LEARNING FROM AN EMERGENCY: THE INTERSOS TERRITORIAL RESPONSE MODEL IN ROME

Good practices and lessons learned 9 months following initiation of the intervention to restrict the effect of COVID-19 in the capital city

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However, in the large number of ministerial decrees and procedures aimed at restricting contagion there are no traces of provisions aimed at protecting the health of homeless people or those who are provided with accommodation at reception centres, nor are there indications of plans aimed at safeguarding the health of operators who work there. Nor is there any indication of an adequate and effective reorganisation of the system of territorial assistance aimed at arranging for home-based monitoring and the management of less serious cases, apart from occasions of intervention which are extremely limited with respect to actual requirements. Moreover, the interpretation of the severity of the epidemic curve trend uses as an element of assessment a ‘hospital-centred’ vision of the phenomenon and, that is, the trend of the occurrence of access to intensive-care units. There is not even an indication of a health-care and social services plan that envisages the strengthening of an approach based on the proximity principle and equity, which, in other words, would be calibrated according to the specific needs of the different types of citizens.

On the contrary, unfair, emergency-based visions and measures have prevailed which do not present a general health-care and social services approach and are therefore fragmentary.

For example, in some regions (such as the Veneto and Emilia Romagna) the Special Units for the Continuity of Regional Assistance (USCAR), which were created with the specific intent of implementing home care activities, have indeed intervened in a virtuous manner since March. Conversely, in the Lazio region these units got off to a slow start, with procedures, objectives and resources varying considerably throughout the area, and also presenting a very poor capacity of coordination with local communities, general medical practitioners and the various departments involved. Not having any instruments which would allow for a detailed understanding of the needs of the local territory, their use in fact appears to be limited to the administration of swab testing at home and is apparently devoid of any logic of integrated home care.

It is precisely in order not to leave anyone excluded that, in these nine months, the INTERSOS teams active in Italy have readjusted their activities, focusing on the implementation of anti-COVID-19 measures targeted at the most marginalised groups of the population. In Rome, and also in the city of Foggia and in the regions of Calabria and Sicily, INTERSOS operators started from the basic knowledge of the territory acquired over the years to reach and support thousands of fragile people, contributing towards ensuring not only the protection of health at the individual and collective levels but also supporting the Regional Health-Care Systems.

In Rome, in particular, since March 2020 the INTERSOS24 project (active since 2016, thanks to the partnership with UNICEF Italy, with a health-care and social services unit, a ‘safe-space’ and a mobile team) has focused on the implementation of anti-COVID-19 measures aimed at assisting the homeless population or people living in a condition of ‘social exclusion’ in order to ensure the protection of their health and to support the Health-Care System of the Lazio Region. The impact of these interventions in terms of the capacity to manage outbreaks of the disease, early detection of cases among the more fragile population and compliance with the measures adopted for containment has produced interesting results. The aim of this report will be to analyse the procedures relating to the INTERSOS intervention in Rome, to highlight good practices that have emerged and to interpret the intervention retrospectively as a possible model for the territorial response and proximity medicine.
OPERATIONAL METHODOLOGY

Every action that INTERSOS carries out has as its premise the principle of always providing support to the Health-Care System and to competent Local Authorities. For this reason every intervention is performed in close collaboration with these bodies, according to the principle of ‘horizontal subsidiarity’. This approach, also in the case of activities aimed at combating COVID-19, has made it possible to create effective opportunities for contact and dialogue between the communities and the virtuous bodies of some Local Health-Care Authorities or Departments of reference, achieving excellent results in terms of health supervision and the management of the risks of infection, but also ensuring sustainability and the continuity of intervention. More specifically, the operational methodology of the interventions of INTERSOS aimed at combating COVID-19 has followed three main directions:

1. promotion of ‘health-care initiative’ measures, i.e., the active offer of medical examinations for an early identification of suspected cases and their inclusion in protection plans

2. promotion of approaches based on the needs and characteristics of individual communities

3. the dialogue with institutions improves the accessibility and usability of prevention measures also for people presenting forms of vulnerability

On the basis of numerous requirements identified in the area two mobile health-care teams were thus created. These are composed of an operations representative, two physicians (one in charge of operations and the other responsible for coordination), a nurse (health promoter), two humanitarian workers capable of providing a linguistic and cultural mediation service, a case manager focusing on social aspects and a logistician. The action taken by the two teams has focused on and still concerns health-care surveillance activities, health-care training and the promotion of health in organised spaces used for residential purposes (‘organised urban housing settlements’), informal settlement solutions (spaces adjacent to main railway stations) and accommodation centres for Italian and foreign people in conditions of fragility, for asylum seekers and for unaccompanied foreign minors (UFM).

In particular, in the squats, by exploiting the greater organisation of the communities it has been possible to identify and train community health-care operators in order to facilitate health surveillance in these settlements and the widespread dissemination of the good practices concerning prevention that are referred to during health-care training sessions.
The health-care training sessions have been offered to operators of the accommodation centres and also to individuals and communities. The topics covered during the health-care training sessions have partly concerned the methods adopted in the prevention and control of infection but have also been modulated to respond to the doubts and the information and knowledge gaps of the various attendees and to strengthen networks existing between institutions and communities.

An interesting example is represented by the link which, through the intermediation of the teams, was established between the health-care operators within the communities and key figures in the competent pertinent Local Health-Care Authorities. This direct connection has in fact facilitated the management of suspected cases and persons in isolation in the peak phase of infection in the informal settlements.

In specific terms health surveillance has consisted in on-site medical examinations, frequent contacts with the relative health-care operators of the various settlements, the drafting of operational flowcharts for the management of suspected or positive cases within the communities and mediation between the communities and the prevention department and/or the Complex Operative Unit (UOC) of the pertinent Local Health-Care Authorities.

Depending on the scenarios encountered, the single activities have been modulated on the basis of a ‘high-intensity’ and ‘low-intensity’ surveillance approach.

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The reception component was also modified, with the activation of ‘Emergency shelters’, through conventions established with hotels, and the assignment of apartments in the area. The former guests of the centre were transferred to these ‘Emergency’ shelters and other vulnerable people found on the streets were assisted at these points thanks to the activities of the mobile teams. In addition to providing overnight accommodation the staff provided emotional support, food, health and hygiene kits, basic necessities and a sanitizing service for clothing. Each guest was supported, while physically present or remotely, through their acceptance and a form of multidisciplinary management. In particular, the team’s activities allowed the guests not to fully experience the institutional abandonment generated by the lockdown. The INTERSOS Case Manager thus created procedures planned according to the needs of individual beneficiaries and aimed at providing: legal support and referral, health and social welfare support through medical examinations, accompaniment to drive-in units for swabs, training on personal hygiene and the use of communal spaces, contact with and the reporting of vulnerabilities to Local Council Services (Social-Care Operations Unit, Immigration Office, anti-violence network). In addition the Team has continued to provide job placements for users despite the strong bureaucratic difficulties which the closure of public offices has caused with respect to requesting the registration of residence, registration at employment centres, company interviews and the initiation of internships. On the other hand, face-to-face or remote psychological support activities have been enhanced and an ad-hoc service for the provision of emotional support conducted in the language of the assisted person has been activated for female victims of gender-based violence who have contracted COVID-19 and for persons living in hotels allotted to victims of the virus.

The staff and the health-care and social welfare operations were transferred to public spaces, enhancing the work of the mobile team, already active since 2016 in its partnership with UNICEF. The activities introduced aimed at monitoring places of high interest with respect to the vulnerable migrant population and comprised an orientation towards health-care and social welfare services and activities relating to child protection and health promotion in the housing occupations in the south-east area of Rome.
The INTERSOS24 centre has also been transformed into a logistics hub with spaces dedicated to the storage of material and the preparation of kits to be distributed on the road and, above all, with the creation of ‘dirty/clean’ areas for the staff's clothing and equipment in order to ensure full compliance with safety protocols.

This new role of the centre has also favoured completion of the renovation works on the upper floor of the structure, where over 600 square meters will be used as workshops. The social tailoring cooperative was started in September with women forming part of the Cygnus association who participated in the social welfare, educational and training courses organised by INTERSOS24.

Starting from experience gained in the field and to align the procedures, in July the staff also organised social welfare and health training courses, held face-to-face and remotely for all the staff of INTERSOS24 in Rome and of the IntersosLAB centre in the Ottavia district.

All networking activities with civil society organisations, informal groups and various local entities were also intensified and support was provided to the offices of the Municipality of Rome and the Local Health-Care Authority to assist in dealing with the emergency, initiating joint initiatives concerning health-care, networking and training. The dialogue and support activity relating to the Municipality of Rome resulted in the signing of various protocols, on the basis of which INTERSOS has performed and will carry out the following activities.

**Specific training** on the basic principles of prevention and control of SARS-Cov-2 for male and female operators at the accommodation centres.

**Medical triage** for an assessment of COVID-19 risks at three ‘bridge’ structures for prudential isolation aimed at inclusion in the SIPROIMI.

The drafting of a proposal for ‘Guidelines for reception facilities in the COVID-19 health emergency period’ which will be presented to the competent Local Health-Care Authorities and to the Municipality for approval and integration; The Guidelines, in their final version, will be presented to the Centres and adopted by the City of Rome in local services for the purpose of ensuring uniform procedures and clearly defined health-care provisions aimed at reopening the reception facilities in the Centres which were unable to operate during the medical emergency.

**Drafting of a guide and training courses** on the assessment of the risk of COVID-19 infection for the ‘street unit’ service of the Social-Care Operations Unit of the Municipality of Rome.
workers and is enriched by highly specialised professionals, including physicians, cultural mediators, psychologists and social operators, who, in a versatile and multidisciplinary way, produce ad-hoc interventions. A constant and versatile presence in the principal places of interest (informal settlements, social spaces, railway stations) and the existence of a physical space which the target population and the institutions recognise and are aware of has undoubtedly represented a fundamental premise for the capacity to provide - also in emergencies - concrete and equitable responses to basic needs. From the very beginning of the intervention to the present the mobile teams have intercepted and supported 1,583 people through medical examinations and health-care training sessions.

To cope with its various needs the Team has also distributed various types of Kits to the intercepted population according to the needs that are identified. The materials provided also include dispenser columns for hand sanitisation placed at the entrances of the buildings used as dwellings involved in the intervention and about 500 litres of disinfectants for the sanitisation of communal areas. Distribution began in September and is still ongoing.

To achieve this goal on the part of the teams involved in interventions to combat COVID-19 the first step was to ensure a continuous presence in the local territory of the teams formed by individuals capable of responding to the different needs of beneficiaries and adopting a multidisciplinary approach. Thanks to these two elements it was thus possible to easily modulate the response on the basis of emerging needs. For some time now the INTERSOS mobile team, which has been acting together with UNICEF since 2016, has in fact been the cornerstone of a constant monitoring of the main needs of vulnerable population groups in the capital city. These requirements include the need for safe spaces for Unaccompanied Foreign Minors (UFM) in transit, medical examinations in the most seriously deprived contexts of the city and support for women and children exposed to sexual and gender-based violence. Thus, the core of the Team comprises a central nucleus of humanitarian
4 different KITs have been created and distributed:

**HOME HYGIENE KIT:** distributed to families or individuals in fiduciary isolation. The Kit contains: a guide focusing on cleaning and sanitising spaces (translated into 6 languages), a ‘Covid FAQ’ information brochure, a degreaser, soap, bleach, gloves, a cleaning cloth, a floor rag, a bucket, denatured alcohol, floor cleaning detergent, hand alcohol, laundry disinfectant and surgical masks.

**BABY KIT:** distributed to children in isolation to work on emotional decompression and promote adherence to the isolation measure. The Kit contains: an illustrated COVID-19 information brochure, soap and hand-sanitiser gel, a reusable cup, disposable napkins, woodland animal gel holder, notebooks, pens, paints, colouring book, puppets.

**WOMEN’S KIT:** distributed to single women or to families. The Kit contains: an information brochure and useful numbers relating to gender violence, a multilingual ‘Covid FAQ’ brochure, soap, toothbrush, toothpaste, napkins and cleansers for intimate hygiene, disinfectant gel, masks, female and male condoms and a pouch with nail polish, nail clippers and files, tampons.

**HOMELESS KIT:** distributed to men who are homeless or in a condition of socio-economic vulnerability. The Kit contains: multilingual sources of information, soap, toothbrush, toothpaste, deodorant, comb, napkins and disinfectant gel, disposable razor blades, surgical masks, male condoms.

In addition, distribution of the ‘COVID-19 POSITIVE KITS’ will start in December. This material will be delivered to positive COVID-19 patients that we follow during medical examinations in the various contexts. The Kit contains: information concerning the COVID virus and a health-parameter self-assessment sheet, an oximeter, a thermometer, individualised treatment, gels and disinfectants for personal use and surface-cleaning, FFP2 masks.
SUPPORT FOR TERRITORIAL HEALTH-CARE SERVICES

Territorial health care, the strong point for an effective and sustainable management of public health, is in fact not accessible for a number of vulnerable people. From March to August INTERSOS health teams followed about 250 people with no registered residence (and, therefore, not having the possibility to be supported by a general practitioner), people with 'Non-Registered European' or the 'Foreign Subject Temporarily Present' status who live in autonomous dwellings or in particular marginal situations (public housing, overcrowded homes) and fragile people without any type of territorial reference. These people were supported by means of indications regarding the evaluation of symptoms and risk situations: medical examinations and reporting to the Prevention Departments of the relative Local Health-Care Authorities for inclusion in surveillance measures; admission to 'medical-care' hotels or protected structures; secure accompaniment to 'drive-in' units for fragile people without any private means of their own. In this regard, it is important to underline the lack of ‘walk-in’ facilities, which has led to the improper use of public transport for many people who have to reach the local ‘drive-in’ units.

250
service orientation for people presenting symptoms

12
fragile COVID-19 positive families reported to the Prevention Departments and followed according to the medical case-management procedures

36
suspected or positive cases accompanied to the drive-in sites

*data referring to the period March - August
THE EXPERIENCE IN THE OCCUPIED BUILDINGS

EMPOWERMENT

a process whereby people gradually become better organised in order to improve the level of control which, as subjects and as a community, they can exercise over the social and political determinants of health. Especially the more seriously deprived communities, being more exposed to numerous social determinants of disease, benefit from participatory approaches in health management.

One of the main health risk factors is undoubtedly precariousness with respect to housing and accommodation. It is for this reason that the INTERSOS health-care and social welfare teams have been implementing empowerment and community participation intervention schemes for people in occupied buildings since 2018. A substantial part of this population is in fact exposed to various factors of marginalisation, such as the lack of work or precarious or undeclared employment. To these common factors are added further difficulties for the migrant population in irregular conditions and for asylum seekers. During these months of intervention the INTERSOS teams have intervened in various occupied buildings in the territorial district of Rome and in two of these they have initiated an authentic participatory process for medical surveillance and the promotion of good health. The two occupied buildings are located in the south-east suburban district of Rome and provide accommodation to more than 500 people. The groups include elderly individuals, cancer patients and also women and children, single men and Italian and foreign families with numerous chronic diseases. About 45% of the occupiers in the two settlements do not have the support of a GP or a paediatrician of their own choice.

Training activities and community involvement

Thanks to familiarity acquired and mutual trust established during health-promotion activities carried out in the pre-COVID-19 era it was initially possible to activate a schedule of medical check-ups and, subsequently, to set up training sessions for community health-care operators (health-promotion activists) identified within the communities. These activities, which took place in July and August, in addition to representing an
occasion of practical and direct training, allowed for shared reflection that led to the co-planning of paths and procedures for managing the risk of infection.

Forms of interventions conceived and planned by the community for the community.

The procedure was also an opportunity to become aware of doubts and fears at both the personal and community level. The assessment of needs as a whole and a reinterpretation of rules and risk factors from two points of view (that of health-care professionals and that of the community itself) has allowed for the identification of criticalities and strengths, transforming the latter into protective factors for the community.

In each of the two sites **seven training and shared reflection meetings** were held for health promoters. These sessions were attended by **25 people**, aged between 25 and 56, from Peru, Ecuador, Morocco, the Dominican Republic, Egypt, Bangladesh, Senegal, Italy and Eritrea.

The training sessions covered a wide range of issues relating to COVID-19: the nature of the disease; prevention measures and terminology related to the medical emergency, sources from which information on the topic may be obtained, the emotional repercussions in general and specific repercussions in children, and to the point of reaching a collective elaboration of internal procedures regarding isolation, prevention and sanitisation pre- and post-contact with positive people. These topics were dealt with in a participatory, cross-cultural manner with the assistance of cultural and general mediators and with tools facilitating a shared understanding and reflection. In general, all of the meetings have always aimed at preparing the communities by systematically **valorising and rationalising their strengths** and constantly maintaining a channel of communication and the sharing of experiences with the Complex Operative Unit (UOC) dedicated to Health Protection of Migrants and Foreign citizens of the RM2 Local Health-Care Authority.

During the period between May and August the objective was to **prepare an intervention plan in view of a new wave** that was expected to occur in the Autumn. The actors involved were on the one hand the community health-care representatives and, on the other hand, operators of the Complex Operative Unit (UOC) dedicated to Health Protection of the RM2 Local Health-Care Authority. The tools available for this intervention plan were: the implementation of a dialogue between the community and the health-care institution, albeit with a lack of regional operational guidelines and adequate infrastructures (an insufficient number of COVID19 hotels); ‘proximity care’ and, that is, home-based health assessments and listening to the community; valorisation of the ‘self-organisation’ capacity of the community itself, working towards valid solutions in terms of public health.
Health-care intervention to combat COVID-19

In the two settlements 42 health-care interventions were implemented between March and October, with a total of 450 medical examinations. With regard to the epidemiological trend it is interesting to note that in the relative community, from March to July, only 3 suspected cases were identified and these subjects were subsequently found to be negative following a swab test. However, from August to October, in accordance with the regional and national epidemiological trend, the number of cases drastically increased and the scenario completely changed.

In fact, starting from the end of August, with the identification of the first positive cases within the first community, INTERSOS has facilitated the connection between the Complex Operative Unit (UOC) dedicated to the Health Protection of Migrants of the RM2 Local Health-Care Authority and the community health-care operators for the joint definition of management methods of health surveillance. Alongside this virtuous dialogue, which subsequently continued also independently, INTERSOS guaranteed several sessions of medical examinations and the clinical and emotional management of individual cases, always in conjunction with the RM2 Local Health-Care Authority (Complex Operative Unit dedicated to the Health Protection of Migrants and the RM2 Hygiene and Public Health-Care Service) and with GPs and freely-chosen paediatricians (when present).

In fact, each week an INTERSOS physician and nurse guaranteed home-based medical check-ups and daily telephone contact. In addition, oximeters and thermometers and also multilingual explanatory brochures were also delivered when the clinical situation required this action.

For each of the two communities the health-care operators, adequately trained with respect to prevention measures and the control of infection, focused on relations with the male and female operators of the Local Health-Care Authority. They also provided their services to individuals in isolation, managing not only the bi-directional communication of needs (between patients and health professionals and vice versa) but also coordinating mutualist practices which the movement the sites are a part of had put in place, such as self-organisation in the distribution of food and basic necessities.

In the group of people recognised as COVID-19 positive only 4 required hospitalisation and 8 were transferred to a COVID-19 hotel.

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**450**

medical examinations carried out between March and October

**125** *

people in home isolation were visited and examined

**88** *

people positive to COVID-19 were visited and examined

**43** *

people positive to COVID-19 were followed in a ‘case-management’ process

*dati riferiti al periodo settembre - ottobre*
The surveillance measures implemented may be defined as occurring on a ‘concentric circle’ basis. In practical terms this means that for each suspected case identified the tracing of close contacts was carried out, both inside and outside the building. Each close contact was informed of the occurrence of contact and was interviewed or checked, isolated and monitored to verify any appearance of symptoms both during face-to-face meetings and remote telephone contacts.

It is interesting to underline how the management of the surveillance and the containment of the epidemic was coordinated by a multidimensional group made up of Local Health-Care Authority operators, community operators and the INTERSOS team. More specifically, the Local Health-Care Authority operators dedicated to the specific population target coordinated actions through contact with and the participation of the community operators, who, in turn, were supported from an operational point of view by the INTERSOS multidisciplinary team, which provided health-care personnel for home assessments, a psychologist for remote psychological support and a cultural mediation service.

Furthermore, the INTERSOS team provided constant support to the health-care operators by following them in the process of developing the instruments necessary to deal with the various situations. In this regard, an extremely virtuous example of management of the epidemic was the ability to self-organise which the community promoted in the absence of institutional solutions, in order to cope with the risk factors linked to the architectural characteristics of spaces. In fact, one of the two buildings is fitted with toilets shared by several tenants. This element led to the transfer to the COVID-19 hotel of the first positive people encountered. However, the availability of places was rapidly reduced and became unsustainable. The community representatives, supported by the INTERSOS health-care staff and thanks to the mobilisation of the community itself, reorganised the larger space that the building has available, dividing it into housing modules which could accommodate two families and 5 single people. This area of the building, which has been called the ‘isolation space’, is fitted with toilets and overlooks a large outdoor area far from access points open to the rest of the community.

“The women with small children or the lady with a child affected by Down Syndrome would otherwise have been forced to remain alone in a space of just a few square meters and in poorly ventilated rooms, reflecting only on their problems and worries, or to move to an unknown location, with the double malaise of experiencing a period of illness and having to cope with it alone and far from their family environment. The isolation space, on the other hand, allows people who already know each other to share this difficult moment, supporting and assisting each other, and even for the sole reason their children can thus play together.”

M., Community health-care operator
Thanks also to this process it was possible to support the Department of Social Policies (with particular reference to the Immigration Office) and the RM2 Local Health-Care Authority (Prevention Department and the Complex Operative Unit dedicated to Health Protection) in the creation of a ‘Bridge Centre’, called Barzilai, for the fiduciary isolation of people applying for reception in the SIPROIMI system.

In fact the establishment of this type of reception in August allowed for the safe reopening of shelters (for men and women approved as beneficiaries of protection) which were otherwise suspended due to a lack of prevention measures, as in the case of all other shelters, starting from March 2020.

10 accommodation centres were involved in the training activities, for a total of 60 male and female operators. The training course, in addition to responding to the need for a response and clearly identified procedures on the part of the operators of the centres, was a precious opportunity to further map the needs of the population receiving the INTERSOS health-care and social welfare intervention, as well as an opportunity to set up a model of health surveillance and health-care and social welfare assistance which the institutions have not established.
Although the shelters were formally suspended in March with a circular issued by the Council of the City of Rome, some circuits have remained permeable (SOS Health Emergency and reception of UFMs), while others, starting from June, have resumed the sheltering service, organising themselves independently where they have had the possibility to provide for isolation in single rooms with a bathroom.

The INTERSOS health-care team supported these circuits by means of: medical examinations for COVID19 risk assessment for new entrants; reports submitted to the relative prevention department for admission and the administration of nasal and pharyngeal swabs for the identification of Sars-Cov-2; monitoring of health conditions during the period of isolation carried out in single rooms with a bathroom.

In this regard 4 centres are currently supported (besides the Barzilai ‘bridge centre’). This activity made it possible to carry out a screening of a vulnerable part of the population and to intercept COVID-19 positive subjects, also in the absence of symptoms or known epidemiological links. Positive subjects have been transferred by the RM2 Local Health-Care Authority to COVID-19 hotels and, when necessary, have had access to psychological support and cultural mediation provided by the INTERSOS staff.
The experience of the COVID-19 epidemic is highlighting in an exceptional way the extent to which health and choices made that affect its protection are interconnected, multi-sectoral and complex. Suffice it to consider, for example, the degree to which the lockdown and restrictions imposed to control the spread of the epidemic are strongly influencing economic dynamics and areas related to work and scholastic activities, and also how clearly vulnerabilities related to transportation and infrastructures are emerging. However, the critical issues that are emerging in a more worrying manner concern the public health service and highlight the increasingly urgent need for forms of reorganisation which will facilitate intervention aimed at strengthening territorial and also hospital-based assistance. In this regard the experience of the INTERSOS mobile teams in Rome may be seen as a pilot scheme of territorial assistance which is integrated (social, public and private sectors), transcultural (involving both Italian and foreign populations in a marginalised situation), multidisciplinary and based on community involvement.
Good Practices

A mobile health-care team in close collaboration with the Prevention Departments performs a home-based assessment of the health and social needs of individuals and households.

**EFFECTS**

Persons otherwise excluded from health-care monitoring (for example, ‘Foreign Subject Temporarily Present’ status or without the support of a general practitioner) have entered into paths of diagnosis and treatment for COVID-19, avoiding the use of inappropriate solutions (recourse to emergency departments) and their right to treatment has been respected.

People affected by COVID-19 with mild symptoms are managed at home and access sub-intensive or intensive services only when necessary on the basis of the clinical assessments that are carried out. The physical presence of or telephone contact with health workers improves the patients' ability to self-manage the disease at home and consequently their adherence to isolation measures.

The Prevention Department benefits from 'territorial sentinels' for early detection, for the management and assessments relating to 'contact tracing' and control of the infection in closed or vulnerable communities.

Mitigation of critical issues related to administrative and bureaucratic difficulties (delays in the sharing of medical reports, delays in the drafting of illness certificates and similar documents) through the possibility of direct interaction between physicians, patients and Local Health-Care Authority.

Patients in the area, patients who have benefited from integrated and proximity management have had the advantage of clear instructions and access to direct communication channels with the Complex Operative Unit (UOC) and with the Prevention Department with regard to procedures, timing of isolation and disease management.
Activation of communities and support for the creation of competent groups for the health management of the epidemic in organised informal settlements.

**EFFECTS**

Creation of a control room unit formed by operators of the health-care institution, community operators and INTERSOS for the participatory evaluation of the measures to be implemented in order to manage the outbreaks.

The community has had the opportunity to negotiate with the Department the measures to be implemented to contain the infection in vulnerable contexts.

The Department has been able to modulate the measures to be implemented for the management of outbreaks, benefiting from a relationship with the community itself, its capacity for self-management, its cohesion and its specific competence on the subject.

In particular, it is important to underline how the latter example may be seen as a litmus test of the effects that proximity management of the epidemic may have, not only on communities in vulnerable conditions but also with respect to the entire territory. In other words, the informal organised settlements with which INTERSOS has worked are in fact small communities in which it has been possible to experiment, adopting practices offering an alternative to total lockdown. The outbreaks that have affected them, in fact, were managed on a 'concentric circle' basis and, that is, it was possible to immediately isolate close contacts of positive people. Moreover (in some cases), it was decided to arrange isolation only for children of school age and for people who carry out care work and so on.

This has been possible thanks to the proximity factor at the settlements, a condition which, in turn, has allowed for the training of competent operators. Thanks to these elements the health-care authority, oriented towards the valorisation of attending to community needs and supported by the presence of medical assistance in the field, has been able to modulate and monitor the action undertaken.

We may thus state that, in fact, the restrictive measures are also the result of a lack of capacity to establish a dialogue with the various areas in question, construed not only as health-care districts but also as spaces inhabited by citizens.

A virtuous vision of proximity medicine thus aims at valorising the territorial health-care network and the experiences of establishing contact, co-planning and rendering patients and citizens responsible for their action. In this sense, virtuous experiences may be identified in the micro areas of Trieste or at the Casa della Salute delle Piagge (Florence), not only as far as the epidemic is concerned but also on account of the fair, effective and sustainable management of chronic diseases, the management of prevention campaigns and the promotion of health in general.
Prudential isolation centres for the safe reopening of shelters in the territory of the City of Rome.

**EFFECTS**

The opening of the ‘bridge centre’ for the prudential isolation of persons who are candidates for reception in SIPROIMI system, albeit with a lack of clear regional operational indications, has made it possible to **reactivate an essential service**, which, at the same time, becomes a precedent for the extension of the practice to other types of reception.

The presence of a health-care team of reference allows for the performance of **risk assessments in the initial phase** and also for the possibility to have a medical operator who will monitor the progress of isolation and any other basic underlying forms of pathology.

Support for health surveillance in accommodation centres, training for operators and medical examinations for risk assessment.

**EFFECTS**

The fact that operators are physically reached by qualified health-care professionals for the sharing of standard information on the management and control of infectious diseases has increased adherence to procedures, has mitigated feelings of insecurity and has improved adherence to procedures.

From the bottom upwards, the uniformity of practices relating to new reception events and to the management of suspect cases.

Testing of an integrated health-care and social welfare system for the management of the epidemic in reception centres.

Starting from resources available in the community itself (from points of contact of the community and operators at accommodation centres) the proximity and community participation approaches have in fact made it possible to overcome institutional deficiencies which remain clearly evident as unresolved issues. On the other hand, the pandemic has allowed for an acceleration of the experimentation of integrated and territorial organisational approaches that have proved to be particularly effective if applied to ‘hard-to-reach’ populations and would generally be desirable for care and health practices for the population in general.
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