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DIVERSITY RESPONSIVENESS IN HEALTHCARE. A MULTILEVEL PERSPECTIVE

BACKGROUND

European health systems have been drawn to the attention of the health of migrants. Complex political, demographic and economic dynamics are changing our societies and health systems are confronted with a highly differentiated population.

In 2008, the World Health Organization called for migrant sensitive health policies, practices and health systems with the WHA 61.17 Resolution on the 'Health of migrants' and in 2017 it endorsed the Resolution on 'Promoting the Health of Refugees and Migrants' that urges Member States to identify and collect evidence-based information, best practices and lessons learned in addressing the health needs of refugees and migrants (WHO, 2008, 2017). Health services have a central role to promote equity and to amplify or mitigate the impact of inequities (O' Donnell et al., 2016). Indeed, «health care systems themselves can also be considered a social determinant of health, interacting with migrant status to perpetuate inequities in health care access» (Marmot et al., 2008 p. 1665).

A key concept in this field is cultural competence (CC) for professionals and organizations, defined as: "a set of congruent behaviors, attitudes, and policies, that come together in a system, agency, or among professionals, and enable effective work in cross-cultural situations" (Cross et al., 1989, p. 28). In the USA, National Standards for Culturally and Linguistically Appropriate Services (CLAS) were developed by the Office of Minority Health (2001, 2013) to provide a common understanding and consistent definition of cultural competent healthcare services. In Europe, a first set of recommendations was provided in 2004 by the Amsterdam declaration 'Towards migrant friendly hospitals in an ethno-culturally diverse Europe'. These definitions expanded the scope of CC beyond the interpersonal domain of cross-cultural care in order to address multiple levels, including the important role of the whole organization.

CC healthcare, in particular, develops organizational commitment, empirical evidence on inequalities and needs, a competent and diverse workforce, access for all users and responsiveness in care provision, patient and community participation, and promote equity through cooperation with other organisations and across sectors (Seeleman et al., 2015). Good practices in culturally competent healthcare often include the training of staff, diversification of the workforce, use of cultural mediators, and adaptation of protocols, procedures and treatment methods (Fernandes and Pereira Miguel, 2009).

Definition and operationalization of CC domains vary referring to different scopes, contexts and types of diversity. For decades the main aim of CC has been matching health services to the needs of migrant users, to bridge 'cultural gaps' (Ingleby, 2011). Over time, some authors criticized CC discourse by highlighting the lack of conceptual clarity around the use of the term 'culture' in clinical encounters and the inadequate recognition of the 'culture of medicine' (Thackrah and Thompson, 2013). The most recent development in the concept of 'cultural competence' has called into doubt the very centrality of the concept of 'culture' itself, arguing instead for the adoption of an 'intersectional' approach. This approach calls for a more general improvement of the health system's 'sensitivity to diversity', encompassing gender, age, religion, disability, sexuality and socio-economic position (Mock-Muñoz de Luna et al., 2015).

In the absence of a consensus on its definitions in the medical field, administrators have implemented cultural competence in various ways and culturally competent care and services at the organizational level is addressed in different ways depending on the local context (Bhui et al., 2007). Organizations do indeed have their own views of cultural competence (Whaley and Longoria, 2009) and an empirical study found that most administrators defined cultural competence through group-based, demographic traits compared to person-centered definitions (Aggarwal et al. 2016).

Reflecting the complexity of CC definition and its translation to practice, it remains unclear which are the best ways to develop and implement cultural competency interventions (Troung et al., 2014). Organizational CC remains heterogeneously implemented and poorly sustained among health professionals (Chiarenza et al., 2015; Seeleman et al., 2009).

Despite advocacy for a systems-level approaches to cultural competence, that integrates practices throughout the organisation's management and clinical sub-systems, by requiring an amalgamation of attitudes, practices, policies and structures, the primary focus in the literature remains on competency strategies aimed at health promotion initiatives, workforce development and student education (McCalman et al., 2017).

Some studies have shown that culturally competent practices among organizations are adopted to varying degrees, but more research is needed in this area (Troung et al., 2014).
A study showed that hospitals have better performance in patient-related cultural competency practices, such as data collection on inpatient populations, interpreter services, and clinical cultural competency practices. However, they tend to lag in integrating **cultural competency into management practices**, such as leadership and strategic planning, Quality Improvement, and **community representation** (Weech-Maldonado et al,2002; .2008; 2012; Whitman & Davis, 2008). These results are similar to those in European studies examining cultural competency activities. In general organisations have difficulties in establishing **specific policies and plans that promote equity in the organisation, in developing involvement and participation of users** in the planning, delivery and evaluation of services and equity through cooperation with other organisations and across sectors (Chiarenza, 2015).

With the concerning low implementation in healthcare, barriers and incentives to organizational change should be considered. Barriers and facilitators of implementation of innovation and change are present at multiple levels of health care delivery: the patient level, the provider team or group level, the organizational level, or the market/policy level (Ferlie e Shortell, 2001). However, efforts to systematically examine the drivers of implementation of innovative culturally responsive practices in health care are limited (Guerrero at al., 2017).

In Italy research into migrant health inequalities remains not extensive (Tognetti Bordogna, 2013). Indeed, it was only this year that the first systematic study on migrants' health was published, reporting evidence of health risk conditions related to social inequalities for migrants' groups and reaffirming the need for the health system to promote diversity responsiveness (Petrelli et al., 2017).
Despite the presence of national migrants' health policies and good practices to improve data monitoring, access to services, structural or training interventions, they remain mostly patchy (Rinaldi et al., 2013). Also it remains unclear what specific messages health care organizations have received and if and how they have acted in relation to international and national directives.

General research questions

The main general question is how cultural competence is implemented in health services in Italy. This project aims to contribute to the understanding of the organizational conditions that influence the implementation and diffusion of diversity responsiveness of the healthcare services, using a multilevel perspective.

In particular we would investigate good practices and organizational conditions to improve: a) migrants' and community participation in designing and implementing services, developing participatory and collaborative partnerships; b) organizational commitment: top management commitment toward cultural competency

The project is organized in two studies: study one addresses the intersection between the political level and the organizational one, i.e. the connection between policies and healthcare implementation, while study two focuses on the organizational implementation and delivery of CC practices.

The study design of study 1 and study 2 and the first results of study 2 will be presented below.

STUDY 1. DIVERSITY RESPONSIVENESS IN POLICIES

Policy and procedural directives represent structural determinants of health and organisations are more likely to develop culturally competent care if political incentives require it (Drogra et al., 2009; Taylor at al.,2014). Policy directives represent the interface between the institutional goals and the care provided by healthcare professionals.

STUDY 1.1 DIVERSITY RESPONSIVENESS IN POLICIES- document analysis

This study examines how Diversity Responsiveness and CC are conceptualized and incorporated in Regional policies i.e. in the Social and Health Plan of three Regions. These three Regions, in previous studies, showed a high level of attention to the health policy on migrants' health and initiatives to improve data monitoring, access to services, structural or training interventions (Geraci et al., 2010; Mipex, 2015)

- We aim to determine whether health equity for migrants is a current driving value in the documents, and how Diversity responsiveness, CC, organizational commitment, and migrants' participation in health services are conceptualized.
- We performed a document analysis and a review framework was developed to analyse documents (Grant et al., 2013; Pinto et al., 2012; Palestini et al., 2010).

Tab. 1 Analysis framework

DIVERSITY RESPONSIVENSS APPROACH AND COMMITMENT
Were the terms explicitly mentioned and defined? • Equity/inequalities • Cultural competence • Diversity Responsiveness
STRATEGIES
What specific strategies for implementation were identified? (Grant,2013)
Were there any strategies involving migrants/ steakeholder participation?
Were there any strategies involving organizational commitment to equity for migrants health (leadership, data and performance, policies, organizational strategic planning)
ATTENTION TO IMPLEMENTATION PHASE
Are there clear, measurable targets and deadlines with processes for monitoring and evaluating progress?
Are there penalties and incentives to promote or aim for uniform implementation or targeted implementation?
POLICY CONSTRUCTION PROCESS
How was it developed and by whom? Were stakeholders involved in the development? (Grant, 2013)

STUDY 1.2 DIVERSITY RESPONSIVENESS IN POLICIES

This study aims at contributing to the existing literature by examining stakeholders' perception of migrant health policies to improve organizational CC, in particular migrants' and community participation and organizational commitment. The perception of significant stakeholders on migrant health policies hasn't been investigate to

understand the interplay between policy and services. Stakeholders are an important source of information in health research, providing critical perspectives and new insights on the complex determinants of health (Shiller at al., 2013).

Main Research Question: How migrant health policies influence the development of organizational CC of health care services in the Italian context?

Specific aims:

- To explore the perception of current policies and policy making-process at the regional level for organizational commitment to equity for migrant's health and promoting migrants' participation.
    - Identify critical areas, areas of improvement and priorities.
- To explore the perception of implementation of these policies into local health service practices.

Method: Semi-structured interviews have been conducted with key stakeholders of Three Italian regions. Interviews last 45-60 minutes.

Analysis: Thematic Analysis (Braun & Clarck, 2006) will be performed to afford direct representation of individual point of view and description of experiences, beliefs and perceptions.

Sample: we include stakeholders of different groups such as policy makers, civil society organizations, health services providers. Purposive sampling was chosen, aiming to reflect the heterogeneity of actors involved in migrants' health issues. Being participation a research topic, it was decided to include, where possible, migrants' associations. The sample size was defined according to practical criteria and the number of participants indicated during the snowball sampling. We have chosen to involve 6/8 people per Region.

Actual sample = 13 participants

	Stakeholder's groups	**Profession**	**Role for migrants'health equity**
Reg 1 **1**	CIVIL SOCIETY ORGANIZATIONS AND ACADEMIA	HEALTH PROVIDER, GLOBAL HEALTH RESERACHER	SIMM (NATIONAL ASSOCIATION FOR MIGRANTS HEALTH) REGIONAL COORDINATOR
2	HEALTH SERVICES	SOCIAL RESEARCHER (PSY)	REGIONAL ORGANISM FOR EQUITY IN HEALTH SERVICES
3	CIVIL SOCIETY ORGANIZATIONS AND HEALTH SERVICES	EPIDEMOLOGIST	EQUITY AUDIT
4	HEALTH SERVICES	HEALTH PROVIDER	PUBLIC HEALTH SERVICES FOR MIGRANTS

Reg 2 1.	CIVIL SOCIETY ORGANIZATION AND ACADEMIA	MED PROFESSOR	SIMM (NATIONAL ASSOCIATION FOR MIGRANTS HEALTH)- REGIONAL COORDINATOR
2	CIVIL SOCIETY ORGANIZATION	SOCIAL REARCHER	SIMM (NATIONAL ASSOCIATION FOR MIGRANTS HEALTH)- REGIONAL COORDINATOR OXFAM
3	CIVIL SOCIETY ORGANIZATION	HEALTH PROVIDER	NGO-HEALTH SERVICES FOR VULNERABILTIES
4	PUBLIC HEALTH	RESEACHER	REGIONAL ORGANISM FOR MIGRANT HEALTH

Reg3 1	CIVIL SOCIETY ORGANIZATIONS AND ACADEMIA HEALTH SERVICES	EPIDEMIOLOGIST	SIMM (NATIONAL ASSOCIATION FOR MIGRANTS HEALTH)- REGIONAL COORDINATOR REGIONAL EPIDEMIOLOGICAL SERVICES- MIGRANT UNIT
2	CIVIL SOCIETY ORGANIZATIONS	HEALTH PROVIDER	SIMM (NATIONAL ASSOCIATION FOR MIGRANTS HEALTH)- member
3	MIGRANT- CIVIL SOCIETY ORGANIZATION	CULTURAL MEDIATOR	PARTICIPANT IN NATIONAL GUIDELINES
4	MIGRANT- CIVIL SOCIETY ORGANIZATION	CULTURAL MEDIATOR	

5	HEALTH SERVICES	MEDICAL DOCTOR, EPIDEMIOLOGIST	CENTRE FOR CANCER PREVENTION IN TURIN

STUDY 2: COMPARATIVE CASE STUDY

1.1 Introduction

Cultural competence has become a very popular approach in healthcare services but there is a continuing debate as to whether interventions to improve cultural competency can lead to a reduction in health disparities caused by racial/ethnic discrimination. Review has highlighted the complexity of research in this area due to lack of consensus of CC definitions, multiple outcomes and methodological issues. Literature tends to gravitate towards practitioners' training, while few studies have examined the impact of systems-level approaches to cultural competence. McCalman et al. (2017) found evidence suggesting that system-level cultural competence should work, but the overall effectiveness of system-level interventions to reform health systems remains unclear because interventions were context- specific to both the country, setting and population, and to the type of health care services concerned. For this they concluded: "There is little guidance for healthcare organisations about how to identify what mix of cultural competence strategies works in practice; when and how to implement them properly".

Furthermore, there is a controversy on the principles that guide CC, on how to approach diversity, and on the importance of individual patient's characteristics versus cultural or group characteristics (Seelman et al., 2015). While focusing on cultural characteristics can lead to stereotype, an individualistic approach to diversity can also carry a risk, because the most serious inequities in health care are strongly associated with differences in group membership and social situation.

Culturally competent practices can be considered an innovation because their implementation requires active coordination between many organizational members and they are not routinely applied in health care settings (Guerrero et al., 2017).

Implementation is a social process that is intertwined with the context in which it takes place. For implementation research, 'context' is the set of circumstances or unique factors that surround and interact with a particular implementation effort (Damschroder et al., 2009).

It has been suggested that CC organizational cultural competence implementation involves an understanding of the strengths and weaknesses of the health care organization and the unique needs of the people it serves. There is an important body of literature about the organizational factors influencing cultural competence but few studies assessed the practical effect of such organizational factors on cultural competence (Dauvrin et al., 2017).The organizational factors often cited are perceived cost-effectiveness, leadership and accountability, organizational cultures and values, staff support (Dauvrin, 2013).

In particular, McCalman's systematic review on organisational system-approaches to improving cultural competence in healthcare (2017) revealed that organizational commitment and patient and community participation are most commonly reported principles for implementing system-level interventions to improve culture competence.

Organizational commitment and patient and community participation are dimensions of several CC frameworks with important implication for implementation and delivery of CC practices. While the importance of user participation is that it results in more responsive care and it helps in identifying appropriate interventions, assuming that healthcare users from diverse ethnic and racial backgrounds often have different worldviews and needs, organizational commitment is critical in creating a culturally competent environment, cohesive workforce and sustainability of CC practices.

1.2 Organizational commitment

Successful implementation of cultural competency requires that the health care organization as a complex structure of interconnected people, policies, and practices can work in concert to achieve the common goal of a culturally competent organization.

Organizational commitment can be described as top management commitment toward cultural competency; it includes integrating cultural competency into strategic planning and throughout all the management systems of the organization, having dedicated staff and resources to achieve diversity goals and promote community engagement (Weech-Maldonado et al., 2012).

Embedding cultural competency in organizational policy documents such as position statements and strategic plans are more likely to result in sustained change within organizations. In particular, leaders, through their statements, behaviors, and allocation of resources, strongly shape both the culture of a health system and how health care personnel perceive system priorities (Cunningham et al., 2014). Theory suggests that leadership affects implementation both directly and indirectly by shaping the organizational context, which then influences employee behaviors (Dauvrin et al., 2017). Providers may be influenced by their organization's commitment and actions in relation to cultural diversity and vice versa.

Previous studies show that healthcare services and managers have several difficulties in pursuing the aim of "working in concert to achieve the common goal of a culturally competent organization":

- Cultural competency means different and conflicting things to various stakeholders (Whaley et Longoria, 2009). Managers and line workers have different perceptions about the meaning of diversity and CC (Aries, 2004).
- Managers have often an individual vision of CC: managers' discourse mainly focuses on the individual practitioner's responsibility for cultural competence practice, with the organisational responsibility largely ignored (Aries, 2004).
- Lack of organizational commitment and support lead to piecemeal and fragmented organizations' approaches to CC and to the lack of perceived administrative support and recognition by frontline professionals (Aries, 2004; Taylor et al., 2010).

1.3 Migrants' and community participation

Migrants' and community participation is multifaceted and involves many components at the managerial and professional level, such as conducting needs assessments and community outreach, utilizing a variety of mechanisms to facilitate community and patient involvement in designing and implementing services, developing participatory, collaborative partnerships (Seelman et al., 2015; Weech-Maldonado et al., 2012).

Participation practices connect health and human service providers with ethnic and racial minority communities in ways that benefit individual health outcomes and behaviors, as well as care delivery systems (Anderson et al., 2015).

From an organizational point of view it requires senior management to prioritise and support and ensure that staff was trained to facilitate the collaborative practice (McCalman et al., 2017). Migrants' and community participation has struggled to overcome significant challenges associated with translating the rhetoric of empowerment and participation into practice. In fact, promoting inclusive participatory mechanisms requires to identify innovative strategies, since the use of standard methods to implement participation may not help much

in improving the accessibility and quality of healthcare services for groups such as migrants and ethnic minorities (De Freitas, 2014; Popay, 2014).

User participation is also a value-laden, culturally and contextually bound, political concept, which is interpreted differently across social groups and cultural, organisational, and political cultures (Snape et al., 2014; Tse, Tang, & Dip, 2012). Studies have examined how user involvement is conducted in health services in Europe. They revealed that health services developed different strategies to promote responsiveness for migrant users such as community mobilisation, stakeholders' sociopolitical development, and community alliances and coalitions. These strategies were effective to engage migrants in health service police, but their involvement appear to be temporary and transitory (De Freitas, 2014 et al.,2015).

Two types of barriers can negatively affect the inclusiveness of participatory mechanisms at the organisational level: barriers that impede representation of certain groups and barriers that hinder the ability of representatives to influence decision-making once they take part in participatory processes (De Freitas, 2014). Service users and other members of the community are usually treated as a homogeneous group of people when in fact they have different needs, values and interests. In addition participatory mechanisms can be ineffective because of laypeople feeling unclear about their role and what is expected of them, a shortage of human and financial resources and infrastructure to support the process, concerns about representation, negative attitudes and resistance from healthcare staff and managers (Ocloo et al., 2015).

1.4 Research gaps and aims

Since much of the research on cultural competence has taken place in North America or Australia, it is reasonable to question the relevance of findings to the Italian setting. Moreover, research that systematically addresses issues such as the response of senior and middle managers to issues of diversity and the dynamics by which managerial policies get translated into action, seems to be limited (Aries, 2004).

This study aims at contributing to the existing literature by examining service strategies to improve cultural competence, in particular exploring strategies of organizational commitment and migrants' and community participation. According to a systemic approach to cultural competence we would understand the perspective of various organizational stakeholders.

The aim is to explore not only 'what works' but also what works where and why (Damschroder et al., 2009). We attempt to address this aim exploring contextual factors that affect effective delivery and implementation in healthcare, considering the interplay between intervention and setting. We focus our questions and analysis on collective perceptions of the CC program, inner and outer setting of implementation.

Due to the different extent of implementation of CC practices in Italy a purpose is to gain an understanding of different drivers of implementations.

2. Method

Comparative case studies have been conducted in healthcare services selected for their engagement in migrant-sensitive care. We chose health care services renowned for their good practices in "participation" and/or "organizational commitment" using different sample strategies (see the par. 2.3). Comparative case studies are particularly useful for understanding a single phenomenon within its real-life context and for explaining how context influences the success of an intervention (Yin, 2005).

Individual interviews for managers and individual interviews or focus groups for frontline professionals. We have conducted document analysis (Bowen, 2009), as Yin suggests to collect evidence from multiple sources. Examining information collected through different methods, helps to corroborate findings across data sets and

thus reduce the impact of potential biases that can exist in a single study. Documents provide background information and historical insight that helps to understand historical roots of specific phenomena.

Interviews

Management Level

These interviews explore the health services commitment to CC and the degree to which senior managers play a direct role in implementing diversity policies (see the appendix). In particular:

- The organization's leadership, policy, and strategy on diversity responsiveness;
- How do managers construct their role and responsibilities in developing CC in service delivery and migrants' and community participation
- how the organization prioritizes cultural competence;
- how the organization integrates cultural competence with service provision;
- systems drivers, facilitators and barriers to implementation and delivery of CC services

Frontline staff level

These interviews explore:

- the ways in which diversity affects workers' jobs;
- the extent to which workers perceive the organizational commitment to CC and to migrants' and community participation
- how workers view the organizational supports for culturally competent care and what additional supports are needed
- systems drivers, facilitators and barriers to implementation and delivery of CC services

Document analysis

Relevant documents on organizational commitment and migrants' and community participation have been included. Those could be: the mission statement, the strategic plan, training plans, performance appraisal, patient education materials policies and procedures, website (Cunningham et al., 2014).

2.3 Sample strategies:

- Health care services have been sampled using different methods: key informants such as national/regional experts of migrants' health issues and web research. In total 5 key informants were involved. 8 health services were identified. We decided to preliminary contact 6 health services sending an invitation to the research via mail and proposing additional telephone meeting.
- We have conducted exploratory interviews with the aim of selecting the health service and a "clinical unit" for the case study with managers or informal leaders.
- Six interviews or mini- focus groups were conducted and two health services in two different Regions have been selected for their actual good practices in organizational commitment to equity and participation.
- Within the single organization, managers and staff with experience and responsibility for cultural competence policy development and implementation have been interviewed.

CASE 1- REGION 1

The specific site is a large public health system (AUSL), which includes 4 hospitals, outpatient facilities and 30 community-based health centres i.e "Consultorio Famigliare" [Family clinic]. The data in this study are limited to the central management structure of the AUSL and to one Family clinic, renowned in the organization for its good practices for migrants' health .
This organization participated in projects promoting health equity for migrants and has recently developed managerial structure that coordinates projects for equity, that we considered important for studying organizational commitment strategies.

INTERVIEW SAMPLE

		Professional level	**Organizational role**	**Methods**
1	F	Man	Director of diversity managment office	Interview (minifocus)
2	F	Man	Manager of cultural mediation	Interview (minifocus)
3	F	Man	Director of socio-health department	Interview (minifocus)
4	F	Man	Regional Director of "Family Clinic"	Interview
5	F	Man	Local Director of "Family Clinic"	Interview
6	F	Man	Manager of "Family Clinic" -unit immigrant women	Interview
7	F	Prof	Midewife of "Family Clinic"	Focus group
8	F	Prof	Midewife of "Family Clinic"	Focus group
9	F	Prof	Gynecologist of "Family Clinic"	Focus group
10	F	Prof	Gynecologist of "Family Clinic"	Focus group

DOCUMENTS SAMPLE

	TYPE	SOURCES	DATA
1	ORGANIZATION CHART	sitoweb	Organizational structure for equity
2	PATIENTS CONSULTATION ORGANISM "COMITATI CONSULTIVI MISTI"	sitoweb	Participation organism
3	ORGANIZATION PLURIANNAL PLANNING AND STRUCTURE	sitoweb	Organizational structur, culture (mission and vision).
4	HEALTH SERVICES PRESENTATION	sitoweb	Organizational structure
5	EQUITY MANAGEMENT OFFICE PRESENTATION, PERFOMANCE PLAN 2018, EQUITY BOARD PRESENTATION 2014, ORGANIZATIONAL POLICIES EQUITY BOARD 2014	sitoweb	Organizational committment
6	CULTURAL MEDIATION ORGANIZATIONAL PRES	sitoweb	CC organizational strategies
7	REPORT-IRREGULAR MIGRANTS-2016	sitoweb	Cc organizational strategies
8	GOOD PRACTICE FOR MIGRANTS WOMEN HEALTH 2014	delivered	CC service strategies
9	ORGANIZATIONAL STRATEGIC PLANNIG, MULTILINGUAL GUIDE	delivered	CC ORGANIZATIONAL strategies

Case 2- REGION 2

The specific site is a large public health system (AUSL). This organization participated in regional projects promoting health equity for migrants and has recently developed a managerial structure that coordinates projects for migrants' health equity "Migrant and Vulnerable Groups Office".

SAMPLE

		Professional level	**Organizational role**	**Methods**
1	F	Man	Director of the Migrant And Vulnerable Groups Office	Interview

2	F	Prof	Mental health child services (Informal lead on CC)	Interview
3	F	Man	Manager of "Family Clinic"	Interview
4	F	Prof	Midewife of "Family Clinic"	Focus group (in October)
5	F	Prof	Gynecologist of "Family Clinic"	Focus group (in October)
6	F	Prof	Social worker "Family Clinic"	Focus group (in October)
7	F	Prof	Cultural mediator "Family Clinic"	Focus group (in October)
8	F	Prof	Antropologist "Family Clinic"	Focus group (in October)

DOCUMENTS

	TYPE	SOURCES	DATA
1	ORGANIZATION CHART	sitoweb	Organizational structure for equity
2	PATIENTS CONSULTATION ORGANISM "COMITATI CONSULTIVI MISTI"	sitoweb	Participation organism
3	CULTURAL MEDIATION ORGANIZATIONAL PRES	sitoweb	CC organizational strategies
4	REFUGIES FACILITIES -WEB COMMUNICATION	sitoweb	Cc organizational strategies
5	INTERCULTURAL TRAINING- WEB COMUINCATION	sitoweb	CC organizational service strategies
6	MIGRANT WOMEN HEALTH PREVENTION PROGRAM	sitoweb	CC service strategies
7	MIGRANT AND VULNERABLE GROUPS OFFICE PRESENTATION	delivered	CC organizational strategies

3. Analysis

The data have been analysed using inductive thematic analysis (Braun & Clarke, 2006). First, the data were read carefully to identify meaningful units of text relevant to the research topic. Second, units of text dealing with the same issue were grouped into analytic categories and given provisional definitions. The same unit of text could be included in more than one category. Third, the data were systematically reviewed to ensure name and definition.

The analysis is in progress and the results of top manager interviews of the Case 1 will be presented below.

4. Results

Case 1: Management Level

Top management

- **Organizational commitment: structure, leadership, planning**

There is a strong formal organizational commitment to equity that is explicit in the mission of the company.
A structure of Diversity Management was instituted in the Dep. of Strategic Direction, that is an evolution of a previous interdepartmental coordination office called "Tavolo sull'Equità". It is the organizational structure dedicated to equity and participation management. The company has a matrix organigram, i.e. the staff for equity project changes in relation to the equity plan.

In the organization there aren't formal leaders dealing with the health of migrants, but the director of the diversity management structure, the social-health director and the referent on cultural mediation are all recognized responsible for that issue. More specifically, they showed different sensitivity for prioritizing migrants' health in the organization.

Organizational management strategies are based on the use of Equity Assessment tools: Equity Audit and Equity Impact Assessment. In the last two years these tools have been dedicated to the analysis of the pathways of maternal and infancy health and of diabetes.

"Equity audit is a real audit. Therefore, it is cyclical with six steps, the first of which is the involving of the patient and the stakeholders, together we define what priorities are to be investigated. Then one acts, it is activated by defining the goal we want to achieve, with the results we understand what to investigate. Then we do an equity profile of the population investigated to highlight any gaps; when they are highlighted at the quantitative level we start with the qualitative investigation; an analysis, rather sociological, that sees the whys and the how. We use various types of research, from focus groups to semi-structured interviews to short questionnaires and participatory observation, we use them all depending on where we need to act. From the intersection of the results, we give possible solutions agreed with the stakeholders, we report them to the management and see what is sustainable what is not; and among the sustainable ones, we decide from which actions to start. Then the cycle resumes because it is monitored" (Interview 1).

- **Migrants' and community participation**

Participation is seen as a key value of the organization in analogy with the city culture, where the organization is located. It emerges that to make sure that the services design is efficient and needed by the population almost all the participants highlighted the importance of involving stakeholders during design. There is a central structure and dedicated staff to increase participation. Different processes of participation are cited: research with the community, and co-production and identification of vulnerable groups that risk being excluded. They speak of "community participation" rather than patient participation. However, the participation of people of immigrant origin is seen non-structural but a precarious activity. Interviewees recognize as a limitation the lack of representativeness of the community in the organizational participative bodies "*comitati misti partecipativi*". An interviewee defines participation with migrants as a "*difficult scouting activity*". The strategies to increase immigrant users' participation are:

- involving mediators, and mapping associations and communities of foreigners;

- health education interventions involving "*consulta degli stranieri*" and municipality on the issues of primary care.

- **Strategies in the service provision**

A property of the strategies implemented is the differentiation by identified areas and health problems.
Strategies have been developed to respond to health needs of different migrant subgroups: women, long-resident, irregular and refugees.
Strategies aim to reduce barriers to access, to increase staff competences, and to increase migrants' health navigation abilities.
A main organizational actual effort is to diffuse diversity responsiveness in all the company.

Cultural mediation is seen as one of the main activities to reduce inequality but not the only one: "mediation is one of the strategies". Mediation, present in the company since 2003, has different methods: fixed and call hours on high-traffic services.
The other implemented actions are:

- WebSite: multilingual materials
- A convection with a NGO for a health service for STP (irregular migrants)
- Health literacy training with Lifelong learning courses with the municipality
- Training:

- ❖ For staff on diversity and anthropological and cultural barriers;
- ❖ For cultural mediators;

❖ Multidisciplinary teams for mental health issues;
❖ Collaboration with RTP community;

Conflicting views
Strategies to reduce health inequalities for migrants are presented as:
- equity-based, not just for migrants' groups;
- diffused, by avoiding the creation of dedicated services.

Conflicting views about diversity responsiveness emerged between the participants. A part of the interviewees values the "equity-based" approach for different reasons: first, it allows to act according to the principles of justice and to recognize the different forms of discrimination of the organization and the different groups that can be discriminated; second, it is responsive to the health needs of the second generation; third, it decreases the risk of contro-culture and intra-organizational conflict.
Another part recognizes some disadvantages: it decreases the ability to advocate and to create coordination on CC practices; it demands for continuous efforts to integrate and diffuse CC Culture in the organization.

- **Facilitators**

One on the main facilitator is the regional commitment on equity and the participation of health organization in the political construction process. Furthermore, according to Regional disposition, 8 objectives of the General Director are related to equity.

- **Barriers**

The current political climate is recognised as an external barrier to CC implementation. Working on migrants' health issues became a sort of "taboo" activity "*not socially legitimated and valued*".

5. Future directions

Two main future direction of the project are planned:

In relation to study 1: it is planned to widen the sample of interviewees to the stakeholders of social policies since the connection between social and health sector has emerged as fundamental for CC.
In relation to study 2: it is planned to deepen the experience of the leaders and to explore in more specifically the aspects of coordination and integration of CC practices.

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APPENDIX

INTERVIEW GRID (managerial level)

Intro	First of all I would ask you to tell me briefly what is your professional role and link to the issue of equity for migrants' health
CO_strategic planning Co= CC COMMITTIIMENT	1. What are current programs or efforts at your institution for promoting equity for migrants' health? 2. Does your institution have a specific mission? Strategic plan?
Drivers	3. Which were the drivers?
CO_ leadership	4. What are the people/ structures that formally or informally have responsibilities for migrants' health equity at your institution?
Co-culture-lead	5. Do you think that organizational equity for migrants mission or programs are diffused and knew at your institution?
Co-integration/coord-lead	6. Can you describe the relationship between departments or units in relation to advancing equity for migrants' health at your institution?
CO- structure-lead	7. What are the pros and cons about the current nature of the organizational structure at your institution?
Partecipative strategies	8. Are migrants,/migrants' stakeholder or community representatives routinely involved in the planning and design or evaluation of in-patient?
CO_Leadershi_part	9. Is there a person, office or committee who has dedicated responsibility for promoting participation?
Facilitors_PA	10. What are the facilitators to advancing and implementing migrants' participation?
Barriers_PA	11. What are the barriers to advancing participation?
Barriers_implementation	12. Reflecting on your experience or thinking about a specific program: What are the barriers to advancing and implementing equity strategies for migrants' health?
Faciliators_implem	13. What are the facilitators to advancing and implementing?
Culture	14. Do you think that overall, diversity and organizational cultural competence are valued at your institution?
CO_resouces	15. What are the economic resources that support programs? There is dedicated budget?
CO_organizational policies	16. Do you recognize organizational policies for migrants' health equity? Formal practices?
Co_ regional policies	*17.* Do you recognize regional policies that sustain implementation?

Leadership coord	18. As manager, how to facilitate CC program effective implementation at different organizational levels and among different professionals?
Leadership_Culture_	19. How can this theme be supported as a org. Priority? What levers did you use?
Organizational values/drivers	20. What do you think would best help diversity and cultural competence become more embedded at your institution?
Improvements	21. What d you think would improve CC implementation and efficacy ?