Health of older refugees and migrants

Technical guidance

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Knowledge Hub on Health and Migration

The Migration and Health programme

The Migration and Health programme, the first fully fledged programme on migration and health at the WHO Regional Office for Europe, was established to support Member States to strengthen the health sector's capacity to provide evidence-informed responses to the public health challenges of refugee and migrant health. The programme operates under the umbrella of the European health policy framework Health 2020, providing support to Member States under four pillars: technical assistance; health information, research and training; partnership building; and advocacy and communication. The programme promotes a collaborative intercountry approach to migrant health by facilitating cross-country policy dialogue and encouraging homogeneous health interventions along the migration routes to promote the health of refugees and migrants and protect public health in the host community.

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Abstract
Population ageing caused by consistently low birth rates and increased life expectancy represents a major current social trend across Europe. This technical guidance aims to inform policy and practice development specifically related to improving the health of older refugees and migrants within the European Union and the larger WHO European Region. Both ageing and migration are in themselves complex multidimensional processes shaped by a range of factors at the micro, meso and macro levels over the life-course of the individual, but also with intertwined trajectories. Responding to the needs of older refugees and migrants, therefore, must be integrated into all dimensions of ageing policies and practices across Europe. Relevant areas for policy-making include healthy ageing over the life-course, supportive environments, people-centred health and long-term care services, and strengthening the evidence base and research.

Keywords
AGED, HEALTHY AGING, REFUGEES, TRANSIENTS AND MIGRANTS, HEALTH POLICY, POLICY MAKING

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Contents

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Abbreviations

EU	European Union
NGO	nongovernmental organization

Summary

While the majority of the WHO European Region has been experiencing a demographic trend of ageing populations caused by consistently low birth rates and increased life expectancies, the Region has also been experiencing increased migration into and between countries. Both of these shifts represent challenges and opportunities for older adults with refugee or migrant background as well as for European societies. Older refugees and migrants include those who have recently arrived and those who age in the country of destination (ageing in place). Older adults share a range of similar experiences and needs, irrespective of country of birth (e.g. the ability to maintain functional capability, health, quality of life and access to health and long-term services at old age). As such, it is crucial to find ways to maintain sustainable societies that foster active and independent living into old age for older refugees and migrants, and the communities and societies they are part of.

This technical guidance aims to inform policy and practice development specifically related to improving the health of older refugees and migrants within the WHO European Region. While a growing body of literature explores health and well-being among older refugee and migrant populations, the evidence base is still fragmented, with little internationally comparable information, and is limited in providing insight into effective strategies to ensuring healthy and active ageing in these groups.

A broad scoping review of available demographic and epidemiologic data involved examining policies and practices in both health and social welfare sectors. The findings are structured according to the three thematic priority areas for action stated in the Strategy and Action Plan for Healthy Ageing in Europe 2012–2020: healthy ageing over the life-course, supportive environments, and people-centred health and long-term care systems. Overall, there are similar disease patterns across migrant populations and majority host populations; however, refugee and migrant populations have a different trajectory when ageing compared with majority populations, influenced by disadvantaged socioeconomic positions, long-term effects of traumatic experiences and different exposures to risk factors (before migration, during transit and after arrival in the final destination country).

Despite the combination of being a migrant and an older person creating potential vulnerabilities and challenges, it is important to recognize the agency demonstrated by older refugees and migrants and their communities as socially active, economically productive and valuable resources of knowledge in their communities. A comprehensive approach working with individuals, families, communities and relevant formal sectors is needed if health among older refugees and migrants is to be enhanced and, in turn, that of the communities and societies they are part of. This entails involvement of health care services, long-term care systems and wider age-friendly environments, as outlined in WHO strategies and action plans within the field of ageing and health.

Diversity-sensitive policies and practices should be integrated throughout health and long-term care sectors for older adults to accommodate the needs of diverse older adults, including those from a refugee or migrant background.

Introduction

Ageing in the context of migration

Population ageing caused by consistently low birth rates and increased life expectancy represents a major social trend across the WHO European Region, bringing with it both challenges and opportunities *(1,2)*. In response to this demographic change, a range of intersectoral policies and practices have been implemented at country levels that focus on individual, social and environmental/structural factors *(1–6)*. All of these affect the ability to maintain health and uphold active and independent living into old age, thereby ultimately aiming for sustainable societies in the context of population ageing. Healthy and active ageing are concepts capturing life-course processes that enable older adults to live independently in good health, stay engaged in social relationships within families and communities, and uphold social roles important to well-being *(2)*.

Concurrent to population ageing, the WHO European Region has experienced increased migration into and between countries, a process that has been more pronounced in the north-western and some southern countries than in eastern European countries *(7)*. Such migration represents both challenges and opportunities for individuals, communities and societies, depending on the ability to respond to increased diversity in life experiences and cultural and linguistic backgrounds within populations *(7–9)*. Diversity-sensitive policies and practices are seeking to address the health and social needs both of newly arrived refugees and migrants and those who are "aging in place" as they have been living in European societies for decades *(10)*.

Both ageing and migration are in themselves complex multidimensional processes shaped by a range of factors at the micro, meso and macro levels over the life-course of the individual *(6,7,11)*. At the same time, ageing and migration come together as intertwined trajectories in creating both needs and opportunities for older adults with refugee or migrant background as well as for European societies *(9,12)*. It is, therefore, imperative to focus on and respond to health and well-being among the growing and diverse population of older refugees and migrants, with a specific emphasis on turning insights from the current evidence base into policy and practice developments across countries in the WHO European Region.

Objectives

The objective of this technical guidance is to inform policy and practice development specifically related to health of older refugees and migrants. Developed under the umbrella of the Knowledge Hub on Migration and Health, the document highlights key principles, summarizes priority actions and key challenges, lists available tools and provides practical suggestions and references for further guidance to enhance health and well-being of older refugees and migrants within the European Union (EU) and the larger WHO European Region. Focus is on providing evidence and considerations at the policy and programmatic levels based on a scoping review of available resources.

Methodology and a note on the evidence base

Put simply, older refugees and migrants are just older adults that have at a point in their lives migrated to another country. Migration is, therefore, a distinguishing feature or a life event that adds an extra layer of complexity to the ageing trajectory for older refugees and migrants. Underlying this added layer is a wide range of similar experiences and needs shared with older adults in general irrespective of country of birth. Keeping this in perspective is important while appraising the literature and teasing out considerations for diversity-sensitive policies and programmes for older adults. This scoping review combines general principles for supporting healthy ageing, as outlined in particular in the Strategy and Action Plan for Healthy Ageing in Europe 2012–2020 *(1)* and the Global Strategy and Action Plan on Ageing and Health, combined with key resources on specific needs and experiences of older refugees and migrants *(6)*. The literature on older refugees and migrants has grown in recent years, with a number of studies reporting on various dimensions of healthy ageing in these groups. This includes health status; access to quality health and long-term care; community dimensions, including specific needs in relation to age-friendly environments; and, although so far limited, interventions to support refugees and migrants in optimizing their health, stimulate inclusion and enable well-being in older age. Placed in the intersection between migrant studies and gerontology, the emerging evidence base is shaped by different disciplines. While this transdisciplinary approach is necessary to capture the full picture of the migration–ageing nexus, the field of migration and ageing tends to remain marginal within the separate scientific disciplines, and there is not currently a solid evidence base solely related to older refugees and migrants. In particular, the paucity of routine data on older migrant and refugee populations in the WHO European Region and evidence on best practices among these groups necessitates exploration of services for refugees and migrants irrespective of age to identify key principles, tools and guidelines that would also be relevant for the older group. In this process, acknowledging the diversity among older refugees and migrants in terms of factors such as their demographic and socioeconomic circumstances is necessary to avoid oversimplification of the subject matter *(9,12)*.

For the purpose of this document, a scoping review providing a broad situational analysis was conducted based on the available demographic and epidemiological data; evidence and best practices; policy documents; and case studies across countries participating in the EU Health Programme. As the ageing–migration nexus is distinctly interdisciplinary and shaped by policies and practices across sectors in different contexts, evidence from both health and social welfare arenas was incorporated. Published peer-reviewed literature, grey literature, action plans/guidelines, tools and case studies in Danish, English, German, Norwegian or Swedish were all considered. This guidance, however, does not present a comprehensive overview of the existing policy reports and other grey literature documents across countries. Rather, given the limited evidence base and the broad scope of the subject area, the literature was critically appraised and synthesized with priority given to areas with more solid evidence and to well-documented examples of good practices.

The case studies included represent interventions across health topics, sectors and tools, thus highlighting sources of inspiration rather than giving a comprehensive overview of prior and current projects for these groups. Narratives are included to provide more contextualized, personal experiences of older refugees and migrants. To ensure relevance to the current migration context in the WHO European Region, only literature published since 2003 was retrieved. Policy and practice considerations have been based on the overall synthesis of the literature combined with discussions with the external expert committee. A consultation process involving representatives from the Healthy Ageing Task Force of the WHO European Healthy Cities Network took place during an extended meeting in Copenhagen on 31 May and 1 June 2018.

Refugees, migrants and special subcategories

Although the document builds on definitions of refugees, migrants and asylum seekers set out by the International Organization for Migration and the Office of the United Nations High Commissioner for Refugees, some categories of special relevance for this technical guidance should be emphasized. Older refugees and migrants are considered in two groups: older recently arrived refugees and migrants and those who arrived in younger age and have aged in the country of destination. Some of the latter group are more likely to be employed in precarious and/or service sector employment, with possible health consequences in old age *(13)*. Particularly vulnerable groups, including asylum seekers and migrants in irregular situations, are further subcategories to be acknowledged.

Overview

Development in numbers of foreign-born older adults over time per country

Fig. 1 gives an overview of the development in the population of foreign-born people above the age of 60 for selected countries in the WHO European Region in the period 2000–2017 *(1)*. Data for countries participating in the EU Health Programme are presented in Annex 1. Note that as data do not allow a more fine-grained analysis, it is not possible to single out refugees and migrants or countries of origin as defined in this technical guidance. Overall, most countries in the Region have seen increases over time, albeit with some variation as declining numbers of foreign-born older people are seen in countries experiencing high outward migration flows.

Fig. 1. Population of foreign-born people aged 60+ in selected countries

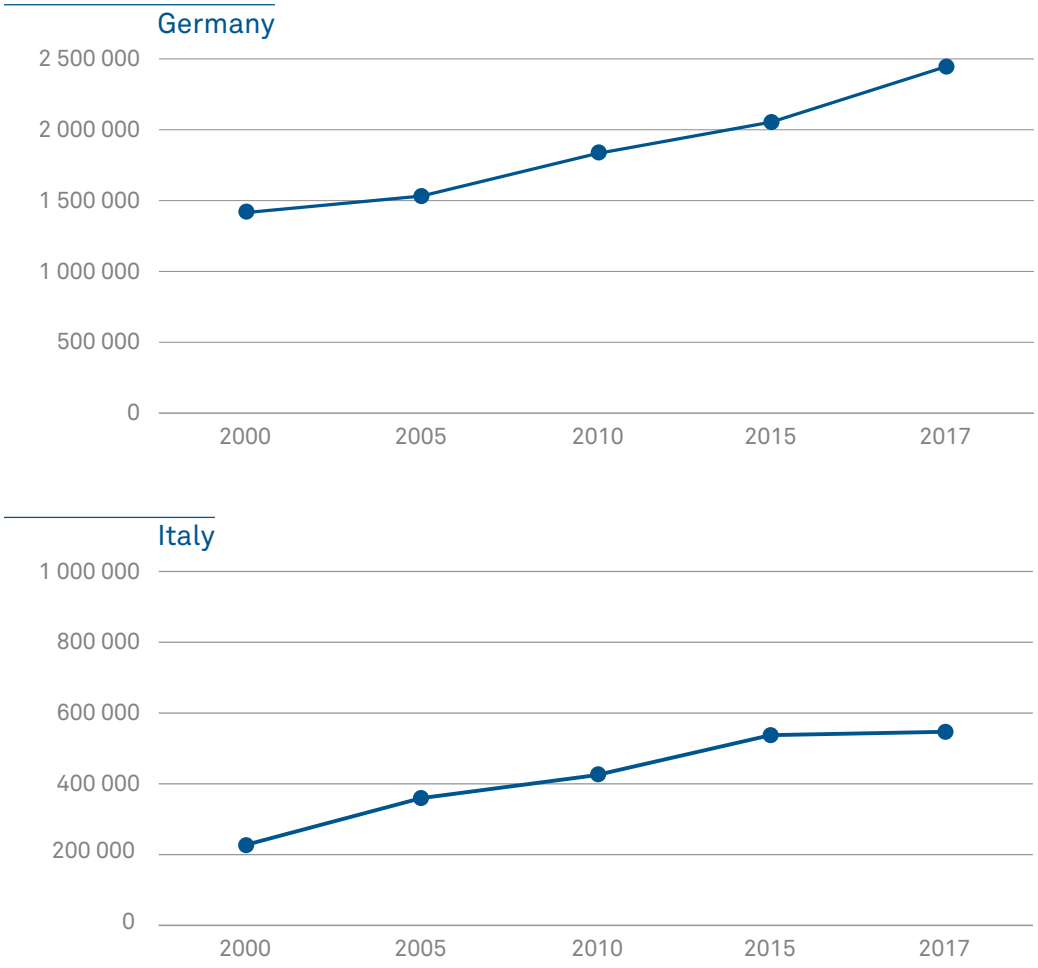
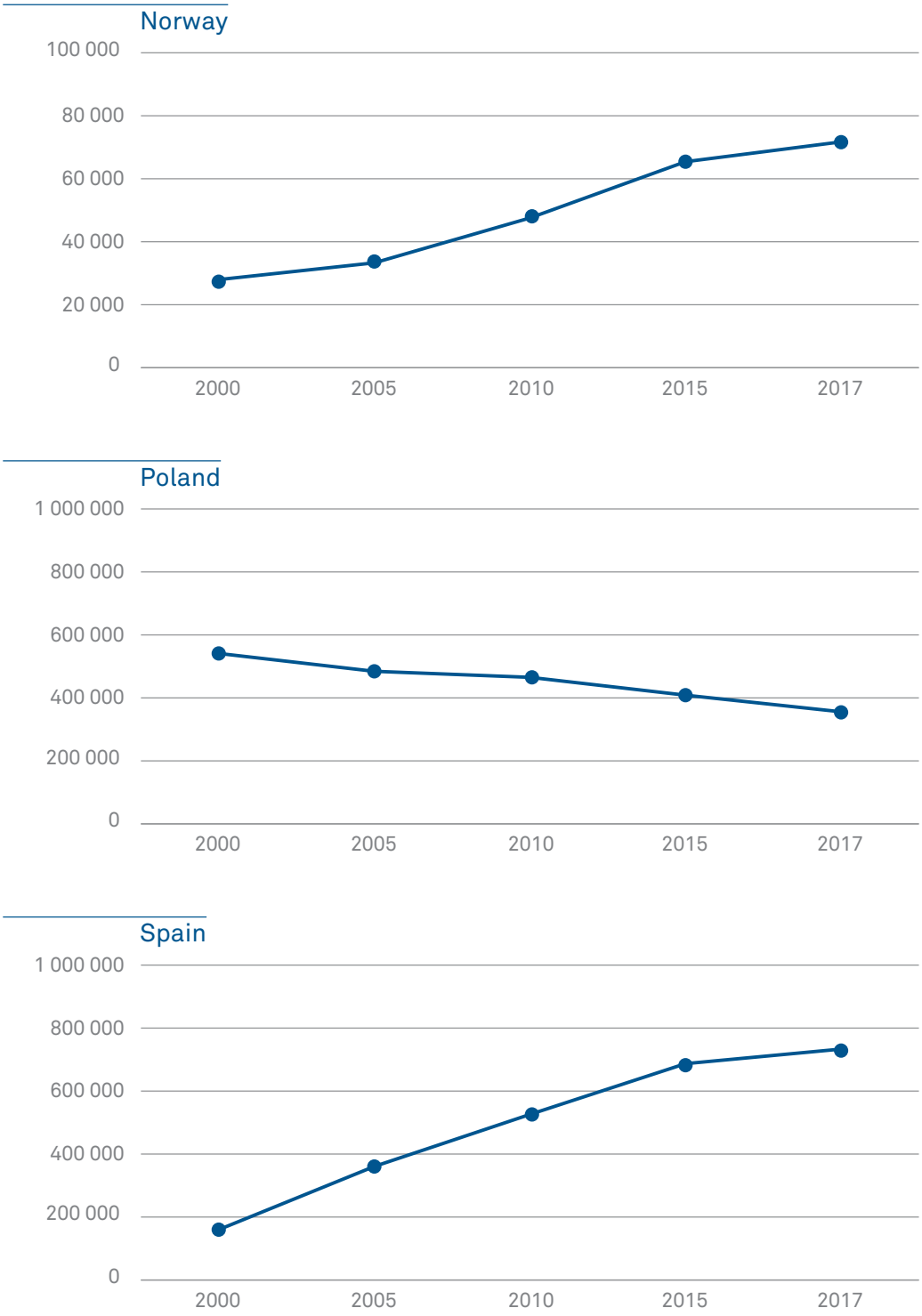


Fig. 1 (contd)



Notes: Data are mid-year (1 July) estimate of the number of people living in a country or area other than that in which they were born; if the number of foreign-born was not available, the estimate refers to the number of people living in a country other than that of their citizenship; because of variation in population size across countries, numbers on the vertical axis are not comparable between graphs.
Source: United Nations, 2017 *(14)*.

Evidence

This brief overview is structured according to the three thematic priority areas for action stated in the Strategy and Action Plan for Healthy Ageing in Europe 2012–2020 *(1)*.

When appraising the literature, it is important to keep in mind the great diversity in health and well-being in older populations in general. Migration forms an additional layer of complexity. Therefore, although there may be specific needs in terms of health and well-being caused by this life event for refugees and migrants, there are many similarities with those of the general population of older adults. (The majority group in the country of destination is referred to in this document as the majority population.) Also, although a growing body of literature explores health and well-being among older refugee and migrant populations, the evidence base is still fragmented, with little internationally comparable information and limited insight into effective strategies for ensuring healthy and active ageing in these groups.

Healthy ageing over the life-course

- Health behaviours and morbidity patterns vary greatly within older refugee and migrant populations according to a range of factors interacting over the life-course of the individual. These include exposures to risk factors in the country of birth, along the migration trajectory and in the country of destination.
- Overall, migrants tend to be healthier upon arrival than both the average citizen of the majority population in the host country and the background populations in their country of birth, but this healthy migrant effect is gradually lost with health behaviours, and morbidity and mortality converge to that of the country of destination over time.
- Variations in health and well-being across the phases of ageing are important to recognize, for example needs and resources often differ between healthy middle-aged adults and the oldest old population, which is at risk of increased frailty, multimorbidity and dependency.
- Whereas majority populations may benefit from a delayed onset of morbidity to older ages (referred to as compression of morbidity), there are indications that migrant populations may not benefit in the same way, thus contributing to growing differentials in health between population groups.
- Self-rated health, well-being and mental health status tend to be lower among older refugees and migrants than in majority populations, with deterioration over time in the host country. Long-term effects of traumatic experiences are of particular concern in refugee populations.
- Gender differences in healthy ageing emerge, with earlier onset of decline, for example, in functional ability in women from some refugee and migrant groups and in older men at risk of loss of social identity tied to working life and friendship circles, in particular when affected by frailty and multimorbidity.

- Refugees and migrants tend to have lower all-cause mortality levels than the comparable majority group in the country of destination despite their often more disadvantaged socioeconomic circumstances. Different exposures to risk factors in the country of birth underlie the varying mortality patterns.

Supportive environments

- Older refugees and migrants are more likely to be financially deprived than older people in the majority population.
- Social networks, including intergenerational and diaspora networks, may be important sources of emotional, financial and practical support for older refugees and migrants.
- Social isolation, feelings of displacement or competing priorities within extended social networks affect health behaviours, health status and utilization of health and long-term care facilities.
- Nongovernmental organizations (NGOs), including faith communities, constitute sources of emotional and practical support, in particular for single or widowed older refugees and migrants.
- While care provided within extended families may be preferred and may be an important source of support, these practices may also lead to risks of overburdening informal caregivers.

People-centred health and long-term care systems

- Informal barriers (e.g. language barriers, lack of awareness of available services) and structural constraints (related to availability, timing and distance) affect access to timely, coordinated and people-centred health and long-term care services for older refugees and migrants.
- Diversity-sensitive policies and practices are needed across the range of health and long-term care sectors for older adults. This includes enhanced cultural competence training for professionals, and adaptations of long-term care services and community-based services to accommodate needs of diverse groups of older adults, including those from a refugee or migrant background.

Core technical content

An overview of health behaviours, morbidity and mortality among older refugees and migrants is necessary for appropriate policy and practice development in the area of ageing and migration. In addition, insights into encounters between these groups and services of relevance to older adults may feed into strategies for improving access to and quality of health and long-term care. The following subsections highlight key findings related to the first three strategic priority areas for action outlined in the Strategy and Action Plan for Healthy Ageing in Europe 2012–2020, and tease out implications for the policy and programmatic levels. As a backdrop to this text, it is important to keep in mind the general risks associated with ageing, which will affect migrant populations in the same way as majority populations (e.g. cognitive impairment, frailty, morbidity, social isolation and dependency) and are in themselves shaped by socioeconomic position and gender. Migration is, therefore, a process of social change adding to these general ageing trajectories, and thus shaping the overall experience of ageing, through its effect on issues such as the ability to maintain functional capability, health and quality of life, and to access quality health and long-term care services at old age. With refugee and migrant populations as active and resourceful citizens of their communities across the European Region, it is important to keep in mind the capabilities and agency of these groups while also attending to unmet needs in older age. Finally, broad generalizations are unwarranted as there is a limited evidence base in the field and there is substantial variation in and among groups with regard to country of birth, length of stay, socioeconomic position, exposures to risk factors and available resources over the life-course.

For most purposes, a distinction should be made between older refugees and migrants ageing in place as they live and grow older in the European Region and newly arrived older refugees and migrants transitioning into the Region at old age.

Healthy ageing over the life-course

Health behaviours, morbidity and mortality patterns vary greatly within older migrant and refugee populations according to a range of factors interacting over the life-course of the individual. These encompass exposures to risk factors in the country of birth, along the migration trajectory as well as in the country of destination. In addition, there are wide differences in health and well-being across the phases of ageing, reflected in the variation in circumstances and needs between, for example, often healthy middle-aged adults and the oldest old population, which is at increased risk of frailty, multimorbidity and, therefore, dependency.

Health behaviours

Health beliefs and health behaviours are largely established prior to old age and shaped by interrelated factors including cultural contexts, gender, religion, socioeconomic

position and wider environmental conditions in both local communities and diaspora communities spanning countries *(15)*. In addition, there are intergenerational differences and variation across the life-course of the individual as well as between newly arrived and more long-term migrants. Variations, consequently, are huge, not least in the context of migration, where understandings of health, well-being and ageing are unfolded in multicultural contexts *(15)*. However, research on health behaviours of older migrants, both newly arrived and those living in the European Region for longer periods, is so far limited.

Gender, or the complex pattern of perceived roles, responsibilities, norms and values of men and women, shape health behaviours across the life-course into old age and the pattern itself is shaped by cultural practices *(15,16)*. This is reflected in many health behaviours; for example, some migrants, in particular from Middle Eastern countries, are less likely to drink alcohol, and ageing migrant women tend to have lower smoking rates compared with majority populations *(17,18)*. Lower participation in screening programmes impedes early detection of diseases of old age *(19,20)*. Again, patterns differ, with some migrants being less likely to participate, possibly because of language barriers not accounted for in service provision or differences in risk perceptions, while others, such as Turkish women in Germany, show high participation rates *(21)*. Overall, there is a need for adapting health promotion programmes to reflect the diverse perspectives and needs of older refugees and migrants, preferably through participatory and engaging approaches co-produced with target groups *(22–25)*. Adaptation to culture and language is essential, and involvement of peers or community health workers should be considered in health promotion programmes for older refugees and migrants *(22,26)*.

Physical health

Overall, there are strikingly similar disease patterns across refugee and migrant populations and background populations but with some variation reflecting a combination of specific exposures to risk factors in the country of birth (e.g. infectious diseases) and, in the European context, modifiable risk factors such as smoking, diet and exercise. While migrants, and to a lesser extent refugees, tend to be healthier upon arrival than both the average majority population citizen and the background populations in their country of birth, this healthy migrant effect is gradually lost over time with health behaviours, and morbidity and mortality gradually converge to that of the country of destination *(27)*. Again, the life-course perspective is important to keep in mind. This is exemplified in the lower risk of developing cancers among many migrant groups in Europe, which is lost with time not only through changes in health behaviours, such as increase in smoking and sedentary lifestyles, but also through exposures to different contextual risk factors, including stressors associated with migration *(28,29)*. For those migrating at older age, research indicates a tendency to poorer overall health at arrival and a higher risk for developing health problems in the country of destination, with a steeper health decline in later life *(10,12,30,31)*. From a health perspective, therefore, the processes of migration and ageing may together

constitute a so-called double burden *(9,12)*. While there is, of course, evidence to show this double burden often does result in vulnerability to poor health, there are also many cases where this is not the whole picture. Many older migrants experience improved well-being, are resource rich and economically and socially active members of families and societies *(9,12,32,33)*. Studies point to the need for screening for both communicable and noncommunicable diseases, and to ensure provision of multidisciplinary and multisectoral health care services at reception centres and other temporary facilities for newly arrived refugees and migrants, with specific needs of older adults integrated under this approach *(34)*.

In terms of chronic diseases, few studies have focused specifically on older refugees and migrants. Complex patterns of health differentials within and between groups appear, with refugees and migrants faring both better and worse than majority populations depending on country, study type, health outcomes chosen and conceptualization of the migrant and refugee populations under study *(27,35)*. Some studies indicate that unfavourable exposures in the country of birth and the country of destination may lead to earlier onset and potentially more severe chronic disease with age among migrants compared with host populations *(36)*. While most cancers are less frequent among migrants from low-income countries, stomach cancer and liver cancer are more common in some groups because of low hygiene and infection with *Helicobacter pylori* and hepatitis B/C viruses in the country of birth *(9)*. For cardiovascular diseases, the picture is more heterogeneous and depends on the risk in the country of birth as well as modifiable risk factors related to diet, exercise and smoking *(37–39)*. In particular, migrants of south Asian origin are at higher risk of both diabetes and cardiovascular diseases, again largely through exposure to modifiable risk factors *(38,40–42)*. Some migrant groups have higher rates of gastrointestinal diseases (including oesophagitis, gallstone disease, pancreatitis and Crohn's disease), infectious diseases (e.g. tuberculosis and hepatitis C) and higher risks of respiratory disease compared with host populations *(43)*. As is the case in the general population, and in particularly among ageing people, multimorbidity is common among migrant groups in Europe *(41,44)*. Older migrants often show poorer health status even after controlling for social and economic disadvantages, and health differentials between migrants and the majority population increase with age for both men and women *(45)*. This raises concerns that migrant and refugee groups may not benefit in the same way as majority populations from an increasing compression of morbidity at old age. This would contribute to growing differentials in health between population groups, although more evidence is needed in this area *(46)*.

Self-rated health and mental health

Self-rated health is strongly related to future morbidity and mortality, and ageing refugees and migrants may be comparatively more likely to rate their health as poor *(45)*. Psychological distress is related to a range of individual and contextual factors, including stressful situations such as marginalization, poor housing conditions, low standards of living and absence of family and confidants, which may be more common

among refugees and migrants of lower socioeconomic position and may carry particular significance at old age *(9,47,48)*. In particular, migrants in irregular situations and the growing group of asylum seekers are at risk of adverse mental health outcomes through a combination of risk factors encountered during prolonged phases of insecurity and lack of access to mainstream health and long-term care, including social services *(49)*. Long-term effects of traumatic experiences may be particularly evident among refugee populations. Lower subjective well-being and mental health (as reflected in depression, anxiety and loneliness) tend to be more common in migrants, and further may deteriorate with time, albeit with great variations between countries and migrant groups *(47,50,51)*. Integration policies play a role, with one study finding more restrictive policies to be associated with lower levels of subjective well-being *(50)*. The prevalence of poor mental health tends to be higher among migrant groups overall and in particular in refugee populations, partly as a result of exposure to stressors during migration; specifically, depression, anxiety and post-traumatic stress syndrome are of importance among older refugees *(47,51–53)*. Suicide is a less common cause of death, although suicide rates among ageing migrants are increasing *(42,54,55)*. It is, therefore, important to differentiate between those migrants who are long-term residents and those who are newcomers to a country when developing mental health screening programmes and services targeted at improving mental health among older refugees and migrants.

Higher burdens of mild cognitive impairment and dementia among migrant groups compared with majority populations have been documented *(56)*. Migrants are often diagnosed with dementia later, are prescribed and take medication to a lesser degree and are less likely to be admitted to nursing homes; they also have different views on end of life care compared with majority populations *(57)*. These inequalities may reflect cultural differences, limited knowledge and awareness, previous negative experiences with personnel or systems and language barriers. The loss of second language (that of the country of destination) is of particular concern.

Persistent or chronic pain has been identified as a burden, in particular for migrant and refugee women, with considerable negative effects on quality of life, social participation within and outside of families and health care utilization *(57)*. Gender differences in healthy ageing emerge, with differences in experiences of ageing processes *(57–59)*. Ageing processes among older refugees and migrants are shaped by the experience of low levels of functional capability; this is of particular significance in women with multimorbidity and low social support, who may experience declining health and lack of possibilities for mastery as early as in their forties *(57,58)*. For older men, in particular those who are single or widowed, transitioning from work life to retirement and the loss of social identity tied to working life and friendship circles in this context may be accentuated by frailty and multimorbidity *(59)*. Finally, migrants may have lower levels of activities of daily living compared with majority groups in a range of countries; however, relative differences depend on the level of functioning in majority groups *(60)*.

Mortality patterns

Few studies have explored mortality among older refugees and migrants, making it necessary to extrapolate from patterns based on populations encompassing all age groups and often with little differentiation according to sex, socioeconomic position, country of birth and duration of stay. Return and circular migration processes, and associated underreporting of mortality in refugees and migrants, compromises the ability to provide detailed insight into mortality differences *(61)*. In general, refugees and migrants tend to have lower all-cause mortality levels than the majority group in the country of destination in the first generation despite their often more disadvantaged socioeconomic circumstances *(27,37,54,62–64)*. The cause-specific mortality pattern differs according to disease, age group and country of destination; for example, most migrants have higher mortality linked to infectious diseases and cardiovascular diseases while cancer mortality and suicide rates are lower *(42,65)*. Different mortality patterns compared with majority populations in a study of nine European countries are partly explained by exposures in the country of birth in addition to the variation of factors at play over the life-course of the individual *(7,27)*.

Supportive environments

Supportive environments enable older refugees and migrants to live independently in good health, stay engaged in social relationships and uphold social roles important to well-being. In particular psychosocial circumstances, informal care and community dimensions emerge as important for the health and well-being of older refugees and migrants.

Psychosocial circumstances

Migration affects the psychosocial circumstances of individuals, families and larger communities in both country of birth and country of destination. As younger and healthier individuals are more likely to migrate, resources in the community of origin may be drained, leading to changes in supportive family and community structures that affect older adults left behind in countries of origin but also in rural areas with often fewer and more dispersed services available for older people. Older refugees and migrants are more likely to be financially deprived because of lower income, higher unemployment rates and, therefore, less generous pension plans accrued over their life-course. Of particular relevance for health behaviours and disease management among ageing migrants are the competing demands they may experience in daily life, making it hard to prioritize health. This relates, for example, to extended families. While these may comprise a valuable source of support in everyday life for older migrants, social roles and obligations may also be resource demanding *(58,59,66)*. Responsibilities for the well-being of extended families and preferences for upholding care within families may negatively affect the ability to maintain health (e.g. through regular physical activity) or to seek health care if symptoms arise *(58)*. Financial obligations (e.g. sending remittances to family members in the country of birth) may be an additional

responsibility for ageing migrants, thus reducing their financial capability for health-related expenses *(66)*. However, it is important to note that emotional, financial and practical support in intergenerational relationships are often circular and help to provide solidarity across older migrants and their family members within and across nation states *(67)*. In this sense, social networks may contain both buffering and stress-inducing capacities. Psychosocial circumstances such as social isolation, feelings of displacement or competing priorities within extended family networks among some older migrants may nevertheless reduce engagement in health promotion activities and negatively affect their ability to cope with disease, thus shaping health status and health care utilization *(57,66)*. Whereas old age in some cultures is associated with high status and respect within families and communities, this is often not the case in the countries of destination, leading to a loss of social status and social roles that may be hard to cope with for older refugees and migrants.

Even if refugees and migrants are part of extended family networks, the availability of supportive networks should not be assumed, in particular among refugee groups. Through the process of resettling into the WHO European Region, family networks may have been dispersed, sometimes across several countries. This transnational feature of the social networks of refugees and migrants is important for policy and practice development as intergenerational support for care at old age may be challenged by geographical distances, affecting both relatives abroad and older refugees and migrants in European countries. Against this, transnational networks may be important providers of resources in old age. In particular, recent migrants and those experiencing functional decline at old age may find themselves in a situation with few contacts to the wider community if isolation is not countered through bridging these groups with available public, private and third sector (voluntary and community) services and resources *(58)*. Faith communities, for example centred on churches, mosques and temples, play an important role as sources of emotional and practical support, in particular for single or widowed older refugees and migrants *(68,69)*. While faith communities and other sources of informal support constitute important and culturally appropriate settings and resources, they may fill gaps in access to formal care services rather than supplementing these services. This is a cause of concern in terms of ensuring diversity-sensitive supportive environments. In addition, those with potentially stigmatizing diseases may be socially isolated and correspondingly in need of formal social support provided by professionals or patient or volunteer associations *(59)*.

Informal care and community dimensions

There may be differences in norms related to family responsibility in that some ageing refugees and migrants prefer to be cared for by their family members rather than professional caregivers *(70,71)*. While this can constitute important resources for older adults and their communities, the risks of overburdening informal caregivers should be acknowledged, in particular younger female relatives. In addition, housing conditions in most European contexts do not necessarily accommodate extended families *(70)*. Again, diversity across different groups exists, with some refugees and

migrants preferring formal, paid care *(72)*. Both long-term care and assisted living arrangements should be inclusive of refugee and migrant populations, for example through ensuring staff represent different linguistic and cultural backgrounds; providing interpreters and translated materials; offering culturally appropriate food and catering for diversity in traditions; and enabling a more active role of relatives in caring for older adults, thus supporting intergenerational engagement *(72–74)*. From a community planning perspective, strategies in the field of age-friendly environments should accommodate for the growing proportion of older refugees and migrants in terms of physical environments, social environments and municipal services. In particular, social inclusion, non-discrimination and social participation are important in the context of increased diversity in ageing communities. NGOs, sometimes based on cultural, religious and/or political ties, are often a source of social embeddedness for older refugees and migrants that could be engaged in partnerships, for example when planning and delivering community-based health promotion activities *(74–77)*. Although little research exists on the role of social enterprises, often run by refugees and migrants in their communities, these small businesses may comprise important resources of engagement and social participation for older refugees and migrants. For example, they may be involved as paid part-time or voluntary staff, thereby reducing the risk of isolation after abrupt retirement. Identifying and engaging with such associations, enterprises and resource people in specific groups and communities with high proportions of older refugees and migrants can support user engagement, ensure the relevance and accessibility of services and may provide important avenues for linking older adults and their families with public and private services.

People-centred health and long-term care systems

Access to timely and high-quality people-centred health care, as well as to the range of relevant long-term care services over the life-course and for older people in particular, is important for healthy and active ageing to take place. Therefore, people-centred health and long-term care systems acceptable for older refugees and migrants in terms of access, entitlements, utilization and quality of care form part of a universal health coverage approach. In this framework, all individuals irrespective of country of birth should be ensured access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship *(78)*. Research on access to and utilization of health and long-term care among ageing refugees and migrants in the WHO European Region is scarce. Inequity in health care access and quality may be a particular concern since austerity in health systems is reflected also in reduced support for interpreter services across the Region, which will affect older refugees and migrants disproportionally. Structural constraints related to availability and timing of services and geographical distances may affect access and utilization of services as these may no longer be able to adapt to take account of factors such as working schedules of those still working and/or carers providing transport to medical appointments. Often, main barriers lie in accessibility and awareness of

available services across health and long-term care systems. For example, utilization of primary health care services, health promotion programmes and rehabilitation programmes is often lower among migrants than among the majority populations *(79,80)*. Language barriers are a key factor, in particular for those newly arrived but also for those who, with age, experience a loss of learned second languages, thus necessitating care provided in their mother tongue or access to trained interpreters in caring encounters *(13,81,82)*. Limited proficiency in the majority language negatively affects the ageing process, in particular for those who lack a social support network within their own language and cultural group *(82)*. Older migrants are at risk of becoming dependent on others to bridge language barriers, and they express insecurity that impacts formation of social ties, feelings of belonging and well-being *(58,81,82)*. In addition, other processes, or differential treatment based on preconceived opinions among professionals, can negatively affect caring encounters for older migrants *(59,83,84)*. There is a need for diversity-sensitive approaches that ensure services accommodate values and practices of different groups in terms of issues such as food preferences, religious practices, and roles and expectations for involvement of informal carers. Finally, there is a clear need for cultural competence training as part of all education involved in health and long-term care services *(13,35,59,85)*.

Other likely barriers for people-centred care for older refugees and migrants, albeit understudied, include low health literacy, which also affects the ability to benefit from innovations in the rapidly expanding field of e-health and other digital technologies, and co-payment/user fees, which affect lower income groups disproportionately. Furthermore, fragmented social networks have an adverse effect on the ability to seek care and adhere to treatment plans among ageing refugees and migrants *(86–89)*. Stigmatized and/or isolated groups, such as those living with mental illness or substance abuse, are particularly at risk of suboptimal access to care. A combination of language, cultural, spatial and financial barriers are often at play *(90)*. Formal barriers related to financial (e.g. health insurance coverage) and legal entitlement (residency status and/or legal status) to services should be addressed to protect the right to health. Special attention should be given to vulnerable groups, such as migrants in irregular situations and asylum seekers, who may experience lack of entitlement to care and, therefore, depend on services provided by NGOs *(49,91,92)*. Given the often more disadvantaged socioeconomic circumstances of refugees and migrants, services requiring user fees/co-payment are more inaccessible and this is reflected in lower uptake of areas such as dental services among migrants *(9,93)*. Lack of medication adherence is a concern among older refugees and migrants, in particular those with multimorbidity and associated polypharmacy issues. This results from a complex interplay of illness perceptions, low health literacy, language barriers and disadvantaged socioeconomic circumstances, which at times can restrict the ability to purchase prescribed medications *(94–96)*.

Circular migration, or temporary and usually repetitive movement of migrants between country of birth and other countries, is motivated by a range of factors, including sense of belonging, need to visit relatives abroad, employment opportunities but also health care utilization. Cross-border health care use is probably more common among

migrants than refugees because of the particular legal and practical restrictions on movements for the latter group. Seeking health care for diagnosis or treatment abroad may be costly and result in suboptimal care trajectories, and it often reflects barriers for and dissatisfaction with available services in the country of destination *(97,98)*. Dialogue between patients and health care providers related to possible parallel health care use is recommendable to ensure effective case management, which is of importance also for polypharmacy and treatment outcomes.

With an increase in the number of older refugees and migrants, services such as long-term care facilities and palliative services should be responsive to the needs of these groups. Barriers for the provision of diversity-sensitive care at the end of life are related to limited awareness of available services, lack of resources for case management when faced with complex needs and language barriers, and insecurity on the part of professionals in terms of how to raise issues of death and bereavement with families of different cultural backgrounds *(9,27,77,99)*. Overall, there is a need for diversity-sensitive policies and practices in different health and long-term care sectors of relevance to the growing and diverse population of older refugees and migrants *(7,9,32,100)*. Narrative approaches to caring encounters, elucidating stories of health, illness, displacement and other life experiences influencing their health and well-being in old age, are particularly useful as tools to improve care for older refugees and migrants. Such approaches capture the cultural, migrant-related and more general psychosocial circumstances of importance to the individual, often with implications for provision of care. This would include illuminating key life experiences, resources and strains in social relationships and perceptions of ageing trajectories (Box 1) *(58,101,102)*.

Box 1. Family, freedom and belonging: voices of older migrant and refugee women

A study explored perceptions of ageing and return migration among middle-aged and older migrant and refugee women in Denmark. They appreciated the availability of high-quality health care and social services providing financial and tangible support for older people, but they highlighted the need for adjusting long-term care facilities to the languages spoken and the cultural backgrounds of older migrants and refugees:

> *I think there should be at least one home for older migrants per municipality. We understand each other because I've seen this [experienced the same things as other migrants], and it helps a bit.*

Social ties to children and grandchildren in Denmark and feelings of belonging further nourished a wish to stay in Denmark rather than return to the country of origin.

> *Because we have children here, my daughter here, and all family here, what should I do in Iraq? Only my mother [is in Iraq] .... But all family is here. I can't leave.*

> *I feel more Danish in my behaviour and thinking and such things, but Pakistan is still inside of me. But when we travel to Pakistan for a month and up to a month and a half, then you get tired, then you would like to go home [to Denmark].*

Box 1. (contd)

However, dilemmas were apparent, in particular for older refugees who had little room for deciding on where to grow older.

> *You'd prefer to die in your own country rather than dying in a foreign country.*
>
> *For me, I'm happy to be here. Especially, when I came to Denmark, we feel free. Here, we can talk... We can do what we want. I mean, especially, we were forbidden [in country of birth], afraid to talk about everything. Now it is too late to [return]. I feel like, this country, I have got used to it.*

Source: Kristiansen et al., 2015 *(58)*.

Summary: explanatory factors and opportunities for action

Health, well-being and quality of life of older people depend on ageing in good health and upholding meaningful roles and activities within immediate and wider social relationships. With increased heterogeneity in older populations created by migration patterns into the WHO European Region, practices and policies should reflect the diversity in understanding of what it means to age well and how this can be achieved despite the various limitations that growing old can generate *(103)*. As discussed, a range of individual, social, contextual and policy level factors come together in explaining differences and similarities in health behaviours, health patterns, access to and quality of health and long-term care, and more broadly the healthy ageing trajectories, in older refugees and migrants *(3,4,7)*. Some key explanatory factors at play across the life-course include:

- migration trajectories, with vast heterogeneity in resources and exposures to risk factors before, during and after migration between individuals, groups and indeed countries of destination;
- age in itself, with differences in circumstances across the different phases in the ageing trajectory;
- age at migration, with differences in needs and resources among recently arrived older refugees and migrants compared with those who have lived in the Region for longer periods, thereby ageing in place;
- gender, with women having both specific risks (e.g. violence or isolation) and specific resources (e.g. in terms of social relationships and social roles); and
- socioeconomic status and psychosocial circumstances, with refugees and migrants showing both vulnerabilities but also agency as they mobilize sociocultural resources to uphold a meaningful and active old age given structures and past experiences.

All this is shaped by social determinants of health, which include community level and policy factors. A comprehensive approach working with individuals, families,

communities and relevant formal sectors is needed if we are to enhance health among older refugees and migrants and, in turn, the communities and societies they are part of. This entails involvement of health care services, long-term care systems and wider age-friendly environments as outlined in WHO strategies and action plans within the field of ageing and health *(1,2,5,6)*. Preferably, strategies should combine ones for high-risk groups and population-based approaches, with a focus on early interventions across the life-course. Recognizing diversity within the heterogeneous and growing population of older refugees and migrants is of paramount importance, not least to avoid stigmatizing groups that are already at risk of both stereotyping and discrimination through their minority status and age (ageism) *(83)*. While services specifically targeted to older refugees and migrants may be warranted to respond to issues such as language and cultural needs, the overall aim should be to ensure diversity-sensitive policies and practices that enable inclusive communities and health and long-term care systems for diverse ageing populations based on the right to health of all groups in society *(104)*. Finally, while the combination of being both a migrant and an older person may create particular vulnerabilities to be overcome, it is important to acknowledge the agency enacted by older refugees and migrants and their contribution as socially active, economically productive and rich resources of knowledge in their communities *(7,9,12,33)*.

Areas for intervention

Overall, there is a limited evidence base in terms of effectiveness of interventions to promote health and well-being among older refugees and migrants across countries in the WHO European Region. While a range of mostly short-term interventions targeting different dimensions of healthy ageing has been implemented across the Region, external evaluations, in particular with stronger methodological designs, are scarce, thereby limiting transferability of activities and learning across contexts.

Case studies 1-6 represent examples of promising practices and are chosen to represent a diversity in approaches to enhancing health over the life-course, ensuring supportive environments and facilitating people-centred health and long-term care systems inclusive of older refugees and migrants.

Case study 1. Health education and exercise to improve mental health of older migrants (the Netherlands)

A randomized controlled trial of a Dutch health education intervention conducted in six cities among people born in Turkey aged 45 years and older found positive mental health effects in participants. Participants were socioeconomically disadvantaged and had low levels of fluency in Dutch. A Turkish peer educator delivered the intervention, which consisted of a total of eight two-hour sessions based on exercise and health education (focusing on means to maintain good health) adapted to culture and knowledge of the target groups.

Source: Reijneveld et al., 2003 *(105)*.

Case study 2. The migration bus project linking older migrants to communities and services (Switzerland)

The migration bus project was a social and relational-focused initiative seeking to engage migrants who had lived their working life in Switzerland. Many of these migrants stayed in Switzerland after retirement, as they wanted to stay close to their children or because they no longer had social relations in their country of birth. The function of the migration bus was to provide information material in a range of languages and to bring volunteers representing migrant origins closer to older migrants in various areas of Switzerland. The volunteers would contact older migrants at multicultural festival events, discussion podiums and through visits to older people's homes.

Source: European Older People's Platform, 2008 *(106)*.

Case Study 3. Association Ayyem Zamen: addressing health needs of older migrants through social inclusion (France)

The association AYYEM ZAMEN was founded in 2000 and provides the legal framework for the creation of Café Social and Shared Homes. The association responds to needs among older migrants living in precarious conditions, isolated, not knowing their rights and or the means of accessing benefits and services. This grouping may have specific needs in old age, but service provision is not always adapted to these.

The Café Social initiative addresses the lack of attention given to migrants experiencing the transition from working life to retirement and experiences related to older age. The aim is to reach out to older migrants, focusing on participation in their social life. Café Social offers a meeting place for this group, promoting social bonds and integration, and supporting them to age well in respect of their choices and their expectations. It aims to create, coordinate and promote strategies to welcome, listen to, value, guide and support these people; to preserve their autonomy; and provide access to rights information. The drop-in service operated in the reception offers social worker support, access to health promotion and facilitates access to health services. During an interview at reception, the social worker first makes an assessment of the social situation of the person and his or her needs. The social workere will then develop a plan of action and identify a dedicated support to guide the older person to get the services required.

Source: Le café Social, 2018 *(107)*.

Case study 4. Involving the third sector (voluntary organizations) in active ageing interventions across generations and settings (EU)

A best practice competition held in 2008 highlighted promising approaches in the arena of active ageing among older migrants in the EU. A broad range of activities across countries was represented among winners of the competition. These included senior citizen centres specifically targeting refugees and migrants. Activities in these centres included an open multilingual consultancy and diverse culturally sensitive leisure activities for different groups of older refugees and migrants. Intergenerational activities also showed potential as exemplified in projects with migrant women visiting majority population residents at nursing homes. This approach aimed to enhance support and well-being of participants while contributing to integration through unlocking resources among migrants and building bridges between minority and majority groups. Further examples were initiatives building on older migrants engaging with youth also of migrant origin. This approach addressed both loneliness in old age by activating competences and maintaining abilities of older people and provision of support for teenagers, who were often found to be in need of supportive role models.

The competition also highlighted successful collaborations between public and voluntary sectors in advocacy and co-creation of age-friendly communities that encompass the needs of older refugees and migrants.

Source: Ministry for Intergenerational Affairs, Family, Women and Integration of the State of North Rhine-Westphalia, 2010 *(108)*.

Case study 5. Digital tools for inclusion and integration in communities (EU)

Different mobile phone applications (apps) are emerging with the aim of helping migrants upon arrival into various cities across Europe. Apps, if appropriately designed for use in older populations (e.g. in terms of size of print), may help in overcoming a range of challenges upon settling in a new context, many being of particular importance for older refugees and migrants. They need to be accessible for migrants with restricted phone plans and to be available in multiple languages. Functionalities are many, including maps of cities; help in understanding public transport schedules; information on available health and social services; and language support, such as basic phrases in majority languages and access to online translation chat rooms staffed by volunteer translators. In addition, apps are used to involve refugees and migrants in campaigns at social media platforms to highlight diversity and show evidence of the positive contributions of migrants, as exemplified by the TOGETHER app created by the International Organization for Migration.

Source: International Organization for Migration, 2018 *(109)*.

Case study 6. People-centred engagement of older migrants in health and long-term care (the Netherlands)

Leyden Academy in the Netherlands has developed an instrument to provide citizen-centric assessments of life domains of importance to older adults, the so-called Life and Vitality Assessment (LAVA) *(110)*. The instrument was developed together with older people to map and discuss what older people found important in their lives, how satisfied they were with this and if they wished to change this (or accept this); if so what steps they would like to take and who or with whom they would take these steps. The instrument is a conversation guide encompassing a wide range of domains in life while allowing for additional domains to be raised and assessed in encounters. A migrant version was developed in conversation with interest organizations for older people with a migrant background and professionals. This was informed by focus groups among the largest migrant groups in the Netherlands, identifying domains of importance for migrants, and adaptation of the procedure, layout and material for older people with a migrant background with considerations of using pictograms rather than text.

Source: Leyden Academy on Vitality and Ageing, 2018 *(110)*.

Policy considerations

The following overall guiding principles and more specific considerations may inform policy and practice developments to enhance health and well-being of older refugees and migrants within the EU and the larger WHO European Region.

General guiding principles

- With migration playing a significant role in shaping European populations, the intersection between migration and ageing is of key importance – both as a challenge and as an opportunity – for policy-makers and practitioners in the WHO European Region.
- Older refugees and migrants are just older adults that have at one point in their lives migrated. Migration, therefore, adds yet another layer of complexity to the already very diverse ageing trajectories in populations across the Region.
- Health of older refugees and migrants is an integral part of human rights. Healthy ageing policies attending to diversity can contribute to closing the gaps in health inequalities in older populations.
- Policies and practices should reflect the huge diversity among older refugees and migrants, and avoid adding to negative sentiments towards these populations, which are socially active, economically productive and rich resources of knowledge in their communities.
- For most purposes, a distinction should be made between older refugees and migrants ageing in place as they live and grow older in the Region and the newly arrived older refugees and migrants transitioning into the Region at old age.
- Responding to the needs of older refugees and migrants should be integrated into all dimensions of ageing policies and practices across the Region, with adequate resource allocation.
- To be effective, policies and practices should endorse life-course approaches to counter inequalities in older life among refugees and migrants in the Region. Particular attention should be given to vulnerable groups, including migrants in irregular situations, asylum seekers and traumatized refugees.
- Health and long-term care systems should ensure that services are accessible and acceptable to all groups, including more settled refugees and migrants ageing in place and recently arrived groups. This also entails accommodating diversity (e.g. gender, culture and socioeconomic position) and recognizing variations in resources and needs among middle-aged individuals and the oldest old part of the population.

Specific considerations

Healthy ageing over the life-course

- As health in old age is shaped by accumulated disadvantages and buffering resources over the life-course of the individual in his/her wider context, a true comprehensive approach to enhance health and well-being at old age should target factors as they unfold over the relevant phases of the life-course. This comprehensive longitudinal approach challenges current policies and practices with a local focus since risk factors for refugees and migrants unfold in the country of birth, along the migration trajectory and in the country of destination.
- There is a need for a special focus on diseases known to be of higher prevalence in older refugees and migrant groups. This should be embedded within gender-sensitive and age-relevant frameworks to accommodate for diversity across social identities and life-course phases.
- Important focus areas are poor mental health, long-term effects of traumatic experiences and social isolation in widowed or lone refugees and migrants or in the oldest old population of refugees and migrants living with frailty.

Supportive environments

- The third sector, and in particular social enterprises run by refugees and migrants in their communities, may provide important, yet untapped, resources of engagement and social participation for older refugees and migrants.
- Collaborations with NGOs based in local communities may enhance access to support needed at old age, in particular for single or isolated older refugees and migrants.
- Informal caregivers should be supported to avoid overburdening these individuals while also ensuring access to formal care when needed.
- For strategy and programme purposes, estimation of care demands and preferences among older refugees and migrants is needed.
- Special focus should be given to ensuring age-friendly communities, including adequate housing, outdoor areas and community services in areas with high proportions of older refugees and migrants, who are often of lower socioeconomic position.

People-centred health and long-term care services

- Overall, diversity-sensitive policies and practices across health and long-term care facilities for older adults are needed to ensure that all people and communities, including older refugees and migrants, can use the services they need, that these services are of sufficient quality to be effective and their use does not expose the user to financial hardship. Ensuring access to skilled interpreters in both health and long-term care systems is an integral part of universal health coverage and should be enforced also in times of austerity.

- Services specifically targeted to older refugees and migrants may be warranted to respond to issues such as language and culture-specific needs, or to ensure outreach that will bridge between available services and underserved groups. This includes providing materials in relevant languages; delivering activities relevant for specific religious practices, such as informing on health dimensions of fasting; or recruiting into mainstream services through involvement of cultural mediators.
- Sharing of knowledge and experiences in services development, implementation and advocacy for older refugees and migrants across countries is needed to develop best practices and leverage resources and capabilities across the WHO European Region.
- Older refugees and migrants, given the heterogeneity of their life-courses and migration trajectories, must be involved in formulating and shaping their care based on principles of inclusive, people-centred care provision. User engagement tools building on elucidating life-stories, illness perceptions and care needs and preferences are important, although to the best of our knowledge few tools have been tested in older refugee and migrant populations.
- Implementation of diversity training across professions in health and long-term care sectors is needed to ensure provision of culturally appropriate, people-centred and inclusive care for all older adults irrespective of country of birth. A variety of delivery modes should be considered, including webinars, training programmes, written material, case studies and supervision. Involvement of older refugees and migrants in material such as framing case studies should be encouraged.

Strengthening the evidence base and research

- Monitoring of health and utilization of health and long-term care facilities for older refugees and migrants is needed at country levels. This will facilitate accountability towards ensuring the right to health for all groups, as well as allowing for identification of underserved and/or at-risk groups in need of policy and practice initiatives. A minimal set of indicators is needed to facilitate comparisons across countries, and data should be segregated by factors such as country of birth, ethnicity, sex, age and socioeconomic position.
- More detailed analysis of the range of individual, social and structural factors shaping health among older people in general, and in refugee and migrant groups in particular, is needed. This will help to unpack the relative and combined effects of general socioeconomic circumstances (e.g. income, education and housing conditions) and factors specific for refugees and migrants (e.g. risks along the migration trajectory, cultural norms, language barriers and dispersed social networks) feeding into interventions.
- More systematic evaluations of policy and practice initiatives for, or inclusive of, older refugees and migrants are needed to strengthen the evidence base. More applied, participatory research is needed to ensure diversity sensitivity in emerging practice initiatives. Theory-driven evaluation and complex intervention designs may bring important insights into what works for whom in what settings

and why, thereby bringing in the role of context for transferability of interventions across groups, settings and countries.

- More insight into access to and quality of health and long-term care for older refugees and migrants is needed to identify informal and structural barriers to be overcome when working towards diversity-sensitive care provision. Particular emphasis should be on identifying vulnerable groups with complex needs and/or suboptimal access.
- More research into the role of different formal and informal community organizations, settings and resource personnel is needed, including potential gaps in service delivery reflected in the involvement of informal sectors.

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Recommended reading

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Annex 1. Development in numbers of foreign-born older adults over time

Table A1.1. Population of foreign-born people aged 60+ in countries participating in the EU Health Programme, 2000–2017

	2000	2005	2010	2015	2017
Austria	193 162	224 549	245 457	288 619	374 800
Belgium	132 714	133 949	173 301	174 166	177 512
Bosnia and Herzegovina	12 615	7 729	5 744	5 301	5 193
Bulgaria	11 877	16 481	20 223	27 638	28 004
Croatia	143 890	156 387	168 878	169 615	171 266
Cyprus	7 296	11 139	18 258	22 045	22 858
Czech Republic	80 748	52 645	20 082	34 326	38 478
Denmark	39 265	49 857	60 441	74 280	80 883
Estonia	101 960	101 041	100 175	101 698	93 483
Finland	12 650	16 317	19 979	25 767	29 881
France	1 550 100	1 731 831	1 955 773	2 329 726	2 368 429
Germany	1 415 713	1 531 962	1 831 192	2 054 235	2 446 503
Greece	133 429	132 019	136 298	171 223	188 121
Hungary	100 600	104 070	107 533	105 094	108 343
Iceland	1 558	1 715	1 866	2 591	2 822
Ireland	32 182	54 086	67 083	79 278	87 726
Italy	227 781	359 487	424 326	537 580	547 059
Latvia	166 818	146 094	153 723	149 933	148 382
Lithuania	65 551	73 803	62 298	57 721	55 233
Luxembourg	18 740	20 276	33 615	41 573	42 563
Malta	3 047	3 897	5 081	6 830	7 133
Netherlands	206 111	256 437	294 638	362 597	377 163
Norway	27 976	33 299	47 548	65 414	71 708
Poland	541 121	484 426	465 291	408 641	355 875
Portugal	52 207	60 574	59 897	101 165	116 423
Republic of Moldova	73 601	54 191	55 732	55 084	52 676
Romania	65 634	69 679	71 718	44 364	46 779
Serbia	262 416	281 961	299 735	305 816	343 606
Slovakia	34 153	43 622	56 005	62 238	64 037
Slovenia	22 549	36 116	55 551	61 879	66 671

Table A1.1. (contd)

	2000	2005	2010	2015	2017
Spain	159 928	360 681	525 758	687 058	733 320
Sweden	202 891	230 111	275 480	323 935	334 007
United Kingdom	939 371	1 019 840	1 171 281	1 244 432	1 266 591

Notes: Data are not available for Montenegro and the former Yugoslav Republic of Macedonia; Data are the mid-year (1 July) estimate of the number of people living in a country or area other than that in which they were born; if the number of foreign-born was not available, the estimate refers to the number of people living in a country other than that of their citizenship.
Source: United Nations, 2017 *(1)*.

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Annex 2. Resources and toolkits

Healthy ageing

The Life and Vitality Assessment (LAVA) and a range of other resources in the field of healthy ageing for diverse populations are available from the Leyden Academy on Vitality and Ageing.

Leyden Academy on Vitality and Ageing (2018). Life and vitality assessment. Leiden: Leyden Academy on Vitality and Ageing (https://www.leydenacademy.nl/life-and-vitality-assessment-2/, accessed 29 August 2018).

The Report, Active ageing of migrant elders across Europe from 01.12.2007 to 30.11.2009, summarizes a project carried out over a two-year period within a German state and across Europe, including input from several voluntary organizations of migrant elders and scientific experts. The Report provides evidence and considerations for action at municipal, regional and European level for supporting elderly migrants.

Ministry for Intergenerational Affairs, Family, Women and Integration of the State of North Rhine-Westphalia (2010). Active ageing of migrant elders across Europe from 01.12.2007 to 30.11.2009. Report of the project. Düsseldorf: Ministry for Intergenerational Affairs, Family, Women and Integration of the State of North Rhine-Westphalia (http://www.healthyageing.eu/sites/www.healthyageing.eu/files/resources/Active_Ageing_of_Migrant_Elders_Across_Europe_Project_Report.pdf, accessed 30 August 2018).

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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