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Hidden Voices

SHIFT-ing services from clinics to communities to reach those most at risk

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Work Package 2:
Working with Vulnerable Communities

WP2 aimed to engage people aged 45+ who might be more vulnerable to poor sexual health outcomes, by bringing SHIFT sexual health services directly to local communities, at-risk individuals, and support services.

Partners:

- Soa Aids Nederland (Netherlands, Lead Partner)
- METRO Charity (UK, Support Partner)

Groups we hoped to reach

- People identifying as LGBTQ+
- People from black or minority ethnicity backgrounds
- People living with, or affected by, HIV
- People who are homeless or poorly housed
- Sex workers
- Refugees and Asylum seekers
- People living in poverty
- People who are geographically isolated
- People with physical or mental health disabilities

Understanding Need: WP2 Specific Outcomes

When we looked specifically at survey and interview outcomes amongst individuals identified as being from one or more vulnerable groups, we found additional barriers to good sexual health,including:

- Cultural Norms and Taboos
- Fear of diagnosis and subsequent disclosure
- Generational views (eg, don't need to bother)
- Fears of racial discrimination
- Worries about lack of anonymity/privacy/confidentiality
- Concerns over bad experiences if LGBTQ+, disabled, or BAME

Specific Considerations: Older LGBTQ+ People

- Many older LGBTQ+ people had negative experiences of coming out
- High levels of fear and shame about sexuality
- Historically many have felt unsafe to express their gender or sexual orientation
- Much higher rates of closeted sexuality or gender expression with age, particularly within healthcare settings or care facilities
- Older LGBTQ+ individuals are more likely to be single and to live alone
- Potential trauma due to loss of peer group through HIV epidemic
- Queer gender identities becomes fetishized; can be more difficult for many trans-people to establish healthy relationships as they age

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Specific Considerations: Sexual Health & Religion

- Sinful Activities
  - Sex before marriage
  - Non-monogamy
  - Adultery
  - Divorce
  - Masturbation
- Sex is only for reproduction
- Lack of acceptance of sexual or gender diversity
- Expectations of a higher power to obey / reproduce / follow specific gender roles
- Beliefs about illness and healing, eg, “God will heal HIV”
- People following the advice and example set by their religious leader

Specific Considerations:
Cultural influences across generations

- Rituals around sexual contact
  - eg ritual washing before or after sex, no sex during menstruation
- Beliefs about cleanliness and disease
- Arranged marriage vs. Love marriage
- Monogamy for women; Polygamy for men
- Restriction of access to knowledge and/or treatment
- Believing in traditional versus western medicine, eg, to treat HIV
- Shared sense of stigma, fear of judgement
  - Eg, women wanting to use condoms are untrustworty, dirty, or promiscuous
- Unequal power balance and/or freedoms between genders
- Sex “only happens” within the context of marriage

Specific Considerations: Language

- Actual language- can prevent or limit understanding
  - People often say they understand when they don't
  - Many people fear using a translator from their community due to concerns about confidentiality
- Social language- about what is good or bad, who is good or bad, what kind of sex or relationships are good or bad
  - Can prevent people from seeking support
- Health literacy- the degree to which someone is able to understand and interpret information given to them
  - Eg, talking to someone about the importance of cervical screening, when they don't know what their cervix is or why it needs screening

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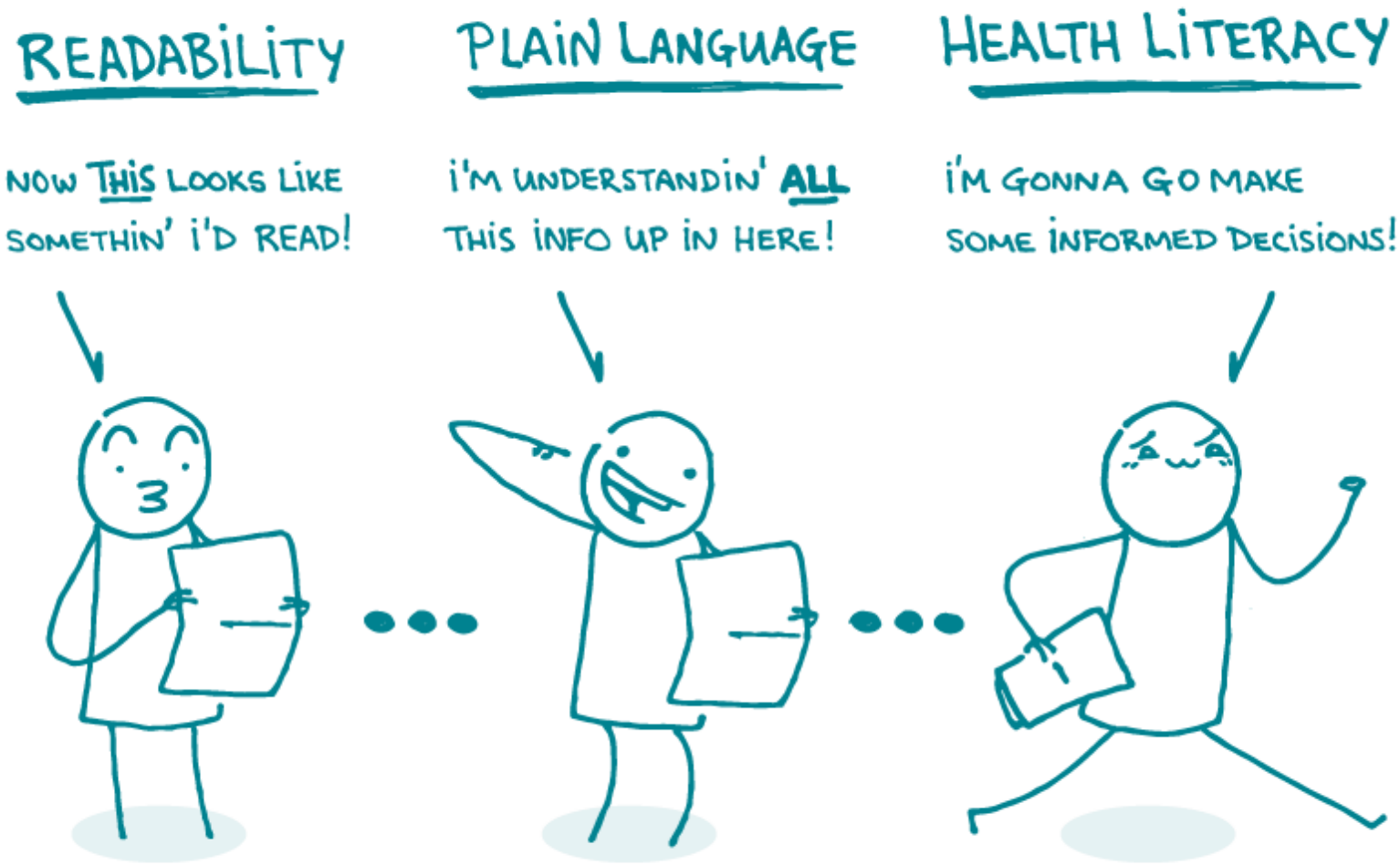

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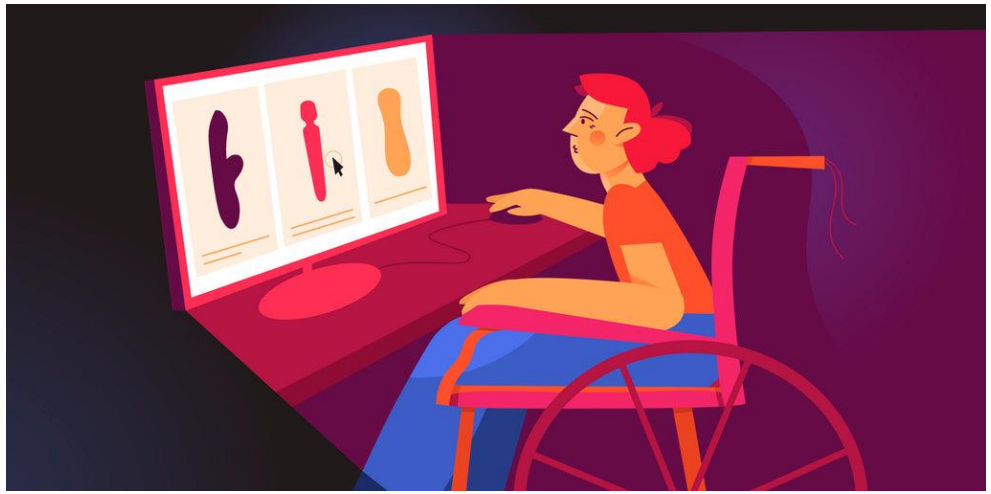
Specific Considerations: People with disabilities

- Are often overlooked as having sexual needs, feelings, and desires
- Suffer from the cultural perception of who “should” and “should not” have sex
- Are often dependent on carers and/or have little privacy
- More likely to suffer abuse, coercion, exploitation, rape, and assault
- Can have mental or physical limitations which make it difficult them to both understand and communicate consent, boundaries, choices, and right to privacy
- Might struggle to access or use condoms or contraceptive methods
- Might display problematic socio-sexual behaviours that preclude fulfilling relationships, care, and ability to find pleasure
- Might be more inclined to take risks, especially with mental health illness
- Might have a reduced ability to understand and mitigate risk



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Meeting Needs

METRO Charity & SOA AIDS used different approaches to try and meet the needs of specific communities, based on their unique community connections and organisational expertise

Some outcomes were similar; others varied!

METRO: Target Groups

Due to experience, existing connections, and time limitations, we wanted to reach:

- People identifying as LGBTQ+
- People who are homeless or poorly housed
- People who are from BAME communities
- People living in poorer areas, or likely to be from lower socio-economic backgrounds

METRO: Strengths

- Strong connections with local pride events meant we were welcomed, promoted, and supported
- Connections with local authorities in Kent County Council, Brighton & Hove City Council, and Medway Council meant that we were supported to park our health bus in areas of need
  - Also supported to identify relevant areas, eg, high deprivation / rates of HIV
- Build on existing groups within other METRO services
  - EG Peer support group for women living with HIV
- Good awareness of local services and expertise in collaboration
- Expert staff trained to identify, raise, and respond to need

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METRO: Limitations

- Lack of time to plan due to covid delays
- Some local authorities had competing priorities or poor inter-departmental links
- Some recommended locations were not ideal for outreach
- Inclement weather
- Train and travel delays, including strikes
- Staff capacity to support / deliver
- More connections in younger groups and within London (not part of SHIFT area)
- Staff more used to supporting young people

METRO: Method

- 3 outreach sessions at local PRIDE events in SE England
- 3 health bus outreach sessions in known areas of deprivation across Kent, Medway, and Brighton (SE UK)
- 1 bespoke group session for women of colour, living with HIV
- 2 drop-in sessions to local homeless shelters
- 1 ad-hoc session at a local bed & breakfast

METRO: Outcomes

Leaflets Given Out	2610
Condoms Given Out	1725
Lube sachets given out	2150
General Conversations	336
Recorded Conversations	54
STI Testing	71
HIV Testing Queries	32
Menopause Concerns	116
Erectile Dysfunction Concerns	23
Directed to SH Clinic	67
General Sexual Health Concnerns	79
Homeless Support	45

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METRO Observations: Who we saw

- Balance of men, women, transgender, and gender queer people
  - Heterosexual men tended to come alongside a female partner
- Balance of sexual orientations and people in different types of relationships
  - Married, divorced, widowed, single, polyamorous, open relationships, etc
- People who were homeless- both at shelters and on the street
  - Street-dwellers often went to find their friends and bring them to see us; good community network to build upon
- People with disabilities and chronic health conditions, particularly people living with HIV and people living with mobility issues
- People from lower socio-economic backgrounds and/or experiencing geographic isolation from key sexual health services
- Good age ranges, from 45-85 (majority 50-70)

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METRO Observations: Who we missed

- People from black and minority ethnicities
  - Were particularly less likely to engage if in mixed-sex groups
  - Best engagement was via targeted support group women of colour living with HIV
- People living with mental health illness
- People with drug or alcohol abuse issues
- Sex workers
- Gypsy, traveller, and Roma communities
- Refugees and asylum seekers, and first-generation immigrants in general

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METRO Observations: Menopause

- Menopause noted as the most critical, unmet need by people experiencing menopause, as well as by their partner(s)
  - Low libido, pain during sex, vaginal dryness, pelvic floor issues, physical changes, mental health concerns, fatigue and insomnia
    - All affect self-esteem and intimate relationships
- Experience of healthcare often not positive
- Can't afford Hormonal Replacement Therapy (HRT)
- Aren't followed up on / tweaked / etc
- Rarely, if ever, brought up proactively by healthcare providers
- Peri-menopausal symptoms often experienced long before they are recognised as part of the menopause
  - EG, misdiagnosed anxiety, depression, etc

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METRO Observations: “I am fine without sex!”

- Many people we spoke to presented to us the idea that the time for sex in their lives was behind them, and appeared to accept this
- Whilst this is likely true in some cases, we also know via other research that there is a huge decline in sexual satisfaction with every decade of aging
- What this tells us is that many people who are outwardly okay with not having sex, would actually like to
  - So, how do we reach them? How do we get them to talk about it? What would good support look like for them?

METRO Observations: Homelessness & STI Testing

- Much STI testing for the UK for patients who are asymptomatic has been pushed to at-home testing
- This doesn't work for people without an address
- Many homeless people are having sex with one or more partners
- Difficult to access condoms, lubricant, and STI testing
- Sexual health clinics are not within viable travelling distance, or not felt to be welcoming to people who are homeless
- We need to collaborate with homeless shelters, soup kitchens, homeless GP services, and roving homeless support teams
- Have STI kits on site, send regular stocks of condoms and lubrica hold monthly roving clinics?

Ideas for future projects

- Build on strength of homeless people wanting to support other homeless people via peer-based health promotion initiatives
- Menopause! Menopause! Menopause!
  - Policies, training, peer mentorship, primary care capacity building, etc
- Start to work more closely with socio-economically disadvantaged groups to explore beliefs around the right to pleasure and sexual satisfaction

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Specific Outcomes Netherlands

Specific barriers present for Dutch participants:

- Cost of care or medication
- Disability
- Lack of passport or identification

Soa Aids Nederland (SANL): Target Groups

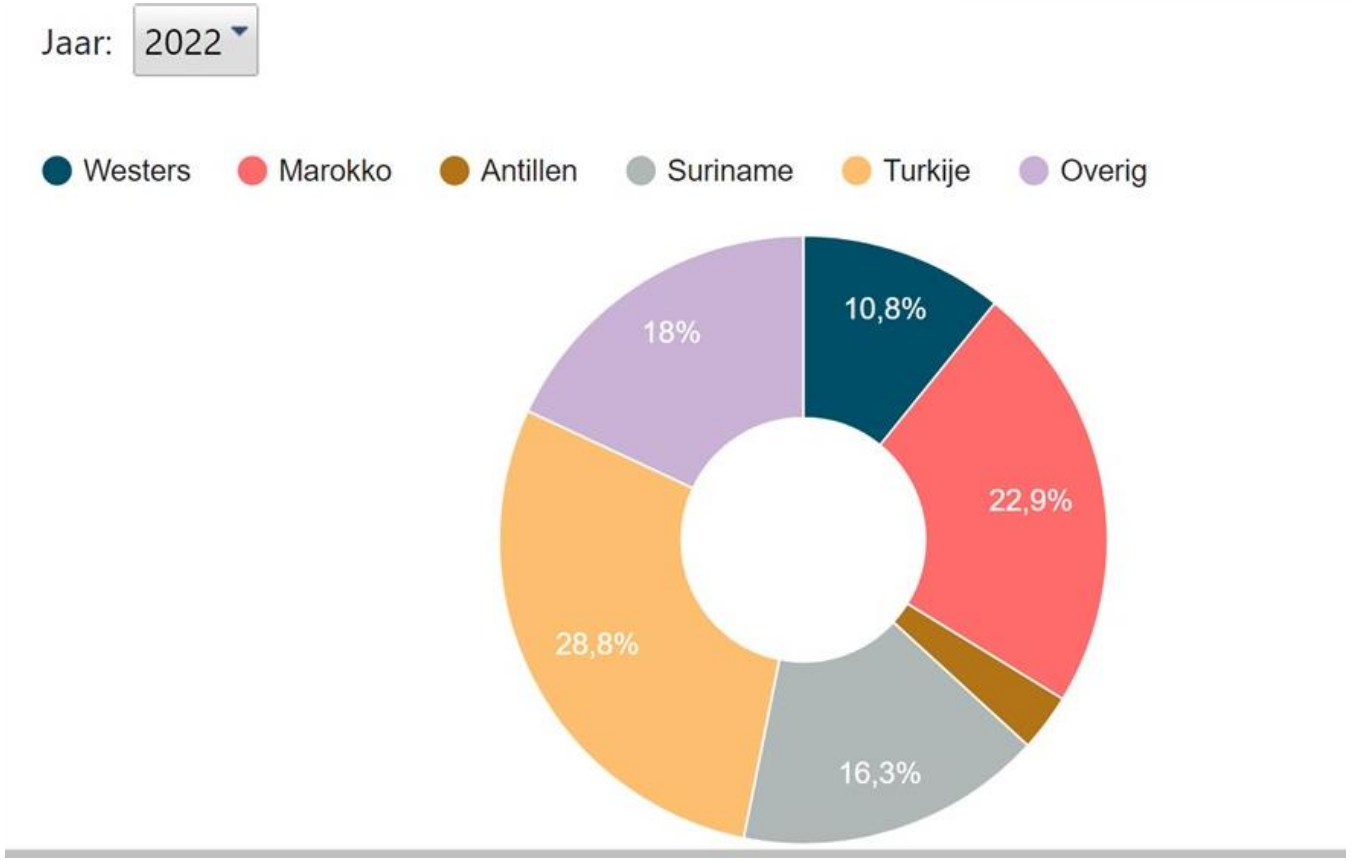
Due to the national priorities and our experience, we wanted to reach:

- Non-native Dutch speakers (first and second generation migrants)
- People from a lower economic status
- People living in marginalized areas

- Less strict on 45+ age limitation when reaching out to these target groups

SANL: Method

- Neighborhood-based approach in one of the marginalized areas
- Schilderswijk
- Total population in 2022: 30870
- Non-western migration background 25000 (81.16%)



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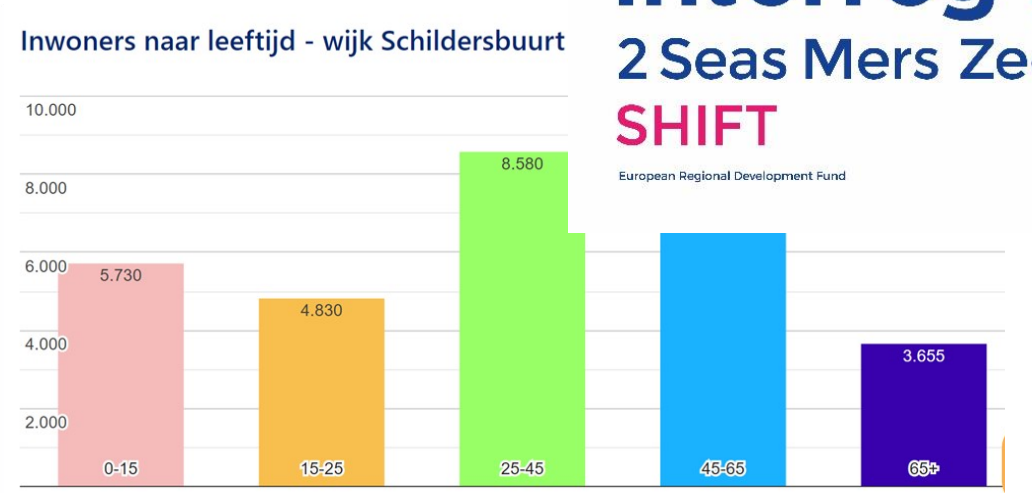
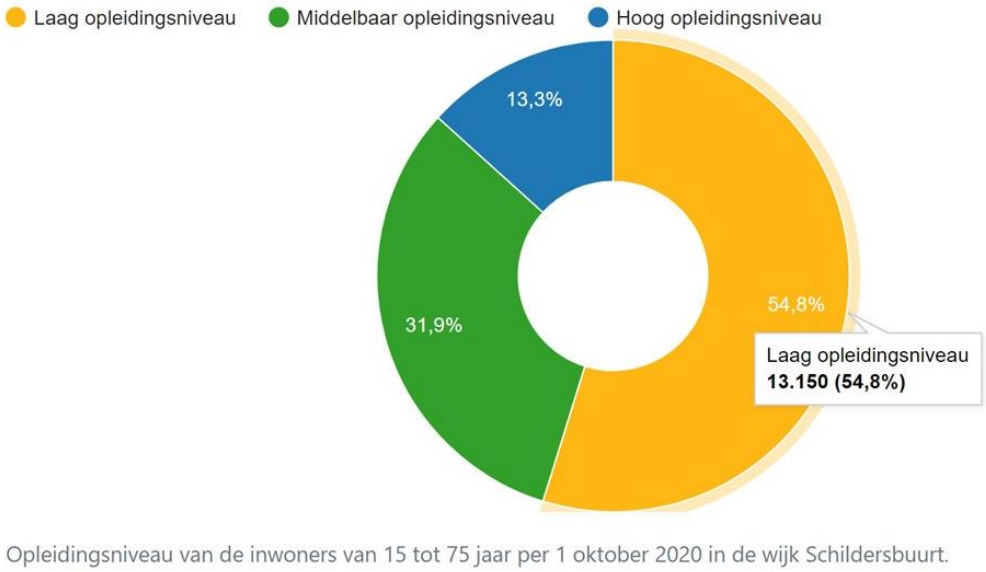
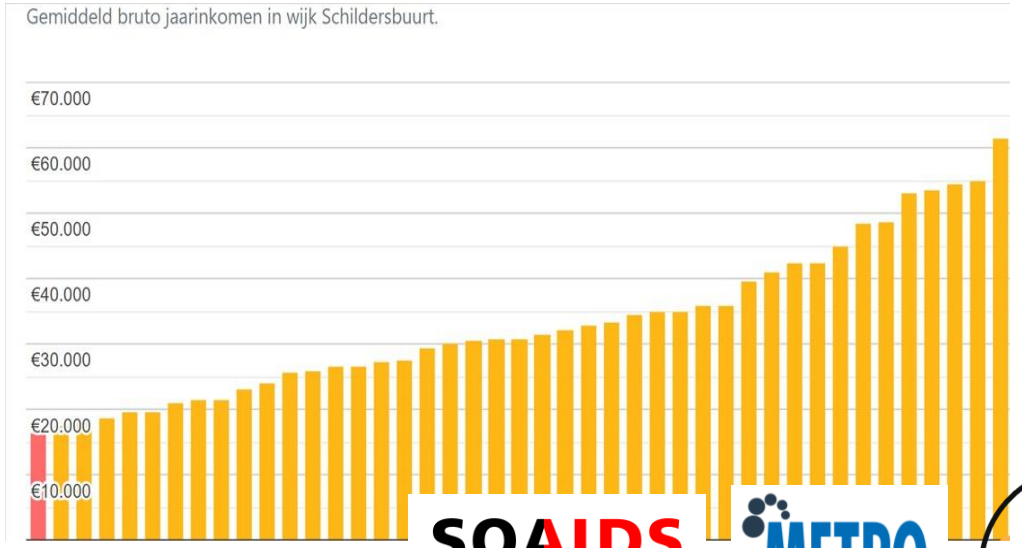
SANL: Method

Schilderswijk





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



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SANL: Method

Schilderswijk:

- Well-defined metropolitan district with a clear infrastructure of care and community organizations
- With professionals and community members with a lot of initial enthusiasm and commitment for the theme

<u>> Environmental restructuring</u>

- In collaboration with the community center (Buurtcentrum) de Mussen
  - Information sessions for local residents
  - Training of Schilderswijk Mothers
  - Training of sport coaches
  - Outreach in collaboration with Doctors of the World

  and Public Health Services (GGD)

- Information sessions for undocumented migrants/homeless population in collaboration with the World House (Wereldhuis)
- Information sessions for clients of the Food bank
- Training of GP assistants

SANL: Outcomes

Sessions organized	**23**
Participants information sessions	**351**
Schilderswijk mothers trained	**18**
Sport coaches trained	**2**
People reached out (testing, contraception, sexual health consult)	**12**
GP-assistants trained	**14 + 30**

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SANL Observations: Who We Saw

- Heterosexual women with migration background
- Mostly married, small number widowed or divorced
- Different ethnic background: Morocco, Turkey, Middle East, Suriname, Africa
- People from lower socio-economic background
- Mostly middle-aged, almost no 65+

SANL Observations: Who We Missed

- Men!

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Barriers We Faced

- COVID pandemic: lockdown and social distancing; very short operational phase
- Reaching women by Schilderswijk Mothers
- Reaching men by trained sport coaches
- Extreme workload at GPs due to COVID

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SANL Observations:

- Menopause noted as the most critical, unmet need by people experiencing menopause
  - Physical and mental complications
  - Mostly don’t know if/where they can get help

- Lack of basic knowledge about anatomy, and body in general

- Missing involvement of healthcare professionals

Lessons Learned

- Longer duration of project to ensure better planning and continuity of activities

- Both community and professional infrastructure and commitment of professionals and community representatives can prove to be a solid basis for innovative future neighborhood approaches

- Involving community and healthcare professionals from the beginning; Setting goals and developing a trajectory based on local priorities

Ideas For Future Projects

- Practicing broader ‘man-appealing’ approaches to reach migrant heterosexual men

- More intensive neighborhood approaches (environmental restructuring)

- More combined outreach

Next Steps

- Publish and disseminate outcomes from SHIFT
- Work with local authority and commissioning bodies, as well as third-sector funders, to create awareness of need and generate project opportunities accordingly
- Direct healthcare professionals to SHIFT outcomes to build capacity and awareness of key issues

Final Thoughts…

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.

From clinics to communities!