

ARTICLE

Towards a Black Feminist Health Science Studies

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Abstract

Black Feminist Health Science Studies (BFHSS) is a critical intervention into a number of intersecting arenas of scholarship and activism, including feminist health studies, contemporary medical curriculum reform conversations, disability studies, environmental justice, and feminist technoscience studies (Bailey, 2016). We argue towards a theory of BFHSS that builds on social justice science, which has as its focus the health and well-being of marginalized groups. We would like to move towards a social justice science that understands the health and well-being of people to be its central purpose. This formulation of BFHSS provides evidence of the co-constitutive nature of medical science and popular perception, underscoring the need to engage them simultaneously. Health is both a desired state of being and a social construct necessary of interrogation because of the ways that race, gender, able bodiedness, and other aspects of cultural production profoundly shape our notions of what is healthy (Metzl & Kirkland, 2010).

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During a 1964 speech in Harlem, New York, famed civil rights activist Fannie Lou Hamer told the audience that she was “sick and tired of being sick and tired.” Although Hamer’s words are often understood as a concise expression of Black folks’ general weariness and anger at living under white supremacy and anti-Black racism, her attention to literal sickness, bodily vulnerabilities, and health outcomes for Black people are overlooked. Hamer told the Harlem audience about the harrowing beating she received in a Mississippi jail for her civil rights work (Brooks & Houck, 2011, pp. 57–64). She described, in detail, how her body was beaten head to toe. She talked about the way that her past illnesses, including polio, made her body even more vulnerable to the beating she received in jail. She mentioned that after such a savage physical attack, she, and other inmates who were similarly assaulted, were denied medical treatment for the duration of their jail stay. She also described a later visit to a medical specialist who told her that the beating had permanently damaged one of her eyes. Hamer’s declaration that she was sick and tired was not simply a metaphor for activist fatigue; it was a declaration of literal pain, illness, and physical exhaustion. Fannie Lou Hamer’s words highlight the way that physical and mental health has always been a metric for understanding both the process and impact of oppression for people of color.

Black feminist health science studies (BFHSS) is a product of Hamer’s clarion call to attend to Black peoples’ health and wellness as an integral part of social justice labor. As such, BFHSS critically intervenes in a number of intersecting arenas of scholarship and activism, including feminist health studies, contemporary medical curriculum reform conversations, disability studies, environmental justice, and feminist technoscience studies (Bailey, 2016). We argue for a theory of BFHSS that builds on social justice science, which has as its focus the health and well-being of marginalized groups. We would like to move towards a social justice science that understands the health and well-being of

people to be its central purpose. This formulation of BFHSS provides evidence of the co-constitutive nature of medical science and popular perception, underscoring the need to engage them simultaneously. Health is both a desired state of being and a social construct necessary of interrogation because race, gender, ablebodiedness, and other aspects of cultural production profoundly shape our notions of what is healthy (Metzl & Kirkland, 2010).

BFHSS research connects the messages within the seemingly objective realm of biomedicine to the social contexts in which they emerge and are shared. In looking at the ways representation is used to explicitly teach, learn, practice, and experience medicine, we explore how media is an important technology in the institutionalizing of medical practice as well as explore how it impacts public perception of difference. We understand media as a public health pedagogy that teaches us about what our society believes about health. We explore the feedback loop between popular media representation and medical media to tease out the undergirding structures that support their interconnection (Bailey, 2016). We believe that media and health are co-constitutive. Therefore we must critically analyze media texts as they relate to health, as well as critically engage with and comprehend the media in health texts. In “Misogynoir in Medical Media: On Caster Semenya and R. Kelly,” Moya Bailey explores the real-life impact of misogynoir in medical media by explaining how the biomedical knowledge produced by physicians constructs certain bodies as normal and others as pathological (Bailey, 2016). We believe that the way we talk about health in the media impacts the way we experience health. The ways in which popular media shapes ideas about the healthy body are not unlike the ways that media produced in medical settings shapes ideas about what healthy bodies look like as well.

As interdisciplinary scholars who began our careers in women’s, gender, and sexuality studies as undergraduates at women’s colleges, we are deeply invested in and knowledgeable of the theoretical tools of the discipline. That said, we still feel the need to carve out space for and

curate scholarship that is not fully recognized as addressing the complicated and necessarily intersectional issues of Black women's health. We propose BFHSS as an emergent lens and praxis, built on existing and growing research that demands a multi-pronged approach to ameliorating the health disparities of Black women. BFHSS is not a fleeting intervention but one that will grow roots into the marginalizing narratives and material practices of health, wellness, science, and medicine until they have fundamentally altered and addressed.

We draw on the work of Dorothy Roberts, Alondra Nelson, Cathy Cohen, and Evelyn Hammonds, among others, as we grow an interdisciplinary community dedicated to creating better health outcomes for Black women. We believe, as the Combahee River Collective states, that "If Black women were free, it would mean that everyone else would have to be free since our freedom would necessitate the destruction of all the systems of oppression" (Combahee River Collective 1995, p. 237). Similarly, if Black women as a whole were healthy, it would mean that many of the barriers to quality health care would necessarily be removed, creating a more ethical and just health culture for everyone.

Like other critical feminist technoscientists, we have struggled with the field's continued US centrism and whitewashing of women. Anne Pollock and Banu Subramaniam's important intervention, "feminist postcolonial technoscience," gets at many of the issues that we wish to raise here (Pollock & Subramaniam, 2016). However we eschew the political term *women of color (WOC)* in favor of *Black* to attend to the disparate realities that Black women face in the medicojuridical systems of our world. Although WOC is a widely used and important term for collaboration and identifying patterns of marginalization, we insist on the specificity of talking about Black women to get to the nuances of Black women's health disparities and the role Black women's bodies have played in the development of biomedical science. Although we focus on Black women in the United States, scholarship that advances similar theoretical perspectives comes from theorists of all disciplines, racial backgrounds, genders, and continents.

As people born and raised in the United States, we have inherited a US centrism that we are working to deconstruct. Although our genealogy of BFHSS has centered the US, we endeavor to incorporate scholarship, collaborators, and perspectives that reflect the diaspora. However, BFHSS builds on the legacy of US medical experimentation on Black patients, exposing the invention of Blackness as a social caste with the advent of chattel slavery. The ways in which American medical education is informed by the history of slavery cannot be understated.

We have divided this article into three sections. First, we identify the genealogies of this field, articulating the legacies of Black women scholars and ancestors whose lives and work shape our understanding of the field. In the second part of the essay, we identify the how feminist science studies laid the groundwork for BFHSS but also highlight what differentiates this nascent field from its predecessors. We end with what we see as the way to actualize our scholarship, through praxis. We identify where we want our research to go and the type of collaborations and interdisciplinary scholarship necessary to create better health outcomes for Black women.

Black Women's Bodies in the Hands of White Men and Women

Black women's historical and contemporary experiences in the West have long been rooted in a denial of their humanity. The classification of Blackness as bound to the animal and natural world and, therefore, outside of the realm of logic and culture, meant that Black bodies were more easily considered Objects available for use by white Subjects imagined to be superior. The historical reduction of Black women's humanity to the level of animal meant that Black women were not regarded with the same care and ethical consideration that their white counterparts were afforded. The systematic and grotesque neglect of Black women's bodies is demonstrated in Hamer's story of jailhouse abuse and in the histories we unpack in this section, which include Sarah Baartman and J. Marion Sims. As we outline below, the denial of

humanity is what undergirds the structures of power and exploitation that have made it possible for Black women to be rendered ideal objects for medicoscientific experimentation and neglect.

Sarah Baartman, a young Khoisan woman from what we now call South Africa, was displayed throughout Europe and was dissected and studied upon her death by white scientists at the beginning of the nineteenth century. Sarah Baartman's body represented for Europeans a primitive femininity, wrought of her prodigious backside and comparatively large genitalia (Gilman, 1985). As Rosemarie Garland-Thomson points out in "Integrating Disability, Transforming Disability Theory," Baartman was seen as deformed and abnormal because of her racial and sexual characteristics (Garland-Thomson, 2002). The shifting context informed how Baartman's body was interpreted. Leaving a world where she looked like the people around her effectively produced her viability as a curiosity. European scientists equated Baartman's anatomical differences with deviance. Conclusions were drawn about her sexuality (and subsequently the sexuality of Black women) based on her appearance, and were used to justify racist violence and the enslavement of Africans (Gilman, 1985). Baartman's body was used to bolster claims that Black people were not far down the evolutionary tree from apes. This was also used to explain the purported animalistic nature of Black women's sexuality. Real-life consequences of these fallacies included the legal inability for Black women to be raped because of their perceived receptivity (Collins, 2000). This sordid history continues to undergird medical practice to this day.

J. Marion Sims, posthumously credited as the father of modern gynecology, achieved his celebrity through experimentations on Black enslaved women that led him to perform the first successful surgery to treat vesicovaginal fistulas. With a fistula, a tear of the lining between the bladder and vagina, usually the result of difficult childbirth in malnourished women, creates a passage for the leaking of urine into the vaginal cavity. Women with the condition were in a nearly constant state of discomfort, and in the case of slave women, unable to work. Sims

developed the procedure by performing more than thirty surgeries each on Anarcha Westcott, Lucy, and Betsy between 1845 and 1849 (Axelsen, 1985). They were regarded as ideal patients because Sims and others of the time believed that Black people had a higher tolerance for pain than whites and also because they were considered property and had no say in decisions about their health and treatment. Sims remarked that his attempts to perform these surgeries on white women were unsuccessful because they could not stand the pain. This specious argument misses the differential power relation between a free white woman and an enslaved Black woman receiving treatment. Historian Diane Axelsen points out that enslaved women were conditioned to endure pain with a tight-lipped stoicism that was then equated with animal forbearance (Axelsen, 1985, p. 11). For this reason, Sims did not provide anesthesia for his patients even when it became available. Despite the ethical questions surrounding Sims's work, he is still regarded very positively, with numerous statues erected and awards granted in his honor (Dudley, 2012).

The abolition of slavery did not end socially sanctioned, disparate treatment of Black women. In fact, the end of slavery marked the need to reformulate stereotypes about Black women's bodies. During slavery, Black women's reproduction was encouraged as it generated more slave labor for masters; however, Reconstruction and the first half of the twentieth century were characterized by a policing of Black women's supposedly rampant childbearing (Clarke & Olesen, 1999; Washington, 2006). The eugenics movement targeted poor and Black women whose sexuality was seen as a threat to the wealth of the nation.¹ These women were depicted as producing offspring that they could not afford and that the state would have to support. Their children were also depicted as future criminals in the propaganda of the time (Pernick, 1996; Roberts, 1997). Margaret Sanger promoted negative eugenics, or lowering fertility in populations that were deemed genetically undesirable in the ideal nation state (Chesler, 2007, p. 195). Her promotion of birth control among poor white and Black women was simultaneously liberatory and

oppressive, allowing more reproductive choice yet promulgating stereotypes about these groups. The hypersexual representation of Black women fueled eugenic practices when only a few years before, Black women's reproduction was promoted as a cost-saving and money-generating strategy on the plantation (Roberts, 1997, p. 61; Savitt, 2002).

The Jim Crow South had its own version of policing Black women's sexuality and reproduction. Black women who were in the hospital for any reason could be given hysterectomies without their consent or knowledge. This practice was so widespread that in Mississippi it was dubbed a "Mississippi appendectomy" (Roberts, 1997, p. 92). Fannie Lou Hamer, whose story opens this article, was one of the women subjected to this practice and the experience was a major impetus for her activism (Lee, 2000, p. 21). Sterilization abuse as a tool of white supremacy exceeded the Jim Crow era and continued well into the 1970s with victims like the young Relf sisters in Alabama. Black women were not alone in their fight for the right to have children; Puerto Rican, Mexican, and Native American also experienced high rates of sterilization abuse.

The life of Henrietta Lacks offers yet another example of Black women's historical lack of agency in negotiating health and treatment. Lacks is famous for being the woman from whom the infamous HeLa cell line came. Despite seeking treatment for cervical cancer, Lacks never seemed to benefit from medical science in the way it benefited from her, nor did her surviving family. HeLa cells were the engine behind much of twentieth-century science and medical development. Yet Henrietta Lacks died at the young age of thirty-one and left a husband and children who have never been able to fully access the professional mental and physical health care they needed (Skloot, 2010). Moreover, it is not evident that Mrs. Lacks or her husband ever gave permission for her cells to be removed for research purposes. Like Anarcha Westcott before her, Henrietta Lacks health needs mattered only in so far as they were connected to larger scientific needs, interests, and goals.

In the 1990s, anxieties around Black motherhood were reproduced

within the context of the burgeoning crack epidemic. An organization called CRACK, Children Requiring A Caring Kommunity, responded by offering \$200 to women of color using crack if they agreed to long-term or permanent birth control (Hirschenbaum, 2000). Instead of offering resources or assistance to help the women overcome their addictions, CRACK promoted sterilization through a small monetary incentive. Again, as in the cases of Sims and Sanger, the supposed good intentions of these efforts were overshadowed by the racist implications of projects that targeted Black women.

Black women's history in the development of US biomedical science and practice is not limited to the story of their mistreatment but also includes their advocacy, activism, and resistance. The healing traditions of Black midwives, for example, demonstrates Black women's agency in meeting individual and community health needs in an ethical way. Granny midwives were birth attendants who saw inherent value in Black fertility, reproduction, and futurity at a time when the dominant value of Black women's reproduction was decided by its relationship to white supremacist capitalist growth. Black granny midwives understood that the women and families with which they worked bore inherent value as full human beings. Though now recognized as an early tool of racial and gender justice in health care, the work of Black granny midwives was maligned and stigmatized in the early-to-mid-twentieth century as professional and institutionalized medicine aimed to discredit lay healers, turn people seeking care into patients, and define doctors and hospitals as the only legitimate site of care and healing. Black granny midwives found themselves the subjects of targeted narratives by doctors, nurses, and medical associations who sought to discredit their vast experiential knowledge (Bonaparte, 2015). These narratives drew on racist and sexist ideas about Black women as inherently unhygienic and ignorant to make claims that they were unfit for medical care, particularly when educated white men were available as doctors.

These and other historic abuses perpetrated by medical and public health institutions are generally not publicly acknowledged, though they

have a lasting impact in the Black community. They affect the willingness of patients to seek treatment. The sociocultural factors that helped engineer these systemic practices of mistreatment are beginning to be theorized, along with the patient-led activism that attempted to counteract them (Nelson, 2011). Building on the important work begun by feminist health advocates, historians of Black America, Black feminist theorists and activists, and the field of feminist science and technoscience studies, this article adds to this growing literature through the introduction of BFHSS, in hopes of ameliorating these concerns through interdisciplinary scholarship and praxis.

Bringing History Forward: Defining Black Feminist Health Science Studies in the Contemporary Moment

Feminist science studies emerged as a reaction to the totalizing effects of positivist science. Theorists exposed dominant sociocultural scripts in the supposed objectivity of science. The anthropomorphizing of cells in accordance with our socially constructed gender biases is one of the sites of investigation in feminist science studies. Emily Martin's now classic work on the gendering of the egg and sperm in human fertilization is evocative of this intervention. The mainstream scientific community constructed the egg's role in fertilization as passive and insignificant. The egg is a virtual "damsel in distress" waiting on the "heroic" sperm to come and save her (Martin, 1991). Martin also investigated the negative language associated with menstruation, generally represented as the "failed" fertilization of the egg rather than a natural cycle of regeneration, devoid of failure or success. This contrasts sharply with representations of sperm as "valiant" and "tenacious." Nancy Tuana similarly addresses scientific knowledge, or rather lack thereof, regarding the clitoris in relation to the penis. These imbalances in knowledge around the science of sexuality exacerbate power relations between doctors and patients (Tuana, 2004). It is this attention to language, power, and representation that we bring to BFHSS.

Like feminist scientist Banu Subramaniam, we appreciate the formulation of feminist science studies “because it allows the possibility of construction and collaboration in addition to critique” (Hammonds & Subramaniam, 2003, p. 929). Feminist bioethicists grapple with difficult questions like “can clinical research be both ethical and scientific?” (Holmes, 1989). Feminist science studies analysis reveals important yet hidden processes such as scientists’ selectivity in which parts of the body become objects of interest, which do not, and what they then interpret those parts to mean. In “Body Matters: Cultural Inscriptions,” Lynne Segal points to the clitoris, whose primary purpose, or perhaps only function, is to incite pleasure. Segal cites the clitoris as indicative of how women’s bodies trouble the scientific mythology that sexuality only exists in service of reproduction. She also challenges the notion that men are always ready to have sex with the reality that the penis is rarely erect (Segal, 1999). Segal’s work invites new questions about the ways social beliefs inform scientific conclusions about how the body works and why, despite clear evidence that challenges biological understandings supportive of Western sociocultural practices. How do scientists invested in empirical data arrive at conclusions that are not supported by their own findings? Martin’s, Tuana’s, Subramaniam’s, and Segal’s work helps us to see how scientific objectivity and health are both social constructs whose meanings are strongly influenced by the prevailing social order and cultural beliefs. Similarly, Jonathan Metzl and Helena Hansen’s work on structural competency addresses how medical students are shaped by their education to ignore the construction of health via particular classed, raced, and gendered beliefs about the body (Metzl & Hansen, 2014).

We aim to build on and expand incisive and far-reaching critique developed by feminist science and technoscience studies in at least five key ways. First, BFHSS radically and unapologetically centers Black women’s historical and contemporary experiences of health, medicine, wellness, and science. It also centers Black women as experts capable of theorizing our own experiences and our freedom. Second, BFHSS is

radically interdisciplinary, drawing from fields as diverse as public health and media studies. Third, the interdisciplinarity of this nascent field is further supported by our subversion of the high tech/low tech divide present in science and technoscience studies. Fourth, we recognize media as a powerful part of creating and sustaining health. Fifth, BFHSS incorporates justice as a guiding theme and goal of its work. Pivoting the center of feminist science studies away from whiteness, critically engaging the potential of interdisciplinarity, refusing the high tech/low tech binary, engaging popular media forms as co-constitutive of health, and prioritizing justice as both method and outcome are radical and utterly necessary steps for feminist engagements with health, medicine, and science.

Black women in the US exist at the intersections of several hierarchies of oppression. By focusing on Black women's health, we are required to examine the ways that class, race, sexuality, region, education, gender, and ability are all brought to bear on health outcomes. We believe that addressing our health care concerns will inevitably improve health care for all given the intersecting nature of oppression. Additionally, the histories of science, medicine, and health care are literally built on the bodies of Black women. How is it that our bodies have been instrumental in advances in these fields when we still have some of the worst health care outcomes in this country?

In the spirit of Ruha Benjamin's "Sankofa science" (Benjamin, 2013), we, like the Sankofa bird, look back to retrieve our stories and attend to the historical and contemporary experiences of Black women in American medical experimentation and practice, stitching them together in a critical genealogy. Though nearly a century and nearly 900 miles apart, women like Henrietta Lacks, Anarcha Westcott, Lucy, and Betsy are linked in a shared history that has long positioned Black women's bodies as expendable, even as they have been integral to medicoscientific and social progress. BFHSS centers this history because we recognize the ways that it continues to dictate the contemporary conditions under which Black women like Ethel Easter, who recorded her

doctors making racist and disparaging remarks about her while they operated on her unconscious body (Wang, 2016), access and experience health and medical care today.

Moreover, we privilege the work of Black women as experts on their histories and experiences with health, wellness, and US biomedicine. Black women's critical scholarship often begins with the recognition of the intersectional nature of Black women's experience of the world. This basic yet critical acknowledgement is a hallmark of Black feminist scholarship and activism and one that differentiates it from other critical scholarship on race or gender. We contend that Black women are best equipped (but not solely equipped) to see the specific and, at times, unique contours of our experiences. Black women reproductive health scholar-activists, for example, coined the term "reproductive justice" (RJ) in the early 1990s to call attention to and better address the ways Black women's struggles for reproductive autonomy and freedom were bigger than abortion and contraception access. Activists like Loretta Ross and the SisterSong Collective argued that although the right to control fertility via abortion and contraceptive access was critical to women's reproductive autonomy, Black women had been also struggling for the right to have children in the face of a history of eugenics-based population control practices like forced sterilizations (Ross & Solinger, 2017). The broader nature of Black women's struggles for reproductive freedom necessitated the creation of an alternative framework that could simultaneously account for the difference that race, class, gender, sexuality, and nation made. The development of reproductive justice as a theory and movement is an excellent example of the ways that Black women are best able to name and address their own marginalization and liberation.

As a framework and theory, RJ has always included critical attention to the impact of environmental racism and justice on Black peoples' reproductive lives. Research shows that Black communities are disproportionately affected by pollution and poor air quality. Black households are more likely to be situated in food deserts, places where

grocery stores and health food options are difficult to access. Air quality and food accessibility impact how, why, and if people can and do parent. On these issues, we look to Black women scholars like Naa Oyo A. Kwate, whose important research on alcohol advertising in Black communities highlights the irony of ads that actively promote alcohol use in areas where African Americans are struggling to find healthy and affordable food (Kwate, Jernigan, & Lee, 2007; Kwate & Meyer, 2009). Similarly, the ongoing water crisis in Flint, Michigan and the lead paint present in communities of color's homes and schools all contribute to the lack of quality health care for Black people.

The development of reproductive justice is also an example of Black women's effort to reclaim health from a strictly medical context and rearticulate it to better reflect the specificities of Black women's histories, experiences, and needs. Alondra Nelson argues that white supremacist approaches to Black peoples' health and wellness went back and forth between models based on social control and social abandon (Nelson, 2011). Social control models are marked by the explicit manipulation of Black bodies for white gain (e.g., the control of enslaved African women's fertility in service to the southern plantation economy), and social abandon models are characterized by inadequate or completely absent care and resources (e.g., the infamous Tuskegee syphilis experiment). Nelson's scholarship on the Black Panther Party's medical activism offers an alternative to the dominant white supremacist approaches of social control and social abandon. Much like Fannie Lou Hamer's 1964 speech, Black women's efforts to theorize health in culturally relevant and ethical ways are evidence of a long-standing investment in Black wellness as an individual need and a collective political weapon. Nowhere is this more evident than in Audre Lorde's famous declaration, "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare" (Lorde, 1988, p. 131). Lorde, along with Black feminist health activists like Byllye Avery identified self-care and, in Avery's case, "self help" as an important part of both Black women's health and Black women's politics (Silliman, Fried, Ross, & Gutierrez, 2004). These

women's efforts further reflect the articulation of Black women as subjects of health and wellness rather than as objects that mark its antithesis.

In BFHSS, we build on the work of scholars like Lorde, Avery, and Dorothy Roberts, whose groundbreaking *Killing the Black Body* is an essential text for thinking about the relationship between history, women's reproductive freedom, the state, and race (Roberts, 1997). Although Roberts's choice of subject alone is enough to solidify the book's place in the Black feminist cannon, her interdisciplinary method further positions the work as a critical text for investigating Black women's engagements with the US biomedical complex. Roberts practices a critical interdisciplinarity through her use of legal theory, critical race studies, history, media studies, and feminist theory. The nature of Black women's roles in social, scientific, and political notions of health requires creative and innovative analyses that exceed the boundaries of any one scholarly or practical approach.

We look to critical collaborations that cross disciplinary and practical boundaries for best practices on how to new create new paths and models for radical Black futures. We draw on genre-defying work such as Audre Lorde's *Cancer Journals* (1980) and Bettina Judd's *Patient* (Judd, 2014; Lorde, 2006). Lorde and Judd both go beyond the standard conventions of poetry and prose by offering deeply historical, sociological, political, and personal accounts of Black women's status as "patients" in US medicine and science. In our own scholarship, we practice trans/multidisciplinary modes of inquiry. For example, in a forthcoming article on Henrietta Lacks and Rebecca Skloot's book about her life, we bring the field of Black biography into conversation with the impact of biomedicine on Black lives. Our analysis allows us to ask critical questions about the limits of biomedicine for telling Black women's life stories and achieving justice for individual Black women and Black communities more broadly. An additional way that we are practicing deep interdisciplinarity is by connecting with scholars in practice-based fields. Though trained primarily in women's and gender

studies, Moya Bailey is currently partnering on a research study with public health scholar Madina Agenor.

Moreover, using an interdisciplinary focus, BFHSS is also poised to take on issues like the decidedly low-tech labor of baby and talcum powder, which are now clearly identified as carcinogens. In addition to being used as body management tools, these products have particular meaning for Black women who have long used these products, along with douching and vaginal deodorant sprays, in higher number than their white counterparts to achieve vaginal “hygiene” and desirability. The goals of vaginal hygiene and attractiveness are tied to long-held stereotypes about the dirtiness of both Black and female bodies (Ferranti, 2011). As Omise’eke Natasha Tinsley points out, “if racism posits that blacks reek, and misogyny teaches us that vaginas are rank, how difficult does it become for black women to love the scent of our healthy vaginas” (Tinsley, 2016). Although baby powder is certainly not science or technology in the same way that eggs, sperm, and hormonal contraceptives are, it is nonetheless a product marketed to and used by Black women as a tool to engineer a socially acceptable body. Its use as tool of body modification and management for social and cultural acceptance renders baby powder more than a simple consumer product; it is a technology of self-fashioning and re-fashioning for cultural intelligibility. Moreover, Tinsley reminds us of what becomes visible when we center Black women’s bodies and health in the spirit of intersectionality. Without centering Black women, we might have missed the ways that racist narratives of Black uncleanliness further complicated the seemingly straightforward story of female hygiene. Through an intersectional and interdisciplinary lens, we can begin to unpack the baby powder scandal as an immediate biological health threat and the product of media and cultural narratives about race, gender, marginalization, and shifting notions of hygiene.

Whitney Peoples draws on the work of feminist science and technology studies (STS) and feminist health scholars in her research on the oral contraceptive YAZ, yet she expands both frameworks by

integrating feminist media and cultural studies. Peoples ultimately argues that, though they are outside of the realm of biomedical and lab science, marketing strategies for contraceptives are just as important to feminist critiques of science as the biological effects of the medications themselves. According to Peoples, contraceptive advertising is critically important public pedagogy around reproductive and sexual health in the face of social and cultural silence sustained through, among other things, the United States' lack of a standardized sexual health education curriculum. In research that links advertising, critical media literacy, and feminist health advocacy, Peoples calls for a new form of feminist health education and practice that explicitly includes media literacy as a women's health imperative (Peoples, 2015).

Finally, we regard justice as a critical quality of both the practice and outcomes of BFHSS. Laura Mamo and Jennifer Fishman have argued that science and technoscience studies have failed to take up justice as critical concept (Mamo & Fishman, 2013). We take up Mamo and Fishman's call for a more robust engagement with justice in science, technoscience, and health studies by making it a defining feature of our work. Much like Benjamin's "Sankofa science," we long for a critical practice committed to producing more than knowledge for knowledge's sake. As social justice scholarship, BFHSS aims to produce knowledge for intervention, disruption, transformation, and ultimately liberation. We call for just analyses of Black women's lives with respect to health and wellness. We call for analyses that privilege Black women's voices and engage with the multidimensional and everyday contexts that structure and nuance Black women's health. We look to create just models of action and best practices informed by ethical histories and analyses of Black women's individual and collective health.

An important part of this social justice scholarship is the ability and willingness to move beyond the pages of the journals in which we publish to practical application in the world. By having a truly interdisciplinary cadre of scholars and practitioners we hope to move our scholarship and research outside of the ivory tower so that it may actually begin to be put

into useful practice. As scholars of color, we feel that part of our work has been providing more and more evidence of the inequities that exist in our world, saying it through different mediums and different disciplines. Ultimately kyriarchy morphs, and we experience versions of the same oppressive and life threatening forces. By working together across the research and practitioner divide, in ethical collaborations informed by the key features of BFHSS, we hope to forestall these problems.

This Is How We Do It: Black Feminist Health Science Studies in Action

We are suspicious of the individualism and siloing practices rewarded in the academy and see collaboration and interdisciplinarity as core strengths of BFHSS. Though we are two authors listed here, we have made copies of this article available to previous collaborators. In addition to the peer review that this journal requires, we wanted to make sure that our work is legible and well received by the communities from which it comes. No publication is actually a single-authored text, and we think it is important to bring that reality to the fore in the spirit of our new field. We endeavor to make our work as transparent as possible so that it can be adapted for other communities and broadened to other arenas.

Central to our ideas regarding collaboration is an understanding of interdependence that suggests that we are better together than apart. We have skills that were honed in the academy, but our collaborators have skills that spread beyond its borders. People who are health care providers, healers, and community members all have skills and knowledge that should be respected and included in our thinking about what is needed to create better health outcomes for Black women. With feminist concerns about reproductive technology growing and African diasporic inquiries into health care disparities mounting, it is an opportune moment for collaborative theorizing under the banner of BFHSS. We do not assume that our PhDs automatically afford us more knowledge than the communities with whom we collaborate. This work is

an exchange and we are members on the same team with a similar goal to improve the health and lives of Black women in this country.

We are creating a critical vocabulary that helps to describe the world we live in as well as the world we want. *Social justice science* (Fasanmi et al., 2012), *Sankofa science* (Benjamin, 2013), *palimpsestic memorialization* (Bailey, 2015), *misogynoir* (Bailey, 2010), and *informed refusals* (Benjamin, 2014) are a few of the concepts that we are creating that are informing our praxis in the world. By creating new terminology, we are also calling in new ways of being that allow for more precise analysis and problem solving. We believe that this specificity actually engenders more accountability because it requires us to be less abstract in our theory-making as we are thinking through the impact of our praxis in real-world contexts.

As stated above, a large part of our collaborative practice is built on our existing relationships. Izetta Mobley and Moya Bailey have written together on disability. In their article “Work in the Intersections: A Black Feminist Disability Framework” they write that they want to build a framework that:

utilizes a practice that centers the well-being of those working within it. To that end, we commit to a new sustainable productivity—a productivity that does not involve the sacrifice of the self—specifically one’s health, which normative knowledge production in academia demands. Our interest in praxis also means that we endeavor theoretical conversations that have impact in our world....we want scholarship that can actually help inform better direct services and actions for our people who are living through social death everyday (Alfieri, 2011; Sexton, 2011). When the material body is centered, how do our theoretical arguments and subsequent activism and organizing need to change? (Bailey & Mobley, forthcoming)

Like a Black disability framework, BFHSS wants to shift our lens and focus towards theories that bring us closer to liberation. In addition to creating scholarship that is attentive to our labor as researchers, we also

see our connection to the communities we write about as an asset and not a liability. We are the ones we have been waiting for and we are the ones who will help shift the tide for Black women's health. With this in mind, we take our own health and well-being seriously, supporting self-care and group care. We emphasize group and community care here because we realize that the strong Black woman myth perpetuated in the academy often impacts our health. We embrace collaborative scholarship not only because of the theoretical interdisciplinarity it engenders but also because of the way collaborative labor can counteract the isolation and workaholicism that the academy can create.

The specter of the Black woman's body at the intersections of socially constructed and medically reinforced hierarchies of biological difference remains a trope in contemporary media and dates back to our earliest uses of mass communications. BFHSS centers the biomedical infrastructure in this country and analyzes both its ideological impact and the sociocultural mores that shape it. BFHSS incorporates epistemic frames from outside the West. African diasporic understandings of health, the body, and healing help to explode the already faltering binaries endemic in Western thought. An important feature of our research is exposing the implicit biases within medical definitions of health that idealize white bodies as exemplars, leaving other bodies working to meet these standards.

BFHSS allows us to bring multiple disciplines together, particularly scholarship that is framed as marginal but is essential to pursue interdisciplinary questions. Beyond our own disciplinary penchant of critique, we endeavor to create research that is applicable in the world. Building on Karl Marx's and Paulo Freire's use of praxis, health praxis signals the actions taken to produce the theories of health that directly address the lives of Black women. Our collaborative, interdisciplinary, and transparent working process described above is an example of how we envision praxis. This praxis marks a willingness to experiment and try research strategies that may help our communities. Black women are building networks of information and support that impact their health and

well-being outside of a biomedical infrastructure, which is the kind of praxis BFHSS hopes to propagate.

Notes

¹ The eugenics movement in the United States marked a period of social engineering in which religious leaders, scientists, doctors, and politicians advocated for the betterment of the human race via human intervention in gene management. Positive eugenicists wanted to encourage reproduction among people with desirable traits while negative eugenicists sought to limit the reproduction of people with undesirable traits. Ideas about favorable traits followed longstanding social hierarchies with Blacks, Jews, poor people, people with disabilities, criminals, and other stigmatized groups targeted by negative eugenicists through sterilization procedures, legal statutes, and increased social stigma.

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Bios

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