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**Envisioning “Loving Care” in Impermanent Healing
Spaces: Sacred and Political Organizing Towards
Decolonial Health/Care in Oakland, California**

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Envisioning “Loving Care” in Impermanent Healing Spaces: Sacred and Political Organizing Towards Decolonial Health/Care in Oakland, California

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This paper explores a self-determined space of health and healing centering ancestral, traditional, and Indigenous medicine and spiritual practices. While ancestral, traditional, and Indigenous (ATI) medicine overlaps with what is conventionally recognized as “alternative” medicine, what sets ATI apart in this work is the political orientation of the Oakland-based Healing Clinic Collective (HCC) and its network of ATI practitioners. Their political orientation and motivation for community organizing begins from practicing and promoting ATI healing modalities to address the impact of interrelated generational experiences shaped by institutional legacies of colonization vis a vis racial capitalism, eurocentrism, and white supremacy. I use a transdisciplinary and decolonial framework to analyze the HCC’s “ceremonial organizing” model and show how the HCC clinic space offers expansive conceptions of what counts as health, healing, and care at the level of community health. I also show how the HCC is situated in a Bay Area radical community organizing continuum for community survival and self-determination. A transdisciplinary decolonial framework allows me to think alongside two concepts, therapeutic landscapes and third space, to discuss what it means to organize and hold a healing clinic without replicating a “clinical” experience. Based on ethnographic research, this paper is guided by the following questions: How does the politicized space created by the HCC clinics interrogate and re-define what counts as health, healing, medicine, and health/care knowledge? How does this sacred-political healing landscape shape a different approach to and experience of community organizing and social movement as a practice of community health/care?

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Introduction

I've been waiting for three hours. But it's worth it. I have to wait longer at Highland [Hospital] just for a doctor to come in the room and diagnose me without even looking at me. I would rather wait here and learn how to help myself. – Healing Clinic Attendee

We've organized in this neighborhood for 20 years. We lay prayers in that park down the hill every week. We've heard stories of people wrestling bears in that park. We also hear stories of our young people killing each other in that park. The healing today and gathering today is for all of that. For all of us. Movement is part of healing, social movement and movement in prayer. We have never separated the two. – Xitlalmina (pseudonym), Xicana organizer, Mexica danzante/ceremonial dancer, and long-term Oakland resident, speaking during opening prayer at the October 2018 healing clinic.

This paper conceptualizes a decolonial politics of health/care¹ as a framework that contends with three disparate conversations: 1) existing public health interventions on health inequity, 2) social movement organizing, and 3) spirituality in relation to ancestral, traditional, and Indigenous (ATI) medicine and healing. These three themes capture the vision of the main figure in this paper, the Oakland-based organization, the Healing Clinic Collective (HCC).

Using ethnographic methods, this paper explores the HCC's temporary clinics as self-determined ATI medical spaces of health/care—organized ceremonially—as an interruption to the embodiment of colonization via structural inequity and medical violence. I show how healing space is experienced by minoritized people as both ATI practitioners and community organizers and the potential for politicized healing space as an upstream (public) health intervention. I am not using the public health framework to shape this research, rather I am using it as a common language with which to speak with other health researchers interested in unconventional

¹ Conventional healthcare is epistemologically and methodologically bound to biomedical procedures and organized as industrialized means towards capitalistic ends. Using the slash reminds us of the concepts of “health” and “care” allowing for space to contemplate and develop the meaning of each through the work of the Healing Clinic Collective. I also use the slash between health and care to show the both/and potential of the concepts: health as care and care as health.

approaches to alleviating health inequities, as much as possible, beyond what is available and controlled by state apparatuses and for-profit health industries.

The paper highlights common themes that emerged from interviews with practitioners and organizers who participated in the logistical and community organizing of the HCC's temporary healing clinics. What sets these healing clinics apart is the provision of ancestral, traditional, and Indigenous (ATI) healing care through a "sacred political framework" (HCC website) that challenges practices and ideologies of biomedically mediated care. Research shows that racialized and gendered narratives about the perceived health of minoritized groups of people affect our ability to seek and receive care (Anderson 2007; Browne and Fiske 2001; Hart 2015; Roberts 1997; Sacks 2019). These biomedical narratives often describe minoritized people as individuals always already at-risk for disease and ill-health.

Biomedicine and public health are *limited* in their analysis of root causes of ill-health—thus limiting their intervention models— and I suggest a consideration of the HCC's organizing framework and healing clinics as upstream interventions to the intergenerational and structural embodiment of such narratives. This paper will show how the clinics are a sacred-political health/care space where minoritized communities are offered an opportunity to experience self-determined healing in/with/for community beyond both 1) biomedical healthcare spaces and 2) the narratives that pave paths away from health.

I argue that healing clinics are spaces where self-determination "gets worked out" as health/care and healing. That is, where people from populations made vulnerable through racialization and minoritization experience and interact with the concept of "self-determination" on multiple levels including the embodied self, the collective body, social structures, and the natural environment. To "work things out" in a clinic changes the signification of a "clinic" as a

biomedical space that one person enters at a specific time and for a specific purpose, towards a communal, interactive, impermanent, and sacred ceremonial landscape where “healing” comes in a variety of forms. Healing, then, has less to do with conventional and ableist conceptions of health as achieved through a linear path towards a “healthy body,” and more to do with reconnecting the physical, emotional, and epistemological ruptures of colonization that endure via white supremacy, heteropatriarchy, and extractive capitalist economic systems.

Methods

Data Collection

Data for this project comes from participant-observation and semi-structured interviews I conducted between 2013 and 2018 in Oakland, California, while organizing with the HCC as a practitioner, clinic organizer, and core member. Interviews were conducted with eleven ATI medicine practitioners and clinic organizers who volunteered at one or more of six temporary healing clinics organized by the HCC. Practitioners in this study are defined as individuals trained in one or more modalities that fall outside of the biomedical purview. They are either formally trained through herbal, traditional Chinese medicine, or massage therapy schools, or else apprentice with traditional healers in their local or international communities. Clinic organizers are defined as individuals who participated in the organization and execution of one or more healing clinics. Clinic organizers have experience as multi-issue social justice community organizers. Practitioner-organizers are defined as individuals who are trained in one of the ancestral/traditional modalities in addition to participating in organizing the clinics. Participants identify as either Black, Native/Indigenous, Pinay, X/Chicana, Latina, Chinese, Korean or mixed race and identify their life experiences with those of the HCC’s target

populations. Gender pronouns were not asked; however, several participants did note that the majority of organizers and practitioners (including those not interviewed for this paper) identified as women and queer.

Interviews were semi-structured, lasting approximately 45-60 minutes. Nine interviews were conducted in person at local cafés or participants' homes in Oakland and Berkeley, and two interviews were conducted by telephone. All interviews were recorded and transcribed. Participant-observation was conducted at thirteen clinics from 2013 to 2018. Unless otherwise cited, the material below is from interviews and field notes.

Methodology

I approach my research practice in a way that privileges knowledge coming from the outside/underside of Western epistemologies and theories. I acknowledge that much of the production of academic knowledge is extracted via outsider observations while building on preexisting Eurocentric knowledge (Grosfoguel 2012). I do this research fully aware of the critiques and limiting nature of the factory that produces academic work, in that this work will only be read by a handful of people (my academic interlocutors) and, *on its own*, may not be transformative within the Western academic institution. At the same time, I remain hopeful that it will contribute to the project of ethnic studies, the decades-long¹ transdisciplinary epistemological struggle of recovering and re-centering community wisdom, Indigenous knowledges, and processes that work in the service of life.

¹ I'm tracing this to the emergence of ethnic studies as a result of student and community organizing in 1968-1969. However, this epistemological struggle is centuries-long. See Grosfoguel 2013.

As a practitioner-organizer-researcher, I have been involved in ATI and biomedical spaces since 2010, when I formally began my training as a traditional birthworker.² I also identify as someone who has experienced and is directly and vicariously impacted by institutional discrimination, exclusion, and violence, so I relate to many wellness-seekers drawn to a health and healing politic framed through ATI. As an insider and what I'm calling a *side-by-sider*³ to this research, the bulk of my inquiry focuses on the creative vision, practical everyday solutions, and the interactions and responses to healthcare as we know and experience it as racialized, minoritized, and historically dehumanized groups of people. In this vein, I want it to be very clear that this research privileges the work and experiences of these groups of people—following decolonial and decolonizing transdisciplinary methods and methodologies—and I share it with the permission of the HCC.

² A traditional birthworker is similar to a doula (a person that provides physical, educational and psychological support); however, a traditional birthworker may or may not be certified by a professional doula organization. As a traditional birthworker, I follow original teachings of the ceremony of birth, and of birth as the first ceremony of life. I support pregnant people through pregnancy, birth (including miscarriage and abortion), postpartum, and parenting. I also integrate teachings passed to me from my grandmother and great-grandmothers who are/were curanderas (healers), yierberas (herbalists) and parteras (traditional midwives) in their families and communities in Mexico and the U.S. I have also been mentored by several curanderas, herbalists, and midwives in Mexico and the U.S. over the past 13 years.

³ One function of ethnic studies scholarship is to interrogate existing methodologies and imagine new ones. What I am conceptualizing as “side-by-side” methodology builds on the work of Patricia Hill Collins “outsider within” Black Feminist standpoint methodology (2004) and epistemology and Chela Sandoval’s third word Women of Color “oppositional consciousness” (2004) as a key concept in her “methodology of the oppressed.” To be a “side-by-sider” means to have the epistemic and positionality privilege to work alongside both institutions of power and marginalized spaces. For me, as a person trained as a researcher and scholar in a modern/colonial university and as a traditional birthworker who works alongside biomedical practitioners, traditional midwives, and ATI healers, I do not see myself as quite inside or outside of these spaces. The privilege that I bring comes from the knowledge I carry about each healing tradition. In addition, my social position as a Brown, Xicana, mother, survivor/thriver, who was raised by a working class/working poor single mother allows me the privilege to work alongside others like me without requiring them to explain to me their intimate struggles and trauma. This is important as a practitioner and as a researcher who is working in favor of body and community autonomy around health and knowledge production. I do not solely focus on individual narratives of suffering (important as they are for the individuals to tell if they choose); rather, I focus on the larger impact of structural oppression, particularly within public health and biomedicine.

Background: The Healing Clinic Collective

The Healing Clinic Collective (HCC) was envisioned and founded in 2011 by Carla Perez, a long-term⁴ Oakland resident with decades of experience in both environmental justice organizing and organizing ceremonies in her spiritual community. During a visit with her ceremonial mentor⁵ in New Mexico in 2010, she was invited to a *feria de salud* (health fair) organized by a local intertribal⁶ Native community for pregnant women in substance use recovery. Through her experience at the feria, Carla envisioned what access to traditional, ancestral, and Indigenous medicine and healthcare for Black, Brown, and Native communities in Oakland could look like. In March 2012, Carla organized a well-attended event, “Restoring Health, Childbirth, and Independence from Industrial Medicine,” through her work with Movement Generation, a local grassroots ecological justice organization that she also co-founded. The intention of this event was to begin a conversation with the local Bay Area community about the possibilities of a non-pharmaceutical and culturally relevant healing model for the most systematically traumatized people in the Bay Area communities that Carla and other organizers and practitioners worked with and alongside. This event is credited by several founding HCC members as the seed that sprouted the HCC as an Oakland-based organization, including the network of volunteers and practitioners that continue to support the HCC’s work.

The HCC organizes a number of events, such as political education workshops, annual HCC network gatherings, collaborative healing clinics and teach-ins with local organizations, speaking engagements, clinic logistical consultations, and practitioner referral services.⁷ This

⁴ I define long-term resident as someone who has lived in Oakland for 20 or more years.

⁵ Carla did not use this term to identify the person I call her mentor; however, this is the best word I could use to describe the person.

⁶ Mexican diasporic indigenous (Mexican/Nahuatl) and Northern Native community (Dine) among others.

⁷ www.healingcliniccollective.net

paper focuses specifically on the HCC’s temporary, day-long “healing clinics.” The HCC healing clinics center ATI health and healing modalities⁸ for the most marginal populations including low-income, working class, queer/trans/non-binary, people of color, im/migrants, formerly incarcerated, systems-impacted, survivors of domestic violence, survivors of sexual abuse and violence, and survivors of state violence (this list is not exhaustive). White people attend clinics primarily as operational volunteers; clinic attendees are almost all Black and/or Brown. Later in the paper, I will give a description of what happens at these clinics.

The HCC and the healing clinics are an extra-institutional grassroots social justice organizing space, an undercommons (Harney and Moten 2013; Kelley 2003) of seasoned movement activists, organizers, and healers that center ATI medicine as a path to liberation and autonomy. Aurora,⁹ a practitioner-organizer, describes the emergence of the HCC’s vision for the clinic:

We come from social justice backgrounds—environmental justice, immigration, youth work—so [the HCC] is just much more holistic, and it just felt like [through the clinics] we were still going to be doing that [organizing work]: taking care of the community through social justice but in a much more holistic way.... It was new, and I feel like it was at the edge of organizing. People may not look at [the clinics] as an organizing tool or as a social justice tool, but that is in our vision...and at the core of what we’re doing this for is to heal in community and healing is social justice work.

Ceremonial Organizing

A central component of the HCC’s social justice work is to address intergenerational trauma by amplifying generational healing through creating access to ATI healing sessions offered by local community practitioners. By focusing on a vision of generational healing through deepening community relationships, the HCC moves away from centering trauma as a starting point for seeking healing. Transgenerational trauma is a concept that has been acutely

⁸ See appendix for list of modalities.

⁹ All names used are pseudonyms except Carla Perez.

understood by oppressed populations for generations (Levins Morales 1999; Anzaldua 1999; Fanon 2008) and introduced in mental health work as intergenerational trauma (Duran and Duran 1995). In health and medical literature, studies on intergenerational trauma appear in both psychosocial and epigenetic research demonstrating the ways various forms of external stress—such as racism and poverty—experienced by pregnant people impact the life course of the human in utero (Bombay, Matheson, and Anisman 2009; Cohn and Morrison 2018; Goodman 2013). The transmission of trauma to successive generations of minoritized communities continues in part from repeated structural exclusion from multiple systems of health/care, including ancestral, traditional and Indigenous health/care.

Carla shares that the initial vision of the clinics was to serve populations “who have never received care at all, ever in their life” while also connecting them to the healers in their community that they might not otherwise have access to. She says:

We bring in community healers that don't necessarily get to serve their own community because reality is that [the healing practitioners] need to make money so they're serving richer people or people who can afford their services, but they're not actually getting to serve their own auntie, they're not getting to serve their neighbors. So it was to help them connect with each other when they usually can't even though they're in the same community.

The HCC framework also privileges embodied healing and ATI medicine as preventative care.

An emphasis on “a sacred political framework” enacted through “ceremonial organizing” sets the HCC apart from biomedical oriented health or wellness fairs and clinics. The HCC defines sacred-political as being spiritually grounded and trusting in Spirit and original instructions¹⁰ that center relations between all life in our natural environment. As Sophia, a core HCC member, describes:

I think that it's crucial to have your own spiritual practice, grounding...really having that understanding and background to do this work because if you go into this work and into these healing clinics with the same mindset as working in a corporate job, the work is not going to happen the same, it's not going to flow the same, it's impossible. We learn to trust that spirit is guiding us and spirit is supporting us. If we don't go into

¹⁰ “Original instructions” are traditional and indigenous ways of living that recognize the relationship of life, land, and spirit (M. K. Nelson 2008).

this with a certain level of spiritual understanding or practice of our own, it's not going to flow the same way. Every time we were like, "What are we doing?" We would stop and say, "Let's call on our ancestors, let's take a minute." That was our anchor, our understanding that this is something bigger than us, something bigger than just providing a service.

Sophia's reference to a spiritual praxis also underlies the anti-industrial and anti-capitalist trajectory of the HCC's philosophy of health and healing as it intersects with social justice. A sacred-political framework incorporates the HCC's spiritual politics and practices, their collective work as community organizers, and their lived experiences of race, class, gender, and sexuality oppression.

To date, the HCC has organized thirteen one-and two-day temporary clinics in the East Bay Area, serving over 1400 people,¹¹ accomplished through grassroots fundraising via individual donations and small foundation grants (The Healing Clinic Collective 2018).¹² The clinics also rely on non-monetary donations from community members such as food to feed clinic attendees and supplies for practitioners. While there is no fee charged to receive care at the clinics, a small basket is placed at the registration table for attendees who would like to gift a monetary offering, as well as a central altar for small non-monetary gifts such as tobacco, sage, cedar, and flowers. While the organizing committee receives a small stipend for their work—an organizing process that takes from five to seven months—all ATI practitioners volunteer their time with no monetary compensation. Most of the money raised for the clinic pays for rental fees, food and supplies not covered by donations, and organizer stipends. In addition to the

¹¹ The HCC does not use social media (Facebook, Twitter, Instagram, etc.) to do outreach for clinics. They rely solely on in-person/phone call/email outreach to individuals at organizations that serve the community members they are targeting for each clinic. For example, for the recent 2018 Clinic, the intention was to provide a Clinic for survivors of sexual and gender-based violence. Committee members identified existing relationships and also organizations we hoped to build relationships with. We met with or gave presentations to organizations and asked them to share the clinic information with their constituents. The reasons behind why social media is not used vary, however the HCC organizers return to "trust" as a guiding principle to ceremonial organizing and creating a healing space. To build meaningful relationships is slow and it takes time to move towards trust. The intention is that people will arrive at the clinic (either as a volunteer or attendee) because of the relationship they have to the person or organization that invited them. Social media tends to be very impersonal, very fast, and for the most part, not intentional. Therefore, this decision to exclude social media as an avenue for outreach has held strong within the organization.

¹² "We look for city funds and grant money from foundations or donors who fund women's health, services for low-income folks, cultural preservation, community health or for other specific issues/populations (i.e. birth justice, BLM, immigrants)" (The Healing Clinic Collective 2018, 12).

thirteen HCC clinics thus far, there have been at least six clinics organized by Clinic volunteers and practitioners that consulted and replicated the HCC model on a smaller scale including a community clinic in Los Angeles, a women's clinic at UC Berkeley, and ongoing healing clinics in Santa Cruz.

Clinic Logistics¹³

Each clinic uses a standard set up (Image 1) and logistical workflow. There are designated areas for registration, waiting, treatments, post-treatment rest, childcare, and a kitchen. Since the healing clinics are temporary one-day clinics, organizers map out in advance the space of the church, school, or park recreation center that houses the clinic for the day. Once the clinic is set-up, doors open at 10am for community members to register and sign-up for treatments. Treatments are offered on a first come-first served basis, so people often wait up to several hours to be called for their treatment. To pass the time, the HCC organizers schedule small group skill-shares for attendees. These skill-shares include herbal medicine making, self-limpias (energetic cleanse), drumming, and yoga. Most of the time however, attendees connect and socialize with other attendees and enjoy snacks while they wait. When an attendee is called to receive their treatment, they are escorted by a volunteer to their practitioner's station, usually located in a large treatment hall with stations separated by dividers. Healing sessions last between 30 and 60 minutes, depending on the treatment. After the treatment, attendees are either escorted to the recovery room or rejoin the waiting area. Sometimes a practitioner will recommend that the attendee receive an extra treatment. For example, if someone receives an

¹³ For an in-depth description of clinic logistics see "Planting a Seed for a Return to the Sacred: A HCC Guide for Organizing a Healing Clinic" (2018).

acupuncture session for chronic headaches, they might be referred to the herbal medicine station to receive a formula to help facilitate their healing. The last treatment ends usually around 6pm, and volunteers break down the clinic. By 8pm, there is usually no physical trace of the clinic in the host space.

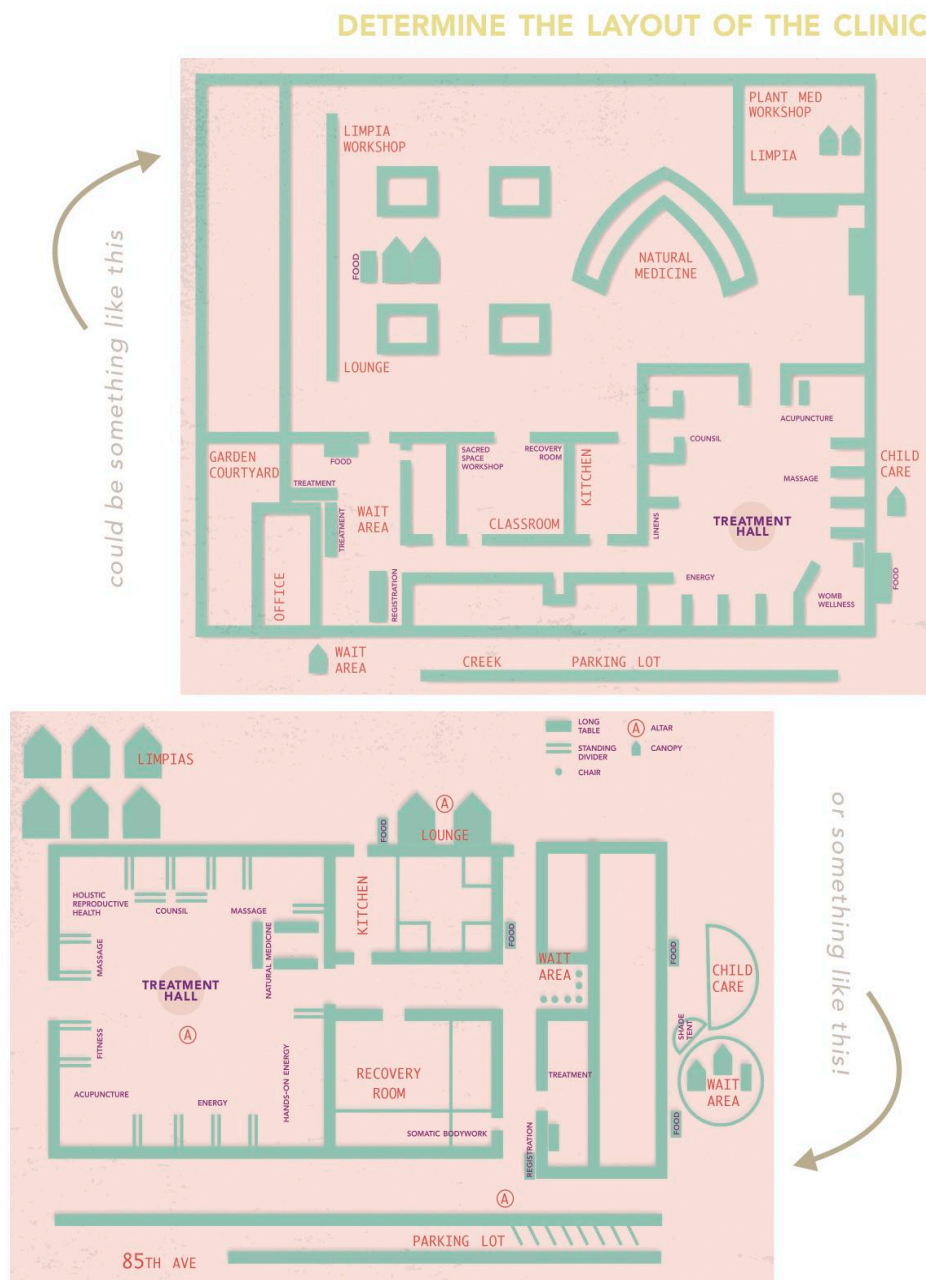


Image 1: “Clinic Layout” from “Planting a Seed for a Return to the Sacred: A HCC Guide for Organizing a Healing Clinic,” 2018

Literature Review

Public Health and the Politics of Health/Care Knowledge: Risk Narratives and Racialization

In 2013, the Bay Area Regional Health Inequities Initiative (BAHRII) introduced a new framework for addressing health inequities focusing on upstream social factors and measures affecting health outcomes (Image 2).

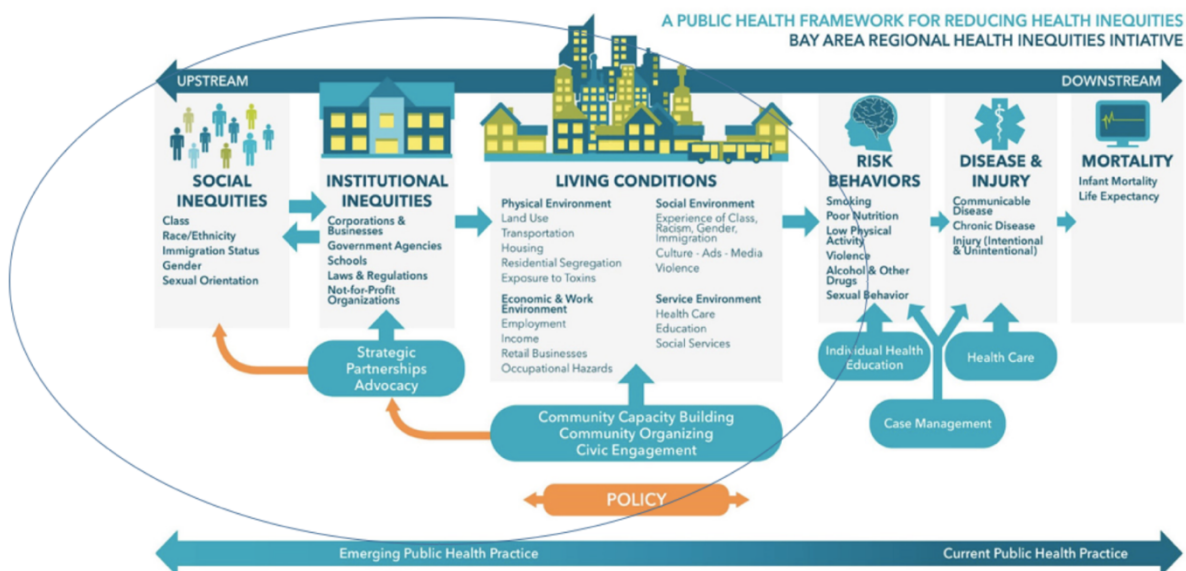


Image 2: Bay Area Regional Health Inequities Initiative Framework (<http://barhii/framework/>)

The BAHRII framework is a critique of a Public Health¹⁴ framework that focuses much of its research and policy development and implementation addressing downstream factors such as disparate rates of mortality/morbidity among populations, health care access, and health education. This leaves a critical need for shaping intervention at the most upstream health

¹⁴ I capitalize Public Health to denote its existence as a hegemonic state apparatus that has dominated and determined what gets to count as health and healthcare in the United States and globally.

factors including mainstream and institutional narratives about risk that shape enduring health inequities.

Public Health researchers primarily use epidemiological data to narrate patterns of health and disease happening at the population level. Epidemiological data relies on discrete demographic categories such as race and sex to determine and communicate a patient's health risks. Thus, some providers are trained to recommend treatment plans based on a patient's level of risk, arrived at through generalized bits of information about a particular demographic (Krieger 2011; Fordyce 2012). What some health researchers and providers may not see is that this way of creating and communicating risk hides the structural influences¹⁵ contributing to unhealth.¹⁶ Alyshia Galvez (2011) uncovers unfavorable birth outcomes among first- and second-generation Mexican immigrant women “not as a biological problem but an epistemological one,” citing experiences of Mexican women receiving public perinatal care. The more biomedical risk narratives are shared with the women by their providers or else circulated through other communicative mediums, the higher their rates of complications during pregnancy or birth. Cultural norms within the Mexican immigrant community, including narratives of pregnancy and birth as a normal life event that pregnant people are “well equipped to accomplish,” are protective factors until encounters with the biomedical establishment communicate pregnancy risks through prenatal diagnostics and discussions of possible interventions.

¹⁵ The *structural competency* (Metzl and Hansen 2014) framework is a more critical approach for biomedical healthcare workers to consider the cultural and social aspects of lived experiences of their patients. However, I see structural competency models as still existing in a hierarchical paradigm. The theory and resulting application of structural competency trainings are created by medical doctors and other academics who have experience working with minoritized and structurally oppressed populations yet do not necessarily share the historical and contemporary lived experiences of these populations.

¹⁶ I use the term “unhealth” rather than illness or disease to indicate a historically deliberate and transgenerational impetus *away from health* for minoritized people of color in the U.S. rather than a state of being or disorder that affects one body for a limited period of time.

Similarly, T.S. Harvey (2008) argues that the creation of the biomedical category of “patient” is a process arrived at through the biomedical clinical encounter and complicates or jeopardizes care for patients who are at cosmological odds with Western biomedicine and who understand the “patient” as beyond one physical body. Western biomedical practitioners might perceive this behavior as “irrational or deviant” (591) rather than an epistemological difference in what it means to seek wellness. At the same time, the wellness-seeker might be seen as incapable of understanding practitioners’ (hegemonic) role in the biomedical clinical encounter.

Medical anthropologists and critical public health scholars argue that risk-making in health research and provision both shapes encounters with the most vulnerable populations as well as perpetuates deficit narratives about minoritized people (Galvez 2011; Fordyce 2012; Lupton 2013; Hart 2015; Hayes-Bautista and Chiprut 1998; Nichter 2008). Risk narratives speculate a health deficit created by the body, thus producing fear and anxiety of one’s *own* body, an epistemological shift that I argue maintains the root system of health inequity. Thinking alongside European colonial processes of racialization with the process of risk-making, we see the parallel production of public anxiety through the creation of subhuman characteristics embodied by Black, Native, and immigrant bodies (Briggs and Mantini-Briggs 2003; Shah 2001; Molina 2006; Roberts 1997). In racialized scripts, anxiety creates an “other” to be feared and conquered or exterminated. In Western biomedicine, risk is the conduit of fear and anxiety not only of a subjective other, but of the body itself. When medical risks are coupled with racialized deficit narratives and circulated both within the biomedical sphere and the public sphere, an already culturally and racially othered and minoritized people embody and project unhealth. An inherently unhealthy subjectivity is internalized as of our own making and facilitates disconnection from the communal body.

I see risk narratives as posing a major challenge to the notion of body autonomy and self-determination and localized health/care. As I will show, the HCC directly addresses institutional deficit narratives as upstream factors of health inequity through community organizing and promotes generational healing by repairing access to spirituality through ancestral, traditional, and Indigenous medicine specifically for minoritized and structurally oppressed people. In so doing, the HCC clinics contribute to redefining minority health in a way that does not start from understanding ourselves always already at-risk. Instead, the HCC begins from recognizing the systematic way institutions interact to create unhealth and impede access to non-biomedical and non-Western healing epistemologies. In this vein, the HCC is not proposing nor working towards biomedical integration or institutional reform, but rather another way, an original way, of moving towards community autonomy as a pathway to physical health.

The Role of Social Movement Organizing and Mobilizing for Community Survival

The history of the United States is undergirded by untold stories of struggle for community autonomy within racialized, gendered, and minoritized communities. Oakland, California—the main location where the HCC clinics and organizing work take place—is an international, intercommunal (Newton and Brown 2009), intercultural, multi-racial city with a rich history of social movements (Self 2005; Rhomberg 2003), many of which address the symptoms of what Black and Brown radical scholars came to recognize as the internal colony. Leaders of radical movements for community self-determination in the late 1960's, inspired by international decolonization movements, provided a socio-political analysis of people of color in the U.S. living under colonial conditions. Internal, domestic, or neocolonialism (Allen 1990; Ture and Hamilton 1992; Moraga and Anzaldúa 1984; The Combahee River Collective 1979; A.

Garcia 1997) are similar conceptual frameworks that emerged in response to assimilationist and culture of poverty theories (Lewis 1966; Moynihan 1965) that willfully ignored the historic and systematic disenfranchisement of Indigenous, Black, and immigrant racial/ethnic groups living in poverty, within the borders of the so-called United States (Grosfoguel 2013; Allen 1990).

Proponents of the internal colony model suggest the material conditions and organizational structures of power in the ghetto, barrio, and reservation are similar to colonial structures in other parts of the world (Blauner 1969; Estes 2019). This includes the use of police to patrol poor Black and Brown communities (Allen 1990), the perpetual underfunding of urban public schools (Noguera and Banks 2003; Valenzuela 1999), and little to no access to basic healthcare systems (Loyd 2014; Washington 2006; A. Nelson 2011; Matthew 2015).

A key concept marking the difference between integrationist civil rights policies for minoritized people and revolutionary and radical social movement politics of the late 1960s is the idea of community self-determination, achieved through autonomous community organizing. The struggle for self-determination “was understood to mean community control within the urban environment” (Kelley 2003) of local schools, hospitals, economies, justice systems, political representation, and overall local governance. Community organizing is an overarching term for a method of building power within communities through mobilizing people for some kind of change or to maintain the status quo (Warren-White 2006). The epistemological framework that influenced community organizing methodologies used during the radical social movement era was staunchly anti-capitalist, anti-imperialist and anti-white supremacist (Melendez 2005; Warren-White 2006; R. Spencer 2008; Blackwell 2011; Smith and Warrior 1996; Estes 2019). Building a base of young activists with a revolutionary political consciousness towards community liberation and autonomy became central to radical organizing

methodologies in the late 1960s and 1970s. However, this also made the young activists in radical Black, Brown, Yellow and Red¹⁷ community organizations targets of violent government repression.

Activists and community organizers involved in radical third world solidarity movements of the 1960's were spurred to action by national and international state violence committed against minoritized communities. They were also left scarred and heartbroken, grieving the deaths and incarcerations of their comrades who were assassinated and framed by COINTELPRO, the counterintelligence program that effectively left the work of radical U.S. third world self-determination towards liberation an unfinished project (O'Reilly 1991; Churchill and Wall 2001; Earl 2010). They were also left divided, with many women, queer, and trans and non-binary people continuing to experience oppression and violence within revolutionary and so-called liberatory spaces.

While government repression and internal splits slowed the appearance of radical organizing and mobilization on a national scale, smaller community-based projects initiated by radical community organizations took root in Oakland, specifically in healthcare. Legacies of the late 1960's Black Power, Chicano, American Indian, Asian American, and Gay Liberation movements are visible in existing health care spaces including the Native American Health Center, La Clinica de la Raza, Asian Health Center, The Harriet Tubman Clinic, and most recently the Roots Community Health Center. These clinics frame health care provision through culturally and linguistically appropriate biomedical healthcare models in response to the lack of resources and care for non-English speaking migrants and minoritized people of color in Oakland and the surrounding areas.

¹⁷ The Black Panther Party, Brown Berets, Young Lords, American Indian Movement, EastWind and other organizations that came out of the 1960s and 1970s radical movement.

One major difference between the type of care offered at these movement legacy clinics and the emerging presence of ancestral and traditional healing spaces like the HCC healing clinics in Oakland is the modalities that people seek to make themselves well. Self-determined health care during the radical movement era sought to establish fair and democratic *biomedical* institutions for all people, but especially those who were discriminated against by various state apparatuses. Free health clinics in the late 1960s and 1970s were established by “health radicals” to counter the racist exclusionary practices of biomedical facilities as well as a general distrust of the power imbued within biomedicine, addressing its deliberately mystified and “undemocratic” knowledge (A. Nelson 2011).¹⁸

Even though the HCC and the healing clinics do not aim to be part of a biomedical regime of care, they are part of a radical organizing continuum located in Oakland, California, that focuses on community survival partly achieved through healthcare access and provision. The similarities between a (re)emerging ATI health and healing movement and the approach of health radicals of the 1960’s are found in 1) the arc of movement building and community organizing around issues addressing racial injustice and gender/sexuality oppression and 2) the demographics of key players, namely people from minoritized populations in the Bay Area.¹⁹

¹⁸ Free clinics organized by health radicals were largely staffed by volunteer biomedical clinicians and lay volunteers. In contrast, the HCC clinics have only two biomedically trained practitioners in their network of 150 ancestral and traditional practitioners. Moreover, of the 150 practitioners on the roster, only 21 are white/European descended (including self-identified White Latinx) practitioners. The vast majority of practitioners identify as Xicanx/Chicano, Mexican, Black, African Diasporic, and Indigenous American. There is a small number of Native, Japanese, Chinese and Korean practitioners.

¹⁹ A “healing justice” framework stands at the edge of what it means to center healing for communities of color in social justice work and centers ancestral practices. This term dates back to the 2010 U.S. Social Forum (USSF) when a group of queer/trans Black, disabled activists and movement organizers organized a healing space at the USSF. The need came after a generation of queer, trans, disabled Black activists and organizers recognized the repeated pattern of activist burnout or else the limited ways that queer/trans, disabled, and parenting people of color were welcomed or not into activist and organizing spaces. The HCC answers the call of healing justice movement language to create spaces that, as Cara Page states, “intervene on the generational trauma and violence” (Piepzna-Samarasinha 2016) (Piepzna-Samarasinha 2016), specifically in an intentionally ceremonial way, centering the leadership of queer people of color who are deeply grounded in original teachings and actively participate in ceremony. The HCC also recognizes its limitations as a core of non-disabled people and mostly cis-gendered people, and members are currently working to educate themselves and practice a politic that speaks to limitations and possibilities of their work.

What emerged in the 1960's then, was not only a shift in political organizing strategy within minoritized/U.S third world communities, but what Ramon Grosfoguel (2012) calls an “epistemic insurgency,” an intellectual and cosmological uprising. This epistemic shift of the late 1960s set in motion both the sacred political consciousness shaping health/care intervention made possible through the HCC healing clinics and the return towards privileging ancestral, traditional, and Indigenous medical knowledges.

Spirituality and Non-Western Medicine and Healing

Spirit/spirituality are at the center of ancestral, traditional and Indigenous medicine and healthcare and are all but absent in hegemonic biomedical epistemology. The World Health Organization was petitioned by an international body of practitioners and public health researchers to add “spiritual health” as an official fourth dimension of health in its constitution—in addition to physical, mental, and social dimensions— but the inclusion was never ratified (Dhar, Chaturvedi, and Nandan 2013; Chirico, n.d.). The reluctance to move spirituality and religion from the margins of health research comes from a firm rooting of research and health services within a Western scientific epistemology based on Cartesian dualism. Empirically, spirit cannot be observed by the five senses, much less measured via positivist methods used in the health and social sciences (Tuhiwai Smith 2012). At the same time, numerous recent studies capture evidence and demonstrate *pathways* between religion/spirituality and health (Milstein 2008; Oman and Thoresen 2007; Strawbridge et al. 2001).²⁰

²⁰ While these studies are produced in academic research settings and have provided robust evidence to show that religion/spirituality and health is an issue that public health should be concerned with, I found that very few Schools of Public Health make an effort to include the study of spirituality and religion at a population level. At UC Berkeley School of Public Health, the Public Health and Spirituality course is offered, but not required, and spirituality/religion is not integrated into the overall curriculum. John Hopkins University, through the Institute for Spirituality and Medicine, focuses on physician training about the major world religions (JHU website). George Washington University's Institute for Spirituality and Health (GWish)

Moreover, in both mainstream and academic-stream, Indigenous spiritualities are viewed through timeless narratives or as artifacts of the past or else analyzed via the conceptual categories of folklore and folk medicine in anthropology and ethnomedicine (H. Garcia, Sierra, and Balam 1999). This move only continues to “other” the communities where these knowledges and practices are based, again doing a disservice to understanding the full dimensions of public health needs. Indigenous and traditional spirituality and religious couch traditions in material reality, leading to more creative possibilities for incorporating—or rather re-membering—medical epistemologies that do not disembodify spirit and spirituality.

Traditional healer and scholar Estela Roman (2012) defines health as coming back to the senses. She writes that illnesses manifest in the body because of the way we are socialized to think, not feel. We *think* about health, rather than *feeling* healing. This observation again invokes Cartesian dualism, a central feature of a modernity that ushered in dehumanizing structures of colonization and systems of hierarchy including the mind over body over spirit. The tenets of bio-medicine draw from this hegemonic model of social organization, resulting in social relations that make the body inferior. Nancy Scheper-Hughes and Margaret Locke write that non-Western systems “do not logically distinguish the body, mind, and self and therefore illness cannot be situated in mind or body alone” (1998, 21). A colonial, Eurocentric regime of knowledge that reinforces mind/body dualism in Western medical thought leaves most people without the

prioritizes medicine and training physicians to honor the spiritual health of individuals while studying the effects that religion and spirituality have on a person’s whole health. The GWish has a specific goal of integrating “spirituality, defined as meaning, purpose, and connectedness, into all levels of health care as part of a strategy to create more compassionate systems of care.” Harvard School of Public Health offers one class in School of Public Health titled “Religion and Public Health.” All other courses are offered through Harvard School of Medicine and Harvard Divinity School. The University of Michigan-Ann Arbor launched the Landmark Spirituality and Health Survey, a nationwide study that uses a variety of measures and biomarkers to “show how *religion* may affect physiological changes in the body” (emphasis mine). This leads me to suspect that spirituality is understood as always relating to a religion, which limits a population level discernment of religion and spirituality.

knowledge or agency to be part of their own healing process. Instead, potential for healing and curing is placed on an authority figure, bio-medicine.

Simultaneous to the scientific and medicalized othering imposed on non-Western bodies was the pillaging of Indigenous sciences and knowledges and in some places almost a complete destruction of documented evidence of these knowledges (Grosfoguel 2013). Modern/colonial knowledge production resulted in, as Linda Tuhiwai Smith writes, a deliberate attempt at disconnecting colonized peoples from their “histories, their landscapes, their languages, their social relations and their own ways of thinking, feeling and interacting with the world” (2012, 4).

In ATI medicine generally and in the HCC clinics specifically, ceremony is the space and time where the embodiment of spiritual rituals can have “physiological and psychological consequences that can serve as protective factors in community and family health” (Gonzales 2012, xxiii). Indigenous ceremony is a pedagogical practice that creates a space where spirituality becomes tangible and learnable. However, the word “ceremony” changes based on context. For example, there are many ceremonies in the non-Indigenous world that do not incorporate spirituality or religion. For Indigenous communities, ceremony is the way Indigenous spiritual epistemologies endure across generations (Cajete and Bear 1999; Broyles-Gonzalez and Khus 2011; Gonzales 2012). As Ohlone elder Ann-Marie Sayers and countless Indigenous elders have repeated, “When our ceremonies die, we die.”²¹ It is within this context of the meaning and importance of spirituality and ceremony that the Healing Clinic Collective situates their work, as I will discuss later in the paper.

The remainder of the paper explores the “ceremonial organizing” of impermanent spaces of healing created by the HCC. First, I will discuss the space and place of the clinic in relation to

²¹ Personal communication.

theories of third space and therapeutic landscapes. Next, I will present four themes I identified based on interviews and participant observation: 1) health/care as loving care, 2) healing as movement as healing, 3) healing as embodiment and 4) the healing potential of impermanence.

The Healing Clinic: Decolonial Health/Care Space and Place

I frame the clinics as impermanent spaces of healing and radical movement building by thinking alongside a decolonial²² third space that considers the elements of structural oppression that impede or slow personal and social transformation that happens through a healing process. “Third space” as conceptualized by decolonial feminist writers (Anzaldúa 1999; Pérez 1999; Lugones 2003) approaches the anthropological concept of liminality through a politicized lens of transformative potential and as an interstitial site of contestation, contemplation, and respite, tethered to the possibilities of structural change: an impermanent, sacred political space. The HCC healing clinics as decolonial third space enable a personal transformation for attendees,²³ but also of the *place* itself thus not limiting the transformative journey to that of one human individual. This makes entering the healing clinic space a communal act that temporarily transforms a permanent and public physical place. Over the years, community members that regularly utilize the permanent structures hosting the healing clinics (e.g., churches, community

²² “Decolonial” is an epistemological shift that aims to centralize ways of knowing and being that are relegated to the underside or else completely invisibilized in modern, Western canons of knowledge. I draw from multi and transdisciplinary scholars from the Global South and the U.S. third world who privilege the knowledges, cosmologies, and practices of people from these places. For specific theoretical contributions to decolonial thought see Wallerstein and Quijano (1992), Wynter (1992), Mignolo (2000), Sousa Santos (2010), Perez (2007), Maldonado-Torres (2009) and Grosfoguel (2012). While not mutually exclusive, it serves to note that decolonial is not the same as “decolonizing,” a term used primarily in Indigenous and Native studies and in Indigenous Native communities referring to structural and institutional decolonization and the return of land rights, among other re-indigenizing processes. For a discussion about the use of “decolonizing” within education and academia, see Wang and Tuck (2012).

²³ I use “attendees” to refer to all people who attend the healing clinics including practitioners, organizers, other volunteers, and people attending solely to receive treatments. I do this because all who enter the space of the clinic can potentially receive healing.

centers, and schools) have reported a palpable shift in energy after the clinics. Perhaps it is a result of the prayers, healing songs, or liberated tears that are welcomed to flow freely and in community throughout the day-long clinic.

In this vein, the paper also touches on the concept of “therapeutic landscapes” to analyze the space/place of the clinic. Therapeutic landscape is utilized in health geography to analyze sites of healing, such as a medical clinic, a physician’s office, a home, and a hospital for example, to see how these sites contribute to individual physical and mental well-being (Gesler 1992; Wilson 2003). Therapeutic landscapes also analyze the symbolic landscapes created through systems of cultural practices and beliefs that initiate a sense of spatial familiarity, helping to manage or maintain health (Wilson 2003). Building off of this concept, I conceptualize the clinics as a “healing landscape.” A healing landscape moves away from Western therapeutic geographies of seeking cure and managing health, to ATI healing geographies of movement through processes of organizing, giving/receiving care and transmitting culturally-relevant knowledge about autonomous community care.

Health Care as Loving Care

Over the years a common sentiment surfaced in interviews, and while hanging out and working alongside practitioners. Tona, a core organizer with the HCC, states:

We are expressly not trying to be like Kaiser and county hospitals [where] you have your 15 minutes and then you have to go because someone else has an appointment right after you that equally deserves their 15 minutes. [The HCC] acknowledge that healing, energetic and spiritual work doesn’t function on that clock, because it’s not just holistic, natural and traditional care, it’s loving care...we are holding people in an emotional space as well.

Here, Tona juxtaposes the conventional healthcare medical encounter with the type of encounter experienced at a healing clinic. Using the term “loving care” points specifically to this type of care as one that honors “emotional space.”

Espy, a practitioner of *curanderismo*, describes the communal dimensions of loving care as experienced by an attendee:

An older Black woman asked me a few questions about the *limpia*, and I asked her if she had received one or was waiting for one... She said, “I’m just hanging out around here. It’s healing just being here.” I glanced around at the children playing and the women, almost all were women of color, talking, laughing and crying.... People were hanging out all day... Women came too late to sign up, but stayed to volunteer just to be in the space...

Espy describes the clinic itself as a healer and as a space of intergenerational loving care that is virtually non-existent in biomedical healing spaces. Research shows that group medical visits provided in biomedical community clinics can include integrative healing practices such as acupuncture and result in improved patient and provider healthcare satisfaction (Thompson-Lastad 2018). However, group medical visits are not created with the intention of communal generational healing for systematically oppressed people, but rather to facilitate and offer a different clinical experience for the individual, regardless of their social experience.

The healing landscape created by the HCC clinic also promotes communal healing through the perceived safety of being in community with others going through the healing process. Dae, an organizer from the 2015 Youth Healing Clinic, described the experience of a group of youth who traveled to Oakland from Richmond to attend the clinic:

The way that the clinic holds the space is sacred... The young people at the clinic, [many] of them have never experienced anything like that. One of the biggest stories that came out of that day was these young people from Richmond were taking a nap together in the little recovery room and they had just gone through a couple of [healing] sessions. Some had [talk] therapy sessions, and also one of them had a *limpia*... They took a nap at the clinic and they were talking to people around the clinic about it like, “Damn I haven’t felt safe enough to take a nap in a long time at home, like we can’t do that stuff at home, in the hood, at school.” But something about that space and the healing sessions that they went through, the experience they had gave them safety and that’s big, you know?

For the youth from Richmond, health/care came in the form of safety, and a communal experience of loving care allowed for the medicine they all needed: sleep.

To provide and receive loving care—especially by and in the presence of someone who does not need quantitative, pathological, or empirical evidence of suffering and pain—not only changes the medical/healing encounter, it changes relationship to and belonging in community for healing clinic attendees. It changes the way people can work things out on their healing journey, both in their body and with others. In the clinic, health/care as loving care is experienced communally and also vicariously.

Vicarious healing is an essential component of loving care; Tona summed up the “vicarious healing” that can happen at a clinic by reflecting on the moment she realized the power of witnessing another person’s cathartic healing session and the way the practitioner physically held the person as she cried. Tona said, “I realized that I had never been held like that by someone I was receiving a treatment from—and been allowed to just emotionally release... Change happens in a moment like this, you can feel it. The same way you can experience vicarious violence and trauma, you can experience vicarious healing.” Structural oppression that foments deficit narratives about health in minoritized communities and self-alienation from the body and other racialized bodies also ruptures the ability to love and be loved and loving. Research shows that belonging—or what I like to think of as “social love”—can determine thriving health, especially for minoritized people (Richmond, Ross, and Egeland 2007). For clinic attendees who may have possibly never felt a loving embrace from strangers, as people whose expression of emotion might make them a target for state-sanctioned violence, or simply for people whose emotions are consistently invalidated or pathologized in a biomedical clinical

encounter (Waitzkin 1993; Sacks 2019), the clinic becomes a place where someone can feel loved simply by witnessing the uninhibited care of others.

The intention of “vicarious healing” for the most underserved and undercared for people of our community is also captured in the HCC’s tagline: “Healing with the People”²⁴ as well as in the language of their mutual consent form that all attendees and practitioners sign. The HCC carefully considered the hierarchy of power within conventional clinical interactions and how the interactions at the healing clinics could serve as an opportunity for attendees to practice accountability and body autonomy. One part of the “Treatment Recipient Responsibilities” form that all attendees sign reads: “To build honest, receptive relationships with the practitioners here today. To share my needs with them in a timely honest way, including if I am uncomfortable by any treatments, suggestions, touch, or any other offering of the practitioner” (HCC Guide).

While I was working the registration table at the most recent clinic, a young person approached the table, and I handed them a consent form. As they read the form, they looked up at me with tears in their eyes and told me, “I feel like I’m getting healing just by reading this.” The HCC consent form was primarily drafted by a founding core member of the HCC who is also a nurse practitioner midwife. Familiar with biomedical consent forms that focus on potential harm and risks, the HCC consent form acknowledges the role of attendees as active participants in their healing, shifting the perception of power from the provider/practitioner to an expectation of a reciprocal healing exchange.

An interactive practice between space and people, loving care emerges as the foundation that sustains the clinic attendees—the organizers, practitioners, and community members—in

²⁴ The original tagline for the HCC was “Bringing healing to the people.” However, the core organizers discussed the ways this created a sense of authority that did not capture the intention of the HCC’s work, since the practitioners and volunteers also receive healing through their service and experiences at the clinic.

their work with the HCC and beyond. As an alternative to biomedical care, loving care circulates through a healing landscape of belonging and cultivates political consciousness through the practice of body autonomy.

Healing as Movement as Healing

Through my work with the HCC, I see how embodied grief animates a healing journey. For some of us, it moves us to organize for change against systemic oppression. Indeed, many social justice movements emerge as responses to a nexus of communal grief from memories and experiences of broken treaties, trails of tears, forced sterilizations, ongoing lynchings, imperial wars of aggression, and white supremacy. This same impetus leaves us vulnerable to complete depletion in mind, body, and spirit (Alzate González 2015; Talcott 2014). Social movement scholars refer to this phenomenon as activist burnout and describe it as a “formidable barrier to movement sustainability” (Gorski 2019, 683). Research on racial justice activist burnout suggests that the experience of activists of color with racist structures intensifies the effects of burnout.

Considering the varied solutions to activist burnout including the popular and highly individualized notion of self-care, I contemplated Xitlalmina’s statement from the epigraph of this paper that “movement is part of healing,” and I asked myself over and over again, can movement organizing be healing and can healing be movement organizing? I think about Oakland’s surviving activists who were involved in radical third world solidarity movements of the late 1960s and 1970s. While ancestral medicine and healing was not explicitly a central part of radical organizing frameworks during that era, we see through their organizing platforms, memoirs, artwork, stories, and root work that their movement efforts were trying to engage

community in collective healing through collective struggle and survival towards liberation (Hull 2001; R. C. Spencer 2016; Shakur and Davis 2001; The Dr Huey P. Newton and West 2008; Chavez 2000; Melendez 2005; Taylor 2017).

Several practitioners describe the political origins of their path to healing work as rooted in their own healing journeys and their astute and embodied experiences of being othered and made vulnerable through institutional deficit narratives. For others, early childhood memories of the care they received through ATI healing practices compared to their experience of biomedical encounters opened their paths towards becoming ATI healing practitioners.

Aja, a practitioner and a seasoned Bay Area community organizer, shares her perspective on the way the healing clinics mobilize community:

Community, that is the fundamental thing that we have lost, community and holding and love and that's what is so powerful about this [clinic], it's like a moving community that brings community together and that is critical for our healing because the grief, the crisis, the sickness, all of that, we need each other to heal it. We need to go in, we need people to hold us, you know, so it's powerful medicine.

The message of “needing each other” is paramount to social justice community organizing methodology; we quite literally need each other to mobilize a mass base. We need to organize each other to build a movement, and we also need each other to heal. But “healing” and “organizing” are two concepts that are rarely uttered in the same context. Over the years, clinic attendees refer to the healing they receive by merely being at the clinic or, particularly for the organizers, by witnessing the culmination of their many months of organizing work. I do not want to romanticize the clinic organizing aspect. There are certainly conflicts that come up during organizing and during the clinic. Yet even within conflict, the clinic itself remains the great healer.

Xitlalli, an organizer from the Youth Healing Clinic, reflects on their commitment to HCC organizing work in a way that challenges the inevitability of social justice activist burnout:

I'm ride or die now...even though it's hard work, I think that a lot of it is about unveiling the resources that are there, you know they are there! I think the way this [HCC organizing] model works is to show how much can get done without an extreme dependency on capital, on money, on corporate support, you know just grassroots community building and community-based support and love as a foundation is huge. Even for us as organizers, doing the work further empowers us to see the capacity and abundance that's around us and helps us shift a paradigm shaped around scarcity [that says] "This is impossible, how can we possibly do that?" ... I think that this is one of the beauties of the clinics.

The communal work of organizing a clinic shapes a political consciousness and healing landscape that amplifies the health assets and economic abundance within communities riddled by racialized hegemonic deficit narratives of unhealth and poverty. Xitlalli describes a politic that challenges the extractive and dependent relationship we have with a capitalist economic system towards one that re-members relationality—a foundational concept in Indigenous epistemologies—through communal “support and love.” In the next section, this paper turns toward the centrality of spirit/spirituality in ATI healing epistemologies and health/care through sacred-political and ceremonial organizing.

Holistic Healing as Decolonial Embodiment

Part of the original vision of the HCC is to “relate to ourselves as whole people” (HCC Guide). While “holistic healing” is often used as a generic phrase for alternative or complementary medicine, sometime for a profit motive, the work of the HCC effectively reclaims the term to capture the way spirituality, the senses, and emotions are intrinsic to health/care and indivisible from each other. Having a sense of “self” is integral to definitions of health from multiple medical knowledges including Western biomedicine (Million 2013). Biomedicine capitalizes on a neoliberal sense of self undergirding a lucrative biomedical marketplace. There are also ATI practitioners who draw on a neoliberal understanding of self-care for their own individual profit or as part of a New Age cosmivision that includes among other things, “playing Indian” or, especially for white participants, distancing themselves from

whiteness (Heelas 1996; Deloria 1999; Funes 2016). However, for healing clinic practitioners who volunteer their time, energy, experience, and labor to the sacred political vision of the HCC, the concept of self is relational with their community's experience.

For the HCC, spirituality and connection to spirit is salient to their organizing principles including determining which ATI practitioner modalities are selected for the clinics.²⁵ Four of the modalities offered at the clinics are directly tied to African Diasporic and Turtle Island (Western Hemispheric) indigenous spiritual traditions: the ancestral traditions of a large majority of minoritized and oppressed Black and Brown people in the U.S. The “ceremonial organizing” work of the HCC directly exemplifies research on decolonial spiritualities coming from ethnic studies scholars (Anzaldúa 1999; Tuhiwai Smith 2012; Hull 2001; Perez 2007; Facio and Lara 2014). These scholars identify three themes recurring in spiritualities and religions indigenous to the Americas and the African Diaspora and practiced by people who culturally and ancestrally relate to peoples from those regions: resistance/resilience, the politics of memory, and the healing potential of spirituality. Aligned with the HCC's sacred and political framework is Laura Perez's research on post 1960's Chicana art and the politics of spirituality. Perez writes, “In various genres, Chicanas were engaging in the spiritual *alongside* more familiar areas of social struggle (gender, sexuality, class, “race”) as another terrain upon which to challenge the cultural blind spots in mainstream values, in our assumptions and dismissals, in our pretensions to the universality and superiority of our beliefs, and in our anti-religiosity or religious dogmatism” (2007, 3). Her argument points to the presence of spiritual politics and the imperative of spiritual activism in the work of the artists. In a similar vein, the HCC's sacred political framework and ceremonial organizing contribute to an epistemological shift about health and healing towards a

²⁵ See Appendix for modality descriptions.

decolonial embodied imperative of transmitting health/care knowledge that is inter-relational. At the healing clinics, spirit and spirituality—concepts that cannot be empirically measured according to epistemologies based in Western science—become present through the act of feeling.

The theme of “feeling” emerged throughout participant-observation and interviews: feeling encompasses both touch (as well as other sensations) and emotion. I will go in depth into one clinic where feeling was most present, the 2014 Men’s Healing Clinic held at a large, social-justice-oriented Christian church located just outside of downtown Oakland.

The prayer for the Men’s Clinic was expressly for a space that allowed all men—cis gendered, trans, masculine of center, and non-binary people—to experience healing as complex subjects in a heteropatriarchal, racist, capitalist society that imposes a detrimental type of masculinity on them.²⁶ For the practitioners and organizers at the men’s healing clinic—who included queer, trans, non-binary, and cis-men—the prayer was to create a space where men could heal together. Reflecting on the planning stages of the clinic, Ola, a clinic organizer, noted, “The men in the [organizing committee] shared why they were invested in the work. We had people be like, ‘I’m working on challenging my internalized patriarchal bullshit’... We came in from backgrounds where some of us struggled with being violent, or those kinds of things.”

It was that “internalized patriarchal bullshit” that had some practitioners and organizers wondering if they could execute a Healing Clinic for men, where men could provide and, most importantly, receive loving care from another man. This sentiment was echoed across organizers

²⁶ Acting like a man means, colloquially and philosophically, to not exhibit emotion, to be forceful, and rational. The health effects of a heterosexist masculinity do appear marginally in public health research, naming the social experience of being a man as a risk factor, especially for men of color (Courtenay 2000).

and practitioners for this particular clinic, especially around the issue of safety for trans men and gender non-conforming and non-binary attendees. Temo, another clinic organizer, noted:

Some folks in the committee were adamant about including all men... People have an idea that the majority of violence or harassment that comes toward gender varying people is from men. But it was actually nothing like that at the [men's] clinic. I think it was really impactful to see that when we created a space where people could be open and tap into the healing themselves, into spirit, in a way we're denied as masculine folks, people are gonna respond to it. They're gonna be open.

Touch is rarely utilized in biomedical encounters except for diagnostic purposes. ATI treatments offered at the healing clinics are rooted in consensual, loving touch, in sound, and in embrace. The clinic facilitated a space to feel, and however fleeting and impermanent the feeling is, that memory of "feeling" remained with the participants I interviewed.

Eli, a practitioner, commented on his observation of men doing exactly what gendered oppression and a detrimental construction of masculinity continue to constrain men from doing: feel and heal.

A word I would use for what happened at the clinic is that it was a sensual experience. Not from a sexual perspective, but from an actual feeling perspective. Often people think that men don't feel, but we feel extremely. A lot. Society doesn't give us that space to feel. And so, I think of—from a sensual perspective—how individuals went to the clinic and they had to go *there*. They had to be able to. And that's also the way that I like to deal with things in my practice like, 'What's the feeling behind the underlying cause of disease?' You got to have a feeling. It's either anger, lust, I mean many, many different feelings.

Eli makes the distinction between sensual and sexual as a way to disrupt the one-dimensional perception of sensuality as a sexual experience. To say that men "feel extremely" seems to further the distinction between sexual and sensual as it is used to describe the clinic. Eli emphasizes that men "go *there*," "there" referring to a space of feeling, necessary to begin the healing process. "Controlling images" (Collins 2000) of Black and Brown men portray them as sexual perpetrators, so Eli's careful distinction between sexual and sensual is perhaps an attempt to move away from a racialized and gendered narrative that has caused harm to and within Black and Brown communities.

In another perspective on the Men's Clinic, Temo reflects on the sociopolitical responsibility of men and masculine-presenting people:

We really need to honor and acknowledge how long women have been oppressed, and all the damage that has happened to the women in our society and how that's so intricately tied to colonization. And in this healing movement, the strongest leaders are women and queer folks... Many of our different movements—like in the late sixties—there was so much patriarchy embedded in those movements... It's important to really acknowledge if we're organizing a men's healing clinic, and we recognize that one of the most destructive threats to our community is violent masculinity and patriarchy, we really need to hold that space and talk and pray about that shit. That needs to happen. More often than not, it needs to happen with just men.

Men praying, healing, and witnessing other men do the same created a space that many of the participants had never experienced before, or since. Ola notes that before the clinic, he understood his healing outlet to be the work he puts in at his job. He shared his amazement at “people coming in the door one way and leaving another... seeing big-ass tatted up dudes coming out of their sessions all puffy-eyed and crying,” challenged what he called a “hyper masculine culture” that forces oppressed people in general to numb their feelings, keep their heads down, and work.

By investigating the historical processes that inform categories of risk within biomedical and public health research, that then in part shape racialized gender in the U.S, we gain a deeper understanding of how tropes of racialized and gendered people circulate via medical authority (Briggs 2005) and within similar logics that uphold a white supremacist, heteropatriarchal, neoliberal, carceral state. These logics place people, places, and ecosystems on a racialized and gendered hierarchy of destruction through disconnection and the superiority of material bodies over spirit and the spiritual. In the third space of the clinic, embodying spirit is a political move to transform oppressive social structures.

The Healing Potential of Impermanence

It is 6pm. The energy begins to shift. The vibrancy of the early morning and afternoon transitions to a soft hum. Late-arriving community members hoping to receive a treatment are informed that all of the healing session slots have been full for hours. The inevitable time to break down the clinic has arrived. It all happens rather quickly. Practitioners clean up their spaces. Kitchen volunteers retrieve dishes and snacks from the waiting area, sorting the perishables into a give-away box for volunteers and remaining attendees to take home to their families. Non-perishables and un-opened items are packed away for the HCC to use at their next meeting or event. Tables are folded up and chairs are stored away. Tablecloths and towels are placed in a laundry pile for a volunteer to take home and wash, and the signage on the walls and doors that kept the clinic logistically organized is removed. The pop-up canopies that sheltered limpia practitioner stations are collapsed into their compact size as soon as the practitioners attend to their last “patient.” Inside the main hall, the dividers that offered semi-privacy and demarcated each practitioner’s space during sessions are folded up and carried out to the vans, pick-up trucks, and other vehicles belonging to volunteer community members whose only role that day is to transport clinic supplies.

As the moon rises, remaining attendees gather in a closing prayer of gratitude and solidarity for all of the community members, ancestors, and Spirit that made the clinic possible. After the final prayer, remaining volunteers turn their focus back to finishing the final tasks: sweeping the floors and emptying the garbage. One last walkthrough of the space ensures all is as it was at 7am that morning when the first volunteer arrived. I walk out and watch as the last volunteer exits the main entrance, closing the door behind her. No physical trace of the Clinic remains, or at least not that any of us are aware. We gather for a few moments, sharing laughs

and hugs before someone says what we are all thinking: “I’m tired!” Several volunteers have one more logistical task of unloading the clinic supplies and storing them in Carla’s basement, where they stay until the next healing clinic is brought to life.

The impermanence of the clinic is noted by most of the participants that I interviewed. Some lament the fact that the clinic is only one day, and only held once or twice per year. One practitioner shared, “We need to be doing this for the people every weekend!” Other participants see the long-term intention of bringing specific community members together, organizing them through healing. Eli states, “As long as I leave a seed and it impacts someone [to know] that it’s okay to come to a place to actually view your true self. Being in a safe space to do it, that’s part of what the clinic did but also part of what I also did for myself while I was there.”

Eli acknowledges that many of the people he treated at the clinic were stressed and in need of *some* kind of care. To have a safe space to “view your true self” also acknowledges the decolonial third space of the clinic as both a place of respite from a world that does not allow people, especially racialized, gendered, and minoritized people, to express their true selves, and as a healing landscape that makes space for emotions to move through their bodies. The clinic then, becomes a healing memory for attendees to call upon in moments where an imposed sense of self leads to feelings of dis-ease through disembodiment.

Aurora offers an honest critique that also implies the necessity of less frequent clinics by reflecting on both the critical healing work of the clinic, and the unsustainability of organizing more than one clinic per year. She says simply, “It’s beautiful. And it’s unsustainable for us if we’re the only one’s doing it.” The perspective and assessment of the clinic’s impermanence varies among clinic attendees; however, there is a benefit to impermanent spaces that adds to

their sacredness relative to community health and communal healing of oppressed people living in an urban environment.

A tenet of self-determination persistent through a radical community organizing continuum in Oakland is that oppressed communities need permanent and complete control over our local governance and institutions including schools, hospitals, and financial institutions. While I agree, we must also contend with the fact that although some of these institutions benefit the communities they aim to serve, many also lose the radical anti-capitalist, anti-colonial spirit that initiated their work (Herrera 2015). The healing clinics as impermanent spaces exist in the same radical political dimensions as, for example, the Black Panther Party for Self-Defense's (BPP) community programs, which they called "Survival Programs *Pending* Revolution" (emphasis mine). Like the BPP survival programs—which included activities such as serving breakfast for children, giving elderly people rides to their doctor appointments, providing groceries for Black and poor families, and creating free clinics and sickle cell anemia testing sites—the healing clinics are not intended to be permanent fixtures *within* a Western biomedical system. They are a multifaceted self-determined healing landscape pending the embodiment of a political consciousness that enables a just transition²⁷ away from structurally oppressive colonial institutions continuing to shape our understandings of our own bodies, our communities, and our natural environment.

In a transitory healing landscape, impermanence facilitates healing as a *process*, not a state of being. The healing clinics do this by invoking the constant movement—thus impermanence—of community organizing and momentum building. Impermanence as a spiritual

²⁷ As summarized by Movement Generation, an SF Bay Area based ecological justice organization: "A Just Transition requires us to build a visionary economy for life in a way that is very different than the economy we are in now. Constructing this visionary economy calls for strategies that democratize, decentralize and diversify economic activity while we damper down consumption, and (re)distribute resources and power" ("Movement Generation | MG's Just Transition Zine" n.d.).

and political tenet helps us fully experience the *present* moment by embodying the changes we imagine.

As a mobilizing, educational, healing—thus ceremonial—space for the transitional time²⁸ we find ourselves in on the global level, the clinic is an example of grassroots community building. Each time the clinic is co-created anew in a dynamic, sacred-political process.

Conclusion

As I have shown, ceremonial organizing facilitates a politic of “loving care” and a politicized healing landscape where people can “work things out” on multiple levels. Working things out is the healing process that happens through receiving loving care. Organizers work things out throughout the challenging process of bringing a clinic to life. Participants work things out by re-membering spirit through feeling. By participating in the visionary practices of an impermanent healing landscape, the community catches a glimpse of sacred-political and alternative ways to work things out together.

For health/care, the work of the HCC presents opportunities for marginalized, minoritized, and historically dehumanized people to see and feel the practice of receiving care in various forms, most importantly seeing and experiencing health/care rooted in our ancestral knowledges, reminding us of complex histories and intellectual contributions of our ancestors, demystifying the risk narratives that teach us to fear ourselves and each other. The HCC’s approach is not in opposition to biomedicine, but an expansive alternative and decolonial medical third space and healing landscape where healing is a relational and interactive process

²⁸ Ibid.

and health is much more than an individualized and ableist notion of physical and mental balance. The healing clinics are an example of self-determined health/care that guides our ability to look towards multiple health knowledges, economies, and paths of healing. Changing the way minoritized and dehumanized people can *be healthy* in the world requires us to look away from a colonial, white supremacist, ableist, and for-profit health care system and state-sanctioned Public Health policies; to imagine, organize for, and practice something different; and to remember that imagining possibility is a spiritual act.

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Appendix

Description of most common healing modalities from the clinic guide:

SPIRITUAL CLEANSE | LIMPIA Energetic / spiritual cleanse and healing of trauma symptoms using herbs, water, instruments and prayer. *Limpia espiritual y sanación de las síntomas de las traumas usando hierbas, el agua, los instrumentos y la oración.*

ACUPUNCTURE | ACUPUNTURA Acupuncture: placing tiny needles in points on the body to promote balance and stimulate the flow of energy and circulation. *Acupuntura: la colocación de pequeñas agujas en puntos del cuerpo para promover el equilibrio y estimular el flujo de energía y la circulación.*

MASSAGE | MASAJE Rubbing and kneading of muscles and joints of the body with the hands, especially to relieve tension or pain and release trapped energy. *Sobar los músculos y articulaciones del cuerpo con las manos, sobre todo para aliviar la tensión o el dolor y liberar la energía atrapada.*

REIKI: Using hand placement to channel Life Force Energy for stress reduction, relaxation and healing. *Usa colocación de las manos para canalizar la Energía Vital de la Vida para la reducción del estrés, la relajación y la curación.*

JIN SHIN JITSU: Jin Shin Jitsu is a hand's on, light touch practice that can balance the body physically, emotion- ally, and spiritually. The individual is fully clothed, as the practitioner places their hands on different points on the body. Jin Shin Jitsu is ideal for people who need help in relieving pain, anxiety, allergies, and acute and chronic conditions of every nature. *Jin Shin Jitsu es una práctica suave que puede balancear el cuerpo físicamente, emocio- nalmente, y espiritualmente. El individuo completamente vestido, mientras que el practicante presiona sus manos en diferentes puntos del cuerpo. Jin Shin Jyutsu es ideal para personas que necesitan ayuda aliviando el dolor, angustia, alergias, y cualquier tipo de condiciones crónicas agudas.*

SOMATIC BODYWORK Working directly with the places in the body that have held traumatic experiences or are hyper-sensitive or numb. Somatic bodywork uses touch, conversation, imagination and emotional processes to support the shift from contraction and dissociation to openness and embodiment. *Trabajando directamente con las partes del cuerpo que han mantenido las experiencias traumáticas o están hiper-sensible o insensible. Carrocería somática utiliza el tacto, la conversación, la imaginación y los procesos emocionales para apoyar el cambio de la contracción y la disociación a la apertura y la realización.*

AFRICAN/ORICHA INDIGENOUS CLEANING/ Limpias Indigena Oricha de Origin Africano Oricha/African

Indigenous Cleaning from an Initiated Elder Oricha Priest. The Oricha are African deities of healing and power. I will be using herbs, water, prayer and song for cleansings. This treatment is

ideal for people who are experiencing, depression, confusion, recovering from violence and other injustices, or a broken heart. *Limpieza indígena Oricha / Africana de una Mayor Iniciada Oricha Sacerdote. Los Oricha son deidades africanas de la curación y el poder. Utiliza las hierbas, el agua, la oración y el canto de las limpiezas. Este tratamiento es ideal para personas que están experimentando, depresión, confusión, recuperándose de la violencia y otras injusticias, o un corazón roto.*

SPIRITUAL COUNSELING Deep listening and reflection of people's stories and experiences. Guidance toward self- healing, and if needed, make referrals for continued support. Ideal for people experiencing feelings like helplessness, grief, sadness, and stress who want to create a more enjoyable life. It is also open to people who have questions about how to support a family member experiencing mental health challenges. *Escuchar profundamente y reflexionar sobre las historias e experiencias personales. Guía hacia auto-recuperación, y si necesario, hacer referencias para apoyo continuado. Ideal para personas experiment-tando impotencia, tristeza, y estres que quieren tener una vida mas agradable. Tambien es ideal para personas que tienen preguntas sobre cómo apoyar un miembro de la familia con dificultades de salud mental.*

DIVINATION | LA DIVINIDAD Tarot card reading and divination. Doesn't tell the future because we make the future with our actions every day, but can help people get clearer on what is going on in their lives and what they can do about it. *Uso de cartas del Tarot y adivinación. No predice el futuro porque hacemos el futuro con nuestras acciones cada día, pero puede ayudar a la gente tener más claridad sobre lo que está pasando en sus vidas y lo que pueden hacer al respecto.*

(The Healing Clinic Collective 2018, 28)



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