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The experience of intercultural mediators in the Italian COVID-19 vaccination campaign

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ABSTRACT

This research investigates the experience of intercultural mediators who worked with local health authorities and civil society organizations to disseminate information about COVID-19 vaccines to migrants in two Italian territories. Interviews with intercultural mediators underlined the challenges that they faced when translating on the frontline of the vaccination campaign, including the translation of highly specialized terminology and the handling of vaccine-hesitant narratives circulating among the migrant population. In the context of COVID-19, translation involved not only transmission between languages, but also a negotiation between medical discourse and the hopes, concerns, fears, and desires of a culturally and linguistically diverse population.

Il presente studio si concentra sull'esperienza dei mediatori culturali che hanno collaborato con aziende sanitarie locali e terzo settore nel corso della campagna vaccinale COVID-19 presso comunità migranti in due regioni italiane. Tramite interviste con mediatori, lo studio mette in luce sfide affrontate dagli stessi nella campagna: quali la gestione della terminologia medica, e la risposta a opinioni avverse al vaccino circolanti presso l'utenza. Lo studio evidenzia come nel contesto sociopolitico della pandemia, l'attività dei mediatori non coinvolgesse solo gli aspetti puramente linguistici della traduzione, ma anche la mediazione fra sapere medico e le opinioni di una popolazione culturalmente e linguisticamente plurale.

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COVID-19; intercultural mediation; crisis translation; migration; multilingual healthcare communication

Introduction

The first paragraph of the World Health Organization's guidelines on 'Communicating Risk in a Public Health Emergency' underlines how 'accurate information provided early, and in languages and channels that people understand, trust and use' (WHO, 2017, p. 1) allows protecting communities in public health emergencies. WHO Europe Regional Offices also published recommendations highlighting the link between the need for 'awareness of cultural contexts' (Napier et al., 2017, p. ix) and the social determinants of health. Language can be considered by all intents and purposes a social determinant of health (Marmot, 2017), since belonging to language groups that do not speak the main language(s) statistically correlates to a higher incidence of certain diseases (Elias et al., 2019; Federici, 2022).

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In 2020, the global spread of COVID-19 made universally apparent the urgent need for multilingual efforts to communicate risks and preventative measures to a variety of communities across and within national states who may otherwise lack access to such vital information (Blumczynski & Wilson, 2023; Piller et al., 2020). Accessible, translated, and understandable messages that were part of the WHO 'Principles for Effective Communications' were put to the test during the COVID-19 pandemic.

The challenges of communicating COVID-related information to multilingual populations intensified when COVID-19 vaccines started distribution. In June 2021, a report from the European Centre for Disease Prevention and Control noted 'evidence of low COVID-19 vaccination rates in some migrant and ethnic minority groups in the EU/EEA', citing both cultural and socio-political factors as causes. The report recommended that medical information be 'translated into key migrant languages and effectively disseminated' (2021, p. 3).

This article relates the results of a study that took place between November 2021 and January 2022, investigating the strategies employed by intercultural mediators working with local health authorities and civil society organizations (CSOs) to disseminate information about COVID-19 vaccines to the migrants in two Italian territories. The study considers how intercultural mediators worked to adapt to the needs of the target population, which very often involved tasks that went beyond the simple relaying of information in a different language.

Contextual background and rationale

Within the context of COVID-19, the health of individuals was affected disproportionately based on socio-economic factors. For Horton (2020, p. 874), 'limiting the harm caused by SARS-CoV-2 [demanded] far greater attention to … socioeconomic inequality' than initially admitted. In this section, we briefly outline how migrants were affected in the Italian context, and the linguistic measures put in place to assist them. We refer to 'migrants' as a shorthand for the populations who were targeted by these measures. Similarly, for ease of discussion, we use the term 'migrant communities' in relation to foreign nationals who share one language and/or a country of origin living in the same territory. We acknowledge that the term *migrant* is problematic (Nese, 2023), as it fails to capture the complexity and variety of experiences of human mobility (Crawley & Skleparis, 2018). Following similar research in healthcare contexts, we use the word 'migrant' to define individuals who 'come from different cultural and health systems and experience a range of migration journeys, resulting in different migrant statuses, levels of entitlement and experiences of health care' (Piacentini et al., 2019, p. 257).

It is crucial to note that the Italian healthcare system is constitutionally committed and obliged to protect the health of residents in its legal territories, regardless of nationality and legal status. The universal access national healthcare system legally defines public health as a public good to be guaranteed (Law 833 of 23 December 1978). The system is based on the principles of *equality* (all citizens have the right to health), *universality* (everybody has the right to access healthcare, as health is intended as a resource for the whole community), *equity* (same access to treatment is to be guaranteed to all). Another crucial point is that since the 1990s reforms of the legal framework devolved the delivery of the national health plan to regional health authorities. The Decree of Law 502 of 23/10/1992 devolved responsibility for delivering free (or financially accessible) health at point of access to 650 units at regional level. Further reforms in 1999 (Decree of Law 229, 19/6/1999), 2001 (Law 154, 30/3/2001), and 2017 (Decree of the Presidency of the Council of Ministers, DCPM, 24/11/2017) emphasized the role of the territorial units in terms of prevention and public health (including vaccination); regional health care; and hospital care. The Decree of Law 286 of 25/7/1998, art.35, par.3c, guarantees foreign nationals' free access to vaccines, as part of national public health campaigns. When COVID-19 hit Italy, there were no legislative barriers preventing migrants from accessing the same health measures available to all other residents of the country.

Nevertheless, public health research underlines how migrants who contracted COVID-19 generally were diagnosed later and more likely to be hospitalized, with a higher risk of death, than Italian nationals (Fabiani et al., 2021). Administrative, cultural, and linguistic factors were listed

among the 'barriers' that could result in unequal healthcare access for migrants and Italian nationals. Da Mosto et al. (2021) and Di Napoli et al. (2022) measured the impact of barriers to access to healthcare in Italy on migrant communities during the COVID-19 pandemic. Within this context, and the heavily localized nature of Italian healthcare, migrant communities are served very differently by local health authorities whose work often recognize the vulnerability of migrant populations and sides with them.

A pilot study on the provision of multilingual information to migrants in Italy during COVID-19 (Laricchia, 2021) revealed that, at national level, the Italian government did not make sufficient provisions to communicate multilingually. Regional devolution meant that local health authorities adopted different approaches to disseminate information about COVID-19, with markedly different provisions. Regions such as Emilia-Romagna provided COVID-related information in as many as 21 languages, while others such as Campania worked in only 4 languages (Laricchia, 2021, pp. 30–31). To some extent, the disparity of offering reflects the distribution of the migrant population in Italy: Emilia-Romagna, for example, was in 2022 the region with the highest percentage of foreign residents (ISTAT, 2022). The two areas covered by our study, the municipality of Rome and Emilia-Romagna, by themselves hosted 20% of foreign residents in Italy, with 516,297 and 562,257 respectively (ISTAT, 2022). As it became apparent during the research, the presence of a great number of CSOs with a focus on migrant integration and migrant health also favoured similar responses in both areas.

On 27 December 2020, the Italian COVID-19 vaccination campaign started. Legally, the local health authorities are responsible for vaccination campaigns, without distinguishing between national and non-national residents. Several local actors stepped in, including local health authorities and CSOs (often working in collaboration), and operated within the context of the COVID-19 vaccination campaign to minimize the risk of exclusion of migrants from the campaign. Researchers have observed high levels of diffidence towards vaccines in migrant communities across Europe for years (Mipatrini et al., 2017), and the same emerged in relation to the COVID-19 vaccine (Crawshaw et al., 2021). Reasons for migrant hesitancy towards the COVID-19 vaccine (Knights et al., 2021) may include lack of trust in local governments and/or health authorities; misconceptions about the vaccine due to cultural beliefs; widespread misinformation; or lack of access to adequate information (Larson, 2020).

Local health authorities involved intercultural mediators to disseminate information. This profession tends to combine translation and interpreting with elements of social work and intercultural communication. The mediator's remit is not always defined, as the profession remains poorly regulated at national level (Filmer & Federici, 2018). The Italian Institute for Public Policy Analysis (INAPP) profiles intercultural mediators under the rubric of *Servizio di mediazione interculturale* (services of intercultural mediation) within the healthcare sector (profile code ADA.19.02.12). INAPP's profiling lists activities and tasks performed, but it does not regulate minimum levels of language proficiency, education, training, or qualifications. Hence, there may be disparities in educational backgrounds and expertise. Intercultural mediators could be trained interpreters, or people with a migrant background who speak Italian and have completed ad-hoc vocational training. Mediators operating in Asian or African languages are more likely to have a migration background themselves, as they work through languages that are locally in demand, but that are absent, or extremely rare, in the Italian education system.

The mediator's role generally differs from that of an interpreter because 'unlike interpreters, intercultural mediators are expected to get involved in conflict prevention and resolution' (Pokorn & Mikolič Južnič, 2020, p. 99). Mediators work in a variety of contexts, from asylum applications to healthcare, with the task of facilitating mutual comprehension between speakers of different languages. This includes forms of sight translation or interpreting, together with planned provision of relevant information about cultural norms and behaviours, and efforts towards conflict avoidance/resolution. A WHO report indicates the mediator's position in a healthcare encounter in Europe as 'impartial/ neutral but with an additional focus on inequity/inequality' adding that their 'explicit mission is patient empowerment and advocacy' (Verrept, 2019, p. 48). With this in

mind, we proceeded to find out how the linguistic and advocacy components of the profession became intertwined in the COVID-19 vaccination campaign.

Literature review

In a crisis, translation may provide crucial information to diverse communities, generating trust in responders and institutions, and countering 'cascading effects' of the crisis that may 'widen existing vulnerabilities or engender new ones by means of miscommunication' (O'Brien & Federici, 2020, p. 131). This is a common occurrence with translation in crisis contexts (Alexander & Pescaroli, 2019). An emerging body of research on COVID-19 has confirmed many findings on crisis translation, including the importance of considering the needs of local multilingual populations, levels of literacy and technological affordances, and existing or new policies (O'Brien et al., 2021).

Studies suggest that COVID-19, due to its novelty and syndemic nature (Mendenhall, 2020), demanded 'creative mediation strategies among actual heterogeneous and dynamic readerships' (Hu, 2022, p. 180). These demands included translating across a variety of languages, styles, and media, often in unprecedented combinations (Gu, 2023), including interpretation, translation, and multilingual/multimedia communication (e.g. information videos on social media).

Challenges individuated by crisis translation research also include the need to handle new concepts and terminology. Interviews with Australian CSOs outlined how they often simplified the language of institutional COVID-19 related material, because target communities found the language too difficult (Karidakis et al., 2022, p. 68).

Multilingual communication in healthcare settings concerns interpreting and translation across a variety of modes (from leaflets to subtitled audiovisual messages delivered on social media channels). Deontologically, healthcare communication should be inclusive by design (Chipman et al., 2023). Communication needs in such contexts can never be considered only 'language barriers', but instead as the result of a 'complex interplay of multi-dimensional markers of difference, in addition to language differences, relating to migratory, ethnicity and socio-demographic variables' (Piacentini et al., 2019, p. 261).

Taibi and Ozolins speak of a 'dual cross-cultural transfer' performed by community translators when they translate both 'between the subculture of public services and that of lay users' and between languages at the same time (2016, p. 39). Research on interpreting and translation between medical professionals and multilingual patients has underlined the challenges that come with this interplay of languages, expertise, and social roles (Montalt, 2022). In short, this literature demands attention to linguistic and cultural challenges that extend the scope of multilingual communication tasks beyond the 'mere' linguistic translation to include cultural and social work.

Working within contexts of linguistic inequality and potential discrimination, interpreters may view the task of explaining a medical term rather than finding an equivalent (if any) in the target language, as part of their general task of facilitating understanding in the target population. In 1998, research carried out among medical professionals and community interpreters in Austria found that both categories saw community interpreting as a 'multi-faceted task beyond "mere translation"', that invested interpreters with labels such as 'explainer', 'cultural mediator', and similar (Pöchhacker, 2000, p. 65). Interpreters interviewed by Angelelli (2004) explained their strategies for dealing with technical terms and 'medicalese', generally by avoiding technicisms in the target language and providing ad-hoc explanations. Lengthier explanations, paraphrases, and even stories (McCabe et al., 2003) are used to ensure a better understanding of specialist medical terms in contexts when 'two languages have very different sets of vocabularies available to discuss medical and health issues' (Ching, 2017, p. 50). This pragmatic approach often results from power imbalances between a dominant language and other languages spoken by minorities or marginalized groups (Coombs & Tachkova, 2023).

Other studies noted that, beyond the linguistic value of such explanations, healthcare providers valued the emotional support provided by interpreters; seeing them as 'more than conduits' and

'active agents in providing culturally appropriate and sensitive care' (Hsieh, 2008, p. 196). This, on the other hand, may create conflicting expectations when healthcare providers expect interpreters to 'summarize information and show empathy' towards patients while interpreters may be bound to impartiality by the code of their professional associations (Crezee & Jülich, 2020, p. 230).

According to Martín and Phelan, mediators tend 'to provide cultural explanations to explain a barrier or perhaps a patient's unwillingness to participate' while interpreters 'usually allow the other participants to sort out a cultural problem by allowing them to ask more questions', only providing 'a cultural explanation as a last resort' (Martín & Phelan, 2011, p. 17). Indeed, while there is 'a considerable overlap' between the roles of interpreters and mediators, 'they also differ significantly, in particular regarding ethical positioning' (Pokorn & Mikolič Južnič, 2020, p. 100).

Angelelli acknowledges that 'co-construction of meaning' is typically part of the healthcare interpreter's task, stressing however that it is important that 'every party to the conversation stays within the expected role' to avoid unpredictable outcomes (2018, p. 132). Conversely, a recent Italian training manual, influenced by practices of local health authorities in Rome (Vercillo et al., 2019), indicates a range of possibilities for the mediator's role in a medical encounter. They range from being mere translators to serving as cultural interpreters and even co-therapists; provided that both the mediator and the medical professionals involved have received adequate training. Studies conducted in Southern Italy since 2015 define *mediatori* as an activist community of practice (Taviano, 2020) invested in the '*politics of hospitality* and an *ethics of hospitality* which are contingent upon local practices' of hosting (Taronna, 2016, p. 297, author's emphasis). Given the regulatory uncertainty surrounding the profession (see above) this definition may apply variably to different mediators.

In summary, an international body of research identifies key challenges when mediating a healthcare encounter. These challenges relate to the relaying of complex medical concepts and terms across gaps that may be linguistic, cultural, and socio-economic at once. Researchers often identify situations in which interpreters or mediators are called on to explain, rephrase, or negotiate within the space of the encounter. Based on their respective deontological tenets, interpreters and mediators have different ethical approaches to such challenges, even if there is significant overlap in concrete between their respective tasks.

Materials and methods

The study took place within the context of the STRIVE project (Sustainable Translations to Reduce Inequalities and Vaccination hEsitancy), funded by British Academy. The project intended to ascertain to what extent multilingual communication (or the lack thereof) could influence vaccine hesitancy among migrants living in Italy; and what was the role of translators, interpreters, and intercultural mediators in providing access to information about the COVID19 vaccine. It was housed at UCL in partnership with Università di Bologna-Forlì and focused on two highly diverse areas of Italy, the metropolitan area of Rome and the Emilia-Romagna region.

STRIVE combined quantitative and qualitative methods, including a multilingual questionnaire based on the vaccination hesitancy (VAX) scale (Martin & Petrie, 2017), maps of distribution of languages spoken by migrants in the two areas, and an interview-based study. This article relates the results of the latter, which consisted in semi-structured interviews to investigate the role and challenges of intercultural mediators in the vaccination campaign. It builds on recent research where interviews have yielded significant results in assessing NGO's translation strategies, and attitudes towards the political/ethical dimension of translation (Footitt et al., 2020; Tesseur, 2023).

The study was approved by UCL's Ethics Committee (approval no. 6625/009). Researchers contacted approximately 40 entities that have different roles in supporting migrants in the vaccination campaign, including both local health authorities and CSOs. The team mainly targeted CSOs that support migrants' health and/or work at the intersection of advocacy and healthcare; occasionally including organizations that play broader advocacy roles to support migrants' rights. Initial contact

was made through phone/email in November 2021. After initial contact, nine entities agreed to organize interviews with their staff members.

Within each organization, the research team endeavoured to recruit participants, whenever possible, to form two groups. The first included intercultural mediators (for short, 'Mediators'). The second included individuals with a working relationship with the 'Mediators', including administrative personnel, social workers, and medical personnel (for short, 'Commissioners'). For anonymity, participants were assigned an identifier starting with 'P' followed by a number indicating the chronological order of the interview. Interviews mostly took place online (P22 was interviewed in person) between 24/11/2021 and 26/1/2022. Of the total number of participants, 21 interviewees were based in Rome, while 12 were based in Emilia-Romagna (Bologna, Modena, Forlì, Parma). In terms of participant groups, 11 interviewees were commissioners, while 22 interviewees were mediators. They all provided informed consent to being included in the study.

Interviews were carried out by Ciribuco and by four research assistants. Questions were partially adapted from O'Brien et al. (2021), and researchers were instructed to stress any topic that they deemed relevant to the vaccination campaign in their follow-up questions. The interviews were audio-recorded and then transcribed. Successively, transcriptions were coded using NVivo 12, with nodes concerning: awareness of the linguistic needs of target population; accountability and responsibility-sharing for translation; mechanisms for handling medical terminology; mediators' standing within the target community; and handling of 'fake news' concerning the COVID-19 vaccine. Based on language maps, and interviews with the 'Commissioners' groups, we evaluated organizational strategies for multilingual communication, providing practical recommendations to institutions and CSOs (Federici et al., 2022). Here we draw on interviews with 'Mediators' to investigate the challenges they faced during the vaccination campaign, and the impact on their self-perception as multilingual professionals.

Results

The scope of the mediators' task

Organizations collated information from governmental briefings and memos, released in Italian, and in written format. Then, they endeavoured to communicate and circulate the information in the languages and formats that they deemed most appropriate based on their knowledge of each area. They operated in multiple contexts, from healthcare settings (hospitals, vaccination centres, mobile clinics) to refugee reception centres, informal settlements (i.e. buildings in Rome where asylum seekers have taken up residence without being recognized by the city council), and a prison (in Bologna). These settings represented the ordinary remits, contexts, or jurisdictions of each organization whose participants were interviewed. Hence, their rapid appraisal of local language needs also determined the languages in which they operated to disseminate information about the vaccine.

The mediators interviewed mention 23 languages as their working languages. These included international lingua francas such as English (Pidgin is sometimes mentioned as a variety of English, and sometimes as a separate language), French, Arabic; and languages of numerically relevant communities in Italy: Romanian, Albanian, Tagalog, Bangla. Some languages (Wolof, Bambara, Amharic) were present even if these nationalities are not numerically as relevant in Italy; however, they were found in refugee reception centres or informal settlements. Some mediators also use additional African languages, which they did not name explicitly but indicate as 'dialects'.

Mediators provided a variety of services ranging from the translation of information leaflets; oral interpretation in clinical settings such as mobile clinics and vaccination centres; assisting medical personnel presenting the vaccine to target populations; multilingual videos disseminating basic vaccine-related information and messages via social media; and helping patients navigate the online vaccination booking system. Very often, mediators provided two or more of these services at once.

The mediator-doctor nexus

To carry out their tasks, the mediators needed to collaborate closely with a network of doctors, nurses, social workers, and administrative personnel. They relied on health authorities and medical personnel for their source material, as well as for medical knowledge and expertize in responding to patients' questions and concerns about vaccination. Given the novelty of the disease (and consequently of the vaccine), it was vital to have access to trusted and up-to-date information.

During the vaccination campaign, the key source of information consisted of written material on the COVID-19 vaccine provided by the Italian Ministry of Health. Most organizations forwarded this material to the mediators via email; in some cases, CSOs also provided supplementary material (for example, P15 received a list of about forty frequently asked questions).

Many organizations also set up in-person meetings between mediators and medical personnel. Meetings often provided the organizations with first-hand insight into the communities (Federici et al., 2022, p. 24). Mediators could report to the doctors the types of concerns and the factors of vaccine hesitancy that they encountered within their language communities: these interactions also enhanced the medical personnel's understanding of the language- and culture-specific needs of different language groups. In turn, the ensuing discussions better equipped the mediators to respond to key queries from their target population. In some cases, the mediators discussed their own vaccine hesitancy. P1, a project manager from a Rome-based CSO, reports that mediators 'sometimes were the first to be [vaccine] hesitant' (interviews were held in Italian and translated into English by the authors).

'Fake news'

Generally, the mediators' main task was translating information which came from official documents or medical personnel. They sometimes frame this task in opposition to the task of convincing individuals to take up vaccination, which they emphasize was not their goal:

> P15: We do not force people: 'Come Ahmed or Mohamed or Ali or Omar, come get vaccinated'. Absolutely not, this is not our job. Provide information against rumours, the things that you hear around, like, the vaccine changes your DNA, the vaccine is not for pregnant women, things like that.

> P31: I translate for the doctor, the doctor gives the information to the user. Yes, as I said, I don't convince anyone to get vaccinated or not, because it's not my job.

At the same time, as is evident from P15's answer, some interviewees often interpret their task of relaying accurate medical information in opposition to contrasting discourses about the vaccine and its supposed side-effects that circulated among migrant communities. P15 refers to concerns about the safety of vaccines during pregnancy, while P18 mentions infertility concerns, which have been observed elsewhere as a factor of COVID-19 vaccine hesitancy (Naqvi et al., 2022). Mediators report that African patients often would speak of COVID-19 as a 'Westerners' disease' (P32).

The English expressions 'rumours' and 'fake news' recur in the commissioners' interviews (P1, P19, P20) and in the mediators' interviews (P2, P15, P27). P23 talks about 'rumours' in relation to target populations' fear and resistance, stating that their job in public encounters between a CSO and Rome-based Bangladeshi communities included 'dispelling various rumours'.

P31, quoted above denying that the mediator's job includes 'convincing' anyone to get vaccinated, in the same exchange talks about working in collaboration with social workers to 'fight' misconceptions about the vaccine:

> P31: I also tell the social worker: 'Let's try to find a way to help this lady overcome the thoughts she has regarding this vaccine'. If she wants to get vaccinated she will, otherwise not – we don't force anybody.

In their responses, the mediators stress that their task was guided by objectivity and impartiality; at the same time, they side with the CSOs or local health authorities in the fight against

'fake news'. Interestingly (especially in the light of P1's comments on vaccine hesitancy among mediators, reported above), no interviewee explicitly calls into question the validity of COVID-19 vaccines within the context of the interview. One participant lamented experiencing non-specified side effects of the vaccine, which they claim made them doubtful about a fourth dose.

Medical terminology and knowledge

From a linguistic point of view, COVID-19 required the use of a specific (and sometimes, new) medical terminology by an increasingly greater number of individuals. Mediators had to navigate this challenge in their work in several ways, depending on the target language resources (and their perceptions of the literacy levels of their target language population).

Collaboration with medical personnel was key. Within P16's organization, doctors would help mediators tailor translations to the audience:

> P16: Because of this difficulty you have to discuss, they must explain well what it is about, what this word is about, what is the target we're getting at. So to get to that point we explain to people in this way. So we write in a way that people understand, it's not like we go word for word but it's about how they can understand this thing.

P15, who often resorted to doctors' explanations, talks about the challenge of rendering Italian medical terms into an adequate register of Arabic, that would not be too difficult to understand, nor too simplistic.

P4, working into Tigrinya and Amharic, states that the need to adapt to different cultural norms often led them to avoid 'technical terms' (they do not mention specific terms in their answer). P4 reports that in their work, they strived to stay 'faithful' to the text while privileging 'clarity' to 'reach' the target. This type of difficulty was particularly apparent in the words of mediators working in African languages. P2, working mainly through Bambara, describes the difficulties of explaining COVID-19 to their target population:

> P2: COVID is something we don't know in Africa and there's a lot of words to explain something, you need five minutes to explain a single word and then, for COVID, you would start from something that looks like COVID, from symptoms like fever or cough.

The apparent 'lack' of medical terminology in the target languages is a common theme among interviewees working with Western African communities (Mali, Senegal, Ghana). P29 reports for example that they could not find the Bambara equivalent of some key terms: they give the example of sanitizer, which they often explained as a type of 'specialized soap'. Interviewees also would link these lexical challenges to the educational background and literacy skills of their target populations. They report turning to other mediators in their social networks to exchange terminological tips and translation strategies.

Challenges were not experienced in the same way across different languages. For example, a participant working with Spanish speaking communities (P27) noted how the similarities between the two languages helped understanding even medical terms, which are heavily Latin- or Greek-influenced in both Italian and Spanish.

Difficulties in understanding did not only invest the terminology, but also medical procedures and rationale for those procedures: for example, P17 discusses having to explain that for some types of vaccines (Johnson & Johnson) only one shot was needed, while others needed two. In this context, mediators were not only tasked with explaining, but also with collecting feedback and requests for more information:

> P23: So we met the communities and asked them what they wanted to learn more about, what aspects of health. And maybe from the community we got feedback that they wanted to know more about vaccines, Green Pass, doses, no doses, then our Health Promoter organized a meeting with that community.

The mediators appear more aware of knowledge gaps and health-related concerns among migrants than the healthcare professionals, and were able to escalate those concerns to the CSOs they worked with.

The mediator as bodily presence

As Italy implemented lockdown measures in March 2020 to prevent the spread of SARS CoV-2, the work of mediators increasingly relied, like several other professions, on communication technology. P5 describes a situation where non-medical personnel could not enter medical settings and had to rely on video call software. P5 mentions some initial difficulties in the switch to remote mediation, in terms of mastering tools and handling the turns in the conversation.

While one participant (P6) expressed appreciation for remote intercultural mediation via video call, as this spared a commute, most stated their preference for in-person mediation. Interviewees often stressed the importance of the mediator's physical presence in the setting of intervention. P17 maintains that in-person mediation works particularly well with low-literacy patients, who have issues reading forms and information material that they may receive at a clinic. More often, mediators mention how their physical presence helps the patient feel safe. P22 notes how often patients require P22's presence in medical consultations even if they speak Italian, so that they can rely on P22 if needed.

P7's narrative on convincing vaccine-hesitant migrants stresses that their intervention starts 'in the streets' and leads to the mediator 'accompanying' the migrants to vaccination centres:

> P7: It's about being there, create a relation of trust with these guys and [inaudible] regarding vaccine it was useful. Thanks to our intervention, the work we did in the street, they got vaccinated, we accompanied many of them to get vaccinated.

P21 also remarks on the importance of physical presence, underlining how the presence of Tigrinya-speaking mediators in an informal settlement in Rome induced behaviour changes among Eritrean residents.

The importance of the intercultural mediator as a 'friendly face' appears to have generated instances in which they found themselves carrying out tasks that were beyond the remit of translating information about the vaccine. In some cases, mediators (P17, P23) stress that their role entailed practical help in removing bureaucratic hurdles. For example, they helped fill in forms required to access vaccination or obtain the digital certificate (known in Italy as 'Green Pass') to access workplaces and public transportation. P15 speaks with pride of being responsible for exactly 192 individuals receiving their Green Pass.

Sometimes the mediators were involved in conversations about the efficacy and/or side effects of vaccines. Patients for example would ask P31 if they were vaccinated:

> P31: What can I say? I say: 'I'm vaccinated'. And maybe, I don't know, maybe someone thought 'If the translator who comes from my country, or a nearby country, is like me, if she got vaccinated maybe I can too'. I don't know.

P18 recounts being involved in a similar conversation, where P18 advised a couple to get vaccinated, so that the man would not lose his job due to the restrictions in place in 2021. The following day, one of the patients contacted P18 to report a loss of eyesight. The mediator offered to call an ophthalmologist for him if the symptoms persisted – which was not the case. This appears to be the only case in the interviews where a mediator was explicitly asked for a medical opinion.

Discussion

The interviews underline how intercultural mediators faced several of the challenges identified by researchers in healthcare interpreting before COVID-19. They confirm the urgency of coordinated

efforts to consider language and culture as key factors to support healthcare provision, as noted by Napier and colleagues: 'Our experiences of health and well-being are fundamentally influenced by the cultural contexts from which we make meaning' (2017, p. xi). The interviews show how some of these challenges of making meaning of the available healthcare provision intensified in the syndemic context.

Challenges include, for example, the need to rephrase specialist knowledge into accessible language(s), without loss of meaning, while all languages were grappling with specialist terminology that may have been used for decades in medical domains but had not circulated in general language. COVID-19 'forced us all to learn a new language' that 'propagated at remarkable speed' and evolved so rapidly as to make terminology obsolete in a matter of weeks (Garrigou-Kempton, 2023, p. 91). P2 and P29 especially report terminological challenges when working in Bambara, while mediators working through *lingua francas* (see P27) tended to downplay terminological challenges. The explanation for this difference may lie in the different sociolinguistic status of Bambara and Spanish in Europe, and the different availability of medical terminology in each language (Ching, 2017; Federici et al., 2022, p. 24). This is however only part of the issue: differences in medical knowledge, literacy, ideology, and expectations about the medical encounter play a crucial role. In fact, Taibi and Ozolins (2016, p. 39) emphasize that encounters between lay persons and medical professionals 'involve two distinct subcultures (sets of beliefs, expectations and values)' and when the two have very different linguistic repertoires 'there is an *additional dimension* of cultural difference and intercultural communication' our emphasis. Language is only one of many factors at play.

P2 and P29's answers are particularly relevant to this debate, because they frame the need to come up with adequate explanations as a search for terminology that happens in conjunction with a lack of familiarity with medical professionals and certain ideologies ('a white person's disease', P29).

Participants appear acutely aware of the sociolinguistic profile, literacy levels, and personal trajectories of the people they worked with. Their experience (including personal experience as migrants themselves) made mediators attuned to the needs of their target populations, which influenced their approach to the work of mediating. P2 speaks of taking the time to explain complex concepts ('five minutes to explain a single word') and guiding patients towards understanding ('starting' from description of symptoms to 'get' understanding). P23 describes a situation where mediators would take time to listen to migrants' concerns, with the idea that those concerns would be reported to healthcare professionals and inform future engagements. In the fast-paced environment of the COVID-19 crisis, it is remarkable how often the mediators' answers underline the need to take time to build a conversation with doctors and target populations to ensure the latter's understanding. These approaches are reminiscent of what Cronin terms the 'slow language' ideal of 'ecological necessity of time, care and attentiveness in doing justice in translation' in an age that promises quick, disembodied translation via technological means (Cronin, 2017, p. 63).

In terms of the mediators' ethical stance, the findings of the STRIVE project generally seem to corroborate the aspects of advocacy and empathy of their job, in terms of going somewhat 'beyond' translation and 'ensuring comprehension/understanding of messages exchanged between care provider and patient' (Verrept, 2019, p. 48). If the answers discussed above testify to the importance of cultural awareness and empathy in their work, another important theme is that of physical presence. Most participants stress the importance of their bodily presence in vaccination hubs, as paperwork facilitators or 'friendly faces'. Their answers often delineate scenarios and narratives in which the physical presence of the mediator makes it possible to interact with target populations in settings that are hard to reach (such as informal settlements). P7 talks of the importance of 'frequentare' (*frequenting*) the areas where migrants are, building rapport with their users over time. In these settings, a mediator can rely on social and cultural capital that derives from a combination of linguistic repertoire, training, political conscience, and – often – being themselves a recognizable member of the migrant community.

Taronna (2016, p. 296) observes that 'having been a migrant […] gives the mediator an understanding of both the psychological and the practical difficulties' experienced by migrants, which can generate greater empathy but also greater pressure and expectations coming from users. Hence, the physical and visible presence of mediators is another aspect that differentiates between mediating and interpreting. This is not because interpreters are disembodied entities whose physical presence does not make a difference, as researchers have effectively disproved (Boéri, 2023); in fact, some mediators were trained interpreters too. As our participants' answers denote, on-site presence becomes important in virtue of the socio-political stakes that mediators are willing to assume. Drawing from one's presence in the field to advocate, reassure, guide, explain, casts mediators in the position to use their bodies as tools of the trade, enabling them to act as points of contact. Mediators with a background of migration, the overwhelming majority of our participants, became recognizable for both users and medical personnel alike, positioning them visually and politically between the world of migrants and that of institutions.

This type of personal relation and on-site emphasis formed part of the mediator's work since before the pandemic (P21 refers to relations with target community starting in 2007). COVID-19, however, seems to have introduced a different layer to the conversation and its relevance on the public sphere. During the vaccination campaign, not only did the (vaccinated or non-vaccinated) body of the mediator become part of the interaction between medical staff and migrants, but also part of the debate on migrants' vaccine hesitancy that was internal to the organizations where they worked. Interviewees were aware of discourses circulating among migrants, as well as of their role in opposition to these discourses. Comments by P15, P31 and others, indicate that they had a clear opposition in mind between the texts that they translated and the 'fake news' that some patients believe.

There is an apparent contradiction (evident especially in P15 and P31's comments) between the mediators' claims that they did *not* intend to convince anyone to get vaccinated, and their avowed goal of countering negative views of the vaccine. This happened both as planned involvement in vaccination campaigns (P5) and as unplanned outcome of conversations between individual migrants and members of the medical staff (P18, P31). In the latter case, interviewees describe the mention of their own vaccination choices into the conversation with some uneasiness. As P31 admits, it was also impossible for them to ascertain whether this type of first-person involvement had a decisive effect in convincing migrants to get the COVID-19 vaccine.

Conclusion

The participants' narratives testify to how, within the context of COVID-19, 'viewing communities as "targets" at which information or instruction is to be "fired" causes (understandable) confusion, resentment and rejection' (Blumczynski & Wilson, 2023, p. 5). In the context of a crisis as widespread as COVID-19, with its socio-political implications, the work of translation needs to be contextualized within the wider negotiation between medical discourse and the concerns and needs of different populations. Recent developments in the debate on medical knowledge translation point to the necessity to rethink the communication of medical knowledge as the re-contextualization of an 'original scientific message, which is assumed to have universal validity, independent of the contexts and textual genres in which it is produced' into a new text (Engebretsen et al., 2020). Rather, medical knowledge translation may imply a political dimension 'because it serves an instrumental purpose that often goes far beyond what the knowledge was originally meant for' and 'does at times produce demands that challenge established hegemonies' (Sadler et al., 2024, p. 164). Within emerging contacts between medical humanities and translation studies, our analysis of the ethical stance of intercultural mediators has the potential to study such connections on the ground, through the eyes of individuals who were tasked with linguistic operations of translation that were *also* the transmission of medical knowledge, and that cast them in a politically relevant position.

Mediators in our study found themselves researching medical terminology to fill in gaps in the information they received; discussing strategies for intervention with medical authorities and CSOs; removing bureaucratic hurdles; acting as facilitators in vaccination hubs; acting (willingly or not) as testimonials for the vaccine in the fight against 'fake news'.

Mediators were performing tasks that can be subsumed as political advocacy for (largely voiceless) migrants. It is important to note that mediators also pro-actively worked within institutions before and after COVID-19, changing institutional practices. The intercultural mediators' voices through their interviews allude to the potential of being disruptive from within, which could lead to long-term changes. They advocated and pursued more accessible forms of healthcare communication. They also pursued some independence (while following their code of conduct) as actors of changing social interactions. The apparent dichotomy between their claim to impartiality in translation, and their investment in fighting 'fake news' may be read through this peculiar position of advocates *within* institutions, who defended the migrants' perspective while operating within a chain of command that clearly followed the organizations' mission: namely, that of ensuring migrant access to healthcare.

Guidance and advocacy were often included in the mediators' job description before the pandemic: according to the interviewees, their previous experience prepared them to have the necessary flexibility to work with medical personnel in the COVID-19 vaccination campaign. Mediators stress the importance of physical presence in the field, enabling not only flexibility in linguistic support (for example, by reading a document aloud to someone who cannot read), but also emotional support to the individuals that they worked with. Translation scholarship has recently increased its focus on material interplay of people, spaces and objects (Ciribuco & O'Connor, 2022), thus making it paramount to reflect on the bodily presence of the translators, interpreters, and intercultural mediators and how such presence permeates interactions and potentially alters dynamics between them and the linguistic/social communities that they serve.

Because of the limitations of the study (involving mediators and their commissioners but not patients), we do not know how the target populations experienced the campaign. Further STRIVE research considers the perspective of service users, to understand how the messages were received by migrants in Rome.

In conclusion, we would like to note that at the time of our interviews in 2021/22, many mediator participants were at the end of their precarious contracts. They were likely to continue their work in other healthcare sectors (mental health, for example), or to abandon the field of healthcare altogether, which may have already happened – causing the dispersal of accumulated know-how. Given the crucial importance of preparedness for disaster prevention and response (O'Brien & Federici, 2020), it is imperative to expand our understanding of the work of mediators in COVID-19 beyond the limited scope of this study. Knowing the challenges, they encountered, and advocating for translation funding in a pre-emptive (rather than responsive) manner, is key to building preparedness.

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