MULTICULTURAL CENTRE FOR WOMEN'S HEALTH

Health in my Language

Clear Horizon

Health in My Language

2025-2026 FINAL EVALUATION REPORT

AUGUST 2026

Disclaimer

This document has been produced with information supplied to Clear Horizon by Multicultural Centre for Women's Health, comprising surveys, monthly partner reports (via the HIML dashboard) and Most Significant Change (MSC) stories. Additional data collection by Clear Horizon as agreed by the client included focus groups with Bilingual Health Educators, two learning workshops with MCWH staff and program coordinators, and an MSC Story Summit. While we make every effort to ensure the accuracy of the information contained in this report, any judgements as to suitability of the information for the client's purposes are the client's responsibility. Clear Horizon extends no warranties and assumes no responsibility as to the suitability of this information or for the consequences of its use.

Note on Language

Multicultural Centre for Women's Health is committed to promoting the health and wellbeing of all people impacted by the intersections of racial discrimination, gender inequality and the migration system in Australia, including migrants and refugees who identify as non-binary, gender diverse and transgender people. Throughout the project and this report, we use the term 'women' to mean women who identify as migrants and refugees inclusive of non-binary, transgender and gender diverse people who have identified with the aims of this project. The term 'migrant and refugee' in this report refers to people living in Australia who were born overseas or whose parent(s) or grandparent(s) were born overseas in a predominantly non-English speaking country.

Acknowledgements

Clear Horizon and Multicultural Centre for Women's Health (MCWH) acknowledge Aboriginal and Torres Strait Islander Peoples as the Traditional Owners and Custodians of the lands and waterways across Australia on which this project took place. We pay our respects to Elders past and present. We acknowledge that sovereignty was never ceded, and this land always was, and always will be, Aboriginal land.

We are grateful for the dedication and support of the following individuals and organisations who made this evaluation possible:

- The Department of Health, Disability and Ageing for supporting and funding the Health in My Language project and this evaluation.
- The Health in My Language partnership, comprised of the Australian Red Cross (NT, TAS, SA), True Relationships and Reproductive Health (QLD), Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (NSW), Women's Health Matters (ACT), and Ishar Multicultural Women's Health Services (WA).
- MCWH Health in My Language team who participated in the design of the Measurement, Evaluation and Learning Plan and subsequent project meetings to implement this evaluation.
- MCWH staff and educators who supported the implementation and administration of surveys and recruitment for interviews and focus groups.
- MCWH staff and partners who participated in learning workshops and offered their expertise to verify and refine the evaluation findings.
- Session participants who took part in interviews offering invaluable insights into their experiences with the Health in My Language education sessions.

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Acronyms	Description
ACT	Australian Capital Territory
BHE	Bilingual Health Educator
CoP	Community of Practice
FY	Financial Year
GP	General Practitioner
HIML	Health in My Language
HREC	Human Research and Ethics
KEQ	Key Evaluation Question
MCWH	Multicultural Centre for Women's Health
MEL	Measurement, Evaluation and Learning
MSC	Most Significant Change
NA	Not Available
NSW	New South Wales
NT	Northern Territory
PD	Professional Development
QLD	Queensland
SA	South Australia
SRH	Sexual and Reproductive Health
STARTTS	Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
STI	Sexually Transmitted Infections
TAFE	Technical and Further Education
TAS	Tasmania
TOC	Theory of Change
TRUE	True Relationships and Reproductive Health
VIC	Victoria
WA	Western Australia

Executive Summary

Health in My Language 2025 – 2026: Key Findings and Recommendations

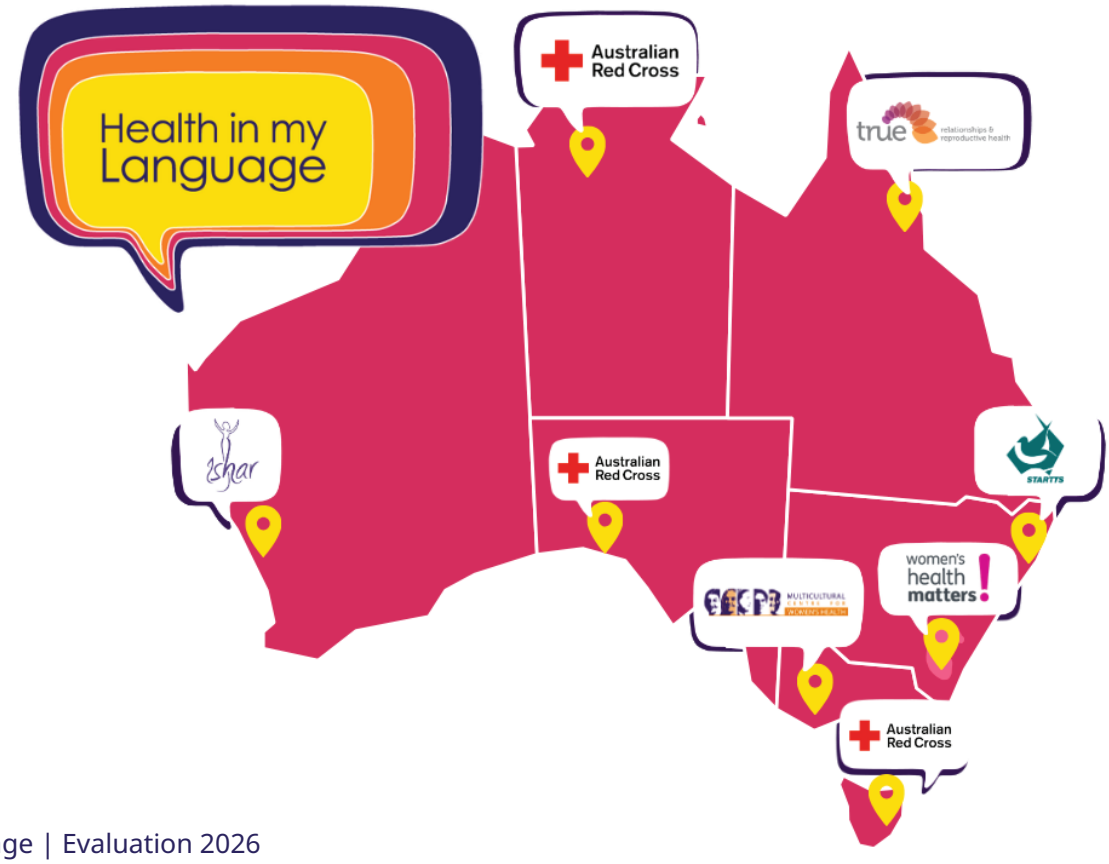
About the Project

The Health in My Language (HIML) project is a national initiative led by the Multicultural Centre for Women's Health (MCWH) in partnership with organisations across every state and territory in Australia. The aim of the project is to improve access to health information and education for migrant and refugee women through the delivery of health education sessions.

The HIML project was first established in March 2022 as a national response to the COVID-19 pandemic. Subsequent HIML projects focused on cancer screening in 2023 and sexual reproductive health (SRH) in 2024 – 2025. In 2025 - 2026, HIML continued delivering these topics and expanded its program to include mental health. The health education sessions were delivered by project partners and a national workforce of bilingual health educators (BHEs) from many different language and cultural backgrounds.

What we found

The evaluation found that the HIML project had a positive impact and was effective at supporting migrant and refugee women to learn more about the health topics and navigating the Australian healthcare system. Migrant and refugee women felt more confident to share what they learned with others and to take action to access different types of health services. These impacts were supported by strong and effective partnerships, an overarching project infrastructure held by MCWH, and a professional, national BHE workforce with close community connections.



Key Findings

Reach

The HIML project delivered 1,376 health education sessions in over 30 languages to 17,224 migrant and refugee people across Australia. These sessions were well attended with representationacross diverse age, language, and cultural groups.

Stakeholder engagement was a critical aspect of implementing the HIML project with the project demonstrating substantial stakeholder reach by engaging an estimated 22,712 stakeholders across 1,729 engagement activities. Stakeholder engagement served to promote the project, develop trust with community, gauge interest levels in the health education topics, and understand how the project was best tailored to specific contexts.

Effectiveness

The project was consistently effective in increasing migrant and refugee women's knowledge and confidence about the topics delivered through health education sessions across the country.

There was strong evidence that the sessions helped participants set intentions to share their knowledge with friends and family, encourage others to attend sessions and talk to health professionals. Further insight into the changes experienced by session participants included attending health appointments and screenings, sharing health information with others and increased confidence navigating the Australian healthcare system. Together, these themes indicate a transition from new knowledge to practical action and suggest a potential ripple effect whereby information extends beyond direct program participants and out into their broader communities.

17,224
attendees participated in

1,376
sessions in over

30+
languages

22,712
stakeholders across

1,729
engagement activities

> "Through the program, I learned how to access appropriate health services. One night when my four-year-old son became unwell, I was able to stay calm and use an after-hours home visit doctor service instead of going to the emergency department. This saved time, reduced stress, and provided a more comfortable experience for both my child and our family" – Session participant

> "Before I started the HIML sessions, I was anxious and overwhelmed whenever I thought about using the healthcare system... I had no idea how to ask for help or navigate the health system... the knowledge I gained gave me the courage to overcome my past hesitations and encouraged me to go to the clinic" – Session participant

Effectiveness

Knowledge

Knowledge of session topics

3% → **81%**

81% of participants rated their knowledge of session topics as 'high' after the session compared to only 3% before the session.

Knowledge of health services

4% → **80%**

80% of participants rated their knowledge of health services as 'high' after the session compared to only 4% before the session.

Knowledge of their healthcare rights and options

3% → **84%**

84% of participants rated their knowledge about their healthcare rights and options as 'high' after the session compared to only 3% before the session.

Confidence

Confidence to talk about health topics with friends and family

6% → **79%**

79% of participants rated their confidence to talk about health topics with friends and family as 'high' after the session compared to only 6% before the session.

Confidence to talk about health topics with healthcare professionals

6% → **78%**

78% participants rated their confidence to talk about health topics with healthcare professionals as 'high' after the session compared to only 6% before the session.

98% participants intended to **share their learning** with other people after the session.

Navigating the Australian Mental Health System was the most attended session (n=2846), followed by ***Let's Talk Mental Health*** (n=2084).

The effectiveness of the project was enabled by several conditions, including:

- Extensive project materials and health education resources to support high-quality delivery at a national scale
- A professional national workforce of BHEs, supported by continuous professional development
- Overarching HIML infrastructure paired with flexible state-based delivery
- HIML's sustained presence over four years which fostered strong stakeholder relationships and streamlined delivery

Challenges

Barriers that challenged the implementation and delivery of the HIML project included:

- Limited numbers of BHEs per state/territory – limiting in-language delivery
- Lack of career progression opportunities for BHEs leading to turnover
- Inadequate budget allocation for BHE travel – limiting project reach
- The timing and duration of funding decisions which impacted stakeholder relations and staff retention, and pressured project planning and session delivery

Recommendations

The recommendations provided below are categorised under actions that would strengthen the project, opportunities to expand the project, and advocacy actions to support ongoing project development and implementation.

Strengthen

- **Recommendation 1:** Continue to deliver tailored, in language sessions nationally to migrant and refugee women by BHEs who are trusted peers in local cultural communities.
- **Recommendation 2:** Continue delivering a comprehensive mix of health topics to respond to migrant and refugee women's health information needs and work with communities to decide which topics are most appropriate to begin with.
- **Recommendation 3:** Continue to use evaluation methods to support continuous learning, and program improvements. This should include collecting data from session participants post-attendance to understand how session content translates into changes in perspectives, awareness and behaviours.
- **Recommendation 4:** Continue to invest in BHE capability-building, including safe spaces for peer support and workshopping challenges, to strengthen tailored support, identify further guidance needs and maintain consistent quality delivery.

- **Recommendation 5:** Continue to conduct quality assurance of data submitted by BHEs to ensure accuracy of the HIML Dashboard – a data visualisation tool used by MCWH.

Expand

- **Recommendation 6:** Use the HIML Dashboard to identify trends across and between states to identify opportunities for learning, information sharing, and improvement.
- **Recommendation 7:** Expand the topics on offer to respond to community identified areas and emerging health needs to improve health equity.
- **Recommendation 8:** Further invest in the growth and development of the Multilingual Resource Portal to provide high-quality, evidence-based resources and materials to aid effective session delivery.
- **Recommendation 9:** Where appropriate, identify further actions BHEs can take to support participants in translating health knowledge into action, for example partnering with healthcare providers to support scheduling appointments.
- **Recommendation 10:** Consider strengthening the HIML theory of change (TOC) with evidence of how health education sessions also create supportive spaces for connection and include this in future evaluation.

Advocate

- **Recommendation 11:** Advocate for funding to support travel costs, expanding HIML's reach in states and territories with geographically dispersed populations to reach migrant/ refugee communities in regional and remote areas.
- **Recommendation 12:** Advocate for a longer-term, multi-year funding model, with earlier confirmation of funding decisions, to support more effective forward planning, strengthen stakeholder relationships and improve BHE retention.

Introduction

This report presents the evaluation findings for the Health in My Language (HIML) project (or 'the project') covering the period 01 July 2025 – 30 June 2026.

The evaluation was commissioned by the Multicultural Centre for Women's Health (MCWH) with funding from the Department of Health, Disability and Ageing (the Department).

This introduction provides background information about the project and the evaluation followed by sections describing the evaluation methodology and the results including the project's reach, effectiveness and the enablers and barriers of project implementation. The results section begins with a brief discussion of the evaluation's findings followed by related data and information and the Most Significant Change (MSC) stories. Recommendations are summarised at the end of the report followed by the conclusion. Finally, the "Appendix" details supporting information about MCWH and Clear Horizon and details of the evaluation approach.

About Health in My Language

Health in My Language is a national initiative lead by MCWH in partnership with organisations across every state and territory in Australia to improve migrant and refugee women's access to health information and services. The HIML partnership is comprised of:

- True Relationships and Reproductive Health (True) - Queensland (QLD)
- Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) - New South Wales (NSW)
- Women's Health Matters - The Australian Capital Territory (ACT)
- Australian Red Cross - Tasmania (TAS)
- Australian Red Cross - South Australia (SA)
- Australian Red Cross - Northern Territory (NT)
- Ishar Multicultural Women's Health Services - Western Australia (WA)

HIML is guided by a feminist intersectional approach, which recognises that migrant and refugee women's health outcomes are shaped by their experiences of gender, migration, cultural background, language and socio-economic position. This approach focuses on addressing the structural barriers impacting migrant and refugee women's health and wellbeing to achieve health equity. MCWH coordinates this national partnership to ensure the delivery of high-quality, consistent health education through the overarching project infrastructure and direction held by MCWH, while drawing on partners' expertise and local stakeholder relationships in their respective jurisdictions.

Through this partnership, health education sessions are delivered by a national workforce of Bilingual Health Educators (BHEs) and supported by MCWH's health education model developed since 1978. BHEs are trusted, trained community leaders who often share the cultural background and language of session participants. The sessions are designed using evidence-based resources that are adaptable and

tailored to community members' cultural backgrounds, and languages to support their access to health information. MCWH leads and strengthens the partnership approach by delivering accredited training for BHEs, developing evidence-based session content, and providing ongoing support to partners and BHEs. This support includes leading Communities of Practice (CoPs), professional development (PD) workshops, networking activities, and regular debriefing opportunities. MCWH also manages the Multilingual Portal, which offers multilingual resources and referral pathways to support the delivery of education sessions.

The HIML project was first established in March 2022 as a national response to barriers to vaccine literacy and uptake during the COVID-19 pandemic. Subsequent HIML projects focused on cancer screening in 2023 and sexual reproductive health (SRH) in 2024 – 2025. In 2025, further funding was secured and the HIML project expanded beyond the four focused SRH topics to reintroduce three cancer screening topics and two new topics related to mental health. Cancer screening and mental health were identified as priority topics during the previous evaluation. The health topics included in the HIML project for 2025 – 2026 were as follows:

- Contraception Choices
- Safer Sex (sexually transmitted infections)
- Pregnancy Choices (including abortion and reproductive coercion)
- Understanding Menopause
- Let's Talk Mental Health
- Navigating the Australian Mental Health System
- Lung Cancer Screening
- Breast Cancer Screening
- Bowel Cancer Screening
- Cervical Cancer Screening
- Managing Mental Health[1]

1 A small number of 'Managing Mental Health' education sessions were delivered in VIC prior to the introduction of the new mental health topics in November 2025.

About the Evaluation

Purpose

The primary purpose of the evaluation was to determine the effectiveness of the project in producing changes in knowledge, awareness, perspectives, confidence, and behaviours of migrant and refugee women[2] (inclusive of nonbinary, transgender and gender diverse people) who attended one or more health education sessions.

The secondary purposes of the evaluation were to understand the:

- Reach of the project through community engagement activities, media promotions and health education session delivery
- The enablers and barriers of project implementation

The evaluation purpose informed the key evaluation questions (KEQs) as described further in the "Methodology" section.

Approach

Building on learnings from the previous evaluation, a Measurement, Evaluation and Learning (MEL) Plan was co-designed with MCWH to guide the evaluation approach and activities. The plan provided instruction for the systematic collection, analysis, interpretation and reporting of findings. It was built on a participatory, theory-based evaluation approach that included the following key ingredients:

Theory of Change (TOC): a visual diagram depicting how the HIML project's inputs and activities are expected to produce a change in outcomes for migrant and refugee women participating in the health education sessions.

Measurement: regular collection and analysis of quantitative data produced by HIML reporting tools.

Evaluation: using measurement data and other data collection methods to answer bigger questions about the value of the HIML project pertaining to its reach, effectiveness, and enabling conditions.

Methodology

Theory of Change

The HIML TOC was updated based on a key recommendation from the previous evaluation to include outcomes for migrant and refugee (M/R) women about shifts in awareness and perspectives on health topics, rights and options, and navigating the Australian healthcare system.

2 The HIML TOC was updated based on a key recommendation from the previous evaluation to include outcomes for migrant and refugee (M/R) women about shifts in awareness and perspectives on health topics, rights and options, and navigating the Australian healthcare system.

Figure 1. HIML Theory of Change

Migrant and refugee women across Australia are empowered to make informed choices about their healthcare

Long term Outcomes
Aspriational change we want HIML to contribute to

- **M/R women advocate for equitable health services**
- **M/R women prioritise their healthcare needs**

line of expected contribution

Intermediate Outcomes
Flow on results are attending HIML education sessions

- M/R women openly discuss a greater breadth of health topics
- M/R women share health information with their friends and family
- M/R women encourage other women to attend health education sessions
- M/R women seek out healthcare services and professionals
- M/R women ask for healthcare services that meet their specific language and cultural needs

Influence Activities
HIML activities implemented to influence change

Confidence

- M/R women increase confidence to navigate the healthcare system
- M/R women increase confidence to talk about health topics with friends and family
- M/R women increase confidence to make choices about their healcare needs and rights
- M/R women increase confidence to talk about health topics with healthcare professionals

Intention

- M/R women intend to encourage others to attend health education sessions
- M/R women intend to share learning with friends and family
- M/R women intend to discuss health issues with healthcare professionals

Knowledge, awareness and perspective

- M/R women increase knowledge about health topics included in sessions
- M/R women increase knowledge about their healthcare rights and options
- M/R women increase knowledge about relevant health services
- M/R women broaden their awareness about health topics
- M/R women increase knowledge about navigating the Australian healthcare system
- M/R women change their perspectives about health topics

Outputs
Direct result of influence activities

- **Culturally appropriate in-language health education sessions delivered to M/R women across Australia**
- BHEs are ready to provide health edcation to M/R women
- Resources and materials ready for session delivery
- Partners are ready to implement health education sessions
- Community stakeholders support M/R women to participate in health education sessions

Influence Activities
HIML activities implemented to influence change

- Deliver national training to BHEs in health education
- Provide ongoing professional development support to BHEs
- Support and collaborate with HIML partnership network
- Promote health education sessions widely to stakeholders
- Implement culturally appropriate in-language health education/resources
- Engage with and build relationships with communities

Foundational Activities
Activities and processes before implementing HIML

- Conduct research and consultation about priority health topics for M/R communities
- Develop HIML project plans and partner plans
- Recruit BHEs for HIML program
- Develop BHE training, CoPs and professional development support
- Collate in-language and culturally appropriate resources
- Develop program implementation tools and resources
- Develop stakeholder engagement & communications strategies
- Advocate for sustainable funding and formal recognition of the national BHE workforce
- Undertake BHE capability-building needs assessment
- Embed an intersectional approach into MEL plan and tools

Inputs
Resources used to develop HIML

- MCWH Strategic Plan
- MCWH Intersectional feminist approach
- MCWH HIML team & departments
- MCWH Partnership Advisory Group
- Accredited BHE training program
- MCWH Quality Standards for Health Education
- BHE professional development needs assessment
- Commonwealth Government funding
- National Women's Health Strategy and policies
- HIML Health Education Manual
- MCWH Multilingual Resource Portal

Key evaluation questions

The evaluation was guided by three KEQs about the HIML project's reach, effectiveness, and enabling conditions. The KEQs were informed by the TOC and developed during MEL planning with MCWH.

1. **How well did the HIML project reach migrant and refugee women and community stakeholders across Australia?**

2.a. **How effective was the HIML project in producing anticipated outcomes for migrant and refugee women?**

2b. **To what extent did the HIML project produce unanticipated outcomes for migrant and refugee women whether positive or negative?**

3a. **What enabling conditions support the ongoing effectiveness of the HIML project?**

3b. **What barriers hindered these conditions and the HIML project's effectiveness?**

Data Collection and analysis

Methods

Mixed methods were used for measurement and evaluation activities to answer the KEQs about reach, effectiveness, and enabling conditions of the project (see "Appendix A" for the "Evaluation Map"). This work involved systematically collecting, analysing and synthesising data from a range of sources using quantitative (numbers) and qualitative (stories) methods. Data collection included MCWH's own reporting tools and specific evaluation methods managed by Clear Horizon.

In summary, these methods and their samples included:

Tool/Method	Description	Sample size
HIML post-session group survey	MCWH internal reporting tool used to collect post-session data from participants via a survey conducted by trained BHEs. The survey is conducted verbally as a group survey via show of hands at the end of each session. Responses are then entered into the SurveyMonkey platform by BHEs (except in VIC where it is in Smartsheet).	1,376 surveys were administered to 17,224 attendees.

CoP and PD surveys	MCWH internal reporting tool used to collect data via a survey of individual BHEs who participated in 3 CoP sessions and 5 PD sessions.	150 survey responses were analysed across the 8 sessions.
HIML partner monthly report (via SurveyMonkey)	MCWH internal reporting tool used to collect stakeholder and media engagement data from all partner agencies monthly.	96 partner reports were analysed.
Document review	Evaluation method used to review HIML background documents to understand the project's context, design and implementation processes.	25 documents were reviewed.
BHE focus groups	Evaluation method used to ask BHEs about their experiences with capability building activities, delivering health education sessions, and observations of outcomes and significant changes.	Two focus groups were held with 13 BHEs in total.
Session participant most significant change (MSC) stories	15 BHEs were trained in MSC technique to capture stories from participants in their preferred language.	13 MSC stories from session participants.

Learning workshops and learning briefs

As part of the evaluation, ongoing learning was supported through two Learning Workshops facilitated by Clear Horizon and attended by representatives from the HIML partner organisations and MCWH. The workshops were held in December 2025 and April 2026.

Discussions, insights and questions emerging in the workshops were documented by Clear Horizon in learning briefs along with further analysis and recommendations to support continuous learning and improvement for MCWH and HIML partners.

Most Significant Change Training for BHEs

To support the evaluation and contribute to furthering capability development of BHEs, Clear Horizon also conducted a three-hour training in the MSC technique. MSC is a qualitative, story-based approach to capturing program impacts from those most closely involved and impacted.

For this evaluation, 15 BHEs were trained in MSC and, with the support of tailored resources, each undertook an interview with a HIML session participant. During the interviews participants were asked about changes they had experienced because of the HIML sessions and asked which of these they felt was the 'most significant' and why. From these interviews, BHEs wrote MSC stories, keeping them as much in the words of the participants as possible.

These stories were then reviewed by Clear Horizon, and seven stories were selected for the Story Summit, attended by representatives from MCWH and state/territory-based delivery partners. During the Story Summit the stories were read aloud and considered against the folowing set of ‘significance’ criteria to enable story selection:

- → Strength of evidence
- → Significance of impact
- → Alignment of the outcomes in the story to TOC outcomes
- → Any unanticipated but positive outcomes.

Through the workshop discussion, key themes and outcomes were identified, and four stories were collaboratively selected for inclusion in this report. These stories substantiate the Effectiveness findings within the report.

Synthesis and sense-making

Once analysed, all data was summarised and synthesised into an evidence table. Triangulation of data through multiple methods was conducted where possible to strengthen the evidence. An internal sensemaking session was held by the Clear Horizon evaluation team to identify key findings and make comparisons with data reported as part of the previous evaluation.

Ethical considerations

Clear Horizon paid special consideration to ethical protocols and risks to ensure our conduct complied with privacy legislation and standards for the ethical conduct of evaluations.

Participants for all surveys were provided with information about the survey purpose and content and informed that participation was completely voluntary and confidential. Consent was opt-in when a person chose to participate in the survey.

Interview and focus group participants were provided with a privacy collection statement through verbal or written means (depending on their preference and language needs). The privacy statement ensured that participants were fully informed of the voluntary nature of participation, their right to consent and withdraw from participation, and their right to request access to their information. Verbal consent, including for audio-visual recording (for transcription purposes) was documented before proceeding with the interview or focus group.

Session participants interviewees (migrant and refugee women) were remunerated with a voucher for their time. BHEs were paid by MCWH for their time in focus groups and MSC training as per their employment contracts. A low-risk Human Research Ethics Committee (HREC) application was also conducted through IRIS Ethics prior to the BHE MSC training to ensure training and participant interview materials were ethical and safe.

Limitations

While an effort was made to ensure the rigour of the evaluation process and findings, the following limitations are associated with the methodology:

Data entry challenges

Errors and omissions

Some data entry errors and omissions affected data accuracy. This is

expected given the size of the BHE workforce and the scale of project activities and data collection.

Pre- and post-session data is captured through a group survey format: the BHE reads questions aloud, participants respond by a show of hands, and the BHE counts and records the responses, later entering them into SurveyMonkey. Discrepancies may arise from several sources: time constraints that prevented the survey being administered; the voluntary nature of the survey, meaning some participants chose not to take part or skipped questions; participants raising their hand for multiple responses; or BHEs miscounting, recording, or entering responses incorrectly. As a result, exact metrics may be slightly inaccurate. However, given the volume of data analysed, we are still able to draw accurate conclusions overall, noting a small margin of error in some instances.

Accuracy of reach data

Reach data for stakeholder engagement activities is reported as an estimated total across several subsets, rather than an exact count. Since reach so far exceeds the evaluation target, this is not considered a concern. In future, separating more direct engagement methods (20 or fewer participants) from larger-scale engagements may support more accurate reporting.

Group Survey

The group survey format carried a risk of bias that could affect the validity of results. To manage this, the evaluation shifted from measuring only a shift to a "high" knowledge response, to considering whether any substantial shift occurred (e.g. low to medium, or medium to high). In future evaluations, MCWH may adjust this scale to 'confidence stayed the same' or 'confidence increased' to better align with their other programs. It is possible that reported numbers would be slightly lower under a non-group format; however, results remain consistently high across sessions and across BHEs delivering in different states and territories. This was also confirmed through qualitative data from the BHE focus groups and session participant interviews, providing us with confidence that a substantial shift for participants did occur.

Inconsistent data collection questions

Surveys collecting BHE perspectives on CoP and PD sessions asked questions inconsistently, making complete comparisons across sessions difficult. Where questions were similar enough, they were mapped to enable shared reporting; where they differed, they have been reported separately.

Sample sizes

Qualitative methods

Budgetary and time constraints limited the sample size for session participant MSC interviews, which represent just 0.12% of the total participant cohort. This means that while the interviews offer meaningful insight into the project's effectiveness, findings cannot be confidently extrapolated as representative of the whole cohort. For this reason, MSC stories are reported as emerging themes and used to strengthen findings related to the project's effectiveness.

HIML Dashboard Development

To support MCWH in owning and visually representing HIML data in an ongoing and accessible basis, a HIML Dashboard was developed in partnership with Clear Horizon. The dashboard draws on partner monthly reporting and session surveys, collected via SurveyMonkey and (for Victoria only) Smartsheet.

Transition to new tools

Informed by learnings from the previous evaluation and changes made to the HIML TOC, updates were made to both the session participant survey and the partner monthly report. These changes took effect in November 2025.

Data limitations arising from the transition

- Language of session: Language data is only available in the dashboard from the point the new tool was introduced. While language was captured in the old tools, this was as a free text rather than a dropdown, enabling respondents to list multiple languages. The new tool uses a single-selection dropdown, enabling accurate counts, but this means old and new language data could not be combined. Consequently, sessions delivered in language are not a complete dataset for the full reporting period.
- Cultural group data: Some cultural group data recorded in the old tools was unstructured or inconsistent and has been excluded from the dashboard as a result.
- Mental health and cancer screening surveys: Post-session survey data for mental health and cancer screening topics was not captured during the tools transition period. These datasets are therefore unavailable for that period (with the exclusion of VIC).
- Changes to data collected: some data points were no longer collected using the new tools, for these areas data is only available between 01 July 2025 and the introduction of the new tools.

While these data limitations have impacted this year's project evaluation, the transition to new tools is a worthwhile investment in MCWH's long-term capability to build own their evidence base and respond to it in real time.

Results and Impact

This section details key findings from this evaluation set out against the KEQs in the following structure:

Reach

- → How well did the HIML project reach migrant and refugee women and community stakeholders across Australia?

Effectiveness

- → How effective was the HIML project in producing anticipated outcomes for migrant and refugee women?
- → To what extent did the HIML project produce unanticipated outcomes for migrant and refugee women whether positive or negative?

Enabling Conditions and Barriers

- → What enabling conditions support the ongoing effectiveness of the HIML project?
- → What barriers hindered these conditions and the HIML project's effectiveness?

Where relevant, data and findings from the previous evaluation have been included to support comparison across the findings.

Reach

1. How well did the HIML project reach migrant and refugee women and community stakeholders across Australia?

Findings summary

The health education sessions were well attended with representation of a high level of diversity across age, language, and cultural groups. In FY 25/26 a total of 17,224 attendees participated in 1,376 sessions about eleven health topics. The total participation is higher as compared to FY 24/25, with a total of 8,152 attendees in 759 sessions.

"Navigating the Australian Mental Health System' was the most attended session (n=2846), followed by Let's Talk Mental Health (n=2084), while Pregnancy Choices (n=816) was the least attended topic.

Stakeholder engagement continues to be a critical aspect of implementing the HIML project with the project demonstrating substantial stakeholder reach by engaging an estimated 22,712 stakeholders. While much of this reach came via estimated contacts with stakeholders and community members in largescale community festivals and events, direct reach outs and other forms of smaller scale engagement accounted for the majority of community engagement activities. Stakeholder engagement serves to promote the project, develop trust with community, gauge interest levels in the health education topics, and understand how the project is best tailored to specific contexts.

Social media was a key communication method used to promote the project and encourage session bookings with a total of 109 social media activities in FY 25/26. Traditional media was less utilised than social media in this phase of HIML with 49 traditional media activities reported, though this is higher than the 17 traditional media activities reported in the previous year.

The reach of the project was measured by stakeholder engagement through community facing activities and social and traditional media, and by the engagement of participants in health education sessions.

Please note the reach data below has some limitations pertaining to the likelihood of the same stakeholders being recorded through various engagement methods, estimates of community members at high volume events (e.g., festivals or conferences), and repeat attendees who participated in multiple health education sessions.

17,224
attendees participated in

1,376
sessions in over

30+
languages

Engagement in session delivery was high and targets were exceeded

Target: 11,000 attendees in 1,100 sessions
Actual: 17,224 attendees in 1,376 sessions
Result: Target exceeded

There was a total of 17,224 attendees (157% of target or 57% above target) participating in 1,376 sessions (125% of target or 25% above target) about the eleven health topics. In FY24/25 the session delivery target was not met, however, in FY 25/26, the target has been exceeded. This was supported by several factors including an expanded topic list to better meet community need and interest, additional time to establish community relationships, and strong existing state/territory delivery partnerships. Despite encountering some delays in the project establishment phase, BHEs were also able to continue delivering SRH sessions from 01 July 2025, while awaiting training in the additional topics.

Table 6 shows the number of participants reached by state/territory, demonstrating the spread of engagement across the country. All states bar ACT and WA saw increases in the number of attendees with QLD, SA, TAS, and VIC each more than doubling the number of attendees.

Table 1. Number of attendees by state/territory

State/ territory	# of attendees FY 24/25	# of attendees FY 25/26
ACT	364	270
NSW	2340	3911
NT	507	999
QLD	927	2040
SA	1077	2676
TAS	298	644
VIC	1323	5571
WA	1316	1113
TOTAL	**8152**	**17,224**

Mental Health topics gained high attendance

Navigating Mental Health and Let's Talk Mental Health were the most attended sessions, while Pregnancy Choices was the least attended session. Pregnancy Choices was also the least attended session during the previous SRH-only iteration of HIML. Reasons for the lower attendance and delivery rate of Pregnancy Choices is likely due to the combination of the relevance of this topic for the dominant age cohort and potential sensitivities related to the subject matter.

Alternatively, the previous evaluation found that Understanding Menopause was more relevant to the dominant age group and viewed as a less sensitive topic. Due to this it was often used to introduce the project to communities and develop trust. According to BHEs during this phase of implementation, mental health and cancer screening topics were used in a similar manner. Understanding Menopause continued to be well attended as the third most attended session in FY 25/26.

Table 2. Number of attendees by session topic

Session topic	# of attendees FY 25/26
Navigating the Australian Mental Health System	2846
Let's Talk Mental Health	2084
Understanding Menopause	1944
Bowel Cancer Screening	1690
Cervical Cancer Screening	1510
Lung Cancer Screening	1499
Breast Cancer Screening	1479
Safer Sex (STIs)	1456
Contraception Choices	1007
Pregnancy Choices	816
Managing Mental Health (VIC only)	355

Attendee diversity across age, language, and cultural groups was high

The sessions were attended by 16,367 females and 855 males, which supports the project's intent to focus on migrant and refugee women as the priority cohort while offering limited male only sessions.

Sessions engaged with a highly diverse population of migrant and refugee women across age groups ranging from under 20 to over 60. The highest number of attendees fell in the over-60 years bracket (n=4,118), closely followed by 41-50 years age bracket (n=3,854). The age range skews higher with approximately two-thirds of participants belonging to age categories over 41.

The three most highly represented cultural groups in sessions were the same in FY24/25 and FY25/26: Afghan, Chinese and Vietnamese. However, the ranking shifted between years. In FY24/25 the order was Afghan, Chinese, Vietnamese while in FY 25/26 it was Afghan, Vietnamese, Chinese. There was a considerable increase in attendees from Vietnamese and Chinese backgrounds and more limited growth in attendees from an Afghan background.

Health education sessions were delivered in 32 languages, reaching culturally and linguistically diverse communities across the nation.

- Amharic
- Arabic
- Assyrian/Chaldean
- Bengali
- Burmese
- Burmese
- Cantonese
- Croatian
- Dari
- Dinka
- English
- Farsi
- Greek
- Hakha Chin
- Hindi
- Italian
- Japenese
- Karen
- Khmer
- Mandarin
- Nepali

- Samoan
- Serbian
- Sinhala
- Solomon Islands Pijin
- Spanish
- Sudanese Arabic
- Swahili
- Tetum
- Thai
- Turkish
- Ukrainian
- Vietnamese

In table 11 the high number of English sessions (with variations) was likely due to several factors including:

- High levels of session delivery to multicultural groups, including in workplace and educational settings (e.g., TAFE).
- Availability of BHEs who speak particular languages in specific states.

Table 3. Number of attendees by gender

Gender	# of attendees
Female	16,367
Male	855
Total	**17,222**

Table 4. Number of attendees by age range

Age group (in years)	# of attendees FY 24/25	# of attendees FY 25/26
Under 20	170	241
21 - 30	1079	1829
31 - 40	2011	3267
41 - 50	2109	3854
51 - 60	1390	3571
Above 60	893	4118
Unknown	NA	378
Total	**7652**	**17,258**[3]

Table 5. Number of attendees by cultural group (top 5 in FY 24/25 and FY 25/26)

Cultural group	# of attendees FY 24/25	Cultural group	# of attendees FY 25/26
Afghan	1467	Afghan	1763
Chinese	641	Vietnamese	1595
Vietnamese	538	Chinese	1401
Iraqi	587	Greek	812
Nepalese	444	Nepalese	788

Table 6. Number of attendees by session language (top 5 in FY 24/25 and FY 25/26)

Language	# of attendees FY 24/25	Language	# of attendees FY 25/26
English[4]	2832	English	5154
Dari	1029	Dari	1105
Arabic	964	Arabic	896
Mandarin	409	Assyrian/ Chaldean	628
Ukrainian	367	Nepali	477

3 This total is higher than the total number of attendees recorded, indicating inaccurate data collection or entry (see Limitations section for further details).
4 The following recorded languages were all counted as English in the table above: English, Plain English, Simple or Simplified English, Easy English.

Stakeholder reach was exceeded through community engagement activities

Target: 600 stakeholders including groups, agencies, networks, and individuals were reached through community engagement activities

Actual: 22,712 stakeholders

Result: Target exceeded

In FY 25/26 the project reached an estimated total of 22,712 individual stakeholders, exceeding the target. ACT, SA, and WA all increased the number of stakeholders engaged across FY25/26 compared to the previous year while all other states and territories saw a decrease in the total number of stakeholders engaged. Despite this, the number of community engagement activities was higher across all states and territories bar TAS and VIC, with the total number of activities in FY25/26 totalling 1,729 to 1,333 in FY 24/25.

Table 1 details the results disaggregated by state and territory. This marked outperformance of the stakeholder target is largely due to engagement through largescale events, festivals, and celebrations.

Table 7. Number of stakeholders engaged by state/territory

State/ territory	# of stakeholders engaged FY 24/25	# of stakeholders engaged FY 25/26
ACT	720	1014
NSW	3059	2422
NT	8779	4892
QLD	4404	3527
SA	2895	3851
TAS	1046	614
VIC	1540	1315
WA	4084	5077
Total	**26527**	**22,712**

Table 8. Number of community engagement activities by state/territory

State/ territory	# of activities FY 2025 (Jul24-Jun25)	# of activities FY 2026 (Jul25-Jun26)
ACT	63	79
NSW	199	249
NT	88	178
QLD	295	490
SA	52	107
TAS	312	256
VIC	139	136
WA	185	234
Total	**1333**	**1,729**

The tables below show the most utilised community engagement activities, stakeholder types, and stakeholder cultural/ language groups. From this data we can see that targeted community groups and non-profit organisations are the most popular stakeholder categories. The high reach with multicultural communities/ language groups relate to community festivals and events. Again, while attendance at these festivals contributes to high reach numbers there is a substantial number of more direct engagement methods as shown in table 5 where emails and meetings account for a collective 1,016 community engagement activities compared to just 202 community festival/ networking events.

Table 9. Number of community engagement activities by stakeholder category (top 5)

Stakeholder category	# of activities FY 25/26
Targeted community groups	225
Non-profit organisation	192
Tertiary education institution	67
Health services	20
General public	18

Table 10. Number of community engagement activities by cultural/ language group

Cultural/ language group	# of activities FY 25/26
Multicultural	544
Any other	207
Undisclosed	166
Afghan	96
Chinese	91
Nepalese	80
Vietnamese	43

Table 11. Number of community engagement activities by activity type (top 5)

Community engagement activity type	# of activities FY 25/26
Email	602
Meeting	414
Other	402
Community festival or event	108
Networking event	94

The project was promoted through social and traditional media

There was a total of 109 social media posts across FY 25/26 disaggregated by state/ territory as shown in table 12 below.

Traditional media was utilised to a greater extent when compared to FY24/25, though still to a lesser extent than social media. Over the past year, 49 traditional media promotions were reported, with the majority conducted in the Northern Territory (n=35), followed by ACT (n=7), SA (n=5) and NSW (n=2). Other states did not have any traditional media activities reported.

Table 12. Number of social media posts by state/territory

State/ territory	# of social media activities FY 25/26
ACT	21
NSW	24
NT	14
QLD	14
SA	4
TAS	15
VIC	9
WA	8
Total	**109**

Effectiveness

2a. How effective was the HIML project in producing anticipated outcomes for migrant and refugee women?

2b. To what extent did the HIML project produce unanticipated outcomes for migrant and refugee women whether positive or negative?

Finding summary

The results in this section show that the project was consistently effective in increasing migrant and refugee women's knowledge and confidence about the topics delivered through health education sessions across the country.

There was also strong evidence that the sessions helped participants set intentions to share their knowledge with friends and family, encourage others to attend sessions, and talk to health professionals. This result was commonly reported in survey data and confirmed with the Most Significant Change interviews with participants who provided further insight into the changes they experienced as a result of participating in sessions. These changes include having increased confidence to navigate the Australian healthcare system and taking action to share health information with others and to attend health appointments and screenings.

Together, these themes indicate a transition from acquiring new knowledge to taking action and suggest a potential ripple effect whereby information extends beyond direct program participants and out into their broader communities.

The results below address the knowledge and confidence changes and the intentions for action from quantitative survey results complemented by qualitative feedback from session participants and observations by BHEs.

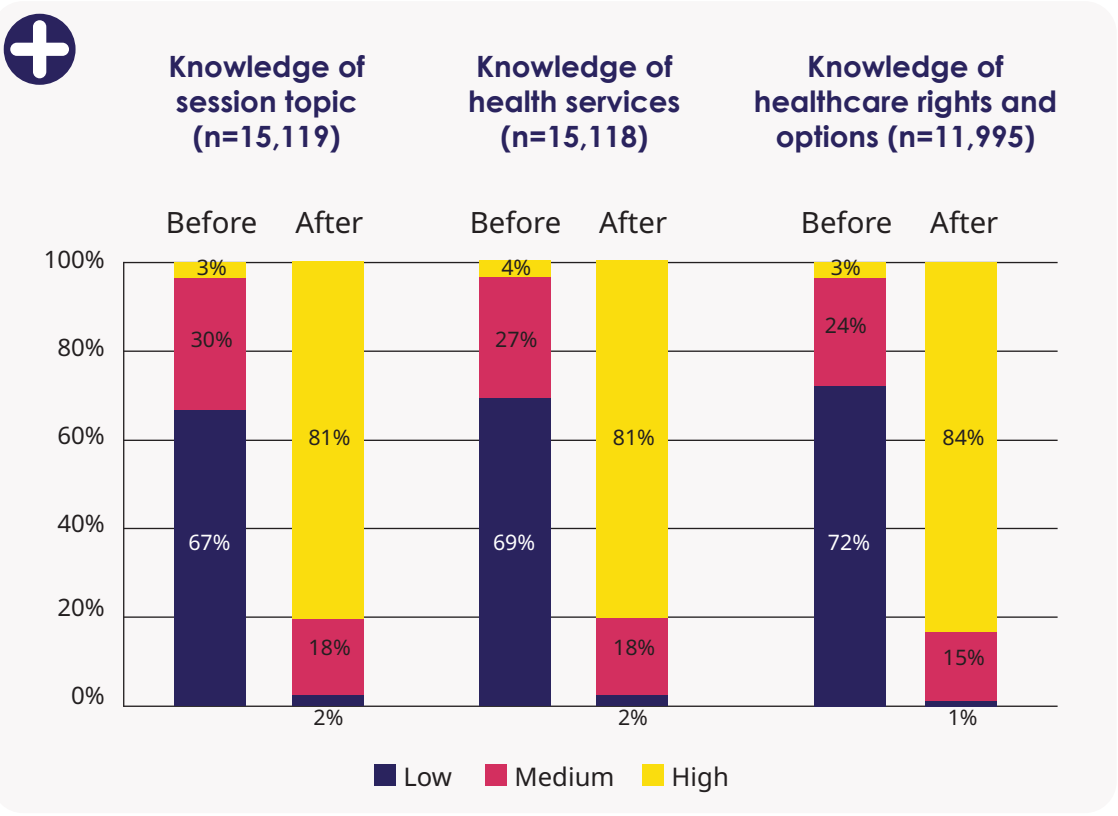
The quantitative surveys show a substantial positive shift in participants post-session knowledge and confidence.

A total of 81% of participants (n=15,119) rated their knowledge of session topics as 'high' after the session was delivered with a before-session 'high' percentage of 3%. The difference knowledge increase of participants who reported 'high' was 77 percentage points.

A total of 80% of participants (n=15,118) rated their knowledge of health services discussed as 'high' after the session was delivered with a before-session 'high' percentage of 4%. The difference knowledge

increase of participants who reported 'high' was 76 percentage points.

Similarly, 84% of participants (n=11,995) rated their knowledge about their healthcare rights and options as ‘high’ after the session was delivered with a before-session ‘high’ percentage of 3%. The difference knowledge increase of participants who reported 'high' was 80 percentage points.



Qualitative analysis confirmed that participants experienced improvements in knowledge related to the session topics, health services, and their healthcare rights and options.

> “ Before attending the health information sessions, I believed I should only consult my GP if my health condition was severe.... after attending these health information sessions, I now understand that I can seek assistance from my GP even when experiencing early or mild symptoms of health conditions" – Session participant

> “ I was previously unaware of the symptoms of mental health conditions, and I was also unsure where to seek help. Attending mental health information sessions has significantly improved my understanding of mental health" – Session participant

Spreading the word to community and making sure we all stay healthy

This story demonstrates the important role community leaders play in encouraging participation from others in their community. It also shows how a leader or other participant can shift from reluctant or duty-driven participation to recognising the personal benefit of the information shared. Notably, the storyteller who had lived in Australia for many years still found this information new, demonstrating that the program's value extends beyond newly arrived migrant and refugee women, to women of diverse cultural backgrounds, religions, education levels, and lengths of time in Australia.

The full Most Significant Change story can be read on the next page.

BHEs observed that participants deepened their understanding of their rights in relation to making informed decisions about their health.

> “They've learned about healthcare rights and responsibilities. So [now] they know it's their decision to make" - BHE

Qualitative analysis also found evidence of increased knowledge about navigating the Australian healthcare system and evidence of where this was successfully practised by session participants.

> “As a migrant and a single mother of two teenagers, I have struggled to settle into a new country, and navigating complex systems, including healthcare, has been challenging. Learning how to maintain mental wellbeing and identifying where to access professional support has been very helpful to me" – Session participant

Spreading the word to community and making sure we all stay healthy

I first heard about the event through a community member, but I did not know much about it. We knew there would be a church service led by a Pastor, so we came to show our support. We knew there would also be an information session after, but we did not plan to stay for it.

On the day, when I saw that it was you that would be speaking to the women on women's health, I decided to stay. Just to support you and some of the quieter girls who were there, because I could see they didn't want to stay unless us leaders stayed. I did not expect to get much out of it or learn anything new. I only came to show my support to you and the other girls. Before the session, I didn't know what information you would share, I had never heard of it before. It's not something we talk about, and we rely on our doctors to tell us when to do things.

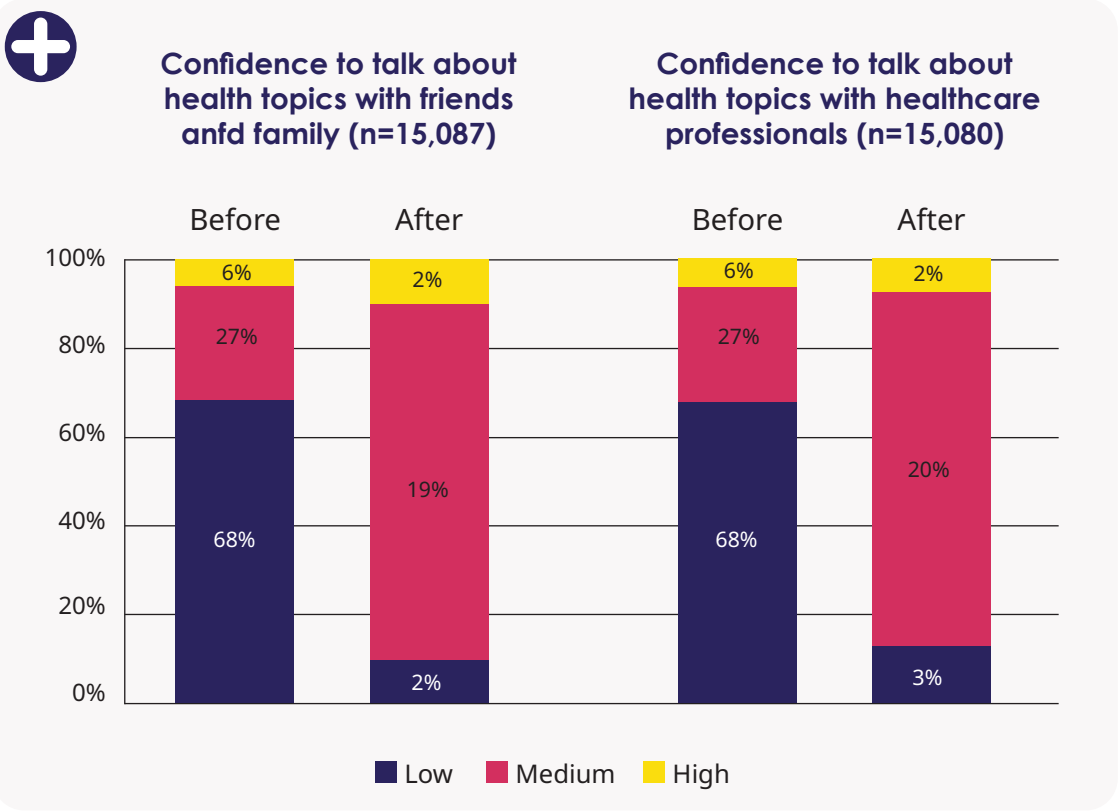
When you were sharing the information, it was so interesting to me because I had never heard of it before. I thought I knew most things, as I've been living in Australia for 16 years. So, it was so interesting to listen and learn that there's so much that I don't know. Even when you were explaining the different menstrual products, contraception methods, I thought to myself wow I didn't know all of that existed. When you were talking about cervical screening, it was very eye opening to me. I was shocked because I'm 37 and have never done a cervical screening before. I thought we only do that kind of test after we give birth because that's the only time that I had one.

I learnt a lot from that one session. After that day, I told myself I was going to book a cervical screening because you made me feel more comfortable around the idea of getting screened. You told me about the self-collection option and what the process would look like, which just made me more comfortable and confident enough to book my cervical screening. I booked it for the week after and I'm so glad I did it too.

When it comes to screenings and tests around our health, a lot of us in the community don't know. I thought I knew myself, but when I attended the session, the information was new for me too. Now I even tell other ladies in community about the cervical screening test, and I know who to talk to if I ever need more information. Spreading the word to community and making sure we all stay healthy is the most important thing for me.

A total of 79% of participants (n=15,087) rated their confidence to talk about health topics with friends and family as ‘high’ after the session was delivered with a before-session high percentage of 6%. The difference knowledge increase of participants who reported 'high' was 73 percentage points.

Similarly, 78% participants (n=15,080) rated their confidence to talk about health topics with healthcare professionals as ‘high’ after the session was delivered with a before-session high percentage of 6%. The difference knowledge increase of participants who reported 'high' was 73 percentage points.



Across the interviews, participants shared that receiving health education about the topics and available health services reduced anxiety over accessing healthcare and increased their confidence to take steps to access screenings.

> “Before I started the HIML sessions, I was anxious and overwhelmed whenever I thought about using the healthcare system. I had never attended any health education programs before and due to language barriers... I had no idea how to ask for help or navigate the health system... It left me feeling unsure, isolated, and disconnected from taking care of my health. Today, I feel much more comfortable and confident when using health services. The knowledge I gained gave me the courage to overcome my past hesitations and encouraged me to go to the clinic” - Session participant

When accessing care, participants also felt more confident to exercise their rights by discussing their options, seeking second opinions, and doing their own research.

> “Attending sessions on contraception provided me with valuable knowledge at a time when I needed it most. I learned that there are many different contraceptive options available, which gave me the confidence to discuss these options with my GP and choose the method that best suits my needs” – Session participant

Evidence demonstrated strong intention setting by participants to recommend the session to others, talk to a health professional, or share their learnings with others.

In FY26, 96% participants (n=3,148) rated intent (somewhat or very) to recommend the session to other people as compared to 98% (n=7792) in FY25.

In FY26, 96% participants (n=3,040[5]) rated intent (somewhat or very) to talk to a health professional about their sexual and reproductive health as compared to 94% (n=7861) in FY25.

In FY26, 98% participants (n=14,099) rated intent (somewhat or very) to share their learning with other people as compared to 96% (n=7957) in FY25.

Positive intent indicators have remained high even as the number of sessions has increased, suggesting that session quality and the effectiveness of knowledge transfer have been maintained.

Intent indicators	FY 2025 (Jul24-Jun25)		FY 2026 (Jul25-Jun26)	
	% participants	n	% participants	n
Participants rating their intent (somewhat or very) to **recommend the session to other people**	98%	7792	96%	3,148
Participants rating their intent (somewhat or very) to **talk to a health professional about their sexual and reproductive health**	94%	7861	96%	3,040
Participants rating their intent (somewhat or very) to **share their learning with other people**	96%	7957	98%	14,099

5 New tools introduced in November 2025 no longer asked participants about their intention to talk to a health professional or share learning with others leading to lower response numbers for these questions.

Following sessions, high numbers of participants intended to recommend the session to others, speak with a health professional, or share what they had learned. Qualitative findings reinforced this, identifying sharing knowledge as a commonly reported outcome, either immediately after the session or later, when a relevant topic arose in the life of someone close to the participant.

> “Because of my positive experience, I have encouraged several of my friends to join the program. I strongly believe that programs like this are extremely valuable, especially for migrant and refugee women who may face barriers in accessing health information” – Session participant

Many participants also took concrete steps toward accessing healthcare including making appointments with GPs or accessing cancer screening services. In some instances, BHEs directly supported the transition from acquiring new knowledge to taking action. In one instance the BHEs arranged for someone from Breast Screening Australia to attend the session and support participants who were interested in scheduling a screening appointment. In another instance, the BHE arranged a day of appointments for cancer screening and a bus to transport the women to attend as a group.

Overcoming Fear to Seek Support

This story demonstrates strong alignment with intended outcomes within the TOC. Story Summit participants felt it exemplified how women often need more than one session to feel comfortable enough to take action. They noted that the HIML session made a difference in this participant’s efforts to seek medical support, self-advocate, and ultimately receive a diagnosis. The story speaks to overcoming health-related fears and highlights the importance of providing safe, non-judgemental, and accessible health information.

The full Most Significant Change story can be read on the next page.

Qualitative data also revealed how participants’ perspectives on health topics shifted after exposure to new health information delivered in their own language and in culturally relevant ways.

> “At first, some sessions, such as sexual health and pregnancy choices, were culturally difficult for me to attend. However, after participating, I realised how valuable and important the information was” – Session participant

Overcoming fear to seek support

About a year ago, I attended a Health in My Language session about women's health and cancer awareness. During that session, information about stomach and bowel cancer especially stayed with me. At the time, I remember feeling worried because some of the symptoms discussed sounded familiar to me. However, after the session ended, I still did not go to the doctor.

I think part of me was scared. I kept telling myself that maybe it was stress, tiredness, or something not serious. In my culture, many women are used to enduring discomfort and putting their health last. I was also nervous about the healthcare system and felt embarrassed talking openly about symptoms connected to digestion and women's health.

Over the following year, the information from the session stayed in my mind. When I heard that the session would be running again, I asked if I could attend one more time. I felt that maybe this was my second chance to finally do something instead of continuing to ignore my health concerns. During the session, the information was explained in a very open, respectful, and supportive way. I felt safe listening and asking questions. Hearing the information again, in my own language, made me realise how long I had been avoiding seeking help because of fear.

After the session ended, I approached the health educator privately and shared my concerns. For the first time, I openly spoke about the symptoms that had been worrying me for a long time. The educator listened carefully, without judgment, and helped me book an appointment with a GP.

At the medical appointment, I explained my symptoms and concerns. Even though routine screening was not yet recommended for my age, the doctor decided to organise further medical investigations because of the symptoms I described. After completing the tests, doctors identified changes that required medical attention and early treatment. I was told that addressing the issue early helped prevent more serious complications and possible long-term consequences. Hearing this was emotional for me because I realised that if I had continued ignoring the symptoms out of fear, the situation could have become much worse.

The most significant change for me was understanding that fear should not stop us from taking care of our health. The HIML session gave me not only information, but also the confidence and emotional support to finally seek help. I truly believe that attending the session for the second time changed the direction of my health journey.

I feel deeply grateful that I returned, listened again, and found the courage to speak up. Now I encourage other women not to ignore symptoms, not to wait too long, and not to be ashamed to ask questions or seek support.

This was also observed by BHEs who noted community groups becoming increasingly comfortable engaging with previously sensitive topics.

“The biggest change I’ve seen … is a decrease in fear and anxiety surrounding taboo topics that we … speak about as a community. Now that women are more comfortable in learning about topics, they’re spreading the word and I think that’s [creating a] ripple effect…After so many years …it’s a bit more open when we bring a topic” - BHE

Participants shared how new health knowledge broadened their awareness. Evidence was particularly strong as this related to undertaking preventive health actions such as accessing cancer screenings.

> “Learning about menopause was particularly insightful; I am currently experiencing menopause and was previously unaware that my symptoms were related to menopause. Learning how to manage these symptoms felt very personal and empowering” – Session participant

> “Back in my home country, we usually only go to the doctor when we are very sick or when something does not feel right. Preventive health checks or cancer screenings are not something people talk about openly…after attending the HIML session, I became much more conscious about my own health, [and] the session encouraged me to seriously think about doing the cervical screening test myself” - Session participant

Creating Safety and Agency

This story speaks to how empowered some participants feel by having new information, and the confidence to act on it. Story Summit participants felt it demonstrated how broadening someone’s awareness of health topics can help them overcome cultural barriers or past experiences to take action related to their own health, and to encourage others in their community to do the same. It also highlighted the importance of professional, culturally safe, and accessible health information for women who may otherwise receive much of their health information from family members.

The full Most Significant Change story can be read on the next page.

Creating safety and agency

Before attending the Health in My Language sexual and reproductive health session, I carried many struggles quietly within myself. As a refugee woman and mother, most of my life had been focused on caring for my family before myself. Growing up in rural area my country, conversations about women's health, pregnancy, contraception, or reproductive wellbeing were rarely spoken about openly. We simply accepted pain, fear, and silence as part of life.

After resettling in a new country, new challenges appeared. I struggled with loneliness, language barriers, and understanding the healthcare system. During medical appointments, I often felt embarrassed because I could not fully understand the information given to me. I avoided asking questions about my health and reproductive wellbeing because I lacked confidence and felt ashamed.

Everything started to change when I attended the HIML session. For the first time, I received health information in my own language and in a setting where I felt safe and respected. Sitting in a room with other refugee women who shared similar experiences made me realise I was not alone.

During the session, we openly discussed sexual health, contraception, women's rights, and the importance of regular health check-ups. Hearing other women share their stories gave me courage to reflect on my own experiences. I learned that many of the risks and fears women faced in the past could be prevented with proper healthcare, education, and support.

One of the most important changes for me was gaining confidence. Before attending the HIML session, most of my understanding about contraception and reproductive health came from others, especially from my husband's perspective. After the session, I felt informed enough to make my own decisions and ask questions without fear.

I also began taking my own health more seriously. I booked health appointments, attended regular check-ups, and started speaking more openly with healthcare providers. I learned how important it is for women to care for both their physical and mental wellbeing.

What made this change most significant for me was not only the knowledge I gained, but the feeling of empowerment. For many years, I believed my role was simply to endure hardship quietly. Now, I understand that my health and voice matter too.

Today, I share what I learned with younger women, friends, and family members in my community. I encourage pregnant women to attend antenatal appointments, seek medical help early, and talk openly about reproductive health concerns. I want younger generations of women to feel supported and informed in ways many of us never were.

The HIML session did more than provide health education. It created a safe community where women could speak honestly, heal from past experiences, and build confidence together. It reminded me that when women are given culturally safe healthcare, language support, and compassion, they become stronger not only for themselves but for their families and communities as well.

Connection, Confidence, and Change

This story provided strong evidence of positive outcomes beyond those anticipated within the TOC, including increased social connection, improved mental health and wellbeing, and growing self-esteem. Story Summit participants noted that the storyteller described how, even when barriers to attendance arose, the effort to attend still felt worthwhile given how much she gained.

The full Most Significant Change story can be read on the next page.

Most Significant Change themes and outcomes

Through the deliberative process undertaken during the Story Summit key themes and outcomes were identified by workshop participants. Themes identified included:

- How HIML health education sessions are valued by and relevant to not only newly arrived migrant and refugee women, but also for people who have been in Australia for longer amounts of time.
- The different roles community leaders can play in spreading the word about the project, encouraging attendance, and creating safety within sessions.
- Common outcomes beyond the intended outcomes in the Theory of Change – the strongest being the ability to connect with others in positive ways during the sessions.

Not raised during the discussion but also identifiable across the stories was the ability of BHEs to create safe, supportive and comfortable spaces during the sessions.

Connection, confidence, and change

Before attending the Health in My Language sessions, I had never really participated in group programs like this before. I decided to attend the sessions to learn more about my health and gain useful information. What encouraged me to keep attending was the positive and welcoming environment within the group. The facilitator and the women involved made me feel safe, comfortable, and supported, which gave me the confidence to continue attending more sessions. At the beginning, I did not know much about the health topics being discussed, but as I listened, participated, and became more involved, I started to understand their value more deeply.

Through these sessions, I realised there was a lot of important information and support that I had never had access to before, mainly because I spent most of my time at home and did not go out much. Since arriving in Australia in 2011 until separating from my husband, I rarely left the house. I did not have friends or people to visit or spend time with. I lived in what I would describe as forced isolation. My ex-husband and his family controlled many aspects of my life, and because of fear and the difficult experiences I went through, I became very withdrawn and lost confidence in myself. Even my children became used to seeing me as someone with very little confidence. Before attending these sessions, I struggled to see my own value. I found it difficult to accept myself or even look at myself properly in the mirror.

What encouraged me to continue attending was not only the information shared during the sessions, but also the atmosphere and activities involved. The sessions included exercises, interactive activities, and some were even held in outdoor environments. All of these experiences helped me feel more connected and engaged. Over time, the sessions became something I genuinely looked forward to, to the point that even when I felt tired or unwell, I still wanted to attend.

Every topic discussed during the sessions connected to something in my life. At times, I realised there were experiences I had gone through but had never fully understood before. The sessions helped me develop a better understanding of my health and wellbeing. I especially benefited from topics such as mental health and menopause. Before attending, I had very little information about menopause or the changes related to it, but the sessions greatly increased my understanding and knowledge.

One important change was that I started sharing what I learned with my sister and other family members, even though I am usually not someone who talks a lot. I enjoyed going home and explaining to my sister what we had learned during the sessions.

The sessions also supported me socially. I began making friends and building relationships with others in the group. I believe all the women who attended benefited because many of us shared similar needs and life experiences.

One experience that impacted me deeply was the retreat that was organised. I felt “like a bird that had been in a cage and was finally free.” It was something I had never experienced before in my life. I especially enjoyed the group circle discussions where we sat together and spoke about different health topics, as well as the drawing activities. I still keep my drawing today. I also enjoyed

the yoga and swimming activities. It was such a meaningful experience that afterwards I felt confident enough to attend another camp with a different group. However, I did not enjoy it in the same way because this retreat felt unique due to the strong connection between women from different cultures and backgrounds.

At first, some sessions, such as sexual health and pregnancy choices, were culturally difficult for me to attend. However, after participating, I realised how valuable and important the information was. I was even able to support a woman close to me who went through an abortion by sharing some of the information I had learned during those sessions.

After attending the sessions, I noticed many changes in myself, especially psychologically. I felt happier and emotionally better. Even though I would often feel tired from travelling to the sessions, I still felt more energetic because I was finally leaving the house and interacting with people.

The sessions helped me build social connections and provided emotional relief from the difficulties in my life. On the days I attended, I would return home feeling happy and sleep better at night, even though I normally rely on sleeping tablets to sleep. I genuinely noticed a significant difference in my mood and energy whenever I attended the sessions.

The biggest change for me was socially and psychologically. Before joining the group, I felt broken. Now, I feel like a different person, as though I arrived carrying one version of myself and left with another. The social connections I built and the knowledge I gained had a major impact on me.

I believe this confidence came from the support, encouragement, and social connections I gained through the sessions.

Even small moments had a big impact on me. I remember one day when the facilitator noticed my newly dyed hair and complimented me by saying, “Wow, you look beautiful today.” It was such a simple comment, but it impacted me deeply and strengthened something inside me. Moments like this made me feel seen, appreciated, and acknowledged.

The sessions also gave me something positive to focus on instead of constantly thinking about my problems. They improved my mental health and helped me feel that I exist, that I matter, and that I can support others through the information and knowledge I gained.

I truly hope these sessions continue, even if some topics are repeated, because repetition helps refresh my memory, especially as I often forget things. What made the sessions special was that they never felt boring or overly formal. They felt like open conversations with interactive activities and a warm, welcoming environment. The sessions were also culturally appropriate, which made it easier for me to feel comfortable and connected. The facilitator would not just give us information like we were sitting in a lecture, but would also ask about our own knowledge, experiences, and opinions, which made the sessions feel more engaging and respectful.

Overall, these sessions brought joy into my life. I genuinely enjoyed attending them, and they helped me feel better about myself and my life.

Enabling Conditions and Barriers

3a. What enabling conditions support the ongoing effectiveness of the HIML project?

3b. What barriers hindered these conditions and the HIML project's effectiveness?

Finding Summary

The findings below describe the key conditions enabling the implementation of the HIML project, which in turn support achieving the outcomes described in earlier sections in relation to the projects reach and effectiveness. Barriers encountered during project implementation are also described.

The effectiveness of the project was enabled by several conditions. An extensive and growing collection of project materials and health education resources alongside a national workforce of BHEs supported by ongoing professional development, enabled high-quality delivery at a national scale. HIML's overarching project infrastructure and direction, held by MCWH, paired national consistency with flexible state-based delivery. HIML's sustained presence over four years fostered strong stakeholder relationships and effective partnerships between MCWH and state/territory partners.

Several barriers challenged the implementation of the HIML project. A limited number of active BHEs in each state/territory restricted opportunities to reach specific cultural groups with in-language health education. The timing and duration of funding decisions affected planning and session delivery, stakeholder relations, and staff retention. The absence of clear career progression pathways for BHEs contributed to voluntary turnover, and inadequate budget allocation for BHE travel limited project reach.

Enablers and barriers of the project were identified through the Learning Workshops and BHE focus groups and supported by other methods including the document review and quantitative data from CoP and PD surveys.

Enabling conditions

An extensive and growing collection of project materials and health education resources has been developed to support high-quality project implementation nationally. Twenty-six of these

resources were reviewed as part of this evaluation comprised of:

MCWH Quality Standards: the quality standards document outlines seven standards for health education that guide how sessions are to be developed and delivered. The standards are: women's empowerment, cultural and linguistic appropriateness, accuracy of health information, access and equity, confidentiality, collaboration, and continuous improvement.

Session delivery: session delivery guides and accompanying slide decks were provided for each of the HIML topics delivered in FY 25/26. Each guide and accompanying deck describes the expectation that these materials are to be templates for session delivery and encourages BHEs to design and tailor the sessions for their community contexts and participants. BHEs may also add other evidence-based resources but are expected to ensure tailoring still meets the MCWH Quality Standards.

Stakeholder engagement: a HIML Community Engagement Guide and radio interview tips sheet were produced to support ongoing stakeholder engagement by BHEs and program coordinators.

Referral pathways: in addition to the multilingual resource portal, a list of SRH services in each state/territory was provided to support referrals.

These resources support consistent and high-quality implementation, while encouraging and creating space for culturally relevant contextualisation. BHEs noted that MCWH continued to respond to calls for additional resources to meet gaps identified during implementation. In some cases, MCWH worked with BHEs to address specific language gaps (e.g., Bosnian, Khmer, and Nepalese) by having BHEs provide in-language voiceovers or subtitles for existing resources.

Other project resources included an overarching MEL plan for the project, associated data collection tools, and the HIML Dashboard which visualises key metrics related to the projects reach and effectiveness support ongoing learning for continuous improvement.

A highly skilled, trained, and professional BHE workforce, supported by ongoing professional development was a key enabler of the project.

A total number of 52 BHEs are employed for this HIML phase.

Table 13. Number of BHE's by state

State	# of BHE's
VIC	15
NSW	7
QLD	6
TAS	5
SA	6
ACT	2
WA	5
NT	6

Continued funding for the project meant that most BHEs were retained across FY 24/25 – FY 25/26 resulting in not needing to recruit as many BHES, an implementation challenge identified in the previous evaluation. Ongoing professional development opportunities were identified as important for continuing to grow and strengthen this workforce. In FY25/26 the BHE workforce was supported through ongoing capability building activities comprised of accredited health education training, and optional additional PD sessions, CoPs, and weekly check-ins.

Communities of Practice

Across three CoPs held during this phase of HIML, BHEs consistently reported satisfaction with the CoP, increased knowledge and increased confidence.

Cancer Screening CoP

93% of BHEs who attended agreed (strongly agree/ agree) that the CoP:

- provided a safe space to share successes and challenges of working with migrant and refugee women
- improved their confidence to deliver culturally responsive sessions
- improved their confidence to share the knowledge and skills learned with colleagues, and
- had value in fostering mutual support and advocating for issues affecting migrant and refugee women (including gender diverse and non-binary people, if applicable)

> "We had a lot of training, like intensive trainings and assessments ...that helped us to build more confidence in delivering the health content" – BHE

From Training to Practice CoP

More than 90% agreed that the CoP:

- provided a safe space to share successes and challenges of working with migrant and refugee women and improved their confidence to share knowledge and skills with colleagues.

A further 89% agreed that the CoP:

- improved their confidence to deliver culturally responsive sessions, and
- had value in fostering mutual support and advocating for issues affecting migrant and refugee women (including gender diverse and non-binary people, if applicable).

> "The trainings and PDs helped me to know what to expect during session delivery ... and the other thing is I also understand the scope of the role. And I was a bit confused. I'm not a health professional. What am I going to do if participants ask me very, very technical things that really explaining ourselves and understanding the scope of the role is also one of the big tip that I get from the PDs, the support sessions the trainings and everything" – BHE

Leading with Strength CoP

More than 85% of BHEs who attended agreed that the CoP:

- provided a safe space to share successes and challenges of communicating and engaging with migrant and refugee women (including gender diverse and non-binary people, if applicable)
- improved their confidence to tailor communication and messaging for different settings
- helped them feel more confident talking about the HIML program, and
- was highly relevant to their work and provided practical tools and examples to support their day-to-day work.

Professional Development

Five PD sessions were conducted for the BHEs across the following topics:

- Navigating the Mental Health System (n=24)
- HIML Community Engagement Guide (n=14)
- Trauma Informed Practice (n=23)
- Understanding and Responding to Female Genital Mutilation/Cutting (n=14)
- SRH - Hepatitis B and Congenital Syphilis[6] (n=20)

BHEs reported the sessions were a helpful method to support their professional development, with high content relevance that served to increase their confidence in performing their roles.

All BHEs who attended Navigating the Mental Health System, HIML Community Engagement Guide and, SRH - Hepatitis B and Congenital Syphilis reported (Strongly Agree/ Agree) that the session was a welcoming space for exchanging relevant information for their professional development.

More than 95% BHEs from the two sessions (Navigating Mental Health System and SRH - Hepatitis B and Congenital Syphilis) reported increased confidence as a health educator as a result of attending the session, and 79% BHEs from the HIML Community Engagement Guide report increased confidence.

All BHEs who attended the Trauma Informed Practice session reported (Very/ Mostly) content relevance, with more than 95% BHEs reporting increased confidence and deepened understanding of the topic.

All the BHEs who attended the session, Understanding and Responding to Female Genital Mutilation/Cutting reported (Strongly Agree/ Agree) that the session provided useful information to support their work as a health educator, was a respectful and safe space to discuss sensitive topics such as Female Genital Mutilation/Cutting (FGM/C) and, increased confidence in discussing Female Genital Mutilation/Cutting (FGM/C) in community education settings.

> “It’s really good for us to exchange opinions and experiences because should one health educator discover something new or make a mistake, when they report it, they help the rest of us because… we all learn from each other’s mistakes or experiences” - BHE focus group

> “It allows… educators to communicate their questions, concerns, [and] needs in a safe space, just like we do for our participants. I think that’s what stands out for me. It allows me a space to go and ask questions and therefore present or do better sessions for the community. It equips me with better skills to be more precise” - BHE focus group

The informal check-ins were considered a valuable opportunity to troubleshoot challenges with other BHEs and to share what works well.

BHEs felt that these were safe and trusted spaces to share mistakes they had made or challenges they were encountering and discuss learnings with their colleagues. There was no concern among the BHEs within the focus group that expressing a challenge or sharing when something had not gone to plan would elicit any type of punitive response and these were instead seen as opportunities to share and support each other’s growth as health educators.

6 These topics were added to the SRH Safer Sex topic in response to national health priorities and included in updated versions of the SRH modules and guides.

These capability-building opportunities further developed BHEs confidence and provided ongoing learning opportunities, peer support, and practical strategies for anticipating and responding to delivery challenges.

While participant satisfaction with the sessions was not a key area of inquiry for this evaluation, results from the group survey show high satisfaction ratings, with an average of 95% of participants reporting they were 'very satisfied' across five key domains: clear and easy to understand, convenient and accessible location, met my cultural needs, met my language needs, and was useful and relevant to me. From this high satisfaction rating we can conclude that the delivery of sessions nationally by BHEs is of consistently high quality and contextualised in ways that meet the diverse cultural and information needs of migrant and refugee women.

The sustained presence and delivery of HIML over four years streamlined project delivery.

Previously, the nature of partner's readiness (including if they were already established in the HIML partnership, had prior experience with SRH education, needed to recruit BHEs for the project, and needed to build relationships with new stakeholder communities) meant that some partners had a delayed start to delivering sessions. In this phase, MCWH's existing partnerships and established systems, ways of working within the partnership with state-based delivery partners, and state-based delivery partners familiarity with project process helped to streamline project delivery and to "keep the project rolling by itself" – Project Coordinator, Sensemaking Workshop.

Overarching HIML infrastructure, paired with flexible state-based delivery supported project implementation and reach.

State partners felt that the overarching HIML infrastructure, paired with flexible state-based delivery, was key to effective implementation of the multi-year partnership.

Examples of this infrastructure included: clear key performance indicators (KPIs) set by MCWH, which helped Project Coordinators (PCs) track project performance and understand expectations; the multilingual resource portal and other project resources; and the professional training and capability development offered to BHEs. PCs felt this ensured quality standards and project targets could be met, while state/territory partners were freed up to focus on developing stakeholder relationships, providing tailored 1:1 support to BHEs, and adapting delivery to specific cohorts.

The infrastructure supporting ongoing monitoring, reporting, and learning (including reporting tools and the HIML Dashboard) was also seen as a valuable aspect of the HIML infrastructure, with MCWH's responsiveness to emerging learnings viewed as an enabler of implementation.

Barriers

The limited number of BHEs per state/territory restricted in-language delivery and reach.

The limited number of active BHEs in each state/territory restricted opportunities to reach specific cultural groups with in-language health education. While BHEs could deliver sessions in English, many community members value receiving sessions in-language from someone with a shared or similar cultural background. Attempts to mitigate this barrier included leveraging BHEs from other states to deliver online sessions for cross-state participants. However, a strong preference for in-person delivery remained.

Inadequate travel budget for BHEs limited reach, particularly in states/territories with dispersed populations.

Inadequate travel funding limited reach, particularly in states and territories with widely distributed populations (e.g. Queensland, WA, NT). Online sessions were offered as an alternative where travel wasn't feasible but again was less preferred by communities than face-to-face delivery.

The timing and duration of funding decisions impacted planning and delivery, stakeholder relations, and staff retention.

The timing of federal funding decisions, and the short duration of funding allocated to date (one year), limited MCWH and partners' ability to plan and created pressure at project inception (as noted in the previous evaluation) for example by delaying the ability to deliver mental health topics as BHEs first needed to be trained. It also strained stakeholder relationships, with partners left waiting to learn whether future sessions will be delivered, and what topics will be available. This uncertainty can impact staff retention, as BHEs without guaranteed future work left for more secure roles.

A lack of career progression pathways contributed to BHE turnover.

Many BHEs have held their roles for several years, undertaken extensive health and facilitation training, and bring strong professional backgrounds and qualifications, which may or may not be formally recognised in Australia. The absence of clear career progression pathways contributes to voluntary turnover among experienced BHEs who move on to different roles or organisations.

Recommendations

The recommendations provided below are categorised under actions that would strengthen the project, opportunities to expand the project, and advocacy actions to support ongoing project development and implementation.

Strengthen

- **Recommendation 1:** Continue to deliver tailored, in language sessions nationally to migrant and refugee women by BHEs who are trusted peers in local cultural communities.
- **Recommendation 2:** Continue to delivering a comprehensive mix of health topics to respond to migrant and refugee women's health information needs and work with communities to decide which topics are most appropriate to begin with.
- **Recommendation 3:** Continue to use evaluation methods to support continuous learning, and program improvements. This should include collecting data from session participants post-attendance to understand how session content translates into changes in perspectives, awareness and behaviours.
- **Recommendation 4:** Continue to invest in BHE capability-building, including safe spaces for peer support and workshopping challenges, to strengthen tailored support, identify further guidance needs and maintain consistent quality delivery.
- **Recommendation 5:** Continue to conduct quality assurance of data submitted by BHEs to ensure accuracy of the HIML Dashboard.

Expand

- **Recommendation 6:** Use the HIML Dashboard to identify trends across and between states to identify opportunities for learning, information sharing, and improvement.
- **Recommendation 7:** Expand the topics on offer to respond to community identified areas and emerging health needs to improve health equity.
- **Recommendation 8:** Further invest in the growth and development of the Multilingual Resource Portal to provide high-quality, evidence-based resources and materials to aid effective session delivery.
- **Recommendation 9:** Where appropriate, identify further actions BHEs can take to support participants in translating

health knowledge into action, for example partnering with healthcare providers to support scheduling appointments.

- **Recommendation 10:** Consider strengthening the HIML TOC with evidence of how health education sessions also create supportive spaces for connection and include this in future evaluation.

Advocate

- **Recommendation 11:** Advocate for funding to support travel costs, expanding HIML's reach in states and territories with geographically dispersed populations to reach migrant and refugee women in regional and remote areas.
- **Recommendation 12:** Advocate for a longer-term, multi-year funding model, with earlier confirmation of funding decisions, to support more effective forward planning, strengthen stakeholder relationships and improve BHE retention.

Conclusion

The evaluation found that the HIML project was effective in increasing migrant and refugee women's knowledge and confidence across the health topics delivered, in every Australian state and territory.

While evidence of follow-on actions was limited, findings showed that culturally relevant health education helped women take meaningful steps to attend health appointments and screenings, share health information with others, and build confidence to navigate the Australian healthcare system. Together, these findings point to a genuine transition from knowledge to action and suggest a ripple effect, with benefits extending beyond program participants into their families and broader communities.

Extensive stakeholder engagement and high-quality health education training and materials were foundational to achieving the outcomes described in this report, as were the four years of consistent HIML delivery, and MCWH's robust national infrastructure paired with flexible, state/territory-based delivery.

At the same time, several barriers continue to constrain implementation including the limited number of BHEs per state/territory, a lack of career progression pathways for BHEs contributing to workforce turnover, insufficient BHE travel budgets to support outreach activities, and the uncertainty relating to the timing and duration of funding decisions.

Overall, the evaluation findings strongly align with HIML's TOC and highlight additional positive outcomes that emerged beyond those originally anticipated, including the creation of safe and supportive spaces for participants to connect with others and strengthen social networks.

Recommendations have been provided to support further investment in the ongoing development and implementation of the HIML project.


Strengthening health equity for migrant and refugee communities through Australia's health educator workforce
#HiMLforum
My Health, My Language:
Multicultural Women's Health

Appendix

A.1 About Multicultural Centre for Women's Health

Multicultural Centre for Women's Health (MCWH) is a national, community-based organisation, led by and for women, non-binary and gender diverse people from migrant and refugee backgrounds. MCWH works to promote the health and wellbeing of migrant and refugee communities through advocacy, social action, multilingual health education, research, training, and capacity building MCWH advocates for the rights to health and safety of all migrant and refugee women, non-binary and gender diverse people living in Australia. This includes temporary migrants, permanent residents, asylum seekers, undocumented migrants, migrants with citizenship and people who identify generationally as part of a migrant community, and those who are subjected to intersecting forms of discrimination.

A.2 About Clear Horizon

Clear Horizon is woman-led and certified B-Corp that works to enable 'for purpose' organisations to achieve more and better. We specialise in collaborative approaches for measurement and evaluation with a strong focus on learning partnerships. We have a well-deserved reputation for being at the cutting edge of evaluation theory and practice. Our deep theoretical understanding of evaluation is grounded in our extensive experience of conducting over 200 evaluations across all levels of government, not-for-profits, regional agencies, industry bodies, and international organisations. We partner with leading agencies, service providers, philanthropies and social innovators to co-design and evaluate solutions for people, place and planet. We are strongly committed to decolonising and feminist approaches in all of our work and believe in the continual need to learn and adapt and create space for genuine partnerships to drive systems-wide change.

A.3 Documents Reviewed

Session Delivery Resources:

- Breast Cancer Screening delivery guide
- Bowel Screening delivery guide
- Cervical Cancer Screening delivery guide
- HIML SRH Contraception Choices delivery guide
- HIML SRH Understanding Menopause delivery guide
- Let's Talk Mental Health delivery guide
- Navigating the Mental Health System delivery guide
- Lung Cancer Screening delivery guide
- HIML deck Bowel Cancer Screening
- HIML deck Contraception Choices
- HIML deck Let's Talk about Mental Health
- HIML deck Navigating the Mental Health System

- HIML deck Understanding Menopause
- HIML deck Pregnancy Choices
- HIML deck Safer Sex
- HIML deck Breast Cancer screening
- HIML deck Cervical Cancer screening
- HIML deck Lung Cancer Screening

Standards and Conditions

- MCWH Quality Standards
- Terms and conditions of Health Education Delivery HIML
- Course information for students

Engagement resources

- HIML Community Engagement Guide
- Radio interview tips sheet

Other resources:

- HIML FAQs
- SRH clinics all states

A.4 Evaluation Map

KEQ: Reach

1. How well did the HIML project reach migrant and refugee women and community stakeholders across Australia?

Indicator	Target	Data Source
1.1 # of engagement activities disaggregated by: event size state/territory, activity type, stakeholder category, stakeholder cultural/language group	600 stakeholders (groups, networks, individuals)	Partner Survey- Community Engagement Report
1.2 # and type of social media promotion activities disaggregated by state/territory		Partner Survey – Social media report
1.3 # and type of traditional media outputs disaggregated by state/territory		Partner Survey- Traditional media report

1.4 # of session participants reached through # of education sessions disaggregated by state/ territory, session topic, gender, age range, cultural group, and languages	11,000 participants reached through 1100 sessions (~10 participants per session)	Session participant survey

KEQ: Effectiveness

2a. How effective was the HIML project in producing anticipated outcomes for migrant and refugee women?

2b. To what extent did the HIML project produce unanticipated outcomes for migrant and refugee women whether positive or negative?

2a.1 Increased M/R women's knowledge of health topics included in sessions	**Substantial positive change in participants pre and post session ratings**	**Session participant survey**
2a.2 Increased M/R women's knowledge of health services discussed in sessions	Substantial positive change in participants pre and post session ratings	Session participant survey Session participant MSC Stories
2a.3 Increased M/R women's knowledge about navigating the Australian healthcare system		Session participant MSC Stories BHE focus groups
2a.4 Increased M/R women's knowledge about their healthcare rights and options	Substantial positive change in participants pre and post session ratings	Session participant survey Session participant MSC Stories
2a.5 M/R women change perspectives about health topics		Session Participant MSC Stories BHE focus groups
2a.6 M/R women broaden awareness about health topics		Session Participant MSC Stories BHE focus groups

2a.7 Increased M/R women's confidence to talk about health topics with friends and family	Substantial positive change in participants pre and post session ratings	Session Participant MSC Stories Session participant survey
2a.8 Increased M/R women's confidence to talk about health topics with healthcare professionals	Substantial positive change in participants pre and post session ratings	Session Participant MSC Stories Session participant survey
2a.9 Increased M/R women's confidence navigating the Australian healthcare system		Session Participant MSC Stories BHE focus groups
2a.10 Increased M/R women's confidence to make choices about their healthcare needs and rights		Session Participant MSC Stories BHE focus groups
2a.11 M/R women intend to encourage others to attend health education sessions	Substantial positive change in participants pre and post session ratings	Session Participant MSC Stories Session participant survey
2a.12 M/R women intend to discuss health issues with healthcare professionals		Session Participant MSC Stories BHE focus groups
2a.13 M/R women intend to share their learning with friends and family		Session Participant MSC Stories BHE focus groups
2b.1 M/R women experience unanticipated outcomes or changes		Session Participant MSC Stories BHE focus groups

KEQ: Enabling Conditions

3a. What enabling conditions support the ongoing effectiveness of the HIML project?

3b. What barriers hindered these conditions and the HIML project's effectiveness?

Indicator	Target	Data Source
3a.1 BHE workforce trained and supported in an ongoing way to provide health education to M/R women		MCWH Document Review CoP Survey Learning workshops BHE focus groups
3a.2 MCWH and partners feedback and learning from implementing foundational and influencing activities		As per 3a.1
3a.3 Trusted established partnerships support implementation and continuous learning for impact		As per 3a.1
3b.1 Barriers to project effectiveness		As per 3a.1

Contact Information

Multicultural Centre for Women's Health
8/255 Bourke Street, Melbourne VIC 3000

Phone: (03) 9418 0999
Freecall: 1800 656 421
Email: info@mcwh.com.au

mcwh.com.au

MULTICULTURAL CENTRE FOR WOMEN'S HEALTH

Health in my Language

Clear Horizon