AN UNEQUAL PANDEMIC

The Proximity Public Health interventions carried out by INTERSOS in informal settlements in Italy during the COVID-19 emergency
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EXECUTIVE SUMMARY
Executive summary


INTERSOS has been active in Italy since 2011, with various projects aimed at the protection and implementation of the right to health of people living in conditions of severe social exclusion, with the aim of achieving their full inclusion into the public health service. The spread of the SARS-CoV2 infection and the health, social and economic crisis that followed, created the urgent need to build prevention, monitoring and referral interventions that could be adequate and sustainable in contexts of extreme social marginality. In collaboration with local institutions and Regional Health Services (Servizi Sanitari Regionali), INTERSOS immediately started to reshape its ongoing projects. At the end of February in the province of Foggia (Capitanata), the project was re-adapted to strengthen the prevention and monitoring activities of seasonal workers in agriculture living in informal settlements. During the first stages this was made possible thanks to private donations; starting from the end of March 2020, the European Commission’s Emergency AMIF funds1 under the project “Su.Pr.Eme. Italia”2 secured the ongoing work. The project in Rome was also readapted to the unfolding pandemic; at the beginning of March the activities of the INTERSOS24 center were converted to meet the current health needs; two mobile health teams were set up to conduct outreach activities in partnership with UNICEF, carrying out COVID-19 risk assessment with homeless populations in informal urban settlements and in housing squats. This was carried out within the project: UNICEF & INTERSOS intervention for the care, support and skills development of refugee and migrant children in Italy. Projects with the same objectives were also launched in Ionian Calabria (provinces of Crotone and Cosenza) and in Sicily (provinces of Syracuse and Trapani) in informal rural settlements inhabited mainly by agricultural workers with a migratory background. This was made possible thanks to co-financing from the European Commission’s Emergency AMIF funds under the “Su.Pr.Eme. Italia” project. The operational methods that were used for the reconversion of existing INTERSOS projects and the launch of new ones during the COVID-19 emergency aimed at implementing prevention measures, monitoring and supporting with case management and referral. These methods were also adapted to best protect the health of population groups that, due to their lack of means and difficulties in accessing resources, are more exposed to -and more affected by-

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1 The project has been funded with support from the European Commission. This publication reflects the opinion of INTERSOS only and the European Commission cannot be held responsible in any way for its content.

2 The SU.PR.EME. (the South as a major Player in overcoming Crises within the context of severe labour exploitation and the marginality of migrant citizens legally residing in the 5 least developed regions of Italy) Italia Programme is funded by the AMIF – Emergency Funds (AF2019) of the European Commission – DG Migration and Home Affairs, in partnership with the Ministry of Labour and Social Policies and the regional governments of Apulia, Basilicata, Calabria, Campania and Sicily.
the spread of COVID-19. Indeed, these groups are also more “hard to reach” by the health system. The protection of the health of migrants and of the most vulnerable populations is fundamental for public health. It must be guaranteed by social and health policies, both because the right to health is a fundamental and inalienable right of people, but also and above all because protecting the health of the most vulnerable means defending that of the entire community.

FIG. 1 • CONVERSION OF EXISTING INTERSOS PROJECTS AND LAUNCH OF NEW ONES FOR COVID-19 OPERATIONS

2020

Province of Foggia (s.c. Capitanata), from February 26 2020, ongoing
Strengthening prevention and monitoring activities in informal settlements for seasonal workers in agriculture. During the first stages this work was supported by private donations; starting from the end of March 2020, the European Commission’s Emergency AMIF funds under the project “Su. Pr. Em. Italia” secured the ongoing work.

Rome, Beginning of March 2020, ongoing
Conversion of activities of the INTERSOS24 center; two mobile health teams were set up to conduct outreach activities in partnership with UNICEF, carrying out COVID-19 risk assessment with homeless populations in informal urban settlements and in housing squats. This was carried out within the project: UNICEF & INTERSOS intervention for the care, support and skills development of refugee and migrant children in Italy.

East Sicily, June and July 2020
Launch of a project through the support of the European Commission’s AMIF emergency funds.

East Sicily, June and July 2020
Launch of a project through the support of the European Commission’s AMIF emergency funds.

West Sicily, November and December 2020
Launch of a project through the support of the European Commission’s AMIF emergency funds.
There were many ministerial decrees and procedures that were issued to contain the spread of COVID-19, but there was no trace of measures or guidelines to safeguard the health of homeless people, of people housed in shelters or of people working in these contexts. The only non-binding operational guidelines in this regard appeared late, at the end of July. This happened also because of the advocacy of involved networks and organizations from the service sector, including INTERSOS.

There was also very little trace of an adequate and effective reorganization of the community health assistance system, which should have been carried out with the aim of implementing medical supervision and home management for less serious cases. Even just by taking into account the established methods for measuring the severity of the pandemic in Italy, the phenomenon is evaluated through a “hospital-centric” approach, for example by counting the increase in the number of patients accessing intensive care units.

Finally, there was no trace of a plan to boost health and social services to tailor them to the specific needs of different sections of the population, which could have been achieved, for example, by focusing on proximity (as will be defined in the next paragraphs) and equity.

What prevailed were inequitable emergency measures, which lacked a socially sensitive approach to healthcare and were, therefore, inevitably fragmentary. Some of the most worrying elements, however, concern the public health service. These observations highlight the increasingly urgent need for a reorganization that can favor interventions aimed at strengthening local social and health services as well as hospital care.

The work presented here by the mobile teams of INTERSOS in the four regions can be read as a pilot experience; it takes an integrated and local approach (through public-private social assistance) in varied contexts (urban and rural), it’s transcultural (involving both Italian and foreign populations in conditions of marginality), multidisciplinary and based on community involvement. The organized informal settlements with which INTERSOS has worked are in fact small communities, often particularly mobile, in which it has been possible to experiment with alternative practices to total lockdown. The outbreaks that have affected them, in fact, have been managed “in concentric circles”. It was possible to immediately isolate the close contacts of people who tested positive through an analysis of the relationship between the two categories of people, and by anticipating the direction of the spread that might take place through the close contacts. This analysis could not have been achieved without a significant community participation.

Indeed, INTERSOS has chosen to develop its interventions through a focus on Proximity Public Health (PPH). In the words of Baglio, Eugeni and Geraci, who are among the main proponents of this framework, proximity public health is defined as “the complex of relations between public institutions, private social organizations and communities present in a given territory, aimed at promoting access to prevention and care resources through the active provision of healthcare outside clinical settings (outreach), the reorientation of healthcare services with a view to greater permeability and usability (system mediation) and the involvement of the population in empowerment processes.”

It has been possible to implement this model through our staff’s physical proximity to the settlements. This made it also possible to train competent medical contact persons directly from the community.
Working methods in the COVID-19 Emergency Projects

ORGANIZING THE WORK

In response to the needs that emerged when the pandemic broke out, INTERSOS promptly reorganized its work, strengthening the staff that was already active in Rome and the province of Foggia and opening up new projects. The need to expand or build teams in the midst of a health emergency imposed very tight deadlines for the recruitment of personnel that could be ready to work in multidisciplinary teams in unstructured contexts. The teams integrated various professional figures: doctors, linguistic-cultural mediators, social and health workers, educators, nurses, psychologists, health promoters, legal practitioners, all of which were coordinated by project managers.

intersos developed Standard Operating Procedures (SOPs), which have been used as a guide for staff with regard to hygiene and health procedures, safety and methods of intervention at all stages. The Rome, Foggia province, Ionian Calabria and Sicily teams counted a total of 35 active staff members in the field so far, with 7 mobile units.

The organization of the staff’s work is based on a daily briefing and debriefing, and a weekly meeting for coordination and collective processing, which included the emotional aspect of the job. It also included regular cycles of internal training, which can be understood as a process of constant learning and building interdisciplinary, action-oriented knowledge. The four INTERSOS teams involved in the COVID-19 emergency took part in a research study on the wellbeing of humanitarian workers, with a focus on mental health and on the impact of the COVID-19 emergency on the lives of those working in emergency contexts and severe social exclusion. This study, which is outlined in the appendix of this report, aimed to explore our personnel’s experiences in relation to their work. Indeed, it also created a space for discussion where the people involved could reflect as a group on the progress of the operation, their feelings, and their experiences.

FIG. 2 • SITES OF THE INTERVENTION AND RESOURCES MOBILIZED BY INTERSOS

<table>
<thead>
<tr>
<th>Team</th>
<th>Mobile units</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rome</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Capitanata</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Ionian Calabria</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Sicily</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>(East Sicily)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(West Sicily)</td>
<td>2</td>
</tr>
</tbody>
</table>
INTERSOS’ approach to setting up projects with the community is based on the key principles of promoting health and protecting it as a right. This is achieved by operating on multiple levels to bring together communities’ participation in defining their own needs and interventions on one side, and institutional advocacy for the right to health on the other. WHO states that health promotion is an indispensable strategy in a pandemic context; the Organization recommends ensuring community involvement to improve responsiveness, emphasizing the role of individuals and communities in protecting their own health. Operations with communities involved in INTERSOS’ projects have been developed along the following guidelines:

- **to ensure the presence and continuity of social-health projects** in contexts of strong social exclusion; as the pandemic spread, the people that were supported through the project experienced growing isolation, which resulted in an increase in their needs;

- **to build operational methods for the prevention and monitoring of the SARS-CoV2 epidemic that could be appropriate to the contexts of intervention** and at the same time acceptable for populations living in conditions of extreme marginality. In such contexts, the implementation of the most essential prevention measures (from keeping up the recommended hygienic-sanitary conditions to physical distancing) is impossible due to living conditions marked by extremely limited resources (precariousness, overcrowding, exclusion and poor access to services, vulnerability to blackmail, violence and exploitation);

- **to prepare ad-hoc plans for health promotion**, and train health promoters within the population of the communities in the squats in Rome, who then became qualified contact persons (referred to in the project as health promoters);

- **to strengthen institutional collaboration with the public health service**, through the Proximity Public Health (PPH) approach, developing structures and strengthening networks that foster health promotion in the contexts that are most difficult to reach by local health institutions.

The implementation of the intervention posed the need to integrate working conditions that would protect the staff from the risks posed by the epidemic with the adoption of operational methods that would be understood and accepted by the populations with whom they work. This need was met by INTERSOS standard procedures through “confidentiality in safety”, using clothing that would be easy to sanitize but at the same time did not look medical or evoke hospital contexts. Multi-disciplinary staff prepared information sessions on the COVID-19 emergency based on elements that had been brought up by the communities through focus groups, or on the experience gained through many years in the field. These sessions were carried out by integrating health, social and cultural mediation skills and by defining key messages regarding the disease and its management to be shared with the communities.

In addition to the information sessions and all the actions, pre-triage and health screening activities were carried out for the early detection of cases at risk for SARS-CoV2 infection. The medical evaluation of risk criteria was carried out through a tool developed by INTERSOS, which allows the monitoring of the patient while in self-quarantine at home or in dedicated facilities, and the activation of the procedures for the execution of nasopharyngeal swabs in accordance with agreements made with local health authorities. An analysis on the impact of the pandemic on people’s lives, in terms of psycho-social wellbeing, was also carried out. The qualitative and quantitative survey was conducted thanks to the integration of testing tools.
EXECUTIVE SUMMARY - AN UNEQUAL PANDEMIC

The WHO Quality of Life-BREF and the Impact Event Scale-Revised), interviews and focus groups; the aim was to better understand the impact of the emergency situation linked to COVID-19 on the quality of life and mental health of people living in conditions of social exclusion.

INTERSOS interventions in Rome, Province of Foggia, Ionian Calabria and Eastern Sicily in the period between March and October 2020 reached 3,639 people, with 4,188 hygiene kits delivered, 3,269 people provided with health education sessions, 1,680 people monitored for COVID-19 risk, 227 people accompanied to relevant health services, carrying out full case management.

WITH NATIONAL AND LOCAL INSTITUTIONS

INTERSOS pursued an approach to local and national institutions that combines advocacy with operational collaboration between the public and private sectors. The guiding principle was to support health services and public policies while raising awareness on the existing critical issues and shortcomings, emphasizing the contexts institutions should be aware of, as well as the measures they must take in order to fully protect the health of individuals and communities. The advocacy actions highlighted some aspects that required urgent institutional response, such as the degrading conditions that marginalized people suffer from, and the absence of national guidelines for the management of the SARS-CoV2 epidemic in such contexts. In order to protect the health of individuals and communities, it is essential to include the most marginalized populations in the process of defining public policies. These populations, faced with complex health needs, have limited access to resources and services, limited protection, and consequently greater exposure to health risk factors. This, in turn, amplifies social and health inequalities.

INTERSOS interventions were planned on the basis on the principle of subsidiarity, according to which social services and support should be provided primarily at the most immediate or local level, through local systems and associations, with central authorities exercising only a subsidiary function. This was done by establishing a collaboration with the Regional Health Systems (hereinafter RHS), through the local public health authorities (known as ASL) of Rome and Foggia, and the provincial public health authorities (known as ASP) of Syracuse, Trapani, Crotone and Cosenza; in the case of Rome also with the Municipality's Social Policy department. This principle foregrounds an alliance between the public institutional sector (which should be responsible for the governance aspect) and the sections of civil society that are engaged in protecting the health of the migrant population. Indeed, the latter should be seen as a valuable resource, as it can observe and report on the realization of the right to health from the field. With this vision, INTERSOS collaborated with local health institutions, contributing the skills built up through years of field work for the definition of
operational protocols. These integrated national provisions with a proximity public health approach, which focused on developing structures and strengthening networks to foster health promotion, aimed at the most hard to reach contexts. Our staff carried out training sessions on COVID-19-related risks at the Social Operations Room (SOS), a hub of emergency services set up to tackle social crises in the Municipality of Rome, which are still underway. This training, organized through systematic cycles, is based on a memorandum of understanding signed with the Department of Social Policies. Training cycles for private social workers were also carried out in the Province of Foggia (hereinafter Capitanata) and Ionian Calabria.

Key actions and accomplishments

ADVOCACY FOR GLOBAL HEALTH AND STRUCTURAL ACTIONS

INTERSOS has supported a number of advocacy actions directed at national and local institutions, which have brought attention to the need for urgent action by public institutions to adopt measures to prevent and contain the pandemic, particularly with regard to populations living in conditions of extreme marginalization. At the national level, the advocacy highlighted the urgent need to promote access to water, sanitation and waste removal in informal settlements, and campaigned for the provision of hygiene kits for preventive health care, and for facilities for fiduciary isolation and / or quarantine to be made available. Finally, it pushed for the removal of administrative barriers that hinder access to local health services in such contexts of social marginality. While crucial, these emergency interventions do not address the causes of exposure for people in informal settlements, the social causes which lead to the existence of such degrading contexts in the first place, and which put people at risk on numerous levels, in addition to COVID-19. From this standpoint, advocacy efforts highlighted the need to transfer people from informal settlements to appropriate reception facilities, with a suitable size to ensure compliance with preventive measures to combat the spread of SARS-CoV2, without any distinction based on legal status.

INTERSOS, along with other organizations, strongly objects to the use of quarantine ships for people who have just arrived to Italy by sea. These ships have been hosting people who tested positive for SARS-CoV2, as well as those who had not yet been tested, and people already living in reception centers, who were transferred onboard after testing positive; similarly, INTERSOS opposes the use of quarantine buses, a measure that in September 2020 affected 30 migrants in Udine, a measure that was taken with the aim of segregation rather than safeguard of public health. Finally, addressing urban housing precariousness and overcoming rural informal settlements is imperative to safeguarding individual and collective dignity and health, and requires complex multidisciplinary, multi-level and simultaneous approaches. The Capitanata Proximity Network (Rete di Prossimità della Capitanata), of which INTERSOS is a co-founder, makes suggestions on possible approaches for informal rural settlements inhabited by farm workers.

ADVOCACY FOR THE DEFINITION OF HEALTH PATHS AND COLLABORATION WITH LOCAL SERVICES

INTERSOS, along with a network of national actors, immediately raised the issue of the limited capacity of local services to respond to the needs of migrant populations and of those in vulnerable conditions. They also raised awareness on the extreme heterogeneity of responses adopted at the
Collaboration with health institutions and local public actors in all territories, has allowed for an increased impact of the prevention, monitoring of populations reached and the case management and referral of suspected or verified cases as well as of the people with risk conditions for COVID-19.

In the four regions, a model of health monitoring and follow up and social-health assistance has been developed and implemented to protect people who are homeless, or in conditions of vulnerability, or living in informal settlements; in Rome INTERSOS, in close collaboration with the competent ASL, implemented a timely strategy to support the city’s reception centers.

INTERSOS, along with other organizations belonging to the Immigration and Health Roundtable and the Asylum Roundtable, was consulted regarding the elaboration of the ‘Interim operational guidelines for the management of facilities with people in conditions of high fragility and social-health marginality in the context of the COVID-19 epidemic’ published on July 30 by the National Institute for Health, Migration and Poverty (NIHMP), and subsequently updated on October 20, 2020. Many critical issues remain in the management of COVID-19 risk in informal settlements, and the guidelines are applied in very different ways across the country.

Thanks to the collaboration between INTERSOS, the Department of Social Policies of the Municipality of Rome and the ASL RM2 (Department of Prevention and Unit for the Protection of immigrants and foreigners) an Bridge Center, called Barzilai, was established in July 2020 for the precautionary quarantine of people who were going to move into SAI reception centers for refugees and asylum seekers. To protect the health of guests and facility staff, it was necessary to establish an intermediate center, i.e., a safe place equipped with single rooms and private bathrooms in which to wait for the days necessary to ensure safe entry into the SAI service to which one is assigned, after having performed a nasopharyngeal swab test upon entry and exit. Since then, INTERSOS has been providing medical screening in that facility, complemented with other activities such as orientation to local services in response to emerging health needs.

The establishment of this bridge center has in fact allowed for the safe reopening of the reception system for men and women with international protection status, otherwise suspended for lack of prevention procedures, like all other shelters. Another crucial element was the establishment of another intermediate facility

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3 The SAI system, or System for Reception and Integration, is one of Italy’s reception systems, and can host refugees and asylum seekers. This system has been changed many times through the last years depending on governments’ political inclinations, and has had different acronyms, SIPROIMI (up until December 2020) and SPRAR. For the sake of clarity, the most updated acronym SAI will be used almost exclusively in this report.
for single women or families waiting for a buffer or who need a protected place for quarantine/isolation before moving into the SAI system.

This Bridge Center, called “Casa Bakhita”, was activated in January 2021, again through a protocol between the Department of Social Policies of the Municipality of Rome and ASL RM2 (Unit for the Protection of Immigrants and Foreigners) with the support of INTERSOS for triage and health care.

PREVENTION, MONITORING, CLINICAL RISK ASSESSMENT AND CASE MANAGEMENT FOR PEOPLE AT RISK OF COVID-19

Health education and health promotion were at the foundation of the interventions with communities, and from the earliest stages they aimed to reach the entirety of the target populations. The teams have carried out cycles of health education on COVID-19 and on the changing norms, with the support of multilingual information materials, in paper and video form, and providing basic tools aimed at protecting the right to health and to orientation to public services. The identification and progressive involvement of people from the communities allowed rooting the prevention work within the communities. This strategy amplified knowledge on the pandemic and the perception of risk, while strengthening the collaborative relationship between staff and community. This has been the case of community mobilizers in Capitanata and health promoters in Rome. Moreover, in March 2021 two squats activated a Health Room for orientation to health services and COVID-19 risk management. Hygiene kit distributions were also organized in the 4 regions of intervention; in southern Italy this was done in collaboration with regional institutions. The purpose of the distributions, which varied according to the categories of recipients, was to provide immediate concrete support, albeit partial, for the implementation of prevention measures in contexts where it remains impossible to apply them in their entirety.

Clinical risk assessment and management protocols for COVID-19 have been implemented in collaboration with local health authorities and have provided guidelines for conducting pre-triage, triage and clinical assessment activities. Clinical activities in already active projects have been reorganized to protect the health of staff and beneficiaries: special mobile outpatient clinics have been set up, focusing on prevention activities and medical examinations for early screening of symptoms that might indicate COVID-19, contact tracing of suspected and confirmed cases, monitoring of patients who travelled or were otherwise exposed to risk. Continuity of care, orientation to local services and, in the case of the most fragile categories, in-person accompaniment to services was guaranteed. In particular for the contexts of Rome and Capitanata, it was essential to organize a system of contact tracing of ascertained cases with the
local Public Health services, in which linguistic-cultural mediators assumed a central role, thanks to the construction of collaborative relationships with the people concerned. In addition, INTERSOS staff collected and analyzed the socio-demographic and clinical data of individuals who were followed up on and monitored over time for COVID-19 risk. This was done if they presented at least one of the triage positivity criteria (travel to and/or from at-risk locations; exposure to confirmed cases, suspected cases, high-risk locations; symptoms of COVID-19) and if, in the absence of triage positivity criteria, they presented conditions of fragility such as known chronic conditions and/or declared vulnerability that needed closer follow-up. This quantitative data does not represent the totality of people who accessed the services offered by INTERSOS, but only those in states of increased risk of COVID-19.

In Rome, the people supported by the Mobile Team for COVID-19 risk from March to October amount to 615 (out of the 1,381 who had access to the service), prevalently men (70%), prevalently from Italy, Bangladesh, Senegal, Nigeria and Peru. Almost half of the sample population lives in housing squats (44.4%), while about a quarter (24.3%) are homeless. Moreover, they belong on average to a middle-aged to senior age group: half are over 42 years old, and a fifth are over 60 years old. It should be noted that 250 people (40.7%) have at least one known chronic pathological condition, a condition that is more frequent in the female population (48.3% of women compared to 37.7% of men). Among those affected, only 52% have an assigned a general practitioner. In addition, 32.8% of the population reports the presence of known vulnerabilities. With respect to COVID-19-related risks, upon medical evaluation, 430 people (70%) were clinically monitored, 180 underwent nasopharyngeal swabs (including 84 at the dedicated facility), and 5 refused to have the examination performed. Among those who underwent the test, 88 people tested positive for SARS-CoV2 (48.9% on swabs performed and 14.3% of the sample population) and 92 tested negative (51.1% on swabs performed and 15% of the sample population).

In Capitanata, 213 people were monitored for risk of COVID-19 from March to October, mainly men (almost 90%) living in the settlement of Borgo Mezzanone, where there was a peak in August. The countries of origin were mainly Senegal, Nigeria, Gambia and Mali; of the 24 women monitored for risk of COVID-19, 23 are from Nigeria. This sample describes a younger population than that of the Roman context: half of the subjects are young adults between 22 and 31 years of age, while those over 42 years of age reach almost 15%. On the other hand, the age distribution of the monitored women shows a tendency towards more advanced ages. The presence of known chronic pathological conditions affects 16% of the population, with a proportion that increases with age, although an important percentage (10%) is also found among young subjects under 32 years of age. The majority of women monitored for risk of COVID-19 had started being monitored because of their chronic pathological conditions, a figure that is consistent with a tendency for older age in this category of the sample population. This finding suggests that younger women are likely to have greater difficulty accessing the offered services, and this aspect may be related to social dynamics of control that they experience in such contexts, exacerbated by the fear and stigma attached to COVID-19, particularly in the most vulnerable groups.
According to medical evaluation, 77.5% of the people underwent monitoring of clinical conditions and 22.5% was offered nasopharyngeal swab. Of these persons, 30 underwent the test while 18 refused it. Among those who underwent the test, 21 tested positive for SARS-CoV2 (9.9% of the sample population) and 9 tested negative (4.2% of the sample population). Interestingly, among the people who refused the swab, 15 were exposed to the risk of contracting the virus but displayed no symptoms: this highlights the limited awareness of the disease, particularly in the absence of manifest signs; it also illustrates the difficulty of a part of the population in perceiving COVID-19 as a priority, when living in a context so widely determined by issues that appear more urgent, a point that is also made in the research on the impact of COVID-19 on the quality of life of people living in contexts of social exclusion.

FIG. 4 • CAPITANATA, BREAKDOWN OF MONITORED POPULATION

68 PEOPLE

In Ionian Calabria, the people monitored for risk of COVID-19 from April to July are 68 (out of the 338 who came for examination), of which 7 are women and 61 are men. The main countries of origin are Nigeria, Morocco, Senegal, and The Gambia. The population primarily consists of young adults, about 18% being older than 42. People who report suffering from at least one chronic condition are about one third, with a proportion that increases with age and becomes significant at as early as 32 years of age. A third of the population also reports experiencing conditions of vulnerability.

55.9% had at least one element that could be linked to positivity at triage, while the remaining 44.1% were followed and monitored for risk of COVID-19 because of the presence of known chronic conditions or vulnerabilities. The entirety of the population was monitored for clinical conditions, including two individuals who refused to take the swab as advised.

FIG. 5 • IONIAN CALABRIA, BREAKDOWN OF MONITORED POPULATION

This data highlights an important share of known conditions of vulnerability and fragility, which are already likely to be underestimated, found in populations living in conditions of extreme deprivation; these conditions gradually erode the state of health, and are at the basis for the development of both communicable and non-communicable diseases. In addition, as is known in the literature and confirmed by socio-demographic data, these populations have limited access to services (while at the same time having a greater need for health care) due to access barriers such as the absence of a regular residence permit or a precarious legal status, economic barriers, administrative-bureaucratic barriers, linguistic-cultural barriers, discriminatory processes and racism. In assessing and managing the risk of COVID-19 in INTERSOS projects, what emerges is a picture of extremely vulnerable populations, with significant health risk factors that originate from -and are perpetuated by- social contexts marked by deprivation and inequality.
THE IMPACT OF COVID-19 ON THE QUALITY OF LIFE OF POPULATIONS EXPERIENCING SOCIAL EXCLUSION

The research on the impact of the COVID-19 emergency on the quality of life in contexts of social exclusion explored the involved populations’ own perceptions of their health and living conditions. The collected data shows that there is a strong connection between health and the dynamics of oppression and exploitation faced by the respondents. Health, or the absence of it, therefore, can be understood as a core element of the analysis; this focus allows us to understand how precariousness or labor exploitation, lack of documents, unworthy housing conditions, lack of a support network and the resulting sense of disempowerment, or lack of power to change their living conditions, can influence health conditions.

The quantitative analysis, carried out by means of testing tools, shows a high frequency of Post Traumatic and Chronic Stress Disorder (59%), probably linked to the experiences before, during and after migration. 62% of those interviewed reported a predominantly low quality of life, especially in relation to the environment and context, and a widespread perception of existential insecurity; only 4% reported a good quality of life.

FIG. 6 • PRESENCE OF CHRONIC POST-TRAUMATIC STRESS DISORDER (PTSD) AND QUALITY OF LIFE OF INTERVIEWED POPULATION

Of the 54 people who were asked to take the WHO Quality of Life-BREF and the Impact Event Scale-Revised testing tools, 10 were intercepted in Rome, 29 in Capitanata and 14 in East Sicily.

The qualitative survey shows how the different dimensions of people’s lives in the contexts in which INTER-SOS operates are inextricably linked and perpetuating each other: it is difficult to break out of a condition of labor exploitation, or to find a job that allows for more dignified life conditions without a valid document; in turn, without a regular job and a document it becomes impossible to live in stable housing conditions.

As many of the people involved in the research state, such living conditions are not a choice, but a consequence of social dynamics of exploitation, by which people in vulnerable conditions are widely and easily blackmailed and do not have the possibility or the right to complain. In this scenario the pandemic and the consequent health and social crises must be understood and managed as part of
a structural rather than transitory set of problems. These structural injustices were already causing suffering when the pandemic hit. The Coronavirus, therefore, represents a problem that adds to the many pre-existing challenges to people's health. For many, living conditions are so degraded that they fail to recognize the health hazards brought by the pandemic as a more urgent problem than other conditions that are sources of suffering and over which they perceive to have no control or power.
Conclusions

The work carried out by INTERSOS projects in response to the COVID-19 emergency highlights the structural processes that produce exclusion, and the need to support the right to health for marginalized populations in a way that is designed and carried out with the populations themselves. The aim is to support advocacy and community empowerment actions starting from existing needs, on which the health institutions must be proactive. The COVID-19 emergency must be contextualized within a situation of extreme deprivation that already acts as a negative determinant of health. The new virus represents a new source of exclusion and isolation that increases the invisibility of these people’s needs and acts as an amplifier of social and health inequalities. Public policies aimed at the inclusion of migrant populations and of those living in socially marginalized contexts are therefore more important than ever to truly protect the health of individuals and communities.

For this to happen, it is essential to strengthen local health systems, enhance public social and health services, and remove obstacles to accessibility and fruition, as well as actively involve the communities in health promotion. It is also crucial to address the issues of housing and legal insecurity, as well as the often-resulting labor exploitation in the countryside throughout Italy, as major elements that subtract to health. These issues must also be tackled by the affected communities, which must be actively involved from the very beginning.

This analysis shows how proximity public health (PPH) approaches and community participation have made it possible, starting with the resources available in the communities themselves, to fill institutional gaps that still stand out as unresolved issues. The pandemic has therefore provided the opportunity to boost the experimentation of integrated and grassroots organizational approaches that have proven particularly effective and necessary when applied to
populations that are more difficult to reach. This approach is also generally desirable for the treatment and health of the general population. In the first stages, the implementation of COVID-19 emergency interventions in all projects clashed with a general low perception of the risk, particularly in rural contexts in Southern Italy. As illustrated in section 3.4, this perception stems from cultural and structural aspects: on the one hand, people living in such marginalized conditions perceive COVID-19 as only one in many problems that need to be addressed, which does not assume a priority role compared to other aspects such as work, housing or documents; on the other hand, it is evident that living conditions marked by such a strong deprivation makes it objectively impossible to apply the simplest prevention norms.

If the pandemic reveals and amplifies social problems that go well beyond merely clinical concerns, it renders more evident than ever how much of the risk component in these contexts is preventable through policies that favor equity and social justice. “Medicine is a social science,” wrote the renowned pathologist Rudolf Virchow, “and politics is nothing more than medicine on a large scale.”

The pandemic has shed light on problems of social justice, poor accessibility and usability of services, and the weakness and constant undervaluation of a locally administered health services.

The population has been called upon to take individual responsibility, but making no distinction and compounding all individuals within a paradigm of ir/responsibility resulted in drowning out and ignoring the difficulty many people encountered in applying the provisions that would have made them “responsible.” All the attention paid to individual responsibility has diverted attention from the equally necessary public responsibility to make all individuals sufficiently safeguarded. Only then can administrations credibly call for such individual responsibility.

The pandemic teaches us the hard way that the health of the entire population is interconnected, that the conditions of people left on the margins of society - among which there are squatters, farm workers, homeless people, migrants without residence permits- affect everyone, with no exception. What is needed is a strong collective responsibility in acknowledging that the role of politics and of the National Health System is to counteract inequalities and to protect the dignity and health of everyone.
AN UNEQUAL PANDEMIC
INTERSOS is a non-profit humanitarian organization that operates in 19 countries around the world, providing assistance and help in situations of emergency and extreme exclusion, and paying particular attention to the protection of the most vulnerable people. In Italy INTERSOS has been active since 2011 with various projects aimed at protecting and implementing the right to health of people living in conditions of severe social exclusion. Here, its approach is based on the support of the National Health System, in pursuit of the full inclusion of people living in marginal contexts into the public health service.

The rapid spread of the SARS-CoV2 virus starting in February 2020 and the health and social crisis that followed, have created the need to build prevention, monitoring, case management and referral interventions addressing contexts of social marginality. These projects were set up to safeguard the health of population groups that already suffer barriers to access public services; these people are also harder to reach by the Regional Health Services, a situation that has been only further exacerbated in crisis conditions.

The course of the epidemic has shown that migrant people are more affected and vulnerable to the spread of COVID-19 than the general population, precisely because of the conditions of deprivation in which they live and the fewer resources to which they have access (1). In fact, the social and economic crisis linked to the spread of the epidemic has a negative impact on the social determinants of health, with results in the amplification of inequalities and worsening of exposure to risk and negative health outcomes. This happens along the lines of resource and opportunity distribution within society (2). In fact, the consequences of the pandemic include greater job insecurity and unemployment, with reduced incomes and increased poverty or risk of poverty, factors that affect those
who are already living in more disadvantaged social conditions in a more significant way. Moreover, the precariousness of housing conditions in which the most marginalized sectors of the population live poses a risk factor for people’s health in itself. With the spread of the pandemic, this is highlighted by the fact that it is not possible to implement the simplest and most fundamental prevention measures in the presence of overcrowding, poor sanitary conditions and minor access to hygienic devices. Finally, the drastic reduction in services, the blockage of mobility, the reduced economic availability caused by the financial crisis, the reduction of third sector activities and supporting networks in many contexts causes the exacerbation of access barriers, and increases the difficulty in accessing social and health services (3, 4).

In the first period of the spread of the COVID-19 epidemic in Italy there were no specific national guidelines on the construction of interventions supporting migrant people and people living in conditions of social marginalization: the first government decrees did not include adequate measures to protect people who are socially more fragile and who by virtue of this are more at risk of contracting the disease. The guidelines published by the WHO in March 2020 on the health of migrants and refugees in relation to COVID-19 specifies that public health interventions implemented during health emergencies must be based on inclusive approaches, considering the risk of infection and health needs of the most vulnerable populations without exclusion and discrimination. Among these, the WHO emphasizes the importance of adopting culturally appropriate approaches to effectively engage and provide information to migrant people, as well as the importance of providing adequate facilities to manage isolation, quarantine, and physical distancing measures where these are not possible, i.e. in overcrowded and precarious housing conditions (5). International documents on the prevention and control of the spread of COVID-19 among migrant populations emphasize that standards of preventive and health-promoting measures must be guaranteed as for the rest of the population, with particular attention to the protection of people suffering from vulnerable conditions, given the exacerbation of processes of exclusion and marginalization and their consequences on health (6).

The first data published in Italy with respect to the epidemiological trend of the epidemic in the immigrant population (April 2020) showed a picture of higher rates of hospitalization and mortality and a higher risk of late diagnosis in the foreign population (7), confirming what the scientific literature on health inequalities has already shown.

Five months after the beginning of the emergency, on July 30, 2020, the National Institute for Health, Migration and Poverty (NIHMP) published the ‘Interim operational guidelines for the management of facilities with people in conditions of high fragility and social-health marginality in the context of the COVID-19 epidemic’4. These guidelines, which were set up also through the advocacy actions of the networks and associations in the third sector coming together through the Asylum Roundtable and in the Immigration and Health Roundtable4, provide guidance on the management of the epidemic in complex, high-density settings, and are written for those involved in the management of care and reception of people in fragile and marginal conditions (8).

In the absence of specific national guidelines for the protection of the health of people living in conditions of extreme social exclusion, INTERSOS began to reorganize existing projects already at the end of February 2020, in order to build prevention and monitoring interventions that could be appropriate for the contexts in which it operates. In collaboration with local institutions and Regional Health Services, INTERSOS has reshaped the projects underway in Rome and in the informal rural settlements of seasonal workers in agriculture in Capitanata. It has subsequently launched projects in rural Ionian Calabria and in East and West Sicily. The aim was to build operational methods aimed
at the implementation of prevention measures with homeless people, or people living in precarious housing conditions, who already experience exclusion from services. Here, it is necessary to build proximity interventions that are appropriate for the context and based on existing health needs. This report describes the main results of the actions implemented by INTERSOS, covering the period from the first phases of the spread of the pandemic in Italy in February 2020 until October 2020. The activities carried out by the teams in West Sicily in November and December 2020, and the results of their advocacy up to the end of January 2021, are also added to the analysis. The projects are still ongoing in Rome and Foggia, constantly evolving to better adapt to current needs and challenges.

INSTITUTIONAL DONORS, PARTNERS AND PHILANTHROPIC INSTITUTIONS

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**City of Rome:** project “Intervention for the care, support and skills development of refugee and migrant children in Italy” in partnership with UNICEF;

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1. THE COVID-19 EMERGENCY AND INTERSOS INTERVENTIONS IN ITALY - AN UNEQUAL PANDEMIC

1.1 THE CONVERSION OF EMERGENCY PROJECTS AND INTERVENTION SETTINGS

1.1.1 Rome

In Rome INTERSOS has been operating since 2011, with the opening of the night center A28, set up for unaccompanied and separated minors (UASMs) and which over the years has represented an important safe space for UASM transiting in Italy. This project later evolved, transforming into the new INTERSOS24 center in the neighborhood of Torre Spaccata in 2017. The center has developed on different project levels; it is now a night and day center for the reception of UASMs and women in transit in Italy, who have had to abscond from institutional paths, who might have been exposed to gender-based violence (GBV) and labor and/or sexual exploitation. It offers psycho-social activities with vulnerable populations and a community outpatient clinic, which have been developed over the years, and offers primary care, orientation to social and health services and mental health support since 2018. Since 2016, a mobile outreach team has also been active in Rome, in partnership with UNICEF (within the project UNICEF & INTERSOS intervention for the care, support and skills development of refugee and migrant children in Italy). This multidisciplinary team of humanitarian workers carries out monitoring activities in the places of greatest interest for the vulnerable migrant population, and for homeless people, and conducting orientation to social-health services, health promotion and child protection activities in the housing squats in the southeast area of Rome.

The Social Operations Room (Sala Operativa Sociale, SOS), a hub of emergency services set up to tackle social crises in Rome, estimates that approximately 3,600-5,000 people in the city are homeless, and an unquantifiable number of people are without legal residence permits. With the onset of the COVID-19 pandemic, INTERSOS24’s space and activities were entirely converted. Staff and social-health activities were moved to the streets, enhancing the work of the mobile teams (Mobile Health Teams in response to the COVID-19 Emergency) monitoring the places of greatest interest for the vulnerable migrant population, and for homeless people, and conducting orientation to social-health services, health promotion and child protection activities in the housing squats in the southeast area of Rome. The people who were previously living in the reception facility were transferred to hotels and apartments, with whom INTERSOS set up agreements.

The activities were re-designed to strengthen legal referral, social and health support through medical examinations, as well as by accompanying people to the drive-in facilities for nasopharyngeal swab tests, or to COVID hotels dedicated to isolation. New activities also included training on personal hygiene and cleanliness of common spaces, and referring and connecting vulnerable people to the Municipality’s services (Social Operations Room, Immigration Office, anti-violence network). Moreover, the project strengthened psychological support activities, with an ad hoc service in different languages for the emotional support of women who were victims of gender-based violence, who tested positive to COVID-19 and therefore were being hosted in hotel facilities. The activities of INTER-
SOS in Rome are ongoing and evolving.

TARGETED AREAS

TRAIN STATIONS (TERMINI AND TIBURTINA STATIONS)

Population
Predominantly men, average age between 20 and 50, mostly homeless.

Main countries of origin
Italy, Bangladesh, Ethiopia, Morocco, Eritrea, Egypt, Tunisia, Nigeria, Burkina Faso, Libya, Guinea, S. Leone, Ukraine, Romania, Poland, Moldavia, Afghanistan, Bulgaria and Kurdistan region.

Social context
The population engaged by the project is extremely heterogeneous in terms of geographical origin, socio-economic status and life prospects in the area. At Termini station (via Giolitti side) it is mainly the Bengali community, which is living and trading at the Esquilino market; at Tiburtina station it is mostly people from sub-Saharan Africa, homeless people, people in transit and only temporarily present. This area is systematically threatened by evictions by the hand of the police and frequently exploited in political and media campaigns. Many people were involved in the “black” or “gray” labor market. Those who have housing accommodation often live in overcrowded conditions, and several people show signs of psychological and social suffering. Moreover, the Tiburtina settlement has no toilets or close access to water: during the lockdown period the number of inhabitants grew to almost 200 people, many of whom arrived after transit between regions was blocked by virus-related restrictions. Indeed, this prevented the mobility of seasonal workers, who ended up in the street after the expiration of their allotted time in reception facilities. The people that have been involved in the project have little knowledge of their social and health rights, as well as of local services and how to access them.

Main health needs
INTERSOS staff identified gastro-intestinal, osteo-muscular, metabolic, cardio-vascular and dental pathological conditions, some of which were chronic and could have been cured had there been a functioning proximity public health network when they emerged.
The people involved report difficulties in accessing and using health services, even when possessing a health card, STP code (a social security number for undocumented foreigners to access public healthcare) and general practitioner (hereafter, GP). In these cases, the main difficulties were due to language barriers, outdated websites with no language options, or the limited opening hours of some health services that render the latter unreachable for those who have been able to maintain a job. There are frequent elements of vulnerability, some of which can be traced back to torture suffered in Libyan prisons. Most people display significant psychological discomfort.

**Main critical points**

- Homeless people’s settlements are subjected to regular police raids. They reorganize not far from the initial point. They also suffer from equally constant intimidations and acts of discriminatory violence, fueled by neo-fascist groups or city policies focused on the urban “decoration.” Urban “decoration” is an extreme phrasing of public order in the Italian legal system that engages with the moral aesthetic of a city. This framing often causes homelessness to be treated as an inappropriate or displeasing element of the urban landscape that needs to be hidden rather than a sign of social problems that require urgent attention.

- The public health service is insufficient in terms of accessibility (due to, among other things, language barriers, inefficiencies in the use of the STP code, huge obstacles in accessing nasopharyngeal swab tests, particularly in the initial phase, that were solved only by calling the emergency number 118);

- There is limited capacity in the search for alternative housing solutions and/or integrated operational responses for homeless people and/or people in psychological distress;

- It is important to note the failure of previously initiated therapeutic treatments and dispersal of the patients, also due to the closure of services in the context of the pandemic.

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5 “Black” labor is without a work contract, “grey” labor is work with a contract that exhibits multiple unlawful elements, such as declaring only a fraction of the working hours, or almost nonexistent retirement fund sections.
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OPERA DON CALABRIA

Population
Almost all are men between the ages of 40 and 60, predominantly homeless Italians.

Main countries of origin
Italy, Ukraine, Romania, Poland, Bosnia, Bulgaria

Social Context
The facility offers meals, laundry and shower services for homeless people in the North-West area of Rome. During the lockdown, it continued to offer meals in the courtyard outside, in a manner similar to take-away, a mandatory condition in the country for all catering services. The users, mostly Italian, are quite stable; some people have a history of drug addiction, alcohol and substance abuse; situations of family abandonment are frequent.

Main health needs
Almost all have a health card or STP number; they have widespread knowledge of the Regional Health System (hereinafter RHS) and access to care. Osteo-muscular pathological conditions, chronic metabolic conditions, drug addiction, and widespread psychological distress are the most common health concerns.

Main critical points
• Failure of previously initiated therapeutic treatment and dispersal of the patients, also due to the closure of services in the context of the pandemic, particularly problematic in the case of NHS-run services for drug addiction (known as SerD) for people with addiction problems.
• Absence of alternative housing solutions and/or integrated operational responses aimed at people who are homeless and/or in conditions of mental distress: for example, one homeless person tested positive with a PCR test in April 2020, but having nowhere to self-quarantine while waiting for the results of the test, he ended up unintentionally infecting other people who relied on the services offered by the cafeteria. The outbreak was contained and died out shortly after having promptly reported the case and the complications encountered to the competent local public health authority (ASL).
HOUSING SQUATS AND SEMI-STABLE INFORMAL SETTLEMENTS

Population
The 5 housing squats involved in INTERSOS’ social-health interventions in 2020 are composed on average of about 300 people, mainly women, between 20 and 60 years of age; a large component of the population is of pre-school and school age, and to a smaller extent young adults. The people there constitute highly organized internal community structures and use participatory decision-making methods. In addition to these sites, there is an informal settlement in an abandoned building in North Rome with about 300 people, which is poorly organized and has challenging internal dynamics.

Main countries of origin
Prevalent countries of origin: Peru, Ecuador, S. Domingo, Venezuela, Cuba, Bolivia, Uruguay; to a smaller extent: Ethiopia, Morocco, Senegal, Eritrea, Moldavia, Romania, Bulgaria, Bangladesh; Italians are also widely present. In the settlement in North Rome: Senegal, Gambia, to a smaller extent Sudan.

Social Context
Most of the housing squats were born between the end of the 2000s and the beginning of the 2010s, when the movements for housing rights in the city were growing and getting stronger. The buildings are almost all publicly owned (former INPS, INPDAP, public utilities managers) and equipped with running water, electricity, single-family housing units with kitchenette. Only some have private bathrooms, the remaining ones are shared. They are all in buildings with multiple floors, most are located at the city boundaries, marked by highway circling the city, known as the Grande Raccordo Anulare; only a few are in fairly central locations. In the squats that were involved in the project, most of the inhabitants have jobs in various sectors: the younger ones, often South American, tend to work in logistics, with a regular contract, adults generally from sub-Saharan Africa tend to work as street vendors. Some adult women from Eastern Europe or Central and North Africa tend to work as caregivers at homes; however both younger and older women often report having no employment at all. There is little or no relationship with neighbors outside the squats. Sanitary conditions appear to be under control, despite the age of some of the buildings. On the other hand, the settlement in North Rome provides overcrowded housing conditions. For some, living in this settlement is a temporary solution before moving to other housing, for others it is a point of transit before going elsewhere in Italy, particularly to the south (Calabria, Puglia, Sicily) to carry out street vending or seasonal work. A large part of the community does not speak Italian, does not work regularly and does not have administrative or health documents in order.

Main health needs
Most of the occupants have health cards or STP codes; children are followed by legally-assigned pediatricians. Widespread knowledge about the regional health system (RHS) and access to care; exactly the opposite occurs in the informal settlement, where there are generally no health cards or STP codes, and where knowledge about the RHS and access to care is practically inexistente, with frequent improper access to emergency services, even through the emergency number 118. Requests for medical examinations were mainly made for chronic metabolic and cardiovascular pathological conditions and osteo-muscular pathologies.

Main critical issues
• Discrimination and isolation against the housing squat;
• Shared bathrooms (in most of the squats);
• Failure of previously initiated therapeutic treatments due to closure of public services and dispersal of patients;
• Demand for psychological support due to mental suffering exacerbated during lockdown.
1.1.2 Capitanata

INTERSOS has been carrying out inclusion and health education activities in the province of Foggia (hereinafter Capitanata) since 2018. The aim is to support vulnerable people, mainly migrant seasonal workers in agriculture, who find themselves either temporarily or permanently outside reception systems and social and health protection schemes.

The province of Foggia is the third largest in Italy; it has about 10 informal settlements within a 55km radius of Foggia, with an estimated number of workers ranging from 2000 during the winter to 6,500 during the summer, when the tomato harvest takes place, for which Capitanata is among the world’s largest producers.

These settlements have existed here for over 20 years, and have historically been linked to labor exploitation. The latter is rooted in the large-scale retail chains’ logic of purchasing on rebate, but also in the lack of ways for workers, who have been on the national territory for a long time and without any protection at work, to obtain permits to stay and regularize their condition. Despite repeated institutional attempts to overcome these conditions, institutions have not been able to solve this serious violation of human rights.

The main activities supported over the years have been primary medical care with two mobile units, health orientation services as well as health promotion sessions, as well as accompanying highly vulnerable patients to competent facilities. The interventions involve several informal settlements: the former airport runway in Borgo Mezzanone, the Gran Ghetto, Borgo Tre Titoli and surrounding areas, Palmori, the former Daunialat factory in Foggia, Borgo Cicerone, Borgo San Matteo and the area between Poggio Imperiale and Lesina.

In 2019 the project entered a memorandum of understanding with the ASL of Foggia, with which it set up a training program and is planning to hire linguistic and cultural mediators in health facilities, in order to increase the usability of health services for foreigners.

Starting from the end of March 2020, thanks to the co-financing of the European Commission “Su. Pr. Eme. Italia” and the agreement with Apulia’s AReSS (Regional Agency for Health and Social Strategies) in response to the COVID-19 emergency, INTERSOS’ activities and presence at the settlements were strengthened to focus on prevention and monitoring activities and ensure primary health care and orientation to services. Collaboration with the Apulia Region was intense and productive during the pandemic; it allowed the identification of facilities in which to isolate positive cases for COVID-19 as early as April 2020, and the provision of hygiene and sanitation kits in all settlements for two cycles. Similarly, collaboration with the ASL of Foggia has also been positive, and made it possible to regularly use USCAs (Special Continuity of Care Units), in synergy with the university hospital Ospedali Riuniti in Foggia, and guaranteeing linguistic-cultural mediation for both institutions, which have also been supported by the local association Africa United.

The INTERSOS team in Capitanata continues to operate on a regular basis, through two mobile units.
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FORMER AIRPORT RUNWAY OF BORG Mezzanine

Population
The population of this settlement fluctuates significantly between winter (approximately 800 people) and summer (up to 2,500 people). They are predominantly adult men between the ages of 20 and 40, with an estimated 12% of women.

Main countries of origin
The most common nationalities are Senegal, Nigeria, Gambia and Ghana.

Social context
The settlement is located on the former airport runway of Borgo Mezzanone, which was last used by cargo planes employed in the Kosovo war. This is the largest informal settlement in Italy; it is made up mostly of shacks made with wooden bases and strips of corrugated iron and plastic, or other waste material as roofs, but also to a lesser extent by structures of brick and concrete, constructed by the residents, and of abandoned structures and facilities belonging to the former airport buildings.

There is a limited number of bathrooms, none have running water; there are 3 non-drinkable water points and since March 2020, thanks to the advocacy action of INTERSOS and the support of the Apulia Region, 5 drinking water points managed by the Apulian Acqueduct (Acquedotto Pugliese) were installed. The electricity supply is provided through an informal connection from the adjacent Reception Center for Asylum Seekers (in Italy, C.A.R.A.). Waste is collected in several places but there is no disposal system, which creates a serious problem of unhealthy accumulation. There are about 60 catering businesses, cafes and emporiums, and there are other businesses (hairdressers, tire shops, mechanics, bakeries, and sale of gas cylinders). There are also 3 mosques and a church. The former runway is connected to Foggia through an often overcrowded bus line. The bus stop is 2 km away from the settlement. The population is made up of seasonal workers, workers in related businesses and in the informal services of the settlement; women are generally involved in trafficking networks. Although more than half of the inhabitants have residence permits or are in the legal process of obtaining them, the number of people without a residence permit has risen as a result of the effects of the 2018 laws (the so-called Decreti Sicurezza, Security Decrees) tightening restrictions on legal residence and criminalizing migration, among other things. For many people, living in this settlement is their only choice, as they are forced into their condition by the social and bureaucratic obstacles that have compromised their migration plans. The women living in the settlement experience additional difficulties that determine further vulnerability, as they are frequently subjected to sexual exploitation and trafficking. This phenomenon becomes even more evident during the summer season. The area was partially confiscated by the Public Prosecutor’s Office in Foggia, has undergone 4 partial evictions during 2019, and is still at risk of eviction.

Main health needs
The main health needs that were identified are related to pathologies in the following areas: osteo-muscular, gastro-intestinal, respiratory, chronic cardiovascular and metabolic, gynecological. Only a low percentage of the inhabitants of the settlement are enrolled with the Regional Health System (RHS) and there is a general lack of knowledge of how the health system works. Individuals are required to understand complex administrative and bureaucratic systems just to access health services. The greatest obstacle is to obtain administrative recognition of the settlement as a place of domicile;
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This is a required condition in order to proceed with enrollment in the health system and with the assignment of a General Practitioner (hereinafter GP). Many people do not have a clear prospect of how long they will stay in the area. The main health reference points are the Emergency Room and private social services; people frequently self-medicate.

This settlement is the one with the largest female population in Capitanata, which brings up several obstacles in access to consultori, a problem that is currently being assessed with the ASL of Foggia.

Main critical points

- Highly precarious housing conditions, with no heating, no waste management, no sewage system or sanitation;
- Conditions of extreme marginalization and consequent psycho-social malaise predominantly determined by the constant job insecurity and dynamics of exploitation;
- Difficulty in implementing strategies for the prevention of health risks in a structured way that can open reflection on the meaning of health and increase awareness of ways to take care of one's own health and that of others. This is caused by the often temporary nature of the people's stay in the settlement;
- Very limited social housing offered by municipal authorities;
- Scarce knowledge on the part of the residents of the RHS services;
- Distance from the city and its services.

In the Italian NHS these are low threshold clinics that safeguard sexual and reproductive health, called consultori, or counseling centers.
1. THE COVID-19 EMERGENCY AND INTERSOS INTERVENTIONS IN ITALY - AN UNEQUAL PANDEMIC

GRAN GHETTO / TORRETTA ANTONACCI

Population
The population of this settlement fluctuates significantly between the winter (approximately 400 people) and summer season (up to 1,100 people). It is composed predominantly of adult men between the ages of 20 and 40, with an estimated 10% of women.

Main countries of origin
The most common nationalities are Gambia, Senegal, Mali, Guinea Conakry.

Social context
The settlement was created after the eviction of the former sugar factory in the countryside of Rignano Scalo in the early 2000s. In 2017, the area underwent an eviction; those same days two workers lost their lives as the result of a fire in the settlement. The settlement was re-built immediately after the eviction, and was then once again partially destroyed by another fire in December 2019.

The authorities responded to this with a temporary container camp that could accommodate up to 400 people, equipped with toilets and showers and located right on the area that had been cleared by the eviction in 2017. Because of the health emergency, the container camp was not dismantled, but instead expanded. The water is supplied through cisterns set up by the Apulia Region through the Apulian aqueduct, which were expanded during the health emergency. There are frequent internal tensions within the settlement; over the years several actors of the private social sector such as NGOs, and the people that use their services, have been repeatedly subjected to intimidation by a group that detains forms of internal power. There is a smaller percentage of females with respect to the former airport runway of Borgo Mezzanone, with a slightly older average age. The settlement is very distant from urban centers and poorly connected by public transport. Here too, the nearest bus stop is 2 km away from the dwellings.

Main health needs
The main identified health needs are pathologies in the following areas: osteo-muscular, gastro-intestinal, respiratory system, chronic cardiovascular and metabolic. In this settlement there is an even lower rate of enrollment in the RHS, and of knowledge of the health system, with respect to its counterpart in Borgo Mezzanone. Individuals are required to understand complex administrative and bureaucratic systems just to access health services. The greatest obstacle is to obtain administrative recognition of the settlement as a place of domicile; this is a required condition in order to proceed with enrollment in the health system and with the assignment of a GP. This difficulty was successfully addressed with the ASL of Foggia during the pandemic, by making residents undersign a self-declaration of domicile (See below). Many people do not have a clear prospect of how long they will stay in the area. The main health reference points are the Emergency Room and private social services; people frequently self-medicate.

Main critical issues
- Highly precarious housing conditions, with no running water, no heating, no waste management, no sewage system or sanitation;
- Conditions of extreme marginalization and consequent psycho-social malaise predominantly determined by the constant job insecurity and dynamics of exploitation;
- Difficulty in implementing strategies for the prevention of health risks in a structured way that can open reflection on the meaning of health and increase awareness of ways to take care of one's own health and that of others. This is caused by the often temporary nature of the people's stay in the settlement;
- Scarce knowledge on the part of the residents of the RHS services;
- Distance from the city and its services, insufficient public transport.
OTHER SETTLEMENTS
Palmori, Poggio Imperiale, Borgo Cicerone, Borgo Tre Titoli, Pozzo Terraneo, Contrada Ragucci, Contrada San Matteo, ex Daunialat

Population
In the various settlements, population fluctuates between 20 and 300 people during the winter, and between 40 and 400 during the summer season. The settlements are located within a radius of 55 km from Foggia, to the north and to the southeast of the city. Almost all the residents are young men (20-40 years old), with women constituting up to 8% of the population in one settlement.

Main countries of Origin
Ghana, Mali, Senegal, and to a lesser extent Gambia, Mali, Guinea Conakry, Guinea Bissau, Sudan, Ivory Coast.

Types of settlement
Groups of abandoned farmhouses, and one abandoned factory.

Social Context
All the settlements, apart from the factory, completely lack connection to public transportation, as well as electricity and network connection, a problem that is usually remedied through power generators, and in some cases solar panels. After a solicitation by INTERSOS, all the above-mentioned settlements were guaranteed access to drinking water by the Apulia Region and Apulian Aqueduct through regularly filled water tanks, and in one case through a tap connected to the water network. The population is mainly constituted of seasonal agricultural workers, most of whom have a regular residence permit or are in the legal process of obtaining it; They work without a regular contract. The local population has subjected the inhabitants of the former Daunialat factory to repeated intimidations over the years.
# 1. THE COVID-19 EMERGENCY AND INTERSOS INTERVENTIONS IN ITALY - AN UNEQUAL PANDEMIC

### Main health needs
- Mainly osteo-muscular pathologies, more rarely gastro-intestinal;
- Great difficulty in accessing health services due to numerous barriers to access, mainly economic, administrative, linguistic and cultural, and due to discriminatory dynamics. Therefore, access occurs mainly when strictly needed or in cases of emergency rather than in a continuous way.

### Main critical issues
- Conditions of extreme marginalization and consequent psycho-social malaise predominantly determined by the constant job insecurity and dynamics of exploitation;
- For the former Daunialat factory: discriminatory and hostile dynamics perpetuated by locals against the inhabitants. There were repeated episodes of serious violence in the summers of 2019 and 2020 by the hands of Italian aggressors, which resulted in 11 injuries including one with severe permanent consequences;
- Absence of sanitation. Latrines in three settlements were built by the inhabiting population;
- Absence of waste management systems;
- With the exception of one settlement, distance from urban centers and total absence of public transport services.
1.1.3 Ionian Calabria

In 2014 INTERSOS opened the outpatient clinic MESOGHIOS in Crotone, which offers medical assistance, social and health services and psychological assistance to migrants, asylum seekers and Italians living in poverty. The activities in the outpatient clinic were complemented by medical care activities for the guests in different centers. As of 2018, the outpatient clinic was moved under the management of the Provincial Public Health Authorities (in Italian Azienda Sanitaria Provinciale, hereinafter ASP) of Crotone, and is still operational. INTERSOS staff continued to operate in the facility with a social and health project that focused on orientation to psychological support and healthcare for people with a migratory background and/or people living in conditions of destitution and/or homelessness. The aim of the project was to ensure the identification, emergence and referral of patients in vulnerable conditions to healthcare services, in order to provide effective responses to health needs.

From the end of April until July 2020, INTERSOS’ intervention in Calabria in response to the COVID-19 emergency can be credited to the co-financing from the European Commission’s Emergency AMIF funds under the “Su.Pr.Eme. Italia” project, and conducted in collaboration with local institutions, in particular with the ASP of Crotone and Cosenza. It was also supported by Armut und Gesundheit in Deutschland e.V. Association, through the donation of a mobile unit. The intervention was divided in two areas: the first is the Province of Crotone (Area 1), where INTERSOS has already been operating in previous years; second is in the Province of Cosenza (Area 2) in which INTERSOS set up a new intervention. In both areas, the intervention was mainly focused on places in the vicinity, more easily reached by the population to whom the service is addressed.
AREA 1 – PROVINCE OF CROTONE
Historical center; railway station; bus station; Island of Capo Rizzuto.

Population
Predominantly male population, mostly between 20 and 40 years old, but with a group of people over 60.

Main countries of origin
Mainly Pakistan, Bangladesh, Iraq and Afghanistan (historical center, bus station), and Horn of Africa, Sub-Saharan Africa and Maghreb (train station).
The number of people per settlement varies from 20 to 160.

Social context
The historical center of Crotone is characterized by the vast heterogeneity in its migrant population, ranging from family units to apartments inhabited by a few people. The majority report living in overcrowded housing situations.

Main health needs
There is a high number of people that display signs of vulnerability and that are not using social and health care services. The main needs reported are related to:
• Lack of knowledge of services in the area (for residence, choice of doctor, STP code request, offices for wavering possible medical bills, for the renewal of residence permits and functions carried out by the police station);
• Chronic pathologies, neglected because of failure to assign a GP, people with a GP in another region or that, because of the insufficient number of GPs in Crotone, is not under proper medical supervision and follow-up for therapy; finally, linguistic-cultural barriers to access.

Main criticalities
• High mobility of residents
• Overcrowded housing conditions
• Housing reportedly in precarious hygienic and sanitary conditions;
• Poor orientation to social and health services;
• Difficult relationship with services due to lack of linguistic-cultural mediation.
AREA 2 – PROVINCE OF COSENZA
8 settlements in the municipalities of Rossano Calabro, Corigliano Calabro, Schiavonea, and Sibari.

Population
Predominantly male population between the ages of 20 and 40. In 6 settlements: predominantly Nigeria, Ghana, Senegal, Mali, and other sub-Saharan countries. In one settlement: Pakistan, Afghanistan, Iraq. In one settlement: Poland, Russia, Ukraine, Romania. The number of people per settlement varies from 10 to 70.

Social context
6 informal settlements are linked to work, predominantly agricultural. People have settled on a more long-term basis in only 3 out of the 8 settlements. A small component of these are self-employed.
2 settlements are places of transit, in particular for people who are waiting for the renewal of their residence documents.

Main health needs
Mainly osteo-muscular and dermatological pathologies, related to working conditions. The main identified needs concern orientation to services in the area (for residence, choice of doctor, STP code request, offices for waiving of possible medical bills, for the renewal of residence permits and functions carried out by the police station.

Main critical issues
- Precarious hygienic-sanitary conditions (only one settlement has running water);
- Problems of lack of legal assistance;
- Conditions of strong isolation;
- Barriers to accessing services of various kinds (of a linguistic, intercultural, economic, and administrative nature);
- Absence of services providing support for people facing psycho-social challenges and addiction problems.
1.1.4 Sicily

The intervention was co-financed by the European Commission’s Emergency AMIF funds under the “Su.Pr.Eme. Italia” project, in East Sicily in June and July 2020, and in West Sicily in November and December 2020. In East Sicily, an INTERSOS mobile team that consisted of a coordinator, a doctor, two linguistic-cultural mediators and one psycho-social practitioner was activated. The team was set up to work in collaboration with local institutions, in particular with the Provincial Public Health Authorities (in Italian Azienda Sanitaria Provinciale, hereinafter ASP) of Syracuse, at the informal settlement in the area of Cassibile. In West Sicily, two mobile teams were activated in collaboration with the ASP of Trapani, one of which used the mobile unit donated through the support of Armut und Gesundheit in Deutschland e.V. Association. The teams were made up of one coordinator, two doctors, two psychologists, four cultural-linguistic mediators and two legal practitioners.

EAST SICILY

CASSIBILE

Population
All-male population, predominantly 20-40 years old. Population ranges from 10-20 people during low work season to 250-300 people during high work season.

Main countries of origin
Mainly Sudan (also in low season), Senegal, Morocco and Gambia; to a smaller extent Tunisia, Eritrea, Chad, Ivory Coast, Mali, Guinea Bissau, Guinea Conakry.

Social context
The seasonal camp of Cassibile forms every year between the end of March and the beginning of July. It is located within a private piece of land and is adjacent to old agricultural structures. The settlement consists of about 80 homes; there are 4 taps connected to the aqueduct and there is no connection to the electricity; people use a petrol-fueled generator instead, there is a weekly service of waste disposal. In the settlement there are two dining joints and convenience stores and three mosques. In this settlement, stable working relationships are preferred. The work in the fields is mainly picking strawberries (March/May) and potatoes (April/June), and the working conditions are very hard. “Grey work” is very widespread, whereby workers have contracts but with various irregularities (such as fake working hours or false names). The town of Cassibile is hostile to the presence of the settlement, and demonstrates it through acts of intolerance that occurred during the working season.

See footnote 5
As a result, the inhabitants of the settlement avoid the neighboring towns and distrust their inhabitants. There are several adult men with refugee status or subsidiary protection, or that have been in Italy for at least 10 years, people with regular residence permits, people with expired permits, and with pending legal procedures. In addition to the difficulties in renewing the residence permit, there are also difficulties in obtaining domicile and/or residence.

**Main health needs**

The people often contract osteo-muscular pathologies from heavy loads, gastro-intestinal problems, sleep disorders and migraine, dental problems, dermatological problems, chronic metabolic and cardiovascular conditions.

The main health needs are for:

- Improved sanitation;
- Possibility of receiving health screenings in a safe and culturally sensitive space;
- Possibility to have specialized medical checks;
- Less degrading working conditions.

**Main critical issues**

- Insufficient public health services in terms of services offered and accessibility;
- Distance from public health facilities
- The citizens of Cassibile are hostile towards the informal settlement and its inhabitants;
- Limited capacity to find alternative housing solutions and/or integrated operational responses aimed at the homeless and/or those in situations of mental distress;
- Syracuse’s administrative services deny people’s right to register their residence there; for this reason, applications for the renewal of residence permits are dismissed on the grounds of the lack of a registered residence at the declared address. To register for residency, the local administration requires a regularly registered rental contract, a condition that is difficult to obtain in the case of nomadic seasonal workers.
Population
There are about 50 people consistently living in the settlement at the “former Calcestruzzi Selinunte”. However, a total of about 2000 people were staying at the settlement during the autumn of 2020 (in previous years there had never been more than 1,500 people at any time); The great majority of the population (97.5%) is male, women make up only 2.5% of the population, and live there exclusively during the months of the agricultural harvest.

Main countries of origin
Mostly from countries in Sub-Saharan Africa, Maghreb and Horn of Africa.

Social context
The settlement is mainly made of wooden shacks with plastic materials, corrugated metal sheets and other waste materials, often including slabs of asbestos used as roofs; sometimes people live in camping tents, and there is little or no space between the dwellings. From 2016 to 2019, an official camp managed by the Italian Red Cross had been set up at the former Oil Mill “Fontane d’oro”, which was confiscated from organized crime in the municipal territory of Campobello di Mazara. Although the camp had only been intended for a minority of seasonal workers, namely those possessing a residence permit and/or a work contract and who received the payment of a daily fee, in the last year the absence of this service further aggravated the situation of the workers.

Main health needs
The people often contract osteo-muscular pathologies due to heavy loads, gastro-intestinal affections, sleep disorders and migraines, dental and dermatological problems, chronic metabolic and cardiovascular conditions. Drinking water was provided through cisterns, which were not regularly replenished. In October 2020 the municipality of Campobello provided for the installation of four water taps at about 700 meters from the field, while the municipality of Castelvetrano, with constant interruptions and technical problems, transported drinking water with a tanker truck for some time. The service was interrupted in August due to technical problems and was reactivated only in the last weeks of November. In December it was interrupted again, only to be reactivated in January 2021. There is no connection to the electricity, the population uses petrol-powered generators and gas cylinders, which carry with them related risks. There is no access to toilets.
Main criticalities

- Insufficient public health services in terms of services offered, accessibility and usability;
- Distance from public health facilities;
- Limited capacity to find alternative housing solutions and/or integrated operational responses aimed at the homeless and/or those in situations of mental distress;
2. Approach to the development of the interventions

2.1 THE DEVELOPMENT OF WORKING GROUPS AND MAIN INTERNAL ACTIVITIES

2.1.1 Approaching the work and team composition

The composition of the project teams and their performance are central aspects of INTERSOS’ approach to the development of interventions.

The project teams were devised prioritizing multidisciplinarity and an agile internal structure, with the aim of combining an efficient exchange of information and skills with the need for decision-making processes that could be suited for the health emergency in which the teams were called upon to operate. The staff of the projects in Rome, Capitanata, Ionian Calabria and Sicily are composed of a variable number of people (from 5 to 18 depending on the contexts) from a range of professions such as doctors, linguistic-cultural mediators, social and health workers, nurses, psychologists, health promoters, legal practitioner, all of whom were coordinated by project managers.
PROFESSIONAL FIGURES AND ROLES WITHIN INTERSOS TEAMS

All teams report to the Head of Mission, i.e. the director of INTERSOS’ European Region, through their coordinators. The medical referent, in close collaboration with the Head of Mission, defines and implements the medical strategy of the missions and is responsible for planning and coordinating all activities, medical and personal resources of the projects, in accordance with INTERSOS’ policies and ethical principles and in compliance with international and national protocols.

The project managers take care of the preliminary phases of project implementation (the assessment phase and the creation of the team); they coordinate and manage the activities planned in the program; they maintain an active relationship with relevant institutions and with the referents from local projects. They have to define procedures and operational strategies and coordinate the staff that is operating in the field. The choice of having coordinators who remain operative throughout the project allows for a more fluid reshaping of daily activities on the basis of necessities. This is particularly convenient in contexts that pose multiple elements of instability, as it determines better responsiveness to changes in external conditions, and gives the possibility to enrich the advocacy plan and engage institutions in a constant productive dialogue that is based on concrete experience in the field.

The doctors, in liaison with the medical referent and the project coordinator, are responsible for defining the health aspects and operational procedures in the project. Their main role is to provide outpatient medical care to the people addressed by the project, using up-to-date medical knowledge, and operating in line with the values supported by INTERSOS and in accordance with internal protocols. They participate in the development of training programs for the team and guarantee, in coordination with the medical referent, a continuous training of the multidisciplinary team in order to strengthen the staff’s health-related skills and improve the quality of interventions. They also participate in the collection and analysis of epidemiological data.

The linguistic-cultural mediators have the fundamental role of linking the different contexts in which the project operates with access to the clinics’ activity. In coordination with the doctor, they are responsible for organizing patients’ access to the mobile clinic, and they carry out mediation activities during medical examinations. Under the supervision of the coordinators, they also have the task of reading and interpreting the context in which the project operates and the social dynamics that take place there, in order to better tailor the social and health activities carried out by the project. These include health prevention sessions, identification of community needs and social mapping, with the aim of gradually building a stronger base of practical knowledge and understanding of the context, which in turn can support all team members in their work. During field work, the mediators conduct information sessions on the COVID-19 emergency and its consequences: these sessions convey how the virus is spread, what prevention measures can be taken, the diagnosis and the procedures that should be adopted in case of suspected or confirmed cases, rapid tracking of close contacts, and maintaining communication with people in isolation or quarantine. They also play an important role in guiding people to public services in the area, and improve access to and use of social and health services, thereby supporting and strengthening people’s right to health and making them aware of their duties when interacting with the public system.

Psychosocial practitioners (psychologists, nurses, social and legal workers), along with the mediators, are responsible for interacting with communities and analyzing social dynamics at intervention sites, facilitating the identification of psychosocial needs. Depending on the context, they perform other activities such as group and individual information sessions, focus groups, questionnaire administration, and other cross-cutting psychosocial reporting activities. They support cultural mediators and doctors in the collection of health data, in the registration of patients accessing the outpatient clinic and in information sessions for accessing social services; in some specific cases they accompany people to the relevant facilities and support social and health practices related to the sphere of protection of rights.
HIRING NEW STAFF IN HEALTH EMERGENCIES

The need to expand or build teams in the midst of a health emergency imposed a very tight schedule for staff recruitment. Among the preferred characteristics for candidates was having already gained experience in the field of health and migration, having acquired skills in the field such as the capacity to work in teams and with a multidisciplinary approach. Candidates with personal characteristics that would allow them to work well in emergency settings and contexts of social exclusion were also given precedence. Such personal characteristics include strong adaptability, flexibility, and especially a collaborative attitude and the ability to work and live in groups. Indeed, with the exception of Rome, part of the teams’ staff also share living spaces inside the project’s guesthouses. While on the one hand this aspect simplifies and speeds up work processes, on the other hand it requires a greater care of relational dynamics and the development of a delicate balance between the working and personal spheres.

DEFINITION OF OPERATING PROCEDURES

At the beginning of INTERSOS projects for the COVID-19 emergency, Standard Operating Procedures (SOPs) were drawn up to comply with the Ordinance issued by the Minister of Health on 21.02.20: “Additional prophylactic measures against the spread of COVID19 Infectious Disease.” This document was prepared by the medical referent to facilitate compliance with national and international guidelines on the prevention and management of the COVID-19 emergency, and was periodically renewed according to newly issued regulations and scientific literature. It was used as a guide for all social and health workers in the staff with respect to the special hygienic and sanitary procedures that had to be adopted and to the methods of intervention. The latter needed to balance the need to work in conditions of safety while at the same time maintaining an acceptable approach to the context of the action, protecting confidentiality and building a relationship of trust with people. In particular, this confidentiality in safety was maintained through the use of work uniforms in material that could be easily sanitized, which were made of blue fabric and had the INTERSOS logo, that were provided to the staff along with instructions for their correct sanitization. In view of the numerous activities that would be carried out in the common areas of informal settlements and sometimes in homes, this approach has often made it possible to avoid the use of disposable garment covers in high-risk contexts outside the areas designated for medical examinations, after having learned through focus groups that the use of this type of garment had a negative impact when used in the common areas of settlements and in living spaces. In agreement and close collaboration with local health authorities, the SOPs also include clinical guidelines for risk assessment and procedures to follow in cases of suspected and confirmed cases of contagion.

OPERATIONAL METHODS, WORKING TOOLS, EVALUATION AND REMODELING OF ACTIVITIES

The coordinator of each team organizes weekly internal meetings. Here team members update each other, share their objectives and achieved results, report on the emergence of critical issues and perhaps also on the need to adapt and modify project activities. The daily presence of the coordinators in the field also allows them to carry out briefing sessions before the departure to the sites of the intervention and debriefing at the end of the working day. This gives space to communicate the emergence of problems, difficulties and other issues that need to be discussed and elaborated at group level. The communication between the coordinators and the medical referent occurs periodically and when it is needed, in order to make project implementation as consistent as possible also between the different sites of intervention, despite the territorial specificity of the projects. The constant communication between different levels, the sharing of data and tools allows for
the collection of useful elements for the constant evaluation of the progress of activities. It also allows for reshaping activities according to new aspects that might emerge, to the epidemiological trend of the epidemic and to the needs detected by the staff members in the field. Internal evaluation takes place on two interdependent levels: on the coordination level there is a weekly session in which the staff evaluates the shared methods that are being used and re-adapts it to better fit the evolving situation, and at the operational level, the staff updates each other daily on individual cases to be followed.

INTERNAL STAFF TRAINING AND KNOWLEDGE BUILDING

The internal training of staff members is conceived as a continuous process of knowledge building, which starts from the experience on the field, and is done collectively. The enhancement of the individual’s skills within the team, the multidisciplinary character of the working groups, the constant acquisition of concrete experiences from the field are all parts of a process of continuous learning and interdisciplinary knowledge building. It is common knowledge in the field of pedagogy, particularly in social education, that learning is an integral part of social work: it is not a separate activity but an aspect of all activities, which takes on different forms according to the context in which these activities take place and to the relational dynamics that are formed there. Indeed, learning is not just about the acquisition of notions, tasks and functions, but it involves the person's dedication within their network of relationships and field of action (9). In addition to this form of learning, acquired by gaining experience in the field, time was regularly set aside for internal self-training, which was carried out autonomously by the staff during meetings. Here, everyone shared informative material, dedicated time for discussion and for critical readings of the documentation. The issues addressed by the staff, on different levels of detail and with attention to local specificities, mainly concerned:

- **The safety procedures** for the prevention of biological and microbiological risk in the workplace;
- **the core concepts for correct prevention sessions** in the context of informal settlements for COVID19 emergency;
- **the correct use of personal protective equipment (PPE)**;
- **dressing and undressing in safety**;
- **the preparation of work settings**;
- **The relationship with local services** and the relations with institutional actors;
- **Access to social and health services** and orientation to public services;
- **The legislation on the conversion of undeclared work into regular employment for foreign workers**, regulated by Law Decree N. 34/2020, converted into Law n. 77/2020 (the so-called Relaunching Decree) and the changes introduced in the so-called Security Decrees (the 2018 laws tightening restrictions on legal residence and criminalizing migration, among other things);
- **Aspects related to community work and cultural mediation**: communication strategies, ways of relating to the community, distributing questionnaires and conducting focus groups.
2. APPROACH TO THE DEVELOPMENT OF THE INTERVENTIONS - AN UNEQUAL PANDEMIC

2.1.2 INTERSOS staff on COVID-19 emergency projects

CITY OF ROME (COVID-19 OPERATION FROM MARCH 2020 - ONGOING)
Mobile units active from Monday to Friday (every day, in case of emergency), in partnership with UNICEF. Two mobile teams, made up in total of 8 people:
- one supervisor for operations in Rome
- one medical coordinator
- one doctor
- two linguistic-cultural mediators
- one social worker
- two psychologists
- one nurse
- one logistician

CAPITANATA (COVID-19 OPERATION FROM FEBRUARY 26, 2020 - ONGOING)
Two mobile teams, active from Monday to Saturday (every day, in case of emergency situations), made up in total of 10 people:
- the medical referent for INTERSOS’ Migration Unit
- one project coordinator with legal and protection skills
- two full-time doctors
- two linguistic-cultural mediators from Senegal;
- one linguistic-cultural mediator from Nigeria;
- one linguistic-cultural mediator from Ghana;
- two social and healthcare workers with experience in the field of orientation and participatory research.

Starting from October 2020 the staff has further expanded to include 8 community mobilizers. Community mobilizers are contact people identified in the settlements and involved in the projects, which assume the role of bridging between the staff and the community, facilitating the dissemination of relevant information to the community, and supporting awareness raising activities, and the timely and mass distribution of materials.

IONIAN CALABRIA (COVID-19 OPERATION IN MAY AND JUNE 2020)
A mobile team, operating Monday through Friday, made up of 6 people.
- one coordinator
- two doctors
- three linguistic-cultural mediators.

EAST SICILY (COVID-19 OPERATION IN JUNE AND JULY 2020)
One mobile team operating from Monday to Friday, made up of 5 people:
- one coordinator
- one doctor
- two linguistic-cultural mediators
- one social and healthcare worker

WESTERN SICILY (COVID OPERATION - NOVEMBER 19 AND DECEMBER 2020)
Two mobile teams, operating from Monday to Friday, made up of 11 people in total:
- one coordinator
- two doctors
- two psychologists
- four linguistic-cultural mediators
- two legal counselors
2.1.3 Survey on mental health and quality of life within INTERSOS teams

An important activity carried out in the context of the INTERSOS Projects for the COVID-19 Emergency was proposed by the Rome staff and concerned the wellbeing of the staff, particularly their mental health, and the impact of the COVID-19 emergency on the lives of those who work in contexts of emergency and strong social exclusion.

With the explosion of the health emergency, a study was launched with the aim of exploring the experiences of staff in relation to their work. This allowed the four teams involved in the investigation (Rome, Capitanata, Ionian Calabria and East Sicily) to create a space for discussion where they could reflect as a group on the progress of the intervention, the strengths and weaknesses that emerged, the emotional aspects of the work and experiences they gained.

The survey methodology and the main results of the work are presented in the Appendix: “Humanitarian work during the COVID-19 emergency: an analysis of the experiences of INTERSOS staff in Italy.”
2. APPROACH TO THE DEVELOPMENT OF THE INTERVENTIONS - AN UNEQUAL PANDEMIC

2.2 DEVELOPING THE COVID-19 EMERGENCY INTERVENTION WITH THE COMMUNITIES

INTERSOS’ approach to the development of interventions alongside the community is based on the key principles of health promotion and the protection of the right to health. Health promotion is defined in the Ottawa Charter (10) as “the process of enabling people to increase control over their own health and to improve it,” through the adoption of strategies on various levels:

- empowering people and communities
- mediating between sectors and between different levels of social organization
- doing advocacy to support the right to health.

In this sense, community participation is a fundamental principle, because of the transformative value it brings through relational processes, increased social support and the development of forms of self-organization; this allows for the people who are involved to be implicated on the front line in activities that affect their own lives and health, and ensures the development of collective forms of action (14).

With respect to the context of the pandemic and the need for multidisciplinary interventions across sectors, the health promotion approach becomes fundamental for the implementation of healthcare activities on individual, collective and institutional policy levels. WHO recommends community involvement to improve responsiveness to the pandemic, and suggests interventions that move from exclusively health education to health promotion, focusing on the role of individuals and communities in protecting their individual and collective health (15).

The health promotion approach includes (and is strengthened by) another pillar of INTERSOS’ action: the protection of the right to health for everyone, and thus the inclusion of people who suffer most from processes of exclusion, violence and exploitation. Despite the fact that Italy is a country with one of the most inclusive legislations on access to care, it is widely known that barriers to access services breeds exclusion from diagnosis and treatment. This, in turn, amounts to a failure to ensure equity in health, a founding principle of the NHS. For example, regulations on access to healthcare for foreigners are highly inconsistent throughout different municipalities, provinces and regions, often leaving ample space for discretionary behavior on the part of employees and civil servants; this gives rise to situations in which rights are guaranteed only on paper, and require many complex steps to become enforceable, a situation that greatly increases the barriers to access services on a bureaucratic, economic and cultural level (16). The presence of social-health teams in con-
texts of strong social exclusion allows the populations involved to gain access to important tools to facilitate the fulfillment of the right to health, and access to public services. It also allows teams to become aware of the health needs of these populations and to document them, as well as to direct people towards the most suitable healthcare services for their needs, trying to build better responsiveness from the public health service to the health demands of populations that would otherwise remain invisible.

Although INTERSOS’ work in this context consists mainly of medical activities, its constant presence in certain contexts gives teams the chance to identify needs that go beyond healthcare. Because of the multidisciplinary composition of the teams and the relationships of trust that are established between the staff and the community, the people sometimes choose to express these other types of issues. This way, the teams can propose forms of protection and safeguard they can make available through their own professional skills, and through the possibilities offered at the local level. This aspect is an integral part of the social-health intervention; according to the determinants of health approach, health should be understood as stemming from the intersection of social processes, and must be protected as a fundamental human right. Therefore, if working to improve health is conditional on the realization of people’s rights, the main objective becomes to achieve decent living and working conditions, free from forms of exclusion and violence; in this sense, the construction of safe spaces where people feel secure enough to share the violations of rights they experience, the documentation of the testimonies and advocacy actions conducted based on the expressed needs of the population are essential elements of the action itself and are essential to promote health.
2.2.1 Methodological principles in preparing the actions

The methodology of intervention with the communities in the contexts of action was developed according to the following principles:

- **Ensuring presence and continuity in contexts of strong social exclusion.** This became even more important when the SARS-CoV2 epidemic spread and national containment measures were implemented, as poor policy choices led to an increase in these communities' isolation and invisibility, particularly when it came to people's needs. This is critical both for the protection and support of these communities and to create the conditions for the identification, monitoring, and addressing of health needs of populations otherwise unreached by the public health service;

- **Building operational methods for the prevention and monitoring of the SARS-CoV-2 epidemic that are appropriate to the contexts of the intervention**, and that are acceptable to populations living in conditions of extreme marginality, while at the same time applying national guidelines in these complex contexts. In such contexts, living conditions marked by extremely limited resources (precariousness, promiscuity of environments, exclusion and poor access to services, vulnerability to blackmail, violence and exploitation) make it impossible to implement even the most essential prevention measures (from hygiene and sanitation to physical distancing). In relation to and as a result of this, COVID-19 represents a critical element that adds to the already-existing difficulties for those who live in such conditions of deprivation, and is not set as a priority with respect to other aspects such as work, documents, and the search for decent living conditions;

- **Strengthening the collaboration with the public health service**, moving from orientation to the services to the development of an intervention based on the Proximity Public Health (PPH) approach, built in collaboration with local health institutions. The implementation of the intervention has posed the need to build a delicate balance between the need for INTERSOS staff to work safely with respect to the risks tied to the epidemic and the need to adopt operating methods that are understandable and acceptable to the populations with whom they work. The implementation of prevention measures and population monitoring systems in such contexts represents a complex challenge in terms of public health. However, this work is fundamental for the protection of the health of the entire population and extremely necessary given the absence of specific national guidelines or dedicated public services.

The already consolidated presence in the area in the case of Rome and Capitanata, and the previously gained experience, knowledge and connection with the networks in Ionian Calabria and Sicily, made it possible to apply the selected approach for the intervention both when remodeling the already ongoing projects, and with projects opened in response to the pandemic. In many cases, this allowed our projects to protect continuity of care even at the time of increased closure or limited accessibility to public services. The reorganization of services for the emergency in the healthcare system has in fact posed important obstacles for continuity of care for those who already suffer from the well-known barriers to access; this situation amplifies inequalities in health and represents a risk factor in particular for those with chronic pathologies, or who suffer from conditions of vulnerability. In other words, while the total closure of the country applies to everyone, the consequences on people's lives in terms of protection, access and usability of services goes along the lines
of resource and opportunity distribution; those who have fewer resources will have more difficulties accessing what they need. It is also important to emphasize that the prohibition of mobility and travel except for proven necessity and the control implemented across the country constituted an important limitation for those without a regular residence permit, who in many cases have suspended the course of their health treatments either because it had become impossible either to access those services or to physically travel to where they were offered. Adopting prevention measures in all projects required some important adaptation work. The information that needed to be conveyed, which was necessary to understand the phenomenon of the pandemic and to protect individual and collective health, had to be made relevant to the context and had to be disseminated extensively to ensure it reached everyone. The adoption of culturally appropriate approaches to effectively engage and provide information to immigrant populations is a key step in building tools to support community work.

**PREPARING INDIVIDUAL AND COLLECTIVE INFORMATION SESSIONS**

From the very early phases of the spread of the pandemic in Italy INTERSOS teams organized focus groups with the communities they were already working with, involving doctors and linguistic-cultural mediators. The aim of these focus groups was to gain an understanding of the communities’ knowledge and perceptions about the COVID-19 epidemic. Based on the collected data and on the prior knowledge gained during INTERSOS’ work, the multidisciplinary staff developed and re-adapted the training sessions, integrating health care skills with social and cultural mediation skills. The result was the development of key messages on essential aspects about the disease and how it can be managed:

- Signs, symptoms and risk factors;
- Modes of transmission
- Rules of prevention;
- The diagnostic procedure to be carried out in case of suspected cases;
- Information on services to contact in case of need;
- How to find useful information and how to contact INTERSOS staff in case of need.

In order to convey the information in a direct and efficient way, all teams developed multilingual graphic material based on the results of the focus groups, distributed it to people and posted it in particularly busy places (such as shops or stations and stops for public transportation).

The content of the information sessions was periodically modified according to epidemiological trends, national legislation and staff evaluations, thus integrating elements regarding perceptions and experiences with COVID-19, useful for improving prevention interventions.

In addition, the Rome and Capitanata teams identified people who already acted as reference points within the communities, people with skills or sensitivity and attention to health issues, with a good knowledge of the social dynamics of the context and with a good network of relationships in the community. These people were included in the project as community mobilizers and health promoters (see paras. 3.3.3 and 3.3.4 in
support of the teams. This strategy has facilitated the good dissemination of information on COVID-19; moreover, it allowed teams to act with greater cultural and social competence to contrast incorrect perceptions or information on health, through actions of peer-to-peer education that led to the construction of a more solid collective awareness within the community. The presence of public health proximity references, or contact persons, belonging to the community also strengthens the trust with the staff, and facilitates the population's access to the services, and gives the means to the people to communicate health needs, or to the staff to identify them.

CLINICAL AND EPIDEMIOLOGICAL RISK ASSESSMENT

Pre-triage and health screening is carried out for the early detection of cases at risk for SARS-CoV-2 infection during all information sessions, all interactions between the staff and the community, and at the opening of each medical visit. For this purpose, every person encountered is asked a set of questions to identify the presence of symptoms that suggest the subject might have contracted COVID-19 (cough, fever, and more nuanced symptomatic pictures), exposure to at-risk contacts, whether the person has traveled from and/or to at-risk locations, as well as the presence of known chronic pathological conditions and vulnerabilities for which it would be advisable to perform closer monitoring. If at least one of these criteria is present, patients undergo medical evaluation according to a specifically developed clinical risk assessment form, in accordance with national guidelines and with the guidelines of the Italian Federation of General Practitioners (Federazione Italiana dei Medici di Medicina Generale) [See Annex 1 - INSERT ASSESSMENT FORM]. This structured assessment guides the doctor in monitoring the patient's clinical conditions while in self-isolation at home (where possible) or in dedicated facilities, or alternatively in activating the procedures for carrying out the naso-pharyngeal swab according to agreements with local health authorities.

THE NEED TO PROTECT PEOPLE, OPERATE SAFELY, AND ADOPT A CULTURALLY APPROPRIATE APPROACH

INTERSOS has worked to adapt national and international guidelines to the characteristics of populations and intervention settings, working safely in compliance with national standards of prevention, while maintaining appropriate methods of intervention to the cultural and social context of the intervention. This has meant that the teams carried out most of the social-health activities in open environments, thanks to the use of outdoor gazebo tents with adequate ventilation; the patient's privacy was maintained through the use of a curtain. The “confidence in safety” approach was maintained by using the necessary personal protective equipment for both staff and assisted people, while in constant compliance with safety distance and hygiene standards for all the materials that were used. This has made it possible to act safely while at the same time protecting a relationship of trust, so as to avoid reactions of fear and mistrust that might cause the population to disengage, all while carefully protecting the privacy of patients at risk. It is important to consider that, especially in the early stages of the emergency and when the first cases were spreading, being at risk of contracting COVID-19 was linked to a strong social stigma; people who were exposed also risked being isolated by the community and having to face mounting fears from the population.

The guiding principle was therefore to carry out the actions safely, protecting the health both of the team members and of the people reached, complying with the current regulations, while at the same time actively providing care outside clinical settings (outreach), adapting the work to the needs of the people, keeping it a low threshold service, and upholding cultural sensitivity and equity.
CRITICAL ISSUES LINKED TO PREVENTION IN CONTEXTS OF DEPRIVATION

One of the most critical aspects of the intervention is linked to the precariousness of the concerned populations’ housing conditions. Already in itself, this factor constitutes a risk for public health in many ways. The pandemic shows that in situations of overcrowding, poor sanitary conditions and reduced access to hygienic devices, it is impossible to implement even the simplest and most fundamental prevention measures.

In support of this assessment, in the focus groups carried out in the communities with the aim of detecting the obstacles to the implementation of preventive measures, people also brought attention to overcrowded housing, poor access to water and inadequate or absent sanitation. Based on this, on the one hand INTERSOS worked on health education with communities, on the other, it undertook institutional advocacy actions stressing the importance of swift and effective actions to protect collective health.

Finally, INTERSOS conducted advocacy on the institutional and local level to bring attention to the highly critical problems posed by the fact that for many people it’s impossible to self-isolate, as they either live in overcrowded housing, in degrading conditions, or they are homeless (see par. 3.1 and 3.2).
2.2.2 The impact of the COVID-19 emergency on the quality of life of migrant populations living in conditions of social exclusion

An important part of the community-based intervention focused on the impact of the pandemic in terms of psycho-social wellbeing; the survey carried out with INTERSOS staff also falls under this aspect. From June to September, a qualitative-quantitative survey was carried out in order to better understand the impact of the emergency situation linked to COVID-19 on the mental health of people living in conditions of social exclusion in Rome, Capitanata and East Sicily.

It should be specified that, in this context, quality of life is understood as a multidimensional construct based on the perception that the individual has with respect to their place in life, in relation to the cultural context, their value system and with respect to their own existence (goals, expectations, standards and interests) (17, 18). This is a very broad and complex concept that takes into account each individual’s physical, psychological, and social health status, level of independence, social relationships, personal beliefs, and relationship to salient features of the environment (19). This definition supports the idea that quality of life refers to a subjective assessment that includes positive and negative dimensions and is embedded in a given cultural, social, and environmental context.

The survey explored whether migrant people perceive their needs as being met, and what kinds of strategies and resources they deploy to feel fulfilled. In addition to this, the survey also dedicated a special focus to the health and social crisis, exploring how the radical change brought about by the health emergency has affected the quality of life and level of satisfaction, as well as mental health, of the migrant population; if and in what ways people have perceived a decline in their quality of life; what kind of strategies they have put in place to cope with the situation.

INTERSOS staff in Rome, Capitanata and East Sicily were trained and instructed to follow a structured research plan, which involved handing out questionnaires and conducting interviews and focus groups with the people met during the mobile teams’ interventions.
TOOLS

Social and Personal Data Form
Prior to the beginning of every session, the staff completed the Social and Personal Data Form, which was the same for all three types of instruments.

Quantitative tools
Two testing tools were used: the WHO Quality of Life-BREF and the Impact Event Scale-Revised (IES-R). Questionnaires were provided in French, English, and Italian to persons with a good understanding of one of these languages.

The WHO Quality of Life-BREF is a tool developed by the World Health Organization to assess quality of life. The WHOQOL-BREF is an abbreviated form of the WHOQOL-100, and it explores a person's subjective perceptions of their state of health through 26 items.

The Impact Event Scale-Revised (IES-R) was used to assess COVID-19-related post-traumatic stress symptoms and for the general assessment of the impact of the event on the affected population. The IES-R is a short, easily administered self-assessment questionnaire containing 22 items. The IES-R is not a diagnostic tool for post-traumatic stress disorder; rather, it is based on the patient's own description of the symptoms and is used to assess response no earlier than one to two weeks after a traumatic event. Questions on the IES-R are designed to assess the emotional impact and traumatic effects of an event, as well as the severity of PTSD symptoms over the previous seven days. The IES is divided into 3 subscales: intrusiveness (difficulty staying asleep, dissociative experiences similar to flashbacks), avoidance (the tendency to avoid thoughts or reminders about the event), and hypervigilance (feelings of irritation, anger, difficulty in sleeping).

Qualitative tools
The research explored the impact of the health crisis on the quality of life of migrants living in conditions of social exclusion through the use of two qualitative tools: the semi-structured interview and the focus group. The use of the semi-structured interviews and focus groups made it possible to analyze the participants' perceptions regarding the areas that are determinant in quality of life: physical health, psychological health, social relations, environment. The research focused particularly on the ways in which subjective perceptions of quality of life have changed since the pandemic, and included questions about the participants' well-being before and during the health emergency. The interviewer followed a pre-set framework that outlined the topics that needed to be covered. Since this was a semi-structured interview, interviewers started from previously identified broad questions, and during the course the interview adapted the questions to the conversation with the participant. At the same time, creative methods were employed: for example in some cases, the interviewers invited respondents to quote phrases, images, or lyrics from a song that they thought could represent their experience, or help them better express their perception of how their quality of life had changed since the advent of the pandemic.

The qualitative data collected through interviews and focus groups were audio-recorded, transcribed, and underwent thorough thematic analyses according to the methodology proposed by Braun and Clarke (20). The main results of the survey are presented in section "3.4 The impact of the emergence of COVID-19 on quality of life in contexts of social exclusion".

8 Available at: https://www.who.int/tools/whoqol/whoqol-bref

2. APPROACH TO THE DEVELOPMENT OF THE INTERVENTIONS - AN UNEQUAL PANDEMIC

2.3 INSTITUTIONAL ADVOCACY AND COLLABORATION WITH THE PUBLIC HEALTH SERVICE

INTERSOS has pursued an approach that combines institutional advocacy with collaboration between public and private social sectors. The projects set out to support the health service and public policies while raising awareness on critical issues and inefficiencies, whenever necessary, over shortcomings and critical issues. They then bring attention to the areas and actions that national and local institutions must take on in order to fully protect the health of individuals and communities. Local and national advocacy interventions were developed also through the support and joint work with networks made up of organizations and associations engaged in the field of ‘health and migration’, both on the local and at the national level (for example by participating in the Immigration and Health Roundtable10 and the Asylum Roundtable11).

In the context of the COVID-19 emergency these have drawn attention to some serious institutional failures in the management of the pandemic in contexts of strong social marginality. Institutional advocacy actions have aimed to address public policies and the allocation of resources to protecting the health of people and communities, through the strategic use of information and experiences built up on the field. The actions have mainly focused on two core critical aspects that were exacerbated by the onset of the pandemic:

- **The living conditions of people in contexts of social exclusion.** The actions paid special attention to the social determinants of health and focused on the protection of the right to health from a global health perspective. This way, they highlighted the structural interventions necessary to truly protect individual and collective health, both from a context-specific viewpoint and on the broader level of migration policies. In the specific case of the COVID-19 emergency, this means providing people with the tools to implement basic preventive measures, to access local health services without barriers and discrimination, to be protected by inclusive policies aimed at integration and recognition of human rights;

- **The absence of national guidelines for the prevention, monitoring and management of the SARS-CoV2 epidemic for populations living in contexts of extreme marginality and in conditions of high vulnerability.** In the emergency context of the pandemic, the elaboration of data and guidelines regarding the migrant population and/or those in conditions of social exclusion arrived only after months, and also thanks to the advocacy actions of organizations that were already active in the field. What is evident, independently of the COVID-19 emergency, is that the most marginalized populations must always be included in the political agenda, in the organization of social and health interventions and in the definition of public policies, as a necessary condition to protecting the health of individuals and communities. Indeed, faced with complex health needs, these populations have less access to resources and services, less protection, and consequently greater exposure to health risk factors; the result is the amplification of social and health inequalities.

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10 The Immigration and Health Roundtable (Tavolo Immigrazione e Salute) brings together 10 different organizations: Associazione per gli Studi Giuridici sull’Immigrazione (ASGI), Emergency, Centro Astalli, INTERSOS, Medici contro la Tortura, Médecins du Monde, Medici per i Diritti Umani (MEDU), Médecins Sans Frontières (MSF), Società Italiana di Medicina delle Migrazioni (SIMM) and Caritas Italiana, are the founding members; since then, NGO Sanità di Frontiera also joined. UNHCR, IOM, the Italian National Institute of Health (Istituto Superiore di Sanità, ISS) and NAGA also participate in the meetings as permanent external members.

INTERSOS established a collaboration with the public sector and specifically with the Regional Health Services, in addition to the social policies department of the Municipality of Rome. This choice was based on establishing and maintaining a dialogue between institutions and private-social organizations active in the territories, in accordance with the principle of subsidiarity. According to this approach, the alliance between the public institutional sector (which exercise governance in order to guarantee the universality of the right to health) and civil society committed to the protection of the health of the immigrant population is fundamental. Indeed, civil society should be seen as a valuable local resource, as it can observe and report on the accessibility of the right to health from the field, as well as provide expertise and access to already active networks of associations and services; on the basis of this, social and health interventions can be more efficiently designed (21).

In the absence of national guidelines, from the earliest stages of the pandemic INTERSOS proposed a collaboration with local health institutions to define operating procedures, based on the theoretical and practical principles of Primary Health Care (22).

This has made it possible to integrate the national provisions relating to COVID-19 with the Proximity Public Health (PPH) approach aimed at the most hard to reach contexts, to reign in the skills built up through years of field work and to place the community at the center of interventions, as the bearer of needs and resources.

INTERSOS simultaneously intervenes on the local level and supports the public health service. This approach has led the organization's activities to develop from mainly orientation to local services and empowerment of the population, to becoming a formal partner of the Regional Health System and other local public institutions. This has entailed the acquisition of a mandate to carry out prevention and monitoring activities regarding pandemic trends in the contexts in which it operates. This has allowed for the skills and experience gained over time by INTERSOS staff to be put to full use in supporting the public sector's efforts to implement a community-based approach to health work. Indeed, the public health service must assume central role in protecting the health of populations in vulnerable conditions, and consequently of the entire community.
2. APPROACH TO THE DEVELOPMENT OF THE INTERVENTIONS - AN UNEQUAL PANDEMIC

**BOX: CASE STUDY**

**CASE STUDY - THE PROCESS OF TRANSFORMING UNDECLARED WORK INTO REGULAR EMPLOYMENT: A CRITICAL PERSPECTIVE FROM THE CAPITANATA EXPERIENCE**

*Authored by Daniela Zitarosa and Elda Goci*

**CONTEXT**

Today, due to the governments’ failure over the last decade to plan a sustainable migration policy that could offer sufficient legal pathways to enter and remain in the country, hundreds of thousands of third country nationals who have been living in Italy for a long time are without a residence permit. Instead, recent governments have introduced highly restrictive legislation governing migration to Italy, the peak of which was reached with the so-called “Security Decree” in 2018 (L. 132/2018). The people affected by these policies are mostly workers in important sectors of the Italian labor market (such as family assistance, agriculture, logistics, etc.), or rejected asylum seekers.

There are several causes behind the immense difficulty to obtain a residence permit, which afflicts thousands of people. Among them we can find the lengthy bureaucracy behind the administrative practices, public administrations’ improper and in some cases illegitimate practices and finally the lack of legal pathways to access Italy, including, in the area of labor migration, the absence of ad-hoc provisions establishing quotas of entry.

Finally, the entry into force of Law 132/2018 (the s.c. Security Decree), has drastically affected foreigners’ chances of obtaining and maintaining legal residence in Italy, and has made the legal status and reception conditions of asylum seekers even more precarious.

According to data provided by the Italian Institute for International Political Studies (ISPI) in its latest report published on January 31, 2020, the number of foreigners irregularly present in Italy is estimated to be around 600,000. This number is also in line with the estimate in ISMU foundation’s report on immigration, which sums together the irregular immigrants present as of January 1, 2019, the people who have received a rejection of their asylum application as of the beginning of 2019 (until May 15, 2020), and the people with cases that were still pending on May 15, 2020, bringing the total to about 690,000 people.

Despite the lack of reliable data, it is estimated that approximately 40,000 seasonal agricultural workers are employed every year in Apulia. Of these, at least half work in the Province of Foggia; here, an increasing number of people are forced to settle permanently or for significant parts of the year in informal settlements that lack the minimum conditions for a dignified life. It is well known that the majority of foreign people employed in agriculture are in precarious working conditions. It is equally well known that labor exploitation is a consolidated phenomenon across the province, and that in the recent past conditions have sometimes deteriorated to the point of slavery.

**THE LEGAL PROCEDURES BEHIND TRANSFORMING UNDECLARED WORK INTO REGULAR EMPLOYMENT**

Despite the appeals and proposals made by civil society for an integrated and coherent response to the demand for regularizing foreigners in Italy, the provision adopted by the Government does not solve or remedy to the needs of the thousands of foreign persons exposed to exploitation and social marginalization. This procedure was regulated by Article 103, paragraph 1 of Decree-Law No. 34 of May 19, 2020 converted with amendments into Law No. 77/2020. The purposes of the provision, as written in the article, were to ensure adequate levels of protection of individual and collective health in response to the current health emergency and to encourage “the conversion of undeclared work into regular employment”
THE LAW - IN BRIEF

It should be noted that INTERSOS did not carry out any legal counseling activities and therefore did not follow the regularization procedure on an individual basis. In the framework of the social and health project in Capitanata, we proceeded - after an ad-hoc training with the staff - to give general information about regularization. The aim was to refer the people we engaged with to the services that could provide stable and continued legal support. Moreover, the procedure was not very clear from the beginning in terms of the law itself, and contained, among other things, particular causes for exclusion. For this reason, INTERSOS decided not to proceed with group information sessions but to refer towards individual sessions with competent actors, in order to facilitate an individual assessment of the situation, and of the requirements that needed to be fulfilled to proceed with the application.

In the next paragraphs we will briefly examine some parts of the procedure, in order to better shed light on how its limitations had a visible effect in the context in which the INTERSOS medical and social-health project was operating. However, this is by no means a comprehensive account of this complicated legal provision.

The procedure for the conversion of irregular work into declared employment was only active for a specific period of time. In this sense, although it did not foresee quotas, it was similar to a *decreto flussi*, an Italian legal provision that is issued annually and establishes how many non-European citizens can enter Italy for work. Moreover, this provision concerned only specific work sectors, namely agriculture, domestic work and personal assistance. Regularization could be carried out in two ways:

1. The employers (Italian citizen, EU citizen or third country national) if they worked in the above-mentioned sectors, could:
   • enter an ex-novo contract with a foreign citizen who is present in Italy;
   • reveal the existence of an ongoing irregular work relationship with Italian citizens, EU citizens or foreign citizens who are present in Italy.

2. Paragraph two allowed third country nationals whose residence permit had expired or could not be converted after 31.10.2019 and who could prove previous employment in one of the above-mentioned areas, to apply for a temporary residence permit. The permit would last six months from the submission of the application. During this time, the permit could be converted into a work permit if the foreign national could meet certain requirements.

In both cases, applicants needed to provide proof of presence in the country since before 8.03.2020 and proof of not having left the country after this date. The presence in Italy before the expected date could be demonstrated through the following evidence:

• Declaration of presence on national territory pursuant to Law n.68 of 28.5.2007;
• Photographic identification and fingerprinting;
• Certificates or documents issued by public entities with a stated date.

In addition, third country nationals who wanted to access the application for a temporary work permit of stay also had to demonstrate:

• That they had carried out work activities, particularly if these could be duly proven, before 31.10.2019, provided that they were in certain work sectors.

Income requirements were also required, which will not be examined here.

MAIN LIMITS

I. The work sectors identified by the law:
This legal provision excluded many economic sectors in which foreign nationals are also largely employed in irregular work, such as industrial manufacturing, construction, the commercial sector, logistics, transportation, and the food and catering sectors. Therefore, a large part of the population without residence permits that is currently employed or employable in one of the excluded sectors has been left out.

II. The requirements to prove presence in Italy and the ownership of a permit that expired only after 31.10.2019
One of the pieces of evidence that are allowed as proof of one's presence in Italy before the established date was related to photographic identification and fingerprinting. Many foreigners, despite having lived in Italy for many years, have never been officially registered through this process. For example, this excludes the people who are imprisoned at home by their exploiters, or people who are employed in irregular work and subjected to regimes of control and deprivation of personal freedom.

The requirement for the second option (the one offered by paragraph two), that is having a residence permit that expired or could not be converted only after 31.10.2019, is even more difficult to prove. Many people have been present in Italy for longer and in conditions of irregularity, but could not submit an application because of lack of the required “support” of their employer. Even though they possessed every other requirement, many people living in the settlements could not access the procedure offered in para. 2 because their residence permit had expired or had not been converted before that date.
III. Possession of a valid passport

Another exclusionary requirement was the ownership of a valid passport. Many of the people present in Italy do not have one, not to mention the fact that the consulates - which should issue of passports - require highly time-consuming procedures, which were not publicly accessible during the period of the COVID-19 emergency.

IV. Costs of the procedure

The costs, which differed according to whether they were for the first or second paragraph, in practice fell entirely on the third country national. INTERSOS gained indirect information that there have been some cases of fraud against the applicants, who paid much higher sums of money than those required by the provision, and who are not even sure whether their application was successful.

V. Causes of exclusion

Finally, it should be noted that a criminal record or a judgment of social dangerousness (pericolosità sociale) is another grounds for exclusion that results in the inadmissibility and rejection of the application, for both employers and employees. These clauses will not be examined here; although they impacted a small group, they have further limited the possibility to access the procedure.

CONCLUSIONS

The low number of applications from agricultural workers only confirms the inadequacy of a measure that does not take into account the complexity of the problem. The provision did not lead to the regularization of many people, who remain undocumented in Italy. According to the official data published in the report available on the Ministry of the Interior’s website, the total number of received applications was 207,542. About 85% of the total applications concerned domestic work and personal assistance, compared to only 15% of applications for the regularization of employment, corresponding to 30,694 applications; among these, only about 29,500 involve the agricultural sector. Noting that the majority of the applications were presented by employers in the field of domestic work and assisted living, it can be easily deduced that the problem of labor exploitation in the agricultural sector has not been properly addressed. This assessment is further supported by the data on the applications submitted in the Province of Foggia, an area that has been historically affected by this social problem.

In Apulia the total number of applications submitted for regularization of employment is 2,871, of which 1,268 in the province of Foggia. It should be noted that this data does not refer to successful applications, but only to the total number of applications submitted.

In conclusion, the muddled phrasing and sheer amount of loopholes and limitations contained in this provision has made the procedure very complicated and limiting. It was issued without paying attention to the broader picture and to the exploitation most irregular migrants experience, in the agricultural sector and beyond.

Beyond the limited scope of the legal provision, there were also further obstacles encountered in putting it in practice; the result was that the process certainly did not meet the expectations generated among the people to whom the regularization was addressed.

A reform of national legislation on immigration and on regularization of people residing in the country without a permit is the only way to counteract the exploitation of these workers and to allow them to acquire a legal status as persons and not only as labor. Comprehensive institutional action is needed on several interconnected levels. Planning must lead to effective social, housing and work inclusion and must effectively counter the system of exploitation on which the entire agricultural work chain is based, from sowing to harvesting agricultural products. In fact, the institutional actions taken so far are clearly partial and unsatisfactory, quantitatively and qualitatively insufficient, and even harmful to the purpose of freeing people from conditions of exploitation, degradation and, sometimes, slavery.
3. Main actions and achievements in the COVID-19 emergency projects

This section introduces the main results of INTERSOS’ Projects on the COVID-19 emergency. The first section describes the institutional advocacy actions on a national level (3.1), followed by a section on collaboration with territorial services in individual contexts (3.2); section 3.3 presents the activities carried out with the communities, including the main results of the quantitative analysis of the data collected through the clinical risk assessment forms. The final, concluding section presents the results of the qualitative-quantitative survey on the impact of the pandemic on the quality of life of people living in contexts of extreme social exclusion (3.4).
3. MAIN ACTIONS AND ACHIEVEMENTS IN THE COVID-19 EMERGENCY PROJECTS - AN UNEQUAL PANDEMIC

3.1 ADVOCACY ACTIONS AT THE NATIONAL LEVEL

From the earliest stages of the spread of the epidemic in Italy, INTERSOS, in collaboration with other non-governmental organizations and networks of associations,12 initiated a considerable amount of advocacy actions at the national and local level to ensure the timely adoption of measures to prevent and contain the pandemic in contexts of extreme marginalization.

ADVOCACY FOR GLOBAL HEALTH: ACTIONS ON A STRUCTURAL LEVEL

Since the beginning of March, a number of letters have been sent to the Ministries of Health, of the Interior, of Labor and Social Policies, of Agricultural Food and Forestry Policies, to the Italian National Institute of Health (Istituto Superiore di Sanità, ISS), to the Presidents of the Regions of Lazio, Campania, Apulia, Calabria, Basilicata and Sicily, and to the “Emergency Government Commissioners for overcoming situations of particular social hardship” who were appointed in 2017 for the areas of Manfredonia (FG), San Ferdinando (RC) and Castelvolturno (CE). These institutional advocacy actions, combined with informative communications,13 highlighted the urgent need to adopt further prevention measures, in terms of promoting access to health services, water, sanitation and measures to guarantee personal hygiene for people in conditions of social marginality.

The letters sent by INTERSOS and the other signatory organizations emphasized the risk posed by the overcrowded living conditions and the scarce or inexistent access to water and sanitation in these contexts, as well as the possibly serious consequences in terms of containment. Moreover, the letters urgently requested the Regions to coordinate with other competent institutions in the area (prefectures, municipalities, local health authorities, etc.) to quickly transfer the people living in informal settlements to suitable reception facilities. These should be small or at least able to guarantee the respect of the hygienic and sanitary measures detailed by the government decrees on the COVID-19 emergency. In view of the state of emergency, it was suggested that this measure be adopted without making distinctions on the basis of individual legal status, so as to avoid excluding persons without a residence permit or with a type of permit that does not allow inclusion in reception facilities for people with international protection (known as SAI), or on the basis of the cessation or revocation of previous reception arrangements.

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12 Immigration and Health Roundtable, Asylum Roundtable, Italian Association for Juridical studies on Immigration (ASGI), Médecins du Monde Missione Italia, Medici contro la Tortura, Medici per i Diritti Umani, MSF, Società Italiana di Medicina delle Migrazioni, ARCI, A Buon Diritto Onlus, ActionAid, Ero Straniero campaign, CNCA, Federazione delle Chiese Evangeliche in Italia, Oxfam, Sanità di Frontiera, Terra!

These letters also indicated that while such transfers were being arranged, it was essential that a series of measures be urgently adopted to ensure:

- an **emergency water supply** providing the necessary amount of drinking water;
- the distribution of **hygiene kits** on a regular basis;
- the availability of **toilets** and **regular waste collection**;
- **information and orientation activities**, distributed with the help of cultural mediators or community mobilizers from the main nationality groups living the settlements, and the distribution of information material in multiple languages;
- **interventions** (e.g. through mobile units) to enable the **timely identification of persons with symptoms or risk factors for COVID-19**, so that the necessary sanitary measures can be taken immediately;
- **identification of facilities where people could be placed for self-isolation and/or quarantine**.

The letters also highlighted the need for regional institutional roundtables coordinating the social and healthcare aspects of the management of the epidemiological emergency, in collaboration with private social organizations that are active in the area. Another point that was raised was the need to remove administrative barriers that hinder access to local health services.

Finally, the letters raised the critical issue related to the territorial competence of the provincial Police Headquarters (**Questure**) responsible for the bureaucratic-administrative procedures determining legal status. In fact, as permit applications are managed by local authorities, most of the people living in these settlements, who started the application procedure in another city, was put in the condition of having to travel around the country at a time when this was severely restricted and discouraged.

**ADVOCACY FOR THE DEFINITION OF PATHWAYS TO ACCESS LOCAL HEALTH SERVICES**

In addition to what has already been highlighted, the first phases of the pandemic were marked by the absence of specific national guidelines for interventions safeguarding people with a migratory background and other people in conditions of social marginality. The Immigration and Health Roundtable and the Asylum Roundtable have immediately brought attention to the limited response capacity at the local level and to the inequality in inconsistency of the measures adopted in different areas, emphasizing the need for national governance and for clear, coherent guidelines for services at the local level.

This was considered a necessary step to avoid fragmentary and improvised responses and to ensure the protection of the right to health for people and groups living in conditions of marginality.

In March and April, after having monitored the management of the COVID-19 emergency in the reception facilities within their networks, the Asylum Roundtable and the Immigration and Health Roundtable asked the Ministers of the Interior, of Health, and of Equal Opportunities as well as the Civil Protection Department to elaborate specific guidelines addressing populations in conditions of vulnerability and marginality.
These letters called for:

- **the definition of guidelines for open and safe access to the reception system** (mainly under the management of the municipalities, the national association of Italian municipalities, known as ANCI and the prefectures);
- **the activation of a technical roundtable** by Italian National Institute of Health for the definition of ad interim national guidelines;
- **a stronger governance effort** of these processes and the adoption of monitoring systems.

In July and September 2020, INTERSOS participated (and also represented the two roundtables) in the delegation that was invited to the meetings convened by the Ministry of Health as a consultant for the elaboration of the ‘Interim operational guidelines for the management of facilities hosting people in situations of high fragility and social and health marginalization in the framework of the COVID-19 epidemic’. These guidelines were drafted by the National Institute for Health, Migration and Poverty (NIHMP) (8).

In this meeting, the delegation also raised the need to draft operational guidelines dedicated to informal settlements. In the following months, the dialogue with the institutions continued, and INTERSOS shared some critical issues that emerged from the teams’ direct experience in the field.

Despite the initial results obtained with the publication of the interim guidelines in July, and their updated version in October, it should be noted that the institution only addressed these issues at a late stage, and that the operational guidelines are not binding for the Regional Health Systems. Indeed, a complicating factor is that health services are under the jurisdiction of regional governments, whereas migration policies are managed exclusively by the national government. Therefore, the subject of “health and immigration” remains ambiguously suspended between the legislative powers of the State and that of the Regions. The result is the inconsistent application of national regulations and guidelines at the local level, with consequent inequalities in protection of health and access to health services (16).

**THE CASE OF THE QUARANTINE SHIPS AND QUARANTINE BUSES IN UDINE**

INTERSOS, along with other organizations from the Migrant Minors Roundtable (Tavolo Minori Migranti), the Immigration and Health Roundtable and the Asylum Roundtable, has carried out advocacy actions regarding the use of quarantine ships. These ships are used for people who have just arrived to Italy by sea, not only for those who tested positive for SARS-CoV2, but also for those who have not yet been tested. Moreover there have been many cases of adults who were transferred on board after testing positive in reception centers on land, who had therefore already been in Italy for some time.

With regard to the Unaccompanied and Separated Minors (UASM) who had just arrived in Italy and were placed on the ships for a 14-day quarantine (or, for positive cases, for all the duration of the infection), the Migrant Minors roundtable requested and obtained a meeting with the Ministry of the Interior.

Here it strongly emphasized the illegitimacy of the detention of UASMs on quarantine ships, and proposed some alternatives, such as the transfer of UASMs who tested positive for SARS-CoV2 to AMIF centers that could function as spaces for self-quarantine while waiting to be placed in a reception center for minors (in...
the SIPROIMI\textsuperscript{14} system). As a result of the joint advocacy effort, UASMs were no longer placed on quarantine ships.

The Asylum Roundtable wrote a joint letter to the Ministry of Interior, advocating against the placement of adults and families who have just arrived to Italy on ships for the 14-day quarantine, and with respect to the transfer of positive adults from reception centers to ships. While they obtained the interruption of such transfers from land, the placement of people who have just arrived in Italy has continued.

Another serious case of poor management of the mandatory quarantine period occurred in Udine, where two buses were used as quarantine facilities. On September 5th two buses were parked in a city park; the authorities asked 30 people coming from the Balkan Route to spend the quarantine period here without leaving. Two chemical toilets and a hose were the only means offered for personal hygiene. On September 14 INTERSOS, together with the Udine-based association Ospiti in Arrivo, ASGI and ActionAid, wrote to the Prefect of Udine and to the Head of the Department of Civil Protection about this violation of human rights. The letter recalled the March 17, 2020 government decree, the so-called 	extit{Cura Italia}, according to which prefects can requisition suitable facilities to host people under medical surveillance and self-quarantine. It was not until September 24 that the 30 people were finally transferred, and since then this unworthy, harmful and discriminatory practice was stopped. This episode shows how improvised solutions can be highly inadequate, stigmatizing and disregarding of human rights and how the only acceptable reception conditions, regardless of the pandemic and even more so now, are in small facilities that should be well distributed in each area. This would be the preferable way to protect a person's dignity, and ensure access to a healthier environment that could be appropriate for prevention.

\textsuperscript{14} The SIPROIMI system would later change acronym to SAI system in December 2020.
INFORMAL SETTLEMENTS OF AGRICULTURAL LABORERS AS NEGATIVE DETERMINANTS OF HEALTH.

How to overcome a system that produces ghettos?

The system of exploitation on which the entire food supply chain is based starts from the large-scale retail chains, which impose low prices. This situation harms above all the last link in the production chain: agricultural workers. The most exploited and blackmailed part of these workers are migrants, who sometimes get as little as €3 per hour, and who populate the informal settlements, particularly in southern Italy, forming what could unmistakably be defined as ghettos. For over 20 years there have been repeated institutional attempts to overcome these places where people’s rights and dignity are continuously denied, where the precariousness of living conditions undermines the health of the inhabitants. Sadly, these efforts reaped no effective result, because they have often been framed as emergency interventions and have not been systematic.

Priority objectives must range from proper communication to the legal protection of foreign nationals, from reception to the right to housing, from public transport to the fight against caporalato and exploitation in agriculture, enforcing respect for all regulations and wage levels established by law and collective agreements, and ensuring an effective match between supply and demand for labor.

The precariousness of the legal condition makes these workers easily blackmailed and often willing to accept any condition in order to have a job; the lack of an effective recruitment system determines the presence of intermediation, fueling irregularities and the improper exercise of power over workers, conditions that are strongly detrimental to their rights. Finally, large-scale housing solutions for agricultural workers should be avoided, as they respond only to the need for housing, without considering the complexity of exploitation and the need for a multidisciplinary approach, creating the risk of reproducing the dynamics of ghettos in an institutionalized form.

In September 2019, the Capitanata proximity Network, made up of 12 associations that operate stably in the province, created a Platform in which it presented the critical aspects and limitations of the initiatives carried out so far in the area; first of all, it criticized the evictions of the informal settlements, implemented in a way that was completely unrelated to the needs and the will of those who live there and, more importantly without providing real alternatives to workers.

It is essential to directly involve the communities living in the settlements, more than the private social sector that provides assistance. The communities are too often ignored by the institutions that manage the phenomenon. It is also essential to structure paths of social integration that put an end to the season of hatred and discrimination that has recently governed the issue of migration, a stance that has fed on misrepresentations of reality.

15 Caporalato is an illegal form of recruitment and organization of labor in the workforce. The name derives from the jargon word for the middlemen - the caporal - who hire workers for a short period of time (daily or weekly at most) without respecting the rules for hiring or the workers’ rights.

3.2 LOCAL ADVOCACY ACTIONS, DEVELOPMENT OF INTERVENTIONS, AND COLLABORATION WITH LOCAL SERVICES

In terms of collaboration with local services, numerous critical issues were raised in the initial phase, which varied from context to context. In general they can be summarized in the following points:

- **The lack of targeted interventions** in informal settlements and in contexts of strong social exclusion by the health services;
- **The absence of dedicated facilities** for the self-isolation of asymptomatic but COVID-19 positive persons who do not have an appropriate place in which to self-isolate;
- **The need for immediate transfer** of persons with known conditions of vulnerability to appropriate facilities;
- **In Rome, the absence of a coordination platform** for Regional-Community-ASL-private social service interventions, to issue key directives and procedures, and to set up a coherent operational strategy.

The need to build targeted interventions for and with the most marginal populations is based on the principle of equity, one of the founding pillars of the NHS, and on the imperative to protect the health of the most fragile as a strategy to protect the health of the entire population.
3. MAIN ACTIONS AND ACHIEVEMENTS IN THE COVID-19 EMERGENCY PROJECTS - AN UNEQUAL PANDEMIC

3.2.1. Rome

From the earliest stages of the pandemic, the strategy of the Mobile Health Teams in response to the COVID-19 Emergency has been to ensure the continuity of the activities of orientation to the local healthcare services. The ‘mobility’ aspect of the activity was enhanced, and the team’s activity was presented as a proximity COVID-19 risk assessment unit, which was also developing collaborations with local health institutions. This is also because, in the complexity of the Roman context, INTERSOS has rapidly pointed out to local institutions the absence of access to diagnoses for symptomatic or at-risk homeless people, as well as the absence of facilities for the accommodation of symptomatic people or people who show mild symptoms, or who had contacts that put them at risk, who are homeless or in a condition of social vulnerability. As early as the beginning of March, the remodeling of INTERSOS’ activities led to the development of intervention strategies to support the homeless population and the people in conditions of social exclusion. To this effect, INTERSOS proposed a collaboration with the local authorities; this immediately led to the formalization of support by the Municipality of Rome, and a strengthening of the operational collaboration with ASL RM1 and RM2 (both with the Migrant Health Operational Unit of ASL RM1 and with the Hygiene and Public Health Service of ASL RM2).

The teams in Rome conducted health education activities, risk assessment and referral to healthcare services that take charge of cases posing SARS-CoV-2 related risks for the homeless and socially marginalized. They focused on the main housing squats in the area under the management of ASL RM2 (assessed on the basis of the number, social fragmentation and hygiene and health conditions), and on the informal settlements nearby and at the main stations of Rome: Tiburtina and Termini. In April, following the requests of citizen committees, of service sector organizations and of the ASL itself, the activity was extended to other housing squats, low-threshold services and proximity spaces (an overview can be found in the first section).

The implementation of interventions for the prevention and monitoring of the pandemic clashed, in the initial stages, with the difficulty of building an inter-institutional dialogue on social and health care. This is tied with the lack of coordination of interventions in such a complex urban landscape in which different actors of the public and private sector operate.

The city has suffered from the weakness in health governance with regard to the management of access to health and prevention measures for people in more fragile conditions and situations of social exclusion. This, in turn, has limited the ability to build effective and integrated operational responses.

An additional critical issue is posed by the suspension of new admissions into shelters since March, with the exception of persons with serious vulnerabilities, minors and persons who needed access to shelters for highly vulnerable people.

However, the absence of clear operational procedures has made placement in facilities difficult, even in the cases where this remained possible. The responsibility for the management of the health aspect of admissions was delegated to the referents of the various municipal departments who, in turn, developed more or less valid procedures. The result was an extreme fragmentation and arbitrariness in access to facilities. The suspension
of new admissions has meant not having housing solutions to offer to people who would have needed protection more than ever.

In collaboration with a network of organizations in the area and the Municipality of Rome, INTERSOS immediately began discussions with the Chief of Staff of the Lazio Region, the Councilor for Social Policies, the Councilor for Welfare, Local Authorities, the Head of the Secretariat of the Department of Health and Social-Health Integration, the directorates of ASL RM2 and ASL RM1, with the aim of:

- allowing access to information on the good practices and the specific rules to follow for the prevention of COVID-19 for the homeless population and/or for people in a condition of social exclusion;
- identifying people in this context who show symptoms (cough, fever, cold) at an early stage and referring them to medical surveillance plans established by the Regional Health System (RHS);
- supporting the RHS, in collaboration with local institutions (Municipality, Prefecture and Civil Protection Committees), to guarantee the reception and health surveillance of homeless and/or socially excluded people.

The discussions revealed the need to structure a coordination service to monitor the evolution of the epidemiological situation for the homeless population or for people living in a condition of marginality, as well as the need to dedicate one or more facilities for the reception of symptomatic homeless persons and/or those who presented particular risk factors for COVID-19.

Already in March, the Municipality of Rome (Assessorato alla Persona, Scuola e comunità solidale) proposed a collaboration agreement to open an emergency health center with 21 beds for the reception of Italian and foreign homeless people in vulnerable conditions. Access to the center occurs through a referral from the Social Operations Room (Sala Operativa Sociale). INTERSOS has been asked to carry out screening for COVID-19 risk upon entry into the facility, also due to the competent ASL's lack of responsiveness at that specific time.

In May, INTERSOS concluded a collaboration agreement with the Municipality of Rome (Reception and Inclusion Directorate, Contrast to Social Exclusion Unit) for the development and implementation of a model of medical surveillance and social-health care to protect people who are homeless or otherwise vulnerable. In close collaboration with the relevant ASLs and managing bodies, INTERSOS launched support activities for the city's reception centers and services related to the Social Operations Room (SOS), for a total of 24 facilities.

Support actions include training the personnel in the reception centers on the basic principles of prevention and control of care-related infections (including the appointment of specific dedicated figures) the definition of standard operating procedures and flowcharts on the active search for suspected cases of COVID-19 in reception facilities, accompanied by constant support and supervision. In addition to this, medical examinations are carried out to assess the risk of COVID19 and guidance is provided for new admissions and for inhabitants who are showing symptoms, pending transfer, when needed, into other suitable facilities for quarantine.

A total of three memoranda of understanding were signed between INTERSOS and the Social Policy Department of the Municipality of Rome:

17 Società Italiana di Medicina delle Migrazioni, Caritas, MSF, Medici per i Diritti Umani, Médecins du Monde, Comunità di Sant’Egidio.

18 Department for the Person, School and Solidarity Community.
1. Municipality of Rome - prot.n 19110 of 19 March 2020 (Subject: ANTI-COVID 19 measures addressed to people who are homeless and/or in conditions of social exclusion in Rome), for an intervention with homeless people in stations, social canteens and in support of the Social Operations Room;

2. Municipality of Rome - prot.n 27527 of 04 May 2020 (Subject: collaboration agreement for the development of a model of medical surveillance and social-health care to protect people who are homeless or in a condition of fragility in the context of the COVID 19 health emergency) for the support to the city's reception centers of the city, to the centers of the Social Operations Room reception circuit and to the SAI/SIPROIMI center for emergency use Barzilai;

3. Municipality of Rome - prot. QE/2020/70797 of November 16, 2020 (Subject: Collaboration agreement for the monitoring, screening and assistance of people with social and health fragilities, within the framework of the COVID-19 health emergency), for the implementation of guidelines for the reopening of reception facilities in Rome, training in centers for UASMs, anti-trafficking centers and SAI centers, and for the medical surveillance of bridge centers.

In addition to this, INTERSOS signed a protocol with ASL RM2 and the Municipality of Rome:

4. ASL RM2 and Municipality of Rome, December 22, 2020 (Subject: quarantine protocol in Barzilai and Bakhita intermediate facilities; i.e. bridge centers)

and a fifth one with ASL RM2:

5. ASL RM2, INTEROSOS, Medici per i Diritti Umani, Sanità di Frontiera onlus, January 13, 2021, for the strengthening of primary health care (PHC) for foreign and Italian citizens in fragile conditions, in view of the ongoing COVID-19 epidemic.
BOX: DEEPENING

THE ESTABLISHMENT OF INTERMEDIATE FACILITIES, OR BRIDGE CENTERS, IN ROME

In July 2020 a Bridge Center, called Barzilai, was established for the precautionary isolation of people who are waiting for transfer in SAI/SIPROIMI reception centers for asylum seekers and refugees, through the collaboration between INTERSOS and the Department of Social Policies (particularly the Immigration Office) and the ASL RM2 (Department of Prevention, and Operational Unit for the Protection of Immigrants and Foreigners). An intermediate facility, or bridge center, is a safe place equipped with single rooms and private bathrooms in which to wait for the days needed to ensure a safe entry into the SAI/SIPROIMI service to which one is assigned. Here, a nasopharyngeal swab test is carried out at the beginning and at the end of the stay. The establishment of an intermediate facility was necessary to protect the health of guests and staff. INTERSOS guarantees medical screening for the people in the facility and orientation to services in response to emerging health needs; at the same time, the ASL guarantees the swabs, which are carried out upon entry and on the 14th day (currently on the 10th day, according to the latest guidelines from October 12). When there is a positive case, the person is transferred to the Urban Hotel in Rome, which has been converted into a hosting facility for cases with mild or no symptoms.

BARZILAI

Barzilai is a SAI/SIPROIMI reception center managed by the cooperative Medihospes, in the south-east of Rome. It is set in a building made up of single rooms, on 3 floors; 1 floor is dedicated to women, and the other 2 accommodate men, for a total of 21 rooms, each of which is equipped with private bathrooms and is suitable to spend precautionary isolation according to the current guidelines. The structure of the rooms accommodates one user per room, therefore families or couples are excluded. The guests, all from the SAI/SIPROIMI circuit, are hosted after undergoing a health screening by INTERSOS, and are housed in the rooms for 10 days, with rapid tests carried out upon arrival and departure. In case of confirmed negativity, after the 10 days they are transferred to a new reception center. If the test comes back positive, the guest is transferred to a COVID Hotel in the Municipality of Rome. Guests are provided with food and everything they need during isolation. INTERSOS has been operating in Barzilai center since July 2020 organizing training sessions for the staff at the facility, composed mainly of social workers and psychologists. The training days focused on the procedures for the correct management and prevention of infection, proper use of personal protection equipment (PPE), and correct procedures for reporting suspected or confirmed cases of SARS-CoV-2 infection.

The establishment of this type of reception, in August, has in fact allowed for the safe reopening of the reception system for men and women who have a form of international protection, which had been otherwise suspended for lack of prevention procedures, like all other reception facilities. Another crucial element was the establishment of a structure dedicated to single women or families who need a protected place for quarantine/isolation in view of a placement in a SAI reception facility. This Bridge Center, called Casa Bakhita, was activated in January 2021, again through a protocol between the Department of Social Policies of the Municipality of Rome and ASL RM2 (Unit for the Protection of Immigrants and Foreigners) with the support of INTERSOS for triage and health care.

CASA BAKHITA

Casa Bakhita is located in East Rome. It is composed of small apartments suitable to host families with children. The procedures for being transferred and hosted there are the same as in Barzilai: health screening, identification of possible health needs with particular attention to maternal and child health, information sessions on SARS-CoV2 and on relevant local services. This center provides all the necessary services for the children's well-being, respecting their age and needs. This structure is also managed by the cooperative Medihospes, and the collaboration is active as of January 2021, within the same terms registered by ASL RM2 for Barzilai and by the Municipality of Rome with INTERSOS. Guests assigned to the two centers undergo a pre-hospitality interview conducted by the Immigration Office: a necessary precondition for reception in these centers is the stated willingness to remain isolated for the pre-defined period of time. When INTERSOS carries out the health assessment, it also provides another round of orientation and guidance on the rules of the reception facility, and on information regarding COVID-19.
Since the beginning of the project Barzilai hosted 174 people, of which 133 men and 41 women\(^\text{19}\)\(^{19}\); The center hosts about 15-20 guests at a time, in cycles, under the coordination of the Immigration Office of the Municipality of Rome, which also manages the transfers to the SAI/SIPROIMI circuit. In the Bakhita facility, since the beginning of the project, 9 families have been hosted and screened, staying in the 6 available apartments (one is left empty to isolate anyone who tests positive upon entry). The families are hosted exclusively in the Bakhita center. They have mostly been single-parent families, composed of mothers and very young children; at the end of January, 24 people were hosted: 14 women, 9 children under 3 years of age, and 2 children under 17 in total. Most of the hosted people come from other reception facilities and have applied for international protection, but there are also cases of homeless people, or people who have found hospitality in private homes with friends or relatives already present in Italy. The most common countries of origin are from Western Sub-Saharan Africa (primarily Ghana, Senegal, Burkina Faso) and Eastern Africa (Sudan, Somalia, Eritrea), but also the Middle East (Iraq-Kurdistan, Syria Afghanistan), as well as a significant number of people from Bangladesh. The average age of the guests is between 20 and 40, mostly men. In the Bakhita Center, the average age for the adult guests is slightly lower; most of them are mothers with very young children, ranging from 9 months to 17 years old.

The difficulty in accepting isolation has often been noted and reported by the center’s staff, who are always very patient and good at communication; furthermore, being locked in a room for 10 days can pose objective difficulties, even though the facilities are organized to provide as much comfort as possible during isolation. INTERSOS provides all people with a hygiene and sanitary kit that includes information material. Children are provided with a similar kit, with simplified information, toys, and hygiene and sanitation materials.

The protocol between the Municipality of Rome, ASL RM2 and INTERSOS allows for an effective prevention method for the containment of infections and community-based management. So far, this method has allowed for the interception of 11 positive cases: without this “filtering” mechanism these people would have probably, despite themselves, contributed to the spread of the SARS-CoV2 infection, forcing entire shelters to measures of mass screening, total quarantine and an enormous deployment of funds and energies.

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\(19\) Numbers last updated on 31/1/21
3.2.2 Capitanata

The Capitanata Project already had an ongoing operational collaboration with the ASL of Foggia since 2018, formalized through a memorandum of understanding in July 2019, and a number of collaborative relationships with other institutional actors in the territory, such as the Apulia Region, the Regional Strategic Agency for Health and Social Care (AReSS Apulia), and the university hospital Ospedali Riuniti in Foggia. In March, the rapid evolution of the pandemic situation has led to an agreement signed with AReSS for the implementation of the intervention for the COVID-19 emergency in informal settlements in the context of the “Su.Pr.Eme. Italia” project, co-financed by the European Commission. Within this framework, INTERSOS has an operational collaboration with the ASL of Foggia for the implementation of Proximity Public Health (PPH) interventions in informal settlements to combat the COVID-19 emergency with two mobile health units. There is a constant exchange with the General Directorate and Health Directorate of the ASL of Foggia, with the Department of Prevention and with the Hygiene and Public Health Service, for the referral of suspected and positive cases, the management of isolations and quarantines, contact tracing, as well as for the discussion of critical issues that emerged during the field work. INTERSOS also carried out an assessment regarding the impossibility of isolating suspected or positive cases for SARS-CoV-2 or their contacts in informal settlements, which was shared with local institutions. This led, in March, to the activation of one of the first hotel facilities for isolation and quarantine in Italy, in San Giovanni Rotondo, through a resolution issued by the Apulia Region. The facility remained available until July 2020, after which the management of the hotel did not renew the agreement. The positive or suspected cases were subsequently isolated in containers or in adequate spaces offered by services and health facilities already in the area, thus adopting improvised solutions until the obtainment of a second agreement with another COVID hotel. In the district of Foggia, the ASL accepted INTERSOS’ request to open the possibility for temporary registration with the local health authorities and the assignment of a GP for those whose place of actual residence does not coincide with their formal residence (such as seasonal agricultural workers). This could be done through a self-certification of domicile.20 With the appearance of the first cases of COVID-19 at the settlement of Borgo Mezzanone, in August, INTERSOS further highlighted the need to take various measures in the area to strengthen case monitoring, including:

- simplified processes for diagnosis through the establishment of a testing point similar to a “drive through” at the former Runway of Borgo Mezzanone;
- the rapid implementation of isolation facilities through the activation of isolation units inside the CARA reception facility or in the former Runway. This was necessary to ensure immediate temporary isolation while waiting for the transfer of suspected cases and of the close contacts of confirmed positive cases;
- the activation of a facility dedicated to the isolation of positive cases to COVID-19 who do not require hospitalization;
- the immediate transfer in reception centers or appropriate facilities for people with vulnerable conditions, after precautionary quarantine;
- the increased presence of qualified linguistic-cultural mediators in public health services;
- instructing agricultural employers to carry out measurements of the employees’ body temperature before the work shift.

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20 Self-certification of domicile allows for temporary and renewable enrolment in the RHS for persons with regular residence permits, in accordance with art. 42, paragraphs 1 and 2 of Decree no. 394/1999. For the purpose of demonstrating domicile, no additional documentation should be necessary unless otherwise stated by law (which may ask for a declaration of hospitality, rental contract, the cession of a property). This is because in law, domicile is the place where the person has established the main seat of their business and interests, and not the place where the person lives regularly, which is considered their residence (Civil Code, Art. 43).
From the month of August and until the end of the outbreak of SARS-CoV-2, a **Special Unit for the Continuity of Medical Assistance operated by the Region** (USCA) set up a post at the former runway of Borgo Mezzanone; here, a testing point was also set up to carry out nasopharyngeal swab tests, and it remained active for the duration of the period of recurrent cases of positivity. 50 isolation units were arranged through containers in the vicinity of the former runway to ensure the temporary isolation of any suspected case and/or close contacts of confirmed cases, pending the activation of other dedicated facilities; in addition, one of the emergency health service (118) stations dedicated to the COVID-19 emergency has been exclusively assigned to the Borgo Mezzanone settlement.

In addition, an **integrated data collection system** was created between the **Public Health Service and INTERSOS** personnel. In agreement with AReSS and INTERSOS, ASL Foggia and the University Hospital of Foggia have selected cultural mediators (of the same linguistic-cultural origin as most of the people assisted) to facilitate the referral of patients. Despite the construction of operational procedures in agreement and in constant dialogue with local institutions, the absence of a method for securing an appropriate procedure for people with high risk profiles or other vulnerabilities has led to many critical issues.

A number of obstacles emerged, determined first of all by the discriminatory distinction made between people with regular residence permits and people without. No service that has been assigned responsibility for the latter, even if they are also in conditions of vulnerability. Only actors from service sector who have enough capacity can take up their cases, a difficult condition given that this sector is already overloaded. However even for people with residence permits there are still many obstacles, primarily bureaucratic, but also in some cases in terms of the availability of reception facilities.

Following the requests made to national and regional institutions by the INTERSOS team, since April 2020 the **Region started hygiene and sanitation interventions to provide a water supply inside the settlements**. On April 23rd installation works were concluded; the new tanks for the supply of drinking water in the Capitanata area are periodically replenished by the Apulian Aqueduct (**Acquedotto Pugliese**). Water points with tanker trucks have been activated in 6 different settlements in the province of Foggia, including Borgo Mezzanone, where the water supply had previously been absent. Specifically, 12 cisterns were installed at the ex-track in Borgo Mezzanone, 1 cistern in Borgo San Matteo, 2 cisterns in Palmori, 2 cisterns in Borgo Cicerone, 4 cisterns in Poggio Imperiale and 4 cisterns in Pozzo Terraneo, in the Cerignola area. Water storage and distribution capacity was also increased at Gran Ghetto and Borgo Tre Titoli. Toilets were installed in Borgo Mezzanone and new ones were also added in the Gran Ghetto, and garbage was removed in both settlements.
3.2.3 Ionian Calabria

The collaboration between the ASP of Crotone and INTERSOS dates back to 2014, the year of the first memorandum of understanding for the Mesoghio project. This memorandum allowed for the development of an outpatient clinic dedicated to people without a residence permit or in transit, which until then had not existed in the area, and that later went under the management of the ASP. The relationship with the ASP of Crotone was renewed in 2016 (the year in which the ASP-INTERSOS co-financed project began, AMIF Prog-99 “Integrated system for the reception and care of cases of psychological, social and health vulnerability among the migrant population in Ionian Calabria”).

The collaboration was taken up once again in 2020 with the COVID-19 prevention activity that is framed in the above-mentioned “Su.Pr.Eme. Italia” project. INTERSOS also had a direct collaboration with the Special Unit for the Continuity of Medical Assistance operated by the Region (USCA) for the management of suspected cases in area 1. A good operational synergy was built with the ASP of Cosenza through the constant coordination with the Health Directorate, for the area of Corigliano and Rossano (area 2), a new area of intervention for INTERSOS. The mobile team has made itself available to the health authorities to support activities related to prevention and emergency management. However, the characteristics of an emergency intervention leave a limited margin for developing long-term solutions, which should go beyond the management of the emergency and define paths of protection for the immigrant population in this area.

In the complex historical time in which the project activities were started, the network of previously-built relationships and collaborations was fundamental, as this facilitated the implementation of actions, reaching as many people as possible despite the restrictions related to the spread of the pandemic.

In addition to coordinating with the regional project IN.CI.PIT against the exploitation of victims of trafficking21, it was essential to collaborate with the Aylan Project22, dedicated to the protection of the health of migrants in a condition of psycho-social vulnerability (supported the National Operative Protocol on Legality fund (PON legalità) managed by the ASP of Crotone, in partnership with the Calabria Region and the Ministry of Labor and Social Policy), which has facilitated the management of vulnerabilities encountered in the field. In the context of the Aylan project, the INTERSOS intervention is carried out with two psychologists, in coordination with Arci23 and the Italian Red Cross, and is set up to identify and offer support for a range of different types of vulnerability. During the activities for COVID-19 prevention, the migrants’ association Arci “Djiguya” has offered its headquarters for the preparation of the kits and facilitated distribution and exchanges with the recipients.

In the large and complex area of the Plane of Sibari, the Sibaritide, where INTERSOS operated for the first time, the support of the organizations that have been working in the area for some time

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21 For more information, see https://www.progettoincipit.com/
22 For more information, see https://ponlegalita.interno.gov.it/progetti/aylan
23 ARCI is an Italian network of cultural/social associations.
has been fundamental for the success of the intervention. The creation of a network in the area of intervention called Corigliano-Rossano (area 2) has also made it possible to include a training session for social workers in the area within the project activities. Specifically, the sessions carried out have seen the participation of groups of about 30 volunteer workers from Caritas, employed in the people’s canteens of the Municipality of Corigliano Rossano, in coordination with the manager of the canteens. The topic of the training was the prevention of COVID-19 risk in the settings of the canteens’ social activities.
3.2.4 Sicily

**EAST SICILY**

The health emergency led to the start of activities in the context of the “Su.Pr.Eme Italia” Project at the informal settlement in the area of Cassibile (SR), in collaboration with the Sicilian Region (Regional Department of Family, Social Policies and Labor), the Municipality of Syracuse (Department of Social Policies), the Prefecture, the Police Headquarters, the ASP of Syracuse, the Employment Centre and the Inspectorate of Labor. Two years ago, the Municipality of Syracuse approved a project for the construction of a formal settlement and the installation of wooden houses connected to bathrooms. However the project was blocked because of bureaucratic obstacles and problems with the resources to be allocated for its realization. During the course of the intervention, health support was paired with orientation to housing possibilities and support to mobility, given the imminent end of the season for agricultural work. The team conducted regular focus groups, individually analyzing the primary needs of the participants. In the first half of July the inhabitants of Cassibile committed acts of intolerance against the settlement and its inhabitants. In the following days, in parallel with the health activities, a successful collaboration was established with the Mayor and the Councilor for Social and Family Policies of the Municipality of Syracuse, as well as with the associations of the area, to meet the settled workers’ housing needs, which were highlighted during the focus groups. This way it was possible to offer alternative housing solutions to the settlement, in order to protect the safety of the workers.

**WEST SICILY**

The Health Support intervention carried out in partnership with the ASP of Trapani in the informal settlement of Campobello di Mazara/Castelvetrano, also within the “Su.Pr.Eme. Italia” project, foresaw the use of two mobile medical units, stored at the former Cement Factory. These were employed in response to the important gap in healthcare that was affecting the area during this emergency period. The intervention took place in November and December 2020. Health education and the distribution of hygiene and sanitary kits addressed the entire population, which was made up of almost 2,000 workers. In addition to COVID-19 risk monitoring and medical examinations, this intervention employed two psychologists to offer a psychological support service, particularly to the female population. In also offered legal counseling, through the project’s two legal practitioners. After the USCA identified 6 cases of positivity to COVID-19 in mid-October, before the beginning of INTERSOS’ intervention, the tests showed no more positive case for SARS-CoV-2. Local authorities had not devised plans in case multiple positive cases occurred. What emerged from the exchange with the 802 workers who received legal assistance is that many people lost their permit to stay as a result of the provisions introduced by Decree Law 113/2018 (the s.c. Security Decree), which abolished the humanitarian permit to stay. In many of these cases, the difficulties posed by the conversion of these expiring permits into work permits were insurmountable, due to the expiration of the deadline for renewal, or because the people lacked the requirements for the conversion.
The constant relationship with local administrations made it possible to obtain small improvements with respect to the basic needs of the recipients of the settlement.

The continuous exchange with the mayors of Castelvetrano and Campobello di Mazara allowed for the creation of a technical roundtable and led to an opening on the part of the administrations towards the possibility of opening access to “fictitious” residence. On several occasions, it was possible to reactivate the water supply service, and thanks to the collaboration with the waste disposal services of Castelvetrano (Sager), the number of bins available for waste collection was increased.

Despite the constructive work carried out in partnership with the ASP 9 of Trapani, there continue to be several critical issues in the public health service:

- **Lack of training of the health personnel** in public facilities, hospitals and the local continuity of care unit, (in particular in the health registry for access to services and transcultural approach) on health rights and on the rules of basic health services, which are part of the LEA (basic level of care), and should be guaranteed by the national health system. This lack of training, which had been guaranteed to INTERSOS mobile teams’ health professionals and/or legal practitioners by the technical support, has resulted in the insufficient provision of the service;

- **Very few STP codes were issued.** These are required for undocumented people to access public health services;

- **For those with a regular residence permit and regular registration** with the health card system, there was a lack of registration on the local lists for the assignment of GPs and enormous difficulties in obtaining it;

- **Lack of linguistic-cultural mediators,** which are necessary for every phase of the patient’s care, from understanding the medical history to prescribing a treatment. This has repeatedly led to the issuance of health certificates that are incomplete or that contain false information, with all the consequences this entails.
3.3 PREVENTION, MONITORING AND MANAGEMENT OF CASES AT RISK OF COVID-19

3.3.1 Implemented actions

In all projects, particularly in the rural contexts of Southern Italy, the initial phases of the interventions in response to the COVID-19 emergency clashed with people's low perception of the risk. This perception, which will be examined extensively in section 3.4, should be understood through the many cultural and structural dimensions at play. On the one hand, people living in such marginalized conditions see COVID-19 as only one among many problems that need to be addressed, which does not assume priority with respect to other aspects such as work, housing or documents; on the other hand, the context of the intervention makes it extremely evident that it is objectively impossible to apply the simplest norms of prevention in living conditions marked by such strong deprivation. Although in some of these contexts the pandemic had a limited impact during the time frame referenced in this report, there was nevertheless an attitude of growing openness and interest in the theme of prevention already after the first months of work. This led to the progressive involvement of people from the community (such as health promoters in Rome and community mobilizers in Capitanata) in prevention and monitoring activities. This section presents the main results of the work done with the communities; the first part describes the activities that were carried out and the second part relates the quantitative analysis of the data collected through the clinical risk assessment forms.

Health education and health promotion activities have been a fundamental part of the interventions with communities; from the earliest stages of all projects, these activities aimed to reach the entire target population. Therefore, in all projects, linguistic-cultural mediators and doctors held health education sessions together, both on COVID-19 disease and, as they happened, on the changes of the regulations in relation to the trends in the pandemic. The right to health and access to public services were always at the heart of the content and discussion.

Trainings were also organized with other local actors (in all areas except Sicily) and with members of the communities (in all areas), with the aim of amplifying the dissemination of information and of strengthening the relationship of trust and collaboration with the communities.

For example, in Rome, the team quickly initiated health education sessions on the best behaviors to adopt during a pandemic and on the specific rules regarding the prevention of COVID-19. These sessions were held at the main housing squats under the health administration of ASL RM2 (evaluated on the basis of the number of inhabitants, level of social fragmentation and hygienic-sanitary conditions), at the neighboring informal settlements, and
at Tiburtina and Termini stations, with distribution of information material, in paper and video form, and in multiple languages. Moreover during the months of July and August, thanks to the relation that had already been established before the pandemic, INTERSOS started a participatory and cross-cultural training course with people living in the housing squats, at the end of which some of them could act as health promoters. Following their proposal, two Health Rooms were activated in March 2021 in two large squats (see par. 3.3.3). In addition to this, training will be provided to the staff of the reception centers of Rome regarding COVID-19-related risks (see par. 3.3.5).

In the Capitanata area, information has been disseminated in print, including posters on risk factors that were adapted to the settlement. Moreover the team carried out focus groups, held information sessions based on the knowledge gained, and produced personalized leaflets for groups that were particularly at risk. Prevention activities have been intensified at strategic points of the city, such as the bus station, the neighborhood around the train station and the police headquarters, with posters and information sessions. In all settlements, people who already acted as reference points in the community were also appointed to become community mobilizers (see par. 3.3.4). The role of community mobilizers is to disseminate key information in a capillary way among the population and recognize any problems that emerge from the community, thereby strengthening the connection and collaboration between staff and community.

In Ionian Calabria, health education activities were strengthened by training professionals and volunteers that were active in the area, in coordination with some low-threshold services aimed at populations in conditions of marginality. These activities responded to the needs of the volunteers, but also enabled staff to share the critical issues encountered during the activities carried out in proximity areas.
DISTRIBUTION OF HYGIENE KITS FOR IMPLEMENTING PREVENTION MEASURES

Another important element of INTERSOS’ activities has been the distribution of hygiene kits containing essential materials for implementing prevention measures. Living and working conditions in these contexts render many prevention measures unfeasible, such as physical distancing in overcrowded spaces or hand hygiene without running water. However, the need to intervene immediately with a concrete support, however incomplete and insufficient it may be, has led to the organization of a widespread distribution in all places of intervention, carried out both independently and in collaboration with local institutions.

In Capitanata, the Apulia Region accepted INTERSOS’ suggestion to organize mass distributions in all settlements and purchased 2,500 kits for feminine and male hygiene. In April, distributions began in the settlements, and in May INTERSOS, along with the Civil Protection and Red Cross, supported the Region in distributing over 1,400 hygiene kits in Borgo Mezzanone. Through INTERSOS, the kits were delivered to 6 more informal settlements, and mass distributions were organized in 2 more settlements, reaching almost all the inhabitants of the informal settlements in Capitanata. The kits came in a number of different variants: individual kits for men, women, and children, kits for persons who presented elements that could be conducive to positivity at triage, home hygiene kits, kits for informal shops in the settlements, kits for informal hairdressing businesses in the settlements.
CLINICAL ACTIVITIES AND MANAGEMENT OF SUSPECTED CASES

INTERSOS protocols for the assessment and management of the COVID-19 risk have enabled the standardization of pre-triage, triage and clinical assessment activities in informal settlements or in proximity areas, depending on the context.

The clinical activity in the projects that were already active had to be reorganized. The focus shifted towards prevention activities and medical examinations for early screening of symptoms of COVID-19, for contact tracing of suspected and confirmed cases, and for monitoring patients and people who travelled or were exposed to risk. With the awareness that the health needs of the concerned populations are not limited to the management and containment of the pandemic, the social and healthcare work activities also maintained a focus on continuity of care and orientation to health and social services. This was done also by facilitating access to care through direct dialogue with health institutions and, where necessary, by physically accompanying the person to the services. Medical examinations, which in the very first phase of the pandemic took place inside mobile vehicles, (or in the case of Rome, in the clinic) were transferred to special external clinics, in order to comply with national safety standards and internal INTERSOS procedures. Particularly for the contexts of Rome and Capitanata, it was essential to organize a system of contact tracing of confirmed cases, which would be otherwise difficult to reach by the local institutions’ Public Health services. In this context, the role of the linguistic-cultural mediators has been fundamental in building a collaborative relationship with the people who were infected, in order to retrace the contacts exposed to the risk of infection, and then reach them by phone or in person (in compliance with safety and prevention measures) and activate, depending on the case, monitoring activities or diagnostic testing with nasopharyngeal swab tests.

TAB. 1 • NUMBER OF PEOPLE REACHED BY THE PROJECTS’ ACTIVITIES FROM MARCH TO OCTOBER 2020

<table>
<thead>
<tr>
<th></th>
<th>ROME</th>
<th>CAPITANATA</th>
<th>IONIAN CALABRIA</th>
<th>EAST SICILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health education sessions</td>
<td>1,583</td>
<td>2,441</td>
<td>540</td>
<td>162</td>
</tr>
<tr>
<td>Medical examinations</td>
<td>1,488</td>
<td>1,258</td>
<td>156</td>
<td>148</td>
</tr>
<tr>
<td>Evaluations of the clinical risk for COVID-19</td>
<td>1,381</td>
<td>213</td>
<td>68</td>
<td>-</td>
</tr>
<tr>
<td>Number of distributed hygiene and health kits</td>
<td>240</td>
<td>3,285</td>
<td>515</td>
<td>148</td>
</tr>
<tr>
<td>Persons who were accompanied to health services</td>
<td>36</td>
<td>163</td>
<td>1</td>
<td>27</td>
</tr>
</tbody>
</table>
3.3.2 Training health promoters in the housing squats of Rome

CONTEXT OF THE INTERVENTION

As expressed above, one of the main risk factors for health is undoubtedly housing insecurity. It is for this reason that the INTERSOS' social-health teams have been activating empowerment and community participation strategies with people living in housing squats in Rome since 2018.

A large part of this population is in fact exposed to several factors that determine marginalization, such as unemployment, precarious employment or working in the “black,” or “gray” job market.24

Undocumented migrants and asylum seekers are burdened with additional obstacles that add on to these factors. INTERSOS has been working in the squats of Rustica and Sambuci since 2018, with health education and health promotion activities. In March 2020, INTERSOS activated a weekly medical post to carry out medical surveillance for COVID-19-related risks, for early detection of suspected cases and for their inclusion in care programs.

In June 2020, once the first emergency phase of the pandemic was over, the Rome team discussed ways to improve and strengthen the health services offered within the communities, with whom they had established a very collaborative relationship. The objective was on the one hand to help these communities be more prepared for possible new epidemic outbreaks; on the other, to allow them to achieve autonomy in taking charge of the community’s health through awareness, prevention, and transfer of knowledge. Because of the high organizational capacity of the communities, it has been possible to identify and train Health Promoters, i.e. community health contact persons who monitor health conditions and spread good practices for the detection and prevention of COVID-19. As argued by Laverack (11), an expert on health promotion and inequalities, empowerment is to be understood as “a process […] by which people become progressively better organized” in order to improve the level of control that they can exercise over the social and political determinants of health, as individuals and as a community.

LA RUSTICA

The community of Rustica has about 90 families, 66% of the people are men and 34% women, 50% of people are between 22 and 40 years old.

People come mainly from South America (Peru, Ecuador, S. Domingo, Cuba, Venezuela, Bolivia, Uruguay), from African countries (Ethiopia, Morocco, Senegal, Eritrea) and from Eastern Europe (Moldavia, Romania, Bulgaria).

SAMBUCI

The community of Sambuci has about 70 families (more than two hundred people), 60% are women and 40% men, 40% of the people are between 22 and 40 years old. People come mainly from South America (Dominican Republic, Peru, Ecuador), from African countries (Morocco, Senegal, Ethiopia, Cape Verde), from Eastern Europe (Moldova, Romania, Bulgaria) and to a smaller extent from Bangladesh.
METHODOLOGICAL NOTE

This initiative was carried out in July and August, and not only did it serve as a moment of practical and direct training, but it also created a space for shared reflection. This resulted in the team and the community co-designing plans and procedures for the management of the risk of infection, so interventions designed by the community, for the community.

Seven meetings for shared reflection and training of health promoters were held at each of the two sites.

The Health Promotion Workshop Series covered a wide range of topics related to COVID-19: the nature of the disease, prevention measures and terminology related to health emergencies, sources to learn about the issue, emotional repercussions in general and specific repercussions on children, finally opening discussions for the collective development of internal procedures regarding isolation, prevention and sanitation before and after contact with infected persons.

The topics were treated in a participatory way, with a non-hierarchical and transcultural approach; information materials were co-created during the meetings to facilitate understanding and shared reflection, which were also used as starting points for subsequent meetings.

The trainings were based on active engagement, participation and community empowerment. Decisions were made by consensus, trying to prioritize the needs emerging from the community (bottom up) while employing the technical and scientific knowledge offered by the literature (top down): in this way a shared operational plan was achieved, tailoring protocols and risk scenarios on the basis of lived reality and reaching a shared synthesis easily and effectively.

OBJECTIVES

The Health Promotion Workshop Series was carried out between July and September 2020, and later picked up and expanded between December 2020 and January 2021. In the communities of Rustica and Sambuci these workshops provided the space and time for a more in-depth analysis of health around the theme of COVID 19, providing participants with social and health skills on the subject and increasing the communities’ awareness of the “rights and duties” of health.

The Health Promotion Workshop Series, in addition to serving as a moment of practical and direct training of community health referents with health monitoring tasks, was an opportunity to:

• collect doubts and fears, both on the personal and community level;
• listen to and understand the worries and joys that parents experienced in this trying time;
• allow a shared reflection that led to co-designing plans and procedures for the management of the risk of infection.

TARGET

The course was on the basis of voluntary participation; the only requirement was to be an inhabitant of the housing communities. The participants in the Health Promotion Workshop Series were 25 people between 25 and 56 years old, from Peru, Ecuador, Morocco, Dominican Republic, Egypt, Bangladesh, Senegal, Italy and Eritrea.
DESCRIPTION OF THE PROGRAM

The results of the seven workshops for shared reflection and training of health promoters were shared by the two groups of health promoters and the competent local health authority ASL, in both squats. The following is a brief description of the meetings:

- **First workshop:** Determinants of Global and Community Health.

- **Second workshop:** Focus Group - Individual emotional experiences during the lockdown and quarantine period.

- **Third workshop:** COVID-19 and Children - communication and lived experience of families with children during lockdown, questions and clarifications on the symptoms of COVID in pediatric age.

- **Fourth and fifth workshop:** A 360° understanding of COVID, part I and part II - use of Personal Protective Equipment (PPE) that can be found in common use (not strictly health equipment); general concepts in microbiology, immunology, dynamics of contagion and prevention, symptomatology; definition of “Suspected Case”; “at Risk Case”; “self-quarantine” and “precautionary isolation”; framing of the main symptoms, definition of “swab” and “antibody test”; outlining the role of the ASL in the protection of public health. Role-play game with simulation of positive case inside the squat;

- **Sixth workshop:** A 360° understanding of COVID part III - Collective development of internal procedures regarding isolation, prevention and sanitization before and after contact with an infected person. Definition of the work of the individuals and the community in the “Prevention Time” and in the “Action Time”, in particular the presentation of an experimental score-based screening tool for symptoms, for non-healthcare use, to be used for the epidemiological analysis of a suspected case, and the elaboration of an operational flow-chart starting from the 3 suspected cases: return from abroad, contact with an infected case, symptomatic person.

- **Seventh workshop:** emotional management for the community and the role of the promoter - the psychotherapist of the INTERSOS team guided and supervised the health promoters in elaborating their own emotional experiences of the epidemic, and how they were handled, and how these can be related to the community’s emotional experience and needs.

Following the seventh meeting, **two meetings to convey the results were organized with the Operational Unit for the Protection of Immigrants and Foreigners of ASL Rm2.** The Unit’s personnel had in fact followed the epidemiological developments and supported the planning of health interventions for housing squats by ensuring nasopharyngeal swab tests, contact tracing, constant telephone monitoring with health promoters, in synergy with the INTERSOS medical team.

RESULTS

In both communities, the program should have ended at the end of September; however in the month of September both communities were affected by COVID-19 outbreaks, reporting a total of one hundred positive persons, with a small proportion of the infected people requiring hospitalization. Forty percent of the people who followed the program offered their availability as health promoters during the health emergency and others joined later, in support and sometimes to replace the people who needed to self-isolate or quarantine.
COVID-19 RISK SCENARIOS AND SYSTEMATIC ACTIONS AT SITES WITH HEALTH PROMOTERS

1. Normal (no suspected cases)
   - Sanitization of common areas and arrangement as per space requirements
   - Masks in common areas
   - Sanitizing gel in common areas
   - Clotheslines and washing machines always used by the same households (if common)
   - Registration of guests
   - Each resident keeps a record of the events they attend

2. Suspected case (presumed positive/contact with positive case/waiting for swab test)
   - Restriction of non-essential communal activities (assemblies reduced to minimum number of participants)
   - Frequent sanitization of common bathrooms and common areas, if used
   - Isolation and quarantine for suspected case and initiation of contact tracing: identified contacts reduce activity in the squat to a minimum, and always wear mask
   - Selection of a bathroom for the exclusive use of suspected case(s), as close to their quarters as possible
   - No more guests allowed into the squat

3. Confirmed positive case
   - Complete halt to communal activities (assemblies are moved online)
   - Wearing masks upon leaving one’s home
   - Temperature measurement by residents at least once a day
   - Sanitization of bathrooms and common areas with alcoholic solutions before and after each use
   - New contact tracing: each person who has come into contact with a positive case is asked to identify the people with whom they have been in contact in the previous week; they will be asked to minimize their activities until the results of the swabs are available

When the epidemic outbreak hit the two communities, the health promoters had the task of collecting any reported symptoms of infection with SARS-CoV-2 and communicating them in a timely manner to INTER-SOS and the Health Authorities; they were contact persons for the interaction between the community and the competent ASL, and organized health activities within the squat (rearranging rooms to accommodate the Regional Authorities’ Special Continuity of Care Unit USCAR, maintaining contact with the infected people through daily monitoring, collection of health data and initiation of contact tracing).

THE ACTIVITY OF HEALTH PROMOTERS - COVID 19

The Health Promoters become active in relation to COVID-19 in three possible cases:

1. **Someone returning from an at-risk country**: the person goes into isolation, the GP is alerted, a swab test is prescribed (if not the GP, then the competent ASL or its department on public health and hygiene (SISP) is alerted)

1. **Contact with a positive case**: GP/ASL is alerted, person goes into isolation, beginning of internal contact tracing; application of RISK SCENARIO 2; depending on test result, there is a shift to RISK SCENARIO 3 or back to RISK SCENARIO 1

1. **Person shows symptoms**: GP/ASL is alerted, swab test prescribed, internal contact tracing initiated, RISK SCENARIO 2; depending on test result, switch to RISK SCENARIO 3 or back to RISK SCENARIO 1; SCORE-BASED RISK ASSESSMENT TOOL FOR COVID-19

It is crucial to keep a registry of the people present in the two squats, and that a good relationship be maintained between the promoters and the community. The risk scenarios were envisioned to simplify procedures so that they are clear to every resident. On the basis of epidemiological and structural evaluations, it will be possible to decide whether or not to send children to school.
The Health Promoters played a role of intermediation between the community and the multiple active health actors. Furthermore, they have been responsible for assessing the health needs of the community from within, for implementing procedures to keep the risk of infection low, and for informing people in the community about whether or not they are positive for the virus, managing the emotional response to positivity, and supporting the positive population in their daily lives. These tasks are carried out on several levels: preventive - health - emotional - social.

HEALTH PROMOTERS’ RESPONSIBILITIES

<table>
<thead>
<tr>
<th>Informative</th>
<th>Preventive</th>
<th>Health</th>
<th>Emotional</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>• inform the community of events taking place in health facilities (screening, presentation of services)</td>
<td>• health data collection</td>
<td>• inform people in the community about new positive cases for COVID-19</td>
<td>• managing emotional responses to positive cases</td>
<td>• supporting the person who tested positive in their daily tasks (grocery shopping, trash, any pets, etc.)</td>
</tr>
<tr>
<td>• carry out orientation for the community on specific services (ICARE project\textsuperscript{21}, FARI\textsuperscript{22}, STP clinic, etc.)</td>
<td>• contact tracing</td>
<td>• arrange rooms to accommodate USCAR (Special Continuity of Care Unit – Lazio Region)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Case management of social needs: support groups have been organized with the task of supplying basic necessities and medicine to people in isolation, ensuring that the most urgent needs are met.

Risk scenarios: during the meetings, health promoters developed procedures for the containment of the disease and isolation of positive cases in conjunction with the INTERSOS health team. These added to health promoters’ tasks related to health monitoring. These procedures predicted different stratified scenarios of contagion, starting from some elements of risk, which required the application of a specific set of measures: the transition between scenarios was imagined to take place through a fluid dynamic, applying the same principles applied on a large scale by national provisions to a closed community context.

The re-elaboration process, and then the communication of the results to the health authorities, was an occasion to formalize and institutionalize the promoters’ role, allowing for the establishment of a direct communication channel with the authorities. While communicating the results of the process, both communities expressed the will to activate a physical place in which health needs can be identified and tracked.

Through this process, the co-construction of the Health Room in Sambuci and La Rustica was completed at the end of March 2021. INTERSOS is providing a computer, a printer and some simple self-medication equip-

\textsuperscript{21} The European project ICARE (Integration and Community Care for Asylum and Refugees in Emergency) was created with the aim of improving access to Local Health Services for asylum seekers and people with international and temporary protection status, by ensuring a response to health needs that is as consistent and systemic as possible.

\textsuperscript{22} The project FARI 2 – Train, Assist, Re Rehabilitate, Include, financed within the framework of the Asylum and Migration Integration Fund (AMIF) 2014-2020, aims at providing effective responses to the physical and mental health needs of asylum seekers and refugees (including people with subsidiary/temporary protection status, and including minors) present in the Lazio Region, through experimental, innovative and integrated health care intervention models.
3. MAIN ACTIONS AND ACHIEVEMENTS IN THE COVID-19 EMERGENCY PROJECTS - AN UNEQUAL PANDEMIC

The aim is to enable communities to strengthen their control over their own health and to improve it, also through a more conscious and direct relationship with the competent ASL. This will allow the health promoters to extend the reach of their work beyond the current pandemic. More specifically, training courses on maternal and child health and prevention of cardiovascular and metabolic diseases will be activated. The two rooms will be used to promote activities aimed at the identification of needs, health guidance and orientation to specific projects of ASL RM2.

This methodology is particularly effective in combating the pandemic emergency, can be reproduced in other contexts, and will allow for a better protection of the health of residents, through a stronger bridge with public health services. Moreover, it will help to increase accessibility to health services through greater community awareness and participation.

3.3.3 Grassroots advocacy and Community Mobilizers in Capitanata

At the end of January 2020 INTERSOS activated a grassroots advocacy project within the social-medical project. The project selected 8 people living in informal settlements, and supported them in implementing grassroots advocacy actions, following participatory research-action workshops on data collection methods.27

This project sought to be a tool for self-determination, to spark initiatives for self-expression and reappropriation of the narrative, and to convey living conditions in informal settlements from the communities’ perspective. The participatory research project has directly and indirectly involved the inhabitants of the settlements, with the ultimate goal of giving them the tools to bring their perspective to light and make their own experience known.

The process, on which the whole project was based, foresaw the involvement of the members of the advocacy group in all phases. Every action was taken according to the following pattern:

- **Identification of the problem**: regular group sessions were organized, within which every member of the team shared the issues they considered most problematic with respect to life in the settlements, not only in the light of their own experience but also considering the perceptions of most of the people living in the settlements;
- **Shared decision-making regarding the data collection tools**: the issue considered the most urgent was identified, also through focus groups with an expert sociologist in participatory research; together, the team chose the tools to collect quantitative and qualitative data that could be useful to plan future actions from the inhabitants of the settlements;
- **Participatory elaboration** within the team, thinking of possible actions that can be taken to respond to the problem.

The same participatory methods have been at the basis of the necessary reorganization of the advocacy project. Starting from April 2020 the planned activities were redesigned in view of the health emergency. The way the country managed the health emergency provided another starting point for reflection, both for the

27 For a detailed description of the grassroots advocacy project and an analysis of the data collected in that context, a report will be published by the end of March 2021, downloadable at www.intersos.org.
staff of the advocacy team and for the inhabitants of the settlements, and for demanding greater protection and rights for the people involved. In view of this emergency and the needs that emerged from it, the decision was made to identify additional figures, which would be called community mobilizers. Specifically, two people were identified at the settlement of the former Daunialat factory in Foggia, seven people in the settlement of Poggio Imperiale and twenty people at the former Runway of Borgo Mezzanone.

The community mobilizers provided a reference point for actions of sensitization and contrast to COVID-19. These people were identified for their charisma, recognition by the community, and the commitment and reliability they demonstrated. They took health awareness sessions with INTERSOS’ doctors and cultural-linguistic mediators, and later assisted the team in raising awareness among the inhabitants of the settlements about the risks related to the ongoing epidemic, disseminating the information on the correct behavior to keep for the inhabitants to best protect their own health and that of others, and the distribution of Personal Protective Equipment (PPE). Moreover, these individuals have been crucial in cases where there were problems in tracking down people who had tested positive for SARS-CoV2 or tracing their close contacts.

3.3.4 Training on COVID-19 risk at the Reception Centers under the management of the Social Operations Room (sos) and of the municipality of Rome

Starting from June 2020 INTERSOS began a training course on the prevention and management of risk of infection from Sars-Cov-2 dedicated to the reception centers under the management of the Social Operations Room (SOS) and the Municipality of Rome. This action falls under the Collaboration Agreement for the development and implementation of a model of health monitoring and social-health assistance in support of homeless people or people in a condition of fragility. This collaboration was set up in the context of the COVID-19 Emergency and signed by INTERSOS and the Department of Social Policies of the Municipality of Rome on May 4, 2020, in collaboration with the relevant sectors of the ASLs.

The data on the trainings shown here relate to the cycle that ended in December 2020, which will resume again in March 2021 involving new centers. To date, the specific training courses have involved the staff of 10 reception centers, 4 of which belong to the Municipality’s network and 7 to the Social Operations Room (SOS) network.

Given the absence of standard operating procedures for risk management at a local level, the objectives of the training course were:

- **to provide basic information** regarding the control and management of the risk of infection, adapting it on the basis of the contexts;
- **to activate the local network’s capacity and to promote consistent practices** regarding early detection, active monitoring and reporting of suspected cases to the prevention departments of the competent ASL.

The topics covered concerned two main areas: the first, informative part dedicated to the **management and prevention of infections**, with particular reference to SARS-CoV-2; a second part, more focused on
operational aspects, was an orientation to the local services and the procedures to implement in case of new admissions, and suspected and confirmed cases of COVID-19 among guests. During the training course, the teams of each reception center were asked to fill out a questionnaire, to understand which areas most needed in-depth study and/or standardization with regard to the ability to manage the SARS-CoV-2 infection risk. The content of the program was adapted on the basis of the results of the questionnaire. Each training course took place over three 5-hour days, and was organized into three different modules, for a total of 15 hours of training (Table 2).

**TAB. 2 • TRAINING MODULES AND DESCRIPTION OF THE TOPICS ADDRESSED**

<table>
<thead>
<tr>
<th>MODULE</th>
<th>TOPIC</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td><strong>Personal Protection Equipment (PPE): basic knowledge, correct use and disposal</strong></td>
<td>Theoretical elements and practical exercises tailored to the center’s risk areas</td>
</tr>
<tr>
<td>1.2</td>
<td><strong>Basic elements for the prevention and control of infectious diseases in the context of communal living: from individual protection to sanitization of shared spaces</strong></td>
<td>Theoretical elements and practical exercises tailored to the center’s risk areas</td>
</tr>
<tr>
<td>1.3</td>
<td><strong>COVID19: basic elements for the early detection and definition of risk situations.</strong></td>
<td>Theoretical elements and practical information sheets for the evaluation of COVID19 risk.</td>
</tr>
<tr>
<td>2.1</td>
<td><strong>COVID19: basic elements for the early detection and definition of risk situations in the specific context.</strong></td>
<td>Participatory analysis of different risk elements in the activities of each center: suggestions for useful measures to reduce the risk of contagion and to contain the infection in the facility and in the community.</td>
</tr>
<tr>
<td>2.2</td>
<td><strong>Orientation on the correct and timely use of local services in case of suspected case of COVID19: an overview of regional circulars (memos) and of possible operational flowcharts</strong></td>
<td>Overview of the guidelines established in the Lazio Region’s circulars (memos) regarding the control and management of the COVID19 risk in different contexts; overview of useful numbers of the relevant services within the competent ASL and possible operational flowcharts for the management of guests showing symptoms.</td>
</tr>
<tr>
<td>3.</td>
<td><strong>Tips to manage emotional responses and to maintain a positive relationship between reception staff and guests during COVID19: communicating COVID19 risk management with a transcultural approach.</strong></td>
<td>Communication and handling of the illness and the emotional responses it can trigger, in response to the difficulties encountered by the reception staff in handling guests during lockdown and isolation.</td>
</tr>
</tbody>
</table>

The training days referred to the decrees that were in force when they were carried out as well as the needs of the various facilities involved in the project. A total of 68 people took part in the training sessions, equal to 78% of the total staff working in the centers. It mainly involved coordinators, social workers, specialized personnel and cleaners, as well as those in charge of meals and distribution.

The people using the services provided by the centers, about 64828 people, can be considered indirect beneficiaries of the program.

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28 Number calculated based on total capacity of individual centers at the time of the pandemic; the number of indirect beneficiaries may increase as the shelter system is fully reopened.
3.3.5 Quantitative analysis of data collected through risk assessment for COVID-19

(With the collaboration of Chiara Di Girolamo for the elaboration and analysis of the quantitative data)

This section reports on the main results of the quantitative analysis of the socio-demographic and clinical information collected from the risk assessments for COVID-19 performed at the intervention sites. The following sections describe the main characteristics of the populations addressed in the contexts of Rome, Capitanata and Ionian Calabria until October 2020. Data on interventions in Sicily are not included in this section, as the social-health activity carried out in East Sicily did not lead to the identification of COVID-19 risk cases, while the intervention in West Sicily occurred after this round of quantitative data collection was concluded.

The population described in this section has been followed and monitored over time for COVID-19-related risks. Therefore it is made up of all the people who fulfilled at least one of the following positivity criteria at triage:

- **travel** to and/or from at-risk locations;
- **exposure** to confirmed positive cases, suspected cases, or to high-risk locations;
- **symptomatology** suggesting COVID-19 according to the risk assessment form used for clinical activity;

It is also composed of the people who, even in the absence of positivity criteria at triage, presented elements of fragility such as known chronic conditions and/or declared vulnerabilities that called for closer follow-up even in the absence of risk conditions for SARS-CoV2 infection.

Thus, the numbers reported here do not refer to all the persons that have been reached in the four intervention settings; the relevant overview data has already been presented in the previous section on work with communities.
The COVID-19 Mobile Risk Team monitored 615 people during the period between March and October 2020, out of the 1,381 who accessed the service. The trend in the absolute number of cases followed over time is described in Figure 7.

FIG. 7 • TREND IN CASES MONITORED FOR COVID-19, ROME

<table>
<thead>
<tr>
<th>Month</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>70</td>
</tr>
<tr>
<td>April</td>
<td>193</td>
</tr>
<tr>
<td>May</td>
<td>57</td>
</tr>
<tr>
<td>June</td>
<td>67</td>
</tr>
<tr>
<td>July</td>
<td>38</td>
</tr>
<tr>
<td>August</td>
<td>42</td>
</tr>
<tr>
<td>September</td>
<td>83</td>
</tr>
<tr>
<td>October</td>
<td>65</td>
</tr>
</tbody>
</table>

During medical examination, nearly half of the population reported living in housing squats (273 people, or 44.4% of the total). Of the remaining 342 people, 24.3% are homeless, 13.3% are housed in one of the bridge centers that is acting as a buffer for access to SAI reception facilities, 12% have another living arrangement, and 6% (37 people) live in a reception center.

The COVID-19 Mobile Risk Team monitored 615 people during the period between March and October 2020, out of the 1,381 who accessed the service. The trend in the absolute number of cases followed over time is described in Figure 7.

FIG. 8 • HOUSING CONDITIONS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing squats</td>
<td>44.4%</td>
</tr>
<tr>
<td>Homeless</td>
<td>24.3%</td>
</tr>
<tr>
<td>Housed in one of the bridge centers</td>
<td>13.3%</td>
</tr>
<tr>
<td>Other living arrangement</td>
<td>12%</td>
</tr>
<tr>
<td>Reception center</td>
<td>6%</td>
</tr>
</tbody>
</table>

There were 174 women (28%) and 432 men (70%), while for 9 people the data on gender is not available. The monitored persons are from 56 different countries (for 16 persons the data is not available). The five most represented countries of origin are Italy (87 people, 14% of the sample population), Bangladesh (53 people, 8.6%), Senegal (51, 8.3%), Nigeria (43 people, 7%) and Peru (40 people, 6.5%). Other regions of origin for a significant number of people are Eastern Europe (Romania, Poland), North Africa (Morocco, Egypt, Tunisia), sub-Saharan Africa (Sudan, Somalia, Mali, Eritrea) and Ecuador. The distribution by gender of the main countries of origin shows that the population of Nigeria, Peru and Ecuador is primarily composed of women, while the population from Senegal, Sudan and Mali is primarily male.

The distribution by age groups shows that on average the monitored population tends to be middle-aged and senior, with about a quarter of the population between the ages of 42 and 59 (160 subjects) and one fifth over the age of 60 (139 subjects).

The sample population is distributed as follows in the remaining age groups: 7 subjects under 10 years of age (1.1%), 9 subjects in the 11-14 age group (1.5%), 29 subjects between 15 and 17 years of age (4.7%), 18 between 18-21 years of age (2.9%), 131 between 22-31 years of age (21.3%) and 99 between 32-41 years of age (16.1%); for 23 subjects the data is missing (3.7%).

The gender distribution by age overlaps with the trends for the total population, showing a slightly higher prevalence of men than women between the ages of 18 and 41.
Of the total of 615 persons monitored, 392 are legally residing in Italy (citizenship, permit to stay or in the process of obtaining it, 63.7%), 84 (13.7%) do not have a regular residence permit; for 139 persons the data is not available (22.6%). It should be noted that of those without a regular residence permit, 50% are homeless and 39% live in housing squats.

Although the data is not available for 155 persons, it should be noted that 280 persons (45.5%) have an assigned general practitioner (predominantly among those with a fixed living arrangement or living in housing squat), while 180 persons did not have an assigned GP (29.3%, primarily among the homeless population).

**FIG. 9 • LEGAL STATUS**

![Pie chart showing legal status: 63.7% documented, 13.7% undocumented, 6.9% homeless, 5.3% housing squat, 22.6% data unavailable.]

**FIG. 10 • PERCENTAGE OF DISTRIBUTION OF PEOPLE SUFFERING FROM AT LEAST ONE CHRONIC CLINICAL CONDITION BY AGE GROUP, ROME**

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>ABSENT (%)</th>
<th>PRESENT (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10</td>
<td>42.9</td>
<td>57.1</td>
</tr>
<tr>
<td>11-14</td>
<td>66.7</td>
<td>33.3</td>
</tr>
<tr>
<td>15-17</td>
<td>79.3</td>
<td>20.7</td>
</tr>
<tr>
<td>18-21</td>
<td>77.8</td>
<td>22.2</td>
</tr>
<tr>
<td>22-31</td>
<td>76.3</td>
<td>23.7</td>
</tr>
<tr>
<td>32-41</td>
<td>63.6</td>
<td>36.4</td>
</tr>
<tr>
<td>42-59</td>
<td>36.9</td>
<td>63.1</td>
</tr>
<tr>
<td>&gt;60</td>
<td>58.3</td>
<td>41.7</td>
</tr>
<tr>
<td>Unspecified</td>
<td>69.6</td>
<td>30.4</td>
</tr>
</tbody>
</table>

Figure 10 shows the percentage of distribution of people suffering from at least one chronic clinical condition by age group that were detected during the medical examination. It is noteworthy that 250 persons (40.7% of the population described) had at least one known chronic medical condition.

It’s important to note that out the seven children under 10 years old, 4 have a chronic condition (cardiac, respiratory, metabolic and oncological). The presence of chronic conditions recurs more often in the female population (48.3% of women have at least one chronic condition, while for men the percentage is 37.7%).

Still, with respect to the presence of chronic pathological conditions, it should be noted that among those affected, only 52% have a general practitioner.

32.8% of the population (202 people) declares the presence of known vulnerabilities and the distribution does not show differentiation by sex. The main known vulnerabilities recorded are: age over 60 years (135 subjects), psychological and psychiatric vulnerability (37 subjects), UASM (18 subjects), with a slight prevalence of known vulnerabilities in the male population, and in the 15-17 age group. Of those with known vulnerabilities, 54% have a general practitioner.
COVID-19 risk and case management

Of the 615 persons monitored for COVID-19 risk, **232 (37.7%)** had at least one of the three positivity criteria at triage, while **383 (62.3%)** were monitored because of chronic conditions and/or vulnerability in the absence of triage positivity criteria. Out of the total monitored population, 144 persons (23.4%) had at least one symptom for which the team initiated monitoring or performed investigations; 66 persons (10.7%) were exposed to risk and 48 persons (7.8%) were monitored because of travel to and/or from risk locations.

Differently from the Foggia context, most people were followed up and monitored for COVID-19 risk because of the presence of known chronic conditions or vulnerabilities, including being older than 60 years; this population (age 60+) in 85% of cases had no symptoms and 93% of cases had no exposure to risk. Among the 232 people with positivity criteria at triage, 89.2% presented only one criterion of positivity, 10.3% presented two criteria, and 0.5% presented three criteria. The distribution of risk factors analyzed by gender does not show important differences, except for a slightly more pronounced prevalence of exposure to risk for women.

On the basis of the medical evaluation, 430 persons (69.9%) were monitored without the performance of the nasopharyngeal swab test, 185 persons (30.1%) were offered to perform the swab test; among them, 84 persons underwent the assessment at the dedicated bridge center (13.7% of the total).

Of these 185 cases, 5 persons (2.7%, all men) refused to undergo the test; among those who performed the test, 88 persons tested positive for SARS-CoV2 (48.9% of the swabs performed and 14.3% of the sample population) and 92 tested negative for SARS-CoV2 (51.1% on the swabs performed and 15% of the sample population).
3. MAIN ACTIONS AND ACHIEVEMENTS IN THE COVID-19 EMERGENCY PROJECTS - AN UNEQUAL PANDEMIC

CAPITANATA
SOCIO-DEMOGRAPHIC DESCRIPTION OF THE POPULATION

MONITORED PEOPLE 213
89% men 11% women

The INTERSOS team for COVID-19 risk monitored 213 people during the period from March to October 2020, following the criteria described in the previous paragraphs. The trend in the absolute number of cases followed over time is shown in Figure 11.

FIG. 11 • NUMBER OF PEOPLE MONITORED FOR COVID-19 RISK PER MONTH, CAPITANATA

<table>
<thead>
<tr>
<th>Month</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>8</td>
</tr>
<tr>
<td>April</td>
<td>27</td>
</tr>
<tr>
<td>May</td>
<td>9</td>
</tr>
<tr>
<td>June</td>
<td>10</td>
</tr>
<tr>
<td>July</td>
<td>19</td>
</tr>
<tr>
<td>August</td>
<td>100</td>
</tr>
<tr>
<td>September</td>
<td>31</td>
</tr>
<tr>
<td>October</td>
<td>9</td>
</tr>
</tbody>
</table>

The monitored people are highly mobile; depending on the job offer, they move between different work places and informal settlements in the area. However, at the time of the medical examination, about three quarters of the population declared that they lived in Borgo Mezzanone (154 people, 72.3% of the total). The remaining 59 persons are distributed in smaller settlements in Capitanata as follows: 15 (7%) persons monitored at Gran Ghetto, 11 (5.2%) persons at Palmoni, 9 (4.2%) at Poggio Imperiale, 9 (4.2%) at San Matteo, 8 (3.8%) at Pozzo Terraneo, 4 (1.9%) at Borgo Cicerone, 2 (0.9%) at Serra Capriola, 1 (0.5%) at Ex-Fabbrica Daunialat. Of the total monitored population, 24 are women (11.3%) and 189 are men (88.7%).

Distributing the population by age group reveals that half of those followed are young adults between 22 and 31 years of age (107 persons, 50.2%); the other half of the population is distributed as follows: 12 people between 18 and 21 years old (5.6%), 39 people between 32 and 41 years old (18.3%), 25 people between 42 and 59 years old (11.7%), 6 people over 60 years old (2.8%). Data is not available for 24 people (16.7%). The age distribution of the monitored female population, which represents one fifth of the total, seems to tend towards an average older age than men, with percentages represented as follows: no women in between 18
and 21 years old, 45.8% between 32 and 41 years old, 8.3% between 32 and 41 years old, 20.8% between 42 and 59 years old, 8.3% over 60.

**FIG. 13 • PERCENTAGE DISTRIBUTION OF AT LEAST ONE CHRONIC CLINICAL CONDITION BY AGE RANGE, CAPITANATA**

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>ABSENT (%)</th>
<th>PRESENT (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-21</td>
<td>91.7</td>
<td>8.3</td>
</tr>
<tr>
<td>22-31</td>
<td>92.5</td>
<td>7.5</td>
</tr>
<tr>
<td>32-41</td>
<td>82.1</td>
<td>17.9</td>
</tr>
<tr>
<td>42-59</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>&gt;60</td>
<td>33.3</td>
<td>66.7</td>
</tr>
<tr>
<td>Unspecified</td>
<td>79.2</td>
<td>20.8</td>
</tr>
</tbody>
</table>

Figure 13 shows the percentage distribution by age group of the presence of at least one chronic clinical condition. 16% of people (34 out of 213) have at least one chronic pathological condition and, as expected, the proportion increases as age increases; it is interesting to note that about 10% of young people under 32 years old also have at least one chronic condition.

Within the group of people who came to the attention of the project, possibly due to the reason behind the choice to access the offered services, the women followed present chronic conditions more frequently (15/24, i.e. 62.5% of women) than the men (19/189, with a percentage of 10.1% of the total number of men). In this case, however it may be useful also to keep in mind the age range distribution by gender.

Only 8 individuals (7 of whom are men) reported conditions of vulnerability, mostly in the psycho-social realm. Taking into account the population and the dynamics involved, it is likely that this figure is an underestimation.
COVID-19 risk and case management

Of the 213 persons followed for COVID-19 risk, **192 had at least one of the three positivity criteria at triage and 21 suffered from chronic conditions and/or conditions of vulnerability**. Among the 192 persons with positivity criteria at triage, 119 persons (55.9% of the total) had at least one symptom for which monitoring was initiated or investigations were performed; 92 persons (43.2%) had been exposed to risk; 61 persons (28.6%) had traveled to and/or from at-risk locations. Among these 192 subjects, 123 persons (64.4%) had only one positivity criterion at triage, 58 persons (30.4%) had two criteria simultaneously, and 11 persons (5.8%) had all three: symptoms, exposure to a positive contact and travel from/to risk locations. The presence of at least one of the three positivity criteria at triage differed between men and women; in fact, while among men 95.8% presented one or more criteria including travel, exposure, and symptoms suggesting infection by COVID-19, among women the percentage of subjects with at least one criterion dropped to 47.8%. This data indicates that **most of the women in the sample are monitored prevalently for their chronic conditions**, in what is mostly a prevention activity; the data might also indicate a lower access to the service by women, especially young women, an aspect that may be related to the pressure and social control they suffer in such contexts, exacerbated by the fear and stigma attached to COVID-19 in particular in the most vulnerable groups.

After medical evaluation, **77.5% of people (165) were monitored for clinical conditions** with daily temperature measurement in home isolation, with no nasopharyngeal swab test. The remaining 48 people (22.5%) were offered to undergo the test, mainly in dedicated facilities (hospital or isolation facilities) or on-site, through the intervention of the ASL personnel.

Of the 48 cases who were offered to undergo the swab test, **30 people performed the test** while the remaining 18 people (37.5% of the proposed swabs, representing 8.5% of the total population) refused to undergo the assessment. Among those who underwent the nasopharyngeal swab test, 21 subjects tested positive for SARS-CoV2 (70% of the people who got tested, 9.9% of the sample population) and 9 tested negative for SARS-CoV2 (30% of the tests performed, 4.2% of the sample population). **Among the 18 persons who refused to undergo the test, 15 (83.3%) had been in contact with established or suspected cases or in at-risk locations but did not show symptoms**, whereas 3 (16.4%) showed symptoms (fever in all three cases, but no cough or other symptoms) but no exposure to risk. This figure may highlight the **poor perception of the disease in the absence of detectable symptoms and the difficulty of a part of the population in perceiving COVID-19 as a priority**, in a context so widely marked by issues that appear more urgent. This point will be further explored in the research on the impact of COVID-19 on the quality of life of people living in contexts of social exclusion.

Of the 18 people who refused the swab, 3 are women, all asymptomatic and with exposure to risk cases. Despite the numerical difference between men and women in the sample and considering only the number of people with positive elements at triage who were offered the swab test, it should be noted that 3 out of 4 women (75%) refused to undergo the procedure, while the men who refused were 15 out of 44 (34%); as mentioned above, this aspect is probably related to the dynamics of power and social control that afflict the population, particularly the most vulnerable.
Out of the 338 people reached by the INTERSOS team, 68 were monitored for COVID-19 risk between April and July 2020. The trend in the absolute number of cases followed over time is depicted in Figure 14.

**FIG. 14 • NUMBER OF PEOPLE MONITORED FOR COVID-19 RISK BY MONTH, IONIAN CALABRIA**

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of People Monitored</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>16</td>
</tr>
<tr>
<td>May</td>
<td>34</td>
</tr>
<tr>
<td>June</td>
<td>12</td>
</tr>
<tr>
<td>July</td>
<td>6</td>
</tr>
</tbody>
</table>

Most of the people (33) monitored for COVID-19 risk in Ionian Calabria had a medical visit in Crotone city (Area 1), 4 at the *Isola Capo Rizzuto* settlement, while 31 individuals were visited at sites and settlements in the Corigliano, Rossano and Sibaritide area (Area 2).

Out of the described population, 7 are women (10.3%) and 61 are men (89.7%).

The countries of origin of the 68 people monitored for COVID-19 risk are 18: most of them come from Africa, specifically Nigeria (19%), Morocco (13.2%), Senegal and The Gambia (both 11.8%), and from the Indian sub-continent, specifically Pakistan (8.8%) and Bangladesh (7.4%). The 7 women came from: Nigeria (3), Bangladesh (2), Morocco (1), and Romania (1). Two of the monitored women were pregnant.
COVID-19 risk and case management

Of the 68 persons monitored for COVID-19 risk, 38 had at least one positive criterion at triage (55.9%), while the remaining 30 persons were followed up and monitored for COVID-19 risk because of the presence of known chronic conditions or vulnerabilities, and did not show positive criteria at triage (44.1%). One quarter of the population (17 persons) were monitored for showing at least one symptom, and investigations were performed; 16 persons (23.5%) had been exposed to risk and 9 persons (13.2%) were monitored for travel to and/or from risk locations. Among persons with positive criteria at triage, most of them (34 subjects) had only one criterion of positivity while the remaining 4 persons had two criteria of positivity simultaneously at triage.

According to medical evaluation, 66 persons (97%) underwent monitoring of clinical conditions in home isolation without the performance of a nasopharyngeal swab test, whereas 2 persons (3%) were offered the test. Both persons refused to perform this assessment, and underwent monitoring of clinical conditions while in self-isolation.
CONCLUDING REFLECTIONS ON QUANTITATIVE DATA

The data presented here, in addition to offering a snapshot of the population reached through the monitoring activity of the spread of COVID-19 in the contexts of intervention, makes it possible to make some more general considerations on the health of the immigrant population living in contexts of strong social exclusion, on the existing possibilities for their protection and on access to services.

As it is known from the most recent evidence on the health of the migrant population in Europe (23), there are some salient features that seem to characterize the health profile of the migrant population. On the one hand there are the needs related to and associated with the recent, dramatic, migration flows, which carry with them specific vulnerabilities (violence, trauma, exploitation or trafficking) and a set communicable and non-communicable diseases potentially resulting from the experience. On the other hand, it is evident that the time spent in this context results in a progressive and more silent onset of chronic diseases, which grows over time until it reaches rates similar if not higher than those of the resident population, but with different and often worse outcomes than the rest of the population. Numerous factors can influence the health conditions of migrants, and the entire migration process can be considered an important determinant of health (24). It is not only living conditions and events that happen before and during the migration journey (socio-economic factors, trauma, violence, disadvantaged living conditions during the journey and before departure, inefficiency of the health system in the country of origin) that determine conditions of vulnerability. Indeed, a number of factors emerge after migration, such as poor living and working conditions, as well as barriers to access to both formal and informal services and in general dynamics of exclusion (25). The scientific literature shows that the health conditions of migrants upon arrival to Europe are generally good, but seem to worsen over the years, with an increase in the prevalence of non-communicable diseases in proportion to the duration of stay, reaching percentages similar to or higher than the resident population, but often with worse outcomes (26). Specifically, considering the populations with which INTERSOS works, it is well-known that health outcomes tend to be worse for people who belong to the most disadvantaged segments of the population, with fewer economic resources, living in disadvantaged urban areas, often in overcrowded conditions, penalized by bad access to the labor market, with precarious employment or in the black market system (26, 27).

While faced with an increased risk of fragility, their access to care is hindered by a number of barriers to access, such as the absence of a regular residence permit or discontinuity in their legal status, economic barriers, administrative-bureaucratic barriers, and linguistic-cultural barriers. Additional problems that contribute to reducing access to care should also be considered, such as the presence of xenophobia, racism and discrimination, especially in a hostile political and cultural context that tolerates discriminatory behavior even within public services (28, 29).

As WHO states in its report “No public health without refugee and migrant health” (23). If migration is a structural phenomenon, the protection of the health of the foreign population becomes an essential and unavoidable act of public health, which must be guaranteed by all social and health policies, not only because the right to health is a fundamental and inalienable right of the individual, but also because defending the health of migrants means defending that of the entire community. The way in which health care is organized and provided becomes central to this discussion, as it can be both a vehicle for perpetrating mechanisms of inequality and illness, and a part of the solution (25, 29).

The data from all the contexts presented here describe a population with an important share of known conditions of vulnerability and fragility, which are probably largely underestimated. These populations are exposed to significant risk factors, they live in conditions of deprivation that can gradually erode their state of health and that are at the root of the development of pathological
conditions, acute and chronic, communicable and non-communicable.

It should also be noted that, despite the documented presence of risk conditions and of known chronic conditions and/or vulnerability in the populations, the data and field experience show that these people have limited access to the local health services (for example, in Rome only about half of people with chronic conditions or other vulnerabilities report having a general practitioner).

Health and illness are closely related to living conditions and to the social, economic and environmental context in which people live; the production of health inequalities is affected by the different levels of exposure of individuals to a number of risk factors. It is precisely the most vulnerable groups in the population that are most affected and have the worst health outcomes (30), particularly at the intersection of multiple social identities (defined by race, gender, sexual orientation, socioeconomic status, disease, disability etc.). These problems emerge in personal experiences, but they reflect the dynamics and large-scale processes of privilege and oppression (i.e., racism, sexism, heterosexism, classism, etc.) (31). Specifically, the lower access of young women to the service offered by INTERSOS (as documented in the data from Capitanata) is likely a manifestation of this.

In the absence of inclusive public policies and targeted interventions to protect populations in vulnerable conditions, these aspects inevitably lead to the amplification of health inequalities.

As noted in the introduction, the course of the epidemic has shown that migrant people are more affected and more vulnerable to the spread of COVID-19 than the general population, precisely because of the conditions of deprivation in which they live and the fewer resources to which they have access (1). An editorial in The Lancet defines COVID-19 not as a pandemic but as a ‘syndemic’, i.e. it is a SARS-CoV2 epidemic combined with an array of non-communicable diseases (NCDs), which cluster in social contexts marked by deprivation and inequality (32). If the causes of this “syndemic” are ignored and no structural interventions are carried out to address the conditions that expose people to differential levels of risk based on their social position, it will remain impossible to talk about effective measures, on a global scale as much as on the individual level.
3.4 THE IMPACT OF THE COVID-19 EMERGENCY ON THE QUALITY OF LIFE IN CONTEXTS OF SOCIAL EXCLUSION

Authored by Silvia Scirocchi, Flavia Calò, Marianna Parisotto, Elda Goci

3.4.1 Socio-demographic description of the population

| PARTICIPATING POPULATION | 78 | 69% men | 31% women |

The population that participated in the research is made up of 78 persons, divided in the three researched regions as follows: Lazio (25), Puglia (36), and Sicily (17).

CARATTERISTICHE SOCIODEMOGRAFICHE

Of the 78 people involved, 69% are men (54) and 31% are women (24). 52% of the population is between 26 and 40 years old. The people involved come from 21 countries, from three geographic areas: Latin America (Dominican Republic, Ecuador, Venezuela, Peru); Africa (Morocco, Egypt, Senegal, Sudan, Gambia, Nigeria, Mali, Cameroon, Chad, Guinea Bissau, Ivory Coast, Ghana); Asia (Pakistan, Iraq and Bangladesh). 24% come from Senegal, 22% from Nigeria, 9% from Gambia, 6% Sudan, 6% Ecuador, 6% Dominican Republic, 4% Ghana, 3% Mali, 4% Morocco, 3% Peru, 3% Chad and the remaining 10% from Venezuela, Bangladesh, Iraq, Pakistan, Cameroon, Ivory Coast, Egypt and Guinea Bissau.

FIG. 16 • COUNTRY OF ORIGIN AND SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE

![Country of Origin and Socio-Demographic Characteristics of the Sample](image-url)
Level of education
54% (43) of the people reached have a medium to high level of education: 37% (29) secondary level of education, 14% (11) completed specialized technical programs and 3% (3) university level education. 29% (22) of the population has a pre-elementary and elementary level and 17% (13) reported being illiterate.

Working conditions
Regarding work life, 45% (34) of the people reported being unemployed/outside the labor market at the time of the interview.

Legal status and housing conditions
64% (50) declared that they have some form of legal document; among these three are also Italian citizens. 36% (28) declared that they do not have any form of document.

65% (51) of the surveyed population lives permanently in an informal settlement, 19% (15) in a housing squat, 4% (3) are homeless, 8% (6) live in a home, 3% (2) at reception centers, one person lives on the street in an informal settlement (1%). Below is a chart showing the proportions in terms of legal status and housing conditions (Figure 18).

Despite the fact that 50 of the people interviewed are legally resident in Italy, only 5 live in a house. 28 people live in an informal settlement, 3 in a squatted building and 2 people live on the street.

Among the 50 people who have documents, only 45 are enrolled in the Regional Health System and have a health card. 5 people have an STP code and 28 do not have any health document. Among the 45 people enrolled in the Regional Health System, only 39 have a GP, while about 50% of the total sample (78 people) does not.

FIG. 18 • PROPORTIONS IN TERMS OF LEGAL STATUS AND HOUSING CONDITIONS

<table>
<thead>
<tr>
<th>Housing conditions</th>
<th>documented</th>
<th>undocumented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal settlement</td>
<td>28</td>
<td>23</td>
</tr>
<tr>
<td>Housing squat</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Live in a home</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Homeless</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Reception centers</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

FIG. 19 • RESIDENCE PERMIT AND REGISTRATION WITH THE PUBLIC HEALTHCARE SYSTEM

36% (no residence permit) and not registered with the public healthcare system.

45 registered with the RHS
5 have an STP code
IMPACT OF THE HEALTH CRISIS

The 78 people involved the study were also asked where they spent the lockdown and what the health crisis meant for them.

**Where they spent the lockdown**

Only 6 of the 51 participants living permanently in an informal settlement left during the lockdown, while 44 (56%) remained in the settlement. 8% (6) reported spending the lockdown period at a friend’s house, while 4% (3) spent it in a private home. 2% (2) stayed in a shelter. 20% (15) of the sampled population live in a housing squat, and spent the lockdown there. 10% (8) did not respond.

**The consequences of the health crisis**

For 32% (25) the health crisis led to unemployment. For 24% (19) it resulted in total immobility, i.e., the inability to move in order to work. For 17% (13) it meant simply a halt in mobility. For 5% (4) there was a reduction in work and for 1% the loss of a place in a reception center. 7.6% (6) reported that nothing changed, alluding to a life already full of hardships. 12% (10) did not respond.

At the time of the interview, 93% (73) of the population did not know anyone who contracted COVID-19. We know for a fact (from fieldwork in the places where we conducted the interviews) that this figure is profoundly different today.
3.4.2 Quantitative analysis conducted with the Who quality of life-bref and impact event scale-revised (ies-r) tools

**SAMPLE**

54 people participated in this section of the research, of which 10 (19%) were women and 44 (81%) were men.

33 people (61%) have a type of document and 21 (39%) have no document.

Of the 33 people who possess a type of document for living in Italy, 30 are enrolled in the RHS and of these only 27 have a GP. 5 have a document such as the STP code and 20 people are not enrolled in the NHS and do not have a health card.

46% (25) of the people involved in this study have a medium-high level of education (technical-specialist (7) and secondary education (18)), 16% (8) have an elementary level of education, 9 (16%) have a pre-elementary level of education, 12 (22%) are illiterate.

**FIG. 20 • LEVEL OF EDUCATION**

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>technical-specialist</td>
<td>13%</td>
</tr>
<tr>
<td>secondary education</td>
<td>33%</td>
</tr>
<tr>
<td>primary (elementary) education</td>
<td>16%</td>
</tr>
<tr>
<td>pre-elementary level of education</td>
<td>16%</td>
</tr>
<tr>
<td>illiterate</td>
<td>22%</td>
</tr>
</tbody>
</table>

49% (26) of the persons reported being unemployed/out of the labor market, 38% (21) are working with a form of contract, 1% (1) are self-employed, 11% (5) are working without a contract, and one (1%) is a student.

**FIG. 21 • EMPLOYMENT STATUS**

49% unemployed
38% work with contract
11% work without contract
1% self-employed
1% students

The 54 people reside in private homes (4), in housing squats (1), in the informal settlements of Cassibile and Borgo Mezzanone (46), in a reception center (1). 2 people are homeless.

The 54 people were asked where they had spent the lockdown:

- 40 spent it in an informal settlement (of which 38 were already living there, one person lived on the street there, and one person previously lived in a private home)
- 6 spent it at friends' homes (before lockdown one person was living on the street, three were living in an informal settlement, 1 person was living in a reception center, and 1 person was living in a house)
- 2 spent it in a housing squat (1 person was already living there and 1 person got stuck there)
- 1 person remained in their own home
- 1 person was hosted in a reception center
- for 4 people the data is not available.

Through the frequency distribution it is possible to visualize where the people spent the lockdown period (Table 3)
3. MAIN ACTIONS AND ACHIEVEMENTS IN THE COVID-19 EMERGENCY PROJECTS - AN UNEQUAL PANDEMIC

### TAB. 3 • FREQUENCY DISTRIBUTION “HOUSING CONDITIONS PRIOR TO LOCKDOWN” AND “HOUSING ARRANGEMENTS DURING LOCKDOWN”

<table>
<thead>
<tr>
<th>Housing arrangements during lockdown</th>
<th>Homeless</th>
<th>Squatting</th>
<th>Informal settlement</th>
<th>Reception center</th>
<th>Private home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal settlement</td>
<td>1</td>
<td>0</td>
<td>38</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Home/Squat</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Home/Friends</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Own home</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Reception center</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No data</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

For 16 people, the health crisis had a major negative impact on their lives; 11 reported the health crisis had a strong negative impact on their lives, 9 reported a negative impact, for 17 people the crisis had little impact (15) or very little impact (2) in their lives. Of 21 individuals there is no information.

### RESULTS

The 54 individuals were asked to fill out the Impact Event Scale-Revised (IES-R) to assess post-traumatic stress symptoms resulting from the impact of the COVID-19 emergency.

As recommended by Creamer et al. (33), a “probable case of PTSD” was determined taking 33 as a cut-off score. The following score ranges were established:

- **score between 24 - 32**: do not have a defined Post Traumatic Stress Disorder, however, may show some of the symptoms (34)
- **score between 33 - 36**: cut-off score to diagnose the presence of Post Traumatic Stress Disorder (35)
- **score of 37 or more**: this score signals a Chronic Post Traumatic Stress Disorder (34)

### TAB. 4 • PRESENCE OF PTSD

<table>
<thead>
<tr>
<th>Presence of PTSD</th>
<th>Number of person</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No symptoms</td>
<td>15</td>
<td>28%</td>
</tr>
<tr>
<td>Some symptoms</td>
<td>7</td>
<td>13%</td>
</tr>
<tr>
<td>PTSD</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Chronic PTSD</td>
<td>32</td>
<td>59%</td>
</tr>
</tbody>
</table>

Observing of the frequency of Impact Event Scale-Revised scores, we can infer that the persons who participated in the study do not display symptoms attributable to COVID19-related post-traumatic stress (absence of symptoms for 15 persons and presence of some symptoms for 7 persons). **32 people**
(59%) reported symptoms of Chronic Post Traumatic Stress Disorder (with symptoms lasting more than three months). This finding may support the fact that more than half of the people included in the study had already experienced other traumatic events that had a disruptive impact on their mental health but, unfortunately, had never been identified and placed in care.

Given the countries of origin of the people who took part in the research (99% from Sub-Saharan Africa), we can hypothesize the trauma might also be linked to experiences before and/or during migration; however, we cannot exclude traumas occurring after arrival, which could be caused by their current situation and be linked to their living conditions.

From the observation of the average scores in the three subscales of the IES-R (Intrusive Symptoms, Avoidance Symptoms and Hyperarousal Symptoms), the most frequently reported symptoms were those of avoidance (14.6) followed by intrusive memory symptoms (13.6%) and hyperarousal symptoms (9.5%).

In addition, the people who took part in the study were also asked to fill out the WHO - Quality of Life-BREF (WHOQOL-BREF) to assess quality of life. The first two questions assess self-perceived quality of life and satisfaction with health, the remaining 24 questions refer to four areas: physical health, psychological health, social relationships and environmental conditions.

The Quality of Life (QoL) investigated with the WHO tool resulted in a broad assessment; while being closely related to a person's emotional state, it also represents a subjective evaluation of oneself and one's social and material world that goes beyond the person's psychological state.

Following the literature (36), the following score range was used:

- **score ≤45**: low QoL;
- **score 46 to 65**: moderate QoL;
- **score >65**: relatively high QoL.

34 out of 54 people (62%) perceive having a low quality of life. 18 people (33%) perceived having a moderate quality of life, only 2 people (4%) reported having a good quality of life. One person (1%) did not answer all the questions in the questionnaire, so their scores were not processed.

In the WHOQOL-BREF, 4 areas are carefully explored (the physical, psychological, interpersonal relations, and environmental or context areas) to determine the extent to which the subject is satisfied or dissatisfied with each. **Results show that the area to which the highest level of suffering is ascribed is environmental, and related to the context of life.** The following research sought to better understand what factors might affect the people who perceive themselves as experiencing a “low quality of life.” As can be seen from the table below (Table 5) the perception of low quality of life among people living in informal settlements is significantly high.

Similarly, we investigated possible correlation with variables in employment status, legal status and documentation needed to access the RHS (health card or STP), Table 6.

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29 PTSD is defined as “acute” if the duration of symptoms is less than 3 months, and “chronic” when symptoms continue for 3 months or more.
Precarious housing conditions, the absence of work or job insecurity, the absence of residence permits and documents to access the RHS are associated with a low perception of quality of life among the population.

In conclusion, the results obtained in this part of the study, which counts 54 people of whom we have direct clinical knowledge, lead to some reflections. The subjective evaluation of quality of life, assessed with the WHOQOL, is decidedly low. The indicators of quality of life, namely employment, environment, physical and mental health, and relationships, paint a picture by which 64% of the people in the sample perceive themselves in a state of existential precariousness. 33% have a perception of their lives as average in quality. Only 4% perceive their lives to be good in quality.

Moreover, given the origin of the people who participated in the research (99% were from Sub-Saharan Africa), we can hypothesize that the presence of trauma may also be linked to the experience before and during migration; however, we cannot exclude that they might have incurred in trauma after arrival, probably originating from their current life style and linked to their living conditions. It must be kept in mind that the complications brought by a chronic or untreated PTSD can have consequences at the community and social level, with difficulties in integration and growing pockets of discomfort and social vulnerability. Without a correct diagnosis and an appropriate and specific therapeutic treatment, post-traumatic disorders have a tendency to become chronic or to progressively worsen. The timeliness of an adequate treatment in a specialized environment is therefore crucial for the future of these people; a prerequisite for this is a timely and correct diagnosis.
3.4.3 Qualitative analysis

The qualitative work conducted with migrant populations consisted of 10 semi-structured interviews conducted on an individual basis (Rome: 3; Capitanata: 5; East Sicily: 2) and 2 focus groups conducted at housing squats in Rome (with 6 and 8 participants, respectively). The research was conducted between June and August 2020. In this period the so-called “first wave” of the Coronavirus outbreak had just ended, and the contagion curve had gone down.

The collected material was organized according to 6 thematic areas: work, documents, social-housing condition, support network, (dis)empowerment and resources, and perspectives. Each of the thematic areas was analyzed in relation to the links with health and quality of life, with claiming rights and with the impact of the COVID-19 pandemic, as experienced by the participants.

It was particularly evident that the effects, in terms of changes, experienced by our participants as a consequence of the health crisis were very few. Indeed, the priorities of the people involved in the research were mainly directed towards achieving more dignified living conditions; the Coronavirus was experienced as a side event whose perceived impact was minimal in the face of much greater suffering and difficulties. The participants configure carrying out prevention measures to the risk of contagion as a luxury that they cannot afford, as they have to cope with difficult living conditions in each of the examined contexts.

RESULTS

**WORK**

“If there is no work, I can’t take care of myself or anyone else and I [have to] leave everything in God’s hands.”

The people met within the context of the research have different stories and work situations, in relation to the analyzed context. These stories depict very different situations, which mostly share dynamics marked by job insecurity, exploitation and undeclared work. The difficulties experienced in the working environment, connected to exploitation and the absence of protection regarding working conditions, or even to the great difficulty of finding a job, were inevitably exacerbated by the social crisis that resulted from the pandemic. The study participants also highlight the link between working conditions (or lack thereof) and people’s quality of life. In the summer, the population in the rural settlements increases up to threefold. Many workers come from other parts of Italy, following the routes of seasonal agricultural work. The dynamics of exploitation and the consequences that these have on people’s lives emerge from the research material and from what the organization’s staff witnessed in their daily work with the population. In fact, most people work in the black or gray labor market, without rights or protection, especially in case of illness or injury. Participants denounce a situation of exploitation that has been ongoing for years, as they were promised contracts that never arrived. Cases of illegitimate contracts or bogus paychecks are common occurrences. People also report non-payments, late payments and working conditions that take a heavy toll on their health. Like this woman:

“When I arrived I had papers but no job. I have always worked in the countryside, a lot in Rosarno, Calabria with oranges, at that time without a contract. Now I have a contract but the contract they give us is false! It is false! They
don’t give us a regular contract. They use us to do everything, from A to Z but they don’t give you the money they promise you because you don’t understand Italian, we’ve been working for nothing for years, it’s not good, things have to change! You give me a contract, you tell me it’s for one year, I work for you for three months and then you tell me the job is over. I tell you I have to go renew the papers, so give me the paycheck, I see the paycheck and I ask “is this all the money you paid me?” “No. Better to leave it all, this is wrong, things have to change!”

Capitanata

What emerges in particular is the pain of those who work long hours and receive extremely low compensation. Many people suffer these work conditions, which border on slavery. A laborer in the Foggia area describes this experience, when talking about “someone’s son”. This son who, in the end, refers to himself and to all the “brothers and sisters” who live in the same conditions:

“Yeah, you can’t just take someone’s son, wake them up at 3am and take them to work in this sun, look at the temperature…. it’s really high, they pay you 4 euros an hour and only after a long time. Today is the 21st and they still haven’t paid me for the past month. And it’s a two-month job even though they told me [it would be] a year.”

Capitanata

For all interviewees, these life conditions are not a choice. People recount finding themselves in an informal settlement and working for a caporale\(^{30}\) because they had no other means of survival. Often, it is not only for personal survival but also for the survival of the family, in Italy or in the country of origin.

“...a lot of the guys don’t have documents, that’s the first big problem. If you don’t have documents you don’t have anything and [your] health is not good. Even when they go look for work the first thing they ask you is for your documents, and if you don’t have documents you don’t have work, or you go work off the books.”

Rome

Both in rural and urban contexts, interviewees draw an explicit link between work and health, on a physical, psychological and social level.

There are many health problems that affect populations living in informal settlements. Our interviewees who work in the agricultural sector listed,

“Stomach problems, respiratory problems, those who work in the fields have leg problems. Many get hurt at work.”

Capitanata

There is an awareness of working in unhealthy environments and in conditions that do not protect health, and there is also an awareness of being inside a system of labor exploitation:

“The work I do is not good for my health but what else can I do? We work for 3-4 euros per hour. It’s not enough. We have pains, we are sick but to survive we still have to work.”

Capitanata

Job instability and exploitation also have a strong impact on people’s psychological well-being and on their way of relating to others.

“A lot of people here talk like they are crazy, a lot of people here have head problems. People

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\(^{30}\) Gangmaster. See footnote 18.
don’t have work and housing, that makes your head burst. The Italian government has to find solutions to let people work.”

Capitanata

Many participants say they experience anger and confusion, and that this finds expression in a frustrated attitude that, they say, causes several problems in their relationship with themselves and others. A participant who lives in the settlement of Borgo Mezzanone explains this well when she states:

“If there is no work I cannot take care of myself or anyone else and I [have to] leave everything in God’s hands.”

Capitanata

Labor exploitation intersects with other forms of discrimination and oppression, such as racism, putting people in positions of social disadvantage and vulnerability to blackmail. One consequence, among other things, is that the people lack the resources to demand and obtain greater protection and respect for their rights. It is this condition of psychological and social annihilation that, at the end of the day, according to the interviewee, leads people to “leave everything in God’s hands” as the only possibility for salvation.

“Here if you don’t speak Italian, if you can’t read and write, they won’t give you a job. And if the normal pay for a job is 10 euros per hour if you are black they give you 4. Sometimes 3, 4 or 5, per hour. Which is really bad.”

Capitanata

The impact that the Coronavirus pandemic has had not only in terms of health and risk of infection, but also in social terms, of loss of employment and isolation, emerges very strongly from our interviews. The crisis, in fact, does not seem to have directly impacted people from a health point of view as much as on the relational and social level, even leading, in the words of this interviewee, to real despair.

“There is despair when you hear about someone being sick. When you are left without a job. This Coronavirus has hurt so many people not just those who have gotten sick from the Coronavirus.”

Rome

The pandemic, in these contexts of job insecurity, has increased people’s vulnerability to blackmail: overnight, many have found themselves out of work and encountered great difficulty in sustaining themselves. If losing one’s job is a problem in general, it is even more so for those who are undocumented and do not have access to any kind of state protection, as is the case with people without regular documents.

“One person went to work almost four years without a contract, no paperwork, he worked in a restaurant. Under COVID the owner kicked him out and he got no severance pay, nothing. [With] No contract, [you get] nothing.”

Rome

Some people found themselves on the street or without access to food, without any support network; this had severe psychological consequences. As one interviewee pointed out, “being out of work forces you to stay home and think a lot.”

“During the lockdown almost no one was working. Now slowly someone is going back to work. Fortunately, the tomato harvest starts soon and we will all work. The main problems caused by the Coronavirus, as far as I am concerned, are the lack of food and work. People are suffering. We were forced to stay at home forced to think a lot. [With] No movement possible, we spend our days thinking and eating, when there is food.”

Capitanata

There are also people who, in this situation, have had to continue supporting their family in their country of origin.

“There is despair when you hear about someone being sick. When you are left without a job. This Coronavirus has hurt so many people not just those who have gotten sick from the Coronavirus.”

Rome

“The impact has been with my family in Africa, I can’t support them economically; they always call me because I have to send money, I told them things have changed, I’m locked at home, I’m not working, so I can’t help, but making them understand that there is this pandemic has been difficult.”

East Sicily
“We move forward, but life without documents is undignified.”

The link between residence permit and work contract pushes people into irregular work systems for years on end, with little chances to get out, without protections and rights. This is due to the absence of an effective and inclusive migration policy, which should aim at regularizing people without residence permits who are living in the country. In the countryside of Southern Italy there are many accounts of this.

For most immigrants, obtaining a regular residence permit is tied to the work contract; the restrictions introduced by the Bossi-Fini Law in 2002 generate, regardless of the work sector and context (both in the countryside and in the city), conditions of vulnerability to blackmail and to other threats, which in turn have important consequences on a social, health and rights level. In particular, people's perception is that even if their intentions are to work with a regular contract and put their skills to use in the honest exercise of any profession, the condition of administrative irregularity determined by the absence of documents makes any path to inclusion unachievable. This has serious consequences in terms of building a future, making life in Italy without documents “unworthy”.

“If I go to the police they ask for my work contract. If you don't have documents you don't have a work contract. Everyone here does undeclared work, they don't work for the Arabs but for the Italians. Italians should treat black people like human beings, and I will keep saying that!”

Capitanata

“We don't have documents and without documents we can't take even one day of sick leave. Many people here are not well. We've been working for years without papers.”

Capitanata

And the claim to one's rights as a human being also starts from being master of one's own choices. This possibility is perceived as denied because of the lack of a document, which renders people “slaves to the choices of others” and forces them to put up with unworthy social and living conditions.

“The problem remains the document. In that place, the main problem for the people who live there is the lack of documents. We can't do anything without documents. There are people who have been living here for about 15 years without documents. Yes, without documents we can't do anything. We have no choice, we are slaves to the choices of others.”

Capitanata

“If I had documents today I would leave. People are desperate because of documents, because...”
The condition of vulnerability to blackmail and powerlessness associated with the vicious cycle of regularization, whereby seeking regular work becomes impossible for undocumented people, has worsened over the course of the pandemic.

"Now they tell you ‘do you have documents?’ ‘No I don’t have papers.’ ‘[Then] you can’t do that!’
Many employers used to tell me ‘I won’t make you a contract unless you give me the money I have to spend to make the contract.’

Rome

Among the people involved in the research, many are well aware of how these dynamics of exploitation, largely based on the difficulty of obtaining a legal permit to stay in Italy, are functional to the maintenance of the economic and productive system, based on cheap labor and undeclared work.

“All this while we work for you, the least you could do is give us documents. We are the soldiers of

Capitanata

It is clear that this condition of administrative irregularity weighs heavily on people’s health from a physical, psychological and social point of view. Access to services is inevitably difficult, despite the existence of tools such as the STP and ENI codes. These services, in fact, are experienced as impenetrable, distant and difficult to access both in bureaucratic, geographical and linguistic terms. More generally, even taking care of oneself is difficult when the priority is to survive.

“The government should help us and give us documents. People are dying here. If I had rights I would know how to take care of myself, but I am not given any rights.”

Capitanata

SOCIAL AND HOUSING CONDITIONS

“If there was a good job out of here, no one would be stupid enough to live here.”

The social and housing conditions of the participants in this study are all characterized by precariousness and social distress, but in a rather varied way. Some live in an informal settlement in southern Italy and find themselves ensnared in labor exploitation; here, in order to work you have to accept certain rules and housing conditions. There are those who live in housing squats, where community life is constant and any decision is made collectively through assemblies. This is rooted in a common struggle for the right to live, as part of the urban civil movements. There are those who share a house with many other people, of the same or different nationalities, and every month try to save enough money to pay the rent, even just for a bed; and there are those who live on the street, without a fixed home, in an informal settlement, and with difficulties that are structural and chronic.

Precarious housing conditions emerge as the core point that characterizes the poor quality of life of the interviewees, for the people who live in an informal settlement as much as for those who live in a housing squat and, clearly, for those who are homeless. The social and housing conditions in which the interviewees live emerge as one of the aspects that generate the most suffering, placing people in conditions of vulnerability and exposure.
3. MAIN ACTIONS AND ACHIEVEMENTS IN THE COVID-19 EMERGENCY PROJECTS
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to health risks.

The people who live in the settlements of Southern Italy make it clear that the mere existence of such degraded housing conditions is a violation of human rights and that all the people who live there suffer an injustice: feelings of indignation and anger emerge in several accounts, and accompany the description of social, housing and hygienic conditions.

“No work, no food, and housing that is not fit to live in. Do you see where we live? How can you sleep in here?”

East Sicily

Those who live in rural informal settlements emphasize how living in shacks, having limited access to water or drinking water sources, the absence of toilets and of waste disposal systems, the distance from towns and services, represent health risk factors.

“We don’t have bathrooms here, we go in the fields, does that seem right to you? What about infections? It’s not safe. Sometimes if I have to defecate... what if it rains? Then it rains in the shacks, we’re suffering.”

Capitanata

“These are not homes, these are not places fit to live in. It is very important that we can live a decent life. This place is not good for health and safety.”

Capitanata

However, this awareness clashes with the fact that these living conditions are not a choice, but one of the consequences of social dynamics based on exploitation, in which people in vulnerable conditions are easily blackmailed and do not have the possibility and the right to claim and access decent living conditions.

“This place is not healthy, I don’t like this place but I have no choice.”

Capitanata

The lack of choice in the urban context is manifested in the precariousness of housing solutions (that sometimes lack even electricity and water), but especially with regard to overcrowding in rooms and homes, which even in this context, is not a choice but a need determined by social conditions of exclusion and vulnerability to blackmail. Living in conditions of overcrowding is not only a well-known risk factor for the circulation of infectious diseases, but can also cause emotional and psychological pain. Indeed, overcrowding infringes on personal space and often the people who have to share the space have no emotional ties or affinity.

“Unfortunately, yes, I am not doing great. Because if I had a room with a light in it... I live with five people in.... Yeah that’s not good. If I live with five people in a room there are problems with my head that is not doing well, everyone’s health is not good because we are all too close.”

Rome

The health implications also emerge explicitly from those who, in an urban context, do not have a fixed home; many people in this situation suffer from conditions of material deprivation and experience difficulties in accepting their condition of exclusion and isolation. Several people report the repercussions that this suffering has on their mental health, on their relationship with themselves and others, referring to behaviors that emerge because of a lack of social support and relations.

“... then living on the street, and not accepting living on the street, affects one’s mental state. The body doesn’t accept it and so it goes up to the head and the person reacts in a wrong way, in a way that if they were in their family they wouldn’t have done it. (…) it is difficult to bear all this. I, for example, don’t have a house, I don’t have an address where I can take a shower, sort myself out... I also had mental repercussions. How much it has changed my way of acting, of seeing, of being with other people. (…) Yes yes, I feel a lot of fear in my body and I’m also afraid for others.”

Rome

The Coronavirus pandemic is therefore part of already precarious social, economic and housing
conditions, in which the implementation of basic prevention measures becomes a complex endeavor. Particularly in rural informal settlements, where there is a lack of running water, poor hygienic conditions already represent a health risk, and the Coronavirus becomes a problem that adds on to the many existing dangers to people's health.

In the urban context, however, particularly in housing squats, the perception of the danger of the virus and the risk of spreading it within the squats is much stronger: the awareness of the people’s condition of vulnerability, the high risk of spread in such a densely populated context and the consequences that this may entail, leads to maintaining focus on prevention measures for everyone’s safety.

“We were vulnerable at that time because if I contracted it and took it home to my family and that was the issue that kept us scared.”

Rome

The consequences of the pandemic are reported mainly on the social and economic level, namely the loss of employment and on the impoverishment that has resulted from it, as well as on the management of daily life.

“Those who have children have nothing to buy groceries, maybe if you have savings, but I don’t think foreigners but also Italians [can] make it now. It’s hard everywhere. It’s a mess. We experience still now the bad consequences of this disease.”

Rome

In addition, those who live in urban settings emphasize how the living conditions of homeless people have worsened, at a time when services are closed and access to support networks and solidarity is impossible, exacerbating their conditions of exclusion.

“I saw so many things in the street: people sleeping in the street in Termini, there were so many people, during COVID, people couldn’t go out and these people had difficulties, how could they eat? This made my heart ache.”

Rome

The issue of the halting of services during lockdown represented a challenge for those who were in ongoing treatments, and their disruption is reported with particular distress for those who were undergoing therapies for their mental health.

Particularly in the urban context and in more organized contexts, interviewees also reported how the implementation of preventive measures has led the general population to pay more attention to sanitary conditions at home and in shared spaces, as a practice to protect the health of individuals and of the whole community.

“Everyone has become more aware of hygiene standards, the use of masks, and even children have been taught to be careful and wash their hands. That alone is worth a lot, because before it was taken for granted.”

Rome

These positive aspects do not transpose, however, to the rural context, where the conditions of isolation and marginality became more binding during the course of the pandemic and especially in the more restrictive phases of its management. The difficulty in accessing a residence permit, the lack of a regular work contract, of services and of decent social and housing conditions remain the priority and the main demands of the population residing in the informal settlements and working under conditions of labor exploitation. In these contexts, in fact, the risk of the spread of COVID-19 is not perceived as a preeminent problem, because the precariousness of the living environment, the absence of protection, the condition of general exploitation and the feeling of powerlessness, represent risks and dangers from which it becomes a priority to defend oneself.

“No one can live in a place like this. I’m not safe here, I sleep with one eye open, fire can come at any time. (...) Would you allow one of your family members to work in these conditions?”

Capitanata
The interviews also investigated the impact that social relationships and support networks have on the quality of life of migrant people, and how the health emergency might have affected them. The research investigates the family network and the relationship with family members in the country of origin on the one hand, and the presence or absence of a community support network in Italy on the other.

Regarding family members living in countries of origin or in other countries, their reactions to the outbreak of the epidemic have been varied. Many of the interviewees kept their families informed, making them understand the seriousness of the situation and the importance of protecting themselves and others by adopting prevention measures.

“...fear, sadness for my relatives, my son, my mother and everyone. Because in the country it’s really a chaos. Here, for better or for worse it was okay, because everyone was distanced and the rules were followed, so it was a protection, but seeing the news of my country where people were dying even in the streets gave me tremendous fear, sadness.”
Rome

The use of technology has made it possible to maintain a stable contact with family members and this has played an important role in terms of quality of life. Maintaining relations with loved ones represented a fundamental form of support in such a moment of crisis and suspension of in-person relations, in which feelings of loneliness and isolation were added to the fears, worries and pain caused by the emergency situation.

“...Nostalgia, I had a lot of nostalgia in these three months, because I have these two children in the country which are far away from me and I couldn’t be near them. I was supposed to leave on the 9th or 8th of March but I couldn’t leave anymore because everything was closed. I was supposed to go to see my children, my father, my mother and my sister, but nothing, I didn’t go anymore. Everything was blocked. And I got so homesick. I call them to see how they are but it’s not the same thing as going there and seeing them. I go there every year. It wasn’t easy.”
Rome

The family in the country of origin, even if distant, had in some cases a supporting role not only on
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an emotional level for moral support, but also economically:

“During the lockdown I would call my dad who is in Germany. He would send me a bit of money and comfort me a little. Even if they were in the same situation. We video chat and I see that he lives better. He also wanted me to go there, because he says that it is better there. But I am here. The Italians saved me at sea and I preferred to stay here. To have my job.”

Rome

However, the contact with the family in the country of origin is not always a moment of support and of sharing the great difficulties experienced, but rather an exacerbation of the experience of shame for their current conditions and for the perceived “failure” in the outcomes of their migration. Indeed, their situation is very complex, and is rendered even more unsustainable by the pandemic, so much so that some compare it to a war, perhaps the war from which they escaped.

“No, I preferred not to say that. So as not to worry them. To not make them think that in Italy we live on the streets, because there is war there and to make them think that even here it is still war is difficult. I don’t want to make them worry.”

Rome

On the other hand, with regard to community support and its role as a protective factor in terms of quality of life, it is necessary to make a distinction based on the different contexts in which this research was conducted. Indeed, while in the squats the housing movements provide support and constitute a bonding agent for the occupying communities, what emerges looking at the settlements of Southern Italy is the strong fragmentation and isolation of the communities living there.

In particular, the sense of belonging to a community, and therefore of mutual support and shared responsibility, emerges as central in the context of housing squats. In these self-organized situations, respect for shared rules by all components of the community is of fundamental importance. Consequently, everyone’s commitment to the respect for preventive measures has led to collectively organized procedures, defined by the housing movement, to protect individuals and the entire community.

“It is us who maintain the occupation. If the people who live inside the squat are conscious, we keep the occupation alive, if you keep the squat neglected, you keep it all dirty, it’s normal that you get diseases, even if it’s not COVID. We have managed COVID well, because each household has been responsible not only for its own spaces, but also for the entire squat. When no squat had been closed to guests yet, we closed it, we got the guests out, we closed it and no one came in, not even close relatives, and after a while we opened it only for close relatives to avoid contagion, because if one got infected the whole squat would have to go into lockdown. And thank God no one here has been infected by anyone, because we have had the responsibility that one for all, all for one, and not that if my family is well and I don’t care about the others; we have all thought about the well-being of everyone. We are of different nationalities, however when we think as a team we are united, we don’t think in terms of ‘I take action, that one does not’ – we all take action.”

Rome

The state of emergency has amplified the sense of solidarity between people who share a condition of exclusion, particularly where they are involved in collective and self-organized forms. Through this solidarity, they find an answer to part of their needs. Therefore, in the context of the squats, some interviewees talk about the support they received from the movement in difficult situations (for example, in guaranteeing the computers and tools to carry out online schooling without major interruptions); there are some who talk about having shared their resources with others, some who tried to give as much support as possible to the homeless, while respecting the rules for prevention, with a general awareness of the needs that exist since before the onset of the pandemic and that remain unresolved. In some contexts, the health, economic and social
emergency has strengthened a sense of community, as well as solidarity and mutuality practices.

“I think it has helped us to have more regard for our health and also to be more sincerely humanitarian/altruistic, because we often got lost in other things... like selfishness. We realized that life is good. Before people thought about what's mine and what's not mine... now people realized that even with all the money you have... You’re not worth anything... we are equal, a family.”

Rome

Belonging, however, to such a large and collectively organized reality based on assemblies, with its goals also in terms of activism, also leads, according to some participants, to strong stress and therefore an impact on health.

“Yes because let's say the things that we have to do for the squat are not every day. They are asking us, there is a demonstration for the 20th, they are already communicating that. They are planning and saying it. If one cannot, there were some things that you cannot ask justification for, you have to go otherwise it would be absence [meaning your absence would be noted], so to say those things like that, that is stressful.”

Rome

Outside the organized contexts based on the community and born through the community, it is more difficult that a real sense of support and belonging emerges. This is also demonstrated by the interviews collected in informal urban and rural settlements. Here the general perception is linked to a deep sense of loneliness and isolation, which is expressed in not being able to ask anyone for help even in situations of explicit need.

This sense of isolation, according to some interviewees, is linked to the fact that people do not have the possibility and the autonomous capacity to build and experience their own community.

“We are different... we are only together because the system made us be together. (...) There are positive things but also negative ones, for example it can be hard to understand each other. You can have problems, sometimes the police come to calm down [the situation]”

Rome

In this context, difference leads to a lack of understanding, difficulty in empathizing, and therefore inevitably to a clash. According to the interviewees, this clash is also given by the absence of networks of solidarity and of the feeling of being able to count on others in times of need, the lack of a sense of belonging to a community.
The absence of solidarity mentioned in the previous theme is precisely at the root of a widespread feeling of helplessness; of impossibility, that is, of being able to make any changes in one’s condition. This sense of powerlessness and resignation is widespread, accompanied with the awareness of having been deprived of fundamental rights. In the face of this, however, the people interviewed turn to a series of individual, spiritual or, where possible, local resources (for those who live in areas where there is some kind of service, such as in the urban areas of Rome).

Therefore, as we have seen in the theme “Support networks”, the fact that people do not have the possibility and the autonomous capacity to build and experience their own community leads to the absence of relationships and networks of solidarity, and consequently to a sense of isolation and difficulty in autonomously managing certain areas of their lives. According to many of the interviewees, this community fragmentation, which as we have seen is experienced particularly in the context of the rural settlements of southern Italy, is intrinsically linked to the impossibility of making structural changes to one’s own conditions. However, it is more difficult to oppose the dynamics of exploitation in the absence of a community organization in which its members can define priorities, needs and demands.

“For the problem is that we blacks are not united. If we were united no one would go to the countryside. (...) Look at the conditions we live in: I just got back from the fields, 4 euros an hour, it’s really bad and you have to insist to get paid. It’s the 21st and they still haven’t paid the previous month, does that seem fair to you?”

Capitanata

The sense of powerlessness and the inability to control, choose, determine important aspects of one’s life has a negative impact on health and quality of life. This, in turn, has disruptive consequences in terms of mental health:

“Unfortunately I am alone some days and it’s not good at all. I can be with people chatting and laughing but sometimes I sit alone and cry because I don’t know ... I don’t know ... it’s not my dream to be here, to live this life, even in Africa I lived better”

Rome

For most of the people involved in the research, religious faith represents one of the main forms of support and hope, helping them to deal with complex and unjust situations. Religion assumes particular importance where feelings of isolation and helplessness are predominant.

“I don’t like to ask for help. When I need help I ask God. Because he is the only person who is there and helps you all your life.”

Rome

It is precisely the inability to determine aspects of one’s working and living conditions that makes faith essential, as this excerpt from a Nigerian woman who lives in Borgo Mezzanone shows:

“Who do I complain to? If you tell me who to turn to... Last year I had an accident, I was on my way to work, I have proof! I went to my Oga (boss, employer) and he replied, “what do you want from me?” What if I had died? There was blood everywhere, they called the ambulance. I hurt my neck and it still hurts. If I had any rights I would have reported him. I don’t know what to do so I’m entrusting everything to God. God never sleeps.”

Capitanata

In the face of the pandemic and its social consequences, many people report having no other resource but to pray, as the only possible way to live through a situation of such magnitude that it is not
manageable “on a human level.”

“I don’t know, I have faith in God, my God has the truth, they say it’s true, but we prepared ourselves by praying to God every day. The only thing we can do is to pray to Jesus, it is not something within our reach, only God can do something, we can pray for our children.”

Capitanata

Another resource that has proven important during the outbreak of the pandemic has been the use of digital technologies, which have made it possible to maintain contact with loved ones despite the impossibility to meet. This has ensured communication with family members despite geographic distances, and for those within school age, it has ensured continuity of education, despite the difficulties and changes that online schooling entails.

“Technology has helped me a lot, for example the phone, I talked to friends, even if we do not see each other there is video calling, so I talk to them to feel good.”

East Sicily

The use of technology, however, becomes “a double-edged sword” in terms of social relationships: in some cases it can limit them, as in the case of online schooling (DAD). The transition to online schooling means ensuring only apparent continuity to the learning process, which is impoverished of the social and “informal” component of academic exchange, both between students and between students and professors.

“At first I was happy but then I missed my classmates, I wanted to go back to school to attend classes and see friends. All these things have been replaced with technology that, let’s say, doesn’t have the same effect as being all together in class doing the lesson. (...) Because anyway in class you talk to your classmate, you have those little moments, even with the professors, if you didn’t understand something you can go and ask them, even private things, instead with the lockdown this wasn’t [there].”

Rome

It is precisely the informal exchange and support among students and between students and professor, moreover, that constitutes a useful tool to complement lessons in situations in which there is greater difficulty, as in the case of foreign students or non-native speakers.

However, it is precisely the continuity of schooling, and the fact that this has been prioritized and protected, that makes the school perhaps the only institution that has actually supported the people, even in conditions of economic and social difficulty.

“For example, we didn’t have a computer and I used to do lessons on my phone, which many times would freeze and I wouldn’t participate in the lessons, and the school gave me a computer to follow the lessons. It was very useful for my end-of-term paper. The school helped us, others didn’t.”

Rome

During the spread of COVID-19 and the consequent social and health crisis, most of the support came from service sector networks, in the urban areas as much as in the countryside of Southern Italy. Indeed, some people shared how helpful associations were in Rome, when all services were suspended, in guaranteeing goods and services of first necessity, as well as the networks of volunteers that formed in the city and that carried out activities with and for people living in conditions of marginality. In a rural context, an inhabitant of an informal settlement very far from the city expresses great thankfulness to the social-health personnel who, from the first phases of the pandemic in Italy, have been committed to informing people who are difficult to reach by institutional services and to giving them the tools to protect themselves and others.

“Yes, because we made, let’s say, a program, people would come by the houses and give a product and it would be brought here, and here the girls would distribute it to each family that needed it, that had requested it, they would come with the package every 15 days.”

Rome
“Where I live is very far from the city, on foot it takes almost two hours. There is nothing there, no assistance, no transportation. You guys came to see us during the emergency and explained things to us.”

Capitanata

Recognition for this kind of work leads to understanding the staff of such a social-health project as allies, with whom to share claims for a better life and decent living and working conditions.

“It can change with your help, improving housing conditions, containers are good. (...) You have to help black people live in better conditions. These are not houses, these are not places to live in. It is very important that we can live a decent life. This place is not good for health and safety. The ambulance doesn’t come in here even if a person is dying, that has to change.”

Capitanata
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PERSPECTIVES

“We all have bigger dreams than this place here”

A job with a regular contract, a decent home and the documents to be legally present in the country. These are the priority claims and needs that all the people living in these contexts bring, across differences. The living conditions narrated here have nothing to do with the peoples’ migratory project; everyone aspires to a change in their lives and in the management of migration policies.

“If I could talk to the Prime Minister... I would like him to hear my voice, I would like to tell him that his son and daughter would never work in these camps. And we are working for you, so you have to respect us and treat us as human beings. We need help. (...) If I had a chance to meet the Prime Minister, I would take him by the hand and say “come with me to see this”. I’d show him where we live, how we wake up at three o’clock in the morning to go to work, he’d see people leaving to go to work already at 2.30 am. People who have no home, who have nothing. (...) A good contract, a good job, that’s what we need. (...) We need work.”

Capitanata

As is evident in these excerpts, the claims are always formulated in hypothetical form, and upon suggestion of the interviewer. The real power of the individual or the community to bring about change is perceived as very scarce, despite the fact that the need to improve one’s own conditions is pressing.

Hopes always turn towards a change, even a geographical, physical one; a change of place that corresponds to a symbolic change made towards more dignified living conditions.

“If everyone else in the world what I want is to be well, to work, to earn, to have money, in a legal way. To make my life the way I wanted it. (...) Yes to have a house, a wife. Unfortunately I live through it, I have to live through it, to be like this, but unfortunately I always think about that you understand. This is not my place.”

Rome
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Discussion

Something that emerges strongly from the data collected is a strong connection between health and the dynamics of oppression and exploitation faced by the interviewees. Health, or the lack thereof, can be understood as a central pivot around which every other factor builds up; precariousness, labor exploitation, lack of documents, terrible housing conditions, lack of a support network and the consequent sense of disempowerment, or lack of power to change their living conditions all feed back into health.

The identified theme areas, in turn, are inextricably linked to each other, and convey the circularity of social discomfort, the interconnectedness of the factors causing it. As pointed out by the participants, it is difficult to achieve emancipation from a condition of labor exploitation, or to find a job that allows for more dignified living conditions, without documents that provide a legal status. The consequent absence of a regular job and of a document makes it almost impossible to create stable housing conditions, forcing people to live on the street, in settlements, or to join the struggle for the right to housing, also by living in housing squats.

The support network proves to be a resource in cases where it is really present, such as in the housing squats. Here, however, the pressing demands of the community (in terms of participation in assemblies, demonstrations, and the coordination’s events) make it difficult to balance private and community life, and to preserve spontaneity of participation as opposed to simple compliance with rules imposed from above. In most of the cases of the people we interviewed, however, the support network is mostly absent, with almost all participants declaring that they “do not turn to anyone in times of difficulty”. People, in this case, turn mainly to faith, “to God,” as the main advocate of their own destiny, over which, however, they have no power. Therefore, in accordance with this awareness, another thing that emerges strongly from this research is the sense of disempowerment experienced by the participants: a shared awareness of not really being able to change their own condition, even though this causes them great suffering.

It is in this scenario, already characterized by chronic/structural rather than transitory issues and by lives that are already suffering, that these people are asked to ascribe meaning to the pandemic and its consequent health and social crises. The people interviewed were relatively skeptical of the impact that this event had on their lives. The pandemic appears as a sort of collateral damage in front of the difficulties they have to face in their daily lives. The Coronavirus, therefore, represents a problem that only adds to the many existing dangers to people’s health. Moreover, our interviewees report having been affected above all by the social and economic consequences of the pandemic. This has resulted in the loss of work or the total isolation of the settlements during the first outbreak and lockdown (with consequent difficulty in finding food and basic necessities).

Concluding remarks

The results collected through the questionnaires show high levels of chronic PTSD, which by nature of their chronicity cannot be ascribed to a recent traumatic experience linked to the experience of the COVID-19 pandemic. It is safe to assume that the high levels of PTSD, in fact, are attributable to traumatic experiences experienced in the country of origin, during migration and after arrival to Italy, which were never properly diagnosed and treated. Moreover, the perceived quality of life is predominantly low, especially in relation to the environment. The social-housing condition of the people involved in the study, in fact, has a very strong impact on their quality of life and health. The indicators of quality of life in terms of employment, environment, physical and mental
health, and relationships reveal that of 64% of the addressed persons live in a perceived state of existential precariousness. This can generate a sense of dependence on the external environment, because it is as if the person no longer believes to have the ability to influence it, or that their efforts to do so are in vain.

The results of the quantitative data are consistent with the findings of the qualitative evidence gathered through interviews and focus groups: the participants highlighted how their living conditions are cause of extreme suffering, to the extent that the pandemic and the consequent restrictions, as well as the health and social crisis, had but a relatively small impact. The areas that generate most suffering are related to working life, as well as to the absence of documents, the social-housing conditions and the absence of a support network, causing low quality of life.

It is interesting to note that the people involved in the interviews and focus groups identify obtaining a document and a regular job, and consequently decent social-housing conditions, as the key to improving their quality of life. These aspects are understood as pivotal, with particular reference to a change that must also be “geographical,” meaning a change in the environment (this is also consistent with the fact that the lowest QoL factors according to the collected questionnaires relate to the “environmental” sphere). However, the quantitative analysis brings to light that many of the people whose working conditions and legal documentation were stable, nevertheless experienced a generally very low quality of life, and in some cases symptoms attributable to Post Traumatic Stress Disorder.

This is particularly relevant, since it is plausible that the traumatic experiences linked to the migratory experience make it particularly difficult for these people to achieve a satisfactory quality of life, even if they can achieve better social conditions. For this reason, it should be a priority to place a stronger focus on the protection of migrants and refugees’ mental health, from a perspective that takes into account the historical, social and cultural dimensions of the experienced suffering.

Many of the participants in the interviews, in fact, emphasize that their living conditions are so undignified that they cannot focus on other factors, such as the health emergency. Health, and even more so mental health, become a “luxury” people can’t afford to take care of, from the perspective of a life spent in the midst of garbage, sleeping “with one eye open” for fear of one’s neighbors or of a possible fire in the settlement, working all day for a meager salary since adolescence, without contractual guarantees.

To make the picture even more dramatic in terms of quality of life and mental health, there is the awareness of being “alone” in the face of all this suffering. A large part of the participants report not having a support network. While informal and friends’ networks are missing, making the collaboration between people living this difficult life even more challenging, institutional networks that take care of these people are equally absent in this context. The absence of services that intercept the physical and mental health needs of these populations is evident, and the consequences of this were tragic when the pandemic broke out. It was only in this instance, when public health directly depended on everyone’s ability to access health services - no one excluded - that institutions took action, turning to NGOs, to reach these populations.

The absence of a network pushes people to turn to faith as the main strategy of psychological survival to cope with their living conditions. Aware of their inability to make changes in their lives, stuck in the short-circuit of job, legal status and housing insecurity, some people choose to rely on an “external”, impartial divinity, who watches over their survival when no one else does. The disenfranchisement experienced by these people is an outstanding element in life stories marked by a historical and colonial “resignation”; made of poverty, exploitation and discrimination. “Social” immobility is a shared experience and the absence of external support (if not faith) is the thread
that connects the lives of all the participants, who are otherwise symbolically isolated from each other. This immobility and isolation can ideally be traced back to a “post-colonization stress disorder,” to use an expression coined by Comas-Díaz (37), who wants to emphasize the political and historical matrix of post-traumatic stress disorder suffered by racialized migrants. INTERSOS’ outreach and Proximity Public Health work (PPH), therefore, aims to highlight the structural dynamics of violence and isolation faced by these populations. These dynamics are the root causes of poor mental and physical health conditions, and the main outcome of the work carried out has been the promotion of the institutions’ role in taking charge of these situations. It is only by acknowledging the importance of empowerment and visibility for these populations that it becomes possible to support ways to break out of this condition of immobility.

By its very nature, this research has attempted to lay the grounds for future work, one that can be based on a better understanding of the living conditions of people affected by these dynamics, gained directly through their voices. As such, it is interesting to mention how the involvement of communities in this process also provided a springboard for structured intervention projects, such as the development of grassroots advocacy in informal settlements and capacity building for health promoters in squats. Some of the participants in this study also took part in these projects, along with other key actors that were identified as focal points in the communities; the aim was ultimately to support the communities in making their claims more visible and their communication more direct with the social and health institutions directly involved in protecting their health in a global sense.

Conclusions

The work carried out by INTERSOS projects in response to the COVID-19 emergency highlights the structural processes that produce exclusion, and the need to support the right to health of marginalized populations in a way that is co-developed with the populations themselves, building advocacy and community empowerment actions starting from pre-existing needs. The COVID-19 emergency should be framed within the conditions of extreme deprivation that already act as negative determinants of health; from this perspective, it poses a further factor of exclusion and isolation that increases the invisibility of people’s needs and acts as an amplifier of social and health inequalities. Public policies aimed at the inclusion of migrant populations and of the people living in socially marginalized contexts are therefore highly necessary to truly protect the health of individuals and communities.

For this to happen, it is necessary for the health system to understand that it is imperative to strengthen Proximity Public Health, promote the activity of social and health services, and remove obstacles to accessibility and usability; it is also necessary to actively involve communities in health promotion, and enhance the presence of linguistic-cultural mediation in health services.

Moreover, it is essential to address the issues of housing and legal insecurity, as well as labor exploitation in the countryside across Italy, as these dramatic elements subtract to health, and they must be addressed starting from the communities involved.

The approaches of Proximity Public Health and community participation have allowed, starting from the resources available in the community itself, to fill institutional gaps that still stand out as unresolved knots. From the point of view of opportunity, it can therefore be said that the pandemic has made it possible to accelerate the experimentation of integrated and local organizational approaches that have proven to be particularly effective and necessary if applied to populations that are more difficult to reach; these approaches would
be generally desirable for the care and health of the population in general.

From the experience gained in the field and from the results of the quantitative and qualitative research conducted in INTERSOS projects for the COVID-19 emergency, we can say that supporting the right to health of marginalized populations without challenging in a co-developed way the social processes that produce exclusion does not improve the health conditions of the populations themselves; indeed, the lack of critical analysis of the dynamics of exploitation feeds the perception, even in the subjects themselves, that they are unable to exercise autonomous control over their own lives. On the contrary, promoting health from a perspective of equity means focusing attention on the processes that produce exclusion and inclusion, through the analysis of why, how and for whom such contexts of deprivation are produced, and examining the way this system favors institutions and individuals who maintain this system of poverty and exploitation (11).

INTERSOS’ work poses some important reflections for the definition of public policies aimed at protecting the health of migrant populations and of those living in contexts of extreme social marginality. It shows the need to produce scientific evidence from field experience and to integrate quantitative and qualitative research tools, so that they can ‘give voice’ to people whose lives are marked by deprivation and oppression, and support advocacy actions and community empowerment.

If, then, the pandemic reveals and amplifies social problems that go well beyond the mere (and already high) clinical risks, it becomes evident how much of the risk component of the contexts described here is preventable through policies that focus on equity and social justice. “Medicine is a social science,” wrote renowned pathologist Rudolf Virchow, “and politics is nothing more than medicine on a large scale.”

The pandemic has laid bare the problems of social justice, of poor accessibility and usability of services, of the weakness of the local networks providing social and health services, which have never been sufficiently valued. The pandemic painfully teaches us that the health of the entire population is interconnected, that the conditions of people left on the margins of society, squatters, farm workers, homeless people, migrant people without a residence permit, affect everyone with no exception.

The development a strong collective awareness and sense of responsibility of the role of politics and of the National Health System is urgently needed, which should counteract inequalities and protect the dignity and health of everyone.


31. Institut national de santé publique, Quebec (2015) Health Inequalities and Intersectionality, Centre de collaboration nationale sur les politiques publiques et la santé


RISK ASSESSMENT FORM

_Description:_ This form is meant to provide the basis for the structured assessment and prevention of COVID-19 related risks. It is designed to guide medical assessment of the patient's clinical conditions and exposure to risk, and when necessary, to activate the procedures for carrying out the naso-pharyngeal swab test. It's made up of:

- A section on personal information (name, date of birth, phone number etc.)

- A section for triage (do they show symptoms, were they in contact with suspected cases? Did they travel to/from at-risk locations?)

- A section for additional information (on living conditions, recent activities that might have exposed the person to risk, on relevant symptoms, on social-medical conditions that can pose other risk factors or vulnerabilities)
SCHEDA DI VALUTAZIONE DEL RISCHIO

Data____________________   N. PROG. CONTATTO: ______________________

NOME E COGNOME:______________________________   Cell:__________________________

SESSO:_____  ETÀ: ____  PROVENIENZA:__________________   Lingua parlata_________________

VALUTAZIONE DI PAZIENTE SINTOMATICO PER AFFEZIONI VIE RESPIRATORIE.

Valutazione del rischio per prevenzione COVID-19 e procedure di intervento

TRIAGE

HA O HA AVUTO FEBBRE E/O TOSSE  ☐ SI  ☐ NO  ☐ NON NOTO

HA VIAGGIATO NELLE UTLIME DUE SETTIMANE?  SI – DOVE

QUALCUNO DEI SUOI CONOSCENTI HA O HA AVUTO FEBBRE E/O TOSSE  ☐ SI  ☐ NO  ☐ NON NOTO

INFORMAZIONI AGGIUNTIVE

1 DOVE VIVE?

CON CHI VIVE?

HA UNA CAMERA DA LETTO PERSONALE?

DOVE E CON CHI MANGIA

1.1 SOGGIORNO IN PAESE/LOCALITÀ A RISCHIO (NEGLI UTLIMI 14 GIORNI)?

Se si, SPECIFICARE LOCALITÀ___________________

DATA DI PARTENZA DALLA ZONA A RISCHIO____/____/___.

SE RISPONDE SI, ed è senza dimora: rassicurare il paziente e CONTATTARE 112/118.

Se RISPONDE SI ed ha una Dimora, rassicurare il paziente, contattare il Medico di base e il SISP di competenza.


26 Un viaggio internazionale con particolare riferimento a Cina, Sud Corea, Iran o una delle seguenti zone d’Italia: Regione Lombardia; Province di Padova, Treviso e Urbino (Marche) e province di Alessandria, Asti, Novara, Verbano-Cusio-Ossola, Vercelli.

27 Servizio di Igiene e Sanità Pubblica (SISP).

28 Per le definizioni di caso si veda Circolare Ministero della Salute del 09 marzo 2020
2 ESPOSIZIONE?

2.1 ESPOSIZIONE A CASI ACCERTATI (vivi o deceduti)?

2.2 ESPOSIZIONE A CASI SOSPETTI O AD ALTO RISCHIO (CASI PROBABILI)?

2.3 CONTATTI CON PERSONE RIENTRATE DA PAESE/LOCALITÀ A RISCHIO (negli ultimi 14 giorni)?

2.4 CONTATTI CON FAMILIARI DI CASI SOSPETTI

SE RISPONDE Sì, ed è senza dimora: rassicurare il paziente e CONTATTARe 112/118.
Se RISPONDE Sì ed ha una Dimora, rassicurare il paziente, contattare il Medico di base e il SISP di competenza.

2.5 HA FREQUENTATO LUOGHI AD ALTO RISCHIO CONTAGIO (ES. OSPEDALI)?

2.6 LAVORA ATTUALMENTE?

2.7 EFFETTUA UN LAVORO A RISCHIO? (Es. Badante, sanitaria/o, commesso/a?)

3 FEBBRE

3.1 Negli ultimi 14 giorni hai avuto o pensi di avere avuto febbre?
DATA DI COMPARSA DEI SINTOMI: ___/____/____.
TEMPERATURA ATTUALE: _____°C

4. TOSSE?

Se si da quanto tempo? ________________
SATURAZIONE (SpO2): _____________

NEL CASO DI FEBBRE E/O PRESENZA DI ANCHE 1 SOLO ELEMENTO TRA I SEGUENTI ALLERTA DIRETTAMENTE 118/112:

COSCIENZA ALTERATA
PRESSIONE SISTOLICA BASSA (MINORE O UGUALE 100)
HA DIFFICOLTÀ A RESPIRARE A RIPOSO.

Nel caso non sussistano le condizioni precedenti, procedere a VALUTAZIONE DI CONDIZIONI DI RISCHIO, STATO VACCINALE, CLINICA:

5. VALUTAZIONE DELLE CONDIZIONI DI RISCHIO NOTE AL MEDICO O RIFERITE ALL’ANAMNESI:

- Malattie Polmonari
- Malattie metaboliche
- Gravidanza
- Isolamento sociale (vive solo, e/o senza fissa dimora)
- Non autosufficiente
- Malattie cardiache
- Malattie renali
- Malattie sistema immunitario
- Malattie oncologiche

6. VALUTAZIONE DELLO STATO VACCINALE NOTO AL MEDICO O RIFERITO ALL’ANAMNESI:

- Vaccinato antinfluenzale
- Vaccinazione antipneumococco
- Nessuna delle precedenti vaccinazioni
7. VALUTAZIONE CLINICA:
(TOSSE, MAL DI GOLA, DOLORI MUSCOLARI, MALESSERE GENERALE, ANORESSIA, VOMITO, CEFALEA)

SE IL PROCESSO DIAGNOSTICO (CONDIZIONI DI RISCHIO, DATO VACCINALE E QUADRO CLINICO) È SUGGESTIVO DI SOSPETTO IMPEGNO POLMONARE (POLMONITE) SI RICHIÉDE ATTIVAZIONE DEL 118/112 + SEGUIRE PROFILO 3 (Vd Tabella 1) PER VALUTAZIONE DOMICILIARE SECONDO DIRETTIVE REGIONALI.

SE IL SOSPETTO DIAGNOSTICO È FORTEMENTE SUGGESTIVO DI COVID19, RASSICURARE IL/LA PAZIENTE, DISPORRE L’ISOLAMENTO DOMICILIARE E ATTIVARE IL SISP DI COMPETENZA PER CONCORDARE L’EFFETTUAZIONE DEL TAMPONE NASO-FARINGEO E/O ALTRE EVENTUALI PROCEDURE DEL CASO.

8. VULNERABILITÀ (MSNA/GBV/PSY/OVER65/OTHERS):

9. CONDIZIONE ABITATIVA
Con quante persone abita?
Quante persone dormono nella stessa camera da letto?

CONDIZIONE LAVORATIVA
Con quante persone si reca al lavoro e in che mezzo?
Con quante persone lavora?

10. ESITO CONSULENZA:

11. CODICE FISCALE:______________________________
RESIDENZA:____________________________________
DOMICILIO:____________________________________

FIRMA PAZIENTE______________________________
APPENDIX

Humanitarian work during the COVID-19 emergency: an analysis of the experiences of INTERSOS staff in Italy

Authored by Silvia Scirocchi

1. INTRODUCTION

2. METHODOLOGICAL NOTE
   2.1 Objectives
   2.2 Tools
   2.3 Participants
   2.4 Analysis

3. RESULTS
   3.1 Humanitarian work during the COVID-19 emergency: fear and responsibility
   3.2 COVID-19 as a priority?
   3.3 The relationship with the institutions
   3.4 The relationship with the press
   3.5 The relationship with the beneficiary population
   3.6 Cultural and linguistic mediation and the role of mediators
   3.7 The team as a group

4. DISCUSSION: WHAT IS THE EMOTIONAL COST FOR HUMANITARIAN WORKERS?

5. CONCLUDING REMARKS
1. Introduction

In recent years, many studies have emphasized the great impact of humanitarian work on the mental health on humanitarian workers and people working with populations who have survived traumatic experiences. Many of the studies have focused on the risk of burnout, anxiety, depression, and vicarious trauma in humanitarian workers engaged in missions abroad (Eriksson, 2009; Ager et al., 2012; Lopes Cardozo, 2012; Connorton et al, 2012; Strohmeier, Scholte & Ager, 2018), while others on people working with migrants and refugees in Italy (Gemignani & Gilberto, 2020; Nonnis et al., 2020) and other international contexts (Wirth et al., 2018; Guhan & Liebling-Kalifani, 2011; Akinsulure-Smith et al., 2018; Robinson, 2013). These studies have highlighted the high risk the workers employed in this sector run in terms of mental health, and have analyzed the role of various protective factors such as emotional intelligence, coping strategies (Akinsulure-Smith et al., 2018), social, organizational, and religious support (Eriksson, 2009) mutual aid, outlining possible intervention scenarios to support these professionals.

Similarly, many recent studies have investigated the impact of the COVID-19 emergency on the work of professionals employed in the health sector, such as physicians, nurses, and social and health workers in the international arena (Dobson, 2020; Banerjee, Vijayakumar & Rao, 2020; for a review of the currently available literature see de Brier et al, 2020) and in Italy (Barello, Palamenghi & Graffigna, 2020; Vagni et al. 2020), also outlining potential intervention scenarios to take charge of emerging mental health needs (Chirico, Nucera & Magnavita, 2020).

However, the impact of the COVID-19 emergency on humanitarian workers engaged in interventions with migrant and refugee populations still remains uncharted territory. Since March 2020, INTERSOS staff has been working on the front lines to counter the COVID-19 emergency, providing essential social and health services for migrant populations experiencing vulnerable conditions. The objective of this study has been to explore the experiences of INTERSOS staff in relation to the work conducted since the health emergency.

In particular, four focus groups were conducted with staff involved in the COVID-19 intervention in four different regions of Italy: Lazio, Apulia, Calabria and East Sicily. The aim was therefore to create a space for discussion in which to reflect as a group on the progress of the intervention, the strengths and weaknesses that emerged, the experiences and the emotional aspects of the work.

During the focus groups it was possible to address the staff’s issues related to various group experiences and identities in relation to the different roles, exploring how team members give meaning to their professional work and negotiate their sense of belonging and their function within the organization and within the operation. The relationships with various institutional and non-institutional stakeholders, as well as the impact that the difficulties faced in the field when providing emergency health care has had on the staff’s wellbeing are also addressed here.

How to talk about the risks posed by Coronavirus, a disease characterized by being “invisible,” whose symptoms and modes of transmission can often appear unclear to people living in an informal settlement, in a ghetto, in a housing squat? How to accommodate the demands for responses to social needs, to denied rights, that communities claim, while having to carry out a health intervention aimed at identifying risk of COVID-19? How to prioritize the risk of infection by COVID-19, a virus experienced as invisible and distant, when the pressing needs to which people demand a response are others?

These are some of the questions that INTERSOS staff has had to tackle.
2. Methodological note

2.1 Objectives

The objective of this part of our study was to explore the experiences of INTERSOS staff in relation to the work carried out during the health emergency. In particular, we investigated how the various operational teams accepted the changes they were facing, since in all cases they were already working before the emergency and had to make changes to the operation itself. A particular focus was kept in relation to the emotional sphere of the experiences during the operation and the analysis of this, as well as a joint reflection on what were the strengths and weaknesses of the operation.

2.2 Tools

The main tool used to explore these dimensions has been the focus group. All focus groups conducted were audio recorded, transcribed, and analyzed through thematic analysis (Braun & Clarke, 2006).

The structure of the focus group was designed dynamically, without a precise outline, but conducted by guiding the thread of discussion through a series of creative prompts (Appendix 1. Focus group staff guide).

For example, after presenting the objectives, methods and timing of the study and outlining some basic rules for conducting the focus group, participants were asked to begin by listening to an audio track with the testimony of a young boy who experienced the first wave of COVID-19 inside a reception center, collected by the “Invisible Guides” project (link: https://soundcloud.com/guideinvisibili/sets/guide-mascherate-messaggi?fbclid=IwAR2zLoHz4LJ8qUOlCUkKAPG9q2UU5wS4CyeASzZMj1TZ1zzXn0GKHBUy). This audio piece had the function of allowing participants to reminisce the beginning of the health emergency, to when the staff and the communities they worked with began to drastically change habits and when the various teams had to reorganize operations. The recording was of a young migrant boy who recounts the impact of the Coronavirus from his point of view; this audio track was taken from a Roman radio project called Invisible Guides.

After listening to the audio track, participants were each asked to write down on a sheet of paper the feelings, phrases, words, and memories that the audio track had generated. The discussion then began, leading the staff to collectively review the events related to the beginning of the COVID-19 interventions, asking when the project began, how it was designed, and what the salient events were.

Subsequently, INTERSOS staff was asked to reflect on the predominant feelings they experienced during the operation. More specifically, the staff was asked to make a colorful mark on a series of paper sheets on which the names of feelings were written, in correspondence with what they felt. Some paper sheets were left blank so the staff could add other feelings if they felt the need to.

The participants in the focus groups experienced this activity as particularly significant, because it allowed...
for the creation of a physical and symbolic space in which to store and share the emotions felt during the past months. As we will see in the section dedicated to the analysis of the collected material, the efficiency, the need to respond to emerging needs in a timely manner, made it impossible to stop and examine one’s own feelings, although these were particularly strong and invasive. One Foggia staff member describes it well:

“It is very significant to be in a room where we are physically surrounded by feelings, which by hanging on the wall take on a feeling of reality, become a little more concrete and so you can look at them in the face. Probably my strategy has been to set them aside, to carry on and move forward, in a situation that is difficult in itself and for the context in which we operate, for all the critical issues that we know, the isolation within the isolation, in this precise moment the Coronavirus certainly has amplified a whole series of discomforts and it is very complicated. It was actually finding ourselves in front of those feelings, that we also tried to recognize them, even if stopping for a moment, “what did I feel, what didn’t I feel”, giving ourselves the right space to recognize them and... always going forward. I’ve kind of set them aside, even with respect to the chronological aspect, I have to have the calendar in front of me to remember all the significant moments, not to put everything together and compressed. Actually, I’ve been here since January and we’re already in July: a lot of time has passed! There have been some very significant moments that I’ve compressed a bit though, a bit all together. So it’s definitely helpful to stop for a moment and give a space to acknowledge all the events that have happened and the feelings I’ve had. Very nice.”

Capitanata

As a follow-up activity, participants were asked to outline together what were the strengths and weaknesses of the intervention as it had been conducted up until that point. Together, they went over what had emerged in the first part of the focus group, writing down the strengths and weaknesses on the board. At the end of the focus group, participants were asked to share their future prospects and desires in relation to the various operations.

2.3 Participants

Four focus groups were conducted with teams from the four areas in which the INTERSOS COVID-19 intervention took place: Lazio, Apulia, Crotone and Siracusa. The focus groups with the teams from the regions of Apulia, Crotone and Syracuse were conducted by a psychologist from the Lazio team (who was therefore external to the internal dynamics of the different teams). Another psychologist who was about to enter the team at that time conducted the focus group with the Lazio team. The focus group with the Crotone team, for logistical reasons, was conducted via video call.

The teams in the regions were composed as follows:

<table>
<thead>
<tr>
<th>Staff Lazio</th>
<th>Staff Foggia</th>
<th>Staff Crotone</th>
<th>Staff Siracusa</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total participants:</strong> 6</td>
<td><strong>Total participants:</strong> 8</td>
<td><strong>Total participants:</strong> 6</td>
<td><strong>Total participants:</strong> 5</td>
</tr>
<tr>
<td>1 Medical coordinator</td>
<td>1 Medical referent</td>
<td>1 Project coordinator</td>
<td>1 Project coordinator</td>
</tr>
<tr>
<td>1 Doctor</td>
<td>1 Project coordinator</td>
<td>1 Doctor</td>
<td>1 Doctor</td>
</tr>
<tr>
<td>1 Nurse</td>
<td>2 Doctors</td>
<td>4 Cultural Mediators</td>
<td>2 Cultural Mediators</td>
</tr>
<tr>
<td>1 Psychologist</td>
<td></td>
<td></td>
<td>1 Social Worker</td>
</tr>
<tr>
<td>1 Cultural Mediator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Social Worker</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.4 Analysis

The audio recording of the four focus groups was then analyzed through the methodology of thematic analysis (Braun & Clarke, 2006).

As a result of the analysis, 7 thematic areas emerged and will be discussed below:

- Humanitarian work during the COVID-19 emergency: fear and responsibility.
- COVID-19 as a priority?
- The relationship with institutions
- The relationship with the press
- The relationship with the beneficiary population
- Mediation and the role of mediators
- The team as a group
3. Results

3.1 Humanitarian work during the COVID-19 emergency: fear and responsibility

A transversal element mentioned by the participants in the focus groups was the fear of working in the field during the acute phase of the emergency, especially during the lockdown. In a country that had come to an almost complete standstill, with many activities being organized to encourage work from home, INTERSOS staff were present “in the field” more than ever. The contexts in which the teams found themselves operating often had a very strong emotional impact, as this staff worker well describes when talking about Rome:

“Look, to me what struck me the first few days was the ghostly appearance of the city: the total emptiness, it looked like a post-apocalyptic MadMax. And the only people walking around were just the homeless and those who had nothing. [...] We were ghosts walking around Termini with these masks on. That was the first impact.”

Lazio

In this scenario, the fear of starting the intervention in a highly dangerous and uncertain situation emerges very strongly, both from the coordination and from a personal point of view, of the fear of contagion. At times, the fear of being infected, infecting loved ones, or not being able to sufficiently protect one’s staff (in the case of coordinators) emerges overwhelmingly and calls into question the presence in the field itself:

“And so I remember this great fear, the apprehension of my parents, the call from V who asked me “are you up for it?” and I immediately said yes, but then I kept on feeling scared sh**less honestly! Because in any case, in moments of fear, I get flashes of everything that could happen, and in these flashes I remember seeing the intubation, the lack of breath. [...] I remember my friends saying “S., where are you going? Why are you going?”

Lazio

But next to this fear another thing that emerges is the strong drive to make a contribution in a moment of generalized crisis, which as such inevitably affects “the most vulnerable,” the socially excluded. It is precisely this drive, this sense of responsibility, that drives humanitarian workers to take to the field, despite initial reluctance:

“When they called me to go to work for this moment I said “no way! I don’t even want to go outside!” [...] And then I did my own self-reflection…. I won’t deny the work that I do. My being a mediator, I agreed to work with them.”

Apulia

“It was hard for sure. Because in this moment, even going outside, to do this, but... I met P, AL and L two years ago... When I started, first there was fear: because of contracting this Coronavirus, but when he told me ____ in this moment, I say no! But it was important, we have to go. I said it was important, we have to go and help these people because they have needs. There are so many people out there that have needs, so we have to make that sacrifice and help them. When they told me that, I said, ‘yeah, you’re right.’

Calabria
Many staff workers, therefore, talk about how they felt “the duty” to overcome their fear and go into the field, because of their mission, the need to “help those in need”: The assumption of such a strong responsibility, and the experience of, among other things, a feeling of powerlessness when witnessing many conditions of extreme hardship, have an emotional cost for humanitarian workers, as will be discussed in the conclusions.

3.2 COVID-19 as a priority?

“We were going to visit, looking for this guy to have a talk, and I remember walking through a cloud of waste that was burning and thinking “but who gives a s*** about Coronavirus!” I mean really, I’m aware that okay, this is my job, this is my activity, the focus of my work right now, but having said that... I’m the first to be aware that everybody’s priorities here are quite different.”

Apulia

The constant conflict between the function of the “COVID-19 project” and the needs and demands of the context, is a theme that is very strongly experienced by all the INTERSOS staff, even if in different ways. The staff in Rome and Foggia had already previously worked with these populations, and this greatly helped during the health emergency in building a relationship of trust, allowing them to work together on their shared objectives.

However, especially in the first phase of the intervention, during which the focus groups were held, in both contexts the staff had to come to terms with great skepticism from the population towards the real scope of the health crisis, especially in Foggia, where the cases of Coronavirus in the beginning of the pandemic were very few. The staff of the Crotone project has been working in that area for many years, like the staff in Foggia and Rome, but increased the activities of their mobile team to contexts of informal aggregation that were still unknown to them at the time. The staff in the focus groups emphasized the difficulties of operating in unfamiliar contexts, especially for the “new” staff, who joined the teams out of the larger needs determined by the COVID-19 intervention. Finally, the Syracuse staff found themselves working from scratch, having worked mostly in other areas of Sicily in previous operations. Despite this, the hired staff had a great amount of prior knowledge of the area, gathered before the beginning of the operation and before INTERSOS’ presence in the area. This has favored the construction of a relationship of trust with the populations they worked with.

During the focus groups, it was repeatedly discussed how the health emergency made the social emergency more evident. However, the latter seems to be given little space in the national discussion on the pandemic, while those who work on the front line to meet the basic needs of people living in conditions of social exclusion experience it very strongly on a daily basis. Indeed, INTERSOS staff intervenes in areas of social exclusion at a time when these areas, which were already isolated and ghettoized, are experiencing extreme isolation.

But it is precisely the presence of INTERSOS staff and their intervention that show the chronic social inequalities and deprivations of rights. As such, these should be addressed in a holistic, structured and continuous manner. One of the most critical aspects experienced by the interviewed INTERSOS staff is the difficulty in always having to frame their work in an emergency perspective.

In other words, INTERSOS staff has to deal with people whose paper and housing conditions are so critical (undocumented people and/or people who have been homeless for years) that health care alone, although temporarily effective in stopping the emergency and preventing the onset of further health problems, is not always sufficient. Indeed, the participants in the focus groups from all teams emphasize the need to take care
of people’s social and psychological conditions in addition to the purely medical ones. This is the only way, they say, to ensure that any health intervention, including the one under their own mandate, is effective.

The need to integrate the health intervention with social and political components, tackling the social determinants of health holistically and continuously, is often strongly requested by the beneficiaries. Staff recounts how, in all contexts in which they operate, another of the difficulties in their work has been to bring the issues posed by the health emergency to the people’s attention.

“The issues are the documents. When you talk to a person, even if they have other health issues, but the first thing the person wants is their document. [...] You, as a mediator, talk to these people, you can say one thing or give another information, some thing “first thing that I want to know, that I want to have, is the document. How do I do that?” Even the person is feeling sick.”

Apulia

The migrants with whom the staff has been working understandably see the issue of health emergency as secondary to their daily problems: the unhealthiness of their environments, the precariousness of housing, the work exploitation, and the lack of documents.

During the operation, there are also requests for support that go beyond the health emergency and to which the staff has to respond with the resources and tools at its disposal. The teams report that people’s concern about the health emergency was so low in the first months of intervention that many people totally denied the existence of this crisis. “A doctor in the Foggia team pointed out that the Coronavirus was a distant and “unknown” element, partly due to the low infection rate in Apulia. This resulted in the intervention, which was focused on risk containment, seeming at times disconnected from reality.

“[...] dissociation. Since at first it felt like we were on the verge of chaos. [But here it was] As if it never got here. For a long time we didn’t see anyone infected with COVID-19. At that time, it might as well have never existed as far as the place we were in was concerned. So, at one point, I felt a little dissociated, it was very strange to talk about it. It felt like we were talking about something very distant. And it was very difficult to communicate it because others felt this too.”

Apulia

How can you inform someone about the safety in place if they feel the virus is something far away from them and, rightfully, emphasize the urgency of other fundamental needs? How to talk about hygiene measures to people who, because of the lockdown, are having difficulty getting food? These are only some of the difficulties mentioned by the staff of the projects in southern Italy who found themselves intervening in informal settlements where the people’s isolation has only increased with this health emergency, from the already dramatic level they have been experiencing over the last years.

The case of the Roman project is slightly different, as in this context the number of infections was higher than in the southern regions. This meant that people were more aware of the reality of the danger and therefore more concerned about it.

“I can say that the kids pushed us even more to take this much more seriously. Because they were interested, they were scared, because they’re always outside, so they were the ones who brought back this desire to prepare.”

Lazio

The emergency nature of INTERSOS’ work, on the other hand, is experienced as particularly challenging in
those contexts in which the health intervention was set up after the lockdown: in Crotone and Syracuse, the projects were activated respectively in April and May. This was immediately after the more restrictive measures put in place during the lockdown had started to lift, and people were slowly allowed to move again. In that period, people were starting to “breathe a sigh of relief” and were finally allowed to leave their homes. This meant additional efforts for staff in interacting with the population, who at that time had the perception that “COVID is over” and therefore could not understand the purpose of INTERSOS’ presence.

Despite these difficulties, the staff felt the duty to take action, with the personal and professional tools at their disposal, to respond to needs “other than COVID” that were often also non-medical, but which proved to be of high importance to the people affected.

“Yes, like today, for example, we accompanied another boy who has a problem with his documents [to the lawyer]: this is one of the most beautiful things about INTERSOS. You can reach out to others: you can accompany them, even if it’s not planned in the project, you can go to the lawyer.”

Sicily

3.3 The relationship with the institutions

Institutions and their relations with the projects have played a central role in the management of the operation, as reported by the participants in the focus groups. There has been renewed interest on the part of institutions such as the ASL or the Municipalities in outreach work in spaces of social exclusion, prompted by the emergency scenario and the dangers related to public health. This has made INTERSOS’ work crucial in the eyes of institutions, who have turned to the humanitarian world for support.

The health emergency seems to have ignited dialogue between public institutions on social issues and policies related to the places of exclusion in which INTERSOS has been working for several years.

“That then you, [this] was actually the first experiment that brought together Prefecture, Police Headquarters, Employment Center, Inspectorate, and the Municipality of the area, to talk about the settlement and find common policies.”

Sicily

One of the tasks carried out by humanitarian organizations, therefore, has been to mediate between communities and institutions. Humanitarian workers, as frontline workers in these communities, know many of the dynamics that characterize them, and have worked for a long time in facilitating people’s access to institutional services of various kinds. This is possible thanks to the prior relationship of trust built with many communities and a deep knowledge of the contexts in which they operate. This function clearly became fundamental during the pandemic, when institutions needed tools to “approach” communities.

There was no shortage of difficulties, especially in the first part of the intervention, in mediating within the various communities on the health measures to be implemented. Most of the staff, particularly in the Roman and Foggia contexts, mentioned the difficulties encountered in requesting a swab test, especially in the first part of the intervention. While on the one hand, the bureaucratic paperwork needed to carry out a swab test required certain times and procedures, there was on the other hand the pressing need to work with the communities to make them understand what was happening. In fact, a series of community and relational dynamics of stig-
matization, fear, isolation and deprivation of freedom of movement were often associated with the swab test. This led many people to refuse taking the swab test, putting INTERSOS staff in the position of having to prioritize either individual freedom or public health, while relating and explaining the situation to institutions.

“So, the first few outings I was doing there with M and S, there was this guy who, from my perspective, according to certain clinical criteria, needed to get tested for the virus. And initially he had agreed, maybe we had to take a little bit more time to agree with him on this, to be even more sure that he really wanted to do it, but since he had agreed I called the ambulance to come to the settlement and do the swab but the moment we called the ambulance he ran away. [...] After that we found this person, we talked with him for a long time to try to calm him down about the possible consequences of the [testing]. [...] We certainly don't want to be the police in the situation. No, this is not the meaning of our work, of our presence here. That is to bring a protection for you and for others. And that didn't go as we had hoped. It didn't work... This didn't succeed. And there.... In a situation... Obviously you can't force a person to do a treatment that they don't want to do, despite the fact that in these times there are a number of critical issues etc etc, but we would not have taken a repressive attitude. That is, you also have the responsibility to be there, in the field, [you are] responsible with institutional mandate to do prevention and monitoring in a settlement where the classic, commonly known measures of prevention and isolation are not possible, so this is also a big disconnect.”

What is evident in this excerpt is the strong theme of the responsibility of being the frontline actors, who have been delegated by the institutions to deal with risk assessment in contexts where the institutions themselves struggle to reach communities.

The fear of stigmatization, on the other hand, is shared in the many different contexts, from the informal settlements in the countryside to the housing squats in urban contexts. Despite everything, collaboration with “peers”, that is with other institutional frontline workers, and with people who work within institutions, was perceived to be particularly fruitful in the Roman context.

“It's one thing to communicate to a person who's [living] home alone that they have to isolate, someone who doesn't need to be accountable to anybody. It's already difficult this way because you're going to tell them that they might be sick with a disease that's making everybody scared, so you have to be able to manage the emotional aspect or think about how to manage the communication of that. [It's another thing] If then maybe you have to consider that then the whole squat will know about it, that you can be stigmatized, or perhaps not, but it can happen... every time I thought about it 300 times, saying to myself “S**t A, what do you do, do you monitor this one and keep it very low-key and quiet, or do you really have to report it?” And when I had to, then it always went well, except once when a guy wanted to beat me up, afterwards he came back to apologize, also thanks to S. There, let's say it was difficult but it went well. People felt protected, I think... at least, that's what they communicated to me. Protected both in taking charge of the COVID, so to say “yes, I needed the swab test, thanks, I got one thing less to worry about” as well as with respect to the context in which they lived. Even the collaboration with the local institutions went well: there was an added security given by being able to call the staff by name and surname, so although the institutions at the time were fugitive [meaning they were not always responding], the staff workers on the other hand were, like you, on the front line, however, on the institution's side of it .... it was felt.”

Not only in the Roman context was the collaboration with the institutions a characterizing element of the intervention during the health emergency. The perception of such a synergy between humanitarian organization and institutions in planning the work in the field would inevitably be boosted by the health emergency,
becoming essential to the protection of public health.

“The collaboration of the health authorities [ASL/ASP], who made themselves immediately available and, although we had no cases, the feeling… the perception that at least I had was that they could immediately take charge of a case, and in these contexts it is not always this way.”

Calabria

Yet, the relationship with institutions can also elicit strong feelings, such as anger. Being on the front line, INTERSOS staff is forced to see with their own eyes and experience on a daily basis the conditions in which people are living, the systematic violation of their rights, the social injustices.

The fact is that they are on the front line, alone and often powerless, because the structural decisions that could change the status quo are made elsewhere, precisely by the institutions. And the institutions, while not being present on the front lines, know the dynamics of structural violence related to those places, but seem to ignore them; this can only generate a strong sense of anger:

“So much anger, because the places where these people live, in a way almost all of us do…no human being should be where they are. And that brings anger, it brings anger in the moment where those who must take charge do not know, do not have solutions, or do not listen to the ones proposed. It’s hard to accept because for decades those places have been frequented by health workers, social workers, researchers, journalists, everything: despite this, there has been no real change. That makes you angry. It’s not that you know things that those who are supposed to take charge don’t. But then why do these places still exist now? Anger is inevitable.”

Apulia

3.4 The relationship with the press

Among the difficulties and challenges encountered during the intervention, all INTERSOS staff in the various regions mentioned the complex relationship with the press. Some experienced it directly, having to manage operations and the presence of journalists in the field at the same time. Others felt the effects of the political exploitation of the situation and of their daily work.

The latter has been the case in Syracuse and Foggia. In Syracuse there are many cases of political exploitation of the situation in the informal settlement of Cassibile, a place where INTERSOS staff worked for the first time during the health emergency. The repercussions of the image that the press gives of the places where INTERSOS operates, inevitably has an impact on the work that is carried out there.

In the case of Syracuse, this is even more true: the staff had to deal with highly violent verbal attacks from the people of Cassibile, who saw them as the only actors who were physically present and to whom they could communicate their indignation about the presence of the informal settlement in that area of their city.

“Yes, in fact there was this thing [reportage that was broadcast] on ‘Striscia la Notizia’, and we were here. There was this reportage in Cassibile, giving a completely distorted image, which is an image that the people of Cassibile do not have, that not even the people of Cassibile want to endorse, of these people who are there to laze around at the expense of, etc. etc.. And, also, through a national television program that is very followed and known for low-level populism. And pressing on this COVID [situation]:“see? They go around without [wearing] the mask! The people
of Cassibile are very concerned about the situation!" It's obvious, if they say it on ‘Striscia la Notizia’, which is still a national show etc etc, we have intervened in this situation, it was inevitable."

Sicily

The exploitation of places of social exclusion for political purposes and the type of discourse that is fueled around these issues in the mass media place a strong symbolic and emotional burden on the work. This, in turn, causes strong emotional reactions such as, in the words of a team member from Foggia, “bitterness and sadness”; these feelings are difficult, he points out, not to “take to bed.”

“Another difficulty that has invaded our professional space is the political exploitation, which is invisible to the media, by the very people no one would ever suspect, which has damaged first and foremost the community that we assist. It's something that has devastated us, it's come to take a month of work away from me... A bitterness, a discouraging sadness, adding up to an already tough time. And I know others share this thought as well.”

Apulia

On a similar note, the Roman staff reports the difficulties encountered in managing the presence of journalists in the field. Migrant communities here, who also fear that their situation could be exploited for political gains, do not experience the presence of the press in the informal gathering places of the capital in a positive way. Important factors also come into play, such as the shame of living in these conditions, as well as the fear that the videos may reach their families in their countries of origin, who do not know the living conditions of their loved ones in Italy.

All these factors signify that the presence of the press in the field during INTERSOS’ operations must be managed very effectively and with extreme sensitivity. Despite all efforts to handle the presence of journalists, the impact of the cameras is almost always felt by the mobile team during subsequent outings in which the population looks at INTERSOS staff with more suspicion than usual for facilitating access to the press in the various informal gathering spaces.

“I said to someone, I don’t remember who anymore, I would rather do 100 medical check-ups in two hours than handle the journalists and all those interviews. [...] I realized that it wasn’t that they were coming because it was nice. But because it was critical to communicate what was going on, what we were doing. [...] I mean, when the journalist comes and we were doing the tour with the camper, with the mobile unit, to see if there were new things.... We stopped at Castro Pretorio to chat a bit with some people. It was the first time they had seen us, and the journalists were following us from I don’t know where, they stop in front with the camera outside the car, I say "guys, go see who that is" no, actually I say “I’m going to see who they are” and the people were there. I mean, these people got pissed off “Go away! You came with the cameras!”; I send the reporters away. We try to talk to them, but they were pissed off as hell, and we were in the van and I made some phone calls saying “I’m sorry”. That’s one of the... And we couldn’t go back there anymore...”

Lazio
3.5 The relationship with the beneficiary population

Often during the focus groups, the expression “isolation within isolation” came up. Many participants mentioned loneliness as a highly complex element to deal with during an emergency. Loneliness is an element that characterizes the contexts in which the staff goes to work, as places isolated and excluded from the rest of society, but it is also the loneliness experienced in being the only actors present. Moreover, there is the loneliness shared with a large part of the Italian population, especially at a time when sociality has been “blocked” in order to contain the contagion.

In the field, the INTERSOS staff experienced a whole series of emotions, most of which were very strong. The predominant emotions have to do with the conditions in which people find themselves working. Everyone responds emotionally to the conditions they witness on a daily basis in different ways: anger, understandably, is one of the emotions recognized as a reaction to injustice:

“It makes me really angry to see brothers inside these places, who are physically and mentally in shape, who have studied in Africa, people who started from scratch, who had diplomas and now it’s as if they have to start all over again, or do jobs they have never done. It’s not like with words alone we can change this, I know it’s a political issue. It always takes time to understand, to talk to those we live with. It’s not easy here.”

Apulia

Several participants from different teams also mentioned experiencing a sense of guilt and embarrassment resulting from the injustices they witness daily in their work. The embarrassment is related to the awareness of one’s own privilege and possibilities in terms of a “more worthy life”.

These differences probably cause so much embarrassment because in the fieldwork, it becomes even more evident how they are exclusively the result of class differences and ethnic privilege, historically and politically rooted, while everyone involved is equally human. This shared humanity emerges strongly in the daily work in which humanitarian workers and the people they assist find themselves immersed in the same contexts of social discomfort, sharing spaces and difficulties. However, at the end of the day the humanitarian workers can return to the warmth of their homes, while their counterparts are alone again, powerless in their invisibility.

“Syracuse, a beautiful city, so especially the initial phase in which we were going around even just to adapt to Syracuse, also from a ‘touristic’ point of view, there was the fact that we spent the day immersed in an inhumane condition. And then you walked 10, 200 meters and you were in another reality. The fashionable reality, the rich one... So I remember the first days there was this sense of... anger, anguish, injustice. Also of anguish because I, [...], [felt a] sense of guilt. I have experienced so much guilt in these weeks for various aspects. However, among the feelings of guilt there was also this: I was there, I worked, then I went out, and I was in a comfortable place etc etc. So the idea that, in 2020, in a city like Syracuse, inside Italy, anyway, there is that thing. It exists. There is that degree of inhumanity that is absolutely inhuman. It’s not poverty, it’s not a socially more difficult neighborhood. It’s an inhuman condition. It’s a ghetto. Very often I have called it ghetto. Even, perhaps spontaneously, without realizing it. It’s a ghetto! Exactly a ghetto. So this initial anger was justified by this sense of guilt, all this.”

Sicily

“Embarrassment’ I’m the one who put the mark on embarrassment, because on a few occasions when I would finish my grocery shopping and go home, someone would go shopping with me and not go home, because they didn’t have a home. That’s something that I feel a lot. Where I live, there are often people camped nearby. And I feel embarrassed when I come home. Even pissed off at the people who don’t give them a home and don’t give
everyone a home. With the person, though, I feel embarrassed. I have it and you don’t: I’ll put my groceries in my pantry and in my refrigerator, and you’ll take them to the cardboard next to you, if you’re lucky."

Rome

It also happens, however, that the emotions felt are not as strong as one might imagine, according to some of the staff who have been working in contexts of social exclusion for a long time, because a sort of emotional numbness, a “habitation” to the situation comes into play. The sense of powerlessness at that point becomes the baseline on which feelings such as frustration and embarrassment build up. The first is linked precisely to the knowledge that as humanitarian workers, they can only partially respond to this injustice, and will always “hit a wall”.

The second is linked to the handling of the direct relationship with the beneficiaries and their hopes and expectations, and the powerlessness and the feeling of not having the answers to the injustices that determine the contexts of social exclusion. This emerges strongly and makes it “embarrassing” to have to disappoint people’s expectations.

“I didn’t feel much anger, I wrote “frustration” and not “anger”. And embarrassment too. I don’t know why... really, what the contact with certain realities provokes in you... also a bit because I am emotionally numbed; maybe. Maybe I’ve felt that anger before, so at some point the anger breaks down and you wonder why you feel the anger in the first place. I found these emotions to be much more true to my experience, precisely because so many times I would get frustrated... It wasn’t that I was pissed off, I didn’t have high expectations of the situation in general. So it was more the frustration of when you hit a wall. Some days I felt just like the Tomb Raider against the wall. And then in the relationship with someone who instead has expectations of you... You feel discomfort and awkwardness, actually, as well as the feeling of anger, the frustration of the fact that someone’s going to carry on in that situation and probably survive, and then the fact that you can come in and out whenever you want. You have to make peace with that. Personally, these are feelings that I have taken and absorbed, because you can’t live being constantly uncomfortable, constantly embarrassed, but actually when I enter, when you are with [meaning: in the middle of] the garbage, you can also sit and have a coffee with him, share a moment, but then you don’t stay there."

Apulia

There is also a sense of powerlessness in the relationship with beneficiaries, in the knowledge that “you can’t save everyone.”

“Yes, and often the anger also transforms into something else when maybe you think you are aware of these things, you give tools and then you expect that person to use them. If they don’t use them because they don’t have the strength, because at that moment they don’t have the conscience or a way to say ‘look I’m not in this,’ and I’m thinking of Eric or, always, poor Ismail, that you give them tools and they say that to you. So you know you have made a lot of effort, to give him that thing that is not obvious you could give, and he does not accept it, or at least does not take it as you expect that he should accept it, and you even get angry with him. But no, it is a risk that we take, but I always tell myself that we are not always successful. First of all, I believe that we should never think, and I say this out loud because this is what I really think, that we are saving the world or the individual, because we are not anyone’s saviors. But we build, we are builders of things. And these things, that is, to try to force people to go inside what we have built is another violence. But I have to tell myself this all the time, it’s something that helps me a little and is there [in my mind] for a while, with a little tag “remember”. Because the risk, I realize, especially with Ismail, is “now I got him an appointment and he has to go, if he doesn’t go he’s an a***. No. If he doesn’t go, he’s free. And you, in accepting that, you really make him free.”

Lazio
Finally, many staff members also wanted to emphasize **positive emotions in their work**. As they rightly pointed out, if there were not also positive emotions, they would not have chosen to work in these contexts.

"Because, actually, I think, and this is about me, the driving force behind the things that I do is to have a positive principle: so if there wasn’t hope that something could change even just a little bit, and trust that it can change, that there are people that you work with for that, the rest wouldn’t come. And I think it’s that thing that we all...I mean, we’re still here for that reason."

Apulia

Happiness, joy, satisfaction are almost always tied to positive feedback from the people you’ve worked with:

"Yes. Every once in a while a person calls you, thanks you. For a sentence you said, when you have spoken to many people. And there, he may have followed what you said. And after a certain amount of months he came back to say thank you. And he goes out of his way to look for you. And those are wonderful things."

Apulia

In addition to the feedback given by beneficiaries, great accomplishments as an organization are also a source of pride and satisfaction, and they help move the work forward by outlining new goals:

"Then there are the things that fuel you: the things that fuel you are the small satisfactions, the small joys. Satisfaction can be something relatively small: for example, the water that is regularly brought to all the settlements, because it is a broad-scale problem, but it is a goal that we, together with the community, have brought forward."

Apulia

### 3.6 Cultural and linguistic mediation and the role of mediators

Among the staff involved in humanitarian interventions carried out by INTERSOS during the Coronavirus health emergency, mediators played a central role. During the focus groups, these figures expressed a particularly strong drive and motivation to be present in places of exclusion during this very delicate historical moment, despite fears and personal fatigue that they, and the rest of the staff, have experienced. In the case of mediators this is felt as a “life vocation to help” and is extremely strong, given also the subjective experiences that often characterize these professionals: they are often personally closer to the subjective experiences of the beneficiaries with whom INTERSOS works, often sharing the experience of migration, as well as the values, beliefs and cultures of the people addressed. This subjective closeness, given by often similar positioning and biographies, based on shared experiences of oppression and isolation, generates a very strong feeling of brotherhood and sisterhood, reported on several occasions by participants and focus group attendees:

“What is Borgo Mezzanone really like? What is the life they live like? The first day I went to Borgo Mezzanone was with INTERSOS, they were close to me and supported me. Especially I worked with B, who was very close to me. He always told me "take it easy," he always he gave me courage. "Look, it’s like this, it’s normal." Because seeing how they live... life unfortunately goes like this. But then, I put myself in their shoes too. To be humble, to be like them. Because we are all the same. Their pain must be felt. Their cry must be heard. You don’t have to feel superior because maybe you work, you’re here, you know how to, and they... don’t. So that’s how I felt. To be right on the same level."

Apulia
“You have to learn their problems too. We are there as INTERSOS, but we are also all brothers: Gambia, Senegal, everyone. We talk, we play, we do everything together. Also a beautiful thing. The work there for me, or for everyone, has been great.”

Sicily

In this sense, the intervention to provide information and containment of risk from Coronavirus is experienced as an important responsibility to the beneficiaries:

“Because we had the responsibility, or because I had the responsibility to better explain what's going on. And so I felt that responsibility. And so I would prepare, on the weekend, and try as much as I could to rest so that I could face the next week. I would read things, I would study things. And in fact now, that maybe things have calmed down a little bit, I feel the fatigue that is slowly coming up.”

Lazio

Something that makes the imperative to act and help support “one's brothers and sisters” even stronger is the awareness of a common destiny, rooted in a common experience of oppression, discrimination, and exploitation. Despite this, for obvious reasons related to the complexity of the intervention, this is still experienced as inevitably scary and intimidating, as well as demanding on a psychological and physical level, as it is for the rest of the staff.

Similarly to the beneficiaries, faith plays a central role in providing that “reason” for which to go on with daily work and non-work life. Religion is configured, in the words of both mediators and beneficiaries, as a resource that helps to cope with the difficulties of life.

“I've seen so many people who have died.... For me it was... I was sick, I was really sick. And I said 'but are we all at risk?' I was praying, I was praying, I said 'thy will be done for this moment'... Tremendous fear. But there was also joy. As long as there is faith that helps me get through things.”

Apulia

In addition to being a push to overcome difficulties, religion also serves other functions. As a signifier for life events that is shared by mediators and beneficiaries, it becomes a way to more easily “mediate” health and protection norms.

“Yes, from the point of view of culture, even religious culture, it has been difficult [to convey] this information, what is happening. Even going around, you say it changes your life, that this is happening, what is happening to Chinese people or also to Muslims in China. With some of them, you have to come in like a religious figure. Like something of a religious priest to even make them understand that there is some disease, to make them understand that it is real. Actually before, the Community didn't want to hear from anybody. At some point even I had to press on the religious aspect to try to convince [them].”

Apulia

Mediators see conveying information to people about the current health emergency as one of the central aspects of their work. During the focus groups, the difficulties that mediators have faced have emerged, as they often had to respond to the skepticism and denial of many of the beneficiaries. It becomes crucial to correctly communicate safety rules to be adopted, such as interpersonal distancing, the use of masks or hand hygiene, while always maintaining a transcultural approach and a socially nuanced view of the realities where they operate.
“It was almost impossible to apply those protective measures inside the ghettos. Even culturally, people ate together, and it’s not like the person who makes the coffee pays attention to all these considerations... Knowing all these things, and given the work we are doing, it was a duty to go and inform. Not just inform, but mediate. And the mediation was like this: first there was misinformation. That if you eat one, two or three garlics a day, you don’t get the disease; that this is a disease for whites, not for blacks.... All these things. We brought correct information, carefully mediated, that slowly overcame this misinformation ______, however it was very difficult. It was very difficult. Because they tell you “brother, we have been in this **t for a long time”, what can they say? “But this thing is invented by governments,” no. You have to go step by step, by sub-community, to do the mediation to bring people back to the conscious protection of their health.”

Apulia

“So many of them, I think, after the lockdown were saying, “but now the Coronavirus is over, what are you doing here?” And so we have these difficulties with them: those who don’t believe in this Coronavirus, but it’s a real thing. It’s not their fault: so many of them don’t have the opportunity to watch television, they can only hear what people are saying, that people are not dying. It’s hard for these people to understand that this is a real thing.”

Calabria

“Going back to the COVID situation, another thing has made it complicated. The contact. Physical contact. In a community where physical contact is the basis of brotherhood. We worked a lot with the people so that they didn’t experience this as yet another ______. They were really questioning us, there was a discussion between us about how to approach this”

Sicily

Even mediators experience adherence to the rules of personal protection with extreme difficulty, especially when establishing rapport with the beneficiaries. Wearing a mask, by some, can even be read as a “betrayal” to their native culture and adherence to the rules imposed by the host country.

“For me it’s a problem when I meet people in the street, [because] I smile as a greeting.... Once, after a month that I was at the Runway, with the Nigerian girls ___, at a certain point I had to take off my mask and they, after a month, told me ‘we had never seen your face’.”

Apulia

3.7 The team as a group

When INTERSOS staff was asked to reflect on what strategies they had put in place to deal with the difficulties encountered during the intervention, what emerged most of the time were reflections on cohesion and the role played by the team as a group. In each of the contexts, the staff team as a group was mentioned as a source of support and security in work in the field.

“At one point, we didn’t know what was going to happen. Every day there was something new. So every morning was a ‘let’s see what happens’: I was managing it though, because I thought, anyway, I’m not alone, I’m on a team, I’m counting on the team.”

Sicily

At the same time, relationships among colleagues became a reference point on a personal level to manage
high-pressure situations, thanks to mutual support outside of work. Simple moments of sharing, such as tending to the vegetable garden, buying food to take a break during work, or even just knowing you can count on your colleague(s), were all helpful in feeling the workload as less burdensome.

As one of the doctors in Foggia eloquently pointed out, such moments are symbolic of a collective healing process:

“Maybe this isn’t the same for everyone, but I think there was a lot of healing and care anyway. In their own small way, even the vegetable garden and our cozy “safe space” in the garden show that. And there was a lot of care so that we could find comfort, even in a difficult situation.”

Apulia

In the case of the teams in Foggia, Syracuse and Crotone, the guesthouse stood as a shared physical space that somehow made it inevitable to create deep relationships among those who lived there.

Some staff members found themselves sharing both the domestic spaces as well as the daily work with people they had just met and this required a great capacity for adaptation.

“Let’s say that maybe for us the COVID dimension of it was the minor uncertainty of this situation, because it was the only dynamic that maybe we knew a little bit better, but as P said we were called on Easter Monday and we left the next day, with an association that we knew only by name, with people we had never seen before that evening, and we were going to live in the guesthouse, in an area of a region where neither of us had ever been before, with clearly peculiar dynamics that we did not know at all. This created a strong initial disorientation, then, fortunately, as AL said, a beautiful and unforeseen relationship of trust was created, in which they also trusted us.”

Calabria

In the case of Rome, the staff never found themselves sharing a guesthouse, but it emerged during the focus group how, particularly during the lockdown, the other members of the team were among the few people encountered during those days when much of the population was inside their homes.

Finding oneself sharing domestic spaces and/or daily work in potentially risky contexts inevitably requires the creation of a good relationship of trust. Having to “trust” the other person in a moment of emergency, even though the other person is a “stranger” is a difficult task with which some of the INTERSOS staff, especially those involved in new projects, have had to come to terms.

“And then the trust that was, thankfully, built up right away. An unthinkable relationship of trust! Because it really happened very quickly”

Calabria

It’s this trust in their colleagues, with whom they face risky situations side by side, that helps humanitarian workers to carry out their work. The knowledge that, no matter what happens, your colleagues know what they are doing. Protection, therefore, does not depend solely on the use of personal protective equipment or on emergency evacuation measures, but also on the knowledge of being in a cohesive team that is prepared to face difficulties together.

“The protection that you mentioned, from a more relational point of view, the support: really they made me feel protected from day one. So that’s also something that went very well.”

Lazio
“Mutual help comes in the process: mutual help can also be a joke, a small thing, a plate of pasta...but without that you don’t.... You don’t carry on.”

Foggia

A team that is also capable of organizing itself and working with a multidisciplinary perspective, without overlapping, as reported during the focus group held with the Sicilian project team:

“Yes, the fact that everyone had a different training, be it mediator, doctor etc etc, if among us we made a reference to our knowledge, everyone relied on it, and so if I made a medical note, I was listened to: “ah yes, clear, okay, right, good”. Or R from his point of view, which is much more cross-cutting, clearly is strategic in the situation, ‘okay, perfect’, or the mediator giving you the cultural insight... And so we would readjust each other’s work in relation to the advice that the other gave. Yes, this was fundamental.”

Sicily

Trust, however, cannot be vested in another if there is no feeling of esteem from a professional point of view. Another important element that emerged across the four surveyed contexts was admiration for other team members.

“I felt admiration for the staff: we wouldn’t be able to work without this kind of positive relationship.”

Apulia

Even the projects that have been running for the longest time saw their teams grow and new staff being hired, with all that this entails: renegotiation of the sense of belonging to the group, on-the-job training on the work done so far, and redistribution of tasks. These teams went through all these relational group dynamics during the emergency, requiring a further effort to adapt to a context that was already in constant flux and characterized by instability.

“Then it was difficult to try to set up, again from my perspective, a team that worked harmoniously but also in a way that was...conscious. Creating widespread awareness and co-responsibility. I don’t know if this was successful, but it is what I wanted, what we aspired to as staff, as a team. I say this because before, my feeling was that there was not this degree of co-responsibility. I tried to address the risk and the tools we were trying to acquire to deal with it at the same time.... That was difficult.”

Lazio

Alongside the many positive notes mentioned by participants in the focus groups in relation to the group as a resource thanks to which “work becomes lighter,” there is no shortage of critical issues, which are only to be expected in a context of high stress and “forced” cohabitation:

“Two days a week we all slept together in Rossano, because the area was so vast that out of convenience, to make the intervention more effective, we chose to sleep there 2 days a week. So really, it was a 24/7 experience, which repeated itself every week. So if there hadn’t been willingness to compromise on the personal level as well, it would have been very complicated. There’s SG who is winking now, but we had our own good dose of arguments during the project. Because maybe then, character-wise, you don’t always have a... let’s say compatibility, right? You have to work on it. For example I’m used to... I’m a lone wolf. So finding myself with 5 people for 7 days a week, let’s say it was a nice challenge, it was stimulating. However, in the end, they gave back more than I asked for. Not just in terms of project results, but on a human and personal level. And so it was maybe the most important protective factor in the activities that we did.”

Calabria
This shows how living, working, and relational closeness can also be a critical aspect of humanitarian work. Teams have to negotiate strong dynamics of entanglement and conflict, making the boundaries between the personal and professional spheres extremely blurred and constantly having to question those very balances on which, by necessity, they must rely.

“On the second month, the two emotions I put up are “fun” [laughs] for a lot of very good moments that we had with the staff and that lightened up the work, which is what I carry with me the most: the moments in which we laughed so much. And “gratitude.” Because precisely for the dynamics that we managed to build, the second month was much lighter, it almost flew by, thanks to what we had built together.”

Calabria
4. Discussion: what is the emotional cost for humanitarian workers?

The impact working with migrant and refugee people has on mental health has been widely discussed in academic literature (e.g., Gemignani & Gilberto, 2020; Nonnis et al., 2020).

As we saw in particular in the section “3.1 Humanitarian work during the COVID-19 emergency: fear and responsibility”, staff convey feeling compelled to make their contribution in this time of emergency, intervening in the field even where the fear of infection was very strong. Many studies have found similar feelings of responsibility in personnel working with migrants and refugees in relation to their lives. (Argentero & Setti, 2011) However in the case of INTERSOS workers involved in the COVID-19 intervention, an additional factor comes into play: fear. Facing up to this fear and taking to the field despite everything entails a great amount of stress. And an almost omnipotent thought comes into play of being duty-bound to help, and to have to do so in a cross-cutting, integrated manner, also possibly at the expense of one’s own well-being outside work.

As seen in the paragraph “3.2 COVID-19 as a priority?”, in fact, it is not possible to respond exclusively to health needs linked to the risk of contagion, without taking into account the social, legal and psychological needs of the people with whom the teams work. However, within the context of an intervention conceived and designed, also in agreement with the institutions, as a purely health-related response to the crisis (see “3.3 The relationship with the institutions”), the tools to respond to other related needs are inevitably scarce, both in terms of human resources and time.

This inevitably leads to the experience of not being able to truly make a difference in the lives of migrants (Posselt, Deans, Baker, & Procter, 2019). The perceived sense of responsibility, in fact, leads professionals to shared experiences of powerlessness (Kavukcu & Altintas, 2019) and the feeling of not having enough tools, in terms of skills and knowledge, to respond to the needs of the beneficiaries (Guhan & Liebling-Kalfani, 2011).

In the case of the INTERSOS team, in fact, staff reports that they attempt to respond to emerging needs also from a global health perspective and taking into account the social determinants of health. Aware of the ineffectiveness of a circumstantial and compartmentalized intervention, the staff often finds themselves operating outside of their role and their working time limits.

This need to structure a holistic intervention while having only an emergency mandate, and being active during a period in which they are the only organization on the field (INTERSOS operates in contexts that other actors generally do not reach, particularly during health emergencies) has a strong emotional cost for INTERSOS workers.

And the need to be omnipresent, to work tirelessly, because the problems are too complex and too many, also emerges as an all-encompassing dimension of the focus group itself. One staff worker, in fact, underlines how, if we wanted to address all the problems humanitarian workers had to deal with here, “we would never leave the session”: “If we touch on all these things here, we’re not going to leave this session. Because there’s so much to say. The problems, if you want to solve them, or even if you want to talk about all the prob-
The problems are probably overwhelming while conducting work on the field, and the staff perceives the answers they can give as inevitably incomplete. It is precisely this sense of powerlessness and loss of control that makes humanitarian workers feel compelled to “never stop” thinking, no matter what they do, that they are “not doing enough.” As Gemignani & Giliberto (2020) insightfully point out, “When challenges become too demanding and overwhelming, working harder, transcending professional boundaries, and assuming responsibility are desirable responses from a neoliberal logic of production, but they are also telling forerunners of burnout.”

However, it is not only the work in the field that constitutes an emotional burden that is difficult to manage: the relationship with institutions, the press and the beneficiaries themselves are also particularly stressful elements for humanitarian workers in this context (see “3.3 The relationship with institutions,” “3.4 The relationship with the press,” “3.5 The relationship with the beneficiary population”).

Often, staff working to meet the needs of migrants or refugees report having to cope with demands and expectations from society and from the recipients of the service, as well as constantly changing working conditions (Gemignani & Giliberto, 2020). In this sense, job stress is closely related to personal, social, political, and cultural constructs about one’s professional identity. This is even more true for mediators, whose professional identities are built on complex identities, biographies, and positioning, many elements of which they often share with the people with whom INTERSOS works (“3.6 Cultural and linguistic mediation and the role of mediators”).

Professional identity rests on a fabric of responsibilities and complex ideological positioning, negotiated within the team, within the organization and in relation to various institutional actors. In other words, during the course of the COVID-19 intervention, the INTERSOS staff found themselves experiencing the pressures of a constant negotiation between their own mission and the fear of infection, between powerlessness and the requests made by recipients and institutions, between feelings of affection and care towards the people they tried to support and the awareness of a distance determined by differences in social privileges and, finally, between relying on the group as a resource and the entanglement between personal and professional relationships.

The group factor (“3.7 The team as a group”) is shown to be protective for much of the staff: cohesion and mutual support are configured as elements on which to rely in times of difficulty, as also found in other studies of a similar nature (Ager et al., 2012; Eriksson et al., 2013; Lopes Cardozo et al., 2005). At the same time, the entanglement generated from the “forced” closeness of staff both in fieldwork, and in the domestic sphere with the guesthouse, are challenging elements for humanitarian workers.
5. Concluding remarks

All the experiences shared by the INTERSOS staff who took part in the focus groups reveal dynamics that are complex and difficult to manage. Staff also mentioned many positive aspects that help them conduct their daily work, which are similar to those that have emerged in the literature: job satisfaction (Argentero & Setti, 2011), that is the awareness that their work is beneficial, especially when the people addressed show their appreciation, the favorable work environment (Sifaki-Pistolla et al., 2017), with teams that show cohesion and mutual support in times of difficulty (Ager et al., 2012; Eriksson et al., 2013; Lopes Cardozo et al., 2005).

However, another thing that emerges is that staff is nonetheless faced with consistent stress and emotional fatigue, which could lead to burnout, vicarious trauma, and secondary traumatic stress. Burnout symptoms are emotional exhaustion, depersonalization, and a reduced sense of self-realization (Maslach, Schaufeli, & Leiter, 2001). Vicarious trauma, on the other hand, is the change in worldview that takes place as a result of prolonged contact with traumatic stories over a long period of time; this can cause distress and change in the worker’s cognitive patterns (Nimmo & Huggard, 2013). Secondary traumatic stress occurs when the worker begins to exhibit traumatic responses similar to those of people with whom they work that were directly exposed to trauma (Pearlman & Saakvintne, 1995). Symptoms of secondary traumatic stress are very similar to those of Post Traumatic Stress Disorder, such as hypervigilance and intrusive thoughts, even though the exposure to trauma is secondary instead of primary (Bride et al., 2004).

Moreover, as we have seen, the identity construction of many of the participants involved in this study appears to be particularly tied to their perceived mission as professionals. In other words, humanitarian workers identify strongly with the work they do, as shown by their strong sense of responsibility and drive to work to bring about change. This means that the consequences of burnout, vicarious trauma, and secondary stress for these professionals can surface in deeply debilitating ways (Guskovict & Potocky, 2018). Furthermore, self-care and mental health care are critical for humanitarian professionals to be able to effectively work with populations that survived traumas (Lipsky & Burk, 2009).

In managing the emotional cost related to the COVID-19 intervention, it is also important to emphasize the importance of the research process itself, particularly with the creation of spaces for exchange with the focus groups. All staff involved in the focus groups emphasized the usefulness of such moments of joint reflection on the emotional impact, difficulties and resources related to the intervention. Sharing experiences in the group context and the chance to stop and create a space for joint reflection have been an important moment for the teams, which have often found themselves unable to create structured spaces for sharing, due to the large amount of work that needed to be done on the operational front.

The care of emotional-relational aspects in the group, therefore, is a fundamental prerequisite for the project to function. The creation of spaces for discussion in order to understand together how to “be” a group, and not simply be in the group because it is a necessary condition to carry out operations seems to be fundamental, not least to reflect on power dynamics between members.

This confirms the importance and urgency of establishing these spaces for reflection and, if necessary, psychological support for the emotional experiences of this group of professionals. These would act as protective factors to avoid that the experiences of emotional exhaustion become chronic, as well as to avoid the onset of burnout, vicarious trauma or secondary traumatic stress. As seen, the staff considers the
group space as a space to find care and support, and this can be a protective factor when the work becomes too difficult to tolerate (as also noted by Ager et al., 2012; Eriksson et al., 2013; Lopes Cardozo et al., 2005). Therefore, it is even more urgent and important to establish predefined spaces for group care that are professionally conducted through clinical supervision. Only in this way will it be possible to establish a shared thought about the relationship between power and responsibility that can include social, organizational and political factors within the discussion, making people more capable of configuring possible mandates for themselves. This is to help people develop a sense of agency and efficacy with respect to their work, but also to support in sharing difficulties, which are too often experienced only on an individual level and not placed in a group, or a social, organizational and political perspective.
Bibliography


The population has been called upon to take **individual responsibility**, but making no distinction and compounding all individuals within a paradigm of ir/responsibility resulted in drowning out and ignoring the difficulty many people encountered in applying the provisions that would have made them “responsible”. All the attention paid to individual responsibility has diverted attention from the equally necessary **public responsibility** to make all individuals **sufficiently safeguarded**. Only then can administrations credibly call for such individual responsibility.

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**AN UNEQUAL PANDEMIC**

The Proximity Public Health interventions carried out by INTERSOS in informal settlements in Italy during the COVID-19 emergency.