
COVID-19 Recovery:
Building Future Pandemic
Preparedness and
Understanding Citizen
Engagement in the G7

COVID-19 Vaccination Campaign Among Migrants in Rome and the Emilia-Romagna Region

*Intercultural mediation and
vaccine hesitancy*

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About COVID-19 Recovery: Building Future Pandemic Preparedness and Understanding Citizen Engagement in the G7

The programme is the result of a partnership between the British Academy, the Social Sciences Research Council (SSRC) and the Science & Innovation Network in the USA (SIN USA) to award funding to ten transatlantic studies focusing on UK-US COVID-19 vaccine engagement. It follows a pilot study exploring levels of vaccine engagement in four locations across the US and UK, while the larger programme was expanded to study multiple locations. The programme was funded by the UK's Department for Business, Energy and Industrial Strategy.

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Executive summary

The migrant¹ population in Italy constantly increased in the first two decades of the 21st century, reaching 5 million on 1 January 2020². Italian legislation guarantees foreign residents full access to vaccines, as the right to health is enshrined in the *sistema sanitario nazionale universalistico*, universal access national healthcare system. Vaccine equality is linked to legal residency (Law 40/1998) not citizenship status. However, on 3 February 2021, the Agenzia Italiana del Farmaco (AIFA, Italian Medicines Agency) stated that vaccination rights extended to all residents regardless of their migrant or residency status. Therefore, the 2021-2022 COVID-19 vaccination campaign targeted everybody living in Italy, national and foreign residents. The principle of equal healthcare access, however, was not easy to implement in practice. For migrants to be able to fully benefit from healthcare, they also need reliable medical information in a language, format, and channel of communication to which migrants have access³. Across Europe, migrant languages have been considered among the factors contributing to low rates of vaccine uptake⁴. In Italy, local health authorities at regional level (*azienda*, or *azienda unità sanitaria locale*) adopted different approaches to disseminate information about the COVID-19 vaccination campaign to members of migrant communities (including irregular migrants). On 12 May 2021, the Società Italiana di Medicina delle Migrazioni (SIMM, Italian Society of Migration Medicine) denounced serious issues on several regional online platforms that were used to book the vaccination. Online booking forms demanded proof of residency defined as ‘regularly present’ (*stabilmente presenti*) even though, in February, AIFA had reiterated that healthcare codes assigned to migrants who were ‘temporarily present’ (STP, *stranieri temporaneamente presenti*) were legally sufficient to access COVID-19 vaccination. **On the platform, the rule of law was contradicted by the bureaucratic requests.** Practical issues and confusing information created vaccine inequality at point of access, and may have contributed to increasing vaccine hesitancy among migrants in Italy. Combined with limited proficiency in Italian, which may have prevented many from navigating these bureaucratic issues, there was a concrete risk of exclusion from the vaccination campaign. Other factors, such as distrust in the authorities and/or medical communities, or the influx of scientifically inaccurate information in their native language through social media, led some migrants to opt out of vaccination.

The STRIVE project, whose findings are reported here, aimed to understand whether effective translation practices can contribute to reducing the impact of linguistic differences as factors determining lower rates of vaccine uptake among migrants in Italy.

To address the research question, the STRIVE team carried out 33 interviews. Interviewees included personnel of civil society organisations and personnel of local health authorities (ASLs, AUSLs) who organised language mediation for local migrant communities, as well as translators, interpreters, and intercultural

1 This report adopts the term ‘migrant’ for ease of readability. The term is more appropriate than foreign nationals, as the team conducted interviews with migrant communities, excluding foreign tourists, business travellers, or high-earning foreign residents in Italy. The report uses the term ‘migrants’ but never considers them as a homogenous group. The term does not neutralise the extreme diversity among social and economic migrants, refugees, asylum seekers, temporarily displaced people, or stateless people. In the analysis of interviews, when it is relevant to do so, the report specifies the group to which the emerging information pertains.

2 Eurostat (2022), ‘Migration and migrant population statistics’.

3 WHO. (2017), *Communicating Risk in Public Health Emergencies. A WHO Guideline for Emergency Risk Communication (ERC) policy and practice*. Geneva: World Health Organization

4 ECDC (2021), *Reducing COVID-19 Transmission and Strengthening Vaccine Uptake Among Migrant Populations in the EU/EEA – 3 June 2021*. European Centre for Disease Prevention and Control, p.10.

mediators. The researchers analysed language access policies, and evaluated quantitative data on migrants' preferred languages, as distributed in Rome and the Emilia-Romagna Region. Information about language distribution was necessary to compare and contrast local language needs, provision, and budgeting issues with the language mediation.⁵ Rome and the Emilia Romagna region host similar numbers of migrant residents; their migrant population combined adds up to over 1 million and represents 20% of the national total. The STRIVE team was able to evaluate and compare approaches in rural, semi-urban, and urban areas, which have shown different levels of testing, infection, and vaccine hesitancy.⁶

Key findings

1. Rather than vaccine hesitancy, unequal access to healthcare information in a language that migrants could understand magnified existing health inequalities among migrant communities in Rome and the Emilia-Romagna region, according to interviews with frontline intercultural mediators.
2. Existing networks of local health authorities and non-profit organisations supporting the Italian COVID-19 vaccination campaign among migrant communities in Rome and the Emilia Romagna region collaborated widely and effectively, leveraging on their existing collaboration, and adapting their strategies for communication and intervention to a rapidly changing context.
3. Advocacy groups supporting access to healthcare in Italy operate across the national health service, local health authorities, civil society organizations, and intercultural mediators; they contributed to communicating health measures to migrants during the pandemic.
 - 3.1. Leveraging existing trust relationships with language communities and extensive knowledge of intercultural mediators was key for local health authorities stretched by a rapidly evolving pandemic context, while operating with fixed budgets.
 - 3.2. The solutions put in place for the COVID-19 emergency are likely to benefit ordinary health service provision for migrant communities, supporting health professionals.
 - 3.3. It is likely that intercultural mediations targeted at specific language communities lowered vaccine hesitancy among those who faced the bureaucratic barriers to accessing the vaccine through the online booking system.
 - 3.4. Many of the successful initiatives described by commissioners of language mediation and intercultural mediators relied on intercultural mediators hired on precarious, fixed-term, and low-paid contracts.
4. Information provided in multiple languages, in multiple formats, including easy-to-read (simplified) Italian, across multiple channels, and targeting specific age groups with their preferred channel and format were determinant factors in establishing trusted channels of communication in the early phases of the

5 Language mediation is used here to refer to multiple forms of language service provision, as offered by translators, interpreters, or intercultural mediators.

6 Di Napoli, A., Ventura, M., and Petrelli, A. (2022). 'Effetto della pandemia sulla popolazione immigrata: Primi risultati dal progetto interregionale dell'INMP', *Quaderni di Epidemiologia*, 4, pp.50-77.

- pandemic. Local health authorities capitalised on these during the vaccination campaign.
5. It is likely that the combination of vaccine hubs, walk-in/pop-up clinics, and door-to-door information campaigns in Rome and the Emilia-Romagna region bridged some of the health inequality created by the absence of formal, nation-wide language policy to be implemented at local level matching the language needs of local migrant communities.
 - 5.1. It is very likely that vaccine access via pop-up clinics, vaccine buses, and other solutions lowered hesitancy among migrants, as these types of vaccination hubs reduced bureaucratic barriers to access.
 - 5.2. Ease of access to vaccination for those without residency documentation would, however, make it more difficult to track migrants' vaccine uptake and to measure exact impact of culture-, language-, and community-appropriate communication among the migrant communities in Rome and the Emilia-Romagna region. Public health and right to vaccine took priority to reduce community diffusion of SARs-CoV-2.
 6. It is necessary to identify indicators to measure the value of language mediation in healthcare settings in support of migrants, in relation to the costs to the health service providers when no language mediation happens or informal language brokering takes place (carried out by family members, child interpreters, untrained bilinguals, etc.). The latter may increase information loss, distrust in institutions, waiting times, and compromise diagnoses and interactions with general practitioners and/or hospital staff.
 7. A significant language data gap exists regarding migrants' preferred languages.
 - 7.1. The current support available in major languages spoken by numerically significant communities (from English, Arabic, and French to Pidgin and Urdu) is not sufficient to match the language needs of migrant populations with different levels of literacy and who may speak different variants of the same language (e.g., Nigerian English).
 - 7.2. Better language data in flexible, accessible, and regularly updatable formats, such as language maps, were considered as useful tools by key stakeholders; investing on formal, nation-wide data collection to gauge migrants' 'preferred languages', in addition to 'country of origin' indicators in local and national survey will optimize time and resources among healthcare providers.

Recommendations

Accurate, timely, and appropriate communication can influence trust in healthcare measures among those with limited Italian proficiency. STRIVE researchers suggest four strategic recommendations⁷, based on practices identified in the report:

- 1) Co-design guidelines with language service providers, health authorities, civil society organisations, and communities of foreign nationals and migrants to

⁷ Section 5 of the Full Report (<http://doi.org/10.53241/CenTraS/003>) includes practical suggestions for implementing the recommendations.

address language needs systematically in Italy.

- 2) Develop networks with culturally and linguistically diverse communities and identify their preferred ways of accessing information. Deliver information in multiple formats, in multiple modes (written, audiovisual, signed, interpreting, intercultural mediation), and via multiple channels of communication to address the intended recipients with the best modes, channels, formats, and languages.
- 3) Collect data about languages used by migrants in Italy through systematic, reusable, updatable, and sharable formats. Include language data collection in ISTAT annual surveys of the migrant population to create detailed information on language needs for access by institutions, civil society organisations, and training organisations.
- 4) Assess the impact of communication in migrants' preferred languages with large-scale surveys among language communities regionally and nationally.

Introduction

This report summarises and discusses the main findings of the project STRIVE⁸, *Sustainable Translations to Reduce Inequalities and Vaccination hEsitancy* in five sections. The first section of the report introduces the cultural, linguistic, and juridical context in which the COVID-19 communication campaign occurred (from the mitigating measures responding to the first wave, via preventative measures in between waves, and with a particular focus on the vaccine campaign). The second section presents the methods used to collect the data (including ongoing activities). The third section looks at the data from qualitative interviews and the interactive language maps (accessible online). The fourth section explains how our findings support the project's strategic recommendations. The fifth and final section focuses on the recommendations.

1.0 Background

The STRIVE project aimed to understand whether effective translation practices can contribute to reducing the impact of linguistic differences as factors determining lower rates of vaccine uptake among migrants in Rome and the Emilia-Romagna Region in Italy. Vaccine hesitancy depends on multiple factors; among them, the availability of reliable, trustworthy information in a format, language, and channel of communication to which migrants can have access.⁹ Even though the Italian law guarantees equal access, vaccine inequality can be driven by bureaucratic or practical issues. STRIVE carried out a qualitative study of the role of migrants' preferred languages in relation to having access to the COVID-19 public health and vaccination campaigns. It explored how local health authorities organise language mediations and which practices support the principles of equal access to healthcare enshrined in the Italian law.

The STRIVE project investigated whether vaccine hesitancy was part of a broader issue of vaccine inequality connected with migrants' unmet language needs. Three macro-issues must be considered when looking at the crisis communication campaign mounted in Italy to support migrants' access to the COVID-19 vaccine. These are 1) migration and vaccination in Italy; 2) the little-known role of language in vaccination inequality and its potential impact as vaccination hesitancy; 3) language as a social determinant of health and the language data gap in Italy. These are explored in this order in the next three sub-sections; the fourth section describes the partnerships that facilitated this project.

1.1 Migration and vaccination in Italy

The migrant population in Italy constantly increased in the first two decades of the 21st century, reaching 5 million on 1 January 2020¹⁰ and 5,171,894 over the pandemic.¹¹ The figure includes migrant citizens of countries outside Europe, citizens of non-EU member-states in the geographical area (e.g., the UK and Switzerland), and citizens of other EU member-states (e.g., Poland, Romania).

1.1.1 Migration as a social determinant of health in action

In June 2021, the European Centre for Disease Prevention and Control (ECDC) released a report which looked at the efficacy of the vaccination campaign of European countries among the non-national communities. The report points to evidence across multiple G7 countries that low levels of proficiency in the local language can act as a barrier to public health messaging.¹² Language diversity – combined with other syndemic risk factors, see Box 1 – was considered among the causes of vaccination inequalities among local populations and contributed to driving lower rates of vaccine uptake, resulting in higher (on average) rates of Covid infection and mortality¹³.

9 WHO (2017), 'Human Rights and Health. World Health Organization'.

10 Eurostat (2022), 'Migration and migrant population statistics'.

11 ISTAT (2022), 'Stranieri residenti al 1° gennaio'.

12 Cf. several studies focused on indicators about hospitalisation, intensive care, and mortality by country, e.g., for Italy (Di Napoli et al., 2022), for the UK (Gutman et al., 2020), for the USA (Kim et al., 2020), for Sweden (Drefahl et al., 2020), etc.

13 ECDC (2021), *Reducing COVID-19 Transmission and Strengthening Vaccine Uptake Among Migrant Populations in the EU/EEA – 3 June 2021*. European Centre for Disease Prevention and Control, p.9-10.

Box 1. From pandemic to syndemic

In Singer's and Clair's definition¹⁴ 'syndemic points to the determinant importance of *social conditions* in the health of individuals and populations' (emphasis in the original). Mendenhall¹⁵ emphasised that 'syndemics allow us to recognise how political and social factors drive, perpetuate, or worsen the emergence and clustering of diseases.' For that very reason, recognising the specificity of each context 'matters a great deal', which demands caution when it comes to analysing the Italian context. There appear to be syndemic conditions, as much as there is also evidence of concerted actions to address inequality and support the right of health of the resident migrant population.

One of Mendenhall's most cogent observations is that 'recognising political determinants of health is central to the syndemic construct'¹⁶. Whether or not, Italy's COVID-19 has been a syndemic for the migrant residents remains to be established.

1.1.2 Health equality in principle and inequality in practice

The Italian legislation guarantees full access to vaccines as part of the right to health. This principle is enshrined in the universal access national healthcare system, which considers public health as a public good to be protected and fostered (Law 883 of 23 December 1978), according to the principles of equality, universality, equity. Free access to vaccines is guaranteed as part of national public health campaigns (Law 286/1998). Since the 1990s, several reforms to the legal framework increased the centrality of the regional units (*azienda or azienda unità sanitaria locale or ASL/AUSL*) in the delivery of the national health plan in terms of prevention and public health, including vaccination. These local health authorities are, therefore, responsible for the COVID-19 vaccination campaign with a view that they are best suited to respond to the needs of the residents in the geographical area that they cover.

Migrants whose residency status is not clear risked being precluded access to the vaccine. In February 2021, the Agenzia Italiana del Farmaco (AIFA, Italian Medicines Agency) explicitly asserted that vaccination rights were temporarily extended to all foreign residents, including undocumented migrants as part of the pandemic vaccination campaign. The current legal framework regulating the Italian healthcare system expects vaccination campaigns to be implemented by the local health authorities. The legal framework delegates both the implementation of the law and the costs of vaccination campaigns to the ASL/AUSL. Therefore, the 2021-2022 COVID-19 vaccination campaign targeted everybody living in Italy, nationals and non-nationals. Providing vaccine access takes priority over legal concerns about citizenship during epidemics and pandemics.

The principle of equal healthcare access, however, is not easy to implement in practice. For migrants, vaccination depended on information in a language, format, and channel to which they have access.¹⁷ In fact, the Italian nation-wide integrated platform to monitor and record vaccine uptakes (ARVA Target) reports low rates among migrants in Italy even for regular vaccination campaigns.¹⁸

14 Singer, M., and Clair, S. (2003), 'Syndemics and public health: Reconceptualizing disease in bio-social context', *Medical anthropology quarterly*, 17(4), pp.423-441.

15 Mendenhall, E. (2020), 'The COVID-19 syndemic is not global: context matters', *The Lancet*, 396(10264), p. 1731.

16 Mendenhall, E. (2020), p. 1731.

17 WHO. (2017), *Communicating Risk in Public Health Emergencies. A WHO Guideline for Emergency Risk Communication (ERC) policy and practice*. Geneva: World Health Organization.

18 Dalla Zuanna, T., Del Manso, M., Giambi, C., Riccardo, F., Bella, A., Caporali, M. G., Dente, M. G., Declich, S., Iannazzo, S., and Mignuolo, A. D. (2018), 'Immunization offer targeting migrants: Policies and practices in Italy', *International Journal of Environmental Research and Public Health*, 15(968), pp.1-14.

1.1.3 Vaccination hesitancy and inequality: impact of language diversity

Vaccination campaigns need to reach as many individuals as possible to achieve herd-immunity thresholds. Hesitancy against vaccination increases risks because it delays reaching the threshold. The SAGE Working Group on Vaccine Hesitancy of the World Health Organisation categorises all the social determinants of health in relation to their impact on vaccine hesitancy, summarising them in the “3 Cs” model.¹⁹ Although the ‘Working Group concluded that communication was a tool not a determinant [of hesitancy]’, it also stressed that ‘when [communication] is poor or inadequate it can negatively influence vaccination uptake and contribute to vaccine hesitancy’.

In their assessment of the factors affecting hesitancy, the Working Group considered the role of language in relation to vaccination convenience, which ‘is a significant factor when physical availability, affordability and willingness-to-pay, geographical accessibility, ability to understand (*language and health literacy*) and appeal of immunisation services affect uptake’. Therefore, language is important to ensure vaccine access. By the end of 2021, it became apparent that 56 countries (most of them in Africa) were ‘effectively excluded from the global vaccine marketplace’ and unable to meet the WHO’s target of vaccinating 10% of their population by September 2021.²⁰ However, vaccine inequality has been driven by the level of access to information for migrant communities in Europe, as ‘language barriers and social exclusion contribute to a deficit of accurate and accessible information’.²¹ Lack of information in suitable languages and formats became a factor lowering rates of vaccine uptake, creating vaccination inequality.

In Italy, the devolved nature of the vaccine campaign further fragments the communication campaign. Disparities across the Italian regions in terms of timing, bookings, and procedures for the vaccine roll-out, resulted in disparities in communication. Vaccination was bookable online and through direct booking by phone. Both the offline and the online booking system pose challenges, in terms of language literacy and the digital divide (a factor that affected also the UK rollout).²²

1.2 Language as a social determinant of health and the data gap

For decades, public health has been discussed in relation to the social determinants of health. According to UCL’s Institute of Health and Equity’s definition,

social determinants of health (SDH) is a term used to describe the social and environmental conditions in which people are born, grow, live, work, and age, which shape and drive health outcomes. Factors that determine how the SDH conditions are experienced across societies include the distribution of power, money, and resources. Unfair distribution creates avoidable health inequalities, known as ‘health inequities’. Therefore, social, economic, and environmental factors, as well as political, and cultural factors, constitute the ‘social determinants of health’.

19 Macdonald, N. E. (2015), ‘Vaccine hesitancy: Definition, scope and determinants’, *Vaccine*, 33(34), pp.4161-4164.

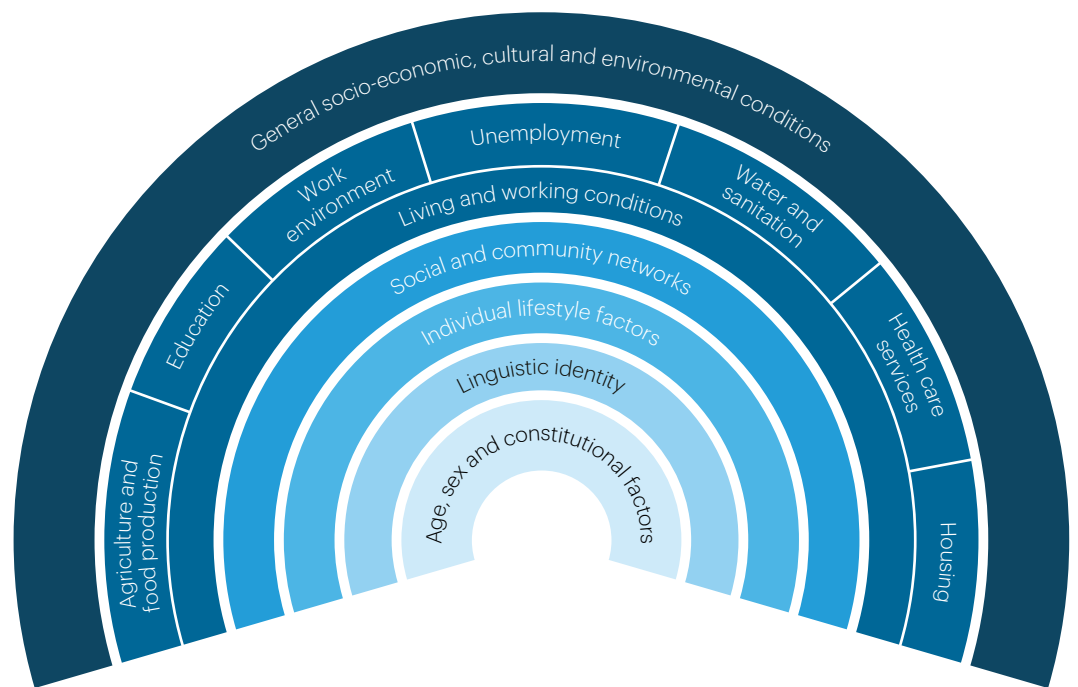
20 WHO (2021), ‘Vaccine Equity Campaign’.

21 ECDC (2021), *Reducing COVID-19 Transmission and Strengthening Vaccine Uptake Among Migrant Populations in the EU/EEA – 3 June 2021*. European Centre for Disease Prevention and Control, p.10.

22 Knights, F., Carter, J., Deal, A., Crawshaw, A. F., Hayward, S., Jones, L., and Hargreaves, S. (2021), ‘Impact of COVID-19 on Migrants’ Access to Primary Care and Implications for Vaccine Roll Out: A National Qualitative Study’, *British Journal of General Practice*, pp.e583-e595.

Often represented through the Dahlgren and Whitehead rainbow (1991),²³ the social determinants have an impact on individual health. A growing body of evidence is calling for extensive analysis of language as a social determinant of health.²⁴ Figure 1 represents Federici's adaptation of the rainbow, with increased prominence given to language. For migrants, language is a social determinant of health among the many affecting their health outlook.

Figure 1: Federici's adaptation of Dahlgren & Whitehead 1991 model, with the inclusion of linguistic diversity²⁵



Language is an individual characteristic as much as a social and group determinant. Many features determine the linguistic identity of individuals who have moved from their country of origin (be it as migrants or transient residents). The use of one language or another, for migrants, is not only a matter of effective communication, but also of cultural belonging and, ultimately, of personal identity. Migrants are often polyglots; however, they do not have the same level of competences in all their languages²⁶; and they often speak one (or more) *lingua franca*, a widely spoken language globally (e.g., English, Arabic, Chinese), or regionally (French, Spanish, Swahili, Hindi-Urdu). Language is a social determinant of health, certainly for migrants, because their access to healthcare services in a country must be measured against their ability to speak, read, and understand the local language.

23 See for instance the programme Healthy People 2030 of the US Centers for Disease Control and Prevention; this initiative separates language and literacy skills from education and ethnicity.
 24 See discussion in Federici, F. M. (2022), 'Translating Health Risks: Language as a Social Determinant of Health' in Federici, F. M. (ed.), *Language as a Social Determinant of Health* (Cham: Palgrave Macmillan), pp.1-35.
 25 See Dahlgren G, and Whitehead, M. (1991). Policies and strategies to promote social equity in health. (Stockholm: Institute for Futures Studies); and Dahlgren G, and Whitehead, M. (2021). 'The Dahlgren-Whitehead model of health determinants: 30 years on and still chasing rainbows', *Public Health*, 199, pp. 20-24.
 26 Blommaert, J., and Backus, A. (2013), 'Superdiverse Repertoires and the Individual,' in de Saint-Georges, I. and Weber, J. (eds.), *Multilingualism and Multimodality: Current Challenges for Educational Studies* (Rotterdam, Sense), pp.11-33.

1.2.1 The language data gap

The extensive understanding of the local language needs gave advantages to organisations that had an established presence in their geographical areas of activity in Italy. However, granular data about migrants' preferred languages is not easily available. The Italian Institute for National Statistics (ISTAT) carried out a survey to collect data on migrants' main spoken languages in 2011-2012, which has not been updated since. Besides being obsolete, the 2011-2012 census provided a very sketchy overview of the linguistic diversity of foreign residents in Italy. The limitations of the data are confirmed by a comparison with the data on 'foreign residents' organised by country of origin. ISTAT's own data on foreign residents in Italy on 1 January 2022 lists over 200 countries of origin only for the migrants currently living in the Emilia-Romagna region, but the data does not fully represent the language needs of the migrant residents in the regions.

The COVID-19 pandemic forced the EU Commission and the European Migration Network (EMN) to submit a formal query to EU Member States to assess local procedures used to identify migrants' spoken languages at the point of reception, or arrival in the country in which they intend to apply for asylum, to gauge language needs for all communication campaigns. From the Italian authorities, EMN²⁷ received confirmation that there is no standardised procedure to identify the spoken languages of asylum seekers, refugees, and vulnerable migrant groups. Upon arrival in Italy, they may have access to information only in Italian or a main regional lingua franca.

1.2.2 Linguistic equality

The language data gap emphasises another discrepancy, between practices and high-level principles of equality, present in Article 3 of the Constitution of the Italian Republic, which recognises equal dignity and equality before the law to all citizens regardless of gender, ethnic origin, language (including protection of language minorities in Article 6), religion, or political views. The Italian peninsula has seen the coexistence of multiple dialects and languages in use for eight centuries; the Italian Society of Linguistics promotes a language policy based on 'Multilingualism of individuals, of societies', which are seen as values 'to protect and promote in any democratic perspective'.²⁸

Grounded in its history of internal multilingualism, Italy's current language policy-making principles recognise that there are always two factors at play: practical use of Italian and personal use of language as part of the individual's identity. In terms of language policies, the Presidential Decree (DPR) 179 of 14 September 2011, entitled *Regolamento concernente la disciplina dell'accordo di integrazione tra lo straniero e lo Stato* [Regulation regarding the integration agreement between a foreign person and the State] conceives knowledge of the Italian language as an essential pre-requisite for integration. The law considers the gradual steps required by all non-EU foreign individuals intending to remain in Italy (including refugees, asylum seekers, and work migrants) in order to emancipate themselves from the need for language mediation to attain a permanent residency or citizenship in Italy. Non-EU citizens are expected to gain an A2 competence in Italian – according to the Common European Framework of Reference for Languages – as well as 'sufficient understanding' of civic life in Italy in relation to health, schooling, social services, employment, and taxation. *Both the principle of linguistic equality in Italy and the contractual*

27 EMN (2020), *Ad Hoc Query on 2020.48 part 2: Procedures for language identification by reception authorities*, p. 18.

28 GSPL (2013), *Sette Tesi per la Promozione di Politiche Linguistiche Democratiche*. Translations from Italian are all by the authors unless otherwise specified.

agreement for migrants to be integrated in Italy rest on an understanding that during the process of integration, migrants will need to have access to language service provision in many aspects of their lives in Italy.

1.3 Communicating COVID-19 to migrants in Rome and in the Emilia-Romagna region

There is a convergence in the legislative context concerning the equality of healthcare access and of access to information. However, there is a similarity between the *intentions of equality* and the practical hurdles that impede the implementation of multilingual practices, with the notion of equal access to the healthcare services. As language is a tool to access the equal right to healthcare, the two dimensions are crucial in analysing and understanding the operational perspectives in which local health organisations, charities, advocacy groups, and language mediators operated regarding the COVID-19 risk communication and vaccination campaigns. Disentangling the two rights of *access to information* and *access to healthcare* would be detrimental to understanding how they are both considered as essentials in the pursuit of health equality among culturally and linguistically diverse communities among foreign nationals and migrant residents in Italy. The STRIVE project focused on the practices adopted in Rome and in the Emilia-Romagna region to respect the principles, despite the practical challenges they pose.

The geographical areas were chosen because of the distribution of migrant communities: while Rome – together with Milan – has the highest rates of foreign residents (respectively 9.3% and 12.3%), the composite context of the Emilia-Romagna region includes urban areas, smaller towns, and rural areas, which demand different approaches to language service provision for migrant residents.

1.3.1 Rome

According to ISTAT,²⁹ the municipality of Rome is the largest inhabited urban territory in Italy, as it occupies over 1,287 km², 0,4% of the Italian territory, with a population of 2,848,084 residents. The broader conurbation, which makes up the administrative area named Città Metropolitana di Roma Capitale, reaches a total of 4,253,314 residents. Rome is Italy's capital and the largest municipality, with the largest foreign population in Italy, consisting of 516,297 migrants. Due to its history, the city has been for centuries a culturally diverse and multilingual environment.

1.3.2 The Emilia-Romagna region

The Emilia-Romagna region extends over 22,509,67 km², the 6th largest region of Italy. According to ISTAT,³⁰ the region's population amounts to 4,464,119 residents. Emilia-Romagna organises its local authorities into 8 units, which offer a set of services subdivided into smaller districts to accommodate the needs of the local residents. The region has a population of 562,257 migrants.

29 ISTAT (2022), 'Stranieri residenti al 1° gennaio'.

30 ISTAT (2022).

1.4 Research partnerships

In response to emerging evidence of vaccine inequalities between migrant communities and local populations in Europe, STRIVE worked with civil society organisations (CSOs), local health authorities (ASL/AUSL), and cross-sectorial networks to understand the role of translation and multilingual communication in reducing these inequalities in Italy. The research team was supported actively by local health authorities in Rome (Azienda Sanitaria Locale, ASL), the regional health authority in Emilia-Romagna (Azienda Unità Sanitaria Locale, AUSL), CSOs working with migrants and refugees, CSOs with a specific focus on healthcare equality and healthcare (such as Medici per i diritti umani, [Doctors for human rights], Sanità di Frontiera [Frontline healthcare], Medici Senza Frontiere [Médecins sans frontières], Medici del Mondo [Médecins du Monde/Doctors of the World], and InterSOS). Within the scope of the goals set out by the British Academy's program of research responses to the COVID-19 vaccination campaign, the project looked into:

- How do linguistic and socio-economic divides affect the reception, interpretation, and spread of health communication among migrants?
- What role do linguistic and cultural factors play in vaccine engagement and vaccine polarisation among migrants?
- What are the contemporary roles of different organisational structures and institutions, e.g. civil society organisations, in facilitating or inhibiting health communication to migrants?

2.0 Methods

STRIVE collected three typologies of data and analysed them with three different methodologies. A qualitative descriptive research design informs the data collection from the interviews with key stakeholders. To better understand local language needs, STRIVE researchers mined information about distribution and spread of languages to map on the geographical areas considered in the project. They collaborated with the IDOS Research Centre, whose researchers piloted a mixed-method sampling to collect data on migrants' preferred languages in Rome. For the language mapping, STRIVE used data mining and data collection techniques for manipulation through a geographic information system mapping to create datasets that can be overlaid on digital maps, later integrating data collected by the IDOS team. A quantitative questionnaire was designed, adapting Martin and Petrie's (2017) vaccination attitude examination (VAX) scale to include data about migrants' perception of COVID-19 communication strategies and level of trust towards Italian healthcare provision.

2.1 Ethnographic study

The STRIVE researchers contacted approximately 40 entities that have different roles in supporting migrants in the vaccination campaign, including both local health authorities and civil society organisations (CSOs). For CSOs, we chose to focus predominantly on those that support migrants' health and that work at the intersection of advocacy and healthcare, occasionally expanding the typology of stakeholders to include organisations that play broader advocacy roles to support migrants' rights.³¹ Some of these organisations were selected on the basis of Laricchia's pilot study,³² while others have been identified through web searches, or recommendation from other participants (snowballing technique). All 33 interviews took place between 24 November 2021 and 26 January 2022. The interviews were conducted in Italian by members of the UCL STRIVE team, including research assistants. 32 were held on videoconferencing platforms (Zoom and Microsoft Teams), 1 in person. The interviews were transcribed. Most transcriptions were coded by a researcher who was not involved in the interview (bar four exceptions). Interviewees belong to two groupings, broadly reflecting their roles enabling language mediation of the COVID-19 vaccination campaign:

- A. 'Commissioners' broadly indicates individuals from participating organisations who are not professional translators or interpreters, but who have a working relationship with translators, interpreters, intercultural mediators in the context of their activities.
- B. 'Intercultural Mediators' indicates translators and/or interpreters, who work as language mediators, a professional figure known in Italy as *mediatore culturale*.

Intercultural mediators often, but not always, share an experience of migration with the target populations. Commissioners, on the other hand, are more often Italian nationals, but it is possible that they have a migration background and that they have previously worked as mediators before assuming managerial roles.

31 The study was reviewed by the Ethics Committee of University College London (Project No. 6625/009) and the data have been processed and registered in compliance with Data Protection regulations (registration code Z6364106 2021 06 97).

32 For details, see full report (<http://doi.org/10.53241/CenTraS/003>).

2.2 Language mapping

Language maps provide an immediate visualisation of languages spoken locally. There are limitations in terms of demographic data about migrants' preferred languages. Existing datasets (ISTAT, Municipio di Roma) allow researchers to access granular data on a migrant's country of origin, but no information is collected by any organisation on the migrants' preferred language (or linguistic identity). The absence of reliable and granular data encouraged STRIVE researchers to pilot a study that would collect data on migrants' preferred languages and handle it in a format that support its visualisation as maps.

Data on the foreign population in Rome is sparsely found on the official website www.comune.roma.it. Several reports describe the distribution of the foreign population in Rome by survey date. The most comprehensive report appeared to be *L'immigrazione a Roma* (2017) presented by the Dipartimento per la Trasformazione Digitale U.O. Statistica Open Data. Along with other statistics, the document provides the distribution of the 15 most common nationalities across each Municipality of Rome. This is the most detailed report as other documents only present the Municipality's top 5 most common nationalities. Detailed data can be found in Table 7, 'Popolazione straniera per cittadinanza e Municipio di residenza (Prime 15 cittadinanze)'. With the support of a bespoke mixed-method survey conducted by the Centro Studi e Ricerche Immigrazione DOssier Statistico (IDOS Research Centre), granular data is used to create the interactive, digital maps available on the STRIVE website. The data is limited to Rome as the pilot language data collection was carried out between 8 and 28 February 2022. Maps can be generated and tested within a day; this feature makes them a tool to visualise detailed datasets in a user-friendly manner.

2.2.1 Data: extraction, aggregation, manipulation, and limitations

Initial data presented in PDF documents had to be extracted into a manageable form using the open-source tool Tabula (<https://tabula.technology>). The software allows data extraction by manually selecting a section from the PDF and automatically drawing tables using two formatting methods: 'Lattice' and 'Stream'. For extracting this data, the Lattice method was used. It was later integrated with the collected via the IDOS pilot project and organised in a spreadsheet (XLSX format). For Rome, the data showed the distribution of the 15 most common foreign nationalities (top15) of people residing in the area of Rome per municipality. This included the total number of non-Italian residents, comprising those nationalities not among the top15. For completeness, the sum of all individuals belonging to the top15 was subtracted from the total of non-Italians to obtain the 'other' category, which included all non-top15 individuals. The method used involves several steps which might corrupt the data, and for that reason, some results might lead to inaccuracies. Extra reviewing was necessary to ensure the quality of the results. Other limitations include the absence of up-to-date statistics and more detailed data on the distribution of the nationalities not accounting for the top 10/15 most common nationalities.

2.3 Questionnaire

The STRIVE project designed a questionnaire that embedded the questions included in Martin and Petrie's VAX scale questionnaire,³³ within sections intended to capture the specifics of the Italian context. The questionnaire consists of 72 questions. They include 3 consent questions, 11 questions on personal details (with a 'no-answer' option), 6 Y/N questions, 2 multiple questions, and 50 Likert-scale questions (from '1 strongly disagree' to '6 strongly agree'). Despite its length, it can be completed in as little as 10 minutes, 20 minutes if completed by a low-proficiency speaker of the language. The questionnaire was written in English and Italian, optimised in these two languages with informal piloting with peers. After the tool was granted approval by UCL Ethics Committee, it was translated into 13 languages (Albanian, Arabic, Chinese, French, Hausa, Polish, Romanian, Russian, Spanish, Swahili, Urdu, Yoruba, and Wolof).

The questionnaire was to be administered both online and in presence, leveraging STRIVE's stakeholders' networks and the project's research assistants based in the Emilia-Romagna region and Rome. Enabling paper administration of the questionnaire – or in-person collection via tablet – was expected to be key to reach the minimum threshold of participants and to avoid discriminating our population due to the digital divide. Several methods were used to recruit participants. A poster was shared with stakeholders for distribution to migrants in their networks. The change in mitigating measures brought in at the end of November 2021 made it necessary to administrate the questionnaire only online. We attempted to disseminate it in vaccination centres as additional needs to use the Green Pass (EU digital Covid certificate) emerged and the spread of the omicron variant led to increased activity in these. However, the project did not receive formal clearance to collect data in these from the Italian public health authorities.

The questionnaire was reopened in February 2022. STRIVE researchers decided to extend collection of data until 31 August 2022 (<https://www.striveproj.com/questionnaires>). supported by the extended networks of the stakeholders (GrIS, local health authorities, and IDOS Research Centre).

33 Martin, L. R., and Petrie, K. J. (2017), 'Understanding the dimensions of anti-vaccination attitudes: The vaccination attitudes examination (VAX) scale'. *Annals of Behavioral Medicine*, 51(5), pp.652-660.

3.0 Data analysis

The project collected three typologies of data to assess language needs in specific geographical context (maps), ways in which these needs had been addressed according to different stakeholders (interviews), and migrants' perceptions of COVID-19 information and vaccination campaign among migrants (questionnaire).

3.1 Ethnographic interviews

Interviews with intercultural mediators and commissioners from different types of organisations involved in the research have enabled the STRIVE team to compare the organisations' different approaches to guiding the mediators working for them. The intercultural mediators of different organisations operated in a variety of settings, including hospitals (3 participants), doctors' clinics (3), informal settlements (2, all of them in Rome), mobile clinics (2, all of them in Rome), prisons (1), refugee reception and accommodation centres (3), and vaccination centres (3). To respect anonymity, interviewees' comments are reported by using P (=participant) Number (=order of interview).

The comparative analysis showed no significant difference in approaches between Rome-based organisations and Emilia-Romagna-based ones; rather, differences emerge in terms of the strategies adopted by organisations of different sizes. The experience of the COVID-19 pandemic presented an array of challenges and the CSOs responding to the pandemic were also different in that Rome-based organisations were often the Italian branches of international NGOs, while in Emilia-Romagna there was a prevalence of smaller, more locally focused CSOs. Target populations presented differences in terms of legal status within the country (asylum seekers, refugees, documented/undocumented migrants), geographic origin, age, and gender.

However, several unifying factors were present. Firstly, many organisations work in more than one setting. Secondly, several participants from Group B (mediators) have offered their linguistic expertise to more than one organisation throughout their career: P23, for example, has worked as a mediator for ASL Roma 1's mental health unit, and for their refugee health services (SAMIFO), before joining Medici Senza Frontiere. Thirdly, in both settings, there was a connection between successful results and the effectiveness of the networks that emerged, or, to a lesser extent, consolidated between organisations during the COVID-19 public health campaign.

During the interviews, and in discussions with stakeholders, it was possible to see how organisations often worked in unprecedented ways with each other. Even before COVID-19, collaborations between a CSO and a local authority were the norm, either as partners in a specific project or as providers of specific services as a result of public tenders. During COVID-19, these collaborations were maintained and formed the basis for local responses to the pandemic. Interviewees from CSOs who operated in hard-to-reach environments in Rome, for example, directly liaised with ASL to report COVID-19 infections among the city's homeless population (P3) and among the inhabitants of squats and other informal settlements (P1). Others liaised with local authorities when advocating for beneficiaries who could not obtain their Green Pass (P14). Key factors in these networking process were the existence of national health

equity advocacy networks such as the SIMM³⁴ with their in-field networks, the Gruppi Immigrazione e Salute (GrIS); and the activities of projects such as ICARE³⁵ driven by the local health authorities. The ICARE project focuses on creating resources (bilingual glossaries), translations of COVID-19 documentation, infographics, reports, cross-sectorial training on how to work with mediators, deployment, training, and interaction with intercultural mediators, and support for medical professionals. SIMM, GrIS, and ICARE provided crucial information and protocol sharing, which in turn increased efficiency in communication (and translation).

Existing collaborations became the basis for local responses to the pandemic. Summarising their practices, a participant explained

P26: We try to reach comprehensively across the territory, so that communication is not centralised, but it can reach different places. One thing we say, we would like to stress the efficiency of these activities, in that we always try to avoid useless repetition: that means if something was translated, we share it at national level among all partners and all the AUSLs, which is done to reach a better efficiency by avoiding replicate translations. If something, for example, is translated in Sicily we share it with Emilia-Romagna with Lazio, with Tuscany, and the other way around.

Most interviewees discussed 1) local knowledge regarding language needs of local migrants; 2) how to achieve accuracy of information in familiar languages with the constraints of having to describe new terminologies and processes; 3) the concerns about professional recognition, alongside job precarity that has an impact on discontinuity of collaborations; 4) the intercultural mediators' role in dealing with distrusts in institution or the vaccination campaign; 5) approaches to build trust; 6) interpersonal relationships, empathy, and deep engagement with the communities; also linked to 7) helping with bureaucracy and working as advocates. The following sections summarise key findings emerging from the themes.

3.1.1 Local knowledge and migrant needs

All interviewed participants, regardless of their affiliation and the type of language service provision they offer, concurred that migrants' access to information in the context of the pandemic meant knowing the literacy levels, language needs, and format preferences of the local migrant communities, so as to match them. All the civil society organisations, from the institutional services to the NGO sector, equally emphasised that all their organisations included multilingual services in their Covid response.

Concurring on the general point, all commissioners stressed how awareness of the linguistic needs of the migrants in their territory was a priority. This awareness shapes the response as it influences 1) the choice of translation mode, for instance translation of information leaflets; 2) the means of delivery, for instance as online, shared, or downloadable leaflets; 3) the type of interaction, for instance in-person interpretation during doctor-patient consultations or with intercultural mediator; and 4) the spaces in which the language service is best received, for instance at the vaccination centre in the presence of mediators, or at vaccine-related information sessions.

34 See Società Italiana di Medicina delle Migrazioni (Italian Society of Migration Medicine).
35 See Progetto I.C.A.R.E. Integration and Community Care for Asylum and Refugees in Emergency.

The analysis of the interviews underlines that three groups of languages are variably used in addition to Italian by the organisations: European *lingua francas* (English, French), widely spoken non-European *lingua francas* (e.g., Chinese, Arabic, Farsi, Hindi, Urdu), and National languages of communities that are numerically significant in Italy (e.g., Albanian, Tagalog, Bangla) or that are spoken by communities that are particularly vulnerable. P10 discussed the importance of awareness of the numerical presence of composite and linguistically diverse communities in some areas of Rome and P19 stressed the importance of complementing information about large language communities, who certainly need language support, with accommodating the language needs of communities who ‘may not be numerically significant but [are] indeed significant in terms of [vaccine] hesitancy and the need for better understanding/information’. These activities could succeed because they were based on previous engagement with the communities, returning on the importance of existing stakeholder networks including local health authorities, non-profit organisations, and contacts within the language community, as well as support by urgent scoping studies.

Organisational policies for deciding what languages will be included within language provisions therefore seem to be guided by two main factors: **a) presence of speakers of those languages within the territory; b) evidence of socio-economic factors that may result in vaccine hesitancy within the population.**

The presence of intercultural mediators was deemed crucial by healthcare professionals in simplifying the technical or bureaucratic language used by national or regional authorities. Disseminating the information to target populations who may have low levels of education could only be helped through the work of mediators, as indicated by a commissioner:

Researcher: And do you think that your translations and mediations [...] aided the vaccination campaign?

P27: Yes, yes, they aided a lot. Because the language of information material that comes from the Ministry, or from the regional health authority, can be very technical sometimes. So, in English, for example, and for some users who have low levels of education, this was a great obstacle at first.

3.1.2 Collaboration and recognition

In all the interviews, the participants emphasised that by virtue of the variety of tasks carried out and skills that they deployed, intercultural mediators that have been trained to collaborate with local health authorities and to liaise between medical professionals and migrant language communities deserve greater recognition of their professional category. All mediators concurred that their tasks were rarely confined to ‘just’ translating. Their work involves the deployment of linguistic and cultural skills in a variety of contexts, usually with an imbalance of power between one linguistic community and the other. It often means carrying out tasks that do not involve the translation of a text, or the direct interpretation between two parties in a dialogue – but rather, assistance in understanding texts and the medical concepts that are contained in it; and in doing so, providing a point of reference in a language that individuals speak and understand. Mediators became advocates for a migrant community, or the face of the host country’s integration policies. This has concrete repercussions at a practical level, and it invests the emotional, affective dimension of both mediators and the individuals for whom they translate.

STRIVE interview data highlights a need for a wider recognition of the intercultural mediators because of the skills and competences that they have acquired, and they deployed not only during the COVID-19 vaccination campaign but also before. These appeals are made in a context where the job of *mediatore culturale* is poorly regulated in Italy, not always provided with adequate opportunities, time, and funding for training and support, and generally subject to a lack of job security. The appeals were consistent among intercultural mediators (e.g., P4, P8), focusing on professional acknowledgement and regularisation:

P30: I would request more consideration for the profession of mediators. In Italy, mediation, the profession of intercultural mediator is not recognised yet. So this is what I would ask, especially for those who are trained, who have degrees, have finished their studies, have experience.

The main issue emerging from the interviews is substantial, but not new: the quality of intercultural mediation is not recognised with appropriate remuneration within the Italian market or institutional settings. Concerns about standards and recognition echo the findings of the *Health Evidence Network Synthesis Report 64* published by the WHO Regional Office for Europe.³⁶ The recognition of the profession and its organisation could benefit medical professionals and enhance access to health services for migrants. These skillsets and networks could be leveraged to support crisis communication more widely (e.g., organisations involved in the study specialise on responding to humanitarian crises and disasters, InterSOS, Doctors without Borders, etc.).

3.1.3 Accurate and familiar

It is worth focusing on the interview data concerning the specifics of the COVID-19 public health and vaccination campaigns. The priority of ensuring that translation in different languages is medically accurate was pursued by different organisations in different ways. Intercultural mediators encountered cultural and linguistic challenges concerning the concepts, expressions, and practical matters such as new processes and procedures pertaining to the COVID-19 vaccination campaign.

Interviewed commissioners focused on the efforts that were made to overcome these challenges and fill gaps in the mediators' medical literacy. Intercultural mediators were recruited among individuals who had a degree of experience working within healthcare contexts and collaborating with different types of medical personnel. Of 23 mediators interviewed, most reported that they had worked in healthcare settings before the start of the pandemic – indicating length of experience and range of settings (P8, P18, P4), some were domain-specialists (P4). Though they knew the types of patient-doctor interactions and their settings, they had to face the novelty of the disease, engage with different text types and activities (translating leaflets, when mainly used to oral mediation), and engaging with technologies to carry out forms of remote interpreting.

Each language presented specific challenges. Most languages used by mediators, such as English, have extensive vocabulary to discuss SARS-CoV-2. Other languages as Albanian or Arabic have developed more or less extensive vocabulary, including practical information and technical aspects of the pandemic, with which migrants deal in everyday *Italian* contexts (e.g., 'antigen test' or 'PPE'). In this case, the risk is

36 Verrept H. (2019), 'What are the roles of intercultural mediators in health care and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region?' Health Evidence Network (HEN) synthesis report 64. (Copenhagen: WHO Regional Office for Europe).

that migrant communities will be exposed to competing *vocabularies of COVID-19*, as they also read online materials in their home languages, from their country of origin. This situation may lead to confusion, especially in individuals with limited medical literacy. When working with less-widely used languages, the question of translation and interpreting is deeply connected with the fact that even in their home countries, standardised and widely used medical terms may not have been created in those languages (where a colonial language such as French may be used instead by medical or administrative professionals). The goal of the mediator is then working within the beneficiary's language to fill gaps and counter inequalities that originated outside of Italy, but that have a concrete bearing on the Italian vaccination campaign.

Unsurprisingly, the interviews detail how the 'accuracy' of medical information and up-to-date medical terminology to be provided to mediators, in advance of meetings with target populations, was a concern of all organisations. Not all organisations, however, adopted the same strategies and provided the same level of guidance to mediators. No significant difference emerges between Rome-based organisations and Emilia-Romagna-based ones; rather, differences emerge in terms of the strategies adopted by organisations of different sizes. While Rome-based branches of established international NGOs presented evidence of clear protocols to inform mediators about the key aspects of COVID-19 vaccination, smaller organisations appeared more likely to pass on vaccine-related information simply by forwarding documents from the Italian health minister to the mediators. There seems to be, in many interviews, a degree of reliance on personal research that seems to be inherent in the work of mediating in healthcare contexts.

3.1.4 Addressing distrust

Mediators working with migrant communities encountered instances of distrust in the COVID-19 vaccine, which were rooted in the relationship between the community and the host country more than in the COVID-19 vaccination campaign itself. Both groups of interviewees discuss at length their perceptions of migrants' (lack of) trust in the vaccine, and the efforts that their organisations make to build trust – which often involve reliance on intercultural mediators to act as points of reference. This problem is compounded with low-literacy issues or generally low levels of schooling among the target population, which sometimes led organisations to create bilingual or multilingual video-messages to reach a wider section of the population, and disseminated these via social media.

Differences exist between migrants coming from Eastern Europe and Africa regarding the roots of vaccine hesitancy – dependent on the respective countries and the local political context and history of public health actions. Differences were maintained also because of the influence of debates concerning the vaccine happening in their own preferred languages, in their country of origin. Some interviewees link vaccine distrust with how a specific community perceives themselves with respect to the Italian or 'Western' mainstream populations.

Intercultural mediators working with one or more communities with Eastern European background recognised vaccine hesitancy in their communities linked with socio-cultural factors affecting the recent history of their countries of origin and/or the present situation in said countries. P18, a mediator from Albania, ascribes vaccine hesitancy in their community to the fact that in their home countries vaccines were mandatory under Communist regimes, which has left a historical association of vaccine with the broader restrictions to personal liberty of these regimes. P35, who is also Albanian, saw vaccine hesitancy connected with the loose preventative measures against the pandemic adopted in Albania. The controversial history of medical trials in Africa interacts with the pervasiveness of conspiracy

theories that circulated through social media and instant messaging apps, such as the idea that COVID-19 does not affect Black individuals. P29, a mediator who works with West African languages, provided specific examples of the mindset of some of the migrants from West Africa who would be vaccine hesitant:

P29: Because at the beginning it was white people's sickness, right? They were telling us, at the beginning, right? 'Black people cannot catch it, so what are you saying?' 'Have you ever seen', they would ask me: 'Have you ever seen a Black guy catch Covid? I haven't.' Questions like this, which would raise a smile, but they also gave you the sense of how people experienced this disease at first.

Other mediators (P2, P32) reported a similar discourse circulating among Black migrants. This finding confirms, for the Italian setting, some of the findings from Knights et al.³⁷, who observed the same discourse circulating in the UK. The STRIVE interviews point to possible roots of distrust in the community's previous history with the host country and with the abstract idea of 'Europe' or 'the West' at large.

3.1.5 Building trust

Mediators build trust by capitalising on their linguistic skills and their social standing within the migrant community. Since the intercultural mediators often, but not always, come from the same backgrounds as the target populations they work with, their work is deemed essential in building trust by inserting themselves in these manifold conversations that refer to discourses in Italy and in the migrants' home countries. They may be too vaccine hesitant; one intercultural mediator was, and the commissioner stressed that the conversations with intercultural mediators could often be a litmus test of what they would face with a specific language community (P1, P12). For instance, informing the communities with persuasive explanation relied on preliminary discussions with the mediators:

P1: So these themes actually were very interesting as moments of discussion with mediators, because they came to us with elements that were indicative of what our job would be like with people in the reception centres or in informal settlements.

From the intercultural mediators' point of view, the building of trust is seen both as an extra responsibility, and a matter of pride in their work (P30), as well as leading by example, giving proof that the vaccine was safe (P5). Building trust means also supporting migrants breaking down informal barriers, such as bureaucracy (P2). From the commissioners' points of view, there was also a need to build trust between themselves and their mediators (P12).

Several intercultural mediators expressed how if, on the one hand, the use of technology created new opportunities to reach the target populations safely and efficiently, on the other hand, they felt technology risks undermining the trust-building component of their work.

3.1.6 Accountability and community feedback

Organisations consider accountability as part of their engagement with target populations. However, they report how they have not collected systematic feedback.

37 Knights, Felicity, Jessica Carter, Anna Deal, Alison F. Crawshaw, Sally E. Hayward, Lucinda Jones, and Sally Hargreaves. 2021. "Impact of COVID-19 on Migrants' Access to Primary Care and Implications for Vaccine Roll-out: A National Qualitative Study." *British Journal of General Practice* 71 (709): E583-95. <https://doi.org/10.3399/BJGP.2021.0028>.

Interview data suggests that there is a deep interconnection between local healthcare authorities and civil society in managing the translation process. Reaching out to migrant populations with the information does not occur homogeneously. Some local health authorities, as in the case of ASL Roma 1's SAMIFO centre, retain a hands-on approach and oversee the whole process, hence remaining accountable for the delivery of accessible health information. Others may have relied on more informal routes and, even if the commissioners highly valued their relationship with their language service providers and the migrant communities they would serve together, there was no systematic process for collecting feedback.

This can be ascribed to the emergency nature of organisational response to the pandemic, or the mode of mediation (translators of written texts and videos are less likely to have contact with the target populations). P34 laments that there was no possibility to collect feedback on multilingual information videos that were distributed to their target population, and therefore not knowing whether their work was successful in convincing individuals to get vaccinated. This may also be due to the scarcity, within organisations, of speakers of the target languages *except* the mediators themselves. Commissioners and most mediators agreed that collecting feedback would help them measure the effectiveness of their strategies.

3.1.7 Bureaucracy and advocacy

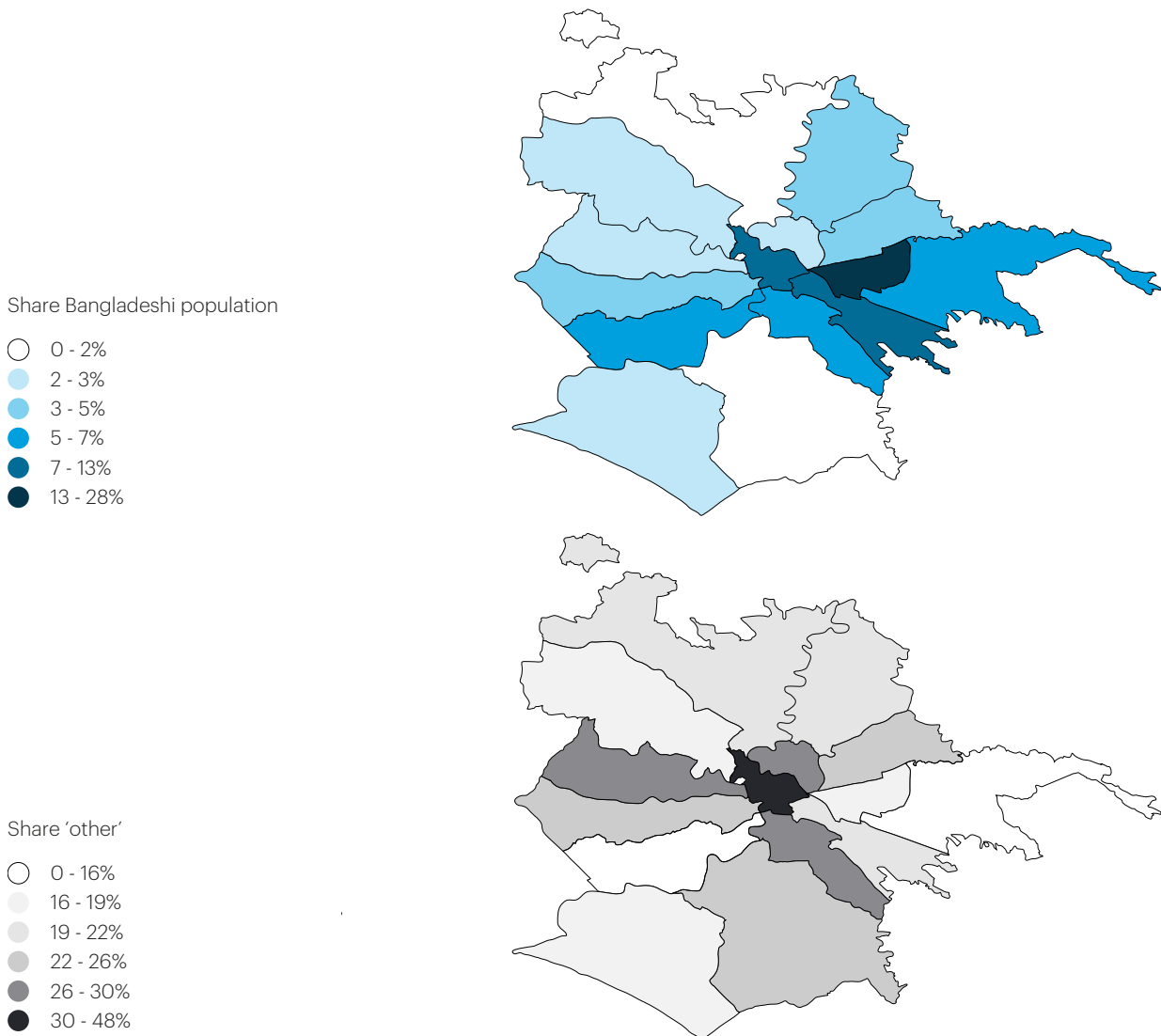
Both civil society organisations and mediators found themselves working to bridge the additional, informal gaps created by bureaucracy (P3, P14). In October 2021, the Green Pass became a necessary element for individuals' mobility in Italy. The introduction of Green Pass became a factor influencing the degree of vaccine engagement among migrants. For instance, many migrants encountered bureaucratic barriers and linguistic difficulties when attempting to obtain their Green Passes. Mediators often played an active role in helping the target populations obtain their Green Pass (P8, P17) by

- Explaining its role and function and answering frequently asked questions.
- Helping users navigate the website and/or fill in the form in Italian.
- Advocate for the recognition of vaccinations undertaken outside of Italy.

3.2 Language maps

Language maps provide an immediate visualisation of languages spoken locally; when organising ordinary and extraordinary public health campaigns, in the international humanitarian sectors, this relatively new tool has been considered useful to facilitate planning and delivering information in multilingual contexts of crisis. Overlaying language data on digital maps supports planning of budget and resources, and organisation of language service provision in pop-up clinic and healthcare personnel in home visits to migrant communities living in non-official (irregular) buildings. The STRIVE project piloted a granular data collection to create interactive language maps. Figure 2 shows how using only the available demographic indicator 'country of origin', maps give some sense of the distribution of the Bangladeshi communities in Rome, by district (and online by healthcare provider).

Figure 2: Static versions of language maps



The digital maps are interactive and can be navigated to find out more specific information. Since 2 March 2022, the prototypes based on the demographic indicator of 'country of origin' are available on the STRIVE website.

4.0 Findings

The findings of the STRIVE project show that the most effective practices emerged from structurally embedded projects that adapted their standard operations to the new challenges, leveraging existing networks and ensuring that having access to COVID-19 information and the vaccine campaign happened through a range of modes of language mediation. The existing network of actors deployed their practical solutions systematically: they could adopt the strategies that enable them to support migrants' access to ordinary healthcare provision by expanding these strategies to respond to the challenges of changing mitigating measures against COVID-19, and to reaching potentially vaccine hesitant migrants.

Key findings

1. Rather than vaccine hesitancy, unequal access to healthcare information in a language that migrants could understand magnified existing health inequalities among migrant communities in Rome and the Emilia-Romagna region, according to interviews with frontline intercultural mediators.
2. Existing networks of local health authorities and non-profit organisations supporting the Italian COVID-19 vaccination campaign among migrant communities in Rome and the Emilia Romagna region collaborated widely and effectively, leveraging on their existing collaboration, and adapting their strategies for communication and intervention to a rapidly changing context.
3. Advocacy groups supporting access to healthcare in Italy operate across the national health service, local health authorities, civil society organisations, and intercultural mediators; they contributed to communicating health measures to migrants during the pandemic.
 - 3.1 Leveraging existing trust relationships with language communities and extensive knowledge of intercultural mediators was key for local health authorities stretched by a rapidly evolving pandemic context, while operating with fixed budgets.
 - 3.2 The solutions put in place for the COVID-19 emergency are likely to benefit ordinary health service provision for migrant communities, supporting health professionals.
 - 3.3 It is likely that intercultural mediations targeted at specific language communities lowered vaccine hesitancy among those who faced the bureaucratic barriers to accessing the vaccine through the online booking system.
 - 3.4 Many of the successful initiatives described by commissioners of language mediation and intercultural mediators relied on intercultural mediators hired on precarious, fixed-term, and low-paid contracts.

4. Information provided in multiple languages, in multiple formats, including easy-to-read (simplified) Italian, across multiple channels, and targeting specific age groups with their preferred channel and format were determinant factors in establishing trusted channels of communication in the early phases of the pandemic. Local health authorities capitalised on these during the vaccination campaign.
5. It is likely that the combination of vaccine hubs, walk-in/pop-up clinics, and door-to-door information campaigns in Rome and the Emilia-Romagna region bridged some of the health inequality created by the absence of formal, nation-wide language policy to be implemented at local level matching the language needs of local migrant communities.
 - 5.1 It is very likely that vaccine access via pop-up clinics, vaccine buses, and other solutions lowered hesitancy among migrants, as these types of vaccination hubs reduced bureaucratic barriers to access.
 - 5.2 Ease of access to vaccination for those without residency documentation would, however, make it more difficult to track migrants' vaccine uptake and to measure exact impact of culture-, language-, and community-appropriate communication among the migrant communities in Rome and the Emilia-Romagna region. Public health and right to vaccine took priority to reduce community diffusion of SARs-CoV-2.
6. It is necessary to identify indicators to measure the value of language mediation in healthcare settings in support of migrants, in relation to the costs to the health service providers when no language mediation happens or informal language brokering takes place (carried out by family members, child interpreters, untrained bilinguals, etc.). The latter may increase information loss, distrust in institutions, waiting times, and compromise diagnoses and interactions with general practitioners and/or hospital staff.
7. A significant language data gap exists regarding migrants' preferred languages.
 - 7.1 The current support available in major languages spoken by numerically significant communities (from English, Arabic, and French to Pidgin and Urdu) is not sufficient to match the language needs of migrant populations with different levels of literacy and who may speak different variants of the same language (e.g., Nigerian English).
 - 7.2 Better language data in flexible, accessible, and regularly updatable formats, such as language maps, were considered as useful tools by key stakeholders; investing in formal, nation-wide data collection to gauge migrants' 'preferred languages', in addition to 'country of origin' indicators in local and national survey will optimise time and resources among healthcare providers.

5.0 Recommendations

Accurate, timely, and appropriate communication can influence trust in healthcare measures among those with limited Italian proficiency. STRIVE researchers suggest four strategic recommendations, based on practices identified in the report.

1. Co-design guidelines with language service providers, health authorities, civil society organisations, and communities of foreign nationals and migrants to address language needs systematically in Italy.

Engage with migrant communities to influence and shape appropriate and efficient communication with the communities, in collaboration with community members, to understand preferred languages, authentic needs, and target them with community support, that will help set out workable and optimised approaches.

Public institutions should carry out a systematic revision of current policies at central, regional, and local level to accommodate language needs in healthcare settings, as part of the legislative framework regulating equal and equitable access to healthcare in Italy. Enhancing policies about language access can leverage the centrality of the role of language in pursuing equity healthcare, making these policies valid to meet language needs of culturally and linguistically diverse communities in other contexts in which crisis and emergency communication is necessary (e.g., in civil protection, in disaster response). In other words, sharing the networking practices established in the sector, consolidated by the response to the COVID-19 pandemic could benefit all other forms of crisis and emergency risk communication to nationals and non-nationals, from foreign business travellers and tourists to migrants (e.g., fires on ferries, severe weather emergencies, terrorist threats, earthquakes, flooding).

2. Develop networks with culturally and linguistically diverse communities and identify their preferred ways of accessing information. Deliver information in multiple formats, in multiple modes (written, audiovisual, signed, interpreting, intercultural mediation), and via multiple channels of communication to address the intended recipients with the best modes, channels, formats, and languages.

Communication with multilingual migrant communities worked at best when easy-to-read Italian (*italiano semplificato*), translation, interpreting, and intercultural mediation were all adopted.³⁸ Information was disseminated more broadly and effectively when it was provided through multiple channels, in multiple formats, and using multiple modes of translation, with interpersonal relationships playing a role in establishing trust. Translation of information was crucial. However, in a context where regulations and safety procedures changed almost weekly, organisations responded better to rapid changes by combining different modes,

³⁸ See Progetto I.C.A.R.E. *Integration and Community Care for Asylum and Refugees in Emergency*.

including translation, interpreting, and intercultural mediation. The vaccination campaign reached diverse groups in the Emilia Romagna region by diversifying the offer of language support reaching migrants of different ages, education, literacy level, languages, and cultural backgrounds. Appropriate channels of communication and modes of language mediation were matched with known preferences (e.g., Facebook delivery for middle-aged users) and by testing new delivery channels (e.g., Instagram for younger migrant groups). Using appropriate channels does not automatically imply overspending; it could lead to optimised uses of budget, with an increase of reach among migrants.

Keeping up with the changes in mitigating measures was possible because of a flexible and comprehensive approach to language mediation. Actors built on networks that had been nourished over many years by disseminating information in multiple formats, through multiple trusted sources (civil society organisations in Rome held workshops with community members, intercultural mediators from the community, and healthcare personnel to identify preferred channels of communication). In all instances, tailoring modes, channels, and languages to the appropriate groups showing respects for the knowledge of the groups' preferences increased trust, strengthening relationships, and increasing *trust* in the message. Structured and systematic approaches to understand language needs are considered in the evidence-based recommendation but they are also a crucial factor in establishing trust and flexible channels of communication. These practices should be an integrated part of Civil Protection practices; training and exercises for risk reduction could adopt checklists of questions to ensure potential, local language needs are covered when testing emergency plans for crisis and emergency risk communication. Civil Protection activities in Italy are rooted in local territories, embedding language policies in this local knowledge would mean adopting appropriate and cost-effective measures as part of regular training activities.

3. Collect data about languages used by migrants in Italy through systematic, reusable, updatable, and sharable formats. Include language data collection in ISTAT annual surveys of the migrant population to create detailed information on language needs for access by institutions, civil society organisations, and training organisations.

The language gap needs to be addressed. Embedding questions about language preferences in existing regular surveys will keep the demographic data up-to-date and will not require extensive and costly investments in terms of budget, while it will return an instrument that enables targeting language support more effectively.

4. Assess the impact of communication in migrants' preferred languages with large-scale surveys among language communities regionally and nationally.

There is qualitative evidence among the interview participants that the relationship of trust established between healthcare service providers and intercultural mediators working within and with their own language communities influenced vaccine uptake. A large-scale survey among migrant communities is necessary to gather granular data that identifies the impact of language on their access to healthcare and services.

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