Advancing Health Equity for Men From Culturally and Linguistically Diverse Backgrounds: Outcomes From a Culturally Adapted Community Wellbeing Program

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Advancing Health Equity for Men From Culturally and Linguistically Diverse Backgrounds: Outcomes From a Culturally Adapted Community Wellbeing Program

Michelle C. Attard | Camilla L. Brockett

Victoria University, Melbourne, Victoria, Australia

Correspondence: Camilla L. Brockett (camilla.brockett@vu.edu.au)

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ABSTRACT

Introduction: Culturally and linguistically diverse (CALD) communities are recognised as a priority population within Australia's preventive health strategies. Community-based wellbeing programs can enhance mental and physical health, but culturally tailored approaches are essential for engaging CALD populations and reducing health inequities.

Methods: Over 3 years, we worked with Vietnamese, Iraqi Syriac, and Indian men and men from the African diaspora in metropolitan Victoria to adapt an existing health education and exercise program, Sons of the West (SOTW). Guided by community consultations, the culturally adapted program (CALD SOTW) was delivered across 10 sites to 317 participants aged 19–84. Feedback was collected via open-ended surveys, focus groups, and facilitator interviews.

Results: Dropout rates ranged from 0% to 33%, and retention from 17% to 95%. Cohorts with older participants and higher rates of retirement or unemployment showed greater attendance and retention. Participant feedback indicated CALD SOTW was culturally appropriate, acceptable, and contributed to positive health behaviour changes by the end of the program.

Conclusions: Findings highlight barriers and enablers to participation and inform recommendations for program deliverers to effectively engage CALD men in wellbeing programs.

So What? This study demonstrates that culturally adapting community-based health programmes can improve participation and retention among men from diverse backgrounds, supporting efforts to reduce health inequities. By engaging Vietnamese, Iraqi, Syriac, Indian and African diaspora communities in Australia, it expands the limited evidence base on CALD experiences of wellbeing programmes and offers a transferable model, with practical recommendations, for programme deliverers working with diverse communities.

1 | Introduction

Australian males experience poorer health outcomes than females, including lower life expectancy and higher mortality rates [1]. Their leading non-communicable causes of death include coronary heart and cardiovascular disease and lung cancer [1], and males also die by suicide at higher rates than females [1]. Males are more likely to engage in risky health behaviours such as tobacco, alcohol, and substance abuse, and their primary causes of disease burden include heart disease and mental health and substance use disorders [2]. They are also less likely to seek health care services [2].

In response to these patterns, key elements for effective men's health interventions have been identified by Robertson and colleagues [3], including suitable and accessible (preferably

informal) settings, gender-sensitised approaches that incorporate specific aspects of identity, engagement of men in program design, trained program personnel, and partnerships with local community organisations. Many of these elements have been reinforced by other studies [4–7]. Community-based wellbeing programs informed by such principles aim to build knowledge and skills that strengthen protective factors and reduce health risks [8], and can benefit participants' mental health, physical functioning, and social connection [9–11]. A growing body of research over the past two decades has examined such programs and their impact on men's health-related behaviours and outcomes for [4, 5], with physical activity—including structured exercise and sport—frequently used as a catalyst for engagement. To be relevant, effective, and scalable, however, programs also need to be customised to the specific community context [6].

Australia is home to a significant proportion of migrants from culturally and linguistically diverse (CALD) backgrounds, with more than one in five people speaking a language other than English at home [1]. The term 'CALD' is commonly used in Australia and New Zealand, and like any other complex terminology designed to represent heterogenous 'sets' of people, its scope and utility have undergone debate [12, 13]. In this study we use 'CALD' to refer to "...groups and individuals who differ according to religion, race, language and ethnicity, except those whose ancestry is Anglo Saxon, Anglo Celtic, Aboriginal or Torres Strait Islander" [14]. While we aim not to focus on vulnerability and deficiency, we acknowledge the "social inequalities and disadvantage resulting in health inequity—the unfair and avoidable differences in health status" [15] that CALD populations face as part of our intention to promote inclusivity in the health program landscape. Such disparities occur across multiple levels—individual and family, community and organisational, and systems and policy levels [16]. In response, CALD people are considered a 'priority population' as part of the Australian Government's National Preventive Health Strategy 2021–2030 [17].

Structured leisure-based physical activity and participation in group sports have both been found to enhance mental health and wellbeing among migrants [18]. However, numerous studies highlight the barriers and enablers that adults—particularly men from CALD backgrounds—encounter when engaging in wellbeing, sport, and recreation programs [13, 19–22]. These factors are commonly classified across several levels, including individual, interpersonal, community, built environment, and cultural domains [19]. There are clear recommendations for sport and recreation programs to be both targeted and tailored for CALD contexts [23, 24], with recent reviews particularly highlighting the importance of direct engagement with CALD communities to ensure relevance and promote program success [21, 25].

For CALD migrant populations, physical activity and sport are recognised as key correlates of (or, are seen as a means to) acculturation [26], and as mechanisms for the (re)production and negotiation of cultural capital [13]. *Embodied cultural capital*—the internalised knowledge, skills, attitudes, and dispositions that shape behaviour—can act as "...both an asset to, and a source of exclusion from, sport participation" [13] (p. 851). Australian studies have questioned policy assumptions that people from CALD backgrounds will readily integrate into existing community contexts [27] or transition from CALD-specific to mainstream programs [28]. These critiques underpin calls for alternative, tailored sport and active recreation programs that reflect CALD community needs. In health promotion, this aligns with arguments that tailored approaches can maximise participation among those who are excluded from mainstream offerings [27], and that "...ethnocentric sport models do not necessarily have a use-by-date..." [23] (p. 37).

A recent review on mental health and suicide research highlights the need for cultural appropriateness but notes that the prohibitive cost of developing *new* interventions can be mitigated by adapting existing mainstream programs for greater inclusion and accessibility [29].

Program adaptation has become increasingly common in prevention research. Castro and colleagues [30] described the "dynamic tension" between maintaining program fidelity and pursuing cultural adaptation through community-based participatory research. Adaptations may involve changes to both program content and delivery. Examples include Rosso and McGrath's [27] co-design of a "locally responsive" adaptation of an existing football (i.e., soccer) program with five CALD communities in South Australia, and Gary-Webb and colleagues' [31] pilot to culturally adapt the National Diabetes Prevention Program for African American and Latino men in New York City. Both examples emphasised community consultation, iterative feedback, and ongoing modification to enhance cultural fit and engagement.

1.1 | Key Features of Programs for CALD Communities

Kara and Khawaja [8] identified participant priorities for wellbeing programs for CALD Australians: supporting both CALD identity and acculturation, exploring parenting experiences, and ensuring flexible, holistic content that extends beyond Western wellbeing models. Montayre and colleagues [32], in a systematic review of effective physical activity programs for CALD older adults, found that culturally specific programs—often modified from existing ones—were most effective when delivered in-language, close to participants' homes, and featuring familiar activities. In addition to co-designing with target groups, the authors highlighted the importance of evaluating cultural adaptations from participants' perspectives. Related studies reinforce the value of qualitative approaches and larger, more diverse samples [33].

Two recent reviews—a scoping review of CALD physical activity participation in Australia [21] and an international review of physical activity interventions for CALD populations [25]—identified key features that optimise reach, adoption, and effectiveness: community consultation, language adjustments, use of bilingual or bicultural personnel, and culturally relevant materials. El Masri and colleagues [25] call for improved methodological reporting, while Qiwei and colleagues [21] stress the importance of "...theoretically-informed interventions embedded in implementation frameworks to enable scale-up and sustainability" (p. 1215).

Program adaptations can also be conceptualised through *surface* and *deep structure* frameworks [34]. Surface structure adaptations address observable characteristics (e.g., language translation; ethnically representative facilitators) while deep structure adaptations reflect cultural values and practices influencing behaviour (e.g., an approach that recognises the importance of family) [35]. Dennaoui and colleagues [36] advanced this field by categorising both forms of adaptation in physical activity interventions for CALD children and adolescents. Of the 20 studies reviewed, only half incorporated both surface and deep structure changes—though combining them is recommended to enhance participant experience and outcomes [34, 36].

This paper reports on the cultural adaptation of an evidence-based men's wellbeing program designed to improve accessibility and engagement for CALD men in Melbourne. Developed in partnership with priority CALD communities identified through the delivery organisation's existing relationships and local partnerships (described in detail in the Methods), the study aimed to: (1) assess program appropriateness, acceptability, and short-term outcomes; and (2) identify features that shaped participant experiences and inform future delivery.

2 | Methods

2.1 | Study Approaches/Frameworks and Design

This study was guided by two key frameworks: (1) An *ecological model of health*, which recognises that health is shaped by multiple interacting levels—from individual to societal—and that people both influence and are influenced by their environments [37]; and (2) *Resnicow's Cultural Sensitivity model*, outlined in the Introduction, which distinguishes between surface- and deep-structure approaches to cultural adaption [34].

A multiphase mixed-methods design [38] was employed, integrating qualitative and quantitative data within a pragmatist framing. Qualitative focus groups in Phase 1 informed the cultural adaptations delivered in Phase 2, in which descriptive quantitative data (participant demographics and attendance) characterised program reach and engagement. In Phase 3, qualitative data (open-ended surveys, focus groups, facilitator interviews) were merged with the Phase 2 quantitative data at the interpretation stage through a convergent approach to evaluate program acceptability, appropriateness, and short-term outcomes. This design was selected because evaluating culturally adapted programs in real-world community settings requires both measurable reach and experiential insight; qualitative data were privileged to centre community, participant, and facilitator voice, consistent with community-based participatory research principles; and the multiphase structure supported iterative refinement across successive program iterations.

Within this design, we applied a place-based, community-based Monitoring, Evaluation, and Learning approach, incorporating interim evaluations to assess program acceptability, appropriateness, and short-term outcomes. *Acceptability* can be defined as "perception among implementation stakeholders that a given treatment, service, practice, or innovation is agreeable, palatable, or satisfactory" [39] (p. 67) and *appropriateness* as "the perceived fit, relevance, or compatibility of the innovation or evidence based practice for a given practice setting, provider, or consumer; and/or perceived fit of the innovation to address a particular issue or problem" [39] (p. 69).

2.2 | Existing/Mainstream Sons of the West Program

Sons of the West is a free, English-language, gender-sensitised health promotion and prevention program that has run annually and expanded since 2014. It is designed for adult men (aged 18+ years) living, working, or recreating in selected metropolitan and regional areas of Victoria's west. Several of these local councils rank among the lowest socio-economic areas in the state [40], with 38% to 59% of residents speaking a language other than English at home [41].

The program leverages the brand of the Western Bulldogs AFL (Australian Football League) Football Club. Delivered by the Western Bulldogs Community Foundation (WBCF) —a registered charity organisation based at the club—the program uses club branding, colours, and naming to create familiarity, safety, and credibility. As an added engagement strategy, participants are invited to attend at least one home game during the season, receiving free tickets and merchandise.

Recruitment occurs through mailing lists, targeted physical and online media, community groups and noticeboards, and word of mouth. Participants may return for up to 3 years to build on their health behaviours and support newer cohorts.

The program aims to generate long-term health changes in five key areas: (a) sustain participation in physical activity; (b) strengthened social networks; (c) improved mental well-being and skills to access psychological support; (d) maintenance of positive health behaviours including preventative screening and service access; and (e) challenge rigid masculine norms and promote gender equity.

Internal evaluations have demonstrated positive outcomes across multiple domains, and prior research has shown improvements in psychosocial wellbeing [11, 42]. Further program details are available in the Supporting Information.

2.3 | Culturally Adapted Program: CALD Sons of the West

2.3.1 | Timeline

The culturally adapted program (CALD SOTW) was delivered between 2021 and 2024. The study design comprised three phases: pre-program community engagement, program delivery, and post-program evaluation (See Figure 1).

2.3.2 | Participants

Participant inclusion criteria to join the program (and study) were: man, aged 18 years or older, and CALD background (i.e., migrant or first-generation Australian).

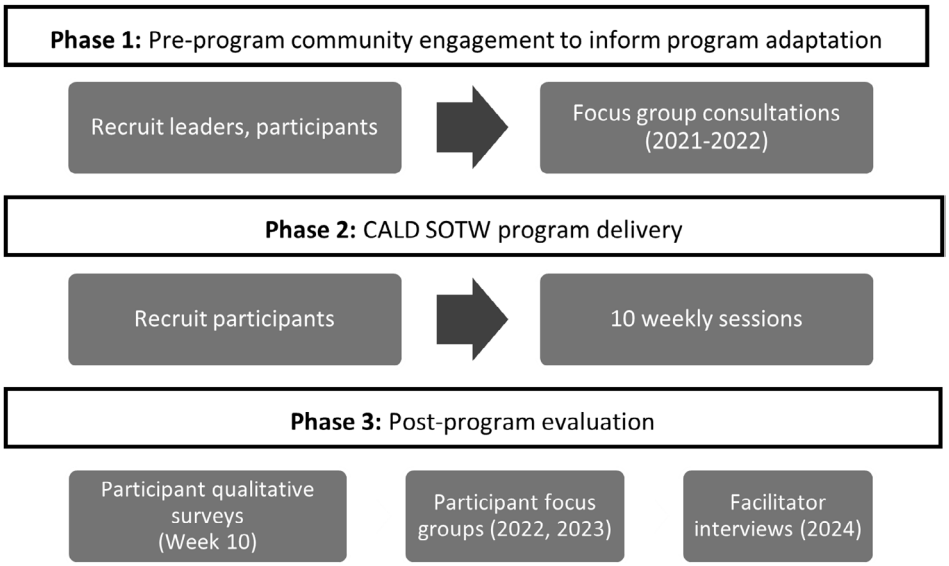

FIGURE 1 | Study design: Phases of participant and facilitator engagement.

2.3.3 | Program Adaption—CALD SOTW: Phases of Community Engagement and Data Collection

The CALD SOTW program used a three-phase approach involving community engagement through pre-program consultations, culturally tailored delivery with trained facilitators and bilingual support, and post-program evaluation using surveys, focus groups, and interviews. Together, these phases ensured the program was adapted with communities, responsive to cultural and language needs during delivery, and systematically evaluated to inform ongoing improvement. See Table 1 for an outline of cultural adaptations. See Supporting Information for a detailed description of the adaptation phases, a summary of staff and participant engagement across cohorts (Table S1), and a list of the health education topics delivered to each cohort (Table S2). See Appendices A–C for data collection instruments.

2.4 | Data Collection

2.4.1 | Procedures

After obtaining informed consent, demographic information was collected from participants upon them registering for a CALD SOTW program. Participant focus groups (pre- and post-program) were co-led by the authors. Translation was provided by community leaders/facilitators as needed. Facilitator interviews were led by authors. To prompt comfort and safety, no sessions were audio-recorded; instead, researcher notes were compiled and reconciled afterward. Participants and facilitators were encouraged to offer constructive feedback.

2.4.2 | Author Positionality

We acknowledge differences in positionality between researchers and CALD participants, which may influence interactions and analysis. While authors hold varied personal and professional experiences relating to CALD identity, we share the following commitments:

1. Recognition of an inherent insider–outsider dynamic [43];
2. The principle that culturally appropriate healthcare is a human right; and
3. The importance of privileging CALD participants' own perspectives.

Researchers engaged in reflexivity practice and applied principles of community-based participatory research, including strategic partnerships with leaders in the CALD community leaders.

2.5 | Data Analysis

Qualitative data (Phase 1 and 3 notes and open-ended survey responses) were analysed using conventional (manifest) content analysis [44]. Responses were de-identified. Quantitative data (Phase 2 demographics and attendance) were analysed descriptively.

3 | Results

This section summarises findings across all phases. Participant and facilitator responses from Phase 1 and Phase 3 are presented as direct quotes (*italicised*) or researcher notes (regular font). Additional examples appear in Table 2.

3.1 | Phase 1—Pre-Program Community Consultation to Inform Program Adaptation

Participants described various things they currently do for their health, including exercise (walking, cycling, gym,

TABLE 1 | Cultural adaptations made to the existing/mainstream Sons of the West program for CALD SOTW.

	Program phase/context		
1. Surface level structures	**Pre**	**During**	**End/post**
Promotional materials depicting relatable community members	×	N/A	N/A
Community locations that are accessible, familiar and comfortable, and unintimidating For example, Program promotion—visiting community venues, attending community events; Program delivery—African 18–25—secondary school; Indian A1, A2: community centre that participants already attend	×	×	×
Bilingual/bicultural facilitators, mental health professionals, educators	×	×	×
Language adjustment: Forms (registration, participant information, evaluation and research) translated in-language where applicable[a] Bilingual facilitators available to support form completion	×	N/A	×
Language adjustment: Bilingual resources where applicable	N/A	×	N/A
Language adjustment: Delivery in language where applicable—or, less often, interpreted from English (program education, exercise where feasible; Graduations)	×	×	×
Culturally relevant experiences For example, Graduations—food, music, dance or other performances where feasible			×
	Program phase/context		
2. Deep level structures	**Pre**	**During**	**End/post**
Engagement with key stakeholders (community leaders, potential participants, participants, facilitators)	×		×
Recognising, respecting, and meeting cultural expectations For example wellness-focused language used for topics like mental health in promotion and education; African 18–25 education on celebrating culture and discussing community issues; harnessing importance of family—with education topics like respectful relationships, Parallel CALD SOTW and Daughters of the West for Vietnamese (3rd) and Iraqi Syriac cohorts (2nd), participant family and friends encouraged to attend Graduations	×	×	×

[a]Applicable to Vietnamese, Iraqi Syriac, and Indian cohorts.

sport—also valued for social connection), healthy eating, adequate sleep, spending time with family and friends, adhering to medication, and leisure activities that support relaxation. One participant noted limited recent exercise and poor nutrition.

Barriers to maintaining positive health behaviours included low motivation, poor sleep, mental health concerns, and winter weather. The African 18–25 participants emphasised language barriers, social isolation (particularly at university), stigma surrounding mental health, uncertainty about where to seek help, and discomfort seeking support due to a lack of culturally safe services and representation.

> It can sometimes feel hard or uncomfortable to talk about mental health; [our communities] tend to disregard focus on mental health.

> The person on the other end, some random white guy. Not feeling that the other person has empathy. It's easy to sympathise but you can't empathise unless you've walked in my shoes.

Participants also described competing family responsibilities, such as caring for siblings or helping parents with English-language tasks.

> Family responsibilities are a big one...It's a must, it's only right for us to take on those responsibilities.

When asked what would attract them to CALD SOTW, participants prioritised culturally safe, inclusive environments—particularly in-language delivery (Vietnamese cohort) and relatable, trustworthy facilitators.

> A Vietnamese safe space, particularly important if you don't understand much English.

Other drivers included a welcoming venue, confidence the program would be valuable, peer connection, and positive associations with the football club.

> Sharing and listening, being able to connect with and learn from others.

> To be a SOTW! Association with WBFC.

TABLE 2 | Example participant and facilitator responses from pre- and post-program focus groups and interviews.

Example categories	Example responses
Phase 1	
Barriers to looking after health	- Low self-motivation (work long days, hard to get motivated); need an exercise partner to help motivate you. - *The most vulnerable…are the group with minimal English*
Factors that would attract potential participants to CALD SOTW	- Important that participants know what the benefits will be for them (free program, free items like food and merchandise) - *Someone running the program we can relate to and trust; Always easier opening up to someone you can relate to* - Knowing the program *actually helps*
Topics of interest for health education sessions	- Mental health—strategies for optimising, navigating the health system, supporting others
Phase 3	
Suggestions for program promotion	- The men said that they *took a leap of faith*…but other people might be reluctant to *take the risk* - Those who have never seen or heard of the program before may not necessarily see the value - Promote at Vietnamese Veterans Group and other groups (particularly when those attendees know the SOTW facilitator) - Advertise on Facebook, in the Vietnamese newspaper, and on Australian Special Broadcasting Service (SBS) Radio Vietnamese - *Please advertise program more and more* - *Encourage friends so that they join the program* - *Explain the program details and how people may benefit from it; This could include details of the program, a typical session example, end goal* - *Promote at the local Plaza* - *Having a participant with lived experience of the program to talk about the program could be useful*
Experiences of the health education component	- *The topics were impressive—very much required. We learnt a lot; All the program sessions are very informative* - *Excellent presentations; Good style*; She was very nice and had a strong style - *Interactive*; [The educator] tried to deliver the information creatively Favourite sessions and reasons: - *AFL session [because I] know more about the sport and can play with my grandkids* - Session on Alcohol cultures was useful, as it can be common to *experience boredom as a senior citizen*, and consuming alcohol can be a time-passing activity. As such, the Showcase of local services and supports was beneficial. - *Elder abuse [because] I'm a senior; The Elder Abuse topic was useful to put into the context of Australian policy.* - *Diabetes [because] I'm a diabetic* - *Healthy food [because] very necessary for me; Healthy food because it is very necessary at my age* - *Health and physical exercise [because] something new about this country* - *Brain and stroke session. Have a family member who has had a stroke, now know what to do* - *Business and Employment (Session 10) [because] it provided me information I needed* - *Mental happiness and bonding of relationships. I want to become new friends and relationships with family* - *Mental Health: [because] the conversations on the day gave me a different outlook on it and I enjoyed learning about it; it aimed to break down the stereotypes men have; I learnt to breathe better*

(Continues)

TABLE 2 | (Continued)

Example categories	Example responses
Suggestions for future health education topics	- Physical health conditions and prevention/management: *More diabetes information; Heart health; Blood pressure; Would be good to have a GP come in, or other well-known health professionals in the community* - Mental health: *More on mental health*; Would like the psychologist to have more floor time... - Holistic aspects of health and wellbeing: Meditation, Acupuncture; *Alternatives to taking medication for diseases such as diabetes, high blood pressure and cholesterol; Spiritual brotherhood/mentorship* - Australian policy and culture: *More information about various health services; Updated information about policy for seniors; Social awareness and more knowledge about country*; Want to learn more about Australian culture, lifestyle, wellbeing
Experiences of the exercise component	- Having a professional [*Exercise Physiologist*] present was a strong motivator; *Exercise by trained teachers* - The personal trainer was excellent—he chatted and gave positive feedback to each person (African facilitator) *- It was refreshing and nice* *- I enjoyed doing exercises together with my friends and with the English group* *- They made me realise that physical activity is not just about weightlifting...I like the fact that they were conducted with no extra equipment needed* *- I'm an athlete so it doesn't hurt to get some extra work in* - The shared exercise component was a beneficial way to avoid community seclusion and promote cross-community engagement.
Program outcomes	*- Learn so many things I didn't know* - Learnt much more than expected, particularly around self-care and wellbeing *- Gives me places [to seek help] if needed* *- Made me more determined to be physically active to improve health...* *- Going to sleep earlier* - Started swimming *- Helped improve strength and mobility, and reduce pain*
General program comments	*- It is very beneficial for me; This program is helpful day to day* *- We are so lucky to sit with you and be part of the community in Australia*
Enablers to participation	- Felt excited with anticipation about each upcoming weekly session—it was something to look forward to each week, which improved mood and motivation *- Being in Hindi language is very good* *- Enjoyed being there; Felt happy, smiling; Had fun* - The program provided an opportunity to interact with others and make friends - Participants had a common mindset and values for attending (open, non-judgemental, common goals) *- Well organised; Good organisation and management of the program* *- Getting reminders from the facilitator to attend* *- The staff showed proactivity; The facilitator was engaging* *- Leaders and trainers were very friendly*; The psychologist was engaged and worked to build rapport *- Staff viewed participants as individuals and remembered participants' names*
Barriers to participation	*- 6:30–8:30 pm is usually mealtime and considered important time with family* - Some men are driving for up to 1 h to attend the program.

Note: Participant and facilitator responses from Phase 1 and Phase 3 are presented as direct quotes (*italicised*) or researcher notes (regular font).

Proximity to public transport was especially important for the African 18–25 participants, who were less likely to hold a driver's licence.

Across the cohorts, desired education topics included general health promotion, illness prevention, and mental health. The African 18–25 group emphasised stigma-reducing language, addressing racism, and support for personal and career development.

> Wellbeing. Healthy body, healthy mind. Resilience, bouncing back from setbacks. Dealing with and adapting to situations, how to open up.

Exercise-related requests included technique and injury-prevention guidance, stretching, and access to a personal trainer capable of delivering high-intensity options.

> A lot of us already do play sport like futsal so the high intensity can complement this.

For recruitment, the African 18–25 participants recommended promoting the program through flyers or videos featuring community members, highlighting *fun and high-intensity exercise*, and relying on word of mouth.

> If one of the boys were into it, then it's just a matter of one and then another one.

3.2 | Phase 2—CALD SOTW Program Delivery

Participant demographic information and attendance data appear in Tables 3a–4b and Supporting Information (Table S3). Almost all participants were first-generation migrants; only 11% of the African 18–25 cohort were born in Australia. All participants had at least one parent born overseas. Ages ranged from 19 to 86, and most participants were not working during the program period.

Across all cohorts, 317 men attended at least one session. Average weekly attendance varied substantially from large Indian A1, A2 cohorts ($n = 59$, 68) to the smaller African ($n = 5$, 7) and Vietnamese ($n = 8$, 13, 19) cohorts. Dropout rates ranged from 0% to 33%, and retention (attending ≥ 7 of 10 sessions) ranged from 17% to 95%.

Attendance patterns suggest an inverse relationship between (a) average age/employment status and (b) session attendance/retention: cohorts and those with higher rates of retirement/unemployment tended to attend more sessions and show higher retention.

Repeat attendance was notable for some groups. Across the Vietnamese cohorts, nine participants attended years 1–2, five attended years 2–3, and one attended all 3 years. Thirteen Iraqi Syriac participants attended years 1–2. The Indian A groups were almost entirely new cohorts each year due to seniors' club membership demand. There were no repeat attendees in the African 18–25 and open-age cohorts.

3.3 | Phase 3—Program Evaluation

3.3.1 | Promotion and Recruitment

Participants typically heard about the program through facilitators and 'word of mouth'—both within seniors' cohorts (Iraqi Syriac, Indian) and more broadly. A small number joined through knowing about other WBCF programs (e.g., African youth, Daughters of the West).

Strengthening promotion was the most common suggestion for improvement. Participants encouraged "tell them it is such good program, share it, spread the message to join", and recommended inviting "more African men from different countries" to increase diversity. Harnessing friends and family networks was seen as essential, though participants also emphasised that clear program information is needed to support recruitment.

> Shyness in the community...not being familiar with local community in Australia is an issue with getting [Vietnamese] people to register for the program.

Participants wanted information about program goals, session examples, and expected benefits. Suggested promotion strategies included stronger online presence, advertising through ethnic media, and visibility at community events, places of worship, and local spaces, including program participants sharing their lived experience, were seen as ways to help build community awareness and trust by reinforcing the presence of the program and its driving partners around the West.

> Did not see any social medial posts; would have liked to see promotion online.

> Need more presence at festivals and cultural events.

Participants also highlighted the value of community leaders (including local council and the Mayor) speaking about the program to increase trust and credibility.

3.3.2 | Experiences of the Health Education Component

Facilitators stressed the importance of bicultural delivery:

> Having a health educator who was *part of our culture* and *understood the needs of our people* (Iraqi Syriac).

> It was good to provide hard-copy in-language health resources (Vietnamese).

Participants consistently praised educator competence, clarity, and engagement:

> Presenters were knowledgeable.

> Easy to understand; [The educator] explained it well.

The African program facilitator noted that arranging chairs in a semi-circle and sitting among participants fostered an informal, conversational atmosphere.

Most participants valued all topics:

> There was something to learn in each session.

When selecting specific favourites, relevance to personal circumstances was the primary driver (e.g., mental health, diabetes, elder abuse, AFL, alcohol use, stroke, employment pathways). Indian cohort members particularly emphasised heart health, blood pressure, stroke, and diabetes.

Participants also valued content that helped them understand Australian systems and culture (e.g., elder abuse laws, cancer types, health services).

Suggestions for future topics included:

- More detailed content on nutrition, chronic disease, and exercise
- Sessions with a general practitioner (GP) or local health professionals
- Expanded mental health education and more time with the mental health professionals
- Practical components (e.g., cooking demonstration, reading nutritional labels)
- Content on legal rights, Australian policy, and senior entitlements
- Resumé development and employment pathways.

Some Vietnamese participants requested a more interactive approach, shorter sessions, more time for questions, and fewer but deeper topics. Starting and ending the education sessions on time was important in hybrid delivery contexts. Small group participants (African 18–25) noted that low numbers limited discussion. Suggestions for supporting knowledge retention included access to slides, session recordings, and pre-reading.

3.3.3 | Experiences of the Exercise Component

Participants described the exercise sessions very positively:

> I like all of the exercises very much; Loved it all.

They valued the presence of trained staff and their communication style:

> Encouraging without being pushy.

> Benefited from good, clear instructions provided by the personal trainer.

One Indian participant suggested an instructor closer in age to seniors.

The group-based format was highly appreciated:

> I like the fact that they were conducted as a group activity...

> The physical activity was great for having a laugh out loud/at each other (African program facilitator).

Vietnamese participants said English-speaking cohort members helped with demonstrations, enhancing confidence over time. Participants enjoyed the variety of activities (ball games, stretching, yoga) and the tailored nature of sessions across fitness levels. Some expressed that challenges (e.g., unfamiliar yoga poses) were positive. However, the Iraqi Syriac facilitator felt some exercises were overly complex and recommended lower intensity in future.

Requested additions included more variety, additional sports (e.g., badminton, volleyball, swimming), outdoor sessions, Tai Chi (Vietnamese), and yoga (Indian). Some Vietnamese participants preferred fewer exercises with more time to focus on technique.

Across groups, participants felt larger group sizes—within fitness levels—would create more energy.

3.3.4 | Program Outcomes

Participants frequently described broad health improvements, feeling stronger, and gaining new knowledge:

> Good program for health and new knowledge.

> Showcase of local services...I did not realise that there were so many things for us to engage in.

New knowledge often led to behaviour change, especially in diet and physical activity:

> Eating healthier; Avoiding fatty foods.

> Walking every day; Started to do more yoga.

Participants also planned to maintain habits:

> Create a habit to exercise daily.

> Find out new physical exercises to include in my day.

Facilitators reported examples of continued activity: group swimming trips (Indian A1), regular walking/cycling meetups (Indian A1, B; Iraqi Syriac), and home stretching with family. African diaspora participants continued weekly online suggested group outings. Vietnamese participants preferred follow-up support from facilitators to link them to community activities.

Psychosocial benefits were widely reported. Indian participants used terms such as *alert, positive thinking*, and *mentally fit*. African diaspora participants emphasised belonging and openness, and linked participation to reduced device use and improved mood. They also described enhanced mental health literacy:

> I am confident to speak about my mental health.

> I learned different ways to maintain a happy mental wellbeing.

Participants valued cultural experiences, particularly AFL-related activities, which helped them understand Australian culture.

TABLE 3a | Participant demographic information: Vietnamese, Iraqi Syriac program iterations.

Demographic information	Vietnamese 1	Vietnamese 2	Vietnamese 3	Iraqi Syriac 1	Iraqi Syriac 2
n for whom demographic data is available (withdrawn participants excluded)	14	23	33	17	20
Average age (range)	54 (23–69)	61 (24–85)	71 (45–86) ($n=29$)	70 (60–81)	70 (33–84) ($n=19$)
% born outside of Australia	100% (Vietnam)	100% (Vietnam)	100% (Vietnam)	100% (Iraq)	100% (Iraq)
% 1 or both parents born outside of Australia	100% (Vietnam)	100% (Vietnam) ($n=18$)	100% (Vietnam)	100% (Iraq)	100% (Iraq)
% speak language(s) in addition to English	100% (Vietnamese)	100% (Vietnamese)	100% (Vietnamese)	100% (100% Arabic and Syriac)	100% (100% Syriac, 14% Iraqi Arabic)
Majority employment status	43% employed; 43% retired	58% retired; 32% employed ($n=17$)	90% retired ($n=31$)	88% unemployed, not looking for work; 12% unemployed, looking for work	53% unemployed, not looking for work; 11% unemployed, looking for work

TABLE 3b | Participant demographic information: Indian and African program iterations.

Demographic information	Indian A1	Indian A2	Indian B	African 18–25	African
n for whom demographic data is available (withdrawn participants excluded)	64	75	38	9	12
Average age (range)	69 (58–78)	67 (51–83)	68 (55–78)	22 (19–24)	43 (29–60) ($n=11$)
% born outside of Australia	100% (98% India; 2% Kenya) ($n=63$)	100% (93% India; others: Australia, Kenya, Myanmar, Pakistan)	100% (India)	89% (Egypt, Kenya, Other, South Sudan, Sudan)	100% (92% Kenya, 8% South Africa)
% 1 or both parents born outside of Australia	100% (98% India; 2% Kenya) ($n=63$)	100% (97% India; others: Kenya, Pakistan)	100% (India)	100% (Sudan, South Sudan, Other)	100% (92% Kenya, 8% South Africa)
% speak language(s) in addition to English	100% (73% Gujarati; 36% Hindi; 5% Punjabi [$n=59$])	100% (74% Gujurati, 50% Hindi, 1% Kiswahili [$n=72$])	100% (52% Gujurati; 48% Hindi; 48% Punjabi [$n=33$])	78% (71% Dinka, 57% Arabic)	100% (specific data not collected—those who migrated from Kenya speak Swahili)
Primary employment status	71% at-home parent/household coordinator; 21% unemployed, not looking for work ($n=62$)	92% retired	100% retired	56% employed; 33% unemployed, looking for work	100% employed (64% full time) ($n=11$)

TABLE 4a | Participant attendance data: Vietnamese, Iraqi Syriac program iterations.

	Vietnamese 1	Vietnamese 2	Vietnamese 3	Iraqi Syriac 1	Iraqi Syriac 2
n attended ≥ 1 sessions	17	24	33	18	20
Average weekly attendance *n* (range)	8 (2–14)	13 (10–21)	19 (3–26)	13 (12–15)	16 (13–18)
Average number of sessions attended	5	6	6	7	8
Withdrawal rate[a]	25%	8%	0%	25%	9%
Dropout rate[b]	33%	33%	27%	11%	10%
Retention rate[c]	47%	46%	61%	72%	80%

[a]Withdrawal refers to participants who registered but did not attend at all.
[b]Dropout refers to participants who attended ≤ 3 sessions.
[c]Retention refers to participants who attended the minimum number of sessions required to graduate (≥ 7/10).

TABLE 4b | Participant attendance data: Indian, African program iterations.

	Indian A1	Indian A2	Indian B	African 18–25	African
n attended ≥ 1 sessions	70	75	38	12	12
Average weekly attendance n (range)	59 (49–67)	68 (62–73)	25 (18–30)	5 (2–8)	7 (3–10)
Average number of sessions attended	8	9	7	4	5
Withdrawal rate[a]	3%	1%	46%	N/A	8%
Dropout rate[b]	11%	0%	26%	33%	33%
Retention rate[c]	89%	95%	61%	17%	58%

[a]Withdrawal refers to participants who registered but did not attend at all.
[b]Dropout refers to participants who attended ≤ 3 sessions.
[c]Retention refers to participants who attended the minimum number of sessions required to graduate (≥ 7/10).

One Vietnamese participant noted learning "a lot about living in Australia" despite having been in the country for 30 years.

Volunteering interest and community engagement increased, especially following the showcase of local supports. Examples included library visits and participation in council planting programs. Vietnamese participants expressed a desire to represent their "Vietnamese-Australian heritage through volunteering", though some noted language as a barrier. This was also mentioned by Indian participants when considering joining other community programs.

3.3.5 | General Program Comments

Participants frequently expressed appreciation for the program:

- The program is very good for us and the community.
- I believe...this is such an important program.

Participants highlighted its particular value for older adults:

> There need to be more programs available for people of older age [I am 79].

- [CALD SOTW] is a vital program for seniors.

Many requested a longer program or repeated delivery.

3.3.6 | Enablers to Participation

Key logistical enablers were proximity of venues and suitable scheduling. Participants found the program inherently motivating due to its health focus and novelty:

- The program was new...so it was exciting.
- Motivation; Learning new things.

Facilitators similarly described strong participant enthusiasm.

Culturally appropriate facilitation and education were critical enablers:

> Facilitator was an accepted, trusted community member.

> The in-language education sessions helped participants learn.

Participants also emphasised good organisation, reminders, friendly staff, and strong rapport with educators and the mental health support staff.

Regarding alternative delivery formats, some Indian and Vietnamese participants were open to simple-English mixed-CALD groups as opportunities for socialising. Iraqi Syriac participants were open to English education if interpreting was

maintained and saw value in hybrid models for cultural exposure. Vietnamese participants echoed the value of shared exercise for reducing community isolation.

The program's social environment was a major enabler, consistently described as friendly, safe, inclusive, and supportive:

> Sense of belonging; Felt comfortable; Good friendships.

> The group worked well together and helped each other.

Indian participants noted that pre-existing connections within their seniors' groups motivated their engagement. For the first-time African diaspora programs, 'ice breakers' were helpful for build relationships. The Vietnamese facilitator highlighted that the program provided a positive space for men to connect, with cohesion across increasing over successive iteration as participants and staff became more familiar and comfortable with one another. Similarly, the Iraqi Syriac cohort valued becoming accustomed to the main educator through her ongoing presence.

African 18–25 participants appreciated cultural recognition and suggested incorporating more cultural elements in future:

> Good to have a cultural focus, to celebrate and not forget our culture.

> [For future programs] could add costumes, rituals, music, dance.

In the final iterations, the Daughters of the West running in parallel were highly valued by Vietnamese and Iraqi Syriac participants, allowing shared attendance with family. Indian participants expressed interest in a future combined-gender "Families of the West" program, while Iraqi Syriac participants were mixed.

3.3.7 | Barriers to Participation

Indian participants in the English-language program reported difficulty understanding the Australian accent, limiting comprehension. They preferred presenters to speak more slowly rather than shifting entirely to in-language delivery. In addition, the Vietnamese facilitator noted that paperwork (e.g., for registration, personal and health information, and evaluation) posed challenges for the older participants.

Common barriers across cohorts related to scheduling and season: winter weather, dark evenings, mealtime conflicts, fatigue after work, and concerns about travel at night. Distance from venues and reliance on carpooling also affected attendance.

The most frequent barriers were competing commitments—work, family responsibilities, travel, and social or sporting activities. For some, migration-related obligations (e.g., settlement appointments) took priority. Illness and medical appointments posed additional challenges. Facilitators often followed up with absent participants, and participants commonly communicated absences in advance.

4 | Discussion

This study examined the cultural adaptation of an established men's wellbeing program for CALD communities, with the aims of assessing program appropriateness, acceptability, and short-term outcomes, and identifying features shaping participant experiences to inform future delivery. Across 3 years and 10 program sites, findings demonstrate that CALD SOTW was largely acceptable and appropriate to participants, evidenced by moderate to high retention in most cohorts, repeated participation, and overall positive participant and facilitator feedback. Qualitative findings highlight how both surface- and deep-structure cultural adaptations—particularly community leadership, in-language delivery, culturally safe facilitation—were central to engagement and reported benefits. Collectively, these findings suggest that cultural adaptation influenced not only perceived relevance but also the mechanisms through which men engaged, sustained participation, and translated program content into meaningful behaviour change.

Cohorts with the highest retention rates (i.e., Indian B and Iraqi Syriac) were already established social groups before, and participants joined knowing their community leader would facilitate and their peers would attend. These cohorts also demonstrated positive attendance trends across repeat iterations. Vietnamese cohorts showed similar improvements despite not being pre-formed, suggesting that sustained community presence, familiarity, and word-of-mouth support engagement when cohorts are recruited 'from scratch'. Phase 3 reflections reinforce this, indicating that multiple program iterations may be needed for individually recruited groups to reach retention levels comparable to established cohorts. Retention of 58% or higher in seven of 10 cohorts, along with requests for repeat delivery, indicates strong appropriateness and acceptability. Taking an intersectional lens, it is possible that the challenges that older participants may face—such as limited income, social isolation, chronic disease risk, and language barriers—further reinforced participation because of increased availability, motivation, and perceived relevance of a free, social embedded, in-language health and wellbeing program (often delivered during the daytime). The lower retention observed among the African 18–25 cohort may reflect structural and life-stage constraints rather than lack of program acceptability. Younger participants described competing educational, employment, and family responsibilities, alongside transport barriers and limited discretionary time. From an ecological perspective, these factors sit largely beyond the reach of surface-level program adaptations, and may point to the need for complementary system-level supports. Our findings reinforce that CALD men's engagement cannot be understood through cultural identity alone. Rather, participation was shaped by intersecting factors including age, migration history, language proficiency, employment status, family responsibilities, and gendered expectations. Consistent with intersectionality frameworks [45], these overlapping social

positions produced different constraints and opportunities across cohorts. The CALD SOTW adaptations—particularly in-language delivery, bicultural facilitation, accessible venues, and flexible scheduling—were therefore acceptable to participants not because they addressed "culture" broadly, but because they responded to multiple intersecting determinants of engagement simultaneously.

Across in-language cohorts—particularly the Vietnamese—participants emphasised the program's value for strengthening cultural identity and supporting social inclusion [13]. For groups less familiar with sports like AFL, the typical "sport hook" may relate more to connection with Australian culture than a pre-existing affinity with a specific sport or club.

The overall positive feedback on the health education and exercise components illustrates how culturally safe delivery and peer-based learning environments transformed standard health education content into socially legitimate and personally relevant knowledge.

Notably, many preferred education topics addressed traditionally stigmatised areas (e.g., mental health, respectful relationships, substance use). Embedding these topics within a broader wellbeing program appeared to reduce stigma by normalising discussion in non-clinical, trusted community settings. Some suggestions (e.g., holistic health approaches) point to opportunities for future deep-structure cultural adaptation. The three-tiered exercise model was especially valued by Vietnamese cohorts and is more feasible in larger or hybrid groups; smaller cohorts, such as the Iraqi Syriac group, required additional consideration to ensure tailoring within resource constraints. Constructive feedback—such as lowering exercise intensity or ensuring education sessions conclude on time—highlights the need to routinely monitor fidelity when adapting mainstream programs. This suggests that, for some CALD men, sport-based programs function less as performance-oriented activities and more as culturally mediated entry points into belonging and social participation.

The range of positive outcomes participants reported across health knowledge, exercise engagement, and psychosocial wellbeing is consistent with literature on multicomponent programs for CALD migrants [22]. Psychosocial benefits were expressed differently across cohorts, possibly reflecting cultural perspectives and/or English proficiency, which underscores the value of qualitative approaches for capturing nuanced forms of wellbeing. The direct mental health-related reflections from African diaspora participants are encouraging given the significant access barriers identified both in our consultations and in the broader literature [45, 46]. Although specific comments about the bilingual/bicultural mental health professionals were limited, their role warrants further exploration alongside less formal approaches to promoting psychosocial wellbeing. Deep-structure adaptations—such as celebrating cohort-specific culture (African 18–25 cohort) and fostering cross-cultural identity development (Indian, Iraqi Syriac and especially the Vietnamese cohorts)—were highly valued, suggesting that such adaptations can simultaneously strengthen cultural affirmation and create pathways for intercultural engagement rather than positioning the two as competing goals.

Some participants also expressed openness to future multi-CALD cohorts delivered in simple English, aligning with findings that physical activity can support intercultural connection [22]. Engaging with the wider community—including through cultural exchange—can build language proficiency, enhance wellbeing and integration [47], and reinforce shared experiences across different backgrounds, helping to normalise topics such as mental health [48].

Parallel delivery of CALD SOTW and Daughters of the West (DOTW) for Iraqi Syriac and Vietnamese cohorts—based on post-program feedback from earlier iterations—was another well-received deep-structure adaptation. By engaging male and female household members concurrently, this model likely reinforced attendance, motivation, and within-household continuity of learned health behaviours, consistent with literature positioning family as a central health asset for resettled and migrant populations [47]. Enthusiasm for mixed-gender formats nonetheless varied across cohorts, underscoring that gender-sensitisation needs are not uniform: they sit at the intersection of cultural norms around gender mixing, religious expectations regarding modesty or segregation, and life-stage or generational differences in comfort with co-ed health settings. This reinforces the case for gender-responsive program design that treats gender as inseparable from—rather than additive to—cultural and religious context, and that retains flexibility to deliver in single-gender, parallel, or mixed formats according to cohort preference [4].

Participants varied in their prior exposure to physical activity and exercise. For those less experienced, simple and equipment-free exercises supported carry-over into home settings. Participant engagement outside the program further promoted motivation, particularly among Indian and Iraqi Syriac cohorts, where social networks and leadership facilitated ongoing activities (e.g., local outings supported by grant funding). For some Vietnamese participants, tensions emerged between interest in community programs and perceptions of cultural "fit". Requests for exercise options such as Tai Chi or yoga relate to "ethnic sports" and "ethno-specific sports contexts," which have documented benefits for migrant wellbeing [13, 18]. These findings reinforce the value of culturally adapted programs like CALD SOTW as inclusive, empowering community "spaces" [28], not merely pathways into mainstream settings.

Enablers echoed pre-program consultation themes and existing literature [8, 20]. Bilingual/bicultural facilitators and educators and non-representative staff each contributed to a culturally safe environment. The Vietnamese cohort's facilitator pathway—from participants to volunteers to employed leaders—illustrates how programs can foster leadership and skill development, aligning with recommendations that sport and recreation initiatives support personal growth alongside physical outcomes [28]. Our findings reaffirm the importance of community leaders as "insiders" who model behaviour, facilitate bonding, and advocate for participants [47, 49]. Advocacy examples—such as raising concerns about exercise intensity or excessive paperwork—demonstrate this critical role. Further, the facilitator pathway from participant to leader illustrates how culturally adapted programs can generate community capacity and leadership, extending impact beyond individual health outcomes. Recommendations for program deliverers are summarised in Table 5.

TABLE 5 | Recommendations for program deliverers.

Program area	Recommendation
1. Development	
Partnerships	• Develop and sustain partnerships with credible community organisations—including local councils, not-for-profits, schools, universities, places of faith, and community groups/clubs—to support a place-based approach and share knowledge, skills, and resources across key stages (e.g., cohort scoping, promotion, staffing, delivery, and post-program pathways) • Build relationships with existing community groups and their leaders, and collaborate to identify community needs and preferences
Staffing	• Employ trusted community leaders as facilitators, and provide appropriate training on the existing program model • Aim to engage representative community members as volunteers, educators, exercise staff, and mental health professionals wherever possible • When recruiting additional facilitators, prioritise past volunteers or program 'champions' to strengthen community capacity, maintain a culturally safe and familiar environment, and support long-term program sustainability
Education	• Identify participants' education needs within and across cohorts, including topics related to cross-cultural connection, and information about culturally appropriate local health services and supports • When engaging health education providers, discuss how the content and delivery style can operate at a deep-structure level—drawing on cultural values and practices that shape specific health behaviours—and explore opportunities to maximise this for each cohort
Promotion	• Use non-stigmatising language when describing the program • Apply multiple formal and informal promotional methods (e.g., word of mouth; culturally appropriate flyers; social media; CALD newspapers and radio; visits to community groups, events, and venues) and use them consistently to build trust, credibility, and familiarity • Provide clear, engaging explanations of program content, including example session topics and physical activities, and incorporate facilitator and past participant perspectives (e.g., via videos, Q&A sessions) • Feature voices valued by the community—such as local leaders, program partners, and people with lived experience—to highlight program benefits and outcomes • Consider recruitment incentives for current participants in later iterations (e.g., bringing a new participant along)
Enablers and barriers to participation	• Identify enablers and barriers to participation within and across cohorts • Develop sustainable strategies to address key barriers and strengthen engagement, drawing on both surface- and deep-structure cultural adaptations
Format	• For smaller cohorts, consider a hybrid format where CALD SOTW groups share the exercise component with mainstream English-language programs to create a more energised atmosphere and support cross-cultural connection • Offer a mixed-CALD option with education delivered in simple, slower-paced English for participants who wish to build their [Australian] English skills in a cross-cultural setting • Explore mixed-gender formats based on cohort preferences, including parallel delivery (e.g., CALD SOTW and CALD Daughters of the West at the same time and venue), or a fully shared "Families of the West" model as a deep-structure cultural adaptation • Consider grouping programs by life stage (e.g., 18–25, working-age, seniors) to align with cohort needs and preferences
2. Delivery	
Fidelity	• Ensure consistent implementation of the core elements of the existing program model across all sessions
Safe environment	• Foster a culturally safe environment throughout the program and at Graduation through inclusive elements such as signage, music, food, and decorations

(Continues)

TABLE 5 | (Continued)

Program area	Recommendation
Staffing	• Maintain consistency in educators, exercise staff, and volunteers across sessions and program iterations to build participant familiarity and trust • Employ bilingual/bicultural facilitators and support staff who are trusted within the community, and engage representative volunteers wherever possible • Provide facilitators with tailored training and ongoing support to ensure they feel confident and well-prepared to lead the program • Ensure non-representative staff and volunteers have demonstrated experience working effectively with CALD communities
Education	• Set up the room to create an informal, welcoming environment that encourages sharing and connection • Use seating arrangements that promote interaction—for example a semi-circle or angled rows rather than a lecture-style layout—and consider culturally appropriate educator positioning (e.g., seated among participants) • Where possible, deliver education directly in-language by relatable educators, with interpreted English as a secondary option • Provide opportunities for participants to ask questions, share stories, and build on each other's knowledge, to deepen understanding, extend those with prior topic familiarity, and strengthen social cohesion—see Hillegass and colleagues (2023) for examples of culturally appropriate facilitation • Consider focusing on a smaller number of education topics per program block (e.g., four) and exploring these in depth across multiple sessions • Offer pre-session information about upcoming topics to support preparation and engagement • Provide in-language take-home materials, including options that do not rely on literacy (e.g., summaries, slides, videos, audio recordings, fact sheets, relevant websites)
Exercise	• Ensure exercise components (warm-ups, routines, activities) are engaging, varied, and responsive to participants' preferred intensity levels • Where appropriate and aligned with participant interest, incorporate "ethnic sports" to draw on and strengthen existing cultural capita—see Elshahat and colleagues [18]; Smith and colleagues [13] • In addition to facilitators, include staff who can provide in-language instruction or interpreting to maximise participant understanding and support timely, ongoing feedback • Consider the optimal number of exercise routines or activities per session to ensure participants can focus on technique and build confidence
Mental health supports	• Use non-stigmatising, strengths-based language when discussing mental health • Explore culturally appropriate options for participants to access formal and informal mental health support during and after the program (e.g., pre-session wellbeing 'check-ins', guided mindfulness between education and physical activity components, end-of-session relaxation, involvement of counsellors or faith leaders)
Connection to Australian culture	• Where there is participant interest, incorporate free staff-led group outings that provide safe, supported exposure to Australian culture (e.g., attending an AFL match)
Participant feedback	• Identify efficient, low-burden and culturally appropriate methods for collecting interim and end-of-program participant feedback on education content, exercise components, and other program elements • Foster a culture of openness and non-judgement to support honest feedback. Encourage participants to share what is working well and what could be improved, and provide options to give feedback privately to preferred staff outside of sessions. • Where feasible, implement program adjustments based on participant interim feedback within the same program iteration
Facilitator feedback	• Identify efficient, low-burden and culturally appropriate ways to gather facilitator feedback on program successes, role enablers/barriers, and support needs • Where feasible, implement program adjustments based on facilitator interim feedback within the same program iteration

4.1 | Study Strengths and Limitations

This primarily qualitative approach adds to evidence on CALD communities' experiences of place-based, gender-sensitised wellbeing programs in Australia. It contributes by focusing on metropolitan-based Vietnamese, Iraqi Syriac, Indian, and African diaspora migrant men (and some second-generation youth), including those with refugee backgrounds. Engagement through both established community groups and individually recruited cohorts across multiple program iterations enabled more nuanced insights into program processes. Detailed descriptions of both the mainstream and CALD-adapted program models enhance transparency and replicability. Findings reflect established principles of community development—such as consultation and relationship building—and health promotion strategies, including partnership development and capacity building [7, 50].

Limitations include the self-selected nature of participants and facilitators, who may differ from non-attendees. While we synthesised themes across participants, substantial diversity exists within and across CALD communities. Most feedback was positive, raising the possibility that participants withheld criticism to avoid conflict or ensure program continuation. As we did not examine the experiences of participants who dropped out early, barriers they may have encountered remain unknown. The involvement of interviewers during the program may have facilitated openness for some participants and inhibited candour for others. Feedback collected within 2 weeks of program completion may reflect a recency effect.

4.2 | Implications and Future Directions

Our study findings reinforce that culturally adapted health and wellbeing programs should avoid treating CALD men as a single category. Tailoring should instead consider multiple intersecting identities—for example, young African students vs. older Vietnamese retirees—recognising that a program calibrated for one such group may not transfer to another without further adaptation. Attending to intersectionality in this way supports acceptability, appropriateness, and scalability [39] by clarifying which adaptations are universal and which are subgroup-specific. By demonstrating how surface- and deep-structure adaptations intersect with age, migration stage, and social context, this study offers practical guidance for designing equity-oriented wellbeing programs for diverse CALD populations.

Future research should examine wellbeing programs that incorporate more extensive deep-structure adaptations, and look beyond program completion to assess how culturally appropriate post-program pathways affect sustainability of behaviour change. CALD communities in regional and rural areas warrant comparable attention to those in metropolitan settings, as do additional intersections—including faith, socio-economic status, disability, migration pathway, and duration of settlement in Australia. Examining facilitators' own experiences of the role would also help strengthen program delivery, supervision, and support structures.

5 | Conclusions

This study positions CALD SOTW as a culturally adapted, community-based wellbeing program that is appropriate, acceptable, and associated with positive shifts in health behaviours among CALD men in metropolitan Victoria. The findings demonstrate that meaningful adaptation requires attention to both surface- and deep-structure elements, and that intersecting identities—cultural, generational, religious, and migration-related—should shape program design rather than be flattened into a single "CALD" category. Sustained, culturally informed collaboration with communities will be essential to maintaining relevance and extending impact across the diverse populations these programs aim to serve.

Author Contributions

Both authors meet the criteria for authorship based on the ICJME guidelines. M.C.A.: conceptualisation, data collection, data analysis, interpretation, and writing – original draft preparation, reviewing and editing. C.L.B.: conceptualisation, funding acquisition, data collection, interpretation, writing – reviewing and editing. Both authors edited and approved the final manuscript version. Partner investigators (non-author contributions) – the authors wish to acknowledge Ms. Nina Pombuena and Ms. Leyla Asadi from the Western Bulldogs Community Foundation for their contributions to this manuscript, namely via assistance with participant recruitment, data collection, and technical editing of the manuscript.

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Ethics Statement

Ethics approval was granted by the Victoria University Human Research Ethics Committee (HRE21-071; HRE23-044).

Consent

The authors have nothing to report.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The datasets used and analysed during the current study are available from the corresponding author on reasonable request.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Table S1:** Summary of CALD SOTW staff and participant engagement across cohorts. **Table S2:** CALD SOTW Health education topics delivered by cohort. **Table S3:** Participant attendance data by cohort in the context of age and employment status.