A profile of Victorian Seniors from Refugee Backgrounds
Health and wellbeing needs and access to aged care health and support services

A study conducted by
the Refugee Health Research Centre, La Trobe University
for the Department of Human Services, Victoria
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Published by the Refugee Health Research Centre
(A partnership between the Victorian Foundation for the Survivors of Torture and La Trobe University)
www.latrobe.edu.au/rhrc
December 2005
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This report was funded by the Department of Human Services, Victoria, as part of the Home and Community Care (HACC) Culturally Equitable Gateways Strategy (CEGS). It was produced by Rebecca Atwell, Ignacio Correa-Velez, and Sandy Gifford, with assistance from Sue West.

Design by markmaking

Acknowledgements
Thanks go to Calvin Graham, Sue Casey and Caroline Butterworth at the Department of Human Services

Maps by Ian Sebastian Woodcock

The authors would sincerely like to thank everyone who contributed information and advice in the course of this study.
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List of Acronyms

ABS – Australian Bureau of Statistics
AMES – Adult Multicultural Education Services
CALD – Culturally and Linguistically Diverse
CEGS – Culturally Equitable Gateways Strategy
DIMIA – Department of Immigration and Multicultural and Indigenous Affairs
EP – English Proficiency
HACC – Home and Community Care
LGA – Local Government Area
MIC – Migrant Information Centre
MRC – Migrant Resource Centre
PAG – Planned Activity Group
TAFE – Technical and Further Education
TPV – Temporary Protection Visa
UNHCR – United Nations High Commission for Refugees
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What are the experiences and needs of older refugees living in Victoria? Currently in Australia, there is a focus on “ageing in place” and an emphasis on supporting older people to remain in their homes and communities for as long as possible. However, the reality for many older people who have come to Australia as refugees is that they face “ageing out of place”. For recently arrived older refugees in particular, the experiences of forced displacement, torture and trauma, are layered on top of the challenges of growing old in a new country. This report describes Victoria’s ageing refugee population and explores their needs for, and access to, community health and support services.

The state of Victoria receives approximately 30% of Australia’s refugee intake. Between 1996 and 2005, 85,604 people arrived in Australia on Humanitarian visas. They came from more than 50 different countries and ranged in age from less than a year to over 80 years of age (see Appendix 1). Since 1996, the proportion of refugees from different regions has varied (see Figure 4.1) with fewer coming from Europe and an increasing number coming from Africa. It is estimated that there are currently at least 4,241 people from refugee backgrounds living in Victoria over the age of 40 years, who have arrived since 1996. While these numbers are small compared to other migrant groups and to refugees from other age groups, the needs of this group are large. Their small numbers and high levels of need pose a challenge to health and community services because many of these refugee communities have neither the capacity nor the resources to support their elderly, or to lobby for appropriate care services.

1. Aims and Objectives of the Research

This research project was undertaken with the aim of scoping the health and wellbeing needs of Victorian Seniors from refugee backgrounds, and reviewing their access to community health and support services. The focus is on smaller and more recently arrived communities as these are the groups on which there is the least information and which are likely to be the most vulnerable. Research has previously been done into the needs of older refugees from the Polish and Jewish communities who arrived in Australia after the Second World War (Joffe, 1996; 2000; 2003; Drozd et al. 2004), and into the needs of the Vietnamese and Cambodian communities (Silove et al., 1995; Steel et al., 2002; Tran, 1990; Thomas, 1999b). However, although these communities share some of the experiences of torture, trauma, displacement, and the subsequent complications of ageing with more recently arrived refugee communities, their experiences of resettlement will have been different.

1. Extensive research has also been conducted internationally into the effect of trauma and torture on ageing Holocaust survivors, and, to a lesser extent, on survivors of the Cambodian genocide.
The findings of this research are intended to provide policy makers, service providers and organisations working with refugees, with an overview of the broad issues affecting refugee seniors as well as detailed information on the needs of specific communities in Victoria.

The project objectives include:
— a review of the literature on refugee seniors,
— profiles of seniors from key refugee communities in Victoria,
— a review of aged care services available to these communities,
— identification of innovative models for addressing the needs of refugee seniors, drawing on examples from Australia, and other resettlement countries,
— identification of areas for further research.

Due to the limited time frame for the research, information on the refugee communities was gathered from consultations with community workers rather than refugee seniors directly.

The overview of services is focused on the Home and Community Care (HACC) program and is intended to supplement work being carried out under the Department of Human Services’ Culturally Equitable Gateways Strategy (CEGS) for seniors from Culturally and Linguistically Diverse (CALD) backgrounds.

2. Scope of the report

The report provides a broad overview of the issues affecting refugee seniors in resettlement contexts, together with detailed data on specific refugee communities in Victoria. Chapter 2 provides a review of the available literature on refugee seniors in Australia and other resettlement countries. The community profiles in Chapter 9 include demographic data on the size, age and gender structure, language proficiency, and settlement patterns of each refugee community. They also provide details of the circumstances of displacement, the resettlement context, cultural context, health and wellbeing issues, and beliefs and norms regarding the health care and support for seniors in each of the communities. Twenty refugee communities, identified as having the most vulnerable and least well serviced seniors, are profiled.

Data on the availability and use of services by refugee seniors is presented in Chapter 4 and Appendix 2, together with an analysis of the key barriers to accessing services for refugee seniors.

Drawing on data gathered from consultations with community workers, a discussion of the key issues affecting refugee seniors in Victoria is provided in Chapter 5. Innovative models for addressing such needs, drawn from state, national and international examples are presented in Chapter 6. Chapter 8 provides a discussion of issues that warrant further consideration in relation to how refugee seniors’ needs might be better met and how barriers to accessing services might be overcome in Victoria, and points to areas for further research.

It is intended that this report will be used as both an introduction to the general issues affecting refugee seniors, and as a resource for service providers in Victoria. It is hoped that policy makers will use the report as a resource in planning for service provision and take on board the issues for consideration in Chapter 8 when reviewing strategies for improving access to HACC services.
Whilst all efforts have been made to ensure that the data provided is as accurate as possible at the time of writing, it should be noted that more detailed research, including interviews with refugee seniors and consultations with families and communities, is recommended before specific service innovations are begun.

3. Summary of Key Findings and Issues for further Consideration and Research

The key finding from both the literature review and the consultations carried out in this research is the extreme vulnerability of refugee seniors. Their refugee experiences and the challenges they face as older people in a resettlement context put them at especially high risk of social isolation and mental illness. The low numbers of seniors in many of the more recently arrived refugee communities, and the difficulty of identifying them in census and settlement data, further increases the risk that their needs will be overlooked.

Older refugees and their families face numerous challenges which vary according to their refugee experiences, the age at which they arrived in Australia, the length of time they and their community have been in Australia, and the resources within their community. Some of these challenges are detailed in the country-specific sections in Chapter 9 of this report. Within this variety, it is possible to identify a common set of key issues affecting the health and wellbeing of many refugee seniors. These include:
- social isolation,
- mental health vulnerability,
- the expectation of family care,
- cultural barriers to using aged care services,
- lack of knowledge of services,
- fear of using services,
- lack of ethno-specific services.

Numerous detailed responses to these issues are needed at the various levels of service provision and community development, and more work is required to identify the specific challenges facing each of the communities. On a broader level, several suggestions for meeting some of the more common issues arose from this study. They are discussed in detail in Chapter 8 but can be summarised as follows:
- Recognising that refugees often require aged care services at a younger age than other populations would help to ensure that they have access to the services they need at the appropriate time.
- Improving access to information about aged care services among refugee communities would help older refugees and their families make informed choices about using the various care options.
- Improving the links between refugee settlement services and the aged care sector would also help to ensure that older refugees are informed about, and better able to access appropriate services.
- Marketing aged care services as complementing rather than replacing family care would help overcome some of the cultural barriers to using aged care services.
— Sensitizing aged care workers to the specific needs of older people who have experienced torture and trauma would enable services to be more responsive to the needs of refugee seniors.
— Improving the accessibility and accuracy of data on the number and whereabouts of refugee seniors would assist service providers in identifying and meeting their needs.
— Building and strengthening the capacity of refugee communities to advocate for and support their elderly would increase the availability of suitable care options and improve access to other service providers.
— Ensuring older refugees have access to suitable English language tuition would help to improve their knowledge of, and access to a greater range of services, and help overcome social isolation.
— Greater opportunities for people from refugee backgrounds to access training, employment and voluntary positions within the aged care services would help to overcome the shortage of bi-cultural workers available to care for older refugees.

In order to address some of these issues, further research is also required. Potential research topics arising from this study are discussed in Chapter 8 and include:
— Research into the specific needs of elderly torture and trauma survivors, and their carers,
— Research into other models of care for refugee seniors,
— In-depth research with refugee seniors themselves.

The findings of this report suggest that meeting the complex needs of refugee seniors is a process that requires the engagement of individuals and organisations at all levels, from community based organizations, up to state and federal governments. As a small and vulnerable group within an already marginalised minority, older refugees have specific needs that need to be addressed with care and sensitivity. Having survived some of the worst experiences imaginable in their early lives, they surely deserve the dignity of a comfortable and healthy old age.
Chapter 2  Refugee seniors living in a resettlement context: A review of the literature and key issues

1. Defining a Refugee Senior

Who is a refugee?

The United Nations High Commission for Refugees formally defines a refugee under the 1951 Refugee Convention as a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country". The UNHCR works to protect refugees in the countries where they first seek asylum, and to resettle them in third countries where this is considered the best way of ensuring their long-term protection and security. A number of countries, including Australia, accept refugees for resettlement and in doing so commit to providing them and their families with access to civil, political, economic, social and cultural rights similar to those enjoyed by nationals (UNHCR, 2004). Refugees who come to Australia under the UN resettlement program are identified and referred by the UNHCR, and come under the 'refugee' or 'women at risk' programs. In addition to UN recognised refugees, Australia also accepts a number of refugees under a Special Humanitarian Program. Individuals under this program are recognised as having been subject to substantial persecution amounting to gross violation of their human rights and must be living outside their home country. The latter category must have their applications proposed by an Australian citizen, permanent resident or organisation. Both Special Humanitarian Program and UN refugees are offered resettlement services including health care, language tuition, translation services, housing and social security (UNHCR, 2004).
Individuals who arrive in Australia seeking asylum or who seek protection after entering the country on tourist visas, are considered ‘unlawful arrivals’ and are subject to mandatory detention. If, following consideration of their application, they are found to be refugees, they are offered temporary protection visas (TPVs) and are entitled to access health and welfare services. TPV holders may subsequently be granted permanent protection visas, in which case they become eligible for the full range of settlement services.

Refugees on permanent protection visas are entitled to propose members of their family for resettlement under the ‘split family’ provisions of the humanitarian program if they are in immediate danger of human rights abuses. Alternatively, relatives can be sponsored by family members through the family stream of the migration program.

When considering the needs of refugee seniors, it is worth remembering that people who have had refugee-like experiences, including being forcibly displaced, experiencing loss and trauma, and in many cases also experiencing torture, come to Australia on a range of visa types, not all of which are humanitarian visas. Thus, in many contexts, it is more appropriate to consider communities who have come from refugee source countries rather than limiting the definition to those on refugee visas.

Who is a senior?

Definitions of ‘aged’ and ‘senior’ vary greatly between countries and cultures, and are an important area to explore in relation to refugees. The UNHCR defines ‘older’ according to life expectancy in the region from which refugees originate, allowing for enormous variation between countries in the developing and developed world (Bartolomei et al., 2003). In some cultures, chronological age is not recorded or known, and a person is considered an ‘elder’ from the birth of their first grandchild, even if this is in one’s thirties (Chenoweth and Burdick, 2001). In other cases, social status or physical agility determine the definition. These variations in the understanding of the term have implications for refugees who find themselves categorised by their chronological age in resettlement countries and assessed on this basis for entitlement to pensions, health care and income support. As Chenoweth and Burdick point out, “some elder refugees are surprised to learn that they are not considered old by their new country’s standards, and [that] they are expected by society and public assistance rules to work and be self-sufficient” (ibid.).

The social status of ‘elders’ and the differences in their roles and duties in different cultures can have a significant impact on older refugees in a resettlement context. Older people from many non-western countries, are often shocked to discover that in their country of resettlement, age does not necessarily confer the respect and status accorded to ‘elders’ in their own culture. They are likely to experience this difference particularly harshly if their children and grandchildren adopt the attitudes of their resettlement country (Bartolomei et al., 2003).
CHAPTER 2: REFUGEE SENIORS LIVING IN A RESETTLEMENT CONTEXT

2. Circumstances of Forced Displacement, Flight and Resettlement

Refugees who arrive in Australia have had a wide range of experiences that have caused them to flee their home countries and seek protection. Some will have been tortured or unlawfully imprisoned, others will have experienced bombing or the violence of war. Others still will have suffered years of surveillance, discrimination and prejudice. Many refugees flee their homes at short notice with little idea of where they are going and whether or not they will return. Family members often become separated and individuals can endure enormous hardships and face extreme risks as they travel in search of safety. Many Southeast Asian refugees in Australia fled their countries by boat and were attacked by pirates or shipwrecked. African refugees will often have travelled great distances on foot and gone long periods without food or shelter.

Many refugees will have spent some time in refugee camps prior to resettlement in Australia. Although officially places of sanctuary, these camps are often extremely basic and living conditions are harsh. Even in camps under the auspices of the United Nations, food, shelter and water are often scarce and personal safety is not always guaranteed. Women in particular are at risk of rape and sexual abuse in refugee camps, and are especially vulnerable if they have to leave the camps, for example to collect firewood or water. Older people and children are often at risk of contracting diseases, especially if they are weakened from traveling long distances or from poor nutrition. In regions such as Southeast Asia or the Horn of Africa where conflicts have lasted many years, some refugees will have spent ten or more years living in camps awaiting resettlement.

Selection for resettlement depends on a variety of factors including age and health status. Older refugees are usually resettled under the family reunification program, but as the UNHCR notes, they are sometimes reluctant to move and may choose to remain in their first country of asylum, which tends to neighbour their home country and have factors such as weather, language and culture in common (UNHCR, 2004). Refugees who are selected for resettlement rarely get to choose which country they go to. Children and elderly parents will usually be reunited with family members who have already been resettled, but in some cases, families may find themselves scattered across two or three resettlement countries.

In all these ways, the experiences of refugees differ greatly from those of migrants who choose when to leave, where to settle, and leave knowing they can return. Although they may experience similar difficulties due to language barriers and a lack of knowledge about their new country during resettlement, migrants do not carry the burden of trauma or the concern about family members still in situations of danger, which both have significant impacts on refugees’ abilities to rebuild their lives (Pittaway, 1999).
3. Being a Refugee Senior in a Resettlement Context

Research into the mental health of refugees has identified older adults as a particularly vulnerable group during the resettlement period (Porter and Haslam, 2005). Other studies have noted the several layers of ‘jeopardy’ or difficulty faced by older people who have resettled in new countries. Norman, researching migrants in the UK, identifies the ‘triple jeopardy’ of being old, poor and from an ethnic minority community (Norman, 1985). The fourth jeopardy of gender was identified by S. Ebrahim (Ebrahim, 1992), and Bartolomei et al. identify the multiple jeopardies of trauma, loss of home and ‘ageing in the wrong place’ which are added to this for refugees (Bartolomei et al., 2003). As Chenoweth and Burdick point out, in addition to the challenges faced by all older people, such as adjusting to retirement and a lack of independence, and needing to review one’s life and accept the proximity of death, older refugees have to do all of these in an unfamiliar environment where they may feel isolated and alienated from both their own culture and that around them (Chenoweth and Burdick, 2001).

The age of a refugee on arrival in their country of resettlement will be crucial in determining their experience of resettlement. Those who arrive in middle age and have time to become familiar with their new country, and to understand its structures and culture, tend to cope better with the experiences of ageing than those who arrive in old age (Bartolomei et al., 2003). Those who arrive later in life may also suffer culture shock in a more negative way, as they are more likely to have stronger ties with their own cultures and be less flexible in their outlook. The feeling of ‘ageing in the wrong place’ and in a way that had not been anticipated earlier in life is strong and often disturbing for older refugees (ibid).

Certain features of the experience of being a refugee senior recur in much of the literature and were evident in the findings of this research. Some of them, such as the loss of independence, are common to many older people, but are experienced more acutely by refugees and migrants. Others, such as social isolation, are more specific to migrants and refugees and have a potentially more serious impact on their health and wellbeing. The following issues are central to the experience of refugee seniors in a resettlement context:

Social Isolation

Social isolation was mentioned repeatedly by interviewees in this study as a major issue affecting older refugees and as a priority to be addressed in attempting to improve their health and wellbeing. This is reflected in the literature on refugee seniors which also analyses some of the contributing factors to the problem.

Refugee seniors experience the barriers to social integration common to refugees of all ages. These include:
- Limited proficiency in English,
- An internalised fear and suspicion of others, resulting from prolonged exposure to persecution and corruption in their countries of origin,
- Limited familiarity with social conventions in Australia,
- Lack of understanding of the needs of new arrivals in the wider community and in some cases racism and xenophobia,
- Barriers to participating in education and employment which provide natural opportunities for social connection,
— Lack of awareness of forums and opportunities for social connection in Australia. (This is particularly important as many new arrivals will have originated from countries where social connections are made informally in public spaces such as streets and markets),
— Limited financial capacity to participate in social and recreational activities. (Rice, 1999 and VicHealth, 2003).

However, as older people, these are compounded by the additional barriers of:
— physical limitations which may affect their use of public transport, (Bartolomei et al. 2003),
— memory loss,
— low literacy,
— lack of confidence.

Individuals will vary in the degree to which they are affected by these barriers, and depending on their country of origin and the extent of their community structures and networks in Australia, will be affected by some of these barriers more than others. However, for many older people from more recently arrived communities, all of these barriers will be pertinent, especially to older people who are not able to work.

A factor that arose from this research and is also prominent in the literature, is the importance of housing in determining social connectedness for refugee seniors in Australia. Bartolomei et al. note that housing commission accommodation is often not appropriate for the larger extended families of many refugees, and older people sometimes find living with their children and grandchildren in cramped conditions stressful and frustrating (Bartolomei et al., 2003). For those who want to live near but not with their families, the reality of ‘intimacy at a distance’ is sometimes difficult to achieve when families are on low incomes and dependent on government housing. For families who are struggling to support themselves, and find their way around the systems of their new country, an older relative living one or two suburbs away can easily become isolated and neglected. Accommodation in inappropriate areas is also a problem if older people feel they are unsafe. Past experiences of trauma can cause older people to become very frightened if they feel their personal safety is at risk outside the home, and may lead to them becoming housebound (Bartolomei et al., 2003).

The majority of refugees in Australia are resettled in urban areas where there is a greater density of public housing and organisations offering integration support. For refugees from rural backgrounds, and particularly older refugees, the transition to urban life can be difficult and painful, and result in feelings of isolation and alienation. Those who have lost their traditional social networks may feel they are “villagers without a village” (Rowland, 1991) and this can affect their sense of identity, especially if they feel their social status is not recognised or is lost. Their ability to cope with this loss is also hampered because they no longer have the networks of friends and peers they would usually rely on for emotional support (Bartolomei et al., 2003). Several community workers interviewed as part of this research, noted that older refugees often missed the opportunities for social interaction they were familiar with in village life, and found the ‘closed door’ culture of Australia very strange and alienating.
Lack of language

The inability to speak the language of the country of resettlement is a key issue for the wellbeing of older refugees. It intensifies the experience of isolation and alienation, compounds dependence on family, and can seriously affect levels of self esteem. A refugee respondent quoted in Bartolomei, et al. describes her lack of English as “like living in the dark”. Inability to communicate can make older refugees afraid to go out alone and can severely limit their knowledge and use of services.

Younger refugees will often need to learn the language of their host country for work or school and will have opportunities to use and practice it. Older refugees who are not working will not have this urgency and many are reported to feel that they are too old or that it is too late for them to learn (Bartolomei et al., 2003). For those who choose to learn, the ongoing impact of trauma can mean concentration is difficult and many older refugees do not like learning in a classroom setting with younger people because they are embarrassed to ask questions or to be seen to be slow. Research from the United States has shown that older refugees also tend to dislike having teachers younger than themselves and will often drop out of classes if they feel uncomfortable (Chenoweth and Burdick, 2001).

Loss of independence

Whilst most older people experience a gradual loss of their independence due to declining physical and mental health, it is a commonly noted fact in the literature on refugee seniors, that they experience the loss of independence as a sudden occurrence when they arrive in their country of resettlement (Chenoweth and Burdick, 2001). Refugee seniors, who are usually resettled under the family reunification program, tend to find themselves heavily dependent on their families for everything from money to translation and transport. Those who are too young to receive a pension but too old to find work, can find it demeaning to be entirely financially dependent on their children, and even dependence on the state can cause feelings of uneasiness and shame (Bartolomei et al., 2003).

Fear of using public transport and of being out of the house alone in an unfamiliar environment can lead to older refugees becoming dependent on younger members of the family for transport. For families busy with work and schooling, the needs of older relatives to leave the house is not always a priority, and older relatives risk becoming trapped in the home (Chenoweth and Burdick, 2001).

Such sudden and complete dependence on family often causes feelings of uselessness among older refugees, and much of the data gathered in this research suggests that concern with being a 'burden' is a common experience. For older men who are used to heading the household and supporting family members, the role reversal in financial and practical dependence can come as an especially painful and difficult shock (Bartolomei et al., 2003). As well as the loss of their financial and practical independence, many older refugees also lose their roles as advisers and arbiters as a consequence of resettlement. Where they had once been the guardians of tradition, they suddenly find their knowledge and experience obsolete (Chenoweth and Burdick, 2001), and anxiety about their diminished authority in the family and society can lead to older family members becoming autocratic and bullying (Thomas in Rice, 1999).
Positive experiences of being an older refugee

Bartolomei et al. in their research with refugee seniors in New South Wales, discovered that although refugee seniors face many difficulties in the course of resettlement, they are often also keen to highlight the positive aspects of living in Australia (Bartolomei et al., 2003). The most commonly expressed sentiments in this regard are the feeling of freedom and the experience of peace in contrast with the countries they had fled. Government welfare services and in particular pensions and health care are also regarded positively, and many older refugees express their gratitude for the assistance they are offered. Research among community workers in Melbourne uncovered similar sentiments of gratitude for services, including a feeling among some refugee seniors that they had received so much help with resettlement they could not accept any more government services, such as home care for the elderly.

a. Family and Forced Displacement

Families are often separated for long periods during forced displacement and in many cases family members are lost or killed. The desire to reunite families is usually extremely strong among refugees and many younger refugees who arrive in Australia strive to bring their older relatives to join them through the family reunification migration program. The expectations of family unity and harmony after long periods of separation and suffering are often high, but the reality can sometimes be cause for disappointment and upset (Rousseau et al., 2004).

As mentioned above, older refugees who join their families in resettlement countries, have often lost their normal social networks, and the family therefore becomes their principle locus of social and emotional interaction and support. The most commonly recorded experience among refugee seniors following family reunification, is that of role reversal, in which older relatives who would normally act as guardians and advisors to younger members of the family, become dependent on their children and grandchildren. This role reversal is exacerbated when older parents join children who have been in the resettlement country for some time and the sudden clash of expectations and cultures can be devastating. Older refugees sometimes feel they have been “robbed of their children and grandchildren” by the new society they find themselves in, especially when the younger generations no longer recognise, respect or uphold traditional practices or cannot communicate in their grandparents’ language (Schweitzer, 1991). As a consequence, older people can often feel rejected and unvalued, and at the same time constrained by their on-going financial and emotional dependence.

For older refugees who have experienced trauma or torture, the clash of cultures within the family can be heightened if younger relatives who did not experience such events, do not understand the impact this type of experience can have on their mental health. Older refugees trying to reappraise their lives may be haunted by memories of past trauma which can influence their behaviour and attitudes. Their trauma experiences may make them overprotective of their family, and younger family members may rebel against or reject their older relatives’ instinct to protect them (Bartolomei et al., 2003). The pain caused by this misunderstanding can compound the already fragile mental health of some older refugees and lead to more severe conditions.
A PROFILE OF VICTORIAN SENIORS FROM REFUGEE BACKGROUNDS

The financial pressures on refugee families during resettlement often require them to take on work that involves long or irregular hours away from the family home. The need to care for children in a new environment is also time consuming, and the middle generation may find they have limited time available for their older parents. This inevitably leads to both tensions and anxiety for older relatives who may feel they are being neglected (Chenoweth and Burdick, 2001). Bartolomei et al. identify the difference between ‘caring about’ and ‘caring for’ as key to understanding the difficulties which are often experienced in refugee families with older relatives (Bartolomei et al., 2003). In many cultures from which refugees originate, ‘caring about’ ones relatives is generally expressed through ‘caring for’ them during times of illness or in old age. In Western cultures these concepts are separated out by the use of third party carers who ‘care for’ family members. Adult refugees who have spent some time in Australia may accept that ‘caring about’ does not necessitate ‘caring for’, but this will often be an anathema to their older relatives who hold more traditional beliefs regarding familial duties. The potential for misunderstanding on this issue can have serious consequences for the wellbeing of older refugees and their relationships with their families.

The conflict that can occur between the generations in a refugee family as a result of the issues mentioned above, can be extremely damaging to family unity and can sometimes lead to older people choosing to move out of the family home. Bartolomei et al. report that although this is not normative in many societies from which refugees originate, it is not uncommon following migration (Bartolomei et al., 2003). As discussed above, family break-down causes knock-on problems in relation to housing and transport, and heightens the potential for social isolation and mental illness among the elderly.

Despite the risks of family reunification, it is nevertheless an overwhelming priority for most refugees following resettlement. Elderly refugees are known to experience severe anxiety as a consequence of having children remaining in the countries from which they have fled, anxiety which can be compounded if family unity in the country of resettlement is also under threat (Thomas, 1999a; Bartolomei et al., 2003). In some cases of course, family reunification is successful, and elderly relatives feel they have a useful role to play in assisting with the care or education of grandchildren. Bartolomei et al. report that although in some instances grandparents can feel exploited if they are expected to provided full-time child care, in many cases this reciprocal care can give older relatives a sense of purpose and improve their self-esteem (Bartolomei et al., 2003).

b. Gender Specific Issues

The refugee experience necessarily varies between people from different countries of origin, and people of different age and gender, but little work appears to have been done on how gender impacts on the experience of older refugees or on how it influences the experience of resettlement. Whilst generalisations do not give an accurate picture of the complexities and diversity of the refugee experience, there are certain themes related to gender which recur in the literature and research.
One theme mentioned in the literature and expressed by interviewees in this study, is that men and women from refugee backgrounds often have different experiences of resettlement based on their expectations of employment. Refugee men coming from patriarchal societies where they are expected to head the household and provide an income, often find the loss of social status experienced as a result of unemployment or having to take low skilled jobs, particularly difficult to deal with. Women from these communities, who are used to working in the home and can continue to perform familiar domestic tasks, are thought to suffer less from this loss of status and sense of uselessness. The risk they face is that of isolation and depression if they remain in the home and have no social contact outside the family (Chenoweth and Burdick, 2001).

Another theme arising in the literature and from the research, is a feeling among some refugee men that Australia is “a woman’s country” in which the law favours women by allowing them to divorce, and by offering them means to leave their families, such as women’s refuges (Bartolomei et al., 2003). Some research has also demonstrated that men who have experienced or witnessed torture are more likely to use domestic violence in the home (Pittaway, 1999) and women are less likely to tolerate this in countries of resettlement once they discover that they have legal rights to protection.

Women and children make up a vast majority (80%) of the world’s refugees and an estimated 85% of female refugees are likely to have been raped or sexually abused (Pittaway, 1999). Many women do not disclose incidents of rape as part of their refugee claim, for fear it will jeopardize their application. Many also do not tell their husbands for fear of rejection (ibid). The burden of shame and trauma this can create is an additional source of anxiety and stress for older refugee women, on top of the other factors common to the refugee experience.

c. Cultural Issues

The ‘culture shock’ experienced by all migrants and refugees on arrival in a new country can be a particularly overwhelming experience for older people. Maintaining some cultural continuity after resettlement is especially important for older refugees who are likely to already suffer from trauma and for whom displacement was forced rather than chosen. Findings from the research with recently arrived refugee communities carried out in this study, and evidence in the literature, indicate that establishing and maintaining contact with people from similar cultural backgrounds who share one’s values and speak the same language, is a high priority for older refugees and is viewed as critical to ensuring their wellbeing (VicHealth, 2003). The importance of maintaining these networks among older migrants is borne out by the large number of ethno-specific senior citizens’ clubs offering cultural activities in the more settled migrant and refugee communities (see Appendix 2).
Some of the most important cultural practices for many communities are related to religion. Religion plays a central role in cultural identity for many older refugees and is a crucial factor in maintaining a sense of community, continuity and stability (Bartolomei et al., 2003). Places of worship are often important focal points for older people and sometimes the only places outside the family where they have a sense of belonging to a community. It is important that cultural services for older refugees incorporate religious institutions and leaders if they are to be seen as appropriate by their target community (Bartolomei et al., 2003).

Although refugees in Australia come from a wide range of cultural and religious backgrounds, many of them have more in common with each other than with mainstream western culture. Common features of many of the cultures from which refugees originate include unconditional respect for elders, the importance of the family unit, and clearly prescribed gender distinctions. Whilst other cultural practices, including religion, clearly differ between refugee communities, these key similarities mean that the experiences of resettlement in Australia, especially for older refugees, are often remarkably alike. Details of the specific cultural factors that are relevant to the resettlement experiences of seniors from different refugee communities are provided in Chapter 9.

Cultural attitudes towards health, and particularly mental health, are important factors in resettlement in western countries. Western understanding of health and mental health can seem very alien for refugees from non-western cultures and this will affect how they interact with and use medical and social services. As Trang Thomas notes, “mental health symptoms are not readily reported in many cultures. Southeast Asians have been found reticent to mention psychological symptoms, and would rather report physical symptoms and bodily discomforts such as feeling chilly or skin problems” (Thomas, 1999b). The lack of distinction between physical and mental illness is common to many cultures from which refugees in Australia originate, and treatment such as counselling or psychotherapy are often unfamiliar. As research for this study revealed, many older refugees are reluctant to give up their culture-specific understanding of health and are consequently wary of using Australian health services.

Whilst culture clearly plays a crucial role in the success or otherwise of refugee resettlement, other factors such as the length of time a community has been in Australia or the political divisions within a community, also have important influences on the resettlement experience.

4. Health and wellbeing issues affecting refugee seniors in resettlement

One factor that all refugees have in common, whatever their country of origin, is the experience of displacement and exposure to high levels of stress or trauma. The long term impact of trauma, combined with the effects of long periods of hardship, poor nutrition, disrupted healthcare and education, and exposure to disease, has serious implications for the physical and mental health of refugees following resettlement (VFST, 2004). When the natural decline in health that occurs with ageing is also a factor, the potential for serious mental and physical health problems is high.
The psychological disorders caused by exposure to trauma and displacement, include diagnosable disorders such as post traumatic stress disorder (PTSD), depression, and anxiety disorder. In old age the symptoms associated with these disorders can be exacerbated by, or mistaken for, the onset of natural mental decline. Studies with Holocaust survivors have shown that in many cases the identification of ‘senile dementia’ in refugees is in fact a mistaken diagnosis of unresolved PTSD that had been suppressed until retirement, or other circumstances, allowed time for reflection and contemplation of earlier trauma (Wilson, 1990 quoted in Pittaway, 1999).

In addition to clinical disorders, trauma and displacement can have a more far reaching impact on the everyday lives of refugees. Many find that their ability to concentrate and learn is diminished or that their sleep is disrupted by nightmares and anxiety. Other common experiences include feelings of guilt for having survived, an inability to trust people other than close family, and a loss of meaning and purpose (VFST, 2004). For older refugees, these symptoms are likely to be experienced in the context of also feeling isolated and alienated, and of ‘ageing in the wrong place’. Without the distractions of work or domestic duties to occupy them, and isolated from their usual social support networks, older refugees are at a higher risk of developing more serious psychological disorders as a result of trauma (Parker and Haslam, 2005).

Refugee mental health needs cannot solely be attributed to pre-arrival trauma. Research has found that the symptoms of torture are more pronounced in those who migrate from their country of origin (Ater, 1998) and a recent study of Somali refugee women in Australia, found that the majority attributed their ongoing emotional distress to the everyday realities of family separation, loss of community cohesion, marginalisation and isolation that often characterise the resettlement experience (McMichael, 2003). For older people in particular, the resettlement process can be an especially stressful and painful time, marked by family conflict and social isolation, which can lead to mental illness.

The high risks of suffering psychological disorders among older refugees are often coupled with a low likelihood of having them treated (Rice, 1999). Unwillingness to acknowledge mental health problems, low exposure to or understanding of health care services, and the possible fear or mistrust of medical practitioners, means older refugees are often unlikely to seek or accept treatment. A lack of understanding of the relationship between trauma, stress and mental health also means the families of older refugees may not pick up on symptoms, and may struggle to understand and cope with mentally ill elderly relatives.

In addition to the psychological impact of trauma and displacement, some refugees also suffer on-going physical symptoms resulting from torture, war injuries and hardships endured during displacement. Old injuries and long term conditions tend to worsen with advancing age and result in refugee seniors having age-associated frailties or disabilities earlier in life. Resettlement and a change of climate and diet can also affect the physical wellbeing of older refugees. Research for this study found that high levels of diabetes and high blood pressure were reported among the elderly in many refugee communities, as were high incidences of colds and influenza.
5. Health service and support needs of refugee seniors

Research carried out in 1996 into the use of health and support services by seniors from small ethnic communities in Australia identified both their vulnerability and low visibility (Barnett et al., 1996). Both factors stem from the fact that minority communities are generally too small to have the necessary resources to attract policy makers and service providers’ awareness of their needs, and from the fact that their limited numbers make service providers reluctant to consider them for ethno-specific services (ibid.). As a minority within a minority, refugee seniors are at high risk of both low visibility and vulnerability. More recent research has found that very few service providers recognise the needs of refugee seniors as distinct from the needs of other migrant groups, and thus rarely have policies in place to meet them (Bartolomei et al., 2003).

The low visibility and vulnerability of refugee seniors is also related to factors other than the size of their communities. In common with migrants from countries with non-western health care systems, many refugees lack knowledge and understanding of the available aged care services in Australia, and for the many refugees who come from developing countries, even the concept of aged care may be unfamiliar. In addressing this, the issue of language is also pertinent, as many older refugees are unlikely to speak English, and may not be literate in their own language (Barnett et al., 1996). If this is compounded by social isolation, informing refugee seniors of available services can prove very difficult.

If the first key issue in meeting the health care needs of refugee seniors is to address their knowledge and understanding of services, the second most important issue is to address the cultural barriers preventing them from using these services. The expectation among many refugee communities that family members should provide care for the elderly, is perhaps the most widespread of these barriers. For refugee communities who have previously experienced surveillance or persecution at the hands of state authorities, the expectation of family care is combined with a fear of allowing workers from government agencies and even medical professionals, to become closely involved in the care of family members. Although refugee families are often over burdened with the practical needs of resettlement and may struggle to find the time to care for their elderly relatives, the conflation of ‘caring about’ and ‘caring for’ which may determine family care duties, can produce strong opposition to utilising aged care services. Traditions of family privacy which exist in many of the Asian societies from which refugees come to Australia, are another cultural barrier to the use of residential and home care services, and also militate against the take up of respite and carer support services. In addition, the embarrassment and shame associated with mental illness, which are common to many refugee communities, mean psychological disorders in refugee seniors are likely to go unreported and untreated. For these reasons, formal aged care models involving residential, home and respite care are often considered inappropriate by refugee communities, and addressing their needs requires a flexibility in service delivery that allows for family and the community to play a central role (Barnett et al., 1996).
The one type of aged care service which is very popular among refugee seniors and which, as described above, is vital to overcoming the problems of social isolation, is that which allows for organised social gatherings of seniors from the same country or of those who speak the same language. As Barnett et al. note, these and other services are often most successful in reaching their target audience, and building community capacity, if they are at first built around existing community focal points such as places of worship (Barnett et al., 1996). Research for this study found that the vast majority of people who worked with refugee seniors, especially those from smaller and newer communities who lack community structures and resources, felt that social activities would be very popular and could play a vital role in improving the wellbeing and health of their clients. Many stressed that transport was a major issue in organizing such activities, but that once this is overcome, the social and emotional support offered by such groups can have a significant impact on improving the psychological, emotional and even physical wellbeing of refugee seniors.

Other than European refugees who arrived following the end of the Second World War, the numbers of refugee seniors in Australia are still relatively low in comparison with other migrant groups. However, these numbers will increase, both as the refugee populations age, and as increasing numbers of younger refugees bring their older relatives to join them through the family reunification program. Innovative approaches to providing services for them will require consultation and flexibility, at least until communities reach a critical mass at which they can acquire ethno-specific care services or have the organisational capacity to provide these services themselves (Rowland, 1991; Barnett et al., 1996). As refugee seniors have health and wellbeing needs that are distinct from those of other migrant and non-English speaking communities, and because they are a particularly vulnerable minority, it is important that their needs are addressed sensitively and promptly.
Chapter 3  
Research Design and Methods

The information presented in this report was gathered over the course of 4 months, through a broad scoping of the published and unpublished literature, reviews of relevant State and Commonwealth documents, interviews with a range of service providers and community organizations, and analysis of data provided by the Victorian Department of Health and Human Services, the ABS 2001 Census and the DIMIA Settlement Database. Given the time constraints of the project, consultations were not carried out with refugee seniors themselves or with their families or carers. Below, we describe in more detail the methods of data collection and analysis.

1. Data Collection

a. Quantitative data

The quantitative data used to develop the profile of seniors from individual refugee communities (Chapter 9) comprised six key fields. These fields and their data sources are described in Table 3.1 below:

<table>
<thead>
<tr>
<th>FIELD</th>
<th>DATA SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migration categories</td>
<td>DIMIA Settlement Database (DIMIA, 2004a)</td>
</tr>
<tr>
<td>Languages spoken</td>
<td>DIMIA Settlement Database (DIMIA, 2004a)</td>
</tr>
<tr>
<td>English language proficiency</td>
<td>DIMIA Settlement Database (DIMIA, 2004a)</td>
</tr>
<tr>
<td>Age and gender profile</td>
<td>2001 Australian Census (ABS, 2003); DIMIA Settlement Database (DIMIA, 2004a)</td>
</tr>
<tr>
<td>Place of settlement</td>
<td>DIMIA Settlement Database (DIMIA, 2004a)</td>
</tr>
</tbody>
</table>

‘Community Information Summaries’, published by DIMIA, provided additional data included in some community profiles. The DIMIA Settlement Database was also used to develop the overall patterns of migration to Victoria between 1996 and 2004 (see Figures 4.1 and 4.2).

The quantitative data used to develop the profile of HACC users from refugee-source countries (Figure 5.1) was based on 2003-2004 datasets provided by HACC.
b. Qualitative data

Qualitative data on the health and wellbeing needs of refugees seniors was gathered from three distinct sources:

**Literature Review**

Literature ranging from academic papers to government reports and service providers’ manuals was reviewed and used to identify the principal issues relating to the health and wellbeing of refugee seniors. As well as research undertaken in Australia, findings from other resettlement countries including the United States, the UK and New Zealand were reviewed and considered in the analysis of common themes.

**Interviews with service providers**

State and local government authorities, as well as non-governmental organisations providing services in the areas of aged care and support to refugees were interviewed. Examples of the type of organisations consulted include local council HACC service providers, Migrant Resource Centres and the Victorian Foundation for Survivors of Torture. Information was gathered on the needs of refugee seniors who use these services, and on issues such as the perceived barriers to the take up of services and efforts being made to encourage use of services among refugee communities.

**Interviews with community workers**

Community workers from the refugee communities identified in Chapter 9 were interviewed in order to discover the community-specific health and wellbeing needs of seniors. Information was gathered on factors ranging from definitions and understanding of the concept of ‘elder’, to cultural norms relating to family structures and duties, and attitudes towards health care.

Interviews were conducted using a mixture of questions designed to elicit specific information (such as which refugee communities used services provided by a specific local council), and open ended questioning aimed at enabling interviewees to elaborate on their own experiences and provide case studies.

Due to time limitations, interviews and focus groups with refugee seniors were not carried out, but would be recommended in any further studies in this area.

2. Data Analysis

a. Quantitative data

The analysis of the quantitative data included:

**Resettlement in Victoria:**

The total number of persons from each community who were living in Victoria was compared across the 1996 and 2001 Census. The proportion of people living in Victoria from the total Australian population of those born in each of the refugee-source countries was also included. Line graphs are used to illustrate the individual communities’ pattern of humanitarian migration over time (between 1996 and 2004). These line graphs are based on all age groups.
Migration categories:
Pie charts are used to illustrate the proportion of humanitarian entrants from each community since 1996 compared with the other migration streams. This categorisation aims to qualify both the quantitative and the qualitative data included in the context of the refugee experience. For instance, while most entrants from countries like Sudan have come under the humanitarian category, recent arrivals from other countries such as Egypt, have come under the family and skilled migration streams. Thus, it can be assumed that most in the Sudanese community, and only a third in the Egyptian community has had refugee-like experiences.

Languages spoken:
The main languages spoken by humanitarian entrants (between 1996 and 2004) from each of the refugee-source countries are tabled in decreasing frequency.

English language proficiency:
The English Proficiency (EP) index is used to categorise the English language proficiency of humanitarian entrants. The EP index is based on the proportion of arrivals for each country of birth in the five years up to the 1996 Census who spoke ‘good English’ or ‘English only’ at the Census. The EP groups are:
- EP 1: 98% or higher spoke good English or English only
- EP 2: 80% to less than 98% spoke good English or English only
- EP 3: 50% to less than 80% spoke good English or English only
- EP 4: less than 50% spoke good English or English only

Age and gender profile:
Bar graphs are used to represent the estimated population of each community in Victoria in 2004. The graphs include total number and gender distributions by individual age categories. For most communities, entrants under all migration categories between 2001 and 2004 are added to the population recorded at the 2001 Census.

Place of settlement:
The patterns of settlement by Local Government Areas (LGAs) for those aged 35 years and over who have arrived since 1996 are listed for each community in decreasing frequency. Age was that recorded at time of entry to Australia. For instance, those aged 35 who arrived in 1996 would be 43 years of age at 2004. This data is also represented in map form in Appendix 3.

b. Qualitative data

Data gathered in the literature review was analysed in order to identify common themes in the findings of research into the health and wellbeing needs of refugee seniors. Research from different countries was compared, and the findings are presented in a discussion of the key issues affecting refugee seniors in a resettlement context in Chapter 2.

The qualitative data gathered from interviews with service providers and community workers was analysed inductively. This involved a review of the responses given by interviewees and the identification of common themes and issues. These themes are cross referenced with issues arising from the literature review in Chapter 2, and drawn out in more detail in Chapter 5.
Data gathered from interviews was also used both as the basis for the community profiles in Chapter 9 and in the review of the use of services by refugee seniors in Chapter 4. The profiles in Chapter 9 are supplemented by case studies from service providers and community workers.

Innovative models for addressing the needs of refugee seniors were identified from the data gathered from service providers and are highlighted in Chapter 6. Service providers’ recommendations for improving access for refugee seniors are included in Chapter 8.

3. Limitations

a. Quantitative Data

Several limitations have to be acknowledged concerning the quantitative data. First, although the data sources used here are the most reliable sources of information regarding humanitarian entrants (DIMIA, 2004a) and overseas-born persons living in Australia (ABS Census data), care should be taken when using these figures. For example, it has been reported that the DIMIA Settlement Database is undercounting records (skilled stream by 5%, family stream by 3%, and humanitarian stream by 0.5%) (DIMIA, 2004a). Similarly, the ABS has made some adjustments to the 2001 Census data for confidentiality reasons where numbers are very low.

Second, as the estimated 2004 population of most communities included in the report is based on the 2001 Census and the Settlement data between 2001 and 2004, these estimates do not take into account interstate or overseas migration, or mortality data. In addition, the age groupings reported in the 1996-97 to 2002-03 settlement databases (i.e. 0-24, 24-34, 35-44, 45-54, 55-64, 65+) were different from those reported in the 2003-04 database (i.e. 0-19, 20-29, 30-39, 40-49, 50-59, 60+). Some adjustments are made to the latter age groupings in order to give an estimate based on common age categories.

The third limitation is related to the place of settlement. The data presented in this field reflects the settlement patterns of recent arrivals for each community, and not the place of residence of each community’s total population in Victoria. In this context, the patterns of settlement may help to identify gaps in services and to develop strategies for the planning and future implementation of services as recent arrivals settle in new local government areas.

A final limitation relates to individual communities for whom some data was not available. For example, although data on the East Timorese began to be recorded at the 2001 Census after East Timor’s independence from Indonesia, the DIMIA settlement database does not capture East Timor as a separate entry within the country of birth indicator, which makes it difficult to know the migration category distribution and the number of humanitarian entrants in recent years. In cases like this, data was obtained from other sources including consultations with communities and service providers.
b. Qualitative Data

The gathering of qualitative data was largely limited by the amount of time and resources available to conduct the research. Due to these restrictions, it was not possible to conduct first-hand interviews with refugee seniors and the data, especially in the community profiles, must be considered with this in mind. The fact that only one or two community workers from each refugee community could be interviewed, also has implications for the scope and quality of the data gathered.

Data gathered from community leaders who run refugee community organisations, needs to be considered in light of the fact that such individuals may not be representative of the majority in their community. Community leaders are likely to be from educated backgrounds and tend to be from a family with higher than average social or political status. In communities where different factions and groups do not mix, community leaders will usually only be able to offer the opinions of one faction of the community, and may provide limited or distorted information regarding other groups. Pride in the culture and traditions of a community, and a sensitivity to criticism from outside, may also discourage community leaders from discussing problems affecting their community. Sensitive issues to do with mental health and elder abuse could possibly be talked down or not conveyed to researchers.

Similar limitations apply to the information gathered from service providers due to the fact that time did not allow for a comprehensive survey of all organisations working with refugee seniors. Those interviewed could only speak about their particular geographical area or field of service provision which again, must be kept in mind when considering their comments on barriers to access or suggestions for improvement.

The gender of interviewees, especially community workers, will also have an impact on the quality of the data gathered. The majority of carers in most refugee communities are female, and female community workers were often able to give first hand examples of the issues they have encountered in caring for their own elderly relatives. Male interviewees tended not to provide information from first hand experience, but rather from their experience of organising community events for older people. For communities where only male community workers and leaders were interviewed, it was therefore often the case that less detailed information on the health and wellbeing issues affecting refugee seniors was gathered.

Due to the limitations of this research, wherever possible, literature based on first-hand consultations with refugee seniors was consulted and compared with the data gathered in this study. However, as relatively little research has been done into the health and wellbeing needs of refugee seniors, some of the literature used was over 5 years old and cannot be guaranteed to accurately represent the current reality of a community’s attitudes and beliefs.
Chapter 4  A profile of HACC services: Issues for Refugee Seniors

1. Introduction

The Home and Community Care (HACC) program is jointly funded by Federal and State governments. Its aim is to enhance the independence of frail older people and disabled individuals of all ages who require help with daily living tasks, by enabling them to remain in their homes and avoid the need for residential care. The aversion to residential aged care among many refugee communities makes home and community based care the obvious option for meeting the needs of refugee seniors, and yet these services are notably underused by this population. This chapter examines the services offered through HACC, the accessibility and availability of these services for seniors from refugee backgrounds, and ways in which HACC usage could be increased among this group.

2. HACC and CEGS services

Services offered to clients under HACC program include:

  — Assessment and Care Management, including eligibility and priority assessment, nutritional risk screening and monitoring, development of care plans, respite planning and care management.
  — Home Care, including cooking, cleaning, laundry, shopping, escorting to medical and related appointments, assistance with personal administration and any other tasks that help enhance or maintain an individual’s independence.
  — Property Maintenance, including minor repairs and maintenance of house and garden, and home modifications to assist with mobility.
  — Personal Care, including assistance with bathing, dressing, grooming, toileting, mobility, eating, medication and the use of disability aids such as callipers and hearing aids.
  — Delivered Meals and Centre Based Meals
  — Planned Activity Groups for both physically independent clients who do not require specialist care, and for high need clients such as those with dementia or a physically limiting disability.
— Respite Care, including in-home, outings and overnight respite.
— Volunteer Coordination including friendly visiting programs, telelink services, carer support programs, transport services, respite care and respite camps.
— Nursing to maintain an individual’s abilities and health, provide information, advice and education on health maintenance, assist access to appropriate health services, and to carry out clinical assessments.
— Allied Health including podiatry, physiotherapy, occupational therapy, speech pathology, dietetics and counselling.

(DHS, 2003)

Each year over 200,000 people in Victoria use HACC services. The majority are aged over 70, many live alone and in 2004-2005, 21% of HACC clients were from non-English speaking backgrounds. Approximately 4% of the annual HACC budget in Victoria is allocated to ethno-specific and multicultural agencies to provide mainly social support services to Culturally and Linguistically Diverse (CALD) communities.

In 2004 the Victorian Minister for Aged Care allocated an extra $6.2m over three years for the Culturally Equitable Gateways Strategy (CEGS) (Jennings 2004). The CEGS initiative is aimed at expanding and improving the use of HACC core services such as; Personal Care, Home Care, Property Maintenance, Respite and Delivered Meals, by people over 65 from CALD backgrounds. CEGS funding has been allocated to Local Government Authorities, Migrant Resource Centres and ethno-specific agencies.

The aims of the strategy are:
— To build the capacity of local government assessment and care management services to provide a culturally friendly gateway to HACC services and ensure appropriate linkage with ethno-specific agencies.
— To build capacity in large and established ethno-specific services to provide practical support to local councils and encourage culturally appropriate services and service linkage.
— To fund flexible service responses by small and emerging ethnic agencies.
— To improve leadership and sector development within and across ethno-specific, multicultural and local government in order to improve service provision.
— To increase recruitment of bi-lingual and multicultural staff in HACC service providers.

(DHS website, May 2005)

3. Availability and Use of Seniors Services for Refugees

In 2004 – 2005 HACC funded 60 ethno-specific agencies to provide services for CALD clients. These agencies serviced around 30 ethnic groups with two or more servicing the Greek, Polish, Vietnamese, Italian and Jewish communities. Included in this list of 60 agencies are 11 ethnic peak body organisations and Migrant Resource Centres who serve a wider range of smaller communities including more recently arrived refugee communities.
Based on available data, the table in Appendix 2 summarises the distribution of HACC funded ethno-specific community organisations relevant to the refugee communities living in Victoria in 2004-2005. It includes organisations funded under both HACC and CEGS, and also lists non-HACC funded organisations who serve seniors from each of the refugee communities. In line with DIMIA data, refugee communities are identified by country of birth rather than language or ethnicity. However, care has been taken to identify the relevant language and religion for each country that takes into account the complexities of the refugee populations. For example, Russian, Ukrainian and Romanian services are identified as potentially serving the Moldovan community in order to reflect the ethnic make-up of the country and the refugees who have come from it.

It should be noted that this table describes services that could potentially be used by communities, and does not describe actual use of these services. It also does not account for individuals who access HACC services through Local Councils, although anecdotal evidence suggests the numbers of refugees who do this are low. For details of the actually take up of HACC services by individuals from refugee communities see table 5.1.

Table 4.1 Utilization of HACC services by individuals from refugee-source countries: Victorian Regions 2003–04

<table>
<thead>
<tr>
<th>Country of Birth</th>
<th>WMR</th>
<th>EMR</th>
<th>SMR</th>
<th>NMR</th>
<th>Barwon</th>
<th>Hume</th>
<th>Loddon</th>
<th>Grampians</th>
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WMR: Western Metro Region; EMR: Eastern Metro Region; SMR: Southern Metro Region; NMR: Northern Metro Region

1. Data provided by DHS
As Table 4.1 and Appendix 2 reveal, there is a great deal of variance in the use of HACC services by refugee communities, in number of ethno-specific seniors’ organisations serving each of the refugee communities, and in the amount of funding allocated through HACC and CEGS. The number of community organisations and the amount of ethno-specific funding is generally in proportion to the size of the community when pre-1996 arrivals are taken into consideration. Well established communities, such as the Polish, Former Yugoslavian, Former Russian, Chinese and Vietnamese, in which the majority of refugees arrived before 1996, also tend to be better served by senior citizens groups and ethno-specific HACC funded agencies.

Of the more recently arrived communities, in particular those from the Middle East and Africa, most have few ethno-specific seniors organisations/services available to them (see Appendix 2). This is partly due to the fact that newer refugee communities tend to be made up of younger individuals, and partly because they have not had time to establish community organisations such as senior citizens’ groups.

Particular communities where need for services is expected to grow are:

— The Iraqi Community. This has been growing consistently since the first Gulf War in 1991 and currently shows no sign of slowing. Whilst the majority of recent humanitarian arrivals are young, there is a significant number of older Iraqi individuals living in Victoria (see Figure 9.6.3) who are likely to have refugee backgrounds, even if they arrived under the family migration scheme. There are a number of Arabic and Islamic senior citizens’ groups, one Arabic HACC funded ethno-specific organization and one Kurdish senior citizens’ association.

— The Iranian Community. This is another group that has been increasing since 1996 and which has a growing number of individuals over 50. Unlike Iraqi seniors, Iranians, who mainly speak Persian (Dari/Farsi), are unable to access existing Arabic senior citizens services and have no community specific services to meet their needs.

— The Afghan Community. Similar to the Iranian and Iraqi community, the number of Afghan humanitarian entrants to Australia has increased over the last 10 years. The majority of humanitarian arrivals have been under 35, but increasing numbers of older individuals are arriving through the family migration scheme. The community is fairly well established in Victoria and has a small number of ethno-specific community organisations.

— The Burmese Community. Although this is a small community in which the majority are young, it is of concern because other than one community organisation, there are no senior citizens’ associations and language and cultural differences would make it difficult for Burmese seniors to access other available ethno-specific services for Indo-Chinese communities.

— The East Timorese Community. Both of the ethnic groups within this community are disadvantaged by speaking minority languages. Whilst those living in Richmond are generally well served by community and health services with bi-lingual workers, those in other suburbs are less likely to have appropriate services they can access.
The Horn of Africa Communities. Humanitarian entrants from Sudan, Somalia, Ethiopia and Eritrea represent one of the fastest growing refugee populations in Victoria. Whilst the majority are young, there are significant numbers of older individuals arriving through the family migration scheme. At present, there are several general welfare organisations to assist these communities with settlement, and two HACC funded agencies. In order to improve access to HACC services by small and emerging communities, $100,000 was allocated as part of the CEGS initiative to encourage partnership between smaller communities, established ethno-specific and multicultural agencies and local government.

4. Barriers to Access and Delivery of HACC Social Support Services for Small and Emerging Refugee Communities

Of the $8.8m provided for ethno-specific HACC organisations in 2003-2004, 46% was spent on Planned Activity Groups (PAGs). These groups, which allow seniors from ethnic communities to meet in a convenient venue for culturally appropriate meals and activities, are vital for maintaining social connectivity, enabling the sharing of personal and community histories, and providing CALD seniors with information about services. For small communities in particular, they offer older people some of the familiarity and continuity that they are likely to miss living in a foreign society.

The popularity of PAGs among CALD communities is testament to their importance for older people from non-English speaking backgrounds. Additionally, the lack of senior citizens' groups for some communities, while not a responsibility of the HACC program, is also an issue of concern. As explained above, newly arrived communities are less likely to have the resources in terms of time, finances and people to be able to set up and run senior citizens' groups. Finding and paying for a place to meet, transport to collect people, and the resources to provide meals and activities is well beyond the needs of many recently arrived refugee communities. The formalisation of social gatherings is also likely to be alien to those communities accustomed to living in close proximity to large families and groups of friends.

It is also important to acknowledge that communities which would appear to be easily grouped together due to their countries and regions of origin, such as the Horn of Africa and the Indo-Chinese, generally consist of a range of ethnic groups with different religious and cultural practices. The differences between these community groups can cause social gatherings to be difficult and make providing services to the communities as a whole challenging. Service providers need to be sensitive to the diversity within groups who appear to be easily classed together.
The high potential for isolation among refugee seniors from more recently arrived communities, makes social support services vital to improving their wellbeing and in many cases their mental health. Because these services are complimentary to family care duties, they do not attract the stigma of some core HACC services and are more likely to be readily taken up by refugee communities when provided in a culturally and linguistically sensitive way.

5. Barriers to Access and Delivery of HACC Core Services for Small and Emerging Refugee Communities

On arriving in Australia, refugees often take several months, and sometimes years, to become familiar with the range of government services available. Many will have come from places with less developed state infrastructures, or from countries where government services are viewed as part of an oppressive or intrusive state machinery. Refugee families are unlikely to seek information regarding aged care services if they have no experience of services for the elderly, or are wary of government workers and services.

Lack of knowledge and understanding of the aged care system is compounded by a lack of appropriate information. Recently arrived refugees tend to have one or two points of contact (usually a community organisation or an MRC) which they consult for information regarding life in Australia. Evidence from interviews with community associations suggests that many workers in these organisations do not know about or fully understand the range of services available, including HACC, and would therefore be unlikely to promote or explain them. Additionally, low levels of literacy among refugee seniors makes developing appropriate information and materials problematic. MRCs have done some work in promoting HACC services to their clients via the ethnic media and information sessions, but have not seen significant increases in referrals, therefore indicating other potential barriers.

The low take up of HACC core services, even among communities who have been informed of them, uncovers what is perhaps the most significant barrier to accessing and delivering core services to some refugee communities. In the majority of these communities, cultural or religious expectations dictate that it is the duty of the family to care for their elderly and that to do otherwise is negligent and disrespectful. Although families are often smaller in Australia than they would be in their countries of origin, and lack the support of extended families and social networks, the expectation that they will care for their elderly is invariably strong. The need to bring in external care would in many communities be taken to indicate that the family were failing in their duty to look after one another, and would be deeply shameful. Evidence from interviews with community organisations also suggests that the elderly from some communities are very reluctant to have strangers care for them, especially when they speak another language and are from another ethnic group or culture.

2. Interview with Horn of Africa Community Worker, 24/05/05
3. See AMES example, Chapter 6.
Within other communities, divisions between different factions make families suspicious of workers who speak their language and who might be from a different faction of the community.

Whilst this aversion to using external care services for the elderly is common in many refugee communities, other groups express an interest in the service, but lack information about how to access it. These communities, when provided with information, may be more likely to take up HACC services, but may also face difficulties negotiating the referral and assessment procedures. Assessment procedures in particular may prove problematic for refugee communities due to both language barriers and past experiences of assessment and interviews. The effect of traumatic experiences which lead to families becoming refugees, and their experiences of applying for asylum, may also have an impact on seniors’ performance during assessment. Mental health issues, whilst likely to be common, may well be denied or glossed over, or may have the effect of making elderly individuals feel there is no point improving their lives (see Case Study E, page 113). Cultural factors such as a reluctance to give negative answers, and a lack of confidence in how the information will be used, are also issues likely to affect refugee seniors during assessment. The use of family members as translators is a well recognised problem when discussing matters of health and personal care, and one that is equally important for refugees.

Issues of eligibility for accessing HACC also pose certain barriers for refugee seniors. HACC services are delivered on the principle of “relative need” which recognises that “the financial resources available to HACC may not meet the needs of all those people who would benefit from assistance [and]...acknowledges that the needs of individuals are not equal even though a person’s needs may be significant enough to benefit from assistance when viewed in isolation from the needs of other individual consumers” (DHS, 2003). The common indicators of higher need level include:

- That the frail elderly person or younger person with a disability experiences difficulty with a range of tasks of daily living.
- That the frail elderly person or younger person with a disability needs medical or nursing help on a short-term intensive or long-term basis.
- That the frail elderly person or younger person with a disability lives alone or with a carer who is frail, ill, stressed or has a disability.
- The social contacts of the frail elderly person or younger person with a disability are limited or non-existent.
- The home environment of the frail elderly person or younger person with a disability is physically unsafe.
- That the frail elderly person or younger person with a disability is socially or geographically isolated.
- That the frail elderly person or younger person with a disability is financially disadvantaged.

(DHS, 2003)
Whilst refugee seniors might meet the priorities of experiencing difficulties with a range of daily living tasks and be financially disadvantaged, they are more likely to live with their families than other communities and so may not be obviously socially isolated. Nevertheless, as the evidence presented in Chapter 9 illustrates, social isolation is a serious problem for older people in many refugee communities who have little or no contact outside the family, and are often alone for long periods during the day because of their families’ need to work.

Interestingly, eligibility for HACC services is not dependent on residency, so arrivals who come through the family reunification program and who have to wait two years to obtain residency, are able to apply for assessment. This is especially important for families struggling to support sponsored older family members in the period before they become eligible for full social support.

For refugee seniors who are found to have high level needs and who are provided with HACC services, the quality and appropriateness of care is important. Each community and family has specific cultural and religious norms regarding behaviour, food and domestic practices which need to be respected. If the service provider is unaware of these expectations, misunderstandings may result in discomfort and in some cases the termination of services. One example provided by a community worker described a Muslim family who, requiring overnight respite care for their disabled daughter, were sent a male carer. Their religious and cultural beliefs made it unacceptable for them to leave their daughter alone with an unknown male and put them off requesting respite care again. As with all communities, there are great variations between families and individuals, and care needs to be taken to adapt services to the individual needs of clients and their families.

4. Interview with Eastern Region MIC worker, 26/05/05
6. Conclusion

As the data in Appendix 2 reveals, there are certain communities with little or no support services for the elderly. Further research is needed to determine the kind of services that would be acceptable and relevant, and how these could best be made available to the widest range of clients. Although many of these communities have only small numbers of elderly at present, they are likely to increase as more seniors arrive under the family migration scheme, and as the younger members of the population age.

As with other CALD communities, refugee seniors are likely to face a range of cultural and linguistic barriers in accessing and using HACC services. In addition to these, refugee seniors from small communities may not have community organisations and senior citizens’ groups to provide social support, and risk becoming very socially isolated. Those from small communities also suffer from a lack of appropriate language services. Service providers need to be sensitive to the fact that refugee experiences can impact on the attitude families and older people have towards government services and having strangers in their home, whilst their experiences of claiming asylum or refugee status may affect their attitude towards assessment. Refugee seniors are more likely to suffer mental health problems than older people from other CALD and English speaking backgrounds, and this may affect their willingness to seek help and their attitude towards improving their lives.
Chapter 5  Listening to Refugee Communities: Common Circumstances and Concerns

The lived experiences of refugee seniors, their families and their care givers provide powerful insights into the impact of policy on daily life. It was beyond the scope of this report to gather this important information from refugee seniors themselves; however the voices of community workers and community based organizations, working closely with refugee seniors and their families were documented. This chapter provides an overview of the felt needs of refugee communities from the point of view of those who work closely with them in providing services and care.

The qualitative data gathered from interviews with community workers is analysed in an effort to draw out the key factors affecting the health and wellbeing of refugee seniors and their communities. The themes highlight the common concerns of community workers, but also provide opportunities for examining the differences between refugee communities and the different groups that comprise them.

1. The impact of the asylum process on wellbeing

The majority of refugees in Australia, and in particular older refugees, come through the offshore humanitarian program. Under this scheme, their applications for refugee status are assessed in their country of first asylum, either by the UNHCR or by Australian immigration officials. If they are granted a visa, refugees are entitled to a range of benefits and services that assist them with resettlement, including counselling and support for trauma. In contrast, those who seek asylum after having entered Australia, are subject to detention and intensive interviewing in order to process their asylum claims. According to evidence gathered in this research, the onshore asylum process can have a damaging impact on the mental health and wellbeing of asylum seekers.

Community workers assisting refugees who have claimed asylum in Australia, report high levels of re-traumatisation caused by having to recount experiences of persecution. According to community health workers, having their experiences questioned, and living in detention or with the threat of return, results in high incidences of depression, psychosis and paranoia among asylum seekers. A worker with a group of recently arrived asylum seekers from East Timor, reported high levels of attempted suicide and re-traumatisation. Other workers report a fear of government services and officials among refugees who claimed asylum having entered the country on tourist visas, and who had to undergo intensive questioning in order to process their claim. Reports of older Kurdish refugees who entered Australia in this way, describe them as finding the process bewildering and frightening.
2. Social isolation and the strains of resettlement

Perhaps the most consistent theme in the qualitative data gathered in this research is the issue of social isolation that affects refugee seniors following resettlement. A combination of factors including language barriers, access to transport, and a shortage of places to meet, all create circumstances in which older refugees risk becoming extremely isolated and consequently more vulnerable to the psychological disorders caused by the refugee experience.

Most community workers identified the lack of English language skills as a key contributing factor to the social isolation of refugee seniors in Australia. Because many older refugees do not immediately need to learn English for work or school, and because second language acquisition can be difficult in later life, many never learn more than a few basic words. Workers reported cases of older single women from the Horn of Africa who, despite having completed language courses, are still unable to communicate in English and struggle to navigate the Australian service system without family or community support. One such woman described by a community worker, cares for an adult daughter with a mental disability who requires assessments, medical and respite care. She finds dealing with health authorities extremely difficult and stressful. Access to services is limited for many older refugees by the need for translation, and speakers of minority languages may have to rely on younger family members to translate. This can affect the efficacy of communication, and workers reported cases in which sensitive information had been withheld during medical appointments, because elderly patients were ashamed of revealing symptoms to family members.

The data also suggested that in some communities, older refugees may have limited literacy in their own language, and would therefore be unable to make use of translated written information from their own community organizations or service providers. Several community workers described a preference for oral and visual information among the elderly, as well as for word of mouth communication.

Lacking basic language skills affects the willingness of many older refugees to venture outside the home. With a few exceptions, most community workers reported reluctance among older refugees to use public transport because they are unable to speak English and fear getting lost. As many refugee seniors are also unable to drive, the lack of transport for older refugees was regularly mentioned as a major contributing factor to their social isolation, with one worker describing older refugees as being ‘trapped in their homes’. With family members often busy during the week, many older people are unable to attend community meetings or senior citizens’ groups, and struggle to meet with friends and peers unless they live in close proximity. When asked for recommendations of services that would improve the wellbeing of refugee seniors, a significant proportion of the community workers interviewed recommended improved transport services for the elderly.
Requiring transport assumes there are meeting places where older refugees from each community can congregate. For some communities these places are religious centres such as mosques, temples or churches which sometimes run activities or provide services for the elderly. For some of the larger communities, there are established community centres with specific meetings for the elderly that allow them to congregate, share meals and engage in appropriate activities. However, many of the smaller and more recently arrived refugee communities, have no community centres or regular meeting places. African community workers from countries outside the Horn of Africa felt this was a particular problem for their communities which are mostly small and have only been in Australia a short time. These communities use the Migrant Resource Centres for assistance with resettlement, but do not have the resources to organise culturally specific activities.

Within communities where groups speak different languages or have different political or religious affiliations, funding for ethno-specific activities will often go to the majority, leaving minority groups with few, if any, services. Several community workers described the difficulties older people encounter in communities that are divided along factional or political lines, when ethno-specific activities are dominated by a group they do not mix with. Some smaller refugee communities also tend to be grouped together for the provision of services, for example the ‘Indo-Chinese’ or the ‘Horn of Africa’ communities. These groupings, based on geographical origin, disguise significant differences between people from the different countries, some of whom may even have fought on opposite sides of a war, as in the case of Ethiopia and Eritrea. Again the smaller communities within these groupings tend to be marginalised as services are provided for, and dominated by, the larger language and cultural groups. These subtleties may not be immediately visible to service providers seeking to meet the needs of older refugees, but were of grave concern to the community workers interviewed for this research. A lack of social contact with peers and friends has serious implications for refugee seniors, many of whom are trying to cope with trauma and with the bewildering experience of resettlement. It seems that older refugees who have time to reflect on their experiences of trauma and resettlement, highly value the opportunity to spend time and share memories with people from similar backgrounds.

In discussing opportunities for older refugees to meet with friends and peers, community workers expressed a range of opinions on how gender affected the resettlement process. In some communities it was felt that older women were most at risk of social isolation because they were less confident about leaving the home and were more reluctant to visit public places without members of their family. In some cases this was related to traditional expectations that women should remain in the private sphere, whilst in others it was to do with religious rules regarding mix-gendered gatherings. Community workers who identified older women as being particularly at risk, noted that older men in their communities tended to gather informally in cafes or shopping centres, and that this would be inappropriate for women. In contrast, workers from other communities identified older men as being at the highest risk of social isolation. This tended to be related to the greater change in status many refugee men undergo following resettlement, when dependence on younger relatives and lack of employment can result in feelings of having no role or value in the home or community. In some cases this loss of status was linked to depression.
and withdrawal from social activities. Several workers identified single older men as being at particularly high risk of social isolation. These were men who had either come to Australia alone, or who had divorced and moved away from their families following resettlement. It was noted that these men often struggled to care for themselves and risked becoming isolated from their families and communities. An example provided by one worker, described a man from the Oromo minority within the Ethiopian community who suffered paranoia, lived alone and had no contact with his community. He had no knowledge of how to prepare or cook food and became ill from a very limited diet. A few workers noted that single women faced similar risks, but it was generally felt that refugee women did not often undergo the same loss of status as men, and were better able to cope with their changed circumstances by keeping busy with domestic and family duties. Older women with families were also reported to be more involved in the care of grandchildren and therefore have more sense of purpose and usefulness.

Social isolation among refugee seniors is of great concern to community workers and reportedly to the elderly themselves. The factors that contribute to social isolation vary between and within communities, and in these different contexts, between men and women. The importance of social interaction for elderly refugees is viewed as being closely related to their need to deal with past experiences of trauma and current experiences of resettlement. Community workers clearly consider it vital to their health and wellbeing.

3. Dashed Dreams: Disappointing family reunions

For many refugees, the first priority following resettlement is the reunification of their family. Those who have been separated for long periods or who have left behind relatives in dangerous circumstances, will often use all their available resources to bring relatives to safety. Under these circumstances the expectations of family reunions are understandably high and refugees, who have been through trauma and displacement, may feel that by restoring family unity they can begin to restore some normality to their lives. In the first instance, these expectations are often met; as a worker from the Ethiopian community explained, the first few months after a refugee family is reunited are “like a honeymoon”.

Unfortunately the realities of resettlement and of being a refugee quickly overtake the joy and relief of family reunification. A recurring theme in the data gathered during this research was the issue of intergenerational conflict caused by different expectations of the resettlement process and by the changes in family dynamics that occur following migration. Both of these issues particularly affect older refugees, for whom the family tends to be the primary source of social interaction and support.

For older people joining their families following resettlement, the contrast between the dominant culture of the new country and that of the society from which they have come, can be challenging. This is especially so if younger family members have begun to adopt the dress, speech and other cultural markers of the new society. Community workers from many refugee groups mentioned the concern among older refugees that their children and grandchildren were losing touch with the culture of their country of origin, and that this caused them a great deal of sadness and anxiety. Other workers
described how older people had gradually adapted to their new environment, even on sensitive issues such as allowing their daughters to go on mixed-sex school trips. However, the common experience described by community workers was one of loss, and a sense among many older refugees that their families had rejected them and their values.

Intergenerational difficulties were starkly illustrated by two community workers who described situations in which younger family members had taken advantage of their older relatives’ lack of understanding of the Australian welfare and social services system. In one example, a worker with the Horn of Africa communities reported a commonly held view among older refugees that their children were being “snatched from them”. This sentiment was the result of several cases in which young people in the community, frustrated by living with their families and envious of the independence of young refugees who had arrived as unaccompanied minors, had told social workers they were being abused at home and had requested to be taken into welfare housing. In another case, this time in the East Timorese community, a worker described a case in which young people on whom families depended for translation and interaction with services, had told their parents that under Australian law they were not allowed to be disciplined. Both cases had caused considerable pain and anger for their parents, and compounded the sense of loss for older generations who saw the structures and values of their communities falling apart.

The theme of loss appeared again in the descriptions given by community workers of many older refugees’ sense of their low value and usefulness within the family. The role reversal that occurs when elders find themselves in an environment where younger members of their families are better equipped to understand and navigate their way through daily life, can be devastating for older refugees, especially when they have come from societies where elders are traditionally respected and looked to for advice. Community workers from a range of communities reported older refugees feeling “useless” and “of no value” to the family, and described the depression and isolation this can cause. The sense of uselessness experienced by older refugees is exacerbated by their almost complete dependency on their family for financial and practical support. As discussed above, transport and language are two major contributing factors to the social isolation of older refugees and two areas in which they are especially dependent on their families.

One area in which some community workers reported older people overcame their feelings of “uselessness” was in the care of young grandchildren. With parents often working long hours and spending a lot of time away from the home, grandparents in many communities are reportedly relied on for childcare. In several cases this was described as providing them with a role within the family, and an important opportunity to pass on cultural practices and values. In other cases however, workers reported grandparents feeling used and worn out by the demands of child care and the physical strain this put on them.
4. Living with the family but being alone

In the overwhelming majority of communities consulted in this research, older refugees were reported to live with one or more members of their family. In most communities, this was considered the appropriate way in which older people should be cared for, and there was a widespread mistrust or dislike of residential aged care services. Where older people lived alone, this was generally considered a sad necessity caused either by family break down or by the complexity of the resettlement program which sometimes causes families to be split up. Whilst the family was considered the best and most suitable environment for ensuring the wellbeing of older people, many community workers reported cases of older people suffering loneliness and isolation within the family home. Three types of isolation are identifiable in the descriptions provided by community workers: practical, social and emotional isolation.

Practical isolation of older refugees is reported to occur because the pressures and demands of resettlement often require family members to spend long periods away from home, either at work, school or attending to general resettlement requirements such as housing and language learning. Consequently, older relatives can be left alone in the home for long periods and may only see their family members once or twice a week. Several community workers reported this as being an issue for the elderly in their communities and one that was only overcome where extended families lived close together and had enough resources to enable one or more adults to remain at home and care for the elderly.

Social isolation within the family occurs as a result of practical isolation, but also, according to interviewees, because older individuals, who are not engaged in employment or education, may feel they have a decreasing amount in common with their children and grandchildren. Community workers reported how, whilst their families adapt and participate in a new culture, older relatives may cling to the values and traditions of their old culture, and consequently feel they are losing touch with their relatives or being ignored and undermined by them. As one Cambodian worker described it, older people can feel “discarded” by their families who provide them with a minimum of practical support but nothing more. Some community workers also reported that grandchildren who have been born and educated in Australia sometimes have difficulty communicating with their grandparents if they do not speak English.

Finally, emotional isolation from family members happens as a result of both practical and social isolation, and also because older relatives fear becoming a burden on their children. Community workers reported a prevalent concern among older refugees that having lost their roles as cultural advisors and conduits of tradition, they were “useless” to their families and did not want to burden them further with their emotional needs. This concern was mentioned more frequently in cases where older relatives were suffering mental and physical health problems, and where they felt seeking emotional support would only be more of a burden on their families. In a few cases, family members were reported not to have understood the correlation between past trauma and mental health, or to have attributed the effects of trauma to homesickness. Such misunderstandings not only prevent families from seeking the right treatment for their elderly relatives, but may also make it harder to discuss the causes of the trauma which may be affecting the elderly person.
Deliberate practical, social and emotional isolation can amount to elder abuse or neglect and this was reported in one or two cases. In one example, an elderly refugee woman was living with her two daughters and grandchildren. She suffered chronic arthritis and could barely walk, but was given no assistance around the house and was left alone during the day with her young grandson. Her daughters kept all of her pension, allowing her just $30 reward a week for childcare. She was socially and emotionally isolated and eventually sought help at a community welfare office where she begged to be taken to a refuge. The family reported the association to the police for taking her away, but no charges were laid. She spent two months in the refuge before being offered council housing. She was diagnosed with stress and depression related disorders and began receiving treatment, but eventually returned to her family after falling very ill. She now wishes to return to her country of origin. As this example demonstrates, living with family is no guarantee of social interaction, and may actually hamper attempts at independence and recovery from trauma.

5. Reluctance to use HACC Services

A recurring feature in the data collected from community workers regarding the use of HACC services by refugee seniors, was the almost complete lack of knowledge of aged care services among refugee communities. Even among community workers themselves, knowledge of these services was limited. The principle reason given for this was a lack of information in a form that can be assimilated. Many community workers pointed out that older refugees rarely speak or read English and may also be illiterate in their own language. The usual channels of communicating information about services, such as leaflets, flyers or advertisements in local newspapers, would therefore not work to reach this group. Several community workers also pointed out that information regarding services for the elderly needs to be targeted at their families, as they are more likely to be able to speak or read English, and tend to be more familiar with government services such as Centrelink or Medicare.

Of the community workers and their clients who had some knowledge of HACC services, it was commonly reported that refugee seniors did not use them because they thought they were ‘not appropriate’. This belief was based on a range of practical, cultural and personal factors, some of which are specific to the refugee community.

The most common practical reason given for why refugee seniors did not use HACC services was that of language. Several community workers reported that elderly refugees would not want to be cared for by someone with whom they were unable to communicate. The assumption that most, if not all, HACC workers would be English speaking, was widespread and one of the main causes for a lack of interest in using the services.
Allied to this practical issue are the more complex concerns over the ‘cultural appropriateness’ of using HACC services. In most cases using HACC services was considered ‘culturally inappropriate’ because caring for the elderly is deemed to be a family duty, and using outside help is understood as failure to fulfill this basic role. In general, this belief appeared to be stronger among refugee communities from Southeast Asian and Middle Eastern countries than among communities from Europe and Africa, although attitudes to residential care were equally negative amongst the latter. Despite the pressures on families following resettlement and the obvious need for assistance in some circumstances, issues of privacy and shame are powerful cultural influences on attitudes towards using HACC services for some communities. An additional factor among some Buddhist refugees, was a reported reluctance to use any aged care or medical services because being unwell is an accepted part of ageing, and attempts to improve or prolong life are viewed as pointless. For those who would consider using certain HACC services, other cultural concerns relating to the observance by carers of religious norms were prevalent; for example that Muslim women should not be cared for by men, or that food should be halal. In many cases, community workers suggested that HACC services would only really be welcomed if carers were from the same background as their clients. Many of these concerns around ‘culturally appropriate care’, and the cultural appropriateness of accepting care, are common to all migrant communities but certain concerns relating to HACC services gathered in this research are specific to refugees. One of these concerns, raised by several community workers, is the issue of trust. Refugees from all backgrounds are likely to have experienced a betrayal of trust at some point in their journey to resettlement. At the most extreme, this may have been an experience of genocide such as occurred in Rwanda and the former Yugoslavia, in which friends and neighbours turned against each other during an outbreak of inter-ethnic violence. Similarly damaging instances include those in which minorities or individuals are tortured, kept under surveillance or spied on by their governments. At the less severe, but nevertheless damaging end of the scale, is the experience of broken promises of help given to refugees on their journey to asylum, and the interrogation and questioning they undergo in the process of their refugee or asylum application. Asylum seekers subjected to detention on arrival in Australia might be especially wary of Australian government bodies, even after gaining refugee status. The impact of any one or more of these experiences can potentially affect refugees’ willingness to use home care services. In some refugee communities, workers explained that services of any kind would only be used if they had been tried and recommended by a prominent and trusted member of the community or by someone known personally to the individual. In communities where literacy is low, older people in particular, were described as more likely to accept and believe information passed on by word of mouth. In other communities, and especially those such as the Iraqi Kurds and Assyrians, who have suffered government surveillance, persecution or interrogation, community workers reported a reluctance, and in some cases fear, of revealing personal information such as that gathered during HACC assessments. These groups are also often very reluctant to allow strangers into their home, in particular if they speak the clients’ language and could be suspected of spying. Among refugee communities such as the Burmese, where the state authority they fled is still in power, there is a real fear of spies who are sometimes known to undertake surveillance of dissidents in other countries.
In these communities, workers reported that carers from the same background would not be acceptable.

The research revealed that on top of the practical and cultural reasons for not using HACC services, which are common to many migrant communities, there are additional and specific reasons why some refugee communities are likely to avoid them. As these reasons differ for each community depending on their refugee experiences, sensitive and targeted research and education would be required to overcome these fears and concerns. In a few cases reported by community workers, this had clearly been achieved on an individual basis, and examples were given of elderly refugees who used and trusted HACC carers. In one instance, an elderly Eritrean woman whose daughter was struggling to care for her and her own sick husband, was provided with a HACC worker to assist with homecare. Although she only had limited English, she got on well with the worker and referred to her as her ‘second daughter’.

6. Daughters who Care

In almost all the communities consulted, care of the elderly was generally assumed to be the duty of female relatives. Even in communities where parents traditionally live with their sons who provide them with financial support, day-to-day caring in the form of cleaning, cooking, dressing and washing are almost always performed by women. Resettlement changes many of the dynamics in refugee families, including the relationships wives and daughters have with their parents, their parents-in-law, and their children. Many of the discussions with community workers around the needs and wellbeing of refugee seniors included some reference to the roles of daughters and daughters-in-law and the pressures on them in a resettlement context.

The most common observation made by community workers with regard to daughters who care, was the financial necessity for many refugee women to work outside the home. Because their husbands are often only able to find low paid work, many refugee women who have never worked before, are obliged to take jobs to supplement their family’s income. However, expectations of their duties at home do not often change, and they are still responsible for the care of children and elderly relatives. This pressure places great strain on many women and can lead to high levels of stress and tension within families.

For some refugee women, the opportunity to work outside the home is a welcome one, and a few community workers, for example those in the Iraqi community, reported that older women are often envious of the opportunities and freedoms enjoyed by their daughters in Australia. The new found freedom of some refugee women, together with an awareness of their rights to equality and protection, can however lead to conflict with male relatives and resentment of their communities’ more conservative expectations of them. Several community workers from African communities reported the sentiment among refugee men that Australia is ‘a woman’s country’ where the traditional ways of dealing with family conflicts are undermined by the divorce laws, social services and institutions such as women’s refuges.
A significant proportion of refugees in Australia are offered protection under the ‘Women at Risk’ program. These women, many of them from the Horn of Africa, have often lost their husbands and male relatives and arrive with their children. Some of them are able to bring their parents to Australia, either through the same program if their mothers are widowed, or through the family reunification scheme. These women have an enormous burden of care, both in terms of providing financially for their families, and in caring for them. Most also have low levels of education, speak very little English and are unfamiliar with the Australian health and welfare system. Community workers described how these women often receive little community support and create their own support systems such as savings groups and informal social networks. These women were also identified as a group who would be likely to welcome the assistance of HACC services in meeting the care needs of their elderly relatives, but who lack easy access to information about such services.

Whilst single women are probably the most vulnerable refugee group in terms of their burden of care, many refugee women find themselves caught in the double bind of providing care for their parents or parents-in-law, and for their children. This middle generation are regarded by many community workers as the key group to be targeted to increase the take up of aged care services. However, the potential for these women to be socially isolated by the requirements of care, often makes them difficult to reach, and innovative ways of getting information to them are being trialed by some community organisations and MRCs. One model being used by the Victorian Arabic Social Services involves encouraging GPs to provide information about HACC services and the process of applying for them, to refugee families who appear to be struggling with the care of their elderly relatives. Another method being employed by an MRC in eastern Melbourne is a series of ‘expos’ held in shopping centres which refugee families are known to visit (see Chapter 6 for more details).

Although community workers reported that many refugee daughters and daughters-in-law are struggling to meet the demands of care and resettlement, they also explained that most of these women do not expect assistance and only look for services when they reach crisis points. In many communities, using external care services would be regarded as a failure by a daughter or daughter-in-law to fulfill her duty, and using respite care would be viewed as lazy and self-centred. In order to overcome these barriers, one MRC worker described how her team had ‘marketed’ care and respite services to refugee communities by emphasising the benefits to the caree, rather than the carer. They found carers and their families were more open to using home care services if they were advertised as supplementing rather than replacing family care, and if respite care was described as offering opportunities for the caree to benefit from different experiences and a change of scene, rather than as an opportunity for the carer to have time off. Nevertheless, community workers also described instances when refugee families had tried using HACC services but where a lack of cultural sensitivity had confirmed their expectation that such services were not appropriate for them.
Refugee women who care for elderly relatives are clearly a vulnerable group, who juggle the expectations of their communities and their own sense of filial duty, with the pressures of resettlement and changing family dynamics. The strong cultural barriers to using external services and the difficulties of reaching these women with information about services, both militate against the take up of HACC among refugee communities. One suggestion for overcoming these barriers that was raised by several workers from African and Southeast Asian communities, was that younger members of these communities should be offered training to become HACC carers. This was regarded as a way of providing employment, meeting the needs of refugee families and making HACC services more acceptable. In contrast, workers from some Arabic speaking communities explained that because caring is regarded as a low status profession in their cultures, this would not be an appropriate way of overcoming the opposition to using HACC services. More research is required to discover which communities would welcome such a scheme, and whether this would be a feasible strategy for service providers.

7. Coping with loss and guilt

Past experiences of loss and trauma affect all refugees, and have the potential to cause feelings of great sadness, depression and mental illness. Many young and middle aged refugees address this by keeping themselves busy and looking towards the future rather than back at their past. Financial pressures often require them to work hard both in and out of the home, and the challenges of resettlement and language learning provide distractions from painful memories. Older refugees, however, may not have such opportunities to keep busy and focus on the present, and, as discussed above, may spend long periods alone. Several community workers reported that having the time to contemplate past experiences was a significant contributing factor to the poor mental health of many older refugees. For those without support networks of friends and peers, and those who live with their families but are socially and emotionally isolated, coping with traumatic memories alone can be extremely difficult, especially in an unfamiliar environment. Trauma experiences can be further complicated by age onset diseases such as Alzheimer's and dementia, cases of which were reported in some Arabic speaking communities.

Many refugees will have lost family members in the course of their refugee experiences and journeys. Some may have witnessed the death of parents, siblings or children, or may have had to leave them behind when they sought asylum. Feelings of loss among refugees who have been through these experiences were widely reported by community workers, and are especially difficult for older refugees who are trying to come to terms with the loss of their own independence and status. Guilt among those who have survived atrocities when other members of their families have not, was also reported and was often described as being a cause of depression. Similarly, shame at having been tortured, abused, and in the case of many women, raped, was also reported by workers as being a contributing factor to the poor mental health of many older refugees.
Feelings associated with past trauma, are often experienced by older refugees in the context of stress and anxiety caused by issues in the present. For more recently arrived communities, such as those from Sudan, anxiety around the wellbeing of relatives and friends still in danger was reported by community workers as being of particular concern. The issues of isolation discussed above, and the loss of social support networks for dealing with grief, loss and guilt, make coping with the impact of the refugee experience especially difficult for people as they age.

8. Contemplating the End of Life

The process of contemplation and life review that many elderly people go through as they approach the end of their lives is usually an opportunity to achieve a sense of completion and peace. For refugees this is clearly problematic because of the experiences of trauma upon which they will reflect. For some older refugees the process is extremely painful and can lead to a sense of the pointlessness of their own ruined lives. This sense that life no longer has any value was reported among several widows from Bosnia who had witnessed the massacre of their male relatives. A worker with this community described how one elderly widow “saw it as her lot that her life had been ruined” and saw no point in making any effort to improve it. This disregard for their own wellbeing was also reported among Somali widows, one of whom was reported to visit her doctor for the opportunity for social interaction, but who took no real interest in her health and wellbeing.

The sense that one’s life has no value is often caused by a combination of past trauma and present loneliness and anxiety. For some older people, experiencing the effects of trauma in a strange environment can lead them to want to return to their countries of origin, even if their safety is compromised. Regret at having moved and the desire to return was reported among refugees from several backgrounds, but especially among individuals who had bad experiences of family reunion and resettlement. In contrast, older refugees from communities such as the East Timorese who had had everything familiar destroyed, regarded arriving in Australia as the start of a new life and workers reported little interest in wanting to return. In either case, the stark realisation that one’s life has turned out very differently from how it was imagined, and the need to deal with painful memories, is unique to the experience of older refugees, and requires particular sensitivity and care in attempting to meet their needs.
Chapter 6  Innovation in Addressing the Needs of Refugee Seniors

Research and consultation with refugee workers in Victoria and New South Wales has revealed that the issues affecting older refugees from small and emerging communities in Australia are generally not well researched or understood and very little work has been done to address their specific health and wellbeing needs. In most cases, refugee seniors are included under general strategies aimed at CALD communities and little account is taken of factors specific to the refugee experience.

The following chapter provides examples of how health and other service providers have met some of the needs of refugee seniors in Victoria, in Australia and around the world. They are all examples of projects aimed both specifically at refugees and more generally at migrants, and present some options for how the needs of the communities highlighted in Chapter 9, might be met.

1. Improving Social Integration and Mental Health

A key finding from this research was the importance of social integration for maintaining the mental wellbeing of refugee seniors. Being able to leave the home and socialize with people who share their language, culture and experiences plays a huge role in enabling older refugees to re-establish and preserve a sense of identity and belonging, and helps the process of overcoming trauma and the disorientation of resettlement. Bringing groups of older refugees together with a specific purpose can also help overcome their feelings of uselessness and loss of status, and encourages recognition and respect from the community. Any gathering of older refugees is also an opportunity to inform them of services that may be relevant and which they may not otherwise have encountered.

The following projects focus on providing opportunities for older refugees to gain skills they can use for commercial benefit. In doing so they offer the chance to interact with peers, gain independence and re-establish their status as elders who have valuable knowledge to pass on to the next generation.

a. AMES (Adult Multicultural Education Services) United Wood Cooperative: Carpentry Unit Trust for older African men in Brunswick, Melbourne

Background

With the assistance of AMES, a group of 12 older Ethiopian and Eritrean men from varied professional backgrounds, who had been in Australia for between 2 and 6 years, set up a carpentry co-operative in North Melbourne in 2002. All had fought in the Ethiopian-Eritrean war and had spent some time in refugee camps and/or prison. They were all members of the Hararian Community Association group for senior citizens in North Melbourne where they met every Sunday to socialise and play cards. They were not politically active within their own communities and had little interaction with mainstream society.

6. Information collected during a visit to the project and in an interview with the AMES co-ordinator, 04/05/05
Older men were chosen for the project because they were one of the most marginalised groups within the community. They had very few English skills, were unable to find work and were socially isolated. Many were from the ruling classes in Ethiopia and Eritrea and were suffering a loss of status and purpose following migration to Australia. Older men were also more likely to form a stable group, were less likely to have dependent children, and were less inclined to move into other employment or education.

The men were trained in carpentry, and offered parallel English lessons to meet their practical needs for reading instructions, answering the telephone, talking to customers and so on. They have also learnt management skills, computer skills, financial skills and driving. All members of the group own ‘units’ in the company and manage it with support from AMES. They are jointly responsible for the financial management of the company and have just brought in an hourly rate of pay for themselves. They have also recently organised themselves into divisions with specific roles in the production of goods. They employ trainers to teach them specific skills and have ‘transitional members’ (currently two Sudanese men) who are not full owners but receive payment.

The co-operative makes planters and cheese boards, and have just begun making pieces on commission for a kitchen furniture company. The sell their goods at markets and trade fairs, as well as directly from the workshop.

The group will soon begin training younger men from Horn of Africa communities who will complete 60 hours of training before going into employment in the kitchen furniture company for whom the group already do some contract work. The group will be paid an hourly rate to carry out the training and will thus bring in more income for the company. The scheme is also intended to draw on the traditional practices of younger men learning from their elders, which will help to re-establish the older men’s sense of status and usefulness in the community.

Outcomes

MENTAL HEALTH Despite coming from opposite sides of the conflict in Africa, the group members give each other a lot of emotional support, as they can share and understand each others’ experiences. The immediate impact on the men’s mental health was clear. They took pride in their ownership of the business, and within the first few months, their wives came to thank the project for giving the men a sense of purpose and for getting them out of the house.

SOCIAL STATUS The project was initially situated near where most of the Ethiopian and Eritrean community lived in North Melbourne, and the fact that community members saw the men working gave them a lot of prestige. Boys and young men in the community who used to cause trouble in the area, were quickly moved on by the older men. They were also useful to the community members who would ask them to do small carpentry jobs in their homes.

The group take pride in the fact that they are now able to offer training to younger members of their communities, and that an external body is willing to pay them for performing this work. They have begun monitoring their own behaviour (time keeping, responsibility to others etc.) because they are keen to be good role models for their trainees.
LANGUAGE SKILLS  Many of the men have progressed much faster in their English learning now that it is work related, but their general level of English has also improved and they are more interested in learning it for other purposes. Because of this they now have more interaction with and are more interested in mainstream society and are able to communicate with people wishing to buy their products.

Difficulties

The group have had difficulties with trainers who have not been able to cope with some of their mental health needs. One incident resulted in them being taken to an employment tribunal where they were charged with unfair dismissal. Although this was hard for the group, they learnt a lot about workplace practices and how to interact with staff.

Doing manual work sometimes reminds the men of their status as refugees and the fact that had they been able to stay in their own countries they would have had comfortable retirements and community respect. However, pride in what they have achieved with the group usually outweighs this disappointment.

Health Issues

Most members of the group suffer from diet-controlled diabetes and one member of the group suffers from Parkinson’s disease. This latter individual is unable to use some of the machinery and although it took him some time to come to terms with this, other members of the group now look out for him and ensure he works safely.

b. “The Sorghum Sisters”: AMES Older Women’s Catering Co-operative, Carlton Primary School, Melbourne

Based on the model of the older men’s carpentry company, a group of 4 older Eritrean, Ethiopian and Somali refugee women have recently been selected to own and run a catering co-operative based in Carlton Primary School. To qualify for the scheme they needed to be living in the Carlton high-rise development, be unemployed and have children or grandchildren at Carlton Primary School. The women were chosen because they are a disadvantaged group suffering high levels of unemployment and social isolation. They all have low levels of literacy in their own languages and low levels of English.

The group will be trained in catering and gain a TAFE certificate in food preparation and hygiene. They will then train other women from their communities with the intention that they will go on to work in the catering industry. Whilst they are completing their training, the women will make money by selling food to the community and the school, and catering for functions. They will also be paid to spend 2 hours a fortnight discussing school issues with teachers in order to increase parental participation in a school where 80% of the students are from the Horn of Africa.

The project aims to improve the women’s social networks and the integration between different ethnic groups within the Horn of Africa community in Carlton. As with the men’s project, it is hoped that their increased social interaction and the respect they will gain from owning and running their own

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7. Information collected during a visit to the project and an interview with the AMES co-ordinator, 04/05/05
business will improve their mental health. The opportunity to improve their English and their interaction with the school is also intended to boost their confidence in interacting with English speakers in service provision settings.

2. Improving Access to Information about Health Services

One of the biggest barriers to accessing health services for refugees, and refugee seniors in particular, is a lack of information about the welfare system and how it works. Many refugee seniors in Australia have low levels of English and those from countries with less developed health care systems may find the Australian system very complicated and difficult to navigate. By providing accessible information about available services, health care providers are taking the first step in empowering refugee seniors to make choices about their own wellbeing.

The following examples offer innovative ways of reaching refugee seniors with the information they need in an accessible format.

a. Eastern MIC: HACC information ‘expos’

The Eastern Migrant Information Centre in Melbourne has worked for many years on improving access to HACC services for isolated migrant communities. One method they have used are ‘expos’ held in shopping centres known to be frequented by the target community. At these events, information is displayed and handed out, and people speaking the appropriate language(s) are on hand to explain HACC services to anyone who shows an interest. These events have led to increased enquiries about HACC home care services among the target communities, but have generated little interest in respite care.

Benefits and Limitations

Providing the information in a public place such as a shopping centre, has both positive and negative impacts. Firstly it is effective in taking information to people in a familiar environment where they are less likely to feel intimidated by the concept of using government services, and will reach people who never visit government offices, MRCs or community organisations. Conversely, it may only reach those people who are able to leave their homes, unless the information is also targeted at the carers of the elderly.

Providing the information in a relevant language and having people who speak that language on hand is very important in ensuring that the information is communicated and understood. It will also reassure potential users that they can communicate with service providers, and use government services even if they have limited English.

b. Switzerland: Health Adviser

This booklet, published by the Federal Office for Health Issues, the Swiss Red Cross and Caritas, contains information on what to do in case of a medical emergency, who to turn to, who will cover the cost of treatment, how to lower insurance premiums and why additional fees may have to be paid. It also provides answers to 20 of the most commonly asked questions concerning

8. Information collected in an interview with an MRC worker, 26/05/05
health and has a glossary of important medical terminology. Importantly it offers listings of social services and the services they provide. It is published in 19 languages including Albanian, Arabic, Bosnian, Farsi, Croatian, Serbian, Somali, Tamil, Thai, Turkish, Urdu, and Vietnamese (ECRE, 2002).

3. Addressing Barriers to the Use of Services

Cultural reasons are often cited in explanations for why refugee seniors are under represented in government service use. It is certainly the case that in many of the societies from which refugees come to Australia, using outside help to care for one’s elderly is considered a sign of failure on the part of the family and is an important barrier in preventing the take up services. The following examples provide models for how these barriers can be overcome.

a. The Netherlands: Information Series

This model was developed in the Netherlands and has since been adopted in Germany and Belgium. The principle is to address two key emotional barriers to the use of aged care services by older refugees and migrants through group meetings, videos and discussions. The first barrier addressed is ‘the illusion of return’. The program helps older people come to accept that due to practical, financial and medical reasons, they will probably never return home and need to make plans for their old age and death in their country of resettlement. The second barrier is that of ‘the illusion of the ever-supporting family’ which is addressed through discussion of the pressures on families in post-migration settings and introduces options for how older people can be cared for without becoming a burden on their families.

The program was very successful in raising awareness of services and increasing interest in them, but was criticised for being too expensive and labour intensive (ECRE, 2002).

b. Ireland: Tailored language learning

The Refugee Language Support Unit in collaboration with the Department for Education and Science, and the Centre for Language and Communication provide free English language classes for people unable to attend formal classes due to child care needs, distance to travel to classes or health reasons. They enable women with children and older people to learn in a more informal environment in a way that is appropriate to their needs (ECRE, 2002).

4. Conclusion

In sum, there are a range of innovative projects being carried out in Victoria, across the States and Territories and internationally. However, many of the projects are not well documented and are not available in the published literature. Further research is required to identify innovative approaches providing culturally sensitive, appropriate and effective support to refugee seniors and their families. A specific challenge in addressing innovation in this area is that one size will never fit all, and that services that are flexible and locally based may well prove to be the most effective strategies for providing support to refugee communities as they age.
Chapter 7 Summary and Conclusions

The findings from this research and from the limited available literature, all point to the extreme vulnerability of refugee seniors. As older people, they face the various challenges of ageing, but do so whilst also coping with the numerous difficulties of resettlement. As a minority within a minority, they are doubly disadvantaged in terms of specialist services and at high risk of having their needs overlooked.

Whilst refugee seniors from different backgrounds are affected by many of the same general disadvantages, this research also highlighted the variety of experiences, both positive and negative, that are part of their lives. The findings revealed that within communities from the same country of origin, differences in language, religion, politics and class affect the cohesion of the community as well as their engagement with Australian society. Generalisations about refugee seniors are just that, as are generalisations about the individuals within each community grouping. Nevertheless, some common themes did emerge and the following three key areas highlight factors that need to be considered in any attempts at improving the wellbeing of refugee seniors.

1. The difficulty of identifying refugee seniors

As discussed in Chapter 3, the data available for identifying and locating refugee seniors in Victoria is limited and inaccurate. DIMIA are known to have undercounted some of their settlement data in the skilled migration, family reunion and humanitarian programs, and the census data is deliberately adjusted to maintain privacy in small communities. In both data sets, small communities are grouped together, either by language or country of birth, making identification of some groups impossible. Other limitations include the lack of complete data available on settlement patterns and the invisibility of some refugee groups such as those who have come via New Zealand.

Whilst efforts have been made to account for these difficulties in this research, the lack of readily available and easily accessible accurate information has obvious implications for service providers wishing to identify and target refugee seniors. The low level or lack of infrastructure and resources in many refugee communities also makes it difficult for them to make their needs known and attract the attention and resources of service providers. Whilst refugees are in general well catered for by specialist resettlement services in the first few years after their arrival, they are noticeably under-represented as users of more long term services such as HACC, in part due to the difficulties discussed earlier in this report.
2. **Key issues affecting the health and wellbeing of refugee seniors**

Consultations with community workers provided data on the key issues affecting the health and wellbeing of refugee seniors in Victoria. Variations obviously occur between and within different groups, and these are discussed in detail in Chapters 9 and 5. The following summary recap some of the most common factors that impinge on older refugees’ health and wellbeing.

a. **Social Isolation**

Social isolation is a crucial issue affecting the wellbeing of almost all refugee seniors. The factors causing it vary between and within communities depending on individuals’ refugee experiences and the level of resources, organisation and cohesiveness within the resettled community. Details of the pertinent factors for each community are given in Chapter 9, but the following list summarises the key contributing factors to social isolation among refugee seniors that arose from this research:

- low levels of English and literacy,
- fear of using public transport, an inability to drive, and a lack of targeted transport services,
- lack of suitable places for older refugees to meet,
- factionalism within communities,
- unfocused ethno-specific funding (e.g. ‘Indo-Chinese’) which leaves minority groups unresourced,
- fear of officials and government services.

b. **Mental Health Vulnerability**

Past experiences of trauma and the challenges of resettlement, combined with the onset of age-related illnesses such as Alzheimer’s and dementia, make refugee seniors a particularly vulnerable group in terms of mental health disorders. Data from the research revealed a range of issues that affected the mental wellbeing of refugee seniors in the resettlement context and whilst these necessarily vary between individuals and communities, the following are common factors that contribute to mental health vulnerability among this group:

- re-traumatisation caused by the asylum process,
- having time for contemplation of past trauma experiences,
- social isolation,
- changed status of ‘elders’ in resettlement countries,
- role reversal within families, and dependence on younger relatives,
- loss of status within the family and community,
- fear of being a burden on the family,
- intergenerational conflict when younger family members adopt the lifestyle and attitudes of the resettlement country,
- loss of support networks of friends and peers,
- changing gender roles.

Understanding and attitudes towards psychological disorders varied between communities and individuals, but a general tendency to dismiss mental illness as a symptom of old age, homesickness or a physical illness was apparent.
c. The Family Care Trap

In every refugee community consulted in this research, a preference for providing care for the elderly within the family was expressed. This belief in the duty of family to care was variously described as a cultural or religious duty and the inability to fulfill it was generally regarded as shameful. However, case studies and evidence from community workers suggest that the strength of this belief in the duty and propriety of family care is often undermined by the reality of resettlement hardships. The family care trap occurs when the families will not countenance outside assistance, even though they are struggling to cope with the demands of resettlement and the care needs of their elderly relatives. Older refugees caught in this trap, tend to be socially and emotionally isolated both within the family and the wider community as the families on whom they depend are too busy to spend much time with them. The family care trap puts at risk the health and wellbeing of older refugees as well as the unity of the family, and is a hugely important issue to tackle if refugee seniors are to be sufficiently cared for.

3. Service Use

Information gathered from community workers and from data on the use of HACC services by refugee seniors, revealed apparently low service use. Again, reasons for this low service use varies between groups, depending on their background, level of relative need for services and the level of appropriate information available, but the following common themes emerged:

a. Lack of knowledge of services

Unfamiliarity with the Australian service system is common among many migrant groups but appeared as a recurrent theme among refugee communities. Smaller communities in particular complained of a lack of accessible information regarding services and little effort on the part of service providers to reach them. Language and literacy were both important factors, although even several English speaking community workers knew little about aged care services or where to go to find out about them.

b. Cultural Barriers

In several communities, aged care services, including HACC, were described as culturally inappropriate because they clashed with the expectation of family care. In other communities, research revealed that families would be interested in using HACC services, if they knew about them, and if the care provided was appropriate in terms of the background and gender of the carer. Residential services were almost universally viewed as culturally inappropriate, although workers from some communities foresaw that ethno-specific residential services might become acceptable as the number of elderly in their community increased. Meals services were without exception unpopular as the food was assumed to be unacceptable to non-Australians.
c. Trauma related fear

Refugees from several communities who had suffered persecution at the hands of government authorities were found to be wary of using state services and afraid of allowing strangers into their home. The fear of spies was reported among seniors from communities that had experienced surveillance, and created a reluctance to use interpreters or have carers from within the community.

d. Lack of ethno-specific services

Unlike many larger migrant groups, very few refugee communities receive support for ethno-specific services to provide opportunities for social interaction among seniors. Where funding is available it tends to go to groups under regional umbrellas which, as mentioned above, risk marginalising minorities. The lack of resources in many refugee communities also limits opportunities for advocacy on behalf of seniors and perpetuates the low visibility of these groups among service providers.

4. Conclusion

Overall, refugee seniors who are members of small ethnic groups more often than not remain invisible because of their low numbers, but may have high needs for care and support. In fact, the small numbers of aged refugees within the more recently arrived communities could be argued to constitute a risk to their own wellbeing and to that of their families. ‘Small in number, high in need’ defines the challenges of providing innovative and effective programmes, policies and strategies to ensure that this segment of Victorian seniors is able to access services relative to their needs.
1. Issues for further Consideration

This study has examined the issues which affect the health and wellbeing of refugee seniors and their access to community based services which could improve their quality of life. Drawing on the findings of this study, and the consultations with refugee community workers, a number of issues have been identified which warrant further consideration.

a. Definitions of ‘Aged’ and ‘Seniors’

The HACC program provides services to people of all ages who have been assessed as needing assistance due to moderate, severe or profound disability. However, program data indicates that 67% of all HACC clients are aged 70 years and over. Many HACC agencies take age into consideration when determining priority of access to HACC services. Due to their experiences of hardship, displacement and trauma, refugees may require services at a younger age than other populations. Different cultural traditions also categorise the status of the “elderly” based on factors such as mobility or life stage, rather than chronological age. Consideration needs to be given to developing a range of criteria for identifying priority for aged care services within refugee communities that takes into account a more flexible understanding of the definition of ‘aged’. Such an approach would assist in facilitating greater access and use of appropriate services by refugee seniors and their families.
b. Awareness, Information and Communication

Information regarding services for seniors is often unavailable in appropriate formats, community languages or through accessible media. Literacy is also low in some refugee communities, particularly among the elderly who may have had limited access to schooling in their home countries. Consideration should be given to identifying a range of innovative and effective communication strategies that include, but are not limited to, the translation of key information resources into the many community languages spoken by newly emerging refugee communities, and the use of visual and verbal formats. Consideration should also be given to promoting information regarding aged care services in a range of accessible and familiar locations such as Centrelink offices and MRCs, which refugee seniors and their families already visit on a regular basis.

Older refugees are particularly vulnerable to social isolation and to other social factors that act as barriers to accessing information about social services. Their families also face many challenges over the settlement period and may not be proactive in seeking out services that could assist them with the care of their elderly. A range of initiatives should be considered to build partnerships between refugee resettlement organizations and aged care services in order to develop more effective ways of raising the awareness among new arrivals and newly emerging communities of aged care services. These initiatives would also build capacity in the refugee service sector to help meet the needs of refugee seniors and their families.

Another range of strategies and initiatives that could be explored to assist in building social connections and overcoming social isolation, would be the development of models for providing appropriate English language tuition for older refugees, in smaller classes and using older tutors. Not only would such initiatives assist in improving older refugees’ ability to communicate their needs, but they could also increase awareness of and access to resources for further community development.

c. Caring for our own on our own: Initiatives to help share the burden

In common with many communities, families may be reluctant to access aged care services because of values and expectations that the family should be the primary provider of care for the elderly. In addition, refugee families may have lived in countries prior to their arrival, where there were minimal or no social services available, let alone social support for the elderly. One means of overcoming this reluctance to use aged care services, suggested by an MRC worker interviewed in this study, was to market aged care services as complementing and supporting families to care for their elders rather than as replacing family care. Further investigation could be undertaken into how to better facilitate the uptake of respite care, with a focus on the benefits for the caree, rather than for the carer. Such programmes might be especially valuable in reducing the social isolation of the elderly by providing opportunities for social interactions that compliment the family setting.
Some refugee communities will have more specific reasons for being unwilling to use aged care services, related to previous experiences which have left them afraid of interacting with government or official agencies. Further research could be undertaken into how to build capacity in the aged care sector to become aware of the impact of torture, trauma and forced displacement on the elderly and their families and how to respond more effectively to their needs.

d. The low visibility of refugee communities

The low visibility of refugee seniors is often related to the small population size of their communities and the small numbers of elderly within these communities. Improved accuracy and availability of data on where refugee seniors are living would greatly assist in identifying these vulnerable groups. Small and newly arrived refugee communities also face many challenges but have little capacity and few resources for meeting them. Strategies to facilitate community development and capacity building so that communities can better advocate for their elderly, organise voluntary visiting and befriending schemes, and compete for existing resources would help to address some of the barriers hampering them.

e. Carers from the Community

Several community workers interviewed for this study explained that members of their communities would be interested in working in the aged care sector but that limited English language skills and their need for further education prevented them from achieving the standards necessary to qualify within the existing systems. Initiatives to open up opportunities for refugees to become employed in the aged care/community care sector need to be further investigated. A training scheme that allowed carers from refugee backgrounds to qualify at a lower entry level to enable them to provide care within their own community would help meet the needs of the elderly in smaller communities and provide employment for younger refugees. Further investigation is needed into how such models could act as entry points and pathways for further education and training in the health care/aged care sector.
2. Issues for Further Research

There is a dearth of evidence on how to best address the needs of refugee seniors and how to offer effective support to their families and communities. Policy-relevant action-based research would help to fill some of the gaps in our knowledge base, and would contribute to building a body of evidence about what works and why.

Specific priority research areas include:

a. Research into the needs of elderly trauma survivors

In the course of this research, we identified a range of challenges specific to elderly refugees who are survivors of genocide and extreme trauma. These issues include:
— the return of lost memories of traumatic events that occurred in their youth,
— guilt for having survived which causes feelings of being unworthy of care in old age,
— newly occurring nightmares, and anxiety from trigger events,
— the loss of short term memory.

While there is a body of research into these issues among Jewish Holocaust survivors, there is little research into these issues among other refugee communities including Cambodians, and communities from Africa and the Balkans, who have also fled genocide and extreme mass trauma. This research identified a number of areas that warrant further investigation, including the impact on families of caring for such elderly, and the training needs of carers in aged care and nursing homes.

b. Research into other models of care for refugee seniors

This research conducted a preliminary review of local, national and international literature to identify innovative models of home and community care for refugee seniors. However, very little published literature was available on social policy, social services or models of community development that addressed the needs of refugee seniors and their families. A comprehensive, systematic review of both the published and grey literature in this area would be of benefit in providing a foundation for an evidence base of successful practice models and for informing innovation in policy and service delivery in Victoria.

c. In-depth research with refugee seniors

This study was limited in scope and thus we were not able to interview or consult with refugee seniors themselves. Consequently, the voices of refugee seniors and their direct carers are absent. It is always a difficult and risky position to “speak for” or on behalf of individuals and communities and further participatory action research with refugee elders and their carers/families would be especially beneficial for providing a window into the lived experiences of growing old as a refugee in Australia.
Conclusion

The principle finding from this study is that the needs of refugee elders should not be dismissed because they are small in number. In many parts of the world, the respect paid to the elderly and their status within their society increases as their numbers dwindle. It is important that on coming to Australia having survived trauma and displacement, elderly refugees from smaller communities are accorded appropriate respect and care, and are supported to age with dignity and respect.


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A profile of Victorian Seniors from Refugee Backgrounds
Health and wellbeing needs and access to aged care health and support services

A study conducted by
the Refugee Health Research Centre, La Trobe University for the Department of Human Services, Victoria

Chapter 9 and Appendices
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<th>Description</th>
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<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>AMES</td>
<td>Adult Multicultural Education Services</td>
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<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
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<td>CEGS</td>
<td>Culturally Equitable Gateways Strategy</td>
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<tr>
<td>DIMIA</td>
<td>Department of Immigration and Multicultural and Indigenous Affairs</td>
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<td>EP</td>
<td>English Proficiency</td>
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<td>HACC</td>
<td>Home and Community Care</td>
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<td>LGA</td>
<td>Local Government Area</td>
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<td>Migrant Information Centre</td>
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<td>MRC</td>
<td>Migrant Resource Centre</td>
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<td>PAG</td>
<td>Planned Activity Group</td>
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<td>TAFE</td>
<td>Technical and Further Education</td>
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<td>TPV</td>
<td>Temporary Protection Visa</td>
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<td>UNHCR</td>
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</table>
Chapter 9  A profile of refugee seniors in Victoria

Introduction

Since 1996, the demographic profile of the refugee population in Victoria has changed as successive waves of refugees from different parts of the world have arrived through the humanitarian program. The significant numbers of refugees from the former Yugoslavia who arrived during the nineties have begun to fall away, and larger numbers of refugees from African countries, and Sudan in particular, have begun to arrive. The number of refugees arriving from Iraq and Afghanistan has remained significant and fairly constant since 1996 (see Figure 9.1). The source country profiles of older arrivals have generally followed a similar pattern, although some differences are apparent. For example, until 2002, refugees from Bosnia-Herzegovina and the Former Yugoslavia continued to make up the largest number of new arrivals over the age of 40, and were only replaced by Sudanese and Iranian refugees in 2004 (see Figure 9.2). Tracking these waves of refugee arrivals is a useful way of predicting the population of refugee seniors, which is made up of a mixture of those who arrive when young and age in Australia, those who arrive when they are older, and those older people from refugee backgrounds who join their families through the family reunification program. Studying the age structures of the various waves of refugee arrivals is useful for understanding the context in which refugee seniors live and provides an insight into the capacity communities have to support and care for their elders.

The following chapter offers detailed profiles of twenty refugee communities in Victoria. This is not a comprehensive list, but focuses on those communities with significant numbers of arrivals over the age of 35 in the last ten years, and those with large ageing populations who are not well serviced by ethno-specific HACC services or community services for the elderly (see Appendix 2). The reason for focusing on refugees aged 35 and over (and in some cases 40 years and over) is that up to date data specific to age/population size is not always available by refugee source country and it was beyond the scope of this report to calculate population age projections by year of arrival and refugee source country. These communities were chosen because they represent those currently most in need of improved services, and those vulnerable communities who are likely to have large numbers of seniors within the next ten years. Well established communities, such as those who arrived from Europe after the second World War, have not been included because some research has already been conducted into their health and wellbeing needs (Joffe, 1996; 2000; 2003; Drozd et al. 2004) and because they already have extensive and well resourced ethno-specific aged care services.
This chapter provides detailed community profiles of recently arrived communities and the specific needs of their elders. The chapter is divided into geographical regions and each profile is divided into a number of sections providing an overview of:
- Circumstances of displacement
- Resettlement in Australia
- Migration categories
- Languages spoken
- English language proficiency
- Age and gender profiles
- Place of residence by local government area
- Cultural norms
- Family roles and structure
- Gender specific issues
- Specific health and wellbeing issues and beliefs
- Norms regarding the health care and support for seniors.

These profiles provide a resource for local councils, service providers and agencies in planning and delivering services to support refugee seniors and their families. The information provided is a useful entry point for planning relevant and responsive services for recently arrived communities. However, the profiles need to be used with some caution. It is acknowledged that there is considerable diversity both within and between refugee communities and while we have attempted to describe these variances, we cannot claim to have fully comprehensive profiles of all communities. Consequently, these profiles should be used as a starting point, and readers are advised to gain more detailed information about the refugee communities they plan to work with through direct consultations with the specific target groups. While this chapter provides information valuable for planning and policy, it should be acknowledged that there are limitations to the data and that there is a need for more specific consultations at the local level.
The countries detailed in this chapter are:

**Africa**
- Sudan
- Somalia
- Ethiopia
- Eritrea
- Egypt
- Other Central and West African Countries
- Other Southern and East African Countries

**Asia**
- East Timor
- Vietnam
- Burma (Myanmar)
- Cambodia
- Laos

**Europe**
- Former Yugoslavia
- Bosnia-Herzegovina
- Croatia
- Federal Republic of Yugoslavia

**Middle East**
- Iraq
- Afghanistan
- Iran
- Lebanon
Figure 9.1 Top Countries of Birth of Humanitarian Settlers in Victoria: All age groups, 1996-97 to 2003-04

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1. DIMIA settlement database
### Figure 9.2 Top Countries of Birth of Humanitarian Settlers in Victoria: 40 years and above, 1996-97 to 2003-04

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1. AFRICA

Figure 9.3  Source countries for African humanitarian settlers in Victoria, 1996 – 2004

- SIERRALEONE
- LIBERIA
- EGYPT
- SUDAN
- ETHIOPIA
- SOMALIA
- KENYA
- UGANDA
- TANZANIA
- RWANDA
- BURUNDI
- DRC
- Eritrea
- Egypt
- Sudan
- Ethiopia
- Somalia
- Kenya
- Uganda
- Tanzania
- Rwanda
- Burundi
- DRC
AFRICA

SUDAN

1. CIRCUMSTANCES OF DISPLACEMENT

Sudanese refugees arriving in Australia have fled the civil war between the northern Sudanese government and the southern rebel group, the Sudan People’s Liberation Army (SPLA). The latest phase of this war lasted from 1983 until January 2005, and followed on from an earlier conflict between the north and south which began after independence in 1956 and ended in a tenuous peace in 1972. Both wars began when the southern states, where the majority of the population are African and follow Christian or traditional religions, rejected the imposition of Islamic ‘sharia’ law by the northern government (Kemp and Rasbridge, 2004).

The fighting in both wars was principally concentrated in the south and caused large scale displacement, death and famine. Civilian settlements were routinely targeted by government aerial bombardment followed by military ground attacks. An estimated 4 million southerners were displaced and either fled north to the capital Khartoum, or south into Kenya and Uganda (ibid).

The majority who headed north to Khartoum settled in the Internally Displaced Peoples (IDP) camps around the capital where they received few services, struggled to find employment, and lived under sharia law. From Khartoum many went to Egypt in the hope of gaining refugee status, but often waited years without employment, housing or education rights, and suffered racism and police brutality. Those who fled to Kenya and Uganda were usually accorded refugee status and settled in large UNHCR camps where they received basic housing, provisions and in some cases education.

Most Sudanese refugees arriving in Australia are from the south and are likely to have spent many years in IDP or refugee camps. A significant proportion will have lost family members in the war or during migration, and may have experienced war-related trauma, periods of under-nourishment and deprivation. Many will have had few opportunities for education.

2. RESETTLEMENT IN AUSTRALIA

Of the 11,320 Sudanese who have resettled in Australia since 1996, 31% have come to Victoria (DIMIA, 2004). In 2001, 20.3% of all Sudan-born persons in Australia were living in Victoria. The 2001 Australian census (ABS, 2003) recorded 966 Sudan-born people in Victoria, an increase of 210 per cent from the 1996 Census (ABS, 2000).

As seen in Figure 9.3.1, the number of humanitarian entrants from Sudan markedly increased between 2001 and 2004.
CHAPTER 9: A PROFILE OF REFUGEE SENIORS IN VICTORIA

5. DIMIA settlement database

6. DIMIA settlement database

3. MIGRATION CATEGORIES

Figure 9.3.2 shows the migration categories among Sudan-born arrivals to Victoria over the last eight years. Almost all recent arrivals from Sudan came to Victoria under the Humanitarian Program. Many of those who came within the Family migration stream were also likely to have had refugee-like experiences.

Figure 9.3.1 Humanitarian entrants from Sudan (Victoria, 1996-2004): All age groups

Figure 9.3.2 Migration categories among Sudan-born arrivals to Victoria 1996-2004: All age groups

---

5. DIMIA settlement database
6. DIMIA settlement database
4 LANGUAGES SPOKEN

The top languages spoken by Sudan-born humanitarian entrants to Victoria between 1996 and 2004 are (DIMIA, 2004a):

<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage</th>
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<tr>
<td>Arabic</td>
<td>76.1%</td>
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<tr>
<td>Tigrinya</td>
<td>1.9%</td>
</tr>
<tr>
<td>English</td>
<td>1.4%</td>
</tr>
<tr>
<td>Acholi</td>
<td>0.5%</td>
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<tr>
<td>Asante</td>
<td>0.4%</td>
</tr>
<tr>
<td>Amharic</td>
<td>0.3%</td>
</tr>
<tr>
<td>Swahili</td>
<td>0.3%</td>
</tr>
<tr>
<td>Others</td>
<td>19.1%</td>
</tr>
</tbody>
</table>

The ‘other’ category includes mostly ‘African not further defined’ (7.6%) and ‘Middle Eastern and North African not elsewhere classified’ (6.8%). The principle languages in the former category are likely to include dialects of Dinka, Nuer and other Nilotic and Bantu languages spoken in southern Sudan.

5. ENGLISH LANGUAGE PROFICIENCY

Sudanese entrants to Victoria between 1996 and 2004 have been categorised within the English Proficiency (EP) index 3, meaning between 50% to less than 80% of arrivals spoke good English (DIMIA, 2004a). The majority of these speakers are likely to be younger refugees who have spent time in refugee camps in Kenya and Uganda. Anecdotal evidence from service providers suggests that English language proficiency among Sudan-born seniors is very low.

6. AGE AND GENDER PROFILE

Figure 9.3.3 shows the estimated number, age and gender distribution of Sudan-born people living in Victoria in 2004. Three hundred and ten persons were aged 45 years and above. Of them, 173 (56%) were male and 137 (44%) were female.
7. PLACE OF RESIDENCE

In Victoria, humanitarian arrivals from Sudan (all age groups) between 1996 and 2003 have settled mainly in the Local Government Areas (LGAs) of Greater Dandenong, Brimbank, Maribyrnong, Moonee Valley, Darebin and Monash. Table 9.3.4 shows the LGA settlement areas of Sudanese-born persons aged 35 years and over.

Table 9.3.4 1996-2003 Sudanese-born arrivals to Victoria aged 35 years and over: Settlement by LGA

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<th>Local government area</th>
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<td>44</td>
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</tr>
<tr>
<td>Glen Eira</td>
<td>8</td>
<td>2.4</td>
</tr>
<tr>
<td>Melbourne</td>
<td>8</td>
<td>2.4</td>
</tr>
<tr>
<td>Others</td>
<td>44</td>
<td>12.9</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>339</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Unknown LGA</strong></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>358</td>
<td></td>
</tr>
</tbody>
</table>

7. 2001 Census (ABS, 2003); DIMIA settlement database
8. DIMIA settlement database
8. CULTURAL NORMS

Southern Sudan comprises over 60 identified cultural groups, who speak over 150 languages and dialects. Many share common cultural practices but generalisations need to be treated with care.

The main groups of Sudanese to have come to Australia are from the dominant Dinka and Nuer cultural groups from the Bahr-el-Ghazal and Upper Nile regions. Both are traditionally pastoralist patriarchal societies in which duty to the family and clan are strong, with strict moral codes governing marriage. Many Dinka and Nuer adopted Christianity during colonial times and are aligned with various branches of Catholic, Anglican, Coptic and Greek Orthodox churches.

9. FAMILY ROLES AND STRUCTURE

Both Dinka and Nuer traditions allow men to take more than one wife, and wives are passed to their brothers-in-law on the death of their husbands; a practice that is important in preserving family unity, especially during times of war (Kemp and Rasbridge, 2004). Large extended families tend to live together, with wives and daughters responsible for domestic duties and the care of children and the elderly. Distinctions between siblings and cousins are not as formalised as in Australian society and it is not uncommon for families to adopt children from within the extended family if they have lost or become separated from their parents.

Elders play an important role in family life and are traditionally treated with great respect. They are responsible for arranging marriages and negotiating bride prices. Children are expected to take advice from their elders on important decisions and elders are called on to resolve family and community disputes.

The majority of Sudanese refugees in Australia are under 35, but for the older individuals who have come to Australia, displacement and the experiences of resettlement have affected their roles as elders in the family and community. Where traditionally they would have been the cultural guardians and administered traditional law, they can feel disempowered in a country where state and federal laws govern family matters and do not allow for traditional means of resolving family and community disputes.

10. GENDER SPECIFIC ISSUES

Traditional family structures in Sudan have frequently been disrupted by war and displacement, and many single mothers now find themselves at the head of extended families. A significant proportion of the refugee families who have come to Australia are headed by single mothers. This is considered a problem by some in the community, as women are not familiar with these roles, and due to the lack of role models, young men are thought to be losing their traditional identity as they assimilate into Australian culture.

Older men in particular are affected by family break downs and anecdotal evidence suggests that the majority of the elderly who live alone are men.

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9. Information from a Sudanese community worker, 16/05/05.
10. Interview with a Horn of Africa Community Worker, 04/05/05
11. Interview with the Eastern and Central African Communities Association of Victoria 31/05/05
11. SPECIFIC HEALTH AND WELLBEING ISSUES

For Sudanese elders, familiar with living in close proximity to their extended families and peers, the separation from these social networks has an enormous impact on their wellbeing. Although many live with family members, the demands of resettlement often require children and grandchildren to work long hours or spend long periods of the day away from home. Workers with Sudanese elders talk of them feeling “trapped” in their houses in a society where casual visiting is not the norm and where they may not live near other elderly with whom they would choose to socialise12. Those who are not able to travel independently, either because they cannot drive or because they are unfamiliar with using public transport, can end up rarely leaving their homes.

The lack of English language skills is another factor contributing to many older people’s sense of isolation. Those with little or no English depend on their children for translation; a situation which can reinforce their feelings of disempowerment and alienation.

The cumulative effect of isolation and dependency can cause frustration and depression and in some cases feelings of uselessness and despair. Concern for family members still in Sudan or separated during migration, adds anxiety and stress to the situation, with the unsurprising outcome that many elderly Sudanese suffer poor levels of mental health.

Physical health among the Sudanese elderly varies according to their pre-arrival experiences, with some suffering ongoing illness or pain from war injuries. Following settlement in Australia, conditions including diabetes, high blood pressure and gout are reported to increase among the middle aged and elderly. Being unfamiliar conditions, it is reported that they often go untreated until symptoms become acute13.

12. BELIEFS AND NORMS REGARDING HEALTH CARE AND SUPPORT FOR SENIORS

It is widely accepted in Sudanese society that families should care for their elderly relatives when they become frail. Resettlement has not affected this belief but the practicalities of family separation and the effort involved in resettlement means the reality of care does not always meet expectations. Recently arrived families have a lot to do to arrange employment, housing, English language tuition and schooling for their children, and may have little time to attend to the needs of their elderly relatives. Some older people, whose children were killed or lost in the war, came to Australia as the guardians of their grandchildren. Although they may need care themselves, they are likely to be looking after their grandchildren and struggling to support them at an age when finding employment is extremely difficult. A minority of elderly Sudanese came to Australia alone and have no family to support or care for them. These individuals depend on the good will of their community, and tend to be the most isolated and vulnerable of all the Sudanese elderly14.
Most Sudanese refugees coming to Australia have very little experience of social services. Familiarity with the Australian service system will vary according to the length of time since resettlement, the level of English language proficiency within the family, and the educational background of family members prior to migration.

Anecdotal evidence suggests that many elderly Sudanese have no knowledge of aged care services or of where to go for information about services\(^{15}\). Community organisations are the only point of contact many people have for information regarding services, and workers in these organisations are not always familiar with the aged care system\(^{16}\). However, interviews with community organisations and workers revealed that were services known of and understood, many elderly would be glad to make use of them, although there would be some reluctance to use workers who did not speak their language.

Concurrent with unfamiliarity with organised health care systems, is a lack of experience and understanding of western medicine among some Sudanese refugees. Those who have spent time in UNHCR camps will have had some exposure to health screening, immunization and basic health care, but may be unfamiliar with medicating practices and procedures. Community organisations describe a preference among Sudanese adults, and elders in particular, for traditional herbal remedies over prescription drugs. However, these familiar and trusted treatments are not always available due to quarantine restrictions in Australia. Dosage is also known to be a problem with some traditional preparations, as is the interaction they can have with prescribed medication. When western medication is used, problems can arise when patients are unable to follow instruction leaflets, or when medication is shared or passed on to others\(^{17}\).

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15. Ibid.
16. Telephone conversation with the Eastern and Central African Communities Association of Victoria.
17. Interview with Horn of Africa Communities Network, 04/05/05
1. CIRCUMSTANCES OF DISPLACEMENT

Prior to independence in 1960, the land inhabited by the Somali people was divided between the French, the British and the Italians. The country that became Somalia has since fragmented in the course of more than forty years of violent civil conflict. The system of clan factionalism on which Somali society is based, quickly tore apart the first multi-party democracy after independence and brought to power Siad Barre’s Supreme Revolutionary Council in a military coup in 1969 (Griffiths, 2005; Putnam and Noor, 1993).

Barre held the country together for nearly 10 years through manipulating clan allegiances, and through extensive militarisation, but opposition movements had begun to come together against the regime by the late 1970s. Defeat in the Ogaden war with Ethiopia in 1988 led to large scale conflict between Barre’s forces and opposition groups in the north-west of the country. When the opposition took control of the towns of Hargeisa and Burao, Barre unleashed a campaign of aerial bombardment which killed an estimated 100,000 civilians, forced 365,000 to flee to Ethiopia and displaced a further 60,000. By 1991 agreement between the anti-Barre factions enabled three opposition groups to converge on Mogadishu and remove Barre from power (Griffiths, 2005).

Intense fighting followed the collapse of the Somali state as clans fought for control of land and resources in the south. An estimated 800,000 refugees fled to Kenya and Ethiopia and 2 million more were internally displaced. The north-western region of Somaliland declared independence in 1991, and enjoyed relative peace and development until an outbreak of violence in 1994 created 90,000 refugees and 200,000 internally displaced people. In a referendum in 2001 the population of Somaliland overwhelmingly voted for continued independence from Somalia, enabling a degree of development to continue (ibid).

Unsuccessful UN attempts at nation building in Somalia between 1993 and 1995 ended in failure, and fighting between a series of regional administrations provoked on-going outbursts of conflict. Despite a lack of any state infrastructure, some businesses continued to thrive but drought and famine caused further death and displacement, and refugees continued to flow out of the country in large numbers. Puntland in the north-east declared autonomy in 1998, but erupted in conflict again in 2001. It has not formally separated from Somalia, but maintains a degree of peace under the rule of councils of elders (ibid).

The formation of a Transitional National Government (TNG) in 2000 was opposed by key warlords and has so far failed to bring the country to peace. Despite a ceasefire agreed in 2002, there have been serious outbreaks of violence in recent years and outbreaks of drought have forced yet more refugees to leave. The TNG parliament elected a president in 2004 but still only controls a small area around Mogadishu and has limited support within the country (ibid).

Somalia has been one of the largest refugee producing countries for over twenty years and large migrant communities now live in North America and Europe, with the majority since 2000 going to the UK. A large proportion of Somali refugees are women and children (ibid).
2. RESETTLEMENT IN AUSTRALIA

Many Somalis were accepted as refugees in New Zealand, and have since come to Australia on New Zealand passports. Many younger Somali refugees are likely to have been born in refugee settlements in Kenya and Ethiopia and will therefore not be evident as Somali in the settlement data. The 1996 Census recorded 1,351 Somalia-born people in Victoria; this figure increased to 2,284 at the 2001 Census, that is, about 63% of all Somalis living in Australia. Figure 9.3.5 shows the Somalia-born humanitarian entrants to Victoria since 1996.

Figure 9.3.5 Humanitarian entrants from Somalia (Victoria, 1996-2004): All age groups\textsuperscript{18}.

3. MIGRATION CATEGORIES

The migration categories among Somalia-born arrivals to Victoria between 1996 and 2004 are shown in Figure 9.3.6. Sixty-seven percent of arrivals came under the Humanitarian Program. Many of those who arrived under the Family migration stream were also likely to have come from refugee backgrounds.

Figure 9.3.6 Migration categories among Somalia-born arrivals to Victoria 1996-2004: All age groups\textsuperscript{19}

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18. DIMIA settlement database
19. DIMIA settlement database
4. LANGUAGES SPOKEN

The languages spoken by Somalia-born humanitarian entrants to Victoria between 1996 and 2004 include:

<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somali</td>
<td>87.8%</td>
</tr>
<tr>
<td>Arabic</td>
<td>8.5%</td>
</tr>
<tr>
<td>Other</td>
<td>3.7%</td>
</tr>
</tbody>
</table>

5. ENGLISH LANGUAGE PROFICIENCY

English proficiency among Somali entrants to Victoria from 1996 to 2004 was categorised within the EP 3 group, that is, between 50% to less than 80% of arrivals spoke good English or English only\(^\text{20}\).

6. AGE AND GENDER PROFILE

The estimated number of Somalia-born people living in Victoria at 2004, their age and gender distribution are shown in Figure 9.3.7. An estimated 308 persons were aged 45 years and over. Of them, 158 (51.3%) were male and 150 (48.7%) were female.

Figure 9.3.7 Estimated Somalia-born population in Victoria at 2004: Age and gender profile\(^\text{21}\)

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20. DIMIA settlement database
21. Census 2001 (ABS, 2003); DIMIA settlement database
7. PLACE OF RESIDENCE

Somalia-born entrants to Victoria between 1996 and 2003 (all age groups) have settled mostly in the LGAs of Banyule, Melbourne, Moonee Valley, Darebin and Hume. Settlement areas of Somalis aged 35 years and over are shown in Table 9.3.8.

Table 9.3.8 1996-2003 Somalia-born arrivals to Victoria aged 35 years and over\textsuperscript{22}: Settlement by LGA\textsuperscript{23}

<table>
<thead>
<tr>
<th>Local government area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banyule</td>
<td>53</td>
<td>20.6</td>
</tr>
<tr>
<td>Moonee Valley</td>
<td>42</td>
<td>16.2</td>
</tr>
<tr>
<td>Melbourne</td>
<td>37</td>
<td>14.3</td>
</tr>
<tr>
<td>Darebin</td>
<td>27</td>
<td>10.4</td>
</tr>
<tr>
<td>Hume</td>
<td>27</td>
<td>10.4</td>
</tr>
<tr>
<td>Moreland</td>
<td>16</td>
<td>6.2</td>
</tr>
<tr>
<td>Maribyrong</td>
<td>8</td>
<td>3.1</td>
</tr>
<tr>
<td>Glen Eira</td>
<td>6</td>
<td>2.3</td>
</tr>
<tr>
<td>Port Phillip</td>
<td>6</td>
<td>2.3</td>
</tr>
<tr>
<td>Other</td>
<td>37</td>
<td>14.2</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>259</td>
<td>100.0</td>
</tr>
<tr>
<td>Unknown LGA</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>269</td>
<td></td>
</tr>
</tbody>
</table>

8. CULTURAL CONTEXT

The clan structure is central to Somali society and although Somali refugees are on the whole ethnically and linguistically homogenous, the Somali community in Australia is fragmented along clan lines. Because the different factions do not tend to mix, communication can be difficult, as information will not generally be passed between different groups. Clan groups are likely to have their own community organisations and welfare associations (Jupp, 2001).

The vast majority of Somalis are practicing Sunni Muslims who observe religious festivals and teachings regarding women’s dress. Because of clan factionalism, they do not attend common mosques. Although Somali society is patriarchal, it is also generally egalitarian in that decisions are made through discussion and consensus. Elders are given respect but do not usually have outright decision making powers (Kemp and Rasbridge, 2004).

War, displacement and a largely pastoralist society in Somalia mean that many refugees have low levels of education prior to arrival. Few speak English, although some will speak Arabic as a second language. Consequently, unemployment following arrival has been a major problem for the Somali community in Australia. Those who have found employment have mostly worked in manual or low skilled jobs (Jupp, 2004).

\textsuperscript{22} At time of entry to Australia
\textsuperscript{23} DIMIA settlement database
9. FAMILY ROLES AND STRUCTURE

Within the clan structure, the family is the principal social unit and identity is largely based on genealogy (Putnam and Noor, 1993). Families are traditionally large, but fragmentation during migration has split many families up and made it difficult for some to cope without these extended social support networks. There are also many separated or unaccompanied children in the diaspora who were smuggled out of Somalia by their parents hoping they would have a better life and prospects elsewhere. They tend to be adopted by relatives, although older children may live alone in social welfare housing.24

Many single mothers have also come from Somalia. Community workers report that these women are often struggling to cope with caring for their children and have little understanding or knowledge of the welfare system. The middle-aged population, who have often brought their elderly relatives to live with them through the family reunification scheme, are also reported to struggle with the pressures of caring for and supporting their children and their parents.25

10. GENDER SPECIFIC ISSUES

Rape was used as an instrument of war following the fall of Barre’s regime, as it is a way of disrupting clan genealogies. Sexual assault was also widespread in the refugee camps in Kenya that many Somali refugees in Australia will have passed through (Griffiths, 2005). The consequences of these experiences make Somali women a vulnerable group in terms of both their mental and physical health.

Female circumcision is a common practice in Somalia and women may suffer ongoing medical problems from operations performed in their youth or from complications during childbirth (Kemp and Rasbridge, 2004).

In a culture where male status and pride are closely related to clan and family structures, Somali men who have had little education and have found it difficult to gain employment in Australia, may find their loss of social role and status difficult to cope with. Older men are especially vulnerable to social isolation and depression if they are dependent on their children for translation and transportation, and if they do not live near other seniors with whom they can mix.26

11. SPECIFIC HEALTH AND WELLBEING ISSUES

According to community workers, common medical complaints among older Somali refugees include high blood pressure and rheumatism. Changes in diet have also affected the health of the elderly who are reported to suffer high levels of diabetes and obesity. In the winter many also suffer from colds and influenza.

24. Interview with MRC worker, 17/05/05
25. Ibid.
26. Ibid.
Traditional herbal medicines are reported to be popular among Somali refugees and older people in particular are likely to prefer to use these before seeking medical help (Kemp and Rasbridge, 2004). When medication is prescribed by doctors, refugees who speak little English and have low literacy, may have difficulty following instructions, and medicines are reported to be shared or taken incorrectly.

Somali refugees are likely to have witnessed or experienced violence and may well suffer mental health problems as a consequence. Displacement and separation from family also contribute to stress and depression, and concern about family members still in Africa can be a cause of ongoing anxiety. Due to the divided nature of the Somali community in Australia, opportunities for social interaction may be limited, and older people in particular, if they are unable to communicate in English or use public transport, risk becoming socially isolated.

12. BELIEFS AND NORMS REGARDING HEALTH CARE AND SUPPORT FOR SENIORS

Families are traditionally expected to care for their elderly relatives, although low life expectancy in Somalia means anyone over 50 is generally considered an elder. Although there is a stigma associated with being seen to be unable to care for one’s elderly relatives, community workers report that in families struggling with unemployment and resettlement, home help services would be very welcome.

The principle barrier to accessing services for the Somali community is a lack of knowledge of the welfare system and a shortage of information in appropriate languages and formats. The elderly themselves often have very limited English and low levels of literacy, whilst the middle-aged generation who are caring for the elderly, tend to only be familiar with a limited range of services. A project at the Northern Migrant Resource Centre in Melbourne, has demonstrated that once introduced to services for seniors, the Somali community is enthusiastic in using them. Since engaging a group of elders on issues around services for Somali seniors, a group of women have started a walking group and a gentle exercise class, and the Somali men have requested an information session on Centrelink services and housing, as well as swimming and gym classes.*

1. CIRCUMSTANCES OF DISPLACEMENT

Until 1974, Ethiopia was ruled by a succession of emperors and was the only African country never to be colonised. The Derg government, led by the military leader Mengistu Haile Miriam, which came to power in a coup in 1974, was a repressive Marxist regime under which opposition was crushed. People’s daily lives were tightly controlled and large numbers of people were forcibly moved around the country in an attempt to counter famine. During a period in the late 1970s known as the ‘red terror’, thousands of people left Ethiopia for Kenya, Djibouti, Yemen and Sudan, and were resettled in Europe, the USA and Australia. During Mengistu’s rule, Somalia invaded the Ogaden desert in the east and in 1991 opposition forces marched on Addis Ababa. Mengistu escaped and a new government set out to pursue multi-party democracy (Dessalegn, 2005).

In 1998, war erupted when Eritrea sought separation from Ethiopia. More than 350,000 people were displaced or evacuated from the border region. The majority remained inside Ethiopia and 80% returned to their homes after a peace agreement was signed in 2000. At the end of 2002 there were estimated to be more than 20,000 Ethiopian refugees in neighbouring countries, although the majority had been displaced during the Mengistu era (ibid).

Ethiopia hosts a large number of refugees from the surrounding countries of Sudan, Somalia, Eritrea, Djibouti and Yemen, as well as from Rwanda, Burundi, Angola, Liberia, Uganda and South Africa (Dessalegn, 2005). Most of these populations live in camps in the north, east and west of the country, where they receive food and basic supplies from the UN. Significant numbers also live in the urban centres of Addis Ababa and Dire Dawa. Some refugee populations have been in Ethiopia for over 20 years, and it is likely that some migrants to Australia whose county of birth was Ethiopia are in fact from one the neighbouring countries (ibid).

2. RESETTLEMENT IN AUSTRALIA

Since 1991, the majority of Ethiopian refugees who have come to Australia have settled in Victoria. The 1996 Census recorded 1,358 Ethiopia-born people in Victoria. This figure increased to 2,019 at the 2001 Census, that is, 56.2% of all Ethiopians living in Australia. Figure 9.3.9 shows the Ethiopia-born humanitarian entrants to Victoria since 1996.
3. MIGRATION CATEGORIES

The migration categories among Ethiopia-born arrivals to Victoria between 1996 and 2004 are shown in Figure 9.3.10. Almost 60% of all arrivals came under the Humanitarian Program while the Family stream accounted for 38% of entrants. Those who arrived under the Family category are likely to have had refugee-like experiences.

4. LANGUAGES SPOKEN

The languages spoken by Ethiopia-born humanitarian entrants to Victoria between 1996 and 2004 include:

- Amharic: 48.8%
- Oromo: 22.4%
- Tigrinya: 13.6%
- Arabic: 6.3%
- Somali: 2.9%
- Other: 6.0%

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27. DIMIA settlement database
28. DIMIA Settlement Database
29. DIMIA Settlement Database
5. **ENGLISH LANGUAGE PROFICIENCY**

Between 50% to less than 80% of humanitarian arrivals from Ethiopia since 1996 spoke good English or English only at time of entry to Australia (EP 3 index).  

6. **AGE AND GENDER PROFILE**

The estimated number of Ethiopia-born people living in Victoria in 2004, their age and gender distribution are shown in Figure 9.3.11. Two hundred and eighty eight people were aged 45 years and over. Of them, 158 (54.9%) were male and 130 (45.1%) were female.

![Figure 9.3.11 Estimated Ethiopia-born population in Victoria at 2004: Age and gender profile](image)

7. **PLACE OF RESIDENCE**

Ethiopia-born entrants to Victoria between 1996 and 2003 (all age groups) have settled mostly in the LGAs of Maribyrnong, Moonee Valley, Greater Dandenong, Brimbank and Yarra. The settlement areas of those aged 35 years and over are shown in Table 9.3.12.

<table>
<thead>
<tr>
<th>Age groups (yrs)</th>
<th>Number of persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 24</td>
<td>Female: 848, Male: 1003, Total: 1851</td>
</tr>
<tr>
<td>25 - 34</td>
<td>Female: 655, Male: 126, Total: 781</td>
</tr>
<tr>
<td>35 - 44</td>
<td>Female: 126, Male: 76, Total: 202</td>
</tr>
<tr>
<td>45 - 54</td>
<td>Female: 76, Male: 86, Total: 162</td>
</tr>
<tr>
<td>55 - 64</td>
<td>Female: 86, Male: 126, Total: 212</td>
</tr>
<tr>
<td>65+</td>
<td>Female: 86, Male: 126, Total: 212</td>
</tr>
</tbody>
</table>
Table 9.3.12 1996–2003 Ethiopia-born arrivals to Victoria aged 35 years and over\(^\text{32}\): Settlement by LGA\(^\text{33}\)

<table>
<thead>
<tr>
<th>Local government area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maribyrnong (C)</td>
<td>44</td>
<td>28.9</td>
</tr>
<tr>
<td>Moonee Valley (C)</td>
<td>35</td>
<td>23.0</td>
</tr>
<tr>
<td>Greater Dandenong (C)</td>
<td>15</td>
<td>9.9</td>
</tr>
<tr>
<td>Melbourne (C)</td>
<td>10</td>
<td>6.6</td>
</tr>
<tr>
<td>Monash (C)</td>
<td>10</td>
<td>6.6</td>
</tr>
<tr>
<td>Brimbank (C)</td>
<td>8</td>
<td>5.3</td>
</tr>
<tr>
<td>Yarra (C)</td>
<td>7</td>
<td>4.7</td>
</tr>
<tr>
<td>Darebin (C)</td>
<td>5</td>
<td>3.3</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>11.7</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>152</td>
<td>100.0</td>
</tr>
<tr>
<td>Unknown LGA</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>162</td>
<td></td>
</tr>
</tbody>
</table>

8. **CULTURAL CONTEXT**

The Ethiopian community in Victoria is deeply divided along ethnic lines with some groups not even identifying as Ethiopian. There is little sense of national identity and relationships between groups are strained. The main ethnic groups in Victoria are the Tigray, the Oromo, the Amhara and the Harari. Smaller groups include the Garaghe, Afar and Sidamo. The ethnic divisions are reinforced by religious groupings. The Tigray and Amhara communities are largely Ethiopian Orthodox, whilst the majority of Oromo, Harari, Garaghe and Afar are Muslim. The Ethiopian Orthodox church in Maribyrnong is the focus for the Christian community, although smaller groups attend Pentecostal churches, and many Christian Oromos attend the Oromo Christian Fellowship in South East Melbourne. There is no particular mosque favoured by Ethiopian Muslims (Jupp, 2001).

The majority of refugees from Ethiopia came from rural backgrounds and will have low levels of English language and general education. Oromo and Harari Muslims were systematically discriminated against in Ethiopia and would have had very few opportunities for education. Coming from these backgrounds, refugees often find adjusting to city life very difficult and struggle to find work. Unemployment is high and those who can find work, tend to be manual labourers. Many families are also under pressure to send money back to relatives in Africa. This puts an extra strain on already tight finances and discourages taking time out from work for education (Jupp, 2001).

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\(^{32}\) At time of entry to Australia

\(^{33}\) Source: DIMIA settlement database
11. FAMILY ROLES AND STRUCTURE

In Ethiopia, extended families traditionally live together and are headed by men. Male elders are responsible for making decisions and resolving disputes, as well as for contact between the family and the outside world. Displacement and migration have broken up many families, some of whom are headed by single mothers who came to Australia with their children under the ‘Women at Risk’ humanitarian migration scheme. Marital break up following arrival in Australia is also not uncommon and has resulted in more female headed families. These families often struggle financially and because they are headed by divorced or separated women, can be ostracized from the community (Jupp, 2001).

Intergenerational conflict occurs when parents and elders, whose children and grandchildren have become assimilated into Australian society, feel they are not shown the respect they deserve. Single mothers in particular struggle to control male children who lack male role models.

10. GENDER SPECIFIC ISSUES

On coming to Australia, Ethiopian women often find they have more rights and opportunities than previously, and this can cause marital conflict. However, family breakdowns tend to leave women more vulnerable because they traditionally depend on their husbands for financial and social support. Child care duties often mean women are unable to work, and their low levels of education and English language also limit their employment opportunities. The stigma of being a divorced woman can isolate some women from the community and, unlike men, they are not traditionally allowed to remarry (Jupp, 2001).

In families who stay together, it is often men who are reported to struggle to cope following migration. The lack of employment and their diminished social status can lead to depression and a feeling of powerlessness. Older men, who have no hope of finding work, and who feel their authority within their families and the community has been diminished, are particularly vulnerable to depression.

11. SPECIFIC HEALTH AND WELLBEING ISSUES

Following an initial ‘honeymoon period’ after arrival, many older people are reported to sink into depression and loneliness. Although they may live with their children and grandchildren, the pressures on the younger generations to work, often mean older relatives can become very isolated. If they are frightened to use public transport, they may only leave the house to attend church or mosque. Those living near other families from their community may have social networks, but due to the fragmented nature of the Ethiopian community, social circles tend to be small. Depression is often put down to homesickness and not dealt with because it is considered shameful. It is considered weak to show symptoms of trauma, and a lack of knowledge and understanding of the Australian health care system makes it unlikely that people would seek help.

34 Interview with Horn of Africa community worker 04/05/05
35 Ibid.
36 Interview with Ethiopian community worker 24/05/05
Infectious diseases, such as tuberculosis also attract stigma and are sometimes left untreated. Diabetes, high blood pressure and rheumatism are reported to be common among the Ethiopian elderly, partly due to changes in diet and lifestyle. Traditional healing methods are popular, especially among older members of the community.

12. BELIEFS AND NORMS REGARDING HEALTH CARE AND SUPPORT FOR SENIORS

In Ethiopian culture, people over the age of 55 are generally considered ‘elders’. Because of the low number of older people in Australia, those over 45 are considered ‘elders’. Across all ethnic groups, it is the duty of children to care for and respect their parents. To put one’s elderly in a nursing home is taboo, and community disapproval makes it very rare. Daughters and daughters-in-law are usually responsible for caring for their older relatives, although they often struggle if they are also caring for and supporting children.

Because of their experiences of surveillance in Ethiopia, some ethnic groups are suspicious of using government services. However, the biggest barrier to accessing services for most of the community is a lack of information. Once people learn about a service, they are often keen to use it, although they may still struggle with navigating systems, making bookings and overcoming language and literacy barriers. Factionalism within the community also makes the use of interpreters difficult. Ethiopian community workers report that the use of Eritrean Amharic interpreters by many services, dissuades Ethiopians from using them.

Community workers report that many Ethiopian elderly would greatly benefit from having community groups where they could meet for activities. They would need to be consulted in designing the services to ensure incompatible groups were not put together, for example, Christians and Muslims, who will not eat food prepared by each other. The existing Horn of Africa elderly group is dominated by Eritreans who most Ethiopians would not wish to mix with.

CASE STUDY A

A Vulnerable Older Woman Living Alone

A 67 year-old Ethiopian woman lost her husband in the Eritrean-Ethiopian war. She fled to Sudan with her son, where she lived in a refugee camp for 27 years. When her son was killed in Sudan, she was granted refugee status in Australia under the ‘Women at Risk’ Humanitarian Program. She was settled in a flat on her own in the western suburbs of Melbourne. She spoke no English and had no family contacts in Australia.

She became seriously ill and had to have 2 major operations. On returning home from hospital she was given home help services, but was very reluctant to use them as she could not communicate with her carer in Amharic, and was suspicious of having a government employee in her home. She terminated the service at the first opportunity.

A community organisation arranged for a young woman to live with her and be her carer, but the women did not get on and the elderly lady asked her to leave.

Having got in contact with the Ethiopian Orthodox Church in Maribyrnong, she now plays an active role in the church community and is cared for by community members who visit her. She speaks only a few words of English and still lives alone.
ETHIOPIA

CASE STUDY B  The taboo of residential care for the elderly
A middle aged Ethiopian man was struggling to look after his elderly father. When he put him in a residential care unit, it created a scandal and he was forced by community members to bring his father home.

CASE STUDY C  Living with family but feeling alone: A vulnerable older man
An Ethiopian man aged 62, lives with his wife, their children and grandchildren. He feels his grandchildren do not show him enough respect and when he tries to discipline them using corporal punishment, they object. He has no friends or contacts outside the family. He feels he has lost his role in the family and suffers from depression and asthma, but there is nowhere he can go for treatment that he would find acceptable. He is saving money so that he can return to Ethiopia.
1. CIRCUMSTANCES OF DISPLACEMENT

Until 1941 Eritrea was an Italian colony and until 1952 it was ruled by the British. In 1952 it was given to Ethiopia as part of a federation. Ethiopia’s annexation of Eritrea in 1962 led to a 30 year war of independence which destroyed much of the country’s infrastructure and finally ended in 1991. In 1993, following a referendum, Eritrea became fully independent (Dessalegn, 2005).

A border dispute with Ethiopia sparked another war in 1998 which only ended in 2000. More than 100,000 soldiers from both sides were killed, along with thousands of civilians. Over 1 million people on both sides of the border were displaced, and over 58,000 have been unable to return to their homes due to the risk of unexploded ordinance and mines (ibid).

Eritrea hosts over 2,000 refugees from Somalia and Sudan, and Eritrean refugees still live in camps in Ethiopia and in urban centres in Egypt. The country is extremely poor and food and water security are of ongoing concern. Members of unsanctioned religious minorities and opposition groups are subject to arrest, harassment, detention and sometimes torture (Refugees International website, 2005).

2. RESETTLEMENT IN AUSTRALIA

Prior to 1983, small numbers of Eritreans arrived in Australia as refugees and students. After 1983 the Australian government introduced a special humanitarian quota for Eritreans and Ethiopians and the numbers increased significantly over the following years. Of the 973 Eritrea-born persons who have resettled in Australia since 1996, 56% have come to Victoria. The 1996 Census listed 734 Eritreans in Victoria. By 2001 the number increased to 990. The number of Eritrea-born humanitarian entrants to Victoria since 1996 is shown in Figure 9.3.13.

Figure 9.3.13 Humanitarian entrants from Eritrea (Victoria, 1996-2004): All age groups

40. DIMIA settlement database
3. MIGRATION CATEGORIES

The migration categories among Eritrea-born arrivals to Victoria between 1996 and 2004 are shown in Figure 9.3.14. The Humanitarian program accounted for 65% of all arrivals. Those who arrived under the Family stream (33%) were also likely to have come from refugee backgrounds.

Figure 9.3.14 Migration categories among Eritrea-born arrivals to Victoria 1996-2004: All age groups

4. LANGUAGES SPOKEN

The languages spoken by Eritrea-born humanitarian entrants to Victoria between 1996 and 2004 include:

- Tigrinya: 47.0%
- Arabic: 43.3%
- Amharic: 7.2%
- Other: 2.5%

5. ENGLISH LANGUAGE PROFICIENCY

English proficiency among Eritrea-born humanitarian entrants to Victoria from 1996 to 2004 was categorised within the EP 3 group, that is, between 50% to less than 80% of arrivals spoke good English or English only.

6. AGE AND GENDER PROFILE

Figure 9.3.15 illustrates the estimated number of Eritrea-born persons living in Victoria at 2004, their age and gender distribution. According to these estimates, 258 people were aged 45 years and over. Of them, 135 (52.3%) were female and 123 (47.7%) were male.

41. DIMIA Settlement Database
42. DIMIA Settlement Database
43. DIMIA Settlement Database
7. PLACE OF RESIDENCE

The main LGAs of settlement of Eritrea-born entrants to Victoria between 1996 and 2003 (all age groups) were Moonee Valley, Melbourne, Maribyrnong, Greater Dandenong and Moreland. Those aged 35 years and over have settled in the following areas:

Table 9.3.16 1996-2003 Eritrea-born arrivals to Victoria aged 35 years and over\(^4^5\): Settlement by LGA\(^4^6\)

<table>
<thead>
<tr>
<th>Local government area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melbourne (C)</td>
<td>46</td>
<td>30.9</td>
</tr>
<tr>
<td>Moonee Valley (C)</td>
<td>41</td>
<td>27.5</td>
</tr>
<tr>
<td>Greater Dandenong (C)</td>
<td>12</td>
<td>8.1</td>
</tr>
<tr>
<td>Yarra (C)</td>
<td>11</td>
<td>7.4</td>
</tr>
<tr>
<td>Maribyrnong (C)</td>
<td>8</td>
<td>5.3</td>
</tr>
<tr>
<td>Moreland (C)</td>
<td>6</td>
<td>4.0</td>
</tr>
<tr>
<td>Hume (C)</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Kingston (C)</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>11.4</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>149</td>
<td>100.0</td>
</tr>
<tr>
<td>Unknown LGA</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>159</td>
<td></td>
</tr>
</tbody>
</table>

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\(^4^4\) Census 2001 (ABS, 2003); DIMIA settlement database  
\(^4^5\) At time of entry to Australia  
\(^4^6\) DIMIA settlement database
CHAPTER 9: A PROFILE OF REFUGEE SENIORS IN VICTORIA

ERITREA

8. CULTURAL CONTEXT

There have been close ties between Australia and Eritrea since the 1980s when larger numbers of refugees began arriving through the special quota program. High level government visits from both sides, business relations and aid have strengthened these ties (Jupp, 2001).

The largest ethnic group in the Eritrean community are the Tigrinya. Other groups include the Tigre, the Kunama, the Afar, and the Saho. The population is equally divided between Muslims and Christians (including Ethiopian Orthodox, Catholics and Protestants). Christians tend to come from the highlands around Asmara, whilst Muslims are from the lowland rural areas (Kemp and Rasbridge, 2004).

The majority of Eritreans who came to Australia in the 1980s were young, literate men who spoke some English. They found unskilled or semi-skilled work in factories and have since brought their families to join them. More recent arrivals are either educated younger people from Asmara, or families escaping the recent border conflict with Ethiopia. The latter are less likely to be educated and many of the families are headed by single mothers who arrived under the ‘Women at Risk’ Humanitarian program (Jupp, 2001).

9. FAMILY ROLES AND STRUCTURE

Eritrean families are traditionally patriarchal and extended families live together. Male elders make important family decisions and resolve disputes. Women are perceived as needing protection by their male family members. Elders are traditionally respected and it is the duty of children to care for their parents in old age\(^\text{47}\).

Family structures have been affected by war and migration. Many men died in the 1998 war, leaving women to head households. Following migration, these women often struggle to support their families, as they have low levels of English and little understanding of the Australian welfare system. They are sometimes caring for their children and their parents and are not always supported by the community who are reported to view single mothers with disdain\(^\text{48}\).

Family breakdown also occurs when younger members reject the value systems and culture of their parents and grandparents and try to move away from the family home. A community worker reported a view expressed by Eritrean parents that their children are being “snatched from them” by Australian society\(^\text{49}\). This was in particular reference to a number of cases where adolescents, seeing the housing and benefits available to unaccompanied minors from their community, had reported to social services that they were being abused at home, in a bid to be moved into welfare housing.

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47. Interview with Eritrean Community Worker, 04/05/05
48. Ibid.
49. Ibid.
Older relatives who care for grandchildren are reported to find it hard work, and because they are often unfamiliar with cities and with Australian culture, they prefer to keep children inside during the day. Older people often see it as their duty to maintain traditions and pass on their cultural knowledge. Women especially are often very involved in organising community weddings and one group have started a storytelling circle and are trying to publish a book of traditional children’s stories in English and other languages to ensure they are passed on to the next generation\(^{50}\).

10. GENDER SPECIFIC ISSUES

The freedom gained by Eritrean women following migration to Australia has caused some concern among older members of the community. The fact that women are supported to move away from the home if they are suffering domestic violence is seen by some to be interfering with traditional methods of mediation and family conflict resolution\(^{51}\).

Older men are considered to be a particularly vulnerable group in the community following migration. They are often unable to find employment due to their low language skills and find the loss of status and authority particularly difficult. They also feel that the greater rights given to women in Australia undermine their social status. According to one community worker, older men often say they “feel they don’t have value” anymore\(^{52}\).

11. SPECIFIC HEALTH AND WELLBEING ISSUES

Older Eritreans, whether or not they live with their families, risk isolation, both practically if their children are working, and socially if they feel alienated and disempowered by their children and grandchildren’s values. Where families live near each other and there is some opportunity for social contact, older people, especially women, take advantage of it. For example, older women living in high rise housing in Carlton have formed a social and savings group in which they help those in their community who are most in need. However, those who live far from other families, and who find public transport frightening and expensive, are at high risk of becoming very isolated and depressed\(^{53}\).

Mental health is not openly discussed in the community as showing weakness is considered shameful. Discussing past traumas is also not popular as people prefer to look forward rather than back at the experiences they have gone through\(^{54}\).

Illnesses including diabetes, high blood pressure and rheumatism are reported to be common among the Eritrean elderly in Victoria and many older people prefer to use traditional healing methods such as the ‘traditional sauna’, before they visit a doctor. When they are prescribed medication, older people sometimes have difficulty following the instructions for taking it, and share their medication or fail to take it correctly\(^{55}\).

50. Ibid.
51. Ibid.
52. Ibid.
53. Ibid.
54. Ibid.
55. Ibid.
12. BELIEFS AND NORMS REGARDING HEALTH CARE AND SUPPORT FOR SENIORS

There is a strong emphasis on the family’s duty of care for the elderly in the Eritrean community, but evidence from interviews suggests that many families are struggling to cope with the pressures of settlement and the need to care for children and elderly relatives. Community workers report that there are no cultural barriers to using home care services for elderly Eritreans, and whilst carers who spoke the appropriate languages would be preferred, there would generally be no serious objection to carers who did not. Community organisations report that a small number of families already use some home care services, and more would be keen to use them if they knew they existed. Information tends to circulate amongst the Eritrean community via word of mouth, and low literacy levels mean that written information is not widely consulted. Were families informed of home care services on arrival in Australia, and if there were people who spoke community languages who could explain the services to them, it is thought that take up would be higher. Anecdotal evidence also suggests that younger women in the community would be interested in training to be carers.

Social groups and activities are popular amongst the elderly in the community and community workers indicated that more would be welcomed. Transport is often an issue for seniors wishing to attend the existing activity group in Kensington.
1. CIRCUMSTANCES OF DISPLACEMENT

There are estimated to be between 500,000 and 3 million refugees in Egypt from 31 different countries. 75% are Sudanese, 17% Somali and 2% Ethiopian. Some of these populations have been in Egypt for more than 20 years. Egypt is considered a ‘first country of asylum’ from where refugees are resettled to third countries. In 2003 there were only 2000 Egyptians seeking asylum in Western countries (Shafie, 2005). From this data it is reasonable to infer that the majority of Egyptian-born humanitarian entrants to Australia are more than likely to be from other Horn of Africa countries.

The majority of Egyptians in Australia are Coptic Christians who first arrived during the 1960s and 70s as economic migrants. Continuing waves of migrants have since arrived under the family reunion program, largely due to ongoing economic and employment discrimination by the mainstream Muslim population. Muslim Egyptians began arriving in the 1970s but in far smaller numbers (Jupp, 2001).

2. RESETTLEMENT IN AUSTRALIA

The 1901 Census recorded 108 Egypt-born people living in Australia. This number increased to more than 8,000 by 1954, in part due to the unrest that followed Egypt’s independence in 1953. Egyptian migration to Australia continued and by 1996 there were 34,139 Egypt-born people living in Australia. The 1996 Census (ABS, 2000) recorded 11,925 Egypt-born people in Victoria; this figure slightly decreased to 11,629 at the 2001 Census (ABS, 2003), that is about 34.7% of all Egyptian-born living in Australia. As discussed above, this figure represents both Egyptians who have come as economic and skilled migrants, as well as refugees from the Horn of Africa who have come under the Humanitarian program. Figure 9.3.17 shows the Egypt-born humanitarian entrants to Victoria since 1996. Arrivals under the Humanitarian program have increased since 2001, echoing arrival patterns for entrants from Sudan, Somalia, Ethiopia and Eritrea.

Figure 9.3.17 Humanitarian entrants from Egypt (Victoria, 1996-2004): All age groups

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56. DIMIA settlement database
3. MIGRATION CATEGORIES

The migration categories among Egypt-born arrivals to Victoria between 1996 and 2004 are shown in Figure 9.3.18. Twenty eight percent of arrivals came under the Humanitarian Program.

Figure 9.3.18: Migration categories among Egypt-born arrivals to Victoria 1996-2004: All age groups

4. LANGUAGES SPOKEN

The main languages spoken by Egypt-born humanitarian entrants to Victoria between 1996 and 2004 are:

<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arabic</td>
<td>98.3%</td>
</tr>
<tr>
<td>Amharic</td>
<td>0.7%</td>
</tr>
<tr>
<td>Acholi</td>
<td>0.3%</td>
</tr>
<tr>
<td>Somali</td>
<td>0.3%</td>
</tr>
<tr>
<td>Other</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

5. ENGLISH LANGUAGE PROFICIENCY

English proficiency among Egypt-born entrants to Victoria from 1996 to 2004 was categorised within the EP 3 group, that is, between 50% to less than 80% of arrivals spoke good English or English only.

6. AGE AND GENDER PROFILE

The estimated number of Egypt-born people living in Victoria in 2004, their age and gender distribution are shown in Figure 9.3.19. More than 8,000 persons were aged 45 years and over; 4,211 (50.5%) of these were male and 4,121 (49.5%) were female. A high proportion of persons within this age category have lived in Australia for many years and are likely to have arrived under the Family and Skilled migration programs.
7. PLACE OF RESIDENCE

Egypt-born entrants to Victoria between 1996 and 2003 (all age groups) have settled mostly in the LGAs of Greater Dandenong, Brimbank, Casey, Monash and Maribyrnong. Settlement areas of those aged 35 years and over are shown in Table 9.3.20.

Table 9.3.20 1996-2003 Egypt-born arrivals to Victoria aged 35 years and over: Settlement by LGA

<table>
<thead>
<tr>
<th>Local government area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manningham (C)</td>
<td>20</td>
<td>11.6</td>
</tr>
<tr>
<td>Whittlesea</td>
<td>19</td>
<td>11.0</td>
</tr>
<tr>
<td>Greater Dandenong</td>
<td>17</td>
<td>9.8</td>
</tr>
<tr>
<td>Monash</td>
<td>16</td>
<td>9.2</td>
</tr>
<tr>
<td>Moreland</td>
<td>11</td>
<td>6.3</td>
</tr>
<tr>
<td>Casey</td>
<td>10</td>
<td>5.8</td>
</tr>
<tr>
<td>Darebin</td>
<td>9</td>
<td>5.2</td>
</tr>
<tr>
<td>Kingston</td>
<td>9</td>
<td>5.2</td>
</tr>
<tr>
<td>Brimbank</td>
<td>8</td>
<td>4.5</td>
</tr>
<tr>
<td>Hume</td>
<td>7</td>
<td>4.0</td>
</tr>
<tr>
<td>Other</td>
<td>47</td>
<td>27.4</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>173</td>
<td>100.0</td>
</tr>
<tr>
<td>Unknown LGA</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>208</td>
<td></td>
</tr>
</tbody>
</table>

60. Census 2001 (ABS, 2003); DIMIA settlement database
61. At time of entry to Australia
62. DIMIA settlement database
8. THE ELDERLY IN AUSTRALIA

As stated above, the majority of Egyptians over 45 are likely to have come to Australia under the skilled and family migration programs and will not have refugee backgrounds. Whilst they will share many of the characteristics of other non-English speaking migrant communities with regard to access and use of aged care services, they do not fall fully within the scope of this research and are therefore not profiled here in detail. For information regarding refugee seniors from other Horn of Africa communities please see the relevant country sections.
OTHER CENTRAL AND WEST AFRICAN COUNTRIES

1. CIRCUMSTANCES OF DISPLACEMENT AND RESETTLEMENT IN AUSTRALIA

Humanitarian entrants to Australia from Central and West African countries have mainly come from Sierra Leone, Liberia, Burundi, Rwanda and the Democratic Republic of Congo. Civil conflict in each of these countries over the last ten years has displaced many thousands of people. Although the numbers of arrivals are currently very small, humanitarian arrivals from Liberia in particular are expected to increase in the coming years.

Figure 9.3.21 shows the number of humanitarian entrants from this African region to Victoria between 1996 and 2003.

2. MIGRATION CATEGORIES

The migration categories among those born in other Central and West African countries that arrived in Victoria between 1996 and 2003 are shown in Figure 9.3.22. Thirteen percent of arrivals came under the Humanitarian Program. A proportion of those entrants under the other migration categories are likely to have come from refugee backgrounds.

Figure 9.3.22 Migration categories among other Central and West African arrivals to Victoria 1996-2003: All age groups

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63. DIMIA settlement database
64. DIMIA settlement database

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OTHER CENTRAL AND WEST AFRICAN COUNTRIES

3. LANGUAGES SPOKEN

The languages spoken by humanitarian entrants to Victoria from other Central and West African countries between 1996 and 2004 include:

<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>French</td>
<td>60.0%</td>
</tr>
<tr>
<td>Arabic</td>
<td>20.0%</td>
</tr>
<tr>
<td>English</td>
<td>10.0%</td>
</tr>
<tr>
<td>Other</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

4. ENGLISH LANGUAGE PROFICIENCY

English proficiency among entrants to Victoria from other Central and West African countries between 1996 and 2004 was categorised within the EP 2 group, that is, between 80% to less than 98% of arrivals spoke good English or English only.

5. AGE AND GENDER PROFILE

The age and gender distribution of entrants to Victoria from other Central and West African countries between 1996 and 2004 is shown in Figure 9.3.23. Only five people were aged 45 years and over.

![Figure 9.3.23 Age and gender profile of entrants from other Central and West African countries to Victoria (1996-2004)](image)

6. PLACE OF RESIDENCE

Entrants to Victoria from other Central and West African countries between 1996 and 2003 (all age groups) have settled mostly in the LGAs of Darebin, Greater Dandenong, Hobsons Bay, Moonee Valley, Moreland and Brimbank.

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65. DIMIA settlement database
66. Census 2001 (ABS, 2003); DIMIA settlement database
OTHER CENTRAL AND WEST AFRICAN COUNTRIES

7. THE ELDERLY IN AUSTRALIA

As Figure 9.3.23 above shows, there have been no arrivals over the age of 54 since 1996. This may well change when current arrivals begin sponsoring their family members to join them through the family reunification scheme, and in the next ten to twenty years the number of older people from this region will begin to increase as the current population ages. Further research into their health and welfare needs will need to be done within the next ten years.
1. CIRCUMSTANCES OF DISPLACEMENT AND RESETTLEMENT IN AUSTRALIA

Arrivals from the Southern and East African region are likely to have come from Angola in southern Africa, and from refugee camps in countries such as Kenya, Uganda and Tanzania where people escaping conflicts in the Horn of Africa have settled. Figure 9.3.24 shows the number of humanitarian entrants from other Southern and East African countries to Victoria between 1996 and 2003.

Figure 9.3.24 Humanitarian entrants from other Southern and East African countries (Victoria, 1996-2003): All age groups.67

2. MIGRATION CATEGORIES

The migration categories among those born in other Southern and East African countries that arrived in Victoria between 1996 and 2004 are shown in Figure 9.3.25. Eleven percent of arrivals came under the Humanitarian Program. Some of those arriving under the other migration categories are likely to have come from refugee backgrounds.

Figure 9.3.25 Migration categories among other Southern and East African arrivals to Victoria 1996-2004: All age groups.68

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67. DIMIA settlement database
68. DIMIA settlement database
3. **LANGUAGES SPOKEN**

The languages spoken by humanitarian entrants to Victoria from other Southern and East African countries between 1996 and 2004 include:

- Arabic 33.3%
- Portuguese 33.3%
- Somali 13.3%
- Other 20.1%

4. **ENGLISH LANGUAGE PROFICIENCY**

Eighty one percent of humanitarian entrants to Victoria from other Southern and East African countries between 1996 and 2004 were categorised within the English Proficiency group 3 (EP 3), that is, between 50% to less than 80% of arrivals spoke good English or English only. The other 19% of entrants from this region were categorised as EP 2 (between 80% to less than 98% of arrivals spoke good English or English only).

5. **AGE AND GENDER PROFILE**

The age and gender distribution of entrants to Victoria from other Southern and East African countries between 1996 and 2004 are shown in Figure 9.3.26. Twenty people were aged 45 years and over. Of them, 11 (55%) were male and 9 (45%) were female.

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69. DIMIA settlement database

70. Sources: Census 2001 (ABS, 2003); DIMIA settlement database
6. PLACE OF RESIDENCE

Entrants to Victoria from other Southern and East African countries between 1996 and 2003 (all age groups) have settled mostly in the LGAs of Moonee Valley, Maribyrnong, Melbourne, Darebin, Yarra, Casey and Greater Dandenong.

7. THE ELDERLY IN AUSTRALIA

As Figure 9.4.26 shows, the numbers of arrivals over the age of 45 is very low. Unlike younger people from this region who are likely to be Sudanese and Somalis born in East Africa, older people from this group are more likely to have come through the family reunification scheme. Whilst they are currently a small group, they will grow as the younger generations age and their health and welfare needs will need to be researched within the next ten years.
2. ASIA

Figure 9.4  Source countries for Asian humanitarian settlers in Victoria, 1996-2004

- Burma (Myanmar)
- Laos
- Vietnam
- Cambodia
- Indonesia
- East Timor
CHAPTER 9: A PROFILE OF REFUGEE SENIORS IN VICTORIA

1 CIRCUMSTANCES OF DISPLACEMENT

East Timor became a Portuguese colony in 1914, following several years of resistance by the indigenous Timorese population. Despite Portugal’s neutrality during the Second World War, East Timor was invaded by Australian forces, and then invaded and occupied by the Japanese. During the occupation, an estimated 40,000 people were killed, hundreds of women were raped and many more fled the country. At the end of the war, Portugal resumed control of East Timor, but eventually withdrew in 1975. A short civil war between conservative and social democrat supporters destabilised the country and precipitated an Indonesian invasion. The Indonesian forces met with significant resistance from the principle East Timorese independence movement, but by 1976 had complete control of the territory. Opposition movements kept up a guerrilla war against the occupation, to which the Indonesian military responded with force. An estimated 200,000 people died from violence or starvation and thousands more fled the country (Hamilton, 2004).

In 1999 Indonesia was persuaded to allow the Timorese a referendum on independence. Despite a campaign of terror by the Indonesian forces, nearly 85% of the population voted for independence. Instead of bringing peace, the vote provoked a further outbreak of fighting in which most of the country’s public service facilities were destroyed or damaged and two thirds of the population were displaced. The UN took control until 2002 when elections were held, and the leader of the main opposition movement became president (ibid).

2. RESETTLEMENT IN AUSTRALIA

There have been four principle waves of migration to Australia from East Timor. The first occurred in 1943 when 525 people of mixed Portuguese-Timorese descent were evacuated during the Second World War. Many returned at the end of the war. The second significant migration saw 2581 refugees from the elite and middle classes arrive in Australia during the 1975 civil war. The third wave of migration occurred between 1979 and 1986 when thousands fled the violence of the Indonesian invasion. Some came to Australia via West Timor and Portugal. The majority of these arrivals in Australia came under the Special Humanitarian Program. The final wave has migrated since 1990 under the Special Assistance Program or the family reunification stream. Many in this final wave arrived as asylum seekers and had to prove their cases in judicial review. 4000 East Timorese were granted temporary protection in 1999 when fighting broke out after the election, but around half have now returned (Hamilton, 2004).

Separate data on the East Timor-born population only began to be captured in the 2001 Census (ABS, 2003). In that year, Victoria had the largest number of East Timorese living in Australia with 5,034 persons; about 54% of the total population in Australia.
The DIMIA Settlement Database (DIMIA, 2004a) does not record East Timor as a separate entry within the country of birth indicator, which makes it difficult to know the migration category distribution and the number of humanitarian entrants in recent years. Entrants from East Timor before its independence, which was internationally recognised in May 2002, were not recorded as part of the migration categories of Indonesian-born persons. Figure 9.4.1 illustrates the migration categories to Victoria of Indonesian-born persons between 1996 and 2004. During this period, only 43 Indonesia-born persons arrived in Victoria under the Humanitarian program. However, given the historical background, it can be estimated that a high proportion of East Timorese living in Australia are from refugee-like backgrounds.

Figure 9.4.1 Migration categories among Indonesia-born arrivals to Victoria 1996-2004: All age groups

3. LANGUAGES SPOKEN

According to the 2001 Census (ABS, 2003), the main languages spoken at home by East Timor-born people living in Australia were Hakka (42.7%), Portuguese (11.1%), Mandarin (10.6%), and Other (33.6%). The ‘other’ category is likely to include Tetum, regional Timorese languages, and Bahasa Indonesia.

4. ENGLISH LANGUAGE PROFICIENCY

About 92% of the East Timor-born population in Australia in 2001 spoke a language other than English at home. Of these, 63% spoke English very well or well, and 36% spoke English not well or not at all (DIMIA, 2004c). 2001 data suggests that many of those over 50 do not speak any English (Jupp, 2001).

5. AGE AND GENDER PROFILE

Figure 9.4.2 shows the number, age and gender distribution of East Timorese living in Victoria in 2001. In that year there were 1,520 persons aged 45 years and over, with 765 (50.3%) being male and 755 (49.7%) being female.

---

71. DIMIA Settlement Database
6. PLACE OF RESIDENCE

Around 57% of Timorese in Australia live in Victoria. According to information obtained from East Timorese community organisations, the main area of settlement is Richmond, with smaller populations in Brimbank, St Albans, Narre Warren and Epping.

7. CULTURAL CONTEXT

There are two distinct ethnic groups in East Timor; the Hakka Chinese and the indigenous Timorese. The former tended to run businesses and were persecuted as suspected communists by the Indonesians. The majority of the indigenous Timorese in Australia are from the mestizo class of Portuguese-Timorese descent, or were the feudal elite. The groups have remained distinct following migration and have limited interaction with each other due to their markedly different religions, traditions and values. The Timorese are mainly practicing Catholics for whom religion, culture and tradition are closely related. Many converted to Catholicism during the Indonesian occupation as churches offered one of the few places of sanctuary, and refused to come under Indonesian rule. In the Chinese community many of those under 45 do not practice a religion, whilst the older community members tend to be Buddhists, Christians or Taoists. The Timorese tend to have higher incomes than the Chinese and are more likely to own their own homes. The Chinese-Timorese are more likely to work in the manufacturing or retail trades, and have lower incomes. Those from both ethnic groups who arrived before 1991 are more likely to work in the public sector or professions (Jupp, 2001).

---

72. 2001 Census (ABS)
The mestizo Timorese, and especially those who were involved in the fight for independence, maintain a strong interest in events in East Timor. Many do not identify with Australian social and cultural values and see their stay in Australia as temporary. Nevertheless, the mestizo Timorese are more likely to work, mix and marry outside their community. The Chinese, in contrast, tend to see Australia as their future but maintain a very closed community. They do not mix with other Mandarin and Cantonese speaking Chinese groups, and put a lot of energy into bringing family members to Australia (Jupp, 2001).

8. FAMILY ROLES AND STRUCTURE

The ethnic Timorese, having often come from the urban and middle classes are more likely to live in nuclear families than Chinese-Timorese who tend to live with their extended families. Both have strong cultures of family care and respect for their elders, and would consider nursing homes deeply shameful. Some families have not brought their elderly relatives to Australia because they did not want to travel. A grandchild is sometimes left in East Timor to care for them.

The majority of the Timorese community live in Richmond where they have community organisations and access to a health centre with Timorese staff. Some families moved to other suburbs to find employment and took their elderly relatives with them. However, finding themselves cut off from their communities, some of these older people have chosen to move back to Richmond and live alone in housing commission flats.

Family conflict is reported to occur when younger members of the family who have grown up in Australia and only speak English are unable to communicate with their parents and grandparents. Dependence on children for translation has also caused difficulties, and anecdotal evidence gathered from interviews, suggests children are known to exploit their position of power by misinforming parents of their rights in disciplining and punishing them.

9. GENDER SPECIFIC ISSUES

Because women and children often arrived in Australia before male family members, some had to find work. Men sometimes found it difficult to get their qualifications recognised, and ended up in low paid labouring and construction jobs. Employment rates for women are still significantly lower than for men, but higher numbers of women than men now gain tertiary qualifications (Jupp, 2001).

Women are generally expected to be home based and to care for children and the elderly, but the new freedom and equality they feel they have in Australia can cause family conflict and in some cases separation. Interviews with community workers suggest that men often feel Australian law favours women and children, and become very frustrated at what they see as their lack of rights. Middle aged and older men often find adjustment and integration hardest and are worst affected by family breakdown. Single older men are probably the most isolated members of the community.

73. Interview with community worker 01/06/2005
74. Ibid.
75. Ibid.
10. SPECIFIC HEALTH AND WELLBEING ISSUES

Older Timor-born men and women who are still physically active tend to be confident using public transport and happy to use medical services on their own. This degree of independence means they tend to have more contact with medical professionals than younger people, at least until they become too frail and need assistance with transport. However, their lack of English skills means the information they obtain from health providers is often limited, and they may not always disclose symptoms, especially if family members are translating. Community workers describe the need to ensure information is accessible, both in terms of the medium for those who are illiterate, and in terms of vocabulary and dialect, as illnesses often have colloquial names.

Older people living in Richmond are well served by community organisations and social activities, and tend not to suffer from isolation. Those living in other suburbs may be more isolated and may only have social contact through the church, where communication can be difficult if they do not speak English. The elderly may have very little contact with people outside their communities and their understanding of Australian society is likely to be limited.

Many Timor-born elderly, from both Timorese and Chinese backgrounds, have suffered serious and in some cases repeated trauma. They are likely to have lived through three or four wars and at least two invasions. Women in East-Timor during the Japanese occupation were sometimes taken as ‘comfort women’ by the army and repeatedly raped. Men and women are both likely to have witnessed or been victims of violence. Mental health problems are particularly prevalent among those more recent arrivals who came as asylum seekers and had to validate their experiences to the immigration authorities. According to community health workers, depression, psychosis, and levels of attempted suicide are high among this group. Guilt at having left family and friends in East-Timor is also reported, but is combined with relief at having escaped. Shame and embarrassment at admitting to mental health problems means many older people are reluctant to seek help, and a lack of understanding among mental health professionals means many find counselling services unsatisfactory.

Smoking related illnesses are high among men, and the elderly are reported to generally suffer high levels of diabetes, cholesterol and asthma. High blood pressure and sleep disorders are a problem for many people during the asylum claim process, but these symptoms tend to subside when visas are granted.

11. BELIEFS AND NORMS REGARDING HEALTH CARE AND SUPPORT FOR SENIORS

According to community workers, very few Timor-born elders use aged care services, as to do so would raise questions regarding their families’ ability and inclination to care for them. Older people would also be uncomfortable with care given by strangers, especially if they did not speak the same language. There are reported cases of families who need extra help caring for their elderly, enlisting young unemployed men from within the community who claim carers’ allowances. These carers cook, clean and oversee medication for the elderly.

76. Ibid.
77. Ibid.
If they live with children who work full time, the elderly are generally not expected to care for grandchildren, but may help by taking them to kindergarten or school.
CHAPTER 9: A PROFILE OF REFUGEE SENIORS IN VICTORIA

1. CIRCUMSTANCES OF DISPLACEMENT

Vietnam was colonized by France in the mid 19th Century and occupied by Japan during the Second World War. Rule passed back to France in 1945, but resistance to French control caused the first Indo-China war. France was defeated and withdrew in 1954 leaving the country to be divided into a communist north supported by China and the Soviet Union, and a Western-backed south. Following the partition, an estimated 1 million people, including many thousands of Catholics, moved south to escape communist rule (Jupp, 2001).

Tensions between the two parts of the country soon escalated, and war between them broke out in 1957. Foreign forces including the United States, Australia and New Zealand, supported the south against northern forces and opposition guerrillas in the south. 10 million people in the south were displaced and around 2 million were killed in brutal aerial and ground attacks, and by chemical weapons and mines (ibid).

The US withdrew in 1973 and by 1975 Saigon fell to the communists. There was chaos as southerners scrambled to leave the country, and the presence of newly installed communist regimes in neighbouring Laos and Cambodia meant many chose to leave by boat. 140,000 southerners were evacuated by the Americans whilst thousands more went by sea to Thailand, Hong Kong, Singapore and the Philippines. By the end of 1978 more than 62,000 “boat people” had fled to camps in southeast Asia from where they were resettled to third countries. As more and more “boat people” kept arriving into 1979, the countries where they landed began turning them back and many thousands died at sea. Resettlement countries agreed to issue more refugee visas and well into the 1980s several thousand Vietnamese a year were still fleeing Vietnam by sea (ibid).

2. RESETTLEMENT IN AUSTRALIA

There have been three main waves of migration to Australia from Vietnam. The first began in 1975 and comprised mostly educated and urban professionals. The second wave arrived after 1978 and were escaping the Communist regime. Many of these were the “boat people” who undertook long and treacherous journeys by sea and came via refugee camps in southeast Asia. The third and most recent wave have arrived since 1992 and are mostly relatives of existing migrants who have come through the family reunification program (Jupp, 2001).

Prior to 1975, about 700 Vietnamese were living in Australia. By 1981, 49,616 had been resettled in Australia; this figure increased to 121,637 in 1991. The 1996 Census recorded 54,956 Vietnam-born people in Victoria; by 2001 there were 56,577 Vietnamese living in the State (about 37% of all Vietnam-born persons in Australia). Figure 9.4.3 shows the Vietnam-born humanitarian entrants to Victoria since 1996. The number of arrivals under the humanitarian program has decreased considerably over the last 5 years.
3. MIGRATION CATEGORIES

The migration categories among Vietnam-born arrivals to Victoria between 1996 and 2004 are shown in Figure 9.4.4. About 75% of arrivals came under the family reunion stream and only 9% entered Australia under the Humanitarian category. Many of those arriving under the family program were likely to have come from refugee backgrounds.

4. LANGUAGES SPOKEN

The main languages spoken by Vietnam-born humanitarian entrants to Victoria between 1996 and 2004 include:

<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vietnamese</td>
<td>96.1%</td>
</tr>
<tr>
<td>Chinese (not further defined)</td>
<td>2.0%</td>
</tr>
<tr>
<td>Cantonese</td>
<td>1.5%</td>
</tr>
<tr>
<td>Other</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

78. DIMIA settlement database
79. DIMIA settlement database
5. **ENGLISH LANGUAGE PROFICIENCY**

English proficiency among Vietnam-born entrants to Victoria from 1996 to 2004 was categorised within the EP 4 group, that is, less than 50% of arrivals spoke good English or English only\(^8^0\).

6. **AGE AND GENDER PROFILE**

The estimated number of Vietnamese-born people living in Victoria at 2004, their age and gender distribution are shown in Figure 9.4.5. Over 16,000 people were aged 45 years and over. Of them, 8,758 (52.6%) were females and 7,898 (47.4%) were males.

Figure 9.4.5 Estimated Vietnam-born population in Victoria at 2004: Age and gender profile\(^8^1\)

7. **PLACE OF RESIDENCE**

Vietnam-born entrants to Victoria between 1996 and 2003 (all age groups) have settled mostly in the LGAs of Brimbank, Greater Dandenong, Maribyrnong, Darebin and Yarra. The settlement areas of those aged 35 years and over are shown in Table 9.4.6.

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80. DIMIA settlement database
81. Census 2001 (ABS, 2003); DIMIA settlement database
Table 9.4.6 1996-2003 Vietnam-born arrivals to Victoria aged 35 years and over\(^82\): Settlement by LGA\(^83\)

<table>
<thead>
<tr>
<th>Local government area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brimbank</td>
<td>283</td>
<td>23.5</td>
</tr>
<tr>
<td>Greater Dandenong</td>
<td>255</td>
<td>21.2</td>
</tr>
<tr>
<td>Maribyrnong</td>
<td>183</td>
<td>15.2</td>
</tr>
<tr>
<td>Yarra</td>
<td>106</td>
<td>8.8</td>
</tr>
<tr>
<td>Moonee Valley</td>
<td>50</td>
<td>4.2</td>
</tr>
<tr>
<td>Darebin</td>
<td>49</td>
<td>4.1</td>
</tr>
<tr>
<td>Hobsons Bay</td>
<td>30</td>
<td>2.5</td>
</tr>
<tr>
<td>Whitehorse</td>
<td>29</td>
<td>2.4</td>
</tr>
<tr>
<td>Moreland</td>
<td>24</td>
<td>2.0</td>
</tr>
<tr>
<td>Whittlesea</td>
<td>24</td>
<td>2.0</td>
</tr>
<tr>
<td>Other</td>
<td>170</td>
<td>14.1</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>1203</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Unknown LGA</td>
<td>114</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1317</strong></td>
<td></td>
</tr>
</tbody>
</table>

8. CULTURAL CONTEXT

The Vietnamese community are a large and heterogeneous group whose socioeconomic status and level of interaction with Australian society will vary according to the length of time since they arrived and their background prior to arrival. Those from urban and educated backgrounds who arrived prior to 1978 have often found employment in the professional or public sectors, are well integrated with Australian society and financially secure. In contrast those who arrived post 1978 tended to be from poorer backgrounds, were less educated and have thus found it harder to secure employment in Australia. Language barriers have also meant that many people from this group of arrivals are unemployed or work in low skilled and low paid jobs (Jupp, 2001).

The Vietnamese community in Australia is made up of both ethnic Chinese and ethnic Vietnamese, as well as Hmong and Khmer minorities. The groups generally mix well and come together to celebrate festivals, participate in fundraising for the community and have joint community organisations (Thomas & Belnaves, 1993). The majority are Buddhists, although a significant minority (20–30%) are Catholics.

Compared to other refugee communities, a significant amount of research has been done on the impact of migration on older Vietnamese refugees. For this reason, and because they are relatively well served by community organisations in Victoria, this profile provides only a brief overview of the issues.

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82. At time of entry to Australia
83. Source: DIMIA settlement database
9. FAMILY ROLES AND STRUCTURE

The family unit is considered of central importance in Vietnamese society and extended families will ideally live together. Families are headed by men, and sons are expected to care for their parents in old age. Elders are traditionally respected in Vietnamese culture and grandfathers make decisions for the family and resolve family conflicts (Kemp and Rasbridge, 2004).

Elderly relatives are often brought over to join their families in Australia and tend to have high expectations for their family reunion and quality of life. They can be disappointed when they discover that their children and grandchildren have lost some of their traditional practices and values, and may not give them the respect they feel they deserve. Communication may also be difficult if grandchildren who have been educated in Australia no longer speak Vietnamese, and can lead to feelings of isolation and alienation. Open family conflict is often avoided but intergenerational tensions are known to occur (Phung, 1993). Family conflict can cause families to break up and older people may prefer to live away from their children.

Community workers report that older men tend to cope with migration better than younger men, as they do not expect to find work and are happier to spend their time socialising. Younger men also find it difficult if their wives work and learn English faster than them as they feel their authority is undermined.

Pressure to support family members who have come through the family reunification program often puts financial stress on families who may already be struggling to find work. Many families are also expected to send money back to relatives in Vietnam (Jupp, 2001).

10. GENDER SPECIFIC ISSUES

Vietnamese women are generally expected to stay at home once they have had children, and following migration, risk becoming very isolated if they do not have a chance to learn English. Older women tend to be more confined to the house than older men (Australian Centre for International and Tropical Health University of Queensland, Undated-c).

Domestic violence is a recognized problem in some sections of the community and is often exacerbated by poverty and the pressures of resettlement (ibid).

11. SPECIFIC HEALTH AND WELLBEING ISSUES

Vietnamese elders are at risk of social isolation and mental health problems as a consequence of their perceived loss of status and respect within the family and their low levels of English (Australian Centre for International and Tropical Health University of Queensland, Undated-c). This is often compounded by their dependence on their children and grandchildren for financial support, translation, transportation, and interpretation of their new environment. Evidence gathered at interview suggests that many older Vietnamese rarely leave their neighbourhood and often have very little contact outside of their family and immediate community.
Community workers report anecdotal evidence of elder abuse among the Vietnamese community in Melbourne, and general unhappiness among many seniors who live with their families. Housing limitations mean that although many would wish to move out of the family home, they are often unable to, and remain very isolated and vulnerable to mental health problems.

Mental health is of particular concern among those who fought in the Vietnam war, but because mental illness is generally considered shameful it is rarely discussed within the family or community, and therefore rarely treated. Psychological symptoms are most likely to be manifested as physical symptoms such as abdominal pains and headaches (Australian Centre for International and Tropical Health University of Queensland, Undated-c).

Community workers report that many older Vietnamese who have come to Melbourne to be with their families often find it difficult to cope with the cold weather and, if they can afford it, will go back to Vietnam for the winter.

A significant amount of research has been done on the health and wellbeing needs of older Vietnamese refugees by Trang Thomas, Gayle Watson, and Z.D. Steel et al. (For more details, see the bibliography at the end of this report.)

12. BELIEFS AND NORMS REGARDING THE HEALTH AND SUPPORT FOR SENIORS

Whilst the expectation is that older people should be cared for at home, there is acceptance in the Vietnamese community of the need for nursing homes and other forms of non-familial care, provided they are staffed by people who speak Vietnamese (Thomas & Belnaves, 1993). Evidence gathered from interviews also suggests that some older Vietnamese do not expect government care and believe they have received enough government services already.

Research findings suggest that social contact with people from a similar background is one of the most important factors for Vietnamese seniors in relieving mental health problems caused by isolation and family conflict (Thomas, 1999b). The number of senior citizens’ groups for the Vietnamese in Victoria (see Appendix 2) suggests that they are popular, although transport is reported to be a barrier to use in some areas. Community workers report that older people will often only use services if they are recommended by friends and if they know that there are other Vietnamese already using them.

In treating illness, older Vietnamese from rural backgrounds may prefer to use traditional medicines before visiting a western doctor. When they do seek medical help, most older people prefer to see doctors who speak Vietnamese (Thomas & Belnaves, 1993).
CHAPTER 9: A PROFILE OF REFUGEE SENIORS IN VICTORIA

1. CIRCUMSTANCES OF DISPLACEMENT

Burma gained independence from Britain in 1947, when the popular general Aung San came to power. Ethnic and religious tensions arose and in 1962 the socialist General Ne Win seized power in a military coup. The country went into rapid economic decline and when students protested against the government in 1987, 3000 were killed. Another coup in 1988 brought the military to power in the form of the State Law and Order Restoration Council (SLORC) who promised elections but imposed a state of emergency and martial law. The opposition movement, the National League for Democracy, formed behind General Aung San’s daughter, Aung San Suu Kyi, who was put under house arrest. When the NLD won 82% of seats in the election, the SLORC refused to recognise the result and imprisoned opposition MPs. Since 1988 the government has restricted free speech and freedom of the press, and has continually persecuted opposition leaders and members of Burma’s numerous ethnic minorities. In 1997 the SLORC reformed as the State Peace and Development Council but the violence only intensified with minority groups targeted in arbitrary executions, rape, torture, forced labour and displacement (Hynes, 2005).

Minority groups make up at least one third of the population and occupy half the land mass. 80% live in rural villages where less than 20% of children complete four years of primary education (Lingam, 2003). Under current government law, they are not allowed to teach their languages and are encouraged to identify themselves only as Burmese. Christians and Muslims are also persecuted by the state. Muslims are not recognised as citizens and cannot build or repair mosques, and Christians, who make up 10% of the population, are subject to restrictions and harassment. Minority resistance armies including the Karen National Union (KNU) and the Shan State Army – South (SSA – South) are engaged in various conflicts with the government. Government forces use the relocation of minority civilian populations as a way of undermining the opposition, and an estimated 1 million people are thought to have been internally displaced. Relocations are often brutal and involve burning villages and religious buildings, mass killings and rape. Living conditions in the relocation sites are generally poor, with little or no shelter, food or medical care. People are often beaten and have to undertake forced labour in the army as fighters or porters (Hynes, 2005).

Political prisoners are routinely held without trial, tortured and killed, and international organisations are not allowed into the country to assess prison conditions. Forced labour is common for women, children and the elderly, and is imposed with threats of violence (Human Rights Watch, 2003).
Several hundred thousand refugees have left Burma since 1988. The majority of Shan, Karenni, Karen and Mon minorities have fled to Thailand despite the very poor conditions in the camps along the border. 67% of refugees in these camps are women and children. The Shan are not recognised as refugees by the Thai government and are not allowed to seek protection in the camps. They tend to work in low paid jobs in factories, the construction industry, domestic work and the sex industry. The Thai government has attempted to repatriate Burmese refugees including women, children and the elderly. Large numbers of refugees have also fled to poorly serviced and restrictive camps in Bangladesh, and the Bangladeshi government has attempted to return them. Refugees in India tend to be treated more sympathetically and generally live in urban areas rather than camps (Hynes, 2005).

2. RESETTLEMENT IN AUSTRALIA

Interruption between the British and Burmese during the British colonisation of Burma in the 19th century resulted in an Anglo-Burmese population. Following Burmese independence in 1948, about 3,500 Anglo-Burmese migrated to Australia. Between 1965 and 1972 and following the 1962 coup, about 2,500 Anglo-Burmese settled in Australia. The Burmese community in Australia has continued growing over the past 30 years due to systematic human rights violations by the Burmese military regime and the consequent intake of Burmese nationals under the Special Humanitarian Program (DIMIA, 2003a).

About 18% of the 1,559 Burmese who have resettled in Australia since 1996, have come to Victoria. The 1996 census reported 1,000 Burma-born persons living in Victoria. This figure increased to 1,178 at the 2001 Census.

The number of Burmese-born humanitarian arrivals to Victoria since 1996 is shown in Figure 9.4.7

Figure 9.4.7 Victorian humanitarian entrants from Burma 1996-2004: All age groups

85. DIMIA Settlement Database
3. MIGRATION CATEGORIES

About 60% of all Burma-born arrivals to Victoria since 1996 came under the Humanitarian Program (Figure 9.4.8).

Figure 9.4.8 Migration categories among Burma-born arrivals to Victoria 1996-2004: All age groups

4. LANGUAGES SPOKEN

The main languages spoken by Burmese-born humanitarian entrants to Victoria between 1996 and 2004 are:

<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burmese</td>
<td>92.8%</td>
</tr>
<tr>
<td>Chinese (nfd)</td>
<td>3.0%</td>
</tr>
<tr>
<td>English</td>
<td>2.4%</td>
</tr>
<tr>
<td>Thai</td>
<td>1.2%</td>
</tr>
<tr>
<td>Burman (nfd)</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

5. ENGLISH LANGUAGE PROFICIENCY

Between 50% to less than 80% of Burmese-born humanitarian entrants to Victoria since 1996 spoke good English at time of entry to Australia (EP 3 group).

6. AGE AND GENDER PROFILE

Figure 9.4.9 illustrates the estimated number, age and gender distribution of Burmese-born people living in Victoria at 2004. Six hundred and three persons were aged 45 years and over, 345 (57.2%) being male, and 258 (42.8%) being female.

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86. DIMIA Settlement Database
87. DIMIA Settlement Database
7. PLACE OF RESIDENCE

In Victoria, arrivals from Burma (Myanmar) between 1996 and 2003 have settled mainly in the Local Government Areas (LGAs) of Greater Dandenong, Hobsons Bay, Maribyrnong, Monash, Whitehorse and Wyndham. Table 9.4.10 shows the Victorian LGA settlement areas of Burmese-born persons aged 35 years and from 1996 to 2003.

Table 9.4.10 1996-2003 Burma-born arrivals to Victoria aged 35 years and over: Settlement by LGA

<table>
<thead>
<tr>
<th>Local government area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hobsons Bay (C)</td>
<td>20</td>
<td>27.0</td>
</tr>
<tr>
<td>Greater Dandenong (C)</td>
<td>18</td>
<td>24.3</td>
</tr>
<tr>
<td>Maribyrnong (C)</td>
<td>5</td>
<td>6.7</td>
</tr>
<tr>
<td>Monash (C)</td>
<td>5</td>
<td>6.7</td>
</tr>
<tr>
<td>Moreland (C)</td>
<td>4</td>
<td>5.4</td>
</tr>
<tr>
<td>Banyule</td>
<td>3</td>
<td>4.0</td>
</tr>
<tr>
<td>Hume</td>
<td>3</td>
<td>4.0</td>
</tr>
<tr>
<td>Knox</td>
<td>3</td>
<td>4.0</td>
</tr>
<tr>
<td>Whitehorse</td>
<td>3</td>
<td>4.0</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>13.9</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>74</td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Unknown LGA</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>75</td>
<td></td>
</tr>
</tbody>
</table>

88. Includes all migration categories; sources: 2001 Census (ABS), DIMIA Settlement Database
89. At time of entry to Australia
90. DIMIA Settlement Database
CHAPTER 9: A PROFILE OF REFUGEE SENIORS IN VICTORIA

BURMA (MYANMAR)

8. CULTURAL CONTEXT

Almost 90% of Burmese are Theravada Buddhists with most of the other 10% made up of Muslims and Christians. Relations between Christian and Buddhist communities are good and the two mix socially and intermarry. Marriages are often arranged, although some young Burmese in Australia will choose spouses recommended by their families in Burma and return to marry them. Muslim communities tend to remain separate from other religious groups and marry within their own communities (Kemp and Rasbridge, 2004).

The Burmese community in Australia is divided along ethnic lines with groups only coming together for specific religious or cultural events. Since 1988 the Burmese government are known to have sent spies to report on democratic movements outside the country. This has created suspicion among the Burmese community further deepening the ethnic divisions. Involvement in Burmese politics remains important for refugees in Australia with some taking the opportunity to speak out against their government. Being a known critic of the government makes it impossible to obtain a visa to visit Burma.91

9. FAMILY ROLES AND STRUCTURE

Different ethnic groups have different family and social structures, but extended families are generally the norm. This changes with migration when families are broken up, although if family members are sponsored to come to Australia, families prefer to live together, even if conditions are cramped.

Women are generally expected to remain in the home, especially when children are young or older relatives need care. Financial pressures on families in Australia mean women sometimes do casual work from home, and are more likely to work once children are in school. Men wield financial power within the home, but decisions regarding children and the family tend to be taken jointly.92 Most Burmese who came to Australia as refugees were men who had fled to camps on the Thai-Burma border. On arrival in Australia they sponsored their families to join them. Couples who met during the conflict in Burma, were separated and have since been reunited in Australia, sometimes struggle to maintain their marriages and keep their families together. Intergenerational conflicts are reported to occur between children who have grown up in Australia and their parents and grandparents, especially when they adopt dress and hair styles which their parents consider indecent or strange. Children who do not use the correct terms of address for their elder relatives also cause offence for failing to show respect.93

In Buddhist tradition, parents are one of the “five objects of worship” and are considered sacred. Disobedience to a parent is sin. Elders are traditionally treated with respect and are responsible for resolving family disputes (Kemp and Rasbridge, 2004).

91. Interview with Burmese Community Member, June 2005
92. Ibid.
93. Ibid.
10. GENDER SPECIFIC ISSUES

Men who have fled the conflict in Burma are reported to sometimes feel guilty for having abandoned the cause, and experience a loss of identity. In addition, men have often found it difficult to find work and have taken low paid manual and factory jobs. Their sense of having lost their role and status is sometimes compensated for by a withdrawal from the family and community into alcohol, drugs and gambling, which in some cases leads to family break up (Lingam, 2003).

Women often suffer grief at the loss of their extended family and can become very isolated in their homes. Many have little if any education, and due to their domestic duties have little opportunity to learn English or seek employment (ibid).

11. SPECIFIC HEALTH AND WELLBEING ISSUES

One of the four Buddhist Noble Truths is that all sentient beings suffer and that illness and suffering are an inescapable part of life, especially in old age. Illness is sometimes considered an imbalance and is treated with changes in diet or with herbal cures, but western medicine is generally preferred (Kemp and Rasbridge, 2004).

Mental health is not openly discussed and admitting the need for psychological help brings shame to the individual and their family. Mental illness is sometimes believed to be a result of conduct in a previous life, although drug and alcohol use in the refugee camps is also considered a cause of on-going mental health problems after arrival in Australia. Younger people who were involved in the conflict after 1988 and spent time in the refugee camps are considered more likely to suffer from trauma related illnesses than older members of the community who arrived through the family reunification stream. Lingam notes that there is no word for ‘counselling’ in Burmese and the concept is regarded with mistrust (Lingam, 2003).

Older Burmese who are physically able, are generally happy using public transport in order to visit friends and attend social gatherings. They meet in each others’ homes, or at temples and churches and, according to community interviews, tend to be socially well connected.

12. BELIEFS AND NORMS REGARDING HEALTH CARE AND SUPPORT FOR SENIORS

Refugees from the ethnic minorities in rural Burma will have little or no experience of health and welfare services and thus, little understanding of how or when to access them. Those who are familiar with services may be hesitant to enquire about accessing them because of suspicions around Burmese community associations and a reluctance to use Burmese interpreters for fear they are spying for the government or would pass information to other community members (Lingam, 2003).
Families consider it their duty to care for their elderly and view nursing homes as a disrespectful way of treating one’s family. However, community members report that care in the home would not attract such stigma, particularly if families were struggling under financial pressures. Carers of the same sex would be preferred, but there may be some reservations about using interpreters for reasons explained above.\textsuperscript{94}

When looking for information regarding services, families are likely to approach Centrelink or a Migrant Resource Centre. Information on life in Australia is also gained from Burmese language radio programs broadcast twice weekly.
1. CIRCUMSTANCES OF DISPLACEMENT

Cambodia was part of French Indo-China until it gained independence in 1954. A communist resistance movement was repressed until the 1960s when the Maoist extremist group the Khmer Rouge, began an armed uprising. A brutal struggle ensued until 1970 when a military coup brought a right wing government to power. The Khmer Rouge, under the leadership of Pol Pot, stepped up their struggle and following five years of brutal conflict, overthrew the government. They immediately began persecuting all opposition, including teachers, monks, and anyone considered ‘corrupted by capitalism’. All schools and universities were closed and people living in cities were moved to agricultural communes where they were forced into hard manual labour. Families were broken up according to labour needs, and thousands died from overwork, starvation and disease. By the time the Khmer Rouge were overthrown by the Vietnamese army in 1979, over 1.5 million people, 21% of the population, had been murdered or had died from starvation and disease. Hundreds of thousands were internally displaced. Over 200,000 refugees fled to camps in Thailand, Laos and Vietnam during the Khmer Rouge era, with more fleeing to Thailand following the Vietnamese invasion. At an international conference in July 1979 it was decided that 452,000 Cambodian refugees from the Thai camps should be resettled in third countries including Australia, Canada and the US. 1980 saw another 300,000 Cambodian refugees arrive in Thailand. They were held in border camps and were denied third country resettlement (Kemp and Rasbridge, 2004).

When the Khmer Rouge was overthrown in 1979, many of their forces fled to the refugee camps on the Thai border from where they fought a resistance war against the Vietnamese. This inevitably caused violence within the camps, where victims of the Khmer Rouge were already sheltering. The camps also became targets for the Vietnamese army and between 1982 and 1985 more than 95 camps had to be evacuated. When Vietnamese troops withdrew from Cambodia in 1989, the civil war escalated, causing yet more displacement and death. A peace agreement was finally signed in 1991 when the UN took over interim control until elections in 1993. Part of the UN’s mission in restoring peace, was to ensure the safe return of refugees and between 1992 and 1993 more than 360,000 refugees from the camps in Thailand returned home (UNHCR, 2000).

2. RESETTLEMENT IN AUSTRALIA

Before the 1970s only a very small number of Cambodians migrated to Australia. Following the takeover of Cambodia by the Khmer Rouge in 1975 the number of arrivals increased rapidly, and between April 1975 and June 1986, 12,813 Cambodians came to Australia under the Refugee and Special Humanitarian Program. Between 1989 and 1991 about 315 asylum-seekers from Cambodia arrived by boat. Subsequently, the Special Assistance Category program was introduced by the Australian Government to encourage these asylum seekers to return to Cambodia and apply for Australian visas under normal migration procedures. As a result, the number of the Cambodia-born population in Australia has increased under the Family migration stream since the 1990s (DIMIA, 2003b).
Of the 3,190 Cambodians who have resettled in Australia since 1996, 42% have come to Victoria. The numbers of Cambodia-born people in Victoria increased from 8,193 in 1996 (ABS, 2000) to 9,022 in 2001 (ABS, 2003).

Very few Cambodians have arrived in Victoria under the Humanitarian program since 1997 (Figure 9.4.11).

Figure 9.4.11 Victorian humanitarian entrants from Cambodia 1996-2004: All age groups

3. MIGRATION CATEGORIES

As shown in Figure 9.4.12, 80% of all Cambodia-born arrivals to Victoria between 1996 and 2004 came under the Family migration stream, and only 8% did so under the Humanitarian Program. It is estimated that many of those who arrived within the Family category were also likely to have had refugee-like experiences.

Figure 9.4.12 Migration categories among Cambodia-born arrivals to Victoria 1996-2004: All age groups

95. DIMIA Settlement Database
96. DIMIA Settlement Database
4. LANGUAGES SPOKEN

All Cambodia-born humanitarian entrants to Victoria since 1996 spoke Khmer/Cambodian\(^\text{97}\), although a significant number of ethnic Chinese Cambodians in Australia also speak Mandarin.

5. ENGLISH LANGUAGE PROFICIENCY

Cambodian arrivals to Victoria under the Humanitarian program since 1996 have been categorised within the EP 4 group, that is, less than 50% of arrivals spoke good English or English only, at time of entry to Australia.

6. AGE AND GENDER PROFILE

The estimated number of Cambodia-born persons living in Victoria in 2004 and their age and gender distribution are shown in Figure 9.4.13. Of the 2,717 persons aged 45 years and over, 1,418 (52.2%) were female and 1,299 (47.8%) were male.

![Figure 9.4.13](image)

7. PLACE OF RESIDENCE

Cambodia-born arrivals to Victoria between 1996 and 2003 have settled mainly in the LGAs of Greater Dandenong, Kingston, Casey, Whitehorse and Monash. Table 9.4.14 shows the LGA settlement areas of Cambodia-born persons aged 35 years and over.

---

97. DIMIA Settlement Database
98. Includes all migration categories; sources: 2001 Census (ABS) and DIMIA Settlement Database
Table 9.4.14 1996-2003 Cambodia-born arrivals to Victoria aged 35 years and over\(^99\): Settlement by LGA\(^{100}\)

<table>
<thead>
<tr>
<th>Local government area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Dandenong (C)</td>
<td>163</td>
<td>64.2</td>
</tr>
<tr>
<td>Kingston (C)</td>
<td>22</td>
<td>8.7</td>
</tr>
<tr>
<td>Whitehorse (C)</td>
<td>15</td>
<td>5.9</td>
</tr>
<tr>
<td>Monash (C)</td>
<td>6</td>
<td>2.3</td>
</tr>
<tr>
<td>Glen Eira (C)</td>
<td>5</td>
<td>1.9</td>
</tr>
<tr>
<td>Hobsons Bay (C)</td>
<td>5</td>
<td>1.9</td>
</tr>
<tr>
<td>Maribyrnong (C)</td>
<td>5</td>
<td>1.9</td>
</tr>
<tr>
<td>Other</td>
<td>33</td>
<td>13.2</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>254</td>
<td>100.0</td>
</tr>
<tr>
<td>Unknown LGA</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>276</td>
<td></td>
</tr>
</tbody>
</table>

8. CULTURAL CONTEXT

The majority of older Cambodians currently living in Australia arrived as refugees in the 1970s and 80s when they were in their 40s and 50s. Most had fled the Khmer Rouge regime and spent several years in refugee camps (Jupp, 2001). These refugees were a mixture of ethnic Chinese Cambodians and Khmer Cambodians. The ethnic Chinese usually speak Mandarin and tend to be Christian, whilst the ethnic Khmers are usually Buddhist and speak Khmer. These categorisations are not strict, as some Buddhists are known to have converted to Christianity, either because of their experiences under the Khmer Rouge, or because many of the agencies working in the refugee camps were associated with churches (Kemp and Rasbridge, 2004).

The Khmer Cambodians are likely to have come from rural backgrounds and tend to be more conservative in their observance of cultural and religious practices. Ethnic Chinese Cambodians are more likely to have come from urban backgrounds and are often more familiar and comfortable with metropolitan life. Because they speak Mandarin, the ethnic Chinese also have more opportunities to interact with other communities and find it easier to access information\(^{101}\).

The Cambodian community in Victoria is divided along political lines that reflect Cambodian and Australian politics. Community members from higher class backgrounds tend to be more politically active. Divisions also occur between those who have been in Australia for 20 or more years and who are familiar with Western customs and values, and those who arrived more recently and have more traditional outlooks\(^{102}\).

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\(^{99}\) At time of entry to Australia  
\(^{100}\) DIMIA Settlement Database  
\(^{101}\) Interview with VFST worker, 24/05/05  
\(^{102}\) Ibid.
9. FAMILY ROLES AND STRUCTURE

The traditional extended family structure of Cambodian society was partly broken down by family separation during the rule of the Khmer Rouge. Smaller family units came to Australia as refugees and remain the norm, although they may contain three generations (Jupp, 2001).

The elderly are traditionally treated with a great deal of respect and are responsible for passing on cultural practices. In Cambodian society, older people tend to spend most of their time at the temple and may regard any other activities, such as socialising, as a waste of important time. Evidence from interviews suggests that older people’s role as cultural guardians has been undermined by the experience of resettlement as their knowledge and experience is no longer regarded as relevant or useful to younger generations. This sense of uselessness is further enforced by the fact that many older Cambodians have little if any English and are therefore dependent on their children and grandchildren for any contact outside the family. The economic pressures on families which require both parents to work, also mean that older family members have had to take on childcare duties for their grandchildren.

According to community workers, family breakdown was a problem when the Cambodian community arrived in Australia because of the pressures on the second generation. This age group, the children of the refugees who arrived in the 1970s and 80s, were under a lot of pressure to learn English and interpret the Australian system for their parents, whilst at the same time maintaining and observing the traditions of Cambodian culture. Daughters in particular, who are traditionally very protected by the family, felt the contrast of being in an environment where young women had more freedom. These women are now the generation caring for their elderly parents and past conflicts can affect this relationship of duty and care.

10. GENDER SPECIFIC ISSUES

Cambodian culture emphasises the separation of the public and the private. Men traditionally head the household and are responsible for contact with the external world whilst women and girls are expected to remain in the home. These roles have been challenged by resettlement. Professional men who have found it difficult to get suitable work have found the loss of status particularly hard. Women are generally considered to have found the transition easier, as they have continued to fulfill their domestic roles and have benefited from greater freedom outside the home. Women are still expected to be the principle carers for children and the elderly within the family.

11. SPECIFIC HEALTH AND WELLBEING ISSUES

Anecdotal evidence suggests that Ethnic Chinese Cambodians and Khmer Cambodians differ in their level of interaction with social and community services. Community workers interviewed, noted that elderly Chinese

103. Interview with community worker 30/05/05
104. Interview with VFST worker, 24/05/05
105. Ibid.
Cambodians were more likely to attend senior citizens groups and activities for the elderly, than Khmer Cambodians. The former tend to use services for Chinese communities as they can communicate in Mandarin, whereas the latter cannot access these services and will often only leave home to go to the temple. Isolation is therefore a much bigger problem for elderly Khmer Cambodians. Elderly Cambodians also tend to be dependent on their children for transport as they cannot drive and are reluctant to use public transport because they lack English skills.

Older Cambodians who lived through the Khmer Rouge era are more than likely to have suffered trauma and to have ongoing mental health problems as a result. Combined with social isolation and a sense of having lost their role in the family, older Cambodians report feeling “discarded” and “useless”. Although there may be a reluctance to admit it, depression and other mental health problems are likely to be common, particularly among the Khmer elderly. Diabetes and high blood pressure are reported to be common among the Cambodian elderly, although these conditions are not always understood or recognised.

12. BELIEFS AND NORMS REGARDING HEALTH CARE AND SUPPORT FOR SENIORS

The importance of privacy in Cambodian culture, combined with the respect that is given to the elderly, means external help in the home would generally be unwelcome and would be seen to demonstrate a failure on the part of the family. Communication difficulties also make external help unpopular. There is evidence of carers from within the community being used, but without great success (see Case Study E).

Buddhist traditions in Cambodian culture influence attitudes toward illness. An acceptance of suffering, particularly in old age, means people do not readily seek help and are not always interested in resolving medical issues. A reluctance to express negative feelings can also cause misdiagnosis (Kemp and Rasbridge, 2004). For Buddhists, physical health is related to spiritual wellbeing and people will often use healing practices that combine the medicinal and the spiritual before seeking professional help. Evidence gathered from interviews suggests that medical instructions are often not followed, either because of communication difficulties or because the practices of western medicine are not well understood.

Language barriers and a general isolation from Australian society, means most families would have little knowledge or understanding of available services. Many Cambodians rely on community organisations for help with everything from migration advice to family counselling, and would be unlikely to approach service providers directly.

106. Interview with community worker 30/05/05
107. Interview with community worker, 30/05/05
13. HACC FUNDING FOR CAMBODIAN ETHNO-SPECIFIC AGENCIES

One Cambodian organisation in Greater Dandenong receives HACC funding for social support services. Two Indo-Chinese organisations also get HACC funding. However, Cambodian community workers point out that Cambodians are generally reluctant to access services that are not Cambodian specific for cultural and linguistic reasons.

**CASE STUDY D  Unsatisfactory Care**

A Cambodian woman who had 4 young children and was caring for her elderly mother who had had a stroke, was sent a Cambodian respite carer from an agency. However, the carer did not seem to be properly trained and brought her young son with her to the house. She spent most of her time looking after her son, and not caring for the elderly woman. She even forgot to feed the elderly woman when the family went out. The daughter did not know what she could do about it and went to a community centre for advice.
1. CIRCUMSTANCES OF DISPLACEMENT

Laos became part of French Indo-China in 1893. It was occupied by Japan during the second world war, but became the independent Kingdom of Lao in 1949. The Vietnam war sparked a civil war in Laos between the communists and the US-backed opposition (Kemp and Rasbridge, 2004). The Hmong, a highland minority, had helped the US war effort and lost 20,000 soldiers and 50,000 civilians. When the war ended in 1975 with the victory of the Communist Pathet Lao movement, many Laotians who had fought against the communists and the Hmong in particular, fled for fear of retribution or detention in ‘re-education’ camps. Others fled the loss of political and economic freedom under the communists, and the fear of conscription into the Lao army. Most went to Thailand where they were settled in refugee camps, awaiting resettlement in third countries. Conditions in the camps were poor and food supplies low. Between 1975 and 1995 thousands of Laotians from these camps were resettled in Europe, north America, Australia and New Zealand (UNHCR, 2000).

2. RESETTLEMENT IN AUSTRALIA

The majority of the Laotian community in Australia arrived in the late 1970s and early 1980s during and after the Indo-Chinese conflict and the invasion by communist forces who took over Laos, Cambodia and Vietnam. Between 1975 and 1995 an estimated 13,543 refugees from Laos were resettled in Australia (UNHCR, 2000). The 2001 Census recorded 2,010 Laos-born persons in Victoria, a decrease of 8% from the 1996 Census (2,184 persons). The 2001 distribution by State and Territory showed that 21.1% of all Laos-born in Australia were living in Victoria. There were no Laos-born humanitarian entrants to Victoria between 1996 and 2004 (DIMIA, 2004a)

3. MIGRATION CATEGORIES

The migration categories among Laos-born arrivals to Victoria between 1996 and 2004 are shown in Figure 9.4.15. More than 90% of entrants came under the Family stream. A significant proportion of these arrivals will have had refugee-like experiences.

Figure 9.4.15 Migration categories among Laos-born arrivals to Victoria 1996-2004: All age groups

108. DIMIA settlement database
4. **LANGUAGES SPOKEN**

According to the 2001 Census, the main languages spoken by Laos-born people in Australia were (DIMIA, 2004b):

<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lao</td>
<td>67.6%</td>
</tr>
<tr>
<td>Mandarin</td>
<td>6.8%</td>
</tr>
<tr>
<td>English</td>
<td>6.5%</td>
</tr>
<tr>
<td>Other</td>
<td>19.1%</td>
</tr>
</tbody>
</table>

5. **ENGLISH LANGUAGE PROFICIENCY**

At 2001, 63.3% of Laos-born people who spoke a language other than English at home, reported speaking English very well or well, while 35.1% spoke English not well or not at all (DIMIA, 2004b).

6. **AGE AND GENDER PROFILE**

Many refugees who came to Australia in the 1970s and 80s arrived in their 20s and are now in their 40s and 50s. Many have since sponsored their parents and other relatives to come to Australia under the family reunification scheme. The estimated number of Laos-born people living in Victoria at 2003, their age and gender distribution are shown in Figure 9.4.16. An estimated 652 Laos-born people were aged 45 years and over, with 343 (52.6%) being male and 309 (47.4%) being female. There is no data available on 2004 arrivals from Laos.

Figure 9.4.16 Estimated Laos-born population in Victoria at 2003: Age and gender profile

7. **PLACE OF RESIDENCE**

The small number of Laos-born arrivals to Victoria – aged 35 and over – between 1996 and 2003 settled in the LGAs of Greater Dandenong, Brimbank, Knox and Moonee Valley.
8. CULTURAL CONTEXT

Refugees from Laos came from a wide range of backgrounds and ethnic groups. The population is largely made up of the Lowland Lao from the Mekong river valley, and Lao Theung, including the Hmong, from the mountainous regions in the north. Within these groupings, the community structure is based on clan lines, with different groups having differing linguistic characteristics and cultural practices. There is also a great deal of variance in the socio-economic background of Laotian refugees, with those from rural areas, including the Hmong, tending to have low levels of education whilst those from urban areas are likely to have been educated professionals or business people. Following arrival in Australia, many Laotians, including those with professional skills and qualifications, found it difficult to find employment, partly because their qualifications were not recognised and partly because of language difficulties. Many worked in unskilled manual labouring or clerical jobs. Younger generations who have been educated in Australia are changing this balance and entering business and the professions (Jupp, 2001).

The majority of Lao refugees practice Theravada Buddhism combined with Brahmanism and a set of practices know as the ‘cult of Phi’ or spirits (Jupp, 2001). Ceremonies related to the cult of Phi are an important part of Lao community life, and are respected by individuals who have converted to other religions (Wang, 1997).

9. FAMILY ROLES AND STRUCTURE

Migration through the family reunification scheme has led to community clustering along family lines, with large extended families often living together (Jupp, 2001). Elderly relatives traditionally live with their sons, although pressure for space means this is not always the case in Australia. Elders are traditionally held in high regard and expect a significant degree of respect and authority within the family (Kemp and Rasbridge, 2004). Their status is often undermined following migration due to their dependence on their children for translation and transportation, and their lack of understanding of Australian society. Anecdotal evidence suggests that this dependence combined with changing attitudes among younger generations, can cause a lot of family conflict and unhappiness for older Laotians. Many older people can also become isolated, especially if their children are working and they are left at home alone or caring for their grandchildren.¹¹⁰

Family privacy is considered important and anecdotal evidence suggests that breaches of it are taken very seriously.

10. GENDER SPECIFIC ISSUES

Older men traditionally head Laotian families and, according to evidence gathered from interviews, many found the loss of status following migration difficult to cope with. It is likely that in the older age groups there will be more women than men, in part due to the numbers of men who died during the war.

¹¹⁰ Interview with Laotian community worker, 26/05/05
11. SPECIFIC HEALTH AND WELLBEING ISSUES

Community workers report a high incidence of strokes among all age groups in the Laotian community leading to significant numbers requiring ongoing care. Among the elderly, stress and depression are also reported, as a result of loss of status and disappointment regarding family levels of care and respect. Professional help is rarely sought for mental health problems as family privacy and dignity are considered to be at stake\(^\text{111}\).

12. BELIEFS AND NORMS REGARDING HEALTH CARE AND SUPPORT FOR SENIORS

Physical and spiritual health are considered to be very closely related in traditional Laotian culture. Older people may prefer to use traditional healing methods and defer seeking medical help until absolutely necessary (Kemp and Rasbridge, 2004).

According to community workers, there is a degree of suspicion of outsiders coming into the home to assist with care, as it is feared they may be checking on a family’s own ability to care, or that they may steal money. Carers who do not speak the client’s language are also treated with mistrust and are reported to have been turned away. There are reported to be 4 or 5 Laotians in Melbourne who are working as nurses and one GP in Flemington\(^\text{112}\).

Limited language and literacy skills make it difficult for many elderly people to find out about services, and their dependence on their children for transport means they are often unable to travel to attend aged specific facilities and activities. In common with the Cambodian community, many Laotians do not use Vietnamese ‘Indo-Chinese’ associations due to language and cultural differences\(^\text{113}\).

\(^{111}\) Ibid.
\(^{112}\) Ibid.
\(^{113}\) Ibid.
Figure 9.5  Source countries for European humanitarian settlers in Victoria, 1996 – 2004
1. CIRCUMSTANCES OF DISPLACEMENT

The Federative People’s Republic of Yugoslavia was created at the end of the Second World War. It was a socialist state comprised of six former republics and from 1953 until his death in 1980, was ruled by President Tito. Following Tito’s death, tensions between the various ethnic groups grew, and in 1991 the republics of Slovenia, Croatia, Macedonia, and Bosnia Herzegovina started breaking away. The initial Yugoslav wars in the early 1990s saw the separation of Slovenia, Croatia, and Bosnia-Herzegovina in a series of bloody conflicts that left many thousands of civilians dead and thousands more displaced. Between 1996 and 2001, Kosovo and Macedonia also broke away, leaving just Serbia and Montenegro to form the Federal Republic of Yugoslavia, which in 2002 was reformed and renamed Serbia and Montenegro (MRCNE, Undated).

For details of the circumstances of migration for each of the states from which refugees have come to Australia, see the relevant sections below.

2. RESETTLEMENT IN AUSTRALIA

Separate data on the individual republics that were once part of the Socialist Federal Republic of Yugoslavia before its dissolution after the 1991 civil war, began to be captured in the 1996 Australian Census. However, some people still felt inclined to answer that they were ‘Yugoslavia-born’. The 1996 Census recorded 19,716 Former Yugoslavia nfdf114-born people in Victoria. Although the 2001 Census did not list ‘Former Yugoslavia nfdf’ as a ‘country of birth’ response category, this option is still included in DIMIA’s Settlement Database (DIMIA, 2004a). This group may include Serbs, Croats, Bosnians, Slovenians and Macedonians. Figure 9.5.1 shows the Former Yugoslavia-born humanitarian entrants to Victoria since 1996.

Figure 9.5.1 Humanitarian entrants from Former Yugoslavia nfdf (Victoria, 1996-2004): All age groups115.

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114. Not further defined
115. Source: DIMIA settlement database
CHAPTER 9: A PROFILE OF REFUGEE SENIORS IN VICTORIA

FORMER YUGOSLAVIA (not further defined)

3. MIGRATION CATEGORIES

The migration categories among Former Yugoslavia-born arrivals to Victoria between 1996 and 2004 are shown in Figure 9.5.2. About three quarters of all arrivals came under the Humanitarian Program.

Figure 9.5.2 Migration categories among Former Yugoslavia nfld-born arrivals to Victoria 1996-2004: All age groups

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humanitarian</td>
<td>2507</td>
<td>73%</td>
</tr>
<tr>
<td>Family</td>
<td>569</td>
<td>17%</td>
</tr>
<tr>
<td>Skill</td>
<td>162</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>186</td>
<td>5%</td>
</tr>
</tbody>
</table>

4. LANGUAGES SPOKEN

The languages spoken by Former Yugoslavia-born humanitarian entrants to Victoria between 1996 and 2004 included:

- Bosnian 61.3%
- Serbian 17.5%
- Croatian 10.1%
- Albanian 6.0%
- Serbo-Croatian 1.9%
- Other 3.2%

5. ENGLISH LANGUAGE PROFICIENCY

Between 50% to less than 80% of arrivals to Victoria from the Former Yugoslavia since 1996 spoke good English or English only (EP 3 index).

6. AGE AND GENDER PROFILE

Lack of data on Former Yugoslavia nfld-born at the 2001 Census makes it difficult to estimate the total current population. Figure 9.5.3 shows the number, age and gender profile of Former Yugoslavia nfld-born arrivals to Victoria since 1996. Seven hundred and forty eight of these arrivals were aged 45 years and over at the time of entry to Australia. Of them, 412 (55%) were female and 336 (45%) were male.

116. DIMIA settlement database
117. DIMIA settlement database
FORMER YUGOSLAVIA (not further defined)

Figure 9.5.3 Former Yugoslavia nfd-born arrivals to Victoria 1996-2004 (all migration categories): Age and gender profile

<table>
<thead>
<tr>
<th>Age groups (yrs)</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 24</td>
<td>1746</td>
<td>935</td>
<td>885</td>
</tr>
<tr>
<td>25 - 34</td>
<td>935</td>
<td>428</td>
<td>1363</td>
</tr>
<tr>
<td>35 - 44</td>
<td>885</td>
<td>59</td>
<td>944</td>
</tr>
<tr>
<td>45 - 54</td>
<td>428</td>
<td>114</td>
<td>542</td>
</tr>
<tr>
<td>55 - 64</td>
<td>206</td>
<td>114</td>
<td>320</td>
</tr>
<tr>
<td>65+</td>
<td>114</td>
<td></td>
<td>114</td>
</tr>
</tbody>
</table>

7. PLACE OF RESIDENCE

Former Yugoslavia nfd-born entrants to Victoria between 1996 and 2003 (all age groups) have settled mostly in the LGAs of Greater Dandenong, Brimbank, Greater Geelong, Darebin and Casey. The settlement areas of those aged 35 years and over are shown in Table 9.5.4.

Table 9.5.4 1996-2003 Former Yugoslavia nfd-born arrivals to Victoria aged 35 years and over: Settlement by LGA

<table>
<thead>
<tr>
<th>Local government area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Dandenong</td>
<td>452</td>
<td>29.8</td>
</tr>
<tr>
<td>Brimbank</td>
<td>292</td>
<td>19.2</td>
</tr>
<tr>
<td>Greater Geelong</td>
<td>68</td>
<td>4.5</td>
</tr>
<tr>
<td>Darebin</td>
<td>61</td>
<td>4.0</td>
</tr>
<tr>
<td>Maribyrnong</td>
<td>59</td>
<td>3.9</td>
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<tr>
<td>Casey</td>
<td>58</td>
<td>3.8</td>
</tr>
<tr>
<td>Frankston</td>
<td>55</td>
<td>3.6</td>
</tr>
<tr>
<td>Moreland</td>
<td>44</td>
<td>2.9</td>
</tr>
<tr>
<td>Hume</td>
<td>43</td>
<td>2.8</td>
</tr>
<tr>
<td>Whittlesea</td>
<td>37</td>
<td>2.4</td>
</tr>
<tr>
<td>Other</td>
<td>348</td>
<td>23.1</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
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</tr>
<tr>
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<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1578</strong></td>
<td></td>
</tr>
</tbody>
</table>

118. Source: DIMIA settlement database
119. At time of entry to Australia
8. SENIORS IN AUSTRALIA

A majority of the refugees who have arrived in Australia since 1996 and who identify themselves as coming from the Former Yugoslavia are likely to be from Bosnia-Herzegovina and Croatia, or Albanians from Macedonia and Kosovo. For details of the issues affecting seniors in each of these communities, see the relevant sections below.
1. CIRCUMSTANCES OF DISPLACEMENT

Bosnia became part of the ‘Kingdom of Serbs, Croats and Slovenes’ (later called Yugoslavia) after World War I. It was the only republic based on geographical and historical boundaries, rather than ethnic identity and was the most ethnically mixed of all the former Yugoslav republics. The three main ethnic groups were Muslims (44%), Serbs (31%) and Croats (17%). Bosnia was occupied by the Germans during World War II, after which it became a part of Tito’s communist Yugoslavia and enjoyed a period of relative calm and prosperity until the 1980s (Maners, 1995).

In 1992, the war that had begun when Croatia and Slovenia declared independence, spilled over when Bosnia-Herzegovina followed suit and declared independence in March. The Serbian government vowed to fight to defend the Serb population and by the end of April 1992, 95% of Muslims and Croats in the main towns in the east of the country had been forced to flee their homes. By mid-June, Serb forces controlled almost two thirds of Bosnia and over a million people had been displaced. A process of ‘ethnic-cleansing’ saw thousands of Muslim and Croat men rounded up in detention camps and killed. In July 1995 a further 70,000 mainly Muslim men and boys were killed when the so called ‘safe haven’ of Srebrenica was over-run by the Serb army. Fighting between Muslims and Croats caused further displacement and by the time the war ended in 1995 over 2.2 million people were either internally displaced or living as refugees in neighbouring countries (UNHCR, 2000).

2. RESETTLEMENT IN AUSTRALIA

Before 1991, Bosnian migration to Australia was small, but during and following the civil war a significant number of Bosnia-Herzegovina-born refugees came to Australia under the Humanitarian Program. Numbers have tailed off since the end of the war as refugees in the surrounding countries are encouraged to return home.

Of the 6,090 Bosnians who have resettled in Australia since 1996, 34% have come to Victoria (DIMIA, 2004a). At the 2001 Census, 36% of all Bosnia-Herzegovina-born persons in Australia were living in Victoria. The number of Bosnians living in Victoria increased from 4,668 persons in 1996 to 8,598 in 2001. The number of humanitarian entrants substantially decreased after 1997-98 (Figure 9.5.5).
Figure 9.5.5 Victorian humanitarian entrants from Bosnia-Herzegovina 1996-2004: All age groups

3. MIGRATION CATEGORIES

Over 90% of Bosnia-Herzegovina-born arrivals to Victoria between 1996 and 2004 came under the Humanitarian Program (Figure 9.5.6). Many of those who arrived under the Family migration category were also likely to have had refugee-like experiences during the civil war.

Figure 9.5.6 Migration categories among Bosnia-Herzegovina-born arrivals to Victoria 1996-2004: All age groups

123. DIMIA Settlement Database
124. DIMIA Settlement Database
4. LANGUAGES SPOKEN

The main languages spoken by humanitarian entrants from Bosnia-Herzegovina settling in Victoria from 1996 to 2004 include:

<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serbian</td>
<td>56.9%</td>
</tr>
<tr>
<td>Bosnian*</td>
<td>32.5%</td>
</tr>
<tr>
<td>Croatian</td>
<td>4.4%</td>
</tr>
<tr>
<td>Serbo-Croatian</td>
<td>3.9%</td>
</tr>
<tr>
<td>English</td>
<td>1.0%</td>
</tr>
<tr>
<td>Others</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

* Bosnian has only been recognised as a distinct language since the end of the war. Prior to this it was regarded as another dialect of Serbo-Croatian and although the two are similar, it is important for reasons of cultural sensitivity that they are seen to be distinct (MRCNE, Undated).

5. ENGLISH LANGUAGE PROFICIENCY

Humanitarian arrivals from Bosnia-Herzegovina to Victoria have been categorised within the EP 3 group. In other words, between 50% to less than 80% of entrants spoke good English.

6. AGE AND GENDER PROFILE

Figure 9.5.7 shows the estimated number, age and gender profile of Bosnia-Herzegovina-born people living in Victoria at 2004. The number of people aged 45 years and above was 2,903 (32.8%). Of these, 1,527 (52.6%) were male and 1,376 (47.4%) were female.

Figure 9.5.7 Bosnia-Herzegovina-born population in Victoria at 2004: Age and gender profile.

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125. DIMIA Settlement Database
126. DIMIA Settlement Database
127. Includes all migration categories; Sources: 2001 Census (ABS), DIMIA Settlement Database.
CHAPTER 9: A PROFILE OF REFUGEE SENIORS IN VICTORIA

7. PLACE OF RESIDENCE

In Victoria, arrivals from Bosnia-Herzegovina between 1996 and 2003 (all age groups) have settled mainly in the Local Government Areas (LGAs) of Greater Dandenong, Brimbank, Darebin, Casey, and Maribyrnong. Table 9.5.8 shows the LGA settlement areas of Bosnia-Herzegovina-born persons aged 35 years and over.

Table 9.5.8 1996-2003 Bosnia-Herzegovina-born arrivals to Victoria aged 35 years and over: Settlement by LGA

<table>
<thead>
<tr>
<th>Local government area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Dandenong (C)</td>
<td>344</td>
<td>32.1</td>
</tr>
<tr>
<td>Brimbank (C)</td>
<td>173</td>
<td>16.2</td>
</tr>
<tr>
<td>Darebin (C)</td>
<td>77</td>
<td>7.2</td>
</tr>
<tr>
<td>Maribyrnong (C)</td>
<td>56</td>
<td>5.2</td>
</tr>
<tr>
<td>Casey (C)</td>
<td>52</td>
<td>4.9</td>
</tr>
<tr>
<td>Greater Geelong (C)</td>
<td>38</td>
<td>3.6</td>
</tr>
<tr>
<td>Hobsons Bay (C)</td>
<td>37</td>
<td>3.5</td>
</tr>
<tr>
<td>Moonee Valley (C)</td>
<td>30</td>
<td>2.8</td>
</tr>
<tr>
<td>Moreland (C)</td>
<td>29</td>
<td>2.7</td>
</tr>
<tr>
<td>Frankston (C)</td>
<td>21</td>
<td>2.0</td>
</tr>
<tr>
<td>Hume (C)</td>
<td>21</td>
<td>2.0</td>
</tr>
<tr>
<td>Kingston (C)</td>
<td>21</td>
<td>2.0</td>
</tr>
<tr>
<td>Others</td>
<td>171</td>
<td>15.8</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>1070</td>
<td>100.0</td>
</tr>
<tr>
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<td>11</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1081</td>
<td></td>
</tr>
</tbody>
</table>

8. CULTURAL CONTEXT

Before the war, villages and towns in Bosnia-Herzegovina were relatively ethnically mixed and inter-marriage between ethnic groups was common. However, divisions created during the war led to neighbours and friends turning against each other and consequently caused a severe break-down in trust between the ethnic groups (Maners, 1995). Bosnian communities in Australia tend to be divided along ethnic lines and families from mixed marriages may find it difficult to socialise within ethnically exclusive community groups (Jupp, 2001).

The majority of refugees arriving in Australia from Bosnia-Herzegovina are Muslims, although there is a significant proportion of Serbian Orthodox Christians, Croatian Catholics and people of no stated faith. Most Bosnian Muslims lived in cities before the war and were generally relaxed in their observance of Islamic clothing and dietary laws. In Australia, community activities tend to be based around religious organisations although there are secular sports and social clubs (ibid).
Many Bosnians who came to Victoria settled in the outer suburbs of Melbourne near to other migrants from the Former Yugoslavia. Although well-educated, many spoke little or no English and could only find low-skilled employment in the manufacturing and construction industries (ibid.).

9. FAMILY ROLES AND STRUCTURE

The majority of Bosnian arrivals in Australia are nuclear families or couples and their elderly relatives. For those who came from urban areas these family structures will be familiar, whilst those from rural backgrounds may miss the practical and social support of their extended families (Jupp, 2001).

Older people are traditionally highly respected in Bosnian society, and live with their sons and daughters-in-law. Daughters-in-law are generally expected to care for and respect their husbands’ parents. Migration has often altered the balance of this relationship as older people, who lack English language skills, have become dependent on their children for communication outside the home. Fear of getting lost and of being outside the home alone, are also likely to make older Bosnians reluctant to use public transport and therefore more reliant on younger members of their family. This dependency and the consequent loss of status is reported to have the affect of making some older people feel useless and a burden on their families129.

10. GENDER SPECIFIC ISSUES

Many Bosnian women who have come to Australia lost their male relatives during the war, and young families who arrived as refugees have often brought their older female relatives with them. For those families who have survived intact, the war experience has led to an increase in domestic violence and many couples suffer marital problems, leading to separation (Australian Centre for International and Tropical Health, Undated-a).

Men whose qualifications are not recognised in Australia or who are unable to find work because of their standard of English, are reported to often suffer from depression and in some cases alcoholism. Family break-up can leave both men and women socially and emotionally isolated.

11. SPECIFIC HEALTH AND WELLBEING ISSUES

Bosnia had a fairly well developed public health system before the war with an emphasis on primary care. Refugees will be familiar with western medical practices and common illnesses such as diabetes and heart conditions.

There is reported to be a high incidence of post-traumatic stress disorder (PTSD) in the Bosnian refugee community, which is often aggravated by the stresses of forced migration and resettlement. However, there is a stigma attached to mental illness, and a general mistrust of therapy (Mackling and Kemp, 2004). Patients suffering mental health problems may prefer to present

129. Interview with VFST worker, 10/05/05
with physical symptoms, or may have difficulties explaining their symptoms due to a lack of English language skills. Bosnian men and women tend to visit doctors more often than the general population (Australian Centre for International and Tropical Health, Undated-a) although anecdotal evidence suggests that older people suffering from their war-time experiences can become seriously depressed and may feel there is no point seeking treatment. Many Bosnian refugees have seen members of their families tortured or killed and may still suffer grief and survivor guilt. Those who were not able to trace family members after the war, may suffer on-going anxiety and stress from the uncertainty and grief of never knowing what happened.

Because of the high levels of mental health problems and the reluctance to treat them, alcohol abuse is not uncommon within the community, particularly among men. Many men also smoke and tend to take little exercise (Mackling and Kemp, 2004).

There is reported to be a higher than usual incidence of tuberculosis among those who came from refugee camps. Dental health is also often poor and tooth decay common (Australian Centre for International and Tropical Health, Undated-a).

12. BELIEFS AND NORMS REGARDING HEALTH CARE AND SUPPORT FOR SENIORS

It is generally expected that families will care for older adults within the home and residential care tends to be viewed with disdain. However, the expectation of family care can be hard to fulfill when adult children are working.

Home care services are often refused by older Bosnians who view them as an acknowledgement of family failure and individual mental decline. Community workers report that maintaining domestic and family roles can be very important for older people in helping to retain a sense of identity and normality.

Anecdotal evidence suggests that encounters with service providers are often frustrating for older Bosnians who feel their experiences are not understood and respected. One unsuccessful experience with a service can put people off using them again.

CASE STUDY E

A ruined life

A Bosnian woman in her 60s lost her husband and son in the massacre at Srebrenica and feels guilty that she has survived. She lives with her daughter and son-in-law in Melbourne. She suffers from a degenerative eye condition and a heart condition that has led to two heart operations. She visits her Bosnian doctor regularly, but when she was offered an assessment for her eye condition and was given the chance of having someone read to her, she rejected both.

She suffers from depression and “saw it as her lot that her life had been ruined”. She can’t see the point of improving her life and is often “full of despair”. Physical suffering doesn’t matter so much to her, and she regrets coming to Australia because life isn’t what she had imagined for her old age. She also feels she is a burden on her family.

130. Ibid.
1. CIRCUMSTANCES OF DISPLACEMENT

Croatia was part of the Austro-Hungarian empire until its collapse in 1918 when it became a part of the Kingdom of Serbs, Croats and Slovenes, later named Yugoslavia. With the help of Italy, Croatia became semi-autonomous from Yugoslavia in 1939, and fully independent when Germany invaded Yugoslavia in 1941. During the Second World War, Croatia was under the military control of Germany and Italy, and several hundred thousand people were killed in concentration camps (Jupp, 2001).

At the end of the war, Croatia was reincorporated into Yugoslavia. When it eventually declared independence in 1991, Serb forces reacted by taking an area of North East Croatia and ‘ethnically cleansing’ it of the Croat population. Croatia was accepted into the European Union in 1992, and in 1995 attacked and regained most of its Serb held territory, displacing the Serbs who had settled there. Croatia supported Bosnia in its war for independence in 1995 and played a role in negotiating the Bosnian peace agreement.

Many Croats who have come to Australia as refugees since 1995 are from Bosnia-Herzegovina where they made up 17% of the population before the 1995 war. Croats and Muslims were both persecuted by the Serbs who rounded them into detention camps and killed thousands of men and boys. (See the Bosnia-Herzegovina profile above for more details).

2. RESETTLEMENT IN AUSTRALIA

Croatian migration to Australia began in the 19th century. By 1933, about 2,800 Yugoslavia-born people were living in Australia, many of them Croats. After World War II, the Yugoslavia-born population in Australia increased from 5,888 in 1947 to 22,856 in 1954. Many arrived under the Displaced Persons Scheme and a significant proportion spoke Croatian. Over the next two decades, the number of Yugoslavia-born (including Croatian) arrivals continued to increase, in part due to an economic crisis in the former Yugoslavia. From 1961 to 1976, almost 100,000 Yugoslavia-born persons migrated to Australia after the Government of Yugoslavia allowed their citizens to seek employment abroad. Many of these settlers were Croats (Jupp, 2001).

The 1991 Census listed 160,479 Yugoslavia-born people in Australia. Since the civil war that began in the former Socialist Federal Republic of Yugoslavia (SFRY) in 1992, about 30,000 Yugoslavia-born persons have arrived in Australia, most of them under the Humanitarian program. Many of these arrivals were Croats from Bosnia-Herzegovina and Croats are now the largest ethnic group from the former Yugoslavia living in Australia.

Separate data on the Croatian-born population only began to be captured in the 1996 Census. That year, 17,527 Croats were living in Victoria (ABS, 2000). It is likely that the number of Croats was somewhat understated, as some still felt inclined to report that they were Yugoslavia-born. Of the 5,761 Croats that have resettled in Australia since 1996, 22% have come to Victoria (DIMIA, 2004a). By 2001, the number of Croatia-born people living in Victoria increased to 18,943 (ABS, 2003).
Figure 9.5.9 shows the number of Croatia-born arrivals to Victoria under the Humanitarian program since 1996. The numbers have gradually decreased since 2001.

Figure 9.5.9 Victorian humanitarian entrants from Croatia 1996-2004: All age groups

3. Migration Categories

The number of entrants to Victoria between 1996 and 2004 by migration category is shown in Figure 9.5.10. Almost 90% of arrivals came under the Humanitarian Program.

Figure 9.5.10 Migration categories among Croatia-born arrivals to Victoria 1996-2004: All age groups

131. DIMIA Settlement Database
4. LANGUAGES SPOKEN

The main languages spoken by Croatia-born humanitarian entrants to Victoria since 1996 are:

- Serbian 62.2%
- Croatian 27.6%
- Serbo Croatian 5.3%
- Bosnian 2.2%
- Other 2.7%

The ‘other’ category includes English, Romanian and Former Yugoslav Language not further defined.

5. ENGLISH LANGUAGE PROFICIENCY

According to DIMIA Settlement Database (DIMIA, 2004a), between 50% to less than 80% of Croatian-born humanitarian entrants to Victoria spoke good English or only English at time of entry (EP 3 index).

6. AGE AND GENDER PROFILE

Figure 9.5.11 illustrates the estimated number, age and gender distribution of Croatia-born people living in Victoria at 2004. An estimated 13,125 persons were aged 45 years and over. Of them, 6,805 (51.8%) were male and 6,320 (48.2%) were female.

7. PLACE OF RESIDENCE

In Victoria, arrivals from Croatia between 1996 and 2003 have settled mainly in the Local Government Areas (LGAs) of Greater Dandenong, Greater Geelong, Brimbank, Casey and Maribyrnong. The Victorian LGA settlement areas of Croatia-born persons aged 35 years and over are shown in Table 9.5.12.
Table 9.5.12  1996-2003 Croatia-born arrivals to Victoria aged 35 years and over: Settlement by LGA

<table>
<thead>
<tr>
<th>Local government area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Dandenong (C)</td>
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</tr>
<tr>
<td>Brimbank (C)</td>
<td>92</td>
<td>16.3</td>
</tr>
<tr>
<td>Greater Geelong (C)</td>
<td>66</td>
<td>11.7</td>
</tr>
<tr>
<td>Casey (C)</td>
<td>39</td>
<td>6.9</td>
</tr>
<tr>
<td>Maribyrnong (C)</td>
<td>25</td>
<td>4.5</td>
</tr>
<tr>
<td>Hobsons Bay (C)</td>
<td>21</td>
<td>3.7</td>
</tr>
<tr>
<td>Darebin (C)</td>
<td>18</td>
<td>3.2</td>
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<tr>
<td>Moreland (C)</td>
<td>13</td>
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<td>Whittlesea (C)</td>
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<td>1.9</td>
</tr>
<tr>
<td>Other</td>
<td>73</td>
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<td><strong>Subtotal</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>575</td>
<td></td>
</tr>
</tbody>
</table>

8. THE CROATIAN ELDERLY IN AUSTRALIA

Significant numbers of the elderly Croatian refugees who have arrived in Victoria since 1996 will have come from Bosnia-Herzegovina (see above) and will suffer many of the same mental and physical health issues as Bosnians.

The already established Croatian community in Victoria offers a range of ethno-specific services which new arrivals can make use of and from whom they can get information and advice. Two ethno-specific Croatian organisations in Maribyrnong and Greater Dandenong currently receive HACC funding for social support activities and for work aimed at improving local government responsiveness to community needs. The community is also well served by a large number of senior citizens’ clubs across Victoria (see Appendix 2).
1. **Circumstances of Displacement and Resettlement in Australia**

Migration to Australia from the ‘Kingdom of Serbs, Croats and Slovenes’, later called Yugoslavia, has had a long history, with four main waves of resettlement (DIMIA, 2003c). The period prior to 1948 saw the first wave of 11,000 arrivals, mostly Croats (80%), some Macedonians (8%) and Serbs (8%). Following the Second World War in the period between 1948 and 1960, about 25,000 Yugoslavs (mainly Croats and an increasing number of Serbs and Slovenes) arrived in Australia as displaced persons followed by several thousands who came either as refugees or sponsored by relatives in Australia. In the third wave, from 1960 to 1990, migration took place mainly for economic reasons and the majority of arrivals in this period were Macedonians. The fourth wave of migration followed the 1991 civil wars in which the Republics of Slovenia, Croatia, Bosnia and Macedonia broke away, leaving only Serbia and Montenegro in the new Federal Republic of Yugoslavia.


2. **Migration Categories**

The migration categories among arrivals to Victoria from the Federal Republic of Yugoslavia between 1996 and 2004 are shown in Figure 9.5.14. About 20% of all arrivals came under the Humanitarian Program.

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132. DIMIA Settlement Database

* The Federal Republic of Yugoslavia comprises the former Yugoslav states of Serbia and Montenegro.
CHAPTER 9: A PROFILE OF REFUGEE SENIORS IN VICTORIA

FEDERAL REPUBLIC OF YUGOSLAVIA

3. LANGUAGES SPOKEN

The main languages spoken by Federal Republic of Yugoslavia-born humanitarian entrants to Victoria between 1996 and 2004 were:

- Serbian 48.1%
- Albanian 45.5%
- Bosnian 1.3%
- Croatian 1.3%
- Other 3.8%

4. ENGLISH LANGUAGE PROFICIENCY

English proficiency among humanitarian entrants to Victoria from the Federal Republic of Yugoslavia between 1996 and 2004 was categorised within the EP 3 group, that is, between 50% to less than 80% of arrivals spoke good English or English only.

5. AGE AND GENDER PROFILE

The estimated number of Federal Republic of Yugoslavia-born people living in Victoria at 2004, their age and gender distribution are shown in Figure 9.5.15. An estimated 11,739 people were aged 45 years and over, with 6,017 (51.3%) being male and 5,722 (48.7%) being female.
6. PLACE OF RESIDENCE

Entrants from the Federal Republic of Yugoslavia to Victoria between 1996 and 2003 (all age groups) have settled mostly in the LGAs of Greater Dandenong, Brimbank, Darebin, Greater Geelong and Casey. The settlement areas of those aged 35 years and over are shown in Table 9.5.16.

Table 9.5.16 1996-2003 Federal Republic of Yugoslavia-born arrivals to Victoria aged 35 years and over: Settlement by LGA

<table>
<thead>
<tr>
<th>Local government area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Dandenong</td>
<td>30</td>
<td>21.6</td>
</tr>
<tr>
<td>Brimbank</td>
<td>17</td>
<td>12.2</td>
</tr>
<tr>
<td>Casey</td>
<td>10</td>
<td>7.2</td>
</tr>
<tr>
<td>Darebin</td>
<td>10</td>
<td>7.2</td>
</tr>
<tr>
<td>Greater Geelong</td>
<td>7</td>
<td>5.0</td>
</tr>
<tr>
<td>Port Phillip</td>
<td>7</td>
<td>5.0</td>
</tr>
<tr>
<td>Maribyrnong</td>
<td>6</td>
<td>4.3</td>
</tr>
<tr>
<td>Hobsons Bay</td>
<td>5</td>
<td>3.7</td>
</tr>
<tr>
<td>Monash</td>
<td>5</td>
<td>3.7</td>
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<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>142</td>
<td></td>
</tr>
</tbody>
</table>

136. Census 2001 (ABS, 2003); DIMIA Settlement Database
137. At time of entry to Australia
138. DIMIA settlement database
7. The Elderly in Australia

Whilst there are large numbers of people from the Federal Republic of Yugoslavia in Australia, some of whom will have had refugee-like experiences, the vast majority came before the civil wars as economic migrants in the post-Second World War period and thus do not come under the scope of this research. These communities now have high numbers of seniors who, because of the length of time they have been here, and because of their relative wealth, are well served by community seniors organisations and HACC funded ethno-specific agencies (Appendix 2).
Figure 9.6 Source countries for Middle Eastern Humanitarian settlers in Victoria 1996-2004
CHAPTER 9: A PROFILE OF REFUGEE SENIORS IN VICTORIA

1. CIRCUMSTANCES OF DISPLACEMENT

Iraq gained independence from Britain in 1932. In 1933 a small Assyrian Christian revolt was violently crushed, setting a precedent for future minority uprisings. Shortly after independence, the Kurds in northern Iraq also began their fight for autonomy, provoking several decades of violent repression by the central government. In 1958 Iraq was declared an Islamic republic and in 1963 the Arab socialist Ba’ath party came to power. The 1970s saw increased violence by the Ba’ath regime against the Kurds, including the forced evacuation of at least 250,000 people from the northern border areas. By the time Saddam Hussein came to power in 1979, the Ba’ath party had embarked on a process of ‘Arabization’ in northern Iraq which continued until 2003 (Chanaa, 2005).

The Iran-Iraq war between 1980 and 1988 was highly destructive and drove thousands more people from the northern border areas. The Kurds sided with Iran, and as the war came to an end, the Ba’ath regime wreaked its vengeance in a campaign known as ‘Anfal’. Up to 200,000 people are thought to have been killed using conventional and chemical weapons. Another half a million were moved to ‘collective settlements’ and detention centres, and many thousands more fled to Iran (ibid).

When Iraq invaded Kuwait in 1990 it provoked the first US-led Gulf War. The war destroyed large amounts of infrastructure in both Iraq and Kuwait, and although it was won by the US-led Coalition, they did not unseat Saddam or the Ba’ath regime. The Kurds in the north and the Shi’a in the south took the opportunity of Saddam’s defeat to rebel, provoking vicious reprisals. Hundreds of thousands of Kurds fled but were trapped in the mountains when Turkey refused to open its borders, eventually leading to the establishment of a US-protected safe haven and no-fly zone in the north. In the south, rebels fled to the marshes where they were pursued by government forces and subjected to detention, torture, execution and the use of poison and napalm. A canal was also built to divert water from the marshes, leading to outbreaks of disease (ibid).

After the Gulf War, repression of all opposition continued and fear was maintained through the use of random arrests, torture and summary executions. Sanctions reduced supplies of food and medical goods, and affected an already weakened infrastructure (ibid).

The recent war in Iraq has further weakened the infrastructure, and continuing insecurity has made reconstruction difficult. Although Saddam was removed, an estimated 300,000 people are thought to have been displaced. There are now estimated to be over 1 million internally displaced people in Iraq and up to 4 million exiles and refugees around the world. Most refugees live in neighbouring countries, with almost 50% in Iran. In other Middle Eastern states, many Iraqis do not have refugee status and are subject to racism, exploitation and deportation. Many have sought asylum in Europe, the US and Australia (ibid).
The Iraq-born population in Australia was first recorded in the 1976 Australian Census (DIMIA, 2003d). In that year there were 2,273 Iraqis living in Australia. This number increased to 5,186 by the end of the 1991 Gulf War. After the war, many Shi’a and Kurds were persecuted by the Iraqi regime and a significant number of Iraqis came to Australia under the Humanitarian program. In recent years, a number of Iraq-born asylum seekers arrived on boats and were placed in immigration detention centres. Many of these were found to be refugees and were granted Temporary Protection Visas.

The 1996 Census recorded 3,411 Iraq-born people in Victoria. This figure increased to 6,096 at the 2001 Census, that is, 24.7% of all Iraq-born settlers living in Australia. Figure 9.6.1 shows the Iraq-born humanitarian entrants to Victoria since 1996.

3. MIGRATION CATEGORIES

The migration categories among Iraq-born arrivals to Victoria since 1996 are shown in Figure 9.6.2. Seventy five percent of all arrivals came under the Humanitarian Program while 20% arrived within the family migration stream. A significant proportion of these were likely to have had refugee-like experiences.

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139. DIMIA settlement database
4. LANGUAGES SPOKEN

The languages spoken by Iraq-born humanitarian entrants to Victoria between 1996 and 2004 included:

- Arabic: 75.2%
- Assyrian: 19.7%
- Kurdish: 3.1%
- Turkish: 0.6%
- Other: 1.4%

5. ENGLISH LANGUAGE PROFICIENCY

Between 50% to less than 80% of humanitarian entrants from Iraq since 1996 spoke good English or English only (EP 3 index)\(^\text{141}\).

6. AGE AND GENDER PROFILE

The estimated number of Iraq-born people living in Victoria at 2004, their age and gender distribution are shown in Figure 9.6.3. An estimated 1,276 persons were aged 45 years and over. Of them, 732 (57.4%) were male and 544 (42.6%) were female.

\(^\text{140}\) DIMIA settlement database
\(^\text{141}\) DIMIA settlement database
7. PLACE OF RESIDENCE

Iraq-born entrants to Victoria between 1996 and 2003 (all age groups) have settled mostly in the LGAs of Hume, Moreland, Darebin, Whittlesea, Greater Dandenong and Greater Shepparton. The settlement areas of those aged 35 years and over are shown in Table 9.6.4

Table 9.6.4 1996-2003 Iraq-born arrivals to Victoria aged 35 years and over\textsuperscript{143}: Settlement by LGA\textsuperscript{144}

<table>
<thead>
<tr>
<th>Local government area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hume</td>
<td>290</td>
<td>38.5</td>
</tr>
<tr>
<td>Moreland</td>
<td>151</td>
<td>20.0</td>
</tr>
<tr>
<td>Darebin</td>
<td>71</td>
<td>9.4</td>
</tr>
<tr>
<td>Whittlesea</td>
<td>66</td>
<td>8.7</td>
</tr>
<tr>
<td>Greater Dandenong</td>
<td>46</td>
<td>6.1</td>
</tr>
<tr>
<td>Greater Shepparton</td>
<td>27</td>
<td>3.6</td>
</tr>
<tr>
<td>Brimbank</td>
<td>18</td>
<td>2.4</td>
</tr>
<tr>
<td>Maribyrnong</td>
<td>15</td>
<td>2.0</td>
</tr>
<tr>
<td>Monash</td>
<td>13</td>
<td>1.7</td>
</tr>
<tr>
<td>Casey</td>
<td>10</td>
<td>1.3</td>
</tr>
<tr>
<td>Other</td>
<td>47</td>
<td>6.2</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>754</td>
<td>100.0</td>
</tr>
<tr>
<td>Unknown LGA</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>789</td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{142} Census 2001 (ABS, 2003); DIMIA settlement database

\textsuperscript{143} At time of entry to Australia

\textsuperscript{144} DIMIA settlement database
8. CULTURAL CONTEXT

The three main groups of refugees to have come to Australia from Iraq are the Kurds, the Assyrians and the Shi’a ‘Marsh Arabs’ of southern Iraq.

The Kurds are an ethnically distinct non-Arab people who make up approximately 19% of the Iraqi population. The majority of Kurds are Sunni Muslims and come from northern Iraq near the border with Iran and Turkey. They have faced persecution in Iraq since the 1970s and have sought refuge in countries around the world. Many Kurds fled in the late 1980s and early 1990s following persecution after the Iran-Iraq war and the 1991 Gulf war. They are divided along political and clan lines, and there can be significant rivalries between different groups which remain after migration (Kemp and Rasbridge, 2004).

The Assyrians are Christians who lived mainly in Iraqi cities and in the rural areas of the north-east. They belong to one of four churches: the Chaldean, the Nestorian, the Jacobite and the Syrian Orthodox. Like the Kurds, they have faced decades of persecution in Iraq and often had to hide their cultural and religious identity. Assyrians left in large numbers in the 1970s and 1990s and recent arrivals to Australia have often spent up to five years in refugee camps in Middle Eastern countries (Chanaa, 2005).

The Shi’ā of southern Iraq, sometimes know as the ‘Marsh Arabs’, sustained a long guerilla campaign against Saddam and suffered the consequent persecution. Following their uprising at the end of the first Gulf War in 1991, many families fled to Iran and Saudi Arabia where they lived in large refugee camps. Iraqi Shi’a Muslims tend to be more orthodox in their observance of religious practices, dietary habits and the women’s dress codes, than other Iraqi refugee groups (Kemp and Rasbridge, 2004).

9. FAMILY ROLES AND STRUCTURE

The Iraqi population in Victoria is ethnically and religiously diverse, and practices and beliefs vary between groups, clans and families. The following general observations were gathered from interviews with community organisations working with Arabic and Assyrian speaking communities, and do not cover all the complexities and variations of the population.

Across most ethnic and religious groups in Iraq, loyalty and allegiance to family is strong. Islam stipulates the duty of caring for one’s parents and Assyrians value family unity and respect for the elderly. The norm in all groups is for older people to live with their families.
Workers with both Arabic and Assyrian speaking communities report the potential for intergenerational conflict when younger family members, who have taken on some of the lifestyle and cultural values of Australian society, clash with their older relatives. The clash was described as being between a more traditional collectivist way of thinking and behaving, and a modern, more individualist outlook. In the Muslim community it was reported that although these conflicts occurred, religion was an important bond between the generations. Where families have been in Australia for some time, older people are reported to be coming to the realisation that the traditions they brought with them many years ago have moved on, and they are becoming more open to accepting change.

Both communities reported a concern among older people that they were a burden on their children, although among the Assyrian community it was reported that seniors saw it as their role to pass on and maintain cultural traditions. In both communities it was reported that older relatives, especially grandmothers, were involved in caring for grandchildren, although this could sometimes be the cause of tension if they felt they were being taken advantage of.

Iraqi families may well have been separated for long periods of time, and might have lost relatives in war or had family members ‘disappear’ under the Ba’ath regime. Trauma and the impact of not knowing what happened to relatives will put strains on families that can make reunification in a strange country especially challenging.

10. GENDER SPECIFIC ISSUES

The status of Iraqi women varies between groups from urban and rural, ethnic and religious backgrounds, but it is notable that women in Iraq have traditionally enjoyed more rights and freedom than in many middle-eastern countries. Kurdish women have historically enjoyed more freedom than most, have never worn the ‘abbaye’ and often worked outside the home (Kemp and Rasbridge, 2004). Workers with Arabic speaking Iraqi women report that on coming to Australia, many are envious of the greater freedoms and rights enjoyed by women here. Younger Iraqi women tend to be keen to take advantage of these opportunities and even older women are reported to be breaking with traditional practices by not wearing black and cutting their hair.

Anecdotal evidence suggests that older men have often found the experience of migration especially challenging, particularly if they have had difficulty finding work and learning English. Many men also came alone and had to go through the initial stages of resettlement without family support.

145. Interview with community workers, 16/05/05
146. Interview with the Imam, Preston Mosque, 17/05/05
147. Interview with community workers, 16/05/05
11. SPECIFIC HEALTH AND WELLBEING ISSUES

Whilst the majority of older Iraqis live at home with their families, many suffer isolation due to their lack of English and dependence on their children for translation and transport. It is reportedly not uncommon for their only social contact to be with their families and for them to spend many hours alone during the day while their children are at work.

Mental health problems are known to be an issue among more recent Iraqi arrivals who came as asylum seekers and spent time in detention. There is also some evidence that the recent war in Iraq will have stirred up memories of previous conflicts (Procter, 2005) and caused concern for families who still have relatives living in areas affected by the conflict and the ongoing insecurity.

12. BELIEFS AND NORMS REGARDING HEALTH CARE AND SUPPORT FOR SENIORS

Many Iraqis in Australia are from minority groups in Iraq who have suffered years of state persecution. As a result, they often have a deep mistrust of government services and will be very reluctant to either proffer information about themselves or have government workers in their homes. Workers from within their own community may also be regarded with suspicion as family privacy is important.

A lack of understanding regarding mental health and the symptoms of mental illness among Iraqi families is also reported by researchers. The link between earlier traumatic experiences and emotional difficulties in later life are not necessarily made by families unfamiliar with the notions and terminology of mental health. Older relatives can spend months, even years, seeking help for the physical symptoms of mental illnesses, and this can put additional strain on family members caring for them.

Family pride will limit willingness to make use of home care services, although there is less stigma associated with home care than with residential care. Community workers reported that even when older people are suffering a lack of care at home, they will very rarely express the need for assistance as to do so would reflect negatively on the family.

Community interviews revealed a general lack of knowledge of home care services in the Iraqi community, which is compounded by low English skills. It was noted that the children of refugee seniors need to be informed about aged care services, and that GPs should be encouraged to inform their patients and make referrals. Misinformation was also noted as being a problem, and concerns that receiving home care services would affect Centrelink payments were reported.

Lack of transport was also identified as being an important factor in the social isolation of older people who are often afraid to take public transport and rely on their family members to drive them.

148. Ibid.
149. Interview with Refugee Health Research Centre worker, 16/06/05
150. Interview with community workers, 16/05/05
1. **CIRCUMSTANCES OF DISPLACEMENT**

Afghanistan has a long history of inter-tribal conflict, but full scale war began in 1979 when the Soviets invaded and unleashed a ‘wave of terror’ on the civilian population. The refugees who fled over the border to Pakistan organised themselves into the Mujahadeen resistance, and with military support from the West, fought a long and violent decade of civil war. Over 5 million people fled the country between 1979 and 1986, most seeking protection in camps in Pakistan and in refugee integration schemes in Iran. The majority of refugees were ethnic Pashtuns who shared a common ethnic and cultural heritage with many communities in Pakistan. Thanks to this they were able to work and in some cases rent land during their time in exile (Poppelwell, 2005).

When the Soviets withdrew from Afghanistan in 1989, 900,000 refugees from Pakistan returned, but fighting between the Communist government and the Mujahadeen continued. Following the Mujahadeen capture of Kabul in 1992, 1.4 million refugees returned over the next two years. Fighting continued between the tribal factions and many major cities suffered violent battles. Many refugees who had already fled the country once, were forced into exile again. The Pashtun-led Taliban formed in Pakistan in 1994 and gradually won ground during two years of violent fighting until they took control in 1996. Under their rule, civilians from tribes in the north were persecuted and several thousand were forced to flee. Following the US invasion in 2001 and the formation of the interim authority and the subsequent new government, nearly 2 million refugees have returned (ibid).

2. **RESETTLEMENT IN AUSTRALIA**

The first Afghans to arrive in Australia came in the 1860s to work as camel drivers for the early explorers. They played an important role in the camel transportation business in NSW, Victoria, Queensland, South, Central and Western Australia and by the 1930s there were an estimated 3000 Afghans living in Australia, the majority of them single men (Jupp, 2001).

From 1980 Australia accepted around 500 Afghan refugees a year with a peak of nearly 1000 arriving in 1991 and 1992. The majority were Pashtuns and were settled in the state capitals. During the rule of the Taliban, several hundred refugees, mostly young men, arrived by boat and were sent to immigration detention centres. They were later granted asylum and given Temporary Protection Visas (ibid).

The 1996 Census recorded 1,874 Afghanistan-born people in Victoria; this figure increased to 3,217 at the 2001 Census, that is, 28.7% of all Afghans living in Australia. Figure 9.6.5 shows the Afghanistan-born humanitarian entrants to Victoria since 1996.
3. MIGRATION CATEGORIES

The migration categories among Afghanistan-born arrivals to Victoria between 1996 and 2004 are shown in Figure 9.6.6. Seventy five per cent of arrivals came under the Humanitarian Program. Those who came under the Family Migration stream (20%) were also likely to have come from refugee backgrounds.

Figure 9.6.6 Migration categories among Afghanistan-born arrivals to Victoria 1996-2004: All age groups

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151. Source: DIMIA settlement database
152. DIMIA settlement database
4. LANGUAGES SPOKEN

The languages spoken by Afghanistan-born humanitarian entrants to Victoria between 1996 and 2004 include:

<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persian/Farsi/Dari</td>
<td>54.4%</td>
</tr>
<tr>
<td>Uzbek</td>
<td>27.6%</td>
</tr>
<tr>
<td>Pashto/Pushto/Pakhto</td>
<td>13.7%</td>
</tr>
<tr>
<td>English</td>
<td>1.5%</td>
</tr>
<tr>
<td>Afghan</td>
<td>1.2%</td>
</tr>
<tr>
<td>Arabic</td>
<td>0.6%</td>
</tr>
<tr>
<td>Asante</td>
<td>0.5%</td>
</tr>
<tr>
<td>Urdu</td>
<td>0.1%</td>
</tr>
<tr>
<td>Others</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

5. ENGLISH LANGUAGE PROFICIENCY

English proficiency among Afghans entrants to Victoria from 1996 to 2004 was categorised within the EP 3 group, that is, between 50% to less than 80% of arrivals spoke good English.\(^\text{153}\)

6. AGE AND GENDER PROFILE

The estimated number of Afghanistan-born people living in Victoria at 2004, their age and gender distribution are shown in Figure 9.6.7. Six hundred and forty three people were aged 45 years and over. Of them, 355 (55.2%) were male and 288 (44.8%) were female.

Figure 9.6.7 Estimated Afghanistan-born population in Victoria at 2004: Age and gender profile.\(^\text{154}\)

153. DIMIA settlement database
154. Census 2001 (ABS, 2003); DIMIA settlement database
AFGHANISTAN

7. PLACE OF RESIDENCE

Afghanistan-born entrants to Victoria between 1996 and 2003 (all age groups) have settled mostly in the LGAs of Greater Dandenong, Casey, Monash, Frankston and Wyndham. Settlement areas of Afghans aged 35 years and over are shown in Table 9.6.8.

Table 9.6.8 1996-2003 Afghanistan-born arrivals to Victoria aged 35 years and over: Settlement by LGA155

<table>
<thead>
<tr>
<th>Local government area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Dandenong (C)</td>
<td>123</td>
<td>35.8</td>
</tr>
<tr>
<td>Casey (C)</td>
<td>76</td>
<td>22.1</td>
</tr>
<tr>
<td>Monash (C)</td>
<td>35</td>
<td>10.2</td>
</tr>
<tr>
<td>Frankston (C)</td>
<td>22</td>
<td>6.4</td>
</tr>
<tr>
<td>Wyndham (C)</td>
<td>14</td>
<td>4.1</td>
</tr>
<tr>
<td>Boroondara (C)</td>
<td>10</td>
<td>2.9</td>
</tr>
<tr>
<td>Kingston (C)</td>
<td>8</td>
<td>2.3</td>
</tr>
<tr>
<td>Brimbank (C)</td>
<td>7</td>
<td>2.0</td>
</tr>
<tr>
<td>Darebin (C)</td>
<td>7</td>
<td>2.0</td>
</tr>
<tr>
<td>Knox (C)</td>
<td>7</td>
<td>2.0</td>
</tr>
<tr>
<td>Others</td>
<td>35</td>
<td>10.2</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>344</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Unknown LGA</strong></td>
<td>13</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>357</td>
<td></td>
</tr>
</tbody>
</table>

8. CULTURAL CONTEXT

Tribal allegiances are strong in Afghanistan and have been at the root of much conflict, although inter-tribal mixing over the centuries has blurred some of the ethnic and racial boundaries. Afghanistan is ethnically and linguistically diverse, but the dominant groups; the Pashtuns, the Takjiks and the Hazara make up 69% of the population. The Pashtuns, the largest tribal group in Afghanistan, have a moral and legal code of social order and responsibility known as ‘Pashtunwali’ which emphasises honour, solidarity, mutual support and revenge. Pashtun society is guided according to these codes by male elders who make decisions and elect leaders at tribal assemblies, or ‘jirgas’ (Poppelwell, 2005).

84% of Afghans are Sunni Muslims and 15% are Shi’a. Minorities of Ismaelis, Hindus, Jews, Sikhs and Bahais were persecuted during Taliban rule and most left the country. Although Islam provides the dominant moral code for many Afghans, religious principles sometimes come secondary to the social Pashtunwali code, particularly among Afghans from rural backgrounds (ibid).

155: DIMIA settlement database
Most Afghans who have come to Australia are Pashtuns from middle class urban backgrounds. The majority are Sunni Muslims who maintain a close interest and involvement in Afghan politics. Most have settled in the state capitals and formed close-knit communities around political and tribal divisions (Jupp, 2001).

9. FAMILY ROLES AND STRUCTURE

Islam and Afghan social codes determine a patriarchal family structure in which daughters marry out and sons are responsible for the care of their parents. Respect for parents and elders is strong, with elder men having the final say on all family and community matters. Parents live with their sons who, together with their wives, are expected to care for them “financially and morally” (Jupp, 2001). Grandmothers will sometimes assist with childcare, but older men are not expected to undertake any domestic duties. Inability or unwillingness to care for one’s elderly relatives is deeply shameful, and community leaders are proud that very few Afghans are in nursing homes.

Family and community conflict occurs when the younger, more integrated generations, disagree with community elders. Whilst traditional social structures are still strong in the Australian Afghan community, older members are reliant often on their children for transport and translation.

10. GENDER SPECIFIC ISSUES

Because Afghan society is strongly patriarchal and because daughters marry out of the family, emotional and financial investment is focused on sons. “Daughters are counted as the future member[s] of another people’s family” whilst sons “are considered the fruit of the family” (Jupp, 2001).

Although older men play a pivotal role in Afghan communities, many are reported to have found the transition to life in Australia difficult due to the problems of finding employment. Having often come from middle or higher class backgrounds, they found working in low skilled jobs, or having no work at all, degrading and undermining. Anecdotal evidence suggests that women and children have sometimes found integration and English language acquisition easier than men, which adds to men’s concerns about the loss of their status and authority.

11. SPECIFIC HEALTH AND WELLBEING ISSUES

Many older Afghans have little or no English and depend on their children for translation and communication outside the community. This separation from mainstream culture can lead to misunderstandings and a fear of integration, especially in relation to Australian moral and social codes. There is anecdotal evidence of elderly Afghans who, coming from a very conservative Islamic society, are appalled at advertising and television programs featuring nudity and sex, and who, because of their limited interaction with mainstream culture, have a very distorted and negative opinion of Australian society which they fear their children will become a part of.

156. Interview with community worker, 23/05/05
157. Interview with VFST worker, 29/04/05
158. Ibid.
Dependency on family members for translation can also cause feelings of frustration and isolation, and in the case of male elders, can contribute to a sense of undermined authority. Lack of English skills also makes it harder for elderly Afghans to find out about and use services.

In families where both adult children are working, grandparents sometimes stay at home to care for their grandchildren. Whilst this can be rewarding and give older relatives a role in the family, it can also be hard work and lonely.

A lack of access to transportation is another isolating factor for many Afghan elderly, most of whom reportedly depend on their children to drive them to appointments and social gatherings. Nevertheless, Afghan community organisations in the South East and East of Melbourne hold regular social gatherings for the community at which the elderly have an opportunity to mix with other families and their peers. Mosques are also an important meeting point for the older members of the community, and shared religion plays a central role in maintaining bonds between the generations.

12. BELIEFS AND NORMS REGARDING HEALTH CARE AND SUPPORT FOR SENIORS

Both Afghan social codes and Islam stress the importance of respecting and caring for the elderly within the family. Whilst sons are ultimately responsible for their parents’ well being, it is usually daughters-in-law who carry out the day-to-day caring duties.

Putting elderly relatives in nursing homes is considered deeply shameful, but community workers suggest that home care would be acceptable, so long as it was culturally appropriate. Carers would need to be of the same gender as their clients, preferably speak the same language, and be sensitive to Islamic practices.

The principle barriers to the use of services by the elderly are a lack of knowledge within the community, and a shortage of information in appropriate languages. Elderly Afghans could best be informed of services through their community organisations and via print and audio media in Pashto and Persian.

CASE STUDY F

Loss of status

An older Afghan man who had worked in the Ministry of Trade in Afghanistan, and travelled widely in Europe and Asia, found it hard to learn English on coming to Australia and is learning more slowly than his wife. He feels he no longer has a role to play, has begun drinking and is sometimes violent. Being Muslim he also feels guilty about drinking and this makes him depressed.

159. Interview with community organisation, 23/05/05
160. Interview with the Imam, Preston Mosque, 17/05/05
161. Interview with Afghan community worker, 23/05/05
1. CIRCUMSTANCES OF DISPLACEMENT

Prior to 1979, Iran, known as Persia, was ruled by a succession of kings, or ‘Shahs’. A parliament was created in 1911, and elected Prime Ministers took on some of the monarchy’s power. In a 1953 coup, thought to have been backed by the US and UK, the Prime Minister of the time was removed and the Shah’s powers fully reinstated. The dictatorial rule of the Shah led to a number of violent protests which culminated in the revolution of 1979. The Shah fled Iran and an Islamic republic was formed under the rule of the Ayatollah Khomeini (Columbia University, 2005).

Khomeini instituted sharia law in Iran. The rights and freedom of women were restricted, and non-Muslim minorities, in particular the Baha’i, were persecuted. Opposition to the Ayatollah was harshly punished (ibid).

In 1980, Iran was invaded by Iraq. The war cost thousands of lives, with both sides using human wave attacks, some involving children, to breach each other’s lines. Iraqi troops also used urban bombing campaigns and chemical weapons. By the time a peace agreement was reached in 1988, an estimated 1.5 million Iranians had been killed and major damage had been done to the country’s infrastructure. Many middle class families fled the country and oil production slumped (ibid). The hardline religious rhetoric of the regime which had isolated Iran from international relations during much of the 1980s softened after the war, but despite recent democratic reforms, it is still regarded with some suspicion, in particular by the USA.

Iran hosts approximately 2.5 million refugees; more than any other country in the world. The majority are from Afghanistan and Iraq, and some have been in Iran for over 20 years. Consequently, some younger Iranian-born refugees coming to Australia are likely to be of Iraqi or Afghan origin (UNHCR, 2000).

2. RESETTLEMENT IN AUSTRALIA

Prior to 1979, Iranian migrants to Australia were mostly oil workers who have formed a well established community and are now ageing. When the Iran-Iraq war broke out in 1980 a second wave of Iranian migrants, this time mostly young, middle-class refugees began arriving in Australia. Since the revolution, religious minorities, and the Baha’i in particular, have suffered persecution. Many have come to Australia under a special humanitarian program. By the end of the 1980s around 2,500 Iranians, mostly Baha’is escaping religious persecution, had arrived in Australia. More recent arrivals have included economic migrants who have come under the skilled migration scheme, and political activists who have sought asylum from persecution. The majority of the latter are young and educated (Jupp, 2001).

At the 1996 Census, 2,640 Iran-born people were listed in Victoria; by 2001 the number increased to 3,174. This figure represented 17% of all Iran-born people in Australia. Iran-born humanitarian entrants to Victoria since 1996 are shown in Figure 9.6.9.
3. MIGRATION CATEGORIES

Figure 9.6.10 shows the migration categories among Iran-born arrivals to Victoria between 1996 and 2004. Over 50% of all arrivals have come under the Humanitarian Program.

4. LANGUAGES SPOKEN

The main languages spoken by Iran-born humanitarian entrants to Victoria since 1996 were:

<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persian/Farsi/Dari</td>
<td>65.6%</td>
</tr>
<tr>
<td>Turkic</td>
<td>22.0%</td>
</tr>
<tr>
<td>Arabic</td>
<td>5.4%</td>
</tr>
<tr>
<td>Assyrian</td>
<td>2.1%</td>
</tr>
<tr>
<td>Kurdish</td>
<td>1.6%</td>
</tr>
<tr>
<td>Turkish</td>
<td>1.0%</td>
</tr>
<tr>
<td>Other</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

162. Source: DIMIA settlement database
163. Sources: Census 2001 (ABS, 2003); DIMIA settlement database
5. **ENGLISH LANGUAGE PROFICIENCY:**

English proficiency among Iran-born entrants to Victoria from 1996 to 2004 was categorised within the EP 3 group, that is, between 50% to less than 80% of arrivals spoke good English of English only\textsuperscript{164}.

6. **AGE AND GENDER PROFILE**

The estimated number of Iran-born people living in Victoria at 2004, their age and gender distribution are shown in Figure 9.6.11. According to this estimate, 1,123 people were aged 45 years and over, with 621 (55.3%) being male and 502 (44.7%) being female.

![Figure 9.6.11 Estimated Iran-born population in Victoria at 2004: Age and gender profile\textsuperscript{165}]

7. **PLACE OF RESIDENCE**

The main LGAs of settlement of Iran-born entrants to Victoria from 1996 to 2003 (all age groups) are Manningham, Whitehorse, Greater Dandenong, Monash and Darebin. The settlement areas of those aged 35 years and over are shown in Table 9.6.12.

\textsuperscript{164} DIMIA settlement database
\textsuperscript{165} Sources: Census 2001 (ABS, 2003); DIMIA settlement database
8. CULTURAL CONTEXT

Although the majority of the Iranian population are Shi’a Muslims, a disproportionate number of Iranian refugees in Australia are Baha’is who have sought protection from religious persecution. The Baha’i faith was founded in Iran in the 19th century, but was considered a breakaway sect of Islam. Their views on the equality of men and women, and belief in the right to freedom of expression made them an obvious target for the ruling regime (Jupp, 2001).

The different waves of migrants from Iran who have come from different socio-economic, religious and political backgrounds, have created a diverse Iranian population in Australia. Deep suspicion exists between groups with opposing political allegiances and those who fled persecution are often still fearful of those outside their immediate family (ibid).

One uniting feature reported in Iranian culture is the strong distinction made between private and public life. The private domains of family, beliefs, values and morality are considered distinct and almost unrelated to the public and social persona that must be adopted when interacting with the outside world. This is considered to facilitate assimilation whilst enabling the maintenance of cultural identity and continuity (ibid).

9. FAMILY ROLES AND STRUCTURE

As in many Middle Eastern societies, family bonds in Iranian society are strong. Social networks tend to be based around the extended family and are founded on the expectation of loyalty and duty to ones relatives. Elders are traditionally greatly respected and cared for within the family. Grandmothers are often involved with arranging marriages and sometimes in naming grandchildren.

---

166. At time of entry to Australia
167. DIMIA settlement database
The loss of the extended family network for Iranians who have come to Australia can be very distressing, particularly for older people. Concern about family members still in Iran can be another cause of stress, especially for those forced to flee because of their religious or political views.

Intergenerational conflict often occurs when children who have grown up in Australia no longer accept the social codes of their parents and grandparents. Communication can also become a problem if children no longer speak their family language and if their older relatives speak little English.

10. GENDER SPECIFIC ISSUES

Gender roles and expectations vary greatly among Iranians depending on their background. Those from the middle classes and urban areas will have far less conservative views concerning the rights and freedom of women than those from lower socio-economic backgrounds. Middle class Iranian women are likely to be educated and to have worked outside the home. However, on coming to Australia, they may struggle to have their qualifications recognised and have to take lower skilled jobs than they would wish. Women from lower socio-economic backgrounds are more likely to remain in the home to care for children and the elderly. They run a higher risk of becoming socially isolated in Australia, especially if they speak little English. Older women living with their children and grandchildren may help with the care of the grandchildren (Jupp, 2001).

The lack of recognition of qualifications is a significant issue for Iranian men in Australia. The loss of status and income can cause depression and in some reported cases alcoholism. The shock of coming to Australia from a country where men’s authority over their wives and families is enshrined in law, is also likely to be a challenge, particularly for older men (ibid).

11. SPECIFIC HEALTH AND WELLBEING ISSUES

Specific health problems will depend on the background of Iranians who come to Australia, but mental health is known to be a significant issue for those who have come as refugees and escaped from religious or political persecution. Minorities who have been subjected to years of living under surveillance and the threat of arbitrary arrest and disappearance, are likely to have high levels of mental illnesses such as paranoia, anxiety disorders and depression. The experience of resettlement can also cause stress-related illnesses (Jupp, 2001).

Willingness to seek help for mental illness will vary according to the level of education, and access to information in a family or community. One research project among educated, middle-class Iranian women in northern Sydney revealed that the use of health services for mental health problems among this group was high (reported in Jupp, 2001), but this may well not be the case for men, or for families from lower socio-economic backgrounds. The same study revealed that many physical symptoms, including arthritis and asthma, only developed in the population following migration.
13. BELIEFS AND NORMS REGARDING THE HEALTH AND SUPPORT FOR SENIORS

Family pride, respect for the elderly and the importance of family privacy, make it very unlikely that Iranian families in Australia would seek out home care services for their frail older relatives. Even if elderly relatives were living apart from their families, anecdotal evidence suggests that female relatives would still fulfill the role of carers, as to do otherwise would be both disrespectful and shameful for the family.

The experience of living under constant surveillance, having telephones tapped and homes inspected, has made many Iranian refugees very wary of strangers in general, and government services in particular. Having care workers coming into the home is therefore likely to be very unpopular with certain sections of the Iranian community. Similarly, experience of interrogation both in Iran and in Australia for those refugees who have claimed asylum, is likely to make the process of assessment for services additionally stressful.

Divisions within the Iranian community make many reluctant to use interpreter services and wary of unknown community members. This factor, combined with a lack of information in relevant languages and unfamiliarity with the Australian welfare system, are additional barriers to Iranian refugees accessing and using home care services. According to available data, there are currently no ethno-specific services for Iranian seniors and no Iranian senior citizen’s groups in Victoria (see Appendix 2).

CASE STUDY G

Family duty and resistance to outside help

An Iranian couple who came to Australia as visitors to see their children, claimed asylum and stayed on. They have 7 sons and lived with their eldest. They were cared for by their daughter-in-law who also cared for her aunt and uncle. Their daughter-in-law took them to medical appointments and cooked and cleaned for them. She found it a strain caring for them, but family expectations meant it was her role and she would have been unlikely to seek help. Occasionally they went and stayed with another son to give their daughter-in-law a break, but usually only for a night or two. Eventually they moved into their own house and another family member came to live with them.

The couple, especially the husband, were involved with politics and held a lot of meetings at the house. The husband considered himself head of the family.

Both the husband and wife suffered from high blood pressure and arthritis. The husband had a heart condition, and eventually died of a heart attack. After he died, his wife moved back in with her eldest son.

They would never have considered using home help services because they would only trust relatives to look after them. Because of the divisions within the Iranian community, they would not have trusted interpreters or carers who spoke their language. They used a doctor who spoke their language if possible, but otherwise would take a family member to appointments to translate for them.

Intergenerational tensions were kept quiet and the children were expected to respect and care for their parents without questioning them.
1. CIRCUMSTANCES OF DISPLACEMENT

Following the collapse of the Ottoman Empire at the end of the First World War, Lebanon was ruled by France. It gained independence in 1943 and has since suffered years of instability as well as cycles of economic success and decline.

Conflict between the Muslim and Christian factions in Lebanon in 1958, was a precursor to a longer and harsher war that divided the country between 1975 and 1990. Sparked by the presence of large numbers of Palestinian refugees in southern Lebanon, it drew in its neighbours Syria and Israel. By 1982 it had descended into a proxy war between the two external enemies who employed militias inside Lebanon to fight their battles. The international community reacted by sending in a multinational force to calm the conflict, but by 1988 the country had descended into chaos following the failure of the National Assembly to elect a president. An Arab League sponsored peace agreement was signed in 1989 and Israel withdrew in 2000. Syrian ‘peace keeping’ forces remained in Lebanon until April 2005. In all, an estimated 100,000 people were killed, and another 100,000 injured during the 15 years of war. Thousands more emigrated to Europe, North America and Australia (Jupp, 2001)

2. RESETTLEMENT IN AUSTRALIA

The first Lebanese migrants arrived in Australia at the end of the 19th Century. They were mostly Christians who settled in New South Wales where they built up successful trading and manufacturing businesses. A second wave of Lebanese migrants arrived between 1947 and 1976. They were also Christians who came as economic migrants. Following the outbreak of war in 1975, a third wave of migrants from Lebanon arrived in Australia. The majority of this group were Muslims who were allowed entry on humanitarian grounds, although they were not granted refugee status, and had to depend on relatives already in the country for financial and material support. The majority of arrivals since the 1980s have come through the family reunification scheme (Jupp, 2001).

At the 1996 Census 13,848 Lebanon-born persons were living in Victoria. By 2001, the number had increased to 14,160 (19.9% of all Lebanese living in Australia). In 2001 there were estimated to be 150,000 Australians of Lebanese descent. The Lebanese-born humanitarian arrivals to Victoria since 1996 are shown in Figure 9.6.13.
3. MIGRATION CATEGORIES

The migration categories among Lebanese-born arrivals to Victoria between 1996 and 2004 are shown in Figure 9.6.14. Eighty five percent of arrivals came under the Family migration stream and only 3% arrived under the Humanitarian Program.

4. LANGUAGES SPOKEN

Ninety eight percent of the humanitarian arrivals to Victoria between 1996 and 2004 spoke Arabic.

5. ENGLISH LANGUAGE PROFICIENCY

English proficiency among Lebanon-born entrants to Victoria from 1996 to 2004 was categorised within the EP 3 group, that is, between 50% to less than 80% of arrivals spoke good English or English only.

168. DIMIA settlement database
169. DIMIA settlement database
170. DIMIA settlement database
6. **AGE AND GENDER PROFILE**

The estimated number of Lebanon-born people living in Victoria at 2004, their age and gender distribution are shown in Figure 9.6.15. About 5,550 Lebanon-born people were aged 45 years and over. Of them, 3,069 (55.3%) were male and 2,481 (44.7%) were female.

**Figure 9.6.15** Estimated Lebanon-born population in Victoria at 2004: Age and gender profile

7. **PLACE OF RESIDENCE**

Lebanon-born entrants to Victoria between 1996 and 2003 (all age groups) have settled mostly in the LGAs of Darebin, Hume, Whittlesea and Greater Dandenong. The settlement areas of those aged 35 years and over are shown in Table 9.6.16.

**Table 9.6.16** 1996-2003 Lebanon-born arrivals to Victoria aged 35 years and over: Settlement by LGA

<table>
<thead>
<tr>
<th>Local government area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moreland</td>
<td>33</td>
<td>21.2</td>
</tr>
<tr>
<td>Hume</td>
<td>27</td>
<td>17.3</td>
</tr>
<tr>
<td>Darebin</td>
<td>20</td>
<td>12.8</td>
</tr>
<tr>
<td>Greater Dandenong</td>
<td>11</td>
<td>7.1</td>
</tr>
<tr>
<td>Brimbank</td>
<td>9</td>
<td>5.8</td>
</tr>
<tr>
<td>Banyule</td>
<td>6</td>
<td>3.9</td>
</tr>
<tr>
<td>Casey</td>
<td>6</td>
<td>3.9</td>
</tr>
<tr>
<td>Whittlesea</td>
<td>6</td>
<td>3.9</td>
</tr>
<tr>
<td>Boroondara</td>
<td>5</td>
<td>3.3</td>
</tr>
<tr>
<td>Kingston</td>
<td>5</td>
<td>3.3</td>
</tr>
<tr>
<td>Other</td>
<td>28</td>
<td>17.5</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>156</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Unknown LGA</strong></td>
<td>22</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>178</td>
<td></td>
</tr>
</tbody>
</table>

171. Sources: Census 2001 (ABS, 2003); DIMIA settlement database
172. At time of entry to Australia
173. Source: DIMIA settlement database
8. CULTURAL CONTEXT

The Lebanese community in Melbourne is made up of Muslims (41%), Catholics (40%), Orthodox Christians (13%), Druze (2%) and Protestants (2%). For historical reasons, religion is a key factor in divisions which exist within the Lebanese community. As well as divisions between the Christians and Muslims, the Catholic and Orthodox sects within the Christian community, and the Sunni, Shi'ite, Druze and Alawi sects within the Muslim community have very little interaction. Each sect tends to have their own community organisations based around their church or mosque and rarely congregate around any national Lebanese associations (Jupp, 2001).

The degree of integration, and the social and economic wellbeing of Lebanese families depends a great deal on when they arrived in Australia. Christians who arrived following the outbreak of the 1975 war were integrated into the existing communities and churches that had been established by the earlier migrants, and often found work in Lebanese-run businesses. Muslims arriving in this period did not have these networks to support them and tended to take longer to find employment and establish themselves. The post 1975 arrivals generally found it harder to find employment than earlier waves of Lebanese migrants, in part because of the decline in the manufacturing industry in the 1980s, and partly because they had often had their education disrupted by the civil war. Arrivals who have come to Australia in more recent years as economic migrants tend to be better educated and reportedly do not mix with earlier waves of migrants74.

9. FAMILY ROLES AND STRUCTURE

Family bonds for both Lebanese Christians and Muslims are strong and the family is the focal point for much cultural and religious activity. In recent years, families have been the principle conduit for migration and play a vital role in ensuring the wellbeing of new arrivals. For communities who have been in Australia a while, the function of the family tends to change following migration as the family goes from being the main source of welfare and security, to being the principle institution for maintaining cultural and religious practices, and educating family members in cultural history (Jupp, 2001).
Lebanese Muslim families are traditionally larger than Christian ones and tend to be more patriarchal (Jupp, 2001). In both communities it is considered preferable for older relatives to live with their children and grandchildren, although, in cases where younger generations have become assimilated into Australian society, clashes between the generations are reported to occur. Community workers report that older people who speak little English and depend on their children for transport, often feel they are a burden on their families. They also report that older relatives who are charged with caring for their grandchildren while their adult children go out to work, can feel isolated and overworked. Cases are reported of older relatives who move out of the family home to avoid family conflicts, but end up feeling they have been rejected by their families.

10. GENDER SPECIFIC ISSUES

It is reported that among some Muslim Lebanese communities in which a strong code of honour is observed, women can be subject to restrictions on their movement, employment and education, and girls encouraged to marry younger than is legal in Australia (Jupp, 2001). Traditional patriarchal roles within the family are often challenged when, following migration, economic necessity means women work outside the home and consequently have a greater degree of freedom than women who traditionally remain in the home. Community workers report that older women often envy the freedom of their daughters and grand-daughters although it can cause tensions with older male relatives.

Low employment among recent Lebanese arrivals, combined with intergenerational conflicts, and the effect of war trauma are all reported to contribute to domestic violence among certain vulnerable groups. The sense of loss of status among men in areas where unemployment levels are high is also reported to contribute to the take up of gambling (Jupp, 2001).

11. SPECIFIC HEALTH AND WELLBEING ISSUES

Social isolation is a reported problem for older Lebanese who have low levels of English and who are unable to travel independently. As the population ages, there are also growing numbers who suffer from dementia, and whose children are unable to provide sufficient care.

Community workers report some cases of elder abuse or neglect which often go undetected because older people are ashamed to admit that their families are not caring for them.
12. BELIEFS AND NORMS REGARDING THE HEALTH AND SUPPORT FOR SENIORS

Elders are traditionally respected in Lebanese society and have a good deal of authority in family and community matters. However, older Lebanese who came to Australia in the 1970s and 1980s and who often have little English and little understanding of Australian society, can have these roles undermined if they have to rely on their children for translation and transport.

The use of government services among older Lebanese is limited by a lack of knowledge of the welfare system among the elderly and their children and by the preference that families provide care. Although there are HACC funded services for Arabic speaking elderly, and many Lebanese mosques and churches run senior citizens’ groups, community workers report that some families are wary of using them for fear that outsiders may interfere with family matters. Respite is an area of care similarly affected by these concerns and most people who are provided with respite or home care following hospitalisation don’t want carers from their own community.

Although it is considered shameful to place elderly relatives in a nursing home, community workers report that there is a growing need for Arabic residential aged care facilities as the number of older Lebanese with dementia and other serious illnesses increases.
2004-2005 Resettlement Patterns

In the 2004-2005 period, the highest number of refugees resettling in Victoria under the Integrated Humanitarian Settlement Strategy have come from Africa. These recent arrivals comprise (DIMIA, 2005):
— Four groups of Ethiopians from Abu Rakham camp,
— 97 Liberians who arrived in January 2005 and settled across Melbourne and Geelong,
— A further group of Liberians who arrived in mid-April 2005,
— In early March a group of 60 Burundian Hutus (within 9 family units) arrived in Melbourne from refugee camps in Tanzania and were settled in the northern, western and southern suburbs of Melbourne
— Very limited or no English skills and low levels of literacy has been noted in some of these groups of recent arrivals.
Appendices

Appendix 1  DIMIA Settlement Data 1996 – 2005

a. Humanitarian Stream Arrivals: Sex and Age distribution for Australia,
   1 July 1996 – 30 June 2005

Sex and Age Distribution for
Migration Stream: Humanitarian - Refugee; Humanitarian - Special Assistance; Humanitarian -
Special Hum Program; Onshore: Humanitarian;
Ethnicity: All Settlers
Geographic Area: All Settlers
Sex: All Settlers
Settlers Arriving from 1 Jul 1996 to 30 Jun 2005

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female</th>
<th>Male</th>
<th>Not Stated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>9,019</td>
<td>9,688</td>
<td>0</td>
<td>18,717</td>
</tr>
<tr>
<td>10-19</td>
<td>8,786</td>
<td>10,826</td>
<td>1</td>
<td>19,613</td>
</tr>
<tr>
<td>20-29</td>
<td>7,102</td>
<td>9,451</td>
<td>1</td>
<td>16,554</td>
</tr>
<tr>
<td>30-39</td>
<td>7,277</td>
<td>8,327</td>
<td>0</td>
<td>15,604</td>
</tr>
<tr>
<td>40-49</td>
<td>4,173</td>
<td>5,082</td>
<td>0</td>
<td>9,255</td>
</tr>
<tr>
<td>50-59</td>
<td>1,740</td>
<td>1,804</td>
<td>0</td>
<td>3,544</td>
</tr>
<tr>
<td>60-69</td>
<td>939</td>
<td>773</td>
<td>0</td>
<td>1,712</td>
</tr>
<tr>
<td>70-79</td>
<td>316</td>
<td>193</td>
<td>0</td>
<td>509</td>
</tr>
<tr>
<td>80+</td>
<td>41</td>
<td>27</td>
<td>0</td>
<td>68</td>
</tr>
<tr>
<td>Unknown</td>
<td>12</td>
<td>16</td>
<td>0</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>39,405</td>
<td>46,197</td>
<td>2</td>
<td>85,604</td>
</tr>
</tbody>
</table>

Source: Department of Immigration & Multicultural & Indigenous Affairs Settlement Database.
Data extracted on 23 Aug 2005

Notes:
1. Age is recorded as at date of arrival.
2. The data shown here includes both persons who arrived during the reference period as migrants and
   persons who arrived as temporary entrants and were later granted permanent resident status onshore.
3. Data on non-visual permanent arrivals (eg. New Zealand citizens) is not included.
4. The data in this report has been compiled from a number of information sources within DIMIA.
   The collection of some data items in these information systems is not mandatory. As a consequence
   there may be a large number recorded as 'unknown' for some items, including some of the selection
   variables on which this report is based. Because of the possibility of a high number being recorded as
   'unknown' for some items, the data shown here should only be taken as indicative of the actual number
   of settlers with these characteristics.
5. It has recently been found that the Settlement Database is undercounting records, both onshore and
   offshore, particularly in the Skill stream in recent years. For example, for arrivals in 2004-05, the Skill
   stream is undercounted by 3%, the Family stream by 3% and Humanitarian by 0.5%. Though estimates
   of settlement patterns will not be greatly affected, correction of this problem is processing as a priority.
6. In addition to the numbers shown in the table above, there were a small number of settlers for whom
   sex was not recorded.
   "nfd" - not further defined
   "nec" - not elsewhere classified

Sex and Age Distribution for
Migration Stream: Humanitarian - Refugee; Humanitarian - Special Assistance; Humanitarian - Special Human Program; Onshore: Humanitarian;
Ethnicity: All Settlers
State / Territory: Victoria;
Sex: All Settlers
Settlers Arriving from 1 Jul 1996 to 30 Jun 2005

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>2,737</td>
<td>2,924</td>
<td>5,661</td>
</tr>
<tr>
<td>10-19</td>
<td>2,627</td>
<td>3,226</td>
<td>5,853</td>
</tr>
<tr>
<td>20-29</td>
<td>2,145</td>
<td>2,659</td>
<td>4,804</td>
</tr>
<tr>
<td>30-39</td>
<td>2,193</td>
<td>2,441</td>
<td>4,634</td>
</tr>
<tr>
<td>40-49</td>
<td>1,177</td>
<td>1,444</td>
<td>2,621</td>
</tr>
<tr>
<td>50-59</td>
<td>505</td>
<td>509</td>
<td>1,014</td>
</tr>
<tr>
<td>60-69</td>
<td>262</td>
<td>198</td>
<td>460</td>
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<td>70-79</td>
<td>74</td>
<td>44</td>
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<td>80+</td>
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<td>13</td>
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<tr>
<td>Unknown</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>11,739</td>
<td>13,459</td>
<td>25,198</td>
</tr>
</tbody>
</table>

Source: Department of Immigration & Multicultural & Indigenous Affairs Settlement Database.
Data extracted on 22 Aug 2005

Notes:
1. Age is recorded as at date of arrival.
2. The data shown here includes both persons who arrived during the reference period as migrants and persons who arrived as temporary entrants and were later granted permanent resident status onshore.
3. Data on non-vented permanent arrivals (eg New Zealand citizens) is not included.
4. The data in this report has been compiled from a number of information sources within DIMIA.
5. The collection of some data items in these information systems is not mandatory. As a consequence there may be a large number recorded as 'unknown' for some items, including some of the selection variables on which this report is based. Because of the possibility of a high number being recorded as 'unknown' for some items, the data shown here should only be taken as indicative of the actual number of settlers with those characteristics.
6. It has recently been found that the Settlement Database is undercounting records, both overseas and offshore, particularly in the Skill stream in recent years. For example, for arrivals in 2001-02, the Skill stream is undercounted by 5%, the Family stream by 3% and Humanitarian by 0.5%. Though estimates of settlement patterns will not be greatly affected, correction of this problem is proceeding at a priority.
7. In addition to the numbers shown in the table above, there were a small number of settlers for whom sex was not recorded.
8. nz = not further defined.
9. nesc = not elsewhere classified.
Appendix 1  DIMIA Settlement Data 1996 – 2005 (continued)


State Distribution for
Migration Stream: Humanitarian - Refugee; Humanitarian - Special Assistance; Humanitarian - Special Hum Program; Onshore Humanitarian;
Ethnicity: All Settlers
Sex: All Settlers
Settlers Arriving from 1 Jul 1996 to 30 Jun 2005

<table>
<thead>
<tr>
<th>State of Residence</th>
<th>Number of Settlers</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>32,236</td>
</tr>
<tr>
<td>Victoria</td>
<td>25,384</td>
</tr>
<tr>
<td>Western Australia</td>
<td>9,459</td>
</tr>
<tr>
<td>Queensland</td>
<td>7,585</td>
</tr>
<tr>
<td>South Australia</td>
<td>7,542</td>
</tr>
<tr>
<td>Tasmania</td>
<td>1,554</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>834</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>567</td>
</tr>
<tr>
<td>Not Stated</td>
<td>423</td>
</tr>
<tr>
<td>Total</td>
<td>85,694</td>
</tr>
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</table>
### Appendix 2: Seniors’ Services for Victorian Refugee Communities

<table>
<thead>
<tr>
<th>Refugee Community by Country of Birth⁹</th>
<th>Refugee arrivals aged 50+ since 1996⁹</th>
<th>Areas of settlement: All age groups¹¹</th>
<th>HACC funding for Community Organisations 2003-2004²</th>
<th>Non-HACC funded Community Organisations providing services for the elderly¹³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Former Yugoslavia</td>
<td>311</td>
<td>Greater Dandenong 29.8%</td>
<td>Slavic $72,883</td>
<td>• Australian Yugoslav Multicultural Pensioners Group (Broadmeadows),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brimbank 19.2%</td>
<td>Serbian $92,722</td>
<td>• South-East Yugoslav Pensioners’ Group of Springvale,</td>
</tr>
<tr>
<td>Federal Republic of Yugoslavia</td>
<td>15</td>
<td>Greater Geelong 4.5%</td>
<td>Croatian: $172,306</td>
<td>• United Slavic Pensioners Group (Yarraville),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Darebin 4%</td>
<td>Macedonian $81,564</td>
<td>• Women’s Group ‘Nase Zene’ (City),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maribyrnong 3.9%</td>
<td></td>
<td>• Albanian Australian Community Association (Footscray),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Casey 3.8%</td>
<td>• Australian Croatian Community Services</td>
<td>• Bosnian &amp; Herzegovinian Elderly Club (Noble Park),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frankston 3.6%</td>
<td>(Footscray)</td>
<td>• Bosnian &amp; Herzegovinian Elderly Citizens’ Group (Noble Park),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moreland 2.9%</td>
<td>• Croatian Catholic Welfare Association</td>
<td>• Bosnian &amp; Herzegovinian Islamic Society (Noble Park),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hume 2.8%</td>
<td>(Dandenong)</td>
<td>• Muslim Merhamet Elderly Club (Noble Park),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wittlesea 2.4%</td>
<td>• Macedonian Community Welfare Association</td>
<td>• Australian Croatian Senior Citizens’ Club (Dallas),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other 23.1%</td>
<td>• Serbian Social Services and Support</td>
<td>• Australian Croatian Senior Citizens’ Association (Corio),</td>
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<tr>
<td></td>
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<td>(St Albans)</td>
<td>• Australian Croatian Senior Citizens’ Club of Broadmeadows,</td>
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<td></td>
<td></td>
<td>• Australian Croatian Senior Citizens’ Club of Gladstone Park,</td>
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<td></td>
<td>• Croatian Elderly Citizens’ Club of Footscray,</td>
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<td></td>
<td></td>
<td>• Croatian Senior Citizens’ Group Keysborough,</td>
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<td>• Croatian Senior Citizens’ Club of St Albans,</td>
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<td></td>
<td>• Australian Croatian Senior Citizens’ Group of Brimbank,</td>
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<td></td>
<td>• Croatian Senior Citizens’ Group (Springvale),</td>
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<td>• Altona Croatian Senior Citizens’ Group,</td>
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<td>• Anglo-Australian Senior Citizens’ Centre (Footscray),</td>
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<td>• Croatian Senior Citizens in Sunshine,</td>
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<td></td>
<td>• Australian Macedonian Pensioners’ Group of Reservoir,</td>
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<td>• Avondale Heights Elderly Citizens’ Clubs,</td>
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<td>• Bitola Macedonian Senior Citizens’ Group (Epping),</td>
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<td>• Errington Community Centre (St Albans),</td>
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<td>• Goce Delchev Senior Citizens’ Club (Epping),</td>
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<td>• Golden Sun Disabled and Elderly Citizens’ Club (Thomastown),</td>
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<td>• Keilor Downs Community Centre,</td>
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<td>• Keilor Macedonian Elderly Group (St Albans),</td>
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<td>• Macedonian Community Group (Springvale),</td>
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<td></td>
<td>• Macedonian Elderly Citizens’ Group of Geelong,</td>
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<td></td>
<td>• Macedonian Pensioners’ Association (Footscray),</td>
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<td></td>
<td></td>
<td></td>
<td>• Macedonia Pensioners’ Group (Bulleen),</td>
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9. DIMIA arrivals database  
10. DIMIA settlement database  
11. DIMIA settlement data 01/07/1996—30/06/2004  
12. DHS data  
## Appendix 2: Services for Victorian Refugee Communities (continued)

### Former Yugoslavia

#### Federal Republic of Yugoslavia (continued)

<table>
<thead>
<tr>
<th>Refugee Community by Country of Birth</th>
<th>Refugee arrivals aged 50+ since 1996</th>
<th>Areas of settlement: All age groups</th>
<th>HACC funding for Community Organisations 2003-2004</th>
<th>Non-HACC funded Community Organisations providing services for the elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bosnian-Herzegovina 253</td>
<td>Greater Dandenong 32.1%, Brimbank 16.2%, Darebin 7.2%, Maribyrnong 5.2%, Casey 4.9%, Greater Geelong 3.6%, Hobsons Bay 3.5%, Moonee Valley 2.8%, Moreland 2.7%, Frankston 2.0%, Hume 2.0%, Kingston 2.0%, Others 15.8%</td>
<td>Slavic $72,883, Serbian $92,722, Croatian $172,906</td>
<td>- Macedonian Senior Citizens’ of Hobsons Bay, Macedonian Senior Citizens’ Club (Sunshine West), Macedonian Senior Citizens’ Club (Altona North), Macedonian Senior Citizens’ Club (Preston), Macedonian Senior Citizens’ Club of Keysborough, Macedonian Senior Citizens’ Group (Herne Hill), Macedonian Senior Citizens’ Group, St Nicola ( Thomastown), Macedonian Senior Citizens’ Group of Monash, Monash Greek Macedonian Elderly Citizens’ Club, Greek Macedonian Elderly Club of Werribee, Macedonian Senior Citizens’ Group of Thomastown, Lator and Epping, Macedonian Women Pensioners’ Association of Footscray, Macedonian Women’s Social Club (Lalor), Montenegran Social Club (Prahran), Natarl Senior Citizens’ Clubs (Epping), Northcote Senior Citizens’ Group, Federation of the Macedonian Senior Citizens Groups (Doncaster), Serbian Australian Pensioners’ Association of Keysborough, Serbian Welfare Association of Victoria (Dandenong and St Albans), Serbian Community of Gippsland, Serbian Senior Citizens and Pensioners Club ‘Tzar Lazar’ (Rockbank), Slovenian Association of Melbourne (Eltham), Kew Migrant Chaplaincy, Slovenian Group in the La Trobe Valley, Slovenian Welfare Agency (Kew)</td>
<td>- Bosnian &amp; Herzegovinian Elderly Citizens Club (North), Bosnian &amp; Herzegovinian Islamic Society (North), Bosnian Muslim Elderly Citizens’ Group (Noble Park), Muslim Merhamet Elderly Club (Noble Park)</td>
</tr>
<tr>
<td>Refugee Community by Country of Birth</td>
<td>Refugee arrivals aged 50+ since 1996</td>
<td>Areas of settlement: All age groups</td>
<td>HACC funding for Community Organisations 2003-2004</td>
<td>Non-HACC funded Community Organisations providing services for the elderly</td>
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<tr>
<td><strong>Croatian</strong></td>
<td>153</td>
<td>Greater Dandenong: 34.3%</td>
<td>Croatian: $172,306</td>
<td>• Australian Croatian Senior Citizens’ Club (Dallas),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brimbank: 16.3%</td>
<td></td>
<td>• Australian Croatian Senior Citizens’ Association (Corio),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greater Geelong: 11.7%</td>
<td>Australian Croatian Community Services</td>
<td>• Australian Croatian Senior Citizens’ Club of Broadmeadows,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Casey: 6.9%</td>
<td>(North, West and South Met),</td>
<td>• Australian Croatian Senior Citizens’ Club of Gladstone Park,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maribyrnong: 4.5%</td>
<td>Croatian Catholic Welfare Association</td>
<td>• Croatian Elderly Citizens’ Club of Footscray,</td>
</tr>
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<td></td>
<td></td>
<td>Hobsons Bay: 3.7%</td>
<td>(Dandenong)</td>
<td>• Croatian Senior Citizens’ Group Keysborough,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Darebin: 3.2%</td>
<td></td>
<td>• Australian Croatian Senior Citizens’ Club of St.Albans,</td>
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<tr>
<td></td>
<td></td>
<td>Moreland: 2.3%</td>
<td></td>
<td>• Australian Croatian Senior Citizens’ Group of Brimbank,</td>
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<tr>
<td></td>
<td></td>
<td>Whittlesea: 2.1%</td>
<td></td>
<td>• Croatian Senior Citizens’ Group (Springvale),</td>
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<tr>
<td></td>
<td></td>
<td>Whitehorse: 1.9%</td>
<td></td>
<td>• Croatian Elderly Citizens’ Group,</td>
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<td></td>
<td></td>
<td>Other: 13.1%</td>
<td></td>
<td>• Angliss Senior Citizen’s Centre (Footscray),</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Croatian Senior Citizens in Sunshine</td>
</tr>
<tr>
<td><strong>Former USSR nfd</strong></td>
<td>27</td>
<td>Glen Eira: 34.9%</td>
<td>Russian: $153,200</td>
<td>• Russian Ethnic Representative Council of Victoria (Met and Geelong),</td>
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<tr>
<td>Russian Federation</td>
<td>1</td>
<td>Port Phillip: 33.7%</td>
<td></td>
<td>• St John of Kronstadt Russian Welfare Society (Dandenong)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stonnington: 12.0%</td>
<td></td>
<td>• Russian Welfare Society (Dandenong South)</td>
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<td></td>
<td></td>
<td>Monash: 4.8%</td>
<td></td>
<td>• Club Nadezhda (St Kilda)</td>
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<td></td>
<td></td>
<td>Bayside: 2.4%</td>
<td></td>
<td>• Moreland Russian Social Support</td>
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<td></td>
<td>• Russian Elderly Club (Dandenong)</td>
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<td></td>
<td>• Russian House Cultural Advancement Society (Fitzroy)</td>
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<td>• Russian Orthodox Church Abroad (Collingwood)</td>
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<td>• Russian Pensioners’ Club (Prahran)</td>
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<td>• Russian Senior Citizens’ Club of Box Hill</td>
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<td>• Russian Senior Citizens’ Club of Yarraville</td>
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<td>• Russian Senior Citizens’ Group (Dandenong)</td>
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<td>• Russian Social Support Club (Fitzroy)</td>
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<td>• Russian Social Support Group (Glenroy)</td>
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<td></td>
<td>• Russian Womens’ Club (Dandenong and Fitzroy)</td>
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<tr>
<td><strong>Belarusian</strong></td>
<td>N/A</td>
<td>N/A</td>
<td>See Russian entry above</td>
<td>See Russian entry above</td>
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<tr>
<td><strong>Ukrainian</strong></td>
<td>6</td>
<td>Ukrainian</td>
<td>Ukrainian $57,417</td>
<td>• Ukrainian Elderly Peoples’ Home (Delahay),</td>
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<td>• Ukraine Senior Citizens Centre (Ardeer),</td>
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<td>• Australian Ukrainian Senior Citizens’ Golden Age Fellowship (St Albas),</td>
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<td>• Ukrainian Elderly Citizens’ Club (Noble Park),</td>
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<td></td>
<td>• Ukrainian Pensioners’ Club (Hamlyn Heights),</td>
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## Appendix 2: Seniors’ Services for Victorian Refugee Communities (continued)

<table>
<thead>
<tr>
<th>Refugee Community by Country of Birth</th>
<th>Refugee arrivals aged 50+ since 1996</th>
<th>Areas of settlement: All age groups</th>
<th>HACC funding for Community Organisations 2003-2004</th>
<th>Non-HACC funded Community Organisations providing services for the elderly</th>
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<tbody>
<tr>
<td>Moldovan</td>
<td>N/A</td>
<td>N/A</td>
<td>Russian $153,200</td>
<td>See Russian and Ukrainian entries above</td>
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<td></td>
<td></td>
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<td>• Russian Ethnic Representative Council of Victoria (Met and Geelong),</td>
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<td>• St John of Kronstadt Russian Welfare Society (Dandenong),</td>
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<td></td>
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<td></td>
<td>• Association of Ukrainians in Victoria (Moonee Valley),</td>
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<td></td>
<td></td>
<td></td>
<td>• Australian Romanian Community Welfare, Health and SA of Victoria (North)</td>
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<tr>
<td>Latvian</td>
<td>2</td>
<td>N/A</td>
<td>Latvian $10,687</td>
<td>Latvian Friendly Society Hostel (Wantirna)</td>
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<td></td>
<td>• Latvian Friendly Society Hostel (Wantirna)</td>
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<tr>
<td>Polish</td>
<td>N/A</td>
<td>N/A</td>
<td>Polish $356,783</td>
<td>Australian Polish Benevolent Association of Victoria, Polish Retirement Home (Bayswater),</td>
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<td>• Australian Polish Community Services (Footscray),</td>
<td>Ardeer Polish Senior Citizens’ Club</td>
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<td>• Polish Community Council of Victoria (Boroondara)</td>
<td>Bentleigh Senior Citizens’ Club</td>
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<td>• Eastern Districts Polish Association (Rowville)</td>
<td>Errington Community Centre (St Albans)</td>
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<td>• Glengala Community Centre (Sunshine West)</td>
<td>Keilor Downs Community Centre</td>
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<td>• LaTrobe Valley Polish Senior Citizens’ Club (Morwell)</td>
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<td>• Melbourne Polish Senior Citizens’ Club (North Melbourne)</td>
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<td>• Polish Cultural and Social Club (Strathmore)</td>
<td>Polish Elderly Citizens’ Club of Gippsland</td>
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<td>• Polish Ladies Association in Oakleigh</td>
<td>Polish Senior Citizens’ Club of Dandenong</td>
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<td>• Polish Senior Citizens’ Club of Albion</td>
<td>Polish Senior Citizens’ Club of Altona</td>
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<td>• Polish Senior Citizens’ Club of Altona</td>
<td>Polish Senior Citizens’ Club of Caulfield</td>
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<td>• Polish Senior Citizens’ Club of Collingwood</td>
<td>Polish Senior Citizens’ Club of Doncaster</td>
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<td>• Polish Senior Citizens’ Club of Endeavour Hills</td>
<td>Polish Senior Citizens’ Club of Footscray</td>
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<td></td>
<td>• Polish Senior Citizens’ Club of Frankston</td>
<td>Polish Senior Citizens’ Club of Geelong</td>
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<td></td>
<td>• Polish Senior Citizens’ Club of Glenroy</td>
<td>Polish Senior Citizens’ Club of Geelong</td>
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<td></td>
<td>• Polish Senior Citizens’ Club of Frankston</td>
<td>Polish Senior Citizens’ Club of Glenroy</td>
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</tbody>
</table>


## Appendix 2: Seniors’ Services for Victorian Refugee Communities (continued)

<table>
<thead>
<tr>
<th>Refugee Community by Country of Birth</th>
<th>Refugee arrivals aged 50+ since 1996</th>
<th>Areas of settlement: All age groups</th>
<th>HACC funding for Community Organisations 2003-2004</th>
<th>Non-HACC funded Community Organisations providing services for the elderly</th>
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</thead>
<tbody>
<tr>
<td><strong>Polish (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td>• Polish Senior Citizens’ Club of Mount Waverly</td>
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<td>• Polish Senior Citizens’ Club of Prahran</td>
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<td></td>
<td>• Polish Senior Citizens’ Club of Reservoir</td>
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<td></td>
<td>• Polish Senior Citizens’ Club of Richmond</td>
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<td>• Polish Senior Citizens’ Club of St Kilda</td>
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<td></td>
<td></td>
<td>• Polish Senior Citizens’ Club of Werribee</td>
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<tr>
<td><strong>Uzbek</strong></td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td><strong>Iraqi</strong></td>
<td>220</td>
<td>Hume 35% Arabic $67,098</td>
<td>Islamic Elderly Group (Reservoir),</td>
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<td></td>
<td></td>
<td>Moreland 20%</td>
<td>Arabic Female Senior Citizens’ Group (Prahran),</td>
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<td></td>
<td>Whittlesea 11%</td>
<td>Kurdish Association of Victoria (Pascoe Vale),</td>
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<td></td>
<td></td>
<td>Darebin 10%</td>
<td>Arabic Older Peoples’ Group (Doveton),</td>
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<td>Arabic Senior Citizens’ Group (Brunswick),</td>
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<td>Arabic-Speaking Senior Citizens’ Group (East Melbourne),</td>
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<td>Elderly Arabic Group (Carlton North),</td>
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<td></td>
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<td>Northern Suburbs Arabic Senior Citizens’ Group (Dallas)</td>
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<tr>
<td><strong>Iranian</strong></td>
<td>53</td>
<td>Whitehorse 12.9%</td>
<td>Islamic Elderly Group (Reservoir)</td>
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<tr>
<td></td>
<td></td>
<td>Manningham 12.3%</td>
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<td></td>
<td></td>
<td>Monash 10.5%</td>
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<tr>
<td></td>
<td></td>
<td>Darebin 7.4%</td>
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<td></td>
<td></td>
<td>Greater Dandenong 6.3%</td>
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<td></td>
<td></td>
<td>Knox 6.3%</td>
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<td></td>
<td>Moreland 5.2%</td>
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<td></td>
<td></td>
<td>Boroondara 4.5%</td>
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<td></td>
<td></td>
<td>Greater Geelong 4.5%</td>
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<tr>
<td></td>
<td></td>
<td>Banyule 3.8%</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Other 26.3%</td>
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<td></td>
</tr>
</tbody>
</table>

### Refugees from Refugee Backgrounds

- **Polish (continued)**
  - Polish Senior Citizens’ Club of Mount Waverly
  - Polish Senior Citizens’ Club of Prahran
  - Polish Senior Citizens’ Club of Reservoir
  - Polish Senior Citizens’ Club of Richmond
  - Polish Senior Citizens’ Club of St Kilda
  - Polish Senior Citizens’ Club of Werribee

- **Uzbek**
  - N/A

- **Iraqi**
  - Hume 35%
  - Moreland 20%
  - Whittlesea 11%
  - Darebin 10%
  - Arabic $67,098

- **Iranian**
  - Whitehorse 12.9%
  - Manningham 12.3%
  - Monash 10.5%
  - Darebin 7.4%
  - Greater Dandenong 6.3%
  - Knox 6.3%
  - Moreland 5.2%
  - Boroondara 4.5%
  - Greater Geelong 4.5%
  - Banyule 3.8%
  - Other 26.3%
### Appendix 2: Senior Services for Victorian Refugee Communities (continued)

<table>
<thead>
<tr>
<th>Refuge Community by Country of Birth</th>
<th>Refugee arrivals aged 50+ since 1996&lt;sup&gt;9&lt;/sup&gt;</th>
<th>Areas of settlement: All age groups&lt;sup&gt;11&lt;/sup&gt;</th>
<th>HACC funding for Community Organisations 2003-2004&lt;sup&gt;12&lt;/sup&gt;</th>
<th>Non-HACC funded Community Organisations providing services for the elderly&lt;sup&gt;13&lt;/sup&gt;</th>
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</thead>
<tbody>
<tr>
<td>Afghan</td>
<td>110</td>
<td>Greater Dandenong 35.8%</td>
<td>$1,023,416</td>
<td>• Afghan Communities Council of Victoria (Endeavour Hills),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Casey 22.1%</td>
<td></td>
<td>• Australian Afghan Welfare Association (South East),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monash 10.2%</td>
<td></td>
<td>• Afghan Australian Elderly Group (Wheelers Hill)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frankston 6.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wyndham 4.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Boroondara 2.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kingston 2.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brimbank 2.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Darebin 2.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Knox 2.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Others 10.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Israeli</td>
<td>0</td>
<td>N/A</td>
<td></td>
<td>• Jewish Kadimah Club (Elsternwick),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Jewish Seniors’ Club (Doncaster),</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• National Council of Jewish Women Victoria (Kew),</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• South Caulfield Hebrew Congregation,</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• The Jack Kronhill Drop-in Centre (St Kilda)</td>
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<tr>
<td>Lebanese</td>
<td>2</td>
<td>Darebin</td>
<td>$67,098</td>
<td>• Frail Elderly Lebanese and A-S Group (Coburg),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hume</td>
<td></td>
<td>• Lebanese Elderly Group (Preston),</td>
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<td></td>
<td>Whittlesea</td>
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<td>• Australian Lebanese Welfare – general welfare (Coburg),</td>
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<td></td>
<td>Greater Dandenong</td>
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<td>• Western Suburbs Lebanese Welfare Committee – general welfare (Altona East),</td>
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<td>• Islamic Elderly Group (Reservoir),</td>
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<td>• Arabic Female Senior Citizens Group (Prahan)</td>
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<td>Palestinian</td>
<td>N/A</td>
<td>N/A</td>
<td>$67,098</td>
<td>• Islamic Elderly Group (Reservoir),</td>
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<td>• Arabic Female Senior Citizens Group (Prahan),</td>
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<td>• Arabic Older Peoples’ Group (Doveton),</td>
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<td>• Arabic Senior Citizens’ Group (Brunswick),</td>
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<td>• Arabic-Speaking Senior Citizens’ Group (East Melbourne),</td>
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<td></td>
<td>• Elderly Arabic Group (Carlton North),</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Northern Suburbs Arabic Senior Citizens’ Group (Dallas)</td>
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</table>
### Appendix 2: Seniors’ Services for Victorian Refugee Communities (continued)

<table>
<thead>
<tr>
<th>Refugee Community by Country of Birth</th>
<th>Refugee arrivals aged 50+ since 1996</th>
<th>Areas of settlement: All age groups</th>
<th>HACC funding for Community Organisations 2003-2004</th>
<th>Non-HACC funded Community Organisations providing services for the elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turkish</td>
<td>2</td>
<td>Hume 27.2%</td>
<td></td>
<td>Broadmeadows Turkish Senior Citizens Club,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mildura 26.6%</td>
<td></td>
<td>Whittlesea Turkish Elderly and Pensioners Association,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moreland 21.2%</td>
<td></td>
<td>Turkish Elderly Women’s Group (St Albans),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yarra 7.1%</td>
<td></td>
<td>Turkish Senior Citizens Club (Sunshine),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greater Dandenong 3.3%</td>
<td></td>
<td>Errington Community Centre (St Albans),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Glengala Community Centre (Sunshine West),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Kingston Turkish Senior Citizens’ Club (Bentleigh East),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Turkish Elderly and Pensioners’ Club (Coburg),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Turkish Older People (Noble Park).</td>
</tr>
</tbody>
</table>

| Pakistani                             | 1                                    | Darebin 30%                         |                                               | Chinese Senior Citizens Association (Footscray),                           |
|                                       |                                       | Greater Dandenong 30%               |                                               | Federation of Chinese Associations — Social Welfare Centre (City),          |
|                                       |                                       | Casey 22%                           |                                               | Box Hill Chinese Senior Citizens Club,                                    |
|                                       |                                       |                                    |                                               | Elderly Chinese Home (Parkville),                                          |
|                                       |                                       |                                    |                                               | Knox Chinese Elderly Citizens Club,                                        |
|                                       |                                       |                                    |                                               | Chinese Senior Citizens Club of Manningham,                                |
|                                       |                                       |                                    |                                               | Waverley Chinese Senior Citizens Club                                    |
|                                       |                                       |                                    |                                               | Xinjiang Senior Citizens Association (South East),                         |
|                                       |                                       |                                    |                                               | Western Suburbs Chinese Women’s Association (St Albans),                  |

| Chinese                               | 5                                    | Boroondara 16.3%                    | Chinese $550,928 | Chinese Community Social Services Centre (Monash and Manningham),         |
|                                       |                                       | Greater Dandenong 16.3%             |                   | Victorian Elderly Chinese Welfare Association (West)                      |
|                                       |                                       | Manningham 11.6%                    |                   |                                                                           |
|                                       |                                       | Monash 11.6%                        |                   |                                                                           |
|                                       |                                       | Darebin 9.3%                        |                   |                                                                           |
|                                       |                                       |                                    |                   |                                                                           |
|                                       |                                       |                                    |                   |                                                                           |
| Vietnamese                            | 7                                    | Brimbank Vietnamese $90,598         |                   | Australian Vietnamese Women’s Welfare Association (Richmond),             |
|                                       |                                       | Greater Dandenong Indochinese $217,659|                   | Indo-Chinese Elderly in the Eastern Suburbs (Blackburn),                |
|                                       |                                       | Maribyrnong                          |                   | Indo-Chinese Elderly Refugees Association (Richmond),                    |
|                                       |                                       | Darebin                               |                   | Vietnamese Community in Australia, Victoria Chapter (Footscray)            |
|                                       |                                       | Yarra                                 |                   |                                                                           |
|                                       |                                       |                                    |                   |                                                                           |
|                                       |                                       |                                    |                   |                                                                           |
|                                       |                                       |                                    |                   |                                                                           |

| Vietnamese                            | 7                                    | Brimbank Vietnamese $90,598         |                   | Australian Vietnamese Women’s Welfare Association (Richmond),             |
|                                       |                                       | Greater Dandenong Indochinese $217,659|                   | Indo-Chinese Elderly in the Eastern Suburbs (Blackburn),                |
|                                       |                                       | Maribyrnong                          |                   | Indo-Chinese Elderly Refugees Association (Richmond),                    |
|                                       |                                       | Darebin                               |                   | Vietnamese Community in Australia, Victoria Chapter (Footscray)            |
|                                       |                                       | Yarra                                 |                   |                                                                           |
|                                       |                                       |                                    |                   |                                                                           |
|                                       |                                       |                                    |                   |                                                                           |
|                                       |                                       |                                    |                   |                                                                           |
|                                       |                                       |                                    |                   |                                                                           |

### Areas of settlement: All age groups
- Hume
- Mildura
- Moreland
- Yarra
- Greater Dandenong

### HACC funding for Community Organisations 2003-2004
- Chinese
- Vietnamese
- Indochinese

### Non-HACC funded Community Organisations providing services for the elderly
- Broadmeadows Turkish Senior Citizens Club
- Whittlesea Turkish Elderly and Pensioners Association
- Turkish Elderly Women’s Group (St Albans)
- Turkish Senior Citizens Club (Sunshine)
- Errington Community Centre (St Albans)
- Glengala Community Centre (Sunshine West)
- Kingston Turkish Senior Citizens’ Club (Bentleigh East)
- Turkish Elderly and Pensioners’ Club (Coburg)
- Turkish Older People (Noble Park)
## Appendix 2: Services for Victorian Refugee Communities (continued)

<table>
<thead>
<tr>
<th>Refugee Community by Country of Birth</th>
<th>Refugee arrivals aged 50+ since 1996</th>
<th>Areas of settlement: All age groups</th>
<th>HACC funding for Community Organisations 2003-2004</th>
<th>Non-HACC funded Community Organisations providing services for the elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodian</td>
<td>0</td>
<td>Greater Dandenong 64.2%</td>
<td>Indo-Chinese $217,659</td>
<td>• Cambodian Community Welfare Association – general welfare (Nunawading),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kingston 8.7%</td>
<td></td>
<td>• Indo-Chinese ADASS Program (Footscray),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Whitehorse 5.9%</td>
<td></td>
<td>• Springvale Indo-Chinese Mutual Assistance Association,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monash 2.3%</td>
<td></td>
<td>• Fitzroy Indo-Chinese Elderly Group.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Glen Eira 1.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hobsons Bay 1.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maribyrnong 1.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other 13.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burmese</td>
<td>5</td>
<td>Hobsons Bay 27.0%</td>
<td></td>
<td>• Australia Burma Myanmar Society – general welfare (Chadstone)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greater Dandenong 24.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maribyrnong 6.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monash 6.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moreland 5.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Banyule 4.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hume 4.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Knox 4.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Whitehorse 4.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other 13.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laotian</td>
<td>N/A</td>
<td>Greater Dandenong</td>
<td>Lao $37,760</td>
<td>• Lao Australian Welfare Association (Forest Hill)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brimbank</td>
<td>Indo-Chinese $217,659</td>
<td>• Indo-Chinese ADASS Program (Footscray),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Knox</td>
<td></td>
<td>• Springvale Indo-Chinese Mutual Assistance Association,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mooney Valley</td>
<td></td>
<td>• Fitzroy Indo-Chinese Elderly Group.</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
### Appendix 2: Services for Victorian Refugee Communities (continued)

<table>
<thead>
<tr>
<th>Refugee Community by Country of Birth</th>
<th>Refugee arrivals aged 50+ since 1996(^a)</th>
<th>Areas of settlement: All age groups(^{11})</th>
<th>HACC funding for Community Organisations 2003-2004(^2)</th>
<th>Non-HACC funded Community Organisations providing services for the elderly(^{13})</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Timorese</td>
<td>N/A</td>
<td>Richmond, Brimbank, St Albans, Narre Warren, Epping</td>
<td>Precise figures not available</td>
<td>• Timorese Chinese Middle and Aged Association (Richmond)</td>
</tr>
<tr>
<td>Indonesian</td>
<td>4</td>
<td>Moonee Valley 20.0% Yarra 16.7% Brimbank 13.3% Casey 13.3% Golden Plains 6.7%</td>
<td></td>
<td>• Australian Timorese Elderly Citizen’s Group (Meadow Heights)</td>
</tr>
<tr>
<td>Sri Lankan</td>
<td>43</td>
<td>Greater Dandenong 31.8% Monash 13.7% Whittlesea 8.4% Brimbank 6.7% Kingston 6.7%</td>
<td>Ceylonese $2,365 Sri Lankan $12,417</td>
<td>• Australian Timorese Elderly Group (Springvale)</td>
</tr>
<tr>
<td>Somali</td>
<td>62</td>
<td>Moonee Valley 21% Melbourne 12% Banyule 12% Hume 11%</td>
<td>African $55,309</td>
<td>• Al Ansar Islamic Association – general welfare (Kensington),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Somali Community in Victoria — help for new arrivals (Flemington),</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Southern Somali Welfare Association — help for new arrivals (Coburg),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Horn of African Communities Network (Footscray),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Maribyrnong Horn of Africa Women’s Group</td>
</tr>
</tbody>
</table>

\(^1\) Refugee arrivals aged 50+ since 1996

\(^2\) HACC funding for Community Organisations 2003-2004

\(^3\) Refugee Community by Country of Birth

\(^11\) Areas of settlement: All age groups

\(^12\) Non-HACC funded Community Organisations providing services for the elderly
## Appendix 2: Services for Victorian Refugee Communities (continued)

<table>
<thead>
<tr>
<th>Refugee Community by Country of Birth</th>
<th>Refugee arrivals aged 50+ since 1996(^9)</th>
<th>Areas of settlement: All age groups(^1)</th>
<th>HACC funding for Community Organisations 2003-2004(^2)</th>
<th>Non-HACC funded Community Organisations providing services for the elderly(^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sudanese</strong></td>
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<td>• Australian Southern Sudanese Support Group – help for new arrivals (Holmesglen),</td>
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<tr>
<td></td>
<td></td>
<td>Maribyrong 12.9%</td>
<td></td>
<td>• Sudanese Community Association in Australia – help for new arrivals (Dandenong),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moonee Valley 9.1%</td>
<td>• North West Region Migrant Resource Centre – African Communities Elderly Association of Victoria (North Melbourne),</td>
<td>• Southern Sudanese Christian Fellowship of West Footscray,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monash 8.6%</td>
<td>• Horn of Africa Senior Women’s Program (Kensington),</td>
<td>• Horn of African Communities Network (Footscray)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brimbank 8.0%</td>
<td>• Victorian Arabic Social Services (Broadmeadows),</td>
<td>• Maribyrng Horn of Africa Women’s Group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Manningham 6.8%</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kingston 5.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Darebin 5.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Glen Eira 2.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Melbourne 2.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Others 12.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ethiopian</strong></td>
<td>24</td>
<td>Maribyrong 28.9%</td>
<td>African $55,309</td>
<td>• Ethiopian Community Association in Victoria – help for new arrivals (Footscray),</td>
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<td></td>
<td></td>
<td>Moonee Valley 23.0%</td>
<td></td>
<td>• Hararian Community Association – help for new arrivals (North Melbourne),</td>
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<td></td>
<td></td>
<td>Greater Dandenong 9.9%</td>
<td>• North West Region Migrant Resource Centre – African Communities Elderly Association of Victoria (North Melbourne),</td>
<td>• Horn of African Communities Network (Footscray),</td>
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<td></td>
<td></td>
<td>Melbourne 6.6%</td>
<td>• Horn of Africa Senior Women’s Program (Kensington),</td>
<td>• Maribyrng Horn of Africa Women’s Group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monash 6.6%</td>
<td>• Association,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brimbank 5.3%</td>
<td>• North West Region Migrant Resource Centre – St Mary’s Coptic Church</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Yarra 4.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Darebin 3.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other 11.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eritrean</strong></td>
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<td>Greater Dandenong 38%</td>
<td>African $55,309</td>
<td>• Eritrean Community Association (Hotham Hill),</td>
</tr>
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<td></td>
<td></td>
<td>Maribyrong 21%</td>
<td></td>
<td>• Victorian Eritrean Community Association (Footscray),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moonee Valley 21%</td>
<td>• North West Region Migrant Resource Centre – African Communities Elderly Association of Victoria (North Melbourne),</td>
<td>• Horn of African Communities Network (Footscray),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Horn of Africa Senior Women’s Program (Kensington),</td>
<td>• Maribyrng Horn of Africa Women’s Group</td>
</tr>
<tr>
<td><strong>Egyptian(^5)</strong></td>
<td>9</td>
<td>Manningham 11.6%</td>
<td>Arabic $67,098</td>
<td>• Islamic Elder Group (Reservoir),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Whittlesea 11.0%</td>
<td></td>
<td>• Arabic Female Senior Citizens Group (Prahan),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greater Dandenong 9.8%</td>
<td>• Victorian Arabic Social Services (Broadmeadows),</td>
<td>• Arabic Older Peoples’ Group (Doveton),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monash 9.2%</td>
<td>• North West Region Migrant Resource Centre – African Communities Elderly Association,</td>
<td>• Arabic Senior Citizens’ Group (Brunswick),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moreland 6.3%</td>
<td>• North West Region Migrant Resource Centre –</td>
<td>• Arabic-Speaking Senior Citizens’ Group (East Melbourne),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Casey 5.8%</td>
<td>St Mary’s Coptic Church,</td>
<td>• Elderly Arabic Group (Carlton North),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Darebin 5.2%</td>
<td></td>
<td>• Northern Suburbs Arabic Senior Citizens’ Group (Dallas)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kingston 5.2%</td>
<td></td>
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</tbody>
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### Appendix 2: Seniors' Services for Victorian Refugee Communities (continued)

<table>
<thead>
<tr>
<th>Refugee Community by Country of Birth</th>
<th>Refugee arrivals aged 50+ since 1996</th>
<th>Areas of settlement: All age groups</th>
<th>HACC funding for Community Organisations 2003-2004</th>
<th>Non-HACC funded Community Organisations providing services for the elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egyptian (continued)</td>
<td>9</td>
<td>4.5% (Brimbank), 4.0% (Hume), 27.4% (Other)</td>
<td>• Horn of Africa Senior Women's Program (Kensington)</td>
<td></td>
</tr>
<tr>
<td>Other Central &amp; West Africa</td>
<td>N/A</td>
<td>Darebin, Greater Dandenong, Hobsons Bay, Mooroolbark, Moreland</td>
<td>African $55,309</td>
<td>• Eastern and Central African Communities of Victoria (Prahran)</td>
</tr>
<tr>
<td>El Salvador</td>
<td>1</td>
<td>N/A</td>
<td>Spanish $128,802</td>
<td>• Circle of Spanish Elderly (City), Primavera Latin American Association (Prahran), Spanish Speaking Elderly Group (St Albans), ACRO IRIS Spanish Elderly Group (Footscray), Spanish Speaking Pensioners of Werribee, Amigos de America (Noble Park), Errington Community Centre (St Albans), Groupa Primavera Spanish-Speaking Group (Prahran), Latino-Spanish Senior Citizens' Club (Springvale), Spanish Elderly Citizens’ Citizens’ Club of Clayton, Spanish Prodela Women’s Group (Springvale), Spanish Senior Citizens’ Club (Broadmeadows), Spanish Senior Citizens’ Club (St Albans), Spanish Speaking Friendship Club (Endeavour Hills), Spanish Speaking Group of Carlton, Spanish Speaking Group of Pensioners and Citizens (Werribee), Spanish Speaking Women’s Group (Meadow Heights), Spanish Speaking Friendship Club (Endeavour Hills), Spanish Speaking Group of Pensioners and Citizens (Werribee), Spanish Speaking Women’s Group (Meadow Heights).</td>
</tr>
<tr>
<td>Colombia</td>
<td>3</td>
<td>N/A</td>
<td>Spanish $128,802</td>
<td>• Circle of Spanish Elderly (City), Primavera Latin American Association (Prahran), Spanish Speaking Elderly Group (St Albans), ACRO IRIS Spanish Elderly Group (Footscray), Spanish Speaking Pensioners of Werribee, Amigos de America (Noble Park), Errington Community Centre (St Albans), Groupa Primavera Spanish-Speaking Group (Prahran), Latino-Spanish Senior Citizens’ Club (Springvale), Spanish Elderly Citizens’ Citizens’ Club of Clayton, Spanish Prodela Women’s Group (Springvale), Spanish Speaking Friendship Club (Endeavour Hills), Spanish Speaking Group of Pensioners and Citizens (Werribee), Spanish Speaking Women’s Group (Meadow Heights), Spanish Speaking Group of Pensioners and Citizens (Werribee), Spanish Speaking Women’s Group (Meadow Heights), Spanish Speaking Friendship Club (Endeavour Hills), Spanish Speaking Group of Pensioners and Citizens (Werribee), Spanish Speaking Women’s Group (Meadow Heights).</td>
</tr>
</tbody>
</table>
## Appendix 2: Services for Victorian Refugee Communities (continued)

<table>
<thead>
<tr>
<th>Refugee Community by Country of Birth</th>
<th>Refugee arrivals aged 50+ since 1996 (^9)</th>
<th>Areas of settlement: All age groups (^{11})</th>
<th>HACC funding for Community Organisations 2003-2004 (^2)</th>
<th>Non-HACC funded Community Organisations providing services for the elderly (^13)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Spanish Senior Citizens’ Club (Broadmeadows),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Spanish Senior Citizens’ Club (St Albans),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Spanish Speaking Friendship Club (Endeavour Hills),</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Spanish Speaking Group of Carlton,</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Spanish Speaking Group of Pensioners and Citizens (Werribee),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Spanish Speaking Women’s Group (Meadow Heights).</td>
</tr>
</tbody>
</table>

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\(^9\) \(^{11}\) \(^{13}\) \(^{2}\)
Appendix 3  Maps showing Settlement Patterns by LGA for Selected Refugee Communities in Melbourne
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Appendix 3  Maps showing Settlement Patterns by LGA for Selected Refugee Communities in Melbourne (continued)
Appendix 3  Maps showing Settlement Patterns by LGA for Selected Refugee Communities in Melbourne (continued)
Appendix 3  Maps showing Settlement Patterns by LGA for Selected Refugee Communities in Melbourne (continued)
Appendix 3  Maps showing Settlement Patterns by LGA for Selected Refugee Communities in Melbourne (continued)

1996-2003 Cambodia-born arrivals to Victoria aged 35+
Settlement by LGA

LEGEND

- 163 / 64.2% (Greater Dandenong)
- 22 / 8.7% (Kingston)
- 15 / 5.9% (Whitehorse)
- 6 / 2.3% (Monash)
- 5 / 1.9% (Glen Eira, Hobsons Bay, Maribyrnong)
Appendix 3  Maps showing Settlement Patterns by LGA for Selected Refugee Communities in Melbourne (continued)
Appendix 3  Maps showing Settlement Patterns by LGA for Selected Refugee Communities in Melbourne (continued)
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Appendix 3  Maps showing Settlement Patterns by LGA for Selected Refugee Communities in Melbourne (continued)

1996-2003 arrivals in Victoria from other Southern & Eastern African countries (all ages)

LEGEND

Moonee Valley, Maribyrnong, Melbourne, Darebin, Yarra, Casey, Greater Dandenong
Appendix 3  Maps showing Settlement Patterns by LGA for Selected Refugee Communities in Melbourne (continued)
Appendix 3  Maps showing Settlement Patterns by LGA for Selected Refugee Communities in Melbourne (continued)
Appendix 3  Maps showing Settlement Patterns by LGA for Selected Refugee Communities in Melbourne (continued)
Appendix 4 Organisations and Individuals Consulted

The authors would like to thank all those listed below who generously gave of their time and experience to assist with this study:

Community Workers

Abdul Khaliq Fazal, Afghan Australian Association of Victoria, Dandenong
Amina Malakin, Horn of Africa Senior Women’s Program, Kensington
Melika Shiekh-Eldin, Horn of Africa Communities Network, Footscray, and
AMES Senior Women’s Project, Carlton
Terefe Aborete, Horn of Africa Family Services, CentaCare Footscray
Theresa Sengaaga Ssali, Ayuel Bulkoch, Arhet Geberat and Wepukhulu Zebet,
Eastern and Central African Communities of Victoria, South Central Region
MRC, Prahran
Poly Kiyaga, Sudanese Australian Integrated Learning Program, Footscray
Bunnary Soch, Cambodian Community Welfare Centre, Nunawading
Youhorn Chea, Cambodian Association of Victoria, Springvale
Etervina Groenen, East Timorese Community Worker, Richmond Community
Health Centre
Boungnou Phaosihavong, Lao-Australian Welfare Association, Nunawading
Eva Makim, HACC Programs Co-ordinator, Victorian Arabic Social Services,
Broadmeadows
Lina Hassan, Iraqi Community Worker, Victorian Arabic Social Services,
Broadmeadows
Lien Thai, Vietnamese Family Services worker, Centacare, Footscray
Sheikh Fehmi Naji El-Imam, Preston Mosque
Chris Pearson, Project Manager, United Wood Cooperative, AMES Carpentry
Unit Trust for older African men, Brunswick
Sarah Castle, Jesuit Social Services, Richmond
Lew Hess, Regional Manager, Victorian Foundation for the Survivors of Torture
Therese Meehan, Regional Manager, Victorian Foundation for the Survivors of Torture
Maria Tucci, Counsellor Advocate, Victorian Foundation for the Survivors of Torture
Sab Flamuris, Counsellor Advocate, Victorian Foundation for the Survivors of Torture

Ethnic Communities Council of Victoria

Jenny Ashby, CEGS Co-ordinator
Migrant Resource Centres

Elizabeth McGarry, Aged and Disability Team Leader, North West Region MRC, St Albans
David Lukudu, Settlement Support Co-ordinator, North West Region MRC, Broadmeadows
Kass Halastanis, HACC Advocacy and Equity Worker, South Central Region MRC, Prahran
Nirmala Abraham, Social Worker Small and Emerging Communities Seniors Project, Northern Region MRC, Preston
Wina Kung, HACC Equity and Access Officer, Eastern Region Migrant Information Centre, Mitcham

Local Councils

Katherine Wositzky, CEGS Co-ordinator, Municipal Association of Victoria
Carol Fraser, CEGS Officer, Maribyrnong Council
Libby Mattheson, HACC Officer, Dandenong Council and South East Region MRC
Melis Cevik, Cultural Access Officer, Hume City Council

Individuals

Tint San, Refugee Health Research Centre
Sara Bice, Refugee Health Research Centre
Robyn Sampson, Refugee Health Research Centre