

Article

“Love and Prayer Sustain Our Work” Building Collective Power, Health, and Healing as the Community Health Board Coalition

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Abstract: Over the course of the last few months, we have seen how structural racism has compounded the impact of COVID-19 on Black, Indigenous, and People of Color (BIPOC) in the United States, resulting in disparate rates of infection and death. The COVID-19 pandemic has revealed how the consequences of deeply entrenched inequities are fatal to BIPOC communities, whether death is a result of the novel coronavirus or the everyday violence of structural racism that manifests as poor health outcomes. We examine the formation of the Community Health Board Coalition (CHBC), a BIPOC-led organization in Washington state, to show how 15 communities have organized for health and healing amidst the collective trauma associated with COVID-19. We note that biopower—literally power over life, the unspeakable—and slow violence have been normalized and escalated in our communities. The use of an antiracist lens and decolonial practices have assisted us in our survivance (survival and resistance). We use autoethnography and testimonio as decolonial theory and method to give voice to individual and collective experiences that brought us to our roles as CHBC founding members and inaugural cochairs.

Keywords: community organizing; healing; structural racism; biopower; slow violence; unspeakable; autoethnography; testimonio; survivance



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1. Introduction

The impact of the COVID-19 pandemic is particularly acute in Black, Indigenous, and People of Color (BIPOC) communities. Across the United States, BIPOC face disparate impacts of COVID-19 due to structural racism. In fact, those living in the most impoverished, crowded, and racial and economically polarized regions experience substantially elevated rates of COVID-19 infection and death (Chen and Krieger 2020).

In Washington state, BIPOC are disparately burdened by COVID-19, including higher rates of infection, death, economic impact, and incidences of hate/bias and racial profiling¹. In King and Pierce counties, the state’s largest metro region, BIPOC are disproportionately impacted at every uptick of transmission and infection rates of the coronavirus. A recent increase in infection rates in rural Yakima county targeted BIPOC essential workers, including Latinx and Indigenous farmworkers whose lack of worker rights and protections made them especially vulnerable². Rates of transmission and infection among BIPOC are believed to be higher, but centuries of medical racism (Bailey et al. 2017) have resulted in a deep mistrust of health systems that informs whether sick individuals seek medical care, even when infected with a fatal virus.

BIPOC also have experienced significant COVID-19-adjacent impacts, including surges in mental illness and homelessness. Health care professionals across Washington state

¹ CHBC is at the frontlines of the COVID-19 response in the Seattle and King County region. Our members are medical doctors, nurses, mental health providers, community health workers, hospital administrators, professors, and researchers. Data on the disparate impact of COVID-19 on BIPOC in our region is rooted in the lived-experiences and expert wisdom of our members. We also draw on emerging data from our broader base.

² (De la Rosa 2020).

are seeing an increase in hospitalizations, substance abuse, and overall collective fatigue as the pandemic continues. For BIPOC communities, racism, and the persistent stigma surrounding mental illness compounds, the risk for severe effects on mental health. Prior to COVID-19, Seattle and King County declared a state of emergency in response to the homelessness crisis. A dramatic spike in homelessness rates among BIPOC communities is expected as the moratorium on evictions ends and emergency COVID-19 financial assistance is exhausted.

COVID-19 is a revealer; and it is showing that during a global pandemic, racism continues to be the greatest indicator of a person's opportunity at life or death. While this fact may be surprising to some, it has long been an inescapable truth for BIPOC communities. Systemic racism is ingrained in the US aspects of law, health, education, and other systems (Carter 2007). It is only in the last 20 years that health research and systems have paid heightened attention to the social determinants of health. There is now growing understanding that health disparities do not exist in isolation but are part of a complex web of problems associated with unequal access to power and resources (Williams and Mohammed 2013; Lopez and Gadsden 2016).

To achieve health equity, it is necessary to "undo the colonial legacy behavioral, ideological, institutional, political, economic and cultural systems of exploitation and erasure of oppressed peoples by socially dominant groups" (Chandanabhumma and Narasimhan 2019, p. 831). Colonial legacy is defined as "not only to the existence of historical colonial powers that magnify, transform or constrain existing power relations but continued cycles of subjugation and disenfranchisement of people impacted by the colonial legacy (or PCL), which includes Indigenous Peoples and other individuals and communities marginalized by colonization (Chandanabhumma and Narasimhan 2019, p. 831). We see this being enacted by biopower, literally "power over life" (Agamben 1995) and will explore this further.

BIPOC communities have long been organizing and advocating for health systems and policy change that addresses the root cause of health disparities. This is how we manifest survival through the combination of survival and resistance (Vizenor 2009). In fact, community organizing is a vital strategy for unleashing the collective power necessary to uproot inequities at the core of health disparities (Pastor et al. 2018).

2. Community Health Board Coalition

Formed in 2017, CHBC is a BIPOC-led organization that works to improve the health outcomes of communities of color in Washington state through community-led research, and systems and policy change. CHBC has 15 member-health boards:

Afghan Health Board
African American Health Board
African Leaders Health Board
Afro Descendant and Indigenous Health Board
Cham Health Board
Congolese Health Board
Eritrean Health Board
Ethiopian Community Health Council
Filipinx Health Board
Iraqi/Arab Health Board
Khmer Community Health Board
Latinx Health Board
Pacific Island Health Board
Somali Health Board
Vietnamese Health Board

For the CHBC, movement building is essential for collective health and liberation. We are contributing to building a movement that is decolonial, racially just, and intersectional at its root. Our organizing is deeply rooted in decolonial practices that affirm and nurture

relationships within our coalition. As a BIPOC-led organization, we understand that relationships are sacred and must be protected within the context of dominant US society (Wilson 2008). We value connection over expediency, collectivity over individualism, and purposeful intent over status quo. Our intentional focus on relationships has yielded powerful results; in a matter of 3 years, our coalition has grown from 9 health boards to 15. This rapid growth has not come at the expense of our relationships. In fact, solidarity and collaboration across health boards is common practice. Recently, with the leadership of the African American Health Board, the Pacific Islander Health Board, and the Afro Descendant and Indigenous Health Board, we initiated our coalition's first major campaign in response to COVID-19. As a result, CHBC was successful in realizing our demands to local and state public health organizations for rigorous and inclusive COVID-19 data that captures racial, ethnic, and linguistic disparate impacts on BIPOC communities.

As a coalition of 15 health boards, our membership is rich in lived and embodied experiences. As such, our organizing is both working against current systems and actively building a new world where other worlds are possible. To do so, we have had to examine our own relationship to settler colonialism and racism. This work is necessary, complicated, and on-going for our coalition. The creation of the Afro Descendant and Indigenous Health Board in 2019 is an example of our commitment to decolonizing practices. The Afro Descendant and Indigenous Health Board was created to elevate and make visible Black and Indigenous communities within the myth of a homogenous Latinx identity. The need for such a health board in our coalition is a reminder that settler colonialism is a structure, not an event and that antiblackness runs along a common fault line among communities of color (Wolfe 2012).

3. Responding to the Ongoing COVID-19 Pandemic

Our communities continue to experience the disparate impact of structural violence that manifests in lack of opportunity and access to the social determinants of health. The pandemic is adding yet another layer of exclusion and suffering to our communities. Our strategy to survive COVID-19 includes both addressing our communities' immediate needs through mutual aid and long-term health systems and policy work.

Our strategy to meet immediate needs through mutual aid includes community-specific work led by our health boards. Notable examples include organizing seamstresses in our community to sew masks and earn income to counteract loss wages and job insecurity; cultivating land to grow culturally-specific foods and medicine to ensure our communities are connected to ancestral ways of healing during the pandemic; and developing culturally-grounded mutual aid, care, and communication strategies.

The social determinants of health (SDOH) are defined as the "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. SDOHs include both race and class, which are difficult to detangle when the data are not disaggregated.

COVID-19 has affected our BIPOC communities inequitably. The incidence of COVID-19 BIPOC communities in the United States can be attributed to both biomedical factors and the social determinants of health (Tai et al. 2020). Racial disparities in income and other outcomes are among the most visible and persistent features of American society (Chetty et al. 2020). One study examining the social determinants of health related to COVID-19 calculated incidence in relation to ABSMs (ABSMs: % below poverty, % crowding, % population of color, and the Index of Concentration at the Extremes) and found stark differences by analyzing complex gradients of deaths due to COVID-19 by county-level ABSMs, with dramatically increased risk of death observed among residents of the most disadvantaged counties (Chen and Krieger 2020). Researchers who hypothesized a higher incidence of COVID-19 in counties with a large minority racial/ethnic groups and a higher rate of poverty found that "while the excess burden of both infections and deaths was experienced by poorer and more diverse areas, racial and ethnic disparities in COVID-19 infections and deaths existed beyond those explained by differences in income"

(Adhikari et al. 2020, p. 3). These authors recommend disaggregating data by poverty level and race/ethnicity. The relationship between race/ethnicity and class COVID-19 incidence in the United States is complex.

Racism is a key social determinant of health. Racism is the systematic distribution of resources, power, and opportunity in our society to the benefit of people who are white and the exclusion of people of color. People who experience race-based traumatic stress and the concomitant barriers to equity have endured profoundly unjust outcomes including psychological trauma and mental health concerns brought upon by these systems of oppression (Carter 2007). In a meta-review of 293 articles examining the relationship between reported racism and mental and physical health outcomes, researchers found that racism was associated with poorer mental health (negative mental health: $r = -0.23$, 95% CI $(-0.24, -0.21)$, $k = 227$; positive mental health: $r = -0.13$, 95% CI $(-0.16, -0.10)$, $k = 113$), including depression, anxiety, psychological stress, and various other outcomes (Paradies et al. 2015). Racism was also associated with poorer general health. The field of mental health has yet to ascribe interventions that target the systemic etiology of trauma and racism to mental health concerns (Carter 2007). BIPOC communities are disproportionately affected by chronic health problems and have lower access to healthcare. Racism has impacted the incidence of COVID-19 in our communities because racism is a primary factor in the incidence of comorbidities, the role of discrimination in impeding access to resources such as healthcare, the adverse effects of the built environment on food accessibility, transportation and educational achievement, and the lack of economic stability (Singu et al. 2020).

In our work with the CHBC during the COVID-19 pandemic, we have observed how CARES Act resources have been rolled out in ways that exclude our community members. Some of these ways include “first come, first serve” programs targeted to privileged people who have digital equity, computer literacy, and are English speakers, setting up COVID screening in places inaccessible to BIPOC communities and placing quarantining facilities in only the most vulnerable of communities. Furthering the complications of race-related disparities are the class-related factors such as being in living and work conditions that predispose them to worse outcomes (Tai et al. 2020). Other factors include being overrepresented in low wage essential work employment and living in multigenerational households.

Poverty is a social determinant of health. Inherited wealth has been greatly affected by the enslavement of Black people and the colonization of Native Americans in the United States. Mechanisms in the New Deal exemption of domestic, agricultural, and service occupations; the practice of tipping workers; and right to work laws, as well as a lack of antidiscrimination laws, have increased poverty in BIPOC communities (Solomon 2019).

The variable of class should be examined for its effect on the incidence of COVID along with data on age, gender, and race/ethnicity, which are routinely recorded in medical records (Khalatbari-Soltani et al. 2020). In a study examining the association between poverty and the incidence of COVID-19 between January and April of 2020, the variable of poverty was explored. Results of this study revealed that “during the early weeks of the pandemic more disadvantaged counties in the United States had a larger number of confirmed Covid-19 cases, but that over time this trend changed so that by the beginning of April, 2020 more affluent counties had more confirmed cases of the virus. The number of deaths due to Covid-19 were associated with poorer and more urban counties” (Finch and Hernández 2020). These researchers note that these surprising results may be confounded by the limited availability of COVID screening in poorer communities and may change over the course of time. Counties with higher overall income inequality tend to have higher infection rates. Race becomes a confounding factor as a higher population share of Black Americans and Hispanics is associated with higher infection rates (Brown and Ravallion 2020). Population density is a factor in higher infection rates; however, this factor is greatly attenuated when controlled for socioeconomic characteristics,

especially racial composition (Brown and Ravallion 2020). Despite the confounding and intersectional factor of race, it is clear that poverty plays a role in the incidence of COVID 19.

It is no accident that BIPOC are overrepresented in COVID-19 transmission, infection, and death rates in the United States. The confluence of racism and capitalism is deadly in the everyday lives of BIPOC. COVID-19 is intensifying this convergence and creating new racial and socioeconomic inequities that will persist long after the pandemic subsides. Racial capitalism theorizes that racialized exploitation and capital accumulation mutually construct systems and social conditions that devalue and harm the lives of racially minoritized and economically deprived groups (Robinson 2000). A focus on racial capitalism requires greater attention to the processes that shaped the modern world, including colonization, primitive accumulation, slavery, and imperialism (Pulido 2017). Similarly, naming racial capitalism as a fundamental cause of disease and health inequities demands that public health interventions should address social inequality through systems and policy change to achieve health equity across pandemics (Laster Pirtle 2020).

3.1. Mental Health

For CHBC, mental health emerged as a priority prior to COVID-19. The emotional and psychological stress caused by the pandemic is particularly acute in our communities and has solidified our focus on mental health systems and policy work.

Preliminary qualitative data collected by CHBC since the onset of the pandemic describes the crises brought on by COVID-19 as historical trauma akin to trauma emanating from genocide, forced removal, and segregation. Historical trauma (HT) is defined as cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma (Brave Heart et al. 2011; Brave Heart 2008). The historical trauma response is a set of characteristics that arise from massive group trauma; the possibility of historical unresolved grief, in response to historical trauma “is the profound unsettled bereavement resulting from cumulative devastating losses” accompanied by the prohibition and loss of Indigenous healing practices and ceremony (Brave Heart et al. 2011, p. 283).

There are scales to measure the presence of historical trauma especially as they are related to PTSD and depression, and some evidence that interventions designed to mitigate the effects of historical trauma may be effective (Brave Heart et al. 2011, p. 286). It is most likely that the BIPOC communities that are represented in the CHBC have endured colonization, genocide, oppression, and racism, antecedents to historical trauma. The resultant health inequities are present in our communities and made blatant by the COVID pandemic. Brave Heart et al. (2011) recommend assessing for the presence of historical trauma, attending to the collective oppression, trauma responses, and unresolved grief and validating the existence of not only the traumatic history but also the continuing, contemporaneous oppression. There is a need for individual, familial and community level interventions. Lastly, Brave Heart acknowledges the validity of traditional, ancestral, and ceremonial practices that lead to healing. Our communities have endured both the historical and contemporaneous traumas.

CHBC is working to address mental health issues our communities are experiencing within the context of the COVID-19 pandemic. We are doing this through mental health systems and policy work in the following four areas:

- Strengthening partnerships and training among community health workers and mental health systems.
- Advancing programs and services that address the root causes of mental illness in BIPOC communities.
- Increasing the number of BIPOC mental health priorities.
- Ensuring that BIPOC communities have access to culturally grounded mental health services.

3.2. Community Health Priorities Work

Our research, designed to assess community health priorities, began before the onset of the COVID-19 pandemic. Using a community-based participatory research framework, health board leaders interviewed their community members using a semi structured interview guide. The data was analyzed using content analysis and in vivo coding. Findings were analyzed by researchers from the community and triangulated by two focus groups. We found that the majority of health boards listed health care access, quality food, and mental health services as needed to maintain health. Community health priorities included healthcare access, mental health access, community well-being, and economic well-being. The most common stressors in our communities included financial stressors, lack of access to education, language barriers, and systemic racism. Challenges in accessing health care were financial, cultural, and language barriers, and distrust of the health care system was cited by several health boards. Several communities cited that financial barriers led to an avoidance of health care. The majority of health boards affirmed trauma as adversely affecting community health. These preliminary findings indicate a need for access in terms of culturally and linguistically appropriate mental and physical healthcare access, as well as financial well-being. The findings lead us to conclude institutionalized racism and trauma are negatively affecting our members community health. Strengths of our communities were community and family support and mental health. The finding of mental health as a resilient form of overcoming adversity contrasts with the need for mental health resources and underlines the need to provide culturally safe mental health resources for these communities. It is notable that the CHBC has been working on culturally grounded mental health as well as developing our various community's capacity by providing training related to community mental health. We also note that the CHBC is a place where community gathers and healing occurs by using a decolonized paradigm.

We envision our work laying the essential foundation for long-term health systems and policy work that will inform how BIPOC interfaces with health care services in our region. The foundation we will build will be firmly rooted in equity and racial justice. In addition, it will be a foundation that bridges historical and present-day health inequities with the potential for transformative change informed by our communities' resilience and leadership.

4. Arriving to the Work and Sustaining the Movement Together

We use autoethnography and testimonio as decolonial theory and method to give voice to individual and collective experiences that brought us to our roles as CHBC founding members and inaugural cochairs.

The methodology of autoethnography, "is an approach to research and writing that seeks to describe and systematically analyze (graphy) personal experience (auto) in order to understand cultural experience...and treats research as a political, socially-just and socially-conscious act" (Ellis et al. 2011) Testimonio is a story of resistance that is told from a place of intent and understanding of social, political, and historical contexts (Caballero et al. 2019). Unlike more Western ways of research, testimonio challenges the notion of unbiased research and objectivity by locating the individual in a collective experience marked by marginalization, oppression, or resistance (Delgado Bernal et al. 2012). Nevertheless, we will intersperse our testimonio with scholarly research that legitimizes our own lived experience and analysis. Testimonio empowers the storyteller to document how power structures are felt, experienced, and resisted by oppressed groups. By telling a testimonio, storytellers establish themselves as knowledge producers and reclaim space that would otherwise be marginalized by dominant discourse (Carmona and Luciano 2014) thereby decolonizing the dominant narrative of our histories. Indeed, testimonio exemplifies one manifestation of what Chela Sandoval calls the methodology of the oppressed," defined as a process of taking and using whatever is necessary and available in order to negotiate, confront, or speak to power (Sandoval 2000; DeRocher 2018).

Adverse childhood experiences, the unspeakable, structural violence, internalized oppression, historical trauma, and manifestations of biopower inform our historical and contemporaneous stories. These social determinants of health affect our rates of COVID. These phenomena are embedded in our stories both on an individual and a system level. We learn from our shared stories in a manner consistent with Freire's³ conscientization and an awareness that needs no academic explanation; these are the lived experiences of our peoples. We have recognized each other through our shared experiences and turned our trauma into wisdom and advocacy through survivance. The unspeakable can be defined as that which is so threatening to the status quo and power dynamics that there is a lack of language to describe the phenomena (Merton 1966). We write here to give voice to our stories and celebrate our power and survival. By centering the power of storytelling through autoethnography and testimonio, we actively write ourselves into history. Our stories present an intersectional and macrolevel critique of healthcare systems and community organizing to build collective power, health, and healing. In the context of the COVID-19 pandemic, our storytelling is a vital tool for creating the social change needed for the survival of our communities.

5. Robin

As I tell my story, I will switch back and forth from my personal life to my life as a nurse, academic, and activist. The experiences of adverse childhood experiences contrast with the experience of being Marshallese and experiencing historical trauma. The idea of the Unspeakable (Georges 2011) is woven throughout my experiences and the notion of worth is interwoven with the idea of biopower (literally power over life, which is determined by worth) (Agamben 1995; Georges 2008) is seen in my personal and professional life as well as my community. Our histories have been filled with trauma and slow violence (Nixon 2011), which becomes normalized; evolving into the unspeakable, and we wonder why in our grief, we have lost our confidence, pride, and agency. The agency of the Somali mothers I cared for taught me how to exercise my agency. These lessons all shaped how I arrived at the CHBC. I am gratified being amongst people who have similar histories and understandings of the world. We learn from each other and act with great intention. I am proud to be in a group of people who fight for our communities' well-being through advocacy and policy work. Autoethnography is not so different from talking story, which is what we did at my father's table, with good food and good talk, keeping our island ways, and so I begin.

5.1. Growing Up with Adverse Childhood Experiences

Early life experiences set one on a trajectory. As a person of Marshallese descent (Ri Majol), I had a vague knowledge of the historical trauma of the nuclear testing and radiation exposure in my ancestral islands. Being Marshallese means growing up shy and humble with a vague knowledge of the Unspeakable, the horrors that our elders do not talk about. It would not be until decades later that I would understand better what this history meant to my family and community.

The Unspeakable is seen in the absolute absence in most Americans mind of the nuclear testing in the Republic of the Marshall Islands, most Americans do not know or remember the nuclear testing—it is not in American history books. The Unspeakable is that which is exceeding the power of speech, unutterable, inexpressible, and indescribable. Tyler (1987) uses the concept of the Unspeakable to describe patterns of discourse rendered so “natural” to the speaker that they have disappeared from her or his consciousness. All that is left of it are the health inequities that seem to afflict us with no apparent cause except our “lifestyle choices” thereby reducing causality to individual and lifestyle factors. This amnesia and invisibility of our historical trauma normalize the lack of compassion we face

³ Consistent with Freirean pedagogy, we use the notion of conscientization and work to mitigate the culture of silence which Freire describes as when oppressed people are unable to critically reflect on their world and become fatalistic and dominated (Freire 2000).

as our health care disparities in cancer, early mortality, birth anomalies and high rates of COVID continue.

My adolescent years were filled with what we academically call “adverse childhood experiences” (ACEs). Much of my life was marked by invisibility and stigma. The experiences were horrific, and yet my life was normalized because the experiences were too shocking to acknowledge. As a child I learned quickly to become invisible, and the silencing of my voice only added to this sense of being nobody. I lost my sense of self and agency. That trauma took away my confidence and forced me to remember every bit of spiritual knowledge I had been gifted in order to survive. I spent my twenties in intentional healing from these experiences. I was fortunate enough to have the resources. Maybe time heals all. I survived.

Despite this early trauma, I earned my associate degree in nursing at an impossibly young age. A nurse at the age of 20, I had been vocationally tracked into an associate degree nursing program when my high-school counselors noted in hushed tones that I came from a working-class family with social disarray, social worker code for “dysfunctional family.” The most memorable thing a teacher ever said to me was that I “performed below capability,” but what does that mean to a 17-year-old navigating a life that included these adverse childhood experiences? Being the eldest daughter of an ill mother, and an immigrant father far from home, and the sister of 4 siblings, two of whom had long-term illnesses, gave me plenty of experience in caretaking. For what other reason was I here if not caring for others? My worth was predicated on the ability to give care to another. Nurses have historically been associated with an increase in social mobility from a lower class to middle class, especially if they earn a graduate degree, however, many nurses identify with the oppressed classes because of these gendered and class norms (Whitehead 2010). My worth was predicated on the ability to give care to another. This worth is coded depending on one’s racial, ethnic, and class background and all the other possible intersections of identity. The notion of worth comes up in the stories of communities seen as unworthy of regard and is seen in the historical trauma, slow violence, and the resultant health inequities we too often see in our communities.

In my mid-twenties, I began working on a childbirth unit. I spent my days off of my first nursing job taking the occasional class in medical anthropology or political studies. When I was not taking a class, I bicycled to the grand graduate library at the nearby university, to study medical anthropology journals. Maybe it was a lack of confidence, maybe it was the fact that I spent years working on healing from what we so academically call “Adverse Childhood Experiences” but I never imagined myself as a professor. Maybe it is what historical trauma does to one, taking all sense of cultural pride, slowly eroding our very souls. It was not until I was in my forties that I earned my BSN and that was only after experiencing so much moral distress in my workplace that I could not stay in nursing without feeling that I had no moral compass if I was to stay.

In my thirties, I began working on a high-risk labor and delivery unit in an academic medical center, I could have gone on like that for years if it had not been for that one patient. Her story influenced my own story. I often navigated the daily nursing assignment negotiations at the start of the shift by taking the Somali mothers as many nurses found them difficult. I enjoyed caring for the East African women who came to our labor and delivery unit—their use of their agency moved me. They were refugee and immigrant women, telling their providers that they did not want an IV or pitocin induction; they would rely on their faith in Allah. Their use of agency was astounding to me given the traumatic experiences they had endured in the civil war, refugee camps, and the diaspora. This was so different from what I had been socialized to believe about appropriate responses to trauma. I learned that their survival was predicated on their belief in their own capacity to act with power. I was slowly learning.

The sense of sisterhood in the Somali women’s maternity rooms, smell of chai, and bantering amongst the women folk felt oddly familiar; perhaps it reminded me of how women are all over the world, maybe it reminded me of island ways. Suffice it to say

here, that I had a brief, glinting, premonition in her room that morning that her birth story would mean something in my life, and I knew I should take a bird's eye view that day. Her labor was complicated. Her mistrust of a health care system, which for the last decade had failed her community, meant she could not accept our recommendations; she would trust Allah . . . and I realize now, as I write, that it was this utter failure of a system to care for an individual or community that was so familiar to me. When her baby was born, later that afternoon, it was clear that something had gone terribly wrong. It became clear that her newborn daughter had severe neurological anomalies. The hushed silence, the lack of words or emotion on behalf of the healthcare workers, as her newborn was whisked away to be taken to the Newborn Intensive Care Nursery contrasted with the usual celebration, much the same way the unspeakable has always normalized trauma.

Four years later in the courtroom, my testimony helped "save the hospital millions of dollars." I was devastated in the courtroom, the testimony was centered around the physiological processes of labor and the concomitant biomedical and technological interventions. The acknowledgement of decades of mistrust, lack of community engagement, and inequities in the Somali community were missing and normalized. The use of a biomedical paradigm saved that healthcare institution in the courtroom, but I knew that had a paradigm of social justice been used, the institution would have surely lost. To say, "we won" in such a tragic story was abhorrent to me, especially after hearing the lawyers for the health care institution say, "juries will throw money at a mother with a damaged newborn." There was no winning in this tragic story in my mind, and my testimony and role in this story only exacerbated my moral distress.

In the context of nursing, the Unspeakable is "the creation/maintenance of biopolitical spaces in which compassion—for oneself or one's patients—is rendered severely diminished to nearly impossible" (Georges 2011, p. 131). The unspeakable has become normative, in that it is no longer a part of our individual or collective consciousness despite its profound effect on what we speak, think, and practice (Georges 2011, p. 131). The "unspeakable" is the proverbial "elephant in the room." I find this theme echoing in my own life, experience with the mothers I worked with as a nurse and with the communities that comprise the CHBC. The malpractice allegations resulting from the birth of a newborn with severe neurological deficits, is never, in my mind, something that can be seen to be won. The fact that a mother did not trust a health care system and that reproductive inequities existed in her community, with little to no outreach from the health care system, cannot be viewed as something that is winnable. Yet the results of the malpractice suit were seen as a win. In the words of Jane Georges, it is the Unspeakable when compassion for one's patient is severely diminished.

I could no longer continue as a nurse in that capacity. I briefly thought of trying to find a new career but, mostly on a whim, applied at a Registered Nurse to Baccalaureate of Nursing Science (BSN) program, and was accepted. I earned my BSN, Master of Nursing, and PhD (Doctor of Philosophy in Nursing Science) in 9 years. I volunteered for a newly formed Somali Health Board. Going back to school was far easier than working in an environment that did not seem to value me, nor the women and families in my care. I used my studies to understand what had happened in that hospital room, and by proxy learning what had happened to me. The personal is political. I was slowly able to fill in the gaps by applying my newfound knowledge from classes in epidemiology, bioethics, Community-Based Participatory Research, globalization, epistemology, and evidence-based practice to the reproductive outcomes in the stories of the Somali women I cared for as a nurse. I began to understand how the historical trauma and structural violence became the unspeakable in the birthing rooms of the mothers in my care. I was becoming more authentic to my values. I was part of the conversation that birthed the inaugural Somali Health Board. I was asked to help form the Pacific Island Health Board by a previous professor who knew I was Micronesian. Those health boards were among the first to form the Community Health Board Coalition.

5.2. Historical Trauma and Slow Violence

The agency of the Somali mothers I cared for contrasted with my own sense of agency. My disenfranchisement, I am certain, was caused by both the adverse child experiences I had survived, the historical trauma of my paternal ancestors, and the slow violence they endured after the nuclear testing in the 1940s and 1950s; which left them with a grief too profound to speak of. From 1946 to 1958, the United States conducted 67 nuclear tests in the Republic of the Marshall Islands. If their combined explosive power was parceled evenly over that 12-year period, it would equal 1.6 Hiroshima-size explosions per day. Due to miscalculations in dosage, wind direction, and speed; the Ri Majol were exposed to massive amounts of radiation. Ri Majol living on nearby atolls were not relocated and suffered immediate and long-term injuries and illnesses from exposure to nuclear fallout (Mcelfish et al. 2015; Prävälje 2014). This genocidal act has gone on with impunity on the world stage. We, Ri Majol, are still experiencing health disparities related to the colonization of our islands and the nuclear exposure. The nuclear testing in the Republic of the Marshall Islands has been described as slow violence, by Nixon, who describes slow violence as occurring out of sight, delayed by being dispersed across time and space, incremental, and accretive. These displacements provide a way for amnesia, become irretrievable to those who once inhabited those places, and pass by unacknowledged by society (Nixon 2011). This slow violence becomes normalized and is the cause of the disparate rates of health inequities in my community. The structural factors that contribute to our poverty and poor health outcomes also contribute to our high incidence of COVID.

5.3. Biopower

We, Ri Majol, know we are deemed unworthy. The not-so-subtle message of the nuclear testing is that we are deemed, by those with power, to be unworthy of any humane consideration. Biopower is defined as power over life. Perhaps the most common definition of biopower is “an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations” (Foucault 1978, p. 140). This disciplinary practice is performed through the act of the gaze or surveillance, leading to the subject becoming compliant or docile. Compliancy negates agency. Georges, a nursing theorist who uses a critical feminist perspective, defines biopower as “power over life,” (Georges 2011, p. 131) and explains, “Other more recent scholars, most notably Agamben, have invested the term with a broader purview and used it to signify an ongoing theme in Eurocentric thought from classical times onward in which “sovereignty,” as a socially constructed phenomenon, included the power over life and death of those being ruled. All power, Agamben asserts, is by its very nature biopower, and the ultimate locus of power is the ability to determine who lives (bios) and who dies (zoe)” (Georges 2008, p. 6). Acts of biopower revealed, with no uncertainty, how the Ri Majol were regarded. We Ri Majol have navigated colonization, nuclear testing and exposure, forced immigration, and high prevalence of chronic illness such as cancer and diabetes. The fact that we endure is testimony to our strength. The CHBC is a place where historical trauma and biopower while being part of our story, is relegated to the background as we demonstrate our agency, accountability and resiliency.

5.4. Survivance

Coined by Gerald Vizenor (2009), survivance is survival and resistance together. It is an “active sense of presence, the continuance of native stories, not a mere reaction, or survivable name. Native survivance stories are renunciations of dominance, tragedy, and victimhood. Survivance is resisting colonial and racist narratives and policies so Indigenous knowledge and lifeways may come into the present with new life and new commitment to that survival (King et al. 2015).

We write here not to claim victimry, but as a messenger to those who would silence and normalize the oppressions and the intergenerational, cumulative inequities experienced today by our community members. We have cut our teeth listening to the stories of

our ancestors. These are the stories that guide us and enable us to resist these oppressions. Yet, we are still here, we have survived, and we resist these practices. We have survived the cumulative, historical, and allostatic load that comes by way of race and class oppressions most often implemented through the machinations of biopower. Our survivance is victorious over nihilism. Still we rise.

5.5. The Birth of the Community Health Board Coalition

The members of Community Health Board Coalition have experienced similar histories of trauma and slow violence. That deeming of someone unworthy of regard (which justifies the violence of biopower) is too often seen in our BIPOC and immigrant health boards. We see this trauma in the faces of people who are undocumented, caged, and being denied asylee status, in the Khmer whose untold stories of the Pol Pot regime echo in the silence of their children. We see it in the murders of Black people by a brutalized police force because Black people are deemed unworthy. Black people who cannot walk down a street, sleep in bed, drive on a street and more, without risk of being murdered, with absolutely no accountability, no convictions in a court of law are haunted by biopower. One could say it was seen in the labor and delivery room of a Somali mother or in the unjust treatment of an uncle who had HIV. These examples are in our communities and continue in the current stories of COVID-19 pandemics—they are stories that will be tomorrow's historical traumas. I have wondered if these experiences and the recognition of our survival and our resilience has helped us bond together into a cohesive whole.

The CHBC counters this trauma by decolonizing the way we work, by reveling in our success as we increase our capacity, voice, and determination to be in the spaces filled with power. Representation matters. I was nominated to be one of the inaugural cochairs, along with Damarys Espinoza, and have been honored to be trusted to do this work. While meeting Damarys the first time, I was struck with a feeling of tenderheartedness. I had witnessed so many women's birth stories and I wondered what her story was. I recall wanting to offer support, and at the same time wanting to honor her privacy and agency. I see now that she navigated her pregnancy with less support than I wish she had. Her subsequent pregnancy was complicated by the arrival of the COVID pandemic. Despite these profound challenges, she has mothered her children in a profoundly intentional way, worked in a demanding public health position, and led the CHBC. She brings a deep intellectual analysis of the CHBC, in real time, which strengthens our strategy. Her ability to mother, work and lead astounds us.

The operation of the CHBC is designed to diffuse power over the whole CHBC. We have engaged with each other through our decolonial and antiracist training and designed the cochair position and leadership council so that no one person has all the power. We instituted a leadership council of 5–6 volunteer engaged people who are readily available to make urgent decisions, advise, and do the work. Members of the leadership council develop their capacity as leaders, and they mentor others on the CHBC. Without fail, every single person in the leadership is capable of taking over as a cochair. Currently and not by design, every one of the CHBC leadership council is a woman. The wisdom, grace, and critical lens of each of the leaders is astounding, and we all bring different skill sets to the group.

The most incredible aspect is the sense of deep accountability each person brings to the CHBC. We have had very tough, transparent discussions on racism, privilege, and colonization. Despite our challenges, there is a deep and abiding love and respect for the people who make up the CHBC. Our stories, which all contain elements of the unspeakable, slow violence, and biopower have helped us recognize ourselves in each other. Our combined advocacy and love for each other counters the trauma we have endured and changes it into resilience and strength.

6. Damarys

My testimonio weaves together fragments corresponding to specific lived experiences that shape how I approach my work at the CHBC. By threading these fragments together, I reclaim my wholeness and the complete arc of my story (Vega 2018).

6.1. One

I first became aware of the failure of health systems as a child when I witnessed my uncle die of HIV/AIDS. Having been diagnosed with the disease in his twenties, my uncle never received the medical care he deserved, and his health rapidly deteriorated over the course of a few years. The cultural stigma and homophobia of the 1990s and anti-immigrant policies like Proposition 187, which prohibited undocumented immigrants from using nonemergency health care, public education, and other services in the state of California, denied my uncle the inherent right to live and die with dignity. My uncle was deemed unworthy of receiving health care services and the manifestation of biopower served to further genocidal acts on my community. In fact, it is the inextricable link between social institutions and structural violence, what Huanani Kay Trask calls “quiet violence,” that constrained my uncle’s agency and exacerbated his suffering (Smith and Ross 2004). The violence built into the structure manifested in unequal power and consequently, as unequal life chances for my uncle (Galtung 2016). Moreover, because structural violence is subtle, less overt, and less identifiable in terms of specific individuals committing the acts, it was difficult for my family to demand accountability for the everyday violence and dehumanization that marred my uncle’s life and death (Waterston and Rylko-Bauer 2006). Healing, much like accountability, was unattainable for my family. In the years that have passed, the trauma of witnessing my uncle’s death has itself unfolded into unresolved grief causing “small wars and invisible genocides” within my bloodline (Scheper-Hughes 1996).

My uncle’s death changed me. It ushered in a new politic and consciousness, a “theory of the flesh” born of the physical reality of my life and the immeasurable grief of losing my uncle (Moraga and Anzaldúa 2015). Years later as a graduate student in medical anthropology, I found myself researching the same interlocking systems of violence that informed my uncle’s death, this time within the context of gender-based violence.

6.2. Two

As a survivor, the choice to focus my doctoral research on gender-based violence, was itself a radical act of healing. My research examined the myriad ways structural violence soaks into the most intimate spaces of our everyday lives, particularly our relationships with intimate partners. At this point, I was in my early twenties and had just left an abusive partner. I was also reclaiming my own Indigenous feminist roots as a Xicana and Náayeri descendant.

The teachings I gathered while working with Indigenous women—survivors and advocates—gave me a sturdy foundation for health justice and paved the path for my work with CHBC. I learned that when we are at the forefront of advocacy in our own communities, we can move mountains. Additionally, I learned there is healing and liberation in knowing that as a survivor, I am not to blame for the harm that was done onto me both by my perpetrator and by the systems that failed to protect me and generations of Indigenous women in my bloodline and community.

“Cada quién lleva su moralito. A algunos les pesa más que a otros.”

This is how women in my family speak heartache

How abuela y mama invoke stories of dispossession and violence

The weight of patriarchy and colonialism anchoring stories deep within the children they birthed

To emerge, again and again, in the softness of intimacy

In the daybreak of relationships

*In the loneliness of self-reflection,
In the tired shoulders of a lover betrayed by a history too heavy to carry alone*

6.3. Three

It is a late summer evening in 2017, and I am sitting in a dark and crowded room in south Seattle. The room has no windows and no air conditioning. The lights have been turned off to keep the place cool, yet the heat is unbearable. I am 7 months pregnant and feel droplets of sweat gather at the small of my back. For the past few weeks, a group of us have been meeting to build a coalition of health boards led by BIPOC communities in our region. As the meeting ends, a friend introduces me to Robin Narruhn from the Pacific Islander Health Board. She sees my pregnant belly and tells me she worked as a labor and delivery nurse for decades and is now a professor at a local university. I feel a connection to Robin, an inextricable pull to a common ground, a shared history. We exchange contact information and plan to connect in the upcoming weeks. My pregnancy, already classified as high-risk, becomes more challenging in the last trimester and I take a break from meeting with the coalition. In early 2018, when my son Hai'uunari is 2 months, I return to the newly named Community Health Board Coalition. For the remainder of the year, we focus on strengthening relationships among the members, and we grow from 9 founding health boards to 11. We hold off on formalizing a governance structure and instead learn how to work across differences while building upon our shared vision. At the beginning of 2019, Robin and I were nominated, and eventually elected as inaugural cochairs of the CHBC.

6.4. Four

My daughter Maxkirai was born 24 days after Breonna Taylor was murdered while in the sanctity of her own home and 11 days after George Floyd begged for his mother as he was killed by police officers kneeling on his neck and back.

When I am nursing my daughter late into the night, I often think about their mothers.

Not long after George Floyd's murder, I came across a picture of him as a child in his mother's arms. The love that radiates between them is indescribable.

I carry my daughter in a rebozo as she sleeps. Her warm head rests on my heart. I work on CHBC through the night and whisper in her ear, "this is for you." The love that radiates between us is indescribable.

Maxkirai, I loved and prayed you into existence. You, our family's future matriarch, are hope made flesh. Just as my love and prayer birthed you, it is love and prayer that sustain my work with the CHBC, which ultimately is to create a world where you and others like you will live a full and healthy life. This, daughter, is y(our) birthright.

7. Conclusions

In early 2020, public health departments in Washington State described COVID-19 as an "equal opportunity disease," yet our communities were already experiencing the disparate impact of the pandemic. Nearly 8 months later, the disparate impact of the COVID-19 pandemic continues to weigh on our shoulders. Prior to the pandemic, CHBC was actively organizing and advocating for health systems and policy change that addressed the root cause of health inequities among BIPOC communities in Washington state. Within the COVID-19 context, CHBC is building the collective power that is necessary to uproot inequities at the core of health disparities.

The CHBC has made recommendations to disaggregate data, to implement antiracist policy in healthcare settings, increase representation of disenfranchised community members in decision-making spaces, to implement interventions that increase access to opportunities for BIPOC, and to decolonize health promotion practices. The CHBC has worked with state and local health departments, health care institutions, community organizations, and legislators to work towards the enactment of these recommendations.

Recommendations to decolonize health care are described in a framework by [Chandanabhumma and Narasimhan \(2019\)](#). This framework requires practitioners to attend to the historical context and its multigenerational effect on the current health status of community members. Attending to colonial trauma enables practitioners to understand the reality of our lives. The second premise in the framework calls for the legitimization of our ancestral wisdom. Indigenous epistemologies and ancestral wisdom should be legitimized and regarded as intellectual property without the risk of co-optation. The last premise is that of praxis—the application of our ancestral knowledge and the critical reflection on the colonization of our lifeways in order to undo the effects of colonization. ([Chandanabhumma and Narasimhan 2019](#), p. 837).

These decolonizing practices can be made at the multiple levels. Decolonizing health care practices can happen at the individual level when practitioners “examine the ways in which the historical, cultural and epistemological manifestations of the colonial legacy influence contemporary practice and perspectives of health promotion and reflect on the benefits of colonization to individuals and communities involved (e.g., material gains) and the proclivities to perpetuate colonization within the field” ([Chandanabhumma and Narasimhan 2019](#), p. 834). At the practitioner level, this entails understanding how one’s worldview can impede understanding the intersectional manifestations of power that influence their thinking and practice. These authors recommend the use of the Indigenous lens of the Maori of Cultural Safety. Culturally safe health care is defined as, “when patients have no feelings of inferiority or alienation and are not being deprived of health care and also respects cultural tradition or, beyond that, includes the recognition of the social and political conditions of particular groups in society” ([Bozorgzad et al. 2016](#), p. 34). Cultural safety requires health care workers to engage in critical self-reflection to identify their own bias and its impact on the delivery of health care. Furthermore, cultural safety requires accountability, power sharing, and the use of agency in the aim of achieving health equity. Critical consciousness is required to recognize the identification of culturally safe care as defined by the individual or community ([Curtis et al. 2019](#)).

Guarding against the co-optation of Indigenous knowledge is a necessary component in this decolonized framework. At the system level in health care, decolonizing health care entails a persistent effort to reveal the manifestations of colonization in methodological and professional aspects of the practice ([Chandanabhumma and Narasimhan 2019](#)). De-centering the lens from the dominant to marginalized people will assist in the decolonization of health care ([Chandanabhumma and Narasimhan 2019](#)). The implementation of decolonizing and culturally safe practices will lead to greater health equity.

Lastly, we suggest the praxis of structural competency defined as “competency as the capacity for health professionals to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures” ([Neff et al. 2020](#), p. 2) and use of structural competency as a pedagogical tool, which promotes the understanding of healthcare students and workers regarding the effects of structural factors such as colonization, racism, and poverty in the health outcomes of disenfranchised people ([Metzl et al. 2018](#); [Woolsey and Narruhn 2018](#); [Woolsey and Narruhn 2020](#)).

Being founding cochairs of the CHBC has been an incredible honor. We are filled with hope as we work with extraordinary people, who without fail, are working towards health and social justice in their communities in a myriad of ways. Not only have our members survived the genocide of our ancestors but we have also resisted the practices of the continued colonization of our lives. Coming together as a Coalition, we have intentionally developed a decolonized, antiracist, and critical lens. We have had tough conversations, shared tears, prayers, laughter, and love. The work we do at the CHBC gives us hope and changes this grief into hope and wisdom. It is our manifestation of our agency and resilience. Our healing comes from our fierce agency that arises from our mother’s heart, the Indigenous ways we respect, our community, from the laughter, the prayers, truth, the hope we have for our children, and love we share.

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