Sociology and Social Work Review
Volume 10 (Issue S1)/2026 | pp. 102-116



DOI: 10.58179/ SSWR10S107
https://journals.globalresearchpublishing.com/index.php/sswr/



Original Article

Critical Health Literacy and Ageing Trajectories among Migrants: Agency, Institutional Encounters, and the Role of L2 Educational Spaces

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Abstract

Immigrant populations experience significant health inequalities that accumulate across the life course and often result in unequal ageing trajectories. Ageing is approached not as a purely biological stage but as a socially and institutionally mediated process shaped by access to knowledge, services, and communicative agency. Limited health literacy, compounded by linguistic barriers, legal precarity, and restricted access to institutional resources, represents a key mechanism through which these disparities emerge. The ASPIRE project investigates these dynamics through an interdisciplinary study conducted in Italian L2 (IL2) classrooms in Bari, conceived as linguistically and culturally heterogeneous "Third Spaces" where identity negotiation and communicative agency develop (Bhabha 1994).

This exploratory study builds on the critical dimension of health literacy, emphasising the socio-political capacity to act upon health determinants (Nutbeam 2008), and on the social determinants of health framework (Dahlgren and Whitehead 1991) to examine how structural factors—such as legal status, housing conditions, and access to services—shape migrants' well-being. Adopting an explanatory sequential mixed-methods design, the study employs a decolonial and culturally responsive perspective attentive to power asymmetries and knowledge hierarchies (Thambinathan and Kinsella 2021; Tervalon and Murray-García 1998).

Quantitative findings suggest a significant positive association between health literacy and perceived quality of life, particularly in physical and psychological domains. Demographic variables display limited explanatory power, suggesting that material stability, communicative competence, and the ability to navigate health and bureaucratic systems are central to continuity of care and future-oriented practices. Qualitative analyses highlight how bureaucratic complexity may suspend life planning, while IL2 classrooms assume a compensatory role through educators' mediation within fragmented institutional contexts.

The paper discusses these findings alongside project outputs—including multilingual informational tools and an open-access digital platform—arguing that IL2 educational

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environments can foster inclusive health literacy and support more equitable ageing trajectories.

Keywords*: critical health literacy; immigrants; ageing; education; Italian language; IL2 classrooms; quality of life; well-being; third space.*

1. Introduction

Migration has long shaped contemporary societies, contributing to cultural, economic, and demographic transformations while raising critical challenges related to social cohesion, health equity, and policy adaptation. In Italy, it has been argued that despite migration being a structural rather than temporary phenomenon, policy responses frequently operate through an emergency-oriented framework that shapes reception and integration systems. Such an approach may risk obscuring the long-term and systemic nature of the inequalities experienced by immigrant populations, particularly in relation to health and well-being across the life course. In the Italian context, this emergency-oriented logic is particularly problematic given the country's current demographic winter. While the native population is rapidly ageing, the migrant population—once perceived as a temporary and young workforce—is also beginning to reach later life stages. This intersection creates a condition of double invisibility: older migrants are often excluded from mainstream geriatric services due to linguistic barriers, while simultaneously being overlooked by integration policies that focus almost exclusively on younger cohorts. Addressing this phenomenon is not merely a social requirement but a necessity for the sustainability of the national welfare system.

The relationship between migration and health has been widely examined within public health research, with consistent findings pointing toward persistent inequalities in access to healthcare, health outcomes, and quality of life among migrant populations. Health trajectories are influenced not only by pre-migration conditions, but also by experiences during migration and early resettlement, whose effects can extend over time and shape later-life vulnerability (Bradby et al. 2015). These cumulative disadvantages are often intensified by difficulties in navigating unfamiliar healthcare and bureaucratic systems, socio-economic precarity, linguistic barriers, and legal uncertainty (Allegri et al. 2025). These cumulative disadvantages operate through a multiplicative rather than additive logic. For instance, legal uncertainty does not only cause immediate psychological stress; it actively prevents individuals from securing stable employment, which in turn restricts access to health-promoting resources such as adequate housing and nutrition. Over time, this cycle of precarity accelerates biological weathering, leading to premature health decline and complex ageing trajectories that the current fragmented healthcare system is ill-equipped to manage.

Within this framework, limited health literacy emerges not merely as an individual deficit but as a socially situated and relational capacity that influences migrants' ability to build continuity of care, plan for the future, and sustain healthier ageing trajectories. In this study, ageing is therefore approached not as a later-life condition but as a temporally structured process shaped by migrants' everyday encounters with institutional environments. Against this background, the present exploratory study investigates the relationship between health literacy, perceived quality of life, and the socio-educational environment of Italian as a second language (IL2) classrooms in Bari, conceptualised as

"Third Spaces" where mediation practices may contribute to mitigating structural vulnerabilities.

2. Theoretical Framework

Health literacy represents a key analytical lens for understanding health inequalities among migrant populations, who consistently report lower levels of health literacy and encounter multiple barriers related to language acquisition, unfamiliar healthcare systems, socio-economic precarity, and legal uncertainty (Park et al. 2018; Wångdahl 2017; International Organization for Migration 2017). It is also crucial to move beyond an individual-centric view of health literacy toward the concept of the Health Literacy Environment. Scholarship suggests that even an individual with high cognitive skills can be rendered functionally illiterate when faced with a system that is linguistically opaque or institutionally rigid. This systemic health illiteracy places the burden of navigation on the individual, further exacerbating the exclusion of those who already face socio-economic marginalization.

Initially conceptualised as a set of cognitive and social skills enabling individuals to access and use health information (Nutbeam 1998), health literacy has progressively been reframed as a socially situated capacity emerging from the interaction between individual competencies and structural conditions (Nutbeam 2017).

This conceptual evolution is reflected in the distinction between functional, interactive, and critical health literacy (Nutbeam 2008). While functional literacy concerns basic comprehension skills, critical health literacy (CHL) refers to the ability to recognise, interpret, and act upon the social determinants shaping health opportunities, including access to resources, institutional pathways, and social capital (Lorini et al. 2020). In this perspective, health literacy becomes closely linked to agency, enabling individuals not only to manage immediate health needs but also to anticipate risks and sustain healthier life trajectories over time. Drawing on Freire's notion of critical consciousness (Freire 1993), literacy is thus understood as a transformative process through which individuals develop the capacity to interpret and challenge structural constraints affecting everyday life. This perspective introduces a temporal dimension to health literacy, framing agency not only as immediate problem-solving but as the capacity to sustain continuity across disrupted life trajectories. This transition from functional to critical health literacy mirrors the Freirean concept of 'conscientization'. In the context of the IL2 classroom, literacy is not about the passive absorption of vocabulary but about developing the communicative agency needed to challenge the power imbalances inherent in the doctor-patient encounter. By gaining the tools to interpret medical documents and institutional norms, the migrant transitions from a passive recipient of care to an 'active negotiator' of their own health rights.

Migrants' health experiences must therefore be analysed within broader structural and temporal conditions. The social determinants of health framework highlights how inequalities emerge from the conditions in which people are born, live, and work, shaped by unequal distributions of power and resources (World Health Organization 2022). In migration contexts, legal uncertainty, housing instability, precarious employment, and fragmented institutional pathways often produce forms of temporal instability, limiting individuals' ability to plan for the future and maintain continuity of care. Such conditions discourage preventive practices and contribute to cumulative vulnerability across the life course.

Within this framework, health literacy extends beyond understanding health information and becomes a resource for navigating institutional complexity, restoring agency, and re-establishing temporal continuity. Critical health literacy can therefore be interpreted as a capacity that supports migrants in constructing more stable health and ageing trajectories within structurally constrained environments.

If ageing trajectories are shaped through everyday encounters with institutions, it becomes crucial to examine the concrete environments where such encounters are mediated. Educational settings represent one of the primary sites where migrants learn to navigate institutional systems and reconstruct continuity within their life courses. Homi Bhabha's (1994) concept of the "Third Space" provides a useful lens to understand how migrants negotiate linguistic and cultural meanings through interaction. Language learning environments, rather than functioning as sites of assimilation, can be understood as intercultural spaces (Kramsch 1993) where identities are renegotiated and new forms of agency develop. Within this liminal space, acquiring the host country's language becomes not only a functional skill but also a pathway to institutional recognition, participation, and continuity of care. In this sense, the language classroom operates not only as a cultural space but as an intermediary institutional environment where access, recognition, and participation are negotiated, including access to healthcare information, services, and bureaucratic pathways, with direct implications for long-term health trajectories.

From this perspective, critical health literacy does not develop solely at the level of individual knowledge but emerges through situated practices in which migrants learn to interpret and navigate institutional systems over time. Language learning environments constitute privileged settings where these processes become visible, as everyday interactions with educators and institutions shape access, recognition, and continuity of care. Examining such contexts therefore offers an opportunity to explore how health literacy, mediation practices, and lived experiences intersect in shaping migrants' health and ageing trajectories.

3. Methodology

Building on the theoretical framework outlined above, the study adopted an explanatory sequential mixed-methods design. The research was structured in two interconnected phases: a preliminary quantitative assessment used to identify broad patterns of health literacy and quality of life, followed by a qualitative phase designed to explain and contextualize these statistical results through participants' narratives. In the first phase, quantitative data were collected to identify statistical correlations between health literacy and quality of life. In the second phase, these findings informed the thematic focus of the focus groups, which aimed to clarify the social and institutional mechanisms underlying the quantitative scores. This design allowed for a deeper understanding of how 'low' or 'high' health literacy scores translate into lived experiences of institutional navigation. This explanatory sequential design was strategically selected to overcome the 'statistical silence' often associated with vulnerable populations. While quantitative scores provide a necessary snapshot of the phenomenon, they cannot capture the emotional weight of institutional friction. The subsequent qualitative phase was therefore essential to 'give voice' to the data, allowing the narratives of the participants to function as a counter-discourse to the standardized metrics of health literacy

The research investigated Italian as a Second Language (IL2) classrooms as situated environments in which migrants negotiate access to services, continuity of care, and future-

oriented health practices across their life trajectories. In this perspective, health literacy was conceptualised not only as an individual competence but as a cumulative social resource shaping long-term health opportunities. Educational interactions were therefore analysed as moments in which migrants acquire or negotiate capacities that may influence their ageing trajectories, particularly in contexts marked by institutional complexity and unequal access to welfare systems.

Participants were recruited through a non-probabilistic sampling strategy. The study involved 73 individuals: 46 migrants and 27 teachers and volunteers from six local associations offering Italian as a second language courses (Penny Wirton, Etnie Onlus, CPIA San Nicola, Casa delle Culture, Comunità Sant'Egidio, Impegno 95). Given the exploratory nature of the study and its focus on the specific socio-educational context of Bari, the sample size (N=73) does not aim for statistical representativeness. Rather, it serves to ensure analytical depth and to capture the heterogeneity of linguistic repertoires and migratory trajectories within the IL2 classroom. A subgroup of 25 educators (92.6%) and 20 migrants (43.5%) later participated in dedicated focus groups, enabling a more layered exploration of perspectives and experiences. The coexistence of participants at different stages of adulthood within the same learning environments offered a unique opportunity to observe how migration intersects with ageing processes before old age becomes visible as a categorical condition. Variations in educational histories, employment stability, and length of residence highlighted how vulnerabilities accumulate over time, contributing to differentiated prospects for healthy ageing. The heterogeneity of the sample, which includes individuals from over 23 nationalities with varied lengths of residence, is an analytical strength. It allows for a cross-sectional observation of how social capital is either depleted or accumulated over time. For recently arrived asylum seekers, the IL2 classroom represents a site of initial orientation; for long-term residents, it serves as a space for the re-elaboration of identity in the face of the emerging challenges of senescence.

Before formalising the research instruments, an exploratory phase of participant observation was conducted in the IL2 classrooms to contextualize everyday interactional dynamics and refine the protocol. Data collection followed the sequential design logic. Initially, sociodemographic questionnaires, the HLS-EU-Q16, and the WHOQoL-BREF were administered. To ensure epistemic justice and communicative comfort, all instruments were provided in Italian, English, and French, allowing participants to self-select the language of interaction. Quantitative data were processed using SPSS (v.29) and Jamovi (v.2.5). Given the non-normal distribution of the variables, non-parametric tests were employed, including Spearman's ρ for associations and the Kruskal-Wallis test for group comparisons. Subsequently, qualitative insights were generated through semi-structured focus groups with both learners and educators. The resulting transcripts were analysed using T-LAB software (v.10), applying co-occurrence analysis and the identification of core thematic nuclei. This lexicometric approach allowed for an objective mapping of the conceptual associations between health, institutional barriers, and agency, effectively integrating the quantitative scores with the participants' lived narratives.

Beyond methodological triangulation, the research adopted a participatory approach grounded in prolonged engagement within IL2 classrooms. These environments were not treated as neutral educational settings but as socially and institutionally mediated spaces where identity negotiation, linguistic agency, and institutional learning unfold simultaneously. In line with the concept of the Third Space, classroom interactions enabled observation of how migrants encounter institutional norms while actively reinterpreting

roles, expectations, and possibilities for participation. The classroom thus functioned as an intermediary environment linking personal biographies with broader healthcare, bureaucratic, and social systems. Observing these interactions longitudinally within the research period made visible how repeated encounters with language learning and institutional practices gradually reshape participants' sense of agency. Such processes are particularly relevant for ageing studies, as they influence the development of confidence, self-efficacy, and future orientation—dimensions closely associated with adaptive ageing.

Particular attention was devoted to the temporal dimension of participants' experiences. The sample included migrants aged between 18 and 65 years, bringing together individuals positioned at different stages of the life course within the same learning environment. Rather than considering age as a purely demographic variable, the study approached ageing as a process shaped by continuity, anticipation, and the capacity to project oneself into the future. Differences in learning pace, confidence, and institutional navigation revealed how migration histories and educational biographies intersect with ageing trajectories.

Within this perspective, the WHOQoL-BREF provided an analytical entry point into ageing understood as lived quality of life over time, capturing how physical, psychological, social, and environmental conditions influence migrants' ability to sustain well-being and plan future pathways. Complementarily, focus groups explored participants' narratives of health, vulnerability, and agency, including expectations regarding their future lives, whether in Italy or elsewhere. Discussions frequently connected present well-being with past disruptions and imagined futures, making visible how health literacy operates as a resource for reconstructing temporal continuity after migration.

Taken together, this methodological approach allowed ageing to be examined not as a biological stage but as a socially situated process emerging through everyday encounters with institutions, learning environments, and relational networks. By observing how migrants learn to navigate systems, access care, and re-establish future orientation within IL2 classrooms, the study investigates how critical health literacy contributes to shaping sustainable ageing trajectories. Rather than focusing exclusively on later life, the study highlights how ageing inequalities begin to take shape much earlier, through everyday negotiations of language, access, and recognition within institutional contexts.

4. Results

The findings move beyond a purely descriptive account, highlighting how health literacy and well-being emerge within educational environments where migrants negotiate identity and future trajectories. Following an explanatory sequential logic, quantitative patterns are here integrated with qualitative lexicometric analyses (T-LAB) to examine how institutional interactions shape migrants' well-being across the life course.

4.1 Quantitative findings: Health literacy and quality of life

Within the specific scope of this study's cohort (N=46; 70% male; M=30.8), quantitative analyses revealed a statistically significant positive association between health literacy (HLS-EU-Q16) and overall perceived quality of life (WHOQoL-BREF). The strongest links appeared in the physical ($\rho \approx 0.45$) and psychological ($\rho \approx 0.42$) domains.

This statistical link finds immediate correspondence in the qualitative co-occurrence analysis, where the lemma "Health" (salute) is significantly associated ($\chi^2 > 10$; $\rho < .001$) with "Life" (vita), "Sense" (senso), and "Integration" (integrazione).

These integrated findings suggest that health literacy relates not only to cognitive skills but to the embodied and emotional dimensions of everyday life. Interestingly, variables often assumed to explain migrant well-being—such as nationality (23 nationalities represented) or household composition—accounted for only limited variance ($\Delta R^2 < 0.08$), challenging demographic reductionism. While the small sample size invites caution, this suggests that well-being is shaped by shared relational and institutional conditions rather than fixed cultural categories.

4.2 Determinants of well-being

Legal stability and housing conditions emerged as central determinants of perceived well-being. Legal status, in particular, appeared to structure participants' temporal horizons: 52% of the sample held asylum seeker or international protection status, configurations marked by bureaucratic uncertainty. This quantitative disparity is elucidated by the T-LAB analysis, where a specific cluster links "Waiting" (attesa), "Bureaucracy" (burocrazia), and "Documents" (documenti), reflecting a state of "suspended life" and reduced agency.

Housing conditions also demonstrated a significant association with quality of life, concentrated primarily within the social domain ($\rho = 0.029$). The qualitative data corroborate this: residents of the C.A.R.A. centre described crowded or institutionally regulated environments as inhibiting supportive networks. Thus, housing functions less as a material variable than as a relational environment that either enables or forecloses social participation and continuity.

Sociodemographic data reveal a highly heterogeneous migrant population characterised by diverse linguistic repertoires, migratory trajectories, and educational backgrounds, alongside indicators of structural vulnerability, including legal precarity and limited social networks.

Legal status emerged as a central determinant of perceived well-being. Beyond its administrative function, legal status appeared to structure participants' temporal horizons. Uncertain documentation regimes limited the possibility of making long-term decisions regarding employment, housing, and healthcare, producing what participants described as prolonged states of waiting. Such conditions interrupt the accumulation of resources typically associated with healthy ageing, transforming present vulnerability into potential long-term inequality. Participants experiencing bureaucratic uncertainty reported lower WHOQoL-BREF scores across domains, reflecting how restricted agency and suspended future planning shape lived experience. These patterns indicate that migrants' health trajectories are strongly influenced by institutional arrangements that regulate access to services, mobility, and long-term stability (Ager and Strang 2008).

Overall, the findings suggest that interventions strengthening communicative access, information navigation, and relational support may have greater impact on well-being than approaches centred solely on demographic or cultural variables. This pattern challenges intervention models focused primarily on cultural adaptation or behavioural change. The results instead indicate that agency develops where institutional environments become intelligible and navigable, allowing individuals to translate knowledge into

sustained participation. Well-being therefore emerges from the interaction between personal competencies and enabling social infrastructures.

4.3 Mediating educational spaces: IL2 classes

The socio-educational context of the IL2 classrooms (6 local associations involved) operates as a critical mediating infrastructure. Educators (*N*=27) described an environment marked by structural precariousness, where irregular attendance (reported by 21 respondents) and linguistic heterogeneity (noted by 17 educators) require a "reactive" pedagogy.

However, within this complexity, the classroom functions as a "Third Space" where health (n = 18) and bureaucracy (n = 18) dominate the curriculum. Qualitative insights reveal that communication—specifically the ability to "Explain" (spiegare) and access "Information" (informazione)—is perceived as a fundamental form of agency. Participants' accounts suggest that learning how to navigate healthcare systems reconfigures their position from passive dependency toward negotiated participation. Repeated successful interactions appeared to rebuild confidence in institutional engagement, gradually transforming experiences of uncertainty into expectations of manageability.

4.4 Health literacy and ageing trajectories

Aging emerged not as an age-dependent difference (the sample ranged from 18 to 67 years), but as a temporal orientation. Individuals reporting higher quality-of-life scores tended to describe practices of anticipation and future planning more frequently.

The T-LAB analysis of the "Trauma" cluster—associated with terms like "Journey" (viaggio), "Story" (storia), and "Recognise" (riconoscere)—highlights how migration trajectories are often marked by identity ruptures. In this context, health literacy operates as a resource for reconstructing biographical continuity. By reducing bureaucratic strain and enabling meaningful interaction with institutions, the IL2 environment helps transform experiences of uncertainty into opportunities for sustainable aging trajectories. These processes indicate that inequalities in aging begin to take shape long before later life, rooted in the present capacity to project oneself toward a stable future.

4.5 Participatory interventions as mediating infrastructures

Beyond classroom interactions, project-based educational outputs offered an additional empirical lens through which the processes described above became observable in practice. Within the ASPIRE project, dissemination activities themselves became sites of observation, revealing how health literacy develops through relational and institutional mediation rather than through information transmission alone. Observing these activities revealed how knowledge acquisition occurs through collective interpretation rather than passive reception. Participants frequently relied on shared discussion to contextualise information within their own biographies, indicating that health literacy develops through relational processes that link personal histories with institutional expectations.

The seminar series *Conoscere per curare*, involving professionals from healthcare, social services and intercultural mediation, functioned as dialogical environments in which participants collectively interpreted healthcare procedures, rights and institutional

expectations. Discussions frequently exposed feelings of uncertainty and temporal suspension linked to bureaucratic complexity, while shared explanations contributed to increased confidence in navigating services. Training for healthcare providers should move from cultural competence (often based on stereotypes) to cultural humility, a process of self-reflection that acknowledges the power imbalance in the patient-provider encounter.

Similarly, the multilingual brochure and the digital platform did not operate merely as informational tools but as mediating devices supporting participants' orientation within healthcare pathways. Their multilingual and multimodal design responded to heterogeneous literacy levels and enabled learners to revisit information autonomously, reinforcing a sense of continuity and control over future health decisions. Participants described these resources as facilitating not only access to services but also a renewed capacity to plan and imagine longer-term trajectories within and beyond Italy.

These findings suggest that culturally and linguistically mediated tools contribute to health literacy by reducing institutional opacity and restoring temporal agency, highlighting how educational and communicative infrastructures may support processes of ageing marked by mobility, uncertainty and negotiated belonging. In this sense, participatory interventions function not only as informational supports but as temporal stabilisers, helping participants reconnect fragmented past experiences with actionable futures. The capacity to revisit information, seek clarification, and collectively interpret institutional procedures appeared to foster a renewed sense of continuity, a dimension central to equitable ageing trajectories.

5. Discussion

The findings of this exploratory study suggest a fundamental shift in the conceptualization of migrant health and ageing, moving away from individualistic models toward a relational and life-course perspective. While the observed correlations indicate a link between health literacy and quality of life, the qualitative evidence suggests that this relationship is not merely a matter of individual "skills" but a situated achievement emerging from the interaction between personal resources and institutional environments. From an epistemic perspective of social justice, addressing migrant health is not a technical challenge but a political and ethical imperative that requires moving beyond emergency responses toward structural integration.

A central contribution of this research is the characterization of IL2 classrooms as more than educational settings; they operate as relational infrastructures that compensate for an "institutional void." The analysis reveals that educators frequently assume surrogate responsibilities for mediation and care, filling gaps left by fragmented welfare systems. However, in line with current debates, the indispensable role of these non-governmental actors must not become an "alibi" for governments to abdicate their fundamental responsibilities (Matlin et al. 2018). While the classroom assumes the role of a Third Space (Bhabha 1994) where bureaucratic opacity is decoded, the agency developed here remains fragile if not supported by inclusive healthcare policies that protect rights independently of immigration status. As noted by the EU Agency for Fundamental Rights (FRA) (2023), the increasing digitalization and complexity of public services risk further marginalizing those who lack these relational mediators, transforming access into a privilege rather than a right.

Adopting a decolonial perspective requires rethinking the biases implicit in how health literacy is measured and framed. Traditional Western biomedical perspectives often

describe "appropriate" health literacy in ways that leave little room for cultural-specific practices or the lived realities of those outside the Global North (Mantwill and Diviani 2019). This study challenges such reductionism by showing that well-being depends less on fixed demographic categories like nationality than on the ability to navigate asymmetric power relations. Critical health literacy, therefore, should not be seen as a substitute for tackling the "causes of the causes"—the underlying inequities in the distribution of power, resources, and opportunity (Nutbeam and Lloyd 2021). Within the IL2 classroom, following Freirean principles, health literacy becomes an exercise in critical awareness, allowing communities to recognize structural racism and institutional barriers as the primary determinants of their health trajectories.

The results challenge chronological definitions of ageing by highlighting how "healthy ageing" for migrants is rooted in the restoration of biographical continuity. In a context where legal precarity and "waiting" suspend life trajectories, the IL2 setting acts as a "temporal stabilizer." The role of multilingualism is particularly significant here: beyond its functional use, maintaining and expanding a multilingual repertoire may function as a protective factor against accelerated ageing. By strengthening cognitive flexibility and social participation, language learning supports cognitive resilience, effectively allowing migrants to project themselves into stable futures despite the disruptions of migration (Amoruso et al. 2025). This shift from focusing on individual deficits to developing critically health-literate communities (Sykes and Wills 2019) is essential for sustaining functional autonomy across the life course, as promoted by European initiatives like IROHLA.

6. Policy and Practice Implications

The ASPIRE project provides empirical insight into how health literacy interventions can function as intermediary infrastructures, bridging the gap between vulnerable migrant populations and fragmented welfare systems. Rather than operating as isolated educational initiatives, the project's outputs were designed as evidence-based responses to the structural barriers—linguistic, procedural, and relational—identified during the research phase.

The first strategic intervention involved a series of professional seminars entitled "Conoscere per curare". These sessions moved beyond the traditional concept of Cultural Competence, which often risks essentializing ethnic differences, to embrace the framework of Cultural Humility (Lekas et al. 2020). By involving experts from regional healthcare in Puglia, social services, and ethnopsychology, the seminars fostered a critical reflection on the structural inequalities that govern access to care. From a policy perspective, this suggests that training for healthcare and social work professionals must transcend technical skills to include a deep awareness of the 'power asymmetries' inherent in institutional encounters. Strengthening the communicative agency of practitioners is as vital as strengthening that of migrants; health literacy is, in this sense, a distributed and relational capacity that requires a shift in the institutional mindset of the host society (O'Brien et al. 2024).

A second key output, the multilingual information brochure, was developed to address the navigational dimension of health literacy. Translated into nine languages (Italian, English, French, Spanish, Arabic, Albanian, Hindi, Bengali, and Ukrainian), the tool was distributed across a capillary network of pharmacies, health centres, and community spaces in Bari. By adopting the Navigational Health Literacy model (Griese et al. 2020), the brochure does not merely translate information; it decodes the 'institutional

logic' of the Italian healthcare system. This intervention directly addresses the "cognitive and emotional load" identified in participants' narratives, providing a stable reference point that reduces the uncertainty associated with bureaucratic navigation. For policy-makers, this highlights the need for transcreated rather than merely translated materials—tools that respect the symbolic and linguistic repertoires of the target populations.

To ensure long-term sustainability and digital inclusion, the project launched an open-access digital platform. This repository hosts multimodal resources, including audio-video versions of the materials, specifically designed to bypass the limitations of traditional literacy. In an increasingly digitalized society, where the EU Agency for Fundamental Rights (FRA) (2023) warns against the risk of technological exclusion, providing multilingual and multimodal digital pathways is a matter of epistemic justice. The platform functions as a 'temporal stabilizer', allowing migrants to revisit information autonomously, thereby restoring a sense of control over their future health decisions and supporting adaptive ageing processes.

Ultimately, these interventions suggest that policies for healthy and active ageing must move beyond administrative categorizations. Effective practice requires investing in community-based educational environments—such as the IL2 classrooms—that can act as permanent hubs for health mediation. Integrating linguistic learning with institutional navigation represents a cost-effective strategy for promoting long-term health equity, transforming the "emergency-oriented" logic of reception into a structural commitment to social inclusion.

7. Conclusion

The issue of migrant health addressed in this study must be understood within a broader epistemic framework of social justice and life-course inequality. Migration is no longer an exceptional phenomenon but a structural condition shaping contemporary societies, and its implications increasingly extend into processes of ageing. As global displacement continues to rise, health systems are confronted with the challenge of supporting equitable ageing trajectories for diverse populations. From a decolonial perspective, this requires rethinking the assumptions embedded in research and policy. Health literacy cannot be reduced to an individual cognitive competence, nor can it be measured exclusively through Western biomedical norms. Rather, it must be viewed as a situated and relational capacity that develops through interaction with institutional environments. The integration of qualitative T-LAB analyses alongside quantitative measures in this study allowed participants' lived experiences to illuminate how health and future orientation are negotiated across cultural and institutional contexts.

Importantly, strengthening critical health literacy should not be seen as a substitute for addressing the structural determinants of inequality. Interventions targeting individual skills cannot replace the need to confront the "causes of the causes"—the unequal distribution of power and resources. The findings presented here suggest that bureaucratic uncertainty and legal precarity directly shape migrants' ability to plan their futures. This is graphically illustrated by the qualitative clusters linking "Waiting" and "Documents" to a perceived suspension of life trajectories, reinforcing the argument that institutional opacity acts as a primary barrier to well-being. Within this perspective, ageing emerges not simply as a biological process but as a socially mediated trajectory. Educational environments such as IL2 classrooms illustrate how access to language and relational support can restore

agency. These spaces function as overlooked infrastructures of healthy ageing, where multilingualism acts as a "temporal stabiliser." As suggested by Amoruso et al. (2025), the cognitive and social engagement found in these settings may support adaptive ageing by strengthening resilience and future orientation.

Policy implications follow directly from this shift. While non-governmental actors play a crucial role in filling "institutional voids," their work cannot be an alibi for the abdication of state responsibility. Inclusive healthcare must recognise migrants as structural members of society and invest in community-based environments that foster critically health-literate communities. This study has limitations, including its non-probabilistic sampling strategy (N=46 for the migrant cohort) and cross-sectional design, which prevent causal generalisations. However, these limits point toward future longitudinal research to trace how health literacy and institutional participation evolve over time. Promoting migrant health is a political and ethical commitment to creating conditions in which individuals can age with dignity and genuine belonging. The findings align with European evidence advocating for investments in health-literacy and digital inclusion (Brainard et al. 2016; European Union Agency for Fundamental Rights (FRA) 2023). Educational environments that integrate linguistic learning with institutional navigation may represent sustainable infrastructures for long-term health equity, following the recommendations of frameworks such as IROHLA (European Commission 2024).

Authors' Contributions

All three authors contributed equally to the Introduction, Methodology, Discussion and Conclusion, G.M.E. Lafasciano was responsible for Theoretical Framework, and M. Schiralli authored Results.

Declaration of conflicting interests

There are no conflicts of interest to disclose regarding the research, authorship, or publication of this article.

Funding

Progetto ASPIRE (Alfabetizzazione Sanitaria per Persone Immigrate attraverso Relazioni Efficaci) - CUP: B37GG24000220006. PNRR, Missione 4 Istruzione e ricerca – Componente 2 dalla ricerca all'impresa – Investimento 1.5, finanziato dall'Unione Europea – NextGenerationEU -Programma di Ricerca e Innovazione dell'ecosistema di innovazione "THE - Tuscany Health Ecosystem" codice ECS00000017 - Bando a cascata per Organismi di Ricerca per lo Spoke 10.

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Received: 21 February 2026 / **Revised:** 15 April 2026 / **Accepted:** 22 April 2026