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Legitimacy and Citizenships

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Pardo and Prato's edited volume on *Legitimacy: Ethnographic and Theoretical Insights* (2019) raises important questions about the relationships between authority, power and trust, especially (though not exclusively) in the realm of governance. As a medical anthropologist with long-term interests in the use of hand-made, botanically-based remedies (including cannabis), issues related to the legitimacy of these medicines have been implicit (if not explicitly addressed) in my research. However, after reading several of the chapters in Pardo and Prato (2019), I realized that the relationship between legitimacy and citizenship is actually of greatest significance for (and has the most resonance with) my work. As they explain in the introduction to the book, governance and law fail when they do not meet the challenge of establishing a working relationship between formal law and people's cultural requirements. Thus, ethnographic studies of legitimacy at different levels of power raise fundamental questions about citizenship. This brief essay focuses on issues of legitimacy in relation to three anthropological conceptualizations of citizenship: biological citizenship (Rose and Novas 2003), cultural citizenship (Ong 1995; Goldade 2011) and spiritual citizenship (Guzman Garcia 2016). It takes inspiration from various chapters in Pardo and Prato (2019) and other related literature on citizenship, and draws on some of my own ethnographic work with Jamaican migrants in the United Kingdom.¹ I show that while legitimate claims to biological citizenship are defined by both government and medical institutions, they must compete with the grassroots legitimacy that underpins cultural and spiritual citizenship.

Citizenship — that is, membership in the governing body of a nation state — has been cast as a 'natural' birthright (De Genova and Peutz 2010), and as nations are defined by their geo-political borders there is a long, historical relationship between citizenship and territoriality. However, states are the only competitors for people's allegiance that depend on territorial integrity (Appadurai 2003). In the contemporary world, citizenship is being redefined as new political spaces are created (Ong 2005) in which people can give their allegiance to, among other things, specific therapeutic systems (Whyte 2009). In parliamentary democracies citizens' control over whether or not their representatives are legitimate is legally regulated through elections (Prato 2019). However, as Atalay (2019) explains, institutions like the EU and IMF operate beyond the borders of nation states. Despite democratic systems in these nation states, their citizens can be affected by bureaucrats in these

¹ My research with Jamaican migrants in London was funded by a small grant from the British Academy, as well as support from the Public Engagement with Research Fund at the University of Kent. Many thanks also to Dennis Francis and Cheryl Sealey for their assistance.

international organizations, who were not democratically elected. Likewise, the sovereignty of nation states may be overruled by international public health authorities (Pfeiffer and Nichter 2008) that subject citizens to policies (for example, quarantines) and procedures (for example, mandatory vaccination) which are not under the control of the democratic process but have profound biological implications.

Historically, the biological dimensions of citizenship have been linked to concepts of race and racial purity. Since the first half of the 20th century notions of purification have been combined with concepts of risk and the body politic so that foreign bodies (people) became pathologized as disease-carrying threats to the nation state (Harper and Raman 2008). Contemporary biological citizenship is no longer driven by a search for racial purity, but rather by the potential to generate biovalue; for example, characteristics of genes of citizens that may provide a valuable resource for biotechnological innovation (Rose and Novas 2003). Biological citizenship is also very much concerned with how biological knowledge shapes understandings of vital rights, identifications and affiliations (Beck 2011). Much of the ethnographic work on biological citizenship has been focused on the rights of citizens to make claims for medical services and to participate in health policy decisions (Whyte 2009). In one of the first ethnographic studies of biological citizenship, Petryna (2002) shows how survivors of the Chernobyl nuclear disaster actively created a massive demand for a form of social welfare based on medical criteria that acknowledges and compensates for biological injury. People also exercise their rights to medical information and to develop their own expertise in matters of health and disease. In a case study of New Zealand families of children with rare genetic disorders, active biological citizens understand that doctors make mistakes and can be out of date, so they take part in the selection of care/interventions (Fitzgerald 2008). However, biological citizenship can also embody a demand for the cessation of particular policies or actions (Rose and Novas 2003). One thinks, for example, of Prato's (2019) description of responses to a power station in Brindisi, Italy, which included protest groups involving health sector professionals.

Rights are double-edged, with disciplinary and regulatory aspects (Flear 2008), and policy imposes an ideal type for what a normal citizen should be (Spyridakis 2019). While some studies of financial citizenship focus on inclusion and exclusion of individuals (assuming inclusion is a basic right), others consider inclusion to be financial appropriation (Atalay 2019) rather than a right. Likewise, some of the literature in medical anthropology challenges the assumption that neo-liberal enactments of biological citizenship are the only legitimate options. For example, Ecks (2005) asks not just how legal citizenship determines rights of access to pharmaceuticals, but also what implications taking pharmaceuticals has for a person's status as a citizen—for example, whether taking certain pharmaceuticals impairs one's rights as a fully responsible citizen; whether patients can regain full citizenship rights if they do not undergo pharmaceutical treatment. The healthy and responsible biological citizen in a neoliberal society such as the UK has routine medical check-ups of various sorts, eats according to government guidelines (for example, consume their 'five a day'), exercises in

specific ways, takes prescribed medicine as directed, maintains basic knowledge about self-treatment with a variety of regulated medicines, supports corporate research and enterprise systems, and makes reasonable demands on the health system. As Rose and Novas (2005: 451) describe, engaging in such responsible behaviours ‘has become routine and expected, built into public health measures, producing new types of problematic persons—those who refuse to identify themselves with this responsible community of biological citizens.’

In some ethnographic contexts, there is not the same access to a legitimate position in society for all. Rather, legitimacy is finite; when one group gains, another loses (Andrews 2019). This is certainly the case with the rise of biomedicine in the US and UK where the professionalization of medical science was facilitated by active campaigns to delegitimize other types of healers (Baer 1989). What happens when people choose healing modalities that have been marginalized or even outlawed? Although this aspect of biological citizenship is largely untested ethnographically (Whyte 2009), a study of how deviant, drug-using bodies are transferred into healthy biological citizens in a Chinese drug treatment clinic shows that one of the basic tenets of the treatment is creating post-addiction individuals who agree to live within the boundaries of the moral obligations attached to citizenship (Hyde 2011). However, while actions taken at the grassroots level may not always be strictly legal, they are still legitimate in the eyes of the actors and others who share their moral understandings (Pardo 2019). For example, in the US medical marijuana patients are attempting to build an alternative way of managing health and healing, as Federal laws remain in place that would strip them of many of the basic rights of American citizens. While technically still illegal (at the Federal level) in the US, globally the legitimacy of cannabis as a medicine is increasing year on year, especially in countries such as Canada and Uruguay.

The power of legal, political and medical authorities to divest citizenship rights from people who use illegal drugs is matched by the power to deny such rights to individuals who reside in a country without legal entitlement to do so. The boundary between the state and medical practitioners in determining rights of citizenship is becoming increasingly blurred (Harper and Raman 2008). The hospital is a mode of therapeutic and bureaucratic governance that can distinguish between citizens with rights and lives/bodies that have limited value (Miklavcic 2011). Citizenship status is dependent on certain medical documentation, as prospective citizens are expected to provide proof of vaccines, tuberculosis tests, pelvic exams, and so on (Ong 1995). Having a diagnosis of a serious medical condition is an official Immigration and Naturalization Services category for denying tourist visas and legal residency status in the US (Quesada et al. 2011). However, ‘while the standards for citizenship in a regime of predictive medicine thus become stricter, there is a possibility that fewer people will receive access to the infrastructure they need for acquiring the norms of this mode of citizenship’ (Van Hoyweghen et al. 2006: 1234). This helps control populations by restricting/regulating movement and maintains a class of non-rights bearing workers. Just as biomedical surveillance and management are required for citizenship through naturalization,

non-citizenship status is often a barrier to mainstream biomedical care, which perpetuates the problem.

In my work with Jamaican migrants in London, I have seen how struggles around immigration status are related to barriers to the National Health Service (NHS), as well as to the alternative constructions of how to be a healthy, productive member of society that many migrants hold (I have also seen how policies aimed at removing ‘illegal’ migrants cause harm to the health and wellbeing of British citizens). The UK government has been actively implementing policies to create a hostile environment for ‘illegal’ immigrants since 2012. The hostile environment makes it difficult for all migrants to open bank accounts, rent property, and access medical care. It also places strict penalties on landlords, teachers and doctors, who fail to report suspected ‘illegal’ migrants to the authorities. In March 2019 a High Court judge ruled that the policies aimed at preventing ‘illegal’ immigrants from renting property are discriminatory and in breach of human rights laws. This means that at least some of the hostile environment policies being implemented by the legitimately elected British government are illegal. Moreover, in the UK deportation is distinguished from administrative removal (that is, of persons with no legal entitlement to remain) by being deemed ‘in the interest of public good’. Thus, it has been a process of removal generally reserved for migrants with criminal convictions, even if they have been granted permanent settlement in the UK (Hasselberg 2015). However, the recent ‘Windrush deportation scandal’ has revealed that the impacts of the hostile environment are not limited to individuals with criminal records and those who have overstayed visas. By the time reports of the scandal became widespread in the national (and international) press in April 2018, over 100 African-Caribbean people had been wrongly deported. Hundreds more were detained unlawfully and threatened with deportation, and thousands lost their homes, jobs and/or public benefits.

Before 1971, members of Commonwealth countries were considered imperial subjects and were immune to deportation from Britain. Deportation powers that were introduced in 1971 made Commonwealth peoples non-citizens rather than fellow subjects (Anderson et al. 2011). African-Caribbean men and women of the Windrush generation came to the UK in the 1940s-70s. They, along with their children, who either travelled with them or were born in the UK, comprise a community of established migrants who are in many ways distinct from a ‘newcomer’ generation who migrated in the 1990s-2000s (Reynolds 2012). Despite amnesties in the 1970s-80s, large numbers of Windrush generation migrants never formally registered as permanent residents or British citizens when they had the chance. Others have lost documents such as passports and residency permits over the years. It was only when UK immigration policy turned hostile six years ago that these individuals were caught out. The British government has publicly apologised to the Windrush generation and has pledged to help affected members secure the documentation they need to prove their right to permanent settlement and/or citizenship in the UK. However, it continues to defend hostile environment policies and the deportation of foreign national offenders from the Caribbean (many of which

are from the 1990s wave of migration), including permanently settled migrants with spent convictions for non-violent offenses.

Most of my work on deportability in London has been with Rastafari men from Jamaica who came to the UK as young adults in the late 1990s. Rastafari is an Afrocentric spiritual, political and social movement that began in 1930s Jamaica and has since spread around the globe. Important components of the Rastafari spiritual lifestyle include food and health sovereignty; that is, eating organically produced and minimally processed vegan foods and using alternative medicines such as herbal remedies and spiritual healing. During summer 2017, with the help of a Jamaican research assistant, I collected interview data from 10 Jamaican Rastafari men who ranged in age from 35-57 and had been living in the UK for 15-25 years. These men had police records ranging from minor civil offenses to drug convictions, and all were fathers of children born in the UK. Another thing that these men had in common was minimal engagement with the NHS, although the reasons for this varied. Several men insisted that Rastafari ‘bush medicine’ was more effective than mainstream medicine and suggested that if people ‘live good’ (that is, keep fit and eat natural, healthy food) they can avoid the need for doctors. One man in his early 40s proudly claimed to me that he has never needed to see a GP (general practitioner) in all his life. However, others avoided mainstream medical care because they had previously experienced cultural incompatibility and racism.

Regardless of the main motivation for avoiding professional medicine, doing so can eventually have repercussions that make it more difficult for Jamaican men to regularize their immigration status in the UK. For example, during his ultimately successful deportation appeal, ‘Len’ was advised by his solicitor to get a letter from his GP to verify his address and length of stay in the UK. However, Len had not been to his GP in several years after an unsatisfying appointment, during which he had been chastised for using Jamaican bush medicines. When he finally went back for a check-up, and to ask for a letter in support of his appeal the GP refused to issue one. Because he had not seen Len in years, he could not verify that he had been living continuously in the UK. However, in the hostile environment (where doctors are expected to act as border agents), regular engagement with the NHS does not necessarily make regularizing one’s immigration status any easier. For example, at one of many community meetings held in London to address the Windrush scandal, which I attended in summer 2018, an elderly woman recounted the story of the difficulty she was facing in sorting out her status. Like many of her fellow Windrush generation migrants, she did not have any form of valid identification, which is required as part of the process of applying for settled status. In order to obtain an identity card, she needed her medical records from the NHS. However, her GP surgery had informed her that she could not access her records without a valid form of identification.

Referring to the experiences of precarious migrants in Russia, Reeves (2013) shows that there is an inherent uncertainty about where the boundary between ‘legal’ and ‘illegal’ presence actually lies; that is, (il)legality is a space of relations rather than an unambiguous line. The UK’s hostile environment has made the division between citizens and non-citizens

equally uncertain and ambiguous. As one of the community activists with whom I worked last summer explained, she and many other Windrush generation migrants did not register as British citizens three or four decades ago because as citizens of the Commonwealth (and former colonial subjects) they understood themselves to be already British. Up until the hostile environment policies were implemented, their experiences of living, working and raising families in the UK never made them think any different. Cultural citizenship is the study of how migrants conceptualize community and where they do or do not feel a sense of belonging. It allows us to understand that citizenship is a collective experience that does not depend on top-down distinctions between legal and illegal residents in a given territory (Goldade 2011). In other words, claims to cultural citizenship get their legitimacy from the grassroots. Windrush generation migrants have enacted a form of cultural citizenship, but sadly the acts of citizenship they have engaged in (such as paying taxes, receiving state benefits and patronizing the NHS) were not enough to protect them from the hostile environment.

As for my Rastafari interlocutors, they seem to be engaging in a form of spiritual citizenship, which refers to the role of religious participation in mitigating deportability (Guzman Garcia 2016). Where cultural citizenship draws legitimacy from the grassroots, spiritual citizenship is underpinned by Divine authority. For example, among Zimbabwean migrants and asylum seekers in British detention centres, Biblical narratives play a role in affirming detainees' humanity and asserting their right to be in Britain (McGregor 2012). Likewise, while some participants in a study of undocumented migrants in the United States felt that they were 'invading' a foreign country that they did not belong to, they justified their presence with the idea that God created the earth and thus all places are available to Christians (Guzman Garcia 2016). In Rastafari, the same ethos of self-sufficiency and (health) sovereignty that leads migrants toward bush medicine and away from mainstream medical care, can also make them see themselves as global citizens. Rastafari migrants from Jamaica challenge deportation and other hostile environment policies on the grounds that borders are man-made creations that conflict with Divine law. For example, 'Ababa' explained that 'Rastafari say we gather the people together. No boundaries or man-made borders shall hold the people apart from themselves. All borders was created by man, see? So, I say the world is just one community for I and I.' Thus, apart from any claims they may make as Jamaicans to cultural citizenship in the centre of the Commonwealth, Rastafari migrants who follow a spiritual lifestyle also see themselves as deserving of citizenship in any nation in which they choose to live, as this is what the creator intended.

In conclusion, the most important lessons I learned from reading Pardo and Prato (2019) are 1. that legitimate governments may not always act within the law, 2. that grassroots actions can be legitimate without necessarily being legal and 3. that the legitimacy of governments come from their citizens. In applying these lessons to my own work with Jamaican migrants in the UK, I have considered how migrants enact different concepts of citizenship in a hostile environment created by unlawful government policies. Hostile

environment policies have placed expectations on medical professionals to act as border guards and deny medical care to certain migrants. Biomedical surveillance is required for citizenship through naturalization, but non-citizenship status is a barrier to biomedical care. However, while claims to (biological) citizenship are challenging or even elusive, Jamaican migrants in London are able to live as good cultural and spiritual citizens. With the help of lawyers, journalists and activists, Windrush generation migrants have forced the Home Office to recognize their legitimacy as British residents and citizens. Likewise, in asserting their Divine rights as spiritual citizens and resisting deportation, Rastafari migrants have succeeded in settling lawfully in the UK and starting on the path to British citizenship. Thus, work in the anthropology of legitimacy gives us hope that citizens of all sorts will ultimately retract the legitimacy of unlawful governments.

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