



Minerva Access is the Institutional Repository of The University of Melbourne

Author/s:

Fernandez, B;Athukorala, H

Title:

Care Support Experiences of Older Ethiopian Refugees Resettled in Australia

Date:

2022-07-29

Citation:

Fernandez, B. & Athukorala, H. (2022). Care Support Experiences of Older Ethiopian Refugees Resettled in Australia. *Australian Social Work*, 77 (1), <https://doi.org/10.1080/0312407X.2022.2101935>.

Persistent Link:

<https://hdl.handle.net/11343/333062>

Care Support Experiences of Older Ethiopian Refugees Resettled in Australia

Bina Fernandez¹
Handun Athukorala²

¹*School of Social and Political Sciences, University of Melbourne, Australia;*

²*Western Sydney University Online, Australia*

Correspondence to: Associate Professor Bina Fernandez, Development Studies, School of Social and Political Sciences, The University of Melbourne, Room E475, John Medley East, Parkville, VIC 3010, Australia. Tel: +61 3 83443205; email: bfernandez@unimelb.edu.au
ORCID 0000-0002-1611-7217

Abstract

Drawing on qualitative research, the authors analysed the care support experiences of older Ethiopian refugees resettled in Australia. In-depth interviews conducted with 12 Ethiopians revealed that older Ethiopians experienced language and cultural barriers in accessing formal care services, and that they often did not view these services as entitlements they were due as citizens. Findings demonstrated a significant familial orientation to expectations around, and provision of, care support to older Ethiopians, which may be under-recognised in the Australian social work context. The authors argue that given this familial orientation and the difficulty in accessing formal care services, the reconfiguration of care relationships post-resettlement has resulted in increased reliance on adult daughters' attenuated capacity to meet the care needs of older parents, which raises serious concerns about the long-term viability and gender equity of such arrangements.

Implications Statement

- Older Ethiopian refugees resettled in Australia may experience “care poverty” due to unmet needs for aged care services. Social work practice to redress this should recognise gendered cultural and linguistic barriers to services, and provide effective, culturally competent translation services.
- The familial orientation of elder care amongst Ethiopians may potentially over-burden adult daughters who are care-givers; care support policies should therefore aim to provide services to prevent gendered care inequalities.

Keywords

Aged care, Ethiopian, resettled refugee, Australia, gender equity, care inequality

Aged care policies in Australia have increasingly focused on enabling older populations to live independently and out of formal aged care for as long as possible. The aged care system is funded and managed by a combination of local, state, and federal government, non-government, and private agencies. Since 2016, government-funded aged-care programs have been consolidated into three types of care support: residential aged care; the Commonwealth Home Support Program (CHSP); and Home Care Packages (HCP). CHSP and HCP provide access to similar services, including in-home assistance, allied health services, nursing, and respite care.

The key difference is that CHSP provides one or two basic home-based services, either short-term or on an ongoing basis, while HCP is for people who need additional services, with four tiers of package to meet varying levels of need¹.

Research on refugees from cultural and linguistically diverse backgrounds points to the intersecting and compounding challenges they face due to their age, their refugee status, and their backgrounds. Older refugees can have many physical and psychological health issues due to years of deprivation of food, shelter and medical care, prolonged experiences of physical violence, torture and trauma, together with age-related diseases and disabilities such as sight, hearing, and memory loss, and mobility impairment (Atwell et al., 2007; NGO Committee on Ageing, 2018; NSW Refugee Health Service, 2018). Further, transitioning into a new sociocultural context in later stages of life can cause high levels of stress and challenges in adaptation and service utilisation due to limited resources, knowledge, awareness, funding, and established community support networks to care for, or advocate on behalf of older refugees (Atwell et al., 2007; Bartolomei et al., 2002). Significant challenges are also generated by cultural and linguistic differences, producing social isolation and feelings of disconnection as networks of friends and family may be weakened or severed and older refugees experience the loss of support and freedom (Atwell et al., 2007; Bartolomei et al., 2002; Slewa-Younan et al., 2016), or undergo language reversion with age (Tipping & Whiteside, 2014). Therefore, older refugees from culturally and linguistically diverse backgrounds often also face difficulties when accessing health services, food, and shelter. In addition, lower health literacy among culturally and linguistically diverse communities may result in a lower uptake of formal services and supports. Studies have shown that older people from culturally and linguistically diverse backgrounds have limited English language proficiency, as acquiring a new language is more challenging for older people than other age groups (FECCA, 2015; Ip et al., 2007); and that older people from culturally and linguistically diverse communities encounter difficulties in the utilisation of care services and in consultations with medical and care professionals (Bartolomei et al., 2002; Teshuva & Wells, 2014). Further, research on ageing and mental health has found that older people from culturally and linguistically diverse backgrounds have a higher risk of mental health issues than other Australians and evidence underuse of mental health services (Federation of Ethnic Communities Council of Australia [FECCA], 2015). Due to these unique sets of challenges, older people from refugee backgrounds may have higher resettlement needs compared to refugees from other age groups or other older persons from culturally and linguistically diverse backgrounds.

Research on caregiving among many refugees and culturally and linguistically diverse communities has found a strong cultural expectation of family-based caregiving (Atwell et al., 2007; Ip et al., 2007; Morse & Messimeri-Kianidis, 2002; Teshuva & Wells, 2014). Caring for older people is often considered a duty of children and it is considered shameful to seek outside help to perform these responsibilities (Atwell et al., 2007; FECCA, 2015; NSW Refugee Health Service 2018). A study undertaken by Carers Victoria, for example, found that there were notable differences in attitudes toward, and uptake of, the use of professional carers' support services between carers from six target ethnic groups studied (Cole & Gucciardo-Masci, 2003). This orientation to family-based caregiving for older people has been more widely observed;

¹ For further information, see the Australian Government's portal on aged care services *My Aged Care* (<https://www.health.gov.au/initiativesand-programs/my-aged-care/about-my-aged-care>).

ageing and health research in the United States of America by Knight and Sayegh (2010) used the concept of “familism” to explore the interplay between values and beliefs and the physical and mental health outcomes of caregivers and the older family members being cared for. A gendered dimension to this familial orientation has also been highlighted, with research on culturally and linguistically diverse communities in Australia demonstrating that women have a higher burden of responsibility in caring for older members of the family compared with men (Abbato & Durham, 2011; Morse & Messimeri-Kianidis 2002). For example, a small study of Russian-speaking women in Melbourne found women caregivers tended to under-utilise social welfare support for family caregivers from the Australian Government, “based on their expectations of the gendered and private nature of their role on the social policies in countries of their origins” (Victoria Team et al., 2007, p.397).

While forced migration can reconfigure care relationships in that refugees adapt to care services and care practices in a new context, it should be noted that Australian research on care experiences of older refugees has tended to focus primarily on the needs of well-established migrant and refugee communities from Europe and Asia. Findings from recent research into the resettlement experiences of African communities in Australia (Abdelkerim & Grace, 2012; Ochala & Mungai, 2016) has highlighted a need to better acknowledge the diverse ageing population and to address the relative paucity of information on the aged care experiences of African communities.

Ethiopian refugee arrivals in Australia began in 1991, on humanitarian and family reunification visas. The largest numbers (around 3,000) arrived between 2000 and 2005, many of whom were single women and their children (Evason, 2018). The Australian Government granted a further 1,345 humanitarian visas to Ethiopia-born refugees between 2012 and 2017 (Evason, 2018). According to the Australian Government (Department of Home Affairs, 2016), the 2016 Census recorded 11,792 Ethiopia-born people in Australia, an increase of 39.5% from the 2011 Census, and over half (54%) of these people resided in Victoria. However, since the Australian Government has placed restrictions on family visas and parent visa migration, many older family members of Ethiopians refugees have been unable to, or have chosen not to come to Australia. Consequently, only 2.5% of the Ethiopian-born population in Australia was over 65 years in 2016 (Evason, 2018). These relatively small numbers can potentially place older Ethiopians at risk of marginalisation from aged care policies in Australia.

Current Research

The aim of this article was to explore the care needs and care support experiences of older Ethiopian-born Australians, both refugees and migrants, who have resettled in Australia, and who are an under-researched community. The current study drew on a subset of data from a larger research project on the care needs of Ethiopian refugees and migrants. The analysis discussed in this particular article aimed to examine the care support available to older Ethiopians from emic perspectives, to explore the subjective meanings participants attached to these experiences of care support, and to analyse these experiences within the participants’ social context. The authors drew on Hill’s (2021) conceptual framework of “care poverty” and “care inequality” to analyse older Ethiopians’ experiences of care support. Hill defined the concept of “care poverty” to describe a fundamental deficit with regard to human needs, and “care inequality” to describe inequitable access to formal care services, as well as other inequalities in

access to informal caregiving, service literacy, and efficacy in navigating the aged care system. Consonant with Hill's (2021) framework, the focus of this study was on unmet care needs of older Ethiopians (for formal services and informal support), their carers (paid or unpaid), and the relationship of the care dyad (or network).

Method

This study was designed as an exploratory study (Stebbins, 2001) within a qualitative, interpretivist paradigm (Hennink et al., 2020). Research ethics clearance was obtained from the University of Melbourne Human Research Ethics Committee. Semi-structured interviews were conducted by the first author, with the assistance of interpreters in the Ethiopian ethnic languages of Amharic, Tigrinya, and Oromiffa. Initially, the first author attempted to recruit participants directly at Ethiopian community events but these individuals were reluctant to be interviewed. Their reluctance was due to the author's non-Ethiopian identity and their wariness about whether, as former refugees, they or their families (in Australia and Ethiopia) would be endangered in any way by the research. Subsequently, the first author approached and secured the support of two community organisations: the Horn of Africa Communities Network and the Australian Oromo Community Association. Both organisations played an invaluable role in facilitating contact with interviewees, vouchsafing the research and the author's credentials, and reassuring participants about their safety concerns.

A purposive sample of older Ethiopians above the age of 60 was identified by the two community organisations. Individuals who expressed willingness to participate were contacted by the interpreter, who set up a time and location convenient for them to meet the researcher. At the meeting (either in the participant's home or a public place), participants were oriented to the study, provided with a plain language statement in their language, and their written consent to participate was obtained. Interviews were audio recorded with consent, and lasted between 45-90 minutes. Interviews inquired into the participants' migration trajectories, employment, family histories, and care arrangements (formal and informal support, including the gendered division of care responsibilities among family members). Interviews were translated and transcribed in English. Interview transcripts were coded by the second author using data-driven coding. The first author cross-checked and confirmed the emergent four key themes and subthemes, developed an inductive analysis from the coded data, and selected quotations to illustrate the analysis presented in this article.

Findings

Demographic Characteristics

Findings of this research were based on in-depth, semi-structured interviews with 12 Ethiopians living in and around Melbourne. Nine were older men and women aged between 60-75 years, and three were adult daughters who were caregivers for older parents. Details are shown in Table 1. Two interviews were paired (husband-wife and parent-adult child pairs) conducted to elicit information from different positional perspectives within the family (Wilson et al., 2016), and to offer insight into the care dyad (Hill, 2021).

Insert Table 1 about here

Themes

Four primary themes were identified from coded interview data: language and cultural barriers; challenges accessing care support; the importance of family and community bonds; and attitudes to residential and home-based care programs.

Language and Cultural Barriers

Unsurprisingly, since most older interviewees spoke little or no English, an emergent theme was the language and cultural barriers they experienced in access to care, despite the availability of interpreters in their own languages for consultations with doctors and other care service providers. Variation in interpreter accents, reluctance to complain about interpreters, the gender of the interpreter and care provider, and the gendered attitudes of shame in talking about intimate care needs were key subthemes identified as barriers.

Several older people as well as their adult children interviewed expressed dissatisfaction with interpreters' failure to effectively communicate healthcare needs. Consequently, older people were often dependent on their adult children for information about, and access to, care services. Lalistu², a young Oromo woman, said that she would accompany her mother to the doctor: "She doesn't speak English. Her speech is very weak – so... I have to go [with her]. I have to be involved in her care like 110 percent". Even when interpreters were used, another Oromo woman, Rabiya, pointed out that her mother felt these interpreters did not properly understand their accents: "We have different accents... So, when she gets an interpreter, they don't have our accent. She doesn't understand many things... That's why I said, okay, let me help you". In a separate interview, Rabiya's mother, Meeto, also observed that it was difficult to be critical of the interpreters as she recognised this could damage a compatriot's reputation and livelihood: "You see, you cannot easily tell that person you are not speaking my language properly because you know it is his job and know that he is an African fellow who is trying to make a living".

Finally, in addition to language, gendered cultural barriers could pose significant challenges, particularly for older women. Meeto went on to explain how initially she experienced embarrassment speaking to doctors about her post-trauma depression and multiple physical problems:

Elders like me are still conscious of our culture. In our culture we keep certain things secret, we are nervous to openly [...] tell doctors if we feel sick in our reproductive organs... I would not tell my doctor openly about my mental health condition, incontinence and the complication I had due to medication, thinking that the doctor may despise me...

For some women, the gender of the doctor or the interpreter, or both, could also be troubling, particularly when communicating what were perceived as intimate healthcare needs. As Boorana, an older Oromo man observed, his wife was not comfortable with male interpreters:

² Pseudonyms have been used throughout this article to ensure anonymity of participants.

“She didn't want a male interpreter, but female interpreters can't be found everywhere as you want...Hence when we were in Adelaide and when we came here, I used to go with her”. Therefore, we observed that older Ethiopians have continued to rely significantly on family members to cope with language and cultural barriers to accessing care support, and that these barriers were more acutely felt by older women.

Challenges Accessing Care Support

Respondents reported multiple other challenges to accessing care support, which pointed to unmet care needs. Challenges included difficulties in adjusting to a new context, navigating a complex care system, and restricted financial support that did not cover the high cost of care. Here too, respondents reported reliance on informal care support from adult daughters. While a few participants were able to maintain social connections and access community support, some older Ethiopians' mobility, and therefore access to social support, was negatively impacted due to their deterioration in health. Daniel and Fiyori, a Tigrayan couple who arrived in Australia as older people, initially found adjusting to the new context very challenging. As Daniel observed: “Because I came as an older person, everything was upside down. The children were okay. Because they are young, they could understand”. Daniel spoke of the challenges they faced in learning to navigate the Australian welfare system, and said that he and his wife worked to mutually support each other. After his wife became chronically unwell, he and his children had to take care of her and the household maintenance responsibilities, and he began to receive a carer support allowance. Notably, in her interview, Fiyori did not mention Daniel, but rather spoke of how their daughter, Elsa, was the primary source of care support for her after her knee surgery 8 years previously, saying that: “[Elsa] leaves her home to be with me, if she doesn't come, she calls me. She looks after me day and night”. Similarly, Sara, another older Tigray woman, who had more serious mobility difficulty than Fiyori, had also been assigned a carer who would assist with household maintenance work.

The lack of mobility and the deterioration in health made it challenging for older Ethiopian women like Fiyori and Sara to maintain social connections with other Ethiopians. As Fiyori pointed out: “When I first got here, I used to visit friends, but ... now that I am not so healthy, I stopped visiting people. I just go to church and get back home”. However, Fiyori's daughter, Elsa, has played a role in her social support network by linking her with a local organisation that coordinated regular outreach support with older Ethiopian women:

Fiyori: They came with a car and would take us. We were four old women and they would take us out, to the sea. They ask us if we have shopping and help us with that.

Interviewer: All Ethiopians?

Fiyori: They help anyone, but we were four Ethiopians. I have been going for one year now, but the other three Ethiopian women were in the program for long time.

Daniel and Fiyori received fortnightly pension payments through Centrelink, and additionally received the carer support allowance due to Fiyori's continued difficulty with mobility after the operation. However, Fiyori said these payments were not enough to cover the cost of the medication she needed. In his interview, Daniel said that the payments were not enough to meet their needs, but also observed: “If you don't work, if you depend on the government, there is nothing you can do except accept [what you get]”. A similar point of view was echoed by Robel,

another older Tigrayan man. Robel and his wife were a childless couple, who had resettled in Australia in 2004. Robel's wife had diabetes and hypertension, and like Daniel, Robel was primarily responsible for his wife's care and received a carer support allowance. The couple was similarly dependent on their pension payments from Centrelink:

Even if it's not enough, it must be enough. We just accept it, there is no other option... The fact that we are here and don't get what we want is due to our unemployment and we don't put that on anyone else.

These interviews highlight shifts in gender relations, as older women become unwell and men take on some of what were traditionally perceived as women's domestic responsibilities. However, the burden of care was also shifted onto children, particularly daughters. The interviews highlighted a sense of gratitude for the formal care support accessed from the government, but also revealed that the support was experienced as inadequate to meet the needs of older Ethiopians. Importantly, respondents appeared resigned to coping with unmet care needs, and did not view care support services as an entitlement that they were due as Australian citizens.

Importance of Family and Community Bonds

Respondents emphasised the importance of family and community bonds in different ways: they spoke of intense isolation experienced during initial resettlement that led some to relocate to Melbourne in order to be connected to a larger Ethiopian community. Interviewees also reported significant transnational care connections and obligations for older family members who remained in Ethiopia and the countries of first asylum. Ethiopians place strong emphasis on family and community life: "mahiberawi nuro" (collective life, in Amharic) refers to the social, emotional and financial mutual support provided by family and community (Evason, 2018). Interviewees viewed connection to family and community as an integral characteristic of Ethiopian culture that resettled refugees carry with them to Australia. As Isaias, an older Ethiopian man who was living temporarily on his own because his wife had returned to Ethiopia for a short while, observed: "My life becomes good with my family. Right now, I was alone, until my daughter came two days ago to visit... For us Ethiopians, it's really hard to live alone. We can't do it. It's bad for us".

Several interviewees recounted that although they were initially resettled by the Australian Government in regional areas and other cities such as Darwin, Adelaide, or Hobart, within a few years (and in a few cases, months), they moved to Melbourne in order to be better connected to their community. For instance, Robel and his wife were childless and had no family or friends in Australia when they arrived: "I arrived in Tasmania and my main problem was being a stranger and I was very lonely. I was a stranger and it was quite different from Ethiopia and it affected me and my wife". Since their initial resettlement in Launceston, Tasmania was deeply isolating for the couple, after three years they decided to move to Melbourne.

Beyond family, wider community connections of mutual support were strongly evident, particularly within the Oromo community. The Australian Oromo Community Association played an important bridging role, helping newly arrived Oromos to connect to the community, and providing them with important information and insights on how Australian systems worked.

Crucially, for some who were separated from immediate family in Kenya or Ethiopia, the association had supported them to apply for family reunification visas. An older Oromo woman spoke of how the Association had collected money to fund and support her to make, an application to bring her adult children to Australia under the family reunification program. Similarly, another woman was being supported by the Association to process an application for her adult son who was in Kenya to join her in Australia.

An important emergent subtheme was the significant level of transnational caring for older family members who remained in Ethiopia and the countries of first asylum (Kenya in particular). There was a strong sense of emotional connection and obligation to these family members, and several respondents were financially supporting family members overseas. Hawwani, an Oromo woman in her 40s, spoke not only of financially supporting her older father who was still in Ethiopia, but also of travelling back to care for him when he was hospitalised a few years earlier. She ensured that he was moved from a regional hospital at Dukem to a private hospital in Addis Ababa, where he would get better quality care, and she remained in Ethiopia for two months until her father was fully recovered. Respondents recognised that the hardships family members overseas faced were often more gruelling, with little or no government or other support. Therefore, they felt obligated to share even from their limited resources. As Daniel observed, he and his wife Fiyori alternated sending money from their welfare payments to their respective families in Ethiopia: “Even though the money we have is not excess, we are sharing it, so, we have to share this money on the basis of the need. My family needs, we send them; if her family needs, we send them”.

Attitudes to Residential and Home-based Aged Care

Respondents stated that although they or their aged parents might need care support services, aged care homes were not something they would consider; rather, they expressed a marked preference for home-based care. However, their reasons differed by generation, with older Ethiopians expressing fears of being neglected or mistreated in residential aged care homes; while the younger generation of adult daughters felt that home-based care support would be a better option to help them balance competing demands. For older migrants like Daniel, in part, this rejection was due to lack of familiarity with such residential aged care institutions, and a fear of being neglected, as he said: “First, I don’t know its benefits and harms. I will be cast away there. You are thrown there, and they think you are useless... I prefer to go to my graveyard from my home, instead of going there”. The fear of being discarded and neglected was also the reason why Fiyori vehemently rejected the idea of an aged care home. Others like Meeto did not like the idea of being separated from their families: “I like living with my community but I don’t want to live in an aged care house...I want to [live with and] see my children, I want to look after them”. Such views were not necessarily contingent on the older person having children willing to provide some level of care and support, as Robel and his wife had not considered residential aged care an option, even though they were childless and had no family connections in Australia: “We haven’t thought of anyone taking care of us when we get older, but we believe God will take care of us”.

In contrast to the largely negative views on residential aged care, there was positive endorsement of home-based care support. This endorsement was strongest from the younger generation

Ethiopian women who were often the caregivers of older parents. In the words of Rabiya, who was caring for her mother Meeto:

My mom she doesn't want to [go into residential care]. She said better to take me back to Kenya... The solution is maybe someone to help her, you know, come to help her in the house. I think for us it would be much easier.

Rabiya went on to say that she was under a lot of stress balancing the care for her mother Meeto alongside bringing up her two young children and also trying to complete a degree, and that she was therefore in favour of home-based care services for her mother.

Discussion

Findings reported in each of the four identified themes resonate broadly with other research on older people from culturally and linguistically diverse communities in Australia. For instance, previous observations that older people from such backgrounds encounter barriers in accessing medical and care services due to their limited English language proficiency (Bartolomei et al., 2002; Teshuva & Wells, 2014, FECCA, 2015; Ip et al., 2007) were also true for participants in this study. Additionally, this study has pointed to ways in which these barriers have persisted *despite* the presence of interpreters. Importantly, the study has also highlighted the unequal gendered dimensions of access to care, first in that older women experienced gendered cultural barriers more acutely with regard to shame and reluctance to speak about intimate healthcare needs to strangers, particularly men; and second, that the primary burden of caregiving seemed to be shifted onto adult daughters. Although the allocation of primary caregiving responsibilities was similarly gendered even in Anglo-Australian and other culturally and linguistically diverse communities (Abbato & Durham, 2011; Morse & Messimeri-Kianidis 2002, Victoria Team et al., 2007), an additional gendered expectation observed in this study was that some adult daughters who were caregivers became responsible to fill in the gap for their older parents' unmet care needs due to language and cultural barriers.

Further points about access to care support arising from the narratives of Daniel, Fiyori, and Robel are worth emphasising. First, despite limited knowledge of English, they were able to access the carer support allowance. With the assistance of their daughter, Elsa, Fiyori also accessed a community outreach support program. Second, interviewees expressed a deep sense of gratitude for the support received from the Australian Government, particularly in contrast to the lack of support they had prior to coming to Australia. However, as both Daniel and Robel's interviews indicated, they did not view this support as a right that they were entitled to as citizens, and thought that they should accept whatever they received, even if it did not fully meet their needs. Finally, the finding that the older Ethiopians in this study relied heavily on family members for care support resonates with research that has pointed to "familism" (Knight & Sayegh, 2010) in caregiving for older people. Studies examining access to aged care services and support in culturally and linguistically diverse communities in Australia have indicated that cultural beliefs and values hold aged care as a private family responsibility, which reduces the likelihood of these community members reaching out and accessing formal aged care services and supports (Atwell et al., 2007; Ip et al., 2007; Morse & Messimeri-Kianidis, 2002; Teshuva

&Wells, 2014; Cole & Gucciardo-Masci, 2003). Familism was strongly evident among Ethiopians in this study; it was evident in the strong resistance of older Ethiopians to residential aged care, and in their preference for home-based care. The Ethiopian “familial” orientation to aged care is unsurprising, particularly given that the family is the primary provider of care in Ethiopia, in the transit countries, and in Australia. Ethiopian familism is also apparent in the importance given by respondents to transnational care, particularly for older family members left behind in Ethiopia or other countries, which continues to form part of the caring responsibilities of those who are resettled in Australia.

Limitations

A key limitation of the study was that due to language and resource constraints, some loss of nuance was possible as interviews were interpreted and translated, and the study could not afford participants the opportunity to check transcripts in their own languages. A further limitation is that, as this article drew on a small sample restricted to Ethiopians living in Melbourne, there may be issues that are not reflected in the analysis, for example, the concerns of older Ethiopians based in regional and other parts of Australia.

Conclusion

Results of this study have raised important issues that impact on older Ethiopians’ experiences of care support. First, that older Ethiopians frequently experience language, cultural, and gender barriers in accessing aged care services. As Hill (2021) observed, we can view such unmet needs for aged care through the concept of “care poverty”. Notably, if the support services older Ethiopians received were insufficient, they tended to “make do” with what they received, as they did not view these support services as an “entitlement” they were due as citizens, or that they were entitled to seek more or better services. Second, this study, which focused on older Ethiopian refugees resettled in Australia, suggests that consideration of “care inequality” (Hill, 2021) should also extend to their carers, as it is often women who provide the greatest amount of informal familial care to their ageing parents, and provide them with crucial assistance to negotiate the gaps and barriers in access to care services. These women may carry multiple responsibilities, as they care for their own children, undertake study or employment, and thus experience pressure and shame if the care needs of their older family members cannot be met. Therefore, it is important to recognise the effects of familism on the caregiving process, rather than implicitly assuming that familism has positive effects on caregiving. This study observed that the reconfiguration of care relationships post-resettlement could result in the increased reliance of resettled Ethiopian refugees on adult daughters, on their attenuated and overstretched capacity to meet the care needs of older parents. This in turn raises serious questions about the long-term viability and gender equity of such arrangements. To further develop the insights from this exploratory study, it would be necessary to investigate other dimensions of inequalities in access to, and quality of aged care, and the consequences of unmet needs for care on both the older person and the carer.

Acknowledgements

The first author received funding from an Australian Research Council Discovery Early Career Researcher Award (DE150100443) to conduct field research for this study. She also gratefully

acknowledges the invaluable support of the Horn of Africa Communities Network and the Australian Oromo Community Association in Melbourne in recruiting research participants for the study; as well as the excellent assistance in interpretation of interviews in Tigrinya, Amharic and Oromiffa provided by Godefa Gher and Dr Oush Nure.

References

- Abbato, S & Durham, J. (2011). *Ageing your way, my way – working together: spiritus research into the emerging ageing CALD communities in Brisbane*. Spiritus HACC multicultural program.
- Abdelkerim, A., & Grace, M. (2012). Challenges to employment in newly merging African communities in Australia: a review of the literature. *Australian Social Work*, 65(1). <https://doi.org/10.3316/mais.53130>.
- Atwell, R, Correa-Velez I, & Gifford S.M. (2007). Ageing out of place: health and well-being needs and access to home and aged care services for recently arrived older refugees in Melbourne, Australia. *International Journal of Migration, Health & Social Care*, 3(1), 4–14.
- Department of Home Affairs. (2016). *Ethiopia-born community information summary* <https://www.homeaffairs.gov.au/mca/files/2016-cis-ethiopia.PDF>.
- Bartolomei, L, Hugman, R & Pittaway, E. (2002). 'You never stop being a refugee': the special needs of older refugees. Centre for Refugee Research and School of Social Work, University of New South Wales.
- Cole, R & Gucciardo-Masci, T. (2003). *For love, for faith, for duty, for deed: Beliefs and values about caring in Anglo-Celtic, Greek, Italian, Polish, Turkish and Vietnamese communities in Victoria*. Carers Victoria, Melbourne.
- Evason, N. (2018). *Ethiopian Culture*. SBS Cultural Atlas. <https://culturalatlas.sbs.com.au/ethiopian-culture/ethiopian-culture-references#ethiopian-culture-references>
- Federation of Ethnic Communities Council of Australia (2015). *Review of Australian research on older people from culturally and linguistically diverse backgrounds*. <http://fecca.org.au/wp-content/uploads/2015/06/Review-of-Australian-Research-on-Older-People-from-Culturally-and-Linguistically-Diverse-Backgrounds-March-20151.pdf>
- Hennink, M. M., Hutter, I., & Bailey, A. (2020). *Qualitative research methods* (Second edition.). Sage.
- Hill, T. (2021). Understanding unmet aged care need and care inequalities among older Australians. *Ageing and Society*, (First View), 1-30. <https://doi.org/10.1017/S0144686X21000222>.
- Ip, D, Lui, C.W & Chui, W.H (2007). Veiled entrapment: a study of social isolation of older Chinese migrants in Brisbane, Queensland. *Ageing and Society*, 27(5), 719–738.
- Knight, B.G & Sayegh, P. (2010). Cultural values and caregiving: The updated sociocultural stress and coping model. *Journals of Gerontology - Series B Psychological Sciences and Social Sciences*, 65B(1), 5–13.
- Morse, C.A & Messimeri-Kianidis, V. (2002). 'Keeping it in the family: Caregiving in Australian-Greek families'. *Social Work in Health Care*, 34(3-4), 299-314.

- NGO Committee on Ageing, G. (2018). *The rights of older persons in the global compact on refugees*. <https://www.unhcr.org/en-au/events/conferences/5a6703357/rights-older-persons-global-compact-refugees.html>
- NSW Refugee Health Service (2018). *Older refugees: Fact sheet no 7*. https://ranzocg.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/About/NWHS/Resources/Older-refugees-a-factsheet.pdf
- Ochala, Y., & Mungai, N. (2016). The challenges facing single female parents of African background in regional Australia. *Australian Social Work*, 69(3), 311–322.
- Slewa-Younan, S, Santalucia, Y, McDonald, R & Salem, M 2016, 'Enhancing the lives of older refugees: an evaluation of a training resource', *International Journal of Mental Health Systems*, 10(36). <https://doi.org/10.1186/s13033-016-0067-5>.
- Stebbins, R. A. (2001). *Exploratory research in the social sciences*. Sage.
- Teshuva, K., & Wells, Y. (2014). Experiences of ageing and aged care in Australia of older survivors of genocide. *Ageing & Society*, 34(3), 518–537. <https://doi.org/10.1017/S0144686X12001109>
- Tipping, S. A., & Whiteside, M. (2015). Language reversion among people with dementia from culturally and linguistically diverse backgrounds: the family experience. *Australian Social Work*, 68(2), 184–197. <https://doi.org/10.1080/0312407X.2014.953187>
- Victoria Team, Markovic M, & Manderson L. (2007). Family caregivers: Russian-speaking Australian women's access to welfare support. *Health & Social Care in the Community*, 15(5), 397–406. <https://doi.org/10.1111/j.1365-2524.2007.00709.x>
- Wilson, Angela K.; Onwuegbuzie, Anthony J. & Manning, LaShondra P. (2016). Using Paired Depth Interviews to Collect Qualitative Data, *The Qualitative Report*, 21(9), 1549-73.

Table 1 Participant Characteristics (n=12)

Pseudonym	Gender	Category	Ethnicity	Relationship with other Participants
Mariam	Female	Older person and caregiver for disabled son	Amhara	None
Daniel	Male	Older person and caregiver for wife	Tigray	Husband of Fiyori
Fiyori	Female	Older person	Tigray	Wife of Daniel
Isaias	Male	Older person	Tigray	None
Boorana	Male	Older person	Oromo	None
Sara	Female	Older person	Tigray	None
Robel	Male	Older person and caregiver for wife	Tigray	None
Heeran	Male	Older person	Oromo	None
Meeto	Female	Older person	Oromo	Mother of Rabiya
Rabiya	Female	Caregiver	Oromo	Daughter of Meeto
Lalistu	Female	Caregiver	Oromo	None
Hawwani	Female	Caregiver	Oromo	None