Health in My Language – Sexual and Reproductive Health

FINAL EVALUATION REPORT
AUGUST 2025

MULTICULTURAL CENTRE FOR WOMEN'S HEALTH

Health in my Language

Clear Horizon

Acknowledgements

Clear Horizon and Multicultural Centre for Women's Health 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 including the Australian Red Cross (NT, TAS, SA), True Relationships and Reproductive Health, Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, Women's Health Matters, and Ishar Multicultural Women's Health Services.
- 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.
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- MCWH staff and partners who participated in sense-making workshops and offered their expertise to verify and refine the evaluation findings.
- Session participants who took part in interviews offering their invaluable insights into their experiences with the Health in My Language education sessions.
- Interpreters from the Translation and Interpreting Service National for helping us communicate with session participant interviewees.

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Dictionary

Acronyms	Description
ACT	Australian Capital Territory
AES	Australian Evaluation Society
BHE	Bilingual Health Educator
CoP	Community of Practice
COVID-19	Coronavirus Disease 2019
EFTPOS	Electronic Funds Transfer at Point of Sale
HIML	Health in My Language
IUD	Intrauterine Device
KAP	Knowledge, Attitude and Practices
KEQ	Key Evaluation Question
MCWH	Multicultural Centre for Women's Health
MEL	Measurement, Evaluation and Learning
MHT	Menopausal Hormone Therapy
MSC	Most Significant Change
NSW	New South Wales
NT	Northern Territory
QLD	Queensland
RAP	Research, Advocacy and Policy (MCWH Department)
SA	South Australia
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
STARTTS	Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
TAS	Tasmania
TOC	Theory of Change
True	True Relationships and Reproductive Health
VIC	Victoria
WA	Western Australia

Disclaimer

This document has been produced with information supplied to Clear Horizon by Multicultural Centre for Women's Health including surveys, monthly partner reports, and advice provided via project meetings, workshops and email communications. Additional data collection conducted by Clear Horizon as agreed by the client included session participant interviews, key informant interviews and focus groups with Bilingual Health Educators. 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.

Executive Summary

Background

This report provides the background, findings and recommendations for the evaluation of the Health in My Language, Sexual and Reproductive Health (HIML SRH) project. The HIML SRH project was led by Multicultural Centre for Women's Health (MCWH) in partnership with key specialist agencies in every state and territory and a national workforce of Bilingual Health Educators (BHEs). The evaluation was conducted by consultants in the Social Impact Unit at Clear Horizon.

The HIML SRH project aimed to provide health information and education to migrant and refugee women (inclusive of non-binary, transgender and gender diverse people) about four sexual and reproductive health (SRH) topics and their related health services: 'Understanding Menopause', 'Safer Sex', 'Contraception Choices' and 'Pregnancy Choices'. SRH education sessions also included information about navigating the Australian health system to access sexual and reproductive health services.

Evaluation Purpose and Scope

The primary purpose of the evaluation was to determine the effectiveness of the HIML SRH project in producing changes in knowledge, attitudes, confidence, and behaviours of migrant and refugee women who attended four different types of SRH education sessions.

The evaluation covered the period of the project implementation from 1 July 2024 to 30 June 2025. The scope included conducting a mixed methods implementation and impact evaluation to determine the project's effectiveness and answer the key evaluation questions as described below.

Key Evaluation Questions

The evaluation sought to answer the following questions:

1. **Implementation Quality:** How well did processes and strategies enable the successful implementation of the HIML SRH project?
2. **Reach:** How well did the HIML SRH project reach migrant and refugee women and community stakeholders across Australia?
3. **Relevance:** How relevant was the HIML SRH project for meeting the SRH informational and educational needs of migrant and refugee women?
4. **Effectiveness:** How effective was the HIML SRH project in improving migrant and refugee women's knowledge, confidence, attitude and behaviours related to sexual and reproductive health?

Evaluation Approach and Methodology

A measurement, evaluation and learning (MEL) plan instructed the evaluation approach and methodology to enable the systematic collection, analysis, interpretation and reporting of findings against indicators for the key evaluation questions. The MEL plan was built on a Theory of Change (TOC) depicting how the HIML SRH project was expected to produce positive outcomes for migrant and refugee women.

Mixed quantitative (numbers) and qualitative (stories) methods were used to gather evidence to answer the key evaluation questions and produce the recommendations provided in this report. These methods involved the analysis of MCWH's own reporting tools and the application of specific evaluation methods managed by Clear Horizon. Altogether, these methods included surveys, interviews and focus groups with migrant and refugee women who participated in the SRH sessions, the BHEs who delivered the sessions and key informants including the national partners and external stakeholders. Mixed methods support triangulation and rigor in the findings; however, there are some limitations pertaining to data entry challenges, survey bias and sample sizes as described further in this report.

MCWH and Clear Horizon engaged in a learning partnership throughout the evaluation by analysing measurement data on a regular basis and providing progress reports to enable continuous learning and improvement. Workshops were held at the project's conclusion to review and verify initial findings, address gaps, and develop recommendations for this final evaluation report.

Key findings

The key findings described here are summarised from the detailed results presented in the report. These findings and the data reported pertain to the evaluation period of 1 July 2024 to 30 June 2025.

Implementation Quality

- The effectiveness of the project to produce positive outcomes for migrant and refugee women was supported by implementation processes and strategies that enabled the delivery of relevant and evidence-based education to a highly diverse population across the country.
- These processes and strategies included a well-developed project management approach, extensive project resources, an established partnership model, and ongoing capability-building for BHEs delivering SRH education sessions.
- A critical aspect of project implementation was the extensive stakeholder engagement work undertaken by the national partners and BHEs to socialise and promote the project and gain trust for booking SRH education sessions in local communities.
- While there were challenges related to pressured project inception and readiness in the early stages of implementation, the project is now well positioned with an established implementation approach to enable greater impact into the future.

Reach

- The project reached 8,152 attendees (60% of target) in 515 sessions (56% of target) across a highly diverse population of migrant and refugee communities in every Australian state and territory.
- While targets for the number of sessions and participants reached were not achieved, this result was likely due to a number of factors including setting a target based on previous HIML projects (with a different focus), delayed project commencement, and the sensitive nature of introducing SRH topics to communities and stakeholders. This required additional time and resources to establish relationships and trust prior to implementing sessions.
- The reach to community stakeholders totalled an estimated 26,527 stakeholders which supported relationship building and gaining trust for session bookings. While much of this reach came via largescale community festivals and events, extracting that data from the overall figure still showed engagement with over 8000 stakeholders, exceeding the project target.
- Social media was a key communication mechanism used to promote the project and sessions with a total of 34,580 social media impressions exceeding the original target.

Relevance

- The project's relevance for migrant and refugee women was grounded in an evidence-based approach as MCWH and partners drew upon academic and reputable resources to select the SRH topics, support BHE capability-building, and establish session content that could be tailored to community and cultural contexts.
- Relevance was also reflected in participant satisfaction ratings, which showed that approximately 90% of participants reported that they were 'very satisfied' with the sessions on measures for clarity, relevance, accessibility and meeting their cultural and language needs.

- Participants provided positive feedback that the sessions provided useful information about the topics in an engaging and culturally sensitive way using community languages or variations of English as required (e.g., Plain English, Easy English).
- Group-based learning through session delivery was viewed as a valuable opportunity for participants to share their experiences together, reduce their isolation and normalise asking questions and being curious about SRH topics.
- Attitudinal shifts were also evident in the findings as participants overcame initial concerns about the relevancy or appropriateness of SRH topics.
- The evaluation collated a range of suggestions to enhance relevance and improve the sessions overall, including providing one-on-one follow up support to participants where needed, addressing language gaps for resources, supporting community-led topic selection and investigating the possible SRH education needs of men in the community.

Effectiveness

- The evaluation found that the project was consistently effective in increasing migrant and refugee women's knowledge and confidence in relation to the four SRH topics.
- Evidence was limited in terms of how consistently women later went on to translate their knowledge and confidence into action, however, there were strong findings that the sessions helped them set intentions to share their knowledge with family and community, encourage others to attend sessions and talk to health professionals about their sexual and reproductive health needs.
- Participants' interest in sharing knowledge with others was a recurring theme and profound finding suggesting a potential ripple effect where women may help to improve SRH topic and service literacy in their own families and communities.
- Stories of impact and significant change illustrate the broader impact of the project in creating safe spaces for participants to share knowledge and experiences with each other, improve their confidence to navigate the healthcare system, and seek help for their own sexual and reproductive health needs.

Conclusion

Overall, the evaluation found that the HIML SRH project had a positive impact contributing to changes in outcomes for migrant and refugee women supported by a well-developed national partnership and bilingual workforce model with high-quality implementation processes.

The findings showed migrant and refugee women experienced increased knowledge and confidence in relation to SRH issues and that their participation in education sessions helped change attitudes and supported them to consider next steps for their SRH needs.

The project's continued impact will be supported by ongoing investment and development of the HIML program overall to address current challenges and strengthen the enablers of success. The recommendations in this report provide a roadmap to support this work at this critical juncture for implementation.

Recommendations

Recommendations are grouped into categories related to improving implementation processes, session relevance, advocacy, and measurement and evaluation.

Implementation process

- Ensure national HIML project implementation includes a sufficient establishment period (3 months) and a longer timeline (2 years or more) to achieve deliverables and targets.
- Collaborate with BHEs to redesign and test participant surveys, considering also the limitations of the group survey format.
- Conduct a readiness assessment with partners (new or existing) prior to implementing future iterations of the HIML project on new health topics.
- Invest in BHE capability-building to further strengthen tailored support with an emphasis on addressing general health and sexual health knowledge gaps; targeted activities for confidence building; interactive adult learning approaches; and peer-learning opportunities (e.g., CoPs).

Session relevance

- Continue to deliver tailored, in-language sessions to community members by BHEs who are trusted peers in local cultural communities.
- Consider allocating additional resourcing for BHEs to provide one-to-one follow up support after the session to participants as needed.
- Audit the breadth of demonstration kits and interactive activities used in session plans to address any gaps and support standardised inclusion of these strategies.
- Continue to work with BHEs to support session delivery strategies and activities that support relevant, safe and accessible educational experiences.
- Provide a health education module on 'Healthy Relationships' alongside SRH module offerings that will strengthen participants capacity to manage conversations about what they have learnt.

Advocacy

- Advocate for continued investment in the collaborative partnership approach for national health education with migrant and refugee communities.
- Advocate for funding to enable the development of evidence-based resources to address known language gaps and/or support partnership work with other organisations who may have access to translators or existing resources.
- Advocate for a longer-term funding model that enables HIML to be developed further through community consultation to ensure that session topics are both evidence-based and responsive to emerging community needs.

- Use the findings of this evaluation to advocate to the health sector about the value of SRH education and the importance of training for healthcare providers to respond to the SRH needs of migrant and refugee women.
- Communicate community interest in men's SRH education to the Department to enable their own investigation and development of an appropriate, complementary intervention.

Measurement and evaluation

- Find opportunities to contribute to the evidence-base by sharing the evaluation findings with health promotion sector partners and funders.
- Strengthen the Theory of Change with evidence about how SRH education contributes to changes in attitudes, particularly in relation to topics previously considered irrelevant or taboo.
- Strengthen the Theory of Change to include changes in participants' knowledge about navigating the Australian healthcare system with regard to their information and language needs.

Introduction

This report presents the evaluation findings for the Health in My Language, Sexual and Reproductive Health (HIML SRH) project (or 'the project') covering the period 1 July 2024 to 30 June 2025.

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). Clear Horizon was contracted to design and deliver the evaluation.

The primary purpose of the evaluation was to determine the effectiveness of the HIML SRH project in producing changes in knowledge, attitudes, confidence, and behaviours of migrant and refugee women (inclusive of non-binary, transgender and gender diverse people) who attended four different types of SRH education sessions. These sessions were 'Understanding Menopause', 'Safer Sex, 'Contraception Choices' and 'Pregnancy Choices'.

This introduction provides background information about the project and the evaluation followed by sections describing the evaluation methodology and the results about the project's implementation quality, reach, relevance, effectiveness and impact. The results section begins with a brief discussion of the evaluation's findings followed by related data and information. Recommendations are provided throughout the results and summarised at the end of the report followed by the conclusion.

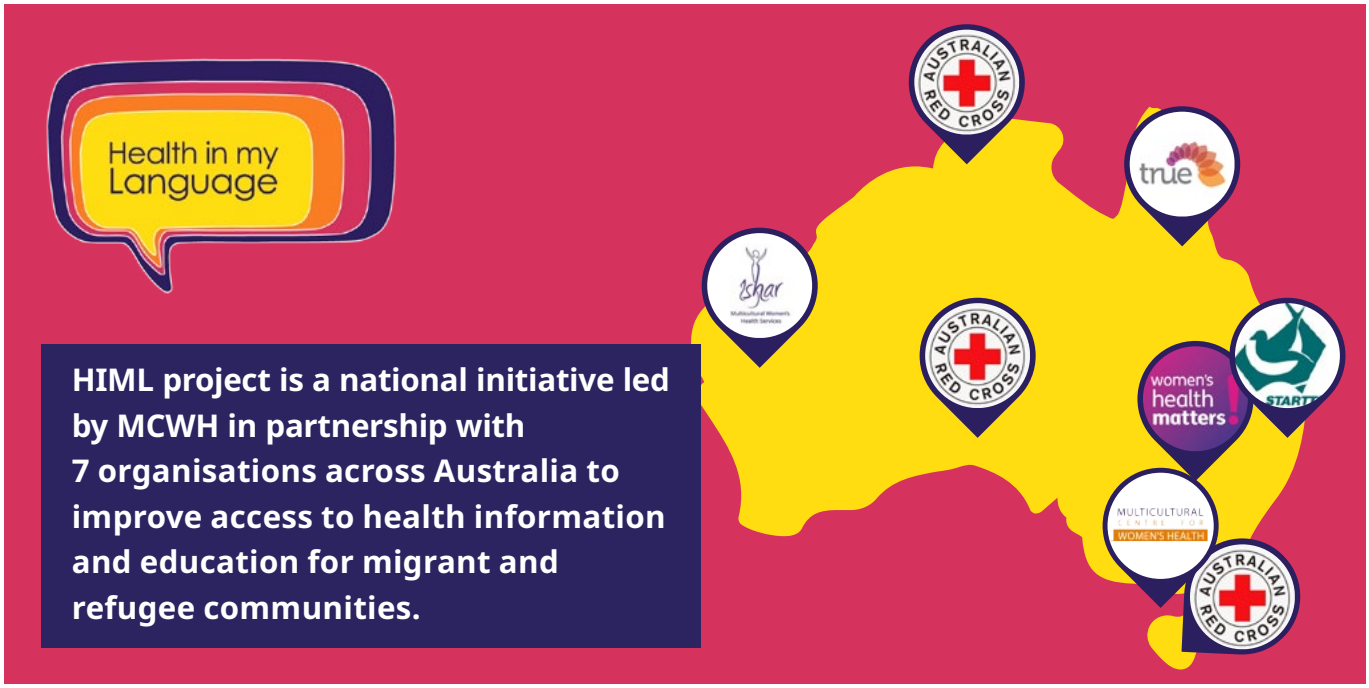
Finally, the *"Annex"* details supporting information about MCWH and Clear Horizon, and the evaluation approach and methods, as well as a list of project resources.

About Health in My Language

The Health in My Language (HIML) project is a national initiative led by MCWH in partnership with organisations across every state and territory in Australia to improve access to health information and education for migrant and refugee communities.

The HIML partnership organisations include:

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



The coordinated national partnership approach aims to ensure the delivery of high-quality, consistent health education, 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 share the cultural background and language of session participants. The sessions are designed using evidence-based resources yet adaptable and tailored for community members' cultural backgrounds, languages, location and the best timing 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 (CoP), professional development 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 vaccine uptake during the COVID-19 pandemic. This groundwork laid the foundation to implement other subsequent HIML projects focused on cancer screening in 2023 and sexual and reproductive health in 2024.

In the 2024–25 Budget, the Commonwealth Government provided $5.6 million to MCWH to continue delivery of the HIML program and expand its focus to include sexual and reproductive health. This funding supported the establishment of the HIML SRH project, including the recruitment, training, and coordination of BHEs across the country, and the evaluation described in this report.

The HIML SRH project specifically aimed to provide health information and education to migrant and refugee women about four SRH topics and their related health services: 'Understanding Menopause', 'Safer Sex', 'Contraception Choices' and 'Pregnancy Choices'. SRH education sessions also included information about navigating the Australian

health system for sexual and reproductive health services and support.

This project aim was supported by the following objectives:

- deliver effective, culturally appropriate, and tailored health promotion activities to address barriers to accessing SRH services among migrant and refugee communities
- continue oversight and coordination of the National Bilingual Health Educator (BHE) program, including supporting partner organisations in recruitment of bilingual health worker staff and providing accredited BHE training and ongoing mentorship and support
- coordinate the deployment of BHEs to provide information and education about SRH to multicultural communities across Australia.

About the Evaluation

Purpose

The primary purpose of the evaluation was to determine the effectiveness of the HIML SRH project in producing changes in knowledge, attitudes, confidence, and behaviours of migrant and refugee women (inclusive of non-binary, transgender and gender diverse people) who attended four different types of sexual and reproductive health education sessions.

The secondary purposes of the evaluation were to understand the:

- quality of the project implementation processes and strategies including BHE capability building, partnership work and stakeholder engagement
- reach the project through community engagement activities, media promotions, and education session delivery
- relevance of the sessions for meeting the informational and educational needs of migrant and refugee women.

The evaluation purpose informed the key evaluation questions as described further in the *"Methodology"* section.

Principles

The following principles guided how MCWH and Clear Horizon worked together to deliver the evaluation.

- **Partnering for success:** establish a strong foundation to work together in a trusting and respectful partnering relationship.
- **Participatory approach:** engage key project staff in co-designing the MEL Plan and seek guidance from MCWH about when and how to engage other key stakeholders in participatory or co-design activities to centre the voices and perspectives of migrant and refugee women.

- **Learning together:** provide regular progress reports and check in on our ways of working throughout the evaluation to intentionally review our approach and ensure continuous learning and improvement.
- **Intersectionality and cultural responsiveness:** take special care being guided by MCWH's expertise in intersectional feminism and culturally responsive approaches to ensure that the evaluation is delivered respectfully and responsive to the needs of project stakeholders and participants.

Approach

Informed by the above principles, 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 SRH project's inputs and activities are expected to produce a change in outcomes for migrant and refugee women participating in the education sessions.
- **Measurement**: regular collection and analysis of quantitative and qualitative data produced by HIML SRH reporting tools.
- **Evaluation**: using measurement data and other data collection methods to answer bigger questions about the value of the HIML SRH pertaining to its implementation quality, reach, relevance and effectiveness
- **Learning:** using evidence throughout the project for continuous learning and improvements to enable greater impact of the HIML SRH project.

Further information about the approach is provided in *"Methodology"*.

Audiences

MEL planning with MCWH included the identification of primary and secondary audiences for the evaluation.

The primary audience was defined as stakeholders who will use the detailed evaluation findings to make decisions about improving, continuing, and funding the HIML SRH project. This audience includes MCWH, national partner organisations, BHEs, and the Department.

The secondary audience was defined as stakeholders who may have an interest in the evaluation findings, but do not necessarily require all the details of the evaluation methodology and findings. This audience includes:

- community organisations and stakeholders involved in supporting the delivery of HIML or other health education sessions
- health promotion services relevant to women's health, multicultural communities, migrants and refugees
- migrant and refugee women who participated in (or plan to participate in) HIML SRH education sessions
- other potential future funders (e.g., government, philanthropy).

Methodology

The methodology described here begins with the TOC used to guide the MEL Plan for this evaluation. This section also includes information about the key evaluation questions (KEQs), data collection and analysis methods, learning and reporting cycle, ethical considerations, and the limitations of the findings. See the *"Annex"* for further information about the evaluation approach and methods.

Theory of Change

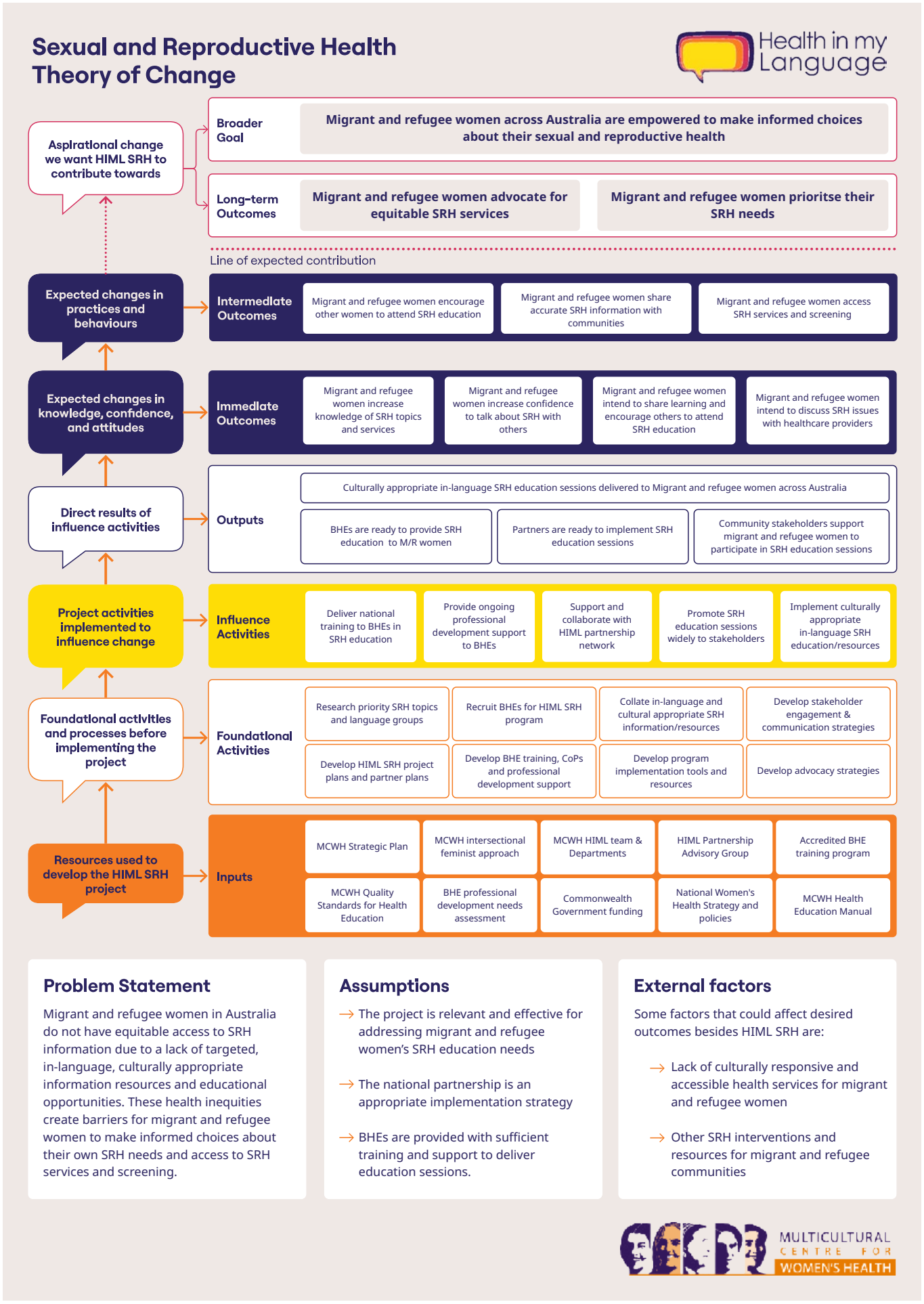
The TOC for the HIML SRH project visualises how the project's resources and activities are expected to produce positive outcomes for the migrant and refugee women who participated in the education sessions (see *"Figure 1: HIML SRH Theory of Change"* below).

The outcomes shown in the TOC are based on MCWH's decades of experience delivering health education projects with migrant and refuge communities combined with the Knowledge, Attitude and Practices (KAP) model. The KAP model is a behavioural change theory outlining how exposure to health education, information and support enables changes in knowledge, attitudes and practices or behaviours. This model does not suggest that health education alone is enough to produce changes, however, such education can be a necessary building block for change and better health outcomes.

The KAP model provides only a basic generalised understanding of behavioural change and does not necessarily account for the complex and multi-dimensional ways in which migrant and refugee women receive and act on information about SRH issues. This evaluation, therefore, was designed to understand how effectively the project enabled outcomes in the context of migrant and refugee women's lived experiences. This context included an understanding that migrant and refugee women have various experiences with prior exposure to SRH information and education and different responses and behaviours related to their SRH needs situated in their personal beliefs and values, cultural and intersectional backgrounds, migration history (e.g., newly arrived or more established), and experiences with health services and systems, both positive and negative.

A more detailed *"Theory of Change Narrative"* is provided in the *"Annex"*.

Figure 1: HIML SRH Theory of Change



Problem Statement

Migrant and refugee women in Australia do not have equitable access to SRH information due to a lack of targeted, in-language, culturally appropriate information resources and educational opportunities. These health inequities create barriers for migrant and refugee women to make informed choices about their own SRH needs and access to SRH services and screening.

Assumptions

- → The project is relevant and effective for addressing migrant and refugee women's SRH education needs
- → The national partnership is an appropriate implementation strategy
- → BHEs are provided with sufficient training and support to deliver education sessions.

External factors

Some factors that could affect desired outcomes besides HIML SRH are:

- → Lack of culturally responsive and accessible health services for migrant and refugee women
- → Other SRH interventions and resources for migrant and refugee communities

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Key Evaluation Questions

The evaluation was guided by four KEQs about the HIML SRH project's implementation quality, reach, relevance, and effectiveness. The KEQs were developed from the TOC and MEL planning with MCWH. Table 1 below outlines each KEQ with operational definitions.

Table 1. Key evaluation questions

Criteria	Definition	KEQ
Relevance	The extent to which the project responds to migrant and refugee women's needs and priorities	How **relevant** was the HIML SRH project for meeting the SRH informational and educational needs of migrant and refugee women?
Implementation Quality	The extent to which the strategies and processes used enabled successful implementation of the project	How well did processes and strategies enable the successful **implementation** of the HIML SRH project?
Reach	The extent to which the project reached targeted stakeholders and migrant and refugee women via community engagement and SRH sessions	How well did the HIML SRH project **reach** migrant and refugee women and community stakeholders across Australia?
Effectiveness	The extent to which the project achieved its intended outcomes (immediate and intermediate)	How **effective** was the HIML SRH project in improving migrant and refugee women's knowledge, confidence, attitude and behaviours related to sexual and reproductive health?

Data collection and analysis

Methods

Mixed methods were used for measurement and evaluation activities to answer the KEQs about implementation quality, reach, relevance and effectiveness of the project (see the *"Annex"* 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. The *"Annex"* provides a *"Data Collection and Analysis Methods"* table with detailed descriptions of the data sources, samples, methods and tools and how they were used for MEL activities.

In summary, these methods and their samples included:

- **HIML SRH Session Participant Group Survey:** Internal reporting tool used to collect data from session participants. The survey was voluntary and conducted verbally as a group survey via show of hands at the end of the session with responses entered by BHEs into the Survey Monkey platform. 755 surveys were administered to 8,152 attendees in 515 sessions.
- **HIML SRH BHE Training Survey**: Internal reporting tool used to collect data from BHEs who participated in training in September 2024. A total of 32 BHEs completed the survey.
- **HIML SRH Community of Practice (CoP) BHE Surveys**: Internal reporting tool used to collect data from BHEs who participated in two CoP sessions held in November 2024 and March 2025. A total of 45 BHEs completed the two session surveys.
- **HIML SRH Partner Monthly Report:** Internal reporting tool used to collect stakeholder and media engagement data from all partner agencies on a monthly basis. A total of 59 partner reports were submitted and analysed.
- **Document Review**: Evaluation method used to review HIML background documents to understand the project's context, design and implementation processes. A total of 50 documents were reviewed.
- **Session Participant Interviews:** Evaluation method used to ask session participants about their experiences, outcomes, and any significant changes resulting from attending HIML SRH sessions. 11 participants were interviewed.
- **Key informant Interviews:** Evaluation method used to ask key informants (partners and external stakeholders) about their experiences with project implementation and observations of outcomes and significant changes. 11 interviews were completed with 14 key informants, the majority of whom were representatives of HIML partner organisations (n=9) and others were external stakeholders (n=2).
- **BHE focus groups**: Evaluation method used to ask BHEs about their experiences with capability building activities, delivering SRH sessions, and observations of outcomes and significant changes. Four focus groups were held with 18 BHEs in total.

755
SRH Session Participant Surveys administered

515
sessions

8,152
attendees

32
BHEs responded to training survey

45
BHEs responded to Community of Practice surveys

59
Partner monthly reports analysed

50
Documents reviewed

11
Session participants interviewed

14
Key informants interviewed

18
BHEs in

4
Focus groups

Most Significant Change

The Most Significant Change (MSC) technique was used to capture qualitative data in the form of stories about significant changes experienced by session participants or observed by BHEs, partners and stakeholders in delivering the HIML SRH project.

MSC questions were integrated into the qualitative question guides and data were then reviewed against the following criteria co-developed with MCWH to select MSC stories:

- the level of descriptive detail contained in the story
- which cohort's perspective is represented
- the strength of evidence
- any unanticipated but positive outcomes
- alignment with intermediate outcomes within the TOC.

Eleven stories were then prepared for a sense-making workshop with MCWH staff, including four session participant stories, four stories from BHEs, and three stories from key informants. During the workshop, the stories were read aloud and considered against the following set of 'significance' criteria to enable story selection:

- strength of evidence
- significance of impact
- alignment of the outcomes in the story to TOC outcomes
- representation across the cohort and partner locations.

Through the workshop discussion, a number of key themes and outcomes were identified, and five stories were collaboratively selected for inclusion in this report.

Impact Stories

The partner monthly report logged impact stories observed by partners and BHEs over the course of project implementation. These impact stories were documented with justifications about how the story shows the contribution of HIML SRH on the change or impact observed.

Stories with sufficiently robust detail for further review were selected and discussed in the sense-making workshop that examined the MSC stories. Ten stories were brought to the workshop and four were selected to include as pop-outs throughout the report.

Synthesis and Sense-making

Once analysed, all data were summarised and synthesised into materials used in two consecutive sense-making workshops held in June 2025 with the national partners and MCWH. These materials included the MSC stories and impact log stories, and an evidence table summarising initial key findings with associated data and qualitative quotes. The evidence table also identified gaps in evidence and context for further exploration and resolution in the sense-making workshop.

The participatory approach of the workshops enabled the verification and strengthening of evidence to support evaluative conclusions and recommendations.

Learning and reporting cycle

Throughout the project, measurement data from MCWH's internal reporting tools were analysed regularly by Clear Horizon using statistical and qualitative thematic analysis methods. The findings were provided in progress reports as 'emerging trends' with recommendations to support continuous learning and improvement throughout the implementation of the HIML SRH project.

Eight progress reports were provided in total with trends and recommendations discussed in regular project management meetings. A midpoint review in January 2025 provided an opportunity to consolidate and review all recommendations at that stage to enable greater impact in the final six months of the project.

The sense-making workshops (see *"Synthesis and Sense-making"*) were also a learning opportunity for everyone involved including MCWH, partners and Clear Horizon, to inform the development of the final evaluation report.

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. We were guided by the following resources:

- Clear Horizon's Privacy and Security Guidelines for Staff and Contractors [internal document].
- Clear Horizon's Privacy Policy [public document].
- Guidelines for the Ethical Conduct of Evaluation, Australian Evaluation Society.
- Ethical Considerations in Quality Assurance and Evaluation Activities, National Health and Medical Research Council.

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 offered interviews via interpreter in their preferred language and the option to participate via a phone call or online video call. They were remunerated with an EFTPOS voucher for their time. Professional key informant interviewees were not remunerated as participation in the evaluation was part of their employment with the HIML SRH project. BHEs were paid by MCWH for their time in focus groups as per their employment contracts as casual employees.

All data provided to Clear Horizon were stored securely in files only accessed by team members directly involved in this evaluation. Personal, sensitive and identifying information was removed from data for analysis and reporting. Data will be destroyed after the evaluation has concluded and in accordance with privacy legislation.

Limitations

Data entry challenges

The session participant survey and partner monthly report were administered and managed by the BHEs and partners. Data entry was conducted as efficiently and accurately as possible, however, there were some data entry challenges that affect the evaluation findings.

DELAYED DATA ENTRY

Because of project implementation pressures, there was a delayed start to data collection during the July to October 2024 period. Some of the sessions delivered in this period do not have accompanying group survey data reported, and not all of the eight partners had stakeholder engagement or media data that was ready to submit during this time.

ERRORS AND OMISSIONS

There were some data entry errors or omissions that affect data accuracy. Such errors are to be expected given the size of the BHE workforce and the scale of project activities and data collection. It should be recognised that the partners and BHEs accomplished a substantial feat by translating and documenting data from multiple languages with diverse cultural communities in a variety of settings and contexts. Some of the discrepancies and omissions found in the data may be explained by time constraints and the voluntary nature of the survey itself as not all participants may have elected to participate in the survey or answer every question.

ACCURACY OF REACH DATA

The group survey format administered to session participants carries a risk of bias that affects the validity of results and should be considered with the evaluation findings.

MCWH have trialled both individual and group survey approaches over many years. They advised that individual surveys had very low response rates in comparison to group surveys which made it possible to administer the survey across multiple language groups and enabled participation from those with literacy barriers. The group format, however, meant that session participants were not provided with an individual survey to answer on their own as the BHE read the survey questions aloud and participants responded by a show of hands. This introduced a bias as the participants could be influenced by each other's responses.

To help mitigate the bias, the BHEs were trained in different survey administration options that they could choose to use depending on their assessment of whether an option was culturally appropriate or acceptable to participants. These options included administering the survey with participants' eyes open and seeing each other's responses or using a more anonymous approach with participants either facing away from each other or closing their eyes. For the small number

of sessions delivered online, some BHEs had the option of setting up an anonymous online poll for participants to answer the questions.

Overall, the 'eyes open' format was selected for the majority of surveys. Of the 755 surveys administered:

- 590 (78%) were conducted with participants eyes open, seeing each other's responses
- 105 (14%) were conducted with participants facing away from each other
- 39 (5%) were conducted with eyes closed
- 21 (3%) were conducted using an online poll.

Another issue of bias pertains the recording of qualitative responses in the survey on behalf of participants by BHEs. BHEs were trained to record participants feedback into the survey related to changes in their knowledge and confidence and their views on session relevance and improvement. While it is very likely BHEs recorded this information as accurately as possible, there is still a chance that BHEs own perspectives, choice of words and decisions about what to include in the survey may inadvertently introduce some bias into the results. This was mitigated to an extent, however, by observing the emerging trends in the high volume of qualitative data coming through the survey over the course of the project and triangulating this data with session participant interviews.

Sample sizes

BHE SURVEYS

The sample sizes for the training and CoP surveys administered to BHEs were relatively small as not all of the BHE workforce participated in these voluntary methods. For some questions in the training or CoP survey, the difference between achieving a target or not may only be a matter of having one more respondent to the survey. As such, the smaller survey sample sizes limit the generalisability of these results.

QUALITATIVE METHODS

The sample sizes for interviews and focus groups were sufficient to provide meaningful insights into the project's implementation, relevance and effectiveness. Nevertheless, budgetary and time constraints for this evaluation meant that sample sizes were limited.

Eleven interviews (of 12 planned) were completed with participants who had attended at least one of the four SRH topics and represented various cultural and language groups in most states/territories; however, Western Australia and Queensland did not refer any interviewees. As such, the participant interview sample size is relatively small given the scale of session delivery and participation, and participants from two states were not represented.

Eleven interviews (of 12 planned) were completed with 14 key informants, the majority of whom were representatives of HIML partner organisations (n=9). This enabled the collection of rich data from those directly tasked with project implementation. Two interviews were conducted with external stakeholders from agencies where sessions were delivered providing interesting insights into their perspectives, however, this small sample is not representative of this cohort.

Eighteen BHEs participated in four focus groups (of 25 BHEs purposefully sampled). These BHEs came from every state and territory and a variety of cultural and language backgrounds and experiences as health educators, offering insightful information about session delivery; however, this number represents less than half the national BHE workforce (N=50) and may not represent all BHEs views or experiences.

Triangulating this qualitative data with survey results and sense-making activities helped to improve the robustness and accuracy of findings.

Results and Impact

Implementation Quality

+ Key Evaluation Question: How well did processes and strategies enable the successful implementation of the HIML SRH project?

The results presented below describe the specific implementation processes and strategies that enabled the quality of the HIML SRH project's delivery and supported achieving the outcomes described later in sections about the project's reach, relevance and effectiveness.

Overall, the effectiveness of the project in producing positive outcomes for migrant and refugee women was supported by the quality of implementation processes and strategies used to deliver relevant SRH education with a wide reach across the country. These processes and strategies included a well-developed project management approach, extensive project resources, an established national partnership model, and ongoing capability-building for the BHEs delivering the SRH education sessions.

A key aspect of project implementation was the extensive stakeholder engagement work undertaken by the national partners and BHEs to socialise and promote the project and gain trust for booking SRH education sessions in local communities.

The results below also discuss some challenges associated with pressured project inception and readiness, delivering session surveys, and meeting BHEs' capability-building needs over time.

Project management

DEDICATED HIML PROJECT MANAGEMENT

The HIML SRH project was managed by MCWH with a dedicated team working closely with the national partner coordinators and other key MCWH departments for health education, evaluation, research, policy, and communications.

MCWH led various project management, communication and implementation mechanisms including:

- Project Advisory Group (PAG) meetings (bi-monthly) with representatives from the HIML partners and the Department to provide technical and practical advice about the project implementation ensuring rigor and relevance and support ongoing decision-making as required.
- Partner meetings (monthly) with HIML SRH partner coordinators from each state and territory.
- Project management meetings (weekly) with MCWH staff.
- Regular check-in meetings, professional development workshops and Communities of Practice with BHEs.

The project management approach enabled MCWH and partners to utilise dedicated staff and resources to manage the implementation, BHE recruitment and capability-building, support the partnership model, and maintain an ongoing working relationship with the Department and the independent evaluator.

While there were issues with a pressured project inception (see below), the activities and effort required to manage the HIML SRH project would not have been feasible without the concerted and collaborative efforts of MCWH's HIML team, departments, partners and national BHE workforce.

EXTENSIVE PROJECT RESOURCES

An extensive collection of project resources were instrumental for enabling the quality of the project's implementation as they informed evidence-based project design, project management BHE capability-building and SRH education session delivery described throughout this report.

Examples of key project resources are included below and outlined in further detail in the *"Annex"*:

- Project implementation: internal project plan, community engagement guide, and both an internal HIML partner webpage and a public facing community webpage about HIML.
- Project MEL: MEL plan developed with Clear Horizon and ongoing progress reports for measurement data against the KEQs throughout project implementation.
- Project reporting: MCWH reports to the Department providing updates about implementation progress and achievements.
- BHE capability building: SRH specific capability-building materials for in-person and online training, CoPs and professional development, including presentations, case scenarios and handouts.
- SRH session delivery: Session guides and presentations for BHEs to adapt and use for delivering SRH sessions on the four topics.
- SRH information resources: Over 500 written, video, and audio resources specific to SRH issues were verified and uploaded to the Multilingual Portal for BHEs and partners to access and share with stakeholders and communities.

Notably, the 500+ SRH materials available in the Multilingual Portal included 119 resources that were added following 62 requests received via BHEs and partners during project implementation. This responsive approach enabled the provision of resources and materials about SRH topics in various community languages as required. Gaps in resources for some languages were also noted throughout the project and documented for improving the relevance of SRH education (see *"Relevance"*).

PRESSURED PROJECT INCEPTION

The project was funded from July 2024 with expectations that session delivery would commence as soon as possible to meet deliverables and targets within a one-year funding period. This created a pressured situation to undertake several of the project's foundational activities in a short period of time, including:

- developing project management plans and reporting tools
- orienting and establishing the HIML partnership's new focus on SRH education
- recruiting an expanded national BHE workforce
- training BHEs in MCWH's mandatory accredited health education training and assessment program (delivered over a six-week period)

- developing and implementing additional SRH-specific BHE training sessions in September 2024
- sourcing and developing SRH education session content and materials
- creating and delivering communications strategies for media, stakeholder engagement, and session promotions
- relationship building with community stakeholders to gain interest in session bookings
- procuring an independent evaluator and developing a MEL plan.

Partners reported that the rushed BHE recruitment was particularly challenging as recruiting and training this specialised workforce on a national scale takes substantial time and effort alongside the partner organisations' business as usual activities.

The challenge of rapid inception meant that only BHEs who had previously completed accredited training could deliver the initial SRH sessions, as partners were still recruiting and onboarding new BHEs into their organisations. BHEs reported that onboarding and training felt rushed and those who did not complete their training and assessment requirements in time were not able to deliver sessions until a few weeks after project inception (see *"BHE capability building"*).

Ultimately, standing up the project took most of July to September 2024 before active session delivery started to ramp up in October and November. The consequence of this meant that the project was not able to meet its targets for session delivery (see *"Reach"*).

Recommendation 1: Ensure national HIML project implementation includes a sufficient establishment period (3 months) and a longer timeline (2 years or more) to achieve deliverables and targets.

SESSION SURVEY ISSUES

The rushed project inception also meant that the participant group survey and BHE training survey were developed in a rushed manner with little time for testing and refining these tools prior to implementation. This contributed to some of the limitations of the findings (see *"Limitations"*).

Many BHEs held concerns that the survey was too long and time consuming to deliver after the session or did not feel confident to deliver the survey. To address this, MCWH staff held training workshops and support sessions with BHEs to support their confidence to deliver the survey.

Further, some felt that the group survey format introduced too much bias into the results as most session participants opted for the non-anonymous option (eyes open) to answer the questions by show of hands. While survey participation was completely voluntary and anonymous, in some cases, the survey was viewed as a risk to trust and rapport with participants who had no prior contact with HIML sessions or were suspicious of data collection due to past negative experiences.

Recommendation 2: Collaborate with BHEs to redesign and test participant surveys, considering also the limitations of the group survey format.

Partnership model

SUPPORTIVE COLLABORATION

The evaluation found strong evidence that the project operated in a highly supportive and collaborative partnership model developed since the first iteration of HIML in 2022. Partners reported that they felt well-supported by MCWH as the project manager, with dedicated HIML staff providing responsive guidance along the way. This approach extended to the BHEs who in turn reported that they felt well-supported by partners (their employers) and MCWH.

Supportive collaboration was aided by MCWH's staff undertaking in-person project induction workshops held with partners and BHEs at locations across the country. This activity was an important part of strengthening partnership work and supporting project implementation, stakeholder engagement, and BHE capability-building.

MCWH also provided partners with an updated dedicated HIML partner webpage and Multilingual Resource Portal to enable project implementation on a national scale (see *"Extensive project resources"*).

✱ **Recommendation 3: Advocate for continued investment in the collaborative partnership approach for national health education with migrant and refugee communities.**

VARIED PARTNER READINESS

Differences in the structure and focus of the partner organisations meant that there were various states of readiness to implement the project, particularly with the added pressures for BHE recruitment at the project inception, as described previously.

The nature of partners' readiness had much to do with whether they were: 1) already established in the HIML partnership; 2) had prior experience with SRH education; 3) needed to recruit BHEs for the project; and 4) needed to build relationships with new stakeholder communities. As such, these differences meant that some partners had a slower start than others.

> "We have to go and build new relationships with communities who've never interacted with us... we've knocked on doors for two years and only in the last sort of six months have we had those organisations come back to us and request more." – Key informant interview, partner

✱ **Recommendation 4: Conduct a readiness assessment with partners (new or existing) prior to implementing future iterations of the HIML project on new health topics.**

BHE capability building

The BHE workforce were supported through ongoing capability building activities including accredited health education training, face-to-face inductions, dedicated SRH training events, professional development presentations, CoP sessions, and direct support as needed.

All BHEs were required to participate in MCWH's accredited training and assessment program delivered over six weeks through live sessions and online modules. The program aligns with the National Training Register Unit of Competency 'Communicate and work in health or community services' as well as the MCWH Quality Standards for Health Education. The training addressed the intersectional barriers to health experienced by migrant and refugee women and strategies for delivering sensitive and culturally/linguistically appropriate health education. Assessments to complete the training included role plays for handling a session request, delivering a practice health education session, and debriefing a session and written activities including preparing a detailed session plan, practicing the session survey, and completing the training survey.

In addition, BHEs were required to participate in dedicated SRH training sessions delivered by MCWH and True on 12 and 17 September 2024 during the early phase of project implementation. The training content included an introduction to the four SRH topics and education delivery. BHEs could access more in-depth course content online after the sessions concluded.

Following the training, face-to-face inductions were held at HIML partner locations, and ongoing professional development presentations, CoP sessions, and direct support as needed, was provided to BHEs throughout the project implementation.

The professional development presentations and their presenters are outlined in the list below:

- Referencing and citing evidence-based SRH information - MCWH Research, Policy and Advocacy Department.
- Best practices for tailoring SRH presentations - MCWH Communications Department
- Menopause and perimenopause - The Australasian Menopause Society.
- STIs and bloodborne diseases - Sexual Health Victoria.
- Affirmative consent - Sexual Health Victoria.
- Consumer and healthcare rights - Australian Commission on Safety and Quality in Health Care.
- Australian healthcare systems and Medicare - STARTTS.

Two CoP sessions were delivered in November 2024 and March 2025. These sessions responded to emerging trends in BHE feedback via the session survey and communications via the national partners, including managing challenges in session delivery and understanding reproductive justice and abortion care in Australia (delivered with Marie Stopes International). The CoP sessions also provided opportunities for BHEs to share and learn from their experiences in the project.

The results below show that the target for BHE training completion was met as were all the targets for BHEs satisfaction with the training and CoP sessions, and outcomes related to their increased knowledge and confidence to deliver SRH education with migrant and refugee communities. These results are followed by qualitative findings about BHEs' experiences with capability-building activities.

TRAINING COMPLETION TARGET MET

100%
50 BHEs fully trained

Target: 50 BHEs fully trained

Result: Met

The training target of 50 BHEs (100%) fully trained in the accredited and SRH-specific training programs was met. Thirty-six BHEs were fully trained by October 2024 following completion of training and assessment requirements. Forty-eight BHEs were trained by January 2025, and the 50th BHE was fully trained as of May 2025.

TRAINING SATISFACTION TARGET MET

Target: 75% of BHEs report 'very satisfied' on all survey questions about the training quality.

Result: Met

Of the 32 BHEs who responded to the training survey:

91% were very satisfied with the approachability of the trainers (n=29).

91% were very satisfied with the relevance of content to learning (n=29).

88% were very satisfied with the ease of understanding the presentation (n=28).

78% were very satisfied with the engagement level of the activities (n=25).

While still meeting the target, the lower scores on satisfaction with 'ease of understanding the presentation' and 'engagement level of the activities' aligns with BHEs focus group feedback as described below.

TRAINING KNOWLEDGE INCREASE TARGET MET

Target: 85% of BHEs score their post-training knowledge as 'high'.

Result: Met

Of the 32 BHEs who responded to the training survey:

88% rated their understanding as 'high' for the impact of gender inequality on the health and wellbeing of migrant and refugee women and non-binary and gender diverse people (n=28).

78% rated their understanding as 'high' for the impact of social, structural and systemic factors on SRH for migrant and refugee women and non-binary and gender diverse people (n=25).

81% rated their understanding as 'high' for the pathways to access SRH services and support (n=26).

78% rated their understanding as 'high' for how to access reliable information and resources about the SRH topics (n=25).

While still meeting the target, the lower scores on 'the impact of social, structural and systemic factors' and 'access reliable information and resources' aligns with BHE focus group feedback described below.

TRAINING CONFIDENCE INCREASE TARGET PARTIALLY MET

Target: 85% of BHEs score their post-training confidence as 'high'.

Result: Partially met

Of the 32 BHEs who responded to the training survey:

88% rated their confidence as 'high' for applying knowledge about SRH to deliver sessions (n=28).

81% rated their confidence as 'high' for applying a gender lens to deliver sessions (n=26).

81% rated their confidence as 'high' for supporting people to make informed decisions about SRH (n=26).

88% rated their confidence as 'high' for delivering culturally responsive sessions (n=28).

81% rated their confidence as 'high' for sharing SRH resources and service pathways (n=26).

69% rated their confidence as 'high' for responding to misconceptions and difficult questions during sessions (n=22).

Targets were met for some of the ratings, but not all. As discussed in the *"Limitations"* section, the small sample size for the survey can influence the results. For example, a score of 81% (n=26) as seen above is only one person short of reaching the target.

Notably, the lower score for 'responding to misconceptions and difficult questions' reflects BHE focus group feedback described below and was factored into the first community of practice (November 2024) which addressed this concern.

COMMUNITIES OF PRACTICE SATISFACTION TARGET MET

Target: 85% of BHEs 'agree' or 'strongly agree' with survey statements about the CoP quality.

Result: Met

Of the 45 BHEs who responded to the two CoP surveys:

93% agreed (n=10, 22%) or strongly agreed (n=32, 71%) with the statement "The CoP was a safe space to share successes in the HIML SRH project".

93% agreed (n=11, 24%) or strongly agreed (n=31, 69%) with the statement "The CoP was a safe space to share challenges in the HIML SRH project".

91% agreed (n=13, 29%) or strongly agreed (n=28, 62%) with the statement "The CoP shared resources that are useful for my work in the HIML SRH project".

91% agreed (n=10, 22%) or strongly agreed (n=31, 69%) with the statement "The facilitators were approachable and engaging".

COMMUNITIES OF PRACTICE KNOWLEDGE INCREASE TARGET MET

Target: 85% of BHEs 'agree' or 'strongly agree' with survey statements that the CoP improved their knowledge about SRH-related issues.

Result: Met

Of the 45 BHEs who responded to the two CoP surveys:

89%
agreed (n=13, 29%) or strongly agreed (n=27, 60%) with the statement "The CoP improved my understanding of sexual and reproductive health topics".

85%
agreed (n=13, 29%) or strongly agreed (n=25, 56%) with the statement "The CoP improved my understanding of sexual and reproductive health screening and services".

In the November 2024 CoP survey, the target for 'improved understanding of SRH screening and services' fell short with 78% of BHEs who agreed or strongly agreed with this statement. The target was achieved, however, by the March 2024 CoP survey when 91% of BHEs agreed or strongly agreed with the same statement. This change was possibly related to the March CoP specifically addressing issues pertaining to reproductive justice and abortion access: a topic frequently requested by BHEs up until that point in the project.

COMMUNITIES OF PRACTICE CONFIDENCE INCREASE TARGET MET

Target: 85% of BHEs 'agree' or 'strongly agree' with survey statements that the CoP improved their knowledge about SRH-related issues.

Result: Met

Of the 45 BHEs who responded to the two CoP surveys:

87%
agreed (n=13, 24%) or strongly agreed (n=28, 62%) with the statement "The CoP improved my confidence to deliver culturally responsive sessions about sexual and reproductive health to gender diverse and non-binary people".

91%
agreed (n=9, 20%) or strongly agreed (n=32, 71%) with the statement "The CoP improved my confidence to deliver culturally responsive sessions about sexual and reproductive health to migrant and refugee women".

CAPABILITY-BUILDING RESPONDED TO NEED OVER TIME

The various capability-building activities undertaken throughout implementation provided a package of support to BHEs that responded to their needs over time, with some areas for improvement provided in qualitative feedback.

Notably, the training provided at the start of the project occurred in the pressured inception circumstances described earlier with the added constraint of minimal resourcing at MCWH with one staff member available to design, coordinate and deliver training in a short time frame. These constraints were later mitigated, however, by the in-person induction activities, direct

support, professional development presentations and CoPs. As such, BHEs reflected mixed views about their initial training experience, but found that the continuous support in their learning journey was highly valued.

Many BHEs found the training to be a valuable introduction to the four SRH topics with an intersectional feminist lens and understanding of systemic barriers to sexual and reproductive healthcare. While the training was not the only touchpoint for capability-building, some BHEs remarked, however, that they would have preferred more time and detail spent learning about the four SRH topics. A related theme was the need for more training on how to demonstrate the use of SRH related materials such as contraception kits, STI tests and menopause hormone treatments (MHT).

> “I think the training was not enough. Because they didn’t go in depth like, for example, when we are delivering the contraceptive session. [For each option] they give like brief information on it. They have only given like there is option available, but it should be like more depth information on the topic.” – BHE focus group

Additionally, BHEs sometimes provided feedback throughout the project that they experienced challenges managing resistance from participants when discussing sensitive SRH topics, such as abortion care, contraception, and safer sex. These skills were addressed with positive results through professional development and CoPs, however, many BHEs felt they would have preferred this support earlier in the training at the start of the project.

> “Personally, I think [the CoPs] helped, but it’s just a bit late, because I feel like I needed that information at the beginning.” – BHE focus group

Sense-making discussions also revealed that the training assumed a base level of knowledge amongst BHEs about sexuality and sexual health issues more generally; however, once the project commenced it became apparent that some BHEs had not received prior sexual health education in their own lives and required extra support in these areas.

While less of a concern, some BHEs also found that the training was dense and fast-paced, with long screen times and insufficient breaks. Time zone differences and technical access issues also posed challenges.

Key feedback for improving training, included:

- → demonstrations of ‘hands on’ SRH related kits and materials
- → baseline education in sexuality and sexual health
- → longer, more interactive training sessions spaced out over more days
- → greater depth on session delivery in community settings and strategies to overcome resistance and challenges on SRH topics.

In comparison to training, the CoPs and other professional development activities were consistently described by BHEs as highly valuable and beneficial, as was the direct support provided by partners and MCWH.

> “And I also really appreciate the support from the team. Whenever I had the question, or I felt unsure about it, I can approach to them easily.” – BHE focus group

Partners emphasised the importance of this direct support approach provided throughout the project.

> “All the BHEs around Australia know that they have enough support, like from their own coordinator and also from MCWH’s part, which is really important. And they can get back to them if they have any question or if they want to pass some information from community members.” – Key informant interview, partner

These capability-building opportunities provided ongoing learning opportunities, peer support, and practical strategies for responding to challenges such as myths, misconceptions, and sensitive topics like abortion. BHEs appreciated the opportunity to learn from one another and share resources, though some felt more time was needed for peer learning and discussion in the CoP sessions in general.

Recommendation 5: Invest in BHE capability-building to further strengthen tailored support with an emphasis on addressing general health and sexual health knowledge gaps; targeted activities for confidence building; interactive adult learning approaches; and peer-learning opportunities (e.g., CoPs).

Community stakeholders

ENGAGING THROUGH TRUSTED STAKEHOLDER RELATIONSHIPS

Stakeholder engagement aimed to establish and strengthen relationships with organisations and community leaders to build trust and enable session delivery with migrant and refugee women in local communities.

While project inception activities were underway, the partners and BHEs made use of this time by commencing a range of community engagement and social media activities to promote the project. Indeed, these activities were essential for socialising and promoting the project with stakeholders and booking sessions with community groups. This engagement approach was largely enabled by the pre-existing relationships and trust that the partners already held with stakeholders. Furthermore, this sense of trust was enabled by the established and respected role many BHEs held in their communities.

> “Also what helped was the BHEs are from the same community. The person that’s coming to deliver these sessions are from your community. Some of them (BHEs), they are community leaders, so people respect them.” – Key informant, partner

In some cases, trust could diminish where different BHEs delivered subsequent sessions after one BHE established an initial trusting relationship in the first session. There were other examples, however, where different BHEs were purposefully deployed to session topics to manage potential reputational risks for BHEs whose everyday community role might be compromised by engaging in more sensitive subject matters (e.g., pregnancy choices and abortion).

MANAGING STAKEHOLDER RESISTANCE TO SRH EDUCATION

Resistance by stakeholders to the project could be found in cases where partners and BHEs were establishing new relationships with stakeholders and community groups, or where there was significant concern about the sensitive nature of SRH topics. This resistance created challenges for booking sessions and resulted in slower uptake in some settings and communities.

To manage this concern, MCWH developed a communication guide to support partners and BHEs to frame the key messages about the project and enable engagement. Partners and BHEs used this resource and also undertook various strategies to build rapport and trust, such as:

- setting up booths to informally engage stakeholders at community festivals, events and celebrations
- holding preliminary meetings with stakeholders to discuss the session content and gauge comfort levels with SRH topics
- starting the session series with a less sensitive topic such as 'Understanding Menopause' which was initially viewed as more acceptable than other topics
- tailoring some SRH terms to make the session more acceptable, such as describing the safer sex topic as ‘sexual health’ or ‘safer intimacy’.

> “The choice of words sometimes can help. Safer intimacy has the same meaning as safer sex. But in my community, it’s considered more polite.” – BHE focus group

> “At the beginning we had a little struggle to get communities to engage. And what we have implemented is actually before we conduct any sessions, we will go out to the group just as community engagement, speak to them about the overview of the program and what topics we offer, and then we give it back to the group to choose which session they would like to start with so they can feel ownership of the sessions and they can feel empowered that they chose this.” – Key informant interview, partner

These strategies helped to gain community trust and rapport by demonstrating respect for community and culture, which resulted in increasing uptake and advance bookings for HIML SRH sessions over time.

Impact Story: Stakeholder engagement

This impact story was written by a partner describing their experience of relationship and trust building with communities to enable project implementation and session bookings.

“We met with [stakeholder organisation] last month to plan the delivery of SRH sessions to their group. During the meeting, the group facilitator and project coordinator requested a gentle, relationship-building approach. We agreed to begin by participating in their Eid celebration to help establish trust and connection with the group. Following that, we will host an introductory workshop to present an overview of the program and its topics. Based on this approach, four sessions have now been booked and will be delivered over the coming months. SRH topics are not easily accepted to be discussed [within their] community. HIML needed to build a communication channel with the community to build trust between the team and the community. By being part of community celebrations, we avoid any misconception by the community that the team is promoting for people to go against their cultural beliefs and faith. When the team engages in and participates in cultural activities, we demonstrate respect for the community’s culture and beliefs. This helps us build communication channels and mutual trust, ensuring our work in women’s health is better received and that the community is more open to engaging with the program and its sessions.”

Reach

+ Key Evaluation Question: How well did the HIML SRH project reach migrant and refugee women and community stakeholders across Australia?

The reach of the project was measured in terms of stakeholder engagement through community activities and media promotions used to implement the project, and engagement with migrant and refugee women through the SRH education sessions.

As noted under the *"Implementation Quality"* section above, stakeholder engagement was a critical part of project implementation to promote the project and gain trust to deliver SRH sessions in the community. The project demonstrated substantial stakeholder reach by engaging an estimated 26,527 stakeholders. Much of this reach came via estimated contacts with stakeholders and community members in largescale community festivals and events. Extracting that largescale event data from the overall figure, however, still showed engagement with over 8,000 stakeholders: a figure well exceeding the projected target.

Social media was a key communication mechanism used to promote the project and encourage session bookings with a total of 34,580 social media impressions generated through a wide variety of posts during project implementation. This result exceeded the original target demonstrating the project's strong social media presence. While less utilised, opportunities with traditional media outlets enabled the delivery of 17 traditional media engagements predominantly through print media features.

The SRH education sessions engaged with highly diverse age, language and cultural groups across the country. A total of 8,152 attendees (60% of target) participated in 515 sessions (56% of target) about the four topics. 'Understanding Menopause' was the most attended session, while 'Pregnancy Choices' was the least attended session.

While targets for the number of sessions and participants reached were not achieved, this result was likely due to a number of factors including setting a target based on a previous HIML projects (with a different focus), delayed project commencement, and the sensitive nature of introducing SRH topics to communities, which required additional time and resources to establish relationships and trust prior to implementing sessions.

Please note that the reach data described below has limitations pertaining to the likelihood of the same stakeholders recorded through various engagement activities, the estimates of community members attending high volume events (e.g., conferences and festivals) and repeat attendees who participated in sessions about some or all of the SRH education topics (see *"Limitations"*).

Stakeholder engagement

STAKEHOLDER REACH WAS EXCEEDED THROUGH COMMUNITY ENGAGEMENT ACTIVITIES

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

Result: Met

The project reached an estimated total of 26,527 individual stakeholders, exceeding the target. Table 2 details these results by state and territory. Achieving this figure was mainly due to engagement through largescale community festivals, celebrations and events, which were likely provided as attendance estimates rather than actual counts of stakeholders and community members (see *"Limitations"*). Nevertheless, even without these types of largescale events included, the total reach still exceeds the target with 8,616 stakeholders.

Table 2. Number of stakeholders by state/territory

State/Territory	Number of stakeholders engaged
ACT	720
NSW	3,059
NT	8,779
QLD	4,404
SA	2,895
TAS	1,046
VIC	1,540
WA	4,084
Grand Total	**26,527**

The tables below show the top five community engagement activities, stakeholder types, stakeholder cultural groups, and stakeholder language groups. Language groups include where singular or combinations of languages were recorded for an engagement. From this data, we can see that partners frequently reported high reach with multicultural communities and various language groups through community festivals and events.

Table 3. Number of stakeholders by community engagement activity (top 5)

Community engagement activity	Number of stakeholders
Community Festival or event	17,911
Conference or Forum	2,074
Meeting	1,589
Networking Event	1,458
Other	1,409

Table 4. Number of stakeholders by type (top 5)

Stakeholder type	Number of stakeholders
General public	10,631
Targeted community groups	4,634
Non-profit organisation	4,065
Tertiary education institution	2,589
Health services	1,719

Table 5. Number of stakeholders by cultural group (top 5)

Cultural group	Number of stakeholders
Multicultural[1]	19,905
Assyrian/Chaldean[2]	683
Serbian	446
Ukrainian	437
Afghan	362

Table 6. Number of stakeholders by language (top 5 - singular)

Language	Number of stakeholders
English[3]	4,454
Serbian	372
Nepali	364
Dari/Hazaragi[4]	246
Ukrainian	202

1. Where the cultural group was reported as 'multicultural' or where more than three cultural groups were listed for a single engagement (e.g., 'Bolivian, Japanese, Egyptian') it is represented as 'Multicultural' in the table above for reporting purposes.

2. Assyrian and Chaldean are represented together in the table above due to the high frequency of data entries in the partner monthly report as 'Assyrian/Chaldean' without a distinct number provided for either group. Community members from Assyrian and Chaldean backgrounds may identify with these cultural groups in different ways and reporting in this way only intends to reflect the data and not a conflation of backgrounds and identities.

3. The following recorded languages were all counted as English in the table above: English, Plain English, Simple or Simplified English, Easy English.

4. Dari and Hazaragi are represented together in the table above due to the high frequency of data entries as 'Dari/Hazaragi' without a distinct number provided for either group. Community members from Dari and Hazagari backgrounds may identify with these cultural groups in different ways and reporting in this way only intends to reflect the data and not a conflation of backgrounds and identities.

Table 7. Number of stakeholders by language (top 5 – combinations)

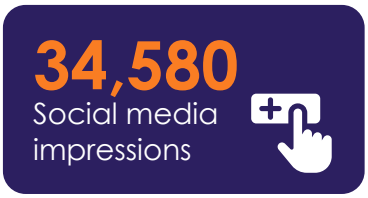
Language	Number of stakeholders
Various community languages[5]	15,600
Arabic and English	807
Chaldean and English	520
Vietnamese and English	500
Bengali and Hindi	200

Media promotions

THE PROJECT WAS HIGHLY PROMOTED THROUGH SOCIAL MEDIA

Target: 10,000 social media impressions (likes, shares, clicks)

Result: Met



There was a total of 34,580 social media impressions disaggregated by state/territory as shown in table 8 below.

Table 8. Number of social media impressions by state/territory

State/Territory	Number of social media impressions
ACT	580
NT	1,271
QLD	4,624
SA	651
TAS	113
VIC	26,102
WA	1,239
Grand total	**34,580**

TRADITIONAL MEDIA WAS LESS UTILISED

Traditional media was not utilised to a great extent as the partners could not control this medium as they could with social media. Over the course of the project, there were 17 traditional media promotions, with the majority conducted in the Northern Territory (n=10). Traditional media included:

- 14 x written media features (e.g., newspapers, newsletters, magazines)
- 2 x SBS radio features
- 1 x podcast features.

5. Where the language spoken was reported as 'Various Community Languages' or where more than three languages were listed for a single engagement (e.g., 'Spanish, Japanese, Egyptian Arabic') it is represented as 'Various Community Languages' in the table above.

Session delivery

ENGAGEMENT WAS HIGH BUT SESSION DELIVERY TARGET NOT YET MET

Target: 13,500 attendees reached through 1,350 sessions

Result: Not met

8,152 attendees reached

515 sessions

There were 8,152 attendees (60% of target) in 515 sessions (56% of target), therefore, the target has not yet been met during the evaluation period. This result was partly due to delayed start at project inception (see *"Pressured project inception"*) and short project timeframe (one-year).

As shown in figure 2, twenty-two sessions were delivered to 255 participants between July and October 2024 with these numbers increasing from November onwards.

Figure 2. Monthly session attendance

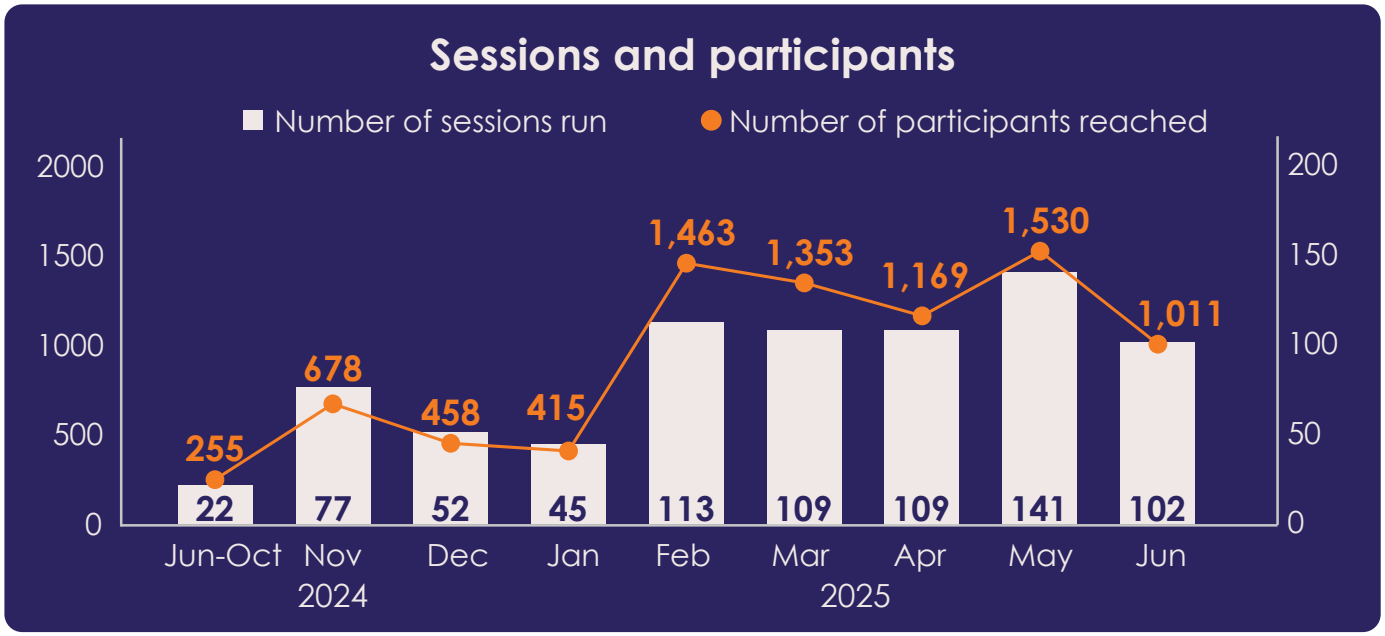


Table 9 shows the number of participants reached by state/territory, demonstrating the spread of engagement across the country.

Table 9. Number of attendees by state/territory

State	Number of attendees
ACT	364
NSW	2,340
NT	507
QLD	927
SA	1,077
TAS	298
VIC	1,323
WA	1,316
Grand total	**8,152**

UNDERSTANDING MENOPAUSE GAINED HIGH ATTENDANCE

As shown in table 10 below, 'Understanding Menopause' was the most attended session, while 'Pregnancy Choices' was the least attended session. This result aligns with the finding that the menopause topic was often used to introduce the project to communities as it was viewed as a less sensitive issue for initial group-based discussion (see *"Community stakeholders"*).

Table 10. Number of sessions and attendees by topic

Topic	Number of sessions	Number of attendees
Understanding Menopause	233	2,798
Safer Sex (STIs)	217	2,384
Contraception Choices	197	1,775
Pregnancy Choices	112	1,195
Grand Total	**759**	**8,152**

HIGHLY DIVERSE AGE, LANGUAGE AND CULTURAL GROUPS WERE ENGAGED

The sessions engaged with a highly diverse population of migrant and refugee women across the country representing several age groups ranging from the twenties to the sixties and older, and approximately 96 cultural groups and 34 languages in total.

The highest number of attendees in an age bracket was 41-50 years old (n=2,109), closely followed by the 31-40 age range (n=2,011); however, combined totals of all age ranges over 50 years old came to 2,283 attendees: the largest group overall. This result aligns with the higher attendance in Understanding Menopause sessions, which is more likely a concern for this age group.

The tables below present the age ranges (excluding those recorded as 'unknown'), and the top five cultural groups and languages recorded in the survey data, including where the data were recorded as a single language used in the session, or a combination of languages used in the session.

Sensemaking discussions found that the high number of English sessions (with variations) was likely due to several factors including:

- limited availability of BHEs in some locations who spoke particular languages
- high levels of session delivery to multicultural groups, including in workplace and educational settings
- specific requests for sessions to be delivered in English to help improve English skills.

Table 11. Number of attendees by age range

Age Range	Number of attendees
Under 20	170
21-30	1,079
31-40	2,011
41-50	2,109
51-60	1,390
60+	893
Grand total	**7,652**

Table 12. Number of attendees by cultural group (top 5)

Cultural Group	Number of attendees
Afghan	1,467
Chinese	641
Iraqi	587
Vietnamese	538
Nepali	444

Table 13. Number of attendees by language (top 5 - singular)

Language	Number of attendees
English[6]	2,832
Dari/Hazaragi[7]	1,029
Arabic	964
Mandarin	409
Ukrainian	367

6. The following recorded languages were all counted as English in the table above: English, Plain English, Simple or Simplified English, Easy English.

7. Dari and Hazaragi are represented together in the table above due to the high frequency of data entries as 'Dari/Hazaragi' without a distinct number provided for either group. Community members from Dari and Hazagari backgrounds may identify with these cultural groups in different ways and reporting in this way only intends to reflect the data and not a conflation of backgrounds and identities.

Table 14. Number of attendees by language (top 5 – combinations)

Language	Number of attendees
Farsi and English	140
Vietnamese and English	83
Dari/Hazaragi and English	67
Mandarin and English	27
Arabic and English	26

Relevance

+ Key Evaluation Question: How relevant was the HIML SRH project for meeting the informational and educational needs of migrant and refugee women in Australia?

The question about relevance was premised on the notion that SRH education must respond to the needs of migrant and refugee women to enable outcomes for improving their knowledge and confidence and intentions to take some form of action (see *"Theory of Change"*). Investigating relevance relied on document review to understand whether an evidence-based approach informed key aspects of the project's implementation and asking participants about their satisfaction with the sessions and suggested areas for improvement.

The results below demonstrate that an evidence-based approach did indeed inform several aspects of the project design, including the selection of the four SRH topics, and subsequent development of BHE capability-building activities and SRH session content and resources provided to participants.

Participant satisfaction rates with the sessions was high, exceeding the target set out for this evaluation. Qualitative feedback showed that the participants consistently found that the sessions provided useful SRH education in an engaging and culturally sensitive way that met their language needs. Some participants also reflected that the group-based learning approach helped reduce isolation and normalise discussions and learning about sensitive SRH topics.

It is evident from the results that the sessions helped shift attitudes toward topics that some participants may not have initially viewed as relevant to them, usually due to personal circumstances or stage of life, and further provided a safe space to shift mindsets about SRH issues that were considered sensitive or taboo.

Various strategies deployed by BHEs, such as interactive adult learning approaches, helped enhance the relevance of the sessions for participants. Further investment and consideration of these strategies provides an opportunity to strengthen the relevance and accessibility of SRH education for community members.

Participants, partners and BHEs also provided a range of suggestions to enhance relevance and improve the sessions overall, including providing one-on-one follow up support to participants where needed, addressing language gaps for resources, supporting community-led topic selection and investigating the possible SRH education needs of men in the community.

Relevance of research and resources

EVIDENCE INFORMED THE PROJECT DESIGN

A review of key documents and sense-making discussions found that the project design was informed by research evidence and reputable resources about sexual and reproductive health.

At the commencement of the project, the MCWH Research, Advocacy and Policy (RAP) Department produced an internal research report from a review of SRH issues for migrant and refugee women. This review drew on and cited academic literature and reports including prior research conducted by MCWH[8] combined with the partners' expertise in health education and national health policy priorities.

While the report correctly noted the limitations of the current evidence base regarding the specific SRH needs of migrant and refugee communities, there was sufficient information to identify and justify the selection of the four SRH topics for the project.

The project design was also informed by a variety of evidence-based SRH resources found in the Multilingual Portal, including materials produced by MCWH and other reputable health promotion agencies, such as the partner agency, True. Other internal evidence-based resources were also produced during the project to address specific community concerns, such as briefs to dispel myths about IUDs and cancer, and changes to abortion legislation in New South Wales. Over the course of the project, MCWH also responded to BHEs resource requests to support their session work, including contraception kits and illustrations, menopause treatment kits, safer sex conversation cards, pelvis models, and medical images (e.g., tubal litigation, vasectomy, menstruation).

EVIDENCE INFORMED BHE CAPABILITY-BUILDING AND SRH SESSION DELIVERY

The evidence-based resources described above were used to develop the BHE training and shared in CoPs and professional development activities. These activities also included presentations by experts from a variety of agencies including the Australasian Menopause Society, Sexual Health Victoria, Marie Stopes International, and the Australian Commission on Safety and Quality in Health Care.

Similarly, the variety of evidence-based resources described above were used to develop the SRH Resource Pack that BHEs used to deliver sessions. This pack included session guides, presentations, and links to key resources.

BHEs were expected to tailor the session materials for their community contexts and participant needs, while also ensuring they met the MCWH Quality Standards for Health Education. Partners described how they would use the training and assessment procedures to fulfil this requirement (see *"BHE capability building"*). Notably, in December 2024, BHEs were also provided a professional development session on 'References and Citations' to support best practices in using relevant and evidence-based information in SRH session delivery.

8. For example: MCWH (2024). *Submission to the Senate Inquiry on Issues Related to Menopause and Perimenopause*; Suha, M. et al. (2022). Reproductive coercion as a form of family violence against immigrant and refugee women in Australia. *Plos one*, 17(11); MCWH (2021). *Data Report: Sexual and Reproductive Health*; Poljski, C., Quiazon, R, & Tran, C. (2014). Ensuring rights: improving access to sexual and reproductive health services for female international students in Australia. *Journal of International Students*, 4(2),150-163; Hach, M. (2012). *Common Threads: The sexual and reproductive health experiences of immigrant and refugee women in Australia.*

This approach was noticeable to session participants, with some feedback highlighting the contribution of evidence-based resource to their improved confidence.

> “There’s obviously a vast difference when you make a decision with, sometimes no information at all than having some information. When it’s evidence-based information as you shared, the level of confidence definitely goes up higher.” – Session participant survey feedback

Overall, these findings provide an opportunity to share this evidence-based approach with other organisations involved in health promotion work with migrant and refugee communities and contribute to the evidence base about educational interventions in this context.

*** Recommendation 6: Find opportunities to contribute to the evidence-base by sharing the evaluation findings with health promotion sector partners and funders.**

Session satisfaction and relevance

PARTICIPANT SATISFACTION WAS HIGH

Target: 70% of participants report ‘very satisfied’ on survey questions enquiring about session satisfaction and relevance.

Result: Met

Targets were met across all satisfaction measures for clarity, relevance, accessibility and meeting participants cultural and language needs:

91%
7,292 participants (N=7,993) were very satisfied that the session was clear and easy to understand.

89%
7,079 participants (N=7,942) were very satisfied that the session was useful and relevant.

90%
7,200 participants (N=7,979) were very satisfied that the session met their language and cultural needs.

94%
7,512 participants (N=8,023) were very satisfied that the session was held in a convenient and accessible location.

PARTICIPANTS FOUND THE SESSIONS RELEVANT

Qualitative survey responses showed that overall participants found the SRH sessions to be relevant in that they provided useful information about the topics in an engaging and culturally sensitive way using community languages or English/Easy English as required.

Group-based learning was viewed as a valuable opportunity for participants to share their experiences together, reduce their isolation and normalise asking questions and being curious about SRH topics. This feedback was also reflected in participant interviews with several noting that they found the SRH sessions to be relevant to their needs and delivered in a way that bolstered their learning, confidence and curiosity.

> When you've got a lot of people in a group. And everyone's jotting down the information or taking pictures. Yeah. You feel like, OK, this is this is really cool!. 'Cause, you're definitely not alone. And there's actually more people who like it than you ever thought." – Session participant interview

Some interviewees also remarked that they were motivated to attend the sessions because they anticipated its relevance for providing information they had not previously received.

> I can't get this knowledge from the person in my country or maybe from my community because everyone is little bit shy or maybe they can't openly talk about this, so I think it's better for me to attend this sort of session so I can get the knowledge without any judgement." – Session participant interview

Although less of a concern, relevance could be challenged at times when the session topic did not appear matched to the participant group.

> Sometimes we find some challenges in finding the right group for the topic. For example, when you talk about contraception we have to find women, for example, between 20 to 50... It's very challenging to find a specific group range. I was sent to deliver a session about contraception and I was shocked, when I saw the women are between 65 and 80 and I had to talk about contraception. It was clearly irrelevant for them" – BHE focus group

There were also instances, however, where participants found that the topic was relevant to them in a way they had not expected.

> I always thought contraception was only for young women. I didn't realise that even after 50, it's still important to know about it." – Session participant survey feedback

SESSIONS HELPED CHANGE ATTITUDES ABOUT SRH

Even where the session was not initially viewed as relevant to the individual, many participants reported that their attitudes shifted during session delivery as they became more aware of healthcare services and options in Australia and the utility of this information to prepare for future needs or share information with friends, family or young people in their lives.

These attitude shifts were also commonly observed by BHEs as they saw participants overcoming their initial discomfort with topics and opening up during the session.

> Some of them at first, they show some restriction, like they don't like to listen, but at the end of the session they say, "Yeah, it was very informative, we didn't know there are more than 12 methods for contraception" – BHE focus group

Some BHEs also described their own attitude shifts where they previously held expectations that participants would be resistant to SRH topics and were pleasantly surprised by how willing they were to learn and engage in discussions.

> So we expected that the community wouldn't like to hear those things and they will think like, 'What are you trying to do? Are you trying to mess with our minds, our way of thinking?' On the contrary, people loved those sessions!" – BHE focus group

One common and persistent area of concern was the topic of abortion discussed during the 'Pregnancy Choices' session. For some communities, this topic was considered particularly sensitive. BHEs often reported challenges in discussing this issue and requested and received additional support as needed. The March 2025 CoP, in particular, focused on the topic of abortion care and reproductive rights (see *"Implementation Quality" "BHE capability building"*). From that point onward, the concern was less often reported as BHEs implemented strategies to discuss abortion in a neutral manner so that participants understood abortion as one option among many in Australia.

> The topic that is the hardest for our community would be the pregnancy options... so when I give that session and I want people to feel comfortable, I always state that we are here only to deliver information because it's your right to know as a person living in in Australia. We are not pro anything. We are only here to educate, and that's it. So this way they will feel that they trust me still." – BHE focus group

Sensemaking discussions also considered that while some topics may be stigmatised in some religious or cultural contexts, this issue extends to many parts of the Australian population who may or may not be aware of SRH issues themselves.

*** Recommendation 7: Strengthen the Theory of Change with evidence about how SRH education contributes to changes in attitudes, particularly in relation to topics previously considered irrelevant or taboo.**

Impact Story: Changing Attitudes

This impact story is written by a BHE describing observations of how the session contributed to a participant's change in attitudes about an SRH topic.

"In a recent 'Pregnancy Choices' session at (community agency), a participant shared how she once judged women who chose to end a pregnancy, believing it was a sin. Through real-life case scenarios and open discussion, she gained a deeper understanding of the struggles many women face. The session helped her replace judgment with empathy. She said: 'I used to blame women for ending a pregnancy... but now I understand everyone has their own struggles. I won't judge anymore – I'll support and share this knowledge.' This story reflects how SRH education can challenge deep-rooted beliefs and create a more compassionate, informed community."


How does Mirena work?
it blocks sperm from reaching or
fertilising your egg by thickening
the mucus in your cervix.
It makes the lining of your
uterus thin.
It stops normal sperm function
inside your uterus and fallopian
tubes, preventing fertilisation.

VARIOUS STRATEGIES ENABLED SESSION RELEVANCE

It is evident from multiple data sources that various strategies were used to help enable session relevance over the course of project implementation:

- Interactivity: Interactive adult learning engagement such as using contraceptive choices kits (frequently reported as highly valuable), visual aids, arts and crafts activities, and Q&A discussions.
- Creating safe spaces: Using 'soft skills' to create an atmosphere of kindness and informality (as opposed to a 'lecture style') while using easy to understand terms, answering questions and assuring privacy and confidentiality.
- Dispelling misinformation: Accessing evidence-based resources to ensure participants received accurate information and address various myths or misinformation in a non-judgemental way.
- Session setting: Choosing accessible session settings where participants usually gathered (e.g., community centres, schools, prisons, workplaces) or supporting participants to choose the locations themselves.
- Childcare: Where possible, providing childcare services so that women could participate more fully in the sessions.
- Food/drink: Having snacks and tea/coffee available for participants to make the sessions more comfortable and relaxed.

> "It's nice it's comfortable. Yeah. And the educator is nice. We actually open up, I feel more comfortable." – Session participant interview

> "There was someone who look after the kids. So you feel... comfortable for you to be ready to listen...Your mind is not on the kids and someone is looking after them." – Session participant interview

The value and positive feedback about these strategies provides an understanding of the ongoing investment and effort required to meet participants needs and ensure that SRH education is relevant, safe and accessible.

Recommendation 8: Continue to work with BHEs to support session delivery strategies and activities that support relevant, safe and accessible educational experiences.

Impact Story: Safe space to learn

This impact story is written by a BHE describing her observations about creating a safe space for participants to share and learn about sensitive topics.

"During a Pregnancy Options session, several migrant women shared that they didn't know abortion is legal in Australia. One participant said, "I thought abortion is illegal here. In my country, it's very secret." The discussion opened space for women to ask questions about legality, access, and support services. Many expressed surprise and interest, saying it was the first time they had heard about safe options in Australia. The session helped break the silence around a topic that is often considered taboo in their home countries. This moment of impact was observed directly during a HIML SRH session. The information provided created a safe space for learning and open discussion. It was clear that the project contributed to this change, as participants pointed to the session as their first source of reliable information on this topic. Their questions and comments showed that the HIML session filled a critical knowledge gap and encouraged confidence in accessing local services."

Session improvements

SESSION DURATION AND FOLLOW UP SUPPORT

Sessions are typically delivered in a one-hour time slot (or tailored for a setting, such as during breaks in workplace settings). Session participants and BHEs both reported at times that they would like the one-hour sessions to be longer to discuss more details about the session topic and allow more time for Q&A, interaction and survey administration.

Additionally, some BHEs reported receiving individual support requests from participants who were embarrassed to ask questions in the group and wanted to discuss personal concerns with the BHE in a more confidential manner. BHEs described referring these participants to a healthcare provider, but sometimes the participant wanted an initial chat privately beforehand. Some BHEs felt that this type of follow up support should be available in a more equitable manner and built into the program as a standard offering.

*** Recommendation 9: Consider allocating additional resourcing for BHEs to provide one-to-one follow up support after the session to participants as needed.**

SESSION INTERACTIVITY AND VISUAL AIDS

As noted above, the use of interactive demonstrations, visual aids and arts and crafts activities were highly valued by participants and noted by BHEs as an important strategy for enabling learning about SRH topics and creating a casual and relaxing atmosphere[9]. That said, there appeared to be differential access for some BHEs to interactive resources and activities for their session plans. Until the end of the evaluation period, participants continued to feed back their interest in more visual and interactive learning strategies.

9. Please note that the arts and crafts activities were not therapeutic, rather, they were reported as 'hands on' activities that helped participants feel more relaxed when engaging in learning, such as weaving.

Feedback suggests that standardisation of various aids would be useful including ensuring all BHEs have access to contraceptive kits, menopause treatment kits (e.g., MHT), STI testing kits, and case scenarios tailored to cultural contexts for all topics. It may be useful to audit the interactive approaches and visual aids used across the partners and support the continued growth and implementation of interactive approaches for adult learners.

Recommendation 10: Audit the breadth of demonstration kits and interactive activities used in session plans to address any gaps and support standardised inclusion of these strategies.

GAPS FOR IN-LANGUAGE DELIVERY AND RESOURCES

While in-language session delivery was highly valued, there were some challenges that could warrant further support. One of the most common issues reported were difficulties with sourcing handouts and audio-visual resources for some languages. A compiled list of languages with SRH resource gaps included: Arabic, Bosnian, Chaldean, Chinese (simplified or traditional), Croation, Dari, Dinka, Karen, Khmer, Nepali, Serbian, Sudanese, Swahili, Urdu and Vietnamese. BHEs sometimes compensated for this lack by translating English resources in the sessions or using visual aids, although this is less ideal than evidence-based in-language resources.

Other language barriers described by BHEs include challenges providing education to mixed language groups compared to single language groups. Interpreters were sometimes, but not always, engaged for these sessions depending on whether partners had prior awareness that participants were actually from different language groups. Additionally, sessions delivered in English/Easy English faced challenges when there was variability amongst participants English language capabilities.

Recommendation 11: Advocate for funding to enable the development of evidence-based resources to address known language gaps and/or support partnership work with other organisations who may have access to translators or existing resources.

COMMUNITY-LED TOPIC SELECTION

As discussed earlier, the four SRH topics delivered through the current iteration of the HIML project were selected through evidence-based research to address health education needs for migrant and refugee communities. Participants frequently advocated for more SRH education for the community, demonstrating the value they saw in the project.

Delivering SRH education on only four topics, however, restricted partners and BHEs from responding to participant and stakeholder requests about other SRH or women's health topics. These requests came through participant feedback in the survey and interviews. The most commonly requested topic was cancer screening. Other topics requested were fertility and pregnancy health, menstruation and menstrual health, nutrition and healthy eating, and healthy relationships.

> "Just recently I did a (SRH) topic, and all the participants wanted different topics, especially cancer screening, mental health, self-care. These are the three topics they really wanted."
> – BHE focus group

Partners and BHEs reported that not being able to meet community needs sometimes placed a strain on stakeholder relationships.

> “[Not being able to deliver certain topics] is a bit hard because now we are not like empowering the community members and we are not hearing their voice” – Key informant interview, partner

There was a strong interest in developing HIML further as a community-led project that recognised and responded to stakeholders’ emerging needs to keep trusted relationships intact. This approach was viewed as an important next step for HIML to harness the evidence-base alongside a responsive approach to community needs.

Recommendation 12: Advocate for a longer-term funding model that enables HIML to be developed further through community consultation to ensure that session topics are both evidence-based and responsive to emerging community needs.

SRH EDUCATION PATHWAYS FOR MEN

Although less commonly reported, some participants noted the importance of also providing SRH education to men in their families and communities. Men also expressed interest in the sessions via their family members and directly to partners and BHEs.

BHEs also provided feedback that they felt they had ‘cut off’ part of their audience as previous iterations of HIML were not gender specific (e.g. COVID-19). MCWH supported partners and BHEs to manage these circumstances including providing resources for men to take away, and communicating the value of targeted sessions with women using the intersectional feminist approach and MCWH Quality Standards to ensure SRH education was relevant, safe and inclusive for the target audience.

There were rare instances where men did attend sessions and their interest in learning was documented.

> “We can only see the physical difficulties a woman is having during the pregnancy and so easily we say every woman go through it, you’re scared and making excuses. But we forget about what it actually does to her body, mind and the fact that it changes her life completely. We forget about her wish, her desire about her own health and plans for life. A lot of the times, as husbands, we fail to take stand for our wives against our families and society. Thanks for giving me the confidence. From now on, it will be her decision and her health first even before the baby, family and the society." – Session participant (male) survey feedback

This finding does not suggest that HIML partners hold responsibilities for addressing men’s SRH needs, however, it does reveal a possible gap in SRH education opportunities for men that requires further investigation and intervention.

Recommendation 13: Communicate community interest in men’s SRH education to the Department to enable their own investigation and development of an appropriate, complementary intervention.

Effectiveness

The results in this section show that the project was consistently effective in increasing migrant and refugee women's knowledge and confidence about the four SRH topics delivered through health education sessions across the country. This positive shift occurred even while knowledge and confidence targets were not met due to various possible contextual factors as discussed below.

There was also strong evidence that the sessions helped participants set intentions to share their knowledge with partners, family and community, encourage others to attend sessions and talk to health professionals about their SRH needs. This result was commonly reported in survey data and confirmed with participant interviewees who provided further insight into the changes they experienced as a result of participating in sessions, such as sharing what they learned with others, making health care appointments and attending screening services. Indeed, participants' interest in sharing knowledge with others was a recurring theme and profound finding suggesting a potential ripple effect where women may help to improve SRH topic and service literacy in their own families and communities.

The results below address the knowledge and confidence changes and the intentions for action from quantitative survey results completed by qualitative feedback and observations. Following this, the 'most significant change' stories are presented at the end of this section to illustrate the broader impact of the project in creating safe spaces for participants to share knowledge and experiences with each other, improve their confidence to navigate the healthcare system, and seek help for their own SRH needs.

Knowledge and Confidence

KNOWLEDGE INCREASE TARGETS NOT MET

Target: 75% of participants score their post-session knowledge of SRH topics as 'high'.

Result: Not met

The result fell short of the target with 70% or 5,555 participants (N=7,982) rating their knowledge of SRH topics as 'high' after the session was delivered. Overall, however, participants knowledge of SRH topics did increase. On a scale of 1-100, the before-session average score was 26 points (low-medium range), and the after-session score was 83 points (high range).

Target: 75% of participants score their post-session knowledge of SRH services as 'high'.

Result: Not met

The result fell short of the target with 69% or 5,517 participants (N=7,994) rating their knowledge of SRH services as 'high' after the session was delivered. Overall, however, participants knowledge of services did increase. On a scale of 1-100, the before-session average score was 25 points (low-medium range), and the after-session score was 82 points (high range).

CONFIDENCE INCREASE TARGET NOT MET

Target: 75% of participants score their post-session confidence to talk about SRH topics with others as 'high'.

Result: Not met

The results fell short of the target with 64% or 5,121 participants (N=7,977) rating a high score for confidence to talk about SRH topics with others after the session. Overall, however, participants confidence did increase. On a scale of 1-100, the before-session average score was 24 points (low-medium range), and the after-session score was 79 points (medium-high range). Additionally, participants increased confidence to talk about SRH issues is likely linked to their interest to share knowledge with others and discuss their needs with healthcare professionals, as described in the next section (see *"Intention and Action"*).

VARIOUS FACTORS CONTRIBUTED TO KNOWLEDGE AND CONFIDENCE SCORES

Sensemaking discussions articulated the various factors that may contribute to falling short of the knowledge and confidence increase targets. These factors include:

- BHEs developing their own capabilities to deliver SRH sessions (in the context of a pressured time frame), potentially affecting whether participants experienced changes in knowledge and confidence
- some participants held little or no prior knowledge of some SRH topics, resulting in them selecting modest ratings for changes in their knowledge and confidence
- the SRH sessions are limited educational opportunities that may not necessarily provide enough of an intervention to have a substantial change in participants' knowledge or confidence
- the target itself may be set too high of an expectation given the complexity of SRH education in migrant and refugee contexts.

PARTICIPANTS EXPERIENCED IMPROVEMENTS IN KNOWLEDGE AND CONFIDENCE

Although targets were not met, qualitative analysis showed that participants experienced improvements in their knowledge and confidence from attending SRH sessions. This finding aligns with the above quantitative results regarding knowledge and confidence shifts from lower to higher scores overall.

> So in my culture, maybe it is not appropriate to talk about these topics…People is not very open to talk about these topics. But now my level of confidence to talk about this is, you know, become higher" – Session participant interview

Many participants reported that receiving education about the SRH topics helped them feel more confident to talk about them openly, take control of their SRH needs, and exercise rights to bodily autonomy.

> It was good to learn about all those pregnancy options, but the best part was to know that it's our right to make decisions about our own body and health." – Session participant survey feedback

BHEs observed the link between these changes and receiving in-language, culturally safe education.

> The language barrier is…very big. When they receive the information with the culture, with the same language, with the person they know, it is a kind of a treasure for them, and a lot of them say they built the confidence to talk with each other and build their confidence to gain some knowledge." – BHE focus group

Some participants also discussed the importance of learning about the topic alongside education about navigating the Australian healthcare system, including what to expect from a GP, requesting female GPs if preferred, requesting interpreters, knowing that it is okay to ask questions during healthcare appointments and taking time to think over options.

> I've never had to make pregnancy-related choices in Australia, so I hadn't had the chance to learn about them before. That's why I found the session very helpful. It gave me a good overview and useful materials that I can review in more detail later. If I need more information, I'll speak to a female GP. I found the information in the resource provided to be very thorough and detailed. It even covered things I was too shy to ask about. That's why I found this session really helpful." – Session participant survey feedback

While participants reported positive feedback about improvements in their knowledge and confidence on all SRH topics, they most frequently commented on increased knowledge and confidence related to menopause and contraception. This finding, however, should be considered in light of the higher number of sessions delivered on these topics.

Participants remarked on the value of learning about menopause, whether they were already experiencing this stage of life, preparing for the future, or supporting other women in their friend and family relationships. There were examples of participants learning about menopause for the first time, as well as situations where participants realised that their own physical and mental health changes were potentially menopause related. The knowledge gained about menopause enabled many participants to normalise their experiences and feel more confident to talk about this issue with friends, family, partners and health care providers.

> “For years, I thought menopause was just the end of periods, but I never understood what was happening to my body. Learning about perimenopause, menopause, their symptoms and ways to manage them has been an eye-opening for me. It’s great that this topic is no longer an open secret. Now, I feel confident not only in managing my own health but also in supporting my daughters and friends through this stage of life. This session was truly empowering. Thank you!”
> – Session participant survey feedback

Knowledge gained about the various contraception methods available was also frequently reported by participants as a positive experience from the sessions. Many participants commented on the value of having the opportunity to see real contraceptive options (where kits were available) and consider what might suit their needs. These sessions were particularly useful for women who had minimal exposure to contraceptive methods or family planning information. Those who were familiar with contraception reported that the session expanded their options so they could make more informed choices.

> “I didn’t know the word. I didn’t know have many choices [and] method to prevent and not just one kind. Now have more choices and more knowledge so I can choose (contraceptives)... Not just be limit and worry. More worried before. Yeah, but now it’s more confident. Less worry.”
> – Session participant interview

Recommendation 14: Strengthen the Theory of Change to include changes in participants’ knowledge about navigating the Australian healthcare system with regard to their information and language needs.

Recommendation 15: Continue to deliver tailored, in-language sessions to community members by BHEs who are trusted peers in local cultural communities.

Impact Story: Knowledge and Confidence

This impact story was written by a BHE sharing her observations about how the session helped improve a participant’s knowledge and confidence to manage her SRH issues.

During the session, a participant shared that her prior knowledge about contraception mainly came from her husband and reflected his perspective. After engaging with the session content, she expressed that she felt more knowledgeable about the range of contraceptive options available for women. She said the session made her feel more empowered and confident to make decisions that are in her own best interest. This moment highlighted how access to accurate, women-focused information can shift power dynamics and support informed, independent decision-making. I know the HIML SRH Project contributed to this impact because the participant directly shared her experience during the session. She acknowledged that most of her knowledge previously came from her husband, but the session gave her new information and a broader understanding from a woman’s perspective. She clearly attributed her increased confidence and sense of empowerment to what she learned through the project, demonstrating the direct influence of the session content on her mindset and decision-making.

Intention and Action

PARTICIPANTS INTEND TO SHARE KNOWLEDGE ABOUT SRH WITH OTHERS

Target: 75% of participants rated that they were likely (somewhat or very) to share what they learnt with others.

Result: Met

The target was met with 96% or 7,639 participants (N=7,957) rating that they were likely (somewhat = 20% or very = 76%) to share what they learned with others.

Qualitative findings supported this result as the intention to share what they learnt with others was the most commonly reported outcome aside from the intention to talk to healthcare professionals about their SRH needs (see below). It was also common for interview participants to describe sharing their learning with others in their lives.

Sensemaking workshops generated discussion that sharing knowledge with others is a common behavioural trait that partners observed in their work with migrant and refugee communities. This outcome may be due to various factors including collectivist cultural norms and a strong interest in helping each other navigate services and systems, particularly for more newly arrived groups.

On the topic of menopause, many participants often expressed an intention to share what they learnt with other women in their lives, especially peers or mothers in the peri/menopause stage of life.

> “It’s useful because I have mother, she’s almost at that age, so it’s good to have information around that [menopause] so that I can let my mother know because she can’t get access to that information.” – Session participant interview

Although less commonly reported, several participants described an intention to share what they learnt with their partners, particularly on the topics of contraception and safer sex. This finding has a possible relationship with the aforementioned need for SRH education for men.

> “I never felt comfortable discussing contraception with my partner, but now I feel ready to have an open conversation about what works best for both of us.” – Session participant survey feedback

Participants also often described an intention to share their learning with the younger generation, including teenage or young adult children and grandchildren. A major motivation for this intention is to ensure that younger family members are equipped with knowledge and attitudes that empower them to manage their own SRH needs. There were also some instances where participants felt that they may not be able to apply some of the information in their own lives (e.g., because opportunities for contraception use and family planning had passed), however, they held a deep desire that younger women could use this knowledge to exercise greater agency and choice that they were not able to enjoy for themselves.

> “I had a woman say ‘Ah! This is good information, but even if I want to do something about it. I’m not going to do anything about it, because my husband will (restrict her choices) but I’m going to tell my daughter about it so she can stand up from the beginning, not when it’s too late’. That woman who had her power taken away from her, give that power to her daughter was, very moving” – BHE focus group

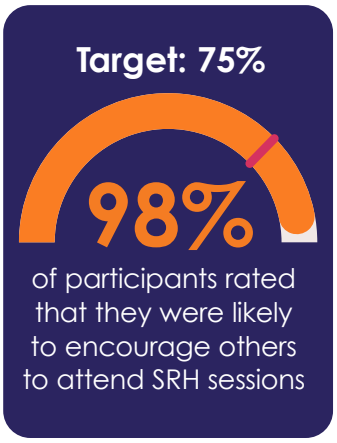
While sharing knowledge was seen as an important ripple effect of the HIML SRH project, there were some concerns raised in sensemaking discussions that this action could cause conflict for some participants if family or community members react against them for doing so. It was suggested that sessions could be improved by offering guidance to participants about how to safely have conversations about SRH with others, especially partners, particularly in relation to sensitive topics and issues.

*** Recommendation 16: Provide a health education module on 'Healthy Relationships' alongside SRH module offerings that will strengthen participants capacity to manage conversations about what they have learnt.**

PARTICIPANTS INTEND TO ENCOURAGE OTHERS TO ATTEND SRH SESSIONS

Target: 75% of participants rated that they were likely (somewhat or very) to encourage others to attend SRH sessions

Result: Met



The target was met with 98% or 7,792 of participants (N=7,951) rating that they were likely (somewhat = 13% or very = 85%) to encourage others to attend SRH sessions.

There were signs in some of the data reported that other community members attended a session as a result of a participant’s recommendation. In one documented instance, a woman attended a session multiple times even though they were already familiar with the topic in order to bring friends and family along with them.

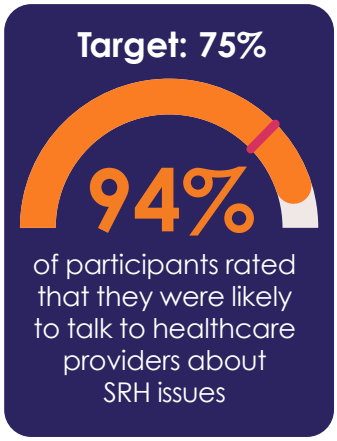
> “They try to involve other people, also their friends, their families, and they’re like, you know. I attended this, but I don’t mind attending it again, because last time I understood. But this time I want to know more.” – BHE Focus Group

More broadly, qualitative survey results often reported participants’ hopes for more SRH and women’s health sessions so that others in the community could benefit.

PARTICIPANTS INTEND TO ACCESS SRH HEALTHCARE

Target: 75% of participants rated that they were likely (somewhat or very) to talk to healthcare providers about SRH issues.

Result: Met



The target was met with 94% or 7,389 participants (N=7,861) rating that they were likely (somewhat = 23% or very = 71%) to share what they learned with others.

Target: 75% of participants rated that they were likely (somewhat or very) to access SRH services and screening.

Result: Met

The target was met with 92% or 7,197 participants (N=7,812) rating that they were likely (somewhat = 26% or very = 66%) to access SRH services and screening.

Aside from intentions to share knowledge from others, participants most frequently reported qualitative feedback about their intention to talk to GPs or other healthcare professionals about SRH issues either following the session or sometime in the future, as the needed.

Multiple interview participants specifically reported feeling more confident talking to their GP because they now better understood the SRH information their doctor discussed with them, and furthermore, they knew what to ask about, and how to weigh up their options.

> “So when I go there and doctor show me I totally understand and know ‘cause I already learn about that one. So even it doesn’t take time for doctor to describe for me” – Session participant interview

Some of the participants interviewed did seek healthcare appointments and SRH screenings after attending the sessions. BHEs also reported that they helped some participants book appointments immediately after the session. As this data is qualitative and observational, however, we are unable to make definitive conclusions about the extent to which intention to access SRH care translated into actively seeking services.

Importantly, sensemaking discussion highlighted that migrant and refugee communities generally hold valuable knowledge that they actively share with each other, yet they often lack access to appropriate in-language health education and come up against a healthcare system that is not designed with multicultural communities in mind. As such, while many participants may be likely to turn their intentions into action, they may also be likely to face embedded systemic barriers to access their SRH care needs and rights.

Recommendation 17: Use the findings of this evaluation to advocate to the health sector about the value of SRH education and the importance of training for healthcare providers to respond to the SRH needs of migrant and refugee women.

Most Significant Change Stories

A key aspect of assessing the project's effectiveness involved gathering and analysing stories of significant change either experienced directly by the participants' themselves or observed by the partners and BHEs. These MSC stories illuminate the effectiveness and impact of the SRH sessions alongside the impact stories described throughout the findings.

Eleven MSC stories were prepared for collaborative analysis in the sense-making workshop and five were selected for inclusion in this report (see *"Methodology"*).

MSC themes and outcomes

Through the discussion of the stories and the criteria, key themes and outcomes were identified by workshop participants:

- the sessions were safe and open spaces for women to converse and connect, share their experiences, be vulnerable, and reduce isolation
- women gained the language, tools and knowledge to articulate their SRH needs and be active in managing their health
- women gained greater confidence navigating the healthcare system and were empowered to express their needs
- increasing women's knowledge and access has the potential for far reaching impacts as information is shared and ripples out into the community.

Overall, the stories demonstrated how HIML SRH sessions created safe spaces for participants to share their own knowledge and experience with each other – both as it directly related to the topic (such as experiences with different contraceptive methods and navigating the Australian healthcare sector), and even more broadly to encompass other health topics where they felt they had valuable information to pass on to others.

Selected Stories

The five stories selected demonstrated alignment with different outcomes within the TOC. During the workshop the discussion centred on stories that told strength-based examples of change and positive outcomes, with a particular preference for unanticipated outcomes or outcomes that were anticipated but showed up differently than expected. Stories that evidenced multiple outcomes were also considered to be more significant.

Each story below is preceded by information about the story's context, related themes and outcomes, and the discussion that emerged about its significance.

STORY 1: UNDERSTANDING DEPRESSION AND FINDING THE RIGHT SUPPORT

warning: this story contains discussion of suicidal thoughts

Storyteller cohort	Session participant
Relevant SRH session	Contraception Choices
TOC outcomes	Confidence and intention to share SRH knowledge with others
Unanticipated outcomes	Help-seeking for mental health support

What happened?

I was motivated to attend the session because it was something that I haven't really learned - we weren't informed about these things back in my country. So, it seemed like something beneficial, and it wasn't something that was talked about very much back home.

The contraception part was very interesting. You know, what to use as contraception, what things to use. This is not normally talked about much, but it was good to hear about these things openly. I'm more informed about things and I've shared it with friends and family, my daughters.

Usually, the sessions are separate but, on that day, everyone sat together, so everyone got to talk about things together and discuss and hear each other's opinions.

In the group I got to speak about my mood and being depressed and how it was affecting me, and that's when somebody told me about depression. I went to my doctor, and I got help and it has changed a lot of things in my life. So, you know out of all of this I opened-up about that and it really helped. You know, I got some advice, because I almost become suicidal, I wanted to end my life, so for me having that confidence to speak about what I'm going through and getting help has been the most beneficial, like lifesaving thing for me out of this.

And I thank the people who organised this session because this was really helpful.

Why was this significant?

This story demonstrates positive unanticipated health outcomes in relation to identification and help-seeking for depression. Workshop participants felt this story was significant as it demonstrated how the delivery format of the sessions created safe and open spaces for women to converse, share their experiences and be vulnerable. While the information the storyteller acted on after the session wasn't directly related to SRH, participants felt this story demonstrated an important unanticipated outcome emerging from improved knowledge outcomes and support to access relevant services.

STORY 2: EXERCISING AGENCY IN A HEALTHCARE SETTING

Storyteller cohort	Session participant
Relevant SRH session	Contraception Choices, Pregnancy Choices
TOC outcomes	Increased knowledge Intention to access SRH services Confidence and intention to share SRH knowledge with others

What happened?

When you get pregnant, it sometimes is hard for you and you need to know more because the learning never ends - even when you know something, you will need to know more. As women when we get pregnant, we don't have energy, we don't feel OK. So, another part of the learning is that you get encouragement like "Oh, it's OK to feel that way", and if you don't want to feel uncomfortable in that way, you can even prevent pregnancy.

That topic (contraception choices) is good because when you don't want to have a baby, you can use those ways. And when you want a baby, you can stop for that time and then continue when you need it again. You know, as women sometimes you think, I'm gonna get married and get pregnant, but she (BHE) described that you can... that it's your choice to have the baby, or to stop and look after the one's you have for them to grow well and healthy. And then even for your health, for you to look after yourself, because when you have more kids, you're busy. I shared this with some of my friends, I did, we talked about it and then some told me what they like to use.

[I went to a healthcare professional] one week ago, and she was talking about contraception. She was offering me the sticky one - the one they use like when you go fishing, the one you put in (IUD). She said, this one, I can put it in for you. And I said let's give time for me to think about it and then when I'm ready, I can come. When I went to the session, I got the idea (to see the doctor) because we were learning by listening and she was even describing "this one work like this, this one like this". So, when I went to the doctor and she showed me I totally understood because I already learned about that one. So, it didn't take as much time for the doctor to describe for me.

It gives you more ideas, there are some things you think are weird, but you get more ideas, you understand more about how you can be careful and what action you can take. It is important because now I'm being careful, and I have an idea of what I can do. So, I'm being careful, but now I need to go to the doctor to do the action. First you have to get information and second you have to take action. When you talk with somebody, it's kind of pushing you reminding you, you have to do it *now*. You know? Going to these sessions is a good thing because you will be free and feel confident.

Why was this significant?

This story demonstrated the value and importance of honest conversations during the session about the real challenges experienced during pregnancy and motherhood. Participants felt this was significant in helping women feel that it's 'ok to not be okay' and to share with others when things are difficult. Workshop participants also felt this story was significant as it evidenced that as a result of the session the storyteller not only accessed healthcare but demonstrated confidence and empowerment in navigating her needs with the doctor and taking time to make the choice that was right for her.

STORY 3: NAVIGATING HEALTHCARE AS A NEWLY ARRIVED MIGRANT

Storyteller cohort	BHE
Relevant SRH session	Contraception Choices
TOC outcomes	Increased knowledge
Unanticipated outcomes	Greater understanding of accessing health services in Australia

What happened?

I just wanted to share one story that I came across. I met this lady she came to Australia late last year in 2024. She is in her 30s and has several children.

So when she heard about contraception, she was like, I need this. I need this because I need to explain this to my husband. Can you tell him? Can you give me information? He's the only person who can write and read. Do you have these resources in Somali? She was asking me, and I was like yes, of course I had to print that out for her and give that to her.

She didn't know she had these options, all of these options, some of them that she can have for five years. And she was just putting herself first because she's new to the country, so that was great to hear, it made me happy, and she was willing to share that with her husband as well. So it was really good.

I encouraged her to talk to a doctor and asked what kind of doctor do you have? She was like a male doctor. I was like you can get a female doctor and it might be much more comfortable for you to talk to her about these topics because she was very shy and could not comprehend it that you can discuss these things with your doctor.

I was like, yes, you can here, and if you don't feel comfortable with a male doctor, you can talk to a female doctor, and there will be an interpreter. She was like the interpreter is (from my culture), they will know my business, and I was telling her you can tell them I don't want a face-to-face interpreter. I want to have telephone interpreter, and she was like, is that option available? I was like, yes, that's available. So she was really fascinated, and I was so happy with that.

Why was this significant?

This story was selected as a significant example of women having new knowledge around navigating the Australian healthcare system. The discussion about this story focussed on how during the session, the participant not only learnt about SRH, but came away with new knowledge about the practicalities of navigating the Australian healthcare system as a woman from a multicultural background, such as requesting a female GP and having an interpreter join the appointment via the phone. This was seen as a significant enabler and also information she would be likely to pass on to others.

STORY 4: EMPOWERED IN SEXUAL HEALTH

Storyteller cohort	BHE
Relevant SRH session	Contraception Choices
TOC outcomes	Increased knowledge Increased confidence

What happened?

In today's session, one of the women told me, my husband he doesn't allow me to use any type of contraception, so I'm not using anything. But after, we talked about her right to choose, because it's her body in the end and it's her right to decide whether she wants to be pregnant or use contraception or not.

At the end of the session she was like, I can discuss this with him, maybe I need to share with him what I feel, what I need. Maybe I need to talk to my GP about what option do I have that doesn't affect both of us.

So, yeah, definitely, there is a great impact at the end of the session.

It is like she's already received the proper information, where to seek help. She knows about her health and her health rights as well.

We always encourage women, of course, to discuss, because it's sensitive and in some cultures, you know, women might think that we're turning them against their partners. Just like, if you want to get your rights doesn't mean that you need to offend anyone else.

At the end of the session we noticed, like a great change, a great impact on the women with that information, we've noticed great change. When we talk about information, their attitude, their behaviour, and even their confidence, as well because when they have proper materials between their hands they know what they have to do. Eventually it will affect her life, her health, her relationship with her partner.

We can feel it from the feedback she's giving to us, and it will definitely have a positive impact on her life.

Why was this significant?

This story shows how the sessions helped equip women with the language, tools, and knowledge to articulate their needs in relation to their sexual health and wellbeing. Workshop participants discussed how this story demonstrated a shift in the storyteller from feeling not in control when it came to her sexual health, to gaining relevant, women-centred knowledge and information, to speaking about becoming more active in expressing her needs and managing her sexual health.

STORY 5: WOMEN AS COMMUNITY KNOWLEDGE SHARERS

Storyteller cohort	Key informant stakeholder
TOC outcomes	Intention to share SRH information with others
Unanticipated outcomes	Reducing isolation Older generations modelling new ways of being

What happened?

What stood out to me, last time I was putting together the monthly report, was the session around consent, with the Serbian Bosnian community and the participants actually never knew what consent was until attending the session. They had no idea, and one of the ladies mentioned that when she got married, her mum told her, your job is to make your husband happy. That's it. Don't come back to me and tell me, oh, he's leaving me. So they never understood what consent was. And then after the sessions, one of the older ladies, I'd say probably in her 60s said, I'm going to go and speak to my grandson so he understands that consent has to come from both sides.

So, it's instances like that where you see these changes within people's, let's say not behaviours, but more their perspective on things and they actually get information that is relevant to them, they had no idea that it's their right.

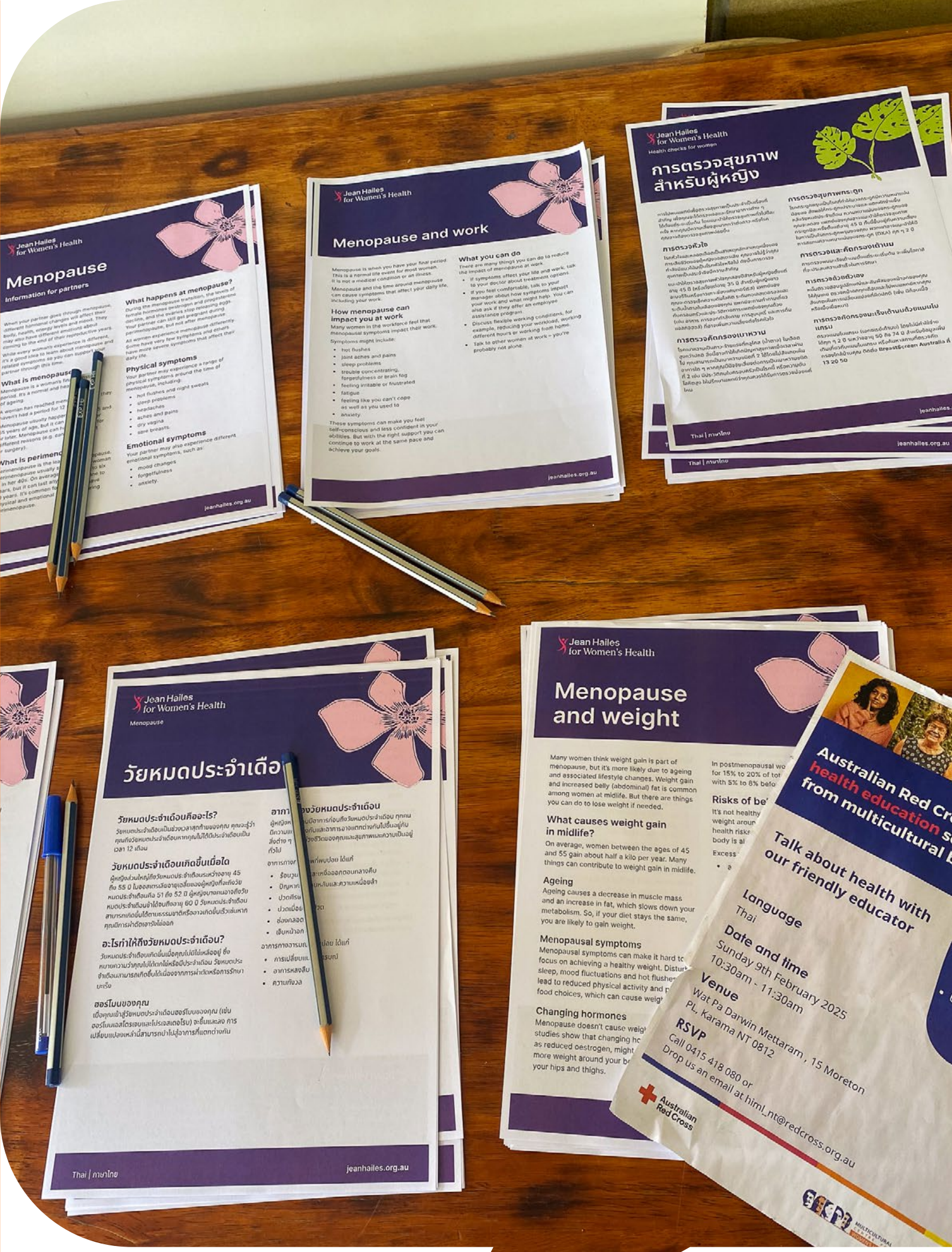
Seeing that a participant would actually educate younger members of the family or community members, you can see that they are accepting of this change or they're accepting of this information and they'll relay it back to other people within their community. I don't think they would have this information, especially as there's not many programmes across Australia that deliver health education in their language so communities find it hard to access this information due to lack of resources and translated materials and things like that.

I think because sometimes younger people get information, but they don't accept it. But sometimes hearing it from someone within your family or someone that's older with a completely different perspective is like - Oh, if my grandma is telling me this is the correct way and she's grown up in our country, let's say in Bosnia or Serbia, and she's making these changes, then I should be making these changes as well.

That's how I see it and I see a lot of need for elderly people to receive this education, not just because it's information that they need, but also because it breaks their isolation. They get to a certain point in their life that they have no connections with anyone. So coming to these groups builds their connection to members within the community that are going through the same thing. So it's breaking isolation as well as receiving health information sessions.

Why was it significant?

Several of the stories shared in the sensemaking workshop evidenced women sharing information they learned during the SRH session more broadly – often with female friends and relatives. This story was selected in the workshop as an example of information rippling out from those in the session into the broader community, including to men and boys. Workshop participants felt this was significant as it demonstrated how even when working with a specific cohort there can be much broader reaching impacts out into the community.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our friendly educator
Language
Thai
Date and time
Sunday 9th February 2025
10:30am - 11:30am
Venue
Wat Pa Darwin Mettaram , 15 Moreton
PL, Karama NT 0812
RSVP
Call 0415 418 080 or
Drop us an email at himl_nt@redcross.org.au
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Recommendations

The recommendations provided throughout the report are categorised below for improving implementation process, session relevance, advocacy, and measurement and evaluation.

Implementation process

- Ensure national HIML project implementation includes a sufficient establishment period (3 months) and a longer timeline (2 years or more) to achieve deliverables and targets.
- Collaborate with BHEs to redesign and test participant surveys, considering also the limitations of the group survey format.
- Conduct a readiness assessment with partners (new or existing) prior to implementing future iterations of the HIML project on new health topics.
- Invest in BHE capability-building to further strengthen tailored support with an emphasis on addressing general health and sexual health knowledge gaps; targeted activities for confidence building; interactive adult learning approaches; and peer-learning opportunities (e.g., CoPs).

Session relevance

- Continue to deliver tailored, in-language sessions to community members by BHEs who are trusted peers in local cultural communities.
- Consider allocating additional resourcing for BHEs to provide one-to-one follow up support after the session to participants as needed.
- Audit the breadth of demonstration kits and interactive activities used in session plans to address any gaps and support standardised inclusion of these strategies.
- Continue to work with BHEs to support session delivery strategies and activities that support relevant, safe and accessible educational experiences.
- Provide a health education module on 'Healthy Relationships' alongside SRH module offerings that will strengthen participants capacity to manage conversations about what they have learnt.

Advocacy

- Advocate for continued investment in the collaborative partnership approach for national health education with migrant and refugee communities.
- Advocate for funding to enable the development of evidence-based resources to address known language gaps and/or support partnership work with other organisations who may have access to translators or existing resources.

- Advocate for a longer-term funding model that enables HIML to be developed further through community consultation to ensure that session topics are both evidence-based and responsive to emerging community needs.
- Use the findings of this evaluation to advocate to the health sector about the value of SRH education and the importance of training for healthcare providers to respond to the SRH needs of migrant and refugee women.
- Communicate community interest in men's SRH education to the Department to enable their own investigation and development of an appropriate, complementary intervention.

Measurement and evaluation

- Find opportunities to contribute to the evidence-base by sharing the evaluation findings with health promotion sector partners and funders.
- Strengthen the Theory of Change with evidence about how SRH education contributes to changes in attitudes, particularly in relation to topics previously considered irrelevant or taboo.
- Strengthen the Theory of Change to include changes in participants' knowledge about navigating the Australian healthcare system with regard to their information and language needs.

Conclusion

The evaluation found that the HIML SRH project was effective in increasing migrant and refugee women's knowledge and confidence in relation to the four SRH topics delivered through health education sessions in every Australian state and territory. While evidence was limited in terms of how consistently women later went on to translate their knowledge and confidence into action, there were strong findings that SRH education helped them set intentions to share their knowledge with family and community, encourage others to attend sessions and talk to health professionals about their sexual and reproductive health needs.

The effectiveness of the project was supported by implementation processes that enabled the delivery of relevant and evidence-based education to a highly diverse population across the country. These processes included a well-developed project management approach, extensive project resources, an established partnership model, and ongoing capability-building activities for the BHEs delivering health education sessions. An important and notable aspect of project implementation was the extensive stakeholder engagement work undertaken by the national partners and BHEs to socialise and promote the project and gain trust for booking SRH education sessions in local communities. The considered approach to stakeholder engagement established the important groundwork needed to enable migrant and refugee women to participate in sessions and gain the outcomes described in this report.

Overall, the evaluation's findings showed alignment with the project's theory of change, in terms of positive outcomes for migrant and refugee women's knowledge, confidence and intentions to take some form of action. The theory of change could be strengthened with evidence about how the project contributed to attitudinal changes about SRH topics (particularly if perceived as irrelevant or taboo) and improved knowledge of how to navigate the Australian healthcare system with regard to cultural and language needs. The assumptions of the theory of change also appear to hold true, including that bilingual health education effectively meets migrant and refugee women's needs and a national partnership approach is an appropriate implementation strategy. The assumption that BHEs required sufficient training to deliver sessions is evident in the finding that while views on the initial training were mixed, ongoing capability-building and professional development support was valued by this specialised national workforce.

Recommendations are provided in this report to enable a roadmap for further investment, development and implementation of the HIML project, including for the SRH focus and potentially other iterations into the future.

Annex

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.

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.

Theory of Change Narrative

The HIML SRH project seeks to address this **problem**: Migrant and refugee women in Australia do not have equitable access to SRH information due to a lack of targeted, in-language, culturally appropriate information resources and educational opportunities. These health inequities create barriers for migrant and refugee women to make informed choices about their own SRH needs and access to SRH services and screening.

To address this problem, various **inputs and resources** are invested to undertake **foundational activities** for the project's implementation such as project planning, training development, BHE recruitment, session planning, and stakeholder engagement strategies. If these inputs are invested and foundational activities are undertaken, this will enable the **influence activities** such as BHE capability-building, project and stakeholder partnerships, and the promotion and delivery of SRH education sessions.

If activities are successfully implemented, this will produce the **outputs and outcomes**. The desired outcomes (using the KAP model) include the more **immediate outcomes** that are expected from migrant and refugee women's direct exposure to the SRH education sessions, including changes in knowledge, attitudes and confidence which support intentions and action to share learning with others, encourage others to attend sessions, or contacting healthcare providers to discuss SRH issues. The **intermediate outcomes** are expected to occur sometime after sessions as these intentions turn into real action depending on women's needs and circumstances. If these intermediate outcomes are successful, this may lead to the **longer-term outcomes, and ultimately the broader goal** whereby migrant and refugee women across Australia are empowered to make informed choices about their sexual and reproductive health.

Importantly, while the TOCs inputs, activities and outputs are **within the project's control**, the project is only one type of SRH-focused intervention in a complex context and may only contribute to influencing the immediate or intermediate outcomes for migrant and refugee women. The longer-term outcomes and broader goal are aspirational and should be understood as the population-level changes that the HIML SRH project may contribute to alongside other initiatives related to migrant and refugee women's SRH needs in Australia. As such, the TOC draws an **expected 'line of expected contribution'** to create a boundary around the outcomes included in this evaluation.

Finally, this TOC must be understood in light of certain **assumptions** and **external factors** that may affect the outcomes and/or create risks to the success of the project. These assumptions include that the project is relevant for addressing migrant and refugee women's SRH education needs and an effective means for changing their knowledge, confidence, attitudes and behaviours (if they need changing at all). It is also assumed that a national partnership is an appropriate implementation strategy and that BHEs are provided with sufficient training and support to deliver education sessions. External factors include health service accessibility issues impacting migrant and refugee women and the potential that other SRH interventions and resources for migrant and refugee communities may also contribute to the desired outcomes.

Evaluation Map

KEQ 1. Relevance

HOW RELEVANT IS THE HIML SRH PROJECT FOR MEETING THE INFORMATIONAL AND EDUCATIONAL NEEDS OF MIGRANT AND REFUGEE WOMEN IN AUSTRALIA?

Indicator	Targets (if applicable)	Data Source/Method
1.1 Relevant SRH educational needs for cultural/language groups identified through evidence-based research	N/A	Document review of internal SRH research reports
1.2 BHE training modules/ resources reflect evidence-based research in SRH education	N/A	Document review of BHE training modules/resources
1.3 SRH education session modules/resources reflect evidence-based research in SRH education	N/A	Document review of SRH education session modules/ resources
1.4 % of migrant and refugee women's satisfaction levels with SRH education sessions	70% 'very satisfied' score for relevant survey questions	Session participant group survey
1.5 Qualitative feedback from participants about session relevance and improvement	N/A	Session participant group survey Session participant interviews BHE focus groups

KEQ 2. Implementation Quality

HOW WELL DID PROCESSES AND STRATEGIES ENABLE THE SUCCESSFUL IMPLEMENTATION OF THE HIML SRH PROJECT?

Indicator	Targets (if applicable)	Data Source/Method
2.1 # of BHEs trained in SRH education disaggregated by state/territory	50 BHEs trained	Document review of training attendance record
2.2 % of BHEs' satisfaction levels with professional development	75% 'very satisfied' score for relevant survey questions	BHE training survey

Indicator	Targets (if applicable)	Data Source/Method
	85% 'agree or strongly agree' score for relevant survey questions	BHE CoP survey
2.3 Increased BHE knowledge/understanding of the gender and intersectional factors, topics, resources and services relevant to SRH education	85% 'high' post- score for relevant survey questions 85% 'agree or strongly agree' for relevant survey questions N/A	BHE training survey BHE CoP survey BHE focus groups
2.4 Increased BHE confidence to deliver SRH education to M/R women, and gender diverse people	85% 'high' post- score for relevant survey questions 85% 'agree or strongly agree' for relevant survey questions N/A	BHE training survey BHE CoP survey BHE focus groups
2.5 Qualitative feedback about quality of SRH training, Communities of Practice and professional support and extent to which these activities helped BHEs to improve delivery of the SRH sessions	N/A	BHE training survey BHE CoP survey BHE focus groups
2.6 Qualitative feedback about implementation quality relevant to: • **project design and components** • **project implementation, structure and operations** • **partnership work and collaboration** • **community engagement and participation** • **barriers and enables for project success**	N/A	Key informant interviews BHE focus groups

KEQ 3. Reach

HOW WELL DID THE HIML SRH PROJECT REACH MIGRANT AND REFUGEE WOMEN AND COMMUNITY STAKEHOLDERS ACROSS AUSTRALIA?

Indicator	Targets (if applicable)	Data Source/Method
3.1 # stakeholders reached through community engagement activities disaggregated by: state/ territory, activity type, stakeholder type (category, stakeholder cultural/ language group	600 stakeholders (groups, networks, individuals)	Partner monthly report (tab 1)
3.2 # and type of media promotion activities disaggregated by: state/ territory, media type (social or traditional), and engagement results (likes, shares, impressions, clicks)	10,000 social media impressions	Partner monthly report (tab 2, tab 3)
3.3 # of M/R women reached through # of SRH education sessions disaggregated by session topic	13,500 participants reached through 1350 sessions (~10 participants per session)	Session participant survey
3.4 # of M/R women participating in the session survey disaggregated by: state/territory, session topic, age range, cultural group, and languages	N/A	Session participant survey

KEQ 4. Effectiveness

HOW EFFECTIVE WAS THE HIML SRH PROJECT IN IMPROVING MIGRANT AND REFUGEE WOMEN'S KNOWLEDGE, CONFIDENCE, ATTITUDE AND BEHAVIOURS RELATED TO SEXUAL AND REPRODUCTIVE HEALTH?

Indicator	Targets (if applicable)	Data Source/Method
4.1 Increased M/R women's knowledge of SRH topics and services	75% 'high' post-score for relevant survey questions	Session participant survey Session participant interviews
4.2 Increased M/R women's confidence to talk about SRH topics with others	75% 'high' post- score for relevant survey questions	Session participant survey Session participant interviews
4.3 M/R women intend, and take action, to share their learning and encourage others to attend SRH education	75% 'somewhat likely or very likely' for relevant survey questions	Session participant survey Session participant interviews
4.4 M/R women intend, and take action, to discuss SRH issues with healthcare providers and access SRH services/screening	75% 'somewhat likely or very likely' for relevant survey questions	Session participant survey
4.5 M/R women report the most significant change from participating in SRH education	N/A	Session participant interviews (MSC stories)
4.6 Qualitative reports of instances of impact (expected and unexpected changes/ outcomes) emerging from the HIML SRH project	N/A	Partner monthly report (tab 5) – for final evaluation only MSC stories

Data Collection and Analysis Methods

Method/tool and description	Data source/sample	MEL use
HIML SRH Session Participant Group Survey MCHW internal reporting tool used to continuously collect data from participants via a survey conducted by BHEs. The survey was implemented in Survey Monkey to collect the following information: • quantitative data about participants' age ranges and cultural backgrounds • quantitative data about changes in participants' knowledge, confidence, and attitudes in relation to SRH topics, including attitudinal intention to share their learning and access SRH services. • quantitative data about participants' satisfaction with the session in terms of clarity, relevance, language/cultural needs and accessibility. • qualitative feedback about session relevance and improvement from both participants and BHEs The survey was voluntary and conducted verbally as a group survey via show of hands at the end of the session with responses entered by BHEs into the Survey Monkey platform. Participants were asked to retrospectively rate and compare their pre-session and post-session levels of knowledge and confidence on a three-point scale (low, medium, high). A three-point likelihood scale was used to answer multiple choice questions about participants intentions to act on their learning. A three-point satisfaction scale was used to answer multiple choice questions about participants satisfaction with the session. Qualitative feedback was documented by the BHEs through quotes and general reflections they received from participants in the sessions.	8152 attendees (60% of target) in 515 sessions (migrant and refugee women who participated in sessions, may include repeat attendees).	Session survey data were cleaned and analysed by Clear Horizon using statistical and qualitative thematic analysis methods. The findings were included in all progress reports provided to MCWH for continuous learning. All session survey data for the evaluation period were aggregated to provide findings for the final evaluation report.
HIML SRH BHE Training Survey MCWH internal reporting tool used to collect post-training data via a voluntary survey from individual BHEs recruited to the HIML SRH project. The survey was administered in September 2024 to collect quantitative data about changes in BHEs knowledge and confidence to deliver SRH sessions. BHEs were asked to rate and compare their pre-training and post-training levels of knowledge and confidence on a three-point scale (low, medium, high). The survey also collected quantitative data about BHEs satisfaction with training (using a three-point satisfaction scale) and qualitative data about session improvement.	32 BHEs participated in the training survey: an 89% response rate from the 36 BHEs who were trained in September.	Training survey data were cleaned and analysed by Clear Horizon statistical and qualitative thematic analysis methods in October 2024 and included in the July-October 2024 progress report provided to MCWH for continuous learning. The data were also included in the final report.

Method/tool and description	Data source/sample	MEL use
HIML SRH Community of Practice BHE Survey MCWH internal reporting tool used to collect post-data via a voluntary survey from individual BHEs about Communities of Practice (CoP) that were delivered on two occasions during HIML SRH implementation (November 2024, March 2025. A third CoP was originally planned for May 2025 but postponed outside of the evaluation period. The survey collected quantitative data about the quality of the CoPs and the extent to which they supported improvements in BHEs knowledge and confidence to deliver SRH education sessions.	45 BHEs in total participated in both CoP surveys.	CoP survey data were cleaned and analysed by Clear Horizon using statistical and qualitative thematic analysis methods and included in progress reports provided to MCWH in November 2024 and April 2025 for continuous learning. The data were also included in the final report.
HIML SRH Partner Monthly Report MCHW internal reporting tool used to collect monthly data from the eight HIML SRH partners via an Excel spreadsheet. The spreadsheet documented quantitative data about community engagement activities, social and traditional media campaigns, and SRH education sessions. It also collected qualitative impact stories using an impact log format that MCWH used for promotional and reporting purposes.	For the period July-October 2024, three partner monthly reports (ACT, VIC, NT) were analysed as the other partners were not yet ready to implement HIML SRH. From November 2024 to June 2025, eight partner monthly reports were received each month. This resulted in 59 partner monthly reports collected in total.	Partner monthly report data were cleaned and analysed using statistical methods by Clear Horizon and included in all progress reports provided to MCWH for continuous learning. Analysis for progress reports did not include impact log data, however, this information was reviewed for qualitative themes and analysed further via a sense-making workshop for inclusion in the final evaluation report. All partner monthly report data were aggregated to provide findings for the final evaluation report.

Method/tool and description	Data source/sample	MEL use
Document Review Audit and content analysis of documents provided by MCWH to support TOC and MEL Plan development, and evidence building against indicators to answer specific KEQs	50 documents were reviewed including: 1 x project brief 1 x project plan 1 x community engagement guide 6 x background documents including MCWH organisational theory of change, MCWH strategic plan 2022-2026, and project materials from previous HIML iterations (COVID, Screening Saves Lives). 10 x MCWH research documents 8 x Project reports to the Department 1 x MCWH Quality Standards for Health Education document 1 x BHE training attendance record 4 x SRH specific BHE training materials including session outlines, presentations and case scenarios 1 x online SRH training course provided by True 7 x CoP session documents 4 x SRH session guides (for each topic) 4 x SRH session presentations (for each topic) 1 x SRH services national handout	Project background documents were reviewed to inform the development of the HIML SRH TOC and MEL Plan and provide descriptive information for the final evaluation report. Other documents listed were used in the final evaluation report to provide contextual and descriptive information about HIML SRH and to answer KEQ indicators related to Relevance and Implementation Quality.

Method/tool and description	Data source/sample	MEL use
Session Participant Interviews Semi-structured interviews (45-60 minutes, online or phone) conducted with session participants (migrant and refugee women) using a question guide to explore participants' views as per the KEQs/ indicators and stories of change using the MSC technique.	Session participants volunteered for interviews via an expression of interest (EOI) process managed by the BHEs during SRH session delivery. 11 participants were then purposefully sampled from the EOI list and interviewed from March to May 2025. The sample represented session participants who had attended at least one of the four SRH topics in most states/territories except for WA and QLD as no interviewees were referred from these states. The sample included migrant and refugee women from Nepali, Dari, Vietnamese, Chinese, and Arabic speaking backgrounds. All participants were offered an interpreter, and three chose this option with the rest of the interviews conducted directly in English.	The interviews were audio recorded, transcribed and cleaned prior being subjected to thematic deductive coding and analysis against the KEQs and indicators. The interview transcripts were also reviewed to draw out MSC stories that were further analysed and selected via a sense-making workshop for inclusion in the final report.
Key informant Interviews Semi-structured interviews (60 minutes, online or phone) conducted with HIML partner representatives, MCWH HIML staff and key stakeholders recommended by MCWH. Interviews were conducted using a question guide to explore key informants' views as per KEQs/indicators and stories of change using the MSC technique.	11 interviews were conducted with 14 key informants (three interviews included two participants each) from March to May 2025. This included 9 interviews with HIML partner representatives, and two interviews with stakeholders that supported the implementation of SRH sessions in their agency settings.	The interviews were audio recorded, transcribed and cleaned prior to thematic deductive coding and analysis against the KEQs and indicators. The interview transcripts were also reviewed to draw out MSC stories that were further analysed and selected via a sense-making workshop for inclusion in the final report.
BHE focus groups Semi-structed focus groups conducted with BHEs (60 minutes, online) who delivered SRH education sessions across Australia. Focus groups were conducted using a question guide to explore BHE's views as per KEQs/indicators and stories of change using the MSC technique.	25 BHEs were initially purposefully sampled and 18 BHEs attended the four focus groups (4-5 per group) held in April 2025. The sample represented most state/ territories except for the ACT which did not refer BHEs for participation, and included BHEs from Nepali, Dari, Chinese, Chaldean, Ukrainian, Thai, Hindi, Serbian, Karen, and Arabic speaking backgrounds.	The focus groups were audio recorded, transcribed and cleaned prior to being subjected to thematic deductive coding and analysis against the KEQs and indicators. The focus group transcripts were also reviewed to draw out MSC stories that were further analysed and selected via a sense-making workshop for inclusion in the final report.

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Health in my Language

Clear Horizon