Belgium

Population
11,550,000

Area
30,528 km^2

Capital
Brussel

3 largest cities
Antwerp (529,000)
Ghent (264,000)
Charleroi (203,000)

Neighboring countries
France, Germany, Luxembourg, the Netherlands

1. Migration history

Belgium was an emigration country in the past. Between 1830 and 1914, a large part of the population emigrated due to poor working conditions and economic circumstances. During the two world wars, about two million people fled the country. The history of immigration began during the First World War when people from neighbouring countries, Eastern Europe, and Italy searched for work in Belgium. In the interwar years, migration increased significantly as a result of government recruitment campaigns for the prospering coal industry. In 1930, the Belgian mining industry employed approximately 30,000 foreign workers. After an agreement with Italy, 110,000 workers arrived between 1946 and 1956 from Italy. Subsequently, Belgium concluded bilateral recruitment agreements with countries such as Spain (1956), Morocco (1964), and Turkey (1964). In the late 1960s and early 1970s, Belgium then attempted to limit immigration through strict guidelines. However, this led to the situation wherein people who had already immigrated from non-European countries stayed permanently. In addition, refugees from conflict areas, foreign students, and migrants from the new EU member states took the place of migrant workers. Overall, immigration figures continued to rise until 2011. After a brief decline in migration as a result of a more restrictive immigration policy towards non-EU foreigners, the figures increased again from 2015 onwards. In 2017, migrants from Morocco were the largest migrant group with 215,000 people, followed by France (185,000), the Netherlands (130,000), and Turkey (98,000) [1]. Between 1990 and 2019, the migrant population (born abroad) increased from 1.3 to 2 million people and the migrant proportion in the total population rose from 12.8 to 17.2% [2]. The net migration rate has always been positive and as of 2020 amounts to 4.2 [3].

2. Estimated number of people with a migration background with dementia

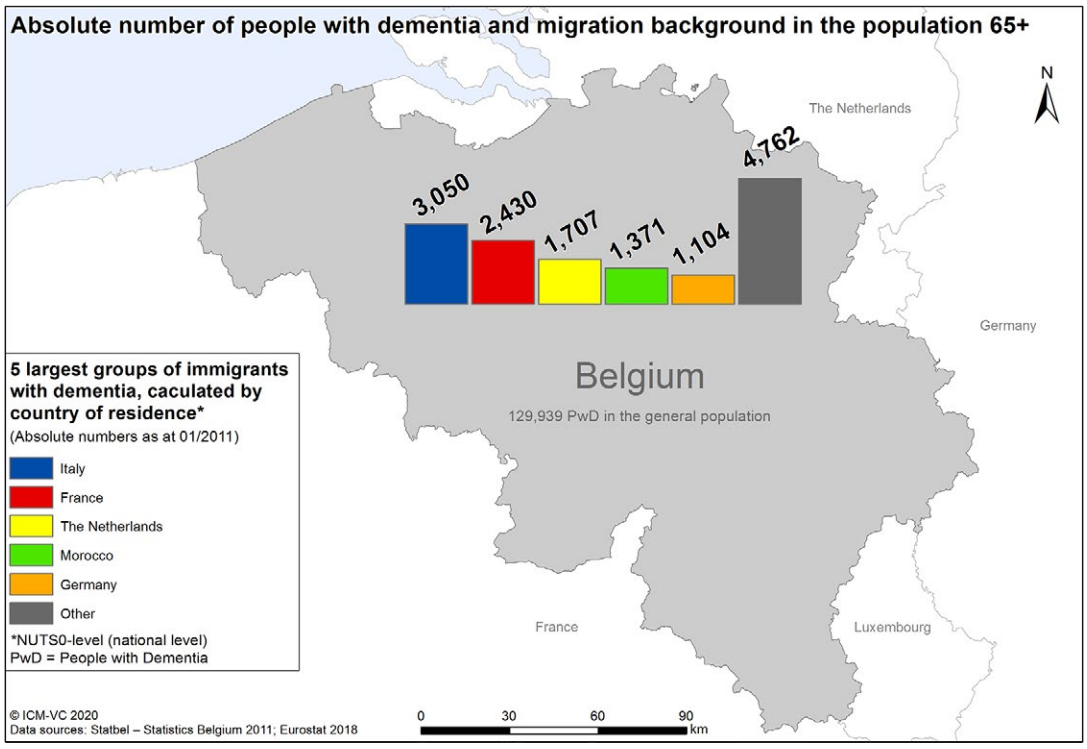

Fig. 3.7.2.1: Absolute number of PwM with dementia aged 65+ (Belgium – Nation)

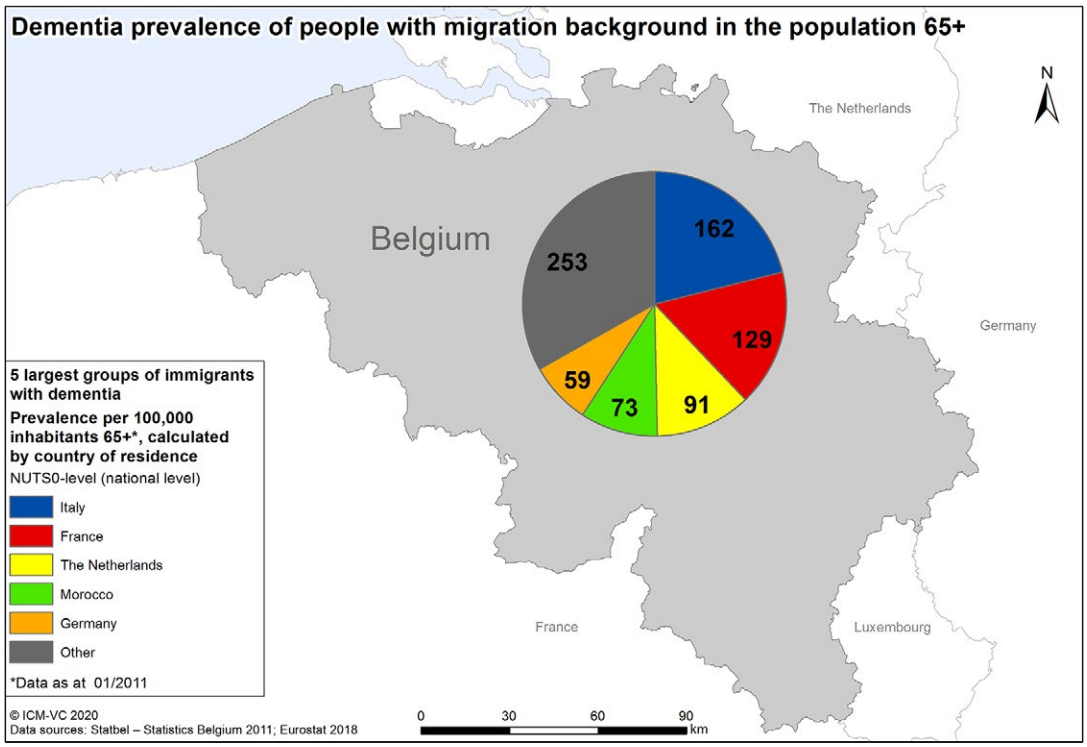

Fig. 3.7.2.2: Prevalence of PwM with dementia among the population aged 65+ (Belgium – Nation)

Tab. 7: PwM with dementia: Absolute numbers, prevalence among PwM aged 65+, and prevalence among overall population aged 65+ (Belgium – Nation)

NUTS	Total	AT	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Absolute Numbers								
Belgium	129,939	115,517	IT 3,050	FR 2,430	NL 1,707	MA 1,371	DE 1,104	4,762
Prevalence/10,000 inhabitants with migration background 65+								
Belgium	6,217	-	IT 146	FR 116	NL 82	MA 66	DE 53	227
Prevalence/100,000 inhabitants 65+								
Belgium	6,900	6,134	IT 162	FR 129	NL 91	MA 73	DE 59	253

Data Source: Statistics Belgium (2011)

There are 209,000 PwM aged 65 or older. Of those, approx. 14,400 are estimated to exhibit some form of dementia. Figure 3.7.2.1 shows the most affected migrant groups presumably originate from Italy (approx. 3,100), France (approx. 2,400), the Netherlands (approx. 1,700), Morocco (approx. 1,400), and Germany (approx. 1,100) (Fig. 3.7.2.1). The second graph highlights the number of PwM with dementia in Belgium per 100,000 inhabitants aged 65 or older (figure 3.7.2.2). Table 7 displays the values depicted in the maps on the national level. The following maps show the distribution of non-migrants and PwM with dementia from Italy, France, the Netherlands, Morocco, and Germany throughout the country in the NUTS2 regions (figures 3.7.2.3 – 3.7.2.8).

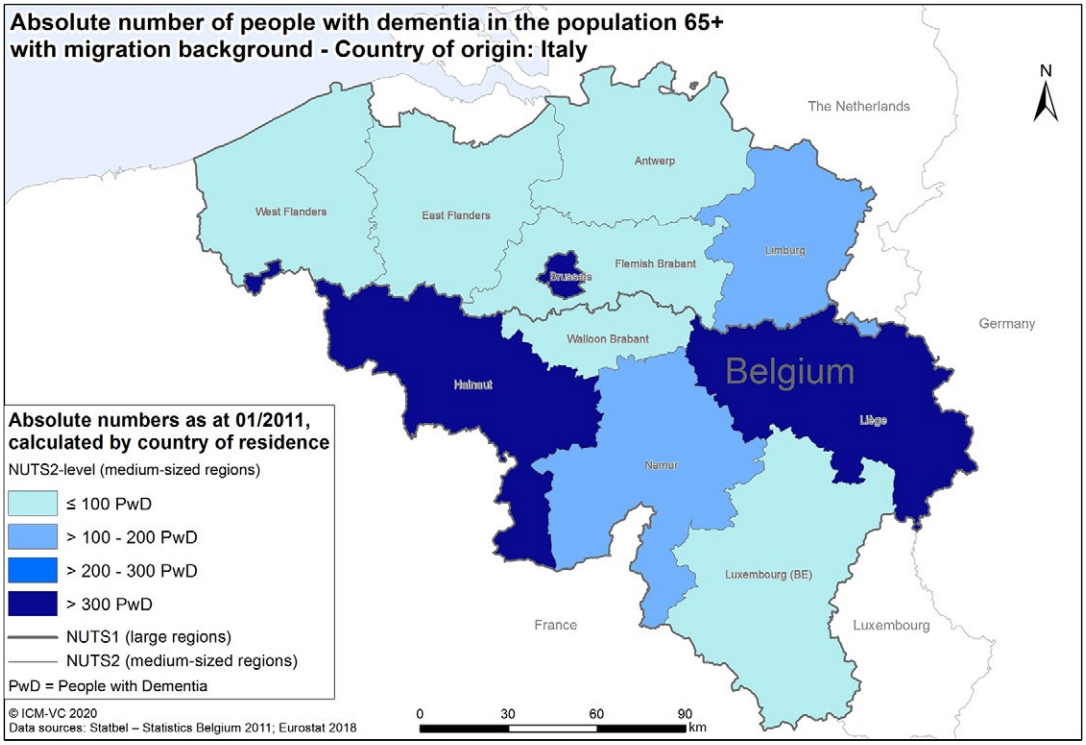

Fig. 3.7.2.3: Absolute number of PwM with dementia aged 65+.
Country of origin: Italy (Belgium – NUTS2)

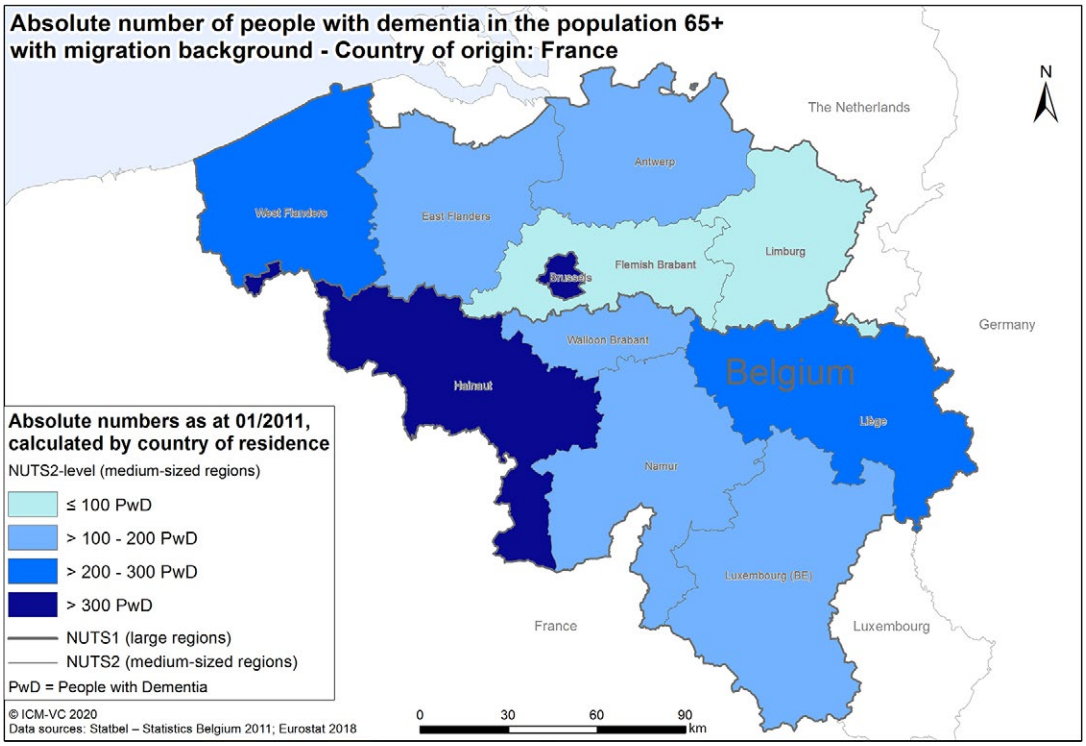

Fig. 3.7.2.4: Absolute number of PwM with dementia aged 65+.
Country of origin: France (Belgium – NUTS 2)

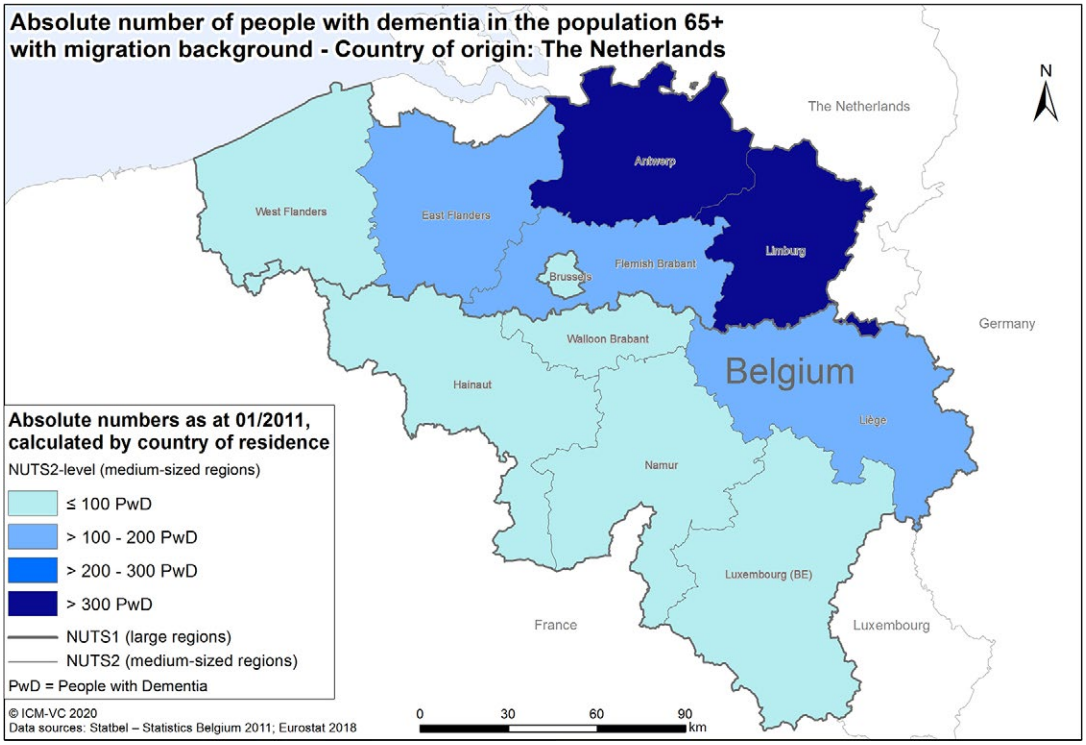

Fig. 3.7.2.5: Absolute number of PwM with dementia aged 65+.
Country of origin: The Netherlands (Belgium – NUTS2)

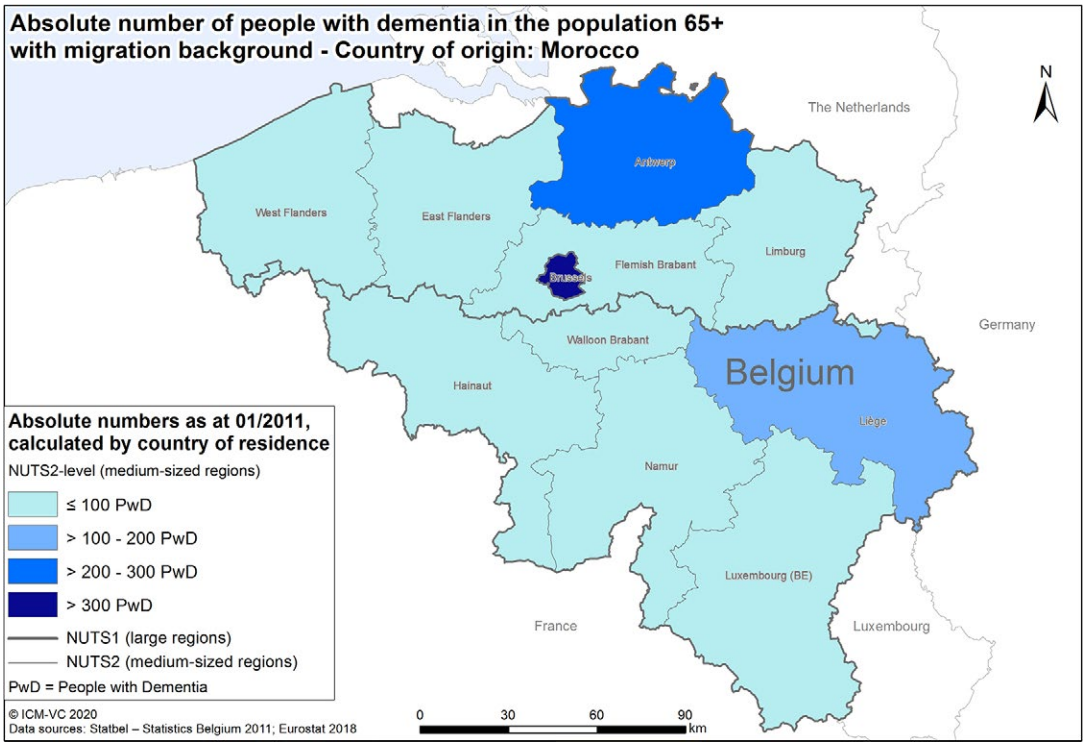

Fig. 3.7.2.6: Absolute number of PwM with dementia aged 65+.
Country of origin: Morocco (Belgium – NUTS2)

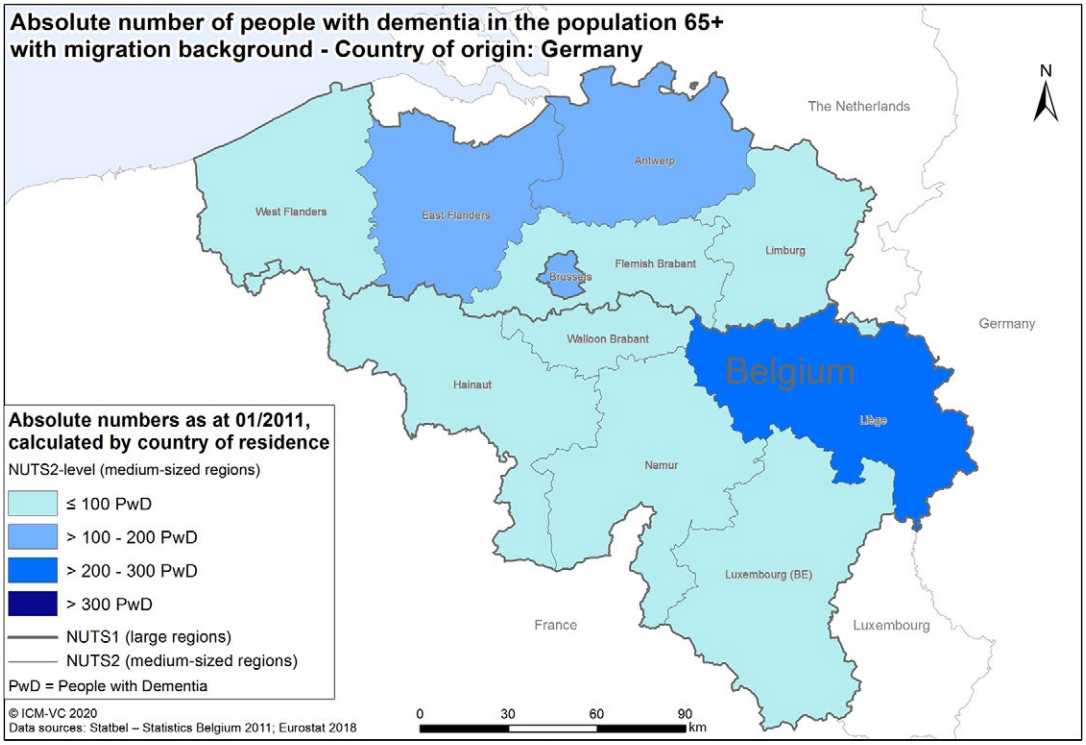

Fig. 3.7.2.7: Absolute number of PwM with dementia aged 65+.
Country of origin: Germany (Belgium – NUTS2)

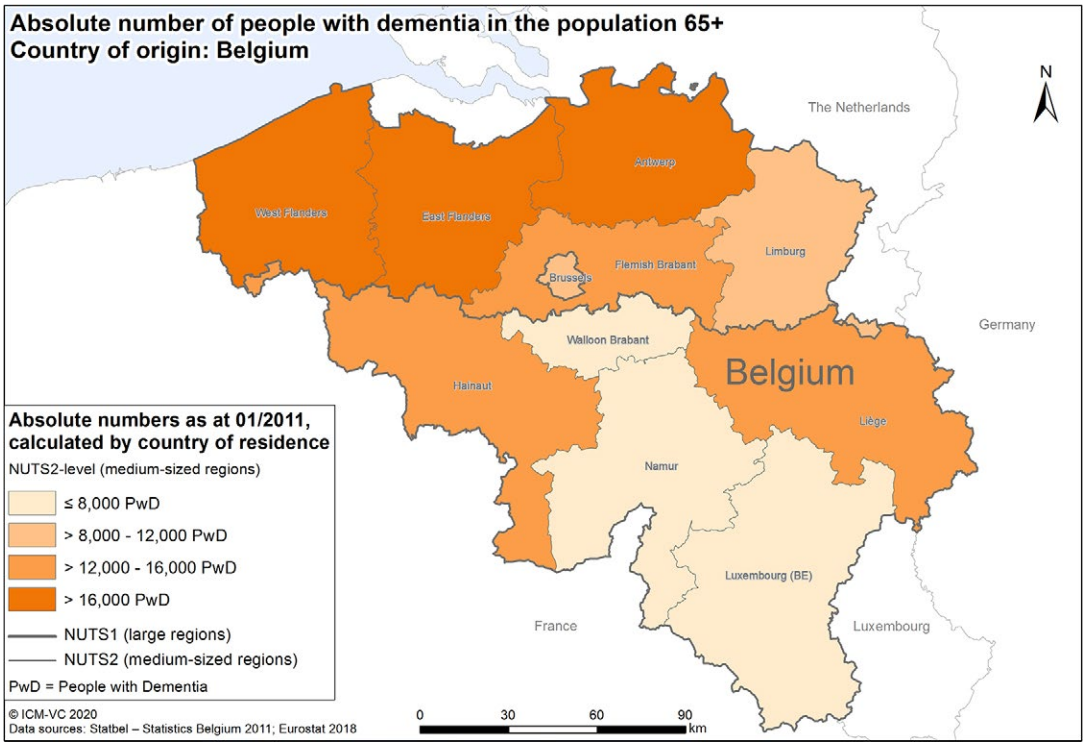

Fig. 3.7.2.8: Absolute number of people with dementia aged 65+.
Country of origin: Belgium (Belgium – NUTS 2)

The graphics below highlight which immigrant groups are estimated to be the most affected at the NUTS2 level. The first map displays the absolute numbers of PwM with dementia in the NUTS2 regions (figure 3.7.2.9). The second graph shows the number of PwM with dementia per 100,000 inhabitants aged 65 or older in the NUTS2 regions (figure 3.7.2.10). The values from the NUTS2 level can be found in table 8 [4-6].

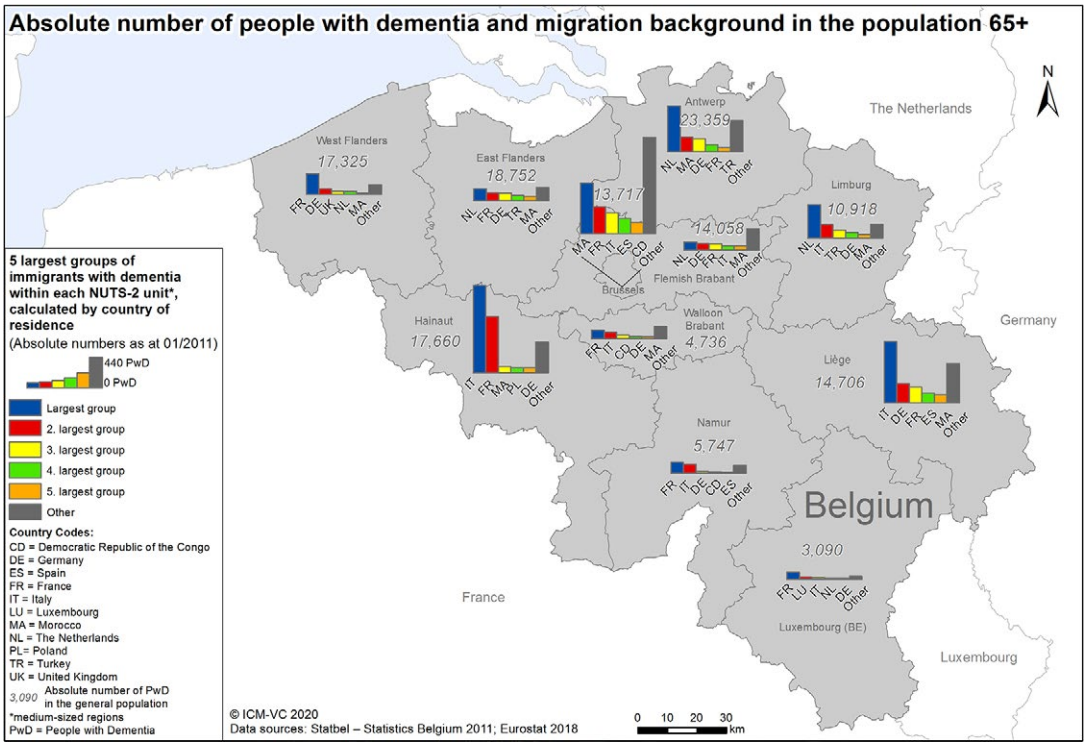

Fig. 3.7.2.9: Absolute number of PwM with dementia in the total population aged 65+ (Belgium – NUTS2)

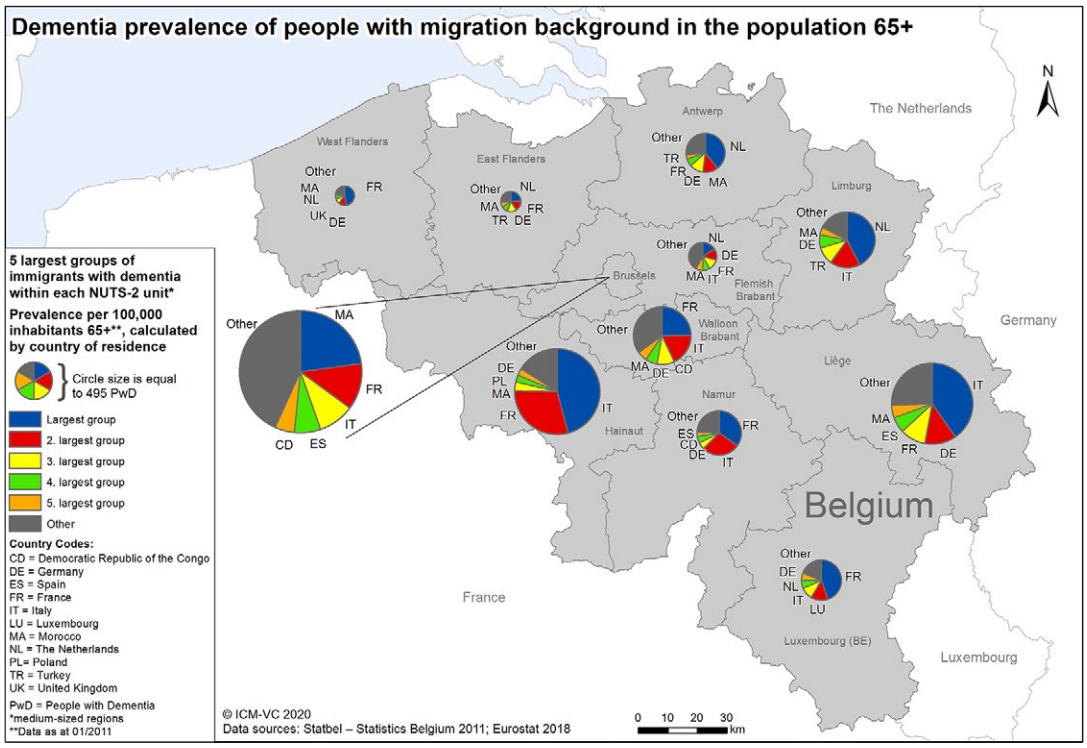

Fig. 3.7.2.10: Prevalence of PwM with dementia among the population aged 65+ (Belgium – NUTS2)

Tab. 8: PwM with dementia: Absolute numbers, prevalence among PwM aged 65+, and prevalence among overall population aged 65+ (Belgium – NUTS 2)

NUTS	Total	BE	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Absolute Numbers								
Brussels	13,717	10,534	MA 723	FR 388	IT 305	ES 223	CD 167	1,377
Antwerp	23,359	21,684	NL 662	MA 211	DE 189	FR 103	TR 60	450
Limburg	10,918	9,813	NL 470	IT 193	TR 115	DE 83	MA 51	193
East Flanders	18,752	18,060	NL 167	FR 112	DE 104	TR 72	MA 56	181
Flemish Brabant	14,058	13,327	NL 118	DE 95	FR 89	IT 62	MA 59	308
West Flanders	17,325	16,707	FR 292	DE 81	UK 50	NL 41	MA 18	136
Walloon Brabant	4,736	4,228	FR 124	IT 93	CD 50	DE 33	MA 28	180
Hainaut	17,660	14,899	IT 1,266	FR 813	MA 93	PL 74	DE 72	443

Belgium

NUTS	Total	BE	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Liège	14,706	12,518	IT 881	DE 277	FR 223	ES 136	MA 114	557
Luxembourg (BE)	3,090	2,861	FR 102	LU 32	IT 23	NL 15	DE 14	43
Namur	5,747	5,277	FR 163	IT 131	DE 24	CD 22	ES 15	115
Prevalence/10,000 inhabitants with migration background 65+								
Brussels	2,974	-	MA 157	FR 84	IT 66	ES 48	CD 36	299
Antwerp	9,624	-	NL 273	MA 87	DE 78	FR 43	TR 25	184
Limburg	6,814	-	NL 297	IT 122	TR 73	DE 53	MA 32	36
East Flanders	18,697	-	NL 166	FR 112	DE 103	TR 72	MA 56	181
Flemish Brabant	13,260	-	NL 111	DE 89	FR 84	IT 58	MA 49	299
West Flanders	19,353	-	FR 326	DE 90	UK 56	NL 46	MA 20	152
Walloon Brabant	6,431	-	FR 168	IT 126	CD 68	DE 45	MA 39	244
Hainaut	4,413	-	IT 316	FR 203	MA 23	PL 19	DE 18	111
Liège	4,637	-	IT 278	DE 87	FR 70	ES 43	MA 36	176
Luxembourg (BE)	9,329	-	FR 307	LU 96	IT 69	NL 44	DE 42	132
Namur	8,445	-	FR 239	IT 193	DE 35	CD 33	ES 22	168
Prevalence/100,000 inhabitants 65+								
Brussels	6,900	5,299	MA 364	FR 195	IT 153	ES 112	CD 84	693
Antwerp	6,900	6,405	NL 195	MA 62	DE 56	FR 31	TR 18	133
Limburg	6,900	6,201	NL 297	IT 122	TR 73	DE 53	MA 32	122
East Flanders	6,900	6,645	NL 61	FR 41	DE 38	TR 27	MA 21	67
Flemish Brabant	6,900	6,541	NL 58	DE 46	FR 44	IT 30	MA 29	152
West Flanders	6,900	6,654	FR 116	DE 32	UK 20	NL 16	MA 7	55

NUTS	Total	BE	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Walloon Brabant	6,900	6,160	FR 181	IT 135	CD 73	DE 49	MA 42	260
Hainaut	6,900	5,821	IT 495	FR 318	MA 36	PL 29	DE 28	173
Liège	6,900	5,873	IT 413	DE 130	FR 105	ES 64	MA 53	262
Luxembourg (BE)	6,900	6,390	FR 227	LU 71	IT 51	NL 33	DE 31	97
Namur	6,900	6,336	FR 196	IT 157	DE 28	CD 27	ES 18	138

Data source: Statistics Belgium (2011)

3. National dementia plan

Belgium's health system is organised at a regional level. Therefore, it does not have a dementia plan that applies to the whole country. For the southern region Wallonia, no plan could be identified [7]. The northern region Flanders published 'Dementia Plan for Flanders 2016–2019' in 2016, but it has no separate chapter on migration. However, in two paragraphs of the chapter on the prevalence of dementia and in three sections of the chapter on objectives and measures, brief references are made to migration. In these chapters, PwM are identified as a risk group for dementia. The proportion of PwM in the Flemish population has increased in recent years, especially in the 65+ age group, and a further increase is expected. PwM suffering from dementia are considered as a group that should be given special attention in scientific research and the development of care strategies. It is pointed out that they have specific care needs that must be taken into account when developing dementia strategies. Flanders aims to offer necessary care and support to PwM with dementia and increase the knowledge about dementia among immigrant communities. Simultaneously, it also intends to raise public awareness regarding the importance of cultural diversity in dementia care. The dementia plan of Flanders aims to ensure that PwM have access to dementia-specific care and that culturally sensitive care services are made available. Currently, there still seems to be a lack of culturally sensitive healthcare services for PwM with dementia in Flanders. The specific situation of this vulnerable group had not been given special attention in the past. According to the 'Dementia Plan for Flanders 2016–2019', this is set to change in the future [8].

4. National dementia care and treatment guidelines

According to a representative of the Agence pour une Vie de Qualité (=Walloon Agency for Quality of Life) (AVIQ), Wallonia does not have any publicly accessible documents that contain dementia-specific treatment or care guidelines [9]. For Flanders, four such documents could be found. While the 'Transit Plan Dementiekundige Basiszorg in het Natuurlijk Thuismilieu' from 2014 does not take migration into account [10], the other three guidelines refer to it to different extents. The document 'You and Me, Together We are Human: A Reference Framework for Quality of Life, Housing and Care for People With Dementia' from 2018 refers to migration in a section with two large and one small paragraph. The focus is on the problem description. At first, it is discussed that increasing diversity in western societies poses challenges for carers. Then, a few differences in the perception of dementia and in the needs and care practices between PwM and non-migrants are mentioned. It is pointed out that some cultures perceive dementia as a pathology of the brain, while other cultures see it as a part of normal aging, a psychiatric problem, a religious or mystical experience, or punishment for bad behaviour. In some of these cultures, dementia is strongly taboo. As a result, such people need to be better informed and their awareness of dementia needs to be raised. The reference framework concludes that current healthcare services for migrants are insufficient. The care institutions are directly invited to consider the culture-specific needs of people without falling into stereotyping and over-culturalization. In the future, Flanders wants to focus in particular on culturally sensitive healthcare for PwM with dementia. However, there are no plans to develop specialised for this group [11]. In the 'Memorandum' of 2014 published in 2013 by the 'Expertisecentrum Dementie Vlaanderen' and the 'Vlaamse Alzheimer Liga', it is mentioned that the number of older people from Italy, Morocco, or Turkey is increasing, which is one reason for the growing pressure on informal care and the rising importance of diversity of care [12]. The 'Memorandum' of 2019 from 2018 describes the situation with the same wording. This indicates that the situation has not changed in recent years—the number of older migrants continues to rise, the pressure on informal care continues to increase, and diversity of care is still being neglected. This could be the reason why at the end of the memorandum the recommendation is made that in the future greater attention should be paid to PwM with dementia [13].

The analysis of the Flemish documents has shown that the topic of dementia and migration is becoming more important in Flanders and is also increasingly taken into account while writing documents on dementia care. PwM with dementia are identified as a vulnerable group with specific needs to whom culturally sensitive care should be offered in the future. Currently, there seem to be major gaps in this regard.

The following parts on services and information for PwM with dementia, professional care and support for family caregivers are based on a conducted interview and reflect the experience and opinion of the experts. A selection bias in information and a discrepancy to results from the previous sections might ensue.

5. Services and information for people with a migration background with dementia

There are large gaps in care for PwM with dementia since dementia and migration is a new topic in society, politics, science, and the healthcare system, and is currently not being given any structural attention within these systems. The two experts interviewed are part of the sole research project running on the topic. Until now, the Belgian healthcare system, policymakers, and care organisations have not identified PwM with dementia as a group with special needs. As a result, no national or regional programs, guidelines, or official documents (published by the government) that raise awareness of dementia and migration among healthcare providers can be identified.

According to the interviewees, PwM are not included in the healthcare system in Belgium at all. Thus, there is already a lack of focus on health and migration, which is reflected in the absence of public policies and best practice examples addressing the subject. In the current situation, the provision of culturally sensitive services to PwM with dementia is dependent on initiatives taken on an individual level, with no involvement of the state. The experts state that there are currently no specialised healthcare services for PwM with dementia in Belgium and the government, the healthcare system, and the healthcare organisations are also not taking any measures to ensure future intercultural care or support for people with dementia. At the individual level, there are a small number of healthcare providers and caregivers who are sensitised to the specific needs of PwM with dementia and offer culturally sensitive care based on their own profile (e.g. own migration background) and experience of working with PwM. The experts mentioned the following two examples. First, a day care centre for PwM with dementia was set up in Brussels in 2017 by a group of nurses; the day care has looked after about ten people since it was launched (estimation of one expert). The second example was the culturally sensitive dementia café in Mons. There are also individual nursing homes with a high proportion of migrants, such as a nursing home in Brussels with many migrants from Italy, which have been sensitised to the topic. According to the experts, with the exception of these examples, there is no specific attention on ensuring adequate care for PwM with dementia in Belgium. No standard of care, no policy, and no systematic consideration of the needs of this specific group of individuals seem to exist. Due to understaffing in the field of elderly care, there is a general lack of sensitivity to personal needs for dementia patients; this applies in particular to PwM.

6. Professional qualification and people with a migration background in healthcare

According to the interviewed experts, intercultural or culturally sensitive care is not an integral part of the professional training of health or nursing staff. Although there are courses on intercultural care, they are not a mandatory module, are not offered nationwide to all students, and are not considered as an important basic component for care provision. Moreover, these courses are often only attended by those who are already sensitised to the topic. The large majority of trainees/students do not attend courses on intercultural care.

Regarding cultural diversity and the proportion of healthcare professionals with a migration background, region (rural or urban) and professional qualification play a key role. In cities and for low qualification jobs, the proportion of professionals with a migration background is much higher than in rural areas and jobs requiring advance qualifications. In residential care in Brussels, for example, it is very high. In addition, the proportion of migrants among doctors is much lower compared to nurses. Likewise, the proportion of cleaning staff with a migrant background is probably 80 to 90% (estimation by one expert). This may indicate that jobs with lower qualifications are generally those undertaken by migrants. With regard to regions and countries of origin, the group of professional caregivers with a migration background in residential care in cities is very heterogeneous (from all parts of the world, e.g. Eastern Europe, America, Pakistan). In most hospitals (except those in Brussels), the proportion of migrants and cultural diversity is much lower. Overall, the diversity among staff in inpatient care is lower than in outpatient care. The two experts pointed out that there are currently some structural and social conditions in Belgium that represent a barrier to the inclusion of PwM in the entire spectrum of healthcare professions. PwM are often seen as one group in policy, which leads to the false expectation that caregivers with a migration background generally offer culturally sensitive care, because of their migration background, and thus have the skills and knowledge to manage care among these populations. Overall, the experts state that higher expectations are set for healthcare providers with a migration background than for healthcare providers without a migration background. In terms of regular healthcare tasks and duties, both are expected to have the same level of expertise. At the same time, both are expected to be prepared to provide translation services when necessary and offer culturally sensitive care. A high level of ethnic diversity among the staff provides great potential but does not automatically lead to culturally sensitive care. The diversity needs to be utilised fruitfully with the help of elements such as good leadership, communication, and supportive non-stereotypical policy. According to the experts, another central problem is the structurally caused lack of inclusion of PwM in high-skill jobs in the health system, in which they are underrepresented.

7. Support for family caregivers

The experts explained that the family network plays a key role in supporting caregivers of PwM with dementia. However, generally, families and other potential support networks such as religious communities and migrant organisations are largely unfamiliar with dementia care, and therefore, they must first be sensitised and informed about it. In contrast to fam-

ilies, religious communities and migrant organisations currently do not play an important role in providing dementia-specific support to family caregivers. According to the experts, this is not due to an absence of willingness, but due to lack of awareness and knowledge related to dementia. However, there are also differences between the individual migrant organisations. Some countries of origin are better organised and other countries are not represented in migrant organisations at all. Thus, the extent to which family caregivers receive support from these organisations depends on the country of origin. Migrants from Italy, for example, have a social service that supports them in terms of access to care, while people from Morocco do not have such an organisation. Currently, the closest family caregivers support the person with dementia most of the time. They are also the ones who educate their social circle about dementia, which in turn increases the burden of care.

According to the experts, there is a general problem of support and information for family caregivers of people with dementia in Belgium. This problem is even greater and more complex with regard to the relatives of PwM with dementia. There are no specialised information resources (such as books, films) enabling them to discuss the topic of dementia with their family in their mother tongue. In addition, the information available on dementia is not culturally sensitive or culturally adapted in terms of individual elements (e.g. people or situations depicted in pictures, illustrations, or videos). For the relatives of PwM with dementia, it is important that they can recognize themselves in the (virtual) information. Overall, there is a great need for specialised services providing support and information to this population. It is necessary to develop linguistically and culturally sensitive information bearing in mind that this information must be accessible and lead to accessible care services.

8. References

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