Embodied Belonging: In/exclusion, Health Care, and Well-Being in a World in Motion – Workshop Report

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'Belonging' is a fundamental aspect of human life. People's increasing mobility and global dis-, and replacement in the context of recurring environmental, political and humanitarian crises profoundly shape the experience, interpretation, and negotiation of belonging. At the 2017 conference of the German Anthropological Association (GAA), anthropologists explored the physical, affective, and moral challenges of varying actors in face of mobility, crisis, and economic hardship, but also the emergence of new forms of belonging incited by these challenges.

The conference workshop entitled 'Embodied Belonging: In/exclusion, Health Care, and Well-Being in a World in Motion' – organized and chaired by Claudia Lang (Cermes3, Paris) and Dominik Mattes (Freie Universität Berlin) – set the scene for understanding why and how belonging becomes relevant in the context of health and well-being. Special emphasis was placed on health-related transformations in people's lives in the context of migration, displacement and replacement.

All people who have migrated – whether or not they have been forced to – have particular health needs, yet a considerable number of them are – partly or fully – excluded from health care provision. As Willen and colleagues (2011) argue, to many observers, unauthorized im/migrants' exclusion intuitively 'makes sense'. In public debates regarding healthcare policies and regulations – which contribute to an increasingly controlled environment for irregular migrants – exclusionary health policies come to be accepted as common sense, constructing a division between 'deserving' and 'underserving'/'undesirable' (political) subjects (see also Kehr 2012). However, like many scholars of health and social justice, as well as political activists and humanitarians, medical anthropologists find this logic deeply flawed and have long made efforts to advance an engaged critique, thereby drawing attention to perspectives that otherwise may have escaped notice (see Castañeda et al. 2016; Holmes 2013; Holmes & Castañeda 2014; Huschke 2013; Willen 2011).

In line with such constructive critique, the convenors of the workshop invited participants to critically engage with and further develop the notion of 'embodied belonging' – a term they proposed to connect social, moral, and political-legal aspects of belonging with its bodily and affective dimensions – in order to fertilize medical anthropological analysis. The concept, they argued, holds great potential for the analysis of contemporary processes of social transformation, insofar as it brings into view three closely interlocked dimensions of human existence: An individual, intimate sense of belonging, which demands attending to a persons' social, emotional, and moral embeddedness in particular environments and social collectives. Secondly, belonging understood as a political and discursive resource, which constructs, claims, justifies, or resists forms of socio-spatial inclusion/exclusion. And thirdly, belonging as both

process and outcome of affective, deeply sensorial interrelations with place that translate into specific spatial attachments.

On the basis of these considerations, participants were invited to discuss a set of interrelated questions, such as: How does belonging matter in the suffering, (health) care and well-being of migrants and refugees, but also of homeless and otherwise socially disadvantaged people? Which are the effects of particular politics of belonging and corresponding administrative regimes on institutional setups of health care provision? What are the consequences with regard to people's capacities to maintain and re-create a sense of belonging and to sustain their well-being? How are the body and the senses entangled in perceptions and re-creations of embodied belonging?

Drawing on in-depth anthropological studies conducted with people in various parts of the world (i.e. Israel, Norway, UK, Japan, Germany, and South Africa), whose life trajectories have been marked by a high level of movement, displacement, exclusion or precarity, seven speakers explored how the notion of (embodied) belonging – or non-belonging – becomes anthropologically meaningful.

Sarah Willen (University of Connecticut), opened the panel with an inspiring keynote entitled 'Dangerous to Dignity, Dangerous to Health: Migrants' Socio-political Abjection through a Medical Anthropological Lens'. For over 15 years, Sarah Willen has been researching on how different idioms of social justice mobilization – for instance, 'health equity' and 'humanitarianism' – are employed by different actors in their efforts to promote health. By putting forward her critical perspectives on migration and health, embodiment and experience, and drawing on relevant theoretical concepts such as 'dignity' and 'deservingness', Willen sparked a productive discussion on how to engage the notion of belonging anthropologically. Moreover, she urged (medical) anthropologists to persistently claim an active role in reframing scholarly and/or public health debate about pressing global (health) issues such as (forced) migration, experiences of refugeeism or displacement. She furthermore brought up the question of how anthropological approaches to new forms of belonging in an interconnected world can contribute to new and useful analytical frameworks, but also how they can be expressed in a language that is comprehensible beyond disciplinary boundaries.

Willen pointed out the flipsides of belonging: 'objection' and 'precarity'. The question of 'dignity' is of particular pertinence in this regard. Willen's research about the impact of illegalization on unauthorized migrants and their advocates in Tel Aviv has lots to say about illegalization as a form of socio-political abjection: a form of abjection that endangers both health *and* dignity.

Starting from the claim that in these turbulent times anthropology faces an "urgent call to think politics, people, and scholarly praxis anew", Willen explored the ways in which various dimensions of dignity are addressed in theoretical discussions. Abstract conceptions of dignity, she argued, whatever their genealogy, hold little anthropological value, especially those deduced from the intersubjective matrix and flow of human being-in-the-world. Instead, the notion of dignity becomes ethnographically visible – and anthropologically meaningful – only *in motion*: as dignity harmed, denied, or violated – or, conversely, as dignity safeguarded and

reclaimed. From this vantage point – which relinquishes any desire to define or quantify – dignity is more *vector* (than thing). We might think of it as a *lodestar* that guides the striving of individuals/groups within relational social fields that are gridded by constraint and fraught with indeterminacy (see also Willen 2014). Metaphors like these, she argued, can help decompose abstractions like dignity and reassemble them in ways that bear new explanatory power – a move that is also highly relevant for scholarly engagements with 'belonging'. By reflecting on the experience of African migrants in Israel and how they were treated (i.e. embodied forms of indignity and humiliation), Willen extended her argument: an ethnographic approach to dignity can enrich the anthropological understanding of subjectivity, intersubjectivity, and experience. In order to confront migrants' health challenges, she concluded, health professionals must understand and acknowledge how closely health and dignity are intertwined.

Though only in passing, Willen also took up the complicated matter of health-related 'deservingness'. As was further elaborated in the second paper and across the workshop, debates about who is and who is *not* deserving of health-related attention are highly contentious, particularly against the backdrop of todays global recession, changing welfare regimes, or the increasing infrastructures of inequality that divide the world's rich and poor (see also Huschke 2014; Knipper 2016; Willen 2012).

Synnøve Bendixsen's study (University of Bergen) revealed how discourses of undeservingness can become embodied, especially when im/migrants internalize negative assessments of themselves as 'undeserving of care'. Drawing on fieldwork with irregular migrants in Norway, she explored the impacts of limited rights to healthcare on migrants' perception of the body, their sense of self and belonging. Referencing Fassin (2008) and Larchanché (2012), Bendixsen drew attention to the various ways in which exclusionary discourses and stigmatizing representations – that partly follow from the construction of an 'illegal' subject – become part of how irregular migrants not only think about their position in society but how they experience (embodied) belonging and non-belonging. Access to healthcare, she demonstrated, is not only a question about legal regulations, but also a matter of migrants' understanding of their rights and practical entrée. In line with Sarah Willen's multidimensional approach to 'illegalization' (see Willen 2007), Bendixsen suggested exploring illegalization ethnographically as a juridical status, a sociopolitical condition, and a migrant's particular mode of being-in-the-world.

While most empirical research into precarity and migration focuses on *exclusionary* practices, it was **Natassia Brenman's** interest to unpack the spaces of *inclusion*. Brenman, affiliated with the London School of Hygiene and Tropical Medicine, provided a different angle with regards to access to healthcare: how access to psychotherapy in a marginal setting engenders a precarious belonging within the UK health system. The place she drew her ethnographic data from is an intercultural psychotherapy centre in inner-city London. Her interlocutors' stories point to multiple experiences of vulnerability/uncertainty ("the suffering of the waiting room") which come under the umbrella narrative of people from im/migrant backgrounds, who have accessed this voluntary service as an alternative to a mainstream system known to marginalise such groups. Precarity, Brenman argued, was not an existing characteristic of a particular 'client group', but – following Butler's (2012) conceptualisation – part of a broad sociality that was made up by multiple practices assembled 'in place'.

The aim of **Luna Dolezal's** (University of Exeter) paper was twofold: to provide a precise conceptual definition of belonging within health research and to examine how the experience of embodied belonging can contribute to specific health outcomes. To her, without a consensus on how to define belonging – a concept both ill-theorized and often taken for granted in social sciences as if its meaning was somewhat self-explanatory – it is difficult to effectively design (public) health interventions that address the relationship between belonging and health. Dolezal argued that both the concept and experience of belonging within health research literature are deployed variably, and often conflated with a range of other, arguably distinct concepts (such as identity, citizenship, cultural integration). Consequently, she suggested to establish a foundational sense of *the experience* of 'embodied belonging', which then may form the basis for understanding how familial, social, political, geographical or other experiences of belonging are related to (mental) health.

Dolezal's paper triggered a general concern that surfaced at several points throughout the workshop's discussions: Who is the audience of such conceptual work, for whom is it relevant, and who are we addressing as (medical) anthropologists? More broadly, how can we reinvigorate critical medical anthropology that is ready to intervene in respective public debates? Are new – better? – 'forms of belonging' created in our home and research communities through anthropological research?

The need to create a singular meaning of belonging was discussed controversially. It is not the ethnographer's task, some argued, to come up with a precise definition of belonging, nor was there much value in seeking out conceptual correlates or coherent phenomenological accounts across disciplines. It was rather of interest to create a productive space in order to find answers to health-related challenges associated with unauthorized im/migration and related notions and experiences of belonging. These, it was claimed, should draw from both, a robust theoretical framework for research on 'illegality' and health within the field of medical anthropology, as well as an *actively* set up dialogue with partner disciplines in order to influence policies and public debate. This, however, raises all sorts of slippery epistemological questions around how evidence is produced, evaluated, and legitimized. Others advanced the argument that general definitions of belonging are needed in order to render respective anthropological considerations comprehensible to colleagues in partner disciplines and broader audiences engaged in politics, policymaking, public health, or clinical practice. And yet, it was cautioned that it was precisely the semantic *multiplicity* of the concept that holds great potential for anthropological analysis of contemporary processes of social change.

Jieun Kim (Freie Universität Berlin) offered empirical examples from her ethnographic work within a 'free clinic' in Japan/Yokohama. As her research findings illuminated, moral sentiments surrounding ideas of care in Japan mark underclass men – in particular those living in enclaves known as *yoseba* districts (day laborers' quarters) – as undeserving members of society. The marginality of *yoseba* inhabitants, in this sense, was emblematically emphasized by their difficult entry into Japan's universal health care system. Focusing on the struggle for health care in a *yoseba* district, Kim chronicled how *yoseba* medical activists for the underclass have improvised alternative relations of care – and hence opened up a space for 'alternative belonging'. In particular, she paid attention to local practices of "place-making" and "rhythm-

making" in various sites from waiting rooms to communal graves. Belonging, she argued, might be enacted less as a membership to a larger entity, but as spatio-temporal attunement of bodily care coordinated among various agents.

Jörg-Christian Lanca, member of the Collaborative Research Center "Affective Societies" at Freie Universität Berlin, presented parts of his on-going research on "affective efforts of migration" among a specific migrant group: From the 1960s up to 1989, the German Democratic Republic recruited foreign so-called 'contract workers' – the largest group of which were Vietnamese. Based on biographical interviews conducted with former Vietnamese labour migrants, Lanca showed how political changes in Germany ensuing the reunification strongly affected their feelings of belonging, life courses, health and well-being. For the majority, the transition towards democracy and a changed (legal) status (including the loss of their economic basis of existence) was far from smooth. Lanca elaborated what strategies the migrants employed in order to cope with their affective crises, given that for a long time German institutions neglected their needs. Only recently have specialized institutions addressed this large migrant group (e.g. by offering a psychiatric outpatient unit for Vietnamese migrants located at the Charité Berlin).

Drawing on research in post-apartheid Johannesburg, the paper presented by **Emma Monama** (University of the Witwatersrand) looked at spirituality as an embodied expression and manifestation of health and well-being that is practiced through and as part of the city's urban fabric. How is spirituality embodied? How do local migrants rethink urban spirituality? How differently is it expressed and how do spiritual practices intersect with 'place'? Spiritual traditional healing practices, she argued, are embodied in people's everyday lives and aspirations where bodies and spaces become significant sites through which articulations of being and belonging are (re)imagined, negotiated and lived.

Discussion

The overall conference aimed at illuminating the practices that (re-)produce individual and collective forms of belonging in specific localities, as well as the exclusions that are experienced in relation to being connected (to persons, places, and non/material entities). The intensification, weakening and novel constitution of forms of belonging are closely related to social or economic processes of diversification: these confront people in a globalized world with varied possibilities but also pressures concerning (re)location as, for instance, within the context of migration.

With its focus on health-related 'embodied belonging', this workshop constituted a valuable, explicitly medical anthropological contribution to the larger concerns of the conference. The panelists employed a wide range of ethnographic methods to familiarize themselves with the social life and practices of those studied, and in so doing, carved out senses of belonging that are deeply entangled with local realities.

One important outcome is the emphasis medical anthropologists have to place on the various forms of (mental) health intervention/provision and their relations to im/migrants and otherwise

marginalized communities, but also to concerned people's subjective experiences of being entitled to health care. People's sense of belonging in diasporic contexts – which is always in the making – emerges in constant interplay with 'host' cultures. This process, as was shown, is marked by manifold frictions and dynamics of exclusion. Exclusionary mechanisms, as we learned from the panelists, not only depend on people's legal status, but also on the respective nation-state's regulations and laws, institutional practices of care and public discourses on irregular migrants in a given socio-historical time and space. By considering both, centralized state power and charity/humanitarian settings, new dynamics of giving and receiving care could be elaborated, especially in attending to the material and spatial dimensions of experiencing access to care. Through interaction with state institutions (case study Norway) as well as in the encounters with actors of the civil society such as medical activists (Japan) or voluntary organisations (UK), different moral, political and affective practices are formed and transformed, thereby destabilizing taken-for-granted ideas of belonging. The contributions convincingly reflected upon how illegality and precarity shape embodied lived experience as well as migrants' perception of belonging. This was illustrated by individuals' perceptions of space in a psychotherapy centre in London, by particular understandings of selfhood among irregular migrants in Norway and by the socio-political abjection experienced by unauthorized migrants and their advocates in Tel Aviv.

It was further shown that classifications of deservingness and belonging are powerful tools for those employing them, and that they are closely tied to morally charged notions of in- versus outsiders. The studies provided insights how care is tied to notions of a deserving patient and, more precisely, in the ways institutional actors negotiate and reckon deservingness. By focusing on varying actors' sense of deservingness, participants aimed at capturing the affective, moral, and ideological dimensions of how people conceive themselves and others as (un)equal, and (non-)belonging to society.

To belong in the sense of developing spatial attachments presupposes possibilities of *entering* into a productive relationship with place. Considering the ways in which uncertainty shapes people's ways of being in the world and belonging to places, as was shown, can provide us with a more nuanced understanding of belonging. The papers thus revealed how profoundly political and economic transformations, structural change or neglect by state agencies – processes that are always historically situated – impact the formation and valuation of belonging. In the case of former migrant workers from Vietnam, for instance, structurally challenging environments disrupted sentiments of belonging, which were closely tied to self-esteem based on people's economic foundation.

To conclude, this workshop helped to establish an understanding of belonging that acknowledges the importance of affectivity for social life in the mobile worlds of the 21st century. It provided room to reflect upon what the field of medical anthropology can offer to analyse the interplay between belonging, (refuge related) mobilities, human rights, and deservingness. The ethnographic examples suggested a range of key conditions for people to establish a sense of belonging and convincingly illustrated how closely related such a sense is to suffering, (health) care and well-being of im/migrants, refugees, but also otherwise socially disadvantaged people. In these times, when public discussions about who belongs and who does not – especially in regard to un/authorized im/migration – are becoming increasingly polarized and contentious, a

critical medical anthropology perspective is perhaps needed more than ever. An anthropology that discursively intervenes in debates through which exclusionary health policies come to be accepted as common sense and effectively translates its insights into non-academic settings.

Bio Statement

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