"Ageing Your Way, My Way - Working Together"

Spiritus research into the emerging ageing CALD communities in Brisbane

S Abbato &
J Durham
JULY 2011

Spiritus
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home and community care
A JOINT COMMONWEALTH AND STATE/TERRITORY PROGRAM PROVIDING FUNDING AND ASSISTANCE FOR AUSTRALIANS IN NEED

Samantha Abbato And Associates
Evaluation, Research, Strategic Planning

Citation: Abbato, S and Durham J. Ageing Your Way, My Way-Working together: Spiritus research in to the emerging ageing CALD communities in Brisbane. Spiritus HACC Multicultural Program, Brisbane.2011

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ACKNOWLEDGEMENTS

We would like to thank all the representatives of community organisations and individuals who gave their time and shared their wisdom to participate in the consultations for this project. We sincerely hope you benefit from this research as you age in Australia.

EXECUTIVE SUMMARY

In 2011 Spiritus Multicultural Program received HACC funding to conduct research into the emerging ageing culturally and linguistically (CALD) communities in the greater Brisbane area.

Following demographic research, the communities identified were: Pacific Islander, Vietnamese, people from the former Yugoslavia, Indian, Filipino, Central & South American, Sri Lankan and African.

Research staff met representatives of these communities, discussed their identified issues related to ageing in Australia, what current supports they used, any unmet needs, and how HACC service providers can best engage with senior members of these communities.

This information has been collated, and brief cultural profiles for each community group were developed using the information gained from interviews and a literature review.

In all traditional cultures it is customary for younger members of the family to care for their aged. It is a clear duty of the younger people and an expectation by their elders. In Australia, the lifestyle is different and younger people are busy with work and their own families and have less capacity to do this. In many cases this unmet need is not spoken about as it is associated with 'loss of face', and shame. For many seniors, the shame is worse than the isolation.

Some of the findings confirmed existing knowledge – that the greatest issues for CALD seniors is isolation, even within their own families, that they lack knowledge and understanding of aged care services, and identify transport as a key unmet need.

Less well known was the extent of small, un-funded and volunteer run community groups providing social services to their own communities. Leaders of these groups have established community networks, the trust of the community, the ability to organise social events for elders and also act as a liaison between service providers and the community. Some suggested strategies to link with and support these groups are identified.

Recommendations include community development and communication strategies to increase awareness and understanding of HACC services among emerging CALD communities, and the model of a "community navigator" who can support people to navigate health and aged care systems, as well as provide links and information to service providers.

A separate report (Part 2) lists all the community organisations contacted for this research, as well as a couple already in the Queensland Multicultural Resource Directory (Queensland 2009). This list is provided as a resource for all HACC services, and participants agreed to publication with the proviso that it be made available only for this purpose. For this reason Part 2 of the report is available to HACC service providers only.

The aim of this research is to facilitate connections between CALD communities and HACC services, to enable all Queenslanders, no matter what language or cultural background, to age with dignity and appropriate care.

ABBREVIATIONS

ABS	Australian Bureau of Statistics
CALD	Culturally and linguistically diverse
ELS	Ethnic Link Services
HACC	Home and community care
NGO	Non-government organisation
PNG	Papua New Guinea

BACKGROUND TO THE PROJECT

The population of Brisbane is becoming more diverse, with over a quarter (493,678 or 28%) of the population born overseas, and more than half of these from culturally and linguistically diverse (CALD) backgrounds. According to the 2006 ABS Census, 16% of Brisbane residents speak a language other than English at home, this is an increase from 13.5% in 2001 (Australian Bureau of Statistics 2007).

Some CALD communities are currently experiencing a peak in their aged population, with younger generations integrating into the mainstream culture, speaking English, accessing services and fully participating in the Queensland community. Examples of these are Italian, Greek and Polish communities, with 76%, 70% and 49% of people born in these countries aged 55 or older in the 2006 Census (Australian Bureau of Statistics 2011).

Other CALD communities have emerging ageing populations and will experience an increase in the proportion of people aged 55 or older in the next 10 to 20 years.

The aim of this project was to identify these emerging ageing populations, to begin a dialogue with them, to learn the needs of the older people in these communities in order to inform future Home and Community Care (HACC) service delivery.

OBJECTIVES

The objectives of the project were:

-Identify the emerging ageing CALD communities with the largest population numbers aged 55 and older.

- Determine the most appropriate services, organisations and groups within these emerging communities to consult with on aged care needs, and create a database of these contacts, to be available to all HACC service providers in Brisbane and surrounds.

-Explore what is currently in place to support the needs of these seniors and note any self-identified unmet needs.

-Develop a brief profile on the seniors in each community identified, in order to guide HACC service providers in providing more culturally appropriate care.

CONSULTATION PROCESS

The Consumer Participation Strategy Framework was used to guide the process of the consultation (Brager and Sprecht 1973; Centre for Culture, Ethnicity and Health 2011). Consumer participation in health has been shown to lead to more accessible and effective health services, and to improve health outcomes as well as the quality of health services (National Resource Centre for Consumer Participation in Health 2001; Centre for Culture, Ethnicity and Health 2005; Metropolitan Health and Aged Care Services Division 2005). The Consumer Participation Framework lists a range of strategies along a continuum; from the consumer being informed and being consulted, to the consumer advising and jointly planning with the organisation, enabling increased control in decision making. This framework is shown in Figure 1. The methodology for the current project was based on the second column of strategies- “the consumer is consulted”.

Figure 1: Consumer Participation Strategies Framework (Centre for Culture, Ethnicity and Health 2011)

The consumer	Receives information	Is consulted	Advises the organisation	Plans jointly	Has delegated control	Has control
Description	CALD consumers receive one-way information from a service or organisation	CALD consumers are invited to a structured discussion where they share their knowledge and views on a particular topic.	A formal process is established to enable CALD consumers o provide information to the organisation on a regular basis.	CALD consumers are a core part of the organisation's planning processes, as well as implementation and evaluation.	CALD consumers are given the responsibility to make decisions about an aspect of an organisation or its services	CALD consumers have representation in governing bodies and actively participate in the organisation's decison-making processes.
Example	▪ Information sessions ▪ Printed material ▪ Media (e.g. Radio or newspapers)	▪ Focus groups ▪ Forums ▪ Community consultations ▪ Stakeholder interviews ▪ Surveys or feedback forms	▪ Consumer advisory groups ▪ Project advisory groups	Input from consumer representatives is factored into each stage of planning.	▪ Consumer planning days ▪ Consumer representatives sign off on planning outcomes	CALD consumers on Board
Benefits	▪ Informs consumers about a specific issue or service ▪ Consumers can make informed decisions ▪ Can reach a large number of people in a small amount of time ▪ Consumers can take information away to review	▪ Organisation can ask specific questions of interest ▪ Provides opportunities for consumers to express their views ▪ Allows for the consumer's specific cultural and linguistic requirements to be met ▪ Small-group discussion allows topics to be explored in depth	▪ Consumers are able to initiate discourse and topics for discussion ▪ Organisation can collect diverse perspectives on an issue or topic ▪ Organisation is able to target particular communities and engage with them on a specific issue	▪ Plans reflect the needs of CALD consumers ▪ Consumers who are involved in planning are more likely to promote teh service within their communities ▪ Potential consumer issues can be identified and managed at an early stage	▪ Community has greater ownership of the process ▪ Plans and services are more likely to be culturally appropriate ▪ Services are tailored to meet the needs of CALD consumers	▪ Consumers are represented across the decision-making process ▪ Organisation can build strong links with community leaders ▪ Consumer representatives have opportunities for skill enhancement and social participation ▪ Cultural and linguistic considerations can be addressed at all levels of the program and service planning
Actions for success	▪ Use simple English or relevant languages ▪ Pilot-test resources prior to use, to ensure their effectiveness ▪ Use culturally appropriate venues and disseminate material through community representatives ▪ Provide opportunitiers for consumers to provide feedback on the information provided	▪ Provide incentives for participation ▪ Consider more than one form of consultation to cater for age, gender and availability ▪ Ensure that survey tools are linguistically appropriate ▪ Where possible, provide feedback on findings or action to the community ▪ Train bilingual facilitators in consultation methodologies	▪ Select consumer representatives who have knowledge and interest in the issue to be discussed ▪ Field-test questions to ensure that consumers can understand and respond to them	▪ Use ethno-specific and multicultural organisations as a starting point for identifying and recruiting consumer representatives ▪ Find representatives who have strong links with thier communities ▪ Support and mentor consumer representatives	▪ Ensure that there is sustained involvement throughout the process of planning, implementation and evaluation ▪ Ensure that interpreting and translating services are provided as required ▪ Consult with the consumers to develop procedures for planning days or steering groups	▪ Consult with CALD communities to identify appropriate representatives ▪ Train, support and mentor the consumer representative ▪ Provide interpreting adn translating services as required by the consumer representative
Remember...	▪ Pitch information at the appropriate comprehension and literacy levels of your audience	▪ Consumers may not be familiar with consultation techniques ▪ Field-test questions and survey tools ▪ Consider whether written surveys are appropriate for particular groups	▪ Consumer input must influence decision-making processes; the group's contribution should not be tokenistic ▪ Ensure that the issue is relevant to consumers before seeking their advice	▪ Be flexible about meeting times, structures and processes ▪ Be clear what you expect from consumer representatives ▪ Provide incentives for participation	▪ Some consumers may no be experienced in attending meetings or collaborative decision-making processes ▪ Planning days and steering groups can take some time to coordinate ▪ Evaluate the process to identify what worked and what could be improved	▪ One consumer cannot represent all CALD communities ▪ The consumer representative is not a 'cultural expert' for their entire community ▪ Identified 'leaders' may only represent certain sections of the community ▪ Cultually, people may notg be familiar with providing direct opinions in a public setting

METHODS

IDENTIFYING AGEING CALD COMMUNITIES IN BRISBANE

The 2006 ABS census was used to identify CALD countries and regions of birth with the highest absolute numbers in the 55 and older age group in Brisbane. Those communities experiencing peaks in the 55 and older age group from 2011 to 2020 were excluded. These groups (e.g. Italian, Greek, Polish and Dutch) have established aged-care services to support their ageing population. Other CALD communities with established aged care services specific to their community were excluded. These were Chinese, Finnish and Middle Eastern communities of Islamic faith.

Priority for inclusion was given to people from countries of origin with high numbers of refugees. People from refugee backgrounds have similar needs to other migrants in terms of receiving culturally appropriate services. However, people from refugee backgrounds will experience specific biological, psychological and social effects as they age including premature ageing, post traumatic stress disorder and additional communication barriers (Ageing Disability and Homecare: Kathryn Knight 2011) .

Using these criteria, eight CALD regions/countries were identified as emerging aging CALD communities in Brisbane:

1. Pacific Islander Australians
2. Vietnamese Australians
3. Countries of the Republic of Former Yugoslavia: Bosnian, Serbian and Croatian Australians
4. Indian Australians
5. Filipino Australians
6. South and Central American Australians
7. Sri Lankan Australians
8. African Australians.

DEVELOPMENT OF AN ANNOTATED LIST OF CALD COMMUNITY GROUPS

The Queensland Multicultural Resource Directory (Queensland 2009) was initially used to identify CALD community services, organisations, cultural and religious groups for the eight identified regions/countries. The Spiritus HACC Multicultural Program Manager and Principal Consultant provided additional contacts known through previous projects for each of the eight regions/countries. These community contacts were contacted by phone and email to determine the role of the listed organisations and groups in relation to ageing issues and to identify the appropriate representatives of each group to consult about aged care service issues.

Individuals identified as having a role relevant to ageing issues were invited to participate in a face-to-face or phone interview and a date, time and venue convenient to them was determined. Participants were informed of the Spiritus Privacy Statement and verbal consent sought to include their contact information in a listing of CALD community representatives, in cases where they were not previously publically listed. This database is to be available to all HACC services in Brisbane and surrounds, to encourage linkages, where appropriate, with local CALD groups. The extent of the current consultation and recommendations for future engagement were recorded by the consultant.

The annotated list for community groups is presented in Part 2 of this report, available to HACC service providers.

IDENTIFICATION OF AGED CARE SERVICE NEEDS OF CALD COMMUNITIES

A combination of interviews and group discussions were conducted for each of the eight CALD regions/countries. The consultants were accompanied by a staff member from Spiritus HACC Multicultural Program. Between three and six interviews/discussions were conducted with identified community representatives from each CALD region/country.

After verbal consent was obtained, the interviews were guided by a list of broad questions about the needs of the ageing community (see Appendix). The face-to-face interviews and group discussions were between 60 and 75 minutes in duration. The phone interviews were between 30 and 45 minutes long. Brief notes taken by the consultant during the interviews were expanded and typed into a word processing document. The interview and discussion notes were read by both project consultants and analysed for specific content and themes. This was considered overall for all CALD regions/countries and individually for each of the eight CALD regions/countries separately.

DEVELOPMENT OF CULTURAL PROFILES FOR EACH CALD COMMUNITY

Profiles were developed for each of the eight regions/countries by:

- Analysing relevant data on ageing by country of birth of the ABS 2006 Census database.
- Reviewing the research and unpublished literature in Australia and overseas.
- Analysing the responses to the interview questions (see Appendix) of the CALD community representatives in the current project.

FINDINGS

The findings are presented in three sections:

1. The statistics identifying the top eight culturally and linguistically diverse ageing communities in Brisbane
2. Cultural profiles of the eight communities based on a review of the literature, analysis of 2006 ABS Census data and interviews and discussion with CALD representatives.
3. A summary of findings across all eight CALD community groupings

The annotated listings of community organisations are presented in Part 2 of the report.

1. SUMMARY OF EIGHT CULTURALLY AND LINGUISTICALLY DIVERSE AGEING COMMUNITIES: POPULATION STATISTICS IN BRISBANE[1]

Table 1 below shows the age distribution and numbers and percentage of the population aged 55 and older for the eight identified emerging ageing CALD populations of Brisbane.

Table 1: Age distribution of identified emerging CALD populations of Brisbane[1]

	AGE CATEGORY								
	0-19 yrs		20-39 yrs		40-54 yrs		55+ Years		TOTAL
COUNTRY/REGION OF BIRTH	No.	Percent	No.	Percent	No.	Percent	No.	Percent	
1. Pacific Islands[2]	2,141	10.9%	7,857	40.1%	6,367	32.5%	3,212	16.4%	19,577
2. Vietnam	510	4.3%	5,150	43.4%	4,136	34.9%	2,062	17.4%	11,858
3. Countries of the Former Republic of Yugoslavia[3]	702	11.1%	1,638	25.9%	1,969	31.2%	2,009	31.8%	6,318
4. India	760	10.1%	3,239	42.9%	1,767	23.4%	1,780	23.6%	7,546
5. Philippines	1,279	13.0%	3,622	36.7%	3,533	35.8%	1,435	14.5%	9,869
6. Spanish speaking countries[4]	444	8.4%	2,252	42.6%	1,530	28.9%	1,066	20.1%	5,292
7. Sri Lanka	370	10.3%	972	27.0%	1,266	35.1%	997	27.7%	3,605
8. Africa[5]	1,779	29.9%	2,178	36.6%	1,480	24.9%	518	8.7%	5,955

NOTES

1. Numbers based on 2006 Census, Australian Bureau of Statistics. Analysed using CDATA. The Brisbane statistical subdivision includes: Beaudesert and Caboolture shires, Inner Brisbane, Ipswich City, Logan City, Northwest Inner and Northwest Outer Brisbane, Pine Rivers Shire, Redcliffe City, Redland Shire and Southeast Inner and Southeast Outer Brisbane.
2. For the purposes of this project, Pacific Island countries included in these statistics are: Cook Islands, Fiji, Niue, Papua New Guinea, Samoa, Tokelau and Tonga. New Zealand Māori are also included but the statistics are not available by country of birth only by ancestry.
3. Current countries that were previously the Republic of former Yugoslavia include Bosnia and Herzegovina, Croatia, Macedonia, Montenegro, Serbia, Kosovo and Slovenia
4. Spanish speaking background countries include: Spain, Colombia, Peru, Venezuela, Ecuador, Guatemala, Cuba, Bolivia, Honduras, El Salvador, Paraguay, Costa Rica, Panama, Puerto Rico, Mexico, Argentina, Chile, Dominican Republic, Nicaragua and Uruguay.
5. Africa includes Central and West Africa, Southern and East Africa and North Africa. It excludes the countries of: South Africa, Zimbabwe, Seychelles and Mauritius.

2. INDIVIDUAL CALD PROFILES ON AGEING IN BRISBANE AND SURROUNDS

The profiles presented here are a summary of information based on the literature and project findings combined. It should be noted that no person fits a cultural stereotype and these profiles should be used as a guide only. The findings of this project reinforced the observation that there are many layers of diversity within each cultural group, influenced by migration experience, religion, education, professional qualifications and family support - all impacting on how older migrants live in Australia.

PACIFIC ISLANDER PEOPLE- INFORMATION ON AGEING IN BRISBANE AND SURROUNDS

Population

Table 2: Age distribution of Pacific Islands-born[1] Australians by region in Brisbane and surrounds (Source- 2006 ABS Census data (Australian Bureau of Statistics 2011))

REGION	AGE CATEGORY								
	0-19 yrs		20-39 yrs		40-54 yrs		55+ yrs		TOTAL
	No.	PERCENT	No.	PERCENT	No.	PERCENT	No.	PERCENT	
SE Brisbane	474	10.3%	1,901	41.4%	1,419	30.9%	802	17.4%	**4,596**
NW Brisbane	769	13.0%	2,441	41.1%	1,818	30.6%	904	15.2%	**5,932**
Inner Brisbane	41	7.2%	344	60.2%	123	21.5%	63	11.0%	**571**
Logan City	501	12.6%	1,523	38.2%	1,304	32.7%	656	16.5%	**3,984**
Redcliffe	55	11.5%	153	31.9%	164	34.2%	108	22.5%	**480**
Redland	79	10.6%	251	33.8%	281	37.8%	132	17.8%	**743**
Pine Rivers	119	10.2%	473	40.4%	405	34.6%	175	14.9%	**1,172**
Ipswich	187	11.0%	653	38.5%	580	34.2%	276	16.3%	**1,696**
Caboolture	119	11.2%	369	34.6%	380	35.6%	198	18.6%	**1,066**
Beaudesert	9	5.1%	68	38.4%	65	36.7%	35	19.8%	**177**
West Moreton	32	14.3%	80	35.7%	80	35.7%	32	14.3%	**224**
Sunshine Coast	19	7.2%	98	37.3%	97	36.9%	49	18.6%	**263**
Gold Coast	226	9.7%	992	42.4%	733	31.4%	387	16.6%	**2,338**

Table 3: Age distribution of Māoris[2] in Australia by region in Brisbane (Source- 2006 ABS Census data (Australian Bureau of Statistics 2011))

0-19 yrs		20-39 yrs		40-54 yrs		55+ yrs		TOTAL
No.	PERCENT	No.	PERCENT	No.	PERCENT	No.	PERCENT	No.
2,717	38.2%	2778	39.1%	1196	16.8%	419	5.9%	7,110

Greeting and communicating with seniors

- When meeting, a firm handshake is an appropriate greeting for most Pacific Island-born men and women. Individual islands have different protocols and ways of greeting, particularly if the person being greeted has a position of authority. As a generalisation, women may greet each other by kissing on one cheek; on some islands men may hug each other.
- In most cases it is appropriate to address a person using his or her title, Mr, Mrs, Miss and their full name. Do not use first names unless invited. It is appropriate to ask the client and their family members how they wish to be addressed (Wergowske and Blanchette undated).

[1] Includes countries of: Cook Islands, Fiji, Niue, Papua New Guinea, Samoa, Tokelau and Tonga.
[2] Māori is defined as reported Māori ancestry based on the 2006 Census ancestry question.

- Some Pacific Islander Australians may say yes when they do not necessarily understand or agree with what is being said (Allotey, Manderson et al. 1998; Diversicare: Tiumalu F 2009).
- Literacy[3] rates in local languages in the Pacific Islands vary greatly from relatively high literacy levels in Samoa, Tonga, Fiji and the Cook Islands (above 93% for both men and women) to relatively low levels in Papua New Guinea (57% overall and 51% for women) and NZ Maoris (Central Intelligence Agency (CIA) 2010; The Ministry of Social Development 2010).
- Proficiency in spoken English as measured in the ABS 2006 Census as those who can speak English well or very well is above 85% for all six Pacific Island communities. Table 4 below shows the proficiency in English for each country of birth for all ages (Australian Bureau of Statistics 2011). Table 5 shows proficiency in English for those aged 55 and older.

Table 4: Proficiency of spoken English by Country of Birth within the Pacific Islands for all ages (2006 ABS Census).

Country of birth/Ancestry	Proficiency in English-Men (Percent)			Proficiency in English-Women (Percent)		
	Well/Very	Not well	Not at all	Well/Very	Not well	Not at all
Cook Islands	93.8%	6.0%	0.2%	94.1%	5.2%	0.7%
Fiji	97.8%	1.8%	0.4%	94.9%	4.2%	0.9%
Papua New Guinea[4]	95.9%	3.5%	0.6%	94.5%	4.9%	0.6%
Samoa	85.5%	13.5%	2.0%	88.3%	9.9%	1.8%
Tonga	85.9%	13.3%	0.8%	86.2%	11.6%	2.2%

Table 5: Proficiency of spoken English by Country of Birth within the Pacific Islands for people aged 55 or older (2006 ABS Census)

Country of birth/Ancestry	Proficiency in English-Men (Percent)			Proficiency in English-Women (Percent)		
	Well/Very	Not well	Not at all	Well/Very	Not well	Not at all
Cook Islands	85.9%	12.5%	1.6%	80.5%	16.7%	2.8%
Fiji	91.7%	7.5%	0.8%	74.9%	20.1%	5.0%
Papua New Guinea[5]	93.6%	5.7%	0.7%	88.3%	11.2%	0.5%
Samoa	70.6%	25.7%	3.7%	66.8%	24.1%	9.1%
Tonga	67.4%	30.1%	2.5%	61.2%	30.4%	8.4%

Health Issues Impacting on Ageing

Health conditions

- Many Pacific Island populations have higher rates of chronic disease such as diabetes and cardiovascular disease compared to the total New Zealand or Australian populations (Ministry of Health 2008; Sundborn, Metcalf et al. 2008; McGarvey and Seiden 2010; Queensland Health in preparation).
- Tuberculosis rates are relatively high in Pacific Islander people in Australia compared to the rates in non-Indigenous Australian born (Roche, Bastian et al. 2007).

[3] Literacy is defined as those aged older than 15 years who can read and write.
[4] Australian census data on Papua New Guinea-born people is impacted by the high percentage of people who are the children of Australians working in Papua New Guinea. As a result, proficiency in English figures is not accurately represented for ethnic Papua New Guineans.

Health beliefs and practices

- Many Pacific Islander people are Christian and seek healing and comfort in prayer. Some Pacific Islander people may also believe in traditional myths and legends and spiritism (Queensland Health and Faculty of Medicine 2009). These two belief systems are not mutually exclusive.
- Pacific Islander people may use traditional medicines to complement Australian medicines when managing illness (Queensland Health and Faculty of Medicine 2009; Everyculture.com 2011; Queensland Health in preparation).
- If Australian medical practice is perceived as ineffective, some Pacific Islander Australians may use traditional healers (Queensland Health and Faculty of Medicine 2009; McGarvey and Seiden 2010).
- Pacific Islanders are very private, preferring to resolve issues within the family and this may result in delay in seeking professional help. Mental health problems are not easily discussed with people from outside the family due to shame and stigma (Allotey, Manderson et al. 1998).

Social Issues Impacting on Ageing

- The levels of education (non-school qualifications[6]) of Pacific Island born Australians vary depending on country of birth (Australian Bureau of Statistics 2011). In most cases, the levels of education are lower compared to the total Australian population. In some cases, such as Fiji and Papua New Guinea-born, the levels are higher compared to the total Australian population(Australian Bureau of Statistics 2011).
- The median income of Pacific Islands-born Australians is level with or higher than the median income of the total Australian population (Australian Bureau of Statistics 2011).
- Table 6 shows the levels of education and median income for some Pacific Island countries of birth.

Table 6: Levels of education and median income for some Pacific Island countries of birth compared with the total Australian population (2006 ABS Census)

Country of birth	Non-school qualifications (%)	Median income (weekly)
Cook Islands	33.0%	$485
Fiji	56.9%	$562
Papua New Guinea	58.8%	$593
Samoa	35.2%	$450
Tonga	35.4%	$475
Total Australian population	52.5%	$466

- Changes to the Australian Social Security Act in 2001 have had an impact on the eligibility of Pacific Islanders who are New Zealand citizens, for Centrelink payments. New Zealand citizens arriving in Australia after 2001 are not immediately eligible for the unemployment benefit and other social security payments and do not have access to the full range of government employment services. Community members state that this has had a great impact on the financial situation of Pacific Islanders arriving in Australia after 2001 (Centrelink 2011; Current Project - Spiritus 2011).
- Many Pacific Islanders send remittances home to their families remaining in the Pacific Islands (Current Project- Spiritus 2011). This is a strong obligation, even if the family in Australia is not financially secure.

[6] Non-school qualifications are awarded for educational attainments other than those of pre-primary, primary or secondary education.

- Many Pacific Islander people live with extended family, sometimes with three generations under one roof (Rochford 2004).
- Research suggests that domestic violence may be more prevalent in Pacific Island communities in Australia than in the total population of Australia, (McGarvey and Seiden 2010).

Caring for Seniors

- Pacific Islanders place a high reliance on their own families and social groups (e.g. church) for care and support (Nguyen and Kagawa-Singer 2008; Current Project - Spiritus 2011).
- Pacific Islander people traditionally revere their elders and they have a strong sense of duty to care for them (Wergowske and Blanchette undated).
- However in Australia, this changes as frequently younger family members work full-time, attend school and have other commitments. Seniors may feel isolated at home, a loss of status in the family, that their skills are not needed and that they lack purpose (Current Project - Spiritus 2011).
- Many Pacific Islanders find it difficult to negotiate Australian systems to access social and health services (Current Project - Spiritus 2011).
- Pacific Islander people may be reluctant to accept assistance from HACC workers in the home when they have not developed a prior relationship with them (Current Project - Spiritus 2011).
- This project found some resistance amongst Pacific Islander Australians to home care assistance. Culturally, if someone outside of the family is brought in to work in the home, this is associated with 'loss of face'. A person using such services may be perceived as 'lazy' and their family members may be perceived as not taking proper care of their elders (Current Project - Spiritus 2011).
- Many Pacific Islanders are resistant to nursing homes even if they are staffed by members of their own communities. Many seniors return home to the Pacific Islands when they are elderly and require more care (Current Project - Spiritus 2011).
- Cleanliness and hygiene practices were cited as one barrier to nursing home access. For example, many Maori use different towels and different soap for washing their face and for the rest of the body. A towel that has been used on the body cannot be used on the hair or face. Another example cited was if blood or urine specimens have been placed on a table, a meal placed on this table cannot be eaten (Current Project - Spiritus 2011).
- When working in the home of a Pacific Islander, some hygiene practices may include:
    - removing shoes or placing a plastic cover over shoes
    - the use of different towels for face and body
    - not washing hair in the bath
    - not placing a hat or brush (classified as dirty) on a table
    - using different cloths for different cleaning tasks (e.g. vanity different from bath) (Current Project - Spiritus 2011).

Provision of Information about Services

- Suggested strategies for providing information about services:
    - churches
    - community newspapers
    - word of mouth through family and friends (Current Project - Spiritus 2011).
    - community radio

- Providing information face-to-face is preferable to sending letters and leaflets (Current Project - Spiritus 2011).
- Printed information should be translated into community languages, or should be in very simple English (Current Project - Spiritus 2011).
- The collectivist and hierarchical nature of the Pacific Island culture is an important consideration in the provision of information to the community. For example, it is important to request permission from and establish relationships with pastors, chiefs, elders and community leaders before accessing other members of the community. (Current Project - Spiritus 2011)

VIETNAMESE AUSTRALIANS- INFORMATION ON AGEING IN BRISBANE AND SURROUNDS

Population

Table 7: Age distribution of Vietnam-born Australians by region in Brisbane and surrounds (Source- 2006 ABS Census data (Australian Bureau of Statistics 2010))

REGION	AGE CATEGORY								
	0-19 yrs		20-39 yrs		40-54 yrs		55+ yrs		TOTAL
	No.	PERCENT	No.	PERCENT	No.	PERCENT	No.	PERCENT	
SE Brisbane	99	3.2%	1,359	43.6%	1,094	35.1%	562	18.0%	**3,114**
NW Brisbane	308	4.9%	2,715	43.4%	2,143	34.3%	1,090	17.4%	**6,256**
Inner Brisbane	23	4.0%	211	36.3%	208	35.8%	139	23.9%	**581**
Logan City	33	5.9%	241	43.4%	212	38.2%	69	12.4%	**555**
Redcliffe	0	0.0%	18	40.0%	16	35.6%	11	24.4%	**45**
Redland	9	9.6%	40	42.6%	31	33.0%	14	14.9%	**94**
Pine Rivers	7	13.0%	25	46.3%	22	40.7%	0	0.0%	**54**
Ipswich	46	4.9%	425	45.6%	346	37.1%	115	12.3%	**932**
Caboolture	0	0.0%	64	51.6%	39	31.5%	21	16.9%	**124**
Beaudesert	6	6.1%	43	43.4%	30	30.3%	20	20.2%	**99**
West Moreton	3	4.1%	33	45.2%	30	41.1%	7	9.6%	**73**
Sunshine Coast	0	0.0%	3	33.3%	0	0.0%	6	66.7%	**9**
Gold Coast	20	5.3%	193	51.6%	112	29.9%	49	13.1%	**374**

Greeting and communicating with seniors

- Traditionally, Vietnamese people greet each other by joining hands and bowing slightly. However, in Australia the handshake has been adopted by many Vietnamese and is an appropriate way of greeting. In Vietnam, women rarely shake hands with each other or with men (Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre 2002).
- In most cases it is appropriate to address a person using his or her title and their first name. Sometimes older people find it shocking to be addressed by their first name but understand it is Australian custom and accept it if treated respectfully in other ways (Current Project - Spiritus 2011).
- The smile of a Vietnamese Australian can be difficult to interpret as it may be used to show many different emotions including happiness, anger, embarrassment or grief(Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre 2002).
- Some Vietnamese Australians may appear to say “yes” or “da” to all questions This may be a polite way of saying “Yes, I am listening” or “Yes, I am confused” (Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre 2002).
- Vietnamese Australians usually prefer minimal eye contact when talking particularly with people senior in age. Speaking in a low tone is respectful. (Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre 2002).

- Older Vietnamese people may prefer to speak about sensitive subjects indirectly. This is in part to avoid conflict in their relationships with others (Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre 2002).
- Proficiency in spoken English is low as reported in the 2006 ABS Census with 64 percent of Vietnam-born men and 50 percent of Vietnam-born women reporting that they speak English well or very well (Australian Bureau of Statistics 2011). Proficiency in spoken English is even lower for Vietnam-born people aged 55 and older with only 34 percent of men and 18 percent of women reporting that they speak English well or very well (Australian Bureau of Statistics 2011). See Table 8 below.
- Although Vietnamese Australians may benefit from using an interpreter when they are ill or in a high stress situation, sensitivity is needed in introducing the need for an interpreter, as many Vietnamese Australians take pride in their ability to speak, read and write English and may feel offended (Current Project - Spiritus 2011).

Table 8: Proficiency of spoken English for Vietnam-born Australians – all ages compared to 55 years and older (2006 ABS Census)

Age group	Proficiency in English- Vietnam-born Men (Percent)			Proficiency in English- Vietnam-born Women (Percent)		
	Well/Very	Not well	Not at all	Well/Very	Not well	Not at all
All ages	63.9%	31.2%	4.9%	50.0%	38.8%	11.2%
Aged 55 or older	34.1%	48.8%	17.1%	17.6%	44.6%	37.8%

- Vietnamese (78%) and Cantonese (16%) are the most common languages spoken at home by Vietnam-born Australians (Department of Immigration and Citizenship 2006).

Health issues impacting on ageing

Health conditions

- Vietnamese Australians have a higher incidence of tuberculosis than the Australian born population excluding indigenous Australians. (Durward and Wright 1989; Keane, O'Rourke et al. 1995; Marino, Wright et al. 2001; Marks, Simpson et al. 2001).
- Vietnamese Australians may be more susceptible to chronic diseases such as heart disease, stroke, hypertension and diabetes (Tran and Hinton 2010).
- Vietnamese from a refugee background have been shown to have high levels of depression, anxiety and post-traumatic stress disorder (PTSD) and these conditions can occur many years after experiencing the traumatic events (Hinton, Chen et al. 1993; Steel, Silove et al. 2002).

Health beliefs and practices

- Many Vietnamese Australians use traditional herbal remedies, either alone or in conjunction with western medicine (O'Callaghan and Quine 2007).
- Other traditional remedies can include coining and cupping. Cupping uses a round glass cup containing a lit taper which is pressed onto the skin. This can leave bruising. Coining uses a coin to rub or scratch medicated oils onto the chest and back. These appear as lines of scratches. These practices are believed to release negative influences from the body. However when viewed by western people these abrasions and bruises may be mistaken for abuse. (Tran and Hinton 2010).
- Psychiatric and psychological problems maybe somatised and expressed as physical symptoms such as abdominal pain or headaches (Allotey, Manderson et al. 1998). Mental illness is associated with shame and stigma and is often not discussed in the family or community.

Social issues impacting on ageing

- Vietnam-born Australians have lower levels of education compared to the total Australian population. The 2006 Census showed that 35 percent of Vietnam-born people aged 15 years or older had some form of higher non-school qualification compared to 53 percent of the total Australian population (Department of Immigration and Citizenship 2006).
- The participation rate in the workforce (2006 Census) was 61.9 per cent and unemployment rate was 11.4 per cent compared to the corresponding values of 64.6 per cent and 5.2 per cent in the total Australian population. The median weekly income for Vietnam-born people in Australia aged 15 years or older was $349 compared to $466 for the total Australian population (Department of Immigration and Citizenship 2006).
- The main religions of Vietnam-born Australians are Buddhism (59%) and Christian Catholicism (22%) (Department of Immigration and Citizenship 2006).
- Respect for elders, and maintaining the memories of ancestors is an important cultural value in the Vietnamese community. (South Eastern Migrant Resource Centre 2010)

Caring for seniors

- The primary decision maker for the family is traditionally the eldest male. If there is no son in the family, the eldest son-in-law or the eldest male relative takes on this role. (Tran and Hinton 2010).
- In Vietnam, elders were the leaders in families and had a strong influence in decision making. In Australia, without land or income, elders may become financially dependent on their children, creating a role reversal (South Eastern Migrant Resource Centre 2010).
- Older Vietnamese Australians want to live with and be cared for by their families. Traditionally, this is the role of the eldest son's wife or any unmarried family members (Tran and Hinton 2010). However, as the younger generations have adapted to the Australian lifestyle, they may have different values and work commitments that limit their ability to care for their ageing parents. (Current Project - Spiritus 2011).
- Older Vietnamese Australians can become socially and culturally isolated. (South Eastern Migrant Resource Centre 2010), and may even return to Vietnam to the care of family members remaining in Vietnam (Current Project - Spiritus 2011).
- Language is a major barrier to ageing Vietnamese Australians' access to health and social services (Current Project - Spiritus 2011).
- Older Vietnamese Australians do accept care workers coming into the home if needed, but they prefer to have consistency with the same worker. They also advised that they like workers to speak in a quiet voice, and to remove or cover their shoes. (Current Project - Spiritus 2011)

Provision of information about services

- It is suggested that information about services be provided through:
    - Vietnamese community newspapers. (Current Project - Spiritus 2011).
    - Attending community meetings and speaking face-to-face, using an interpreter if necessary.
- Providing translated information prior to meeting with community members is recommended (Current Project - Spiritus 2011).
- In many cases Vietnamese Australians prefer to receive and provide information as a group rather than on an individual basis. (Current Project - Spiritus 2011)

BOSNIAN, CROATIAN AND SERBIAN AUSTRALIANS- INFORMATION ON AGEING IN BRISBANE AND SURROUNDS

Population

Table 9: Age distribution of Bosnian, Croatian and Serbian Australians and other Former Yugoslavian by region in Brisbane and surrounds (Source- 2006 ABS Census data (Australian Bureau of Statistics 2011))

REGION	AGE CATEGORY								
	0-19 yrs		20-39 yrs		40-54 yrs		55+ yrs		TOTAL
	No.	PERCENT	No.	PERCENT	No.	PERCENT	No.	PERCENT	
SE Brisbane	365	13.2%	802	29.0%	881	31.8%	721	26.0%	**2,769**
NW Brisbane	88	8.4%	251	23.8%	335	31.8%	379	36.0%	**1,053**
Inner Brisbane	24	8.4%	73	25.6%	76	26.7%	112	39.3%	**285**
Logan City	209	15.6%	352	26.2%	415	30.9%	366	27.3%	**1,342**
Redcliffe	0	0.0%	11	13.6%	29	35.8%	41	50.6%	**81**
Redland	14	5.6%	39	15.5%	69	27.5%	129	51.4%	**251**
Pine Rivers	12	8.1%	36	24.3%	50	33.8%	50	33.8%	**148**
Ipswich	16	8.1%	41	20.8%	63	32.0%	77	39.1%	**197**
Caboolture	6	4.2%	15	10.5%	43	30.1%	79	55.2%	**143**
Beaudesert	0	0.0%	20	29.9%	22	32.8%	25	37.3%	**67**
West Moreton	0	0.0%	0	0.0%	13	31.7%	28	68.3%	**41**
Sunshine Coast	0	0.0%	3	6.7%	15	33.3%	27	60.0%	**45**
Gold Coast	216	9.1%	501	21.0%	705	29.5%	964	40.4%	**2,386**

Totals above includes: Slovenia, Croatia, Bosnia and Herzegovina, Montenegro, Serbia and other Former Yugoslavia

The largest population groups in Brisbane and surrounds include people born in Bosnia and Herzegovina, Croatia and Serbia. Table 10 below shows numbers in each group by age category for Brisbane based on the 2006 Census (Australian Bureau of Statistics 2011).

Table 10: Age distribution by country of birth in Former Yugoslavia for Brisbane and surrounds

	0-19 yrs		20-39 yrs		40-54 yrs		55+ Years		TOTAL
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	
Bosnia and Herzegovina	393	16.8%	798	34.0%	757	32.3%	396	16.9%	**2,344**
Croatia	120	5.7%	370	17.6%	643	30.7%	964	46.0%	**2,097**
Former Yugoslav Republic of Macedonia	53	8.9%	172	28.8%	210	35.1%	163	27.3%	**598**
Slovenia	4	1.6%	25	10.2%	55	22.4%	162	65.9%	**246**
Montenegro	0	0.0%	7	15.6%	13	28.9%	25	55.6%	**45**
Serbia	132	13.4%	266	26.9%	291	29.5%	299	30.3%	**988**
TOTAL	**702**	**11.1%**	**1,638**	**25.9%**	**1,969**	**31.2%**	**2,009**	**31.8%**	**6,318**

Three separate profiles are presented below for Bosnian, Croatian and Serbian Australians.

BOSNIAN MUSLIM AUSTRALIANS

Many people who identify as Bosnian in Australia are Bosnian Muslims. Catholic and Orthodox Bosnians may not identify as Bosnians but as from the Former Yugoslav Republic because they are not Muslim (Current Project - Spiritus 2011). This profile focuses on Bosnian Muslims.

Greeting and communicating with seniors

- A handshake is an appropriate and respectful form of greeting for both men and women.
- Referring to people by their title and surname is recommended.

- Literacy levels in Bosnia and Herzegovina are high at around 97 percent in total (99% for men and 94% for women) (Central Intelligence Agency (CIA) 2010).
- Proficiency in spoken English, measured in the ABS 2006 Census as those who can speak English well or very well was 75 percent for Bosnia and Herzegovina-born men, and 72 percent for women (Australian Bureau of Statistics 2011). For those aged 55 years or older, proficiency in spoken English was 49.3% percent for men and 35.8% percent for women (Australian Bureau of Statistics 2011). See table 11 below.

Table 11: Proficiency of spoken English for Bosnia and Herzegovina-born Australians – all ages compared to 55 years and older (2006 ABS Census)

Age group	Proficiency in English- Bosnia and Herzegovina-born Men (Percent)			Proficiency in English- Bosnian and Herzegovina-born Women (Percent)		
	Well/Very	Not well	Not at all	Well/Very	Not well	Not at all
All ages	74.8%	21.4%	3.8%	71.6%	22.2%	6.2%
Aged 55 or older	49.3%	39.2%	11.5%	35.8%	40.1%	24.1%

- Bosnian (47%), Serbian (24%) and Croatian (18%) are the most common languages spoken at home by Bosnia and Herzegovina-born Australians (Department of Immigration and Citizenship 2006).

Health issues impacting on ageing

Health conditions

- Musculo-skeletal problems are common in women (Allotey, Manderson et al. 1998).
- Health concerns among Bosnians from refugee background include:
    - management of chronic diseases such as hypertension
    - smoking cessation
    - nutrition and diet (Erwin, Leung et al. 2001)
- Bosnian Australians may experience psychological distress as a result of past trauma associated with war. This distress is often expressed as somatic symptoms including gastro-intestinal or respiratory symptoms (Allotey, Manderson et al. 1998). Post traumatic Stress Disorder (PTSD) and depression are prevalent in Bosnian Australians and in many cases result in social and occupational disability (Momartin, Silove et al. 2004).

Health beliefs and practices

- Mental illness is associated with shame and stigma is not traditionally discussed openly (Allotey, Manderson et al. 1998).

Social issues impacting on ageing

- Bosnia and Herzegovina-born Australians have levels of education comparable to the total Australian population. The 2006 Census showed that 51.8 percent of the Bosnia and Herzegovina-born population aged 15 years and older had some form of higher non-school qualification compared to 52.5 percent of the total Australian population (Department of Immigration and Citizenship 2006).
- Participation in the workforce (2006 Census) was 53.9 percent and unemployment rate 7.8 percent compared to the corresponding values of 64.6 percent and 5.2 percent in the total Australian population. The median weekly income for Bosnia and Herzegovina-born people in Australia aged 15 years and older was $299 compared to $466 for the total Australian population (Department of Immigration and Citizenship 2006).

- Lack of recognition of professional qualifications and experience gained overseas has been expressed as source of emotional stress for Bosnian Australians (Tilbury, Clark et al. 2004).
- Islam (31%), Eastern Orthodox (26%) and Catholicism (22%) are the main religions of Bosnia and Herzegovina-born Australians (Department of Immigration and Citizenship 2006).
- Survivors of torture and trauma are at risk of ageing prematurely and may require support at an earlier age than the general population
- As survivors of torture and trauma, many Bosnian Australians may experience additional impacts of ageing (Ageing Disability and Homecare: Kathryn Knight 2011).
    - As their short term memory declines they may experience resurfacing of painful memories and symptoms of unresolved post traumatic stress disorder.
    - As their mobility becomes limited by physical problems such as chronic pain, they may experience increased social isolation, depression and feelings of cultural dislocation.
    - As their cognitive function diminishes, they may lose competence in English and revert to their first language(Ageing Disability and Homecare: Kathryn Knight 2011).

Caring for seniors

- Older Bosnian Australians traditionally expect to be cared for by their children (Multicultural Communities Council Gold Coast Inc 2006; Current Project - Spiritus 2011).
- Although there is the expectation for older Bosnians that their family will care for them, many are willing to accept aged care services including home based care and day respite. However, Bosnian Australians are reluctant to leave the home for overnight respite and to enter into residential care (Multicultural Communities Council Gold Coast Inc 2006; Current Project - Spiritus 2011).
- Elderly Bosnian Australian women prefer to receive care from a female carer (Multicultural Communities Council Gold Coast Inc 2006; Current Project - Spiritus 2011).
- It is important to Bosnian Muslims to have an aged care worker from their cultural background who speaks their language (Current Project - Spiritus 2011).
- Elderly Bosnian Australians may prefer that their family are involved in decisions about their care (Multicultural Communities Council Gold Coast Inc 2006).
- When entering the home of a Bosnian Australian:
    - It is advisable to remove shoes or place a plastic cover over shoes
    - It is important to accept offered hospitality
    - Refrain from bringing food into the home or ask first.
- Older Bosnian Australians who have experienced torture and trauma may be prone to PTSD flashbacks that can be triggered by different things. Some examples of triggers are showering or bathing, shaving, haircuts, certain food, people writing things down, confined space and closed doors (Ageing Disability and Homecare: Kathryn Knight 2011).

Provision of information about services

Suggestions for providing information about services:

- Deliver information and education sessions with existing seniors groups
- Local ethnic radio (4EB)
- Bosnian Newspaper based in Melbourne
- Display board at Bosnian mosque
- Translated written information (Current Project - Spiritus 2011).

CROATIAN AUSTRALIANS

Greeting and communicating with seniors

- In most cases, a handshake is an appropriate greeting (South Eastern Region Migrant Resource Centre 2010).
- Croatian Australians usually greet each other with a kiss on both cheeks (South Eastern Region Migrant Resource Centre 2010).
- Referring to people by their title and surname is recommended. As familiarity grows, the use of the first name may be appropriate.
- Croatian (64%), English (17%) and Serbian (12%) are the main languages spoken at home by Croatia-born Australians (Department of Immigration and Citizenship 2006).
- Many Croatians were born in Bosnia and Herzegovina or in other parts of former Yugoslavia and speak a local dialect. It is recommended to enquire which ethnicity a client identifies with, in addition to the language they speak. (South Eastern Region Migrant Resource Centre 2010).
- When booking an interpreter, it is recommended a Croatia-born, Croatian speaking interpreter is requested. Many Croatian Australians have experienced war trauma and reject interaction with people of other ethnicities from former Yugoslavia (South Eastern Region Migrant Resource Centre 2010).
- Literacy levels in Croatia are high at around 98 percent in total (99% for men and 97% for women) (Central Intelligence Agency (CIA) 2010).
- Many elderly Croatian Australians do not have good English proficiency and some have lost English proficiency due to dementia (South Eastern Region Migrant Resource Centre 2010). Proficiency in spoken English as measured in the ABS 2006 Census as those who can speak English well or very well was 78 percent for Croatian-born men and 75 percent for women (Australian Bureau of Statistics 2011). Table 12 shows the proficiency in spoken English for Croatian-born men and women overall and for those 55 years and older.

Table 12: Proficiency of spoken English for Croatia-born Australians – all ages compared to 55 years and older (2006 ABS Census)

Age group	Proficiency in English-Croatia-born Men (Percent)			Proficiency in English-Croatia-born Women (Percent)		
	Well/Very	Not well	Not at all	Well/Very	Not well	Not at all
All ages	78.4%	19.5%	2.1%	74.9%	21.6%	3.5%
Aged 55 or older	73.2%	24.2%	2.6%	65.5%	29.2%	5.3%

Health issues impacting on ageing

Health conditions

- Major health issues for Croatian Australians include:
    - Diabetes
    - High cholesterol
    - High blood pressure
    - Heart disease
    - Mental illnesses including depression, anxiety and post traumatic stress disorder (PTSD) (South Eastern Region Migrant Resource Centre 2010).

Health Beliefs and Practices

- Croatian Australians may use alternative therapies including herbal medicines, alone or in conjunction with western therapies. (South Eastern Region Migrant Resource Centre 2010).
- Croatian Australians tend to openly discuss their health conditions (South Eastern Region Migrant Resource Centre 2010) They expect health professionals to pay a lot of attention to described symptoms. They also may not consider a treatment to be valid unless they are prescribed medication (Current Project - Spiritus 2011).
- Mental illness is associated with shame and stigma (South Eastern Region Migrant Resource Centre 2010)

Social issues impacting on ageing

- The 2006 Census showed that 45.4 percent of the Croatia-born population aged 15 years and older had some form of higher non-school qualification compared to 52.5 percent of the total Australian population (Department of Immigration and Citizenship 2006).
- The participation in the workforce was 45.9 percent and unemployment rate 5.6 percent compared to the corresponding values of 64.6 percent and 5.2 percent in the total Australian population. The median weekly income for Croatia-born people in Australia aged 15 years and older was $307 compared to $466 for the total Australian population (Department of Immigration and Citizenship 2006).
- Catholicism (77%) and Eastern Orthodox (14%) are the main relations of Croatia-born Australians (Department of Immigration and Citizenship 2006).
- The elderly are highly respected and are seen as a knowledgeable source of information on culture, traditions and history (South Eastern Region Migrant Resource Centre 2010).
- Survivors of torture and trauma are at risk of ageing prematurely due to trauma and hardship and may require support at an earlier age than the general population
- As survivors of torture and trauma, many Croatian Australians may experience additional impacts of ageing (Ageing Disability and Homecare: Kathryn Knight 2011).
    - As their short term memory declines they may experience resurfacing of painful memories and symptoms of unresolved post traumatic stress disorder.
    - As their mobility becomes limited by physical problems such as chronic pain, they may experience increased social isolation, depression and feelings of cultural dislocation.
    - As their cognitive function diminishes, they may lose competence in English and revert to their first language(Ageing Disability and Homecare: Kathryn Knight 2011).

Caring for seniors

- There is an expectation that family members will provide care for their elders (South Eastern Region Migrant Resource Centre 2010).
- Croatian Australians have a strong preference for ethno-specific aged care services (South Eastern Region Migrant Resource Centre 2010).
- Croatian Australians may be reluctant to seek assistance and to sign papers and forms (South Eastern Region Migrant Resource Centre 2010).
- Elderly Croatian Australians fear their loss of independence and self sufficiency (South Eastern Region Migrant Resource Centre 2010).
- Croatian Australians are very reluctant to enter into residential care (Current Project - Spiritus 2011).

- Older Croatian Australians who have experienced torture and trauma may be prone to PTSD flashbacks that can be triggered by different things. These triggers vary by person but include such things as showering or bathing, having a medical procedure, shaving, haircuts, certain food, people writing things down, confined space and closed doors (Ageing Disability and Homecare: Kathryn Knight 2011).

Provision of information about services

- According to the Croatian community representative interviewed, Croatian people in Brisbane have their own services run by their own community members. He stated they were not really interested in hearing about aged care services run by other agencies. The Croatian community have a small ethno-specific HACC program as part of Diversicare. This has been in place for over 20 years. (Current Project - Spiritus 2011).
- It is recommended that information provided is translated. However, pamphlets are not seen as a very useful way of reaching the Croatian community (Tilbury, Clark et al. 2004).
- Ethnic radio, newspapers, respected professional publications and television have been suggested as effective ways of disseminating information to the Croatian community (Tilbury, Clark et al. 2004)

SERBIAN AUSTRALIANS

Greeting and communicating with seniors

- In most cases, a handshake is an appropriate greeting(South Eastern Region Migrant Resource Centre 2010).
- Serbian Australians usually greet each other with a kiss on both cheeks (South Eastern Region Migrant Resource Centre 2010).
- Referring to people by their title and surname is recommended. As familiarity grows, the use of a first name may be appropriate (South Eastern Region Migrant Resource Centre 2010).
- Serbian (76%) is the most common language spoken at home by Serbia-born Australians(Department of Immigration and Citizenship 2006).
- Because many Serbs were born in Croatia and Bosnia and Herzegovina, it is recommended to ask clients what ethnicity they identify with, in addition to the language they speak. (South Eastern Region Migrant Resource Centre 2010).
- When booking an interpreter, it is recommended a Serbia-born, Serbian speaking interpreter is requested. Many Serbian Australians have experienced war trauma and may reject interaction with people of other ethnicities from former Yugoslavia (South Eastern Region Migrant Resource Centre 2010).
- Literacy levels in Serbia are high at around 96 percent in total (99% for men and 94% for women) (Central Intelligence Agency (CIA) 2010).
- Proficiency in English as measured in the ABS 2006 Census as those who can speak English well or very well was 83 percent for Serbia-born men and 79 percent for women (Australian Bureau of Statistics 2011). For Serbia-born aged 55 years or older the percentages are lower. See Table 13 below.

Table 13: Proficiency of spoken English for Serbia-born Australians – all ages compared to 55 years and older (2006 ABS Census)

Age group	Proficiency in English- Serbia-born Men (Percent)			Proficiency in English- Serbia-born Women (Percent)		
	Well/Very	Not well	Not at all	Well/Very	Not well	Not at all
All ages	83.0%	15.6%	1.4%	78.7%	18.0%	3.3%
Aged 55 or older	71.4%	26.3%	2.3%	61.8%	31.2%	7.0%

Health issues impacting on ageing

Health conditions

- Major health issues for Serbian Australians include:
  - ischaemic heart disease,
  - cerebrovascular diseases,
  - lung cancer,
  - unipolar depressive disorders,
  - diabetes
  - high rates of smoking (Jankovic, Vlajinac et al. 2006)

Health Beliefs and Practices

- Mental illness is associated with shame and stigma (South Eastern Region Migrant Resource Centre 2010).
- Serbian Australians are generally comfortable with visiting a doctor. They may be less familiar with the need to make an appointment rather than go to the surgery and wait to be seen without an appointment (South Eastern Region Migrant Resource Centre 2010).
- There may be a lack of familiarity with the role of the general practitioner as in Serbia general practitioners are specialists rather than generalists. They may expect that they can see a specialist without a referral from a GP. (South Eastern Region Migrant Resource Centre 2010).
- Serbian Australians tend to openly discuss their health conditions. They may expect health professionals to pay a lot of attention to described symptoms. They may not consider a treatment to be valid unless they are prescribed medication (Current project, Spiritus)

Social issues impacting on ageing

- Serbia-born Australians have levels of education comparable to the total Australian population. The 2006 Census showed that 51.5 percent of the Serbia-born population aged 15 years and older had some form of higher non-school qualification compared to 52.5 percent of the total Australian population (Department of Immigration and Citizenship 2006).
- The participation in the workforce (2006 Census) was 51.7 percent and unemployment rate 7.3 percent compared to the corresponding values of 64.6 percent and 5.2 percent in the total Australian population. The median weekly income for Serbia-born people in Australia aged 15 years and older was $338 compared to $466 for the total Australian population (Department of Immigration and Citizenship 2006).
- Eastern Orthodox (77%) is the main religion of Serbia-born Australians (Department of Immigration and Citizenship 2006).

Caring for seniors

- Traditionally children look after their aged parents. Placing an aged parent in a nursing home is culturally unacceptable(South Eastern Region Migrant Resource Centre 2010).
- Many adult children caring for their aged parents at home are in need of support (South Eastern Region Migrant Resource Centre 2010).
- Social and recreational support needs are high for elderly Serbian Australians (South Eastern Region Migrant Resource Centre 2010).

Provision of information about services

- It is suggested that information about services is provided face-to-face through community meetings (Current Project - Spiritus 2011).
- The use of Serbian ethnic radio in Serbian language has been shown to be an effective way of disseminating information to the Serbian community (Dedijer 2001).

INDIAN AUSTRALIANS- INFORMATION ON AGEING IN BRISBANE AND SURROUNDS

Population

Table 14: Age distribution of India-born Australians by region in Brisbane and surrounds (Source- 2006 ABS Census data +(Australian Bureau of Statistics 2011))

REGION	AGE CATEGORY								
	0-19 yrs		20-39 yrs		40-54 yrs		55+ yrs		TOTAL
	No.	PERCENT	No.	PERCENT	No.	PERCENT	No.	PERCENT	
SE Brisbane	277	10.6%	1,274	49.0%	556	21.4%	494	19.0%	**2,601**
NW Brisbane	330	11.4%	1,110	38.4%	777	26.9%	672	23.3%	**2,889**
Inner Brisbane	48	8.4%	407	70.9%	57	9.9%	62	10.8%	**574**
Logan City	40	8.9%	165	36.7%	102	22.7%	142	31.6%	**449**
Redcliffe	4	5.3%	15	19.7%	20	26.3%	37	48.7%	**76**
Redland	21	7.2%	56	19.2%	76	26.1%	138	47.4%	**291**
Pine Rivers	18	6.5%	74	26.5%	84	30.1%	103	36.9%	**279**
Ipswich	9	4.3%	100	47.8%	41	19.6%	59	28.2%	**209**
Caboolture	3	2.1%	31	21.8%	28	19.7%	80	56.3%	**142**
Beaudesert	0	0.0%	4	16.7%	11	45.8%	9	37.5%	**24**
West Moreton	6	14.3%	6	14.3%	7	16.7%	23	54.8%	**42**
Sunshine Coast	7	9.9%	6	8.5%	23	32.4%	35	49.3%	**71**
Gold Coast	104	8.8%	490	41.6%	234	19.9%	349	29.7%	**1,177**

Greeting and communicating with seniors

- Indian Australians usually greet each other in a formal and respectful way, with the word *Namaste* and a slight bow with the palms of the hands together.
- For Australians greeting Indian Australians, a handshake is appropriate, although, it is not usual to shake hands with the opposite gender (Kwintessential 2010). Handshakes are gentle, rather than firm (Migrant Information Centre (Eastern Melbourne) 2010). Some Indian Australians may be uncomfortable with physical contact with strangers (Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre 2001).
- Naming conventions vary across India. Many Indians do not use surnames, but may be referred to by their title and first name (Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre 2001). However, Indian Australians have adopted western naming conventions (Migrant

Information Centre (Eastern Melbourne) 2010). It is advisable to ask permission before addressing someone by their first name. (Periyakoil and Dara 2010).

- In India direct eye contact is generally considered rude, so Indian Australians may prefer minimal eye contact (Ahmed and Lemkau 2000; Kwintessential 2010).
- Indian Australians may avoid saying *no* and give a non direct answer such as *I will try* (Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre 2001). In some circumstances, shaking of the head may indicate agreement (Migrant Information Centre (Eastern Melbourne) 2010).
- Indian Australians may not use the words *please* and *thank you,* believing that actions are performed from a sense of duty and do not require these courtesies (Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre 2001).
- Most Indian Australians are literate and have high levels of education (Department of Immigration and Citizenship 2006; Australian Bureau of Statistics 2011).
- Proficiency in English is high overall with 97 percent of men and 92 per cent of women reporting that they speak English well or very well in the 2006 Census (Australian Bureau of Statistics 2011). Proficiency in English is lower for people over 55 years, particularly women. See Table 15 below.

Table 15: Proficiency of spoken English for India-born Australians – all ages compared to 55 years and older (2006 ABS Census)

Age group	Proficiency in English- India-born Men (Percent)			Proficiency in English- India-born Women (Percent)		
	Well/Very	Not well	Not at all	Well/Very	Not well	Not at all
All ages	97.0%	2.3%	0.7%	92.1%	5.9%	2.0%
Aged 55 or older	91.9%	6.1%	2.0%	69.7%	18.7%	11.6%

- English (34%), Hindi (20%), Punjabi (10%) and Tamil(7%) are the most common languages spoken at home by India-born Australians(Department of Immigration and Citizenship 2006).

Health issues impacting on ageing

Health conditions

- People of Indian background have been shown to have relatively high rates of diabetes, hypertension and cardiovascular disease (Petersen, Dufour et al. 2006; Abate and Chandalia 2007; Periyakoil and Dara 2010).
- Lactose intolerance and vitamin D deficiency are common (Periyakoil and Dara 2010).
- Women of Indian background are at higher risk for osteoporosis (Periyakoil and Dara 2010).
- Cancer rates for India-born Australians are lower than for people born in Australia, but higher than rates in India (Grulich, McCredie et al. 1995).

Health Beliefs and Practices

- Many Indian Australians use traditional medicine and spiritual practices such as Ayuveda, Siddha, Urani, Tibbi, homeopathy, naturopathy and acupressure in conjunction with western medicine (Migrant Information Centre (Eastern Melbourne) 2010; Periyakoil and Dara 2010).
- Mental illness is associated with shame and stigma, especially among the older Hindu population (Ahmed and Lemkau 2000; Periyakoil and Dara 2010; Current Project - Spiritus 2011)
- Some Indians believe that mental illness is due to possession of "the evil eye." Shame and denial are typical responses to any suggestion of mental illness. Because mental illness is concealed, it is often presented as somatic complaints such as headaches or stomach pain rather than as anxiety or depression (Periyakoil and Dara 2010).

Social issues impacting on ageing

- India-born Australians have higher levels of education compared to the total Australian population. The 2006 Census showed that 76.1 percent of the India-born population aged 15 years and over had some form of higher non-school qualification compared to 52.5 per cent of the total Australian population (Department of Immigration and Citizenship 2006).
- The participation rate in the workforce (2006 Census) was 72.3 percent and unemployment rate 7.2 percent compared to the corresponding values of 64.6 percent and 5.2 percent in the total Australian population. The median weekly income for India-born people in Australia aged 15 and older was $543 compared to $466 for the total Australian population (Department of Immigration and Citizenship 2006).
- Hinduism (44%), Catholicism (24%), Sikhism (11%) and Christianity (5%) are the main religions of India-born Australians (Department of Immigration and Citizenship 2006).
- Traditionally, men are the decision-makers in families, especially in the older generations. (Current Project - Spiritus 2011).
- Sending remittances to relatives in India is a common practice for Indian Australians (Current Project - Spiritus 2011).

Caring for older people

- People of Indian background have a high reliance on their family to provide care and support (Periyakoil and Dara 2010). Although older Indian Australians often live with their families, they may still feel isolated as their children and grandchildren are out during the day to work and school (Current Project - Spiritus 2011).
- Religion and spirituality are important to older Indian Australians. It is recommended aged care workers are aware of food restrictions related to religion (e.g. Hindus prohibition of eating beef) (Current Project - Spiritus 2011).
- The role of home care workers may be unfamiliar to older people of Indian background. (Periyakoil and Dara 2010). However in many cases, older Indian Australians are open to care workers coming into the home to assist them if they are treated with respect. It is preferable that care providers are from the same culture as the client (Current Project - Spiritus 2011).
- When entering the home of an Indian Australian it is advisable to ask if they want shoes removed. It may be important to remove shoes before entering the home or before entering a particular room, for example, where deities are kept (Current Project - Spiritus 2011).
- Traditionally, placing an elderly person in a nursing home is seen as inappropriate (Periyakoil and Dara 2010; Current Project - Spiritus 2011). However it is acknowledged as necessary in some cases, even in India (Current Project - Spiritus 2011). The term 'nursing home' has negative connotations and describing it in other ways (e.g. Aged care) is likely to be more acceptable. Short-term respite is likely to be more accepted in the Indian Australian community if explained sensitively (Current Project - Spiritus 2011).
- Elderly Indian Australians may be stoic in their expression of pain, so it is important for health workers to observe non-verbal behaviour (Alagiakrishnan and Chopra, Undated).
- The involvement of family members in major and minor health decisions is crucial for many Indian Australians(Ahmed and Lemkau 2000).

Provision of information about services

- It is suggested that information about services be provided through:
    - Indian Australian aged associations using informal 'kitchen table' discussions
    - local Indian radio
    - translated written information (Current Project - Spiritus 2011).

FILIPINO AUSTRALIANS- INFORMATION ON AGEING IN BRISBANE AND SURROUNDS

Population

Table 16: Age distribution of Philippines-born Australians by region in Brisbane and surrounds (Source- 2006 ABS Census data(Australian Bureau of Statistics 2011))

REGION	AGE CATEGORY								
	0-19 yrs		20-39 yrs		40-54 yrs		55+ yrs		TOTAL
	No.	PERCENT	No.	PERCENT	No.	PERCENT	No.	PERCENT	
SE Brisbane	332	12.1%	1,075	39.2%	944	34.4%	393	14.3%	**2,744**
NW Brisbane	422	14.0%	1,144	37.8%	1,049	34.7%	410	13.6%	**3,025**
Inner Brisbane	47	13.5%	177	50.7%	93	26.6%	32	9.2%	**349**
Logan City	163	13.6%	417	34.8%	452	37.7%	167	13.9%	**1,199**
Redcliffe	32	13.7%	68	29.1%	95	40.6%	39	16.7%	**234**
Redland	52	13.3%	105	26.9%	165	42.3%	68	17.4%	**390**
Pine Rivers	66	11.9%	202	36.4%	212	38.2%	75	13.5%	**555**
Ipswich	81	13.5%	212	35.3%	222	36.9%	86	14.3%	**601**
Caboolture	68	10.3%	198	29.9%	258	39.0%	138	20.8%	**662**
Beaudesert	13	12.1%	37	34.6%	47	43.9%	10	9.3%	**107**
West Moreton	24	9.7%	112	45.3%	75	30.4%	36	14.6%	**247**
Sunshine Coast	10	7.4%	52	38.2%	50	36.8%	24	17.6%	**136**
Gold Coast	341	13.2%	877	34.1%	955	37.1%	402	15.6%	**2,575**

Greeting and communicating with seniors

- A firm handshake with a smile and eye-contact is an appropriate greeting for most Filipino Australians (Dela-Cruz and Periyakoil 2010). Both men and women greet each other by bowing or shaking hands (Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre 2002).
- Older Filipino Australians generally prefer to be addressed by their title (e.g. Mrs, Mr) followed by their surname (South Eastern Migrant Resource Centre 2010).
- Nicknames are common and may be different from Christian names (Centre for Philippine Concerns Australia 2003).
- Brief and frequent eye contact is recommended rather than prolonged direct eye contact (Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre 2002; Dela-Cruz and Periyakoil 2010)
- Filipino Australians may be reluctant to show disagreement and may say "yes" even when they do not agree. They may say "Maybe" or "I don't know" when they really mean "No" or "I can't"(Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre 2002).
- It is more appropriate to ask "Do you have any questions?" than to ask "Do you understand?" as implying that someone does not understand may cause embarrassment.
- Filipino Australians may maintain a smile when disagreeing or when feeling embarrassed (Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre 2002).
- Although Filipino Australians may benefit from using their own language when they are ill or in a high stress situation, sensitivity is needed in introducing the need for an interpreter as many Filipino Australians take pride in their ability to speak, read and write English and may feel offended.

- Literacy rates in the Philippines are between 92 and 93 percent for both men and women (Central Intelligence Agency (CIA) 2010).
- Proficiency in spoken English is high with more than 97 percent of Filipino men and women reporting that they speak English well or very well in the 2006 Census. These relatively high levels of English proficiency persist for people aged 55 years with more than 89 percent of man and women aged 55 or older reporting that they speak English well or very well(Australian Bureau of Statistics 2011). See Table 17 below.

Table 17: Proficiency of spoken English for Philippines-born Australians - all ages compared to 55 years and older (2006 ABS Census)

Age group	Proficiency in English- Philippines-born Men (Percent)			Proficiency in English- Philippines-born Women (Percent)		
	Well/Very	Not well	Not at all	Well/Very	Not well	Not at all
All ages	97.0%	2.8%	0.2%	96.6%	3.2%	0.2%
Aged 55 or older	93.6%	6.1%	0.3%	89.5%	9.7%	0.8%

- Tagalog (39%), Filipino (29%) and English (27%) are the most common languages spoken at home by Philippine-born Australians (Department of Immigration and Citizenship 2006).

Health issues impacting on ageing

Health conditions

- There is little published information on the health of Filipinos in Australia, but research from the United States shows:
    - Filipino Americans have a higher incidence of chronic diseases including hypertension and diabetes compared to Caucasian Americans (Cuasay, Lee et al. 2001; Araneta, Wingard et al. 2002; Dela-Cruz and Periyakoil 2010).
    - Rates of breast, lung and liver cancer are higher for Filipino Americans and survival rates for many cancers are poor(Dela-Cruz and Periyakoil 2010).
    - Other major causes of illness and death of Filipino Americans include cardiovascular disease, stroke, chronic lower respiratory disease and asthma(Dela-Cruz and Periyakoil 2010).
- Filipino Australian widows may be vulnerable to poor mental and emotional health, related to social, and sometimes geographical isolation (Current Project - Spiritus 2011).
- Diabetes and osteoporosis were identified as health problems by Filipino Australian participants in the current project. (Current Project - Spiritus 2011).

Health Beliefs and Practices

- Filipino Australians from rural areas in the Philippines are often knowledgeable about home remedies, traditional healing techniques and faith healers (Dela-Cruz and Periyakoil 2010; South Eastern Migrant Resource Centre 2010).
- Filipino Australians from urban areas may be more likely to rely on western medical practice and over-the-counter medicines (Dela-Cruz and Periyakoil 2010; South Eastern Migrant Resource Centre 2010).
- Traditional therapies such as traditional massage or *hilot,* herbal, nutritional supplements and home remedies may be used in conjunction with Australian medical practice and prescribed medications (South Eastern Migrant Resource Centre 2010).

Social issues impacting on ageing

- Philippines-born Australians have higher levels of education compared to the total Australian population. The 2006 Census showed that 64.9 percent of Philippines-born people aged 15 years or older had some form of higher non-school qualification compared to 52.5 percent of the total Australian population (Department of Immigration and Citizenship 2006).
- The participation rate in the workforce (2006 Census) was 73.1 per cent and unemployment rate was 5.2 per cent compared to the corresponding values of 64.6 per cent and 5.2 per cent in the total Australian population. The median weekly income for Philippines-born people in Australia aged 15 years or older was $538 compared to $466 for the total Australian population (Department of Immigration and Citizenship 2006).
- There is an expectation for many Filipinos in Australia to provide financial support to parents and siblings still living in the Philippines (Thompson, Manderson et al. 2002).
- An important cultural value of Filipinos is *hiya*, which can be roughly translated as *embarrassment*, *shame* or *face*. It has been described as anxiety, a fear of being left exposed, unprotected and unaccepted. Having *hiya* means that people may feel very sensitive to social slight and as a result are very careful of the feelings of others (Centre for Philippine Concerns Australia 2003).
- Religion is very important to most Filipinos. More than 80 percent of Filipinos are Catholic and about 10 percent are Christians of other denominations. Approximately 5 percent are Muslim (Department of Immigration and Citizenship 2006; South Eastern Migrant Resource Centre 2010)
- Domestic violence is an issue for some Filipino women in Australia, and Catholic beliefs and values may influence some women's decisions to remain in abusive relationships despite personal cost. These women may be reluctant to seek help , and not feel comfortable discussing issues of domestic violence with strangers (Allotey, Manderson et al. 1998; Woelz-Stirling, Kelaher et al. 1998; Current Project - Spiritus 2011).

Caring for seniors

- Filipinos value their seniors. A law in the Philippines, the Philippine Senior Citizen's Act, grants benefits and privileges to people who have reached the age of sixty (South Eastern Migrant Resource Centre 2010).
- Older Filipinos have a high reliance on their family for care and support (South Eastern Migrant Resource Centre 2010). It is expected that the children will care for their elders and financially support them as they age (South Eastern Migrant Resource Centre 2010).
- Filipino Australians may be reluctant to openly express pain or hardship and are inclined to persevere with an illness or disability rather than seeking help when signs and symptoms first appear (South Eastern Migrant Resource Centre 2010).
- In the Philippines it is customary for three generations to live under the one roof and parents living apart from their children and grandchildren may be seen as shameful (South Eastern Migrant Resource Centre 2010).
- Grandparents in Australia may be expected to fulfil their role as housekeeper: cleaning the house, doing laundry, picking up grandchildren from school and cooking dinner for the household (South Eastern Migrant Resource Centre 2010).
- In general Filipinos are very social and prefer to spend time with family, relatives, church groups and social clubs rather than alone (South Eastern Migrant Resource Centre 2010).
- Filipino organisations and church groups in Australia actively support and care for their Filipino seniors (South Eastern Migrant Resource Centre 2010).

- Filipino seniors may be reluctant to seek help from aged care services because of the stigma of losing their independence and fear that their children will be criticised for not looking after them adequately. (South Eastern Migrant Resource Centre 2010). However, many Filipino Australians may also be open to receiving aged care services if these services are delivered with respect and cultural sensitivity. (Current Project - Spiritus 2011).
- Filipino seniors may feel more comfortable with a bilingual Filipino worker to support them (South Eastern Migrant Resource Centre 2010).
- Spiritual preparation for death is very important for Filipino Australians (Current Project - Spiritus 2011).
- A major concern of older Filipinos and their families is where they will be buried when they die. Many older Filipinos wish to be buried in the Philippines and this can cause financial stress for families. (Current Project - Spiritus 2011).

Provision of information about services

- It is suggested that information about services be provided through:
    - providing written information to churches
    - newspapers and television(Current Project - Spiritus 2011).
    - Some older Filipinos may require information to be translated or interpreted.

SPANISH SPEAKING AUSTRALIANS- INFORMATION ON AGEING IN BRISBANE AND SURROUNDS

Population

Table 18: Age distribution of Spanish-speaking7 Australians by region in Brisbane and surrounds (Source- 2006 ABS Census data (Australian Bureau of Statistics 2011))

REGION	AGE CATEGORY								
	0-19 yrs		20-39 yrs		40-54 yrs		55+ yrs		TOTAL
	No.	PERCENT	No.	PERCENT	No.	PERCENT	No.	PERCENT	
SE Brisbane	171	8.8%	796	41.0%	549	21.9%	425	21.9%	**1,941**
NW Brisbane	173	10.1%	729	42.5%	458	20.7%	354	20.7%	**1,714**
Inner Brisbane	40	9.4%	281	66.1%	75	6.8%	29	6.8%	**425**
Logan City	51	8.2%	202	32.6%	213	24.7%	153	24.7%	**619**
Redcliffe	3	4.1%	24	32.9%	12	46.6%	34	46.6%	**73**
Redland	18	9.9%	42	23.2%	64	31.5%	57	31.5%	**181**
Pine Rivers	45	17.6%	68	26.6%	79	25.0%	64	25.0%	**256**
Ipswich	47	9.5%	205	41.5%	167	15.2%	75	15.2%	**494**
Caboolture	3	2.4%	37	29.1%	33	42.5%	54	42.5%	**127**
Beaudesert	0	0.0%	16	21.3%	45	18.7%	14	18.7%	**75**
West Moreton	0	0.0%	9	25.7%	6	57.1%	20	57.1%	**35**
Sunshine Coast	11	13.9%	15	19.0%	28	31.6%	25	31.6%	**79**
Gold Coast	111	8.7%	414	32.3%	361	30.8%	394	30.8%	**1,280**

- Although Spanish-speaking people in Australia come from several different countries, each with its own history and customs, they share language and a similar culture as a result of a mixed population descended from Spaniards, Indigenous South American groups, Italians and Africans.

[7] Includes countries of Spain, Colombia, Peru, Venezuela, Ecuador, Guatemala, Cuba, Bolivia, Honduras, El Salvador, Paraguay, Costa Rica, Panama, Puerto Rico, Mexico, Argentina, Chile, Dominican Republic, Nicaragua and Uruguay.

Greeting and communicating with seniors

- Older Spanish-speaking Australians prefer to be addressed by their title (e.g. Mrs, Mr) followed by their surname (Allotey, Manderson et al. 1998).
- It is appropriate to maintain eye contact.
- Spanish-speaking Australians generally have a smaller personal space than Anglo-Australians (Allotey, Manderson et al. 1998).
- After initial rapport is developed, friendly physical contact such as touching the shoulder, is appreciated (Allotey, Manderson et al. 1998).
- Some Spanish speaking Australians will nod "yes" when they do not understand what is being said (Talamantes, Lindeman et al. undated).
- Literacy rates in Latin American countries vary. In Chile and Argentina literacy rates are over 95 percent for both men and women. In El Salvador literacy rates are 83 percent for men and 80 percent for women (Central Intelligence Agency (CIA) 2010).
- Proficiency in English as measured in the ABS 2006 Census as those who can speak English well or very well was between 75 and 88 percent for women and 78 and 89 percent for men from Argentina, Chile, El Salvador and Spain (Australian Bureau of Statistics 2011). Table 19 below shows the proficiency in spoken English for each of three most common countries of birth for Spanish-speaking people living in Brisbane. Table 20 shows the rates for people aged 55 years or older. Spanish-speaking representatives report that English literacy of Spanish-speaking seniors are low and that language is a major barrier to service access (Current Project - Spiritus 2011).
- Although Spanish speaking Australians benefit from using an interpreter when they are ill or in a high stress situation, sensitivity is needed in introducing the need for this as they take pride in their ability to speak, read and write English and may feel offended.

Table 19: Proficiency of spoken English by Country of Birth for Spanish-speaking countries for all ages (2006 ABS Census).

Country of birth	Proficiency in spoken English- Men (Percent)			Proficiency in spoken English-Women (Percent)		
	Well or very well	Not well	Not at all	Well or very well	Not well	Not at all
Argentina	89.3%	9.5%	1.1%	88.3%	9.9%	1.8%
Chile	85.3%	13.2%	1.5%	81.7%	15.0%	3.3%
El Salvador	86.4%	12.1%	1.5%	78.4%	17.0%	4.5%
Spain	77.7%	20.8%	1.5%	75.1%	22.0%	2.9%

Table 20: Proficiency of spoken English by Country of Birth for Spanish-speaking countries for people aged 55 years and older (2006 ABS Census).

Country of birth	Proficiency in spoken English- Men (Percent)			Proficiency in spoken English-Women (Percent)		
	Well or very well	Not well	Not at all	Well or very well	Not well	Not at all
Argentina	76.2%	21.3%	2.5%	73.2%	21.7%	5.1%
Chile	71.9%	24.8%	3.3%	64.5%	27.4%	8.1%
El Salvador	48.7%	42.8%	8.5%	33.4%	44.6%	22.0%
Spain	65.7%	32.1%	2.2%	59.1%	36.0%	4.9%

Health issues impacting on ageing

Health conditions

- There is little published information on the health of Spanish speaking Australians.
- In both Australia and the United States, people from Latin America have been shown to have lower mortality rates than the general population (Allotey, Manderson et al. 1998; Talamantes and Sanchez-Reilly 2010).
- In the United States, leading causes of death for Latin Americans include: heart disease, cancer, cerebrovascular diseases and diabetes (Talamantes and Sanchez-Reilly 2010).
- Spanish speaking Australians from Latin America may suffer long term, untreated PTSD, as when they arrived in Australia 30-40 years ago, there were few trauma counselling services. As they age, the impact of trauma may re-surface, particularly if people lose short term memory, and long term memories become more significant (Ageing Disability and Homecare: Kathryn Knight 2011; Current Project - Spiritus 2011).

Health beliefs and practices

- Health concepts vary widely amongst Spanish speaking Australians. Most people have an understanding of Western health concepts (Allotey, Manderson et al. 1998). Some people may believe health and illness are influenced by spirits and supernatural causes(Office of the Surgeon General (US) 2001).
- Depression is likely to be expressed in physiological symptoms such as headaches(Office of the Surgeon General (US) 2001).

Social issues impacting on ageing

- Spanish speaking Australians including those from Spain, El Salvador, Chile and Argentina have either equivalent or higher levels of education compared to the total Australian population. The 2006 Census showed that 51.0, 54.9, 58.9 and 59.6 percent of Australians aged 15 years or older born in El Salvador, Chile, Argentina respectively had some form of higher non-school qualification compared to 52.5 percent of the total Australian population (Department of Immigration and Citizenship 2006) .
- Based on the 2006 Census, the participation rate in the workforce for Australians born in Spain, El Salvador, Chile and Argentina was 52.3, 70.4, 67.4 and 69.7 percent respectively, compared to 64.8 percent for the total Australian population. The unemployment rates were 5.0, 8.0, 6.7 and 5.3 respectively compared to 5.2 percent in the total Australian population (Department of Immigration and Citizenship 2006).
- Catholicism is the main religion of Spanish speaking Australians (Department of Immigration and Citizenship 2006).
- Many Latin American elders do not seek outside help until advice is obtained from their extended family and friends(University of Missouri- Kansas City College of Arts and Sciences undated).
- Senior Spanish speaking men appear to be more isolated than women, with smaller numbers joining social groups (Current Project - Spiritus 2011).
- Some Spanish speaking Australians including El Salvadorian, Chilean and Columbian people left their countries as refugees and are survivors of torture and trauma. Post traumatic stress disorder (PTSD) is common in these groups (Allotey, Manderson et al. 1998).
- Survivors of torture and trauma are at risk of ageing prematurely due to trauma and hardship and may require support at an earlier age than the general population

- As survivors of torture and trauma, many Spanish Speaking Australians may experience additional impacts of ageing (Ageing Disability and Homecare: Kathryn Knight 2011).
    - As their short term memory declines they may experience resurfacing of painful memories and symptoms of unresolved post traumatic stress disorder.
    - As their mobility becomes limited by physical problems such as chronic pain, they may experience increased social isolation, depression and feelings of cultural dislocation.
    - As their cognitive function diminishes, they may lose competence in English and revert to their first language(Ageing Disability and Homecare: Kathryn Knight 2011).

Caring for seniors

- Older Spanish speaking Australians prefer to be known as seniors as this is regarded a more polite term than 'aged' or 'old people' (Current Project - Spiritus 2011).
- Many Spanish speaking seniors are isolated with language barriers, lack of access to transport and insufficient information about services, resulting in low use of community aged care services. (Current Project - Spiritus 2011).
- In addition to lack of information, a lack of conceptual understanding of services is a barrier to service use. For example, words like respite, carer, hospice and counselling, are not familiar concepts. (Current Project - Spiritus 2011).
- Although there is a high reliance on family members for support as people age, current research indicates many Spanish speaking Australians are open to receiving home care services. However, most people know little about these services- how to access, availability, eligibility and cost. (Current Project - Spiritus 2011).
- Older Spanish Speaking Australians who have experienced torture and trauma may be prone to PTSD flashbacks that can be triggered by different things. These triggers vary by person but include such things as showering or bathing, having a medical procedure, shaving, haircuts, certain food, people writing things down, confined space and closed doors (Ageing Disability and Homecare: Kathryn Knight 2011).
- Recommendations for the provision of in home care include:
    - Seniors to be contacted prior to workers arriving at the home either a day prior or when the worker is on the way (Current Project - Spiritus 2011).
    - It is preferable that the worker is a Spanish speaker for communication as well as to promote rapport and trust.
    - It is important that the worker maintain professional boundaries. (Current Project - Spiritus 2011).

Provision of information about services

- It is suggested that information about services be provided through:
    - face-to-face information sessions in Spanish at seniors groups
    - information in the local Spanish newspaper, Español.
    - newsletters produced by the church (Current Project - Spiritus 2011).

SRI LANKAN AUSTRALIANS- INFORMATION ON AGEING IN BRISBANE AND SURROUNDS

Population

Table 21: Age distribution of Sri Lanka-born Australians by region in Brisbane and surrounds (Source- 2006 ABS Census data (Australian Bureau of Statistics 2011))

REGION	AGE CATEGORY								
	0-19 yrs		20-39 yrs		40-54 yrs		55+ yrs		TOTAL
	No.	PERCENT	No.	PERCENT	No.	PERCENT	No.	PERCENT	
SE Brisbane	135	11.7%	367	31.9%	385	33.5%	263	22.9%	**1,150**
NW Brisbane	144	9.4%	375	24.4%	572	37.2%	446	29.0%	**1,537**
Inner Brisbane	20	12.7%	80	51.0%	45	28.7%	12	7.6%	**157**
Logan City	10	4.8%	49	23.7%	65	31.4%	83	40.1%	**207**
Redcliffe	10	8.8%	11	9.6%	26	22.8%	67	58.8%	**114**
Redland	15	13.5%	18	16.2%	34	30.6%	44	39.6%	**111**
Pine Rivers	9	5.5%	44	26.8%	67	40.9%	44	26.8%	**164**
Ipswich	7	10.4%	19	28.4%	24	35.8%	17	25.4%	**67**
Caboolture	11	13.3%	15	18.1%	33	39.8%	24	28.9%	**83**
Beaudesert	0	0.0%	6	50.0%	3	25.0%	3	25.0%	**12**
West Moreton	4	13.8%	9	31.0%	7	24.1%	9	31.0%	**29**
Sunshine Coast	3	9.1%	0	0.0%	10	30.3%	20	60.6%	**33**
Gold Coast	35	9.4%	89	23.9%	113	30.3%	136	36.5%	**373**

Greeting and communicating with seniors

- A handshake is an appropriate greeting for Sri Lankan people. They are accustomed to soft rather than firm handshakes (Ahmed and Lemkau 2000).
- Although naming conventions vary depending on ethnicity, in most cases the family name comes first and given name second (Ancestry.com 2010)
- When addressing the elderly, it is important to use their appropriate title (e.g. Mr, Mrs) followed by their family name (Migrant Information Centre (MIC) 2004; Kwintessential 2010).
- Sri Lankan Australians usually prefer minimal eye contact, particularly in interactions where respect is important, such as with the elderly (Ahmed and Lemkau 2000).
- Although in many cases, a nod is used to indicate "yes" and a horizontal head swing used to indicate "no", this is not always true. (Ahmed and Lemkau 2000).
- About one-third of Sri Lanka-born Australians are Buddhist. The following customs or practices are particularly important for elderly Sri Lankan Buddhists.
    - Using both hands to give and receive an object is a sign of respect (Barron, Okell et al. 2007).
    - The head is considered spiritually the highest part of the body and therefore sensitivity is required if it is necessary to touch the head (Barron, Okell et al. 2007).
    - When seated, it is disrespectful for legs to be stretched out with feet pointing towards a person (Barron, Okell et al. 2007).
- Literacy rates in Sri Lanka are about 91 percent (92% for men and 89% for women) (Central Intelligence Agency (CIA) 2010).
- Proficiency in English as reported in the 2006 Census is relatively high with 97 percent of men and 92 percent of women reporting that they speak English well or very well (Australian Bureau of Statistics 2011). For men and women aged 55 and older these percentages drop to 96 and 83 percent respectively (Australian Bureau of Statistics 2011).
- Sinhalese (39%), English (35%) and Tamil (23%) are the most common languages spoken at home by Sri Lanka-born Australians (Department of Immigration and Citizenship 2006).

Health issues impacting on ageing

Health conditions

- There is little information on the health of Sri Lankan Australians.
- Tamil asylum seekers and refugees have been shown to have high rates of depression, anxiety and post traumatic stress disorder (PTSD) (Silove, Steel et al. 1998; De-Vries 2001).
- Vitamin D deficiency is common (Periyakoil and Dara 2010).
- Sri Lankan Australian women may be at higher risk of osteoporosis (Periyakoil and Dara 2010).

Health beliefs and practices

- Many Sri Lankan Australians use traditional medicines and spiritual practices such as Ayuveda and Sinhala in conjunction with Australian medicine (Caldwell, Gajanayake et al. 1989; Migrant Information Centre (MIC) 2004; Broom, Wijewardena et al. 2010).
- Mental illness is associated with denial, shame and stigma (Ahmed and Lemkau 2000).

Social issues impacting on ageing

- Sri Lanka-born Australians have higher levels of education compared to the total Australian population. The 2006 Census showed that 64.8 percent of the Sri Lanka-born population aged 15 years and over had some form of non-school qualification compared to 52.5 percent of the total Australian population (Department of Immigration and Citizenship 2006).
- The participation rate in the workforce (2006 Census) was 70.9 percent and unemployment rate 6.5 percent compared to the corresponding values of 64.6 percent and 5.2 percent in the total Australian population. The median weekly income for Sri Lanka-born people in Australia aged 15 and older was $555 compared to $466 for the total Australian population (Department of Immigration and Citizenship 2006).
- Buddhism (31%), Christianity (27%) and Hinduism (19%) are the main religions of Sri Lanka-born Australians (Department of Immigration and Citizenship 2006).
- Survivors of torture and trauma are at risk of ageing prematurely due to trauma and hardship and may require support at an earlier age than the general population.
- As survivors of torture and trauma, many Sri Lankan Australians may experience additional impacts of ageing (Ageing Disability and Homecare: Kathryn Knight 2011).
    - As their short term memory declines they may experience resurfacing of painful memories and symptoms of unresolved post traumatic stress disorder.
    - As their mobility becomes limited by physical problems such as chronic pain, they may experience increased social isolation, depression and feelings of cultural dislocation.
    - As their cognitive function diminishes, they may lose competence in English and revert to their first language(Ageing Disability and Homecare: Kathryn Knight 2011).

Caring for seniors

- Many older Sri Lankan Australians rely on their children to care for them as they age, and when their children go to work, the elderly are often left alone in the house contributing to feelings of isolation (Andrews 2005).
- Some older Sri Lankan Australians are not proficient in English and have difficulties accessing public transport, driving and adjusting to life in Australia (Andrews 2005). These are all factors contributing to isolation.
- The Sri Lankan community in Melbourne has identified the need to establish senior citizens groups with transport services (Andrews 2005).

- Elderly Sri Lankan Australians have reported a dislike of Australian food provided by HACC and other aged services (Andrews 2005).
- Nursing homes are not generally considered an appropriate option for the Sri Lankan aged. (Andrews 2005).
- Older Sri Lankan Australians who have experienced torture and trauma may be prone to PTSD flashbacks that can be triggered by different things. These triggers vary by person but include such things as showering or bathing, having a medical procedure, shaving, haircuts, certain food, people writing things down, confined space and closed doors (Ageing Disability and Homecare: Kathryn Knight 2011).

Provision of information about services

- The Sri Lankan Australian community elsewhere in Australia has expressed a lack of knowledge of services for aged care. Strategies for providing information suggested:
  - Community radio,
  - Community newspapers
  - Community television (Andrews 2005).

AFRICAN AUSTRALIANS- INFORMATION ON AGEING IN BRISBANE AND SURROUNDS

Population

Table 22: Age distribution of Africa-born8 Australians by region in Brisbane and surrounds (Source- 2006 ABS Census data (Australian Bureau of Statistics 2011))

REGION	AGE CATEGORY								
	0-19 yrs		20-39 yrs		40-54 yrs		55+ yrs		TOTAL
	No.	PERCENT	No.	PERCENT	No.	PERCENT	No.	PERCENT	
SE Brisbane	974	35.4%	1,084	39.3%	531	19.3%	166	6.0%	**2,755**
NW Brisbane	418	26.1%	558	34.8%	492	30.7%	135	8.4%	**1,603**
Inner Brisbane	69	21.6%	165	51.7%	63	19.7%	22	6.9%	**319**
Logan City	250	36.5%	216	31.6%	164	24.0%	54	7.9%	**684**
Redcliffe	16	25.0%	9	14.1%	22	34.4%	17	26.6%	**64**
Redland	20	10.3%	36	18.5%	92	47.2%	47	24.1%	**195**
Pine Rivers	34	15.8%	48	22.3%	105	48.8%	28	13.0%	**215**
Ipswich	16	11.7%	55	40.1%	30	21.9%	36	26.3%	**137**
Caboolture	6	6.4%	19	20.2%	49	52.1%	20	21.3%	**94**
Beaudesert	6	35.3%	3	17.6%	8	47.1%	0	0.0%	**17**
West Moreton	46	43.0%	24	22.4%	25	23.4%	12	11.2%	**107**
Sunshine Coast	9	8.1%	9	8.1%	49	44.1%	44	39.6%	**111**
Gold Coast	92	14.2%	153	23.6%	260	40.2%	142	21.9%	**647**

- Africa-born Australians includes people from a range of countries with different histories, cultures and customs. The purpose of this profile is to identify some features that Africa-born Australians may have in common as an initial guide to assist in the provision of appropriate aged-care services. It is not intended as a conclusive guide, and cultural practices always need to be checked with the individual person.

Greeting and communicating with seniors

- In many cases, shaking hands when greeting someone or saying goodbye is appropriate. It is recommended however, that men do not initiate a handshake with women unless the woman extends her hand first. African women often greet each other with a kiss.

[8] Includes countries of North Africa, Central and West Africa, Southern and East Africa. Excludes South Africa, Zimbabwe, Seychelles, and Mauritius.

- In many cases, it is appropriate to address people by their title (e.g. Mr, Mrs) and first name or first name only. It is advisable to ask the older people how they would like to be addressed.
- The appropriateness of eye contact varies throughout Africa. For example, eye contact is very important among Sudanese people and indicates a caring attitude. However for other Africans, e.g. Burundian, avoiding eye contact is a way to show respect for the elderly, and people in authority (Palls 2010).
- When greeting some Africans, excessive smiling may be seen as making fun of, or mocking the person being met. (The example given was a Dinka lady at Centrelink, who asked the interpreter "Why is she laughing at me?" Current Project – Spiritus 2011)
- Most Africa-born Australians prefer a same gender interpreter.
- It is recommended that when contracting the services of an Arabic interpreter for a Sudanese Australian that a Sudanese-Arabic interpreter is requested. The Sudanese Arabic language is distinct and the person may not understand an interpreter from another Arabic speaking country (South Eastern Region Migrant Resource Centre 2007)
- In many African countries including Sudan, Ethiopia and Burundi, literacy rates are low and vary from about 35 to 52 percent in women and from about 50 to 72 percent in men (Central Intelligence Agency (CIA) 2010).
- Proficiency in English based on the 2006 Census shows that there is a high degree of variation depending on country of birth and gender. From only 19 percent of Burundian women reporting that they speak English well or very well to 91 per cent of Somali men reporting that they speak English well or very well. Tables 23 and 24 below show English proficiency levels for men and women for some African countries of birth based on the 2006 Census for all ages and for those aged 55 years and older (Australian Bureau of Statistics 2011).

Table 23: Proficiency of spoken English by Country of Birth by selected African countries for all ages (2006 ABS Census).

Country of birth	Proficiency in spoken English- Men (Percent)			Proficiency in spoken English-Women (Percent)		
	Well or very well	Not well	Not at all	Well or very well	Not well	Not at all
Burundi	35.7%	46.0%	18.3%	19.0%	49.3%	31.7%
Congo	72.3%	22.0%	5.7%	67.5%	26.5%	6.0%
Eritrea	86.3%	11.3%	2.4%	69.2%	24. 3%	6.5%
Ethiopia	89.9%	18.6%	1.5%	78.1%	18.0%	3.9%
Somalia	90.9%	7.9%	1.2%	75.2%	21.1%	3.7%
Sudan	76.3%	20.3%	3.4%	60.2%	32.0%	7.8%

Table 24: Proficiency of spoken English by Country of Birth by selected African countries for people aged 55 years and older (2006 ABS Census).

Country of birth	Proficiency in spoken English- Men (Percent)			Proficiency in spoken English-Women (Percent)		
	Well or very well	Not well	Not at all	Well or very well	Not well	Not at all
Burundi	42.9%	57.1%	0.0%	33.3%	33.3%	33.3%
Congo	88.9%	0.0%	11.1%	80.9%	19.1%	0.0%
Eritrea	67.0%	27.2%	5.8%	37.7%	33.9%	28.4%
Ethiopia	65.3%	22.2%	12.5%	53.0%	28.2%	18.8%
Somalia	73.6%	22.6%	3.8%	23.3%	45.7%	31.0%
Sudan	78.9%	17.3%	3.8%	55.4%	26.6%	18.0%

Health issues impacting on ageing

Health conditions

- Common health conditions in Africans from a refugee background include:
    - Vitamin D deficiency
    - Hepatitis B, Malaria, gastrointestinal infections, Schistosomiasis and Latent Tuberculosis
    - Dental disease
    - Musculoskeletal problems including old fractures that have not been treated adequately at the time
    - Depression, anxiety and post traumatic stress disorder (PTSD) (Martin and Mak 2006; Tiong, Patel et al. 2006; Victorian Foundation for Survivors of Torture Inc. 2007; Tempany 2009).
- African refugees settling in Australia have been shown to have high rates of depression, anxiety and post traumatic stress disorder (PTSD). Following settlement in Australia, many Africans are more concerned with current stressors such as family re-union, employment issues, housing and transport than they are about past trauma (Tempany 2009; Current Project - Spiritus 2011). The experience of past trauma becomes an increasing issue for older Africans as they become more isolated and as long-term memories surface. (Current Project - Spiritus 2011)

Health beliefs and practices

- Many African Australians practice herbal and traditional health remedies. However, in Australia this practice is limited by lack of available plants and herbs, and a shortage of traditional healers. (Hodes 1997; Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre 2001; Texas Department of State Health Services 2007).
- African Australians may be unfamiliar with a formal, structured health system, Australian medical practices or being treated by a doctor of the opposite gender (Department of Immigration and Citizenship 2007).

- Some older Africans feel that they cannot communicate their symptoms to doctors even through an interpreter because they do not understand the cultural framework in which they experience and describe their symptoms. As a result they may not seek health care when it is needed. (Current Project – Spiritus 2011)

- *An African leader provided the following story to illustrate. An elderly African woman saw a doctor, using an interpreter. When the doctor asked her what the issue was. She replied, "At 6pm every day four big men come and cut at my arms and my legs with an axe." The doctor said "Have you reported this to the police." The African woman exclaimed, "Why are you making a joke of this?" and left the surgery without having her pain investigated and without any treatment.*

- African Australians may share medications with other family members (Current Project - Spiritus 2011).
- Many African Australians prefer injections to taking tablets (Hodes 1997).

Social issues impacting on ageing

- Overall, Africa-born Australians have lower levels of education (non-school qualifications) compared with the total Australian population (Australian Bureau of Statistics 2011).
- The median income of Africa-born Australians is lower than that of the total Australian population (Australian Bureau of Statistics 2011). For example, in 2006 the median weekly income for Sudan-born people and Ethiopia-born people aged 15 or older was $231 and $342 respectively, compared to $466 for the total Australian population (Department of Immigration and Citizenship 2006; Department of Immigration and Citizenship 2006).
- Elders are highly respected in Africa. Being an elder is not related to age but it is about ones place in the community hierarchy and their responsibilities. In African Australian communities there are 'young' elders who learn from older elders and these 'young' elders demonstrate leadership and are respected. The word 'senior' is used for African Australians who are older in chronological age (Current Project - Spiritus 2011).
- African Australians describe a 'role reversal' where in Africa, the older people had language skills and financial capability, but in Australia, they rely on the younger generations for information and in some cases financial support. There is also a generation gap between older Africans who can only speak their own language and their grandchildren who can only speak English. These are all factors contributing to isolation of the older Africans. (Current Project - Spiritus 2011).
- Sending remittances to family remaining in Africa is a strong obligation (Current Project - Spiritus 2011).
- Religion is important to many older African Australians and it may become more important as people age. Most African Australians are either Christian, Muslim or have traditional beliefs such as animist and tribal religions. (Current Project - Spiritus 2011)
- Many older African Australians are not proficient in English and have difficulties accessing public transport, driving and adjusting to life in Australia generally (Current Project - Spiritus 2011).

Caring for seniors

- Many older African Australians rely on their children to care for them as they age and when their adult children go to work, they are left alone in the house. Older Africans are reluctant to ask for assistance from outside of the family because of the shame and 'loss of face' associated with the community knowing that their family are not fulfilling their obligations to care for their older family members. In addition, African Australians prefer to have care provided by workers of the same gender (Current Project - Spiritus 2011).

- It is important for Muslim Africans that assistance provided for the aged does not have a religious component other than Islam. In this project, a community representative enquired about the church connection associated with Spiritus, and expressed a community fear that a church based organisation may try to convert Muslims (Current Project - Spiritus 2011).
- Recommendations for the provision of community care include:
    - Seniors are contacted prior to workers arriving at the home.
    - Shoes are removed where appropriate, especially for Muslim clients.
    - An African Australian worker provided where possible to assist with the development of trust and rapport (Current Project - Spiritus 2011).
- A major concern of older African Australians and their families is where they will be buried when they die. Many older Africans want to be buried in Africa in their traditional country. This can cause much stress and tension in families as it is very expensive to transport a body back to Africa for burial. Many families are reluctant to talk about this but with trust it may be possible for a service provider to discuss the issue in an informal way to assist with planning for ageing, illness and dying (Current Project - Spiritus 2011).

Provision of information about services

- It is recommended that information about services is provided face-to-face at meetings, at gatherings of seniors and elders, and at community events. Most African cultures are verbal cultures so the provision of written information, even translated, may not be useful. (Current Project - Spiritus 2011).
- Many senior Africans listen to local ethnic radio (4EB FM). Providing information in African languages on radio an effective way of reaching more isolated seniors (Current Project - Spiritus 2011).

3. SUMMARY OF FINDINGS- NEEDS OF EMERGING AGED CALD COMMUNITIES IN BRISBANE

COMMUNITY CONSULTATION

- Many of the communities consulted have participated in consultations with government and non government organisations in the past and in some cases have not seen the results or benefits of these consultations. As one of the Spanish-speaking consultants describes it: "People will open up and listen (to agency representatives) once but when they don't get feedback then it becomes a problem." Some communities have had the experience of developing relationships with agencies offering programs to their community and raising expectations, only to see projects finished when funding ended. This project experienced some reluctance by some community groups to consult with agencies such as Spiritus.
- Many community representatives participating in the consultation had not heard of Spiritus as an organisation and were not aware of services provided. Concern was expressed by some communities about the name, 'Spiritus' and the negative connotations it has in their culture. For example, for the Spanish-speaking communities, the name evoked the concept of 'Spirits' in a negative connotation and one representative asked, 'What kinds of Spirits are they?' When it was explained that the service was a combination of Anglicare and St Luke's Nursing Service, the response was 'Why change from Anglicare?' A Muslim African community representative, at interview, expressed his concern that the Christian religion would be promoted. He explained how religious practices were increasingly important to Muslims as they age and people will worry about being exposed to Christian icons or symbols (for example, if a Christian church is used as a venue or a cross is present). He explained that Muslims in Africa have experienced help from Christian NGOs in refugee camps and quoted "Food in one hand, the Bible in the other." Their reluctance to accept food from them was in case they "Exchanged heaven for some food".
- Using the Community Participation Strategy Framework (Figure 1) as a guide, the current project was based on the second column 'Consumer is consulted' without consumers first receiving sufficient information to be informed about Spiritus and HACC services. Providing community representatives and consumers with more information prior to the consultations may have reduced the uncertainty and resistance to consultation.
- The next stage in the recommended consultation process is to develop strategies for the CALD consumer representatives to advise HACC services. This could be through initiatives such as advisory groups and consumer planning days (Centre for Culture, Ethnicity and Health 2005).

INFORMATION NEEDS

- Communities consulted expressed lack of information about aged care services, enquiring about the differences in services provided by different organisations, costs of services, if interpreters were used, and who to contact.
- Some concepts and words used in aged care are not familiar. For example, the concept of providing respite for carers has no equivalent word in many languages.
- A major barrier to CALD community members being informed of and having access to services is lack of competence and confidence in English.
- Many communities require information provided in their own language and the preferred way of doing this is face-to-face at meetings and events attended by their seniors.
- This could be done by a bi-lingual information/education worker in aged care, or by using a professional interpreter.

COMMUNITY CAPACITY

- The representatives of the CALD communities who participated in this project were already supporting the elders in their community in a voluntary capacity, in most cases with very little funds. These were the identified significant issues for them:
    - Transport. Community representatives cite low numbers of seniors participating in community activities except when transport can be provided. For example, The Vietnamese Senior Citizens Association offers social activities twice a week and special activities (such as birthday celebrations) less frequently. Small numbers come to the regular days due to lack of transport, but when volunteers provide transport for the 'special' days, there is large increase in participation.
    - Cost and availability of meeting venues: Many seniors' activities are held in venues with minimal cost (such as church halls) but in some cases the times of availability of the venue is limited.
    - The high reliance on a few active volunteers in these community organisations impacts on their sustainability.
    - Most programs for seniors offered through these local grass roots community organisations were of a social nature with activities like dancing, playing music, singing, games, English lessons, and bus excursions. These groups function with little or no funds. The community consultants identified that they would appreciate help to run the activities on a more frequent basis, and help with provision and coordination of transport.
    - These local community organisations have the existing community networks, the trust of the community, the ability to organise social events for elders and also act as a liaison between service providers and community members. However, in many cases, they do not have the capacity or desire to apply for grants to fund their programs, as this required onerous accountability measures associated with such grants.
    - The literature shows that sometimes when a grass roots community organisation receives a grant to run their own social programs, they may be so overwhelmed by the tasks of organisation and administration required to manage the grant, that they may even consider declining the grant (Centre for Culture, Ethnicity and Health 2005). Offering community organisations support in a way that is directed by them and responds to the needs they identify themselves, has been shown to build their capacity to coordinate activities, in some cases beyond the length of the grant (Centre for Culture, Ethnicity and Health 2005).
- HACC services such as home care and respite were not available through these local community organisations.
- The needs of African seniors have been recognised through the formation of the African Seniors Club of Australia. Although they have received small amounts of funding for one-off projects, staff are volunteers. They identified a need for regular social activities for African seniors to reduce isolation and they require a specific venue for this. Supporting African seniors to provide social activities will become increasingly important as, although there are only around 500 African Australians aged 55 and older living in Brisbane now, this number is expected to increase three times in the next 15 years.
- Workforce capacity. This project was informed that there are CALD community members with skills and qualifications relevant to paid and volunteer work in aged care. For example, many people participating in current seniors' activities run by their communities have overseas qualifications in nursing and medicine. Also, according to a Somali community leader, there are now more than 25 young Somali women with recent Australian aged care qualifications.

AGED CARE SERVICE NEEDS

- There are layers of diversity within each of the different communities consulted for this project For example the African, Pacific Islander and Latin American communities have many different cultures and many different languages. There are also differences in the migration experience as some have migrated for family reunion, some as skilled migrants and some to flee violent conflict and persecution. These differences in culture, language and migration experience all impact on the needs of people as they age.
- There are also different needs for younger and more mobile migrants compared to the older, less mobile seniors. For example, many Filipinas and Papua New Guinean women in their 40s, 50s and 60s who are married to Australian men, end up as carers for their husbands who may be twenty years older and need respite and care services.
- A major theme of all the consultations was isolation. An African consultant described a common situation for older Africans. Their children and grandchildren go to work and school and they are left at home. They can't understand television; they can't communicate with their grandchildren as many of them speak only English. They fear leaving the house because they can't communicate in English, they can't understand public transport timetables. So they stay at home by themselves "locked in a prison" and "closed from the rest of the world". (Current Project - Spiritus 2011)
- In many cases, representatives of the CALD communities and grass roots organisations participating in this project were highly resistant to the idea of agencies outside their community organising social activities for them. They value self sufficiency and autonomy.
- So how best to provide support? As in other studies of CALD populations in Australia, community participants suggest a bicultural/bilingual, community-based "navigator" service to help people to access the aged care system. A recent study in Logan of health care needs of CALD communities showed that participants envisaged a community navigator model of local CALD people, knowledgeable about services, who would be able to respond to individual and community needs, supporting people to navigate the health system, educating health professionals and building the capacity for future health promotion within the community (Henderson and Kendall 2011).
- Some communities (Pacific Islander and African communities particularly) identified a loss of role, respect and identity for their seniors. They feel their skills and knowledge are not valued in Australia, including by the younger generations of their families. Many seniors held professional qualifications not recognised here. They describe a "role reversal" where their authority as an elder and their major role in decision making in the family is weakened and it seems that the children have more power. This has been observed in other studies of CALD elderly(South Eastern Migrant Resource Centre 2010).
- This loss of role in the family appears to be greater for men than for women, (as women still have a role caring for children and the home) making men's role in community activities even more critical to their self-esteem and confidence. (Current Project - Spiritus 2011)
- This project supports the finding of other studies, that older people of CALD backgrounds feel socially and culturally isolated from the younger generations (South Eastern Migrant Resource Centre 2010). Participants in this project talked about the need to create stronger links between older and younger generations in Australia, to help bridge some of the gaps that migration contributes to. One strategy suggested to help bridge this gap, was to record stories of their life for future generations.
- For all communities participating in this project, it is traditional for younger members of the family to care for their aged. It is a clear duty of the younger people and an expectation by their elders. In Australia, the lifestyle is different and younger people are busy with work and their own families and have less capacity to do this. This unmet need is not spoken about as it is associated with 'loss of face', and shame. For many, the shame is worse than the isolation. Aged

care service providers need to be very sensitive when offering help, framing care needed as a result of living in the Australian context rather than because the family is unable to help.

Care services provided by non community people.

- CALD people recognise that there are differences in culture between Australia and their country of origin and tolerate these differences in care workers. They emphasise that what they feel is most important is that the care workers develop rapport and trust and are respectful. Face-to-face communication between care workers and clients and the need for consistency in service provision is important. For example, having continuity with the same care worker is important. Respect can be shown through asking questions about how the elderly person would like them to behave in their home. Examples given were: the care worker asks how the older person would like to be addressed, that they ask if they would like them to remove their shoes, that they are polite and not loud.
- For home care services to be culturally appropriate this development of rapport and trust was seen to be crucial. However, because of the diversity between and within culturally groups, the methods of developing rapport and trust are different.
    - For example, for Pacific Island communities it appears to be important for workers to develop a close relationship with the seniors they are assisting. A Samoan community representative talked about the reluctance of the elderly to have anyone from outside the family to come to the house to help with housework. They said that there is one Samoan worker that provides home care, but it is important is that they continually talk to the older person as they work so that they feel comfortable. For a person outside of the family to be accepted, they need to become in some way, "part of the family".
    - In contrast, the Spanish-speaking representatives expressed the importance of home care workers maintaining a professional distance from their clients. They explained that workers need to make sure they set boundaries between the personal and professional and that respect of status is critical.

RECOMMENDATIONS

1. **Effective community development and communication strategies to increase awareness and understanding of HACC services amongst emerging CALD communities.**

   Suggested strategies:

   - Offer information sessions at existing regular social events facilitated by CALD groups (e.g. Vietnamese elders) and at other culturally appropriate events and venues. HACC services need to be explained in simple terms, using examples understandable in different cultural contexts
   - Develop relationships with key representatives of CALD communities enabling these representatives to inform other community members about aged care services and disseminate information. These key representatives can also encourage consumers to give feedback on the information provided to them.
   - Provide practical information about services offered, eligibility and differences in services offered by different HACC services
   - Promote HACC services on 4EB and other ethnic radio
   - Provide information at multicultural festivals and community events.

   Issues to be aware of:

   - Sensitivity is required in explaining support services to people from non-Christian faith, especially Muslims. They require assurance that support services do not include religious symbols, are not held in religious buildings, and participants will not be proselytised.
   - Absolute clarity is required in early consultations about what the agency is able to provide and what it is not able to provide. This will assist in establishing realistic expectations.

2. **A model of bilingual/bicultural workers trained as aged care support staff and employed by HACC services.**

   An example of such a model is Ethnic Link Services (ELS), South Australia (Uniting Care: Wesley Port Adelaide 2011) . This model has a pool of bilingual/bicultural workers who are trained in aged care, supported by coordinators and deliver services to people of CALD background. They are an integral part of service delivery to the CALD client and the contact point with the client and they work according to a case plan. Ideally the bilingual/bicultural workers are already part of their local CALD community. These bilingual/bicultural workers provide:

   - language assistance
   - advocacy on behalf of clients
   - information to clients about available services
   - links to a range of services for clients' needs
   - client support in the processes of assessment and referral
   - a greater focus on development of trust and rapport

   Based on the Consumer Participation Strategies Framework, this model is working further along the continuum from consultation to enabling consumers to advise services and to plan and have more control over services through the bilingual/bicultural workers who are already part of their local community.

3. **Develop relationships with and build the capacity of existing CALD community groups**

   a. Develop relationships to nurture potential partnerships with grass roots community organisations, such as the Latin American Grandparents group, African seniors, Vietnamese seniors, Voice of Samoa. Examples of support needed include: providing transport to social activities and helping them become financially viable to provide additional social activities for their seniors.

   b. Develop a model of working with CALD community representatives and groups that acknowledges and uses their expertise and capability to run appropriate social programs for their seniors. A model which supports them to increase the frequency and effectiveness of their programs. One example is the model of bilingual/bicultural workers of the Ethnic Link Services (ELS) which has been used to establish social groups to relieve social isolation in CALD communities. This could include:

      - Developing formal links with individuals and ethno-specific organisations currently facilitating social programs
      - Building skills and capabilities within CALD communities
      - Providing support and mentoring CALD community representatives
      - Building community representative's financial capacity by helping them apply for and manage funding grants

   c. Consider ways of assisting older community members in using their skills in a voluntary capacity. For example, to develop volunteer roles for social activities for elders that could be coordinated by bicultural/bilingual workers and facilitators.

4. **Provide a mechanism for CALD consumers to advise HACC services**

   To progress to the third stage of the Consumer Participation Strategies Framework (Figure 1) by developing processes to enable CALD consumers to provide advice on HACC services (e.g. Consumer advisory group) and build partnerships with CALD community organisations currently running activities. This can be achieved by community representatives participating in consultation (e.g. Vietnamese Seniors, Voice of Samoa, and Latin American Grandparents) and build community capacity to provide services to seniors through these partnerships.

5. **Consider initiating projects linking the older to the younger generations**

   For example, a project of documenting stories of CALD elders for younger generations, as a way of enhancing the self-esteem and confidence of CALD seniors.

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APPENDIX

INTERVIEW QUESTIONS FOR COMMUNITY INTERVIEWS

- Can you tell us what is currently being done in your community to support people as they get older?
- What is the most appropriate way of engaging with your community about issues for your people as they get older?
- Who are the most appropriate organisations/individuals to meet with to talk to about how to help your community members as they age?
- What are the main issues/concerns **for** people from your community as they get older?
- What do you see as the most important things people from your community need to help them age healthily and happily in Australia? How could services like Spiritus help?
- About your group/association. Who is involved in your group- who is in? Who is out? (boundaries of group)
- How do people want to receive information about services? What is the literacy level of older people (>55) in their own language and in English?
- What are the general attitudes in your community about being provided care in the home as people get older?
- Are there any particular cultural practices that you would like workers to know or do, when coming into your home to provide care? (e.g. *removing shoes, call first, certain time of day preferable, involve family*)
- How would we recruit people from your community to work in aged care?