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Tesi

I bisogni di salute di una popolazione multiculturale: l'esperienza della comunità di Camini

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"Nessuna madre metterebbe il proprio figlio su una barca
in mezzo al mare se non pensasse che il mare sia più
sicuro della terra che sta lasciando"

Dedicata a tutti coloro che hanno trovato un porto
sicuro, e a chi invece non ce l'ha fatta.
Perché la Cura vinca sempre sull'indifferenza.

Abstract

Introduzione. Migranti e rifugiati appartengono ai gruppi più emarginati del mondo. Barriere legate ai determinanti della salute possono spesso precludere l'accesso ai diritti umani fondamentali e avere un impatto negativo sulla salute stessa e sul benessere. Nonostante un crescente interesse per la migrazione forzata, persiste una mancanza di informazioni sulla percezione dei bisogni di salute da parte dei rifugiati e richiedenti asilo, e sugli elementi che li influenzano. Uno studio sulla dimensione soggettiva della salute dei rifugiati e richiedenti asilo fornirebbe informazioni cruciali per guidare interventi di presa in carico proattivi e per migliorare le cure infermieristiche. La sfida del XXI secolo nel campo infermieristico è infatti quella di adottare una prospettiva globale. Uno sguardo transculturale è essenziale per fornire ai servizi una nuova visione, garantendo un'assistenza inclusiva in sintonia con i diversi sistemi culturali**.** In Europa, e soprattutto in Italia, pochi studi hanno finora esplorato approfonditamente i punti di forza e le barriere nel percorso di accoglienza di una popolazione migrante in contesti multiculturali. Per promuovere la salute ottimale dei migranti, dei rifugiati e dei richiedenti asilo, risulta fondamentale esaminare i punti di forza e gli ostacoli sia per coloro che si occupano del benessere dell'intera popolazione multiculturale che per i rifugiati e i richiedenti asilo durante il processo di reinsediamento.

Obiettivo: L'obiettivo generale di questo Programma di Ricerca Dottorale è quello di fornire nuove conoscenze relativamente ai bisogni di salute di una popolazione multiculturale con il fine di costruire percorsi di salute mirati. In relazione a ciò, sono stati identificati i seguenti obiettivi specifici: **i**dentificare i bisogni di salute di rifugiati e richiedenti asilo in una comunità multiculturale, esplorare la costruzione soggettiva della salute e della malattia dei membri di una comunità multiculturale, identificare le variabili che influenzano la salute e il benessere di una comunità multiculturale, descrivere le risposte ai bisogni di salute realizzate dagli operatori sociali e sanitari.

Metodi: Nel primo studio abbiamo compendiato le conoscenze esistenti sui bisogni di salute fisici e psicosociali dei rifugiati e richiedenti asilo del Mediterraneo, attraverso una revisione sistematica della letteratura. Nel secondo studio abbiamo individuato i problemi più emblematici della progettazione e conduzione di uno studio qualitativo

tra paesi con culture diverse e identificato le possibili strategie per risolverli garantendo rigore, attraverso un contributo scientifico metodologico. Nel terzo studio abbiamo analizzato il vissuto esperienziale degli operatori sanitari e sociali relativamente alla cura di una popolazione di rifugiati e richiedenti asilo, con un' Analisi Interpretativa Fenomenologica sulle interviste di 16 operatori sociosanitari operanti nel progetto di accoglienza dei migranti, e nel quarto studio esplorato l'esperienza dei rifugiati e dei richiedenti asilo relativamente ai bisogni di salute percepiti e agli elementi che influenzano la salute e il benessere, su un campione di 19 interviste. Nel quinto studio abbiamo introdotto una nuova metodologia di analisi dei dati denominata Analisi Automatica dei Dati Testuali (AADT), attraverso un contributo scientifico metodologico. Nel sesto studio abbiamo esaminato il punto di vista degli stakeholder sull'assistenza ai migranti nel progetto di accoglienza utilizzando l'AADT e nel settimo studio abbiamo condotto un'Analisi Automatica dei Dati Testuali su un campione diversificato, coinvolgendo la simultanea analisi delle interviste condotte sui 16 stakeholder, 19 migranti e 15 residenti.

Risultati: Nel primo studio i risultati hanno mostrato che i fattori principali che influenzano o determinano la salute dei migranti includono il livello di integrazione e di acculturazione, la discriminazione linguistica ed etnica, le condizioni abitative, il reddito, l'adattamento socio-culturale, i bisogni psico-fisici, l'ottenimento del permesso di soggiorno. Inoltre, i problemi familiari e gli eventi traumatici influiscono sulla salute generale e mentale e sulla qualità della vita. Nel secondo studio sono emerse le principali strategie per garantire rigore metodologico nella conduzione di uno studio qualitativo con culture differenti nelle seguenti fasi: disegno, costruzione dei metodi, trascrizione e analisi, reporting. Nel terzo studio l'esperienza degli operatori socio-sanitari si è sintetizzata nelle seguenti tematiche: 1) Movimento dei bisogni; 2) interconnessione tra competenze e nelle relazioni; 3) Lotta contro le carenze territoriali e contro il tempo. Dai risultati del quarto studio emerge che la famiglia rappresenta un elemento in stretta relazione con la salute e il benessere dei rifugiati, così come il sentirsi parte di una comunità e la possibilità di raggiungere una condizione di vita stabile e sicura. Nel quinto studio, l'AADT si è rivelato un approccio innovativo per la sua significativa integrazione tra analisi qualitativa e quantitativa e i risultati hanno messo in evidenza le potenzialità nel condurre diversi tipi di analisi partendo dallo stesso set di dati, facilitando l'interpretazione di fenomeni complessi.

Nel sesto studio i risultati hanno mostrato diverse dimensioni, sia manifeste che latenti, che influenzano la salute della popolazione multietnica e gli interventi messi in atto dagli stakeholder, in principal modo l'attenzione rivolta alla famiglia, l'organizzazione dell'accoglienza, l'integrazione lavorativa dei migranti beneficiari del progetto di accoglienza e il rispondere alle esigenze dei migranti, con particolare attenzione alla salute mentale. Nel settimo studio i risultati hanno messo in evidenza le attività proattive finalizzate all'integrazione e all'inclusione sociale dei professionisti mediante interventi volti a stabilire una relazione di cura e supporto, e il campione dei residenti ha portato all'attenzione i benefici del progetto di accoglienza sull'intera comunità oggetto di studio. Infine, il tema legato alle carenze strutturali e le sfide connesse all'assistenza sanitaria, dovute alla mancanza di risorse, strutture adeguate e mezzi di trasporto idonei è risultato centrale.

Conclusioni: I risultati del programma dottorale confermano che la salute è un costrutto composto da dimensioni bio-fisiologiche, psicologiche e sociali che si interconnettono e che necessitano di una visione di insieme, più che di un approccio analitico e focalizzato sui singoli domini che la compongono e hanno fornito una chiave di lettura delle priorità dei bisogni di salute dei migranti, utile ai Servizi Socio-Sanitari nel loro impegno di accoglienza e cura di queste popolazioni. Gli studi si pongono inoltre come spunto di riflessione sulla necessità di indirizzare gli sforzi della ricerca sull'implementazione di modelli di cura fondati su un approccio comunitario, nel quale la figura dell'infermiere di comunità potrebbe fungere da connessione nella rete dei servizi, in un'ottica interculturale. La ricerca futura dovrebbe direzionarsi verso l'indagine delle relazioni tra le variabili che influenzano la salute nei migranti e gli outcome di salute e analizzare il ruolo del self-care all'interno di queste relazioni. Lo studio del self-care potrebbe supportare i professionisti nell'implementare interventi di promozione della salute e fornire cure mirate e culturalmente competenti che potrebbero migliorare la vita dei migranti e ridurre i costi sanitari.

Indice

CAPITOLO 1

Introduzione

I fenomeni migratori

La spinta motivazionale che induce gli individui a oltrepassare i confini nazionali rappresenta un elemento cruciale che distingue la migrazione, nel suo significato più ampio, da altre forme di spostamento. Le teorie presenti nella letteratura, come quella di Castelli (2018), mettono in evidenza la complessità dei flussi migratori, rifiutando una semplice relazione di causa-effetto e considerando tutta una serie di componenti multidimensionali che definiscono la scelta individuale di intraprendere il viaggio migratorio (Castelli, 2018).

Nella concezione comune, il termine *migrazione* fa principalmente riferimento a spostamenti volontari caratterizzati da finalità economiche, quali la ricerca di opportunità occupazionali e lo sviluppo nei Paesi di accoglienza, o il desiderio di ristabilire legami sociali e comunitari, come quelli famigliari. Questa categoria di individui è comunemente identificata come *migranti economici*, ovvero persone che si spostano principalmente alla ricerca di migliori opportunità di lavoro e condizioni di vita. Tra di loro si possono trovare lavoratori temporanei, stagionali o coloro che cercano una migrazione permanente. Simultaneamente, vi è una sempre più crescente incidenza di fenomeni migratori involontari, che emergono a seguito dell'imperiosa necessità di lasciare contesti di vita difficili, caratterizzati dalla presenza di conflitti armati, gravi squilibri economici, regimi antidemocratici, persecuzioni e violazioni dei diritti umani che spingono gli individui a cercare vie di fuga irregolari. Sono, dunque, *migranti clandestini o irregolari* individui che attraversano i confini o risiedono in un paese senza l'autorizzazione legale richiesta. Questa categoria comprende una varietà di persone, tra cui rifugiati e richiedenti asilo (de Smalen et al., 2021).

Si definiscono *rifugiati* individui che fuggono da situazioni di estrema difficoltà nei loro paesi d'origine. Queste difficoltà possono includere conflitti armati, persecuzioni basate su motivi etnici, religiosi o politici, violenze generalizzate o gravi

violazioni dei diritti umani. La protezione dei rifugiati (status di rifugiato) è sancita dal diritto internazionale, in particolare dalla Convenzione delle Nazioni Unite del 1951, la quale definisce un rifugiato come una persona che *"a causa di fondati timori di essere perseguitata per motivi di razza, religione, nazionalità, appartenenza a un particolare gruppo sociale o opinioni politiche, si trovi fuori del paese di cui ha la cittadinanza e non possa o, a causa di detti timori, non voglia avvalersi della protezione di detto paese"* (UNHCR, 2004). Una volta riconosciuti come tali, i rifugiati hanno il diritto di ricevere asilo in un altro paese e di godere di determinati diritti e protezioni, compreso il divieto di respingimento verso il paese da cui fuggono.

I *richiedenti asilo* sono soggetti che si rivolgono a un altro paese in cerca di protezione, presentando domanda di asilo perché temono persecuzioni nel loro paese d'origine. La domanda di asilo è un processo legale attraverso il quale un individuo chiede al paese ospitante di riconoscerlo come rifugiato e di garantirgli asilo. Il processo di valutazione del caso di asilo prevede di esaminare attentamente le ragioni della richiesta e determinare se l'individuo soddisfa i criteri definiti dal diritto internazionale per lo status di rifugiato (UNHCR, 2024). Durante il periodo di attesa della valutazione, la persona è nota come "richiedente asilo." Se la richiesta viene accettata, il richiedente asilo ottiene lo status di rifugiato e può godere di diritti e protezioni simili a quelli accordati ai rifugiati. Tuttavia, se la richiesta viene respinta, il richiedente asilo potrebbe dover affrontare il rimpatrio nel suo paese d'origine, a meno che ci siano ragioni umanitarie o altri motivi legali per concedere una forma di protezione.

I rifugiati e i richiedenti asilo si distinguono, dunque, dalle altre tipologie di migranti in quanto non hanno scelto di migrare volontariamente, ma sono stati costretti a fuggire dai loro paesi d'origine (IOM, 2022).

I flussi migratori in Europa: dati epidemiologici

Durante il corso degli anni l'Europa è divenuta, per motivi di collocazione geografica e di posizione economica, un polo di attrazione su scala globale e di approdo nella geografia migratoria accogliendo un afflusso straordinario di rifugiati, richiedenti asilo e altri migranti. Sono stati registrati 232.350 attraversamenti irregolari delle frontiere esterne dell'Unione Europea nei primi otto mesi del 2023, decretando un

aumento dell'18% rispetto al 2022 (Frontex, 2023). Gli impatti sociali, economici, politici e culturali generati dalla presenza di centinaia di migliaia di migranti irregolari all'interno del continente europeo hanno coinvolto anche l'Italia negli ultimi anni. Nel 2023, il Paese ha registrato circa 157.652 rifugiati e richiedenti asilo, tra cui 17.319 minori non accompagnati, secondo dati del Dipartimento per le Libertà Civili e l'Immigrazione (2023) (Fig. 1).

I flussi migratori diretti verso l'Europa si manifestano principalmente attraverso rotte marittime, delineando la *Rotta Mediterranea* che traccia le migrazioni illegali dall'Africa e dal Medio Oriente. Questa rotta si suddivide principalmente in tre direttrici: Mediterraneo centrale, orientale e occidentale. La rotta del Mediterraneo centrale testimonia gli arrivi irregolari dall'Africa sub-sahariana e settentrionale verso le coste italiane, prevalentemente con partenze dalla Libia. La rotta del Mediterraneo orientale concentra i flussi verso Grecia, Cipro e Bulgaria, evidenziatasi notevolmente nel 2015 durante l'afflusso di rifugiati sfuggiti alla guerra civile in Siria. La rotta del Mediterraneo occidentale agevola l'accesso irregolare in Spagna per migranti provenienti dall'Algeria, dal Marocco e da vari paesi dell'Africa subsahariana. Un'altra via migratoria significativa è la rotta dei Balcani occidentali, frequentemente percorsa dai migranti provenienti dall'est, questa volta via terra, spesso a piedi o in mezzi di trasporto sovraffollati come camion e vagoni ferroviari (Council of the European Union, 2023). Tali attraversamenti sono spesso segnati da tragedie che coinvolgono un numero significativo di individui, inclusi bambini. Secondo i dati del Missing Migrant Project (2024), il numero registrato di casi di migranti dispersi o deceduti in mare ha raggiunto i 61.753, rappresentando un aumento significativo dal 2014 (IOM, 2024b).

Questa portata imponente del fenomeno della migrazione illegale ha posto la società italiana di fronte a notevoli sfide, in particolare riguardanti l'accoglienza, l'inclusione e la gestione della salute di questi individui (Anci, 2017; UNHCR, 2022).

I bisogni di salute dei rifugiati e dei richiedenti asilo

Nel contesto della salute, i rifugiati e i richiedenti asilo che affrontano il periglioso attraversamento del Mediterraneo sono spesso segnati da traumi profondi, sia fisici che psicologici (Davoren et al., 2023). Le difficili condizioni presenti nelle loro regioni d'origine, caratterizzate da estrema povertà, disastri naturali, conflitti armati, minacce

terroristiche e persecuzioni politico-religiose, spingono questi migranti a cercare rifugio in paesi più prosperi, affrontando confini in modo irregolare e in condizioni estreme. Inoltre, la complessità dei percorsi migratori caratterizzati da impoverimento, isolamento sociale, violazioni dei diritti umani e stress connesso alla migrazione forzata e alla separazione familiare rende estremamente difficile il mantenimento di un adeguato stato di salute (Legido-Quigley et al., 2019; Rodriguez-Pena, 2023). Si tratta di individui che portano con sé non solo le sfide della migrazione, ma anche le cicatrici delle esperienze traumatiche che segnano il loro percorso (Commodore-Mensah et al., 2021).

Nonostante i migranti siano esposti a rischi, una volta raggiunto il nuovo paese si osserva un iniziale buono stato di salute rispetto ai residenti. Tuttavia, una volta nel paese di destinazione, i migranti possono affrontare condizioni come l'esclusione sociale e la scarsa conoscenza dell'utilizzo dei sistemi sanitari, che possono portare a una riduzione del loro capitale di salute. Questo fenomeno è meglio noto come *effetto migrante sano* (Elshahat et al., 2022). L'esito è principalmente determinato da fattori post-migrazione, quali reddito, occupazione e alloggio, dimostrati essere influenti sulla salute mentale (Hynie, 2018). Le barriere linguistiche e organizzative, unite alla mancanza di sensibilità e alla discriminazione da parte del personale sanitario emergono come ostacoli all'accesso ai servizi sanitari, contribuendo alla marginalizzazione della popolazione migrante e causando una significativa riduzione nella segnalazione dei sintomi (Chynoweth et al., 2020). A tali sfide si aggiunge un prolungato e complesso periodo di adattamento e acculturazione (van der Zee & van Oudenhoven, 2022).

In considerazione di ciò, il rapporto tra salute e migrazioni si configura come un fenomeno intricato e dinamico. Le politiche a livello internazionale e nazionale dovrebbero concentrarsi sulla completa integrazione dei migranti nei servizi socio-sanitari, promuovendo il loro inserimento sociale e lavorativo, agevolando l'assimilazione culturale e assicurando l'accesso inclusivo ai servizi sanitari nel rispetto dei diritti umani universali, come indicato negli obiettivi di sviluppo sostenibile dell'Agenda 2030 (IOM, 2024a).

Lo sguardo multiculturale della cura

L'esperienza del rifugiato e del richiedente asilo si presenta come un contesto intriso di incertezza, in cui l'individuo si trova "sospeso" tra due realtà socioculturali distinte, superando non solo confini geografici ma anche quelli culturali e psicologici. Questa condizione di sospensione si traduce in una transizione delicata e complessa, in cui la persona deve affrontare una serie di sfide legate all'adattamento a un nuovo contesto, alla preservazione della propria identità e al superamento di traumi pregressi. In questo contesto, la migrazione si configura come un fenomeno intricato, influenzato da variabili socio-politiche e umanitarie che richiedono una risposta complessa e compassionevole da parte delle istituzioni e della società internazionale (Sim et al., 2023).

La diversità culturale, accentuata dalla crescente presenza di cittadini stranieri e dalla loro integrazione nel tessuto nazionale, si riflette in modo significativo anche nel settore sanitario. La coesistenza di diverse realtà etnico-culturali, spesso marcatamente differenziate dal punto di vista sociale ed economico, spiega la crescente richiesta di assistenza da parte di utenti con un background multiculturale ed esigenze specifiche. La varietà di realtà etnico-culturali attualmente presenti richiede un approccio inclusivo che favorisca la comprensione reciproca e ottimizzi la qualità dell'assistenza sanitaria (Segal, 2019). Le sfide connesse alla gestione delle relazioni con pazienti provenienti da contesti culturali, linguistici e valoriali diversi dovrebbero stimolare l'implementazione di politiche sanitarie orientate all'integrazione (Marchetti et al., 2023). Parallelamente, l'attuale emergenza derivante dagli afflussi migratori via mare impone una risposta immediata nell’affrontare la sfida migratoria in maniera efficace.

L'attenzione alle diverse culture trova origine con Madeleine Leininger, la pioniera del nursing transculturale, il cui interesse si focalizza sulle differenze e affinità tra le varie culture. L'obiettivo è fornire un'assistenza congrua, ovvero adatta e specifica, affrontando in modo culturalmente coerente l'esperienza di malattia o morte (Leininger, 2002). Questo approccio, basato sulla comprensione delle diverse culture, trasforma l'assistenza da un semplice atto in un'azione terapeutica. Per implementare il modello infermieristico di Leininger, che combina infermieristica e antropologia, è essenziale avere operatori preparati e sensibili in grado di fornire un'assistenza

culturalmente adeguata (van Loenen et al., 2018). L'infermiere deve acquisire conoscenze approfondite sul paziente, la sua cultura e gli elementi che influenzano le sue necessità e i suoi desideri. Questo implica riconoscere e rispettare le differenze individuali o di gruppo senza cadere nella stereotipizzazione dell'utenza. La sfida del XXI secolo nel campo infermieristico è quella di adottare una prospettiva globale. Il nursing transculturale è essenziale per fornire ai servizi una nuova visione, garantendo un'assistenza inclusiva in sintonia con i diversi sistemi culturali (Commodore-Mensah et al., 2021).

I percorsi di accoglienza e di presa in carico

I percorsi di presa in carico nel contesto europeo e italiano sono orientati a promuovere solidarietà, legalità e inclusione, seguendo il principio dell'Agenda 2030 di "non lasciare indietro nessuno" (United Nations, 2020). Educare la società al dialogo interculturale e al superamento dell'etnocentrismo è imperativo, e attraverso le politiche esistenti, si mira a costruire una società che riconosca nell'altro una risorsa preziosa per lo sviluppo. Ciò implica promuovere l'inserimento sociale e lavorativo, facilitare l'assimilazione culturale e garantire l'inclusione dei gruppi migranti nei servizi sanitari (Commodore-Mensah et al., 2021).

Il sistema di accoglienza dei migranti in Italia ha subìto varie evoluzioni nel corso degli anni, evidenziate da numerosi atti legislativi. Attualmente, il Sistema Accoglienza e Integrazione (SAI) si articola su due livelli: la prima accoglienza e la seconda accoglienza. Il SAI fornisce servizi volti all'empowerment, all'integrazione e all'autonomia del migrante attraverso un percorso di presa in carico. Questi servizi comprendono assistenza di base, orientamento legale e territoriale, nonché orientamento al lavoro e formazione professionale (SPRAR, 2016). In sintonia con le politiche migratorie europee, in Italia è attivo un sistema di presa in carico improntato al principio dell'Agenda 2030, con l'obiettivo di eliminare la discriminazione e ridurre le disuguaglianze nei Paesi (IOM, 2024a). Il SAI in Italia prevede una serie di servizi erogati nell'ambito dei progetti degli enti locali. Questi comprendono servizi di accoglienza materiale, quali la fornitura di alloggi destinati ai beneficiari durante il loro periodo nel SAI, e servizi finalizzati all'empowerment, all'integrazione e all'autonomia. Tra questi ultimi, rientrano servizi di assistenza sanitaria, sociale e psicologica, nonché

quelli dedicati alla mediazione linguistica, all'orientamento legale e territoriale, e servizi di orientamento al lavoro e alla formazione professionale (Camera dei deputati, 2024). La presa in carico dei beneficiari riguardo alla tutela della salute prevede l'attivazione tempestiva delle procedure per l'iscrizione al Servizio Sanitario Nazionale, garantendo così l'inclusione nei percorsi di prevenzione e cura previsti per tutti i cittadini (Department of Civil Liberties and Immigration, 2023).

Problema di ricerca

La complessità dei sistemi di accoglienza, coinvolgendo diverse figure nei progetti, solleva interrogativi su modalità efficaci per la presa in carico dei bisogni di rifugiati e richiedenti asilo. Si riflette sulle risorse, le criticità e gli aspetti prioritari per offrire una cura culturalmente congruente orientata all'inclusione e integrazione (Mammana et al., 2020).

Nonostante un crescente interesse per la migrazione forzata, persiste una mancanza di informazioni sulla percezione dei bisogni di salute da parte dei rifugiati e richiedenti asilo, e sugli elementi che influenzano salute e benessere (Lancet, 2019). Il dibattito su questo tema sembra limitato a chi detiene potere istituzionale trascurando i contributi vitali che i migranti possono offrire. In un contesto di pluralismo e eterogeneità, fondamentale è ascoltare e comprendere le esigenze delle popolazioni migranti per adattare l'assistenza sanitaria ai loro desideri e bisogni auto-percepiti (Lebano et al., 2020). Uno studio sulla dimensione soggettiva della salute dei rifugiati e richiedenti asilo fornirebbe informazioni cruciali per guidare interventi di presa in carico proattivi.

In aggiunta, in Europa, e soprattutto in Italia, pochi studi hanno finora esplorato approfonditamente i punti di forza e le barriere nel percorso di accoglienza di una popolazione migrante in contesti multiculturali. Nonostante diversi studi abbiano focalizzato l'attenzione sui migranti nell'ultimo decennio, sono stati condotti pochissimi studi all'interno di comunità così diversificate. Un esempio è rappresentato dal lavoro di Driel and Verkuyten (2022), il quale ha indagato sulle interazioni quotidiane tra residenti di diverse origini etniche a Riace, nel Sud Italia, una comunità che ha ospitato e integrato rifugiati per oltre due decenni. Tuttavia, in generale, si registra una carenza di letteratura che esamini i bisogni di popolazioni multiculturale

confrontando le prospettive delle parti interessate, inclusi migranti e residenti, che convivono nello stesso contesto.

Per promuovere la salute ottimale dei migranti, dei rifugiati e dei richiedenti asilo, è imperativo coinvolgere l'intera comunità interessata al fine di comprendere i complessi processi di accoglienza e integrazione in una nuova società. Risulta fondamentale esaminare i punti di forza e gli ostacoli sia per coloro che si occupano del benessere dell'intera popolazione multiculturale che per i rifugiati e i richiedenti asilo durante il processo di reinsediamento.

Obiettivi del Programma di Ricerca Dottorale

L'obiettivo generale di questo Programma di Ricerca Dottorale è quello di fornire nuove conoscenze relativamente ai bisogni di salute di una popolazione multiculturale con il fine di costruire percorsi di salute mirati. In relazione a ciò, sono stati identificati i seguenti obiettivi specifici:

1. Identificare i bisogni di salute di rifugiati e richiedenti asilo in una comunità multiculturale.
2. Esplorare la costruzione soggettiva della salute e della malattia dei membri di una comunità multiculturale.
3. Identificare le variabili che influenzano la salute e il benessere di una comunità multiculturale.
4. Descrivere le risposte ai bisogni di salute realizzate dagli operatori sociali e sanitari.

Il contesto di studio

Il contesto scelto per la realizzazione del presente Progetto Dottorale è rappresentato da Camini (RC). Si tratta di un piccolo borgo situato sopra le coste del Mar Jonio nel quale è attivo un progetto di accoglienza dei migranti incluso nella rete SAI gestito da una cooperativa sociale, che vede operare al suo interno professionisti di differente estrazione sociale, educativa e sanitaria. Camini rappresenta un esempio di convivenza tra popolazione nativa ed immigrata, in uno scenario di povertà di risorse socio-economiche e sanitarie.

Negli ultimi 20 anni, Camini ha subìto un forte processo di spopolamento ed è stato inserito nel programma Strategia Nazionale Aree Interne (SNAI) come E-Periferico all'interno dell'Area Versante Jonico-Serre. L'assistenza e la promozione della salute è infatti una sfida per un territorio già carente di strutture sanitarie. Persone di diverse origini, lingue, religioni, rappresentazioni culturali della salute e della malattia con vissuti traumatici, obbligano a formarsi per acquisire conoscenze e competenze transculturali per erogare servizi sanitari coerenti con i valori etici, religiosi e culturali della persona. Sul territorio è già presente una rete di accoglienza dei migranti, costituita da un Centro di Accoglienza SIPROIMI (Sistema di Protezione per titolari di protezione Internazionale e per Minori stranieri non accompagnati) e un Centro di Accoglienza Straordinaria (CAS) che, trovando una nuova vocazione socioculturale ed economica attraverso l'accoglienza agli immigrati, hanno modificato la configurazione sociodemografica del Paese invertendo la tendenza allo spopolamento. La cooperativa Eurocoop Servizi, fondata con l'obiettivo di facilitare l'inserimento lavorativo di soggetti svantaggiati, ha ampliato la sua missione dal 2011 attraverso il progetto "Jungi Mundu" (in dialetto locale, *Unisci il Mondo*). Tale iniziativa fornisce servizi di accoglienza a migranti, rifugiati e richiedenti asilo, mirando principalmente a garantirne l'indipendenza e l'integrazione.

Camini è un caso di studio complesso ma esemplificativo capace di fornire strumenti per comprendere ed agire per l'integrazione tra salute e migrazione. Fornire strumenti in grado di interfacciarsi correttamente con persone con differenti bisogni e percezioni di sé del corpo della salute e della malattia e ideare programmi di educazione sanitaria condivisi. Superare e non solo da un punto di vista organizzativo la logica emergenziale con la quale si è affrontata l'immigrazione fino ad oggi rappresenta un'opportunità di crescita e sviluppo dell'offerta sanitaria particolarmente carente nelle aree interne. Predisporre una modalità strutturata e sistematica di accoglienza, di assistenza sanitaria di promozione della salute e di integrazione non è quindi una questione unicamente legata all'immigrazione ma permette di operare per garantire il raggiungimento del più alto standard di salute possibile per tutti gli individui presenti sul territorio.

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CAPITOLO 2

Physical and Psychosocial healthcare needs of Mediterranean migrants, refugees and asylum seekers landing in Europe. A systematic review

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Abstract

Objective. To summarize the knowledge about the physical and psychosocial health needs of migrants, asylum seekers, and refugees who have arrived in Europe via the Mediterranean routes.

Design. Following PRISMA guidelines, a systematic review was conducted from September 2022 to February 2023. The electronic databases PubMed, Cinahl, and Scopus were consulted. Two independent researchers blindly performed the screening. Authors The articles were critically appraised independently using the Joanna Briggs Institute (JBI) checklists.

Results. Seventeen articles were included after the screening process. Post-migration challenges included barriers to integration and acculturation, cultural and religious affiliation, language and ethnic discrimination, permanent housing, and poor housing. Also, family problems and traumatic events affected general and mental health and Quality of Life. Accessing healthcare services was found to be a crucial barrier.

Conclusions. It's essential for professionals to fully understand the significant challenges faced by undocumented migrants, refugees, and asylum seekers, to better and effectively address them with culturally competent care.

Keywords: "migrants", "refugees", "asylum seekers", "health needs", "Mediterranean", "Europe".

Background

Migration is a remarkably complex and growing global phenomenon (Hossin, 2020). In 2022, there were more than 104,400 new irregular arrivals in Europe, and in the first 20 days of 2023, they were nearly 3,700, including 704 minors (Department of Civil Liberties and Immigration, 2023). Over the years, migration provided Europe with a pole of attraction on a global scale and a landfall in migration geography for reasons of geographic and economic location. Migration to Europe is essentially by sea, mainly from Africa and the Middle East (Council of the European Union, 2023).

Irregular migration is often preceded by traumatic events that cause the migrant to move forcibly (pre-migration stressors) and inevitably followed by a prolonged period of adaptation and acculturation in the new country (post-migration stressors) (Morgan et al., 2019). Furthermore, undocumented migrants, refugees and asylum seekers could experience worse psychological and physical health, such as social, economic, and cultural problems (WHO, 2018), significantly increasing disease burden, poverty, and risks associated with migration (Iqbal et al., 2022).

Social health determinants refer to non-medical factors such as income and social protection, education, unemployment and job insecurity, food insecurity, housing, social inclusion and non-discrimination, and structural conflicts that have a significant impact on health and play a significant role in creating and perpetuating health inequalities could positively or negatively influence health equity (World Health Organization, 2023). Addressing social and health determinants requires action from society, recognizing that health is not solely determined by medical care but by broader social factors (Vega-Escaño et al., 2018).

Although several systematic reviews summarized knowledge about migrants, however, more of them were extensively focused on a few specific diseases and conditions, such as oral health (Lauritano et al., 2021), infectious diseases (Asundi et al., 2019), metabolic and cardiovascular diseases (Ismail et al., 2022), maternity (Balaam et al., 2022), and mental health (Martin & Sashidharan, 2022), while others investigated patterns of access to health services (Nowak et al., 2022). To our knowledge, evidence investigating the psychosocial health of undocumented migrants, refugees and asylum seekers is still lacking. Given the broad significance of the

phenomenon, it is crucial to know the health status of undocumented migrants, refugees, and asylum seekers, making it a global priority and respecting the principle of the right to health for all to design a tailored reception and propose a set of interventions suitable for the care and treatment of one of the most disadvantaged populations in the world. For health care to adequately meet the health needs of migrant populations, it must be tailored to their self-perceived wants and needs (WHO, 2021).

Research Questions

For these reasons, the aims of this systematic review were (1) to summarize the knowledge on the physical and psychosocial health needs of undocumented migrants, refugees, and asylum-seekers landing in Europe and (2) to analyze what factors determine health status and how professionals, authorities, and the community can help undocumented migrants, refugees, and asylum seekers to achieve better health and well-being.

Methods

This systematic review, registered on the PROSPERO register (n. CRD42023388940, available at https://www.crd.york.ac.uk/prospero/), included all the studies aimed at answering the research questions. Therefore, all the studies providing information about psychosocial health, perceived health, health needs, dimensions, health-related quality of life, perceived well-being and factors influencing health were selected. The population comprised adult undocumented migrants, refugees and asylum seekers migrating from non-European countries to Europe. Study characteristics were identified through the PICOS approach.

Eligibility criteria

The following eligibility criteria were adopted in this review: (1) undocumented migrants, refugees, and asylum seekers from Africa and the Middle East landing in European countries; (2) first-generation undocumented migrants, refugees, and asylum seekers, (3) undocumented migrants, refugees, and asylum seekers aged ≥18 years; (3) qualitative, quantitative, and mixed-methods primary research; (3) articles

in English and Italian; (4) studies investigating health, perceived health, health needs, dimensions of health, factors influencing health, health-related quality of life, and perceived well-being; (5) studies conducted in Europe.

Information sources

A comprehensive search was conducted until the end of 2022 using the following databases: PubMed, CINAHL and Scopus. In addition, a search was conducted on Google and Google Scholar, analyzing the grey literature.

Search strategy

A search string was constructed using the following keywords and the appropriate Boolean operators. Keywords were related to population ("Migrants," "refugees," "asylum seekers"), the outcome ("Health," "Healthcare needs") and context ("Mediterranean," "Europe"). The resulting search string is as follows: (migrant OR refugee OR "asylum seeker" OR "asylum seekers") AND (health OR "healthcare needs") AND (Mediterranean OR Europe). The search key has been purposely left broad for the most retrievable results. No time limits or system filters were affixed to the search.

Selection process

All studies meeting the inclusion criteria were included in the review. Two researchers (MF and PA) assessed independently and blindly each retrieved study's eligibility based on the title and abstract and, secondly, on full-text screening. A third researcher (GP) analyzed any different evaluations. All studies that included other populations in addition to the one of interest (e.g., other types of migrants, natives or stakeholders, or populations that were not from Africa and the Middle East) or topics other than those established (e.g., physical health, problems accessing health services, stakeholders point of views) were included if the data of interest were ratifiable and extractable. All articles that did not meet the inclusion criteria were excluded.

Data collection process

All retrieved articles were downloaded from each database in BiBiTex format and imported into the bibliographic management software, EndNote. Subsequently, citations were imported into the online software, Rayyan® (Ouzzani et al., 2016), specifically designed for systematic reviewers. This software allows blind screening, where each reviewer can include or exclude studies without other team members knowing their decision until the blind is removed upon completion of screening. Two research team members (MF and PA) independently reviewed the titles and abstracts of all studies. Once the screening was completed, the blind mode was removed for comparison. The two researchers met to resolve differences of opinion through discussion. When consensus could not be reached, the doubtful abstract was included in the next phase for full-text reading and subsequent decision. At this point, two researchers (MF, PA) independently screened all full texts of studies included in the first selection. As in the previous phase, once the screening was completed, the blind mode was removed for comparison. The two researchers met to discuss conflicts in decisions, resolving differences of opinion through discussion. In case of conflicts, these were resolved through consultation with a third member (GP).

Data items

Data extraction was guided by two main variables: factors influencing health and health outcome. By factors influencing health, we understood physical and psychological needs, social issues, integration and acculturation challenges, problems with family, and others. The outcome was defined in terms of mental health, health-related quality of life, perceived well-being, and self-reported outcomes.

In the second step, we focused on the type of health problem. Other data of interest were the country where the study was conducted, the population involved, and the type of relationship between the variables (e.g., correlation or regression), which helped us understand the relationship between the variables under investigation.

The data of our interest were collected in an Excel spreadsheet. According to Popay et al. (2006), a data extraction table was constructed that included the following variables: Title, author, year, general objective, specific objectives, type of study,

methodological approach, participants, country of execution, variables analyzed, themes explored, main results, and limitations.

Two researchers independently collected the data (MF, PA) and then compared them.

Study risk of bias assessment

The selected studies were evaluated for methodological quality by two independent researchers (MF and PA) using the critical appraisal tools provided by the Joanna Briggs Institute (JBI) (Porritt et al., 2014). The checklist corresponding to the study design was used for each article. Any reviewer disagreement was resolved through discussion or consultation with a third reviewer (GP). Based on the results of the JBI checklists, each study received a percentage score according to the rating obtained. The researchers also agreed that studies with a score below 66% should be excluded.

Synthesis methods

The results were analyzed using an empirical narrative synthesis based on the aim of the systematic review. Based on preliminary research, the authors predicted that the data would not be suitable for quantitative clustering due to heterogeneous statistical parameters. Therefore, a narrative synthesis of the results was necessary. The narrative approach was used to synthesize qualitative and quantitative findings, allowing for in-depth exploration and collective understanding from multiple studies, which developed a broader perception of the phenomenon under study (Popay et al., 2006). If the studies demonstrated sufficient methodological and clinical similarities, the results were grouped by the health problems found. The Preferred Reporting Items for Systematic Review and Meta-Analysis statement (PRISMA) for systematic reviews were used to report the results (Page et al., 2021).

Reporting bias assessment

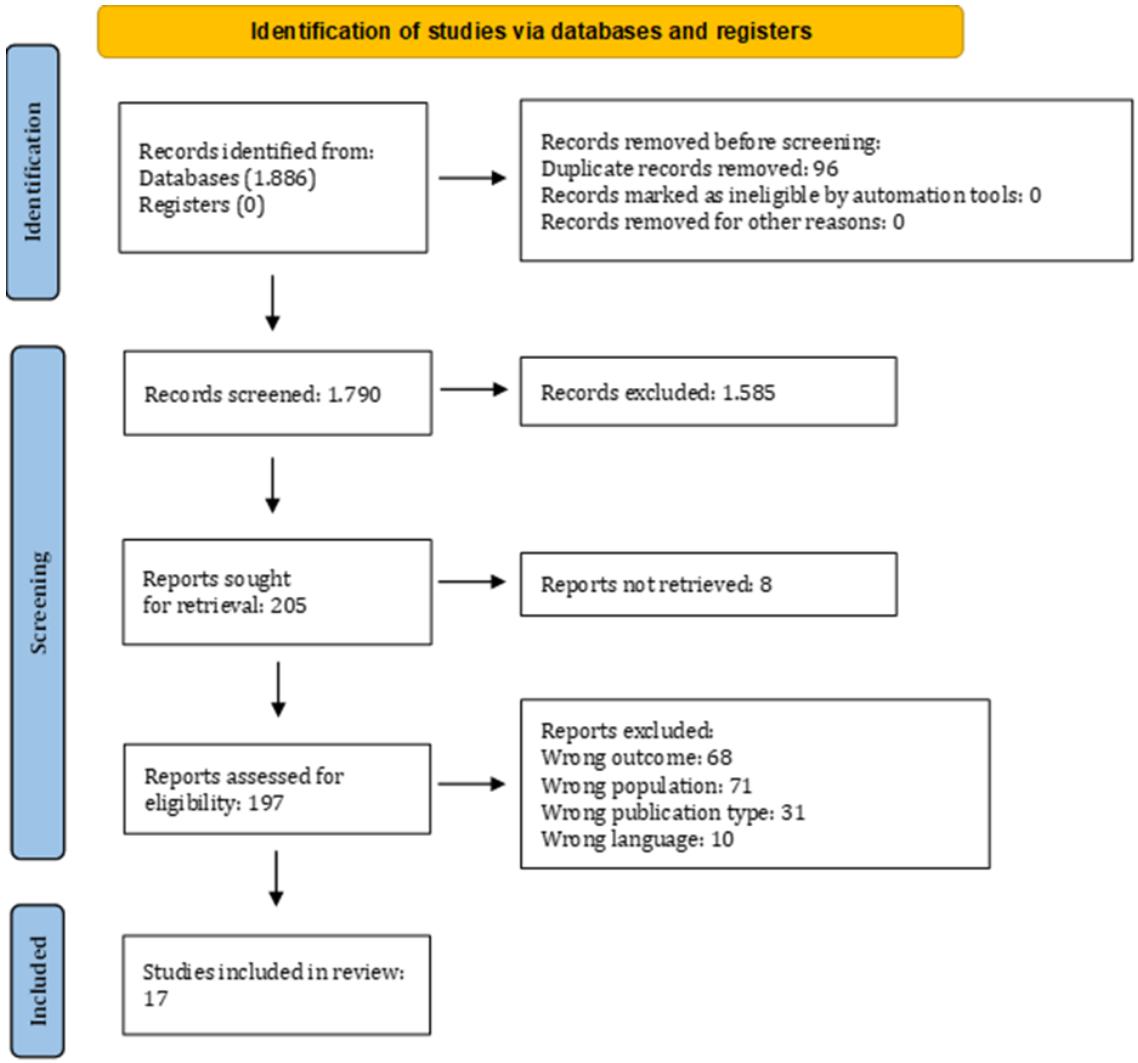
There was no plan to evaluate meta-bias within this review. Studies with missing data or variables non clearly defined were excluded from the analyses.

Results

Study selection

Seventeen studies were included in the review. The screening process with the reasons for exclusion are given in the Prism flow chart (Figure 2.1)

Figura 2.1: PRISMA screening process flow diagram



Studies characteristics

Studies characteristics (Setting, population, design, and centre) are described in detail in Table 2.1.

Table 2.1: Data extraction

Author, Year	Title	Setting	Population	Design	Centre	Notes
Brea Larios, D. et al., 2022	Explanatory models of post-traumatic stress disorder (PTSD) and depression among Afghan refugees in Norway	Norway	27 Afghani refugees	Qualitative cross-sectional	Monocentric	
Gewalt, S. C. et al., 2019	"If you can, change this system"- Pregnant asylum seekers' perceptions on social determinants and material circumstances affecting their health whilst living in state-provided accommodation in Germany – a prospective, qualitative case study	Germany	9 pregnant refugees (4 from Africa, 2 from Asia)	Qualitative Prospective (during pregnancy and six months after giving birth)	Monocentric	Sample extracted
Jesuthasan, J. et al., 2018	Near-death experiences, attacks by family members, and absence of health care in their home countries affect the quality of life of refugee women in Germany: a multi-region, cross-sectional, gender-sensitive study	Germany	663 refugees and asylum seekers [Syria (47%), Afghanistan (25%) and Iraq (11%)]	Quantitative Cross-sectional	Multicentric	
Kiselev, N. et al., 2020	Problems faced by Syrian refugees and asylum seekers in Switzerland	Switzerland	30 Syrian refugees	Qualitative Cross-sectional	Multicentric	

Kuittinen, S. et al., 2017	Causal attributions of mental health problems and depressive symptoms among older Somali refugees in Finland	Finland	28 Somali refugees	Quantitative Cross-sectional	Monocentric	
Laban, C. J. et al., 2008	The impact of a long asylum procedure on quality of life, disability, and physical health in Iraqi asylum seekers in the Netherlands	Netherlands	294 Iraqi refugees	Quantitative Cross-sectional	Monocentric	
Leiler, A. et al., 2019	Mental health and quality of life among asylum seekers and refugees living in refugee housing facilities in Sweden	Sweden	577 refugees from Africa and MiddleEst	Quantitative Cross-sectional	Monocentric	Sample extracted
Löfvander, M. et al, 2014	A case–control study of self-reported health, quality-of-life and general functioning among recent immigrants and age- and sex-matched Swedish-born controls	Sweden	Baseline: 93 migrants from Iraq and Somalia with recent residence permits Follow up: 66 migrants	Quantitative prospective case - control	Monocentric	Sample extracted
Mangrio, E. et al., 2021	Risk for mental illness and family composition after migration to Sweden	Sweden	681 Arabic-speaking refugees	Quantitative Cross-sectional	Monocentric	
Mölsä, M. et al., 2016	Mental health among older refugees: the role of trauma, discrimination, and religiousness	Finland	128 Somali refugees	Quantitative Cross-sectional	Monocentric	
Niessen, A. et al., 2021	Post-migration Stressors and Subjective Well-Being in Adult Syrian Refugees Resettled in Sweden: A Gender Perspective	Sweden	1215 Syrian refugees	Quantitative Cross-sectional	Monocentric	

Sharareh, A. et al., 2007	The health of female Iranian immigrants in Sweden: a qualitative six-year follow-up study	Sweden	10 female Iranian immigrants	Qualitative Longitudinal	Monocentric	
Steel L. J. et al., 2016	The Psychological Consequences of Pre-Emigration Trauma and Post-Migration Stress in Refugees and Immigrants from Africa	Sweden	240 African refugees	Quantitative Cross-sectional	Monocentric	
Sundvall. M. et al., 2020	Safe but isolated – an interview study with Iraqi refugees in Sweden about social networks, social support, and mental health	Sweden	31 Iraqi refugees	Qualitative Cross-sectional	Monocentric	
Tinghög, P. et al., 2010	The association of immigrant- and non-immigrant-specific factors with mental ill health among immigrants in Sweden	Sweden	509 middle east refugees (250 born in Iran (49.9%) and 259 born in Iraq)	Quantitative Cross-sectional	Monocentric	Sample extracted
van Loenen, T. et al., 2017	Primary care for refugees and newly arrived migrants in Europe: a qualitative study on health needs, barriers and wishes	Greece, Slovenia, Croatia, the Netherlands, Italy, Austria	98 refugees from Syria (39) Afghanistan (30) Iraq (12) Pakistan (6) Nigeria (4) Somalia (2) Gambia (1) Ghana (1) Iran (2) Egypt (1)	Qualitative Cross-sectional	Multicentric	Sample extracted
Wiking, E. et al., 2004	Ethnicity, acculturation, and self-reported health. A population-based study among immigrants from Poland, Turkey, and Iran in Sweden	Sweden	Turkish (n = 840) e Iraqi (n = 480) refugees	Quantitative Cross-sectional	Monocentric	Sample extracted

Studies outcome

Studies outcome and results in single studies are shown in detail in Table 2.2.

Table 2.2: Studies outcome and main results

Author, Year	Title	Health outcomes / Themes Explored	Main Results	Limitations in single studies
Brea Larios, D. et al., 2022	Explanatory Models of post-traumatic stress disorder (PTSD) and depression among Afghan refugees in Norway	Mental health	EM varies by gender, age, generation, and migration histories. Females tended to emphasize domestic problems and gender issues, while males focused more on acculturation difficulties. Younger males talked mostly about traumatic experiences before and during the flight.	Sample not homogeneous The sample was not enrolled based on a definite diagnosis of psychopathology.
Gewalt, S. C. et al., 2019	"If you can, change this system"- Pregnant asylum seekers' perceptions on social determinants and material circumstances affecting their health whilst living in state-provided accommodation in Germany – a prospective, qualitative case study	Health needs perception	Health challenges were associated to: Material circumstances (housing, neighborhood quality, poor hygiene standards, food accommodation neglecting religious practices. Behavioral factors (loss of appetite due to bland food and unfamiliar tastes, fear of disease and restless sleep due to threats of violence.	20 Euro compensation. Possible losing information caused by interpretations. Nine study participants
Jesuthasan, J. et al., 2018	Near-death experiences, attacks by family members, and absence of health care in their home countries affect the quality of life of refugee women in Germany: a multi-region, cross-sectional, gender-sensitive study	Quality Of Life	The described quality of life by the women was moderate and slightly worse than that of European populations due to older age, having had a near-death experience, having been attacked by a family member, and absence of health care in case of illness. Refugee women experience multiple traumatic experiences before and/or during their journey, some of which are gender specific.	Voluntary participation may have overestimated the sample of people with traumatic events.
Kiselev, N. et al., 2020	Problems faced by Syrian refugees and asylum seekers in Switzerland	General health problems	Besides physical health problems, Syrians experience primarily two types of problems: practical and psychological (emotional) problems.	Questions based on personal experiences. Recruitment through the study team's personal contacts.

			The finding that almost half of the participants reported typical symptoms of mental health disorders suggests that a considerable number of Syrian refugees and asylum seekers might need mental healthcare	Only German-speaking Switzerland. Interviews not audio-recorded Participants' asylum status not collected
Kuittinen, S. et al., 2017	Causal attributions of mental health problems and depressive symptoms among older Somali refugees in Finland	Mental health	Five causal attributions of mental health problems categories: (a) somatic, (b) interpersonal, (c) psychological, (d) life experiences, and (e) religious causes. Men tended to attribute mental health problems to somatic and psychological causes, and women to interpersonal and religious causes. Participants with a psychiatric diagnosis and/or treatment history reported more somatic and psychological attributions than other participants. Those who attributed mental health problems to life experiences (e.g., war) reported marginally fewer cognitive depressive symptoms (e.g., guilt) than those who did not.	BDI scale might not recognize salient forms of distress among Somalis. Proxy measures to assess acculturation. Focus only on causal attributions of mental health problems.
Laban, C. J. et al., 2008	The impact of a long asylum procedure on quality of life, disability, and physical health in Iraqi asylum seekers in the Netherlands	Quality of Life (QoL), mental health	A long asylum procedure was associated with significantly lower QoL, higher functional disability, and more physical complaints. Length of stay is the strongest predictor for a low overall QoL. Lower QoL was predicted by psychopathology, higher age, adverse life events in the Netherlands and the PMLP clusters: family issues, socio-economic living conditions and socio-religious aspects. Disability was predicted by psychopathology, higher age and the PMLP clusters: family issues and socio-religious aspects. Physical complaints were predicted by length of asylum procedure, psychopathology, female sex, adverse life events in Iraq and PMLP-family issues. A long asylum procedure has a negative impact on the overall	A longitudinal design would have been more appropriate for studying the effects of a long asylum procedure.

			health situation and the QoL of asylum seekers. 56–58.4% reported clinically significant levels of symptoms of depression, anxiety, and risk of having PTSD.	
Leiler, A. et al., 2019	Mental health and quality of life among asylum seekers and refugees living in refugee housing facilities in Sweden	Quality Of Life (QoL) And Mental Health	Prevalence estimates were higher among asylum seekers than among those who had received their residence permit. Quality of life was generally rated below population norms and correlated negatively with mental health outcomes.	Convenience sampling.
Löfvander, M. et al, 2014	A case–control study of self-reported health, quality-of-life and general functioning among recent immigrants and age- and sex-matched Swedish-born controls	QoL, SWB And General Functioning	Statistically significant differences between the groups across all time points in terms of psychological health and social relationships. At both the baseline and 6-month follow-up, the PPS-group demonstrated higher levels of well-being, health, and quality of life compared to the Sb group, regardless of gender. These new immigrants did not have inferior physical or psychological health, quality-of-life, well-being, or social functioning compared with their age- and sex-matched Swedish born pairs during a 1-year follow-up.	Sb recruitment with less than 50% agreeing to participate in the survey. Rather short follow-up time of 1 year to observe changes in QoL. Many refugees were reluctant Some PPSs did not readily comprehend the personal questions about body and sex life.
Mangrio, E. et al., 2021	Risk for mental illness and family composition after migration to Sweden	Mental Health	Marital status was not associated with a risk for mental illness. For male Arabic-speaking refugees with a spouse or child left behind in the home country there was a border line significant increased risk for mental illness The risk for female Arabic-speaking refugees was non-significant. Arabic-speaking refugees who were separated from family members reported an increased risk for mental illness after arriving in the host country.	The moderate external dropout rate may have a negative impact on the generalizability of the findings. The way that family composition was asked for in the questionnaires were not considered a choice of covariates in the adjustment model.

				Language proficiency measurement was not sensitive and sophisticated enough.
Mölsä, M. et al., 2016	Mental health among older refugees: the role of trauma, discrimination, and religiousness	Mental Health	Newly arrived refugees with non-permanent legal status and severe exposures to war trauma, childhood adversity, and discrimination endorsed greater PTSD symptoms, while only war trauma and discrimination were associated with depressive symptoms. High religiousness could play a buffering role among older Somalis	The cross-sectional study setting does not allow establishing causal relations between retrospective reporting of past trauma or adversities and mental health. The childhood adversity scale would have required cultural modification. The choice of tailoring an eight-item religiousness questionnaire serves criticism. It would be necessary to consider contextual factors.
Niessen, A. et al., 2021	Post-migration Stressors and Subjective Well-Being in Adult Syrian Refugees Resettled in Sweden: A Gender Perspective	Subjective Well-Being	Financial hardship poses the greatest risk to subjective well-being, especially for men. Gender, education, and potentially traumatic experiences are associated with subjective well-being. Post-resettlement social strain, but also financial strain, had clear gendered effects on SWB, with much stronger effects in males than in females. Social support seems to mitigate the negative effects of financial strain on SWB	Risk that selection bias may have affected results. The findings may not be generalized to other refugee populations. It is possible that some of the questions in the scale rest too heavily on assumptions and expectations. The cross-sectional design of the study places clear limits on causal interpretations. No pre-registered study protocol.
Sharareh, A. et al., 2007	The health of female Iranian immigrants in Sweden: a qualitative six-year follow-up study	Perception Of Health Needs	During the first decade after migration, female immigrants may overcome some health-related factors such as experiences of traumatic events. Unemployment or experiences of discrimination and racism, however, were observed even two decades after migration.	Homogeneous and limited number of interviewees. Similar backgrounds may have influenced the study group's perception of health and the factors that influence their own health in Sweden

Steel L. J. et al., 2016	The Psychological Consequences of Pre-Emigration Trauma and Post-Migration Stress in Refugees and Immigrants from Africa	Mental Health	Males reported a significantly greater number of traumatic events [and post-migration stress than females. Females reported a higher prevalence of depressive symptoms when compared to males. Those with a shorter duration in Sweden reported higher rates of PTSD. The greater number of traumatic events was found to be significantly associated with the severity of PTSD symptoms. 82 and 83 % of the variances associated with anxiety and depression, respectively, were explained by gender, education, religion, PTSD, and post-migration stress. Sixty-nine percent of the variance associated with PTSD included education, number of traumatic events, depressive symptoms, and post-migration stress. Forty-seven percent of the variance for acculturation was accounted for by a model that included age, education, duration in Sweden, anxiety, depression, and post-migration stress. These predictors were also significant for employment status except for depressive symptoms.	Non-random sampling. The use of interpreters may have led to a different interpretation of the questions. Cross-sectional study that does not allow a cause-and-effect relationship to be established.
Sundvall. M. et al., 2020	Safe but isolated – an interview study with Iraqi refugees in Sweden about social networks, social support, and mental health	Social Support	Weakened social networks, barriers to integration and challenges to cultural and religious belonging were the main post-migration challenges. Negative contact with authority persons was often seen as humiliating or discriminating. Acquiring a new cultural belonging and changing family and gender roles made it more difficult to preserve and develop the culture of origin. Traumatic experiences and mental health problems were common in this group. Family issues were more often associated with mental health problems.	A subgroup of the sample was recruited from individuals who had sought help for psychological problems. Interviewers' preconceptions about the challenges of migration may have influenced the outcomes. The large interval of time spent in Sweden may have had an impact on several outcomes.

Tinghög, P. et al., 2010	The association of immigrant- and non-immigrant-specific factors with mental ill health among immigrants in Sweden	Mental Health And SWB	Mental ill health among immigrants is independently associated with non-immigrant-specific factors and immigrant-specific factors	The non-response rate was high. Low statistical power for some of the study's analyses. Cross-sectional study that does not allow a cause-and-effect relationship to be established.
van Loenen, T. et al., 2017	Primary care for refugees and newly arrived migrants in Europe: a qualitative study on health needs, barriers and wishes	Perception Of Health Needs	The main health problems of the participants related to war and to their harsh journey like common infections and psychological distress. Important barriers in accessing healthcare. They wish for compassionate, culturally sensitive healthcare workers and for more information on procedures and health promotion.	Limited time in conducting the research and lack of professional interpreters. Lack of previous literature.
Wiking, E. et al., 2004	Ethnicity, acculturation, and self-reported health. A population-based study among immigrants from Poland, Turkey, and Iran in Sweden	Self-Reported Health	The strong association between ethnicity and poor self-reported health seems to be mediated by socioeconomic status, poor acculturation, and discrimination	Health status is self-reported instead of diagnosed diseases. Basic education is differently defined in different countries and different ages. The causality must be handled with caution. The non-response rate was higher in the immigrant group than among the Swedish control group.

Risk of Bias in Studies

All included studies received a qualitative methodological evaluation following the JBI guidelines, as shown in Tables 2.3, 2.4, and 2.5. None of the 17 studies was excluded due to critical appraisal.

Table 2.3: Quantitative cross-sectional studies' qualitative methodological evaluation

QUANTITATIVE CROSS-SECTIONAL STUDIES												
	ITEM	**Jesuthasan, J. et al., 2018**	**Kuittinen, S. et al., 2017**	**Laban, C. J. et al., 2008**	**Leiler, A. et al., 2019**	**Mangrio, E. et al., 2021**	**Mölsä, M. et al., 2016**	**Niessen, A. et al., 2021**	**Steel L. J. et al., 2016**	**Tinghög, P. et al., 2010**	**Wiking, E. et al., 2004**	**Q. A. SCORE**
1	**Were the criteria for inclusion in the sample clearly defined?**	+	+	+	+	+	+	+	+	+	+	**100%**
2	**Were the study subjects and the setting described in detail?**	+	+	+	+	-	+	-	+	-	+	**70%**
3	**Was the exposure measured in a valid and reliable way?**	+	+	+	+	+	+	+	+	-	+	**90%**
4	**Were objective, standard criteria used for measurement of the condition?**	+	+	+	+	-	+	+	+	+	+	**90%**
5	**Were confounding factors identified?**	+	+	+	-	+	-	+	-	+	-	**60%**
6	**Were strategies to deal with confounding factors stated?**	+	+	+	-	+	-	+	-	+	-	**60%**
7	**Were the outcomes measured in a valid and reliable way?**	+	+	+	+	+	+	+	+	+	+	**100%**
8	**Was appropriate statistical analysis used?**	+	+	+	+	+	+	+	+	+	+	**100%**
	Overall appraisal	**Included**	**Included**	**Included**	**Included**	**Included**	**Included**	**Included**	**Included**	**Included**	**Included**	
	QUALITY ASSESSMENT SCORE	**100%**	**100%**	**100%**	**75%**	**75%**	**75%**	**87.5%**	**75%**	**75%**	**75%**	

Table 2.4: Quantitative case-control studies' qualitative methodological evaluation

QUANTITATIVE CASE - CONTROL STUDIES			
	ITEMS	Löfvander, M. et al, 2019	**Q. A. SCORE**
1	Were the groups comparable other than the presence of disease in cases or the absence of disease in controls?	+	100%
2	Were cases and controls matched appropriately?	+	
3	Were the same criteria used for identification of cases and controls?	+	
4	Was exposure measured in a standard, valid and reliable way?	+	
5	Was exposure measured in the same way for cases and controls?	+	
6	Were confounding factors identified?	-	
7	Were strategies to deal with confounding factors stated?	-	
8	Were outcomes assessed in a standard, valid and reliable way for cases and controls?	+	
9	Was the exposure period of interest long enough to be meaningful?	+	
10	Was appropriate statistical analysis used?	+	
Overall appraisal		Included	
QUALITY ASSESSMENT SCORE		80%	

Table 2.5: Qualitative studies' qualitative methodological evaluation

QUALITATIVE STUDIES								
	ITEMS	Brea Larios, D. et al., 2022	Gewalt, S. C. et al., 2019	Kiselev, N. et al., 2020	Sharareh, A. et al., 2007	Sundvall. M. et al., 2020	van Loenen, T. et al., 2017	**Q.A.SCORE**
1	Is there congruity between the stated philosophical perspective and the research methodology?	+	+	+	+	+	+	100%
2	Is there congruity between the research methodology and the research question or objectives?	+	+	+	+	+	+	100%
3	Is there congruity between the research methodology and the methods used to collect data?	+	+	+	+	+	+	100%
4	Is there congruity between the research methodology and the representation and analysis of data?	+	+	+	+	+	+	100%
5	Is there congruity between the research methodology and the interpretation of results?	+	+	+	+	+	+	100%
6	Is there a statement locating the researcher culturally or theoretically?	+	+	+	+	+	-	83%
7	Is the influence of the researcher on the research, and vice-versa, addressed?	+	+	+	-	+	+	83%
8	Are participants, and their voices, adequately represented?	+	+	+	+	+	+	100%
9	Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	+	-	-	-	-	+	33%
10	Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	+	+	+	+	+	+	100%
	Overall appraisal	Included	Included	Included	Included	Included	Included	
	QUALITY ASSESSMENT SCORE	100%	90%	90%	80%	90%	90%	

Results of syntheses

The current systematic literature review identified the following areas related to factors influencing or determining the health of undocumented migrants, refugees and asylum seekers from Africa and Middle East to Europe: Sociodemographic factors, psychopathology and adverse events, residence permit, basic needs, physical problems, and housing conditions, barriers to accessing healthcare, income and social protection, socio-cultural adaptation, and family issues. Results of syntheses are described in detail in Table 2.6.

Table 2.6: Result of synthesis

	Result of synthesis
Sociodemographic factors	❖ Female and/or divorced/widowed -> mental symptoms and depression in both Middle East and African refugees (Steel et al. 2017; Sharareh et al. 2007; Tinghög et al. 2010) ❖ Interpersonal and religious causes (Somali women) (Kuittinen et al. 2017) ❖ Domestic issues and gender issues (Afghani women refugees) (Brea Larios et al. 2022) ❖ Discrimination (Iranian-origin women) (Wiking et al., 2004) ❖ Man = social stress (Nissen et al. 2021) Traumatic experiences in afghani (Brea Larios et al. 2022) Acculturation challenges in young afghani (Brea Larios et al. 2022) ❖ High age and low education -> low quality of life in Middle Eastern refugees (Laban et al. 2008; Jesuthasan et al. 2018)
Psychopathology and adverse events	❖ War trauma, childhood adversity, and travel trauma -> PTSD and depression (Brea Larios et al. 2022; Kuittinen et al. 2017; Mölsä et al. 2016; Sundvall et al. 2020; van Loenen et al. 2018) ❖ Traumatic experiences, psychopathology, and adverse events -> lower QoL (Jesuthasan et al. 2018; Laban et al. 2008) ❖ N. of traumatic events -> anxiety, depression, and PTSD (Tinghög et al. 2010; Steel et al. 2017) ❖ Feelings of uncertainty, frustration, and injustice were the most common psychological issues among refugees (Kiselev et al. 2020)

Residence permit	❖ Permanent residence for Somali and Iraqi -> not influenced physical and psychological health, social relationships, environmental experiences, and social functioning (Löfvander et al., 2014) ❖ A.S. had a mental health than individuals with residence permits (Leiler et al., 2019) ❖ Newly arrived refugees with non-permanent legal status exhibited higher PTSD symptoms (Mölsä et al. 2016) ❖ Migrants with a lengthy asylum procedure reported significantly lower quality of life, more significant functional disability, and more physical disorders (Laban et al., 2008) ❖ Iraqi asylum seekers in the Netherlands for more than 2 years reported significantly lower quality of life, higher disability, and more chronic physical disorders than those who arrived less than 6 months. ❖ Individuals with a shorter duration in Sweden reported higher rates of PTSD (Steel et al., 2017) ❖ Asylum seekers reported practical problems related to the government, authorities, and residence permits (Kiselev et al. 2020).
Basic needs, physical Problems, and housing conditions	❖ Colds, diarrhoea, vomiting, and dehydration due to limited fluid intake and reception conditions (Kiselev et al., 2020; van Loenen et al. 2018) ❖ Poor housing conditions were associated with low quality of life and lack of access to healthcare (Leiler et al., 2019, Jesuthasan et al. 2018) ❖ Scarcity and overcrowding, lack of privacy and comfort with poor hygiene conditions - > dissatisfaction for the population (van Loenen et al., 2018; Kiselev et al., 2020) ❖ Food with unsatisfactory catering services that neglected religious practices and food with adequate caloric intake but unappetizing and unfamiliar (Gewalt et al., 2019)
Barriers in accessing healthcare	❖ Difficulties accessing pregnancy and mental health primary healthcare (van Loenen et al., 2018) ❖ Insufficient information about the rules and procedures of the centers, the organization and location of healthcare services, and the lack of continuity of care (Kiselev et al., 2020) ❖ Time pressure, lack of trust, and lack of information were reported as the main barriers to care (Kiselev et al., 2020) ❖ Syrian women who preferred female doctors from the same geographic/cultural background (Kiselev et al., 2020)

Income and social protection	❖ Poor social network and poor economic situation: risk factors for mental health (Tinghög et al., 2010) ❖ Satisfaction with personal relationships was high, highlighting the role of social support and social cohesion crucial for well-being (Jesuthasan et al., 2018) ❖ Employment and education issues: risk factors for health (Kiselev et al. 2020) ❖ Lower QoL was correlated with socio-economic living conditions (Laban et al., 2008) ❖ Post-resettlement social and financial stress had gender effects on SWB, with stronger effects on males than female (Nissen et al., 2021) ❖ Low socio-economic status -> poor self-reported health in Turkish-origin men and women and Iranian-origin men (Wiking et al. 2004) ❖ Social support mainly provided by family members and integrated by authorities' support, although social weakening has emerged as a theme related to health problems (Sundvall et al. 2020).
Socio-cultural adaptation	❖ Low level of socio-cultural adaptation: risk factor for mental health (Tinghög et al. 2010) ❖ Barriers to integration and challenges to cultural and religious belonging can be post-migration challenges (Sundvall et al., 2020) ❖ Cultural differences, language, and ethnic discrimination can be post-migration challenges (Kiselev et al., 2020) ❖ Socio-religious aspects were predictors of poor quality of life and mental health (Kuittinen et al. 2017; Laban et al. 2008) ❖ A high religiosity may serve as a buffer for elderly Somali refugees and mental health problems (Mölsä et al. 2016) ❖ Refugees who experienced discrimination were more likely to exhibit PTSD and depression (Mölsä et al., 2016) ❖ Acculturation was not associated with such problems (Kuittinen et al. 2017) ❖ Ethnicity has been associated with poor self-reported health status (Wiking et al., 2004) ❖ Fear of stigma and language differences, can play an important role (van Loenen et al., 2018)
Family issues	❖ Family problems have been associated with a lower quality of life, with integration difficulties and mental health problems (Laban et al. 2008) ❖ Arabic-speaking refugees with incomplete families were likelier to suffer from mental disorders than those with all family members present (Mangrio et al. 2021) ❖ Women from the Middle East mainly travelled with family members and children, while women from East Africa reported travelling more often alone, likely due to the structural and political situations of their countries of origin (Jesuthasan et al. 2018) ❖ Failure to reunite with family members and worry for relatives were particularly distressing (Sundvall et al., 2020)

Discussion

This systematic review summarized the knowledge about the health needs of undocumented migrants, refugees, and asylum seekers migrating from Africa and the Middle East to Europe. Most of the reviewed articles focused on the health status of migrants and refugees, examining mental health, quality of life, subjective well-being, and self-reported health. What emerged was the impact of migration on the physical and psychosocial sphere and how the conceptualization of needs differs according to cultural beliefs and social conditions, allowing us to identify possible areas of intervention for professionals to address these needs and ensure good health and quality of life.

Many studies were conducted in Northern Europe, and 8,609 undocumented migrants, refugees and asylum seekers from Africa and the Middle East were included. Most included studies adopted a cross-sectional quantitative research design, while others utilized a qualitative design. All included studies underwent a methodological evaluation, and none were excluded based on quality assessment. The highest scores in quantitative studies were achieved for clearly defined inclusion criteria, valid and reliable outcome measures, and appropriate statistical analysis. In qualitative studies, the items receiving lower scores were related to ethical approval and the cultural/theoretical positioning of the researcher.

Consistent with the systematic review by Iqbal et al. (2022) and the study by Mattar and Gellatly (2022) which involve migrants from all over the world, our findings confirm that migration is a significant health stressor at all stages of the migration process, especially for refugees who experience significant displacement, emotional and physical trauma, and cultural dissonance associated with resettlement experiences before and after migration to the host country. Specifically, in the post-migration phase, the most common health problems related to the physical and psychosocial spheres, particularly mental health, social support, access to health care, and basic needs, need to be adequately and urgently addressed.

Mental health has been one of the most explored fields in the articles included in our review, confirming the hypothesis that an uncertain migration status causes mental health problems. Our study highlighted how refugees and asylum seekers

showed a significant need for psychological assistance manifested by post-traumatic stress disorder (PTSD), depression, and anxiety. Indeed, as described by a review by Bustamante et al. (2018) and the study by Knefel et al. (2022) which involve mental health professionals' perspective, migration is associated with specific stressors, primarily related to the migratory experience and the necessary process of acculturation that occurs during adaptation to the host country, which have significant consequences for mental health. Among all disorders, PTSD among migrants has the highest prevalence (47%), especially among refugees, who experience it at nearly twice the rate of migrant workers (Bustamante et al., 2018). Although pre-migration trauma emerges as one of the leading causes of mental stress (Steel et al., 2017), mental health is also strongly influenced by post-migration life problems (PMLP), which include social and financial stresses (Kiselev et al., 2020; Nissen et al., 2021) and socio-cultural factors (Brea Larios et al., 2022), in line with the study by Brunnet et al. (2022) investigating migration experience and mental health in France and Brazil. However, according to previous studies by Fakhoury et al. (2021) which included also economic migrants and the scoping review by Lebano et al. (2020), mental health is not recognized as a health priority by migrants. Our results support that mental health likely represents a substantial and often unrecognized burden of illness affecting this population group, which needs to be addressed through multifaceted interventions.

The included articles strongly linked social stress and health status (Nissen et al., 2021). Socio-economic conditions, issues with residence permits (Löfvander et al., 2014), and language-related problems (Wiking et al., 2004) emerged as significant causes of poor health. Alongside these factors, several studies have examined the influence of sociodemographic factors on health, including gender, age, marital status, and education level (Brea Larios et al., 2022; Jesuthasan et al., 2018; Steel et al., 2017), highlighting how meeting these needs involves the creation of a solid social network. Often, for migrants, the social network consists of their family. When separated, their health is compromised, highlighting their close connection (Jesuthasan et al., 2018; Mangrio et al., 2021).

Social support could be a protective factor for health as it generates positive experiences that reduce the stress related to cultural changes experienced by migrants, as also found by Henríquez et al. (2022) in Venezuelan migrant populations. Our

findings show that a lack of integration and inclusion may cause social stress and mental disorders (Mölsä et al., 2016; Steel et al., 2017). Therefore, support that promotes socio-cultural adaptation through inclusion, acceptance, and even socio-economic support is necessary (Nissen et al., 2021), while still taking into account the specific cultural identity of each person, which is a challenging process without adequate support (Tinghög et al., 2010). Social networks and dedicated infrastructures can facilitate adaptation and a sense of well-being and belonging (Lebano et al., 2020). For this purpose, creating a robust social network and leveraging resilience could significantly improve the health status of migrants, (Walther et al., 2021).

Regarding basic needs, these include housing problems and poor living conditions (Kiselev et al., 2020; Sundvall et al., 2020), environmental hygiene issues, problems related to food and water, and physical problems (van Loenen et al., 2018). The "healthy migrant effect" explains how the environment is crucial in determining health status (Costa, 2017). Exposure in the post-migratory phase to difficult environmental, relational, and cultural situations, such as unsafe or unhealthy living and working conditions, changes in lifestyle related to the acculturation process, and limited access to health services, may cause a deterioration in their health (World Health Organization, 2023). Therefore, optimal reception environments, the promotion, and assurance of access to healthcare become essential for care and prevention (Klein & von dem Knesebeck, 2018).

Despite the aspiration for universal healthcare, inequalities persist in healthcare access and utilization (Lebano et al., 2020). These include legal rights, knowledge of the healthcare system in a new country, previous experiences with healthcare, language and cultural barriers, beliefs and attitudes related to health, and the structure of the healthcare system itself in the new country (Bradby et al., 2015; O'Donnell et al., 2016). In the literature, lack of funding and trained and stable human resources, organizational dysfunction, and poor coordination among different actors are all cited as factors hindering healthcare provision to migrants and refugees (Lebano et al., 2020).

Implications

The literature on the health needs of undocumented migrants, refugees, and asylum seekers appears rich and highly exhaustive in some aspects. This systematic review can be helpful for researchers and clinicians seeking to understand the overall health status of migrants and refugees and provide a comprehensive overview of their general health. From a clinical perspective, it is essential for professionals to fully understand the significant challenges faced by undocumented migrants, refugees, and asylum seekers, to understand better how to address the reported needs, understand the hidden needs, and effectively address their healthcare requests by culturally competent care. This systematic review provides a valuable overview of the most common healthcare needs, useful for professionals to implement levels of care and reception for migrant populations in Europe.

Limitations

This systematic review also presents several limitations. Firstly, the lack of standard definitions (e.g., definitions of migrants, non-migrants, optimal care, etc.) and clearly defined objectives hinder the analysis and comparisons of studies. It is often unclear whether a migrant is a labour migrant, an economic migrant, or part of the undocumented migrant, refugee, and asylum seeker group, making clustering difficult, likely because stakeholders do not always know, and given the sensitivity of migration status, it can be challenging to establish.

Furthermore, although there is an interest in understanding the health status and access to healthcare for migrants, data collection is fragmented and conducted in different contexts and periods.

From a methodological perspective, a substantial lack of longitudinal or prospective studies emerged despite the high heterogeneity of studies available in the literature. Long-term studies could provide knowledge about the changes in migrants' health and needs over time.

Conclusion

Migration is recognized as a significant stressor, particularly for refugees who experience significant displacement, emotional and physical trauma, and cultural dissonance associated with resettlement experiences before and after migration to the host country. The systematic review showed how the European situation regarding the health needs of migrants, according to their experience and the experiences of practitioners, is very heterogeneous, and it is difficult to draw definitive conclusions because of the limited evidence. However, it is noticeable that the available literature regarding the health status of migrants in Europe and Italy and from the Mediterranean basin is rich in publications that have mainly exploited quantitative analysis methods. Thus, a gap emerged in collecting information related to the health needs of migrants in Italy, as the lack of research on their direct experience concerning perceived emerging needs was observed. Providing treatment that is culturally responsive and trauma-informed is essential due to refugees' specific challenges, such as numerous barriers to receiving care, including language and legal barriers, acculturation factors, lack of information on how to access care, lack of health insurance, and mental health stigma (Mattar & Gellatly, 2022).

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Competing interests

The author declares no conflicts of interest.

Availability of data, code, and other materials

Data extracted from included studies are publicly available, and any other materials used in the review can be requested from the authors/journal.

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CAPITOLO 3

Designing and conducting qualitative research across countries and cultures: challenges for inclusiveness and rigour

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Cuoco, A., Arcadi, P., Figura, M. C., Piervisani, L., Alvaro, R., Vellone, E., & Durante, A. (2022). Designing and conducting qualitative research across countries and cultures: challenges for inclusiveness and rigour. European journal of cardiovascular nursing, 21(8), 873–879. https://doi.org/10.1093/eurjcn/zvac067

Abstract

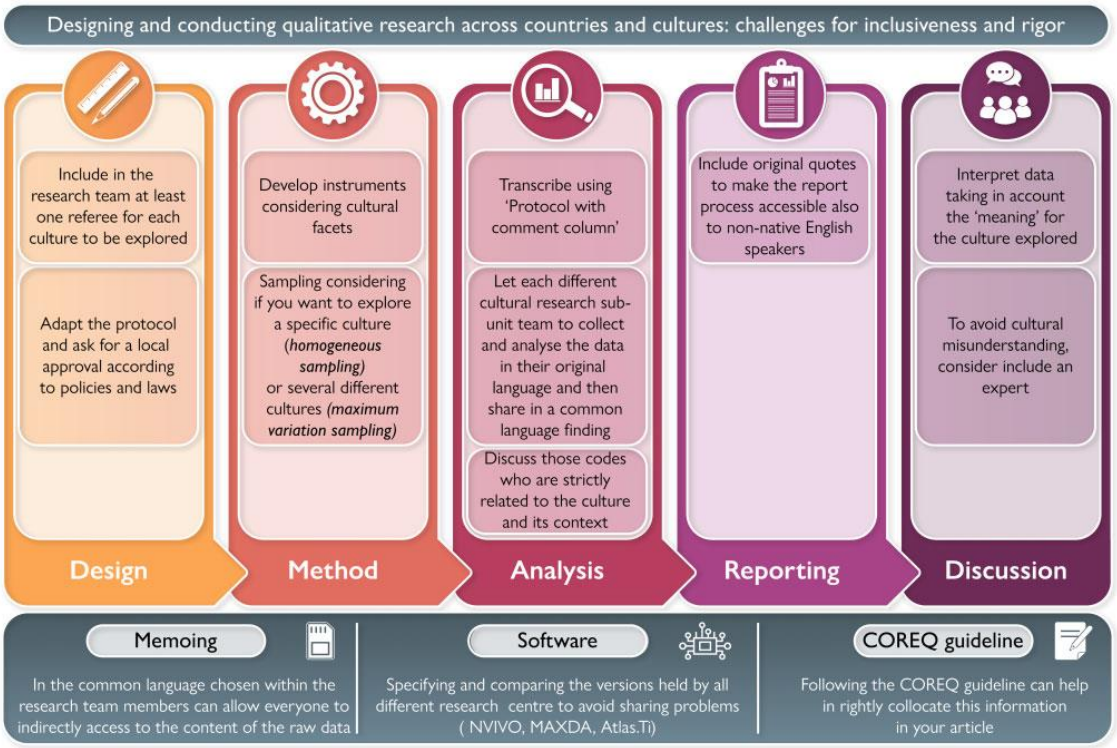
Qualitative research is fundamental to understanding the nature and complexity of human phenomena. While cultural and psychometric validations exist for quantitative tools, the same cannot be said of qualitative ones.

There are other many challenges when conducting a multinational qualitative study, which includes different cultural and linguistic 'biases'.

This paper presents some key issues that researchers may encounter when designing and developing multinational and multicultural qualitative studies, and also provides some strategies to overcome difficulties and ensure rigour.

Keywords: Qualitative research, Multicultural research, Qualitative method, Inclusiveness, Rigour

Graphical abstract



Learning objectives

- Identify common problems in the design and conduct of multinational qualitative studies.
- Describe cultural and linguistic challenges in qualitative analysis.
- List two strategies to enhance rigour of multinational qualitative studies.

The Problem

Qualitative research aims to study human phenomena by exploring and interpreting their meaning from the perspectives of those who experience them. Qualitative research explores emotions, feelings, experiences, and behaviors of both individuals and groups of people in natural contexts and attempts to describe the meanings people attribute to them. In nursing and related health sciences, qualitative studies are particularly useful because they allow us to better understand human behaviors. Moreover, qualitative research can help us understand how culture influences health and illness representation across the lifespan (Bradby, 2002).

In the current era of globalization, people with different linguistic and cultural backgrounds connect with broad global networks, and qualitative researchers from different geographical locations and backgrounds collaborate much more extensively than ever before. Although the number of multilingual qualitative studies has expanded in recent years, investigations on the methodological issues arising from the use of different languages within single research studies are still scarce. Many existing studies have been more concentrated on issues related to the use of interpreters and translation, during or after data collection, and in contrast have paid less attention to ensuring methodological rigor during all phases of the study. Put simply, when studying people from different cultural and linguistic backgrounds, it is critical to address epistemological and methodological challenges which are aimed at avoiding cultural bias across all study phases (Baumgartner, 2012).

Cultural bias is a common problem experienced in multinational qualitative. Cultural bias is a tendency to interpret a word or action according to culturally derived meaning assigned to it, and it is sensible to cultural variation which is the diversity in social practices that different cultures around the world (Haddad et al., 2019). The American Psychological Association add to this definition the judgment, stating that this “tendency… sometimes leads people [investigators] to form opinions and make decisions about others in advance of any actual experience with them (see prejudice).” (APADictionary, 2022). If present, this prejudice, can lead to unintentional misinterpretation, discrimination, or exclusion of the actual nature of the population. Specific groups can also be excluded or misinterpreted by the researchers, producing knowledge that is an incomplete and unreliable representation of the experience.

Prejudice also can create misleading opinions and preconceptions even prior to the onset of investigation (Thurkettle, 2014). Thus, is important to have appropriate cultural representation when designing the interview guide. Hence, it is important to define which contextual and cultural problems may arise in the different phases of a qualitative study. Accordingly, the aims of this method corner paper are to:

a) present the main challenges researchers may experience in the design and analysis phase of multinational and multicultural qualitative studies, and,
b) provide strategies to overcome difficulties and ensure rigor in the conduct of multicultural qualitative studies.

Challenges in Design: Protocol Translation and Question Adaptation

Research questions are crucial to explore the phenomenon under study, orienting the entire investigation process, and above all, interpreting the results. But researchers who are not part of the population under investigation could formulate research questions that are not culturally congruent or appropriate.

Consequently, by constructing research questions that are not appropriate to the culture of the sample to be explored, the risk is to commit a series of 'chain errors' that compromise the veracity of the study findings.

Health concepts and issues are deeply embedded in culture. Words and their meanings are not fixed as often displayed in dictionaries. Apart from cognitive meaning, there are also cultural meanings which are not revealed in lexical definition (Lê & Le, 2006). Additionally, investigators may be capturing phenomena other than those originally conceived because they lack knowledge of cultural values or beliefs specific to that population. For example, if we want to explore the phenomenon related to drug prescription among nurses in Europe, we have to consider that not all European countries allow nurses to prescribe medications despite the free circulation of European nurses established by European laws (2005/36/CE). The same reasoning applies to the choice of data collection instruments. For example, if we want to build an interview guide for a cross-cultural study based on the research question “how did you experience pre-infarct symptoms?” to explore how people experience this acute circumstance, we have to take into account that the perception of symptoms is a process of self-reported health complaints influenced by culture. The study by

Arslanian-Engoren shows that Hispanic women were more likely than Black women to perceive the symptom of headache as indicative of a myocardial infarction (Arslanian-Engoren, 2005). This evidence suggests that ethnic differences influence the perception of one's own state of health. This evidence needs to be taken into account when people from different cultures are included in a qualitative study, so both the overall structure of the study and the interview guide will have to be constructed with these differences in mind in order to ensure the credibility of the study according to the Lincoln & Guba criteria (Lincoln & Guba, 1986).

The choice of the approaches for data collection (i.e., interview guide, diaries, focus groups, ethnography) also is affected by the above-mentioned issue. Importantly, if the tool is developed without considering cultural facets, it could lead to the attribution of different meanings to words or terms used during data collection. Developing an interview guide in different languages means having a serious reflection on the terms to be used, and also considering their etymological roots. For example, despite the fact that facilitator and help are often used as synonyms, at an etymological and linguistic level, help is an action given to aid, while a facilitator is a person who provides help in order to reach a consensus on opinions or actions. A similar example can be observed also with the words problem and need (in health). In qualitative interviews there is a tendency to use positive words, that is, why the term need is preferred to the word problem. But, trying to identify the needs of a population without exploring the information about the problems is like trying to fish without a pond.

For example, what are the right terms that we should use in an interview guide for a multicultural study (including England, Spain, and Italy) in which we want to investigate barriers and facilitators in Left Ventricular Assist Device (LVAD) management? A typical question might be “How confident do you feel about LVAD management?”. Assuming we wanted to translate the interviews, what would be the most suitable terms according to each language? The first translation of “confident” in Italian is “sicuro”. “Sicuro” in the Italian language, like other words, can take on different meanings. In fact, “sicuro” can mean not only “how confident do you feel (e.g., able to handle it)" but also "how safe do you feel (e.g., to use this device)", but also "how protected/secure do you feel" in general. Linguistic issues such as these, require good

communication and agreement among researchers, not only in terms of the content to be included, but also in terms of the meanings they wish to investigate.

Another question might arise is the inclusion of secondary sites to replicate the primary study. Taking the previous example as a hypothesis, let us suppose that the study was first carried out in England, and then it is decided to replicate it in Italy. In the interview guide, there might be a question such as: “How did you apply the advice received from the discharge nurse?”. There would not be a problem here from a semantic point of view, but it would still be impossible to include this question, as it is inapplicable for the Italian context. Understanding "discharge nurse" as that professional who makes contact and calls to organize follow-up services, equipment, and supplies, as well as reinforcing patient instructions and preparations for discharge, it would not be possible to apply it to the Italian context. In fact, in Italy, at the time of discharge, the hospital specialist refers the patient to his or her home under the supervision of the attending physician.

Finally, the last problem we want to address is how to include minorities that are integrated into the major culture. For example, there are countries that are highly globalized or with rich immigration phenomena, thus there are subcultures that are perfectly integrated into the native population. In Italy, for example, a strong nurse migration phenomenon occurred in the 90s, especially from countries such as Romania, Albania, and South America. If today we conducted a study among nurses, part of our sample would easily include professionals originating from those countries but who had been working in Italy for a long time. Thus, in planning our research, we should consider if the different cultural backgrounds could constitute a selection bias. But “How can the different nursing education and cultural background impact the care given in a different population?”. Also, there are possible problems of cultural adaptation in studies on entire native populations, which are internally rich in different official languages like in Switzerland (French, German and Italian) or Pakistan (Punjabi, Pashto, Sindhi, Saraiki, and Urdu). Does this linguistic difference only require an accurate translation or is there more than linguistic difference in these countries?

Planning and preparing an interview guide for a cross-cultural study

We already know that there are three kind of qualitative interview:

1) structured (questions asked in the same inflexible order for all the participants);
2) semi- structured (some pre-defined questions that the researcher follows in a flexible way);
3) unstructured (the researcher has a clear sense of purpose of the study and questions the participant without the need for an interview guide) (Mason, 2017).

Depending on the research questions, an interview structure may be more or less adaptable to the aim of the study. However, if our aim is to explore the interviewee's experience, it is advisable not to remain too anchored to the interview guide. In fact, if we follow the interview guide as a strict script, and do not let ourselves be guided by the interviewee's answers, especially if he or she does not belong to our culture, we might end up with unexpected answers. It is therefore necessary to apply a strategy that reconciles the need to answer research questions with the duty to conduct a study that is methodologically and ethically correct with regard to the culture to which the interviewees belong.

Adapting what Mason (Mason, 2017) proposed about the planning and preparation for qualitative interviews, we have identified a strategy to helping the construction of an interview guide while considering the cultural differences among participants (see Figure 3.1).

Figure 3.1: Strategy for interview guide construction.

For all these reasons also, data collection requires particular attention, in which the characteristics of both the interviewer and the research team cannot be left to chance. Researchers with different cultural backgrounds may not guarantee the criteria of methodological rigor required (Guba, 1981). How to represent what is perceived by the researcher to be congruent with what is expressed by the person interviewed and the "real" reality? (credibility). How does one ensure that the results are a function of the informants only and not of cultural bias? (Neutrality/Confirmability) (Lincoln & Guba, 1986).

Approaches to developing rapport and ensuring psychological and cultural safety.

Achieving cultural safety in health research involves understanding the social, political and historical contexts of the population of interest in the study. It requires social intelligence skills (Raeissi et al., 2019), cultural humility, awareness and sensitivity in understanding that between researchers belonging to the dominant culture and populations belonging to vulnerable groups there are power imbalances in the self-determination of their own cultural concepts of health and well-being (Williams, 1999).

Vulnerable population groups, experiencing inequalities in their health experiences and health outcomes are subsequently subjected to the enquiring lenses of researchers and their interpretation. Just as in clinical practice we apply the Latin maxim 'Primum non nocere', in the same way in research researchers need to create 'safe spaces' in which those being researched can negotiate with researchers on how research is to be conducted in accordance with socio-cultural characteristics and protocols (Wilson & Neville, 2009). Furthermore, is also important to consider that the concept of culture includes age or belonging to different generations of researchers and research sample, gender identities and sexual orientation, socioeconomic status and religious or spiritual belief.

Consequently, culturally safety requires reflexivity. Reflexivity "means turning of the researcher lens back onto oneself to recognize and take responsibility for one's own situatedness within the research and the effect that it may have on the setting and people being studied, questions being asked, data being collected and its interpretation" (Berger, 2015). Reflexivity is challenging because it implies questioning personal beliefs, more or less conscious, that we have assumed throughout our lives from our surroundings, our families or religion. However, reflexibility led to transparency and consequently reinforced the rigor of the study (Arriaza et al., 2015). To obtain beneficial and relevant research outcomes in cross-cultural studies we have to respect the principles of '4 Ps'.

The 'P' of '4Ps' are corresponding to: Partnership: Participation, Protection and Power.

- The principle of Partnership requires that between researcher and research object there is a relationship based on mutual trust and respect for each other diversity.
- The principle of Participation entails the continuous involvement of the researched groups in the planning and decision-making processes within a research project, and ideally in the research itself in order to achieve a more conscious respect of their cultural rituals and behavioural protocols.
- The principle of Protection requires not only respect for the participants' values and beliefs but also active safeguarding of them.

- The essence of the principle of Power can be summed up in this famous quote from the Marvel comics: “With great powers comes great responsibility”. Indeed, the researcher must reflect upon their own privileged position within the relationship with the research subject, who may feel potentially denigrated especially if the researcher belongs to the dominant culture of that context (Wilson & Neville, 2009).

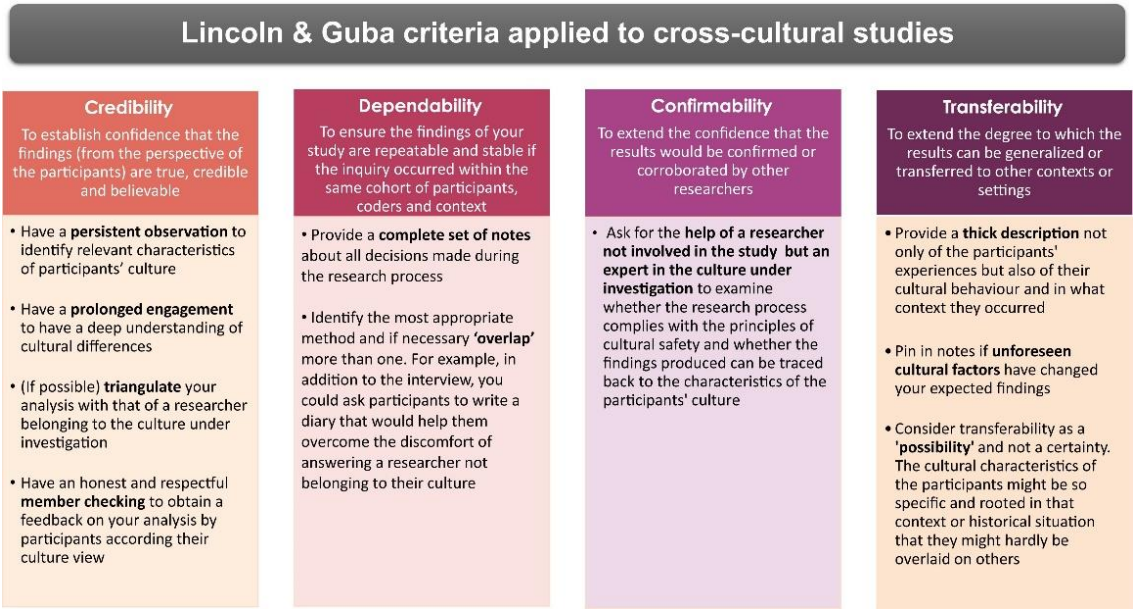
Problems in Analysis: To translate or Not to Translate

Data coding is crucial in any qualitative study. The researcher elaborates and aggregates codes to formulate themes or explanatory categories of the studied phenomenon (according to the degree of abstraction chosen). Each culture may attribute a different meaning to a word or phrase extrapolated from the text under analysis; consequently, the risk is that each researcher might code differently because they are influenced by their cultural orientation. In these cases, a coding bias is very high. Currently, most of the analytical methods to analyze qualitative data do not include specific coding rules and even less coding by considering multicultural populations or languages. But before adopting coding rules, the first challenge of the analysis phase is: to translate or not to translate, that is the question.

The Solutions

Below, the authors suggest some tips on how to apply the Lincoln & Guba criteria to a cross- cultural study.

Figure 3.2: Application of Lincoln & Guba Criteria



Sampling: which sampling is most suitable for a multicultural study?

A famous song by Jarabe de Palo named "Depende" said: "De según como se mire, todo depende" (depending on how you look at it, it all depends). The metaphor of the 'lens' used to look at the phenomenon under study is widely used in qualitative research. In the same way as the choice of lens curvature is important for capturing the best image, the sampling must be chosen appropriately to what we want to collect from our participants. There is no one-size-fits-all strategy for all studies requiring consideration of the cultural background of the participants.

"Depende ¿de qué depende?" ("It depends on what?")

It should be considered, however, that the design will have to include the sampling strategy best suited to the research question. For example, homogeneous sampling is more suitable for those studies that aim to explore one specific culture or sub-culture. While maximum variation sampling will be more appropriate for those studies that aim to include several different cultures or sub-cultures in a unique sample (Sandelowski, 1995).

Cultural bias and research process

The quality of research is always important, especially to transfer findings into practice and care delivery (Noble & Smith, 2015). Qualitative research is frequently criticized because it lacks generalizability, the analytical procedures might be considered poorly transparent and the findings are very subjective and grounded on personal opinions (Rolfe, 2006; Sandelowski, 1993). This sense of disputable subjectivity is more perceived in studies where participants and researchers do not belong to the same culture. The qualitative researcher is part of the research process, and their assumptions and beliefs could influence the research process, both positively and negatively.

One way to make the researcher's cultural background a “positive influence” is to involve, at the design level while writing the protocol, a member from the cultural context that will be explored as a cultural co-researcher. An example of this approach can be found in the study by Haghshenas and Davidson, which included, in their study on cardiac rehabilitation, health professionals from diverse professional and language backgrounds (Haghshenas & Davidson, 2011). When it is not possible to include researchers, who know the cultural background of study participants, it is important to include at least researchers belonging to the country of the study’s participants. For example, one could include a local interviewer or a cultural mediator to help participants to communicate more efficiently, especially when they use some “untranslatable” words. Communication is at the crux of data collection in a multilingual setting. Especially oral data collection in different languages presents additional issues (Thurkettle, 2014). Another useful tip is to engage a local interviewer to help investigators discover culture-based themes that would be best included or excluded when designing the interview guide or focus groups. For example, there are cultures in which there can be a gender or social “unwritten rule” that can block the research purpose if ignored.

The Analysis Dilemma

As previously written, another important issue in multicultural studies concerns transcription, translation and interpretation of the qualitative data collected. In many cases, translating the collected data into the presentation language is fraught with methodological pitfalls related to the handling of colloquial phrases, jargon, idiomatic expressions, word clarity and word meanings (Oxley et al., 2017; Wong & Poon, 2010). In the same way, the most used "verbatim" transcription and consequential translation -often in English- could be the least appropriate way to preserve linguistic and cultural differences. A trick that could help the researcher while they are designing the study is to choose a specific transcription system which ensures that transcripts are understandable for the whole multicultural research team. For example, the "Protocol with comment column" (Mayring, 2014) allows us to include, in addition to the literal transcription of the registrations, the cultural-specific meaning of uttered words in a column alongside the transcription text.

Considering, Pierce's semiotic theory (Atkin, 2010) which defined signification as a complex triadic interaction between object, sign and the interpretant, we must take into account that "meaning" depends on who expressed the concept and how, and who perceives it. In our experience, a good strategy to avoid misunderstanding was to let each different cultural research sub-unit team collect and analyze the data in their original language and then share it in a common language finding. This strategy allowed us to catch the meaning of all those idiomatic expressions that translated "word-for-word" in another language lost in translation. Furthermore, a specific method called "Contextual Coding" (Younas, under review) was developed from our international experience.

As described above, globalization is an increasing phenomenon in our society. This leads to a process whereby the boundaries that determine cultural minorities are becoming increasingly blurred (e.g., second-generation children of immigrants or business travelers who settle for many years in a non-native place). The fundamental issue concerns if these kinds of participants should be included or not. Considering our past experience, we included them regarding their different cultural background in contrast to the rest of the population in data interpretation (Author Blinded et al., 2022).

Software: What hardware and/or software is needed for this method?

Another fundamental issue in multiple cultural and multicentral studies concerns the use of Computer-assisted qualitative data analysis software (CAQDAS) (e.g., Nvivo, MAXQDA, IraMuteq or Atlas). CAQDAS are computer programs for Qualitative Content Analysis that allow to analyze the consistent quantity of qualitative data and transfer them into a software program to control step-by-step text analysis (Mayring, 2014). During the design of the project, it is important to immediately check the CAQDAS and the version available in each participant center. Comparing the versions at the beginning is mandatory to avoid sharing problems, which may cause time and data loss while sharing them from one software to another that may not be compatible. They are a valid support also because they allow storing not only transcriptions but also original audio or video. Furthermore, "memoing" in the common language, chosen by the research team members, can allow everyone to indirectly access the content of raw data.

Reporting: How to report? What parameters/features to report?

In line with the problems expressed before, at first, it is essential to clearly state the identified cultural adaptations of the protocol that had been necessary to carry out the research. So, if there were a need to apply changes in the structure of the questions or to have an interviewer with a specific characteristic, then it would be necessary to make it known. Following the COREQ guideline can assist in rightly placing this information in your article (Tong et al., 2007).

Furthermore, it could be useful to include in the reporting the original quotations of the findings with the translation to make the report process clearer (Author Blinded et al., 2022) and accessible also to non-native English speakers. Moreover, a good strategy to report the findings in the clearest and most transparent way is to declare the possible cultural bias and probably linguistic gap due to translation. If possible, the support of a linguistic expert can reduce the risk of translation and adaptation mistakes. Moreover, this will enhance the collaboration between experts from different fields of knowledge.

Conclusion

Despite it being challenging to conduct multicultural studies, it would be also challenging to conduct studies without considering culture in a globalized health reality, both from patient and clinician perspectives. In accordance with previous studies, when designing the study, the challenge is to know when ethnicity makes a difference and/or mediates a person's relationship with service support and when it does not (Astin et al., 2008). Thus, health professionals should develop a cultural repertoire to engage with diversity and differences (Astin et al., 2008) even if English is the language of science and almost all literature in this field is written in this language (Hamel, 2007). It is not possible to ensure that the strategies here presented are exhaustive to ensure inclusion and cultural sensibility in health research topics. However, multicultural studies are still few in cardiovascular care, so further research is needed to build solid evidence which can turn into a real setting practice.

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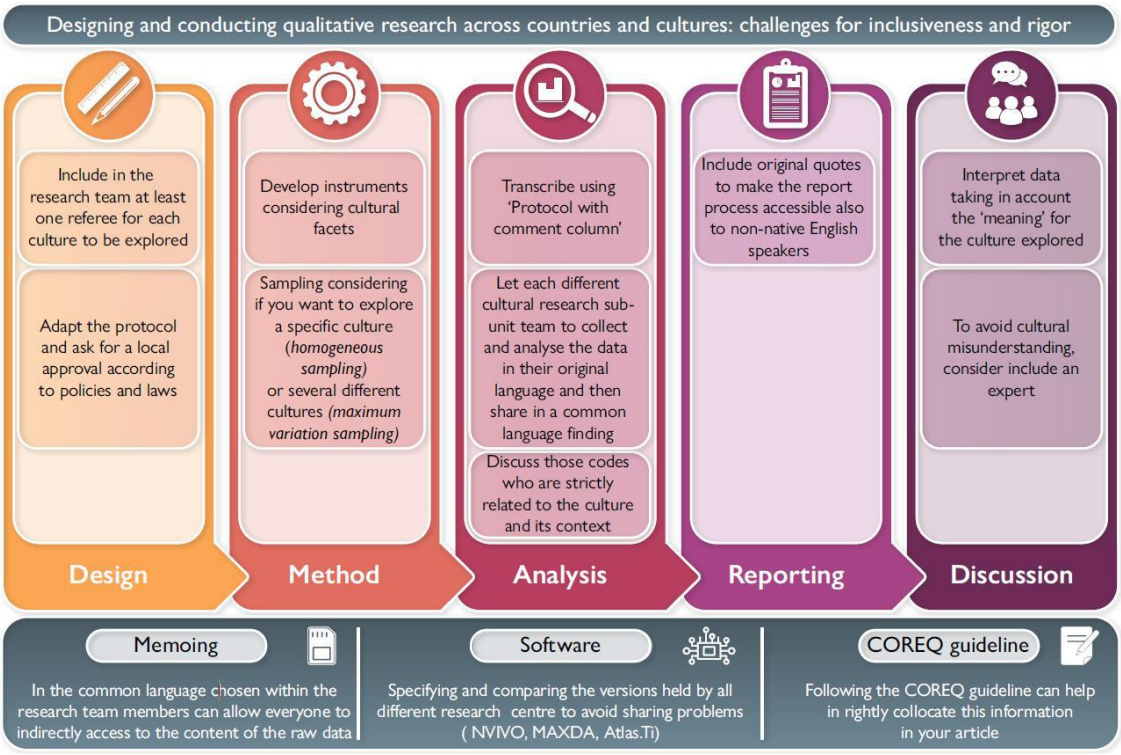
Conflict of Interest

The Authors declare that there is no conflict of interest.

Data Availability Statement

Data sharing not applicable to this article as no datasets were generated or analyzed during the current study.

Visualization



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CAPITOLO 4

The experience of health professionals and social workers providing care to migrants: phenomenological study in a multicultural context

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Abstract

Introduction: Migrants and refugees belong to the most marginalized groups in the world. Barriers related to the determinants of health can often preclude access to basic human rights and have a negative impact on health. Therefore, it is essential to understand how to properly interface with people with different perceptions of health and disease and how to design programs based on available resources.

Aim: to explore the experience of socio-health workers who work in the context of a reception project in Italy related to taking care of the health needs of a migrant population in a multicultural context.

Methods: This research was a qualitative phenomenological study with an interpretive approach adhering to the Consolidated Criteria for Reporting Qualitative Research guidelines. Data were collected using a semi-structured face-to-face interview. The conversations were audio- recorded, transcribed, and read in depth. Reflexive analysis was used to analyse the data.

Results: Three main themes were extracted: 1) Movement of needs; 2) Iinterconnection; and 3) Struggles.

Discussion: What the study found underscores the importance of designing interventions that consider the unique perceptions and experiences of professionals who engage with migrants in daily practice. The complex health needs, experiences and different cultural representations of health and illness must be read and approached with a culturally competent vision.

Conclusion: The study reveals how much the strengths of taking care of migrants' health lie in the ability to interconnect various competencies. This study gives elements for professionals and health organisations to understand the complexity of caring for the migrant population.

Keyword: Migrants, culturally competence, health-care workers experience, health needs, nursing/nurses, qualitative research, community care.

Introduction

In the 21st century, the increasing wars, conflicts, and persecution has become one of the leading causes of migration worldwide (Lenderts et al., 2021). This phenomenon is reshaping the traditional arrangements on which living in societies was based locally and internationally (Dao et al., 2021). In the last decade alone, 100 million people have fled their homes to seek refuge within or outside their countries' borders (UNHCR, 2019). According to the Mid-Year Trend report, published by the U.N. Refugee Agency (2021), there was an exponential growth in migration. More than 84 million people worldwide migrate forced by violence, insecurity, and climate emergency (UNHCR, 2021).

In this context, an unprecedented influx of refugees, asylum seekers, and other migrants have been observed in Europe, where approximately 1.5 million people have arrived in Europe since 2015, more than 1 million of whom have sought asylum after fleeing countries affected by war, conflict, or economic crisis (Mammana et al., 2020). The social, economic, political, and cultural impacts generated by migration within the European continent are also reflected in Italy, which the last 20 years, shifted progressively into a "country of immigration". At the end of 2021, Italy hosted over 165,000 refugees and asylum-seekers in reception facilities, including over 12,000 unaccompanied children. Most people of concern came from Nigeria, Pakistan, Afghanistan, Mali, Somalia, and Gambia (UNHCR, 2022). It is estimated that in 2015-2020, about half a million people arrived on our coasts, crossing the central Mediterranean route that connects the two shores of the Mediterranean. These events inevitably confronted Italian society with the challenge of reception and inclusion (Anci et al., 2017; Capello et al., 2014; SPRAR, 2016).

Background

Concerning health, migrants from the Mediterranean are often affected by physical and psychological traumas resulting from the violence they experienced during the journey (Commodore-Mensah et al., 2021; Fazel et al., 2005; Hameed et al., 2018). In addition, poverty, social isolation, armed conflict, human rights violations, stressors related to forced migration and separation from family make it very difficult to maintain an optimal health status (EpiCenter, 2013; Gümüşsoy et al., 2021; Legido-

Quigley et al., 2019; WHO, 2018). What has been said is also amplified by the linguistic and cultural barriers and by the perception by migrants of a lack of consideration of their own needs, values, beliefs, and cultural practices by the host countries (Lenderts et al., 2021). All these aspects could complicate the process of adaptation and social integration within host countries, lead to health inequalities (Commodore-Mensah et al., 2021; Vasquez et al., 2011) and negatively impact the perceived Quality of Life (QoL) of migrants and refugees (D'Egidio et al., 2017; Toselli et al., 2018).

In addition, the so-called "healthy migrant effect," a form of self-selection at origin whereby only those in good health decide to migrate (Fennelly, 2007), is described in the literature. However, once they arrive in the host countries, migrants progressively see their health status depleted, as they are exposed to many risk factors related to generally poor living conditions and poor integration policy, as well as prejudice and stigma that limit access to care (Fennelly, 2007; Nizzi Grifi et al., 2020; WHO, 2022).

Therefore, to protect migrant health, international and national policies should insist on the integration into social and health services, as outlined in the Sustainable Development Goals of Agenda 2030 (IOM, 2022) and by the Global Compact for Safe, Orderly and Regular Migration (2018). To build a society that includes people, valuable resources for its development become relevant. It is crucial to promote social and labour insertion, foster cultural assimilation of the other and the inclusion of migrant groups in health services and ensure the care of a clientele bearing specific biographies, cultures, traditions, beliefs and needs while respecting universal human rights (Commodore-Mensah et al., 2021). In this context, Transcultural Nursing emphasises the importance of knowing the priority health problems affecting specific cultural groups considering cultural substrate and individual and contextual needs, making it relevant to develop a culturally congruent care plan (Leininger and McFarland, 2002; Oleson et al., 2012).

To respond to the needs of migrants, refugees and asylum seekers, many European countries united by hosting high migratory flows have adopted a specific system of reception and integration implemented by Local authorities. Various services are implemented as part of organised reception and the support of projects composed of multidisciplinary teams, including healthcare workers (European Union Agency for Asylum, 2022; Mancini et al., 2019; Priebe et al., 2011). The aim is to guarantee

protection and material, health, social and psychological reception thanks to individual paths of socioeconomic insertion and integration into the community (Reception and Integration System, 2022). These territorial projects provide for implementing social accompaniment activities aimed at knowledge of the territory and adequate access to local services, including social and healthcare. Specialised projects for the reception are also implemented to support people with specific vulnerabilities such as disabilities or health problems (physical and mental), unaccompanied minors, victims of torture, single-parent households, and single pregnant women.

Moreover, specific projects are implemented in Italy to enhance Italy's inland areas, i.e., those geographic contexts mainly characterised by a low number of residents and a shortage of health services. An emblematic example is Camini, a small Italian country located on the Ionian Sea coast in the Calabria region of Southern Italy. It represents an example of integration between native and immigrant populations (Bianco et al., 2015; Reception and Integration System, 2022).

Although several studies have analysed the complexity of immigration (Albers et al., 2021; Lebano et al., 2020; Segal, 2019), only a few studies in Europe, particularly in Italy, have explored professionals' views regarding strengths and barriers in the care of a migrant population (Driel, 2020; Mancini et al., 2019; Priebe et al., 2011; Viola et al., 2018). However, to the best of our knowledge, no studies have analysed the experience of social and health workers in a shelter rooted in the local area, in a situation of close coexistence between migrants, the native population and the workers themselves.

Understanding how to properly interface with people with different needs and perceptions of self, body, health, and disease, and how to design programs to take care of the health of 'migrants', is fundamental to overcoming the emergency logic with which it has been faced to date. Migration can represent an opportunity for the growth and development of the health supply that is notably lacking in these areas. The complexity of reception systems also raises questions about the most effective ways to take care of the needs of migrants and the challenges and resources needed to ensure a higher level of health and provide culturally congruent care aimed at inclusion and integration. Setting up a structured and systematic modality of reception, health promotion and integration allows us to work to achieve the highest possible level of health for all individuals in the area, whether they are migrants or natives. Knowing the

experiences of professionals working in the field of welcoming migrants can therefore help to highlight that which has already been done in this direction and be able to promote an improvement in the entire healthcare process.

The study aimed to explore the experience of social and health professionals working within a reception project in Italy concerning taking care of the health needs of a migrant population.

Methods

Design

A qualitative phenomenological study with an interpretive approach was conducted. Interpretative Phenomenological Analysis (IPA) focuses on the in-depth meaning of the participants' experiences (Smith et al., 2009). On the one hand, it adopts an idiographic approach because of the individual case investigation. On the other hand, it uses an interpretive one, following the principles of hermeneutics (Welch, 1999).

Finally, the phenomenological perspective is used to get knowledge from phenomena, free from theoretical presuppositions that assign meanings to experience *a priori* (Larkin and Thompson, 2012). Researchers run into the personal representations of the experience of people immersed in a linguistic, relational, cultural, and physical world, taking part in intersubjective meaning-making, where one cannot avoid interpretation but must reflect on one's role in producing such interpretations.

Sampling and recruitment

A propositional criterion was used for sampling (Polit & Beck, 2014). Since the standard length of participation in a reception project for each migrant is six months, participants recruited were social and health workers working on the migrant reception project in Camini (RC) with at least six months of work experience. This minimum period was chosen to include professionals who have experienced at least an entire project with a migrant. A shorter work experience in the project probably would not have been sufficient to understand the health needs of migrants and possible health

interventions to implement. Involvement in the study lasted until data saturation was reached (Polit & Beck, 2014).

Data collection

Data were collected in April 2021 in Camini, a rural centre in Southern Italy, at a location agreed upon by the participants. After identifying possible participants for the study, they were contacted individually by the host project leaders to agree on the date and time of the interview. Previously, the participants had had no contact with the researchers. Following the chosen methodology, each researcher involved in the study performed bracketing before the data collection (Creswell, 1994), writing ideas, preconceptions, and beliefs about the phenomenon under investigation. This first step is crucial because researchers' preconceived notions could influence data analysis in studies using a phenomenological interpretive approach (Trufford & Newman, 2012).

By performing this "reflective technique" before data collection and analysis, researchers can take more outstanding care to avoid introducing preconceptions that could negatively influence the research. Data were collected using a semi-structured face-to-face interview (Smith, 2017). This type of interview was chosen because it was particularly informative, allowing the researcher to create the schema for the topics covered. However, the interviewee's responses determine how the interviews are directed (Whiting, 2008). In addition, the semi-structured interview guide provides a clear set of instructions for interviewers and, at the same time, can provide reliable and comparable qualitative data.

The interviews track is shown in table 4.1.

Table 4.1 Interview guide

Based on your professional experience and role, can you tell me what needs are reported to you by the people you care for and how you respond?
Based on your professional experience and role, can you tell me what you see as the priority needs for these people to take care of?
Based on your professional experience and role, what should be the interventions to be put in place to address the needs you mentioned?
Would you tell me about a significant situation that is particularly positive for you concerning your professional experience with migrants?
Would you tell me about a significant situation that is particularly negative for your professional experience with migrants?

During the interviews, the researchers maintained an empathetic attitude, expressing warmth and reassurance, to facilitate the participants' narration of their experiences. Field notes were written, which are useful for recording personal reflections, notes related to the setting and nonverbal language used by the interviewees. According to Corbin and Strauss (1998), interviews were conducted without interruption until participants stated that they had nothing more to add or until new information emerged. Data saturation (Polit & Beck, 2014) was reached after 16 interviews.

A socio-demographic questionnaire, explicitly created for this project, was used to gather information on the characteristics of the participants.

The Consolidated criteria for qualitative research standards for reporting were followed in writing the research report (Tong et al., 2007).

Ethical considerations

The procedures applied in this study followed the principles outlined in the Declaration of Helsinki. Approval was obtained from the Ethics Committee of the University of Rome Tor Vergata (protocol registration number 160.21). The purpose of the study was explained to each participant, and written informed consent was acquired to ensure anonymity, confidentiality, and data protection. All participants were assured they could withdraw from the study at any time. Each interview was

assigned a sequential alphanumeric code, with no possibility of identifying participants.

Data analysis

The interviews were audio-recorded and then transcribed in full by assigning an identification code to each interview. Interviews, data analysis, and the verification of results were conducted in the local native language of the study participants (Italian). The interviews and field notes were read and re-read in depth by two interviewers (PA and SS) independently, initially proceeding to annotate descriptive, linguistic, and conceptual elements that emerged from the text (Smith et al., 2009).

Next, emergent themes were identified, organised in a table to implement a comparison (clustering of themes), and finally grouped within superordinate themes. Each superordinate theme was linked to the underlying themes, which, in turn, were related to the participants' original quotes (Smith et al., 2009). A consensus validation was performed between the two researchers. No discrepancies or disagreements were revealed. Finally, the identified themes were exemplified with a descriptive narrative and illustrated with quotes from the participants.

Rigour

The criteria of credibility, transferability, and reliability described by Guba and Lincoln (1986) were considered to ensure the study's methodological rigour. Member checking was performed (Sandelowski, 2000). The findings were shared with participants, who were asked to confirm the emerging themes and share any additional information. At this point, translation was performed to compile the research report. The processes of translating and back-translating the in-text citations to enhance the themes were carried out according to the World Health Organisation (2016) methodology and focused on conceptual content rather than literal equivalents. The purpose of the translation was to look for the conceptual equivalent of a word or phrase and not a word-for-word translation. Thus, it was ensured that the original meaning of the data obtained was respected.

Findings

The sample comprised sixteen people working on a welcoming project, with a prevalence of male gender (68%) and an average age of 41 years (SD 11.5). In total, 37.5% were healthcare professionals, 37.5% were social workers, and 25% were people involved in community management. Concerning education level, most participants had a higher education level than high school. At least twelve people (75%) attended a specific course in the multicultural field. The sample worked in Camini for an average of 6 years (SD 5). The main sociodemographic results are reported in Table 4.2.

Table 4.2: Sample characteristics

I.D	Gender	Age	Educational level	Marital status	Job occupation	Year of work experience	Year of work with migrants	Multi - cultural training
AZ01	M	44	High school	Married	Project Director	20	10	Yes
BV02	F	43	High school	Married	Project Coordinator	8	8	Yes
CU03	F	33	Bachelor's degree	Married	Psycologist	8	4	Yes
DT04	M	48	Bachelor's degree	Single	Social Operator	15	3	Yes
ES05	M	45	High school	Married	Teacher	20	5	Yes
FR06	F	32	Bachelor's degree	Married	Social Operator	7	7	Yes
GQ07	F	34	Master's degree	Single	Educator	7	7	Yes
HP08	F	38	Master's degree	Married	Ethno-psycologist	10	2	Yes
IO09	F	32	Bachelor's degree	Married	Legal Operator	2	3	Yes
JN10	M	68	Master's degree	Married	Specialist Doctor	41	6	No
KM11	F	34	Middle school	Married	Home Care Worker	7	7	No
LW12	M	33	Master's degree	Married	Psycologist	9	4	Yes
XC16	F	42	Master's degree	Married	Cultural Mediator	10	10	Yes
XY13	F	66	Bachelor's degree	Single	General Doctor	38	13	No
YB15	F	30	High school	Single	Teacher	6	6	No
ZA14	F	34	Bachelor's degree	Married	Nurse	7	1	No

Data analysis identified three main themes: 1) Movement of needs; 2) interconnection between skills and in the relationship; and 3) Struggle against shortage. Each theme encompasses different subthemes, summarised in Table 4.3.

Table4.3: Summary of themes and sub-themes

Main theme	Sub-theme
Movement of needs	The discrepancy between priorities of perceived needs Independence and autonomy Manifest and non-manifest needs
Interconnection	Multidisciplinary approach Empathic understanding
Struggle	Struggle against territorial shortages Struggle against time

Movement of needs

This theme includes the participants' attribution of meaning to the needs and necessities of migrants. The interviewees' experience is rich in references to how these needs are expressed and their different facets. First, what in the community represents the "status" of migrants emerges. Although they do not speak the same language, it seems that the operators can perceive the primary needs expressed. The migrant population, although coming from different life experiences and cultural references, is united by the same needs, which manifest themselves as the very consequence of "being a migrant."

In this sense, practitioners describe a commonality of needs, rather than a differentiation based on each person's peculiar context of origin. *"They arrive at a place where they symbolically need to be welcomed, embraced, protected and helped for everything, starting from the foundation to start living again. They express so many complex needs in so many ways, sometimes openly, sometimes we must understand the needs they fail to bring out" (GQ07). "As soon as they arrive, there is the problem of language, but we are now able to understand what they need immediately, because the migrant needs the same thing, regardless of where he or she arrives" (BV02). "They come here with the same needs, and we try to help them" (CU03).* This macro-theme generated three specific sub-themes.

The first sub-theme highlights the discrepancy between the needs reported by the migrants and those identified as priorities by the operators. *"The most noticeable thing at the beginning is that they come with needs and requests that we want to welcome, but, at the same time, these needs don't fit with the goals of the project; it's as if we have different priorities" (XC16).* Among the needs reported, for migrants, it was essential to return to the land of origin; stakeholders, instead, recognised inclusion in the new country as a crucial aspect aimed at promoting integration between the different cultures. *"They always want to return to their homes ... to their roots, and we struggle because our goal is to integrate them into our community (...). It is crucial to understand the boarding line between my point of view as a practitioner and that culture, which must be maintained. The integration between the two cultures is the real challenge" (GQ07).*

The sub-theme "Independence and autonomy" emphasises the operators' strong point of the reception project. Integration and job insertion are achieved through interventions aimed at making them autonomous and independent in society, defined by interviewees as an intrinsic value of any insertion project. At the same time, the operators maintain the recognition of the identity of each one. *"This identity is powerful from a psychological point of view. It gives them the possibility of being recognised as people with personal values, and it is something that leads people to love the community" (HP08).*

However, a consciously unexpressed need would seem to emerge, namely that of learning the host country's language. *"In one case, there was a literacy problem, which paradoxically was a great asset because the lack of literacy denied a person access to an educational path from a work perspective. It is as if they also did not want to eradicate their identity through the difficulty of learning our language" (DT04).* Literacy is thus a pathway that is often hindered by the migrants' lack of motivation to study the host language and by their tendency toward welfarism rather than the acquisition of independence. Interviewees think that the project's limitation lies in the risk of responding to beneficiaries' immediate needs and failing to promote their autonomy*: "They often do not work hard enough to learn the language, which leads to an obstacle in hiring a job. If they cannot interact with their partner or employer (...), we often lull ourselves a bit on our laurels" (GQ07). "A deficit of these projects I see (...) is a defect of*

origin. The paternalism that is "we do everything for you" means that when they come into the project, they go into a muffled reality, depending on the beneficiary agency" (ES05).

Migrants report different needs to operators, but unexpressed needs, not perceived by migrants, are often common. They usually regard mental health as being embodied in bodily forms, and they emerge when help is sought, generating an experience of helplessness on the part of study participants: *"We often find psychosomatic disorders which in reality may conceal a psychic discomfort" (CU03)."I am often confronted with no real request for help, and no real manifestation of distress; this I regret, I don't know what to do to help them" (FR06).*

Interconnection

The second theme explores the experience of health and social workers in dealing with the team and migrants.

The interviews show that the success of taking care of migrants' needs depends mainly on the ability to create connections between professionals and with the migrants regarding skills and mutual understanding. Sharing the peculiarity of living in the same territory in which migrants are welcomed, the work of professionals is directed toward the needs of individuals but oriented toward creating a multicultural community, of which they are part. In the latter aspect, therefore, migrants are not passive users but become active participants in constructing a community that involves both those who are welcomed and those who receive. *"I feel the need for openness, for confrontation, to welcome through listening to the colleague and the migrant the best way to help them, but also to help themselves along a path that a whole community, just as a community, not as individuals, but as a collection of individuals who are walking the path of mutual help" (DT04). "We put our skills to work for them, and they restore our confidence and tell us how we can best work for them and how we can live together."(HP08).*

The main theme emerges from two specific sub-themes: (1) Multidisciplinary approach and (2) Empathic understanding. The real strength of a group working with migrants is its members' cohesion and interdependence, important aspects which are felt by the study participants. Teamwork skills are based on relationships, listening to

each other, and the ability to interconnect, which is the self-representation that emerges most from the interviewees' experience. Indeed, the participants speak of mouldable skills that are not rigidly defined; the complexity of migrants' needs and the immediacy with which they demand response require mutual adaptation, elasticity, and the ability to respond by uniting different perspectives and points of view. *"The union, because we are a truly united team which works in tune, means that we listen to each other and that every day we do more and more in a continuous union. One person without the other doesn't make sense in this project. We are connected" (YB15). "What can't be achieved by someone, another does. Sometimes you can't say 'this is up to me,' because the needs they bring to us are about nuanced skills, for which each person can participate in taking charge in a continuous mutual listening" (XC16).*

The sub-theme "empathic understanding" mainly originates from the condition of migration that social workers share with the migrant population. From the interviewees' words emerged a deep meaning of "being a migrant", given by the experience of those who left their country to seek better living conditions in a new land. It represents a condition they share because, personally or referring to close affections, they have experienced migration from the particularly resource-poor South Italy to Northern Regions or other nations. *"I have been a migrant. Or rather, I come from reality, as I told you before, that my class had 35 pupils in elementary schools in the post-war period. Of these, 33 have now migrated far away" (JN10).* Sharing this experience is a privileged condition because it allows the operators to understand the needs, expectations, and desires of the migrants they encounter in their work. *"Also, because of our ancestors or we passed this experience. In my opinion, you should not burden a person who comes from another place, but you must integrate him and make him feel like a person from the community. Because we know what it's like to live in a land other than ours, maybe we can help them better" (CU03).*

Struggle

This theme summarises the central experience of fatigue in social and health workers. It was caused by the multiple deficiencies that the territorial context in which they are placed manifests, the time limits of the reception project, and elements that often lead to the inability to provide the most effective response to the health needs of

the migrant population. It is a significant dilemma experienced by the caregivers because they oversee care but at the same time are aware that they do not possess all the resources to be able to do this to the best of their ability. The struggle is a constant in their caregiving. It is experienced with frustration but at the same time with acceptance, as they grew up in this poor context that led them to struggle to receive care, economic support, and job opportunities for themselves. *"Referring to deficiencies, I say that many times they can be determined, in my opinion as I said before, by deficiencies concerning services, access to services in the territory (...). What happens is that now we have been cornered. In essence, we have extended this stay of some beneficiaries even though the project should be concluded, but they still need" (BV02). "We too are 'health migrants,' we too know what it is like to struggle to get a job, and that is why we used to struggle to emerge, and now we are doing it for them as well" (AZ01).*

This third central theme comprises two specific sub-themes: (1) struggle against territorial shortages; and (2) struggle against time. Participants speak of a daily "struggle" to assert health and social rights in a scenario of territorial scarcity. According to an empathetic vision consistent with the interconnection theme, this situation unites the migrants as much as the operators, who feel alone acting as intermediaries and accompanying the project beneficiaries in the weak services network.*"In Calabria, we work in a poor territory, not only from an economic point of view but also because of the lack of services and territorial network. We often must face difficulties alone, when problems should be shared with a complex system of taking charge, instead" (LV12). "Calabria, a land of love and lack. For them but also us. That's why we try to be a liaison in the network because we know what it means not to have services"(AZ01).*

Finally, a feeling of anger and helplessness for the absence of taking care of migrants by the area's Social-Health Services, due to cultural prejudices ingrained in the System, prevails. *"Seeking an alliance with public facilities that in the case of migrant patients refuse to take them in, we had great refusals despite going with mediators(...) So much anger!" (HP08).* The other element that social workers struggle against is time. Reception projects are temporary and, given the complexity of the health needs and integration needs of individual migrants and their families, time is not sufficient to achieve the project's goals.

Literacy, job placement, autonomy and economic independence require resources that are unlikely to be deployed in a limited period, especially in the socio-environmental scenario in which the project is embedded. *"Especially for the vulnerable cases, it is almost impossible to get job placement, so we have to prolong the situation, but now you just can't go back, now they have to get out of the project, and we are trying to find solutions" (BV02)."Time is not enough, mainly because of the difficulties we have in helping them find a home, because of prejudice, but even in other regions of Italy we struggle, even the time to care for them is long" (XY13).*

Discussion

This study explored the experience of social and health professionals working in an Italian reception project about taking care of the health needs of a migrant population. Analysis of the interviews identified three themes: 1) Movement of needs; 2) Interconnection; and 3) Struggles.

In the first theme, the movement of needs is represented first and foremost by the priority given by migrants and caregivers throughout the reception process. The latter's perception sometimes seems to move in different directions. For migrants, it is crucial to maintain their identity roots with the hope of returning to their original country. It is a human condition that is described in the literature as an element that can hinder adequate settlement (Nicolais et al., 2021) and lead to resistance to language learning, which turns out to be the first intervention to facilitate the achievement of autonomy and independence in the host country, as reported by study participants. Language barriers and cultural norms are interrelated elements that result in barriers to settlement and access to care (Mammana et al., 2020; Manuti et al., 2010; Mladovsky, 2007; Naing et al., 2020; Priebe et al., 2011; Serre-Delcor et al., 2021). The tendency toward welfare described by the interviewees seems to be a consequence of the difficulty of attachment to a place that is typical of settlement approaches (Albers et al., 2021).

In contrast, studies report that the host society may unconsciously exclude migrants if there is no possibility of providing consistent forms of livelihood (e.g., with low-skilled job offers or low-paid occupations) (Galabuzi, 2004; Mancini et al., 2019; Van Loeneen et al., 2018). This "social exclusion" approach can delay or even prevent

the integration of migrants into the host society (Mancini et al., 2019). The other aspect already mentioned and described by the participants in the study concerns the cultural differences that underlie a different perception of priority in the needs expressed by migrants and detected by the professionals. The literature reviewed agrees that professionals experience the difficulty related to the perception of an "immeasurable" distance between the cultural and traumatic experiences experienced by migrants and the help and support that can be provided to them (Bischoff et al., 2009; Mammana et al. 2020; Mancini et al., 2019; Serre-Delcor et al., 2021). The real challenge, then, of a reception project is to maintain the identity of the migrant, recognising cultural roots as the value elements on which to base interventions of caregiving and treatment.

According to Betancourt et al. (2003), cultural competence in healthcare involves different elements. Firstly, to understand the importance of cultural influences on people's health beliefs and behaviours, secondly to consider how these factors influence the healthcare delivery system at different levels and, finally, to design interventions that take these issues into account to ensure quality care. As stated by Leininger (2002), providing adequate training in intercultural competence is indeed the strategic level for transforming the "foreigner" into a person who feels part of a community. They recognise it as their own and emphasise the crucial role of culturally competent nurses in leading the paradigm shift in reception and caretaking. Not only that but considering the needs of migrants with a cross-cultural perspective also means being able to go beyond the most superficial manifestations of those needs. Indeed, the study shows that there are often unexpressed needs or needs that manifest themselves in bodily forms. In general, the literature agrees that psychological distress is more common among asylum seekers and refugees compared to other types of immigration (Lindert, 2009; WHO, 2018) and that in response to psychosocial stress, somatoform disorders often occur (Giammusso et al., 2018; Lanzara et al., 2019; Manuti et al., 2013). In this regard, psychosocial characteristics (ethnicity, culture, religion, exposure to traumatic events, causes of migration, and other individual elements) influence the perception of one's needs and altered psychological health status, as well as help-seeking behaviour (Lanzara et al., 2019; Satinsky et al., 2019). Although there is a high incidence of mental health-related problems among immigrants, they show lower rates

of utilisation of mental health services than natives (Giammusso et al., 2018; Satinsky et al., 2019), an assumption confirmed by the experiences reported by interviewees.

The answer to the complexity of migrants' health needs lies in channelling different skills capable of ascertaining expressed and unexpressed needs to provide culturally congruent responses (De Melo et al., 2014). The second theme that emerged from the analysis emphasises the interconnectedness among the members of the socio-health team of a receiving facility. Participants in the study report the experience of a multidisciplinary approach as a guide to caregiving action. They provide that health is a construct composed of interconnected bio-physiological, psychological, and social dimensions that require an overall view rather than an analytical approach focused on the individual domains (Dahlgren and Whitead, 1991). Indeed, the flexibility of skills and organisation is described as a strength in a migrant intake service (Bottura & Mancini, 2018; Loenen et al., 2018; Priebe et al., 2011), as is the ability to ground care interventions by placing the relationship with the individual migrant and different cultural groups at the centre. According to the literature, migrants experience a sense of attachment to the hosting place and responsiveness to their needs when they are in contexts in which they engage in new positive relationships and feel welcomed expectations and difficulties (Harmsen et al., 2005; Priebe et al., 2011). The scenario is one in which health is seen as the ability to carry out the tasks of daily life without resorting to the dependence non others (Godlee, 2011; Huber et al., 2011).

In the study conducted, interconnectedness among group members and with migrants was concreted thanks to the development of empathic skills. Empathy is the main attribute of welcoming and caring for migrants. It is manifested in the study participants with the characteristics of the concept itself: the ability to understand the feelings and experience of being a migrant and communicate participation and understanding (Gümüşsoy et al., 2021; Kunyk & Olson, 2001; Morse et al., 1992; Wiseman, 1996).

The third central theme was summarised as "struggle against shortage". Responding to migrants' health needs faces structural, spatial, and time constraints. Much literature on the topic confirms that even in countries with public and universalistic healthcare systems, migrants face significant barriers to accessing health services due to bureaucratic, administrative, and organisational factors (Captain et al.,

2013; Institute of Medicine, 2003; Mammana et al., 2020; Mavratza et al., 2021; Salami et al., 2018; Serre-Delcor et al., 2021). There is evidence of a lack of cultural competence in health services or the ineffectiveness of interventions aimed at overcoming these barriers and building immigrant-friendly services focused on migrant health needs and geared toward ensuring equity and appropriate care, both at the time of initial reception and in the long-term (Mammana et al., 2020; Serre-Delcor et al., 2021).

As reported by interviewees, the fragmentation of services and the lack of a continuous and coordinated intake network seem to be the leading cause of delays in diagnosis and treatment and disparities in outcomes (Mancini et al., 2019). The peculiar context of the study, however, revealed a substantial similarity with what is experienced by native citizens. As literature confirmed, they would experience a similar level of healthcare utilisation and the same critical access to care produced in similar contexts in southern Italy (Bianco, 2016; Manuti et al., 2010; Manuti et al., 2013). Indeed, these are economically poor territories, lacking health facilities that can respond to citizens' care needs and often forcing them to migrate to other regions of the country to access services. In addition, migrants must deal with stigma and discrimination that is still very much present, as narrated by study participants, which further limits access to care (Gil-Salmeron et al., 2021; Mak et al., 2021; White, 2016; WHO, 2018).

The present study provides numerous implications for clinical practice. First, it gives elements for professionals and health organisations to understand the complexity of caring for the migrant population. Secondly, the comprehension of the needs is relevant and introduces a widespread intercultural matrix training in every educational context of our society and not only in the exercise of social-health professionals. Moreover, it stands as food for thought on the need to direct research efforts on the implementation of models of care based on a community approach, in which the figure of the community nurse could act as a connection in the network of services from an intercultural perspective. To achieve this result, it would be desirable to continue the research by exploring migrants' views regarding perceived health needs and correlating health status with the interventions implemented by the receiving and caring communities.

Limitations

The study has some limitations. First, it was conducted in a single European country. Hence, the results cannot be generalised, because social and demographic differences between countries that we have not considered may give rise to different findings. Secondly, the heterogeneity of the participants' professional backgrounds may not have allowed them to capture the connections between them and the saturation of some elements that emerged. In addition, having conducted the interviews with readily available personnel selected by the shelter project coordinators may have influenced the participants' responses and orientation to the phenomena under study.

Conclusion

In conclusion, we can say that the study's results have provided multiple insights to guide the intake and care of a migrant population. The complex health needs, experiences and different cultural representations of health and illness must be read and approached with a culturally competent vision. At the same time, this is embedded in a system that can provide organisational structures and a network of coordinated interventions that effectively support taking care of the problems and needs of migrants themselves.

What the study found also underscores the importance of designing interventions that consider the unique perceptions and experiences of professionals who engage with migrants in daily practice. The study reveals how much the strengths of taking care of migrants' health lie in the ability to interconnect various competencies. This finding confirms, even further, the need to develop the advocacy function of nurses in the context of migration and to recognise that clinical nurses, researchers, and educators are critical to the provision of health services to migrants, as they can act as collectors and guarantors of their health rights. Nurse-led models of intake and care could also help to avoid or reduce disparities in access to care and produce culturally congruent outcomes.

Conflict of interests

The author(s) declares no conflicts of interest concerning the research, authorship and/or publication of this article.

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CAPITOLO 5

The health of a migrant population: a phenomenological study of the experience of refugees and asylum seekers in a multicultural context

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Abstract

Background. Refugees and asylum seekers (AS) bring with them a plurality of cultures, traditions and values that could prove crucial in influencing perceived health needs, requests for intervention or willingness to undergo specific health treatments.
Although studies have focused on the health consequences of forced migration in recent years, information is still lacking on how refugees and AS represent their experience of perceived health needs and on the elements that influence health and well-being.
Aim. This study aims to explore the experience of refugees and AS in Italy regarding perceived health needs.
Methods. A qualitative phenomenological study was conducted with an interpretive approach. Data were collected using a semi-structured face-to-face interview. The interviews were transcribed, read in depth, and analysed.
Results. Nineteen refugees and AS were interviewed. Three main themes were extracted: (1) centrality of family, (2) feeling part of a community, and (3) stability and security.
Discussions. The results confirm that health needs, experiences and different cultural representations of health and illness should be read and addressed with a culturally competent vision.

Background

Migration is a global, significant, complex and fast-growing phenomenon influenced by geographic, socio-economic and political factors (Hossin, 2020). In the last decade, 100 million people have fled their homes to seek refuge within or outside their countries' borders (UNHCR, 2022). According to the MId-Year Trend report, there was exponential growth in migration in 2022. More than 84 million people worldwide were forced to migrate due to violence, insecurity and the effects of the climate emergency (UNHCR, 2022). Europe has experienced an unprecedented influx of refugees and Asylum Seekers (AS): about 1.5 million people have arrived since 2015, more than 1 million of whom have sought asylum after fleeing countries affected by war, conflict or economic crisis (Mammana, 2020).

Refugees and AS differ from other migrants because they did not choose to migrate but were forced to flee their countries (International Rescue Committee, 2022). The migration phase following flight is often unpredictable, exhausting, and sometimes marked by encounters with different traumatic experiences. The refugees' experience is punctuated by conditions of uncertainty in which the person is "suspended" between two different societies and forms of culture. Indeed, those who flee their country cross geographic borders and cultural and psychological of the hosting countries (Braca et al., 2014).

The social, economic, political, and cultural consequences, generated by hundreds of thousands of forced migrants within the European continent also manifest themselves in Italy, a country which has seen a significant increase in landings in the last years. In 2019, Italy reported about 354,700 refugees, including AS, representing 5.7 percent of the total migrants (United Nations, 2018). It is estimated that in 2015-2020 about half a million migrants arrived on Italian shores, crossing the central Mediterranean route that connects the two shores of the Mediterranean. Inevitably, this phenomenon led the hosting society to confront the challenge of reception and inclusion (Anci, 2017; SPRAR, 2016).

On the health front, refugees and AS, arriving from the Mediterranean often, report trauma from the physical and psychological violence experienced during the migration (Commodore-Mensah et al., 2021; Fazel et al., 2005; Hameed et al., 2018). Furthermore, poverty, social isolation, armed conflict, human rights violations,

stressors related to forced migration and separation from family make it difficult to maintain optimal health status (Legido-Quigley et al., 2019; World Health Organization, 2023).

The so-called "healthy migrant effect" is known in the literature, which recognizes better health outcomes in migrants than those of the native population (Costa, G. 2017). Nonetheless, post-migration exposure to difficult environmental and cultural situations, such as unsafe or unhealthy living and working conditions, changes in lifestyles related to the acculturation process, and limited access to health services (World Health Organization, 2023) can be the cause of a reduction in their health capital.All these challenges are amplified by language and cultural barriers (Lebano et al., 2020) and the non-uncommon perception by migrants that their needs, values, beliefs, and cultural practices are not considered.

All these aspects could complicate the process of adaptation and social integration within host countries and lead to health inequalities (Commodore-Mensah et al., 2021; Lebano et al., 2020). To protect the refugees' health, therefore, international and national policies should insist on their integration into social and health services, as outlined in the Sustainable Development Goals of Agenda 2030 (I.O.M., 2022) on promoting social and labour insertion, fostering cultural assimilation of the other and inclusion in health services., recalling the principles guiding Transcultural Nursing. Indeed, as described by the transcultural model, nurses should emphasize the importance of knowledge about health problems affecting specific cultural groups, ascertaining cultural substrate and individual and contextual needs to develop a culturally congruent plan of care (Leininger, 2002). Furthermore, migrants bring with them a plurality of cultures, traditions, and values that could be crucial in influencing perceived health needs, requests for intervention, or willingness to undergo specific treatments (National Bioethics Committee, 2017).

A large body of literature indicates that the exposure of refugees and AS to traumatic war-related events has a significant impact to the persistence of mental health disorders (Neuner et al., 2004; Taylor et al., 2014; De Leo et. al, 2021). Refugees and AS share a past trauma that threatens their mental integrity. As described by literature, indeed, trauma is one of the most significant risk factors for depression (Vonnahme et al., 2015), post-traumatic stress disorder (Neuner et al., 2004) and anxiety (Taylor et al., 2014). Many studies have led to greater interest in post-migration

issues, especially stressors and how these affect refugees' psychological well-being (Fazel et al, 2005; Hameed et. al, 2018; Garcia-Cid et al, 2020), while others were focused to analyze specific indicators of social disadvantage, such as unemployment, poor living conditions, single status, and limited social networks (Stilo et al., 2017).

However, although studies were focused on the health consequences of forced migration in recent years, there is still a lack of information on how refugees and AS represent their experience of perceived health needs and elements influencing health and well-being (Luiking et al., 2019). Refugees and AS contribute vital to the debate about their treatment and health, but the dialogue surrounding them seems limited to those in positions of institutional power (Lancet, 2019). Based on the critical assumption that, as of today, we are in a context of pluralism and heterogeneity that cries out to be heard and understood, for health care to meet the health needs of migrant populations adequately, it should be adapted to their needs, in terms of their self-perceived wants and needs (Lebano et al., 2020). A study that explores the subjective dimension of the health of refugees and AS would provide important information to guide the interventions to take charge of these populations in a proactive logic.

The study aims to explore the experience of refugees and AS in Italy concerning perceived health needs and the elements that influence health and well-being.

Methods

Design

A qualitative phenomenological study with an interpretive approach was conducted. Interpretative Phenomenological Analysis (I.P.A.) focuses on the in-depth meaning of the participants' experiences (Smith J. A., 2009). On the one hand, it was adopted an idiographic approach because of the individual case investigation. On the other hand, it used also an interpretive one, following the principles of hermeneutics (Welch M, 1999). Finally, the phenomenological perspective was used to get knowledge from phenomena, free from theoretical presuppositions that assign meanings to experience *a priori*(Larkin & Thompson, 2012).Researchers run into the personal representations of the experience of people immersed in a linguistic, relational, cultural

and physical world, taking part in intersubjective meaning-making, where one cannot avoid interpretation but must reflect on one's role in producing such interpretations.

Sampling and Recruitment

The study was conducted in Camini, a rural village in southern Italy located above the coast of the Ionian Sea, in which a project for the reception and integration of refugees and AS is active and which represents an example of coexistence between native and immigrant populations (Bianco et al., 2016; RIS, 2022).

A propositional criterion was used for the sampling. Since the standard duration of participation in a reception project for each migrant is six months, participants were recruited who had been included in the Camini reception project for at least 3 months. This minimum period included people who could consciously tell about their experience concerning the subjects being studied. A shorter experience in the project probably would not have been sufficient to provide comprehensive information on health needs perceived and accrued over time. Involvement in the study lasted until data saturation was reached.

Data collection

The data was collected in December 2022 in Camini at an agreed-upon location with the participants. After identifying the possible study participants, the host project managers individually contacted them to agree on the date and time of the interview. Previously, the participants had not had contact with the researchers.

Following the chosen methodology, each researcher involved in the study performed bracketing before data collection, writing down ideas, preconceptions, and beliefs about the phenomenon under investigation. This first step is crucial because researchers' preconceived notions could influence data analysis in studies using a phenomenological interpretive approach (Larkin & Thompson, 2012). By performing this "reflective technique" before data collection and analysis, researchers can be more careful to avoid introducing biases that could negatively influence research. Data were collected using a semi-structured face-to-face interview (Smith J. A., 2009). This type of interview was chosen because it is particularly informative, allowing the researcher to create the framework for the topics covered. However, the respondent's responses

determine how interviews are conducted. Furthermore, the semi-structured interview guide provides a clear set of instructions for the interviewers and, at the same time, can provide reliable and comparable qualitative data (Smith J. A., 2009).

The interviewers invited each participant to give an answer thorough description of one's health experience starting from an open and general question, such as: "At this time in your life, what do you need most to be well?". Then, the interviews took the form of free interviews conversation, using open-ended reflections and responses requests to facilitate discussion. The interviewers probed participants' experiences of health needs, trying to highlight their feelings, changes, challenges, and expectations.

A cultural mediator was used in cases of non-comprehension of the researchers' language (Italian language). During the interviews, the researchers maintained an empathetic attitude, expressing warmth and reassurance, to facilitate the participants narrating their experiences (Simeone et al., 2022). Field notes were written, helpful in recording personal reflections, notes relating to the setting and the non-verbal language used by the interviewees. According to Corbin & Strauss (1998), interviews were conducted without interruption until participants said they had nothing more to add or until new information emerged. Data saturation was reached after 19 interviews. A sociodemographic questionnaire explicitly created for this project was used to collect information on the characteristics of the participants.

The established qualitative research standards criteria for reporting were followed in writing the report (Tong et al., 2007).

Data analysis

The interviews were audio-recorded and transcribed in full by assigning an identification code to each interview. The translation of the interview parts into the native language by a cultural mediator unrelated to the study to keep the text's original meaning as much as possible and to control the cultural bias in the data analysis phase (Cuoco et al., 2022). The interviews and field notes were independently read and reread in depth by two interviewers (PA and SS), initially annotating the descriptive, linguistic and conceptual elements that emerged from the text (Smith J. A., 2009).

Subsequently, the emerging themes were identified, organized in a table to implement a comparison (grouping of themes), and finally grouped within superordinate themes. Each superordinate theme was linked to the underlying themes, which, in turn, were related to the participants' original quotes (Smith J. A., 2009). A consensus validation was performed between the two researchers. No discrepancies or disagreements emerged. Finally, the themes identified were exemplified with a descriptive narration and illustrated with participant quotations.

Rigour

The criteria of credibility, transferability, and reliability described by Lincoln and Guba (1986) were considered to ensure the study's methodological rigour. Member checking was performed. The findings were shared with participants, who were asked to confirm the emerging themes and share any additional information. At this point, translation was performed to compile the research report. The processes of translating and back-translating the in-text citations to enhance the themes were carried out and focused on conceptual content rather than literal equivalents. The purpose of the translation was to look for the conceptual equivalent of a word or phrase and not a word-for-word translation. Thus, it was ensured that the original meaning of the data obtained was respected.

Ethical considerations

The procedures applied in this study followed the principles outlined in the Declaration of Helsinki(World Medical Association 2013). Approval was obtained from a University Ethics Committee (protocol registration number 160.21). The purpose of the study was explained to each participant, and written informed consent was acquired to ensure anonymity, confidentiality, and data protection. All participants were assured they could withdraw from the study at any time. Each interview was assigned a sequential alphanumeric code, with no possibility of identifying participants.

Findings

The sample comprised nineteen people, with a prevalence of female gender (52,6%) and an average age of 30,6 years (SD 8.7). Participants came from nine countries and arrived in Italy between 2014 and 2021. The main sociodemographic results are reported in Table 5.1.

Table 5.1: Sample Characteristics

I.D.	Gen.	Age	Place of birth	Mar. status	N. of Child.	Y. of arrival in Italy	Ed. Level country of origin	Ed. Level in Italy	Job occupation in the country of origin	Job occupation in Italy	Training courses in Italy
AZ01	F	30	Nigeria	Unm.	0	2011	Middle School	Noone	Hairdresser	Hotel	Italian Language
BY02	F	28	Nigeria	Unm.	2	2016	Middle School	Noone	Dressmaker	Bag-Labour (Weaving)	Italian Language
CX03	M	41	Morocco	Marr.	3	2017	High School	Middle School	Security	Bag-Work (Electrician)	Italian Language
DW04	M	18	Syria	Unm.	0	2016	Middle School	Middle School	Noone	Ceramist	Ceramist
EV05	F	21	Syria	Unm.	0	2016	Middle School	High School	E-Commerce	Language Mediator	Italian Language
FU06	F	35	Syria	Marr.	5	2015	Elementary School	Noone	Noone	Noone	Noone
GT07	M	33	Morocco	Marr.	2	2020	Middle School	Noone	Butcher	Tailor	Italian Language
HS08	F	23	Morocco	Unm.	0	Not avaiable	Middle School	Noone	Noone	Noone	Italian Language
IR09	M	23	Syria	Unm.	0	2018	High School	High School	Student	Noone	Italian Language
JQ10	F	24	Somalia	Div.	1	2018	Noone	Noone	Noone	Noone	Italian Language
KP11	M	25	Somalia	Div.	1	Not avaiable	Noone	Noone	Noone	Noone	Italian Language
LO12	F	39	Libya	Marr.	4	2020	Bechelor Degree	Noone	Noone	Tailor	Italian Language
MN13	F	44	Pakistan	Marr.	4	2014	High School	Middle School	Noone	Noone	Italian Language
ZA14	M	47	Pakistan	Marr.	4	2014	High School	Noone	Goldsmith	Tailor	Italian Language
YB15	M	24	Bangladesh	Unm.	0	Not avaiable	Noone	Noone	Clerk, Gardener	Noone	Italian Language
XC16	M	35	Senegal	Marr.	5	2014	Middle School	Middle School	Farmer	Masoner	Italian Language
WD17	M	28	Lebanon	Unm.	0	2020	Middle School	Noone	Employee	Tailor	Italian Language
VE18	F	29	Morocco	Marr.	2	2020	Noone	Noone	Noone	Noone	Italian Language, Tailor
UF19	F	30	Nigeria	Marr.	3	2015	Middle School	Middle School	Telephones Seller	Bag-Labour	Italian Language

Data analysis identified three main themes: (1) centrality of the family, (2) feeling part of a community and (3) stability and security. Each theme encompasses different subthemes, summarised in Table 5.2.

Table 5.2: Themes emerged from the analysis.

MAIN THEME	SUB-THEME
Centrality of the family	The symbolic role of territorial function
	The reunification of the family unit
	Individual well-being depends on the well-being of the family
Feeling part of a community	Reception, support and inclusion
	Language learning as a tool for integration
	Maintenance of cultural identity
Stability and security	Independence
	The support of services

Centrality of the family

In this theme, the family system, a microsystem with a pivotal role within the individual's life, represents the place of affection and stable and deep relationships and can enhance the individual's quality of life. The family is configured as the primary organism that acts as the glue between its various constituent members and in which the individual can feel safe, experience relationships with others and recognize themselves, and carries with it a value system that, rooted in traditions, is projected into future generations.

"*My family is the meaning of my life, and I carry with me what I have been taught to give to my children even if we are far away. This makes me feel good"* (KP11). The importance of the affective dimension with family members translates into a supportive relational network, and the unity of the members can be a source of strength in facing all kinds of obstacles, as well as being the essential element in creating a positive family environment. "*When we do something, we all decide it together. It is the strength we have in this new world"* (JQ10).

Three specific sub-themes generate the theme of family centrality. The first concerns the symbolic role of parenting: children represent the most crucial positive externality of the male-female relationship. The importance of parenthood translates

into the individual's need to develop specific skills in caring for their children, among which it is a priority to take action to ensure that they have a peaceful future; this motive is often at the root of migration processes*: "It is always for our children (that we left the country), both for my husband and me, we do and are doing everything for our children"* (FU06). Conversely, the inability to adequately meet their needs generates feelings of discomfort that result in actual physical discomfort: "*Being sick is when my children have needs, but I can't meet them*" (MN13).

The second sub-theme concerns the need for family reunification, an essential tool for enabling family life: in the most common cases, migrants go through the delicate and complex experience of separation from the family unit, and although they have shared with the family the decision to undertake the migratory journey, dictated by the fundamental need to acquire a source of income, beneficial to themselves and their family, they pay the high price of forced separation, aware that efforts to strengthen ties through long-distance communication will not be able to compensate for the nostalgia and lack of family affection. This situation generates nostalgia in the respondents, affecting their health: *"It is impossible to feel good because I have not seen my mom for 5 years and my dad for 20 years".*

The third and final sub-theme refers to how the individual's well-being is affected by the family's well-being. Respondents report that *"To feel good, I need the main things, namely that the family is well" (LO12); conversely, they report feeling bad "if the husband is sick"* (MN13). This feeling is often the basis of an activation process aimed at achieving greater well-being for family members: "I had to make a decision and go to a place where I am sure my family will be better off" (GT07).

Feeling Part of a Community

The second theme emphasizes the importance to respondents of being part of a group. The desire for ties with others, relationality, and the need to belong to a social and cultural group is an expression of the relational dimension of man. Significantly, the need to become an accepted part of society in terms of reciprocity, equal exchanges and proportional relationships is particularly felt by migrants as individuals who, by definition, unlike natives, move, sometimes against their will, to new areas where they will be called to live. The inclusion of migrants is not declined in a one-way

assimilationist perspective. Still, it presupposes welcoming diversity, reformulating one's ideas according to it, and rethinking the other as the bearer of a cultural system that can be considered an added value to the community. *"We hold on to our roots, and we feel good when these are recognized, accepted as a value even for this country that welcomes us"* (VE18).

Interviews show how the level of integration experienced has the power to promote in the other a sense of identity belonging, directly affecting one's well-being: *"Here I feel better than I did in my country, in the sense that they treat me as I treat them, I don't feel like a foreigner, they treat me well"* (LO12).

The need to feel part of a community consists of three specific sub-themes. The first sub-theme concerns the need for the migrant to be welcomed, supported, and included in the host country. This sub-theme emphasizes the need for the migrant to receive an act of openness: this means recognizing the other, making them part of something of their own, building mutually enriching relationships, putting the other in a position to ask for help and to be helped: *"Here we live like a family, so they are the ones who take care of everything (...) if you need something or anything else you have to go to them and tell them, and they will try to help you (...) they are like a family (...) there is a cooperation with the other person"* (IR09).

Living in a welcoming family dimension fosters bonding with others and influences one's perception of oneself: *"I feel like I was born here, I feel like this, even though I just arrived, I feel like I've been here for a long time because of the bond that has been created with people"* (XC16).

The second sub-theme focuses on language learning as a critical tool for promoting migrants' well-being. Interviews reveal how language learning is seen as a form of enrichment of one's identity and an indispensable tool for social inclusion in terms of job opportunities, use of services, and socialization: *"I have to study the language more, which is an important part of integration and being able to be comfortable here (...) the first thing you have to do in the country where you live is to learn the language"* (GT07).

"My future needs to study the Italian language. Without that, I can't do anything (...) well, starting with learning the language of this country"(KP11).

The process of adapting to the new communicative environment can start from the possession of a standard language code, an essential requirement for establishing a dialogue with the other and expressing one's needs and intentions, as well as a means of sharing the experience, which can have positive implications*: "By learning the language we were also able to explain why we are the way we are or why we have the veil and now they have accepted it, or when we are sick and why"* (EV05).

The third sub-theme concerns the need to maintain one's ethnic-cultural identity: acquiring one's identity occurs through an interactive process constituted by a phase of assimilation and one of differentiation from the other. Therefore, the need for integration and cohesion is accompanied by the need for diversification, that is, the need for identity reappropriation of one's roots*: "We are integrated, yes, but something is missing, for example, our tradition, and sometimes I feel awful even physically because of that. I would like to find a way to live my culture here too"* (FU06).

The need for migrants to keep alive that identity heritage transmitted by inheritance can only be met if, on the other hand, there is an attitude of recognition and respect for cultural differences that paves the way toward a climate conducive to freedom of expression, and in which the individual can become the authentic spokesperson for a specific system of practices and beliefs related to the culture to which they belong: *"For example, in Libya, we had some prayers to recite, but they were heard outside, and we could not recite them, here in Camini we can. We are free. Or when there is a religious occasion, we can celebrate it freely, a beautiful normal life" (*ZA14).

Stability and security

The third theme generated concerns about the respondents' need for stability and security. Health, as revealed in the interviews, is linked to the search for better living conditions, in terms of stability-understood as lasting inclusion in the new society of arrival-and security, understood as the need to have a secure base, an anchor of primary importance to feel comfortable. Feeling safe, protected and away from danger is a fundamental need related to individual and group well-being, as well as being a fundamental prerequisite for the realization of needs related to one's self-realization: *"Feeling safe, I missed so much in my country, where I was always in danger. Now being able to leave home without fear, feeling protected is something that gives me so much*

well-being" (VE18). *"I am not well until I feel autonomous, integrated into the country, able to provide for my own life and respond to my children's wishes"* (CX03).

Two specific sub-themes generate the theme of stability and security. The first relates to independence: the interviews reveal the need to achieve individual well-being to gain positive autonomy*: "Being healthy means being autonomous and not needing anyone"* (IR09).

The main aspirations and desires expressed by respondents regarding their future concern the need to learn a trade to acquire skills and abilities helpful in entering the world of work. It is also perceived as essential to maintaining a stable job, through which one can realize one's need for economic independence, a source of health: *"The first thing I need is work and being able to support myself economically. Without this, there is no health"* (KP11)

The need for economic independence is often necessary to be able to help one's family of origin, and it also translates into the need for respondents to access a durable housing solution, which is essential for social inclusion and well-being*: "I want to be able to do something for myself and to support my family. (...) Work to take care of their needs and everything else and have a home where I can feel good"* (UF19).

The second sub-theme concerns the need for support from services in the area. Indeed, migrants' well-being is linked to the need to live in a context supported by territorial services, including health, local transportation, and childcare services.

"I hope the services will be more and better, medical visits, health services that welcome us without discriminating against us, and a place where our children can be welcomed, schools, sports" (WD17).

Discussion

The present study aimed to explore the perceived health needs of refugees and AS in Italy. Analysis of the interviews generated three main themes: 1) Centrality of Family; 2) Feeling part of a community; 3) Stability and Security.

Refugees and AS converge their health experience around one word: family. Although complex and sometimes compromised by a journey of separations, homesickness, obstacles and reunifications, family relationships play a decisive role in the individual's life. Indeed, emigrating means leaving an identity space and a physical one, the unbreakable bond between family members is bound to endure even after leaving the country of origin. Transnational families experience distress resulting from family separation can undermine bio-psycho-social integrity and often could be correlated with physical and depressive symptoms (Galvan et al., 2022). Conversely, living in a family context reduces the risks of falling into deviance (Ambrosini et al., 2019).

Refugees and AS, as confirmed by our study, direct all the efforts related to adaptation in the new living context to promote their family's well-being. Our findings also reveal the central role of parenting in the lives of migrants as an issue closely related to health. According to the literature (de Haan, 2012), in the post-migratory period, supportive relationships in the family reorganize and become more oriented toward child support, which is undoubtedly the priority element to be activated for. Women, especially mothers, feel a desire to want to change their lives with hope that their children do not experience their same sense of instability. (Gewalt et al., 2019).

The second theme generated, called "Feeling part of a community", focuses on refugees' desire to experience a sense of belonging to the community of the host country. They need to have a social life mediated by a feeling of identity, as an expression of membership in the community in which they can feel a part. Innate and fundamental tendency for the species to have interpersonal ties, generates well-being; on the contrary, its deprivation, and therefore the lack of interactions, can have negative effects on health (Taormina & Gao, 2013). As observed in our study, the need for belonging is expressed by the desire to feel included, welcomed and supported. Inclusion refers to a complex phenomenon of socio-economic incorporation into the

host society and socio-cultural adaptation (Saharso, 2019). Inclusion and welcome are two strongly interrelated elements, as each finds its limit in the successful implementation of the other. Finally, social support, such as the possibility of receiving availability, protection and care from the network of interpersonal relationships, represent the glue in the relationship between the feeling of belonging and individual well-being. Social support is a protective factor on health as it generates positive experiences and reduces stress due to cultural changes experienced by refugees and AS. (Henríquez et al., 2022).

The interviewees identify most language learning as the primary tool for integration into the target community. Although language integration is not necessarily a guarantee of full integration, acquiring skills in the majority language could undoubtedly facilitate it (Council of the European Union, 2023). The expression in the refugees' and AS' positive adaptation process is found by the feeling of belonging to the group of the host country, representing a crucial factor for psychosocial and economic well-being (Isphording & Otten, 2014). Lack of language skills, on the contrary, could be a barrier on communication of emotional states. Leading to self-isolation and alienation could be significantly associated with a higher prevalence or severity of psychiatric symptoms and mental disorders (Montemitro et al., 2021).

Being part of a community is essential for developing and maintaining well-being. Conversely, the perception of cultural discrimination can lead to lower well-being, particularly feelings of guilt, powerlessness, and the individual's lack of participation in the social and health network (Urzúa et al., 2018). On the other hand, a sense of community and acceptance of cultural uniqueness could protect against the perception of discrimination and its consequences (Garcia-Cid et al., 2020). The real challenge, then, of a system based on reception is to maintain the identity of the migrant, recognizing cultural roots as value elements on which to base interventions of caregiving and treatment. According to Betancourt et al. (2003), cultural competence in health care involves: understanding the importance of cultural influences on people's health beliefs and behaviors, considering how these factors interact at multiple levels of the health care delivery system, and, finally, designing interventions that take these issues into account to ensure quality care. Providing adequate training in intercultural competence is indeed the strategic lever, as Leininger (2002) states, for transforming

the "stranger" into a person who feels part of a community they recognize as their own and emphasizing the vital role of culturally competent nurses in leading the paradigm shift in reception and caretaking.

"Stability and security" is the third theme identified. For interviewees, the need for security and stability is embodied in the opportunity of gaining or rebuilding complete independence, as a form of labour and housing autonomy. Many studies highlighted how the access to the labor market and having a stable and safe housing could two essential aspects for refugees' and AS' health (Combes et al., 2019; Llinares-Insa et al., 2020; Spagnoli et al., 2020). There is a significant association between refugees' and AS' mental health and work quality (Lai et al., 2022). Private housing solutions correlate with lower levels of psychological distress and higher levels of life satisfaction than living in shelter environments (Walther et al., 2021). In addition, refugees and AS often face significant barriers to accessing services due to bureaucratic, administrative, and organizational factors (Cattacin Sandro, 2013; Mammana et al., 2020; Serre-Delcor et al., 2021). Studies also highlight the difficulty of designing services focused on the refugees' and AS' health needs and aimed at guaranteeing equity and adequate care, both at the moment of first reception and in the long term (Mammana et al., 2020; Serre-Delcor et al., 2021).

The present study provides numerous implications for clinical practice. Firstly, it confirms that health is a construct composed of interconnected bio-physiological, psychological, and social dimensions that require an overview rather than an analytical approach focused on the individual domains that comprise it (Dahlgren & Whitehead, 1991). Second, it provides the key to understanding the priorities of refugees' and AS' health needs, which is helpful in Socio-Health Services in lor efforts to welcome and care for these populations. Providing services should not be interpreted as a mere act of health and social support but as the possibility, together with the provision of means of subsidy, of promoting autonomy and satisfying the need to feel valid and recognized; pro-sociality could reduce the effects of the social fragility experienced by migrants, promoting social integration, and reducing inequalities.

However, this study has also several limitations. First, it was conducted in a single European country. For this reason, our findings could be not generalizable to other

countries which could have different health system and different transcultural approaches. Second, the different cultural backgrounds of the participants may have affected the attribution of meaning to the phenomenon explored. In addition, having conducted the interviews with migrants who were readily available and selected by the host project coordinators may have influenced the participants' responses and orientation to the phenomena under study.

Conclusion

In conclusion, our findings have provided helpful information to guide the healthcare providers working in a transcultural context. The complex health needs, experiences, and diverse cultural representations of health and illness should be read and addressed with a culturally competent view. The study emphasizes the importance of designing interventions that consider the unique representations and experiences of migrants and how health is a construct whose cultural and social dimensions need to be known and considered. It confirms the need to develop the advocacy function of nurses in migratory contexts and to recognize that nurses can act as guarantors of their health rights.

Declaration of Conflict of Interest

The author(s) declared no potential conflicts of interest concerning this article's research, authorship, and/or publication.

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CAPITOLO 6

New frontiers for qualitative textual data analysis: a multimethod statistical approach.

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Abstract

In recent years, the increase in textual data production has meant that researchers require faster text analysis techniques and software to reliably produce knowledge for the scientific–nursing community.

Automatic text data analysis opens the frontiers to a new research area combining the depth of analysis typical of qualitative research and the stability of measurements required for quantitative studies. Thanks to the statistical–computational approach, it proposes to study more or less extensive written texts produced in natural language to reveal lexical and linguistic worlds and extract useful and meaningful information for researchers.

This article aims to provide an overview of this methodology, which has been rarely used in the nursing community to date.

Keywords: Qualitative research, Automatic textual analysis, Multimethod approach, Multidimensional qualitative method, Rigour.

Introduction

Qualitative research is widely used in nursing and caring sciences to generate knowledge about human phenomena by considering in-depth, context-driven details (Carr, 1994; Góes et al., 2021). The main potential of qualitative research lies in exploring the complex meanings of social phenomena experienced by individuals in their natural context (Froggatt, 2001). Supported by standard scientific criteria, checklists, and guidelines, such as the commonly used COREQ checklist, amongst others (Cypress, 2017; Dierckx de Casterlé, De Vliegher, Gastmans, & Mertens, 2021; Y. S. Lincoln, 1995; Yvonna S. Lincoln & Guba, 1986; Tong, Sainsbury, & Craig, 2007), qualitative research methods involve the systematic collection, organisation and interpretation of text derived from documents, discourses, or observations (Khankeh, Ranjbar, Khorasani-Zavareh, Zargham-Boroujeni, & Johansson, 2015). Data are analysed using step-by-step processes, following precise procedural rules to ensure reliability (Yvonna S. Lincoln & Guba, 1986; Renz, Carrington, & Badger, 2018). It is considered a real investment in studying complex phenomena or constructing a new theory.

Although qualitative analysis is excellent in comparing different perspectives of the same phenomenon by adding meaning to the quantitative value (Froggatt, 2001), some authors report that researchers have often experienced time-consuming and costly data analysis techniques. They usually deal with many pages of qualitative data offering unique stories and perspectives. In contrast to faster quantitative methods, researchers have to read texts several times to extract codes and get close enough to the meaning units and themes, trying to retain the integrity of each respondent's story (Dierckx de Casterlé et al., 2021; Froggatt, 2001; Jormfeldt, 2019; Sasso, Bagnasco, & Ghirotto, 2015). Patterns, themes, and categories do not emerge on their own but demand intellectual work, and it becomes more challenging when dealing with profuse and unstructured textual data, such as Big Data or Natural Language (NL) (Bolasco, Bisceglia, & Baiocchi, 2004; Dierckx de Casterlé et al., 2021; M. Fraire, 2009; Mary Fraire, Spagnuolo, & Stasi, 2016).

Actually, some of the best-known software for qualitative analysis (e.g., ATLAS, NviVo) provide some features that facilitate the researcher in data analysis - such as for the sentiment analysis performed by Nvivo -, but they are only available for a semi-

automatic analysis. It means that they assist the researcher in coding and extracting meaning units and themes, but they typically do not analyse the data automatically; instead, they make them more manageable and easier to handle (Renz et al., 2018). Moreover, managing a large amount of data runs the risk of mistakes in analysis and interpretation (Dierckx de Casterlé et al., 2021); except for some features, analysis and interpretation of qualitative data are consequentially still laborious for the researcher. Finally, there is ample evidence of the difficulty for researchers to extract latent content (Box 6.1), except by adopting laborious analysis techniques (Graneheim, Lindgren, & Lundman, 2017). Although there are a lot of great strengths to conventional approaches to qualitative data, it is still little is known about the practical use of newer data analysis techniques and their strengths and pitfalls in the analysis of complex qualitative data, and there are few published studies.

Box 6.1: Table of definitions

Multidimentional Analisys	Multidimensional analysis of textual data is a set of statistical techniques for analyzing large amounts of data from different points of view (dimensions) to interpret complex phenomena. It is characterized by the joint observation of k variables (v.) over n statistical units (v.). The multidimensional analysis includes three groups of statistical methods: 1) classificatory (cluster analyses); 2) factorial for two-way tables (principal component analysis, simple and multiple correspondence analysis, multidimensional scaling etc.); 3) analysis for multiple tables (three-way and multi-way data analyses). These are analyses with a solid computational basis and, therefore, only possible with computers and the appropriate advanced software (Bolasco, 2013; M. Fraire, 2009).
Lexical corpora / Corpus	Collection of text (i.e., interviews, journal articles, book chapters) considered consistent and relevant to be studied from some point of view or property (Bolasco, 2013).
Latent dimensions	Latent content is not directly observable and consists of the interpretation of the meaning underlying the text. Differently from the manifest content, which easily emerges from the text (it is defined as "close to the text"), the latent content (defined as "distant from the text") refers to something like the "red thread" between the lines. During analysis, the researcher often begins by sorting the manifest content coded into categories and continues to look for latent content and formulates it as themes at various levels. In this way, the researcher takes different scientific positions depending on the study's objective (Graneheim et al., 2017).

Adopting an innovative multimethod approach connecting qualitative data and quantitative analysis, helped by sophisticated software that automatically analyzes

data (such as Iramuteq, Lexico, T-Lab, etc.), allows qualitative researchers to take advantage of various strategies, ensuring rigour, rapidity and originality of in-depth qualitative data analysis (Acauan et al., 2020; Góes et al., 2021). Moreover, it can help overtake issues that led to the researcher's influence on data interpretation and help analyse data collected from larger and more representative samples. All these elements have always been considered challenges in qualitative studies for credibility, trustworthiness, reproducibility and also rigour, which, differently from quantitative research, is not always guaranteed (Boddy, 2016; Graneheim et al., 2017; Malterud, 2001). This is a need that also emerges in cardiovascular nursing, an area in which many qualitative studies have been conducted. Examples include the lived experience of living with cardiovascular disease (Simeone et al., 2018), the processes of heart failure trajectory (Riegel, Dickson, & Faulkner, 2016), and cultural orientation in stroke and cardiovascular disease recovery (Dickson, McCarthy, Howe, Schipper, & Katz, 2013; Luciano et al., 2012).

Concerning technological development and the increase of electronic sources, Automatic Analysis of Textual Data (AATD) could represent a substantial innovation in qualitative research, able to increase qualitative analysis' credibility and trustworthiness compared to traditional methods (Acauan et al., 2020; Soares et al., 2022; Soares et al., 2021) and, at the same time, maintains the hermeneutic character and characteristics typical of qualitative research, and the latent dimension extractions and context analysis is considered in data interpretation. in the EMDA approach (Giuliano L, 2010).

Little is known about the practical use of AADT and its strengths and pitfalls in supporting the complexity of qualitative data analysis in nursing science. This article aims to shed light on this new and exciting area of research and to give an overview of the usefulness of AATD in nursing studies, which is still little known to nurse researchers (Jusoh & Alfawareh, 2012; Kami et al., 2016; Souza, Wall, Thuler, Lowen, & Peres, 2018).

Overview of the methodology

First developed by Reinert (1990), "AATD proposes a qualitative analysis strongly integrated with the quantitative one to ensure the stability of the measures" (Bolasco, 2021). The process aims to extract the underlying real-world lexical corpora of entire documents (e.g., interviews, monologues, debates) (Durante et al., 2022; M. Fraire, 2009; Piervisani et al., 2021; Robieux, Karsenti, Pocard, & Flahault, 2018), by applying statistics on textual data from an exploratory-descriptive perspective and using software that can analyse texts automatically.

Statistical measurements are applied following Fraire's Exploratory Multidimensional Data Analysis model (EMDA) (M. Fraire, 2009), in which multivariate variable-driven statistics allow the interpretation of complex phenomena (such as disease-related phenomena) related to the context. Further, Text Mining (TM) and Latent Semantic Analysis (LSA) techniques achieve the information extraction and attributions of the meanings. Specifically, TM encodes unstructured textual data, automatically associates information and extracts relevant meanings (Ananiadou, Chruszcz, Keane, McNaught, & Watry, 2005; Bolasco et al., 2004; Mingo & Nocenzi, 2020). LSA is an advanced TM approach (Aryal, Gallivan, & Tao, 2015; Maletic & Marcus). It provides not only the text's explicit information for extraction but also the semantic structures that are partially hidden by the randomness of word placement (latent information), promoting the recognition of more relevant meanings (Evangelopoulos, 2013; Landauer, Foltz, & Laham, 1998).

EMDA includes several types of statistical techniques (M. Fraire, 2009), such as factorial analysis (e.g., principal component analysis - and simple and multiple correspondence analysis) and classifier methods, such as Classificatory Hierarchical Dendrograms (Reinert, 1990). Correspondence Analysis indicates a word's proximities projection on a factorial plane, allowing for the exploration of lexical profiles and latent semantic dimensions (Leblanc, 2015; Neta, 2021; Veraszto, Camargo, Camargo, Simon, & Miranda, 2018). According to Reinert (1990), cluster analysis is an unsupervised process of classifying texts with similar vocabulary based on algorithms (Monteiro, 2021; Talib, Kashif, Ayesha, & Fatima, 2016). Finally, factorial correspondence analysis illustrates the relationships between classes projected on a factorial plan (Neta, 2021; Six, 2019). Thanks to the combination of statistical models and sophisticated software,

it is possible to generate graphs that, with immediate impact, describe word proximities, similarities, distances, contrasts, and thematic patterns that emerge by applying statistics. It allows a more significant amount of distinct analyses based on the same corpus of data (Canuto, Braga, Monteiro, & Melo, 2020; Monteiro, 2021).

Among the advantages offered by AATD, it is possible to overcome issues related to the different interpretations of the same texts (Peyrat-Guillard, Miltgen, & Welcomer, 2014). Secondly, it allows for the reliable analysis of extensive collections of texts and complex qualitative data (i.e., Big Data and NL) without prior reading. Finally, this approach makes it possible to compare single parts of the same text and different texts, a procedure that traditional methods cannot perform. (Bolasco, 2021). It is essential to emphasise that software automatically analyses data without eliminating or replacing the researcher's role (Soares et al., 2022). Instead, the researcher plays a central role in both making data robust for the analysis (Soares et al., 2022) and interpretation that, guided by theoretical frameworks, allows researchers to develop themes and identify multiple subjectivities without preconceived ideas (Bolasco, 2012 ; Giuliano L, 2010; Nascimento Martins, Sarro Gomes, & Corrêa de Paula, 2022; Ramos, do Rosário Lima, & Amaral-Rosa, 2019). However, scientific rigour and complete efficiency in managing and retrieving qualitative data will depend on the researcher's knowledge of the software and its functionality, their mastery of computer technology and their ability to analyse organised data (Acauan et al., 2020; Soares et al., 2022).

Concerning the disadvantages of the method, decontextualization of words could occur if context analysis is not done correctly, as researchers work first on words and then on concepts. As a result, researchers might find it challenging to catch linguistic ambiguities if they are not adequately trained. Finally, the possible excess of automaticity and standardization of processes could be questioned. While it strengthens the rigour and trustworthiness of research, traditional qualitative researchers might find it difficult to accept the quantification of qualitative phenomena and concepts and the translation of texts and words into numbers and indices.

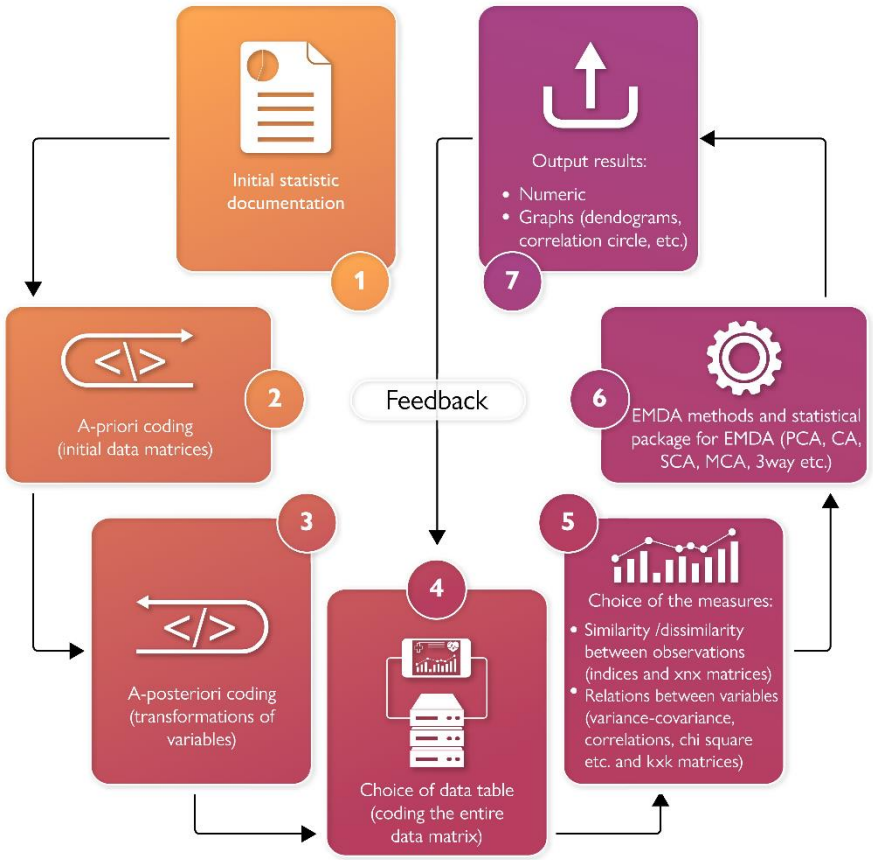
However, it is also true that we can affirm the two-dimensionality of research data. In a sense, all data are qualitative: all the data we collect correspond to material, psychic, and cultural events/objects that we try to translate into words to form

empirical bases helpful in explaining social phenomena and controlling our theories. But we could also say that all data are quantitative because it is always possible to convert the language of words into the language of numbers through a process of encoding and then, in turn, lead the numbers (or rather the measures) and the relationships identified among the numbers back to interpretations and explanations that can be nothing more than ordered sequences of words endowed with meaning (Giuliano L, 2010).

Step-by-step approach

According to M. Fraire (2009), there are seven essential steps to carrying out EMDA *(Central Illustration)*. The first four steps are the preliminary phases in which data must be organized for analysis.

Central illustration



Step one: In this phase, the investigator defines the object and purpose of the research, the material, and data collection to address all the further analysis.

Step two: is called "a-priori coding". In this phase, researchers start working on data. All texts collected (i.e., the set of interviews or articles) are organized into a single document, called "textual corpus", corresponding to the initial data matrix. In this phase, some pre-processing and processing operations on text (normalization, lexicalization, and lemmatization) are required to permit the software to recognise words and work on them. Normalisation aims to remove typos and standardise spaces, apostrophes, and accents; through lemmatisation, it is possible to recognise the grammatical categories and lead the words to their basic form, useful, for example, for word counting; lexicalisation is needed to identify composed words and transform them into one by placing an underscore between them. Then, according to the aim, the corpus can be subdivided into smaller units by putting metadata lines between them. Smaller units could be single texts (i.e., an interview or a single chapter of a book), fragments (i.e., the single answer to a question or a paragraph) and elementary sense units (single words). Metadata lines (i.e., **** *n_1, **** n_2 up to **** *n_21) are command lines created by external variables, according to the aim. For example, if your corpus is composed of interviews or focus group discussions, you can run the analysis based on the questions, themes treated or interviewers' characteristics. Instead, if you have a corpus of journal articles or book chapters, your command line can present variables related to 'journal' or 'book' references. These command lines will permit the selection of the variable guiding the multivariate analysis described later.

Step three: This is called "a-posteriori coding". It is about lexicometric (or lexical) analysis, which means a first statistical description called "lexical balance". It is based on the primary standard criteria (e.g., frequency, co-occurrences, and proximity of the words) of the initial data matrix and provides a descriptive overview of your text. From this analysis, you can obtain three primary data: the total number of occurrences (i.e., frequency of words) determining the corpus size (N), the largeness of vocabulary (V) (i.e., the number of unique words in the text) and the number of Hapax (H) (words occurring only once in the text or rare forms). According to Bolasco (2012), to proceed to multidimensional analysis, some prerequisites lead to consistency, and statistical reliability must be satisfied. For these reasons, some indices, such as linguistic richness

(V/N) providing information about the language richness, percentage of Hapax, and the number of total occurrences in the text (at least 25.000 needed), must be calculated.

Step four: the initial data matrix (based on segment frequencies) is coded into contingency tables compatible with multivariate analysis on which statistical measures and TM will be applied.

Once the preliminary steps have been completed, the researcher proceeds with the multidimensional analysis with the following three steps.

Step five: consists of the "choice of the measure" to apply to the just-produced contingency tables. It is very similar to quantitative, multidimensional analysis but adapted to the type of data table (contingency in this case). The most used statistical measures the researcher can choose are the scalar product, cosine (standardized measure) and chi-square ($\chi 2$). The choice of measure depends on the aim of the analysis and the type of matrix (lexical or textual) the researcher wants to work on. For further information, see "The Automatic Analysis of Texts. Doing Research with Text Mining" by Bolasco (2013).

Step six: This step enables the development of multidimensional statistics (i.e., clustering, and factorial plans). Step seven: This step returns the summary outputs of the results, both numerical (eigenvalues, factorial weights, factorial scores, trajectories, etc.) and graphical (graphs of factorial plans, correlation circles, dendrograms, etc.) (M. Fraire, 2009).

Software

There are several software packages for data analysis. The most commonly used by researchers are IRaMuTeQ 0.7 alpha 2 ("IRaMuTeQ 0.7 alpha 2,"), Taltac ("Taltac,"), Lexico ("Lexico,") and T-Lab ("T-Lab,"). Given the complex and technical discussion of single software descriptions and their selection criteria (not feasible in the article), the authors refer to Bolasco's (2021) papers or software websites for a more in-depth discussion.

Example of EMDA in the cardiovascular field

Although EMDA is just beginning to make its way into the nursing field, to our knowledge, only one study has been published in the cardiovascular field (Durante et al., 2022). The authors applied multidimensional statistics on interviewees to investigate caregivers' needs and the challenges of individuals with heart failure related to their sociodemographic characteristics. Applying EMDA, it was possible to obtain findings associated with sociodemographic characteristics, such as country of origin, age, gender, and the kind of informal caregiving relationship with the patient, highlighting that they are continually trying to cope with their social isolation and deteriorating health.

Reporting

Since the AADT is a multimethod approach that originates from qualitative data and provides structured information, a scientific paper needs to primarily report the descriptive indices of the analysis related to the lexical balance. Moving on to the description of the graphs, the classificatory hierarchical dendrogram must be discussed in terms of class relationships, the theme that emerged, and the percentage of variance covered by each class. Factorial plans, showing, respectively, words' and classes of words' proximities projections, need to be described from both lexical and textual points of view, and the relationships that emerge from the content of the graphs, must be interpreted in terms of meaning (Neta, 2021; Six, 2019). It is essential to report the factors extracted and their percentage of variance covered.

Conclusion

Nursing is recognized as a human science because it understands experiences as humans live them. AATD is a versatile, person-centred strategy that allows us to study relationships between previously unobserved questions and subgroups. Although AADT exploits computational strategies and statistical measurements with methodological rigour increasing the reliability of the analysis, it should not be conducted without full consideration of theory, previous research, and the clinical relevance of the results (Góes et al., 2021; Jusoh & Alfawareh, 2012; Soares et al., 2022).

Visualization

For further clarification of the practical use of the entire process of EMDA on textual data, readers can refer to the article "*The nurse in the mirror: image of the female nurse during the Italian fascist period*" (Piervisani et al., 2021), where also graphs and their respective interpretations are clearly shown.

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Conflict of interests

The author declares no conflicts of interest.

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CAPITOLO 7

Migrants' health care needs from Stakeholders' point of view. Multidimensional analysis of textual data

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Abstract

Introduction: An unintentional movement to a new country often brings consequences that make achieving optimal health status.

Background: Organized reception and support systems, composed of multidisciplinary professional and non-professional teams, including healthcare workers, are implemented in Europe.

Aim: To identify migrants' and refugees' healthcare needs, barriers to the care process, and possible related intervention areas.

Methods: Qualitative research with in-depth interviews was performed with stakeholders in a migrants' and refugees' Welcoming Centre in southern Italy. Data analysis was carried out by following the Exploratory Multidimensional Data Analysis. Authors have adhered to relevant EQUATOR guidelines COREQ in writing the research report.

Findings: Some barriers emerged due to the lack of cultural-free psychosocial tools, practitioners' specific training, and territorial public services and facilities deficiencies. Assisting family units and researching a symbolic dimension was crucial for the optimal reception of needs in a multicultural territory.

Discussion: The most significant finding showed how crucial it was to adopt a multidisciplinary approach and design Evidence-Based, culturally competent care in a welcoming project whose structural characteristics are common to most southern European reception centres.

Conclusions: Promoting intervention programs for professionals involving managers, administrators, and policymakers would improve health outcomes where desire, commitment, empathy, and dedication help address the severe lack of support and resources that affects the population's health status.

Implications for Nursing and Implications for Nursing Policy: This study would help develop an exportable hosting model in similar settings. In the analyzed context, a transcultural advanced practice nurse is crucial in strengthening the network among professionals and with the territory in all those rural areas with severe territorial deficiencies and understanding population culturally-based needs.

Keywords: Factors influencing health, Health dimensions, Healthcare needs, Migrants, Multicultural, Multimethod data analysis, Nursing, Refugees, Stakeholders, Textual analysis.

Introduction

Migration is a phenomenon that has always been inherent in human nature and is a widely debated topic at all levels. Under pressure from internal and global political conflicts, economic instability, and climate change impacts, the world has witnessed a dramatic increase in refugees and displaced persons over the past decade. In 2020, there were 272 million migrants (3.2% of the world's population) and twenty-four million refugees, with nearly half children under 18 (UNHCR, 2022).

An unintentional movement to a new country often brings consequences that make it challenging to achieve optimal health. In addition to the physical issues reported by the World Health Organisation (WHO, 2021), poverty, lack of care, social isolation, armed conflict, human rights violations, and post-traumatic disorders related to forced migration experiences represent issues that negatively impact the health and well-being of migrants. Additionally, a widespread phenomenon is migrants perceiving a lack of consideration of their cultural needs, values, beliefs, and practices in host countries. These elements, amplified by language and cultural barriers, hinder access to care and the defence of fundamental human rights. As a result, an already tricky adaptation and social integration processes for one of the most discriminated groups worldwide get more complicated (Commodore-Mensah et al., 2021).

In conjunction with the already-known public health and social services issues, several challenges for health systems and professionals who want to respond to the migrants' needs have recently emerged. For example, the increasing number of migrants landing on European coasts has led to a limited number of places for asylum and the multilevel and multiphase system which migrants must face, together with bureaucratic issues, delays the achievement of good health status, well-being and socioeconomic integration. Also, questions have been raised about the most effective ways to take care of the needs of migrants and the challenges and resources needed to ensure a higher level of health and provide culturally congruent care aimed at inclusion and integration (Mancini et al., 2019).

Background

As outlined in the Sustainable Development Goals of Agenda 2030 (I.O.M., 2022) and by the Global Compact for Safe, Orderly and Regular Migration (United Nations, 2018), to promote good migrant health, it is crucial to promote social and labour insertion, foster cultural assimilation and social inclusion in health services and ensure the care of people bearing specific biographies, cultures, traditions, beliefs and needs while respecting universal human rights. Attempting to respond to healthcare, reception and inclusion needs, the European Union has adopted immigration policies. Organised reception and support systems, composed of multidisciplinary professional and non-professional teams, including healthcare workers, are implemented for social accompaniment (i.e., knowledge of the territory and adequate access to local services, including social services and healthcare) and people with specific vulnerabilities (i.e., unaccompanied minors, victims of torture, single-parent households, and single pregnant women).

This kind of project has also been implemented in Italy, which is a place full of small contexts geographically characterised by a low number of residents and a deficiency of health services (Mancini et al., 2019). Here, guaranteeing protection, material, health, social and psychological reception thanks to individual paths of socioeconomic insertion and integration into the community, inclusion policies represent an emblematic example of integration between native and immigrant populations which can lead to an opportunity for the growth and development of the health provision that is notably lacking in these areas (European Union Agency for Asylum, 2022).

According to these preconditions, it is crucial to investigate strengths, barriers, and challenges for professionals in reception systems, mainly where migration is a very current phenomenon and first rescue operations, primary healthcare, pre-identification and counselling on asylum and relocation procedures usually occur, such as in Europe. According to Leininger's Transcultural Nursing Model (Leininger, 2002), professionals are responsible for accompanying migrants along the settlement path. By adopting an anthropological perspective, they are called to provide culturally congruent care adapted to individuals' and groups' cultural beliefs and lifestyles aimed at inclusion, integration, and adequate care guarantee. In this context, the nurses' role

becomes crucial. Having a cross-sectional view of people's needs and dealing with the health needs of different natures, nurses act as a link between professionals and the population under investigation (Commodore-Mensah et al., 2021).

An Italian reception centre of excellence is in Camini, a rural area in the Calabria region of southern Italy. Through the six-month reception project "Jungi Mundu" (in the local dialect, "unite the world"), dozens of migrants, refugees, and asylum seekers, mainly from Africa and the Middle East, are received to ensure their necessary health care, economic independence, and integration. Health professionals, professionals from the socio-educational area, and components from the organizational-managerial area work daily to provide migrants, refugees and asylum seekers with healthcare, welfare, housing, vocational courses, and language classes. The strength lies in experimenting with an approach based on housing self-management to develop the autonomy of the project beneficiaries, exercising social engagement through inclusion programs managed by a multidisciplinary team of qualified experts, and a material shelter plan, which includes room and board and a monthly contribution. This kind of reception is a unique case in Italy as it proposes a structured welcome to a migrant population intending to put them in a position to achieve the same goals as the natives, with whom they are in close ties of coexistence, given also by the small size of the country.

Understanding how to properly interface with people with different needs and perceptions of self, body, health, and disease and how to design programs to take care of the health of migrants based on the available resources is fundamental to overcoming the emergency logic with which it has been faced to date. Moreover, knowing professionals' experiences working on welcoming migrants can highlight what has already been done and promote improvements in the healthcare process. Although several studies have analysed the complexity of immigration, only a few studies in Italy have explored professionals’ views on strengths and barriers in the care of a migrant population (Driel & Verkuyten, 2022; Mancini et al., 2019). Among these studies, only a few have deeply explored dimensions by adopting a multimethod data analysis technique that automatically extracts latent dimensions from qualitative data (Viola et al., 2018). To the best of our knowledge, studies focusing on the experience of

stakeholders working in such proximity with migrants and natives in a rural area welcoming centre seem to be lacking.

Aim of the study

The study aimed to explore the professionals' perspective on a multiethnic population care model of a welcoming project, unique in its species, in the South of Italy. We wanted to investigate the health needs and the strengths and barriers of the healthcare process in a multicultural territory, where stakeholders, migrants and residents live together, which has had positive outcomes. In addition, the study attempts to contribute to the existing nursing methodological knowledge by shedding some light on a data analysis technique able to support the researcher in the extraction of the underlying dimensions of the text. It is a qualitative data analysis technique that has rarely been used in nursing science and even less in analysing the needs of the migrant and refugee populations.

Methods

Design

A qualitative study was conducted. Face-to-face semi-structured interviews were collected with stakeholders to identify participants' experiences within the context under study. The research team consisted of seven nurse researchers. Six of them, including three women (MF, PhD student; PA, PhD student; LP, research fellow) and three men (GP associate professor; SS associate professor and EV associate professor), interviewed the entire population to ensure complete individual and contextual data collection. The seventh woman author (RA- full professor) was the supervisor. All researchers had experience in multicultural settings and were confident with qualitative surveys and interviews due to their professional backgrounds. Before the study, telematic meetings took place with the project coordinators for organizational purposes. During the visit to Camini, the researchers, introduced by the project coordinators, met the stakeholder community, and explained the project's objectives, modalities and phases. Stakeholders understood the modalities and purpose of the project more readily because of their cultural and professional backgrounds. The researchers clarified all uncertainties with utmost helpfulness. Concerning interview

general themes, the researchers investigated the participants' perspectives on the health needs of the multiethnic population they assist and the strengths and barriers in meeting those needs.

Data analysis was performed using a multimethod approach to carry out a discourse and content text analysis. According to Fraire's statistical model, called Exploratory Multidimensional Data Analysis (EMDA) (Fraire, 2009), it was provided a statistical analysis of qualitative data. The quantitative approach was based on a computer-analysed statistics technique called Automatic Analysis of Textual Data (AATD) (Bolasco, 2021), which involves converting data into statistical formats using specialized software. This technique can produce a comprehensive understanding of the phenomena observed, allowing the researchers to access the fundamental meaning of the interviews and to study the significant nuance of what the participants expressed in depth. In addition to the presence of large amounts of texts to be analyzed, there is the complexity of the explored phenomena characterized by numerous statistical units (whose characters are representative of interacting dimensions), which only EMDA can govern due to the numerous multivariate statistical techniques it uses. An exploratory-descriptive approach guided the interpretation of the findings, which emerged as graphs and tables describing the themes of the phenomenon. (Bolasco, 2021). The open-source software IRaMuTeQ 0.7 alpha 2 (IRaMuTeQ 0.7 alpha 2) was used for data analysis (Neta, 2021). According to the aim, the researchers considered Automatic Analysis of Textual Data the appropriate data analysis technique fitting the study to understand the complexity of the themes. The criteria set by the COREQ qualitative research standards were followed in writing the research report (Tong et al., 2007).

Study Setting and Recruitment

Data were collected in Camini (R.C.) in April 2021 at an agreed-upon location with the participants. A purposive sampling approach was used to enrol a representative component of stakeholders working on the welcoming project. Specifically, stakeholders were initially clustered by professional backgrounds (i.e., professionals from the socio-educational area, healthcare professionals and professionals from the organizational-managerial area) and then recruited by the researchers' decision. Sixteen stakeholders actively engaged in the community were recruited. They were six

health professionals (an ethnopsychologist, a nurse, two general practitioners, and two psychologists), six professionals from the socio-educational area (a social worker, an educator, a teacher, a luthier, a cultural mediator, and a social-health worker), and four components from the organizational-managerial area (the project coordinator, the project manager, a job placement worker, and a legal assistant). Everyone agreed to participate in the study. Researchers explained the aim of the study and the consensus rules before starting the interviews. After identifying possible participants for the study, they were contacted individually by the project coordinators to define the date and time of the interview. Participants were interviewed during their free time.

Data collection

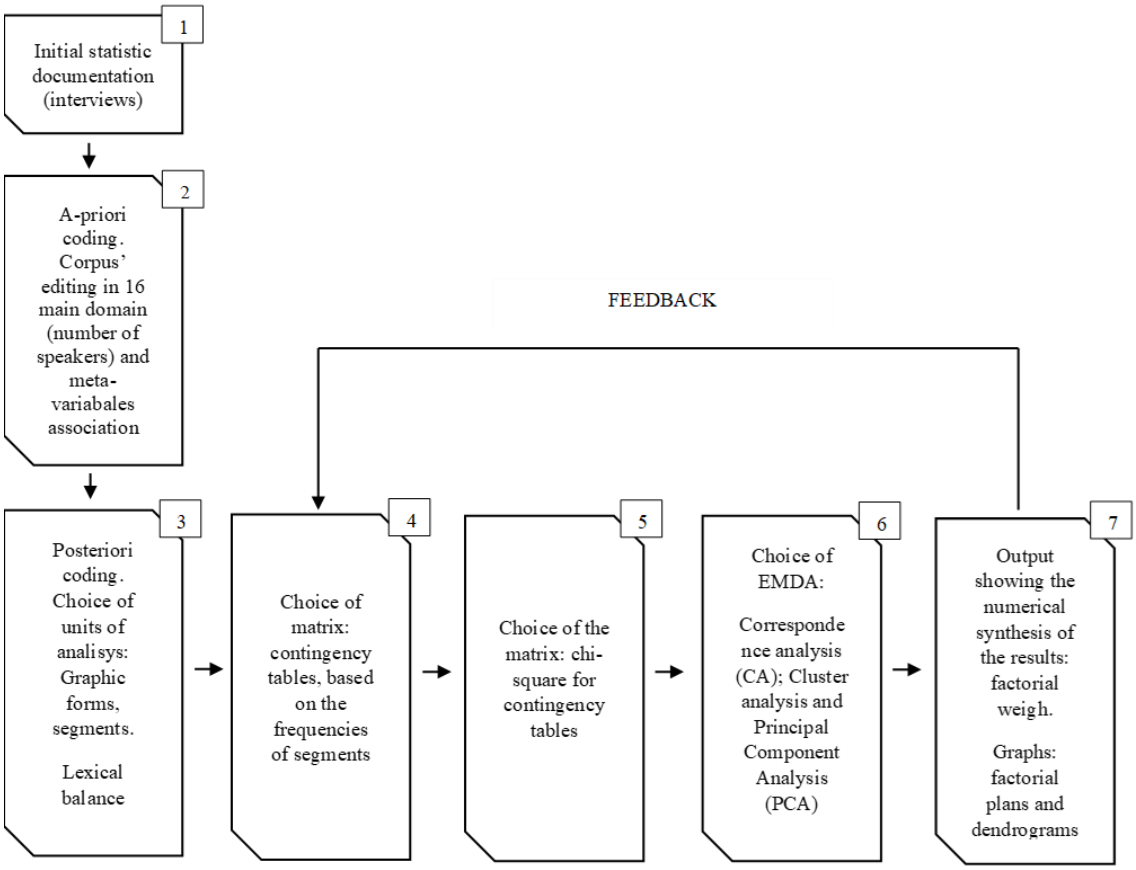
Interviews were conducted through individual semi-structured interviews, audio-recorded and stored on a digital device. Interviews were conducted in Italian, the native language of the participants and researchers. The interview guide contained eleven open-ended questions based on the researchers' professional experience, used to investigate the community healthcare expressed and unexpressed needs and the necessary interventions to enhance the health status and quality of life and ensure the best care. Questions related to the needs were: "Based on your professional experience and role in the project, can you tell me what are the needs that people you assist report to you and how you address them?" and "Based on your professional experience and role, can you tell me the non-reported needs you see and how you can address them?". To explore the intervention area, researchers asked: "Based on your professional experience and role, what are/should be the interventions you see as priorities that need to be improved to respond to the requests you mentioned?". In addition, questions concerned the interviewee's subjective experiences in the community, the meaning they attribute to being a migrant and the strengths and weaknesses of the welcoming project. Finally, an open-ended question was asked: "Do you have anything else you would tell me about your experience in the community?". No people were present during the interviews outside of the researchers and the facilitator where necessary. The researchers maintained an empathetic attitude, expressing warmth and reassurance, to facilitate narrating participants' experiences. According to Corbin and Strauss (2008), interviews were conducted without interruption until saturation was reached, that is until participants said they had nothing more to add or until new

information emerged. Data saturation, jointly agreed upon by the researchers, was reached with the participants initially enrolled, which is why more participants were not recruited. Interviews lasted an average of 40 minutes, and the investigation was conducted without the researcher's influence. In addition to the interviews, the researchers used a short questionnaire to collect sociodemographic data from the participants, which was helpful for the multidimensional data analysis and a general description of the sample.

Data Analysis

According to Fraire's method model (Fraire, 2009), some necessary statistical-informatic were performed on the data to carry out an Exploratory Multidimensional Data Analysis (Supplementary figure 7.1).

Supplementary figure 7.1: EMDA framework, according to Fraire (2009)



The first four steps were considered preparatory and consisted of corpus disposition for statistical analysis guided by the aim of the study (preliminary phases).

They were crucial to the entire process because they were determined by specific statistical choices driven by the research aim. They also provided some descriptive indices of the corpus, such as word frequencies and some reliability and consistency indices. Steps 5 to 7 (steps 5, 6 and 7) involved applying statistical analysis on the textual data, called multidimensional statistics, which extracted the underlying meanings of the text (latent content) and revealed the relationships between themes through in-depth content analysis. Further information is contained elsewhere (Figura et al., 2023). The following paragraphs describe the analysis process separated into steps for easy reading.

Text preparation

According to step 1 of the framework, all the interviews were transcribed verbatim to a Word document (*.docx) and checked for accuracy by the researchers. After the first round of reading the raw material, in step 2, researchers defined the matrix of texts to be analysed. This matrix was called “corpus” and contained all the interviews together. According to the software rules, the pre-processed text was cleaned of irrelevant text forms (e.g., articles, digits, conjunctions, onomatopoeias, prepositions). In this step, the corpus was also algebraically structured in “a priori coding” according to the main domains of the study. The corpus was divided into sixteen shorter texts according to the number of participants. Then, in the third step, the framework provided for “posterior coding”, which consisted of the transformations of variables to select the units for lexical analysis. By using the quantitative data collected, the researchers created meta-data lines, which are such coding strings of participants’ sociodemographic variables collected by questionnaires (e.g., gender, education, specialised training, year hired at the cooperative, number of children, working area, etc.) (Supplementary table 7.1).

Supplementary table 7.1: Metadata lines

META-DATA LINES
**** *parl_edsoc *gen_d *form_pl *formspec_1 *assunz_2014 *figl_0 *sett_socioed
**** *parl_assistsoc *gen_d *form_l *formspec_1 *assunz_2017 *figl_1 *sett_socioed
**** *parl_inf *gen_d *form_l *formspec_0 *assunz_2020 *figl_1 *sett_sanit
**** *parl_ins *gen_d *form_s *formspec_0 *assunz_2015 *figl_0 *sett_socioed
**** *parl_opinsprof *gen_u *form_s *formspec_1 *assunz_2020 *figl_1 *sett_org
**** *parl_resp *gen_u *form_s *formspec_1 *assunz_2001 *figl_1 *sett_org
**** *parl_epsi *gen_d *form_pl *formspec_1 *assunz_2019 *figl_0 *sett_sanit
**** *parl_coord *gen_d *form_s *formspec_1 *assunz_2013 *figl_1 *sett_org
**** *parl_medcult *gen_d *form_pl *formspec_1 *assunz_2011 *figl_0 *sett_socioed
**** *parl_osa *gen_d *form_m *formspec_1 *assunz_2014 *figl_1 *sett_socioed
**** *parl_opleg *gen_d *form_l *formspec_1 *assunz_2018 *figl_1 *sett_org
**** *parl_liut *gen_m *form_l *formspec_1 *assunz_2020 *figl_0 *sett_socioed
**** *parl_psi *gen_d *form_l *formspec_1 *assunz_2017 *figl_1 *sett_sanit
**** *parl_mmg *gen_d *form_l *formspec_0 *assunz_2008 *figl_0 *sett_sanit
**** *parl_mmg *gen_u *form_pl *formspec_0 *assunz_2015 *figl_1 *sett_sanit
**** *parl_psisup *gen_u *form_pl *formspec_1 *assunz_2017 *figl_1 *sett_sanit

KEY			
parl	Speaker	*psisup*	Supervisor Psy
sett_sanit	Healthcare worker	*psi*	Psychologist
sett_socioed	Socio-educational professionals	*ed_soc*	Educator
sett_org	Organizational-managerial professionals	*assistsoc*	Social worker
gen_d	Woman	*inf*	Nurse
gen_u	Man	*ins*	Teacher
form_l	Graduate	*opinsprof*	Placement officer
form_pl	Advanced degree	*resp*	Manager
form_s	High school graduate	*epsi*	Ethnopsychologist
form_m	Middle school graduate	*coord*	Coordinator
formspec_1	Transcultural training: yes	*medcult*	Cultural mediator
formspec_0	Transcultural training: no	*osa*	Social care worker
assunz	Year starting work on the project	*opleg*	Legal assistant
figl_1	Children: yes	*liut*	Luthier
figl_0	Children: no	*mmg 1,2*	General practitioners

Meta-data lines were positioned before each text and allowed to choose a discriminant variable to conduct multidimensional statistics. Moreover, this step involves the selection of the units for lexical analysis. This was done according to Bolasco's procedure, in which the text is organized into sentences (segments) made of a minimum of three occurrences and word frequencies to a maximum of 10. It is a lexicometric approach based on the main standard criteria: frequency, co-occurrences, and the proximity of the words (Bolasco, 2021). According to the selection of the units for lexical analysis, further pre-processing and processing operations were required. These were normalisation, which aimed to remove typos and standardise spaces, apostrophes, and accents; lemmatisation, helping to recognise grammatical categories and leading the words to their primary form; and lexicalisation, which was needed to

identify composite words and transform them into one by placing an underscore between them. According to the software rules, the Word file was saved as a UTF-8 standard encoding form (Unicode Transformation Format 8-bit code units) before starting the analysis.

Corpus descriptive statistics

Step 4 provided some procedures which can be compared to the descriptive statistics of the quantitative analysis. First, a data matrix was automatically created by software from the frequencies of the text segments, which made it possible to obtain an initial descriptive statistic of the corpus under consideration, called "lexical balance." The lexical balance contained several indicators: the number of texts into which the corpus has been divided, the number of occurrences in the text (which corresponds to the number of words contained in the corpus, including repeated words), the number of forms (the number of words contained in the corpus, excluding repeated words), the number of Hapax (the rare words, mentioned only once), and the average number of occurrences for each text. These descriptions were also helpful in checking whether the corpus met the recommended eligibility criteria for multidimensional statistical analysis and for stating the content validity. According to Bolasco (2021), the corpus must contain at least 25,000 occurrences to guarantee reliability in statistical analysis. For content validity, it was calculated the lexical richness index, called Type/Token Ratio (TTR), which correlates the number of forms (Type) and the number of occurrences (Token). If the value of TTR was less than 20%, the corpus was considered lexically rich. To state the content validity, we also considered the percentage of Hapax. Less than 50% of Hapax is considered a criterion of lexical richness to be met (Bolasco, 2021). At this point, the researchers identified the table of lexical data, called x shapes or contingency matrix, on which to conduct the multidimensional statistics.

Multidimensional analysis

Step five was called "choice of measure". It provided a very similar quantitative multidimensional analysis, but it was adapted to the type of data table (contingency in this case). Therefore, working on textual analysis (text-text matrices-TT), chi-square (χ^2) was chosen to measure the association between words. The sixth step developed

the Exploratory Multidimensional Data Analysis, which provided factorial and classificatory analyses. Our study applied Multiple Correspondence Analysis and Classificatory Cluster Analysis, followed by Principal Component Analysis. In Correspondence Analysis, the meta-data lines allowed to develop of a three-mode classification linked to the stakeholders' working area, represented by healthcare professionals, professionals from the socio-educational area, and professionals from the organizational-managerial area, used as a discriminating factor for the placement of the words on the factorial plan within three dimensions. Concerning Classificatory Cluster Analysis (or Descending Hierarchical Classification or Hierarchical Cluster Analysis), cluster analysis classifies and aggregates terms into thematic clusters, grouping the words with a similar vocabulary in the same class, based on the Alceste method (Ratinaud, 2009). The correlation was measured using Chi-squared (χ^2), which reports the words' significance in affinity to the class. Finally, the seventh step involved the output of the synthesis of the results, both numerical (e-g. factorial weights, factorial scoring) and graphical (factorial planes and dendrograms). Researchers analysed sample characteristics (quantitative data) using descriptive statistics.

Rigour and reflexivity

According to Lincoln and Guba's criteria, methodological rigour (reliability) was ensured (Lincoln, 1995). Researchers collected the interviews by performing bracketing, that is, writing down ideas, preconceptions, and beliefs about the phenomenon under investigation before collecting the data not to allow researchers' preconceived notions to influence the data analysis. This first step was critical because researchers' preconceived notions could influence data analysis in studies using content analysis. By performing this reflexive technique before data collection and analysis, researchers can be more careful to avoid introducing biases that could negatively influence the research (Tufford, 2012). The trustworthiness of qualitative findings was ensured in several ways. To achieve rigour and credibility in the results, each interview was independently analysed by two researchers (MF and LP) (researchers triangulation). Credibility was reached by discussing the interpretation of the graphs' contents and their justifications within the research team until the agreement was reached. We asked all participants to confirm the results (member checking), allowing critical reflection on the research results and minimizing the risk

of bias, supporting scientific rigour, and ensuring depth of analysis of the studied phenomenon. As for the computer-statistical analysis of the textual data, the study's validity was ascertained by a preliminary descriptive-exploratory analysis of the corpus aimed at probing the consistency of the text for statistical reliability (Bolasco, 2021). The analysis of qualitative data performed automatically by a computer program improves the accuracy and reliability of the researcher's classifications, increases the rigour of the reflections, and ensures the control of all data. Historically, it is considered one of the shortcomings of qualitative research. According to Fraire, the rigour of the chosen statistical analysis technique and the use of software limited the manipulation of variables to their choice (Fraire, 2009).

Ethical considerations

The Ethics Committee of the university of Tor Vergata approved this study on 07/07/2021 (protocol registration number 160.21). To protect privacy, all respondents signed an Informed Consent Form according to the responsibilities provided by the rules of good clinical practice and in full compliance with current legislation on personal data protection (World Medical Association 2013). Ethical norms and guidelines for the research project have been respected, and confidentiality was guaranteed. All participants gave consent to the processing of data for research purposes.

Findings

Sample

The sample interviewed comprised sixteen people working on a welcoming project. Six people (43,75%) were professionals from the socio-educational area, four (18,75%) people were from organizational-managerial areas, and six (37,5%) people were health care professionals. There was a prevalence of the male gender (68%) and an average of 41 years of age (SD 11.5). Concerning education level, most stakeholders had a higher education level than high school. At least twelve of the total sample (75%) attended a specific course in the multicultural field. The sample worked in Camini for an average of 6 years (SD ±5) (Supplementary table 7.2).

Supplementary table 7.2: Sample characteristics

I.D	Gender	Age	Educational level	Marital status	Job occupation	Year of work experience	Year of work with migrants	Multi - cultural training
AZ01	M	44	High school	Married	Project Director	20	10	Yes
BV02	F	43	High school	Married	Project Coordinator	8	8	Yes
CU03	F	33	Bachelor's degree	Married	Psycologist	8	4	Yes
DT04	M	48	Bachelor's degree	Single	Social Operator	15	3	Yes
ES05	M	45	High school	Married	Teacher	20	5	Yes
FR06	F	32	Bachelor's degree	Married	Social Operator	7	7	Yes
GQ07	F	34	Master's degree	Single	Educator	7	7	Yes
HP08	F	38	Master's degree	Married	Ethno-psycologist	10	2	Yes
IO09	F	32	Bachelor's degree	Married	Legal Operator	2	3	Yes
JN10	M	68	Master's degree	Married	Specialist Doctor	41	6	No
KM11	F	34	Middle school	Married	Home Care Worker	7	7	No
LW12	M	33	Master's degree	Married	Psycologist	9	4	Yes
XC16	F	42	Master's degree	Married	Cultural Mediator	10	10	Yes
XY13	F	66	Bachelor's degree	Single	General Doctor	38	13	No
YB15	F	30	High school	Single	Teacher	6	6	No
ZA14	F	34	Bachelor's degree	Married	Nurse	7	1	No

Corpus description

The corpus analysed by Automatic Analysis of Textual Data comprised sixteen interviews. A preliminary lexical balance was calculated on the corpus description and showed a rich and lexically researched text (Type/Token Ratio: 8.35%; Hapax: 3.96%; 3.96% of occurrences), with a suitable for multidimensional statistical reliability (50.277 occurrences) (Supplementary table 7.3).

Supplementary table 7.3: Corpus description

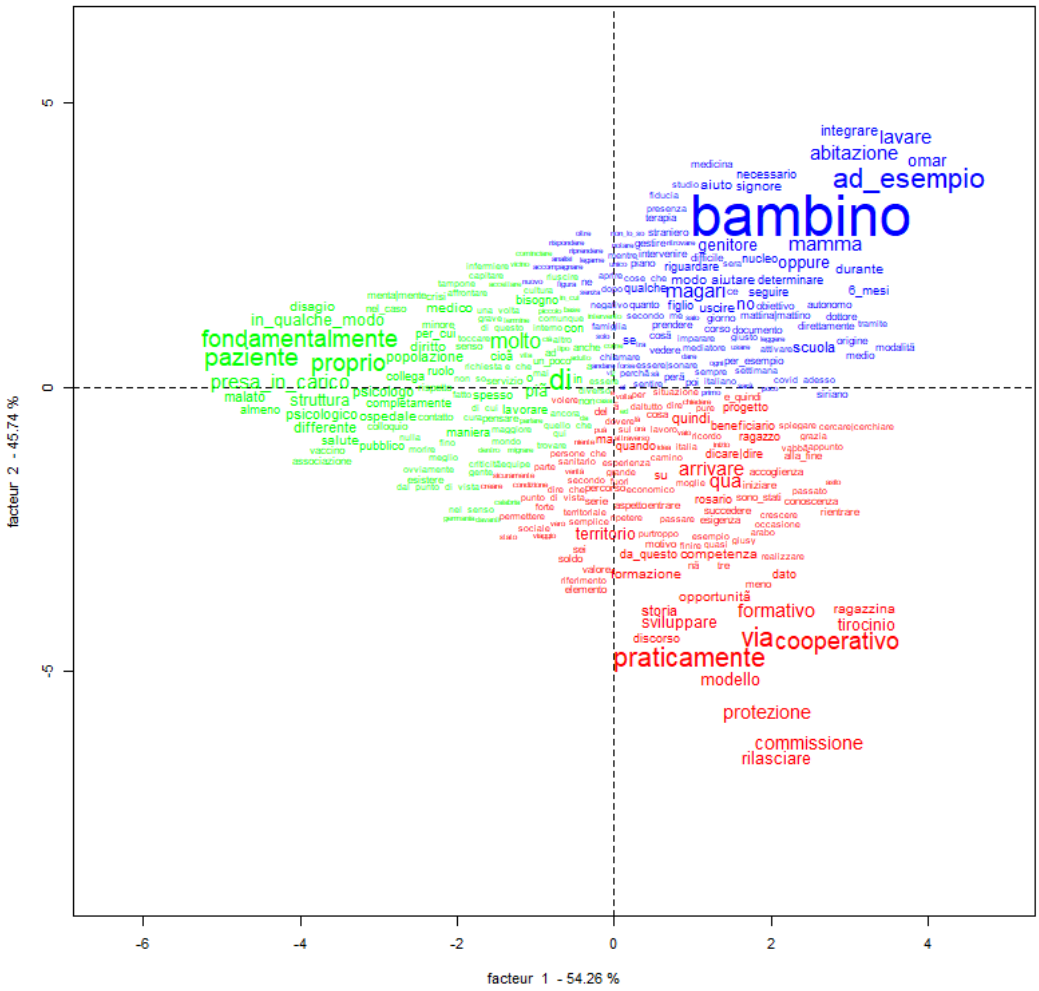
Corpus lexical balance	
Corpus	16 interviews
Number of texts	32
Number of text segments	1442
Number of occurrences	50277
Number of forms	4200
Number of Hapax	1987 (3.96% of occurrences – 47.31% of forms)
Mean of text occurrences	1571.16

Multidimensional analysis

Correspondence Analysis

In Correspondence Analysis (Figure 7.1), developed by active forms and with an index >2, the graph shows the word's proximities projection on a factorial plane, allowing lexical profiles and latent semantic dimensions to be explored (Neta, 2021). According to the three-mode classification related to the professional working area (*a priori* coding), three main dimensions differentiated by colour emerged.

Figure 7.1: Correspondence Analysis according to each working areas



The blue occurrences showed the dimension linked to the socio-educational professionals, represented by the words *child* (bambino), *mother* (mamma), *parent* (genitore), *integrate* (integrare), *help* (aiuto), *house* (abitatione), *wash* (lavare), *school* (scuola), *to call* (chiamare), *family* (famiglia), *to answer* (rispondere), *to accompany* (accompagnare). All these words reflect the importance of responding to a family unit's needs and accompanying them within the integration process, discussing the children as the entry door to caring for families. Cultural influences and the interaction with typical ethical dynamics, such as educational models often emerging from the children's behaviours, are highlighted. It is in an entirely positive area, so professionals from the socio-educational area may have only reported positive community elements.

The occurrences in red represent the management dimension. It is composed by the words *cooperative* (cooperativa), *away* (via), *training* (formazione), *to arrive* (arrivare), *to develop* (sviluppare), *history* (storia), *protection* (protezione), *committee* (commissione), *to release* (realizzare), *territory* (territorio), *experience* (esperienza), *path* (patto), *beneficiary* (beneficiario), *youth* (ragazzo), *person* (persona), *project* (progetto), *internship* (tirocinio), *to arrive* (arrivare), *integration* (integrazione). Positioned between a positive and a negative line, these words showed, on the one hand, the principal challenges migrants must face to be autonomous in a new place, including language learning and job training. On the other hand, the strength of the welcoming project is mentioned, including interventions aimed at integration into the community.

Finally, the green occurrences *facility* (struttura), *sick* (malato), *psychologist* (psicologo), *role* (ruolo), *right* (diritto), *distress* (disagio), *health* (salute), *public* (pubblico), *to understand* (capire), *to communicate* (comunicare), *to cope* (aiutare), *patient* (paziente), *need* (bisogno), *mental* (mentale), *request* (richiedere), *minor* (minore), *role* (ruolo), *doctor* (medico), *nurse* (infermiere), *take in charge* (presa in carico), *service* (servizio), *money* (soldo), *territory* (territorio), *value* (valore) are the word most used by the healthcare professionals. These words, positioned between a positive and a negative line, showed the devotion of professionals in responding to migrants' needs, mainly focusing on mental health, coming closer to the challenges due to the weakness of cultural-free tools and the lack of territorial structures and professional cultural competencies hindering a community's optimal health status and social integration. In addition, the complexity and variability of the symbolic-cultural matrix underlying migrants' needs, the different languages carrying peculiar sensory patterns and the singularity of experiences mean that there is not always a complete correspondence between real needs and the needs perceived by practitioners. Some keywords are *modality* (modalità), *context* (contesto), *truth* (verità), *relationship* (relazione), *to compare* (confrontarsi), *meaning* (senso).

Two factors from the factorial plan were extracted. Factor 1 has an eigenvalue = 0.07 and covers a variance of 54.26%. The positive semi-axe is called "The importance of caring for families and children and integrating them in the community". It groups words reflecting the positive aspects of caring for families and children, shown as a

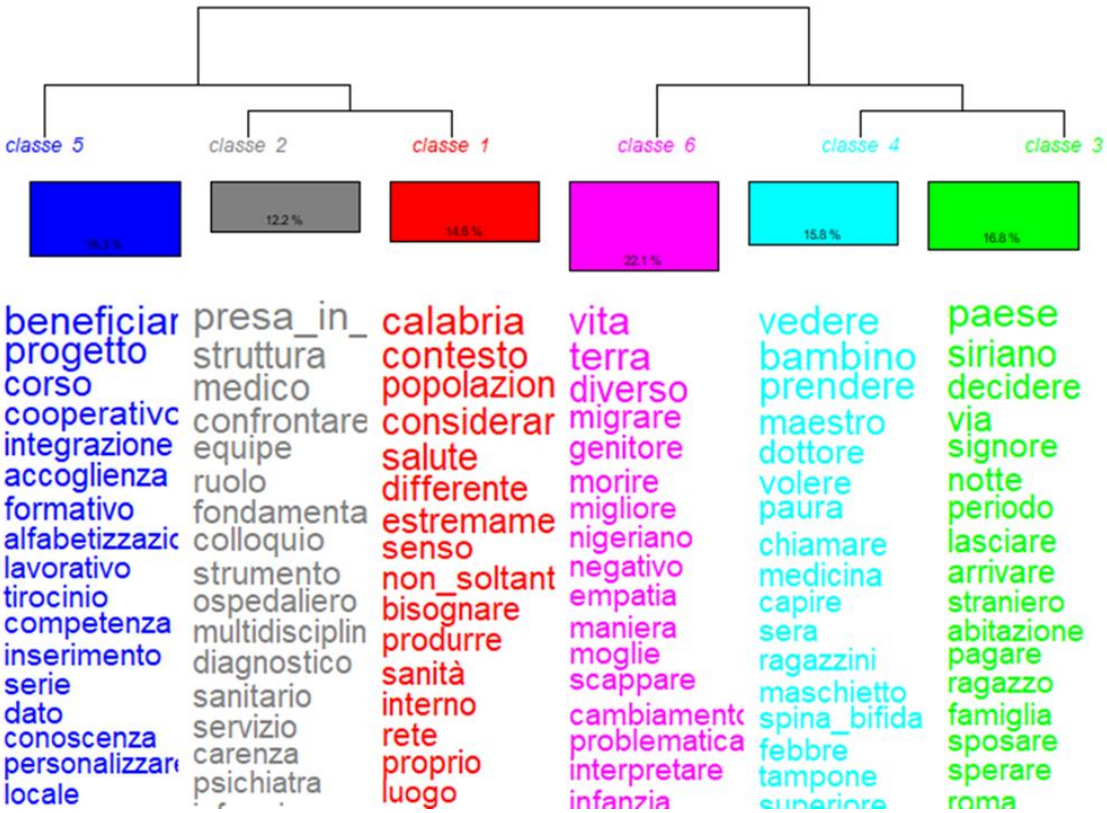
reference point for the community and the entry door to caring for families from a social point of view. The negative semi-axe, called “Healthcare system issues”, underlines the healthcare professionals' dedication to caring for the population, coming closer to problems affecting the healthcare system. The weak structures, professionals, cultural competencies, and cultural-free tools hinder the multicultural populations' professional healthcare.

Factor 2, with an eigenvalue = 0.05 and a covered variance of 45.73%, is named “Strength and barriers in responding to a multiethnic community’s need”. It shows the cooperative's intervention to take care of people and promote integration as the strengths of the welcoming project and the challenges in social integration, like bureaucratic, territorial, and structural issues, making it difficult to respond to needs, promote integration and hindering the development of migrant personal stories. Also, cultural aspects are included in the positive axes and considered central community elements to caring and integration, explained by the words: *culture* (cultura)*, need* (bisogno)*, to accompany* (accompagnare)*, foreigner* (straniero).

Cluster analysis

Figure 7.2 presents the Classificatory Hierarchical Dendrogram, which considers valid classes and shows, for each cluster, the word grouping and the covered variance percentage on the whole corpus (Neta, 2021).

Figure 7.2: Cluster analysis – Descending Hierarchical Classificati



The whole text covered rate (rate of text analysed by the software) was 98.17% (supplementary material, table 7.4).

Supplementary table 7.4: Clusters characteristics

Number of clusters: 6						
(Text segments retention 98,17%)						
	(χ^2)	*Covered variance (%)*		*Aut*	*Perc*	*Perc. cumulata*
Cluster 1	1,13	14,8%	Factor 1	0,39	27	27,00437
Cluster 2	1,29	12,2%	Factor 2	0,26	20,7	47,69266
Cluster 3	1,11	16,8%	Factor 3	0,25	20,2	67,90791
Cluster 4	1,19	15,8%	Factor 4	0,20	16,4	84,32663
Cluster 5	1,07	18,3%	Factor 5	0,20	15,7	100
Cluster 6	0,98	22,1%				

Reading the figure 2 from left to right, Cluster 5 (var. 16.3%), in blue, is called "project mission". It shows words such as *beneficiary* (beneficiario)*, project* (progetto)*, course* (corso)*, cooperative* (cooperative)*, integration* (integrazione), *reception* (accoglienza)*, training* (formative)*, literacy* (alfabetizzazione)*, labour* (lavorativo)*, internship* (tirocinio)*, skill* (competenza)*, insertion* (inserimento)*, local* (locale). It reported the Project's Mission which provides for migrants' social integration, job training and literacy teaching.

Cluster 2 (var. 12.2%), in grey, reports the following words: *take in charge* (presa in carico), *facility* (struttura), *physician* (medico), *to compare* (confrontare), *team* (equipe), *role* (ruolo), *multidisciplinary tool* (strumento multidisciplinare), *hospital* (ospedaliero), *service* (servizio)*, shortage* (carenza)*, psychiatry* (psichiatria). This cluster is denominated "Healthcare challenges" and talks about the necessity for professionals to be helped by the appropriate multicultural tools and lacking structures, such as psychiatry services, complicating the care process.

Cluster 1 (var. 14.8%), in red, was called "Territorial Context". It shows the words *Calabria* (Calabria), *context* (contesto), *population* (popolazione), *health* (salute), *need* (bisogno), *produce* (produrre), *health* (sanità), *network* (rete), *place* (luogo). It reflects the territorial background in which stakeholders respond to the community's needs. It also refers to barriers in the connection between the community and the healthcare services, making it challenging for professionals to respond to the needs.

Cluster 6 (var. 22.1%), in pink, is about families' needs and is represented by the words *life* (vita), *land* (terra)*, different* (diverso)*, to migrate* (migrare)*, parent*

(genitore), *to die* (morire), *best* (migliore), *Nigerian* (nigeriano), *empathy* (empatia), *manner* (maniera), *wife* (moglie), *to escape* (scappare), *change* (cambiamento), *problematic* (problematica), *to interpret* (interpretare), *childhood* (infanzia). It talks about families' needs from the parent's point of view. A very crucial, explanatory sentence emerged from the interviews: *"No parent would put their child in the middle of the sea if it were not safer than the land"* [Jn10], explaining the mining of this critical action, the strength with which parents take a risk for a better future for their children, escaping from a dangerous life and risking an uncertain future.

Cluster 3 (var. 16.8%), in green, is about the youth's migration experience and needs and is represented by the words *country* (paese), *Syrian* (siriano), *to decide* (decidere), *away* (via), *night* (notte), *leave* (lasciare), *arrive* (arrivare), *foreigner* (straniero), *house* (abitazione), *to pay* (pagare), *boy* (ragazzo), *family* (famiglia). This cluster is about youths, including young fathers, who decide to move from their native country to an unknown one to find a better life, job, and house. They often leave at night on ships, abandoning their families (wives and children) in their native land, where there is no possibility of finding a job because of the wars and poverty and to which they send money for survival.

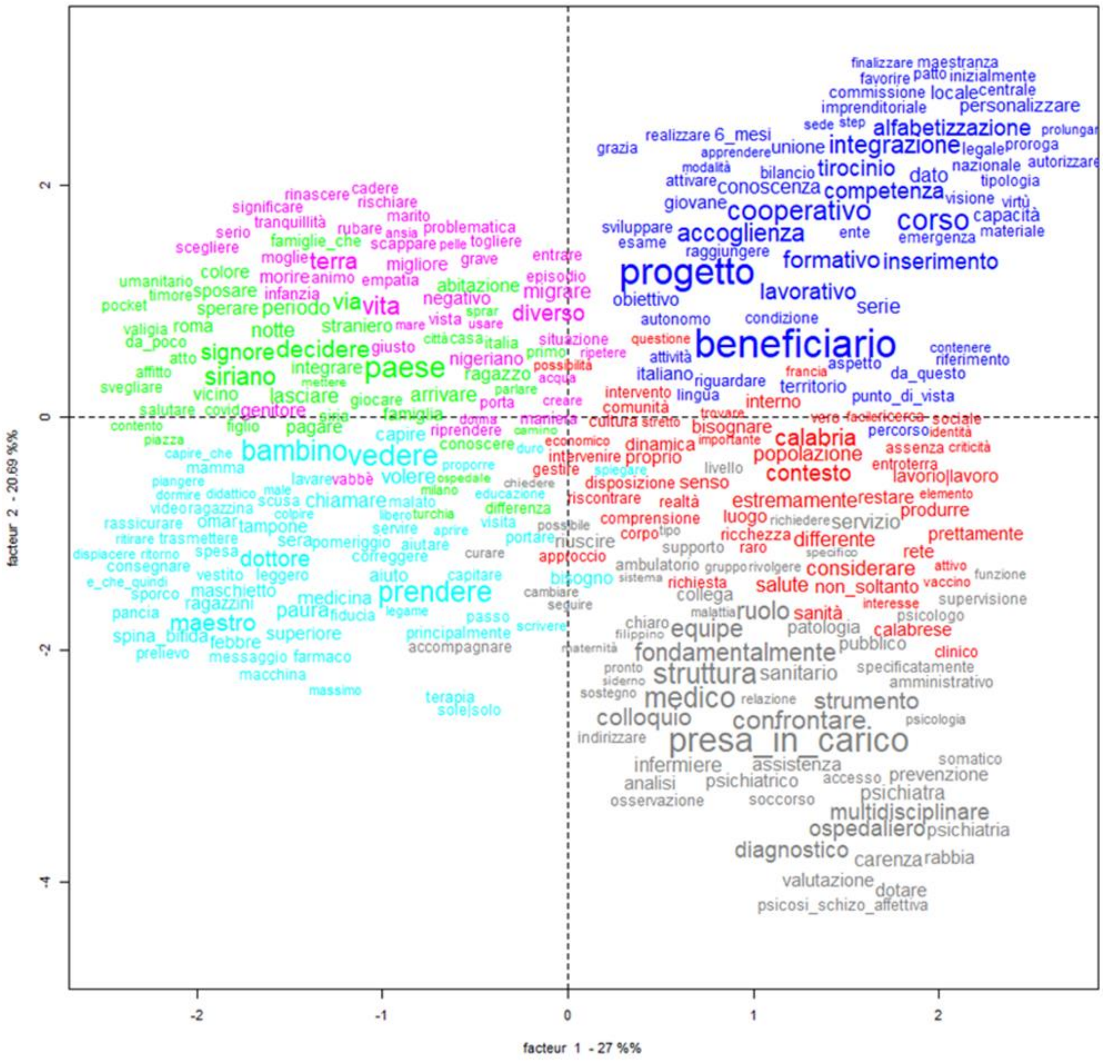
Finally, cluster 4, in light blue, is about children's needs and is represented by the words *see* (vedere), *child* (bambino), *to take* (prendere), *teacher* (maestro), *doctor* (dottore), *fear* (paura), *medicine* (medicina), *to understand* (capire), *kids* (ragazzini), *spina bifida* (spina bifida). This cluster talks about medical and children's needs. It reported the experience of a child named "Omar", who was suffering from spina bifida, who became very important to the community because of his condition, uniting it. Moreover, schools were opened thanks to children and the area was repopulated.

From the graph, two major ramifications can be noticed. The first one includes cluster 6 (22.1%) and a subgrouping with clusters 3 (16.8%) and 4 (15.8%) and can be attributed to the interventions acted by the stakeholder. The second one groups cluster 5 (18.3%), and a subgrouping with clusters 1 (14.8%) and 2 (12.2%) are about migrants' needs.

Principal Component Analysis

Factorial Correspondence Analysis, shown in Figure 7.3, is the projection of the clusters on a factorial plan to show relationships between classes, distinguishable by colours, according to the positioning in quadrants (Neta, 2021).

Figure 7.3: Principal Component Analysis



Class 5, related to the project mission, first emerges, occupying the Q1 (top left) quadrant almost entirely. Conversely, class 4, related to the child's needs, occupies rather exclusively Q3 (bottom right). A strong association emerges between the two quadrants, dictated by their opposite position on the factorial plan. It expresses the project's success and the importance given to all the interventions put in place for success for an adult and children as one of the main focuses and investments of the

project. However, these classes are very different semantics and are in different quadrants.

In Q2 (top right) and Q4 (bottom left) quadrants, clusters 6-3 and 2-1 merge in two pairs. In Q2, we see the overlap between Class 6, family needs, and Class 3, youth needs. A strong relationship emerges as they are on the same side, confirming the presence of semantic areas with broad points of contact and, consequentially, immediate needs. In the same way, in Q4, we see the overlap between Class 1 and Class 2, in which semantic areas appear to be very similar. The emerging theme deals with challenges in healthcare that are strongly related to territorial deficiencies.

As a confirmation of the dendrogram, clusters can mainly be grouped into two blocks. The first considers Clusters 3, 4 and 6 (on the left side of the graph), which almost overlap and are attributable to the migrants' needs. On the other hand, we have Class 1 in the middle between Classes 2 and 5 (on the right side of the graph), showing interventions implemented by the workers and, simultaneously, barriers hindering their realisation.

It is also possible to extract five factors from the analysis, showing the latent dimensions, but only two are shown in the graph. Factor 1 (27% of covered variance) shows the following words on the positive semiaxes: “comunità” (community), “cultura” (culture), “stretto” (narrow), “bisogno” (need), “ricerca” (search), “sociale” (social), “Calabria” (Calabria), “percorso” (path), “Importante” (important), “popolazione” (population), “entroterra” (hinterland), “contesto” (context), “lavoro” (job), “punto di vista” (point of view), “riferimento” (reference). These words emphasize the importance of reception in Camini, a phenomenon that has seen the country change leading to repopulation and socioeconomic restart. On the negative semiaxes, we found the words “salutare” (greet), “contento” (glad), “piazza” (square), “figlio” (son), “pagare” (to pay), “famiglia” (family), “giocare” (to play), “arrivare” (to arrive), “paese” (country). These words highlight the devotion with which the cooperative takes charge of the migrants it hosts in the country, recognizing their difficulties and the barriers that emerge in the resettlement process, especially for those migrants who arrive with their families and bring young children.

Factor 2, which covered 20,69% of the variance, on the positive semiaxes showed the words: “entrare” (to enter), “episodio” (episode), “migrare” (to migrate), “diverso” (different), “situazione” (situation) which highlighted the interventions that the cooperative puts in place best to welcome arriving migrants and foster integration into society. On the negative axe, we found words such as: “economico” (economic), “intervenire” (intervene), “gestire” (to manage), “possibile” (possible), “riuscire” (succeed), “approccio” (approach), “cambiare” (to change). These occurrences denote stakeholders' challenges and barriers in meeting the population's needs. Many of these barriers are structural and economic.

Discussion

This study explored stakeholders’ points of view about caring for migrants hosted in an Italian reception project stetted in a rural area. Our analysis revealed different manifest and latent dimensions influencing the multiethnic population’s health and professionals’ caring in a rural area whose structural characteristics are common to most southern European reception centres.

One of the most important findings was the symbolic-spiritual dimension as one of the central elements crossing all the participants’ tales. Our sample considered each person a bearer of different representations of self, body and efficacy and an expert disease therapist, from whom stakeholders revealed essential to be guided in the care process. However, the complexity and variability of the symbolic-cultural matrix underlying the needs of migrants, the different languages carrying peculiar sensory patterns and the singularity of experiences mean there is not always a complete correspondence between the reported needs and the needs perceived by professionals. This is related to awareness and regrets for difficulties in constructing health demand and delayed response by professionals when lacking specific skills.

As reported by literature (Legido-Quigley et al., 2019; Ponce Blandón et al., 2021), migrants often report somatic complaints that reflect more profound illnesses related to migration (adjustment difficulties or the trauma of travel) or cultural practices, including depression and stress resulting from abuse or religious practices. This aspect shows how cultural peculiarities underlie migrants' needs and are often connected to the individual's perceptions of health and illness. From our interviews, the relationship

with the body was highly problematic, with very important frailties, so all informal aspects are essential. It appeared vital to building a trusting relationship before creating a needs analysis to help people reconstruct their societal identity. However, this process often takes time and is not always feasible due to the narrow context and training necessities.

Basing the relationship on dialogue, adopting openness to communication, and active listening requires a culturally personalised approach. This issue is strongly connected to the need for specific training for professionals, the lack of culture-free tools for assessing, diagnosing, and treating migrants and the lack of an adequate setting for caring for migrants' needs, naturally leading to the risk of the constant search for psychosomatic problems, which diverts attention from the cultural area and distracts from the fundamental health problem research. Other studies considered this theme central (Driel & Verkuyten, 2022). The ability to communicate and empathise with people from different cultural backgrounds is vital for professionals engaged in multicultural territories (Gümüşsoy et al., 2021).

From this, the necessity of culturally competent care comes naturally. Moreover, an appropriate setting emerged as essential in correctly interpreting and responding to the most complex and various needs. As reported by stakeholders having an appropriate setting available can help to separate work contexts from private life in a narrow territory, which often removes the boundary between patient and practitioner. There is ample evidence that living in a small setting, on the one hand, can encourage the community's informal moments, providing a different way to enter into the relationship, but, on the other hand, it does not define an appropriate care setting and makes it challenging to consider multiculturalism an advantage (Gunn et al., 2021; Serre-Delcor et al., 2021).

Another finding from the study was the quality of professional groups, defined as one of the strong points for stakeholders' community well-being. Stakeholders reported hospitality and empathy as the main driving forces, guided by a willing and enthusiastic leader who transmits values to the entire population and increases migrants' sense of belonging. However, they reported the difficulty related to paternalism. Also, the literature confirmed the contribution of solid leadership and values. Although communication skills and an aptitude for empathy are considered the

entry key for connections between cultures, inclusion in a new territory, and impacting thoughts, emotions, and behaviours, it is also documented that substituting beneficiaries' efforts to achieve a minimum level of autonomy could be a mechanism used to compensate for the deficiencies of health services or job offers (Mancini et al., 2019).

Concerning cohesion and educational, inclusion and caring interventions, stakeholders reported the high involvement of most of the population in the care process, which is a great strength compared to contexts in which the natives remain excluded. Indeed, in our study, one of the central elements influencing good health and community well-being was good migrant integration with natives. As confirmed by Mancini and Rossi (2020), the involvement of natives in migrants' activities results in feelings of integration and better health status of the entire community, individuals empowerment and inequalities reduction. Among the activities provided by the cooperative are language and vocational courses, open not only to migrants but to the whole population. Language improvement, job skill valuations and training courses were revealed to be essential to promoting migrant settlement and autonomy, acclimatisation and active community participation, and is demonstrated by literature as a social determinant of health (Mancini et al., 2019).

According to Leininger's Transcultural Model (Leininger, 2002) and other studies (Mammana et al., 2020; Serre-Delcor et al., 2021), a strong relationship between good literacy, integration and good health status is often related to punctuality in reporting health problems, access to health services and continuity of care. Moreover, to promote the integration and the social inclusion of migrants, workshops were designed to work on and help recover from the consequences of gender violence in females' and minors' social theatre activities and, to reduce disparities, our interviewees reported the importance of extending activities aimed at migrants to residents. However, stakeholders reported that the lack of time and the short duration of projects emerged as crucial barriers to social integration. Also demonstrated by the literature, frequent migrant turnover often negatively impacts healthcare responses and integration, although it leads to conspicuous cultural contamination (Serre-Delcor et al., 2021).

Another key point from the results was the families' reception. It was also one of the main challenges that European territories faced in the past decade (Sacks & Peca,

2020). In our study, the child emerged as a crux for those families who were hesitant because of cultural beliefs and, like glue for community integration, inducing adult socialisation and cultural contamination. Indeed, parents were often willing to go beyond cultural barriers to make their children receive care when sick, causing some cultural peculiarities to emerge. Stakeholders opened schools, playrooms, and workshops to promote a well-settled community and establish an optimal relationship between family and community.

As other authors describe (McIntyre, 2021), including children in the community is essential to establish safe, friendly, respectful and generous spaces for mothers, infants and families and creating a robust social network within contemporary society. This is crucial for readjustment to a new area, benefiting health promotion and disease prevention (Nielsen et al., 2020). However, one of the most critical caregiving issues emerged with adults with mental disabilities. In contrast to paediatrics, barriers emerge with rehabilitation from psychomotor disabilities, even if psychological intervention is offered on par with other services and requested from the territory whenever antisocial behaviour is manifested.

Crucial territorial barriers to welcoming emerged despite stakeholders' efforts, cohesion, and dedication. Lack of facilities, fragmentation of services and bureaucratic issues complicated an excellent community's quality of life. Territorial support for migrants' treatment path only occurs when severe manifestations of psychological distress arise, defined as one of the causes of delays in diagnosis, treatment and disparities in care delivery for migrants (Gunn et al., 2021; Mancini et al., 2019). However, such significant barriers intensify the difficulties in meeting the healthcare needs of each ethnic group and for residents.

As confirmed by our study and other authors, it is common for native citizens to experience conditions typical in rural areas in southern Italy and elsewhere (Gunn et al., 2021; Mammana et al., 2020; Serre-Delcor et al., 2021). The goal, therefore, is to devise territorial support aimed at prevention and care from the earliest moments of care, where professionals can mediate with other populations and simultaneously not pathologize behaviours, which must be implemented. Finally, studies report challenges for migrants related to stigma and discrimination (Serre-Delcor et al., 2021), positively not emerged by our study.

Limitations

This study also presents some limitations. Firstly, the small size of the town and the context may limit the representativeness of the sample and the generalisability of our findings.

Secondly, locating and recruiting readily available stakeholders selected by the shelter project coordinators may have influenced the participants' responses and orientation to the phenomena under study.

Although not considered a limitation, researchers report that qualitative knowledge is inevitably shaped by preconceptions and biases (Gewurtz et al., 2016). Given the context in which the data collection was conducted, where cultures were very different from the researchers', bracketing was carried out before data collection.

Finally, only one nurse was present on the territory. It would have been desirable to interview more than one nurse to get a complete view of the picture.

Conclusion

Health is a fundamental human right. Considering the complex health challenges, providing opportunities for stakeholders to tell their stories allows the community health needs to be identified, along with the best ways to meet those needs, enabling the delivery of practical help compatible with cultural beliefs and practices and developing effective evidence-based strategies to improve healthcare delivery to migrants. In this area, the ICEN (2012) emphasises the vital role of culturally competent nurses in leading the change in thinking in both reception and caregiving.

Implications for nursing practice, nursing policy, health policy and social policy

The present study has several clinical implications. Firstly, it provides an essential insight into how different dimensions, including structural and economic factors, specific professionals' preparedness, and the openness towards welcoming migrants, can influence health and quality of life in a multicultural territory, and many areas for intervention emerged.

Our findings also showed how important a multidisciplinary approach and culturally competent care are in designing Evidence-Based interventions that consider the unique perceptions and experiences of health professionals interacting with newly arrived migrants in their daily practice.

Considering the point of view of professionals who adopt culturally competent care, we can identify hidden needs that are often not verbalised, which is crucial in responding to the healthcare needs of migrants and promoting their well-being. In addition, extending these cultural competencies to the organisational area would speed up administrative and bureaucratic procedures that limit the welfare of beneficiaries.

Improving this area would also affect migrants' feeling of belonging, which has emerged as crucial for improving population coping and promoting better health and integration outcomes, as demonstrated in the literature. Finally, analysing the strengths and limitations of the reception system of a small rural area and solving challenges could result in the development of an exportable reception model in other similar contexts that would improve economic growth and resources and result in depopulation.

One suggestion for addressing these challenges could be to act on all dimensions that determine the state of health. Therefore, promoting intervention programs for professionals involving managers, administrators, and policymakers would improve health outcomes where desire, commitment, empathy, and dedication help address the severe lack of support and resources that affect the population's health status.

Finally, the presence of only one interviewed nurse, who had not received adequate training in multicultural settings, brings out the importance of introducing an advanced nurse practitioner who can take charge of and respond to the needs of a

population of mixed cultures and would act as a glue with territorial services and professionals, who emerged from our study to be disconnected and deficient from the point of view of taking charge, due to the territorial barriers. The study makes a valuable contribution to nursing scientific knowledge due to the introduction of the family and community nurse.

Conflict of interests

The author declares no conflicts of interest.

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CAPITOLO 8

Living in a multicultural context: Health and integration from the perspective of undocumented Mediterranean migrants, residents, and stakeholders in Italy. A qualitative-multimethod study

This chapter is published in the following source:

Figura, M., Arcadi, P., Vellone, E., Pucciarelli, G*., Simeone, S., Piervisani, L., & Alvaro, R. (2024). Living in a multicultural context: Health and integration from the perspective of undocumented Mediterranean migrants, residents, and stakeholders in Italy. A qualitative-multimethod study. Journal of Advanced Nursing, 00, 1–13. https://doi.org/10.1111/jan.16036

Abstract

Aim. To catch a representative view of a multicultural population's needs.

Design. Qualitative study.

Methods. Semi-structured interviews were conducted from July 2022 to January 2023 with the project's stakeholders, migrants, and residents. Data analysis was performed using a multimethod textual analysis technique.

Findings. Territorial barriers, lack of social network and specific professionals' training emerged as healthcare delivery obstacles. For migrants, language improvement emerged as a health priority. A deep relationship with migrants emerged as a deficiency for residents.

Conclusion. A welcoming project equipped with solid leadership and the right resources can be fundamental in mediating health promotion and integration. In this process, the involvement of the resident population is essential.

Implications for the profession and/or patient care. Analyzing the migrants' needs and the strengths and limitations of a reception system could help identify the challenges for professionals in delivering culturally competent care. In this context, the nurse's role becomes relevant, being responsible for taking charge and caring for the population and the link between professionals and the population.

What problem did the study address? The study addressed the problem of improving the overall health of migrants, refugees, and asylum seekers, mainly focusing on reception and integration into a new society process.

What were the main findings? Worse health was identified with adaptation, integration, and family problems. Territorial barriers emerged, hindering good health.

Where and on whom will the research have an impact? These research findings can be valuable for health professionals who want to improve the reception process and enhance a care model integrated with residents.

Patient or Public Contribution: No Patient or Public Contribution.

Reporting method. To describe the research report, we referred to the COREQ checklist (Tong et al., 2007).

Keywords: Nursing, migrants, health, needs, refugees, asylum seekers, qualitative, mixed methods

Introduction

Over the years, millions of people, including undocumented migrants, refugees, and asylum seekers, have been forced to flee their country due to armed conflicts, economic imbalances, persecution, and human rights abuses (Iqbal et al., 2022). According to the 2022 mid-year trend report by the United Nations High Commissioner for Refugees (UNHCR), the number of displaced people worldwide exceeded 84 million (UNHCR, 2022). In the first 7 months of 2023, more than 117.600 landings, including more than 22.300 minors, fled from the Middle East, North Africa, Sub-Saharan Africa, and Central and South Asia (UNHCR, 2023). Italy, a strategic location on this migration route, reported approximately 139.280 undocumented migrants, refugees, and asylum seekers in the first 10 months of 2023 (Ministry of Interior, 2023).

Undocumented migrants, refugees, and asylum seekers flee natural disasters, wars, violence, and persecution, often undertaking overnight journeys on dangerous sea routes in ill-equipped boats (International Organization for Migration, 2022). In the new country, they are often traumatized, with few resources, and face more significant challenges to resettling into the host society than regular migrants (de Smalen et al., 2021). International literature documented various post-migration living problems (PLMP), including mental health problems, physical and psychological issues, and social, economic, and cultural challenges that significantly impact their health and wellbeing in the new country (Mattar & Gellatly, 2022). Consequently, migration affects the Social Determinants of Health, and irregular migrants are a fragile population with poor physical and psychosocial health, requiring significant support from hosting countries (Iqbal et al., 2022).

Although multiculturalism brings an enriching, multicultural society with diverse identities, cultures, and values, it also poses a critical challenge to host societies regarding reception and inclusion to ensure the wellbeing and integration of migrants (International Organization for Migration, 2022). Addressing social determinants requires action on the part of society and recognizing that health is not solely determined by medical care but broader social factors (Vega-Escaño et al., 2018).

Background

The significant increase in migrant landings in Europe has highlighted severe gaps in the European reception and asylum system, posing considerable challenges for healthcare systems, social services, and professionals striving to meet the needs of migrants (Mancini et al., 2019).

Following the asylum system reform proposed by the European Parliament in 2020 (European Parliament, 2023), Italy has set up second-level reception centers in inland areas (i.e., sparsely populated small areas due to their distance from urban centers). Thanks to inclusive initiatives where stakeholders work intensively to address migrants' needs, inland areas have been restructured to welcome, train, and reintegrate migrants into society, resulting in increased cultural diversity and richness (Reception and Integration System, 2022).

An example is an Italian reception center in Camini (RC), an inland area in the Calabria region of southern Italy. Through a six-month reception project called "Jungi Mundu" (meaning "Join the world" in the local slang), many migrants, refugees, and asylum seekers receive welcome and essential support for healthcare, economic independence, and social integration. Health professionals, social workers, and administrators work daily to provide migrants, refugees, and asylum seekers with accommodation, vocational training, and language classes. The project's effectiveness lies in the experimentation with a self-managed housing approach to enhance the autonomy of project beneficiaries, demonstrating social commitment through inclusion programs overseen by a multidisciplinary team of qualified experts and a material reception plan encompassing food, lodging, and a monthly stipend. Furthermore, this enables them to attain the same health objectives as residents, helped by cohabitation (Reception and Integration System, 2022). Nonetheless, significant challenges in care may arise due to territorial limitations and the high levels of multiculturalism stemming from diverse cultures that necessitate support and integration with residents.

Although several studies have focused on migrants in the last decade, very few studies have been conducted in such a multiethnic community. For instance, Driel and Verkuyten (2022) investigated everyday interactions between inhabitants of different

ethnic backgrounds in Riace in Southern Italy, which has hosted and integrated refugees into the local community for over 20 years. While the health needs of migrants, refugees, and asylum seekers (Sundvall et al., 2020) and professionals' perspectives (Mancini et al., 2019) have been widely studied, there is a shortage of literature investigating the needs of a multicultural population by comparing the perspectives of stakeholders, migrants, and residents living in the same context. Given the significance of the problem, this represents a gap.

The Study

To improve migrants, refugees, and asylum seekers' good health, it is essential to involve the entire interested population to understand the reception and integration processes into a new society. Therefore, it is crucial to investigate the strengths and barriers for stakeholders who care for the entire multicultural population, as well as the challenges faced by migrants in the resettlement process. It is essential to integrate the residents' perspective to understand how the integration processes within a community can impact the health status of migrants.

Aim

For this reason, this study aimed to gather the experience of a multicultural population, composed of a project's stakeholders, migrants, refugees and asylum seekers and residents, to investigate perceived health needs and aspects related to reception, integration, and support to obtain a comprehensive and representative view of all constituents involved.

Methods

Study Design

A qualitative study was conducted using semi-structured face-to-face interviews.

Methodological Framework

We used an innovative multimethod data analysis technique called automatic analysis of textual data (AATD) to analyze the semi-structured interviews. Based on the exploratory multidimensional data analysis (EMDA) framework by Fraire (2009),

this approach provided a quantitative-statistical analysis of qualitative data using specialized software. An exploratory-descriptive approach guided data interpretation to understand better the participants' perspectives and the underlying dimensions of discourse and lexical corpora concerning the real world. We used the open-source software IRaMuTeQ 0.7 alpha 2 (IRaMuTeQ) to analyze data. To describe the research report, we referred to the COREQ checklist (Tong et al., 2007).

This approach satisfies the study's objectives for multiple reasons. On the one hand, it allows us to compare the different populations' perspectives by studying their typical language. On the other hand, it lends rigor to the analysis and findings interpretation due to the statistical analysis conducted on textual data, overcoming some of the limitations inherent in qualitative analysis (Figura et al., 2023). Therefore, it was chosen by the authors as the most suitable data analysis technique following the purpose of the study.

Study Setting and Recruitment

According to the aim, three different components of the population were selected from lists provided by the cooperative and the municipal administration: stakeholders who work within the center, migrants (beneficiaries of the hosting project), and residents. We used a purposive sampling approach to recruit a representative participants component.

Specifically, stakeholders were clustered by professional fields (health professionals, social workers, and administrative area members). Migrants were clustered by country of origin, gender, age range, and length of stay. Migrants who were at least 18 years old and had been enrolled in the Camini's reception project for at least three months were selected, as the standard duration of participation in a reception project for each migrant is six months, and a shorter time would not have allowed for an informed experience. Finally, residents were clustered by sociodemographic characteristics (gender and age), selecting participants at least 18 years old. All three participant samples were enrolled based on their willingness. Involvement in the study lasted until data saturation was reached. All researchers involved had expertise in multicultural contexts and were confident in qualitative research according to their professional backgrounds.

Data Collection

Data were collected from July 2022 to January 2023. After identifying potential study participants, we scheduled interview dates, times, and locations with project coordinators. Interviews were conducted in three phases (one for each sample) in a location agreed upon with participants and during their free time.

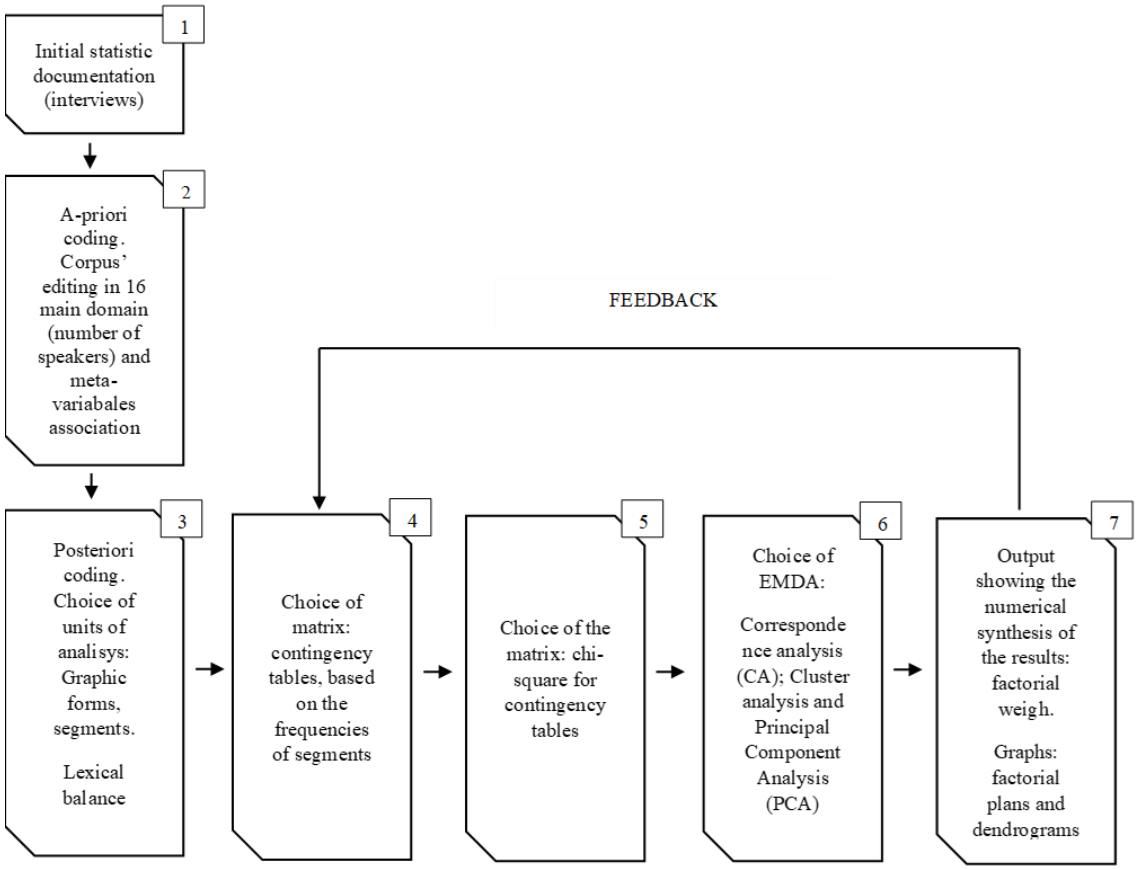
Participants were interviewed through semi-structured individual interviews, audio-recorded, and stored on a digital device. Stakeholders were asked to speak about the expressed and unexpressed health needs of the multicultural population they assist, the strengths and barriers in meeting those needs, and the strengths and weaknesses of the reception project from their professional perspective. For migrants, the interviews were based on their migration experience, experience in the reception center, related health needs, and their conception of health and illness. Residents were asked to speak about their experience with the reception, health needs, and conception of health and illness. All three groups were finally asked questions about their subjective experiences in the community, the experience of integration and relationships between culturally different population groups, and the meaning they attribute to migration, experienced personally and not. Finally, an open-ended question was asked: "Do you have anything else to tell me about your experience in the community?". During the interviews, no one was present other than the researchers and cultural mediators for migrants. Interviews were conducted in the researchers' language (Italian), and cultural mediators intervened in cases where questions were not understood by migrants (Cuoco et al., 2022).

Researchers maintained an empathetic attitude, expressing warmth and reassurance, to facilitate narrating participants' experiences. According to Corbin & Strauss (1998), interviews were conducted without interruption until saturation was reached, meaning until participants stated they had nothing more to add or until no new information emerged. Data saturation, agreed upon by the researchers, was reached after 16 interviews with stakeholders, 19 interviews with migrants, and 15 interviews with autochthonous participants. In addition to the interviews, researchers used a brief questionnaire to collect participants' sociodemographic data, which was helpful for data analysis and a general description of the sample. The interviews lasted an average of 40 minutes each.

Data Analysis

Data analysis was conducted using Fraire (2009), which consists of seven phases (supplementary figure 8.1). In the first phase, all interviews were transcribed separately into a Word document (.docx).

Suplementary figure 8.1: EMDA framework, according to Fraire (2009)



Subsequently, they were transferred into a single document called the 'corpus' and checked for accuracy by the researchers. In the second phase, text pre-processing procedures were applied (Figura et al., 2023) following the IRaMuTeQ software protocols, and the corpus underwent a priori coding. This coding divided the corpus into shorter parts, referred to as 'texts,' based on the study's objectives. In our investigation, each text corresponded to an individual interview.

To each text were associated metadata lines, i.e., descriptive information providing relevant information, useful for organizing and categorizing documents within a textual corpus and enabling more effective data search and analysis about the

text. In our corpus, metadata line contained sociodemographic variables associated with each interviewee (speaker, citizenship, gender, age, nationality, profession, etc.) (supplementary table 8.1), which helped define the variables for conducting the analyses (Bolasco, 2021).

Supplementary table 8.1: Metadata lines and key

META-DATA LINES
**** *parl_01 *camp_migr *gen_f *age_30 *naz_nig *statciv_sin *figl_0 *it_2011 *cam_2021
**** *parl_02 *camp_migr *gen_f *age_28 *naz_nig *statciv_sin *figl_1 *it_2016 *cam_2020
**** *parl_03 *camp_migr *gen_m *age_41 *naz_mar *statciv_1 *figl_1 *it_2017 *cam_2019
**** *parl_04 *camp_migr *gen_m *age_18 *naz_sir *statciv_sin *figl_0 *it_2016 *cam_2016
**** *parl_05 *camp_migr *gen_f *age_21 *naz_sir *statciv_sin *figl_0 *it_2016 *cam_2016
**** *parl_06 *camp_migr *gen_f *age_35 *naz_sir *statciv_mar *figl_1 *it_2015 *cam_2016
**** *parl_07 *camp_migr *gen_m *age_33 *naz_mar *statciv_mar *figl_1 *it_2020 *cam_2020
**** *parl_08 *camp_migr *gen_f *age_23 *naz_mar *statciv_sing *figl_0 *it_2021 *cam_2021
**** *parl_09 *camp_migr *gen_m *age_23 *naz_sir *statciv_sing *figl_0 *it_2018 *cam_2021
**** *parl_10 *camp_migr *gen_f *age_24 *naz_som *statciv_wid *figl_1*it_2018 *cam_2019
**** *parl_11 *camp_migr *gen_m *age_25 *naz_som *statciv_wid *figl_1 *it_2019 *cam_2019
**** *parl_12 *camp_migr *gen_f *age_39 *naz_lib *statciv_mar *figl_1 *it_2020 *cam_2020
**** *parl_13 *camp_migr *gen_f *age_44 *naz_pak *statciv_mar *figl_1 *it_2014 *cam_2015
**** *parl_14 *camp_migr *gen_m *age_47 *naz_pak *statciv_mar *figl_1 *it_2014 *cam_2015
**** *parl_15 *camp_migr *gen_m *age_24 *naz_ban *statciv_sing *figl_0 *it_2021 *cam_2021
**** *parl_16 *camp_migr *gen_m *age_35 *naz_sen *statciv_mar *figl_1 *it_2014 *cam_2014
**** *parl_17 *camp_migr *gen_f *age_29 *naz_mar *statciv_mar *figl_1 *it_2020 *cam_2020
**** *parl_18 *camp_migr *gen_f *age_30 *naz_nig *statciv_mar *figl_1 *it_2015 *cam_2019
**** *parl_19 *camp_migr *gen_m *age_33 *naz_ghan *statciv_wid *figl_1 *it_2017 *cam_2020
**** *parl_20 *camp_res *gen_m *age_74 *lav_ pen *viss_1 *res_cam *istr_ lm *statciv_mar *fig_1 *naz_ita
**** *parl_21 *camp_res *gen_m *age_71 *lav_ pen *viss_1 *res_vic *istr_laur *statciv_mar *fig_1 *naz_ita
**** *parl_22 *camp_res *gen_m *age_61 *lav_ pen *viss_1 *res_cam *istr_lm *statciv_mar *fig_1 *naz_ita
**** *parl_23 *camp_res *gen_f *age_52 *lav_ dip *viss_0 *res_cam *istr_dip *statciv_ mar *fig_1 *naz_ita
**** *parl_24 *camp_res *gen_f *age_54 *lav_ dip *viss_0 *res_cam *istr_lm *statciv_ mar *fig_1 *naz_ita
**** *parl_25 *camp_res *gen_m *age_64 *lav_ pen *viss_0 *res_cam *istr_lm *statciv_sing *fig_1 *naz_ita
**** *parl_26 *camp_res *gen_m *age_61 *lav_ lp *viss_1 *res_cam *istr_laur *statciv_ mar *fig_1 *naz_ita
**** *parl_27 *camp_res *gen_m *age_34 *lav_ dis *viss_0 *res_ria *istr_dip *statciv_ mar *fig_1 *naz_ita
**** *parl_28 *camp_res *gen_m *age_60 *lav_ dip *viss_0 *res_cam *istr_dip *statciv_sing *fig_0 *naz_ita
**** *parl_29 *camp_res *gen_f *age_83 *lav_ pen *viss_0 *res_cam *istr_le *statciv_wid *fig_1 *naz_ita
**** *parl_30 *camp_res *gen_m *age_83 *lav_ pen *viss_1 *res_cam *istr_le *statciv_wid *fig_1 *naz_ita
**** *parl_31 *camp_res *gen_f *age_83 *lav_ pen *viss_0 *res_cam *istr_dip *statciv_wid *fig_1 *naz_ita
**** *parl_32 *camp_res *gen_m *age_31 *lav_ dip *viss_0 *res_cam *istr_laur *statciv_wid *fig_1
**** *parl_33 *camp_res *gen_f *age_81 *lav_ pen *viss_0 *res_cam *istr_le *statciv_wid *fig_1 *naz_ita
**** *parl_34 *camp_res *gen_f *age_56 *lav_ dip *viss_0 *res_cam *istr_dip *statciv_wid *fig_1 *naz_ita
**** *parl_35 *camp_stake *prof_edsoc *gen_d *form_pl *formspec_1 *assunz_2014 *figl_0 *sett_socioed
**** *parl_36 *camp_stake *prof_assistsoc *gen_d *form_l *formspec_1 *assunz_2017 *figl_1 *sett_socioed
**** *parl_37 *camp_stake *prof_inf *gen_d *form_l *formspec_0 *assunz_2020 *figl_1 *sett_sanit
**** *parl_38 *camp_stake *prof_ins *gen_d *form_s *formspec_0 *assunz_2015 *figl_0 *sett_socioed
**** *parl_39 *camp_stake *prof_opinsprof *gen_u *form_s *formspec_1 *assunz_2020 *figl_1 *sett_org
**** *parl_40 *camp_stake *prof_resp *gen_u *form_s *formspec_1 *assunz_2001 *figl_1 *sett_org
**** *parl_41 *camp_stake *prof_epsi *gen_d *form_pl *formspec_1 *assunz_2019 *figl_0 *sett_sanit
**** *parl_42 *camp_stake *prof_coord *gen_d *form_s *formspec_1 *assunz_2013 *figl_1 *sett_org
**** *parl_43 *camp_stake *prof_medcult *gen_d *form_pl *formspec_1 *assunz_2011 *figl_0 *sett_socioed
**** *parl_44 *camp_stake *prof_osa *gen_d *form_m *formspec_1 *assunz_2014 *figl_1 *sett_socioed
**** *parl_45 *camp_stake *prof_opleg *gen_d *form_l *formspec_1 *assunz_2018 *figl_1 *sett_org
**** *parl_46 *camp_stake *prof_liut *gen_m *form_l *formspec_1 *assunz_2020 *figl_0 *sett_socioed
**** *parl_47 *camp_stake *prof_psi *gen_d *form_l *formspec_1 *assunz_2017 *figl_1 *sett_sanit
**** *parl_48 *camp_stake *prof_mmg *gen_d *form_l *formspec_0 *assunz_2008 *figl_0 *sett_sanit
**** *parl_49 *camp_stake *prof_medanest *gen_u *form_pl *formspec_0 *assunz_2015 *figl_1 *sett_sanit
**** *parl_50 *camp_stake *prof_psisup *gen_u *form_pl *formspec_1 *assunz_2017 *figl_1 *sett_sanit

KEY			
parl	Speaker	Statciv_mar	Married
camp	Sample	Statciv_sing	Single
Figl_0	Have no children	Statciv_wid	Widowed
Figl_1	Have children	age	Age
statciv	Marital status	gen_u	Man
gen_d	Woman	Camp_stake	Stakeholders
sett_sanit	Healthcare worker	psisup	Supervising psychologist
sett_socioed	Socio-educational area	psi	Psychologist
sett_org	Organizational-managerial areas	ed_soc	Educator
form_l	Graduate	assistsoc	Social worker
form_pl	Advanced degree	inf	Nurse
form_s	High school graduate	ins	Teacher
form_m	Middle school graduate	opinsprof	Employment placement officer
formspec_1	Transcultural training: yes	resp	Cooperative manager
formspec_0	Transcultural training: no	epsi	Ethnopsychologist
assunz	Year starting work on the project	coord	Cooperative coordinator
opleg	Legal assistant	medcult	Cultural mediator
Camp_migr	Migrants	osa	Social care worker
cam	Transfer year to Camini.	Camp_res	Natives
it	Transfer year to Italy	lav	Occupation
naz	Nationality	Lav_pen	Retired
nig	Nigerian	Lav_ dip	Employed
mar	Moroccan	Lav_lp	Freelance
sir	Siryan	Lav_dis	Unemployed
Som	Somali	res	Residence
Lib	Lebanese	Res_cam	Residence in Camini
Pak	Pakistani	Res_vic	Residence in Vicenza
Ban	Bangladeshi	Res_riace	Residence in Riace
Sen	Senegalese	Viss_0	Lived outside of Camini
Ghan	Ghanaian	Viss_1	Didn’t lived outside of Camini.

Following the software's rules, once the Word file was prepared, it was saved in the standard UTF-8 (Unicode Transformation Format 8-bit code units) encoding format before commencing the analysis.

During phase three, called 'a-posteriori coding,' descriptive statistics were provided for the texts under examination, resulting in a lexical balance, and the reliability and content validity criteria for multidimensional statistical analysis were verified. The lexical balance included frequency tables of active forms, supplementary forms, and hapaxes (graphical forms appearing only once).

Regarding the reliability criteria of the statistical analysis, according to Bolasco (2021), the corpus should contain at least 25,000 occurrences to ensure the reliability of the statistical analysis. Furthermore, the ratio between type (corpus vocabulary) and token (total occurrences contained in the corpus), called the 'type/token ratio', should be below 20%, and the percentage of hapax should not exceed 50% (Bolasco, 2021). Subsequently, in the fourth step, frequency matrices of active forms, supplementary forms, and hapaxes were generated, and researchers identified the lexical data table for multivariate statistics, known as 'x shapes' or texts contingency table. Since the

objective was text-to-text analysis, the chi-square ($\chi 2$) measure of association between occurrences was chosen.

In the fifth step, measures for the statistical analysis were chosen. In the sixth step, multidimensional variable-driven statistics were applied. Statistical techniques provided factorial analysis (e.g., Principal Component Analysis and Correspondence Analysis) and classifier methods (e.g., Classificatory Hierarchical Dendrograms). Thanks to factorial analysis, extracting occurrences or classes of occurrences' proximity through their projection on a factorial plane allowed for the exploration of lexical profiles and latent semantic dimensions. Using clustering, an unsupervised process based on algorithms, it was possible to classify texts with similar vocabulary. The seventh step generated lexical and numerical output graphs (Figura et al., 2023).

Ethical Considerations

The university of Tor Vergata Ethics Committee approved this study on 7 July 2021 (protocol registration number 160.21). Ethical norms and guidelines for the research project were respected, and confidentiality was ensured. To protect privacy, all interviewees signed an informed consent form following the responsibilities provided by good clinical practice standards and in full compliance with the current regulations on personal data protection (World Medical Association 2013). All participants consented to their data being used for research purposes.

Findings

Sample Description

Sixteen stakeholders (eleven women and five men with an average age of 41 years), nineteen migrants and fifteen residents (nine men and six women, with an average age of 63 years) were enrolled in this study. The demographic characteristics of participants were reported respectively in table 8.2, 8.3 and 8.4 – supplementary material.

Supplementary table 8.2: Stakeholders characteristics

I.D	Gender	Age	Educational level	Marital status	Job occupation	Year of work experience	Year of work with migrants	Multi - cultural training
AZ01	M	44	High school	Married	Project Director	20	10	Yes
BV02	F	43	High school	Married	Project Coordinator	8	8	Yes
CU03	F	33	Bachelor's degree	Married	Psycologist	8	4	Yes
DT04	M	48	Bachelor's degree	Single	Social Operator	15	3	Yes
ES05	M	45	High school	Married	Teacher	20	5	Yes
FR06	F	32	Bachelor's degree	Married	Social Operator	7	7	Yes
GQ07	F	34	Master's degree	Single	Educator	7	7	Yes
HP08	F	38	Master's degree	Married	Ethno-psycologist	10	2	Yes
IO09	F	32	Bachelor's degree	Married	Legal Operator	2	3	Yes
JN10	M	68	Master's degree	Married	Specialist Doctor	41	6	No
KM11	F	34	Middle school	Married	Home Care Worker	7	7	No
LW12	M	33	Master's degree	Married	Psycologist	9	4	Yes
XC16	F	42	Master's degree	Married	Cultural Mediator	10	10	Yes
XY13	F	66	Bachelor's degree	Single	General Doctor	38	13	No
YB15	F	30	High school	Single	Teacher	6	6	No
ZA14	F	34	Bachelor's degree	Married	Nurse	7	1	No

Supplementary table 8.3: Migrants characteristics

I.D.	Gen.	Age	Place of birth	Mar. status	N. of Child.	Y. of arrival in Italy	Ed. Level country of origin	Ed. Level in Italy	Job occupation in the country of origin	Job occupation in Italy	Training courses in Italy
AZ01	F	30	Nigeria	Unm.	0	2011	Middle School	Noone	Hairdresser	Hotel	Italian Language
BY02	F	28	Nigeria	Unm.	2	2016	Middle School	Noone	Dressmaker	Bag-Labour (Weaving)	Italian Language
CX03	M	41	Morocco	Marr.	3	2017	High School	Middle School	Security	Bag-Work (Electrician)	Italian Language
DW04	M	18	Syria	Unm.	0	2016	Middle School	Middle School	Noone	Ceramist	Ceramist
EV05	F	21	Syria	Unm.	0	2016	Middle School	High School	E-Commerce	Language Mediator	Italian Language
FU06	F	35	Syria	Marr.	5	2015	Elementary School	Noone	Noone	Noone	Noone
GT07	M	33	Morocco	Marr.	2	2020	Middle School	Noone	Butcher	Tailor	Italian Language
HS08	F	23	Morocco	Unm.	0	Not avaiable	Middle School	Noone	Noone	Noone	Italian Language
IR09	M	23	Syria	Unm.	0	2018	High School	High School	Student	Noone	Italian Language
JQ10	F	24	Somalia	Div.	1	2018	Noone	Noone	Noone	Noone	Italian Language
KP11	M	25	Somalia	Div.	1	Not avaiable	Noone	Noone	Noone	Noone	Italian Language
LO12	F	39	Libya	Marr.	4	2020	Bechelor Degree	Noone	Noone	Tailor	Italian Language
MN13	F	44	Pakistan	Marr.	4	2014	High School	Middle School	Noone	Noone	Italian Language
ZA14	M	47	Pakistan	Marr.	4	2014	High School	Noone	Goldsmith	Tailor	Italian Language
YB15	M	24	Bangladesh	Unm.	0	Not avaiable	Noone	Noone	Clerk, Gardener	Noone	Italian Language
XC16	M	35	Senegal	Marr.	5	2014	Middle School	Middle School	Farmer	Masoner	Italian Language
WD17	M	28	Lebanon	Unm.	0	2020	Middle School	Noone	Employee	Tailor	Italian Language
VE18	F	29	Morocco	Marr.	2	2020	Noone	Noone	Noone	Noone	Italian Language, Tailor
UF19	F	30	Nigeria	Marr.	3	2015	Middle School	Middle School	Telephones Seller	Bag-Labour	Italian Language

Supplementary table 8.4: Residents characteristics

I.D.	Gen.	Age	Place of birth	Residence	Marital status	N. of Child.	Ed. Level	Job occupation	Migration experience
N1	M	74	Camini	Camini	Married	2	Middle S.	Retired	Yes
N2	M	71	Messina	Vicenza	Married	1	Bechelor D.	Retired	Yes
N3	M	61	Camini	Camini	Married	3	Middle S.	Retired	Yes
N4	F	52	Locri	Camini	Married	1	High S.	Employee	No
N5	F	54	Camini	Camini	Married	3	Middle S.	Employee	No
N6	M	64	Licata	Camini	Unmerried	2	Middle S.	Retired	No
N7	M	61	Locri	Camini	Married	2	Bechelor D.	Self-Employed	Yes
N8	M	34	Soverato	Riace	Married	2	High S.	Unemployed	No
N9	M	60	Camini	Camini	Unmerried	0	High S.	Employee	No
N10	F	83	Riace	Camini	Widowed	2	Elementary S.	Retired	No
N11	M	83	Camini	Camini	Married	3	Elementary S.	Retired	Yes
N12	F	83	Quartavalle	Camini	Married	4	High S.	Retired	No
N14	M	31	Soverato	Camini	Married	1	Bechelor D.	Employee	No
N14	F	81	Camini	Camini	Married	3	Elementary S.	Retired	No
N15	F	56	Camini	Camini	Married	2	High S.	Employee	No

Corpus Description

The corpus analyzed using automatic textual data analysis included fifty texts, in line with the number of interviews. The lexical balance (Table 8.1) showed a lexically rich text (type/token ratio: 5%; 42.9% hapax on total forms; 107.467 occurrences). These indices met the reliability criteria for multidimensional statistical analysis.

Table 8.1: Corpus characteristics

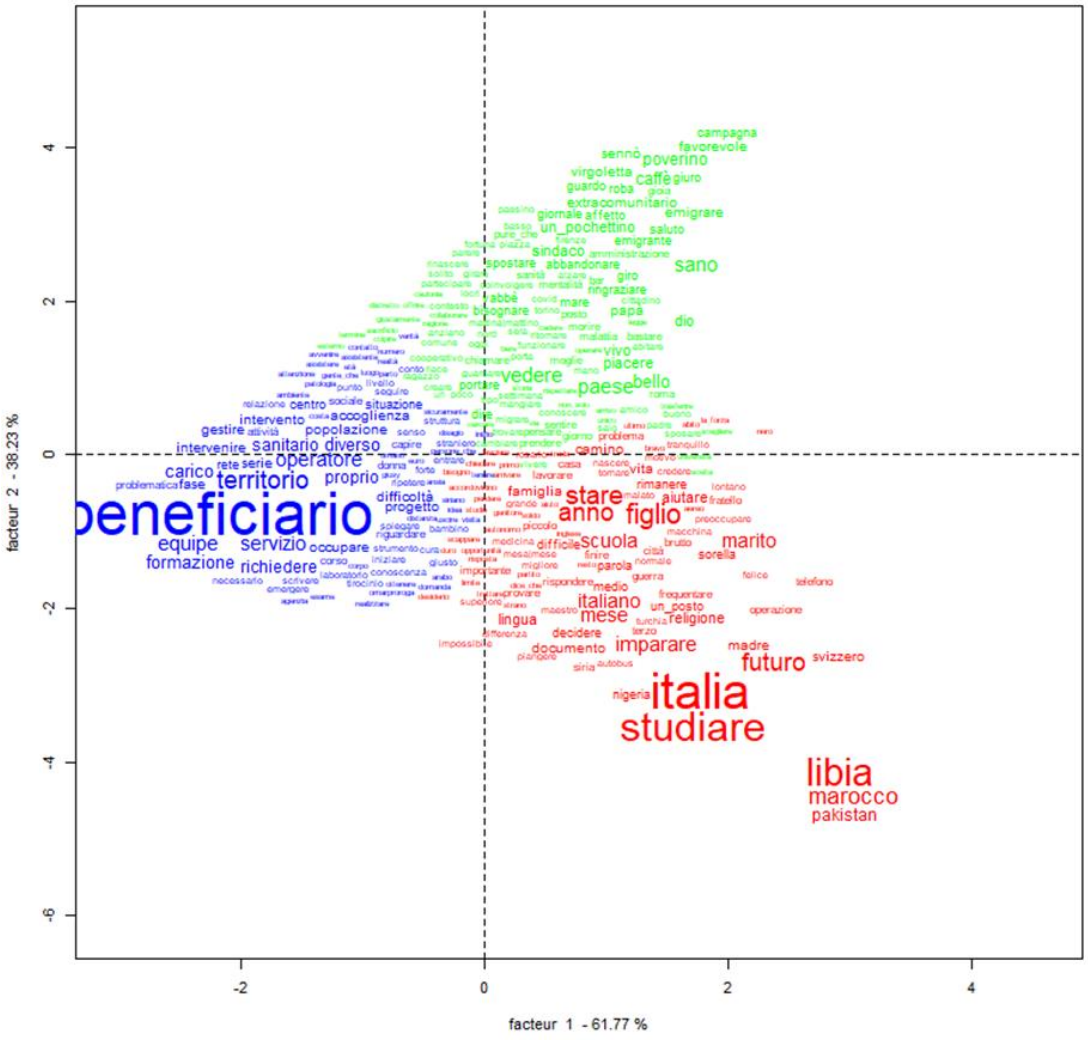
Corpus Lexical balance	
Number of texts	50
Number of occurrences (N)	107467
Number of forms (V)	5499
Number of hapaxes	2360 (2.20%of occurrences - 42.92% of forms)
Average number of occurrences per text	2149.34

Multidimensional Analysis

Correspondence Analysis

This analysis began with projecting the factorial plane of the samples under study (Figure 8.1). The data reading considers the position of the occurrences on a plane concerning factors, sections, and proximity. It resulted in three blocks, each associated with one of the interviewed samples. The stakeholder dimension was assigned to the blue block of occurrences called 'project mission'; the migrant dimension was associated with the red block of occurrences titled 'migrants' needs', while the residents dimension referred to the green block of occurrences called 'reception by residents'.

Figure 8.1: AC according to the variable "sample"



From the occurrences' arrangement on the factorial plane, themes emerged from the stakeholder dimension were the management of economic and social interventions, healthcare interventions, and the relational aspect with different populations represented by occurrences such as 'to manage' (gestire), 'intervention' (intervento), 'economic' (economico), 'social' (sociale), 'to intervene' (intervenire), 'activity' (attività), 'healthcare' (sanitario), 'centre' (centre), 'reception' (accoglienza), 'relationship' (relazione), 'population' (popolazione), and 'different' (diverso). The reception of migrants was conceived as a proactive activity aimed at integration and social inclusion through interventions to establish a caring and supportive relationship in the social, healthcare, and economic aspects. Simultaneously, themes representing barriers to care and support emerged with the occurrences' team' (equipe), 'training' (formazione), 'necessary' (necessario), 'to request' (richiedere), 'service' (servizio), 'territory' (territorio), 'issue' (problematica), 'charge' (carico), 'network' (rete), 'course' (corso), 'laboratory' (laboratorio), 'internship' (tirocinio), 'tool' (stumenti), 'care' (cura), 'difficulty' (difficoltà), 'project' (progetto), 'to start' (iniziare), 'knowledge' (conoscenza), 'healthcare professional' (operatore sanitario), and 'to explain' (spiegare). These occurrences highlighted the need for specific training for the team, the difficulty in requesting necessary services for proper care from the territory, the need to create a network among professionals and services, and the lack of care and support tools that respect cultural peculiarities. Finally, challenges for stakeholders in establishing the helping relationship with some beneficiaries due to their high turnover emerged. Despite the significant stakeholders' efforts in establishing a helping relationship by adopting the principles of cultural humility (Foronda et al., 2016), younger people tend to move to larger places with more opportunities due to the territorial limitations and low attractiveness of the country, differently from families who tend to settle in the territory, instead.

From the migrant dimension, themes related to the need to learn the language of the host country to ensure social and economic integration emerged with the occurrences 'to study' (studiare), 'school' (scuola), 'Italian' (Italiano), 'to learn' (imparare) and 'language' (lingua). Another central theme was family, with which migrants often associated their state of health, clear with the occurrences' child' (figlio), 'little' (piccolo), 'family' (famiglia), 'husband' (marito), 'sister' (sorella), and

'mother' (madre). On the one hand, the pain for migrants who have left family members in their country of origin due to economic impossibilities, serious health problems, and the unwillingness of some members to leave their country. On the other hand, the difficulty of adapting to the new culture and preserving traditions and customs without being influenced by the new customs, especially when having children attending school. Finally, with the occurrences' war' (guerra), 'Libya' (Libia), 'to decide' (decider), 'to cry' (piangere), 'difficult' (difficile), and 'end' (fine), the pain associated with the trauma of migration emerged, as well as the need for access to healthcare. In contrast, occurrences such as 'normal' (normale), 'happy' (felice), 'religion' (religione), and 'operation' (operazione) expressed a clear desire for normality, social integration and access to healthcare and the desire to feel accepted despite differences.

The residents' dimension was about the sociodemographic change in Camini due to the reception project, evident with the occurrences 'to see' (vedere), 'to bring' (portare), 'to know' (conoscere), 'country' (paese) 'beautiful' (bello), 'alive' (vivo), 'pleasure' (piacere), 'sea' (mare), 'bar' (bar), and 'movement' (movimento). Thanks to the reception project that welcomed not only families but also young migrants and children, Camini has experienced demographic and economic growth, the opening of schools, commercial venues, and activities. Residents considered it as a 're-born' of the country. However, occurrences such as 'unfortunate person' (poverino), 'coffee' (caffè), 'non-European' (extracomunitario), 'to involve' (coinvolgere), 'greeting' (saluto), and 'favourable' (favorevole) highlighted a lack of deep relationships. Although the presence of feelings such as respect, compassion, understanding, and closeness towards the migrants was likely linked to the residents' first-hand experience of migration, moments of proper integration seem limited to a few moments of the day, such as sporadic encounters in the central square and during coffee, as emphasized by the occurrence 'coffee' (caffè). Therefore, we can suppose reception by residents seems like a 'moral duty,' even though approached with enthusiasm and openness. The third theme, represented by occurrences such as 'reside' (abitare), 'to die' (morire), 'illness' (malattia), 'elderly' (anziano), and 'to function' (funzionare), underscores the structural deficiencies and difficulties related to healthcare due to a lack of resources, adequate facilities, and suitable means of transportation.

From the analysis, it was possible to extract two factors (supplementary table 8.5) from which the latent content of the text can be derived.

Supplementary table 8.5: Factors extracted from CA

	Valeurs propres	Pourcentages	Pourcentage cumules
Facteur 1	0,192342	61,76848	61,76848
Facteur 2	0,11905	38,23152	100

Factor 1 (the horizontal one), which accounts for almost 62% of the variance, is named the 'Reception project' and shows the opposite project's vision between the two main parties involved, stakeholders and migrants, on the two axes. On the left semi-axis, we find occurrences pronounced by stakeholders: 'to intervene' (intervenire), 'health' (salute), 'different' (diverso), 'operator' (operatore), 'social network' (rete sociale), 'to understand' (capire), 'foreigner' (straniero), 'charge' (carico), 'territory' (territorio), and 'problem' (problema). Despite the solid cooperative aptitude and the established leadership role in the area, the territorial reception system still lacks the implementation and support of interventions aimed at inclusion, growth, and healthy development of the multicultural community. From this, it can be deduced that the territory is probably not yet structurally and culturally ready to respond to the needs of a population that, by definition, presents difficulties and characteristics related to the social condition of migrants. On the right semi-axis, occurrences like 'home' (casa), 'believe' (credere), 'to be born' (nascere), 'life' (vita), 'Camini,' 'calm' (tranquillo), 'to return' (ritornare), and 'work' (lavoro) expressed by migrants manifested the hope of rebirth and wellbeing they cultivate upon their arrival in the project.

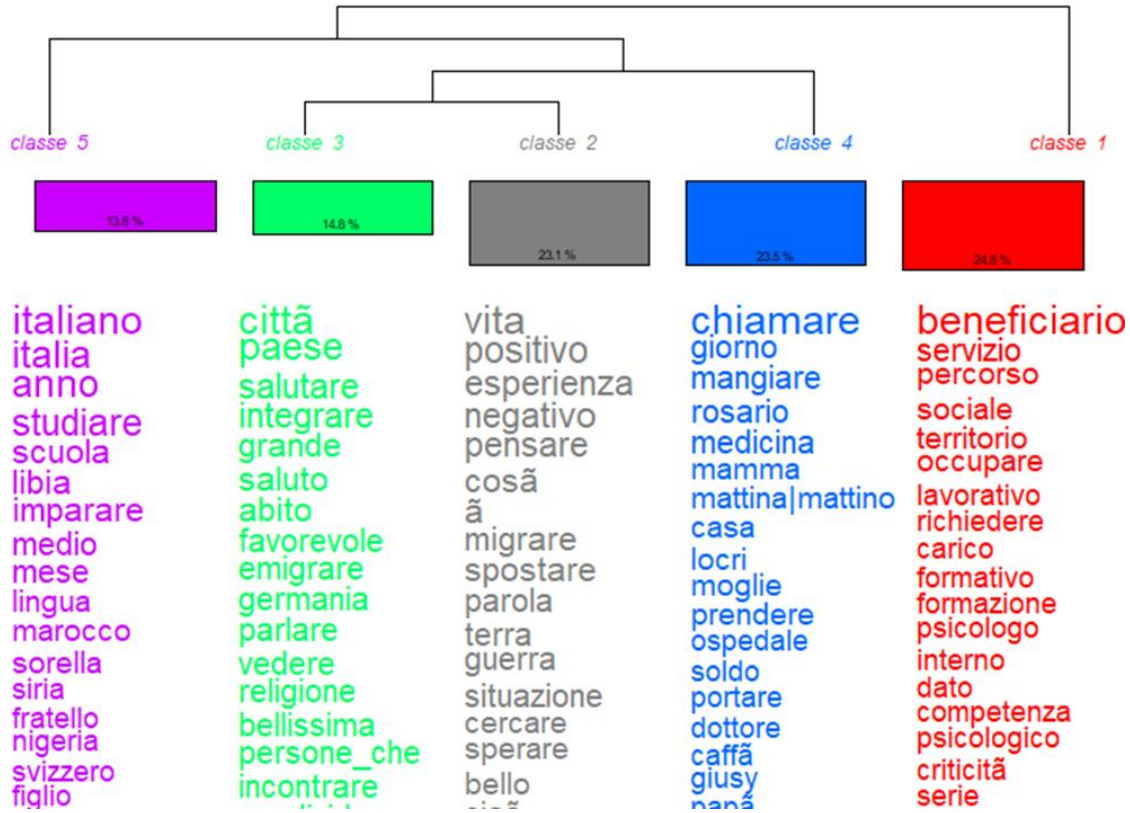
Factor 2 (the vertical one), which accounts for approximately 38% of the variance, is called the 'Migration phenomenon.' It sees, on the two axes, the perception of migrants' needs by residents and migrants themselves. The dynamism of change associated with migration and the need to adapt to new situations is evident on the upper semi-axis. Occurrences like 'luck' (fortuna), 'to tour' (girare), 'need' (bisogno), 'to bring' (portare), 'to change' (cambiare), 'to migrate' (migrare), 'to move' (spostare), and 'involve' (coinvolgere) indicated the idea of facing new challenges, opportunities, and contextual changes that characterize the migration experience. These occurrences reflected the dynamic and evolving aspect of migrants' lives and the need to adapt to new environments, situations, and roles during migration. The challenge of

communication and integration during the migration process emerges on the below semi-axis. Occurrences such as 'important' (importante), 'language' (lingua), 'difference' (differenza), 'impossible' (impossibile), 'opportunity' (opportunità), 'need' (bisogno), 'to ask' (chiedere) and 'close' (vicino) highlighted the difficulties and barriers that migrants face in the linguistic and cultural context of the new country. These occurrences indicated the need to overcome linguistic, cultural, and social differences to integrate into the new society. The participants also expressed a request for support, a willingness to learn the local language, the importance of interaction and proximity to the local community for better integration, and the opportunity to meet fundamental needs during the migration process.

Cluster Analysis

The cluster analysis (Figure 8.2) identified five classes, with a textual coverage of 96% (supplementary table 8.6).

Figure 1: Discendent Hierarchical Classification



Supplementary table 6: Abstract of cluster analysis

Abstract	
Number of texts	50
Number of text segments	3098
Number of forms	8881
Number of occurrences	107467
Number of lexemes	5499
Number of active forms	4990
Number of supplementary forms	445
Number of active forms with frequency >= 3	1933
Average number of forms per segment	34.689154
Number of clusters	5
2974 segments classified by 3098 (96.00%)	

Cluster 1, highlighted in red, was named 'the reception system.' It mainly included interventions implemented by stakeholders, indicated by occurrences such as 'service' (servizio), 'path' (percorso), 'social' (sociale), and 'work-related' (lavorativo). These activities provided social and occupational integration services, including language learning, skills assessment, and psychological and healthcare support.

Cluster 2, in grey, was named 'the migration movement.' Occurrences such as 'life' (vita), 'to migrate' (migrare), 'to move' (spostare), 'land' (terra), 'war' (guerra), 'to seek' (cercare), and 'beautiful' (bello) reflected various aspects of migrants' migration experience. What emerged was the search for a new life in a different place, dealing with geographical movements and changes, facing the consequences of war, and finding beauty or opportunities in the new destination.

In Cluster 3, 'welcoming and rebirth' was described in green. The occurrences' city' (città), 'country' (paese), and 'beautiful' (bello) emphasized the aspect of the country's rebirth thanks to the welcoming of migrants. The occurrences 'to greet' (salutare), 'to integrate' (integrare), 'favourable' (favorevole), 'to meet' (incontrare), and 'religion' (religione) highlighted residents' positive view regarding the reception. Additionally, the occurrences 'to emigrate' (emigrare) and 'Germany' (Germania) referred to the migration experience personally experienced by some residents who emigrated to Northern Europe after the second world war.

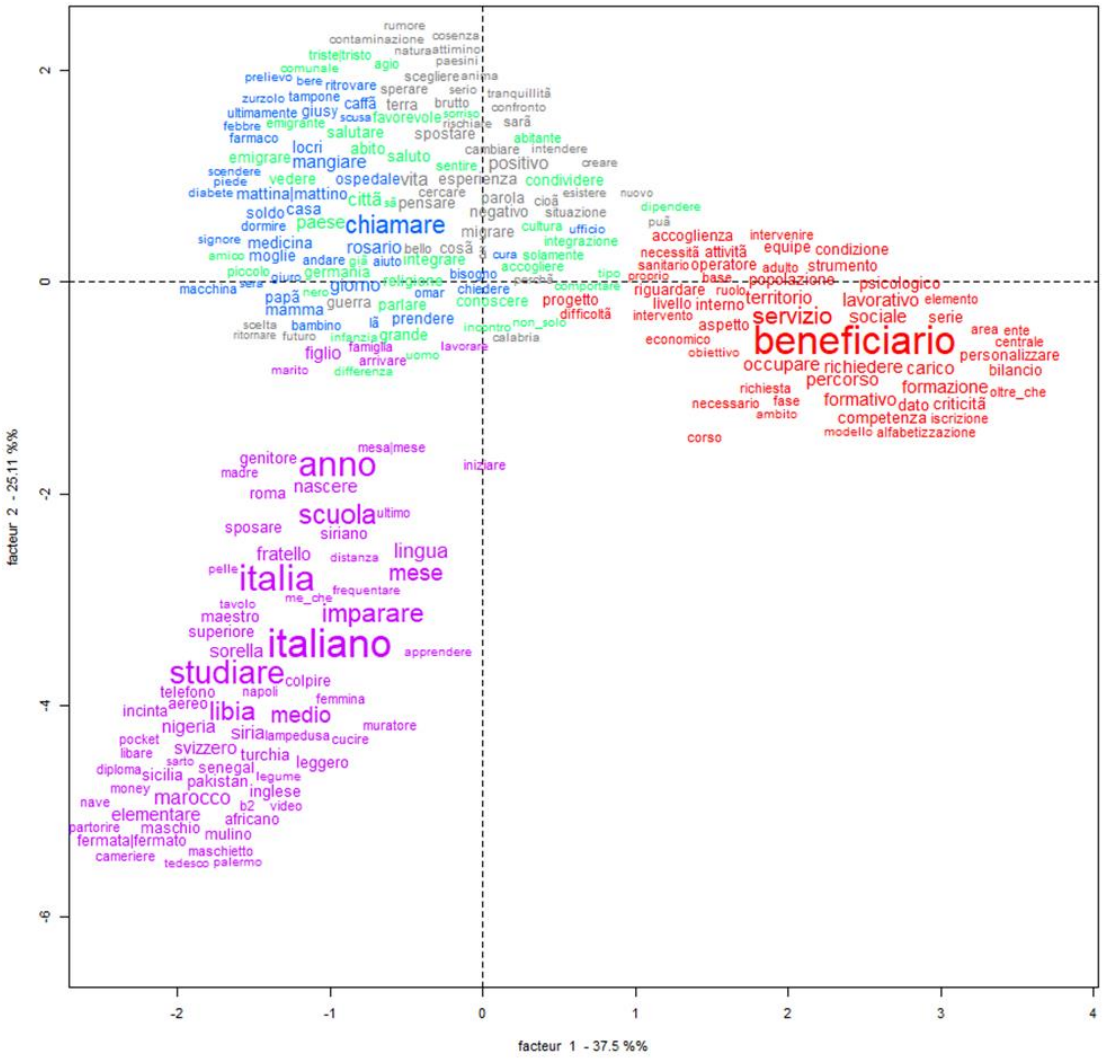
Cluster 4, in blue, is named 'primary needs.' These needs ranged from basic needs, expressed with the occurrences of 'home' (casa) and 'food' (cibo), to economic needs, represented by the occurrence of 'money' (soldo), and healthcare needs, expressed by 'medicine' (medicina), 'hospital' (ospedale) and 'doctor' (dottore). Finally, the terms 'Rosario' and 'Giusy,' respectively, were the names of the project manager and coordinator who were recognized as significant reference points for the entire community and demonstrated the importance of cooperative support.

Cluster 5, in purple, is called 'linguistic integration.' It represented the needs of migrants from their perspective, prioritizing the need for linguistic integration, as indicated by occurrences such as 'Italian' (Italiano), 'to study' (studiare), and 'school' (scuola). Additionally, the theme of family emerges with occurrences like 'sister' (sorella), 'brother' (fratello), and 'child' (figlio).

Principal Component Analysis

In principal component analysis (PCA), the five lexical worlds that emerged through exploratory cluster analysis were projected (Figure 8.3) to identify relationships between clusters. The graph shows three separate and independent clouds of occurrences. In quadrant 2 (upper left), clusters labeled 'the migration movement,' 'welcoming and rebirth,' and 'primary needs' are wholly overlapped. These clouds of occurrences approach the 'reception system' cloud, positioned between quadrants 1 (upper right) and 4 (bottom right). From this proximity, the shared cultural background between stakeholders and residents emerges. Therefore, the first factor (var. 25.11%) was named 'the welcoming phenomenon.'

Figure 8.3: Principal Component Analysis



On the left semi-axis, occurrences' money' (soldo), 'to sleep' (dormire), 'medicine' (medicina), 'wife' (moglie), 'dad' (papa), 'mom' (mamma), 'child' (figlio), and 'religion' (religione) identified areas of economic needs, basic needs, family challenges, and physical health needs of migrants identified by the other two samples. Conversely, on the right semi-axis, the occurrences' project' (progetto), 'psychological' (psicologico), 'intervention' (intervento), 'work-related' (lavorativo), 'healthcare' (sanitario), and 'social' (sociale), highlighted the interventions implemented through cooperation, including the presence of crucial psychological support and personalized assistance from a social and occupational standpoint.

Finally, the 'linguistic integration' cluster is positioned separately in quadrant 3 (bottom left). The second factor (var. 25.11%) is named 'the migration experience.' The occurrences' experience' (esperienza), 'to migrate' (migrare), 'positive' (positivo), 'comparison' (confronto), and 'tranquillity' (tranquillità) on the upper semi-axes expressed the residents' perception of migration. On the bottom semi-axis, occurrences such as 'to star' (iniziare) and 'to work' (lavorare) show the priority for migrants and manifest the need for job occupation.

Discussion

This study aimed to gather the experience of stakeholders, migrants, and residents coexisting in a multicultural context. The study has investigated perceived health needs and aspects related to reception, integration, and support in a hosting project where a multidisciplinary team implements daily interventions for migrants' wellbeing and their social and economic integration. The chosen setting allowed in-depth observation of integration processes, dynamics between populations, and modalities of responses to needs. Through multidimensional statistics, it was possible to compare themes from each sample and identify similarities and differences in health perceptions through lexical analysis.

The main findings from stakeholders concerned the project's strengths. The main stakeholders' mission was to tailor economic, social, and healthcare interventions and build a strong community relationship. According to Leininger (2002), cultures are characterized by different perceptions and health priorities. However, the literature agrees unanimously that post-migration problems significantly impact physical,

mental, and social health and require urgent attention (Jannesari et al., 2020). Our findings showed that the cohesion among stakeholders and attention to cultural specificities represent the strengths, and stakeholders play a fundamental role in recognizing and responding to the needs of migrants through inclusion interventions and the growth of a healthy community. However, the healthcare system still presents shortcomings. In line with Mancini et al. (2019), the lack of specific training, bureaucratic barriers, and an inadequate territorial network emerged as stakeholders' main challenges to assistance.

Also, lack of specific training, territorial deficiencies, and high turnover of beneficiaries emerged as barriers to assistance and care. These problems are not unique to this context but are common in similar cases (Driel & Verkuyten, 2022; Thoennessen, 2021). The high turnover of beneficiaries in the project is primarily due to the short 6-month duration imposed by the Government, which poses challenges for migrants in terms of language acquisition and skill development. However, the project's core mission of providing housing and financial independence has facilitated successful integration, particularly for families with children.

On the other hand, younger individuals often opt to relocate to larger cities, despite the cooperative have become vital references for both beneficiaries and residents thanks to the adoption of cultural humility, as revealed by our findings. Therefore, enhancing the area's appeal through investments in infrastructure and healthcare facilities could substantially reduce beneficiary turnover and stimulate population growth (Bottura & Mancini, 2018; Mancini et al., 2019).

From the migrants' perspective, resettlement in the new context emerged as the main challenge to good health. Acculturation, social integration, adaptation needs, and aspects related to family and the trauma of migration were mentioned as primary needs.

Acculturation and language integration are among the primary needs expressed by migrants in our study. The literature has documented how language problems, often exacerbated by a lack of personal resources necessary for language learning, result in an inability to carry out daily activities, difficulties in integration, and acculturation stress for the population involved (Choy et al., 2021). Kiselev et al. (2020) and van

Loenen et al. (2018) agree that language difficulties inevitably lead to overall health alterations, decreased quality of life, and mental health issues, significantly impacting anxiety and depression. Consistent with Mancini and Rossi (2020), language learning is correlated with social and professional integration in our findings. According to the stakeholders interviewed in our study, the leading cause of migrants' poor acculturation is the short duration of projects. The literature confirms these findings, documenting that longer stays in the host society and better knowledge of the language significantly reduce the perception of discrimination and acculturation stress, improving health (Löfvander et al., 2014).

In line with Mangrio et al. (2021) and Mölsä et al. (2016), our findings confirm the importance of family in providing social support and influencing migrants' health. On the one hand, there are concerns for family members left behind in their country of origin. This element could cause mental health problems and loneliness in the new country (Mölsä et al., 2016). On the other hand, adaptation to the new community could be stressful and cause conflicts within the family due to the contamination of cultural traditions and religious beliefs. As Hun et al. (2022) maintain, migrants must renegotiate their identity to fit into the new context but also seek to preserve their identity during cultural assimilation. In this way, family support positively influences economic strain, social tension, the effort of competence, and discrimination, yielding promising results in terms of subjective wellbeing, mental health, quality of life, and social stress (Jesuthasan et al., 2018; Nissen et al., 2021).

The pain associated with the trauma of migration and the desire for a "normal" and better life emerged as central themes from our study, hence the need for social integration and feeling accepted despite differences. Literature unanimously recognizes migrants' post-migration mental health problems (i.e., post-traumatic stress disorder - PTSD -, depression, and anxiety) due to pre-migration wars, political persecution, and the migration experience (Brance et al., 2023). From our findings, stakeholders attempt to address psychological needs as best as possible. However, managing psychiatric symptoms was challenging due to a lack of adequately trained staff and territorial support. In this sense, improving support for professionals regarding psychological assistance could be beneficial. However, according to Nissen et al. (2021), maintaining good mental health and adequate integration and perceiving

migration as an opportunity for self-expression, a sense of belonging, and personal development promotes a positive adaptation process. In this sense, resilience is crucial for migrants in enhancing the wellbeing and facilitating a successful integration into new societies (Walther et al., 2021). To foster resilience, immigrants could have access to and draw upon religious beliefs, faith, hope, and community-oriented mindsets that bolster resilience and supportive social connections (Mwanri et al., 2022). Our findings showed good participants' resilience, promoted by cooperative and community support that enabled them to cope effectively with the challenges of resettlement despite the traumas they had to face.

Residents mainly referred to migrants' inclusion and integration into the community and the barriers to accessing healthcare due to a lack of structural and professional resources. The relationship between migrants and residents is another focal point of our findings. In general, residents reported reception as a positive experience. However, we could deduce a lack of deep relationships between migrants and residents, which seemed to occur mainly during social moments of community life. According to Driel and Verkuyten (2022), friendship and interaction between people of different ethnic backgrounds is the crucial social glue of the community.

On the other hand, social inequality, group stereotypes, group-based friendships, and space division are common (Driel & Verkuyten, 2022). From our findings, we can hypothesize that integration occurred following the example of the cooperative. According to Kokab et al. (2020) and Sundvall et al. (2020), inclusion and integration are closely linked and broadly impact mental health and quality of life. Following Walther et al. (2021), feeling accepted and safe and overcoming social isolation through social networks and dedicated infrastructure promote good adaptation, integration, and wellbeing. Most studies agree that marginalization leads to a lack of identity and community sense of belonging (van der Zee & van Oudenhoven, 2022), resulting in depressive and anxious symptoms. Conversely, integration is associated with lower depressive symptoms and has a more significant positive effect (Jesuthasan et al., 2018). For this reason, further exploration of relationships could be necessary.

Concerning primary needs, differently from what is specified in the literature by Gewalt et al. (2019) and Kiselev et al. (2020), our findings did not report unmet primary needs such as the need for food and shelter. Maybe migrants felt basic needs

were met by the cooperative and didn't feel the necessity to mention them in their responses.

Given the magnitude of the problem, it is essential to investigate the reception and processes of integration of migrants into a new society involving the entire interested population. However, to obtain a global understanding of the phenomenon under study, it would be desirable for future research to expand the study to several Italian and European centers. Furthermore, it would be advisable to integrate qualitative data with quantitative measurements, thus allowing the generalization of results that can be applied to clinical practice. Integrating these data and including multiple centers in the study could lead to developing a care and management model that considers specific and contextual information. Therefore, future research exploring similar contexts in depth is recommended to strengthen the information network and establish a territorial care model for this population, effectively promoting social, linguistic, and economic integration and ensuring a response to health issues while maintaining their cultural identity.

Based on the findings of this study, from a clinical perspective, it would be desirable to adopt a transcultural approach to promote critical skills among all healthcare, educational, and social personnel. Promoting intervention programs for professionals involving managers, administrators, and policymakers would improve health outcomes where desire, commitment, empathy, and dedication help address the severe lack of support and resources that affect the population's health status. In this context, the nursing profession deserves particular attention. Introducing adequately trained nurses would help deliver quality care in constructive collaboration with other professionals and create support networks to improve health outcomes and promote integration. In addition, as emerged from our findings, it would be desirable to investigate further the relationship between migrants and residents, given the influence of integration, social support, and quality of life on general health status widely underlined by the literature.

This study also has limitations. First, our study was conducted in a single European country. This characteristic could limit the generalization of the findings because, as highlighted in our study, context analysis is crucial in determining healthcare needs. It would be desirable to incorporate other similar contexts to

understand better and adapt the care response from the perspective of implementing care models that can be applied elsewhere. Concerning data collection, interviews were conducted using the researchers' Italian language. Thanks to cultural mediators for each ethnic group, this proved to be the most favorable method for data collection.

As for the sample, the significant age differences between migrants and residents emerged due to two crucial factors. On the one hand, migrants arriving in Europe are generally young because of their ability to cope with the arduous journey across the Mediterranean. On the other hand, residents are older because Camini is an inland area that has witnessed severe depopulation by young people over the years due to the territorial barriers typical of inland areas.

Moreover, we analyzed stakeholders in a separate population based on their professional and societal roles, but they are still residents. This factor may lead to prejudice in some answers to interview questions. In addition, the stakeholders were asked some questions about their profession, which differed from those of the rest of the population, although other questions were the same for the whole sample. Finally, there was insufficient representation of the nursing profession, as only one nurse existed.

Conclusion

The global discourse on migration has become highly contentious, yet it is imperative to recognize the humanity inherent in each migrant's pursuit of a better life.

Our research underscores the transformative impact of a well-organized reception project led by competent leadership, specifically addressing the health needs of the entire population. Engaging highly qualified stakeholders, characterized by unwavering dedication and a commitment to cultural humility, can significantly influence the health outcomes of the hosted population. This approach serves as a vital tool in mediating the promotion of integration and inclusion for migrants, mitigating the challenges typically encountered during resettlement in a new country. Notably, the active involvement of the resident population is indispensable and has the potential to shape health outcomes.

Moreover, the analysis of the stakeholder sample, representing residents in terms of culture and demographics, illuminates that cultural background is not determinative in fostering welcoming and inclusive societies. Rather, the key factors lie in the societal role played and the level of engagement in the care process and activities geared towards inclusion. This underscores the importance of personal commitment in creating an inclusive society that acts as a bridge connecting populations, fostering improved reception, integration, and enhancing the migrants' sense of belonging.

These research findings can be valuable for healthcare professionals operating in reception centers who aspire to refine the reception process and enhance the care model for a multicultural population seamlessly integrated with residents. Consequently, the introduction of a territorial nurse equipped with specific cross-cultural nursing skills becomes imperative in aligning with this vision.

For future research endeavors, broadening the scope of the study to encompass more centers could aid in identifying and formulating a nursing care model applicable to similar settings. This is particularly relevant in the European context, given the significant magnitude of the migration phenomenon.

While acknowledging that there is still much work ahead to enhance relationships between diverse communities, this study serves as a promising starting point for initiating positive changes.

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Conflict of interest statement

The author declares no conflicts of interest.

Peer review

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.16036

Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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CAPITOLO 9

Discussione e conclusioni

Risultati principali del Programma Dottorale

Questo programma di ricerca dottorale si prefiggeva diversi obiettivi. In generale, si proponeva di fornire nuove conoscenze relativamente ai bisogni di salute di una popolazione multiculturale con il fine di costruire percorsi di salute mirati. In primo luogo, si è cercato di identificare i bisogni di salute di rifugiati e richiedenti asilo in una comunità multiculturale italiana. In secondo luogo, si è cercato di esplorare la costruzione soggettiva della salute e della malattia dei membri della comunità multiculturale e di identificare le variabili che influenzano la salute e il benessere. Infine, si è proceduto a descrivere le risposte ai bisogni di salute poste in essere dagli operatori sociali e sanitari.

Come primo risultato, nel capitolo 2 abbiamo compendiato le conoscenze esistenti sui bisogni di salute fisici e psicosociali dei rifugiati e richiedenti asilo del Mediterraneo, attraverso una revisione sistematica della letteratura. I risultati hanno mostrato che i fattori principali che influenzano o determinano la salute dei migranti includono il livello di integrazione e di acculturazione, la discriminazione linguistica ed etnica, le condizioni abitative, il reddito, l'adattamento socio-culturale, i bisogni psico-fisici, l'ottenimento del permesso di soggiorno. Inoltre, i problemi familiari e gli eventi traumatici influiscono sulla salute generale e mentale e sulla qualità della vita. L'accesso ai servizi sanitari è risultato essere un ostacolo cruciale per il mantenimento della salute.

Nel capitolo 3 abbiamo individuato i problemi più emblematici della progettazione e conduzione di uno studio qualitativo tra paesi con culture diverse e identificato le possibili strategie per risolverli, garantendo rigore metodologico. Mentre infatti esistono validazioni culturali e psicometriche per gli strumenti quantitativi, lo stesso non si può dire per quelli qualitativi. Le principali strategie individuate si collocano in tutte le principali fasi di conduzione di uno studio: nella fase di disegno, includendo nel team di ricerca un esponente delle differenti culture studiate; nella fase di costruzione dei metodi, con tecniche di campionamento

omogenee e sviluppando strumenti che considerino le diverse sfaccettature culturali; nella fase di trascrizione e analisi, tenendo traccia del significato culturale specifico delle parole utilizzate in una colonna accanto al testo della trascrizione; nella fase di reporting, includendo le citazioni in lingua originale e nella fase di discussione dei risultati, interpretando i dati tenendo conto del significato attribuito dalla cultura oggetto di studio.

Nel capitolo 4 abbiamo studiato e analizzato il vissuto esperienziale degli operatori sanitari e sociali relativamente alla cura di una popolazione di rifugiati e richiedenti asilo in un contesto multiculturale. Abbiamo effettuato uno studio fenomenologico qualitativo con Analisi Interpretativa Fenomenologica sulle interviste di 16 operatori sociosanitari operanti nel progetto di accoglienza dei migranti. I risultati hanno fatto emergere l'attribuzione di significato dei partecipanti relativamente ai bisogni e alle necessità dei migranti. Anzitutto esiste una discrepanza tra i bisogni riportati dai migranti, e quelli identificati come prioritari dagli operatori. Per i primi prevale il bisogno di ritornare nella terra di origine, per i secondi la necessità di inserimento nel nuovo Paese, con il fine ultimo di promuovere l'integrazione tra le differenti culture di appartenenza, nonché l'autonomia e l'indipendenza di ciascun migrante nel nuovo contesto di vita. In secondo luogo, sono emersi i punti di forza della presa in carico dei rifugiati e richiedenti asilo, rappresentati dall'approccio multidisciplinare come elemento fondamentale della relazione con il gruppo di lavoro, e la dimensione dell'empatia come strumento di comprensione dei bisogni di salute individuati. In ultimo, sono stati portati all'attenzione i principali vissuti di fatica degli operatori sociosanitari, causati dalle molteplici carenze che il contesto territoriale in cui sono inseriti manifesta e che conduce all'incapacità di fornire la risposta più efficace ai bisogni di salute della popolazione migranti.

Nel capitolo 5 abbiamo esplorato l'esperienza dei rifugiati e dei richiedenti asilo relativamente ai bisogni di salute percepiti e agli elementi che influenzano la salute e il benessere, attraverso la conduzione di uno studio fenomenologico con Analisi Interpretativa Fenomenologica effettuata su un campione di 19 interviste. Dai risultati emerge che la famiglia rappresenta un elemento in stretta relazione con la salute e il benessere dei rifugiati. Nel novero delle relazioni affettive primarie si attestano, infatti,

le relazioni familiari che tuttavia appaiono complesse e talvolta compromesse da un percorso fatto di separazioni, nostalgie, ostacoli e ricongiungimenti. Tutti gli sforzi del migrante si traducono pertanto nella necessità di garantire il benessere alla propria famiglia, che è direttamente proporzionale al proprio benessere percepito. Accanto alla dimensione famigliare, anche il sentirsi parte di una comunità ha ripercussioni sulla salute delle persone. Per i migranti, infatti, è centrale il bisogno di avere una vita sociale completa mediata da un sentimento identitario, espressione di una adesione alla collettività in cui potersi sentire partecipe; al contrario la privazione della soddisfazione di questo bisogno, e dunque la mancanza di interazioni, può avere esiti negativi sulla salute. Il bisogno di appartenenza può esprimersi con il desiderio di sentirsi inclusi, accolti e supportati. Anche l'apprendimento della lingua maggioritaria è un bisogno avvertito dalla maggioranza degli intervistati e, sebbene l'integrazione linguistica non sia necessariamente garanzia di una piena integrazione, l'acquisizione di competenze nella lingua maggioritaria può sicuramente facilitarla. L'ultimo elemento che influenza la salute è raggiungere una condizione di vita stabile e sicura. Il bisogno di sicurezza e stabilità si configura in relazione alla possibilità di ottenere (o ricostruire) una piena indipendenza, intesa come forma di autonomia personale, in termini lavorativi e abitativi. L'accesso al mercato del lavoro e alloggi stabili e sicuri sono condizioni essenziali per la salute dei migranti. Il bisogno di stabilità e sicurezza si traduce inoltre nella necessità per i rifugiati e richiedenti asilo di ottenere un supporto dalla rete dei servizi territoriali nei diversi settori della vita sociale, attraverso un sistema integrato di servizi orientati alla persona e al nucleo familiare.

Nel capitolo 6 abbiamo introdotto una nuova metodologia di analisi dei dati denominata Analisi Automatica dei Dati Testuali (AADT). Questo approccio si differenzia dalla ricerca qualitativa tradizionale per la sua significativa integrazione tra analisi qualitativa e quantitativa. Basandosi sul modello di Analisi Esplorativa dei Dati Multidimensionali (EMDA) di Fraire, l'AADT utilizza statistiche multivariate basate su variabili in un approccio esplorativo-descrittivo, supportato da sofisticati software informatici. Questo approccio permette di condurre diversi tipi di analisi partendo dallo stesso set di dati, facilitando l'interpretazione di fenomeni complessi e l'identificazione di corpi lessicali sottostanti al testo. L'impiego dell'AADT si rivela vantaggioso nel superare le sfide legate alle diverse interpretazioni del testo e

nell'esecuzione di analisi affidabili su vasti insiemi di testi e dati qualitativi complessi, come interviste, monologhi e dibattiti. In questo contesto, il ricercatore, guidato da framework teorici e guide di riferimento, assume un ruolo centrale nell'assicurare la solidità dei dati sia per l'analisi che per l'interpretazione. È essenziale per un ricercatore riconoscere la dualità dei dati di ricerca, i quali presentano una natura qualitativa riflettendo fenomeni soggettivi, psichici e culturali che vengono trasformati in linguaggio verbale per costituire basi empiriche utili nell'analisi di fenomeni sociali e nel supporto alle teorie. Parallelamente, si può affermare che ogni dato è intrinsecamente quantitativo, poiché è sempre possibile tradurre il linguaggio descrittivo delle parole nel linguaggio numerico attraverso il processo di codifica. In questo modo, i numeri (o più precisamente, le misurazioni) e le relazioni tra di essi possono essere interpretati e presentati come sequenze ordinate di parole dotate di significato. Tuttavia, allo stato attuale, questo tipo di approccio è ancora scarsamente utilizzato dalla comunità infermieristica.

Nel capitolo 7, abbiamo esaminato il punto di vista degli stakeholder sull'assistenza ai migranti nel progetto di accoglienza utilizzando l'Analisi Automatica dei Dati Testuali (AADT). L'analisi delle interviste condotte su 16 operatori ha fatto emergere i seguenti tre cluster relativi alle diverse discipline: professionisti sanitari, professionisti socio-educativi e professionisti dell'ambito organizzativo. I risultati mostrano diverse dimensioni, sia manifeste che latenti, che influenzano la salute della popolazione multietnica e gli interventi messi in atto. Per ciò che concerne l'area dei professionisti socio-educativi, il fulcro del loro agire è rappresentato dal migrante bambino e, in correlazione, dall'attenzione dedicata alla famiglia. Il bambino è stato riconosciuto come un elemento fondamentale per favorire l'integrazione nella comunità, facilitando la socializzazione degli adulti e la condivisione culturale. Inoltre, l'assistenza ai bambini rappresenta la porta d'accesso alla presa in carico dell'intero nucleo familiare. I professionisti mettono in atto interventi per favorire la formazione di una comunità ben integrata e instaurare relazioni ottimali tra la famiglia e la comunità (es. attraverso l'apertura di scuole, laboratori etc). Analizzando il cluster relativo ai componenti dell'area organizzativa, sono emerse tutte le attività volte all'organizzazione dell'accoglienza e all'integrazione lavorativa dei migranti beneficiari del progetto di accoglienza, pur dovendo lottare contro la mancanza di infrastrutture e

la frammentazione dei servizi. Per quanto riguarda i professionisti sanitari, l'analisi ha evidenziato l'impegno di questi ultimi nel rispondere alle esigenze dei migranti, con particolare attenzione alla salute mentale, affrontando le sfide legate alla mancanza di strumenti culturalmente neutri e alla carenza di strutture territoriali e competenze culturali professionali. Questi fattori vengono descritti come ostacolanti il raggiungimento di uno stato di salute ottimale e un'efficace integrazione sociale della comunità. Infine, il coinvolgimento dei residenti nella vita comunitaria è risultato essere particolarmente rilevante per ottenere una buona salute comunitaria.

Nel capitolo 8 è stata condotta un'Analisi Automatica dei Dati Testuali (AADT) su un campione diversificato, coinvolgendo la simultanea analisi delle interviste condotte sui 16 stakeholder, 19 migranti e 15 residenti. Per gli stakeholder sono emersi temi associati alla gestione di interventi economici e sociali, alle iniziative nel campo della salute e all'aspetto relazionale con le diverse popolazioni, con particolare attenzione al rispetto delle peculiarità culturali. L'accoglienza dei migranti viene concepita dagli stakeholder come un'attività proattiva finalizzata all'integrazione e all'inclusione sociale mediante interventi volti a stabilire una relazione di cura e supporto negli ambiti sociale, sanitario ed economico. L'analisi sul campione dei migranti ha confermato la centralità della famiglia, alla quale viene associato il benessere, e sono emerse altresì le difficoltà legate all'adattamento alla nuova cultura e alla preservazione di tradizioni e usanze della cultura originaria. Infine, i migranti descrivono il dolore associato al trauma della migrazione, il desiderio di normalità, integrazione sociale e accesso alle cure, unitamente al desiderio di sentirsi accettati nonostante le differenze. Il campione dei residenti ha portato all'attenzione i benefici del progetto di accoglienza sull'intera comunità oggetto di studio: la crescita demografica ed economica, l'istituzione di scuole, attività commerciali è stata interpretata dalla popolazione nativa come una "rinascita". Tuttavia, è emersa anche una carenza di relazioni profonde all'interno della comunità multietnica e una integrazione che rimane "formale". Infine, in concerto con gli altri due campioni, il tema legato alle carenze strutturali e le sfide connesse all'assistenza sanitaria, dovute alla mancanza di risorse, strutture adeguate e mezzi di trasporto idonei è risultato centrale.

Limiti

Questa ricerca presenta alcuni limiti che è importante considerare.

In primo luogo, è stato condotto in un unico paese europeo, pertanto le differenze sociali e demografiche tra i paesi che non sono stati inclusi potrebbero dar luogo a conclusioni diverse. In secondo luogo, è stata condotta in un contesto in cui è presente un modello di accoglienza dalle caratteristiche così peculiari che potrebbero rendere difficile il confronto con altri contesti, pur rappresentando il punto di forza.

Per quanto riguarda la raccolta dati, i migranti intervistati sono stati intervistati nella lingua nativa degli studiosi (l'italiano), con l'ausilio di mediatori culturali per ciascun gruppo etnico. Questo approccio è stato considerato il più idoneo per favorire la comprensione reciproca.

Infine, l'analisi degli stakeholder è stata condotta su una popolazione separata in base al ruolo professionale e sociale, pur appartenendo alla categoria dei residenti. Ciò potrebbe aver introdotto dei pregiudizi nelle risposte alle domande dell'intervista.

Implicazioni per la pratica

Il presente programma dottorale fornisce numerose implicazioni per la pratica clinica. Anzitutto conferma che la salute è un costrutto composto da dimensioni bio-fisiologiche, psicologiche e sociali che si interconnettono e che necessitano di una visione di insieme, più che di un approccio analitico e focalizzato sui singoli domini che la compongono.

In secondo luogo, fornisce una chiave di lettura delle priorità dei bisogni di salute dei migranti, utile ai Servizi Socio-Sanitari nel loro impegno di accoglienza e cura di queste popolazioni. Fornire i servizi non deve essere interpretato come un mero atto di supporto sanitario e sociale, ma come la possibilità, assieme alla fornitura di mezzi di sussidio, di promuovere l'autonomia e soddisfare il bisogno di sentirsi utili e riconosciuti; la pro-socialità potrebbe infatti ridurre gli effetti della fragilità sociale sperimentata dai migranti, favorendo l'integrazione sociale e riducendo le disuguaglianze.

Si pone inoltre come spunto di riflessione sulla necessità di indirizzare gli sforzi della ricerca sull'implementazione di modelli di cura fondati su un approccio comunitario, nel quale la figura dell'infermiere di comunità potrebbe fungere da connessione nella rete dei servizi, in un'ottica interculturale. I complessi bisogni di salute, i vissuti e le diverse rappresentazioni culturali della salute e della malattia devono essere letti e affrontati infatti con una visione culturalmente competente.

In questo contesto, gli infermieri con competenze transculturali assumerebbero un ruolo cruciale nel facilitare la comunicazione, rispettare le varie prospettive sulla salute e adattare le pratiche assistenziali in modo sensibile alla cultura di appartenenza, configurandosi come figura chiave nel garantire che le cure siano permeate da sensibilità culturale, e svolgendo un ruolo strategico nella promozione della salute e nella prevenzione delle disuguaglianze nella salute.

Sviluppi futuri di ricerca

Per prima cosa, per ottenere una comprensione completa del fenomeno in esame, risulta importante estendere li indagine a diversi centri di accoglienza italiani ed europei. Inoltre, affiancare l'osservazione qualitativa con la misurazione dei costrutti emersi dalle analisi consentirebbe una generalizzazione dei risultati con possibili applicazioni pratiche nella pratica clinica. L'integrazione di tali dati e l'ampliamento del numero di centri inclusi nello studio potrebbero contribuire alla formulazione di un modello di assistenza territoriale in grado di considerare informazioni specifiche e contestuali. A tal fine, è stato avviato un progetto per una seconda fase quantitativo-descrittiva che si propone di indagare le relazioni tra le variabili che influenzano la salute nei migranti e gli outcome di salute.

La revisione sistematica e gli studi presentati in questo programma di ricerca dottorale hanno evidenziato le principali variabili che influenzano la salute psicosociale dei migranti, tra cui il trauma della migrazione, le strategie di coping, l'acculturazione, il livello di integrazione e di supporto sociale, e fattori psicologici come ansia, stress e depressione. Gli outcome evidenziati principalmente sono la qualità di vita, la salute generale, il benessere psicologico e il grado di soddisfazione.

Inoltre, il progetto di studio si propone di analizzare il ruolo del self-care all'interno di queste relazioni.

Sebbene siano state condotte numerose ricerche sulla salute dei migranti (Graetz et al., 2017; Jannesari et al., 2020; Salami et al., 2021), conosciamo ancora poco riguardo al loro self-care. È ampiamente dimostrato che il self-care è un importante predittore di una migliore salute e benessere nelle persone con malattie croniche, con conseguente minore utilizzo dei servizi sanitari e risparmi economici (Buck et al., 2015; Riegel et al., 2011; Tol et al., 2015). Tuttavia, questa evidenza manca nei migranti.

Lo studio del self-care potrebbe supportare i professionisti nell'implementare interventi di promozione della salute e fornire cure mirate e culturalmente competenti che potrebbero migliorare la vita dei migranti e ridurre i costi sanitari. Si auspica che tali risultati possano informare politiche e interventi futuri finalizzati a garantire il benessere di questa popolazione vulnerabile.

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