Hindawi
Health & Social Care in the Community
Volume 2023, Article ID 8371077, 12 pages
https://doi.org/10.1155/2023/8371077

Research Article

Quality of Life and Social Inclusion of Migrants and Refugees Attending an Elderly Care Training in Four Mediterranean Countries: Results from the HERO Project

Sara Santini,[1] **Matteo Finco**,[1] **Paolo Fabbietti**,[2] **Sotiria Moza**,[3] **Elena Kyprianou**,[3] **Christina Yerou**,[4] **Theologia Tsitsi**,[4] **Maria Victoria Soulé**,[4] **Andreas Charalambous**,[4] **Panos Kassidakis**,[5] **and Flavia Galassi**[1]

[1]*Centre for Socio-Economic Research on Aging, IRCCS INRCA-National Institute of Health and Science on Aging, Via Santa Margherita 5, Ancona 60124, Italy*
[2]*IRCCS INRCA-National Institute of Health and Science on Ageing, Center for Biostatistics and Applied Geriatric Clinical Epidemiology, Ancona, Italy*
[3]*Materia Group, Athalassis 41, Nicosia 2221, Cyprus*
[4]*Cyprus University of Technology, 30 Arch. Kyprianos Str., Limassol 3036, Cyprus*
[5]*Aktios Elderly Care Units, Ipeirou 17, Athens, Greece*

Correspondence should be addressed to Matteo Finco; m.finco@inrca.it

Received 1 July 2023; Revised 30 August 2023; Accepted 18 November 2023; Published 6 December 2023

Academic Editor: Kelly Hall

The progressive population ageing observed in Western countries determines a growing need for long-term care for older people. At the same time, migrants and refugees often have integration difficulties in regards to the hosting country society and labour market, with one reason being the lack of EU recognition of the educational degrees obtained in their native country. Creating educational opportunities in elderly care for migrants may facilitate their social inclusion, increase their employability, and constitute a response to the growing labor demand. The HERO project moved in this direction by planning, designing, and carrying out an original training curriculum targeted to migrants and refugees from African and Middle Eastern countries, piloted in four Mediterranean countries (Cyprus, Greece, Italy, and Portugal). The impact of the training on migrants and refugees' quality of life was assessed through the WHOQOL-BREF questionnaire, while social inclusion was assessed through semi-structured interviews and participant observation carried out during the internship in elderly care facilities. Eighty-two migrants (70.7 percent women) were involved in the study. The results showed that despite the fact that the training did not have an impact on the trainees' quality of life, it was associated with social inclusion. Four ideal types of migrant learners were drawn: "ex-professional trainees," "fall-back trainees," "care-oriented trainees," and "nonprofessional care workers," based on which as many possible educational pathways were drawn to optimise the trainees' learning process. The study results shaped the formulation of suggestions on migrants' education in elderly care.

1. Introduction

In 2022, more than one fifth of the European (EU) population was aged 65 and over [1], while the average share of the population aged 80 or more was 6.1 percent, with some Mediterranean countries being above it, like Portugal with 6.9 percent, Greece with 7.2 percent, Cyprus with 3.9 percent and Italy with 7.6 percent [2]. In general, the progressive ageing of the population, entails the increase of multimorbidity and the consequent risk of long-term care (LTC) dependency [3]. At the same time, the sustainability of national LTC systems across Europe, both from the economic [4, 5] as well as the management perspective [6], is threatened by the disproportion between older people in need of care

and people in working age that could be employed in this sector [7]. The World Health Organization has estimated a projected shortfall of 10 million health care workers by 2030 [8]. Attracting, employing and retaining workers in the healthcare sector is really challenging in Europe [9], where the assistance of dependent older people is managed through a mix of formal and informal care whose proportion depends both on the level of LTC systems development and on the care regime [10]. In countries characterised by "familistic" care regime, as those in the Mediterranean area, e.g., Italy, Greece, Cyprus, and Israel [11–15], informal caregivers have to cover the care gap created by scarce public services by providing care themselves and/or by hiring private care workers [16]. Very often, the latter has a migration background [17]. The employment of migrant care workers (MCWs) is so common that some scholars refer to it as "shifting responsibilities" of care towards migrants [18]. In fact, non-EU citizens employed in the European labour market are overrepresented compared to EU citizens, especially among cleaners and helpers, personal services workers, and personal care workers, i.e., jobs related to care [1]. Nevertheless, figures regarding the number of MCWs across the EU are insufficient as many countries do not provide data on MCWs or do it in a very limited way [19], or because many of them are still working without a regular contract or are formally employed as cleaners instead of care assistants. In many European countries, migrant care provision is encouraged by the state through generous cash benefits for employer families [20, 21].

As "undeclared" and/or live-in workers, migrants often experience heavy, poor, and unfair working conditions due to several factors, e.g., the information asymmetry between care workers, intermediaries, and employers; the emotionally and physically intensive nature of live-in care work; the lack of sick leave and time off; health and safety issue at work; and low resilience at the individual level [22, 23]. However, compared to two decades ago, when the MCWs were mainly live-in workers [24, 25], nowadays only approximately one third of all migrant carers are still live-in carers in Italy, mainly those of a higher age and coming from Eastern European countries [26].

During the pandemic, some MCWs lost their job or returned to their countries of origin, or were not able to come back to the country in which they worked, while others had to accept dangerous circumstances in order to work, for instance, remaining isolated in the care receiver's home [20]. Thus, MCWs experiencing social isolation [27], and many suffering from mental disease [18] already, were even more stressed during the pandemic [28], and many of them, belonging to ethnic minorities, experienced inequalities at the workplace depending on the intersectionality of multiple factors such as gender, race, and migration status [29].

Nevertheless, the pandemic increased the visibility of MWCs in countries with a familistic care regime because their presence in the households of older people with long-term needs became the only means for continuing to provide daily assistance during the lockdown, when governments imposed moving restrictions and social distancing measures [30].

MCWs do not often have a formal and certified education in healthcare, which is required to be employed in the formal care sector, such as in nursing homes, elderly facilities, and hospitals, this limiting their employability. In fact, the existing elderly care training indeed looks like it does not match the educational and social needs of the migrant learners nor those of the care facilities' managers, thus hindering social integration and work inclusion [31]. Conversely, educational programs may be a strong and powerful means for migrants and refugees' social inclusion, by keeping them in contact with peers and hosting countries people, and for their working integration, by favouring the local culture and language learning. Moreover, training that meets the needs of both migrants and employers could also help overcome the latter's prejudice and mistrust of care workers from developing countries. In fact, in some Mediterranean countries, such as Italy, care managers have a low propensity to hire migrants, even when they have a formal education certification, because they complain about a healthcare workforce with a migrant background without properly knowing the language of the host country, the cultural context, and the healthcare organisation mission and vision [31].

The HERO project, funded by the Erasmus+ Program (ID: KA204-0C583C5), was designed to respond both to the demand for care by the ageing population of Mediterranean EU countries and to the inclusion of migrants and refugees. It is no coincidence that the program took place in Cyprus, Greece, Italy, and Portugal, that are the countries on the main immigration routes to Europe from North Africa and the Middle East and with the biggest migration hotspots. The HERO project had the objective of designing and carrying out an original and specialised training curriculum to train migrants and refugees in the elderly healthcare sector, with the aim of giving them the chance to be included into the European labour market.

2. Materials and Methods

2.1. Aims and Design. Within the HERO project, this study is aimed at highlighting the potential benefit of nonformal education on migrants and refugees' quality of life. To this purpose, the study combined quantitative and qualitative research methods, and data were collected at three time points over the educational intervention: before the training started (T0), in the middle (T1) of the training, and one week after its completion (T2).

Migrants and refugees were interviewed three times (pre-, mid-, and post-training) and were asked to answer a questionnaire twice (before and after the training) for collecting their perspective on education, ageing, and future plans. It is worth to clarify that the mid-term interview was aimed at identifying difficulties encountered by learners during the first part of the training and collecting suggestions for improving their experience with it. Since the outcomes of the mid-term assessment do not concern the impact of the training neither on the quality of life nor on other life realms, e.g., social inclusion, they are waived in this article and will be part, together with the experts'

perspective, of another one focused on the SWOT analysis of the HERO educational program. Conversely, the outcomes from the pre- and post-training interviews, whose topics are deepened below, represent the main source of finding of this paper.

To grasp the cultural aspects of learning and care, two participant observation (PO) sessions were carried out during the trainees' internship in the care facilities (a geriatric hospital in Italy and nursing homes in Cyprus, Greece, and Portugal). The first session was held in the first week of trainees' internship, while the second was held in the last week, to monitor and register the change in observed subjects' behaviour and interaction with care staff and with older people (where possible). Every PO wave included four two-hour observations, for a total of minimum 16 to a maximum of 22 hours.

2.2. Participants' Inclusion Criteria and Recruitment Channels. Trainees (i.e., migrants and refugees) were included in the study if they had knowledge of the host country language corresponding to the A1 of the Common European Framework of Reference (CEFR) [32], a work permit, or the status of a refugee; the informed signed consent and willingness to attend the training. At least 50 percent of participants had to be from African and Middle Eastern countries to comply with the original project idea. Trainees, such as nurses, gerontologists, and psychologists, were recruited through a word-of-mouth basis, dissemination of flyers, personal contacts, and organisations' network, through local Nongovernmental Organisations (NGOs) working in the educational and migration sectors, and were screened through a face-to-face interview administered by researchers, to confirm their real interest and motivation to attend the training.

Trainers were recruited within the healthcare organisations to carry out the study on the basis that they had: a good knowledge of English (B1-B2) so as to communicate with trainees in a common known language; at least three years of experience in their field; the informed signed consent, and willingness to attend the courses.

The individuals who accepted to take part in the study, were provided with an informed consent form both in English and in the host country language, and they were asked to carefully read and sign for acceptance, and then return it to the researchers. In the few cases where the migrants did not know the language of the host country or English well enough, the information sheet was translated by the language mediator who, together with the researchers, ensured that every aspect of the document was understood.

All responses to the survey were collected anonymously, in compliance with the EU Regulation No. 679 of the European Parliament and of the Council of 27 April, 2016, and the Helsinki Declaration (2013). The data collected were processed in a completely anonymous and aggregated form and stored in a password-protected file. The protection of individuals, with regard to the processing of personal data and the free movement of such data, was ensured in accordance with Regulation 2016/679 of the EU Parliament.

In accordance to the "Ethic and data protection" document delivered by the EU Commission [33], ethical review and approval were waived for this study, because it consisted of the mere assessment of the impact of the training on learners' social dimensions, such as social and work inclusion. In fact, the study did not raise any ethical risks for participants since neither did it process special categories of personal data, like respondents' political opinions, religious or philosophical beliefs, genetic, biometric, and health data (such as specific diseases), nor did it involve vulnerable subjects, e.g., children or people who have not given their explicit consent to participate in the project.

2.3. The Training Structure. The training was carried out between June 2022 and October 2022 in Italy, Cyprus, Greece, and Portugal. The curriculum, developed in four languages (English, Greek, Italian, and Portuguese), was organised into two parts: the first one on the language of the host countries (i.e., Italian, Greek, and Portuguese) and the second one on elderly care (see Supplement-HERO training curriculum (available here)). The overall training lasted 100 hours out of which 78 were face-to-face lessons (24 hours of language training and 54 hours of elderly care training), plus 22 hours of internship.

The language course incorporated a blended methodology conceptualized as a combination of on-site (i.e., face-to-face) with online experiences to produce effective, efficient, and flexible learning.

It included nine units and every unit consisted of five sections: (1) texts in the form of dialogues, schedules, instructions, descriptions, and reports; (2) vocabulary related to the topic of each unit; (3) phrases from the texts useful in the care contexts; (4) grammar/function of the language used in the texts of each unit; and (5) activities put into practice about what had been learned in the previous sections [34].

The elderly care course included four modules: (1) "Ageing and Neurocognitive Disorders"; (2) "Communication Skills and Competences"; (3) "Person-Centred Care and Strategies"; (4) "Nursing Care and Practices." The lessons were designed as asynchronous training modules (Microsoft PowerPoint presentations), and they were integrated along with videos, working groups, case-studies, simulations, and testimonies from care professionals and family caregivers.

The internship was planned so that trainees could cover different shifts corresponding to different day times and often to different tasks. Every shift lasted between six and eight hours and took place in the morning or in the afternoon. During morning shifts, for example, trainees could experience routines of elderly care, such as toileting, hygiene, feeding and physiotherapy, and occupational

therapy. During the afternoon shifts they could deal with the support, communication and social relationships with older people, especially in nursing homes.

2.4. Data Collection Tools and Outcome Measures. This multimethod study used four different data collection tools: one questionnaire, two semistructured interview topic guides, two focus group topic guides, and one grid for the participant observation.

The questionnaire for migrants was developed through a socio-demographic section followed by the WHO-QOL-BREF [35], measuring the trainees' quality of life. The WHOQOL-BREF was made up of 26 multiple-choice questions covering four domains (physical health, psychological health, social relationships, and environmental health) based on a five-point Likert ladder through which the trainees placed a score to several life realms such as overall quality of life, health, level of satisfaction with themselves, their life, and their relationships. It was administered by researchers before and after the intervention.

The impact of the training on the trainees and especially on their social inclusion was evaluated through semi-structured interviews and the participant observation. The trainees were interviewed before and after the training by sociologists and psychologists skilled in qualitative methods. The pretraining interview topic guide was developed based on three areas: (a) migration pathway; (b) representation of older age; and (c) expectations on the training and plan for the future.

The posttraining topic-guide interview addressed four realms: (a) feedback on the training; (b) representation of older age; (c) the experience of the training; and (d) plan for the future.

The PO had a common structure in the four study countries, foreseeing the same number of hours of observation (from a minimum of 16 to a maximum of 22 hours), and it was carried out by researchers who had spent time with trainees from the very beginning of the training. Due to the fact that researchers got to know the trainees and had a prolonged interaction with them, they therefore established trustworthiness, as recommended by Guba and Lincoln [36]. As the internship was built on shifts, the observers could visit the setting under study at different times of the day, and they could see the differing experiences depending on the time and day, as suggested by Kutsche [37].

Researchers were equipped with an observational grid including the topics to pay attention to [38–40]: physical environment and social context; dynamics occurring in the medical/nursing staff; number and quality of the trainees' interactions with tutors, older patients, and between themselves; the trainees' verbal and nonverbal behaviour and communication (with the related emotions that could be evidenced); the verbal and nonverbal behaviour of older patients and formal carers as well. The researchers took quick notes during the observation and wrote down extensive fieldnotes immediately after it.

2.5. Data Analysis. Demographic information collected through the questionnaire was analysed through descriptive measures, given the small sample size. Comparisons between national groups were performed with the nonparametric statistics Mann–Whitney U for ordinal and continuous variables or the chi-squared test for categorical variables. Variables normality was evaluated by Kolmogorov–Smirnov test. Results were expressed as median (interquartile range) for continuous variables because not all of them were all normally distributed, and as percentage for categorical variables.

Comparisons of each domain of the WHOQOL-BREF scale between pre- and post-training were performed through a paired samples t-test. Statistical significance was set at $a < 0.05$. The WHOQOL-BREF index was calculated by summing the point values for the questions corresponding to each domain and then by transforming the scores to a 4 to 20 point interval. The scores ranged from 1 to 5 points for all questions. For almost all questions, the worst possible health status corresponded to 1 point, while the best possible corresponded to 5 points (5-point Likert scale). All statistical analyses were performed with SPSS version 24 (SPSS Inc., Chicago, IL, USA).

Textual data arising from semistructured interviews to trainees were recorded and the contents were transcribed verbatim in the national languages and only few quotations were translated into English for cross-national comparison. Qualitative data were thematically analysed by the first author with the support of MaxQda Plus software. After the identification of themes and subthemes [41], they were shared with one researcher from every national team for verification and then compared by country according to the framework analysis [42].

The observation fieldnotes were reported into a narrative by focusing only on the topics of interest for the study [37]. Then, all narratives were summarised at the national and cross-national level, and coded to select and emphasise information answering the research question, and finally, the codes were merged in themes [43].

Data from interviews and participant observation were triangulated for drawing ideal types of migrants and refugees in the elderly healthcare educational pathways, i.e., migrants and refugees with recurring and typical traits and characteristics. The ideal types were meant as a unified analytical construct that helped scholars grasp the characteristics of the phenomenon and, in turn, plan effective training [44].

3. Results and Discussion

3.1. Description of the Trainees. In total, 120 migrants and refugees were contacted to be enrolled into the training, but only 82 were included in the final sample (Table 1). In fact, 17 individuals answered only the pretraining questionnaire and then withdrew from the training: they were considered drop-outs. Moreover, 21 individuals, who were called "renouncers," attended only a few classes and never continued for different reasons. Drop-outs and renouncers were not included in the final sample. Trainees' characteristics are reported in Table 1. The sample majority was women (70.7

percent), with an average age of 33 years old. One-third attended the training in Portugal, while almost 30 percent in Greece, and 23.5 percent in the Republic of Cyprus. Italy had the remaining 11 percent. Almost 40 percent of the trainees came from Central Africa, and a quarter of them from South America. About 10 percent came from South Africa and the Middle East, while 6 percent came from Asia. A residual portion came from other areas (only one person from Europe). Only a quarter of respondents were married, 61.7 percent reported to be single/separated, and half of respondents had children.

More than one third of the trainees had a higher educational degree (Bachelor's or equivalent; only 2 have a master's degree) and another 30.5 per cent attended the Upper Secondary School.

Almost a quarter of participants (26.8 percent) had already attended a course in healthcare prior to HERO, receiving a proper certificate. Finally, ten (10) percent declared themselves affected by an illness at the time of the pre-training interview. This last information was useful for the interpretation of the WHOQOL-BREF questionnaire, whose results are described below.

3.2. Impact of the Training on Migrants and Refugees. Concerning the QoL, the trainees rated their physical and psychological health in the fourth quartile (16.3 and 15.9, respectively, at the baseline) (Table 2). This means that they considered these realms quite good. Conversely, they perceived the social relationship and the environment to be quite poor (14.6 and 13.8, respectively, at the baseline). There are no significant differences between the scores of pre- and post-training questionnaire in the four domains.

The analysis of the interviews identified five themes: (a) the motivation to attend the training; (b) representations of older people in native and hosting countries; (c) plan for the future; (d) the evaluation of the training; and (e) positive and negative aspects of taking care of an older person.

Since the same realms were explored three times during the training, it was possible to grasp the changes that occurred in the trainees' perspective over time. Every theme and its evolution are described in Table 3.

3.2.1. Theme 1: Motivation to Attend the Training. Across the four countries, trainees agreed to attend the training with the aim of getting knowledge and competences and find a job in the care sector: "*I chose the Hero program because it will give me the opportunity to do what I love and study. Because it will help me to gain more experience in the job I like to do and also it will be useful to learn the Greek basics*" (Female, 33, Zambia, Greece); "*have a sustainable job, tranquillity and not be persecuted*" (Female, 35, Guinea Bissau, Portugal).

Only one male, who was a doctor in Somalia, mentioned that the reason for attending the training was to get to know the healthcare system rather than to acquire knowledge and skills.

3.2.2. Theme 2: Representations of Older People. In the trainees' native countries, older people are assisted quite exclusively by family members (most young family members) and, in some cases, such as in Somalia, by the overall community, without any support from the government. Migrants and refugees thought that older people are respected and well cared for in the hosting Western countries, but they were also surprised by the fact that they are often entrusted by family members to people outside family. A trainee from Somalia underlines this in the following quotation: "*There are many old people in Italy. Maybe for the pasta. But very often they are alone at home, instead they should be together in a facility, a rest home. In Somalia there are many people, many children, there are no old people alone in the house. People alone at home weaken anyway, they have more diseases, even Covid for example*" (Male, 30, Somalia, Italy).

Some trainees changed their perspective on ageing over the course, by focusing most on older people's frailty and dependency. Before the training, they had given generic definitions and descriptions of older people e.g.: "*An older person is someone who grows up and forgets something because of the age and has no power to do something like before*" (Male, 33, Congo, Cyprus). Conversely, after the training, participants from all the four study countries reported more specific definitions of older people, like the following: "*It just means not being able to satisfy yourself on your own. . . that is, not being autonomous and being dependent on other people, so you always need someone to be there for you. And then with ageing so many things change intellectually but also physically*" (Female, 23, Cameroon, Cyprus).

3.2.3. Theme 3: Plan for the Future. Concerning the plan for the future, before the training, migrants and refugees had generic plan such as finding a job, getting married and having children. After the training, many trainees mentioned they wanted to continue to learn, to attend another course for becoming a nurse or a care professional, and to start working as a care professional in a care unit or a hospital in the four countries. Here is a quotation reported from the Cypriot group, as example to be considered applicable cross-nationally: "*My plan for next year is to become caregiver and the plans for next five years is to become nurse I always want to be medical Professional*" (Male, 32, Somalia, Cyprus).

3.2.4. Theme 4: Evaluation of the Training. While before the training started, migrants and refugees enrolled in the educational program had not referred to any fear related to the course, in the middle, when they were briefly interviewed, they reported a bit of frustration for the difficulty in learning and fully understanding the local language. At the end of the training, in all the study countries, trainees identified the contents, the relationship both with trainers/teachers and with peers as the training's main strengths together with

Table 1: Trainees' description and drop-out subjects.

Variables	Participants ($n = 82$)	Drop-outs ($n = 17$)	p
Gender, n (%)	24 (29.3)	4 (23.5)	0.633
Female	58 (70.7)	13 (76.5)	
Age (years), median (IR)	33.0 (25.5-38.2)	31.0 (25.5-42.0)	0.693
Place of training, n (%)			
Cyprus	20 (24.4)	6 (35.3)	0.352
Greece	24 (29.3)	3 (17.6)	0.328
Italy	11 (13.4)	8 (47.1)	0.001
Portugal	27 (32.9)	0 (0.0)	0.006
Marital status, n (%)			0.149
Single separated	51 (62.2)	7 (41.2)	
Married	19 (23.2)	8 (47.1)	
Divorced	6 (7.3)	0 (0.0)	
Living as married	4 (4.9)	2 (11.8)	
Widowed	2 (2.4)	0 (0.0)	
Children, n (%)	39 (47.6)	9 (52.9)	0.686
No of children, median (IR)	1.0 (1.0-2.0)	1.0 (1.0-2.0)	0.435
Place of birth, n (%)			
Middle East	8 (9.8)	2 (11.8)	0.802
Asia	6 (7.3)	6 (35.3)	0.001
Central-Africa	32 (39.0)	4 (23.5)	0.227
South Africa	11 (13.4)	0 (0.0)	0.109
South America	20 (24.4)	2 (11.8)	0.254
North Africa	4 (4.9)	2 (11.8)	0.279
Europa	1 (1.2)	1 (5.9)	0.214
Highest education, n (%)			0.846
Early childhood education	1 (1.2)	0 (0.0)	
Primary education	8 (9.8)	1 (5.9)	
Lower secondary education	5 (6.1)	2 (11.8)	
Upper secondary education	25 (30.5)	5 (29.4)	
Postsecondary nontertiary education	4 (4.9)	0 (0.0)	
Short-cycle tertiary education	8 (9.8)	3 (17.6)	
Bachelor's or equivalent	29 (35.4)	5 (29.4)	
Master's or equivalent	2 (2.4)	1 (5.9)	
Certification in healthcare, n (%)	33 (40.2)	4 (23.5)	0.195
Training before HERO, n (%)	22 (26.8)	4 (23.5)	0.778
No of training months, median (IR)	11.0 (5.2–13.5)	1.0 (1.0–36.2)	0.130
Currently ill, n (%)	8 (9.8)	0 (0.0)	0.179
Doctor contacted, n (%)	9 (23.1)	3 (50.0)	0.165

Table 2: Quality of life of migrants and refugees attending the HERO training.

WHOQOL-BREF ($n = 82$)	Pre	Post	p
Physical health	16.3	16.3	0.988
Psychological health	15.9	16.3	0.106
Social relationship	14.6	14.4	0.574
Living environment	13.8	13.9	0.534

being offered an opportunity to find a job, representing the first step towards social inclusion.

A common suggestion was that of using videos during the face-to-face lessons, because they found them more appealing and because the images would help migrants understand the contents, especially when their host country language knowledge was not very good.

The main weaknesses of the training differ from country to country. In Cyprus, trainees complained about problems of connectivity and the low motivation of someone to attend the course steadily. In Greece, the theoretical lessons were considered to be difficult to understand and "confusing". In Italy, the main problem was the language, but also the lack of recognition of previous educational achievement that made trainees with a degree in healthcare feel not "valorised." In Portugal, the theoretical lessons acquired without practice seem to have caused confusion among some trainees who had never been in contact with older persons.

3.2.5. Theme 5: Taking Care of an Older Person. In the respondents' opinion, the main positive aspect of taking care of an older person was found in feeling useful when you

Table 3: Themes from trainees' interviews and key-points capturing their evolution over time.

Themes	Key-points
(1) The motivation to attend the meeting	Trainees in the four countries were pushed to attend the training by the common willingness of increasing their competences and finding a job for improving their quality of life
(2) Representation of older people	Trainees' representations of older people changed over the training depending on the level of impairment of the patients they met
(3) Plan for the future	The training experience influenced the trainees' plan for their future life by helping them identify work priorities
(4) Evaluation of the training	The trainees' perspective on the training included both positive and negative aspects and the difficulties faced
(5) Taking care of an older person	Caring for an older person with long-term care needs was rewarding but also exhausting and shocking especially for some trainees who came in contact with older people with severe neurological impairment

provide proper care and emotional closeness. Negative aspects include emotional distress and having to manage behavioural disturbances. In most cases, the relationship with older people was friendly and trust-based: "*Although there was a language barrier but then again, the most. There was a time I was feeding a lady in the same place with her husband and she had severe dementia and her husband was not severe and I was feeding her. After the feeding I was escorting them to their room and the husband was like my wife and it really touched me and it made me happy and later we brought back his wife to the room*" (Female, 28, Somalia, Cyprus).

In Italy, the contact with hospitalised older people with disabilities, especially patients with neurological impairment, shocked the trainees. Such a condition limited the communication with older people and, consequently, the establishment of empathy. "*The problem is that he cannot speak; if a patient asks him something, he cannot answer*" (Male, 34, Afghanistan, Italy).

The relationship with the care staff unit was respectful, friendly and cooperative in all four countries: "*They were all friendly and open to questions, so we built a good relationship*" (Male, 36, Guinea, Greece) and "I have a good relationship with everyone that works with me. The manager and the nurses as well" (Male, 27, Congo, Greece).

3.3. Trainees' Behaviour and Relationship with Care Recipients and Care Staff. Three main themes emerged through participant observation: (a) trainees' behaviour and feelings; (b) interaction with the care staff; and (c) interaction with older patients.

3.3.1. Theme 1: Trainees' Behaviour and Feelings. In all the study countries, most of the trainees were curious, interested and respectful during the internship. They followed the work of the tutors and tried, where possible, to interact with the older patients to create a relationship of trust. Initially, there was some anxiety on the part of some of them, which then seemed to subside. Many women showed love, kindness, and empathy, though in some cases they felt sad, sorry, and upset when seeing the hospitalised people suffering. More than one of the trainees said phrases like: "*They really need our help*," "*I see them as my grandparents*."

3.3.2. Theme 2: Interaction with the Care Staff. The staff in general was well disposed towards the trainees, welcoming, smiling and kind. Very often they explained the activities one by one, especially when it related to how cleaning should be done.

Even if there were some language barriers, the care staff and the trainees found a solution to communicate what was needed. Most of the time, the trainees would help each other if one of them was having a difficulty.

All the trainees were encouraged by the head nurses and the rest of the staff to ask as many questions as they wanted in order to get the right instructions for learning the job.

Among the three trainees who were doctors or nurses in their home country, a feeling of frustration and sadness emerged because they would have wanted to intervene for helping patients, especially if they asked for help the trainees were not allowed to provide.

3.3.3. Theme 3: Interaction with Older Patients. Older people were smiling at the trainees, they were asking them questions to get to know them better and sometimes they were trying to touch their hands and were happy and curious for having new people to talk to.

Interaction and communication seem to have increased over time; in fact, they were reported more in the observations conducted in the later shifts on the ward, where a good degree of knowledge of the environment and people had already been established.

Regarding verbal communication, a few times trainees expressed feelings of sadness or anxiety seeing so many people bedridden and in distress, e.g., one trainee states "*It's scary huh*!."

With older patients having dementia, the trainees had the opportunity to observe different ways of communicating and testing their effectiveness.

3.4. "Ideal Types" of Migrant Elderly Care Learners and Personalized Education. Based on the results shown above, we identified four ideal types of migrant learners: "ex-professional", "fall-back," "care oriented," and "non-professional" care workers. The criteria for assigning a subject to an ideal type rather than to another are given by the combination of educational level (High = Bachelor and

Master's Degree; Medium = High school; Low = up to Secondary school), motivation to attend the training, and expectations for the future. For each of the ideal type described above, a corresponding educational pathway has been drawn, in order to optimise the trainees' learning process and to motivate them to attend similar trainings in the future (Table 4).

"Ex-professional" trainees are individuals who worked in the health sector in the native country and attending the course because it was the nearest to their knowledge and professional competences. In this group there are doctors and nurses whose educational certification acquired in the native country is not recognised in the host one. For the subjects belonging to this group, attending the HERO training has been frustrating because they felt demoted from general practitioner or professional nurse working in the public healthcare sector to "family assistant" working in a nonfully professional environment (mainly at the home of the older people with disability). The "ex-professional" category of trainees attended the course with moderate interest; sometimes they were bored because the course dealt with simple topics for people like them, as this had the highest qualification in the medical field. Nevertheless, they attended the course regularly, because they were used to fulfilling their commitment. They would like to work in the healthcare sector in the hosting country after their educational certification was recognised.

The "ex-professional" trainees need help to be integrated in the professional healthcare sector as doctors and nurses, e.g., a curriculum that helps them re-access the academy. Meanwhile, a strong cooperation is needed between NGOs, Trade Unions, training organisations and the entitled authority, for the recognition of the educational degree achieved in the native country. In this case the informal education may be the bridge towards the formal education by helping "ex-professional" trainees integrate the curriculum acquired in the native country with items required in the host country, so that the educational degree is recognised, and they can work in the healthcare sector as professionals again.

The second ideal type, called "fall-back trainees", included mainly around 20-year-old youngsters who started attending the training because they had no other training and/or working opportunities and they knew that there is a high elderly care job demand in the Western countries. They attended the course with discontinuity and showed a lack of interest. They did not want to work in the elderly care sector, but they might do it as a fall-back in case of lack of alternatives. "Fall-back" trainees they should be oriented toward educational paths other than those related to personal care. To this purpose, a great cooperation between public work centres and training organisations is needed to re-orient these trainees and design tailored curricula.

"Care oriented" trainees decided to start the course out of curiosity but became passionate about the subjects. They attended the course regularly, expressed interest in continuing their studies in the healthcare sector to acquire the title of health and social worker or nurse. They need support to begin professional nursing training.

The fourth group, named "nonprofessional care workers," included subjects already integrated in the hosting country and who were already working in the informal care sector (e.g., as migrant care workers hired by older people). It was hard for them to combine training and work. They attended the course to increase their knowledge and competences, have more work chances and improve their working condition. They wanted to continue working in the informal care sector, but with more awareness and knowledge. They needed a longer internship preferably at the home of the elderly and under the supervision of a healthcare professional (e.g., a nurse), such that they could provide better assistance to the older care recipients.

3.5. Discussion. To the best of our knowledge, HERO is one of the first European projects linking migration and long-term care demand of older people living in Mediterranean European countries and focusing on their education. Previous studies indeed, focused on migrants and refugees as patients or users of healthcare services [19] or as live-in MCWs employed by older people's families [45].

Quantitative analysis showed that the HERO training did not significantly affect the overall QoL of trainees, probably because they had primary and complex social, psychological, and economic needs e.g., the need for a job, for a respectable house, and for family reunion, that cannot be addressed just by a training. Nevertheless, HERO represented a chance for socialising and understanding the elderly care practice. In fact, despite language difficulties, migrants, and refugees were able to establish good relationships with other trainees, older care recipients and healthcare personnel, and to overcome cultural bias and the dearth of understanding of the care facility vision, that are the main concerns hindering the employment of migrant workforce in elderly care facilities [31].

Like most migrants, trainees have experienced broken family ties due to their departure from their country of origin. Many of them traced their relationship with older patients back to the one they had had or could have had with their parents or grandparents. On the one hand, the care work can be an opportunity for some migrants to mend the generational rift that occurred with migration; on the other hand, it may be the chance for some older people for establishing interpersonal bonds going beyond the mere care interaction towards affection and empathy.

Although the training favoured the participants' social inclusion, it increased the sense of frustration of trainees who had a healthcare certification obtained in the native countries, confirming the urgency of a system for the evaluation and recognition of the university health science degrees acquired abroad [46–48].

4. Training Suggestions

In the light of the study results, future courses on elderly care targeted to migrants and refugees should be to the greatest possible extent. They should have more hours devoted to the host country language learning, ICTs usage, and the development of culture of ageing and care.

Table 4: Ideal-types of learning pathways in the elderly healthcare.

Ideal-types of trainees	Educational level	Motivation to attend the training	Expectations	Pathway
Ex-professional	High educational level	To be integrated into the care system	To work in the healthcare sector as professionals	Recognition of previous healthcare certification
Fall-back	Medium educational level	Other training and work opportunities missing	To work in any economic sector	Re-orientation in the work market
Care oriented	Medium educational level	Curiosity	To continue studying healthcare subjects	Professional healthcare education
Not-professional trainees	Medium educational level	To improve their knowledge in elderly care	To continue working as not-professional care workers	Complete healthcare informal education

Recruiting and retaining migrants and refugees in the course was not easy because their priority was to find a job rather than join a training that possibly stands in the way of their employment. Future courses should, therefore, be organised during nonworking hours (e.g., after dinner).

Special attention should be paid to women, because they are often young mothers, without a family support network and without the financial resources to be able to afford a private babysitter or a childcare centre to which they can entrust their children while attending the course. To overcome this obstacle, it is important that the training managers cooperate with local volunteers who can look after the children of the migrant women.

Finally, the internship should take place in a hospital, at a care home for the elderly, and elderly care facilities, such as rest home and day-care centres, so that trainees can see and experience different types of older people with different care needs.

5. Study Limitations and Research Suggestions

The first limitation of the study is the nonrandomised purposive and small-sized sample further reduced by the high number of drop-outs, despite measures taken by the consortium, that did not allow the generalisation of the results. This calls for a careful assessment of the time of year and time of day in which to run courses similar to HERO, favouring the winter period and an evening schedule, so that the education does not hinder the seasonal work. It is also important to find new appealing participatory research methods for engaging migrants and refugees and retaining them, as well as creative research and educational tools such as for comics, dance, music in an effort to find a common universal language, overcome cultural barriers, and improve communication and understanding between researchers and migrants.

The second limitation is the lack of specific questions on migration and elderly care education from a gender's perspective which did not allowed a gender analysis of the impact of the training on men and women. The latter is recommended in future studies, considering that migrant women are at high risk of gender inequalities in accessing both education and employment, especially if they are mothers.

Yet another limitation relates to the fact that the study did not gather older people's proclivity towards receiving assistance from migrants and refugees and their effective experience during the internship. A positive reaction to the migrants' assistance was observed only in Greece and in Portugal by means of the participant observation, but future studies should also listen to the voice of older patients and their family carers. Ethnographic research mixed to the policy analysis of long-term care systems is welcome.

The original study design did not include a long-term follow-up: this representing another limitation. Nevertheless, to cover this gap, a follow-up is ongoing to assess the long-term effects of the training. In late Summer 2023, the trainees were interviewed by phone, following a topic-guide interview asking about trainees' current employment and training condition and plans for the future. The follow-up outcomes will be reported in another dedicated paper.

6. Conclusions

Migrants are an indispensable resource to meet the growing demand for LTC and ageing in place in Europe. However, they must be properly trained so that they can provide high-quality care to older people. To build a successful training for such a target, care staff, educators, teachers, social workers, and volunteers must cooperate to create community ties and support services which put migrants in a position where they are able to devote themselves to their studies.

Data Availability

The data used to support the findings of this study are included within the article.

Ethical Approval

Ethics committee approval was not mandatory in the study countries. The study was conducted in accordance with the Declaration of Helsinki.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Authors' Contributions

S.S. conceptualized the study and performed the methodology. S.S. and M.F. performed formal analysis. S.S., M.F., and F.G. performed investigation. M.F. and F.G. wrote the original draft. S.S., C.Y., T.T., M.V.S., A.C., P.K., and S.M. wrote, reviewed, and edited the article. S.M. and E.K. contributed to funding acquisition and performed project administration. All authors have read and agreed to the published version of the manuscript.

Acknowledgments

The authors acknowledge Julian Ulecia (SPSI, SA) for data collection in Portugal and all refugees and migrants who attended the HERO training. This research was funded by the ERASMUS+ Program, grant number 2020-1-CY01-KA204-066039. The study was also supported by the Ricerca Corrente funding from the Italian Ministry of Health to IRCCS INRCA, Istituto di Ricovero e Cura a Carattere Scientifico, and Istituto Nazionale Ricovero e Cura per Anziani (Scientific Institute for Research, Hospitalization, and Healthcare National Institute of Health and Science on Aging). Open access funding provided by BIBLIOSAN.

Supplementary Materials

Supplement-HERO training curriculum. (*Supplementary Materials*)

References

[1] The Statistical Office Of The European Union (EU), "Population structure and ageing," 2023, https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Population_structure_and_ageing.

[2] The Statistical Office Of The European Union (EU), "Population age structure indicators," 2022, https://ec.europa.eu/eurostat/statistics-explained/images/0/0e/Population_age_structure_indicators%2C_1_January_2022_%28%25%29.png.

[3] D. Koller, G. Schön, I. Schäfer, G. Glaeske, H. van den Bussche, and H. Hansen, "Multimorbidity and long-term care dependency—a five-year follow-up," *Bone Marrow Concentrate Geriatrics*, vol. 14, no. 1, p. 70, 2014.

[4] V. Atella and V. Conti, "The effect of age and time to death on primary care costs: the Italian experience," *Social Science and Medicine*, vol. 114, pp. 10–17, 2014.

[5] D. Howdon and N. Rice, "Health care expenditures, age, proximity to death and morbidity: implications for an ageing population," *Journal of Health Economics*, vol. 57, pp. 60–74, 2018.

[6] Organisation for Economic Co-operation and Development (OECD), *Who Cares? Attracting And Retaining Care Workers For the Elderly, OECD Health Policy Studies*, Organisation for Economic Co-operation and Development (OECD) Publishing, Paris, France, 2020.

[7] World Health Organization (WHO), *Integrated Care for Older People. Realigning Primary Health Care to Respond to Population Ageing*, World Health Organization, Geneva, Switzerland, 2018.

[8] World Health Organization (WHO), "Health workforce," 2020, https://www.who.int/health-topics/health-workforce#tab=tab_1.

[9] The Statistical Office Of The European Union (EU), "Overall figures of immigrants in European society," 2022, https://commission.europa.eu/strategy-and-policy/priorities-2019-2024/promoting-our-european-way-life/statistics-migration-europe_en.

[10] A. Anderson, "Europe's care regimes and the role of migrant care workers within them," *Population Ageing*, vol. 5, no. 2, pp. 135–146, 2012.

[11] G. Casanova, A. Tur-Sinai, and G. Lamura, "Innovating long-term care provision in mediterranean welfare states: a comparison between Italy and Israel," *Journal of Aging and Social Policy*, vol. 32, no. 1, pp. 55–82, 2020.

[12] T. Maroukis, "Migrant care workers' trajectories in a familistic welfare regime: labour market incorporation and the Greek economic crisis reality-check," *Journal of Ethnic and Migration Studies*, vol. 44, no. 14, pp. 2358–2374, 2018.

[13] F. van Hooren, "Migrant care work in Europe: variety and institutional determinants," in *The Transformation of Care in European Societies*, pp. 62–82, Springer, Cham, Switzerland, 2014.

[14] H. Nies, K. Leichsenring, and S. Mak, "The emerging identity of long-term care systems in Europe," in *Long-Term Care in Europe*, pp. 19–41, Palgrave Macmillan, London, UK, 2013.

[15] M. Ferrera, "Italy as a familistic care regime: "The Southern model of welfare in social Europe"," *Journal of European Social Policy*, vol. 6, no. 1, pp. 17–37, 1996.

[16] A. Charalambous, *Informal Caregivers: From Hidden Heroes to Integral Part of Care*, Springer, Cham, Switzerland, 2023.

[17] M. Artero, M. Hajer, and M. Ambrosini, "Travailler avec une famille. Comment un système de soins basé sur la famille ouvre la frontière aux travailleuses des soins domestiques immigrées," *Revue Européenne des Migrations Internationales*, vol. 37, no. 1-2, pp. 117–138, 2021.

[18] S. Hussein, "The global demand for migrant CareWorkers: drivers and implications on migrants' wellbeing," *Sustainability*, vol. 14, no. 17, Article ID 10612, 2022.

[19] A. Sowa-Kofta, L. Rodrigues, G. Lamura et al., "Long-term care and migrant care work: addressing workforce shortages while raising questions for European countries," *Eurohealth: The Journal Of The European Observatory*, vol. 25, pp. 15–18, 2019.

[20] F. van Hooren, *Covid-19, Migrant Workers and the Resilience of Social Care in Europe. Think Piece, Migration Policy Centre*, European University Institute, Florence, Italy, 2020.

[21] M. Cordini and C. Ranci, "Legitimising the care market: the social recognition of migrant care workers in Italy," *Journal of Social Policy*, vol. 46, no. 1, pp. 91–108, 2017.

[22] M. Åhlberg, C. Emberson, L. Granada, S. Hussein, and A. Turnpenny, "The vulnerability of paid, migrant, live-in care workers in London to modern slavery," Project Report, University of Nottingham Rights Lab, Nottingham, UK, 2022.

[23] L. De Vita and A. Corasaniti, "Regulating domestic and care work in Italy: assessing the relative influence of the familistic model today," *Critical Social Policy*, vol. 42, no. 3, pp. 531–549, 2022.

[24] V. Horn, C. Schweppe, A. G. M. Böcker, and M. M. Bruquetas Callejo, "Live-in migrant care worker arrangements in Germany and The Netherlands. Motivations and justifications in family decision-making," *International Journal of Ageing and Later Life*, vol. 13, no. 2, pp. 83–113, 2019.

[25] G. Lamura, M. D. Rosa, R. Papa, A. Poli, and F. Barbabella, "Implications of the use of migrant care work and web-based services on family caregivers' health," *International Journal of Care and Caring*, vol. 3, no. 1, pp. 97–116, 2019.

[26] S. Pasquinelli and F. Pozzoli, "Badanti dopo la Pandemia. Milano, time to care," 2021, https://www.aclilombardia.it/0/wp-content/uploads/2021/04/RAPPORTO-BADANTI-2021.pdf.

[27] B. Anderson, "Worker, helper, auntie, maid? Working conditions and attitudes experienced by migrant domestic workers in Thailand and Malaysia," 2016, https://www.ilo.org/asia/publications/WCMS_537808/lang--en/index.htm.

[28] N. Alcaraz, L. Lorenzetti, S. Thomas, and R. Dhungel, "Breaking isolation: social work in solidarity with migrant workers through and beyond COVID-19," *Social Work*, vol. 67, no. 1, pp. 48–57, 2021.

[29] S. Hussein, "Employment inequalities among British minority ethnic workers in health and social care at the time of covid-19: a rapid review of the literature," *Social Policy and Society*, vol. 21, no. 2, pp. 316–330, 2022.

[30] K. Leichsenring, S. Kadi, and C. Simmons, "Making the invisible visible: the pandemic and migrant care work in long-term care," *Social Sciences*, vol. 11, no. 8, p. 326, 2022.

[31] S. Santini, M. Finco, and F. Galassi, "Education and employment of refugees and migrants in the formal elderly healthcare sector: results from an online survey in Italy," *Sustainability*, vol. 14, no. 6, p. 3540, 2022.

[32] Council of Europe, *Common European Framework of Reference for Languages: Learning, Teaching, Assessment*, Press

Syndicate of the University of Cambridge, Cambridge, UK, 2001.

[33] European Commission, "Ethics and data protection," 2021, https://ec.europa.eu/info/funding-tenders/opportunities/docs/2021-2027/horizon/guidance/ethics-and-data-protection_he_en.pdf.

[34] M. V. Soulé, K. Stylianou, C. Yerou, E. Xerou, T. Tsitsi, and A. Charalambous, "The HERO project: language training for migrants' professional career as caregivers through blended learning," in *Call and Professionalisation: Short Papers from EUROCALL 2021*, N. Zoghlami, C. Brudermann, C. Sarré, M. Grosbois, M. Bradley, and S. Thouësny, Eds., pp. 273–278, Research-Publishing.net, Paris, France, 2021.

[35] World Health Organization (WHO), *WHOQOL-BREF: Introduction, Administration, Scoring and Generic Version of the Assessment: Field Trial Version*, World Health Organization, Geneva, Switzerland, 1996.

[36] E. G. Guba and Y. S. Lincoln, "Competing paradigms in qualitative research," in *Handbook of Qualitative Research*, N. K. Denzin and Y. S. Lincoln, Eds., pp. 105–117, Sage Publications Ltd, Thousand Oaks, CA, USA, 1994.

[37] P. Kutsche, *Field Ethnography: A Manual for Doing Cultural Anthropology*, Prentice Hall, Hoboken, NJ, USA, 1998.

[38] B. B. Kawulich, "Participant observation as a data collection method," *Forum for Qualitative Social Research*, vol. 6, no. 2, p. 43, 2005.

[39] C. Marshall and G. B. Rossman, *Designing Qualitative Research*, Sage Publications Ltd, Thousand Oaks, CA, USA, 1989.

[40] S. B. Merriam, *Case Study Research in Education: A Qualitative Approach*, Jossey-Bass Publishers, San Francisco, CA, USA, 1988.

[41] L. De Santis and D. N. Ugarriza, "The concept of theme as used in qualitative nursing research," *Western Journal of Nursing Research*, vol. 22, no. 3, pp. 351–372, 2000.

[42] J. Ritchie and J. Lewis, *Qualitative Research Practice—A Guide for Social Science Students and Researchers*, Sage Publications Ltd, Thousand Oaks, CA, USA, 2003.

[43] V. C. De Munck and E. J. Sobo, *Using Methods in the Field: A Practical Introduction and Casebook*, AltaMira Press, Lanham, MD, USA, 1998.

[44] M. Weber, *The Methodology of the Social Sciences*, Free Press, Glencoe, IL, USA, 1949.

[45] A. Rogalewski and K. Florek, "The future of live-in care work in Europe Report on the EESC country visits to the United Kingdom, Germany, Italy and Poland following up on the EESC opinion on "The rights of live-in care workers"," 2020, https://www.eesc.europa.eu/sites/default/files/files/report_on_the_eesc_country_visits_to_uk_germany_italy_poland_0.pdf.

[46] A. Sprung, "Adult education in migration societies and the challenge of 'recognition' in Austrian and German adult education," *Studies in the Education of Adults*, vol. 45, no. 1, pp. 82–98, 2013.

[47] S. Guo and H. Shan, "The politics of recognition: critical discourse analysis of recent PLAR policies for immigrant professionals in Canada," *International Journal of Lifelong Education*, vol. 32, no. 4, pp. 464–480, 2013.

[48] L. Morrice, H. Shan, and A. Sprung, "Migration, adult education and learning," *Studies in the Education of Adults*, vol. 49, no. 2, pp. 129–135, 2017.