliable and effective contraceptives is elusive. Tubal ligations were difficult to attain prior to legalization in 1997. After legalization, they remain elusive. The scrutiny, surveillance, and policing of the law brought onto the procedure of tubal ligations has most impacted already marginalized populations. The characterization of tubal ligations as an extreme act, in the face of other contraceptive options, has ramifications for black women who seek them out; there are diminished avenues for securing the procedure. Yet when women have more children than they “should,” their reproductive health and decision-making come into question.

Black women’s attempts to foster health and well-being for themselves and families are often constructed as dysfunctional or unhealthy. Black women recognize the difficulty of raising more than two children. Yet to secure a tubal ligation, as practiced, they may be required to present with more than two children. Juliana, a 39-year-old black separated mother of two, stated:

> But there are people that have a huge difficulty in doing [the tubal ligation] by SUS, due to the waiting list, there are many interviews that you need … Really, it, it is very complicated. You have to have a certain age, you have to be above 25, 26 years of age–I’m not sure but I think it’s this age. You have to have about 4 children to be able … to do it with SUS. It is very difficult. It is not easy to do a tubal ligation nowadays.

Juliana lives in Porto Alegre and was able to secure a tubal ligation through her private insurance. Juliana’s comment echoes those I heard from other people. Some posited older ages, (e.g., 30 or 35) while others posited varying combinations between age and children, such as 25 and three children or 30 and two children. For younger black women to increase their chance of sterilizing, they must exceed two children, which further distances them from achieving an esthetic of a healthy, planned and responsible family. Constructions of black women as promiscuous and overreproductive do not result in gracious and empathic readings of women with more than two children. As one 39-year-old self-identified employed Black woman remarked: “Ever notice how those with means only have like one or two. And those that don’t have means fill up the house?” There is no means to read Maria’s third child as planned or to prove that medical malpractice contributed to the fourth child. A third or fourth child’s appearance – its specific appearance and the appearance within the family

structure – reveal "truths" about mothers regarding sexual behavior, reproductive practices, contraceptive use, and attendant moralities, reinforcing previous constructions of female blackness.

Despite these varying combinations of parity and age, women can have up to four children and have passed the minimum age of 25 and still not be able to secure a tubal ligation. This perpetuates the characterization of black women as over-reproductive and hypersexual, deviant from healthy reproductive practices and sexual practices. Women who want to have only one child deviate from an esthetic ideal of family of two children. As I was told repeatedly by health professionals, a woman with one child would not be able to secure a tubal ligation. And though in this instance, in which the family formation does not signal an excess of children, one child to a single mother can still signal deviance in reproduction. In a two-parent white family, one child is read differently than one child to a brown or black single mother, due to underlying esthetic ideals which associates female blackness with sexual or manual labor (Caldwell 2007).

The rhetoric and relationship of "planned" families to definitions of health and beauty further complicates the recognition of black families as healthy. Silvia de Zordo's research in Brazil reveals the way that the notion of family planning emerges in a eugenic perspective, "aimed at building a modern, developed nation by improving the quality of its population and creating good citizens" (2012:208). Jarrin (2015) has demonstrated the link between beauty, health, and eugenics thinking in Brazil, providing a means for understanding the attention, hierarchies, and importance of appearances and arrangements of families that manifest. In particular, family planning concerns were targeted at poor black people, and those living in the "underdeveloped" parts of Brazil (dos Santos 2012) – another way of signaling nonwhite Brazilians. Notions about planned families and family planning are tied to notions of discipline, the future, responsibility, and neoliberal logics to which blackness is constructed as antagonistic. In other words, blackness continues to be construed as irrational, irresponsible, pleasure-driven and short-sighted in ways that make family planning inconceivable or impossible for blackness without proper education and policing. Blackness, without these interventions, threatens to destroy the rationality, responsibility and modernity of society. Even when blackness "plans" a family, there is no manner for recognition of this, outside of black mothers repeating a refrain of "I planned my child" or "I planned to have this one" or "I didn't plan that one but I planned this one."

The construction of blackness as possessing excessive and abnormal sexuality, in association for instance with large buttocks, hips and fantasized enlarged genitalia, means that black women are assumed or made available for sexual liaisons. The stereotype of Black women for sex but not for marriage reinforces their reproduction as excessive, incomprehensible, against what it means to be human. Black women's experiences of their pregnancies with health professional are marked by violence and mistreatment (dos Santos 2008). Health professionals understand black pregnant women as "dirty," "polluted" and "promiscuous," leading black women to feel that their pregnancies were immoral and shameful (dos Santos 2008). Overall, black women's experiences with health professionals during pregnancy leads dos Santos to summarize this in terms of motherhood "almost automatically becom(ing) incompatible with black women because they are considered 'naturally' immoral, like prostitutes" (2008:366). Further, black women's reproductive and sexual health becomes dehumanized, justifying the construction of black reproductive and sexual health as threatening to moral order, to be regulated and eradicated through medical interventions (dos Santos 2008). In some cases, the lack of regulation or eradication, through the distribution of ineffective contraceptives or denials of tubal ligations, leads to the production of excess. This construction has less to do with any contextual statistical "facts" of excessive reproduction and more with an esthetic that cannot incorporate blackness' reproduction as a marker of health, good, modernity or beauty.

A particular interaction brings this tension into relief. I visited Perola at her stand at least once a week. She is a self-identified *negra*, middle-class, married, evangelical, 42-year-old mother of one. She is married to a *branco* and sells handmade jewelry in a popular tourist part of Salvador. One particular day a friend of hers, Eugenia, passed by with a little boy. Eugenia later passed by with another woman, who was holding an infant and another little boy. Eugenia introduced the other

woman as her sister, Larissa, the mother of all three children. We exchanged pleasantries. While they were still close, Perola turned to me and asked: "She doesn't know Elsimar Coutinho?! He likes cases like this! … No really though, she doesn't know him!? I can introduce her. I'm trying to tie mine and here she is with three." Perola distinguished herself from Larissa, reading lack of intention into the other woman's reproductive decision-making and suggested an introduction to Dr. Coutinho as an appropriate intervention. Dr. Coutinho is a controversial doctor linked with clandestine and genocide-driven distribution of female sterilization by some black activists in Salvador. Dr. Coutinho has also produced texts linking black reproduction and criminality in Salvador.

Perola's comment captures the complexity of aesthetics, race and reproduction for black and brown women in Brazil. On the one hand, despite her light brown complexion, Larissa as mother of three is seen as excessive, undisciplined and in need of a harsh intervention, a tubal ligation without consent. Larissa's light skin does not allow her to escape the stereotypes fixed to female blackness. There is no means by which to entertain the possibility of a failed method, or the lack of the contraceptive brand that works best for her body. On the other hand, the darker complexion of Perola, a mother of one, a child which was largely invisible at the workplace, is unable to access a tubal ligation to ensure that she won't have more children. She uses a contraceptive pill that "doesn't make me gain weight. It doesn't make me nauseous" and that she pays for. And even as she pays for her own contraceptive and seemingly emulates whiteness (e.g., through sexual purity until marriage, giving birth to one child within marriage [heterosexual monogamy, Christian, middle-class, able-bodied]), even marrying a white man and having a child with light skin, there is no guarantee that she will escape how society makes sense of people who look like her and of their family configurations. Perola cannot count on people in society being able to denote her as modern or closer to whiteness because of what black or dark skin is made to signify. In the same way, Larissa's reproductive and sexual life is obscured. Perola's assumptions about Larissa's three children as a result of her unwillingness or inability to control herself is a performance of what society or whiteness does when it renders black reproduction into its varied negative connotations in Brazilian society. These notions operate in medical and public health spaces, with more sinister consequences for black Brazilian women.

Conclusion

Within a context in which the distribution of contraceptives mirrors societal stratifications – those with better living conditions can access better quality contraceptives while others are denied voluntary tubal ligations, Black women continue to be constructed as uncontrollable and without discipline. This is tied to the Brazilian legacy of constructing Black reproduction as problematic, whether through Brazilian elites' concerns with black wet nurses as bearers of disease (Otovo 2016) or by linking black reproduction to the production of criminals (Santos 2012). This maps onto the dominant gendered and racialized hierarchy functioning in Brazil (see Figure 1, above). Denials of tubal ligations can serve to produce logics that justify efforts and campaigns for sterilizing black women without consent. In the Brazilian context, where black women lead in maternal mortality rates, the inequitable distribution of effective contraceptives, criminalization and punishment of botched abortions for those who can't afford to pay for their privacy and life (black and brown women), and refusals of sterilizations are also means by which health inequalities are sustained. Simultaneously, the aesthetics of poor health outcomes, more specifically, Black women's reproductive health outcomes, remain black.

Paying attention to Black women's expressions of concern about bodily aesthetics related to contraceptive use within the unique context shaping their social existence, can help to uncover the esthetic systems governing their lives specifically and society more generally. Rather than focusing on whether or how women contest anti-black rationales, I have focused on how these rationales are already coloring meanings that can be made about their actual and assumed reproductive lives and experiences. This provides an opportunity to explore how these aesthetics permeate the seemingly unrelated realms of family planning and reproductive health outcomes. Attention to the esthetic system facilitates an understanding

of the stakes of medicalizing deviance that maps onto notions of blackness and ugliness, and its production of definitions, interventions and approaches of racialized and aestheticized health. It points to the ways that cultural systems and reproductive health systems are informed by aesthetics. In this case, the need and process for prescribing and constructing values, affects, sensibilities and tastes to the appearance and arrangements of people, places and things is already racialized. Even in its articulated commitments to health as a right and endeavors to improve health outcomes for marginalized populations, a reproductive health system can reproduce the conditions that result in poor health. Studies of health and biomedical systems cannot afford to ignore the esthetic underpinnings that are tied to how we understand, perpetuate and reproduce blackness, whiteness and their relationships to ugliness, death, beauty and life.

Notes

1. A more nuanced explanation of the involvement of Black women activists can be found in Sonia B. dos Santos' (2012) work cited in my bibliography.
2. Pseudonym for a clinic specializing in reproduction, providing contraceptive and fertility services as well as conducting research.
3. By apprehension I am referring to its multiple definitions as understanding, grasping, taking hold, catching, capturing, and arresting.
4. The original: "Branca para casar, mulata para fuder, preta para trabalhar."

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