SHIFT

European Regional Development Fund

SHIFT – The Tailored Strategy

Sexual Health and wellbeing of people aged 45 and older

Aim of this document

SHIFT offers a model to promote sexual health of people aged 45 and older by increasing knowledge and awareness, decreasing stigma and making tailored information and services more accessible for this population. This document describes the strategy to adapt the SHIFT model to reach socio-economically disadvantaged people.

Challenge

Sexual Health and wellbeing of people aged 45 and older

TThe World Health Organization (WHO) defines sexual health as a state of physical, emotional, mental and social wellbeing in relation to sexuality –and not just the absence of disease, dysfunction or infirmity.

This definition does not imply any age-limitation. However, in practice sexual health programmes and services focus on people of reproductive age and people aged 45 and older are often excluded from research, policy and practice.

Mostly it is forgotten that a great majority of people in this age group are sexually active and have diverse sexual lifestyles. There is very limited information and resources around sexual health and wellbeing of this group. Due to (self) stigma and shame, people aged 45 and older do not easily reveal being sexually active and don't seek help and information. The corelation between this gap in information and services and rise in sexually transmitted infection (STI) rates is clear.

Sexual health and wellbeing of socioeconomically disadvantaged people aged 45 and older

WHO's Social determinants of sexual and reproductive health states 'factors beyond the control of the individual' can influence sexual and reproductive health. These are believed to contribute to inequities in use of health services and ultimately observable differences in sexual and reproductive health. Within the 45 plus population, people with one or more socio-economic disadvantages are at a greater risk of having lower knowledge and awareness and being engaged in high risk behaviors such as transactional sex. This groups are being unable to access appropriate services and are underserved by routine services.

Socio-economically disadvantaged people

(in terms of accessing sexual health information and care):

- Homeless or poorly housed people
- People living in poverty
- Socially isolated people
- Migrants (non-native language speakers)
- Refugees and asylum seekers
- People living with, or affected by HIV
- Sex workers
- LGBTQI+
- Geographically isolated people
- People with physical/mental health disabilities.

Objective

The main objective of this work package was to develop a tailored sexual health and wellbeing strategy to adapt the model to engage with people 45 plus who experience one or more socio-economic disadvantages.

Needs assessment

To get insight into sexual health needs and barriers of the 45 plus population, including socio-economically disadvantaged group we conducted a study, consisting of a survey and a qualitative study. The survey was promoted via different social media channels, where 45+ population are active. The qualitative study consisted of in-depth interviews and focus group discussions with 45+ people with one or more socio-economically disadvantages.

According to the study, people with one or more socio-economic disadvantages experience extra barriers in accessing sexual health information and services comparing to general 45-plus population. The most important barriers specific to this group were[1]:

- Cultural norms and taboos
- Fear of diagnosis and subsequent disclosure
- Generational views
- Fears of racial discrimination
- Worries about lack of anonymity, privacy and confidentiality
- Concerns over bad experiences if LGBTQ+, disabled, or have migration background
- Cost of care or medication.

Based on the results of the study, the following key themes were recognized that have an impact on sexual health and wellbeing of 45-plus population including socio-economically disadvantaged people: :

- *Knowledge* on sexual health, wellbeing and healthy aging
- *Awareness* on the (importance) of sexual health and wellbeing
- *Access* to low-threshold sexual health services and information
- *Stigma* in regards to sexual health of 45 plus population.

[1] For complete report and results of the study please refer to the final SHIFT evaluation report.

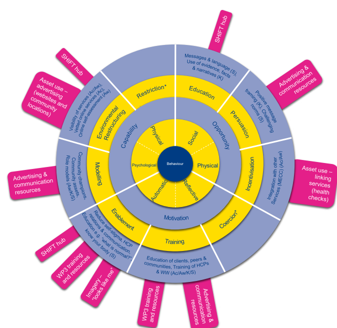
COM-B model

COM-B model for behavior change[2] alleges that **C**apability (C), **O**pportunity (O) and **M**otivation (M) are key factors for changing **B**ehavior (B).

Capability refers to an individual's physical and mental ability to participate in an activity. This also includes knowledge and skills.

Opportunity refers to external factors that make a behavior possible. Physical opportunity, opportunities provided by the environment, and social opportunity are all valid components.

Motivation refers to the conscious and unconscious cognitive processes that direct and inspire behavior.



SHIFT COM-B model
appendix 1-English version;
appendix 2 Dutch version

The SHIFT COM-B model contributes insights into sexual health and wellbeing behaviors, and helps facilitate behavioral change for an individual around their own sexual health and wellbeing.

Through addressing different components of the COM-B model, SHIFT aimed to improve sexual health and wellbeing of the target groups, by increasing their knowledge and awareness, decreasing stigma and normalizing discussion around sexual health of this age group and making tailored information and services accessible for them[3].

[2] http://www.behaviourchangewheel.com/

[3] For more information about the SHIFT-model please refer to the output report WP1

Tailored strategy to engage with socio-economically disadvantaged

According to the SHIFT-model a range of activities and tools were created to reach the general 45-plus public. The most important tools were SHIFT website and films. However, the socio-economically disadvantaged people experience specific barriers in accessing information and services that cannot be decreased with these tools.

The SHIFT model and the tailored strategy were developed through a series of national and cross-border meetings involving project partners, public health organisations, other stakeholders, and most importantly, with community-based organisations and people in the local communities. These meetings made sure a wide variety of people were involved in adapting the model and creating a tailored strategy.

The core of the tailored strategy was to bring SHIFT directly to local communities. The meetings identified that although all of the sub-populations in this target group experience barriers in accessing sexual health information and services, they do not form a homogeneous group and the barriers they face are different. Therefore, for each sub-population targeted outreach activities were created.

The base of the strategy was to **SHIFT services from clinics to communities** and **develop tailored activities** to:

- reach the most hard-to-reach and marginalized populations
- empower them
- motivate them
- create the opportunity for them

to increase their knowledge and awareness, normalize sexual health discussions and stimulate utilization of the accessible low-threshold services.

In creating the targeted outreach activities for each sub-population, people from that specific community were involved and activities were co-created.

The following targeted outreach activities were identified to engage with different subpopulations:

- Neighborhood-based approach
- Mobile outreach services
- Bespoke group sessions
- Drop-in sessions
- Outreach activities at social events.

Asset mapping

Another key element of the SHIFT tailored strategy was collaboration with the organisations working with the subpopulations. In order to gain insight into active organisations, a community asset mapping was conducted. A list of the most prominent charities, community organisations, associations and services that work with or support vulnerable people and organisations working in the field of (sexual) health were gathered. This activity provided us the opportunity to evaluate our links and ensure that any gaps are filled. The organisations that seemed to be relevant and useful were approached by the project partners and the most prominent organisations in reaching these hard to reach groups were involved in SHIFT.

Piloting the strategy

The aim of the pilot was to monitor how the tailored strategies impact the areas that we wanted to impact (knowledge, awareness, stigma and access) and to adapt the strategy accordingly. SHIFT project partners in different countries aimed to reach different sub-populations and piloted different activities based on their national priorities, unique community connections and organizational expertise.

Neighborhood-based approach in the Netherlands:

The prioritised sub-populations in the Netherlands were:

- People with a migration background especially first-generation migrants (non-native language speakers)
- People living in economically deprived areas.

To engage with these groups, a neighbourhood-based approach was piloted. For this purpose one of the most marginalised areas of the Netherlands, Schilderswijk in the Hague, was selected. In terms of demographic, social and financial factors this district is an appropriate place to pilot a neighbourhood-based approach targeting socio-economically disadvantaged population (*Information about Schilderswijk appendix 3*). Besides, community asset mapping and engaging with the local organisations identified that this area is a well-defined metropolitan district where a clear infrastructure of care and community organisations is present. The healthcare and community professionals in this district showed a lot of enthusiasm and commitment to the theme and were willing to cooperate with the project.

After evaluating different centers and organisations, one of the most prominent and well-visited community centers, 'De Mussen'[4], was selected as the main hub for conducting activities in this district. Together with the community workers of this center and people from the target groups a set of activities were planned and implemented to empower the target population, increase their knowledge and awareness and to motivate them to discuss sexual health and wellbeing. Besides, an 'environmental restructuring' was planned to be conducted. "Environmental restructuring includes modifying the physical environment around the target group in order to influence their behavior and health". In other words, it is "improving public health through increased opportunity for healthy behaviors". To increase the opportunities for healthy behaviour, sexual health education were integrated into other activities and programs of the center, wider workforce (community workers and volunteers) and healthcare professionals were trained and outreach healthcare services were made available at the center. The activities which were implemented in this district were as follow:

- **Raising knowledge and awareness**

Through organising various education sessions for migrant women on different aspects of sexual health. The sessions were held at the community center and at schools of this neighborhood for migrant mothers.

These sessions were facilitated by healthcare professionals or experts of knowledge centers. The themes which were discussed during sessions were: menopause, sexual health and wellbeing, sexual pleasure, STI's and HIV, unwanted pregnancy, contraceptives, sexual diversity and sexual forming of young children. During each session there was room for asking questions and discussing concerns and disagreements. Crosscutting subjects such as role of religion, cultural differences, community pressure and taboo were also discussed.

- **Reaching the hardest to reach women**

In order to reach women who do not visit the center regularly and are the hardest group to reach, voluntary peer groups were trained to spread the information and refer women to the specialized healthcare and support centers if needs be.

  - *Schilderswijk mothers are a group of trained female volunteers from the neighborhood who support other migrant women with their daily problems such as filling in forms, financial difficulties, parenting problems or domestic violence. This group were trained on different aspects of sexual health to break taboo and discuss the subject with other women. Also a number of Mothers who were more interested in the subject and willing to delve into it received extra trainings to give more in depth information to other women.*

  - *Training of Somalian Mothers: Another hard to reach population in this district is women with Somalian background. A group of Somalian women who are well-known and well-trusted in the district and are trained to support other migrant women with social problems were trained to reach socially isolated Somalian women with sexual health information.*

- **Sexual health consult and services**

Another factor which contributes to improvement of sexual health and wellbeing is accessibility of low-threshold services. After conducting several educational activities to increase knowledge and awareness and normalize sexual health discussions, sexual healthcare services were made available at the location of the community center, to monitor if it contributes to the utilization of services.

This activity has been implemented in collaboration with, Doctors of the World Netherlands and Municipality Health Services (GGD) of de

[4]De Mussen is a is the oldest community center in the Netherlands. Their mission is to offer equal opportunities to children, young people and their parents in this district for development. Their working method is culture-sensitive, accessible and integral and they work for and with the local residents.

Hague. During this activity sexual health consult, contraception and STI/HIV testing were provided free of charge.

- **Engaging with other people who do not visit the center**

It was known that all vulnerable sub-populations cannot be reached via this community center. Therefore series of targeted outreach activities were planned and implemented in collaboration with other community based organization at different locations of the neighborhood.

Examples of implemented activities:

- o *Education sessions for clients of Foodbank*
  Clients of foodbank are the most financially disadvantaged population. In order to reach this group education sessions were conducted at the location of a church for female clients of Foodbank. The subjects which were raised during these sessions were menopause, sexual health at older age and STIs.

- o *Education sessions for undocumented migrants and homeless population*
  In collaboration with Wereldhuis and other local organisations, educational sessions were held in a church in the Schilderswijk for undocumented migrants and homeless population. Based on the priorities of this population, the main subject of the sessions was sexual violence.

- **Engaging with and training of wider workforce at local organisations**

To increase general awareness on sexual health, normalize discussions about sexual health and wellbeing and to include sexual health information in the routine contact moments of the target population with the community centers, wider work force, volunteers and peers were trained and referred to the SHIFT-website for additional knowledge.

Example of groups who were trained:

- o *Community workers and coordinators of the programs at de Mussen, some volunteers and community workers of the Foodbank and Wereldhuis received a training on sexual health.*

- o *The sport coaches of de Mussen were trained on sexual health and its relation to general health and wellbeing. The goal of this activity was to reach migrant men and raise the subject of sexual health during other health related consults.*

- **Engaging with and training of local healthcare professionals**

In contemplation of increasing opportunities for healthy behavior for the target populations and normalizing discussions on sexual health and wellbeing, general practitioners working in this neighborhood were approached and GP-assistants, who are the first point of contact with the primary healthcare, were trained. The SHIFT-website was introduced to them as a source of information for professionals and patients.

Activities conducted included:

- o *All of the general practitioners who work in Schilderswijk received a phone call from one of the trained GP-assistants cooperating with the project and were informed about the project activities in the district. They were requested to encourage their assistants to take part in the training. Besides, general practitioners and their assistants received newsflashes per email about the project and its activities.*

- o *The GP-assistants were invited to participate in the SHIFT training. Totally 4 training sessions were organized for the GP-assistants and 44 assistants were trained by using SHIFT modules for training of healthcare professionals[5].*

[5]For complete report and results of the study please refer to the final SHIFT evaluation report.

Planned and ad-hoc outreach activities in England

The prioritized sub-populations in England were:

- People identifying as LGBTQ+
- People who are homeless or poorly housed
- People who are from BAME communities (Black, Asian and Minority Ethnic)
- People living in poorer areas, or likely to be from lower socio-economic backgrounds

In order to engage with these groups, series of targeted outreach activities were conducted addressing different subpopulations. The activities included:

- Outreach at social events
  To engage with LGBTQ+ population and increase their awareness, outreach sessions were conducted at local PRIDE events in SE England
- Bespoke group sessions
  For women of color, living with HIV
- Drop-in sessions
  For homeless population at local homeless shelters.
- Mobile outreach services
  Health bus outreach sessions in known areas of deprivation across Kent, Medway, and Brighton

At each event, flyers with information and links to the SHIFT website and free condoms were distributed. Also a variety of lubricants were on display and available for service users to take home. General information and advice was offered. The six SHIFT films were displayed on an iPad on loops. A second iPad was available to support online referrals (for example, to help service users register for at-home online sexual health testing in their area), to show specific sections of the SHIFT website as relevant, and to introduce service users to other services/providers as part of broader community signposting. Demonstration models of devices used to strengthen the pelvic floor and/or the vaginal wall were also available for consideration.

Moreover, a long visual list of the topics was available for discussion, including: healthy relationships, the menopause, sexual dysfunction, masturbation, pain, STIs/HIV, testing and treatment options, local service information, and the menopause.

Conclusions and future recommendations

- Every individual has the right to healthy, fulfilling, safe, and consensual sex and relationships. What this means changes from person to person, particularly when they are vulnerable or otherwise at risk of poor sexual health outcomes. Creating a safe space for someone to talk about their sexual health and wellbeing could change their lives- and this needs to happen in spaces where people live, work, learn, play and love and are therefore most comfortable.

- Involving and engaging with trusted people within the community facilitates the process of reaching vulnerable populations and gaining their trust. However building relationships and trust takes time.

- Bring information and services where the target group is and feel comfortable- community centers, local events, even beauty salons and barberies.

- Experience of this project suggests that a neighborhood-based approach and bringing sexual health information and services to the communities works, but is a time-consuming process. In order to achieve long-term impact by this approach and conduct a comprehensive environmental restructuring, enough time and budget should be invested.

- By conducting a neighborhood-based approach less people will be reached comparing to a website or a campaign, but a greater long-term impact and behavior change is more likely.

- Community and healthcare professionals from the first step is essential for setting goals based on the local needs and priorities and for achieving a change.

- Presence of community organisations and professionals infrastructure as well as the commitment of professionals and community workers is a solid basis for effective neighborhood approaches.

Appendix 1: SHIFT COM-B Model (English version)

Behaviour

Capability

Physical

Psychological

Opportunity

Social

Physical

Motivation

Reflective

Automatic

Restriction*

Education

Persuasion

Incentivisation

Coercion*

Training

Enablement

Modelling

Environmental Restructuring

Messages & language (S), Use of evidence, facts & narratives (K)

Positive message framing (K), Challenging norms (S)

Integration with other Services (MECC) (Ac/Aw)

Education of clients, peers & communities, Training of HCPs & WW (Ac/Aw/K/S)

Reduce self-stigma, HCP relations & communication, Education e.g. "what is normal?", know your body (S)

Community champions, Community assets, Role models (Aw/K/S)

Visibility of services (Ac/Aw), Vetted online services (Ac), Online self-assessment (Aw)

SHIFT hub

Advertising & communication resources

Asset use – linking services (health checks)

Advertising & communication resources

WP3 training and resources

Imagery – "looks like me"

WP3 training and resources

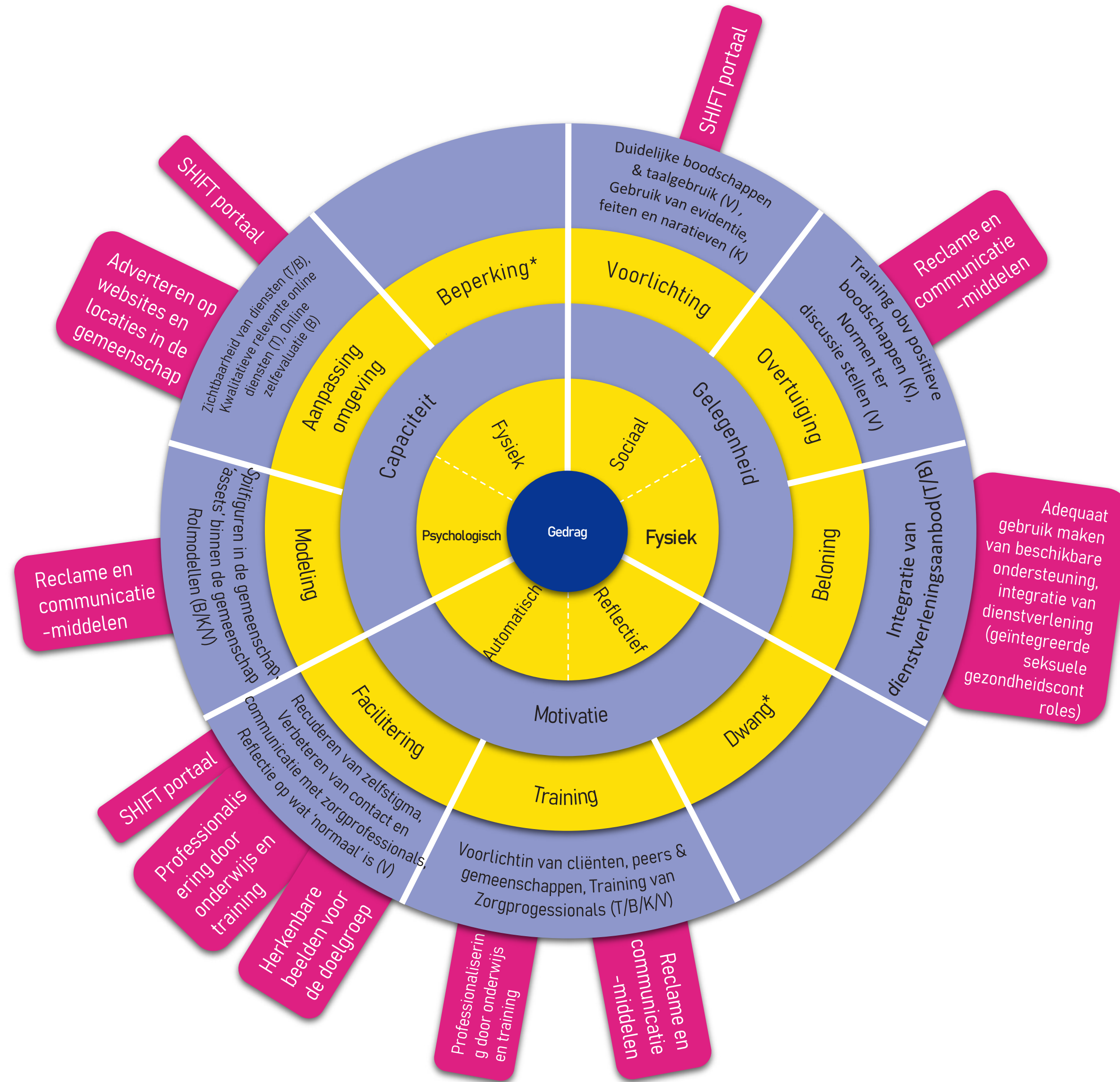
SHIFT hub

Advertising & communication resources

Asset use – advertising (websites and community locations)

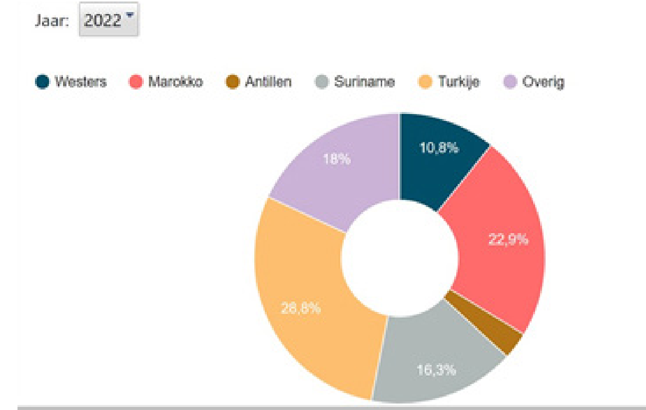
SHIFT hub

Appendix 2 COM-B Model (Dutch version)

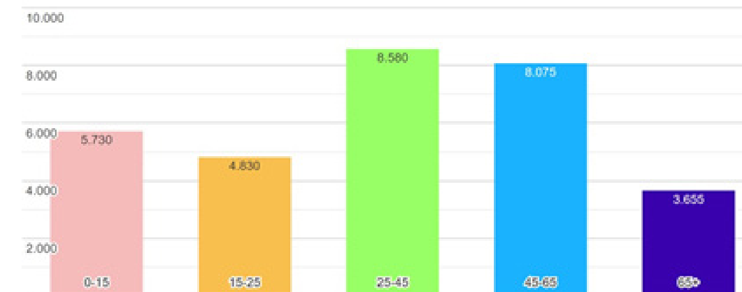


Appendix 3: Schilderswijk

Total population of Schilderswijk is 30,870 (2022).



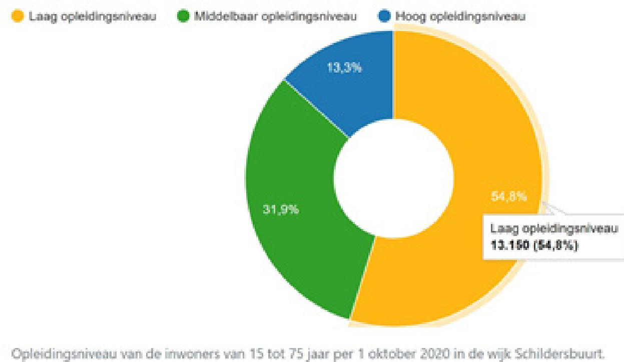
- About 25,000 people 81.16 % of the population have a non-western migration background. The non-Western migrants in this neighborhood are mostly from Turkey, Morocco, Suriname and Dutch Antilles. About 9.85% of the population has a Western migration background. Only 9% of the residents are originally Dutch.
- Almost 12,000 people are at the age of 45 or higher.



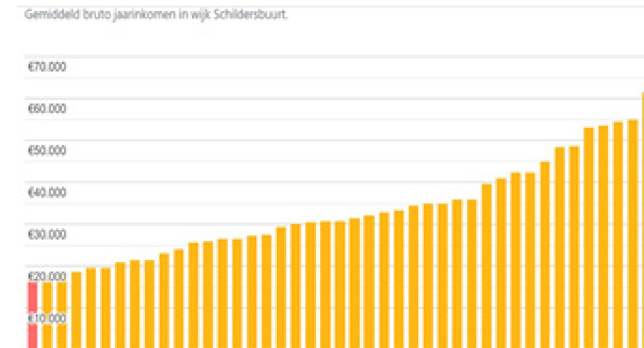
The education level of the residents of this neighborhood is quite lower than the average Dutch education level.

- Only 13.3% of the population has a high (university) education. The average high education rate in the Netherlands is 35.5%
- About 55% of the population has a low education level (elementary or illiterate).

In terms of the financial status, this neighborhood is one of the poorest neighborhoods of the Netherlands. The residents of this area has the lowest income comparing to other neighborhoods of the Hague. 67% of the population in this neighbourhood lives in a social rental house.



Opleidingsniveau van de inwoners van 15 tot 75 jaar per 1 oktober 2020 in de wijk Schildersbuurt.



Gemiddeld bruto jaarinkomen in wijk Schildersbuurt.