POPULATION HEALTH SERIES REPORT

phn MURRAY

An Australian Government Initiative

MULTICULTURAL POPULATIONS

Leadership Collaboration Respect Accountability Innovation

Murray PHN acknowledges its catchment crosses over many unceded First Nations Countries following the Dhelkunya Yaluk (Healing River).

We pay our respects and give thanks to the Ancestors, Elders and Young People for their nurturing, protection and caregiving of these sacred lands and waterways, acknowledging their continuation of cultural, spiritual and educational practices.

We are grateful for the sharing of Country and the renewal that Country gives us.

We acknowledge and express our sorrow that this sharing has come at a personal, spiritual and cultural cost to the wellbeing of First Nations Peoples.

We commit to addressing the injustices of colonisation across our catchment, and to listening to the wisdom of First Nations communities who hold the knowledge to enable healing.

We extend that respect to all Aboriginal and Torres Strait Islander Peoples.

Recognition of lived experience

We recognise the individual and collective contributions of people with a lived and/or living experience of health issues, and their families, loved ones and supporters.

It is through listening to and acting on the voices of people with lived experience, those who provide services, those who fund services, and most importantly, those who use services that we will find the expertise we need to move towards the health system that Australia needs.

Every person's story we hear, and every experience shared, helps to develop our understanding of the system that is required to best meet the needs of people who live with or care for someone with health concerns.

Contributors and attribution

Murray PHN would like to extend sincere thanks to the many contributors to this population health series report, including the members of Murray PHN's Community and Clinical Advisory Councils, Medical Advisors, and to local healthcare consumers, professionals, community members and other stakeholders. We also acknowledge the contributions of Murray PHN staff who were involved in the planning, data collection, analysis and reporting.

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Murray Primary Health Network (2024) Multicultural populations: Population health series report. Murray PHN, Dja Dja Wurrung (Bendigo), Victoria. Retrieved from https://murrayphn.org.au/about-us/key-documents/

Executive summary

Murray PHN's Population Health Series report on Multicultural Populations describes the outcomes of a comprehensive analysis of the health and service needs of communities living within the Murray PHN catchment. The report seeks to highlight priorities, strengths and gaps in primary healthcare capacity to meet the health needs of this population and to identify opportunities to improve access to services.

The report is informed by quantitative and qualitative data to develop insights for service planning, capacity building, and system coordination and integration. Population health data on the location, demographics, and health needs of people from culturally and linguistically diverse (CALD) backgrounds were identified and analysed, together with analysis of stakeholder consultations that included health service providers, community organisations, Commonwealth funded settlement services, as well as Murray PHN Clinical and Community Advisory Councils, Medical Advisors and subject matter experts.

Priorities from this report:

- Areas within the Murray PHN catchment that should be prioritised for language support services and resources are Swan Hill, Mildura, Shepparton, Mitchell, which are in the North West and Goulburn Valley sub-regions (ABS, 2021).
- The PALM scheme workers are a priority population group that are underrepresented in population health data, which need to be prioritised for services and funding, particularly in the North West and Goulburn Valley sub-regions.
- People who speak Italian and Greek languages had higher rates of most chronic conditions and should be prioritised for primary care initiatives (ABS, 2021).
- Diabetes is a priority chronic condition for CALD populations of Italian, Greek, Tongan, Turkish, Tagalog, Nepali, German and Arabic language groups with rates higher than the PHN population average (ABS, 2021).
- The top language group with low English proficiency in each Murray PHN sub-region was Mandarin (North West and Goulburn Valley), Karen (Central Victoria), and Nepali (North East) (ABS, 2021); translated resources and interpreters need to be easily accessible in this areas.
- Mental health and trauma-related conditions are likely to be underreported for CALD populations, particularly for humanitarian entrants, which require mental health and general primary care provider understanding and culturally safe response.
- Small rural towns with more scarce language supports and regional centres with new or emerging CALD population sub-groups require access to telehealth options and translated resources.
- In the Murray PHN catchment, 11.7% of the population (88,217 people) were born overseas, which is lower than the Australian national average of 27.6%.
- 55,305 people (7.9%) use a language other than English at home, with Greater Shepparton and Swan Hill having the highest proportions per population.
- Of all people who speak a language other than English at home, 17.7% have low English proficiency, mainly living in Swan Hill, Mildura, and Greater Shepparton LGAs.
- The CALD population has a younger age profile compared to the whole population, with an estimated mean age of 36.5 years in the Murray PHN catchment.
- The most reported long-term health conditions within multicultural populations were arthritis and diabetes. Psychological and trauma-related conditions, infectious diseases, women's and reproductive health issues, chronic pain, family and gendered violence, and substance use disorders are notable health issues for CALD communities.

With a focus on the above prioritised populations groups and regions, the following key recommendations should be addressed:

- Advocate for the recruitment and retention of more on-site interpreters in regional communities and support health providers in using interpreting services.
- Strengthen formal health system navigation services, particularly in Greater Shepparton, Greater Bendigo and Robinvale regions.
- Advocate for and support primary healthcare services to build a culturally safe workforce through capacity building activities such as cultural humility and cultural safety education, engaging more bilingual and bicultural staff and addressing systemic racism that impacts healthcare access.
- Advocate for health services to collaborate with community leaders to develop tailored health programs and health information for CALD communities.
- Workforce planning should include strategies to increase the number of bilingual workers in rural regions.
- Ensure culturally responsive commissioning through engagement with multicultural communities and stakeholders.

Key insights

Population trends in the Murray PHN catchment		Data reference
Country of birth	88,217 people are born overseas, which accounts for 11.7% of the total population.	Table 1
	63.8% of people born overseas were born in predominantly non-English speaking (NES) countries. This is a total of 52,479 people, which accounts for 7.5% of the whole population.	Table 2
	The LGAs with the greatest proportion of the population born in predominantly non-English speaking countries are Swan Hill (14.4%), Greater Shepparton (14.2%), Mildura (10.8%) and Mitchell (9.5%).	Table 3
	Top five predominantly non-English speaking countries of birth are India, Philippines, Malaysia, Italy and Germany.	Table 4
Languages other than English	55,305 (7.9%) people use a language other than English (LOTE) at home.	Table 5
	The LGAs with the greatest proportion of the population who speak a LOTE at home are Greater Shepparton (17.5%), Swan Hill (16.2%), Mildura (12.2%) and Mitchell (11.4%).	Table 6
	Top five languages spoken are Punjabi (5241 people), Italian (4787), Mandarin (4002), Arabic (2424) and Malayalam (1718).	Table 7
English proficiency	17.7% of those who spoke a LOTE at home indicated they did not speak English well or at all (9565 people). This equates to 1.4% of the whole Murray PHN population with more than 60% of these residents living in the Goulburn Valley and North West regions.	Table 8
	The LGAs with the highest proportion of the LOTE population with low English proficiency are Swan Hill (32.2%), Mildura (26.6%) and Greater Shepparton (19.7%).	Table 9
	The languages spoken at home that have the highest numbers of speakers not proficient in English are Mandarin (1616 people, 40.4% of all speakers), Karen (709, 43.8%) and Vietnamese (666, 40.9%).	Table 10
Immigration	Between 2014-24 there were 25,118 permanent settlers in the Murray PHN catchment. Of these 56% (14,051 people) were issued skilled migrant visas, 29% (7288) were issued family visas and 15% (3779) were issued humanitarian visas.	Table 11
	Greater Bendigo, Greater Shepparton, Albury, Wodonga and Mildura are key regional settlement locations supported through the Australian Government's Humanitarian Settlement Program (HSP).	Pg 25

Population trends in the Murray PHN catchment		Data reference
	From 2014 to 2024 the LGAs with the highest number of permanent migrants were Greater Shepparton (4850), Greater Bendigo (4550), Albury (2951), Mitchell (2893) and Mildura (2364).	Table 11
	There were approximately 6099 PALM scheme workers in Victoria in June 2024; majority are employed in agricultural or meat processing industries located in regional and rural areas (DEWR, 2024). The Goulburn Valley and the North West sub-regions attract substantial numbers of PALM scheme workers.	Pg 25
	Some areas within the catchment such as the Robinvale community within the Swan Hill LGA have fluctuating populations. Official statistics in this community have been shown to underrepresent the actual population due to factors such as seasonal worker fluctuations, undocumented persons and transient populations.	Pg 42
Age profile	The CALD population has an overall younger age profile compared to the whole population.	Fig 5
	The estimated mean age for all residents who speak a language other than English at home is 36.5 years compared to 41.9 years for the whole population of Murray PHN.	Pg 26

Health needs		Data reference
Long term health conditions	Crude rates of all self-reported long term health conditions except for diabetes are lower in the CALD community compared to the whole population. For diabetes the rate is almost the same in both groups at 53 people per 1000 in the CALD community compared to 52 people in the whole population.	Table 12
	The crude rate of self-reports of people with no long term health conditions is much higher in the CALD community at 748 people per 1000 compared to 539 in the whole population.	Table 12
	The top five long term health conditions reported in the CALD community are 'other long-term health conditions' (64 reports per 1000 people): arthritis (56), diabetes (53), asthma (48) and mental health conditions (45). Across the whole population, the top five conditions are the same, but the order and difference in rates between conditions is more varied. For the whole population rates were arthritis (112 per 1000), mental health conditions (107), asthma (99) 'other long-term health conditions' (85) and diabetes (52).	Table 12
	Crude rates of long-term health conditions vary substantially between language groups. People who speak Italian and Greek had notably higher rates of the majority long-term health conditions (including arthritis, dementia, diabetes, heart disease and mental health conditions) compared to the whole population and other language groups. These differences are likely to reflect different age profiles of different language groups.	Table 13
	Crude rates for diabetes were slightly higher in people who speak Tagalog compared to the whole population and the same as the whole population for people who speak Arabic.	Table 13
	Psychological and trauma-related conditions, including stress, post-traumatic stress disorder and mental illness are significant but under-reported issues for many people from CALD backgrounds, particularly humanitarian entrants.	Table 14
Other notable health issues	Infectious diseases such as HIV, tuberculosis, Hepatitis B and C and a range of sexually transmitted diseases are commonly seen in some parts of the CALD community.	Table 14
	Women's and reproductive health were noted issues with antenatal care and monitoring a concern.	
	Chronic pain, family and gendered violence, exploitation, and alcohol and other drug (AOD) use disorders are other notable issues.	

Recommendations

Recommendations		Data reference
Interpreter services and translated health information	Advocate for the recruitment and retention of more on-site interpreters in regional communities.	Table 16
	Support and advocate for health providers in all settings to register and use interpreting services such as TIS National.	
	Support the development of health workforce capacity and confidence to effectively access and use interpreter services and translated health information.	
	Promote and provide education opportunities to upskill primary care and commissioned service providers (including allied health) for working with interpreters.	
	Support coordination between service providers to share existing in-language resources and best practices to facilitate access to health services and information for people with low English proficiency.	Table 16
	Support collaboration between communities, local organisations, government departments and health providers to develop translated resources when not available for a specific health issues or language group.	
Health system navigation	Strengthen and support formal health system navigation services across the region, particularly the Greater Shepparton, Greater Bendigo and Robinvale regions.	Table 16
	Support the diverse range of existing health system navigation services and capacity building of local health systems to understand their communities, build cultural awareness and support health education and service navigation	
	Support health and settlement services to provide accessible health and health service information to all new arrivals.	
	Advocate for health navigation services for priority population groups such as people with disability, older people, PALM scheme workers, asylum seekers and children and young people.	
Tailored health programs	Encourage health service providers to collaborate with established community leaders and groups to develop tailored health programs and health information and/or to engage with target CALD communities via established local networks.	Table 16
Co-ordination and advocacy	Support communication and collaboration between health, settlement and other service providers working with CALD communities to deliver well integrated and co-ordinated support to access primary healthcare services.	Table 16

Recommendations		Data reference
Culturally safe primary healthcare	Address systemic racism that impacts on people's access to health and healthcare outcomes.	Table 16
	Encourage and advocate for primary healthcare services to employ and retain bilingual and bicultural staff in both clinical and non-clinical roles. Focus on new and emerging CALD populations or those with lower levels of English proficiency.	
	Advocate for and support health service providers to build a culturally safe workforce through capacity building and education, enabling services to better meet the needs of multicultural communities.	
Culturally responsive Commissioning	Ensure culturally responsive commissioning through collaborative and flexible engagement with multicultural communities and stakeholders including opportunities to co-design services and establishing appropriate mechanisms to provide feedback.	Table 16
Service mapping and data systems	Support and encourage primary health providers to consistently collect the five key CALD data fields (country of birth, language spoken, interpreter required, ethnicity/cultural background, year of arrival in Australia) in a sensitive way.	Quantitative data limitations
	Advocate for data systems that allow for accurate capture and analysis of CALD data.	
	Improve service mapping of specialist CALD services across the catchment.	
Future HNA processes	Aim to include health service consumers from CALD backgrounds in future consultations around the needs of CALD populations.	Qualitative data limitations
	Actively seek to understand experiences of discrimination and racism within local primary healthcare systems and apply anti-racist needs assessment approaches.	
Murray PHN processes and commissioning	Support implementation of the PHN Multicultural Health Framework across key program areas of Murray PHN including: • ensure staff undertake relevant professional development for cultural access, equity and responsiveness. • ensure multicultural communities are well represented on community and clinical advisory councils. • advocate for multicultural policy and system change.	Table 55

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
AIHW	Australian Institute of Health and Welfare
AMEP	Adult Migrant English Program
AOD	Alcohol and other drugs
CALD	Culturally and Linguistically Diverse
CV	Central Victoria: Murray PHN sub-region
DEWR	Department of Employment and Workplace Relations
ECCV	Ethnic Communities' Council of Victoria
GV	Goulburn Valley: Murray PHN sub-region
HSP	Humanitarian Settlement Program
LGA	Local Government Area
LOTE	Language Other than English
NE	North East Victoria: Murray PHN sub-region
NES	Predominantly non-English speaking (country)
NDIS	National Disability Insurance Scheme
NW	North West Victoria: Murray PHN sub-region
PALM	Pacific Australian Labour Mobility
PHN	Primary Health Network
SETS	Settlement Engagement and Transition Support Program
TIS	Translating and Interpreting Service (TIS National)

Section 1: Narrative

Introduction

In May 2023, the Australian Government allocated funding to Primary Health Networks to support improved access to primary healthcare services for multicultural populations. Murray PHN has undertaken health and service needs analysis to inform future commissioning activities and ongoing needs assessment which is core activity for all PHNs. The purpose of this analysis was to:

- identify and describe the health needs of multicultural people within the Murray PHN region to understand experiences, issues and priorities
- identify and understand service gaps for people multicultural people where there are demonstrated challenges and barriers to primary care access and navigation
- develop recommendations for commissioning, system coordination, and workforce capacity building to enhance primary healthcare access and outcomes for multicultural communities.

Background

Definition of the multicultural population

Multicultural populations refer to groups of people who were born overseas, have parents born overseas, and/or speak a variety of languages. These populations contribute to Australia's rich cultural and linguistic diversity and have long been, and continue to be, integral to the social and economic prosperity of the country, including the vital contributions multicultural people make to various industries including primary healthcare. However, individuals from culturally and linguistically diverse (CALD) backgrounds often face challenges related to language, health literacy, racism and service navigation and exclusion, which can increase peoples' at risk for poorer health outcomes (AIHW, 2023a). Health disparities can be reduced by recognising and responding to population diversity by tailoring healthcare and programs to specific needs (Department of Health and Aged Care, 2023).

For the purposes of this report, the terms 'multicultural' or 'CALD' encompass individuals whose cultural identity differs from the Anglo-Celtic majority or Aboriginal and/or Torres Strait Islander Peoples. This acknowledgment recognises the diverse experiences across cultures, faiths, languages and migration journeys, and the barriers inherent in health systems that are designed by and for white Western people.

The terms multicultural and CALD have been used interchangeably throughout this report and can be used to refer to population diversity with regards to country of birth, family origin, language/s spoken, and religious affiliations.

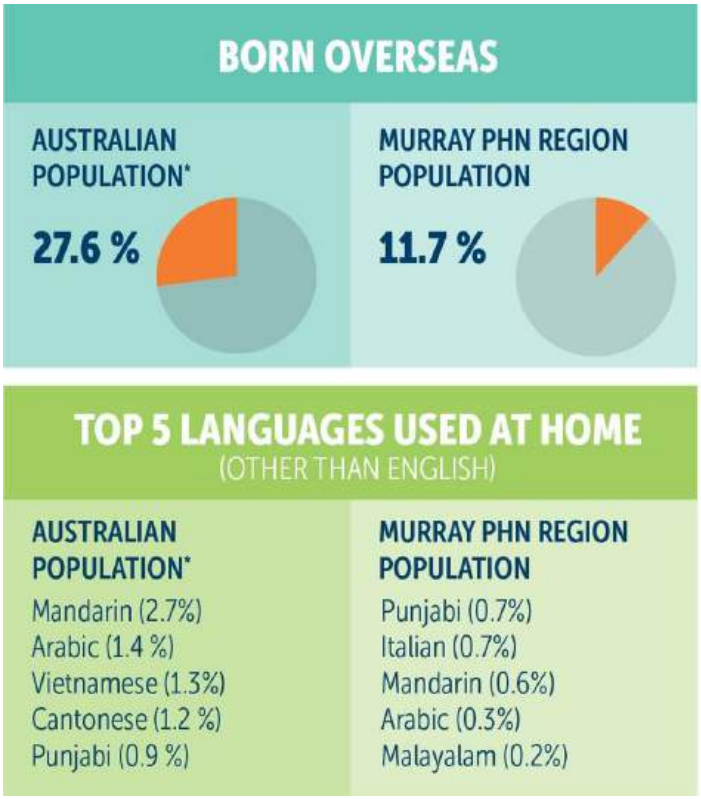
First Nations Peoples

First Nations People have a long and continuous connection to Country and are diverse in language and culture, their experiences and needs as First Peoples are unique and are therefore considered distinct from the multicultural population for the purposes of this report. The health needs of First Nations people across the Murray PHN catchment are considered in a separate report in this Population Health Series.

Overview of the CALD population in Australia

The last national Census conducted by the Australian Bureau of Statistics (ABS) in 2021 showed that across Australia:

- 27.6 % of the population were born overseas.
- Top five predominantly non-English speaking countries of birth were India, China, Philippines, Vietnam and Malaysia.
- Top five languages used at home, other than English, were Mandarin (2.7% of the population), Arabic (1.4 %), Vietnamese (1.3%), Cantonese (1.2 %) and Punjabi (0.9 %).
- Top five ancestries were English (33.0% of the population), Australian (29.9%), Irish (9.5%), Scottish (8.6%) and Chinese (5.5%).
- Top five religious affiliations were no religion (38.9% of the population), Catholic (20 %), Anglican (9.8 %), Islam (3.2 %) and Hinduism (2.7 %).



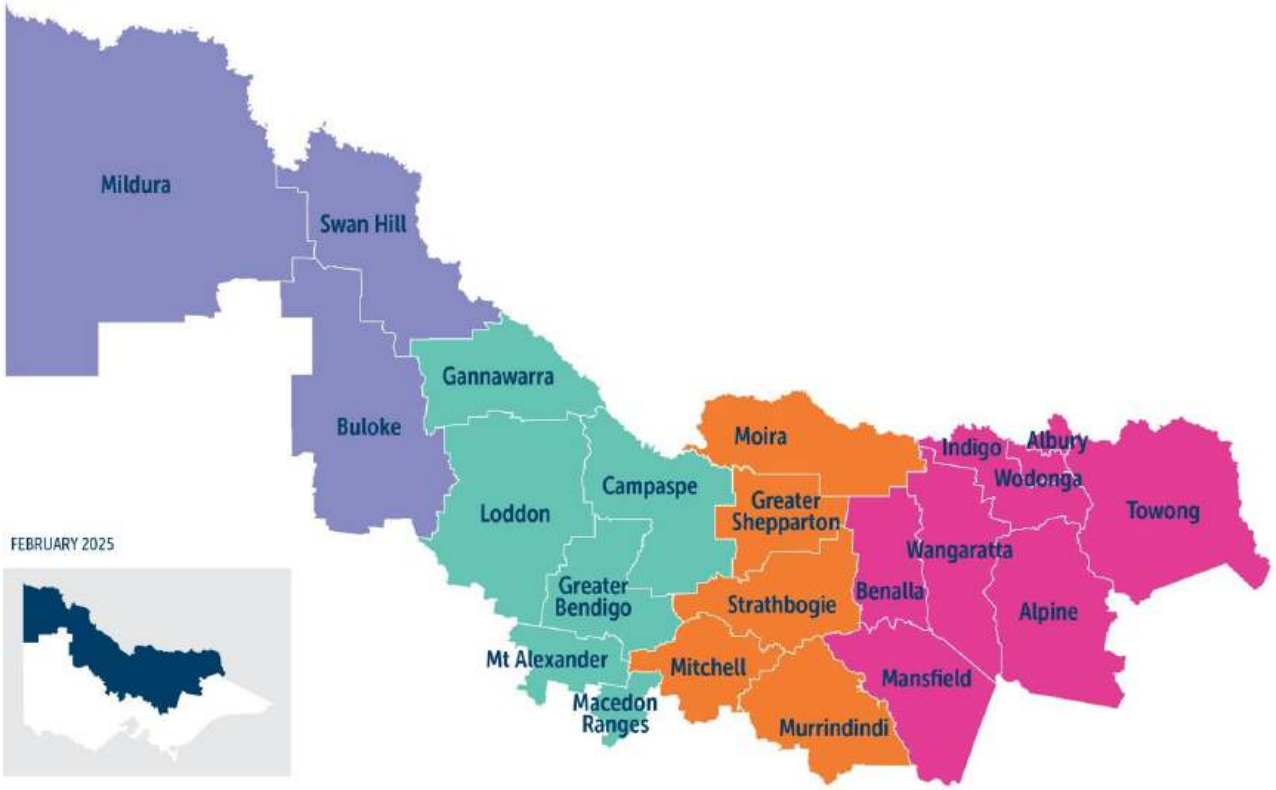
The Murray PHN catchment

The Murray PHN catchment (Figure 1) encompasses almost 100,000 square kilometres, 22 Local Government Areas, and is home to approximately 644,577 people[1] (by PHN catchment; ABS 2022), including almost one third of all First Nations Peoples living in Victoria. The catchment covers 44 per cent of the entire state of Victoria. The Murray River forms the northern border of the catchment, which is inclusive of Albury NSW.

The catchment includes Mildura (Latji Latji Country) in the north, Albury (Wiradjuri Country) to the east, and Woodend (Dja Dja Wurrung Country) in the south. Communities in this catchment are diverse. They range from rural agricultural communities, rapidly growing regional centres, small regional communities, tourism destinations and rural distributed communities.

[1] Note when the PHN population is calculated “by PHN catchment” the total is lower compared to when the PHN population is calculated ‘by LGA” because the geographic boundaries do not align.

Figure 1: The Murray PHN catchment



	Total population	Local government areas (LGAs)	GP Full-time equivalent	Aged care services	General practice services	Public Hospitals	Private Hospitals	ACCHOs
North west Vic	84,559	3	75	39	25	9	1	1
Central Vic	251,963	6	294	62	73	13	3	3
Goulburn Valley	178,008	5	200	85	48	10	4	1
North east Vic	192,817	8	203	60	48	12	7	2
Murray PHN	707,347	22	772	246	194	44	15	7

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*Population and service mapping by LGA; ABS (2021) and Murray PHN CRM (2024). Murray PHN population calculated by LGA.

Process of health and service needs analysis

Population data

Population data were retrieved from a range of sources for the quantitative analyses. A detailed list of the data indicators, definitions and sources that were analysed and presented in this report is provided in Attachment A - Data sources and definitions (see page 68). Data sources were preferred if they had been released in the last five years. The geographic filters used were PHN and LGA as they are the most relevant to Murray PHN's planning and partnership work and provide accurate representations of local and regional diversity. Key data were grouped into the Murray PHN's four PHN sub-regions (CV, NE, NW and GV) to inform more in-depth local planning. Key health and service needs data sources for this report include Australian Bureau of Statistics (ABS) and the Australian Department of Home Affairs.

Stakeholder consultation

Consultation and engagement for this health and service needs analysis was conducted between December 2023 to March 2024. Organisations consulted included multicultural service and support organisations, community ethnic councils and networks, rural and regional health services, shire councils, community health and social services, in addition to Murray PHN subject matter experts, Clinical and Community Advisory Councils and Medical Advisors. Consultations sought to obtain in-depth understandings of population health and service needs of CALD groups residing in the Murray PHN catchment and to identify service strengths, gaps and exemplar models of care.

The multicultural populations stakeholder consultations were conducted through 10 focus groups, 13 semi-structured interviews, and the collection of informal feedback within stakeholder meetings and by email. A total of 163 individuals participated representing 58 organisations. Full details of the key stakeholders involved can be found in Attachment B – Data collection and analysis methods (see page 69).

Section 2: Outcomes of health and service needs assessment

Population health

The Murray PHN catchment is home to a diverse population that includes various migrant groups, such as first and multi-generational migrants, post-war European migrants, permanent and temporary skilled migrants, family and partner visa holders, international students and humanitarian migrants (refugees and asylum seekers).

Country of birth

Table 1 - People born overseas by Murray PHN region, ranked by proportion of sub-region population

Rank	Murray PHN region	Count (persons)	Proportion of sub-region population	Proportion of Murray PHN total born overseas
1	Goulburn Valley	24,762	14.1%	30.1%
2	North West	11,675	13.8%	14.2%
3	North East	20,724	10.9%	25.2%
4	Central Victoria	25,056	10.0%	30.5%
Murray PHN		**88,217**	**11.7%**	**100.0%**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN and sub-region totals calculated using LGA level data.

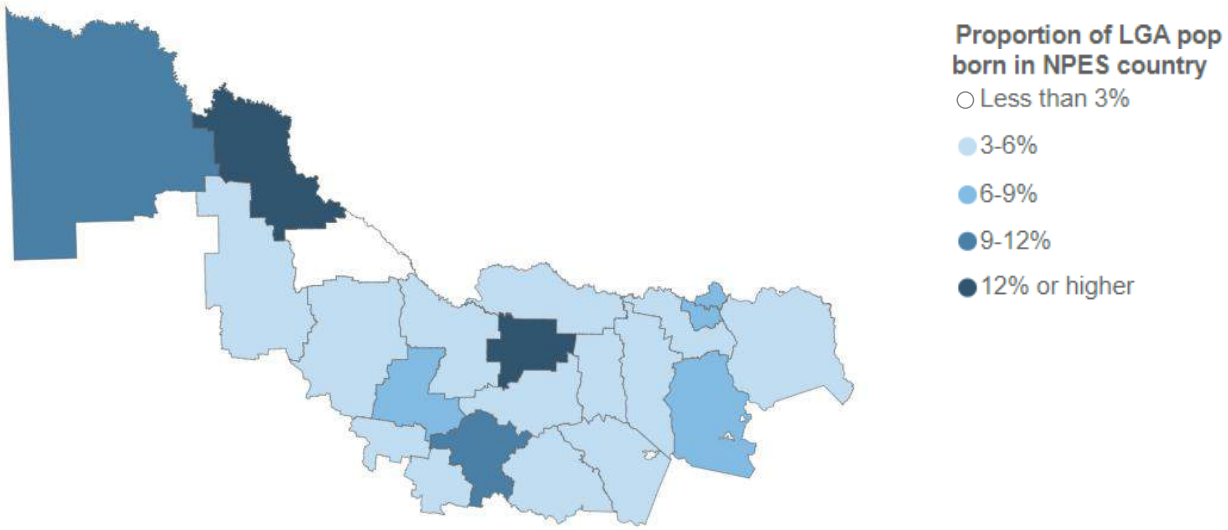
Table 2 - People born in predominantly non-English speaking (NES) countries by Murray PHN sub-region, ranked by proportion of sub-region population

Rank	Sub-region	Count (persons)	Proportion of all overseas born	Proportion of sub-region population	Proportion of Murray PHN total born in NES
1	North West	9445	80.9%	11.2%	18.0%
2	Goulburn Valley	17,235	69.6%	9.8%	32.8%
3	North East	12,380	59.7%	6.5%	23.6%
4	Central Victoria	13,419	53.6%	5.4%	25.6%
Murray PHN		**52,479**	**63.8%**	**7.5%**	**100.0%**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN and sub-region totals calculated using LGA level data.

Figure 2: Proportion of population born in NES countries by LGA



Source: ABS (2021). Public data: accessible to all audiences

Table 3 - People born in NES countries by LGA, ranked by proportion of LGA population born in NES countries

Rank	LGA	Count (persons)	Proportion of all overseas born	Proportion of LGA population	Proportion of Murray total born NES
1	Swan Hill	3089	87.2%	14.4%	5.9%
2	Greater Shepparton	9695	82.0%	14.2%	18.5%
3	Mildura	6156	79.6%	10.8%	11.7%
4	Mitchell	4694	65.0%	9.5%	8.9%
5	Albury[#]	4680	67.2%	8.3%	8.9%
6	Wodonga[#]	3216	66.0%	7.4%	6.1%
7	Alpine	935	51.4%	7.1%	1.8%
8	Greater Bendigo	7542	64.4%	6.2%	14.4%
9	Moira	1666	56.2%	5.5%	3.2%
10	Macedon Ranges	2727	40.6%	5.3%	5.2%
11	Wangaratta	1557	59.0%	5.2%	3.0%
12	Mansfield	520	45.9%	5.1%	1.0%
13	Mount Alexander	998	39.9%	4.9%	1.9%
14	Benalla	693	51.4%	4.8%	1.3%
15	Strathbogie	518	47.2%	4.5%	1.0%
16	Murrindindi	662	40.0%	4.4%	1.3%
17	Loddon	333	50.2%	4.3%	0.6%
18	Campaspe	1521	53.0%	3.9%	2.9%
19	Towong	234	47.5%	3.8%	0.4%
20	Buloke	200	50.5%	3.2%	0.4%
21	Indigo	545	37.5%	3.1%	1.0%
22	Gannawarra	298	50.5%	2.8%	0.6%
Murray PHN		**52479**	**63.8%**	**7.5%**	**100.0%**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN total calculated using LGA level data.

[#]The combined total of people born in NES countries for Albury and Wodonga LGAs is 7915 people which equals a rate of 7.9% of the population across both LGAs and 15.0% of the Murray PHN total, second only to Shepparton.

Together, the top 10 NES countries were the reported birthplace of 30,228 people which accounts for 57.6% of all people born overseas living in the Murray PHN catchment.

Table 4 - Top 10 NES countries of birth within Murray PHN, ranked by proportion of Murray PHN total born in NES country

Rank	Country of Birth	Count (persons)	Proportion of Murray PHN total born in NES country
1	India	7911	15.1%
2	Philippines	4307	8.2%
3	Malaysia	3668	7.0%
4	Italy	3361	6.4%
5	Germany	2500	4.8%
6	Netherlands	2070	3.9%
7	Thailand	1899	3.6%
8	China (excludes SARs and Taiwan)	1828	3.5%
9	Vietnam	1465	2.8%
10	Sri Lanka	1219	2.3%

Source: ABS (2021). Public data: accessible to all audiences.

Languages spoken at home

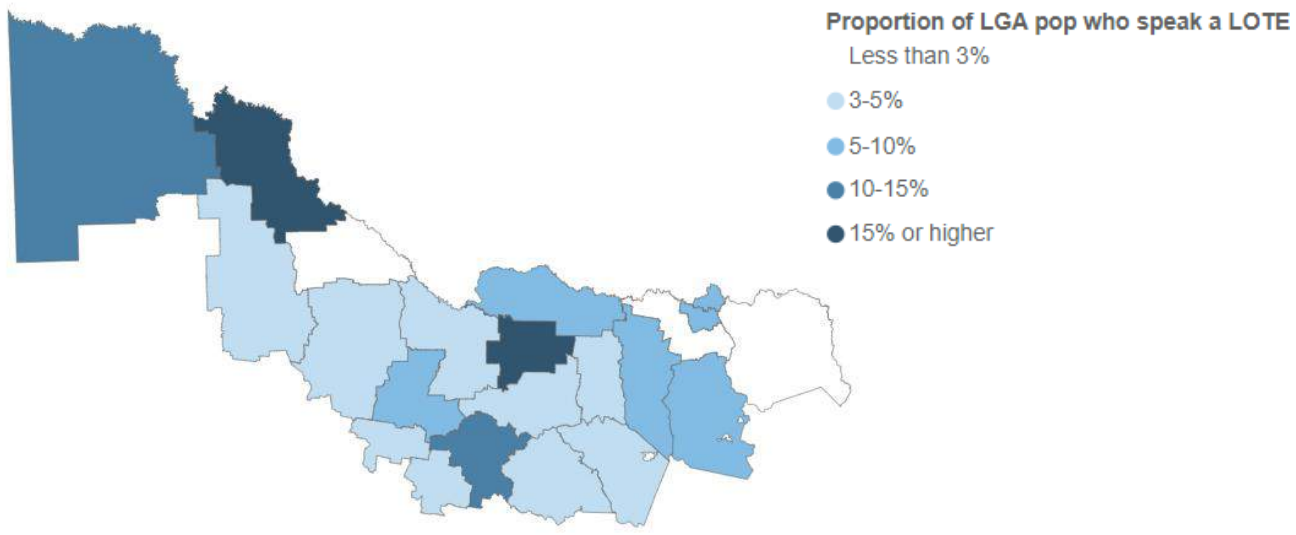
Table 5 - People who speak a language other than English (LOTE) at home by Murray PHN sub-region, ranked by proportion of region population born in NES countries

Rank	Murray PHN sub-region	Count (persons)	Proportion of sub-region population	Proportion of total Murray LOTE population
1	North West	10,646	12.6%	19.2%
2	Goulburn Valley	20,181	11.5%	36.5%
3	North East	11,672	6.1%	21.1%
4	Central Victoria	12,798	5.1%	23.1%
Murray PHN total		**55,305**	**7.9%**	**100.0%**
Victoria		**1,790,637**	**27.5%**	**-**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN total calculated using LGA level data

Figure 3: Map of proportion of population who speak a LOTE at home by LGA in the Murray PHN region



Source: ABS (2021). Public data: accessible to all audiences

Table 6 - People who speak a LOTE at home by LGA, ranked by proportion of people who speak a LOTE at home per LGA population

Rank	LGA	Count (persons)	Proportion LOTE per LGA population	Proportion of Murray LOTE population
1	Greater Shepparton	11,990	17.5%	21.7%
2	Swan Hill	3469	16.2%	6.3%
3	Mildura	6975	12.2%	12.6%
4	Mitchell	5625	11.4%	10.2%
5	Albury[#]	4748	8.5%	8.6%
6	Wodonga[#]	2976	6.9%	5.4%
7	Alpine	901	6.8%	1.6%
8	Greater Bendigo	7814	6.4%	14.1%
9	Moira	1585	5.2%	2.9%
10	Wangaratta	1546	5.2%	2.8%
11	Macedon Ranges	2331	4.5%	4.2%
12	Mansfield	416	4.1%	0.8%
13	Campaspe	1502	3.9%	2.7%
14	Murrindindi	561	3.7%	1.0%
15	Strathbogie	420	3.7%	0.8%
16	Benalla	521	3.6%	0.9%
17	Buloke	202	3.3%	0.4%
18	Mount Alexander	655	3.2%	1.2%
19	Loddon	241	3.1%	0.4%
20	Towong	168	2.7%	0.3%
21	Gannawarra	255	2.4%	0.5%
22	Indigo	396	2.3%	0.7%
Murray PHN total		**55,305**	**7.9%**	**100.0%**
Victoria		**1,790,637**	**27.5%**	**-**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN total calculated using LGA level data.

#The combined Albury and Wodonga total people who speak a LOTE at home is 7724 (Table 6) which equals a rate of 7.8% of the population across both LGAs and 14.0% of the Murray PHN total - third highest after Greater Shepparton and Greater Bendigo.

Table 7 - Top 20 languages spoken at home in the Murray PHN catchment, ranked by count

Rank	Language	Count (persons)	Proportion of all Murray LOTE speakers
1	Punjabi	5241	9.5%
2	Italian	4787	8.7%
3	Mandarin	4002	7.2%
4	Arabic	2424	4.4%
5	Malayalam	1718	3.1%
6	Vietnamese	1649	3.0%
7	Nepali	1622	2.9%
8	Karen	1614	2.9%
9	Tagalog	1603	2.9%
10	Greek	1536	2.8%
11	Filipino	1449	2.6%
12	Malay	1353	2.4%
13	German	1261	2.3%
14	Turkish	1251	2.3%
15	Hazaraghi	1246	2.3%
16	Hindi	1203	2.2%
17	Thai	1118	2.0%
18	Swahili	933	1.7%
19	Spanish	886	1.6%
20	Sinhalese	869	1.6%

Source: ABS (2021). Public data: accessible to all audiences

English proficiency

Table 8 - People with low English proficiency by Murray PHN region, ranked by proportion

Rank	Murray PHN sub-region	Count (persons)	Proportion of LOTE speakers	Proportion of sub-region population	Proportion of Murray PHN total
1	North West	2924	28.1%	3.5%	30.6%
2	Goulburn Valley	3195	16.1%	1.8%	33.4%
3	Central Victoria	1887	15.1%	0.8%	19.7%
4	North East	1559	13.8%	0.8%	16.3%
Murray PHN total		**9565**	**17.7%**	**1.4%**	**100.0%**

Source: ABS (2021). Public data: accessible to all audiences *Murray PHN region and sub-region totals calculated using LGA level data.

Across the Albury and Wodonga LGAs combined, there are 1191 people who self-identified as having low English proficiency. This is equivalent to 15.7% of all LOTE speakers in this community.

Table 9 - People with low English proficiency by LGA, ranked by proportion of LOTE speakers in LGA

Rank	LGA	Count (persons)	Proportion of LOTE speakers in LGA	Proportion of total LGA population	Proportion of Murray PHN total
1	Swan Hill	1099	32.2%	5.1%	11.5%
2	Mildura	1821	26.6%	3.2%	19.0%
3	Greater Shepparton	2341	19.7%	3.4%	24.5%
4	Greater Bendigo	1418	18.4%	1.2%	14.8%
5	Moira	269	17.8%	0.9%	2.8%
6	Wodonga	470	16.1%	1.1%	4.9%
7	Albury	721	15.5%	1.3%	7.5%
8	Campaspe	175	11.9%	0.5%	1.8%
9	Alpine	100	11.6%	0.8%	1.0%
10	Wangaratta	168	11.0%	0.6%	1.8%
11	Benalla	52	11.0%	0.4%	0.5%
12	Loddon	22	10.0%	0.3%	0.2%
13	Mitchell	519	9.5%	1.0%	5.4%
14	Gannawarra	21	9.2%	0.2%	0.2%
15	Strathbogie	32	9.1%	0.3%	0.3%
16	Macedon Ranges	201	8.9%	0.4%	2.1%
17	Mount Alexander	50	8.5%	0.2%	0.5%
18	Towong	12	8.2%	0.2%	0.1%
19	Murrindindi	34	6.3%	0.2%	0.4%
20	Indigo	20	5.9%	0.1%	0.2%
21	Mansfield	16	4.2%	0.2%	0.2%
22	Buloke	4	2.6%	0.1%	0.0%
Murray PHN total		**9565**	**17.7%**	**1.4%**	**100.0%**

Source: ABS (2021). Public data: accessible to all audiences. *Murray PHN region total calculated using LGA level data.

Across the Murray PHN catchment, 18 language groups had more than 100 speakers who identified as having low English proficiency. Together these groups account for 82% of the total residents with low English proficiency across the Murray PHN catchment.

Table 10 - Languages spoken at home with more than 100 residents reporting low English proficiency, ranked by proportion of Murray PHN total low proficiency

Rank	Language	Count (persons)	Proportion of language speakers	Proportion of Murray PHN total low proficiency
1	Mandarin	1616	40.4%	16.9%
2	Karen	709	43.8%	7.4%
3	Vietnamese	666	40.9%	7.0%
4	Punjabi	574	11.0%	6.0%
5	Italian	540	11.3%	5.6%
6	Arabic	482	20.0%	5.0%
7	Hazaraghi	452	36.6%	4.7%
8	Nepali	426	26.4%	4.5%
9	Malay	423	31.3%	4.4%
10	Turkish	317	25.8%	3.3%
11	Thai	305	27.2%	3.2%
12	Non-verbal, so described	276	72.1%	2.9%
13	Swahili	262	28.6%	2.7%
14	Cantonese	210	26.3%	2.2%
15	Greek	169	11.1%	1.8%
16	Dari	166	41.7%	1.7%
17	Tongan	136	20.6%	1.4%
18	Malayalam	124	7.3%	1.3%

Source: ABS (2021). Public data: accessible to all audiences

Refugee settlement and skilled migrants

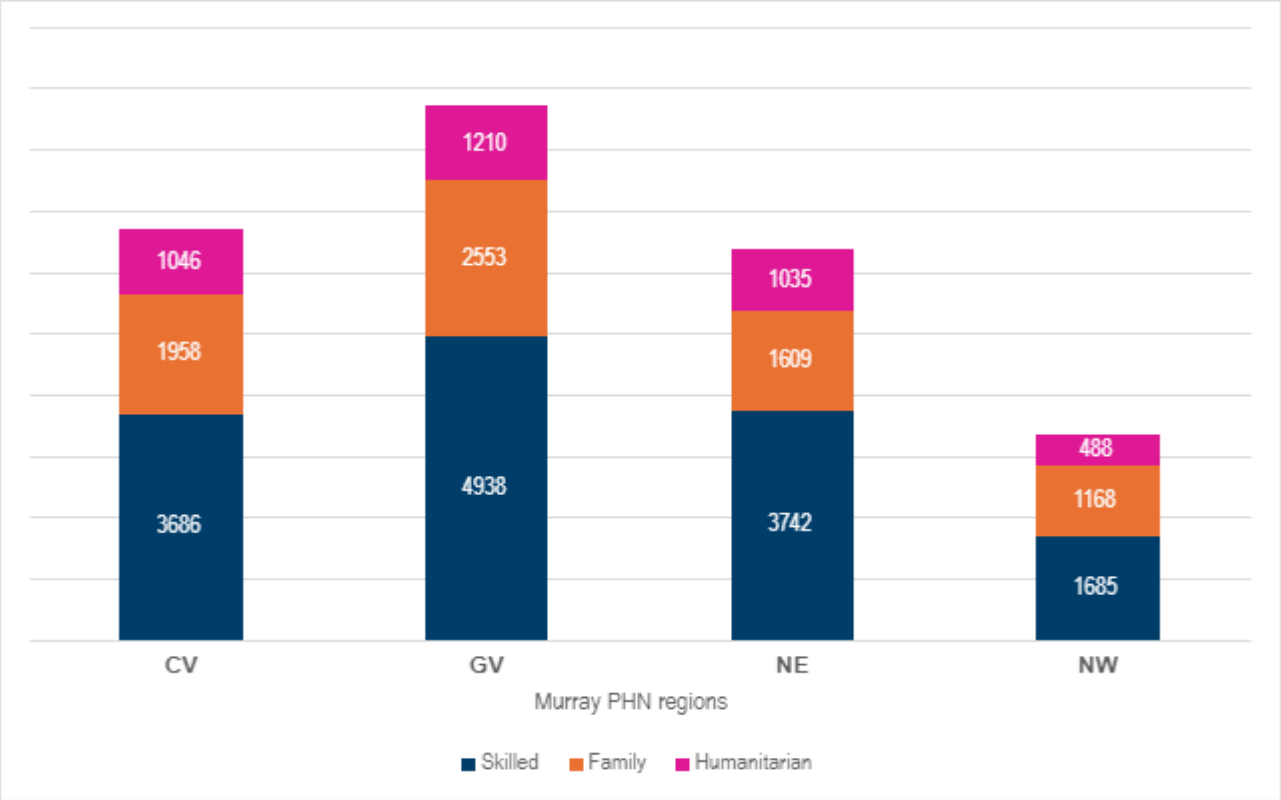
The population across the Murray PHN catchment has increased over time with more temporary and permanent skilled migrants moving to the area in response to government economic initiatives, such as regional skilled worker and employer sponsored visa programs. Over the past decade, the highest number of permanent skilled migrants have settled in Greater Shepparton, Greater Bendigo, Albury/Wodonga, Mitchell and Mildura (Table 11).

In 2005, Shepparton began settling refugees through a joint Commonwealth-Victorian Regional Humanitarian Settlement Pilot project, initially welcoming 10 families from the Democratic Republic of the Congo (Margaret Piper and Associates, 2007). In the following years, other regional centres, including Greater Bendigo, Albury, Wodonga and Mildura became key settlement locations for the Australian Government's regional humanitarian settlement agenda supported by the Commonwealth's Humanitarian Settlement Program (HSP). Other support for these communities is provided along with the HSP by various state and federal funding programs, such as the Settlement Engagement Transition Support (SETS) program, and the Adult Migrant English Program (AMEP).

From 2022, the Australian Government introduced the Pacific Australia Labour Mobility (PALM) scheme. The PALM scheme is a temporary migration program allowing Australian businesses to hire workers from Timor-Leste and Pacific Island countries where there is a shortage of local workers (Australian Government, 2024). Stakeholders estimate that the Goulburn Valley and the Mallee agricultural regions have attracted significant numbers of PALM Scheme workers, up to 5000 workers in peak season.

Permanent immigrants

Figure 4: Regional distribution of permanent settlers by visa stream 2014-24



Source: Department of Home Affairs (2024). Public data: accessible to all audiences

Between 2014-2024 there were 25,118 permanent settlers in the Murray PHN catchment. Of these 56% were issued skilled migrant visas, 29% were issued family visas and 15% were issued humanitarian visas.

Table 11: Permanent settlers by visa stream over 10 years between July 2014 to June 2024, ranked by Total

Rank	LGA	Count (persons)			
		Skilled	Family	Humanitarian	Total
1	Greater Shepparton	2467	1254	1129	**4850**
2	Greater Bendigo	2480	1045	1025	**4550**
3	Albury	1775	569	607	**2951**
4	Mitchell	1949	875	69	**2893**
5	Mildura	1145	769	450	**2364**
6	Wodonga	938	414	390	**1742**
7	Macedon Ranges	495	396	13	**904**
8	Swan Hill	458	349	38	**845**
9	Campaspe	464	256	8	**728**
10	Wangaratta	503	189	6	**698**
11	Moira	335	227	12	**574**
12	Alpine	182	120	22	**324**
14	Benalla	171	113	5	**289**
13	Mount Alexander	102	162	0	**264**
15	Strathbogie	96	102	0	**198**
16	Mansfield	92	89	5	**186**
17	Murrindindi	91	95	0	**186**
18	Indigo	52	85	0	**137**
19	Buloke	82	50	0	**132**
20	Gannawarra	64	63	0	**127**
21	Loddon	81	36	0	**117**
22	Towong	29	30	0	**59**
Murray PHN total		**14,051**	**7288**	**3779**	**25,118**

Source: Australian Government Dept of Home Affairs (2024). Public data: accessible to all audiences

The total number of permanent settlers in the Albury and Wodonga LGAs combined for 2014-2024 was 4693 places it second only to the Greater Shepperton area. In this area there were 2713 skilled visa, 983 family visa and 997 humanitarian visa entrants.

PALM scheme workers

Workers (and their dependant family members) on Pacific Australia Labour Mobility (PALM) Scheme visas need to access health services via private insurance and are not eligible for Medicare.

The exact number of PALM scheme workers residing in the Murray PHN catchment is not known, as data is only currently available at the state level. However, from Department of Work and Employment and Workplace Relations (DEWR) illustrates that the number of PALM scheme worker does fluctuate throughout the year. Statistics from January to June 2024 show:

- The monthly count of PALM scheme workers in Victoria ranged from 5200 to 7065 (mean average of 6099).
- Just under 20% of all PALM scheme workers travelling to work in Australia resided in Victoria (by state; DEWR, 2024).
- Majority of workers are employed in the agricultural or meat processing industries (by Australia; DEWR, 2024), these types of workplaces are often located in regional/rural areas.

Case Study: Vulnerabilities and Health Needs of PALM Scheme Workers

In agricultural regions, Pacific Islander workers can face unique challenges accessing healthcare despite paying for private health insurance. An example from Pacific Islander orchard workers in the Murray PHN region illustrates this disparity. Stakeholders reported that although many workers contribute to private health insurance through deductions from their wages, they rarely use the services they are entitled to. Employers often guide workers to access healthcare, when necessary, as many employees are unaware or unsure of how to seek help.

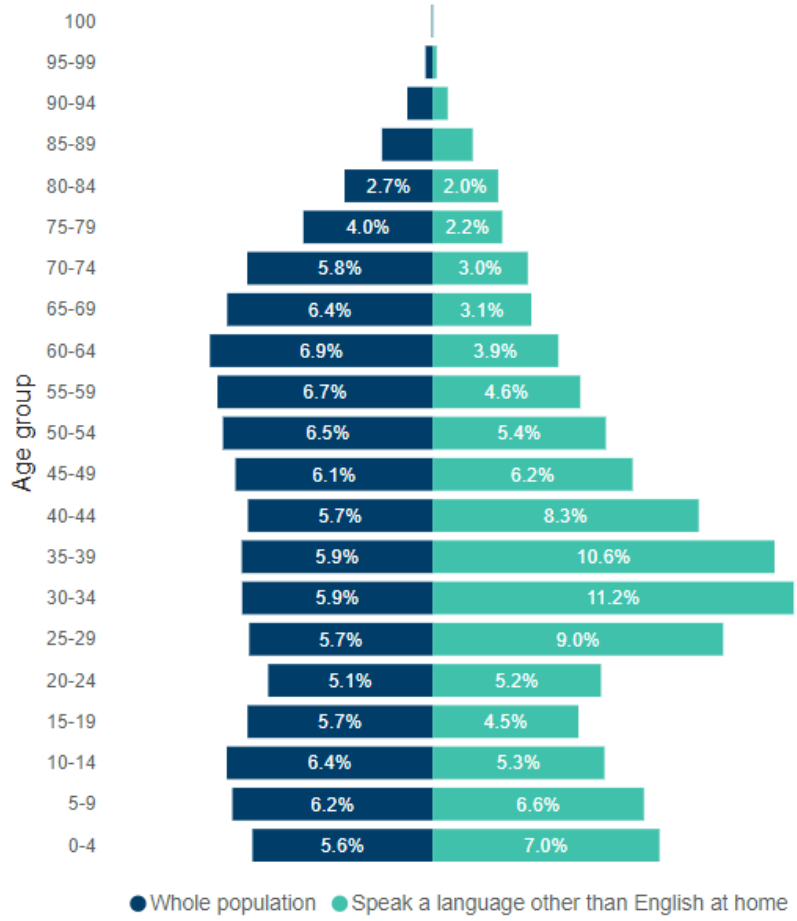
This highlights a crucial gap in healthcare awareness and access among PALM scheme worker communities. To address this issue, interventions focusing on healthcare education, outreach and culturally sensitive support mechanisms are necessary to ensure equitable access to healthcare services for Pacific Islander orchard workers and similar populations.

Population age profile

The CALD population across the Murray PHN catchment has an overall younger age profile than the non-CALD population (by LGA, ABS 2021), as illustrated in Figure 5 below.

- The estimated mean age for all residents within Murray PHN catchment is 41.9 years compared to 36.5 years for those who speak a LOTE at home.
- 50.6% of all people in the Murray PHN region who speak a LOTE at home are between the ages of 20 to 49 years compared to 34.5% of the whole population.
- 16% of the population who speak a LOTE at home are 60 years or older compared to 28.4% of the whole population.

Figure 5: Population age profiles of whole population vs people who speak a LOTE in the Murray PHN region



Source: ABS (2021). Public data: accessible to all audiences.

*Murray PHN totals calculated from LGA level data.

Heath needs and priorities of the CALD population

Table 12 - Rates per 1000* of self-reported long-term health conditions by people who speak a LOTE by Murray PHN region

Health condition	Rate of self-reported health condition per 1000 people					
	People who speak a LOTE at home					Total population
	Central Victoria	Goulburn Valley	North East	North West	Murray PHN	Murray PHN
Arthritis	49	59	62	49	56	**112**
Asthma	50	48	52	41	48	**99**
Cancer (including remission)	17	14	23	14	17	**35**
Dementia (including Alzheimer's)	7	7	10	8	7	**8**
Diabetes (excluding gestational diabetes)	43	56	51	59	53	**52**
Heart disease (including heart attack or angina)	26	29	35	29	29	**49**
Kidney disease	7	8	9	9	8	**12**
Lung condition (including COPD or emphysema)	8	7	10	7	8	**23**
Mental health condition (including depression or anxiety)	53	42	50	37	45	**107**
Stroke	6	8	9	9	8	**12**
Any other long-term health condition(s)	71	61	72	51	64	**85**
No long-term health condition(s)	747	752	732	759	748	**539**

Source: ABS (2021). Public data: accessible to all audiences

*Crude rates are not adjusted for age profiles of the populations which may vary substantially and explain differences between groups.

Cells highlighted red indicate higher rates of ill health compared to total population

Overall rates of self-reported long term health conditions were lower for all conditions in the CALD population compared to the total population. This might be because the rates used are crude (i.e. not age adjusted) and/or due to healthy migrant effect (see literature review page 74). In addition, self-reported data relies on individual factors such as health literacy and therefore differences rates between groups may also be influenced by different individual or cultural understandings of health and/or other social factors such as stigma.

Table 13 - Rates* per 1000 of self-reported long-term health conditions in top 10 language groups across Murray PHN

Health condition	Rates of self-reported health condition per 1000 people									
	Punjabi	Italian	Mandarin	Arabic	Malayalam	Vietnamese	Karen	Nepali	Tagalog	Greek
Arthritis	7	209	12	40	4	14	12	33	37	146
Asthma	15	80	26	68	29	36	26	27	60	74
Cancer (including remission)	2	61	6	7	2	5	6	3	15	30
Dementia (including Alzheimer's)	0	32	1	2	0	0	0	5	0	21
Diabetes (excluding gestational diabetes)	25	129	18	51	41	29	30	48	54	90
Heart disease (including heart attack or angina)	7	102	7	24	11	10	12	12	16	69
Kidney disease	1	29	2	5	4	8	7	7	7	16
Lung condition (including COPD or emphysema)	0	30	4	6	0	3	4	9	2	24
Mental health condition (including depression or anxiety)	6	96	16	51	3	17	17	43	29	107
Stroke	1	30	3	5	0	3	5	0	3	17
Any other long-term health condition(s)	18	114	28	83	24	32	53	54	56	110
No long-term health condition(s)	907	453	881	723	878	822	848	811	776	538

Source: ABS (2021). Public data: accessible to all audiences

*Crude rates are not adjusted for age profiles of the populations which may vary substantially and explain differences between groups.

Cells highlighted red indicate higher rates of ill health compared to whole population

No reliable population data was located for this report about health issues in the refugee sub-population residing in the Murray PHN catchment. Please refer to the literature review for information on the health of refugees in Australia more broadly.

Stakeholder consultation findings

The consultation process with stakeholders across the Murray PHN catchment highlighted a broad range of health and wellbeing issues that were commonly seen in the CALD communities they engaged with.

Table 14 - Health and wellbeing issues evident in the CALD community raised in stakeholder consultations

Health needs	Description
Chronic diseases	Key conditions noted within the CALD population were stroke, heart disease, diabetes, kidney disease and dementia.
Mental health	Despite low rates in the official statistics, poor mental health was a commonly reported concern, especially in the context of trauma, stress, post-traumatic stress disorder and suicide-risk. Cultural differences and understandings of mental health, fear and stigma at the individual, community and health workforce levels were all noted issues.
Women's and reproductive health	High rates of late presentation for antenatal care in some CALD communities as well as multiple pregnancies and other sexual health issues.
Infectious diseases	HIV, Tuberculosis, Hepatitis B, Hepatitis C, Syphilis and other sexually transmitted diseases were noted as more commonly seen in some groups within CALD communities.
Family and gender-based violence	Emphasised as a 'huge issue' in some parts of the CALD community, particularly for people with precarious immigration status.
Alcohol and other drug use	Reported as a concern for some CALD populations, including tobacco, alcohol, opiates and betel nut use. Often presents in conjunction with mental health issues. Additional difficulties noted when use of drugs or alcohol contradict strong individual or community cultural and/or religious beliefs.
Chronic pain	Various presentations, some CALD populations seem to be more commonly affected. A common example was back pain for people with history of manual labour. Adequate pain control can be difficult to achieve, and the use of drugs for pain control including opiates was common.
Late health and cancer screening	Reported as a broad concern, but a serious concern for some specific groups (e.g. the Karen community in Bendigo). A range of factors are thought to contribute such as a lack of health literacy, lack of awareness of screening availability or process, or cultural / community beliefs or misconceptions (e.g. that screening causes cancer).
Occupational health issues	Manual labourers and agricultural workers - key issues are traumatic or overuse injuries and skin and eye conditions.
Autism and other neuro-developmental conditions	These conditions were reported to frequently be undiagnosed in children prior to arrival in Australia but identified once the family has settled.
Exploitation	Sexual exploitation and workplace exploitation can significantly impact health and wellbeing. Some groups within the CALD community were noted to be vulnerable to various forms of exploitation including single women and women on partner visas, refugees, LGBTIQ+ CALD person and people with insecure work and/or visa status.

Nutrition and poor diet	Noted to be an issue of concern by some stakeholders who reported the change in diet and food environment for recent migrants can be problematic. For example, increased availability and consumption of fast food was thought to be a contributing factor to higher rates of diet-related conditions such as heart disease and diabetes.
Homelessness	Reported to be growing issue for CALD populations in some areas (e.g. Bendigo) with housing affordability and availability issues contributing to housing stress with some groups experiencing inadequate housing or seeking alternatives such as setting up informal 'camp' areas.

Stakeholders highlighted several priority population groups who have specific health needs or challenges in accessing adequate primary healthcare.

Table 15 - Priority groups with specific needs identified in stakeholder consultations

Priority group	Description
Children and young people	Stakeholders reported mental health and suicide as a particular concern for CALD young people noting a range of primary health access barriers for this group including lack of service awareness, lack of services in some regional towns, and long waiting lists. The health, education and social needs of some migrant children were also a noted concern for some groups across the region that may be negatively impacted by visa status, Medicare ineligibility, lack of access to preschool and school and other migration challenges families face.
Women and girls	Some CALD or refugee women and girls have a preference to consult female practitioners for cultural, religious or personal reasons. In these cases, engaging with a male practitioner may not result in all of their health needs being met, however stakeholders reported that avoiding this situation was particularly challenging in rural communities with health workforce shortages.
Older people	Certain groups of older CALD people were said to sometimes 'fall through the cracks' of health and other support systems, especially where language was a barrier. For example, stakeholders reported the lack of bilingual workers in aged care homes and aged care support services in rural and regional areas makes communication about even basic needs very difficult for some older CALD people.
LGBTQI+	Stakeholders reported that LGBTIQ+ migrants and refugees often faced additional challenges accessing appropriate support. LGBTIQ+ people from CALD backgrounds were noted be at an increased risk of persecution from non-LGBTIQ+ community members, and/or exclusion from their families. Concerns regarding sexual assault and exploitation, sexual health and mental health support, especially for asylum seekers and persons from ethnic minorities, were also reported.
People with disability	Understanding disability in the Australian context, low health literacy, and poor service awareness and complex health and disability service systems were noted as significant barriers to accessing appropriate health and other services for people with disabilities from CALD backgrounds.
PALM Scheme workers/ families	Stakeholders in the Mildura, Swan Hill and Shepparton regions identified PALM Scheme workers as particularly vulnerable to poor health outcomes. As well as psychological impacts of cultural transition and isolation, environmental health risks were also noted (e.g. manual work accidents and injuries, sun exposure etc) and lifestyle factors, such as alcohol and other drug and tobacco use is a concern for these populations.

	Services report generally lower levels of health literacy, health-seeking behaviour, and service awareness within this cohort. While PALM workers are required to hold private health insurance as a condition of their visa, it was reported that many workers were not using the healthcare system or their insurance coverage.
Asylum seekers and others with uncertain visa status	Service providers reported that some cohorts – people seeking asylum, temporary and bridging visa holders, and unlawful or undocumented residents (e.g. migrants living in Australia on cancelled or expired visas etc) - are especially vulnerable to poor health access. Particularly those ineligible for government support, such as Medicare. Stakeholders noted that the "fear of being found out" was impacting on health access and willingness to seek out healthcare, compounded by a lack of health service awareness and low health literacy to manage the needs of themselves and their families. The exploitation of migrant workers in Australia is pervasive and well documented, with racism, abuse and underpayment of workers, reported by stakeholders.
Torture and trauma survivors	Some populations have survived the trauma of persecution, war or forced displacement and trauma-informed primary care services are essential to healthcare access for these people. Highlighting the importance of trauma-informed care, one stakeholder noted that for many people from CALD backgrounds "trauma itself can be even more of a barrier than language".

CASE STUDY: Bridging Healthcare Gaps for Multicultural Women

Women's Health Goulburn Northeast and Uniting in Shepparton encountered barriers in providing sexual and reproductive health services to multicultural women, particularly Afghan refugees. Language barriers, cultural preferences, and limited access to culturally sensitive healthcare providers posed significant challenges. To overcome these barriers, the service advocated for better interpreter training to ensure interpreters have the necessary medical knowledge and emphasised the importance of debriefing for interpreters to mitigate the impact of misunderstandings. Additionally, they stressed the need for continuous support and reinforcement of health education messages tailored to the cultural backgrounds of the community members. By addressing these barriers and implementing tailored solutions, the service aimed to improve accessibility to sexual and reproductive healthcare for multicultural women in Shepparton.

Strengths and opportunities to address service gaps

Table 16: Service needs, gaps and challenges identified in stakeholder consultations

Service needs	Description

Interpreting services	**Strengths**
	Many primary healthcare and other providers, particularly community health services and funded settlement and refugee health services, are reported to be effectively using interpreting services across much of the Murray PHN catchment.
	TIS National and VITS LanguageLoop were identified as the main providers of interpreting services for primary health services in the catchment. These services generally provide timely access to interpreters, especially when pre-booked. They offer a mix of on-site, phone and video remote interpreting (VRI) services facilitating communication between clinicians and patients, enhancing cultural safety, and improving health outcomes.
	The Victorian Virtual Emergency Department (VVED) was also noted as an effective and free service that incorporates the use of interpreters.
	Gaps and opportunities
	On-site interpreter availability was a challenge in many regions. There were fewer challenges accessing both phone and on-site interpreters in large regional centres such as Bendigo and Shepparton.
	A range of issues were reported in the catchment. They include:
	• Access to on-site interpreters
	  ○ Difficulties accessing in-person interpreters outside larger regional centres.
	  ○ Limited availability of in-person interpreters across the entire catchment.
	  ○ Notable shortages in Albury, Wodonga, Swan Hill, Mildura and more remote LGAs with smaller or new CALD populations (e.g. emerging refugee groups).
	• Use and misuse of interpreters
	  ○ Inconsistent use of interpreters by primary healthcare providers, particularly in private allied health services, specialist clinics, smaller private GP clinics with limited administrative support.
	  ○ Lack of capacity, awareness or skill among primary healthcare providers and staff to organise and use interpreter services.
	  ○ Use of informal interpreters (e.g. community members, family members or bilingual ancillary staff) during medical or specialist appointments, potentially compromising patient privacy, care quality, or therapeutic safety.
	• Privacy and confidentiality
	  ○ Privacy and confidentiality issues, especially in rural towns or communities with small CALD populations where patients may know the interpreter.
	• Cost and administrative barriers
	  ○ Costs of using interpreters for some providers, such as allied health professionals, who may be ineligible for free or subsidised interpreter services.
	  ○ Perceived costs or lack of prioritisation to use interpreting services (e.g. not knowing how to access TIS National).
	  ○ Administrative barriers including booking interpreters, lead times, planning requirements, and availability of interpreters without notice.

Service needs	Description

	• Interpreter competency
	  ○ Inadequate level of health literacy of interpreter
	  ○ Lack of understanding of medical or complex terminology to provide acceptable interpretation
	
	The main reasons reported for healthcare providers not using interpreters include:
	• The cost of engaging interpreter services.
	• Clinics not being registered with interpreter services (e.g. TIS National).
	• Reception staff lacking information (such as booking procedures and access codes).
	• Services reportedly being " not prepared" to book an interpreter.
	
	Case Study: Healthcare access within Refugee Communities
	Stakeholders across the Murray PHN region identified inadequate interpreter use within healthcare settings as a significant barrier to healthcare access. An Albury settlement services provider recalled an occasion whereby a Bhutanese man had been interpreting for his Nepali-speaking refugee wife during her medical appointments, rather than an accredited interpreter. Concerns later arose regarding coercion and control within their relationship, and the impact this had on the woman's privacy, candour with her health practitioner and general help-seeking behaviours.
	Stakeholders also noted concerns about family members, particularly young people, acting as ad-hoc interpreters for their parents or relatives, with concerns raised about errors leading to poor clinical outcomes and the fairness to children in those situations.
	Cases such as these highlight the critical need for safe cultural practices and protocols within healthcare settings. To address this, the settlement service provider sought ways to empower CALD individuals to seek assistance without fear of repercussions, ultimately fostering a culture of trust and support within the community. Advocacy to ensure the appropriate use of accredited interpreters whenever possible was recommended.

Translated resources and information	**Strengths** Translated health information is provided in many parts of the catchment, often through the collaborative efforts of local health and community organisations and local CALD populations. Information often outlines specific medical conditions and treatments and/or how, when and where people can access primary healthcare services. Stakeholders reported using translated health resources for commonly spoken languages in Victoria and Australia that were available through government websites and health networks. Examples of good use of translated resources in the Murray PHN region included: • Bilingual health navigators at Bendigo Community Health Services have developed a range of translated health promotion resources, such as videos, digital books, audio recordings, brochures and fridge magnets etc.

Service needs	Description
	• Gateway Health clinical and non-clinical staff using a combination of translated, Easy English and pictorial 'flash cards' during appointments. • Services in Mildura who collaborated to improve primary healthcare access by promoting and using an online tool that creates appointment reminders via email and SMS in the preferred languages of patients. • Use of the Health Translations website which provides a free online library of high-quality translated health and wellbeing information. The website is an initiative of the Centre for Culture, Ethnicity and Health and is funded the Victorian Government. **Gaps and opportunities** Some gaps or challenges in accessing translated health resources as identified by stakeholders include: • Inconsistent availability of translated resources about specific health conditions or local health services across the catchment. • Inconsistent provision of information in patients' preferred languages. • Limited clinician, staff and consumer understanding of how and where to access translated resources. • Challenges accessing resources for new, emerging or uncommon languages. • A reliance on local communities and organisations to develop resources for languages of local populations often with limited coordination, collaboration or funding support. • Inaccuracies of translations could be a problem with local language speakers identifying errors or discrepancies in the translations provided by recognised translation services and online tools. The use of automated telephone answering systems by health services was also identified as a problem as they are difficult to navigate for people with low English proficiency.

Service needs	Description
Health system navigation support	**Strengths** Stakeholders reported that language barriers, low health literacy and health service awareness often made navigating local health systems challenging for CALD community members. Previous experiences of health systems in individuals' country of origin were also thought to impact on health access, meaning extra support to understand health issues and available services is often necessary. Across the catchment a range of groups provide formal and informal assistance to CALD populations to navigate the health system. This support is offered by: • health services and organisations • settlement support services • ethnic communities' councils • charities, religious organisations and other faith groups • employers • other community and voluntary organisations. Types of support offered might include referral facilitation and direct practical support (e.g. for people with complex and chronic conditions) and support to build health literacy. Some groups also advocate for individuals or groups, encountering specific issues by working with health service providers to improve the 'system' for patients. Some examples of formal health system navigation programs in the Murray PHN catchment include: • The Refugee Health Program - a nurse-led program within community health services aimed to improve primary care access for newly arrived refugee communities. The Victorian Government funded program is delivered in Greater Bendigo, Mildura, Swan Hill, Wodonga and Greater Shepparton. • The Health Systems Navigator program – Commonwealth funded and commissioned by Murray PHN - supports migrant and refugee populations and is currently operating in Greater Shepparton and Greater Bendigo. • Statewide torture and trauma services, such as Foundation House and the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) were noted as important health navigation facilitators providing a range of services to support health access and cultural transition supports. • Murray PHN's HealthPathways tool was recognised as an important clinical tool for GPs and other health practitioners to support health service navigation and health literacy. Other ad-hoc navigation support is also provided by various health and non-health organisations.
	Gaps and opportunities Health system navigation programs are mostly ad-hoc, lacking broader coordination or cooperation between different tiers of government. Funding for health navigation was also reported to be inconsistent or inadequate. Formal navigation programs are not available across the entire catchment and are typically funded in larger regional centres with restrictive scopes, often targeting humanitarian entrants only. Geographic inequity was a noted concern, with many smaller regional LGAs being unable to access necessary funding or resourcing

Service needs	Description
	While some CALD groups report to have good access to health navigation support, disparities exist for several cohorts: • Asylum seekers and people with other visa status face challenges with health system navigation, particularly for those with tenuous or uncertain visa status, such as people with cancelled or expired visas who may fear being identified. • PALM Scheme workers are more likely to interact with the hospital system rather than primary care. Navigation support is usually ad-hoc, provided voluntarily by communities and employers. • People with disability often lack targeted support to navigate health and disability services, obtain appropriate diagnoses, and understand and navigate the NDIS and other disability support systems. Further tailored support is required to help older CALD community members and their families/carers to understand and navigate the Australian aged care system
Settlement support and local coordination	**Strengths** Formal settlement support services are provided by various community organisations, ethnic communities' councils, and charities in several key settlement areas across the catchment via a range of government-funded programs (HSP, SETS etc). These services play a significant role supporting eligible humanitarian visa holders and other migrants to access primary healthcare. Health-related settlement supports include: • Refugee health screening pre and post settlement in Australia • Orientation to government services and the health system (e.g. Medicare, NDIS) • Referrals to GPs and other health providers • Health literacy and health service navigation support • Case management • Community capacity building Adult Migrant English Program (AMEP) providers and TAFEs also provide health-related support to people from migrant and refugee backgrounds learning English. This support includes helping build health system awareness and health literacy. Peak multicultural bodies, such as ethnic communities' councils, also advocate and build capacity within multicultural communities to navigate the health system and facilitate health pathways and partnerships through their established community connections. Active co-ordination and collaboration between health services and other funded settlement services aids the prioritisation of access to healthcare and health screening to recently arrived migrants, as well as streamlining referral processes between a range of health and support services. Stakeholders noted that collaborations between health providers and CALD populations have led to the development of culturally appropriate health programs and resources. Engagement with CALD populations through community events were also reported to foster stronger engagement with health promotion activities, as well as helping develop social connections, networks and improved sense of wellbeing for CALD populations.

Service needs	Description
	Gaps and opportunities Complex eligibility criteria, particularly for some migrant cohorts such as certain visa types being ineligible for support via the SHS and SETS programs, can create confusion about entitlements and access. Stakeholders report significant gaps in the local coordination of settlement-related services, primarily due to issues with resourcing, limited funding, power dynamics, and role clarity. Fragmented services across most Murray PHN sub-regions and a lack of coordination between services and healthcare organisations can lead to sub-optimal support and a lack of care continuity. While community networks and support for some groups, especially newly settled refugee communities, are strong across most regions, the lack of funding for voluntary community support groups and insufficient coordination, collaboration and goodwill between services have undermined efforts to help refugee and other migrant populations integrate and feel supported within their new communities. A lack of engagement and empowerment of local ethnic groups and leaders has also impacted on coordination effectiveness. Feelings of distrust and non-cooperation between services is a factor. Contributing factors include competitive funding models, poor communication, lack of role and purpose clarity, and interpersonal relationship issues. This fractured service system is particularly notable in the North East sub-region, exacerbated by contextual challenges of cross-border service delivery and funding models.
Culturally safe services	**Strengths** Stakeholders gave many examples of primary health services across the catchment that they felt provided culturally safe services to their local CALD communities. The reported actions that these services took included: • employing bilingual and bicultural workers (staff and volunteers) support healthcare access by acting as on-site interpreters within health settings, assisting with health system navigation, accessing health information, and supporting health literacy • offering interpreters and translated health resources • actively seeking to provide a welcoming and culturally safe service • using a trauma informed approach to service provision • providing outreach services • providing integrated care • establishing strong referral pathways between settlement providers and primary care providers • allowing adequate time and opportunities for explanation of important health concepts, treatment advice or referral information. Some local examples of culturally safe primary healthcare services included: • The Multicultural Clinic at Gateway Health (Wodonga), which aims to provide culturally responsive medical care and support to all newly arrived refugees and other patients from culturally and linguistically diverse backgrounds living in the North East region. The clinic is led by refugee health nurses and GPs and supported by bilingual support workers and the use of interpreters. • The 'workforce of multilingual health educators network' (WHOMEn) Project operating out of community health services in Shepparton and Wodonga,

Service needs	Description
	which addresses barriers faced by migrant and refugee women when accessing health related information, aided by in-language health educators. • Bendigo Community Health Services where a team of health system navigators (non-clinical) from local Karen and Hazara refugee populations support service awareness and health literacy in target CALD populations. The navigators also lead the development of health resources in several languages.
	Gaps and opportunities Stakeholders suggested that more bilingual and bicultural workers are needed in primary care settings (in both clinical and non-clinical roles) and particularly in communities with new and emerging CALD populations and regions with higher proportions of people with low English proficiency such as Swan Hill and Mildura. Services also noted that standard GP consultations often do not allow adequate time to engage interpreters, or to ensure that CALD patients clearly understood the information being provided to them. Extending GP appointment times (such as provisions to enable longer consultations through the MBS) may foster understanding and health literacy, and improve access for people from CALD backgrounds, particularly for people with low English proficiency. Examples of systemic racism within the health system include apathy towards using interpreters and avoidance of using interpreter services due to cost and or extra time/effort required. Stakeholders suggest that more needs to be done to address these discriminatory practices and to promote cultural safety education across the primary health workforce. Stakeholders noted that it was often hard for LGBTIQ+ individuals from CALD communities to access services and supports to meet their more complex needs and that more female-specific services and programs were important in improving health access for CALD women and girls.
Health promotion and targeted disease prevention	**Strengths** Some examples of activities across the Murray PHN catchment to support health screening or targeted health promotion activities to specific CALD population sub-groups include: • health promotion activities tailored to communities • targeted screening programs for known health issues, such as breast cancer • torture and trauma counselling and support programs for refugees and asylum seekers • orientation sessions on government programs (Medicare) for newly arrived refugees • targeted programs for women and mothers. Engagement with programs and targeted resources is maximised when service providers can collaborate with local community champions to plan and develop programs, health information and connect with consumers via established community events.

Service needs	Description
Advocacy	**Strengths** Local settlement networks are operating in all four Murray PHN sub-regions. These networks foster collaboration and information sharing between government and non-government organisations, including health, education, faith groups, local government and settlement providers, to support and advocate for the needs of local CALD populations. Goodwill and support for refugee and migrant populations from various community sectors was evident across all Murray PHN sub-regions. Ethnic communities' councils, faith-based groups and charities, and informal interest groups run by volunteers (such as 'community issues groups') were recognised by stakeholders as playing an important role in advocating and advancing the needs of local CALD populations, including health access. Health issues are also advanced at a broader level through various bodies such as the Ethnic Communities' Council of Victoria and the Victorian Multicultural Commission, who remain. Some groups were reported to be effectively advocating for specific health needs of CALD populations and individuals, with examples noted such as advocacy for free hospital care for patient's ineligible for Medicare, or encouraging interpreter use within primary health settings.
	Gaps and opportunities Some stakeholders noted that a lack of coordinated and collective engagement with government agencies, local councils, and other key stakeholders could sometimes reduce the effectiveness of advocacy efforts.
Availability and access to primary healthcare services	**Gaps and opportunities** Access to GP clinic appointments is challenging across the catchment with many reports of practices not accepting new patients and/or having very long wait times to see a doctor. Bulk-billed GP services are in very high demand and can be particularly difficult to access. Workforce issues such as shortages of general practitioners and other primary health workers and high turnover rates in rural and regional areas hinders continuity of care and the ability to build ongoing relationships between CALD populations and health providers. The affordability of standard GP services where gap payments are required is problematic for some CALD groups, particularly those with chronic health issues requiring regular/multiple appointments with a range of providers. Affordability is also a huge issue for CALD individuals who are "invisible" to health and settlement services, either due to fear of identifying themselves (due to visa status etc) or because they are not eligible for Medicare or other funded services. Transport and geographical barriers were a commonly reported challenges to accessing primary health services for CALD communities, examples included: • Transport challenges if groups/families who do not have a driver's licence and/or access to a car. For example, in regional centres some individuals face lengthy/complex bus rides, long walks (sometimes in poor weather conditions) or needing to use (and therefore pay for) taxis to get to medical appointments. • Community transport services are available in some areas but often access was limited by the need to organise/book well in advance and strict eligibility criteria. • In smaller rural towns large geographical distances and therefore long travel times often make to access required health services difficult where there are limited public transport access or the extra expense of petrol when a car is available.

Service needs	Description
	Given the rurality of the Murray PHN catchment, geographic access to primary healthcare and other health services can be limited in many areas. Some specific health services that are difficult to access for some CALD communities include: • Mental health services • Radiology and sonography services. • Dental health services • Paediatric specialist services • Chronic pain services

CASE STUDY: Difficulties navigation essential health service

A stakeholder from Shepparton shared the difficulties faced by a pregnant woman from their local community who due to her visa was ineligible for Medicare. Being unsure of what services were available to her, she had no contact with primary healthcare services for prenatal care. The woman first presented for assistance to a community-based organisation when in active labour as she did not know what else to do. Her first interaction with the medical system was at the local hospital emergency department when she was about to give birth.

This story highlighted the potential health risks and impact that can result from the barriers to accessing primary healthcare services experienced by multicultural communities.

CASE STUDY: Multicultural Community Access to Primary Healthcare

The team at Women's Health Goulburn Northeast (WHGNE) addressed accessibility challenges faced by multicultural communities in accessing primary healthcare. They identified barriers such as language barriers, cultural sensitivities, and lack of tailored resources. To tackle these challenges, they devised resources in multiple languages and collaborated with local organisations like Gateway Health and Uniting to conduct needs assessments focused on gender-specific health issues and disaster preparedness. They implemented practical solutions such as workforce capacity building and used multicultural workers to bridge gaps in healthcare access. By highlighting and addressing these barriers, the service aimed to improve accessibility to primary healthcare for multicultural communities.

Section 3: Regional profiles

North West sub-region

The North West sub-region is a culturally diverse area of the Murray PHN catchment. It has a vibrant agricultural sector with a workforce supplemented by permanent and temporary migrants through programs like the PALM workers scheme which attracts up to 3500 Pacific Island workers to the sub-region during peak seasons. The city of Mildura is also a key regional settlement location for refugees.

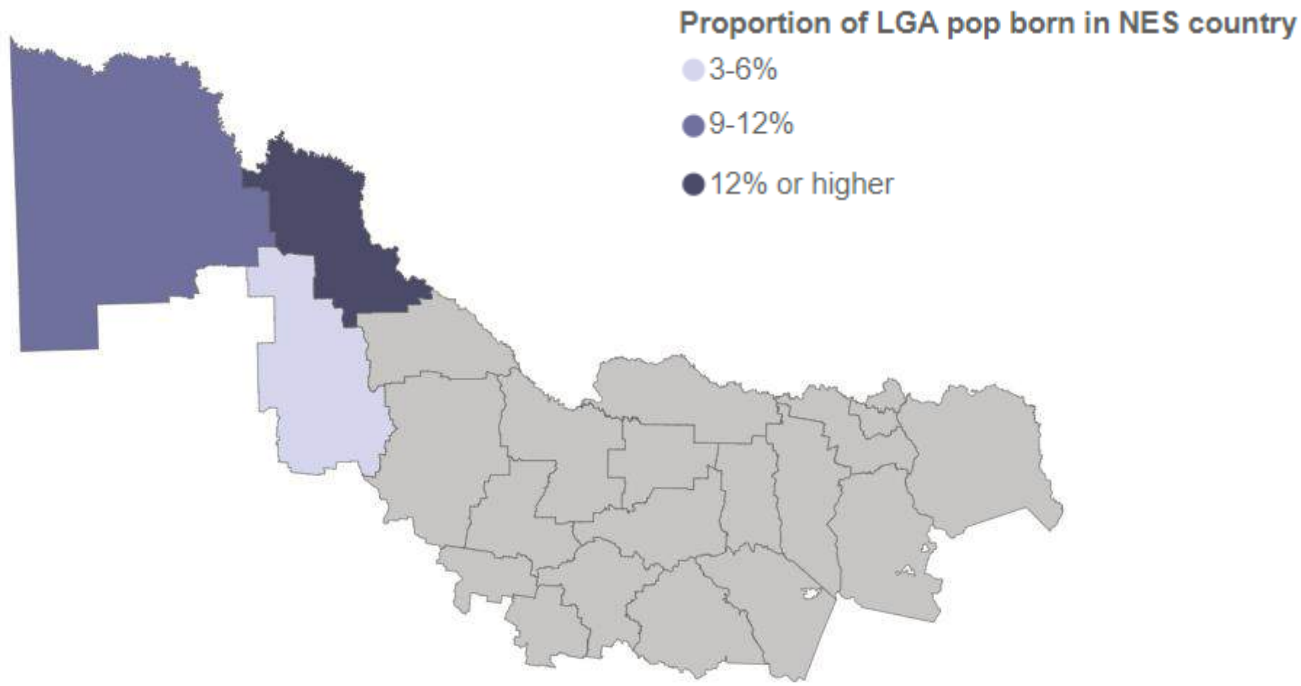
The population of the sub-region fluctuates due to the seasonal workforce particularly in areas such as Robinvale where local studies have shown the population in peak times is over twice that officially recorded in the Census (Geografia, 2019). Therefore, understanding the health needs of these communities through Census data can be difficult.

Services for multicultural communities in the North West are delivered by a range of providers including Sunraysia Mallee Ethnic Communities Council, AMES Australia, Intereach, Robinvale District Health Services, Swan Hill District Health Service and Sunraysia Community Health Services.

Country of birth

The North West sub-region has a total population of 84,543 people, of which 11.2% are born overseas in predominantly non-English speaking countries.

Figure 6: Population born in NES countries in the North West sub-region by LGA



Source: ABS (2021). Public data: accessible to all audiences

Table 17 - People born in predominantly non-English speaking countries in the North West sub-region by LGA, ranked by proportion of LGA population

Rank	LGA	Persons born in NES country	Proportion of all overseas born	Proportion of LGA population	Proportion of Murray total born NESC
1	Swan Hill	3089	87.2%	14.4%	5.9%
2	Mildura	6156	79.6%	10.8%	11.7%
3	Buloke	200	50.5%	3.2%	0.4%

Source: ABS (2021). Public data: accessible to all audiences

Languages spoken

Key insights about languages spoken in the North West:

- Total of 10,646 people speak a LOTE at home
- This is 12.6% of all residents in the NW sub-region and 19.2% of all people who speak a LOTE across the Murray PHN catchment.

Table 18 - People who speak a LOTE at home in the North West sub-region by LGA, ranked by proportion of LGA population

Rank	LGA	Count (persons)	Proportion of LGA population	Proportion of all Murray PHN LOTE speakers
1	Swan Hill	3469	16.2%	6.3%
2	Mildura	6975	12.2%	12.6%
3	Buloke	202	3.3%	0.4%

Source: ABS (2021). Public data: accessible to all audiences

Table 19- Top 10 languages spoken at home in the North West sub-region (ranked by count of persons)

Rank	Language	Count (persons)	Proportion of LOTE speakers in NW sub-region
1	Mandarin	1390	13.1%
2	Italian	1154	10.8%
3	Vietnamese	819	7.7%
4	Malay	768	7.2%
5	Punjabi	622	5.8%
6	Tongan	571	5.4%
7	Turkish	434	4.1%
8	Hazaraghi	358	3.4%
9	Greek	344	3.2%
10	Thai	314	2.9%

Source: ABS (2021). Public data: accessible to all audiences

English proficiency

- Of those who speak a LOTE in the North West, 28.1% reported low proficiency in English (2924 people).
- This is 30.6% of all people reporting low English proficiency in Murray PHN whilst the North West is home to only 12% of the total Murray PHN population

Table 20 - People with low English proficiency in North West sub-region by LGA, ranked by proportion of LOTE speakers within each LGA

Rank	LGA	Count (low English proficiency)	Proportion of LOTE speakers	Proportion of LGA population	Proportion of Murray PHN total low proficiency
1	Swan Hill	1099	32.2%	5.1%	11.5%
2	Mildura	1821	26.6%	3.2%	19.0%
3	Buloke	4	2.6%	0.1%	0.0%

Source: ABS (2021). Public data: accessible to all audiences

Table 21 - Top 10 language groups with low English proficiency the North West sub-region (ranked by count of persons)

Rank	Language	Count (persons)	Proportion of language speakers in NW sub-region
1	Mandarin	776	55.6%
2	Vietnamese	435	53.6%
3	Malay	268	34.9%
4	Thai	163	50.9%
5	Turkish	155	35.5%
6	Italian	149	12.9%
7	Hazaraghi	139	39.0%
8	Tongan	120	21.0%
9	Cantonese	86	38.6%
10	Punjabi	72	11.6%

Source: ABS (2021). Public data: accessible to all audiences

Table 22 - Top 5 languages spoken in each LGA in the North West sub-region, ranked within LGA by Count

Rank	LGA		
	Mildura	Swan Hill	Buloke
1	Mandarin	Malay	Malayalam
2	Italian	Mandarin	Mandarin
3	Turkish	Vietnamese	Filipino
4	Punjabi	Italian	Nepali
5	Vietnamese	Tongan	Tagalog

Source: ABS (2021). Public data: accessible to all audiences

Long term health conditions

Table 23 - Self-reported long-term health conditions in the North West sub-region by people who speak a LOTE at home compared to the total population- (rate per 1000 people)

Health condition	Rate of self-report per 1000 people	
	Speak LOTE at home	Total population
Arthritis	49	101
Asthma	41	99
Cancer	14	31
Dementia	8	8
Diabetes	59	55
Heart disease	29	48
Kidney disease	9	12
Lung condition	7	22
Mental health condition	37	93
Stroke	9	11
Other long-term condition	51	73
No long-term health condition(s)	759	550

Source: ABS (2021). Public data: accessible to all audiences

*Crude rates are not adjusted for age profiles of the populations which may vary substantially and explain differences between groups.

Cells highlighted red indicate higher rates of ill health compared to whole population

Table 24 - Self-reported long-term health conditions in the North West sub-region for the 10 most commonly spoken languages (rate per 1000 people)

Health condition	Top 10 language groups in the North West sub-region									
	Mandarin	Italian	Vietnamese	Malay	Punjabi	Tongan	Turkish	Hazaraghi	Greek	Thai
Arthritis	6	210	22	0	0	35	90	20	183	0
Asthma	19	81	32	18	11	35	97	20	81	16
Cancer (including remission)	0	63	0	0	0	0	28	0	41	0
Dementia (including Alzheimer's)	0	37	0	0	0	7	7	0	29	0
Diabetes (excluding gestational diabetes)	10	153	35	10	48	140	113	36	108	19
Heart disease (including heart attack or angina)	5	101	18	0	5	49	67	11	84	10
Kidney disease	0	25	9	0	0	23	21	0	20	0
Lung condition (including COPD or emphysema)	0	28	0	0	0	0	18	0	35	0
Mental health condition (including depression or anxiety)	5	86	21	5	0	19	150	50	128	13
Stroke	0	31	11	4	0	5	21	0	20	0
Any other long-term health condition(s)	7	120	37	22	6	23	129	81	93	19
No long-term health condition(s)	921	439	795	893	899	739	537	804	480	882

Source: ABS (2021). Public data: accessible to all audiences

*Crude rates are not adjusted for age profiles of the populations which may vary substantially and explain differences between groups.

Cells highlighted red indicate higher rates of ill health compared to whole population

Other health issues

Stakeholders reported the following health issues were specific concerns within CALD communities in the North West sub-region:

- Women's and reproductive health
- Domestic and family violence
- Mental health and AOD issues
- Skin and eye conditions for outdoor workers
- Accidents and injuries for migrant workers doing manual or physically demanding jobs.

Service strengths, gaps and opportunities

Strengths

- Some key primary health service providers (such as Sunraysia Community Health Services and Mallee Family Care) were noted as providing culturally appropriate and responsive services.
- Collaboration between primary health services in Mildura introduced the use of translated appointment reminders.
- Sunraysia Mallee Ethnic Communities Council (SMECC) is recognised for strong leadership, coordination and advocacy in the region.
- The Sunraysia Settlement Network, coordinated by SMECC, collaborates with various community and government organisations to support the needs of refugee and other CALD communities.

Service gaps and opportunities

- Inconsistent access to on-site and telephone interpreters in primary healthcare services across the region.
- A need for more bilingual and/or bicultural health workers in both clinical and non-clinical roles
- Significant lack of access to GP appointments in Swan Hill due to workforce issues
- PALM workers and some migrant groups are ineligible for HSP support, missing out on individualised case management and navigation.
- Opportunity to commission formal health navigation services and support more informal health navigation services for vulnerable groups particularly for PALM scheme workers and their families and other vulnerable groups.

Central Victoria regional profile

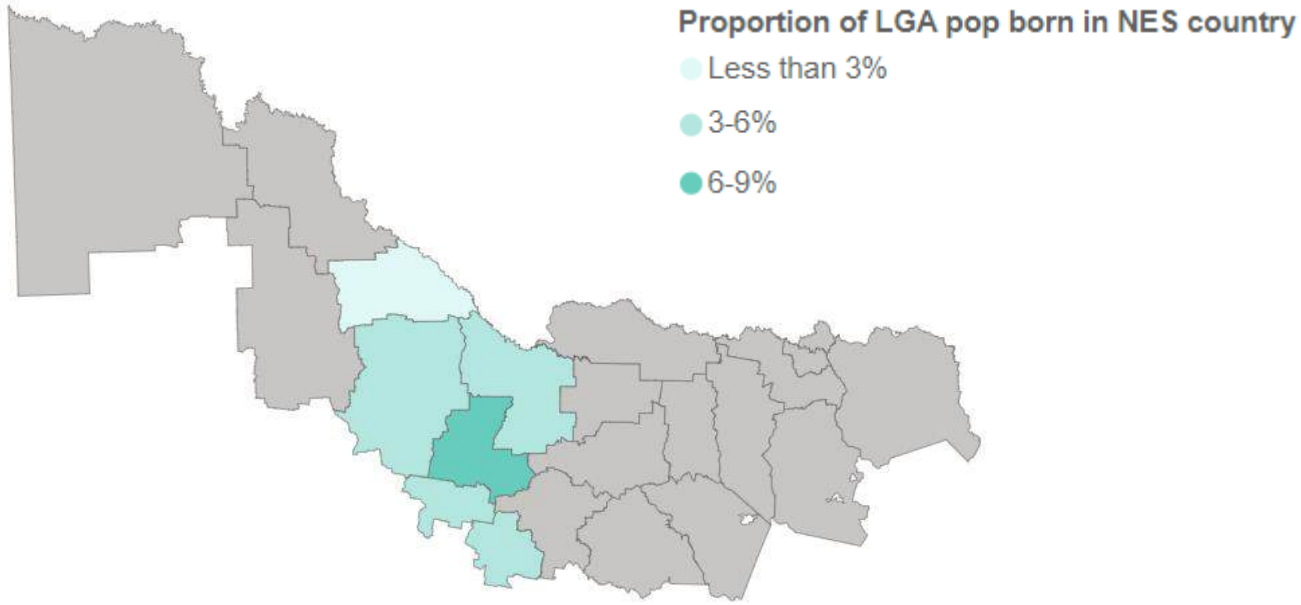
Central Victoria, and particularly Bendigo, has become a significant resettlement area for refugee and migrant populations. Central Victoria has become home to minority ethnic refugee populations such as the Karen from Myanmar, Hazara (Afghanistan), Dinka (South Sudan), and others. Anecdotally, services report that the Bendigo area is home to around 4000 Karen people and 300 Hazara/Afghanis.

To support the settlement and health of refugee and other humanitarian entrants in the region, Bendigo Community Health Services is funded to deliver HSP and SETS services, while Loddon Campaspe Multicultural Services, also based in Bendigo, is sub-contracted by AMES Australia to deliver SETS services in the region. CALD populations considered especially vulnerable to poor health outcomes in Central Victoria include refugee and asylum seekers, migrant workers and elderly CALD people especially those living alone.

Country of birth

Central Victoria is made up of six LGAs and has a total population of 250,379 people, of which only 13,419 (5.4%) are born overseas in predominantly non-English speaking countries.

Figure 7: Population born in NES countries in the Central Victoria sub-region by LGA



Source: ABS (2021). Public data: accessible to all audiences

Table 25 - People born in predominantly non-English speaking countries in the Central Victoria sub-region by LGA, ranked by proportion of LGA population

Rank	LGA	Count	Proportion of all overseas born	Proportion of LGA population	Proportion of Murray total born NES country
1	Greater Bendigo	7542	64.4%	6.2%	14.4%
2	Macedon Ranges	2727	40.6%	5.3%	5.2%
3	Mount Alexander	998	39.9%	4.9%	1.9%
4	Loddon	333	50.2%	4.3%	0.6%
5	Campaspe	1521	53.0%	3.9%	2.9%
6	Gannawarra	298	50.5%	2.8%	0.6%

Source: ABS (2021). Public data: accessible to all audiences

Languages spoken

Key insights about languages spoken in Central Victoria (CV):

- Total of 12,798 people speak a LOTE at home
- This is 5.1% of all residents in the CV sub-region and 23.1% of all people who speak a LOTE across the Murray PHN catchment.

Table 26 - People who speak a LOTE at home in the Central Victoria sub-region by LGA, ranked by proportion of LGA population)

Rank	LGA	Count	Proportion of LGA population	Proportion of all Murray PHN LOTE speakers
1	Greater Bendigo	7814	6.4%	14.1%
2	Macedon Ranges	2331	4.5%	4.2%
3	Campaspe	1502	3.9%	2.7%
4	Mount Alexander	655	3.2%	1.2%
5	Loddon	241	3.1%	0.4%
6	Gannawarra	255	2.4%	0.5%

Source: ABS (2021). Public data: accessible to all audiences

Table 27 - Top 10 languages spoken at home in the Central Victoria sub-region (ranked by count of persons)

Rank	Language	Count	Proportion of LOTE speakers in CV region
1	Karen	1597	12.5%
2	Mandarin	881	6.9%
3	Italian	719	5.6%
4	Punjabi	631	4.9%
5	Malayalam	590	4.6%
6	Filipino	486	3.8%
7	Tagalog	454	3.5%
8	Greek	435	3.4%
9	German	411	3.2%
10	Arabic	353	2.8%

Source: ABS (2021). Public data: accessible to all audiences

English proficiency

Table 28 - People with low English proficiency in Central Victoria sub-region by LGA, ranked by proportion of LOTE speakers

Rank	LGA	Count	Proportion of LOTE speakers	Proportion of LGA population	Proportion of Murray PHN total
1	Greater Bendigo	1418	18.4%	1.2%	14.8%
2	Campaspe	175	11.9%	0.5%	1.8%
3	Loddon	22	10.0%	0.3%	0.2%
4	Gannawarra	21	9.2%	0.2%	0.2%
5	Macedon Ranges	201	8.9%	0.4%	2.1%
6	Mount Alexander	50	8.5%	0.2%	0.5%

Source: ABS (2021). Public data: accessible to all audiences

Table 29 - Top 10 language groups with low English proficiency the Central Victoria sub-region, ranked by Count

Rank	Language used at home	Count (low English proficiency)	Proportion of language speakers
1	Karen	694	43.5%
2	Mandarin	281	31.9%
3	Non-verbal, so described	90	76.3%
4	Vietnamese	59	23.6%
5	Italian	56	7.8%
6	Greek	48	10.9%
7	Punjabi	47	7.6%
8	Malayalam	41	6.9%
9	Thai	39	17.7%
10	Dari	38	48.1%

Source: ABS (2021). Public data: accessible to all audiences

Table 30 - Top 5 languages spoken in each LGA in the Central Victoria sub-region , ranked within LGA by count of persons

LGA	Rank	Language
Campaspe	1	Italian
	2	Filipino
	3	Tagalog
	4	Mandarin
	5	Sinhalese
Gannawarra	1	Filipino
	2	Punjabi
	3	Greek
	4	Tagalog
	5	Malayalam
Greater Bendigo	1	Karen
	2	Mandarin
	3	Malayalam
	4	Punjabi
	5	Tagalog
Loddon	1	Filipino
	2	Tagalog
	3	Bisaya
	4	Malayalam
	5	Italian
Macedon Ranges	1	Italian
	2	Mandarin
	3	German
	4	Greek
	5	Spanish
Mount Alexander	1	German
	2	Greek
	3	Spanish
	4	French
	5	Dutch

Source: ABS (2021). Public data: accessible to all audiences

Table 31 - Self-reported rates of long-term health conditions in the Central Victoria sub-region by people who speak a LOTE at home compared to the total population (rate per 1000 people)

Health condition	Rate of self-report per 1000 people	
	Speaks LOTE at home	Total population
Arthritis	49	116
Asthma	50	99
Cancer	17	37
Dementia	7	8
Diabetes	43	50
Heart disease	26	48
Kidney disease	7	11
Lung condition	8	22
Mental health condition	53	112
Stroke	6	11
Other long-term condition	71	88
No long-term health condition(s)	747	534

*Crude rates are not adjusted for age profiles of the populations which may vary substantially and explain differences between groups.

Source: ABS (2021). Public data: accessible to all audiences

Cells highlighted red indicate higher rates of ill health compared to whole population

Table 32 - Self-reported rates of long-term health conditions in the Central Victoria sub-region for the 10 most common spoken languages (rates per 1000 people)

Health condition	Top 10 language groups Central Victoria sub-region									
	Karen	Mandarin	Italian	Punjabi	Malayalam	Filipino	Tagalog	Greek	German	Arabic
Arthritis	12	16	182	16	5	14	26	117	105	68
Asthma	26	39	103	5	29	70	42	64	41	57
Cancer (including remission)	6	8	53	5	0	0	7	34	39	0
Dementia (including Alzheimer's)	0	0	25	0	0	0	0	0	24	0
Diabetes (excluding gestational diabetes)	27	39	103	17	32	33	66	51	29	65
Heart disease (including heart attack or angina)	12	15	82	0	5	0	22	30	71	54
Kidney disease	8	0	13	0	0	0	0	9	7	25
Lung condition (including COPD or emphysema)	4	9	42	0	0	0	0	21	0	14
Mental health condition (including depression or anxiety)	17	22	125	0	0	6	37	80	131	51
Stroke	5	3	22	0	0	0	0	25	0	0
Any other long-term health condition(s)	50	45	92	27	34	56	59	106	114	110
No long-term health condition(s)	843	839	498	897	907	763	738	566	608	654

*Crude rates are not adjusted for age profiles of the populations which may vary substantially and explain differences between groups.

Cells highlighted red indicate higher rates of ill health compared to whole population

Source: ABS (2021). Public data: accessible to all audiences

Other health issues

Stakeholders reported the following health issues were concerns specific to CALD communities in the Central Victoria sub-region:

- Alcohol and other drug (AOD)
- Chronic pain and back pain
- Late health and cancer screening/diagnoses, particularly in the Karen population
- Poor nutrition and diet and associated risk of dietary related chronic disease
- Homelessness
- Disability.

Service strengths, gaps and opportunities

Strengths

- Several formal health and settlement services are available in the CV sub-region including the Refugee Health Program, Health System Navigators, Humanitarian Settlement Program and Settlement Engagement and Transition Support (SETS). These services are delivered by Bendigo Community Health services, Loddon Campaspe Multicultural Services and Intereach.
- Bendigo Community Health Services was noted as an exemplar in providing culturally safe services. Noted examples of good practice included:
  - employment of bilingual staff from local CALD groups
  - use of written, audio and video translated health resources
  - strong connections and engagement with local CALD community groups.
- The co-location of settlement and health services at Bendigo Community Health supports the streamlining health referral pathways, prioritises healthcare access and supports individualised case management and other settlement objectives (e.g. education, employment, English language).

Service gaps and opportunities

- Language remains a major barrier in Central Victoria, especially for Karen refugees with low levels of English proficiency and literacy in their first language.
- Difficulties accessing GP appointments and long wait times in Bendigo.
- Inconsistent use of interpreters and translated health resources across the wider primary health landscape.

Goulburn Valley regional profile

The Goulburn Valley has a rich history of pre- and post-war migration driven largely by employment in the productive agricultural sector in the region. In recent years, Greater Shepparton has become a key regional settlement location under the Australian Government's Humanitarian Settlement Program with refugees and other humanitarian entrants of various nationalities including Syrian, Afghani, Iraqi, South Sudanese, Malaysian, Sri Lankan and others, having settled in the Goulburn Valley. The growth corridor in Mitchell Shire was also noted for its rapidly growing diverse population, including a large Indian population in the Wallan area.

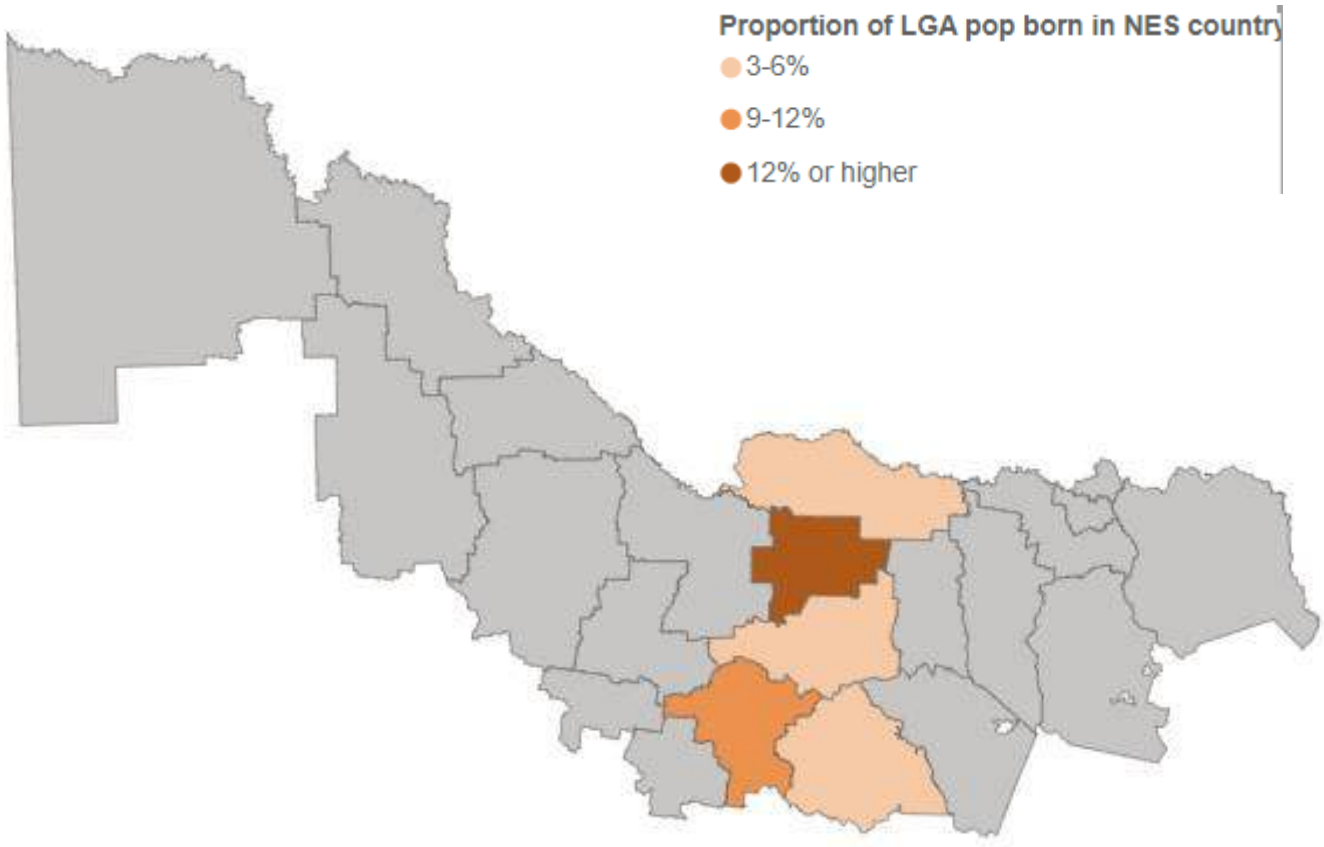
The Goulburn Valley has also become a key employment region for workers engaged under the Commonwealth's PALM scheme, with approximately 1500 (in peak season) workers - mostly from Fiji, Samoa, and Papua New Guinea - filling critical workforce shortages mainly in the region's agricultural sector.

Key service providers in the Goulburn Valley sub-region include Primary Care Connect and Intereach. HSP support services subcontracted by AMES Australia and delivered in Shepparton by Uniting VicTas, and SETS services are delivered by the region's multicultural peak body, the Ethnic Council of Shepparton and District.

Country of birth

The Goulburn Valley sub-region is made up of five LGAs and has a total population of 175,063 people, of which 17,235 (9.8%) are born overseas in predominantly non-English speaking countries.

Figure 8: Population born in NES countries in the Goulburn Valley sub-region by LGA



Source: ABS (2021). Public data: accessible to all audiences

Table 33 - People born in predominantly non-English speaking countries in the Goulburn Valley sub-region by LGA, ranked by proportion of LGA population

Rank	LGA	Count born in NES country	Proportion of all overseas born	Proportion of LGA population	Proportion of Murray total born NES
1	Greater Shepparton	9695	82.0%	14.2%	18.5%
2	Mitchell	4694	65.0%	9.5%	8.9%
3	Moira	1666	56.2%	5.5%	3.2%
4	Strathbogie	518	47.2%	4.5%	1.0%
5	Murrindindi	662	40.0%	4.4%	1.3%

Source: ABS (2021). Public data: accessible to all audiences

Languages spoken

Key insights about languages spoken in GV:

- Total of 20,181 people speak a LOTE at home
- This is 11.5% of all residents in the GV sub-region and 36.5% of all people who speak a LOTE across the Murray PHN catchment.

Table 34 - People who speak a LOTE at home in the Goulburn Valley sub-region by LGA, ranked by proportion of LGA population

Rank	LGA	Count	Proportion of LGA population	Proportion of all Murray PHN LOTE speakers
1	Greater Shepparton	11990	17.5%	21.7%
2	Mitchell	5625	11.4%	10.2%
3	Moira	1585	5.2%	2.9%
4	Murrindindi	561	3.7%	1.0%
5	Strathbogie	420	3.7%	0.8%

Source: ABS (2021). Public data: accessible to all audiences

Table 35 - Top 10 languages spoken at home in the Goulburn Valley sub-region (ranked by count of persons)

Rank	Language	Count	Proportion of LOTE speakers in GV sub-region
1	Punjabi	2890	14.3%
2	Italian	1837	9.1%
3	Arabic	1743	8.6%
4	Mandarin	1158	5.7%
5	Hazaraghi	826	4.1%
6	Turkish	696	3.4%
7	Malayalam	612	3.0%
8	Tagalog	504	2.5%
9	Greek	501	2.5%
10	Hindi	494	2.4%

Source: ABS (2021). Public data: accessible to all audiences

English proficiency

Table 36 - People with low English proficiency in Goulburn Valley sub-region by LGA, ranked by proportion of LOTE speakers within each LGA

Rank	LGA	Count	Proportion of LOTE	Proportion of LGA population	Proportion of Murray PHN total
1	Greater Shepparton	2341	19.7%	3.4%	24.5%
2	Moira	269	17.8%	0.9%	2.8%
3	Mitchell	519	9.5%	1.0%	5.4%
4	Strathbogie	32	9.1%	0.3%	0.3%
5	Murrindindi	34	6.3%	0.2%	0.4%

Source: ABS (2021). Public data: accessible to all audiences

Table 37 - Top 10 language groups with low English proficiency the Goulburn Valley sub-region, ranked by Count

Rank	Language	Count	Proportion of language speakers
1	Mandarin	437	37.5%
2	Arabic	405	23.4%
3	Punjabi	363	12.6%
4	Hazaraghi	295	36.1%
5	Italian	214	11.7%
6	Turkish	152	22.2%
7	Malay	127	28.0%
8	Dari	104	44.8%
9	Albanian	97	20.0%
10	Non-verbal, so described	91	67.4%

Source: ABS (2021). Public data: accessible to all audiences

Table 38 - Top 5 languages spoken in each LGA in the Goulburn Valley sub-region, ranked by Count

Greater Shepparton	1	Punjabi
	2	Arabic
	3	Italian
	4	Hazaraghi
	5	Mandarin
Mitchell	1	Punjabi
	2	Italian
	3	Hindi
	4	Arabic
	5	Mandarin

Moira	1	Italian
	2	Mandarin
	3	Punjabi
	4	Malay
	5	Tagalog
Murrindindi	1	Italian
	2	German
	3	Greek
	4	Mandarin
	5	Punjabi
Strathbogie	1	Mandarin
	2	Italian
	3	Filipino
	4	Thai
	5	Polish

Source: ABS (2021). Public data: accessible to all audiences

Table 39 - Self-reported rates of long-term health conditions in the Goulburn Valley sub-region by people who speak a LOTE at home compared to the whole population (rate per 1000 people)

Health condition	Rate of self-report per 1000 people	
	Speaks LOTE at home	Total population
Arthritis	59	114
Asthma	48	97
Cancer	14	35
Dementia	7	8
Diabetes	56	55
Heart disease	29	49
Kidney disease	8	12
Lung condition	7	24
Mental health condition	42	102
Stroke	8	12
Other long-term condition	61	83
No long-term health condition(s)	752	542

Source: ABS (2021). Public data: accessible to all audiences

*Crude rates are not adjusted for age profiles of the populations which may vary substantially and explain differences between groups.

Cells highlighted red indicate higher rates of ill health compared to whole population

Long term health conditions

Table 40 - Self-reported rates of long-term health conditions in the Goulburn Valley sub-region for the 10 most common spoken languages (rates per 1000 people)

Health condition	Top 10 language groups Goulburn Valley sub-region									
	Punjabi	Italian	Arabic	Mandarin	Hazaraghi	Turkish	Malayalam	Hindi	Tagalog	Greek
Arthritis	12	223	38	14	41	135	5	22	50	140
Asthma	19	76	71	24	10	122	29	53	50	70
Cancer (including remission)	1	58	9	7	0	13	0	6	0	22
Dementia (including Alzheimer's)	0	31	3	0	6	0	0	0	0	22
Diabetes (excluding gestational diabetes)	29	136	53	22	30	98	34	55	65	102
Heart disease (including heart attack or angina)	9	103	18	9	4	53	0	8	8	82
Kidney disease	2	27	3	0	5	4	7	0	12	12
Lung condition (including COPD or emphysema)	0	28	4	0	4	6	0	0	0	12
Mental health condition (including depression or anxiety)	7	94	42	9	23	118	10	6	22	96
Stroke	0	34	2	0	0	16	0	0	6	24
Any other long-term health condition(s)	19	107	85	24	56	119	18	22	54	86
No long-term health condition(s)	894	449	733	889	832	583	863	832	800	535

Source: ABS (2021). Public data: accessible to all audiences

*Crude rates are not adjusted for age profiles of the populations which may vary substantially and explain differences between groups.

Cells highlighted red indicate higher rates of ill health compared to whole population

Other health issues:

Stakeholders reported the following health issues were concerns within CALD communities in the Goulburn Valley sub-region:

- Mental health
- Chronic pain
- Family violence
- Reproductive health
- Infectious diseases.

Service strengths, gaps and opportunities

Strengths

- The Refugee Health Program and Health Systems Navigators programs are both available in the GV sub-region.
- Primary Care Connect who deliver the Refugee Health Program and the Heath Systems Navigators program were noted to provide culturally safe services. They employ bilingual/bicultural workers and provide a range of health and social services.
- Workforce of Multilingual Health Educators' Network (WOMHEn project) provides bilingual health educators in Shepparton. Initially focused on COVID education and vaccinations, it has expanded to cover other health topics, including reproductive health, mental health and prevention of gender-based violence.
- Cross sector collaboration and advocacy has helped to build more consistent referral pathways between settlement and health services.

Gaps and opportunities

- Inconsistent access to on-site and telephone interpreters in primary healthcare services.
- Mental health services are difficult to access with long wait times for initial appointments.
- Opportunity to provide more health service navigation support for priority groups such as PALM scheme workers and older CALD people with low English proficiency.

North East regional profile

North East (NE) sub-region has a long history of migrant and refugee settlement. Following World War II, migrant camps in Benalla and Bonegilla (near Wodonga) were the arrival points for over half of the displaced persons who made Australia their home (NAA). Between 1947 and 1971, more than 300,000 migrants passed through the Bonegilla Migrant Reception and Training Centre, and the Benalla Migrant Camp housed about 60,000 migrants between 1949-1967.

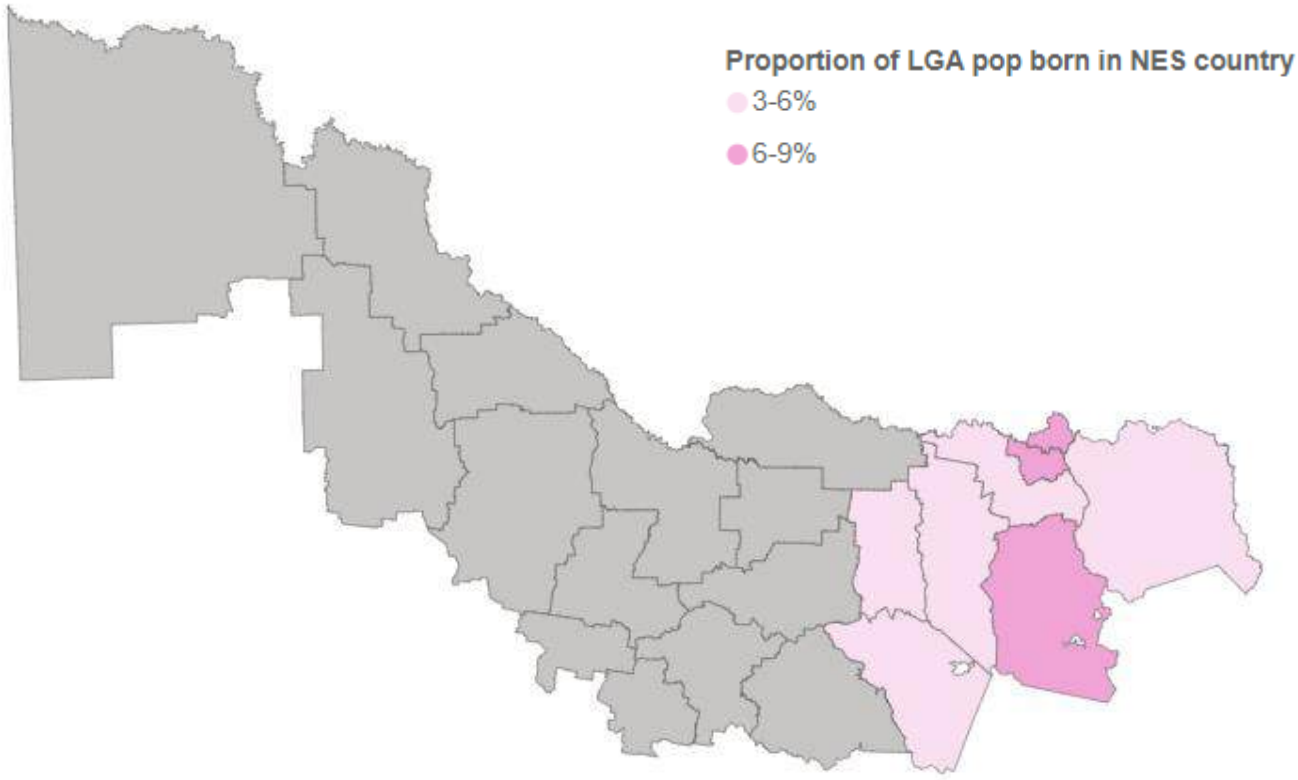
The NE has migrants from more than 80 different birth countries. Stakeholders noted the growth of population of people of Indian and Filipino ancestry across the North East. The sub-region has also become home to emerging communities of humanitarian entrants from countries including Bhutan and Nepal, the Democratic Republic of the Congo, South Sudan, Burundi, Iraq, Iran and Syria supported by the Australian Government's Humanitarian Settlement Program. Within the North East, Albury and Wodonga are key regional humanitarian settlement locations.

Key service providers in the North East sub-region include Albury-Wodonga Ethnic Communities Council, North East Multicultural Association, Gateway Health, Red Cross, Uniting and the Albury-Wodonga Volunteer Resource Bureau.

Demographics of CALD population across the North East sub-region

The NE sub-region is made up of seven LGAs including Albury (NSW). The total population of the sub-region is 190,661 people, of which 6.5% are born overseas in predominantly non-English speaking countries.

Figure 9: Population born in NES countries in the North east sub-region by LGA



Source: ABS (2021). Public data: accessible to all audiences

Table 41 - People born in predominantly non-English speaking countries in the North east sub-region by LGA, ranked by proportion of LGA population

Rank	LGA	Count	Proportion of all overseas born	Proportion of LGA population	Proportion of Murray total born NES
1	Albury	4680	67.2%	8.3%	8.9%
2	Wodonga	3216	66.0%	7.4%	6.1%
3	Alpine	935	51.4%	7.1%	1.8%
4	Wangaratta	1557	59.0%	5.2%	3.0%
5	Mansfield	520	45.9%	5.1%	1.0%
6	Benalla	693	51.4%	4.8%	1.3%
7	Towong	234	47.5%	3.8%	0.4%
8	Indigo	545	37.5%	3.1%	1.0%

Source: ABS (2021). Public data: accessible to all audiences

Key insights about languages spoken in NE:

- Total of 11,672 people speak a LOTE at home
- This is 6.1% of all residents in the NE sub-region and 21.1% of all people who speak a LOTE across the Murray PHN catchment.

Table 42 - People who speak a LOTE at home in the North east sub-region by LGA (ranked by proportion of LGA population)

Rank	LGA	Count	Proportion of LGA population	Proportion of all Murray PHN LOTE speakers
1	Albury	4748	8.5%	8.6%
2	Wodonga	2976	6.9%	5.4%
3	Alpine	901	6.8%	1.6%
4	Wangaratta	1546	5.2%	2.8%
5	Mansfield	416	4.1%	0.8%
6	Benalla	521	3.6%	0.9%
7	Towong	168	2.7%	0.3%
8	Indigo	396	2.3%	0.7%

Source: ABS (2021). Public data: accessible to all audiences

Table 43 - Top 10 languages spoken at home in the North east sub-region, ranked by count of persons

Rank	Language	Speaks LOTE	Proportion of LOTE speakers in the NE region
1	Nepali	1138	9.7%
2	Punjabi	1099	9.4%
3	Italian	1079	9.2%
4	Mandarin	558	4.8%
5	German	503	4.3%
6	Swahili	463	4.0%
7	Tagalog	425	3.6%
8	Filipino	359	3.1%
9	Vietnamese	330	2.8%
10	Hindi	322	2.8%

Source: ABS (2021). Public data: accessible to all audiences

Table 44 - People with low English proficiency in North east sub-region by LGA, ranked by proportion of LOTE speakers

Rank	LGA	Count	Proportion of LOTE speakers	Proportion of LGA population	Proportion of Murray PHN total low proficiency
1	Wodonga	470	16.1%	1.1%	4.9%
2	Albury	721	15.5%	1.3%	7.5%
3	Alpine	100	11.6%	0.8%	1.0%
4	Wangaratta	168	11.0%	0.6%	1.8%
5	Benalla	52	11.0%	0.4%	0.5%
6	Towong	12	8.2%	0.2%	0.1%
7	Indigo	20	5.9%	0.1%	0.2%
8	Mansfield	16	4.2%	0.2%	0.2%

Source: ABS (2021). Public data: accessible to all audiences

Table 45 - Top 10 language groups with low English proficiency the North east sub-region, ranked by Count

Rank	Language	Count	Proportion of language speakers
1	Nepali	385	34.1%
2	Swahili	157	33.8%
3	Mandarin	122	21.7%
4	Italian	121	11.3%
5	Vietnamese	109	32.6%
6	Punjabi	92	8.4%
7	Non-verbal, so described	64	78.0%
8	Lao	40	30.8%
9	Cantonese	38	27.3%
9	Thai	38	15.3%

Source: ABS (2021). Public data: accessible to all audiences

Table 46 - Top 5 languages spoken in each LGA in the North east sub-region, ranked by Count

Albury	1	Nepali
	2	Punjabi
	3	Mandarin
	4	Tagalog
	5	Swahili
Alpine	1	Italian
	2	German
	3	Filipino
	4	French
	5	Mandarin
Benalla	1	Punjabi
	2	Mandarin
	3	Arabic
	4	German
	5	Malayalam
Indigo	1	Italian
	2	German
	3	French
	4	Thai
	5	Dutch
Mansfield	1	German
	2	Mandarin
	3	French

	4	Spanish
	5	Italian
Towong	1	German
	2	Spanish
	3	Filipino
	4	Auslan
	5	Punjabi
Wangaratta	1	Italian
	2	Nepali
	3	Thai
	4	Filipino
	5	Punjabi
Wodonga	1	Swahili
	2	Nepali
	3	Vietnamese
	4	Punjabi
	5	Mandarin

Source: ABS (2021). Public data: accessible to all audiences

Key health issues of the CALD population across North East sub-region

Table 47 - Self-reported rates of long-term health conditions in the North east sub-region by people who speak a LOTE at home compared to the total population (rate per 1000 people)

Health condition	Self-reports per 1000 people	
	Speaks LOTE at home	Total population
Arthritis	62	109
Asthma	52	102
Cancer	23	36
Dementia	10	8
Diabetes	51	50
Heart disease	35	51
Kidney disease	9	11
Lung condition	10	24
Mental health condition	50	111
Stroke	9	12
Other long-term condition	72	87
No long-term health condition(s)	732	539

Source: ABS (2021). Public data: accessible to all audiences

*Crude rates are not adjusted for age profiles of the populations which may vary substantially and explain differences between groups.

Cells highlighted red indicate higher rates of ill health compared to whole population

Table 48 - Self-reported rates of long-term health conditions in the North east sub-region for the 10 most common spoken languages (rates per 1000 people)

Health condition	Top 10 language groups North east sub-region									
	Nepali	Punjabi	Italian	Mandarin	German	Swahili	Tagalog	Filipino	Vietnamese	Hindi
Arthritis	49	0	202	16	157	0	14	19	0	9
Asthma	33	6	67	38	50	0	85	50	18	37
Cancer (including remission)	4	0	75	14	38	0	16	0	0	0
Dementia (including Alzheimer's)	3	0	28	5	34	0	0	0	0	0
Diabetes (excluding gestational diabetes)	59	12	111	25	82	22	33	31	0	50
Heart disease (including heart attack or angina)	13	0	100	7	105	0	0	0	0	0
Kidney disease	5	0	29	0	18	0	12	0	0	9
Lung condition (including COPD or emphysema)	11	0	32	0	24	0	0	0	0	0
Mental health condition (including depression or anxiety)	58	5	97	27	107	0	26	14	0	22
Stroke	0	0	32	0	34	0	0	0	0	0
Any other long-term health condition(s)	73	11	120	30	135	0	71	42	21	25
No long-term health condition(s)	771	956	438	851	459	935	741	816	948	835

Source: ABS (2021). Public data: accessible to all audiences

*Crude rates are not adjusted for age profiles of the populations which may vary substantially and explain differences between groups

Cells highlighted red indicate higher rates of ill health compared to whole population

Other health issues

Stakeholders reported the following health issues were concerns within CALD communities in the North east region (see main report for further details):

- Mental health and trauma
- Women's and reproductive health
- Infectious diseases
- Chronic pain
- Family violence
- Neurodevelopmental conditions in children
- Disability.

Service strengths, gaps and opportunities

Strengths

- Gateway Health is a key primary health provider for CALD communities in the North East. They offer services in Wodonga, Wangaratta and Myrtleford, including a multicultural clinic providing refugee health assessments and refugee health nurses in Wodonga.
- The WOMHEn (Workforce of Multilingual Health Educators' Network) Project provides bilingual health educators in Wodonga. Initially focused on COVID education and vaccinations, it has expanded to cover other health topics including reproductive health, mental health, and prevention of gender-based violence.
- Numerous organisations and groups in the North East sub-region provide health and ancillary services to refugee and migrant populations. These include:
    - HSP services are provided by Red Cross in Albury and by Uniting VicTas in Wodonga.
    - SETS services are delivered across Albury and Wodonga by the Albury Wodonga Volunteer Resource Bureau (case management services) and the Albury-Wodonga Ethnic Communities Council (AWECC) (community capacity building activities).
    - The Albury-Wodonga Multicultural Interagency Network (MIN) facilitates information sharing between agencies and services across various sectors.
    - Voluntary organisations, including the Murray Valley Sanctuary Refugee Group (MVSRG), play a vital role in refugee sponsorship, community support and navigation.

Gaps and opportunities

- Several organisations play a role in providing settlement support, health and ancillary services to CALD communities in the NE region. The interstate, cross-border context in Albury-Wodonga has resulted in a competitive funding and operational environment and led to duplication and inefficiencies, and service navigation challenges for consumers.
- Opportunity to support co-ordination and collaboration between various service providers working in the health and settlement support space.

Section 4: References and attachments

Attachment A Data sources and definitions

Table 49: List of data indicators, sources and definitions

Source	Year	Indicator	Definition/Calculation
ABS	2021	Age (mean) of the CALD population	Estimated mean age calculated from five yar age groups of all people who speak a LOTE at home (excluding Australian Indigenous languages) by LGA, via Census Tablebuilder
ABS	2021	Health conditions in people who speak a LOTE (count)	People who speak a LOTE and reported a long-term health condition, by four digit LANP, LTHP and LGA, via Census Tablebuilder.
ABS	2021	Health conditions in people who speak a LOTE (rate)	(People who speak a LOTE at and reported a long term health condition/ total people who speak a LOTE)*1000, by four digit LANP, LTHP and LGA, via Census Tablebuilder.
ABS	2021	People born in predominantly non-English speaking (NES) countries	No of people born in countries other than Australia, United Kingdom, New Zealand, USA, Canada and South Africa, by LGA, via Census Tablebuilder
ABS	2021	People born overseas	No. of people born in countries other than Australia, by LGA, via Census Tablebuilder
ABS	2021	People who speak a LOTE	No. of people who reported they speak a language other than English at home (excluding Australian Indigenous languages) by LGA or state and language spoken (ABS 4 digit language codes), via Census Tablebuilder.
ABS	2021	People with low English proficiency	No. of people who reported they speak English ‘not well’ or ‘not at all’ by LGA and language (ABS 4 digit language codes), via Census Tablebuilder
ABS	2021	Population	Total population, by LGA, language spoken (2 digit language code) and 5yr age group, via Census Tablebuilder
ABS	2022	Population	Total population by PHN catchment, ABS 2022
Department of Home Affairs	2024	Permanent migrants (by visa stream)	Count of permanent settlers between July 2014 and June 2024 by LGA and visa stream via Settlement reports accessed at www.data.gov.au
DEWR	2024	PALM scheme workers	Monthly counts of total PALM scheme workers January to July 2024, by state or industry via PALM scheme data report accessed via www.palmscheme.gov.au

Attachment B - Data collection and analysis methods

Quantitative data

Quantitative data related to the location, demographics and health needs of people from culturally and linguistically diverse backgrounds were identified. Relevant data were extracted, stored and manipulated to develop key indicators for both descriptive analysis and the modelling components of this health and service needs analysis.

Details and definitions of indicators used in the descriptive analysis are listed in Attachment A - Data sources and definitions.

Quantitative data limitations

Estimating population rates

All rates presented within this report are crude rates and therefore do not take other factors into account that may vary between population groups such as age or socioeconomic status. As such rates should be interpreted with some caution.

Full details for calculations used within this report to estimate population rates are provided in Table 55 in Attachment A - Data sources and definitions.

Using population data sets for analysis at the local level

To avoid the release of confidential and potentially identifiable information, details within publicly available datasets are often suppressed when numbers are small and/or cells are randomly adjusted when extracted at granular levels. Data extracts from the online tools to access data used within this report come with the caveat that, “no reliance should be placed on small cells”. Therefore, the data presented here is the best indication available population demographics and associated issues within the Murray PHN catchment rather than exact numbers. These strategies to protect the confidentiality of the data also affect calculations made when adding small cells within data sets to obtain totals for larger groups. Efforts were made to minimise the impact of this by using direct downloads for grouped totals wherever practical.

Lack of data available for small populations

There is no data available for smaller geographical levels (e.g. LGA) about priority groups with small populations in the Murray PHN catchment because of data suppression and sensitivity reasons, which includes data for refugee populations and PALM scheme workers.

Geographical boundaries

The geographical boundaries for the Murray PHN catchment do not align with LGA boundaries. Subsections of three LGAs (Macedon Ranges, Mitchell and Murrindindi) fall outside the catchment boundary. As a result, data available at the PHN catchment level is calculated using a slightly different geographical area and population compared to totals that are calculated using LGA level data.

In addition, LGA boundaries do not always provide the most useful representation of community structure and function. A key example within the Murray PHN catchment is that when analysing data by LGA, Albury and Wodonga are treated as separate entities. However, in practice, the Albury and Wodonga LGAs largely function as one cross-border community and service access and consumer choice are typically not limited by the LGA/state border, except for practical barriers found in most regional cities such as travel distance.

Another issue is that the use of LGA boundaries in this case may lead to a 'siloing' of the community's demographics. For example, the total numbers or percentage of CALD populations may appear relatively lower than in other regions, or specific health conditions may seem less prevalent. However, when combined, these factors might be higher, which could have implications for service and funding allocation.

Stakeholder consultations

Stakeholder consultations were used to collect qualitative data on health and service needs within multicultural communities. Key stakeholders included service providers from the health and community sectors across the Murray PHN catchment and including people from community organisations and representative groups, primary care services, hospitals and other health services, Commonwealth funded settlement services, multicultural peak bodies, mental health services, and local and state government departments.

The broad stakeholder groups that participated in the consultation are described in Table 10. Snowball sampling was used throughout the consultation process whereby stakeholders identified other key organisations, groups or individuals within their local communities who could contribute additional perspectives.

Table 50: Number of stakeholder organisations and individual participants

Organisation type	No. of organisations represented	Total number of participants
Consumer advisory / representative groups	5	31
Ethnic communities' councils and peak bodies	5	16
Multicultural and settlement service providers	6	15
Primary healthcare providers	9	31
Other health providers (e.g. hospitals, mental health services)	8	28
Local intermediary (e.g. referring service, charity)	12	21
Government / local government	9	11
Other (including Murray PHN Advisory Group / Councils)	4	10
TOTAL	**58**	**163**

Consultation format

Consultations primarily occurred through targeted focus group meetings and semi-structured interviews (in person and online). Other opportunities for gathering information, such as participating in settlement network meetings and communities of practice meetings, were also maximised. Some key organisations were consulted on multiple occasions throughout the consultation process.

Table 51: Number and type of consultation sessions

Consultation method	Description	Number of consultations
Focus groups	Sessions ran for approx. 1.5 hours with representatives from multiple stakeholder organisations.	10
Semi-structured interviews	Sessions ran for 1-1.5 hours with representatives from a single organisation.	13
Other	Unstructured interviews, presentations and feedback sessions conducted at network and Communities of Practice meetings, and written submissions.	6
TOTAL		**29**

Question guide development

Prior to the consultation phase, a literature review was conducted to identify and understand well known issues around access to primary healthcare for multicultural communities in Australia. These findings were used as an entry point for stakeholder discussions and enable elaboration of key issues and in-depth discussions around locally relevant points of similarity or differences. The consultations sought to understand:

- the CALD populations most susceptible to poor health outcomes in the region
- experiences working with or delivering services to CALD populations who access primary healthcare
- experiences (lived/witnessed) of CALD individuals in accessing primary healthcare
- the health status of priority CALD populations and experiences managing conditions
- barriers for CALD consumers when accessing primary healthcare, how these could be reduced and what would enable improved service access
- geographical areas with high identified need and/or low service availability for CALD populations
- the uptake, use and accessibility of current service deliver models to support CALD access to primary healthcare
- innovative or novel service delivery models that enable improved access and health outcomes.

Analysis of qualitative data

Detailed notes were taken in all stakeholder consultation sessions, which were analysed thematically. A descriptive coding strategy was initially used to identify codes relating to key questions and the main themes emerging from the data were then identified and summarised. Results from the analysis are presented in this report according to these themes and any key issues highlighted from a specific sub-region presented in the relevant regional profile.

Table 52: List of key stakeholders involved in consultations for the multicultural health and service needs analysis

External stakeholders
• Adult Migrant English Program (AMEP) providers in Albury, Mildura and Wodonga • Albury-Wodonga Ethnic Communities Council • Albury Wodonga Volunteer Resource Bureau and Multicultural Services • AMES Australia • Arc Justice - incorporating Loddon Campaspe Community Legal Centre and Goulburn Valley Community Legal Centre • Bendigo Baptist Community Care • Bendigo Community Health Services • City of Wodonga • Department of Families, Fairness and Housing (DFFH) • Ethnic Council of Shepparton and District • Gateway Health • GV Health • Haven Home Safe • Loddon Campaspe Multicultural Services • MADCOW Australia • Mallee Accommodation and Support Program • Mallee Family Care • Mallee Track Health and Community Service • Many Coloured Sky

- Mildura Rural City Council
- Mount Alexander Shire Council
- Murray Valley Sanctuary Refugee Group
- NCN Health
- Nexus Primary Health
- North East Multicultural Association
- NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
- Primary Care Connect
- Red Cross
- STRIDE
- Sunbury and Cobaw Community Health
- Sunraysia Mallee Ethnic Communities Council
- The Personnel Group
- The Salvation Army
- Uniting Church in Australia Synod of Victoria and Tasmania
- Uniting VicTas
- Wellways
- Westmont Aged Care Services
- Wintringham
- Women's Health Goulburn North East

Internal stakeholders

- Murray PHN Medical Advisors
- Murray PHN Clinical Advisory Council
- Murray PHN Community Advisory Councils
- Murray PHN First Nations Health and Healing team
- Murray PHN General Practice Team

We acknowledge that there may be other organisations, community groups and individuals, not listed above, who were consulted during this needs assessment, and we thank all of them for their valuable insights.

Resources from the following organisations were also a valuable source of information for this report:

- Victorian Refugee Health Network
- Foundation House
- Centre for Culture, Ethnicity and Health.

Qualitative data limitations

The following limitations to the qualitative methodology are noted:

- Targeted consultation with CALD healthcare consumers was outside the scope of this HNA. However, to ensure the health experiences and perspectives of consumers were obtained, consultation was undertaken with services who directly engage with CALD consumers, such as health service providers, settlement organisations, peak bodies and other services. In addition, many of the consultation participants representing key stakeholders were members of CALD communities and were able to provide insight into their own lived experiences as well as the of their friends, family members and clients and communities they work with.
- Accessing key CALD stakeholders face-to-face was challenging due to project timeframes. To overcome this a variety of consultation methods was used to maximise opportunities for participation (e.g. face-to-face, online, written feedback, phone calls).
- There were no direct questions asked about experiences or observed examples of racism or discrimination within primary healthcare settings, and we noted during the analysis process that there was limited direct discussion of these important issues. All Murray PHN staff and many of the stakeholders involved in the consultation process were from non-CALD backgrounds meaning, on reflection, we had the privilege of choosing not to centre race and racism in the conversations (Goings et al., 2022). The relative absence of the term ‘racism’ has been noted in other recent research of migrant experiences even when asking directly about experiences of discrimination (Wojnicka & Nowicka, 2023). This gap in this qualitative data collection, analysis and reporting will be improved in future needs assessments by planning for power dynamics between interviewer and interviewees and creating safe and brave spaces for discussion about racism.

Attachment C - Literature review

Defining culturally and linguistically diverse populations

There is not a universally accepted or official operational definition of CALD individuals or communities. However, various criteria are commonly used to identify and report on CALD populations. These approaches can vary between organisations (Pham et al., 2021). Two frequently used criteria include:

- *Country of Birth* - This criterion considers individuals born in countries where English is not the primary language. It helps identify people from diverse cultural backgrounds.
- *Language Used at Home* - Individuals who primarily speak a LOTE at home are often considered part of the CALD population (AIHW, 2023a).

Each CALD indicator has its strengths and limitations. Relying solely on a single indicator may not be adequate to fully account for the socio-cultural differences within the CALD population. Therefore, combining multiple indicators provides a more accurate measure of cultural and language background diversity.

The ABS (2022) recommends the use of the '*Standards for Statistics on Cultural and Language Diversity*' when collecting and reporting on information related to CALD status. These standards include a minimum core set of indicators:

- *Country of Birth*
- *Main Language Other Than English Spoken at Home*
- *Proficiency in Spoken English*
- *Indigenous Status.*

The inclusion of Aboriginal and/or Torres Strait Islander status recognises the unique cultural identity of First Nations peoples. In this review as the CALD population was considered as separate to the First Nations population, people who speak an Australian Indigenous language at home were not included as part of the CALD population when LOTE spoken was used as an indicator.

Health needs in CALD populations

Understanding patterns of disease within CALD populations is crucial for providing healthcare services tailored to meet the needs of these communities. However, reporting on the health needs of CALD populations is complex and challenging (AIHW, 2022). Not only are there multiple ways to define the CALD community, but the inclusion of indicators of CALD status within health datasets is inconsistent, with many health datasets including no information on CALD status or collect information on one aspect only. In addition, there is substantial diversity within and between subgroups of the CALD population. For example, those born in the same country may not identify with the same culture, speak the same language or have the same understandings of health.

The "healthy migrant effect" must also be taken into account when considering the health needs within multicultural populations (Huang et al., 2023). The "healthy migrant effect" is a phenomenon whereby migrants from lower income countries migrate to higher income countries, such as Australia, and are generally healthier than people in the host country and their country of origin. The relative health of migrants typically deteriorates over time, eventually levelling out or passing the health status of the local population (Elshahat et al., 2022). There may be several explanations for this, including the rigorous pre-arrival health screening undertaken by migrants means that those who have a chronic illness or disability are less likely to be granted a visa, or that migrants who choose to relocate are typically healthier and wealthier than the populations they leave behind. An important factor to note is that the healthy migrant effect is more likely to be true for voluntary migrants, such as skilled or family stream migrants, and less likely true for humanitarian migrants, such as refugees and asylum seekers.

Mental health in CALD communities

There are significant gaps in data on mental illness prevalence and experiences among CALD populations as data collection systems often fail to capture cultural diversity and national research rarely includes CALD populations. However, we do know that the people within CALD communities can have different mental health experiences compared to other Australians (Embrace Multicultural Mental Health).

People from multicultural backgrounds may have different understandings and perspectives of mental health from the dominant western medical model. These perspectives can affect how they display distress, explain symptoms, seek help and experience stigma or shame around mental ill-health. Research has shown that risk factors for mental health issues in CALD populations include low English proficiency, loss of family bonds, racism, migration stress, trauma, and underused skills while protective factors include religion, social support and higher levels of English proficiency (Embrace Multicultural Mental Health).

People from diverse cultural backgrounds generally have lower and variable rates of access to mental health services compared to the whole population. This can be influenced by factors like country of birth, language, age and gender. These reduced rates of service access often reflect systemic barriers, such as stigma, language issues, cultural misunderstandings and limited knowledge of services, rather than lower levels of distress or need (Embrace Multicultural Mental Health).

Multicultural community members often require additional encouragement to seek mental health support, as they may be reluctant to access support due to these complex cultural and social factors. Language barriers, limited health literacy, lack of knowledge of available support and a feeling of “not being understood” by their GP or specialist (especially if they are from a different cultural background) can also prevent individuals from seeking support (Ethnic Communities' Council of Victoria, 2023). Health professionals who understand these cultural differences and needs can better engage with CALD communities for improved mental health outcomes (Embrace Multicultural Mental Health).

Health needs in refugee communities

Refugees and humanitarian entrants are an increased risk of complex physical and mental health issues due to exposure to trauma and torture, challenges of their migration experience (including experiences in home countries, countries of asylum and periods in immigration detention) and barriers to accessing healthcare both pre- and post-arrival.

While there is limited data available to assess the overall health of the refugees and humanitarian entrant community in Australia, a recent report by the AIHW (2023b) investigated this issue by linking data from several sources. Findings highlighted that compared to the rest of the population, humanitarian entrants had:

- higher rates of diabetes, kidney disease, stroke, heart disease and dementia
- lower rates of arthritis, asthma, cancer, chronic lung conditions and mental health conditions.

After standardising for age, self-reported mental health conditions were 50% lower for humanitarian entrants, and rates of antidepressant prescriptions and GP mental health management plans were also lower for humanitarian entrants than the rest of the Australian population.

An investigation into the use of hospitals and homelessness services by refugees and humanitarian entrants (AIHW, 2024) found that between 2016–17 and 2020–21, humanitarian entrants were nearly twice as likely to be hospitalised or visit an emergency department (ED) compared to other permanent migrants (243 hospitalisations and 293 ED presentations per 1,000 people in humanitarian entrants, compared with 135 hospitalisations and 149 ED presentations per 1,000 people in other permanent migrants).

The Victorian refugee health network provides a comprehensive range of resources and support for health professionals relating to refugee health and referral pathways to health and specialised services at www.refugeehealthnetwork.org.au

Racism and discrimination in the Australian health system

Racism and discrimination are longstanding issues in Australia, with surveys conducted in 2021 demonstrating that 34% of people from non-English speaking backgrounds had experienced racism based on complexion, ethnic origin or religious belief within the last 12 months and 52% of Aboriginal and/or Torres Strait Islander People had encountered at least one form of racial prejudice within the past six months (Australian Human Rights Commission, 2022).

Racial discrimination is known to contribute to disparities in health behaviours, use of care and health outcomes (Williams et al., 2019). In Australia, studies have identified the fear of judgement and/or discrimination based on race, culture or certain health conditions as significant barriers to access to health services for multicultural communities (Bastos et al., 2018; Gatwiri et al., 2021).

Consultations conducted for the recent National Anti-Racism Framework highlighted multicultural groups experience racial discrimination across a spectrum of experiences in the Australian healthcare system including service access, the quality of care received, racism from interpreters and lack of cultural competence from health service providers (Muralidharan et al., 2024).

A recent systematic review of international qualitative studies on racism in healthcare (Sim et al., 2021) revealed that:

- Patients from minority racial groups often felt alienated in healthcare settings and receive less empathetic treatment, which contributes to internalised stigma and racism. People also felt that healthcare professionals made assumptions about their class and social status, or believed they were more likely to exhibit negative behaviours compared to patients from the majority Anglo-Celtic group.
- Racial biases held by healthcare workers were reported to perpetuate racial fault lines through differential treatment of minority patients and shifting blame onto these patients.

A lack of quality cultural safety training for health professionals has been noted in rural Australian health settings (Javanparast et al., 2020).

Barriers and enablers to CALD populations accessing health services

Barriers to accessing healthcare can be cultural, social, environmental and personal and can impede or prevent individuals from obtaining appropriate healthcare when they require it (AIHW, 2020). Recognising and addressing these barriers is crucial for promoting equitable access to healthcare services and improving overall health outcomes.

Table 53: Common barriers CALD communities face when accessing health services

Barrier	Description
Linguistic and cultural Differences	Language barriers can hinder effective communication between patients and healthcare providers. Additionally, cultural differences may affect understanding of health information and willingness to seek care.
Geographic accessibility	Limited access to healthcare facilities due to distance, lack of transportation, or rural/remote locations can prevent individuals from seeking timely medical attention.
Financial constraints	High costs associated with healthcare services, including consultation fees, medications, and diagnostic tests, can deter people from seeking necessary care.
Health literacy	Inadequate understanding of health information, complex medical terminology, and treatment options can lead to delays in seeking help or inappropriate self-management.
Racism and discrimination	Fear of judgment or discrimination based on race and culture or health conditions (e.g. mental health, substance abuse, HIV/AIDS) may prevent individuals from seeking care.
Fear and mistrust	Negative past experiences with healthcare providers, fear of diagnosis, or mistrust of the healthcare system can discourage people from seeking medical attention.
Social and cultural norms	Societal norms, gender roles, and family expectations may influence healthcare-seeking behaviour. For instance, women may prioritise family needs over their own health or for cultural or religious reasons it may be inappropriate for some CALD females to consult a male physician.
Health system complexity	Navigating complex healthcare systems, paperwork, and administrative processes can be overwhelming, especially for vulnerable populations.
Lack of awareness	Some individuals may not be aware of available health services, preventive measures, or early signs of health issues.
Immigration status	Undocumented immigrants or individuals with uncertain immigration status may fear deportation or legal repercussions when accessing healthcare.

The following table outlines factors that enable access to health services for CALD communities based on the “five A’s” principle by Penchansky and Thomas (1981).

Table 54: The five domains of access to health services

Domain	Barriers	Enablers
Affordability the price of services and the capacity of the patient to pay	• Patient cannot afford service or treatment • Patient cannot afford medications • Patient ineligible for Medicare or other financial or government supports • Perceptions of service being high cost	• Equitable service costs • Patient has appropriate health insurance or Medicare coverage • Patient has ability to meet out of pocket expenses or “pay the gap” • Improved perception of value of service

Availability the number and type of services and resource availability	• Lack of services or service types to meet demand or patient needs. • Lack of specialised services (e.g. mental health) • Workforce / personnel shortages • Providers lacking adequate resources (technology, time) to meet the needs of the patient • "Closed books", long waiting lists or long waits in the clinic	• Adequately resourced services (personnel, technology, time etc.) to provide for the needs of patients • Multi-purpose and community health service • Multidisciplinary teams and support networks • Ability to provide longer consultations and shorter waiting lists
Accessibility distance and cost to reach health providers	• Provider's location is hard for patients to reach (e.g. long distance) • The effort and cost to travel to provider is high • Buildings aren't accessible for people with mobility needs	• Services located close to patients • Services reachable by affordable public transport • In-reach and outreach services to minimise patient travel distance and cost
Accommodation how well the provider can meet the preferences (and needs) of the patient	• Restricted service hours • Lack of alternative models of care (e.g. telehealth) • Short appointment times • Long wait times • Waiting lists • Complex intake processes	• After hours services • Telehealth and other consultation and treatment option • Flexible appointments (e.g. ability to book 'walk in' appointments) • Longer consultation times
Acceptability the level of comfort and attitudes of patients and providers about personal or service characteristics	• Patients' attitude to service provider or physician attributes such as ethnicity, culture, sex, age, social class, type or location of facility • Service providers' attitude to patient attributes such as sex, age, ethnicity, culture, socioeconomic status • Provider unwilling to service certain types of patients, or less available to accommodate • Clinical or stigmatising service settings	• Culturally safe and appropriate services, e.g. female physicians available for female patients, if preferred • Non-judgemental, non-stigmatising • 'Welcoming' and suitable service settings • Interpreting services available • Health information and translated resources

Current policy and program context

The following table provides a summary of the current programs and resources that seek to promote health within Victorian and Australian CALD population.

Table 55: Current programs and resources to support the health of multicultural communities in Australia and Victoria

Name	Details
Victorian Department of Health multicultural health action plan 2023-27	This action plan sets out improvement goals and actions to embed cultural competency into the Victorian department of health's services, programs and policies. The plan outlines a vision, together with well as practical resources and supports, good practice principles and examples. The four-year plan has six improvement goals including investing to improve health equity, designing and delivering culturally competent mainstream services and programs, providing language services and accessible communication and building evidence-based approaches through data, research and evaluation.
PHN Multicultural Health Framework (2024)	The Framework was developed to improve health and wellbeing outcomes and experiences for multicultural communities across all PHN regions. The Framework is designed to be a roadmap to improvement and to be flexible, rather than prescriptive, to guide planning and implementation across all areas of PHNs.
Health System Navigator Program	The Health System Navigator Service is commissioned by Murray PHN to health and community organisations through funding from the Australian Government Department of Health and Aged Care and aims to help consumers who face barriers in accessing health services to access the right care, in the right place, at the right time. Health System Navigators provide direct support, health literacy assistance, referral facilitation and advocacy for people with complex chronic conditions. This includes working with health organisations to improve the 'system' for clients.
Refugee Health Program	The Refugee Health Program (formerly the Refugee Health Nurse Program) is funded by the Victorian Government Department of Health and aims to respond and address poor health outcomes and complex health issues of arriving refugees in Victoria. The program is delivered by community health services who employ community health nurses, allied health professionals and bicultural workers.
Good practice approaches in facilitating Primary Health care delivery to Migrants and Refugees	This report describes a diverse range of strategies and initiatives developed by PHNs across Australia to support the health of migrant and refugee populations. It presents a suite of 'good practice approaches' for PHNs that are flexible and can be tailored to meet local community needs as well as regional PHN priorities and capacity. The report emphasises the critical role that collaboration and partnerships with local stakeholders such as health providers, settlement support organisations and CALD communities play in the success of these initiatives.
Better practice guide for multicultural communications (2023)	This guide provides practical insights to enhance communication with multicultural communities. It outlines principles for better communication, suggests various ways to engage diverse audiences, and includes case studies illustrating good practice. The guide emphasises cultural sensitivity and effective messaging.
Framework for Mental Health in	A free, online, national framework developed by Embrace Multicultural Health (the Embrace Project) to support Australian mental health services, practitioners, Primary Health Networks and others to work effectively in a

Multicultural Australia	multicultural context. The framework allows organisations and individual practitioners to evaluate and enhance their cultural responsiveness, with access to a range of support and resources. The framework is mapped against national standards to help organisations meet their existing requirements.
Recommendations for a culturally responsive mental health system (2021)	The Ethnic Communities' Council of Victoria (ECCV) and Victorian Transcultural Mental Health released recommendations for building a culturally responsive mental health system. This document outlines strategies such as increasing access to culturally sensitive mental health services, providing culturally competency training for mental health professionals, improving language assistance services, and promoting community engagement and involvement in mental health initiatives. These recommendations emphasise the importance of understanding cultural beliefs, values, and practices in mental healthcare delivery to ensure equitable access and positive outcomes for all members of Victoria's diverse population.

The following table provides a summary of key policies and programs more broadly related to Australia's multicultural communities.

Table 55: Current policy and program context for CALD communities in Australia

Name	Description
Australian Human Rights Commission	The Basic Human Rights and Freedoms state, "*the right for everyone to the enjoyment of the highest attainable standard of physical and mental health"*.
Racial and Religious Tolerance Act (2001)	A legislative framework aimed at promoting harmony and respect among different racial and religious groups. Enforced by the Victorian Equal Opportunity and Human Rights Commission, the act prohibits conduct that incites hatred, serious contempt, or severe ridicule based on race or religion. It provides avenues for individuals to seek redress in cases of discrimination or vilification, fostering a culture of tolerance, understanding, and equality within the community.
The People of Australia-Australia's Multicultural Policy (2011)	A landmark policy initiative introduced by the Australian Government aimed at fostering and celebrating Australia's cultural diversity while promoting social cohesion and inclusion. The policy emphasised principles of equality, fairness and respect for all Australians regardless of their background.
Multicultural Framework Review (2024)	The review is a first principles review of multiculturalism in Australia. It aims to provide clarity on the principles of multiculturalism, ensuring they are relevant, responsive and adaptable over time. The review seeks to advise the government on what institutional, legislative and policy settings can best build Australia's multiculturalism over the next decade. It also aims to identify how to better meet the needs of Australia's increasingly diverse society.
National Anti-Racism framework (2024)	The National Anti-Racism Framework was developed by the Australian Human Rights Commission and released in November 2024. It provides a roadmap for governments, business and community organisations to address all forms of racism in Australia. The framework outlines 63 recommendations for a whole of society approach to eliminating racism, with proposed reforms across Australia's

	legal, justice, health, education, media and arts sectors as well as workplaces and data collection.
Australian Government Migration Strategy (2023)	The Australian Government's Migration Strategy details a national plan to reorient the migration system to support the attraction of migrants with the skills Australia needs, including in healthcare. With it the strategy recognises the role that a strong healthcare system plays in supporting successful migration in communities.
Pacific Australia Labour Mobility (PALM) scheme:	The Pacific Australia Labour Mobility (PALM) scheme allows eligible Australian businesses to hire workers from nine Pacific islands and Timor-Leste when there are not enough local workers available. The PALM scheme helps to fill labour gaps in rural and regional Australia and allows Pacific and Timor-Leste workers to take up jobs in Australia, develop their skills and send income home.
PALM - Community Connections:	Community Connections is a partnership between the Australian Government and a designated organisation in each state to provide support to PALM scheme employers and workers to help build relationships between workers and their local communities. In Victoria the service is provided by the Uniting Church in Australia Synod of Victoria and Tasmania.
Humanitarian Settlement Program (HSP):	The HSP is funded by the Australia Government Department of Social Services and supports humanitarian entrants and other eligible visa holders integrate into Australian life by helping new arrivals (within the first 12-18 months of settlement) build the skills and knowledge they need. The program has a strong focus on helping people to learn English, gain employment and access education and training.
Settlement Engagement and Transition Support (SETS) Program:	The SETS program is funded by the Australian Government Department of Home Affairs and aims to equip and empower humanitarian entrants and other eligible permanent migrants and their communities to address their settlement needs. It focuses on improving social participation, economic wellbeing, independence, personal well-being, and community connectedness.
Adult Migrant English Program (AMEP)	AMEP is a free service to help eligible humanitarian entrants and other migrants with low English levels to improve their English language skills and settle into Australia. The program aims to support CALD populations to participate more fully in Australian life. AMEP is an Australian Government initiative delivered by TAFE's and other education providers in more than 300 locations around Australia.

Attachment D - References

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