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Educational needs and barriers in dementia care training for migrant family care assistants in Italy: a qualitative study

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Abstract

Background In Italy, migrant family care assistants (MFCAs) represent the most cost-effective answer to dementia home care need and to desire of ageing in place of older adults and family caregivers. Nevertheless, MFCAs very often have no training in elder care and even less in the dementia care. Conversely, elder care training may improve MFCAs' working condition and mental health. Exploring MFCAs' educational needs is one of the objectives of the "Age-It" project, aiming at advancing knowledge and competences on ageing by applying a holistic, interdisciplinary, and problem-solving approach through the synergic work of research and educational institutions, care providers and civil society associations, businesses and industries.

Methods In Autumn 2023, 25 semi-structured questionnaires, including both closed and open-ended questions, were conducted with MFCAs living in two Italian regions: Marche and Molise. The research material was thematically analysed to answer four research questions: Which is the work experience of MFCAs of older adults with long-term care needs? Which are their educational needs? Which are the barriers to training? Did the emigration geographical area of respondents and the migration route influence their willingness to attend an elder care training?

Results Three main themes were identified: (1) Migration: a painful choice to flee poor (violent) societies; (2) Elder care: a stressful work; (3) Needs and barriers to elder care education. Most interviewed MFCAs face many difficulties at work, including stress, burden and lack of free time. Many respondents expressed the need and willingness to improve their knowledge on ageing processes, dementia, behavioural disorders, medicine administration, bedsores and injuries medication. The 24 h work represents the main barriers to attend the lessons.

Discussion Suggestions for future trainings include a co-designed curriculum embedding contents on dementia and behavioural disorders; self-care and resilience; host country language. Concerning policy and practice recommendations, mandatory, free and periodic, blended trainings, a clear offer of elder care education, the recognition of previous courses at EU and national level are encouraged.

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Conclusions Given the pivotal role of MFCAs in the LTC in Italy, it is urgent that they are adequately trained. Given the stressful and 24 h work, a co-designed e-learning platform may be a promising means for reaching and training them.

Clinical trial number Not applicable

Keywords Barriers to education, Dementia, Educational needs, Migrant care workers, Older people, Training curriculum

Background

In 2022, more than 20% of the European Union (EU) population was aged 65 and older [1] and the average proportion of individuals aged 80 or above was 6.1% [2]. The ongoing ageing of the population contributes to a rise in multi-morbidity, leading to an increased risk of long-term care (LTC) dependency. In this context, dementia represents one of the main drivers to the demand for LTC services. In fact, it is estimated that over 55 million people live with dementia globally, with 9,780,678 cases reported in Europe alone [3, 4]. This widespread issue is projected to nearly triple by 2050, particularly in low and middle-income countries [3]. The ageing population, the increase of multimorbidity rate and the unprecedented disproportion between older people in need of care and people in working age that could be employed in the LTC service [5]– with a projected shortage of 10 million healthcare workers by 2030 [6, 7]– are questioning both formal and informal LTC provision across Europe.

In family-oriented care regimes [8], such as Italy, the shortfall in public care services and the willingness of older people of ageing at home are counteracted by private live-in family care assistants, most with a migration background. Migrant family care assistants (MFCAs) help Italian families replicate the traditional family-based care model, which is centred around the home care of the older adults by family members, particularly adult children [9].

In 2024, there were 817,403 domestic workers (both care workers and cleaners) with at least one contribution paid to the INPS (-3% compared to 2023). After the increases recorded in 2020–2021, due to the spontaneous regularisation linked to the lockdown and the decree on the emersion of irregular labour relations (DL 34/2020), a loss of about 158,000 domestic workers, 89% of whom are women, is recorded between 2021 and 2024. It should be noted that in 2024 the share of MFCAs was 50.5%, exceeding for the first time the share of domestic helpers (cleaners) (49.5%) and that they come mainly from Eastern Europe, Middle East Asia, North Africa, South and Central America [10]. MFCAs from Eastern Europe tend to short-term and/or intermittent periods of work in Italy to spend time in their birth country where they have small or adolescent children [11] (Toc and Gutu, 2021).

Although MFCAs play a pivotal role in the daily care of Italian older adults with long-term care needs, most of them have neither experience nor certification in elder care nor in dementia care when they start working as carers [12]. Conversely, training in elder care may provide MFCAs with knowledge ad competences that can help their human development and increase their power on the labour market and then help them reaching better and fairer working condition [13]. Moreover, elder care trainings can enhance social integration [14, 15] and improve well-being and quality of life of migrants and refugees [16]. Nevertheless, the currently available education on elder care in Italy seems not to address the educational, emotional and social needs of MFCAs not those of employers [12]. Moreover, it is quite limited: there are two main training options available for people who want to work as elder care workers in Italy. The first is a free course for 'Family Care Assistants,' funded by the Italian Regions and offered by social cooperatives or private educational organizations, whose length varies from region to region but, in most cases it lasts 100-hour (78 h of theoretical lessons and 22 h of internship). This course qualifies participants to work exclusively in older person's home under a private contract. The second option is the course for nursing assistant (Operatore Socio-Sanitario – OSS in Italian), which consists of 1,000 h of training, including 480 h of theoretical instruction and 520 h of internship. This program, offered by certified institutions, costs between 1.300 and 2.800€ (it depends by the provider) and prepares graduates to work in public healthcare settings, including hospitals and elder care facilities. This education programme offers higher professionalization and better employment opportunities in the formal health sector compared to the Family Care Assistant course, ensuring greater economic security.

Furthermore, the majority of the available trainings are targeted to the general adult population and not specifically designed for MFCA nor co-designed with them. This implies, for example, that contents, times and language of the courses do not fit with their needs and expectations, resulting in a low level of participation and in a high level of drop-out. On the contrary, training in hosting country language can enable MFCAs communicate with the care taker, understand instructions, build relationships and participate in the community [17]. Finally, most of the trainings on elder care, do not consider the social and emotional needs of migrants, who may represent a vulnerable group of learners for

economic and social inequalities as well as for the trauma that they might have lived when they left their birth country and interrupted meaningful ties and relationships, going across difficulties and all sorts of deprivation [15]. During the educational curricula design process, the migration route is often undervalued, despite it may influence choices concerning further education [18] and work in the hosting country [19, 20]. For these reasons, this study also focused on the factors driving emigration and on how it took place.

Exploring migration paths, work conditions and educational needs is therefore, the basic requirement for designing an effective elder care training curriculum for this group of learners, representing the backbone of the home care for many older adults in Italy.

Methods

Study objectives

This study, as part of the Italian national project Age-It (Ageing Well in an Ageing Society), is aimed at identifying the educational needs and barriers to training of a group of MFCAs to help the design of more comprehensive and effective elder care trainings for MFCAs in Italy. The study is aimed at answering the following research questions: Which is the work experience of MFCAs of older adults with long-term care needs? Which are their educational needs? Which are the barriers to training courses? Did the emigration geographical area of respondents and the migration route influence their willingness to attend an elder care training?

Sampling, recruitment strategies and inclusion criteria

The researchers planned to recruit, at least 10 MFCAs per every Italian region (i.e., 10 in the Marche and 10 in Molise). In the two regions, 29 MFCAs were contacted as possible interviewees and only four of them refused to participate in the study due to time constraints (two in Marche and two in Molise). According to a non-probability snowball sampling, 25 MFCAs were recruited via word of mouth and by reaching them in the migrants' organizations and recreational centres in two Italian towns: Ancona (in the Marche region), and Campobasso (in Molise) and surrounding municipalities. In 2023, in the two geographical areas the percentage of population aged 65 years and over was respectively 25.9% in the province of Ancona and 26.2% in the province of Campobasso, higher than the national one i.e. 24.1% [21], making these provinces more likely to have a higher number of MFCAs.

The interviewees were included in the study if they were migrants, were working with an older person with dementia and had signed the informed consent. Individuals matching these criteria were contacted by telephone or in person and then they were interviewed face-to-face.

Data collection and analysis

A semi-structured questionnaire was developed specifically for this study and it included close, multiple-choice and open-ended questions and focused on several topics, such as socio-demographic details, prior conditions in the birth country, living and working conditions in Italy, educational needs and communication with different figures involved in the care process (e.g. relatives of older care takers and health care professionals). To keep the respondents interested and attract a high response rate, the close and open-ended questions were mixed/alternated following the topics of the semi-structured questionnaire [22]. The latter was structured based on methodological principles recommending appropriate, intelligible and unambiguous questions [22–25], and tested with two persons with a migration background living in the Marche region.

A translation of the original Italian semi-structured questionnaire is available in the Supplementary Materials. The interviews (lasting about one hour) were conducted in Italian by one psychologist and one sociologist skilled in qualitative methods. The interviewees had a good Italian proficiency level corresponding about to a B1 or B2 according to the Common European Framework of Reference for Languages (CEFR). Thus, interviewees and interviewers had no problems in expression nor in comprehension during the conversation. The interviews were audio recorded and transcribed verbatim. The textual data were thematically analysed [26], while quantitative data were statistically analysed with descriptive purpose given the small sample size. The text chunks were deductively and inductively associated with codes by two researchers, systematised into a codebook and combined under sub-themes that formed three main themes and eight sub-themes (two for themes n. 1 and n. 2 and four for theme n.3) identified based on the consistency of different codes grouped under the same theme. Discrepancies between the initial encodings of the two researchers were resolved through adjudication by a third researcher, ensuring consistency and coherence in the final coding framework. Once identified the main themes, we explore the possible influence of the emigrating country and migration pathway on education by analysing and comparing the answers of MFCAs from Eastern Europe to those from Southern America. The reliability of the study's qualitative aspects—credibility, dependability, and transferability—was ensured by adhering to methodological rigor and conducting internal process assessments, as recommended in social science research literature [27–29].

Credibility was achieved by designing open-ended questions grounded in the existing literature on MFCAs. These questions allowed respondents to provide a comprehensive account of their experiences, using clear,

non-technical language to ensure comprehension and compliance to the study aims. Regular debriefing sessions within the regional teams and peer reviews further supported this effort. Dependability was established through a detailed study design and planning. Lastly, transferability was facilitated by building upon prior research in this field, with the study's findings intended to serve as a foundation for future investigations.

Ethics

The study was approved on 26th July 2023, with communication N. 0208993, by the Bio-ethic Committee of the University of Bologna.

An informed consent was given to the individuals who confirmed to work as family care assistants of an older person with dementia, and they were asked to sign it. In the informed consent the study objectives were described and it was also specified that the participant could leave the study at any time without consequences.

Table 1 Sample's characteristics

Migrant family care assistants characteristics (*N* = 25)	*N*(%) or Mean ± SD
Gender, N(%)	
Male	1(4)
Female	24(96)
Age, Mean ± SD	55,25 ± 6,46
Country of birth, N(%)	
Romania	8(32)
Ukraine	7(28)
Perù	5(20)
Venezuela	3(12)
Moldavia	1(4)
Poland	1(4)
Educational level, N(%)	
Secondary School	6(24)
High School	14(56)
Bachelor or Master Degree	5(20)
Trained in elder care, N(%)	6(24)
Living condition	
With the care recipient	15(60)
With other relatives (e.g., siblings, cousins)	4(16)
With partner and children	3(12)
With partner only	1(4)
Work in the birth country	
Factory worker/manual work	7(29.1)
Shop assistant	3(12.5)
Shopkeeper/seller	2(8.3)
Housewife	5(20.8)
Ingeneer	1(4.1)
Cooker	1(4.1)
Practitioner	1(4.1)
Nurse assistant/professional educator	3(12.5)
Accountant	1(4.1)
Unemployed	1(4.1)
Care work in Italy	
Hours per week, Mean ± SD	75.91 ± 56.33
More than one care recipient	5 (20.8)
Willingness to change type of work	6(24)

Results

Respondents' description

Out of 25 subjects, 24 were females. The mean age was about 55 years (Table 1). The most represented countries are Romania and Ukraine (eight and seven persons respectively).

Six respondents had a Secondary School degree; 14 a High School degree and five a Bachelor or Master's degree (one dentist, one practitioner, one engineer, one nurse, one pharmacy technician). Only six had attended an elder care training in the past. 15 out of 25 respondents lived with the older care recipient and sevenhad a manual work in their birth country while three worked in the care or educational fields as nurse assistant or professional educator.

Interviewees reported to work about 76 h per week on average and five respondents on 25 cared for more than one person/household.

Outcomes from the thematic analysis

As reported in Table 2, the first theme identified by the analysis is named "Migration: a painful choice to flee poor (violent) societies". It describes the experience of leaving the born country, including pushing factors, difficulties, expectations. Other two themes follow. The theme "Elder care: a stressful work" describes characteristics, duties, shifts and thoughts on elder care work referred by the respondents as well as the difficulties they face. The theme "Elder care education" describes the respondents' educational pathway started in the birth country and resulting in care work or in further education in Italy; the current educational needs; barriers to elder care education and suggestions on further education.

In this section we describe the three main themes arising from the thematic analysis paired with sub-themes.

Migration: a painful choice to flee poor and sometimes violent societies

Motivation to emigrate

All interviewed MFCAs left their birth country for escaping from a poor and often violent society, especially those coming from Southern America Countries, and starting build up a new life rich in promises for them and for their children.

> *I still remember being shocked because I had a grocery shop in Peru, but I was robbed once with a knife to my throat, but what really hurt me was the sec-*

Table 2 The analysis of the answers to the open-ended questions: from codes to themes

Codes	Sub-Themes	Main themes
Economic	Motivation to emigrate	Migration: a painful choice to flee poor (violent) societies
Social (e.g. violence)		
Linear	Migration pathway	
Dangerous		
Shifts/hours of work	Work condition	Elder care: a stressful work
Feelings related to work		
Work plan for the future		
Unfair working condition		
Emergencies	Difficulties faced at work	
Behavioural disorders of older person		
Physical fatigue		
Mental/emotional stress		
Communication (Italian language)		
Education in the birth country	Educational pathway	Elder care education
Education in Italy		
Previous education in elder care		
Care and assistance	Educational needs	
Dementia and behavioural disorders		
Italian language		
Lack of time	Barriers to education	
Lack of interest		
Educational style	Suggestions on education and training	
Educational means		

ond time, when they put a gun to my head. That's when I decided to leave! (ID2, F, 52, Peru)

In Peru I worked as an engineer, but I earned very little. Here I earn twice as much, even three times as much, doing care work. In Peru we earned to eat (survive) (ID8, M, 55, Peru)

I left my country for money. I was alone, my son was in boarding school. He is now 39 years old but when I was widowed he was 17 […] we were 7 siblings and I was always poor […] I worked hard so that my son could study and become an engineer (ID9, F, 58, Romania)

Migration pathways

Migrants from Eastern European countries, such as Romania, started to move to Italy for short periods, often to earn enough money to cover specific expenses such as medical care. Gradually the periods spent in Italy intensified until these female workers moved permanently. Otherwise, MFCAs from non-EU countries, such as Moldova, entered Italy with tourist permits and could only settle in Italy by obtaining a passport from another EU country.

I started coming to Italy in 2014, let's say. In the first 3 years, I came for only 3 months, 90 days. Because I did not have papers [documents], as Moldova is not in Europe. After that I got a Romanian passport and it was easier from there (ID10, F, age missing, Moldavia)

I first came to Italy, to Sicily, in 2007 […] In 2018, in Romania I did a 6-month course to become a family care assistant because in Sicily they had told me at the municipality that it was compulsory to work in the homes of the elderly and I have the diploma which is valid in the EU. (ID4-INRCA, F, 56, Romania)

More complicated, often dangerous, the pathway of migrants from Southern America, such as Peru, as they were victims of traffickers and endangered their lives.

I came alone with a friend who helped me. […] I went through to arrive…because at that time (1994) we did not have free entry to Italy. I managed to enter in 15 days, the police stopped me, sent me back to where I had a tourist visa, and then a smuggler told us he would take us but I had to pay 5,000 euro. In short to get here I did everything! This…smuggler then tricked us, abandoned us in the middle of the mountains and left us a map to cross and get to Bolzano. There, if they (i.e. policemen) caught us, they'd shoot us (ID1, F, 53, Peru)

Elder care: a stressful work

Work conditions

Respondents who have two works and/or care for more than one person declared to work between 10 and 36 h a week. In most cases the person works as care worker during the night and as cleaner during the day.

> *Now I work for an older lady every night from 8 p.m. to 8 a.m., and the other assistant works from 8 a.m. until 6 p.m. […] when I leave work I come home, prepare lunch for the children, an hour or so, and then I go to do the cleaning work: Monday I go to one house, Tuesday to another […] (ID1, F, 53, Peru)*

MFCAs who are mothers of small children prefer to provide care during the nights and work in the morning when children are at school. Reconciling work and family tasks for them it is difficult, as they cannot count on the family support.

> *For me it is difficult with my children still young, working in shifts, I would not know where to leave them. That's why I took this job at night, so the whole day I'm with them*

(ID5, F, 34, Peru)

MFCAs who cared just for one person and did not live with the care recipient declared to work between 36 and 70 h a week, just an example, *"I work 44 hours per week"* (ID14, F, 54, Romania).

Conversely, live-in care workers, who always take care of just one person, referred to work between 30 up to 165 work hours per week: *"I care h24"* (ID11, F, 56, Romania).

Nevertheless, when they were asked about free time, they referred to have two hours break every day and one day and half for resting in a week (mirroring what established by the National Collective Labour Agreement for Family Assistants). They therefore over-estimated the hours of work per day by also considering the night and not considering the hours of rest foreseen by the work contract.

Some interviewees experienced very hard work conditions, due to long and stressing work shifts and intensive care activities with the older care recipients e.g. pads change, bathing, dressing, as depicted by the following quotation:

> *I always start with bed hygiene, then I have to change his catheter, wash him, change his nappy and then, with a kind of lift that helps me get him up I put him in the chair and we go to the kitchen where he eats. I help him. He always has to eat smoothies […] After breakfast, I give him his medication […] Then I continue doing hygiene after breakfast like shaving, emptying the catheter, etc. We spend some time together because the wife goes shopping (ID3, F, 51, Poland)*

Concerning respondents' thoughts on care work, some interviewees expressed feeling of satisfaction and gratitude, as highlighted by the following quotation:

> *Now I am happy of what I have built in 30 years; I have two wonderful children for which I give everything: Italy helped me! I have been working all the time since I came to Italy […] Now all my family is here, they are fine. From being poor, they now have houses in Peru (ID1, F, 53, Peru)*

> *I feel good, I like the work I do…I do it with love and sincerity, because otherwise I wouldn't have done it at all" (ID2, F, 52, Peru)*

One respondent underlined unfair work condition, as depicted by the following quotations:

> *I believe there will never be a shortage of work, but work has worsened, it is less paid, contracts are with fewer hours but you work the same for the same hours. Others want to pay you off the books or even want to pay you less for one hour (ID3, F, 51, Poland)*
> *I met people who did not want to pay me or wanted to account for fewer hours than I actually worked (ID17, F, 57, Ukraine)*

Six respondents out of 25 expressed the desire to change work to have more economic stability and improve the quality of life, despite they were aware that the Italian labour market does not offer many alternative jobs for middle aged women with low education or not certified/recognised educational degree.

> *I would like to be a waitress but I have knee problems (ID15, F, 66, Romania)*

> *I would like to stop working as a family assistant because it is very hard work….though it is very difficult to find another job (ID22, F, 51, Ukraine)*

Difficulties faced at work

Interviewees agreed on the fact that the most difficult aspect of care work is handling the behavioural disorders of the older person with dementia.

> *I worked for a person with dementia for eight months, but I got really anxious and scared. I couldn't take it anymore…she said to me bad words.*

One moment she would talk to me normally, and the next she would start shouting 'Go away!!!'. I kept quiet, I didn't want to hear. But I wouldn't change her pads when I was alone with her (ID2, F, 52, Peru) Once the lady had a crisis, she did not recognise me, she wanted to call the police, I had to call the neighbours on my mobile phone they came and we solved the problem (ID15, F, 66, Romania)

Most of them told how difficult it was to win the trust of the older adults with dementia, especially as soon as the migrant worker starts living in their homes:

Before, my grandmother [the interviewee calls "grandmother" the cared for person] was like the lady in the comic, she was hard on me, she even pulled my hair [...] She didn't even want a hug... she didn't want closeness, she didn't want to change her clothes or wash. Over time I convinced her [...] I approached her without forcing her. [...] I resisted so much, because I understood that she was a lonely person (ID7, F, 54, Peru)

Sometimes, difficulties in the relationship with older person's relatives may be source of stress, especially for live-in MFCAs at the beginning of the co-habitation:

First they say you're a family person and then there's always something wrong (ID9, F, 58, Romania)

Other times, meaningful relationships are established between the care worker and the older person's family:

The relationship with the family is GOOD, in fact excellent, they help me, they send me home as guests, I feel like a family member [...] because I found a family here in Italy and they speak Spanish, my language, now I'm learning Italian (ID23, F, 47, Venezuela)

When the older person has not close relatives, the MFCAs and her family reproducing family ties, may become a surrogate of the real family for both the care worker and the care recipient:

Living far away, relatives do not come. We welcomed her as if she were our grandmother, because unfortunately she has no relatives here and those she does have are far away (ID7, F, 54, Peru)

Elder care education

Educational pathway

Those having a high educational degree i.e. bachelor and master's degree have never tried to get it recognised by the Italian Government or they started and gave up, because conscious of the long times of the process of recognition and of the high demand of elder care that would have ensured to find work quickly and easily.

I have a degree in medicine from Venezuela and I'm a psychiatrist, but I haven't practised medicine for a while, I'm having second thoughts because, in the end, if I have to re-enter the health circuit I would have to start all over again and I don't feel like it because I graduated 28 years ago. I prefer another relevant job that at least gives me the stability to live (ID6, F, 55, Venezuela)

I am an engineer-agronomist [...] but I don't need the degree in Italy, because there is no agreement between Italy and Peru and it cannot be recognised (ID8, M, 55, Peru)

In Peru I had started studying as a pharmaceutical technician. I produced all the documentation to have my studies recognised and to continue here in Italy, but I had to study full-time. I was either studying or working. But I was on my own, if I didn't work who would feed me? Besides, this course of study that would have lasted three or five years did not exist in Ancona, I would have had to go outside to study (ID2, F, 52, Peru)

Some respondents from Eastern Europe attended elder care courses in their countries, preparing them to care for Italian older people at home. Other respondents, already in Italy for a while and working as family care assistants in the informal care sector, started the course for nursing assistant (Operatore Socio-Sanitario-OSS in Italian), for attempting to improve their own work condition. Unfortunately, due to the scarce and confused offer in the field of elder care education in Italy, someone attended the wrong course and then spent money and did not achieve the certification of nursing assistant.

After the Covid-19 pandemic, I thought about the nursing assistant course again, but I made a mistake, I studied at the Institute in Padua for one year, but the course was only for assisting people at home: I threw money away for nothing... it cost me more than 2,000 euro (ID2, F, 52, Peru)

Educational needs

The interviewees' educational needs mirror the difficulties they face at work and then they mainly concern the knowledge of the ageing process and dementia, and the techniques for managing older person's neuro-psychiatric symptoms (e.g. anger, wondering and hallucinations).

Working with older people is not easy and there is a need for informational and training on how to deal with Alzheimer's patients, with dementia. Knowing what this degenerative disease is (ID7, F, 54, Peru)

Many interviewees would also like to learn the Italian language to improve their communication with the older person and his/her relatives.

I would like to improve my Italian because I do not speak it very well (ID13, 52, Romania)

Others would like to learn how to medicate injuries and bedsores and to know medicines properties.

I miss knowing what to do if an older person has an injury [...] When she got hurt it wasn't that the nurse came straight away, I took care of the arm (ID2, F, 52, Peru)
I would like to know medicines (ID22, F, 51, Ukraine)

We also asked them to tell us what they knew about dementia and Alzheimer. The answers showed a generic knowledge of the symptoms, because they have to handle them every day, but they also revealed a scarce understanding of the reasons of dementia and driving factors, and a lack of knowledge of non-pharmacological intervention and techniques for limiting behavioural disturbs and stimulating cognition.

Dementia is a nasty disease that makes people lose control, older adults with dementia look like children" (ID2, F, 52, Peru)

People with dementia overbear at first and then repeat the same words and are distracted (ID1, F, 53, Peru)

It is a disease that causes sudden changes in mood (ID4, F, 56; Romania)

When you have Alzheimer's disease you do not recognise your family anymore! (ID9, F, 58, Romania)

I just know that Alzheimer's is a bad disease! (ID14, F, 54, Romania)

One respondent confused Alzheimer with Parkinson's disease symptoms:

People with Alzheimer's always tremble (ID21, F, 63, Ukraine)

Barriers to education

The major part of the respondents was keen to learn and to improve their knowledge in elder care and assistance, but many of them underlined the difficulty of attending face-to-face trainings because of their demanding and intensive work.

[I would like to attend an elder care course] but how can I come to do it, if I work 24 hours a day? (ID10, F, 52, Moldavia)

By analysing the willingness to attend elder care courses by the emigration geographical area, we noticed that the interviewed MFCAs from Southern America were more willing to attend elder care course (seven out of eight) than those from Eastern Europe (six out of 17 respondents). Noteworthy, the difference between respondents thinking that the course would be useful is not so high: 11 out of 17 in the group of MFCAs from Eastern Europe and seven out of eight in the group of MFCAs from Southern America.

Only two respondents (both from Peru, i.e. ID1 and ID9) said they did not need to attend a course on elder care, because they think that it can be learned by doing i.e. through the daily practice, so highlighting their lack of interest in attending this kind of training. Three MFCAs in the group of respondents from Southern America added to this the fear that working in a care facility would put them in a position to provide lower quality care, since they would have to care for several patients at the same time and not just for one:

The experience taught me so much, perhaps more than a school [...]many people advised me to do the OSS course but I don't feel like it because I am 53 years old and working in an old people's home might be difficult for me because I don't want to lose humanity and I want to care well. I would just do a course for me, to enrich myself (ID1, F, 53, Peru)

Further education

Educational style and means

Most respondents agreed on suggesting to draw elder care courses that can be attended both online (by mobile phone) and in person despite the majority recognised that face-to-face group courses would be more interesting, engaging and useful.

Online course could work, but I think the in-presence part it is also important, because it allows you to interact with people, see, look, touch, make experience. The theoretical part could easily be online, even the discussion. But if you have to work with

people, you have to do it....the in-presence part would be great" (ID6, F, 55, Peru)

Many respondents preferred to access the training or part of it by mobile, except for ID23 (a 47 years old woman from Venezuela), who preferred to do it by personal computer.

Discussion

Contribution of the study to the scientific debate

Educational needs of MFCAs and actual offer of elder care trainings are still under covered by the Italian and international scientific literature. This may depend on the fact that in Italy, characterised by a familistic culture and a family-based care regime, it is still taken for granted that anyone, and especially any woman can properly take care of an older person without the need of attending a course [9, 30]. Thus, this qualitative study represents one of the few studies that can increase the knowledge on this phenomenon in Italy, by answering the research questions that are recalled below.

Which is the work experience of MFCAs of older adults with long-term care needs?

The study confirms hard work condition, long shift and stressful tasks for MFCAs [31–33] and unfair work contracts or payments. In line with the literature, for most of the interviewees, migration was the only possible choice to escape poverty in the case of Eastern European women and violent and unjust societies in the case of some Latin Americans [34–36]. Despite migration allowed them to have a better life than they would have had in their own country, for some of them care work is a downgrade from the educational level and /or the work qualification acquired in their country of origin.

The discrepancy between the realistic and the working hours reported by the respondents, probably mirrors the experienced care burden that make MFCAs perceiving more work than that realistically done and regulated by Law. In fact, the National Collective Employment Contract for domestic workers in force since 1st October 2020 (https://associazionedomina.it/ccnl/#1494956055598-572f5057-8f2e), foresees 10 non-consecutive workin g hours per day (54 h per week) for cohabiting workers and eight non-consecutive hours per day (40 h per week), spread over 5 days or 6 days, for non-cohabiting workers. However, the over-reported working hours may reveal an irregular work condition of some respondents. Unfortunately, it cannot be verified, because we chose not to ask the MFCAs if they were working with a regular employment contract not to frighten them and to prevent them, feeling controlled, from being insincere in their answers.

More than half respondents reported difficult relationships with cared for older people as well as with the family members, especially at the beginning of the work relationship. Others referred very positive relationships built on intimacy and mutual help. This result is in line with Artero et al. (2021) [37], describing how the relationship between the MFCA and the older person (and his/her family members) can be set al.ong a continuum where at one extreme there is an asymmetrical and exploitative relationship, whilst at the other one warm and reciprocal ties are established. This suggests how much it is appropriated to add the adjective "family" to this kind of care workers, not only because they work within older people households, but also because in some cases, family ties dynamics such as intimacy, confidence, solidarity, affection or conflict and incomprehension are reproduced. Sometimes, initial frictions may go through a process of familisation; other times they can solve in a final break-up of the relationship. Like in all real families, even in this re-constructed and fictitious families, conflicts can occur and become additional source of stress and burden.

Which are their educational needs?

The study confirms the lack of knowledge and competences of some MFCAs about the ageing process and caring [12], and it highlights the dearth of comprehension especially about cognitive decline, dementia and neuropsychiatric disorders, similarly to what happens for migrant informal caregivers of relatives with dementia, who may miss cultural and linguistic ability to achieve and understand the diagnosis and how to deal with the symptoms [38]. In fact, most interviewees, except for the neurologist from Venezuela, had no idea of what dementia nor Alzheimer's disease are. The study advances the current knowledge on the educational needs of MFCAs who expressed the desire of learning how to treat injuries and emergencies and how to deal with the disturbs deriving from dementia. They also would like to improve the use of the Italian language, as they are aware that language proficiency may improve the relationship with family caregivers and older caretakers.

Which are the barriers to attend training courses?

In addition to the practical (e.g. transportation) [39] informational, legal [40] and linguistic, barriers [41] to the access to education for migrants and refugees, this study highlights that for MFCAs the main barrier to elder care education, is the lack of time to devote to it, due to the long work shifts and often the co-habitation with the older person. Moreover, the study also highlights the lack of training motivation of some respondents, who believe that elder care can be learned by doing, just through practice, without the need of theoretical knowledge.

Did the emigration geographical area of respondents and the migration route influence their willingness to attend an elder care training?

Based on the inputs coming from the literature, we explored the possible influence of birth country on MFCAs' education. Given the small size of the sample and its qualitative nature, we can only observe that the geographical emigration area just partly influenced the interviewed MFCAs' decision of attending training courses, since other factors might have driven or hindered this decision, such as the educational level and the migration plan.

Most interviewed from Southern America having a medium-high level of education, seem to be more interested and motivated to attend elder care trainings than low-educated ones, mainly coming from Eastern Europe. We can also imagine that, as far as the group of interviewees from South America is concerned, having overcome serious difficulties and dangers along the migration route, such as persecution and repatriation, may have strengthened their desire to improve their economic and social conditions and those of their children, thereby giving meaning to their decision to migrate. Thus, the willingness to learn may depend not only on their long-term migration plan (in contrast to that of MFCAs from Eastern Europe) [11], but also on how they faced the journey and their better attitude to learn, and the willingness to improve their socio-economic status. However, in most cases, discouragement in the face of the difficulty and length of legal proceedings for the recognition of qualifications acquired outside Italy prevails over the desire to improve the quality of life. This is why it happens that a neurologist, a pharmacist, an engineer work in the informal care sector, with minimal social security. Thus, the decision of continuing on the way of the life-long-learning for MFCAs, as well as for any adult, depends on many socio-economic factors that would require a dedicated study.

The comparison of migrants from Southern America with the ones from Eastern Europe, living different migration experiences, has to be considered only an explorative attempt, in fact the data available to us does not allow to identify a clear relationship between the type of migration route and the educational and career choices of the MFCAs involved in this study. Nevertheless, such an attempt may stimulate the reflection on the possibility that such a relationship may exist, and draw further research on this topic.

Table 3 From study results to suggestions on elder care trainings and policy and practice recommendations

Study results	Suggestions and recommendations for
Suggestions on elder care training	
Difficulties in handling the behavioural disorders of the older person with dementia: need to know how to manage behavioural disorders	Lessons on ageing process, dementia and cognitive decline, neuropsychiatric disorders
Unfair working conditions	Module on legal aspects of care work: care worker's rights and duties
Difficulties in the relationship and communication with older person's relatives	Contents of cultural aspects of family and care
	Contents for improving communication competences
	One module on the hosting country language
	Contents improving MFCAs' resilience
Lack of motivation to attend elder care courses	Co-designed, appealing, interactive and not too much theoretical lessons
	Blended trainings also accessible by mobile
Lack of time for education and training	Sensitise the employers (i.e. the older persons' family) on the importance of training for having a better assistance
Recommendations for policy and practice	
No recognition of previous educational certification	Rapid recognition of previous education
No harmonised recognition of certification across Europe	Recognition of the training certification at EU level
Confused and expensive elder care education offer	Sorting out and making clearer the offer of elder care education at national level
	Cheaper or free periodical courses
	Setting up a national register of certified MFCAs
	Mandatory periodical training
	Modularising MFCAs' salaries on the level of preparation in elder care

Training, policy and practice recommendations

In light of the results, some suggestions are given in this section to improve the design of future elder care trainings targeted to care workers with a migration background. In Table 3, the main study results were associated with training and policy and practice recommendations.

Training curriculum that includes lessons on dementia and Alzheimer's disease and that especially proofing neuro-psychiatric symptoms and behavioural disturbs occurring with dementia are a priority, considering that they represent the main reason of the difficulties faced by MFCAs and the first source of burden. In addition, to provide MFCAs with knowledge on work national legislation and care worker's rights and duties, an educational module on the collective national domestic and care work contract is recommended.

Moreover, appropriate training should help acceptance and adaptation to care work by educating MFCAs to develop better coping strategies and providing tools to increase resilience and thus decrease the risk of mental illness. In fact, the discrepancy between the expectations of a better life in Italy at the moment of leaving the birth

country, and the conditions they actually experience, could compile the adaptation to the role of care worker of an older person and lead MFCAs to mental health condition, physical exhaustion, depression and anxiety [33], and expose them to mistreatment and sexual abuse [31, 32]. They may also experience a psycho-social malaise that manifests with a general emotional fragility e.g. crying without (apparent) reason, or intense agitation or irritation. The malaise is in a close relation with their professional conditions and it depends on the meaning they assigned to their migration project, the cohabitation with the cared for person and the separation from their relatives, especially the children that they have left behind in the birth country. The malaise can degenerate in a depressive disorder called "Italy syndrome" [42], a social/psychological phenomenon rather than a formal clinical diagnosis, used in research and media to describe psychological dependence and family disruption among migrant care workers from Eastern European countries [43].

MFCAs work in the homes of the older adult, they come into close contact with his/her family members, and sometimes they may form households which reproduce (albeit forcibly) relationships similar in intimacy and confidence, to those of a family. Then, courses for MFCAs, should also contain lessons on the cultural aspects of family and caregiving i.e. values, division of roles, traditions, customs and expectations and how these have changed over the generations in the hosting country. The older care recipient is likely to have expectations about assistance and caregiving that are different from those of his/her children and the MFCA. Then, a specific training course for MFCAs should be designed with the intention of harmonising these three different points of view. Also being proficient in the use of the hosting country language would help the communication and the expression of feelings, and then contribute to the construction of healthy relationships in the care environment.

To increase the motivation of MFCAs to attend elder care courses, training materials should be co-designed to be appealing, not too much theoretical, and easy to access and always available by a smartphone, because these characteristics may increase the learners' adherence to the training.

Furthermore, to counteract the lack of time for attending educational courses, older adults' relatives (i.e. the employers of MFCAs) should be sensitised and trained to recognise that the training of MFCAs is a greater guarantee of the quality of care provided to their older loved ones in order to push them to take time off work for training to their migrant employees. In fact, despite the fact that Article 20 of the National Collective Labour Agreement (CCNL) for domestic workers provides 40 h per year of paid leave to attend specific training courses on care or for training activities necessary for the renewal of the residence permit (VISA), many families employing MFCAs are not willing to grant these permits and MFCAs themselves do not ask for it for fear of losing their jobs, because it may be not easy to find another trustworthy care assistant for few hours and hiring her/him would be expensive for the older person.

Policy and practice recommendations

The outcomes confirm the confused, fragmented, expensive and unclear offer of education and training in elder care for migrants and they call for a deep reform in the sector. More and cheaper courses should be designed for MFCAs and information about the course costs, contents, work perspectives and certification should be clearly explained. The periodical training of MFCAs should be made mandatory as it is for the care workers in the formal care sector, such that MFCAs are motivated to attend the courses and the employers (i.e. the older adults' families) are obliged to give the consent to the attendance. Of course, a national register of certified MFCAs should be built such that substitutes of care workers attending the course are always available and the older persons can always rely on prepared and skilled carers. The latter should be part of a larger set of measures for contrasting exploitation and inequalities of MFCAs and it should modularise MFCAs' salaries on the level of preparation in elder care; streamline recognition processes for qualifications acquired abroad, particularly outside the EU; strengthening the collaboration between local public bodies responsible for training, volunteer associations, patient and caregiver associations and labour offices, to ensure continuity and circularity between training and care work. Finally, the training certification should be given to trainees in short time and recognised at EU level, since migrants often travel across European countries.

Looking forward: the design of an educational curriculum for MFCAs

Taking into consideration the inputs collected through this study, within the AGE-IT project, an educational curriculum was designed including eleven modules on topics of interests for MFCAs, family caregivers and care professionals, and modules specific for each of the mentioned groups of caregivers. Three modules were drawn specific for MFCAs, as showed by the figure below (Fig. 1).

Despite one third of the respondents said they wanted to improve their Italian, the course does not include a module on Italian language, because translating the educational materials into different languages would have been too expensive and time consuming. Therefore,

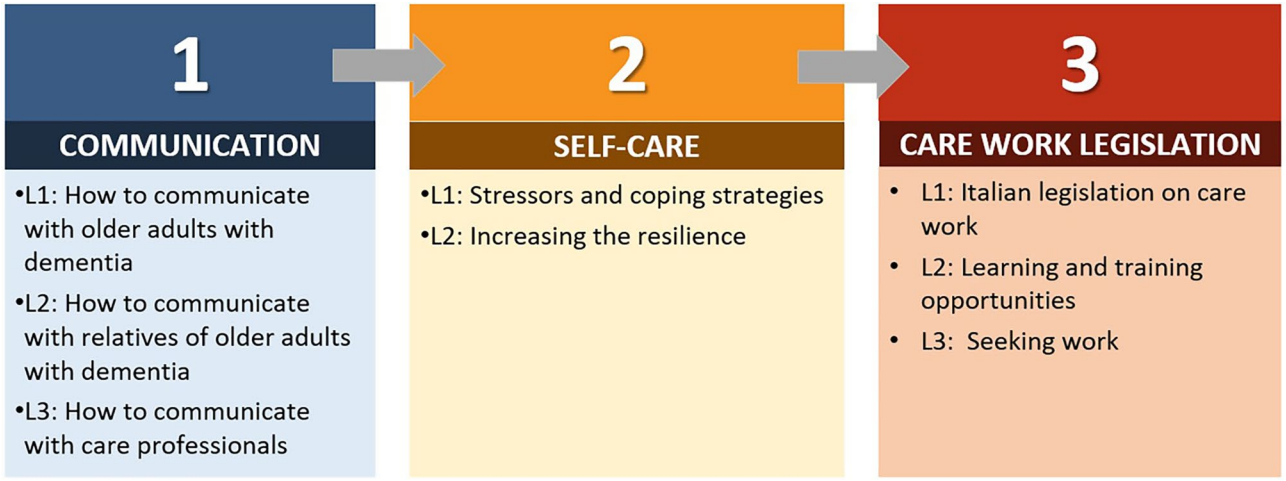

Fig. 1 Learning modules drawn on the narratives of the interviewed MFCAs

during the experimental phase, the educational materials will only be provided in Italian. Given the use of specific terms such as "neurocognitive disorders" or "pressure sores", a language proficiency level of B1 will be a prerequisite for accessing the training and understanding its content. In a second time, it is possible that the information may be delivered also in other languages. The curriculum will be delivered through an AI-powered e-learning intervention, consisting of a chatbot and a digital platform. Caregivers will access the educational content modules on the platform, while the chatbot will enable them to ask questions and be directed to relevant educational content based on their training needs.

Study limitations and research suggestions

The study has several limitations. Firstly, the non-representative and snowball sampling method used, generated results that are not generalizable to the larger population of MFCAs. Additionally, the small sample size may not have captured the full range of experiences and perspectives of this group of population. Moreover, since the study was conducted in two middle-sized cities, the results cannot be representative of the conditions of MFCAs living in metropolitan nor in rural areas. Furthermore, the thematic analysis of the answers to the open-ended questions, while providing rich insights, may also be influenced by the researchers' own perspectives and interpretations, despite all measures for ensuring the analysis trustworthiness were applied.

Looking at the design of the curriculum, its main limitation lies in the lack of an Italian language module, that was asked by the respondents. Given that the development of multilingual modules on elder care would require the use of considerable human and economic resources, artificial intelligence could help by reducing these production costs, in a very near future. As a consequence, the limited language access and the digital divide of migrant learners may undermine the efficacy of the educational platform. The topic addressed by this paper, is quite under covered by the Italian scientific community. Thus, further quantitative studies are recommended focussing on the educational needs of MFCAs of older people with LTC needs, their willingness to attend elder care education and the outcomes of co-designed training courses for them. These studies could address the limitations listed above by employing more representative sampling methods, such as larger and randomised samples. Additionally, using mixed-methods approaches, combining both qualitative and quantitative data, could provide a more comprehensive understanding of MFCAs' educational needs and barriers to training. Moreover, involving MFCAs in the research design and implementation process could help to increase the validity and relevance of the findings. Finally, the perspective of family caregivers could also be collected as well as, when possible, that of older caretakers in order to have a comprehensive vision of how the MFCAs' education can influence the quality of care, the relationship with the older care recipient and the family caregivers, the mental health, human development and social integration of MFCAs.

Conclusions

Given the pivotal role of MFCAs in the LTC in Italy, it is urgent that they are adequately trained and that the training is based on tailored contents concerning ageing process, dementia treatment and neuropsychiatric symptoms management, nursing care (e.g. medications and first aid), and that psychological and emotional, relational and communicative competences are provided. The contents should be conveyed through very agile and friendly means to be compatible with the work time of the trainees. In light of this, an e-learning platform running on the

smartphone that learners can access in any time, seems to be a promising resource, to improve the educational offer to MFCAs, and increase the sustainability and the quality of the home care of Italian older people with multiple disease in need of multiple-type services.

This is what is implemented by the organisations working within the Spoke 5 "Care sustainability in an ageing society" of the Age-It project.

Abbreviations

EU	European Union
LTC	Long-term care
MFCA	Migrant family care assistants

Supplementary Information

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Supplementary Material 1

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Author contributions
S.S. made substantial contribution to the study design, the preparation of the data collection tool, led the analysis and interpretation of data, drafted the work, and was a major contributor in writing the manuscript. A.G. and Flavia Galassi collected the data through the administration of face-to-face interviews with migrant family care assistants. D.G. made substantial contribution to the study design, the preparation of the data collection tool and revised the manuscript. G.C., S.C., I.C., S.T., V.M. e R.P. revised the manuscript draft. R.C. made substantial contribution to the conception and final review of the manuscript. All authors read and approved the final version of the manuscript.

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Data availability
The datasets generated and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
The study was conducted in accordance to the Declaration of Helsinki and approved by the Bio-ethic Committee of the University of Bologna, on 26th July 2023, with communication N. 0208993. Written informed consent was obtained from all participants.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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