

THE PERCEPTION OF DISEASE IN SUB-SAHARAN AFRICA. MANAGING LINGUISTIC AND CULTURAL BARRIERS AND MEDIATION PROCESSES AMONG ASYLUM SEEKERS

RAYMOND SIEBETCHEU
UNIVERSITÀ PER STRANIERI DI SIENA

siebetcheu@unistrasi.it

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Abstract: This article explores the perception of health and illness among sub-Saharan African asylum seekers in Italy, with a specific focus on the challenges posed by linguistic and cultural barriers in healthcare settings. Drawing on a qualitative pilot study involving approximately twenty participants from various African countries, the research compares migrants’ health perceptions with data from the World Health Organization and other national and international sources. The study shows that for many young asylum seekers, health is associated not only with physical well-being or the ability to work, but also with factors such as the capacity to practice sports, financial stability, and emotional balance. The article also highlights the coexistence of biomedical and traditional healing practices, and the persistent role of informal self-medication. Particular attention is given to the concept of “complex linguistic repertoires” and its implications for communication between migrant patients and Italian healthcare providers. The discussion outlines four models of linguistic and cultural mediation and argues for the structural integration of trained mediators into the healthcare system. Ultimately, the paper advocates for a transcultural approach to care that recognizes patients’ cultural backgrounds and lived experiences as central to the therapeutic process.

Keywords: Africa; disease; asylum seekers; immigration; linguistic and cultural mediation; health.

1. Introduction

By the late 1970s, as foreign immigration to Italy grew, the increasing visibility of immigrants in urban centers sparked fears and prejudices, including within the healthcare sector. Officially unaware of the issue, the sector struggled to respond, exacerbating suspicion and insecurity (Geraci and Marceca 2000: 65). Despite the progress made in this sector, the denial of immigrants' right to health – which for many years characterized the Italian healthcare landscape through explicit measures – now appears to persist in the form of more implicit exclusionary mechanisms. This trend is confirmed by the regular monitoring conducted by the Italian Society of Migration Medicine (SIMM), which highlights a kind of schizophrenia in policies concerning immigrant health: on the one hand, there is a growing attention to the issue; on the other, there is significant uncertainty in local-level implementation, and in some cases, a fragmented and inconsistent application of existing regulations.

This article aims to analyze how African migrants perceive their own health, the healthcare systems of their countries of origin, and the Italian healthcare system. By proposing an analysis that encompasses both the African and Italian contexts, the objective is to outline mediation strategies capable of overcoming the linguistic and cultural barriers that hinder access to healthcare services and facilities for African citizens. In addition to data from existing surveys (ISTAT, SIMM, World Health Organization) and the author's direct experience, this article presents the first results of an ongoing pilot study on health perception and mediation strategy.

2. Methodology background

The research combined both quantitative and qualitative analytical methods as well as language portraits and case studies originating from public health and social science research. Commenting on the data from a previous WHO study on health perception in sub-Saharan Africa, this article compares the results of that research by proposing a specific study on the perception of health by applicants in Italy. The WHO study involved 10,880 respondents from 10 countries of the West, Central, East and Southern African subregions. This WHO research was guided by six key questions: (a) How are health and health care delivery perceived by African communities? (b) How is health care implemented in selected urban, peri-urban and rural health districts? (c) To what extent are existing health service delivery systems responsive to community needs? (d) What is the existing potential and capacity of communities to contribute to and engage in health service delivery? (e) How can people and groups in urban, peri-urban and rural communities be empowered in community health development and how can their capacity be increased? (f) What are the perspectives of the communities on the delivery of health care? In this work we will focus attention on the key questions (a), (b) and (c). Our research is involving sub-Saharan African asylum seekers currently residing in Siena (Tuscany Region, Italy). Although the number of informants is still relatively limited (twenty), the

qualitative approach adopted in this research allows us to propose a comparison between WHO data and the responses provided by the asylum seekers involved in our study. The asylum seekers come from central and western African countries: Cameroon, Gambia, Guinea-Conakry, Mali and Senegal. All the interviewees are still underage (under 18 years old), males and they still live in reception centers (CAS) for two years. The interviews focused on 15 questions related to demographics (age, gender, education, country of origin), language profile, perception of illness and health (subjective meaning of illness and health), relationship with Western medicine, Italian doctors and hospitals, relationship with Western and traditional medications; communication problems in the healthcare context; and linguistic-cultural mediation scenarios. In this article, we will focus on some of these questions.

3. Health and healthcare systems in sub-Saharan Africa

Although Africa is the continent with the poorest health data, there is a dearth of information on how Africans perceive their own health. According to Deaton and Tortora (2015), in terms of health care, only 42.4 percent of sub-Saharan Africans are satisfied with the availability of high-quality care near where they live. Overall, Deaton and Tortora's (2015) study reports on a broadly negative picture of self-reported health in sub-Saharan Africa. For instance, in Cameroon, Gabon and Senegal less than 10 percent of the informants reported that they were in perfect health. According to a WHO – World Health Organisation's study (2012), the state of good health in sub-Saharan Africa is associated with a variety of factors. Physical signs were cited most frequently as an indicator of good health. The ability to work is also regarded as an indicator of good health. Income status was also seen as a measure of good health: "Without any money to cater for our needs we cannot be healthy". The spiritual dimension was also mentioned by the respondents of the WHO's survey. One participant recalled the following in this regard: "When I go to church I worship my God peacefully, my heart is at rest, on my part I am in good health. Nothing disturbs my heart, I have no anxiety then I know I am in good health".

Another factor associated with good health is the absence of pain. This latter aspect is rooted in an African cultural perspective that tends to equate illness – and thus the need to seek hospital care – with the presence of clear and manifest symptoms. In contrast to Western countries, where populations are accustomed to undergoing regular health check-ups and are generally well-informed and psychologically prepared to manage illness, this is not always the case in many impoverished regions of the world. One need only consider early-stage cancers or hypertension, which are often completely asymptomatic. As a result, there is a prevailing tendency to seek medical attention only when the patient experiences physical discomfort or acute pain (Machetti and Siebetchu 2017: 104).

The distance observed between many Africans and healthcare facilities, when reported, is primarily linked to three main factors: the shortage of medical infrastructure, especially in rural areas; the lack of financial resources among

many families living in poverty; and the insensitivity of healthcare personnel, who often prioritize financial gain over patient care. These are healthcare systems that fail to provide systematic protection for the population. As highlighted in the WHO (2012) report, over two thirds of the respondents across all SubAfrican countries stated that they were dissatisfied with the public health services. The overall level of dissatisfaction was 64.3%: urban – 66.7%; peri-urban – 62.7 %; and rural – 4.6 %. This feeling of dissatisfaction was more in the Central subregion with 69%, followed by the West subregion (67%). This latter area is the region of origin of the asylum seekers who participated in our pilot study. Terms used by Africans to describe health providers included “lazy nurses, shortage of doctors, rude clerks”. One informant notes the following: “Now, what we see, you bring a sick child, the child is in coma but they ask you to bring drugs, blood and transfusion supplies. By the time you go through all these steps the child’s condition deteriorates” (WHO 2012: 26).

In light of widespread dissatisfaction with the services provided by public healthcare facilities – and considering the economic barriers that prevent access to private care – many families opt for traditional medicine as a substitute for, or alternative to, modern medicine. Traditional medicine in Africa is a holistic healing system that combines herbalism, spiritual practices, and local knowledge to treat both physical and mental ailments. It is a major source of healthcare, relying on a wide range of locally sourced plant, animal, and mineral-based preparations, often used in conjunction with spiritual rituals like divination, prayer, and sacrifice. This system is deeply integrated with cultural beliefs, and practitioners often address the psychological and spiritual causes of illness alongside physical symptoms (Ezekwesili-Ofilu and Okaka 2019). African traditional healers are key figures in healthcare due to their cultural integration, accessibility, and affordability, providing a holistic approach that includes spiritual and mental well-being. Most of the African population relies on traditional medicine for primary healthcare, especially in rural areas with limited access to Western medical facilities. Traditional knowledge, passed down through generations, addresses health issues that are culturally relevant, making it a trusted first point of contact for many. This tendency is confirmed by the following testimonies: “Apart from the hospital, we also go to the traditional healers to cure our illnesses”. “People still have old practices, which lead to keeping patients at home, such as using traditional medicines. If it succeeds, it is better and if it fails, then they bring weakened patients to the health facility. This practice is rare in towns but more frequent in rural areas”; “Apart from the immunization programme, the other programmes do not reach the community needs. Because we are abandoned, the traditional healers help people to solve their health problems”.

The physical distance from healthcare facilities, along with the lack of financial resources, often compels populations to resort to self-medication. This is typically done by turning to informal medicine vendors, who sell pharmaceutical products that are not regulated by the healthcare system and whose preservation conditions are highly questionable. These drugs are often sold on the streets, exposed to the elements – sun, rain, and other environmental hazards. In this regard, one respondent notes: “As for me, if I’m sick and if the

sickness is not too strong, I will not go first to the hospital, I'll just buy medicine from roadside vendors and if after two or three days I'm not feeling fine, then I can go to the hospital".

Concerning the common health problems as perceived by the communities, malaria was cited as the most common health problem in in sub-Saharan countries. Apart from Malaria, the leading most common health problems as perceived are the following: Fever, Diarrhea, Hypertension, Respiratory problems, Arthritis, Diabetes, Eye problems, Pains, Vomiting in children.

The difficulty in accessing healthcare facilities in Africa – as well as their limited availability, already documented by the WHO – was confirmed by our informants. Some made observations such as: “there aren't many hospitals,” “without money you cannot get treatment,” and “doctors want money before treating you”. One respondent who grew up in a rural setting, however, noted: “It wasn't difficult to access healthcare facilities because there weren't as many people as in big cities”. This apparently positive perception of access to healthcare in rural areas, however, must be interpreted with caution. It is often the result of several structural weaknesses: these facilities rarely offer specialized services, the number of doctors is very limited, medications are in short supply, and the infrastructure is often in a precarious state. What appears to be “easy access” is in fact due to the absence of proper services, which forces most people to travel to larger cities to receive adequate care – often at high economic cost – and facing complex bureaucratic barriers, as previously noted. When the socio-economic conditions of villagers do not allow them to reach urban centers for treatment – as is frequently the case – a significant portion of the population turns instead to traditional medicine.

Despite the scenario described above, and although sub-Saharan Africans' overall evaluation of their well-being is considered lower than that of any other population in the world (Deaton and Tortora 2015), these populations often display positive emotional states: smiling faces and a generally optimistic mood, largely rooted in strong spiritual and cultural foundations. Within the broader framework of African migration projects, the challenges experienced with the healthcare systems in their countries of origin give rise to diverging perspectives: on the one hand, the hope of finding a more efficient and accessible healthcare system in Italy; on the other hand, the enduring trust in traditional medicine. In response to these contrasting expectations, mediation strategies are necessary to overcome the linguistic and cultural barriers that migrants face when accessing the Italian healthcare system.

4. The Health profile of immigrants in Italy

According to the Italian Society of Migration Medicine (SIMM) (2014: 238), the presence of foreigners in Italy is in no way associated “with an increase in the frequency of infectious diseases in Italy nor with any particular risk to public health”. On the contrary, foreign nationals tend to enjoy, on average and across all age groups, better health conditions than Italian citizens. While 83.5% of Italians report being in good or very good health, the percentage rises to 87.5%

among immigrants (ISTAT 2017). These findings are supported by a study conducted by the Italian Association of Epidemiology (Petrelli and Di Napoli 2019), which confirms that immigrants' overall health status is better than that of the native population, although with some heterogeneity depending on country of origin and geographic area covered by the study. Compared to Italians, immigrants show significantly lower mortality rates – 17% lower for men and 30% lower for women. A notable exception is the sub-Saharan African population, among whom mortality rates are higher than those of both Italians and immigrants from other regions: 33% higher for men and 69% higher for women.

In addition, foreign nationals are hospitalized less frequently than Italians. Overall hospitalization rates are lower across all cities, particularly in day-hospital settings. Nonetheless, and despite significant variability between centers and regions of origin, adult male immigrants show a 34% higher risk of avoidable hospitalizations – that is, for conditions that could have been effectively treated in outpatient care settings. Although isolated cases cannot be ruled out, SIMM studies indicate that the foreign population residing in Italy is not systematically affected by infectious diseases – as some media narratives might suggest – but rather, in the case of men, by trauma, respiratory diseases, and digestive system disorders; while for women, the main concerns relate to complications of pregnancy, childbirth, and the postpartum period. It should be noted that for a more accurate comparison, it is necessary to also consider the age of the citizens examined. It is worth remembering, as documented in the literature (see Siebetcheu 2017: 99–100), that there are at least two reasons why migrants' poor health is less visible: the “healthy migrant effect” and the “salmon effect”. The first, the “healthy migrant effect,” describes how, at the beginning of their migration journey, migrants often appear to be in better health than the native population. This initial advantage is due to a process of self-selection, whereby those who migrate tend to be younger, healthier, and more motivated. The second, the “salmon effect,” refers to the behavior whereby sick foreigners, especially the elderly, tend to return to their country of origin for treatment. For some, this return is due to the use of traditional medicine from their home country or the need to be reunited with family members, especially when an irreversible and fatal outcome is suspected. The precarious conditions of migrant citizens are documented in Italy largely due to the so-called “exhausted migrant effect”. This refers to the precarious health of foreigners, linked not to presumed diseases brought from their country of origin, but to exposure to risk factors present in the host country. As Geraci and Marceca (2000: 68) pointed out, it is often the overall living conditions to which foreigners must adapt in the host country that can erode and squander, more or less quickly, their initial health assets. This general picture is corroborated by the preliminary findings – though limited in scope – of the pilot study we conducted in the Siena area.

According to our pilot survey, which involved informants from different countries including Guinea, Mali and Camerun, in terms of specific health issues, the most commonly reported problems of 70% of our informants were headaches, foot pain, fatigue, and stress-related symptoms. These ailments appear to be closely linked to the migratory experience itself, rather than to pre-

existing medical conditions. Actually, many respondents associated their physical discomfort with the harsh conditions endured during their journey to Italy, including prolonged walking, lack of adequate shelter or food, and exposure to violence or trauma in transit countries such as Libya or Niger. This pattern resonates with what has been described in the clinical literature as the “survivor syndrome” or “syndrome of the survivor” (Van der Veer 1998), a constellation of physical and psychological symptoms observed in individuals who have survived extreme experiences such as forced migration, detention, or torture. In this context, stress, chronic pain, and sleep disorders are not only medical concerns, but also indicators of the broader psychosocial impact of irregular and traumatic migration routes. Understanding these symptoms as culturally and biographically situated is essential for developing appropriate and effective health responses for this population. However, 30% of respondents also reported experiencing multiple or chronic health issues, a figure that cannot be overlooked. This seemingly contradictory result can be interpreted through the lens of the “exhausted migrant effect” (Bollini and Siem 1995), which posits that prolonged exposure to socio-economic hardships, discrimination, precarious working conditions, and inadequate access to healthcare may lead to a gradual deterioration of health over time. These dual dynamics highlight the complex and evolving nature of migrants’ health trajectories, influenced both by pre-migration factors and by the structural conditions encountered in the host society.

The health profile outlined above for our informants confirms what has already been observed in previous studies regarding the health status of immigrants, which is largely explained by the so-called *healthy migrant effect*. Given the personal investment that migration entails and its associated socioeconomic potential, the *healthy migrant effect* refers to a process of self-selection that typically takes place in the country of origin – often within the family context – and results in the selection of individuals who are physically, psychologically, and intellectually fit to undertake a migratory project. This self-selection process, also confirmed by ISTAT data, helps explain why immigrants generally arrive in the host country with a largely intact health status. That said, some individuals may still present untreated medical conditions, either because they are asymptomatic or due to the inadequacies of the healthcare system in the country of origin.

5. The perception of health among sub-Saharan Africans

In light of what was illustrated in Paragraph 2 regarding the perception of health and illness in sub-Saharan Africa according to the WHO survey, this section provides insights into how the interviewed asylum seekers perceive their own health. When asked: “What does being healthy mean to you?”, 75% of respondents answered that being healthy means being able to practice sports. Unlike the WHO survey, where the dominant answer was the ability to work, in our pilot study sports is regarded as the main benchmark for evaluating one’s state of health. This difference can be explained primarily by two factors: the

interviewees are still minors, and they still live in reception centers (CAS), where basic services are provided directly by the facility. 25% of the respondents, however, said they feel healthy when or if they have a lot of money.

This finding suggests that the perception of health among young asylum seekers is not strictly biomedical, but deeply intertwined with daily functionality, autonomy, and symbolic well-being. The choice of sports as a health indicator reflects both a youthful orientation and the absence of adult responsibilities such as work or caregiving. This resonates with Helman's (2007) view that health is not only "the absence of disease" but "the ability to perform culturally valued tasks". In this context, sports may function as a proxy for energy, mobility, and inclusion, especially in collective settings like reception centers. For asylum seekers, the football field represents an ideal space – perhaps even the true antidote to uprooting-related stress and survivor syndrome. It offers an opportunity to forget past and ongoing hardships and to temporarily escape the anxieties they generate. The football pitch is also a place of encounter and interaction, enabling asylum seekers to connect with others, rebuild a lost identity, and rediscover joy. Through participation in away matches, refugee players have the chance to gain deeper insight into Italian society, transforming not only their mental knowledge of the territory but also their perception of travel – now experienced as a pleasant, risk-free activity (Siebetchu 2016). Aware of the social and symbolic value of sport among immigrant groups, many asylum seekers present themselves as "football players" rather than "asylum seekers". From this perspective, they successfully integrate into the host society, but they also become models of social success.

Furthermore, the association of wealth with health expressed by a quarter of the respondents highlights the economic dimension of well-being, which has been observed in other migration studies (Castañeda *et al.* 2015). As noted by Kleinman (1980), people define illness and health in relation to what they are able or unable to do. For these young migrants, playing football or running may be more telling indicators of wellness than clinical diagnoses. Actually, in this project sports activities were established within the CAS because sports in general, and soccer in particular, were the main communication tool they preferred to use to communicate, especially since many were illiterate upon their arrival. At the beginning of the integration process, sports practice was therefore also the tool for measuring well-being.

As discussed in Siebetchu (2020a), it is interesting to note that these players, also thanks to the use of African languages, make linguistic choices so as to not make themselves understood by their opponents on the pitch and at the same time manage intercomprehension among them. Actually, after the partition of these countries from the former colonies, their populations are now considered as a continuum of culturally and linguistically related peoples. For example, while Malian footballers turn to their Gambian teammates in Bambara language, the latter understand and answer in Mandinka. Bambara and Mandinka are in fact two idioms belonging to the group of Mandingo languages, generally mutually comprehensible. I propose here some sequences showing the linguistic choices of the Malian defender K. towards four teammates during the same game

where he used five languages. In the following example, K. turns to D. (Mali) and respectively uses French, Bambara and Soninké:

- a. D. c'est bien [Well done D.]
- b. I hakili sigui [Stall the ball]
- c. A woi oné [Exploit flanks]

K., then, turns to M. (Gambia) and uses bambara

- a. Kana tikélike [Don't dribble too much]

Then he turns to B. (Ghana) and uses English

- a. Come back

Here, he turns to T. (Ghana) and uses Italian

- a. Uomo, uomo [Man on] (Pay attention, you are marked by an opposing player).

These examples show how the Malian player K. uses different language resources at his disposal to manage communication on the pitch and ensure understanding. K. does not speak English and Italian very well, but the few words he knows are used efficiently. Despite the spontaneity of K.'s linguistic choices, there is a strong negotiation and mediation ability useful to manage communication during the game and contribute to the good performance of the team.

While the well-being of asylum seekers may, on the one hand, depend on the ability to engage in sports and on having the financial means to afford basic necessities, it is important to note that sports and money alone are not sufficient to guarantee health. One can engage in regular physical activity and have considerable financial resources and yet still suffer from asymptomatic conditions that cannot always be treated – even with money. It is therefore essential to acknowledge that a migrant's health extends beyond physical well-being and also encompasses mental, psychological, and spiritual dimensions.

As the data presented in this section show, perceptions of health vary from one culture setting to another. Secondary, there are culturally defined concepts, as quoted: "Illness, a universal component of the human experience, manifests through a multiplicity of languages, beliefs, behaviors, and practices that can only be fully understood by taking into account the individual's culture and social context" (Di Santo 2013:52).

A few specific examples from sub-Saharan Africa help illustrate this point. Malaria is so frequent and normalized in this region that it often functions as an umbrella term used to describe a wide range of health conditions – both serious and minor. Moreover, the perception and management of pregnancy, which in Italy is highly medicalized, are not subject to the same process in sub-Saharan Africa. In this region, the relationship between pregnant women and gynecologists is far less common than in Italy – not only due to a lack of

infrastructure and qualified personnel, but also due to cultural and systemic differences. As for the concept of healing, while Western cultures typically place the physician at the center of the healing process, in many African cultures religious or traditional figures play a central role (Machetti and Siebetcheu 2017).

Given this cultural background, what is the relationship between sub-Saharan Africans and healthcare services in Italy? We offer some data in the following section.

6. Immigrants' access to healthcare in Italy

In response to the question “Where do you go in Italy when you feel unwell?”, all of the participants of our interview stated that they go to the hospital. This access to hospital facilities is facilitated by the presence of linguistic-cultural mediators within the reception centers, who are tasked with assisting young asylum seekers throughout scheduled medical procedures, such as specialist visits, blood tests, and other diagnostic protocols. The presence of intercultural mediators helps overcome not only linguistic barriers, but also administrative and cultural obstacles, thereby enhancing both access to and the quality of care. All respondents reported a positive perception of the Italian healthcare system and expressed willingness to seek hospital care when necessary. Nevertheless, 50% of participants also reported turning to traditional healers when they felt unwell in Italy. This data invites two reflections: on the one hand, it highlights the persistence and relevance of traditional medicine practices among migrant populations, even in European contexts; on the other, it reveals the urgent need to implement processes of mediation and negotiation between traditional healing systems and biomedical healthcare. To create a bridge between Western and traditional African medicine, in Italy, as well as in many other countries such as France and Belgium (Siebetcheu 2017), linguistic-cultural mediators are employed in healthcare settings both to facilitate communication between medical staff and foreign patients and to explain the reasons behind cultural choices related to traditional medicine. Mediation in this case obviously does not intend to combine or separate Western and traditional African medicine, but at least to encourage greater awareness of these issues, also opening up greater intercultural dialogue. The problem is addressed with greater awareness and competence when Western doctors have African origins.

This phenomenon is consistent with findings in migration and health studies, which emphasize the coexistence of plural therapeutic pathways among immigrants (Kleinman 1980; Fassin 2001). For many migrants, biomedical care does not necessarily replace traditional knowledge but is integrated with preexisting health beliefs and practices (Bibeau and Corin 1995). Failure to recognize this cultural complexity may lead to miscommunication, diagnostic uncertainty, or even non-compliance. As Grimaldi *et al.* (2020) underline, intercultural competence among healthcare professionals – supported by the strategic presence of mediators – is crucial not only for linguistic comprehension but for navigating different cultural models of illness and healing.

In our pilot study, all the respondents reported no major communication difficulties, as all linguistic and cultural needs were addressed by the presence of professional mediators in the reception centers. However, this situation reflects a relatively protected environment. In the broader Italian healthcare system, particularly outside of institutional reception settings, language and communication problems remain significant. According to the Italian National Institute of Statistics (ISTAT 2017), language barriers are among the most frequently cited obstacles to accessing health services for foreign-born populations. In the absence of adequate linguistic-cultural mediation, miscommunication may affect diagnosis, delay treatment, and undermine patient trust (Gargiulo *et al.* 2018; Devillanova 2008).

Therefore, the presence of linguistic-cultural mediators is not a marginal support service, but a structural necessity to guarantee equitable access to care. As highlighted in multiple Italian studies (Fondazione Migrantes 2020; Fedeli *et al.* 2016), such mediation services not only facilitate verbal understanding, but also bridge cultural perceptions of illness, interpret non-verbal cues, and help patients navigate complex administrative procedures. To better understand the broader landscape, larger-scale research conducted outside of the reception system would be necessary. Such studies could provide a more nuanced picture of the actual conditions faced by sub-Saharan African migrants in accessing healthcare in Italy and highlight the long-term effects of either the presence or absence of structured mediation systems.

7. Linguistic and cultural mediation processes in healthcare settings

Before offering some reflections on mediation processes in the healthcare sector, it is important to highlight – as noted in several studies on African immigrants in Italy (Siebetcheu 2020b; Guerini 2006) – that the linguistic profile of individuals from this part of the world is highly diverse and falls within what Berruto (1993: 7) defines as “complex and diversified linguistic repertoire”. As an illustrative example, we present here the linguistic repertoires of two Guinean informants (Lamine and Camara).

Table 1: Linguistic repertoire of two Guinean asylum seekers

Usage contexts	Lamine’s languages	Camara’s languages
Brother and sister	Diaranka, Susu, Malinke	Susu
Father and Mother	Diaranka	Susu, French
Friends in Africa	Mandinka, Susu	French, Susu, Bambara
Qur’an	Arabic	–
On the streets in Guinea	French	French, Malinke, Pulaar
Friends School in Italy	Italian	Italian
School in Italy	English	English

This linguistic repertoire was illustrated by the interviewees themselves using the language portrait silhouette technique (Figures 1 and 2). It is

interesting to note how both informants associate the Susu language with head, that is, the language that provides intellectual knowledge (not necessarily linked to the number of years of study) for interacting in society. The languages Diaranka (Lamine) and Pular (Camara) are respectively associated with heart, that is, the language of affection, used primarily within the family context or with close friends. For Lamine, English and Arabic are respectively associated with the right and left foot to underscore the importance of these languages in relation to the path of their global and spiritual world. Camara associates Italian and English with the two feet because these are the two languages that open the doors to integration in the local (Italy) and global (future immigration countries) reality. The languages associated with the hands represent socialization and work. For Lamine, Malinké and Italian enable the building of social and professional relationships. Referring to the Guinean context, Camara instead associates hands with French and Bambara. Interestingly, Lamine also associates eyes, mouth, and ears with Italian. This demonstrates that, despite his still limited knowledge of Italian, the informant considers Italian the primary language of his urban linguistic landscape, both visual (through writing and signs) and listening (TV, radio, street conversations). From this linguistic description and from the interaction with informants, it can be observed that Italian is mainly used for instrumental reasons (school, friends, work, socializing), but not for healthcare. For this reason, informants often refer to linguistic and cultural mediators.



Figure 1. Lamine's language portrait

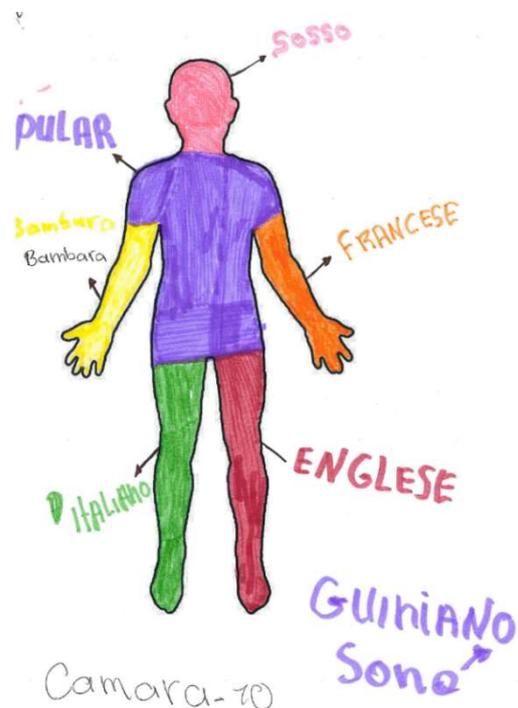


Figure 2. Camara's language portrait

The linguistic repertoire of these two Guinean informants reflects not only linguistic richness, but also linguistic challenges in healthcare settings. Despite the plurilingual competence of many African patients – including all of our informants – their low competence in Italian, and in some cases in the former colonial (now official) languages of their countries of origin, does not always allow for smooth communication with Western healthcare professionals. This communicative barrier is confirmed by the ISTAT survey (2017), which reports that 13.8% of foreign patients experience difficulty in explaining their symptoms in Italian, and 14.9% are unable to understand what the doctor says. However, the language barrier is not limited to the foreign patient alone. In many cases, Italian healthcare personnel are also unable to communicate in the patient's language. This double linguistic limitation can result in “double-layered errors, caused both by the migrant when translating from the local language into an intermediate (official) language, and by the doctor when translating from the intermediate language into Italian” (Colasanti and Geraci 2000: 216).

As suggested by the Companion Volume of the Common European Framework of Reference – CEFR (Council of Europe 2018: 28), ensuring effective communication – even in multilingual contexts – requires targeted mediation strategies. In fact:

Plurilingual competence involves the ability to call flexibility upon an inter-related, uneven, plurilinguistic repertoire to: switch from one language or dialect (or variety) to another; express oneself in one language (or dialect, or variety) and understand a person speaking another; call upon the knowledge of a number of languages (or dialects, or varieties) to make sense of a text; recognise words from a common international store in a new guise; mediate between words from a common international store in a new guise; mediate between individuals with non common language (or dialect, or variety), even with only a slight knowledge oneself; bring the whole of one's linguistic equipment into play, experimenting with alternative forms of expression; exploit paralinguistics (mime, gesture, facial expression, etc).

In this regard, the CEFR Companion Volume (*ibid.*) adds that, in light of the so-called crosslinguistic mediation, “mother tongue,” “first language,” and “language of schooling” are often not synonymous, and even expressions such as “source language” and “target language” can be confusing. For instance, when mediating from another language, one may be mediating into the mother tongue; in this case, the other language is the source language and the mother tongue becomes the target language. The existence of barriers that hinder the relationship between the Italian healthcare system and immigrant patients is undeniable. Overcoming such obstacles requires not only the presence of professional mediators, but first and foremost an adequate level of knowledge and awareness of the negotiation dynamics involved in the interaction between healthcare professionals and foreign patients.

Colasanti and Geraci (2000: 213) observe that in the interaction between Western doctors and migrant patients, there is often significant difficulty in mutual understanding – not only due to linguistic or ethnological factors, but also because of the complex expectations of the migrant. These patients often

live in an ambiguous condition, torn between a past that is never completely left behind and a desire for integration into a new world that they are unable to fully embrace. Mediation in healthcare settings should therefore involve a dynamic relationship between doctor and patient – between two cultural worlds – as an integral part of the care process. Within a transcultural medical framework, before formulating a diagnosis, it is necessary to ensure that the patient is placed at the center of care, as a whole person. This includes understanding the patient's emotions, value systems, attitudes, ways of being, and cultural context. For instance, while a Western physician may treat tuberculosis by recalling that it is caused by the Koch bacillus, a mediation-oriented approach would also consider that, in some African cultures, this disease is viewed as a condition of marginalization or even as a reflection of moral decay. The challenge, therefore, lies not only in proposing effective and cutting-edge treatments, but also in adapting medical care to the patient's specific cultural and social needs.

8. Conclusions

This pilot study contributes to understanding how sub-Saharan African asylum seekers in Italy perceive health and illness, and how their linguistic and cultural repertoires affect communication with healthcare providers. The findings confirm a significant continuity between pre-migration health representations and post-migration practices. Health is perceived not merely as the absence of disease, but as a multidimensional condition encompassing physical ability, social inclusion, economic stability, and psychological balance. In particular, the association between health and the ability to play sports underscores a conception of well-being linked to energy, movement, and relational participation, which differs from both the biomedical and the work-oriented notions observed in WHO's African surveys.

The study also reveals the coexistence of plural therapeutic systems: although all respondents expressed trust in Italian hospitals, half reported continuing to use traditional remedies. This hybridization of care models confirms that migration does not entail an abrupt break with pre-existing cultural frameworks but rather a process of negotiation between different medical rationalities. From a linguistic perspective, the portraits of Guinean informants show that Italian, though perceived as a language of integration, is rarely used in healthcare interactions, where communication depends instead on mediators and multilingual repertoires.

These results highlight the structural importance of professional linguistic and cultural mediation in guaranteeing equitable access to care. Mediation should not be conceived as an ancillary service, but as an integral component of the healthcare process, fostering reciprocal understanding and transcultural competence among both patients and practitioners. Ultimately, the research advocates for a model of "transcultural healthcare" in which the patient's cultural background, linguistic repertoire, and migration history are considered essential diagnostic and therapeutic resources rather than obstacles.

As discussed in Machetti and Siebetcheu (2017), beyond desirable future developments, the current realities of linguistic and cultural mediation in healthcare can be grouped into different scenarios. First, the use of the patient's official national language by the Italian physician. The advantage of this option is that communication is direct. However, if either the doctor or the patient has limited linguistic competence, there is a risk that the deeper aspects of the illness may not be adequately addressed. A second key figure is that of the interpreter, Artificial Intelligence Translation as well as digital assisted translation. This option guarantees the literal translation of the message. However, in the absence of cultural and technical competence, communication challenges may still arise. Moreover, the interpreter or the AI may censor or distort certain answers in order to avoid transmitting to the Western doctor information that, in their opinion, could reflect negatively on the patient or on the community to which they belong (Mazzetti 2000: 225). The third option is the use of foreign healthcare professionals. The advantage here is that it is sometimes possible to find a physician who speaks the patient's language and understands the medical culture of the patient's country of origin. In their dual role as healthcare provider and cultural peer, however, these professionals must be cautious not to overinterpret cultural factors, which may not align with the patient's actual condition or context. Finally, we have the use of a linguistic-cultural mediator. Based on the limitations of the previous three options, it becomes clear that factors such as origin, skin color, and language alone do not determine the success of communication between doctor and patient. A well-trained mediator with appropriate technical, linguistic, and cultural competencies can play a crucial role in the healthcare process.

In a sensitive domain such as healthcare, where privacy and patient trust are paramount, the ideal scenario would be the presence of healthcare personnel who possess not only clinical skills but also linguistic and cultural awareness and experiences in treating foreign patients. In other words, doctors and nurses themselves should also act as mediators. In the specific case of African patients, direct knowledge of the African healthcare system and local customs would enable the Western physician to mediate care processes with greater awareness. Further large-scale studies could expand on these preliminary findings to evaluate the long-term impact of mediation practices and to inform policies aimed at integrating intercultural competence into the training of healthcare professionals.

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