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COVID-19 Crisis as the New-State-of-the-Art in the Crimmigration Milieu

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Abstract: The concept of crimmigration connotes the currently prevailing approach between the different fields of penal, administrative and migration laws. It seems that, progressively, there is an amalgamation of penal law practices with those of civil and administrative law processes in a way creating confusion as to the boundaries of each law discipline and rational. In addition, the protection of public health from COVID-19 interrelates with the above three fields of law while at the same time the measures undertaken for the confrontation of the pandemic are further strengthening the social controls already imposed towards the migrant-refugee populations. Based on the Greek experience, we are particularly interested in mixed migration flows' status of a 'prolonged reception'. We have decided to examine the cases of the 'asylum-seeker' population and the 'undocumented' population who, to a large extent, constitute a large *unseen* category for the national vaccine program implemented to combat the COVID-19 hygiene crisis. The basic idea supported by our present study is that the health field is used as an additive component to crimmigration as it helps the establishment of a concrete screening intensifying the already imposed migration controls. In addition, the official social controls imposed to combat the COVD-19 health crisis contribute to crimmigration through the intensification of the dangerization of mixed migration flows. Currently, the health field, affected by COVID-19, contributes to the intensification of the crimmigration regime and at the same time to a dangerous cul-de-sac.

Keywords: crimmigration; migrants/refugees; COVID-19; vaccination; Greece

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1. Introduction

The COVID-19 pandemic caused great loss of human life as well as social and economic disruption in Europe and the World. Strict measures have been imposed internationally in order to avoid the spread of the disease and protect public health. The most widespread emergency measures worldwide have been the restrictions on movement (quarantine and lockdown projects), promoting 'social distancing', intense testing, personal hygiene as well as hygiene protection measures and, eventually, a vast vaccination program implemented from 27 December 2020 onwards globally (Escritt 2020).

Marginalized migrant populations living in extremely precarious conditions were prone to be disproportionately affected by the spread of the disease compared to those living in well-arranged environments and being in a position to afford necessary precautions for their health protection. In this regard, our present study examines the Greek public policies implemented to protect asylum-seekers and undocumented migrants against the COVID-19 pandemic, as well as the extent to which they have reached their scope in an efficient and timely manner. The basic hypothesis examined is that said policies helped the amalgamation of penal, administrative and migration law processes facilitating crimmigration rather than alleviate the migration-refugee experience. Our paper supports the idea that public health processes in the era of the COVID-19 pandemic are contributing to

the 'dangerization' (Nikolopoulos 2012) of mixed migration populations and have helped the intensification of official controls against them. Given the high visibility of the deviant behavior of migrant perpetrators (Tsiganou et al. 2010), the immigration controls are (re)structured also by means of public health protection processes. Thus, a new field of a manifested and disguised crimmigration emerges.

The literature review reveals that the concept of crimmigration is used to connote the dynamic interplay between the different fields of penal, administrative and migration laws. In some cases, the concept is used to refer to the criminalization of immigration law, or "crimmigration law", (Stumpf 2006) in order to denote the convergence of immigration and criminal law (Stumpf 2006; Guia et al. 2011; Aas and Bosworth 2013; Salamon 2017). In other cases, the concept of crimmigration has been connected broadly with issues such as criminalizatisation (Salamon 2020), border control (Broeders and Hampshire 2013), securitization (Gerard and Pickering 2013), detention (Bourdeau 2019), deportation (Menjivar et al. 2018), exclusion (Rottem 2021) and sovereign bias (Koulish 2016). There are also theoretical and research approaches which witness the infiltration of the crimmigration process within the public health field (Websdale 2020) or have shown "*how COVID-19 has forced new understandings on crimmigration law and politics*" (Koulish 2021). However, public health management in times of pandemics or hygiene crises in conjunction with crimmigration practices needs to be further explored in order to comprehend the dynamic interplay between public health controls and crimmigration processes.

Our study is based on documentary evidence provided through the examination of official documents and news media texts. As already stated, one of our main concerns was to examine whether and to what extent official health policies, even in the emergency occurrence of a pandemic, constitute an additive part of crimmigration. In our undertaking, we have tried to decipher aspects of crimmigration clearly stated, disguised or even hidden throughout our research material, which has been collected through archival research of official documents such as governmental papers, laws and regulations texts, decrees and ministerial decisions, as well as media commentaries and news texts. The research material covers the period from 1 January 2020 to 30 May 2021 when the restrictive measures combating the coronavirus pandemic had been temporarily waved or relaxed.

Our evidence also suggests the reinforcement of the crimmigrant identity through the official management of the health field. As it will be shown, the Greek case bears witness that migrant and refugee populations remain, to a large extent, abandoned without being prioritized in the measures provided to combat the coronavirus pandemic (i.e., hygiene precautions, testing and vaccination). Based on our research material we also argue that such a confrontation has accelerated new forms of mixed migration flows management and control, given the asylum seekers' and undocumented migrants' already existing exclusion from institutional health care. This way, their already established identity as "criminalized subjects"—who do not 'deserve' prioritization in public health care—is reinforced by the state management of the present pandemic inside open/closed 'facilities'.

In the crimmigration context, third-country nationals, as non-citizens, are seen as being always to be blamed and criminalized, their dangerized identity based on the mere fact of their migrant and/or refugee status and the stigma attached to it. Moreover, migrants' and refugees' presence in the 'host' country is perceived as a severe social threat and even as a menace to a society remaining intact before their advent (Salamon 2017). Under the conditions of the present pandemic and the hygiene crisis it has created, migrants and refugees, as non-citizens, are classified not only as (potential) criminals but also as a threat to public health. This way, new negative characteristics are added to their already stigmatized identity so that these populations of non-citizens are confronted and managed not only by means of walls, borders, rules, 'public condemnation' (Stumpf 2006) and 'social closures' (Tsiganou et al. 2010) but also by means of exclusion from assets destined to protect primarily the host country's nationals. Migrants and refugees, as non-citizens, remain excluded once more from access to basic goods—either public or common. As the Greek case testifies, hygiene crises may create new grounds for deepening already existing exclusionary processes.

As the Greek case testifies, under the coronavirus pandemic, migrants and refugees, as non-citizens, remained systematically absent from any prioritization campaign and urgent policy measures to combat the crisis. They have remained, of course, 'quarantined' and systematically untested at their dystopian camps in extreme 'caging' measures for a longer period compared to the native population. It is to be noted that in the official rhetoric, they were represented as being disproportionally not affected by the COVID-19 virus, a justification most handy for the absence of any relevant public care policy. As a result, migrants and refugees, as non-citizens, remained unvaccinated almost half a year after the Greek vaccination plan had been implemented.

Our study concludes by providing a discussion on health discrimination against migrants and refugees, as non-citizens, in a way that creates health and, therefore, societal borders which unavoidably lead to a regime of health 'apartheid' via a vaccination institutional racism that adds new dynamic connotations to 'crimmigrated' identities and the crimmigration conceptualization overall.

2. Methodology

In terms of methodology, we have based the research on to the Critical Frame Analysis originally produced in qualitative research on gender equality policies, having adapted it to our qualitative archival and documentary research of legal documents, administrative decrees, policy texts and media commentaries on immigration. As noted, in the Critical Frame Analysis, "*the concept of frames and framing is presented as a basic concept for the analysis, starting with defining a frame as an interpretation scheme that structures the meaning of reality, and a policy frame as an organizing principle that transforms fragmentary or incidental information into a structured and meaningful policy problem, in which a solution is implicitly or explicitly enclosed. Policy framing then can be seen as the process of constructing, adapting and negotiating policy frames*" (Verloo and Maloutas 2005, p. 2). The Critical Frame Analysis we have followed combines elements from policy theory, discourse analysis and immigration/crimmigration theory. As noted, "*unlike other approaches, frame analysis starts from the assumption of multiple interpretations in policy making, and addresses problems of dominance and exclusion connected to policy making. Implementation of policies is seen as a political process, subject to all mechanisms of political processes. Under conditions of multilevel governance, implementation is a complex process of transfer and translation: unitary concepts or frames, as presented in political decisions and policies at (sub) national and supranational levels contrast with a dynamic reality of multiple frames at national levels. This contrast between an assumed stable unity and a real dynamic diversity is seen as a «black box» of distortions in the implementation of policies. The shifts that occur during implementation often coincide with exclusion processes*" (Verloo 2005, p. 8).

We have thought Critical Frame Analysis as a suitable tool since it enables certain of our research questions to be answered such as the detection of similarities, differences and inconsistencies in the way immigration is perceived or understood as a problem in national and European levels, especially under the urgency of the COVID-19 pandemic circumstances. How are patterns at the national level connected to existing and developing frames at the European Union level? Which processes of exclusion result from dominant frames? What are the consequences of possible inconsistencies detected? We also considered most suitable to our analytic purposes the concepts of policy frames and framing dimensions, since within the Critical Frame Analysis, "*a policy frame is further specified as a specific configuration of positions on the dimensions of diagnosis and prognosis of the policy problem, roles attributed in diagnosis and prognosis and voice given . . . Because not only discursive elements but also attributed roles and voice have an important place in this framework, the approach is labelled Critical Frame Analysis*" (Verloo 2005, p. 20). Whilst we agree with the critique that discourse analysis in general and frame analysis present certain problems for comparisons, especially on how to develop categories that can analyze discourses at various levels that allow for comparison (Van Gorp 2001), and that frame mapping (Riechert 1996) offers no viable alternative as based on frequency and co-occurrence of key terms in text, we felt convinced by the merits of the Critical Frame Analysis, despite the fact that frame analysis

needs further methodological development, especially by studying framing in connection to legitimacy and domination (Verloo 2005, p. 20).

Within the Critical Frame Analysis, a policy frame is considered as "an organising principle that transforms fragmentary or incidental information into a structured and meaningful policy problem, in which a solution is implicitly or explicitly enclosed. Hence, policy frames are not descriptions of reality but specific constructions that give meaning to reality and shape the understanding of reality. Research working with these or similar concepts is based on a constructionist approach to reality, where discourse, through its close connection to the construction of truths is seen as having important material and immaterial impacts. In implementation processes, policy frames are the medium, transferred and necessarily adapted from one level to another, from one area to another. Frame analysis is concerned with the (re)construction and negotiation of reality by social/political actors through the use of symbolic tools (Triandafyllidou and Fotiou 1998)—as cited in the original. Framing, then, can be seen as the process of constructing, adapting and negotiating frames (Verloo 2005, p. 20).

Thus, the methodology of the Critical Frame Analysis helps to overcome the above-mentioned problems by analyzing the dimensions of frames rather than constructing a hierarchical set of codes or typologies of frames. These dimensions allow for a comparable description of various positions. Yet, categorizing beforehand can follow a grounded theory approach (Strauss and Corbin 1997). In addition, Critical Frame Analysis helps to "*track the inner (explicit or implicit) logic of processes of policy frames as a crucial element of exclusion and track the discursive histories that are present in the public discourse, within political institutions (like parliamentary debates and documents), civil society (NGOs) and the media. In order to put the accent on power relations involved in policy texts, Critical Frame Analysis therefore will also have to pay specific attention to the role of various actors in framing processes. More specifically, attention for who has voice in defining the problem and who has voice in suggesting suitable courses of action to resolve the problem, is needed, as well as specific focus on the attribution of responsibilities (for causing the problem or for solving the problem)*" (Verloo 2005, p. 22).

Without wishing to duplicate theories and methods, we are following Critical Frame Analysis in that we are framing crimmigration as a policy problem that is a policy frame which has a typical format connected to politics and policy making. We also start according to the critical frame approach from the general assumption that a policy (proposal) will always contain an implicit or explicit representation of a diagnosis of a situation, a phenomenon or a problem, connected to an implicit or explicit prognosis of what is coming and a call for action. In other words, the analysis is based on the assumption that there is a problem, that some solution to this problem is proposed (including ideas on the causes of or responsibilities for the problem, on the ends that can be reached through the use of certain means and on the desirability of certain outcomes) and that it is made clear who has to do something and what has to be done. The key sensitizing questions used to energize the texts are quite similar to the template proposed in the article of Verloo (2005), so there is no need to duplicate its code and categories scheme here. Suffice is to say that the basic structure consists of the dimensions of Diagnosis, Attribution of Responsibility (renamed Roles in Diagnosis), Prognosis and Call for Action (renamed Roles in Prognosis). The dimension of Voice has been also added in our analysis, since policy frames do not always originate in specific actors but also may commence in institutions (administrations, cabinets, committees, etc.) in our case as well. So, on the one hand, theoretical notions from discourse analysis may be used while, on the other, analysis may be facilitated in terms of exclusion/inclusion and power. At a more detailed level, based on discourse analysis, we have also used the sub-element of the Form (form of argumentation, dichotomies, metaphors) within the dimensions of Diagnosis and Prognosis. In addition, the analysis includes within the dimensions of Diagnosis and Prognosis, Carol Bacchi's critique on policy theory, especially her "what's the problem represented to be?" approach (Bacchi 1999). Furthermore, based on Giddens' structuration theory (Giddens 1984), the Critical Frame Analysis is suitable for placing emphasis on the distribution of and access to

various resources, next to the rules (interpretations and norms) connected to migration or refugee issues. Thus, normativity maybe separately accessed and highlighted as well as the impact assessment of policies.

3. The Healthcare Aspects of Crimmigration

The COVID-19 pandemic and the measures undertaken to confront it have a tremendous, but to a large extent, differentiated impact on both societies and individuals at a global level, which was dependent on the socioeconomic status of each society and the specific population group. Especially, the identity characteristics of population groups are proven to be crucial towards the protection of the individual members against the pandemic. These characteristics are mainly interrelated with citizenship status and membership. From the beginning of the pandemic, migrants and refugees residing in open/closed facilities became—once more—unseen as the focus of the dominant narrative was the declared and/or implemented policies for the citizen population, contrary to the Commissioner Johannson statement during the Committee on Civil Liberties, Justice and Home Affairs meeting on 2 April. As she has stressed, "*refugee camps, in countries of first asylum, are severely ill-equipped to support a large number of persons who already live in precarious conditions. The spreading of the virus in such contexts may result in a massive humanitarian crisis [. . .] To fight xenophobia, discrimination and racism, and to help vulnerable migrants, I will also make the consultation with civil society, employers, trade unions and other relevant organizations to develop options to protect and support migrants and refugees*" (Johansson 2020).

In Greece, living conditions in open/closed facilities are harsh and inadequate (AIDA-ECRE 2021). In particular, "*social distancing is impossible when 1200 people share a single tap*". During the first months of 2020, "*over 40,000 refugees are [currently] being detained in five hotspot facilities on Lesvos, Chios, Samos, Leros and Kos*" (Bilgin and Fyssa 2020). Alarming analyses of media stated that evacuated measures for the camps must have taken place and that people living in them were very concerned (Medecins sans Frontieres 2020; Papanicolaou 2020). In addition, the camp at Moria, which was built for 2757 in 2020, accommodated 18,985 persons, which is 6.8 times over its capacity, without taking into account that the majority of refugees are living in olive groves adjacent to the camp in self-made shelters and tents. (Bilgin and Fyssa 2020). Greek Authorities implemented specific measures to the said facilities (Greek Ministry of Migration and Asylum 2020; Mitarakis 2020), but most of them are "*cosmetic in nature*" because they ignore the real existing conditions that can exacerbate the transmission of the disease as the "*general hygienic rules*" were de facto impossible to be followed by the population living therein (Bilgin and Fyssa 2020). This was much more so especially in view of the tangible reality of the "*prolonged reception*" that created a limbo situation for the host migrant-refugee populations and persistently deteriorating living conditions in camps and hotspots (Tsiganou et al. 2020). Furthermore, the social control of migrants has been intensified through a new legislative Act which foresees that the administrative detention can reach up to 36 months (Law 4636/2019). The Act also provides the State can replace the open facilities in force with closed reception and identification centers and create new pre-departure detention establishments (Law 4686/2020). In addition, according to a new controversial but still pending Legislative Order, areas suitable for the establishment of 'closed' detention centers may be requisitioned for reasons of public interest, in order to address the extremely urgent need to avoid endangering public order and public health (Legislative Act, Government Gazette A'28/10.02.2020).

In terms of access to healthcare, in July 2019, the criteria for third-country nationals and European citizens to receive Social Security Number (AMKA) became extremely strict in Greece. It is to be noted that AMKA is necessary for contacting the Greek Administration in the most important occasions as a result, until the advent of COVID-19 in 2020, a large part of the migrant and refugee populations in Greece has ceased to have unimpeded access to public health facilities, following the decision to abolish the AMKA for foreign nationals[1]. Among those who did not have access throughout the reporting period were children and unaccompanied minors (Amnesty International 2019), in violation of the

general principles of the World Health Organization, the International Convention on the Rights of the Child and the European Directive 2013/33/EU. During this same period, there was no transitional legal provision until the Joint Ministerial Decision 717/2020 (Government Gazette B 199/31.01.2020) which was issued in the advent of the pandemic and foresees the Temporary Insurance and Health Care Number (PAYPA), which ensures the temporary access of the asylum seekers to the health care system and their potential access to the labor market, six months after their asylum application is submitted. In fact, PAYPA came into force in April 2020, that is almost nine months after the ban of asylum seekers from the healthcare system and four months after the pandemic seized the country and the world (Aggelidis 2020). PAYPA is assigned at the local Asylum Offices/Units, where the relevant application is to be registered. The rejection of the asylum application implies the automatic deactivation of PAYPA, while, on the contrary, in case of acceptance of the application, its AMKA is foreseen. Thus, the populations in question need to have their Special Security Number updated every time their status changes (applicant, claimant, beneficiary) in order to have access to health services. Any obstruction or delay cancels the said access. In addition, in case of a negative decision, their access to health services is nullified.

In any case, the above new legal arrangements make the migrant and refugee populations subject to a regime of constant control, intensified through health provisions since they are being permanently put under Damocles' sword for one of the basic human rights, that of access to health. Additionally, in violation of the principle of non-discrimination, the new conditions arising from the measures implemented to combat COVID-19 pandemic have unjustifiably extended the quarantine measures for the hosted migrant and refugee populations and, therefore, their perpetual exclusion. To mention an example, while the first 'quarantine' period (initial lockdown during March–April 2020) ended for the entire population in Greece, it continued exceptionally only for the migrant-refugee populations 'hosted' in camps, without, however, the measure to be officially justified as based to any 'epidemiological situation' within the camps/reception structures (Fouskas 2020)[2].

4. Vaccine Institutional Racism

In the context of the European Union, the coordination of the European Commission and EU Agencies have supported the development of COVID-19 vaccines to be available promptly to the EU territory (European Commission 2020a). Most Member States launched their national vaccination campaigns in December 2020, and because of the limited supply of vaccines, they identified key priorities in forming their vaccination strategies. Most of the member states pursued the following criteria for prioritizing certain parts of the population (FRA 2021):

- Older people, especially those living in long-term care facilities;
- People with underlying medical conditions who are more likely to develop a severe form of the disease or die if they contract COVID-19;
- Frontline health workers and staff of long-term care facilities.

On the other hand, the Worl Health Organization's (WHO) Strategic Advisory Group of Experts identified low-income migrant workers, irregular migrants, refugees, asylum seekers and those unable to physically distance, including those living in camps and camp-like settings, as priority groups for the allocation of COVID-19 vaccination globally, specifically listing migrants and refugees as groups to be prioritized in stages II and III of the vaccine rollout[3]. In conjunction with the above, medical communities and the relevant literature state that "*globally, refugees and displaced persons must be prioritized to receive vaccines*" (Thomas et al. 2021) and "*that medical institutions need to implement policies that will support and protect refugees, asylum seekers, and displaced persons and reduce any network of transmission*" (Saifee et al. 2021). There is, accordingly, strong international guidance about the prioritization of the migrant-refugee populations to receive vaccination for the sake of the protection of the individuals but also of public health. In other words, there

was a global recognition of the precariousness of the said populations and the necessity to be protected receiving priority status.

The explicit rationale of the prioritization of the precarious migrant-refugee populations, as already stated, was not broadly implemented by the EU vaccination plans. Whilst, in 2020, the number of migrants in the EU/EEA (ECDC 2021) (defined as people born in a different country than the one they reside) made up 12% of the total population (453 million people) with the 4% being born in another EU/EEA country or the UK and the other 8% originating from outside the EU/EEA and the UK, more than 3 million refugees and asylum-seekers were registered in 2018, plus fo4ur million undocumented migrants; these groups remained mainly *invisible* for any national vaccine prioritization plan. Especially, concerning persons without legal status or with insecure legal status in the EU only 5 out of 27 Member States have prioritized them in their national vaccination strategies[4]. In addition, key figures about vaccination in the EU, as derived from the European Centre for Disease Prevention and Control (ECDC 2021), do not include any reference to the vaccination of the migrants/refugees populations though other target groups such as residents of long-term care facilities are explicitly mentioned.

Given the initial shortage of vaccines, the criteria for defining who is eligible to receive prioritized vaccination varied among the Member-States' vaccination program as Member States did not take into account the vulnerabilities and the risky living conditions of the precarious populations. Overall, Member States have focused on prioritizing vaccination for older citizens who are disproportionally affected by the COVID-19 virus. However, the age factor, along with the prioritization of other group characteristics, namely, health workers, was not the only variable lying beneath the prioritization scheme. Other 'ghost' factors were to a large extent lurking and set barriers to access to 'healthcare for all', notwithstanding Goal 3 and especially Goal 3.8 of the Sustainable Development Goals of the UN[5] and Article 35 of the Charter of Fundamental Rights of the European Union, which states that health should be ensured without any discrimination[6]. Instead, in the case of the current health crisis, the rollout of vaccination to combat the pandemic has revealed that State-run vaccination plans have been discriminatorily implemented on the basis of the legal status of a person and, particularly, citizenship rights.

According to the latest international research report by the WHO, which seeks to identify how the new coronavirus SARS-CoV-2 (COVID-19) has impacted refugees and migrants around the world, based on their own reported experiences, the following is noted (World Health Organization 2020a):

- Lack of financial means, fear of deportation, lack of availability of healthcare providers or uncertain entitlement to health care were the reasons cited most often for not seeking medical care in case of (suspected) COVID-19 infection.
- Though most refugees and migrants took precautions to minimize the risk of their housing situations, mainly insecure or in crowded camps, the necessity to commute by using public transportation increased the risk of becoming infected.
- Feelings of depression, anxiety and loneliness and increased worries were mainly reported.
- Experiences of perceived discrimination were also reported along with relatively worsening discrimination, especially for those being unemployed.
- Their status concerning work, safety, and financial means have deteriorated.

With respect to the above, the European and Member States' vaccination strategies reveal important deficiencies considering the relevant treatment of migrant and refugee populations, even though the International and Regional Bodies have made a statement for the necessity of inclusive approaches in Member States' health systems (Weekers 2020; ECDC 2020a, 2020b). In addition, European Commission has clearly defined that vulnerable socioeconomic groups and other groups at higher risk, along with groups without physical distance in place, can be defined as priority groups concerning vaccination Member States plans (European Commission 2020b). In addition, the UNHCR (2021a) states that "*by including refugees in their vaccine distribution, they mitigate the risks associated with exclusion*

and discrimination. In particular, risk factors for increased exposure to COVID-19 are interrelated with occupational risk (over-representing in public-facing jobs including health and social care, transport, low-skilled jobs, precarious jobs, obliged to work throughout the pandemic, increased use of public transport), overcrowded accommodation (live in poverty and deprived areas, in camps, reception and detention centers, in shared or temporary accommodation, in multigenerational households) and barriers to public health messaging (lack of knowledge of the host country language, vulnerable to misperceptions and misunderstandings) (ECDC 2021). The current hygiene crisis due to the COVID pandemic has shown more clearly than ever that many works in situations of high risk are too often undervalued, i.e., in care facilities, cleaning and agriculture (PICUM n.d.). Even in the period of the highly infectious delta variant, the major vaccination gap for undocumented migrants and refugees is still present[7].

Consequently, the lack of the prioritization or total exclusion of the marginalized migrant-refugee populations from vaccination underlines a State's unwillingness to address an urgent and unprecedented health issue beyond the notion of State sovereignty and indicates the deportation/expulsion of populations management (see Figures 1 and 2). This exclusionary and segregating policy rationale is an endemic part of the crimmigration regime that is currently manifested through a vaccination institutional racism (Stokely et al. 1967) and expresses the unequal distribution of the vaccines between groups because of 'otherness' and lack of citizenship rights.

Figure 1. Source: The COVID-19 vaccines and undocumented migrants: What are European countries doing? PICUM (Available online: https://picum.org/covid-19-undocumented-migrants-europe/ (accessed on 1 August 2021).

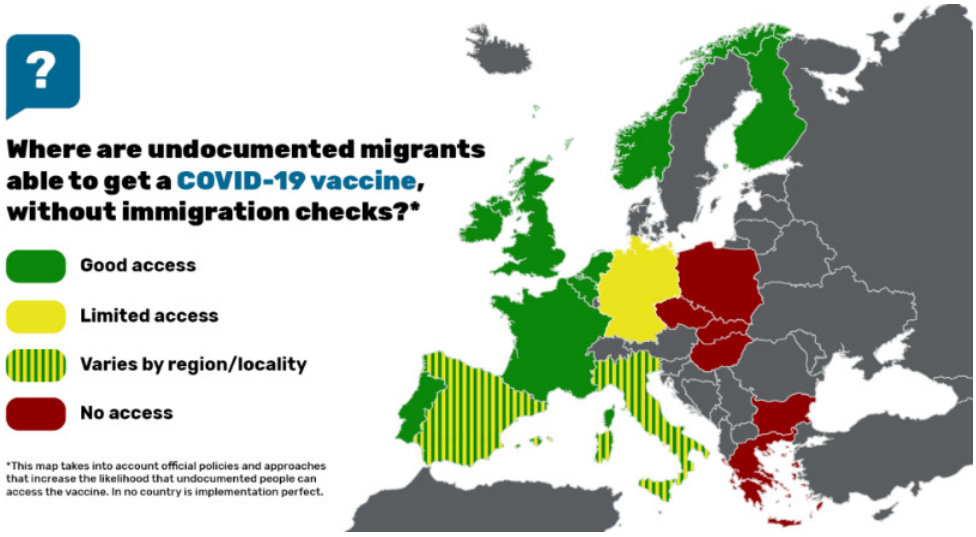

Figure 2. Source: The COVID-19 vaccines and undocumented migrants: What are European countries doing? PICUM (Available online: https://picum.org/covid-19-undocumented-migrants-europe/ (accessed on 15 July 2021)

The Greek Vaccination Plan

The Greek Vaccination Pan, named "Freedom" (Eleftheria) (Greek Government 2021), was launched in December 2020 and initially put in implementation in January 2021. The national booking system operates through a specific website[8] and a mobile application. To register, one needs AMKA and a VAT number (AFM). The site is available in Greek and English and refers only and explicitly to the population group of "citizens". Information in other languages than Greek and English is only provided by the webpage of the UNHCR (2021b).

The Greek vaccination plan consists of three phases with specific identification of the eligible social categories:

1st phase:

- Health and social services workers;
- Residents and staff of nursing homes;
- Residents, patients and staff of care structures for the chronically ill and rehabilitation centers;

2nd phase:

- People 70 years and older (regardless of medical history). Further prioritization:
- People aged 85 and over;
- People aged 80 and over;
- People aged 75 and over;
- People aged 70 and over;
- Patients with diseases that pose a very high risk of COVID-19 disease regardless of age;
- Priority staff for critical functions of the State;
- People 60 to 69 years old (regardless of medical history);
- Patients aged 18 to 59 years with diseases that pose a high risk for disease with COVID-19;
- Priority staff for critical Government functions;

3rd phase:

- People 18 years and older without underlying diseases.

According to the Greek Vaccination Plan, and as also revealed by the FRA (2021) report, in Greece persons without legal status or with insecure legal status did not constitute a

priority group for vaccination in the national vaccination strategy. Additionally, in the same FRA report, it is mentioned that migrants and refugees living in 'hotspots' on the Greek islands have not been prioritized for vaccination. Indeed, only six months after the launch of the National Vaccination Plan in Greece, refugees and asylum-seekers living in camps and reception centers started to receive vaccination. Analytically, for the first months of the vaccination plan, only the AMKA holders could be vaccinated. However, the dysfunctional AMKA delivery system blocked access to vaccines and self-tests for tens of thousands of migrants and refugees. In March 2021, Law 4782/2021 provided for the supporting documents and the steps the person without AMKA or PAYPA should follow in order to apply for a temporary AMKA, called PAMKA. The application for PAMKA started to operate in June 2021. It is evident, therefore, that the addition of PAMKA to the state vaccination plan has been invented and implemented only when it was realized that the vaccination rate of Greek citizens was lower than initially anticipated and, therefore, vaccine redundancy was sufficient to cover those previously and mostly excluded (Emmanouilidou 2021). We may detect to this auxiliary vaccination policy the recruitment of an exploitation plan of migrant and refugee populations in order for the much desired 'immunity wall' to be built nationwide.

In practice, the issue of PAMKA requires that a person should have, in addition to the passport, some other identification documents double-crossed by registers kept at public sector bodies. Should the application which a migrant-refugee person has submitted be accepted, s/he receives PAMKA and then s/he could ask for a vaccination appointment. PAMKA is serving solely for arranging a vaccination appointment and the issuance of a vaccination certificate and it does not provide for any other access to the healthcare system for migrant-refugee populations. In May 2021, the Joint Ministerial Decision 2981/2021 (Government Gazette B'2197/26.05.2021) defined more specific categories of beneficiaries of PAMKA issuance, i.e., asylum seekers and unaccompanied minors without PAYPA as well as detained third-country nationals. Receiving access to vaccination becomes, as a result, a very complicated procedure that does not ensure the issue at stake, namely, the creation of an immunity wall and, ultimately, the defense of public health. Thousands of people without legal status are automatically excluded from the vaccination process. This, in turn, implies a direct negative impact on the course of the pandemic. Although there are places with a large concentration of land workers (i.e., the case of Manolada (Generation 2.0 2019)), or cases of places where thousands of undocumented migrants/refugees are living and working, they are not eligible for vaccination even under the conditions of the said current plan (Generation 2.0 2021). Therefore, those without AMKA, PAYPA, PAMKA, or any document from the Greek Authorities do not have access to vaccination. In other words, an administrative issue such as the acquisition of a permanent or a temporary Social Security Number constitutes the insurmountable obstacle to vaccination that excludes migrants/refugees from a core measure of protection against the coronavirus pandemic.

In addition, irrespectively from access to any kind of Social Security Number, migrant/refugees populations kept in camps have remained and still remain unvaccinated. Greek Authorities have justified their non-prioritization by stating that camps do not address "coronavirus morbidity or spread", so staff and residents will be vaccinated "in turn, according to their age cohort according to the regulations applied for the general population"[9]. However, the analysis derived from the public surveillance data indicates that "*compared to the general population the risk of COVID-19 infection among refugees and asylum seekers in reception facilities was 2.5 to 3 times higher (p-value < 0.001). The risk of acquiring COVID-19 infection was higher among refugee and asylum seeker populations in RSs on the Greek mainland (IP ratio: 2.45; 95% CI: 2.25_2.68) but higher still among refugee and asylum seeker populations in RICs in the Greek islands and the land border with Turkey (IP ratio: 2.86; 95% CI: 2.64_3.10), where living conditions are particularly poor. We identified high levels of COVID-19 transmission among refugees and asylum seekers in reception facilities in Greece. The risk of COVID-19 infection among these enclosed population groups has been significantly higher than the general population of Greece, and risk increases as living conditions deteriorate*"

(Kondilis et al. 2021). On the other hand, the official rhetoric avoids the issue of why the first lockdown in Greece (March–May 2020) ended a couple of months later for the migrant/refugee populations residing in camps (Fouskas 2020). By taking into account these controversial accounts, it seems that new exclusionary tactics against the migrant/refugee populations are at stake. In fact, as the Greek case also testifies, institutional policies have not only left out marginalized third-country nationals from the national vaccination plan, in practice, but they have also imposed harsher mobility restrictions against them, highlighting pre-existing inequalities and politics of exclusion, as it is the case elsewhere (Brown 2020; Evershed 2020).

From June 2021 onwards, Greece announced that the National Public Health Organization (EODY) will vaccinate residents in 34 reception centers, 6 Reception and Identification Centers and 8 pre-removal centers (EASO 2021). The vaccines made available in the camps were only selected according to the availability of the three officially approved vaccine brands[10]. However, contrary to the opportunities and choices offered to the Greek citizens, people from third countries who live in precarious conditions are not in a position to decide upon the vaccine brand they wish. In addition, the local authorities of the Lesvos Island have mentioned that "*as the vaccines cannot be left out of the refrigerator for a long time, the vaccinations will be given to a certain number of people, only by appointment and always inside the KYT (the Reception Centre) so as not to burden the vaccination lines of the local community*"[11]. In July 2021, there were no official data for the vaccination progress of those residing in official State camps, but it is estimated that less than 1000 persons have been vaccinated in 3 reception and identification centers at the island's hotspots and 3 host facilities on the mainland[12]. This is not surprising, as the vaccination plan for the camps provides for availability only twice a week[13], and those who have received a second-degree asylum rejection decision are excluded from vaccination (Aggelidis 2021). What is most striking is the highly symbolic gesture of the Greek Authorities that the unused vaccines are to be administered to prisoners and migrant-refugee populations who live in closed facilities (Gakis 2021).

All the above depict not only aspects of discrimination and exclusion but also aspects of migrant and refugee populations' degrading legal status and health conditions. Such procedures reinforce the pre-existing stigma attached to the above populations as if they possess a lower social status. This stigma further affects the already existing and evidenced negative attitudes towards migrants/refugees (Dixon et al. 2019)[14]. Thus, a contradicting social situation emerges which is signifying a *paradox*. On the one hand, those who are perceived as a danger to public health are eligible only to 'leftovers', that is, without sufficient health protection, while, on the other, they are perceived as a danger to public health due to the insufficient protection they receive. This *paradox* serves the perpetuation of the vicious cycle of migrants/refugees' stigmatization, a cycle reinforced by perceptions emanating from the public health field which operates as an additive component to crimmigration. Thus, administrative procedures establish a concrete negative screening and a practice of official controls which disproportionately affect migrant populations and intensify the trajectories of crimmigration. Currently, the health field affected by COVID-19 contributes to the advancement of the crimmigration regime and at the same time to a dangerous cul-de-sac. In addition, the official social controls imposed to combat the COVD-19 health crisis contribute to crimmigration through the intensification of the dangerization of mixed migration flows.

5. Discussion

The COVID-19 pandemic and the measures imposed to confront it have seriously affected daily life and have created a new social reality marked by numerous precautions and restrictions for the total population worldwide. These measures are aimed at both the avoidance of virus spread and broad transmission and the protection of public health. Special groups of the population, due to vulnerability, such as conditions of living (adequate housing, food, access to health services, personal health condition) pose unprecedented

challenges for every State in managing the new, urgent and demanding situation, as well as in safeguarding their life and dignity. Especially when national vaccination plans started to be implemented in all EU Member States, third-country nationals who live in precarious conditions were left, to a large extent, less protected, forgotten, abandoned and non-prioritized compared to native citizens and State nationals by most of the Member States' policies.

Studying the relevant official Greek policies through documentary and archival research we realize that the already precarious population of asylum-seekers, refugees and undocumented migrants, under the conditions of the COVID-19 pandemic, continued to reside in crowded facilities, lacking adequate hygiene and being mostly unvaccinated for at least half a year after the national vaccination plan had been launched. Moreover, they have remained quarantined in the same undignified living conditions for a much longer period compared to that provided for the Greek citizens. In addition, the great category of those in camps was 'detained' in crowded spaces, although research evidence showed that it was more likely to be inflicted by the COVID-19 virus. Their segregation and invisibility, or, otherwise, their extended social control and encampment, were the effects of consecutive administrative decisions and legal regulations against all scientific evidence and human rights approaches which truly advocate to the contrary.

Concerning vaccination, marginalized third-country nationals have not been included in the first, second or even the third phase of the Greek National Vaccination Plan, despite the fact that the WHO and other international bodies such as the UNHCR provide guidance for prioritization of those living in harsh conditions. Bureaucratic hindrances such as the issue of a Social Security Number (AMKA) refrained them from being registered to receive a vaccine. The specific administrative provisions provided for the acquisition of a temporary security number (PAMKA) allowed for only part of these populations to be included for vaccination. Yet, migrant and refugee vaccination plans were implemented six months later than the general population vaccination plan and only when it was made clear that the available vaccines were sufficient enough to cover the entire Greek population. Segregation also infiltrated the way migrant and refugee populations had access to a vaccine brand. Their vaccination process was also 'camped' since it could only be operated inside the walls of their residence camp and restricted to twice a week administration of dosages.

Most importantly discrimination, further freedom restrictions and diverse levels of exclusion influenced more deeply the migrant/refugee populations as 'non-citizens'. They were subdued to a life of (a) time restrictions since they have not been prioritized regardless of their harsh conditions which make them more vulnerable to the COVID-19 virus; (b) choice restrictions since they are not offered the opportunity to choose the vaccine brand they wish to be vaccinated with; and (c) place restrictions since those living in camps can only be vaccinated therein. Even the condition of the pandemic was not able to surpass such a systemic space segregation. On the contrary, all freedom restrictions have been further intensified 'for the protection of public health'.

Inferentially, the body (the 'non-citizen body'), the time factor, the place/milieu restrictions and the lack of free choice are merged in a new inequity complex which tends to reinforce the crimmigrated identity of the controlled subject. It could be stressed that harsh living conditions coupled with the above restrictions form new 'normal' cycles of rejections next to other pre-existing ones.

6. Conclusions

Our study reveals that even under the conditions of an emergency, such as the occurrence of a pandemic, the 'crimmigrated' approach of the States concerning the marginalized migrant/refugee populations cannot be annulled or even mitigated. On the contrary, emergency pandemic situations constitute another field for intensifying the dangerization controls, segregation and movement restrictions of various social groups, migrant/refugee populations included. In addition, emergency pandemic situations constitute an extra opportunity in the context of a vaccine institutional racism for further stabilizing the identity

of the 'non-citizen crimmigrated' subject as a subject non-liable to prioritized protection. Such a state-of-play provides a 'fertile' ground for new cross-mergers of crimmigration with public health policies. In this sense, the guaranteeing of rights cannot be implemented for all (Arendt 1943), even in situations of great risk and emergency. Although further research is needed, we may validly argue that the way public health policies have been amalgamated with penal, administrative and migration law processes indicates that health field may be used as an additive component to crimmigration as it helps the establishment of a concrete screening intensifying the already imposed migration controls. In addition, the official social controls imposed to combat the COVD-19 health crisis contribute to crimmigration through the intensification of the crimmigration regime and at the same time to a dangerous cul-de-sac.

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Notes

1 Abolition of the Circular Φ80320/οικ.28107/1857/20-6-2019—as derived from the Joint Ministerial Decision 31547/9662/13.02.2018—by the Circular Φ.80320/οικ.31355/Δ18.2084/11.07.2019 of the Minister of Labor (Decision. For AMKA). The above Joint Ministerial Decision safeguarded access to health services for the migrant population in Greece. See also Aggelidis, Dimitris. The hope for the cancer patient falls into a (legal) vacuum, *Efsyn*, 29 November 2019, available online: https://www.efsyn.gr/ellada/dikaiomata/220998_peftei-se-nomiko-keno-i-elpida-gia-karkinopathi-prosfyga (accessed on 3 August 2021).

2 To Vima, The quarantine continues in host facilities because . . . of COVID_19, *To Vima*, 19 July 2020, Συνεχίζεται η απαγόρευση κυκλοφορίας στις δομές φιλοξενίας λόγω . . . κορωνοϊού, Το Βήμα Online.

3 As explicitly stated, "*sociodemographic groups at significantly higher risk of severe disease or death (depending on country context, examples may include: disadvantaged or persecuted ethnic, racial, gender, and religious groups and sexual minorities; people living with disabilities; people living in extreme poverty, the homeless and those living in informal settlements or urban slums; low-income migrant workers; refugees, internally displaced persons, asylum-seekers, populations in conflict settings or those affected by humanitarian emergencies, vulnerable migrants in irregular situations; nomadic populations; and hard-to-reach population groups such as those in rural and remote areas)*", p. 11, (World Health Organization 2020b).

4 Austria, Croatia, Cyprus, Germany, Romania, (FRA 2021). See also Muscat, Gavin. Asylum seekers and foreigners applying for residency 'denied vaccine'–Only people who 'truly' live in Malta will be vaccinated', *Newsbook*, 1 June 2021.

5 (United Nations n.d.), Sustainable Development Goals, Goal 3: Ensure healthy lives and promote well-being for all at all ages, 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all, Health–United Nations Sustainable Development.

6 "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities." EU Charter of the Fundamental Rights, Article 35 of the Charter, https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:12012P/TXT&from=EN (accessed on 8 August 2021).

7 The Washinghton Post. Europe is racing to vaccinate residents. But in some countries, undocumented immigrants have been left out, *The Washington Post*, 11 July 2021e.

8 Vaccination against COVID-19, Εμβολιασμός κατά της COVID-19, available online: https://emvolio.gov.gr/ (accessed on 1 August 2021).

[9] Proto Thema."Mitarakis: Vaccination in the hosting structures starts in early May", Μηταράκης: Αρχές Μαΐου ξεκινάει ο εμβολιασμός στις δομές φιλοξενίας (protothema.gr), 28 March 2021. See also: "*The Greek Minister for Migration Policy stated that Greece planned to start vaccinating residents and staff in refugee camps in May, as epidemiological data did not show particular spread in the camps*", FRA 2021, p. 21.

[10] Efsyn,"Refugee vaccinations on mainland begin on Thursday", Ξεκινούν την Πέμπτη οι εμβολιασμοί προσφύγων στην ενδοχώρα, *Efsyn*, 8 June 2021.

[11] Efyn, Twice a week refugee vaccinations in the camps, Δύο φορές την εβδομάδα οι εμβολιασμοί προσφύγων, *Efsyn*, 3 June 2021.

[12] Kathimerini, Newsroom, Refugees in camps face a greater risk from the coronavirus, Μεγαλύτερο κίνδυνο από τον κορωνοϊό αντιμετωπίζουν οι πρόσφυγες σε δομές, *Kathimerini*, 1 July 2021.

[13] Efsyn, "Twice a week refugee vaccinations in the camps", *Efsyn*, 3 June 2021, ibid.

[14] "*Most Greeks believe that the effects of immigration are negative, especially in the context of the country's scarce resources [. . .] Overall, 51 percent determine that immigration is ultimately 'bad for Greece, costing the welfare state and draining resources that could be spent on Greeks [..] (Greeks) Anxieties about Islam and Muslims are common [. . .] (and) hold concerns about several aspects of the refugee and migration crisis, including [. . .] Perceptions of disorder and authorities' loss of control of the situation [. . .] Security fears: Concerns about the risk of terrorism and increased crime are present in all segments, but much stronger in the 'closed' groups. Overall, 42 percent of Greeks agree with the proposition that it is too dangerous to let refugees in the country due to the threat of terrorism*", (Dixon et al. 2019).

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