Ageing in exile: the experience of older Ukrainian refugees in France

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Abstract

The war in Ukraine broke out on 24 February 2022 and forced millions to flee their country. While many found refuge in neighbouring nations, others sought safety further afield in Europe, including France, where exceptional measures were rolled out to support them. Estimates show that France was granting temporary protection to 69,495 Ukrainian refugees (Eurostat) in October, following a peak of 118,000 in 2022. Most were women and children, since men were called up for military service. Many people arrived as multi-generational families—children, mothers and grandparents—though a significant number of isolated individuals also found themselves on French soil. According to NGO estimates, approximately 10% of these refugees were over 60.

As highlighted in the scientific literature, older people are often rendered invisible in humanitarian crises, despite their greater vulnerability due to age-related health and social challenges. Drawing on semi-structured interviews with 28 Ukrainian refugees aged 55 to 76, as well as with humanitarian professionals and specialists in elderly care and extreme precarity, this study explores the specific challenges facing older Ukrainian refugees in three French regions: Île-de-France, Bourgogne and Alpes-Maritimes. It sheds light on their compounded vulnerabilities and examines how they mobilise solidarity networks to receive the care they need, navigating tensions between autonomy and dependence. The findings reveal a significant disconnect between the humanitarian and medico-social spheres, resulting in a mismatch between existing support systems and the actual needs of older refugees.

Keywords: access to healthcare, humanitarian, elderly, Ukraine, exile.

Résumé (French version)

Le conflit en Ukraine a éclaté le 24 février 2022. Pour fuir la violence, plusieurs millions d’Ukrainiens ont quitté leur pays pour trouver refuge dans des pays voisins ainsi que dans des pays plus éloignés en Europe, comme en France, où des mesures d’accueil exceptionnelles ont été déployées. Selon les dernières estimations d’octobre 2023 (Eurostat), 69 495 personnes ont été accueillies après un pic de 118 000 réfugiés ukrainiens ayant bénéficié d’une protection administrative de la France en 2022. Cette population était constituée d’une très grande majorité d’enfants et de femmes, car les hommes étaient appelés à s’engager militairement. De nombreuses familles composées de plusieurs générations (enfants, mère et grands-parents) et un nombre non négligeable de personnes isolées se sont également retrouvées sur le territoire français. Selon les estimations des associations, environ 10% des personnes ayant fui l’Ukraine vers la France avaient plus de 60 ans.

Comme la littérature scientifique le précise, les personnes âgées sont souvent invisibilisées dans le cadre de crises humanitaires, et ce, malgré les formes de vulnérabilités sanitaires et sociales accrues liées à leur avancée dans l’âge. En nous appuyant sur des entretiens semi-directifs avec 28 personnes âgées réfugiées, âgées de 55 à 76 ans, ainsi qu’avec des professionnels et des experts en aide humanitaire et en accompagnement des personnes âgées en situation de grande précarité, nous avons cherché à comprendre les défis auxquels font face les personnes âgées lors de leur accueil en Île-de-France, en Bourgogne et dans les Alpes-Maritimes, en raison de l’exode forcé des réfugiés ukrainiens. Nous avons cherché à mettre en lumière les difficultés spécifiques rencontrées par ces personnes âgées, en tenant compte du cumul de leurs situations de vulnérabilité. Enfin, nous nous sommes intéressés aux réseaux de solidarité qu’elles pouvaient mobiliser pour accéder aux soins dont elles avaient besoin dans un contexte de tensions entre besoins d’autonomie et d’assistance. Ce travail de recherche a permis d’identifier un cloisonnement important entre les sphères humanitaires et des sphères médico-sociales entraînant une adéquation limitée des réponses apportées aux besoins des personnes âgées réfugiées.

Mots clés : accès aux soins, humanitaire, personnes âgées, Ukraine, exil.

Ageing in exile: the experience of older Ukrainian refugees in France

Introduction

The war in Ukraine broke out on 24 February 2022. To escape the violence, several million Ukrainians fled their country to seek refuge in neighbouring states and elsewhere in Europe, including France, where the latest estimates indicated around 100,000 refugees. Figures show that 69,495 individuals held temporary residence permits in October 2023. The Ukrainian crisis has led to a displacement of people on a scale not seen in Europe since the Second World War (Balmond, 2023), including the displacement of individuals over the age of 60.

Ukrainian refugees were granted exceptional support in France, in line with a European Union decision triggering the right to temporary protection established by the Temporary Protection Directive (2001/55/EC)[1] during the mass displacement of people caused by conflict in the former Yugoslavia. This exceptional measure provided immediate and temporary protection in line with Council Implementing Decision (EU) 2022/382 of 4 March 2022. In France, this led to the issuing of a temporary residence permit *(Autorisation Provisoire de Séjour, APS)*, renewable after six months, which grants immediate access to Universal Health Protection *(Protection Universelle Maladie, PUMA)* and Complementary Solidarity Health Insurance *(Complémentaire Santé Solidaire, C2S)*. It also entitles beneficiaries to free transport, accommodation, social support, access to employment and schooling for children. The APS automatically entitles holders to the Asylum Seekers’ Allowance *(Allocation Demandeur d'Asile, ADA)* and, under certain conditions, to Housing Benefit *(Aides Personnalisées au Logement, APL).* Ukrainian refugees were also given access to various temporary support facilities, such as hubs designed to centralise administrative procedures.[2]

Against the backdrop of this unprecedented situation, we examined access to healthcare, comparing the services available with the actual needs of refugees, and explored reception conditions for older adults. We also sought to understand how those affected experienced this forced exile at a stage of life in which they already faced both physical and mental health challenges in addition to social isolation. How do support and healthcare systems take into account the specific needs of older people in exile?

[1] Implementing Decision - 2022/382 - EN - EUR-Lex (europa.eu)

[2] The term “hub” is commonly used by refugee reception professionals to describe a centralised emergency housing facility designed to orient refugees and direct them toward more permanent housing in other parts of the country. In France, several hubs have been set up in cities including Paris, Nice and Strasbourg.

Literature review

An updated review of the literature since 2018 on the support provided to older people during humanitarian crises highlights their vulnerability in areas such as the “invisibilisation” of their needs, the denial of their rights, the lack of data on their experiences in crisis settings and the need to better include older people in the decision-making processes of humanitarian programmes.

We identified three types of articles:

- Articles that explore the invisibilisation of older people in humanitarian initiatives (Kaga & Nakache, 2019; Simard, 2021; Lupieri, 2022). These works highlight the ageist, sexist and neoliberal biases that can shape humanitarian programmes. In this respect, Lupieri’s 2022 article is particularly insightful: it shows how different mechanisms contribute to invisibilisation. Humanitarian action is often “torn” between the need to allocate resources based on vulnerability and the financial imperative to demonstrate the “cost-effectiveness” of interventions. Although older refugees are deemed “vulnerable”, their socio-economic profile means they are rarely seen as “deserving”, since they are no longer active in the labour market. In systems where refugee integration is primarily employment-oriented, older people are viewed as a burden—an idea reinforced by the perception of shorter life expectancy. What is more, the longstanding humanitarian focus on women of reproductive age and children often leads to the exclusion of women aged 49 and over from programmes, surveys, data collection and targeted health services. Lastly, due to their age, older refugees are generally less mobile and less likely to spread communicable diseases. However, they are more prone to non-communicable, often chronic illnesses—conditions seen as expensive and less urgent compared with the epidemic potential of infectious diseases, which still dominate the humanitarian health agenda.

- Articles that propose methodological tools to better include older people in humanitarian programmes (Richard & Kiani, 2019; HelpAge, 2018a, 2018b; Kehlenbrink et al., 2019, 2022). They identify four main barriers: economic (when people are no longer able to engage in income-generating activities, especially in cases of dependency); physical (such as distance or inaccessible services); social (including isolation or reluctance to leave home); and institutional (such as requiring people to be physically present to apply for support, even if they have mobility issues) (HelpAge, 2018b). Several articles stress the need for public policies that address the needs of older people in tandem with humanitarian and development action (Özmete, 2022; Subhasis, 2020). Further studies examine the role of local health and social workers, their training and the development of more inclusive professional practices regarding older adults (Karlsson & Jönsson, 2020; Özmete et al., 2022; Cox, 2020)

- Articles that document the vulnerabilities of older people in crisis settings. A 2022 study in Ukraine showed that 34% of older people urgently needed medication for chronic illness and 91% required food assistance. The same was true for Ukrainian refugees in Moldova: 28% needed urgent medication and 22% reported a loss of autonomy (HelpAge, 2022a, 2022b). Several articles also point to older people’s vulnerability to illness or death as a result of poor water quality and limited access to sanitation services in the context of natural disasters or armed conflict (Richard & Kiani, 2019). When it comes to access to healthcare in humanitarian settings, one study calls for greater inclusivity in clinical trials by involving geriatricians and gerontologists in international organisations and developing funding mechanisms tailored to the needs of older people (Colenda et al., 2020). In Bangladesh, displaced older women during the COVID-19 pandemic were shown to rely on male household income, limiting their access to health centres (Hossain et al., 2023). A 2014 study in Ukraine found older women particularly vulnerable to psychological distress (Summers et al., 2019). A longitudinal study in India showed that older people may also suffer neglect within the family during crises like landslides and tsunamis (Sandu, 2021).

However, few studies explore the active roles or coping strategies of older people in their communities. Only one article discusses the responsibilities some take on—such as caring for grandchildren—during humanitarian crises (Sandu, 2021). Very few publications examine the positive strategies older people use to build support networks or reduce social isolation.

More broadly, the articles identify three key focal points for action:

1. Strengthening local action by training social workers and involving communities;
2. Valuing and incorporating older people’s voices;
3. Raising awareness to tackle ageism in the humanitarian sector, with key contributions from the Global Protection Cluster and NGOs like HelpAge and Handicap International.

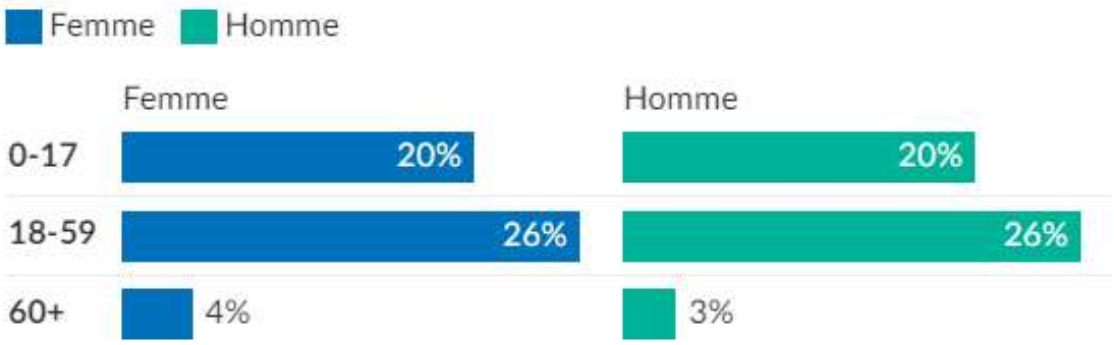
Official data in France

The only official data available on Ukrainian refugees in France is that published via the United Nations portal, which records the total number of individuals granted temporary protection. The most recent figure, as of October 2023, indicates that 69,495 people in the country were covered by temporary protection. However, this data is extremely limited, as it does not take into account the movement of people into and out of French territory.

According to civil society organisations, a significant number of people passed through France in transit and many have since returned to Ukraine. As a result, it is very difficult to determine the actual number of Ukrainian refugees currently in France. An article in Le Monde dated 30 December 2022 cites Didier Leschi, Director General of the French Office for Immigration and Integration *(Office Français de l’Immigration et de l’Intégration, OFII)*, who estimated that there were 106,000 Ukrainian refugees in France at that time, of whom only 50,000 could actually be traced. He acknowledged that no official census had been conducted but expressed hope that one would be possible during the next renewal of temporary residence permits *(APS)* in February 2023.

Another limitation of the data is the lack of information on the age structure of the Ukrainian refugee population. However, one useful indicator was obtained through the Ukraine mission of the French Red Cross. Of the 27,000 people who received financial assistance from the organisation between 29 April and 14 October 2022, Ukrainians over the age of 60 accounted for 11%: 978 men and 2,112 women. While this sample may be subject to certain biases, it nevertheless offers a meaningful snapshot of the population of older Ukrainian refugees currently in France. This is a notably high proportion compared with the global average: in 2023, only 4% of displaced women and 3% of displaced men were over the age of 60.

Figure 1: Global population of forcibly displaced people



(Graph legend : Women/Men)

14 June 2023
Note: The figures do not add up to 100% due to rounding.

* Sources: Estimates of displaced population demographics (IDMC); Palestine refugees under the mandate of UNRWA (UNRWA); refugees, individuals in refugee-like situations, asylum seekers and others in need of international protection, based on available data (UNHCR) and global population estimates (United Nations Department of Economic and Social Affairs).

Source: UNHCR Global Trends 2022

Methodology

Fieldwork was conducted between July 2022 and August 2023 under challenging conditions shaped by the urgency of the crisis and the rapidly changing migration flows and policies. Consequently, the research focused mainly on temporary reception settings, including reception hubs and emergency shelters (CHUs). These fluid environments often disrupted planning and sampling, as individuals might leave one location and arrive in another from one day to the next. Interviews were sometimes conducted in improvised or cramped spaces that were poorly heated, noisy or lacking adequate privacy.

The study is based on 28 semi-structured interviews: seven with Ukrainian refugees aged 55 to 76; eleven with specialists in emergency humanitarian action, healthcare or support for older people in situations of extreme precarity; and ten with frontline workers in Île-de-France, Bourgogne and the Alpes-Maritimes, all of whom had worked directly with Ukrainian refugees in France.

Of the seven interviews with refugees, five were conducted with the assistance of a translator—two with men, two with women and one with a couple—at an emergency shelter (CHU) in Saône-et-Loire. One was carried out in French with a mother and her daughter, who had lived in France for several years and acted as an interpreter. This interview took place at her workplace in Paris. Another interview was conducted with a Ukrainian volunteer and caregiver who had taken in her two elderly parents and was highly involved in refugee support efforts. This interview took place at her home in the Paris region.

Research also included 120 hours of direct participant observation at field locations including the Paris hub, emergency shelters in Île-de-France and Saône-et-Loire, and an association supporting Ukrainian refugees in the Alpes-Maritimes department. We also joined the French Red Cross mobile outreach service. Originally launched in 2021 in response to the arrival of large numbers of people from Afghanistan, the scheme was fully implemented in March 2022 following the arrival of Ukrainian refugees. The mobile unit comprised an ambulance with a doctor, first-aiders and outreach volunteers providing healthcare, guidance and support to maintain family ties. It visited the Paris hub, emergency shelters and refugee camps, mainly in northeastern Paris. We also conducted several more days of observation at the Saône-et-Loire shelter, where five of the interviews took place.

Although the French government set up an interministerial crisis unit to coordinate local responses to Ukrainian displacement, we were unable to establish contact with this central body. Hence the study’s highly localised perspective on care and reception services.

Findings

Drawing on a wide range of data collection methods, this research offers insight into the lived experiences of older refugees, given their various vulnerabilities. It also explores how, amid the tension between the desire for autonomy and the need for support, many managed to build solidarity networks to secure access to essential care. The study highlights a significant disconnect between the humanitarian and medico-social spheres, resulting in a mismatch between existing support systems and the actual needs of older refugees.

The contrasting experiences of older people in exile

We examined the experiences of older Ukrainian refugees in France by looking at the conditions of their arrival and the support networks formed around them. Very few arrived entirely alone or found themselves completely isolated. For example, Mr Olek, 76, travelled by coach for three days to join his daughter and grandson, who had arrived in France several months earlier. Mr Dimitri, 69, came to join his daughters, who had lived in France for the past 20 years. The same was true for the parents of Rosanna, who is now in her fifties and has lived in France with her husband and daughter for two decades. Mr Sergei and Ms Alicia, aged 69 and 63, drove to France in January 2023 with their son to join their daughter-in-law and grandchildren, who had arrived at the very start of the war. Only Ms Talia, 68, came on her own, knowing absolutely no one in France: “I’ve always wanted to come to France, ever since I was a child.”

Her case reflects a broader trend noted by an emergency shelter (CHU) coordinator: “Since I arrived in early September, I’ve seen that many of the people here are older—between 65

and 90—and they’re rarely alone. We do have a few older folk on their own, but it’s quite rare. In most cases, those who are isolated were initially housed by their children or relatives, but over time—because family ties are not always that strong, or housing arrangements are too limited, or because older people vary in how well they adapt to being uprooted—they end up alone.”

Being accompanied by family did not necessarily prevent older people from feeling isolated. Several women described spending entire days shut in their rooms and expressed a strong dependence on relatives for daily support. Male interviewees were more inclined to engage in activities. For instance, Mr Dimitri said he often went out alone and swam at the local pool once a week. Gender and social class appeared to play a role, with differing levels of resources shaping people’s ability to adopt coping strategies. A reception hub coordinator observed: “I still see a real sense of isolation among older people, partly because family members caring for them feel under pressure and tend to manage their access quite closely. […] Older people don’t usually say much—they just go along with things.” This highlights a common dilemma: while the presence of family can offer protection, it also makes it more difficult for professionals to engage directly with older people and assess their needs.

All of the professionals we interviewed agreed that the profile of the Ukrainian population in France has changed considerably over time, as one family links coordinator explained: “Women often came with their mothers too… when it was possible. But the first wave included the better-off. So it was easier to travel with someone older, perhaps much older. But now, with the second, third and later waves, the situation has become increasingly strained. As a result, older people tend to stay behind. I even know of cases where older people have remained in Ukraine. It causes a lot of distress for the families who arrive here. There’s guilt, I think, guilt about leaving a parent behind. And then, of course, there’s the worry.”

Professionals involved in refugee reception all said older people were often the first to return to Ukraine, largely because of the barriers to integration in France. As the president of one refugee support organisation explained: “They’re the ones who adapt the least well. And they struggle because, given their age, they can’t see themselves starting over. They can’t say: ‘I’m going to build a new life in France.’ That’s just not possible. So they are often the first to go back to Ukraine. We’ve seen a lot of people leave this summer. Even those who were doing fine here with their family, with their children, they said: ‘My home is back there—I’m going back.’ Quite a few women made that choice.”

A family links coordinator offered a similar perspective: “It’s really different with families who have young children or are expecting. They operate on a different timeline, one shaped by school enrolment and the future, even if it’s stressful. At least there’s something to build towards. But for older people and people with illnesses, it’s all about uncertainty: end of life, returning home… It’s very hard to support them through that. It's a big emotional burden.”

Exploring how people saw their future proved difficult with our sample. Most had only recently arrived, and given the hardship they faced, it felt inappropriate to ask painful questions. Even so, some did share their thoughts about the possibility of returning to Ukraine. What emerged was a sense of deep uncertainty.

Ms Alicia, for example, said: “I don’t know… Everything is too expensive in Ukraine, you can’t survive. Even gas costs a fortune. If my children stay, we’ll stay with them. As long as they’re here, we’ll stay. We can’t get very far with the car. We’re too tired. And it’s hard to understand the highway code here.”

Mr Olek also expressed uncertainty about whether to remain in France or return, while Ms Talia was steadfast: “No, I don’t want to go back to Ukraine. Life there is too difficult. I’m alone, I don’t work. I’d rather settle here in France.”

For Ms Anita, 70, returning was simply not an option: “I had a house, but it was completely destroyed by a bomb. So I can’t go back.”

A municipal official in Saône-et-Loire added that many people said, “I want to go back to Ukraine. I want to see out my days there.”

Access to care: guaranteed but still hindered by persistent barriers

All the health professionals we interviewed—doctors, medical unit coordinators at emergency shelters, and the lead physician of the mobile outreach service—reported high demand for healthcare among Ukrainian refugees, especially for specialist treatment. The French Red Cross medical mission in Alsace, which operated from 11 March to 29 April 2022, carried out 494 consultations, mainly for the following reasons:

1. Acute infections, particularly viral illnesses.
2. Psychological and psychiatric conditions, complicated by language barriers and the temporary nature of accommodation. This included both acute psychological crises, which involved the emergency psychological support unit *(Cellule, d'Urgence Médico-Psychologique, CUMP)*—which intervened once or twice a week—and more routine mental health concerns, such as insomnia or anxiety.
3. Comorbidities among older people, including difficulties renewing prescriptions and hospitalisation for heart conditions. Dr Litz, the mission's medical coordinator, involved an 80-year-old who had travelled for three days with only a small bundle of belongings and had to be admitted to hospital.
4. COVID-related issues: first-aid teams were authorised to conduct antigen tests on symptomatic individuals, and a dedicated isolation facility was set up in a municipality near Strasbourg.

The medical mission in the Rhône-Alpes region ran from April to June 2022 aboard a boat docked in Marseille. During that time, nurses and doctors carried out 1,400 consultations. 56% of these involved referrals to specialists—including ophthalmology, dentistry, cardiology and rheumatology—and 15% were medical emergencies. Staff also noted both high expectations and widespread confusion about how the French health system works. Many refugees voiced frustration about the long waiting times for appointments. Staff at reception centres had to counter persistent misconceptions.

It is useful to outline some key differences between the Ukrainian and French systems that may explain these misunderstandings and, in some cases, disappointment. In Ukraine, it is relatively easy to see a general practitioner, but there is no universal health insurance. Most people pay out of pocket for medication, hospital stays and tests. Rosanna, a Ukrainian woman living in France for 20 years, offered insight into these contrasts. She volunteers at several refugee support organisations and also cares for her two elderly parents, who fled Ukraine with her help at the start of the war:

“My mother says, ‘Look, we’re getting treatment and it’s free.’ And I tell her, ‘In Ukraine, yes, you can get an appointment right away—but you have to pay the doctor. It’s not official. If you don’t pay, you don’t get the appointment. Here in France, it works differently. You’re currently covered by the public health system, so yes, it’s free and they take care of you—but for us, it’s incredibly complicated. We pay taxes and we have to get top-up insurance to be reimbursed. The GP who sees my parents is supposed to provide free treatment, but my mum always keeps a few euros on her or buys chocolates to thank the doctor […] So for vulnerable people like my parents—who have no income—it’s really hard because you still need money to get care. Yes, you get treated, but only if you can afford it. For example, my father had surgery in Ukraine. He was operated on by a very good surgeon, but only because we paid. We paid €6,000 or €7,000 under the table because they immediately wanted to know: ‘Do you have the money? If so, we’ll operate. If not, he’ll die.’ […] It’s a bit easier for people from big cities. The girls from Kyiv say, ‘It’s very difficult for us here, because sometimes we end up with doctors who are incompetent, who only see us for 10 minutes, and misdiagnose us.’ They don’t get proper treatment. So they go back to Kyiv, get treated there, then return to France. One girl I know had dental issues. She went to see a doctor—I don’t know who did what—but her face started to swell up. She went back to Ukraine for two weeks, found a dentist and paid, but the price wasn’t the same as in France.”

In terms of available care and access to it, most of the people we interviewed were eventually able to get the treatment they needed. Mr Olek, for example, underwent surgery in France after securing healthcare coverage, with help from a social worker. “I had surgery in December,” he explained. “Here, the wait for an appointment is really long—whereas in Ukraine, it’s not like that, it’s much faster. I waited until I got my CMU papers [providing universal health coverage], then I went to see the doctor. Now I’m being monitored at Le Creusot hospital. I’ll probably need another operation. I’m waiting for that now.”

Interviewer: How did you manage to communicate with the doctors?
Mr Olek: I had help from Ms E, a social worker at the emergency shelter (CHU). She booked the appointments for me.
Interviewer: Were you able to go home right after the operation?
Mr Olek: No, I stayed in hospital for four days.
Interviewer: How did things go when you came back here?
Mr Olek: I took a taxi home from the hospital. There’s a lift, so it was no problem.
Interviewer: Did you have to pay for anything?
Mr Olek: No, not at all. Ms E helped with everything—even picking up the medicine. I’m really lucky.

The time spent waiting to receive a temporary residence permit and activate universal health coverage *(Protection Universelle Maladie, PUMA)* created stress and uncertainty. Although Ukrainian refugees were exempt from the usual waiting period—unlike other asylum seekers—processing delays still grew over time. Ms Anita, for example, was still waiting for her papers at the time of the interview. Her glasses had broken during her journey and she was unable to replace them. Only one interviewee reported being refused care: a cardiologist refused to see her without proof of coverage. Most other older people received the treatment they needed, and were accompanied throughout the process by caregivers—whether family members, volunteers or professionals. This was reflected in our observations at the Paris hub: a whole “army” of volunteers—often from within the Ukrainian community—shouldered much of the burden, taking on tasks such as translating, helping with housing, distributing food and clothing, and escorting people to the prefecture or medical appointments.

These findings are consistent with existing literature, with barriers to access including delays in securing entitlements, complex administrative procedures, limited translation services and the reliance on third-party support.

Diverse profiles and case-by-case placement in a care home

Although we did not collect specific health data on older individuals, we did observe a wide range of profiles and were struck by the presence of some very elderly and highly dependent people. Professionals consistently expressed a similar view, typified by this emergency shelter (CHU) coordinator: “Older people don’t speak a word of French—and they’re never going to learn it, not at 90. Some are starting to lose their memory. Many of them... their health already wasn’t good in Ukraine, and when you add trauma on top of that, they’re left completely disoriented.” For this professional working with vulnerable individuals, the greatest concern was the lack of appropriate solutions for those who were very old and had lost their autonomy.

This concern was echoed by the president of one of the largest Ukrainian refugee support associations in France: “These are the really difficult cases […] I don’t have a full overview or the statistics. I can only speak about the cases we’ve handled. I know that, for example, we’ve placed maybe three people [in a care home]. One case involved an elderly woman who had more or less been forgotten. I don’t know if her file slipped through the cracks. She ended up spending three months sleeping at her daughter’s friend’s place. Sometimes she even spent the night in a van. It was a really tough situation. When she came to see me, we filed a report with the town hall, it got escalated to the prefecture, and eventually she was given a place in a care home in X (a town in the Alpes-Maritimes). She was 82.”

Rosanna reflected on the difficulties refugees in gaining access to healthcare, based on her experience as a volunteer: “People say Ukrainians are privileged, and I say: ‘That’s not true—not at all.’ Even with health coverage, we can still be turned away by doctors. You need to know how to book an appointment, how to explain your symptoms—and they don’t know how to do that. You have to find translators; and there aren’t many of us to help; so it’s not easy. And every time, you have to go through it again—this idea that Ukrainians are somehow privileged… […] After six, even ten months, they started saying things like, 'I went to the Social Security office in January and I was told very clearly: ‘Ukrainians, they’re just like everyone else now, we’ll treat them like anyone else.’ But I said: ‘They don’t even have access to their Ameli account [the French national health insurance portal].’ Even just to print the certificate proving their health coverage—which everyone asks for—they can’t do it, because you have to download it, and they don’t know how.” She also described the burden of caring for her two elderly parents, both of whom had serious health issues. She spoke of “a constant struggle” and recalled breaking down in tears in front of doctors. One emergency hospitalisation, she said, was “a nightmare”.

Limited understanding of older people's needs and fragmented fields of action

In France, humanitarian emergency and refugee aid professionals generally have limited experience helping older people, as their efforts have typically focused on young men. In 2022, the average age of adult asylum seekers in France was 32.6.[3] As a result, there is little awareness of the specific and wide-ranging needs of older adults. Unsurprisingly, those experiencing a loss of autonomy were the source of greatest concern, as one refugee aid worker explained: “We’re really limited in what support we can provide. We can help with occasional tasks, but for people with high levels of dependency, we just don’t have the trained staff needed to help with personal hygiene or daily living.”

Our extensive field observations at the Paris hub confirmed the lack of infrastructure for individuals with physical limitations. One emergency shelter (CHU) for vulnerable people, housed in a hotel in one of the inner suburbs of Paris, had only two places for people with reduced mobility. This led to a permanent waiting list. During this time, we repeatedly encountered an 80-year-old man, a leg amputee in a wheelchair, sleeping on a camp bed on the street. He had tried to create a semblance of privacy on the pavement using sheets.

While volunteering at the Paris hub, we were also asked—without any training or guidance—to accompany a 92-year-old woman to the toilet. The lack of accessible facilities significantly increased the risk of falls. Moreover, the absence of training on how to assist physically dependent individuals in intimate situations created major discomfort, not only for the older people themselves, but also for the volunteers and professionals who were unprepared for such situations.

[3] https://ofpra.gouv.fr/libraries/pdf.js/web/viewer.html?file=/sites/default/files/2023-07/OFPRA_RA_2022_WEB%20-%20m%C3%A0j%2007.pdf

This left many professionals wondering how to help older people effectively. One manager at a refugee aid organisation remarked: “That’s a real question—and it opens up a whole Pandora’s box, because ageing is something we don’t really understand. And then you have these overlapping issues—linked to precarity and health inequalities—and how they intersect with ageing. Plus there’s the big question of just what is old age? And how do we support people as they grow old?” This quote clearly illustrates the widespread uncertainty about how to respond to the needs of this specific population.

One CHU professional, who worked specifically with the most vulnerable individuals, admitted feeling overwhelmed by the complexity of the systems intended to support older people experiencing a loss of autonomy. She did not know who to contact to ensure appropriate support for those who were both highly dependent and socially isolated.

A directive issued by the office of Prime Minister Élisabeth Borne on 23 June 2023 sought to strengthen the application of the interministerial note dated 13 May 2022 on the reception of displaced Ukrainians with disabilities or a loss of autonomy.[4] The directive aimed to improve support for these individuals through France’s “360 Community” network, specialised support and service coordination centres *(Pôles de Compétences et de Prestations Externalisées, PCPE)*, and the coordination support systems *(Dispositifs d’Appui à la Coordination, DAC)*.[5]

However, the note made clear that temporary protection status does not entitle individuals to the personal autonomy allowance *(Allocation Personnalisée d’Autonomie, APA)*, under Articles L.245-1 and R.145-1 of the Social Action and Family Code, nor to the disability compensation benefit *(Prestation de Compensation du Handicap, PCH)*, under Articles L.232-2 and R.232-2, as temporary protection does not meet the “stable and regular residence” requirement. As such, the APA and PCH cannot be used to fund support for people with disabilities or loss of autonomy—whether in care homes (e.g. APA-establishment) or for home care (e.g. APA-home or PCH).

Likewise, temporary protection does not entitle recipients to departmental-level social housing support (for care homes or supported living facilities), nor to state-level social assistance, which remains contingent on regularised residency. According to the Ukraine desk officer at a regional health agency (ARS), the French state offered a flat-rate payment of €110 per day to help fund places in care homes for older Ukrainian refugees. Yet to our knowledge, only two people in the Île-de-France region have benefitted from this measure.

Several factors may explain this. First, there is no clear data on how many older people would actually qualify for care home placement. While we did meet individuals who might have been eligible, it is hard to assess needs at the national level. Second, the shortage of available spaces—particularly in public facilities with no out-of-pocket costs—likely contributed to the low uptake. Third, as one local government official pointed out, refugee populations are a specific case: “But when it comes to older people without children or grandchildren nearby, placing them in specialist facilities like care homes is impossible. For them, it’s just not an option. They won’t hear of it, even though, in my view, it might be better than staying in a transitional shelter or a flat.”

We can reasonably assume that older people who arrived with family may be eligible for care home placement, but are instead receiving support from relatives. For older adults who

[4] Interministerial Circular No. DGCS/SD3/2022/145 of 13 May 2022 on the reception of displaced persons from Ukraine living with disabilities or experiencing a loss of autonomy.
[5] Circular No. 6406-SG of 23 June 2023 – Multiannual guidelines for the reception and integration of displaced persons from Ukraine (2023–2024)

arrived alone, without informal carers, the idea of moving into an institution—especially one outside the cultural and social context of the Ukrainian community—may explain their reluctance to accept such placements.

According to Rosanna, there are very few residential facilities in Ukraine for dependent older people, and families are traditionally expected to provide care. She explains: “There are a lot of older people. It’s really complicated, because there’s no entitlement for disability or ageing: no PCH, no minimum pension.”

Although older Ukrainians in France are eligible for the asylum seekers’ allowance (ADA), they are excluded from other forms of social assistance. Yet they are often the least able to integrate, partly due to the near impossibility of learning the language. They also require psychological support—which is extremely difficult to find in the Île-de-France region—and affordable housing.

What emerges is a clear mismatch between the support offered and the actual needs of older Ukrainians who have fled to France. This raises a crucial question: Is funding care home places the best solution, given the apparently low demand—especially when the real need lies in human and financial support? A waiver was granted to exempt Ukrainian refugees from the usual waiting period for health coverage under the APS. Why not consider a similar waiver for access to the APA or other forms of specialised support?

Addressing the issue of whether the response matches the needs of vulnerable older people is critical, but such efforts must go hand in hand with a better understanding of their requirements, as well as the services, benefits and mechanisms that could be employed by humanitarian actors. Ensuring that reception facilities (temporary or otherwise) are accessible and suitable, providing better training for humanitarian workers, increasing availability of interpreters and building cross-cutting expertise—particularly within large organisations like the French Red Cross—are all critical to delivering effective, high-quality support to older people in exile.

Conclusion

Older people experience heightened forms of vulnerability in several interrelated areas: 1. Social vulnerability, as isolation is made worse by difficulties in learning the language and by a sense of estrangement brought on by displacement;[6] 2. Health-related vulnerability, due to complex and often unclear care pathways, coupled with major accessibility challenges; 3. Economic vulnerability, stemming from the lack of financial support specifically designed for people who are unable to work, whether due to age or disability; 4. Institutional vulnerability, resulting from a lack of understanding of older people's needs and the complexity of the French system for supporting ageing and dependency. This creates a landscape that is difficult to navigate, not only for older people themselves, but also for social and humanitarian actors.

[6] The sense of estrangement from the world refers to a feeling—shared by many older people—of detachment and difficulty understanding their environment (Caradec, 2004).

This study—the first in France to focus specifically on older people displaced by a major humanitarian crisis—confirms the findings of international research: older people face compounded vulnerabilities. They are also seldom heard or recognised in their diversity, or in their ability to mobilise solidarity networks in response to exile. Their ability to remain in France over the long term depends largely on access to the right resources, whether human (informal carers) or financial. In reality, housing and healthcare conditions make it difficult to ensure safe and sustainable support for older people in situations of extreme precarity.

The absence of specific support for older people and people with disabilities—those unable to work—within the refugee population hinders their access to healthcare and contributes to situations of dependency. This in turn can lead to neglect and to essential services going unused.

All the professionals we interviewed expressed concern about the specific challenges of supporting older people, but said they had few tools at their disposal to address them. From this perspective, the needs of older refugees remain poorly understood and are inadequately taken into account. Yet population movements involving older adults are likely to increase, and both emergency and long-term support systems must be strengthened.

This research highlights a lack of understanding—on the part of both public authorities and humanitarian actors—regarding the specific social and health-related needs of older people. Humanitarian professionals often lack training not only in how to support this group, but also in the roles, institutions and medico-social systems that could be mobilised. The study aims to underscore the importance of fostering dialogue between these different spheres.

It is also important to note that this major humanitarian crisis coincides with a broader crisis in the French healthcare and hospital systems, as well as in the organisation of care provision nationwide. The repercussions of COVID-19, a shortage of medical professionals, a strained public hospital system and the crisis in some specialties—such as psychiatry—have all compounded existing challenges. At the same time, the long-term care sector faces its own difficulties, including the devaluation of care professions, complex coordination among a multitude of stakeholders and growing mental health issues among carers.

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