KEY CONSIDERATIONS: EQUITABLE ENGAGEMENT TO PROMOTE COVID-19 VACCINE UPTAKE AMONG UNDOCUMENTED URBAN MIGRANTS

Social Science in Humanitarian Action Platform

This brief sets out key considerations linked to the promotion of COVID-19 vaccine uptake among undocumented migrants residing in Rome, Italy. We focus on strategies to equitably distribute COVID-19 vaccines. Evidence from Italy is applicable to other contexts where vaccine administration is tied to "vaccine passports" or "immunity passes". Undocumented migrants have been considered as some of the "hardest to reach" groups to engage in COVID-19 vaccination outreach.[1] This brief uses the term undocumented migrant or migrant for brevity, but we refer to people living without formal Italian citizenship, refugee status or right to remain in Italy.

This brief explores the everyday context of undocumented migrants lives, and how experiences of the COVID-19 pandemic have exacerbated difficult conditions.[23] It links emerging vulnerabilities to perceptions of vaccines, and we suggest that migrants orientate themselves towards the vaccines within frameworks which prioritise economic survival. In many cases, migrants have accepted a COVID-19 vaccine to access paid employment, yet this has often generated mistrust in the state and healthcare system. Accordingly, this brief considers how vaccines can be distributed equitably to boost trust and inclusion in the post-pandemic world.

This brief draws primarily on the ethnographic evidence collected through interviews and observations with undocumented migrants in Rome, along with civil society representatives and health workers between December 2021 and January 2022. This brief was developed for SSHAP by Sara Vallerani (Rome Tre University), Elizabeth Storer (LSE) and Costanza Torre (LSE). It was reviewed by Santiago Ripoll (IDS, University of Sussex), with further reviews by Paolo Ruspini (Roma Tre University) and Eloisa Franchi (Université Paris Saclay, Pavia University). The research was funded through the British Academy COVID-19 Recovery: G7 Fund (COVG7210058). Research was based at the Firoz Lalji Institute for Africa, London School of Economics. The brief is the responsibility of SSHAP.

KEY CONSIDERATIONS

- The Italian COVID-19 Strategic Plan did not identify non-Italian citizens as eligible for vaccination in the early months of the campaign.[4] Though there have been subsequent changes, which have made it possible for non-Italian citizens to access vaccines, confusion about access to COVID-19 vaccines among undocumented communities has persisted for a long time. Regional disparities and digital inequities remain around the access to vaccines, and these particularly affect minoritised groups, including undocumented migrants.
- From July 2021, COVID-19 vaccination across Italy has been linked to the issuance of a Green Pass, a prerequisite to accessing many forms of transport, bars, restaurants and leisure establishments, and workplaces.[5] Informal employers have enforced Green Pass checks. Early exclusions coupled with informal employment have made the impact of these legislative changes particularly significant for migrants.
- In view of regulatory changes, many undocumented migrants understood vaccines not to be primarily a health intervention, but as a form of state governance. Without rights to stay permits or Italian citizenship, migrants widely feared identification/ deportation/ removal by police and state officials. Yet, requiring a Green Pass to earn a living, many felt coerced into accepting a vaccine. Moving forward, to produce trust, vaccine outreach campaigns should address the interface of wider, socio-economic determinants of health, with risk of COVID-19 infection.[6]
- Healthcare – and vaccine campaigns – are subject to the politics of decision-making by actors at national and regional scales. It is important to include this pool of decision-makers, as well as

NGOs, third sector associations, migrant advocacy organisations, as well as migrants themselves, in vaccine policymaking.

Vaccine Hesitant?

- EU policy has labelled undocumented migrants as vaccine hesitant. This stance is often adopted drawing from rights-based studies which equate social exclusion to vaccine hesitancy, and the avoidance of health/ state authorities.[17] It is important to note that policy approaches which homogenise undocumented migrants ignore the diversity which structures vaccine orientation. We found that the popular association of migrants being hesitant is not empirically true. Many migrants had accepted vaccines along their migratory route, or to access workplaces.
- Where undocumented persons have resisted or rejected vaccines, this was often related to structural barriers, including fear or mistrust of state authorities. Though misinformation and fears about vaccine side-effects did exist, this was reported less frequently as a reason for rejecting a vaccine. Health communication must be twinned with strategies to reverse mistrust in authorities.

Engaging Civic Infrastructures

- Undocumented migrants are not easily reached through the national health system, and usually seek medical assistance only after experiencing critical illnesses. It is important to engage civic infrastructures that are actively involved in assisting migrants across several domains, including offering health advice, housing and legal advocacy. A prominent example is a network of activist clinics, where (often) volunteer doctors and nurses regularly come into contact with undocumented persons. Such figures, though often itinerant, are trusted with medical care. In some cases, these networks, as well as third sector associations and NGOs, have also played a role in the vaccination campaign, acting as intermediaries between undocumented persons and health authorities.
- It is of note that infrastructures are sustained by volunteers who are often unpaid or receive limited compensation for their time. Many doctors are, for example, simultaneously employed in full-time service in hospitals. In order to ensure regularity of provision, it is important to fund civic infrastructures, rather than relying on volunteer altruism. This is particularly significant if medical staff are expected to take on additional work in terms of advising and administering COVID-19 vaccines.
- Regional and urban disparities pervade the provision of care through civic infrastructures and volunteers across Italy, and in Rome. It is essential to fund any additional outreach work performed by third sector organisations. Additionally, it is important to link activities to national advocacy to attempt to influence structural changes to the provision of healthcare – and the equity of digital platforms – through which routine and emergency care, as well as vaccination, are accessed by undocumented people.

Tailoring Communication

- Physical outreach, which depends on building connections and trust within localities, must be linked to wider attempts to build inclusive digital platforms to access vaccines. Regional disparities exist in how migrants can book vaccines through digital platforms. It is essential to link civic engagement, and health messaging, to the reform of exclusionary digital platforms.
- Changes to accessing vaccinations for undocumented individuals have been poorly communicated. Though health workers were informed about changing policies, this information had not always reached migrant communities. To reverse the harm perpetuated by early exclusion of non-Italian citizens, it is essential that communications are displayed within housing "occupations" (squats or dwellings), as well as clinics and NGOs, which are trusted by migrants. It is important to include information on legal rights, housing rights and asylum procedures alongside health messages.

- There is a need for communication strategies to be translated into a host of languages which reflect those spoken by migrants. Depending on length of stay in Italy, migrants often do not speak Italian (or English). Important languages include: Romanian, Arabic, Albanian, Chinese, Farsi, French, English, Spanish and Bengali. Given this diversity of languages, it may also be effective to communicate procedures visually, through infographics.
- Migrants use social media more than government websites. It is thus important to design communication strategies which are shared over Facebook, WhatsApp, TikTok and Instagram platforms. These platforms are particularly used by younger migrants, but families are often connected through WhatsApp groups.

BACKGROUND

In 2020, it is estimated that about 519,000 undocumented migrants resided in Italy.[8] Given the obvious difficulties in numerating undocumented groups, the real figure is likely to be much higher.[9] Though the pandemic decreased international mobility throughout 2020, in 2021 67,040 migrant sea arrivals (including nationals from Tunisia, Egypt, Morocco, Iran, Bangladesh, Cote D'Ivoire, Iraq, Guinea and Eritrea) were recorded on the Central Mediterranean route.

Following arrival in Southern Italy, some migrants opt to work on agricultural plantations, through forms of 'caporalato' (a system of illegally hiring day labourers through an intermediary). This type of work is seasonal and involves unpredictable working conditions, with low wages, frequent intimidation of 'gangmasters', without the right to access any services.[10] Accordingly, many undocumented migrants move to urban centres, such as Rome, to seek work in the informal economy,[1] which, whilst unstable and often exploitative, is generally deemed a better option. Others move to the city to pursue asylum or residence claims. In Rome, the percentage of residents from non-EU countries is estimated to be 7.4%.[11] Across the city, the main countries of origin are the Philippines, Bangladesh and China, followed by Ukraine, Egypt and India.

People stay in Italy for different periods. Whilst some undocumented persons had resided in the city for many years, other were recent arrivals. Many had embarked on a process of “regularisation”, which involves applying for a residence permit that can be requested for: international protection; family reunification; or medical treatment. Despite some residing in Rome for a decade, many had never received papers.

Within this study, reported countries of origin were mainly Bangladesh, Ecuador, Albania, Venezuela and Peru. This reflects the networks of the research, and common tendency for people to reside with networks of co-nationals. Migration reasons included: fleeing conflict; escaping economic and/or climate crisis, as well as poverty in country of origin; along with fleeing ethnic, religious or political persecution. A mix of forced migration and economic drivers to leave can thus be detected. The main motivation for staying in Rome among interviewees was the possibility of finding a job in the informal sector, which has been operating for long as a pull factor for undocumented migration in Southern European countries, such as Italy. Our interlocutors mainly included single working men, but also women from Eastern European countries.

Urban Life for Undocumented Migrants

In Rome, urban life for undocumented migrants reflects their liminal citizenship status. People were often employed informally in jobs considered “essential” during the pandemic,[12] as caregivers, housekeepers, with cleaning companies, as restaurant workers, or in factories involved in processing or packaging of food products. Some of these jobs, especially domestic work, are distinctly gendered and feminised.[13,14] Conditions vary between industry, but, due to the unregulated nature of employment, contracts rarely existed, and migrants were often subjected to long working hours, low pay and overcrowded working conditions. Without employment contracts, most migrants do not have access to sick pay or health benefits from their employer. Employers have liberty to dictate working

[1] In 2019, according to ISTAT, the unobserved economy amounts to 11.3% of Italian GDP. The unobserved economy includes irregular work, which alone represents 4.4% of GDP.

conditions. Without rights to stay, undocumented migrants have few channels to contest poor treatment.

Undocumented migrants often live in inadequate or overcrowded housing.[15,16,17] Article 5 of the National Housing Plan (2014) decrees that anyone "illegally" occupying a house cannot apply for official residence.[18] Excluded from the formal rental market by cost of living and lack of papers, many live with other undocumented persons in "occupations", whilst others share flats with co-nationals, without contracts. Many opt to live with those speaking the same language, with associating with a collective also providing security in an urban space structured by class differences. Living in informal housing affects one's access to health and welfare services.

These structural conditions mean that undocumented migrants often have limited recourse to safety nets, the state and little savings. Additionally, many individuals are obligated to remit money to relatives and associates at home, or to those who are embarking on migrant journeys. Where available, assistance and welfare come from NGOs, third sector associations, voluntary groups and informal networks formed by migrants themselves.[19,20,21] However, this is often on an ad hoc basis, and organisations are unevenly spread across the city.

It has been widely documented that the COVID-19 pandemic has expanded and intensified pre-existing inequalities, including for undocumented persons.[22] Much informal labour continued throughout the pandemic, and overcrowded dwellings prevented practicing social distancing. Reluctance to access health facilities means that migrant populations register a higher rate of pre-existing health conditions than Italian citizens. Accordingly, throughout the pandemic, migrants have been at high risk of contracting COVID-19, and being hospitalised by the virus.[23] In many cases, a peak diagnostic delay of up to four weeks was recorded among migrant populations. As a result, infections among non-Italians were diagnosed in a less timely manner, at a more advanced stage of the disease, and with more severe symptoms.[24,25,26] Deaths among migrants were higher than in the rest of the population.[24] Additionally, the Italian state halted bureaucratic processes to grant asylum or provide temporary residence during lockdowns.[27] In 2020 in Italy, 76% of asylum requests were rejected and data processing procedures subject to delays.[28,29] In multiple ways, COVID-19 accentuated the liminal status which characterises urban living for undocumented migrants in Rome.

Health and healthcare of undocumented migrants in Italy

Nominally, the Italian Constitution considers health a fundamental and inviolable right of any individual within its borders.[30] Despite this, structural barriers persist, which deny undocumented persons access to routine and preventative treatment through the national healthcare system.[31]

Without a National Insurance Number (associated with selected permits of stay or Italian citizenship), there are mechanisms through which undocumented persons can access care, though the issuance of a code - the *Straniero temporaneamente presente* (STP) (literally "temporary resident foreigner"). The STP code is obtained physically, at local health authorities. This code is valid for 6 months and can be presented at state hospitals and clinic facilities to access care. The STP code guarantees minimum essential services, such as urgent hospital treatment, pregnancy and maternity care, child health care, prophylaxis, diagnosis and treatment of infectious diseases and vaccinations. However, there are limits to the form of care granted to an individual bearing an STP code, by contrast to a National Insurance Number. Crucially, general practitioner (GP) appointments cannot be accessed with an STP code, since it is a service allocated according to place of legal residence. This is a critical gap, which means that many undocumented people do not access care for non-critical conditions. Accordingly, several studies indicate that ethnic minorities overuse the emergency room.[32,33,34]

Despite the existence of alternative health structures, information campaigns to inform undocumented persons of processes and rights are limited. At present, there is little state support to empower health workers to deliver health messaging, or to provide tailored training on language support and contact with social workers.[35] Thus, there are manifest gaps between official policy frameworks and social realities.

The Italian health system is regionally decentralised, and so differentiated across the country. Differentiation is reflected in the health services dedicated to undocumented migrants, which exist on a continuum from more inclusive approaches, (e.g. in Emilia-Romagna), to more exclusionary ones, (e.g. in Lombardy).[36] In the latter case, NGOs and third sector associations are the main provider of non-urgent care.[37] Rome is host to a multiplicity of state and non-state actors offering health services, and whilst these entities offer services within the limits of organisational mandates, they cannot reverse the "exceptional" status of the undocumented migrants. Thus, the situation of migrants exemplifies deep inequities in the provision of health In Italy. Certain population groups systematically receive different levels of care for the same needs.[38]

Italy's Response to COVID-19

Italy was one of the first countries affected by COVID-19 and has been amongst the countries most heavily affected by the COVID-19 pandemic since its onset in early 2020. Measures to contain the virus were managed by the central government in agreement with regional authorities through the State-Regions Conference. The Italian government declared a "state of emergency" on 31 January 2020, and from 12 March 2020 to 3 May 2020 a stringent nation-wide lockdown was enforced.[39] There was a general re-opening of activities during "Phase 2", which lasted from May to June 2020, though several national and local lockdowns followed during the autumn of 2020 and 2021. The state of emergency has ended only at the end of March 2022.

Italy's COVID-19 vaccination campaign began on 27 December 2021.[40] This plan was developed by the central government, through an internal collaboration between the Ministry of Health, the Council of Ministers and the Istituto Superiore di Sanità (ISS), AIFA (Italian Medicines Agency) and Agenas. The vaccination programme initially had three priorities: age, comorbidity and occupational categories.

On the ground, the delivery of vaccination reflects regional disparities in the organisation of the Italian healthcare system. Healthcare governance has come to be dominated by two trends: either regional autonomy (where regions have significant influence in defining health services) or attempted re-centralisation by the state (where the central government overwrites the autonomy of regions).[41] These two trends can coexist within specific regional systems – the management of hospitals verses GPs, for example, can reflect different struggles for autonomy or centralism within this specific field.

During the pandemic, and particularly during the vaccination campaign, tensions played out between state and regional actors.[41] Whilst nominally, the vaccination campaign (as with COVID-19 restrictions) reflected central government mandate, the vaccine roll-out often differed according to choices made by health policy actors at the regional level, like Regional Health Department and local health authorities. This diversification was evident in the case of vaccinations – whilst the process for obtaining a vaccine was set nationally, the platform for registering was provided regionally. State/ regional decision making affected the inclusion of undocumented persons, and necessitates research conducted at the regional level.

BARRIERS TO INCREASING COVID-19 VACCINE UPTAKE AMONG MOBILE GROUPS

Research shows that undocumented individuals face structural barriers in accessing public health services,[31,35] which have deeply affected their engagement with COVID-19 vaccination campaigns. This section outlines specific barriers which prevent uptake of vaccines among undocumented migrants living in Italy.

Prior Mistrust of Healthcare Facilities

- **The healthcare needs of undocumented persons are not prioritised** by the Italian government. Since social and health policies dedicated to migrant people are characterised by multi-level governance (State-regions-local authorities), there can be limited coordination between different actors and levels of governance. Undocumented people frequently fall between the gaps.[28]

Undocumented people do not perceive the national health care system as a vehicle for equity, but rather as a service differentiated on the basis of rights to citizenship. In addition, migrants are often identified as easy scapegoats for social, economic and health problems, and this long-term process leads to increased exclusion and episodes of racial discrimination and violence.[42]

- **Lack of comprehensive health care provision**. Access to a general practitioner is not among the health services guaranteed through an STP code. This represents a major gap in migrant access to care. For most Italians, the GP is the main reference point for health, and provides a central interlocutor in opening access to the wider health system. The absence of this figure implies the loss of a trusted figure with whom individuals can build relationships over extended time periods.
- **How to get the STP code**. There is insufficient information available on accessible channels which pertains to: how to obtain the STP code; how to access services; and guaranteed rights and protection when seeking healthcare. Despite the centrality of the STP code as a means of accessing vaccination, many undocumented people did not know about it.
- **Language barriers, cultural distances and lack of communication**. It is difficult to find linguistic and cultural mediation services in health care facilities. Healthcare professionals lack specific education and training in the fields of intercultural communication, transcultural medicine, migration and ethno-psychiatry. Italy lacks clear and accessible communication in several languages on the risks of COVID-19. Moreover, where communication does exist, it is often limited to institutional channels, which are not the main source of information for undocumented migrants.[43]
- **Fear of public authorities**. Beyond this, undocumented people are often demotivated to access health facilities because of fear of connection between health and the state authorities.[44,19] Within Rome, Italian police are known to administer fines which, if unpaid, lead to court hearings for undocumented people. Undocumented people fear deportation. Despite health practitioners' reporting of undocumented people to the police being forbidden both by law and by the "code of ethics for doctors", this is not known to many undocumented people. Though attitudes differ, it is sometimes assumed that health facilities are connected to the state. Thus, despite legal protections, many migrants perceive state healthcare facilities as unsafe. Prior experiences of racialised discrimination experienced by migrants produce additional mistrust in the healthcare system.

Digital and Physical Infrastructure Limitations

- **There are deep limitations since the state did not include migrants in digital infrastructure**. The vaccination response for undocumented persons was delayed by 8 months compared to Italian citizens. Despite legislative changes which linked an STP number to vaccination, many undocumented persons could not register on regional portals (even if they met eligibility criteria). In many regions, the inclusion of migrants was delegated to the third sector and NGOs, which undertook exercises to (for example) compile a list of undocumented people to be vaccinated. Yet, although these exercises were regionally diffused, they did not reach many.[45]
- **Regional disparities**. Responses in some regions featured: dedicated vaccination hubs with direct access for migrants; the possibility of registering directly from the regional platform; and 'itinerant' vaccination campaigns.[46] These interventions were limited to arrival places outside the city, and did not reach Rome, where many migrants live.
- **Urban Disparities**. In Rome, the state, in essence, relied on NGOs, third sector associations and informal groups to reach undocumented persons. Whilst there are many associations present in the city, the approaches of gathering information and methods of contact with responsible entities (health services, associations and NGOs) differed from one another. One association activated a telephone number dedicated to booking vaccines and compiled lists to be sent to the health authorities in order to book the vaccinations. Social workers from the local health authorities visited housing occupations once a week to collect the data of those who wanted to be vaccinated (or had other health needs).

- **Limitations of voluntary work**. NGOs, the third sector and informal groups relied on voluntary work. Third sector employment in Italy, prior to the pandemic, was also affected by low salaries, unpaid work, unlimited working hours and sometimes longstanding competition for survival between entities with different ideological orientation. The addition of work for the vaccination campaign, often without specific funding, has intensified the working rhythms and exploitative conditions of health and social workers or volunteers. One health worker remarked: 'I deal with vaccinations but I cannot understand the reasons why they do not open the bookings for everyone. It doesn't make sense as a choice and as a health policy.' Another volunteer explained: 'I put my number on all the flyers about vaccines and everyone called me to ask for information and to get on the list. I received more than 50 calls a day, it was impossible to live, even though it was an important thing to do'.
- **Different opinions on vaccines**. In addition, especially for informal groups, this work was also carried out by volunteers and staff who themselves hold critical views on safety and efficacy of vaccines, and the implications of state issuance of Green Passes. One of the activists of a housing squat in Rome: 'I am against the vaccine, but we still work with the public service to guarantee vaccination for the inhabitants. I won't get vaccinated, but it's my choice and it doesn't affect that of the inhabitants.' Thus, whilst this activist did not allow his personal opinion to inflect on their vaccine advice, it should not be assumed that civil society representatives are "pro-vax". Italy has been the site of a widespread anti-vax movement, and volunteers in Rome themselves exhibited diverse attitudes towards the vaccination.

Limited Information about COVID-19 Vaccines

- **Lack of uniform, effective and timely communication to correct early bureaucratic exclusion**. Institutional communication about the vaccine for undocumented persons was developed too late, and legacies of early exclusion have continued to produce confusion. Communication strategies vary regionally, but in general there have been limited attempts to target migrants specifically.
- **Misinformation**. Additionally, there have been limited attempts to reverse false perceptions of the vaccine. There has been highly limited translation of documents and information on COVID-19 risks and prevention measures[47] and a distinct lack of attention paid to migrant's specific concerns about side-effects.

MIGRANTS' PERCEPTIONS OF VACCINES

Recent EU policies have categorised undocumented migrants as vaccine 'hesitant'. However, people reported diverse orientations towards COVID-19 vaccines.[48][49] This reflected changing policies, whereby vaccines were linked to the EU Digital Covid Certificate (Green Pass).

Vaccine Acceptors

- **Perceptions of vaccines must be understood in connection with the Green Pass**, and the changing restrictions associated with it. This certification is mandatory in the workplace, to enter most public offices, shops (but not groceries), bars and restaurants and all places of gathering Since December 2021, there have been two types of Green Pass in Italy: the Super Green Pass, which is obtained with vaccination or a certificate of recovery; and the "simple" Green Pass, which is obtained with a swab and has a limited duration (24-48 hours). Problems were also reported downloading the Green Pass for those who registered with the STP code. Until the end of August 2021, the Green Pass could only be downloaded with the National Insurance Number, and in the months following, delays still persisted.
- **Although the Green Pass has been presented as a public health measure, the perception of this measure among undocumented persons is often different.** Undocumented migrants explained that they accepted the vaccine in order to safeguard their job. The Green Pass is required at workplaces, and informal employers require a pass as a prerequisite to entering the

workplace and obtaining a daily wage. Reportedly, across informal sectors Green Pass "inspections" had become extensive at the time of research. On account of this, many reported that the Green Pass had become akin to "blackmail", and people were forced to get vaccinated to continue working. One undocumented person who took the vaccine explained that the Green Pass "is a matter of survival".

- **Health and social professionals have on occasion used the argument that one must get vaccinated in order to maintain their job.** Undocumented migrants reported that this approach produced feelings of coercion, and it appeared as if health-workers were on the side of employers, rather than protecting individual health. This aspect is critically reported by a health worker: 'We used to use the Green Pass as incentive to vaccination. […] To convince them [undocumented individuals] we used to say «without it you won't be able to work». That's how we would convince them, and a lot of people got vaccinated for that reason, not for anything else. […] The Green Pass was a kind of blackmail, honestly. It pains me to admit it because I think vaccination is the most important public health measure in the first instance. A serious state has to take responsibility for vaccines, not only for the Green Pass, otherwise […] people decide to vaccinate for work and not for their health.'
- **Feelings of coercion were compounded when people experienced delays in obtaining the Green Pass after booking a vaccination with an STP code.** The inability to obtain the Green Pass has had strong consequences in people's lives, and delays deepened mistrust in health authorities. One woman explained: 'I don't have the contract and I don't have the papers. I have to carry the Green Pass with me, they ask for it every day. Otherwise, they don't let me in and send me away without a job.' Theoretically, the Green Pass should arrive immediately after vaccination. However, because the procedure is different among categories of individuals, there have been delays. In several cases, the delay in receiving the certification forced undocumented people to take a COVID-19 rapid test (which costs about €15 at local pharmacies) several times while waiting for the Green Pass. System malfunctions affected those who were already in a situation of occupational and economic vulnerability and were interpreted as "deception" and further generated an increased lack of confidence in the public health system. A health worker reports: 'You can't imagine how angry the Kurds people were. We went to get vaccines and then the Green Passes didn't arrive. They got angry with us and said 'what happened to our certifications? We need to work!'.
- **Choices to get vaccinated were often influenced more by compliance with governance mechanisms associated with COVID-19 than by the fear of contracting the virus.** Thus, even among undocumented persons who had accepted a vaccine, this was not indicative of trust in the Italian health care system. Interviewees reported feelings of anger, frustration, anxiety and depression at the loss of autonomy. For example: 'I decided to get vaccinated for the Green Pass because everyone asked for it in every space. I wasn't afraid of the virus, but I was afraid of the bureaucracy, and every time the State becomes more discriminatory and racist. I think that Green Pass is an instrument for exclusion.' In many cases, the vaccination campaign did not become an opportunity to connect marginalised people with institutions. Vaccine equity does not end with the availability of the vaccine, but is composed of the processes that are activated around it.

Vaccine Resistors

- **Many urban migrants who had arrived in Italy during the pandemic had already received a vaccine**. Vaccines obtained outside the EU (Philippines, Indonesia, Turkey, Russia, etc.) were often not recognised as valid by the Italian authorities. Migrants were thus trapped in a paradoxical situation: the lack of a Green Pass and at the same time the impossibility of vaccination for medical reasons since people were already vaccinated. As one health worker describes: 'Several times we met people who had already been vaccinated, for example in the Philippines, but they often arrived with the Chinese vaccine, which is not recognised here. Each case was different and different solutions had to be found.'
- **Misinformation**. Many undocumented persons expressed a mistrust of official and institutional news channels providing information on vaccination against COVID-19, echoing discourses

prevalent among No Vax and No Green Pass protest movements that took place in Italy. ICTs (Information and Communication Technologies) and social media play a central role in finding and sharing information during the migration process. The use of these information channels continues to be central even for those who settle in Italy permanently, and they constitute an alternative to institutional and official communication channels, towards which there is a lack of trust.[50,51,52] Even in the case of vaccination campaigns, people often turned to social media, including WhatsApp, Facebook, Instagram, TikTok. Due to the lack of regulation on these channels, migrants often picked up mis-/ dis-information in relation to the vaccine. An undocumented person says: 'For a number of reasons I had to stay away from work for a few weeks and, luckily, I had time to do some research. I know that on television they don't always tell the truth, but luckily there are those who do tell the truth, perhaps on Facebook or in Telegram groups. There, I found information about the real risks'.

- However, the most common reason for rejecting the vaccine was perceptions that the **side effects** could be dangerous. This was related to the fact that many needed to work and were paid daily. The possibility of side effects, which might lead to sick days, was undesirable. But, additionally, fears about side effects relate to earlier alarmist news coverage about blood clots and deaths in Europe after the AstraZeneca vaccine was administered. Additionally, others were concerned by the fact that the vaccine was developed in a short period of time, without proper protocols. Some people perceived themselves to be part of an unsafe scientific experiment.[53]
- Hesitancy was also linked to **preconceptions that the vaccine presented more risk than contracting the COVID-19 virus.** One undocumented person reported: 'Many had witnessed friends or relatives testing positive while suffering limited symptoms. I have never had COVID but many friends have, and, in the end, it is an influence. Why do I have to put an unknown thing in my body for a fever?'
  For others, COVID-19 was interpreted as a "Western disease" that affects people differently depending on their country of origin.[54] Accordingly, many were reluctant to accept a vaccine which could bring unwanted side effects, when the virus itself was not deemed a significant health risk.
- Unvaccinated individuals' feelings of frustration and coercion were exacerbated by **the impossibility to choose which vaccine to receive.** In many clinics and hubs, the Johnson and Johnson's Janssen COVID-19 single dose vaccine was administered, as this was considered the most effective medical intervention to target highly mobile groups, who may not follow up with a second dose. However, research has found that the J and J vaccine has a lower effectiveness (66%)[55] than the others like Vaxzevria (AstraZeneca), BioNTech (Pfizer) and SpikeVax (Moderna) and would require a second dose to cover the variants and the second dose is difficult to administer, precisely because of people's mobile or irregular condition.
- **Since migrants cannot register for the vaccine themselves, this was perceived as health professionals making choices for migrants about vaccine brands, without consulting them**. Among both vaccinated and unvaccinated groups, the inability to choose exacerbated feelings of frustration and coercion. This is made clear in interviews: 'Johnson's vaccine is supposed to have similar technology to AstraZeneca. So, it is dangerous. I don't understand why others can choose which vaccine to have and I can't.'

BOOSTING COVID-19 VACCINE EQUITY AMONG URBAN MIGRANTS

The concept of equity differs from that of equality, in that it takes into account social determinants and people's starting living and socio-economic conditions.[56] Public health services should be proactive and build relationships with individuals and communities. This should also be done 'outside' the pandemic emergency, ensuring continuity of care and relationships.

Tailoring Communication Strategies

- It is essential that communication is tailored to linguistic and cultural specificities. Health advice should be made available in English, French and Arabic, as well as Romanian, Albanian, Chinese,

Farsi, Spanish and Bengali. Given the diversity of language of migrant communities in Italy, it is important that infographics are used alongside textual information. Itinerant information days have been an effective means of reaching undocumented persons, as has distributing information through civil infrastructures and housing occupations. Social medical campaigns, including WhatsApp and Facebook, but also Instagram and TikTok, are important avenues for accessing migrants and need to be considered as such.

- Information should particularly focus on evidence regarding the efficacy of vaccine brands, as well as the process for obtaining the Green Pass. In lieu of recognising vaccines manufactured in China (Sinopharm) or Russia (Sputnik V), it is also important to address how migrants who have previously been vaccinated should proceed within Italy's bureaucratic structures. Ideally, an exception in the acknowledgement of these brands should be granted to migrants (as has recently been declared for refugees fleeing Ukraine). It is important that information addresses concerns about bureaucratic delays in receipt of the Green Pass.

Engaging Civic Infrastructures

- Vaccines should be made available at clinics and facilities proximate to urban areas where large numbers of undocumented migrants are known to live/ work. This decreases the cost of travel to facilities and improves the likelihood that migrants will opt to take vaccines. Information about these locations should be made available at housing occupations.
- Policymakers and health practitioners should establish and build strong collaborations with migrant-led grassroot organisations to engage migrants in vaccination structures. One example could be housing collectives such as the *Occupazione abitativa in Viale delle Province* in Rome, which have been recently mobilised to visibilise housing struggles and upgrade living conditions.[57, 58] It is essential that the additional demands placed on volunteers are properly funded by the Italian state or international agencies. Ideally, funding for secondments of nurses and doctors to migrant clinics should be made available. It would be an additional benefit if medical professionals hailed from dominant migrant countries of origin. Failing this, it is necessary to guarantee the presence of cultural mediators and translators, or "transcultural" training of health personnel.
- Migrant-led and workers' organisations, and, ideally, undocumented persons themselves, should be closely involved in all parts of the design and implementation of vaccine campaigns for undocumented migrants. It is essential to engage in social listening to ensure effective co-production of campaigns. This is essential to ensure that even well-meaning attempts do not produce further stigma or exclusion.

Health Information alongside Advocacy

- **Health information provision must consider the wider socio-economic determinants of health which affect migrants' lives**.[59] As such, health information should also include or signpost to support with asylum claims and employment rights, as well as to support for psycho-social health concerns. In particular, vaccine administration could be accompanied by signposting and complaint mechanisms should be reinforced in the event of harassment, violence and discrimination. Different forms of social media provide an interesting field of experimentation for creating health information campaigns in a shared, participatory and interactive manner.
- **Health professionals maintain a high level of discretion in the provision of healthcare**; thus, they can have several impacts on the possibilities of patients to fully benefit from the services.[60] Training is needed for social and health workers who interface with migrant people. Whilst there is a need to produce information materials, it is important to offer appropriate staff training, so information can be delivered in the right way.
- **Building trust both through social and health staff and volunteers and by using spaces where people feel comfortable**. Consider that healthcare settings can be perceived as distant or even hostile. A proactive approach by health professionals can be useful, not only in the field of vaccination, but also in prevention and health promotion from a community perspective. Trust

building can be understood not only as an outcome, but as a real process in which different actors act and in which the top-down dynamic alone is deconstructed in favour of bottom-up approaches.

- **Building pathways of trust requires thinking in terms of communities**, but also in terms of individuals. In this sense, the doctor-patient relationship must be at the centre of a reflection on the active role that people can play in their own care pathway. We need to understand the fears and expectations regarding the doctor-patient relationship, and to do this we can conduct participatory research with the patients themselves and with the associations, informal groups and NGOs that have long worked with marginalised and racialised people.

CONCLUDING REMARKS

Health officials acknowledged that vaccine distribution to undocumented migrants was characterised by short-termism and a sense of “emergency”. Yet, COVID-19 vaccinations, whilst relying on boosters at 3–6-month intervals to maintain immunity, necessitate continued engagement with health facilities. This brief has outlined measure to boost vaccine equity and address the shortcomings of early inequities created through exclusionary and nationalistic approaches.

Undocumented migrants accepted or rejected the vaccine as it related to demands of work. Hence, immunity passports which afforded the right to access the workplace, even in the informal sector, had created significant increase in uptake among migrants. However, accepting a vaccine did not lead to undocumented persons trusting the state authorities or the healthcare system. Indeed, the brief has shown that state governance of the vaccine, widely perceived as coercive, has produced feelings of disempowerment and disenfranchisement among many migrants. Such approaches should be reconsidered in the administration of booster vaccines to undocumented people.

Whilst NGOs and third sector organisations have made significant impacts in facilitating access to vaccines, their reliance on volunteers, and the adding of vaccination to the delivery of already strained organisation mandates (relating to housing, asylum, health), has tended to overburden staff. Moreover, this patchwork of interventions has been unable to challenge electronic systems, which create a tiered system for migrants to access a COVID-19 vaccine, and a perception of the system as unreliable and exclusionary from below.

Moving forward, it is essential to fund vaccine outreach, and to twin the distribution of vaccines with information regarding asylum applications, housing and health rights. The COVID-19 pandemic has also exposed shortcomings in the type of routine care which can be accessed by migrants – particularly at the general practitioner level. To build trust in the long-term, the visibilisation of these issues during times of crisis must translate into sustained advocacy for migrants.

REFERENCES

1. World Health Organization (2021). COVID-19 immunization in refugees and migrants: principles and key considerations. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/344793/WHO-2019-nCoV-immunization-refugees-and-migrants-2021.1-eng.pdf
2. IOM (2020), COVID-19 and the risk of exacerbating existing vulnerabilities, Migration Factsheet No. 6 – The impact of COVID-19 on migrants https://www.iom.int/sites/g/files/tmzbdl486/files/our_work/ICP/MPR/migration_factsheet_6_covid-19_and_migrants.pdf
3. Taran, P. & Kadysheva, O. (2022). COVID-19, Migrants, Refugees, Mobile Workers: Global Assessment and Action Agenda. *Revista Tecnológica - Espol*, 34(1), 28-57.https://doi.org/10.37815/rte.v34n1.889
4.Armocida, B., Formenti, B., Missoni, E., D'Apice, C., Marchese, V., Calvi, M., Castelli, F., & Ussai, S. (2021). Challenges in the equitable access to COVID-19 vaccines for migrant populations in Europe. *The Lancet Regional Health - Europe*, *6(*100147). https://doi.org/10.1016/j.lanepe.2021.100147
5. DPCM (Decreto del Presidente del Consiglio dei Ministri), 17th June 2021. Published on https://www.gazzettaufficiale.it/eli/id/2021/06/17/21A03739/sg
6. Burström, B.,Tao, W. (2020). Social determinants of health and inequalities in COVID-19. *European Journal of Public Health*, *30*(4), 617–618. https://doi.org/10.1093/eurpub/ckaa095
7. World Health Organization. (2021). *COVID-19 and the social determinants of health and health equity: Evidence brief*. World Health Organization. https://apps.who.int/iris/handle/10665/348333
8. Cesareo, V. (2022). Ventisettesimo Rapporto sulle migrazioni 2021. Franco Angeli.
9. Cortignani, R., Carulli, G.,Dono, G. (2020). COVID-19 and labour in agriculture: Economic and productive impacts in an agricultural area of the Mediterranean. *Italian Journal of Agronomy*. *15*(2), 172–181. https://doi.org/10.4081/ija.2020.1653
10. Perrotta, D. & Sacchetto D. (*2014),* Migrant Farmworkers in Southern Italy: Ghettoes, Caporalato and Collective Action. *Workers of the World*, 1(5) 75-79.
11. Ministero del Lavoro e delle Politiche Sociali (*2020),* La presenza dei migranti nella città metropolitana di Roma Capitale. https://www.lavoro.gov.it/documenti-e-norme/studi-e-statistiche/Documents/La%20presenza%20dei%20migranti%20nelle%20aree%20metropolitane,%20anno%202020/RAM-2020-Roma-Capitale.pdf
12. Franchi, E., & Gili, R. (2020). COVID-19 epidemic in Italy and the Pandora's box of inequalities: Reopened or never closed? *Journal of Public Health and Emergency*, 4, p. 42. https://doi.org/10.21037/jphe-20-43
13. Andall, J. (2016). *Gender, Migration and Domestic Service: The Politics of Black Women in Italy*. Routledge. https://doi.org/10.4324/9781315254586
14. Centro studi e ricerche Idos in collaborazione con Centro Studi Confronti, Istituto di Studi Politici S. Pio V (a cura di) (2021). Dossier statistico immigrazione 2021. https://www.dossierimmigrazione.it/wp-content/uploads/2021/10/SCHEDA-DI-SINTESI-DOSSIER-2021.pdf.
15. Marra, C. (2012). La casa degli immigrati: Famiglie, reti, trasformazioni sociali. FrancoAngeli.
16. Mukumbang, F. C. (2020). Are asylum seekers, refugees and foreign migrants considered in the COVID-19 vaccine discourse? *BMJ Global Health*, *5*(11), e004085. https://doi.org/10.1136/bmjgh-2020-004085
17. Petrillo, A. (2018). La crisi dell'abitare migrante in Italia. Una prospettiva storica. *Sociologia urbana e rurale*, 117, 19-37. 10.3280/SUR2018-117002
18. DECRETO-LEGGE 28 marzo 2014, n. 47. Gazzetta Ufficiale. https://www.gazzettaufficiale.it/eli/id/2014/03/28/14G00059/sg%20
19. Ambrosini, M. (2015). NGOs and Health Services for Irregular Immigrants in Italy: When the Protection of Human Rights Challenges the Laws. *Journal of Immigrant & Refugee Studies*, *13*(2), 116–134. https://doi.org/10.1080/15562948.2015.1017631
20. Sanfelici, M. (2021). The Impact of the COVID-19 Crisis on Marginal Migrant Populations in Italy. *American Behavioral Scientist.* Vol. 65(10) 1323–1341. https://doi.org/10.1177/00027642211000413
21. OECD (2022), *International Migration Outlook 2021.* Available online: https://www.oecd.org/migration/international-migration-outlook-1999124x.htm
22. Bambra, C., Riordan, R., Ford, J., Matthews, F. (2020). The COVID-19 pandemic and health inequalities. Journal of Epidemiology and Community Health, 74(11), 964-968. http://dx.doi.org/10.1136/jech-2020-214401
23. Hayward, S. E., Deal, A., Cheng, C., Crawshaw, A., Orcutt, M., Vandrevala, T. F., Norredam, M., Carballo, M., Ciftci, Y., Requena-Méndez, A., Greenaway, C., Carter, J., Knights, F., Mehrotra, A., Seedat, F., Bozorgmehr, K., Veizis, A., Campos-Matos, I., Wurie, F., ESCMID Study Group for Infections in Travellers and Migrants (ESGITM), (2021). Clinical outcomes and risk factors for COVID-19 among migrant populations in high-income countries: A systematic review. *Journal of Migration and Health*, *3*(100041). https://doi.org/10.1016/j.jmh.2021.100041
24. European Centre for Disease Prevention and Control (2021), Reducing COVID-19 transmission and strengthening vaccine uptake among migrant populations in the EU/EEA. https://www.ecdc.europa.eu/sites/default/files/documents/covid-19-reducing-transmission-and-strengthening-vaccine-uptake-in-migrants.pdf

25. Fiorini, G., Rigamonti, A. E., Galanopoulos, C., Adamoli, M., Ciriaco, E., Franchi, M., Genovese, E., Corrao, G., & Cella, S. G. (2020). Undocumented migrants during the COVID-19 pandemic: Socio-economic determinants, clinical features and pharmacological treatment. *Journal of Public Health Research*, *Journal of Public Health Research*, 27, 9(4). https://doi.org/10.4081/jphr.2020.1852
26. Caritas e Migrantes (2021). XXIX RAPPORTO IMMIGRAZIONE 2020. https://www.migrantes.it/wp-content/uploads/sites/50/2020/10/RICM_2020_DEF.pdf
27. Tazzioli, M. (2021). A "Passport to Freedom"? COVID-19 and the Re-bordering of the World. *European Journal of Risk Regulation*, *12*(2), 355–361. https://doi.org/10.1017/err.2021.31
28. ISMU (2020). Beneficiari di protezione internazionale e integrazione in Italia. Focus sull'accesso al sistema abitativo. https://www.ismu.org/wp-content/uploads/2021/04/Italy-National-report-2020.-Beneficiari-di-protezione-internazionale-e-integrazione-in-Italia.pdf
29. Ero Straniero (2021). Regolarizzazione 2020 a rischio fallimento: tempi lunghissimi e ostacoli burocratici. Alcune proposte per "salvare" una misura necessaria. Available online: https://erostraniero.radicali.it/wp-content/uploads/2021/05/Secondo-report-monitoraggio-regolarizzazione_ERO-STRANIERO.pdf
30. Le decisioni della Corte costituzionale sulla condizione giuridica e i diritti dello straniero. (2012). https://www.cortecostituzionale.it/documenti/convegni_seminari/decisioni_diritti_straniero.pdf
31. Di Napoli, A., Ventura, M., Spadea, T., Giorgi Rossi, P., Bartolini, L., Battisti, L., Cacciani, L., Caranci, N., Cernigliaro, A., De Giorgi, M., Fanolla, A., Lazzeretti, M., Mininni, M., Mirisola, C., Petrelli, A. (2022). Barriers to Accessing Primary Care and Appropriateness of Healthcare Among Immigrants in Italy. *Frontiers in Public Health*, 10(817696), 1-7. https://doi.org/10.3389/fpubh.2022.817696
32. Rossi, P. (2016). Salute e inclusione sociale degli immigrati. La sfida dell'accesso ai servizi sanitari. FrancoAngeli.
33. Allegri, C., Banks, H., & Devillanova, C. (2022). Avoidable hospitalizations and access to primary care: Comparisons among Italians, resident immigrants and undocumented immigrants in administrative hospital discharge records. *EClinicalMedicine*, *46*(101345), 1-10. https://doi.org/10.1016/j.eclinm.2022.101345
34. Nuti, S., Maciocco, G., Barsanti, S. (a cura di) (2013), Immigrazione e salute. Percorsi di integrazione sociale. Il Mulino.
35. Issa, E.-H. (2007). La salute degli immigrati ieri, oggi e domani. *Tendenze Nuove*, *1, 39-44.* https://doi.org/10.1450/23676
36. Pasini, N. (2011), Confini irregolari. Cittadinanza sanitaria in prospettiva comparata e multilivello. Franco Angeli.
37. Olivani, P., Panizzut, D. (2019). Attuale legislazione sanitaria italiana per immigrati irregolari e attuale fruibilità di tale legislazione a livello regionale. Terzo Rapporto. https://www.simmweb.it/attachments/article/973/Report_LEGIS_Naga_2019.pdf
38. Braveman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health*, *57*(4), 254–258. https://doi.org/10.1136/jech.57.4.254
39. Campagna di comunicazione "Resta a casa". (2020, March 14). www.governo.it. https://www.governo.it/it/media/emergenza-sanitaria-coronavirus-resta-casa/14313
40. Ministero della Salute (2021). Vaccino anti-SARS-CoV-2/COVID-19. Piano strategico. https://www.trovanorme.salute.gov.it/norme/renderNormsanPdf?anno=2021&codLeg=78657&parte=1%20&serie=null
41. Neri, S. (2020). Più Stato e più Regioni. L'evoluzione della governance del Servizio sanitario nazionale e la pandemia. *Autonomie Locali e Servizi Sociali*, *2*, 239-255. https://doi.org/10.1447/98719
42. Sciortino, G., Palidda, S., Petti, G., Ruspini, P. (2000). Easy Scapegoats: Sans Papiers Immigrants in Italy, Report for the project "Easy Scapegoats: Sans-Papiers Immigrants in Europe" supported within the DG Employment and Social Affairs programme "Preparatory Actions to Combat and Prevent Social Exclusion, VP/1999/011", Weinheim: Freudenberg Stiftung
43. Behrouz M., Maldonado N., Collins, J., Harriet J., Blundell L. S. (2020). Engaging the vulnerable: A rapid review of public health communication aimed at migrants during the COVID-19 pandemic in Europe. *Journal of Migration and Health*, 1-2. https://doi.org/10.1016/j.jmh.2020.100004.
44. Vilog, R. B. T., & Piocos III, C. M. (2021). Undocumented in the time of pandemic: Exploring legal violence, health care and human rights of irregular Filipino migrants in Italy and the UK. *International Journal of Human Rights in Healthcare*, *14*(3), 209–222. https://doi.org/10.1108/IJHRH-09-2020-0072
45. Merli, G. (2021), Migranti. La campagna di immunizzazione contro il COVID-19 ha raggiunto anche le persone prive di documenti. Ma restano difficoltà e ostacoli per chi è rimasto escluso dall'ultima sanatoria. Published on Il Manifesto, 29.09.2021. Available online: https://erostraniero.radicali.it/irregolari-ultimi-e-vaccinati/
46. Presidenza del Consiglio dei Ministri (2021). *Somministrazione dei vaccini ai migranti*. (2021, September 9). www.governo.it. https://www.governo.it/it/dipartimenti/commissario-straordinario-lemergenza-covid-19/17884
47. Pirouz, B., Nejad, H. J., Violini, G. (2020). The Role of Swab Tests to Decrease the Stress by COVID-19 on the Health System using AI, MLR & Statistical Analysis. *MedRxiv*. https://doi.org/10.1101/2020.06.02.20120394
48. Declich, S., Dente, M. G., Tosti, M. E., Ponte, G. D., Marchetti, G., & Tavoschi, L. (2021). Vaccinations for Migrants and Refugees during and after COVID-19. Policy Brief ISPI. Available online: https://www.t20italy.org/wp-content/uploads/2021/09/TF10_PB06_LM02-1.pdf
49. Società Italiana di Medicina delle Migrazioni, Tavolo Asilo e Immigrazione, Tavolo Immigrazione e Salute (2021), Indagine sulla disponibilità a vaccinarsi contro il COVID-19 da parte delle persone ospitate nei centri/strutture di accoglienza in Italia. Available online: https://www.epicentro.iss.it/migranti/pdf/Terzo%20Monitoraggio%20Covid%20-%20TIS-TAI%20rev.pdf

50. Merisalo, M., Jauhiainen, J. S. (2021) Asylum-Related Migrants' Social-Media Use, Mobility Decisions, and Resilience. *Journal of Immigrant & Refugee Studies, 19(2), 184-198.* https://doi.org/10.1080/15562948.2020.1781991
51. Sanchez, G., Hoxhaj, R., Nardin, S., Geddes, A., Achilli, L., & Kalantaryan, S. (2018). A study of the communication channels used by migrants and asylum seekers in Italy, with a particular focus on online and social media. European Commission. https://doi.org/10.2837/7785450.
52. Frouws, B., Phillips, M., Hassan, A., & Twigt, M. (2016). Getting to Europe the WhatsApp Way: The Use of ICT in Contemporary Mixed Migration Flows to Europe. *Social Science Research Network.* https://doi.org/10.2139/ssrn.286259251.
53. Loomba, S., de Figueiredo, A., Piatek, S.J. *et al.* (2021). Measuring the impact of COVID-19 vaccine misinformation on vaccination intent in the UK and USA. *Nature Human Behaviour*, 5, 337–348 (2021). https://doi.org/10.1038/s41562-021-01056-1
54. Knights, F., Carter, J., Deal, A., Crawshaw, A. F., Hayward, S. E., Jones, L., & Hargreaves, S. (2021). *Impact of COVID-19 on Migrants' Access to Primary Care: A National Qualitative Study* [Preprint]. Primary Care Research. https://doi.org/10.1101/2021.01.12.21249692
55. Centers for Disease Control and Prevention (2022), Johnson & Johnson's Janssen COVID-19 Vaccine Overview and Safety. Updated 4th April 2022. Available online: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/janssen.html#print
56. Wang, Z., & Tang, K. (2020). Combating COVID-19: Health equity matters. *Nature Medicine*, *26*(4), 458–458. https://doi.org/10.1038/s41591-020-0823-6
57. Grazioli, M. (2021). Rethinking Public Housing Through Squatting. The Case of Housing Rights Movements in Rome. *PACO*, 14(2), 788-805. https://doi.org/10.1285/I20356609V14I2P78856.
58. Avallone, G. & Torre, S. (2016). Dalla città ostile alla città bene comune. I migranti di fronte alla crisi dell'abitare in Italia. A*rchivio di Studi Urbani e Regionali,* XL(VII), 51-74. 10.3280/ASUR2016-115003
59. Burton-Jeangros, C., Duvoisin, A., Lachat, S., Consoli, L., Fakhoury, J., & Jackson, Y. (2020). The Impact of the COVID-19 Pandemic and the Lockdown on the Health and Living Conditions of Undocumented Migrants and Migrants Undergoing Legal Status Regularization. *Frontiers in Public Health*, *8*(596887), 1-11. https://doi.org/10.3389/fpubh.2020.596887
60. Perna, R. (2018). Re-bounding EU citizenship from below: Practices of healthcare for '(il) legitimate EU migrants' in Italy. *Journal of Ethnic and Migration Studies*, *44*(5), 829–848. https://doi.org/10.1080/1369183X.2017.1362977

ACKNOWLEDGEMENTS

This brief has been written by Sara Vallerani (sara.vallerani@uniroma3.it) with Elizabeth Storer and Costanza Torre. The research was funded through the British Academy COVID-19 Recovery: G7 Fund (COVG7210058). Research was based at the Firoz Lalji Institute for Africa, London School of Economics.

CONTACT

If you have a direct request concerning the brief, tools, additional technical expertise or remote analysis, or should you like to be considered for the network of advisers, please contact the Social Science in Humanitarian Action Platform by emailing Annie Lowden (a.lowden@ids.ac.uk) or Olivia Tulloch (oliviatulloch@anthrologica.com).

The Social Science in Humanitarian Action is a partnership between the Institute of Development Studies, Anthrologica and the London School of Hygiene and Tropical Medicine. This work was supported by the UK Foreign, Commonwealth & Development Office and Wellcome Trust Grant Number 219169/Z/19/Z. The views expressed are those of the authors and do not necessarily reflect those of the funders, or the views or policies of IDS, Anthrologica or LSHTM.

KEEP IN TOUCH

Suggested citation: Vallerani, S., Storer, E. and Torre, C., (2022) Key Considerations: Equitable Engagement to Promote COVID-19 Vaccine Uptake among Undocumented Urban Migrants, Social Science In Humanitarian Action (SSHAP) DOI: 10.19088/SSHAP.2022.013

Published May 2022

© Institute of Development Studies

This is an Open Access paper distributed under the terms of the Creative Commons Attribution 4.0 International licence (CC BY), which permits unrestricted use, distribution, and reproduction in any medium, provided the original authors and source are credited and any modifications or adaptations are indicated. http://creativecommons.org/licenses/by/4.0/legalcode