INTERIM OPERATING PROCEDURES FOR THE MANAGEMENT OF FACILITIES WITH PERSONS WHO ARE HIGHLY VULNERABLE AND AT HIGH RISK OF HEALTH AND SOCIAL CARE EXCLUSION DURING THE COVID-19 EPIDEMIC

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“A chain is only as strong as its weakest link”
Christiaan Barnard 1922-2001
Interim operating procedures for the management of facilities with persons who are highly vulnerable and at high risk of health and social care exclusion during the COVID-19 epidemic

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Interim operating procedures for the management of facilities with persons who are highly vulnerable and at high risk of health and social care exclusion during the COVID-19 epidemic

Abbreviations

CAS       Emergency Accommodation Centre
CPA       First Reception Centre
CU        Unified Conference
CPR       Migrant Repatriation Centre
DM        Medical supplies and devices
DPI       Personal protection equipment
FAMI      Asylum, Migration and Integration Fund (AMIF)
INMP      National Institute for Health, Migration and Poverty
ISS       The Italian National Institute of Health
MMG       General practitioner
MSNA      Unaccompanied foreign minor
ONG       Non-governmental organization (NGO)
RSC       Roma, Sinti and Caminanti
SFD       Homeless people
SIPROIMI  Protection System for Beneficiaries of International Protection and for Unaccompanied Foreign Minors
SSN       National Health Service
USMAF     Office of Maritime, Air and Border Health
1. THE SCOPE OF THIS DOCUMENT

The Italian Ministry of Health has commissioned the National Institute of Migration and Poverty (INMP) to prepare this technical procedural document by virtue of its mandate: the protection of the health of particularly disadvantaged populations. In this context, INMP, the public body of the National Health Service (SSN) under the supervision of the Ministry of Health, endeavours to "promote health-related assistance, research and training for migrant populations and to control diseases associated with poverty".¹ In agreement with the Italian regions involved, INMP "undertakes interdisciplinary activities of prevention and care [...], guarantees close collaboration between healthcare and clinical, experimental and organizational research [...] adopts, promotes and implements appropriate initiatives of primary and secondary prevention [...] tests and monitors innovative forms of management and organization in the fields of healthcare and biomedical research".² INMP is the national network reference centre for health and social care issues associated with migrant populations and with poverty. Further, INMP is the national centre for transcultural mediation in health.

This document is directed to all those who have any degree of responsibility in managing groups of individuals who are very vulnerable and very socially marginalised, whether they are Italian nationals or foreigners. The purpose of this document is to provide procedures that are clear, easily applicable and in respect of the complex norms implemented in Italy during the emergency phase of the COVID-19 epidemic. The aim of these procedures, which are based on the available evidence and on best practices, is to reduce the risk of infection and to contain its spread among the most vulnerable individuals in the population. Thus, this document aims to contribute to standardising approaches to managing the epidemic in particularly difficult settings, which have not yet received any technical or procedural indications expressly on how to prevent infection and how to contain its spread. Each of the places considered, while respecting the applicability of general directives,³ is subject to its own reference framework of directives.

² Art. 2, Ministerial Decree (d.m.) 22 February 2013, n. 56.
³ The places defined in this document are subject to a regulatory framework. In general, all are subject to, aside from the ordinary regulatory bodies of the sector (such as, for example, the legislation on the protection of health and safety in the workplace as set forth in Legislative Decree (d.lgs.) n.81/2008 231/2001), to the provisions issued as a result of the public health emergency, which provide for general rules to limit the spread of COVID-19 that apply to the entire population (to date, mainly under d.l. 19/2020 (conv. l. 35/2020), d.l. 33/2020 (conv. l. 74/2020), d.l. 125/2020, and the Prime Minister Decree (d.p.c.m.) of 13 October 2020).
As will be specified, the main relevant regulatory complexes are those valid in the field of migration flows and reception and in social welfare services (which, as is known, are differentiated in terms of the distribution of legislative power between the State and the regions where applicable). What’s more, the coexistence of numerous laws and regulations, both general and specific, has often led to the need for instructions or explanatory memoranda to solve single problems and discipline specific situations. At the same time, however, the places and the facilities here considered have specific characteristics that are due to the condition of health and social care vulnerability and marginalization of the individuals to whom these services are directed. For this reason, the effective application of the general and specific provisions to which they are subject requires the adoption of organizational and management solutions, of work methods and of standards of behaviour, rather than specifically designed collaborative strategies based on both individual and collective health protection needs. These needs, in the absence of technical procedures and specific recommendations, risk remaining largely unmet, with serious implications for the fight against the COVID-19 epidemic. In this light, the operating procedures that follow are to:

- support, by means of an evidence-based methodology, the correct reading of risk based on the conditions of the places where vulnerable and marginalised individuals live;
- support the correct application of those existing instructions concerning the use of DM and DPI as well as other simple precaution measures by staff members, healthcare professionals and volunteers who have contact with vulnerable individuals;
- foster the adoption of appropriate behaviours by vulnerable individuals to protect their own health as well as that of others in the communal areas;
- support the early detection of suspected cases of infection, facilitating the timely intervention of the health authorities who are responsible for ascertaining such cases as foreseen by the regulations in force;
- foster cooperation between public and private subjects in the management of groups of vulnerable individuals by means of practical tools that, while taking into account the heterogeneity of the various institutional and organizational contexts, can facilitate clear identification of the tasks and responsibilities according to respective competences.
The recipients of this document are potentially all those who have a position of responsibility or of support in the management of places where various categories of vulnerable and marginalised individuals receive assistance and hospitality. First and foremost, any public entity that has administrative and management responsibilities in these settings, for example, local health authorities, prefectures and the municipalities. The procedures herein presented are also directed towards any body that manages first reception centres, residential centres, community centres or day centres that host migrants or homeless persons. These indications are also directed towards organizations in the third sector that are called upon to defend, at different levels, the health of persons living on the streets, in shacks or in makeshift camps as well as of temporary or long-term squatters in uninhabited buildings or other illegal dwellings.

2. INTRODUCTION

The health problems of vulnerable and marginalised persons in terms of health and social care are the leading challenge modern social welfare systems face. These individuals often escape prevention policies because their legal-administrative status may be temporarily indefinite or because they may be hard to reach. It can be just as difficult for health and social services to assist them. Further, only a few Italian regions have established ways to determine vulnerability on the basis of stratification, like current information flows of the population by risk level. Where this has been carried out, however, these tools have not included those who escape such flows.

This document concerns mainly two groups of individuals who are exposed to situations of vulnerability and health and social care exclusion: migrants present in the reception system and individuals having particular types of housing conditions (homeless people or those living in makeshift dwellings or in occupied buildings).

The operating procedures laid down in this document were developed in full awareness that the issues underlying the vulnerability and exclusion of these two groups require structural and intersectoral solutions that go beyond managing the risk of contracting the
SARS-CoV-2 infection. Nevertheless, on the one hand, the need to contain the epidemic imposes immediate intervention in those places that host these individuals, to be designed and implemented as matters stand or by adapting the setting in such a way as to quickly meet these needs. On the other hand, outlining intervention strategies that are person-centred and setting-dependent as well as building institutional and social partnerships in local areas may open up a path towards delineating the public policies and capacity building that are essential to the future development and implementation of far-reaching solutions. To this end, the effort required of all the recipients of these operating procedures is in this perspective of gradual and progressive change, in which rapid, short-term actions must be taken both to achieve the immediate objectives of prevention and healthcare and as preparation for mid-to-long-term, more structural interventions. The effectiveness of the infection containment strategies and the health and social care protection of vulnerable individuals, subject of these operating procedures, depends on maintaining this delicate balance.

Thus, in light of the COVID-19 epidemic, interventions (i) of infection prevention of persons belonging to the most vulnerable segments of the population, (ii) of early identification of suspected cases of infection and (iii) the resulting assistance present specific problems that can in general terms be attributed to these individuals belonging to various classes of risk associated with the setting in which they live. In this document, risk will therefore be defined:

- on the basis of an evaluation of the degree of organization of accommodations;
- on the basis of individuals’ freedom of movement between the facility where they are hosted and the outside environment;
- on the basis of the risk of complicated COVID-19 for the hosted population.
The “organization” dimension

The organization of the facilities or of informal dwellings certainly represents an important element in identifying strategies to contain the spread of COVID-19. Dwellings, especially during lockdown, have become essential for isolating oneself from others in the community and for self-isolation from the rest of one’s family. The structure of the dwelling greatly determines the effectiveness of self-isolation and of hygiene and prevention measures; it determines to what degree physical distancing between individuals who live together will effectively contain the infection. It appears clear that, for the vulnerable populations who are the subject of this document, providing accommodations that are structurally adequate as well as how they are organized is essential. Some places fully meet the maximum requirement of organization and are often run by a dedicated staff that follows internal procedures through an established chain of command-control and of communication. Other informal accommodations, instead, do not have any appreciable structurality nor any internal organization. They are generally inhabited by persons who are hard-to-reach and hard-to-treat and who result difficult to manage due to linguistic-cultural barriers. What’s more, the limited awareness of how the virus is transmitted and of its symptoms, in the absence of any facilitation in loco provided by dedicated, adequately trained staff and/ or mediators, plays a very important role in the poor compliance with any provisions issued for the containment of infection. Finally, the risks associated with the lack of physical distancing in these places and the fact that suitable spaces for self-isolation or quarantine are frequently lacking certainly complicates their management.

For example, homeless people and those who live in makeshift camps.

For definitions, see Box 1.
The "freedom of movement" dimension

Freedom of movement with the outside world is an additional dimension relevant to determining the risk attributable to a given setting. In relation to the type of buildings and of housing solutions, there are various levels of freedom of movement: from the complete absence of freedom of movement typical of repatriation centres (CPR), to the maximum freedom found in solutions with little or no organization, passing through intermediate solutions, such as first reception centres (CPA), Emergency Reception Centres (CAS), Protection System for Beneficiaries of International Protection and for Unaccompanied Foreign Minors (SIPROIMI) and Centres for Unaccompanied Foreign Minors (MSNA), up to residential, semi-residential and daytime facilities for homeless people.
The “prognosis” dimension

The risk of a complicated case of COVID-19 appears to also be correlated to pre-existing health condition as well as to the individual’s age. Very different health and demographic profiles of those living in the various types of housing have been noted. Young, generally healthy individuals reside in the CPR, the CPA, the CAS, the SIPROIMI centres and the MSNA centres (average age on 15 July 2020 was 27.19 years in the CAS and 28.5 in the CPR). Instead, the health of those living in residential or semi-residential facilities, those who frequent the day centres for the homeless and those living in makeshift camps and abandoned buildings tends to be compromised; these individuals often have multiple chronic conditions and disabilities and are, on average, older, even over age 65 years.

Figure 3- Places classified according to the “prognosis” dimension

The conceptualisation of the context above determines, therefore, the theoretical basis on which the settings are placed in spatial areas of risk as a consequence of the aforementioned dimensions. For such reasons these settings are the recipients of the operational instructions for risk management and mitigation (Fig. 4).

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7 Source: Ministry of the Interior – Department for Civil Liberties and Immigration
a) Organized reception

These places have specific organizational functions for residential accommodation and foresee activities carried out in dedicated facilities. The responsibility for this type of reception lies with the institutions (local authorities, regions, prefectures, etc.) in accordance with the ordinary powers exercised. There are clearly identifiable actors who must give account to the relevant authority, a functionally efficient chain of decision-making and information and a building and the availability of tools and means normally appropriate to the situation.
The persons hosted in such places and the staff that work there constitute a community that is susceptible to infection. The various settings, by virtue of the characteristics of the people who use it, the structure of the buildings and the degree of freedom of movement outside of the housing area of those who live there can result in various levels of risk that must be considered when developing the necessary infection prevention and containment measures as well as the protocols for identifying new cases and for contact tracing.

1. Reception system for migrants

In the context of organized reception, it is important to ensure that reception is provided by the migrant reception system to applicants for international protection, refugees, beneficiaries of international and subsidiary protection, unaccompanied foreign minors and holders of specific residence permits. As of 15 October 2020, the reception system accommodated 82,110 people (source: Ministry of the Interior website – daily dashboard). In the event that foreigners enter Italy illegally by boat or by crossing the land border, they are photographed and fingerprinted and assessed on arrival by the USMAF and/or the Local Health Authority to identify any health-related emergencies and/or vulnerabilities that require specific protected pathways as well as any cases of SARS-CoV-2 infection.

Once the health assessment has been completed, these individuals are placed in a quarantine facility, in compliance with the existing rules on controls of people coming to Italy from a non-Schengen country. Quarantine can take place in dedicated structures and/or in spaces in the largest first reception centres identified as suitable for that purpose. When intercepted, migrants trying to reach Italy on an autonomous basis undergo the initial assessment by the local health authority and are brought back into the flow of first reception.

Following quarantine or isolation measures, all migrants who request international protection are received in a CPA or CAS and, in accordance with Art. 86-bis of Decree-Law n. 18 of 17 March 2020, converted, with amendments, by Law 24 April 2020, n. 27,
in a SIPROIMI for the completion of the assessment procedures of protection requirements.

Non-asylum seekers may be sent back to their country of origin, either through the CPR or through an administrative procedure. Unaccompanied foreign minors, for whom expulsion is generally prohibited, are hosted in facilities specifically for them. From a temporal point of view, reception is organised on two levels:

- **first reception** guaranteed immediately after disembarkation and for the time strictly necessary to carry out the very first material and healthcare interventions, together with identification (photograph and fingerprints) procedures, at facilities activated by the Prefectures throughout the national territory, where all essential services are provided while awaiting examination of the request for international protection;
- **second reception** at the centres belonging to the SIPROIMI system, which provides for both long-term integration pathways managed by the local authorities and reception for asylum seekers during the COVID-19 emergency.

First aid and reception facilities are provided during **first reception** in so-called hotspots, defined as crisis points by art. 10 ter of Legislative Decree n. 286/1998 (introduced by Decree-Law n. 13/2017 converted into Law n. 46/17). These designated areas are generally in proximity to a disembarkation point where, as soon as possible and in compliance with the Italian legal framework, persons arriving undergo medical examination and testing and receive first aid. Any vulnerabilities, including being a minor, are identified, and information on laws governing immigration and asylum is provided. These persons are assessed, pre-identified, and, after having been informed of their current status as undocumented persons on Italian soil and of the possibility of applying for international protection, they are photographed and fingerprinted. The hotspots currently active are in Sicily (Lampedusa (AG), Pozzallo (RG) and Messina) and in Puglia (Taranto). Once identification procedures have been completed, the migrants who have demonstrated their intention of applying for international protection in Italy are transferred to first reception centres located throughout the country, where they remain while their application for international protection is examined. These first reception centres can be either a CPA pursuant to ex art. 9 Legislative Decree n.
142/2015, currently located in the regions of Calabria (Isola di Capo Rizzuto (KR)), Puglia (Manfredonia (FG), Bari, Brindisi), Friuli-Venezia Giulia (Gradisca d'Isonzo (GO), Udine), Sicily (Caltanissetta, Messina) and Veneto (Treviso) or a CAS, buildings requisitioned by Prefects through specific calls for tenders (ex art. 11 Legislative Decree n. 142/15). Currently, there are about 5,000 such facilities operating throughout the country, with an occupancy of slightly under 80,000 places. In the context of first reception, there are also 8 Asylum, Migration and Integration Fund (FAMI) projects for unaccompanied foreign minors currently active, for a total of 350 places, which are due to expire on 31 December 2020.

Pursuant to ex art.14 Decree-Law 286/1998, established to allow the enforcement of expulsion orders by law enforcement agencies, aliens illegally residing in Italy who do not apply for international protection or who do not meet the requirements and against whom identification procedures for expulsion and repatriation have been initiated shall be detained in the CPR. The duration of stay in the CPR is determined by the time needed for identification procedures and subsequent procedures for expulsion and repatriation.

Second reception, instead, is guaranteed through personal assistance and integration projects that are activated by local bodies belonging to the SIPROIMI. As of 15 October 2020, 794 reception projects in more than 1800 municipalities were active, for an occupancy of 30,666 available places; on 30 September 2020, 25,193 places of those available were occupied (source: Ministry of the Interior and the SIPROIMI website).

In terms of freedom of movement, the Italian migrant reception system is made up both of open residential communities, in which the hosted persons – once identification procedures have been completed and legal status has been determined – are registered at entrance but can leave freely on a regular basis (CPA, CPA functioning as hotspots, CAS and SIPROIMI) and of closed centres (CPR), in which migrants' freedom of movement is restricted both towards the outside and in some areas inside the centre. All of these facilities have communal areas, service areas, places to socialize and different types of sleeping quarters, ranging from single rooms to dormitories with dozens of beds. In centres with this latter type of accommodation, the risk of exposure and of infection among the hosted population concerns primarily new arrivals but also contact with the other residents and staff. Characteristic of the
SIPROIMI is its widespread reception and its limited numbers, in large part thanks to housing in private apartments.

Although there is no particular overcrowding in these centres compared to in the past, saturation (number of guests vs the number of beds) can nevertheless play a role in increasing the risk of infection; preliminary data from a national survey conducted by INMP on reception centres and COVID-19\(^9\) show that, while the regional average saturation index calculated on the centres in which no positive COVID-19 cases was found was 78.6%, the same index calculated on the centres with at least one positive case was 87.7% (INMP: unpublished data). For those centres where there is freedom of movement, movement towards outside the centre is the main risk factor for exposure and infection, while routine community activities (communal bathrooms, meals in communal dining rooms, recreational activities, etc.) are the main risk factor for the spread of disease.

2. Reception of homeless persons and of those affected by health and social care exclusion

A clear framework of social services offered to populations without anywhere to live is provided for in the guidelines for combating serious adult exclusion in Italy by the Ministry of Labour and Social Policies (adopted in an agreement reached in the Unified Conference on 5 November 2015). The management and provision of services and of social interventions fall mainly within the administrative functions of the municipalities, which perform them individually or jointly, pursuant to Law n. 328 of 8 November 2000 and to regional legislation (with the reform of Title V of the Constitution of 2001, of which Constitutional Law n. 3/2001, social policies are included in the residual competence of the Regions), as well as based on regional and local planning. Moreover, due to the reciprocal conditioning between social exclusion and health needs, social interventions and services are strongly linked to health and social care services, according to the legal and institutional framework based on Art. 3-septies of Legislative Decree n. 502 of 30 December 1992, as amended and supplemented by Art. 22 of Law n. 328/2000 and by Art. 21 et seq. of the Prime Minister Decree of 12 January 2017, as well as on regional legislation in the sector.

Taking into account that the services are provided through widespread and extensive participation of the third sector, including through forms of accreditation and agreements, there are:

1. low threshold night shelters, with increased availability of access during a declared state of emergency (climatic or health, such as COVID-19)

2. daytime shelters that host homeless people during the day and provide for primary, relational and social needs

3. low threshold services for meeting primary needs (canteens, distribution of necessities, hygiene and personal care services)

4. outpatient services (SSN or third sector outpatient clinics and therapeutic communities\(^\text{10}\)).

The reception facilities referred to in point 1 above are private housing-like facilities and therefore often have shared bedrooms and toilets and some communal areas. The main characteristic of the facilities in points 2 and 3 above is that spaces and activities are shared by the people hosted there and the staff. They have a high turnover and high freedom of movement, meaning that the risk of exposure and infection must be added to that from contact with the services staff.

During the pandemic, in light of the specific condition of vulnerability of homeless people in terms of health and social care and housing and because of their close contact with others while using dedicated, high-frequency services, making them more exposed to infection and to multipliers of the same, the municipalities and those bodies of the third sector most actively involved with these populations have endeavoured to:

- convert night shelters into 24-hour services to limit the number of people leaving then re-entering
- identify additional reception centres, even small-sized ones, borrowing from the example of the SIPROIMI (based mainly on small centres and accommodation in apartments)

\(^\text{10}\) These therapeutic communities include residential and/or semi-residential facilities for the therapeutic rehabilitation of persons with substance abuse disorders, with the goal of these persons' social reintegration.
• reorganize canteen services (reducing the number of accesses and organizing take-out food distribution)
• prepare protocols and facilities for quarantine management.

b) Accommodations with little or no organization

Accommodation with little or no organization includes a number of situations with a variety of characteristics that, however, have in common the fact that they are informal and that basic services are generally lacking. They include: 1) impromptu settlements of small isolated groups living in makeshift shelters in extreme social exclusion; 2) individuals living on the streets in conditions of extreme social exclusion who sometimes use area services, including housing and shelter services; 3) communities, even large in size, that live in illegal types of dwellings, such as squatters in abandoned buildings or those living in makeshift camps or shelters, where essential services such as toilets, electricity, running water or regular garbage collection may be available only at times and always irregularly. These places can be occupied temporarily, as is the case of so-called transients - those migrants transiting through Italy - or over the mid-long term, as is the case of the Roma, Sinti and Caminanti (RSC), in buildings that have been occupied or in camps for seasonal farm workers.

These living conditions certainly are not conducive to adequately protecting the health of the persons who live there and should therefore be eliminated. Nevertheless, in the context of this document, which considers the containment of the risk of exposure to and infection with SARS-CoV-2 a priority, these places are included among the settings to which these management operating procedures are directed.

The sustenance of the people living in these settings depends, to varying degrees, on local networks of services (social services and the third sector), on the availability of

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11 With reference to foreign documented workers, pursuant to art. 103, comma 1, d.l. 34/2020 (conv. l. 77/2020) or to those holding a temporary residency permit pursuant to comma 2 of the same, it is provided that “In order to effectively combat the phenomena of concentration [of the aforementioned] foreign citizens [...] in conditions inadequate to ensure compliance with the sanitary conditions necessary to prevent the spread of the COVID-19 infection, the competent State Administrations and the Regions, also through the implementation of the measures provided for in the 2020-2022 three-year plan to combat undocumented labour in agriculture and the exploitation of these workers, will adopt solutions and urgent measures to ensure the health and safety of housing conditions as well as further interventions to combat undocumented labour in agriculture and the phenomenon of exploitation of these workers. For the above purposes, the Operational Table established by art. 25 quater of the Legislative Decree of 23 October 2018, n. 119, converted, with amendments, into Law 17 December 2018, n. 136, may avail itself, without new or increased charges to public finance, of the support of the National Civil Protection Service and the Italian Red Cross. The Public Administrations concerned will provide towards the implementation of this paragraph with the respective financial, human and instrumental resources available under current legislation.” (thus comma 20 of the aforementioned art. 103, d.l. 34/2020, conv. l. 77/2020).
informal, occasional support (private citizens and benefactors) and on humanitarian initiatives. Thus, any plan or measure regarding the management of the COVID-19 epidemic in these settings must take into account the interdependence between the needs expressed by these individuals, implicitly or explicitly, and the offer of public and private health and social services. In the context of the current epidemic, this relationship can play a role of virtuous junction in favour of those who are hard to reach and hard to engage. In these settings, the public system must necessarily measure itself against the concrete implementation of the principle of horizontal subsidiarity and through a more effective organization of proximity networks of assistance by intervening directly in places where the need manifests itself, addressing it with culturally oriented instruments and with proportionate, appropriate responses. The subsidiary relationship between public and private bodies and the third sector already exists in these contexts. The present operating procedures intend to support this concept specifically in terms of the prevention of SARS-CoV-2 infection, not as a substitute, without prejudice to the responsibilities laid down by law (in particular with regard to the determination of suspected cases, which remains the responsibility of the Local Health Authority), but rather, as a collaboration. Ordinary moments of contact with vulnerable persons are highlighted either as moments of empowerment (basic health education on the rules of personal hygiene, using masks, maintaining physical distance; awareness of horizontal control within small communities) or early reporting to the local health authority of any suspicious cases.

In some settlements, for example the RSC camps, seasonal farm worker camps and in occupied buildings, the population lives there for medium-long periods of time and often is the object of outreach interventions that guarantee some essential services, such as running water, electricity and waste disposal, in proportion to the number of people who stably reside there. Hierarchic structures are often found in these communities, which makes it possible to identify a contact person with whom a relationship can be established to define active interventions. Nevertheless, aside from this kind of population, which we can define as stable, transients are also present in the same settlements, usually for brief periods. Their presence may render the services provided insufficient, making it difficult for the public body to engage the entire community.

Within the framework of the organizational heterogeneity described above, the main risk
factors to take into account are: the absence of a conventional organization that assures a decision chain and information flow management, the frequent lack of essential goods and services, such as running water and electricity, the impossibility of independently obtaining items for correct personal hygiene, the difficulty of respecting the minimum physical distance and the general unavailability of places for the isolation of suspected cases, the extreme social exclusion and difficult access to healthcare services. The latter often have difficulty in accessing the settlements, which prevents early identification of suspected cases and the organization of an effective system of intervention of the health authorities. Further, the frequent presence of persons with multiple chronic diseases and with psychiatric disorders, and the extensive freedom of movement throughout the country makes providing assistance even more difficult.

4. EPIDEMIOLOGIC SITUATION

On 30 January 2020, the World Health Organization (WHO) declared the epidemic due to the novel coronavirus (COVID-19) a “Public Health Emergency of International Concern”, based on the 2005 International Health Regulations. COVID-19 (CoronaVirus Disease-19) is the name the WHO gave to the disease caused by the SARS-CoV-2 virus; the epidemic originated in the wet markets of the city of Wuhan, in the province of Hubei, China. The virus rapidly spread throughout the world, to the point that on 11 March 2020, the WHO changed the definition of the level of the spread of the SARS-CoV-2 infection from epidemic to pandemic.

The epicentre of the pandemic, over the course of the weeks, progressively shifted: first in China, then to Western Europe, followed by the United States, Latin America, Russia and the Indian Subcontinent.
A certain number of cases were also identified in the Middle East and in Africa, where the spread of the virus, however, currently appears to be more contained.

In Italy, the first case was identified on 21 February: a 35-year-old patient in intensive care at the Hospital of Codogno (LO) was found positive for SARS-CoV-2.

To contain the outbreak, the Italian Government implemented the public health prevention measures of physical distancing and restrictions on movement, initially only in those areas that were hardest hit by the epidemic; the Prime Minister Decrees of 9 and of 11 March 2020 subsequently extended lockdown to the entire country.

From the beginning of the epidemic to 14 October 2020, 372,799 positive cases of COVID-19 diagnosed by regional reference laboratories and 36,289 deaths were reported to the national surveillance system. The average age of confirmed cases of SARS-CoV-2 infection is 54 years, from about age 60 in the first few months of the pandemic, to age 30 in the middle of August, to a new increase in the average age of around 42 years, registered in the last few weeks.

The geographic spread of the epidemic in the period January-June 2020 was very limited in the regions in the South and in the Islands, on average higher in the Centre compared to the South and very high in the regions in Northern Italy.

Regarding this initial, important phase of the epidemic, the national curve of diagnosed cases and of deaths began to decrease only at the end of March. The peak in new cases was registered on 21 March (6657 in one day) and in deaths on 27 March (969 cases in one day). On 3 April, the highest number of COVID-19 patients in intensive therapy (4068) was registered, on 4 April that of hospitalized symptomatic patients (9010). The highest number of persons currently positive was registered on 19 April 2020 (108,257).

The improvement in the epidemiologic curve led the Italian Government to approving the reopening of businesses: partial reopening on 4 May and complete reopening on 3 June. However, the containment measures of physical distancing, wearing a mask in indoor public places and quarantine for anyone coming from a non-Schengen country remain in force.

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12 Source: Ministry of Health
Generally speaking, by mid-July, when the first version of this document was published, the number of new cases of infection was small, thanks to the effectiveness of the containment and control measures adopted, including early identification, isolation, active surveillance and treatment (Tracing, Testing and Treating), which improved the chances of breaking any possible chain of transmission as it appeared. Further, the improved knowledge of the course of the disease and the reduction in the time between symptom onset and diagnosis/isolation reduced the percentage of new cases that required hospitalization and the need for intensive therapy. Nevertheless, there were still a number of outbreaks in communities and residential facilities (occupied buildings, boarding schools, factories and residential facilities for the elderly). This indicated that the SARS-CoV-2 virus was still active and that in unfavourable conditions, it could set off new outbreaks, even quite widespread ones.

Since mid-August, the epidemiologic curve has shown an increase in the number of new cases, with a slight increase in the percentage of cases that are clinically severe at diagnosis. In the last few weeks, the situation has deteriorated rapidly, likely due, at least in part, to at-risk behaviours during social activities. In the last two weeks, the daily number of new cases has tripled, going from 2,548 on 1 October to 7,332 on 14 October. It must be remembered, however, that the current situation is unlike that observed during the so-called first wave: the system’s ability to identify cases has increased significantly. It is estimated that the actual number of cases during March-April was at least 6 times that of identified cases, as detected by the national serological survey conducted by the Italian Ministry of Health and by Istat.\(^\text{14}\)

On 14 October, 6.5% of positive subjects were hospitalized with symptoms; of these, 0.6% were in intensive therapy. Given the worsening of the situation, the Government adopted new restrictions, through d.l. 125/2020 and then the d.p.c.m. of 13 October, extending the mandatory wearing of personal protective equipment of the upper airways (i.e., masks) to outdoor spaces\(^\text{15}\) as well as other limitations, especially in terms of

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\(^\text{15}\) Pursuant to the d.l. 125/2020 and the d.p.c.m. of 13 October 2020 (for this profile confirmed by the d.p.c.m. of 18 October 2020), there is in force the obligation throughout the national territory to always have with one a protection device of the upper airways, including the so-called community masks, which must be worn both in closed spaces (other than one’s home) and in outdoor spaces (except in cases where, given the characteristics of the space or the circumstances, continuous isolation between persons who do not live together can be guaranteed). Children under the age of 6 years are not subject to this obligation, nor are persons practicing sport or persons with a disease or disability that is incompatible with mask wearing (as well as those who, when interacting with these persons, cannot wear a mask). Further, wearing a mask is strongly recommended at home when in the presence of persons who do not also live there.
restricting mobility and the number of persons present in the same place; the d.p.c.m. of 18 October imposed further control and prevention measures. The effectiveness of these measures will be evaluated in the coming weeks.

The current trend in Italy therefore suggests a position of watchful waiting, especially as the increase in the number of new cases, unlike what was observed in the first few months of the epidemic, seems to involve all the regions, albeit with varying intensity.

In terms of the burden on the healthcare system due to the considerable increase in the number of new cases, diagnostic testing and contact tracing are currently putting pressure on local healthcare services. In hospitals, the situation is becoming alarming in almost all regions, especially in Lazio and in Campania, where the increase in hospital admissions has seen wards and intensive therapy units, virtually empty over the summer, now showing signs of saturation in terms of the availability of beds for COVID-19 patients. For example, on 31 August in Campania, only 1 ICU bed was occupied, while on 14 October, 61 of the 110 available beds were occupied.

A considerable increase in hospitalizations can also be seen in Lombardy, following the significant uptick in cases over the last few days. Another concern is the sizable increase in the number of positive cases registered in some European countries, particularly in Spain, France and the UK.¹⁶

It is therefore essential to insist on respecting the basic behavioural norms of hand washing, social distancing and wearing surgical masks indoors and outdoors. In this national epidemiologic framework, it is also important to strive to achieve early identification of the conditions that increase the risk of exposure and of infection in particular settings, especially those with vulnerable populations, whether they are in organized facilities and systems or in poorly organized makeshift dwellings. In these contexts, institutional bodies must increasingly share activities of risk management with third sector organizations, whose work in direct contact with vulnerable people is based on responsible involvement in partnerships and collaborations with public services.

¹⁶ At the moment, the international epidemiologic situation has led the Italian Government to distinguish between obligations and restrictions of the those persons entering from abroad (whether EU member countries or Schengen Area countries or countries outside these areas) according to the risk level in the country of departure or transit. For regulations currently in force, see articles 4-8 of the d.p.c.m. of 13 October 2020. A summary of these regulations can be found on the website of the Italian Ministry of Health: http://www.salute.gov.it/portale/nuovocoronavirus/
In this chapter, the actions to be undertaken are defined so that, in terms of the virus, it is possible to operate safely in settings of reception and in those with little or no organization where essential services are provided to mitigate the risk and identify possible cases or clusters at an early stage. Risk assessment is carried out first, followed by a reorganization of routine activities, adapting the premises if necessary, training the staff, gathering information on the persons hosted and defining a flow of information to the health authority. The timely implementation of the preparatory activities is the reasonable prerequisite for the operational procedures subsequently adopted in the various settings to function. This must be emphasized so that each centre can quickly complete the preparatory activities indicated to ensure the safety of the persons hosted.

In the facilities and places where there is little or no organization, it is more difficult to respect these regulations. Nevertheless, every attempt must be made to adopt those that can be carried out (e.g., washing/ disinfecting hands, wearing a mask, maintaining a minimum physical distance), with the essential help of the public assistance staff and/ or of the third sector.

a) Risk assessment

It is necessary to carry out a specific risk assessment in every setting; the aim is to identify, aside from the general risk determined by the position of the building in the risk pyramid, those situations in which the common measures to contain infection – physical distancing, limiting contact with others, hand hygiene and protection of respiratory airways, cleaning and disinfection of indoor environments, the use and availability of DPI and the possibility of safely managing suspected, probable and certain cases (Box 1)
cannot be applied effectively. Specific risk assessment thus makes it possible to identify solutions to mitigate or eliminate the weaknesses detected. The assessment must also include a verification that all the procedures issued are actually known to both care staff and the persons hosted, depending on the relevance. Such an assessment is opportune in every type of setting, taking into account the specificity of the different population groups. For example:

- cultural and linguistic barriers to communicating the risk of contracting the SARS-CoV-2 virus and the protection measures to be adopted;
- whether there are any chronic diseases;
- close physical contact and overcrowding of the spaces;
- sharing objects;
- little or no access to supplies for personal hygiene;
- absence of any suitable place to guarantee effective isolation;
- lack of continuity in the provision of essential services.

The risks evaluated should be registered in a matrix sheet for the actions to be taken to mitigate and control those risks. For each setting, the information flow must also be defined so as to be able to activate the competent health authority to confirm and manage the case and for contact tracing.

b) Reorganization of activities

In all the settings discussed in this document it is common to find living conditions in confined spaces, sharing of communal spaces and a high turnover. These all represent important challenges to effectively applying virus control measures. Therefore, the first action to be carried out in each place, when possible, is to identify the maximum number of people to be hosted in relation to the capacity of the structure, respecting the distance of at least 1 metre between persons, including in communal areas. On the basis of this verification, internal flows will have to be reviewed, and the distribution of the rooms, schedules for the provision of services and identification of delivery points will have to be established so as to reduce the number of people accessing them at the same time. In addition, the subdivision of the people hosted into small groups, with no contact between
each group, would permit limiting the potential spread of the SARS-CoV-2 virus, even in the event of a cluster or an outbreak, which would be contained in a part of the hosted population. Activities should be reorganized in a way that foresees periodic suspensions to ensure that indoor areas are aired out regularly and to frequently clean and disinfect those surfaces and rooms most often used. The access of any external person in charge of essential duties for the rights of the guests (e.g., lawyers, NGO personnel or representatives of international organizations) is regulated by the organization responsible for the setting so as to limit the presence of accompanying persons, to reduce the number of the meetings to the minimum necessary and, whenever possible, to provide for a place to hold such meetings that is separate from the communal areas. Each facility must purchase and store masks for people using the facility and DPI for staff as well as an adequate amount of cleaning and disinfection products\textsuperscript{17} to ensure that these items are always available. In highly organized centres, the supply chain must be defined by identifying the minimum stock level.\textsuperscript{18}

c) Adaption of indoor areas

Indoor areas must be adapted to the needs connected with maintaining physical distance; separate entry and exit routes must be identified. Further, body temperature must be measured at the only entrance point to the facility and a questionnaire must be administered. In addition, barrier screens must be provided for greater protection of those who work in contact with the people using the facility. Prevention measures must be indicated on vertical and horizontal signs, with simple, multilingual messages (information/infographics with pictograms).

A specific quarantine environment must be provided for.\textsuperscript{19} In the case of large reception centres, having more than one isolation room would be opportune. These isolation rooms should be located in an entirely separate room or in a specific wing of the centre in order to limit – if not eliminate – any contact, even accidental, between the other people hosted and those who are in isolation. During quarantine, the person must

\textsuperscript{17} ISS COVID-19 report n. 20/2020 and ISS COVID-19 report n. 25/2020
\textsuperscript{18} See Box 5
\textsuperscript{19} ISS COVID-19 report n. 4/2020 rev
receive assistance (food, clean clothing, medical attention if necessary, and any needed medications) and can interact with only some staff members, who are protected. A communication channel between the people hosted under quarantine and the staff must remain open at all times.

d) Training of staff and providing health education of people hosted

The assistance staff plays a fundamental role in preventing and controlling infection and therefore must be adequately trained to take on the management of the activities and contacts with the people hosted.

Training must also involve any staff members who are not directly involved in assistance activities (e.g., maintenance, security, etc.) so that they themselves do not become vectors of infection. Training must be embedded in the local organizational level. Third sector personnel that work in contact with populations living in poorly organized impromptu dwellings must be trained the same as those working in well-structured facilities. When identifying their own volunteer staff who will apply the operational procedures, it is recommended that third sector organizations identify those volunteers who have already been trained or who have professional skills to give training priority to staff members who do not have any.

The subject of training must be knowledge of SARS-CoV-2 infection so as to understand the mechanisms of its spread and thus the behaviours necessary to prevent outbreaks. Included must be knowledge of the rules of hygiene and social behaviour as well as promoting the correct use of protection measures (hand hygiene, correct use of masks and DPI, both for routine activities and for interacting with suspected cases in isolation) by staff and by the people hosted. Training on personal hygiene measures must guarantee that those who receive training can pass this information and correct behaviours on to the other staff working in the centre. The objective of training is to make the staff capable of safely managing routine daily operations of cleaning areas and objects and disinfecting the same in the event there is no professional cleaning service to perform these tasks. Training on the correct application of operational procedures tends to raise staff awareness on what the tasks are of each position held in terms of the information flow (from whom information is received and to whom it is directed). This is
possible only by sharing the procedures proposed, discussing any parts that are not clear and activating a system of feedback between staff and the hosted people concerning the actual functioning of the procedures themselves so as to be able to propose any corrections that would bring about increased effectiveness.

Non-medical staff will be trained on the early detection of signs and symptoms of possible infection among the hosted population (see Box 1), including by means of a structured questionnaire. Adequate instructions will be given to provide the hosted population with useful information and to reinforce the meaning of the messages concerning prevention measures and appropriate behaviours, starting with personal hygiene, personal protection and physical distancing.

e) Information flow

The epidemic control system is based on the early identification of cases, on their isolation and on identification of contacts by area public health and hygiene services of the Department of Prevention of the local health authorities. Its activity depends on the reporting of cases by general practitioners and other health care professionals and workers, as well as by ordinary citizens. To this end, the regions and autonomous provinces have publicized the emergency COVID-19 contact numbers for that specific purpose. 20

Therefore, for an information flow to be effective, the contact persons in the community (director of the centre or the person who has been charged with these tasks in non-organized places) must be identified to whom information on a case detected during daily checks is reported. These persons must receive clear instructions, ideally agreed on with the Department of Prevention, concerning who must be alerted and how to report the case (informing the Department of Prevention by calling the regional number, informing general practitioners, etc.).

In terms of the healthcare services, therefore, it is important that the local health authority be informed concerning the reception centres and facilities present in its area, along with the characteristics of the same, so as to be able to react quickly to the

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20 Ministry of Health, COVID-19, Regional toll-free numbers and travel info http://www.salute.gov.it/portale/nuovocoronavirus/
detection of a case in the community. For those places with little or no organization, it is important that the Department of Prevention be involved in a partnership developed to manage risk reduction, intervening thus not only in the definition of the modes of communication but also in deciding beforehand how cases are to be handled.

**Specific preparatory activities in those settings with little or no organization**

In the settings with little or no organization, which can be patchy and at times impervious, the community is often the beneficiary of outside support, and the third sector plays the main role. Given this, the third sector can be leveraged for prevention and surveillance, along with its contribution to assistance and provision of essential needs. In other words, the third sector has an important role that, though final responsibility lies with the healthcare services, provides auxiliary support to prevention and surveillance. But risk management in these particular settings is possible only if, aside from collaboration between the public sector (social services and local health authorities) and third sector organizations that work directly with the most vulnerable, the community itself is actively involved.

The involvement of third sector organizations must be based on forms of partnership and collaboration that ensure, notwithstanding the responsibilities as described by the regulation in force, the definition of relative tasks and responsibilities, including the safeguarding of the staff and volunteers of the organizations themselves. In these settings, what is most important is the timely identification of all players, public and private, that can effectively contribute to controlling the epidemic, just as it is necessary to assess the level of attributable risk. The responsibility for maintaining physical distance is generally entrusted to those who live in that particular place; nevertheless, some prevention and risk mitigation strategies can be identified that foresee the collaboration between third sector organizations and public bodies (social services and the Department of Prevention) that are based on involving the resources of the community.

Aside from guaranteeing the continuity of basic assistance services, increasing the number of toilets available in proportion to the number of individuals assisted and facilitating, where possible, the availability of running water and soap and hand sanitizer.

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21 Pursuant to art. 12, co. 1, of d.lgs. n. 31/2001, the regions have the responsibility for the “provision of measures to make possible an emergency water supply to provide drinking water […] for the minimum quantity and period necessary to meet contingent local needs” as well as for “the exercise of substitute powers in cases of inaction of the competent local authorities in adopting the measures necessary for the protection of human health in the drinking-water supply sector.”
in impromptu dwellings, an approach towards a reorganization of services must be agreed on, starting with identifying specific spaces and places – even when not physically separate – to carry out assistance activities safely, maintaining physical distance as much as possible.

Further, it is reasonable to propose to the community its subdivision into groups, preferably based on family relationships, to limit to the utmost any and all contact with anyone outside of the group to which one belongs. This approach, in the case of a cluster in any one of the groups, means that infection can be contained within the group, thereby tracking and assisting fewer people.

In non-organized settings, therefore, every effort must be made to ensure the availability of masks and hand sanitizer to everyone. As it is not possible to keep a minimum stock, the associations must be made aware of the importance of charging a person with the responsibility of guaranteeing, in relation to the supply chain, the immediate availability of these items. All association staff members that interact with the people in these places must wear DPI and must receive the same training as staff in organized reception centres. The recommendation concerning the adoption of collaboration protocols (see below) is also aimed at meeting training needs, which vary according to the actors involved and the level of organization of the context.
An analysis of the settings brings to light the fact that they can be grouped based on the degree of organization and on the freedom of movement the people hosted have with the outside. In particular, two operational procedures can be identified; the first concerns organized reception, which takes into account the needs of open and closed communities. The second concerns settings with little or no organization, where the preparatory actions, first of all engaging civil society and the third sector, play a central role.

a) Procedures in organized reception

Entry into the reception system

At the border, whether land or maritime, it is recommended that, along with the assessment of any vulnerability or specific needs, the persons who have just arrived irregularly undergo a nasopharyngeal swab performed by the local health authority to determine whether that person is positive for the SARS-CoV-2 virus. This recommendation is based on the need to assess quickly, specifically and appropriately whether the person is infected so as to be able to place that person in the right form of accommodation with specific types of isolation, in the absence of the person’s having a private domicile, in such a way as to protect the health of that person and of the community that hosts him/her.

According to the result of the swab:

1. **positive subjects** are put in isolation in pre-identified spaces or facilities after
informing the health authorities.\textsuperscript{22}

2. **negative subjects in groups with confirmed positive cases** are put in quarantine by the health authorities in the facilities indicated in point 1 above, but in a completely separate area from where those in isolation are placed. Where it is not possible to guarantee such absolute separation or to assign negative subjects there due to the unavailability of free places, they are accommodated for the quarantine inside pre-identified, specific areas in the reception centre.

3. **negative subjects in groups with no confirmed positive cases** are put in quarantine in spaces in the reception centres specifically identified for that purpose.

Unaccompanied foreign minors must spend their period of quarantine/ isolation preferably in centres for unaccompanied foreign minors, in areas specifically dedicated and arranged for that purpose (Repertorio n. 80/CU of 9 July 2020). For the management of such areas, see ISS COVID-19 report 1/2020.

Access to the quarantine areas, which takes place through specific pathways established previously within the centre, is reserved only to service staff wearing adequate DPI to clean the rooms and to deliver and pick up meals and bedding to each room. Health authority personnel can access these areas to carry out health surveillance.

**Transfers**

The reception system foresees the internal advancement of the people hosted in relation both to the phases of the pathway and to the availability of places in the facility. There are two types of transfer:

- immediate transfer upon arrival in Italy to complete the period of isolation or quarantine (T1 in Fig. 5). It is compulsory to wear a surgical mask on the transport vehicle as well as to maintain physical distance and to disinfect their hands. The

\textsuperscript{22} See footnote 8 on page 13
driver of the vehicle must wear an FFP2 respirator, as must accompanying personnel, who must also wear a disposable gown, gloves and protective glasses.

- transfer after completing isolation/quarantine (T2 of Fig. 5), during which all passengers, including the driver and accompanying personnel, must wear surgical masks and respect the rule on physical distancing and hand hygiene. These procedures also apply to organized transfers from one reception centre to another.

To avoid repeated clinical examinations and tests that are inappropriate for the migrant and to support the continuity of care, in the occasion of transfers as described in point 2 above (T2), the migrant brings with him/her the relevant clinical documentation.

Access and stay in organized reception facilities

Upon arrival in all organized reception facilities where a staff member is always on duty, there must be one point of entry only in an area set up for the early identification of any suspected cases; all those entering must do so one at a time and in a controlled manner.

During the early identification process (Box 2), the person entering must wear a surgical mask, provided by the staff member if necessary. The latter will carry out the following three procedures:

1. take the person's temperature with a device that does not require contact with the person being examined (e.g., using a scan thermometer) to ensure that body temperature is below 37.5°C;
2. examine the person for signs and symptoms of COVID-19;
3. request information about close contact with anyone who is SARS-CoV-2-positive;

Procedures 2 and 3 are carried out with a short structured questionnaire; a cultural mediator is available to assist when necessary.

If all three procedures are negative, the person can enter the centre.

23 Instructions taken from the “Linee guida per l’informazione agli utenti e le modalità organizzative per il contenimento della diffusione del covid-19 in materia di trasporto pubblico”, recently attached to the d.p.c.m. of 13 October 2020 (see attachment n. 15)
If body temperature is over 37.5° C and/or the answers to the questionnaire confirm points 2 and 3, the person is immediately placed in an isolation room and the Department of Prevention of the local health authority is alerted to carry out all necessary investigations and measures.

These procedures, which function as a sort of triage in the broadest sense, ensure early detection of any and all suspected cases. As such, they must be performed by the person responsible even in small facilities, where there is not always a staff member on duty.

In the CPR, which do not allow the people hosted any freedom of movement outside the facility, at triage upon arrival:

a) anyone who has been detected by police personnel in the territory must present documentation that a negative nasopharyngeal swab for the SARS-CoV-2 virus was performed in the preceding 48 hours.

b) In the event that he/ she cannot present said documentation, the person undergoes the nasopharyngeal swab on entrance to the facility and is put in isolation inside the centre until the result is available.

c) If, instead, the person is arriving directly from a hotspot or a CPA in which he/ she has completed the period of quarantine, he/ she must show documentation of a swab done in the preceding 48 hours. In the event certification of a swab performed in the preceding 48 hours is not available, entry takes place following point b) above.

**Stay in open centres**

In those centres where there is always a staff member on duty, it is recommended that triage, as described above, be performed once daily. In those centres, instead, where the continuous presence of a staff member is not guaranteed, the triage procedures are performed by persons who are tasked to do so; these may be the guests themselves, who have been trained specifically to do so; when a staff member is scheduled to be present, he/ she performs triage.

According to the procedures agreed on previously, in the event of a suspected case, the person in charge of the centre telephones the Department of Prevention of the local health authority; should the suspected case be enrolled in the SSN, his/ her general practitioner is also informed.
Interim operating procedures for the management of facilities with persons who are highly vulnerable and at high risk of health and social care exclusion during the COVID-19 epidemic

Figure 5 - Management of access to residential and semi-residential centres and day facilities

- **New irregular arrivals from non-Schengen countries**
  - Health assessment and Police identification
  - Nasopharyngeal swab
    - **T1**
      - Positive
        - Quarantine in dedicated accommodation\(^{24,25}\), separate from that for positive cases. If not available, in dedicated areas for isolation in CPA\(^{25}\)
      - Contact with positive
        - Quarantine in dedicated area at CPA if available
    - Negative swab
      - 10 days
      - 14 days
      - Transfer to assigned facility\(^{26}\)

- Triage on entry
  - Yes
    - Perform swab
      - Negative swab
        - Close facility\(^{27}\)
          - Yes
            - “Triage” on entry
          - No
            - Transfer to another facility
  - No
    - Result of swab in preceding 48 hrs
      - Yes
        - Admission to facility\(^{26}\)
      - No
        - Transfer to another facility

\(^{24}\) See footnote 8 on page 13 of this document.

\(^{25}\) Whenever possible, unaccompanied foreign minors, whether positive or negative on swab, must undergo the corresponding period of quarantine/isolation in specific areas for this purpose in the centres for unaccompanied foreign minors.

\(^{26}\) Modes of transfers are defined in Chapter 6, letter (a).

\(^{27}\) Facilities may be closed due to their structural characteristics (CPR) or by provisions of government authority.

\(^{28}\) Open facilities may be residential (e.g., homeless night shelters, CPA, CAS, SIPROIMI), semi-residential and day centres (e.g., day shelters, low threshold services).
In the meantime, the managing body shall implement the isolation measures of suspected cases until the outcome of the verification performed by the Department of Prevention is received; all the precautions as set out in the current procedures will be taken. Personnel will proceed with direct assistance of the suspected case in isolation, entering the room as infrequently as possible and using suitable DPI (including FFP2 respirators). When it is not possible to guarantee effective isolation measures in the centre itself, the local health authority will determine whether the suspected case is to be transferred to a specific external facility, taking into account the personal conditions of the subject (i.e., age, sex, any condition of vulnerability or need of assistance, for example, a disable person).

b) Procedures in situations with little or no organization

It has already been mentioned that, given its daily contact with the groups of assisted people, the third sector can support the functions of monitoring the health of the same during the course of providing assistance or essential services by, for example, taking their temperature and collecting information using a short structured questionnaire. These routine tasks help the Department of Prevention quickly identify any suspected case, limit the event to a small group in the community and assist infected persons to avoid any possible outbreak. In the effort to mitigate risk, therefore, and even harm, timing and proximity are the two drivers of active community surveillance and of the early identification of cases.

To mitigate risk, it is therefore necessary to conduct an epidemiologic evaluation of each site to determine the risk of infection, based on the national and local epidemiologic situation, the health-related characteristics of the community and the characteristics of the site in terms of whether they amplify transmission (i.e., identify within the site those areas at risk of overcrowding or with a higher percentage of vulnerable persons). On the basis of this evaluation, a specific plan of preparation and response must be developed for each community site or for types of sites (e.g., RSC camps, occupied buildings, etc.), in line with national and local plans, that takes into account the specific risks and clearly defines communication with the local health authorities.

A community that is properly trained and made aware, therefore, plays an important part
in the early identification of cases. Considering the difficulty in identifying and assessing the health conditions of new arrivals, the community must receive clear instructions concerning behaviours to adopt to prevent transmission, DPI must be guaranteed available and information must be provided on the symptoms of COVID-19, how to behave in the presence of suspected cases and to whom cases should be reported.29 These instructions should be conveyed, when necessary, in multilingual informative material30 and should be properly communicated to the trained volunteer or professional staff. The operating protocol, set out later in the text, represents the ideal instrument for identifying these persons in the third sector bodies or administrations involved (in particular, municipal social services and local health authorities) so that their availability can be confirmed or, if not, that identifying suitable persons can take place.

Further, all assistance services must remain active, even on site, or they must be strengthened based on the aforementioned evaluation (distribution of food and other essential items, registration/enrolment for assistance, education, etc.). These services must be organized in such a way as to avoid that crowds form and to limit contact with others as much as possible. In this case, distribution must be processed and organized so as to maintain physical distancing (organization in multiple shifts, days of distribution and different distribution points).

The staff that provides these services must be adequately informed of the risks of possible infection deriving from their activities and must, therefore, follow all instructions to contrast the spread of the virus. Any staff member who identifies a suspected case or who receives information that a person using the services is waiting to do the swab must immediately inform the contact person tasked with signalling the case to the local health authority. The contact person must also begin to collect information on any close contacts of the suspected case to support the Department of Prevention in carrying out prevention measures and isolation. It is essential, therefore, that the chain of communication with the contact person and the reporting of suspected cases, as previously defined, is respected.

In impromptu and makeshift dwellings, it is also important to consider negative cultural

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29 Identification of subjects and arrangements for the implementation of these activities should be the subject of the cooperation protocol – see Box 6.

30 For information, numerous multilingual resource materials are available online concerning infection prevention and management, including material developed by INMP (https://www.inmp.it/ita/Coronavirus-cose-da-sapere) and by the ARCI-UNHCR (https://coronavirus.jumapam.com/it_it/).
Interim operating procedures for the management of facilities with persons who are highly vulnerable and at high risk of health and social care exclusion during the COVID-19 epidemic

**Figura 6 - Checklist for the management of settings with little or no organization**

**Establish partnership between institutions and third sector organizations regarding settings with little or no organization**

- The associations that operate in the setting have been recognized.
- Responsibilities and roles have been defined.
- Effective communication between subjects providing assistance has been established.
- The sharing and spread of procedures among staff and community members have been ensured.

**Qualify the specific risk of infection attributable to the setting**

- The setting population and level of turnover have been identified:
  - Degree of overcrowding
  - Average age
  - People with chronic conditions
  - Language barriers
  - Other (specify) __________________________

- The availability of the following services has been assessed (from 0% to 100%):
  - Running drinkable water .......%
  - Showers .......%
  - Toilets .......%
  - Waste disposal .......%

**Actions to mitigate risk and identification of person in charge of each action**

- The population has been broken down into groups that access services at different times.
- Availability of DM/ DPI (masks, hand sanitizer, waste bins) has been ensured.
- Adequate amounts of drinkable water, food, bathrooms, showers, waste disposal are available.
- Alternative accommodation solutions are available for the most vulnerable.
- The staff members that provide a specific service on every specific day are registered.
- Staff members have received training on procedures.
- Information material on symptoms, infection prevention measures and how to use DPI has been made available, taking into account linguistic and cultural barriers.
- Each person in the community is provided with DPI (masks) and with disinfectants (hand sanitizer).

**Apply measures for early identification of cases**

- The main moment of daily contact between staff and community has been identified to take temperature and note signs/ symptoms during history taking.
- Instructions regarding symptoms, infection prevention measures and use of DPI are available.
- The community has been informed of the name of the person in the third sector organization in charge to whom onset of signs/ symptoms and at-risk contacts should be reported.

**Define modes of assisting suspected cases**

- The place and manner of isolation while awaiting the assistance of the Department of Prevention have been identified.
- Modes of communication with the Department of Prevention have been defined.
- The contact person at the Department of Prevention who manages the case has been identified.

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31 Including third sector associations, municipal social services, local health authorities, prefectures, community representatives.

32 See topics to be discussed in the collaboration protocol (Box 6)
and social mechanisms relative to the limited amount of space in the available accommodations and to any grouping of people based on relationships other than family relationships (e.g., children and women of different families sleeping together, adolescent and adult men sharing lodgings). In the case of individuals at particularly high risk of having a serious form of COVID-19 due to pre-existing health conditions, they must have priority in terms of being offered an alternative accommodation or, at the very least, receive greater attention from the staff of third sector organizations to provide more in-depth health checks and to use directly observed therapy (DOT) techniques of those with chronic diseases. If guaranteeing effective isolation measures in a given setting is not possible, the reference local health authority will determine whether the guest should be transferred to a specific external facility, taking into account the personal conditions of that person (i.e., age, sex, any situation of vulnerability or need of assistance, for example, a disabled person).

In conclusion, it is strongly recommended that the public body or bodies (local health authority and the municipality) formalize an operating protocol\textsuperscript{33} with third sector organizations that operate in this context in which the specific role of the third sector workers is defined within the framework of public action of prevention and active surveillance of hard-to-reach and hard-to-treat populations. These activities in support of public health actions will be performed essentially in encounters with such populations for the distribution of food and antiseptic products and when providing essential services.

The community itself, having received clear, culturally oriented information on the signs and symptoms to take note of, becomes an active player in prevention, mobilizing its potential in the service of the public good and thus helping to better qualify the right to citizenship of members of that community.

\textsuperscript{33} See recommended contents in Box 6.
The PubMed search engine was used to identify published studies on the topic. A search string was developed using some keywords related to the reference population (migrant, refugee, asylum seeker, drug user), to the setting (repatriation centres, reception centres, squatter settlements, etc.), to the outcome considered (prevention of SARS-CoV-2 infection) and to the type of study (review, guidelines, operating procedures). The search produced 136 results; of these, 115 were excluded because they were not deemed pertinent. Thus, 21 studies were considered potentially of interest, but after further evaluation, no study proved to be pertinent to the specific purpose of this document. Instead, a search of the websites of national and international institutions as well as those of the Italian regions and autonomous provinces made it possible to retrieve some documents that were completely or partially relevant to the focus or to technical aspects of this document. Some of the websites consulted include the Italian Ministry of the Interior, the Italian Ministry of Health, the Italian National Institute of Health (ISS), the World Health Organization (WHO), the European Centre for Disease Prevention and Control (ECDC), the Centers for Disease Control and Prevention (CDC), the Inter-Agency Standing Committee (IASC), the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) as well as the websites of EU agencies.
8. REFERENCES

- Centers for Disease Control and Prevention (CDC), 2020. Interim guidance for homeless service providers to plan and respond to coronavirus disease 2019 (COVID-19).


- European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2020. Aggiornamento dell'EMCDDA sulle implicazioni della COVID-19 per le persone che fanno uso di droghe e gli erogatori dei servizi per le tossicodipendenze.


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• Istat-Ministero della Salute. Primi risultati dell'indagine di sieroprevalenza sul SARS-CoV-2. 3 agosto 2020.


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• Regione Piemonte - Direzione Sanità e Welfare - Settore Prevenzione e Veterinaria, 2020. Linee di indirizzo per le strutture di accoglienza, servizi destinati ai minori e per i servizi di prevenzione e contrasto alla violenza.


• Servizio centrale del Sistema di protezione per titolari di protezione internazionale e minori stranieri non accompagnati, “Circolare operativa per la
rete SIPROIMI in conseguenza delle disposizioni di cui all’art. 86 bis legge 24 aprile 2020, n. 27” (prot. 6564/2020, 4 maggio 2020).

The definition of case (suspected, probable and confirmed) is important not only to making a diagnosis quickly and prescribing any necessary treatment but also, and above all, to carrying out the specific actions of isolation and quarantine in the effort to reduce the possible risk of infecting other, healthy subjects. The definition of suspected case, as formulated by the WHO and adopted by the Italian Ministry of Health, foresees the association of various conditions.

A person with acute respiratory infection (sudden onset of at least one of the following symptoms: fever, cough, difficulty breathing) and for whom at least one of the following three conditions applies:

1. travel to or residence in a country/ area where local transmission of the virus was reported during the 14 days prior to symptom onset
2. close contact with a probable or confirmed case of COVID-19 in the 14 days preceding symptom onset
3. hospitalisation has been necessary (SARI - severe acute respiratory infection), with no other aetiology that would fully explain clinical presentation

In the current epidemic, during which the virus clearly continues to circulate, and taking into account the conditions of the settings considered in this document, which favour transmission, adopting a criterion of greater caution, similar to what is provided for in primary care or emergency departments, is opportune. As a result, in any type of community, the following definitions apply:

**Suspected case**

1. Anyone who has had a sudden onset of at least one of the following signs/symptoms: fever ≥ 37.5°C, cough and/ or difficulty breathing, with no other cause that would fully explain clinical presentation
2. Anyone who, in the 14 days prior to onset of respiratory symptoms, was in close contact with a probable or confirmed case of infection
**Probable case**

A suspected case whose result on the SARS-CoV-2 test is uncertain or inconclusive according to the specific protocols of real-time RT-PCR assays for the detection of SARS-CoV-2 performed at regional reference laboratories or is positive to a pancoronavirus RT-PCR assay.

**Confirmed case**

A suspected case that has tested positive on a nasopharyngeal swab for the virus, regardless of whether there are any clinical signs or symptoms. It is extremely important to report (notify) all confirmed cases to the local health authority of the geographic area where the facility in which the confirmed case was detected is located.

It is extremely important that all the reception staff immediately report suspected and probable cases identified in their community to the local health authority in order to confirm suspicion and to assist these cases and their contacts.

**Close contact with a probable or confirmed case**

- anyone who lives in the same house as a COVID-19-positive case
- anyone who has had direct physical contact with a COVID-19-positive case (e.g., shaking hands)
- anyone who has had direct, unsafe contact with the secretions of a COVID-19-positive case (e.g., touching a used paper tissue)
- anyone who has had direct face-to-face contact with a COVID-19-positive case, at least 2 meters distance and for at least 15 minutes
- anyone who has been in an indoor environment (e.g., classroom, conference room, hospital waiting room) with a COVID-19-positive case without appropriate PPD
- a health worker or other person who provides direct assistance to a COVID-19-positive case or laboratory personnel who handle samples from a COVID-19-positive case without using DPI or using unsuitable DPI
- anyone who has traveled by train, plane or any other form of transportation and was seated within two seats (facing any direction) from a COVID-19-positive case. Close contact includes traveling companions and any staff of the section of the plane/train where the case was seated.
The presence of at least two confirmed cases in the same area and in the same period represents a cluster. When the numbers are higher, this is an outbreak, i.e., an increase in the number of cases compared to the expected number in a well-circumscribed community or region.

**Asymptomatic positive cases**

Those asymptomatic persons who are positive to the SARS-CoV-2 test can return to community housing after at least 10 days of isolation from the date of the positive result, after having tested negative on the molecular test (10 days + test).

**Symptomatic positive cases**

Those symptomatic persons who are positive to the SARS-CoV-2 test can return to community dwelling after isolation starting 10 days from symptom onset (excluding anosmia and ageusia/dysgeusia, which may persist over time), with a negative molecular test performed after at least 3 days without symptoms (10 days, with at least 3 days without symptoms + test).

**Long-term positive cases**

Those persons who, despite no longer having symptoms, still test positive on the SARS-CoV-2 molecular test, are symptom-free (except for ageusia/dysgeusia and anosmia, which can persist long after recovery) for at least one week can stop isolation 21 days after symptom onset. This criterion can be modified by the local health authority in agreement with clinical experts and microbiologists/virologists, taking into account the immune status of the persons in question (immunosuppressed patients may be contagious longer than are healthy subjects).

**Asymptomatic close contacts**

Those persons who have had close contact with cases of SARS-CoV-2 infection that have been confirmed and identified by health authorities must observe:

- 14 days of quarantine since the last exposure to the case, or
- 10 days of quarantine since the last exposure, with a negative result on either an antigenic or a molecular test done on the 10th day.
Isolation of documented cases of SARS-CoV-2 infection means separating the infected persons from the rest of the community for the duration of the period of infectiousness in an environment and in the conditions that prevent transmission of the infection.

Quarantine, instead, means restricting the movement of healthy persons for the duration of the incubation period but who may have been exposed to an infectious agent or to an infectious disease. The aim is to monitor any onset of symptoms and to rapidly identify new cases.34

Box 2 - Performing early detection procedures of suspected cases

Assess once a day everyone who enters the facility (facility users, people hosted, personnel, visitors); in settings with little or no organization, perform triage when having contact with persons who access services.

Staff:

- wear FFP2 respirator and disposable gloves and ensure that the person is wearing a mask
- avoid all physical contact with the person, keeping a distance of at least 1 meter
- measure body temperature with a scan thermometer
- ask the person whether:
  - in the last 14 days he/ she had a fever over 37.5°C
  - in the last 14 days he/ she had any of the following symptoms: cough, chills, difficulty breathing, muscle ache, loss of sense of smell and/ or taste
  - in the last 14 days he/ she had contact with anyone with respiratory

34 Circular of the Ministry of Health, 12 October 2020 “COVID-19: indicazioni per la durata ed il termine dell’isolamento e della quarantena”.
In the case of a fever of or over 37.5 °C and/or positive response to at least one of the questions above:

- place the person in a dedicated area for temporary isolation
- take temperature again after 15 minutes
- follow the operating procedures for suspected cases and for informing the Department of Prevention

N.B. In the case the person’s clinical condition is serious, do not perform triage; immediately call the emergency number (112 or 118).

**Box 3 - Transmission of infection**

Knowledge of the transmission of the SARS-CoV-2 virus remains incomplete. The primary mode of infection is when respiratory secretions in the form of droplets of ≥ 5 μm, released when coughing and/or sneezing, come into contact with the mucous membranes of healthy individuals. Generally, the droplets do not spread beyond a distance of 2 meters and fall to the ground quickly, especially when they are larger. The closer two people are, the greater the likelihood of transmission.

Other modes of airborne transmission have also been hypothesized, through smaller particles that remain in the air in the form of aerosol. In this form, it seems that the infectious particle can survive up to three hours. However, data on this mode of
transmission are essentially experimental in nature; infection via aerosol has not yet been demonstrated.\textsuperscript{35} That said, frequently airing out indoor spaces where there are a number of people reduces the possibility of transmitting the virus via aerosol.

Further, the virus survives on surfaces for varying lengths of time according to the material and the viral load. In this case, infection can take place though indirect contact, when a person’s hands have touched infected surfaces and, before having adequately washed them, the person touches his/ her mouth, nose and/ or eyes.

To date, no case of oral-faecal or blood transmission has been reported.

The precise interval during which infection can be transmitted has not yet been established. An increasing number of studies have shown that the virus can be transmitted both in the 2-3 days before symptom onset (preclinical or pre-symptomatic phase) and when the disease manifests, especially during the first week. Although the scientific community does not agree on recognizing the infectiousness of asymptomatic positive cases, caution dictates that these individuals should be subject to the same provisions of isolation as paucisymptomatic/ symptomatic individuals.

Ultimately, the risk of virus transmission depends on a series of environmental factors, including the type of exposure (the type of activity being done at the moment of contact, whether indoors or outdoors, in a crowded place or not), the duration of exposure and the use of DPI. The risk of infection is greater among people who live together, especially in a community of any sort, but it is also high for those who participate in group events, whether for work or for pleasure, especially if these events take place indoors.

\textsuperscript{35}WHO. Transmission of SARS-CoV-2: implications for infection prevention precautions. Scientific brief 09 July 2020
The person is isolated in a single room with, if possible, a private bathroom. In the case of a number of SARS-CoV-2-positive cases, these can share the same rooms (cohort isolation).

**a) What the positive case must do**

- stay in his/her room or in dedicated areas
- if bathrooms are shared, carefully clean all surfaces with disinfectants
- wash hands often with soap and water or with an alcohol-based solution. Dry hands with disposable hand towel.
- regularly air out his/her room to ensure adequate fresh air
- avoid sharing any objects, including towels, sheets, plates, glasses, cutlery, etc.
- sneeze or cough in a disposable tissue, avoiding touching respiratory secretions, and carefully wash hands immediately with soap and water or rubbing hands together with a hydroalcoholic product for at least 40 seconds.

**b) Assistance provided to persons in isolation (health workers or reception centre staff)**

- limit the number of contacts with persons in isolation and, if possible, maintain a distance of at least one metre
- wear DPI as described in Box 5 below. Once assistance has been provided, the staff member must undress, place disposable DPI in the plastic bag available for that purpose and carefully wash hands
- do all cleaning wearing the DPI as described in Box 5. Handle dirty towels and bed linens used by the person in isolation without shaking them. After having removed disposable gown, gloves, mask and glasses, carefully wash hands.
c) Cleaning during isolation

- the waste produced by the person in isolation (e.g., paper tissues, masks) or for assistance to him/her (disposable gowns, gloves, masks) must be disposed of in a double plastic bag, which will be sealed and thrown out in a closed bin (e.g., foot pedal garbage bin)
- laundry must be collected in a separate bag and must be washed in a washing machine at 60° C for at least 30 minutes, or for less time at higher temperatures. Laundry detergent must be used.
- at least once a day, all surfaces of the rooms and areas used by the person/people in isolation must be cleaned with cleaning products and then disinfected with chlorine-based products (e.g., bleach) at a concentration of 0.5 % active chlorine or of 70% alcohol. Special attention must be paid to surfaces that are frequently touched.
- reusable trays used for food service are to be washed with normal dish soap.

d) Stocks of DM and DPI in the facility

- surgical masks, disposable non-woven gowns, sanitizable protective glasses and disposable latex gloves (see Box 5).
- FFP2 respirator masks (to be worn in the presence of positive cases in isolation)
- cleaning products (everyday products for cleaning and disinfection)
- products to disinfect surfaces and hands. Sodium hypochlorite- (0.5%) and ethanol/alcohol-based (at least 70%) solutions and gels

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36 Sodium hypochlorite-based solutions are sold as bleach in various concentrations. If the concentration is 5% chlorine, the 0.5% solution corresponds to 1 litre of bleach and 9 litres of water. A concentration of 10% corresponds to one litre of bleach and 20 litres of water.
Box 5- Guide to calculating the quarterly need of DM / DPI in reception centres

<table>
<thead>
<tr>
<th>HEALTH WORKERS AND STAFF WORKING IN ISOLATION AND QUARANTINE AREAS</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DM/DPI</strong></td>
<td><strong>Quantity</strong></td>
<td><strong>Number of changes per day</strong></td>
<td><strong>Monthly need</strong></td>
<td><strong>Quarterly need</strong></td>
<td><strong>Number of staff per day</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Disposable surgical masks</td>
<td>1</td>
<td>2</td>
<td>60</td>
<td>180 pieces</td>
<td>N: (………………)</td>
<td>a</td>
</tr>
<tr>
<td>Non-sterile powder-free disposable latex gloves</td>
<td>1 pair</td>
<td>4</td>
<td>120 pairs</td>
<td>360 pairs</td>
<td>N: (………………)</td>
<td>b</td>
</tr>
<tr>
<td>Disposable non-woven gown</td>
<td>1</td>
<td>4</td>
<td>120 pieces</td>
<td>360 pieces</td>
<td>N: (………………)</td>
<td>c</td>
</tr>
<tr>
<td>Sanitizable surgical glasses</td>
<td>1</td>
<td>1</td>
<td>1 pair / operator</td>
<td>1 pair / operator</td>
<td>N: (………………)</td>
<td>d</td>
</tr>
<tr>
<td>FFP2 respirator face masks*</td>
<td>stock 20 pieces</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLEANING AND DISINFECTION STAFF</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DM/DPI</strong></td>
<td><strong>Quantity</strong></td>
<td><strong>Number of changes per day (including DPI / 2 cleaning shifts)</strong></td>
<td><strong>Monthly need</strong></td>
<td><strong>Quarterly need</strong></td>
<td><strong>Number of staff per day</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Disposable surgical masks</td>
<td>1</td>
<td>6</td>
<td>180 pieces</td>
<td>540 pieces</td>
<td>N: (………………)</td>
<td>f</td>
</tr>
<tr>
<td>Non-sterile powder-free disposable latex gloves</td>
<td>1 pair</td>
<td>6</td>
<td>180 pairs</td>
<td>540 pairs</td>
<td>N: (………………)</td>
<td>g</td>
</tr>
<tr>
<td>Sanitizable surgical glasses</td>
<td>1</td>
<td>1</td>
<td>1 pair / operator</td>
<td>1 pair / operator</td>
<td>N: (………………)</td>
<td>h</td>
</tr>
<tr>
<td>Disposable non-woven gowns</td>
<td>1</td>
<td>6</td>
<td>180 pieces</td>
<td>540 pieces</td>
<td>N: (………………)</td>
<td>i</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PEOPLE HOSTED IN THE CENTRE</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DM/DPI</strong></td>
<td><strong>Daily need/ person</strong></td>
<td><strong>Number of changes per day</strong></td>
<td><strong>Monthly need/ person</strong></td>
<td><strong>Quarterly need/ person</strong></td>
<td><strong>Average number of people hosted quarterly</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Disposable surgical mask</td>
<td>1 /person</td>
<td>1</td>
<td>30 pieces /person</td>
<td>90 pieces /person</td>
<td>N: (………………)</td>
<td>l</td>
</tr>
</tbody>
</table>

| **GRAND TOTAL** |   |   |   |   |   |   |
| Surgical masks | (a+f+i) |   |   |   |   |   |
| Non-sterile powder-free disposable latex gloves | (b+g) |   |   |   |   |   |
| Disposable non-woven gowns | (c+i) |   |   |   |   |   |
| Sanitizable surgical glasses | (d+h) |   |   |   |   |   |

*only in cases of isolation of positive cases

The circular of the Ministry of the Interior - Department for Civil Liberties and Immigration, dated 4 February 2020, provides that, with regard to the supply of goods and services in the first reception centres, along with a capacity of 50 places, a permanent medical clinic is guaranteed within the centre. Such a facility is also provided for in the CPR.
Box 6 - Recommended contents when drafting a protocol of collaboration with third sector associations for the management of proximity interventions in settings with little or no organization

1. Identify subjects responsible and indicate the activities normally carried out/responsibilities normally held in the setting:
   a) Qualification of the public subject
      - Prefecture
      - Municipality/Managing body of social services ...
      - Local Health Authority – Department of Prevention ...
      - Other ...
   b) Qualification of the private subject
      - Third Sector Party X ...
      - Third Sector Party Y ...
      - Third Sector Party Z ...

2. Identification of contact person for each subject identified
   - ..................................................
   - ..................................................

3. Identification of any contact person within the community of intervention
   - ..................................................

4. Assignment of responsibilities for identified instrumental actions and relative costs
   a) Management and control of access to places
   b) Risk mitigation measures (of those recommended)
c) Supply of DM/DPI and materials to volunteer staff; identify one person responsible for supply and another for distribution

d) Training volunteer staff

e) Supply DM/ DPI to community members: masks, hand disinfectant, etc. Identify one person responsible for supply and another for distribution (and frequency)

f) Health education of community members regarding the basic rules of hygiene to prevent infection

g) Performing periodic triage in the community: responsibilities and methods

h) Possible methods of active engagement of community members

5. Information flows and management of suspected cases:

   a) reporting suspected case

   b) placing suspected case in quarantine (while awaiting the intervention of the Department of Prevention)

   c) Support in collecting information on contacts – contact tracing

6. Forecasting any insurance coverage for the benefit of third sector volunteers

7. Treatment of personal data

8. Duration of the protocol, review, withdrawal
“Interim operating procedures for the management of facilities with persons who are highly vulnerable and at high risk of health and social care exclusion during the COVID-19 epidemic” is a technical-procedural document whose aim is to provide holders of responsibility at various levels in the management of groups of very vulnerable, marginalised people, both Italian and foreign, clear, easy-to-apply instructions that are consistent with the legislative framework produced in Italy during the COVID-19 public health emergency. The Undersecretary of State at the Ministry of Health, Sandra Zampa, requested that INMP prepare this document, on the basis of the legislative mandate it holds, its experience in the field of equity in health and the guidance documents it has produced on these specific topics. The health problems of people who are highly vulnerable and at risk of health and social care exclusion, in fact, represent the main challenge of modern welfare systems. Such people frequently escape prevention policies as their legal-administrative status may be indefinite, or they may simply be difficult to reach. It is therefore difficult for public services to provide assistance. There is thus the need to produce a useful document that guides standardized national prevention measures in these population groups in the completely new and rapidly evolving context of the coronavirus epidemic. The document provides not only instructions on how to prevent infection and its spread but also a careful assessment of the risks attributable to the diverse contexts in which these people live. This multidimensional assessment considers the organization of dwellings, the freedom of movement towards the outside world people living in facilities have and the demographic and health profiles of these people, all of which play a key role in determining the specific risk of infection and of disease. These three dimensions, therefore, determine the theoretical basis on which the various settings are placed in spatial contexts of risk determined by said dimensions; the settings are the recipients of the operating procedures to manage and mitigate said risk. The ad hoc operating procedures are therefore situated in the context of the Italian migrant reception system, structured as first reception, necessary to carry out the very first interventions of material and health assistance after embarkation or crossing the land border, and second reception in SIPROIMI facilities, which foresee long-term integration pathways managed by local institutions and reception of asylum seekers during the COVID-19 emergency. The procedures are considered ad interim precisely because they concern the current epidemiologic situation and are therefore subject to change in light of any variation in the epidemiology of the novel coronavirus itself. To produce a document that is as complete as possible, INMP has availed itself of the collaboration with various institutional subjects, including the National Association of Italian Municipalities (ANCEI), the Italian National Institute of Health (ISS), the Ministry of the Interior, and the Presidency of the Council of Ministers, with the Department for Antidrug Policies and the Civil Protection Department. We thank them all for their precious contribution.