Sociology and Social Work Review
Volume 10 (Issue S1)/2026 | pp. 90-101

DOI: 10.58179/ SSWR10S106
https://journals.globalresearchpublishing.com/index.php/sswr/

Original Article

The Condition of Older Muslims with Disabilities in Italy: From Religious Foundations to Care Practices. Educational and Training Perspectives

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Abstract

Population ageing among people of Muslim background in Italy poses significant pedagogical and educational challenges. Within the Qur'anic worldview that guides the lives of Muslim believers, older persons occupy a central position: they are owed respect, care, and responsibility by the family. For this reason, in Muslim-majority countries residential facilities for older adults comparable to Western nursing homes have historically developed to a limited extent, since support is traditionally ensured within the family unit. In Western migration contexts, however, this model comes under strain. When older Muslims lose family support for economic, occupational, or relational reasons, they may experience solitude and heightened vulnerability. The presence of physical or psychological disabilities makes this situation even more critical, increasing exposure to isolation and marginalisation. From a pedagogical standpoint, it is necessary to prevent such outcomes through integrated educational and social policies. This requires promoting a system that coordinates institutions, health and social services, and community-based associations, while strengthening communal networks and intercultural support. The overarching aim is to ensure dignity and inclusion for older Muslims, safeguarding their role as intergenerational mediators and as custodians of memory and cultural identity. Drawing on intercultural pedagogy and care ethics, this paper is a theoretical-normative essay.

Keywords: *Islam; older adults; disability; prevention of abandonment; integrated educational system.*

1. Introduction

The ageing of Italy's population of Muslim background raises a set of crucial questions that are fundamentally educational and formative in nature. In the Qur'anic conception—

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normative for those who identify with the Islamic religious tradition—older persons merit the highest consideration, attention, and care from the entire family. For this reason, in societies where Islam functions as a guiding norm, there are no residential reception facilities comparable to Western "nursing homes." The problem emerges when older people of Islamic faith and culture, particularly in Western contexts, lose— for a wide range of reasons—the support and comfort of their family and find themselves alone. If, in addition to advanced age, there is any form of physical or psychological disability, their existential condition worsens significantly, increasing the risk of abandonment and isolation. From a pedagogical perspective, the task is to prevent risks associated with the abandonment of older persons with disabilities of Muslim background in Italy, by raising awareness—within the framework of an Integrated System that relies on local associations—of active and practical care, so that older adults are adequately supported and do not lose their role as a connective hinge between generations.

This essay adopts a theoretical–interpretive and pedagogical-analytical genre, situated within the field of social and intercultural pedagogy. Its scope is not empirical or statistical in a strict sense, but rather critical and reflective, aiming to frame the ageing of Muslims with disabilities in Italy as a complex educational and social issue at the intersection of welfare, culture, and religion. The contribution draws on an interdisciplinary perspective, integrating pedagogical theory with sociological, anthropological, and religious insights, in order to illuminate both structural conditions and lived experiences. Epistemologically, the essay is grounded in a constructivist and hermeneutic approach, which understands care, ageing, and disability as socially and culturally mediated phenomena, and emphasises the role of interpretation, dialogue, and relational meaning-making in the construction of inclusive and culturally responsive care practices.

2. Ageism and Older Muslims in Italy: A Pedagogical Analysis

From the period immediately following the Second World War, Italy saw the settlement of a community with an Islamic cultural background, composed predominantly of workers from the Middle East and North Africa, recruited to support post-war reconstruction. These individuals and their communities largely consisted of young people and adults who aspired to family reunification. Today there are numerous families in Italy who identify with Islamic faith and culture; they have in turn generated second and third generations of children and grandchildren who speak Italian fluently, aspire to full political rights, and contribute to shaping a pluralistic—and, ideally, peaceful—social coexistence.

According to the most authoritative statistical dossiers, as of 1 January 2025, 1.7 million people in Italy identified with Islamic faith and culture, corresponding to 30% of the resident foreign population (ISMU, 2025). Today the descendants of those workers who actively contributed to Italy's material reconstruction in the post-war period must face the challenges of ageing, challenges that intersect with the growing prevalence of disability and non-self-sufficiency.

This situation constitutes a crucial test for Italian health and social services. It is a "new" phenomenon because large-scale migration to Italy has a relatively recent history and because many welfare arrangements were designed on the basis of majority family and cultural models. Yet it is also an "ancient" phenomenon in the sense that care for older—and therefore fragile—persons is a long-standing anthropological and religious question: it involves ethics, representations of vulnerability, bodily dignity, intergenerational reciprocity, and the very meaning of community.

Indeed, while the respect owed within Muslim families to parents and grandparents—who function as a bridge between generations and are therefore regarded as a "necessary good" to be safeguarded and protected—is widely recognised, contemporary lifestyles, characterised by the fragmentation of family units due to work-related pressures, often generate situations of isolation. Those who suffer most are precisely older persons with disabilities, confined within domestic walls and frequently affected by chronic illness. Moreover, appropriate reception structures equipped with religiously responsive services capable of meeting their existential needs are often lacking.

A mythologised narrative frequently romanticises a culturalist ideal of the "Muslim family" as naturally and invariably able to sustain fragility. The Italian reality instead reveals a field of tensions: between moral obligations and material conditions, between religious norms and transformations of gender roles, between the desire to care within the family and the need for formal supports, and between identity and integration.

The ageing of migrant populations represents one of the most significant demographic and social transformations in contemporary European societies. The picture becomes even more complex when old age is accompanied by disability. In such cases, multiple dimensions of vulnerability intersect: advanced age, disability, migrant positioning, and religious affiliation. This intersection can generate marginalisation and discrimination that fall within the broader phenomenon of ageism, understood as the set of stereotypes, prejudices, and social practices that devalue older persons.

In the case of older Muslims with disabilities living in Italy, ageism cannot be interpreted solely as age-based discrimination. Rather, it appears as a complex dynamic emerging from the encounter between different cultural systems, transforming family models, and welfare systems not always adequately equipped to address cultural plurality. From a pedagogical perspective, this issue is strategically important. Social and intercultural pedagogy is called to interrogate the educational, relational, and institutional models that regulate care for older persons in societies characterised by increasing cultural pluralism. In this sense, the study of ageism affecting older Muslims with disabilities offers a privileged vantage point for understanding the educational challenges posed by contemporary multicultural societies.

As is well known, the concept of ageism was introduced in the late 1960s by gerontologist Robert Butler to denote the multiple forms of discrimination experienced by older people. Butler defined ageism as a form of social prejudice comparable to racism or sexism, characterised by the tendency to regard older persons as unproductive, dependent, or socially irrelevant.

Contemporary Western societies are particularly exposed to this type of discrimination. The dominant cultural model tends to valorise economic productivity, speed, innovation, and individual performance. In this context, old age risks being perceived as a phase of decline, loss of autonomy, and progressive social irrelevance.

Numerous sociological and pedagogical studies have shown that ageism manifests not only through individual attitudes, but also through institutional practices and organisational models in social services. Welfare systems, for example, may inadvertently reinforce age-related stereotypes when they treat older persons exclusively as recipients of assistance rather than as bearers of resources and competences.

When ageing unfolds within migration contexts, ageist dynamics take on specific characteristics. Older migrants often experience a dual marginality: they are subject to age-

based discrimination and, at the same time, may be perceived as culturally alien to the host society. In the case of Muslim populations in Europe, the issue is further complicated by the presence of cultural and religious systems that attribute to older persons a role profoundly different from that dominant in Western societies. As noted above, in Islamic tradition the older person is generally associated with wisdom, experience, and communal memory. Respect for older persons is a foundational value in Islamic ethics and translates into a strong moral obligation of care on the part of children and the family.

This cultural model rests on a relational conception of personhood and family. The older person is not viewed as an isolated individual, but as a central member of the familial and communal network. Care for older adults takes place primarily within the family and is only rarely delegated to external institutions.

Migration, however, can destabilise this balance. Migrant families often live in urban environments characterised by intense work rhythms, limited living spaces, and restricted family networks. Under these conditions, sustaining traditional models of family-based care becomes difficult. When disability is added to old age, the situation becomes even more complex. Ageing with disability entails highly articulated care and relational needs. Older persons with disabilities often require continuous health care, support in daily activities, and psychological accompaniment. For older migrants, these needs intersect with additional difficulties related to language, knowledge of services, and cultural mediation. In particular, older people with a migration background encounter greater obstacles in accessing health and social services than the native-born population.

For older Muslims with disabilities in Italy, these difficulties may be amplified by a lack of culturally responsive services. Health and social care facilities, as noted, are not always prepared to address specific religious needs, such as dietary practices, prayer times, or demands connected to the spiritual dimension of care. This may generate a form of invisible marginalisation: older Muslims with disabilities risk finding themselves isolated both from their community of origin and from the host society.

3. Older Muslims with Disabilities at the Crossroads of Worlds that Must Meet: Pedagogical Perspectives

In response to the social transformations described above, intercultural pedagogy is called to develop specific interpretive and operational tools, both for analysis and for the training-oriented work of fostering social inclusion. From an intercultural perspective, it is not sufficient to promote tolerance between different cultures; it is necessary to foster processes of dialogue, mutual recognition, and transformation of social institutions. In the case of care for older migrants—especially those living with disabilities—this means rethinking welfare and assistance models in light of the cultural and religious differences embedded in Islamic conceptions of the world, of old age, and of disability.

The training of health and social care professionals is a central element of this process. Practitioners working with older migrants must develop intercultural competences enabling them to understand value systems and care practices in the concrete case of older persons with disabilities who identify with Islamic faith-culture. At the same time, it is necessary to promote specific intergenerational education projects that encourage encounters between older Muslims and Italian youth. Such educational pathways can help counter stereotypes and prejudices by valuing older persons' experiences and competences.

4. Between Pedagogy of Care and Intercultural Welfare Models: Promoting and Designing Training for the Well-being *for* and *of* Older Muslims with Disabilities

Within current scholarship, a specific pedagogical field concerns the construction of intercultural welfare models. Social policies must be rethought so that they respond to the needs of an increasingly culturally and religiously diverse population. From the standpoint of a pedagogy of care, it is crucial to consider the educational relationship as central to care processes. Care for older persons cannot be reduced to a set of technical performances; it must be interpreted as a relational process involving emotional, cultural, and spiritual dimensions.

For older Muslims with disabilities, this approach implies the ability to recognise the role of religion in the construction of individual well-being. Spirituality is a fundamental resource for many older persons and can support resilience and adaptation processes. The ageism affecting older Muslims with disabilities in Italy is a complex issue that reflects transformations in contemporary societies. Conceptions of affective care within the family and professionalised care in dedicated health institutions differ, as do family models—moreover in continuous evolution—and welfare systems not always adequately prepared to address such forms of social vulnerability.

Addressing this specific challenge—supporting Muslim families in care pathways and in promoting the well-being of older persons with disabilities—requires an interdisciplinary approach integrating sociological and pedagogical-intercultural perspectives. Designing specific training initiatives for relatives, caregivers, and health and well-being professionals can play a decisive role in building a culture of care capable of recognising the dignity of the older person, together with their specific disability and religious affiliation.

5. Islamic Religious Foundations: Dignity, Filial Duty, Mercy

Within Islam's ethical and spiritual horizon, respect for older persons and the care of parents are not merely moral recommendations or generic exhortations to kindness; they constitute structural elements of the good life and of religious responsibility. The Qur'an forcefully calls for benevolence towards parents, especially in the moment of their fragility and old age, urging believers never to show harshness or impatience towards those who generated and raised them.

This is complemented by the Prophetic tradition (Sunna), which consistently emphasises mercy (raḥma), the protection of the vulnerable, and the moral duty not to abandon those who depend on others. Within this anthropological and religious perspective, fragility is not meaningless; rather, it is an existential condition that challenges the conscience of the community and reveals its spiritual quality. Care for the older person thus becomes not only an assistential act but a gesture of religious responsibility and, at the same time, a process of humanisation involving the whole community.

Within this symbolic and normative horizon, the figure of the older person assumes a particularly significant pedagogical function. The older person is not conceived as unproductive or as a social burden, but as a bearer of memory, experience, and blessing. Islamic tradition attributes to older persons a dimension of *baraka*, that is, a form of blessing deriving from accumulated experience and proximity to the spiritual dimension of life. This symbolic recognition produces a profoundly relational conception of care. The older person is not reduced to a "service user" or to a recipient of provisions; they remain a person

endowed with moral authority and intrinsic dignity. Even when loss of autonomy becomes evident, the older person continues to serve as an identity reference point for the family and the community. Care, in this perspective, cannot be interpreted solely as a technical performance or a health service; it is a moral relationship expressing reciprocity, gratitude, and intergenerational responsibility.

From this viewpoint, the family occupies a central position in care cultures within Muslim-majority societies. Filial obligation is a fundamental element of family ethics and implies that children assume direct responsibility for the well-being of their ageing parents. In many Islamic cultural contexts, the residential institutionalisation of older persons may be perceived as a form of moral failure or as a sign of social shame, insofar as it would indicate the family's inability to care for its most fragile members. This cultural orientation, however, confronts profound social transformations when Muslim families live within migration contexts such as Italy. Migration modifies traditional family structures, reduces extended kinship networks, and introduces new work rhythms that make continuous home-based care more difficult. In these situations, forms of ambivalence frequently emerge. Some families resist for a long time the recourse to formal support, striving to keep care within the family nucleus up to the point of exhaustion of available resources. Other families, when forced to turn to social or health services, experience this transition with guilt or with fear of community stigma.

Care for the older person thus also takes on the meaning of a communal test. When the family is absent, weakened, or affected by conflict, protective responsibility tends to shift towards broader proximity networks. In many Muslim diaspora communities these networks include extended kinship, faith communities, cultural and religious associations, and neighbourhood relations. Within these spaces, spontaneous forms of solidarity emerge that help prevent older persons' isolation. However, such informal resources are not always sufficient to address situations of disability or complex frailty. A specifically pedagogical task therefore emerges: educating communities towards new forms of support capable of integrating family responsibility with the opportunities offered by welfare systems. This implies fostering processes of collective learning that can overcome mistrust, fears, and stereotypes, thereby building a relationship of trust between migrant communities and public institutions.

The issue becomes even more complex when old age intersects with disability. In the Italian context, the condition of older Muslims with disabilities is often marked by multiple vulnerability. Alongside advanced age and functional limitations, there are factors related to migration such as linguistic difficulty, cultural distance, economic or housing precarity, and, at times, limited health literacy. The digital divide may further hinder access to information and services. Within this perspective, disability cannot be interpreted solely as a medical or individual problem. Pedagogically, it is essential to adopt a bio-psycho-social view, such as that proposed by the International Classification of Functioning, Disability and Health (ICF), which considers disability as the outcome of interactions between health conditions and environmental contexts. Functional limitations are exacerbated when the social environment produces linguistic, administrative, or cultural barriers that prevent the person from fully exercising their rights.

Alongside this bio-psycho-social perspective, a human-rights-based approach is indispensable, as indicated by the United Nations Convention on the Rights of Persons with Disabilities. This perspective underscores that every person, regardless of health conditions or degree of autonomy, must be able to participate in social life and access adequate

services. In the case of older Muslims with disabilities, this implies recognising and addressing specific barriers that may hinder inclusion. These barriers include difficulties in communicating with institutions, cultural misunderstandings related to bodily care practices, gender differences in relationships with professionals, religious needs connected to prayer or diet, and, at times, mistrust of systems perceived as culturally distant.

A further element of complexity concerns the diverse religious interpretations of disability within Muslim families. In some cases, disability may be lived as a trial calling for patience and reliance on the divine will; in other cases it may generate feelings of shame or fear of community judgement. There are also families that approach disability pragmatically, without attributing explicit religious meanings. These differences show that Islam cannot be treated as a monolithic bloc. Families' lived experiences depend on multiple factors, including migration histories, levels of religious observance, social position, gender, and the presence of community networks. For this reason, the training of social and health care professionals must avoid generalisations and develop intercultural competences capable of recognising the plurality of experiences.

In Italy, support for older persons with disabilities is situated within a complex ecosystem involving municipal social services, home care, general practice, rehabilitation services, family caregivers, and third-sector organisations. Within this system, older Muslims may encounter specific obstacles. Communication and bureaucratic barriers can delay access to support measures; symbolic distance from institutions may generate mistrust or fear; value conflicts may arise in everyday care practices, especially concerning the bodily dimension, modesty, diet, and prayer times. In some cases, intra-community stigma may make it difficult to recognise cognitive or psychological disabilities and may hinder help-seeking. A particularly significant issue also concerns the overload experienced by family caregivers—often women—who silently carry a very high care burden without receiving adequate support.

From this standpoint, the care of older Muslims with disabilities cannot be addressed solely through technical or administrative interventions. It requires a pedagogical approach capable of promoting processes of mutual learning between institutions and communities. Building culturally responsive services entails training professionals in intercultural sensitivity, developing linguistic and cultural mediation practices, and actively involving religious and associative communities in the design of social policies. At the same time, educational pathways supporting families and migrant communities are needed so that they can better understand the opportunities offered by welfare systems and overcome fears or stigmas.

Intercultural pedagogy can provide valuable tools for building relationships of trust and for promoting a model of care grounded in reciprocity. The aim is neither to assimilate cultural differences nor to enclose them within a logic of separation, but to build a space of dialogue in which religious traditions and public institutions can recognise one another as allies in safeguarding human dignity. In this sense, the fragility of older persons with disabilities becomes a test case for the ethical quality of contemporary societies. It calls for welfare policies to be rethought in inclusive terms and for care to be recognised not only as an individual or familial task, but as a collective responsibility involving the entire civic community.

6. Culturally Responsive Care Practices for Older Muslims with Disabilities in Italy: Towards a Pedagogy of Proximity and Intercultural Inclusion

In the case of older Muslims with disabilities in Italy, the promotion of well-being and formative care profoundly challenges the categories through which care, fragility, and collective responsibility are conceived. Appropriate care does not require the construction of supposedly "exotic specialisms," nor the introduction of segregated or culturally stereotyped practices. What is needed is a rigorous educational work that reshapes how professionals, institutions, and communities understand the care relationship.

The first level concerns the capacity to listen to and recognise the person. Pedagogically, the older person with disability cannot be reduced to a medical diagnosis or identified exclusively through functional or administrative categories. Likewise, religious belonging cannot be compressed into a standardised list of "cultural needs." Authentic care presupposes a listening stance that acknowledges the subject's biographical complexity. Older Muslims living in Italy often carry long migration histories marked by profound existential passages: detachment from the country of origin, the loss or transformation of family roles, migrant labour experiences, and the struggles of linguistic and social integration. These dimensions are compounded by bereavements, nostalgia for the mother tongue, and the sense of dependence accompanying the progressive loss of autonomy.

In this context, autobiographical pedagogy and narrative medicine are particularly significant. They enable older persons to recover a sense of subjectivity that institutional practices may sometimes obscure. Telling one's story, being heard in the language of the heart, and sharing memories of who one was prior to illness or disability constitutes a form of recognition that humanises services. Narrative listening is therefore not merely a relational add-on to care, but a pedagogical infrastructure capable of restoring dignity and building trust among service users, families, and professionals.

A second decisive domain concerns linguistic-cultural mediation. Too often, mediation is viewed as an accessory element or an occasional support meant to resolve translation problems. In reality, it is a structural component of care quality. It involves not only transferring words between languages, but also constructing shared meanings across different cultural systems. Through mediation, it becomes possible to explain care pathways, social rights, timelines, and the modalities of health assistance, as well as the clinical rationales underpinning decisions. At the same time, mediation allows professionals to understand fears, modesty concerns, and resistances that might otherwise be interpreted simply as refusal or distrust.

Many interruptions of care pathways and forms of service disengagement arise precisely from symbolic or communicative misunderstandings. When cultural mediation is stably integrated into services, such fractures can be prevented, turning the care relationship into a space for negotiation and reciprocal learning. In this sense, mediation is not only a technical device, but an educational practice that helps build common ground between institutions and citizens.

A third dimension concerns the ethics of care and the recognition of the religious dimension. Educational sciences and care ethics have highlighted that care cannot be reduced to a set of technical performances; it should be understood as a responsible relationship characterised by attention, continuity, and sensitivity to vulnerability. In Muslim family contexts, this perspective naturally resonates with the centrality of mercy and with the moral duty to protect those who are fragile.

Recognising the religious dimension does not mean turning services into confessional spaces; rather, it entails viewing spirituality as a possible resource for well-being. Operationally, this requires concrete sensitivity to needs that may carry significant symbolic meaning for older Muslims: respect for bodily modesty—when possible through attention to the caregiver's gender—availability of times and spaces compatible with daily prayer, care in food provision and meal preparation, and sensitivity to ritual practices or spiritual moments connected to end-of-life. These are not privileges granted to a minority, but conditions for equitable and dignified access that allow persons to feel recognised in their identity.

Alongside the individual dimension of care, the community dimension emerges forcefully. One of the most serious risks affecting older migrants with disabilities is loneliness. The progressive loss of traditional family networks, geographical distance from relatives and friends in the country of origin, and difficulties in building new relationships in the host context can generate particularly painful isolation. For this reason, individual case management is not sufficient. A true community pedagogy is needed to promote proximity networks capable of sustaining fragile persons.

In this perspective, intercultural associations, faith communities, civic volunteering, and local territorial organisations operating in neighbourhoods become crucial. Parishes, cultural centres, and third-sector organisations can also become spaces for encounter and cooperation among people of different backgrounds. An integrated care system functions effectively when it neither shifts the entire burden of responsibility onto the family nor delegates all assistance to institutions. Distributing responsibilities among different actors makes it possible to build more stable accompaniment pathways and to ensure continuity in the care relationship.

The educational and training perspectives emerging from this framework concern multiple levels of social life. First, the need to strengthen the training of professionals working in social, health, and educational services is evident. Intercultural competence cannot be reduced to superficial knowledge of customs; it must be understood as a reflective capacity to grasp cultural differences within a professional relationship. Professionals must be prepared to communicate with frail older persons and with family caregivers under emotional strain, to manage ethical value conflicts that may arise in therapeutic choices, and to negotiate sensitively issues such as informed consent or the refusal of certain medical practices. It is also essential to develop the ability to collaborate with cultural mediators and with associative networks in the territory. Training attentive to spiritual care can further help professionals recognise the religious dimension as a meaning-making resource, avoiding both intrusion and neglect.

Alongside professional training lies the training of communities and families. In many Muslim families, recourse to formal services may be experienced with embarrassment or guilt, as though seeking help entailed failing in the religious duty of care. Educational interventions co-designed with community associations and religious leaders can help overcome such perceptions. Informational meetings on social rights, available services, the characteristics of cognitive disabilities, and caregiver respite can build greater awareness. Health and digital literacy can also facilitate access to welfare resources. In this process, religious argumentation may become a meaningful ally: in Islamic tradition, caring for older persons does not necessarily mean doing everything alone, but rather responsibly activating all available resources to protect dignity.

A further educational field concerns the intergenerational dimension. Older persons, even when experiencing frailty or disability, remain a bridge between generations. They hold cultural memories, migration histories, and symbolic heritages that can become educational resources for younger people. Projects involving schools, associations, and local communities can facilitate encounters between young people and older adults through autobiographical narration workshops, culinary activities linked to cultural traditions, and dialogue moments on migration experiences and family histories. These experiences are not only affective or cultural; they represent a genuine pedagogical strategy capable of countering older persons' social invisibility and strengthening community belonging. A society that knows its older members and listens to their stories is less likely to abandon them.

The ageing of Italy's population of Muslim background therefore assumes a significance that extends beyond the management of care needs. It challenges educational sciences and training policies because it compels a rethinking of the relationship between culture, religion, and welfare. In the Qur'anic worldview, the older person is a figure worthy of honour and respect, while contemporary migration contexts can generate vulnerabilities that destabilise traditional care models. The response cannot be the imposition of Western models indifferent to the religious dimension, nor a total delegation of responsibility to the family. What is needed is the construction of an integrated, culturally responsive, and spiritually respectful care framework that combines social rights, community proximity, and professional competence.

Within this horizon, pedagogy plays a central role. It is not a mere theoretical supplement to social policies, but the discipline that enables the translation of dignity into everyday practices of relationship, education, and care. The educational challenge is to make possible a fruitful encounter among religious traditions, welfare systems, and local communities, so that the fragility of older persons does not become a reason for exclusion but an opportunity for shared responsibility. In this way, care for older Muslims with disabilities can become a laboratory for the humanisation of contemporary pluralistic societies, in which mercy, rights, and professionalism converge in a concrete synthesis in everyday life.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

This work did not receive any specific grant, financial support, or funding from public, commercial, or non-profit entities.

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Received: 19 February 2026 / **Revised:** 14 April 2026 / **Accepted:** 19 April 2026