Children for children wellbeing:
strengthening National Child Care System to guarantee equal rights for all children
European Union's Rights, Equality and Citizenship Programme (2014-2020)
Agreement number: 785676 – REC-RCHI-PROF-AG-2017
Capacity-building in the area of rights of the child1

The Questionnaire of Analysis and monitoring

Good Practices in Sheltered Communities

6th Area Health and Care

6th Area Health and Care

The part related to care and health contains the analysis of many best practices that, at an international level, have highlighted the importance of a link between housing communities and care facilities, especially health.
The importance of the application of these best practices consists not only in the fact that the child's health is monitored and protected, but also in the fact that the child is given the ability and the aptitude to take care of his or her own health and, at the same time, to develop the ability to move within the system of access to care.
For each question, there were four response modes aimed at identifying whether the adoption of good practice by the community is oriented only towards formal compliance or is part of the daily process of education and care of the child.
The first question looks at the relationship between the housing community and the ASP for the care of the child. This kind of aspect is connected to two elements. The first one, already seen in before concerning the ability of the community to establish operational and concrete collaboration relationships with other institutional subjects, aimed at guaranteeing the minor full access to all rights and opportunities.
Regarding the field of health, and in particular the ASP, the possibility of establishing collaboration protocols for the activation of periodic health screening allows the communities, from a practical and operational point of view, to have concrete support in the management and care of the health of the minor, from an educational point of view, to allow the minor to understand the mechanisms and experience the formalities through which it is possible to access medical care.
As specified earlier, an attempt was made to determine, through four modes of response, the type of approach and commitment that communities pour into the adoption of the practice. In this case as well, an approach aimed only at activating formal contacts or mere collaborations that do not lead to a concrete application of the planned activities, serves only to highlight a formal commitment that must be transformed into a concrete and operational commitment. On the other hand, if the good practice is exercised in a constant and continuous manner, activating procedures and processes, it shows how the good practice is applied and how positive effects on the child's growth can be expected.
The activation of collaborations with the NPI core is also an important element. Again, in this case there is the possibility for communities to receive support in a fundamental area for the growth of the child without having to activate internal resources. Even in this case, the response modalities are graded in order to understand if the approach is aimed only at activating a formal relationship or if it is oriented towards the activation of direct and operational procedures.

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In the area of personal care, attention to access to dental care or hygiene is one of the fundamental elements in making the minor understand the importance of proper hygiene and how the process of prevention is also fundamental. As in the case of the other modalities, it is fundamental, for the purposes of our analysis, to understand how much commitment and attention is put in place by the communities.
Psychological support also becomes an element to be paid attention to in the care of the minor, also with a view to promoting his/her autonomy and individual growth. In this case, the attention is not so much in the presence of agreements with third parties, but how these are provided in terms of continuous support by the community. From other parts of our analysis, we know that the communities have such figures in their staff, as the data will then show, it will be one of the useful aspects that will draw a general profile of the strong commitment of the communities on this front.
The last aspect is related to sexual education. We are referring to minors between 14 and 17 years of age, a group in which this type of support and education, if not provided by the family, must be provided by other parties in order for the minor to develop the awareness that this issue requires. As we will see later, the responses will be very diversified and this is determined by the differences between communities. The theme of sexual education is a theme that is very much felt, for example, by women-only communities, while it is felt less in other communities.
The last aspect that we wanted to include in this section is the one related to safety rules. Besides being a good behavioral norm, involving the minor in safety also means allowing him/her to be fully aware of the precautions and risks that can exist in the management of the home and in the performance of daily activities.
Overall, the section measures the degree of attention, and how it is concretely exercised, with respect to the possibility of showing the minor a path to growth and autonomy.

First evidences

Regarding the data that emerged and the responses provided by the Housing Communities involved in the screening process for the emergence of best practices in relation to the sixth area, that of health and care, this is the information that emerges from an initial analysis:

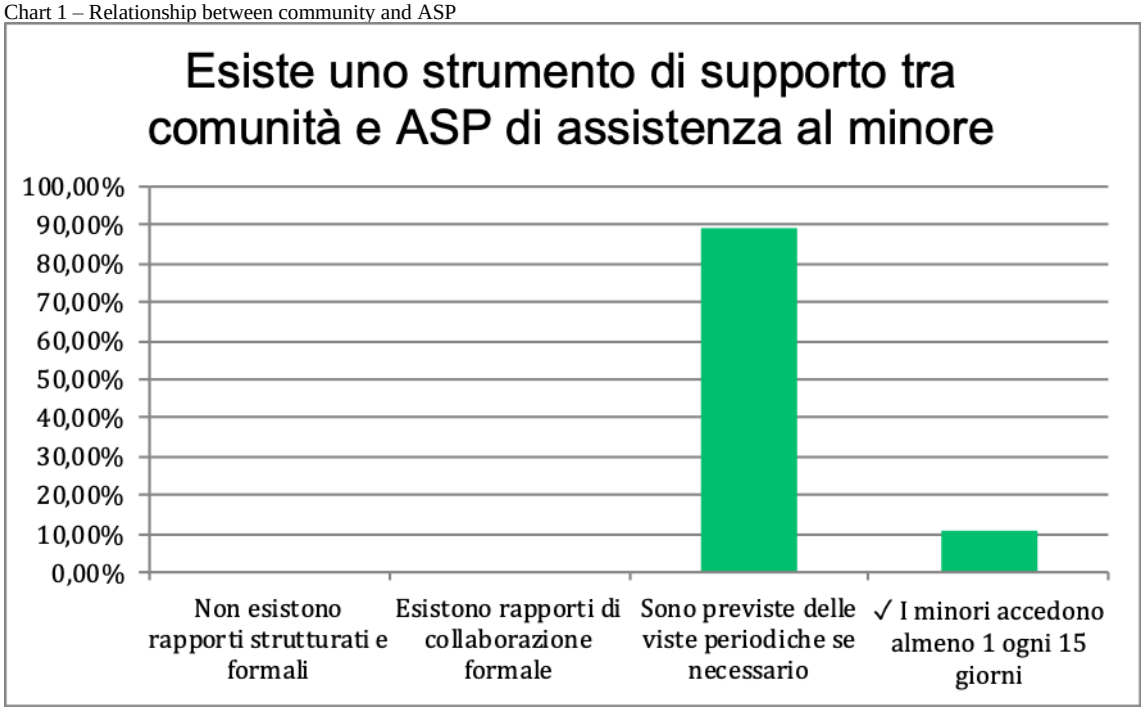
1. Based on the responses collected, 90% of the communities surveyed state that they make periodic visits to ASP outpatient clinics if these are necessary. Only 10% of the communities state that they access care at least once every 15 days. It is clear from the information gathered during the interviews that communities are failing to establish comprehensive screening systems. Access to care when necessary shows that the health of the minor is monitored, but only when a critical situation arises is medical care resorted to. In relation to care leavers, many communities have highlighted the difficulty of providing care for these subjects, given that once they turn 18, it is no longer possible to recover the costs incurred for medical expenses;

2. The percentages for access to NPI care are also identical to those found in the previous question. Ninety percent of the communities interviewed state that they make periodic visits

to the outpatient clinics of the NPI if these are necessary. Only 10% of the communities state that they access care at least once every 15 days;

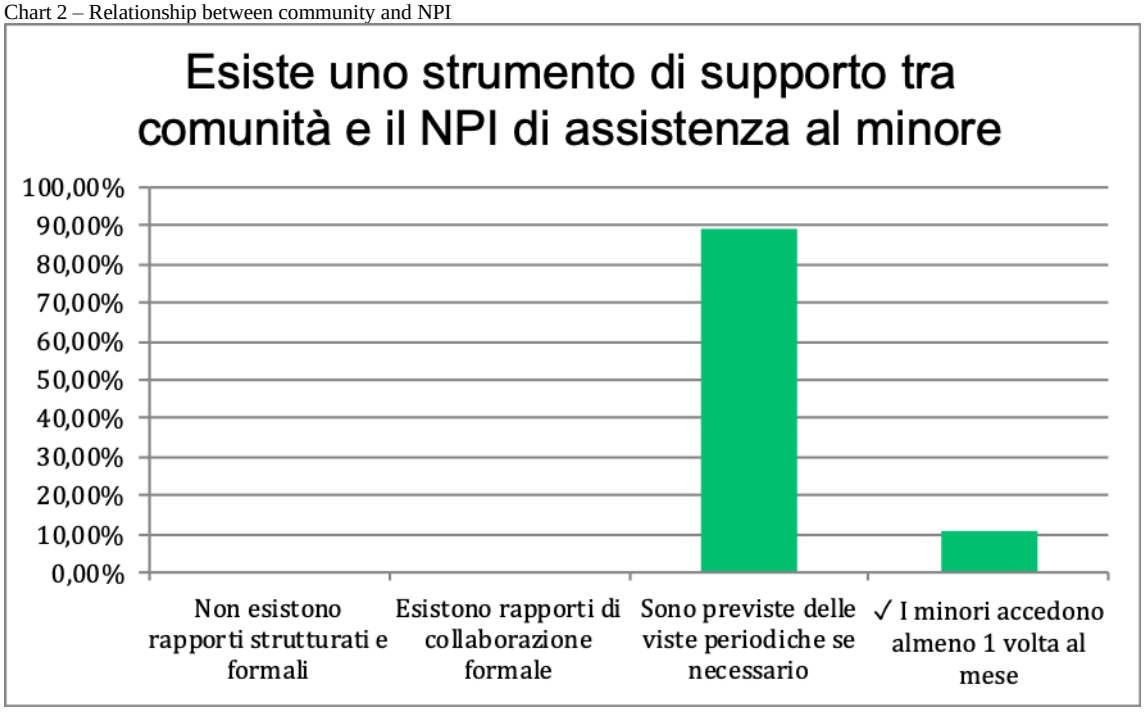
3. The profile of responses related to access to dental care and hygiene is identical to that of the previous two questions. It clearly emerges how there is no consistent screening process. Ninety percent of the responses focus on the mode indicating care as occasional and sporadic, and only 10% indicate constancy in the provision of care;
4. Psychological support is always provided. Almost 35% of the communities interviewed indicated that they provide it occasionally and occasionally, and 65% consistently. The decision to administer the questionnaire directly made it possible to obtain, even for this answer, a more complete vision provided by the stories of the operators. Attention to psychological support is constant in the community, and it is almost a heritage of every educator who tries to read in the minor every signal that might suggest the need for an intervention;
5. The profile of responses linked to sexuality and sexuality education activities is much more jagged and diversified. Twenty-five percent of the communities say they do not provide them, 65% say they provide them occasionally and occasionally, and 10% say they always provide them;
6. The topic of home security and internal rules is treated with great attention. In almost 35% of cases the organizational structure is able to ensure the presence of a person responsible for security, in 20% of cases the communities state that the rules are explained and that activities of this type are carried out occasionally and occasionally, while in 45% of cases the community states that they are always provided;

Chart 1 – Relationship between community and ASP



Q: Is there a support facility of care for the minor between the community and ASP?
Source: Elaboration on data from the questionnaire on good practices

Chart 2 – Relationship between community and NPI



Q: Is there a support facility of care for the minor between the community and NPI?
Source: Elaboration on data from the questionnaire on good practices

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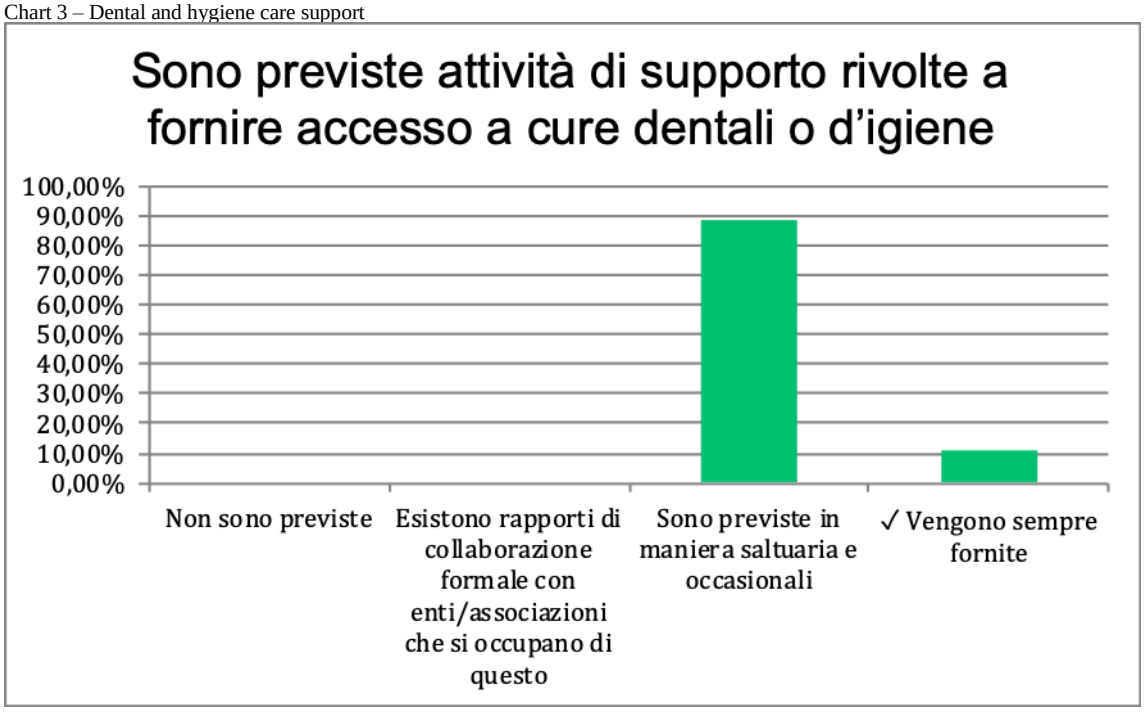
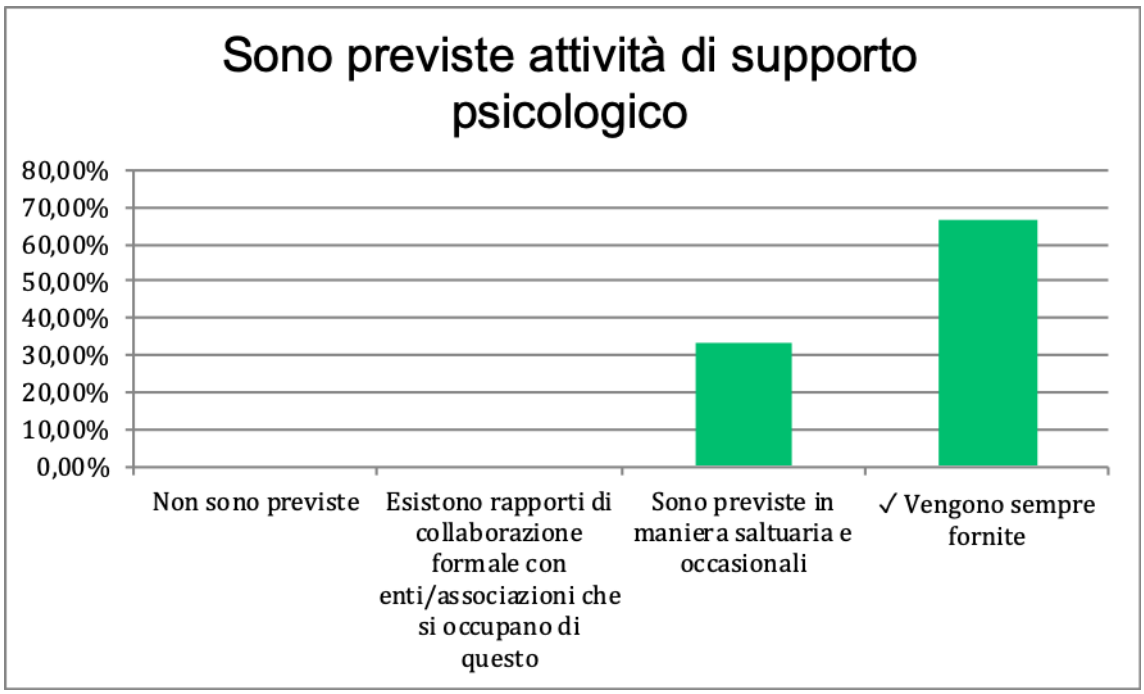
Chart 3 – Dental and hygiene care support



Q: Are there activities aimed at providing access to dental or hygiene care?
Source: Elaboration on data from the questionnaire on good practices

Chart 4 – Psychological support



Q: Are psychological support activities provided?
Source: Elaboration on data from the questionnaire on good practices

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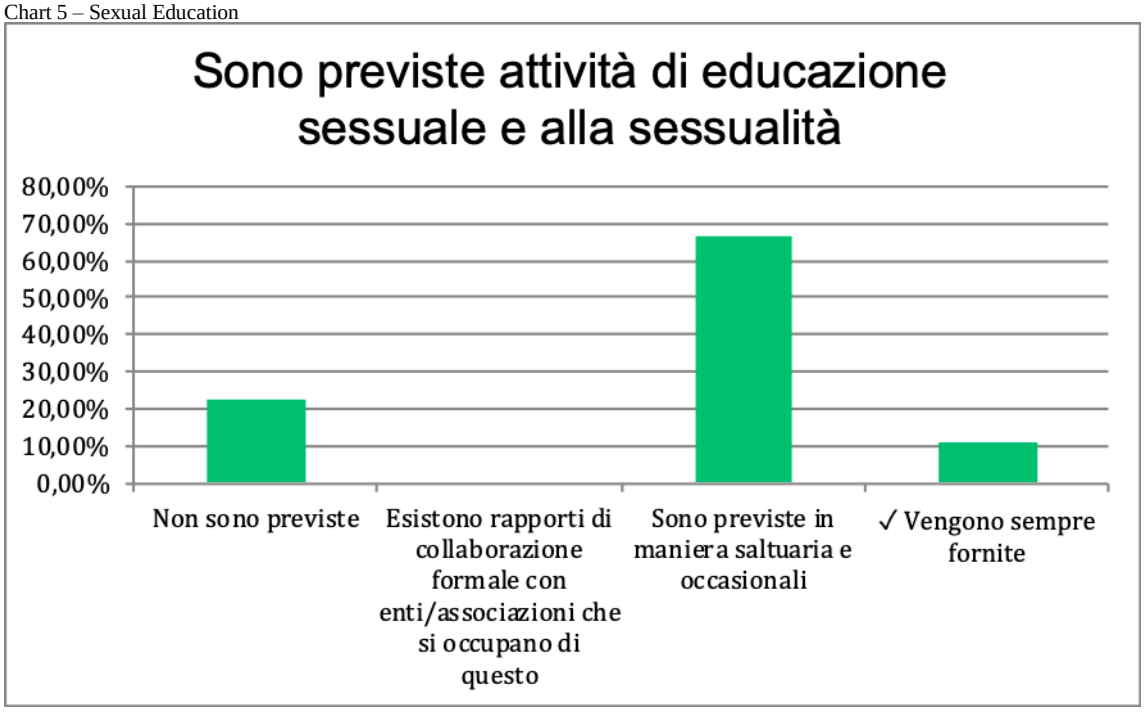
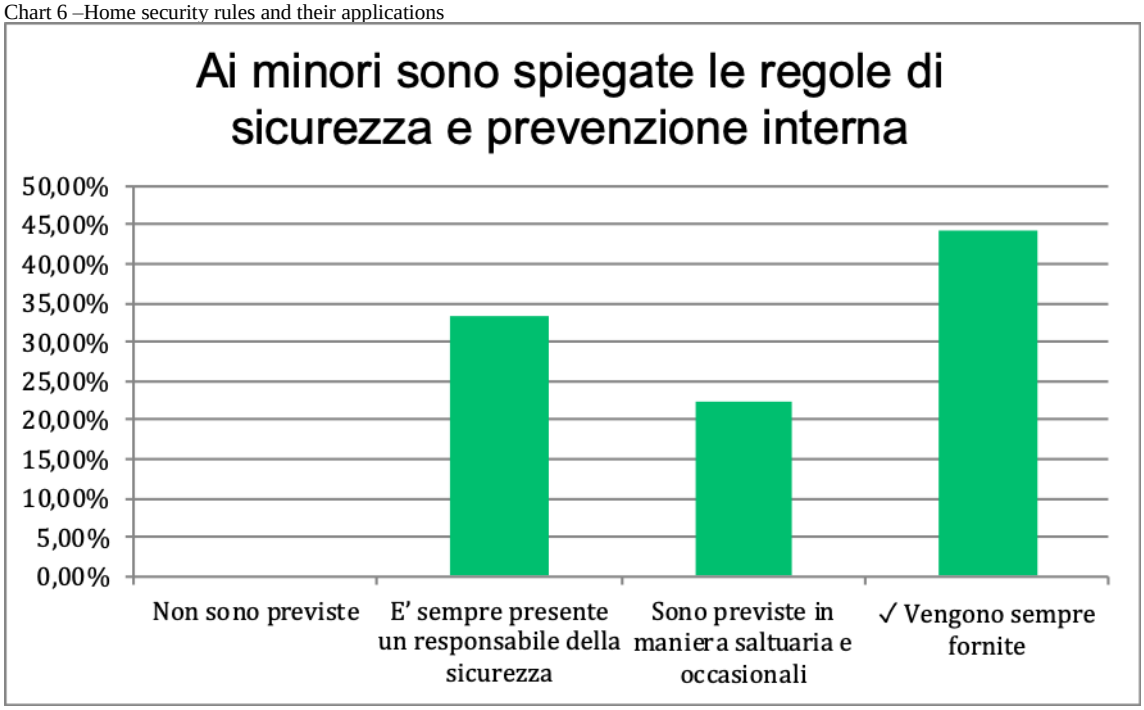
Chart 5 – Sexual Education



Q: Are sex education activities planned?
Source: Elaboration on data from the questionnaire on good practices

Chart 6 –Home security rules and their applications



Q: Are safety rules explained to minors?
Source: Elaboration on data from the questionnaire on good practices

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