HUMANITARIAN ARRIVALS IN MELBOURNE
A SPATIAL ANALYSIS OF POPULATION DISTRIBUTION & HEALTH SERVICE NEEDS
EXTENDED REPORT

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EXECUTIVE SUMMARY

This research was developed in partnership between the Department of Health and Human Services, University of Melbourne and representatives of government, health and settlement services to build evidence about recent humanitarian arrivals across northern and western metropolitan Melbourne.

In many health planning and related forums conversations focused on the increasing numbers of humanitarian arrivals across numerous suburbs of Melbourne and the difficulties that health service providers had in meeting the needs of the rapidly changing and increasingly diverse population. Strangely, little quantitative data was available on the topic and a research project naturally evolved.

The main aim of the research project was to scope and map available data sets to build quantitative evidence about the spatial location of recent humanitarian arrivals and combine this with qualitative information from key informants working with these people in health service provision. Another key objective was to identify data sets to provide a spatial analysis of bilingual General Practitioners and possibly the use of interpreters in health services.

Several quantitative data sets were identified as useful to achieving the objectives of the research: the Australian Bureau of Statistics Australian Census and Migrants Integrated Dataset (2011); Department of Immigration and Border Protection Settlement Database (2010-2015); the AMES Australia Humanitarian Entrants Management System (2013-2015); and the National Health Services Directory for General Practitioner listings.

This report provides spatial analyses of each of these data sets and detailed information on visa categories within locations, countries of birth, languages spoken and changes to settlement patterns over time. These quantitative analyses also informed in-depth interviews with key informants providing health services to humanitarian arrivals including members of the project’s Research Advisory Group.

This extensive report documents this spatial and qualitative research and key findings and recommendations based on these key findings are summarised on the following pages.
KEY FINDINGS

SETTLEMENT PATTERNS

Migration based on humanitarian reasons formed 12% of arrivals to Victoria in 2011.

Humanitarian entrants were predominantly from Sudan, Iraq, Afghanistan and Burma/Myanmar between 2001-2011 while more recently from 2010-2015 most entrants came from Afghanistan, Iraq, Burma/Myanmar and Iran.

Large populations of humanitarian arrivals live within the Local Government Areas of Greater Dandenong, Hume, Casey, Brimbank and Wyndham and each area has people from a diverse range of countries and associated language needs.

In 2011, approximately two-thirds of humanitarian arrivals living in Victoria lived in the 20% most socio-disadvantaged areas of Victoria.

In 2014, over one-quarter of people on Bridging Visa E lived in Dandenong or Doveton.

Numbers of Special Humanitarian Program visas have decreased dramatically between 2003 and 2011 similar to Refugee Visas which peaked in 2008-2009 and steadily decreased leading up to 2011.

Constant changes in the policy environment particularly in terms of visa bands and associated entitlements create confusion for both humanitarian arrivals and health service providers.

DATA SOURCES AND AVAILABILITY

Data on the spatial distribution of humanitarian arrivals are rare, difficult to capture, not easy to access and infrequently reported for planning purposes.

Language spoken, country of birth and year of arrival in Australia should be consistently collected for humanitarian arrivals to gather data and build further evidence needed for health and social services planning.

The Australian Bureau of Statistics Australian Census and Migrants Integrated Dataset (2011) provides a very useful data set that can be analysed in detail but needs to be reconstructed at each Census year to capture rapid changes that occur over time.

Longitudinal data are needed to measure and monitor long term changes in location of humanitarian arrivals and to understand more about secondary migration.

The Department of Immigration and Border Protection Settlement Database was difficult to use and plagued by system faults during 2015 when data were extracted.

Population and service planning provision requires access to annual, recent and detailed data on the demographics and spatial location of humanitarian arrivals.

The most recent data held within the AMES Australia Humanitarian Entrants Management System is an extremely useful data set providing more recent information on language and ethnicity of humanitarian arrivals across Victoria.
LANGUAGES

Language difficulties including native language literacy, English literacy, health literacy, health service system literacy are some of the greatest barriers to health service provision and health outcomes for humanitarian arrivals.

In Victoria there is no central resource that provides information on how to access General Practitioners, specialist medical practitioners or allied health practitioners that speak a language other than English.

A considerable number of General Practitioners speak a wide range of languages other than English in Melbourne but there is no resource available to link humanitarian arrivals or service providers to these medical professionals.

More evidence and resources for language assistance need to be directed towards specialist medical practitioners, mental health professionals and allied health professionals including reception staff making first contact with humanitarian arrivals.

Arabic has consistently been the most common language spoken by humanitarian entrants in Victoria over the past 15 years and Arabic speakers are also commonly proficient in spoken English.

Karen speakers are the least likely humanitarian arrivals to report proficiency in spoken English skills.

The most common languages spoken by humanitarian arrivals to Victoria over the past 15 years are Arabic, Dari, Karen, Hazaragi and Farsi (Persian).

The use of the languages of Farsi (Persian) and Chin Haka increased notably in Victoria between the years of 2010-2015.

Arabic speaking humanitarian arrivals are common in the northern and north-western suburbs of Melbourne while Dari, Hazaragi, Pashto and Arabic are most common in the south-east.

In 2011, approximately two-thirds of humanitarian arrivals living in Victoria lived in the 20% most socio-disadvantaged areas of Victoria.

In 2014, over one-quarter of people on Bridging Visa E were living in Dandenong or Doveton.

Arabic, Dari, Hazaragi, Karen, Farsi (Persian) and Tamil are the most common languages spoken in a select number of towns across regional Victoria.
Findings from this research project are the basis for a number of recommendations for future policy and practice. These recommendations are summarised below and discussed in further detail in Chapter 14 Key Findings and Recommendations.

1. Greatest support for humanitarian arrivals is needed in the Melbourne LGAs of Brimbank, Casey, Greater Dandenong, Hume and Wyndham which are home to the majority of humanitarian arrivals within Victoria. The LGAs of Maroondah, Maribyrnong, Moreland, Greater Geelong and Greater Shepparton also have growing populations of humanitarian arrivals.

2. Data needs to be collected to measure and monitor secondary migration of humanitarian arrivals in Victoria. Future research should also address the issues associated secondary migration of humanitarian arrivals through additional longitudinal research.

3. Year of arrival in Australia, country of birth and preferred language spoken are the three essential pieces of information that should be routinely collected for all humanitarian arrivals.

4. The mapped data of bilingual GPs included in this report should be made available to the general community and also expanded to include other bilingual medical practitioners and allied health workers.

5. Additional training needs to be provided to GPs, medical practitioners, allied health professional and front line administrative staff to build their knowledge and skills in working with humanitarian arrivals and interpreters. This includes training and practical guidelines and toolkits on how to work with interpreters and how to complete Refugee Health Assessments. These should be delivered through the combined support of Primary Health Networks, the Royal Australian College of General Practitioners, undergraduate teaching and community health centres.

6. Advocate for the inclusion of an additional Medicare “Interpreter Item Number” similar to a Long Consultation Item to incentivise the use of interpreters. An additional fee of $5 could decrease the barriers of time and money that prevent GPs in working with interpreters.

7. Interpreters need additional training on the importance of informed consent and additional support for debriefing. This is particularly important when interpreting languages from a small community where confidentiality is difficult to maintain.

8. Further research is needed on the experience and needs of mental health professionals working with humanitarian arrivals.

9. The Australian Health Practitioner Regulation Agency and associated professional boards should collect language skills of all health practitioners during annual registration processes.

10. More general literacy and health literacy support is needed for humanitarian arrivals. This includes literacy in English, literacy in their native language, health literacy and literacy of the local health and hospital systems. Being unable to speak in a language they understand or access and interpreter they feel comfortable with further complicates these issues.

11. More support is needed for case management and Refugee Health Nurses. Inconsistent, short-term, overworked and under-resourced case management and Refugee Health Nurses are factors limiting the health and wellbeing outcomes of humanitarian arrivals.

12. More housing support is needed for humanitarian arrivals in Victoria. Two-thirds of Humanitarian Visa holders were living in the 20% most socio-economically disadvantaged areas of Victoria with housing affordability a large barrier to health, social and economic outcomes. Future research should investigate the impact of broader social determinants of health on long term health outcomes in humanitarian arrivals and health service provision needs.
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1.1 PROJECT OVERVIEW

The Humanitarian Arrivals and Health Services (HAHS) study was prompted by a significant influx of new arrivals from refugee backgrounds into Victoria, with growing numbers particularly evident in Melbourne’s north western and south eastern metropolitan regions.

There is no current evidence on this population that describes the spatial location of recent humanitarian arrivals across metropolitan Melbourne necessary for the planning of appropriate services for health, education, housing, language and support services. This scoping study sought to build evidence describing where recent humanitarian arrivals are living in northern and western metropolitan Melbourne and to gain a better understanding of their service needs. The study began with a focus on the northern and western areas of Melbourne and expanded to include the southern and eastern Melbourne metropolitan areas during data collection. Funding support of $41,000 was provided by the Department of Health and Human Services (DHHS) as part of the partnership agreement between the University of Melbourne and Department of Health and Human Services, North and West Metropolitan Region.

1.2 PROJECT OBJECTIVES

The objectives of this scoping study were to:

1. Identify relevant data sets and use them to describe the spatial distribution of recent humanitarian arrivals across metropolitan Melbourne;
2. Provide spatial analysis of the location of recent humanitarian arrivals in relation to key social and economic indicators across metropolitan Melbourne;
3. Identify relevant data sets and provide spatial analysis of the availability of General Practitioners (GPs), bilingual GPs and the use of interpreters in health services;
4. Use key informant interviews to further understand key issues identified in the spatial data analysis in relation to meeting the health needs of recent humanitarian arrival populations.

In summary, the aim of the study was to investigate the availability of health services for humanitarian arrivals, including specific refugee health services and bilingual GPs in relation to the location of humanitarian arrivals. This report maps initial data on health services locations relative to humanitarian migrant communities, and considers the following questions:

- What data are available concerning health services for humanitarian entrants, and where are there gaps in information compilation?
- Of the information available, where are relevant health services located with capacity to work with people from humanitarian backgrounds?
- Where is there spatial mismatch between humanitarian migrant populations and health services? This could be defined by health services apparently serving disproportionally large catchments, or by humanitarian arrival communities with limited services nearby.

1.3 PROJECT GOVERNANCE

The study was governed by a Research Advisory Group that was established to provide advice and direction to the HAHS project team located within the McCaughey VicHealth Unit for Community Wellbeing and the Jack Brockhoff Child Health and Wellbeing Program at the Melbourne School of Population and Global Health. The Research Advisory Group met during 2015 and the Terms of Reference for the Group were to provide advice and direction to the study. Additional roles included: assisting with the identification of possible datasets; devising strategies to optimize the relevance of the research; provide linkages to existing policy and programmatic initiatives of relevance; engage key stakeholders in the project; share information on related
The project team also acknowledges the contribution of Dr Iain Butterworth from the Department of Health and Human Services who assisted with the development of the project in 2013.

1.4 REPORT STRUCTURE

The report begins by explaining the background and rationale for the research before presenting results that are arranged according to the different data sources used in the research. Results from the quantitative data analyses are presented in chapters 3-10. Data sources include the Australian Bureau of Statistics Australian Census and Migrants Integrated Dataset (2011), the Department of Immigration and Border Protection Settlement Database (2010-2015), the AMES Australia Humanitarian Entrants Management System (2013-2015), the National Health Services Directory for General Practitioner listings. Chapter 13 summarises findings from the Key Stakeholder interviews. The report concludes by discussing the implications of these analyses in relation to the research objectives and future recommendations for policy and practice. The methodologies used to analyse each data source are described at the beginning of each data chapter.

The extensive analyses presented reflect the range of ethnicities among the humanitarian arrival population in Victoria. In related work, we use the concept of ‘superdiversity’ to reference the diversity of the Victorian and the population of Victoria in general (Davern, Warr, Higgs, Dickinson, & Phillimore, 2015). In settler cities, such as Melbourne, more people are arriving from more countries than ever before but little data are capturing where people are settling and the impact on health service provision. Multiple data sources have been included consistent with the project objectives and in response to the need for the most current and comprehensive information.

A summary of the key chapters included in the report are provided in Table 1.
This report is intended for multiple audiences, hence the next chapter provides some brief background information on summarizing visa programs and humanitarian arrival pathways that will be helpful for those less familiar with these issues. Readers with expertise in the area are directed straight to Chapter 3 where data are first presented.

<table>
<thead>
<tr>
<th>Table 1 SUMMARY OF REPORT CONTENT</th>
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<tr>
<td><strong>Report Chapter</strong></td>
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<tr>
<td>Chapter 1</td>
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<td>Chapter 13</td>
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<tr>
<td>Chapter 14</td>
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</table>
Australia’s Humanitarian Program has resettled over 800,000 refugee and displaced persons since the end of the Second World War (Phillips, 2015).

For the purposes of this project, humanitarian arrivals include people who have entered Australia with a refugee or other Humanitarian Visa and asylum seekers. The United Nations High Commissioner for Refugees defines a refugee as someone who, as a result of a well-founded fear of being persecuted, due to their race, religion, nationality, membership of a particular social group or political opinion, has sought protection outside the country of their nationality (UNHCR 2009). Asylum seekers included in this report are people within Australia who are seeking Australia’s protection as refugees, but whose claim for refugee status has not yet been assessed (Australian Human Rights Commission 2015). Asylum seekers include those who arrive by boat through unauthorised channels without sanctioned travel documents and those who arrive by plane, with or without valid travel documents.

2.1 VISA PROGRAMS

Australia’s permanent immigration program consists of two components: the Migration Program (Skilled, Family and Special Eligibility Stream migrants); and the Humanitarian Program (predominantly refugees, special Humanitarian Visas and asylum seekers who have subsequently received a visa to remain – also referred to as Humanitarian Arrivals). The Australian Government Department of Immigration and Border Protection manages and grants visas within these programs each year in accordance with relevant legislation, government planning and policy. The purpose of Australia’s Humanitarian Program is to provide permanent resettlement to those deemed most in need in desperate situations overseas, including in refugee camps and protracted humanitarian situations.1

The main aims of Australia’s Humanitarian Program are to:

- reunite refugees and people who are in refugee-like situations overseas with their family in Australia; and
- use resettlement strategically to help stabilise refugee populations, reduce the prospect of irregular movement from source countries and countries of first asylum, and support broader international protection.

The focus of the current investigation, Humanitarian Arrivals and Health Services, concentrates predominantly on permanent humanitarian entrants to Australia entering through the Humanitarian Program who are living in Victoria. Asylum seekers without a permanent visa are also included where data are available and within the qualitative interviews as this population group is also of concern to the service providers being interviewed.

A summary of refugee and asylum seeker health service pathways (Victorian Refugee Health Network, 2016) is presented in Figure 1 on the following page. A summary of selected Humanitarian Visa subclasses are described in detail within Table 2 on page 16.

The Humanitarian Migration Program comprises offshore resettlement and onshore protection components. The most common pathway to a permanent Humanitarian Visa is to have a visa granted outside of Australia - referred to as ‘offshore’. Offshore resettlement offers permanent migration to Australia for people overseas deemed to be in the greatest need of resettlement. Of this migration stream, the principle categories are Refugee (200) visas, and Special Humanitarian (202) visas – as described in Table 2.

Protection visas granted to those who apply for Humanitarian Visas after arriving in Australia whether by plane or by boat, are described as ‘onshore’. These ‘onshore’ pathways have seen myriad and politicized changes over time. The onshore protection/asylum component currently offers Permanent Protection Visas (866) for people who arrived lawfully in Australia (with a
Asylum seekers who are Medicare ineligible, can access Pro bono GPs are available at Asylum Seeker Resource Centre.

Refugees who have permanent residency are eligible for Medicare.

Refugees who have temporary visas, are eligible for Medicare.

People with refugee like backgrounds who arrive through other migration program. Medicare status varies depending on visa type.

Asylum seekers in community detention: health services are arranged by International Health and Medical Services (IHMS) who subcontracts GPs, Community Health Service and specialist health providers.
### TABLE 2  SELECTED VISA DEFINITIONS (DECEMBER 2015)

<table>
<thead>
<tr>
<th>Visa Type</th>
<th>Type and Sub Class</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refugee Visa</td>
<td>Offshore 200</td>
<td>This visa is for people who are subject to persecution in their home country and are in need of resettlement.</td>
</tr>
<tr>
<td>In-Country Special Humanitarian Programme Visa</td>
<td>Offshore 201</td>
<td>This visa offers resettlement to people who have suffered persecution in their country of nationality or usual residence and who have not been able to leave that country to seek refuge elsewhere.</td>
</tr>
<tr>
<td>Global Special Humanitarian Programme (SHP) Visa</td>
<td>Offshore 202</td>
<td>The Special Humanitarian Programme (SHP) visa is for people who, while not being refugees, are subject to substantial discrimination and human rights abuses in their home country. People who wish to be considered for a SHP visa must be proposed for entry by an Australian citizen or permanent resident over the age of 18, an eligible New Zealand citizen or an organisation operating in Australia.</td>
</tr>
<tr>
<td>Emergency Rescue Visa</td>
<td>Offshore 203</td>
<td>This visa offers an accelerated processing arrangement for people who satisfy refugee criteria and whose lives or freedom depend on urgent resettlement.</td>
</tr>
<tr>
<td>Woman at Risk Visa</td>
<td>Offshore 204</td>
<td>This visa is for female applicants, and their dependents, who are subject to persecution or are of concern to the United Nations High Commissioner for Refugees (UNHCR), are living outside their home country without the protection of a male relative and are in danger of victimisation, harassment or serious abuse because of their gender.</td>
</tr>
<tr>
<td>Protection Visa</td>
<td>Onshore 866</td>
<td>This permanent protection visa is for applicants who arrived in Australia with a valid (non-humanitarian) visa and are subsequently assessed as engaging Australia’s protection obligations.</td>
</tr>
<tr>
<td>Temporary Protection Visa (TPV)</td>
<td>Onshore</td>
<td>This visa is for applicants who arrived in Australia without a valid visa and are assessed as engaging Australia’s protection obligations. TPVs allow the holder to stay in Australia for up to three years.</td>
</tr>
<tr>
<td>Save Haven Enterprise Visa (SHEV)</td>
<td>Onshore</td>
<td>This visa is for applicants who arrived in Australia without a valid visa and are assessed as engaging Australia’s protection obligations. A SHEV holder must declare an intention to work and/or study in regional Australia and may stay for up to five years.</td>
</tr>
<tr>
<td>Bridging Visas</td>
<td>Various</td>
<td>Temporary visas that allow people (including asylum seekers) to stay in Australia legally while they are awaiting (or appealing) a decision on their application for a longer term visa.</td>
</tr>
</tbody>
</table>
tourist or student visa for example) and were then found to be refugees under the Refugees Convention, or engaged Australia’s protection under other international conventions. These visa holders are entitled to live and work in Australia as permanent residents. Since 2013, arrivals by boat no longer have the possibility of permanent settlement in Australia. Temporary Protection Visas are only currently granted to people recognised as needing protection but who arrived in Australia without a valid visa - and these are not counted within the Humanitarian Migration Program quota. Temporary Protection Visas and other categories of temporary protection have changed periodically in recent years, as have procedures for detention of arrivals by boat. Depending on myriad factors including the date and mode of arrival, asylum seekers without a Protection Visa may be living in Australian or offshore detention centers, in community detention or in the community awaiting a decision on their status.

Refugee, Special Humanitarian, and Protection Visa holders have varying entitlements to services within Australia. People in detention centres are not included within the scope of this research with little data available on their characteristics or location.

Each year the government sets the number of visas that may be granted under the Australian Humanitarian Program. In 2014–15 the Humanitarian Program included 13,750 places comprising:

- a minimum of 11,000 places offshore (including up to 1000 places for women at risk); and
- the balance of places allowed for Permanent Protection Visas granted onshore for people who have arrived in Australia legally.

In Victoria, AMES is responsible for Humanitarian Settlement Services reporting providing quarterly statistics to the Australian Department of Immigration and Border protection. In Victoria, AMES worked with 3,627 people arriving through the Humanitarian Program in 2014 and 2,532 people in the first 3 quarters of 2015. These numbers are likely to rise rapidly in 2016 following the Syrian crisis in 2015 and subsequent global population relocation. In September 2015, the Australian Government committed to an additional 12,000 places within the Australian Humanitarian Program in response to conflict in Syria and Iraq and approximately 4,000 humanitarian arrivals are expected to arrive in Victoria from 2016.

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2.2 COMPLEXITIES OF RESSETLEMENT

The resettlement experiences of refugees are physically and emotionally challenging. On arrival, many have complex health needs. According to the DHSS Refugee and Asylum Seeker Health Services Guidelines for the Community Health Program (2015), humanitarian arrivals have generally had limited or interrupted access to healthcare, particularly illness prevention and health promotion. In addition, needs associated with access and care, due to language, cultural issues and stresses associated with resettlement are common to humanitarian arrivals.

The reasons why refugees flee their country of origin are often traumatic, and include war, famine and ethnic persecution (Flatau, Colic-Peisker, Bauskis, Maginn, & Buergelt, 2014). This in turn can sometimes lead to difficulties with transitioning into Australian society for a number of physical and psychological reasons. Khawaja, White, Schweitzer, and Greenslade (2008) advance that the forcible displacement of refugees from their homelands combined with potentially direct experiences of torture, physical and sexual abuse, separation from family members and living in camps or detention centres, means that many refugees suffer from post-traumatic stress disorder (PTSD).

Pre-migration experiences have a significant impact on psychological distress and post-migration stressors. Difficulties with resettlement and the loss of social and cultural support add significantly to post-traumatic stress disorder symptoms. Porter and Haslam (2001) provided evidence about how post-migration experiences such as accommodation and financial stresses exacerbate mental health outcomes (Khawaja et al. 2008, p.490).

There are many budgetary, practical and political challenges involved in the resettlement of humanitarian arrivals (Flatau et al., 2014). Government at all levels, as well as contracted service providers from non-government organisations and private sectors are well aware of complexities associated with factors such age, English language skills, gender, and/or cultural practices when humanitarian arrivals have to navigate, comprehend and adapt to the social, cultural, economic and bureaucratic norms of the host nation (Broadbent, Cacciattolo, & Carpenter, 2007; Phillimore, 2011).

Policy-makers and service providers need to adapt to the constantly changing demographic profile of new arrivals and policy landscape to ensure that the needs of humanitarian arrivals are met and that their migratory experiences are smooth (Flatau et al., 2014). The majority of refugee specific primary care is delivered

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by general practice and refugee health nurses, although hospital and hospital emergency services also deliver primary services. The Victorian Foundation for Survivors of Torture (Foundation House) was established in 1987 to meet the needs of people who were subjected to torture or traumatic events in their country of origin and had fled their country of origin and is a key provider of mental health services to humanitarian arrivals3. The fluctuating needs and policy landscape set the backdrop to this study.

Recent humanitarian arrivals have significant needs for health and social services; however, their access to these services can be limited due to a range of complex factors and a heavy demand on available services. As the data we present will show, humanitarian arrivals tend to settle in suburbs that already have significant migrant-background populations. This can ease some aspects of the settlement process but can produce high demands on services and resources. Humanitarian arrivals have varying eligibility for services, limited income and limited case work. In northern and western metropolitan Melbourne, generalist and specialist health services are rallying to meet the needs of these populations. However, services are struggling to meet demand and gain a comprehensive understanding of key issues impacting on eligibility and access to services.

Key issues include:

- presenting health care needs;
- service utilisation;
- internal migration patterns influencing where people present to access services and resources; and
- additional factors impacting on health outcomes.

Provision of appropriate services for health, education, employment, housing, language and social support services is complex and requires an integrated evidence base for future planning and services provision. Difficulties in planning and preparing for the needs of refugee populations are compounded by a lack of available demographic data and the contexts in which visa conditions, circumstances of migration, funding sources and the workforce are frequently changing. This study explores the resettlement trajectories of humanitarian arrivals. It will investigate specific data gaps and challenges for service provision for humanitarian arrivals and map their settlement patterns.

2.3 EXISTING DATA GAPS IN HUMANITARIAN ARRIVALS

Reliable and effective data collection facilitates government and funded agencies to improve their understanding of the needs of their client group and monitor the accessibility of the services they provide. However, several gaps exist in this space, hindering planning and implementation of resettlement efforts and processes. The findings of the Victorian Auditor-General’s Office (2014) support the current research findings in that government departments and service providers all discussed the challenges of the lack of effective and reliable data.

Data concerning asylum seekers in Victoria is often incomplete or unreliable. At 3 March 2014, there were 24,000 asylum seekers on a Bridging Visa E in Australia, with 8,680 or 36% living in Victoria. This visa permits its holder to stay in Australia in order to either finalise their immigration matters or make arrangements to leave the country. On 3 March 2014, there were around 1300 asylum seekers in community detention arrangements in Victoria, comprising vulnerable families, vulnerable adults and unaccompanied minors.

There are no data currently available to capture the number of asylum seekers making secondary moves to Victoria from other states and territories or secondary migration within Victoria from metropolitan to rural and regional areas.

In 2015, there were also changes made to the visa process for asylum seekers under the Abbott Government. Temporary Humanitarian Concern Visas (THCV) were introduced, which prevent asylum seekers from exercising a legal right to apply for a Permanent Protection Visa (PPV-866 XA Visa). Temporary Protection Visas (TPVs) existed from 1998-2008 and were reintroduced in October 2013 by the Abbott government. Humanitarian arrivals on TPVs have no right to apply for family reunion with spouses and children who remain overseas in high risk situations, receive little in the way of Centrelink support, and have no right to funded English classes, interpreting or translation services, and no access to emergency accommodation and only limited access to state housing. These people previously had the right to apply for a PPV (886 Visa) but now can only apply for another TPV at the termination of their current TPV, remain in detention, or be returned to the country of origin.

A further complication to data integrity is the possibility of people being eligible for multiple visas. This complexity

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3 www.foundationhouse.org.au/
and ambiguity leads to further confusion about the humanitarian arrival population and data reliability. Navigating the visa terrain is particularly challenging, with frequent changes to legislation affecting outcomes for all humanitarian entrants and associated access to government services. To complicate the matter further, people eligible for multiple visas might be excluded to service access on one visa but have access via a secondary visa – a particularly complex task to navigate with limited English language skills as a new arrival to a country.

Service planning and delivery is impeded by several mitigating factors that prevent government departments and service providers collecting and analysing data on humanitarian arrivals. A key problem outlined in the review conducted by the Victorian Auditor-General’s Office (2014) was the unavailability of Commonwealth data for state planning purposes and this was raised by multiple agencies during their audit.

The Commonwealth Government does not provide states and territories with accurate or timely data on settlement cohorts. In addition, there is a lack of integration across systems and datasets utilised by various Commonwealth and state departments. This includes a lack of integrated data describing immigration (Department of Immigration and Border Protection), humanitarian settlement (Department of Social Services), Status Resolution Support Services, Centrelink (Department of Human Services) and Medicare (Department of Human Services).

### 2.4 EXISTING DATA GAPS

The period following resettlement can be a time of great uncertainty and limited information on secondary migration patterns within metropolitan areas is a significant issue. This includes both people from outside Victoria (interstate migration) and people moving within Victoria (intragroup migration) to new locations within the state. The Victorian Auditor General’s Office report (2014) states that this information is collected by the Department of Immigration and Border Protection who have access to the systems that could provide the most accurate and comprehensive data about secondary migration of asylum seekers and the Department of Social Services has access to information about refugees. However, this information is not currently provided to states and territories.

Data on the settlement of humanitarian arrivals are generally poor because of an over-reliance on Australian Bureau of Statistics Census data – and in 2015 when analyses were conducted, the 2011 data were the most recent release. Recent geo-political crises have ensured that the origin of people arriving on Humanitarian Visas and seeking asylum in Australia changes rapidly during a 5 year Census collection time and therefore Census data don’t adequately reflect an up-to-date snapshot of humanitarian arrivals. This makes it problematic for long term planning, with limited available data in the short to medium term (Victorian Auditor-General’s Office, 2014). Another major impediment to accurately capturing humanitarian arrivals’ service access and utilisation is that country of origin and year of arrival information have been inconsistently recorded. There are several reasons for this including a lack of willingness by humanitarian arrivals in sharing this information, not remembering the specific details of their arrival or not being able to communicate this information accurately or clearly. Even more importantly, data systems have not required systematic collection or reporting of this information. There has been a focus on Visa type, yet this is not as helpful because of the constantly changing policy terrain and visa allocations.

Another major reason for poor data capture is that there is no overarching whole of government monitoring or mapping of the full range of humanitarian arrivals or culturally and linguistically diverse community related services and initiatives being provided. For example, there is a lack of streamlined information concerning who is delivering these programs, where, to which groups, as well as assessing impact and current service gaps. While there are some cross-agency mechanisms in place to support collaboration, there is still a lack of clarity around the roles and responsibilities of specific stakeholders. Furthermore, there is often some overlap in activities, such as grants management. This reduces opportunities for the major service providers to be more coordinated and strategic in planning how to address the diverse and changing needs of migrants, refugees and asylum seekers.

Gaps also exist in terms of primary care needs and there are significant gaps and needs for readily available general practice data relating to refugee epidemiology and service utilisation as well as the need to be able to search general practice databases by refugee status or country of birth. Similarly, there are gaps around the utilisation of allied health services, oral health services, local government services (immunisation and maternal and child health services), disability services and preventive activities by refugees. Related to this is a clear absence of written information that describes the experiences of using local health services from the
refugee client perspective.

Cultural competency is another area where there are data gaps or a lack of measurement across health service providers. According to the Victorian Auditor General’s Report (2014), it was felt to be problematic that there was a lack of clarity and transparency about the various requirements and levels of cultural competency of staff, in various levels of employment and both in central and regional offices. In fact, it was unclear whether any training was ever received. While the audit did not examine the specific gaps in training or the requirements for these activities, the report does stipulate that there should be an impetus within annual reporting requirements to stipulate cultural competence training and assessment. The report emphasises that multicultural awareness and enhanced accountability are an essential part of improving refugee and asylum seeker service access.

Language is another important influence on engagement with health service providers. It is not surprising that the acquisition of English language can sometimes be a lengthy process for humanitarian arrival populations. Hence, the role of bilingual GPs and interpreters are vital to the provision of care to these people. The lack of availability of bilingual GPs, and the accessibility, utilisation and quality of interpreters has been an impediment to the successful delivery of services for humanitarian populations. According to the Victorian Auditor General’s Report (2014), industry-specific issues such as inadequate remuneration and poor job security act as barriers to attracting and retaining quality interpreters. Furthermore, it is very difficult to plan and keep up with demand when humanitarian arrival populations are constantly changing and there is no available and reliable data measuring changes.

2.5 DATASETS INCLUDED IN THIS INVESTIGATION

This document presents data on humanitarian arrivals and migrant communities in Victoria according to 3 main sources: the Australian Census and Migrants Integrated Dataset (ACMID) from the Australian Bureau of Statistics (ABS); the Department of Immigration Settlement Database (SDB) and AMES Australia Humanitarian Entrants Management System (HEMS).

The ABS Census data provides detailed population data on migrant populations, particularly when merged with the Department of Immigration Settlement Database into the ACMID 2011 dataset. However, the most recent available Census data are from 2011. As a result, more recent migration data (to the end of 2014) from the Department of Immigration SDB is appropriate, particularly if it indicates that source countries and destinations have shifted in recent years. However, limitations of the more recent SDB are that data from this source don’t have the same spatial and socio-economic detail as Census data. Both of these two major sources are included in this report to tell more or less overlapping stories of spatial patterns in humanitarian migrants to Victoria over 2001-2014: ACMID data covering 2001 – 2011 and SDB data covering 2010-2014. Geographic Information Systems (GIS) are used to produce layered maps showing the spatial distribution of indicators for humanitarian arrivals. However, it should be noted that the 2 main source datasets differ in some aspects of basic structure and framing, as described in the following section. Ethics clearance for this research was obtained from the University of Melbourne Population and Global Health Human Ethics Advisory Group (Project ID 1443140).

2.5.1 THE AUSTRALIAN CENSUS AND MIGRANTS INTEGRATED DATASET 2011

ACMID 2011 (ABS Cat. 34170.55.001) is a combination of 2011 Census of Population and Housing data with the Department of Immigration and Border Protection’s Settlement Database. Access to these data is provided via ABS Table Builder software. ACMID contains records of people who responded to the Census, and those who “had a permanent visa record on the Department of Immigration and Border Protection’s Settlement Database with a date of arrival between 1 January 2000 and 9 August 2011 (inclusive).” ACMID is structured around permanent migrants as at 2011, and their most recent visa – it will not capture information on entrants to Australia between 2001 and 2011 who were not in the Census or who had not become permanent migrants as at 2011.

Records have been merged by the ABS, with 76% (1,003,532) of 1,315,048 SDB records linked to a Census record. After scope exclusions, the main dataset is 974,545 persons (Australia-wide); weighted to add to a total of 1,273,701 persons. ACMID records have been assigned weights to account for biases in which settlement records were more or less likely to be successfully matched to Census records. The data returned are not always an integer; and the totals have slight discrepancies due to rounding. The dataset returns estimates only which are to be treated with caution on account of the possibility for false links between records.

The advantage of the ACMID dataset is that it provides
detailed Census information – demographic, socio-economic, and location variables. This is specifically linked to Humanitarian Visa types and other settlement information. Census data on its own captures migration data – for example countries of birth and years of arrival – but is not broken down by visa type. The disadvantage of ACMID data is that, as with the Census data, it is constructed based on the most recent 2011 Census release. It provides a picture of the location and characteristics of permanent humanitarian arrivals but not of other temporary visa types or asylum seekers.

2.5.2 DEPARTMENT OF IMMIGRATION AND BORDER PROTECTION SETTLEMENT DATABASE

The Department of Immigration and Border Protection Settlement Database (SDB) captures relatively recent visa information on permanent migrants. The SDB can be queried using the settlement database tool. Disadvantages are that the filtering process is complex and repetitive in comparison to ABS Table Builder. There are ongoing issues with the process and data, which the Department of Immigration and Border Protection acknowledges. SDB data are also more limited in its available spatial and demographic information. Its main advantage is that the data are available up to the end of 2014 and, for some data, part way into 2015. This is crucial to mapping current location-specific trends in migration.

The SDB data in this document were obtained through custom requests to the settlement database providers, and through queries to the online database (when operational). There are some discrepancies in that the online settlement database covers until March 1st 2015 (total 22,864 humanitarian entrants to Victoria since 2010) whereas the custom request covers until the end of 2014 (22,276 humanitarian entrants to Victoria since 2010).

2.5.3 DEPARTMENT OF IMMIGRATION AND BORDER PROTECTION – REPORTS

The Department of Immigration and Border Protection publishes reports on selected aspects of migration or of the humanitarian program. There is some spatial detail included in some of these reports, but this is not generally suited to mapping for specific locations. In this document, some report data on temporary visas has been included from the report data provided by the Department of Immigration and Border Protection.

2.5.4 AMES HUMANITARIAN ENTRANTS MANAGEMENT SYSTEM (HEMS) DATA

AMES provides settlement services to Humanitarian migrants for 6 to 12 months after arrival in Victoria. AMES captures data at the ‘case’ (i.e. family) level, as well as members in a family. HEMS data is captured by AMES and reported to the Department of Immigration and Border Protection on a quarterly basis. Data includes address and accommodation type (long term or accommodation on arrival); country of birth; ethnicity; family size; language; gender; and age. AMES was an important partner to this research and with permission from the Department of Immigration and Border Protection provided HEMS data on humanitarian arrivals within Victoria for the period of April 2013 – April 2015. These data had the advantage of high levels of spatial disaggregation for very recent arrivals receiving assistance. It was also the only dataset to contain information on family groupings and sizes; and on internal migration patterns. AMES data included 9,089 records with associated spatial data.

2.5.5 NATIONAL HEALTH SERVICES DIRECTORY

The National Health Services Directory (NHSD) is a national initiative of Australian governments and sources data from State and Territory governments on allied health, hospital and community services. It was developed to provide professionals and consumers with reliable information about health services. The directory is managed by Healthdirect Australia and is based on the successful implementation of the Victorian Human Services Directory. Healthdirect Australia conduct regular audits on the data contained in the directory and self-authorship is used to maintain currency and changes to the directory over time. The 2015 NHSD data used in this project included information on bilingual speaking GPs and were accessed through partnership with the Australian Urban Research Infrastructure Network (AURIN).
3. VISATYPE

Quantitative results are presented according to data sources and topics in Chapters 3-12, and stakeholder interviews are presented in Chapter 13. Each quantitative chapter begins with an explanation of relevant data sources.

3.1 AUSTRALIAN CENSUS AND MIGRANTS INTEGRATED DATASET (2001-2011)

The ABS ACMID dataset profiles all permanent migrants to Australia who arrived between 2001 and 2011. Of the full ACMID dataset (1,273,702 person records), the minority – 138,356 or 11% of people held Humanitarian visas (VISAP). The majority of entrants to Australia held skilled (716,792, or 56%) or family (418,554, or 33%) visas. In Victoria in 2011 there were 41,732 Humanitarian Visa holders enumerated, making up 12% of migrants. Most Victorian migrants were in the Skilled (55%) or Family (33%) streams.

Of respondents enumerated in Victoria with a permanent Humanitarian Visa class, migrants are in three principle groups – Refugee entrants, Special Humanitarian Program entrants, and Protection Visa (866) holders. These are shown in Figure 3. The largest group was Special Humanitarian Program entrants (19,568 or 47%); followed by Refugee (14,841 or 35%); and Protection visas (6,986 or 17%). There is also an ‘Other’ grouping (317 or 1%). Table 4 shows the specific visa codes – Global Special Humanitarian (202) visas being the most common (19,568 or 47%); followed by Refugee (200) (12,789 or 31%); Protection (865) (6,986 or 17%) and Woman at Risk (204) (1,704 or 4%). Table 2 shows how visa codes aggregate to broader categories within the humanitarian migration program.

The majority (34,811) of humanitarian entrants in the ACMID dataset applied for their visa offshore. Of the onshore applicants (6,918 persons), all were Protection Visa (866) entrants. This distribution is shown in Figure 5.

The ACMID dataset includes people who arrived on Humanitarian Visas but who are now Australian citizens. The split of citizen and non-citizen humanitarian entrants by year of arrival to Australia is shown at Figure 7. Those who arrived in 2004 or earlier were predominantly Australian citizenships as at 2011; those who arrived after 2008 were predominantly not Australian citizens. Overall, 22,122 (53%) of humanitarian entrants in Victoria in the ACMID database were Australian citizens and 16,869 were not (2,612 were not stated).

3.2 HUMANITARIAN VISATYPE AND CODES – 2010-2015 DATA

The Department of Border Protection Settlement Database provides more recent statistics on the humanitarian migration program. There were 22,864 arrivals in the humanitarian stream between 2010 and March 2015; of which nearly half (10,704 or 47%) were refugee entrants and 21% (4,728) were Special Humanitarian program entrants (see Figure 8). In these data the “invalid/unknown” category is large – 7,422 humanitarian entrants and might represent bridging visa holders or 866 visa holders. 866 visa holders are permanent Protection Visas given to asylum seekers granted protection after arrival and prior to 2013 this included both boat and plane arrivals. Since 2013 boat arrivals are excluded from receiving these permanent visas. The presence of an invalid/unknown category is also present when Settlement Database (SDB) data are broken down by visa code (Figure 9), suggesting the complexity of changes to migration pathways.
FIGURE 2  MIGRATION STREAMS, VICTORIA, 2011 ARRIVED 2001-2011 (ACMID)

- Family: 111,508 (33%)
- Family: 111,508 (33%)
- Skilled: 188,223 (55%)
- Humanitarian: 41,732 (12%)

FIGURE 3  HUMANITARIAN ENTRANTS BY TYPE, VICTORIA, 2011 ARRIVED 2001-2011 (ACMID)

- Special Humanitarian Program (202): 19,568 (47%)
- Refugee (200, 201, 203, 204): 14,841 (35%)
- Protection (866): 6,986 (17%)
- Other: 317 (1%)
<table>
<thead>
<tr>
<th>VISAP Visa Type</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Humanitarian - Refugee</strong></td>
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<tr>
<td>Refugee (200)</td>
<td>12,789</td>
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<tr>
<td>In-Country Special Humanitarian (201)</td>
<td>343</td>
</tr>
<tr>
<td>Emergency Rescue (203)</td>
<td>5</td>
</tr>
<tr>
<td>Woman at Risk (204)</td>
<td>1,704</td>
</tr>
<tr>
<td><strong>Total Humanitarian - Refugee</strong></td>
<td>14,841</td>
</tr>
<tr>
<td><strong>Humanitarian - Special Humanitarian Program</strong></td>
<td></td>
</tr>
<tr>
<td>Global Special Humanitarian (202)</td>
<td>19,568</td>
</tr>
<tr>
<td><strong>Total Humanitarian - Special Humanitarian Program</strong></td>
<td>19,568</td>
</tr>
<tr>
<td><strong>Protection (866)</strong></td>
<td></td>
</tr>
<tr>
<td>Protection (866)</td>
<td>6,986</td>
</tr>
<tr>
<td><strong>Total Protection (866)</strong></td>
<td>6,986</td>
</tr>
<tr>
<td><strong>Humanitarian - Other</strong></td>
<td></td>
</tr>
<tr>
<td>Refugee (After Entry) (803)</td>
<td>-</td>
</tr>
<tr>
<td>Camp Clearance (205)</td>
<td>-</td>
</tr>
<tr>
<td>Citizens of Former Yugoslavia (Displaced Persons) (209)</td>
<td>203</td>
</tr>
<tr>
<td>Burmese in Burma (211)</td>
<td>-</td>
</tr>
<tr>
<td>Sudanese (Special Assistance) (212)</td>
<td>29</td>
</tr>
<tr>
<td>Burmese in Thailand (Special Assistance) (213)</td>
<td>35</td>
</tr>
<tr>
<td>Cambodian SAC (214)</td>
<td>-</td>
</tr>
<tr>
<td>Sri Lankan (Special Assistance) (215)</td>
<td>39</td>
</tr>
<tr>
<td>Ahmadi SAC (216)</td>
<td>12</td>
</tr>
<tr>
<td>Vietnamese SAC (217)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Humanitarian - Other</strong></td>
<td>317</td>
</tr>
<tr>
<td><strong>Total Humanitarian</strong></td>
<td>41,713</td>
</tr>
</tbody>
</table>
FIGURE 6
YEAR OF ARRIVAL BY VISA TYPE, HUMANITARIAN ENTRANTS, VICTORIA, 2011
ARRIVED 2001-2011 (ACMID)

FIGURE 8
SETTLEMENT DATABASE HUMANITARIAN ENTRANTS BY TYPE, VICTORIA 2010-2015
### TABLE 4 SETTLEMENT DATABASE VISA SUB-CLASSES, HUMANITARIAN ENTRANTS, VICTORIA, 2010-2015

<table>
<thead>
<tr>
<th>VISA Sub-Class</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Humanitarian - Refugee</strong></td>
<td></td>
</tr>
<tr>
<td>Refugee (200)</td>
<td>9,153</td>
</tr>
<tr>
<td>In-Country Special Humanitarian (201)</td>
<td>338</td>
</tr>
<tr>
<td>Emergency Rescue (203)</td>
<td>13</td>
</tr>
<tr>
<td>Woman at Risk (204)</td>
<td>1,200</td>
</tr>
<tr>
<td><strong>Total Humanitarian - Refugee</strong></td>
<td>10,704</td>
</tr>
<tr>
<td><strong>Humanitarian - Special Humanitarian Program</strong></td>
<td></td>
</tr>
<tr>
<td>Global Special Humanitarian (202)</td>
<td>4,728</td>
</tr>
<tr>
<td><strong>Total Humanitarian - Special Humanitarian Program</strong></td>
<td>4,728</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
</tr>
<tr>
<td>(210, 851, 818, 817)</td>
<td>10</td>
</tr>
<tr>
<td>&quot;Invalid/Unknown&quot;</td>
<td>7,422</td>
</tr>
<tr>
<td><strong>Total Humanitarian</strong></td>
<td>22,864</td>
</tr>
</tbody>
</table>

### FIGURE 10 TOP COUNTRIES OF BIRTH, HUMANITARIAN ENTRANTS, VICTORIA, 2011 ARRIVED 2001-2011 (ACMID)

- Other: 10,891 (26%)
- Sudan: 6,423 (15%)
- Iraq: 6,385 (15%)
- Afghanistan: 5,790 (14%)
- Somalia: 815 (2%)
- Sri Lanka: 1,095 (3%)
- Bosnia and Herzegovina: 1,231 (3%)
- Thailand: 1,505 (4%)
- Iran: 1,641 (4%)
- Ethiopia: 1,713 (4%)
- Burma (Republic of the Union of Myanmar): 4,243 (10%)
4. VICTORIAN DATA

COUNTRY OF BIRTH

4.1 TOP COUNTRIES OF BIRTH (ACMID) 2001 - 2011

The most common countries of birth for Humanitarian Visa holders in the ACMID dataset (humanitarian entrants to Victoria 2001-2011) were: Sudan (6,423); Iraq (6,385); Afghanistan (5,790); and Burma (4,243). Other significant source countries were Ethiopia (1,713); Iran (1,641); Thailand (1,505); Bosnia and Herzegovina (1,231); Sri Lanka (1,095); and Somalia (815). This is shown at Table 5.

Key countries of birth for humanitarian migrants have changed over time, and continue to do so. Entrants from Sudan were high in 2003-2005 but dropped off steeply. Entrants from Burma were highest in 2006-2008. In the later period covered by the ACMID dataset (2009-2011) most humanitarian entrants were from Iraq, Afghanistan, and Burma (see Table 5). Source countries are shifting – however, significant numbers of humanitarian migrants from earlier migration programs reside in Victoria.

<table>
<thead>
<tr>
<th>Country of birth</th>
<th>Prior to 2000</th>
<th>00 - 02</th>
<th>03 - 05</th>
<th>06 - 08</th>
<th>09 - 11</th>
<th>NS/NA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudan</td>
<td>36</td>
<td>871</td>
<td>3,743</td>
<td>1,262</td>
<td>217</td>
<td>294</td>
<td>6,423</td>
</tr>
<tr>
<td>Iraq</td>
<td>243</td>
<td>1,457</td>
<td>1,144</td>
<td>1,634</td>
<td>1,610</td>
<td>298</td>
<td>6,385</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>186</td>
<td>1,413</td>
<td>854</td>
<td>1,366</td>
<td>1,660</td>
<td>310</td>
<td>5,790</td>
</tr>
<tr>
<td>Burma (Republic of the Union of Myanmar)</td>
<td>5</td>
<td>116</td>
<td>257</td>
<td>2,214</td>
<td>1,533</td>
<td>118</td>
<td>4,243</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>24</td>
<td>431</td>
<td>595</td>
<td>287</td>
<td>296</td>
<td>80</td>
<td>1,713</td>
</tr>
<tr>
<td>Iran</td>
<td>35</td>
<td>342</td>
<td>341</td>
<td>250</td>
<td>610</td>
<td>64</td>
<td>1,641</td>
</tr>
<tr>
<td>Thailand*</td>
<td>-</td>
<td>14</td>
<td>61</td>
<td>816</td>
<td>559</td>
<td>56</td>
<td>1,505</td>
</tr>
<tr>
<td>Bosnia and Herzegovina</td>
<td>14</td>
<td>1,077</td>
<td>93</td>
<td>12</td>
<td>-</td>
<td>35</td>
<td>1,231</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>29</td>
<td>122</td>
<td>103</td>
<td>347</td>
<td>434</td>
<td>60</td>
<td>1,095</td>
</tr>
<tr>
<td>Somalia</td>
<td>119</td>
<td>308</td>
<td>128</td>
<td>57</td>
<td>161</td>
<td>42</td>
<td>815</td>
</tr>
<tr>
<td>Other</td>
<td>348</td>
<td>1,924</td>
<td>2,553</td>
<td>2,326</td>
<td>1,921</td>
<td>1,814</td>
<td>10,891</td>
</tr>
<tr>
<td>Total</td>
<td>1,039</td>
<td>8,074</td>
<td>9,871</td>
<td>10,572</td>
<td>9,000</td>
<td>3,171</td>
<td>41,732</td>
</tr>
</tbody>
</table>

*Humanitarian arrivals from Thailand are predominantly those born to families of Burmese origin who fled Burma and were living in Thailand or in camps along the Thai/Burma border
4.2  TOP COUNTRIES OF BIRTH (SDB) 2010 - 2015

Drawing on the Settlement Database, in the more recent period, 2010 to March 2015, the top countries of birth for humanitarian entrants to Victoria were: Afghanistan (4,885); Iraq (3,816); Burma (3,692); Iran (2,524) and Pakistan (1,231). These are shown at Figure 11. Some of these common countries of birth for humanitarian migrants cross over with earlier periods (Afghanistan, Iraq, Burma) whereas others have emerged more recently (Iran, Sri Lanka, Syria). Some key countries for humanitarian migration to Victoria between 2001 and 2011 are no longer substantial and include Sudan, Bosnia and Herzegovina, and Somalia.

![Figure 11: Top Countries of Birth (2010-March 2015), Humanitarian Entrants, Victoria (Settlement Database)](image-url)
### Table 6: Top Countries of Birth (2010-March 2015), Humanitarian Entrants, Victoria (Settlement Database)

<table>
<thead>
<tr>
<th>Country of Birth</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>4,885</td>
<td>21.4%</td>
</tr>
<tr>
<td>Iraq</td>
<td>3,816</td>
<td>16.7%</td>
</tr>
<tr>
<td>Burma</td>
<td>3,692</td>
<td>16.1%</td>
</tr>
<tr>
<td>Iran</td>
<td>2,524</td>
<td>11.0%</td>
</tr>
<tr>
<td>Pakistan</td>
<td>1,231</td>
<td>5.4%</td>
</tr>
<tr>
<td>Thailand</td>
<td>898</td>
<td>3.9%</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>661</td>
<td>2.9%</td>
</tr>
<tr>
<td>Syria</td>
<td>578</td>
<td>2.5%</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>496</td>
<td>2.2%</td>
</tr>
<tr>
<td>Malaysia</td>
<td>403</td>
<td>1.8%</td>
</tr>
<tr>
<td>Other</td>
<td>3,680</td>
<td>16.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22,864</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

### 4.3 Comparison Over Time and Datasets – Top Countries of Birth

The chart at Figure 12 shows the top 10 countries of birth for humanitarian entrants to Victoria, for both the ACMID data covering 2001-2011, and for the Settlement Database covering 2010-March 2015. Countries of birth are shown by their proportion of total humanitarian migration. Sudan dropped considerably between the earlier and later period; whereas Iraq, Afghanistan, Burma, and Iran were top countries in both periods and increased as shares of migration in recent years. Other countries of birth which have increased in recent years are Thailand, Sri Lanka, Pakistan, Malaysia, and Syria. However, increases from these countries are also likely to be associated with people fleeing other countries before arriving in Australia. For example, a number of families might have been in refugee camps in Thailand for considerable periods of time after fleeing Burma, or relocated from Pakistan after fleeing Afghanistan. Malaysia could also be a transit destination for many humanitarian arrivals from numerous different origins. Countries of birth that decreased in importance were Sudan, Ethiopia, Bosnia and Herzegovina, and Somalia.
FIGURE 12  TOP COUNTRIES OF BIRTH, HUMANITARIAN ENTRANTS VICTORIA, 2001-2011 (ACMID) AND 2010-2015 (SDB)

% of humanitarian arrivals to Victoria

- Sudan
- Iraq
- Afghanistan
- Burma/Myanmar
- Ethiopia
- Iran
- Thailand
- Bosnia and Herzegovina
- Sri Lanka
- Somalia
- Pakistan
- Malaysia
- Syria

% of 2001-2011 Humanitarian migrants (ACMID)
% of 2010-2015 Humanitarian migrants (SDB)
5. VICTORIAN DATA

5.1 TOP LANGUAGES 2001-2011 (ACMID)
For Humanitarian Visa entrants in Victoria over 2001 to 2011 the most common languages spoken at home were Arabic (8,362); Dari (3,373); Karen (3,027); Dinka (2,593); Hazaraghi (1,890); English (1,679); Persian (excluding Dari) (1,545); and Chaldean Neo-Aramaic (1,479). These are shown at Figure 13.

5.2 TOP LANGUAGES 2010 – 2015 (SDB)
The most common languages named as the main language spoken by humanitarian entrants to Victoria over the more recent period, 2010-2015, were: Arabic (4,089); Hazaragi (2,762); Dari (2,343); Farsi (Persian) (1,143); Chin Haka (899); Persian (794); Karen (732); and Burmese (726). These are shown at Figure 14.

5.3 COMPARISON OVER TIME – LANGUAGES
Figure 15 compares the relative importance of the top 10 languages in each dataset / time period – comparing the 2001-2011 ACMID data with the 2010-2015 SDB data. Arabic is the main language in each dataset and time period.
The relative importance of Hazaraghi and Dari languages has increased substantially; whereas the importance of Karen and Dinka languages has decreased. However, it is important to note that the ACMID and SDB databases code some languages differently, with some languages aggregated in one source and disaggregated in another. Farsi (Persian) is not listed in the ACMID dataset – and might be included in Persian. Farsi, as a distinct form of Persian, is included as an important language in the later SDB data. Similarly the Chin and Karen S’Gaw languages are not listed in the earlier ACMID data but have substantial numbers in the SDB data. These languages might be included in the aggregate category of Burmese in the ACMID data.

Coding issues aside, an observation from the languages data on humanitarian migrants to Victoria is not that Arabic is the dominant language; but that Dari, Hazaraghi, Persian, Farsi, Assyrian and Assyrian Neo-Aramaic, Chaldean Neo-Aramaic, and other (and sometimes) overlapping languages have significant numbers of speakers. It should also be noted that both data sources record only the main language spoken at home – which might be distinct from all languages spoken, and is distinct from the speakers’ proficiency in English.

### 5.4 PROFICIENCY IN ENGLISH

Of Humanitarian Visa entrants to Victoria in the ACMID dataset, around a third (29.2%) self-identified as speaking English “very well”; and a similar amount as speaking English “well” as shown in Table 8. A quarter (24%) spoke English “not well”; and 8% did not speak English at all. Those speaking English “not well”, or “not at all”, are classified as being not proficient in spoken English.

As shown in Figure 16, the three main language groups with high numbers of humanitarian entrants not proficient in spoken English were Arabic – with 2,220 speakers not proficient in English (26.6% of speakers); Dari – with 1,141 speakers not proficient in English (33.9% of speakers); and Karen – with 1,943 speakers not proficient in English (64% of speakers).

Arabic speakers more often claimed to be proficient in English, but with large numbers of Arabic speakers overall, the Arabic speaking population with poor English is comparatively large. In the smaller Karen population, the majority (64%) of speakers were not proficient in English.
FIGURE 15  TOP LANGUAGES SPOKEN (MAIN LANGUAGE), HUMANITARIAN ENTRANTS VICTORIA, 2001-2011 (ACMID) AND 2010-2015 (SDB)
### TABLE 7
**TOP LANGUAGES SPOKEN (MAIN LANGUAGE), HUMANITARIAN ENTRANTS VICTORIA, 2001-2011 (ACMID) AND 2010-2015 (SDB)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Arabic</td>
<td>8,362</td>
<td>4,089</td>
<td>20.1%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Dari</td>
<td>3,373</td>
<td>2,343</td>
<td>8.1%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Karen</td>
<td>3,027</td>
<td>732</td>
<td>7.3%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Dinka</td>
<td>2,593</td>
<td>138</td>
<td>6.2%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Hazaraghi</td>
<td>1,890</td>
<td>2,762</td>
<td>4.5%</td>
<td>12.1%</td>
</tr>
<tr>
<td>English</td>
<td>1,679</td>
<td>372</td>
<td>4.0%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Persian (excluding Dari)</td>
<td>1,545</td>
<td>19</td>
<td>3.7%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Chaldean Neo-Aramaic</td>
<td>1,479</td>
<td>76</td>
<td>3.5%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Serbian</td>
<td>1,460</td>
<td>-</td>
<td>3.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Assyria/Assyrian Neo-Aramaic</td>
<td>1,432</td>
<td>646</td>
<td>3.4%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Burmese</td>
<td>1,266</td>
<td>726</td>
<td>3.0%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Chin Haka</td>
<td>428</td>
<td>899</td>
<td>1.0%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Farsi (Persian)</td>
<td>n/a</td>
<td>1,143</td>
<td>-</td>
<td>5.0%</td>
</tr>
<tr>
<td>Chin</td>
<td>n/a</td>
<td>692</td>
<td>-</td>
<td>3.0%</td>
</tr>
<tr>
<td>Karen S’Gaw</td>
<td>n/a</td>
<td>669</td>
<td>-</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

### TABLE 8
**PROFICIENCY IN SPOKEN ENGLISH, HUMANITARIAN ENTRANTS, VICTORIA, 2011 ARRIVED 2001-2011 (ACMID)**

<table>
<thead>
<tr>
<th>Proficiency in Spoken English</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well</td>
<td>12,172</td>
<td>29.2%</td>
</tr>
<tr>
<td>Well</td>
<td>13,140</td>
<td>31.5%</td>
</tr>
<tr>
<td>Not well</td>
<td>10,153</td>
<td>24.3%</td>
</tr>
<tr>
<td>Not at all</td>
<td>3,186</td>
<td>7.6%</td>
</tr>
<tr>
<td>Not stated - both language (LANP) and proficiency (ENGP) not stated</td>
<td>684</td>
<td>1.6%</td>
</tr>
<tr>
<td>Not stated - language (LANP) stated, proficiency (ENGP) not stated</td>
<td>711</td>
<td>1.7%</td>
</tr>
<tr>
<td>Not applicable</td>
<td>1,679</td>
<td>4.0%</td>
</tr>
<tr>
<td>Total</td>
<td>41,732</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
FIGURE 16  LANGUAGES SPOKEN AT HOME BY PROFICIENCY IN ENGLISH – HUMANITARIAN ENTRANTS VICTORIA, 2011 ARRIVED 2001-2011 (ACMID)

- Arabic: 2,200
  - Other / not stated: 1,141
  - Not proficient in spoken English: 927
  - Proficient in spoken English: 1,141
- Dari: 1,943
- Karen: 415
- Dinka: 762
- Hazaraghi: 572
- English (excluding Dari): 639
- Persian Neo-Aramaic: 543
- Serbian: 566
- Assyrian Neo-Aramaic: 566
6. VICTORIAN DATA

LOCATION – LOCAL GOVERNMENT AREAS

6.1 LGA LOCATION 2001-2011 (ACMID)

In the ACMID dataset the main Local Government Areas (LGAs) of residence in Victoria for humanitarian entrants was Greater Dandenong (6,629). This was followed by Hume (5,262); Casey (4,800) and Brimbank (4,427) (Figure 17).

By year of arrival (Figure 18), Greater Dandenong was the most common residence for most of those who arrived over 2000-2011 though the relative importance of other LGAs shifted over this time frame. Hume generally increased as a destination - the main arrival group for humanitarian entrants in Hume was those who arrived later in the period covered by ACMID (2009-2011, with 1,431 entrants living in Hume). Brimbank had high numbers of entrants who arrived in 2003-2005 (1,397) but this number declined for arrivals between 2006-2008 (1,042) and 2009-2010 (862). Casey likewise had high numbers of entrants from 2000-2002 and 2003-2005, but this declined over time.

Thus of the most recent period of arrival covered by the ACMID dataset (2009-2011), the main destination LGAs were: Greater Dandenong, Hume, and Brimbank. However considering entrants across the whole 2000-2011 period other LGAs including Casey, Wyndham, Greater Geelong, Maroondah and Maribyrnong had significant numbers (over 1,000) of humanitarian arrivals. Differences in locations over time are partly a function of different arrival groups over time.

FIGURE 17 MAIN LOCAL GOVERNMENT AREAS FOR HUMANITARIAN ENTRANTS, VICTORIA, 2011 ARRIVED 2001-2011 (ACMID)
FIGURE 18  MAIN LOCAL GOVERNMENT AREAS FOR HUMANITARIAN ENTRANTS, VICTORIA, 2011 ARRIED 2001-2011 (ACMID), BY YEAR OF ARRIVAL

FIGURE 19  MAP OF LGAS FOR HUMANITARIAN ENTRANTS, VICTORIA, ARRIVED 2011 (ACMID)
FIGURE 20  MAP OF LGAS FOR HUMANITARIAN ENTRANTS, VICTORIA, ARRIVED 2001 (ACMID)

FIGURE 21  MAP OF LGAS FOR HUMANITARIAN ENTRANTS, VICTORIA, ARRIVED WITHIN THE DECADE OF 2001-2011 (ACMID)
6.2 LGA LOCATION 2010-2015 (SDB)

The Settlement Database shows that the main Victorian LGAs for humanitarian entrants over 2010 to March 2015 were Greater Dandenong (3,914) and Hume (3,586). Other LGAs with significant numbers of entrants included Casey (2,100); Brimbank (1,836); Wyndham (1,386) and Maroondah (1,314). In 2013 and 2014 the number of humanitarian entrants to Hume was significantly larger than to Greater Dandenong. The total humanitarian entrants to Victoria over 2010 to March 2015 were 22,291. Overall numbers declined from 2011 (5,445) to 2014 (3,503).

The maps at Figure 22 and Figure 23 contrast the main LGAs for arrivals between 2010 and 2014, and the map at Figure 26 shows overall recent (2010-2015 March) LGAs for humanitarian migrants to Victoria.
### TABLE 9  TOP LGAS FOR HUMANITARIAN ENTRANTS, VICTORIA 2010-MARCH 2015 (SDB)

<table>
<thead>
<tr>
<th>LGA Name</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>Total incl. to March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Dandenong (C)</td>
<td>629</td>
<td>972</td>
<td>1,132</td>
<td>592</td>
<td>589</td>
<td>3,914</td>
</tr>
<tr>
<td>Hume (C)</td>
<td>442</td>
<td>900</td>
<td>469</td>
<td>1,002</td>
<td>773</td>
<td>3,586</td>
</tr>
<tr>
<td>Casey (C)</td>
<td>447</td>
<td>613</td>
<td>457</td>
<td>356</td>
<td>227</td>
<td>2,100</td>
</tr>
<tr>
<td>Brimbank (C)</td>
<td>350</td>
<td>445</td>
<td>495</td>
<td>318</td>
<td>228</td>
<td>1,836</td>
</tr>
<tr>
<td>Wyndham (C)</td>
<td>250</td>
<td>308</td>
<td>274</td>
<td>252</td>
<td>301</td>
<td>1,386</td>
</tr>
<tr>
<td>Maroondah (C)</td>
<td>150</td>
<td>223</td>
<td>323</td>
<td>377</td>
<td>241</td>
<td>1,314</td>
</tr>
<tr>
<td>Greater Geelong (C)</td>
<td>204</td>
<td>115</td>
<td>207</td>
<td>274</td>
<td>145</td>
<td>945</td>
</tr>
<tr>
<td>Whittlesea (C)</td>
<td>143</td>
<td>321</td>
<td>265</td>
<td>81</td>
<td>119</td>
<td>929</td>
</tr>
<tr>
<td>Maribyrnong (C)</td>
<td>116</td>
<td>217</td>
<td>228</td>
<td>131</td>
<td>131</td>
<td>823</td>
</tr>
<tr>
<td>Greater Shepparton (C)</td>
<td>91</td>
<td>153</td>
<td>103</td>
<td>172</td>
<td>63</td>
<td>582</td>
</tr>
<tr>
<td>OTHER</td>
<td>1,030</td>
<td>1,178</td>
<td>1,067</td>
<td>895</td>
<td>686</td>
<td>3,914</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>3,852</td>
<td>5,445</td>
<td>5,020</td>
<td>4,450</td>
<td>3,503</td>
<td><strong>22,291</strong></td>
</tr>
</tbody>
</table>

### FIGURE 23  TOP LGAS FOR HUMANITARIAN ENTRANTS, VICTORIA 2010-2014 (SDB)

- **Arrived 2010**
- **Arrived 2011**
- **Arrived 2012**
- **Arrived 2013**
- **Arrived 2014**
Humanitarian migrant arrivals arrived 2014 (Settlement Database) By LGA

Melbourne GCCSA Boundary

Total 2010-2015 / home
- 0.0 - 782.8
- 782.8 - 1565.6
- 1568.6 - 2348.4
- 2348.4 - 3131.2
- 3031.2 - 3914.0
7. **VICTORIAN DATA**

## LOCATION AT LOWER SPATIAL LEVELS

### 7.1 LOCATION ACCORDING TO SEIFA

There are several options available in the ACMID dataset for categorising the Socio-Economic Indexes for Australia (SEIFA) status of areas. The SEIFA Index of Relative Social Disadvantage (IRSD) deciles were selected within Victoria, and for SA2 levels ranked by area with lowest deciles representing greater levels of socioeconomic disadvantage. National based deciles, other SEIFA indices; and LGA and SLA level data are also available but are not reported. In 2011, most (41.5%) of Humanitarian Visa entrants over 2001-2011 lived in areas of the lowest deciles of SEIFA IRSD. A further 21.5% lived in the second SEIFA IRSD decile. Thus, in 2011 approximately two thirds of Humanitarian Visa holders were living in the 20% most socio-economically disadvantaged areas of Victoria.

![Figure 27: SEIFA Status (Victorian Deciles) of SA2 of Enumeration, Humanitarian Visas, Victoria, 2011 Arrived 2001-2011 (ACMID)](image)

### 7.2 LOCATION – STATISTICAL AREAS LEVEL 2 (SA2S)

Drawing on the ACMID data on humanitarian arrivals over 2001-2011, at the Statistical Area 2 (SA2) level the areas in Victoria with the largest numbers of Humanitarian Visa holders were: Dandenong (3,195); Roxburgh Park – Somerton (1,516); Campbellfield – Coolaroo (1,272); Noble Park (1,230); Dandenong North (1,072); Werribee (1,008); Meadow
Heights (1,000) and Hampton Park – Lynbrook (900). These are provided in Table 10 and mapped at Figure 28. Note that more recent Settlement Database data are not available at the SA2 level.

### TABLE 10  TOP TEN SA2 OF ENUMERATION, HUMANITARIAN VISA ENTRANCTS, 2001-2011, VICTORIA (ACMID)

<table>
<thead>
<tr>
<th>SA2 Areas (Enumerated)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dandenong</td>
<td>3,195</td>
<td>7.7%</td>
</tr>
<tr>
<td>Roxburgh Park - Somerton</td>
<td>1,516</td>
<td>3.6%</td>
</tr>
<tr>
<td>Campbellfield - Coolaroo</td>
<td>1,272</td>
<td>3.1%</td>
</tr>
<tr>
<td>Noble Park</td>
<td>1,230</td>
<td>2.9%</td>
</tr>
<tr>
<td>Dandenong North</td>
<td>1,072</td>
<td>2.6%</td>
</tr>
<tr>
<td>Werribee</td>
<td>1,008</td>
<td>2.4%</td>
</tr>
<tr>
<td>Meadow Heights</td>
<td>1,000</td>
<td>2.4%</td>
</tr>
<tr>
<td>Hampton Park - Lynbrook</td>
<td>900</td>
<td>2.2%</td>
</tr>
<tr>
<td>Doveton</td>
<td>831</td>
<td>2.0%</td>
</tr>
<tr>
<td>Shepparton - South</td>
<td>772</td>
<td>1.9%</td>
</tr>
<tr>
<td>Other</td>
<td>28,893</td>
<td>69.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41,688</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

### FIGURE 28  STATISTICAL AREA 2 (SA2) LOCATION OF HUMANITARIAN VISA ENTRANTS, DECADE OF 2001-2011 BY SA2, MELBOURNE (ACMID)

Humanitarian migrant arrivals arrived 2014 (Settlement Database) By LGA

<table>
<thead>
<tr>
<th>Total 2010-2015 / home</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0 - 638.9</td>
</tr>
<tr>
<td>638.9 - 1277.8</td>
</tr>
<tr>
<td>1277.8 - 1916.8</td>
</tr>
<tr>
<td>1916.8 - 2555.7</td>
</tr>
<tr>
<td>2555.7 - 3194.7</td>
</tr>
</tbody>
</table>
7.3 LOCATION – STATISTICAL LOCAL AREAS (SLAs)

Aside from LGA, the more recent Settlement Database contains spatial information on the Statistical Local Area (SLA) of recent entrants. SLAs aggregate to LGAs and are slightly different to the new standard geography of SA2s. The main SLAs of residence for humanitarian entrants to Victoria over 2010-2015 were again Dandenong – specifically Greater Dandenong (C) - Dandenong (3,012); Hume (C) – Broadmeadows (2,042); Hume (C) – Craigieburn (1,613); and Brimbank (C) – Sunshine (1,369). These results are detailed in Table 11 and mapped in Figure 29.

<table>
<thead>
<tr>
<th>SLA</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Dandenong (C) - Dandenong</td>
<td>3,012</td>
<td>13.2%</td>
</tr>
<tr>
<td>Hume (C) - Broadmeadows</td>
<td>2,042</td>
<td>9.0%</td>
</tr>
<tr>
<td>Hume (C) - Craigieburn</td>
<td>1,613</td>
<td>7.1%</td>
</tr>
<tr>
<td>Brimbank (C) - Sunshine</td>
<td>1,369</td>
<td>6.0%</td>
</tr>
<tr>
<td>Greater Dandenong (C) Balance</td>
<td>942</td>
<td>4.1%</td>
</tr>
<tr>
<td>Casey (C) - Hallam</td>
<td>894</td>
<td>3.9%</td>
</tr>
<tr>
<td>Corio - Inner</td>
<td>882</td>
<td>3.9%</td>
</tr>
<tr>
<td>Maribyrnong (C)</td>
<td>833</td>
<td>3.7%</td>
</tr>
<tr>
<td>Maroondah (C) - Ringwood</td>
<td>809</td>
<td>3.5%</td>
</tr>
<tr>
<td>Wyndham (C) - South</td>
<td>776</td>
<td>3.4%</td>
</tr>
<tr>
<td>Other</td>
<td>9,621</td>
<td>42.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22,793</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
7.4 LOCATION OF BRIDGING VISA E – SUBURBS

The Settlement Database itself does not list bridging or temporary visas. However, the Department of Immigration and Border Protection published a separate report on Bridging Visa E holders (Illegal Maritime Entrants on Bridging E Visa September 2014). A Bridging Visa E (BVE) is a temporary visa allowing holders to stay in Australia while they make arrangements to leave or await an immigration decision. It does not allow holders to re-enter Australia (Department of Immigration and Border Protection, 2014).

The 2014 report shows that there were 9,357 people living in Victoria as at September 2014 holding a Bridging Visa E. The largest suburb, by a long margin, for Bridging Visa E holders to be living in was Dandenong (2,088 or 22%); followed by Doveton (386), Sunshine (380), St Albans (372), Springvale (367) and Noble Park (331). The Department lists suburbs with 10 or more Bridging Visa Holders – these are mapped at Figure 30. Key areas are the North West – Dallas, Broadmeadows, Glenroy, Epping, Lalor, Thomastown and Reservoir; the South West – Dandenong, Springvale, Doveton and Hallam; and the West – St Albans, Albion, Sunshine, Braybrook, Footscray.
<table>
<thead>
<tr>
<th>Suburb</th>
<th>BE Holders 2014</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Dandenong</td>
<td>2,088</td>
<td>22%</td>
</tr>
<tr>
<td>2 Doveton</td>
<td>386</td>
<td>4%</td>
</tr>
<tr>
<td>3 Sunshine</td>
<td>380</td>
<td>4%</td>
</tr>
<tr>
<td>4 St Albans</td>
<td>372</td>
<td>4%</td>
</tr>
<tr>
<td>5 Springvale</td>
<td>367</td>
<td>4%</td>
</tr>
<tr>
<td>6 Noble park</td>
<td>331</td>
<td>4%</td>
</tr>
<tr>
<td>7 Lalor</td>
<td>251</td>
<td>3%</td>
</tr>
<tr>
<td>8 Broadmeadows</td>
<td>243</td>
<td>3%</td>
</tr>
<tr>
<td>9 Werribee</td>
<td>228</td>
<td>2%</td>
</tr>
<tr>
<td>10 Glenroy</td>
<td>227</td>
<td>2%</td>
</tr>
<tr>
<td>11 Thomastown</td>
<td>211</td>
<td>2%</td>
</tr>
<tr>
<td>12 Albion</td>
<td>195</td>
<td>2%</td>
</tr>
<tr>
<td>13 Shepparton</td>
<td>194</td>
<td>2%</td>
</tr>
<tr>
<td>14 Epping</td>
<td>179</td>
<td>2%</td>
</tr>
<tr>
<td>15 Sunshine west</td>
<td>179</td>
<td>2%</td>
</tr>
<tr>
<td>16 Reservoir</td>
<td>177</td>
<td>2%</td>
</tr>
<tr>
<td>17 Sunshine north</td>
<td>172</td>
<td>2%</td>
</tr>
<tr>
<td>18 Hoppers crossing</td>
<td>141</td>
<td>2%</td>
</tr>
<tr>
<td>19 Footscray</td>
<td>126</td>
<td>1%</td>
</tr>
<tr>
<td>20 Hampton park</td>
<td>121</td>
<td>1%</td>
</tr>
<tr>
<td>21 Dallas</td>
<td>106</td>
<td>1%</td>
</tr>
<tr>
<td>Other suburbs</td>
<td>2,683</td>
<td>29%</td>
</tr>
<tr>
<td><strong>Total Victoria</strong></td>
<td><strong>9,357</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
7.5  VICTORIAN DATA DEMOGRAPHICS - AGE AND SEX

Humanitarian visa entrants to Victoria were more often male (22,479 or 53.9%) than female (19,243 or 46.1%) in the ACMID database. The most common age groups were those aged 15-24 years (9,707 or 23%); those aged 25-34 years (9,133 or 22%); and children aged 0-14 years (8,896 or 21%). Older people (55 or older) accounted for only 2,792 or 6.7% of the Humanitarian Visa holding population in Victoria. Age ratios were more disproportionately male in the age group 25-34 years (56% male).

The age and sex profile of humanitarian entrants is in contrast to the other visa streams. Skilled visa entrants were predominantly aged 25-34 and 35-44 years, and more often male (52.7%). Family visa entrants were more often female (62.5%) and aged 25-34 years.

In the ACMID database, Protection Visa (866) entrants were disproportionately male and aged 35-34 years. Most children on Humanitarian Visas were Special Humanitarian Program entrants or Refugee entrants.
TOP COUNTRIES OF BIRTH

The following are profiles of top countries of birth represented in both longer term and shorter term humanitarian arrivals to Victoria, as follows:

1. Afghanistan;
2. Iraq;
3. Burma;
4. Iran;
5. Sudan.

Additional information is provided below on humanitarian entrants from each of these countries with data extracted from the ACMID database.

8.5 AFGHANISTAN

ACMID DATABASE 2001-2011

In the ACMID database of humanitarian arrivals 2001-2011, there were 5,797 arrivals born in Afghanistan. The majority of these people lived in the south east of Melbourne in the LGAs of Casey (2,314 or 40%) and Greater Dandenong (2,009 or 35%). Significant numbers also lived in the regional LGAs of Greater Shepparton (458 or 8%), Mildura (175 or 3%) and Swan Hill (80 or 2%).

Humanitarian migrants born in Afghanistan predominantly spoke Dari (3,072 or 53%) and Hazaraghi (1,775 or 31%); with significant numbers speaking Pashto (421 or 7%) and Persian (excluding Dari) (275 or 5%).

SETTLEMENT DATABASE 2010-2015

The Settlement Database records 4,870 humanitarian migrants to Victoria born in Afghanistan who arrived more recently, between 2010 and March 2015. Humanitarian migrants born in Afghanistan predominantly resided in the LGA of Greater Dandenong (2,018 or 41%) and Casey (1,302 or 27%); with significant numbers also in the regional LGAs of Greater Shepparton (345 or 7%), Greater Geelong (313 or 6%), and Mildura (193 or 4%). At the more disaggregated SLA level, humanitarian migrants born in Afghanistan predominantly resided in: Greater Dandenong – Dandenong; Casey – Hallam; Casey – Cranbourne; Greater Shepparton – Part A; and Corio – Inner. The distributions across Melbourne SLAs are shown in the map at Figure 8.1.

From the Settlement Database, Humanitarian migrants born in Afghanistan spoke mainly Hazaraghi (2,386 or 49%) and Dari (1,936 or 40%). Other languages were Farsi (Afghan) (189 or 4%); Pashto (165 or 3%); Farsi (Persian) (65 or 1%); and Persian (59 or 1%).
FIGURE 37  TOP LOCAL GOVERNMENT AREAS OF RESIDENCE, HUMANITARIAN VISA ENTRANTS BORN IN AFGHANISTAN, VICTORIA 2011 ARRIVED 2001-2011 (ACMID)

- Yarra (C) 61 (1%)
- Greater Geelong (C) 64 (1%)
- Knox (C) 64 (1%)
- Maribyrnong (C) 70 (1%)
- Swan Hill (RC) 80 (2%)
- Brimbank (C) 78 (1%)
- Mildura (RC) 175 (3%)
- Greater Shepparton (C) 458 (8%)
- Other 425 (7%)
- Casey (C) 2,314 (40%)

FIGURE 38  TOP LANGUAGES SPOKEN HUMANITARIAN VISA ENTRANTS BORN IN AFGHANISTAN, VICTORIA 2011 ARRIVED 2001-2011 (ACMID)

- Dari 3,072 (53%)
- Hazaraghi 1,775 (31%)
- Pashto 421 (7%)
- African Languages, nec 10 (0%)
- Not stated 101 (2%)
- English 94 (2%)
- Arabic 24 (0%)
- Persian (excluding Dari) 275 (5%)
FIGURE 39  TOP LOCAL GOVERNMENT AREAS OF RESIDENCE, HUMANITARIAN VISA ENTRANTS BORN IN AFGHANISTAN, VICTORIA 2010-2015 (SDB)

- Greater Bendigo (C) 34 (1%)
- Hume (C) 52 (1%)
- Maribyrnong (C) 76 (2%)
- Swan Hill (RC) 95 (2%)
- Brimbank (C) 158 (3%)
- Mildura (RC) 193 (4%)
- Greater Geelong (C) 313 (6%)
- Greater Shepparton (C) 345 (7%)
- Casey (C) 1,302 (27%)
- Greater Dandenong (C) 2,019 (41%)
- Other 284 (6%)

FIGURE 40  SLA OF RESIDENCE, HUMANITARIAN VISA ENTRANTS BORN IN AFGHANISTAN, VICTORIA 2010-2015 (SDB)

Humanitarian migrant arrivals born in Afghanistan (Settlement Database) by SLA

- Melbourne GCCSA Boundary
- N. Afghanistan
  - 0.0 - 3778
  - 3778 - 755.6
  - 755.6 - 1133.4
  - 1133.4 - 1511.2
  - 1511.2 - 1889.0

0 12.5 25 50 Kilometres
8.6 IRAQ

ACMID DATABASE 2001-2011

Looking at the ACMID database of humanitarian arrivals to Victoria over 2001-2011, arrivals born in Iraq lived overwhelmingly in the LGA of Hume (4,088 or 64%). Others lived in Whittlesea (599 or 9.4%); Moreland (301 or 4.7%); Greater Dandenong (266 or 4.2%); and the regional LGA of Greater Shepparton (144 or 2.2%).

At the smaller SA2 level, the most common locations for Humanitarian Visa holders born in Iraq to be living in Victoria were: Roxburgh Park – Somerton (1,378); Campbellfield – Coolaroo (1,004); Meadow Heights (750); and Broadmeadows (436). Some regional areas had populations in this group: Shepparton – South (132); Cobram (85) and Mildura (56).

In the ACMID database, humanitarian migrants born in Iraq predominantly spoke Arabic (3,261 or 51%); Chaldean Neo-Aramaic (1,409 or 22%) and Assyrian Neo-Aramaic (1,317 or 21%).
FIGURE 42  TOP LOCAL GOVERNMENT AREAS OF ENUMERATION, HUMANITARIAN VISA ENTRANTS BORN IN IRAQ, VICTORIA 2001-2011 (ACMID)

- Hume (C) 4,088 (64%)
- Whittlesea (C) 599 (9%)
- Greater Dandenong (C) 266 (4%)
- Greater Shepparton (C) 144 (2%)
- Brimbank (C) 129 (2%)
- Darebin (C) 116 (2%)
- Casey (C) 102 (2%)
- Moira (S) 85 (1%)
- Melton (S) 62 (1%)
- Other 500 (8%)

FIGURE 43  TOP LANGUAGES SPOKEN, HUMANITARIAN VISA ENTRANTS BORN IN IRAQ, VICTORIA 2001-2011 (ACMID)

- Arabic 3,261 (51%)
- Assyrian Neo-Aramaic 1,317 (21%)
- Chaldean Neo-Aramaic 1,409 (22%)
- Armenian 21 (0%)
- Kurdish 112 (2%)
- Persian (excluding Dari) 70 (1%)
SETTLEMENT DATABASE 2010-2015

The Settlement Database records 3,183 humanitarian migrants to Victoria born in Iraq who arrived between 2010 and March 2015. The majority of migrants from Iraq resided in the LGA of Hume (2,583 or 68%). Smaller numbers were in Whittlesea (298 or 8%); Melton (145 or 4%) and Greater Dandenong (134 or 3%). At the smaller level of Statistical Local Area (SLA), the most common SLAs for Iraq-born migrants 2010-2015 were Hume – Craigieburn (1,341 or 35.2%); and Hume – Broadmeadows (1,241 or 32.5%).

Based on the Settlement Database, the majority of Afghanistan-born arrivals spoke Arabic (2,752 or 72%); while significant numbers spoke Assyrian (538 or 14%) and Chaldean (224 or 6%).

FIGURE 44  TOP LOCAL GOVERNMENT AREAS OF RESIDENCE, HUMANITARIAN VISA ENTRANTS BORN IN IRAQ, VICTORIA 2010-2015 (SDB)
FIGURE 45  SLAs OF RESIDENCE, HUMANITARIAN VISA HOLDERS BORN IN IRAQ, 2010-2015 (SDB)

Humanitairan arrivals born in Iraq 2010-March 2015 (Settlement Database) By SLA

<table>
<thead>
<tr>
<th>SLA</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melbourne GCCSA Boundary</td>
<td>0.0 - 268.2</td>
</tr>
<tr>
<td>N_Iraq</td>
<td>268.2 - 536.4</td>
</tr>
<tr>
<td></td>
<td>536.4 - 804.6</td>
</tr>
<tr>
<td></td>
<td>804.6 - 1072.8</td>
</tr>
<tr>
<td></td>
<td>1072.8 - 1341.0</td>
</tr>
</tbody>
</table>

FIGURE 46  MAIN LANGUAGES SPOKEN, HUMANITARIAN VISA ENTRANTS BORN IN IRAQ, VICTORIA 2010-2015 (SDB)

- Assyrian 538 (14%)
- Arabic 2,752 (72%)
- Kurdish 51 (1%)
- Other 33 (1%)
- Persian 77 (2%)
- Chaldean Neo-Aramaic 76 (2%)
- Farsi (persian) 65 (2%)
8.7 BURMA / MYANMAR

ACMID DATABASE 2001-2011

By LGA, drawing on the ACMID database of humanitarian migrants 2001-2011, arrivals born in Burma (Republic of the Union of Myanmar) most commonly lived in the LGAs of Wyndham (987 or 23.2%); Maroondah (853 or 20.2%); Brimbank (465 or 11%); and Greater Dandenong (426 or 10.1%). At the smaller SA2 level, the most common Victorian locations for people on Humanitarian Visas and born in Burma were: Werribee (503 or 11.8%); Croydon (325 or 7.7%); Ringwood (272 or 6.4%); Springvale (246 or 5.8%); Corio – Norlane (243 or 5.7%); and Sunshine (239 or 5.6%).

SETTLEMENT DATABASE 2010-2015

Drawing on the Settlement Database for humanitarian arrivals to Victoria over 2010 – March 2015; humanitarian arrivals born in Burma (Myanmar) commonly lived in the LGAs of Maroondah (989 or 27%); Brimbank (609 or 17%); Wyndham (523 or 14%); and Maribyrnong (327 or 9%). At the more disaggregated SLA level, the most common areas for Burma-born humanitarian migrants to live in were Maroondah – Ringwood (566 or 15.6%); Brimbank – Sunshine (523 or 14.4%); Maroondah – Croydon (423 or 11.6%); and Maribyrnong (327 or 9%). Humanitarian migrants born in Burma recorded a mix of main languages in the Settlement Database. These included Chin Haka (787 or 22%); Burmese (622 or 17%); Chin (612 or 17%); Karen (570 or 16%) and Karen S’Gaw (197 or 5%).
FIGURE 48  TOP LOCAL GOVERNMENT AREA OF RESIDENCE, HUMANITARIAN VISA ENTRANTS BORN IN MYANMAR (BURMA), VICTORIA 2010-2015 (SDB)

Whitehorse (C) 46 (1%)
Greater Bendigo (C) 136 (4%)
Hobsons Bay (C) 142 (4%)
Greater Geelong (C) 154 (4%)
Greater Dandenong (C) 243 (7%)
Yarra Ranges (S) 280 (8%)
Maribyrnong (C) 327 (9%)

FIGURE 49  SLAs OF RESIDENCE, HUMANITARIAN VISA HOLDERS BORN IN BURMA/MYANMAR, 2010-2015 (SDB)

Humanitarian arrivals born in Burma/Myanmar 2010-March 2015 (Settlement Database) By SLA

- Melbourne GCCSA Boundary
- N,Myanmar
  - 0.0 - 113.2
  - 113.2 - 226.4
  - 226.4 - 339.6
  - 339.6 - 452.80
  - 452.80 - 566.0
8.8 IRAN

ACMID DATABASE 2001-2011

The ACMID database records 1,643 humanitarian arrivals born in Iran over the 2001-2011 period. Iran-born migration has increased in recent years (see following section). Of humanitarian migrants 2001-2011 born in Iran, common LGAs of residence were Greater Dandenong (195 or 12%), and Casey (138 or 9%). However Iran-born migrants were comparatively widely distributed across Melbourne.

The ACMID database records the majority of Iran-born humanitarian migrants as speaking Persian (excluding Dari) (1,151 or 70%); with the remainder mainly speaking Arabic (177 or 11%), Dari (108 or 7%) and Kurdish (102 or 6%). The ACMID data does not distinguish Farsi from Persian, as later Settlement Data does.
FIGURE 51  TOP LOCAL GOVERNMENT AREAS, HUMANITARIAN VISA ENTRANTS BORN IN IRAN, VICTORIA 2010-2015 (ACMID)

- Greater Dandenong (C) 195 (12%)
- Casey (C) 138 (9%)
- Manningham (C) 132 (8%)
- Whittlesea (C) 131 (8%)
- Knox (C) 113 (7%)
- Hume (C) 118 (7%)
- Brimbank (C) 86 (6%)
- Whitehorse (C) 86 (6%)
- Moreland (C) 63 (4%)
- Darebin (C) 65 (4%)
- Turkish 6 (0.4%)
- Assyrian Neo-Aramaic 13 (1%)
- Notstated 15 (1%)
- Hazaraghi 17 (1%)
- Kurdish 102 (6%)
- Dari 108 (7%)
- Arabic 177 (11%)
- Persian (excluding Dari) 1,151 (70%)

FIGURE 52  TOP LANGUAGES, HUMANITARIAN VISA ENTRANTS BORN IN IRAN, VICTORIA 2010-2015 (ACMID)
SETTLEMENT DATABASE 2010-2015

The Settlement Database, covering arrivals over 2010 to March 2015, records 2,519 humanitarian entrants born in Iran and living in Victoria. The most common LGAs of residence for Iran-born humanitarian arrivals were Greater Dandenong (396 or 15.7%); Whittlesea (306 or 12.1%); Casey (219 or 8.7%) and Brimbank (163 or 6.5%). At the more disaggregated SLA level, common SLAs of residence for Iran-born humanitarian migrants were Greater Dandenong – Dandenong, and Whittlesea – South West. Compared to other humanitarian migrant groups Iran-born migrants were widely distributed, being less concentrated into one or two LGAs.

Humanitarian arrivals born in Iran spoke Farsi (Persian) (993 or 39%); Persian (628 or 25%); Farsi (Afghan) (265 or 10%); Kurdish (193 or 8%); and Dari (146 or %).

FIGURE 53  TOP LOCAL GOVERNMENT AREA OF RESIDENCE, HUMANITARIAN VISA ENTRANTS BORN IN IRAN, VICTORIA 2010-2015 (SDB)
FIGURE 54  SLAs OF RESIDENCE, HUMANITARIAN VISA HOLDERS BORN IN IRAN, 2010-2015 (SDB)

FIGURE 55  MAIN LANGUAGE, HUMANITARIAN VISA ENTRANTS VICTORIA 2010-2015 BORN IN IRAN (SDB)
8.9 SUDAN

ACMID DATABASE 2001-2011

There were approximately 6,414 humanitarian entrants to Victoria over 2001-2011 (in the ACMID database) who were born in Sudan. Entrants from Sudan peaked around the years of 2003, 2004 (particularly – peak year for entrants with 1,618 entrants); 2005 and 2006. Since then, the number of Humanitarian Visa entrants from Sudan has reduced to very small numbers.

By LGA, Humanitarian Visa entrants over 2001-2011 born in Sudan most commonly lived in: Brimbank (1,276); Greater Dandenong (962); Casey (665); Wyndham (389); Melton (353) and Yarra (351). About 60% of the Sudan-born population with Humanitarian Visas lived in these five LGAs.

At the SA2 level, the most common locations for humanitarian entrants born in Sudan were: Dandenong (304); Noble Park (249); St Albans – North (243); Deer Park – Derrimut (215); Melton (174); and Sunshine West (174).

Half (3,211 or 50%) of Sudan-born humanitarian entrants spoke Arabic at home and a quarter (1,622 or 25%) spoke Dinka. A sizeable number (524 or 8%) spoke the African language Nuer at home. The remainder spoke other African languages – including Bari and Shilluk – or spoke English at home.

FIGURE 56 YEAR OF ARRIVAL, HUMANITARIAN VISA ENTRANTS VICTORIA 2001-2011 BORN IN SUDAN (ACMID)
FIGURE 57  TOP LOCAL GOVERNMENT AREAS OF ENUMERATION, HUMANITARIAN VISA HOLDERS BORN IN SUDAN, VICTORIA (ACMID)

- Brimbank (C) 1,276 (20%)
- Greater Dandenong (C) 962 (15%)
- Casey (C) 665 (10%)
- Wyndham (C) 389 (6%)
- Melton (S) 353 (6%)
- Yarra (C) 351 (5%)
- Maribyrnong (C) 194 (3%)
- Moonee Valley (C) 194 (3%)
- Greater Shepparton (C) 164 (3%)
- Latrobe (C) 180 (3%)
- Other 1,683 (26%)

FIGURE 58  SA2S OF ENUMERATION, HUMANITARIAN VISA ENTRANTS 2001-2011 BORN IN SUDAN, 2001-2011 (ACMID)

CMID2011-Humanitarianvisa holders by SA2 - People born in Sudan
- GCCSA_2011_Melb
- cob_sudan_n
The more recent (2010-2015) Settlement Database shows that very few (258) humanitarian entrants born in Sudan arrived after 2010. However, sizeable numbers of people of a humanitarian migrant background born in Sudan live in Victoria.
TOP FIVE LOCAL GOVERNMENT AREAS (LGAS) WITH HIGH PROPORTIONS OF HUMANITARIAN ARRIVALS

9.5 GREATER DANDENONG

ACMID DATABASE 2001-2011

In the ACMID database of humanitarian migrants to Victoria over 2001-2011, the largest portion – 6,629 or 22% - were living in the LGA of Greater Dandenong. Although Greater Dandenong has been the most important destination

The most common country of birth for humanitarian migrants in Greater Dandenong was Afghanistan –2,009 or 38% of the total. Other significant countries of birth were Sudan (962 or 18%), Burma/Myanmar (426 or 8%), Bosnia and Herzegovina (402 or 8%), Sri Lanka (341 or 6%) and Iraq (266 or 5%).

The common languages spoken by humanitarian migrants arriving in Greater Dandenong from 2001-2011 include Dari (1,134 or 17%), Arabic (1,036 or 16%) and Hazaraghi (751 or 11%).
In the more recent Settlement Database data, of humanitarian arrivals 2010-2015 in Greater Dandenong, humanitarian arrivals born in Afghanistan accounted for over half of humanitarian entrants (2,029 or 51%). Other significant countries of birth were Iran (390 or 10%), Pakistan (367 or 9%), Sri Lanka (258 or 6%) and Myanmar/Burma (241 or 6%).

In more recent years from 2010-2015, the most common language in Greater Dandenong has shifted slightly with greater proportions of Hazaraghi speakers (1,184 or 30%), and Dari (973 or 25%).
FIGURE 62  HUMANITARIAN ENTRANTS BY COUNTRY OF BIRTH, GREATER DANDENONG, JANUARY 2010-MARCH 2015 (SDB) (ACMID)

- Afghanistan 2,019 (54%)
- Pakistan 371 (10%)
- Iran 394 (10%)
- Iraq 135 (4%)
- Thailand 162 (4%)
- Sri Lanka 254 (7%)
- Burma 273 (7%)
- Ethiopia 65 (2%)
- Other 22 (1%)

FIGURE 63  HUMANITARIAN ENTRANTS BY LANGUAGE, GREATER DANDENONG, JANUARY 2010-MARCH 2015 (SDB)

- Dari 973 (25%)
- Hazaragi 1,184 (30%)
- Pashto 100 (2%)
- Other 488 (12%)
- Persian 121 (3%)
- Farsi (persian) 140 (4%)
- Burmese and Related Languages, rnf 142 (4%)
- Farsi (Afghan) 154 (4%)
- Arabic 158 (4%)
- Tamill 244 (6%)
- Burmese / Myanmar 247 (6%)
9.6 HUME

ACMID DATABASE 2001-2011

Of the ACMID database of humanitarian migrants to Victoria over 2001-2011, the second-largest portion - 5,262 or 18% - were living in the LGA of Hume. A popular LGA for humanitarian migrants in recent years, the relative importance of Hume LGA has increased over time.

The vast majority of humanitarian migrants in Hume, as recorded in the ACMID data, were born in Iraq (4,088 or 84%). Smaller proportions were born in Bhutan (159 or 3%), Turkey (124 or 2%) and Iran (118 or 2%).

Of humanitarian entrants in Hume who arrived between 2001 and 2011, the top languages spoken at home were: Arabic (36%), Assyrian Neo-Aramaic (24%); and Chaldean Neo-Aramaic (23%). Other languages accounting for much smaller percentages included Nepali (4%); Turkish (2%) and Somali (2%).

![Figure 64: Humanitarian Entrants by Country of Birth, Hume LGA, 2011](attachment:image.png)
SETTLEMENT DATABASE 2010-2015

Of humanitarian arrivals to Hume over 2010-2015, most (2,587 or 74%) were born in Iraq. Smaller numbers of arrivals were born in Syria (Syrian Arab Republic – 292 or 8%); Bhutan (207 or 6%); Iran (103 or 3%) and Nepal (102 or 3%).

Of humanitarian arrivals to Hume over 2010-2015, the main language spoken was predominantly Arabic (60%); followed by Assyrian (15%); Nepali (8%); Chaldean (5%) and Chaldean Neo-Aramaic (2%).
9.7 BRIMBANK

ACMID DATABASE 2001-2011

The vast majority of humanitarian migrants in Brimbank, as recorded in the ACMID data, were born in Sudan (1276 or 30%). Other major proportions include Burma (465 or 11%), Bosnia and Herzegovina (271 or 6%), Ethiopia (251 or 6%) and Liberia (171 or 4%).

A broad range of languages are spoken by humanitarian entrants in Brimbank who arrived between 2001 and 2011. The top languages spoken at home were: Dinka (21%), Arabic (17%), English (7%), Bosnian (5%), Amharic (4%), Burmese (4%) and Burmese related languages (3%) and Serbian (3%). Other languages, including a range of African languages, account for much smaller percentages.

![Figure 68: HUMANITARIAN ENTRANTS BY COUNTRY OF BIRTH, BRIMBANK LGA, 2011 ARRIVED 2001-2011 (ACMID)]
SETTLEMENT DATABASE 2010-2015

Of humanitarian entrants in the past five years (2010 to March 2015), there were 1,858 entrants living in Brimbank LGA. Of these, the main countries of birth were Myanmar (612 or 33%); Iran (163 or 9%); Afghanistan (160 or 9%); Pakistan (119 or 6%); and Sri Lanka (119 or 6%).

Recent entrants to Brimbank spoke a wide mix of languages – the main being Chin (a south east Asian language) with 252 speakers (17% of humanitarian entrants); Arabic (123 or 8%); Tamil (120 or 8%); Chin Haka (109 or 7%); Pashto (an Iranian language) (109 or 7%); and Hazaragi (105 or 7%).
FIGURE 70  HUMANITARIAN ENTRANTS BY COUNTRY OF BIRTH, BRIMBANK, JANUARY 2010-MARCH 2015 (SDB)

- Myanmar 612 (33%)
- Sudan 43 (2%)
- Eritrea 52 (3%)
- Iraq 67 (4%)
- Ethiopia 90 (5%)
- Malaysia 99 (5%)
- Sri Lanka 119 (6%)
- Pakistan 152 (8%)
- Afghanistan 160 (9%)
- Iran 163 (9%)
- Other 301 (16%)

FIGURE 71  HUMANITARIAN ENTRANTS BY LANGUAGE SPOKEN, BRIMBANK, JANUARY 2010-MARCH 2015 (SDB)

- Chin 252 (17%)
- Arabic 123 (8%)
- Tamil 120 (8%)
- Chin Haka 109 (7%)
- Pashto 109 (7%)
- Hazaragi 105 (7%)
- Burmese/Myanmar 102 (7%)
- Amharic 83 (5%)
- Zophei 68 (4%)
- Persan 66 (4%)
- Tigrinya 65 (4%)
- Dari 56 (4%)
- Kurdish 54 (4%)
- Farsi (Persian) 51 (3%)
- Chin Mara 49 (3%)
- Chin Zotong 40 (3%)
- Karen 29 (2%)
- English 37 (2%)
9.8 CASEY

ACMID DATABASE 2001-2011

The vast majority of humanitarian migrants in Casey, as recorded in the ACMID data, were born in Afghanistan (2314 or 49%). Other major proportions include Sudan (665 or 14%), Croatia (223 or 5%), Bosnia and Herzegovina (184 or 4%), Pakistan (162 or 3%), Sri Lanka (153 or 3%), Iran (138 or 3%) and Egypt (117 or 3%).

The main languages spoken by humanitarian entrants in Casey who arrived between 2001 and 2011 include Dari (1519 or 32%), Hazaragi (626 or 13%), Arabic (612 or 13%), Serbian (393 or 9%) and Pashto (188 or 4%).

FIGURE 72 HUMANITARIAN ENTRANTS BY COUNTRY OF BIRTH, CASEY LGA, 2011 ARRIVED 2001-2011 (ACMID)
SETTLEMENT DATABASE 2010-2015

Of humanitarian entrants in the past five years (2010 to March 2015), there were 2,124 entrants living in the Casey LGA. Of these, the main countries of birth were Afghanistan (1285 or 61%), Pakistan (233 or 11%), Iran (222 or 10%), Sri Lanka (93 or 4%), Iraq (67 or 3%).

Recent humanitarian entrants to Casey spoke a wide mix of languages – the main being Chin (a south east Asian language) with 252 speakers (17% of humanitarian entrants); Arabic (123 or 8%); Tamil (120 or 8%); Chin Haka (109 or 7%); Pashto (an Iranian language) (109 or 7%); and Hazaraghi (105 or 7%).
The vast majority of humanitarian migrants in Wyndham, as recorded in the ACMID data arriving between 2001 and 2011, were born in Burma (987 or 35%), Thailand (650 or 23%), Sudan (389 or 14%) or Ethiopia (151 or 5%).

The main languages spoken by humanitarian entrants in Wyndham who arrived between 2001 and 2011 include Karen (52%), Arabic (9%), Dinka (8%), Burmese (3%) or Serbian (3%).

Note that a number of humanitarian arrivals who stated that their country of birth is Thailand are predominantly born to families of Burmese origin who fled Burma and were living in Thailand or in camps along the Thai/Burma border.
FIGURE 75  HUMANITARIAN ENTRANTS BY COUNTRY OF BIRTH, WYNDHAM LGA, 2011
ARRIVED 2001-2011 (ACMID)

- Burma (Republic of Myanmar) 987 (35%)
- Thailand 650 (23%)
- Sudan 389 (14%)
- Ethiopia 151 (5%)
- Other 200 (7%)
- Somalia 33 (1%)
- Uganda 28 (1%)
- Sri Lanka 31 (1%)
- Egypt 35 (1%)
- Eritrea 35 (1%)
- Sierra Leone 50 (2%)
- Bosnia and Herzegovina 56 (2%)
- Iraq 60 (2%)
- Croatia 65 (2%)
- Kenya South Sudan 27 (1%)

Note: The chart shows the number of humanitarian entrants by country of birth for Wyndham LGA, 2001-2011, obtained from ACMID.
FIGURE 76 HUMANITARIAN ENTRANTS BY LANGUAGE SPOKEN, WYNDHAM LGA, 2011 ARRIVED 2001-2011 (ACMID)

- Karen 1454 (52%)
- Arabic 256 (9%)
- Dinka 214 (8%)
- Burmese 126 (5%)
- Serbian 98 (3%)
- English 89 (3%)
- Amharic 81 (3%)
- Krio 47 (2%)
- Oromo 41 (1%)
- Somali 38 (1%)
- Tigrinya 38 (1%)
- Bari 34 (1%)
- Burmese Related 27 (1%)
- Tamil 27 (1%)
- Madi 21 (1%)
- Other 177 (8%)
The most common languages for humanitarian arrivals in the ACMID database across Victoria 2001 – 2011 include the following:

- Arabic
- Dari
- Karen
- Dinka
- Hazaraghi

The most common languages for humanitarian arrivals from the more recent data extracted from the Settlement Database across Victoria 2010 – 2015 include the following:

- Arabic
- Hazaragi
- Dari
- Farsi (Persian)
- Chin Haka

Combining this information, the most common languages included across both data sets were:

- Arabic
- Dari
- Karen
- Hazaragi
- Farsi (Persian) / Persian

These top 5 languages are profiled in more detail throughout Chapter 10 and for each major language, provide mapped geographic location according to Statistical Local Area (SLA) of humanitarian entrants who speak these languages. The most recent Settlement Database data have been used for this purpose.
10.5 ARABIC

The most common regions for Arabic speaking humanitarian arrivals are Hume – Craigieburn; Hume – Broadmeadows, and Whittlesea – South West.

FIGURE 77 SLAs OF RESIDENCE, HUMANITARIAN VISA HOLDERS – ARABIC SPEAKING, 2010-2015 (SDB)

Humanitarian arrivals - Arabic speaking 2010-March 2015 (Settlement Database) by SLA

- Melbourne GCCSA boundary
- N_Arabic
  - 0.0 - 221.6
  - 221.6 - 443.2
  - 443.2 - 664.8
  - 664.8 - 886.4
  - 886.4 - 1108.0
10.6 DARI

The most common regions for Dari speaking humanitarian arrivals are in Greater Dandenong – Dandenong, Casey – Cranbourne, Casey – Hallam, Corio – Inner and Casey – Berwick.

**FIGURE 78** SLAs OF RESIDENCE, HUMANITARIAN VISA HOLDERS – DARI SPEAKING, 2010-2015 (SDB)

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Humanitarian arrivals - Dari speaking 2010-March 2015 (Settlement Database)

- Melbourne GCCSA Boundary
- N_Dari
  - 0.0 - 178.6
  - 178.6 - 357.2
  - 357.2 - 535.8
  - 535.8 - 714.4
  - 714.4 - 893.0

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86
10.7  KAREN

The most common regions for Karen speaking humanitarian arrivals are in Wyndham – South, Corio – Inner, Wyndham – North, Greater Bendigo – Inner East and Hobsons Bay – Altona.

**FIGURE 79** SLAs OF RESIDENCE, HUMANITARIAN VISA HOLDERS – KAREN SPEAKING, 2010-2015 (SDB)

Humanitarian arrivals - Karen speaking 2010 - March 2015 (Settlement Database) by SLA

- Melbourne GCCSA Boundary
- N_Iran
  - 0.0 - 45.2
  - 45.2 - 90.4
  - 90.4 - 135.6
  - 135.6 - 180.8
  - 180.8 - 226.0
10.8 **HAZARAGHI**

The most common regions for Hazaraghi speaking humanitarian arrivals are in Greater Dandenong – Dandenong, Casey – Hallam, Casey – Cranbourne, Greater Shepparton and Mildura. The population of Hazaraghi speakers also noticeably increased across the years of 2010, 2011 and 2012.

**FIGURE 80** HUMANITARIAN ARRIVALS, HAZARAGHI SPEAKING, BY LGA VICTORIA 2010-2015 (SDB)
10.9 Farsi (Persian) / Persian


FIGURE 81 HUMANITARIAN ARRIVALS, FARSI SPEAKING, BY LGA VICTORIA 2010-2015 ()
Sourcing current data on humanitarian arrivals was a key objective of this research project. The ACMID and Settlement Database data sets could not provide an assessment of the current population of humanitarian arrivals. This led to partnership with AMES and licensed access from the Settlement Branch of the Department of Social Services to extract data from the AMES Humanitarian Entrants Management System (HEMS). Data was extracted for the period of April 2013 – April 2015 and included the following information on humanitarian arrivals to Victoria during this time:

- Country of birth;
- Ethnicity;
- Language spoken;
- Gender; and
- Age

The de-identified data included 9,089 records with associated spatial data and are analysed throughout this Chapter.

11.5 COMMUNITY CODING OF LANGUAGES AND ETHNICITIES

Data collected by HEMS asks humanitarian arrivals to nominate their language and ethnicity and 80 languages and 86 different ethnicities were included in the data. These languages and ethnicities required coding to make them consistent with the ABS definitions provided in the ACMID data set and AMES consulted with numerous community leaders to assist with this process. The results provided in this Chapter have been top-coded or aggregated in accordance with this information on languages spoken and ethnicities and have been mapped across Victoria. Results are presented according to ABS Statistical Area 2 (SA2) for metropolitan Melbourne and languages are presented in alphabetical order.
FIGURE 82  AMES HUMANITARIAN ARRIVALS AND LANGUAGE, BY SA2 MELBOURNE 2013-2015

Language
- Albanian
- Arabic
- Arabic & French
- Dari
- Dari & Hazaragi
- Dari & Pashto
- Hazaragi
- Persian & Farsi
- Burmese
- Chin
- Karen
- Mandarin
- Nepali
- Vietnamese
- Punjabi
- Tamil
- Amharic, Tigrinya & Oromo
- Arabic, Dinka & Nuer
- Dinka
- French
- Kiswahili
- Krio
- Lingala
- Tigrinya & Arabic
- Somali
- PNG

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.

FIGURE 83  AMES HUMANITARIAN ARRIVALS AND LANGUAGE, VICTORIA 2013-2015

Language
- Albanian
- Arabic
- Arabic & French
- Dari
- Dari & Hazaragi
- Dari & Pashto
- Hazaragi
- Persian & Farsi
- Burmese
- Chin
- Karen
- Mandarin
- Nepali
- Vietnamese
- Punjabi
- Tamil
- Amharic, Tigrinya & Oromo
- Arabic, Dinka & Nuer
- Dinka
- French
- Kiswahili
- Krio
- Lingala
- Tigrinya & Arabic
- Somali
- PNG

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
Distribution of Humanitarian Arrivals speaking Amharic, Tigrinya and Oromo languages across Melbourne Metropolitan (N = 214)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8
- 9 - 12

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 20

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
Distribution of Humanitarian Arrivals speaking Burmese languages across Metropolitan Melbourne (N = 562)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8
- 9 - 12
- 13 - 16

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 200

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.

Distribution of Humanitarian Arrivals speaking Chin language across Metropolitan Melbourne (N = 1169)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8
- 9 - 12

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 234

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
FIGURE 88  AMES HUMANITARIAN ARRIVALS, DARI HAZARAGHI SPEAKING, BY SA2 MELBOURNE 2013-2015

Distribution of Humanitarian Arrivals speaking Dari and Hazaragi languages across Metropolitan Melbourne (N= 2028)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8
- 9 - 12
- 13 - 16
- 17+

Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 621

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.

FIGURE 89  AMES HUMANITARIAN ARRIVALS, DARI SPEAKING, BY SA2 MELBOURNE 2013-2015

Distribution of Humanitarian Arrivals speaking Dari language across Metropolitan Melbourne (N = 12)

Number of Humanitarian Arrivals per Household
- 1 - 4

Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 5

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
FIGURE 90  AMES HUMANITARIAN ARRIVALS, Farsi (Persian) speaking, by SA2 Melbourne 2013-2015

Distribution of Humanitarian Arrivals speaking Farsi and Persian languages across Metropolitan Melbourne (N=12)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 25

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.

FIGURE 91  AMES HUMANITARIAN ARRIVALS, Hazaragi speaking, by SA2 Melbourne 2013-2015

Distribution of Humanitarian Arrivals speaking Hazaragi language across Metropolitan Melbourne (N=14)

Number of Humanitarian Arrivals per Household
- 1 - 4

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 4

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
FIGURE 92 AMES HUMANITARIAN ARRIVALS, KAREN SPEAKING, BY SA2 MELBOURNE 2013-2015

Distribution of Humanitarian Arrivals speaking Karen language across Metropolitan Melbourne (N = 868)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8
- 9 - 12

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 188

FIGURE 93 AMES HUMANITARIAN ARRIVALS, KISWAHLI SPEAKING, BY SA2 MELBOURNE 2013-2015

Distribution of Humanitarian Arrivals speaking Kiswahili language across Metropolitan Melbourne (N = 109)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8
- 9 - 12

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 188
FIGURE 94  AMES HUMANITARIAN ARRIVALS, KRIÓ SPEAKING, BY SA2 MELBOURNE 2013-2015

Distribution of Humanitarian Arrivals speaking Krió language across Metropolitan Melbourne (N = 12)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8
- 9 - 12
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 9

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.

FIGURE 95  AMES HUMANITARIAN ARRIVALS, LINGALA SPEAKING, BY SA2 MELBOURNE 2013-2015

Distribution of Humanitarian Arrivals speaking Lingala language across Metropolitan Melbourne (N = 12)

Number of Humanitarian Arrivals per Household
- 2 - 4
- 5 - 8
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 5

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
FIGURE 98  AMES HUMANITARIAN ARRIVALS, PASHTO DARI SPEAKING, BY SA2 MELBOURNE 2013-2015

Distribution of Humanitarian Arrivals speaking Pashto and Dari languages across Metropolitan Melbourne (N = 139)

Number of Humanitarian Arrivals per Household

- 1 - 4
- 5 - 8
- 9 - 12

Number of Humanitarian Arrivals per SA2 Statistical Areas

- 1 - 37

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.

FIGURE 99  AMES HUMANITARIAN ARRIVALS, PUNJABI SPEAKING, BY SA2 MELBOURNE 2013-2015

Distribution of Humanitarian Arrivals speaking Punjabi language across Metropolitan Melbourne (N = 13)

Number of Humanitarian Arrivals per Household

- 1 - 4

Number of Humanitarian Arrivals per SA2 Statistical Areas

- 1 - 3

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
FIGURE 100  AMES HUMANITARIAN ARRIVALS, SOMALI SPEAKING, BY SA2 MELBOURNE 2013-2015

Distribution of Humanitarian Arrivals speaking Somali language across Metropolitan Melbourne (N = 74)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8
- 9 - 12
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 12

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.

FIGURE 101  AMES HUMANITARIAN ARRIVALS, TAMIL SPEAKING, BY SA2 MELBOURNE 2013-2015

Distribution of Humanitarian Arrivals speaking Tamil language across Metropolitan Melbourne (N = 103)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 4
- 5 - 12
- 13 - 16
- 17+
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 60

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
FIGURE 1-02  AMES HUMANITARIAN ARRIVALS, TIGRINYA AND ARABIC SPEAKING, BY SA2 MELBOURNE 2013-2015

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.

Distribution of Humanitarian Arrivals speaking Tigrinya and Arabic languages across Metropolitan Melbourne (N = 123)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 4
- 9 - 12

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 12

FIGURE 1-03  AMES HUMANITARIAN ARRIVALS, AMHARIC, TIGRINYA, OROMO SPEAKING, BY SA2 VICTORIA 2013-2015

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.

Distribution of Humanitarian Arrivals speaking Amharic, Tigrinya, Oromo languages across Victoria (N = 214)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 4
- 9 - 12

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 20
Distribution of Humanitarian Arrivals speaking Arabic language across Victoria (N = 2892)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8
- 9 - 12
- 13 - 16

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 544

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.

Distribution of Humanitarian Arrivals speaking Burmese language across Victoria (N = 562)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8
- 9 - 12
- 13 - 16

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 200

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
FIGURE 106 AMES HUMANITARIAN ARRIVALS, CHIN SPEAKING, BY SA2 VICTORIA 2013-2015

Distribution of Humanitarian Arrivals speaking Chin languages across Victoria (N = 1169)
Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8
- 9 - 12
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 234

FIGURE 107 AMES HUMANITARIAN ARRIVALS, DARI AND HAZARAGHI SPEAKING, BY SA2 VICTORIA 2013-2015

Distribution of Humanitarian Arrivals speaking Dari and Hazaraghi languages across Victoria (N = 2028)
Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8
- 9 - 12
- 13 - 16
- 17+
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 621

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
FIGURE 108 AMES HUMANITARIAN ARRIVALS, FARSI AND PERSIAN SPEAKING, BY SA2 VICTORIA 2013-2015

Distribution of Humanitarian Arrivals speaking Farsi and Persian languages across Victoria (N = 360)

Number of Humanitarian Arrivals per Household

- 1 - 4
- 5 - 8
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

- 1 - 25

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.

FIGURE 109 AMES HUMANITARIAN ARRIVALS, KAREN SPEAKING, BY SA2 VICTORIA 2013-2015

Distribution of Humanitarian Arrivals speaking Karen languages across Victoria (N = 868)

Number of Humanitarian Arrivals per Household

- 1 - 4
- 5 - 8
- 9 - 12
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

- 1 - 188

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
FIGURE 110  AMES HUMANITARIAN ARRIVALS, KISWAHILI SPEAKING, BY SA2 VICTORIA 2013-2015

Distribution of Humanitarian Arrivals speaking Kiswahili language across Victoria (N = 109)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8
- 9 - 12
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 34

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.

FIGURE 111  AMES HUMANITARIAN ARRIVALS, MANDARIN SPEAKING, BY SA2 VICTORIA 2013-2015

Distribution of Humanitarian Arrivals speaking Mandarin language across Victoria (N = 102)

Number of Humanitarian Arrivals per Household
- 1 - 4
- 5 - 8
- 9 - 12
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 1 - 40

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
FIGURE 112 AMES HUMANITARIAN ARRIVALS, PASHTO AND DARI SPEAKING, BY SA2 VICTORIA 2013-2015

Distribution of Humanitarian Arrivals speaking Pashto and Dari languages across Victoria (N = 139)

Number of Humanitarian Arrivals per Household

- 1 - 4
- 5 - 8
- 9 - 12

Number of Humanitarian Arrivals per SA2 Statistical Areas

- 1 - 37

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.

FIGURE 113 AMES HUMANITARIAN ARRIVALS, TAMIL SPEAKING, BY SA2 VICTORIA 2013-2015

Distribution of Humanitarian Arrivals speaking Tamil language across Victoria (N = 103)

Number of Humanitarian Arrivals per Household

- 1 - 4
- 5 - 8
- 9 - 12
- 13 - 16
- 17+

Number of Humanitarian Arrivals per SA2 Statistical Areas

- 1 - 60

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
A key objective of this research was to identify General Practitioners (GPs) who speak languages other than English. These doctors are referred to in the following section as bilingual GPs though many are likely to speak multiple languages or dialects in addition to English. Understanding these services is likely to be an important influence on health seeking behaviours and health outcomes. A thorough investigation of multiple languages spoken by GPs had not been previously completed and is an important outcome of this research. Languages spoken by GPs were coded according to the suggested list of languages provided by AMES community leaders.

12.5 LOCATIONS OF BILINGUAL GPs ACROSS MELBOURNE AND VICTORIA

The following section provides mapped locations of GPs that speak a language other than English from the NHSD (2015) together with the AMES humanitarian arrivals data (2013-2015) presented in the previous Chapter. The location of these bilingual GPs are mapped as point data with a 1.6km access buffer in pink combined with the location of AMES humanitarian arrivals who speak the language in red according to SA2 location. Results are presented for bilingual GPs in metropolitan Melbourne before presenting results for regional Victoria.
Distribution of Humanitarian Arrivals speaking Amharic, Tigrinya and Oromo languages with GPs who speak Amharic and/or Tigrinya across Metropolitan Melbourne

GPs speaking Tigrinya and/or Amharic
1.6km Access Buffer
Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 0
- 1
- 2 - 3
- 4 - 7
- 8 - 20

Note: There are no GPs registered with the NHSD who speak Oromo.

Distribution of Humanitarian Arrivals speaking Arabic language with GPs who speak Arabic across Metropolitan Melbourne

GPs speaking Arabic
1.6km Access Buffer
Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas
- 0
- 1 - 3
- 4 - 7
- 8 - 24
- 25 - 544

Distribution of Humanitarian Arrivals speaking Arabic and French languages with GPs who speak Arabic and/or French across Metropolitan Melbourne

GPs speaking Arabic and/or French
1.6km Access Buffer
Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

0
1 - 4
5 - 6
7 - 10
11 - 17

Note: There are no GPs registered with the NHSD who speak Dinka or Nuer.
FIGURE 119 BILINGUAL GPs BURMESE SPEAKING, BY SA2 MELBOURNE, NHSD 2015

Distribution of Humanitarian Arrivals speaking Burmese languages with GPs who speak Burmese across Metropolitan Melbourne

- GPs speaking Burmese
- 1.6km Access Buffer
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

- 0
- 1
- 2 - 6
- 7 - 24
- 25 - 200

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
National Health Services Directory, October 2015.

FIGURE 120 BILINGUAL GPs NEPALI SPEAKING, BY SA2 MELBOURNE, NHSD 2015

Distribution of Humanitarian Arrivals speaking Nepali language with GPs who speak Nepali across Metropolitan Melbourne

- GPs speaking Nepali
- 1.6km Access Buffer
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

- 0
- 1 - 2
- 3 - 17
- 18 - 21
- 22 - 61

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
National Health Services Directory, October 2015.
FIGURE 121  BILINGUAL GPs PASHTO DARI SPEAKING, BY SA2 MELBOURNE, NHSD 2015

Distribution of Humanitarian Arrivals speaking Pashto and Dari languages with GPs who speak Pashto across Metropolitan Melbourne

- GPs speaking Pashto
- 1.6km Access Buffer
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

- 0
- 1
- 2 - 4
- 5 - 7
- 8 - 37

Note: There are no GPs registered with the NHSD who speak Dari.


FIGURE 122  BILINGUAL GPs PUNJABI SPEAKING, BY SA2 MELBOURNE, NHSD 2015

Distribution of Humanitarian Arrivals speaking Punjabi language with GPs who speak Punjabi across Metropolitan Melbourne

- GPs speaking Punjabi
- 1.6km Access Buffer
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

- 0
- 1 - 3

FIGURE 123 BILINGUAL GPs SOMALI SPEAKING, BY SA2 MELBOURNE, NHSD 2015

Distribution of Humanitarian Arrivals speaking Somali language with GPs who speak Somali across Metropolitan Melbourne

- GPs speaking Somali
- 1.6km Access Buffer
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
National Health Services Directory, October 2015.

FIGURE 124 BILINGUAL GPs TAMIL SPEAKING, BY SA2 MELBOURNE, NHSD 2015

Distribution of Humanitarian Arrivals speaking Tamil language with GPs who speak Tamil across Metropolitan Melbourne

- GPs speaking Tamil
- 1.6km Access Buffer
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
National Health Services Directory, October 2015.
**FIGURE 125** BILINGUAL GPs TIGRINYA ARABIC SPEAKING, BY SA2 MELBOURNE, NHSD 2015

Distribution of Humanitarian Arrivals speaking Tigrinya and Arabic languages with GPs who speak Tigrinya and/or Arabic across Metropolitan Melbourne

- ▲ GPs speaking Tigrinya and/or Arabic
- 1.6km Access Buffer
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

- 0
- 1
- 2 - 4
- 5 - 7
- 8 - 12


**FIGURE 126** BILINGUAL GPs AMHARIC SPEAKING, BY SA2 MELBOURNE, NHSD 2015

Distribution of Humanitarian Arrivals speaking Amharic, Tigrinya and Oromo languages with GPs who speak Amharic and/or Tigrinya across Metropolitan Melbourne

- ○ GPs speaking Tigrinya and/or Amharic
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

- 0
- 1
- 2 - 3
- 4 - 7
- 8 - 20

FIGURE 127  BILINGUAL GPs ARABIC SPEAKING, VICTORIA, NHSD 2015

Distribution of Humanitarian Arrivals speaking Arabic language with GPs who speak Arabic across Victoria

- GPs speaking Arabic
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

<table>
<thead>
<tr>
<th>Range</th>
<th>Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
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<tr>
<td>1 - 3</td>
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<td>4 - 7</td>
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<td>8 - 24</td>
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<td>25 - 544</td>
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</tbody>
</table>

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
National Health Services Directory, October 2015.

FIGURE 128  BILINGUAL GPs BURMESE SPEAKING, VICTORIA, NHSD 2015

Distribution of Humanitarian Arrivals speaking Burmese languages with GPs who speak Burmese across Victoria

- GPs speaking Burmese
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

<table>
<thead>
<tr>
<th>Range</th>
<th>Area</th>
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<tbody>
<tr>
<td>0</td>
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<td>18 - 21</td>
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<td>22 - 61</td>
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</tr>
</tbody>
</table>

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.
National Health Services Directory, October 2015.
Distribution of Humanitarian Arrivals speaking Nepali language with GPs who speak Nepali across Victoria

Number of Humanitarian Arrivals per SA2 Statistical Areas

Note: There are no GPs registered with NHSD who speak Dari.
Distribution of Humanitarian Arrivals speaking Punjabi language with GPs who speak Punjabi across Victoria

- GPs speaking Punjabi
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

- 0
- 1 - 3

FIGURE 131  BILINGUAL GPs PUNJABI SPEAKING, VICTORIA, NHSD 2015

Distribution of Humanitarian Arrivals speaking Somali language with GPs who speak Somali across Victoria

- GPs speaking Somali
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

- 0
- 1
- 2 - 4
- 5 - 9
- 10 - 12

FIGURE 132  BILINGUAL GPs SOMALI SPEAKING, VICTORIA, NHSD 2015
FIGURE 133  BILINGUAL GPs TAMIL SPEAKING, VICTORIA, NHSD 2015


Distribution of Humanitarian Arrivals speaking Tamil language with GPs who speak Tamil across Victoria

- GPs speaking Tamil
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

0
1
2
3
4 - 60

FIGURE 134  BILINGUAL GPs TIGRINYA AND ARABIC SPEAKING, VICTORIA, NHSD 2015


Distribution of Humanitarian Arrivals speaking Tigrinya and Arabic languages with GPs who speak Tigrinya and/or Arabic across Victoria

- GPs speaking Tigrinya and/or Arabic
- Melbourne Metropolitan Zone

Number of Humanitarian Arrivals per SA2 Statistical Areas

0
1
2 - 4
5 - 7
8 - 12
This chapter presents selective findings from key stakeholder interviews to contextualise data presented in previous chapters.

The discussion focuses on four key sets of issues: (1) contexts for service provision, and particularly health and settlement services; (2) the implications of a stratified visa system that provide varying access to income support and services; (3) Language and communication issues impacting on service delivery; and (4) insights into current data gaps and how available data are used.

The insights summarised in this chapter were gathered from fourteen semi-structured qualitative interviews that were conducted with staff based in organisations in the northern and western regions of Melbourne. They worked in program delivery and program development roles in local government, health and settlement support services accessed by people from refugee backgrounds. Interviews were conducted in person or over the phone between June and September in 2015, and took approximately an hour to complete. Potential interviewees and the interview schedule were developed in close consultation with the Research Advisory Group. Quotes have been mildly edited to improve the flow of ideas when reporting findings from these interviews and the following codes have been used to indicate the broad roles of interviewees: SSP for Settlement Services Providers; HSP for Health Service Providers; and LG for personnel working in Local Government.

13.1 ACCESS TO HEALTH SERVICES

Interviewees noted that the quality of health services for humanitarian entrants and asylum seekers following resettlement has significant implications for their long-term health and wellbeing, and capacities to establish their lives in Australia. However, they face a range of barriers in accessing services that include: high demand on limited available services; visa conditions that do not guarantee access to public health services; and a volatile policy landscape.

13.1.1 HIGH DEMANDS ON LIMITED SERVICES

The precarious circumstances of people’s lives mean that services are usually reacting to situations. Service providers observed that clients move around quite frequently (and even interstate) in search of affordable accommodation and employment.

We don’t really know where people are. We know where they start, but we don’t know where they go next. It’s really hard, therefore, to plan service provision for refugee background. (HSP)

I think that the biggest gap that we find in this is that the sector as a whole is very transient and very reactive. Clients being on a bridging visa are able to move freely within the community or are able to move interstate, and as a result people move in and out a lot. While we have, say, 2,800 clients in Victoria at the moment, we have quite a few people who move in and out of our service on a daily basis. It’s very difficult to forward plan for staffing or for services to clients when there is that ebb and flow of clients in and out of service. (SSP)

In this sector there is a lot of that movement in and out and a lot of work you have to do is reacting to that rather than knowing in six months’ time we’re going to have this many clients, and there’s going to be this many new clients and this many clients moving out […] I’ve worked in the sector for maybe three or four years […] and it’s been constant like that in all of that time. (SSP)

Interviewees noted that there were specific issues facing asylum seekers that did not necessarily apply to permanent humanitarian entrants. This was largely associated with the ways in which support for people seeking asylum is funded and delivered. International Health and Medical Services (IHMS) is a private company that is contracted by the Federal Government to deliver health services to people seeking asylum. The service was regarded with wariness by many
Interviewees. While they believed that clients received appropriate care, they were distrustful towards the outsourcing of health care for those in community detention. There were particular concerns towards the organisation’s close association with the Department of Immigration and Border Protection and a perceived lack of transparency regarding the commercial arrangements between IHMS and the Department. There were also concerns related to the lack of choice in accessing service providers, although it was acknowledged that in some instances, there could be advantages for clients in getting access to the private system.

If you are IHMS, you don’t have a Medicare card. You’ve only got one doctor to go to. You can’t go to a dentist anywhere. You’ve got to come here or to a public hospital in an emergency. You come here, and the doctor has to write a referral. They have to fax it to IHMS and IHMS give a copayment, and choose the provider. The strange thing is that the government is really big on the fact that they get no advantage. They do in fact, when they’re IHMS because they go private. (HSP)

If you are a contractor to IHMS, then those records are owned by the Department of Immigration Border Protection. (HSP)

Interviewees discussed the critical role that Refugee Health Nurses (RHNs) have in casework services supporting the resettlement of refugees and asylum seekers. RHNs are usually available to engage with clients for 6-12 months. During this time, and with in-depth understanding of clients’ needs, RHNs are critical sources of support for clients and health providers:

[We] support the doctors to navigate through all the tests, so if you normally go to see your GP like I would off the street, you just go in and you spend your 5 minutes with the GP and that’ll be that, but when clients have a refugee health assessment they’ll see the GP; they’ll have to have a variety of pathology tests afterwards to check them for illnesses and whatnot. That’s where the refugee health nurse supports the doctor, so the clients will go off, and she’ll educate the doctor on this is what the clients will need to do. They’ll have blood tests or urine tests, and they’ll need to be tested for the hepatitis and HIV, and a variety of other illnesses. They help facilitate all those other tests. (HSP)

The refugee health nurses they have to do everything and they’re very holistic and they often go above and beyond the line of duty. They have an enormous role in coordinating care. We couldn’t function without them really, as troubleshooters, liaison workers, de facto case managers, the whole bit. (HSP)

Some interviewees noted that the availability of RHNs did not always align with the settlement patterns of those who most needed their services. This placed significant strains on workers in areas with high numbers of clients needing intensive levels of support:

‘They have to stretch themselves thin’. (HSP)

Interviewees were also unanimous in noting that there are significant service shortfalls in meeting the mental health needs of humanitarian entrants and people seeking asylum. Access to services, such as counselling and improved links between primary health care and mental health services, were viewed as essential because of experiences of, or exposure to, torture and trauma. Issues including stigma and a lack of awareness also delayed or inhibited people from seeking advice and treatment. These issues could be partly addressed by improved understanding of the needs of humanitarian entrants and people seeking asylum among mainstream mental health service providers:

[S]ome of the mental health services are adequate, but they need ongoing [training] in the specific issues of refugees. I’ve had quite a few refugees who were [mis]diagnosed essentially with borderline personality disorder … The other thing is the mental health service doesn’t realize that they’re not going to tell them the whole horrible back story because they’ve only just met them and just going through it again is incredibly re-traumatising. (HSP)

Mental health. It is just a shocker. Even getting traumatised people to travel to [service]. Do you know how much it is like to go by public transport between here and [suburb]? Heaps of money. Those people are only on 89% of Centrelink. Do you know what I’m saying? It’s a huge ask, plus mentally finding your way, public transport, the fees, you’re in a new country. You know? (HSP)

You can imagine the impact on a medical practice when doctors themselves aren’t used to any refugees because, maybe, they don’t come here. They’re absolutely overwhelmed. Don’t know what to do. They’re not used to working with interpreters, but they should be. They make referrals that don’t go to IHMS, so you get errors occurring. [It can lead to situations where] someone’s been waiting for a counselor, psychologist, for severe mental health
torment for, like, 18 months because the GPs are in a hurry. They do 10 minute appointments, even with an interpreter. (HSP)

Other service gaps that were noted were for specialist services, pathology and chronic pain management:

[M]any of our patients have significant pain problems, it’s a huge problem. Chronic pain clinics are very good if you’re well educated and you can understand chronic pain, but most of our refugee patients can’t, so the chronic pain programs don’t work terribly well for them. Often they respond better to complementary therapy as well. We have to really put a bit more energy and funding into setting up suitable pain management systems for people with a refugee background because what is out there, apart from the fact that you can’t get in for a year or so, there’s a high dropout rate. (SSP)

Having access to mainstream health services may be convenient and reduces demand on specialist services. However, limited understanding of relevant health issues and administrative procedures can undermine their value.

13.1.2 POLICY LANDSCAPE

Planning and designing health service delivery models are complicated by a constantly shifting policy terrain. This means that services are often reacting to emerging situations, rather than being proactive after developing understanding of health needs and the resources that are available. The need to keep abreast of policy changes has also created significant challenges for staff because of the myriad associated implications for their work. Interviewees were concerned that when services are under pressure some clients did not receive their required level of care that they are entitled to receive. Clients were also often scrambling to keep up with, and understand the implications of, policy changes. Recent trends were towards ‘light touch’ forms of support eliciting concerns that this was a strategy for further reducing services and support:

[There has been quite a push for families that were previously considered high needs, and had a lot of intensive casework support where a caseworker would visit them once a week, there has been a push to move those clients from there into the lower lighter touch casework. That’s a push which has come from the department … [this] happens relatively quickly over a number of months, and means that service providers have to move quite quickly in getting those clients set up with Medicare and getting them set up and finding accommodation for them. (SSP)

It was felt that these issues were exacerbated by a scarcity of information flowing from the Department of Immigration and Border Protection:

Often the frontline health workers are the last to find out about changes in government policy, so we as a service provider may find out stuff, but it’s not necessarily our place to then pass that information to a health provider. (SSP)

Policy changes were usually disheartening, especially for clients, because they inevitably meant a tightening of conditions and eligibility. This was described by one respondent as ‘shifting the goal posts’, and delays in processing applications can both contribute to poor mental health and worsen health conditions when care and treatment is deferred. People seeking asylum with very limited government support can find it extremely difficult to locate professionals willing to provide services pro bono.

13.1.3 THE SIGNIFICANCE OF VISA CONDITIONS

The various visa conditions were concerns for many interviewees. Bridging visas limited clients’ to critical services leaving significant numbers of people with insufficient access to resources for health and wellbeing:

At the moment, that band 6 cohort makes up by and large the largest cohort of clients for us. It’s quite light touch casework support, sort of drop in casework and workshops and programs and so on delivered out of centres, rather than sort of intensive casework where it involves outreach or anything like that. (role SSP)

Asylum seekers [are] a very special category because they tend to get […] fairly deliberately, very low levels of service from their case managers at AMES, or the Red Cross if they’re in IHMS. They may have some casework, but they don’t necessarily have a lot of help in finding work and, of course, there isn’t much work around. (SSP)

Note that a summary of Status Resolution Support Classification Band Definitions are provided overleaf in Table 13.
SRSS Band 1
Unaccompanied minors in alternative places of detention are unlawful non-citizen unaccompanied minors who are accommodated in alternative places of detention (low-security detention facilities for children and families). For the purpose of the SRSS programme, an unaccompanied minor is a minor under the age of 18 years of age, who does not have a parent or adult relative who is at least 21 years old to provide a carer or supervisory role. Additional care and support services include carer support, independent observer services and transit support. SRSS band 1 recipient’s access health services through International Health and Medical Services (IHMS) for general health needs. Their accommodation needs and day-to-day care requirements are provided for by our detention services provider.

SRSS Band 2 & 3
Community detention recipients are unlawful non-citizens in immigration detention being accommodated under residence determination arrangements. This is known as ‘community detention’. The Minister must make a residence determination under s197AB of the Migration Act 1958 (the Act), in order for a detainee to receive band 2 or band 3 services. The residence determination will specify the address at which the recipient must reside and the conditions of the accommodation arrangements. The health needs of SRSS band 2 and 3 recipients are managed by IHMS through a network of community based providers.

SRSS Band 4
Transitional support services provide assistance to people who are released from immigration detention through the grant of a visa. Transitional support helps recipients transition into the community by linking them with appropriate community support services including Medicare and Centrelink. Transitional support is only available on a short term basis. To be eligible for SRSS band 4 services, recipients must have been recently released from immigration detention through the grant of a visa, require support to transition to independent residence in the community and not have access to other welfare support. For those SRSS band 4 recipients who are granted a bridging visa, SRSS providers administer a range of services that support recipients to resolve their immigration status by addressing their health and wellbeing, vulnerabilities and barriers. This support is usually provided for a period of up to six weeks, however illegal maritime arrival families with children aged 10 and under have access to additional support. Health services provided under SRSS band 4 are similar to those available to Australian citizens through Medicare.

SRSS Band 5
Community assistance support provides is provided to lawful non-citizens living in the Australian community with complex barriers to resolving their immigration status. SRSS band 5 recipients are assigned a Departmental Case Manager and a SRSS case worker to help them resolve their immigration status by addressing their health and wellbeing, vulnerabilities and other identified barriers. Health services provided under SRSS band 5 are the same as those available to Australian citizens through Medicare.

SRSS Band 6
Asylum seeker assistance scheme provides financial assistance to those assessed as experiencing financial hardship and who are seeking to engage Australia’s protection obligations through the grant of an appropriate protection or Humanitarian Visa. Support, including casework assistance, is delivered by professionals employed by the SRSS service provider to help vulnerable asylum seekers live in the Australian community. SRSS band 6 recipients may also be eligible for Medicare.

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**TABLE 13**  
**STATUS RESOLUTION SUPPORT SERVICES CLASSIFICATION BAND DEFINITIONS**

<table>
<thead>
<tr>
<th>SRSS Band</th>
<th>Definition</th>
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<tbody>
<tr>
<td>SRSS Band 1</td>
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</tr>
<tr>
<td>SRSS Band 4</td>
<td>Transitional support services provide assistance to people who are released from immigration detention through the grant of a visa. Transitional support helps recipients transition into the community by linking them with appropriate community support services including Medicare and Centrelink. Transitional support is only available on a short term basis. To be eligible for SRSS band 4 services, recipients must have been recently released from immigration detention through the grant of a visa, require support to transition to independent residence in the community and not have access to other welfare support. For those SRSS band 4 recipients who are granted a bridging visa, SRSS providers administer a range of services that support recipients to resolve their immigration status by addressing their health and wellbeing, vulnerabilities and barriers. This support is usually provided for a period of up to six weeks, however illegal maritime arrival families with children aged 10 and under have access to additional support. Health services provided under SRSS band 4 are similar to those available to Australian citizens through Medicare.</td>
</tr>
<tr>
<td>SRSS Band 5</td>
<td>Community assistance support provides is provided to lawful non-citizens living in the Australian community with complex barriers to resolving their immigration status. SRSS band 5 recipients are assigned a Departmental Case Manager and a SRSS case worker to help them resolve their immigration status by addressing their health and wellbeing, vulnerabilities and other identified barriers. Health services provided under SRSS band 5 are the same as those available to Australian citizens through Medicare.</td>
</tr>
<tr>
<td>SRSS Band 6</td>
<td>Asylum seeker assistance scheme provides financial assistance to those assessed as experiencing financial hardship and who are seeking to engage Australia’s protection obligations through the grant of an appropriate protection or Humanitarian Visa. Support, including casework assistance, is delivered by professionals employed by the SRSS service provider to help vulnerable asylum seekers live in the Australian community. SRSS band 6 recipients may also be eligible for Medicare.</td>
</tr>
</tbody>
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Settlement services use casework models that focus on the circumstances of individuals, providing integrated support to meet their needs, resolve problems and provide support through processes of adjustment. Recognising the combination of legal, accommodation, income, educational, health and psychological issues that are presented, interviewees confirmed the value of this approach. Interviewees noted, however, that increased efficiency could be gained by extending the time periods for providing casework support streamlining entitlements according to need, rather than visa band status:

"There is a lot of initial orientation, so community orientation, getting them set up with bank accounts, physically getting set up in the actual community itself. Particularly with that higher band, so that band 6 [refer to Table 5 for definitions], a lot of the work is based on delivering sort of client workshops or sessions, educational sessions, so that might be on things like money management, understanding housing laws, rights, and responsibilities in Victoria, parenting, mothers' groups, or mens' groups, understanding fines, infringements, those sort of things in Australia." (SSP)

People coming to Australia seeking asylum are not provided with similar levels of casework support and this has significant impacts on the likelihood of successful resettlement:

"Any sort of service they [asylum seekers] get seems to be only short term. They’re expected to build relationships with multiple workers who come and go, and perhaps the longest time they work with anyone is about 6 months. Even a complex case can only last for 3 to 6 months. That’s not often long enough to actually fix some of the complex problems that people have. Sometimes the GP, or the refugee health nurse is the person that they form the longest and [best] quality relationship with." (SSP)

There is a certain cohort of asylum seekers who are not considered eligible for financial or casework support under the department of immigration’s funded contract. Those clients would often fall to the unfunded sector, which is largely [picked up by] the ASRC or other sort of relief organisations [such as the] Salvation Army. (SSP)

There were concerns that inadequate provision for casework support meant that health care needs were not addressed. Without a caseworker, clients experience many difficulties negotiating an unfamiliar health care system. Some people must rely on services such as the Asylum Seeker Resource Centre and the generosity of individual service-providers to access any health care at all:

"There is a small cohort of clients that the ASRC supports, for example[ …] who are not eligible for Medicare and are also not eligible for those sort of costs to be on-costed [paid for by other services]. [They] fall through the gap [and are] reliant on people donating their time or reliant on actually having to pay for essential medical services like a GP or something like that." (SSP)

It was generally agreed that improved access to general health services would be helpful. This is because some clients have to travel long distances to receive care from nominated services providers. Transport could be costly and time consuming, especially when clients were required to travel long distances and multiple members of households required care and treatment. Clients who missed appointments were required to re-sit waiting period times. These issues are complicated by visa conditions:

"With clients that are in the band 2 and band 3 [refer to Table 13 for definitions] - band 2 and band 3 is referred to as ‘residence determination’ - we’ve previously called it ‘community detention’. Those clients are accessing health services through IHMS rather than being Medicare eligible. Some of those, there are specific GPs that they can access that have contracts with IHMS. I know that for some, there are quite a limited number of GPs. For example, there are several hundred clients that we might have in the Greater Dandenong area, and I’d say only one GP in Dandenong, one GP in Noble Park, and one in Hallam that they can use." (SSP)

"As a specific example, we had a family that was living in Mitcham. They were given or designated to attend a GP in I think it was Croydon or Croydon North, and the pharmacy was located in Blackburn. This family was required to take a train and a bus 45 minutes in one direction in order to attend a GP, then a train and a bus the other direction for 45 minutes in order to get to the pharmacy then 20 minutes from there back to their home. For a family with a young child that’s wholly reliant on public transport, this wasn’t really in line with community standards of what we would consider would be appropriate […] Those sorts of things are relatively isolated, but they do come up every now and then." (SSP)
Challenges in securing access to health services for humanitarian entrants and asylum seekers are further complicated by issues associated with having limited English-language skills and difficulties and interpreter services.

### 13.2 LANGUAGE AND COMMUNICATION ISSUES

Low or no proficiency in speaking English is by now well recognised as a significant challenge during resettlement and frequently beyond. Interpreting services are largely accessed from the national Translating and Interpreting Service (TIS). Key issues for humanitarian entrants and asylum seekers populations and those providing services to these groups are: gaining access to interpreters; quality of interpreter services; and access to health information for non-English speakers.

#### 13.2.1 UPTAKE OF INTERPRETER SERVICES

For health service providers, access to interpreter services is critical for establishing rapport with patients and understanding their situations. It impacts on treatment and care options, ensuring accurate and timely diagnoses, and ensuring that patients understand treatment regimes, referrals and other therapeutic instructions. Interviewees discussed a range of barriers in accessing interpreter services. There are ongoing concerns that health service providers are reluctant to engage interpreter services because they are perceived to be costly and time intensive, or unnecessary. Even when health service providers understand the value of interpreters, they can encounter difficulties in accessing services. These are associated with insufficient availability of interpreters, particularly from some language groups, and high demand on available interpreters. A further barrier is that funding for TIS is only available for permanent humanitarian entrant clients, and not the asylum seeker population, although many General Practitioners appear to use TIS when treating this group. Interviewees generally believed that there was room for considerable improvement in the update and organisation of interpreter services. Inadequate training for health service providers in the value and use of interpreters is associated with a reluctance to use them:

*One of the things I think is a real strength is working with interpreters generally pushes you to speak [using clear] language, and it’s a really good clinical skill. I often feel like I have whole days when I don’t use medical terminology, but I think that’s actually okay, and I think it’s something we should be training the medical students and the health discipline students. Particularly working ‘with’ interpreters, that’s another one of my soapboxes, instead of ‘using’ interpreters, I hate that. That’s bad language. We don’t use a speech pathologist, they’d rightly be very cross. And its also very much limited to medical people. We don’t encourage the nurses to pick up a phone and work with the interpreter. We just don’t.* (HSP)

Interviewees recounted stories of people being misdiagnosed and failing to diagnose serious illnesses because interpreters had not been involved in consultations and contacts with medical practice staff, including receptionists who are the first port of call when seeking assistance for a health issue. Medical specialists were identified as particularly recalcitrant when it came to involving interpreters in consultations with patients, as one interviewee noted: ‘Finding a specialist that will use an interpreter unless you’re in the public system is really hard’. (HSP)

#### 13.2.2 QUALITY OF INTERPRETER SERVICES

When health service providers attempt to use interpreter services there can be difficulties in readily accessing interpreters for some language groups. Providers and patients may strongly prefer to have interpreters of the same gender as patients for some consultations. Some providers also prefer to deal with regular interpreters to better establish common understanding of contexts and values:

*One of the problems we have at the moment with the translating/interpreting service is they won’t necessarily allow you to book a specific interpreter […] to see a client. (HSP)*

*The point of the story is that in terms of service gaps, and difficulties that we have in primary care is that, for example, if I want to see somebody and I know that this person could speak it [the specific language] they will turn around and say well we can’t send that specific interpreter, you just have to take who you can get. You might get a woman, you might get the wrong religion, you get the one interpreter that everybody hates because they reckon they don’t really speak it. All that kind of thing. (HSP)*

The use of interpreters can also raise concerns about confidentiality, particularly in small and emerging ethnic communities where clients and interpreters may share social and family networks. Clients may be concerned about judgmental responses from interpreters. This
problem is difficult to resolve until the pool of potential interpreters grows over time.

Although given less attention in many discussions of these issues, a number of interviewees reflected on the stresses experienced by interpreters who are working in challenging environments and often with inadequate support and opportunities for professional debriefing:

[W]e feel that interpreters are now dealing with a very large cohort, and very fragile people, like 25,000 people across Australia trying to put in their applications for asylum, being rejected, being suicidal. As you know, there have been increasing suicides among people. We think that interpreters need some sort of formal debriefing and support and training to assist them because they’re working in what I think is becoming an increasingly stressful time. If people start to get processed and rejected and sent back it’s just going to get really, really horrible. Other professionals usually have some mechanism of debriefing and support, but interpreters, because they’re a very casualised workforce, are often very, very vulnerable. That’s a problem I think. (HSP)

Given the prominence of issues of access to interpreter services for ensuring effective and quality care for humanitarian entrants and people seeking asylum we were keen to include analyses of the distribution of bi-lingual GPs and interpreter use across Melbourne. While our analyses of NHSD data on the location of bilingual GPs have been provided in Chapter 12, our request to TIS to access and analyse their data was denied. It is recommended that TIS make de-identified data available for future research and planning purposes, and particularly information on languages used for interpreting services across different locations and within organisations.

13.2.3 ACCESS TO HEALTH INFORMATION

Limited access to information in key languages for humanitarian entrants and people seeking asylum also remains a persistent problem. Information should be made available in a number of different languages and language spoken should not be assumed based on country of birth and considerate of cultural minority differences within regions. Furthermore, people might not be literate in their home country language so material and information that is translated needs to express messages in simple and clear ways.

13.3 THE VALUE OF DATA AND DATA GAPS

There was wide agreement among interviewees of the importance of having access to reliable and relevant data to inform the work of their organisations:

[It allows] us to do some forward planning, in particular around staffing and that sort of thing and we may want to ensure we have volunteers or staff that can speak certain languages that can assist clients when they come in for support or requesting assistance […] we can see postcodes of where clients are at, so we can ensure that we’re delivering services and running centres out of the right places which are geographically closest to where clients are. (SSP)

Being able to forward plan [that would be good] but it’s also probably the hardest to gather because in some cases that data is outside of even government policy. (SSP)

The department themselves have a portal system where we access client information and are able to pull data from there, so we are able to see number of clients that we have, the primary countries of origin, language, the band that the clients are in, that sort of data. We also have our own internal system that is used across the organisation […] that gathers primary language and secondary languages, information about religion, whether the client is Medicare eligible or otherwise, whether they have work rights or not. […] but it’s not necessarily information that, under the contract, we’re necessarily able to share a lot of that out. Often we go into meetings, and people are wanting to know how many clients have we got from this area. Some of it we’re able to provide, but specific information that’s within that portal system we’re not actually at liberty to share that. It sort of should be coming from the department to whoever needs it. (SSP)

Interviewees also noted critical gaps in data that are currently being collected. Failure to systematically record the year of arrival for humanitarian entrants is a significant issue inhibiting planning and research efforts. Some interviewees proffered a ‘wishlist’ of data that could be usefully collected:

[Year of arrival is the first priority for me, in all of our administrative data sets, because I think it just opens up possibilities for] migration related research, and it’s more important clinically, practically and
population health wise, than having specificity on refugee or asylum seeker status. Even if you did have specificity on refugee and asylum seeker, you still need year of arrival [... this information] lets you understand [...] what happens over time. (HSP)

Our refugee health program has to collect data and I don’t think they collect adequate data. I think they should be able to tell us exactly how many people they’ve seen. What proportion of them had health screening? What proportion of them had health issues? I don’t think it’s adequate to have a coordination program of this scale without having robust data. (HSP)

Country of birth, year of arrival, preferred language, and need for an interpreter. They’re the four basic fields. The reason we have preferred language is the language that they speak may not be the main language of the country if they’re an oppressed or persecuted minority in that country. (HSP)

Inconsistencies in data entry are not uncommon, particularly when entering names and details of cultural practices. One interviewee explained how these mistakes can have important consequences for health.

There’s a number of issues that have come up with being able to retrieve files because people have used different methods of naming [... these practices] trace back to the UNHCR camps on the border [...] That’s how it gets put on the Medicare card, and then when it starts going into our data systems [...] having the gaps really confuses the situation. It’s these kinds of intricacies that [...] turn into risk issues and whether you’re able to find files. (HSP)

Interviewees also raised concerns about current information technology systems in which the health records of humanitarian arrivals were kept. Data entry and retrieval are difficult and time-consuming, there are challenges in streamlining booking systems across services, and critical information is not routinely collected. Inadequate records hinder planning efforts as well as research endeavours:

We want to collect country of birth, year of arrival, preferred language, and everybody needs to collect [it]. Some of the medical software packages have some data [but] it’s not particularly searchable. (HSP)

Track is an appalling system that was rolled out by the State Government many years ago. I remember we tried to use it in our general practice, when I was in the Community Health Service. They tried to make us all use Track, it was hilarious. It took the receptionist 10 minutes to make an appointment. It was completely unusable for any reason. I remember taking the CEO and showing her the difference between Track and the appointment software and the billing software that we currently have, and she took one look and she very sensibly said, “Oh, I see the problem.” (HSP)

Basically, using the computer software integration, we don’t know what the allied health people are doing because they use a different booker. Again, integration of care is really complicated because I can send my refugee patient with chronic pain to them but they don’t usually send you a letter back. Sometimes they’ll write in notes, but not always, so I don’t actually know what they’re doing. I can’t necessarily read their diagnosis or anything. I do find that frustrating in an ongoing sense. (HSP)

Other issues included difficulties in information-sharing to promote the efficient allocation of resources and ensure that patients received adequate follow up:

[These are] problems that bedevil the system as a whole, to some extent. We get very poor communication between hospitals, hospital service, GPs, and other services, because we don’t have the electronic health record. For example, multiple [duplicate] tests are ordered, one of the things for asylum seekers is if the asylum seeker’s application is accepted, so just if you start seeking asylum in this country they’ll have to go and have a health check, you often can’t get the health record, the results. (HSP)

Access to reliable demographic and settlement patterning data is viewed as critical for effective and efficient service provision planning. Interviewees believed that there was scope for small changes in the ways in which data are collected, and the types of data that are collected, to provide accurate insights into the health service needs of humanitarian entrant and asylum seeker populations.
13.4 SUMMARY OF INTERVIEW DATA

The health professionals and other service providers that were interviewed expressed highly consistent concerns. Mental health services were clearly identified as a critical service gap yet there are high needs among humanitarian arrivals populations for these services. Moreover, improved referral processes, communication practices and software systems could enhance patients’ access to allied and specialist services. Further complicating these issues was the limited availability and use of interpreters, and bilingual health service providers - especially General Practitioners.

There was also strong agreement that there was limited potential for planning and prevention efforts and this meant that people are usually reacting to policy changes and situations presenting on the ground. Service providers had limited potential to influence policy development, despite their unique perspectives on issues. A general lack of relevant data describing geographic settlement patterns hindered the capacities of service systems to anticipate demand and plan accordingly and these issues were exacerbated by inadequate information technology systems to capture and coordinate actual service usage. Interviewees identified three essential pieces of information that should be collected from all humanitarian arrivals: year of arrival in Australia; country of birth; and preferred language spoken. This information is particularly important for anticipating needs for interpreting services.

Participants observed that refugees fared better in regards to gaining access to key services and resources than asylum seekers, however, refugees suffered from the inflammatory political and public discussion around the issues of maritime arrivals. This promotes racism and can lead to the poorer treatment of humanitarian arrivals within the health system. Cross cultural training and awareness at all levels of the health service system would promote more effective engagement between patients with refugee and asylum seeker backgrounds and generally smoother settlement processes.
14. KEY FINDINGS AND RECOMMENDATIONS

The central objectives of the HAHS research project were to identify data sets to describe the spatial distribution of humanitarian arrivals across metropolitan Melbourne, link this information to the location of bilingual GPs and extend the quantitative data with key informant interviews.

Data gathering was a complex and time consuming process but use of the ABS ACMID and Settlement Database have proved very useful and clearly identify clustered and changing patterns in the distribution of humanitarian arrivals across Melbourne and Victoria, particularly across time, place, culture and language. An unexpected success of the research project was partnership and collaboration with AMES leading to unique access to the most recent AMES settlement services data from 2013-2015.

All three data sources confirm an uneven distribution of humanitarian arrivals across metropolitan Melbourne with the LGAs of Brimbank, Casey, Greater Dandenong, Hume and Wyndham home to the majority of humanitarian arrivals within Victoria. The most recent AMES data clearly identifies Arabic as the dominant language spoken by humanitarian arrivals but there are also large proportions of people who speak Dari, Karen, Hazaragi and Farsi/Persian. The distribution of these populations cluster around suburbs located in the outer western, north-western, outer northern, outer eastern and south-eastern areas of Melbourne with a growing community in the City of Greater Geelong. Other areas with significant proportions of humanitarian entrants include the LGAs of Maroondah, Maribyrnong, Moreland and Greater Shepparton in rural Victoria. These LGAs are very unique and some areas have large proportions of people from similar countries – e.g. 75% of the Hume LGAs humanitarian arrival population being from Iraq – compared to much greater diversity in the LGA of Brimbank with smaller proportions of people from many different countries with fewer common languages.

Extreme diversity or superdiversity (Davern et al., 2015; Philimore, 2011) leads to even greater challenges in service provision and planning, particularly in terms of language and interpreting needs. It is important to note that data included in this report did not identify humanitarian arrivals in some areas of regional Victoria including East Gippsland and secondary migration cannot currently be traced using any existing data sources. This is a key finding of this report and future research should address secondary migration of humanitarian arrivals through additional longitudinal research.

Many months were spent sourcing data on GPs who spoke a language other than English with no consistent data available across the state. Some organisations had completed local audits but a substantial finding from this research was the lack of services and resources connecting bilingual GPs with other Victorians (not only humanitarian arrivals) who spoke languages other than English. A key finding of this research has been the production of maps of bilingual GPs according to language that also describe a spatial miss-match between the location of medical practitioners that are bilingual and recent humanitarian arrivals based on AMES data. These data could be further expanded in many useful ways to assist service providers that require ready, and easy access to the information. Further research should also investigate bilingual health practitioners within other allied health professions, particularly mental health (as identified through the key informant interviews) which is an underutilised but extremely important service for humanitarian arrivals who have often experienced trauma before arriving in Australia. It is also recommended that the Australian Health Practitioner Regulation Agency and associated professional boards collect language skills of all health practitioners during annual registration processes.

Future research could also investigate the development of a new app that would provide a directory of health practitioner details according to languages spoken for different areas. Future research is also needed to investigate the implications of bilingual health
practitioners in the treatment and service provision of humanitarian arrivals. It is important to note that not all bilingual speakers will have an understanding of the complexity of circumstances that humanitarian arrivals face and could be of completely different class, religious, ethnic or cultural backgrounds that have implications in service provision.

Communication was a very common theme raised by key informant interviews. Communication with humanitarian arrivals using better qualified and more available interpreters, better communication between health practitioners, improved information technology systems as well as cultural and interpreter training for medical students, allied health and professional staff working within a range of health service environments. Policy environments were constantly changing and client entitlements constantly changing in response to these. However, these changes need to be communicated and explained within the context of the literacy and communication barriers that humanitarian arrivals face. This includes literacy in english, literacy in their native language, health literacy and literacy of the local health and hospital systems. Being unable to speak in a language they understand or access an interpreter they feel comfortable with further complicates these issues. Inconsistent, short-term, overworked and under-resourced case management and Refugee Health Nurses are further factors restricting health and wellbeing outcomes.

Housing has not been closely examined within this research project but SEIFA analysis based on 2011 ACMID and SEIFA IRSD data clearly identified that two-thirds of Humanitarian Visa holders were living in the 20% most socioeconomically disadvantaged areas of Victoria. Housing is another factor that is a clear determinant of location for all humanitarian arrivals and housing movements most likely responsive to rental prices which are often less expensive in outer urban areas with poorer access to social infrastructure, public transport, education and employment opportunities. Broader social determinants of health have not been addressed within this research but clearly influence health service provision, long term settlement in Victoria and health outcomes of humanitarian arrivals. Recommendations for policy and practice based on the the key findings of this research are summarised on the following page.
Greatest support for humanitarian arrivals is needed in the Melbourne LGAs of Brimbank, Casey, Greater Dandenong, Hume and Wyndham which are home to the majority of humanitarian arrivals within Victoria. The LGAs of Maroondah, Maribyrnong, Moreland, Greater Geelong and Greater Shepparton also have growing populations of humanitarian arrivals.

Data needs to be collected to measure and monitor secondary migration of humanitarian arrivals in Victoria. Future research should also address the issues associated secondary migration of humanitarian arrivals through additional longitudinal research.

Year of arrival in Australia, country of birth and preferred language spoken are the three essential pieces of information that should be routinely collected for all humanitarian arrivals.

The mapped data of bilingual GPs included in this report should be made available to the general community and also expanded to include other bilingual medical practitioners and allied health workers.

Additional training needs to be provided to GPs, medical practitioners, allied health professional and front line administrative staff to build their knowledge and skills in working with humanitarian arrivals and interpreters. This includes training and practical guidelines and toolkits on how to work with interpreters and how to complete Refugee Health Assessments. These should be delivered through the combined support of Primary Health Networks, the Royal Australian College of General Practitioners, undergraduate teaching and community health centres.

Advocate for the inclusion of an additional Medicare “Interpreter Item Number” similar to a Long Consultation Item to incentivise the use of interpreters. An additional fee of $5 could decrease the barriers of time and money that prevent GPs in working with interpreters.

Interpreters need additional training on the importance of informed consent and additional support for debriefing. This is particularly important when interpreting languages from a small community where confidentiality is difficult to maintain.

Further research is needed on the experience and needs of mental health professionals working with humanitarian arrivals.

The Australian Health Practitioner Regulation Agency and associated professional boards should collect language skills of all health practitioners during annual registration processes.

More general literacy and health literacy support is needed for humanitarian arrivals. This includes literacy in English, literacy in their native language, health literacy and literacy of the local health and hospital systems. Being unable to speak in a language they understand or access and interpreter they feel comfortable with further complicates these issues.

More support is needed for case management and Refugee Health Nurses. Inconsistent, short-term, overworked and under-resourced case management and Refugee Health Nurses are factors limiting the health and wellbeing outcomes of humanitarian arrivals.

More housing support is needed for humanitarian arrivals in Victoria. Two-thirds of Humanitarian Visa holders were living in the 20% most socio-economically disadvantaged areas of Victoria with housing affordability a large barrier to health, social and economic outcomes. Future research should investigate the impact of broader social determinants of health on long term health outcomes in humanitarian arrivals and health service provision needs.

RECOMMENDATIONS

1. Greatest support for humanitarian arrivals is needed in the Melbourne LGAs of Brimbank, Casey, Greater Dandenong, Hume and Wyndham which are home to the majority of humanitarian arrivals within Victoria. The LGAs of Maroondah, Maribyrnong, Moreland, Greater Geelong and Greater Shepparton also have growing populations of humanitarian arrivals.

2. Data needs to be collected to measure and monitor secondary migration of humanitarian arrivals in Victoria. Future research should also address the issues associated secondary migration of humanitarian arrivals through additional longitudinal research.

3. Year of arrival in Australia, country of birth and preferred language spoken are the three essential pieces of information that should be routinely collected for all humanitarian arrivals.

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5. Additional training needs to be provided to GPs, medical practitioners, allied health professional and front line administrative staff to build their knowledge and skills in working with humanitarian arrivals and interpreters. This includes training and practical guidelines and toolkits on how to work with interpreters and how to complete Refugee Health Assessments. These should be delivered through the combined support of Primary Health Networks, the Royal Australian College of General Practitioners, undergraduate teaching and community health centres.

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7. Interpreters need additional training on the importance of informed consent and additional support for debriefing. This is particularly important when interpreting languages from a small community where confidentiality is difficult to maintain.

8. Further research is needed on the experience and needs of mental health professionals working with humanitarian arrivals.

9. The Australian Health Practitioner Regulation Agency and associated professional boards should collect language skills of all health practitioners during annual registration processes.

10. More general literacy and health literacy support is needed for humanitarian arrivals. This includes literacy in English, literacy in their native language, health literacy and literacy of the local health and hospital systems. Being unable to speak in a language they understand or access and interpreter they feel comfortable with further complicates these issues.

11. More support is needed for case management and Refugee Health Nurses. Inconsistent, short-term, overworked and under-resourced case management and Refugee Health Nurses are factors limiting the health and wellbeing outcomes of humanitarian arrivals.

12. More housing support is needed for humanitarian arrivals in Victoria. Two-thirds of Humanitarian Visa holders were living in the 20% most socio-economically disadvantaged areas of Victoria with housing affordability a large barrier to health, social and economic outcomes. Future research should investigate the impact of broader social determinants of health on long term health outcomes in humanitarian arrivals and health service provision needs.
14. REFERENCES


