

## **DNH Mission:**

We are healers, health workers, and activists accompanying communities affected by state sanctioned violence in our collective struggle for health, dignity, and sovereignty. Health is a human right and as health workers we have a collective duty to eradicate systems of oppression which threaten that right.

## **DNH Values:**

1. We believe social movements should be led by the communities they seek to support, honoring the wisdom of lived experience and following the lead of those most impacted by systems of oppression.
2. We demand universal access to decolonized, community-led, patient-centered, multimodal healing.
3. We know structural violence is a public health issue. Policing, incarceration, and the military-industrial complex are the acute, traumatic mechanisms of structural violence. We believe in a future society that exists without these mechanisms. Economic and political policies which marginalize and disenfranchise communities are the chronic, systemic mechanisms of structural violence. We support alternative conflict resolution strategies, that involve community-led solutions.
4. We as a coalition are committed to nonviolent direct action (NVDA) as a creative, beautiful, and powerful healing act of exposing and interrupting violence. We appreciate and support a diversity of tactics and refuse to condemn other forms of resistance, as they can be valid responses to state violence.
5. We cannot heal others unless we work towards healing ourselves in the process. We recognize our fallibility and we seek continued dialogue, learning, and growing. Our methods are tied to our outcomes and through our work we want to create the world we wish to see.

## **DNH Process:**

1. Decisions are made based on consensus
  - 1.1. Consensus is a process--it should not be conflated with unanimity which is an outcome.
    - 1.1.1. "Good faith": a sincere intention to be fair, open, and honest, regardless of the outcome of the interaction.
  - 1.2. Autonomous actions
    - 1.2.1. Members will function to serve as checks and balances for each other.
      - 1.2.1.1. Members and working groups engaging in actions such as NVDA, research, and advocacy are accountable to the rest of the

organization to maintain the values of DNH, and proposed actions can be blocked by other members by demonstrating they violate DNH values.

1.2.1.2. DNH acknowledges the urgency and autonomy through which much social justice work is accomplished.

1.2.1.2.1. We attempt in good faith to balance the needs of rapid mobilization/action with the requirement to gain consensus for DNH processes/actions. See Proposals (2) ]

### 1.3. Organizational decisions

1.3.1. Changes to mission or values must be approved through the following steps:

1.3.1.1. Propose, discuss, and arrive at consensus through the best form of contact, generally a meeting.

1.3.1.2. If approved, the changes are submitted to community groups DNH is affiliated with for feedback and community perspectives.

1.3.1.2.1. If approved by community groups, the proposal can be adopted.

1.3.1.2.2. If rejected, members will incorporate recommended changes and resubmit the proposal at a meeting or agreed upon medium and repeat the community feedback process.

1.3.2. Changes to process must be approved through the following steps:

1.3.2.1. Propose, discuss, and arrive at consensus through the best form of contact, generally a meeting.

1.3.2.2. If consensus is met, changes are submitted to DNH as a whole for opportunity of dissent.

1.3.2.2.1. DNH members will have 21 days to voice dissent

1.3.2.3. At end of 21 day period, members will meet and attempt to re-arrive at consensus regarding changes to proposal

1.3.2.3.1. If approved by meeting members, the process changes can be adopted

## 2. Proposals

2.1. Proposals can be submitted by DNH members that have attended at least 2 general meetings. The DNH "Planning Group," comprised by members who have time and inclination to participate, will facilitate sharing of proposals.

2.2. Action Proposals (and bulletins regarding actions) should contain as much useful relevant information for participants as possible.

### 2.2.1. Basics

2.2.1.1. Organizers, affiliations, bottom line DNH contacts

2.2.1.2. Time and Location

### 2.2.2. Goals

2.2.2.1. Immediate, specific short term goals

- 2.2.2.2. Long term social/community impact
      - 2.2.2.3. How this is aligned (or potentially misaligned) with DNH values and capabilities
    - 2.2.3. Background information
      - 2.2.3.1. Need for the action, history of events leading up to action, political context
    - 2.2.4. Description of action, the plan
      - 2.2.4.1. Roles, accommodations
      - 2.2.4.2. Reasoning behind the tactics
      - 2.2.4.3. Legal, arrestability (i.e. high, medium, low)
      - 2.2.4.4. Contingency plan(s) (weather, weak attendance, logistical errors)
      - 2.2.4.5. Security
    - 2.2.5. Schedule of events and tasks in preparation for the action
    - 2.2.6. Budget, preferably with alternatives, pros and cons, funding sources
  - 2.3. Policy Proposals
    - 2.3.1. Consensus based and discussed with planning group members of the DNH group during a meeting or email.
  - 2.4. Proposal Dissent
    - 2.4.1. If dissent is voiced from an action, proposal, or event all opinions are valued equally. Time permitting, dissent should be raised within a week. If the event occurs within a week, dissent should be raised immediately.
      - 2.4.1.1. The proposal will be held up against the specific mission and values of the organization to determine whether support will be given or not.
      - 2.4.1.2. New proposals are to be presented to the larger group at general meetings or email, and dissent can be followed up via email or at meetings.
3. Meetings
  - 3.1. Facilitation role of all meetings should regularly rotate through members of DNH to promote skill sharing and egalitarian organizational structure.
    - 3.1.1. Facilitators are responsible for co-creating the meeting agenda beforehand and sharing it with the DNH planning group for consensus and additional events or talking points from other members.
4. Skill Sharing
  - 4.1. New members can propose new trainings and skill sharing for the group either directly at a meeting or through email conversation.
  - 4.2. Skill sharing is emphasized within the organization to promote creativity, versatile insights and knowledge expansion.
5. Funding
  - 5.1. Currently, small amounts of funds are utilized from the University of California San Francisco's Registered Campus Organizations.

- 5.2. DNH aims to be an autonomous organization, which allows the organization to be disconnected from institutional constraints that may alter or differ from our mission and values.
  - 5.2.1. We recognize the constraints that often come with funding, and any opportunity for grant submissions that may come with constraints should be discussed within the group.
  - 5.2.2. We hope that the DNH coalition can be self-sustaining, and that any funding donated will align with our mission.

## **Contextual Glossary of Terms:**

1. Health and Healing
  - 1.1. We define health in alignment with the WHO's definition, as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."
  - 1.2. Structural factors have a profound impact on health and not treating these upstream causes of illness is ineffective healthcare.
  - 1.3. Health as a human right pursues the notion that everyone deserves the right to a fulfilling life. We recognize health as the highest achievable level of physical or mental states for an individual or population. This incorporates access to healthcare services, food and diet, sanitation, housing, non-toxic environments, transportation, education, and working conditions.
2. Non Violent Direct Action (NVDA)
  - 2.1. NVDA can include tactics such as, but not limited to, sit-ins, strikes, workplace occupations, blockades, art, music, theater, and other practices that disrupt and dismantle oppressive systems of power.
3. Decolonized (Healthcare)
  - 3.1. Recognizing other modalities of healing, and incorporating traditional and spiritual healing into one's care system as an independent from traditional western philosophies of care.
    - 3.1.1. Biomedicine, or allopathic medicine, is not seen as the dominant and superior modality of healing put forth by western (colonizing) civilizations.
    - 3.1.2. Western medical practice is hierarchical and is presumed to be superior, and decolonized medicine practices a more inclusive medical culture.
4. Universal Access
  - 4.1. For all people, the following are accomplished as determined by the patient: Availability, Acceptability, and Affordability.
5. Structural Violence
  - 5.1. Critical understanding that societal constructs inflict violence on communities and individuals that inherently create division between communities. It is the systematic way in which social structures harm or otherwise disadvantage individuals. Structural violence is subtle, often invisible, and often has no one

specific person who can (or will) be held responsible (in contrast to behavioral violence).<sup>1</sup>

- 5.1.1. Structures can signify policies, institutions, infrastructure, health care systems, economies, educational systems, judicial systems and laws, prisons, militaries and societal organizations.
6. State
  - 6.1. A codification of power used for administering populations of people at all levels of a society. An overarching enforcer of a governing power for a society. The state can be a perceived reality not necessarily a permanent, everlasting thing.
    - 6.1.1. Power is a disciplinary action largely enforced through institutions
      - 6.1.1.1. State power may not always have the authority over those within the State. It is seen as negative and coercive, leading to the resistance of power enforcement.
      - 6.1.1.2. State power may be followed and acknowledged by those within the State, leading to a discipline of power, defining norms and behaviors.
7. Community Defense
  - 7.1. People having and being able to use the resources to defend themselves against outside forces of power.
8. Military industrial complex
  - 8.1. Prioritization of defensive military needs, therefore creating a disproportionate amount of funding and human resources to be spent on building an industry of military capabilities.
    - 8.1.1. Resources are then spent on military rather than elsewhere, creating a detriment to human flourishing.
  - 8.2. The creation of a permanent war economy and a culture of militarization as the first and dominant solution to all problems, and societal reliance on this culture. This economy generates a flow of capital through colonization, invasion, torture, and murder. This economy is supported through the exploited labor of incarcerated people, and modern slavery.
9. Systems of oppression
  - 9.1. The systematic exploitation, mistreatment, or even isolation of individuals or groups of people from societal structures of care. Those who are exposed to such oppression hold less power within society.
10. Structural factors
  - 10.1. Are, but not limited to, discrimination based on race, sex, gender identity, socioeconomic class, religion, refugee and migrant status, housing security, access to information and education, environmental quality, and disability.

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<sup>1</sup> Borrowed from <http://www.structuralviolence.org/structural-violence/>