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Toward equitable dementia care for older migrants: a new conceptual framework

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Abstract

Belgium, like the rest of Europe, has a growing population of older migrants living with dementia. Culturally sensitive care is widely endorsed as the dominant approach to creating accessible care; however, our qualitative research with older labor migrants and their caregivers of Italian, Moroccan, and Turkish descent challenges this premise. This approach reduces complex, intersecting care needs, shaped by socio-economic position, migration histories, religion, and family dynamics, to an essentialist notion of cultural otherness. In doing so, it obscures the role of systemic exclusionary mechanisms, such as assumed neutrality, intersectional otherness, and racialization that obstruct access to quality care. Drawing on intersectionality and decolonial frameworks, this paper develops a new conceptual framework for equitable dementia care. It positions care inequities as structurally produced across interconnected levels and calls for equally layered responses. In doing so, it opens pathways toward more equitable futures of care for minoritized and racialized aging populations.

Keywords: care inequities, dementia care, older migrants, intersectionality, decolonial care

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Introduction

In times of growing visible and invisible diversity, it is crucial to move beyond one-dimensional perspectives and examine the nuanced layers and complexities that diversity brings to care. Therefore, this paper proposes a novel conceptual framework for equitable dementia care that transcends the dominance of culturally sensitive approaches by drawing on intersectional and decolonial perspectives to advance responsive dementia care for older migrants while engaging with the complex and layered realities shaping their care provision in Belgium. This paper is structured into five sections. The methodological approach and limitations of the empirical study that informed the creation of a conceptual framework for equitable dementia care for older migrants are outlined in the first section of this paper. The reasoning behind this paradigm is discussed in the following three subsections. The second section describes the increased diversity among older adults with dementia in Belgium, highlighting the need for more inclusive care responses. The third section critically examines culturally sensitive care as a primary approach to meet the needs of older migrants with dementia, arguing that we must move beyond one-dimensional approaches that reproduce essentialist and culturalist views on care for older migrants and their families. Part four presents a complex and nuanced reality of dementia care provision among older labor migrants in Belgium, which is influenced by their intersectional societal position, intersectional otherness, and racialization as covert and structural exclusionary mechanisms. Based on these insights and informed by intersectional and decolonial perspectives, the fifth section introduces a conceptual framework for equitable dementia care, emphasizing the need to understand the interwoven nature of the intersections of various social identities and the systemic exclusionary mechanisms that affect care quality for older migrants, suggesting actions on the micro-, meso-, and macro-levels for equitable care. This paper concludes by exploring potential applications of the framework, calling for further research to assess its potential in advancing equitable dementia care.

Methods and Limitations

The conceptual framework for equitable dementia care proposed in this paper is the result of a multilayered process of critical analysis and theoretical reflection, guided by the central question: How can an equitable dementia care framework be conceptualized when grounded in the lived experiences of older migrants and informed by intersectional and decolonial perspectives that transcend the limitations of culturalist approaches?

This study draws on findings from a 5-year empirical research project (2016–2020) conducted in Belgium, integrating critical reflection of established care models with insights from intersectional and decolonial perspectives. The research focused on older labor migrants with dementia, their family caregivers of Moroccan, Turkish, and Italian descent, and professional caregivers. At the heart of this study was the question of how dementia care is provided and experienced from the perspectives of these three key actors. To address this question, we employed a combination of cross-sectional and longitudinal qualitative methods. First, 34 family carers and 15 professional carers participated in in-depth interviews. Additionally, five focus groups ($n = 34$) were conducted with professional caregivers. Second, a longitudinal component involved close engagement with five families over 3 years. Through participant observation and repeated interviews with older migrants (65–82 years old) with dementia, their family members, and involved care professionals, this study captured the evolving care experiences over time. Furthermore, three focus groups were held with 52 older labor migrants (above 65 years old) with and without dementia. Each group was organized around a shared migration background representing their Moroccan, Turkish, and Italian origins. To stimulate dialogue, these sessions utilized accessible, culturally, and language-sensitive visual information about dementia and dementia care pathways in Belgium. Participants were invited to share their care preferences and reflect on their experiences with the professional care they received.

Limitations

Despite the depth and scope of this study, several limitations must be acknowledged when considering the proposed conceptual model. First, the participating labor migrants from Moroccan, Turkish, and Italian backgrounds do not fully represent the broad ethnocultural diversification of the Belgian population (Geldof et al. 2023; Statbel 2025).

Second, although the model engages with oppressive systems that have a global dimension, the findings are also shaped by Belgium's distinct history (Salem et al. 2023) and its specific health and care systems (Gerkens & Merkur 2020). These contextual specificities should be considered when interpreting the model's scope and applicability. They also point to the need for further research that extends, deepens, and tests this framework across diverse settings and populations.

Increased Diversity of Older Persons with Dementia

The aging population in Belgium reflects the increasing ethnic diversity seen across Europe due to 20th-century migration patterns (Ciobanu & Hunter 2017). Initially driven by labor migration from countries such as Italy, Morocco, and Turkey, Belgium now hosts a more diverse group of migrants. These include individuals from former colonies such as Congo, transition migrants, and refugees from Afghanistan, and Ukraine, among others (Lafleur et al. 2018). In 2024, 36% of Belgians had a foreign non-Belgian background (Statbel 2025). Of those aged 65 years and above, 15% were of non-Belgian origin. Cities such as Antwerp, Charleroi, and Brussels exhibit higher rates, reaching 20%, 32.5%, and 47%, respectively (Statbel 2025). These figures have continued to increase over the past 5 years, with Brussels alone accounting for 39% of older migrants in 2020 to 47% today (Statbel 2025). Older migrants in Belgium, like their native counterparts, face age-related conditions such as dementia, with an estimated 7% of those aged 65 and above affected (Monsees et al. 2021). Research shows that non-European migrants have higher dementia prevalence than native populations (Alzheimer Europe 2018). For example, Moroccan and Turkish individuals in the Netherlands face rates three to four times higher than the native Dutch (Parlevliet et al. 2016). However, bilingualism may have protective effects against dementia, highlighting the need to avoid simplistic generalizations (Li & Coretta 2026).

Culturally Sensitive Care: The Answer to Unmet Care Needs?

Although awareness of Belgium's ethnically diverse aging population is increasing, mainstream dementia and elder care remain largely inaccessible and inadequate for migrant seniors. Limited health literacy, combined with a lack of information about and limited referral by professional carers to formal care services, contributes to the inaccessibility of dementia care (Duran-Kiraç et al. 2022, 2023). Challenges in delivering adequate dementia care stem from professionals' limited experience and skills in supporting older migrants with dementia and their informal caregivers, leading to insufficient consideration of their needs (Duran-Kiraç et al. 2022). Discrimination and racism in healthcare deepen the encountered inadequacy in care for older migrants (Zemouri et al. 2024). Formal dementia care remains largely untailored to the needs of older migrants (Berdai Chaouni et al. 2020a; Duran-Kiraç et al. 2022). Belgian care policies are presumed to be "neutral" and fail to address cultural and religious needs, especially of non-European and non-Christian older migrants (Ahaddour et al. 2020; Berdai Chaouni et al. 2024). The latter are left to fall through the cracks of inaccessible and inadequate dementia care on the one hand, and fragmented traditional family care on the other (Berdai Chaouni et al. 2020a; Duran-Kiraç et al. 2022).

As in the rest of Europe, culturally sensitive care is proposed as a solution to address the needs of older migrants with dementia in Belgium (Dely et al. 2018; Gove et al. 2019). Cultural sensitivity refers to the sensitivity manifested toward people's cultural backgrounds (Vandecasteele et al. 2024). Transforming an attitude of awareness and respect for the diversity of cultural backgrounds into the ability to collaborate effectively with individuals from different cultures is often referred to as culturally competent care (Nair & Adetayo 2019). Culturally competent care has been argued to increase positive health outcomes and positive care relationships between cultural minority patients/clients and majority professional caregivers (Nair & Adetayo 2019). Both terms are often used interchangeably and emphasize at their core the consideration of the ethnic and cultural background of persons in care, which is believed to be the approach to ameliorating care provision (Claeys et al. 2021; Vandecasteele et al. 2024). Culturally sensitive care, defined as "looking at ways to respect and respond to the cultural diversity of people with dementia, their relatives and friends and of those caring for people with dementia" (Gove et al. 2019: 6), is viewed by Alzheimer Europe as key to inclusive care for older migrants (Gove et al. 2019).

While culturally sensitive care aspires to guarantee better care for ethnic minorities, there are pitfalls to consider. First, it is a Western-centered concept that emerged to be employed in a White, Western context concerning the *cultural*, mainly non-Western *other*. Culture is often framed as a fixed trait of *the other*, vaguely defined and reduced to ethnic background, making it confusing or even meaningless (Ahmad & The 2025; Torres 2019; Torres & Hunter 2023). This static view contrasts with more nuanced understandings of culture as dynamic and shaped through multiple social affiliations and lived experiences (Curtis et al. 2019). This narrow conceptualization of culture is evident in care practices, wherein professional caregivers perceive and implement culturally sensitive care in ways that lead to culturalization and "othering" of migrant care recipients (Claeys et al. 2021; Vandecasteele et al. 2024). Culturally sensitive care assumes that only the migrant/ethnic minority *other* has a culture, relieving professional carers from the culturally dominant group of the responsibility to reflect on how their beliefs and actions are shaped by their own culture (Torres 2019). Culturally sensitive care often relies on simplistic, homogenizing assumptions that erase intragroup diversity and complex identities, reducing quality care to a one-size-fits-all cookbook approach (Ahmad & The 2025; Curtis et al. 2019; Torres 2019; Vandecasteele et al. 2024).

These pitfalls create an implicit divide between older migrants and culturally dominant groups in dementia care. It assumes older migrants' needs can be addressed solely through care focused on their *different* ethnocultural backgrounds. This is also visible in several European dementia policy plans (Schmachtenberg et al. 2020), such as the Flemish reference framework, an inspirational guideline for dementia care in the Northern region of Belgium (Dely et al. 2018). This framework promotes person-centered care (PCC) for ethnically dominant groups, but treats cultural diversity as relevant only for non-EU migrants, framing culturally sensitive care as the solution to *their* specific needs (Dely et al. 2018). Such subtle othering shapes dementia care around dominant norms, marginalizing and essentializing those who differ. Moreover, this culture-based focus in dementia care obscures underlying social inequalities such as racism, hindering the development of effective strategies to address these inequalities (Ahmad & The 2025). Dementia care institutions function as "construction sites" where older migrants are defined through simplified notions of ethnicity, race, and migrancy, deeply influencing how they are perceived and cared for (Torres & Donnelly 2023). Amid rising critique, our findings portray a complex image of dementia care for older migrants, questioning culturally sensitive care as the dominant gaze for improving access and quality.

Various Influences on Dementia Care for Older Migrants

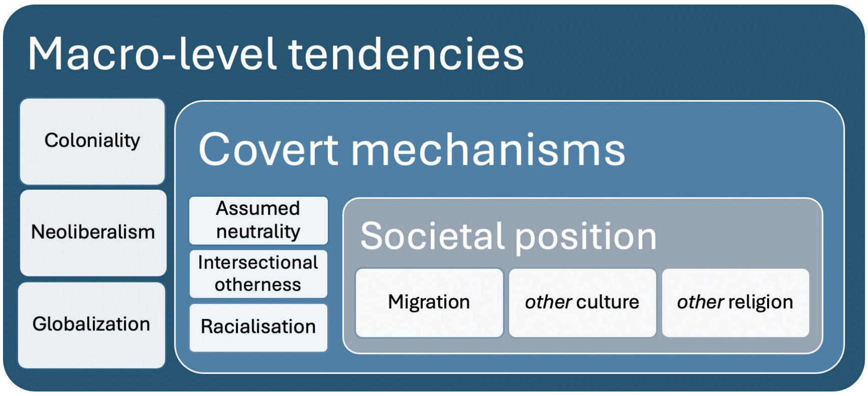
This section discusses findings from our 2016–2020 study on dementia care for older Moroccan, Turkish, and Italian labor migrants in Belgium, drawing on cross-sectional and longitudinal data from migrants, their families, and caregivers, as described in the Methods and Limitations sections (Berdai Chaouni 2021; Berdai Chaouni & Claeys 2022).

These findings were analyzed through the lenses of intersectionality and decoloniality. Coined by Crenshaw (1991) and rooted in the resistance knowledge of Black feminists (Collins et al. 2021), intersectionality focuses on the importance of examining the multiple and interlocking systems of domination (such as racism, ageism, ableism, sexism, and classism) that shape and structure people's lives and experiences through the interplay between intersecting categories of difference (such as race, age, physical and mental ability, gender, and class) with wider systems of domination and underlying variations in privilege and marginalization (Collins et al. 2021). Intersectionality enhances the capacity to understand the complexity and structural roots of the experiences of marginalization in care provision. However, to understand the impact of historically invisible forces shaping the current oppressive systems and the knowledge systems informing care provision, decolonial perspectives are also used (Berdai Chaouni et al. 2021). Our study points to various influencing factors for dementia care provision situated on the micro-, meso-, and macro-levels, which are dynamic and interconnected and shape the dementia care trajectory of our respondents (Figure 1).

The Unique Socio-Economic Position Defines Dementia Care

On a micro-level, our studies show that the care needs of older migrants with dementia are defined by a unique, dynamic, and complex intersection of personal (e.g. own life history, stage of dementia, severity, and

Figure 1. Multiple influencers of current dementia care provision.



fluctuation of dementia symptoms, impact of dementia on personality traits), socio-economic (e.g. having children, economic situation, proximity and level of education of family caregivers), cultural (e.g. food and music preferences, language, own mix of cultural values), migration-experience-related (e.g. own migration trajectory, reminiscence of childhood spent in country of birth, level of attachment to persons and places in the motherland), and religious aspects (e.g. level of personal religiosity and importance of religious practices, level of dominance of religious coping). These aspects influence the care needs of older migrants with dementia and the support needs of their family caregivers. Dementia's fluctuating course, coupled with the pioneering role of older migrants and their families in navigating it, makes the condition particularly challenging and elusive. Another example is how dementia brings migration to the forefront as a significant part of a person's life history. Dementia can surface long-silenced memories, including migration trauma, which families often face and process for the first time through caregiving (Berdai Chaouni & De Donder 2019).

The interplay of having a migrant background and a *different* culture and religious background, together with other factors such as class, gender, ability, and education, determines the starting point from which older migrants and family carers must navigate the dementia care trajectory and co-shapes how that care is provided. For example, cultural and religious values (e.g. respect for one's elders, spiritual needs) and practices (e.g. specific meals, listening to the Quran) are wished for in dementia care but are almost exclusively provided by family care (Berdai Chaouni et al. 2024). Depending on one's possibilities (e.g. competencies, network, economic situation) and migration, cultural, and religious resources (e.g. network and property in the country of origin, cultural heritage, religious coping), family caregivers fill in the professional care gaps to provide suitable, sustainable, affordable, and responsive dementia care. This includes transnational strategies like hiring live-in migrant caregivers or arranging care marriages for widowed fathers with dementia (Berdai Chaouni et al. 2020a, 2024). All the above indicate how the socially constructed, non-inclusive dementia care system (Collins et al. 2021) places the responsibility for addressing migration, cultural, and religious needs in dementia care onto families.

Covert Exclusionary Mechanisms in Dementia Care: Neutrality, Intersectional Otherness, and Racialization

Dementia care is also influenced by hidden exclusionary mechanisms, such as presumed neutrality, intersectional otherness, and racialization that limit access to quality care for older migrants.

Assumed neutrality sets the norms of what is considered professional dementia care, and therefore something to live up to while alluding to being universal. Examples abound of the obliviousness of professional dementia carers to how dominant cultural norms, biomedical dominance, and a White Eurocentric gaze shape diagnostic tools, care standards, and definitions of *good* care. For example, the use of the Mini-Mental State Examination (MMSE) as the gold standard for dementia medication reimbursement in Belgium disadvantages older migrants, both clinically and financially (Berdai Chaouni & Claeys 2022). Its lack of cultural, educational, and linguistic sensitivity leads to biased scores (Nielsen 2022; Nielsen et al. 2012), resulting in medical treatment being withheld or prescribed without reimbursement due to MMSE-based eligibility criteria (Berdai Chaouni & Claeys 2022). Another example is the way Belgian (dementia) care organizations, implicitly or explicitly shaped by Christian values (Ahaddour et al. 2016), problematize, resist, or ignore the religious needs of older migrants (particularly Muslims) under the claim of neutrality (Ahaddour et al. 2016; Berdai Chaouni et al. 2024).

Finally, the belief in the universality of "White templates" in care, such as PCC, while the experiences and needs of older migrants and their families are less recognized and subordinated, often unconsciously, compared to those of the normative group.

Older migrants with dementia and their family members also face intersectional othering and racialization as processes of differentiation, reflecting systems of domination such as racism, ageism, ableism, sexism, and classism. Othering is observed in the experiences of discrimination and interiorization of our respondents based on the intersections of the following characteristics: old age, having dementia, being a migrant, having a migration background, being female in the case of family caregivers, providing care, having a non-dominant ethnicity, having a dark skin tone, speaking another language, and having another culture and religion (Muslims) (Berdai Chaouni 2021; Claeys et al. 2025). Our studies showed that care professionals categorized migrant care recipients and their families based on their perceived *sameness* or *otherness* compared to themselves. For example, although family involvement in dementia care for older migrants is complex and not strictly defined by gender, professionals often perceive female carers as over-involved and male carers as under-involved, particularly among Muslim, non-European families, reinforcing gendered and racialized stereotypes (Berdai Chaouni & De Donder 2019). This resulted in gradations of intersectional otherness, positioning non-European Muslim care recipients (e.g. Moroccan and Turkish) as the ultimate *others,* unlike Italians, who are seen as the *same* based on an assumed shared Whiteness, culture, and religion. The Moroccan and Turkish groups were also more often essentialized to their *other* culture, contributing to poor care provision through uncaring encounters (Söderman et al. 2018) where needs were reduced to deviant requests from another culture. For example, Belgian carers reported systematically avoiding offering the option of professional dementia care, assuming that these families prefer family care due to their culture. This reinforces the stereotype that non-EU migrants favor family care, limiting informed decision-making.

Older migrants with dementia and their family carers are not only othered, but also racialized. Racialization can be defined as an ongoing and dynamic process through which racial meanings are constructed and assigned to individuals or groups based on certain perceived characteristics (e.g. cultural background, physical traits, religion) that were previously not classified as racial, based on the original Black/White binary conception of racism (Gonzalez-Sobrino & Goss 2021). Older migrants with dementia and their family members were racialized based on the following characteristics and their intersections: skin tone, non-European cultural background, being Muslim, and not mastering Dutch. Racialization is manifested through experiences of various forms of racism (e.g. cultural and anti-Muslim racism) recounted by both older migrants and their family carers, mainly with Moroccan and Turkish backgrounds, during their interactions with healthcare professionals in dementia care (Berdai Chaouni & Claeys 2022). These experiences encompass both overt (e.g. verbal aggression, racist remarks) and covert (e.g. avoiding eye contact, adopting a condescending tone, or not addressing clients' questions seriously) manifestations of racism. Encountering racism often triggers reactions such as lowering expectations of care, avoiding certain situations, and efforts to educate caregivers or advocate for better care (Berdai Chaouni 2021). These responses are driven by stress, sadness, and powerlessness. When family caregivers explicitly call out racism, dementia care organizations often respond defensively or dismissively, intensifying the emotional impact.

Coloniality, Neoliberalism, and Globalization as Macro-Forces Shaping Dementia Care

Drawing on a decolonial understanding (Berdai Chaouni et al. 2021), the participants' testimonies revealed that dementia care trajectories are shaped by macro-level forces, such as neoliberalism, globalization, and coloniality, even if these forces are not explicitly mentioned. The concept of decoloniality emerged from the experiences and resistance of dominated peoples who fought against the oppressive structures imposed by Western European colonialism (e.g. Indigenous peoples, enslaved Africans). These insights have evolved into diverse ways of thinking, knowing, being, and doing, which serve as building blocks for current decolonial frameworks.

At its core, decoloniality "… implies recognition and undoing of the hierarchical structures of race, gender, heteropatriarchy, and class that continue to control life, knowledge, spirituality and thought, structures that are intertwined with and constitutive of global capitalism and Western modernity" (Walsh 2018: 17). Decoloniality acknowledges and resists oppressive colonial power mechanisms that persist beyond the formal end of colonial rule, a phenomenon often referred to as coloniality (Mignolo & Walsh 2018), which also shapes healthcare care systems. This legacy affects not only formerly colonized countries, but also Western nations. For instance, Hunter (2021) points to the dominance of "White care" in welfare states, highlighting how historically rooted colonial dynamics of racialization and dehumanization of the *other* persist through systemic racism and racialist structures, contributing to inequitable care practices that center on the White imaginary. Such dynamics lead to the inferiorization and deprioritization of the needs of racialized minorities, as our respondents noted. This underlying dehumanization helps explain why older migrants are often expected to assimilate into dementia and elder care systems (Berdai Chaouni & Claeys 2022), even when culturally and linguistically sensitive care is provided (Carlsson & Pijpers 2021). In other words, without addressing the deeper, often unconscious processes of dehumanization, even well-intentioned culturally and linguistically sensitive care remains superficial and reinforces assimilationist expectations by requiring older migrants with dementia, whose differences are neither fully acknowledged nor respected, to adapt to the care system. The decolonial perspective also points to the coloniality of the mind as a historically invisible structuring force ingrained in our mind frames that shapes power structures, knowledge, and individual experiences (Berdai Chaouni et al. 2021; Mignolo & Walsh 2018). This force also shapes, for example, the above-discussed assumed neutrality, normativity, and universality of Western care practices and the racialization of non-European older migrants and their family carers.

Coloniality, intertwined with neoliberalism and globalization, shapes global power imbalances that influence dementia care provision and individual choices. The influence of neoliberalism was traced in our studies with both professional and family caregivers. They referred to the performance pressures of professional dementia carers with limited room for human aspects of care, such as relationship-building and flexibility, alongside a lack of supportive measures and budget cuts (Berdai Chaouni & Claeys 2022). Neoliberalism reinforces the inferiorization of care by framing it as a product that is not entitled to society's resources and investments to maintain its quality and existence (Miller 2021; Morris 2025). This leads to inequalities in accessible and affordable care. For example, financial pressure and staff shortages were the most frequently cited reasons for postponing investment in culturally sensitive organizational policies by the management of residential care homes in Flanders (Berdai Chaouni et al. 2020b). The intertwining of neoliberalism and globalization is seen in phenomena such as global care chains and outsourcing of care to the Global South (Horn & Schweppe 2019; Schwiter et al. 2020). The alternative care choices of family caregivers of older migrants with dementia, such as care marriages, engaging live-in undocumented helpers, and respite care in Morocco (Berdai Chaouni et al. 2020a), can be seen as a variant of these phenomena.

In summary, the complex and nuanced factors influencing dementia care for older migrants highlight the need to rethink culturally sensitive care as the primary approach for this group. Culturally sensitive care risks being essentialist, as it overlooks the intricate interplay of intersecting categories of difference (e.g. race and gender), processes of differentiation and exclusion (e.g. racialization and intersectional otherness), and structural systems of domination and oppression (e.g. coloniality and racism). These dynamics underpin inequities in dementia care for older migrants and demand a more comprehensive, intersectional, and structural approach.

Introducing an Alternative Conceptual Framework for Equitable Dementia Care

This section introduces a conceptual framework for equitable dementia care, considering the complex factors influencing dementia care needs and provision while accounting for mechanisms driving equity and inequity.

Foundational Insights Inspiring the Conceptual Framework

This conceptual framework draws on key insights, highlighting the nuanced nature of dementia care for older migrants. It builds on established models, Kitwood's PCC (1997), Engel's biopsychosocial model (1978), and Bronfenbrenner's ecological model (1979), expanded by intersectionality (Crenshaw 1991), and decolonial perspectives (Berdai Chaouni et al. 2021). These models provided essential insights but showed limitations when applied to older adult migrants with dementia, which this framework addresses.

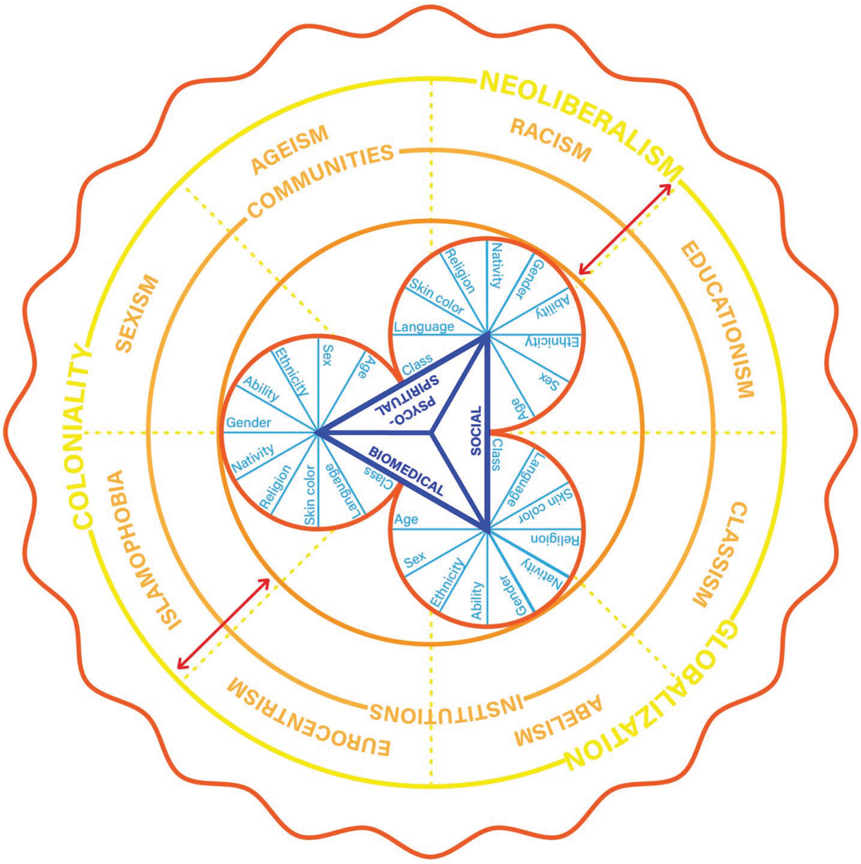
Kitwood's PCC model identifies essential psychological needs – comfort, attachment, inclusion, occupation, and identity – rooted in the central need for love, as critical to maintaining personhood in dementia (Kitwood 1997). He emphasized professional caregivers and supportive environments in addressing these needs, improving quality of life, and reducing stress. It emphasizes relationships, social context, and emotional support in preserving personhood and well-being. Kitwood's work redefined dementia care by viewing individuals as whole persons with unique needs, rather than merely patients defined by their condition, shifting focus from biological to psychosocial factors (Brooker 2019). While this psychosocial and relational perspective remains central, the new framework challenges the individualization of care that overlooks its collective dimensions and the impact of structural inequalities on PCC delivery.

The biopsychosocial model (1978) emerged from dissatisfaction with the biomedical model of illness. It is now generally accepted as a model indicating that illness and health are the result of an interaction between biological, psychological, and social factors. The model is widely used as a structure for healthcare interventions, guidelines, management, and research (Bolton 2023). However, it often overlooks how structural power dynamics such as racism and coloniality shape both health experiences and care trajectories. The proposed framework builds on this model while explicitly integrating these dimensions.

Bronfenbrenner's ecological model (1979) is a theory-based framework to understand the multifaceted and interactive effects of personal and environmental factors. It puts the individual at the center, which is influenced by various systems: microsystem (relationships with immediate surroundings), mesosystem (community), exosystem (institutions), macrosystem (societal influences), and chronosystem (time & historical context). Originally developed to understand human development, Bronfenbrenner's model has since been widely applied and adapted to other fields, including health care (Ornstein & Caruso 2024). The new framework deliberately excludes the exosystem, integrating institutions into the mesosystem alongside communities to highlight their interconnected role in this relational space between the micro- and macro-levels.

The conceptual framework assesses care models through an intersectional-decolonial perspective. This perspective shows that care provision exists within intersecting power systems that marginalize older migrants with dementia and their families, shaping their care needs and experiences with care inequity. Put differently, historically rooted marginalization through oppressive systems and structures defines how the above-mentioned models of care (e.g. PCC, biopsychosocial, and ecological models) are provided and experienced by non-White older migrants with dementia. Torres et al. (2016) demonstrated that individuals categorized as *us* are more likely to receive PCC than those perceived as the *other*. The expectation of *sameness* with the dominant group often hinders the provision of PCC for those who are perceived as *different*. Decolonial perspectives also emphasize the interconnectedness of the coloniality of power, knowledge, and being, highlighting how these dimensions collectively sustain systems of domination and exclusion (Mignolo & Walsh 2018). While coloniality of power underlines the endurance of racialized and inequitable systems of domination globally (Grosfoguel 2011; Quijano 2000), coloniality of knowledge stresses the dominance of Western and Eurocentric epistemologies, marginalizing other ways of knowing and reproducing inequities through knowledge production (Mignolo 2011; Mignolo & Walsh 2018). Coloniality of being highlights the persistence of the color line shaping hierarchies between people through racialization and dehumanization, shaping the lived experiences of these people (Fanon 1952/2008; Maldonado-Torres 2011). In other words, the intersectional-decolonial perspective acknowledges these "behind the scenes" mechanisms also in care systems, providing insights (e.g. the importance of relationality, interdependence, and resistance) and perspectives (e.g. epistemic disobedience, centralization of lived experiences of racialized voices) to address inequity in dementia care as part of broader social justice efforts.

Figure 2. Conceptual framework for equitable dementia care.



The Conceptual Framework

The conceptual framework offers a multilevel perspective comprising four intertwined levels: micro, meso, macro, and chrono, as visualized in Figure 2.

First, at the micro-level, the conceptual framework centralizes the care relationships between the person with dementia, the informal carer, and the professional carer, envisioned as part of a dynamic and (transnational) care network. These care relationships are influenced by needs that can be extended biopsychosocially (i.e. the inclusion of spirituality) for all individuals involved and by an axis or an intersection of multiple axes of their multidimensional social identity (age, gender, ethnicity, ability, nativity, religion, class, language, sexual orientation, and skin color). It is important to acknowledge the structural societal advantage or disadvantage linked to different positions on the axes at any given time and in a specific context or situation (Carbado et al. 2013; Collins et al. 2021). The framework emphasizes the importance of relationality and interdependence of all individuals involved in the care relationship. It acknowledges how their social positions within intersecting power dynamics shape their experiences and their perspectives (Collins et al. 2021) influencing the care relationship itself. Accordingly, the care relationship is understood as dynamic and collectively shaped, embedded within a complex social context while maintaining its core focus on meeting the older person's needs, consistent with PCC principles.

Second, the meso-level refers to the influence on dementia care provision by communities and care institutions. The framework acknowledges that individuals involved in the care relationship are part of communities, shaping their views on care and the context of how care is and should be provided. For example, some migrant communities may lack dementia sensitivity due to limited exposure, contributing to a vulnerability among older migrants shaped by intersections of dementia, culture, and migration (Berdai Chaouni 2021; Wong et al. 2024). The framework also recognizes that community membership is dynamic, with individuals belonging to multiple, overlapping communities. For example, our studies (Berdai Chaouni & Claeys 2022; Berdai Chaouni et al. 2020a) show how transnational ethnic, cultural, and religious ties, even when maintained remotely, influence dementia care. From an intersectional and decolonial perspective, the framework acknowledges that racialized older migrants (e.g. non-White, Muslim) are part of marginalized communities with shared care needs, such as healing from racial trauma that may resurface through dementia (Bryant-Davis 2023; European Union Agency for Fundamental Rights 2023, 2024; The Lancet 2022). It also recognizes these communities as potential sites of collective care and resilience (Alvarez & Farinde-Wu 2022; Page & Woodland 2023; Raap et al. 2022).

Dementia care organizations also play a critical role in shaping care relationships and trajectories, where professional caregivers act within the constraints and logics of institutional structures. Moreover, these institutions are also shaped by historically rooted power systems (e.g. coloniality, racism). For example, healthcare institutions often overlook or even resist acknowledging the systemic racism embedded within their structures, perpetuating health and care inequities (Hamed et al. 2020; Helberg-Proctor & Busari 2023; Nazroo 2024). In other words, this conceptual framework highlights how intersecting systems of domination and oppression operate through interconnected structural, institutional, and interpersonal dimensions, emphasizing that achieving dementia care equity requires addressing all these components.

At the macro-level, the framework highlights how structural forces such as neoliberalism, globalization, and coloniality, shape dementia care for older migrants as evidenced in our studies**.** The underlying power structures (ageism, ableism, racism, sexism, etc.) in society define the axes of advantage/disadvantage at the individual level. Consequently, they determine each person's societal position, whether marginalized or central within the power structure, from which they interact with others. The conceptual model acknowledges the role of actors at the micro- and meso-levels in contributing to these structural mechanisms. It explains, for instance, how covert mechanisms like racialization and othering influence dementia care provision. From this perspective, tackling these structural mechanisms is crucial in tackling inequity in dementia care provision. Finally, the chrono-level in the conceptual framework captures the importance of time in dementia care provision for older migrants. Drawing from our results, time plays a multifaceted role in the care process. It appears through evolving care needs across dementia stages, changing care relationships, and personal histories, where past experiences resurface, are shaped by life course, identity, and social position. Time also emerges in the historical underpinnings of power structures with time frequencies, longevities of, and intergenerational exposure to systems of domination underlying variations in experiences and impact (Gee et al. 2019). It also highlights the temporality of the care provision influences, with varying levels of importance at different moments. For example, certain elements of social identity can take precedence in shaping care priorities: religious practices might be highly valued during the early and middle stages of dementia but may become less central in later stages, where biomedical needs and physical comfort often take precedence.

Taken together, the conceptual framework for equitable dementia care emphasizes that providing tailored and quality care for older migrants with dementia involves three key dimensions. First, care must center on the needs of older migrants with dementia while considering the interconnected needs of informal carers (e.g. the need to feel understood) and professional carers (e.g. the need for reassurance), as these needs shape and influence care provision. Second, there must be an awareness of the complex, dynamic, and situational nature of these needs, which can be bio-psychospiritual, social, visible, or invisible, shaped by the intersectional identity and position of everyone involved and manifesting at the individual level but are reflections of systemic gaps at institutional (e.g. lack of diversity-responsive dementia care organizations) and societal levels. This includes structural health disparities such as the increased prevalence of dementia among racialized populations (Fani et al. 2022), which result from systemic disadvantages rooted in intersecting axes of marginalization like poverty and racism (Adkins-Jackson et al. 2024). Finally, detecting, understanding, and addressing these multifaceted needs require concerted actions across micro-, meso-, and macro-levels to ensure that dementia care becomes equitable for marginalized populations, such as older migrants.

Exploration of Possible Applications

Acknowledging the limitations, this part explores possible applications of the conceptual framework as a critical reflective approach to address various care-related topics at the micro-, meso-, and macro-levels.

Meeting Individual Cultural Needs in Care Provision (Micro)

The conceptual framework critiques the reductive, culturalist understanding of older migrants' dementia care needs, exposing it as inadequate and potentially harmful. Culturally shaped needs become one of a range of important needs of a person, which can be seen as part of biopsychospiritual and social needs, which can vary in time and context (e.g. home vs. hospital), without being oblivious to a person's multilayered identity. It also recognizes that cultural needs and expressions shape everyone in the care relationship, including those from the dominant culture. It highlights how professional care often aligns with dominant cultural norms, treating Whiteness as the invisible standard and Western practices as neutral and normal, reinforcing inequities for marginalized and racialized groups. This view aligns better with the requested critical consciousness and reflective practice in cultural safety (Curtis et al. 2019). Cultural safety aims to advance care equity by addressing the impact of the dominant culture of (health)care providers, manifested by interpersonal and institutional power imbalances, on the quality of care. By shifting focus from the *other* to addressing systemic power imbalances, this approach improves care quality through decolonized practices, critical reflection on bias and stereotypes, and centering marginalized voices in assessing the safety of care interactions (Chakanyuka et al. 2022; Curtis et al. 2019).

Intersectional-Friendly Environment and Inclusive Integrated Care Landscape (Meso)

The conceptual framework helps to envision an intersectional-friendly environment for older migrants with dementia, shaped by caring communities and inclusive care organizations. Various policy guidelines have promoted age-friendly cities (WHO 2023) and dementia-friendly communities (WHO 2021), often through single-focus actions aimed at accessibility and inclusion based on either age or dementia. An intersectional approach strives for the social inclusion of disadvantaged persons based on the different identity axes and their intersections. This approach would better detect and understand why certain communities, like older migrants, are not reached by dementia-friendly initiatives and set up remediating actions to include everyone with dementia. For racialized migrant communities unfamiliar with dementia, promoting dementia-friendly actions can help foster supportive environments for those affected and their families (Berdai Chaouni et al. 2024). This also means recognizing the potential of these communities as sites of collective care, grounded in non-normative knowledge and practices (Alvarez & Farinde-Wu 2022; Page & Woodland 2023; Raap et al. 2022). The framework shifts the focus from individualized to collective care as an approach that deserves greater attention, particularly in the European context (Turton 2024).

These communities should also be considered equal partners in an inclusive, integrated care landscape. A chapter (Berdai Chaouni 2022) applied this conceptual framework to reflect on the shift toward integrated care in Belgium, emphasizing four interlocked key focal points for fostering inclusivity. First, awareness of how intersectional exclusionary mechanisms shape the needs and experiences of marginalized *others*. Second, marginalized voices and knowledge must be actively included in shaping this change process, ensuring that these perspectives inform decision-making processes. Third, an inclusive care landscape is composed of inclusive care organization. Creating inclusive care organizations requires tackling structural exclusionary mechanisms that shape how marginalized and racialized care recipients are treated, factors influenced by organizational culture, policies, and hierarchies (Bourabain & Verhaeghe 2021).

This requires a deep-structure approach (Resnicow 1999): long-term, organization-wide efforts that go beyond superficial happy diversity initiatives (Ahmed 2012; Trenerry et al. 2024) to transform vision, staffing, services, and client policies and ensure equitable care.

Finally, critically reflecting on the care landscape is vital to identify service gaps and foster community-driven innovations. This includes addressing transnational care dynamics, intersecting systems of exclusion, and global trends, such as the bias embedded in algorithmic care tools (Alba 2024).

Intersectional Approach to Guarantee Elder Rights for All

Within this framework, inclusive equitable care can only thrive in a society committed to equity, requiring macro-level actions against ageism, disablism, racism, sexism, and other systemic exclusions. To counter this, the conceptual framework was applied to critically examine a recent initiative by AGE Platform Europe (n.d.) promoting elder rights, aimed at preventing future instances of ageism in care. This became especially urgent during the COVID-19 pandemic, when older adults' perspectives were largely excluded from key decisions, such as nursing home lockdowns (Peisah et al. 2020). From this analysis, the chapter (Berdai Chaouni 2023) identified three essential elements for advancing inclusive elder rights. First, it calls attention to the pitfalls of assumed universality of concepts like elder rights, highlighting that, much as their inspiration in human rights, elder rights can be exclusionary for marginalized and racialized groups. Second, it underscored the importance of an intersectional approach to address overlapping forms of discrimination stemming from intersecting systems of exclusion, such as ageism and racism, arguing that this approach is more beneficial to tackle this intertwined reality than a singular focus on ageism (Gemignani & Hernández-Albújar 2019). This aligns with Atrey's (2020) concept of "intersectional universality," which emphasizes that the intersecting structures of power shaping individual identities and experiences are universal. An intersectional perspective offers a more nuanced manner to identify how human rights are upheld or violated.

Finally, it stressed the need to include marginalized and racialized older adults in shaping elder rights, challenging current participatory processes dominated by White, male, and highly educated voices.

In summary, the examples explored illustrate the potential of the conceptual framework as a critical reflective gaze to examine care realities and trends. It highlights the blind spots of normative approaches, underscores the importance of centering the voices of marginalized and racialized older adults, and incorporates intersectionality to address institutional and systemic exclusionary mechanisms, paving the way for more equitable care. The potential of this conceptual framework remains to be fully explored through further research. For instance, how can an intersectional approach be integrated into individual dementia care plans within care settings? How might this framework serve as a reflective tool to shape inclusive organizational policies that promote equitable care? Additionally, how can it be utilized to foster awareness and reflection within care teams? These are just some of the questions that future research could address.

Conclusion

Dementia care for older migrants in Belgium is a complex and dynamic process, shaped by their intersectional societal position and gaps in professional care that stem from overlooked structural exclusionary mechanisms. This paper argues that this complex and dynamic reality of care provision for racialized and marginalized older adults requires a shift toward approaches that better capture this complexity and address dementia care inequity. Consequently, this paper introduces a new conceptual framework for equitable dementia care. Rooted in intersectional and decolonial perspectives, the model broadens the search for responsive, inclusive dementia care for a diverse population by identifying key building blocks across micro-, meso-, and macro-levels. It provides a comprehensive framework for a nuanced understanding of the impact of institutional and systemic exclusionary mechanisms on care dynamics that hinder equitable dementia care. It also holds the potential to identify future actionable pathways for addressing these barriers while acknowledging and valuing the diverse realities of racialized and marginalized older adults. By advancing this framework, the paper seeks to inspire a reimagination of dementia care paradigms, one that centers equity, responsiveness, and inclusivity in care for all aging populations.

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Ethical Statement

The empirical studies referred to in the paper followed the guidelines of Human Sciences Ethical Committee of the VUB, respecting the European Framework for Research Ethics (European Commission, 2013), and was additionally approved by the ethical committee of Hospital C.H.U. Brugmann in Brussels.

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