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The Classification of "Migrants" as a Discursive Practice in Public Health.
A Sociology of Knowledge Approach

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Zusammenfassung

Die Klassifikation von „Migrant/innen“ als diskursive Praxis in Public-Health-Diskursen: Eine wissenssoziologische Betrachtung

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Das vorliegende Diskussionspapier befasst sich mit Klassifikation und sozialer Kategorisierung als diskursiven Praktiken der Wissensproduktion von staatlichen Institutionen. Im Mittelpunkt steht dabei die Frage, wie Migrantinnen und Migranten im Public-Health-Bereich als eine besondere Gruppe konstruiert und erfasst werden, die sich vom Rest der Bevölkerung unterscheidet. Zunächst wird ein Überblick zur Verwendung der Begriffe „Migrant/in“ und „Ethnizität“ in der Gesundheitsberichterstattung gegeben. Es werden Beispiele für ethnizitäts- bzw. migrationsbezogene Kategorien in der Berichterstattung zu Tuberkulose und HIV/Aids aus Deutschland und dem Vereinigten Königreich angeführt. Daraufhin wird gezeigt, wie sich eine wissenssoziologische Perspektive auf diese Kategorien darstellt und welche Anknüpfungspunkte bestehende soziologische Arbeiten zu Klassifikation und sozialer Konstruktion medizinischen Wissens bereithalten. Ziel dieses Beitrags ist es, einige theoretische Vorannahmen des von der Deutschen Forschungsgemeinschaft (DFG) geförderten Projekts „Kategorien im Wandel: Migrant/innen in epidemiologischen, präventiven und rechtlichen Diskursen zu HIV und Tuberkulose. Ein Ländervergleich (D/GB).“ zur Diskussion zu stellen. Dieser Beitrag möchte den Blick für die sozio-historischen Prozesse schärfen, die der Konstruktion von Public-Health-Klassifikationssystemen zu Grunde liegen. Dabei werden Klassifikation und soziale Kategorisierung von Migrant/innen mit Michel Foucault als gouvernementale Praktiken im Umgang mit Migration begriffen. Insbesondere werden die biopolitische Funktion von Public-Health und das Exklusion/Inklusion-Paradox in Public-Health-Diskursen zu Migration und übertragbaren Infektionskrankheiten diskutiert. Die theoretische Rahmung von Klassifikation, Identifikation und Kategorisierung als sozialen Prozessen lässt die Komplexität von Kategorisierungsarbeit nachvollziehbar werden und erlaubt es die soziale Konstruktion von Kategorien als diskursive Praktik der Wissensproduktion zu begreifen. Im letzten Abschnitt wird ein durch die Wissenssoziologische Diskursanalyse (Keller 2013) informierter Zugang vorgestellt, wobei gezeigt wird, wie sich die methodologische Herangehensweise dieses Forschungsprogramms zur Rekonstruktion von Praktiken der Bedeutungs- und Wissensproduktion im Public-Health-Bereich als hilfreich erweist. Unter Bezugnahme auf die Gesundheitsberichterstattung in Deutschland und dem Vereinigten Königreich wird schließlich davon ausgegangen, dass Klassifikation Wissen erzeugt, das in spezifischen sozio-historischen Voraussetzungen begründet ist, gleichzeitig jedoch stets nur vorläufig und umstritten ist, d.h. von verschiedenen Akteuren in Frage gestellt wird.

Abstract

This paper reflects on the classification and social categorization of ethnically diverse populations as a discursive practice in the production of knowledge by state institutions in the field of public health. It begins by providing an overview of the terms "migrant" and "ethnicity" in public health reporting and by comparing examples of ethnicity and migration-related categories used in tuberculosis (TB) and HIV/AIDS health reporting classification systems in the United Kingdom and Germany. It reviews sociology of knowledge studies focusing on classification and the social construction of medical knowledge to highlight why a sociological perspective on the categories used in public health classifications is a productive line of enquiry. In this regard, an aim of the paper is to discuss the theoretical underpinnings of the DFG-funded project "Changing Categories: Migrants in epidemiological, preventive and legal discourses on HIV and tuberculosis – A discourse analysis comparing Germany and the UK". The paper creates a context for understanding the socio-historical processes implicit in the construction of public health classification systems and their constituent categories by discussing, from a Foucauldian perspective, how the classification and social categorization of migrants are implicated in the governmentality of immigration. More specifically, it will consider the biopolitical function of public health and the exclusionary/inclusionary paradox in public health discourses on migrants and communicable diseases. The paper then discusses classification, identification and categorization as social processes to draw attention to the complexity of classification work and the constructedness of categories as knowledge practices. The final section of the paper draws on the Sociology of Knowledge Approach to Discourse Analysis (Keller 2013) to show how this research programme offers useful methodological tools to reconstruct processes and practices associated with meaning and knowledge production in an institutional field such as public health. By referring to the UK and German health reporting examples, it further reflects on how classification produces knowledge claims that are grounded in prevailing socio-historical conditions but which are potentially unstable and open to contestation by other actors.

Content

1. Introduction

There is a consensus among scholars that we are now living in an era of migration (Castles & Miller 2009). The rise in the numbers of international migrants over the past three decades has been accompanied by the formation of migrant communities in many European countries. These trends pose particular challenges for states, which are bound by democratic principles to foster inclusion and uphold human rights. Among states' obligations in this regard is, for example, the need to provide appropriate health care services and redress health inequalities. Practices of classification have been developed and employed by state authorities to fulfill a range of functions and they also serve these purposes. While official classification is critically important for social policy and is a defining practice of the modern state (Dorling & Simpson 1999), devising classification systems of ethnically diverse population groups is ultimately bound up with the ascription of identities and is a project rooted in complex historical, ethical and methodological issues. Significantly, such classification projects and the underpinning processes of social categorization are not politically neutral but are sites of tension between different state and non-state actors in the enactment of competing agendas. While classification and social categorization constitute modalities of power in the governmentality of immigration and diversity (Foucault 1997a), ethnicity classifications and data collection are integral to human rights protections against discrimination (Ringelheim 2011; UNCESCR 2000) and redressing power asymmetries between the state, individuals and groups.

In public health, the utility of ethnicity and migration-related classifications and their constituent categories can be seen by the numerous tasks ethnic and migrant-related data aim to accomplish. Classifications which involve categorizing groups and populations according to their ethnic background or migration status are useful to governments, for example, in assessing the burden of mortality and morbidity and identifying the health specific needs of diverse groups. In this regard, studies showing an association, not necessarily causal, between ethnic status and health outcomes underscore the importance of ethnicity as a risk indicator (Bhopal 2011). In addition, knowledge of the ethnic composition of a population can facilitate the tailoring of health services and the planning of specific interventions, for example in health promotion and disease prevention. Although the utility of data generated by ethnicity classifications has been integral to public health research, the validity of ethnicity categories and the problematic of measuring "race" and ethnicity are conceptual and methodological challenges

drawing critical attention (Mays et al 2003; Ford & Harawa 2010; Aspinall 2011). Increasing cross national collaborations in the field of epidemiology and harmonization in HIV/AIDS reporting at the European Union level (ECDC 2013a; ECDC 2013b) have also highlighted the diversity of classifications used in health reporting and the specific challenges this presents (Rechel et al 2012).

This paper considers classification in its multiple roles of facilitating states to manage the health related needs of ethnically diverse populations. Specifically, it will reflect on classification and the categories produced in public health as discursive practices of the state constituting knowledge claims about migrants and communicable diseases. The tensions between the imperatives of state governance and the pragmatic tasks involved in classification work will be addressed and reference made to the contrasting experiences of the United Kingdom and Germany in the area of health reporting. The paper broadly aims to discuss some of the theoretical approaches informing our sociological research project "Changing Categories: Migrants in epidemiological, preventive and legal discourses on HIV and tuberculosis – A discourse analysis comparing Germany and the UK" . The paper begins (section 2) by providing an overview of the use of the terms "migrant" and "ethnicity" in public health reporting. Section three (3) presents examples of ethnicity and migration-related categories used in tuberculosis (TB) and HIV/AIDS health reporting classification systems in the UK and Germany. These examples highlight the differing constructions of these categories as well as their instability. The fourth section reviews classical sociology of knowledge studies focussing on classification and the social construction of medical knowledge. This lays the theoretical groundwork for understanding why a sociological perspective on the categories used in public health classifications is a productive line of enquiry. Section five (5) explores the socio-historical context of migrant and ethnicity classifications by discussing from a Foucauldian perspective, how the classification and social categorization of migrants are implicated in the governmentality of immigration and are embedded in power/knowledge complexes that define how immigration and migrants can be spoken about. This section also discusses public health as both a technology of biopower and a means of achieving better health outcomes among disadvantaged migrant and ethnic minority groups. Section six (6) reviews classification, identification and categorization as social processes and practices to draw attention to the complexity of classification work and the constructedness of categories as knowledge practices. Against the theoretical background of the preceding sections, the final section (section 7) will consider how the Sociology of Knowledge Approach to

Discourse Analysis (SKAD) can be employed to reconstruct empirically the processes involved in the creation of ethnicity and migration-related categories comprising public health classifications in the UK and Germany.

2. Migrant and Ethnicity Classifications in Public Health

In many EU countries, the politically preferred method in health care contexts for collecting data on groups considered ethnically different to the host population is according to migrant status (Johnson 2008). Both terms – "migrant" and "ethnicity" – have implications for the classifying principle(s) selected for categorization (i.e. developing categories), which, in order to study HIV in relation to mobility, must draw on accurate and comparable data on migration, health and HIV in order to establish links between these data sets (ECDC 2011b). However, the social constructedness of the respective terms raises certain epistemological issues which render classification for the purposes of epidemiological research and health reporting, complex and imprecise. A principal conceptual problem regarding the term "migrant" concerns the lack of a consensus on defining who constitutes a migrant. Various glossaries (EU 2009; IOM 2004; UNESCO 2008) provide definitions and classifications of forms of migration, but the meaning of the term migrant is not consistent across countries. Instead its bureaucratic definition is informed by the idiosyncrasies of national immigration legislation, reflecting the partial perspectives of policy makers. Its socio-political meaning, however, is constructed through discursive practices grounded in the ideologies and superstructures on migration and diversity in each nation state.

Regarding bureaucratic designations, the most frequently used categorizations of migrants and ethnic minorities in EU countries, other than the UK, are 'country of birth', 'country of origin', 'country of nationality' and 'country of citizenship' (ECDC 2011b:11). Each of these definitions of migrant status possesses limitations (Rechel et al 2012). The category definitions are inherently static as they are not indicative of mobility or migration trajectory. The boundedness and immutability of the category 'migrant' however defined, cannot therefore, indicate when groups are no longer defined as migrants but become socially (re)constructed as minorities differentiated from the host population according to ethnicity or other identity markers. These definitions of migrant status further conflate different sub-groups of migrants such as economic migrants, trafficking victims, asylum seekers and refugees, all of whom may experience differing lev-

els of vulnerability to infectious diseases such as HIV/AIDS and TB and differing access to health services. The conflation of these groups not only homogenizes the category's members but makes invisible other migrants such as the undocumented, who constitute a group that is methodologically and ethically difficult to reach.

In addition to "migrant" categories, some countries (including the UK but not Germany) collect data on "ethnicity". The UK is exceptional with regard to its policy of ethnic monitoring in health care services; the Department of Health started ethnicity data collection in 1995, subsequent to the inclusion of a question on ethnicity in the 1991 census (Psoinos et al. 2011). Aside from the data protection issues surrounding the collection of ethnicity data (Simon 2007; Krizsán & Zimmermann 2001) the complexity of the term "ethnicity" as a theoretical concept and social construct make it difficult to operationalize in research and classification work. Drawing on Weber's classical sociological treatise Economy and Society, Bulmer defines an ethnic group as:

> "(…) a collectivity with a larger population having a real or putative common ancestry, memories of a shared past, and a cultural focus upon one or more symbolic elements which the group's identity, such as kinship, religion, language shared territory, nationality or physical appearance" (1996:35).

Group ethnic identity can, therefore, be seen as pre-social, constructed through primordialist claims to common origins no matter how tenuous these claims may appear in the practice of everyday life and social organisation. It may also be situational, invoked by members of a specific group as a means of self-identification in situations where such identification is useful or necessary. Ethnic identity also has an instrumentalist function and can be used to mobilize a specific group to gain advantages in the market place or more resources from the state (Jenkins 1997; Cornell & Hartmann 1998). These shifting meanings and functions of ethnicity as a social construct form the slippery theoretical foundation of ethnicity classification work. The categories developed should capture identities constituted through the unique historical and social processes of a country such as colonialism, types of immigration experienced and forms of racist practice all of which shape ethnic relations (Aspinall 2012). The confluence of these forces, in specific socio-historic contexts, influence the ways in which ethnic identities are both assigned and asserted within society.

In English-speaking discourses, the term “ethnicity” is increasingly used as a replacement for “race” in epidemiological research (Afshari & Bhopal 2002). The use of the term ‘ethnicity’ to design classifications of migrant and ethnic minority populations necessarily requires an assumption that ethnic groups do exist and that it is acceptable and possible to collect ethnicity-related data. While the UK records ethnicity in censuses and health care utilization registries, in Germany, “ethnic” data are not collected. Instead, migration-related categories have been developed, such as “Menschen mit Migrationshintergrund” (people with a migration background), to collect data on first and second generation immigrants (Statistisches Bundesamt 2006; RKI 2008). Some authors note the lack of ethnicity classifications in Germany is due to concerns that such practices may stir national memories of the categories developed under National Socialism and the data may be misused to incite racism and discrimination (Simon 2007). However, as noted above, it can be argued that ethnicity categories also serve the purposes of understanding health disparities and addressing discrimination. This argument is advanced by various actors in Anglo-American health and social science discourses, but it does not seem to have the same claim to truth nor does it have a similar relevance in the German context. The different discourses in Germany and the UK thus lend themselves to further investigation as they include different classification practices embedded in specific socio-historical contexts. Comparing the discursive practices in the two countries may be a useful heuristic tool for deconstructing the classification practices and questioning their seemingly self-evident nature. Such an exercise also requires an analysis of the various discourses on migration, public health and infectious diseases, contextualizing these classification practices.

3. Examples from UK and German Health Reporting on HIV/AIDS and TB

As knowledge practices, health reporting employs classification systems and their constituent categories to facilitate epidemiology’s functions of disease surveillance and control. In Germany and the United Kingdom, the classification systems of tuberculosis (TB) and HIV/AIDS exposure groups used in health reporting exhibit both similarities and important differences. For example, whereas the categories for men having sex with men (MSM) and injecting drug users tend to be similar in HIV reporting practices of both countries, differences exist particu-

larly with regard to migration-related categories. In Germany, migration-related data were not collected until 2001, except for one category (called “HPL”) in the classification of HIV transmission risks. This category (HPL stands for "Hochprävalenzländer" and was used for people from “high prevalence countries”) was employed until 2011. In the UK (as in most other countries), this category was not used in similar ways as part of regular reporting routines on HIV exposure groups. Other categories and classifications were used instead, including a wide range of migration-related categories (Public Health England 2013). A core category has been “black African heterosexual” which makes explicit reference to ethnicity and a phenotypical identity marker (skin colour) combined with sexuality. In contrast, ethnicity-related categories are conspicuously absent in German health reporting, as stated above. With regard to these country differences and the changes in categories employed to capture diversity in ethnic and migration-related status a number of questions arise. These include how – with which classifications and categories – is scientific knowledge about migrants and infectious diseases produced, stabilised and changed? How are the epidemiological categories socially constructed in Germany and the UK? Which statements, speaker positions and actor formations characterise the discourse on migrants and infectious diseases such as HIV/AIDS and TB? How far do these epidemiological categories shape preventive and legal discursive practices and so display ‘power effects’?

When considering these questions, an important premise is that these categories both constitute and are constituted by health sciences’ discourses on the health and illness of migrants – particularly those regarding communicable infectious diseases. Discourses can be understood as communicative events that stabilize, at least temporarily, meaning attributions and interpretations which institutionalize an order of knowledge. Significantly, discourses have consequences in social collectivities (Keller 2013:3). From this standpoint, the classification of migrant and ethnically diverse populations by state institutions in public health reporting can be viewed as constituting a discursive practice in the production of knowledge. Importantly, these classifications, as well as the “order of knowledge” (ibid) they institutionalize, are unstable and subject to diverse socio-historical factors and processes. As such, these classification systems - including the knowledge they both incorporate and generate - warrant critical analysis.

4. A Sociology of Knowledge Approach

Theorizing the nature and scope of knowledge, in particular medical knowledge, is a key concern of sociological enquiry. One of sociology's defining assumptions is that biomedical knowledge of health and disease is created in a political, social and cultural environment (White 2002). Equally, questions relating to the genesis, role and implications of classifications have been a long standing preoccupation of social theorists. Durkheim's classical studies (Durkheim 1915; Durkheim and Mauss 1963) focused on classificatory processes and developed one of the central tenets of the sociology of knowledge: "the classification of things (…) reproduces [the] classification of men" (p. 11). Durkheim attempted to explain all fundamental categories of human thought, such as time, space, weight, force and mass - although he did not establish their social origins. He argued that these concepts that we use to think with do not reflect nature but instead, they reflect the social organisation of society. Ludwik Fleck (1935 [1979]) applied this insight to the study of scientific and medical ideas. His seminal work on syphilis and anatomical drawings showed how medical knowledge and its main categories were created and that they too were a product of the social. His notion of 'thought collectives' theorized medical knowledge revealing it to be the outcome of historically located interactions between different groups with differing views of reality. This radically reformulated scientific facts as being fundamentally social in origin. Fleck's study on syphilis further historicized medical knowledge by demonstrating that knowledge does not progress in a linear trajectory but is contingent on changes in thought styles.

The constructed nature of medical knowledge and its impact on social organization and experience have been explored by numerous influential scholars. In the anthropological study Natural Symbols, Mary Douglas (1973) illustrates that medicine is similar to other areas of human thought that are essentially cosmological: it has a particular worldview that conjoins diverse experiences and invests them with meaning. As such, medicine comprises a set of categories that serves to filter and construct experiences. Douglas (1991) also explored the connections between classifications and social institutions stressing the meanings of these classifications for social groups. In contrast to the classic studies of Durkheim and Douglas which have sought to explain the origins of classification through their social functions, more recent theoretical developments in the sociology of knowledge seek to understand classifications from the perspective of their social construction (Bowker & Star 2000).

A related approach has stemmed out of an interest in the genesis, implementation and implications of scientific classification systems (Keller 2011a). A productive outcome of this interest has been the development of the Sociology of Knowledge Approach to Discourse Analysis (SKAD) (Keller 2011b). SKAD is a research programme offering useful methodological tools to address empirically questions concerning the origins, trajectories and effects of discursive practices such as ethnicity and migrant classifications and their constituent categories used in public health reporting. Integral theoretical elements of this research approach are not only Foucault's notion of the socio-historical contingency of knowledge but also the coercive aspect of knowledge, which he theorized with his concept of knowledge/power. For Foucault (1980), both knowledge and power are intertwined: power is constituted through accepted forms of knowledge, scientific understanding and 'truth'. Foucault (1980:131) argues that each society has its own "regime of truth", its "general politics" of truth: that is, "discourses which it accepts and makes function as true" but which are in constant flux and negotiation. For this reason, interrogating ethnicity and migrant classifications in public health from a sociology of knowledge perspective requires an understanding of how dominant discourses - those "regimes of truth" in society - define the boundaries of what can be said about immigration and how this in turn shapes migrants' subjectivity.

5. Governmentality and Technologies of Biopower

Increasing mobility, the existential threat posed by the 'immigrant other' and a return to nativism (Casanova 2012) are among the confluence of forces underpinning the governmentality of immigration in many EU states. As an art of government and form of political power, governmentality is broadly viewed as "techniques and procedures for directing human behaviour" (Foucault 1997:82). Crucially, it defines a variety of authorities governing in different sites with different objectives as responsible for managing the conduct of citizens (Rose et al 2006). This includes what Foucault (1979:20) terms the range of "institutions, procedures, analyses and reflections" that objectify populations and which relate the power and administration of the state to the "subjugation and subjectivation of individuals" (Fassin 2011:214). As an analytical perspective, governmentality makes visible political manoeuvering at the national and supra-national level in

the EU that invoke classification and social categorization as techniques in the control of immigration and practices of exclusion. These political developments are significant constitutive elements of the conditions and underlying structures regulating the production of knowledge at a specific time and place (Foucault 1970). They include the racialization of the EU immigration regime (Garner 2010) and a shift towards the deployment of exclusionary liberal norms that define the symbolic boundaries of identity, belonging and the nation state (Adamson et al 2011). This political configuration has generated a range of discursive positions and practices related to the control of migration both within and beyond states' borders. In this latter regard, surveillance has become a cornerstone of policies aimed at both internal migration control and the controlling of immigration flows at borders. Technologies of surveillance employing a network of vast information databases, often including biometric data, are central to the apparatus of control at EU level (Broeders 2007). The information archives created by these digital surveillance systems enable the identification and sorting of 'wanted' and 'unwanted' migrants, which in turn furnish the justification for differential treatment. They become subject to a classificatory regime that distinguishes between nationals and non-nationals ("foreigners"), and then between different categories of foreigners (Garner 2010). These bureaucratic categories are codified into policies as legal statuses ascribing rights and privileges to certain groups, such as the highly skilled, while limiting the rights and imposing sanctions on others, such as asylum seekers and the undocumented. As such, immigration classificatory regimes become operational at border crossings through coercive state power to generate hierarchies of migrants. The distinctive categories employed ultimately shape subjectivities and entrench social identities.

The sorting and administrative classification of migrants is among a diverse range of discursive practices grounded in states' efforts to regulate migration flows as well as preserve national identity and social cohesion at a time of heightened security and economic austerity. Political discourses thus invoke restrictionism and securitization in the production of truth, knowledge and power in immigration control (Ibrahim 2005). Ensuing pronouncements by political elites on the failure of multiculturalism have been accompanied by the linking of immigration, integration and citizenship, which has led to a form of "aggressive integrationism" (Triadafilopoulos 2011). These techniques of migration governmentality are based primarily on mandatory civic integration and language courses for specific categories of migrants from designated countries (Kostakopoulou 2010a & 2010b; Goodman 2010; Groenendijk 2011; Böcker & Strik 2011). As disciplinary

practices targeting select racialized groups, these measures engender new bureaucratic forms of documenting, monitoring and evaluating migrants' suitability for admission to the citizenry, based as they are on techniques of "hierarchical observation" and "normalizing judgments" combined in compulsory language and civil knowledge "examinations" (Foucault 1979). Significantly, these policies and measures cumulatively coalesce into regimes of truth regarding the 'ideal citizen'. As power/knowledge complexes enabling states to procure migrants' conformity to homogenizing societal norms, they implicitly construct categories of migrants as either 'worthy' or 'unworthy' of inclusion thus legitimizing the exclusion of those incapable of fulfilling membership requirements.

However, as discursive practices, classification processes do not solely serve the purposes of the "institutions and procedures" objectifying populations that Foucault (1997) describes. Neither does the power of the state to enact technologies of governmentality remain uncontested. Foucault's conceptualization of modern power as an interactive and shifting network of relations between individuals, groups, institutions and structures draws attention to the possibility of emancipatory practices by a range of actors. By engaging in "critique", which comprises a specific set of reflective capacities about how subjectivities are formed, individuals and groups can learn the "art" of "how not to be governed" (Foucault 1997b). Critique then becomes a practice of freedom, which can enable resistance to how groups and individuals are defined, categorized, and classified (Rajchman 1985). This resistance includes the possibility for the categories to be claimed by actors in other arenas as social identities for the assertion of rights and the negotiation of knowledge production regarding certain social collectives (Epstein 2007). By so doing, these actors work through existing power relations to create and disperse new forms of knowledge that compete with truth claims by the state and at the same time contribute to the production of their own identities.

Public health has emerged as one of the technologies of biopower, a form of regulatory power that works primarily through the state (Foucault 1990). Biopower is responsible for the administering of life through techniques such as the collection of statistical data as well as surveillance and control, which are dependent upon the classification of groups. The field of epidemiology has a defining role in public health projects and intensifies its biopolitical functions due to its focus on the documenting of patterns of disease in populations and across

groups. This it achieves through record taking, measuring and reporting back to a system of government agencies (Lupton 1995).

The integral role classification plays in disciplinary practices targeting the immigrant "other" is, therefore, evidenced in the surveillance and control of migrants as potential sources of infection and disease. The immigrant body as an object of biopolitical concern resonates with symbolic constructions of the body and its boundaries as a model representing bound complex structures, such as social systems, whose boundaries are threatened or precarious (Douglas 1966). This theorization of the body conceptualizes body boundaries as sites of potential danger where power must intervene in order to render these boundaries safe and clean. Anxieties about permeable borders as well as the practices generated to maintain their integrity and eliminate risk, articulate therefore, with fears about the mobile immigrant body. This has come to epitomize the "very mechanism of entry of pathogens" (Pussetti & Barros 2012:44). In tandem with these concerns, the integrity of the immigrant body has become linked to its productive capacities in generating economic growth and development (Council of the European Union 2007). This positions migrants' labour power as subject to the historically formed macro-structural forces shaping global capitalism (Morawska 2012). Their discursive construction as units of labour and ensuing statements placing the onus on governments to attend to their increased health risks (ibid), are consistent with Foucault's argument that disease is an economic and political problem for societies requiring collective intervention (Foucault 1984:274-5).

In this regard, the employment of screening as a public health technique is part of the governmentality of immigration control, which has served to identify and construct migrants as a high risk group for certain communicable infectious diseases such as tuberculosis and HIV/AIDS (ECDC 2011a; Del Amo et al 2004; Ho 2004; Kehr 2009). Public health's role in policing the immigrant body represents continuities with colonialist concerns centring on 'race', hygiene and the containment of disease (Arnold 1988; Macleod & Lewis 1988). Its practices (re)produce "internal borders" (Balibar 2003) demarcating the racialized frontiers separating migrants and the host society. As such, the politics of public health interventionism foster the (re)enactment of power relations characteristic of the historical divide between metropoles in the centre and colonial hinterlands in the periphery.

Knowledge about migrants high risk status has achieved materiality in the development of epidemiological categories used for monitoring and controlling the health of various migrant groups. In these categories, "race and cultural differences are codified in defining what it means to be at risk of acquiring or transmitting an infectious disease" (Reitmanova & Gustafson 2012:912). As knowledge practices, the categorization of migrant groups constitutes power/knowledge complexes, which justify enhanced interventionism and surveillance of migrants (Kehr 2012). The power of these categories is not confined to the discursive constructions of the health of migrants they engender. These categories achieve "power effects" and enact govermentality through a raft of laws, regulations and other socio-political practices.

Yet as a technology of biopower, public health also exhibits tensions regarding categorization as both a technique of control and a tool for redressing health inequalities and inequities. In this latter respect, the intersections between public health and human rights are visible in the core function of public health to ensure accessibility of services on a non-discriminatory basis (Mann et al 1999; UNCESCR 2000). The successful fulfilment of this mandate requires the categorization of potentially vulnerable groups, which in turn proves to be an enabling mechanism for health and human rights activism. Thus, the exclusionary/inclusionary paradox in public health's institutional function finds expression in the deployment of categories both as a means of surveillance and a marker of vulnerable groups most needy of protection. This translates into migrants' dual social categorizations as being 'a risk' and 'at risk,' which becomes inscribed into discourses on their "otherness". The 'order of knowledge' established and disseminated by these epidemiological categories thus becomes an accepted part of social life silencing questions about the categories' origin. In reality, following the trail between these categories and their knowledge sources is fraught with intellectual challenges thus revealing the complexity inherent in their construction and in the design of classification systems more generally.

6. Classification, Identification and Categorization: Clarifying the Terms

The conceptual difficulties of ethnicity and migration-related classifications in public health are related firstly, to trends in contemporary migration, mobility and politics contextualising classification projects and secondly, the very com-

plexity of classification work. With respect to migration trends, an important development is the emergence of new forms of mobility and transnational practices as globalisation facilitates the transcendence of spatial and cultural boundaries. Increasing migration and transnational activities have not only challenged the structures of the Westphalian nation state system (Ahmed et al 2003; Jordan & Düvell 2003). These phenomena have given rise to postmodernist claims concerning the destablization and fragmentation of identities as individuals are no longer confined to developing identities embedded in a singular geographic location (Hall 1996). The use of hyphenated identities reconciling multiple ethnonational identity categories (Verkuyten 2005) and the construction of "new ethnicities" representing the fusion of different cultural identities (Harris 2006) have come to underscore the fluidity and varied inflections of ethnic identity in immigration societies. It is in this shifting terrain of mobility and identity (re)making that the work of ethnicity classification is located. Understanding the complexity of the undertaking in areas such as public health is linked to questions such as: who are the actors and sources consulted?; which discourses and which historical, social and political factors are implicit in influencing inter-ethnic relations and subsequent identity ascriptions?

As systems that both organize knowledge and concurrently construct new forms of knowledge (and thus contribute to the constitution of new realities), classifications are steeped in the histories, socio-cultural contexts, ideologies and work practices of their designers. This array of influences usually remains invisible in the information infrastructures they produce. Yet the emergent categories have an attendant material force that is indisputable. As Starr (1992:176) comments, categories achieve the appearance of being "objective, natural and self-evident" and so become woven into the fabric of society and state (Pierik 2004). Their consequences can be unpredictable and contentious especially when the classification aims to encapsulate malleable social constructs such as "ethnicity" and "race." Efforts to determine the logic and meanings ascribed to such ethnicity classifications require delving through "the dusty archives of classification design" to uncover the decision making processes implicated in their construction (Bowker & Star 2000:5).

Devising classifications of ethnic groups is, however, not just practical work. As Jenkins (2000) notes, identification – entailing the specification of differences and similarities - is necessary to classification. How individuals identify themselves and others along the axes of similarity and difference is central to social

identification. It is a productive and on-going enterprise and as Jenkins (2000:8) notes "there are thus two-ideal typical modes of identification: self- or group identification (internally oriented) and categorization of others (externally oriented). All actors are subject to both". The social constitution of collectivities into groups and categories is, therefore, based respectively on interdependent processes of internal group identification and external social categorization (Jenkins 1996). The theoretical distinction between groups and categories has practical consequences in everyday life. Whereas groups are known as such by their members, categories, which are initially unrecognised by their constituents, are made recognizable by forms of power/knowledge such as social policy, medicine and epidemiology (Jenkins 2000). In these domains categories are intrinsic to the operation of biopower – the politics and discursive practices employed in the management of a state's human resources – and for this reason a state imperative is the collection of statistical data and estimates regarding such demographic factors as immigration, fertility and mortality (Foucault 1990; Schirato et al 2012).

The internal-external dialectic of collective identification precludes, however, the reification of group identities and social categories. Instead, these constructs are constantly subject to renegotiation through the continual processes of group identification and categorization (Jenkins 2000). This (re)negotiation of group and category boundaries is at times rooted in identity politics and underlines the centrality of power to processes of social identification. Significantly, it highlights the asymmetrical power relationship between groups, who exercise the privilege of self-determination and the constituents of categories treated as objects of definition.

The processes of group identification and social categorization constitute the theoretical groundwork for the classification of ethnic groups. The resulting classification system is, as Bowker & Star (2000:10) write, "a set of boxes (…) into which things can be put to then do some kind of work – bureaucratic or knowledge production." The classification system should possess a number of properties including consistent and unique classificatory principles, mutually exclusive categories and complete coverage of "the world it describes" (ibid). As the authors note, these are ideal characteristics and it is improbable that any classification system can fully meet these requirements.

The epistemological challenges of designing a classification system are then quite weighty. This is more so when persons as opposed to material objects or animals are the subjects of the categories to be developed. Pierik (2004:527) defines the former type of categories as "a set of individuals that are considered equivalent on a specific attribute". This attribute is a feature regarded as uniform among the individuals in the category. The attribute can be invariable such as eye colour or variable such as weight. It may also be the result of choice, such as membership in a political party as well as it may not, for example place of birth. The reductionism inherent in categorizing individuals according to select characteristics facilitates an understanding of categories' inferred or observable relationships (Sokal 1974) and fulfills "a basic human need for cognitive parsimony" (Hogg and Abrams 1988:72). Significantly, the work of developing categories involves choices "and each category valorises some point of view and silences another" (Bowker & Star 2000:5). This inevitably makes some people invisible and engenders consequences that cannot always be foreseen. As Bowker & Star (2000:4) aptly comment, classifications are "artefacts embodying moral and aesthetic choices that in turn craft people's identities, aspirations and dignity."

The constructedness of categories and the classification systems they comprise is their defining characteristic. This constructedness necessitates their interrogation not only to understand how classifications are developed and used in achieving the ends for which they are designed. Questioning them also seeks to reveal how they structure social processes and silence certain points of view. In this regard, Polzer (2008) writes there are a series of elements in categorization which need to be considered. These include partiality, which means that all categories have to be analysed through the particular perspective of the actor or actors who constructed them. Functionality refers to the functions or uses for which categories are developed which will define their characteristics. Conflation is an aspect of how the characteristics of the category are implemented which homogenizes members of the category. Immutability refers to the relationship the category has with change over time; categories are rarely mindful of members' previous identities and do not allow for future identity trajectories. Self-confirmation is achieved in the Foucauldian (1972) tradition by the creation of 'knowledge', data and an archive about the group using the categories' defined characteristics. This is a self-reinforcing process that further affirms the impression of the categories' immutability. Negotiability refers to the way in which interactions between different groups – those being defined and those creating

the categories – is implicated in categorization. As Polzer (2008: 480) further notes, these theoretical elements of categorization can be distilled into a series of questions that serve to examine categories. These include:

a. who is defining the category? (partiality);
b. what is the purpose of defining the category at a particular point in time? (functionality and immutability);
c. what characteristics of the category are emphasized over others? (conflation);
d. what sources of information are used or created to confirm the existence of the category? (self-confirmation);
e. what reasons and opportunities are there for the individuals who are targeted for categorization to remain invisible? (negotiability).

The associated conceptual and methodological challenges of designing classifications of ethnic minority and migrant populations in epidemiological research illustrate the tensions between assigning individuals to categories which must fulfill scientific criteria for validity as well as capture salient attributes of a population identified as different to the host population. Within European Union countries, these processes of social identification are rooted in their respective immigration histories, administrative structures and political attitudes towards immigration, diversity and the protection of migrants' rights. Tracing these processes and unraveling the mix of factors implicit in the creation of ethnic minority and migrant-related classifications are essentially an empirical enterprise. Such a project is also sociological because it seeks to understand how the interactions of professional/lay interests, of power and of ethnicity and class enter into the formation of knowledge about migrants and communicable infectious diseases. This further raises questions about which methodological approaches are appropriate to the task.

7. Towards a Methodological Design

The Sociology of Knowledge Approach to Discourse Analysis is a comprehensive research programme grounded in Foucauldian discourse theory, which offers methodological tools that can address the question(s) raised above. SKAD is concerned with reconstructing processes and practices associated with meaning and knowledge production in various institutional fields, such as the sciences, as well as with their consequences. These outcomes are both effects of discourses as

well as 'pre'-conditions for new discourses. This approach sees discourses as not only being actualized in linguistic practices, discourses are also stabilized by dispositifs which are institutionalized infrastructures and measures e.g. classifications, statistics, laws, technologies and areas of responsibility (Keller 2013). Crucially, these dispositifs not only serve to (re)produce a discourse but they also generate specific forms of social reality and achieve 'power effects'. The public health reports referred to in this paper are a constitutive element of the dispositif under-girding epidemiological discourses on HIV/AIDS, tuberculosis and migrants.

While SKAD locates discourse research in the area of the sociology of knowledge, it allows for the development and use of qualitative research methods to pursue its analytical and empirical aims. A qualitative research methodology that may complement SKAD, is situational analysis, a postmodern approach to grounded theory (Clarke 2005). Situation analysis' goal of uncovering contradictions, complexities and the general "messiness" of research situations also has epistemological roots in Foucauldian concerns with knowledge production. It recognizes that researchers as well as the individuals and phenomena being studied are all "producing and awash in seas of discourses" (Clarke 2005:145). Because discourses are considered as socio-historically situated practices that constitute objects rather than representing them, this implies that data such as oral and written texts and other representations including images and visual data are sources crucial to analyzing how discourses are structured and how they produce knowledge claims (Keller 2012). Situational analysis facilitates this analysis empirically because it uses the classical, proven procedures of Grounded Theory (including theoretical sampling, constant comparisons etc.) and also offers new tools of visualization and conceptualization such as situational maps, positional maps and social world/arena maps to identify discursive elements of situations.

Given the primacy of the 'socio-historical' in SKAD, a number of thematic questions emerge in endeavours to reconstruct the processes, contexts and practices associated with the production of categories in German and UK health reporting. Inscribed onto these categories are the longer term historical practices relating to inter-ethnic relations and political ideologies on managing diversity. Both Germany and the UK were colonial powers, a historical fact that generates questions such as how far are attitudes and approaches of actors doing categorization work influenced by colonial histories and discourses? And do historical memories and conceptualizations of nationhood feature in the process? A second related

theme concerns the issue of language and more specifically, languages of diversity in both the UK and Germany. Questions this raises include how are contemporary notions of ethnic and "racial" difference encoded and communicated and in what ways has this been influenced by each nation's past? And where as well as what are the silences regarding diversity – what cannot be spoken about? A third thematic line of enquiry relates to the possible influence of contemporary scientific interest in genetics and "race" on epidemiology. Genetic research and the emergence of race-specific or ethnic specific medicines appear to be reviving the notion of race as having a biological base – at least in the Anglo-American discourse. How far do these ideas penetrate epidemiological thinking and the process of categorization of migrant and ethnic minority groups in the UK and in Germany? A fourth theme concerns HIV/AIDS activism and migrant community organisations which interact and negotiate with the powerful institutional state actors behind categorizations. What has been the role of these civil society groups in the framing of ethnic difference and the development of migrant /ethnic minority categories? In what ways do they work through existing power networks to resist power/knowledge complexes and in the process create new forms of knowledge and (re)make identities?

These questions are by no means exhaustive but represent a starting point for examining the processes of knowledge production and discursive practices pertaining to the categories used in epidemiological discourses. This line of enquiry is also related to the more general question: "Who is authorized and not authorized to make what kinds of knowledge claims about what/whom, and under what conditions?" (Clarke 2005:xxv). Implicated here are assumptions about the contingency of knowledge and the way in which power/knowledge complexes privilege certain perspectives as truth claims. It is also a poignant reminder, however, that struggles over the production of knowledge are ongoing and constitute the pre-conditions for the emergence of new discourses and discursive practices. The 'power effects' achieved are material in the ways they shape subjectivities and productive in the ways they generate new discursive practices of resistance and subsequent knowledge claims.

8. Conclusion

This paper has discussed how the practical work of developing ethnicity and migrant classification systems for health reporting purposes is embedded in theoretical issues of identity ascriptions, the power of definition exercised by state

actors as well as discourses on migration, migrants and communicable diseases. As constructs that both organize and create forms of knowledge, these classification systems and the categories comprising them are discursive practices which have consequences and display power effects in different domains such as communicable disease prevention. The 'order of knowledge' institutionalized by these classifications is neither fixed nor stable. Their inherent categories evolve and develop through country specific social and historical processes. This raises the larger question of how these processes can be investigated empirically in order to understand the statements, speaker positions and actor formations implicit in the discursive constructions of these categories. The Sociology of Knowledge Approach to Discourse Analysis (SKAD) has been presented as methodological programme facilitating answers to this question.

With regard to the classification of migrants and minority ethnic groups considered in this paper, the categories produced are part of a discursive field which we aim to reconstruct using SKAD with the assistance of procedures prescribed by situational analysis. This work will be deconstructive in that classification systems will be disassembled and interrogated using the questions put forward by Polzer (2008) as described above; it will be reconstructive in that the meanings and effects of classification practices as well as the changes in discursive practices will be traced and interpreted; and it will also be constructive in that it will generate interpretations and observations which will add to the discourses and possibly contribute to conditions for new discourses to emerge.

Bibliography

Adamson, F.; Triadafilopoulos, T.; Zolberg, A. (2011) The Limits of the Liberal State: Migration, Identity and Belonging in Europe. Journal of Ethnic and Migration Studies 37(6): 843-859.

Afshari, R. & Bhopal, R. (2002) Changing pattern of use of 'ethnicity' and 'race' in scientific literature. International Journal of Epidemiology 31(5): 1074.

Ahmed, S.; Castaneda, C.; Fortier, A. & Sheller, M. (eds.) (2003) Uprootings/ Regroundings: Questions of Home and Migration. Oxford and New York: Berg.

Arnold, D. (ed.) (1988) Imperial medicine and indigenous societies. Manchester and New York: Manchester University Press.

Aspinall, P. (2012) Answer formats in British census and survey ethnicity questions: Does open response better capture 'superdiversity'? Sociology, 46(2): 354-364.

Aspinall P. (2011) The utility and validity for public health of ethnicity categorization in the 1991, 2001 and 2011 British Censuses. Public Health 125(10): 680-7.

Balibar, E. (2003) We, the people of Europe? Reflections on Transnational Citizenship. Princeton, NJ: Princeton University Press.

Bhopal, R. (2011) Ethnicity, race and health in multicultural societies: Foundations for better epidemiology, public health and health care. Oxford: Oxford University Press.

Bowker, G. & Star, S. (2000) Sorting Things Out: Classification and its Consequences. Cambridge, MA: MIT Press.

Böcker, A. & Strik, T. (2011) Language and Knowledge Tests for Permanent Residence Rights: Help or Hindrance for Integration? European Journal of Migration and Law 13(2): 157–184.

Broeders, D. (2007) The New Digital Borders of Europe EU Databases and the Surveillance of Irregular Migrants. International Sociology 22(1): 71–92.

Bulmer, M. (1996) The ethnic group question in the 1991 Census of Population. In D. Coleman and J. Salt (eds.) Ethnicity in the 1991 Census of Population. London: HMSO.

Castles, S. & Miller, M. (2009) The Age of Migration: International Population Movements in the Modern World. Fourth Edition, revised and updated. Basingstoke and New York: Palgrave MacMillan.

Casanova, J. (2012) The politics of nativism: Islam in Europe, Catholicism in the United States. Philosophy and Social Criticism 38(4-5): 485–494.

Clarke, A. (2003) Situational Analyses: Grounded Theory Mapping After the Postmodern Turn. Symbolic Interaction 26(4): 553-576.

Cornell, S. & Hartmann, D. (1998) Ethnicity and Race: Making Identities in a Changing World. California: Pine Forge Press.

Council of the European Union (2007) Draft Council Conclusions on Health and Migration in the EU. Annex15609/07.

http://register.consilium.europa.eu/pdf/en/07/st15/st15609.en07.pdf accessed 30.09.2013.

Del Amo, J.; Bröring, G.; Hamers, F.; Infuso, A.; Fenton, K.(2004) Monitoring HIV/AIDS in Europe's migrant communities and ethnic minorities. AIDS 18(14): 1867-1873.

Douglas, M. (1966) Purity and Danger: An Analysis of Concepts of Pollution and Taboo. London: Routledge & Kegan Paul.

Douglas, M. (1973) Natural Symbols. Harmondsworth: Penguin.

Durkheim, E. (1915) The Elementary Forms of the Religious Life. New York: The Free Press

Durkheim, E. & Mauss, M. (1963) Primitive Classification. Chicago: University of Chicago Press.

Epstein, S. (2007) Inclusion: the politics of difference in medical research. Chicago: University of Chicago Press.

European Centre for Disease Prevention and Control (2011a) Migrant health: HIV testing and counselling in migrant populations and ethnic minorities in EU/EEA/EFTA Member States. Stockholm: ECDC.

European Centre for Disease Prevention and Control (2011b) Migrant health series: Improving HIV data comparability in migrant populations and ethnic minorities in EU/EEA/EFTA countries: findings from a literature review and expert panel. Stockholm: ECDC.

European Centre for Disease Prevention and Control (2013a) Responses to HIV and migration in western industrialised countries: current challenges, promising practices, future directions. Stockholm: ECDC.

European Centre for Disease Prevention and Control (2013b) Thematic report: Combined reporting. Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2012 Progress Report. Stockholm: ECDC.

European Union (2009) Asylum and Migration Glossary – A tool for better comparability. Brussels: European Union.

Fassin, D. (2011) Policing borders, producing boundaries: the governmentality of immigration in dark times. Annual Review of Anthropology 40:213–26.

Fleck, L. (1935 [1979]) The Genesis and Development of a Scientific Fact. Chicago: University of Chicago Press.

Ford, C. & Harawa, N. (2010) A new conceptualization of ethnicity for social epidemiologic and health equity research. Social Science and Medicine 71(2): 251–258.

Foucault, M. (1970) The Order of Things. Oxon, NY: Tavistock/Routledge.

Foucault, M. (1972) The Archaeology of Knowledge. London: Tavistock.

Foucault, M. (1979) Governmentality. Ideology and Consciousness 6:5–21.

Foucault, M. (1980): 'Truth and Power'. In C. Gordon (ed.) Power/knowledge. Selected Interviews & Other Writings by Michel Foucault, 1972-1977, Brighton: Havester, pp. 109-133.

Foucault, M. (1984) The politics of health in the eighteenth century. In P. Rabinow (ed.) The Foucault Reader. New York: Pantheon, pp. 273-290.

Foucault, M. (1990) The History of Sexuality, Volume 1: An Introduction. New York: Vintage.

Foucault, M. (1997a) Ethics: Subjectivity and Truth. Essential Works of Michel Foucault, 1954–1984. Vol. 1. New York: New Press.

Foucault, M. (1997b) What is Critique? In S. Lotringer & L. Hochroth (eds.) The Politics of Truth. New York: Semiotext(e), pp. 41-82.

Garner, S. (2010) Racisms: An Introduction. London, CA:Sage.

Goodman, S. (2010) Integration Requirements for Integration's Sake? Identifying, Categorising and Comparing Civic Integration Policies. Journal of Ethnic and Migration Studies 36(5): 753-772.

Groenendijk, K. (2011) Pre-departure Integration Strategies in the European Union: Integration or Immigration Policy? European Journal of Migration and Law 13(1): 1–30.

Hall, S. (1996) The Question of Cultural Identity. In S. Hall, D. Held, D. Hubert & K. Thompson (eds.) Modernity: An Introduction to Modern Societies. Massachusetts and Oxford: Blackwell, pp. 596-634.

Harris, R. (2006) New Ethnicities and Language Use. Basingstoke: Palgrave Macmillan.

Ho, M. (2004) Sociocultural aspects of tuberculosis: a literature review and a case study of immigrant tuberculosis. Social Science & Medicine 59(4): 753–62.

Hogg, M. & Abrams, D. (1988) Social Identifications: A Social Psychology of Intergroup Relations and Groups Processes. London: Routledge.

International Organization for Migration (2004) Glossary on migration. IOM: Geneva.

Jenkins, R. (1996) Rethinking Ethnicity. London: Sage.

Jenkins, R. (2000) Categorization: Identity, Social Process and Epistemology. Current Sociology 48(3): 7-25.

Johnson, M. (2008) Making difference count: ethnic monitoring in health (and social care). Radical Statistics 96: 38-45.

Jordan, B. & Düvell, F. (2003) Migration: The Boundaries of Equality and Justice. Cambridge: Polity.

Kehr, J. (2012) Blind spots and adverse conditions of care: screening migrants for tuberculosis in France and Germany. Sociology of Health & Illness 34(2): 251–265.

Kehr, J. (2009) The politics and poetics of migrant tuberculosis: modelling a 'social disease' in French public health. In V. Kalitzkus & P. L. Twohig (eds.) The Tapestry of Health, Illness and Disease. Amsterdam: Rodopi, pp. 99-124.

Keller, R. (2011a) Wissenssoziologische Diskursanalyse: Grundlegung eines Forschungsprogramms 3 Auflage. VS Verlag für Sozialwissenschaften

Keller, R. (2011b) The Sociology of Knowledge Approach to Discourse Analysis (SKAD). Human Studies 34(1): 43-65.

Keller, R. (2013) Doing Discourse Research: An Introduction for Social Scientists. Los Angeles, London, New Delhi, Singapore, Washington DC; Sage.

Kostakopoulou, D. (2010a) Matters of Control: Integration Tests, Naturalisation Reform and Probationary Citizenship in the United Kingdom. Journal of Ethnic and Migration Studies 36(5): 829-846.

Kostakopoulou, D. (2010b) The anatomy of Civic Integration. Modern Law Review 73(6): 933-958.

Krizsán, A. & Zimmermann, M. (2001) Ethnic Monitoring and Data Protection: The European Context. Budapest: Central European University Press.

Lupton, D. (1995) Medicine as Culture: Illness, Disease and the Body in Western Societies. London, Ca., New Delhi: Sage.

Mann, J.; Lawrence, G.; Gruskin, S.; Brennan, T.; Lazzarini, Z., Fineberg, H. (1999) Health and Human Rights. In J. Mann, S. Gruskin, M. Grodin, G. Annas (eds.) Health and Human Rights: A Reader. New York and London: Routledge, pp. 7-20.

Mays V.; Ponce N.; Washington D. & Cochran, S. (2003) Classification of race and ethnicity: implications for public health. Annual Review of Public Health 24:83-110.

Macleod, R. & Lewis, M. (eds.) (1988) Disease, medicine and empire: perspectives on Western medicine and the experience of European expansion. London and New York, Routledge, 1988.

Morawska, E. (2012) Historical-Structural Models of International Migration. In M. Martiniello & J. Rath (eds.) An Introduction to International Migration Studies. Amsterdam: Amsterdam University Press, pp. 55-75.

Pierik, R. (2004) Conceptualizing Cultural Groups and Cultural Difference: The Social Mechanism Approach. Ethnicities 4(4): 523-544.

Polzer, T. (2008) Invisible Integration: How Bureaucratic, Academic and Social Categories Obscure Integrated Refugees. Journal of Refugee Studies 21(4): 476-497.

Psoinos, M., Hatzidimitriadou, E., Butler, C., Barn, R. (2011) Ethnic Monitoring in Healthcare Services in the UK as a mechanism to address Health Disparities: A Narrative Review. London: Swan IPI. ISBN: 978-0-9558329-8-7

Public Health England (2013) New HIV diagnoses and the number of people accessing HIV care in the United Kingdom. HIV and AIDS Reporting Section, Centre for Infectious Disease Control and Surveillance. London: UK. http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/Page/1201094588844#7._HIV_surveillance_slide_set accessed 15.10.2013

Pussetti, C. & Barros, V. (2012) The care of the immigrant self: technologies of citizenship and the healthcare sector. International Journal of Migration, Health and Social Care 8(1): 42 – 50.

Rajchman, J. (1985). Michel Foucault: The Freedom of Philosophy. New York: Columbia University Press.

Razum, O. (2009) Migration, Mortalität und der Healthy-Migrant-Effekt. In Richter, M. & Hurrelmann, K. (Ed). Gesundheitliche Ungleichheit: Grundlagen, Probleme Perspektiven. Wiesbaden: VS Verlag: 267-282.

Rechel, B., Mladovsky, P., Devillé, W. (2012) Monitoring migrant health in Europe: A narrative review of data collection practices. Health Policy 105(1): 10-16.

Reitmanova, S. & Gustafson, D. (2012) Exploring the Mutual Constitution of Racializing and Medicalizing Discourses of Immigrant Tuberculosis in the Canadian Press. Qualitative Health Research 22(7): 911-920.

Ringelheim, J. (2011) Ethnic categories and European human rights law. Ethnic and Racial Studies 34(10): 1682-1696.

RKI (2008) Migration und Gesundheit. Schwerpunktbericht der Gesundheitsberichterstattung des Bundes. Robert Koch Institut: Berlin.

RKI (2010) HIV bei Migranten in Deutschland. Epidemiologisches Bulletin, 5:39-44.

RKI (2012) HIV bei Migranten in Deutschland. Epidemiologisches Bulletin, 3:19-26.

Rose, N., O'Malley, P., Valverde, M. (2006) Governmentality. Annual Review of Law and Social Science 2: 83-104.

Schirato, T; Danaher, G.; Webb, J. (2012) Understanding Foucault: A Critical Introduction. Second Edition. Los Angeles, London, New Delhi, Singapore, Washington DC; Sage.

Simon, P. (2007) "Ethnic Statistics" and data protection in the Council of Europe countries. Study Report. Strasbourg: Council of Europe.

Starr, P. (1992) Social Categories and Claims in the Liberal State. In M. Douglas and D. Hull (eds.) How Classification Works: Nelson Goodman among the Social Sciences. Edinburgh: Edinburgh University Press pp. 154–79.

Statistisches Bundesamt (2006) Leben in Deutschland: Haushalte, Familien und Gesundheit – Ergebnisse des Mikrozensus 2005. Wiesbaden: Statistisches Bundesamt.

Sokal, R. (1974) Classification: Purpose, Principles, Progress, Prospects. Science 185: 115-23.

UNESCO (2008) People on the move: handbook of selected terms and concepts (version 1.0). New York and Geneva: United Nations.

Triadafilopoulos, T. (2011) Illiberal Means to Liberal Ends? Understanding Recent Immigrant Integration Policies in Europe. Journal of Ethnic and Migration Studies 37(6): 861-880.

United Nations Committee on Economic Social & Cultural Rights (2000) General comment 14 on the Right to the Highest Attainable Standard of Health. E/C.12/2000/4. (General Comments); http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En accessed 19.06.2013.

White, K. (2002) An Introduction to the Sociology of Health and Illness. London, Ca: Sage.

Verkuyten, M. (2005) The Social Psychology of Ethnic Identity. Hove: Psychology Press.