"Race and health": Black female healthcare providers in the COVID-19 pandemic[1]

"Raça e saúde": mulheres negras profissionais de saúde no contexto da pandemia da Covid-19

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Abstract

This article stems from postdoctoral research with Black female healthcare providers who worked on the front lines of the COVID-19 pandemic in the state of Pernambuco, Brazil. It sought to understand their experiences based on their family and professional trajectories, when caring for themselves and others, with racism as a common thread. In total, 14 women from different health backgrounds were interviewed. The network of affections technique was used, in which these women indicated other women in their work cycle and/or friendships. The interviews were conducted online or in their workplaces. Analyses were based on the concepts of "device of raciality" and "gendered racism," revealing aspects related to the precariousness of work, exhaustion, loneliness, the erasure of these women's contributions and the colonial continuity in institutional and interpersonal relations in health, which symbolically and materially attributes to Black women functions linked to servitude, which were raised to maximum power in the context of a global health crisis. This study brings a contribution to the field of study on the health of the Black population by showing the need for self-care and institutional care for these workers, focused on the daily micropolitics of confronting racism.

Keywords: COVID-19; racism; care; Healthcare Providers, Black Women

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Resumo

Este artigo é resultado de uma pesquisa de pós-doutorado realizada com mulheres negras profissionais de saúde que atuaram nas linhas de frente da pandemia de covid-19 em Pernambuco, Brasil. Com o objetivo de compreender as experiências das profissionais a partir de suas trajetórias familiares, profissionais e de cuidado de si e dos outros, tendo como fio condutor o racismo, foram entrevistadas 14 mulheres de diversas formações em saúde. Foi utilizada a técnica de rede de afetos, em que elas indicavam outras mulheres que estivessem em seu ciclo de trabalho e/ou amizades. As entrevistas foram realizadas em formato *online* ou nos locais de trabalho das participantes. As análises foram embasadas nos conceitos de dispositivo de racialidade e racismo genderizado, revelando aspectos relacionados à precarização do trabalho, à exaustão e à solidão, ao apagamento de suas contribuições e à continuidade colonial nas relações institucionais e interpessoais no campo da saúde, que, de forma simbólica e material, atribui às mulheres negras funções vinculadas à servidão, elevada à potência máxima no contexto de crise sanitária mundial. O artigo traz uma contribuição para o campo de estudo sobre a saúde da população negra, ao mostrar a necessidade de autocuidado e cuidado institucional para com essas trabalhadoras, focados nas micropolíticas cotidianas de enfretamento ao racismo.

Palavras-chave: Covid-19; racismo; cuidado; profissionais de saúde, mulheres negras.

Introduction

The COVID-19 pandemic, a critical event in the terms attributed by Veena Das (2020), has drastically marked global society. Anthropology has contributed, with its history of research into other epidemics, to unveiling experiences marked by suffering and social inequalities, but also presenting the initiatives and resistance of people affected by the event, as can be seen in the collection *Antropologias de uma pandemia* (Maluf et al., 2024). In Brazil, a country marked by structural inequalities intersected by race and gender, the idea that the pandemic affected everyone in the same way, that it had no race/color, sex, or social class, soon fell apart. In March 2020, Brazilian newspapers carried the news of the first official death from COVID-19, a Black woman, a domestic worker, aged 57, living in São Paulo. Throughout its phases, various studies have pointed to the racial inequalities of the pandemic, in which the mortality rate was higher among the self-declared Black population (Rushovich et al., 2021). The data points to historical continuities of inequalities experienced by the Black population, which places them in the worst health indices (Dantas; Silva; Barbosa, 2022).

Black people have died more, not because of factors from the pandemic, but because they were the most exposed to the danger of contamination, mainly because they worked in jobs considered essential, such as domestic work and health work. During the pandemic, health providers received a lot of attention, especially those who worked on the so-called front line, considered heroes/heroines, even though working conditions made it difficult for public managers to respond adequately. In Brazil, a conservative wave acted against health measures and spread misinformation, making an already difficult situation worse. Images of doctors and nurses talking about exhausting work routines, fear and isolation from their families were common on the news. However, the bodies that occupied these spaces of speech and recognition were mostly White. Where were the Black providers who make up 53% of nursing in Brazil? What were these women thinking? How did the pandemic affect their lives?

Guided by these questions, we began the research *"Quem cuida de mim: experiências de mulheres negras profissionais de saúde no contexto da pandemia da COVID- 19"* [Who takes care of me: experiences of Black women health providers in the context of the COVID-19 pandemic][2] , carried out between August 2021 and August 2022, with a team made up of two researchers and two undergraduate fellows. Fourteen self-declared Black women took part in the study, ranging in age from 30 to 64. The research subjects are residents of Recife and the Metropolitan Region of Recife, in the state of Pernambuco, who worked in public and private health services during the pandemic. In terms of professions, two doctors, four nurses, two nursing technicians (one of whom was a Samu first-aider), three social workers, two psychologists and one community health worker (CHW) were interviewed. Methodologically, the "network of affections" technique was used, in which the participants indicated other women who were in their friendship or professional cycles. The interviews were conducted online and in-person, when possible, as we had just returned from the lockdown and the fear of contamination still lingered. In the in-person interviews, we followed the protocols established by the Ministry of Health, despite the persisting fear being in the field in health institutions that were references in COVID-19 persisted. Our aim was to understand the experiences of these Black providers based on their family, professional, and self-care trajectories, with racism as the common thread.

According to data from the World Health Organization (WHO), Brazil is the country where health providers have died the most as a result of COVID-19. Given this, we were interested in finding out how these Black women were dealing with death, the fear of the unknown, physical exhaustion, the psychological effects and illnesses, and loneliness. The experiences of these women revealed dimensions of institutional and structural racism present in the field of educational training and professional practice in health, but above all, they showed the micro-political dimensions of everyday life, such as internal confrontations in search of self-recognition, self-worth, and survival in health institutions, spaces marked by Whiteness.

It is precisely in these micro-political dimensions that the debate on race and gender has made timid progress, as Grada Kilomba (2019) points out, stating that studies have placed too much emphasis on macro perspectives focusing on the political structures of racism (Almeida, 2018) and too little on the "experienced reality of racism, in subjective encounters where psychic scars have been neglected" (Kilomba, 2019, p. 72, free translation). For the author, in these grand narratives about racism, Black women continue to occupy the position of "incomplete subjects," which leads to their silencing. We saw this clearly when these providers spoke about silencing strategies, about never being heard, about needing a White person to validate their knowledge or confirm their profession, because Black women could not be in positions of power without the validation of a White person, because they have always been placed in different professions, except those responsible for saving lives.

In order to better understand the arguments raised based on the research data, the article has been divided into three complementary parts. In the first part, we present the place of Black women health providers during the pandemic and the consequences of gendered racism on their work experiences. In the second, we mobilize the concept of raciality device to show the colonial continuity present in institutional and interpersonal relationships that reinforce the stigma of "servitude" towards Black women. In the third and final section, with the question "who takes care of me?" we work on aspects related to the loneliness of these women during the pandemic, the need for self-care and the affectation relations in carrying out the research.

The front lines of the pandemic and gendered racism

International research that crossed gender and race to understand mortality from COVID-19

2 As a result of the research, we produced a podcast series entitled "*Quem Cuida de Mim?*" in which we told the stories of six (6) interlocutors. The episodes are available at #1 "*Quem Cuida de Mim?*" Museológicas Podcast | Podcast on Spotify.

showed that the initial data, which indicated a higher prevalence among men, was more complex than previously thought. Black men were the majority across race/sex groups, but when the intersectional data was analyzed, Black women died more than White men and White women (Rushovich et al., 2021). Black feminism has warned of the need for intersectional analysis (Collins; Bilge, 2021; Akotirene, 2019), since the dimensions of power and oppression structure risks in different ways. Research data in Brazil has shown that the health profession was the third in which workers died the most during the pandemic (Silva, 2022). However, it takes a critical and intersectional eye to understand, for example, that there is a process of feminization (70% of health providers are women) and racialization of the health profession, which is mostly made up of Black and young women.

This reality shows that there is a sexual division of labor in the health sector, which has already been addressed in some studies (Lotta et al., 2020), but this finding is not enough to understand the fact that, among the health providers who died the most, the majority were Black women. That is why we need to talk about the racial division of labor in healthcare. According to research by the Getúlio Vargas Foundation (Silva, 2022), Black health providers were the most affected by the pandemic. On the other hand, at the top of the pyramid, White male health providers have the lowest rates of impact with COVID-19, and this is a good example of gendered racism and racial privilege. If all health providers have faced adverse conditions to combat COVID-19, such as a lack of structure and training, lack women have faced even worse situations.

In Pernambuco, where our research was carried out, more than 70% of the health providers affected by COVID-19 were women, but there is no record of data by race/color, which makes looking at racial issues invisible. Among the professions affected, at the top were nursing assistants and technicians (26%), then nurses (11%), biomedical professionals (7.7%) and, finally, doctors (7.6%) (Covid-19 [...], 2020). These data are in line with those presented by our research interlocutors and are directly related to the hierarchization of the health professions, since those who were in direct contact when caring for patients with COVID-19 were nursing providers and health workers, after all, they are the ones who carry out the dangerous care (Pimenta, 2019). However, those who were most exposed to the risks were also those who had the least access to training and personal protective equipment (PPE) (Lotta et al., 2021). The focus on the hegemonic, White, middle-class medical provider, given by the media, erases the experiences of those who were not considered to be on the front line, as reported by a community health worker (CHW), a Black woman, an interlocutor in our research:

> *[...] at those times, we're psychologists, we're doctors, we're nurses, we always have an extra shift. That's at night, it's in the early hours of the morning, during covid itself, a lot of people came to see me. (...) Then, I mean, we did have training, but it was online, we had it, but it was the* ***higher level*** *who had the most. The* ***nurse*** *and the* ***doctor****, we didn't have much, the health worker didn't have much, but there was a lot of work.* (CHW, 2021, emphasis added)

The front lines of healthcare in Brazil are colored and gendered, but despite being the majority, Black women occupy the lowest positions in the hierarchy of professions, as well as political decision-making and management positions. At the time of the research, four of our interviewees held senior positions, two as head nurses, responsible for COVID-19 care units, and two in charge of interdisciplinary teams in field or reference hospitals for COVID-19. Their experiences show how difficult it is for Black health workers to carry out their work, as it is always put on hold. This can be understood through modern separability, which, according to Denise Ferreira (2022), places the Black subject in the logic of obliteration, reaffirming the image of someone defined by a lack of ability, as the narratives below show:

> *I felt it a lot when I arrived to take up the position of nurse, because there was a lot of rejection that we don't expect to happen in the public network, we expect it to happen in the private network. And I found it very difficult to be accepted, both by mid-level staff and by some colleagues who didn't*

accept it, because Black women, you're... what I've just said, you have to prove all the time that you're good. And people often don't even realize it's racism, but they try all the time, even colleagues, nurses, they try all the time to devalue your speech. I know how difficult it is for folks who are Black to take on leadership roles, acceptance is very difficult, isn't it? (Head Nurse, 2021)

[...] I even had a case of harassment this week, I felt really bad. For the simple fact of demanding it, demanding a right that is ours, the right to be able to work, the right to be a doctor, to be the person who decides what is going to be done with the patient and what is not going to be done, that is medical conduct. White people say: "I'm the doctor here" and that's that. No one will question anything. I've already heard reports from several people in the same department where I work about the absurdities that are done by the older White doctors, who have been there for a thousand years, and then people tell it as a joke. In my case, it was a rumpus inside the hospital, once again I'm dealing with the fact that I'm the ugly duckling of the service, despite being the most loved duckling, in theory. That's it (Doctor, 2021)

These narratives reveal the tricks of gendered racism: in general, it is White men or White women who disregard the knowledge of Black women who have the authority to exercise their profession. As Rosana Castro (2022) informs us, a white coat on Black skin is no guarantee of authority. It does not matter if these providers are dressed the same as other providers, they always occupy a place of incompleteness, whether they are managers or in subordinate positions. In this way, there is no other justification for the inequalities in treatment than racism, which in Brazil, as Lélia Gonzalez (2020) teaches us, can be defined as the "Brazilian neurosis" and occurs by omission. Racism is in the unconscious and is reiterated daily in the most trivial social practices. In the case of health, the denial of the Black subject and her knowledge occurs through the need for validation of knowledge by White people.

It's... [long pause]. My experiences weren't easy. I always have a feeling... And I have to say, because it's for a survey, [...] and I've heard this from other Black peers, you know [...] I feel like I'm being watched all the time, being evaluated, even in any context, it's as if I needed to produce more, the pressure were greater, the odds of a mistake were more fatal for me, the consequence of making a mistake. I also feel that there is less flexibility towards me, the flexibility of things. In all my work experiences, I've come across some delicate issues, which I've already told myself about, "Is it something in my head? I'm the one who's difficult?" (Psychologist, 2021)

In addition to the validation of knowledge, there is the social construction of always seeing White people in the highest positions. And when this is reflected in a position where other people's lives are in one's hands, it causes a shock, as it has been socially constructed to deny Black women access to leadership positions. On the other hand, fieldwork showed hard these women worked to carry out their duties and combat rejection, which is daily and not sporadic. The control of their bodies is much greater because there is the social pressure of having to prove that they know. So leadership becomes more tiring, and their specialization and master's degrees are not enough to earn them respect and recognition in the exercise of their professions.

First of all, you need to have a very... archetypal posture, so to speak, in order to be respected, but it's not easy, especially in my field. In healthcare, which is a very aristocratic area, it's a White area, it's not a Black area and the profession of nurse intrinsically requires you to be a leader, you have to graduate understanding that you're going to be a leader, but it's not always possible to exercise this leadership. ***I have a few titles to exercise this leadership****, I'm called sergeant, I'm called so many things, I'm extremely stigmatized, especially in (name withheld). [...] That's impressive, people in the normal environment, doctors, the vast majority of doctors, don't recognize me, don't treat me as a provider, I can clearly see that, that the treatment is different for White nurses. I'm hardly ever invited to the clinical visits that take place every day. They don't recognize my knowledge, my expertise."* (Head nurse, 2021, emphasis added)

We also noticed that these women put a lot of pressure on themselves when it comes to the way they dress, because they always need to be dressed up, wearing heels, no matter how long the shift lasts. And if they take on a different aesthetic than that expected for the job, such as using *Black* hairstyles, many doors are closed to them. One nurse/interlocutor explained her daily strategies which reflect the colonial continuum still present in working relationships involving Black women:

> *Once, I went to get a drink of water at the medical center and a family came in, this family... I was dressed the same way everyone else is because it was a single outfit, today they select class by color. There were two women, when one asked for information about a patient, I didn't even open my mouth and she said: "She's a cleaner," because you're Black and one of the things you'll always see in me is that I'm very careful, I'll always wear heels, I never take them off because I'm sure that even with heels people will still have doubts, because if I wear flats, people will always identify me as a cleaner. Unfortunately, this is a strategy for me, you don't see me without heels, everyone knows that wherever they see me, I'll be wearing heels, but it's a strategy for people to realize that if I'm cleaning the floor, I'm not wearing heels. Because people will always mistake you for someone who's from the cleaning staff.* (Nurse, 2021)

And, in this account, there is no way not to relate the fact that, in the slave-owning past, the first thing the enslaved acquired when freed were shoes, symbols of status and defining social place. Always wearing heels was not just an aesthetic issue, but a survival strategy.

From the raciality device in health: the stigma of servitude

For Sueli Carneiro (2023), the notion of a raciality device offers theoretical resources with the capacity to understand racist practices and racial discrimination in Brazil. The device installs, through certain knowledge, in a field of power, effects of enunciation on the other. For our purposes here, the device has operated to construct the image of Black women in the health field as "beings destined to serve." The power game sometimes works by allowing a large contingent of Black people to occupy healthcare spaces as labor for performing certain functions, and sometimes it works by preventing them from accessing positions at the top of the hierarchy of professions.

In this sense, health work is subject to the sieve of gendered racism and, the higher the hierarchy in these professions, the more this work is questioned, and the less valued the occupation, the more this "work/servitude" is naturalized. It is no wonder that most of the women interviewed in the survey pointed to education as a way to break away from a history of professions linked to subalternization. They invested in their careers in order to overcome the almost always fate of Black women as "domestic servants." But education alone is not enough, at least not in the current form, because, as Suely Carneiro (2023) has shown, there has been a real erasure of these subjects (Black and Indigenous people) in terms of their epistemological contributions. In the case of the pandemic, our research has shown that there is a legacy left by these women in terms of their efforts to save lives, their power of leadership, acceptance, and resilience, but which are not recognized.

For Lélia Gonzalez (2020), racial privilege is the basis for understanding inequalities in Brazil, and this privilege shapes working relationships in the health sector. And, as our interlocutors point out, it is difficult to break with the "imaginary of the maid." In symbolic/practical terms, even if they make it to the top of the health professions, medicine, they will be placed in this position as domestic workers, confused with various other functions, but never identified as doctors. The non-place is a daily struggle for Black women who climb the hierarchy of health professions.

> *Because we have a society in which this structure is racist, but... Which is clear, right? The surprise of the person, when I said I was studying medicine and everything, because it impacts and shocks, because you don't really expect it, you know, from a Black woman's body like that. Especially of a Black woman occupying this position, so even being*

surprised is an expression of racism in our lives. And to this day, yes, I face social racism, about never being identified as a doctor when I'm in my workplace. People look and look, they don't want to see and for a long time, it was the excuse of 'Oh, because you're very young, I didn't think you were a doctor," but then I came to understand more and more that it's the racial issue that weighs heavily on this identification as a provider. I realize that nowadays in the places I work, I've been working there for ten, nine years, I graduated in 2011, but at the beginning I had a lot of difficulty in terms of authority, hierarchy, about people respecting my commands and questioning them. The other health providers, I felt, questioned me: "Is this really what I'm supposed to do?" You know? And it comes from people's insecurity that we're capable of occupying that position." (Doctor, 2021)

Regarding the unequal conditions of Black health providers in the pandemic context, the raciality device operated by showing how they start from different places from White providers, and this shaped the conditions of coping with COVID-19, as we can see in the narrative of the nurse who worked on the front line:

So I couldn't afford to stay at home, I got covid, I asked God not to get covid, but our ICU is a reference in covid, and I asked God not to get covid, because I needed to work. Today, my salary, the salary of a state nurse, is two thousand reais, so if I stop working, I don't have the income to pay my bills, I can't make ends meet, right? [...] So, I have to work, I have to earn my income, pay my monthly expenses, so I didn't have the luxury of being able to stop working, I only really stopped when I fell ill. I had covid, I stayed at home for eight days, which was a financial loss for me, but I stayed at home for eight days, I isolated myself from my family, I isolated myself from my daughters. (Nurse, 2021).

Once again, the racial division of labor reveals a device that privileges White providers who are in more highly valued positions and who have conditions for maintaining a life marked by White privilege. In this sense, racism is not just a symbolic operator, it acts in materiality, in the basic maintenance of the existence of Black women.

It takes me two hours to get from Guabiraba to Jaboatão Centro. So, instead of an eight-hour shift, every day I work a twelve-hour shift, because it takes two hours to get there and two hours to get back. As well as commuting, I work 70 hours a week, because I have to work two jobs to support myself. (Nurse, 2021)

I take the bus, the bus and subway to get here. I usually spend an hour when there isn't heavy traffic. When it's rush hour, I spend an hour and a half, two hours to get here. I get there and back on my feet, I'm already tired. [...] But it was wearing a mask all the time, I always have alcohol at hand, I'm always hygienic, but how can I have this guarantee, this security, if I'm on public transport all the time? If I take the subway and the bus to get here, for example. (Psychologist, 2021).

Another aspect related to the asymmetrical conditions marked by gendered racism is the fact that many Black women in the health field are breadwinners. Because of this, they have to work several jobs, do a lot of shifts and even so are unable to live a comfortable life.

Most health workers are separated from their husbands, most are women, separated and head of the family, you know? If you do a survey here, the majority are women and many suffer violence, I hear the reports, they're heads of households, they're older women who are asked: "Why don't you retire?" Then because she has a loan, because they support grandchildren, they support children. It's really a financial issue. [...] ***But we don't just want applause, we want financial recognition, because that's what makes us die, have a stroke, because most of us are women, heads of families****. That's what kills us.* (Nurse, 2021, emphasis added)

We interviewed women with different backgrounds and jobs within the health field and it would not be fair to say that there is symmetry between them, but even within psychology and social

work, being a Black woman is always a challenge in terms of representation and opportunities to sustain themselves materially. Two of our interlocutors were over 60 and what could have been a process of ending their careers with a peaceful retirement became a problem. Both because they were the breadwinners and because they also assumed political and social responsibility for the rights of the Black population. As in the case of the social worker who works in a referral hospital for violence against women, and is one of those responsible for implementing this policy, or in the case of the psychologist who worked in public management to implement the health policy for the Black population, as well as teaching at a private university and providing private clinical care.

Corroborating what was said at the beginning of this article, it was not the conditions of the pandemic that put Black men and women at the top of the morbidity and mortality rates, but the historically established conditions that put Black women at the bottom of the social pyramid. This is what slowly kills us every day, after all, these bodies are inscribed with the sign of death (Carneiro, 2023; Ferreira, 2022). If Black people are the ones who do the most caring, they are also the ones who die the most. In this sense, the question must be asked: who takes care of those who take care?

Who takes care of me? Loneliness, self-care, and impact in field

As far as the State is concerned, health institutions have done little or nothing to mitigate the effects of a profession marked by overwork, physical and psychological exhaustion, and burnout (Franch et al., 2024). The pandemic has worsened the already precarious mental health conditions of female health workers. All of our interlocutors suffered from anxiety, insomnia, *burnout,* and the use of medication, such as antidepressants, during and after the pandemic.

> *I didn't seek professional care, but I had a lot of insomnia, I was very scared, I cried a lot, I cried a lot alone, and that, I had that fear, that anguish, but I had to show myself strong to my daughters. So, I had my fears, but I didn't share them, I didn't share them. Many times I would be distressed just in my room, inside my room, thinking that everyone was going to die, but I didn't share it, that fear wasn't shared, I didn't look for a professional.* (Head nurse, 2021)

> *So, I had a stroke in the middle of the pandemic and the stroke I had at home, I went to the neurologist, the cardiologist, I managed to reverse it, it was a transient stroke, transient ischemic. I didn't have any sequelae, I had discreet sequelae on my face, but I did physiotherapy, everything virtual, which was very difficult, but I think it helped me to be a nurse and to understand the movements accurately. I went to the psychiatrist, started cardiology, psychiatry, and therapy, but since then, all this has happened to me.* (Head nurse, 2021)

> *I used Citalopram and Rivotril, I had an anxiety attack, I was taken to hospital, when I said I had an anxiety attack, I went into it like this. And the anxiety attack was tachycardia, dyspnea, and shortness of breath, so you can imagine, right (laughs). So I took Citalopram and Rivotril for anxiety attacks. Then I had to go to psychotherapy, anxious because I was working a lot, so I started not delivering much at work, which is why I had to leave one service so I could be 100% in both, otherwise I'd spend 30, 20 in one and end up not delivering what the patient deserved. Then I became anxious and underwent psychotherapy and drug therapy.* (Nurse, 2021)

The accounts of these providers lead us to reflect on the process of silencing that often stems from the introjection of the role of heroine, of fortress. They take care of everyone, but lack time for self-care, which is almost always left in the background. When, during the interviews, we asked the question "who takes care of you?" there was often silence or the immediate response was that the person responsible for the care was herself, the account of the doctor/interlocutor explains better what we want to point out:

> *It's going to be difficult to answer that one, really difficult to understand who looks after me, I look*

after everyone, everyone in my family. For example, at my graduation party, I took care of all the women in my family, from their shoes to their hairstyles, and that's the closest family, there are fifteen people, I took care of everyone, I paid for everyone, and there were the other people who went that I also took care of, I had to choose a dress, choose this, choose that, finance and everything else, then there came a moment on the day of my graduation, I arrived late, because I was alone to put my clothes on, the next day, on the day of the graduation ball, I had some friends here, so everyone helped me, the graduation as I hadn't focused much, even that I needed to hire someone to be here with me, so that didn't happen, because I didn't have time to hire someone to stay with me. [...] Then I looked at it like this, I said: "Oh my God, at the end of the day it's just me." [...] But to say that there's someone there to look after you, no! Even when we get into a relationship, that's what it's like, you're in that caring role all the time, so that was one of the reasons for the separation, because we're always there looking after someone a lot and when it comes to actually looking after you, of course there's some care, but I'm talking about these relationships we have with people, so there's hardly anyone who's going to look after us like that, so before I'd say: "oh, no, but it's a Black woman thing," but there are Black women and Black women, so despite this context of us having a very... similar experience, close in a general sense, but we also have those Black women who are made of steel, who are the ones who come with this thing of strength [...], so I think that thinking about this whole makes us feel alone and that we don't have a reference person to say "this person really looks after me," it's all very collective, and then, in some specific moments, we're left wanting, even though there are so many people, but there's still someone we miss. (Doctor, 2021)

The serving of Black women, which comes from this colonized body, puts us in the place of iron pieces, in which everything must be endured, both in interpersonal relationships and in institutional relationships. Looking at the case of the pandemic, who took care of these providers? What care did employers provide? Who is taking care of them? Who will foot the bill for the after-effects of a pandemic in which thousands of victims have been affected? And how has all this affected the professional body? Who will foot the bill? As the head nurse tells us:

> *It was quite heavy here, we lost a lot of people, we lost a lot of covid patients, young patients who had no other condition. Sometimes they even had hypertension, but no other pathology and they died from covid, we had a very high demand from deaths, we started to see that people we knew were dying, people close to us. Because at first it was numbers, then it started to be names, colleagues leaving and having to carry on and the psychological issue, in fact, it wasn't easy, you have to have psychological support to carry on.* (Head nurse, 2021)

The interview with this nurse was very emotional, because first there was the fear of accessing the hospital after a pandemic in which thousands of people died, feeling the anguish of the health provider who spoke of her wounds, the pain of death and its rituals, the despair of the family being affected and the question that, in the absence of the mother, who is the only caregiver in the family, who takes over? The estrangement of the family made us realize that the need for bonds was based on the cure of the patients, so every death, every emergency, had an impact, especially on those with whom we had built more bonds of affection, and, in the end, loneliness took over, along with the social narrative of care, of servicing, and "in the end we are alone."

It was not just patients and health providers who were affected, but also the researchers. As Black women researching alongside other Black women, it was impossible not to make comparisons with our own trajectories, which are also common to so many others. In this sense, Silva (2022) talks about the need to bring up the issue of race in order to think about self-care and the care of others. There is a collective process characteristic of Black care linked to collective survival that is important (Collins et al., 2019) and appears in the account of one of the doctors interviewed. However, we cannot neglect the fact that, within this collective, Black women are still crossed by various oppressions and even those "made of steel" need care.

Much has been said about the loneliness of Black women, about the social construction of not being destined for love (hooks, 2010) and the pandemic was that moment when loneliness arrived in full force. Three of our women interlocutors split up during the pandemic, others revealed their loneliness even in the presence of partners and family members, after all, there was always fear hanging over relationships. There is a colonial continuum that runs through the experience of being a Black woman in Brazil and loneliness is one of the consequences, as pointed out by bell hooks (2020) and Franz Fanon (2020).

And when we analyze the health field and these providers' experiences, we see that the colonial process that subordinated these bodies is still present and mixes emotion and work. The precarious conditions in terms of salaries, working hours and time to care for their physical and mental health go hand in hand with the conditions of loneliness and erasure of these subjects. Black people have been a reference in health care, but the gears of a moral, economic, and racist order have excluded/deleted this protagonism. When the practice of nursing was institutionalized in Brazil, Black women were prevented from participating in this training process, medicine has always been an elite profession and, to this day, only 20% of doctors trained in Brazil are Black. The Black population was encouraged to pursue technical training, and it is no coincidence that the majority of nursing technicians and assistants are Black.

Final considerations

This research with Black providers led us down several paths, the main one being to understand how these women's bodies entered and exited the pandemic, posing the question: who takes care of those who take care? We identified that there are still several colonial wounds that need to be tended to. We need to think about these women's self-care and the strategies they use to survive in a still racist environment, which tries to place these bodies in subordinate places of "servitude," elevating the experiences of White people as universal (Bento, 2022) and those of Black women as specific. In this process, everything that white people do has greater proportions and the work done by Black providers goes unnoticed. Despite being in the spotlight of the pandemic, the support that these providers had during the period came from autonomous groups of Black psychologists, who identified the need for care, since many Black people have lost jobs, and the first thing that is put aside is mental health care. Thus, according to interlocutor Jesus Moura, a network of providers from different parts of Brazil was created to provide free *online* services to people who needed psychological care. Several of them reported an increase in solidarity among health providers, such as giving up their homes to set up an "HQ" when they were unable to return to their own homes, and caring for the providers hired to work during the pandemic. But all of this came from them, "us for us," as they said, and not from initiatives by managers. A common story in the interviews was the fear of dying, of contaminating the family and the prejudice built up against health providers. All of them reported some episode of discrimination, including by their families, and in some cases, there was total exclusion from contacts, exacerbating the process of loneliness.

Thinking about the pandemic from the point of view of Black providers opens up several possibilities for reflection on important issues in the health field, such as the racialization of health work, showing that the front lines were also configured as a Black front, since direct care was carried out by nursing providers, made up mostly of Black women. In this sense, we need to discuss the material conditions of survival of these women who experience inhumane conditions in the exercise of their professions, such as the excessive workload before, during and after the pandemic and the low wages paid to the nursing sector. It was during the pandemic that the Proposed Amendment to the Constitution (PEC) for a national nursing floor gained notoriety, being approved in 2022, after much struggle and mobilization by the category, and even so, it has been difficult to implement it in several states.

Using the concept of a raciality device to analyze the field of health helped us to understand the gears of gendered racism and intersectionalities superimposed on the experiences of these providers. If the colonial continuum places them as incomplete subjects, it is their experiences of resistance that

confront the racism present in institutions and interpersonal relationships on a daily basis. In terms of caring for others, they give their best, but are not satisfied with praise and aim for effective action, after all "we don't just want applause, we want financial recognition, because (the lack of it) is what kill us" (Nurse, 2021).

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Ana Cláudia Rodrigues da Silva: coordinated the research that led to the article, analyzed the data, and wrote and revised the text. Ana Carla Lemos: Carried out field research, systematized and analyzed the data, and wrote the text.

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