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## **Learning dynamics between cultural mediators in humanitarian healthcare: A case study**

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### **ABSTRACT**

This contribution explores the nature of the learning and learning relationships that have emerged between cultural mediators who have been working for the Italian NGO Emergency ONG *Onlus* at its Castel Volturno outpatient clinic since 2015. The contribution is part of an ongoing qualitative research study based on semi-structured interviews and ethnographic observations. By drawing on Engeström's (1987) theory of expansive learning and Lave and Wenger's (1991) theory of situated learning, the article questions traditional approaches to learning and notions of what constitutes an appropriate learning environment in this context. The findings show that the cultural mediators forge a community of practice that helps them construct and implement a new learning concept for their collective activity through learning by doing. This community of practice is pivotal for the work of the organisation as a whole, as it makes extensive use of languages and cultural mediation to provide guidance and mutual assistance and to contribute to the overall attainment of the organisation's humanitarian goals.

### **KEYWORDS**

(Inter)cultural mediators, *Programma Italia*, Emergency ONG *Onlus*, community of practice, situated learning, expansive learning.

## **1. Introduction**

Recent decades have witnessed an increase in the number of displaced people, forced to flee their homes because of conflict and persecution, poverty and/or environmental degradation (UNHCR n.d.). Given that many migrants and refugees are displaced to countries with different languages and cultures to their country of origin, and since many healthcare providers do not speak their language nor share their culture, the use of interpreting and cultural mediation services has necessarily increased to overcome communication barriers (Hsieh 2016). As a public health intervention instrument, interpreting and cultural mediation, on the one hand, can effectively encourage and support much-needed behavioural changes, helping to prevent and reduce the development of health problems; on the other hand, the provision of quality services is relevant to both the integration of the patient into the local health system and the explanation of health-related notions that have a direct impact on the patient's wellbeing. Building trust between healthcare providers and patients through shared knowledge is a crucial factor in ensuring patients acknowledge the correct diagnosis and treatment of diseases and conditions (Greenhalgh *et al.* 2006).

In contrast to debates on the role of interpreters in institutional healthcare settings, much less has been written on cultural mediation in medical non-governmental organisations (NGOs) on the front line in countries hosting

refugees and migrants. Noteworthy studies have, however, been carried out: Alexakis *et al.* (2017) examine the role of interpreters who worked with emergency medical and psychological teams from MSF (*Médecins sans frontières*, Doctors without Borders) during a refugee mass-gathering incident in Greece, focusing on the stressful conditions in which the medical team and the interpreters performed their work. Loutan *et al.* (1999) and Holmgren *et al.* (2003) explore the psychological stress of humanitarian interpreters working for the Geneva Red Cross and the Danish Red Cross, respectively. Filmer and Federici (2018) and Filmer (2019) investigate language and cultural mediation practices in Eastern Sicily through narrations from intercultural mediators, NGO operators, reception centres and migrants within the context of the ongoing migratory phenomenon. Merlini (2015) highlights the mediator's role as a provider of language support during medical interviews, with positive outcomes for both clients involved, while Rudvin and Carfagnini (2020) stress the need for interpreters and mediators to become aware of the dangers of empathic bonding in terms of vicarious trauma, although they acknowledge the added value that cognitive and emotional empathy can bring to a mediator's toolkit. Even within this limited body of literature, there are still fewer studies that examine how interpreters and cultural mediators working for development and medical NGOs in the aid chain develop their skills in the workplace (Delgado Luchner and Kherbiche 2019; Sanz Martins 2018; Tesseur 2018, 2019).

Against this backdrop, the object of inquiry in the present article concerns the nature of learning and the relationships of learning between cultural mediators working for the medical NGO Emergency ONG *Onlus*<sup>1</sup>, more specifically at the Castel Volturno outpatient clinic. We draw on data stemming from an ongoing case study<sup>2</sup> that investigates the particular context in which cultural mediators operate and the impact that this context has on their work.

We aim to make two key contributions. Firstly, we aim to question traditional forms of vertical learning, specifically providing further evidence of the situated nature of learning that leads to the appropriateness of a horizontal or sideways approach to learning. Secondly, we aim to highlight the difficulty of adopting a traditional approach to learning in the field of humanitarian healthcare given the particularities of each context and the impact it has on the work undertaken by interpreters and cultural mediators.

## **2. *Programma Italia* and Emergency ONG *Onlus***

The Milan-based NGO Emergency ONG *Onlus* (hereinafter referred to as "Emergency") is an independent humanitarian NGO that provides free medical and surgical treatment to civilian victims of war, landmines and poverty, and promotes a culture of peace, solidarity and respect for human rights. It has active projects in Italy and a number of countries worldwide

(Afghanistan, Central African Republic, Eritrea, Iraq, Sierra Leone, Sudan and Uganda). In Italy, Emergency has been running operations since 2006 within the framework of *Programma Italia*, which implements humanitarian projects in areas where the basic health needs of large vulnerable groups are not met (Bellardinelli 2017).

Emergency provides its services in a number of settings: outpatient clinics, mobile clinics (known as *Polibuses* and *Politrucks*) and mobile units. Patients applying to Emergency's outpatient clinics receive both general and specialist medical treatment, as well as nursing, psychological support and health education. They are also advised by cultural mediators on how to gain access to the national healthcare system, and on their rights and how to assert them. *Polibuses* and *Politrucks* travel within agricultural areas, marginalised urban districts, territories hit by disasters and refugee reception centres, all of which are characterised by scarce services and poor public healthcare facilities.

The tasks of Emergency's cultural mediators are well exemplified in Castel Volturno, Caserta, Southern Italy, where the NGO has been present with a mobile unit since 2013 and an outpatient clinic since 2015. Castel Volturno is one of the areas with the highest number of migrants in Italy, many of whom face daily difficulties in accessing healthcare. The vast majority of the patients treated at Emergency's outpatient clinic are migrants. Reports by the International Organization for Migration (IOM 2010) and the Study and Research Centre of Caritas Italy (Caritas and Fondazione Migrantes 2017) estimate that people without Italian citizenship represent a third of the resident population. However, unofficial figures indicate a larger number of individuals without an official residency permit living in the area.

The area is characterised by social exclusion, crime, and environmental and urban degradation, which place it among the most complex and sensitive areas in Italy. The absence of town planning regulations has led to a massive increase in unauthorised construction on coastal and forest land owned by the Italian state (Legambiente 2020). Degraded dwellings originally built as holiday homes have, in parts, been abandoned by their owners and paved the way for the settling of seasonal or illegal migrant workers (D'Ascenzo 2014). In addition, Castel Volturno gradually became a destination for migrants who reached Italy by sea, landing at Southern Italian ports. In recent years, the number of African migrants has increased, with a prevalence of Ghanaian and Nigerian citizens. Furthermore, since the 1980s, organised crime groups within African communities have developed and established ties with the local *Camorra*, i.e. the Italian *Mafia*-type criminal organisation originating in the area of Naples and the region of Campania, where Castel Volturno is located (Bernardotti 2005).

Cultural mediators are only employed by Emergency for operations carried out for projects within *Programma Italia*. No job positions as cultural mediators are offered for projects outside Italy, as language needs in war-

torn and humanitarian contexts in other countries are often addressed by the use of a *lingua franca* or through bilingual personnel acting as *ad hoc* language and cultural brokers. Employment of cultural mediators at Emergency takes place only if needed and never based on a centrally defined recruitment policy<sup>3</sup>. The term *mediatori culturali*, indicated in the job description for *Programma Italia* positions, is a clear reference to the cultural component inherent to all tasks performed by such professionals, thereby highlighting the greater importance that the organisation attaches to the mediators' role as cultural brokers. This stance finds confirmation in literature on dialogue interpreting and mediation: as Pöchhacker (2008) points out, studies on public service interpreting have highlighted that mediation concerns both language and culture. Wadensjö (1998: 75) also shows that interpreters "cannot avoid functioning as intercultural mediators", as interpreting makes it possible to identify non-linguistic features and differences between people, such as differences in worldview. Recent research has confirmed that the cultural work of interpreters working in complex healthcare settings is as relevant as the linguistic aspects, thereby showing that intercultural mediation is essential for healthcare organisations to provide culturally competent care to migrants (Souza 2016). In the Italian context, most healthcare institutions seem to prefer employing intercultural mediators rather than professional interpreters, as the former are presumed to be more competent in dealing with the potential cultural differences between Italian healthcare providers and their migrant patients.

In fact, several studies have shown that healthcare workers wish for interpreters to have an additional role as cultural mediators (Kale and Syed 2010) and as advisors, compensating the disadvantageous position in which some patients find themselves due to asymmetrical relations. Some interpreters come from the same country as the patients, while others share the same vehicular language as the patients but not the same native language. In their study, Gavioli and Baraldi (2011) conclude that, in the healthcare settings that they analysed, there was a preference for working with interpreters who came from the immigrant community rather than from the host country. Interpreters recruited by the United Nations High Commissioner for Refugees (UNHCR) are also often found to belong to the same country as the migrants for whom they interpret: in their study on the role of humanitarian interpreters, Delgado Luchner and Kherbiche (2018) analyse the interpreter's positionality in both the UNHCR and the International Committee of the Red Cross (ICRC). Interpreters working for the latter tend to be "mobile" or expatriate, which means that they are outsiders to the community in which they work, although there are also field officers who do belong to the community. In the case of the former organisation, interpreters tend to be members of the community in conflict. Similarly, MSF extensively recruits interpreters who share the same cultural background as the patients and who are considered not to be a mere conduit, but rather cultural mediators and even co-therapists (Tijerino 2018).

Interestingly, the interpreters/cultural mediators in these settings are usually recruited because they speak the language and share the culture of the migrants and refugees and not because they have received previous training in interpreting or cultural mediation. The cultural mediators working for Emergency are no exception. However, even if their lack of training makes them, in principle, unaware of professional standards and competences in interpreting, they learn by doing through the development of and participation in a community of practice. In this community, they are able to identify the skills to be learned and then acquire them on their own initiative. Drawing on Engeström's (1987) theory of expansive learning, as well as Lave and Wenger's (1991) concept of "community of practice"<sup>4</sup>, it is our belief that the collaborative approach to work of cultural mediators at Emergency allowed them to learn the different skills and tasks as they were being created. In this respect, this paper represents an attempt to account for the situated nature of learning in interpreting in vulnerable settings.

### **3. Situated learning and expansive learning**

Theories of situated learning (Lave and Wenger 1991) highlight the need to create a well-bounded community of practice (CoP; plural CoPs) in which learning stems from participation in culturally valued collaborative activities. A CoP is defined by Wenger *et al.* (2002: 4) as a group of people: "who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis."

According to these theories, newcomers engage in a practice that has developed over time with the aim of gaining competence. They do so by understanding and participating in the practice, while having a stake in its development as they begin to establish their own identity; they eventually become full members of the community in which the practice exists. As an aspect of social practice, learning involves the whole person; it implies not only a relation to specific activities, but a relation to social communities. Activities, tasks, functions and understandings do not exist in isolation but are part of broader systems of relations in which they have meaning. Lave and Wenger (1991) coined the term "legitimate peripheral participation", a view of "learning as participation by which newcomers adopt a group's ways, moving from periphery to the centre of a practice" (Consalvo *et al.* 2015: 1). This kind of participation is particularly prevalent in the workplace. Hodkinson and Hodkinson (2004) highlight the spontaneous nature of communities of practice and consider them as a process rather than an entity than can be simply set up.

These theories of learning assume that individuals learn skills pertaining to a relatively stable and reasonably well-defined practice. Learning is mainly depicted as a vertical process whose objective is to elevate individuals upward to higher levels of competence. Similarly, it is assumed that the

assignment of knowledge creation is unproblematic because what is learned is a management decision that lies outside the bounds of the local process. However, individuals also learn things that are not stable or not even defined ahead of time by those who design, manage and implement; we are always learning new forms of incipient activity “as they are being created” (Engeström 2001: 138). Engeström’s (1987) theory of expansive learning is premised on the notion of “horizontal learning”, according to which learners are directly involved in constructing and building a new object and concept for their activity.

The theory of expansive learning builds on ideas stemming from the cultural-historical activity theory initiated by Vygotsky (1978), particularly on his concept of the zone of proximal development<sup>5</sup>, and further developed by Leont’ev (1981). There are different principles that summarise the essence of activity theory. The prime unit of analysis is the collective activity system, a community of different points of view, traditions and interests that takes shape and transforms over lengthy periods of time. Additionally, contradictions, as evolving tensions, play a central role as a source of development and transformation (Il’enkov 1982). There is also the possibility to carry out expansive transformations in activity systems: as contradictions are aggravated, some individuals deviate from the established norms, ultimately redesigning the activity and envisaging more possibilities than in the previous iteration.

Expansive learning theory is also inspired by Bakhtin’s (1987) concept of heteroglossia, defined as a multivoiced process of discussion and negotiation. Bakhtin posits that the voices of all the members in the activity system are involved and utilised, including the voices of the “common people”.

This hybrid and horizontal learning is not, in principle, contemplated in Sfard’s (1998) two dichotomous metaphors of learning: the learner as an individual or learners as a community. According to these metaphors, learning is primarily a one-way movement from incompetence to competence, be it through acquisition or through participation; the latter metaphor is clearly influenced by the aforementioned notion of a CoP developed by Lave and Wenger (1991). To fill in this gap, Engeström and Sannino (2010: 2) add three additional dimensions, in the form of questions, to the dichotomy of learning as an individual/learning as a community:

- Is learning primarily a process that transmits and preserves culture or a process that transforms and creates culture?
- Is learning primarily a process of vertical improvement along some uniform scales of competence or horizontal movement, exchange and hybridization between different cultural contexts and standards of competence?
- Is learning primarily a process of acquiring and creating empirical knowledge and concepts or a process that leads to the formation of theoretical knowledge and concepts? (Engeström and Sannino 2010: 2)

If we add these dimensions to its definition, the theory of expansive learning puts primacy on communities as learners, on transformation and creation of culture, on horizontal movement and on the formation of theoretical concepts. In other words, learners learn something that is not yet formalised and construct a new object and concept for their collective activity, which they then implement. Therefore, “knowledge creation” would be a third metaphor (Engeström and Sannino 2010; Paavola *et al.* 2004).

#### **4. Methodology**

The empirical work we draw on comprises seven semi-structured, video-recorded interviews conducted in 2019 and 2020 with seven cultural mediators (four male and three female). Four of them were working in Castel Volturno at the time of interview, one was working in Milan, one was working in Polistena and one was a mobile unit coordinator. Those who were not working in Castel Volturno had all previously worked in the clinic for a long period of time. Out of the seven interviewees, one cultural mediator working in Castel Volturno also served as clinic coordinator. Additionally, the current mobile unit coordinator had served as clinic coordinator for a long period of time. This study also draws on notes taken during a visit to the Castel Volturno outpatient clinic in August 2019, on written interviews conducted in November 2018 with the four of the seven cultural mediators who were then working in Castel Volturno and on personal communications exchanged between the authors and the outpatient clinic coordinator from the beginning of the project until 2020.

Ethnography has been chosen as the main methodology of investigation in this study, since, according to Risku (2017: 309), “[i]n ethnographic research, the factors being studied are not defined precisely *a priori*, but are instead identified throughout empirical research”. According to Risku’s (*ibid.*) description of ethnography, research questions are posed prior to the study and then checked through participant observation and full involvement in the situation observed, communication with the study participants, the taking of field notes as documentation and/or qualitative interview methods, such as informal and semi-structured interviews with open questions. More specifically, the ethnographic approach of a case study has been chosen as the main form of analysis of participants, i.e., the case of cultural mediators in Castel Volturno. As Hammersley and Atkinson (2019) point out, ethnography places an emphasis on exploring the nature of particular social phenomena and investigating small numbers of cases, maybe even a single case, in depth and detail. The case is investigated in its naturally occurring setting, as it is believed that the phenomenon explored can be entirely grasped by “examining contemporary events [where] the relevant behaviours cannot be manipulated” (Yin 2009: 11). In this respect, an ethnographic approach to a case study appears to be the most adequate form of investigation for the setting concerned, in which learning and working dynamics are assumed to be influenced by the specific



culture of both the stakeholders in the encounters observed and the NGO employing the cultural mediators.

The methodology used in the project can, furthermore, be considered participatory research, as analysis and meaning making occur throughout the process and are not a separate activity carried out after data collection (Gerhart *et al.* 2007). Echoing Thomas (2017), the focus is, thus, on the co-construction of meaning between the researcher and participants, with participants' perspectives emerging from the joint construction of findings with the researcher and with the latter listening to what is being said, comparing it with his/her personal understandings and trying to determine how the stories make sense together. In the present article, we focus on what participants said about the nature of learning and learning relationships in their job.

## **5. Findings of the study**

The seven cultural mediators interviewed have worked in Castel Volturno at various times. In the two years preceding the outbreak of the COVID-19 pandemic, four of them were employed at the clinic: two Italians, one Nigerian, and one Romanian, with ages ranging from 40 to 49. All the mediators had different backgrounds and qualifications in areas other than language mediation or translation/interpreting (such as political science, economics, cultural heritage) and had previously worked for other regional and international NGOs (notably MSF and Save the Children), the public sector (local health companies, prisons) or international organisations prior to joining Emergency. The languages they mastered included Italian, English, French, Romanian, and a number of Nigerian languages (Esan, Bini and Pidgin English). After the outbreak of the pandemic, resources were reorganised to adapt to the new emergency situation. Consequently, mediators were dispatched to the outpatient clinics most in need. Two mediators continued to work in Castel Volturno, while another was sent to the outpatient clinic in Naples-Ponticelli. The Romanian mediator stopped working for the NGO after their contract expired.

Cultural mediators working for Emergency in any outpatient clinic are called upon to perform tasks that go beyond medical interpreting and that are at the intersection between health mediation, humanitarian aid and social service provision. Not surprisingly, they consider themselves first and foremost as humanitarian aid workers. These tasks include, but are not limited to: welcoming patients and/or health and social service users; providing them with language and cultural mediation prior to and during the medical examination and in compiling medical files at the outpatient clinic; accompanying patients who need hospital treatment, including visits or specialist examinations, to public health facilities and hospitals and assisting them with reception and admission procedures; liaising with the local authorities, regional associations and the National Health Service (NHS) facilities in a cooperative problem-solving approach; informing patients

about their rights; providing healthcare education where necessary; carrying out health and social service orientation activities for patients and, more generally, enabling people to access the care or assistance they need and helping them access the NHS; supporting the computerised management of data; and contributing to the management of certain administrative or logistical aspects of the projects. Different and/or additional tasks are always context-dependent, agreed upon with the Milan-based *Programma Italia* secretariat and implemented accordingly.

The COVID-19 health emergency marked a watershed in the NGO's activities and purpose. Before the health emergency, the specific tasks performed by the cultural mediators in Castel Volturno were those foreseen by the NGO for their professional role as detailed in the previous paragraph. With the widespread propagation of the pandemic, they were forced to adapt their activities to the new circumstances to safeguard themselves and the patients, while continuing to provide the latter with health care and social orientation. Consequently, Emergency placed itself at the disposal of national and local health authorities to manage the coronavirus outbreak, sharing with them the experience it had garnered from treating patients with Ebola in Sierra Leone in 2014 and 2015. New activities and initiatives were launched, while the NGO's traditional services continued to be provided in a different way. A massive information campaign was implemented by cultural mediators involving the creation of WhatsApp groups of patients and targeted messages being sent to vulnerable groups of the population informing them about safety and social distancing rules, as well as referring them to the relevant public health services. Similar content was conveyed through a video in Pidgin English, which was produced by the Castel Volturno mediators and disseminated in the media. All initiatives and new activities were decided centrally and implemented locally, sometimes after being prompted by local good practices tested at a given outpatient clinic. These practices were considered to be potentially effective for other *Programma Italia* projects and were, subsequently, adopted at other outpatient clinics and mobile units.

Despite cultural mediators' pivotal role, interviewees emphasised that they have never received any training in interpreting or humanitarian aid. They were surprised that, upon joining Emergency, they were called upon to perform the role of cultural mediator without any training being provided by the NGO and appeared to be genuinely surprised to discover that there was a wide scope of potential training they could acquire in such areas. They had intuitively begun to understand that well-trained interpreting/language transfer skills are decisive in their work and the lack of said training can represent a major shortcoming. Emergency attaches great importance to the role of cultural mediators, but, paradoxically, the organisation does not offer any training in interpreting or cultural mediation, only courses on legal and administrative issues. These are reportedly considered paramount by Emergency in view of the social orientation and information that mediators provide to migrants and asylum-seekers, which

should be grounded on a solid knowledge of national and local norms and regulations.

The absence of specific training helps to explain the lack of a specific code of ethics to guide mediators' language and cultural mediation activities, although the organisation does have one code that applies to all its staff members. Most interviewees did not refer to this code in interviews and talked instead about their individual ethical values. This being said, their actions and decisions at work are implicitly compliant with and inspired by the organisation's code of ethics, as if Emergency's ethical principles were tacitly transferred to and embraced by the mediators, who then implement them in their daily work.

This goes along the lines of Angelelli's (2004) view that interpreters' work should be considered in the context of an institution and that their role is conditioned by the principles and rules of this institution as a result. In particular, participants agreed that not being judgemental is a major principle to observe, one that is actually implicitly related to the essential principle of impartiality enshrined in the code of ethics of Emergency itself and of other humanitarian organisations. One African cultural mediator interviewed had the impression that patients considered them to be less judgmental than their Western counterparts. Consequently, this participant thought that patients tend to prefer addressing the African mediators, particularly those who belong to their same culture. Conversely, they believed that patients turn to Western mediators when they have something to hide, fearing that an African mediator might report their misconduct to the other members of their community.

Training on cultural issues is strongly demanded by the mediators, who all stress the importance of receiving it on a local and/or project basis. This need appears to be particularly felt in Castel Volturno, where the vast majority of migrants are of Nigerian and Ghanaian origin. Patients from these communities often have an intimate, sometimes pantheistic, spiritual view of their body, medicine and healthcare. All interviewees highlight the role that cultural differences between migrant patients and the health professionals of the organisation or public health authorities might play in the language mediation activity, with the related difficulties mediators face to ensure an effective transfer of meaning, trust towards them and compliance with treatment. According to one participant:

You have to give a migrant twice as much information as you would give an Italian (...) We used to do a lot of health education [*i.e.*, before COVID-19], for example (...) during visits with the doctor and explain about health and anatomy. (...) When talking about anatomy, they discover a whole new world and get to know their body (...). So, we always have to give this information, as there are major cultural differences we need to be aware of in this activity.

Strategies are reportedly adopted and exchanged between peers to overcome said challenges, such as the local division of tasks: one African

mediator, for example, almost always interprets within encounters involving patients sharing their gender and origin, whereas the other mediators deal with social and information service provision in dyadic interactions to a larger extent and work in triadic encounters only when needed.

I ask the patient what's going on, but I need more information to understand well (...) Talking to the *[Nigerian]* patient (...), I need to understand from him where he comes from, what documents he has, where he lives and where he lived before (...) If I understand that he needs to see a doctor, I call my Nigerian colleague and they translate for the doctor, (...) but I am also involved, because I talked to the patient before and if I then have to accompany him to a hospital, I can observe, because after all I am not a doctor, but I need to know

Other strategies include the use of simplified language or the adding of information to convince patients that their spiritual beliefs concerning treatment and their own body should and can be integrated with the prescriptions of Western medicine.

I provided support to a woman whose child was affected by sickle cell disease, the child had to see a paediatrician (...) For cultural reasons, the mother treated him differently (...), she had herbs delivered from Nigeria and had her baby drink teas made from them. It took me a year to convince her that she had to see a doctor in a hospital. I finally managed by convincing her that teas could go hand in hand with the prescriptions from the doctor

These strategies aim to fulfil the ultimate goal that a given health treatment is planned, conducted and communicated in ways that coordinate and establish a common ground with patients' systems of values and beliefs.

Training occurs mutually between mediators and is sought from peers regardless of origin and skills; e.g. African mediators are often looked to for strategies to overcome cultural differences with migrant patients, whereas mediators who are keener on legal and administrative issues serve as examples on how to support patients with more detailed guidance. Mediators do not only seek training from peers, however, but also from training programmes on cultural mediation, intercultural medicine or ethnopsychiatry, which they take on their own initiative.

On this matter, all mediators interviewed advocate for training to implement what Quaranta and Ricca (2012) define as "intercultural medicine", a phrase used to refer to the set of linguistic and practical processes that aim to promote the adoption of clinical protocols and a positive approach to treatment for migrants. The need for intercultural medicine was confirmed by one mediator, who highlighted the aspects, which, in their view, can facilitate effective communication:

Coming from the same country or geographical area and knowing the language of the migrant user plays a major role in mediation, also because each ethnic group has its own body language, which might be completely different from that of another ethnic group. Being of the same gender of the migrant sometimes favours mediation, but this varies from person to person

The findings also highlight that cultural mediators are impacted by the emotional and psychological burden posed by their work and that each of them has envisaged their own way to cope with it. These coping mechanisms vary depending on each individual's personality and past experience. The mediators feel that they must learn ways that enable them to detach from the emotionally challenging cases they deal with at work, in order not to bring home the pain and suffering they witness and to avoid an excessive load on their personal life. Opportunities to learn how to cope with emotionally and psychologically difficult situations, though, are not provided by the organisation. Rather, coping mechanisms are developed both individually and collectively, and mediators are aware that they can refer to the clinic or programme coordinator when in need.

## 6. Discussion

Despite the ideal definition of “medical interpreter” put forward by Gez and Schuster (2018: 822-823) as “trained bilinguals, equipped with the knowledge and skills to bridge language gaps [...] as well as the knowledge to mediate cultural misunderstandings”, and despite the well-accepted preference for trained professional interpreters in medical contexts (Leanza *et al.* 2017), many interpreted exchanges are still performed by natural or untrained interpreters/mediators. Although this is confirmed by the findings of the present study, the cultural mediators working for Emergency are actually able to perform their work through the creation of a CoP that allows them to learn while working, finding solutions to everyday challenges. The case study analysed is an example of workplace learning characterised by informal learning and learning as participation rather than acquisition, contrary to what happens in schools or universities. The cultural mediators, as workers and learners, are integral components of the situations in which they work and learn (Hodkinson and Hodkinson 2004). They learn and share their knowledge not only by *being told* and *telling*, but also by *observing* and *doing*. This is related to Polanyi's (1966: 4) notion of indwelling and his conception of personal knowledge, according to which knowledge only exists within individuals and is grounded in the tacit dimension that people cannot express; telling and learning are more than discrete pieces of information sent and received.

In this CoP, cultural mediators attach considerable importance to their role as cultural brokers, which is in line with a widespread attitude among Italian dialogue interpreters, especially in community and healthcare settings: Rudvin and Tomassini (2008) clearly highlight that, in the provision of healthcare services, the issue of role is even more interesting and dynamic in Italy compared to many other countries. According to Rudvin (2006), cultural mediators facilitate the integration of migrants and generally provide assistance to migrants, functioning as a bridge between two (cultural) communities and between the individual and the institution. Furthermore, the prevailing reference to culture in the definitions referring

to the language professionals employed in these settings shows a preference for cultural competence compared to linguistic or language-transfer skills when dealing with the numerous cross-cultural differences that can be observed between the host society and the patient's culture. In this respect, Rudvin and Spinzi (2014: 56) highlight that the professional role of the language mediator in Italy is still in need of clarification in terms of role and professional mandate, leading to a "terminological turmoil around the word 'mediation' as an activity different from translation and interpreting". In Italy, language and cultural mediation as a profession has evolved along an entirely separate line from the development of language mediation as an academic discipline, whereas in the Anglo-Saxon tradition the two branches are aligned; this probably accounts for some of the terminological confusion surrounding the term.

Interview data suggest that the way cultural mediators learn is an example of horizontal learning and knowledge creation: even though there were general tasks decided and described at a central level, it was the coordinators in each outpatient clinic who, after analysing the situation, tried, together with the cultural mediators, to find the best way to meet the needs of the people applying to the clinic. In other words, the tasks to be performed had not all been previously identified by the central management: some had to be identified by the local staff and others had to be adapted to local needs. Therefore, the central manager's intentions and plans were not the only thing determining the course of the participants' learning actions, in that these actions did not necessarily correspond to the tasks originally assigned by the central management (Engeström *et al.* 2013). This means that local coordinators and cultural mediators took over the leading role; they identified a panoply of nuanced tasks to be performed and embarked on analysis of the situation, identification of needs and shortcomings, modelling of a solution to face the various challenges and implementation of the new model. In this context, new knowledge and new practices for an emerging activity were created through expansive learning. Learning was embedded in the qualitative transformation of the activity system: even if, in principle, mediators were recruited to perform certain tasks, they quickly detected some contradictions or identified new tasks that had not been anticipated. This was the case, for instance, of the video in Pidgin English, which was first developed in Castel Volturno and soon after produced in other minority languages at other clinics, or the triage facility set up to provide COVID-19-related information and direct patients to the most appropriate local health companies and hospitals. Put differently, there were some deviations between the management's intentions and the actual tasks undertaken by the cultural mediators that led them to question the existing practice or adapt it to new circumstances, and made them aware of the possibility for expansive transformations in the activity system.

Aware of these deviations, as well as of their individual limitations, the mediators organised internal meetings to take stock of the situation, discuss

the most challenging cases, find common solutions and exchange good practices. These meetings had not been foreseen by any procedure suggested or imposed by the NGO's national head office, but were rather self-initiated occasions of exchange and learning, shaped and fine-tuned by the clinic's mediators themselves. They also led to a division of labour within the outpatient clinic based on the skills of each cultural mediator, whereby said division of labour was decided autonomously by the mediators themselves and not by the managers.

Many of these deviations were aggravated by the COVID-19 health emergency. As Engeström (1987) argues, transformations in the workplace that derive from periods of acute disturbance or intensive change generate new working situations in which nobody actually masters the work activity as a whole. Even if control and planning are officially in the hands of the management, the tasks to be performed are yet to be identified and, when adopted, they have an effect on the activity as a whole. Moreover, the outbreak of a pandemic usually opens up a field of challenges for practical redesign (Engeström 2008). When whole collective activity systems need to redefine themselves, traditional modes of learning are insufficient, simply because nobody knows exactly what needs to be learned. Along these lines, cultural mediators were put to the test of identifying the new challenges, designing the new activity and acquiring the knowledge and required skills (Engeström 1999).

We observe here the three main types of interaction that are characteristic of expansive learning—coordination, cooperation and communication (Rantavuori *et al.* 2016). These interactions were essential in order to move from identifying the new challenges to consolidating the practice. Even if the practice had been consolidated, the COVID-19 pandemic brought about a new definition of activities, and this led the mediators to question the practice and adapt it, through both expansive and non-expansive actions (i.e. the maintenance of existing practices).

In sum, the cultural mediators found themselves in an environment that forced them to learn on the job, creating new patterns of activity and new forms of work activity. The learning challenge consisted of acquiring a new way of working in which cultural mediators and the other staff at the outpatient clinic would collaboratively plan the activity, taking joint responsibility for its overall progress. There was no readily available model that would fix the problems, no wise teacher with all the answers. Therefore, the community had to get involved in what Engeström (2001: 150) calls "knotworking", a term that implies an expansion of the object of activity to all the parties involved where "no single party has a permanent dominating position and in which no party can evade taking responsibility over the entire professional trajectory". This was particularly evident after the outbreak of the COVID-19 pandemic, which led mediators to question the sense and meaning of their activities and to develop an alternative learning and working model to adapt to the new situation. This learning challenge

could not be met by training individuals or by an individual learners' acquisition of certain skills; the issue at stake was organisational and dependant on a new and constantly evolving scenario, and could not be resolved through the sum of separate individual actions, but rather only through collaborative work.

## 7. Concluding remarks

In this article, we have examined the nature of learning of cultural mediators working in the highly degraded and migration-intensive area of Castel Volturno in the context of a humanitarian medical NGO. Our analysis shows, amongst other things, that this setting is not a stable one in which individuals learn skills pertaining to an immutable and reasonably well-defined practice. Even if the organisation has the mandate to centrally define the tasks assigned to cultural mediators, the latter, organised as a CoP, are ultimately the ones who can decide what tasks to implement, how to implement them and whether to perform modified or additional tasks once they start working, based on the situation and the challenges they face. Cultural mediators learn within their CoP. Learning by doing within their CoP helps them realise where training is most needed and, thus, anticipate training aspects that the organisation should consider when deciding on future training options.

In discussions on work-related learning in challenging contexts, such as the one described in the present study, it is our belief that learning theories should bridge and transcend the gaps between formal and informal, individual and collective, acquisitional and participatory, and transmission and transformation views of learning (Engeström *et al.* 2013) to encompass different modes of learning that take account of real challenges in the workplace. These include, among other things, the need to adapt to particularly challenging humanitarian and social contexts, relate to interlocutors with cultural features that are different in each case, or cope with unexpected events, such as a disaster or a pandemic.

We have attempted to highlight a form of situated learning, whereby the skills developed within the CoP are acquired based on a real situation of work. The cultural mediators' skills are developed as a result of a multivoiced process of discussion and negotiation, foregrounding the voices of those who work in the field and being ultimately capable of informing central decisions on training. In this respect, the present paper can provide some indications for situated training based in the humanitarian setting of a medical NGO, thereby paving the way for future research in the field.

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## Notes

<sup>1</sup> The Italian acronym ONLUS in the official name of the NGO stands for *Organizzazione non lucrative di utilità sociale*, i.e. non-profit making organisation of social utility.

<sup>2</sup> The project was evaluated and authorised by the Ethics Commission of the University where the PhD is currently being pursued.

<sup>3</sup> The information was provided by the *Programma Italia* secretariat and confirmed by Emergency’s HR Department. This information can also be retrieved from the organisation’s webpages on current vacancies and cultural mediators’ job profile

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(Emergency 2020a) on the Emergency portal (Emergency 2020b). We acknowledge the existence of a hybrid nomenclature, especially in Public Sector Interpreting and Translation (PSIT) contexts in Italy, to refer to the language and cultural brokers employed by Emergency. This can include terms as varied as interpreter, community interpreter, cultural mediator, intercultural mediator, etc., that reflect the complexity of the roles and definitions of the profession across fields. We decided to opt for “cultural mediator” to be consistent with the terminology used by the NGO.

<sup>4</sup> As Tipton (2011: 16) points out, “the fact that Engeström draws extensively on Lave and Wenger’s work in the development of his theoretical approach means that the two should be seen as overlapping to a certain extent and not as discrete approaches”.

<sup>5</sup> It is the distance between the present everyday actions of the individuals and the historically new form of the societal activity that can be collectively generated as a solution to the double bind potentially embedded in the everyday actions (Engeström 1987: 174).