

Arabic, Punjabi and Vietnamese women's experiences of and access to contraception and women's health care

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About Jean Hailes

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

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

About Multicultural Centre for Women's Health

Established in 1978, Multicultural Centre for Women's Health (MCWH) is a Victorian-based women's health service that works nationally and across the state to promote the health and wellbeing of migrant and refugee women through advocacy, social action, multilingual health education, research, training, and capacity building.

MCWH applies an intersectional lens to understanding and analysing all health issues, including sexual and reproductive health. This lens goes beyond explanations that use single categories such as gender or ethnicity to address structural inequality. Instead, it recognises that women's experiences of inequality reflect specific social, economic and political contexts, systems and structures.

About IndianCare

IndianCare is Victoria's only ethno-specific community organisation and registered charity, set up in 2013 to address the welfare needs of Indian migrants in Victoria using a strengths-based approach. In 2020, IndianCare's work expanded to include migrants from South Asia: Sri Lanka, Pakistan, Nepal, Bangladesh and Myanmar.

IndianCare works with the Indian community and partner agencies to provide a unique and critical service in Victoria's Indian community. IndianCare undertakes activities to enable self-determination among the Indian and wider South Asian communities in Victoria, including through capacity building, community engagement, and referring clients to specialist service providers for support.

Executive summary

Background

This qualitative research project was designed to better understand the experiences of Arabic-, Punjabi- and Vietnamese-speaking women in relation to contraception and women's health care.

In partnership with Multicultural Centre for Women's Health (MCWH) and IndianCare, we conducted focus groups with 54 women from migrant and refugee backgrounds in 3 languages: Arabic, Punjabi and Vietnamese. We aimed to:

- understand preferences around health care providers for women's health issues
- explore experiences of and knowledge about contraception methods
- understand the potential barriers to accessing and using contraception (especially long-acting reversible contraceptives – LARCs).

This work builds on the data collected in the 2024 National Women's Health Survey (NWHS) which was conducted by Jean Hailes in collaboration with the SPHERE Centre for Research Excellence (CRE-SPHERE)ⁱ. The 2024 NWHS explored the experiences, attitudes and beliefs of English-speaking women across Australia related to pregnancy, abortion and contraception.

This qualitative report is designed to explore some of the issues raised by the 2024 NWHS data among women from Arabic-, Punjabi- and Vietnamese-speaking communities. The findings contribute to addressing key gaps in the existing Australian literature regarding migrant and refugee women's experience of sexual and reproductive health service access and contraception use.

Key findings

- Participants experienced systemic barriers to accessing women's health care, including the complexity of health care systems and the cost of services. For some, these challenges were compounded by individual, social or cultural factors.
- GPs were an important provider of women's health care and a key source of contraception information and access for many women. Most women preferred to see female GPs, and many felt more comfortable seeing GPs who share their cultural background.
- While some women knew about or used LARCs, many were unfamiliar and uncertain about them. Concern about unwanted side effects was a significant barrier to use, compounded for some by a lack of information from GPs, hearing negative stories from friends and family, and low trust in the health care system. These findings show similar patterns to the 2024 NWHS results: many women in the general population are concerned about side effects of contraception, have limited understanding of LARCs, and are hesitant to use them.¹

ⁱ For more information about the 2024 NWHS, see www.jeanhailes.org.au/research/womens-health-survey/2024-reports

- Discussion across all groups highlighted the role of culturally responsive care and tailored, culturally appropriate health information and education in ensuring women from migrant and refugee backgrounds can make informed decisions about their women's health and contraception needs.

Recommendations

Based on the current findings, we recommend the following actions to help advance the reproductive health and wellbeing of Arabic-, Punjabi- and Vietnamese-speaking women. We believe it likely that these recommendations will also support women from migrant and refugee backgrounds more broadly.

- There is a need for culturally appropriate health information resources and education about women's health and contraception that enables women from migrant and refugee backgrounds to make informed decisions about their health. Resources and education should:
 - be developed with input from community members
 - address systemic and other barriers to accessing women's health care, such as system navigation, health literacy and confidence/self-advocacy when discussing difficult topics with GPs
 - include balanced information about effectiveness, other possible benefits, and possible side effects of different types of contraception
 - address migrant and refugee women's specific concerns and uncertainties around different types of contraception, rather than simply providing general contraception knowledge.
- Women's health and community organisations can disseminate information through communication channels preferred by Arabic-, Punjabi- and Vietnamese-speaking women, including online channels and community education sessions, to encourage more balanced information-sharing in social groups and communities.
- GPs of all genders and cultural backgrounds must be supported to provide culturally responsive care for women's health issues, and to approach topics such as contraception sensitively.

GPs must be supported to provide comprehensive contraceptive counselling – including balanced information about different methods, their effectiveness, other benefits, and possible side effects – to women from migrant and refugee backgrounds who are interested in using contraception.

Introduction

The ability to make free and informed decisions about one's reproductive health is an important human right that requires women having access to reproductive health information and services that meet their needs.^{2,3} Increasing the availability of, and access to, tailored sexual and reproductive health information and services (including effective contraception) have been identified as important ways to improve reproductive health outcomes in communities across Australia.⁴ This is especially important for migrant and refugee women, who experience health inequities due to (often multiple, intersecting) experiences of marginalisation and systemic disadvantage.

An evidence-based understanding of migrant and refugee women's experiences with health care access and contraception use is vital to inform health programs and policies that are responsive to their health needs and experiences. Some evidence shows that women from migrant and refugee backgrounds face significant systemic barriers to accessing sexual and reproductive health services in general, and contraception options in particular, but more research is needed to better understand their unique experiences.^{5,6}

Purpose of this project

This qualitative research project focused on gaining a better understanding of the experiences of Arabic-, Punjabi- and Vietnamese-speaking women living in Australia. We focused on these women because they are from large, growing communities in Australia, and these languages are among the most commonly spoken (other than English) in Australia.⁷

Specifically, this research aimed to:

- understand preferences around health care providers for women's health issues
- explore experiences of and knowledge about contraception methods
- understand the potential barriers to accessing and using contraception (especially long-acting reversible contraceptives – LARCs).

Extending the findings of the National Women's Health Survey (NWHS)

This work builds on information collected in the 2024 NWHS, which explored the experiences, attitudes and beliefs of women across Australia related to pregnancy, abortion and contraception, including LARCs. LARCs include contraception methods such as the contraceptive implant, and hormonal and non-hormonal intrauterine devices (IUDs). LARCs are the most effective contraception at preventing pregnancy, and are also cost effective.^{8,9}

Key findings from the 2024 NWHS included the following:

- There is a disparity between the types of contraception that women want to use and what they actually use.
- Knowledge and understanding of LARCs, including their effectiveness at preventing pregnancy, is low.

- LARC uptake is low, including among those trying to avoid pregnancy and those with high rates of unintended pregnancy.
- Significant barriers to use of LARCs include beliefs around short-term and long-term side effects and requirement for insertion.

The NWHS is an annual survey, conducted by Jean Hailes with funding from the Australian Government Department of Health, Disability and Ageing. It is designed to help us understand the issues that affect women in Australia and their health-related attitudes and behaviours. The findings are used to identify health information gaps and policy changes that will help improve the health and wellbeing of women and girls in Australia.

The NWHS provides important information about population patterns and trends, but does not provide in-depth insights into the experiences of specific groups, such as women from migrant and refugee backgrounds.

The current qualitative research with Arabic-, Punjabi- and Vietnamese-speaking women builds on the findings of the 2024 NWHS and helps to broaden our understanding of women's health and contraception access across communities in Australia.

Approach

Partnerships

This research project was conducted in partnership with two organisations working directly with Arabic-, Punjabi- and Vietnamese-speaking communities in Victoria: Multicultural Centre for Women's Health (MCWH) and IndianCare. This approach was chosen to ensure the project was conducted in a way that was culturally appropriate and accessible for women from these communities.

MCWH and IndianCare contributed to the design of the research materials and recruitment strategy, led participant recruitment, facilitated focus groups, contributed to data analysis and co-authored this report.

Participants and recruitment

Women were eligible to participate if they:

- spoke Punjabi, Arabic or Vietnamese at home
- were aged between 18 and 50 years
- lived in Australia
- were interested in discussing contraception and women's health care in a focus group with other women who speak their language.

MCWH and IndianCare led participant recruitment, drawing on their connections to Arabic-, Punjabi- and Vietnamese-speaking communities. Recruitment channels included a mixture of social media, newsletters and face-to-face community engagement.

All focus group participants provided informed consent to take part, and for their deidentified information to be included in reports about the findings of the research. The participant information and consent forms were written in plain language and explained verbally to participants.

Participants were reimbursed for their time and contribution with a \$100 VISA gift card.

Data collection and analysis

Focus groups were conducted in person and online from March to April 2025. A discussion guide was developed in consultation with MCWH and IndianCare and used to support a consistent approach to the group discussions (see Appendix A).

The focus groups were conducted separately for each language group. Focus groups with Punjabi-speaking women were conducted in a mix of Punjabi and English. Arabic and Vietnamese focus groups were all conducted in language by MCWH's accredited Bilingual Health Educators. This approach helped to ensure a safe and comfortable environment for women to speak openly about their experiences of contraception and women's health.

A total of 54 participants were spread across 6 focus groups (see Table 1).

Table 1. Characteristics of focus group participants

Language group	Number of focus groups	Number of participants	Age range
Arabic	2	20	18 to 50
Punjabi	2	16	21 to 47
Vietnamese	2	18	18 to 50

All focus groups were audio-recorded, transcribed, and then translated into English. The translated transcripts were then analysed with NVivo using thematic analysis to identify key themes relating to the project topics in collaboration with partner organisations. This approach ensures that the reporting of findings accurately represents the contexts of women from migrant and refugee backgrounds.

Findings

Women's health care experiences and preferences

While there were many individual differences in experiences of women's health care, in general, we identified similar themes across all focus groups with Arabic-, Punjabi- and Vietnamese-speaking women. The key themes (discussed below) included systemic barriers to accessing women's health care, the key role of GPs, difficulty discussing certain health topics, and the role of religion and culture.

Systemic barriers to accessing women's health care

Across all groups, women were proactive about seeking help for women's health issues but consistently reported experiencing systemic barriers to accessing care. Those barriers, such as costly services and navigating complex health care systems, are compounded for women who do not have access to Medicare due to their visa status. Some women experienced additional challenges due to individual, social or cultural factors such as discomfort discussing issues with some health care professionals and juggling competing priorities such as work, study and family commitments.

Complex health care systems

Many women experienced challenges navigating the health care system in Australia, especially around accessing the information they need.

For example, while many women expressed interest in attending screening programs, they also reported confusion around timing, cost and eligibility for these programs. The lack of targeted information for migrant and refugee women and other systemic factors contribute to their underrepresentation in national screening programs.^{10,11}

"I have noticed, for example, Western women often go for breast cancer screenings or cervical screenings. But I don't know where to find that kind of information." (Vietnamese-speaking participant)

Some women were not aware of the low-cost services they could access, such as free or low-cost women's health clinics operating in Victoria. When they have the appropriate information, women want to engage with those services.

"Now that we know more, we will go there, that's good." (Vietnamese-speaking participant)

This finding may reflect limited promotion of available women's health services in migrant and refugee communities, leading to a lack of awareness of the free or low-cost services.

Issues related to transport and location of services

Lack of transport and the distance to health services was another challenge described by women in the groups.

"The older women might have to travel to other suburbs, or take public transport, or rely on their children to take time off work and bring them to appointments." (Vietnamese-speaking participant)

Time spent travelling to appointments was a concern for some, especially those juggling parenting responsibilities.

“Honestly, even if you're driving a car, for example, I have children in school, I have to go to them and the appointment must be at the same time they are at school, I may not arrive at the appointment on time, so the proximity of the clinic or the doctor will certainly make a difference.” (Arabic-speaking participant)

In addition, dislocated services meant that women might need multiple appointments at different times and locations for the one health issue (for example, if they require blood tests or scans).

Costly services

Cost of appointments was a concern for women and a deterrent to seeking care, particularly when multiple appointments are required for the one health issue. Women noted that the high cost of appointments was compounded for some by intersecting challenges such as low income, lack of access to Medicare due to their visa status, and the general high cost of living in Australia.

“If we can endure it, we will not go to see the doctor. Seeing that the fees are too much, I feel discouraged.” (Vietnamese-speaking participant)

Another participant highlighted that unaffordable services can result in people going to emergency services to access the care they need.

“Also, because of high prices, people go to the emergency, because most clinics now take fees for checkups, so they try to go to the emergency.” (Arabic-speaking participant)

Long waitlists

Availability of appointments and long waitlists, especially to see female GPs, was a concern for many women. In addition to being frustrating, some women noted how long waitlists to see doctors could pose risks to their health.

“It may be a simple issue, but it becomes complicated, because of the period we wait.” (Arabic-speaking participant)

Lack of relevant information and resources on women's health

Women described challenges related to the accessibility of relevant health information. For some, those challenges were due to a lack of awareness and understanding of health issues and preventive health measures. For others, the challenges were around locating information to help them make informed decisions about their health, including a lack of translated information.

“Whenever I go to a GP clinic, I notice they have a lot of brochures about different health issues available in English for patients to read. But I haven't seen any in Vietnamese. I think if there were brochures in Vietnamese explaining common illnesses women often encounter, how to prevent them, or where to go for check-ups, it would be really helpful for people who are migrants like us.” (Vietnamese-speaking participant)

Language barriers

Women spoke about experiencing language barriers when seeing English-speaking GPs and having trouble understanding some medical terminology. While some women described their own strategies to help overcome language barriers, and others were comfortable communicating in English, few

mentioned using interpreting services to help them communicate when they experienced a language barrier.

It was not clear from the discussion why few women used interpreting services. In other research, health services and interpreters themselves have reported a range of systemic barriers, including length of consultation, administrative time required to book an interpreter, availability of preferred gender and language of interpreter, under-resourcing of interpreter services for rare and emerging languages, and the lack of specialised training and support for this workforce.^{12,13}

Challenges related to care from GPs

Women also described challenges related to care in the primary health care system, for example, that GPs can be rushed, do not give enough information, and can be dismissive. Some women spoke of particularly negative experiences that affected their trust in the health system and impacted their intention to engage with health services in the future. The role of GPs in providing women's health care to Arabic-, Punjabi- and Vietnamese-speaking women is described in further detail below.

The key role of GPs

In general, women were proactive about seeking help when they needed it, and GPs were the first port of call for many when they needed help with a women's health issue. Women spoke about various qualities that they valued in a GP, including:

- doctors who help them understand issues, for example, by explaining things clearly and printing out important information such as test results
- expertise in the area or issue of concern
- respect
- trust
- rapport
- continuity of care.

Some women were comfortable talking to a GP about their health issues. They tried to share all the relevant information with their doctor because they felt this was important for receiving the appropriate treatment. Some were 'matter of fact' when it came to discussing sensitive topics with their GPs.

"The doctor's visit is ineffective if we don't talk about our conditions." (Vietnamese-speaking participant)

Some women said that they might delay seeing a doctor if they thought the issue would resolve on its own or with home remedies.

"Not because there's shame or horror about it, no, sometimes I feel that I have to try some things and then go. If it doesn't work, I'll go to the clinic." (Arabic-speaking participant)

Many women preferred to see female GPs when they needed help with women's health issues, especially if they required tests or examinations. For example, some felt they could be more open or comfortable with a female doctor, or that female doctors would have a better understanding of women's health issues.

The discussions also highlighted the importance of culturally responsive care, i.e. health care that is 'respectful of, and relevant to, the health beliefs, health practices, culture and linguistic needs'¹⁴ of different communities.

Some women preferred to see GPs who share their cultural or linguistic background. For some this was due to language barriers, but others described feeling more comfortable, familiar or free to speak more openly with a doctor from their cultural background. For example, one Punjabi-speaking woman said that for her, it was important that her doctor understood her cultural beliefs and upbringing, and felt that doctors from other cultures might make assumptions about her level of knowledge of women's health issues.

"I feel that if it's a Vietnamese doctor, her mum or grandma must be Vietnamese too. So even though she was trained in Australia or she had working experience in Vietnam, she might approach our concerns with a perspective that includes both scientific knowledge and cultural understanding." (Vietnamese-speaking participant)

Difficulty discussing certain health topics

While some women were comfortable talking to their GP about sensitive issues, others discussed finding it hard to talk with their GP about topics including sex, abortion, depression and anxiety, because of fear of judgement, discomfort and social taboos.

“Yes, we can’t openly discuss our problems. We feel that the person in front of us is judging us.” (Punjabi-speaking participant)

Some women spoke about strategies to enable them to discuss challenging topics. For example, one woman described writing down a question that she wasn’t comfortable asking on piece of paper and handing it to their doctor. Another woman spoke about the value of self-reflection, rejecting social taboos and becoming more comfortable with topics such as periods and sex.

“...inside us we have to do our work, like you have to get out of this way of thinking.” (Punjabi-speaking participant)

This finding highlights a need for culturally appropriate health education and resources that help to build women’s capacity and confidence to discuss challenging topics with their GPs. Additionally, it points to the importance of health providers creating a safe environment to encourage women to feel comfortable raising issues without fear of judgement.

The role of religion and culture

Across all groups, women discussed whether their culture influenced their access to women’s health care or contraception. There was a wide range of answers, reflecting the diversity in and across all cultures.

Some women discussed social taboos and social pressures within their communities around topics such as periods, sex and contraception. For example, a few women described trying to conceal the fact that they were menstruating, and hesitating to buy menstrual pads if they noticed other people from the same cultural background nearby. Cultural advisors who attended focus groups with Punjabi-speaking participants noticed that some women who were not married were hesitant to discuss topics such as contraception during the groups, and suggested that this may be due to cultural norms around not having sex before marriage.

Nevertheless, many participants said that their cultural background did not influence their decision-making in relation to contraception.

“For me, I don’t think it’s haram [forbidden], or a shame if you don’t have a child and [sic] you can’t raise him or take responsibility. What is the point of having children if I cannot take responsibility for them or raise them in the right way?” (Arabic-speaking participant)

Women’s answers about whether their religious attitudes impacted their access to women’s health care, including contraception, were equally diverse.

“I think for me, yes, I think religion plays a role in shaping my thinking. Yes, culture also plays a role. If we were white kids, we would have thought something else. (Participants laugh) But now we are Indians and we are not so open. So we think differently.” (Punjabi-speaking participant)

“Vietnam doesn't have that issue of religion; it doesn't affect the use of contraception. So, in my mind, I don't even think about that factor. Maybe it's because of Vietnamese culture.”

(Vietnamese-speaking participant)

These comments highlight the risks of making generalisations about the cultural or religious attitudes or values of any single group based on their ethnicity, and the importance of acknowledging the range of factors that might influence a woman's personal attitudes including age, gender, sexuality, religious background, income, employment and socio-economic background.

Contraception knowledge and experiences

Across all groups, women discussed a range of contraceptives and had varying levels of knowledge and experience with different methods. Women had questions about different methods, including in relation to effectiveness and safety. Many women were keen to learn more about contraceptive options, so that they could make informed decisions about their health and support their children to do the same.

Three key themes related to contraception knowledge and experiences are discussed below:

- GPs are a key source of contraception information and access.
- Family and friends are an important source of contraception information.
- Many women do not know about LARCs and are reluctant to use them.

GPs are a key source of contraception information and access

GPs were a key source of contraception information and access for many women, and the way GPs approach the issue may influence subsequent decisions around use of contraception.

Some women reported that GPs withheld important information about side effects, or that they did not trust the information provided by GPs, potentially leading to decreased trust in the health care system. This is consistent with previous research showing that GPs – and the health care system more broadly – have a key role to play in supporting women’s access to and use of contraception, and that the way health professionals engage in discussions about contraception can influence women’s contraceptive choices and continuation.^{15,16}

This finding highlights a need for all GPs to be supported to provide women from migrant and refugee backgrounds with comprehensive contraceptive counselling that addresses women’s specific concerns, including balanced information about side effects and possible harms, to ensure women feel empowered to make informed decisions about their sexual and reproductive health.

Family and friends are an important source of contraception information

Discussions with family and friends were another important source of contraception information, and women described how their intention to try certain methods was sometimes influenced by information and advice from family and friends.

Many women described hearing about side effects from their friends and family, which influenced their openness to try certain methods in the future.

“Regarding side effects or complications, I have heard a few stories from people who experienced changes after using contraceptive methods including the implant for a few years. They said it a bit affected their behaviour. So, after hearing about those negative side effects, I got a bit scared and didn’t want to try those methods.” (Vietnamese-speaking participant)

Other women spoke about seeking advice from friends or family members with more contraception experience.

“Like after marriage, I think I will ask first [participant’s name] because [participant’s name] is my best friend. If you want to trust a friend, you ask something. Then I first call her and ask about her experience and what is good and what is not good.” (Punjabi-speaking participant)

This finding is consistent with previous research that shows that experiences of friends and peers, as well as the influence of family members, are important factors influencing women's decisions around contraception.¹⁵

Lack of awareness about LARCs

There was a range of attitudes towards and experiences of LARCs within the groups, but in line with the findings from the 2024 NWHHS, many women did not know a lot about LARCs and were uncertain about using them.

"I have not used these. I have heard about its two side effects – periods to stop or become irregular and weight gain or hormonal imbalance. I am not comfortable with them either, I have heard from too many people. For these reasons I stop myself to use it. Again, if we get the knowledge, then we can think about it." (Punjabi-speaking participant)

"I've never heard of an IUD in my life, I haven't tried it, but I have two friends who put IUDs and caused them many problems." (Arabic-speaking participant)

There were also some misconceptions about LARCs, especially IUDs. For example, that they are only suitable for women who have given birth vaginally, that they can be removed by oneself, and that they must be changed with every menstrual period. While only reported by a small number of women, it is important that culturally appropriate health information and education initiatives dispel these myths and ensure women can make informed decisions about the best contraception method for them.

Barriers to using contraception

Women discussed a range of barriers that made it difficult to access and use contraception, including: concerns about unwanted side effects; a lack of tailored, culturally appropriate information; cost; convenience and access; and concerns about contraception insertion. A small number of participants also said that pressure from family members influenced their use of contraception. These barriers were discussed in relation to many types of contraception, but most frequently around the oral contraceptive pill, the contraceptive implant and IUDs.

Concerns about unwanted side effects

Concern about unwanted side effects was the most mentioned barrier to using contraception, and was frequently discussed in relation to hormonal contraceptives like the oral contraceptive pill, contraceptive implant and IUD.

Women discussed their own experiences of contraception side effects as well as the experiences of friends and family members and information they had gleaned from online sources. Some women noted that their concerns about side effects, in the absence of reliable contraception information, deterred them from using certain methods.

Concerns about side effects are not unique to migrant and refugee women. Consistent with the findings from the 2024 NWHHS and other previous research, concerns about side effects and other health impacts are important factors influencing the contraceptive choices of women across Australia and globally.¹⁵

These findings highlight a need for culturally appropriate health information and education that seeks to address women's specific concerns and uncertainties around different types of contraception, rather than simply providing general contraception knowledge.

Lack of tailored, culturally appropriate information

Many women spoke about not having enough information to make informed choices about contraception, and described challenges navigating often conflicting sources of information, e.g. from GPs, online sources or friends and family.

While for some women the internet was a helpful source of information, or a “*non-judgmental go-to person*” (Punjabi-speaking participant), others found the volume of online information overwhelming.

“And the more we open Google, the more different knowledge we get. Every link, every website has something new.” (Punjabi-speaking participant)

Women suggested different ways to improve access to information about contraception, including through group women's health education sessions or having one official source of contraception information.

Cost

Affordability was a concern for some women, particularly in relation to the oral contraceptive pill and LARCs. Women discussed how the cost of taking the pill added up over time and that up-front costs for the contraceptive implant could be prohibitive, especially for those without access to Medicare.

Convenience and access

Convenience of and access to contraception played a role in women's decision-making about contraception. For some, the requirement for insertion and removal of an IUD by a trained professional was difficult due to spending time on waitlists, both to have an IUD inserted and removed.

"You take a referral to the hospital and wait on the waiting list to put it in, and when you want to remove it, you have to do the same. This is the obstacle for me." (Arabic-speaking participant)

Some women discussed feeling embarrassment trying to access the emergency contraceptive pill and felt that the requirement to answer invasive questions (e.g. about when they last had sex) was a barrier.

The requirement to take the oral contraceptive pill every day was described as a challenge for some women, who expressed fear that they would forget to take a pill, knowing that it has to be taken every day to ensure its effectiveness.

On the other hand, some discussed the 'set-and-forget' nature of LARCs positively, with one woman describing it as "*very convenient and practical*" (Vietnamese-speaking participant). Women also spoke about the benefits of using condoms, including the range of different types to choose from and the fact that they are easily accessible from the pharmacy.

Concerns about contraception insertion

Some women had reservations about forms of contraception which required insertion, particularly in relation to LARCs. Some described uncertainty related to the insertion process itself, including that it sounded painful and complicated. Others had fears that the IUD or implant would move inside their body once inserted.

Some women described general feelings of apprehension about having a contraceptive device inside their body.

"I dislike putting strange objects in my body." (Vietnamese-speaking participant)

One woman also noted that the requirement for insertion was particularly challenging due to a lack of trained female GPs who could perform these procedures.

Pressure from family members

A small number of women described experiencing pressure from family members to not use contraception. For example, due to concerns about side effects such as weight gain, or pressure to continue having children.

"There is pressure on me to have my next child in a year and finish off with birthing. I said no – it's not that finish off job. I don't want to rush it." (Punjabi-speaking participant)

"Sometimes your husband refuses that you take pills, needles or any other kind." (Arabic-speaking participant)

Pressure from family members and other forms of reproductive coercion¹⁷ occur across communities in Australia. While little is known about the experiences of migrant and refugee communities, systemic issues can make women from migrant and refugee backgrounds more vulnerable to this form of

abuse.^{18,19} For example, barriers to health care and other forms of support can make it difficult for women to seek help, and some women might have a precarious visa status that can be weaponised to prevent them from seeking help or leaving abusive relationships.

Impact of barriers to contraception

Women reported being impacted by barriers to contraception in different ways. For example, some women mentioned being deterred from using contraception, while others reported using less invasive forms of contraception such as withdrawal and 'natural' methods, which have lower levels of effectiveness at preventing pregnancy.^{20,21}

Strengths and limitations

This qualitative research was designed to gain deeper insights into the experiences of Arabic-, Punjabi- and Vietnamese-speaking women from migrant and refugee backgrounds in relation to contraception and women's health. The findings complement quantitative information from the 2024 NWHHS to broaden the picture of contraception knowledge and use among different communities in Australia.

Partnering with organisations working directly with women from migrant and refugee backgrounds helped Jean Hailes to ensure that the project was conducted in a way that was culturally appropriate. For example, the involvement of accredited Bilingual Health Educators helped to establish a safe environment for women to discuss their experiences. Despite this, given the potentially sensitive nature of topics being discussed, it is still possible that some participants may not have felt comfortable to discuss their views and experiences openly. This should be taken into consideration when viewing the findings of this research.

This research was conducted with a relatively small number of women in Melbourne, Australia, and does not reflect the experiences or views of all women from Arabic-, Punjabi- and Vietnamese-speaking communities. Many factors, including where one lives, their visa status, socioeconomic factors, upbringing, length of time in Australia and individual characteristics can influence women's experience of, and access to, women's health care and contraception.

Conclusions

Participants experienced systemic barriers to accessing women's health care, including the complexity of health care systems and the cost of services. For some, these challenges were compounded by individual, social or cultural factors.

Discussion highlighted the role of GPs as important providers of women's health care, and a key source of contraception information and access for many women. Most women preferred to see female GPs, and many felt more comfortable seeing GPs who share their cultural background.

Some women had a lot of knowledge about LARCs, like IUDs and the contraceptive implant, and some were using them. However, many were unfamiliar and uncertain about LARCs. Concern about unwanted side effects was a significant barrier to use, compounded for some by a lack of information from GPs, hearing negative stories from friends and family, and low trust in the health care system. This is similar to the 2024 NWHHS findings in the general population: many are concerned about side effects of contraception, have limited understanding of LARCs and are hesitant to use them.¹

Discussion across all groups highlighted the role of culturally responsive care and tailored, culturally appropriate health information and education in ensuring women from migrant and refugee backgrounds can make informed decisions about their women's health and contraception needs.

References

1. Jean Hailes for Women's Health. *Australian Women's Knowledge of Intrauterine Devices (IUDs) for Contraception*. Jean Hailes for Women's Health; 2025. https://www.jeanhailes.org.au/uploads/15_Research/nwhs24_report_IUDs.pdf
2. *Beijing Declaration and Platform for Action: Beijing+5 Political Declaration and Outcome*. UN Women; 2014. <https://www.unwomen.org/en/digital-library/publications/2015/01/beijing-declaration>
3. United Nations General Assembly. *Convention on the Elimination of All Forms of Discrimination against Women*. 1979. <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women>
4. Community Affairs References Committee. *Ending the Postcode Lottery: Addressing Barriers to Sexual, Maternity and Reproductive Healthcare in Australia*. Community Affairs References Committee; 2023.
5. Multicultural Centre for Women's Health. *Data Report: Sexual and Reproductive Health 2021*. 2021. <https://www.mcwh.com.au/wp-content/uploads/SRH-Report-2021-for-web-accessible.pdf>
6. Hach M. *Common Threads: The Sexual and Reproductive Health Experiences of Immigrant and Refugee Women in Australia*. Multicultural Centre for Women's Health; 2012. https://www.mcwh.com.au/downloads/publications/MCWH_CommonThreads_Report_WEB.pdf
7. Australian Bureau of Statistics. *Cultural Diversity of Australia*. ABS; 2022. Accessed May 30, 2025. <https://www.abs.gov.au/articles/cultural-diversity-australia>
8. Concepcion K, Lacey S, McGeechan K, Estoesta J, Bateson D, Botfield J. Cost–benefit analysis of enhancing the uptake of long-acting reversible contraception in Australia. *Aust Health Rev*. 2020;44(3):385. doi:10.1071/AH18190
9. FSRH Guideline (January 2019, amended October 2023) Combined Hormonal Contraception. *BMJ Sex Reprod Health*. 2019;45(Suppl 1):1-93. doi:10.1136/bmjsex-2018-CHC
10. Australian Institute of Health and Welfare. *Analysis of Cancer Outcomes and Screening Behaviour for National Cancer Screening Programs in Australia*. Australian Institute of Health and Welfare; 2018. <https://www.aihw.gov.au/getmedia/0c4daae9-d0c6-422a-afbd-47a36c6c8697/aihw-can-115.pdf.aspx?inline=true>
11. Yuill S, Egger S, Smith MA, et al. Participation in the national cervical screening programme among women from New South Wales, Australia, by place of birth and time since immigration: A data linkage analysis using the 45 and up study. *J Med Screen*. 2024;31(1):35-45. doi:10.1177/09691413231184334
12. Foundation House. *Promoting the Engagement of Interpreters in Victorian Health Services*. 2013. Accessed June 16, 2025. <https://apo.org.au/node/35249>
13. Sullivan C, Block K, Murray L, et al. Working with interpreters in the family violence sector in Australia: "It's very hard to be in between." *Int J Intercult Relat*. 2023;96:101871. doi:10.1016/j.ijintrel.2023.101871
14. Victorian Government Department of Health & Human Services. *Cultural Responsiveness Framework - Guidelines for Victorian Health Services*. 2011.

https://content.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/c/cultural_responsiveness---pdf.pdf

15. D'Souza P, Bailey JV, Stephenson J, Oliver S. Factors influencing contraception choice and use globally: a synthesis of systematic reviews. *Eur J Contracept Reprod Health Care*. 2022;27(5):364-372. doi:10.1080/13625187.2022.2096215
16. Dehlendorf C, Krajewski C, Borrero S. Contraceptive Counseling: Best Practices to Ensure Quality Communication and Enable Effective Contraceptive Use. *Clin Obstet Gynecol*. 2014;57(4):659-673. doi:10.1097/GRF.0000000000000059
17. Grace KT, Anderson JC. Reproductive Coercion: A Systematic Review. *Trauma Violence Abuse*. 2018;19(4):371-390. doi:10.1177/1524838016663935
18. Suha M, Murray L, Warr D, et al. Reproductive coercion as a form of family violence against immigrant and refugee women in Australia. Salinas-Miranda A, ed. *PLOS ONE*. 2022;17(11):e0275809. doi:10.1371/journal.pone.0275809
19. MSI Australia. *Hidden Forces: A White Paper on Reproductive Coercion in Contexts of Family and Domestic Violence (Second Edition)*. MSI Australia; 2020. <https://www.msiaustralia.org.au/wp-content/uploads/Hidden-Forces-Second-Edition-.pdf>
20. Teal S, Edelman A. Contraception Selection, Effectiveness, and Adverse Effects: A Review. *JAMA*. 2021;326(24):2507. doi:10.1001/jama.2021.21392
21. Sexual Health Victoria. Withdrawal (pulling out). Published online June 10, 2021. <https://shvic.org.au/for-you/contraception/withdrawal-method-pulling-out>

Appendix A: Discussion guide

About this guide

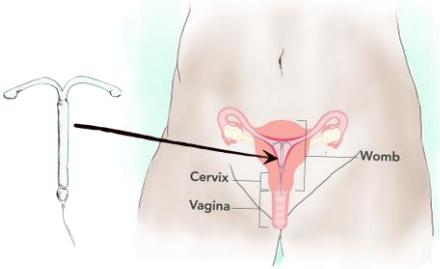
Use this document to guide the discussion with Punjabi, Arabic and Vietnamese-speaking women about contraception and women's health care.

You don't necessarily need to read out every question exactly as it is worded here, as long as all questions are covered.

Use follow up questions to explore the main question in more depth.

Use prompts (in square brackets and blue text) as a last resort if participants aren't saying anything or if participants don't understand the question. Prompts can be used to gently get the discussion back on track.

Question	Follow up questions and prompts
Women's healthcare experiences and preferences	
1 Where do you go when you need help for a women's health issue?	
2 Have you experienced any challenges finding and accessing the women's health care you need? Tell us about your experiences.	What would make it easier to get the women's health care you need? Can you get an appointment when you need one? [Prompts if necessary: difficulty finding the right service, cost, issues related to visa status]
3 Would you say your doctor provides you with information in ways that are easy to understand? Tell us about some examples.	[Prompts if necessary: Do they provide information in your language? Do they use an interpreter?]
4 What is important to you when choosing a doctor?	[Prompts if necessary: Are they the same gender as you (e.g., woman)? Do you prefer them to be from your cultural background? Do they speak your preferred language? Does cost or the availability of bulk billing affect your decision to seek services? Is accessibility, such as proximity to public transport, important to you?]
5 Are there any issues you would be unlikely to raise with your doctor? Why are you unlikely to raise those things with your doctor?	[Prompts if necessary: periods, itchy or sore genitals, sex, menopause]
Contraceptive knowledge and attitudes	
6 One of the uses of contraception is to prevent getting pregnant. What different types of contraception do you know about?	Where did you hear/learn about them? Who or where do you go to for information about contraception? Has your doctor/nurse/health professional ever discussed contraception with you? Which options did they discuss?
7 Do you have a preference for a specific type of contraception?	Which one? Why?

8	Where would you go to access contraception?	
Contraceptive barriers		
9	Is there anything that has made/would make it hard for you to use contraception?	<p>Can you please share more details about the challenges you might face when using contraception? Anything else that makes you feel uncomfortable to use? [Prompts if necessary: cost of the contraception, cost of seeing doctor to have contraception prescribed or inserted, pressure from partner or family member, side effect worries, religious or cultural reasons]</p>
Long-acting reversible contraception (LARC) knowledge, attitudes, barriers		
10	<p>One type of contraception is contraceptive match-sized implant that goes under the skin on your arm.</p>  <p>Have you heard about the contraceptive implant before?</p>	<p>Where did you hear about it? What have you heard about it?</p> <p>Would you consider using the contraceptive implant? Why/why not?</p>
11	<p>Another type of contraception is the intrauterine device (IUD) that is inserted into your uterus.</p>  <p>Have you heard about the intrauterine device (IUD) before?</p>	<p>Where did you hear about it? What have you heard about it? Would you consider using the intrauterine device (IUD)? Why/why not?</p>
Anything else?		
12	Is there anything else that you want to add to the focus group discussion today regarding contraception use and women's healthcare access experiences?	