SUMMER SCHOOL ProMIS

Edizione 6 – Anno 2026

“Equità e integrazione nei sistemi di salute pubblica. *Dalle politiche europee all’implementazione territoriale: strumenti, pratiche e approcci integrati tra ricerca, comunicazione e apprendimento collaborativo*”

30 GIUGNO e 1-2 LUGLIO
NAPOLI

Benedetta Armocida
Istituto Superiore di Sanità

Programma Nazionale Equità nella Salute - PNES 2021-2027
Progetto “La workforce al centro del rafforzamento dei servizi sanitari” - CUP I75E22000590006

Dalla scienza alla pratica: tradurre le evidenze per sistemi di salute più equi

JACARDI experience: 4Cs principle

- **Critical Reflection:** focus on discrimination, bias and stereotypes in healthcare; JACARDI's activities on antiracism is care
- **Context and data:** how data drives intervention; JACARDI's experience on migrant populations
- **Co-design:** involvement of communities on developing the interventions; evidence from JACARDI
- **Communication:** practical tools for inclusive communication
- Monitoring equity and diversity inclusion within European initiatives

JACARDI

Joint action
cardiovascular diseases
and diabetes

From principles to practice: JACARDI's cross-cutting approach to equity and diversity

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The 4Cs principles

Critical reflection

Context and Data

Co-design

Communications

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Critical Reflection

What is Critical Reflection?

- Continuous, life-long self-reflection on biases, stereotypes, and power
- Also referred to as **cultural humility**
- Essential to understand how social determinants shape health outcomes

Why it matters

- Helps uncover hidden structures of inequality
- Supports more equitable decision-making and practice
- Shifts power towards the communities we serve

Key Concept: Cultural Humility

- Recognises communities' knowledge, agency, and lived experience
- Promotes person-centred and participatory approaches

Tool Example: Wheel of Privilege

- Visualises distribution of power and privilege in society
- Supports reflection on one's position and influence
- Highlights intersection of multiple social characteristics

Role in JACARDI

- Foundational pathway for embedding equity & diversity
- Enables a paradigm shift in systems and practices
- Applied across key areas:
  - Context & data
  - Co-design
  - Inclusive & accessible communication

Key Takeaway

- Equity integration starts with self-awareness and willingness to change

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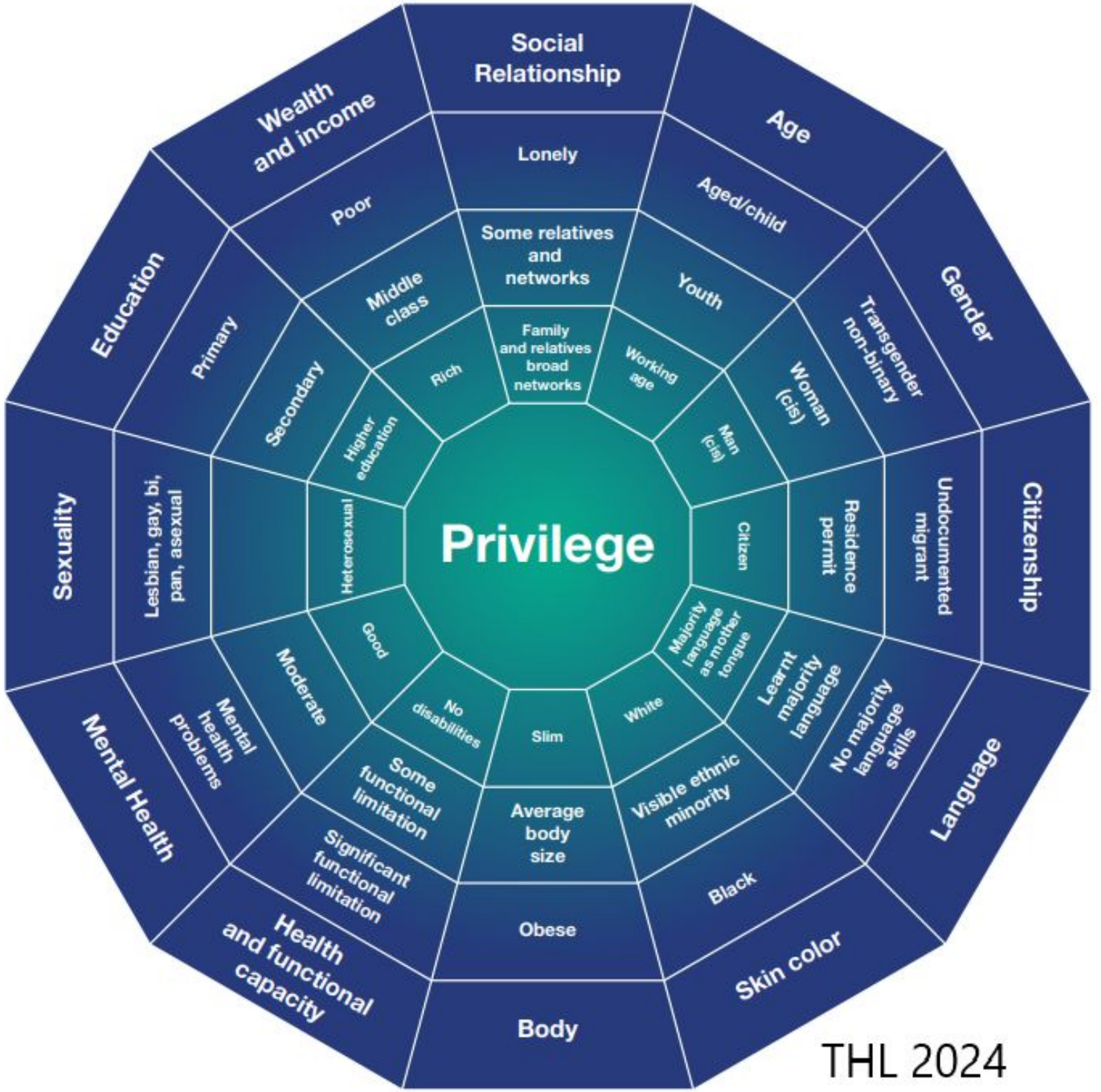
The wheel of privilege



THL 2024

Dicrimination bias and stereotypes in healthcare

Across the globe, Indigenous Peoples as well as people of African descent, Roma and other ethnic minorities experience stigma, racism and racial discrimination. This situation often increases their exposure and vulnerability to risk factors and reduces their access to quality health services. The result is that these populations often experience poorer health outcomes. This has been evidenced and exacerbated during the COVID-19 pandemic, in which some of the starkest inequities have emerged among populations experiencing racial discrimination.

Factors that perpetuate discrimination and racism

Lack of cultural awareness
Problems with access to services
Lack of language services
Cognitive biases
Lack/inaccuracy of research evidence
Race-based medical research and practices

BJA Educ. 2022 Feb 3;22(4):131–137. doi: 10.1016/j.bjae.2021.11.011

Social bias, discrimination and inequity in healthcare: mechanisms, implications and recommendations

Craig S Webster [1,*], Saana Taylor [2], Courtney Thomas [1], Jennifer M Weller [1]

Author information · Article notes · Copyright and License information
PMCID: PMC9073302 PMID: 35531078

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Comment | Published: 27 July 2020

Pulling at the heart: COVID-19, race/ethnicity and ongoing disparities

Peter Chin-Hong, Kevin M. Alexander, Norrisa Haynes, Michelle A. Albert & The Association of Black Cardiologists

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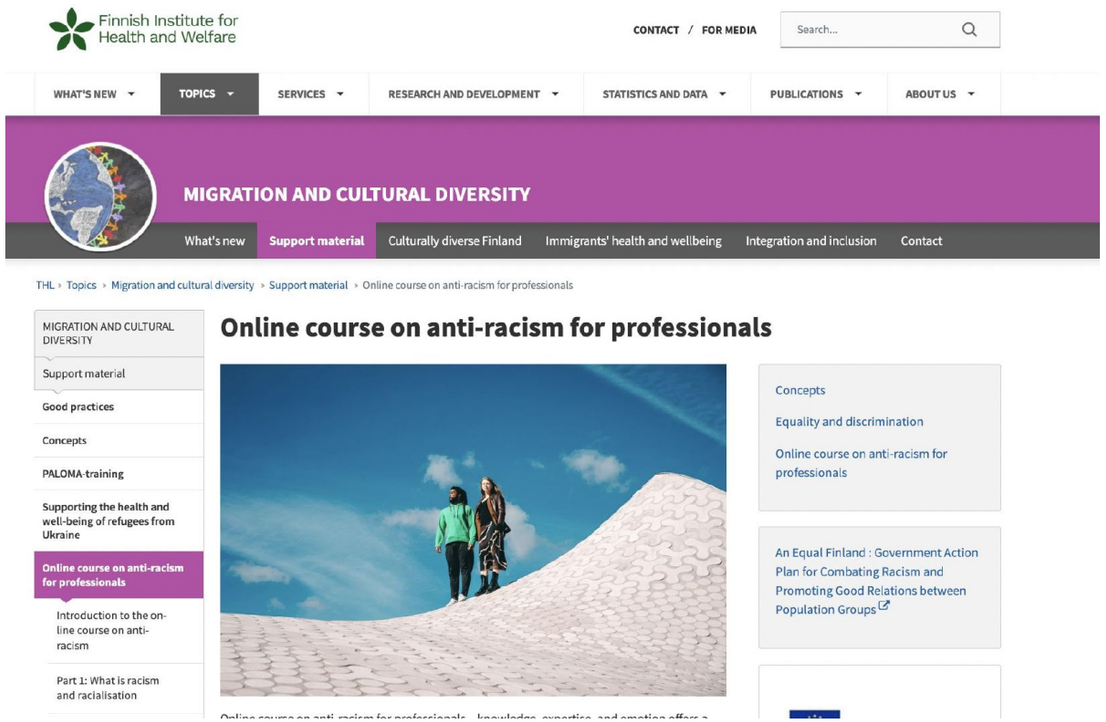
VIEWPOINT · Volume 396, Issue 10257, P1125-1128, October 10, 2020 · *Open Access* · Download Full Issue

From race-based to race-conscious medicine: how anti-racist uprisings call us to act

Jessica P Cerdeña, MPhil [b,c,†] · Marie V Plaisime, MPH [d,†] · Jennifer Tsai, MD [a,†]

JACARDI pilot on antiracism

Title of the pilot project:	Anti-racism trainings for professionals in healthcare
General objective of the pilot project:	The pilot aims to educate healthcare staff on anti-racism in healthcare through workshops featuring educational videos and creating a training manual. The pilot will also include training ambassadors within healthcare services through train-the-trainer workshops for sustainable implementation.
Location/s	Finland, wellbeing services counties, pre- and inservice training providers, universities
Expected number of individuals	200 healthcare professionals in Finland



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Masterclasses

About 10 Masterclasses directed to the JACARDI Consortium have been held such as:

- Critical reflection
- Context and data
- Co-design
- Accessible and inclusive communication
- Gender equity
- Health Interventions & Equity: Who Benefits, Who Doesn't?

Reporting for spring 2025

Two conducted masterclasses (Gender Equity and Health Interventions & Equity)

- Attendance rate approx. 100 people
- On a scale of zero (unlikely) to ten (very likely), how likely would you be to recommend this master class to your colleagues? **9.4 & 9.0**

Two conducted workshops

- Attendance rate approx. 40 people
- Participation in the workshop was worth of my time: **4.3/5**

Equity Lens: Antiracism is integral to reducing health inequalities

Five concrete ways to promote active antiracism

Antiracism requires active action, and there are concrete ways to promote it within healthcare and healthcare research. Dr. Yusuf presented five actions that professionals can take:

1. Admitting the existence of structural racism
2. Having active plans to reduce structural racism
3. Meeting patients without prejudice
4. Disaggregating data in health research for equity monitoring (by country of birth, language, ethnicity)
5. Using participatory approaches involving affected communities

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Context & Data

Why Context Matters

- Social, economic, and political context shapes power, privilege, and resources
- Determines individuals' social position and health outcomes
- Advantages/disadvantages are dynamic and context-dependent

Intersectional Perspective

- Impact varies across overlapping identities (e.g. gender, age, ethnicity, disability)
- Example: different effects for older migrant women with disabilities vs. general population

Role of Critical Reflection

- Identify visible and invisible barriers to participation
- Ask: Who is impacted? How? Who might be excluded?
- Anticipate and mitigate unintended inequities

Impact Assessment

- Essential to design inclusive and equitable interventions
- Supports development of universal approaches that work for diverse groups

Role of Data

- Includes quantitative, qualitative, and experiential data
- Shapes priorities, policies, and visibility of populations
- Key risk: "No data, no problem" → invisibility of vulnerable groups

Data Bias & Gaps

- Reflect on who is represented and who is missing
- Consider biases from methods, sampling, and measurement

Strengthening Data for Equity

- Collect additional data to fill gaps
- Use co-design, interviews, surveys, stakeholder input

Key Takeaway

- Equity-driven action requires context-aware, critically assessed, and inclusive data

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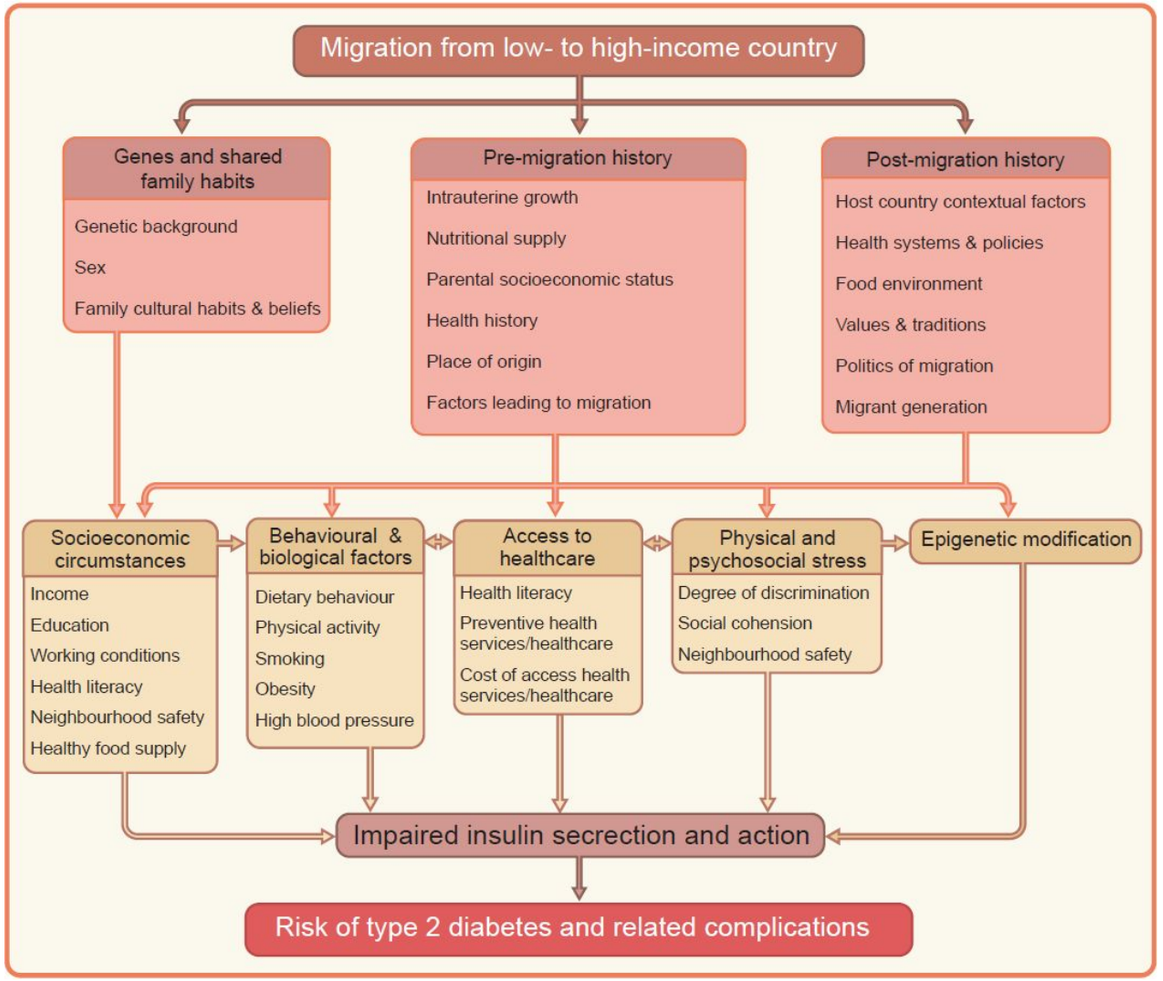
Context & Data - Diabetes

WHO Global Evidence Review (2022)

- The incidence of diabetes is generally higher among migrant populations, although with considerable variation across regions.
- Increased risk is driven by multiple factors, including sociocultural influences, lifestyle changes, and limited access to health information.



Agyemang et al (2021) Diabetologia DOI 10.1007/s00125-021-05586-1

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DIABETES IN MIGRANT POPULATIONS

WHO EUROPEAN REGION

HIGHER BURDEN

Migrant populations have higher incidence, prevalence, and mortality from diabetes compared to Europeans.

WHO Europe, 2018

YOUNGER ONSET

Diabetes occurs at a younger age in migrants compared to non-migrants and host European populations.

Agyemang & van den Born, 2018

MORE COMPLICATIONS

Higher rates of hospitalisations and diabetes-related complications in several settings:

Nephropathy Retinopathy Neuropathy

HIGHER PREVALENCE IN WOMEN

Diabetes prevalence is often higher among migrant women, with variation by ethnicity.

WHO Europe, 2018

STRONG ETHNIC DIFFERENCES IN RISK

Odds Ratios for Type 2 Diabetes
(vs. host European populations)

PARTICULARLY HIGH RISK:

BANGLADESH ×6

Up to 6-fold higher risk of type 2 diabetes compared to host European populations.

Agyemang et al., 2018 (adapted from Meeks et al., 2015)

No public health without refugee and migrant health.
Addressing inequities is essential for better health for all.

World Health Organization
REGIONAL OFFICE FOR Europe

Sources: WHO Regional Office for Europe, 2018. Agyemang C, van den Born B-J. J Travel Med. 2018;107:1–9. Meeks K et al., 2015.

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DIABETES IN MIGRANT POPULATIONS

ITALY

HIGHER PREVALENCE

Higher prevalence in most migrant groups compared to Italians, with particularly high burden among migrants from South Asia (e.g. Veneto study), except some Eastern European groups.

HIGHEST IN SOUTH ASIA

CARE GAP

Migrants are less likely to receive routine monitoring (HbA1c, renal function) and pharmacological treatment, resulting in poorer glycaemic control.

UNDER-TREATMENT DESPITE UNIVERSAL HEALTHCARE

Lower probability of:

	OR (95% CI)
• Insulin prescription	0.81 (0.76–0.86)
• Statin prescription	0.79 (0.74–0.84)
• Antithrombotic therapy	0.74 (0.69–0.78)
• Specialist visits	0.74 (0.64–0.84)

LOWER INTENSITY OF CARE

10–15% fewer diagnostic tests and procedures compared to the Italian population (2010 data).

10–15% FEWER TESTS & PROCEDURES

HIGHER AVOIDABLE HOSPITALISATIONS

Higher risk of avoidable hospitalisation for diabetes-related conditions in migrants, especially in men.

MEN RR 1.62 (95% CI 1.16–2.28)

WOMEN Geographic differences observed

MIGRANTS FACE A DUAL BURDEN IN ITALY: HIGHER RISK AND LOWER QUALITY OF CARE

HIGHER RISK · CARE GAP · UNDER-TREATMENT · LOWER CARE INTENSITY · HIGHER AVOIDABLE HOSPITALISATIONS

EQUITY IN DIABETES CARE FOR ALL

Universal health coverage must translate into equitable access, quality of care and outcomes for migrant populations.

No public health without refugee and migrant health.
Addressing inequities is essential for better health for all.

World Health Organization
REGIONAL OFFICE FOR Europe

References: 1) WHO Regional Office for Europe. WHO report on the health of refugees and migrants in Europe: no public health without refugee and migrant health. Copenhagen; 2018.
2) Fedeli U, et al. Int J Cardiol. 2018;254:362-367. 3) Marchesini G, et al. Nutr Metab Cardiovasc Dis. 2014;24(4):393-399. 4) Marzona I, et al. Acta Diabetol. 2018;55:355-362.
5) Seghieri G, et al. Int J Public Health. 2019;64:595-601. 6) Dalla Zuanna T, et al. Nutr Metab Cardiovasc Dis. 2020;30(9):1535-1543.

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JACARDI – Pilot Empower & Include: Type 2 Diabetes Care in Marche

Diabetes education course supports the Bangladeshi community in the Marche region

Source: https://jacardi.eu/diabetes-education-course-supports-the-bangladeshi-community-in-the-marche-region/

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Context & Data

The 2026 Update of the IDF-DAR Risk Calculator for Fasting in People with Diabetes

Bachar Afandi[1,2,3] Mohamed Suliman[4] Shehla Shaikh[5] Salem A. Beshyah[6,7]
Mohamed Hasannien[8,9]

RISK LEVEL [SCORE]	Medical Recommendations	Religious Guidance
LOW RISK [Score 0 - 3 points]	Fasting is probably safe: 1. Medical evaluation 2. Medication adjustment 3. Strict monitoring	1. Fasting is obligatory 2. Advice not to fast is not permitted, unless the patient is unable to fast due to the physical burden of fasting or needing to take medications, food, or drink during the fasting hours.
MODERATE RISK [Score 3.25 - 6 points]	Fasting safety is uncertain: 1. Medical evaluation 2. Medication adjustment 3. Strict monitoring	1. Fasting is preferred, but patients choose not to fast if they are concerned about their health after consulting the doctor and taking into account the full medical circumstances and the patients' own previous experience. 2. If the patient does fast, he/she must follow medical recommendations, including regular blood glucose monitoring.
HIGH RISK [Score >6 points]	Fasting is probably unsafe	Advise against fasting.

Fig. 3 The integrated medical and religious interpretations and recommendations of the calculated risk score.

Source: https://www.thieme-connect.com/products/ejournals/pdf/10.1055/s-0045-1813010.pdf

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Co-design

What is Co-design?

- Collaborative, bottom-up approach involving end-users, communities, and stakeholders
- Also referred to as: co-creation, coproduction, patient engagement

Why it matters

- Develops solutions that better reflect real needs
- Builds trust, relevance, and sustainability
- Reduces risk of epistemic injustice (exclusion of vulnerable groups)

From Top-down → Bottom-up

- Moves beyond traditional approaches
- Captures diverse lived experiences and perspectives
- Particularly important in health, where needs are complex and contextual

Key Principles for Effective Co-design

- Apply critical reflection (bias, power, privilege)
- Ensure inclusive and diverse participation
- Avoid tokenism and unintended reinforcement of inequities

Three Critical Phases

- Starting point: reflect on biases, ensure meaningful engagement
- Process design: choose inclusive methods & tools
- Outcomes: ensure equity, trust, sustainability

Enabling Conditions

- Create safe spaces (respect, openness, non-discrimination)
- Build capacity in equity and diversity

Role in JACARDI

Applied across the full pilot cycle:

- Problem definition & needs assessment
- Design & implementation
- Evaluation, sustainability & scalability
- Use of stakeholder boards and community consultations

Key Takeaway

- Co-design is essential for equitable, acceptable, and impactful interventions

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JACARDI - OPHELIA Study Florence

Objective

- To promote cardiovascular and diabetes prevention by improving health literacy, Mediterranean diet adherence, and healthy lifestyles among middle-aged women.

Setting & Population

- Florence, Italy (Casa di Comunità Le Piagge)
- 188 women aged 45–70 years
- Community-based, participatory approach

Methodology

Based on the OPHELIA process:

1. Needs assessment – health literacy and nutrition literacy surveys
2. Co-design – participatory group discussions identifying barriers and priorities
3. Implementation – community and specialist-led health promotion activities

Key Findings (Needs Assessment)

Identified 4 distinct health literacy profiles

1. Better understanding of healthy eating & Mediterranean diet
2. Information on menopause, physical activity, and wellbeing
3. Improved communication with healthcare professionals
4. Strong preference for peer/community-based learning

Interventions

- Interactive multidisciplinary sessions
- Practical, dialogue-based education
- Communication-focused workshop (“Beyond Care”) to improve patient–provider interaction
- Emphasis on physical activity and accessible community services

Preliminary Insights

- High engagement and strong peer interaction
- Improved confidence in discussing health topics
- Need for more patient-centered, understandable communication in healthcare
- Community setting reduced traditional patient–provider barriers

Conclusion

Community co-designed, health literacy–driven interventions increase engagement, trust, and empowerment, positioning women as key health multipliers in families and communities

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Communication - Inclusive & Accessible

Why Communication Matters

- Shapes meanings, priorities, and values
- Can reinforce or challenge stereotypes
- Determines who is included or excluded

Equity Perspective

- Communication must be inclusive, accessible, and respectful of diversity
- Builds trust and engagement with communities
- Recognised as a fundamental human right

Role of Critical Reflection

Reflect on:

- Who decides what is communicated
- Who is reached (or not)
- What messages are conveyed (explicit & implicit)
- Where, when, and how communication happens

Principles of Inclusive Communication

- Suitable for all, regardless of abilities, gender, culture, or background
- Reciprocal and participatory (engaging stakeholders)
- Clear, understandable, and multichannel

Key Areas (JACARDI Checklist)

- Communication planning (audience & needs)
- Inclusive language
- Inclusive visuals
- Digital accessibility
- Inclusivity in events

Role in JACARDI

- Cross-cutting across all activities (WP2)
- Supported by guidelines and practical checklist

Key Takeaway

- Inclusive communication is essential to ensure equitable access to information and participation

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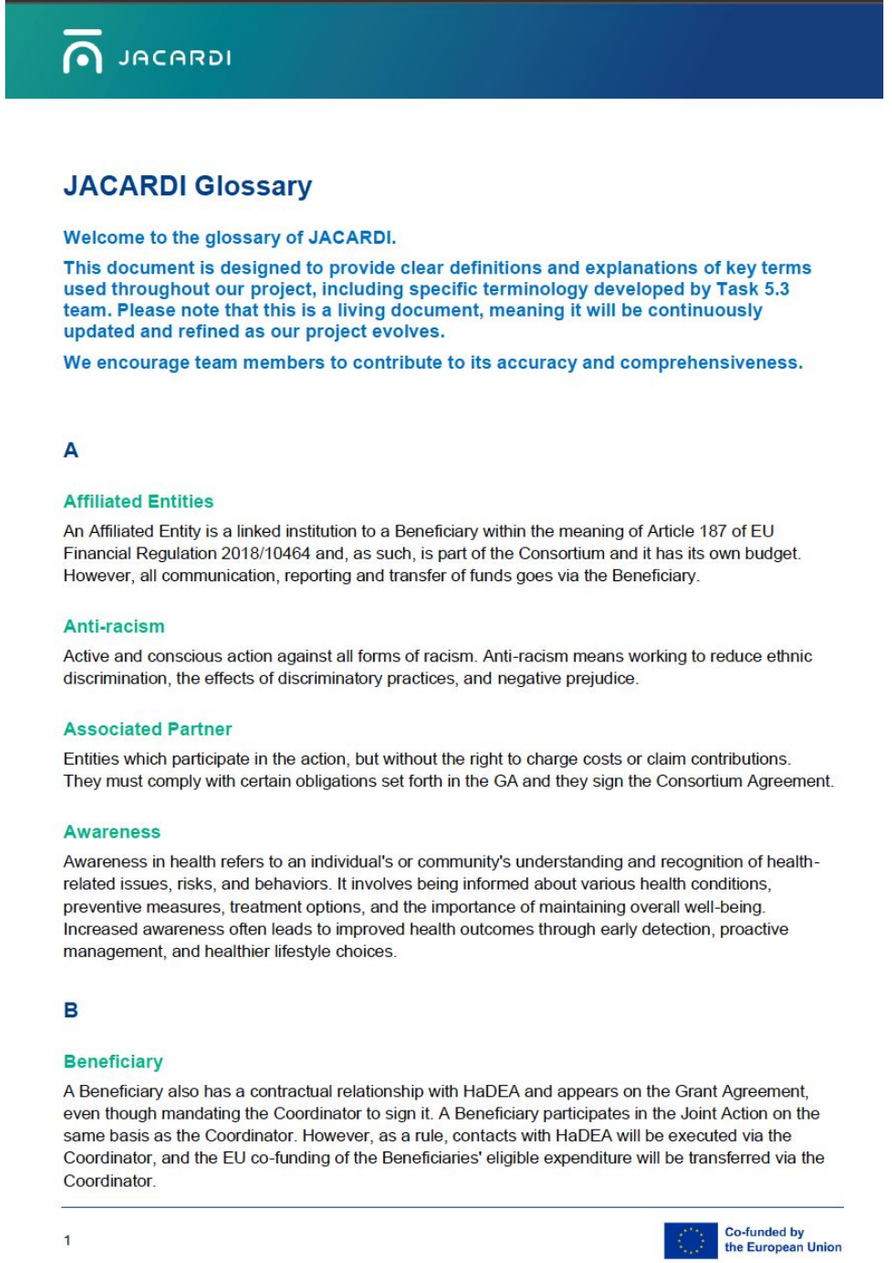
Glossary

Specific Glossary on equity and social determinants provided to all Partners



JACARDI

JACARDI Glossary

Welcome to the glossary of JACARDI.

This document is designed to provide clear definitions and explanations of key terms used throughout our project, including specific terminology developed by Task 5.3 team. Please note that this is a living document, meaning it will be continuously updated and refined as our project evolves.

We encourage team members to contribute to its accuracy and comprehensiveness.

A

Affiliated Entities

An Affiliated Entity is a linked institution to a Beneficiary within the meaning of Article 187 of EU Financial Regulation 2018/10464 and, as such, is part of the Consortium and it has its own budget. However, all communication, reporting and transfer of funds goes via the Beneficiary.

Anti-racism

Active and conscious action against all forms of racism. Anti-racism means working to reduce ethnic discrimination, the effects of discriminatory practices, and negative prejudice.

Associated Partner

Entities which participate in the action, but without the right to charge costs or claim contributions. They must comply with certain obligations set forth in the GA and they sign the Consortium Agreement.

Awareness

Awareness in health refers to an individual's or community's understanding and recognition of health-related issues, risks, and behaviors. It involves being informed about various health conditions, preventive measures, treatment options, and the importance of maintaining overall well-being. Increased awareness often leads to improved health outcomes through early detection, proactive management, and healthier lifestyle choices.

B

Beneficiary

A Beneficiary also has a contractual relationship with HaDEA and appears on the Grant Agreement, even though mandating the Coordinator to sign it. A Beneficiary participates in the Joint Action on the same basis as the Coordinator. However, as a rule, contacts with HaDEA will be executed via the Coordinator, and the EU co-funding of the Beneficiaries' eligible expenditure will be transferred via the Coordinator.

1

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Inclusive and accessible communication

JACARDI Joint action cardiovascular diseases and diabetes

Guidelines and a checklist for inclusive and accessible communication in the JACARDI project

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JACARDI Equity lens and tools

Critical reflection

- Context and Data
- Co-design
- Communications

The aim is to cross-cuttingly integrate cultural and ethnic diversity, other social determinants and commercial determinants in pilot actions

Explanatory framework
Glossary
Matrix tool
Expert consultations
Masterclasses

Some pilots directly **addressing racism in healthcare and health disparities among populations living in vulnerable situation** (e.g. migrants)

This level of integration should become a **standardized model across all EU health initiatives**

Source: Skogberg N, Spadea T, Armocida B, et al. Embedding equity and diversity principles in a complex multinational setting: methods, tools, capacity development and experiences from the first year of the Joint Action on Cardiovascular Diseases and Diabetes (JACARDI). *BMJ Glob Health*. 2025;10(11):e019829. Published 2025 Nov 16. doi:10.1136/bmjgh-2025-019829

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The maturity matrix

The use of the E&D Maturity Matrix

To guide and report how equity and diversity are considered during pilot implementation.

When to use the matrix

- **As a planning tool** – to guide activities **before** implementation cycles.
- **As a reporting tool** – to assess equity and diversity **during and after** implementation.

How to use the Matrix

Three levels of comprehensiveness:

- **Approaching** – critical reflection *(minimum requirement)*
- **Meeting** – clear and planned actions
- **Exceeding** – innovative and sustainable practices

Why it matters

- Supports integration of equity and diversity across JACARDI.
- Informs reports to HADEA, General Assemblies, and publications.

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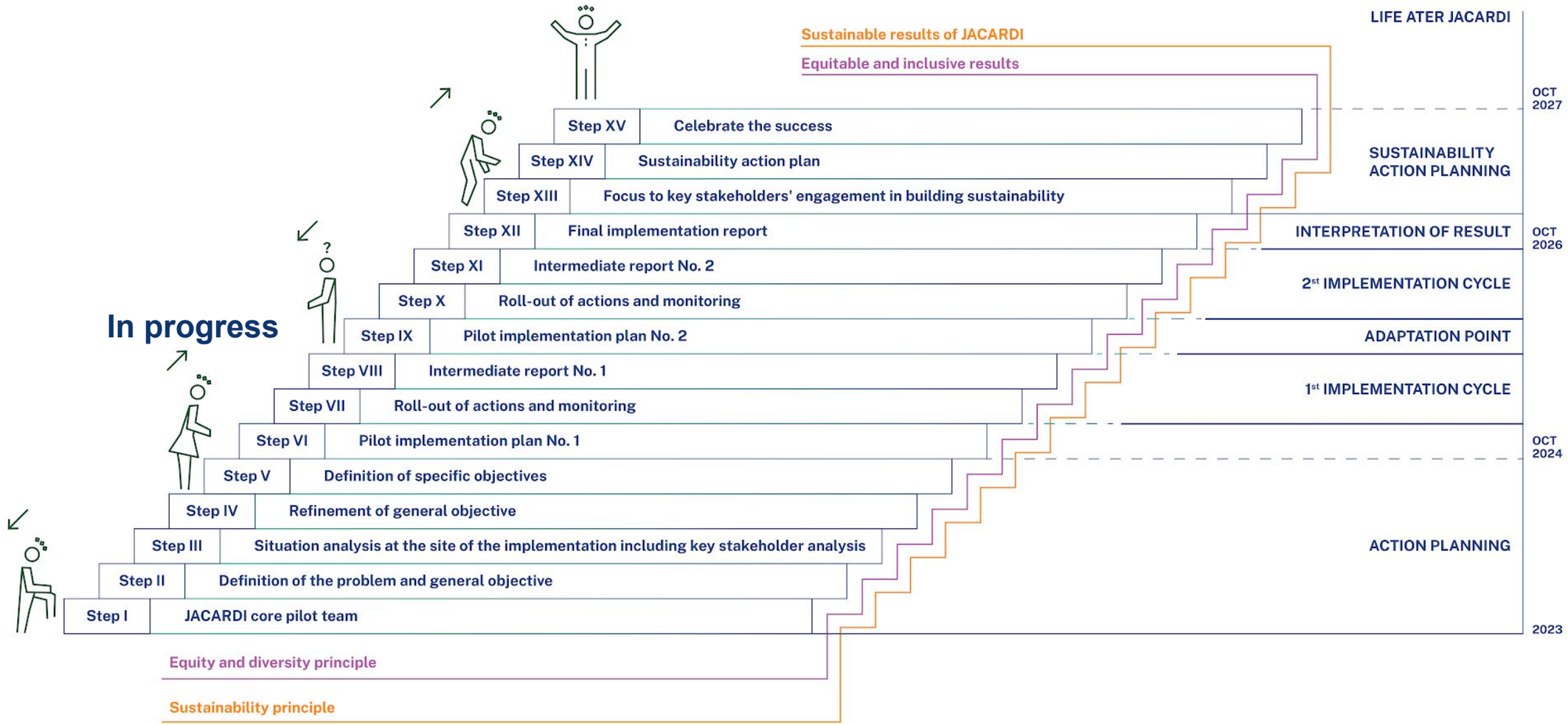
JACARDI methodological guidance



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E&D Maturity Matrix – Step I

Guiding questions

Is the team homogenous, or is there diversity, for example, in disciplines, educational background and stage of career, age and gender, cultural background, and ethnicity?
Is, for example, a person with lived experience included?
Are the members curious? Do they have a positive attitude for change? Are they committed to proactively considering diverse perspectives?
Are they aware of the concepts and processes relevant to equity and diversity, such as critical reflection, co-design, inclusive communication, and the search for the “missing view”?

Is the core pilot diverse and representative of the communities it aims to serve?
Does the core pilot team actively apply the 4C principles of equity and diversity (Critical reflection, Co-design, Context and data, inclusive and accessible Communications)?

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Step II – problem definition and objective

Equity Lens – Guiding principles

1. Apply equity and diversity principles in the definition of the problem and the general objective
2. Who will benefit the most from the intervention? Who would been left behind?

Step II. Definition of the problem and the general objective, Equity and diversity matrix				
	Approaching	**Meeting**	**Exceeding**	**Comments**
2.1 Apply equity and diversity principles in the definition of the problem and the general objective	a) Definition of the problem and general objective were defined based on **critical reflection** of available quantitative and qualitative data on population demographic, socioeconomic, and ethnic and cultural diversity.	b) In addition to using available quantitative and qualitative data, the definition of the problem and the general objective involved **consultations** (e.g. workshops, interviews) with health professionals and end-users.	c) In addition to using available quantitative and qualitative data, the definition of the problem and the general objective involved meaningful engagement of health professionals and end-users through **co-design**.	

D5.1 Box 4. STEP II Equity and diversity matrix

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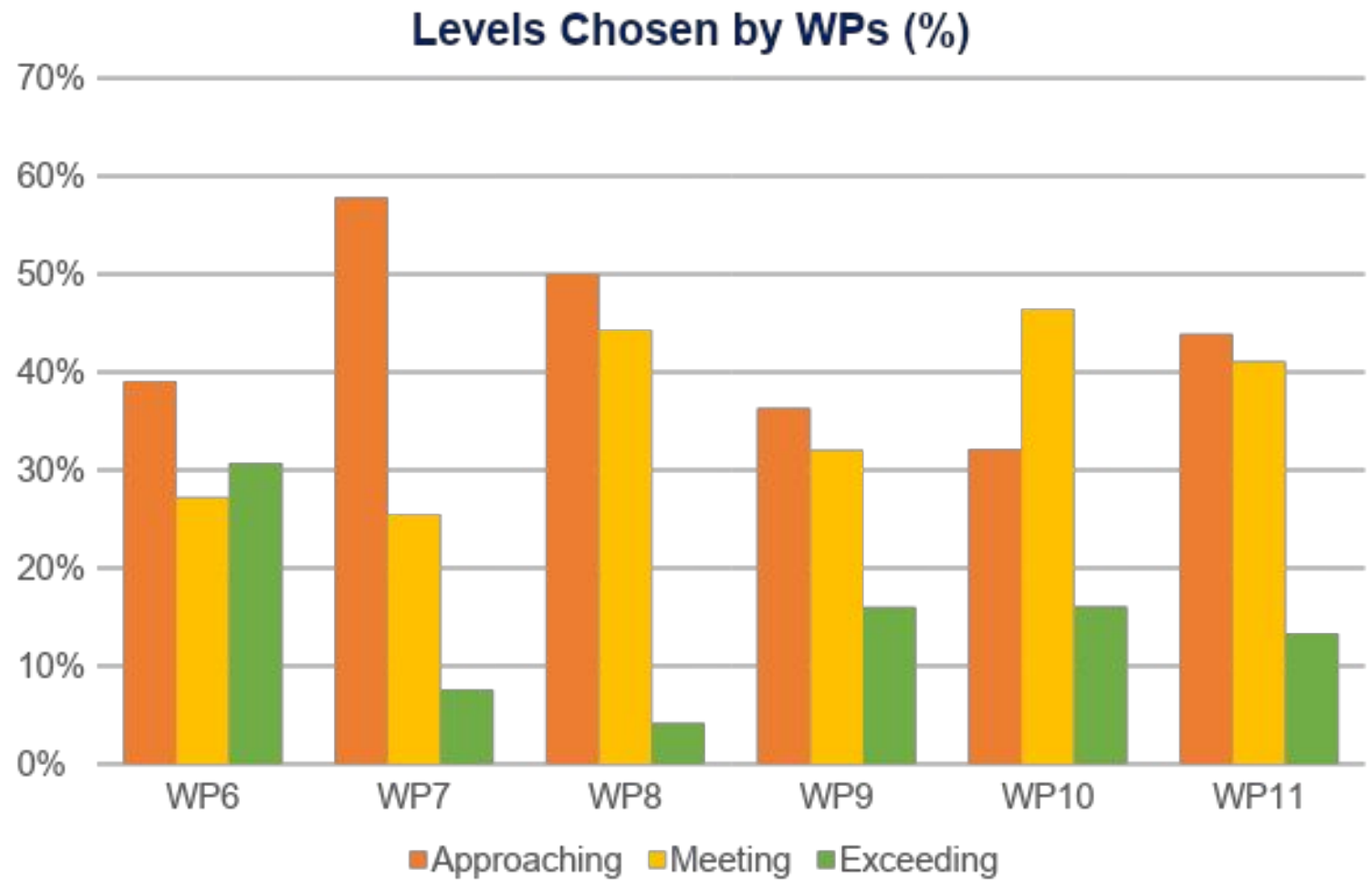
Equity and Diversity maturity matrix



Steps I-VI (6/2024-2/2025)

- 122/142 (86%) pilots responded
- WP10 and WP11 had 100% answer rate

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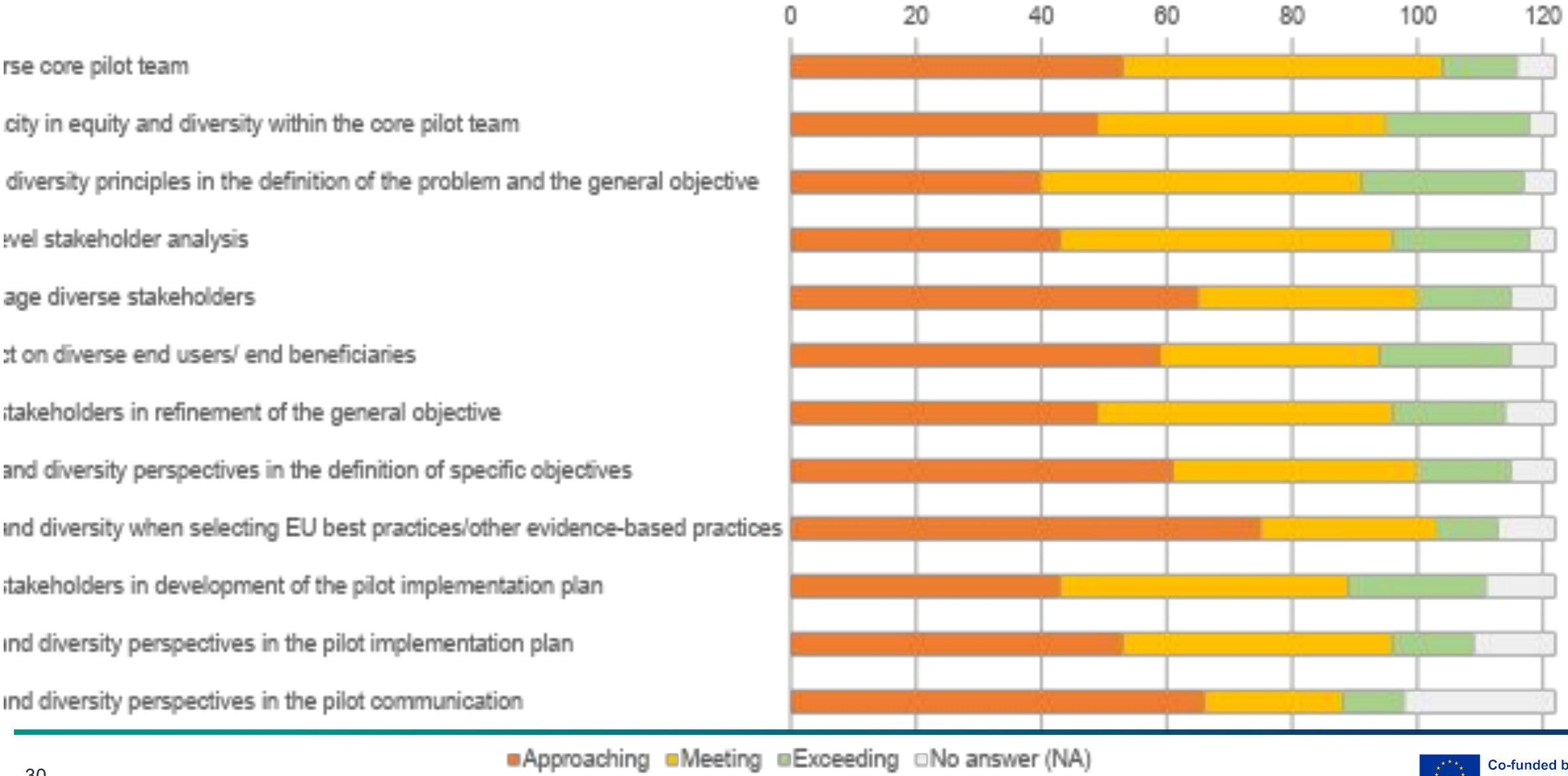
Responses by substeps



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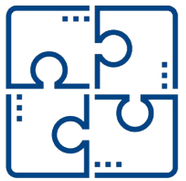
Lessons and key messages

Addressing equity and inclusion of diversity is essential **for tackling health inequities and the NCD-related social gradient in Europe.**

E&D perspectives should be **integrated into the core structures of project implementation**, supported by practical tools, trainings and practical consultations to improve adherence and collaborative understanding across project partners.



Encouraging **critical reflection** among partners within EU Initiatives is pivotal for initiating a paradigm shift towards equity and diversity inclusion.

Health equity is not only measured, it is experienced, co-created, and made visible through **stories, voices, and images**

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JACARDI – Follow us

LinkedIn: https://www.linkedin.com/company/jacardi/

Website: https://jacardi.eu/

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JACARDI

Joint action
cardiovascular diseases
and diabetes

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