

Community consultations with Afghan women on menopause & contraception

A community-led engagement project with
Community Hubs Australia in VIC, SA & QLD

June 2026



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About Jean Hailes for Women's Health

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

Jean Hailes is working to create an Australia in which gender has no influence on health and wellbeing outcomes. We are working collaboratively with and alongside others to systematically identify and overcome structural, social and cultural barriers through a focus on four key pillars:

- providing health information that women need to make decisions about their health,
- conducting advocacy that addresses the barriers that women experience,
- sharing clinical expertise across Australia,
- and partnerships that connect organisations and initiatives across the health and related sectors to facilitate and drive change for women's health.

About Community Hubs

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

Executive Summary

This report presents findings from the community-led consultation project undertaken by Jean Hailes in partnership with Community Hubs Australia. The project explored how Afghan women in Australia access and use women's health information, with a focus on menopause and contraception, and gathered feedback to inform future culturally responsive resources.

Consultations were held with 68 Afghan women across 8 Community Hubs in Victoria, South Australia and Queensland. Women shared their experiences through focus group discussions and surveys in safe, familiar and women-centred settings supported by interpreters, childcare, catering and participant reimbursement.

Key findings indicate that Afghan women actively seek health information, often starting online or through community networks before confirming information with trusted sources such as GPs, female health professionals, family, friends and community leaders. Language, interpreter quality, literacy levels and confidence navigating the Australian health system strongly shaped women's access to information and care.

Menopause and contraception knowledge were shaped by cultural, religious, family and migration experiences. Women wanted clear, practical and non-judgemental information about symptoms, treatment options, contraception methods, side effects and information on when to seek medical advice. Feedback on Jean Hailes resources was largely positive, particularly where information was plain, visual and available in community languages.

The project recommends developing multilingual, visual-first and easy-read resources, including short videos, audio content and practical tools that help women prepare for healthcare appointments. Resources should be shared through trusted community settings such as Community Hubs, English language classes, settlement services, women's groups, maternal and child health services and peer networks.

Introduction

Background

Afghan communities are an important and growing part of Australia's multicultural population.¹ Victoria is home to the largest Afghan community in Australia, with 43,845 people reporting Afghan ancestry and 25,432 people born in Afghanistan.² Recent humanitarian settlement patterns also highlight the continuing relevance of Afghan community engagement, with Afghanistan recorded as the largest citizenship group granted offshore humanitarian visas to Australia in 2024–25.³

Women from Afghan backgrounds, particularly those who have arrived through refugee or humanitarian pathways, are newly settled, or have limited English proficiency, may experience barriers when accessing health information and healthcare services. These barriers can include language differences, limited familiarity with the Australian healthcare system, varying levels of health literacy, cultural and religious considerations, and difficulty finding information that is understandable, relevant and culturally safe.^{4,5}

Existing research with Afghan communities in Australia has explored important areas such as family planning, contraception, pregnancy, early motherhood, sexual and reproductive health and mental health.⁴ However, there remains limited qualitative research on Afghan women's broader women's health information needs, particularly beyond maternal health contexts and across later life stages such as menopause. This gap is important because access to accurate, trusted and culturally responsive information can influence women's confidence, healthcare engagement and capacity to make informed decisions about their health.^{4,6}

Menopause and contraception were selected as focus areas because they represent two life-stage topics where women may need clear, practical and culturally appropriate information, but where discussion can be limited by stigma, privacy, language, family expectations or uncertainty about the Australian health system. These topics also provide an opportunity to better understand how Afghan women prefer to receive health information, who they trust, what formats are most useful, and what support is needed to make resources more accessible.

This project was undertaken to strengthen the evidence base for developing women's health resources with and for Afghan women in Australia. By listening directly to Afghan women through trusted community settings, the project aimed to identify barriers, preferences and opportunities for improving the relevance, accessibility and cultural safety of Jean Hailes resources and future health promotion activities.

About the project

Through a series of community consultations, the project sought to explore how Afghan women, who spoke either Dari, Pashto or Hazagari access and engage with health information, identify barriers and gaps in existing resources, and gather feedback to support the development of culturally appropriate women's health information and health promotion initiatives.

Project objectives

The objectives of this project were to:

- Understand how Afghan women currently access health information and navigate healthcare services.
- Identify gaps, barriers and cultural considerations that may influence women's access to and engagement with health information.
- Explore whether existing Jean Hailes resources are accessible, appropriate and culturally safe for Afghan women.
- Gather feedback to inform the development of future women's health resources and health promotion approaches in partnership with Afghan communities.

Approach

To address these objectives, consultations explored women's experiences of accessing health information and healthcare services, including the sources and channels they use and trust. Participants were invited to share feedback on the accessibility, usefulness and cultural relevance of existing Jean Hailes resources, including the language, format and content. Discussions also explored cultural beliefs, concerns and barriers that may influence engagement with women's health information, as well as gaps in existing resources and topics where further information might be needed. Participants were encouraged to provide recommendations on how resources and health promotion approaches could be improved to better meet the needs of women in their community.

Partnership development

This community project was delivered in partnership with the Community Hubs program, building on an established collaboration through previous Women's Health Week initiatives. The partnership facilitated engagement with Afghan women who speak Dari, Pashto and Hazaragi.

Other organisations supporting Afghan women were also contacted; however, these options could not be progressed within the project timeframe due to capacity of the other organisations.

Key engagement activities with the Hubs included:

- Establishing relationships with Community Hub leaders to identify priority health topics, participant numbers and eligibility requirements.
- Coordinating consultation planning and logistics, including venue bookings, scheduling and resource requirements.
- Collaborating on the development of culturally appropriate consultation questions and incorporating feedback to inform the project approach and evaluation.

Recruiting Afghan women

Community Hub leaders facilitated the recruitment of participants from Afghan backgrounds, providing each with a project flyer and an information sheet outlining the purpose and scope of the consultations. All participants completed a consent form and were clearly informed of the voluntary nature of their involvement as well as the confidentiality of their contributions.

To support accessibility and inclusion, interpreters were used where required to support effective communication. Childcare and catering were also provided to make it easier for participants to attend and take part. In recognition of their time and contribution, each participant received a \$100 Visa gift card.

Data collection and analysis

A mixed-methods approach was adopted for this project, incorporating both qualitative and quantitative data collection. The qualitative component consisted of 8 in-person focus groups facilitated by Jean Hailes staff and supported by interpreters. Each focus group focused on a single topic: either menopause or contraception. In total, three contraception focus groups were held with 28 participants, and five menopause focus groups were held with 40 participants.

A structured discussion guide was used with open-ended questions designed to explore participants' views, experiences, and preferences. The focus groups were audio recorded via Microsoft Teams to support accurate notetaking and ensure the integrity of the data collected.

A general inductive approach was used to analyse the qualitative data. Notes from the consultations were imported into NVivo software to support a systematic thematic analysis. Initial open coding was undertaken, followed by an iterative refinement process in which codes were reviewed, grouped, and consolidated into a set of overarching themes. These themes form the basis of the findings presented in this report.

In addition, a paper-based survey was administered to collect quantitative data. The survey captured participant demographics, information preferences, and the option to give anonymous information. This data provided complementary insights and helped to strengthen the overall interpretation of the findings.

Participants

Overall, A total of 68 Afghan women participated in the consultations across 8 Community Hubs in Victoria, South Australia and Queensland. The sample included women in both topic focus groups, with 40 participants taking part in menopause consultations and 28 taking part in contraception consultations.

Participation was highest in Victoria, with 33 participants, followed by South Australia with 26 participants and Queensland with 9 participants. Overall, the participant group reflected a mix of ages, education levels and settlement experiences, providing useful insight into the health information needs of Afghan women at different life stages and with different levels of familiarity with Australian health systems.

Table 1. Participants across states

State	Number of participants
Victoria	33
South Australia	26
Queensland	9
Total	68

Participant ages were predominantly between 25 and 45 years (87%). Table 2 shows that the 31–35-year age group was the most represented, followed by the 36–40-year and 25–30-year age groups.

Table 2. Participant age distribution and topic of focus group

Age group	Number of participants in Menopause n=40	Number of participants in Contraception n=28
25–30	6	8
31–35	10	8
36–40	12	4
41–45	8	4
46–50	1	1
51–55	2	1
56–60	0	1
60+	1	1
Total	40	28

Participants also represented a range of settlement experiences. All participants identified as first-generation migrants, and the largest proportion (n= 21) had lived in Australia for more than 10 years.

Table 3. Length of time living in Australia

Length of time living in Australia	Number of participants
Less than 1 year	8
1-3 years	16
4-6 years	5
7-10 years	18
More than 10 years	21

Educational attainment varied considerably across the participant group. Just over two-thirds of participants (66%) reported either no formal education or primary school education as their highest level of schooling, while smaller proportions had completed secondary education (15%), vocational training (6%), university education (10%) or postgraduate study (3%).

Table 4. Highest level of education

Highest level of education	Number of participants
No formal education	19
Primary school	26
Secondary school	10
Vocational or job training	4
University	7
Postgraduate	2
Total	68

Key findings

Women's health information

Health information seeking is layered and self-directed

Participants described health information seeking as a step-by-step process that usually begins online before moving into formal healthcare. Google, social media and increasingly AI tools are often the first point of contact used to make sense of symptoms and decide whether something needs further attention. As one participant put it, *"Always search online... then when I go to my doctor, they say the same thing."* Another described this as a *"50/50 belief,"* capturing how information online is considered helpful but not fully trusted.

Online searching was often described less as a source of certainty and more as a way of building awareness. One participant explained it as *"awareness rather than belief."* Social media, including Instagram, TikTok, Facebook and WhatsApp, plays a secondary but notable role in shaping this awareness, particularly when content is shared within trusted community networks or delivered in-language. Engagement cues such as likes and comments are sometimes used as informal signals of credibility. They also check in with friends or community members to sense-check what they've found, before weighing it against GP advice.

GPs remain the most trusted and authoritative source of health information, particularly for concerns perceived as serious, with a clear preference for female GPs reflecting the importance of comfort and cultural safety. However, access to GP services can be a point of friction, with digital tools often used to bridge gaps when appointments are delayed or hard to access.

Overall, no single source is viewed as fully reliable. Participants consistently cross-reference information across channels, comparing online content with GP advice and validating it against community knowledge. This points to a strong appetite for simplicity *"It would be nice to have one place to trust."* Trust is actively constructed through confirmation and comparison, and information is most likely to be acted on when it aligns with a trusted GP or is endorsed within trusted community networks.

Language and communication shape both access and quality of care

Language was a key factor shaping women's experiences of healthcare, influencing how confident, comfortable and understood they felt. Participants reported concerns about interpreter quality and accuracy, particularly for medical terminology. As one explained, *"The interpreter didn't know what endometriosis was. So, they didn't translate it."*

While interpreter services were available, they were not always trusted. Some participants relied on family members to assist with communication, despite concerns about privacy and accuracy, particularly for sensitive health issues. Participants also highlighted challenges relating to interpreter gender preferences, dialect differences between Dari, Farsi and Hazaragi, and varying levels of literacy. As a result, some preferred to manage appointments without an interpreter rather than risk being misunderstood.

Cultural expectations and system complexity influence engagement

The contrast with Afghanistan and in some cases Pakistan, Iran, and refugee camps was very stark. Participants described the Australian health system as very different from what they were used to in Afghanistan. In Afghanistan, access to care was described as more direct particularly in relation to specialists, although often unaffordable. In contrast, Australia's system of GP referrals, waitlists and structured pathways was unfamiliar at first.

Some participants described the difference between the systems as significant, with one likening it to the difference between *"the sky and the earth."* While many reported becoming more familiar with how the Australian healthcare system operates over time, this understanding often developed gradually and required a period of adjustment.

Frustration with the healthcare system was commonly linked to long wait times, delays and uncertainty. One participant reflected the impact of extended referral processes by saying, *"You either die by the time you are waiting."* They also described confusion around requirements for prescriptions and diagnostic testing, which differed from healthcare systems in their countries of origin.

Some participants reported feeling dismissed or that their concerns were not taken seriously, describing experiences of ongoing symptoms without clear explanations or diagnoses. These experiences contributed to a loss of confidence in the system, with one woman stating, *"We prefer to just suffer from the pain as opposed to going to the doctor."* Such accounts highlight the emotional toll that prolonged delays and unmet healthcare needs can have on women's willingness to seek care.

Cultural and religious sensitivities around women's health

Women's health was described as closely shaped by cultural and religious beliefs, family expectations and lived experience. Participants discussed topics such as menstruation in the context of religious practices, hygiene routines, dietary beliefs and traditional remedies, while also expressing uncertainty about which practices were culturally based and which were supported by medical evidence.

Reproductive and sexual health, particularly contraception, was identified as an area where women wanted clearer and more accessible information. Questions focused largely on side effects, suitability and safety, rather than reluctance to discuss the topic. Participants also highlighted a need for guidance on issues such as intimacy during menstruation.

Generational differences were evident, with younger participants, particularly those educated in Australia, more likely to adopt biomedical approaches to health, while older participants were described as maintaining traditional understandings and practices. Mental health, including postnatal depression, was also raised as an important but often hidden issue. As one participant noted, mental health is still *"not talked about"* in some communities because of persistent stigma.

Overall, participants emphasised that women's health is understood within a broader cultural and religious framework, which influences how health information is interpreted, trusted and acted upon. As one reflected, navigating these influences can sometimes make it difficult to distinguish between *"what is cultural and what is medical."*

Menopause

Limited foundational knowledge and vocabulary about menopause

Participants reported having limited knowledge about menopause but a strong interest in learning more. Significant knowledge gaps were identified, including uncertainty about when menopause typically occurs, the meaning of perimenopause, whether periods can stop and restart, the influence of stress on menopause timing, and how long symptoms may last.

Importantly, this reflected a lack of access to information rather than a lack of interest. Participants were actively engaged in discussions and frequently asked questions. When presented with a menopause symptom poster, many recognised and related to the symptoms, often responding with visible acknowledgement. The findings suggest a clear demand for menopause information, with the primary gap being access to trusted, culturally appropriate and easy-to-understand resources.

In addition, participants noted that there is no simple or widely used community term for menopause. Instead, participants often referred to it as their *“last period”* or *“getting dry”*, while the clinical terminology commonly used by healthcare professionals does not readily translate into everyday language. This disconnect can make it more difficult for women to understand health information, recognise and describe their symptoms, and communicate effectively with GPs and other healthcare providers.

Participants also described being more open about the topic than previous generations suggesting that knowledge and comfort are slowly shifting, even without formal information having been shared: *“Before we might be a little shy. Our father and mother would be shy but not us.”*

Menopause understood through both loss and relief

Participants expressed a range of views about menopause. For some, it was seen as a significant life transition associated with ageing, weight gain and the end of their childbearing years, making it feel *“a bit of a sad thing”*. Participants also shared a belief that stressful life circumstances, physical labour, displacement and hardship can lead to earlier menopause. As one participant explained, *“My mother-in-law stopped at aged 40 and thinks it’s because she pushed herself too hard in life.”* These perspectives appeared to be shaped by personal and intergenerational experiences of trauma and adversity. While such beliefs reflect lived experiences, they may also influence how menopause is understood, with symptoms or early onset being attributed to life circumstances rather than being discussed with a GP or healthcare professional.

At the same time, many participants viewed menopause positively as a stage of relief and greater freedom. The end of menstruation was welcomed by some participants, with one commenting, *“I just know that my period stopped and that’s exciting,”* while another said, *“It’s a positive thing because we don’t have a period.”* Menopause was seen as freedom from period pain, fewer restrictions around prayer and fasting, and, for some, an opportunity for greater control over their lives. These positive and negative perceptions often coexisted, highlighting the complex and varied meanings women attach to menopause.

Religious and cultural perspectives that shape how menopause is viewed

Faith was closely intertwined with how participants understood and experienced menopause. Participants explained that menstruation can restrict participation in certain religious activities, including prayer, fasting, attending the mosque, and undertaking pilgrimage. Some described using contraception during Ramadan to avoid menstruation and ensure they could fully participate in religious practices.

For many, menopause was viewed positively because it removed these restrictions and enabled greater involvement in religious life. As one participant explained, *“Some women do feel happy... they can continue to pray and fast,”* while another noted, *“Not having periods means we can take part in our prayers more regularly.”* These perspectives highlight how menopause can represent not only a biological transition but also an opportunity for greater spiritual participation and connection.

Openness is increasing, but conversations remain constrained

Openness towards discussing menopause appeared to vary across generations and length of time living in Australia. Younger participants and those who had lived in Australia longer described feeling more comfortable discussing menopause, whereas older participants and more recent arrivals were perceived as more likely to view the topic as private, shameful, or associated with ageing. As one participant reflected, *“Before we might be a little shy. Our father and mother would be shy but not us.”*

While attitudes appear to be shifting, women noted that openness is often constrained by limited knowledge, concerns about judgement, and differing perspectives across age groups and education levels. One participant explained, *“We feel comfortable but don’t have enough info to talk about it”* and *“We can’t have an open convo with all women... they might judge us.”* These findings suggest that although willingness to discuss menopause is increasing, many still lack the information, language and confidence needed to have these conversations comfortably.

Contraception

Contraception is a private topic, but trusted conversations still occur

Participants consistently described contraception as a private topic, typically discussed with a partner or a small circle of trusted women rather than openly within the broader community. Conversations about contraception often took place with sisters, mothers, close friends and other trusted women, providing an important source of information, support and reassurance. As one participant noted, *“Women influence each other when they talk about it amongst each other.”*

Generational differences were also apparent. Younger women were viewed as having greater access to information and feeling more comfortable discussing contraception, while older generations were often described as more reserved. Several participants observed that discussions about contraception typically occurred later in life, often after marriage or in early adulthood, reflecting broader cultural and generational differences in how reproductive health information is shared and discussed.

Lived experiences and stories shape attitudes towards contraception

While awareness of contraception was generally high, decisions about whether to use a particular method were strongly influenced by personal experiences and stories shared within trusted social networks. Concerns about side effects emerged as a consistent theme, with participants frequently discussing heavy bleeding, weight gain, mood changes and migraines associated with hormonal contraception. Implanon was mentioned particularly often, with several women describing negative experiences. As one participant explained, *“For me my body never got used to it. I just had heavy bleeding. It nearly killed me; a transfusion was needed.”*

Positive experiences were also shared, particularly regarding the IUD. One participant described her experience positively, stating, *“The IUD is very good. I started it when I decided not to have kids. My period is on time. Good experience.”*

These findings suggest that women’s views on contraception are shaped not only by healthcare advice but also by the experiences of other women. Shared stories, particularly those relating to side effects, often played a significant role in influencing perceptions, confidence and decision-making about contraceptive options.

A practical tool for family planning

Contraception was generally viewed as a normal and accepted aspect of family planning, particularly after marriage and once women had children. Participants described contraception as a practical way to space pregnancies, support recovery between births and manage the responsibilities of raising a family. For women living in Australia, family planning was often influenced by the challenges of raising children without the extended family support networks available in Afghanistan. As one participant explained, *“It’s very hard to raise kids here because you don’t have family support here.”*

Many participants felt that contraception became increasingly relevant after having two or more children, with one commenting, *“If we didn’t use it there would be so much population now!”* Overall, contraception was commonly understood through the lens of family wellbeing, financial and caregiving responsibilities, and the desire to provide the best support for existing children, rather than as a controversial topic.

Contraceptive decision-making is influenced by partners, family and cultural expectations

Participants’ decisions about contraception were influenced by a range of factors, including partners, family relationships and cultural expectations around family size and childbearing. Many described discussing contraception openly with their partners and viewed family planning as a shared decision within marriage.

However, experiences varied. Some participants reported that their partner’s views strongly influenced contraceptive choices. As one participant explained, *“My husband says it’s not good, thinks it will hurt my body, so till now I don’t use anything. That was his decision for me.”* Another reflected the trust placed in her partner’s judgement, saying, *“He is mature, he knows everything, his opinion and I trust him.”*

Participants also acknowledged broader cultural expectations that traditionally favoured larger families, although many felt these attitudes were changing. Importantly, religion was generally not seen as a barrier to contraception. Several participants described family planning as being consistent with their faith, with one participant noting, *“The religion says you should bring up kids in a good way. It doesn’t say anything about not using it.”*

Overall, decisions about contraception were shaped by a combination of personal preferences, relationship dynamics, family expectations and practical considerations relating to family wellbeing and caregiving responsibilities.

Australia provides greater access to contraception, but information gaps remain

Participants generally perceived Australia as providing greater access to contraception, reproductive healthcare and health information than they had experienced previously. GPs were consistently identified as trusted sources of advice, and participants valued opportunities to discuss contraceptive options with healthcare professionals.

Many participants reported positive experiences receiving information about available methods, effectiveness and potential side effects. One described their GP as being *“like a mother, easy to talk to.”* Despite this, uncertainty remained about the suitability of different contraceptive options and concerns about side effects continued to influence decision-making.

While awareness of contraception was relatively high, participants often described their understanding as limited, suggesting that access to services alone does not necessarily lead to confidence in choosing a method. Overall, participants highlighted the importance of clear, practical and culturally appropriate information to support informed contraceptive choices.

Jean Hailes’ resources

Menopause

Participants reviewed 4 Jean Hailes menopause resources during the focus groups, including the *Menopause - یانسیگی (Dari factsheet)*, *Menopause factsheet*, *Menopause - Easy Read (English)*, and *Menopause Symptoms Poster - Easy Read (English)*. Feedback was sought on the resources' clarity, usefulness, language, literacy, and accessibility.

Clarity, usefulness, and language literacy

Participants generally found the resources clear, informative and helpful, particularly when information was presented in plain language and supported by visuals. Many reported gaining new knowledge about women’s health and menopause, with one participant noting, *“Very good information, before we knew a little bit, now we know a lot more.”*

Visual elements were especially valued, helping women understand symptoms and key messages, particularly where literacy or English language proficiency was limited. As one participant explained, *“The pictures are valuable. We can guess the symptoms by looking at the photos.”*

Resources available in participants’ first languages were considered particularly useful for improving understanding, with one participant stating, *“Having it in language is the most useful.”* At the same time, some participants appreciated English-language materials as an opportunity to build their language skills.

Participants identified ongoing information needs in the following areas:

- Menopause treatments and therapies
- Post menopause symptoms and experiences
- Vaginal health, discharge and itchiness
- Contraception during perimenopause
- The relationship between hysterectomy and menopause

Participants generally felt comfortable with the content and considered it appropriate to share with other women in their communities. As one stated, *“Yes, I would share this information with other women from the community.”*

Key language considerations for resource development included:

- Providing information in both English and community languages, as some participants found one version easier to understand than the other.
- Making resources available in multiple community languages, including Dari, Pashto, Urdu and Persian.
- Recognising varying literacy levels within communities and supplementing written materials with visual, verbal or other accessible formats.

Preferred formats and accessibility

Participants expressed a clear preference for information delivered through video, describing it as easier to understand than written materials, particularly when presented in their preferred language. Audio resources were also considered valuable, especially for women with lower literacy levels. As one participant noted, *“To listen in language is preferred.”*

Easy Read formats featuring simple language and visuals were viewed as highly accessible, with one participant commenting, *“We like pictures, simple and easy.”* They also emphasised the importance of interactive education sessions that allow women to ask questions and discuss information openly.

Trusted messengers were seen as critical to effective communication. Participants highlighted the value of receiving information from community leaders, health professionals and facilitators who understand their cultural context. As one participant explained, *“We prefer to have the information explained to us and be able to ask questions.”*

Distribution and information sharing

Participants emphasised the importance of distributing health information through trusted services and community settings that women already engage with. Peer-to-peer sharing was identified as a particularly effective communication channel, with information commonly exchanged through WhatsApp groups, community networks and informal conversations among friends and family.

Although many participants regularly use online platforms to seek health information, trust in social media content was generally low, and participants often expressed uncertainty about the credibility of online sources. As a result, information delivered through recognised health, community and settlement services was viewed as more trustworthy and likely to be acted upon.

Suggested distribution channels included community hubs and neighbourhood houses, libraries, English language classes, Maternal and Child Health services, midwives, settlement and humanitarian support services, child and family services, and Centrelink and migrant support organisations.

Contraception

Participants reviewed 3 Jean Hailes contraception resources during the focus groups, including **Contraception - پیشگیری از حاملگی (Dari factsheet)**, **Contraception factsheet (English)**, and **Contraception in Australia factsheet (English)**. Feedback was sought on the resources' clarity, usefulness, language, literacy, and accessibility.

Clarity and usefulness of resources

Participants generally found the resources clear and accessible, particularly when information was available in their preferred language. Several participants noted that the materials reinforced information they had already received from healthcare professionals rather than providing entirely new knowledge.

Despite finding the resources useful, participants identified a need for more practical information about contraception and reproductive health. They wanted clearer information about the effectiveness and side effects of different contraceptive methods, expected bodily changes, and when medical advice should be sought. One commented, *"It's most important to know about the effectiveness and the side effects."*

Key information gaps included:

- Contraception side effects
- Irregular or absent periods
- When periods stop naturally
- Menopause treatments
- Ongoing fertility and pregnancy risk during menopause

Cultural appropriateness

Participants viewed the resources as culturally appropriate and reported feeling comfortable with both the content and its presentation. The topics were considered suitable for discussion among women and indicated they would be willing to share the resources with family members, friends and others in their communities. As one participant stated, *"Yes, happy to share."*

Several participants also reflected on how access to women's health information and contraception options has changed over time. They noted that previous generations often had fewer opportunities to access this type of information and viewed the availability of these resources positively. One commenting, *"This is fine, it just wasn't around before all these options."*

Preferred formats and accessibility

Participants consistently highlighted the importance of language in accessing and understanding health information. Dari was the preferred language for many participants, while bilingual resources that included English were also considered valuable.

They strongly preferred face-to-face education, explaining that busy family responsibilities often make it difficult to read written information at home. As one participant shared, *"If I was given this information and take it home, I will forget it because I'm busy. But if spoken about like in the community hubs, it's more accepted."*

Videos were also seen as a useful and accessible format, particularly for those with lower literacy levels. They suggested short videos in community languages, supported by subtitles and visuals, to improve understanding and engagement. Participants also recommended developing video content that addresses common concerns about contraception side effects, including information on what is normal and when to seek medical advice.

Distribution and information sharing

Participants highlighted the important role that community hubs play in providing health information, social connection and a safe environment for discussion. They described these settings as welcoming and inclusive spaces *"Where it's only women and is a safe space where they gather"* and they feel comfortable learning and asking questions.

There was strong support for ongoing education sessions delivered in women-only environments. One participant explained that *"Afghan women really value gathering together"* with information often shared naturally through conversations and community networks. Many felt that word-of-mouth communication was particularly effective, with one stating, *"Word of mouth is the best. Telling your sister, mother or friend is the best way."*

While social media platforms such as Instagram, WhatsApp and TikTok were also seen as useful channels for reaching women, participants emphasised that information is most trusted when reinforced through community discussions and personal recommendations from family, friends, and other trusted community members.

Participants in the contraception focus groups identified a range of trusted and accessible channels for sharing information. These included community hubs and neighbourhood centres, family support programs, women's groups, TAFE and English language programs, community events and expos, social media platforms such as Instagram, WhatsApp and TikTok, and community websites and

shared online networks. These channels were seen as effective ways to reach women through both formal services and existing community connections.

Recommendations

This section highlights key themes and recommendations that have been drawn from the consultations.

General women's health information

Key Themes	Recommendations
Layered and Self-Directed Health Information Seeking	Design content specifically for digital-first discovery. Create short, accessible, shareable content (e.g. bite-sized videos, FAQs, myth-busting social media posts) that can act as a trusted first touchpoint before clinical engagement.
Healthcare System Navigation as a Key Barrier	Include simple, practical guidance on how the system works (e.g. GP role, referrals, appointments). Use step-by-step explanations or visual journeys (infographics) to show what to expect. Focus on clarity and practicality rather than detail.
Trust in GPs Influences Care Experiences	Complement clinical care with resources that prepare women for consultations (e.g. "what to ask your GP", symptom checklists, how to describe concerns). Create resources for health professionals to be used with patients from a multi-cultural background (e.g. cheat sheets)
Language and communication barriers can reduce the quality, privacy, and effectiveness of healthcare interactions.	Provide high-quality translated resources in key languages (e.g. Dari, minimal Pashto). Use clear, consistent medical terminology and avoid overly technical language. Consider audio or video formats to reduce reliance on literacy and translation accuracy.

Menopause

Key Themes	Recommendations
Literacy levels and learning preferences vary, with women favouring visual, verbal, and peer-based approaches over written information alone.	Develop visual-first resources (short videos, illustrations, audio content) supported by simple, plain language. Prioritise formats that can be shared on social media (e.g. WhatsApp, community groups) and ensure availability in preferred languages through voiceovers rather than text-heavy translations.
Understanding of menopause is limited, with knowledge often shaped by personal experiences and confusion about symptoms, causes, and timing.	Create clear, structured explanations that build understanding from the ground up. Break menopause into simple stages (before, during, after), clearly explain what is normal, and highlight when to seek help. Use repetition across formats to reinforce key messages.
Menopause is viewed as both a transition and a trade-off, bringing feelings of loss and ageing alongside relief from menstruation and childbearing.	Acknowledge both perspectives in a balanced way. Avoid overly clinical or negative framing and build messaging that validates the sense of relief while gently preparing women for potential symptoms and changes.
Menopause is shaped by cultural, religious, and social context. It is closely tied to fertility, ageing, relationships, and religious practices.	Ensure resources reflect lived experiences, including how menopause interacts with family life, identity and religious practices. Avoid purely medical framing and instead embed information within familiar, everyday context.
Confidence to discuss menopause is increasing, but knowledge gaps and limited health literacy continue to restrict open conversations and informed decision-making.	Create content that supports conversation, not just understanding. Include prompts, relatable examples, and storytelling formats that help women discuss menopause with peers, family, and health professionals.

Contraception

Key Themes	Recommendations
Trust shaped by relationships, lived experience and trusted sources	Develop culturally responsive contraception resources that combine evidence-based information with lived experience stories, trusted health messaging, and relatable examples to support informed decision-making and build confidence in the information provided.
Husbands play a significant role in contraceptive decision-making, influencing women's knowledge, access, and choices around family planning.	Engage men in contraception education by providing culturally appropriate information and resources that support informed discussions between partners while reinforcing women's informed choice. Action for Jean Hailes: Explore opportunities to partner with community groups and health professionals to share contraception information and resources with Afghan men.
Greater access to contraception in Australia has improved choice and availability, but significant information and education needs remain.	Develop simple, practical contraception resources that explain available options, how they work, effectiveness, possible side effects, costs, and access pathways. Information should be presented in plain language, translated into relevant community languages, and supported by Easy Read fact sheets or visual guides.
Contraception is a private topic, but trusted conversations still occur	Develop resources that support women to learn privately and confidentially. This may include multilingual written resources, videos, online information and community education sessions that allow women to engage with information in a way that feels comfortable.
Personal experiences and stories strongly shape attitudes towards contraception	Provide clear, balanced contraception information that addresses common concerns about side effects, reflects changes in contraceptive options over time, and acknowledges generational differences in experiences and attitudes. Include practical guidance, realistic expectations, and lived experience stories to support informed decision-making.

Community and women only spaces enable trust and openness

Across all discussions, Afghan women consistently highlighted the importance of women only and shared language spaces for talking about health. These spaces were described as making it easier to ask questions, share experiences and feel understood, particularly for sensitive topics.

As one participant explained, *“Friends can discuss easily amongst the same language. Language is huge, it helps. So, it doesn't matter if it's younger or older, just as long as they speak Dari, it's a relief.”*

What stands out is that language is not just about communication, it is about comfort and trust. Women described feeling more able to engage with health information when it is shared in familiar language and within trusted social circles.

This suggests that community based, women centred approaches remain a key pathway for improving health literacy and supporting engagement with formal health services.

Evaluation of Engagement Approach

Strengths

The partnership with Community Hubs Australia was a key strength of the project, supporting a collaborative approach that increased its relevance to the community and helped build trust and confidence among participants. Working with an organisation that already had established relationships with the women created a strong foundation for engagement, enabling deeper connections and fostering a safe, welcoming, and supportive environment for discussion.

The use of interpreters was another important strength, allowing participants to take part in their preferred language. This was particularly valuable when discussing sensitive topics such as menopause and contraception, as it increased comfort, reduced participation barriers, and enabled those who may otherwise have been excluded to share their experiences and perspectives.

The use of qualitative focus groups with open-ended questions also enhanced the richness of the data collected. Group discussions provided participants with the opportunity to share their beliefs, experiences, and information needs in a culturally appropriate setting alongside others. This conversational approach encouraged participation, generated detailed insights, and created space for participants to learn from and build on each other's experiences.

Limitations

Consultations were conducted with the support of interpreters, which may have affected how some information was communicated and understood. As a result, some nuances, meanings, or personal experiences may not have been fully captured in translation and could have influenced the findings.

The consultations primarily engaged Dari-speaking Afghan women, with limited representation from other language groups. While two Pashto-speaking women participated, interpretation was provided through a Dari interpreter, which may have affected the accuracy and completeness of communication. There is also the possibility that some discussions were not fully understood by all participants, potentially limiting their ability to contribute their perspectives.

Those who participated provided valuable insights; however, future consultations would benefit from a larger and more diverse sample, including women of different ages, life stages, educational backgrounds, and lengths of time living in Australia. Participants noted that younger women and those who have spent longer in Australia may have different experiences, attitudes, and information needs. Future engagement with these groups could provide a more comprehensive understanding of community needs and help inform the development of more tailored health information and resources.

There is also an opportunity for future consultation to specifically engage Pashto-speaking women and other Afghan language groups to ensure a broader range of perspectives is represented and to better understand any differences in health literacy, information preferences, and healthcare experiences across communities.

Feedback from the participants

The survey completed by participants indicated that out of the 68 participants, 60 found the information in the session useful and 8 of the participants said it was mostly useful; keeping in mind that the consultation was not an educational session and more about sharing ideas and perspectives.

Feedback from the participants suggested that educational sessions were in great demand at the Hubs. The participants really appreciated coming together to discuss topics and were asking if there would be more information sessions like the consultation we had held. One participant wrote *“These sessions are very helpful for us and we appreciate such sessions.”*

Feedback from the hub leaders

An anonymous survey completed by hub leaders who partnered with us on this project highlighted positive experiences with the consultation process. Hub leaders reported no barriers to participating in future projects and noted that recruitment was supported by the availability of interpreters. In some cases, interest from women exceeded the available consultation places. One hub leader shared:

“All the women only had good things to say about the consultation. With the small numbers I had to consider who to invite and who would be a good fit. One woman said that this was the first time that she felt comfortable about sharing her experience. Everyone wanted to do this again.”

Hub leaders also reflected that creating women-only, culturally safe environments was instrumental in helping participants feel comfortable and encouraging open, honest discussions. This approach fostered trust and supported meaningful engagement on sensitive health topics. In some cases, the consultations also sparked greater interest in health education, leading hubs to organise additional health information sessions in partnership with other community and health organisations.

“Some shared that they appreciated the information and were really interested in more sessions. As a result, we did engage with other services to host health related sessions and some of the women who participated in the consultation continued to come along to these other information sessions.”

This feedback reinforces the value of community-led engagement approaches and highlights the potential for consultations to act as a pathway to ongoing health education and connection.

Conclusion

This project provides valuable insights into how Afghan women access, understand, and use women's health information in Australia, particularly in relation to menopause and contraception. Participants demonstrated a strong interest in learning more about their health and a willingness to engage with health information when it was delivered in ways that were culturally responsive, accessible, and trusted. The findings highlight that effective engagement extends beyond translation alone, with participants placing significant value on trusted relationships, community-based learning, and consistent messaging delivered through multiple channels.

The consultations identified opportunities for Jean Hailes to better meet the needs of Afghan women through the development of plain language, visually supported resources that can be accessed in the settings where women already seek information and support, including community hubs, peer networks, and primary healthcare services. The partnership with Community Hubs Australia was integral to this work, providing trusted, women-centred environments that enabled open and meaningful conversations on sensitive health topics.

The findings from this project will help inform the ongoing development of Jean Hailes menopause and contraception resources, including decisions about content, language, format, and delivery. Continued collaboration with Afghan women, community leaders, interpreters, and health professionals will be essential to ensuring resources remain relevant and accessible. This work contributes to Jean Hailes' broader commitment to improving health literacy and supporting culturally safe healthcare, empowering Afghan women to make informed decisions about their health and wellbeing at every stage of life.

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