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Education and Employment of Refugees and Migrants in the Formal Elderly Healthcare Sector: Results from an Online Survey in Italy

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Abstract: The increase in older people with long-term care needs and the shortfall in the formal elderly healthcare workforce are questioning the healthcare system sustainability in Italy. Migrants have been employed for many years in the informal care sector as live-in carers often experience unfair working conditions. Appropriate training can help migrants and refugees enter the formal care sector, improve their quality of life, and bring new workforce into the hospital wards and nursing homes. This study is aimed at understanding practices and difficulties of educational and elderly healthcare organisations in training and employing migrants and refugees in Italy, and the latter's educational needs. An online survey, carried out in Spring 2021, reached 17 care facilities managers, 13 educational organisations and five migrants/refugees, who answered three different questionnaires with close and open-ended questions. Quantitative data were analysed statistically and qualitative data by means of the content analysis. Findings showed the need for training specifically designed for migrants and refugees, focusing on language, healthcare terminology and culture of the host country, and on care provider organisations working culture, mission, and vision. Suggestions for boosting migrant and refugees' elderly care education are given to policy makers, elderly care facilities and training organisations.

Keywords: educational needs; elderly care; healthcare training; long-term care; migrants; refugees

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1. Introduction

1.1. The Employment of Migrants and Refugees as a Response to the Shortfall in Healthcare Professionals

The need for workers in (elderly) healthcare is today a matter of global concern; in fact, significant recruitment challenges are emerging due to the growing demand for doctors, nurses, and care workers [1]. The shortage of healthcare workers in formal and informal care settings, caused by low income and the stressful and demanding nature of the job, is exacerbated by the aging of the global population and the increase in comorbidity (i.e., the incidence and prevalence of certain diseases; increase in chronic diseases), that increases the demand for long-term care (LTC). In Italy, the study's target country, 23.2% of the whole population is over 65 [2], and more than one in every two older people reports having at least three chronic diseases [3]. In 2016 (the most recent year for which data are available, this country had approximately 3 LTC workers for every 100 persons aged 65 and over, compared to an average of 5 in OECD countries [4]. Moreover, although Italy is one of the EU-27 countries with the highest number of physicians (400 per 100,000 inhabitants) and caring professionals, including healthcare assistants in institutions (1000 per 100,000 inhabitants), the average age of the professionals is higher than in other European countries. For example, 56% of physicians are aged 55 years or older, compared to 35% in Malta [5].

In view of the foregoing, a new workforce from Europe, namely migrants and refugees, may serve as one of the solutions to counteract the shortfall in healthcare professionals

in Italy. Migrants are people who voluntarily leave their country of origin in search of work and better living conditions and are able to return home securely and without any risks. The term "migrant", therefore, has a more economic connotation. Conversely, the term "refugee" has a very specific legal meaning. Refugee status, in fact, is enshrined and defined in international law by the Geneva Convention of 1951; it is recognized for those who are unable to return to their home country due to a genuine fear of persecution and/or death due to their religion, ethnicity and social and/or political views. For these reasons, refugees must seek protection outside their own country. In this paper, we use the term "migrant" for people coming from abroad, the term "refugee" to indicate the specific legal status of migrants, and the term "migrant care workers" (MCWs) to refer to migrants and refugees employed in the care sector.

A study by the International Organization for Migration (IOM) [6] underlines how the inclusion of migrants and refugees in the workforce of elderly healthcare organizations can improve the quality of care and the relationship between professionals due to their competences in the provision of care. Nevertheless, the same study shows that they need to be trained not only in medical knowledge and competence, but also in the local language and, mainly, they need instruction and information relating to the organizational culture, care environment (for example, compliance with environmental hygiene or waste disposal rules), and patient needs. The absence of these skills is attributable to the fact that many migrants and refugees come from countries where older people are assisted in an informal setting, i.e., by their families and local communities [1].

1.2. Employment of Migrants and Refugees in the Formal and Informal Elderly Healthcare Sector

According to data from the United Nations High Commissioner for Refugees (UNHCR), there are almost 7 million (6,956,151) refugees (26 million worldwide), one million (1,020,625) asylum seekers, and 483,000 stateless people in Europe. Moreover, in 2020, about 95,000 people entered Europe through the Mediterranean Sea [7].

According to the European Commission, until 1 January 2020, 23 million (5.1%) of Europe's population of 447.3 million inhabitants are citizens of countries outside the European Community.

Among the 3 million residence requests submitted, 41% are motivated by job seeking, while 9% are asylum requests. Asylum requests totalled 472,000 (417,000 "first-time applications") in 2020: 23% of applicants came from Asia, the same percentage from Africa, while 21% were from Latin America and an equal percentage from the Middle East [8].

According to the National Statistics Institute (Istituto nazionale di statistica, ISTAT, Rome, Italy), Italy had 5,171,894 foreign residents (8.4% of the population; 52% women) on January 1, 2021 [9] The first ten countries of origin are: Albania, Morocco, Pakistan, Bangladesh, India, Egypt, China, Nigeria, USA, Ukraine [10].

In 2020, 8.7 million non-EU citizens found employment in one of the European Community countries (4.6% of the total workforce). Those working in the healthcare sector accounted for 2.9% of the total, corresponding to 5.1% of those from non-EU countries [11].

If we consider the total number of personal care workers in the EU, the ratio of foreigners (not necessarily "non-EU") to nationals is one in five. In fact, migrants and refugees are generally more likely to work in jobs with relatively poor working conditions (low wages and low demands for the job positions they seek), just like in the case of personal healthcare [12].

Unlike workers from other economic sectors, healthcare workers are often mostly middle-aged women who accept precarious working conditions and low wages. Sometimes they dedicate themselves to healthcare assistance as a second job, often obtained through temporary agencies [13].

Despite there being some estimates, the number of MCWs in Europe is difficult to establish for different reasons: many countries (especially the less developed ones) do not provide data in this respect—or only very limited data; the statistical definitions and criteria for identifying migrants and refugees vary from country to country (for example,

some do not take into account those who only stay for a few months); and above all, there is no internationally agreed definition of "migrant worker" [14].

This is especially true for MCWs employed in the informal care sector, e.g., in older people's homes. Generally speaking, these are migrants providing care, at least on a weekly basis, to someone who has a chronic disease, a disability, or is in need of long-term care. Many of them are paid, at least in part, under the table or their remuneration does not fall within the contractually established parameters [15]. Occasionally, they lack documentation, and are required to work an excessive number of hours without being paid for overtime and without the guarantees afforded to regular employees. As a result of low wages, they often face precarious economic conditions and are at a significant risk of social isolation and psychological stress [16]. In the absence of a well-developed LTC system in Italy, assistance [17] to older people with disabilities is based on a "migrant-in-the-family model". Thus, the demand for home care assistants in this country is constantly increasing due to the growing number of disabled older people, and this trend is projected to continue in the future [18].

In the last twenty years, the number of highly educated live-in MCWs in Italy, mostly women from Eastern Europe, has progressively decreased, making room for workers from North Africa, including an increasing number of men, entering care work [19].

Very often, bad, and unfair working conditions for MCWs are also a result of the absence of a framework for recognizing and validating healthcare knowledge, skills, and qualifications obtained in the country of origin [20,21]. For this reason, finding ways to validate prior learning (be it formal or informal) could facilitate and promote the inclusion of migrants and refugees in the healthcare labour market [22].

It is, therefore, necessary to promote informal live-in care worker education and training through specific courses designed by training and non-profit organizations and promoted by the media and employment services, as well as through a capillary counselling activity directed even at the families of people in need of assistance [16].

To the best of our knowledge, there is a dearth of literature on the training and employment of migrants and refugees in the formal healthcare sector at European level, particularly in Italy, where research studies are mostly focused on migrants employed in the informal elderly care sector, such as at older people's homes by older people's families.

1.3. Study Objectives

The purpose of this needs assessment study [23] was to gain insight into the difficulties and challenges faced by managers of elderly care facilities and educational organizations in training and hiring migrants and refugees, as well as on the latter's educational and employment needs, in order to gather information useful for designing "on the job" training for migrants and refugees.

To this end, an online multi-perspective survey was conducted in Italy, which included binary and multiple-choice answers and open-ended questions generating quantitative and qualitative outcomes, respectively. The survey targeted three types of respondents: managers of elderly care facilities, managers of educational organizations (e.g., vocational education bodies), and migrants/refugees. The study forms part of the HERO project (training program in elderly care and infectious disease prevention for the integration of refugees from Middle Eastern and African countries in western society), funded by the community program Erasmus Plus-KA2 Strategic Partnership for Adult Education. The latter program's overarching goal is to promote the integration of migrants and refugees by developing "on-the-job" training that would enable their inclusion in the labour market (both in their countries of origin and in those of the European Union).

This paper discusses the key findings of the survey conducted in Italy in spring 2021.

2. Materials and Methods

2.1. Recruitment Strategy

The survey involved: (a) managers of public and private healthcare institutions and organizations for the elderly (geriatric hospitals, clinics, nursing homes, and day centres); (b) managers of public and private institutions and organizations that provide training in healthcare; and (c) migrants and refugees coming from Asian and African countries with healthcare work experience.

In Italy, three online questionnaires—one for each type of subject—were developed containing multiple choice questions and open questions. The questionnaires were only distributed once in spring 2021.

In order to recruit managers of healthcare facilities and educational/training organizations across Italy, the INRCA (Istituto di Ricovero e Cura a Carattere Scientifico—National Institute of Health and Science on Aging, Ancona, Italy) contacted organizations in three Italian regions: Marche, Lombardy, and Sicily.

The first region represents the territory of central Italy, where the INRCA's headquarters are located and is its main operational site with a high number of direct contacts. The second is one of the most populous and richest Italian regions, with a large number of healthcare facilities for the elderly and training organizations and is a traditional destination for foreigners seeking employment. Sicily, in the southern part of Italy and located in the centre of the Mediterranean facing North Africa, is a landing point for many migrants and refugees who arrive by sea and has a long tradition of welcoming migrants and refugees.

A further administrative division within the regions is that of provinces. For this reason, we decided to contact at least four organizations of each type (healthcare and training organizations) in each regional province.

This needs assessment study's goal is to analyse the education provided by training organizations for migrants and refugees seeking employment as healthcare assistants, as well as the demand and needs of elderly care facilities and migrants and refugees. For this purpose, a purposive sampling strategy [24] was adopted, which entailed respondents being selected on the basis of their qualifications and positions within the elderly care and educational organizations, rather than the criterion of randomness. Respondents were asked to provide coherent and experience-based answers on the study topic, i.e., the employment of migrants and refugees and their educational needs.

In order to identify possible respondents to the questionnaires, a list of training organizations and healthcare facilities based on the selected regions was drawn up in June 2021 through online research. Approximately 40 healthcare organizations and 35 training organizations were contacted.

At the end of the month, a brief description of the research and its goals, with links to the questionnaires, was sent by email to the directors of training organizations and to the medical or administrative directors of healthcare organizations.

The same organizations were contacted by telephone after about a week to ensure that they had received and viewed the survey (in some cases, we were unable to speak with the directors despite repeated attempts).

Questionnaires were analysed at the beginning of July, once the number of responses stabilized.

For the survey targeting migrants and refugees working in healthcare, researchers contacted non-governmental organizations and associations operating in both the elderly care and migration sectors e.g., Caritas, that might have already come into contact with these kinds of workers. This stage of the research was closed as soon as the minimum number was met due to the difficulty of identifying workers of African and Asian origin.

The survey did not collect sensitive, personal, and health-related data and only elicited respondents' thoughts and impressions on employment and education issues. Therefore, the approval of the Ethics Committee was not required under the Italian privacy law (Law 196/2003, which incorporates the GDPR of 27 April 2016), given that it was not possible to link respondents' responses to their names.

Each questionnaire began with an introduction outlining the study's objectives, while also assuring respondents of the complete anonymity of their responses. Respondents were then asked to flag acceptance options to indicate their consent to the processing and analysis of their data.

2.2. Respondents' Characteristics

The survey elicited responses from 35 individuals. The first questionnaire was answered by 17 owners, presidents, directors, managers, and supervisors of professional elderly healthcare organizations (hereinafter, "elderly healthcare managers"), the second by 13 heads of organizations providing healthcare training and education (hereinafter, "education providers"), and the third by five migrants or refugees.

The results of the three questionnaires will be presented separately, beginning with the one addressed to managers of professional healthcare organizations.

The table below gives an overview of the demographic characteristics of each of the three types of respondents.

2.3. Data Collection Tool

The questionnaires for healthcare facility managers and educational/training organization managers included yes/no, multiple choice, and two open-ended questions. Both questionnaires followed a similar structure: the first section was dedicated to respondents' personal information, while the final section included the possibility of offering suggestions regarding the questionnaires themselves (questions to be included, criticisms, etc.). Two distinct sections for each of the questionnaires were included between the first and final sections.

The questionnaire targeting managers of elderly care facilities included a series of questions relating to the difficulties encountered by such organizations in recruiting staff. The respondents could choose from a pre-set list of problems. Other questions then aimed to elicit, in broad terms, the characteristics of staff employed (age and level of education) and whether the organizations provide training activities for them. A second section was specifically dedicated to migrant and refugee workers: their presence or absence, which countries they come from, the difficulties encountered by the organization (if any), and any training activities held for their benefit.

The questionnaire targeting the managers of educational/training institutions initially focused on their relationships with the organizations that provide health services: whether such relationships exist, which kinds of organizations are involved, and what role is played by training institutions in these collaborations. This questionnaire also included a section relating to the institutions' experience with migrants and refugees: the first question was whether training activities were carried out for foreigners in general and/or specifically for migrants and refugees; if and what difficulties were encountered; whether research on the educational needs of migrants and refugees was carried out and whether such investigations are considered important; and finally, whether this type of training activity is considered useful.

The questionnaire targeting migrants and refugees started with yes/no and multiple-choice questions on gender, age, origin, and legal status in Italy (migrant, asylum seeker [officially recognized], or beneficiary of humanitarian protection). It then examined knowledge of the Italian language (general understanding and spoken and written production). In this regard, respondents were asked if they attended language courses and, if so, which organization provided them.

The online questionnaire for migrants and refugees also incorporated open-ended questions on: 1. Current working conditions (role, organization, and time spent within); 2. Training and education in healthcare; 3. Difficulties encountered during training and aspects to be improved; 4. Difficulties experienced at the workplace; 5. The use of technology during training and any difficulties encountered (given that the questionnaire was sent in June 2021, that is, after one and a half years from the onset of the COVID-19 pandemic

which prevented face-to-face education); 6. The differences in healthcare provision in their country of birth compared to Italy and any difficulties encountered.

The three questionnaires ended with an open-ended question in order to collect suggestions on additional issues to be explored within the study topic. The findings arising from this question are not reported in this article, which is primarily focused on educational and training needs. The online questionnaire was administered through a Google Form. This tool proved to be suitable for our needs, as it collects results in both a graphical format and in Excel sheets, presenting general results in numbers and percentages, but also allowing us to examine the individual answers under each respondent identification number. Moreover, as Google Form stores data in an aggregate manner, it ensures that respondents remain completely anonymous.

Results were also presented graphically once analysed and "purified" of inconsistencies and irrelevant answers.

2.4. Data Analysis

The survey questionnaires produced binary and categorical (not numerical) variables and qualitative content.

The binary and categorical variables emerging from the answers to yes/no and multiple-choice questions were counted and reported in tables as frequencies. Given the limited number of respondents and the purposive (not randomized) sample, data were analysed just for descriptive purposes.

The qualitative data collected through open-ended questions were analysed through content analysis [25]. The textual content was segmented and coded according to a code-tree, and then grouped into macro-categories (associated with the question items) and sub-categories (associated with the contents and meaning derived from the respondents' responses).

The trustworthiness of qualitative data, i.e., its credibility, transferability, dependability, and confirmability [26] was determined by tracking the internal analysis processes, such as through frequent debriefing and reflective commentary sessions within the research team about data coding, categorization, and interpretation [27–29]. In particular, the analysis' credibility was ensured by the contemporary use of closed-ended and open-ended questions, which had already been used in a previous study to assess the needs of healthcare service users. In this way, quantitative and qualitative responses were compared, and any contradictions identified. The transferability of the qualitative analysis was determined by examining and comparing it to previous studies on the same or similar topic, most of which focused on migrants and refugees employed in the semi-formal and informal elderly healthcare sector. This allowed us to design a study protocol that was transferable to other cultural and economic contexts and paved the way for comparison with further research findings. Dependability was addressed by describing and planning data collection and analysis in detail to overcome any weaknesses and bias, and confirmability (or objectivity) was addressed by justifying the choice of methodologies adopted and by identifying the study's weaknesses and strengths.

3. Results

This section discusses respondents' difficulties recruiting social and healthcare workers, the characteristics of the personnel employed at the time of the survey, the training that the organizations provided, the presence of migrant or refugee workers, and any difficulties encountered by healthcare organizations and training providers with migrants and refugees. A sub-paragraph dedicated to the latter's learning and employment experience closes this section.

3.1. Managers of Healthcare Facilities for Older People

The majority of managers of the surveyed elderly care facilities were females (12 out of 17), 14 were aged 40 and over, and just three were under 40 years of age.

Most of the respondents work in the Marche Region (central Italy), where INRCA is based (Table 1).

Table 1. Demographic characteristics of respondents by types of surveyed organisations.

.	Managers of Elderly Healthcare Organisations (N17)	Managers of Educational Healthcare Organisations (N13)	Migrants/ Refugees (N5)
Gender			
Male	5	6	2
Female	12	7	3
Age			
18–30	0	0	2
31–40	3	1	1
41–50	4	7	1
51–60	6	2	1
Over 60	4	3	0
Region			
Marche	5	8	5
Lazio	1	0	0
Sicilia	1	1	0
Lombardia	1	2	0
Emilia-Romagna	0	1	0
Birth country of migrants and refugees			
Guinea	/	/	1
Morocco	/	/	1
Nigeria	/	/	2
Camerun	/	/	1
Juridical Status			
Migrant	/	/	1
Refugee	/	/	3
Humanitarian Residence Permit	/	/	1
Types of organisation surveyed			
Public hospital/LTC unit	10	0	/
Rehabilitation unit	2	0	/
Chronic diseases centre	1	1	/
Private hospital/LTC unit	2	0	/
Day-care centre	1	0	/
No profit organisation	1	2	/
Private organisations accredited	0	7	/
Public bodies e.g., regional educational office for training and education	0	3	/

Ten respondents run a long-term care unit (in Italian, "Residenza Sanitaria Assistenziale"), two run a hospital or private clinic, and two run a rehabilitation centre. Additionally,

a day-care centre, a centre for the treatment of chronic diseases, and a non-profit organization were involved.

Table 2 summarizes the main findings reported by the healthcare managers.

Table 2. Healthcare facilities managers' responses on migrants and refugees' employment and training.

Topics	N
Difficulties in recruiting healthcare workforce	
Yes	15
No	2
Reasons why it is difficult to find adequately trained workers	
Unpleasant tasks to perform	6
Low salaries	5
Too tiring shifts	4
Distance from home	4
Low number of assistants in relation to patient/users	4
Too high amount of hours	1
Distance of job place from home	4
Distance from transportation	1
Migrant/Refugee employees' age	
36–45	10
46–55	8
26–35	5
Migrant/Refugee employees' educational level	
Professional training	9
Secondary School	4
University	3
Primary Schools	1
Training activities provided especially for migrants/refugees	
Healthcare training during working hours	4
Linguistic training	2
Training in the healthcare sector in Italian and English	1
Healthcare training in the national language	1
Type of training provided to workers in general	
In-home+external training	10
Only In home training	4
National training institution	2
External organisation	1
Organisations willingness to employ migrant/refugee workers	
Yes	11
No	6
Origin of migrant/refugee workers employed	
Other areas	16
Latin America	7
North Africa	6
Eastern Europe	6
Central Africa	5

Table 2. *Cont.*

Topics	N
Difficulties with foreigner workers	
Language/communication	5
Cultural difficulties	4
Expressing information	3
Understanding of care methodologies	3
Lack of comprehension of the working methods	2
Prejudices/stereotypes expressed by patients/users	2
Training problems	1
Conflicts with colleagues	1
Racist behaviour	1

Only two out of 17 respondents, one manager of a day-care centre and another manager of a private clinic, stated that they had never had difficulty recruiting healthcare workers. Conversely, 15 respondents reported that they had encountered difficulties.

The types of activities performed (six answers) and the lack of attractiveness of such work due to low salaries, too tiring shifts, distance from home, number of assistants in relation to patients/users, too many hours, distance from transportation, and distance of the workplace from home (it was possible to express up to three preferences) are cited as factors for the difficulties in finding adequately trained workers.

Ten managers stated that most of the migrants and refugees employed in the facilities at the time of the survey were in the 36–45 age group, eight in the 46–55 age group, and five in the 26–35 age group. The 18–25 and over-55 age groups are not represented.

Nine respondents reported that migrant and refugee employees had specific professional training, four said that they had a secondary education, and only three reported that the migrant and refugee staff had completed university studies.

All the respondents stated that their organizations provide healthcare training for employees in order to improve their knowledge, skills, and competences (if not starting from basic employee training).

The main training activities carried out by eight organizations especially targeted at MCWs concern training in the healthcare sector, carried out only during working hours (4), linguistic training (2), training in the healthcare sector in Italian and English (1), and healthcare training in the national language (1).

With respect to the type of training provided, more than half of the respondents (10) adopted a mixed system, i.e., part of the activities were in-house training and part were delivered by an external educational organization. Four healthcare organizations conducted all their training in-house, two relied on a national training institution, and only one outsourced training to an external organization.

Six respondents stated that they did not hire migrant or refugee workers (that is, the question was not about a general and hypothetical availability to hire them, but an effective practice). Conversely, two thirds of respondents (11) stated that they used to employ them.

In 9 out of 17 cases, the respondent organizations already employed migrants and refugees, out of which seven came from Latin America, six from North Africa, six from Eastern Europe, and five from Central Africa. The other 16 migrants came from other geographical areas.

With respect to the types of difficulties encountered with foreign healthcare workers (up to five options could be selected), four of the nine respondents who employed migrants and refugees claimed that they encountered none. In general, the most important problems of migrant and refugee workers were language difficulties, communication difficulties (reported five times), and cultural aspects (reported four times), expressing information and understanding the care methodologies (expressed three times each), and comprehension of

the working methods. Moreover, the prejudices or stereotypes expressed by patients or users towards migrant and refugee employees were reported twice. Training problems, conflicts with colleagues, and racist behaviour by patients were reported once, respectively.

3.2. Managers of Educational and Training Organizations

The questionnaire was completed by thirteen representatives of educational/training organizations: seven women and six men. Seven respondents were aged between 41 and 50 years, three were over 60, and two were under 60 years. Most of them were working in the Marche region (Table 1).

The main results concerning managers of educational and training organizations are reported in Table 3.

Table 3. Educational and training managers' responses on migrants and refugees' training.

Topics	N
Type of collaboration between training and healthcare organisations	
Training for employees/collaborator	7
Mixed training program	5
Training seminars on specific topics	2
Development of a training program taught later by the healthcare organisation professionals	2
Analysis of the educational needs of the employees	1
Providing specific training for migrants and refugees in the healthcare sector	
Yes	8
No	5
Difficulties with foreigner workers	
Language/communication	6
Cultural difficulties	1
Comprehension of the working methods	4
Knowledge of the training system	3
Knowledge of the training methods	2
Knowledge of the labour and welfare system rules and laws	3
Gender equality in the work environment	1
Detection of the migrant/refugee learners' educational needs	
Yes	2
No	11
Opinion on need to provide an initial training for migrants and refugees	
No need of a specific healthcare training	1
Training about the specific terminology in healthcare	7
Exclusively professional courses	3
Courses to facilitating the integration into the social and professional environment	11

Eleven out of thirteen educational organization managers were contacted by healthcare facilities that provide training on elderly care, of which: eight were private for-profit bodies, eight were mainly public bodies, and two were non-profit organizations (it was possible to give more than one answer).

In terms of collaborations with healthcare organizations, seven respondents (it was possible to give more than one answer) provided training for employees/collaborators, five provided training on only a portion of the educational curriculum, two provided training seminars on specific topics, two organizations developed a training program that was then taught by the healthcare organization's professionals, and one was commissioned by the healthcare organization to conduct an analysis on employees' educational needs.

Eight out of thirteen organizations organized training activities for migrants and refugees.

The difficulties encountered during educational activities (more than one preference could be expressed and one of the respondents did not answer) were primarily linguistic in nature (6), knowledge of the organizational function and work system (4), knowledge of the training system (3), and knowledge of labour and welfare system rules and laws (e.g., insurance system, state-provided services, and tax obligations) (3). Other minor difficulties reported by the educational entities' managers were the lack of knowledge on training methodologies (2), gender equality in the workplace (1), and cultural differences.

Only two respondents identified the training needs of refugees and migrants employed in healthcare, and they emphasized the importance of delivering such training "every five years," whereas the other eleven indicated that it should be carried out "often".

There is also almost total agreement on the need to provide initial training in healthcare for migrants and refugees: the importance of courses to facilitate integration into the social and professional environment was selected eleven times (it was possible to indicate additional options here); language courses, also with training on the healthcare sector's specific terminology, was indicated seven times; and the need for purely professional courses was put forward three times.

All the respondents found the survey useful and suggested conducting this type of questionnaire more often, while also adding additional questions to collect data on: training costs; organizational, health and ethical aspects; the training methodologies adopted by trainers; healthcare services for the elderly in the migrant and refugee workers' countries of origin; the training offered therein; and the cultural differences they perceive as being relevant. An "intercultural approach" for engaging with migrant and refugee healthcare workers was also proposed. This includes considering the country of origin's influence on the perception, acceptance, and satisfaction with training, as well as the cultural and social representations of healthcare employment (particularly with regard to interest and adherence to commitments).

3.3. Migrants and Refugees Working in the Healthcare Sector

Five people (three women and two men) answered the third questionnaire, which targeted workers of Asian or African origin (Table 1). All the respondents hail from the African continent: two from Nigeria (a 51-year-old woman and a 21-year-old woman), and the others from Guinea (a 24-year-old man), Morocco (a 50-year-old man), and Cameroon (a 40-year-old woman), respectively.

Only one of the respondents had a prolonged course of study (15 years in total); two respondents had significantly shorter experiences of 8 years and 5 years, respectively; and the other two had very short educational pathways, i.e., one year and three months, respectively.

The three women benefited from refugee status, while one of the men benefited from humanitarian assistance, and the other belonged to the broader category of "migrant."

According to a self-assessment criterion, all the respondents reported having an advanced knowledge of the Italian language ("very good" for three respondents and "good" for the other two) and oral comprehension ("very good" for four respondents and "good" for the last one), while the written language was considered "very good" by only three respondents, "good" by one, and "sufficient" by the other respondent.

These results could presumably be attributed, at least in part, to the fact that four respondents attended free Italian language courses. In three cases, these were provided by a school or training institution, and in the other two cases, by a municipal administration and a private organization.

Three respondents were employed at the time of the survey: one had been working as a care assistant in a long-term care unit for older people (RSA) for two years; one had been a live-in carer for four years; and one was attending a course for social-healthcare workers (in Italian "operatore socio-sanitario") and had been working in the field of patient transport for one year. Another respondent was looking for a job in the same sector after one year of working as a home care assistant. Finally, one respondent did not answer the question.

Table 4 illustrates the main findings from the online questionnaire compiled by migrants and refugees.

Table 4. Responses by migrants and refugees working in the elderly healthcare sector.

Topics	N
Training received	
None	1
Course for social healthcare worker	2
Course for a family assistant (in Italian)	1
Secondary School	1
Difficulties experienced during the training	
Nothing	1
Linguistic	1
Specific Terminology	1
Course too much short	1
Too much "heavy" online training	1
Differences between the healthcare sector in the hosting compared to the original country	
Necessity to pay to access health services and treatments	1
Disorganisation of the healthcare systems of their countries	1
Backwardness of the healthcare systems of their countries	1
In their countries the assistance to the person with disability is provided mainly by the family members	1
Not answered	1

With respect to the problems encountered in the course of their work experience, two respondents stated that the economic crisis had negatively affected their careers, one indicated the lack of access to training, and two indicated "other" without providing further details.

However, when compared to the beginning of their careers, cultural differences, employers' prejudices, and stereotypes were indicated by two respondents as the most difficult obstacles to overcome. Moreover, one respondent indicated the lack of recognition of his qualifications as a challenge to be overcome in order to enter the healthcare sector in Italy. They all managed these difficulties by learning by experience, trying to adapt to the work context and by getting to know colleagues better, or by establishing a good relationship with one of the assisted persons' family members. Moreover, one respondent stressed that attending specific training was useful for understanding the healthcare job and the work context.

In terms of the type of training received, two respondents attended a course for social healthcare workers, and one of them also completed secondary school. The same level of schooling was achieved by another respondent. Another attended a family assistant course (in Italian), and a fifth had not received any training, but both had been trained as live-in healthcare workers by the people they were going to substitute in a sort of handover of competences learned in the field.

The surveyed migrants and refugees encountered several difficulties during the training. The online training imposed by the COVID-19 pandemic and the associated physical distancing measures was defined as "more difficult" than the traditional one. A respondent wrote: "*The online training was more difficult for me*".

An 80-h course for family carers was deemed too short for acquiring the needed knowledge, competences, and skills. The Italian language and healthcare terminology provided during a course for a care worker were found to be very difficult. One respondent wrote: "I have had many difficulties with the language" and another: "*I have problems understanding the Italian name of the tools that I have to use at work*" (for example: band-aid, pad, etc.). For another respondent, the course was "*Much too short*".

At least three respondents indicated that their training course involved some interaction with technologies: two stated that they prefer the Web, while one added personal computer and smartphone applications; the smartphone was also indicated by a third respondent. A quarter of respondents registered online for a training course that did not include any digital or remote components, while a fifth did not specify any technology.

The main differences between the healthcare sector in the host country compared to the country of origin were the following: it is necessary to pay to access health services and treatments; the disorganization (1) and the backwardness (1) of the healthcare systems in their countries; and assistance to persons with disabilities is mainly provided by family members. One of the respondents indicated that he did not know how to answer.

In this respect, one respondent wrote: "If you don't have good financial resources, it's hard to get cured in my country. There is no government assistance. I was very young when I arrived in Italy 20 years ago. There is more family-based care". And another: "It is hard for me to compare the Italian health system with that in my country of birth because I have never worked in the healthcare sector in my country".

4. Discussion

The aim of this study was to gain an understanding of educational and elderly healthcare organizations' practices and challenges in training and employing migrants and refugees in Italy, as well as the latter's educational needs.

This is the first study of its kind in Italy, contributing to bridging the information gap on the subject.

The elderly healthcare facility managers who participated in this study, mirroring the national trend [5], emphasized the high average age of their (mostly Italian) workers and the need for a younger workforce. They also stressed the difficulties in the recruitment and training of healthcare workers (regardless of their country of birth) due to hard and unappealing working conditions, i.e., the shortfall of care workers in relation to the number of patients, long and tiring shifts, and low salaries [29]. Notably, these bad working conditions have been exacerbated by the COVID-19 outbreak, which has placed unprecedented strain on formal healthcare professionals [30,31].

Moreover, it appears as though the existing elderly care training does not match the educational needs of the learners or the organizational needs of the facilities. Fully aware of this, respondents' healthcare institutions (both private and public) organized specialized courses, often in collaboration with external entities. Both healthcare facilities and training organizations frequently offered courses and specific training seminars for healthcare workers on certain topics.

The managers of the elderly healthcare organizations surveyed in this study showed a low propensity to hire migrants and refugees because of the migrant and refugee workers' dearth of linguistic competence and knowledge of the host country's cultural context, religious traditions, and gendered role division within the household. They considered that these might be replicated at the workplace, thus negatively affecting the work environment and the quality of assistance provided to older people.

Therefore, this survey shows that, in many cases, migrant and refugee healthcare workers may lack adequate training. The poor technical knowledge and the cultural gap

among migrants and refugees, as highlighted by facilities managers, can be addressed through periodic training targeted at native employees and MCWs. Notably, the majority of responding healthcare organizations did not carry out specific training activities for their foreign workers, despite almost universal agreement among respondents that these activities are necessary for facilitating the reception of migrant and refugee workers in the healthcare organizations.

With regard to educational and training organization managers, the majority of respondents stated that they carried out activities specifically targeting foreign workers, a significant percentage of whom were migrants or refugees. In this case, linguistic difficulties are the ones reported most frequently, together with knowledge of the work tasks and of the work organization. This demonstrates how important it is for foreign workers to understand the structure and purposes of the organizations in which they are employed. In fact, it is reasonable to expect that this knowledge would facilitate their integration even further and may also avert some linguistic and cultural challenges that arise as a result of misunderstanding the work organization [6].

4.1. The survey's Strengths and Weaknesses

To the best of our knowledge, this needs assessment study on the training and employment of migrants and refugees in the formal elderly healthcare sector (i.e., in hospitals, retirement, and nursing homes) is the first of its kind in Italy. In fact, till now, many studies have focused mainly on migrants and refugees as patients or users of healthcare services in Italy [13] or as live-in MCWs in the informal care sector (the so-called badanti) employed by older people's families [19].

Therefore, this study can provide some input for further studies on the topic especially in Italy, but also in Europe. Moreover, this study may serve as a resource to structure and organize training courses for migrants and refugees, taking into account the needs of trainers, learners, and employers.

Another strength of the study lies in being multi-perspective, as it collected the points of view of trainers (educational entities), employers (elderly care facilities), and employees (migrants and refugees) on the topic. This information can be used to develop training and intervention strategies aimed at boosting learners' vocational education and employability.

Concerning the study limitations, its first weakness is the non-randomized purposive and small-sized sample, which does not allow for the generalization of findings or gender analysis. The latter would have been interesting, given the predominance of female carers in elderly care. Moreover, during the analysis of the results, we realized that we did not adequately consider the unique characteristics of the contribution that migrants and refugees can make to the work environment and to older people with care needs, such as empathy and natural positive behaviour towards older people as a result of cultural roots that encourage migrants and refugees to view older people as a resource. In other words, it would have been appropriate to include at least one question about their "added and unique value" in the workplace (by asking, for example, "What are the roles, tasks, situations in which such characteristics emerge?"; "How do they positively differentiate themselves from their Italian colleagues?"; and "In what ways is their action more specifically defined?").

Furthermore, the study did not include the perspective of the older residents of healthcare facilities. It would be interesting to learn their proclivity towards receiving assistance from migrants and refugees. However, this needs assessment study was not designed to collect their points of view; this will take place during the research's subsequent stages, i.e., the "on the job" training for migrants and refugees.

Another limitation is that migrants and refugees were not asked to assess their degree of understanding of the host country's language (Italian), since it would probably have been difficult for them to fully understand what skills and competences they lacked.

From the methodological perspective, the adoption of an online survey was a mandatory choice imposed by the COVID-19 pandemic—and by the physical distancing measures associated with it—just at the beginning of the research in summer 2021. The questionnaire

targeting migrants and refugees was particularly affected by this method of investigation, which did not enable the establishment of a relationship of trust and the formulation of a greater number of open-ended questions. This could have facilitated the linguistic exchange, the understanding of the topics by migrants and refugees, and consequently, the richness of the collected content.

Finally, the study did not consider the role of older people and their family carers as the first beneficiaries of the assistance provided by migrant and refugee workers. For this reason, it would be important that their perspectives and opinions are also included in other studies.

4.2. Suggestions for the Training of Migrants and Refugees in the Elderly Healthcare Sector

The outcomes and limitations described above inspired several suggestions for the future educational training of migrants and refugees in the elderly healthcare sector. Such suggestions concern the educational (micro) level, the organizational (meso) level, and the policy and research (macro) level.

At the educational (micro) level, subsequent training for people, especially those with a migrant background who want to work in the elderly care sector, should include specific modules to address the specific educational needs of migrants and refugees.

Given the respondents' language, communication, and comprehension difficulties, a language training program should be implemented first, with an emphasis on specific terminology to equip migrants and refugees with language skills that enable them to communicate effectively with patients and colleagues.

Moreover, since many respondents called for courses that could facilitate the social integration of workers, future training should address this need. The educational setting is a "free zone" where all learners are on an equal footing regardless of their economic and social status, educational background, and past experience. The training then has the potential to enhance the social inclusion of migrants and refugees. To this end, it should incorporate some modules on team building, the work environment, cultural aspects, effective communication, the organizational structure, the organizational vision and mission, and work guidelines. These modules should be targeted at both native and foreign employees and should be preceded with ice-breaking activities aimed at getting to know one another and deconstructing any cultural stereotypes and prejudice. Round table narrative sessions focusing on the motivation to become a healthcare professional and involving all learners regardless of their migratory or native status could be beneficial.

Furthermore, it is important for the training to be focused on the specific problems and needs that migrant and refugee women may face at work, as well as their relationships with patients, family members, and medical and nursing personnel involved. In fact, as may be the case with native women as well, they may experience the strain of multiple roles, but with more work-life reconciliation problems due to the absence of a family network supporting them in caring for children and limited access to public social and healthcare services in comparison to Italian women.

The rest of the educational curricula can be implemented once solid interpersonal foundations are established. The curricula should focus on knowledge of the aging process and the most common age-related diseases, such as dementia, Alzheimer's, Parkinson's, and urinary incontinence, and on preparing learners to acquire skills and competences to deal with age-related problems. In addition, more online and mixed training should be provided to migrants and refugees in order to reach a broader audience and maintain the continuity and sustainability of learning pathways.

At the organizational level, better cooperation between healthcare facilities and educational organizations is encouraged to find common ground on the learning objectives, materials, and methodologies so that the training can fully address the learners' and organization's needs.

As regards research, more studies are needed to explore the educational experiences of migrants and refugees in the healthcare sector in order to improve our knowledge on their

educational needs, living expectations (also related to the migration experience), and the attitude towards healthcare work. Little is known about whether working in the healthcare sector is the most convenient or second-best choice for migrants and refugees, whether they enjoy this type of work, whether some of them are more eager than others to do it, and why.

Moreover, the study revealed that the healthcare managers participating in the survey were not willing to hire migrant and refugee workers. The questionnaire did not incorporate questions for a deeper insight into the reasons for this mindset. Thus, it would be necessary to investigate further whether the reason for this can be traced back to an a priori lack of availability towards them (and its source, a lack of trust, a low level of training, prejudice, etc.) or, more simply, to prior experience with the low qualifications of the migrant and refugee workforce.

At the policy level, clear laws and guidelines for the recognition of professional qualifications obtained abroad, especially outside the EU, and the validation of competences acquired in non-formal educational settings are needed in order to give fair value to the migrants and refugees who arrive in Italy and in Europe with a degree in nursing science, midwifery, or medicine. In addition, there is a need for the recognition and validation of competences acquired in non-formal education, so that this certification can open doors to other forms of professional training delivered by authorized bodies such as regions or accredited organizations. For example, it would be beneficial if migrants and refugees who participate in Erasmus+ training could be recognized for a certain number of hours of training if they wish to access additional courses delivered by formal educational bodies, such as Italian regions and NGOs accredited by the Regional Educational Body.

A trilateral agreement should also be implemented between NGOs that provide welcome and first aid to migrants and refugees, governmental bodies that manage their work and learning pathways, and healthcare organizations to ensure the integration and continuity of health, social, educational, and work pathways, as well as the valorisation of migrant and refugee competences. Cooperation between governmental institutions, NGOs, and educational bodies would also facilitate the monitoring of migration flows (which, in turn, are dependent on broader dynamics) from different countries, which could provide important information for modifying the training offer.

Labour legislation should also be updated to ensure long-term employment contracts and fair working conditions for MCWs working in the informal care sector as well as live-in MCW care workers, as their credentials as healthcare professionals acquired in their home country are not recognized in the host country, preventing them from accessing the formal sector. Attending tailored professional training interventions would allow live-in MCWs to pursue employment in hospitals and nursing homes, so allowing them to escape the web of underpaid and often unfair labour.

The survey targeting MCW workers reveals the difficulties encountered by respondents due to cultural differences and employers' prejudices and stereotypes. This implies the need for institutional and governmental (state, region, and municipal) policies and initiatives (by institutions, but *also* by healthcare and training organizations) that could facilitate the inclusion of MCWs in the formal healthcare sector.

The findings seem to suggest that, in the face of a society demanding elderly healthcare, migrants and refugees are not trained to provide it. It then appears vital to identify and train migrants and refugees interested in this kind of work early on. In a country where, as mentioned above, informality in the care sector has significant weight, this may be considered not merely a necessity, but an imperative.

5. Conclusions

Italy has a high proportion of older persons with LTC needs and a low percentage of young people and adults employed in the healthcare sector. Migrants and refugees are a valuable resource that is being used and unfortunately exploited almost exclusively in the informal elderly care sector, where migrants and refugees are hired mainly as live-in

care workers (in Italian, badanti), with low income and unfair working conditions. This is mainly due to the lack of formal, semi-formal, and informal training in elderly care practices, as well as the non-recognition of qualifications acquired in the country of birth or origin. In fact, the limited courses for healthcare workers in Italy do not include modules and teaching methodologies appropriate for migrants and refugees. To be effective, these courses should teach the following: the language of the host country and the technical healthcare terminology; the culture of the host country and the organizational culture of elderly healthcare facilities; and specific modules on aging and the most common diseases related to aging.

Training should be supported by laws, guidelines, and formal agreements between governmental bodies, NGOs, educational entities, and healthcare organizations to ensure the continuity of the reception, training, labour, and social integration processes of migrants and refugees.

In the European context, a long-term and wide-ranging social and healthcare policy should be implemented to finance the training of those individuals who wish to work in the (elderly) healthcare sector and to facilitate the arrival of a young workforce from abroad. This policy could address both the rights of migrants to access the labour market and integration into the host society, as well as the requirements of proper care and assistance for older people and their family carers. In this way, the foundations for the sector's regulation might also be set [19].

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