Germany

Population
83,167,000

Area
357,581 km^2

Capital
Berlin

3 largest cities
Berlin (3,669,000)
Hamburg (1,847,000)
Munich (1,484,000)

Neighboring countries
Austria, Belgium, the Czech Republic, Denmark, France, Luxembourg, the Netherlands, Poland, Switzerland

1. Migration history

In the migration history of Germany in the 19th, 20th, and the early 21st century, several fundamental processes can be identified. From the early 19th century until about 1890, the transatlantic emigration flows of people from Germany dominated [1]. Between 1820 and 1920 about six million people emigrated from Germany due to wars and famines (especially to North America) [2, 3]. The economic success of the German Empire after 1890 led to more people immigrating than emigrating [2]. Most foreigners came from Austria, the BENELUX states (Belgium, the Netherlands, and Luxembourg), the Russian Federation, and Italy. The two world wars of the 20th century and their political consequences led to an enormous increase in forced migration [1]. During National Socialism, many foreigners were expelled, executed in concentration camps, and employed in forced labour [2]. Overall, Germany was a centre of forced migration in Europe during and after both world wars [1]. Especially after the Second World War, there was a large group of expellees and refugees [2]. From the middle of the 20th century, a new migration policy was established in the legal and welfare state. Between 1955 and 1973, foreign workers were recruited with the support of intergovernmental agreements, and the residence status of these workers was gradually consolidated as the length of their stay increased [1]. As a result of the recruitment agreements and the economic upswing, between 1959 and 1964 about one million of these so-called guest workers came to Germany. The countries of origin of these migrants were Italy, Greece, Spain, Turkey, Morocco, Portugal, Tunisia, and Yugoslavia. After the decline in immigration in the 1980s, developments such as the collapse of the Soviet Union led to a sharp rise in immigration rates in the 1990s [2]. East-west migration, which had been severely restricted during the Cold War, became much more important [1]. Actions like the introduction of dual citizenship in 2000 and the 2005 Immigration Act, and developments such as high youth unemployment in southern Europe and the Syrian conflict, led to further growth in the migrant population [2]. In 2005, the proportion of migrants in the total population was 17.9% [4]. By 2017, this number increased to 23.6 percent, equivalent to 19.3 million people [5]. The largest migrant groups are people from Turkey (2.8 million), Poland (2.1 million), the Russian Federation (1.4 million) and, Kazakhstan (1.2 million) [6]. Between 1990 and 2019, the migrant population (born abroad) and their proportion in the total population more than doubled (5.9 million [7.5 percent] to 13.1 million [15.7 percent]) [7]. As of 2020, the net migration rate is 6.6 [8]. Overall, Germany has developed from an emigration country to an immigration country.

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

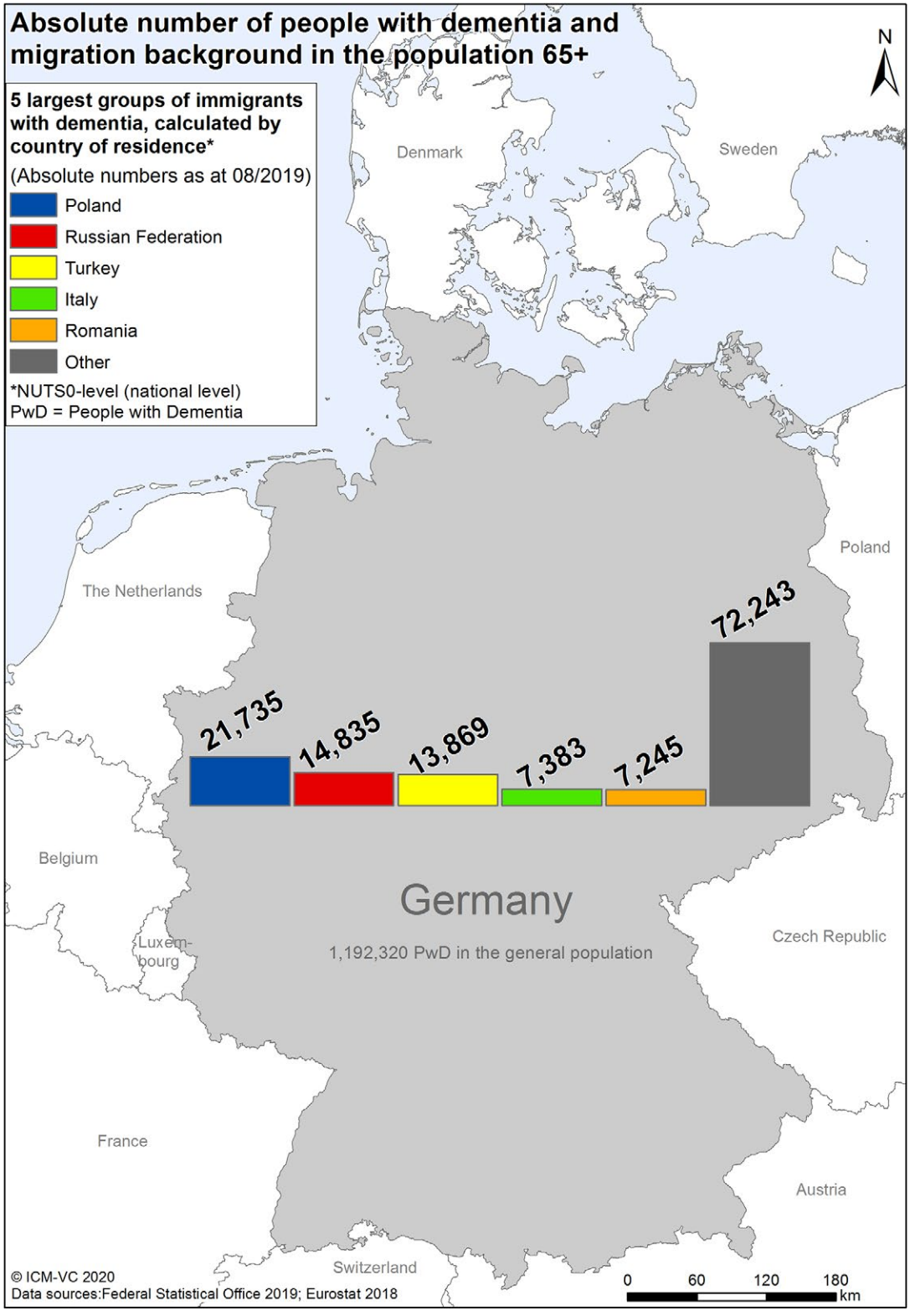

Fig. 3.7.11.1: Absolute number of PwM with dementia aged 65+ (Germany – Nation)

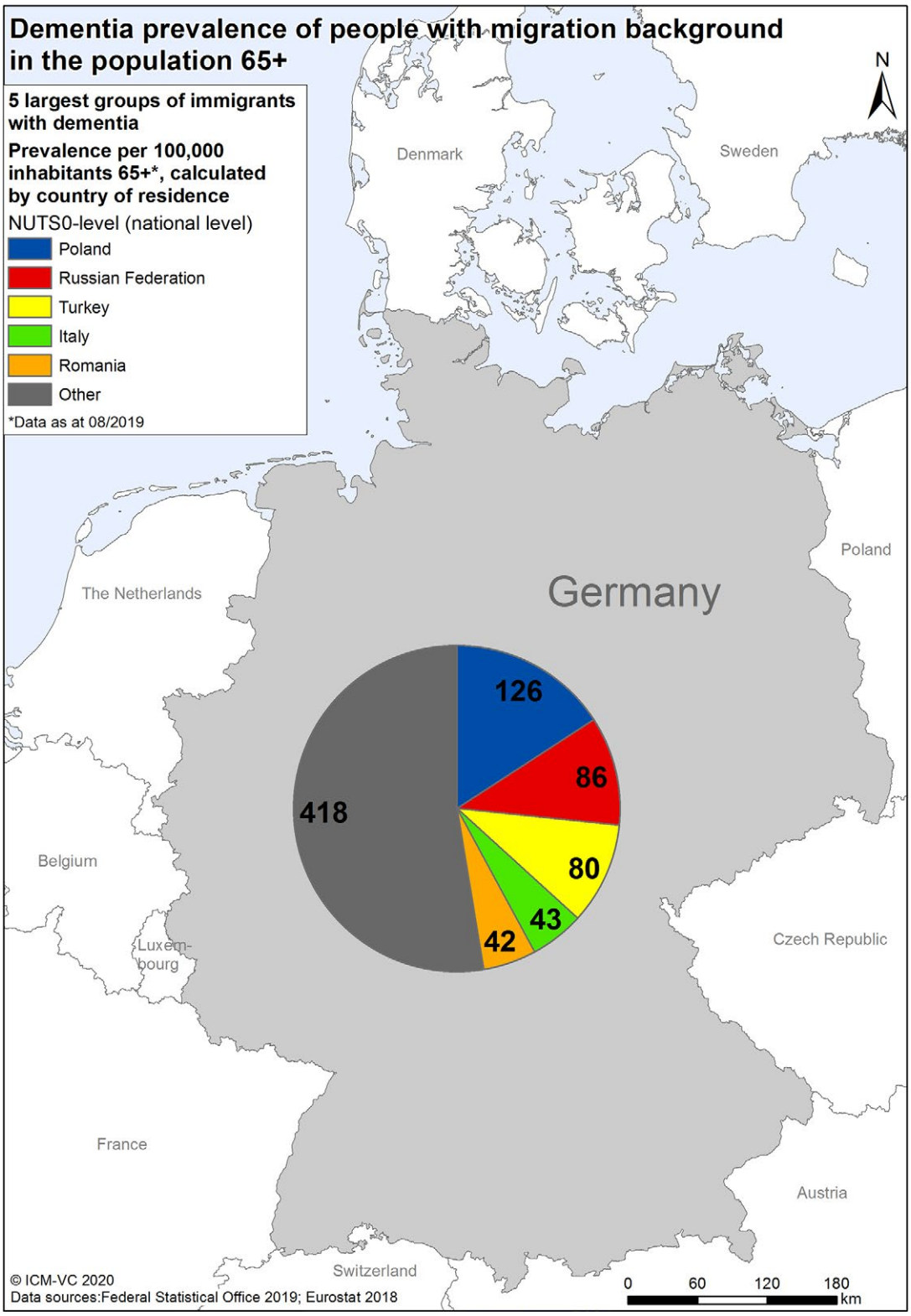

Fig. 3.7.11.2: Prevalence of PwM with dementia among the population aged 65+ (Germany – Nation)

Tab. 21: PwM with dementia: Absolute numbers, prevalence among PwM aged 65+, and prevalence among overall population aged 65+ (Germany – Nation)

NUTS	Total	DE	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Absolute Numbers								
Germany	1,192,320	1,055,010	PL 21,735	RU 14,835	TR 13,869	IT 7,383	RO 7,245	72,243
Prevalence/10,000 inhabitants with migration background 65+								
Germany	5,992	-	PL 109	RU 75	TR 70	IT 37	RO 36	363
Prevalence/100,000 inhabitants 65+								
Germany	6,900	6,105	PL 126	RU 86	TR 80	IT 43	RO 42	418

Data source: Federal Statistical Office (2019)

There are 1,990,000 PwM aged 65 or older. Of those, approx. 137,300 are estimated to exhibit some form of dementia. Figure 3.7.11.1 shows the most affected migrant groups presumably originate from Poland (approx. 21,700), the Russian Federation (approx. 14,800), Turkey (approx. 13,900), Italy (approx. 7,400), and Romania (approx. 7,300). The second graph highlights the number of PwM with dementia in Germany per 100,000 inhabitants aged 65 or older (figure 3.7.11.2). Table 21 displays the values depicted in the maps on the national level. The following maps show the distribution of non-migrants with dementia and PwM with dementia from Poland, the Russian Federation, Turkey, Italy, and Romania throughout the country in the NUTS1 regions (figures 3.7.11.3 – 3.7.11.8).

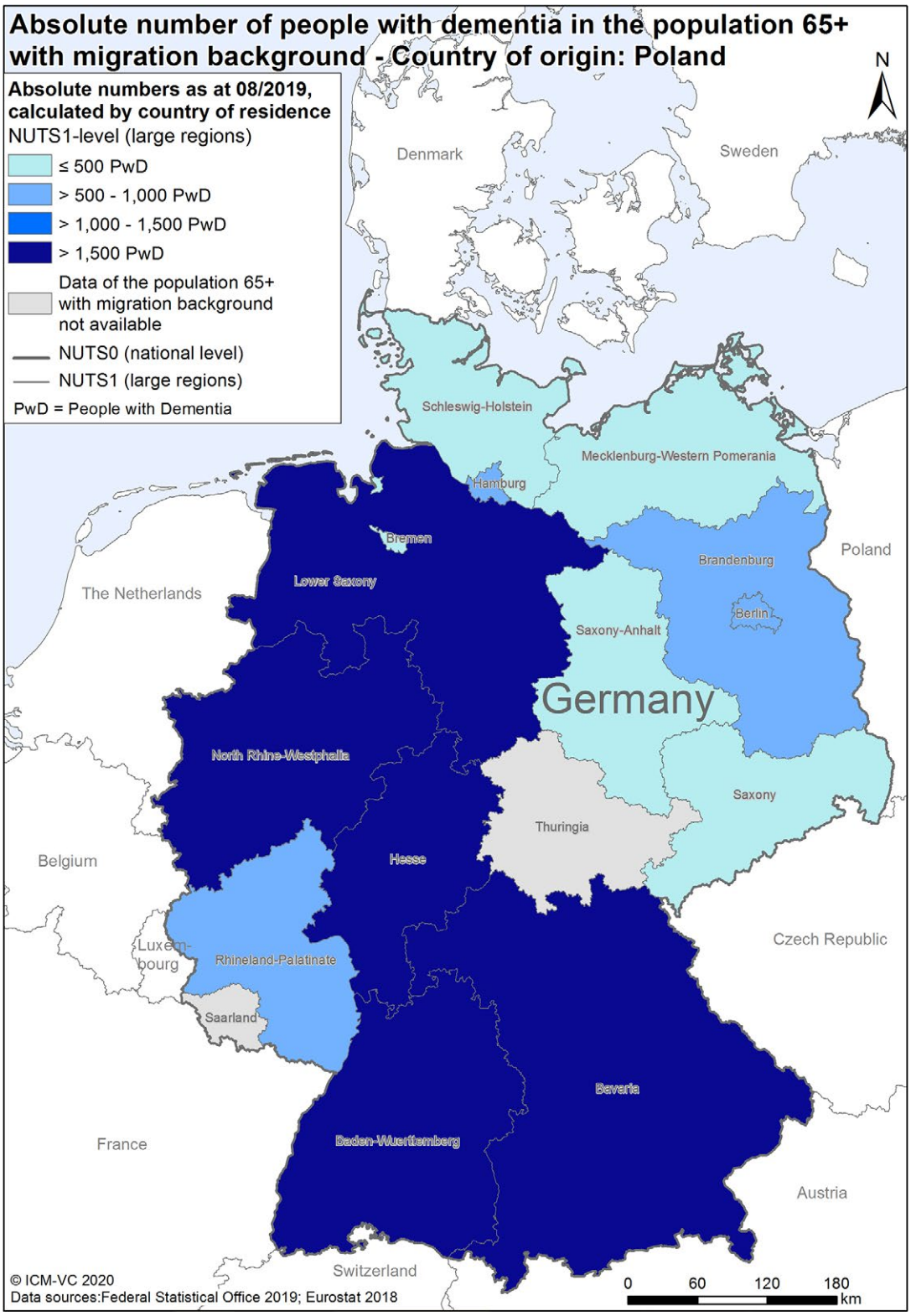

Fig. 3.7.11.3: Absolute number of PwM with dementia aged 65+.
Country of origin: Poland (Germany – NUTS1)

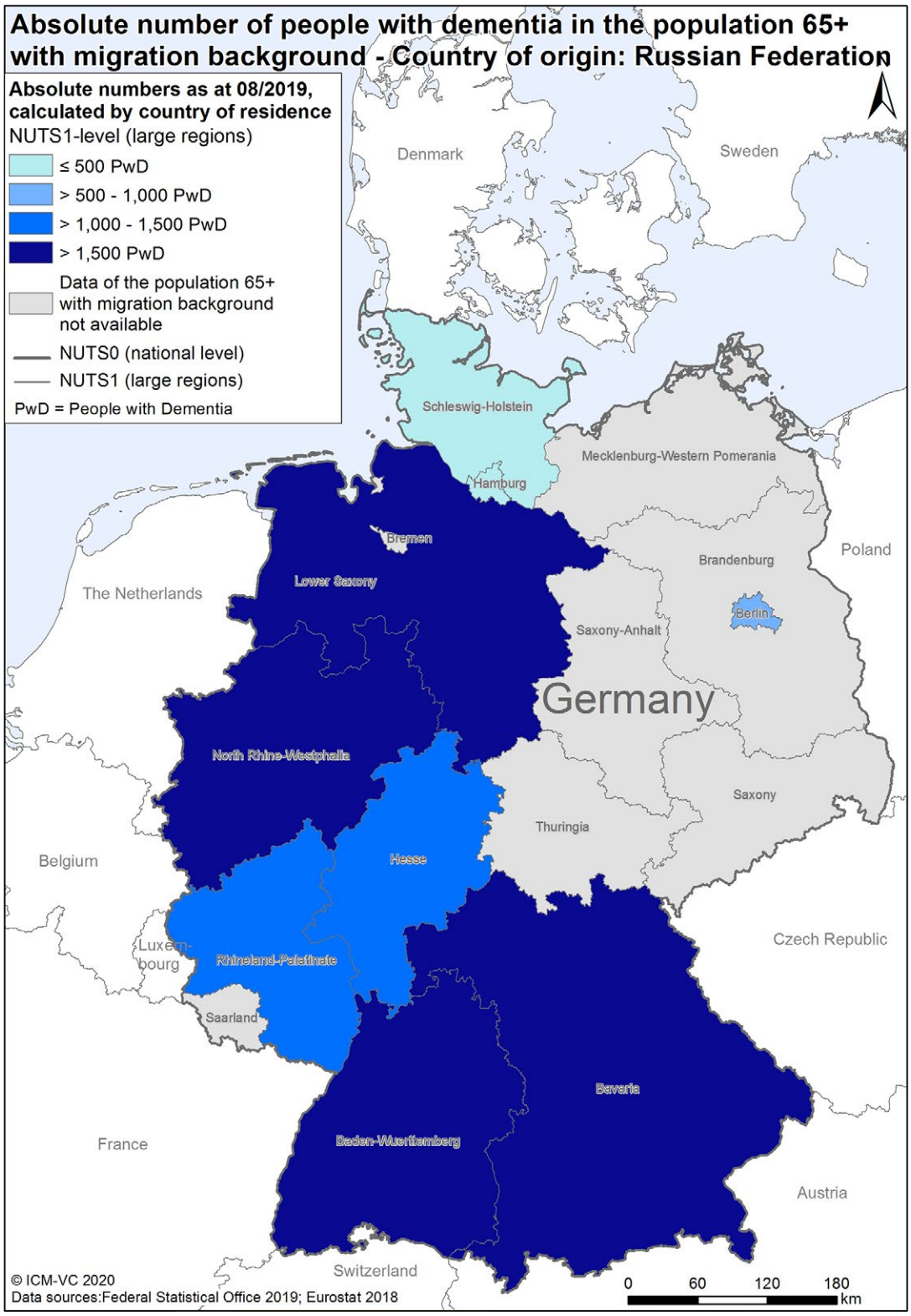

Fig. 3.7.11.4: Absolute number of PwM with dementia aged 65+.
Country of origin: The Russian Federation (Germany – NUTS1)

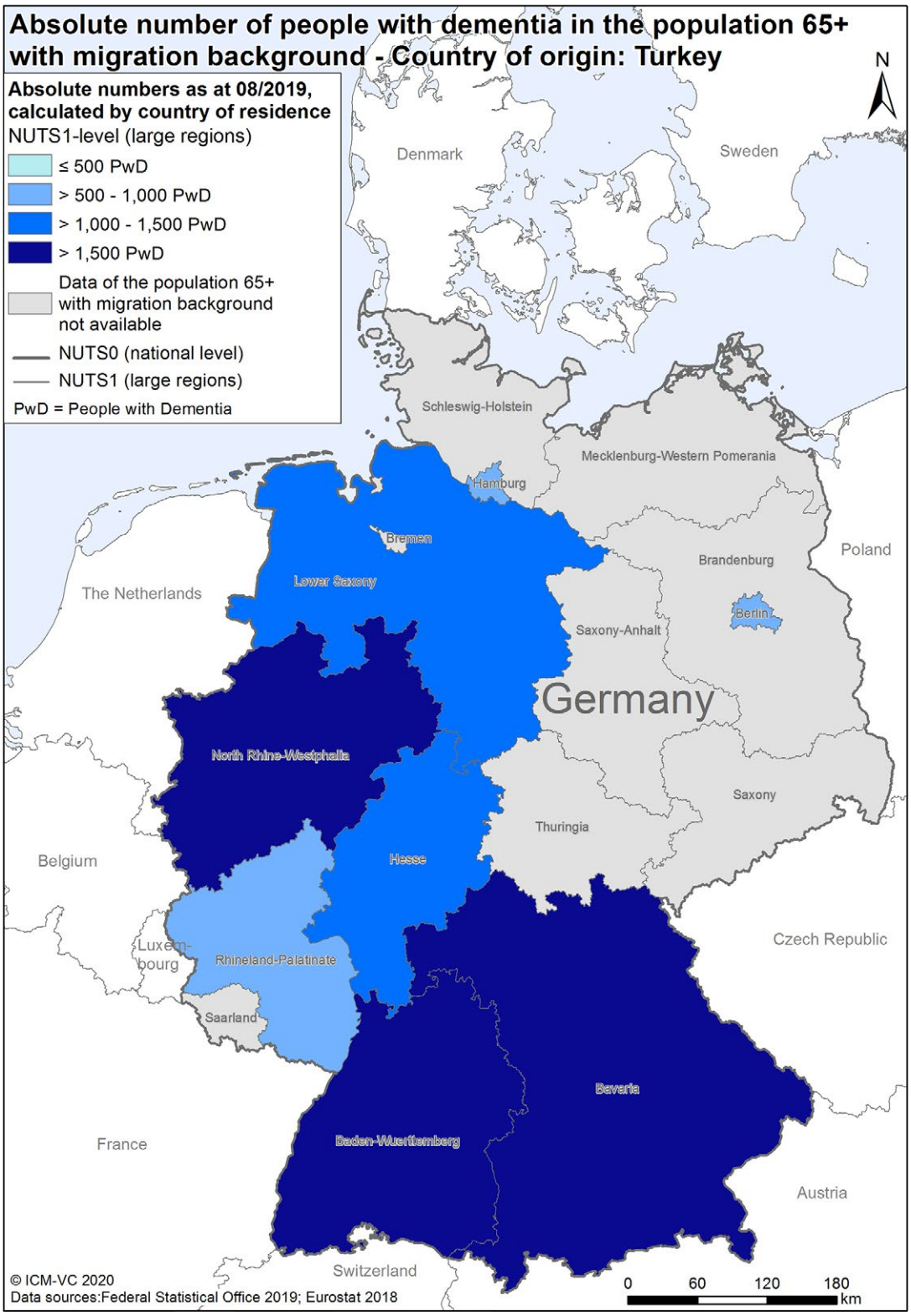

Fig. 3.7.11.5: Absolute number of PwM with dementia aged 65+.
Country of origin: Turkey (Germany – NUTS1)

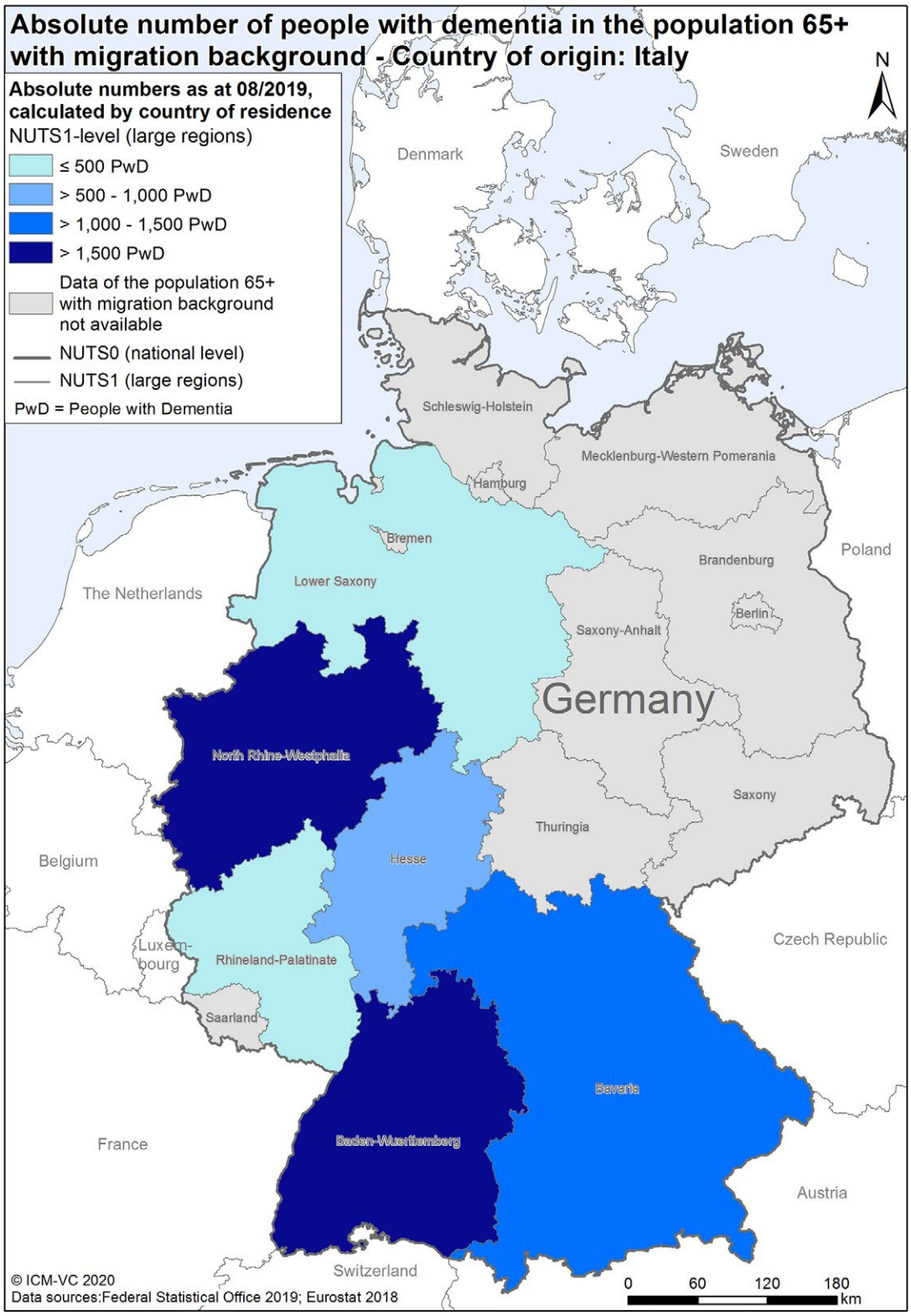

Fig. 3.7.11.6: Absolute number of PwM with dementia aged 65+.
Country of origin: Italy (Germany – NUTS1)

Fig. 3.7.11.7: Absolute number of PwM with dementia aged 65+.
Country of origin: Romania (Germany – NUTS1)

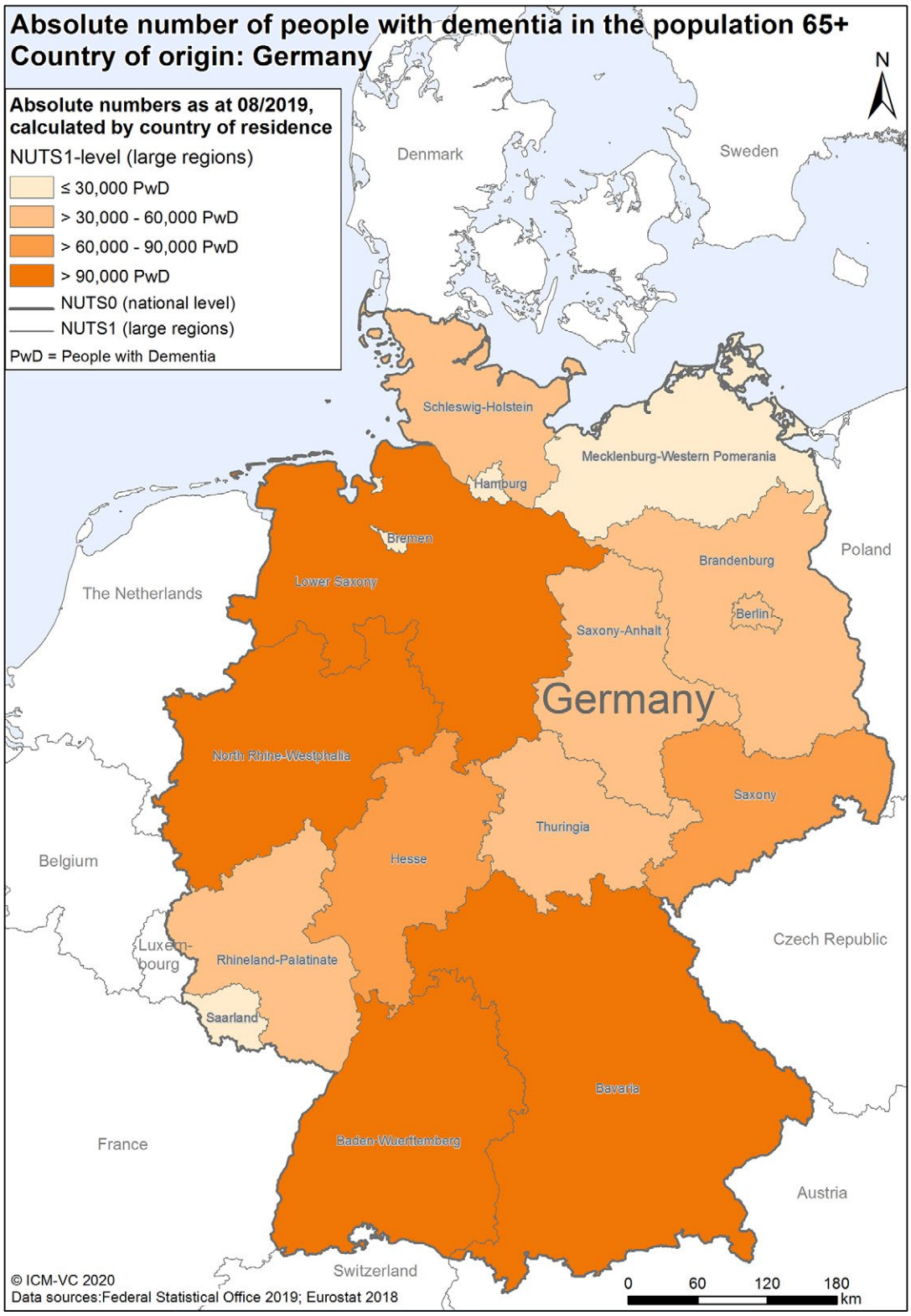

Fig. 3.7.11.8: Absolute number of people with dementia aged 65+.
Country of origin: Germany (Germany – NUTS1)

The graphics below highlight which immigrant groups are estimated to be the most affected at the NUTS1 level. The first map illustrates the absolute numbers of PwM with dementia in the NUTS1 regions (figure 3.7.11.9). The second graph shows the number of PwM with dementia per 100,000 inhabitants aged 65 or older in the NUTS-1 regions (figure 3.7.11.10). The values from the NUTS1 level can be found in Table 22 [9-11].

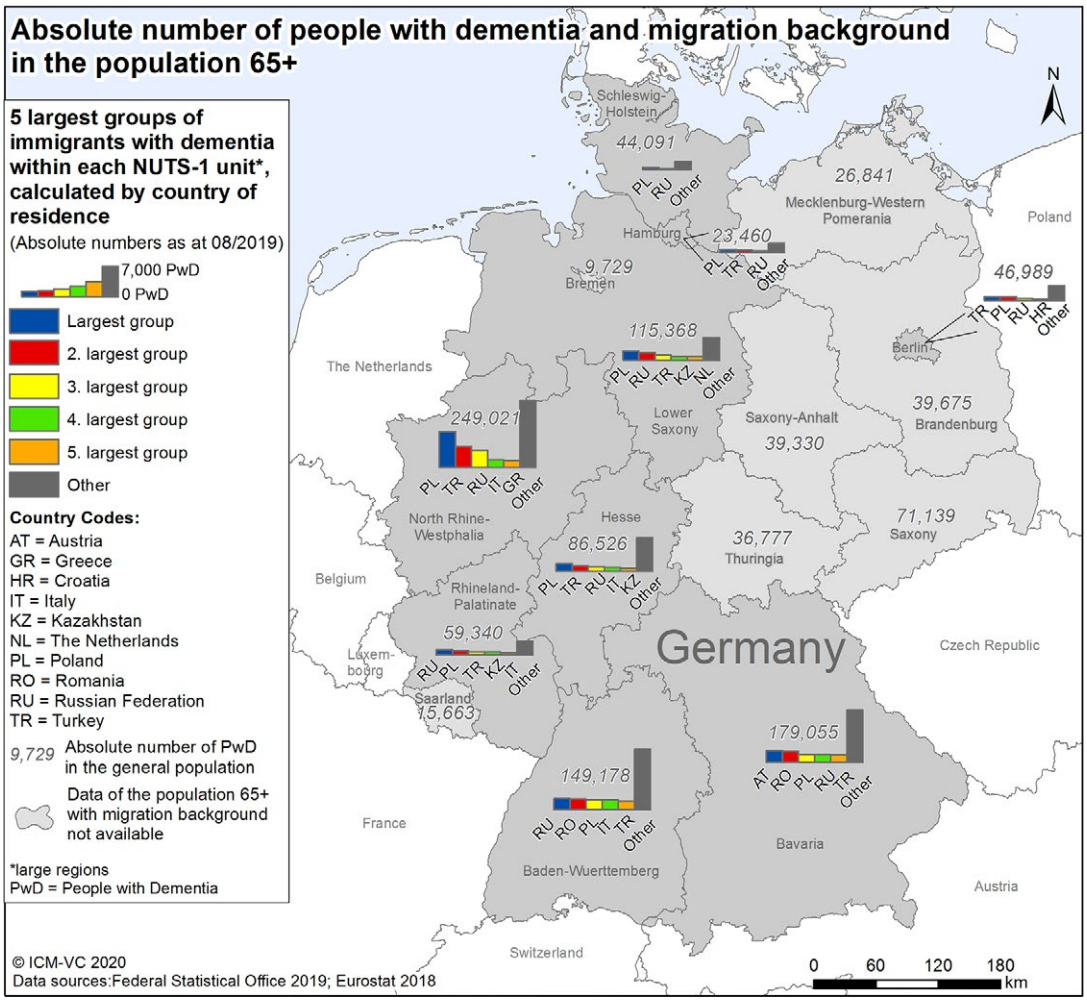

Fig. 3.7.11.9: Absolute number of PwM with dementia aged 65+ (Germany – NUTS1)

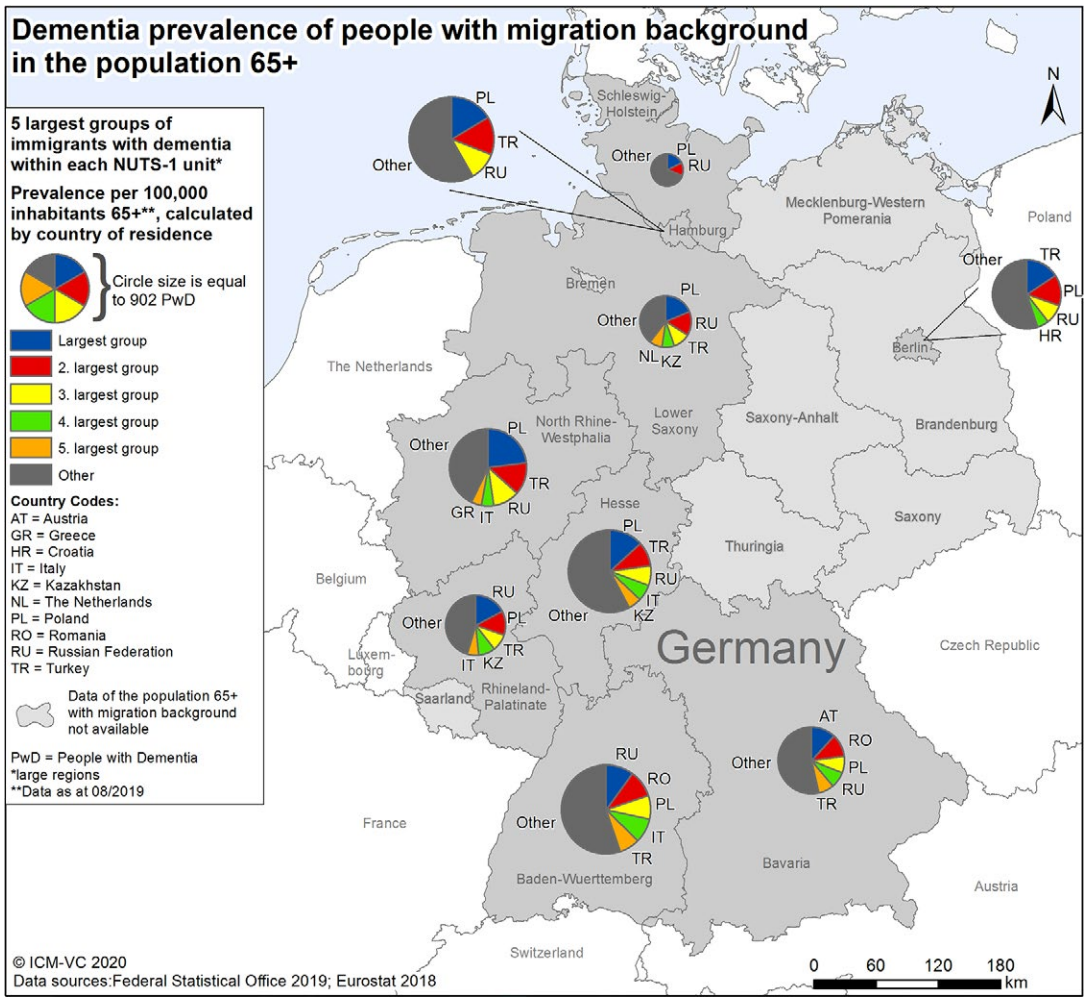

Fig. 3.7.11.10: Prevalence of PwM with dementia among the population aged 65+ (Germany – NUTS1)

Tab. 22: PwM with dementia: Absolute numbers, prevalence among PwM aged 65+, and prevalence among overall population aged 65+ (Germany – NUTS 1)

NUTS	Total	DE	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Absolute Numbers								
Baden-Wuerttemberg	149,178	123,786	RU 2,553	RO 2,484	PL 2,208	IT 2,208	TR 1,932	14,007
Bavaria	179,055	156,285	AT 2,691	RO 2,553	PL 1,794	RU 1,794	TR 1,725	12,213
Berlin	46,989	40,848	TR 966	PL 897	RU 552	HR 345	N/A	3,381
Brandenburg*	39,675	38,295	PL 552	N/A	N/A	N/A	N/A	828
Bremen*	9,729	8,487	PL 414	N/A	N/A	N/A	N/A	828

NUTS	Total	DE	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Hamburg	23,460	19,665	PL 621	TR 552	RU 414	N/A	N/A	2,208
Hesse	86,526	72,933	PL 1,794	TR 1,311	RU 1,035	IT 897	KZ 690	7,866
Mecklenburg-Western Pomerania*	26,841	26,151	PL 345	N/A	N/A	N/A	N/A	345
Lower Saxony	115,368	104,190	PL 2,070	RU 1,725	TR 1,173	KZ 897	NL 897	4,416
North Rhine-Westphalia	249,021	212,451	PL 8,418	TR 4,968	RU 4,071	IT 1,863	GR 1,587	15,663
Rhineland-Palatinate	59,340	52,509	RU 1,173	PL 897	TR 621	KZ 621	IT 414	3,105
Saarland	15,663	14,145	N/A	N/A	N/A	N/A	N/A	1,518
Saxony*	71,139	69,483	PL 414	N/A	N/A	N/A	N/A	1,242
Saxony-Anhalt*	39,330	38,364	PL 414	N/A	N/A	N/A	N/A	552
Schleswig-Holstein	44,091	41,400	PL 483	RU 345	N/A	N/A	N/A	1,863
Thuringia	36,777	36,087	N/A	N/A	N/A	N/A	N/A	690
Prevalence/10,000 inhabitants with migration background 65+								
Baden-Wuerttemberg	4,054	-	RU 69	RO 68	PL 60	IT 60	TR 53	381
Bavaria	5,426	-	AT 82	RO 77	PL 54	RU 54	TR 52	370
Berlin	5,280	-	TR 109	PL 101	RU 62	HR 39	N/A	380
Brandenburg*	18,893	-	PL 263	N/A	N/A	N/A	N/A	394
Bremen*	5,121	-	PL 218	N/A	N/A	N/A	N/A	436
Hamburg	4,344	-	PL 115	TR 102	RU 77	N/A	N/A	408
Hesse	4,392	-	PL 91	TR 67	RU 53	IT 46	KZ 35	399
Mecklenburg-Western Pomerania*	26,841	-	PL 345	N/A	N/A	N/A	N/A	345
Lower Saxony	7,121	-	PL 128	RU 106	TR 72	KZ 55	NL 55	273

NUTS	Total	DE	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
North Rhine-Westphalia	4,699	-	PL 159	TR 94	RU 77	IT 35	GR 30	296
Rhineland-Palatinate	5,994	-	RU 118	PL 91	TR 63	KZ 63	IT 42	314
Saarland	7,120	-	N/A	N/A	N/A	N/A	N/A	690
Saxony*	29,641	-	PL 173	N/A	N/A	N/A	N/A	518
Saxony-Anhalt*	2,6220	-	PL 276	N/A	N/A	N/A	N/A	368
Schleswig-Holstein	11,305	-	PL 124	RU 88	N/A	N/A	N/A	478
Thuringia	36,777	-	N/A	N/A	N/A	N/A	N/A	690
Prevalence/100,000 inhabitants 65+								
Baden-Wuerttemberg	6,900	5,726	RU 118	RO 115	PL 102	IT 102	TR 89	647
Bavaria	6,900	6,023	AT 104	RO 98	PL 69	RU 69	TR 66	470
Berlin	6,900	5,998	TR 142	PL 132	RU 81	HR 51	N/A	497
Brandenburg*	6,900	6,660	PL 96	N/A	N/A	N/A	N/A	144
Bremen*	6,900	6,019	PL 294	N/A	N/A	N/A	N/A	587
Hamburg	6,900	5,784	PL 183	TR 162	RU 122	N/A	N/A	649
Hesse	6,900	5,816	PL 143	TR 105	RU 83	IT 72	KZ 55	627
Mecklenburg-Western Pomerania*	6,900	6,723	PL 89	N/A	N/A	N/A	N/A	88
Lower Saxony	6,900	6,231	PL 124	RU 103	TR 70	KZ 54	NL 54	265
North Rhine-Westphalia	6,900	5,887	PL 233	TR 138	RU 113	IT 52	GR 44	434
Rhineland-Palatinate	6,900	6,106	RU 136	PL 104	TR 72	KZ 72	IT 48	361
Saarland	6,900	6,231	N/A	N/A	N/A	N/A	N/A	669
Saxony*	6,900	6,739	PL 40	N/A	N/A	N/A	N/A	121
Saxony-Anhalt*	6,900	6,731	PL 73	N/A	N/A	N/A	N/A	96

NUTS	Total	DE	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Schleswig-Holstein	6,900	6,479	PL 76	RU 54	N/A	N/A	N/A	291
Thuringia	6,900	6,771	N/A	N/A	N/A	N/A	N/A	129

Note: N/A = not available
Data source: Federal Statistical Office (2019)

3. National dementia plan

At the time of the first search, 1 June 2019, no NDP could be identified for Germany [12]. However, four German federal states (Saarland, Bavaria, Schleswig-Holstein, and Rhineland-Palatinate) have developed their own dementia strategies [13]. Saarland, Bavaria, and Schleswig-Holstein have a dementia plan, which is accessible online. All three dementia plans refer to the topic of migration. The 'Bavarian Dementia Strategy' from 2013 indicates in a separate chapter that the employment of foreign caregivers and domestic help can be a measure to ensure that people with dementia remain in their home environment. It points out several labour law options for the employment of foreign care assistants in private households and presents a strategy which consists of using information material and advisory services to educate affected persons and relatives about the risks and opportunities of using such care assistants. Simultaneously, the problem of lack of data regarding legal and illegal employment relationships is also discussed. In another chapter, it is emphasised that Bavaria would like to develop tailored advertising and information materials to integrate PwM into the elderly care profession. Reference is also made to the project 'Intercultural Network Dementia', which investigates how existing networks of mutual support in the migrant community can be strengthened and access to elderly care improved [14].

In the slightly shorter 'First Dementia Plan of the Saarland' from 2015 there is no chapter on migration. It only refers to the topic in one paragraph and recommends that counselling of dementia patients and their relatives must take into account social differentiation factors such as migration background [15]. The 'Dementia Plan for Schleswig-Holstein' from 2015 refers to migration in more detail. Although it does not contain a separate chapter, it has a section with three paragraphs on the topic of PwM with dementia. There it is discussed that the topic of dementia and migration background is gaining relevance nationwide as well as in Schleswig-Holstein due to the significant increase in the number of older migrants. Besides, the importance of the family in providing care is emphasised and it is explained that external support services are rarely or not at all accepted by PwM. Afterward, it is pointed out that there are hardly any specialised services for this population in Schleswig-Holstein. The third paragraph outlines a possible care strategy. First, a comprehensive installation of special services for this population is rejected due to the low proportion of migrants. Instead, it is recommended to integrate culturally sensitive care into nursing education to a greater extent, to offer more training on this topic, to use trained multipliers to inform the migrant community about support services and to carry out intercultural projects. According to this

document, the strategy should focus on the training of professionals and the education of the migrant community [16]. Overall, the analysis of the dementia plans has shown that official documents on dementia care in individual federal states (3 of 16) deal with some aspects of dementia and migration to varying extents. The focus is on problem identification and description. Specialiced healthcare services were not mentioned. However, the 'Dementia Plan for Schleswig-Holstein' explicitly refers to a lack of specialiced services for PwM with dementia.

On 1 July 2020, Germany published its first national dementia strategy ('Nationale Demenzstrategie'). This strategy refers to migration. In relation to the length of the document (152 pages), the topic does not play a key role, but it is dealt with to varying extents in a total of 14 chapters or sub-chapters. The dementia strategy contains a separate chapter with three sub-chapters on migration and three further sub-chapters on different thematic areas related to migration; also seven other sections refer to this topic (twice in one paragraph and five times briefly with individual sentences or words scattered across the seven sections). First, several challenges and problems regarding the current care situation of PwM with dementia and their families are described. It is identified that diagnosis and counselling for PwM is a particular challenge due to cultural and language barriers and unsuitable diagnostic procedures. In addition, care insurance benefits are often not fully utilised. Language, cultural-religious or institutional barriers, and inadequate culturally sensitive services are cited as causes. Furthermore, the national dementia strategy highlights the current focal points in dementia research and shows that the topic of migration only plays a marginal role there. Only in healthcare research are several aspects related to this topic examined (situation of foreign assistance and care staff, social inequality in support services experienced by relatives of PwM with dementia). Overall, the migration-related sections of the German dementia strategy have a strong action framework. Thereby, the focus is on the sensitizing of healthcare providers, and the development of needs-oriented low-threshold support and counselling services for PwM with dementia as well as their relatives. For this purpose, multipliers for PwM and stakeholders in the healthcare system will be trained in the development of such services and care centres will build up intercultural competencies. Besides, reference is made to the ongoing projects 'Intercultural Bridge Builders in Care', where people from different countries of origin are trained on relevant care-related topics, 'Dementia and Migration', which offers multilingual information on dementia, and 'DeMigranz', which aims to improve access to support and counselling services for PwM and dementia. In several passages, the general aim of expanding and developing culturally sensitive counselling services for people with dementia and their relatives is expressed. Specifically, it is stated by the end of 2024, culturally and religiously sensitive support and counselling services for family caregivers should be available, and all care support and counselling centres should have a range of services tailored to their needs. By the end of 2022, barrier-free information services containing information on multilingual counselling services should already be available in all federal states, and the nationwide database on existing culturally sensitive counselling centres and networking services on the website www.demenz-und-migration.de should be expanded. Also, by the end of 2022, the medical associations Deutsche Gesellschaft für Gerontopsychiatrie und –psychotherapie e.V. (=German Society for Gerontopsychiatry and Psychotherapy) (DGGPP) and Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Ner-

venheilkunde e.V. (=German Society for Psychiatry and Psychotherapy, Psychosomatics, and Neurology) (DGPPN) intend to develop recommendations for the use of multilingual, culturally sensitive assessment instruments for dementia diagnosis. The national dementia strategy thus formulates several objectives with annual figures that aim to develop linguistically and culturally sensitive support, information, and counselling services as well as multilingual and culturally sensitive diagnostic tools for PwM. However, most of these objectives are formulated in very general terms and therefore allow much leeway for varying interpretations. In addition, there is a lack of clarity on how the objectives can be achieved and who would develops the care services or to what extent PwM would be involved [17].

4. National dementia care and treatment guidelines

In the 'S3 Guideline Dementias' from 2016 no direct reference to migration is made at any point. However, one passage addresses the topic indirectly in the form of a discussion about the connection between sociocultural background/language skills and dementia diagnosis. It is shown that socio-cultural background and language skills influence the cognitive performance of people with dementia and can thus also influence the results of dementia diagnostic tests. This leads to the recommendation that detailed neuropsychological tests for differential diagnosis of questionable or mild dementia should take the socio-cultural background or language skills into account. Overall, the topic of migration does not play a significant role in the German guidelines for dementia [18].

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 expert. 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

According to the expert, there are large regional differences in Germany regarding the attribution of importance to the topic of dementia and migration. In some regions and municipalities, the topic already receives more attention, while in other regions it is still completely neglected. As examples of these regional disparities, the expert mentioned the federal state of North Rhine-Westphalia, where the topic is given much importance, and the Free State of Saxony, where it is completely ignored, especially politically. Overall, the issue of dementia and migration only plays a partial role at the national and political level. According to the expert, the issue has been noticed in the German health system for just under ten years, and attention has already declined again in the last two to three years. On the side of the care providers and professionals, the sensitivity regarding dementia and migration is also very different. While many experts recognize that PwM with dementia need special treatment, some feel that people who have been living in the country for decades should begin to adapt. Special needs are identified by service providers and professionals related to different religions and language difficulties. The expert stated that problems arising in the con-

text of care for PwM with dementia are often hastily justified by a person's religion, culture, or origin, which is an obstacle to a differentiated examination of the respective situation. The healthcare system constructs refugees, so-called guest workers, and ethnic German re-settlers as groups with specific problems in the context of healthcare. In the case of refugees, the healthcare providers perceive the biggest problems in language mediation. Besides the expectation of doctors that refugees bring their interpreters, the expert points out, that a central problem is that the decision regarding the necessity of medical treatment for people who do not have an electronic health card is the responsibility of the social services. In the case of guest workers, the existence of a family, that provides part of the care and translation services, is often assumed. Stressful employment biographies and the resulting higher need for care are identified as central problems. Overall, PwM with dementia are identified as a group with specific needs in the context of the diagnosis of dementia (underdiagnosis) and the utilisation of care services. According to the expert, central differences between PwM and non-migrants regarding dementia care consists in the knowledge concerning the entitlement to and application for care services, the access to information on applying for care services, barriers to utilisation of care services, and a different understanding of dementia. Furthermore, PwM are often unfamiliar with the tasks of a professional caregiver in the context of outpatient care, which may cause them irritation.

Moreover, the expert states that care of PwM with dementia is based on a hybrid model with segregative elements (especially for people of from Turkey) and integrative services (for people outside of Turkey). Overall, PwM with dementia are currently not integrated into the healthcare system. According to the expert, little knowledge is available in Germany about the utilisation of care services and the care situation of PwM with dementia. However, it is assumed that this population uses considerably fewer care services than the autochthonous population (only in the case of care allowance [financial support from the state] there are no major differences). In terms of information and counselling for PwM with dementia and their relatives, the expert states the central problem, the expert states, is that the existing counseling structures and information services often focus either on dementia or on the migration background, and a combination of these characteristics or other aspects are rarely or never taken into account. Only in three to four regions are single counselling centres offering specific mother-tongue counselling for PwM with dementia (for example through the Alzheimer Society in Gelsenkirchen and Berlin as well as within the framework of the initiative DeMigranz in Stuttgart). Specialised services for outpatient and inpatient care of PwM with dementia currently are available in individual regions. As examples of existing care services, the expert mentioned the outpatient care service 'Alicare' in Berlin, which provides care in shared flats where people from Turkey and Poland are accommodated. A reference was also made to the inpatient daycare facility 'Veringeck' in Hamburg. Furthermore, some cities such as Berlin, Cologne, or Bielefeld have self-help offices with specific self-help services. Although such services are increasing in numbers, they are currently more the exception than the norm. The expert argues that the existing dementia-specific care services are neither suitable for PwM nor for non-migrants. There are some examples of high-quality care, but overall, the existing care structures are not sensitive to the individual needs of people with dementia. Especially the aspect of intersectionality is completely missing. The existing services are not focused on diversity characteristics of a person and if they take into ac-

count a diversity characteristic such as migration background, they assume a relatively homogeneous group. Consequently, even the few specialised services that already exist are rarely geared towards a heterogeneous population with a migration background. According to the expert, this is a central reason why PwM with dementia hardly use the existing care services. However, measures for intercultural care or support for people with dementia are locally widespread and locally in development. In the expert's opinion, PwM with dementia and their family members rarely participate in the development of care services. If participation occurs, it is only because the managers or staff of the care service organisations have a migration background themselves.

The expert commented that currently culturally sensitive care focuses almost exclusively on religion, country of origin, and food, but in order to encourage more PwM to use dementia-specific care services additional diversity characteristics besides migration background, such as sexual orientation and gender identity, as well as aspects such as traumatisation and loss of the second language, must be taken into account. To ensure person-centred care for PwM with dementia, the expert recommended diversity-sensitive care from an intersectional perspective.

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

According to the consulted expert, the topic of culturally sensitive care plays a rather subordinate role, at least in the education of professional caregivers. When the expert analysed the curricula for nursing education in different federal states a few years ago, some federal states included the topic, even though it was mostly not explicitly termed so. However, cultural sensitivity was only addressed very selectively, for example, by giving knowledge about different religions. Only a few federal states have allocated a fixed number of hours to the topic of culturally sensitive care in education or studies; North Rhine-Westphalia was the state with the highest number of hours. According to the expert, the topic of culturally sensitive care is underrepresented in the education of professional caregivers. A similar situation can be observed in the further training of healthcare professionals. Although there are further training opportunities for professionals in intercultural care, these are not mandatory and are therefore primarily used by those who are already dealing with the issue at their workplace. The professionals who have the biggest need for further training, for example, because they are less open-minded towards PwM, seem to not attend such courses. Moreover, the expert stated that a single training on the topic of interculturality is not sufficient, as the development of a culturally sensitive or diversity-friendly attitude is a long-term process. According to the expert's knowledge, necessary measures such as the establishment of platforms for a continuous exchange on these topics or the initiation of team supervision have not been implemented so far.

The expert stated that based on a study of more than 1,500 caregivers, the proportion of professional caregivers with a migration background is just over 10% in outpatient care and just over 14% in inpatient care. More than half of the professional caregivers with a migration background are originally from the Russian Federation, Poland, Kazakhstan, or another Eastern European country, just under 18% are from Western Europe (including the former Yugoslavia), and just under 7% are from non-European countries (including Turkey).

The expert pointed out that this relatively high heterogeneity among professionals is very positive for the provision of care, but it also poses challenges. As an example, it was mentioned that it can strengthen existing language barriers on the side of people in need of care with a migration background if a care professional speaks a dialect (German or non-German). Moreover, this dialect can trigger a traumatized person in a certain way, which can have a negative effect on the situation of this person. According to the expert, these problems can be countered, if the care providers and professionals are sensitised to them. Simultaneously, the high cultural and linguistic diversity in care also has many benefits. For example, the expert argued that people in need of care with a migration background and their relatives, who do not have perfect German language skills, might have less language-related inhibitions and fear of discrimination if they speak to a professional caregiver who does not speak perfect German herself. In the expert's opinion, the topic of diversity sensitivity in care should be much more present because the diversity of people in need of care as well as the diversity of professional caregivers play a major role. The expert adds that caregivers with a migration background also have a high need for sensitisation. Just because a person has immigrated from a certain country or region does not automatically make them culturally sensitive.

Finally, the expert concluded that the current level of awareness of diversity and cultural differences among healthcare professionals is not sufficient to meet the need for person-centred care.

7. Support for family caregivers

According to the expert, the social network of the family plays a very big role in supporting family caregivers of PwM with dementia. Providers of medical healthcare services are also very important as they are the ones who diagnose and inform about dementia. However, in many cases, they fall short in fulfilling their functions as they do not advise or guide PwM in seeking further dementia-specific care. Therefore, PwM often lack access to outpatient and inpatient care, which means that the formal care and support sector plays a much less active role than it should in the care. Religious communities and migrant organisations generally make low to moderate contributions in providing dementia-specific support for family caregivers, although the support potential of both networks is very large. Currently, the religious communities are willing to provide support, for example, in recruiting participants for studies on the topic of dementia and migration, but they do not have their own stance on this topic, which would be necessary to sensitize the members of the respective communities about dementia.

The need for specialised services providing support and information to family caregivers of PwM with dementia is estimated by the expert to be very high. Currently, there is a huge lack of information about the healthcare system, the nature of dementia, and the prevalence of the disease. Multilingual information resources do exist, but they are hardly used, presumably due to wrong communication mediums. The expert pointed out that research has shown that flyers and other such literature are less effective information transfer mediums for PwM than other mediums such as lectures or films.

Accordingly, it is not only important to provide specialized information adapted to the needs of PwM but also to choose the right medium for information transfer.

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