An Intersectionality Informed Analytical Framework for Health Inequalities in Europe

The co-constituting roles of Socio-economic Position, Gender, and Migration

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Abstract

The current thesis brought together intersectionality and institutional approaches to health inequalities suggesting an integrative analytical framework that accounts for the complexity of the intertwined influence of both individual social positioning and institutional stratification on health. I argued that intersectionality provides a strong analytical tool for the study of health inequalities in Europe beyond the purely socioeconomic by addressing the multiple layers of privilege and disadvantage including race, migration and ethnicity, gender and sexuality. Further, I set out a research agenda considering the interplay between individuals and institutions and involving a series of methodological implications for quantitative and qualitative research. Building on this framework, I carried out research that involved both a quantitative and a qualitative design to study intersectional migration-related health inequalities among settled groups in Europe as well as among newly arrived refugees and migrants at the Greek borders as a context shaped at the intersection of border crossing, humanitarian aid and asylum policy mandated by the Greek government and the European Union. Overall, the results reveal the co-constituting role of socio-economic position, gender and migration in the production of health inequalities, and they highlight the role of migration as a social determinant of health and a stratification mechanism as well as the health impact of border and asylum policies in Europe. Finally, they offer important arguments and conclusions regarding the theoretical and methodological implications of intersectionality informed health inequalities research.

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Preface

"One contribution that intersectional scholarship can make to shifting the focus of health disparities research lies in asking new questions that emanate from the position of outsiders within and are generated from an explicitly recognised social agenda."

Schulz & Mullings, 2006

An outsider within sounds as an appropriate term to describe myself. Coming from a workingclass background, being the only person in my family who has entered the university, a woman, a migrant, and a lesbian, white, and a holder of European passport, it took me some time to understand my life experiences in a coherent way. From this perspective, it is not a coincidence that I spent a little more than four years engaging with intersectionality theory and working on this thesis. The most important lesson I 've learned through this process as a scholar but also as a person is that knowledge and life may work like a puzzle where every piece has its place. Sometimes, pieces do not fit each-other or they even contradict each other and put us in trouble. However, they are all part of the same picture and hence, we cannot simply discard what seems unfitting. My sense is that intersectionality as a perspective urges us to bring everything on the table and engage with the complexity of similarity and difference in order to finally make our research, work, and life puzzles look coherent although maybe not complete.

While working on this thesis, multiple times I felt that my background in quantitative methods and my focus on intersectionality were simply incompatible and I thought the same about myself being white and using a theory developed by black women. Still, through the process, I realised that what I wanted to do with this thesis was to ask new questions and join forces with the scholars who see health equity as the mirror of social justice. From this perspective, I tried to engage with intersectionality in a substantial and self-reflective way in order to understand and communicate to the research community the benefits it carries for health inequalities research not only as an analytical tool but also as a compass for the elimination of harmful social exclusions.

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Finally, I would like to thank Keli for her emotional labour and all the small gestures of care that made a big, big difference in my everyday experience during the final writing-up period.

Author's Declaration

With the current statement I declare that this thesis is a presentation of original work and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as references and they are available in the Bibliography.

Further, parts of this work have been already published or submitted for publication. The relevant papers are:

Gkiouleka, A., Huijts, T., Beckfield, J., & Bambra, C. (2018). Understanding the micro and macro politics of health: Inequalities, intersectionality & institutions-A research agenda. Social Science & Medicine, 200, 92-98.

Gkiouleka, A., Huijts, T. Intersectional Migration-Related Health Inequalities in Europe: Exploring the Role of Migrant Generation, Occupational Status & Gender- Submitted to Social Science & Medicine journal and currently under review.

As the leading author of both papers, I have set the aims and research questions, managed the data, conducted the analysis, wrote the papers and I was responsible for the submission procedure. The co-authors were aware that this work would be part of my PhD-thesis and they contributed by providing comments and approving the submitted material.

All the co-authors have read and approve the current statement.

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Chapter One

Introduction

Within almost fifteen years since EU enlargement in 2004, the initial widespread optimism about socio-economic convergence among the member states has yielded to the challenges posed by the ongoing debt and banking crisis (Kohl, 2015), which reinforced the neo-liberal restructuring of European welfare states and markets and increased social inequalities within and between countries (Hermann, 2017; Streeck, 2014). In this context, health inequalities studies have repeatedly shown that the lower life expectancy and the increased rates of mortality and morbidity among people with lower levels of occupational status, income, and education remain a crucial challenge (Eikemo et al., 2008; Mackenbach, 2006; Mackenbach et al., 1997; McNamara et al., 2017a). Specifically, working class Europeans appear to be the most vulnerable to overall poor health and to a number of noncommunicable diseases (McNamara et al., 2017b), while individuals with lower incomes appear more likely to report poor health even in generous welfare states like those in Scandinavian countries (Eikemo et al., 2008; Mackenbach, 2012). Finally, people with lower levels of education have been found to be more vulnerable to poor health as well as more likely to adopt specific risky health behaviors like smoking (Huijts et al., 2017). We can understand these findings, if we consider that the aforementioned dimensions of low socio-economic position are linked to individuals' health through multiple pathways that involve limited material conditions, an increased psychosocial burden, and health-threatening lifestyles (Balaj et al., 2017; Huijts et al., 2017; Pickett & Wilkinson, 2015; Wilkinson & Pickett, 2017).

Simultaneously, the ongoing and fluid patterns of mobility across Europe have changed the demographic characteristics of the populations residing in the region (La Parra-Casado et al., 2017; Geddes & Scholten, 2016), Moreover, the recent arrival of refugees and migrants from Middle Eastern and African countries through particularly risky and health-damaging migration trajectories (Sigona, 2018) have contributed to the emergence of significant differences between migrant and non-migrant but also within migrant populations in terms of health needs and profiles (Pavli & Maltezou, 2017; Silove et al., 2017). In this constantly changing context, diversity within European populations became more salient and more complicated (Kymlicka, 2015), while competition over socio-economic resources and bargaining for equality has gradually increased involving multiple groups shaped across multiple dimensions of difference like migration or gender (Briskin, 2014; Kymlicka, 2015).

In parallel, within this changing, competitive and exclusive context, research on the social determinants of health and health inequalities has also evolved from the consideration of the impact of strictly socio-economic dimensions like income or social class (Eikemo et al., 2008;; Mackenbach, 2006; Mackenbach et al., 1997; McNamara et al., 2017a), towards more integrative approaches that consider the relevance of additional determinants including gender categories, ethnicities, nationalities, and sexualities (Bambra et al., 2009; Blom et al., 2016; Eikemo et al., 2018; Meads et al., 2012; Stronks et al., 2013; Van der Star & Bränström, 2015) as well as their interactions (see for example Carrasco-Garrido et al., 2010 or Malmusi et al., 2010). Moreover, besides exploring the role of individual behaviors and living conditions, scholars interested in the study of causal drivers of health inequalities among population groups have been increasingly interrogating the role of macro- and meso-level factors and stratification processes as structural causes of inequalities in health (for an overview see Beckfield, 2018). However, what still seems to be missing, regarding the understanding of health inequalitiesproducing mechanisms, is a theoretical framework that will simultaneously integrate the interplay between horizontal (micro-level) and vertical (macro- or meso-level) processes of social stratification and that will document and interrogate inequalities among groups that emerge from the combination of multiple dimensions of difference (e.g. migrant versus nonmigrant working-class women). In this direction, emerging scholarship highlights the relevance of institutional theories of stratification (Bakhtiari et al., 2018; Beckfield et al., 2015), and intersectionality (Hill, 2016; Kapilashrami et al., 2015; Kapilashrami & Hankivsky, 2018; Lapalme et al., 2019; Lopez & Gadsden, 2016) and calls for empirical research that interrogates dynamic processes and pathways bridging upstream and downstream factors (Øversveen et al., 2017).

Contributing to this emerging stream of research and responding to relevant calls, the current thesis approaches health inequalities in Europe as a reflection of unequal social structures operating across multiple intersecting hierarchies of power (Collins & Bilge, 2016) and suggests an analytical framework for the study of health inequalities in Europe that integrates intersectional and institutional understandings of inequality. Further, it demonstrates how such an analytical framework can be integrated in a quantitative research design that allows us to reveal health inequalities among multiple groups as those emerge from the intersection between gender, occupational status, and migration categories; as well as in a

qualitative case study focusing on the health inequalities producing processes and pathways shaped by the intersection between border crossing, humanitarian aid and asylum policies at the Greek borders, and differentially affecting refugees and migrants according to their own intersectional locations.

1.1 Health and Health Inequalities as Political Issues

In everyday life, health more often than not is understood through a biomedical lens, which tends to focus on the absence of disease and symptoms (Maslow, 1981; Smith, 2017). However, this is just one of the multiple interpretations that the concept of health has acquired during its historical evolution that is also reflective of a rather narrow perspective. Specifically, since its earliest definition by Hippocrates in 400 B.C., health has been often understood as a holistic state of harmony and has carried a distinct social meaning that involves environmental as well as lifestyle factors (Ahmed et al., 1979; Larson, 1999). In 1948, the World Health Organization, incorporating this broader understanding, defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1948, Official Records of the World Health Organization, no. 2, p. 100). That way, the WHO expanded the scope of health so that it overlapped with the broader concept of well-being and it associated with its multiple societal implications (Mann et al., 1994). Contributing to this broadening of scope, theorists, since then, have defined health as the condition which allows individuals to adapt to environmental changes (Dubos, 1965); or alternatively as the condition that enables them to effectively undertake roles and tasks for which they have been socialised (Parsons, 1981); or as that situation that enables people to maximise their potential to fulfil their life goals (Seedhouse, 1986); and from a more critical and explicitly political perspective as "access to and control over the basic material and non-material resources that sustain and promote life at a high level of satisfaction" (Baer et al., 1986: 95).

What emerges from all the aforementioned definitions rather clearly is the dual content of health both as a goal to be pursued for itself and at the same time, as a resource necessary for the achievement of social and life goals (Sen, 2001; Simmons, 1989). In its dual role, health as a state of overall well-being has been associated with notions of human autonomy and dignity and it has been framed within the context of 'basic human needs' (Doyal & Cough, 2017). However, at the same time, health as a resource is subject to a series of economic, social and political arrangements (Sen, 2001) and thus, it is unequally distributed among individuals and groups according to their social power (Bambra et al., 2005). Understanding health as a distributed resource itself that enables individuals to secure their life chances and achieve satisfaction underlines emphatically the way that health is entangled within processes of social stratification and its inherent political nature (Bambra et al., 2005; Twaddle, 1974).

The dual and -up to a certain extent- contradictory understanding of health, as a basic human need and as a distributed resource, fuels significant tensions around emerging understandings of health inequalities and their political implications. Not surprisingly, as the concept of health itself, health inequalities have been conceptualized in multiple ways. Existing literature is roughly organized across three distinct approaches (Cockerham, 2015; Graham, 2007). The first approach conceptualizes health inequalities as mere differences between individuals and focuses exclusively on the distribution of health among individuals in a given population, without however accounting for within-population groupings (Goesling & Firebaugh, 2004; Murray et al., 1999). The second approach is rather considered with what we would call the social patterning of health. Hence, it conceptualizes health inequalities as differences between population groups. While it acknowledges that health outcomes differ among social groups defined on the basis of multiple criteria, like gender or socio-economic status, this approach does not address any explicit or implicit connection between inequalities in health and social inequalities between groups (Adler, 2006; Graham, 2007; Thomson et al., 2006).

Finally, the third approach conceptualizes health inequalities as differences between population groups that occupy unequal social positions and thus, it emerges as completely aligned with the social and political understanding of health. Seen from this perspective, health inequalities are understood as the avoidable outcome of social injustice (Dahlgren & Whitehead, 1991; Kawachi et al., 2002) as produced within a context of power asymmetries between different actors that operate at local, national but also transnational levels and shape policies and regulations far beyond the health sector (e.g. economic motives, national security) (Ottersen et al., 2014). In this sense, the social groups who experience the worst health outcomes are the same groups that experience a social disadvantage compared to other groups who are socially advantaged and healthier (Braveman, 2006; Braveman & Gruskin, 2003; Krieger, 2001; Mackenbach, 2005).

However, defining health inequalities in terms of politics and social injustice urges us to pay attention to the uneven distribution of health as a process evolving across two directions. On the one direction, poor health emerges as the outcome of the uneven distribution of social resources across individuals and groups. On the other direction, since health itself is one of individuals' resources or "substantive freedoms to choose a life" they have "reason to value" (Sen, 2001: 74), poor health implies lack of freedom to reach one's potential, and it also implies that one has less opportunities to make the ultimate use of other resources already available to them to achieve their desired goals (Sen, 2001). Given that more resources imply greater privilege and power acquisition, health inequalities among groups (re)produce inequalities in terms of social power. This cyclical process is reflective of the crucial ways that health interferes with social stratification processes and the way that its unequal distribution (re)produces social disadvantage for already socially disempowered groups.

In this light, throughout the current PhD thesis, health inequalities are understood in terms of social inequalities as reflected on the circumstances in which people are born, grow up and age, what social epidemiologists define as *social determinants of health* (Marmot & Wilkinson, 2006), and their uneven distribution. In the following paragraph, I elaborate on how socio-economic position was traditionally approached as the key social determinant of health in health inequalities literature.

1.2 Socio-economic Position as the Key Determinant of Health

Socio-economic position refers to the social and economic factors that influence what positions individuals hold within the structure of a society, and it involves concepts with different historical and disciplinary origins (Galobardes et al., 2006). Before proceeding with the discussion of the theoretical origins of the concept, it is useful to stress that researchers (Flaskerud & DeLilly, 2012; Phelan et al., 2004; 2010) have emphasized the importance of socio-economic position as the key marker of the command that individuals have over social and material resources distributed through major institutions and associated with health risk and disease. From this perspective, socio-economic position has been defined as the 'fundamental cause' of health (Link & Phelan, 1995), and it has been associated with health inequalities as a key determinant of differential access to health promoting or protective resources (Braveman & Gottlieb, 2014; Macintyre, 1997). Research has repeatedly shown that being poor has a negative impact on health and mortality (Antonovsky, 1967; Hu et al., 2016; Huisman et al., 2013; Krieger et al., 1997; Syme, 1992; Sigerist, 1951; 1961); that income

inequality associates with infant and adult life expectancy and mortality (Neumayer & Plümper, 2016; Wilkinson, 1994;1992a,b; Wilkinson & Pickett, 2008). Moreover, beyond its impact on individuals' health and longevity, socio-economic position appears to significantly associate with individuals' beliefs regarding their health as well as the extent to which they feel they are in control of their lives (Hvidberg, et al., 2015; Illsley, 1980; Wardle & Steptoe, 2003;).

The use of socio-economic position in epidemiological research roots back to the work of Marx and Weber. According to Marx, understanding of the society would be effective only through the understanding of the organization of production as the basis for the emergence of social classes within a capitalist society. Throughout his analysis, social class is defined by the relationship of individuals with the means of production, while it is understood both as a condition of social life, and as a stimulus for collective action. From this lens, social class is fundamentally a politicized notion because besides the relationship of individuals with the means of production, it is also telling of the relationships between different social groups as collective agents. Regarding the more economically advanced societies, Marx was particularly concerned with the polarization between the owners of the production means and the workers, and he recognized the conflicts between the two as a vector of social change. More specifically, he defined ownership as the precondition for the exercise of power, not only as economic dominance of the capitalists over the dependent employees but also, as the overall hegemony of the production means' owners across the social, the cultural as well as the political sphere. On the counterpoint of ownership, Marx was seeing deprivation, experienced collectively by the workers, as the outcome of the capital's domination, which could urge workers to act collectively in their pursuit of social power (Marx & Engels, 1967; Schmitt, 2018).

On the other hand, while adopting the baseline of Marx's work regarding the significance of property ownership and the division of labour for the formation of social structure, Weber's own analysis on social stratification takes additional dimensions into consideration. The Weberian line of reasoning suggests that society is hierarchically stratified along many dimensions creating groups whose members share a common market position that consequently results in shared 'life chances' (Galobardes et al., 2006; Weber, 1958). Weber's arguments are mainly based on two observations. First, that beyond capital owners and workers, there is a multitude of property, commercial and social classes, and second that economic as well as political convergence and collective action is often weakened by differences on the basis of ethnicity, citizenship, religion or language. Further, Weber introduced the concept of social status as an 'effective claim to social esteem' associating with ancestry, lifestyle patterns, formal education, or occupation (Weber, 1968: I, 305-6).

What is particularly interesting in his analysis at this point, is his recognition that social status is related to and distributed across multiple dimensions, the salience of which may differ across societies (e.g. citizenship, educational qualifications, income, family formation or other criteria) (Hall & Lamont, 2009). In this line, socio-economic position emerges as an aggregate concept that involves two aspects; namely, one reflecting material social resources and one reflecting the social prestige that derives from one's rank in a social hierarchy (Galobardes et al., 2006; Krieger et al., 1997). This allows the understanding of socio-economic position as a fluid concept that is not solely defined by social class and the rather fixed positions it involves within the economy (e.g. being an employer or employee), but rather it incorporates social class together with other less or more stable components across contexts and across one's life-course (e.g. education compared to parental occupational status) (Krieger, 1997). From another viewpoint but with a similar reasoning, Bourdieu associated socio-economic position with access to a series of goods and resources, or in his own terms, capital (Bourdieu, 1986). Bourdieu instead of focusing solely on economic capital, distinguishes between four main forms; namely, economic capital, social capital involving relationships with significant social others, cultural capital and symbolic capital involving prestige and honour (Bourdieu, 1978; Bourdieu & Wacquant, 1992; Williams, 1995).

Conceptualizing socio-economic position as an aggregate notion that shapes the distribution of material, social but also cultural resources, it comes as no surprise that its impact on health has been extensively explored. Existing research implies that there is no single factor that links socio-economic position to individual health but rather there are multiple mediating pathways including both the material-based and the prestige-based aspects of socio-economic position (Krieger et al., 1997). Studies focusing on the impact of social class from a Marxist perspective have shown that social class understood as a social relation of ownership or control over productive assets, explains inequalities in certain health outcomes and especially among men (Muntaner et al., 2003) and it strongly predicts mortality rates among working class men (Muntaner et al., 2009). Moreover, lower employment position has been associated with greater disease and mortality risks (Macleod et al., 2005). Further, alternative approaches, adopting the Weberian line of reasoning, have revealed that several material components of socio-economic position, especially income and housing tenure associate significantly with inequalities in mortality (e.g. Chandola, 2000). Others focusing on prestige-based resources,

have suggested that the social status as 'a social claim' conditions a person's self- image, selfconfidence and self-efficacy, affecting the levels of stress or anxiety without necessarily involving feelings of relative deprivation (Hall & Taylor, 2009). Finally, other studies have shown that the association between low socio-economic status and health is explained via the differential distribution of material, occupational as well as psychosocial factors (Aldabe et al., 2011; Balaj et al., 2017).

However, the various pathways linking socio-economic position with individual health have not been the sole interest of scholars in the field. An emerging stream of research is increasingly concerned with social position as the outcome of multiple social categories relevant with the distribution of resources and power (Graham, 2007). In line with a Weberian view on socio-economic position as the outcome of multiple dimensions, theorists suggest that health as any other aspect of life is not experienced in layers and thus, it should not be studied as such (Krieger, 2011). In order to understand the impact of social stratification on people's health, we need to take into consideration all the relative dimensions involved in the emergence of the social hierarchical structure that entrenches economic, social and political advantages for certain individuals and groups (Byrne, 2006). However, in order to account for that complexity, we need to be driven by an analytical framework that will allow us to approach social stratification as a process that evolves across multiple intersecting hierarchies of power operating both at the micro- and the macro-level. In the following paragraph, I briefly introduce how intersectionality theory can inform the development of such a framework and allow us to account for the simultaneous and intersecting impact of socio-economic position, gender and migration for the study of health inequalities in Europe.

1.3 Intersectionality and Health Inequalities in Europe: The Co-constituting Role of Socio-economic Position, Gender and Migration

Introduced by Black feminist and critical scholars (Crenshaw, 1989), intersectionality sought to complicate understandings of race and gender-based scholarship. The notion was initially developed by the need of Black critical thinkers to describe multiple disadvantage, like that experienced by African-American women, as a unique experience; one that could not be understood by approaches that treated race and gender as distinct subjects of inquiry (Bauer, 2014). Since then, intersectionality as an analytical framework has gained increasing ground

within the broader field of sociology (Andersen & Collins, 2012; Bowleg, 2008; Choo & Ferree, 2010; Collins & Bilge, 2016; Goldberg, 2009; Walby, 2007) for the understanding of social stratification and social positioning (Yuval-Davis, 2015). Put briefly, intersectionality suggests that social categories like social class or gender are not individual attributes but rather inter-related systems of power hierarchies that operate simultaneously producing social privilege and disadvantage and resulting in complex social, material and cultural inequalities differentially affecting individuals and groups according to their locations across those hierarchies (Collins, 2015). From this point, inequalities emerge from the interplay between horizontal (micro-level) and vertical (macro-level) processes of stratification as the way that individuals are affected by structural factors differs according to their intersectional locations across the multiple axes of social hierarchy (Collins & Bilge, 2016).

The interest of health inequalities researchers in intersectionality has been rather recent, but it seems to bear a promising dynamic (Bauer, 2014; Bekker, 2003; Hankivski, 2012; Iyer et al., 2008; Palencia et al., 2014; Sen & Iyer, 2012). Scholars who encourage the integration of an intersectional approach in the study of population health, trace the benefits of such a project in the following. First of all, such a project compensates for the long-lasting limited scope upon the relationship between social position and health from the perspective of socioeconomic position and accounts for the role of multiple social categories (e.g. gender or ethnicity). Secondly, it opens a new broad field for the investigation of how the distribution of resources as well as the mechanisms and processes behind it disproportionally maintain and reproduce social and -by extension- health privilege and disadvantage among individuals and groups (Kapilashrami et al., 2015). Examples of relevant research include studies on HIV risk among Latino women (Collins et al. 2008) and black African migrants in London (Doyal, 2009), on the impact of intersections between race, class, gender and sexual orientation on individual health and especially on the simultaneous impact of social privilege and/or disadvantage (Iyer, et al., 2008; Sen et al., 2009; Sen & Iyer, 2012; Seng et al., 2012; Veenstra, 2011) or policy analyses focusing on the intersections present at the contextual level between state policies and/or institutions (Hankivsky and Cormier, 2011; Palencia et al., 2014; Raphael & Bryant, 2015; Viruell-Fuentes et al., 2012).

However, despite the increased popularity of intersectionality in various scientific domains (for an overview see Collins & Bilge, 2016), intersectional health inequalities research in Europe is still at a primary stage. Given the theoretical and political roots of intersectionality in the US context, public health scholars interested in the topic have stressed that

intersectionality as an analytical tool for health inequalities in Europe should be used for the study of the intersecting impact of social categories involved in social stratification processes in the particular context. In this direction, beyond socio-economic position or social class, scholars focusing particularly on the UK, have elaborated on the need to consider the role of gender, ethnicity and caste-based categories (see for example Hill, 2016; Kapilashrami et al., 2015).

Building on this work, I consider that while looking at the broader European context, the role of gender as a mechanism of social stratification and a driver of intersecting health inequalities emerges quite clearly regardless of national differences (Palencia et al., 2014). Gender has been extensively studied as a social determinant of health moderating the resources available to individuals to achieve their highest potential in health (Annandale, 2009; Annandale & Hunt, 2000). Given that men have much greater access to health promoting resources than women (Doyal, 2000), health inequalities research has traditionally focused on the study of inequalities between men and women as an outcome of this imbalance. A pattern that appears repetitively in Europe as in other economically advanced countries is that women live longer but enjoy less healthy years than men, and women tend to report worse self-rated health than men, especially so, in countries with social democratic or southern welfare regimes (Bambra et al., 2009). Further, a series of additional studies confirms the excessive prevalence of poor general physical and mental health for women compared to men (Artazcoz et al., 2001; Bambra et al., 2009; Hosseinpoor et al., 2012; Van de Velde et al., 2010). Aiming to analyze those patterns, Palencia et al. (2017) found that men's shorter life expectancy is mainly explained by biological characteristics related with disease susceptibility and by dangerous behavioral patterns among men deriving from mainstream gender stereotypes. However, women's increased vulnerability to poor health was associated with their subordinate position within the patriarchal system.

However, when it comes to ethnicity, as a social category relevant to intersecting health inequalities in Europe as an integrated context of multiple countries, things are more nuanced. Ethnic minorities differ across European countries according to their colonial and migration histories, while the same ethnic groups do not deal with the same conditions across different countries (Blom et al., 2016). On the contrary, I claim that looking at Europe as a broader multinational context, migration emerges as a salient and relevant category for social stratification and health inequalities. Migration as an experience and a legal status has recently emerged as a factor shaped by but also shaping the conditions within which people live and hence, as a

determinant of their health (Castaneda et al., 2015). Migration is associated with a series of social determinants like material deprivation, lack of civil rights, persecution, traumatic experiences, discrimination and racism (Bradby, 2015). Such forces may operate as push factors that motivate people to immigrate, as corollaries of the actual migration process, and as the conditions in which migrants find themselves in the hosting societies for shorter or longer periods of time. Hence, the migration experience has a cumulative impact on individual health. In addition, being classified as a migrant has multiple implications for the extent of social and health care rights that individuals are entitled to and this further affects migrants' opportunity to achieve their health potential (Blom et al, 2016; Link & Phelan, 1995; Thomas, 2015). Relevant research in Europe has revealed that health inequalities between migrants and nonmigrants as well as between different migrant groups do not follow a unitary pattern. Rather, these patterns seem to be subject to migrants' generation status, and to a series of factors both in the country of origin (i.e. political suppression) and in the country of destination (i.e. the quality of health care system) (Huijts et al., 2012; La Parra et al., 2017). Moreover, it has been found that refugees compared to other migrant and non-migrant groups suffer worse mental health and women in particular, report more perinatal problems (Bradby et al., 2015). These findings particularly highlight how migration status interacts with additional social categories and individual characteristics as well as with structural and institutional factors involving policies and welfare systems.

1.4 Aim and Research Questions

In the current thesis, I am concerned with the development of an intersectionality informed analytical framework for the study of health inequalities in the particular context of Europe. This framework explores the intersecting impact of socio-economic position, gender and migration on people's health, while adopting a situated approach (Yuval-Davis, 2015), that renders it open and sensitive to the emergence of additional intersecting categories as reflective of inequality producing processes.

This aim is addressed through the following research questions:

1. What are the theoretical and methodological implications for the study of health inequalities research in Europe that emerge from the development of an intersectionality informed analytical framework?

2. What health inequalities research agenda emerges from such an analytical framework?

3. What health inequalities emerge among social groups, if we consider the simultaneous intersecting impact of gender, socio-economic position and migration status in Europe? Which are the groups with the greatest health advantage and disadvantage?

4. Do European border crossing and asylum policies contribute to health inequalities among migrant and refugee groups in Europe; and what kind of processes taking place at the external European borders are responsible for the production of such inequalities?

1.5 Contributions

The current thesis contributes to health inequalities and intersectionality research in the following ways.

Understanding health inequalities as power inequalities.

The on-going neo-liberal restructuring of European economies and welfare states (Hermann, 2007; 2014) has been combined with the simultaneous financialization of everyday life, the dominance of the ideology of self-responsibility as well as with the subordination of social relationships and problems to economic criteria (Fine & Saad-Filho, 2017). Embedded in this context, where social and political problems are framed in economic terms, studies on health inequalities have tended to seek for causal factors mainly within the individual level and mainly among components that acquire their meaning within market and economy, either this is income, educational attainment, or occupational status. Indeed, all of these components, as indicators of available material resources, or social status have multiple implications regarding how individuals experience their life. Still, these components alone or even combined cannot

fully explain individuals' capabilities to control their life, or their context, and to pursue a life that will satisfy them (Sen, 2001).

As explained in previous sections, understanding health as a broader state of well-being urges us to account for the social and political nature of it and to explore the way health is subject to imbalanced social power dynamics (Bambra, 2005). This implies that we need to explicitly frame health inequalities as social inequalities but at the same time to approach social inequalities not solely as economic differences but rather as imbalanced power relations among individuals and groups (Fine & Saad-Filho, 2017). From this perspective, materialist explanations of health inequalities focusing exclusively on socio-economic inequalities while avoiding or failing to connect them with their underlying political motives and power relations can neither grasp the complexity of the issue nor provide sufficient tackling strategies and solutions (see for example Blane et al., 1998; Eng & Mercer, 2000; Hajat et al., 2007; Mackenbach et al., 1993). Rather, we need to insist on making these underlying political motives explicit and to address the underlying power inequalities, social struggles and conflicts between privileged and disadvantaged groups reflected on uneven resources' distribution (see for example Bambra, 2017; 2018; Beckfield, 2018; Fritzell & Lundberg, 2007; Muntaner et al., 2010).

Incorporating an intersectional understanding of social stratification (Yuval-Davis, 2015), leads us directly to approach socio-economic position as well as gender and migration, as power hierarchies and thus, to frame health inequalities as power inequalities emerging from the intersection between socio-economic, gender and migration hierarchies in Europe. From this perspective, documenting health inequalities between groups, reveals the extent to which certain groups enjoy positive health outcomes emerging from the accumulation of social advantage across the examined power axes (e.g. non-migrant men with high socio-economic position); the extent to which the health of other groups is negatively affected by occupying multiply disadvantaged social locations (e.g. migrant women with low socio-economic status), and the extent to which the interplay between social privilege and disadvantage (as for example in the case of migrant men with low socio-economic position) associates with positive or negative health outcomes (Iver et al., 2008; Kapilashrami et al., 2015). Further, approaching socio-economic position as a fluid aggregated notion (Krieger, 1999), which operates in relation to additional social categories and particularly gender, and migration while being subject to the context where individuals are embedded (Anthias, 2013; Yuval-Davis, 2015), will enrich our analysis of social stratification in Europe regarding its impact on health.

Migration as a social determinant of health in Europe.

As stressed earlier, although migration has been increasingly integrated in health inequalities research in Europe, there are still important gaps regarding the way migration is entangled within stratification processes as a legal status, a social category but also as an experience. Research findings on migrants' health and migration-related health inequalities are still inconclusive, while migration is often conflated with categories of ethnicity, race, nationality or even citizenship (Blom et al., 2016; Stathopoulou et al., 2018). The current thesis acknowledging these gaps builds on existing work on migration as a social determinant of health (Castañeda et al., 2015) and explores its intersecting impact with socio-economic position and gender on people's health in Europe. It addresses the ways that migration as a category is conflated with additional categories and particularly nationality, ethnicity and race in public discourse and in research (De Genova, 2018; Goldberg, 2006), and explores the extent to which different migration categories (i.e. migrant, first-generation, second-generation, and refugee) associate with health disadvantage in Europe (Bradby et al., 2015; La Parra-Casado et al., 2017). This way it manages to highlight the significance of migration as a socially constructed category in the European context that should be integrated in health inequalities research more systematically and it offers useful insights regarding health inequalities within migrants according to their 'internal' differences across migration and generation status, gender, and socio-economic position. Moreover, by offering empirical evidence regarding the negative effect of migration on people's health, it encourages intersectionality research and scholarship in Europe to integrate it as an additional hierarchical system operating in the particular context (Yuval-Davis, 2015).

Up-stream level explanations.

The current thesis contributes to the emergent scholarship considered with the role of macro-level factors (i.e. policies, institutions) in the (re)production of health inequalities and the need for the development of a theoretical framework that will integrate social theory and particularly institutional theories of social stratification (Bambra, 2017; 2018; Beckfield, 2018; Beckfield et al., 2015; Hill, 2016; Kapilashrami et al., 2015; Øversveen et al., 2017; Raphael & Bryant, 2015). In this thesis, institutions are approached in line with new sociological institutionalism (for an overview see Hall & Taylor, 1996) as 'combinations of schemas, resources and practices that organize power' (Beckfield, 2018: 1). From this viewpoint, beyond

formal rules and procedures (e.g. welfare state systems), institutions involve cultural elements that provide certain 'frames of meaning' (Hall & Taylor, 1996) and play a decisive role in social stratification in material (e.g. resources distribution) but also in symbolic terms (e.g. by deciding who is part of a national narrative and who is not). Hence, they involve rule-like arrangements formal or informal, present at multiple levels of analysis including the meso-level (i.e. neighborhoods or organizations) (Beckfield et al., 2015).

Accordingly, the suggested intersectionality and institutionally informed analytical framework for the study of health inequalities as presented in chapter four accounts for the study of institutions as heterogeneous (e.g. from formal policies to symbol systems), intersecting entities that impact on the production of social privilege and disadvantage beyond just socio-economic (re)distribution. Further, it suggests that due to their central role in power organization, institutions are directly or indirectly linked with health inequalities through multiple simultaneous and interacting processes evolving across different analytical levels (Beckfield et al., 2015). In the same chapter, I elaborate on how an intersectional approach offers us the analytical tools to engage with the heterogeneity of institutions and their situatedness in particular contexts, and to interrogate the interactions of the macro, meso and the micro facets of the politics of health. Moreover, based on this broader definition of institutions, I offer an updated health inequalities research agenda that is considered with the health impact of institutional factors that operate outside the domain of labour market, social welfare and healthcare, including migration and border control policies.

Moving on from the suggested analytical framework to the empirical chapters of this thesis, in chapter five, institutions are integrated in the study of intersectional migration-related health inequalities in Europe in the following ways. First of all, the choice of the examined social categories of migration status, gender and occupational status emerged due to their salience as axes of social stratification in Europe. From this perspective, the health inequalities discussed in chapter five are understood as the outcome of the power structures organized across these axes, (i.e. nationalism, patriarchy, and neo-liberal capitalism) and all the 'combinations of schemas, resources and practices' associated with these structures. Moreover, as explained in the chapter, the power structures around gender, class and migration status are global in nature, still, their scope and organization may vary across countries. Although the study does not focus on the role of particular institutions operating in the examined national contexts, the conducted multilevel analysis accounts for their macro-level impact on

individuals' health and hence for their role in the emergence of multiple relationships of health inequality among social groups.

Further, institutions are integrated in chapter six that is a case study on the ways that the intersection between border crossing, humanitarian aid, and asylum policy as shaped by the Greek government and the European Union impacts the health of migrants and refugees in their diversity and produces health inequalities. This case study adopts the broad understanding of institutions presented above and is concerned with formal and informal rule-making arrangements operating at the Greek border spaces, co-producing and distributing health privilege and disadvantage. The data analysed involve documents produced by humanitarian organizations as institutions active at the Greek borders at the meso-level but also embedded in the broader Greek national and European Union's context. Hence, while focusing on the role and narrative of humanitarian organizations as institutions, the analysis is also concerned with the intersecting impacts of the national asylum policies, transnational migration regulations as well as with the broader schemas associated with racism, nationalism, sexism and capitalism in Europe.

Theoretical and methodological challenges in applying intersectionality arguments. The thesis employs intersectionality as a critical analytical lens (Collins & Bilge, 2016; Hancock, 2013) in order to develop a framework for the understanding of health inequalities in Europe across the intersecting dimensions of socio-economic position, gender and migration and the emergence of a research agenda. Further, it explores the extent to which such a framework can be applied in a quantitative and a qualitative design. Through this process, I contribute theoretical arguments regarding the relevance of intersectionality for the understanding of health inequalities between and within groups as well as for the importance of context and institutional factors in health inequalities producing processes (Lapalme et al., 2019). Moreover, I reflect on the methodological challenges I encountered providing critical arguments regarding the extent that the employed quantitative and qualitative research designs aligned with intersectionality's analytical underpinnings. This way, I provide empirical arguments for the development of an intersectional methodology in health inequalities research.

1.6 Format of the Thesis

Chapter Two situates the current thesis within the broader literature on socio-economic inequalities in health, reviewing materialist, behavioural, psychosocial approaches as well as eco-social theory, life-course and political economy approaches. Further, it offers useful insights regarding the way that the political processes of capitalism transition and neo-liberal restructuring, the stratification role of welfare-state regimes, as well as the political integration of subordinated social groups associate with health inequalities. Then, it zooms into women, ethnic, racial and migrant minorities as subordinate groups and offers a brief overview of the available explanations regarding, gendered, ethnic, racial and migration-related health inequalities. Finally, it frames the discussed health inequalities in the context of power relations and introduces the relevance of intersectionality theory.

Chapter Three offers a review of the methods employed in quantitative health inequalities research discussing the different indicators used for the measurement of individual level dimensions including health, gender, migration status, socio-economic position, as well as health inequality, the integration of institutional factors, and the challenges relevant to quantitative comparative designs. Then, it discusses intersectionality's analytical and methodological underpinnings and reviews the ways that intersectionality has been empirically integrated in health inequalities studies. The final section of the chapter introduces the reader on the way that intersectionality is empirically applied in the context of this thesis.

Chapter Four brings together intersectionality and institutional approaches to health inequalities, suggesting an original analytical framework that accounts for the complexity of the intertwined influence of both individual social positioning and institutional stratification on health. This chapter advances the emerging scholarship on the relevance of intersectionality to health inequalities research. I argue that intersectionality provides a strong analytical tool for an integrated understanding of health inequalities beyond the purely socio-economic by addressing the multiple layers of privilege and disadvantage, including race, migration and ethnicity, gender and sexuality. Further, I demonstrate how integrating intersectionality with institutional approaches allows for the study of institutions as heterogeneous entities that impact on the production of social privilege and disadvantage beyond just socio-economic (re)distribution. This leads to an understanding of the interaction of the macro and the micro facets of the politics of health. Finally, I set out a research agenda considering the intersections between individuals and institutions and involving a series of methodological implications for research - arguing that quantitative designs can incorporate an intersectional institutional

approach. This research agenda informs the questions and methods employed in chapters five and six.

Chapter Five integrates intersectionality theory and employs a quantitative design to explore how migration-related health inequalities in Europe interact with migrant generation, occupational status and gender. Single level and multilevel logistic regression analyses are conducted using pooled data from six waves of the European Social Survey (2004-2014), from 27 countries for two subjective health measures (general self-reported health and hampering conditions). The results document that the 'healthy migrant effect' seems to apply particularly for first-generation migrants working as manual employees, that women are more likely to report negative health outcomes than men regardless of their migration and occupational status and that within occupational categories, in certain cases non-migrant women are more susceptible to poor health than migrant men. This evidence highlights how the health impact of migration is subject to additional dimensions of social positioning and calls for further intersectional research on migration-related health inequalities in Europe.

Chapter Six demonstrates how intersectionality used as an analytical tool can be used for the study of the way that institutional factors beyond healthcare and welfare (re)produce health inequalities. This chapter is a case study that focuses on refugees' arrival in Greece and offers an analysis of the health-related response to that heterogeneous population on the move as it evolved from the summer of 2015 till the summer of 2018 at the Greek borders. I conducted an intersectional analysis of the publicly available documents produced by the UNHCR and its major partnering humanitarian organizations involved in the domain of migrants' and refugees' health at the borders in order to explore how the intersection between humanitarian aid, border crossing and the asylum system as shaped by the Greek government and the European Union impacted the health of migrants and refugees in their diversity. Taking into consideration the multiple dimensions of difference within the arriving groups, this analysis adopted intersectionality as critical inquiry (Collins & Bilge, 2016), and explored which social categories and their intersections were explicitly salient and implicitly relevant for the distribution of social determinants of health and health care services in the particular context. The findings show that refugees' reception in Greece as shaped at the intersection of border crossing, asylum policy and humanitarian aid produces health disadvantage for everyone who has to go through the process. However, there are qualitative differences among groups in terms of the specific pathways through which their health is affected.

Finally, Chapter Seven discusses the main conclusions regarding the relevance of the suggested intersectionality informed analytical framework for health inequalities research in Europe, the main findings of the thesis, as well as the relevance of migration as a category for health inequalities in Europe and intersectionality research. Moreover, in this concluding chapter, I discuss the main challenges and implications regarding the development of an intersectional methodology as I encountered them across the research process, and I reflect on the applicability of the suggested intersectionality informed analytic framework.

Chapter Two

Literature Review: Health Inequalities, Mainstream and Integrated Explanations and Power Relations

As described in the introduction, this thesis aims to integrate intersectionality and institutional approaches in health inequalities research in Europe, in order to develop an integrative analytical framework that accounts for the intertwined influence of individual social positioning and macro-level processes of social stratification on individual health. The aim of this chapter is to situate the thesis within the broader literature on health inequalities in Europe, to address the emerging gaps and points of tension and to highlight how the suggested intersectionality and institutional framework can advance our understanding of health inequalities as the outcome of simultaneous processes of horizontal and vertical stratification. In line with the thesis' focus on the co-constituting impact of socio-economic position, gender and migration, the first section of this chapter focuses on socio-economic inequalities in health and reviews the three mainstream explanatory approaches; namely materialist, behavioral, and psychosocial approaches, and continues by engaging with the main points of criticism and alternative views suggested according to eco-social theory and the life-course approach. The next section reviews health inequalities research approaches that examine the role of structural factors and political processes. In that section, I pay particular attention to the transition to capitalism and neo-liberal restructuring, welfare state regimes' stratification and the political integration of subordinated social groups. I continue from there by summarizing the main explanatory approaches on why women, migrants and ethnic minorities bear a health disadvantage due to their subordinate social position and I review the general patterns of gender, ethnic and migration related health inequalities as evidenced by existing empirical studies. Finally, I discuss health inequalities in the context of power relations and introduce the relevance of intersectionality theory.

Before proceeding, I would like to state that in this review, I decided to engage with literature about the social stratification axes that are the focus of my thesis. However, adopting a situated intersectionality approach that is sensitive to the particularities of the examined contexts and the situatedness of categories of social division, their meaning and their power, allows for the emergence of additional relevant axes of social stratification to emerge (Yuval-

Davis, 2015). Hence, throughout the thesis, additional social stratification axes emerge as relevant for health and health inequalities (e.g. sexuality in chapter four, generation status in chapter five, and age and marital status in chapter six) which are not explored in detail within this literature review. Literature on these additional axes' relevance for health is presented within the following chapters.

2.1 Socio-economic Inequalities in Health

The association of higher mortality rates and low socio-economic position has been addressed since the early 19th century. However, it wasn't until the 1970s and Navarro's critical work on the impact of capitalism on health that sociologists started to engage with the mechanisms through which the working and living conditions shaped in capitalist economies affected workers and their families (Turner, 2004). A bit later, in 1980 the release of the Black Report in Britain revealed with accuracy the marked inequalities in mortality and morbidity rates among different occupational classes, with those at the lower strata systematically suffering worse health and higher mortality rates irrespective of death cause (Black et al., 1980). What was particularly striking in those findings was that even in a society with universal access to health care, those less well-off were still disadvantaged in terms of health and longevity. Until today, those alarming findings have fueled a whole new stream of research on health inequalities across various fields (Mackenbach et al., 1997; 2008; Marmot & Wilkinson, 2006; McNamara et al., 2017a; Van Doorslaer & Kooman, 2004; Wilkinson, 1994; 1996; 1997) and generated new insights for policy decision makers and international health institutions (WHO, 1997). What we still see is that people with higher educational levels, occupational status and income are healthier and this applies to a similar extent across societies regardless of their level of economic development (Beckfield et al., 2015; Eikemo et al., 2008; Huijts et al., 2010; McNamara et al., 2017b). Mainstream materialist, behavioral, and psychosocial approaches have explained this imbalance on the basis of individuals' socioeconomic position, perceived as a key determinant of health focusing however on distinct and ostensibly autonomous linking pathways (Bartley et al., 2016).

2.1.1 Materialist approaches.

Materialist approaches were promoted within the Black report as the most effective in explaining health inequalities (Black et al., 1980; Blane et al., 1997) and hence, sparked an increased interest among researchers in the impact of material living and working conditions on peoples' health. The evidence suggesting that there are material causes of health inequalities among different social groups derives from research findings showing that people with lower income present increased morbidity and mortality rates (Marmot et al., 1991; 2001; Neumayer & Plümper, 2016; Raphael, 2011; Shaw et al, 1999). However, the relationship between income and health is not direct, as money and wealth cannot literally influence health outcomes. This pathway is rather mediated by the individual exposure to material hazards like pollution, inadequate housing, accident hazards at the work place and access to material resources (Blane et al., 1998; Eng & Mercer, 2000; Lahelma et al., 2009; Mackenbach et al., 1993; Schrijvers et al., 1998). The theoretical background of this approach lies in the Weberian understanding of socio-economic position as market position and links to Bourdieu's conception of material forms of capital (Bourdieu, 1986). In this line, it is suggested that material resources are distributed among individuals and groups according to their position in the social structure and define what Weber calls 'life chances' (1958) and Sen calls 'capabilities' (2001) meaning the extent that individuals and groups are able to live a 'life worth living'. In this line of argument, it is hypothesized that disadvantaged social groups in terms of income have poorer health because they are exposed to greater occupational and environmental hazards while they have less access to health protecting goods and services. For example, fuel poverty that refers to a household's inability to maintain an adequate level of warmth has been recently found to be a key determinant of health among low-income populations in Europe (Bosch et al., 2019).

One of the challenges rising in relation to materialist explanations derives from findings which show that health outcomes do not only differ between the richest and the poorest groups but rather there is a socio-economic gradient which shows that the higher individuals stand on the socio-economic ladder (whether measured by income, occupational category, or educational level), the better health they enjoy (Adler & Ostrove, 1999; Kawachi et a., 2002; Marmot, 1991). This gradient implies that material health advantages are not only provided by the amount of money that someone earns; if it was so, health disadvantage would disappear as soon as somebody had sufficient access to food, housing and medical care. The gradient in health emerges as an issue that affects the society as a whole and associates with gradients in unemployment, education, conditions of daily life which are nothing less than the reflection of

inequalities in terms of power and the result of social injustice (Marmot, 2015; Wilkinson & Pickett, 2009). Power encompasses the extent that people are able to exercise control over society's resources and thus, it is directly linked to health and life chances individuals enjoy (Bartley, 2004; Beckfield, 2018; Turner, 2004). An illustrative example of research highlighting the relationship between social power and health is found in Krieger's work, that showed that the abolition of Jim Crow Laws in the United States (i.e. state laws legalizing racial discrimination overturned by the US Civil Rights Act) had a decreasing impact on infant mortality among black Americans (Krieger et al., 2013). Further, the capacity of individuals to control their environment and hence, their life, has been extensively explored in health inequalities research in terms of its physiological impact (Lachman et al., 2011; Wilkinson & Pickett, 2009). Feelings of stress and helplessness that people experience when they lose control of their lives, when they lack resources to deal with life challenges and when they are prohibited from participating in the society in their full potential; feelings that are more prevalent among socially disadvantaged groups have a physiological impact to the brain and its neurons that have been associated with negative biological changes (Marmot, 2005; Seeman et al., 2014; Wolfe et al., 2012). The role of income as a moderating factor of exposure to negative feelings and stress takes us to the second main explanatory approach to health inequalities that focuses on the way that social inequality makes people feel (Bambra, 2011) and which is described in the following section.

2.1.2 Psychosocial approaches.

Beyond interrogating the health impact of stress and negative feelings emerging from people's inability to control their life, the psychosocial perspective is concerned with the psychological impact that derives from one's position in the social structure. Hence, the main hypothesis here is that the health gradient is the outcome of feelings emerging from inequality that people experience within the social contexts in which they are embedded (Kawachi et al., 1997; Marmot, 2005; Pickett & Wilkinson, 2015; Wilkinson & Pickett, 2009). Building on this fundamental hypothesis, four prominent models have emerged within the psychosocial approach. The *social stress model*, emerging from the sociologically oriented tendency within stress research (Aneshensel 1992; Pearlin, 1989), suggests that stressors, particularly long term, are unevenly distributed in society in accordance with structural inequalities, while the same

applies for the buffering resources. Thus, psychological stress varies with social position and results in social variations in health. Research in this stream has often focused on increased allostatic load (i.e. the strain caused to the body from the overactivation of the nervous, endocrine and immune system caused every time a person tries to adjust to challenges) and has shown its positive association with negative health and cognitive outcomes (Juster et al., 2010) as well as with low socio-economic position (Gustafsson, 2011; Seeman et al., 2010). Moreover, studies have highlighted the long-term impact of stress exposure and cumulative allostatic load during childhood on health later in life (Danese, 2012; Evans & Kim, 2012; Solis et al., 2016).

The *self-efficacy model* (Aneshensel, 1992) shifts our focus to human agency and suggests that the 'extent to which people see themselves as being in control of the forces that importantly affect their lives' (Pearlin et al., 1981: 340) is a self-promoting factor as it protects us against the damaging effects of adverse external circumstances. This perceived control over one's life circumstances has been associated with one's social status, while the roots of self-efficacy are located in the structural features of the society (Thoits, 1995; 2011). In this frame, social inequalities in health mirror the different extent to which people perceive having control of their life according to their social position (Marmot, 2005). Empirical evidence produced within this stream shows that low socio-economic status associates with poor health and mortality partly via low levels of perceived control (Bosma et al., 1999), while more recent findings show that perceived control reduces mortality risk among low educated groups (Turiano et al., 2014), that health locus control mediates the relationship between individual and neighborhood socio-economic status (Poortinga et al., 2008).

The sociology of emotions focuses on how the social world is experienced in emotionally loaded categories that relate with reactions of our body. In this frame, dimensions of power and status influence emotional modes of being expressed through bodily states, including illness (Freund 1988; 1990; Kemper 1979). Indicative theoretical and empirical studies based on this approach have explored the ways that past experiences with social inequality are associated with a person's psychobiological reactivity to more recent experiences (Freund, 2006) and on the impact of negative or loss experiences on health (Nettleton & Burrows, 2010). Finally, the *social cohesion model* is concerned with the idea of relative deprivation which is considered to increase with material, power and status inequalities and is associated with feelings of anger, frustration, hostility and insecurity which signify psychological stress but also aggravate social relations. In this line, Wilkinson's and Pickett's extensive work on how a society's inequality associates with reduced life expectancy and a multitude of negative health outcomes has been particularly influential (Wilkinson, 1989; 1990; 1994; 1996; 1997; Wilkinson & Pickett, 2009; 2010; 2017; 2019).

2.1.3 Behavioral - cultural approaches.

As their name conveys, these approaches locate the cause of health inequalities in the different behavioral and cultural patterns adopted by individuals and social groups. Theorists who developed this type of explanations (such as Cockerham, 2005; Fucks, 1982; Pearlin, 1989; Siahpush et al., 2006) acknowledge that resources alone cannot explain health inequalities because there is something else that mediates the use of resources. However, in most cases they distance themselves from questions regarding social power and rather focus on cultural patterns and lifestyles. The main focus of such explanations varies from individual psychological characteristics to national cultural traits as the reasons behind certain behavioral choices (Cutler & Lleras-Muney, 2010; Huijts et al., 2017; Lantz et al., 2005; Layte & Whelan, 2009). The main reasoning here is that socio-economic position besides determining access to certain socio-economic resources, also shapes our world understanding including health, our behaviors, tastes and lifestyles (McLaren, 2007; Pampel, 2006; Stempel, 2005). The theoretical justification of this claim lies in Bourdieu's concept of the 'habitus' which is described as the logic behind individuals' everyday practice, the overarching principle of all choices which is subject to people's social locations and it is expressed as a 'taste' (Bourdieu, 1977; Williams, 1995). For Bourdieu, 'habitus' is an unconscious set of dispositions which urges the individual to behave and to interact with others in ways that are consistent with and valued by the social group to which one belongs. All the factors that constitute the habitus are embodied in human beings as embodied agents within time and space and in relation to their context (Jenkins, 1992). The embodied habitus or what Bourdieu himself named 'bodily hexis' (Bourdieu, 1977) is the point where the personal and the social are bridged as culture is imprinted and enacted through our bodies.

Building upon Bourdieu's thinking, either explicitly or implicitly, health inequalities scholars have investigated behavior as a result of 'culture' in terms of shared ideas focusing on class differences in beliefs about healthy behaviors (Blaxter, 2003; Wardle & Steptoe, 2003); in terms of education focusing on the impact of schooling on the adoption of a healthier lifestyle

(Gran, 1995; Hoeymans et al, 1996; Mirowski, 2017); in terms of desirable and valued social roles focusing on the impact of social capital on lifestyle and health-related behaviors (Kawachi & Subramanian, 2008; Siegrist, 1998; 2000); and as a result of culture in terms of social distinction, investigating the hypothesis that certain lifestyles are adopted as ways in which social groups attempt to express their distinction from other groups regardless of whether the lifestyles are consistent with individuals' health understandings and beliefs (Berry, 2007; Graham, 2017; Scheerder et al., 2002; Stuber et al., 2008).

2.1.4 Criticism to mainstream explanations and integrated approaches.

The discussed materialist, psychosocial and behavioral approaches have arguably contributed much to our understanding of health inequalities as a social instead of a purely medical phenomenon and to the identification of the multiple pathways through which socioeconomic conditions can influence individual health. It is evident that the three approaches are complementary, as dealing with poverty more often than not goes pack and parcel with increased feelings of stress and powerlessness, as well as with having less healthy lifestyles. For this, studies have often tested the role of different pathways in combination showing a simultaneous and interrelated contribution to socio-economic inequalities in health (see for example Balaj et al., 2017; Van Oort et al., 2005). However, even when considered together these approaches appear limited in their scope and their effectiveness.

One of the limitations concerns the fact that within those approaches, socio-economic position is approached in a rather single dimension, usually income or educational level (Bartley et al., 1998; Eikemo et al., 2008; Huijts et al., 2010) without involving categories like gender, ethnicity or even marital and parental status despite their decisive influence on social ranking. This practice is systematically challenged by empirical findings which show that i) patterns of health inequalities vary across gender, age, and ethnic groups (Bambra et al. 2009; Eikemo et al., 2019; Huijts et al., 2010; Van Doorslaer, 2004) and ii) health inequalities persist even in countries where national wealth and generous welfare policies would be expected to buffer economic or educational inequalities (Bambra, 2007; Beckfield & Krieger, 2009; Eikemo, 2008; Mackenbach et al., 2016).

An additional limitation lies in the fact that although all the three approaches seem to start from the point that the actual causes of health inequalities are the underlying social inequalities, it seems that the largest share of research developed within these streams has put a disproportional emphasis on highlighting the mediating mechanisms (i.e. environmental hazards, stress or feelings of deprivation, or behavioral patterns) rather than questioning or dealing with the actual cause. In this frame, socio-economic position is perceived roughly as a given, irrespective of the structural arrangements responsible for the distribution of socio-economic resources. In this frame, materialist, behavioral and psycho-social explanations can neither fully explain the variation in health inequalities patterns across countries (Beckfield et al., 2015) nor the different impact that income or education have on health across different contexts (Huijts et al., 2010). By excluding systemic factors from the analysis, they render the discussion on health inequalities as an ostensibly 'a-political' issue, although the distribution of socio-economic resources as well as the relationship between socio-economic position and population health are subject to a number of political decisions and processes that serve the interest of certain social groups (Beckfield & Krieger, 2009; Palencia et al., 2014).

Acknowledging the limitations of the material, psychosocial and behavioral explanations, health inequalities scholars have been increasingly stressing the need for the development of a theoretical framework able to integrate the multiple and structural factors involved in shaping social inequalities in health (Beckfield & Krieger, 2009; Beckfield et al., 2015; Eckersley, 2015; Krieger, 2011; 2012; Link & Phelan, 1995). In this direction, two explanatory models seem to stand out. The life-course explanation of health inequality (Davey Smith et al., 2002) suggests that health at a given point in time reflects all the social, psychological and biological advantages and disadvantages that people experience since they have been born. In this frame, individuals born in socially disadvantaged environments bear an accumulated burden of disadvantage which builds up from their childhood to their adult life (Blane et al., 1993; Braveman, 2014; Power & Matthews, 1997). Within this stream, scholars have examined health inequalities among social groups focusing on the impact of past experiences, either on hazardous events that took place during certain critical periods during development (e.g. first years of life), or on the interaction between past and present experiences (Font & Maguire-Jack, 2016; Kendig et al., 2016; Stansfeld et al., 2011). Integrating developments in the field of epigenetics, scholars have further associated environmental exposure to hazard with intergenerational health inequalities (Stringhini, 2018; Sullivan, 2013; Thayer & Kuzawa, 2011; Wallack & Thornburgh, 2016). However, irrespective of the actual

focus, what these studies share is the belief that patterns of advantage and disadvantage are subject to the socio-economic position of individuals and their families. However, this approach involves a number of methodological challenges that seem to discourage researchers from integrating it into their work. The main challenge lies in that a life-course approach requires measuring data at multiple time points and potentially across generations. Moreover, this data should reflect changes happening in the individual life course but also at the macro-level (e.g. environmental and technological changes, economic instability, traumatic events like conflict and many more). Collection of this kind of data is expensive, time consuming and demands a long-lasting commitment from participants and researchers which is difficult to achieve (Lynch & Smith, 2005).

In a similar path, eco-social theory of health inequalities (Krieger, 1999; 2001; 2011) represents an additional attempt for an integrated explanation. Besides the perspective of time and the evolving accumulation of disadvantage during the life-course, eco-social theory integrates multiple levels in the analysis of health and disease distribution. The core of the theory lies in the perception that human experience is shaped by multiple environmental, social, historical, political and economic forces that operate simultaneously at the micro-, meso- and macro-level, and thus, it should not be approached and analyzed in fragments or layers. It suggests that individuals embody these forces through multiple pathways structured by the socio-economic arrangements present in our context as well as by our biological traits and transcending multiple levels of analysis and life domains. Finally, it incorporates the concepts of accountability and agency as core elements of the way we understand, investigate and theorize health and health inequalities. In this way, it can lead to explanations that take into consideration simultaneously economic and social deprivation, hazardous behaviors, past experiences, socio-economic distribution policies, as well as ways of resistance to structural oppression. This model involves methodological challenges similar to those related with the life-course approach on the basis of measuring the impact of socio-economic arrangements across time and analytical levels. Moreover, it actually calls for a change in the adopted analytical strategies on health inequalities, which implies a shift of our attention from essences to processes. Hence, empirical evidence is still limited although relevant studies have looked upon the differential impact of policies across time and between groups. For example, Krieger and colleagues (2016) have shown that infant death rates in the US across the period between 1980-2010 were inversely associated with state funding for abortion at three time points (2001,

2006, 2010) within the examined period, while black infants were exposed to excessed mortality risk which was even stronger for low income groups (Krieger et al., 2016).

What emerges as a conclusion from the life-course and the eco-social approaches is that for the understanding of health inequalities we need to develop a theoretical framework adequate to approach socio-economic position as an aggregate multi-dimensional notion shaped through time by the political and cultural environment that people live in (Krieger, 1997). This presupposes that besides individual level factors affecting health, we need to consider up-stream factors responsible for the distribution of socio-economic resources among individuals and the political economy of health. In this light, policy and institutional approaches on health inequalities are relevant and necessary.

2.2 Structural Factors and Health Inequalities

Link and Phelan (1995) were responsible for an important shift from the mediating pathways connecting socio-economic position and health towards the structural causes of social inequality. According to their approach, it is the process of social stratification in itself as set by economic and social policies that is responsible for the (re)production of health inequality. In this frame, socio-economic position is a fundamental cause of health inequalities because it involves a web of resources from money to social power, that operate regardless of the mechanisms that link them to health. This shift fueled the discussion about the impact of contextual factors including policies and institutions on health inequalities anew (Beckfield, 2018; Osypuk et al., 2014).

First, psychosocial theory although interested in individuals' biological responses to stress as causes of disease, suggests that the social environment is comprised by a series of socio-economic and cultural arrangements moderating human interaction. These arrangements often function as population stressors which can be directly pathogenic or can increase individuals' susceptibility to allostatic load. Such psychosocial factors include dominance hierarchies, forces of rapid social disorder and change, bereavement, social trauma and social marginalization (Marmot, 2005; 2015). In contrast, social support works as a population level protective mechanism that buffers the impact of environmental stressors (Kawachi et al., 2000; Mithen et al., 2015; Moore & Kawachi, 2017; Wilkinson, 1996). However, research derived from this theoretical tradition has rarely paid attention to any of these contextual factors and the processes through which they are embodied by individuals but rather has focused on

individuals and social support as experienced through family, friendships and extended social networks (see for example Huijts, 2011; Marmot et al. 1991; Matthews et al., 1999; Power & Matthews, 1997).

In a different manner, theories about the social production of disease or the political economy of health seem to be explicitly concerned with the economic and political determinants of health as well as with other structural arrangements limiting people's freedom to live healthy lives (Muntaner et al., 2003; Navarro et al., 2006). Building upon a Marxist understanding of class, they seem to adopt a materialist explanation which states that health inequalities are the outcome of social inequality which is generated by the power imbalance between upper and lower social classes. In this line, groups occupying higher positions in the social hierarchy dominate the production and market processes as well as the cultural sphere and thus, they have extended control over political and economic institutions which function as facilitating tools for the maintenance of their dominance (Bambra, 2011; Conrad et al., 1981; Doyal, 1979; Mooney, 2012; Navarro, 1986; Tesh, 1988). In this frame, the needs of the groups representing the lower social classes are sacrificed in the name of capital accumulation, a process that directly and indirectly hits disadvantaged groups' health (Kim et al., 2000; Stuckler & Basu, 2013). Finally, community empowerment and collective struggle for social change and justice are understood as strategies for tackling health inequalities. Work inspired by this theoretical paradigm, although valuable and socially relevant, is often exhausted in a fair but over-generalized critique of the modern capitalist socio-economic system and calls for urgent upstream interventions while failing to address the actual paths through which certain interventions would influence health outcomes (Krieger, 2001). A study by Reynolds & Brady (2012), is one of the limited empirical examples that shows a significant association between self-rated health and union membership in the US context.

Further, eco-social theory could not but include political and institutional dimensions in the analysis. This approach fully embraces the perspective of the social production of disease while incorporating an ecological together with a biological perspective. What distinguishes this approach from that of the political-economy of health is its particular interest in the ways that social relations are embodied through various pathways as biological expressions through the life-course but also through time as a historical notion. In other words, we would say that this approach is especially concerned with the way that the biological meets the social or individual characteristics interact with contextual factors (Krieger, 1999; 2001; 2011). Research examples include studies that associate sociopolitical stressors (related with

threatening rhetoric or political legislation) with increased preterm birth rates among migrant populations in the US in 2016 (Krieger et al., 2018); or others showing that police related deaths in the US were highest in neighborhoods of low income and residents of color between 2015-2016 (Feldman et al., 2019).

2.3 Health Inequalities and Political Processes

Political or institutional explanations of health inequalities have been rarely the interest of researchers. Sound exceptions are the studies on the role of welfare state regimes in mediating the effects of social determinants of health (Bambra, 2007; Bambra et al., 2009a,b; Eikemo et al., 2008a,b; Lundberg, 2010), and those on health politics (Beckfield & Krieger, 2009; ; De Vogli, 2011; Immergut, 1992; Navarro, 2001; 2007; Navarro & Muntaner, 2016; Shrecker & Bambra, 2015). The existing empirical research on health inequalities in relation to political systems, political economy and changes in politics and policies is organized across three clusters; namely transition to capitalism and neo-liberal reforms, welfare states and regimes, and the political incorporation of subordinated groups (Beckfield, 2018; Beckfield & Krieger, 2009). These clusters seem to involve rather complex political processes encompassing multiple political, economic and organizational components. However, in parallel to empirical comparative studies there has also been an increasing share of critical literature that highlights the mechanisms through which these complex processes shape and reproduce health inequalities. Integrating this empirical and theoretical work, the rest of this section describes the major political processes that have been associated with health inequalities.

2.3.1 Transition to capitalism and neo-liberal restructuring.

Transition to a capitalist economy has inspired a series of studies that as expected concerned former communist countries of Central and Eastern Europe. The key findings suggest that during the period immediately following the transition, health inequalities among different social classes or educational groups increased (Beckfield & Krieger, 2009) referring either to mortality rates (Kaladiene & Petrauskiene, 2005; Kolodjiez et al., 2007; Shkolnikov et al. 1998), life expectancy (Shkolnikov et al., 2006; Leinsalu et al., 2003), self-rated health

(Helasoja et al., 2006) or behavioral and material exposure to hazard (Du Prel et al., 2005; Malyutina et al., 2004). A more recent indicative research example has been that conducted by Stuckler & Basu (2013) who studied the impact of the dissolution of Soviet Russia on population health. Their study revealed the dramatic increase in mortality rates across young men who adopted high risk behavior in relation to alcohol overuse as a coping strategy against stress caused by the rise of unemployment and the dissolution of social support networks of mono-industrial towns in Post-Soviet Russia.

In a similar line, the neo-liberal reform of economic regulations has been the main focus of an important share of work both in relation to theory development and in relation to empirical testing of relative hypotheses. Scholars like Navarro, Labonté and Stuckler have criticized the way that neo-liberal reforms have systematically exacerbated health inequalities irrespective of the country in which they were imposed and the regime that implemented them (Labonté & Shrecker, 2007; Navarro, 2007; Stuckler & Basu, 2013). From a Marxist perspective, Navarro (2007; Navarro & Muntaner, 2016) has criticized extensively the role of state policies for the maintenance and reproduction of health inequality. He suggests that since the very beginning of capitalism, the state has had a distinctive role in the determination of the rules underpinning the operation of markets, and in the redistribution of market income, at least as much as needed for the preservation of social stability. Further, he highlights that with the increasing domination of neo-liberal policies at global scale, the role of the state has not diminished, as it is often suggested by neo-liberal economists, but rather it has transformed. Navarro stresses that within neo-liberal economies, state's distinctive role is to undertake the 'necessary structural adjustments' for the implementation of neo-liberal policies which are everything but synonymous to poverty reduction and well-being improvement. The role of the state has expanded in many developed countries in relation to intervention in production, capital accumulation, trade and even public surveillance. Hence, Navarro urges us to investigate a wide range of state policies in detail, together with the effect of democratic governance in terms of transparency, representation and accountability, in order to understand who benefits and who suffers from states' activity. Such an interest associates with research questions about the political factors that secure access to decision making, the channels through which information is shared, the groups which are represented in certain policies, the short and long-term gains of certain policies for different parts of the population, the extent that policies intersect and supplement each other (Navarro, 2001; 2004; 2007).

As would be expected, neo-liberalism and its impact on population health has been investigated in relation to globalization and the transnational character of the current economy. A number of eminent scholars have stressed the need to investigate health inequalities within and between countries taking into consideration the big picture of the global economy. Away from the theory of globalization, which refers to a sense of 'the world as one' and the 'end of the nation-state' (Chase-Dunn et al., 2000; Featherstone, 1990; Held et al., 1999; Robertson, 1992; Waters, 2001), empirical evidence shows that the effects of globalization have neither the same impact across the globe as if it was 'one', while the nation-state's intervention continues although transformed (Labonté & Togerson, 2005; O' Keefe, 2000; Sassen, 1999; Walby, 2009). Globalization is a process that develops unequally across the world, reinforces inequalities that originate back to the colonial years, and leaves developing countries trapped in the agendas of the developed ones (De Maio, 2015). This asymmetrical effect is what implies that in this changed transnational atmosphere locality remains important and that there are new articulations between the local and the global producing advantage and disadvantage for different countries and social groups.

As Labonté and Togerson (2005) suggest, countries do not simply jump into globalization's track from the same starting point. Rather this happens according to the particularities of each country's history. Countries' history can inform us about pre-existing endowments and political systems and processes. Pre-existing endowments include per capita income or wealth, currency reserves and other monetary measures, natural resources, human and social capital as well as the population's demographic profile. Political systems and processes refer to the acceptance of discrimination, definitions of public need and attitudes towards privatization, determination of public policy, level of unionization and accountability of public administration, conflict and political instability, and social status systems. Each of these interrelated elements interacts with globalization's key economic drivers and it is through these interactions, that we can understand how inequalities in health are produced and reinforced. A characteristic example of how the local and the global interact is found in the dissemination of western medical technology. In strongly patriarchal countries like India and China the use of ultrasound and amniocentesis are widely used to secure families' preferences for sons. This example shows how women and their bodies are disproportionately and differentially affected compared to men by the new medical 'achievements' of the developed nations (Labonté et al., 2011; Larkin, 2007).

2.3.2 Welfare state regimes' stratification.

Probably the most extensively studied political process associated with health inequalities refers to welfare state regimes and their role in social stratification. In this stream, the famous work '*The Three Worlds of Welfare Capitalism*' by Esping-Andersen (1990) has been particularly influential. Esping-Andersen managed to shift researchers' attention from aggregated welfare states' expenditure to the qualitative characteristics that make welfare state regimes differ across countries (Bambra, 2004). In this line, he developed a typology of welfare states across three axes; decommodification, levels of stratification, and the arrangements between the family's role, the state and the market.

According to Esping-Andersen (1987: 86), decommodification refers to 'the extent to which individuals and families can maintain a normal and socially acceptable standard of living regardless of their market performance'. The concept initially involved labor and the extent to which welfare states allow individuals to maintain an acceptable standard of living regardless of whether they are active in the labor market or not. It then expanded to cover health care provision meaning the extent to which an individual's access to health care is subject to her position in the market and the extent to which health provision in a country is independent from the market (Bambra, 2005). Stratification according to Esping-Andersen 'is part and parcel of welfare states' (1990: 3) and this is because they are supposed to mitigate inequality deriving from social stratification. But at the same time, they shape the order of social power relations on their own right. Besides money transfers and income distribution, key aspects of welfare states include educational systems and the organization of social services, which not only have a decisive impact on a country's employment structure but also on the opportunities of upward social mobility. The main dimensions of stratification according to Esping-Andersen involve the organization of social insurance and the degree to which it is segmented across distinct occupational classes; the privileges provided to civil servants; the degree of means-testing and the financial responsibility of the individuals for their own insurance; and the existence or the degree of universal social provision and benefit equality (1990: 69). Finally, the interrelation between the state, the market and the family, refers to the role that family plays as an actual provider of social provision and a mediator of state provided provision.

Based on these three axes, Esping-Andersen came up with three distinct types of welfare state regimes. The corporatist or conservative welfare state where benefits and services are

means-tested and vary across different occupational classes reproducing differences in economic and social status. Here, the state maintains its central role and interferes by providing social provision only when the family's capacity to support its members is exhausted. The liberal welfare state which focuses on provision only to groups living in poverty which need to prove that they comply with strict and often stigmatized criteria. Here, the market has a central role in providing social-insurance. Finally, the social-democratic welfare state which is based on the principle of universalism of social provision, aims for full-employment for the whole population and addresses both the market and the family in a way that maximizes capacities for individual dependence (Bochel & Daly, 2014; Esping-Andersen, 1990). This typology has been often the subject of criticism by numerous scholars for its range as it does include only 18 OECD countries and it does not reflect the welfare states' internal heterogeneity (Arts & Gellisen, 2002; Bambra, 2004; 2005; Bonoli, 1997; Castles and Mitchell, 1993; Ferrera, 1996; Leibfried, 1992); and the methodology used for its development as it seems to be subject to serious limitations in terms of validity and reliability. The most serious limitations refer to the construction of the decommodification indexes and particularly their additive nature and the reliance upon averaging (Kangas, 1994; Pitruzzello, 1999; Ragin, 1994) which apparently minimize the variability of the original raw data. Moreover, the classification of countries based on the use of one standard deviation around the mean has also been criticised (Fawcett & Papadopoulos, 1997) as inefficient to produce a typology with more than three welfare-state categories. Moreover, scholars have criticised the accuracy of the variables' weighting as well as the calculations for the production of the classification (Bonoli, 1997; Fawcett & Papadopoulos, 1997).

An additional point of criticism concerns the absence of gender. The typology seems to completely ignore gender in relation to decommodification, to the extent that women have a central role in the provision of welfare within the family framework and to the fact that gender functions as an additional form of social stratification (Bambra, 2004a; Orloff, 1993; Lewis, 1992; Sainsbury, 1994; 1999). However, research has shown that despite its weaknesses, the typology is still useful for mapping cross-country differences (Bambra, 2004) and thus, it has been used in a series of studies investigating health inequalities across different welfare states. In this area of work, the impact of health care systems as well as that of welfare policies beyond health care and the differences in health inequalities patterns across different welfare regimes has been studied. Contrary to the intuitive expectation that increased social provision would decrease health inequalities, research findings do not support this hypothesis consistently

(Beckfield & Krieger, 2009). Specifically, findings reveal that educational inequalities are largest in South European Welfare regimes, followed by the Anglo-Saxon and East European, Scandinavian and Bismarckian (Eikemo & Bambra, 2008) and that Liberal, Nordic and Conservative welfare states produce similar patterns of socio-economic inequalities in health among men but not necessarily among women (Martikainen et al., 2004). Further, Dahl and Van der Wel (2013) have shown that social expenditures are associated with lower health inequalities among women and, to a lesser extent, among men. Further, a study across 37 countries showed that Nordic countries do have the smallest inequalities in mortality for men and for younger age groups, but this is not the case for women (Popham et al., 2013). Moreover, research in America has shown that inequalities in mortality between white and black Americans and Canadians are not independent from the way political institutions, including welfare-state, have been shaped by historical racism (Kunitz & Pesis-Katz, 2005).

Other welfare state typologies (e.g. Ferrera's (1996) four-fold typology for Anglo-Saxon, Bismarckian, Scandinavian, Southern; or Sainsbury's typology according to gender policy regimes (1999)) have been used much less often in health inequalities research and when this has happened the findings have been again inconclusive (e.g. Eikemo et al., 2008). Still, these inconclusive findings do not suggest that welfare state characteristics are irrelevant to health inequalities. Rather they urge us to insist on testing alternative typologies and to develop models that take into consideration the complexity of welfare states as entities which have been formed across time and as the result of negotiations between multiple social actors and also models that fully take account of gender as a stratification mechanism.

2.3.3 Political integration of subordinated social groups.

A third, less studied, political process associated with health inequalities has been that of political integration or participation of women, Indigenous, ethnic and racial minorities (Beckfield & Krieger, 2009). The underlying assumption in relevant studies has been that increased political integration of subordinated social groups would decrease health inequalities. Indeed, findings, although still limited, in their majority confirm this hypothesis (Freemantle et al., 2006; Houweling et al., 2007; Nannan et al., 2007; Krieger et al. 2008; Reynolds & Brady, 2012; Palma-Solis et al., 2008). Research in Europe has focused mainly on women and migrants and ethnic/racial minorities as subordinated social groups. It has recently revealed

that policies promoting women's participation in the labor force and decreasing their burden of care, (e.g. public services and support for families and entitlements for fathers) associate with lower levels of gendered health inequality (Palencia et al., 2017). From a different viewpoint, Annandale has contributed much to shedding light upon the influence that the feminist movements have had on medical sociology and its approach on gender-based health inequalities in light of social relations of gender and their impact on women's health (Annandale, 2009; Annandale & Hunt, 2000). Further, research on migrant populations in Europe has focused on the impact of integration policies on migrants' health and health inequality (Giannoni, 2016; Ikram et al., 2015; Malmusi et al., 2014) and has shown that poorly rated integration policies associate with increased poor health and mortality among migrants. In the following sections, I present briefly the rationales according to which women, migrants and ethnic minorities bear a health disadvantage due to their subordinate social position and I present the general patterns of gender, ethnic and migration related health inequalities as evidenced by existing empirical studies. More detailed empirical literature is also presented in later chapters.

2.4 Women and Gender Health Inequalities

Women's subordinate position compared to men remains a reality despite the recent advancements. Women occupy fewer positions of power, they are less represented in political, economic and social institutions, and are still disadvantaged across multiple domains including education, labor market and health (Chakrabarti, 2017). Feminist scholarship addresses women's disempowerment within patriarchal capitalist societies through mechanisms of (re)production, (re)distribution, and cultural politics (Fraser, 2012). Similarly, in the field of public health, feminist scholars have been pushing mainstream academic discourses in order to make them (more) inclusive of the women's experience since the 1970s (Wilkinson & Kitzinger, 2013). In this direction, Doyal has been a pioneer in this field of research focusing on women's health and the impact of political economy on gender-based health inequalities. In her work, she has highlighted the inefficiency of traditional medical models to account for health and disease patterns among women across the world and she has analyzed how patriarchy and the deriving economic and social marginalization of women has a crucial impact on the way women experience illness, disability and mortality. In her analysis, she has included fertility control and reproduction policies as well as the organization of domestic and waged labor (Doyal, 1995), the position of women and the role of sexism within the English national

health care system (Doyal, 1979). Further, Annandale (2010; Annandale & Hunt, 2000) has contributed much to shedding light upon the social relations of gender and their impact on women's health and gendered health inequalities, and Bird and Rieker (2008) have demonstrated how policies operating across different domains restrict to a different extent the ability of men and women to make healthy choices.

Research in gender inequalities in developed industrialized countries has produced much evidence that women live longer but they generally report worse health outcomes than men (Bambra et al., 2008; Read & Gorman, 2010). Some researchers have rushed to attribute these differences to biological (see for example Owens, 2002 on the protective impact of estrogens), behavioral (see for example McCartney et al., 2010 on the contribution of smoking and alcohol related deaths to the gender gap in mortality in Europe) or socio-economic differences between men and women (see for example Hosseinpoor et al., 2012 on self-rated health or Van de Velde et al., 2010 on depression). However, earlier feminist studies have engaged with the health impact of social and occupational roles occupied by men and women in patriarchal societies that limit women in the sphere of non-paid or underpaid work, increase dependence by the male 'head of the household' and reduce access to health promoting resources (Artazcoz et al., 2004; Amaro, 1995; Hunt & Annandale, 1993; Carmen et al., 1981). Additionally, more recent work in this stream, has focused on patriarchy as being organized and maintained across institutions and social relations that do not only determine women's and men's access to material resources but also to a series of rights and responsibilities. Studies have explored the association between patriarchy, hegemonic masculinity and structural violence as drivers of health inequality, while they have also integrated the effect of those forces on men (Kruger et al., 2014; Peters, 2012; Scott-Samuel, 2009; Scott-Samuel et al., 2015).

2.5 Ethnic, Racial, and Migrant Groups and Health Inequalities

Race and ethnicity have been often used interchangeably (e.g. Nazroo, 2003; 2006) in health inequalities research referring to the experience of diverse populations of migrant, Indigenous, ethnic or racial minority populations. However, they represent different socially constructed categories with distinct historical loads. Research on racial health inequalities roots back to the 18th century, when race was defined as a reified category of biological difference, and since then, has played an important role in the construction of popular understandings of race and in the entrenchment of racist discourse by representing non-Whites as genetically inferior, inherently diseased, and mentally deficient (Braun, 2002; Williams, 1997). In recent times, social scientists have consented to the socially constructed character of race which now expresses certain relations of racial oppression, and approach racial health inequalities as embodied expressions of these relationships (Krieger, 2000). From this viewpoint, disparities in the health status of different racial groups have been studied mainly in contexts with increased racial diversity like the United States and Britain. Results have repeatedly shown that rates of morbidity and mortality are increased among non-white populations compared to white although the extent of inequalities differs within and between contexts (Bailey et al., 2017; Krieger et al., 2005; 2016; Nazroo & Williams, 2005; Phelan & Link, 2015). Ethnicity has also concerned health inequalities researchers as a classification that separates individuals into those belonging and those non belonging in specific ethnic communities. Disparities in health status among ethnic groups have been increasingly studied in different contexts across Europe and the US, and the patterns that systematically emerge render ethnic minorities to a disadvantaged position compared to majorities whether we talk about life expectancy, self-assessed health, obesity, pregnancy outcomes or risk of serious illness (Blom et al., 2016; Zwart et al., 2010).

Explanations of both racial and ethnic health inequalities are clustered around two main approaches. The first focuses on the association between ethnic minority status and lower socio-economic position and suggests that ethnic inequalities are simply socio-economic inequalities explained by material approaches. The second focuses on discrimination and racism as the main reason behind ethnic and racial inequalities, suggesting that discrimination as experienced at the individual but also at the institutional level by the members of ethnic or racial minorities has a direct or indirect impact on their health (Kawachi et al., 2005; Smith et al, 2000). In the first case, there is a focus on the association between ethnic/racial minority status and lower socio-economic position and a materialist rationale explaining health inequality in terms of socio-economic disparities (Nazroo, 1998). However, assuming that low socio-economic position is a corollary of ethnic or racial minority status is reductionist and seems inconsistent with findings showing that ethnic or racial health inequalities persist among groups even after we control for their socio-economic status (Kapilashrami et al., 2015; Nazroo, 1998).

In the second case, discrimination and racism as experienced at the individual and the institutional level by the members of ethnic or racial minorities is seen to have a direct or indirect impact on their health and to explain the distance from the healthier majorities (Kawachi et al., 2005; Smith et al, 2000). From a materialist perspective, the impact of

discrimination on health is explained through the way it pushes members of minorities to the lower steps of the social ladder (Nazroo, 1998), while psychosocial approaches focus more on the role that perceived discrimination has as a stressor and its negative effect on people's self-esteem (Nazroo & Williams, 2005). Still, things get complicated, if one thinks that experiences of discrimination are not necessarily common among targeted individuals, and that discrimination operates at different levels and life domains resulting in a cumulative experience (Jones, 2000; Krieger, 2012). In this direction, findings show that the association between poor health and experiences of discrimination is stronger for ethnic and racial minorities with a higher socio-economic status (Hudson et al., 2013) as well as for those born or living longer in the hosting country (Krieger, 2012; Viruell-Fuentes et al., 2012).

As already stressed ethnic or racial health inequalities often refer to inequalities between migrant and non-migrant groups (e.g. Blom et al., 2016). In this context, research more often than not attempts to associate migration related health inequalities with migrants' behavioral patterns in terms of lifestyles, and health care utilization (e.g. Carrasco-Garrido, 2007) or with migrants' cultural characteristics and the process of acculturation in the hosting country (e.g. Bhui et al., 2005; Fassaert et al., 2009). Alternative less explored explanations focus on the ways that migrants are disadvantaged in terms of health care access or welfare or how they are affected by restrictive migration policies (e.g. Hagan et al., 2003; Martinez et al., 2013). However, scholars have been increasingly stressing the complexity of the ways that migration interacts with multiple social determinants of health, is entangled to stratification processes driven by welfare states, educational systems, labor markets, associates with experiences of loss, change, and trauma with long-term effects on migrants mental and physical health, and involves populations that are diverse across multiple individual differences. From this perspective, they have suggested that migration itself should be conceptualized as a social determinant of health (Castañeda, 2017; Castañeda et al., 2015; Davies et al., 2009) and be more systematically theorized and studied. Migration-related health inequalities research in Europe has shown that migrants report poorer health outcomes than non-migrant groups, however the gaps are subject to a series of individual characteristics (e.g. gender) as well as to factors operating in the countries of origin as well as in the hosting countries (Blom, 2016; Bradby, 2015). In contrast to this overall picture, there are certain cases where recently arrived or first-generation migrants are healthier than settled migrant groups or non-migrant majorities (La Parra-Casado, 2017). Moreover, although migration related health inequalities appear in many cases to be subject to ethnicity (for example see Gazard et al., 2015), studies that explore

the intersectional impact of migration and ethnicity are scarce both because the two categories are often used as overlapping, and due to the scarcity of datasets that include robust measures of both categories (e.g. European Social Survey offers information regarding respondents' and their parents' country of birth as well as citizenship, however it does not include self-reported measures of ethnicity). Those observed variations offer empirical evidence regarding the complex ways that migration impacts individuals' health and urge us to further engage with its study. In chapters five and six, I present further empirical literature on migration and health in Europe as well as on refugees' health in particular. Moreover, I elaborate on existing intersectionality informed studies that focus on the intersecting impact of migration and additional social categories (i.e. gender, legal status, socio-economic position).

2.6 Power Relations, Institutional Arrangements and Health Inequalities

The political integration of subordinated social groups in relation to health inequalities is probably the political factor that urges us more to think of the issue in terms of social power and power relations among groups. However, all the aforementioned political processes either referring to the transition to capitalist, and neo-liberal forms of governmentality, or to the organization of welfare state regimes hide the very same issue in their core; the extent to which different social groups have the power to influence policy and institutional arrangements in order to promote their interests. Hence, when Navarro (2007) talks about globally organized elites who control the market and the production processes while subordinated groups develop strategies in order to organize their resources to counter the elites' dominance, he explicitly stresses the importance of institutional arrangements as fields of dominance and resistance. Similarly, Immergut (1992) describes political context as an institutional context which includes formal institutions and informal practices that have evolved around the institutions through the struggle of different social groups to exercise their control. She suggests that the institutions shape at the same time the pathways through which pressure for social change can be effective. Still, contrary to Navarro who sees social class as the base for solidarity and social claims for reforms, Immergut reminds us of the importance of other bases of solidarity like political ideology, gender, religion or language, which have been often more salient than class interest for political conflicts across countries. Her argument is based on the idea that power differences do not only exist in terms of resources and organizational power but also in terms of opportunities that derive from the logic behind the existing political decision processes. These opportunities are not equally distributed across social groups but rather differ across multiple social categories. This perspective seems to be relevant to Sen's (2001) notion of capabilities as presented earlier, in a way that implies that besides socio-economic resources there are a number of additional dimensions that determine the extent to which individuals and groups can influence their life and their context.

The same rationale seems to have urged Sainsbury (1996) to suggest a new typology of welfare states from the perspective of gender. Sainsbury integrated mainstream comparative welfare state analysis which tends to ignore gender with feminists' critiques, in order to explore the differences that welfare states make for women and men. For this, she identified a series of gendering dimensions including familial ideology, unit of benefit (household or individual) and recipient (head of household or individual), joint or separate taxation, basis of entitlement, the priority given to men and women by employment policies, the type of care services (private or state offered), and differences in care work (paid or unpaid). She considered these dimensions as the basis of differentiation among welfare states and she introduced a classification which ranges from the Breadwinner model to the Individual model. Sainsbury highlighted the importance of the basis of entitlement identifying four ways that women are entitled to social provision and benefits; namely as wives, as mothers, as workers and as citizens. She concluded that in welfare states that base entitlement on citizenship (such as the Scandinavian countries), gender inequalities tend to be smaller. Sainsbury's typology is particularly successful in making explicit that institutional arrangements reflect the differential extent of control that different social groups have over institutions but also that in order to trace this differential control we need to be sensitive to the impact of additional dimensions besides social class.

With this premise, understanding and dealing with social inequalities in health is rendered a complex task which involves the study of the social power structure as it is experienced by individuals and as it is organized through interdependent institutional and political arrangements. It seems that at the moment, a discussion about the relevance of power relations to health disparities has already started and an increasing number of scholars is getting involved (Beckfield et al., 2015; Eckersley, 2015; Hill, 2016; Kapilashrami et al. 2015; Raphael & Bryant, 2015). It is in this discussion that intersectionality becomes especially relevant.

2.7 Intersectionality as An Emerging Critical Perspective in Health Inequalities Research

Since introduced by Black feminists and critical race theorists (Crenshaw, 1989; The Combahee River Collective, 1986; Davis, 1983; hooks, 1981), intersectionality has been understood and defined in multiple ways. Bilge and Collins in their recent volume suggest that intersectionality is an analytic tool that "gives people better access to the complexity of the world and of themselves" by rendering us able to account for the organization of power and the shaping of our lives by multiple simultaneous and mutually influencing axes of social division like race, gender, or social class (Bilge & Collins, 2016, p.2). What lies at the core of intersectionality as an analytical paradigm is that categories cannot be fundamentally disaggregated, they do not represent individual differences but intersecting hierarchies within systems of social power, and that the distribution of power takes place across the intersections of those hierarchies. From this viewpoint, power is not understood in zero-sum terms (i.e. as something that one either has or not) because individuals according to their intersectional locations more often than not experience simultaneous privilege and disadvantage (Hancock, 2013; Nash, 2008).

In a similar frame, Yuval-Davis claims that intersectionality "should be considered the most valid theoretical approach to study social stratification" (Yuval-Davis, 2015, p.92) for two main reasons. First, because intersectionality contemplates the multiple mutually constituted social divisions in effect in any organization system of power, and second, it acknowledges that the social, political, historic and economic context determine the salience and the effects of those social divisions. From this perspective, she argues for a situated intersectionality approach that will be able to be simultaneously concerned with the categories affecting most people's lives (e.g. gender) and attentive to the impact of categories that shape decisively the life of minorities (e.g. sexuality). In the same way that critical race and feminist theorists suggest that race and gender concern not only Blacks or women, but anyone embedded in those power structures, Yuval-Davis sees as well that intersectionality concerns everyone and not only multiply marginalized subjects (e.g. black women).

Public health and health inequalities researchers have already stressed how intersectionality offers a valuable analytical tool for the study of health and health inequalities as the outcome of multiple intersecting dimensions (i.e. socio-economic position, gender, ethnicity or caste) (Hill, 2016; Hankivsky et al., 2012; Kapilashrami et al., 2015) but also for the integration of structural factors as drivers of health inequalities (Lapalme et al., 2019; López & Gadsden, 2016). From this viewpoint, qualitative and quantitative studies have explored the

health of multiply marginalized groups and those who occupy social locations that combine privilege and disadvantage (Agénor et al., 2014; Doyal, 2009; Collins et al., 2008; Fish, 2008; Iver et al., 2008). Alternatively, researchers have also focused on how certain policies and institutional arrangements have differential impact on people's health depending on their social positioning (Hankivsky et al., 2012; Viruell-Fuentes, 2012). This type of work not only sheds light on the particular situation of individuals and groups who occupy marginal positions within broader categories (e.g. Black women who have sex with women in Agenor et al., 2014), but they also offer useful insights on the ways that the combination of privilege and disadvantage associates with unpredicted outcomes (e.g. non-poor women and poor men sharing similar health outcomes in Sen & Iyer, 2012). Moreover, it contributes to the deconstruction of the tradition that wants the dominant groups to set the 'canon' of what the subordinate groups should achieve and the idea that certain relationships of inequality are more important than others (Weber & Parra-Medina, 2003). Finally, this work often reveals the ways that groups occupying particular intersectional locations fall through the cracks of public policy (e.g. Indigenous girls excluded from policies against violence in British Columbia in Clark, 2012). Building upon this work, chapter four discusses how intersectionality arguments can be further integrated in an analytical framework for health inequalities and suggests an updated research agenda.

2.8 Conclusion

In this section I have situated the thesis within the broader literature on health inequalities, and I have addressed the emerging gaps and points of tension that are summarized in the disproportionate emphasis of health inequalities researchers on the impact of socioeconomic position, and the limited integration of structural and institutional factors in health inequalities explanations. Linking to those emerging gaps, I introduced intersectionality as a critical analytical tool for health inequalities that enables us to account for the simultaneous impact of socio-economic position with additional categories and especially gender and migration, as well as for up-stream factors and power relations. Building on this work, chapter four will elaborate on how those arguments can be used for the development of an intersectionality and institutionally informed analytical framework for health inequalities and an updated health inequalities research agenda. Before proceeding with this discussion, the following chapter reviews the methods used in health inequalities research and addresses how intersectionality has been empirically integrated in the field.

Chapter Three

Methodological Review

This chapter offers a review of the methods employed in quantitative health inequalities research discussing the different indicators used for the measurement of individual level dimensions including health, gender, migration status, socio-economic position, as well as health inequality, the integration of institutional factors, and the challenges relevant to quantitative comparative designs. Then, it discusses intersectionality's analytical and methodological underpinnings and reviews the ways that intersectionality has been empirically integrated in health inequalities studies. The final sections of the chapter discuss the epistemological approach adopted in this thesis, and introduce the reader to the way that intersectionality is empirically applied in the context of this thesis.

3.1 Quantitative Comparative Health Inequalities Research

Health inequalities research has employed quantitative comparative designs in order to test inequalities in health outcomes between groups (e.g. low socio-economic position groups compared to high socio-economic position groups) to a large extent. In this section, I discuss measures and operationalizations of health and individual level characteristics, measures of health inequality as well as challenges regarding comparative quantitative designs.

3.1.1 Measuring health.

Since the notion of health is one that can be seen from multiple viewpoints i.e. medical, social, cultural, and political, its measurement has never been considered an easy task, and there has never been a general consensus on one certain dimension as indicator. Next to this, if one also considers the different ways that health and illness are reported across different countries, the fact that health has been measured with various different ways is warranted. Hence, measurements of health differ in terms of their purpose (e.g. diagnostic, prognostic, evaluative), in terms of their scope or the topics they cover (e.g. narrow-focus measures for particular organs, diagnostic scales, measures of broader syndromes, of overall health or of

quality of life), as well as in terms of the techniques used for the recording of information (e.g. rating scales, questionnaires) (McDowell, 2006).

Within the field of health inequalities research, measurements have been selected on the basis that they provide information about the total population which allows the proportion in poor health to be estimated. Hence, the most common measures used involve mortality rates, life expectancy, morbidity, and self-rated health (Bruner et al., 2017; Graham, 2007; Mackenbach et al., 2016; McNamara et al., 2017ab; Östergren et al., 2018). Mortality rates have been extensively used by epidemiologists to measure population health and health inequalities mainly due to the fact that such information has been systematically recorded across various countries for a long time and in some cases like Britain for centuries (Graham, 2007). Moreover, death rates are also used for the calculation of life expectancy, which refers to the average number of years that a person is expected to live. Life expectancy is estimated either at birth or often at age 65 and then, it refers to the average number of years that a person who survives to this age is expected to live.

However useful, death rates or life expectancy do not actually measure individuals' and populations' health but rather their mortality risk. In the direction of health, a series of subjective measures have been introduced referring either to the overall health status or to restricting long-term conditions. These types of measures have been considered as a useful tool for the collection of information about populations' health as an alternative to evaluation by physicians which is not a feasible option within surveys and other large-scale studies (Latham & Peek, 2013). The main question that emerges in relation to the use and effectiveness of subjective self-assessed measures is the extent to which they associate with objective measures (i.e. diagnosis, or laboratory methods). To answer this, a series of studies have investigated the association of self-rated health measures (commonest is the question 'In general, how would you rate your health''? with response options of "excellent, very good, good, fair, or poor") with subsequent mortality (Benyamini & Idler, 1999; DeSalvo et al., 2006; Idler & Angel, 1990; Idler & Benyamini, 1997; Shadbolt et al., 2002; Subramanian et al., 2008; Walker et al., 2004; Wolinsky & Johnson, 1992; Young et al., 2010), functional health decline (Idler et al., 2000; Idler & Benyamini, 1997; Idler & Kasl, 1995; Lee, 2000; Martinez et al., 2010), and morbidity onset (Latham & Peek, 2013; Møller et al., 1996; Shadbolt, 1997). Their findings suggest that there is indeed a strong association to all of them. Moreover, this association seems to hold true regardless of the country (Jylhä, 2009), the age of the respondents (Manor et al., 2001), their gender (De Salvo et al., 2006), their social class (Burström & Fredlund, 2001), and

the covariates examined (McDowell, 2006). Although research has shown that individuals use different frames of reference to answer this question (e.g. health problems, health behaviors, overall sense of well-being), it seems that this type of measures summarize effectively the various aspects of the health status domain (McDowell, 2006).

3.1.2 Measuring socio-economic position.

Regarding socio-economic position, epidemiologists and health researchers use a variety of measures that respond to the different aspects of socio-economic position and associate to a different extent to various health outcomes (Shavers, 2007). They focus on elements like individuals' level of education, individual or household income, or occupation without however taking into consideration the ways that multiple social categories like race, ethnicity, gender, and marital and parental status interfere influencing these three components (Graham, 2007). An extensive and substantial criticism on this approach has been made mainly by Krieger in the US (Krieger, 1994; Krieger et al.,1997) the central arguments of which are presented below for each one of the commonly used measures.

Occupational status.

Occupational status reflects the position of a person in a society because it is indicative of the material resources as well as of the prestige and social networks individuals enjoy. Additionally, it reflects to an important extent the working conditions and hazards together with the levels of control and stress that people experience while working. Thus, it associates with health through materialist pathways so much as it does through psychosocial pathways. It is an effective proxy for the position of a person in relation to the means of production (Rose & Pevalin, 2003) but at the same time it is subject to the effect of the intersecting categories of gender, ethnicity, or migration status. In practice, this means that it is not accessible in the same way for everyone. Research has shown that women despite their qualifications are less employable (Duberley & Cohen, 2010), acquire less managerial positions and are paid less than men (Diehl & Zubinski, 2016; Graf et al., 2018). While ethnic or racial minorities workers are exposed to more work-related hazards even when education is controlled for (Graham, 2007; Krieger, 1997; Leong et al., 2017). Moreover, it excludes people that are not active in the labor market or work in non-formal schemes. Another weakness of occupational status as

the main indicator of socio-economic position is that it does not capture either the extent of job insecurity and precariousness experienced by individuals nor their actual employment status (full or part-time/ unemployed). However, these two elements have been found to associate positively with increased allostatic load and consequently with health problems (Adler & Newman, 2002; Catalano & Serxner, 1992). Household measures have been used in order to deal with these limitations (Krieger, 1997). However, given that within household occupational status is more likely to reflect men's situation due to the stereotypical gender roles, these alternative measures are also gender sensitive.

Popular classifications of occupations include the UK Registrar General's social class classification (1913) which groups all occupations according to the kind of skills they involve and classifies them in five classes, where the first class which is considered to be the highest one includes professional occupations like doctors, and the fifth considered as the lowest includes unskilled occupations like office cleaners. The UK National Statistics-Socio-Economic Classification (NS-SEC), which superseded the Registrar General's classification in 2001 (Rose et al., 2005), classifies occupations in 'operational categories' according to their dominant structure of relations and working conditions and it involves eight categories from larger employers and higher managerial occupations to never-worked and long-term unemployed (Graham, 2007; Rose et al., 2005). Classifications developed and used for comparative research across countries are mainly based on the International Standard Classification of Occupations (ISCO) initially developed in 1958 and then updated in 1968, 1988 and 2008, for which the International Labour Organization (ILO) is responsible. ISCO groups occupations according to the tasks and duties they involve, and it is usually used in combination with socio-economic status measures or indexes (Ganzeboom, 2010). The latter refer to the Standard International Occupational Prestige Scale (SIOPS), a measure introduced by Treiman (1977) aiming to capture occupational prestige on the basis of their positions within a social status hierarchy; the International Socio-Economic Index of Occupational Status (ISEI) developed by Ganzeboom et al. (1992) in order to capture the indirect effect of education on incomes while minimizing the remaining direct effect; Erikson and Goldthorpe's class categories (1979; 1992), a nominal typology which combines occupational information with information on employment status; and the Wright-scheme (Wright, 2000) that combines ownership, managerial control and credentialism into twelve non-ordinal categories.

Education.

This has been an equally popular indicator of socio-economic position in numerous sociological and epidemiological studies (e.g. Dal & Van der Wel, 2013; Eikemo et al., 2008; Huijts et al., 2017). Educational level measured either as years of schooling or as qualifications acquired is conceived as a proxy both for childhood circumstances and for adult socioeconomic position (Graham, 2007). It is considered independent from changes in life and health during adult life and this is seen both as an asset, in a sense that it can be measured effectively at one point in time, and as a drawback, in a sense that it does not reflect the changes in individuals socio-economic situation which can potentially be multiple and diverse (Galobardes, 2006; Smith et al., 1998). It is also considered as less gender sensitive than occupational status, because it is viewed as more intrinsic to the person compared for example, to income or workplace authority, which are seen as more extrinsic to the person and acquired via others who stand higher in the labor market hierarchy (Reskin, 1988; Ross & Mirowski, 2006). Still, the way that education mirrors socio-economic privilege or disadvantage differs between men and women as it does among different ethnic groups and birth cohorts (Krieger, 1997; Ross & Mirowski, 2006). Moreover, education's structure and grades differ across countries making cross-national comparisons difficult. In this respect, there have been a series of attempts for the development of international classification schemes. The International Standard Classification of Education (ISCED) is probably the most popular, developed initially by UNESCO in 1976 and since then, it has been revisited in 1997 and 2011 (UNESCO, 2012).

Income and socio-economic resources.

The resources include wage earnings, occupational pensions, welfare benefits, and dividends and it is often used as an effective proxy for people's socio-economic position on the basis of a rather materialist approach which sees income as the determinant of access to goods and services (Graham, 2007; Kawachi, 2010). Usually income is measured at the household level and it has been found to be strongly associated with numerous health outcomes (Kawachi, 2010). Changes in income have been found to relate with greater health status changes among poor households than they do among wealthy ones, and reasonably so, given that the increasing income within poor households probably associates with more direct improvement of material circumstances (Mackenbach et al., 2004). However, household income does not reflect whether this income is enough for all the household members or the

distribution of income among them. This difficulty concerns women more than men, given that women often tend to be financially dependent to men within families, in line with traditional gender roles (Sen, 2001). Moreover, it does not say much about the purchase power it implies in a given context (Krieger, 1997). Income data are often used to divide populations in deciles, quintiles, tertiles and so on or they are used for the definition of a poverty line within a society, which often refers to incomes lower than the half of the mean or median household income in a region or a country (Graham, 2007). Measurements of poverty are themselves used as indicators of socio-economic position at the household or neighborhood level especially in the US (Krieger, 1997). In line with the idea of a socio-economic gradient in health inequalities, researchers have also used the notion of material and social deprivation as an effective indicator of the broader socio-economic position. In this field, studies have often used Townsend's (Townsend et al., 1988) and Carstairs Indices (Morris & Carstairs, 1991) as summary measures of socio-economic deprivation for individual and area-based measurements. Carstairs scores involves four indicators reflecting material disadvantage, while Townsend's Index involves materialist components like dietary options and housing facilities together with social components like participation in social institutions and family activities (Morgan, 2006; Townsend, 2014).

3.1.3 Measuring gender, ethnicity and migration status.

Recent approaches on socio-economic position especially in relation to health urge us to take gender and ethnicity into consideration as equivalently important aspects of one's position within the social structure. Gender includes the cultural norms for men's and women's roles and behavior that result in different experiences and opportunities and it differs from sex which refers to biological differences between men and women (Nowatzki & Grant, 2011: 264). In this light, in health inequalities research (as in social sciences overall), gender has been traditionally measured as a binary construct distinguishing men and women. However, there has been some valid criticism regarding this approach mainly across two lines. First, conflating gender and sex, where sex is most often than not treated as a proxy for gender, does not allow us to grasp their interacting impact or to disentangle their separate effects on health and illness (Doyal, 2003). Second, this binary understanding excludes the experience of non-gender binary people and it limits the discussion on differences and inequalities between men and women (Schofield, 2004).

Gender inequality in terms of power and economic resources continues to exist and research on health inequalities needs to consider this reality in order to understand different health and morbidity patterns between men and women. A common pattern in terms of genderbased health inequalities has been that women tend to live longer than men in most societies, although they present higher morbidity rates. This pattern was stronger in previous decades (Nathanson, 1975) while it seems to have been declining in recent years (Hosseinpoor et al., 2012; van Oyen et al, 2013). Factors like working and employment conditions, combinations of unpaid and paid work, as well as family structures and sexism within health care systems have been systematically investigated as potential explanations of health inequalities among women and men (Bambra, 2011; Campos-Serna et al., 2013; Harryson et al., 2012; Malmusi et al., 2014; Read & Gorman, 2010). At the same time, emerging scholarship increasingly stresses that people who do not identify with the gender binary are particularly vulnerable to poor health due to their disadvantaged socio-economic position, discrimination and the limited interest among public health actors regarding their needs (Jennings et al., 2019; Reisner et al., 2016). Thus, scholars have already stressed the need for sex and gender measures effective in distinguishing between men and women but also in capturing their interaction as well as the different realities of people excluded by the traditional binary gender definition (Johnson et al., 2009; Phillips, 2005).

Ethnicity in health inequalities research is used to describe the identification with or belonging to a specific social group on the basis of common culture, values, beliefs, traditions, customs, language and lifestyles (Bates, 2004; Gabe et al., 2004). From this perspective it is usually conceptualized as an identity and/or as a structure reflecting socio-economic hierarchies (Brown & Langer, 2010; Nazroo, 1998). Together with the concept of race, it has been described as an additional dimension shaping the social structure and defining the relationship between different social groups. Operationalizations of ethnicity in health inequalities research as in the broader field of social sciences, involve census or survey responses, that more often than not refer to ethnic groups as mutually exclusive and do not disentangle between the affective and the socio-economic dimensions of the concept (Brubaker & Cooper, 2000). Research on ethnicity and health systematically shows greater morbidity and mortality rates for ethnic minority groups in countries like the US and the UK (Bailey et al., 2017; Krieger et al., 2016; 2005; Nazroo & Williams, 2005; Phelan & Link, 2015) though with significant variations across different ethnic groups. Initial explanations of ethnic health inequalities tended to integrate genetic differences which were supposed to make certain

groups more vulnerable to morbidity than others (e.g. Gupta et al., 1995). However, during the last two decades, research has focused on the impact of ethnicity through differences in lifestyles and much more through differences in the socio-economic position of ethnic groups (Nazroo, 1998; 2003). Research has shown, however, that ethnic health inequalities cannot be fully explained by behavioral and socio-economic differences, if these are approached separately and regardless of structural factors like prejudice and racism (Karlsen & Nazroo, 2002).

Finally, migration status has been increasingly integrated in health inequalities research during the last two decades as an indicator of a migratory experience and/or as a basis for group formation (Blom et al., 2016; La Parra-Casado, 2017; Missine & Bracke, 2012; Safi, 2010). Similar to ethnicity, operationalizations of migration status are based on survey and census responses concerning the respondents' country of birth or the country of birth of their parents (e.g. Blom et al., 2016) or citizenship (e.g. Stathopoulou et al., 2018). However, according to peoples' trajectories and the institutional contexts in which they are embedded, there are multiple sub-categories of migrants including documented and undocumented individuals, refugees, asylum seekers, economic migrants, first- or second-generation migrants or displaced persons (Mladovsky, 2007). Health inequalities research in Europe has been mostly concerned with inequalities between migrant and non-migrant groups, with differences between first- and second-generation migrants or settled and newly arrived migrants (e.g. La Parra-Casado, 2017); or with comparisons between migrant groups of different ethnic origins (e.g. Vandeheede et al., 2015) and less so with comparisons between migrants with different legal status (e.g. Toar et al., 2009). Overall, findings in Europe reveal poorer self-rated health outcomes among migrants and ethnic minorities compared to non-migrant majorities, while differences are also traced between first- and second-generation migrants (La Parra-Casado, 2017; Nielsen et al., 2010).

3.1.4 Measuring health inequalities.

Measuring the magnitude of socio-economic inequalities in health among social groups within or between countries classified on the basis of one or more dimensions of socioeconomic position has been approached in different ways. In their vast majority, relevant research attempts employ a classification based on income, occupation or educational level and set the health status of the more advantaged groups as the reference category for the rest of the population. In the rare cases that the classification is made on the basis of gender or ethnicity, again the health of the most advantaged groups (i.e. men and ethnic majority groups) are used as the reference category (Graham, 2007). In this frame, most comparisons focus on the magnitude of difference between the extreme groups (i.e. most advantaged versus the most disadvantaged). However, the measures used for the estimation of this range differ at least according to three criteria (Mackenbach & Kunst, 1997). The first criterion refers to whether the measures capture *absolute or relative inequalities*. *Absolute inequalities* refer to the absolute differences in the rates of morbidity and mortality between different socio-economic groups. *Relative inequalities*, on the other hand, refer to morbidity or mortality rates of a group (usually disadvantaged) as proportions of rates in the reference group (usually the most advantaged) or in the overall population. Both measures have been found to associate with the overall population health (Houweling et al., 2007). However, relative inequalities are often considered as a more appropriate measure to capture reality, especially when overall health improves (i.e. relative inequalities may increase while absolute inequalities decrease when the frequency of a health outcome declines) (Regidor, 2004).

The second criterion refers to whether measures estimate the *effect* of lower socioeconomic position on a specific health outcome or the *total impact* that health inequalities have on the overall population health. The total impact is not only subject to the size of the effect of socio-economic position on health but also to the extent of inequality between the group with the highest socio-economic position and the one with the lowest position. The higher the inequalities between these two extreme groups the larger the total impact will be (Mackenbach & Kunst, 1997). Measures of the total impact include among others the Relative Index of Inequality and the Index of Dissimilarity. The final criterion refers to the measurement techniques, which can be rather simple like rates ratios and rate differences or sophisticated like regression-based measures.

3.1.5 Challenges in comparative quantitative health research.

Measuring health across groups.

Regardless of the health outcome chosen and the measurement selected for estimating the range of health inequalities across different social groups, the process of group comparison itself involves a series of specific challenges. As said earlier, existing research in health inequalities is patterned with comparisons between socially disadvantaged and advantaged groups which function as a reference category. Although this approach emphasizes on lifting the standards of health of disadvantaged groups (Graham, 2007), at the same time, it does not examine disadvantaged groups' health in its own context but rather as it deviates from the norms set by a healthier privileged group (Weber & Parra-Medina, 2003). Not only does this limits our scope of knowledge on the ways that social conditions are embodied as differential health outcomes but also it contributes much to the pathologization of certain underprivileged groups (i.e. disadvantaged groups are often portrayed as less healthy or more vulnerable or with less healthier lifestyles) (Farmer, 2005).

Measuring health across countries.

Comparing health data and health inequalities across countries is a challenging task both due to reasons of data availability and comparability and due to different definitions of social groups across countries. Given that national data collection systems differ significantly, and funds are systematically oriented towards health research on the world's wealthiest populations, it becomes obvious why the majority of available health data are offered for comparative research only across the richest industrialized countries (Commission on Health Research for Development, 1990; Evans et al., 2014; Lopez et al., 2001). However, even for countries with effective records of population health and of average standards of living, the issue of groups' definition makes cross-national comparisons difficult. For example, health inequalities among natives and migrants are not directly comparable across countries because migrant definitions vary across countries (Rechel et al., 2011). Similar difficulties rise when populations are categorized on the basis of their education, occupation or citizenship.

Research based on survey data.

The main challenge refers to the use of large-scale survey data which narrows the scope of information that can be grasped both at the individual and even more at the institutional level. At the individual level, regardless of being used as representative of an overall population, survey data more often than not fail in being representative of certain population groups which are marginalized within the examined societies. Such groups may include institutionalized individuals, people who escape national institutional pathways due to a precarious legal status (e.g. undocumented migrants) but also people who are considered socially 'invisible' due to reasons of poverty, stigmatization, social and economic deprivation (Weber & Parra-Medina, 2003). Moreover, given that in surveys, data are collected through questionnaires for the sake of time and cost, the resulting information often lacks detail and depth. Finally, comparative research on health inequalities based on survey data tends to disregard the impact of institutional and other macro-level factors as it approaches certain attributes of people's position within the social structure as individual rather fixed characteristics independent of the structural arrangements they result from (Graham, 2007).

Institutions in comparative research.

Institutions are understood as 'combinations of schemas, resources and practices that organize power' (Beckfield, 2018: 1) including for example, health or education systems or social policy, and are thus, complex factors that change across time and space (Immergut, 1992). Moreover, their association with socio-economic problems is also difficult to grasp as institutions can either function as tools buffering the negative consequences of socio-economic problems or as factors exacerbating or even generating these problems (Scharpf, 2000). Thus, examining their role represents one of the biggest challenges in comparative empirical research.

A popular quantitative approach is based on the use of multivariate statistical analyses with pooled cross-sectional data, which reveal the association between specific explanatory and outcome variables while controlling for the impact of other interfering factors. Until recently, this has been done with analyses conducted at one level while adding country and year dummies in the regression to control for country or period specific characteristics (Garrett, 1998). This approach has been useful for the identification of rather stable structural relations between institutional dimensions and specific socio-economic phenomena like (health) inequality or unemployment, but it seems that it falls short in accounting for the various and complex ways that institutional dimensions interact with each other, with specific exogenous factors (e.g. an economic crisis), or with individuals' socio-economic position (Beck & Katz, 1995). To overcome this limitation, researchers have suggested the use of multilevel models, a suggestion that seems to increasingly gain ground among scholars because of the multiple options it offers for the investigation of complex social phenomena shaped by various factors operating simultaneously at different levels. Research examples on health inequalities employing multi-level models include among others studies about the impact of income

inequality at community and country level (Diez-Roux et al., 2000; Subramanian et al., 2003), institutional discrimination (Gee, 2002); welfare state regimes (Eikemo et al., 2008); and health care systems' characteristics (Blom et al., 2016).

Multilevel analysis is used for the analysis of data that are hierarchically structured (e.g. students clustered in schools or individuals clustered within countries) and allows the simultaneous estimation of variability within and between groups/classes (i.e. schools, countries) and of the extent that variability at the lower level depends on factors functioning at a higher level. In other words, it accounts for the fact that observations within the same group/class are not independent. The degree of this dependence is measured with the estimation of intra-class correlation (Diez-Roux, 2002). Moreover, this method simultaneously examines the effect of explanatory factors measured at different levels (e.g. socio-economic position at individual level, and income-inequality at country level) on individual level outcomes taking into consideration error terms at each level. Its basic assumptions are: i) groups are related coming from a larger population of groups ii) errors at the individual level are independent and identically distributed iii) errors at the group level are normally distributed with a mean of zero iv) intercepts and coefficients are allowed to vary between groups. Thus, the distribution of the coefficients specific for each group is summarized in terms of two parts: a 'fixed' part that is equal across groups and a 'random' part that is allowed to vary between groups. Finally, multilevel analysis accounts for the interactions between variables measured at different levels (i.e. cross-level interactions); that is for the modification of the relationship between an individual indicator and the outcome variable by a factor operating at a higher level (Bryk et al., 1992; Hox et al., 2010; Schmidt- Catran & Fairbrother, 2015; Snijders et al., 1999). As a formula, the multilevel model regression can be written as:

$$Y_{ij} = \gamma_{00} + \gamma_{01}G_j + \gamma_{10}I_{ij} + \gamma_{11}G_jI_{ij} + U_{0j} + U_{1j}I_{ij} + \epsilon_{ij}$$

Where γ_{00} refers to common intercept across groups, γ_{01} to the effect of group level variables, γ_{10} to the effect of individual level variable, and γ_{11} to their interaction on the individual level outcome. Y*ij* represents the fixed part, U_{0j} the random intercept component, and U1_i random slope component represents the random part.

On the other hand, researchers interested in the complicated operations of institutions have rather conducted case studies focusing on one or a few countries and based on qualitative information (Scharpf, 2000). These studies have been less popular, mainly because their outcomes cannot be used for general conclusions that apply in countries which are not initially included in the study. However, they provide useful information regarding processes of exclusion and uneven distribution of health promoting resources. In the field of health inequalities, relevant work has been done by Immergut (1992) who investigated the evolution of health care systems and welfare policies across different Western European states considering the role of institutions both as moderators of policy outcomes but also of the strategies used by different interest groups to promote their social claims. In an alternative research stream, the impact of health policies has been also investigated on the basis of various public policy analysis frameworks. Most widely used frameworks include the policy triangle framework (McNamara & Labonté, 2017; Walt & Gilson, 1994) integrating a political economy approach and focusing on the interactions between policy content, actors, context and processes; and network frameworks focusing on the interactions between group of actors and shared decision making (Gale et al., 2013; Marsh, 1998; Marsh & Rhodes, 1992). Moreover, human rights-based approaches have been also employed in health policy analysis focusing on health as a human right and on the integration of vulnerable groups in policy (Ivanova et al., 2015; Keygnaert et al., 2014).

3.2 Integrating Intersectionality in Health Inequalities Research

The benefits of integrating intersectionality in health inequalities research have been stressed quite explicitly by multiple scholars (Hankivsky et al., 2012; Hill, 2016; Kapilashrami et al., 2015) associated with the study of the mutually constituted impact of social categories on people's health as well as with the interrogation of structural and institutional factors as drivers of health inequality. However, the development of an intersectional methodology for the study of health inequalities remains an area to be explored. In this section, I discuss some central issues that concern the methodological implications of intersectionality overall as well as intersectionality informed quantitative and qualitative designs employed in public health and health inequalities research.

3.2.1 Intersectionality: methodological and analytical underpinnings.

In terms of methodology, intersectionality, contrary to the traditional positivistic paradigm that favors reductionism, engages with complexity. Hancock (2013) distinguishes two ways that intersectionality is applied in empirical work, namely as a testable theory that explains social phenomena examining the impact of more than one categories and their interaction, and as a paradigm, that is a justice oriented analytical framework for the understanding of complex social phenomena driven by multiple simultaneous mechanisms. Hancock suggests that in most studies either qualitative or quantitative, researchers employ intersectionality as a testable theory focusing on the intersections of gender, race and class categories without always addressing however, the intersectional conceptualization of power distribution across multiple intersecting hierarchies. She explains that quantitative studies on inequalities between groups that examine the impact of multiple categories-variables and their interaction are a characteristic example of this approach. In contrast, intersectionality as a paradigm entails that researchers should carefully select the categories to be included in their design as shaped by the interplay between individuals, groups and institutions and to be attentive to what populations share in common and what variations exists within groups. That way, she adds, it can be possible to specify which combinations associate with specific results in certain contexts.

In line with the paradigm approach, Collins & Bilge (2016) conceptualize intersectionality as a critical analytic tool and they suggest that intersectionality is often used as a heuristic device for the solution of complex problems and hence, it can take various forms (p.4). However, they recognize the following six core ideas that systematically appear, when people use intersectionality as an analytical framework. First, all the frameworks are concerned with social inequality as the outcome of interactions among various categories. Second, they emphasize power relations understood through the perspective of mutual construction (e.g. racism gains its meaning in relation to sexism and vice versa) and as operating across different domains; namely, interpersonal, disciplinary, structural and cultural. Third, they adopt a relational thinking that emphasizes the interconnectedness of categories and inequality producing processes. Fourth, they are situated in a specific context within which the examined categories, relations and the suggested arguments acquire their meaning. Fifth, they engage with complexity both in terms of the examined social problems and in terms of intersectionality itself as an analytic tool that does not come with a neat and tidy methodology. Finally, these frameworks engage with and aim to enhance social justice.

From another viewpoint, McCall suggests that intersectionality is applied empirically with three different approaches defined mainly by the way "they use analytical categories to explore the complexity of intersectionality in social life" (McCall, 2005, p. 1773). The three approaches could be understood as symbolically standing across a continuum where at the one end, scholars choose to deconstruct existing analytical categories which are considered as oversimplifications that produce inequality (*anti-categorical complexity*) and at the other end, scholars provisionally use existing categories to document relationships of inequality and to reconsider formations of inequality across various and contradictory dimensions (*intercategorical complexity*). In the middle of the continuum, scholars acknowledge the relationships that analytical categories represent but they remain critical towards the categories' boundaries and the 'inclusion' - 'exclusion' processes they entail focusing on subjects at the margins of traditionally constructed groups (*intra-categorical complexity*) (McCall, 2005). After stressing the core analytical and methodological underpinnings of intersectionality, the next section discusses how intersectionality arguments have been empirically integrated in public health and health inequalities research.

3.2.2 Intersectionality in health inequalities research.

Intersectionality's emphasis on multiple intersecting social categories and its upstream focus seems to open a field where research questions regarding health inequalities between groups across contexts. Moreover, this is an area where comparative quantitative research designs can be effectively employed for the exploration of such questions (Bauer, 2014). We start from the premise that an intersectionality informed quantitative research design falls in the range of the inter-categorical approach as categories cannot be by-passed but can be used in a strategic way in order to reveal expected but also unexpected relationships of inequality among groups (McCall, 2005). The utility of quantitative comparative research lies in that it allows the examination of a larger range of intersectional positions and this across different contexts (Bauer, 2014). In this way, not only do we have the opportunity to explore relationships of inequality between the pre-assumed privileged and disadvantaged groups, but also between multiple groups that are formed by the various combinations of the dimensions within each category (McCall, 2005). Such an analytic strategy is able to lead us further from binary

understandings of inequality and to shed light upon relationships between groups that traditional explanations do not examine in relational terms or do not examine at all (Hill, 2016).

Documenting relationships of inequality between groups is not the only benefit we can get from choosing a quantitative comparative research design. The underlying and probably the most important benefit, with implications for policy interventions, lies in that the documented relationships can be analyzed in terms of the examined groups' context. This can be done by comparing groups either within or between contexts. By demonstrating that social groups are differentially benefited or harmed by the same structural forces within a given context, or that relationships of inequality between given groups vary across contexts, we can suggest that there is no 'essence' behind the unequal relationships observed and rather they are products of certain structural mechanisms (McCall, 2005). The outcomes provided by such an analysis could contribute directly to the evaluation and the reform of political and institutional dimensions related with health directly or indirectly. In this field, scholars have highlighted the relevance of multilevel analytical models and the use of interaction terms for the operationalization of intersections between categories (Evans et al., 2018; Hancock, 2013; Scott & Siltanen, 2017; Spierings et al., 2012). As already stressed, multilevel models account for the context's effect on individual level outcomes. From this perspective, they offer a useful tool that allows us to test the health impact of social categories and their intersections as those are differentially salient across contexts which seems to be in alignment with intersectionality's analytical premises. Further, Evans and colleagues (2018) have recently suggested that multilevel models can be used with groups operationalized as clusters, so in that way we can also account for the different impact of categories and their intersections across groups (i.e. the extent that gender and race intersection has equivalent impact for black men and black women).

The main criticism expressed regarding the integration of intersectionality in quantitative designs concerns that the examined categories and their intersections do not necessarily emerge in relation to the study's context, and that their operationalization involves distinct categories (i.e. as data come mainly from surveys, categories like gender are measured as distinct, mutually exclusive and fixed) (Bauer, 2014). Further, it is suggested that in this type of studies, the emphasis is usually on testing the impact of the categories and their intersections (i.e. significance of main and interaction effects), while the hierarchical processes they refer to are ignored (Hancock, 2013). These points do not comply with the core idea of intersectionality; that of inter-relation and inter-construction of categories as power axes. However, despite the

limitations, intersectionality informed studies provide useful insights on relationships of health inequalities that otherwise remain neglected (McCall, 2005).

Hence, scholars have conducted intersectionality informed quantitative research to examine inequalities among groups as those emerge across the intersections of multiple categories employing mainly comparative designs or interaction terms but less so multilevel models. Studies have focused on the intersection between sexual orientation, race/ethnicity, and cervical cancer among women in the US as well as in relation to human papillomavirus vaccination and Papanicolaou test utilization (Agenor et al., 2014; 2015); on testing the multiplicative effects of race, sexual orientation, class and gender on physical activity in Canada (Abichahine & Veenstra, 2016); on the way that union status stratifies self-rated health across gay, lesbian and heterosexual populations (Reczek et al., 2017); on intersections between migration status and ethnicity and their impact on health service use (Gazard et al., 2015); as well as on the impact of migration related categories and their intersections with gender and socio-economic position (Malmusi et al., 2010; Villarroel & Artazcoz, 2012).

Beyond quantitative studies, intersectionality has been also employed in qualitative ethnographic designs interested in the unique experience of marginalized groups like black homosexual men or Latino women with HIV or mental illness (Collins et al., 2008; Doyal, 2009). Although employing an intra-categorical approach, those designs are not necessarily more effective than quantitative ones in connecting the examined intersecting categories with the structural processes they relate to in specific contexts (Hancock, 2013). Finally, intersectionality has also been integrated in health policy research. Hankivsky and her colleagues (2012) suggested a distinct framework for Intersectionality Based Policy Analysis (IBPA) which focuses on an organized set of guiding principles and a list of twelve overarching questions to guide the analysis. The guiding principles are aligned with intersectionality as a paradigm and thus, include: the concept of intersecting categories; power operating at discursive and structural levels; a multilevel analytical approach including micro- meso-, and macro-levels; reflexive practices that recognize multiple truths and diversity of perspectives, privileging the voices of those who are traditionally excluded from policy making; time and space as important elements of the context; the promotion of epistemologies and knowledges produced by people who are typically excluded from knowledge production; and an emphasis on social justice and equity. Building on this work, Palencia et al (2014) have incorporated intersectionality in the evaluation of policy impacts on health equity in Europe, highlighting the social class bias in health inequalities research. Alternative studies that have integrated this

framework have usually focused on the way that marginalized populations are excluded from public health policies (e.g. Clark et al., 2012).

3.3 Methodological Approach

3.3.1 Epistemological underpinnings: social constructionism and intersectionality.

In the frame of this thesis, I build on the presented intersectionality theoretical and methodological arguments in order to suggest a framework for the analysis of health inequalities that integrates simultaneously horizontal (individual level) and vertical (macro-level) processes of social stratification. This framework is presented in the following chapter, which concludes with the suggestion of an intersectionality and institutionally informed health inequalities research agenda involving quantitative and qualitative designs. Chapters five and six demonstrate how this framework can be applied using quantitative and qualitative methods respectively. Before proceeding, I consider it useful to reflect on the epistemological underpinnings of my research, and the way intersectionality is integrated in this thesis.

My research drives on social constructionism, according to which reality and knowledge are socially constructed by the interaction of personal (e.g. scientists) and impersonal (e.g. institutions) agents of construction rather than existing as fixed and objective (Andrews, 2012; Burr, 2015; Schwandt, 2000). From this viewpoint, as already presented in the introductory chapter, this thesis approaches health as a social and political notion rather than a biological reality and in line with a social constructionist perspective, investigates the social etiologies of health inequalities (Bury & Gabe, 2013). Hence, social categories (i.e. gender, migration, socio-economic position etc.) as hierarchical systems are questioned throughout the thesis regarding their salience in the European context, their meaning and their implications for individuals' health and health inequalities.

As Hancock has shown (2016), intersectionality-like thought and social constructionism are connected with strong intellectual bonds formed since the very early intersectionality scholarship (for example see Rincón, 1971). Intersectional scholars have been particularly engaged with studying the ways that cultural constructions (e.g. those regarding Black women) shape the way subordinate groups are viewed in diverse contexts (e.g. healthcare systems, schools etc.) and the material consequences that derive from those representations. Importantly, intersectionality suggests that representations are not only imposed on subordinate subjects from outside, but they are also internalized in psychological terms (Hancock, 2016), while subjects themselves navigate through and engage with these representations finding often ways of resistance (see Lorde, 1982). This suggests a relational understanding of power, in line with post-modernism (Foucault, 1980), however, it does not cancel out the links between intersectionality and social constructionism.

Building on these arguments, throughout the thesis, I focus on the emergence, meaning and symbolic but also material implications of different categories of social location (and particularly gender, migration and socio-economic position) and their relevance to health inequalities. I understand categories as constructed, fluid and negotiated but at the same time associated with hierarchy making processes with material consequences on individuals' experience and health, functioning this way as aspects of both discourse and practice (Anthias, 2012). Hence, and in line with Anthias' suggestions (2012), my intersectional approach is not exhausted in focusing on particular locations resulting from the mutual constitution of categories. Rather it is equivalently concerned with categories separately as key units of social classification, that are context specific, changing and subject to power operations.

3.3.2 Positionality and reflections on the research process

Acknowledging the constructed character of knowledge and reality and my responsibility as a researcher and hence, an agent of construction, I consider important to reflect on my position through the research process and the normative values and experiences that inform the current work.

A short biographical note.

The way I understand myself and my social location involves the categories of a European, white, Greek, young, healthy, lesbian cis-woman. I grew up in Greece as a second-generation migrant, born to ethnically Greek parents but themselves born and raised in Turkey, and I have now reached the point of concluding my Phd at a highly ranked UK university. Due to my migration background and *jus sanguinis* citizenship regime in Greece, I was considered a Turkish citizen until the age of twenty-one. I have also a working-class background and childhood memories of poverty, while I am the first person in my extended family, who completed secondary education and entered university; thanks to the (currently threatened) Greek public education system. Seven years ago, I left Greece pushed by the economic crisis and the devastating unemployment rates that particularly hit educated women. I completed my post-graduate studies based on funding that came exclusively from scholarships and while working part-time for most period.

I first became conscious of my migration background and location at the age of five, when my parents had to register me at school. That process involved a series of stressful bureaucratic procedures, and my first visit to a police station, where I was registered as a migrant. At the age of approximately twenty-one, I acquired Greek citizenship and passport through naturalization. Through the multiple visits at the Greek migration services, I realised how waiting-times and treatment by civil servants was subject to the extent that a foreigner could pass as a Greek. Although it now makes me feel awkward, I remember me using my Greek looks and behavioral code to my benefit, in order to skip long queues of people who were looking less Greek than me. Later, those experiences fuelled my interest in the topic of migration and motivated me to engage with advocacy work in relation to migrant communities in Greece. Just before my thirties, I found myself a first-generation migrant this time, navigating the Dutch culture and bureaucracy, and studying at a prestigious university; things I would probably not have been able to do without my Greek passport. Until nowadays, in the UK, I identify as a migrant and not a foreign student, because there are reasons forcing me to stay away from Greece. The lack of job opportunities for highly educated women and the widely spread conservatism, sexism and homophobia in the Greek society are among them.

As emerges from this brief life-account, I occupy a social position that combines multiple privileges and disadvantages, and this has been accompanied by a fluctuating and long-lasting feeling of not belonging; or to put it more accurately the feeling of not-exactly-belonging across different contexts, including academic environments. Simultaneously, it comes together with an awareness that multiple classification systems present in practice and discourse have shaped together my life experience and that social categories are fluid, changing, visible or invisible. This life experience has been the reason why intersectionality theory resonates so much with the way I understand the world and my position in it, and I can confidently say, after completing this PhD thesis, that it fuelled my motivation to engage with this theory and its application in health inequalities research.

Challenges.

Working with intersectionality has not been an easy endeavour. My encounter with literature on intersectionality theory and research brought up a series of challenges from very early on. The first tension point was relevant with the fact that being myself a white woman, I got engaged with a theory developed through the life experience, scholarship and activism of Black women and women of colour. This posed questions regarding the appropriation of

intersectionality as a theoretical tool produced by socially oppressed subjects and the "whitening" of intersectionality (Bilge, 2013: 412). Following from this, the second point of tension concerned the importance of Black women as the epicentre of intersectionality research (Nash, 2008). I soon found myself reflecting on whether it was legitimate to use intersectionality theory, if I was going to study health inequalities that do not exclusively concern Black women or women of colour. Finally, having been trained in quantitative social sciences research, and working within a medical sociology stream that is predominantly focused on quantitative methods, I questioned the extent that I should, or even could, use a theoretical framework that has been predominantly associated with qualitative research and it has been often described as contradicting to the positivist underpinnings that are common in quantitative research (Bauer, 2014; Bowleg, 2008; Hancock, 2013).

The way I have responded to these challenges can be traced across the thesis, but I would like to summarise some important points. As many intersectional scholars have stressed, the contribution of intersectional research is the emergence and exploration of new questions stemming from the very position of "outsiders-within" (Collins, 1986) and are directly informed by a social justice agenda (Collins & Bilge, 2016; Schulz & Mullings 2006; Weber & Parra-Medina, 2003). As my short biographical note indicates, my intersectional social position and my experience as a marginalised subject in terms of gender, sexuality, class and migration background is the reason I embrace the status of an "outsider-within" in academia (but also outside of it), as well as the reason I aimed my PhD research to be informed by but also promoting a social justice agenda. From this position, I got engaged with the notion of health as a political concept and a human right, and I interrogated the direct link between health inequalities and social injustice and power imbalance. It must be said that looking myself as a researcher from an intersectionality lens allowed me to acknowledge my power to raise innovative and crucial questions regarding the study of health inequalities and at the same time, intersectionality seemed the appropriate theoretical framework for contextualizing my research within a social justice agenda.

Hence, though not a Black woman myself, I decided that my position and intentions allowed me to engage with intersectionality theory. Further, while critically reflecting on issues of theory appropriation and the centrality of Black women in intersectional research, I have consciously tried to engage with intersectionality in a way that highlights its theoretical significance (Bilge, 2013; Collins & Bilge, 2016). Shifting away from using intersectionality as a lens used to describe the experience of racialized women (Bilge, 2013; Nash, 2008), I employed it as an analytical tool for the understanding of health inequalities as the result of

social stratification. This is also reflected in my citation practices, where the theoretical work of Black women scholars and activists is prominent. In the same line, though not particularly focused on Black women, the significance of race and its intersections with gender and other social categories has been stressed throughout the whole thesis.

Finally, regarding the relevance of quantitative research methods, I built on arguments suggesting that what makes a research intersectional is its embeddedness within a social justice agenda in particular social, political, historical and cultural contexts (Bowleg, 2008; Collins & Bilge, 2016; Yuval-Davis, 2015), rather than the qualitative or quantitative methodology. Moreover, drawing on social constructionism that highlights the constructed character of social categories without disregarding their material consequences, I decided instead of taking an *a priori* fixed position (e.g. not using quantitative methods) to integrate this tension point as an integral part of my research. Hence, the challenges that emerge when intersectionality is applied in empirical health inequalities research (Bauer, 2014; Bowleg, 2008), including those specific to quantitative designs, are discussed in chapter four (i.e. the suggested analytical framework), and feed into concrete suggestions for a future research agenda. Further, I adopted a multi-method design that includes a quantitative and a qualitative case study, in order to explore the applicability and effectiveness of those suggestions.

A multi-method design.

At this section, I would like to briefly discuss the choice of the particular research design and the selection of the presented case studies. The current thesis is the outcome of a four-year project that started from a broad question regarding the implications of intersectionality for health inequalities research. The development of the suggested intersectionality and institutionally informed analytical framework presented in chapter four was the first stage of my Phd research. This framework in turn fuelled the research questions and the empirical studies that are presented in chapters five and six.

Aiming for a situated intersectional analysis (Yuval-Davis, 2015), and in line with the social constructionist underpinnings of my research, the development of the framework first involved a consideration of the social categories that are salient and relevant with social stratification in Europe, and hence, with the production of social inequalities in health. In the previous chapter, I explained the relevance of socio-economic position and gender. My particular focus on migration as a salient category for the understanding of health inequalities in Europe emerged from the thorough consideration of the socio-political and historic particularities of the specific context. However, my migration background, my previous studies

in the field as well as my previous experience in advocacy work related to migrant communities, have made me particularly conscious of and interested in studying the significance of migration as a social determinant of health (Castañeda et al., 2015) intersecting with other dimensions of social positioning (i.e. gender and socio-economic position). In the following chapter, I elaborate on this and I also discuss the urgency to focus on migration as a separate but intersecting category affecting life experience and health, and to disentangle it from the categories of ethnicity and race, while studying the ways it informs them and it is informed by them in the European context.

Further, the development of the framework involved the suggestion of an updated health inequalities research agenda posing innovative questions and bearing significant methodological implications for quantitative and qualitative designs. To demonstrate the applicability of this framework, and to illustrate how intersectionality is relevant with health inequalities research overall, I decided to adopt a multi-method design. Hence, in chapter five, I examine migration related health inequalities in Europe employing a quantitative multilevel multi-group analysis and interaction terms to operationalize the intersection between categories of gender, occupational status, migration and generation status and to account for their differential salience and impact across national contexts in line with Scott and Siltanen (2017) and Evans et al. (2018). This case demonstrates that we can use available statistical methods in order to study the material consequences of intersectional social positioning on individuals' health, and that conducting intersectionality informed quantitative research enables us to document the multiple relationships of health inequalities operating in the European context and not captured by mainstream studies.

Further, in chapter six, I conduct an intersectional qualitative analysis of the healthrelated response to refugees and migrants at the Greek borders as it evolved from the summer of 2015 until the summer of 2018 at the Greek borders. Employing a situated intersectionality approach, instead of focusing a priori on a specific group located at the intersection of specific categories (e.g. refugee women), I start my analysis by exploring which categories emerge as relevant to health inequalities in the specific context (Anthias, 2013), and I examine which intersections relate with increased exposure to health risk and damage for refugees and migrants. I conduct my analysis building upon the principles of intersectionality as a paradigm as suggested by Collins & Bilge (2016) as well as on the IBPA framework suggested by Hankivsky (2012). This case demonstrates how intersectionality informed qualitative research is effective in bringing to light the particular situation of multiply marginalized subjects who are often ignored within mainstream health inequalities research, and how the interplay between macro-, meso-, and micro level factors produces vertical but also horizontal health inequalities.

Although both cases engage with the intersecting impact of migration on health and health inequalities, they focus on entirely different groups of people. Moreover, although in both cases the broader context is Europe, the actual study context differs between the two cases. This way, I aimed to illustrate how adopting an intersectional approach involves challenges that concern the whole research process regardless of the actual design but at the same time there are limitations particular to the methods chosen each time. Further, I attempted to make explicit how migration involves a series of other categories (i.e. generation status, legal status, race, ethnicity) and that it is its intersection with those categories that renders certain individuals and groups more vulnerable than others. Importantly, I attempted to highlight how intersectionality encourages us to insist on adopting an explorative approach in order to unveil relationships of health inequalities that are often ignored and the particular situation of groups who are privileged in certain hierarchies and disadvantaged in others. The strengths and limitations of each study are discussed in the relevant chapters but also in the final discussion chapter, in which I reflect upon the applicability of the suggested framework.

Chapter Four

Understanding the Micro and Macro Politics of Health: Inequalities, Intersectionality & Institutions - a Research Agenda

4.1 Introduction

Almost a decade after WHO Commission on Social Determinants of Health published its influential report (2008), health inequalities within and across countries remain high on the research agenda. Acknowledging the complexity of the issue, scholars increasingly stress the need for the development of a theoretical framework that will integrate the multiple factors involved in shaping health inequalities, from individual social positions and experiences to institutions (Beckfield et al., 2015; Krieger, 2011; 2012). In this direction, intersectionality offers a fertile ground upon which such an integrative approach can grow (Bowleg, 2012; Hankivsky, 2012; Hill, 2016; Kapilashrami et al., 2015; Weber & Parra-Medina, 2003). In this chapter, building on the theoretical and methodological tenets of intersectionality, first I outline the relevance of intersectionality for health inequalities research and I elaborate on how it can bring together health inequalities research focusing on the impact of a range of established social determinants of health beyond socio-economic position. Further, I demonstrate how integrating intersectionality and institutional insights on health inequalities allows for the study of institutions as heterogeneous entities that weave social privilege and disadvantage beyond socio-economic stratification (Beckfield et al., 2015) as well as for the use of intersectionality as a context informed analytical tool considered with social categories that matter for individuals' positioning, experience and health (Yuval-Davis, 2005). I argue that such an innovative synthesis allows us to interrogate the fundamental causes of health inequality in light of power relations and to shift our focus from individual attributes to processes of health inequality (re)production. Taking a step forward, I demonstrate how this synthesis can infuse an intersectionality and institutionally informed health inequalities research agenda involving a series of urgent research questions and methodological considerations for qualitative, quantitative and mixed methods designs. I argue that in the present climate of increased forced migration and neoliberal disruption, the demographic shifts taking place in various contexts are accompanied by interlocking processes of social exclusion based for example on gender, racial, ethnic, socio-economic and sexual differences. Hence, intersectionality becomes all the more relevant as it enables us to reveal a range of minority political struggles that are often obscured and diluted within a liberal discourse of 'diversity' (Bilge, 2013; Hankivsky & Christoffersen, 2008). In the following paragraphs, first I elaborate on intersectionality as an analytical tool of stratification and then, I demonstrate its implications for health inequalities research in regard to individual social positioning and to institutional effects.

4.2 Intersectionality: Theoretical and Methodological Underpinnings

Intersectionality was initially developed by Black critical thinkers and activists as a way to conceptualize the multiple disadvantage experienced by Black women as an oppressive experience that could not be captured by approaches that treated race and gender as distinct entities (The Combahee River Collective, 1986; Crenshaw, 1989; 1991; Davis, 1983; hooks, 1981). Since then, intersectionality has influenced scholarship in various fields (see Collins & Bilge, 2016 for an overview) and has travelled across different contexts where in many cases it has developed in new directions, detached from its radical origins (Bilge, 2013; Salem, 2016). Collins (2015) gives the basic tenets of intersectionality as an analytical strategy stating that social categories like gender, race, class, or sexuality are mutually constructed and underlie intersecting systems of power that foster social formations of complex social inequalities. Inequalities are historically contingent and cross-culturally specific, and they are organized via unequal material realities and social experiences that vary across time and space. Individuals and groups are differentially located within the intersecting systems of power and their location shapes their point of view of their own and others' experience.

Intersectionality as an analytical tool of social stratification (Yuval-Davis, 2015) challenges the idea of a single, fixed social hierarchy. It perceives social positioning as a spot within a matrix of intersecting power axes (Crenshaw, 1992). Hence, there are no sociological categories (e.g. race, gender) that have an *a priori* greater significance in shaping individual experience. Rather, social positioning is shaped through an interplay that involves multiple categories within specific socio-historical contexts. And although the consideration of multiple categories has been a significant point of critique on intersectionality (i.e. how we can integrate everything in our analyses without prioritizing certain categories over others), it is the simultaneous concern with the context and the individual that intersectionality provides that is important. Yuval-Davis (2015) elaborates on that and describes intersectionality as a context

informed analytical tool (*situated intersectionality*) that focuses on the categories that reflect the social divisions shaping most people's lives (e.g. race and gender) in certain contexts and simultaneously it is sensitive enough to render visible other divisions shaping the experience of individuals and groups at marginal positions (e.g. sexuality).

Such a view stresses that intersectionality concerns everybody (Yuval-Davis, 2015). Individuals bear varying amounts of disadvantage and privilege associated with varying experiences of oppression and domination specific to their context (Nash, 2008). There are multiple ways in which marginalized subjects may be traumatized by complex systems of power (e.g. patriarchy, white supremacy, heterosexism) like Black homosexual women living in predominantly white heterosexual contexts, but there are as many others in which subjects may enjoy the benefits of their privilege in one system of power, while suffering symbolic violence in another (Iyer et al., 2008; Nash, 2008). For example, white women experience race privilege combined with gender disadvantage. This suggests that we cannot develop a deeper understanding of disadvantage without the consideration of the various mechanisms that produce and establish privilege (Nash, 2008) and that the intersections between disadvantages may turn out in non-anticipated ways (i.e. when being a Black woman has a different effect on one's well-being than the sum of the effects of gender and race). Also, we need to account for differences within categories that may operate for the production of additional internal exclusions (e.g. the exclusion of Black women from anti-racism movements in places such as the US) (Bowleg, 2013; Crenshaw, 1991).

In terms of methodological underpinnings, McCall (2005) in her often-cited work distinguishes three approaches according to which researchers focus on the constructed character of social categories, on the permeability of their boundaries or on the relationships of inequality they imply (i.e. anti-categorical, intra-categorical, and inter-categorical). However, I consider that two additional distinctions should be made for the development of an intersectional methodology applied to health. First, we need to distinguish between the different facets of social reality as described by Yuval-Davis (2015), namely the actual individuals' position within the power structure, their own experience of identity and belonging, and their normative values. Second, between the individuals as members of groups may share common positions with specific material, political, and institutional implications within a power structure while their individual experiences of this membership

may vary significantly. These underpinnings infuse the theoretical arguments and the research agenda discussed in the next sections.

4.3 Intersectionality and Health Inequalities beyond Socio-economic Status

The sizeable health inequalities literature has developed across quite independent streams but with a dominant (and arguably excluding) emphasis on socio-economic position as the key social determinant of health as discussed in chapter two. In some contexts, like the UK for example, 'health inequalities' refer almost exclusively to socio-economic position with little reflection on how that is stratified by other factors such as gender (Bambra et al., 2009). Despite the multiplicity of channels through which socio-economic position impacts health (Bartley, 1998; Link & Phelan, 1995), most studies focus on single linking mechanisms at a time. Socioeconomic position is usually defined by income, occupation or educational level alone, often with other variables like gender serving as a control (Huijts et al., 2010). Respective findings show that people with better socio-economic position are healthier across different societies regardless of their level of economic development (Beckfield et al., 2015; Eikemo et al., 2008). However, this approach obscures the multiple stratification systems that people embody simultaneously (Krieger, 1997). And although there has been significant work on the impact of those additional stratification systems beyond the pure socio-economic (e.g. ethnic, gendered and sexuality-based health inequalities), this has usually evolved as an alternative rather than an integrative focus on health inequalities.

Research on racial or ethnic health inequalities usually conflates the categories of race and ethnicity as equivalent and homogenizes the experience of distinct populations (e.g. migrants, Indigenous, ethnic or racial minorities) with different demographic characteristics, migration trajectories and institutional statuses. Despite empirical findings revealing differential patterns of health inequality between those who are perceived to belong to a nation/state and those who do not (Huijts & Kraaykamp, 2012; La Parra-Casado et al., 2017), the discussion is often focused on the health disadvantage that members of ethnic/racial minorities face due to their lower socio-economic status (Navarro, 1990) or their experience of discrimination (Nazroo & Williams, 2005). More importantly, those two elements are approached as if they are necessary corollaries of minority status with an autonomous and undifferentiated impact on everybody.

In contrast, an intersectional approach considers the distinct socio-historical processes associated with racial and ethnic categories across contexts (Graham et al., 2011) interrogating the categories' salience and impact on individual experience. For example, in Europe, the interchangeable use of race and ethnicity as well as the preference for the term 'ethnic minorities' results in the dismissal of race as an ostensibly irrelevant category and consequently in the mutation of racialized subjects (Bilge, 2013). However, a consideration of the sociohistorical context through an intersectional lens reveals that race has always been a fundamental meaning-making category for the conceptualization of Europe as the land of whiteness (Goldberg, 2006). The European expansion and global dominance are linked to a history of colonization and enslavement associated with violence, exploitation and forced movement of racialized populations. The spheres of global dominance shaped during European imperialism are still in effect to a significant extent across many countries in Asia and Africa. Combined with modern forms of economic and military interventions, colonial legacies are responsible for the underdevelopment that limits those countries' capabilities to achieve their health potential and forces them to migrate often to Europe (De Maio, 2014; Sen, 2001). Simultaneously, the forms of racism that emerged during European colonization (Goldberg, 2006) still inform institutional and everyday discrimination in modern European societies affecting both new-comers and ex-colonial citizens. Hence, race emerges as a crucial category for the study of health inequalities. Racialized subjects in Europe bear a legacy of oppression that is still responsible for increased economic marginalization, physical violence, discrimination, and cultural and institutional barriers in accessing healthcare (Préteceille, 2011). All those factors are by definition determinants of poor health and health inequalities between white and non-white populations within Europe but also between regions at a global scale (De Maio, 2014).

Beyond race, migrant status emerges as a distinct category that should be integrated in intersectional health inequalities research (Castañeda et al., 2015; Krieger, 1999). Migration is often the outcome of particularly health damaging conditions (e.g. poverty or prosecution) while the actual movement itself may cause physical and psychological trauma (Krieger, 1999). As a status, migration has particular implications for individuals' access to a series of civil, political and human rights in the receiving societies and is associated with experiences of discrimination and everyday micro-aggressions especially today within the current climate of rising xenophobia.

In terms of gendered health inequalities, the literature suggests that in developed countries women report generally worse health than men - particularly in terms of mental health- while experiencing lower overall mortality rates (Bambra et al., 2009). While most researchers have attributed these patterns to biological, behavioural, and psychological differences between men and women, radical feminist approaches have problematized patriarchy. Patriarchy has been seen either as a force imposing gender social roles reducing women's access to material resources (Annandale & Hunt, 2000; Doyal; 1995, 1979) or as a complex system of power organized across institutions and social relations that privileges men over women in terms of rights and responsibilities beyond material resources (Kapilashrami et al., 2015; Stanistreet et al., 2005). Today, we face a paradoxical reality where although some women -predominantly white middle class in high income countries- have made it to the top of the ladder in politics, financial institutions or academia, women continue to be overrepresented among the world's poorest populations, and segregated in lower paid and less regulated sectors where gender roles are still strict (Abercrombie & Hastings, 2016). Although women claim their body autonomy dynamically, intimate partner violence is still a serious public health threat especially in less affluent contexts (Devries et al., 2013). Simultaneously, trans* people suffer multiple and particularly violent forms of social exclusion with health consequences that are rarely discussed (Dean et al., 2000).

Gender is therefore still a crucial stratification force although mediated by additional factors. An intersectional approach allows us to capture those mediations. Marxist feminists and critical race scholars emphasize the role of social class and race respectively (review in Salem, 2016). However, if we follow the current discourse on trans* rights, it appears that the extent that individuals conform to the gender binary creates additional hierarchies within men and women with significant health effects. If we further consider migrant status, then it has been demonstrated that the social determinants of health for migrant women (e.g. employment, healthcare access, social security) have often been subject to their dependence on a male family member (Soysal, 1994). Further, if we add sexuality to the analysis, then we see that it drives unique experiences and implies further internal exclusions.

Sexuality has only recently attracted researchers' interest as a meaningful category for the study of health inequalities (Agénor et al., 2014; Doyal, 2009; McNair, 2003; Meyer, 1995; 2001 Reczek et al., 2017). The reasons for this delay lie largely in the impact of common biased understandings of homosexuality or bisexuality and in specific methodological challenges concerning the study of lesbian, gay and bisexual populations (Fish, 2008). Research

approaches have evolved from pathologizing homosexuality as a disorder to be studied, explained and cured (Stevens & Hall, 1991) to obscuring it as irrelevant to individuals' health, and much more recently to associating it with experiences of social exclusion with direct and indirect health consequences (Fish, 2006; Fish & Bewley, 2010, Meyer, 2001).

Although recent and progressive, this stream of research has been criticized for the homogenization of the individuals considered to belong to LGB communities (Fish, 2008; Meyer, 2001). More often than not sexuality has been studied as autonomous from other dimensions of difference present among lesbians, gays, queer and bisexual people (Fish, 2008; Meyer, 2001), either referring to demographic characteristics or to the extent that individuals perceive their sexual orientation as an identity. Terms like gay, lesbian, or queer are perceived as western constructs fitting to the experience of the white, middle class people and creating a paradigm that excludes or downgrades the experience of everyone else (Fish, 2008). Hence, when the health needs of lesbian, gay and bisexual communities are considered, research usually focuses on the experience of dominant subjects within those communities (i.e. middle class white gay men). From an intersectional viewpoint, this selective attention is understood in the frame of intersecting axes of oppression (heterosexism, sexism and racism) that render certain social groups more visible than others (Meyer, 2001). We can see this interplay manifesting in researchers' increased interest in HIV risk among gay men compared to lesbians' risk of breast cancer (Faulkner & Lannutti, 2016); in the scarcity of studies on the psychological impact of being lesbian, gay or bisexual and member of an ethnic or racial minority (Kertzner et al., 2009); or on the health of working class lesbians and gays (McDermott, 2006). An intersectional viewpoint enables us to deal with this kind of scientific bias that renders dominant subjects as the main point of reference (Weber & Parra-Medina, 2003) and to study those excluded both from dominant and subversive discourses or falling outside the boundaries of essentialized categories (e.g. Black lesbians or trans* people).

4.4 Intersectionality and Institutional Approaches on Health Inequalities

Using an intersectional lens to focus on the individual social positioning is necessary but not enough for an integrative understanding of health inequalities. Privilege and disadvantage are not individual attributes but products of the power structures operating at the contexts we are embedded. Although the importance of the context in intersectional frameworks on health inequalities has been acknowledged (Hill, 2016; Kapilashrami et al., 2015), the role of institutions remains neglected. Institutions play a significant role in the politics of health (Bambra, 2016; Beckfield et al., 2015) and in targeting the fundamental causes of health inequality (Raphael & Bryant, 2015), still, their integration in health inequalities research has been limited. Studies have focused mainly on welfare states classified across certain typologies (eg. Esping-Andersen, 1990) as mechanisms that rank people into social hierarchies and (re)distribute social determinants of health. Hence, it has been demonstrated that socio-economic inequalities in health vary across welfare states (Bambra et al., 2010; Eikemo et al., 2008). However, the heterogeneity of welfare policies as well as the impact of simultaneous institutional arrangements in fields beyond welfare (e.g. education, migration, incarceration) still need to be considered in health inequalities research (Beckfield & Bambra, 2016). The same applies for institutions' stratification effects across multiple axes of power beyond the socio-economic (e.g. gender) and their interplay with individual social positioning. These gaps encourage us to shift our attention to the development of an institutional theory of health inequalities that also considers insights from intersectionality.

From its very definition intersectionality emphasizes that intersections between social categories are nothing less than reflections of intersecting systems of power (Collins, 2015). This idea of fluid and permeable boundaries between the structural context and individuals offers a crucial theoretical tool for the development of new institutional theories that do not seek to merely explain how institutions shape individual experience but rather the interaction between the two (Lowndes, 2010). To develop this argument further, we need to acknowledge that the interplay between institutions and individuals does not happen in a vacuum. Institutions are embedded within contexts where specific power dynamics are in effect and negotiated (Lowndes, 2010), they open or close options for connections (Hall & Lamont, 2009) and reforms (Immergut, 1992) and therefore shape the pathways available for social-claims (re)-rendering certain groups more powerful than others. From another view, intersectionality scholars suggest that power is exercised through institutional arrangements controlled by dominant social groups (Weber & Parra-Medina, 2003). However, at the same time they acknowledge oppressed groups' agency and capacity for resistance and social claims (Collins, 2000).

If we bridge those views in relation to health inequalities, institutions are not seen as simple facilitators of the distribution of health promoting resources anymore. Rather, they reframe health inequality in terms of power relations that explain how certain groups enjoy a health privilege at the expense of others (Weber & Parra-Medina, 2003). For example, in Europe, migrants are often excluded from access to social benefits on the basis of certain eligibility criteria (e.g. working permission) that systematically benefit non-migrants. Moreover, it emerges that beyond looking at the stratification effects of institutions, we need also to explore the way they open possibilities for social connections and collective action and its impact on public health. This will allow us to understand the mechanisms through which privilege sustains itself and is associated with health benefits for dominant groups but also the way that oppressed groups exercise their agency through the available institutional pathways and its effects on their health.

An additional benefit of applying intersectionality to institutional approaches lies in that we are offered a theoretical framework that accounts for the heterogeneity and non-linear, simultaneous operation of institutions across time and analytical levels. Immergut (1992) suggests that institutional contexts have developed along a process through which elements that are not always inter-connected have been patched together through time. Moreover, Bambra et al. (2005) have stressed that the majority of social determinants of health are shaped by policies beyond the healthcare sector (e.g. housing or employment) and recently, Beckfield et al. (2015) have approached this issue in terms of "institutional imbrication." Institutional imbrication captures the fact that individuals are simultaneously affected by multiple policies that may work in different domains and levels, in convergence but also in divergence while their impact is always subject to the individuals' intersectional social positioning. The beneficial link between these macro-level arguments and intersectionality's emphasis on interlocking systems of inequality at the individual and contextual level emerges easily (Collins, 1991; Crenshaw, 1989). However, what is more important is that by theorizing institutional imbrication in the light of intersectionality, we not only make our analysis on health inequalities more robust -by accounting for the interaction of different institutional elements with individual social positions- but we also explicitly interrogate the role that institutional imbrication has in the entrenchment of health privilege for certain social groups (e.g. how citizenship regimes and labor market regulations intersections result in consistently benefitting the health of native born populations). This synthesis leads to an understanding of the interaction of both the macro and the micro elements of the politics of health.

Finally, the interconnectedness between institutions and power is crucial for the elaboration of a situated intersectional analysis (Yuval-Davis, 2015) focused on categories and intersections that matter and not on an endless list of interactions. As we stressed earlier, the

question which categories should be integrated in an intersectional analysis of health inequalities in a particular context? is answered through the context itself. Here, institutions as vectors of power struggles have a significant role. They bear crucial information (for example within institutional or policy documents) about the way health and health promoting goods are defined (e.g. citizenship right or as a market commodity), which groups have control over that definition (like doctors, patients, unemployed, capital owners, women) and how their needs are met, which groups have been excluded in that process (like mentally ill patients, prisoners), what is the impact of this exclusion on their health and what are the available pathways for reforms (for example, if migrants suffer poorer health than the rest of the population, what are the formal and informal channels available to them to pursue an improvement of their situation?). By looking at the institutions involved in shaping the social determinants of health or healthcare access, we can trace which categories matter and how their intersection may result in particular benefits for certain groups or in the marginalization of others (Bambra et al., 2005; Hankivsky et al., 2012). Characteristic examples are how welfare reforms in the 1990s have had a disproportionately negative impact on migrants' and noncitizens' social rights (Sainsbury, 2006) or more recently, how austerity has had a particularly devastating effect on women's health (Greer Murphy, 2017).

4.5 Setting an Intersectionality and Institutionally Informed Health Inequalities Research Agenda

Intersectionality informed research on health inequalities has already started to attract scholars' interest and has been examined from a broad series of methodological approaches. Examples include ethnographic studies (Collins et al., 2008), comparative quantitative designs (Abichahine & Veenstra, 2016; Reczek et al, 2017) and policy analyses (Hankivsky et al., 2009; 2011; 2012). In line with the theoretical roots of intersectionality, the dimensions of race, gender and sexuality and their intersections have been considered in most cases in relation to multiply marginalized groups and their experience of health and ill-health (Doyal, 2009) and their access to and utilization of healthcare services (Agénor et al., 2014). Still, the integration of intersectionality and institutions in health inequalities research allows for the emergence of a broader research agenda not just concerned with individuals but also with how the institutions shape individuals' positioning and experience of health. This leads to a series of urgent

questions and challenges us to stretch our limits across all the phases of the research process as described below.

Intersectionality effects everyone and it is a context informed analytical tool. This has particular implications for the emergence of research questions and the particular axes of social division that should be interrogated in relation to health. We live in times of austerity, conflict and increased forced migration. In these circumstances, old and new social struggles coincide (e.g. socio-economic justice and anti-discrimination claims) and the role of the state is again a focus for public health researchers (Bambra, 2016). An intersectional lens allows us to formulate research questions about the situation of specific social groups and interrogate the institutional factors responsible for their increased vulnerability. Examples include questions on the health of women, trans* and LGB refugees and the particular hazards or health damaging experiences they face during their migration trajectories e.g. rape or transactional sex (Freedman, 2016). Does their socio-economic status contribute to the avoidance of such hazards? Does the situation they left in their country of origin (e.g. war, poverty) have a longterm impact on their health? To what extent are their reproductive or sexual health needs integrated in the healthcare schemes developed in refugee camps and across different host societies? How do international asylum policies favor or harm their health? For example, the EU-Turkey agreement has been already found to have a severe negative impact on women and girls and especially for those who do not manage to prove their Syrian background (Women's Refugee Commission, 2016). In such examples we clearly see how gender, ethnicity, and migration status intersect and how an intersectional analysis that considers individuals together with national and even transnational institutional elements is deemed necessary. Chapter six demonstrates how such questions can be explored from an intersectional perspective.

We may further study relationships of inequality between newly arrived migrants and refugees and groups who have been historically marginalized in the hosting countries and especially Black men and women. Those communities have accumulated the effects of structural and individual discrimination across time (Krieger, 2012). Now, they are found in a position where they have to deal with an additional retrenchment of social policy, less regulated labor markets and a reemerging xenophobic atmosphere primarily targeted against migrants but unavoidably hurting communities who may have been present in predominantly white societies for long but they are still considered as non-belonging (Goldberg, 2006). We may compare marginalized groups with those assumed to enjoy a series of privileges like native employed men. We can also make more nuanced distinctions by comparing them with native

(wo)men of working age who have suffered recent downward social mobility due to the crisis and who therefore combine elements of both privilege and disadvantage in terms of the multiplicity of their social position. Further, we may question the impact of newly introduced anti-discrimination and family protection policies for lesbian, gay, bisexual and trans* people on the health of each subgroup stratified by socio-economic inequalities and within the context of welfare retrenchment and austerity. With such comparisons and with the interrogation of migration and welfare policies, labor market regulations, equal opportunity frameworks, citizenship regimes, and family regulations, not only may we unravel the range of emerging or previously ignored relationships of inequality, but also we may grasp what multiple disadvantage means for one's health in certain contexts and what kind of privileges are deemed protective.

Taking this agenda forward will also require a series of methodological considerations. The development of an intersectional methodology has been intensively debated (Bauer, 2014; McCall, 2005; Nash, 2008). Most of the times the discussion has focused on whether intersectionality is applicable beyond qualitative methods. In my view, intersectionality is an analytical tool that transforms the way we do our research either qualitative or quantitative (Collins & Bilge, 2016). Especially in relation to health inequalities research that often focuses on populations, there are certain methodological considerations deemed necessary. Bauer (2014) has given a comprehensive account which we extend with some additional points below.

How do we use social categories?

McCall (2005) in her systematic categorization of intersectional methodologies (i.e. anticategorical, intra-categorical, inter-categorical) emphasizes the importance of this question. Regardless of whether our research focuses on the margins of certain categories (i.e. intracategorical) or on the relationships of inequality that categories produce across contexts (i.e. inter-categorical), we should interrogate their content and the conflations and exclusions they imply. This should be traced easily in our research questions and theoretical arguments but also in the operationalization of our measures. For example, studies on ethnic health inequalities should be explicit about the content of ethnicity. Does it refer to a self-identification or to an institutional label? Does it conflate race or other categories? Are there subjects whose experience is suppressed from this operationalization? How do we account for those experiences? Considering these questions is a step against the normalization of the invisibility of certain individuals, communities, and populations within research.

What is our unit of analysis?

This question should be first answered conceptually. With an individual focus that is often used in health inequalities research, we should be explicit about whether we are interested in individuals as members of a certain group who share a similar positioning within a power structure or treat individuals as cases with unique experiences of identity (Collins, 2003; Yuval-Davis, 2005). Using individuals as proxies for groups and vice-versa is likely to be problematic especially because it may conceal the effect of power relations. For example, generalizing the case of a highly educated white middle class lesbian woman as a representative of lesbians as a group may conceal the group's socio-economic marginalization. On the other hand, studying a group of white lesbians without allowing for socio-economic differences to emerge might conceal internal national or racial hierarchies within the group or the ways that socio-economic advantage may compensate for experiences of social exclusion due to sexual orientation. Being concrete about our unit of analysis will serve for the correct choice of methods and data. For example, in a qualitative design, the content of interview questions should be consistent with the chosen unit of analysis and allow for dimensions of difference to emerge. Similarly, in comparative quantitative studies, the sample should be equally representative for the minority and majority groups included in a population.

Should quantitative methods be avoided?

Despite the intense debate on the applicability of intersectionality to quantitative methods, we suggest that health inequalities researchers should insist on bridging the two traditions (Spierings, 2012). Comparative designs which inevitably fall into the intercategorical approach (McCall, 2005) promise the examination of a large range of intersections and do this across different institutional contexts (Bauer, 2014). Quantitative studies can focus on the actual position of individuals as members of groups within specific power structures and examine how the political, social and institutional implications of this positioning affects health and its social determinants. It also allows the large N population wide analyses. Developing intersectionality informed quantitative designs asks for a change in perspective rather than extremely sophisticated statistical methods. The consideration of location and dispersion statistical measures, the use of dummy variables for the construction of the dimensions of categories (e.g. *migrant* =1, *woman*=1), interaction terms for the operationalization of intersections (e.g. migrant X woman), multi-group models with two way interaction terms for the analysis of the intersections between three categories, and multi-level models for the analysis of cross-level interactions are all available statistical tools that enable us to follow an intersectional direction (Evans et al., 2018; Scot & Siltanen, 2017; Spierings, 2012). The following chapter demonstrates an example of such an intersectionality informed quantitative study on intersectional migration-related health inequalities in Europe, where these methodological options are applied.

How to deal with institutions?

In line with the idea of connectedness as a tool that enables people to deal with life challenges (Hall & Lamont, 2009), I suggest that we need to study the role of institutions in shaping social connections. Given that social connections are shaped across areas beyond the economic sphere, we need to also look upon arrangements involved beyond just social or labor market policies - which has been the main focus of analysis to date (e.g. Bambra, 2008; 2011). Policies relative to education, migration, incarceration but also institutional frameworks relative to collective action, political representation, anti-discrimination, and information exchange should be studied in terms of their health impact. Indexes (e.g. Migrant Integration Policy Index) and aggregated quantitative data could be used for cross-national comparisons, while policy documents, grey literature and other discursive material (e.g. parliamentary speeches, online information pages) could be also used for intersectionality-based policy analysis (Hankivsky, 2011; 2012) e.g. How do institutional actors frame questions of social position and health? In this line, chapter six analyses the health-related response to refugees who arrived in Greece between 2015-2018, using grey literature produced by humanitarian actors involved in the field, and exploring how health disadvantage was produced and unevenly distributed among refugees and migrants affected by the intersecting impact of border crossing, humanitarian aid and asylum policy.

4.6 Conclusion as a Call for Action

Choosing as a research community to integrate intersectionality theory in our work is consistent with our own social positioning as well as with the context in which we are embedded. Enjoying a series of privileges associated with working in an academic context does not exclude the possibility that we deal with oppressions -at least some of us- on the basis of our gender, sexual orientation, working class background, or migrant experience. Being embedded in a Western context where severe disruptions are in effect due to the entrenchment of neo-liberalism as dominant ideology (Labonté & Stuckler, 2016) means that we are called to analyze a series of old and new social struggles characterized by complexity and controversies. In times of massive socio-economic changes and political upheaval, a synthesis of intersectional and institutional insights on health inequalities research highlights how certain groups are excluded from health inequalities discourses and enables the simultaneous analysis of the health effects of both vertical (e.g. institutional factors) and horizontal (e.g. individual/ community factors) social stratifications. It has the potential to bridge the different streams of scholarship (i.e. socio-economic, gender, racial inequalities etc.) and brings to the fore the politics of health while it urges researchers to:

• Reframe health inequalities in the light of power relations and interrogate the processes that produce them instead of individual 'labels.'

• Consider intersections at the institutional level beyond healthcare policy and explore the way they interact with individual positions.

• Avoid conflating categories with distinct socio-historical backgrounds (e.g. race and ethnicity).

• Integrate intersectionality beyond qualitative research to population studies and policy analysis.

• Develop appropriate multifaceted indicators of dimensions of privilege and disadvantage in future data and push for representative data across majorities and minorities and across countries.

• Read existing findings on health inequality with an intersectional lens, reflect upon potential exclusions they may involve (e.g. institutional effects, social categories, marginalized social groups) and develop new research questions accordingly. • Do research as an inclusive process that involves subjects with differential social positioning and viewpoints during all the research stages.

Such a project implies a shift in our perspectives, aims and methodologies of research which is a political shift where the radical roots of intersectionality can find a fertile ground. Chapters five and six demonstrate how the suggested framework can be applied in a quantitative and a qualitative design respectively.

Chapter Five: Intersectional Migration-Related Health Inequalities in Europe: Exploring the Role of Migrant Generation, Occupational Status & Gender

5.1 Introduction

During the last decades, significant political, socio-economic and demographic developments have taken place within the European region. Internal mobility across European countries (La Parra-Casado et al., 2017) as well as fluctuating migration patterns from regions outside Europe towards Southern, Central and Western European countries (Geddes & Scholten, 2016) have coincided with the gradual European Union enlargement as well as with the recent economic recession of 2008, the socio-economic consequences of which are still felt in countries such as Greece, Ireland, Italy, Spain or the UK (Hermann, 2017; Kohl, 2015). In this context, migrants have been significantly marginalized through different processes that have been operating in parallel (Rechel et al., 2011). Regardless of the differences in citizenship and integration regimes across countries, migrants in Europe have mainly represented the most vulnerable segment of the labor force (Farris, 2015), they have been significantly exposed to material deprivation, and they have endured extensive restrictions regarding their access to social security and welfare, their rights to physical and professional mobility, as well as to a series of civil and political rights. Moreover, they have been subjects of persecution, traumatic experiences, discrimination and racism from local authorities and majorities (Bolzman et al., 2004).

It is therefore not surprising that a multitude of migrants' health studies show that migrant groups and ethnic minorities in Europe report worse self-assessed health compared to nonmigrants (Huijts et al., 2016; La Parra et al., 2016; Levecque et al., 2015; Rechel et al., 2011), underlining that migration as a dimension of social division in Europe affects migrants' opportunity to achieve their health potential (Link & Phelan, 1995; Thomas, 2015). However, health inequalities between migrants and non-migrants as well as between different migrant groups do not follow a unitary pattern, since migration operates in tandem with other health determinants (Castañeda, 2015; Krieger, 1999). Socio-economic position or class have been often considered as the driving force of such inequalities (Bécares et al., 2009; Nazroo, 1998). However, findings confirm that in many cases, the health disadvantage of migrants persists regardless of socio-economic differences (Nazroo, 2003). Moreover, it seems that whether migrants have been born inside or outside the hosting country influences the direction of inequalities as it has been often found that first-generation migrants in Europe report better self-rated health than groups of non-migrant origin (Giannoni et al., 2016; La Parra-Casado et al., 2017). Further, migrants' gender appears as an additional factor intersecting with migration in shaping the range of health inequalities (Eikemo et al., 2018; Gkiouleka et al., 2018; Malmusi et al., 2010).

Building on this evidence and drawing on intersectionality theory (The Combahee River Collective, 1986; Crenshaw, 1989; Davis, 1983; hooks, 1981), I aim to explore health inequalities between migrant and non-migrant groups in Europe taking into account that migration, migrant generation status, gender and socio-economic position operate simultaneously shaping individuals' position, experience and consequently health. Using a pooled European Social Survey sample across 27 European countries and six survey waves from 2004 until 2014, I employ a quantitative design in order to explore inequalities in self-rated health and hampering conditions among groups as those groups are shaped across the aforementioned categories and their intersections. Beyond comparing outcomes between migrant and non-migrant origin, first-, and second-generation migrants and within occupational classes. Further, I highlight which groups are particularly vulnerable to poor health. To the best of my knowledge, this is the first study exploring health inequalities in a representative sample of the residing population in Europe integrating an intersectional approach.

5.2 Intersectionality and the Salience of Health Inequality Axes in Europe

Yuval-Davis suggests that intersectionality "should be considered the most valid theoretical approach to study social stratification" (Yuval-Davis, 2015, p.92) for two main reasons. Namely, because it contemplates the multiple mutually constituted social divisions in effect in any organization system of power and it acknowledges that the social, political, historic and economic context determines the salience and the effects of those social divisions. In this frame, public health researchers have employed intersectionality in order to highlight how health patterns and inequalities are shaped by multiple axes of social division (i.e. gender, race and/or class) (Agénor et al., 2014; Collins et al., 2008; Doyal, 2009; Fish, 2008; Iyer et al., 2008) and how certain policies and institutional arrangements have differential impact on people's health depending on their social positioning (Hankivsky et al., 2012; Viruell-Fuentes, 2012).

Looking at the European context, the salience of migration as a stratification mechanism with an accumulative and differential health impact between individuals and groups flows from the way migration influences access to social determinants of health (e.g. labor, safe housing, civil rights, safety) through official state regulations (e.g. work permits) or socio-cultural processes (e.g. everyday discrimination) (Bolzman et al., 2004; Carta et al., 2005). As stressed in the previous section, although integration and citizenship regimes may differ across countries, the dominant ideology of migration policy in Europe has been exclusive (Bradby et al., 2015; Carta et al., 2005; Rechel et al., 2011) driving migrants' social marginalization to a variant extent across states. Further, migrant generation status becomes salient when one considers the way that being born in a country often intersects with access to citizenship rights in Europe but also associates with a thorough acquaintance with the language and the culture of the residence country from a very early age through schooling and participating in neighborhood peer networks (Penninx & Garcés-Mascareñas, 2016), processes that are intertwined directly or indirectly with access to social determinants of health.

Similarly, the salience of socio-economic status as a driving force of health inequalities has been addressed since decades (as described in the literature review of this thesis) and has been documented by the observed lower life expectancy and the increased rates of mortality and morbidity among people with lower levels of occupational status, income, and education (Eikemo et al., 2008; Mackenbach et al., 1997; Mackenbach, 2006). Working class Europeans appear to be the most vulnerable to overall poor health and to a number of non-communicable diseases (McNamara et al., 2017a), while individuals with lower incomes appear more likely to report poor health (Eikemo et al., 2008). Finally, people with lower levels of education have been found to be more vulnerable to poor health as well as more likely to adopt specific risky health behaviors (Huijts et al., 2017). What is significant to notice here is that regardless of the differences across countries in terms of welfare state, economic prosperity, or inclusive policies, socio-economic inequalities in health have consistently the same direction, with lower social strata being systematically disadvantaged (Forster et al., 2018). Similarly, gender has been an always operating social stratification mechanism across countries (Anthias, 2001; Grusky, 2018; Orloff, 1993; Sainsbury, 1996) moderating the resources available to individuals to achieve their highest potential in health (Annandale, 2009; Annandale & Hunt, 2000). A common pattern is that although women live longer, they enjoy less healthy years than men (Bambra, 2009), which is associated with men's greater access to health promoting resources compared to women (Doyal, 2000) and to women's subordinate position within the patriarchal system (Palencia et al., 2017).

Each of the aforementioned axes of social stratification bears a particular meaning and operates in particular ways in each local context (Yuval-Davis, 2015), moreover the extent that they are relevant for individuals and the way they understand their experience varies tremendously (Collins, 2003). However, their role in the organization of power relations in Europe and the (re)production of social exclusion and consequently health disadvantage in the detriment of women, migrants and lower socio-economic strata is unquestionable. What still remains open to question though is the health impact of their intersections. In other words, what patterns of health inequality emerge, if I consider migration, gender and socio-economic dimensions simultaneously? How do multiply disadvantaged migrant women at lower socioeconomic strata evaluate their health compared to multiply privileged groups like non-migrant men in higher socio-economic strata or to groups who are simultaneously privileged and disadvantaged like non-migrant women in lower socio-economic strata? Is migrant generation status an additional intersecting factor that influences those patterns? The current explorative study aims to provide empirical evidence in order to answer such questions, focusing on migration-related health inequalities as the starting point from which to approach these intersections.

5.3 Intersectional Migration-related Health Inequalities in Europe

Acknowledging the interrelation of migration with additional health determinants, researchers have recently taken an intersectional turn aiming to study health inequalities across two or three dimensions. Studies from Spain have shown that migration-related health inequalities are more exacerbated within manual social classes, where migrant women appear to be more likely to report poor health than natives while the opposite pattern appears for men (Malmusi et al., 2010). Moreover, migrant women in the same classes tend to make less use of preventive care for cervical and breast cancer compared to their native counterparts (Pons-Vigues et al., 2011). Additional evidence suggests that beyond gender and socio-economic dimensions, migration-related health inequalities vary according to ethnicity and the actual migration process (Villarroel & Artazcoz, 2012). Those patterns have been associated with the fact that migration selection may benefit men more than women as family migration in Spain favours male employment; with the fact that women may face greater cultural barriers in healthcare settings; but also with the cumulative socio-economic and gender disadvantage women experience in their communities as well as in the labor market (Malmusi et al. 2010;

Pons-Vigues et al., 2011). Similar patterns have been documented also in Italy, where migrant women are less likely to utilise antenatal and postnatal care and more so, those women with low educational and employment status (Lauria et al., 2013); and in Portugal, where migrant women report worse health than men (Dias et al., 2013). This evidence suggests again that the health impact of socio-economic disadvantage may be stronger among migrant women who tend not to prioritize their health (Pons-Vigues et al., 2011), are often more exposed to workplace discrimination (Dzúrová & Drbohlav, 2014) and face greater work-related health and safety risk compared to native women (Mousaid et al., 2016). Moreover, research conducted in Austria has shown that after controlling for socio-economic characteristics, migration's negative health impact becomes stronger among women and that for certain migrant men, higher education and income reduce the chance for good health (Sardadvar, 2014). Finally, a study conducted in London showed that after controlling for demographic characteristics there are no differences between non-migrants and migrants regarding self-rated health, however differences emerge among migrants on the base of ethnicity (Gazard et al., 2015).

Building upon this work, the current study analyses migration-related health inequalities across gender, occupational status and migrant generation status and their intersections within a pooled European sample, in order to explore potential generalisable patterns that apply in the region. Given the variability of the existing findings, I adopt an explorative approach aiming also to be consistent with intersectionality theory suggesting that the configurations of inequalities among multiple and conflicting dimensions are fluid (McCall, 2005) while stratification processes that work in tandem often have unpredicted outcomes (Collins, 2015; Yuval-Davis, 2015).

5.4 Methods

Data description.

I used pooled data from six waves of the European Social Survey (ESS, 2004-2014), which is a cross-sectional survey conducted every two years across all European regions. My sample consisted of 166,734 individuals aged between 25 and 75 years across 27 European countries. Individuals younger than 25 years old were excluded from the sample because of the possibility that they might have still been students at the time of the survey, while those older than 75 years were excluded to overcome the issue of health selection at older ages (Blom et

al., 2016). Individuals of non-migrant origin, first- and second-generation migrants were included in the sample. Given that the data were collected in the language officially spoken in each country and that people with a precarious legal status and those socially marginalized are likely not represented (Weber & Parra-Medina, 2003), I consider that poorly integrated migrants are less likely to be effectively represented in the ESS sample (Huijts & Kraaykamp, 2012). The demographic characteristics of the sample are summarised in Table 1.

	Migrants					
	Non-migrants	1 st generation	2 nd generation			
	(N=141,001)	(N=14,052)	(N=11,681)			
	Mean (SD) / %	Mean (SD) / %	Mean (SD) / %			
Age	49.88 (13.99)	47.46 (13.71)	47.28 (13.55)			
Poor or very poor health	8.8	8.5	9.5			
Being hampered at least to some extent	25.1	22.7	27.7			
Women	53.4	54.8	53.9			
Less than secondary education	9.2	10.1	4.5			
Secondary education	68.2	63.6	70.1			
Tertiary education	22.6	26.4	25.4			
Services	32.6	28.0	35.9			
Intermediate category	27.3	22.5	26.5			
Manual	35.3	43.1	33.8			
Inactive	4.7	6.4	3.8			

 Table 1. Demographic characteristics of the studied sample

Source: European Social Survey (2004-2014)

Dependent variables.

My analysis is based on two self-rated health measures that have been extensively used in health inequalities studies. For the first measure, self-reported general health, I used the item "How is your health in general? Would you say it is very good, good, fair, bad, or, very bad?" operationalized as a dichotomous variable with 'poor or very poor health' coded as one and the rest of the options coded as zero (DeSalvo et al., 2005; Idler & Benyamini, 1997). This measure has proved effective in predicting mortality and morbidity and it is considered valid across different socio-economic groups (Bago d' Uva, 2008; Malmusi et al., 2010). Moreover, it captures the overall well-being of individuals including physical and mental stamina and/or disease. Similarly, I measured hampering conditions using the item "Are you hampered in your daily activities in any way by any longstanding illness, or disability, infirmity or mental health problem? If yes, is that a lot or to some extent?" with three answer options as "yes, a lot", "yes, to some extent" and "no". I constructed a dichotomous variable with 'a lot' and to 'some extent' coded as one and 'no' coded as zero (Eikemo et al., 2008). This item was also used in the analysis in line with previous research (for example, see Eikemo et al., 2008) and as a way to explore potential differences based on the health outcome studied.

Independent variables.

The individual indicators used were gender, migration status, and socio-economic position and all of them were operationalized as categorical variables. Given the limitations of the data, gender was operationalized as a binary variable with woman coded as one and man as zero. For migration status, I used available information on the respondents' country of birth as well as that of their parents. Migrants were defined as those respondents who had at least one foreign born parent, while first- and second-generation status was assigned on the base of whether the respondents had been born or not in the country where the survey took place (Blom et al., 2016). I used occupational status as a proxy for socio-economic position. Specifically, I merged ISCO88 and ISCO08 codes available in ESS waves into ISCO88 (Ganzeboom & Treiman, 2011) and then converted them into the European Socio-economic Classification Scheme (ESeC) (Rose & Harrison, 2007). Finally, I converted the ESeC classification into a four-category variable with the following categories; services including large employers & managers (ESeC classes I & II), intermediate category including higher and lower grade routine non manual employees and self-employed with no or few employees (ESeC classes IIIa, IIIb & IVab), manual employees including manual supervisors and skilled workers together with unskilled workers and farm laborers (ESeC classes V, VI, VIIab), and inactive including respondents who had never worked for six months or longer. The *inactive* category was integrated in the analysis as a separate category although it does not really represent specific occupations, in order to account for the fact that women were over-represented within it (almost 74%). Although, as a category it cannot really be located within a vertical hierarchy

of occupational status from lower to higher, I considered important to test its impact on selfreported health due to its relevance to women. In a similar logic, beyond occupational status, education was also included as a control variable in the models tested as a less gender sensitive measure of socio-economic position (Ross & Mirowski, 2006). Using the International Standard Classification of Education (ISCED, 2011) available in the ESS Survey, I constructed a new variable for the highest level of education achieved with the three following categories: *primary, secondary* and *tertiary* level. Finally, age was also included in the analysis as a continuous control variable.

Analysis.

Drawing on existing work on integrating intersectionality in quantitative research, I built my analysis using combined individual social categories for the creation of an 'intersectional matrix' (Bauer, 2014; Palencia et al., 2014; Sen et al., 2009; Sen & Iyer, 2012; Spierings, 2012). This matrix involved all the possible combinations between the dimensions of gender, migration status and occupational category (e.g. non-migrant woman at the services occupational category). As a first step, after weighting the sample for design errors, I started with a descriptive analysis across all the subgroups calculating the mean percentage of respondents reporting poor or very poor health and being hampered at least to some extent. The results of this descriptive analysis are presented separately for each health outcome in Table 2 and Table 3 respectively.

As a second step, using the pooled sample, I ran a series of multi-group single-level logistic regression models with two-way interactions between gender and occupational status (e.g. *woman X manual employee*) in order to capture the particular intersections and using migration status as the grouping variable in order to grasp the intersection between the three categories (e.g. *woman X manual employee X migrant*). While controlling for education and age, for each multilevel logistic regression model, I saved the predicted probabilities of reporting poor or very poor health and of being hampered at least to some extent as additional variables. At a final step, I calculated the mean predicted probability for each subgroup with a descriptive analysis of those probability variables. This single level analysis focuses on the intersections/ interactions across the three examined categories and their fixed effects (Bowleg, 2012; Evans et al., 2018), without however considering the clustering of individuals across countries and the potential impact of country level differences on the self-rated health

outcomes. Moreover, within these models the salience as well as the impact of all the examined categories as well as their intersections is treated as homogeneous across the European region.

However, based on previous work showing that cross-national differences in health inequalities among migrant and non-migrant groups are related to country level differences (see for example Blom et al., 2016; Huijts & Kraaykamp, 2012; Safi, 2010), as well as on recent theoretical arguments regarding intersectionality informed quantitative research (Evans et al., 202018; Scott & Siltanen, 2017), I considered important to further test the same relationships accounting for the country level variation in the self-rated health outcomes in two ways: First, testing the same single level models controlling for country level factors by adding country as a control variable; and second by testing the same regression models with a multilevel design. The difference between these two additional types of analysis is that the multilevel modeling allows for the relationship between the examined categories, their intersections and the health outcomes of interest to be calculated for each country (Scott & Siltanen, 2017). Thus, it accounts both for the fact that people living in the same country are not completely independent (by being exposed to the same context), and for the fact that the salience as well as the extent of the relationship between the intersecting categories and the health outcomes differs across contexts/countries. From this perspective, the multi-level design is deemed a better fit in terms of methodological robustness as well as in terms of alignment with the theoretical underpinnings of intersectionality (Evans et al., 2018; Scott & Siltanen, 2017; Yuval-Davis, 2015). Finally, testing the fixed country effects revealed Ukraine as rather an outlier case with increased negative values for both the self-rated health outcomes. For this, I ran a sensitive analysis that included the rest of the 26 countries, excluding Ukraine.

5.5 Results

Looking at the results of the different tested models, we observe that the single level models give very similar outcomes, both with and without controls for countries' fixed effects. As shown in the supplementary tables (1,3,5 and 6), most of the two-way and three-way interactions have a significant effect on both health outcomes. However, some variations exist, if we compare the single level with the multi-level models. As described in the methods section, the multilevel models are considered more effective in accounting for within-country similarities and across-country differences and they are better aligned with the theoretical underpinnings of intersectionality. Thus, here I discuss the results of the descriptive analysis

and the multi-level multi-group logistic regression models for the sample of the 27 countries. The results of the additional models are presented in the form of supplementary tables (1-8) and they are available at the end of this chapter.

5.5.1 Descriptive analysis.

Applying all the possible combinations between the dimensions of the examined categories (*gender* X occupational status X migration status), produced 24 distinct groups as shown in Table 2 and Table 3. The percentage of respondents who report bad health or worse varies significantly across groups. Specifically, first-generation migrant men in the services occupational class report the lowest rates (almost 4.1%) followed by non-migrant men in the same occupational category with rates of 4.8%. On the other end, non-migrant inactive women and second-generation migrant women in the manual employees' category report the highest rates, almost 17% and 16.8% respectively. Hence, if we were to put the 24 groups on a continuum from the lowest to the highest rates, we would see that the distance between the first and the last is almost 13%.

Focusing at migration related inequalities, we notice that the lowest prevalence for both self-rated health outcomes is found among first-generation migrant men in the services category. For hampering conditions, this applies across all occupational categories, while for reporting poor or very poor health, beyond the services category it applies also for manual employees. Overall, the ordering of non-migrant, first- and second-generation migrant groups varies across classes and genders. However, larger differences appear among women, with the widest gap found among manual employees between first- and second-generation migrants, who appear the most susceptible to negative health outcomes.

Looking at gendered inequalities across groups, overall women report higher rates of poor or very poor health than men. Exceptions are the first-generation migrants in the intermediate occupational category where the opposite pattern emerges and those in the inactive category where no difference is found. Moreover, for non-migrants and second-generation migrants, gendered inequalities increase as we move from higher to lower occupational categories while for both groups the greatest gender gap exists in the inactive category (4.3% for non-migrants and 7.7% for second-generation migrants). For the first-generation migrants, the picture appears different as the largest gender gap is found in the services category (almost 3.4%).

Looking at socio-economic inequalities in reporting poor or very poor health, we notice that the socio-economic gradient (Marmot, 2005) applies for men and women across all groups. However, the gap between the manual employees and the services occupational categories varies, with the smallest difference found among first-generation migrant men and the largest among second-generation migrant women. Although being inactive in the labor market does not say much about where you actually stand in relation to the rest of the occupational classes, my findings show that people outside the labor market bear a significant burden of poor health compared to that in the services category.

Regarding hampering conditions, the percentages again vary across groups but overall, they are much higher compared to bad health or worse. Second-generation migrant women in the manual employees' category and inactive second-generation migrant men report the highest rates at 38.4% and 38.2% respectively. The lowest rates are found among inactive first-generation migrant women at 11.2%. Again, women report being hampered at higher rates in most cases, however the opposite pattern emerges in the inactive groups and among the first-generation migrants in the intermediate occupational category. The gender gap again appears wider among manual employees and inactive individuals. Finally, the socio-economic gradient applies here as well with the widest gap found among second-generation migrants and especially women (almost 15%).

	Services		Intermediate		Manual Employees		Inactive	
	Men	Women	Men	Women	Men	Women	Men	Women
Non-migrants	4.8% (n=19,792)		6.6% (n=12,649)	7.7% (n=22,034)	10.2% (n=25,437)	14.7% (n=17,747)	12.7% (n=1,638)	17% (n=4,607)
Migrants 1 st generation	4.1% (n=1,576)	7.5% (n=1765)	8.3% (n=1,262)	7.8% (n=1,908)	8.9% (n=3,496)	10.9% (n=2,697)	11.2% (n=241)	11.2% (n=852)
Migrants 2 nd generation	5.7% (n=1,846)	5.7% (n=1,919)	7.1% (n=1,014)	10.2% (n=1,959)	11.4% (n=2,115)	16.8% (n=1,372)	8% (n=162)	15.7% (n=281)

Table 2. Percentages of reporting poor or very poor health across groups

Source: European Social Survey (2004-2014)

	Services		Intermediate		Routine & Manual		Inactive	
	Men	Women	Men	Women	Men	Women	Men	Women
Non-migrants	19.1%	22.4	21.5%	23.6%	26.7%	34.3%	34.7%	17%
	(n=19,746)	(n=18,987)	(n=12,609)	(n=22,022)	(n=25,386)	(n=17,711)	(n=1,621)	(n=4,607)
Migrants	16.9%	21.6%	22.8%	21.5%	22.8%	27.3%	25.8%	11.2%
1 st generation	(n=1,572)	(n=1761)	(n=1,262)	(n=1,899)	(n=3,487)	(n=2,697)	(n=240)	(n=852)
Migrants	21.1%	23.8%	23.4%	28.5%	30.3%	38.4%	38.2%	15.7%
2 nd generation	(n=1,850)	(n=1,921)	(n=1,014)	(n=1,957)	(n=2,119)	(n=1,371)	(n=157)	(n=281)

Table 3. Percentages of reporting being hampered across groups

Source: European Social Survey (2004-2014)

5.5.2 Multi-level logistic regression analysis.

Self-rated general health.

Inequalities between migrant & non-migrant groups.

Looking at the results of the multilevel logistic regression model for self-rated poor or very poor health (Table 4), we notice first that the variance of poor or very poor health is explained by country level factors to a significant extent for all groups but less so for second-generation migrants (24% compared to 30% for first-generation and 33% for non-migrants). This underlines the importance of taking into account cross-national variation through the multilevel models. Regarding inequalities between non-migrants, first- and second-generation migrants (Table 5), within the services category, there are almost no observed differences among men, but differences are observed for women, with first-generation migrant women having the highest probability to report poor or very poor health (pp=0.071). In the intermediate occupational category, inequalities follow a different pattern for men and women as well, with first-generation migrant men and second-generation migrant women being the most likely to report poor or very poor health (pp=0.071 and pp=0.082 respectively).

Among manual employees, first-generation migrant men and women are the least likely to report poor or very poor health although there is a noticeable gender difference (pp=0.086 for men and pp=0.130 for women). Further, second-generation migrant women bear a slight disadvantage (pp=0.163) compared to their non-migrant counterparts (pp=0.147) while for men, differences between second-generation migrants and non-migrants appear negligible (pp=0.110 and pp=0.103 respectively). Finally, for individuals outside the labor market, first-

generation migrant men have the highest probability compared to the rest of men, while the same applies for non-migrant women among women.

Inequalities within migrant & non-migrant groups.

As shown by the results of the multilevel logistic regression model (Table 4), gender has a significant health impact only for non-migrant and first-generation migrant groups which is stronger among the latter (expB= 1.45, p< .005). Further, lower occupational status associates significantly with greater probability of reporting poor or very poor health for all groups but less so for first-generation migrants. In detail, we see that first-generation migrants who belong to the manual occupational category are 54% (expB=1.54, p<.001) more likely to report poor or very poor health compared to their counterparts in the services occupational category, while for non-migrant groups the respective difference is 64% (expB=1.64, p<.005) and for secondgeneration migrants is 70% (expB=1.7, p< .001). Across all groups, individuals outside the labor market bear the greatest disadvantage in their likelihood to report poor or very poor health and particularly so for first-generation migrants (expB=3.38, p<.001). Finally, while no significant differences emerge between the services and the intermediate category for nonmigrants and second-generation migrants, the opposite applies for first-generation migrants who seem to be penalized by intermediate occupational status compared to both services and manual employees (expB=1.64, p<.005). Finally, regarding three-way interactions, there are significant differences for professionally inactive first-generation migrant women and for those in the intermediate occupational category (expB=0.55, p<0.05 and expB=0.61, p<0.05 respectively).

		Non-migrants N=140,377		Migrants 1 st generation N=13,903			Migrants 2 nd generation N=11,630		
	В	SE	Exp B	В	SE	Exp B	В	SE	Exp B
Intercept	-5.08	0.13	0.01***	-4.95	0.25	0.01***	-4.60	0.27	0.01***
Age	0.05	0.00	1.05***	0.05	0	1.05***	0.05	0	1.05***
Gender (ref = man)									
Woman	0.17	0.05	1.19***	0.37	0.15	1.45**	0.18	0.15	1.19
Educational level (ref= pri	mary educa	tion)							
Secondary education	-0.5	0.04	0.61***	-0.56	0.1	0.57***	-0.56	0.14	0.57***
Tertiary education	-1.01	0.05	0.37***	-0.93	0.13	0.4***	-1.24	0.18	0.29***
Occupational status (ref=s	ervices)								
Intermediate category	0.07	0.05	1.07	0.5	0.17	1.64**	0.07	0.18	1.07
Manual employees	0.49	0.04	1.64***	0.43	0.14	1.54**	0.53	0.14	1.7***
Inactive in labor market	0.74	0.09	2.09***	1.22	0.25	3.38***	0.81	0.3	2.25**
Gender*occupational statu	S								
Women inactive	-0.13	0.1	0.88	-0.6	0.3	0.55*	-0.23	0.36	0.80
Women manual	0.08	0.05	1.08	-0.05	0.17	0.95	0.17	0.18	1.18
Women intermediate	0.03	0.06	1.03	-0.5	0.21	0.61*	0.140	0.22	1.15
Random intercept	0.33***			0.3**			0.24**		

Table 4. Multilevel logistic	rearession results	for renorting noor	or very poor health
I UDIE 4. MIUIIIEVEI IDZISIIC	regression results		

Source: European Social Survey (2004-2014) Sig two tailed * $p \le .05$ ** $p \le .005$ *** $p \le .001$

	Services	Intermediate	Manual Employees	Inactive
	Man Woma	n Man Woma	n Man Woman	Man Woman
Non-migrants	0.044 0.053	0.056 0.071	0.103 0.147	0.124 0.156
Migrants 1 st generation	0.045 0.071	0.071 0.074	0.086 0.130	0.144 0.134
Migrants 2 nd generation	0.044 0.057	0.057 0.082	0.110 0.163	0.111 0.143

Table 5. Mean predicted probability of reporting poor or very poor health across groups (ml)

Source: European Social Survey (2004-2014)

Note: Probabilities are calculated as produced by the ML logistic regression models, where I controlled for subjects' educational levels and age. The mean probability was calculated separately for each group.

Hampering conditions.

Inequalities between migrant & non-migrant groups.

Table 6 shows the multilevel logistic regression results for reporting being hampered in daily activities at least to some extent. Looking at the random intercept, it seems that country level factors explain reporting being hampered to a lesser extent than they do for general selfrated health, while there are also differences across groups, with more variance explained at the country level for first-generation migrants (29%). Translating those results into the mean predicted probabilities for each group (Table 7), overall the predicted probability of reporting being hampered at least to some extent is higher than what it is for reporting poor or very poor health. Moreover, first-generation migrant men are the least likely to be hampered compared to all other groups (pp=0.172), followed by non-migrants and second-generation migrants (pp=0.190 and pp=0.204 respectively). Similarly, second-generation migrants appear to be the most susceptible to report a hampering condition across the rest of the categories for men and for the intermediate and manual category for women. Again, among manual employees, firstgeneration migrant men (pp=0.253) and women (pp=0.294) are the least likely to report being hampered compared to second-generation migrants and non-migrants. The same pattern appears in the inactive category as well, where for women the largest probability appears among non-migrants (pp=0.331).

Inequalities within migrant & non-migrant groups.

The multilevel logistic regression results (Table 6) show that gender has an equivalent impact across the three groups which is slightly less strong among second-generation migrants (expB=1.20, p<.005). Again, almost all the categories of occupational status have a highly significant impact across all the groups. Manual employees are the most likely to report being hampered at least to some extent, with the greatest gap between the services and the manual category found among first-generation migrants (expB=1.46, p <.001). Significant impacts appear also for professionally inactive individuals across all groups, with the widest inequality found among second-generation migrants (expB=2.47, p<.001). Finally, regarding inequalities between the services and the intermediate category, significant differences appear only for nonmigrants and first-generation migrants. Among the latter, individuals in the intermediate occupational category are 45% more likely to report being hampered compared to their counterparts in the services sector, which is equivalent to the gap observed between the services and the manual category as well. Finally, looking at the intersections, being a woman interacts significantly with being inactive in the labor market for the benefit of women within all groups and particularly so for second-generation migrant women (expB=0.52, p<.005), while gender interacts also with the intermediate occupational category for the benefit of non-migrant and first-generation migrant women (expB=0.92, p<.05 and expB=0.8, p<.05 respectively).

	Non-Migr	ants N=	-139,977	Mi 1 st Genera	grants tion N=:	14,052	N 2 nd Gener	Aigrants ration N	
	В	SE	Exp B	В	SE	Exp B	В	SE	Exp B
Intercept	-3.35	0.1	0.04***	-3.46	0.18	0.03***	-3.05	0.18	0.05***
Age	0.04	0	1.04***	0.05	0	1.05***	0.04	0	1.05***
Gender (ref = man)									
Woman	0.21	0.02	1.24***	0.21	0.09	1.24*	0.18	0.08	1.2**
Educational level (ref= p	rimary educ	ation)							
Secondary education	-0.28	0.03	0.75***	-0.34	0.07	0.71***	-0.35	0.11	0.7***
Tertiary education	-0.59	0.03	0.55***	-0.62	0.09	0.54***	-0.66	0.12	0.52***
Occupational status (ref=	services)								
Intermediate category	0.12	0.03	1.13***	0.37	0.1	1.45***	0.13	0.1	1.14
Manual employees	0.37	0.03	1.44***	0.38	0.09	1.46***	0.35	0.08	1.41***
Inactive in labor market	0.68	0.06	1.98***	0.77	0.19	2.16***	0.90	0.2	2.47***
Gender*occupational sta	tus								
Women inactive	-0.25	0.07	0.78***	-0.37	0.22	0.69*	-0.65	0.24	0.52**
Women manual	0.04	0.03	1.04	-0.09	0.11	0.91	0.07	0.11	1.07
Women intermediate	-0.09	0.04	0.92*	-0.22	0.13	0.8*	-0.05	0.12	0.95
Random									
Random intercept	0.21***			0.29***		().17**		

Table 6. Multilevel Logistic Regression Results for Reporting Being Hampered

	Se	rvices	Interr	nediate	Manual	Employees	Inactive		
	Man	Woman	Man	Woman	Man	Woman	Man	Woman	
Non-migrants	0.190	0.216	0.211	0.242	0.280	0.348	0.317	0.331	
Migrants 1 st generation	0.172	0.216	0.218	0.241	0.253	0.294	0.294	0.279	
Migrants 2 nd generation	0.204	0.237	0.230	0.262	0.298	0.369	0.357	0.325	

Table 7. Mean Predicted Probability of Reporting Being Hampered Across Groups (ml)

Source: European Social Survey (2004-2014)

Note: Probabilities are calculated as produced by the ML logistic regression models, where I controlled for subjects' educational levels and age. The mean probability was calculated separately for each group.

5.6 Discussion

This chapter presents an intersectionality informed explorative quantitative analysis of migration-related health inequalities in a pooled representative sample of the European population aged 25 to 75, across 27 countries. Employing an inter-categorical intersectional perspective (McCall, 2005), I explored migration-related health inequalities in light of migrant generation, gender, and occupational status. In my study, I operationalized the intersections between gender and socio-economic status using two-way interactions and I ran single level fixed effects and multilevel mixed effects logistic regression models separately for nonmigrants, first- and second-generation migrants (Scott & Siltanen, 2017; Spierings, 2012). The multilevel design of the tested models allowed me to account for the country level variation of the outcomes but also for the fact that social categories and their intersections have a different salience and impact across contexts (Scott & Siltanen, 2017). Both the single level models and the multilevel models, showed significant two-way and three-way interactions between migration status, gender and occupational categories and hence, they provide important empirical evidence regarding the intersectional nature of health inequalities in Europe across these three categories. Focusing on the outcomes of the multi-level models due to their increased robustness and better alignment to intersectionality theory, distinct emerging conclusions for the studied relationships of health inequality are presented below.

5.6.1 Intersectional migration-related health inequalities in Europe.

The first important conclusion that emerges from my findings is that migration-related health inequalities in Europe vary according to gender, occupational status, generation but also the health outcome studied, and this applies regardless of the macro-level differences existing across countries. This adds to the pre-existing evidence from separate countries like Spain, Italy, Portugal, Austria or Czech Republic (Dzúrová & Drbohlav, 2014; Lauria et al., 2013; Malmusi et al., 2010; Villarroel & Artazcoz, 2012) and underlines the relevance of intersectionality in the future study of health inequalities across Europe. Moreover, my results show that the mean predicted probability for reporting a hampering condition is generally higher than for reporting poor or very poor health across all the examined groups. This implies that the respondents of the specific sample do not necessarily evaluate their health as poor or very poor, if they suffer from a condition that hampers their everyday activity but also shows that health inequalities in Europe are subject to the health outcome measured (Gazard et al., 2015).

Regarding differences between migrant and non-migrant groups, my findings are partially in line with the 'healthy migrant effect' (Giannoni et al., 2016; La Parra Casado et al., 2017; Malmusi et al., 2010) according to which recently arrived migrants are generally healthier than non-migrants or second-generation migrants. However, this seems to be subject to occupational status and gender. Specifically, first-generation migrant men and women are less likely to report negative health outcomes compared to non-migrants or second-generation migrants, if they belong to the manual occupational category, while this advantage appears less pronounced in the rest of the occupational categories and between men and women. This might be attributed to a series of reasons ranging from selection (i.e. only the healthier migrants decide to migrate) (Moullan & Jusot, 2014) to structural effects relevant with discrimination (Krieger, 2000; Nazroo, 2003) and processes of 'othering' (Viruell-Fuentes, 2007) that operate simultaneously and in different ways for men and women but also across occupational classes. This finding may also indicate that selection on the basis of physical well-being is mostly important for the manual sector, which is actually the main section of the labor market that migrants are channeled to in Europe (Farris, 2015).

Focusing on second-generation migrants, overall, they report the highest prevalence of negative health outcomes for both the examined measures. This picture is consistent with previous research in Europe (Blom et al., 2016; La Parra Casado et al., 2017; Ronellenfitsch & Razum, 2004) and with explanations suggesting that second-generation migrants are

differentially and cumulatively affected by discrimination in their hosting society compared to recent migrants (Krieger, 2000). However, my intersectional approach has revealed that health inequalities between second-generation migrants and the rest of the groups are wider for women with lower socio-economic status. This finding agrees with what Malmusi and colleagues (2010) found in Spain and hints to the fact that despite being socialized in the hosting country, second-generation migrant women in manual jobs may be exposed to greater workplace discrimination (Dzúrová & Drbohlav, 2014) or health and safety risks (Mousaid et al, 2016).

5.6.2 Integrating intersectionality: what's the added value?

As the prominent scholar Angela Davis put it recently, as academics "what we are doing is trying to find ways to give expression to the social reality that always exceeds our ability to find concepts" (Davis, 2017). In this complex social reality, we need a broad but simultaneously meticulous scope in order to capture social processes in their entirety. Adopting such a scope in the study of health inequalities urges us to move beyond established binary comparisons and explore how multiple dimensions of social positioning are relevant for the emergence of multiple relationships of health inequality. Hence, reading my results wearing an intersectional lens reveals far more relationships of inequality than the traditional binary approaches as my tables can be read vertically, horizontally, diagonally as well as per pairs of columns or lines (Spierings, 2012). Moreover, it allows us to evaluate where each group stands compared to the others and to estimate the difference between those who are best and those worst off. For example, we notice that the mean predicted probability for reporting poor or very poor health ranges from 0.044 among non-migrant and second-generation migrant men in the services' category to 0.163 among second-generation migrant women in the manual employees' category. Furthermore, intersectionality revealed the situation of the middle groups i.e. those that combine privilege in some dimensions and disadvantage in others (Sen et al., 2009). Considering both outcome variables, we see for example that within occupational categories, non-migrant women are worse off than all men. We understand then, that being a man in Europe implies a health privilege both for migrants and non-migrants that is maintained regardless of the socio-economic status. Findings like these offer evidence for the mutual constitution of social divisions (Collins, 2015) but also for the fact that in the European context

the social divisions of gender, migration status and socio-economic position are all crucial for the emergence of health inequalities (Yuval-Davis, 2013).

Additionally, the intersectional approach allowed the study of 'internal' inequalities within migrant and non-migrant groups (Hancock, 2013; Weldon, 2006). For example, it is striking that the widest gender gaps for poor health and hampering conditions are observed in the manual employees' category both for migrants and non-migrants in line with previous research (Borrell et al., 2004; Malmusi et al., 2010). These findings may associate with the fact that horizontal and vertical segregation pushes women in specific sectors (e.g. garment industry) and in lower positions (Campos-Serna et al., 2013; Krieger et al., 1997). Women have been found to experience greater levels of precariousness, to be employed more often with part-time and fixed-term contracts or without contracts and to experience gender discrimination and sexual harassment (Campos-Serna et al., 2013). These factors are likely to be more intense in manual professions and combined with the already increased physical, hygiene and ergonomic hazards of the manual sector may be responsible for the increased burden of poor health among women. Regarding particularly hampering conditions among men and women in the inactive category and the reversed emerging pattern among migrants (women's pp=0.325, men's pp=0.357), we are unable to come up with safe conclusions due to the cross-sectional nature of the data, however we could hypothesize that given that migration has been centered mainly around male employment (Malmusi et al., 2010), being professionally inactive for migrant men may coincide with poor health more often than what it does for migrant women.

5.6.3 Limitations.

The main limitation of my study regards the data and the formation of the examined categories. The gender variable reflects the mainstream binary understanding (Johnson et al., 2009) and does not allow the disentanglement between sex and gender, while measures of migration status could only be constructed indirectly, using information on the respondents' and their parents' country of birth with self-definition information being unavailable. Moreover, robust indicators of race and ethnicity were also unavailable (although technically a proxy variable could be constructed for ethnic origin, on the basis of respondents' or their parents' country of birth, I considered this an ineffective and potentially misleading measure). Hence, I haven't been able to explore migration-related health inequalities on the basis of racial and ethnic differences (e.g. black migrants compared to whites or inequalities between migrant

groups of different ethnic origins). I consider crucial that migration will be integrated in future comparative health inequalities research as a salient category for social stratification in Europe. However, ideally this should also involve the opportunity to explore how its intersection with particular ethnic and racial categories renders certain groups of migrants more vulnerable to poor health than others. The absence or the unsuitability of measures of other axes of social division like ethnicity, race and gender as a non-binary construct, reflect the marginal significance of those axes in the understanding of inequality (Kapilashrami et al., 2015; Weber & Parra-Medina, 2003) and are indicative of the social divisions considered important both in the academic context and the public sphere in Europe (Collins, 2003). Hence, although my study focuses on social divisions that tend to shape the reality of most of us who live in Europe (Yuval-Davis, 2013), it is less effective in integrating others that are neglected within the dominant academic and public discourse (e.g. inequalities affecting lesbian or gay migrants).

An additional relevant limitation concerns the use of self-rated health outcome measures. As discussed in chapter three, self-rated health measures have been found to associate with subsequent mortality, functional health decline and morbidity onset (Benyamini & Idler, 1999; DeSalvo et al., 2006; Idler & Angel, 1990; Idler & Benyamini, 1997; Shadbolt et al., 2002; Subramanian et al., 2008; Walker et al., 2004; Wolinsky & Johnson, 1992; Young et al., 2010) and it is reasonable to use them as effective proxies for actual health. However, there has been an additional stream of research showing that the way people assess their health is subject to their actual and relative social position (Idler & Benyamini, 1997) as well as to the extent of inequality within the societies they live, with people living in more unequal societies tending to evaluate their health as better than it actually is (Barford et al., 2009; Dorling & Barford, 2009; Wilkinson & Pickett, 2019). Scholars suggest that these patterns likely emerge because when people live in unequal and competitive social contexts, their self-image is more often challenged and threatened. As a result, they tend to overestimate their strength and well-being as a way to deal with these threats (Barford et al., 2009). These arguments suggest that probably self-rated health measures do not always capture actual health, at least not in the same way for everyone and across different contexts. The discrepancies between the two outcome measures used in the current study seem to indicate this as well. The multilevel models account for crossnational differences including those concerning the content of self-rated health measures. However, what emerges as relevant here is whether individuals and groups who occupy disadvantaged social positions evaluate their health as better than it actually is, because this means that the observed inequalities in this study are likely an underestimation of the actual

health inequalities operating in the examined context. Future intersectional research would benefit from the use of objective health measures such as life-expectancy and/or mortality.

Another limitation is that due to the small size of certain subgroups (e.g. inactive secondgeneration migrant men), it was not feasible, based on my data, to examine whether my results vary across the countries in my sample (e.g. by including random slope effects of gender, occupational status and their intersections at the country level in my models). On the one hand, the exact role of gender, occupational status and migrant generations in migration-related health inequalities may indeed vary cross-nationally, for example due to differences in the composition of migrant groups across countries. On the other hand, however, my multilevel models do take cross-national differences into account, and I am confident that my results for Europe are not driven solely by a limited number of countries in the sample. Moreover, it should be kept in mind that the power structures around gender, class and migration status are global in nature; although the scope and organization of these structures may vary across countries, hierarchies of privilege and disadvantage are not unique to specific national contexts. Future work, ideally based on data for even larger numbers of people, may be able to shed further light on the extent to which my results are similar across countries in Europe and beyond. Similarly, due to sample size limitations, it was not really feasible to conduct meaningful comparisons across time. My data was pulled across the period of a decade that involved the financial crisis of 2008, which impacted the situation of multiple populations residing in Europe but also their mobility patterns (Hermann, 2017; Kohl, 2015). Hence, it would be meaningful to explore whether the observed health inequalities differed between the period before 2008 and the period after. However, what I was able to do was to run the same analysis while controlling for study wave. That produced the same results and in combination with the fact that data included three waves up to 2008, and three waves after that year and that the examined migrant groups were likely settled across all waves, indicate that the observed health inequalities are rather stable across time for the specific sample. Finally, although my study offers a more integrative and accurate depiction of health inequalities in Europe, the actual mechanisms and processes through which health inequalities emerge (Yuval-Davis, 2015) need to be further explored. These processes involve the way that intersections result into the accumulation of privilege or disadvantage, and the ways that certain individuals and groups counteract the disadvantage they suffer in certain dimensions with the privilege they enjoy in others (Sen & Iyer, 2011). Moreover, they involve macro-level factors such as migrant

integration policies (Malmusi et al., 2014), healthcare policies (Blom et al., 2016), or labor market and equal opportunities policies.

across groups										
		on-migra N=122,11		1st gene	Migrant cration (N	s (=13,612)	Migrants 2nd generation (N=10,615)			
	В	S.E.	EXP(B)	В	S.E.	EXP(B)	В	S.E.	EXP(B)	
Age	0.05	0.00	1.05***	0.05	0.00	1.05***	0.04	0.00	1.04***	
Gender (ref = mar	n)									
Woman	0.38	0.05	1.46***	0.65	0.16	1.92***	-0.03	0.14	0.97	
Educational level	(ref= ter	tiary edu	cation)							
Primary education	0.66	0.05	1.94***	0.42	0.12	1.52***	1.12	0.15	3.07***	
Secondary education	0.45	0.04	1.57***	0.21	0.10	1.24*	0.78	0.12	2.18***	
Occupational stat	us (ref=s	ervices)								
Intermediate category	0.23	0.05	1.26***	0.84	0.17	2.31***	0.02	0.16	1.02	
Manual employees	0.64	0.04	1.89***	0.80	0.15	2.22***	0.41	0.13	1.50***	
Inactive in labor market	0.94	0.09	2.56***	1.28	0.25	3.60***	0.29	0.32	1.33	
Gender*occupation	onal statı	IS								
Women inactive	-0.36	0.10	0.70***	-0.88	0.29	0.41**	0.43	0.38	1.54	
Women manual	-0.06	0.06	0.95***	-0.52	0.18	0.60**	0.38	0.18	1.47*	
Women intermediate	-0.22	0.06	0.80***	-0.52	0.18	0.60**	0.38	0.18	1.47*	

Supplementary Table 1. Single level logistic regression results for reporting poor or very poor health across groups

	Services		Interr	nediate	Manual	Employees	Inactive		
	Man	Woman	Man	Woman	Man	Woman	Man	Woman	
Non-migrant	0.047	0.061	0.066	0.077	0.101	0.147	0.130	0.172	
Migrant 1 st generation	0.042	0.076	0.084	0.078	0.090	0.110	0.114	0.116	
Migrant 2 nd generation	0.058	0.057	0.071	0.103	0.113	0.169	0.080	0.160	

Supplementary Table 2. Mean Predicted probabilities for reporting poor or very poor health across groups (single level)

Source: European Social Survey (2004-2014)

Note: Probabilities are calculated as produced by the single level logistic regression models, where I controlled for subjects' educational levels and age. The mean probability was calculated separately for each group.

groups										
		n-migra =121,85		1 st Gene	Migrants eration (N		Migrants 2 nd Generation (N=10,624)			
	В	S.E.	EXP(B)	В	S.E.	EXP(B)	В	S.E.	EXP(B)	
Age	0.04	0	1.04***	0.05	0	1.05***	0.04	0	1.04***	
Gender (ref = ma	n)									
Woman	0.30	0.03	1.35***	0.32	0.09	1.38***	0.15	0.08	1.16*	
Educational level	(ref= tert	iary)								
Primary education	0.12	0.03	1.13***	0.18	0.08	1.19*	0.57	0.10	1.77***	
Secondary education	0.31	0.02	1.37***	0.08	0.06	1.09	0.34	0.06	1.41***	
Occupational Stat	tus (ref=se	ervices)								
Intermediate category	0.11	0.03	1.12***	0.54	0.10	1.71***	0.06	0.10	1.06	
Manual employees	0.35	0.03	1.42***	0.46	0.09	1.58***	0.32	0.08	1.38***	
Inactive in labor market	0.87	0.06	2.38***	0.87	0.18	2.38***	0.98	0.19	2.67***	
Gender*occupation	onal status	5								
Women inactive	-0.64	0.07	0.53***	-0.84	0.20	0.44***	-1.00	0.24	0.37***	
Women manual	-0.01	0.03	0.99	-0.16	0.11	0.85	0.12	0.11	1.13	
Women intermediate	-0.21	0.04	0.81***	-0.55	0.13	0.58***	0.05	0.12	1.05	

Supplementary Table 3. Single level logistic regression results for reporting being hampered across groups

	Services		Interr	nediate	Manual	Employees	Inactive		
	Man	Woman	Man	Woman	Man	Woman	Man	Woman	
Non-migrant	0.189	0.223	0.215	0.235	0.266	0.342	0.353	0.336	
Migrant 1 st generation	0.169	0.216	0.230	0.214	0.230	0.274	0.265	0.215	
Migrant 2 nd generation	0.213	0.237	0.234	0.282	0.302	0.385	0.385	0.285	

Supplementary Table 4. Mean predicted probabilities for reporting being hampered across groups (single level)

Source: European Social Survey (2004-2014)

Note: Probabilities are calculated as produced by the single level logistic regression models, where I controlled for subjects' educational levels and age. The mean probability was calculated separately for each group.

· · · · · · · · · · · · · · · · · · ·	No	on-migra	nts		Migrant	s	Migrants				
		N=122,11		1st gene		=13,612)	2nd generation (N=10,615)				
	В	S.E.	EXP(B)	В	S.E.	EXP(B)	В	S.E.	EXP(B)		
Age	0.05	0.00	1.05***	0.05	0.00	1.05***	0.04	0.00	1.04***		
Gender (ref = mar	n)										
Woman	0.31	0.05	1.36***	0.53	0.16	1.69***	-0.10	0.14	0.91		
Educational level	(ref= pri	imary edu	cation)								
Secondary education	-0.49	0.03	0.61***	-0.54	0.09	0.58***	-0.73	0.12	0.48***		
Tertiary education	-0.99	0.05	0.37***	-0.85	0.12	0.43***	-1.528	0.16	0.22***		
Occupational stat	tus (ref=s	ervices)									
Intermediate category	0.17	0.05	1.19***	0.79	0.17	2.20***	0.02	0.17	0.99		
Manual employees	0.49	0.04	1.64***	0.68	0.15	1.97***	0.31	0.13	1.36*		
Inactive in labor market	0.77	0.09	2.16***	1.07	0.26	2.92***	0.12	0.32	1.13		
Gender*occupation	onal statu	lS									
Women inactive	-0.24	0.10	0.78*	-0.66	0.29	0.53**	0.64	0.38	1.90*		
Women manual	-0.02	0.06	0.99	-0.47	0.18	0.62*	0.42	0.18	1.52*		
Women intermediate	-0.18	0.07	0.84***	-0.76	0.21	0.47***	0.44	0.21	1.55*		

Supplementary Table 5. Single level logistic regression results for reporting poor or very poor health
across groups controlling for country

		on-migra N=122,11		1st gene	Migrant ration (N	s I=13,612)	Migrants 2nd generation (N=10,615)			
	В	S.E.	EXP(B)	В	S.E.	EXP(B)	В	S.E.	EXP(B)	
Age	0.05	0.00	1.05***	0.05	0.00	1.05***	0.05	0.00	1.05***	
Gender (ref = ma	n)									
Woman	0.26	0.03	1.29***	0.22	0.10	1.24*	0.10	0.08	1.11	
Educational level	(ref= pri	imary edu	cation)							
Secondary education	-0.29	0.03	0.75***	-0.36	0.06	0.70***	-0.60	0.09	0.55***	
Tertiary education	-0.59	0.03	0.56***	-0.45	0.08	0.64***	-0.95	0.11	0.39***	
Occupational stat	tus (ref=s	ervices)								
Intermediate category	0.15	0.03	1.16***	0.56	0.10	1.75***	0.07	0.10	1.08	
Manual employees	0.32	0.03	1.37***	0.43	0.09	1.54***	0.28	0.08	1.33***	
Inactive in labor market	0.86	0.06	2.35***	0.80	0.18	2.22***	0.92	0.19	2.52***	
Gender*occupati	onal statu	IS								
Women inactive	-0.48	0.07	0.62***	-0.68	0.21	0.51***	-0.89	0.24	0.41***	
Women manual	-0.02	0.06	0.99	-0.19	0.12	0.91	0.16	0.11	1.18	
Women intermediate	-0.18	0.07	0.84***	-0.48	0.13	0.62***	0.09	0.12	1.09	

Supplementary Table 6. Single level logistic regression results for reporting being hampered across
groups controlling for country

		-migraı 136,73		Mi 1 st generat	grants ion N=	13,490	Migrants 2 nd generation N=11,025		
	В	SE	Exp B	В	SE	Exp B	В	SE	Exp B
Intercept	-5.01	0.13	0.01***	-4.90	0.25	0.01***	-4.66	0.28	0.01***
Age	0.05	0.00	1.05***	0.05	0	1.05***	0.05	0	1.05***
Gender (ref = man)									
Woman	0.13	0.05	1.14**	0.36	0.16	1.43*	0.18	0.15	1.20
Educational level (ref= prin	nary educa	tion)							
Secondary education	-0.5	0.04	0.61***	-0.58	0.1	0.56***	-0.51	0.14	0.60***
Tertiary education	-1.01	0.05	0.36***	-0.97	0.13	0.38***	-1.20	0.18	0.30***
Occupational status (ref=se	ervices)								
Intermediate category	0.07	0.05	1.07	0.51	0.18	1.67**	0.08	0.19	1.09
Manual employees	0.50	0.04	1.65***	0.43	0.15	1.53**	0.57	0.15	1.77***
Inactive in labor market	0.74	0.09	2.08***	1.31	0.25	3.72***	0.98	0.31	2.65**
Gender*occupational statu	5								
Women inactive	-0.09	0.1	0.91	-0.68	0.29	0.51*	-0.35	0.37	0.71
Women manual	0.11	0.06	1.11*	-0.06	0.18	0.94	0.15	0.19	1.16
Women intermediate	0.07	0.07	1.07	-0.51	0.22	0.60*	0.11	0.23	1.12
Random intercept	0.28***			0.25**			0.21*		

Supplementary Table 7. Multilevel logistic regression results for reporting poor or very poor health (excluding Ukraine)

	Non-migrants N=136,393			Migrants 1 st generation N=13,450			Migrants 2 nd generation N=11,007		
	В	SE	Exp B	В	SE	Exp B	В	SE	Exp B
Intercept	-3.34	0.10	0.04***	-3.48	0.18	0.03***	-3.20	0.18	0.04***
Age	0.04	0.00	1.04***	0.05	0	1.05***	0.04	0	1.04***
Gender (ref = man)									
Woman	0.20	0.02	1.22**	0.20	0.09	1.22*	0.21	0.08	1.23**
Educational level (ref= prin	nary educa	tion)							
Secondary education	-0.28	0.03	0.75***	-0.34	0.07	0.71***	-0.30	0.10	0.74***
Tertiary education	-0.60	0.03	0.55***	-0.64	0.09	0.53***	-0.59	0.12	0.56***
Occupational status (ref=se	ervices)								
Intermediate category	0.13	0.03	1.13***	0.36	0.11	1.44**	0.18	0.10	1.19*
Manual employees	0.37	0.02	1.45***	0.39	0.09	1.47**	0.41	0.08	1.50***
Inactive in labor market	0.68	0.06	1.98***	0.80	0.19	2.22***	1.00	0.21	2.72**
Gender*occupational statu	5								
Women inactive	-0.24	0.07	0.79***	-0.37	0.22	0.69*	-0.68	0.25	0.51**
Women manual	0.04	0.03	1.04	-0.09	0.11	0.92	0.01	0.11	1.01
Women intermediate	-0.07	0.04	0.93*	-0.21	0.13	0.81	-0.10	0.13	0.91
Random intercept	0.18***			0.24***			0.16**		

Supplementary Table 8. Multilevel logistic regression results for reporting being hampered (excluding Ukraine)

Chapter 6

Health at the Border: An intersectional analysis of the health-related response to refugees and migrants at Greek border spaces during 2015-2018

6.1 Introduction

Between 2015 and 2016, more than a million migrants and refugees crossed Europe's external borders via the Aegean Sea (EU Commission, 2017a). During the summer of 2015, the unpreparedness of the Greek state to facilitate the first reception of the arriving populations (Cyril & Renzaho, 2016) as well as the fact that people were losing their lives in their attempt to cross the Aegean Sea urged the United Nations High Commissioner for Refugees (UNHCR) Director for Europe to describe the situation in the Greek islands as a *humanitarian emergency* and to ask for the immediate and coordinated response of the Greek state and the European Union (UNHCR, 2015). Since that time and till today, numerous local and international humanitarian actors have been involved in the rescue and the reception of refugees and migrants at the Greek border spaces offering a variety of services including shelter, catering, and transportation, as well as legal aid, health care and psychosocial support. In parallel, constant changes in the Greek asylum law as well as a series of international developments (i.e. border closures, bilateral Agreements) have created a volatile landscape where fluctuating numbers of people have continued taking the perilous journeys to reach Europe to find themselves in a situation of increased precarity, uncertainty, and violence.

The evaluation of the overall response of the Greek state to the increased needs of those mobile populations has proven to be an ever-evolving and thorny task given the fluidity of the context and the diversity of the arriving groups. However, all the relevant reports produced by humanitarian actors, the increasing academic scholarship, as well as the extensive media coverage of the situation agree on one thing: despite the large amount of funds made available to the Greek government by the European Commission's emergency financial aid and the multitude of actors active in the field, the first reception system at the Greek borders has proved ineffective to say the least (see for example Farhat et al., 2018; Howden & Fotiadis, 2017; Human Rights Watch, 2016). This has resulted in a situation where multiply traumatized people with diversified needs have been increasingly exposed to severe physical and mental

health hazards emerging from the lack of access to basic human rights like shelter, safety and health care (Human Rights Watch, 2016). In this context, humanitarian actors and human rights advocates have continued to warn of the detrimental and long-term impact of the experience at the Greek borders on the physical, mental and psychosocial well-being of those who attempt to navigate the Greek and European asylum system (Amnesty International, 2018; Joint N.G.O., 2017a).

In this frame, the current chapter offers an intersectional analysis of the health-related response to that heterogeneous population on the move as it evolved from the summer of 2015 until the summer of 2018 at the Greek borders. I conducted an analysis (described later in the chapter) of the publicly available documents produced by the UNHCR and its major partnering humanitarian organizations involved in the domain of migrants' and refugees' health at the borders in order to explore how the intersection between humanitarian aid, border crossing and the asylum system as shaped by the Greek government and the European Union impacted the health of migrants and refugees in their diversity. Taking into consideration the multiple dimensions of difference within the arriving groups, this analysis adopts intersectionality as critical inquiry (Collins & Bilge, 2016), and explores which social categories and their intersections have been explicitly salient and implicitly relevant for the distribution of social determinants of health and health care services in the particular context. Further, it interrogates how the construction of the 'vulnerable refugee' in discursive and material terms feeds in the context of power relations in Europe and entrenches refugees' health and social disadvantage. To situate the current analysis in the context of refugee and migrant health, the following section briefly summarizes the existing knowledge and gaps.

6.2 Refugees, Migrants and Health

Scholars have been stressing the importance of migration and asylum as determinants of health (Castañeda et al., 2015; Fleischman et al., 2015; Isaacs, 2018) associating them with experiences of loss, change, uncertainty (Carta et al., 2005; Isaacs, 2018) as well as with physical and psychological trauma produced before and after the departure from the country of origin (Bjertrup et al., 2018). However, when it comes to documenting refugees' health profiles and needs there are certain issues that render the collection of evidence a challenge. First of all, the distinction between refugees and migrants has been extensively debated among scholars

and thus, there is a great variety of definitions used, which in their turn are more often than not entangled or directly informed by the respective legal and political definitions in the frame of migration control policy (Bradby et al., 2015). In very broad terms, it seems that the distinction between the two is based on whether the movement is considered as the outcome of compulsion or as one's voluntary decision (FitzGerald & Arar, 2018; Zetter, 2007). Hence, in line with the Geneva Convention of 1951, the UNHCR defines a refugee as someone who "owing to wellfounded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, is unwilling to return to it" (UN General Assembly, 1951). On the other hand, migrants are perceived to move for social and economic reasons on a voluntary basis (Zetter, 2007). However, this distinction is not fixed not only because these categories cannot effectively capture the complex reality of human experience but also because migration trajectories involve movement across different spaces as well as across statuses that are subject to national political contexts alongside individual goals and opportunities that change over the course of multiple movements (Crawley et al., 2016; FitzGerald & Arar, 2018).

Moreover, literature on refugee health typically focuses on individuals and groups who have been settled in their destination for a substantial period (Kakalou et al., 2018) and on strictly defined health care and health-related social entitlements and services. Less is known about the health of populations on the move and their needs or about the effectiveness of health-related services beyond those regulated and offered by state actors. In this context, refugees are mostly approached as a distinct category from the rest of migrants mainly due to their assumed histories of persecution and their representation as suffering victims (Rajaram, 2002) as well as to the particular entitlements the 'refugee' status entails in terms of welfare and health care (Bradby et al., 2015). In Europe, relevant research developed mainly in the UK, the Netherlands and Scandinavia, has shown that refugees suffer greater rates of mental illness as well as perinatal complications in comparison to the rest of migrants and the non-migrant population while they also face greater barriers in accessing health care services (Asif et al., 2015; Gernaat et al., 2002; Hermansson et al., 2003; Liu et al., 2014; Ochieng, 2012; Teodorescu et al., 2012). Moreover, it has been found that the actual asylum process itself has a negative impact on refugees' mental and psychological well-being (Bradby et al., 2015).

When it comes to refugee health research, questions explored mostly concern the risk of communicable diseases especially when the examined populations reside in refugee camps or other reception facilities (Bozorgmehr et al., 2018; Hammer, 2017), or groups perceived as particularly vulnerable, such as for example unaccompanied minors (Rosen et al., 2017), and/or the risk of mental health illness like depression and post-traumatic stress disorder due to experiences of violence and often detention (Ho, 2018; Hynie, 2018; Minihan et al., 2018). Finally, exploration of refugees' health care access barriers has mostly concerned either the limited availability of services within camps and refugee reception facilities or experienced language and cultural difficulties experienced within the hosting countries' national health care systems (Cheng et al., 2015; Joshi et al., 2013). Something worth noting here is that the research questions explored regarding refugee health are in most cases in a symbolic conversation with the dominant representations of refugees in the public sphere. So, studies on the risks of infectious diseases are undertaken within a context where refugees are portrayed as living in overcrowded reception facilities with problematic hygiene and where xenophobic populist discourses describe them as a 'public health threat' (Shorto, 2017). Similarly, the emphasis on refugees' psychological trauma and vulnerability coincides with the overrepresentation of refugees by humanitarian actors and media as traumatized, helpless victims in need of aid (Malkki, 1996; 2015). Finally, research on the cultural and linguistic barriers in accessing care has been and continues to be conducted at a time when the sustainability of health care systems is increasingly debated across most European countries and migrants and refugees are represented as an additional burden (Ji, 2017). However, despite the fact that research on refugee health has significant political implications and feeds into a discourse that involves racist and xenophobic stereotypes against racialized subjects, relevant studies rarely consider the structural and political mechanisms responsible for the adverse health outcomes among refugees. More often than not, the refugee category is approached as an essential category that involves unique health needs while the health impacts of restrictive and hostile migration control or asylum policies are either ignored or at best are acknowledged but not interrogated.

Further, studies on refugee health are preoccupied with the refugee category as the most important category shaping refugee experience and health. From this viewpoint, refugees are described as a distinct group that differs from the rest of migrants as well as from the nonmigrant populations in the hosting countries. Hence, when refugees are studied, the concept of health inequality usually refers to the asymmetry between the 'sick', 'vulnerable' and 'traumatized' refugees and a healthier normative group. Although empirical evidence suggests that health needs and outcomes among refugees differ on the basis of additional characteristics like gender, age, ethnicity and race as constructed categories (Hémono et al., 2018; Masterson et al., 2014; Russo et al., 2015), health inequalities within refugee groups are rarely explored and much less so in terms of the actual structural mechanisms within the asylum system that generate or reproduce them. In the same way that refugees are approached as a unique, undifferentiated mass of people emphatically defined by their refugee status, their assumed health disadvantage is approached as solely the outcome of their persecution and as an unavoidable corollary of their status (Rajaram, 2002).

Putting this in the context of social determinants of health, one understands that what is actually disregarded is the health impact of the conditions in which refugees find themselves while moving and/or being at the intermediate and first destination points. These conditions are the outcome of a multitude of institutional decisions, regulations and policies that go far beyond the health sector and shape refugees' experience and health differently on the basis of multiple social positioning dimensions that exceed refugee or even migrant status. Importantly, these conditions as experienced during migration journeys can and usually do produce a new health disadvantage for the populations on the move (for example extensive stay in detention camps associates with mental health problems as shown by Steel et al., 2006). This health disadvantage is unfair and avoidable. Hence, although health care access regulations and the broader integration of refugees in national health care systems are rightly studied (e.g. Cheng et al., 2015; Feldman, 2006; Joshi et al., 2013; Toar et al., 2009) as pathways through which health inequalities emerge or are maintained between refugees and other population groups (usually settled), additional structural elements need to be interrogated. Health inequalities are also entrenched and produced through pathways that involve among other things border control policies, refugee reception conditions, access to asylum, anti-discrimination policies, and emergency aid provision. The assumed health disadvantage is not an unavoidable heritage that refugees bring from home and share in common. Instead, it is linked to mechanisms of differential exposure to health damaging environments and risks entangled with migration and asylum processes that need to be observed and understood. The current analysis delineates which mechanisms of differential exposure are relevant for the production of health disadvantage among refugees and migrants who crossed the Greek borders between 2015-2018. Importantly, by adopting an intersectionality perspective this analysis shows how the interplay between structural mechanisms and individual differences (e.g. based on gender, age, etc.) among the new-comers accounts for the differential distribution of this disadvantage.

Before proceeding however, I describe how health is conceptualized in the frame of this analysis. The next and final paragraph of this brief introduction to the chapter serves this purpose.

6.3 Health at the Border

As described in the introduction to this thesis, health is understood as a social and political notion. Health is a goal in itself and a moderating factor of life chances and life satisfaction that is subject to a series of economic, social and political arrangements, while at the same time it decisively shapes the ability of individuals and communities to exert control over such arrangements. However, when discussing refugee health, other conceptualizations of health become relevant depending on the context. The intersection between humanitarian emergency as the outcome of conflict and massive persecutions, migration control policies aiming to regulate the movement of populations across countries, and public health management arrangements activated in the hosting countries encourage us to critically reflect on the meaning of refugee health in the light of different discourses; namely discourses on human rights, security and national public health (Allotey, 2003). The relevance of these discourses is understood by and traced through the role that national and international institutional bodies play in deciding the salience of specific issues/risks relevant to refugee health as well as in the provision of the appropriate health and care services.

In general terms, the European Union as a political institution takes pride in its role in respecting and promoting human rights including the right to health (Keygnaert et al., 2014). According to the relevant definitions of the United Declaration of Human Rights (UDHR), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR), this means that European policies -including those aimed at migration management- should optimally be aligned with everyone's right -including migrants and refugees- to enjoy the highest attainable standard of health; and that all member states should respect this right by providing universal access to the health resources necessary for disease prevention, treatment and rehabilitation (Keygnaert et al., 2014). At the same time, asylum in Europe is optimally developed on the basis of humanitarianism. Sciurba and Furri (2018) note in their recent paper on the right to asylum, that the humanitarian dimension concerns the "minimum content of human rights" (Sciurba & Furri, 2018, p. 771), that involves basic human rights, like the right to life, that should be

warranted under all circumstances even in times of conflict or crisis. Moreover, they suggest that although humanitarian law and human rights are often used interchangeably in mainstream discourse, in reality human rights apply in democratic societies in peace, while humanitarian law is relevant to "irregular" circumstances. In this context, and given that the right to life cannot be fulfilled without the right to health (Evans, 2002), health and the right to health should be regarded as an integral part of asylum that is meant to protect those whose basic rights are violated in their countries of origin (Allotey, 2003). If we remember here the World Health Organization's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of the disease or infirmity" (WHO, 1946, p. 19-22), then a series of crucial points of tension emerge when we discuss refugee health at the borders.

Although refugees flee from places affected by war, conflict and crisis, as soon as they cross the European borders they are found on the ground of democratic states in peace. As such, EU states are expected to provide all the needed resources so that refugees can enjoy the highest attainable standard of health. Moreover, these resources are not restricted to health care access but involve a series of social, cultural and economic determinants as this derives from the fact that the right to health pertains to international conventions of social and civil rights. However, the recent arrival of refugees in European countries like Greece and Italy has been portrayed in the media as well as by agencies and political organizations in terms of a destabilising situation. The massive life loss in the Mediterranean Sea and the media images of crying infants, wet to the bone, trying to reach the European shores have been used for the construction of a 'humanitarian emergency' narrative. This has served to justify a series of decisions regarding the EU asylum policy including the hotspots and the involvement of a series of humanitarian actors funded directly by the EU (Pallister-Wilkins, 2018; Sciurba & Furry, 2018). Here lies the first point of tension: securing the highest attainable physical, mental and social well-being of refugees who are bound to move within spaces where the minimum of human rights apply, namely bordering humanitarian spaces (Agier, 2011) seems to bear an inherent discordance. This discordance renders the threshold for the 'highest attainable level' of well-being negotiable.

The second point of tension emerges from the fact that the humanitarianization of asylum and refugees is all too often in a dialectic relation with criminalisation and securitisation (Fassin, 2013). Hence, we see FRONTEX and even NATO boats sharing the same border spaces with UNHCR or the International Federation of the Red Cross (IFRC). For the EU, undertaking the humanitarian duty of refugee protection coincides with 'securing the safety of the European societies', and as Sciurba and Furry illustrate, in the current times, the employment of a humanitarian discourse serves for the strengthening of securitisation (Sciurba & Furry, 2018, p. 767-9). Hence, the discordance lies in that refugees crossing European borders are optimally entitled to enjoy complete well-being, but at the same moment, they are themselves increasingly criminalised and portrayed as a threat to the well-being of the European national communities. Hence, it is not only the actual definition of a health threshold that is negotiable but also the extent that refugees' health is a goal to be pursued.

The dialogue between humanitarianization and securitisation at the borders is reflected in the health-related practices adopted by the actors involved as well as the health needs and risks that become salient. On the one hand, humanitarian organisations acting in the frame of an 'emergency' stress the vulnerability and suffering of the moving populations and are usually concerned with managing the crisis and with providing care (usually primary) in an organised way within the legal landscape of the hosting country (Pallister-Wilkins, 2018). In this frame, they stress refugees' basic needs for shelter, water, hygiene facilities, nutrition and safety and their efforts are targeted at meeting those needs with the provision of goods and services and a psychosocially supporting environment (Allotey, 2003). On the other hand, national public health agencies act mostly from a health security perspective and they are concerned with the control of infectious diseases that dominate public health response in most refugee settings (Allotey, 2003; MacPherson et al., 2007; Zimmerman et al., 2011). Hence, their efforts are targeted at primary care, medical surveillance and epidemiological control and monitoring.

In this context, understandings of refugee health at the borders and priorities' setting are not only subject to the broader global health agenda but also to the way that the different actors answer to the question *who the refugee is* (i.e. a person who has a non-negotiable right to enjoy complete well-being; a traumatised helpless victim with urgent basic needs; a threat to the national well-being). In reality, different health actors may answer this question in quite different ways and may not necessarily involve refugees' own perspectives (Rajaram, 2002). However, the way that refugee health is understood, and the way that their health needs are met at bordering spaces are the outcome of a negotiation between the involved actors. The final point of tension emerges from the fact that these negotiations take place within the institutional context of asylum and hence, within certain hierarchies of mobility (Pallister-Wilkins, 2018). Within the EU states, the right to asylum has been transformed into a "tool of categorization and exclusion which works against freedom of movement" (Sciurba & Furry, 2018, p. 774). Within this context, refugees' poor health often provides the sole pathway not only to be

granted asylum but even to claim it on the logic of vulnerability (Pallister- Wikins, 2018; Fassin, 2013). Hence, refugee health itself is transformed from 'a state of complete well-being' and a right into a tool for exclusion within European hierarchies of movement.

The current analysis considers the aforementioned points of tension as well as the heavy political load of refugee health and aims to explore their connection with health inequalities among refugees at the Greek borders from an intersectional perspective. In the section that follows, I provide a brief description of the specific context, the most important events of the examined period of 2015-2018, as well as the crucial institutional shifts that took place.

6.4 Sketching the Context

Greece's representation as a country at the external borders of the European Union has become a banality within the narratives of the refugee arrival during the last four years. However, before proceeding with the analysis, it is useful to delineate its context both in terms of geographical space and of crucial timepoints. It is important to note that the events are described here according to the way they have been narrated by the UNHCR and other international humanitarian organizations. Although, to a greater or lesser extent, these actors have attempted to integrate refugees' perspectives in their narrative (e.g. with focus groups and feedback mechanisms established inside the refugee camps) and have been in an ongoing dialogue with national and European governmental institutions, it should not be forgotten that the account presented here represents one narrative among many. The particular choice was made because UNHCR and partner humanitarian agencies undertook the responsibility of assisting refugees in Greece from the very beginning; they have been present and active in the field for the whole examined period being at the meso-level between refugees and state or European institutions; and finally, they have produced rich documentation about their own activity within the specific continuously fluid socio-political context.

6.4.1 Emergency declaration and the first response by the EU and member states.

During the summer months of 2015, the number of people entering Europe via the borders between Greece and Turkey increased significantly. The first points of arrival were in their vast majority the islands that extend at the East of the Greek side of the Aegean Sea, right across from Turkey's coast. The islands of Lesvos, Chios, Samos, Leros and Kos were the main

entrance points for the majority of newcomers, although people were reaching Greece at lower rates via other islands within the Dodecanese complex, like Kalimnos and Rhodes. An additional entry point was the borderland village of Filakio, at the North East region of Evros. Both the islands and Filakio village are remote Greek regions, with limited populations (e.g. Rhodes, the island with the largest population, has approximately 115,000 inhabitants according to the last census of 2011) and even more limited infrastructure, transport and communication links (Christopoulos, 1999). These islands share a long tradition of being neglected by the Greek state's administration, and since 2010, they have been severely affected by the decline of industry and services that increased the socio-economic gap between Athens and the rest of the country (Petrakos et al., 2015; Salvati, 2016). Not surprisingly, reception facilities for refugees and migrants were absent in those islands while the local welfare and health care services were struggling for their maintenance in the context of budget cuts, and lack of staff and resources.

As soon as they arrived in Greece, the newcomers, usually coming from Syria, Iraq and Afghanistan, were arrested by the police or the coast-guard and had to go through an identification and registration process. The process lasted from a few days to a couple of weeks, which meant that they had to spend their first days in Europe either in police identification centres, in police departments or even in makeshift shelters like abandoned hotels, holiday camps and car parks with almost no access to fresh water, showers, or toilets (UNHCR, 2015). After their registration process was completed, they would continue their journey to mainland Greece and towards the north border between Greece and Macedonia, to move further towards Central Europe. The length of the journey as well as the border crossing was subject to the actual circumstances of the individuals on the move as well as to the type of surveillance and border control strategies in the two countries. However, the majority of the people though had to spend an additional period waiting in the open at the border point at the Greek village of Idomeni. Both at the entrance points in the islands and at the exit at the North of Greece, the only aid available to the populations on the move was provided by the UNHCR, local organisations and branches of international NGOs and solidarity groups (Doctors of the World, 2015a; Doctors Without Borders, 2015).

In July of 2015, approximately 50,000 refugee and migrant arrivals were reported taking the overall number of arrivals in the country that year to 124,000, which accounted for a 750 percent increase compared to the arrival rates for the same period the previous year (UNHCR, 2015a). In August, and while increasing numbers of people continued to reach the islands of

the Eastern Aegean, the UNHCR's Director of the Bureau for Europe and Director of Emergency, Security and Supply visited Greece "to assess the refugee crisis in the country" and declared a "(...) humanitarian emergency (...) in Europe" that required "an urgent Greek and European response" (UNHCR, 2015a). According to UNHCR, what constituted the "humanitarian emergency" was the large number of the arriving refugees and migrants in combination with the inexistence of reception facilities in the Greek state. In this line and in order to highlight the urgency of the situation, the summer and autumn months of 2015, with a series of public statements and calls to European and national bodies, UNHCR undertook a leading role in the portrayal of the situation as a 'refugee crisis' and 'not only a migration phenomenon', emphasizing that the overwhelming majority of people who were arriving at the Greek islands had fled from conflict zones and mainly from Syria, Afghanistan and Iraq (UNHCR, 2015b).

From August until November 2015, border controls across the Balkan routes started to become stricter and Macedonian authorities imposed temporary border closures that increased waiting times and forced hundreds of people to stay out in the open, exposed to the weather, criminal groups, as well as to increased violence by national authorities (UNHCR, 2015c). In parallel, European leaders agreed to commit to collective action in order to manage migration across the Eastern Mediterranean - Western Balkans route. With a common statement in October 2015, they announced their will to develop and engage with a collective cross-border plan "in European spirit" and "based on solidarity" (EU, 2015). The basic elements of this plan as described in that statement included the exchange of information between countries for the orderly movement of people across the Balkan route; the limitation of refugee movement across the internal European borders and the discouragement of unilateral actions by states that would wish to allow or enable this movement; the increase of the capacity of Greece and other countries across the route to provide shelter and rest to refugees; the management of the migration flows with the use of biometric data, the identification of vulnerable refugees and the return or re-admission to third countries of people non-eligible to protection; the strengthening of border control with an increased presence of FRONTEX and border patrols in cross-borders operations; tackling smuggling and trafficking with the assistance of Europol, FRONTEX and Interpol; informing refugees and migrants about existing rules and rights but mainly about the consequences of not conforming to screening and registration processes; and the close monitoring of this collective project by the European Commission. The latter also proposed the activation of emergency funding in support of the Greek government on top of the Asylum, Migration and Integration Fund and Internal Security Fund that had been already allocated to Greece under the national programs for 2014-2020 (European Commission, 2017).

As the content of the Agreement suggests, the emphasis of European leaders centred around border control rather than the much-needed mechanisms that would ensure migrants' and refugees' access to human rights. In this atmosphere, on the 20th of November 2015, North Macedonian authorities closed the borders officially for individuals coming from countries other than Syria, Afghanistan and Iraq (nationalities that accounted for the 85 percent of the arrivals in Greece) two days after the same measure had been adopted in Serbia. By February 2016, Afghan nationals were also denied border crossing permission. This resulted in an immediate increase in the number of people who literally remained trapped in-between the borders, spending their days and nights in a nearby facility with smaller capacity than what was needed or right at the border across rail racks that traverse the two countries. Being deprived of aid, they became easy targets for traffickers and smugglers. In these circumstances, the tension within the communities increased and refugees and migrants of the excluded nationalities reacted with protests and hunger strikes. Police and border patrols responded with violence and the use of anti-riot equipment and dogs that, in many cases, caused serious injuries to men, women and children (UNHCR, 2015d; DWB, 2016).

6.4.2 The EU – Turkey Refugee Agreement.

The next important point in this sequence of events was the signing of the refugee Agreement between Turkey and the European Union on the 18th of March 2016. The Agreement that took effect two days later aimed to restrict the arrivals of refugees and migrants at the Greek islands and thus, decided that Turkey would "accept the rapid return of all migrants not in need of international protection crossing from Turkey into Greece and to take back all irregular migrants intercepted in Turkish waters" and that for every Syrian who would be returned in this way to Turkey, another Syrian would be resettled legally from Turkey to Europe (European Council, 2016). Moreover, the Agreement extended the militarisation of the maritime border by inviting the North Atlantic Treaty Organisation (NATO) to establish its activity in the Aegean Sea contributing to tackling measures against migrant smugglers.

Although the Agreement ostensibly aimed to offer migrants an alternative and non-lifethreatening way to reach Europe, and despite the declared respect of international protection law, human rights and aid actors received it with great controversy. The main points of criticism focused on the definition of Turkey as a 'safe third country' and the violation of the 'non refoulment principle' as well as on the ineffectiveness of the Greek asylum scheme to assess migrants' eligibility to asylum fast. Arribas (2016) in her brief commentary piece summarises how Turkey by forcibly returning refugees to Syria, by denying asylum to non-Syrian nationals and by implying an actual persecution threat for Syrian-Kurdish refugees does not suggest a 'safe third country' and thus, Greece violates the non-refoulment principle, when refugees are forcibly returned to Turkey. Regarding the Agreement's impact on the actual asylum process in Greece, as the text suggests, everyone arriving at the Greek islands was now described as an 'irregular migrant' in an explicit way regardless of whether they had fled persecution or war. Moreover, the emergence of Turkey as a 'safe third country' added an extra layer at the registration and asylum process, that of admissibility. What this meant in practice was that a primary 'evaluation' process was introduced in order to distinguish who is eligible to avoid forced return to Turkey and apply for asylum and who is not. The 'admissibility' evaluation in the frame of the Agreement had to take place at the islands and this led to the introduction of a geographical restriction for the newcomers. Further, the temporary registration centres transformed into closed pre-departure units without a respective adjustment in terms of their facilities or a plan for the provision of services. Besides, the assessment of vulnerability became even more integral in the asylum process as the only refugees and migrants who would be exempted from the scope of the EU-Turkey Agreement, apart from those eligible to family reunification, were those considered physically or psychosocially vulnerable and who could ultimately be transferred to the main country in order to receive the necessary support (DOW, 2018).

6.4.3 Later developments and the transition to state-management.

The condition that resulted from the EU- Turkey Agreement of 2016 has been described in graphic terms by the various organisations active in the field (DwB, 2017a; HRW, 2018). The number of arriving migrants and refugees decreased significantly immediately after the Agreement took effect and those who had arrived prior to its implementation were transferred almost in total to the Greek mainland, where they had access to the asylum and family reunification processes. However, those who arrived after 20 March 2016 were kept at the registration facilities in the islands. Since then, men, women and children of all ages and often with serious health conditions or psychosocial vulnerabilities have been literally and symbolically trapped at the margins of Europe exposed to prolonged discrimination, structural violence, uncertainty and numerous other risk factors for their physical and psychological wellbeing (UNHCR, 2016).

From the summer of 2017 onwards, the situation worsened even further as the Greek state gradually became the sole responsible actor for the management of the reception centres in the islands as well as for the provided services including health care and psychosocial support (Joint NGO, 2017a). This transition from an organisations'- to a state-management response coincided with a further degradation of the living conditions inside the camps. Some facilities like Moria Reception and Identification Centre (RIC) in Lesbos and Vial camp in Chios became overcrowded, the available health care staff and psychosocial services reduced, and waiting periods for the asylum claim process and the vulnerability assessment increased. UNHCR's data show that as of June 2017, the number of people restricted in the islands exceeded their capacity by 60% (IFRC, 2017) and that as of June 2018, approximately 14,000 people were living (for a period that in some cases reached two years) in the islands exposed to inhumane conditions and despair (UNHCR, 2018 June 22). During that period, Doctors without Borders and other humanitarian aid actors were consistently warning of a 'new emergency' that had to do with the severe health impact of those developments on the affected populations of migrants and refugees (see for example DWB, 2017). The emerging empirical evidence as summarised in the following section depicts in broad lines this alarming reality.

6.4.4 Refugee health in Greece: emerging evidence.

Within the context of the so called 'humanitarian emergency,' apart from the multitude of diverse aid and solidarity organisations that became active in the field of reception services, international researchers from various disciplines showed great interest in documenting and studying the refugees' arrival (Digidiki & Bhabha, 2017; Farhat et al., 2018; Pallister-Wilkins, 2018; Papataxiarchis, 2016; Pavlopoulou et al., 2017; Rozakou, 2017). Studies of the health status, demographic and clinical characteristics of refugees and migrants, as well as on the particular risk factors, that they have been facing in Greece over the last four years, have been shaping a body of significant evidence. The following paragraphs offer a short review of this.

Part of the existing evidence refers to the clinical and epidemiological profile of the newcomers at the first point of their arrival as well as after they have been relocated to reception facilities in the mainland. Findings suggest that despite the stereotypical assumed association of refugees and migrants with communicable diseases (Gulland, 2015), the most frequent complaints and diagnoses at the borders include mental health problems, respiratory infections, myalgia, hypothermia, dehydration, accidental injuries and burns, gastrointestinal illnesses, as well as pregnancy and birth-related complications (Moris & Kousoulis, 2017; Shortall et al., 2017). Moreover, a study by Kakalou et al. (2018) showed that the rates of infectious diseases at the islands decreased when people were transferred in the region of Attica, while the rates of all the other illnesses increased.

In this context, mental health problems seem to have seriously concerned researchers. Epidemiological surveys show that, depending on the facilities that people live in, anxiety disorder rates range from 73 to 100 percent, with lack of control, experiences of violence, uncertainty regarding the asylum process, social networks' disruption, and passivity and boredom inside the camps being the main driving forces for such disorders (Bjertrup et al., 2018; Farhat et al., 2018). Further, a cross-sectional study in one camp that hosts Syrian refugees reveals that major depression was diagnosed for 43.7 per cent of the residents, while only 20.7 per cent showed no depressive symptoms (Poole et al., 2018a). Further, in the same context, women appear more prone to major depression than men, while each additional child and increased time within the asylum process are also significant risk factors (Poole et al., 2018b). An additional qualitative study on health care services stakeholders' perspectives suggests that mental health disorders, together with risk of gender- based violence, increased rapidly after the implementation of the Agreement between the EU and Turkey (Hémono et al., 2018). Finally, in the same line, a report by Doctors Without Borders about the islands describes the prevalence of mental health problems as a 'mental health emergency' resulting from experiences of violence during the border crossing but also in Greece caused by state forces. The report highlights how the continued exposure to violence has a cumulative impact on refugees' mental well-being and it is responsible for the development of moderate symptoms into more serious conditions (DOW, 2017).

An additional stream of research focuses on health care access. Skleparis and colleagues (2018) in their policy brief stress that although international protection beneficiaries and claimants are entitled to health care and medication within the national health care system and free of charge, access in reality is hindered by a series of obstacles. The lack of women doctors,

interpreters, and transportation to and from hospitals, medical staff that is not effectively trained to work with diverse populations, and charges for examinations and drugs are only some of them. Moreover, it is highlighted that the chronic dysfunctions of the Greek public health system and its retrenchment during the ongoing economic crisis made the integration of the recent refugees and migrants even more challenging and fostered inequality in access between them and the local population (Kotsiou, 2018; Kousoulis et al., 2016). Further, regarding health care within the hosting facilities, inefficient referral mechanisms for social and psychological support, lack of appropriate space and privacy for medical consultations, and gender and language differences between patients and medical staff also reduce access (Hémono et al., 2018; Rojek et al., 2018).

Studies in all the aforementioned streams highlight the importance of social determinants of health and the impact of the living conditions inside the camps on their residents' well-being. Concerns over safety and protection of vulnerable groups, inefficient hygiene facilities, lack of heating during the winter, and non-existence of appropriate spaces for women and children appear to increase susceptibility to non-communicable diseases (Moris & Kousoulis, 2018). Moreover, abusive treatment by the reception centres' staff, inadequate mechanisms of health assessment and monitoring, discriminatory tactics and ethnic profiling by the state authorities have been also associated with severe health effects (Cyril & Renzhano, 2016; DOW, 2017). As the emphasis on certain groups (i.e. women and children) and on discriminatory treatment suggests, the living conditions within the camps as determinants of health are not the same for everybody and do not fail the needs of everybody in the same way.

In the context of a 'humanitarian emergency' where images of tents under the mud and snow or of people queuing for food or aid distribution depict a universally devastating experience, there are certain individuals and groups that may be disproportionately affected on the basis of dimensions other than being a refugee. This differential vulnerability and asymmetrical health impact suggest the existence of an inequality. However, at the time of writing studies on the health inequalities among different groups of refugees and migrants in Greece have not yet been published. This certainly associates with the obvious challenges in studying the health of a mobile population as well as with the evolving nature of the phenomenon. Still, it seems that this lack of concern coincides with the dominant representations of the 'refugee' as 'traumatised' (van Ewijk & Grifhorst, 1998). As Malkki has put it, the representation of refugees as 'a miserable sea of humanity' (Malkki, 1996, p.377) does not leave enough space for the consideration of their personal histories. The implication

here is that this generalised image also suppresses discussion around the additional elements and social positioning dimensions that shape those personal histories, around the differences within the 'refugee group', and around the structural forces through which the differences often associate with inequality (Choo & Ferree, 2010). The next section offers a brief account of the individual differences among the people who crossed the Greek borders during the examined period as those differences have been reported by the humanitarian actors active in the field.

6.4.5 A diverse population.

The representation of the refugees and migrants who crossed the Greek – Turkish borders during the examined period has been quite undifferentiated. Mainstream media has commonly described them using a humanitarian vocabulary as traumatized people in need of care and assistance almost unanimously. Hence, the term 'refugee crisis' was adopted for the description of the situation and the category of the refugee was used as an umbrella term that included a population diverse in terms of demographic characteristics, legal status, and of course personal stories (for more see Crawley & Skleparis, 2018; Lafazani, 2018).

UNHCR reports (see, for example, UNHCR, 2018b) on monthly arrivals with data retrieved by the Hellenic Police* suggest that the people who registered at the Greek borders during the examined period reported more than thirteen different nationalities and that they spoke more than thirty different languages. Nationals of Syria, Afghanistan and Iraq accounted for the 85 percent of the registered arrivals in the country, while there were ten additional reported nationalities; namely Pakistani, Iranian, Palestinian, Bangladeshi, Moroccan, Algerian, Somali, Lebanese, Turkish and Congolese. All the other nationalities documented are not specifically mentioned in the available reports due to the small number of individuals by nationality. Moreover, refugees of the same nationality often differed in terms of ethnicity or religion. For example, Afghan nationals differed in terms of ethnicity with almost equivalent shares of Tajik and Hazara (40 and 33 percent respectively) and smaller shares of Pashtun, Parsi and an 'other' category of ethnicity. Almost 60 percent of them were Sunni Muslims and 40 per cent Shia Muslims. As for Syrians, although the majority claimed Arabic ethnicity,

^{*} Data available via

⁽http://www.astynomia.gr/index.php?option=ozo_content&lang=%27..%27&perform=view&id=70776&Itemid =1240&lang=)

people of Kurdish origin accounted for 20 percent. The vast majority of the interviewed Syrian nationals reported Sunni Islam as their religion, however refugees of Christian denomination have also been registered (UNHCR, 2016a; 2016b).

Additional differences within the arriving groups concerned socio-economic status indicators and particularly education. A preliminary UNHCR analysis of data collected across various border locations suggests that across the summer and until September 2015, the vast majority of the arriving Syrians were men younger than 36 years of age, who had completed secondary or tertiary education, while 86 percent of all the respondents reported secondary or university educational level (UNHCR, 2015e). However, a subsequent UNHCR report on Syrians living in open facilities in the islands, based on data collected during the first five months of 2016, shows a slightly different pattern; 75 percent of the respondents reported primary or secondary school as the highest educational level achieved (UNHCR, 2016a). In contrast, a report on Afghan refugees' profile, during the same period, showed that the majority had achieved lower than secondary education (UNHCR, 2016b).

Moreover, regarding gender and age differences, data suggest that the actual rates of arriving women and children ranged across time, but women and children were steadily representing more than half of the arrivals at the Aegean islands. More than two thirds of the arriving children were younger than 12 years of age (Oxfam, 2016; UNHCR, 2018b). Women were usually found to travel accompanied by family members or within extended family groups. However, information suggests that overall the pattern of travelling with family was most common among refugees from Syria, Afghanistan and Iraq and less so among refugees of other nationalities (UNHCR, 2018b).

What is necessary to consider here is that the existence of individual differences within and between the arriving groups imply differences in the experience of navigating the Greek asylum system as well as difference in exposure to health risk. Acknowledging this reality, the current analysis from an intersectional viewpoint is primarily concerned with health inequalities among refugees who reside at Greek border spaces. Contrary to understandings of suffering as an unavoidable corollary of the migration experience (Bhugra et al., 2014) or a side-effect of asylum, I argue that the structures involved in the management of the arriving populations at the borders are responsible for the production of a health disadvantage for refugees and migrants which however, disproportionately affects certain individuals and groups. Moreover, besides focusing on explicitly traumatising and victimising situations related with border crossing, like prolonged detention, trafficking, or illegality (for example see Castañeda, 2009; Cyril & Renzaho, 2016; Koser, 2000), my analysis is concerned with institutional arrangements that are initially designed to serve the benefit of those who cross the Greek borders, namely the first settlement arrangements, the distribution of aid and the provision of health care and psychosocial services. By interrogating how these institutional arrangements operate within a landscape shaped by migration control regulations will reveal the actual processes by which the health impact of asylum is embodied in the particular context through a multitude of pathways. In the section that follows, I elaborate how the adoption of an intersectional framework is deemed necessary for my analysis.

6.5 Analytical Framework

Intersectionality as an analytical framework that focuses on subjects that symbolically occupy marginal spaces (Schulz & Mullings, 2006) seems particularly relevant for the current analysis. The populations who reached Greece via Turkey during the examined period were exposed to multiple marginalising processes starting from the reasons for taking the perilous journey to Europe to the inhumane conditions they were forced to endure in isolated camps and first reception facilities across the Greek borders. In this section, I discuss why intersectionality as an analytical framework (Collins & Bilge, 2016) serves the purposes of the particular analysis, and I elaborate on the employed approach for accessing and analysing the data.

6.5.1 Why intersectionality?

Refugees and migrants across the Greek borders literally and symbolically have occupied the margins of Europe for shorter or longer periods. The first point that makes intersectionality particularly relevant for this analysis relates exactly to this liminal position that the particular groups occupy within the examined context. As Papoutsi and her colleagues (2018) explain, the European 'hotspot' policy implemented in countries at the external borders of the Union creates liminal territories adjacent to the borders. There, the European institutions have almost overrun national authorities on the base of a declared - constructed emergency and hence, the situation is described as exceptional. Refugees are in reality illegalized (Sciurba & Furri, 2017) and forced to remain on hold within those exceptional territories until it is decided whether they will be able to continue their journey or not. Especially after the implementation of the EU-Turkey Agreement in 2016, this waiting time has been dramatically extended, exceeding two years in certain cases (UNHCR, 2018 June 22). While refugees and migrants remain at the borders they are deprived of any claim to belonging and they are excluded not only from the Greek citizenship regime but also from full international protection. Until recently, their health needs were the concern of only the UNHCR and humanitarian actors that were actually invited by the EU to cover the existing services' gap as surrogate governmental institutions (Kagan, 2012, p. 308-10).

Refugees and migrants who involuntarily have remained within those borderlands, regardless of the fact that they are kept inside Greece, are excluded symbolically but also materially from what Greece as a European state and the European Union itself represent as systems of democracy and human rights (Sciurba & Furri, 2017). At these exclusive and literally isolated positions, they are rendered mutated and invisible, while at the same time their pending status - a situation often described as a *limbo* (Endicott, 2018) - blurs not only the extent of their entitlement to human rights but also the limits between the institutions responsible and accountable for granting them rights. In this situation, it is almost self-evident that the indefinite entrapment within a space where access to even 'basic rights' (Agier, 2011) is not guaranteed poses an immense disadvantage for those groups' physical and mental wellbeing. However, what is not equally self-evident is what mechanisms are responsible for the emergence of that disadvantage. At this point, intersectionality as an analytical framework urges us to pay particular attention exactly to what is framed as an exception (i.e. the transformation of the external borders of Europe as humanitarian spaces where exceptional rules apply, Ramsay, 2019) and to those made invisible (Hancock, 2013) and calls for us to orient our inquiries to what has remained un-questioned (Schulz & Mullings, 2006).

As a starting point, intersectionality implies that we should distance ourselves from regarding refugees and migrants through the lens of their mainstream depictions as victimised beings inherently vulnerable to poor health. Instead, we are called to interrogate the hierarchical processes to which refugees are exposed in the specific context of the Greek borderlands and examine the pathways through which they associate with health risk and harm and consequently with the production of health disadvantage. However, the hierarchical processes taking place at the Greek borders are the outcome of the European asylum regime, the management decisions implemented by the Greek state, and the surrogate role of humanitarian actors that operate in tandem shaping the legal and material circumstances of

refugees and migrants. Their imbrication is what shapes the everyday reality for those populations and unavoidably its health impact.

The presence of a series of multiple actors involved in the field and the imbrication between national and European policies, international regulations and everyday management decisions is one of the reasons that other analytical methods are rendered less effective in this case, particularly when it comes to policy analysis. Regardless of the employed model, policy analysis frameworks are concerned with a particular problem, a policy that mandates a distinct course of action among many, and the evaluation of the consequent achieved or non-achieved outcomes (Dunn, 2016). In this particular case study, on the one hand, refugees' exposure to health risk and harm was not addressed by a particular policy but it was rather seen as a corollary of the border crossing and the asylum procedure. Further, the action taken towards refugees' health needs involved multiple actors with their own protocols and operational procedures as well as multiple domains and sectors. Moreover, health related actions were cut across by border control and migration control policies. Finally, the evaluation of potential outcomes is actually not feasible given that we lack systematic evidence regarding refugees' health outcomes before and after the crossing and the first reception procedure.

Further, as McKinnon suggests, "imagining that inequalities are equal as a method for analysing that inequality can only deny what needs to be changed" (McKinnon, 2013, p.1024). Based on this premise, what intersectionality brings to this analysis is the consideration of the fact that the health disadvantage produced against refugees at the Greek borders was not equally distributed among them but rather varied on the base of additional within-group dimensions of difference (Hancock, 2013; Weldon, 2006). Hence, besides addressing the intersecting hierarchical processes, intersectionality urges us to interrogate the multiple within group (i.e. refugees) differences that are relevant to the unequal distribution of the produced health disadvantage in the specific context. In other words, intersectionality sheds light on processes that produce health inequalities between refugees and local populations in Greece and in Europe but also on internal health inequalities within the refugee group.

Being interested in inequalities within a group that is overall severely disadvantaged by the border crossing and asylum policies is a complex task. As empirical evidence (discussed earlier) suggests, the situation that refugees experienced at the Greek borders, deprived of their human rights, represents a case of profound social injustice, which however was assumed to be equally affecting the populations targeted by border crossing and asylum policies setting the rules of the refugee reception process. However, as already stressed, those rules were differentially enforced through discriminatory practices (e.g. the border closures for certain nationalities), or there were cases where the rules appeared to be the same for everyone but produced unequal outcomes (e.g. refugees were entitled to health care access but women were affected by particular gender-related barriers). In such a context, equality and inequality become elusive (Collins & Bilge, 2016). This represents an additional reason that renders intersectionality as an analytical strategy particularly fitting to the purposes of this study in comparison to traditional thematic analysis. First, due to intersectionality's emphasis on social justice (Collins & Bilge, 2016) and second, due to its consideration of what remains invisible, unspoken or disregarded (Collins & Bilge, 2016; McKinnon, 2013; Schultz & Mullings, 2006).

Finally, an intersectional analytical framework concerns inequality in the frame of power inequality. From an intersectionality perspective, power is organised across four different domains (i.e. structural, disciplinary, cultural and interpersonal) while none of the domains is rendered more significant or distinct from the others (Collins & Bilge, 2016). Hence, tracing processes that produce health inequalities within refugees and between refugees and local populations in Greece and in Europe requires that we look at power inequalities in interpersonal relationships and encounters (e.g. between family or community members or between refugees and camps' personnel) (interpersonal domain); at how individuals are affected by the rules that apply to them (disciplinary domain); by the inequalities operating at the way the first reception was designed and implemented (e.g. gender inequalities within camps' personnel) (structural domain); and also at how they are affected by the ways they are represented in the analysed material. The simultaneous acknowledgement of the four domains of power, renders an intersectionality analysis more fitting to the purposes of the study compared to (critical) discourse analysis which is primarily focused on the way that power operates within discursive structures (Mills, 2001).

6.5.2 Developing an intersectional analytical approach.

The employed intersectional approach has as its starting point that the first reception process at the Greek borderlands between 2015-2018 was an example of population control that juxtaposed the role of the European asylum system as a hierarchical mechanism through which some people are deemed deserving or entitled to the protection of their life chances and others are deemed unwelcome or even disposable (De Genova, 2018; 2016, Holmes & Castañeda, 2016). Asylum regulations as mandated by the Greek state and the European Union,

decide not only who is entitled to international protection, but they also set a series of criteria and presuppositions regarding the rights and entitlements of refugees and migrants from the point of arrival and first reception until the asylum claim examination and its outcome. However, at the Greek borderlands asylum policy intersected with border crossing and humanitarian aid, creating a context where multiple interrelated hierarchical processes operated at the same time. From an intersectionality perspective, I suggest that those processes had a significant impact on refugees' health which associated with the production of health inequalities between refugees and local populations in Greece and in Europe as well as among refugees according to their intersectional differences (e.g. gender, age etc).

In this frame, and in line with the social constructionism underpinnings of this thesis, the purpose of the current analysis is to explore how institutional and discursive arrangements as represented in the examined documents produced by NGOs and humanitarian actors constructed intersecting hierarchical categories in the context of migration camps across the Greek borderlands that affected refugees' and migrants' experience and health. In practical terms, this means that what is sought for in the analysed documents is to reveal the classification systems relevant to the distribution of health promoting resources and exposure to health risk as those emerged in the field throughout day to day routines (e.g. allocation of groups across reception services, access to food, hygiene, care etc). Those systems involved classifications directly mandated by the Greek and European asylum frame (e.g. who is entitled to asylum), and others that indirectly emerged from the ever-operating intersectional power hierarchies in Greece and in Europe (e.g. racism). Those hierarchies underlie asylum policy itself (Davies & Isakjee, 2018), the decisions taken by the various humanitarian actors involved in refugees' first reception in Greece that are simultaneously embedded within the broader global system of power dynamics (e.g. neo-liberal dynamics, see Sözer, 2019) as well as all the relationships between the involved actors in the specific context including refugees, humanitarian and state actors, but also the local community.

As throughout the thesis, in this analysis, I refer to hierarchical categories as fluid, constructed carriers of meaning that bear significant material consequences and generate particular exclusions in the examined context, rather than as fixed positions or identities (Cho et al., 2013; Spade, 2013). Further, I employ intersectionality as a situated analytical tool (Yuval-Davis, 2015). Building on the idea of the constructed character of social categories, the situated intersectionality approach suggests that "categories of social divisions have different meanings -and often different relative power- in the different spaces in which the analysed

social relations take place" (Yuval-Davis, 2015, p.95). Hence, it further suggests that while being interested in the intersections of mutually constituting categories, we need also to deal with categories separately as emerging units within spatial and temporal contexts. This implies that instead of being *a priori* interested in certain intersectional locations (e.g. refugee women), we should rather be attentive to the context of our analysis and explore the particular categories that emerge as located in the operations of power (Anthias, 2013). Although strictly speaking the examined context is defined as the Greek borderlands, the concomitant involvement of European and international humanitarian actors in refugees' first reception forces us to frame our analysis within the broader context of power hierarchies established in Europe.

Hence, attempting a situated intersectional analysis, the first step of my analytical approach was to interrogate the refugee category and its meaning within the specific context, and explore which other migration categories were used for the classification of the newcomers across the asylum hierarchy. Moreover, I explored whether and how the meaning of the refugee and the rest of migration categories employed associated with inequalities in the distribution of health promoting resources and exposure to health risk. Second, drawing on traditional intersectionality scholarship, I questioned the salience of gender and race categories in terms of meaning and implications for health inequalities (Nash, 2009). Third, from an open-ended perspective, I investigated what other hierarchical categories were relevant for the emergence of health inequalities in the specific context. In the same line, instead of focusing *a priori* on groups located at specific intersections (e.g. refugee women) – as is often the case with intersectionality informed analyses (Nash, 2009)- I explored the emergence of particular intersecting locations that associated with increased exposure to health risk in the specific context. In the following section, I elaborate on the process of accessing and analysing my data from this situated intersectional analytical viewpoint.

6.5.3 Accessing and analysing the documents.

Identification and selection.

The material analysed includes publicly available on-line documents produced by the most prominent NGOs involved in the health sector of refugees' first reception. As explained earlier, my interest in documents produced by the humanitarian actors responsible for providing health related services at the Greek borders stemmed from the fact that those actors were systematically present in the field during the whole examined period, at the intermediate

level between refugees and state and European institutions, they advocated for refugees' and migrants' health rights, and they consistently reported on their activity. In order to identify and retrieve the relevant documents, I started my research from the UNHCR's operational portal (https://data2.unhcr.org). Through the search engine available at the portal, I downloaded all types of documents (i.e. Highlights, Needs Assessment, News, and Documents) that referred to the situation in Greece, particularly the Health sector, between 2015 and 2018, in English and in Greek language. The research and the collection of the documents took place during June 2018. Besides documents that were produced by UNHCR bodies, the results also generated joint documents and reports by prominent international organizations (e.g. OXFAM).

Next, through the 'Who's Doing What Where' search engine at the same portal, I identified seven UNHCR partnering organisations with a prominent role in providing health related services at the borders: ARSIS-Association for the Social Support of Youth; High Relief Commission (HRC); International Federation of Red Cross and Red Crescent Societies (IFRC); The Israel Forum for International Humanitarian Aid-IsraAID; Doctors of the World (DOW); Doctors without Borders (DWB); and PRAKSIS. Then, I visited each partnering organisation's website, where available, and I manually searched and downloaded documents referring to the situation at the Greek borders. Using the snowball technique, I also identified and retrieved documents produced by the Women and Health Alliance International (WAHA); an additional crucial actor in providing health related services in the islands. Documents produced by WAHA were retrieved in January 2019.

In total, 417 documents were retrieved from the UNHCR and the eight identified humanitarian organisations, including reports, press releases, news pieces, advocacy pieces, and meeting minutes. The next step was to read the retrieved documents in order to confirm the relevance of their content and their selection. In this process, I excluded from the analysis documents that exclusively concerned refugee facilities in the mainland; or included overlapping information (e.g. with versions available in Greek and English); general European reports without particular references to Greece; periodically produced documents (e.g. arrivals' reports) containing the same type of information with changes only in numbers (i.e. the most recent versions of the documents were selected only for analysis). This selection process resulted in 372 documents that were then integrated in the analysis. The list of the analysed documents can be found in Appendix A.

The selected material included information regarding the activity of each organization at the borders and also in reception facilities at the mainland as well as opinion and advocacy texts highlighting emerging problems, unmet needs, and human rights violations affecting refugees' health and overall well-being. Those documents have been integrated in the present analysis for the following reasons. First, because in order to get a better understanding of any specific text, one needs to approach it within its context of thought and action (Prior, 2003). Documents that strictly refer to health are embedded within a broader body of texts shaping the narrative of humanitarian organizations regarding the developments at the borders and the moments of organizational failure. Second, because across the present thesis, health is understood as a social and political notion shaped by multiple structural factors and social determinants (Link & Phelan, 1995). An intersectional analysis that is considered with the different power domains and aims to reveal how health inequalities emerge in the specific context cannot disregard the multitude of forces that simultaneously affect the everyday conditions that refugees and migrants find themselves in while navigating the asylum process. Hence, information regarding human rights violations, gaps and failures in camp management, inconsistencies, and differences between camps or geographical regions is seen as crucial for the understanding of particular risks and omissions that existed in the specific context and differentially affected individuals and group. Moreover, they are indicative of the power negotiations at play within relationships between the involved actors including refugees and the local community. Last but not least, the organizations that were officially involved in the health sector, according to UNHCR's classification, offered a great variety of services beyond medical care. This is consistent with the understanding of health as a holistic notion of wellbeing with social and political implications and further justifies the integration in the analysis of documents that do not refer to health from a strictly medical viewpoint.

Analysis.

As already stressed, the current analysis is interested in revealing the significant intersecting hierarchical categories in the context of migration camps across the Greek borders that were constructed by institutional and discursive arrangements and affected refugees' and migrants' experience and health. In this process, the examined documents are approached as having a dual function, namely as factual sources and as structuring the meaning of the facts and the subjects involved (Prior, 2003). This dual role of documents follows from and is consistent with the social constructionism epistemological approach adopted in the thesis as

well as with intersectionality. Intersectionality does not consider power domains (i.e. interpersonal, disciplinary, structural, and discursive) as distinct (Collins & Bilge, 2016). Hence, together with the fact that the documents include factual information regarding the material consequences of the hierarchical categories operating in the specific context, the function of documents as discursive materials inscribed in the cultural domain and producing particular worldviews (Flick, 2018; Prior, 2003) is also acknowledged.

The analysis involved uploading the documents into nVivo and coding the emerging themes. Given that I aimed to reveal elusive inequality producing processes, I was equally concerned with what the data say as well as with what they don't say regarding the empirical realities of health harming processes at the Greek borders. Moreover, instead of being exclusively focused on emerging patterns, I also interrogated what is hinted, implied or mentioned as isolated incidents within the documents, in order to grasp subtle processes through which health inequality emerged. This allowed me to trace cases where particular groups of refugees were hurt by discriminatory practices as well as others where groups of refugees were differentially affected by equally applied regulations (Collins & Bilge, 2016).

For the coding and identification of themes, I used the following guidelines. First of all, in line with a situated approach suggesting the need to explore the particular categories that emerge as located in the operations of power in a specific context, before focusing on their intersections (Anthias, 2013), I examined which hierarchical categories emerged as salient in the specific context. As explained in the previous section, although I was conscious of the significance of the categories of the refugee, gender and race, I adopted an explorative approach to allow what was particular to the context to emerge as well. Second, in order to explore the material consequences and exclusions produced by the hierarchical processes and their intersections operating in the Greek borderlands, I organised my analysis across specific topics/questions. I selected my topics guided by the core components of intersectionality as an analytical framework as summarised by Collins and Bilge (2016) (i.e. intersecting categories, power as operating across multiple levels, interconnected inequality producing processes, situated analysis, complexity, and emphasis on social justice and equity), and building on previous work on intersectionality based analysis (Hankivsky et al., 2012; Lombardo & Verloo, 2009). The selected topics/questions aimed to reveal pathways for exposure to health risk or limited/interrupted access to health promoting resources and care in order to uncover inequalities as they emerged at the Greek borderlands and across the interpersonal, disciplinary, structural and cultural domain (Collins & Bilge, 2016). The selected topics/questions were:

- 1. Unmet health needs, health risks as well as references to diseases and epidemiological data.
- 2. Social determinants of health in living conditions (e.g. accommodation, hygiene facilities).
- 3. Health related services and target groups. Those services included health care, preventive interventions as well as services aiming to improve living conditions (social determinants of health).
- 4. Health inequalities observed at the borders.
- 5. Did the offered health related services maintained or buffered addressed inequalities and in what ways (re)produced others?
- 6. Did the first reception and the offered health related services stigmatized certain subgroups or individuals?
- 7. Exposure to discrimination (interpersonal and structural).
- 8. Exposure to violence (who was involved as perpetrator and victim).
- 9. Dimensions of difference among refugees (e.g. gender, age) and in what ways associated with differential exposure to health risk or access to health promoting resources.
- 10. Intersectionality.
- 11. Power hierarchies and domain (e.g. racism, gender inequality).

Following these guidelines, I consider that my analysis is consistent with my epistemological stance, with intersectionality as analytical framework as well as with the examined context and hence, effective in allowing neglected or subtle health inequality producing processes to emerge.

6.5.4 UNHCR and partners.

This section provides information regarding the main activities undertaken by the humanitarian actors involved in the health sector of the refugee response at the Greek borders and which were integrated in the current analysis.

UNHCR.

In a multitude of humanitarian and charity organisations, UNHCR had the leading role across all sectors of refugee reception including health. Being directly funded by the European Commission's Emergency Support Instrument (European Commission, 2017), the UNHCR's engagement involved the direct provision of services to the arriving individuals and groups as well as the funding and support of services provided by other humanitarian organisations, local and national authorities. Their presence at the borderlands was steady and constant across the whole examined period, and their activities are summarised across nine broader areas. Health is one of those main areas including collaborations with national and local authorities for the facilitation of refugees' access to care, identifying referral pathways to public institutions for mental health care, providing long-term support to people who needed intensive care, and funding primary and psychosocial support services. However, most of the rest of UNHCR's other activity areas were also directly or indirectly linked to health as they concerned accommodation and financial assistance, protection (including legal aid), prevention and response to sexual and gender-based violence (SGBV), and education.

International Federation of Red Cross and Red Crescent - IFRC.

The IFRC was also funded by the Commission's Emergency Support Instrument (European Commission, 2017) in order to provide basic health care, psychosocial support and to contribute to the winterisation of the refugee camps, to the food distribution, and to securing water access and sanitation. Beyond that, international and national Red Cross teams were active at the coastlines of the islands, offering first-aid to shipwreck survivors and refugees whose life was in danger after the border crossing (e.g. due to hypothermia). Their presence was steady across the whole examined period.

Doctors of the World - DOW.

DOW, funded by Emergency Support Instrument as well, remained active inside and outside the refugee camps at the borderlands across the examined period. Emergency funds were used for the provision of primary health care services, psychosocial support and referrals for specialised medical care. Additional health related activities included the distribution of medicines and necessary non-food items, interpretation services as well as the identification of medically and psychosocially vulnerable cases.

Doctors Without Borders - DWB.

DWB were also active at the borderlands across the whole examined period. However, they were not funded via the European emergency scheme and they were present inside the refugee camps until the implementation of the Agreement between the European Union and Turkey in 2016. After the implementation of the Agreement, they decided to stop providing services inside the state managed refugee camps but maintained their presence outside those camps and inside non-state managed reception facilities (e.g. shelters run by volunteers). As explained by the organisation, that decision was taken as a form of protest against the Agreement that mandated the transformation of temporary receptions facilities into detention centres (DOW). Their activities included sea rescues in the Aegean Sea and first-aid, primary care, and mental health services, and psychosocial services, identification of vulnerable people and assisting with their transfer to appropriate facilities, distribution of food and non-food items, and ensuring access to water and sanitation and shelter.

The Israel Forum for International Humanitarian Aid - IsraAID.

Responding to a UN request, IsraAID staff and volunteers were also involved in sea rescues and first-aid at the shores of the Greek islands. Further, they supported refugees in continuing their journey towards the north borders of the country by distributing food, water, relief kits, and baby carriers. Additionally, they contributed to the provision of medical assistance and psychosocial support for shipwreck survivors and vulnerable individuals. Their funding came mainly from donations made by European Jewish foundations and non-Jewish international aid agencies. They remained active in the islands until the summer of 2017.

PRAKSIS.

PRAKSIS is a Greek non-governmental, non-profit organization whose objective is the design, application and implementation of humanitarian and medical actions for the support of socially marginalised groups. Their activities involved primary care and psychosocial services in the Reception and Identification Centres (RICs), provision of temporary accommodation for vulnerable individuals and families and provision of temporary accommodation and care for minors and unaccompanied refugee children. Moreover, they were involved in offering humanitarian aid at the north borders of the country. Their funding came mainly from the European Refugee Fund via the UNHCR as well as from international organisations such as International Medical Corps. They were present at the RICs from early 2016 until the spring of 2017.

ARSIS - Association for the Social Support of Youth.

ARSIS is another Greek non-governmental organization working against the social marginalization of children and youth and they were engaged in refugee reception at the Greek borders from the autumn of 2015. Funded by the European Humanitarian Aid and Civil Protection fund (ECHO), they offered emergency support to mothers and their children as well as to unaccompanied minors at the north borders of the country, but they were mainly active in reception facilities in the mainland.

Women and Health Alliance International - WAHA.

WAHA International arrived in Lesbos in September 2015 to offer medical services to the refugees and particularly to women and children at the North shore of the island, where no other aid organization was present before that time. In the coming months of 2015, WAHA expanded their operations with semi-fixed clinics in four islands and with a rescue boat that was also used as a mobile clinic. The organization remained present in the islands until the summer of 2017 offering primary care services and emergency assistance.

6.6 Inequalities at the Intersection of Border Crossing, Humanitarian Aid and Asylum System: An Unevenly Distributed Health Disadvantage among Refugees

As elaborated in earlier sections of this chapter, the representation of refugees as traumatized, helpless victims in need of aid (Malkki, 1996; 2015) associates with their health disadvantage compared to other migrant and non-migrant groups being perceived as inherent to their status; the trace of the persecution, luggage they bring from home. This section presents the results of the intersectional analysis which revealed that although the perilous journeys to and the first reception procedures in Greece involved significant risks for the lives of refugees and migrants, those risks were neither universally distributed nor did refugees and migrants themselves had the same resources to cope with them. The results show that in the specific context, as this was shaped by the intersections between humanitarian aid, border crossing and the asylum system designated by the Greek government and the European Union, the unequal distribution of health risk cut across categories of migration (i.e. refugee, migrant, asylum seeker), nationality, race, gender, marital status, sexuality, age, guardianship, and vulnerability and their intersections. The following paragraphs describe the intertwined processes through which that unequal distribution emerged as portrayed by the documents analysed.

6.6.1 Moving across statuses: from 'refugees' to 'migrants and vulnerable refugees.'

Being concerned with hierarchical processes, the starting point of the analysis was to question the ways that people who crossed the Greek borders were addressed within the analysed sources. In the vast majority of documents, the most common terms were 'refugees' and 'migrants', which were almost always used in combination and often interchangeably. However, and although the organizations declared that they offered their services regardless of individuals' legal status, the documents revealed that across the examined period, there were salient differentiations regarding the status of the newcomers across time.

Throughout the documents published during the peak of the phenomenon, from June until November 2015, it was highlighted that people who crossed the Greek borders through 44 sea landing points and one land entry point, all had to deal with the same response from the Greek state which was summarised in delayed registration procedures and inhumane living conditions until the time they were allowed to leave the entry point and move towards the mainland. However, it is indicative that during that period, the phenomenon was framed as a 'refugee crisis' and throughout documents published primarily by the UNHCR, it was highlighted that the "vast majority of those coming to Greece [were] from countries experiencing conflict or human rights violations" (UNHCR, 2015f). Elsewhere, it was further elaborated that

"This [was] a primarily refugee crisis, not only a migration phenomenon. The vast majority of those arriving in Greece [came] from conflict zones like Syria, Iraq or Afghanistan and [were] simply running for their lives. All people on the move in these tragic circumstances deserve to see their human rights and dignity fully respected, independently of their legal status. But we cannot forget the particular responsibility all states have vis a vis refugees, in accordance with international law" (UNHCR, 2015b).

As put by Malkki (1992), the refugee category is constructed in contrast to that of citizenship and hence, it is unavoidably associated with notions of otherness that render refugees an exceptional population. Further, the construction of a 'crisis' narrative and the reminder of a particular responsibility towards refugees that derives from the international law for all the European states adds further to the depiction of refugees as an exceptional group (Ramsay, 2019). In its turn, this exceptional character of the refugee category links to discourses of deservingness (Feldman, 2015). The statement, that all people deserve to enjoy their human rights but for the case of refugees this suggests a legal obligation for states, describes implicitly but still graphically the existence of a hierarchy of deservingness, the top of which is saved for refugees. It seems then that the 'refugee' emerged as a reference category implying deservingness of protection rights. Further, UNHCR's statements also suggest the existence of a sorting mechanism -a quick filter that differentiated refugees from migrants- and this was no other than nationality. Given that what distinguishes a refugee from the rest of migrants is the experience of persecution, coming from countries affected by conflict or war emerged as an equivalent for being persecuted and hence, proven nationality as sorting tool. This is the first point where refugee status intersected with the category of nationality in the creation of a hierarchy of deservingness and access to human rights at the Greek borders. As it will be elaborated in the following section, the intersection between refugee status and

nationality was crucial for the emergence of health disadvantage across multiple sectors of the first reception.

Another salient point of differentiation that emerged as relevant to inequality through the analysed texts was that between refugees and asylum seekers. Through the first period of the phenomenon until the implementation of the EU – Turkey Agreement, the humanitarian actors' emphasis on the origins of the newcomers from countries in conflict, and particularly Syria, was employed in order to highlight their deservingness for aid and thus, to strengthen the call for a humanitarian response from Greece and Europe towards refugees. However, an interesting element that came out of the documents is that the response that followed, regardless of its effectiveness, was designated for asylum seekers. What is clearly mentioned within the documents is that "refugees who having been officially recognized in Greece [were] not eligible for the majority of services provided in Greece which those [targeted] asylum seekers" (UNHCR, 2017b) due to "the legal basis for funding regulated by instruments linked to the asylum procedures that govern the humanitarian assistance asylum seekers [received]. Recognised refugees on the other hand are subject to EU minimum standards for refugees, which are implemented differently in all EU member states" (CwC National Working Group Meeting Minutes, 21 June 2017).

This meant that the services offered at the Greek borders, involving health care, accommodation or cash assistance, were targeting people who in their majority had escaped conflict zones and were seeking asylum in Europe but only for as long as their asylum claims were pending. Hence, in reality, shifting from the status of an asylum seeker to that of a refugee involved the loss of access to minimum but still crucial support and the exposure to a new form of precarity. Given that the processes of registration and asylum claims were slow (and even more so after the migration Agreement with Turkey) (NGO joint, 2017b), the shift to the refugee status would happen- if ever- after a prolonged period of social isolation or detention, inactivity, exposure to physical and mental health risks and with no actual provision for the transitional period, in a country devastated from almost a decade of recession where refugees would have to compete for resources.

Further, the implementation of the migration Agreement with Turkey increased the salience of differentiations among the newcomers both institutionally and in the public sphere. Once the Agreement took effect, all the people who arrived at the Greek islands from Turkey had to go through an admissibility evaluation that decided whether they were eligible to apply for asylum or not. Eligibility, or else admissibility, overlaps with either assessed vulnerability

or eligibility for family reunification, according to the Dublin III regulations (Joint NGO, 2017b). Failing to meet the admissibility criteria implied forced return to Turkey, that in the frame of the bilateral Agreement is considered as a safe third country. At a symbolic representational level, those developments coincided with a shift in the framing of refugees' arrival from a 'refugee crisis' to an irregular migration phenomenon (Sigona, 2018). What the Agreement with Turkey actually implied was that those who were seeking refuge could actually find it in Turkey and thus, they should have stayed there. If they would decide to move to Europe, they simply aimed to migrate in order to find better circumstances. Hence, those who in their majority had been portrayed as refugees were now, in the frame of the Agreement, depicted as migrants and importantly, irregular migrants. This shift in symbolic terms overlapped with a dramatic increase in violence exerted by state authorities in Greece as well as in Turkey across the borders (DWB, 2017a) and a simultaneous decrease in international attention, so that the observed devastating impact of the Agreement on refugees' and migrants' health was addressed as an emergency by humanitarian actors present in the field (DWB, 2017b) and less so by Greek or European political leaders or in the international media.

On the other hand, at an institutional level, the introduction of the intermediate step of admissibility assessment in the asylum process associated with the emergence of vulnerability as an integral element of the refugee category (Freedman, 2019). According to the Greek asylum law 4375/2016, vulnerability categories include unaccompanied minors, single parent families, pregnant women, people with serious health conditions or disabilities, victims of torture, victims of violence including sexual and gender-based violence, victims of trafficking and survivors of shipwrecks. In one way or another, all the subcategories of vulnerability involve either increased experience or risk of suffering. Thus, the identification and assessment of vulnerable cases was a prominent concern for the humanitarian actors in the field throughout the whole examined period. Simultaneously, assessed vulnerability was linked to a series of services, including accommodation outside the camps, access to care appropriate for each case as well as accelerated asylum procedures. However, within the frame of the EU-Turkey Agreement, vulnerability literally became a presupposition for access to asylum (MHPSS Subworking group meeting minutes, 26 May 2017) and hence, a distributed category used for the unequal distribution of asylum (Sözer, 2019). In light of those developments, two processes took place. First, poor health or increased susceptibility to harm -contained in the meaning of vulnerability- was operationalized as an institutional component of the refugee status. Second, the boundaries of the refugee category shifted, so that the hierarchy of asylum deservingness

included only vulnerable refugees. However, the answer to the question, *who is the vulnerable refugee*, is not easy to give, especially within a context that by definition produces vulnerability (Sözer, 2019). As the following sections will show, pathways of exposure to health risk and vulnerabilities produced during the first reception procedure were subject to specific dimensions of difference among refugees associated with underlying intersecting power hierarchies.

6.6.2 The Syrian refugees and the 'others.'

The nationality of the newcomers emerged prominently as a relevant category shaping not only the meaning of the refugee category and the right to asylum, but to a significant extent the overall first reception experience of refugees and migrants in Greece, their access to rights and resources as well as their exposure to health risk, violence and discrimination. The organizations reported that since the first phase of the phenomenon, the rules employed for the populations' management prioritized people who were coming from 'refugee producing countries'; namely Syria, Afghanistan and Iraq. At later stages from autumn 2015 onwards, when border closures and the implementation of the bilateral Agreement with Turkey took place, the 'filtering' criteria became even stricter discriminating against Afghans and Iraqis as well (UNHCR, 2015g).

In practice, for the discriminated groups, this meant prolonged detention periods and registration waiting times as well as increased exposure to hazardous living conditions and violence. For example, upon arrival in the islands, non-Syrians had to wait often for three days until they could register, after Syrians, while having access to little or no accommodation and assistance (DWB, 2015a). As the number of arrivals was rising, delays in the registration process were followed by delays in the process of departure from the islands. During the summer months of 2015, before they were permitted to travel to Athens, non-Syrians had to wait in the islands for weeks. According to the sources, during those waiting periods, in many cases, they were literally spending nights and days in deserted buildings, parking lots, or squares, with technically no access to hygiene facilities and water. During the same period, a police verbal order was issued regarding nationals of North African countries (UNHCR, 2015g). According to the order, Moroccans, Algerians and Tunisians were universally detained in the islands or they were transferred to pre-removal detention centres in the mainland, without

any exception or appropriate treatment for vulnerable groups. Moreover, during autumn 2015, it was again nationals from non-refugee producing countries who were targeted by the discriminatory border closures and who were forced to wait for days and weeks at the north borders, exposed to inhumane conditions, attacks and excessive police violence. In one case, those circumstances resulted even in the death of a Moroccan man (UNHCR, 2015h).

In a similar logic, the allocation of groups across camps or camps' sections was based on nationality in combination with gender and marital status criteria. Indicatively, in Lesbos island, after the primary registration that was taking place at the RIC in Moria, Syrians and Arabic speakers in their majority were transferred to the camp of Kara Tepe, while refugees of non-Syrian origin and single Syrian men were allocated to different sections inside the centre, in Moria (Save the Children, 2016; DWB, 2015a). The crucial difference here concerns the living conditions in the two camps. Moria RIC, the first and largest RIC in Greece, was set across Greek army and air forces bases, managed by the Reception and Identification Service (RIS). The number of people living in the site, were always exceeding its capacity (1.990) by two or even three times. UNHCR reports on sites (UNHCR, 2018e) mention a series of problems that count for dangerous living conditions including inefficient electricity, hygiene facilities, and sewage system, lack of appropriate hygiene facilities for women and people with physical disabilities, lack of safe spaces for mothers and their children, environmental hazards, food distribution based exclusively on dry food, limited access to primary care at the site due to overcrowding, lack of medical staff and language barriers, limited educational or recreational activities and tensions between communities. On the other hand, conditions in Kara Tepe camp were relatively better. The site was set on a greenfield and it was managed by the municipality, with sufficient electricity and hygiene facilities, separate facilities for women and people with disabilities, regular educational and creative activities available and health services offered in the main language spoken. In some of the documents, it was also mentioned that among the population residing in Kara Tepe, people with medical or psychosocial vulnerabilities were overrepresented, suggesting that overall, the conditions were more aligned to international protection standards (UNHCR, 2018e).

Across most of the accommodation facilities, Syrians represented the majority, and this construed them as the point of reference. Simultaneously, it also created imbalanced dynamics among the groups that resulted in people of non-Syrian nationality often being excluded from services. Reported reasons include language barriers (e.g. interpreters for French were limited and this affected services and asylum procedures for people coming from Central and North

Africa – DOW, 2016); very small numbers (e.g. Yazidis being excluded from focus groups because they were minorities – Oxfam, 2016); and historical enmities between groups compounded with discrimination (e.g. in cases where Syrians and Afghans were housed together, Afghan women reported being harassed by Syrian men and women while trying to use hygiene facilities that were available at floors occupied by Syrians – Oxfam, 2016).

Further, with the implementation of the EU – Turkey Agreement, nationality emerged again as a relevant factor for inequalities in material terms. The aim for a fast return of Syrian nationals to Turkey, as mandated by the Agreement's text, implied even greater delays for non-Syrian nationals, who now had to wait for more than nine months, in order to have their asylum claims examined enduring during that time the constantly deteriorating living conditions in the camps. The following excerpt is indicative:

"I'm blocked here in Moria. It's inhumane. And because I'm from Congo, I know I'm the last person the authorities will pay attention to".

(21-year old man in Lesbos, DWB, 2017a)

Doctors of the World reported that in December 2016, arrivals from countries of Central and North Africa increased while that trend was combined with an increased number of people who had survived physical, psychological and sexual abuse (DOW, 2016). At the same time in Lesbos, Kos and Leros islands, a 'pilot project' was introduced that consisted in newly arrived people coming from countries with low recognition rates being immediately detained upon arrival and for as long as their asylum examination would last (Joint N.G.O., 2017c). Throughout the following period and until the summer of 2018, with the gradual withdrawal of the humanitarian organizations from the sites, the living conditions in refugees' facilities across the islands got worse and so did the physical and mental health of those indefinitely exposed to them. Reporting on their activities in 2017, Doctors without Borders stressed the alarming rates of reported sexual violence and highlighted that the majority of the survivors were coming from the Democratic Republic of Congo, Eritrea, Ethiopia and Cameroon (DWB, 2017b). It is also mentioned that refugees of African origin were dealing with additional discrimination and violence inside the camps, where tensions between nationalities, religious and ethnic groups were escalating in parallel with increased feelings of frustration.

Needs' assessments conducted in Moria RIC, especially highlighted that Africans were less involved in social activities (CwC Meeting minutes, 9 August 2016) and they were at greater risk of not having their vulnerabilities identified due to bearing nationalities deemed 'less deserving'. As the following excerpt describes, Africans were in certain cases the targets of racist attacks by state authorities as well.

"On the 18th of July 2017, after the violent suppression of a peaceful demonstration by people of various ethnicities who [experience] the tragic consequences of the bilateral Agreement between EU and Turkey, trapped for months in Lesbos in miserable conditions, policemen entered Africans' section [in Moria RIC] and by using extensive violence arrested 35 people with a common characteristic: the [Black] colour of their skin".

(translation from Greek, Joint NGO, 18 April 2018)

Although, the above excerpt is one of the very few cases that skin colour as an indicator of race was explicitly addressed in the documents, the salience of race and racism in the specific context was evident. Certainly, this does not come as a surprise, since the refugee image as it has evolved after the WWII to the present has been racialised, so that it associates with refugees from the Global South (Johnson, 2011). What the documents however suggested is that the emphasis on nationality concealed the fact that the people of 'less deserving' nationalities were coming from countries of North and Central Africa and they were in their vast majority blacks. The undifferentiated term 'Africans' used to describe the particular groups is inevitably linked to long-lasting racist discourses representing Africa and Africans as an undifferentiated 'other', inferior to Europe and the West (Mbembe, 2017). It emerges then, that in the specific context, the different racialisation processes for migrants and refugees of heterogeneous origins in Europe (De Genova, 2018) were in a way associated with the emergence of a racial hierarchy inside the refugee camps, and with inequalities among the racialised 'others' both in terms of exposure to health risk as well as in terms of visibility of their health needs. The following section discusses how those health damaging processes were simultaneously gendered.

6.6.3 Intersecting gendered exclusions and health at the borders.

When talking about gender and refugees, the discussion more often than not centres around refugee women, who are presented as particularly vulnerable and in increased need of protection compared to men (Freedman, 2019). Based on UNHCR data, the proportion of women among new arrivals has been increasing and women have been prominently represented in the narrative of the 'humanitarian crisis' as particularly vulnerable refugees. However, the different pathways via which women are exposed to harm have not been equally addressed (Freedman, 2016a; 2016b). At the same time, risks for men's health are deemed overlapping with their refugee status and they are not understood as gendered (Allsop, 2017). In this section, I interrogate the gendered processes that produced health disadvantage for both women and girls as well as for men and boys refugees at the Greek borders.

Refugee women and girls: visible and invisible health disadvantage.

The most prominent issue relative to women's and girls' health emerging through the documents was sexual and gender-based violence (SGBV). Although, in reports, it was explicitly mentioned that SGBV concerned both men and women as well as people with nonbinary gender identity (see for example UNHCR, 2018f or ARSIS, 2018), assessments, interventions and programs were almost exclusively oriented to women and girls, indicating the alarming numbers of survivors. SGBV as defined in the particular context included domestic violence, sexual assault, exploitation and trafficking, lack of access to sexual and reproductive health (SRH), forced marriage, forced prostitution and survival sex.

According to UNHCR data, along routes to Greece, the risk of SGBV during the journey was relatively high (UNHCR, 2018c). For 2016 only, more than 50% of the reported incidents across the country took place in Greece, while more than 80% of them affected women and girls (DOW, 2016a). Reporting on their activities in Lesbos in 2017, DWB warned of an alarming prevalence of relevant incidents and highlighted that the situation was worse for women kept in the RIC in Moria due to the lack of security, of proper illumination and separate hygiene facilities for women (DWB, 2017d). Ironically, in one of the few gendered needs' assessments, it was mentioned that the occurrence of SGBV among women was so common that it was 'normalized' to a certain extent. Women appeared to perceive this kind of violence as associated with their gender and many of them were actively seeking for contraception in order to avoid pregnancy (ARSIS, 2018).

Overcrowding and lack of privacy, as well as the fact that women often had to share their living spaces with men they did not know, were also addressed as risk factors within the documents. Moreover, the same living conditions in the camps were the reason why it was particularly difficult for SGBV victims to be identified and treated within the first and crucial 72 hours. However, SGBV risk was not equally distributed among refugee and migrant women. Namely, women who were travelling alone or as head of households faced an increased risk and so did women from African countries, such as the Democratic Republic of Congo, Ethiopia or the Comoro Islands, who were described as victims of multiple rapes (DWB, 2017b). As stated in the previous sections, the particular groups of women were often allocated in facilities like the RIC in Moria and were exposed to more precarious conditions as well as increased discrimination and racism.

Another emerging pillar in refugee women's health in the specific context concerned sexual and reproductive health (SRH). This domain was directly connected with the prevention and treatment of SGBV but also involved contraception and family planning, abortion services, and perinatal care. However, sources suggested that SRH was not integrated in comprehensive primary care across the islands impacting women in various ways and increasing their feelings of uncertainty.

"I am afraid of the long journey and how tiring it will be. I am also concerned that I will not have regular access to doctors"

(Sarah, young mother of three and pregnant – IFRC, 3 November 2015)

A gender analysis conducted by OXFAM (2016) across the country highlights that needs for SRH remained unmet and that women and girls were particularly concerned for the absence of female medical personnel and interpreters as well as for the lack of information regarding contraception and abortion. Despite the effort given, the conditions in the camps were very dangerous for pregnant women or for those who had just given birth due to the lack of appropriate hygiene and breastfeeding facilities and women and child friendly spaces.

Organizations set up mobile and temporary clinics to fill the observed gaps and offered care for pregnant and lactating women, referrals of complicated pregnancies to hospitals, as well as detection and treatment of vaginal infections. Moreover, in 2017 after observing an

increase in HIV and STIs in Moria RIC, Doctors of the World introduced specific prevention programs (DOW, 2017), while from January till August 2017, Doctors without Borders conducted 1.060 SRH consultations, in their clinic in Mytilene (DWB, 2017e). During autumn, the same organization expanded their activities offering perinatal care to women and new-borns in mobile clinics close to Moria RIC. However, despite the efforts, in spring 2018, they reported a two-fold increase in SRH needs compared to the previous period (DWB, 2018a).

The increased prevalence of SGBV and unmet SRH needs should be considered in the light of women's and girls' overall disempowerment that was reinforced across a series of key sectors of the first reception and which increased their health vulnerability (Oxfam, 2016). Indicatively, IFRC among others, highlighted the feeling of insecurity shared among women caused by the fact that they were forced to share their living spaces with strangers in camps, where inefficient entry and egress control allowed anybody to enter the facilities, often for the purpose of drugs, sex work and criminal activities (IFRC, 2017a). In combination with the lack of proper illumination and separate hygiene facilities, women and girls were choosing to remain in their tents and to avoid walking across the camps even for the use of toilet facilities fearful for their physical security, modesty and reputation. This situation is associated in the documents with women suffering from vaginal infections as well as from gastrointestinal problems.

"I avoid drinking water...in that way I will not to have to go to the toilet."

(Syrian woman in Kos – DWB, 2015b)

Further, due to traditional gender roles that rendered them responsible for the care of their family members, women were weighed down with routine activities like washing clothes or preparing food, that were physically and emotionally exhausting due to the lack of appropriate facilities and material (e.g. problematic sewage systems, soap, clothes detergent). Moreover, the lack of educational and recreational activities for the children implied an additional burden for women and older teenage girls, who were constantly responsible for children's surveillance. Some women with young children even reported that they could not sleep at night, worried that their children would be attacked by insects or animals (Oxfam, 2016). In this situation, women were not only physically and psychologically exhausted but

also, would not have time or would be reluctant to participate in social or educational activities originally designated for them. This technically meant that in many cases, they were being isolated and unable to connect with each other and to access necessary information (e.g. available health care services or food distribution times). This was particularly detrimental for women's access to services, given that information in the camps was usually shared via word of mouth. The documents report that official guidelines and information outlets were scarce and when available, there were also language barriers that again disproportionately affected women compared to men (Oxfam, 2016). Moreover, services related with refugees' empowerment like cash assistance or community consultation activities were oriented towards the head of the households, who in their majority were men. In this context, women were systematically falling through the cracks of management and they were marginalised in new ways within their communities due to the offered services design. This increased their precarity, insecurity, as well as their dependency to men.

Additional vulnerabilities of women stemmed from the gender imbalance found among the service providers in the camps. In a context where shortages in medical personnel and interpreters were directly linked to increased unmet need among refugees, women and girls were particularly affected by the even scarcer presence of female personnel. It is mentioned that women were often reluctant to be examined by male doctors or that when they were examined, they preferred to keep their clothes on and to verbally describe their symptoms to the doctor (Joint N.G.O.2016; Oxfam, 2016). However, this already problematic situation was getting even worse due to language barriers between patients and doctors. Women reported that they could not describe their symptoms accurately to male interpreters or that the latter would not translate correctly or accurately. It is important to note here, that although interpretation services were in various cases offered by volunteers (often refugees themselves), the standard operational procedure for interpretation services discouraged the use of volunteer interpreters in cases of medical consultations and situations where confidentiality was important (UNHCR, 2016 July 5).

Regarding actors' response to SGBV and women's SRH, although prevention and treatment cut across all the aforementioned sectors, the documents suggest that the emphasis was particularly placed on the identification of survivors and of particularly vulnerable cases and their referral to services which were mostly available at the mainland (services included psychosocial support, access to medical and hospital care, and legal aid). Hence, it was repeatedly mentioned that the UNHCR provided training to case workers as well as to

FRONTEX, police and humanitarian personnel regarding the identification of such cases (for example see UNHCR, 2017a,b). However, references to preventive measures, to interventions for the protection and empowerment of women inside the camps, or to the content and quality of the offered health and psychosocial services were scarce, if they existed at all. This imbalance should be understood in light of the fact that being a victim of SGBV meets the vulnerability criteria set for refugees and thus, it is directly linked with the asylum claim process and its outcome. However, as stressed by scholars (see for example Freedman, 2019) as well as humanitarian actors in the field (Oxfam, 2016), the emphasis on specific locations of women's vulnerability and particularly SGBV combined with the simultaneous disregard of their overall disempowerment in the asylum context entrenched women's gendered disadvantage, increased their health vulnerability, and reduced their autonomy and their available resources.

This becomes particularly apparent when one looks at the barriers relevant to SGBV disclosure as described in the analysed sources. The lack of female, language competent, and culturally informed personnel as well as the involvement of non-care actors (e.g. in cases of rape, police are by obligation informed by the hospital), combined with the non-confidential procedures all contributed to the reluctance of women to report violent incidents in fear of stigmatisation. Moreover, the fact that access to appropriate services implied in most cases a transfer to the mainland was also discouraging. In certain cases, women were reluctant to be separated from family members and thus, would not choose to report violent incidents to avoid being transferred to the mainland. In other cases, after reporting the incidents and until they could be transferred to an appropriate shelter, women had to return to the same facilities where they had been attacked having to deal with stigmatization within their family or community and worrying that the incidents would be repeated. The documents reported that women living closer to other men to whom they were not connected with family bonds had their behaviour scrutinized by their family and they were often victims of coercion, excessive control and violence. It was also reported that tensions between men of different nationalities were often initiated on the basis of women's honour (Oxfam, 2016). In such an atmosphere, reporting an incident of SGBV was becoming severely complicated by intersecting gender, national and race hierarchies that underlay not only the actual occurrence of SGBV but also the relationships of women and men within families and communities as well as the way services were designated, and the gender composition of the responsible personnel.

The same intersecting gender and race hierarchies were also illustrated in incidents of institutional discrimination against refugee women in public health care facilities, where beyond the lack of female personnel and interpretation services, refugee women were also targeted by discriminatory practices. Specifically, although abortion is legal in Greece and it is accessible to women up to the 12th week of their pregnancy, hospitals often refused abortion to refugee women or accepted women only until the ninth week of their pregnancy (HWG Meeting minutes, 26 January 2017). Moreover, pregnant women who were giving birth in Greece had access only to emergency and not to regular care. Further, the majority were not allowed to choose their preferred way of delivery. In order for the doctors to save time and to discourage women from visiting the hospital more than once, Caesarean sections accounted for 60% – 65% of labours (Minutes Regional Health Coordination Meeting North Greece, 29 September 2016). In a similar manner, it was almost a universal tactic that instead of breastfeeding training and guidelines, women were offered formula to feed their newborn babies. Finally, the same hierarchies rendered women targets of racist and sexist violent attacks by members of the local communities. Reported incidents in the documents describe incidents against a woman who was attacked for wearing a hijab as well as against a trans-woman (Joint NGO, 2017d).

A masculine disadvantage.

Men's and boys' disadvantage in terms of health was mainly traced across two intertwined areas; namely exposure to violence and mental health. Throughout the documents, men were systematically depicted in relation to physical violence. Incidents concerned torture and persecution in their country of origin, assaults throughout their journey by traffickers and gangs, violent attacks by state authorities like policemen and border patrols as well as by local racist groups, involvement in violent conflicts inside the refugee camps as well as in domestic violence and SGBV. Although exposure to violence in the countries of origin was taken for granted in the analysed sources, exposure that took place during border crossing and in Greece was almost universally attributed to power abuse by authorities and to the living conditions inside the accommodation sites. Organizations reported that they often had to treat serious injuries caused by the police (e.g. broken arms or legs) during the border crossing or after refugees were arrested. Moreover, overcrowding, insecurity, competition over resources and inactivity for men were associated with feelings of frustration and agitation that enabled violent behaviour (Oxfam, 2016). This usually involved violent conflicts between different refugee groups. For example, historical enmities between different ethnic groups were often exacerbated inside the camps due to discriminatory treatment and competition over resources, leading often to violent episodes, which in their turn were met with additional violence from the side of police forces and security guards (IFRC, 2016a). As mentioned previously, such retaliation acts from the side of the authorities were in cases directed exclusively to black men. Reportedly, men were often seriously injured during such episodes and even transferred to hospital. Similarly, there were cases where young single men, being frustrated by the conditions in the camps, were trying to escape by putting themselves in physical danger or by being exploited by traffickers (Oxfam, 2016).

Moreover, some of the men were also at risk of sexual violence and rape. Reportedly, this particularly applied to men with non-heterosexual orientation and young boys. Documents report that in sites with large single male presence, like Moria RIC in Lesbos or Souda centre in Chios, SGBV risk was present (UNHCR, 2017d) and that some of the men residing in those facilities had been also victims of rape during their journey. The following excerpt is indicative.

"I was raped, it happened in Turkey. It was a group of men. One of those gangs. I talked to a psychologist here, but the interpreter was present, and I didn't trust him"

(20-year old man from D.R. Congo – DWB, 2017b)

In contrast to women who were presented as having a rather essentialist understanding of SGBV as a risk emerging from their gender, the same reports noted that for men this type of violence suggested a threat for their masculinity (ARSIS, 2018; Oxfam, 2016). This threat emerged in the context of a broader perceived threat towards men's manhood stemming from their inactivity in the camps and their inability to provide for and protect their families. The reports stated that the experience of forced migration and particularly the situation at the Greek borders caused a rupture in the traditional gender roles and this was a particular stressor for men with a significant impact on their psychological well-being (Oxfam, 2016).

In the texts, experiences of violence in combination with the frustrating living conditions in the camps were directly associated with the serious degeneration of men's mental health, especially from the period after the implementation of the EU-Turkey deal that drastically increased the time refugees spent trapped at the borderlands. Reports from organizations like DWB and PRAKSIS are telling. For 2017, although the prevalence of mental health cases fluctuated throughout the year, in the last three months, 78% of mental health patients treated by DWB were single young men with severe PTSD symptoms, while 76% of the patients were residing in Moria RIC (DWB, 2017d). Similar patterns were reported by PRAKSIS and it was also highlighted that the majority of men who used psychosocial services had single or multiple vulnerabilities (PRAKSIS, 2017). Beyond PTSD, mental health symptoms included depression, stress and psychosis as well as substance abuse, self-harm and suicidal attempts. Depression was most prevalent among men who were staying at the hotspots longest, while substance abuse including alcohol and drugs was adopted as a coping strategy (Joint N.G.O. 2016b; MHPSS WG minutes 16 September 2019).

Similar to other refugee contexts in the Lebanon (IRC, 2016; Turner, 2016) or in Turkey (Sözer, 2019), it seems that also at the Greek borders, refugee men's and boy's vulnerabilities were rendered invisible exactly because of men's gender. Men were often overlooked in terms of psychological and social support at the camps. Simultaneously, many were often hesitant to seek assistance in fear of additional stigmatisation among their communities, a choice that reflects again the impact of essentialist masculinity understandings shared among refugee men (Johnson, 2011; Rettberg & Gajjala, 2015). Due to a lack of mental health care and limited places in appropriate facilities, people with serious problems could not receive the necessary treatment. Often, those with self-harm behaviour were kept in detention. It was also mentioned that the lack of treatment resulted in the exacerbation of symptoms and the development of psychotic disorders that in other circumstances could have been avoided (DWB, 2017a,b,d).

6.6.4 Minor refugees and the unaccompanied.

Age as a relevant category for the distribution of resources and services emerged prominently through the analysed material. However, it is significant to highlight here that age was mostly perceived as 'young age', as the emphasis was put on children and youth, and that it was almost entangled with the category of the 'unaccompanied minor'. Disaggregation of arrivals' data was mainly made by age group (see for example UNHCR, 2018g) and in much of the advocacy and press material analysed, there were explicit references to the increased presence of minors among the newcomers and the consequent need for humanitarian aid and protection (see for example Klein Leichman, 2015).

Being a minor (younger than 18) suggests also a criterion of vulnerability according to the Greek asylum law and this was associated in the documents with families with young children often being prioritised in terms of accessing appropriate accommodation and services. Besides, minors traveling without the company of an adult had to be under the protection of the Greek state and to be provided with all necessary care. However, due to failures in the reception management and the limited numbers of available positions in appropriate accommodation schemes, young children, accompanied or not, were often staying inside the camps sharing the same conditions with adults or even being detained. Reportedly, unaccompanied minors were often kept in police custody until a position became available in one of the few shelters in the islands or the mainland (ARSIS, 2018a).

Regarding children living in the camps, organizations' main concerns included providing primary and paediatric care, creative and educational activities, as well as child-friendly spaces inside the facilities. DWB report that the majority of children examined by them suffered from PTSD symptoms, sleep disorders, urinary disorders and various psychosomatic symptoms, while children who were traveling only with one parent had a greater difficulty in expressing their trauma (DWB, 2015c). In a paediatric clinic operating outside Moria RIC, working teams were offering services to children younger than 16 years old and to pregnant women in order to prevent pneumonia, hypothermia and other conditions caused by winter's low temperatures. The majority of treated children were younger than five and they were suffering from respiratory infections and diarrhoea caused by the inappropriate living conditions (DWB, 2017c). Problems inside the camps were also associated with minors' nutrition. As breastfeeding patterns were far from optimal due to the lack of safe spaces, hospitals' strategy to provide formula to new-borns, and mothers' inappropriate nutrition, one third of caregivers were feeding their children with infant formula. The formula itself was distributed from charities or bought by the caregivers, further burdening their budget. Complementary feeding practices for infants and young children were also problematic, among other reasons due to the lack of cleaning and sterilizing facilities and the insufficient food distribution in terms of quantity and nutritional value (Save the Children, 2016).

Further, for refugee children living in the camps, access to the national educational system – if available at all- was highly problematic either due to the reluctance of local schools and/or parental associations to accept refugee students or due to the lack of transportation services and other management gaps. In parallel, alternative educational and recreational activities in the camps were rarely available in a consistent manner. Needs' assessment reports

highlighted that this contributed to the overall lack of structure in children's everyday routine and negatively affected their well-being causing agitation and aggressive behaviour, while in parallel burdening women caregivers with the duty of children's constant surveillance (Oxfam, 2016). Finally, in this context, minors were at increased risk of SGBV amid poor security. Although the UNHCR coordinated with humanitarian actors and stakeholders in order to enhance children's protection through legal aid, psychosocial support and case management, children's needs remained unmet to a large extent.

Moreover, the documents reported a series of vulnerabilities as particular to unaccompanied minors who in their vast majority were boys older than 12 (UNHCR, UNICEF, IOM, 2017; NCSS, 2018). In order for the unaccompanied minors to be transferred to appropriate shelters, it was necessary to be identified but also to receive the approval of the Public Prosecutor for Minors. In the context of the overall delays and vulnerability identification obstacles, this added an extra layer of delay in the process and in cases where minors' age was not self-evident (e.g. in cases of teenagers close to adulthood), it also implied an age assessment. The actual process of age assessment was described as severely problematic due to the lack of trained staff and paediatricians. Particularly, in advocacy documents it was described as a migration control tool that forced children and youth to undergo unnecessary examinations (DOW, 2016b). The outcome of these processes was that unaccompanied minors had to spend weeks or months inside camps or detention facilities and police departments without the protection and care of an adult. Given that referral processes to appropriate shelters were prioritising girls and younger children -in line again with dominant understandings of vulnerability- (Brown et al., 2017), teenage boys were those exposed to the camps' dangerous conditions the longest.

The overall guidelines of the age assessment suggested that in cases where it was not possible to decide whether the person was younger than 18 years old, the decision should favour the refugee and grant them access to the relevant services for unaccompanied minors (DOW, 2016b). However, given that in the shelters, minors had limited or no ability to go outside, had no access to cash assistance and were kept detached from acquaintances and their communities, it was reported that many young boys who could 'pass' as adults, would choose to report an older age in order not to be transferred to the shelters. This choice was described as the outcome of minors' distorted perceptions regarding their legal options and also of their eagerness to exhaust every possibility in order to continue their journey. Given that Greece lacked a formal guardianship system, it was common among youth to get involved with smugglers to leave the islands regardless of the involved risks. In this frame, youth were often exploited and trafficked (IRIN, 2016), with the risk being particularly salient for young people coming from the non 'refugee producing' countries. Scarce references included information about young boys and girls who were reported as missing (UNHCR, 2017f). An additional form of exploitation in the specific context was that unaccompanied minors often appeared connected to adults who were falsely reporting that they were their relatives, guardians or caregivers in order to derive benefit from the services designated for children's caregivers (DOW, 2016). The documents did not elaborate on the context of those 'connections', however one cannot but see them as potential enablers of dependency, coercion, exploitation and violence against the already disempowered minors.

As no surprise, the documents offered ample references to the extent that these conditions impacted unaccompanied minors' mental health. Both for the children residing in protection facilities and for those in the RICs, common symptoms involved anxiety and PTSD symptoms, hostility, violent behaviour and bullying. Moreover, there were alarming rates of substance abuse that in some cases involved prescribed psychotropic drugs and in others, particularly in the RICs, alcohol or non-prescribed psychotropic substances that were shared with adults. The organizations repeatedly stressed their concerns regarding the way that prolonged detention of minors was worsening their already damaged mental health and creating serious psychopathology with long-term impacts. Still, access to mental health services was even more problematic for children than it was for adults due to the limited number of specialists in the Greek NHS (UNHCR, 2017e). In those circumstances, conflicts and violent episodes between minors and also between minors and adults were common and in certain cases, led to serious incidents with injuries of those involved and with the consequent transfer of minors to temporary shelters. Incidents of sexual assault were also suspected, however references to particular incidents (e.g. report on a young boy who was raped by other minor refugees at Moria RIC - DOW, 2016c) were limited.

6.6.5 Socio-economic inequalities and health among refugees at the borders.

In line with dominant depictions of refugees as an undifferentiated mass of war and poverty-stricken people (Johnson, 2011), socio-economic inequalities among refugees are rarely considered as related to their health and much more so before their settlement. However, the documents suggested that socio-economic differences among refugees were actually

relevant to their access to a series of health promoting resources during their journey to Greece as well as during their stay at the borders. In the specific context, salient socio-economic dimensions included mainly cash availability and education, and particularly proficiency in languages. Foreign language proficiency can be seen as an indicator of socio-economic position, since those with higher education and income are more likely to speak foreign languages (Akram & Ghani, 2013).

One of the limited hints at socio-economic differences among the newcomers was found in IFRC reports. In one of the documents, it was reported that those less well-off, women and children did not own smartphones, or they could not afford sim cards or internet data and thus, they were excluded from information distribution that it was vastly based on online portals, social media and mobile applications (IFRC, 2015a). The inability to afford a smart-phone and relevant expenses hints to the role of cash in the specific context. Cash came either from own sources (e.g. savings or income producing activities) and/or from assistance programs implemented by the humanitarian actors. The UNHCR implemented the largest project that included monthly allowance distributions by household. Based on the households' size and on whether they were self-catered or not, allowances ranged from 90 to 550 euros (UNHCR, 2018d) supposed to cover every-day needs, including medicines, nutritious food, tickets for public transport, treats for the children, cigarettes and other necessities (Oxfam, 2016). According to assessments, refugees appreciated cash distributions more than items distribution, however they were not able to cover their needs with the distributed amounts since their own savings in most cases had been already spent during the journey (Oxfam, 2016).

What implicitly emerged then is that people with more cash available, and the better-off, would probably be able to secure more health promoting resources for themselves and families (e.g. food, medicine, clothing) and they would be more able to overcome relevant health care access barriers (e.g. cover their transport expenses to and from hospitals, visit private doctors, buy medicines themselves). Moreover, in a context where people had to cover their everyday expenses with insufficient cash distributions, the need for cash cannot be seen independently from the risks of transactional sex, trafficking, and other forms of exploitation. As discussed in the previous sections, such risks were unequally distributed among refugees according to intersecting racial, gender, sexuality and age criteria.

The other socio-economic dimension salient in the emergence of inequalities in this context concerned education and particularly language proficiency. It appeared that given the lack of interpretation services, the knowledge of English was vital for accessing information and services including health care as well as for refugees' participation in community consultation processes and structures. Those who could communicate in English took leadership roles and talked on behalf of others (Oxfam, 2016). However, educational inequalities appeared as disproportionately affecting women and minors as women were often marginalised among other reasons due to low literacy and language barriers (Oxfam & Lighthouse Relief, 2016), and children with lower levels of education faced a higher risk of trafficking and exploitation while traveling in Europe (UNHCR, 2017c).

6.7 Discussion

The main aim of the intersectional analysis was to interrogate the processes through which the intersections between border crossing, humanitarian aid and asylum policy at the Greek borderlands were associated with the production of an unevenly distributed health disadvantage among migrants and refugees. Within this context, I have explored which pathways of exposure to health risk and harm were involved in refugees' first reception between 2015-2018, and how those pathways differed according to refugees' and migrants' internal differences and intersectional locations.

Adopting intersectionality as a critical analytical framework (Collins & Bilge, 2016; Hancock, 2013), I analyzed 372 publicly available documents produced by the UNHCR and seven partnering humanitarian organizations involved in the health sector of refugees' first reception at the Greek borders. Building on work on intersectionality as an analytic framework (Collins & Bilge, 2016; Hankivsky et al., 2012) and situated intersectionality (Yuval-Davis, 2015), I approached refugees and migrants as marginalized populations located for shorter or longer periods at the Greek borders, as the geographic and symbolic margins of Europe, and explored which intersecting hierarchical processes were relevant for the emergence of inequality in terms of exposure to health risk and in terms of distribution of social determinants of health. Starting from interrogating the meaning of the refugee category and other emerging migration categories in the specific context and while being cautious to racial and gender categories in line with traditional intersectionality scholarship (Nash, 2009), I adopted an openended approach regarding the dimensions of difference within the refugees' and migrants' groups that were salient in the specific context and I explored how their intersections rendered certain groups more vulnerable than others. In this section, I discuss the main conclusions that emerge from the findings of this analysis and their implications regarding refugee health research.

6.7.1 Health disadvantage and intersecting power hierarchies at the Greek borders.

The results show that the asylum frame and the migration categories it involved were particularly relevant for the entitlements of the newcomers. Specifically, it emerges that despite the alleged concern for all the people arriving in Greece, the distinction between refugees and migrants was salient, shaping a hierarchy that benefitted the former against the latter. As described, in the 'exceptional' space of the Greek borders (Ramsay, 2019), those who were perceived to have escaped persecution were entitled to protection that suggested a legal obligation for the Greek state and the European Union contrary to the rest of migrants, for whom provision of protection rights seemed to fall within the sphere of humanitarian concern or moral obligation (Holmes & Castañeda, 2016; Smith & Waite, 2018). However, the results further suggest that the boundaries of the refugee category were fluid across time and set in relation to additional institutionally constructed categories, namely nationality and, after the 2016 Agreement between Turkey and the EU, vulnerability. Given that refugee status is associated with entitlements, every shift to the refugee category's boundaries was associated with shifts in the established hierarchy of entitlements and hence, with the exclusion of groups of people from access to social determinants of health and with their exposure to health risk (De Genova, 2016). As shown, the introduction of nationality and vulnerability as criteria for refugee status eligibility narrowed down the number of those rendered eligible.

Further, shifts between migration categories for the same person had negative implications for their overall well-being. As explained, the shift from the status of the asylum seeker to that of the recognised refugee implied loss of access to crucial support involving accommodation and cash assistance and exposure to new forms of precarity that in Greece had a devastating impact on refugees' health (Dalma et al., 2018; Skleparis, 2018). Finally, shifts in the terms used to describe people with similar migration trajectories in the political and broader public discourse were also relevant to refugees' and migrants' exposure to health risk. As shown, the bilateral Agreement with Turkey contributed to the framing of the phenomenon as a 'migration control' issue, which overlapped with the portrayal of the newcomers as migrants and importantly, as irregular migrants (Sigona, 2018), that in turn coincided with much more dangerous and violent border crossings.

These findings imply that the extent to which certain distinctions between migration categories can be meaningful or not depends on the context but also on the level we are looking at. At an empirical level, the health risk involved in crossing the Greek borders and going through the first reception procedure was significant across the whole examined period. This meant that regardless of whether the newcomers were deemed eligible for refugee status within the asylum system and of whether they were symbolically seen as migrants or refugees, they had to cross through clashing rocks to reach Greece and to endure a potentially severely health damaging reception and identification procedure. At the same time, this distinction mattered at an institutional and also symbolic level, since portraying the newcomers as (irregular) migrants implied limited or no entitlement to rights as well as the legitimization of harsher migration control and the violent treatment of migrants (Sciurba & Furri, 2018).

Further, the findings suggest that in the context of the camps across the Greek borderlands, all men were harmed during the first reception procedure by their exposure to dangerous living conditions and violence. Moreover, by virtue of their gender, men were particularly affected by their inability to perform the stereotypically masculine roles that involve working and providing for the family, because this inability was experienced as a threat to their masculine identities. Further, the coping mechanisms they used to overcome such stressors and their general feelings of frustration and insecurity involved health-harming behaviour like substance abuse, engagement with violence and dangerous escape attempts from the camps. On the contrary, among men, higher educational level and more financial means implied more resources to deal with the adversities of the camp and the relevant stressors, and access to leadership roles. However, it emerges that among men, particularly young single men from Congo, Morocco and other countries of Central or North Africa were exposed to a greater risk, compared to other groups of men, because they were subject to multiple discriminatory decisions and practices adopted by the state authorities as well as to increased violence from the state authorities and within the camp communities. Similarly, teenage boys, especially when unaccompanied and especially if coming from non-refugee producing countries, and nonheterosexual men were exposed to increased risk of exploitation and sexual violence.

These findings reveal that inside the camps, intersecting power hierarchies (Davies & Isakjee, 2018; Freedman, 2019; 2016b; Ilcan & Rygiel, 2015) operated in very prominent ways in the production of health disadvantage involving categories of nationality, race, gender, age and socio-economic position and also marital status, sexual orientation, and guardianship and rendered certain groups of refugees and migrants more susceptible to health risk than others.

The patterns that rendered Syrian nationals as a situated reference category and black men relatively more susceptible to deprivation of rights and violence reflect an established local hierarchy, that in reality conceals the European racial hierarchy within which black and brown bodies are rendered disposable (De Genova, 2018). The lethal border politics and the inhumane living conditions across the camps target migrants and refugees, including Syrians, who are disproportionately racialised as blacks, although this is rarely considered relevant in mainstream European migration discourse (De Genova, 2018; Davies & Isakjee, 2018). Moreover, the fact that the discriminatory tactics involved within the Greek asylum scheme disproportionately affected people coming from countries of Central and North Africa, who in their vast majority were black people, does not diminish the racialisation processes that affect Syrian and other Middle-Eastern refugees and migrants. Rather, it seems to confirm even more emphatically that race, not as an essential or biological category but as an oppressive social construct, is salient and relevant to the European border politics, since the darker the skin colour of refugees and migrants, the harsher their treatment.

Simultaneously, the established racial hierarchy intersected with local gender and masculinity hierarchies (Choo & Ferree, 2010; Spade, 2013). It appears that the way that refugee and migrant men were exposed to the mainstream intersectional portrayals of masculinity (e.g. man as the family provider) and negative portrayals of refugees' and migrants' masculinity (e.g. dangerous males or feminized victims) but also the way they themselves employed those portrayals shaped in-camp masculinity hierarchies embedded in the power dynamics operating at the European borders (Allsop, 2017; Connell, 1987). As the results highlight, those in-camp hierarchies resulted in certain groups of men being simultaneously harmed by macro-level factors (e.g. universal indefinite detention) and by within community and interpersonal factors (e.g. black men being attacked by other refugees).

At the same time, the pathways of exposure to health harm and risk were different for women, who were dealing with the same power dynamics inside the camps. However, the way they were affected was decisively shaped by their disempowered position as women (Freedman et al., 2017). The results reveal that women's health disadvantage was merely approached by the organizations through the lens of the SGBV and reproduction. However, the sources also suggest that women faced a variety of health risks that were less considered during the first reception procedure; they emerged across women's everyday tasks and different sectors (i.e. protection, hygiene), and they were mainly the outcome of the intersection between gender

inequalities operating within their communities, but also of the structures of the first reception procedure.

Affected by those intersections, women, who were disadvantaged by educational and economic inequalities within their communities during the first reception procedure had to deal with information and cash distributions that advantaged language efficient individuals and household heads, who were usually men. Similarly, while being at increased risk of SGBV violence within their communities, they were allocated in camps with inefficient security. Further, while being scrutinized and coerced within their families and communities, many women were also deprived of safe spaces inside the camps and they were offered services that were not culturally and gender sensitive and which were reproducing their stigmatization. Similarly, while being responsible for traditional caregiving tasks, they were deprived of the necessary means and facilities and this added an extra burden to their physical and emotional well-being.

Despite being portrayed as particularly vulnerable compared to men (Freedman, 2015), refugee and migrant women's vulnerability seems to have been defined in a very narrow way in the frame of the refugee response at the Greek borders. Institutionally, their vulnerability was constructed on the basis of their gender intersecting with their single/divorced/widowed marital or motherhood status and with experiences of sexual violence (Oxfam, 2016). However, in the field, they were experiencing vulnerabilities that were institutionally invisible. Even regarding SGBV, although the definition employed in the context included a series of dangers and violent acts, from rape to domestic violence and transactional sex, there is no actual information regarding the occurrence of the particular forms that this violence was taking neither for the particular ways women were harmed nor for its structural causes. What emerges is refugee and migrant women being particularly vulnerable to an abstract danger of sexual violence -most times rape- almost as a normality of which women themselves were also aware. This danger was more salient again for women from African countries. At the same time, the dimensions of domestic violence, transactional sex or even forced marriage for young women and girls were not addressed. This is particularly problematic regarding women's susceptibility to those 'invisible' types of violence, given that the overall picture that emerges from the sources shows that women were socio-economically marginalised inside the camps and the services they received often increased their dependency to male family members or even stranger men and additionally stigmatized them (Freedman, 2015; 2019; Oxfam 2016).

Finally, regarding minors' health disadvantage, although their susceptibility to harm is almost considered innate (Brown et al., 2017), the results reveal that their vulnerabilities were simultaneously shaped by their nationality, their gender and their guardianship status. The documents depict a particularly alarming situation for underaged unaccompanied boys, who represented the majority of unaccompanied minors (Freccero et al., 2017), suggesting that girls were most of the times prioritized in terms of allocation to appropriate shelters. However, both boys and girls living in the camps were engaged in exchanges and relationships with adults and they were embedded in the local racial and gender hierarchies according to their own gender. Hence, we saw that girls were involved in caretaking together with older women and they were at increased risk of SGBV, while boys were socialised with older men, participating in health damaging activities (e.g. alcohol consumption).

Summarizing these findings in relation to the aim of the analysis, the employed intersectional analytical approach has revealed that refugees' reception in Greece has been producing health disadvantage for everyone who has to go through the process, however, there are qualitative differences among groups in terms of the specific pathways through which their health is affected. Considering the intersecting racial and heteropatriarchal hierarchies operating at the Greek borders, it emerges that, overall, single refugee and migrant men and unaccompanied teenage boys from Central or North African countries were dealing with increased exposure to health risk, violence and discrimination through multiple sectors of the first reception process. Moreover, women as a group were harmed across multiple sectors of the first reception procedure due to their disempowered position within the camps and their increased dependency to men in combination with discriminatory, culturally inappropriate reception services that were not gender sensitive. Among women, those coming from African countries are also presented as dealing with increased risk of SGBV, language barriers and discriminatory treatment. Moreover, the results demonstrate that the health disadvantage of some groups were more visible than those of others (e.g. men from African countries had a greater difficulty to have their vulnerabilities identified), while within the same groups certain forms of vulnerability were visible while others were not (e.g. women's susceptibility to SGBV or perinatal needs were emphasized compared for example to their psychological or mental health needs).

My findings are in line with existing studies documenting the increased mental health problems among recently arrived refugees in Greece (Farhat et al., 2018; Bjertrup et al., 2018), the devastating health impact of the EU-Turkey Agreement (Hémono et al., 2018) as well as

the language and cultural barriers in accessing health care. Moreover, they provide important background information regarding the processes associating with women's greater susceptibility to major depression compared to men (Poole et al., 2018a,b) and they offer important empirical evidence regarding the ways that refugee women's sexual and reproductive health is affected during their first reception. Further, they highlight the increased vulnerability of minor refugees as well as of refugees coming from African countries. These findings suggest that future research on refugees' health and health inequalities should pay particular attention to these areas.

6.7.2 Intersectionality in refugee health research: implications.

The conducted intersectional analysis has revealed the particular ways that a series of routine processes involved in the first reception of refugees and migrants in Europe have a significant health impact on their health and well-being. It has described how Greek and European borders emerge as spaces of structural violence and exclusion produced by the intersection of restrictive European border crossing and asylum policies and humanitarian aid. From this perspective, research on migrants' and refugees' health should insist on investigating the health impact of border control and asylum policies and regulations that take place on a 'temporary' basis or as an exception (Ramsay, 2019) questioning also the impact of measures aiming to benefit migrants and refugees (e.g. aid distribution or vulnerability assessment). This case study of Greece highlights that the increased securitization of the European borders leaves a significant trace on individuals' bodies (Kovras et al., 2016; Pickering et al., 2013), which needs to be addressed, measured and eliminated. The findings offer significant empirical evidence regarding the damaging health impact of the European hotspot policy which was initially introduced in the name of humanitarianism (Pallister-Wilkins, 2018).

Further, the analysis highlights that the pathways through which refugees and migrants are exposed to health risk throughout the first reception procedure cut across intersecting vertical but also horizontal processes of stratification (Beckfield et al., 2015) operating at the specific context and producing health inequalities that target refugees and migrants compared to local groups but also 'internal' health inequalities among refugees and migrants (McKinnon, 2013). The findings show clearly that within the context of the first reception neither all refugees were treated in the same way nor were they affected in the same way by universally applied regulations (Collins & Bilge, 2016). In this light, researchers should interrogate health

inequalities between and within groups of refugees and migrants, be cautious of the use of institutional migration categories or classifications and explore to what extent they associate with different migration trajectories and entitlements. Moreover, observed inequalities between refugees and other migrant and non-migrant groups located mainly in the area of mental and perinatal care (Bradby et al., 2015) should be more explicitly contextualised in the frame of the European asylum policy and particularly hotspots policy, which as the findings show implies significant risks for refugees' and migrants' mental, sexual and reproductive health. Finally, in analytical and theoretical terms, migration in Europe should be considered as an additional stratification mechanism intersecting with socio-economic status, gender, nationality and also race. Hence, migrant and refugee health should be more actively integrated in health inequalities research.

Additionally, the results imply that it is not only the asylum and border crossing policies that produce harmful exclusions against refugees and migrants, but that refugees and migrants themselves as active agents are engaged in a multitude of interpersonal relationships (Collins & Bilge, 2016) and intersubjective practices (Anthias, 2013) within the micro-society of the camps that bear significant health risks. According to their intersectional locations in hierarchies of nationality, race, gender, age and socio-economic position, migrants and refugees are subject to power-inequalities within the camps' communities that link not only to inequalities in exposure to risk but also in terms of available resources to deal with experienced risk and suffering (Fineman, 2010). In this light, refugee camps in Europe emerge as specific locations of structural violence and social exclusion that are simultaneously subject to macrolevel power dynamics (i.e. racism, heteropatriarchy) but they are also fields for the emergence of very local micro-systems of power, almost in similar ways that this happens to incarceration systems (Brinkley-Rubinstein, 2013). From this perspective, having the experience of the camp but also the transition outside has multiple implications regarding the overall physical and psychosocial well-being of refugees and migrants that should be more explicitly addressed in migrants' and refugees' health research.

Moreover, the findings show that the interplay between different domains of power (Brah & Phoenix, 2004; Collins & Bilge, 2016) in certain cases exacerbates the disadvantage experienced by certain groups (e.g. refugee women simultaneously affected by gender insensitive services and domestic coercion), while in others allows for the emergence of an incontext privilege (e.g. men fluent in English were usually taking leadership roles within the communities). Within this interplay, women find themselves affected by gender inequalities

that traverse their intra-community relationships as well as the design and implementation of asylum law and refugee reception but also structural and institutional bodies within the local community. While being scrutinized and coerced by family and community members, women are simultaneously discriminated within refugee reception services and the national health system. Simultaneously, their asylum claims are met with caution by the asylum services, who deliberately refuse to acknowledge the gendered dimension of their persecution (Freedman, 2010; 2016; 2019). While being portrayed as vulnerable and victimized, they are mutated within refugee communities (Freedman, 2019) and their crucial role as public health agents who take care of children, elderly, and men is disregarded. Their bodies are commodified within a frame of financial relationships that include trafficking, transactional sex but also forced marriages (Digidiki & Bhabha, 2017; Farr, 2016; Parrs, 2018), while their susceptibility to SGBV is subject to problematic identification processes due to cultural, linguistic barriers, management gaps and delays. Similarly, minor refugees and migrants, find themselves harmed by services that increase their dependency to the state or to stranger adults, and according to their gender they become subject to exploitation and violence (Digidiki & Bhabha, 2017). Their ostensibly innate vulnerability is assessed via time-consuming and stressful age-assessment procedures (Brown et al., 2017) that are distinct from their own aspirations to continue their journey.

However, the interplay between different domains of power highlights also that refugees and migrants emerge not as solely victimized but also as power agents, who make choices for how to navigate the reception and asylum procedure more or less safely (e.g. women asking for contraception in order to control the damage of a potential rape or minors stating an older age to increase their possibility to leave the islands), who provide care (e.g. women and older girls taking care of young children) but who also abuse their in-context power for their own benefit and to the detriment of others (e.g. adults declaring false familial bonds with unaccompanied minors or men exhibiting violence against women or other men to acquire greater power within the local masculinity hierarchies). This intersectional understanding of power as a continuum rather than as something that someone has or does not have (Iyer et al., 2008; Nash, 2008) opens a whole new field of research questions regarding the effectiveness of aid and health care programs targeting this particular population and the way they buffer or reinforce existing inequalities (Hankivsky et al., 2012). Moreover, it urges us to further explore refugees' and migrants' and particularly women's own strategies of care and their role as public health agents at the borders and inside the camps. Finally, it calls us to integrate populations and groups that are systematically excluded from refugees' vulnerability discourses and research more critically in our work (see for example Turner, 2016 for the exclusion of young men within the Syrian refugee response).

Additionally, this case study provided useful insights regarding the meanings assigned to refugees' and migrants' health vulnerability within the context of the borders and how those meanings are subject to power dynamics as shaped between policy and humanitarian institutions (Anthias, 2013). Identified and assessed vulnerability functioned throughout the whole examined period as a solid institutional refugee category and a filtering tool (Smith & Waite, 2018) for those who had access to rights. Particularly, after the implementation of the Agreement with Turkey, assessed vulnerability became linked to admissibility and emerged as the sole pathway to asylum and protection rights (MHPSS Sub-working group meeting minutes, 26 May 2017). Of course, this does not suggest an unprecedented phenomenon. Traditionally, vulnerability has been associated with hierarchies of deservingness and processes of exclusion in social policy (Brown, 2015) and also in migration and asylum policies (Freedman, 2019; Turner, 2015). Sözer in her recent work describes how within the frame of its neo-liberal transformation, humanitarianism has shifted from being concerned with refugees' and migrants' collective vulnerability to being concerned with only vulnerable refugees and migrants (2019, p 5). However, in Greece, as the events evolved from the summer of 2015 until the Agreement between the EU and Turkey, we witnessed not only the emphasis of humanitarian actors on the 'vulnerable refugees' but a gradual shifting of the boundaries of the refugee category itself so that it includes only 'the vulnerable refugees'. Through that shift, health and particularly harmed health and susceptibility to harm penetrated not only symbolically but institutionally the content of the refugee category. The emphasis of intersectionality on the construction of categories and categories' barriers allows the understanding of vulnerability as the outcome of simultaneous and intersecting categories of disadvantage, but also enables us to understand vulnerability as a constructed category in itself operationalised for the exclusion of populations from the European asylum (De Genova, 2016) and which has material and discursive implications for those 'classified' as vulnerable. Moreover, it opens a whole new field of significant questions for researchers but also for humanitarian and global health actors regarding the processes of vulnerability assessment within the increasingly securitized and militarized context of the European borders as well as regarding the existing or absent entitlements of vulnerable refugees within European welfare states.

Finally, by highlighting the salience of a racial hierarchy operating at the Greek borders hurting particularly black bodies, the analysis urges us to frame European asylum within the historic context of European colonialism. The developments at the Greek borders, as Europe's external but also internal (at the north part of the country) borders, should not be understood as disconnected from Europe's colonial past since the people who are now aiming to reach Europe, via Greece, are coming from Europe's former colonies (De Genova, 2016; Mayblin, 2017). In this vein, Davies and Isakjee (2019: p.3) in their recent work encourage us "to scrutinize the role of race and empire within contemporary border politics" and look at the refugee camps from the point of 'necropolitics' (Mbembe, 2003). From this perspective, the refugee camps emerge as spaces that produce inequality similar to the colonial plantations of the past, as the ultimate spaces of violence, where people are kept alive while at the same time, they are severely harmed, immobilised, and deemed disposable (De Genova, 2016). Indeed, the findings presented leave little space to question the extent that refugees are harmed while trapped at the Greek borderlands, or whether they are deemed disposable while awaiting asylum claim decisions or forced return orders. It appears then, that the European border politics as juxtaposed at the hotspots across the Greek islands entrench already established systems of subordination and marginalization of certain black and brown populations (De Genova, 2018). However, the findings further show that all refugees and migrants as racialized subjects are not all harmed in the same way, reflecting how racial hierarchies in Europe are con-constituted with neo-liberal and heteropatriarchal hierarchies (Lytle, 2017).

6.7.3 Limitations.

The presented analysis is based on documents produced exclusively by the UNHCR and their main partnering organizations involved in the health sector of the first reception procedure at the Greek borders. Although testimonies of refugees, migrants or humanitarian personnel in the field are included in several of those documents, the material analysed remains solely representative of the humanitarian organizations' voice (Verloo & Lombardo, 2007). On the one hand, humanitarian organizations were present in the field across multiple locations and throughout the whole examined period, located symbolically at a level between policy decision makers and refugees and migrants themselves. Hence, one could claim that their perspective is inclusive of the overall developments in the field and the emerged tensions. However, financial dependency on the European Commission for some of them or other aid donors for others does not suggest we should idealize their activities nor to understand them as distinct from politics and profit-making processes (Werker & Ahmed, 2008). In her recent paper, Sözer (2019) describes that the neo-liberal transformation of humanitarianism involves the fragmentation of (I)NGOs activities, their focus on short-term projects and specialized outcomes and the evaluation of their activities according to donors' interests rather than according to their overall impact. From this perspective, the reports and accounts of their activity are more likely targeted towards their donors. Moreover, their reporting is more likely to emphasize evidence of their efficiency which will satisfy their donors and will secure the continuation of financial support rather than beneficiaries' feedback (Banatvala, 2000; Werker & Ahmed, 2008). This limitation has three important implications. First, that (I)NGOs' perspectives and narratives regardless of their important advocacy role remains privileged compared to that of refugees and migrants. Second, that in their attempt to justify their action and to secure donations, humanitarian actors are likely to adopt the mainstream refugees' victimization discourse. Third, exactly due to their embeddedness in economic and political relationships and in the mainstream migration and asylum discourse, it is likely that they are unable or unwilling to grasp processes affecting people located at specific intersections of disadvantage that remain invisible. Although the employed intersectional lens has enabled me to deal with this limitation to a significant extent and to reveal subtle health inequality producing processes, I have to acknowledge that the results would have been richer, if refugees' narratives were more actively and consistently integrated in the analysis.

Additionally, the exclusive focus of this analysis on the Greek context is telling of developments taking place at Europe's external borders and offers useful insights regarding the intersecting health disadvantage emerging through migration control procedures in the region. However, the particularities of the hotspot approach (Pallister-Wilkins, 2018) and the relatively short period that refugees and migrants have spent at the Greek borderlands does not necessarily allow the generalization of the findings across other regions outside Europe (e.g. the Lebanon or Jordan) where refugees' formal and informal settlements involve different actors, services, opportunities for contact with citizens, as well as different forms of exploitation and violence (Martin, 2015; Talhouk et al., 2016; Turner, 2015).

6.7.4 Conclusion.

"In early January 2017, the Greek islands were hit by heavy snowfall and freezing rain. [...] three young men died in Moria camp and a fourth was taken to hospital in a critical condition. Survivors and friends reported that the deceased had no pre-existing medical conditions. To keep warm, the men had been burning cardboard, plastic and scraps of wood in the tents they shared" (DWB, 2017a).

The presented results demonstrate that the first reception processes at the Greek borders were responsible for the production of a yet unmeasured but still obvious health disadvantage for refugees and migrants that was differentially distributed according to refugees' and migrants' intersectional locations in hierarchies of nationality, race, gender, age and socioeconomic position. Beyond what the asylum law and national policies mandated, a series of everyday routines in the refugee camps involved significant health risks for refugees and migrants. The arriving populations after long and dangerous journeys and risky border crossings at sea or at land, were forced to go through registration and identification procedures in a context where nothing seemed to be in order and to spend shorter or longer times at the Greek borderlands enduring inhumane living conditions and violence. Referring to the situation across the North Aegean islands, UNHCR (2016 March 01) talks about a 'self-induced crisis for Europe' highlighting the extent that the first reception project failed to align with international standards of protection. Assessments of the situation in reception facilities through the whole examined period repeatedly mention that overcrowding, limited sanitation and hygiene facilities, exposure to rough weather conditions, limited electricity, lack of safe spaces, poor nutrition, environmental hazards, and limited access to primary and secondary health directly harmed refugees' health and overall well-being and they even led to death in certain cases.

"On 25 November 2016, in Moria 'hotspot' camp on Lesbos, a woman and child were killed in a fire after a gas canister attached to a hot plate exploded inside their small nylon tent. They were using the hot plate to try and keep warm. As a result of the accident, two people died and many more were injured." (DWB, 2017a)

The particularly significant contribution of this intersectional analysis is that it has managed to highlight that while being subject to multiple imbricated policies and regulations, neither all refugees were treated in the same way nor were they affected in the same way by universally applied rules (Collins & Bilge, 2016). Hence, although the border crossing experience and the navigation of the Greek asylum system carried a damaging health impact, this impact was unequally distributed among refugees. Using intersectionality as an analytical framework allowed me to deal with the complexity of the issue, to trace inequality 'on its making' and to show that health inequality producing processes operate simultaneously vertically as well as horizontally (Beckfield et al., 2015).

The analysis demonstrates that there are both qualitative and quantitative differences in terms of refugees' exposure to health damage during border crossing and first reception in Greece and in Europe. The quantitative differences observed portray that black men and women as well as girls and boys dealt with a disproportionate marginalisation, discrimination and violence at the Greek borders compared to other refugee groups. However, at the same time the qualitative differences tell us that neither black refugees nor other refugee groups were affected in the same way. From this perspective, talking about health inequality itself becomes particularly challenging, since inequality implies two parties, one of which is understood as the reference category (Weber and Parra-Medina, 2003). What is the reference category in our case, however? The analysis shows that Syrians overall due to their numbers represented an in-context reference category in the camps, however, for single Syrian men who were allocated in Moria R.I.C. this locally privileged category did not seem adequate to protect them from the inhumane conditions of the camp. Similarly, women indeed were disempowered across multiple domains of the reception process compared to men, but maybe not so, if we talk about a married Syrian woman and a teenage homosexual boy from Cameroon or even more so, if we talk about an illiterate Afghan single woman and a married highly educated Syrian man. This is where the significance of intersectionality emerges more boldly than ever as it

challenges us to shift our understandings from binary notions and linear relationships among individuals and groups and to engage with the complexity of social reality (Collins & Bilge, 2016). The analysis shows emphatically that instead of being concerned with the 'oppression Olympics' (Hancock, 2007; 2011; Martinez, 1993), namely who is the most oppressed and whose suffering is the worst, we should rather focus on the particular ways that this suffering is produced and this not in order to improve the effectiveness of our analysis, but rather in order to be able to tackle the suffering (Collins & Bilge, 2016). Being concerned with achieving social justice, intersectionality invites us to understand inequality not as a relationship between two parties but rather as a relationship between one's position and one's potential; the highest attainable standard of health (Keygnaert et al., 2014).

Another important conclusion is that the suffering juxtaposed in this intersectional analysis is the outcome of the intersecting exclusion processes organised across national, racial, heteropatriarchal and neo-liberal hierarchies (Lytle, 2017) as those operate within asylum policy in Europe, the Greek asylum system, the humanitarian aid organizations, the refugee camps, the refugee communities and families as well as all the interpersonal relationships involved in those contexts. Across all those power domains, refugees were not only the passive recipients of exerted power, but they also exerted power over their own and others' situation. They used whatever capabilities (Sen, 2001) were available or emerging in the specific context in order to navigate the process as successfully as possible and with as little damage as possible in order to achieve their goal, to leave Europe's margins. If we insist on seeing refugees as active agents who employ their power to reach their goal, which is the core element of many health definitions (see for example, Baer et al., 1986; Seedhouse, 1986; Sen, 2001), then the damage imposed on their health at the Greek borders emerges explicitly as an act of disempowerment.

Finally, refugees and migrants in their diversity are forced to endure an experience that produces their health and social disadvantage, while at the same time this disadvantage is differentially visible to the eyes of the asylum system as well as within the refugee discourse in Europe. With the operationalization of poor health as a precondition for refugee status, the constructed category of the 'vulnerable refugee' emerges stronger and bolder than ever as the synonym of the victimized, traumatized 'other' (Malkki 2015; 1996). At the same time, from the moment that poor health becomes an instrument of exclusion, its assessment becomes a field of negotiation where the state and its medical staff decides whose poor health counts and what forms of poor health count (Holmes & Castañeda, 2016; Fassin, 2005; Lytle, 2017).

Hence, health vulnerability although produced and embodied at the borders, is not necessarily institutionally identified and acknowledged. In this context, refugees who bear the consequences of these exclusion processes on their bodies will either have to enter the broader European society harmed and also stigmatized and additionally disempowered or they will be forced to return to non-safe countries bearing a new burden of health disadvantage that they did not have when they were originally persecuted. In both instances, the question that needs to be addressed is who will compensate for this harm?

"I wonder: if the European states want indeed to accept us, why don't they do that legally, via their embassies? Are the whole world blind and they don't see what is happening? [...] Do they bet that we will die before we will manage to arrive?"

(Hannah, Syrian woman – DWB, 2015d, Translation from Greek)

Chapter Seven: Discussion

7.1 Introduction

This thesis has brought together intersectionality and institutional approaches of inequality and health inequalities research in Europe. In particular, I have suggested an intersectionality and institutionally informed analytical framework that allows us to study and understand health inequalities beyond the purely socio-economic by addressing the multiple layers of privilege and disadvantage, including race, migration and ethnicity, gender and sexuality as well as the intertwined influence of both individual social positioning and institutional stratification on health. Building on this framework, I carried out research that involved both a quantitative and a qualitative design to study intersectional migration-related health inequalities among settled groups in Europe as well as among newly arrived refugees and migrants at the Greek borders as the margins of Europe.

The thesis has approached health as a socio-political concept and health inequalities as the outcome of social injustice and power imbalance (Beckfield, 2018), while it employed intersectionality as an analytical approach for the understanding of power and social stratification (Yuval-Davis, 2015). Within the context of imbalanced power dynamics, the structural arrangements affecting health and its social determinants are neither the same for all individuals and groups, nor are individuals and groups affected in the same way by the same structural arrangements (Collins & Bilge, 2016). From this viewpoint, I explored intersectional health inequalities between as well as within privileged and disadvantaged social groups. Groups in this thesis are understood on the basis of a shared location that has particular political, social and institutional implications for health and its social determinants within the European context. In this final chapter, I reflect on the overall findings of the thesis as well as on the process of conducting the research, the challenges and implications that emerged associating my findings with the research questions originally set in the thesis. As presented in the introduction of the thesis my research questions were:

1. What are the theoretical and methodological implications for the study of health inequalities in Europe that emerge from the development of an intersectionality informed analytical framework?

2. What health inequalities research agenda emerges from such an analytical framework?

3. What health inequalities emerge among social groups, if we consider the simultaneous intersecting impact of gender, socio-economic position and migration status in Europe? Which are the groups with the greatest health advantage and disadvantage?

4. Do European border crossing and asylum policies contribute to health inequalities among migrant and refugee groups in Europe; and what kind of processes taking place at the external European borders are responsible for the production of such inequalities?

In the discussion that follows, instead of answering to each question separately, I will integrate my responses to the four questions because they are strongly linked. I considered that answering to each question separately would unavoidably lead to repetitions which would hamper a thorough integrated discussion of my main findings.

7.2 Intersectionality as an Analytical Lens for Health Inequalities in Europe

In the frame of this thesis, intersectionality was employed as a critical research paradigm that allows for research questions that have remained unanswered to emerge (Hancock, 2013). As elaborated in the literature review, health inequalities have been mainly understood and studied as the outcome of a single-dimension stratification process. The vast majority of studies have been focusing on purely socio-economic stratification (Kawachi et a., 2002; Mackenbach et al., 2008; Marmot & Wilkinson, 1997; 2006; McNamara et al., 2017a; Van Doorslaer & Kooman, 2004; Wilkinson, 1994; 1996; 1997), while alternative views on the stratification role of gender, ethnicity and race have developed rather independently from one another (Ingleby, 2012; Read & Gorman, 2010; Williams, 2012). Hence, as it has been demonstrated in this thesis, in the particular context of Europe, integrating an intersectional perspective in this field of research results in new questions to emerge regarding the simultaneous and co-constituting nature of multiple stratification processes organised across socio-economic factors, gender, race, ethnicity, migration, and sexuality.

The first important theoretical implication resulting from studying health inequalities from an intersectional perspective concerns the very definition of health inequality. In contrast to understanding relationships of inequality as binary or vertically organized, intersectionality invites us to broaden our scope in two ways. First, by framing health inequalities as inequalities in social power and second, by acknowledging power in relational terms (Anthias, 2013).

Understanding social position as a spot within a matrix of intersecting power axes (Crenshaw, 1992), where people more often than not are simultaneously affected by privilege and disadvantage (Iyer et al., 2008; Nash 2008) implies that relationships of inequality do not evolve between those who have power and those who do not. Rather, they emerge also in non-vertical ways, within traditionally advantaged or disadvantaged groups. Being considered with relationships of inequality as products of vertical but also horizontal stratification processes implies that these relationships are open questions to be explored empirically (Hancock, 2013). Hence, from this perspective we move from health inequalities between (e.g. poor vs wealthy, migrant vs non-migrant, women vs men) to inequalities within (e.g. poor, wealthy, migrant, non-migrant, women, men). As shown in chapter five, an intersectional investigation of migration-related health inequalities produced not one relationship of inequality (i.e. migrants vs non-migrants) but relationships between 24 groups.

Second, by exploring such relationships within the context of power imbalance, intersectionality strengthens our ability to link health (in)equality with social (in)justice (Marmot, 2005; Wilkinson & Pickett, 2010). From this perspective, health inequality does not exclusively describe a relationship between healthy and less healthy individuals and groups, but it can also describe the extent that certain individuals and groups are disempowered and prohibited from reaching their health potential (Sen, 2001). As highlighted in chapter six, linking health with social and political power reveals how already disempowered groups are hurt by new exclusion processes but also how their health is operationalized as a sorting tool for their access to human rights as well as within repeated stigmatization processes.

Another important theoretical implication as described in chapter four and demonstrated in chapter six, concerns the understanding of institutions as heterogeneous intersecting entities that impact individuals' health through simultaneous processes evolving across different analytical levels (Beckfield et al., 2015). Intersectionality enables us to understand institutional operations within their social but also historical context (Collins & Bilge, 2016; Yuval-Davis, 2015) and to reveal the way they (re)produce and entrench health inequalities through discriminatory logics and practices but also through the different ways they influence individuals and groups according to their intersecting social locations (Hankivsky et al., 2012; Lowndes, 2010; Weber & Parra-Medina, 2003). In chapter six, we saw that the ways that migrants and refugees were differentially exposed to health risk and damage was simultaneously affected by border and asylum policies, and the humanitarian aid distribution. The intersectional lens allowed me to trace processes through which the macro-level factors affected the bodies of refugees and migrants but also to link these processes with the exclusionary logics informing those policies as well as their design and internal hierarchies (Hankivsky et al., 2012).

Another important theoretical implication concerns the health inequality producing processes. According to intersectionality, power is not only organised across different hierarchical axes (e.g. gender, race, class) but also across different domains (i.e. interpersonal, disciplinary, structural and cultural) (Anthias, 2013; Collins & Bilge, 2016). In such power systems, individuals according to their intersectional locations are exposed to multiple and simultaneous advantage and disadvantage producing processes. As shown in Chapter six, refugee women were simultaneously affected by gender inequalities within their families, by the lack of female personnel involved in the offered services, as well as by the ways they were depicted as particularly vulnerable by the humanitarian and policy actors (Freedman, 2016). Such an intersectional understanding of inequalities producing processes sheds a new light upon the study of mechanisms linking social stratification and people's health or mechanisms of embodiment (Krieger, 2001). In this light, material, behavioural and psycho-social pathways are put within the context of power relations and their political character is highlighted. For example, we can still be interested in the dietary habits of ethnic minority children but instead of only examining which groups adopt healthier habits, we will be equally interested in how healthy dietary habits among children associate with the empowerment of ethnic minority women as carers and food providers within and outside their households; or in the extent that public health programs focusing on promoting healthy dietary habits integrate ethnic minorities during their design and their implementation phase. After all, we still need to understand how inequalities in power are embodied as health inequalities. An intersectional lens enables us to pay equal attention to structures and to processes and thus, it does not only open our scope in terms of what macro-level factors are relevant to health but also can guide us through the ways that the thread connecting macro-level factors and individuals' bodies cuts across multiple domains.

Throughout such processes, individuals are not simply affected by structural factors, but they employ their resources and power in order to achieve their own goals (Collins, 2000) and hence, they both shape and are shaped by their context (Øversveen et al., 2017). In this light, behaviours acquire their meaning within a frame of institutional barriers and/or rewards and cultural norms, and they are associated with the leverage of available resources (Sen & Iyer, 2012) as well as with power use and abuse. From this perspective, psychosocial mechanisms, material resources and behavioural patterns do not only operate simultaneously but they are informed by each other. Such an understanding can reveal how inequality within a society affects health not only through uneven resources distribution, reduced social cohesion, and feelings of stress and helplessness (Marmot,2005; 2015; Wilkinson & Pickett, 2010) but also how individuals living in unequal societies engage as power agents in processes that (re)produce or reduce health inequalities.

As discussed in chapters two and four, one of the main issues concerning the development of an intersectional methodology concerns the selection and interrogation of social categories and groups to be studied (Bowleg, 2013; Hancock, 2013; Nash, 2008). I proposed that adopting a situated approach (Anthias, 2013; Yuval-Davis, 2015) can guide us both in the selection of the categories deemed relevant for the production of health inequalities as well as in the way we conceptually deal with categories. A situated intersectional approach suggests that there are categories reflecting the social divisions that shape most people's lives in certain contexts (e.g. gender) and others relevant with more subtle or invisible divisions shaping the life and experience of people at marginalized positions (e.g. sexuality). From this intersectionality concerns everyone. However, perspective, the broadening of intersectionality's scope has often been a point of criticism for scholars who consider that by using intersectionality as a concept that concerns everyone and can be applied everywhere has led to the depoliticization of intersectionality and even to its appropriation by neo-liberal institutional bodies and actors (Bilge, 2013). McKinzie and Richards (2019) in their work on the significance of context-driven intersectionality argue that any sociological work on intersectionality 'should be guided by an ethical commitment to social justice' (p. 2). However, ethical commitments are more easily proclaimed rather than actualized. In line with the authors, I suggested that one way to secure that our intersectional research is aligned with social justice is to start with the context (Hancock, 2013). A thorough consideration of the context reveals the salience and urgency of the inequalities that an intersectional analysis should engage with. Further, a context driven approach secures that intersectionality's concern with social categories is not due to a diversity fetish but due to a focus on the structural conditions producing hierarchies, exclusions and inequalities (Collins, 2000; Collins & Bilge, 2016; McKinzie & Richards, 2019).

However, a challenge that emerges here concerns the definition of the context especially during times when globalization processes have transformed our understandings of the local and the global (Walby, 2009). In chapter five, I focused on the European region and I examined

intersectional migration-related health inequalities in light of gender, occupational status, and generation status on the basis that all the examined categories are entangled within stratification processes operating in Europe. However, my analysis showed that the salience of the examined categories and their intersections are also subject to the examined national contexts. Later in chapter six, we saw that the processes producing health inequalities at the limited area of the Greek borders were linked and subjected to factors operating within the refugee camps (i.e. services offered by the humanitarian actors), at the country level (i.e. police orders and national migration policies), as well as at a transnational level (i.e. Greek asylum as mandated by the European border policies, the bilateral Agreement between the EU and Turkey). The two study examples highlight the complexity that the study of the structural causes of health inequalities implies.

However, again the emphasis of intersectionality on power can guide us not in setting the limits of the context in a superficial way but rather in distinguishing what power dynamics at play are relevant for our work. Hence, the results of chapter five showing that the 'healthy migrant effect' (Giannoni et al., 2016; La Parra Casado et al., 2017; Malmusi et al., 2010) is subject to occupational status and gender encourage us to further investigate how migrants are integrated within national labor markets but also to zoom into particular job sectors and explore processes through which recently arrived migrant men and women are exposed to health risk and damage. Similarly, chapter six revealed that the legacy of the European colonialism is still in effect regarding the health and life chances of black and brown populations in Europe (Davies & Isakjee, 2018; De Genova, 2016; 2018). Hence, it encourages to investigate further the impact of racism in health inequalities research in Europe even in countries that do not have a prominent colonial past, like Greece, and how it is particularly relevant for the experience and health of specific migrant groups and ethnic minorities. This finding suggests that beyond the socio-economic and political structures, the historic context can be equally relevant for the understanding of health inequalities in Europe.

Finally, what also emerges regarding the use of intersectionality as a context driven analytical framework for health inequalities concerns the interrogation of the meaning of social categories. As already highlighted, intersectionality understands social categories as mutually constituted power hierarchies (Collins, 2000). However, what also became clear through the findings of this thesis is that the content of social categories is not fixed but rather it is subject to the operations of power (Anthias, 2013) and hence, it can be fluid and changing across contexts but also across time. In chapter six, I elaborated on how the refugee and the migrant categories were associated with particular hierarchies of deservingness in terms of asylum rights and humanitarian aid but also how the salience as well as their content changed between the period before and after the EU-Turkey migration Agreement. Moreover, the findings revealed how the category of nationality used as a classification tool within the reception and asylum procedures at the Greek borders, in fact incorporates the category of race, the relevance of which in Europe is still debated by scholars (Davies & Isakjee, 2018; De Genova, 2016; 2018; Goldberg, 2006). Moreover, the findings of chapter six showed that categories can emerge within specific contexts as having particular institutional but also representational implications that combined (re)produce the exclusion of marginalized populations. Specifically, we saw that the category of vulnerability was operationalized within the asylum frame in Greece in order to exclude a large share of the arriving populations from accessing asylum. At the same time, this category reinforces stereotypical understandings of refugees as vulnerable, helpless victims and additionally contributes to their disempowerment (Malkki, 1992). Finally, it also emerged that the embodied realities associated with particular categories can be institutionally invisible, as shown in chapter six and particularly regarding the category of vulnerability. This finding encourages us to be particularly attentive to what is revealed and what is hidden within institutional policies and regulation and to investigate processes taking place at the meso-level in order to render the invisible visible. After discussing how intersectionality as an analytical framework advances the way we understand and investigate health inequalities in Europe, in the next section I discuss the emerging methodological challenges and implications.

7.3 Intersectionality and Health Inequalities in Europe: Methodological Implications

As discussed in chapter four, an intersectionality informed analytical framework for the understanding of health inequalities challenges us to stretch our limits across all the phases of the research process and to engage both with qualitative and quantitative research designs. As an attempt to explore the application of the framework, chapter five represents an intersectionality informed quantitative study exploring intersectional migration-related health inequalities in Europe. Further, chapter six is a case study, a qualitative analysis of the health-related response to refugees and migrants at the Greek borders between 2015-2018 and of the production of an unevenly distributed health disadvantage among refugees and migrants at the intersection, I reflect

on the emerging methodological challenges and implications that emerged while conducting both studies.

7.3.1 Quantitative design.

The first relevant implication concerns the selection and the operationalization of the social categories relevant to the emergence of health inequalities among groups. In the previous section, I elaborated on the ways that social categories of interest should be approached analytically through a context driven process. In this section, I am more concerned with the ways that categories and their intersections are operationalized within research designs. McCall (2005) defines three approaches through which researchers deal with categories, mainly the anti-categorical, the intra-categorical, and the inter-categorical. As she says, those three approaches are neither mutually exclusive nor should all of them be integrated in an intersectional research design. As I discussed in chapter four, with intersectionality informed quantitative designs it is rather self-evident that the main point of interest is to document how relationships of inequality differ across contexts or groups, hence they fall within the inter-categorical approach (McCall, 2005; Spierings, 2012).

However, the challenge with quantitative designs is their increased dependence on the availability of data. Taking chapter five as an example, my research questions and the examined categories of gender, socio-economic position, migration and generation status were chosen in the light of stratification processes operating in Europe. Moreover, I chose the European Social Survey as my data source because of the size of the available sample pooled across six waves, the availability of health measures and the high standards adopted regarding the validity and harmonization of the data across countries. However, this data source does not provide information regarding the sexual orientation, the ethnicity or the race of the participants which as I explained in chapter four are also entangled within social stratification in Europe. Further, the operationalisation of the examined categories was also subject to the availability of data. Starting from migration status, I defined a migrant as a person who has either been born outside their country of residence or has at least one foreign-born parent. This is a classification I made on the basis of the European context where the debate on first- and second-generation migrants and their integration is still intense (Kymlicka, 2015), of previous studies that have used this operationalization (e.g. Blom et al., 2016), and of the sample size I needed in order to be able to test relationships between multiple sub-groups of migrants and non-migrants as well as the significance of interaction terms. This operationalization however is not necessarily consistent with the way migrants are institutionally defined across national contexts in Europe and neither with the extent to which people identify as migrants or not.

In a similar way, measuring health across different contexts and across groups generates certain challenges associated with quantitative comparative research and the available data. Building on previous work (e.g. Benyamini & Idler, 1999; DeSalvo et al., 2006; Idler & Angel, 1990; Idler & Benyamini, 1997; Latham & Peek, 2013; Møller et al., 1996; Shadbolt, 1997; Shadbolt et al., 2002; Subramanian et al., 2008; Walker et al., 2004; Wolinsky & Johnson, 1992; Young et al., 2010) showing that self-rated health measures are associated with mortality and morbidity onset, I conducted my comparative analysis using two different self-rated health measures. The results of the analysis showed that inequalities followed the same patterns for both health measures. However, the prevalence of the two outcomes (i.e. poor or very poor health and being hampered) as well as the range of inequalities across groups differed. Reading these findings in light of literature suggesting that the way people assess their health is subject to their social position as well as to the level of inequality in the society they live (Wilkinson & Picket, 2018), raises questions regarding the extent that the results produced represent an accurate depiction of the range of the existing inequalities. According to this literature, individuals who deal with unfair treatment and inequality (i.e. socially disadvantaged individuals) tend to overestimate their health and well-being, in order to effectively deal with the threats posed to their self-image by the conditions they experience (Barford et al., 2009). Although this concerns every type of comparative quantitative study, it is particularly relevant for intersectionality informed quantitative studies. This is because it implies that the intersectional locations of individuals are likely to interfere with the way individuals understand and assess their health in unexpected ways (i.e. emerging from the interplay between privilege and disadvantage). Hence, as with social categories, the operationalization of health is a challenging task for intersectionality informed comparative, quantitative health inequalities research and opens up a whole new field for investigation.

Further, regarding the operationalization of intersections, building on theoretical work on the integration of intersectionality in quantitative research and previous studies (Agenor et al., 2014; Evans et al., 2018; Spierings, 2012) I employed multi-level models and tested interaction terms. That way I was able to account for the multiplicative impact of the examined categories on self-rated health as well as for the extent that these categories and their intersections have a differential health impact across contexts. However, again due to the limited number of people located at certain intersections (e.g. second-generation migrant men not active in the labour market) I was not able to test further interactions between structural level factors and individual differences to account for the way that the impact of categories and their intersections differs not only across contexts but also across groups (i.e. whether the intersection between migration status and gender has the same impact for migrant women and migrant men) (Evans et al., 2018).

However, even with those limitations my findings reveal that second-generation migrants (i.e. people who have at least one foreign born parent) are more likely to report negative health outcomes than both first-generation migrants (i.e. people born outside their country of residence) and people with no-migration background; that first-generation migrants are likely to report better health outcomes than non-migrants only within the manual occupational sector, and that second generation migrant women with low socio-economic position are the most susceptible to negative health outcomes than all the other (gender X migration X generation status X occupational status) groups.

As discussed in chapter three, this thesis engaged with the question regarding the extent to which quantitative methods can be used in intersectionality informed health inequalities research. The conclusions emerging from the presented multilevel comparative case-study suggest that it is not the actual methods that make a study intersectional but rather how the methods are used (Bauer, 2014; Bowleg, 2013) and oppose arguments regarding the ostensible incompatibility of intersectionality with quantitative designs. In this thesis, I have adopted a social constructionist epistemological stance which has informed the quantitative case-study as well. From this perspective, quantitative methods were used to capture the material consequences of hierarchical processes operating in Europe and the resulting health inequalities in line with intersectionality literature (Anthias, 2013). In this process, I adopted a situated explorative approach, I reported explicitly on the inequalities that could be captured with the particular design and those that could not be captured due to data limitations, and the groups that were excluded from my study. Importantly, in this quantitative case-study, health inequalities were framed as the outcome of power imbalance and stratification mechanisms operating in Europe instead of a corollary of certain individual characteristics. Hence, I suggest that quantitative designs can be consistent with intersectionality's theoretical and analytical underpinnings up to a certain extent (Evans et al., 2018; Hancock, 2013), and quantitative health inequalities research can benefit when informed by intersectionality at least in three ways. First, by revealing relationships of health inequality that are traditionally neglected (e.g.

migration and gender related health inequalities among manual workers), second by accounting for the fact that inequalities emerge from the interplay between contextual and individual factors (e.g. with multilevel models) and third, by exploring the health of groups that are both marginalized and privileged (i.e. migrant men).

7.3.2 Qualitative design.

The conducted qualitative case study highlighted the relevance of institutional documents as a source of information regarding processes producing health inequalities in a specific context. The difference of my approach compared to previously conducted intersectionality informed policy analyses or case studies is the following. Instead of focusing a priori on a particular marginalized group (see for example Hankivsky et al., 2012) located at the intersection of multiple hierarchical axes (e.g. refugee women), or on the extent to which intersectionality is addressed within a specific institutional context (see Lombardo & Verloo, 2009), I employed a situated approach (Anthias, 2013; Yuval-Davis, 2015) and I expanded my scope in order to investigate which social categories are relevant for the emergence of health inequalities at the Greek borders as a context shaped at the intersection between border crossing, asylum policy and humanitarian aid. Then, I investigated what particular intersections between those emerging categories were associated with an increased health disadvantage for particular groups and individuals within the newcomers. My decision to follow this intersectional and explorative analytical strategy was based first, on the argument that intersectionality is a tool for the understanding of stratification and hence, it concerns everyone (Yuval-Davis, 2015), and second, on the argument that intersectionality cannot explain the mutual constitution of categories, if categories are not first interrogated separately as particular aspects of practice and discourse (Anthias, 2013). I considered that this strategy offers an effective way to counteract the often- made criticism that intersectionality cannot be empirically applied because the relevant categories for people's experience are endless (Ludwig, 2006).

This strategy revealed that gender, nationality, race, age, socio-economic position, sexuality and marital status were all relevant for the exposure of refugees to health risk, while their intersections rendered certain groups more vulnerable than others or certain risks more visible than others to the eyes of the system. Moreover, methodologically it showed that

employing an open-ended approach can reveal inequalities that otherwise remain invisible. For example, the particular vulnerability of young African men in the refugee camps, as described in chapter six, is a vulnerability that is more often than not disregarded within refugee health research (Turner, 2015; 2016). Similarly, the overall disempowerment of women and girls in refugee camps is often overlooked due to an increased emphasis on women's susceptibility to sexual and gender-based violence (Freedman, 2016b). Moreover, this open-ended approach allowed me to focus on processes rather than fixed categories or structures and this was particularly helpful in tracing inequality producing mechanisms within a complex context that was shaped by the simultaneous operation of local, national, and transnational factors that are not limited within the traditionally defined area of health and care (Beckfield, 2018). Moreover, it revealed how power operates in the interpersonal, disciplinary, structural and cultural domain reinforcing the disempowerment of certain groups and allowing the emergence of 'local' privilege. All these points demonstrate how a situated intersectional approach enables us to analyze qualitative data in a way that makes the invisible (relationships of health inequality, marginalization processes, particularly vulnerable individuals and groups) visible, and to identify hierarchical axes of privilege and disadvantage that emerge from the data without having been postulated or hypothesized a priori (as it happened with the emergence of age as a significant intersecting hierarchical category for refugees at the Greek borders).

However, If I try to classify my analytical strategy according to McCall's classification (2005), I find it rather challenging to decide whether it falls within the inter-categorical, the intra-categorical or the anti-categorical approach. As explained earlier, refugees and migrants at the Greek borders occupied for a shorter or longer period the geographic and symbolic margins of Europe. From this perspective, since my analysis focused on marginalized groups and individuals, it could be understood as an intra-categorical approach according to McCall. However, my analysis was based on the narrative of the humanitarian actors as described through the analyzed documents. This significantly limits the extent that refugees' own perspectives are integrated in my analysis, which is contrary to the intra-categorical approach. Further, interrogating which categories emerged in the specific context as relevant to health inequalities, their meanings, their conflations and their mutual constitution has highlighted how institutional arrangements and discursive strategies construct categories themselves. Further, my analysis highlighted in an explicit way how categories are co-constituted. For example, we saw how being single and man had a different meaning and implications than being single and woman within the context of the first reception procedure. Similarly, homosexuality was

addressed in the specific context only in relation to men. These findings appear to be in alignment with the anti-categorical approach that aims to deconstruct categories and to highlight their role in social exclusion (McCall, 2005). However, at the same time, categories were prominent in my analysis as well as in reporting my findings. My rationale was that the content, implications and experiences associated with certain social categories is fluid and subject to the context, however this does not refuse categories themselves (Anthias, 2013).

An additional methodological implication concerns the simultaneous operation of power at the four domains described by Collins and Bilge (2016). The qualitative analysis of humanitarian actors' documents allowed me to trace how the health of refugees and migrants was affected by processes that were not restricted in the interpersonal, disciplinary, structural or cultural domain but also how the convergence of such processes harmed particular groups more than others (i.e. black refugees and migrants compared to Syrians). Moreover, this allowed me to account for the double nature of analyzed documents as factual and discursive material (Prior, 2003) although this has been a challenging process. Being concerned with linking the observed health inequality producing processes with the power relations as operating at material and discursive levels, I struggled with keeping a balance between the two while conducting the analysis as well as with conveying in a clear way the level(s) I referred to while writing my results. However, these struggles are reflective of the complex ways that power operates and have urged me to remain engaged both with intersectionality as an analytical tool but also with the importance of relationality that rejects either/or binary perspectives and examines the interconnectedness of processes (Collins & Bilge, 2016).

This qualitative study has demonstrated effectively how intersectionality can be used as a situated analytical tool for the study of stratification mechanisms and their impact on health in contexts and within populations that are often excluded from mainstream health inequalities research, how it enables us as researchers to engage with complexity, be sensitive to what the context and the data can tell aside from our own presumptions, and importantly to frame our research within a health rights agenda and question and expose the structural mechanisms that produce health inequality and social injustice (Collins & Bilge, 2016).

7.4 Intersectional Health Inequalities in Europe: Migration as a Stratification Mechanism

This thesis has demonstrated how health inequalities in Europe are the outcome of intersecting stratification processes across gender, socio-economic, and migration categories.

Chapter five revealed that within a sample of settled first- and second-generation migrants with similar demographic characteristics with non-migrant populations, the 'healthy migrant effect' (Giannoni et al., 2016; La Parra Casado et al., 2017; Malmusi et al., 2010) according to which recently arrived migrants are generally healthier than non-migrants or second-generation migrants applies only among manual employees, while this advantage appears nuanced in the rest of the occupational categories and between men and women. Further, second-generation migrants, overall, report the highest prevalence of negative health outcomes. Additionally, the employed intersectional approach showed that health inequalities between second-generation migrants and the rest of the groups are wider for women with lower socioeconomic position.

Further, chapter six has revealed that refugees' reception in Greece as shaped at the intersection of border crossing, asylum policy and humanitarian aid produces health disadvantage for everyone who has to go through the process. However, there are qualitative differences among groups in terms of the specific pathways through which their health is affected. Considering the intersecting racial and heteropatriarchal hierarchies operating at the Greek borders, the chapter showed, that overall, single refugee and migrant men and unaccompanied teenage boys from Central or Northern African countries were dealing with increased exposure to health risk, violence and discrimination through multiple sectors of the first reception process. Additionally, women as a group were harmed across multiple sectors of the first reception procedure by the simultaneous impact of intersecting gender inequalities operating within their communities, within the context of the refugee camp, as well as within the implementation of the refugee response and the logics of the asylum policy. Among women, those coming from African countries were dealing with increased risk of SGBV, language barriers and discriminatory treatment. Moreover, the results demonstrate that the health disadvantage of some groups were more visible than those of others (e.g. men from African countries had a greater difficulty to have their vulnerabilities identified), while within the same groups certain forms of vulnerability were visible while others were not (e.g. women's susceptibility to SGBV or perinatal needs were emphasized compared for example to their psychological or mental health needs).

These findings suggest that migration should be further integrated in health inequalities research as a social determinant of health and a stratification mechanism. They add empirical evidence regarding simultaneously operating migration-related processes of exclusion (Viruell-Fuentes, 2007) that are in effect since the time that migrants and refugees cross the European borders, and which have a differential impact on men's and women's health but also

across socio-economic dimensions. According to the thesis' outcomes, the institutional factors shaping these processes should be traced to migration control and asylum policies, as well as to the domains of labor market integration, health care access, gender equality, and antidiscrimination law.

7.5 Strengths, Limitations, and Future Steps

In chapter four, I presented an intersectionality and institutionally informed analytical framework for the study of health inequalities and I suggested an updated research agenda. In this section, I reflect on the extent to which I managed to integrate this framework and the originally suggested action points in the studies presented in chapters five and six, and I offer some suggestions for future research building on the insights I got from the presented empirical case-studies. Starting with my research questions, I managed to address and examine inequalities between groups as those shaped at the intersection of multiple categories and particularly gender, socio-economic position and migration status. I revealed the situation of middle-groups that simultaneously experience privilege and disadvantage and I highlighted the gaps between multiply marginalized and multiply privileged groups. Further, I managed to focus on institutional dimensions particularly related to migration and border policies.

Categories, context, and units of analysis.

Through a context driven approach, I focused on categories related to the European context and embedded in social stratification processes. However, there was a crucial difference regarding the selection of examined categories between the two studies. In chapter five, I conducted my analysis with an a priori decided focus on certain categories and their intersections. This produced important findings in terms of multiple and nuanced relationships of health inequality. However, it did not allow additional potentially relevant categories of inequality to emerge. Further, the operationalizations I used and the interactions I tested were mainly data driven (i.e. according to available indicators and sample size). This means that the categories were used as fixed across time (i.e. 2004-2014) and between groups; that I was not able to account for potential conflating categories that may have been relevant (i.e. nationality or race); and that my operationalizations were not necessarily responding to an institutional categorization or to an individual experience of identity (McCall, 2005). Future research would

possibly benefit from testing multiple operationalizations and explore for potential variations in outcomes (e.g. different multiple operationalizations of migration status). This is likely to reveal hidden inequalities but also to provide evidence regarding which particular elements existing in different combinations associate with the same negative or positive results (Ragin, 2009).

In contrast, in the qualitative design the selection of categories and intersections were context driven through a process that it was not based on previously made assumptions, and this allowed for multiple categories to emerge as relevant to health inequalities producing processes in the specific context. This has demonstrated emphatically how the intersectional analysis of qualitative data can reveal hierarchical axes with significant health impact that were previously neglected or not considered relevant. Further, I was able to trace how categories' meaning was subject to changing power dynamics across time and the implications of those changes for refugees' and migrants' health as well as the conflating or 'subtle' categories in effect (i.e. nationality concealing race in the context of first reception). Importantly, I was able to interrogate the ways that categories were institutionally defined and operationalized within power dynamics. Finally, in both cases individuals in groups were approached as sharing similar positions within a power structure and they were exposed to the same institutional context. Both studies managed to reveal the ways that individuals within groups (e.g. women among migrants) were differentially affected, while the qualitative design revealed also how institutional rules assumed to be equal for everyone involved discriminatory practices against certain individuals and groups (Collins & Bilge, 2016). However, future research should also aim to integrate individuals' voices and explore the impact of categories as embodied identities (Weber & Parra-Medina, 2003).

Research designs and institutions.

Regarding quantitative methods, building on recently developed arguments (Evans et al., 2018), I have demonstrated how available statistical techniques can be used for an effective and theoretically robust intersectional analysis that is in line with a social constructionist rather than a positivist epistemological approach and which can be effective in documenting the material consequences of hierarchical processes on the health of individuals and groups. Multilevel models emerged as particularly relevant to this type of research (Scott & Siltanen, 2017) that can be further used for the study of institutional effects on health inequalities.

However, what emerged as a source of important limitations is the availability of appropriate data. Future research could benefit from the combination of datasets from multiple sources and quantitative researchers should urge for the integration of intersectionality as a rationale in surveys' design. Regarding the qualitative design, in chapter six, I have managed to show the richness and depth of information available in grey literature, which suggests that future research should integrate these types of documents as well as policy and institutional documentation as data sources in order to examine health inequalities producing mechanisms. Importantly, through this design it has been highlighted that qualitative methods are effective in capturing the complex ways that different institutional factors (e.g. Greek asylum policy, EU-Turkey agreement) operating simultaneously at different levels impact the health of individuals and groups (Beckfield et al., 2015).

Based on the methodological implications and challenges emerging from both designs, I claim that intersectionality benefits health inequalities research regardless of the particular research methods employed. However, the choice of the design should be based on whether we are interested in measuring health inequality or in documenting inequality producing processes and mechanisms. From this perspective, quantitative and qualitative designs can and should inform each other while the emerging research agenda includes questions regarding health inequalities between and within groups; the simultaneous impact of horizontal and vertical processes of stratification; the thread that connects institutional factors with individuals' health; as well as institutions and policies that exceed health care and social policy and particularly migration, border crossing and asylum policies.

7.6 Conclusion

This thesis has reframed health inequalities in Europe in the light of power relations and has been concerned with the structural factors and processes that produce them rather than individual 'labels.' It has managed to explain and document the co-constituting role of socioeconomic position, gender, and migration. Moreover, it has shed new light on the importance of migration as a stratification mechanism and social determinant of health, to reveal the health impact of migration and asylum policies, and to highlight the importance of race as relevant for health inequalities in Europe. By employing a quantitative and a qualitative analysis, it has highlighted the significance of intersectionality as an analytical framework for health inequalities and has produced important arguments regarding its theoretical and methodological implications. What emerges as an overall conclusion is that engaging with intersectionality's complexity rewards us with a deeper understanding of health inequalities in their own complexity as a social problem. It forces us to move away from reductionist perspectives, to push our limits across the whole research process and to set health equity and social justice at the core of our work. It reminds us of our role as political actors and power agents and our ability and duty to transform research into an inclusive process with increased societal relevance.

Appendix A: List of Analysed Documents

- ARSIS, (2018 May 31). Υπηρεσίες προστασίας θυμάτων σεξουαλικής και έμφυλης βίας στη Δομή Φιλοξενίας στη Νέα Καβάλα (Protection services for victims of sexual and gender based violence in the shelter in Nea Kavala). Retrieved from http://www.arsis.gr/ypiresiesprostasias-thymaton-sexoualikis-ke-emfylis-vias-sti-domi-filoxenias-sti-nea-kavala/
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Abbreviations

IBPA: Intersectionality Based Policy Analysis IFRC: International Federation of Red Cross and Red Crescent Societies ISRAaid: The Israel Forum for International Humanitarian Aid DOW: Doctors of the World DWB: Doctors without Borders EU: European Union NATO: North Atlantic Treaty Organisation R.I.C.: Reception and Identification Centre R.I.S. Reception and Identification Service SGBV: Sexual and Gender-Based Violence SRH: Sexual and Reproductive Health UNHCR: United Nations High Commissioner for Refugees WAHA: Women and Health Alliance International

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