Chapter 15
The COVID-19 Pandemic and Refugees in Greece: A New Challenge for Healthcare Service Provision, Public Health Programmes and Policymaking

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15.1 Introduction

Over the past few years, a global change has been witnessed, with forced displacement becoming vastly more widespread, and also a protracted and sustained phenomenon. Refugees and forcibly displaced people have become a key topic in the global agenda for sustainable development. Starting with the New York Declaration for Refugees and Migrants in 2016 (UNHCR, 2016), in which all 193 member states of the United Nations (UN) agreed that the protection of refugees should be a shared responsibility. In the Global Compact on Refugees (United Nations, 2018), agreed by 181 governments in 2018, the values of inclusion and solidarity have been recognised as being of key importance. These values also represent a significant aspect of the European Union's (EU) policy. An important challenge was how to protect these people, including in terms of safeguarding their health and wellbeing. The Sustainable Development Goals (SDG) clearly capture the need to consider

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them in the context of reaching SDG3, i.e. ‘To ensure healthy lives and promote well-being for all at all ages’ and specifically sub-goal 3.8, Universal Health Coverage for all with the key message to ‘leave no one behind’ not only as a key ethical consideration or moral obligation, but as the path to sustainable development for all people across the world (Ghebreyesus, 2017; The Lancet, 2019). Politicians, jurists, health care providers and humanitarian workers, amidst others, have intensely debated which measures are appropriate both in terms of border control and in terms of disease control. The pandemic of the coronavirus SARS-nCoV-2 resulting in millions of cases of COVID-19 across the world intensified debates and uncertainty on the relevance, effectiveness and on the outcomes of the implemented measures.

Greece is a country with critical relevance in terms of examining Europe’s response to COVID-19, but also because it has many commonalities in the challenges many other Balkan and Southern European countries, or countries at the borders of the EU have to tackle. It has experienced a very high volume of refugees and migrants over the previous years and continues to battle key security considerations given its relations to neighbouring Turkey, to which health security issues came to be added over the past year. Greece was successful in implementing key measures in the first months of the pandemic. Nevertheless, search and rescue operations in Mediterranean were suspended early in the pandemic due to logistical difficulties caused by COVID-19 (Kluge et al., 2020). Prior to the COVID-19-related nationwide lockdowns, there were few such operations, with immediate quarantine of new arrivals. It should be noted that at the time the measures were implemented by the government during the first pandemic wave there were no confirmed cases of COVID-19 in Africa. Furthermore, many people coming from countries which did not yet appear to be affected by COVID-19 were entering countries where the number of COVID-19 cases was clearly on the rise.

Additionally, Greece lags behind in terms of the integration of public health and primary care, with well documented disconnectedness between key public health actors as well as central and local authorities (Lionis et al., 2019; Tsiachristas et al., 2015). The high level of uncertainty regarding disease transmission and overall severe disease implications was combined with pre-existing conditions in the settlements for refugees (Subbaraman, 2020). These resulted in a very precarious condition n terms of clear guidelines and referral protocols, sound risk communication and mechanisms for tackling misinformation. The situation led to fear and apprehension amongst people across the world, while for refugees or displaced persons the existing disparities became even more exacerbated, on multiple levels. For all of the abovementioned issues, this chapter aims to elucidate key aspects of the care of refugees and forcibly displaced people from the beginning of the pandemic in February 2020 with the main focus in the period until September 2020 without excluding key developments of 2021, examining the state of affairs in relation to the living conditions and the healthcare provision to these populations, as well as briefly assessing its impact in terms of the ethical and legal implications. It addresses these issues by combining rich knowledge and insights on challenging issues based on the expertise of its interdisciplinary team of authors, through the perspectives of health and legal sciences.

Overall, the chapter aims to inform scholars studying migration issues be they health and social care practitioners, researchers working at the intersection of health, migration and human rights, or social science and humanities migration researchers, about the existing framework of the European legislation. Furthermore, with a broad focus on solidarity and human rights, vital issues are identified in the context of implementation research and capacity-building efforts in the primary health care and community services. These are contextualised within the broader legislative and institutional framework, selectively presented and critically discussed.

15.2 A Focus on European Legislation, Regulations and Solidarity

EU legislation stipulates how asylum applications are to be handled. With the exception of unaccompanied minors, the first port of entry, usually Greece or Italy, becomes the member state that is responsible to process the asylum application. Given the limitation on resettlement at the EU level, most asylum seekers arrive to the EU as irregular migrants. This means that Greece is inordinately burdened in comparison to the other member states. Currently, there are no comprehensive, well-developed people-sharing measures, and except for reuniting families or providing for a limited number of minors, once a person is designated as a refugee, it is up to the Member State to provide for this person, whereas this person does not enjoy the right of free movement to other member states. EU funding has allowed for the implementation of programmes to provide urban accommodation and cash assistance to asylum seekers in Greece. Nevertheless, reception conditions and processing deficiencies persist across the country.

Up to now, the living conditions and the care provision of refugees and migrants did not markedly improve, despite the rhetoric on imminent implementation of fragmented measures to improve their living conditions and the overall handling of migratory populations. At the same time, xenophobia and racism were exacerbated, primarily because of the populist narratives utilised by politicians, taking advantage of other fears and utilising such topics to justify political stagnation and inability to combat the protracted effects of the crisis across Europe. Based on data of an EU funded national survey[1] conducted in 2016, Kalogeraki (2015; Chap. 5 in Kalogeraki, this volume) documents strong and moderate opposition (xenophobia) to Syrian refugees for the majority of the Greek population (seven out of ten responders). The socioeconomic conditions and the protracted financial crisis preceding the refugee crisis appear to have played a very important role; the macro-level conditions, namely the sizable refugee influx and the adverse economic conditions triggering

[1] The survey was conducted in eight countries, including Greece, in the context of the TransSOL European Commission Horizon 2020 project; https://transsol.eu/files/2017/07/D3.1-integrated-WP3-report.pdf?file=2017/07/D3.1-integrated-WP3-report.pdf

socioeconomic concerns, polarisation in political rhetoric and symbolic threats have also shaped these attitudes. Humanitarian values at the core of the European civilisation were replaced by xenophobic movement and the resurgence of extremist organisations because of the deep social crisis and for political parties to seek advantage by advancing skewed narratives. Thus, the inadequate management of the refugee and migrant crisis in Europe, resulted in indifference, profiteering, debasing human life, and fanaticism across involved parties (Triandafyllidou, 2017). There has also been a diversity of patterns of mediatisation and politicisation of the refugee crisis, with stereotypical readings of the recent asylum-seeker and migrant phenomenon becoming the focus media and political agendas, and with strongly mediation-dependent politics generating a broad spectrum of, primarily negative interpretation of this phenomenon, utilised in populistic and opportunistic political campaigns (Krzyżanowski et al., 2018).

The Expert Panel on effective ways of investing in health, the foremost independent panel in all matters pertaining to health convened by the European Commission, has recently issued an opinion entitled *European Solidarity in Public Health Emergencies* (European Commission, 2021). This opinion examines solidarity, clearly identified as a founding principle of the Treaty of the Functioning of the European Union (TFEU), forming the constitutional basis of the Union. Close examination and framework development to operationalise this value, indicates that it contributes towards improved response and preparedness, to strengthen cross-border collaboration and to help absorb learning lessons from the COVID-19 pandemic, by identifying limitations to EU level actions and determining avenues to overcome them.

On a practical level, from the beginning of their operation, the Reception and Identification Centres (RICs[2]) were run beyond capacity, with crowding conditions in them and in the areas surrounding them given their limited capacity and the disproportionally increased migratory flows. The surge of a large number of people in the RICs, the delay in processing asylum applications, as well as the movement of these people inland, coupled with the procedure of returning them to Turkey and its own particular conditions, had a tremendously adverse impact in the hygiene and living conditions of those seeking asylum.

Since the summer of 2019, and with the decision of the new Greek government, the movement of those seeking asylum inland was forbidden. The aim of this decision was to create such conditions in the asylum procedures that would deter new arrivals. As a result of this, the overcrowding in the RICs reached extreme proportions, with people living in abysmal hygiene and living conditions. By November 2019, over 20,000 people were living within or around the *Lesvos* RIC, which roughly corresponds to seven times its capacity. In *Samos*, more than 8000 people were living under similar conditions, whereas the number was also disproportionate to capacity across the rest of the RICs. The services for health and psychosocial care in the RICs were based on the limited resources of the EODY (*Ethnikos Organismos*

[2] In Greek *Kentra Ypodochis ke Taftopoiisis (KYT).*

Dimosias Ygias [National Public Health Organisation]) and various Non-governmental Organisations (NGOs); it should be noted that some of these NGOs are illegally operating in Greece under the Greek legislation provisions. The services of the national healthcare system had repeatedly expressed the inability to serve these groups of people given their multi-vulnerability, coupled with a system of depleted resources given the protracted financial crisis. Although, training modules and materials have been developed quite early on the basis of European funding, the Primary Health Care (PHC) was not formally involved in the planning of care until the present time and its contribution remained limited. It is clear then that even during the period of the pandemic the immigration flow does not stop exacerbating the existing health and social problems that Greece encountered in the effort to care for the migrant groups. It is widely recognised that the COVID-19 pandemic has had an impact on human rights (Libal et al., 2021), in Greece, across Europe, and, indeed, across the world. In response, the United Nations High Commissioner for Refugees (UNHCR, 2020) issued a recommendation to the countries to raise awareness about the long-term damage to human rights and refugee rights from the coronavirus pandemic. Global health security and health threats are issues that have long been discussed in the realm of global public health. For almost two centuries, concerted efforts have been made to safeguard public health and tackle health security issues across Europe, with countries coming together to prevent the spread of diseases. The first International Sanitary Conference in 1851 focused on harmonising quarantine procedures amongst European states. The fruit of such efforts materialised well after the 2nd World War, as a result of discussions in the UN and in the context of activities of the World Health Organisation (WHO). It took the form of the International Health Regulations (IHR) in 1969, currently in place of their 2005 version (WHO, 2005). The IHR are a set of rules establishing common ground for reporting outbreaks and exchanging information, for managing diseases within borders and aligning for cross-border movement, and for establishing a cooperative path to prevent the spread of the disease. These rules are binding, with all 194 WHO member states implementing them. It should be noted that along with the effort to 'prevent, protect against, control, and provide a public health response to the international spread of disease' (WHO, 2005, Article 2) whilst minimising interference with 'international traffic and trade,' (WHO, 2005, Article 17d) of the IHR it is also clearly stated that 'the dignity, human rights and fundamental freedoms,' should be safeguarded for all people (WHO, 2005, Article 32). It is on the basis of the IHR that WHO has been able to establish a global surveillance network to monitor for potential threats ensuring that these are caught at an early enough stage to prevent them from becoming international health emergencies. Of course, any such network is as good as its reporting from the WHO member states.

The IHR requires that all countries have the ability to: *detect* (assuring surveillance systems can detect acute public health events in timely manner; *assess and report* (using the decision instrument in Annex 2 of the IHR to assess public health event and report to WHO through their National IHR Focal Point those that may constitute a public health emergency of international concern); and *respond* to public health risks and emergencies. The goal of country implementation is to limit the

spread of health risks to neighbouring countries and to prevent unwarranted travel and trade restrictions (WHO, 2005).

Notably, disease does not differentiate between the citizens of a country, displaced persons finding themselves in said country and/or migrants and refugees. As previously mentioned, according to the UN 2030 Agenda for Sustainable Development, the needs of these particularly vulnerable persons were recognised and highlighted in the Declaration for Refugees and Migrants adopted by the United Nations General Assembly in resolution 71/1 of 2016, setting out a process for the production of a global compact by 2018.

However, it is important to comprehend the wider institutional regulatory context in relation to legislative acts pertaining to COVID-19, including an examination of all dispositions that constitute emergency law, with due consideration to global health security aspects, as they determine various aspects of entitlements, service provision and access. They also impact upon codes of conduct for health and social care professionals and should provide a guiding framework to safeguard human rights and human dignity, including by addressing stigma and discrimination. The next section of the chapter examines said context.

15.3 Institutional Framework, Rights and Limitations Regarding Refugee Access to Healthcare Provisions During the COVID-19 Pandemic

In the case of Greece, the EU, and more specifically the European Commission, has supported the Greek authorities in implementing an emergency response plan to deal with cases of COVID-19 in the camps. The priority was to ensure the immediate evacuation of vulnerable persons to designated places outside the camps, including to hotels on the islands or mainland, to apartments or to open reception facilities. Separate areas were created for new arrivals and containers, consumables, medical equipment and other necessary facilities were made available for quarantine and treatment purposes. To this end, the Commission and the Greek authorities work closely with UNHCR, as well as with NGOs.

The Commission also coordinates the relocation of unaccompanied minors and severely ill children with their families, from Greece. As of 7 July 2020, 11 member states and Norway are participating in this initiative and there are pledges for the relocation of around 2000 persons. This should provide further relief notably to the Greek islands. Moreover, under the Union Civil Protection Mechanism, Member and Participating States have offered over 90,000 items of in-kind assistance to Greece mainly in the areas of mobility, health, sanitation and shelter. Explicit provisions were made by the European Commission, the UNHCR and the International Organisation for Migration (IOM) working closely with the Greek Authorities, and

supporting the work of NGOs, deemed essential to ensure adequate support for the care of the people in the camps.[3]

Furthermore, the EU's Global Health Strategy lacks a coherent frame beyond the IHR to align responsibility and accountability among WHO, the EU and member states. Efforts for an up-to-date strategy (Steurs et al., 2017) and urgent calls for a robust and cohesive strategy remained largely unaddressed (Speakman et al., 2017). The importance of such measures and a cohesive strategy is magnified when it comes to countries with limited preparedness expertise, capacity and resourcing. This becomes even more critical when these countries are at the borders of Europe and have high geopolitical importance, with potentially conflicting state, EU, and global priorities, and the strong emergence of strong biogeopolitical dynamics at the Southeastern EU borderland of Greece and Turkey (Jauhiainen, 2020). In Greece, measures were mainly introduced through legislative acts handled as emergency procedures. The Emergency Act is an instrument used in cases of threats to national sovereignty and security from external or internal enemies of the state. According to the Constitution of the Hellenic Republic emergency acts can be introduced as Act of Legislative Content (ALCs) (*Sintagma tis Eladas* (Constitution of Greece), 2008, Art. 44 par. 1, or by declaration of a state of siege (*Sintagma tis Eladas* (Constitution of Greece), 2008, Art. 48 par. 1 and 5). ALCs are issued in case of unpredictable need by the President of the Republic, upon proposal by the Cabinet, but without prior suspension of human rights, contrary to the acts issued following the declaration of a state of siege. Critically, ALCs are administrative acts issued only for a limited period of time, unless submitted to and ratified by the Parliament within a specific period of time. According to the jurisprudence of the Council of the State, the exceptional nature of the particular circumstances that led to the publication of an ALC is not subject to judicial review (*Simvulio tis Epikratias,* 1987, 1989, 2002, 2003, 2015b), contrary to its content, which is, theoretically, subject to judicial control (Gerapetritis, 2012); such was recently the case of the Austrian COVID-19 legislation, which was considered to be partially illegal according to the jurisprudence (Verfassungsgerichtshof, 2020). COVID-19 ALCs introduced structural dispositions, but also substantial human rights' limitations to safeguard public health, which is considered an element of public interest. According to the Hellenic Constitution but also to European Human Rights Convention, human rights' limitations should be prescribed by law, be of legitimate aim and proportionate, a necessary condition in a democratic society (Giannopoulou & Tsobanoglou, 2020; Renucci, 2005). Seven ALCs were introduced into national legal order, ratified in due course by the Parliament, thus, acquiring timeless retrospective force. By acquiring a rather permanent character, the totality of the measures introduced through delegated acts (ministerial decisions) rendered them susceptible to judicial review.

[3] Answer given by Ms. Johansson on behalf of the European Commission to the question submitted in the European Parliament by Ska Keller (Greens, DE) in relation to the impact of COVID-19 for people in overcrowded refugee camps on the Greek islands. https://www.europarl.europa.eu/doceo/document/E-9-2020-001906-ASW_EN.pdf

On February 26, 2020, 2 weeks before the WHO declared the severe acute respiratory coronavirus-2 (SARS-CoV-2) pandemic, the Ministry of Health announced the first confirmed case of COVID-19 in Greece. Within hours of the announcement, all leaves of absence were revoked for administrative personnel at the Ministry of Health and for medical and scientific personnel across the country (*Ypuryio Yyias* [Ministry of Health], 2020). Less than a week later, asylum-seeking procedures were suspended with immediate effect (ACL published in official gazette Vol. A no. 45/2020 and later ratified by the article 2 of the Law, published in the gazette Vol. A no 74/2020).

All new arrivals illegally entering the country were to be returned to the country they arrived, or originated, from, with any documentation whatsoever. The time limit for this provision was 1 month. The explicit legal basis of the ACL was the extremely urgent and unpredictable need to confront an asymmetric threat to the security of the country that prevails over international and EU law for the asylum procedure. It is worth noting that the very next day, intense debate erupted across Europe, including in the European Parliament, with key questions being submitted by Socialist & Democrats' members[4] with a focus on whether the Greek government was acting lawfully:

> In the light of the 1951 Convention Relating to the Status of Refugees and EU law, does the Commission consider that the Greek Government has acted lawfully in suspending the receipt of all new asylum applications? Does the Commission consider that the provisional measures under Article 78(3) of the TFEU can be extended to the suspension of the internationally recognised right to seek asylum and the principle of non-refoulement enshrined in EU law?[5]

Ylva Johansson, the EU Commissioner for Home Affairs responded that 'individuals in the European Union have the right to apply for asylum. This is in the Treaty, this is in International Law; this we can't suspend'.[6] During a meeting with Johansson, members of the European Parliament from the Committee on Civil Liberties, Justice and Home Affairs expressed 'deep concern about the deteriorating humanitarian situation both at the border with Turkey and on the Greek islands, where thousands of asylum-seekers, many of them unaccompanied minors, are stranded.' In response, various governments across the EU responded with what they considered to be 'the appropriate share,' the focus being solely children and in total offering to assist 1000–1600 of them. This 'token' of support left Greece stranded, with the European Commission stepping in to launch a new scheme offering 2000 Euros per person as an incentive for people to return to their country of origin from the Greek islands, under the management of the IOM and the European Border and Coast Guard Agency Frontex. In parallel, the relations of Greece and Turkey continued to deteriorate, with Turkey not preventing people

[4] i.e. Domènec Ruiz Devesa, Javier Moreno Sánchez, Juan Fernando López Aguilar, Dietmar Köster and Isabel Santos.

[5] See https://www.europarl.europa.eu/doceo/document/P-9-2020-001342_EN.pdf

[6] https://euobserver.com/tickers/147723

from leaving its territory and indirectly, if clearly, demanding support from the EU on the Syrian conflict in the *Idlib* province.

Apart of the limitations regarding refugee access to healthcare services during the COVID-19 period, it is important to review what we have learned from implementation studies carried out in Greece and to transform them into health policy recommendations in a context-relevant manner. The next section of this chapter focuses on such studies and lessons learnt.

15.4 Care Provision Model, Considerations for Greece and Implications for Access

Care provision research contributes significantly towards system improvement. Taking this into account, we applied the Chronic Care Model (Wagner et al., 1996) to study what we have learned from the Greek healthcare system prior the pandemic period in relation to the migrants and refugees' health care and what changes were needed towards system improvement. This model identifies six fundamental areas that form a system to encourage a high-quality chronic disease management and particularly: Self-Management Support; Delivery System Design; Decision Support; Clinical Information Systems; Organisation of Health Care Community.

Addressing the above six areas of the Chronic Care Model we present below key summary findings of a research implemented in Greece, as paradigms. An important task of the PHC services is to provide care according to people's needs and expectations. To respond to the migrants and refugees' health care needs, proper training and communication skills are needed. Lionis et al. (2018) focused their analysis on the methods used for enhancing PHC for refugees through rapid capacity-building actions in the context of an European project. The methods included the assessment of the health needs of all the people reaching Europe during the study period, and the identification, development, and testing of educational tools. The developed tools were evaluated following implementation in selected European primary care settings. The work was carried out under the auspices of the European Commission funded collaborative project EUR-HUMAN (3rd Health Programme by the Consumers, Health, Agriculture and Food Executive Agency designed and implemented in eight European countries, including Greece.

Key findings based on the above project in the spring of 2016 are also offered, deriving from a qualitative comparative case study, in seven EU countries, in a centre of first arrival, two transit centres, two intermediate-stay centres and two longer-stay centres using a Participatory Learning and Action (PLA) research methodology was implemented (Van Loenen et al., 2018). The data reveal that *the main health problems of the participants related to war and to their harsh journey like common infections and psychological distress. They encountered important barriers in accessing healthcare: time pressure, linguistic and cultural differences and lack of continuity of care. They wish for compassionate, culturally sensitive healthcare*

workers and for more information on procedures and health promotion. A total of 98 refugees and 25 healthcare workers participated in 43 sessions. Transcripts and sessions reports were coded and thematically analysed by local researchers using the same format at all sites; data were synthesised and further analysed by two other researchers independently.

In the context of this project, a two-day Expert European Consensus Meeting on key thematic areas including cultural issues in health care, continuity of care, information and health promotion, health assessment, mental health, mother and child-care, infectious diseases, and vaccination coverage and prepare a set of recommendation the primary health care practitioners (Mechili et al., 2018). The expert participants, invited to reach consensus on the above areas, stressed the need to address mental health problems. The needs reported by refugees and other migrants helped identify a serious gap in terms of compassionate attitudes exhibited by healthcare workers. One of the key messages of this meeting was that *linguistic and cultural barriers exacerbate the effect of the lack of compassion, especially where healthcare information and psychological support are urgently needed but an appropriate supportive framework is missing*.

A focus on re-training the Greek General Practitioners (GPs) and Primary Care Providers has received a strong attention in the literature for several reasons. Mental health problems are highly prevalent amongst undocumented migrants, and often part of their consultations with GPs. To get an insight in the barriers and levers in the provision of mental healthcare for undocumented migrants by GPs in Greece, a qualitative study was conducted using semi-structured interviews with 12 GPs in Crete, Greece (Teunissen et al., 2016). This study revealed that Greek GPs recognised many mental health problems in undocumented migrants and identified the barriers that prevented them from discussing these problems and delivering appropriate care, i.e. growing societal resistance towards undocumented migrants, budget cuts in healthcare, administrative obstacles and lack of support from the healthcare system. Teunissen et al. (2016, p. 123) suggest that ‘to overcome these barriers, Greek GPs provided undocumented migrants with free access to care and psychotropic drugs free of charge and referred to other primary care professionals rather than to mental healthcare institutions.’

In the framework of the EUR-HUMAN project, an online capacity building course of eight stand-alone modules were developed, piloted and evaluated. It contained information about acute health issues of refugees, legal issues, provider-patient communication and cultural aspects of health and illness, mental health, sexual and reproductive health, child health, chronic diseases, health promotion, and prevention (Jirovsky et al., 2018). One hundred and seventy five (175) participants completed all modules of the online course in six countries, 47.7% being medical doctors. The mean time for completion was 10.77 h. In total, 123 participants completed the online evaluation survey; the modules on acute health needs, legal issues (both 44.1%), and provider-patient communication/cultural issues (52.9%) were found particularly important for the daily practice. A majority expressed the will to promote the online course among their peers (Jirovsky et al., 2018, p. 1).

The English course template was translated into seven languages and adapted to the local contexts of six countries. Pre- and post-completion knowledge tests were administered to effectively assess the progress and knowledge increase of participants so as to issue Continuing Medical Education certificates. An online evaluation survey post completion was used to assess the acceptability and practicability of the course from the participant perspective. This training material was used after the end of this European project, and it served many implementations across Europe.

In 2013, a group of researchers and clinicians across Europe (O'Donnell et al., 2013) identified two key issues in relation to healthcare access for migrants and the effect of austerity measures on health care. The RESTORE project started from the observation that an area particularly affected is the provision of interpretation services for patients who speak a foreign language. It explored the implementation of initiatives designed to support multicultural consultations in primary care, in six European countries (Austria, England, Greece, Ireland, Scotland, and the Netherlands). The vision of this project was to draw attention to the disproportionate effect that austerity measures are having on migrant health care, even in countries that seem less affected by the economic downturn. Migrants are included among the vulnerable groups at a high risk for severe COVID-19. A focus on the transformation of the PHC to turn the focus to vulnerable groups including migrants has been clearly highlighted as a key priority for the Greek healthcare system, and to allow transition towards an improved health and social care delivery system. This is relevant for public health programmes, such as vaccination programmes, determining the extent protection can be afforded to safeguard the interests of public health for each and every member of a community, indeed, of our society.

Engagement of community stakeholders in regards the healthcare provision for migrants and refugees has been considered as an essential part of an effective and equitable health care system. However, there is limited knowledge in regards the relevant methodology and the effectiveness of implementation interventions in Greece. As part of the RESTORE project and as a part of a comparative analysis of five linked qualitative case studies, we used purposeful and snowball sampling to recruit migrants and other key stakeholders in primary care settings in Austria, England, Greece, Ireland and The Netherlands and a total of 78 stakeholders participated in the study (Austria 15, England 9, Greece 16, Ireland 11, The Netherlands 27), covering a range of groups (migrants, general practitioners, nurses, administrative staff, interpreters, health service planners). Normalisation Process Theory (NPT) and PLA research to conduct a series of PLA style focus groups has been used. Stakeholders' discussions were recorded on PLA commentary charts and their selection process was recorded through a PLA direct-ranking technique. Among the key results of this study was that 'the need for new ways of working was strongly endorsed by most stakeholders. Stakeholders considered that they were the right people to drive the work forward and were keen to enrol others to support the implementation work.'

In addition to the lessons learnt from implementation studies in regards refugees' health care, it is also important to report the existing organisational issues and

barriers for an effective health and social care system for refugees and migrants. It is the issue of the next session.

15.5 Health and Social Care Delivery and the Organisation Thereof

Several organisational issues and barriers are described here given their impact on the delivery of effective, patient-centred, integrated and compassionate health and social care. Implemented measures exert intense psychological pressure to everyone, whereas, for people on the move, the level of psychological pressure and uncertainty further amplifies as information regarding these measures and their implementation is not communicated to them via appropriate channels, in a formal way, and in a context-sensitive manner, rather, they become aware of them via their implementation primarily by the civil protection and public order (e.g. police force) mechanisms. Misinformation continues to be the prevalent situation in the RICs, as well as in the hospitality centres. In the RICs, hygiene measures, which are imperative for the prevention of the SARS-Cov-2 infection, continue to be practically unenforceable.

The COVID-19 pandemic seems to aggravate pre-existing health conditions, in both adults and children, and to even highlight other forms of vulnerability, resulting in worsening outcomes. Such outcomes are more likely to be identified in the context of mental health conditions where new psychological stressors have been added adversely impacting the life of all displaced people. The understanding of this situation led the UNHCR to raise awareness on mental health support activities for refugees, asylum seekers and migrants (UNHCR, 2020). Additionally, some of the measures formally or implemented from time to time, such as the postponement of scheduled surgeries and medical appointments in the hospital resulted in uncertainty giving way to intense insecurity, fear and psychological pressure with collateral damage effects identified from the very first few months of the COVID-19 pandemic.

Such measures also have a severe impact to the chronically ill, as well as to those newly diagnosed, something which is likely to result in increased hospitalisation, and potentially both morbidity and mortality in the future. In this special population, people's overall health condition, identifying and establishing vulnerability, is key to the asylum procedure and the continuation of their journey towards their destination. Moreover, there are immediate concerns regarding their health, as neglecting the care of the chronically ill and the timely identification and treatment for emerging issues may further increase vulnerability and worsen outcomes. It should be stressed here that for people on the move, there are health problems which need immediate diagnosis and treatment such as tuberculosis, HIV, Hepatitis C, and other communicable diseases, as well as psychological issues related to migration,

and including post-traumatic stress disorder, abuse-related mental health issues, and others.

The role of the triaging at reception and ensuring the timely detection of early signs of physical and mental health issues should always be kept in mind, rather than be eliminated, during the pandemic, as the aforementioned issue will continue to exist, and indications point to them being on the rise. It is important if we consider that refugees often live in extremely close proximity to others, sharing sleeping and washing material with large number of people, thus facilitating the spread of virus inside in their community. Interviews for those seeking asylum are taking place via videoconferencing due to the social distancing precaution measures. Besides the fact that the PHC system should have had a central role in the management of these patients, it was not adequately prepared to provide this kind of service. As a result, PHC provision in RICs is random and unorganised, despite the good will of those involved, thus, compromising outcomes. A key element of PHC is prevention and health promotion. PHC has a central role to play in mass vaccination and other key public health programmes. Here the role of medical advice and the education programmes to facilitate risk communication and tackle the spread of misinformation is prevalent among the displaced people. Implementation has so far lagged behind given limited human resources, inadequate infrastructure, and other shortages. For these reasons the mass vaccination programme was assigned to secondary and tertiary care. These pause key concerns in terms of prioritising groups according to other vulnerability factors beyond age, lack of information in comprehensive Electronic Health Records, lack of communication with Health Care Professionals providing the regular care and, thus having an established trust relationship; it also compromises hospital capacity and overall disease control. The COVID-19 pandemic occurred at a time of difficult conditions in the first quarter of 2020. The protective measures and the guidance on triaging and managing suspected COVID-19 infections in settlements for refugees and migrants were determined by the instructions of the EODY, which were posted to its website on 29 February 2020. Detailed measures were also issued at the same time for the overall protection of the population along with specific guidance for the medical personnel.

Examining the conditions at the RIC of *Lesvos* may clearly indicate the current challenges encountered and facilitate the understanding of the overall challenges for multiple reasons. It has been established for many years, serving as an EU ‘hotspot,’ and is enclosed with a chain-link fence. A former military camp, it has been described as the ‘worst refugee camp on earth’ by the Doctors Without Borders field coordinator in 2018, and given political decisions of the 2018–2020 period, by the summer of 2020 the camp built to accommodate 3000 people accommodated 20,000 people, one third of whom where children and adolescents under the age of 18 (Jauhiainen & Vorobeva, 2020). The personal hygiene within and outside the RIC at the time was very poor given the horrible living conditions and the overcrowding. Additionally, although guidance was provided for hygiene measures, social distancing and mask use, those measures ware almost impossible to enforce. New arrivals have to wait at Foto before moved to a space belonging to the passenger terminal of the *Mytilene* port. This space is not organised in a manner which allowed them to be

appropriately accommodated. According to the EODY's guidance, the EODY's field coordinator had to assign a healthcare professional responsibility to manage the COVID-19 infection; s/he is to be notified and to be present at the points of entry for newly arrived people to proceed with triaging people on the basis of the current definition of 'case' (ECDC reference). This particular guidance had not been implemented until the end of June. The single exception to this was the presence of an EODY physician, who triaged people by taking their temperature, at the time of arrival of 34 persons to the port of *Mytilene.* The medical association of *Lesvos* called for such action, but this was the single arrival event were this happened.

The first measure that the Ministry of Migration and Asylum[7] took was to revoke the operation of the asylum services within the settlements, so as to limit the movement of civil servants to and from the settlements, in order to keep the coronavirus out of 'these closed, in a manner of speaking, communities,' as the Minister mentioned. Additionally, the measure of patrolling the perimeter of the settlement of *Lesvos* was initiated on 19 March 2020, to limit the movement of refugees and migrants towards the urban centres.

By continuing the problems that the current situation meets in the COVID-19 pandemic, the lack of personal protective equipment and of other equipment and resources to combat the coronavirus has been observed across the national healthcare system, the EKAV (*Ethniko Kentro Amesis Voithias* [National Centres for Emergency Care]), but also by NGOs. The living and hygiene conditions, in particular at the Lesvos' RIC, as well as the understaffing, with key medical personnel missing, created conditions that rendered the effective combat against a pandemic not simply improbable, but impossible. In this critical juncture, these conditions may adversely impact not only the national healthcare system and the people of these groups at risk, but the public health of the whole population, whilst seriously jeopardising the overall social cohesion.

The lack of personnel training to manage infectious disease in the state healthcare units, as well as in the NGOs and EKAV was another factor which adversely impacted the management of the current pandemic. The provision of medical and pharmaceutical care to the newly arrived displaced people is non-existent in the desired degree. Limiting them in this particular space designated for migrants-refugees for this pandemic does not limit the number or the extent of contacts, given that this informal settlement is located very closely to the passenger disembarkation space, while various people move through this area, such as volunteers, employees of the port authority, police, and reporters. Issues of lacking security when refugees are referred to a hospital for chronic care need further analysis.

With all new arrivals moved to closed settlements inland, the manner of gathering these people and transporting them does not, under any circumstances, safeguard their health nor does it serve the interests of public health. Because of the intense criticism by international organisations and NGOs, the Ministry of Migration

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[7] It is worth mentioning that the Ministry of Migration and Asylum was founded in January 2020. The Ministry for Migration Policy had been previously established in 2016 but was abolished in July 2019 following the election of the new government.

and Asylum, in collaboration with the Municipality of Western Lesvos created a space in the area of *Sikaminea*, to isolate new arrivals for 14 days. In this space, no medical examination was performed, other than a COVID-19 test upon arrival. The concept of separating people who arrived a few days later in a separate group was not considered at all. This resulted in all people finding themselves in the same space and at high risk for a potential outbreak or getting infected on the last day of quarantine just before leaving this space, thus, carrying out the virus on the way to an inland settlement. In the municipality of *Mytilene* a quarantine space was created in the municipal settlement of *Kara Tepe*, with medical care being provided by NGOs. The continuous limitation of movement of refugees and migrants living in *Lesvos' Moria* camp[8] or the poor living and hygiene conditions, coupled with misinformation, led to the disastrous fire in RIC on 19 September 2020. The population of the centre, including the COVID-19 cases, remained spread around the surrounding areas for many days, within and beyond the city limits. A new space to accommodate up to 10,000 people was created, which consists of tents, with conditions remaining similar to those in the pre-existing RIC.

15.6 Conclusive Remarks and Key Considerations for Preparedness, Resilience, and Evidence-Informed Policymaking

The theme of this chapter was approached in an interdisciplinary manner and with the prisms of public health, community care, law and human rights, and of clinical care, brought on board by the contributors. The chapter reveals the need for a more focused approach on addressing structural aspects, including in terms of those factors that worsen pre-existing health conditions. Poor hygiene and difficulties in maintaining hygienic conditions, include those due to crowding and settings where

[8] At the time of concluding the initial draft of this chapter, a fire largely destroyed *Moria*'s RIC. Although the fire was contained and no casualties were reported, 12,000 asylum seekers, including more than 4,000 children as well as other vulnerable groups, including 407 unaccompanied children, pregnant women and elderly people were directly affected. The UNHCR reported the escalating tensions between people in neighboring villages and asylum seekers who were trying to reach the town of *Mytilene*. The help and support of the Hellenic Army was required for the provision of food and water for asylum seekers, including in the new temporary site which was rapidly established. 'At the request of national authorities and with the support of the European Commission, UNHCR provided a one-off emergency top-up of cash assistance valued at 50 per cent of the regular monthly amount, to cover urgent needs of those affected. In cooperation with partners, UNHCR also distributed core relief items, including blankets, sleeping bags, mats, jerrycans, plastic sheet and hygiene items to cover the essential needs for up to 12,000 people. UNHCR teams and national humanitarian partners are also continuing efforts to identify and assist vulnerable asylum seekers including families with young children and single women, informing them that they can now seek shelter at the new temporary site.' https://www.unhcr.org/news/briefing/2020/9/5f6073db4/unhcr-scales-immediate-shelter-support-moria-asylum-seekers-urges-long.html

displaced people live in extreme proximity to others, the difficulty of communication, and the mass attendance in the clinics for various reasons. The lack of a cohesive approach on risk communication coupled with the unhygienic living conditions make the management of large numbers of people even more difficult and necessitates some urgent interventions. The absence of an effective triage system in the immigrant camp, consistently applied between hospital and the camp, may lead to unnecessary deaths, increased distress for frontline physicians, and a lack of public confidence in the fairness of scarce resource allocation. Recently, several recommendations have been formulated to improve the current situation (You et al., 2020).

Based on the chapter's analysis and published evidence, the key aspects to incorporate across policies and actions pertain to the inclusion of migrants, refugees and all displaced people in preparedness response, and mitigation efforts for COVID-19 and, in general, in the national strategy to combat this pandemic. More specifically, due emphasis ought to be given on the following aspects:

(a) Enhancement of the knowledge and of the understanding of the severity of COVID-19 in relation to vulnerability and provision of accessible, timely, culturally and linguistically appropriate, child-friendly and relevant information on COVID-19 to all displaced people, and especially those living in camps; this necessitates suitable and appropriately designed educational programmes taking into account prevailing beliefs and attitudes and perceived risk. Changing the behavioural patterns of people providing care to displaced person represents a challenging and complex issue. Interventions that are socially, culturally, religiously, and linguistically appropriate are strongly recommended. (Prinzon-Espinoza et al., 2021). Low digital literacy and reduced access to technological means should be considered among other variables, when such interventions are on design.
(b) Improvement of the current living conditions of all displaced people by ensuring access to clean water, basic toilets and good hygiene practices, and as well as by supporting and advocating for safer living and housing conditions to allow for social distancing.
(c) Universal access to COVID-19 testing, health care, mental health and psychosocial support, in parallel, with the establishment a proper and efficient monitoring and health surveillance system. Integrating mental health into primary health care is an important priority.
(d) Reduction of the existing burden by expanding available social and economic programmes, and as well as available community resources, with due consideration to the human and patient rights of all displaced persons. Engaging stakeholders with the participatory approaches that described above seems to be an effective way.
(e) Combating xenophobia, stigma and discrimination by engaging community stakeholders is a high priority.
(f) Strengthening primary health and public health to improve safety and health care provision, and to reduce vulnerability and in the context of the COVID-19 vaccination. Training the primary health care and community care practitioners

to improve communication and the quality-of-care services by using the available EU training materials by using available training material seems to be effective.

(g) Equitable access, incl. in terms of vaccination, as highlighted by the Council of Europe (2021), ensuring intersectionality issues are adequately addressed.

Additionally, to all the abovementioned key considerations, the current socioeconomic conditions and geopolitical parameters have to be taken into consideration for efficient and adequate policymaking, particularly amidst a pandemic.

The recent war emergency situation in Ukraine has created an additional migrant flow affecting multiple European countries. The escalation of the conflict has pushed nearly four million people to forcibly move from the place of their permanent residence seeking security, protection, and support. The response from bordering countries, the European Commission, and the member states demonstrates solidarity. Nevertheless, the response plan should be focused on bringing together international organisations and national governments in a human-centred approach to ensure safe access to territory for refugees, but also potentially for third-country nationals fleeing from Ukraine, according to international law. Furthermore, the situation creates additional challenges in countries like Greece that are the main gates of entrance of greater migrant flows. Institutions should rapidly and effectively be adapted for cross-border collaboration. 'We welcome with open arms those Ukrainians who have to flee from Putin's bombs and I am proud of the warm welcome that Europeans have given them' *[…]* stated the President of the European Commission, Dr. Ursula von der Leyen, setting the tone for the positive political will that should also be accompanied with concrete steps of action.[9] The portal of the Ministry of Migration and Asylum in Greece was rapidly adapted to ensure direct access to information sources and resources for those displaced from Ukraine.[10] It is also important to determine whether stereotyping, racial and ethnic background, refugee origin, i.e. from within the European Region versus Africa or Asia, religious background, etc. play a role in terms of how those arriving are perceived and the extent to which they are considered as population that can be well integrated in Europe and, indeed, Greece.

Equally, it is also important for the local population not to perceive the refugees as a burden, and that the protracted financial crisis, limited access to care resources and COVID-19 measures, to not further contribute towards the promotion of xenophobic and racist views, with asylum seekers being targeted or even scapegoated (Rizakos, 2020). Establishing supporting mechanisms and policies for the people living in areas where the influx of refugees limits other main source of economic activity is critically needed, and may well determine the behaviour, as well as future outcomes for the wellbeing of the local populations and of those arriving from foreign lands. Most importantly, the protection of refugees and of the wellbeing of all

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[9] https://ec.europa.eu/commission/presscorner/detail/en/statement_22_1441

[10] https://migration.gov.gr/en/ukraine/

people in Europe as well necessitates a sound and comprehensive Common European Asylum system, as well as a comprehensive Global Health Policy, encompassing global health security considerations and ensuring implementation of programmes remains both feasible and context relevant. Such mechanisms can only be effective if they are based on fair and efficient asylum procedures and comprehensive cross-border multi-stakeholder dialogue. The most critical element for the EU-wide cohesion and for effective policies is to ensure responsibility-sharing among EU member states. COVID-19 brought to the fore and further exacerbated existing inequalities, for vulnerable groups, including for refugees. It also highlighted the need for Europe to move forward with due consideration upon its founding principle of solidarity for the local populations and for refugees, if Europe is to remain a firm promoter and defender of human rights across the world, as well as within its own borders.

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