# Community consultations with Arabic, Punjabi and Vietnamese-speaking Women on Periods & Health Checks

**A community-led engagement project with community hubs in VIC, NSW & QLD.**

**June 2025**

Jean Hailes for Women's Health

Community hubs
Connect. Share. Learn.

jeanhailes.org.au

# Table of Contents

# Acknowledgements

Jean Hailes acknowledges the Traditional Owners of Country throughout Australia in which this project took place, and recognises their continuing connection to land, waters and culture. We pay respect to Elders past, present and emerging.

We would like to acknowledge and thank the women and hub leaders from the following Community Hubs for their involvement in this community project, and sharing their experiences: Prarievale Public School; Banksia Road Public School; Bankstown Public School; Chester Hill Public School; Inala State School; Davis Creek Primary School; Doherty's P-9 College; Point Cook P-9 College; and Truganina South Primary School.

This project was supported by the Australian Government Department of Health, Disability and Ageing as part of the funding program for the national digital gateway for women's health information.

# About Jean Hailes

Jean Hailes for Women's Health is a national not-for-profit organisation dedicated to empowering women to enjoy their best health and wellbeing at every life stage.

Jean Hailes is working to create an Australia in which gender has no influence on health and wellbeing outcomes. We are working collaboratively with and alongside others to systematically identify and overcome structural, social and cultural barriers through a focus on four key pillars: providing health information that women need to make decisions about their health, conducting advocacy that addresses the barriers that women experience, sharing clinical expertise across Australia, and partnerships that connect organisations and initiatives across the health and related sectors to facilitate and drive change for women's health.

# About Community Hubs

The National Community Hubs Program (NCHP) model is a proven place-based and people-centred way of building connections and social and economic capital within culturally and linguistically diverse communities. Community hubs build social cohesion in Australia. They are welcoming places where families from diverse backgrounds, particularly mothers with pre-school children, come to connect, share and learn. Hubs are embedded in primary schools and help bridge the gap between families and the wider community. They connect families with each other, with their school, and with local services and support.

# Executive Summary

Ensuring women's health is a priority involves recognising and addressing the varied needs of all women in the community, particularly those from multicultural and linguistically diverse backgrounds.

This community-led project, delivered in partnership between nine Community Hubs and Jean Hailes, aimed to centre the voices of Arabic, Punjabi, and Vietnamese-speaking communities to better understand their experiences, preferences, and needs in accessing women's health information in Australia.

Consultations with 69 women across 9 Community Hubs in NSW, VIC, and QLD revealed a range of cultural, linguistic, and systemic barriers to accessing health information. Key themes explored in focus groups included trusted sources of health information, preferred formats for receiving information, cultural perceptions of periods and health checks, and feedback on existing Jean Hailes resources.

The findings revealed strong preferences for visual and bilingual resources, videos featuring lived experience, and face-to-face health discussions in trusted community spaces. Participants identified cultural stigma around menstruation, hesitancy around health checks, and significant gaps in knowledge on topics like hormonal health, menopause, and mental wellbeing.

In light of these findings, some recommendations which could assist in strengthening the promotion of women's health initiatives in Arabic, Punjabi, and Vietnamese-speaking communities and create a supportive, more inclusive and culturally responsive approach are:

- Translate and adapt health resources into community languages.
- Ensure diverse and culturally appropriate representation in visual materials.
- Encourage in-person forums and safe spaces for open discussion.
- Engage trusted community leaders and champions to support outreach.
- Normalise health conversations across generations.
- Encourage men to participate in supportive roles in women's health.

This project highlighted the value of working closely with Community Hubs to connect with Arabic, Punjabi, and Vietnamese-speaking women. Creating a culturally safe space helped women feel comfortable sharing their health needs and experiences. While feedback was overwhelmingly positive, the suggestions offered valuable insights to improve future work and engagement. The lessons learned provide a strong foundation for more inclusive and meaningful women's health initiatives.

# Introduction

## Background

In Australia, the top five languages spoken at home (other than English) are Mandarin, Arabic, Vietnamese, Cantonese, and Punjabi. For this project, Jean Hailes focused on three key language groups: Punjabi, Vietnamese, and Arabic based on population trends, community needs, and health access considerations.

- Punjabi is the highest and fastest-growing language group in Australia, with a significant rise in the number of people speaking it at home. It also represents the second-largest growing overseas-born population.[1]
- The Vietnamese-speaking community has a relatively high proportion of individuals with low literacy levels, and previous community engagement has identified a strong need for translated health resources. [2]
- Arabic is now the second most spoken language at home in Australia and has seen substantial growth since 2016. While Jean Hailes has developed many translated resources in Arabic, there is a recognised need to better reflect cultural diversity within Arabic-speaking communities, considering variations in geography, culture, and religious beliefs. [3]

## About the Project

### Project Objectives

- To work collaboratively with Punjabi, Vietnamese, and different Arabic-speaking women to test whether our existing core women's health content is culturally appropriate, and if certain health topics may need to be revised to account for cultural differences.
- To understand the format and channels used by these groups to get their health information.

---

[1] **Australian Bureau of Statistics.** *Cultural Diversity of Australia.* ABS; 2022. Accessed May 30, 2025. https://www.abs.gov.au/articles/cultural-diversity-australia

[2] **Queensland Health.** *Vietnamese Australians: Community Profiles for Health Care Providers.* Division of the Chief Health Officer, Queensland Health; 2011. Accessed July 7, 2025. https://www.health.qld.gov.au/__data/assets/pdf_file/0029/157439/vietnamese2011.pdf

[3] **Australian Bureau of Statistics.** *Cultural Diversity of Australia.* ABS; 2022. Accessed May 30, 2025. https://www.abs.gov.au/articles/cultural-diversity-australia

- To scope health knowledge gaps experienced by Punjabi, Arabic and Vietnamese-speaking women more broadly, through an ‘engagement’ with the Community Hubs program, scoping the communities’ needs.
- To promote and disseminate women's health information and resources which are found to be culturally appropriate to culturally and linguistically diverse women through the Community Hubs Program in QLD, VIC, and NSW.

# Approach

## Partnership

This community project was undertaken in a partnership between Jean Hailes for Women's Health and the Community Hubs program. This partnership developed through previous collaboration with select Community Hubs during Women’s Health Week events and provided connections to the three language groups for this project.

## Participant overview & recruitment

Of the 100 Community Hubs across South Australia, Queensland, Victoria and New South Wales, 37 were invited to participate in the project, based on language data provided by Community Hubs Australia. Following the expressions of interest, 9 Community Hubs were confirmed. These hubs met the project criteria, had capacity within their schedules, and were confident in their ability to engage their local community members in the consultation process.

To support planning and create a collaborative approach, an online survey was shared with the community hub leaders, followed by a series of meeting to discuss timelines, refine the consultation approach, and co-design the consultation content.

Key activities and engagement included:

- initial introductions and relationship building with Hub leaders,
- scoping discussions to identify relevant health topics, estimate participant numbers and confirm eligibility using survey data,
- coordinating consultation logistics, including resource needs, venue arrangements and session scheduling,
- collaborating to develop and refine consultation questions to ensure cultural appropriateness and accessibility,
- gathering feedback on the overall approach and evaluating the projects effectiveness.

Community hub leaders recruited interested participants from the 3 language groups and were given a flyer and information sheet. Participants completed a consent form and were reminded of the voluntary and confidential nature of the consultations.

To support accessibility and inclusion during the consultation process, translators were appointed where needed to assist with language interpretation. Childcare services and catering were also provided to ensure participants could fully engage. However, the timing of some sessions coincided with Ramadan, and as a result, women observing the fast were unable to participate in the morning or afternoon teas. As a gesture of appreciation for their time and valuable contributions, all participants received a $100 Visa gift card.

## Data Collection and Analysis

A mixed method approach was used for this project, incorporating both qualitative and quantitative data collection methods. The qualitative component involved in person focus groups facilitated by Jean Hailes using a discussion guide with open ended questions to explore participants' views, experiences and preferences. Each session was facilitated by a Jean Hailes team member and a note taker. Out of the 9 focus groups, 6 were audio recorded over teams to support notetaking and ensure accuracy, due to the notetaker being unable to attend in-person. A general inductive approach was applied to analyse the qualitative data. Notes taken during the consultations were imported into NVivo software for thematic analysis. Initial open coding was conducted, followed by a refinement process where codes were grouped, collapsed, and merged into a final set of overarching themes presented in the findings section.

In addition to this, a paper survey to gather quantitative data was also completed. The survey provided complementary data by capturing participants responses to health knowledge, behaviours, and information preferences, helping to strengthen the overall interpretation of the data.

Overall, 69 participants from 12 culturally and linguistically diverse communities, with varied migrant experiences, and English proficiency levels took part in the project. Majority were first generation migrants, with the median age of Arabic and Punjabi participants being 36-40 years old and Vietnamese being 41-45 years old. University education was the most frequently reported highest level of education among participants (30.4%), with secondary school education close behind (29%). Postgraduate qualifications were held by 23.2% of participants, while 13% had completed vocational or job training. Only a small number (4.3%) indicated primary school as their highest level of education.

| Language group | Total number participants | Number of participants in periods | Number of participants in Health Checks |
|---|---|---|---|
| **Arabic** | 30 | 20 | 10 |
| **Punjabi** | 27 | 17 | 10 |
| **Vietnamese** | 12 | 2 | 10 |

**Table 1. Number of participants for each language group for periods and health checks.**

| Language group | 20-25yrs | 26-30yrs | 31-35yrs | 36-40yrs | 41-45 yrs | 46-50yrs |
|---|---|---|---|---|---|---|
| **Arabic** | 0 | 3 | 4 | 11 | 7 | 5 |
| **Punjabi** | 1 | 0 | 9 | 8 | 7 | 1 |
| **Vietnamese** | 0 | 0 | 0 | 5 | 4 | 3 |

**Table 2. Age range of Arabic, Punjabi and Vietnamese participants**

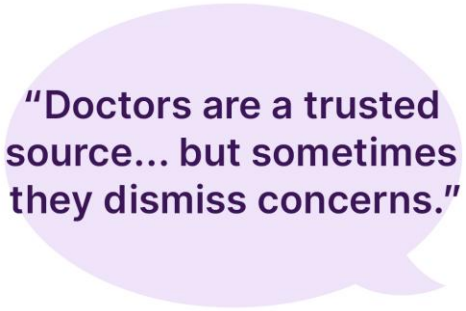
| State | School | Arabic | Punjabi | Vietnamese |
|---|---|---|---|---|
| **New South Wales** | Prarievale Public School | 5 | - | 2 |
| | Banksia Road Public School | 8 | - | - |
| | Bankstown Public School | - | 4 | 6 |
| | Chester Hill Public School | 5 | - | - |
| **Queensland** | Inala State School | 3 | 4 | 2 |
| **Victoria** | Davis Creek Primary School | 4 | 5 | - |
| | Doherty's P–9 College | - | 8 | - |
| | Point Cook P–9 College | 3 | 4 | 2 |
| | Truganina South Primary School | 2 | 2 | - |

**Table 3. Number of participants and language spoken in each state's Community Hub.**

# Key Findings

## Arabic-speaking women

### Trusted sources of health information



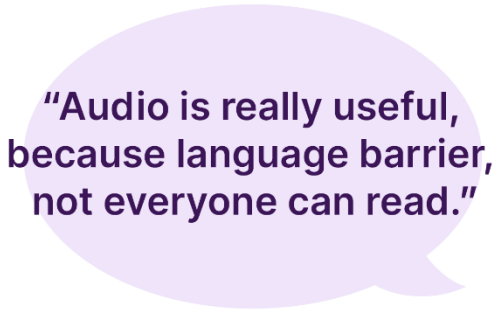

Arabic speaking women rely on a mix of personal networks, professional advice and digital tools when seeking health information. Most commonly, they first turn to friends or family for advice, especially those who have experienced similar health issues. This reflects a strong value placed on lived experience and peer reassurance: *“The first thing I do when facing a problem is ask my friends for advice or support. It's easier to talk to them and I value their input more."*

GPs and specialists are generally respected for their qualifications and expertise, however there is mixed perceptions around this. Participants expressed their mistrust of doctors because of their experiences of being dismissed, receiving contradictory information and not being proactive in their approach to health concerns. One participant described the health system as a *"money-making business"*, expressing frustration and a preference for self-research and community shared knowledge*: “Doctors are a trusted source… but sometimes they dismiss concerns.”*

Women shared that doctors from similar cultural backgrounds, regardless of whether they speak Arabic, are often perceived as being more relatable and understanding towards their health. This highlights how cultural familiarity helps build trust in healthcare settings. Women expressed a preference for female health professionals finding them more relatable, empathetic and easier to talk to about personal health issues. However, they also made it clear that they are open to seeing male doctors when needed, with no cultural or religious restrictions: *“In Arabic there is a saying ‘there is no shyness in medicine.’ It doesn’t matter if I have a male gynaecologist, but there is a lot of shyness, many feel uncomfortable, especially with sexual health topics.”*

Women also trusted peer-shared lived experiences and community groups (through WhatsApp, social media and Facebook groups) as they offered relatable and firsthand advice. Online research is common, often used to cross check or prepare for appointments. Digital literacy appears to empower women to advocate more confidently during medical appointments*: "I use Google for general health information to have background knowledge before visiting the doctor. Sometimes doctors provide incorrect information, so I double check. I once advised a doctor to check for an ear infection for my child, and I was right, knowledge is key!"*

## Preferred formats for receiving health information.




Participants expressed a clear preference for health information that is accessible, engaging and culturally relevant. Audiovisual formats were especially valued for their clarity, simplicity and ability to engage people across different literacy levels and age groups.

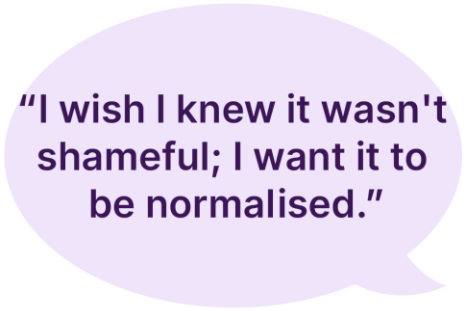
Social media platforms like Facebook, YouTube, and WhatsApp are widely used to access and share health information within community groups. However, participants highlighted the importance of receiving content from credible sources, such as trusted health professionals. This was seen as more trustworthy and impactful than material from influencers.

Paper-based resources are still valued, particularly when bilingual (English and Arabic), and are considered helpful for older adults or those with limited digital access. However, participants emphasized that long, or text-heavy materials can be discouraging: "*I find it helpful to receive info in paper form, provided in both English and Arabic".*

Audio content is also important, particularly for those with low literacy or limited English proficiency: *"Audio is really useful, because language barrier, not everyone can read."*

Interactive formats such as community forums and health sessions were seen as the most effective for learning and engagement: *"Interactive discussions help retain information better than just being told."*

## Experiences and cultural perspectives on periods




Discussions about periods revealed recurring themes of taboo, tradition and transition. Periods were often viewed as a way of cleansing the body of toxins and often considered private or even shameful. This was more common in older generations. However, younger women and mothers are showing a clear shift toward more openness in discussing reproductive health: *“Older generation avoids talking about sexual health and periods with daughters. Younger generations are more open.”*

Arabic speaking women mentioned that women would have their own slang to talk about or describe periods, for example "I got the email". Cultural myths persist, such as avoiding hot showers during periods or beliefs about food and hygiene. These are often passed down generationally and can lead to confusion or misinformation: *“Mum used to tell us that you should never shower in hot water when you have your first day of period.”*

A significant proportion of Arabic-speaking women in this project experienced heavy bleeding, with 14 out of 20 participants identifying it as a personal health concern. There was a clear and consistent call for greater education and normalisation of menstrual health, particularly to support younger generations and break longstanding cycles of silence and stigma within families and communities*: “I wish I knew it wasn't shameful; I want it to be normalised.”*

Religious beliefs can influence how women understand and manage their periods. In Islam for example, women who are menstruating are not required to fast during Ramadan. Their religion also encourages women to rest during their period cycle, acknowledging that it is a time they are exempt from certain religious and domestic duties, including prayer and caregiving duties.

## Experiences and cultural perspectives on health checks

Health checks are generally seen as important, but uptake is inconsistent. When asked why they had delayed or avoided a health check, Arabic-speaking women mostly identified a lack of time as the primary barrier. Other reasons included the cost of services, and limited access to female healthcare providers. Arabic-speaking women also delay checks until symptoms appear, often due to time constraints, fear of diagnosis, or cultural discomfort: *"Only when I am very sick, in the past, I used to go when I felt tired, but now if I don't have symptoms, I don't go."*

Fear of bad news, stigma around illness (especially cancer), and a desire to avoid being pitied were common barriers to women getting their health checks. The way in which health information is delivered also matters. Participants expressed a need for more compassionate, culturally sensitive communication. There was a strong preference for female doctors particularly for intimate health concerns, though professionalism is respected regardless of gender.

When participants were asked what would make it easier for their community to get health checks, they highlighted the following suggestions in order:

1. *Reminders from doctors or community groups*
2. *More information available in Arabic*
3. *Having female doctors or nurses available*
4. *Knowing that health checks are free or affordable.*

## Feedback on Jean Hailes Resources


Jean Hailes' health check and period resources were very well-received. Participants found them clear, informative, and visually engaging. There was a strong call for Arabic translations, particularly in formal Arabic that is widely understood across dialects: *"Having the Health Check poster translated into Arabic is very important for non-English speaking women."*

Suggestions from participants included developing shorter, more visual versions of the materials for older audiences, creating videos to explain procedures, and producing practical items such as fridge magnets or pocket-sized cards for easy reference: *"A video like 'what to expect at an appointment' would help create more comfort"*. The Easy Read format was especially appreciated for its accessibility: *"Easy Read – great for young girls, pictures are great."*

## Knowledge gaps and opportunities for further exploration


There was a desire among Arabic-speaking women for more in-depth, culturally relevant information about hormonal changes across different life stages. Women expressed wanting clear explanations about how hormones affect their health, especially during pregnancy, periods and menopause. Many women expressed that existing health information either oversimplified these topics or did not address the emotional, physical, and cultural experiences they associate with hormonal transitions.

Menopause was highlighted as a topic that is often avoided within their communities, leaving many women feeling unsure, isolated, and lacking support: *"Wanting more in-depth knowledge… especially during pregnancy, periods, menopause."*

Participants across all groups shared that accessing mental health support that felt suitable and non-clinical was challenging. Although awareness of mental health is increasing, many felt that existing services didn't meet their needs or expectations. Women expressed a strong preference for more informal, women-only spaces where they could talk about mental health openly and without judgment.

Some women expressed hesitation and a lack of confidence in performing self-checks, often feeling unsure about how to do them correctly. This uncertainty can create a barrier to early detection and may discourage timely health-seeking behaviour*: "I feel a bit hesitant to do self-checks because I don't trust myself to do them correctly."*

## Punjabi-speaking women

### Trusted sources of health information

> "Our Punjabi doctor was able to help me, ease my feeling because they understand the cultural difference between doctors here."

Punjabi women consistently identified GPs as trusted health information sources, valuing competence, empathy, language, and continuity of care. They felt more confident and respected when GPs were non-judgmental, took time to explain, and showed empathy: *"Our Punjabi doctor was able to help me, ease my feeling because they understand the cultural difference between doctors here."*

Alongside GPs, Punjabi-speaking women often turn to family and friends for informal health advice and emotional support. However, they are aware that talking to peers has limits, especially for personal or sensitive topics. This shows the importance of having safe, judgment-free spaces where women can ask questions without fear of stigma or gossip.

There was some distrust of online sources, due to misinformation or an overwhelming amount of information. However, government health platforms such as Health Direct, 13 Health, and Nurse on Call were mentioned as trustworthy and helpful, even though awareness of these services is low in many communities: *"Many people in areas like Truganina, Point Cook and Tarneit are unaware of these healthcare services."*

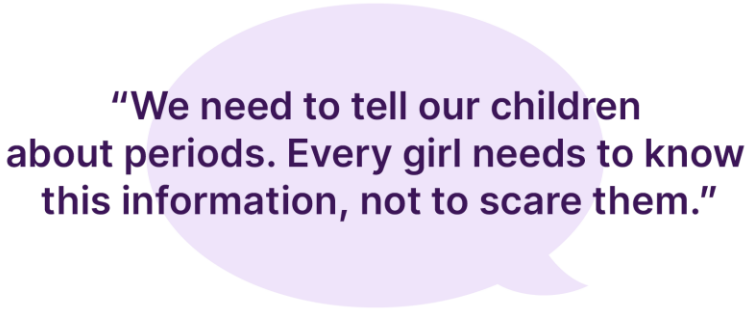
### Preferred formats for receiving health information.

> "If health information is available in temples, it is more likely to be noticed and discussed."

Punjabi-speaking women preferred receiving health information through in-person conversations and visual, culturally relevant materials. They valued concise, bilingual content with real examples and images. Printed resources like posters, brochures, and fridge magnets were seen as important reminders and essential for accessibility. Digital platforms such as YouTube, WhatsApp, and Facebook were commonly used, particularly by parents and older generations. There was a desire for health content to be shareable within these online groups. Community groups run by health professionals are seen as trustworthy: *"Short videos are helpful, not just written info… like small snippets or adverts for quick info."*

In-person sessions remained a keyway to build trust and start important conversations. Many women expressed interest in seeing health information displayed or discussed in familiar places such as temples, community centres, libraries and schools: *"If health information is available in temples, it is more likely to be noticed and discussed."*

## Experiences and cultural perspectives on periods




For many Punjabi women, periods are still surrounded by cultural stigma and often associated with silence or shame, especially amongst older generations. Many participants recalled feeling confused, scared or thinking something was wrong when they first got their period, largely due to a lack of open conversation at home or in school.

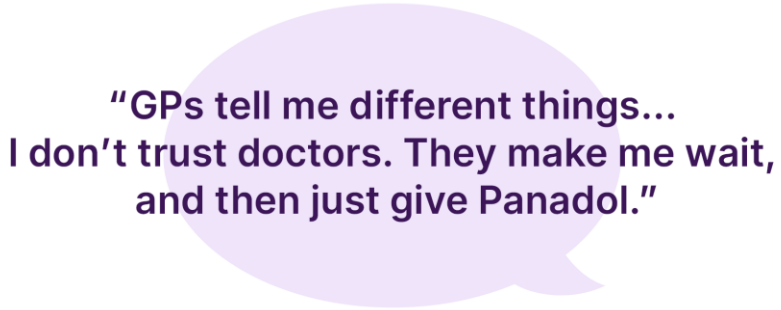
Cultural beliefs have long influences how periods are perceived and managed, with taboos like avoiding entering temples, not touching pickles or staying out of the kitchen mentioned by several women. While these traditions were acknowledged, many women expressed a clear desire to challenge and move away from them, reflecting a growing shift in mindset.

However, Australian culture, exposure to media, and health education in schools are helping break down long-standing barriers. There is a growing openness among younger generations and mothers who want to educate their daughters and sons: *"We need to tell our children about periods. Every girl needs to know this information, not to scare them."*

Many women also highlighted a reliance on mothers, sisters and friends for emotional support and practical advice. Mothers play a crucial role. Natural remedies are commonly used to manage period pain, including carom seeds, turmeric milk, and yoga: *"My mum gave me hot pads, Panadol, warm drinks, she did everything for me."*

However, the reluctance to speak about periods and period pain has had serious consequences for some participants. Some shared stories of untreated conditions like fibroids, ectopic pregnancy and endometriosis, showing how stigma and delayed attention caused bad experiences: *"I was using 4, 5, or 6 pads and I didn't tell anyone for 7 months… I had a fibroid and needed surgery."*

## Experiences and cultural perspectives on health checks




Health checks were widely acknowledged as important, but uptake was inconsistent. Some women had regular screenings such as pap smears, mammograms or blood tests promoted by their GPs, many others seek care only when they were symptomatic or when reminded by their GP or family members: *"I usually only go when I'm sick… if a health issue runs in the family, it pushes me to get it checked out."*

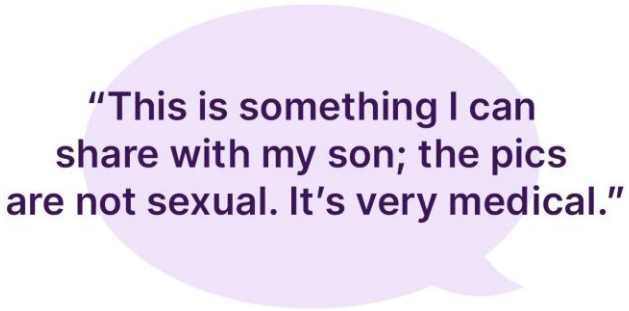
Barriers to women getting regular health checks were the fear of bad news, long wait times, costs, a lack of time or discomfort with some health professionals.

Stigma and discomfort were commonly reported around certain procedures like breast screening, bowel tests or cervical checks. Many felt embarrassed during these intimate health procedures, even with female health professionals. Many women agreed that there was a cultural norm or self-sufficing culture when it came to health checks. They shared that women often prioritise their family's needs over their own health, putting themselves last: *"Women suffer in silence, until it gets worse, then they seek help."*

In addition, many Punjabi-speaking women described a strong reliance on natural remedies and self-care practices as their first line of response to health concerns. These practices are deeply embedded in cultural traditions and often viewed as a more accessible or affordable option, especially when cost, time, or mistrust in the system become barriers: *"Adults often resort to home remedies instead of visiting a doctor because of cost."*

Language was also a key factor in how comfortable women felt during consultations. Punjabi- or Hindi-speaking doctors were especially appreciated by older women, as they allowed clearer communication and a stronger sense of being heard and understood. Another barrier raised by participants was the blunt or rushed nature of some consultations within the Australian healthcare system. They expressed a desire for more compassionate communication and a more proactive, patient-centred approach: *"GPs tell me different things... I don't trust doctors. They make me wait, and then just give Panadol."*

## Feedback on Jean Hailes Resources




Punjabi speaking participants generally found Jean Hailes' resources to be clear, relatable and culturally appropriate, especially Easy Read versions with images and simplified text. This format was praised for its user-friendly design and non-confrontational tone, making it easy to share with others: *"Easy to understand, very simple, especially the pictures. I loved it!"* and *"This is something I can share with my son; the pics are not sexual. It's very medical."*

While many women were confident in reading in English, there was a strong desire for them to be translated into Punjabi and Hindi to support varying levels of English literacy and comfort with medical terms: *"(fact sheet) the medical terminology could be simplified. Not everyone is familiar with medical terms, especially in English."* and *"It would be helpful to have both written and spoken versions."*

Participants strongly recommended including Indian representation and suggested using multimedia formats, particularly visual content such as short videos and animations. They explained that this would make the content more accessible and enable sharing with their friends and family on platforms like WhatsApp and Facebook: *"A short clip to go along with it, with the same words and pictures, would be great."*

## Knowledge gaps and opportunities for further exploration


A common theme was the lack of awareness and confidence around women's health checks and hormonal health, particularly in relation to perimenopause, menopause and cervical screening. Some participants were unfamiliar with terms or did not understand when or why certain checks should be done: *"I recently learnt a new word, perimenopause. I didn't even know it's a thing."*

Many women shared that they lacked the support for education about periods growing up. Often now knowing if symptoms were normal or required attention. There was strong interest in learning more about related conditions such as fibroids, endometriosis, and urinary or vaginal health concerns, topics many participants said were rarely discussed with their families or communities: *"My periods started with heavy bleeding, I didn't understand, and I suffered a lot… If we knew and understood changes, we could go to the doctor to discuss early."*

In relation to mental health, participants noted that emotional wellbeing such as postpartum depression, anxiety, and grief is often dismissed or misunderstood within the community. Many women described cultural attitudes that frame mental health struggles as taboo.

Another key area for exploration is navigating the Australian healthcare system. Many women shared that their families often rely solely on GPs, unaware of other available services such as Nurse-on-Call, screening programs, or community health supports. Some also voiced frustration with the system's complexity, long wait times, and lack of follow-up care: *"People just don't know (about health checks)."*

Language and literacy barriers also shaped access to information, with younger women often helping older family members understand English-language resources. However, there remains a strong need for bilingual, easy-to-read materials, ideally combining visuals, videos, and spoken content.

Similarly to the other language groups, women shared a deep need for culturally safe spaces, like forums, community groups, and women-only gatherings, where they can learn, ask questions, and support each other without judgement.

# Vietnamese-speaking women

## Trusted sources of health information

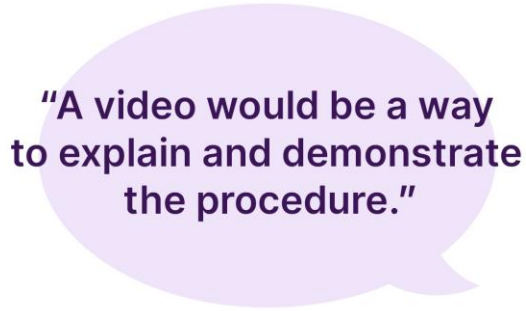

Vietnamese-speaking women described a cautious approach to health information, often starting with natural or home remedies, for common or less urgent issues passed down through generations and remain a big part of how women respond to their health: "*Sometimes I take medicine first, and if it doesn't work, I go to the doctor."*

Common remedies include ginger, turmeric, lemon, artichoke, gua sha, oil massages and steaming. However, women also emphasised the importance of careful fact-checking before using home remedies. GPs are widely trusted, particularly when they are non-judgemental and provide factual, unbiased advice. The credibility of the source was important to Vietnamese women in this project.

Having a consistent family doctor was viewed as important for building trust and receiving personalised care. However, some participants expressed discomfort with male GPs for women's health issues, especially those involving intimate procedures*: "It's important to have one family doctor. But if you keep swapping, they don't know you well."*

Family members and friends were also important and trusted sources of information, particularly for sharing personal experiences and emotional support. Still, many women expressed a preference to cross-check this information through research or medical advice. This peer sharing typically occurs informally during family gatherings, women's groups, or religious events like temple visits*: "We often go to the temple; we have women's gatherings and share experiences."*

### Preferred formats for receiving health information.




There was a strong preference among participants for video content, particularly those featuring lived experiences. Personal stories were seen as more relatable and helped build trust in the information being shared. As one woman explained*: "I don't want to hear from someone who hasn't been through it*". This preference also extended to videos that demonstrate medical procedures, which participants felt helped reduce fear and normalise what to expect. Educational videos were especially recommended for topics like cervical screening*: "A video would be a way to explain and demonstrate the procedure."*

While digital resources were highly valued, many women, particularly older generations or those with lower English literacy, still appreciated paper-based materials, especially when bilingual and visually engaging*: "Posters with pictures… something like a forum or gathering where people explain why it's so important."*

Trusted digital platforms such as YouTube, Google, and social media were commonly used, but participants consistently expressed a preference for content from Australian and official government sources. They were cautious of misinformation and actively sought credible domains.

In person gatherings and forums were also seen as valuable, these settings allowed for shared learning, open discussion, and peer support. Information delivered face-to-face was often better retained and shared within communities.

### Experiences and cultural perspectives on periods

Across consultations, many women described a cultural silence around periods, often viewed as private or taboo, especially by older generations. This led to discomfort discussing periods, even within families, and a lingering sense of shame. While schools and mothers now provide some information, gaps in knowledge remain*: "In the past – they didn't talk about this in school – but when we had the period, we asked our sister or mum."*

Period education has shifted from relying on mothers and sisters to schools as the main source of information. Women shared experiences of pain, heavy bleeding, and irregular cycles, but noted a lack of community awareness about what these symptoms might indicate. One woman reflected that she only learned about conditions like endometriosis through her daughter's experience*: "My teenager has heavy bleeding and doesn't get period regularly. My doctor says it might be endometriosis, and it's not discussed a lot."*

There was also some uncertainty and limited awareness about period products and a lack of education around options like tampons or menstrual cups*: "I don't even know how to use a tampon. My daughters talk about it."*

Cultural beliefs and myths continue to influence attitudes towards periods but are also changing. These included misconceptions that are passed down generationally. A common shared belief by participants was that they recall being told not to touch vinegar while on their periods due to a belief it would spoil or turn black. These beliefs along with social discomfort and lack of open communication contribute to the stigma around periods. This belief was described as one reason why conversations around periods remain limited in families and communities*: "Men get quite uncomfortable when you talk about periods."*

Many participants emphasised the need for more education and accessible information. There was also a desire to support the next generation with better knowledge*: "I want to know more information for my daughter."*

## Experiences and cultural perspectives on health checks

Health checks were widely recognised by Vietnamese women as important and necessary, especially when prompted by GPs or reminders like text messages or postal letters. They appreciated Australia's proactive health system noting that these reminders helped them stay informed and encouraged them to follow through with screenings. Vietnamese women identify several reasons for delaying or avoiding health checks in the post consultation survey. Barriers included fear of bad results, cost concerns, unawareness of screening importance, time constraints, and lack of female doctors. Many women also reported prioritising family needs over their own health, reflecting a common cultural norm across language groups.

Women preferred seeing a regular, trusted GP who knows their history and provides continuity of care. Many also felt more comfortable with female doctors, especially for intimate procedures like cervical screening*: "How do you know you're doing it right? Some of these checks are invasive so you feel like you want a female".*

There is a widespread lack of awarenessabout options like self-screening for cervical cancer, with participants expressing confusion about how to preform them correctly*: "Was unaware that self-screening was an option."*

Cultural expectations around women as caregivers further shaped attitudes towards health checks. Many women across the consultations spoke of delaying their own care due to their responsibilities for caring for children, partners or elderly family members. Many participants recognized that early detection saves lives and shared positive experiences of timely health checks. Community-based English classes and health sessions were effective in raising awareness. To improve access, women highlighted the importance of reminders from doctors or community groups and health information available in their first language.

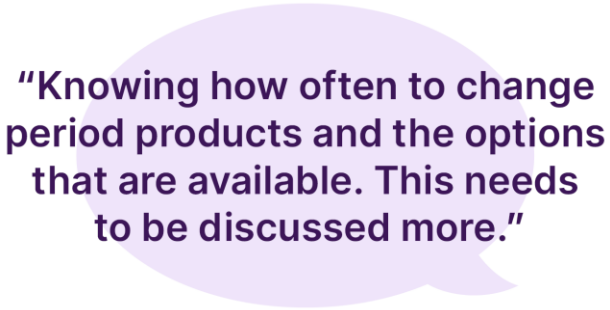
## Feedback on Jean Hailes Resources


Feedback on Jean Hailes Resources were positive. Participants found them clear, trustworthy, helpful, and visually engaging. They appreciated the simple language and visuals and were willing to share the information with others*: "Good easy and simple information" and "The pictures are really good."*

Vietnamese women preferred if resources were both in Vietnamese and simple, easy to read English, especially for older generations and new migrants. However, some participants preferred English for written resources, suggesting a bilingual approach is more inclusive. Women liked the clarity and structure of the resources but noted that frequency of checks could be made clearer*: "In the Easy Read, it doesn't say how often to do the health check."*

Participants agreed printed resources are helpful but most effective when paired with clear, simple calls to action like a phone number or website. They emphasized concise messaging, as overly detailed or text-heavy materials can be overwhelming and less engaging.

## Knowledge gaps and opportunities for further exploration




Some women expressed their confusion around the use of certain period products like tampons, reflecting a lack of basic, practical education about periods, especially for older generations: *"Knowing how often to change period products and the options that are available. This needs to be discussed more."*

Women expressed a desire for clear, straightforward education about periods throughout life, covering irregular cycles, perimenopause, and menopause. They also want this information accessible for younger generations, particularly their daughters. When asked about remaining questions on periods, women responded: *"Irregular periods and when you are going to lose your period" and "Menopause and periods."*

# Information sources, formats, and resource distribution

## Information sources

Across all three language groups, friends or family emerged as the most trusted sources of women's health information, closely followed by healthcare professionals and social media. This highlights the important role of both personal networks and digital platforms in accessing and sharing health information.

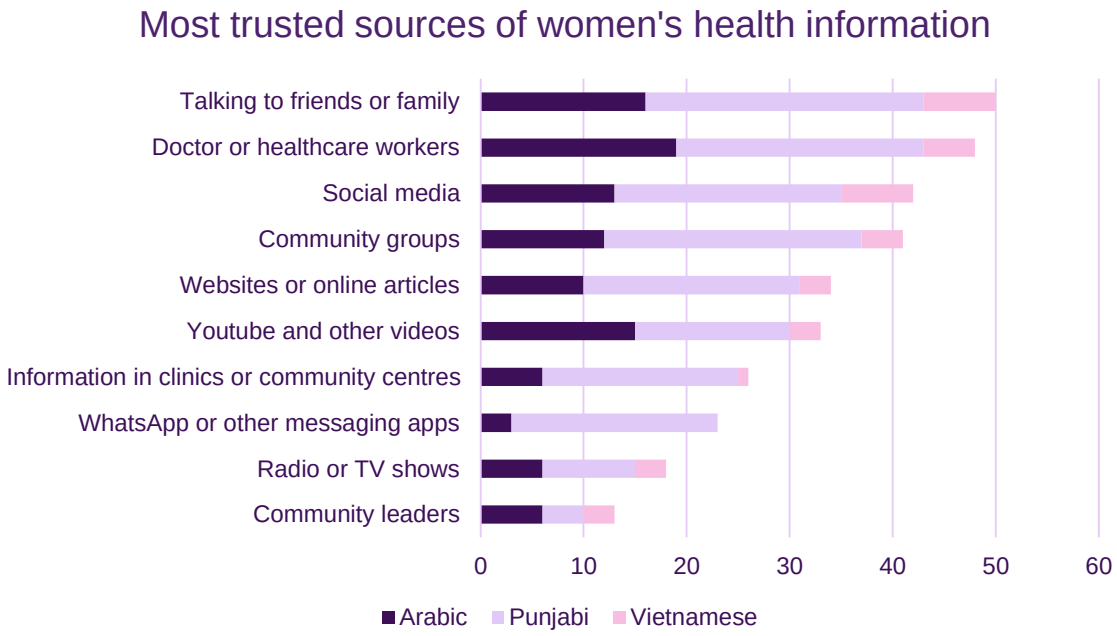



**Figure 1. Most trusted sources of women's health information from post consultation survey**

## Preferred formats

Arabic, Punjabi and Vietnamese women identified a mix of visual, interactive and written sources as preferred formats to receiving women's health information. The data gathered highlights the importance of culturally appropriate and accessible formats for these communities.

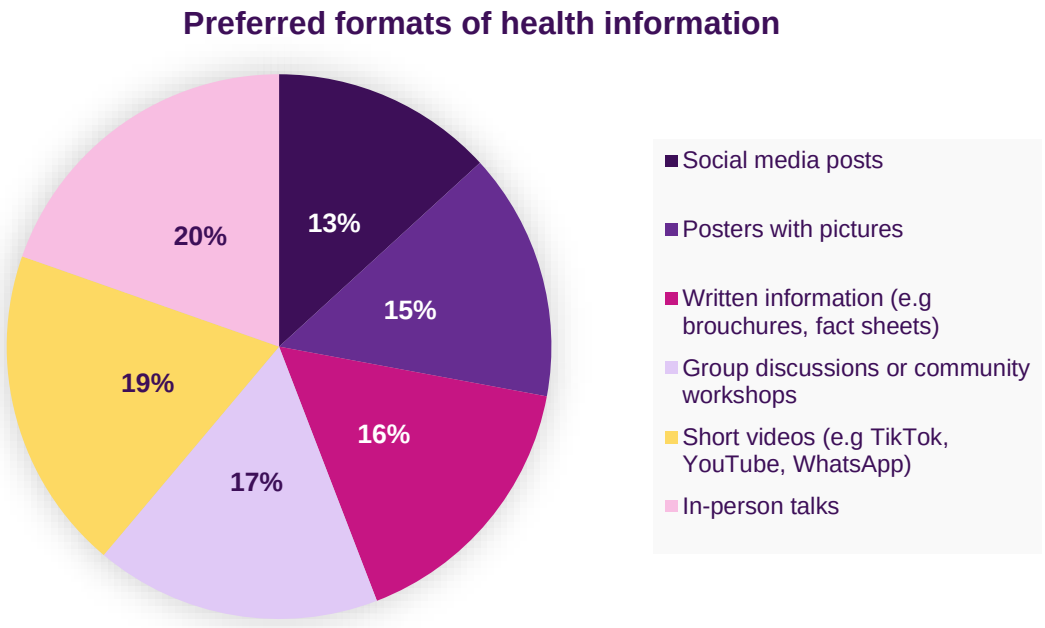



**Figure 2. Preferred formats of health information**

## Sensitive health topics

Several health topics were identified as important yet difficult to discuss. Three key themes emerged consistently across all groups: mental health, breast health, and menopause, areas often considered taboo or sensitive within certain cultural contexts.

| | Arabic | Punjabi | Vietnamese |
|---|---|---|---|
| **1** | Mental health | Sexual health and contraception | Breast health |
| **2** | Periods | Breast health | Mental health |
| **3** | Breast health | Menopause | Healthy eating and exercise |

**Table 4. Sensitive topics for each language group**

## Jean Hailes resource distribution

It was suggested by participants across all consultations that Jean Hailes resources should be distributed widely across trusted and accessible community spaces. There was a shared view that these resources should be made more visible and accessible in places where women naturally come together. Some suggested distribution points include:

- Healthcare settings such as GP clinics, pharmacies,

- Community Hubs, libraries with dedicated displays, schools, and local community centres,
- Faith bases venues such as temples (Gurdwaras), mosques and churches,
- Public places, shopping centres, public toilets, and train stations,
- Online spaces such as WhatsApp, Facebook groups, Instagram, YouTube and even community forums.

To encourage sharing among peers, participants recommended making resources shareable via social media and messaging apps like WhatsApp. They highlighted the importance of including a share icon or clear call to action on digital materials.

# Recommendations

The following table highlights key themes and recommendations that have been drawn from participant data to enhance the promotion of women's health among Arabic, Punjabi, and Vietnamese-speaking communities and, support more inclusive, culturally responsive approaches in health communication, service delivery, and community engagement.

| Key Themes | Recommendations |
|---|---|
| **In-language and culturally inclusive materials:** | Translate key resources (e.g. Health Check Poster, Easy Read Fact Sheets) into Arabic and Punjabi, and update visuals to reflect cultural and age diversity. |
| **Trust through relatable content:** | Develop simple, culturally safe videos featuring real community members, or animations with bilingual audio and captions to increase trust and understanding. |
| **Peer-to-peer sharing and mobile accessibility:** | Enable easy sharing of resources via QR codes, social media-friendly formats, and empower community group and leaders to promote information. |
| **Value of in-person engagement:** | Partner with Community Hubs, community partners and local groups to deliver face-to-face sessions and offer online Q&A platforms for ongoing engagement. |
| **Fear and uncertainty around health checks:** | Create step-by-step explainer videos with subtitles, self-assessment tools, FAQs, and positive lived experience stories to ease fear and promote confidence. |

| | |
|---|---|
| **Lack of awareness about routine checks:** | Provide bilingual health check timelines by age group and run awareness campaigns on asymptomatic conditions and the importance of early detection. |
| **Stigma around periods and reproductive health:** | Develop school-based or parent-child education kits with resources on menstruation and period products. |
| **Need for bilingual formats:** | Use materials in both English and community languages to support varied literacy levels and improve comprehension. |

**Table 5. List of recommendations based on consultation data collected.**

# Evaluation Part 1: Engagement Approach

## Strengths

Jean Hailes partnered with Community Hubs Australia to ensure the project was shaped and delivered with direct input from Hub leaders who work closely with Punjabi, Arabic and Vietnamese-speaking women in their communities. Adopting a collaborative and co-design approach enhanced the project's cultural relevance and helped foster trust and connection with the women from these communities. Working with an organisation that had strong, established relationships with women, enabled deeper, more meaningful and respectful engagement in a safe and supportive environment.

Using both focus groups and surveys to collect data from participants proved to be a strength of the project. Surveys offered measurable data, while community consultations provided richer insights into women's experiences, beliefs, and information needs. This allowed for a more nuanced understanding, particularly for women who may not have felt comfortable speaking openly in a group setting.

## Limitations

Careful planning and the active involvement of Hub leaders helped create a supportive environment for participants to share their views. Given the personal and sensitive nature of women's health topics, particularly in cultural contexts where reproductive and sexual health may not be openly discussed, some participants may have chosen to listen rather than speak. For example, one Hub leader observed that some Punjabi women opted not to express differing views out of cultural respect for the Vietnamese participants. However, this just highlights the importance of cultural sensitivity and mutual respect within group discussions.

The women who participated in the consultations, provided rich and valuable insights, however, future consultations could benefit from a larger and more diverse group of women, including more younger women aged between 20-35.

### Feedback from the participants

There was 68 out of the 69 participants who expressed interest in attending consultations again, with the majority finding the sessions valuable. Common feedback highlighted that participants appreciated hearing diverse perspectives from other women, learning that pain is not normal and gaining insight into myths from different cultures. Many emphasised the importance of discussing periods with their children and addressing common misconceptions. Participants also reported learning about essential health checks, recognising the need to educate young boys, and understanding the significance of openly discussing health issues with friends and family.

### Feedback from Community Hub leaders

As part of the evaluation, reflection meetings were held with each Community Hub leader. Feedback was overwhelmingly positive, with leaders highlighting the strong partnership, culturally appropriate approach, and thoughtful facilitation. Many shared that the women felt empowered and grateful for the opportunity to share their health experiences. One leader noted: *"The women were all extremely grateful for the opportunity… they felt fortunate and empowered to be part of the program."* The simple, clear questions and translated resources made the sessions accessible and engaging. Another reflected: *"It was very organised and well prompted - before, during and after the consultation. The entire experience was wonderful."* Suggestions for improvement were minimal, with recommendations to send a short video of the consultation process to ease any participants' pre-session nerves, and suggestion in keeping language groups separate to encourage more open discussion.

# Conclusion

This project highlighted the value of genuine collaboration and culturally informed approaches in engaging women from Arabic, Punjabi, and Vietnamese-speaking communities. By working closely with Community Hub leaders, Jean Hailes was able to build trust, ensure cultural relevance, and create a safe environment for women to share their health experiences and needs. Overall, feedback was overwhelmingly positive and highlighted the importance of community-based engagement when discussing sensitive women's health topics such as periods and health checks. The combination of qualitative and quantitative methods provided a deep understanding of women's perspectives, and the co-designed process set a strong foundation for future engagement. Insights gathered through this process have informed a consolidated summary of learnings that can guide more inclusive and effective women's health initiatives moving forward for these women.

# References


1. **Australian Bureau of Statistics.** *Cultural Diversity of Australia.* ABS; 2022. Accessed May 30, 2025. https://www.abs.gov.au/articles/cultural-diversity-australia
2. **Queensland Health.** *Vietnamese Australians: Community Profiles for Health Care Providers.* Division of the Chief Health Officer, Queensland Health; 2011. Accessed July 7, 2025. https://www.health.qld.gov.au/__data/assets/pdf_file/0029/157439/vietnamese2011.pdf
3. **Australian Bureau of Statistics.** *Cultural Diversity of Australia.* ABS; 2022. Accessed May 30, 2025. https://www.abs.gov.au/articles/cultural-diversity-australia