Social innovation

Interreg
EUROPEAN UNION
2 Seas Mers Zeeën
SHIFT
European Regional Development Fund

SHIFT
Project Evaluation Report

Contents

1. Sexual Health In the over ForTy-fives (SHIFT) Partnership

The SHIFT Project was a cross-border partnership originally involving 11 organisations from the UK, Netherlands, France, and Belgium.

The SHIFT Project was approved and funded by the EU Interreg 2 Seas Programme (Social Innovation – 2014-2020), co-funded by the European Regional Development Fund which has supported the project over four years from 2019 – 2022 (extended to March 2023).

The Health and Europe Centre, Lead Partner, UK

Kent County Council, Delivery Partner, UK

Kent Community Health NHS Foundation Trust, Delivery Partner, UK

Metro Charity, Delivery Partner, UK

East Sussex County Council, Delivery Partner, UK

University of Chichester, Evaluation Partner, UK

STI AIDS, Delivery Partner, Netherlands

Antwerp University College of Applied Science, Delivery Partner, Belgium

Odisee University College, Delivery Partner, Belgium

Former partners also include Medway Council (UK) and Sante Info Solidarite-Animation (France). There were also three observer partners: Conseil Départmental du Nord (France), East Sussex Healthcare NHS Trust (UK), and Santé Publique France (France).

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3. Report Contributors

Thank you to the talented team of researchers, delivery staff, and translators involved in gathering and collating the variety of data from across the SHIFT activities.

4. Acknowledgements

Our thanks and gratitude to all the over-45s who volunteered their time to engage with the SHIFT project and share their experiences with us. Our thanks also extend to the Project and Delivery Partners for their support and time spent collecting data throughout the project.

Our grateful thanks go to Professor Mike Lauder (project management), Professor Antonina Pereira, and the team at the University of Chichester. Finally, we would like to acknowledge and thank Thomas Molloy and the team at the Health and Europe Centre for their unfailing support in overseeing the project and keeping all partners actively involved.

5. Executive Summary

a. Summary

The SHIFT Project was co-designed to address a common need, identified by project partners in three European countries, in inequalities in sexual health and wellbeing in the over 45s and marginalised populations. This demographic has traditionally not been the focus of sexual health policies and campaigns, despite a backdrop of rising STI rates in older adults and changes in relationships and sexual activity. SHIFT delivered a model of Sexual Health for over 45s and socio-economically vulnerable over 45s, to empower the group to raise awareness and knowledge of their sexual health and wellbeing as well as increase access to support/services and reduce stigma. This incorporated training for healthcare professionals and the wider workforce, narrative films, community and direct outreach, and a website.

The evaluation adopted a mixed-method (quantitative and qualitative data), multi-level (evidence from SHIFT population, healthcare professionals, wider workforce, trainers and partners) approach to provide evidence of the model's Practicability, Effectiveness and Cost-Effectiveness, Acceptability, Side-Effects and Equity. This approach is based on the APEASE framework (Michie et al., 2014).

Project delivery took place between March 2019 and October 2022 with evaluation data collection commencing alongside delivery. This involved approximately 2,690 individuals, 219 healthcare and wider workforce professionals, 4 peer observers, 8 trainers and 9 partners from the United Kingdom, Belgium and The Netherlands as well as third-party analytics data on over 23,000 individuals.

b. Outcomes

The evaluation has been organised to report on the following outcomes:

- Needs Analysis and developing the Sexual Health Model
- Implementing the Sexual Health Model
- Outcome One – Sexual Health Model to engage with people aged 45+
- Outcome Two – Tailored SH&WB strategy to adapt model to engage with people aged 45+ experiencing socio-economic disadvantage
- Outcome Three - Training programmes for Sexual Health Professionals and the Wider Workforce

The evaluation will also provide an account of:

- SHIFT Partner experiences of implementing and delivering the Sexual Health Model and impact of COVID
- Discussion of Findings

c. Glossary of terms

Facilitators: Outreach staff delivering sexual health and wellbeing activities in the target population communities.

Healthcare Professionals (HCPs): Medical staff delivering sexual health or other medical services.

MSM: Men who have sex with men (not necessarily identifying as gay).

Sexual Heath Model: A new delivery model for sexual health and wellbeing for populations aged over 45; and populations aged over 45 and classified as vulnerable.

SH&WB: Sexual health and wellbeing.

Trainers: Staff who delivered the Work Package 3 training programme.

VLE: Virtual Learning Environment (Moodle), an online platform used to deliver asynchronous training.

Vulnerable Population: Populations defined as vulnerable on the basis of one or more indicator of socio-economic disadvantage (e.g. Homeless, Migrant, Sex worker, Non-native language speaker, No formal education, Low income).

Wider Workforce (WW): Staff who contribute to sexual health and wellbeing services through their job role, even if they are not a specialist or practitioner in sexual health.

Work Package 1 (WP1): A co-created and piloted model for future service provision to improve sexual health services and improve the over 45 population's sexual health and wellbeing.

Work Package 2 (WP2): A co-created and piloted model for future service provision to improve sexual health services and improve the over 45 population's sexual health and wellbeing including techniques for engaging with hard-to-reach socio-economically disadvantaged groups.

Work Package 3 (WP3): A jointly produced and piloted training programme relevant to all parts of the 2Seas area based on extensive engagement with healthcare professionals, implemented via existing services.

6. Background

a. Introduction

The World Health Organisation (WHO) have recognised and advocated for the adoption of a life-course approach to sexual health, including the need for improved access to sexual health support for older adults (WHO, 2023). Despite the acknowledgment of Universal Access to Sexual and Reproductive Services as a human right (WHO, 2022), and against a backdrop of rising Sexually Transmitted Infection (STI) rates in this age group, a gap in service remains. Older adults are rarely considered in Pan European and Domestic sexual health policies across the 2seas regions. The issues for over-45s are unique in comparison to those in other age groups, such as entering new sexual relationships after a period of monogamy, dealing with menopause and impotency as a result of ageing, engaging in sexual intimacy after serious illness and consequently require a targeted approach by health services for these specific issues. However, relevant services have highlighted a lack of knowledge and tools for approaching these issues and offering information or treatment to this population. Additionally, within this target group, project partner insights and research has shown that groups with more than one socio-economic disadvantage (such as homelessness, sex-workers, non-native language speakers, migrants, LGBTQ+) are at an even greater risk of lack of awareness and support for their sexual health, and access to relevant services.

b. SHIFT Project

The European Union Interreg funded (2 Seas, Social Innovation) SHIFT project was a cross-border partnership between nine organisations, including seven delivery partners from three countries: UK (East Sussex County Council, Kent County Council, Kent Community Health NHS Foundation Trust, Metro Charity), Belgium (Odisee University, Antwerp University College of Applied Science) and Netherlands (SOA-AIDS). In addition to two other UK partners (Health and Europe Centre and University of Chichester), there were also two former partners (Medway Council (UK) and Sante Info Solidarite-Animation (France) and three observer partners (Conseil Départmental du Nord (France), East Sussex Healthcare NHS Trust (UK), and Santé Publique France (France). The project ran between 2019 to 2023 across the 2 Seas region (Figure 1).

SHIFT aimed to empower people aged over 45 to participate in sexual health services thereby improving their sexual health and wellbeing, with an additional and specifically adapted focus on socio-economically disadvantaged groups across the 2Seas area. The project used insight gathering and testing of existing evidence to co-create an informed, evidence-based service redesign (sexual health model) and adaptation of healthcare systems currently in place in order to provide services that properly suit these groups. SHIFT targeted groups of people who were aged over 45, as well as those aged over 45 who might be socio-economically vulnerable (e.g. homeless, migrant, sex worker, non-native language speaker, no formal education, low income). Expected outcomes of the project were an improvement in awareness in the target groups, and access to sexual health services, therefore increasing wellbeing, testing for STIs and HIV and avoidance of undiagnosed communicable STIs and HIV amongst the over 45s and socio-economically disadvantaged groups. It is anticipated that these outcomes will lead to benefits such as improved quality of life of people aged over 45 (with specific focus on vulnerable groups) and a decrease in health inequalities. In order to achieve this the project developed a new model of Sexual Health, which was then implemented by delivery partners, as well as two new training programmes for sexual health professionals and the wider workforce.

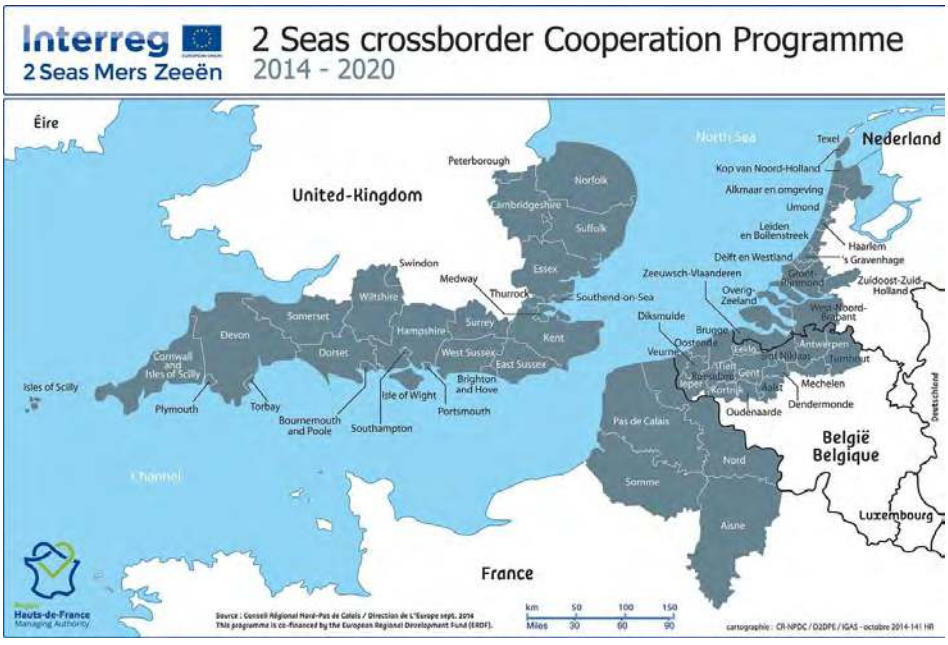


Figure 1. 2Seas region covered by the SHIFT project.

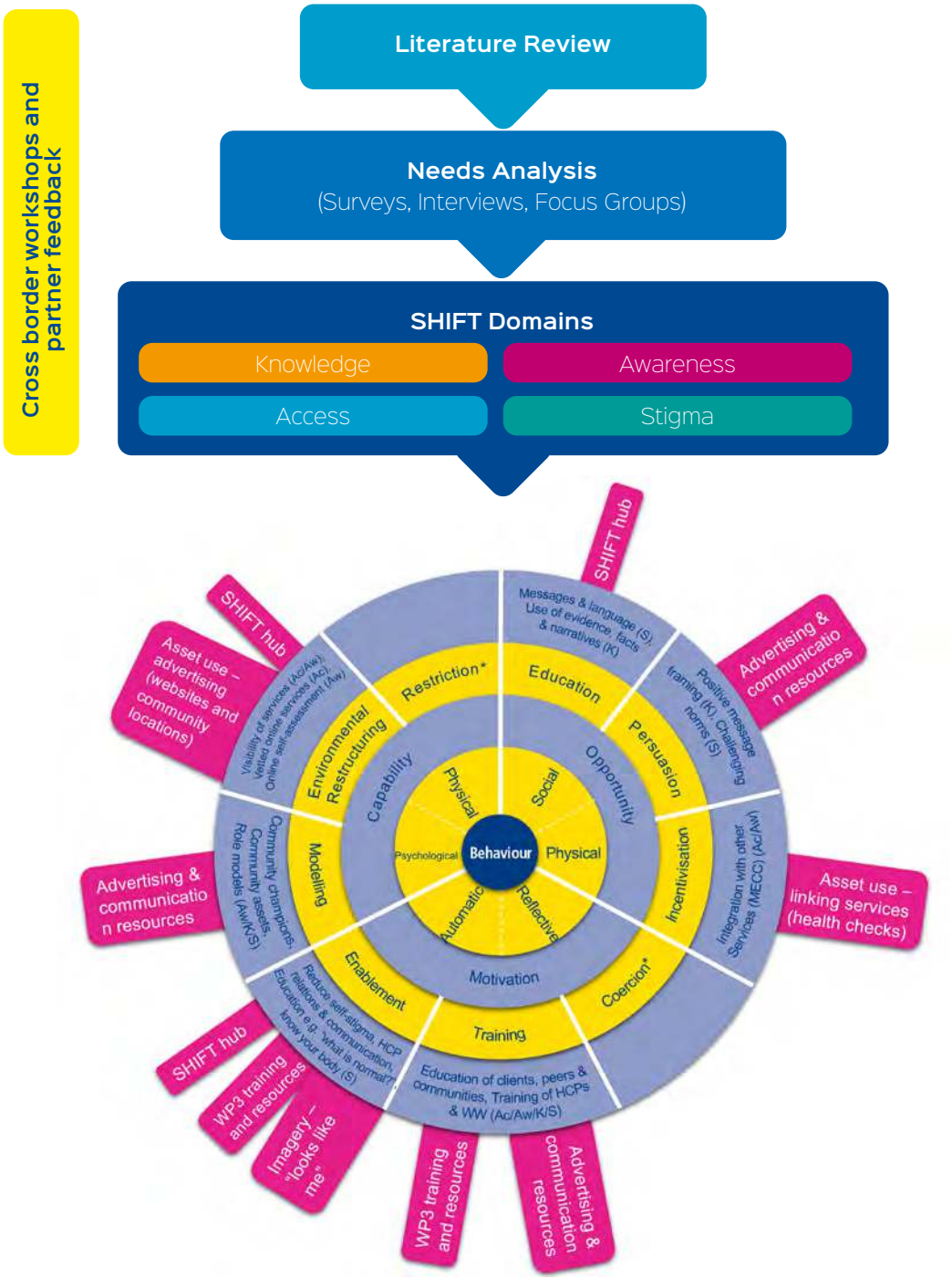


Figure 2. Co-creation methodology of SHIFT Sexual Health Model.

The model was co-created using the methodology described in Figure 2, underpinned throughout by ongoing partner engagement and feedback. This resulted in the SHIFT sexual health model, based on the COM-B Model and Behaviour Change Wheel (a method which translates intervention processes into specific techniques to change behaviours) and was co-created by project partners (Figure 3) to underpin a programme of activities and outcomes (Figure 4). A suite of documents has been created for health professionals explaining the Sexual Health Model, which can be accessed on the SHIFT legacy website.

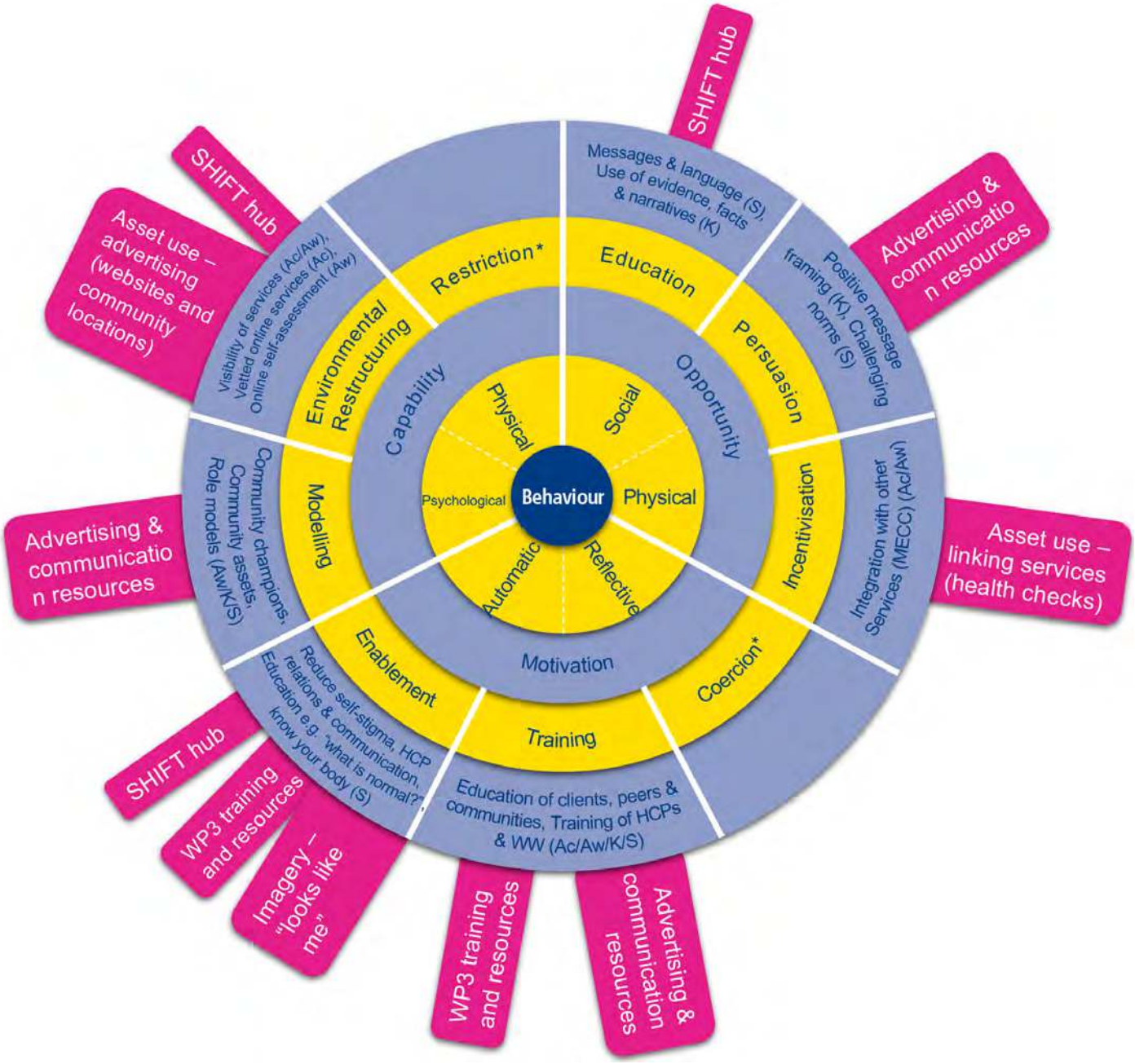


Figure 3. SHIFT project COM-B model.

The training programme was co-created through a series of cross-border workshops and consultation of existing literature, with involvement from all partner organisations.

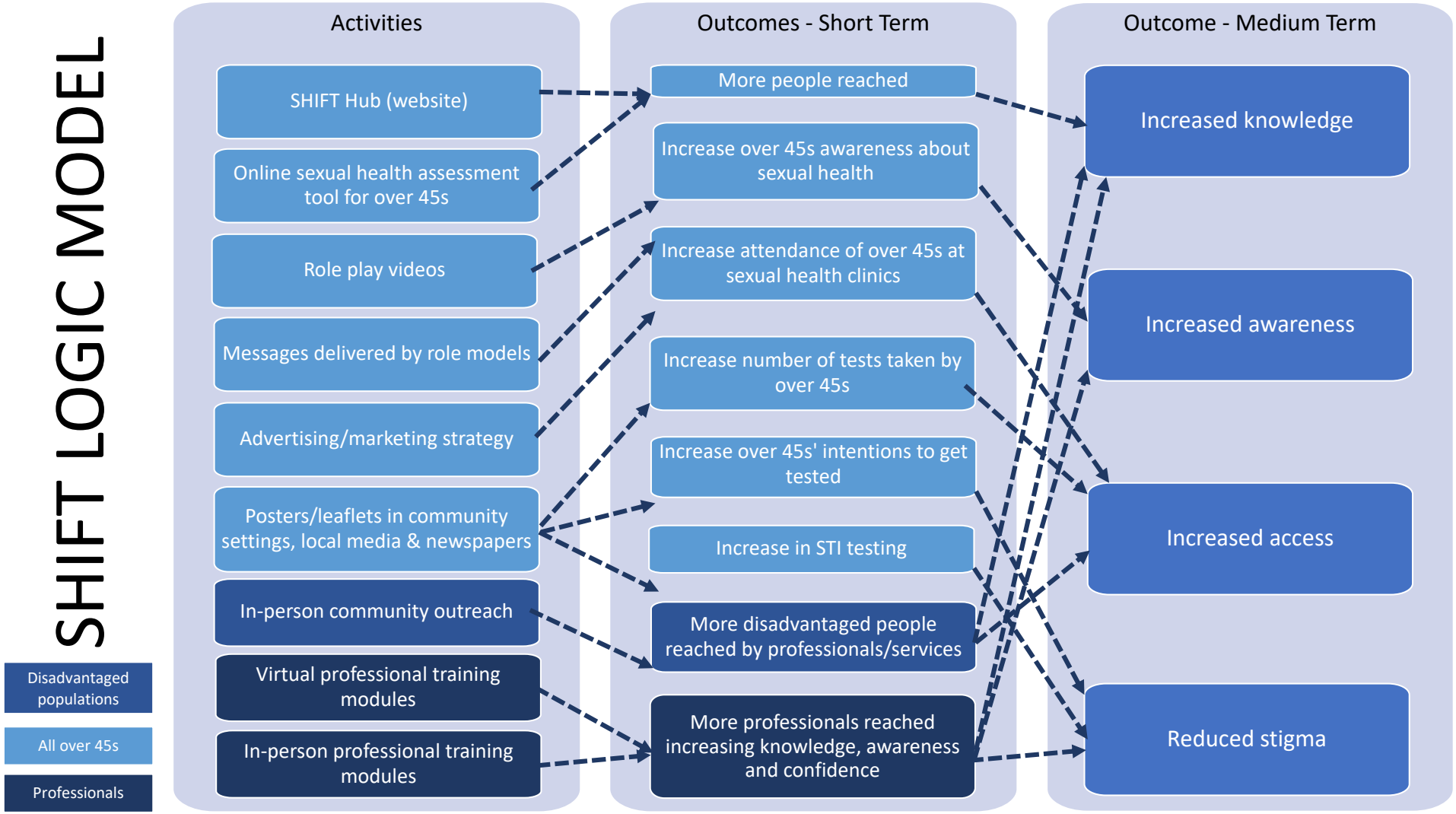


Figure 4. SHIFT Logic Model.

7. Evaluation Method

a. Evaluation Methodology

Overview of Evaluation Methodology

The evaluation adopted a mixed-method (qualitative and quantitative data collection), multi-level (data collection from people aged over 45, people aged over 45 categorised as socio-economically vulnerable, Healthcare Professionals, Wider Workforce, Trainers and Delivery partners) approach. The evaluation was based on an APEASE Framework (Michie et al., 2014) which complements the COM-B model of delivery, to provide evidence of all aspects except affordability:

Practicability - methods of delivery, by whom and its feasibility for wider-scale use.

Effectiveness and Cost-Effectiveness - who the programme reached and whether changes occurred in this population.

Acceptability - evidence of how relevant stakeholders judge the programme to be appropriate.

Side Effects - consideration of any unintended consequences of the programme.

Equity - evidence of the extent to which the programme reduces inequalities between the socioeconomically disadvantaged and the general over 45 population.

The evaluation approach was presented to and discussed with SHIFT Partners at steering group meetings to allow input into the design and delivery of evaluation, and ensure it would be appropriate for the SHIFT population, before a final framework and associated protocols were designed. Ethical approval for the evaluation was obtained from both the University of Chichester's institutional ethics committee (Ref 1819_57, July 2019; 2021_39, June 2021; 2122_64, May 2022; 2122_70, June 2022; 2223_01, August 2022) as well as the NIHR (IRAS ID 302664, Oct 2021). Details of the evaluation method are presented in Table 1. In all data collection phases with the general public and trainees, informed consent was provided in advance of data collection.

Figure 4. SHIFT Logic Model.

	Affordability*	Practicability	Effectiveness & Cost Effectiveness	Acceptability	Side-Effects	Equity
WHO		- Trainers - Partners	- Over 45's - Over 45's SED [1] - Secondary data - HCPs & WW [2]	- Trainers - Partners - Over 45's - Over 45's SED [1] - HCPs & WW [2]	- Over 45's SED [1] - HCPs & WW [2]	- Over 45's SED [1] - Partners
HOW		**Surveys** *- WP3 Peer Feedback* **Interviews** *- WP 1/2/3 Staff*	**Surveys** *- WP2 Outreach* *- WP3 HCP & WW [2]* *- Needs Analysis* **Interviews** *- Needs Analysis* **Frequencies** *- WP2 Outreach* *- WP3 Headcounts* *- WP3 VLE Analytics* **Secondary Data** *- UK Clinical Data* *- Website Analytics*	**Surveys** *- WP2 Outreach* *- WP3 Film* **Screenings** *- WP3 HCP & WW [2] trainings* **Interviews** *- WP1/2/3 Staff* **Observations** *- WP1/2 Website Think Aloud*	**Surveys** *- WP2 Outreach* *- WP3 HCP & WW [2] trainings*	**Surveys** *- WP2 Outreach* **Community Asset Mapping**

[1] SED (Socio-Economically Deprived)
[2] HCP & WW (Health Care Professionals & Wider Workforce)
*Affordability was not used as part of this analysis

i. Pre-project

Needs Analysis Survey

The needs analysis survey was administered online using Qualtrics. Links were shared with project delivery partners via email for dissemination to WP1 (Over 45s) and 2 (Over 45s experiencing one or more socio-economic disadvantage) populations. The survey took approximately 20 minutes to complete and was available in English, Dutch and Flemish. Respondents provided basic demographic information and completed a number of questions on attitudes, knowledge and perception of sexual health and wellbeing (see Table 2).

Table 2. Needs Analysis Survey Topics.

<table>
<tr><th>Demographics</th><th colspan="2">Sexual activity</th></tr>
<tr><td rowspan="2">• Country and region
• Country of birth
• Country of mother's birth
• Country of father's birth
• Ethnicity
• Language (home/ work)
• Gender/ gender assigned at birth
• Age
• Housing security
• Highest academic qualification
• Financial worry
• Marital status
• Sexual orientation and activity</td><td colspan="2">• Level of sexual activity
• Use of protection and reasons
• Level of comfort discussing sex
• Substance use during sex
• Perceived level of risk
• Payment for sex</td></tr>
<tr><th>Promoting sexual health</th><th>Knowledge of sexual health support and advice</th></tr>
<tr><td>• Messages to promote safe sex
• Best ways of communicating about sexual health/services
• Use of social media
• Encouraging access to sexual health services</td><td>• Current understanding of sexual health/ STIs
• Current and future information-seeking for sexual health
• Sources for information-seeking for sexual health</td></tr>
<tr><th>General health status</th><th colspan="2">Knowledge of sexual health testing and treatment</th></tr>
<tr><td>• Mobility
• Self-care
• Normal activities
• Pain or discomfort
• Anxiety or depression
• Current health today</td><td colspan="2">• Testing locations
• Testing location preference
• Location of nearest sexual health service
• Visit sexual health service
• Tested for STI
• Diagnosed with STI
• Treated for STI
• Level of comfort seeking treatment
• Barriers to seeking treatment</td></tr>
</table>

Needs Analysis Interviews and Focus Groups

Interviews took place at the start of the project with the target SHIFT populations (over 45 and over 45 socio-economically disadvantaged) in order to support the co-creation of the WP1 model and WP2 specialist approach. Questions for the interview were developed with the combined knowledge and expertise of all SHIFT delivery partners, and considering the findings from the surveys. The following topics were discussed:

- Demographics
- Age-related changes in sexual health and wellbeing
- Current sexual health care provision for over 45's
- Support and advice for sexual health and wellbeing
- Barriers to accessing sexual health services for over 45's
- Facilitators to accessing sexual health services for over 45's
- Communication for sexual health and sexual health services for over 45's

Focus groups took place at the start of the project with the target SHIFT populations (over 45 and over 45 socio-economically disadvantaged) in order to support the co-creation of the WP1 model and WP2 specialist approach. Questions for the focus groups were developed with the combined knowledge and expertise of all SHIFT delivery partners, and considering the findings from the surveys. The following topics were discussed:

- Local Doctor / GP / GP Surgery
- Knowledge of testing
- Wider workforce
- Stigmatisation, trust and judgement
- Messaging and communication

Partner Meeting to develop Needs Analysis topics.

ii. Outcome 1

Think Aloud

In order to assess the usability and effectiveness of the SHIFT Hub website with the target population, a study was conducted using Think Aloud methodology (Bolle et al., 2016; Hinchliffe & Mummery, 2008) incorporating two main aspects: Think Aloud tasks/subjective experiences; and performance measures. These were further broken down into application tasks, search tasks and evaluation tasks. Examples are outlined in Table 3 below (this list is not exhaustive of all questions asked).

Table 3. Outline of Think Aloud tasks.

Think Aloud Tasks and Subjective Experiences	
• Application Task (physical actions participants had to complete)	Open the website
	Navigate to the 'Sex and Sexuality after the Age of 45' webpage
• Search Task (the time it took to complete these tasks was recorded as the Performance Measures)	Please try to find information on accessing sexual health services
	Please imagine you are (or a loved one is) experiencing a chronic illness, such as COPD. What information would you look for about how this might affect sexual health and relationships? Please look for it on this website
• Evaluation Task (qualitative verbal responses and 5-point Likert scales)	Was it easy to find information on the menopause? What made it easy/difficult?
	Please spend some time exploring the website. Which aspects of sexual health did you learn the most about?
Demographics	
Gender	Relationship status
Age	Sexual orientation
Socioeconomic disadvantage	Sexual activity

Analytics

Google

Analytic data was collated from Google platforms (see Table 4) from May 2022 - January 2023 to capture data on frequencies and effectiveness of the website.

Table 4. Data collated from Google Analytics on the SHIFT HUB website.

Website Performance	
Total Users	Number of total users
Event Count	Total user interactions with website
Event Count per User	Interactions with website per user
Audience Report	
Age	18-24, 25-34, 35-44, 45-54, 55-64, 65+
Gender	Male, Female
Geo	Country
Device	Mobile, Laptop, Tablet
Webpages Report	
Page Title by views	Total views of webpage
Page Title by users	Total user views
Average engagement time	Average time spent on webpage

Clinical Data

Clinical data was provided by a SHIFT project partner, KCHFT, to provide a local case study of a sexual health service utilising the SHIFT model of sexual heath for the start and finish of the SHIFT project (2019 and 2022). The clinical data covered the following:

- Clinic Attendance
- Number of STI Tests
- STI Positivity rate

iii. Outcome 2

Quantitative

Outreach Surveys

The outreach survey was administered to WP2 Populations (Over 45s experiencing one or more socio-economic disadvantage) online using Qualtrics with two recruitment streams: UK WP2 Roadshow/ Outreach Activities and UK WP2 MSM Sauna Outreach Programme, both of which were interviewer administered. Survey responses by participants were anonymous, and informed consent was obtained prior to survey completion. The survey took approximately 20 minutes to complete and was available in English. Respondents provided basic demographic information and completed a number of questions on behavioural intentions and SHIFT outcomes (see Table 5).

Table 5. Outreach survey topics (MSM Saunas and UK Roadshow).

Frequencies	Demographics	Behavioural Intentions	SHIFT Outcomes
Headcounts Survey count Registration forms	Recruitment pathway Gender Age Marital status Sexual orientation Sexual activity SHIFT demographic Reason for conversation Content of conversation Action taken*	Control Confidence Knowledge Awareness Risk-Perception Health Intentions	Knowledge Awareness Access Stigma

*Questions not asked in UK Roadshow surveys

Outreach Observation Surveys

Observation forms using open-ended questions were collated by group organisers for WP2 outreach in the Netherlands. Questions and comments by participants were asked in Dutch and recorded by Outreach staff on a form in English. The following topics were included as part of the observation form:

- Theme of meeting
- Number of participants
- Reaction of participants
- Interest and questions by participants
- Further topics requested by participants
- Reflections by participants

Outreach staff also recorded participant ethnic backgrounds and gender.

Think Aloud

In order to assess the usability and effectiveness of the SHIFT Hub website with the target population, a study was run using Think Aloud methodology as described above in the Outcome 1 Think Aloud Methodology.

Qualitative

Reflective Diary

The delivery partner for the UK MSM Sauna outreach work was asked to record diary entries for each visit to the sauna. Reflection diary writing is a well-known method of capturing and evaluating an individual's reflections. It is suggested that benefits include a deeper understanding, consideration of perspectives and learning from experiences (Plack et al., 2007). There was purposefully no framework provided for the writing, in order to elicit a participant-led response on the issues they felt relevant. The instruction provided was to describe their feelings/thoughts/reactions to their outreach work in the sauna, and reflect upon these experiences.

iv. Outcome 3

Quantitative

Training Surveys

The WP3 training programme surveys were administered to Healthcare and Wider Workforce populations who had completed WP3 training modules, online using Qualtrics. The surveys were administered at two time points - before and after training, with the introductory module (Start to Shift) being a pre-requisite to participation. The survey took approximately 20 minutes to complete and was available in English, Dutch and Flemish. Respondents provided basic demographic information and completed a number of questions on sexual health competencies and experiences of the training module(s) (see Table 6).

Table 6. WP3 Training Programme pre and post survey topics.

Demographics (Pre-Survey Only)	Competencies	Experiences of Training Module(s) (Post Survey Only)
• Gender • Age • Professional Qualifications • Education • Job Title • Sexual Health Promotion Work • Number of years' experience in sexual health promotion • Percentage of week working in sexual health promotion • Age groups of service users • Work with socio-economically disadvantaged • Percentage of week working with socio-economically disadvantaged	• Knowledge • Confidence • Awareness • Interpersonal skills and communication	• Satisfaction • Interest • Relevance • Organisation • Most enjoyed part of module • Least enjoyed part of module • Suggestions for improvement • Additional comments

Film Screening Surveys

Surveys were administered to healthcare and wider workforce professionals who attended events where the educational SHIFT films were screened. The surveys covered demographics (mapped to WP3 training surveys), cognitive and emotional reactions to the films, and open-ended questions allowing for participants to give their professional opinions and feedback. The reactions to the films were obtained for the film the participant ranked as most impactful and the film ranked as least impactful.

Qualitative

Peer Observations of Training

SHIFT delivery partners conducted peer observations on WP3 training modules delivered both online and face to face. The process was based on a collaborative model of peer observation, designed to recognise strengths and suggest areas for attention rather than making judgements. Guidance was provided to observers on how to engage in peer observation (Whitlock & Rumpus, 2004) as well as suggested criteria for observation (Figure 5). Observers completed their feedback using Qualtrics.

Figure 5. Visual representation of peer observation criteria recommendations.

The process was as follows:

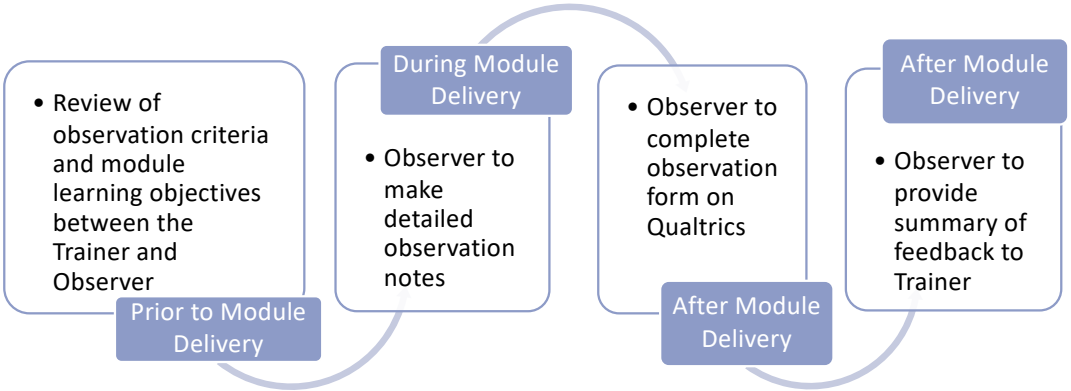


Figure 6. Peer observation process.

Trainer interviews

Interviews took place at the conclusion of the project delivery with the SHIFT WP3 trainers. The following topics were discussed:

- Activity, methods of delivery, and country
- Facilitator interest and motivation
- Planning
- Attendees
- Reflections post-delivery and/or training

Analytics

VLE analytics

Analytic data was collated from the Virtual Learning Environment (VLE) Moodle platform (see Table 7) to capture data on frequencies and engagement with the online training module Start to SHIFT.

Table 7. Data collated from Moodle Analytics on the Start to SHIFT Training module.

Moodle Registration Form	
City/Town	Free-text entry
Country	Free-text entry
Job Title	Healthcare Practitioner, Wider Work
VLE Analytics	
Enrolment	Registrations onto the module
Pages Viewed	Views of the 10 individual pages of the module
Completion	Deemed if individuals viewed each page at least once

v. Post project

Qualitative

Partner interviews

Interviews took place at the conclusion of the project delivery with the SHIFT project partners. The following topics were discussed:

- Activity, methods of delivery and country
- Interest and motivation
- Planning
- Attendees
- Reflections post-delivery and/or training
- Impact of COVID

b. Data Collection and Analysis

Overview of Data Collection

Data collection for WP1 and WP2 UK and Netherlands outreach activities followed broadly the same structure, with slight adaptations to suit the populations with which they were working (Figure 7). Frequencies and demographics were collected on-site by either observational data, surveys or headcounts. Behavioural intentions and SHIFT outcomes were measured through observation forms or surveys, with additional data collected in the UK for the website (Think Aloud study) and MSM Saunas (Reflective diary). Interviews were conducted at the conclusion of the project with project delivery partners.

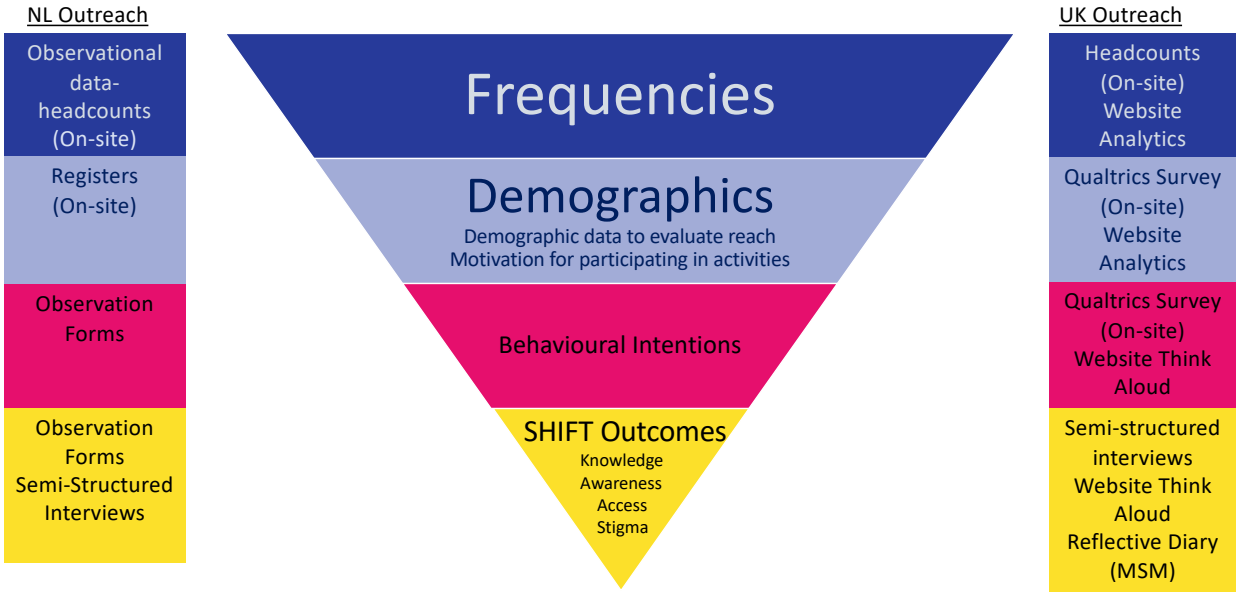


Figure 7. Visual representation of the data collection of work package 1 and 2.

Work Package 3 followed a similar structure to that above, with frequencies and demographics recorded for training modules either using headcounts or VLE Analytics (Figure 8). SHIFT outcomes were recorded using survey data at film screening events as well as (pre and post) training events. A process evaluation was carried out with semi-structured interviews with WP3 trainers as well as peer observation by project partners of WP3 training events.

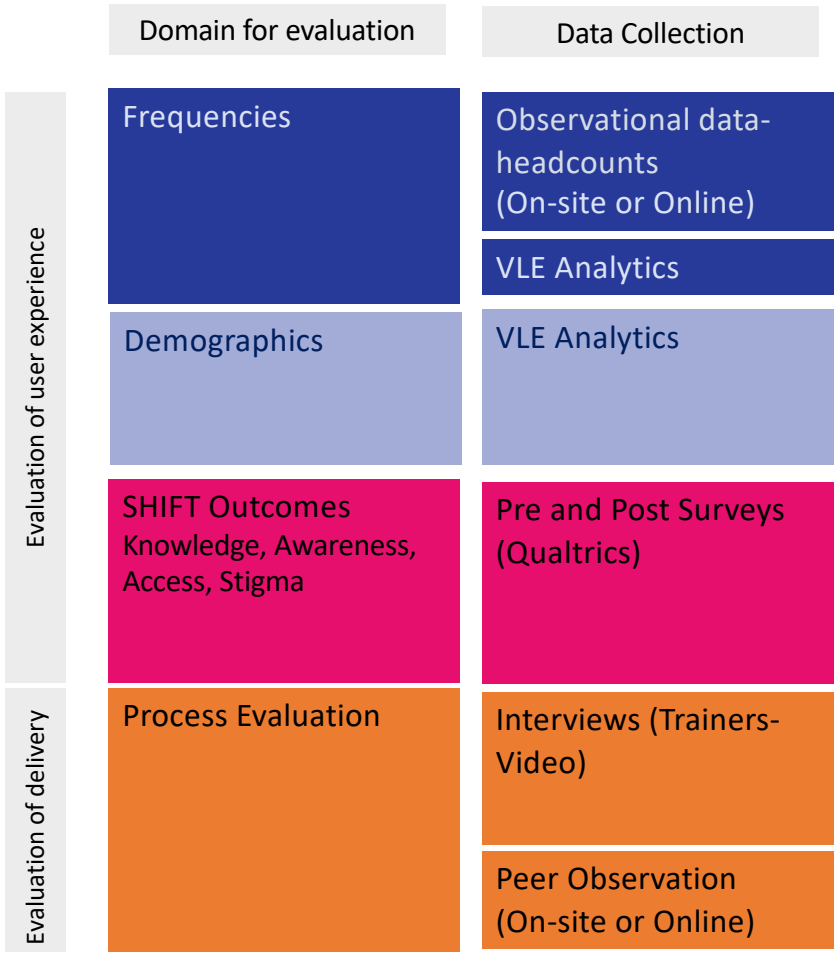


Figure 8. Visual representation of the data collection for Work Package 3.

i. Pre-project

Needs Analysis Survey

The online survey, was published in three languages: French, Dutch and English, relevant to each country involved in the study. Questions were developed using the knowledge and expertise of diverse stakeholders, with substantial experience in sexual health care provision and as support organisations for sexual health needs (e.g., NHS Trusts, Metro Charity UK; SoaAids Netherlands). Due to the taboo nature of sexual health, the survey was pilot-tested with a small group of the target population to ensure the suitability of questions, and adjusted accordingly (see Table 2, section 8a for full list of questions). The survey ran from 6th November 2019 (The Netherlands/Belgium) and 3rd October 2019 (UK), and closed on 3rd April 2020 for all countries. Partners in the UK, Belgium, and The Netherlands used their direct and indirect (through existing connections to other organisations) access to the target population to identify and recruit a sample of participants over the age of 45, via platforms such as clinics, social media and leaflet distribution.

Survey data was exported from Qualtrics into SPSS. The data was cleaned and then different survey versions were consolidated into a single data set for analysis. In total there were 614 responses from WP1 and 163 responses from WP2 participants. Participants were deemed to fall into the work package two demographic (socio-economically deprived) if they self-reported as having below primary education level or worrying 'very often' or 'somewhat often' about paying bills (financial insecurity). (It is worth noting that the Needs Analysis was conducted prior to the energy crisis, and for subsequent data collection different metrics were used to distinguish socioeconomic disadvantage due to the spiralling costs associated with paying bills.) Data was analysed to summarise findings with descriptive statistics (e.g., means) and frequencies.

Needs Analysis Interviews and Focus Groups

Due to the COVID-19 pandemic and restrictions on social distancing/lockdown policies, most interviews and focus groups took place virtually via telephone or video call, across partner countries. Data collection took place from February to November 2020 in the native language of each country (Dutch, Flemish and English). A total of 26 individual interviews and one focus group consisting of four participants was carried out by project staff with the general over 45 population. Individual interviews (94 participants) and one focus group (5 participants) were carried out with the WP2 population (over 45 with one or more socio-economic disadvantage) in the Netherlands and UK from September to December 2020.

Transcripts from 30 WP1 participants and 99 WP2 participants were analysed following Braun and Clarke's (2006) six-step thematic analysis: 1) Familiarisation of Data, 2) Generating Initial Codes, 3) Searching for Themes, 4) Reviewing Themes, 5) Defining and Naming Themes, and 6) Producing the Report.

ii. Outcome 1

Think Aloud

Think Aloud provides a Qualitative perspective on the SHIFT website's usability, usefulness and effectiveness. The methodology asks participants to access the website and vocalise their thoughts, feelings and actions as they work their way through a series of tasks and questions. Think Aloud needs between 5-9 participants, which has been found to cover 80-90% of issues with a website (Nielsen, 1993; Nielsen, 2000). Participants were recruited using partner networks, with sessions run at the University of Chichester and Metro's New Cross Centre in October 2022. Efforts resulted in the recruitment of 7 participants who identified no socioeconomic advantage (thus making them applicable to Outcome 1). There were technical issues in the recording of one participant's data, resulting in 6 participants included for analysis. Participants completed basic demographic information through surveys administered online using Qualtrics. Participants then completed a series of tasks and questions about the website, responses were audio and screen-recorded. Data was triangulated with other sources during data collection sessions, including search and application tasks, performance measures and subjective user experiences.

Think Aloud Data was analysed using three approaches for each set of data:

- Think Aloud Tasks - Mean Likert Scale Ratings of task feedback
- Subjective user experience - Themes identified through analysis of transcription
- Performance Measures - Mean Timings of observed measures in video recording of Think Aloud tasks

The verbatim transcripts from the Think Aloud tasks were read and re-read independently by two researchers and codes were created for identifying themes. Final themes were agreed upon through discussion between the two researchers. Interrater reliability was also agreed upon for the performance measure timings and Likert ratings (where these were verbally stated as opposed to collected by a survey). The timings were scored independently and then compared. All timings were within 5 seconds of each other with the exception of one query, averages were taken as the agreed timings. Out of the 80 Likert scale responses, there were 11 queries raised with only 3 disagreements and this was only by one Likert scale point, agreement was reached with discussion.

Analytics

Google

The SHIFT website developers installed a Google Analytics tracking code to the website in order for the Evaluation team to monitor website traffic, users and activity. Data was collected using the Google Analytics platform from the period 1st May 2022 to 17th January 2023.

Google analytic reports were generated and analysed to explore the number and demographics of visitors and individual journeys to and around the website and its content. The visitation reports were also compared to key dates corresponding to SHIFT activities to look at the impact of these (i.e., outreach events).

Clinical Data

Project partner, KCHFT, provided a case study of a sexual health clinic's implementation of the SHIFT model, using clinical data. Data was from attendance and laboratory records routinely collected and maintained by the NHS for patients over the age of 45 detailing frequencies of patients, tests administered, and test positivity rates. The clinical data for 2019 was compared to that of 2022.

iii. Outcome 2

Quantitative

Outreach Surveys

SHIFT delivery partners disseminated surveys to service-users accessing outreach activities, such as PRIDE events and the Bus Roadshow which took place from June 2022 to September 2022. UK Surveys were administered online, using Qualtrics, by the SHIFT project delivery partners. The survey took approximately 15-20 minutes to complete.

A full list of events can be found in section 11.

Data sets from the surveys were exported from Qualtrics into Excel. They were then cleaned and coded to ensure responses matched up across the different versions for comparison (they were not compiled into one). Quantitative data was summarised using descriptive statistics (e.g., means) and frequencies. These findings were used to create visual representations of the data (e.g., pie charts) and Tables. Qualitative responses to questions were explored to identify reoccurring themes.

Outreach Observation Surveys

Observation forms from the Netherlands were completed by the project partner staff and captured basic demographics and content of the outreach sessions.

The observation forms (23) were compiled into one data set for analysis. Data on the attendees (gender and general background), session themes, key questions asked, and wishes for future sessions was summarised with frequencies. Qualitative participant feedback was also collated and grouped into themes.

Think Aloud

As with Outcome 1, the Think Aloud provides a qualitative perspective on the SHIFT website's usability, usefulness and effectiveness. Participants were recruited using partner networks, with sessions run at the University of Chichester and Metro, New Cross Centre in October 2022.

The demographic data collected as part of the Think Aloud protocol allowed participants to self-report as either fitting the WP1 or WP2 demographic. This allowed the data set to be split accordingly. Data from 4 participants identifying with one or more socio-economic disadvantage was collected (5 participants completed the protocol, but due to a lack of comprehension, the data from one participant was not usable.) The Think Aloud data for Outcome 2 was analysed in the same way as with Outcome 1, detailed on the previous pages.

Qualitative

Reflective Diary

The Sexual Health Nurse who delivered the outreach made 12 visits to the MSM sauna and recorded some diary reflections in MS Word. They provided three reflective diary entries of their experiences of delivering this outreach work to the Evaluation team for analysis. A total of three diary entries were provided.

The diary entries were mapped against the Gibbs reflective cycle (see Figure 9) to allow the reflections to be broken down and explored for underlying themes recurring across the entries. These cycles were then looked at in tandem to the participant data collected from the outreach surveys to get a richer understanding from both the individual and practitioner perspective.

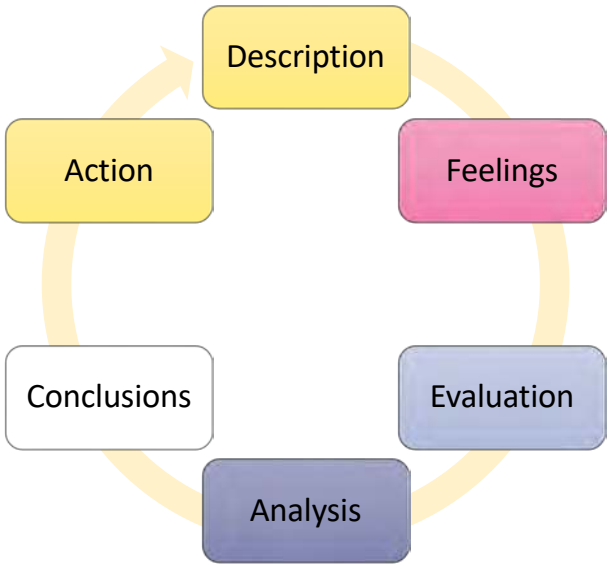


Figure 9. Illustration of the Gibbs Cycle (Gibbs, 1988).

iv. Outcome 3

Quantitative

Training Surveys

A weblink to the pre-survey was embedded into the Start to Shift Moodle page, hosted on Qualtrics, in both English and Dutch. The post-survey was immediately sent to participants on completion of the pre-survey with instructions to complete it after they had completed all of their intended training modules. A further email was sent a week later as a reminder prompt.

The survey data was exported from Qualtrics into SPSS. The data sets from each survey (English and Dutch, pre and post) were cleaned and then compiled into a master data set. Analysis consisted of summary statistics in the form of descriptive statistics (e.g., means) and frequencies. To allow for comparison of the pre and post scores, visual representation of the data was created in the form of bar graphs.

Film Screening Surveys

A QR code that linked to the online survey was shared at a break in the film screening events after the 6 films had been shown. Individuals were encouraged, and given time, to complete the survey by the host of the events. A link to the survey was also emailed round to all participants in the debrief contact post-event to encourage anyone who did not complete it at the event to do so.

Responses from the surveys were exported from Qualtrics into SPSS for analysis. Responses from the two events were combined into one data set. Analysis utilised frequencies and descriptive statistics (i.e. means) to create a narrative summary of the data, largely with a focus on establishing the most and least impactful films (as rated by participants) and their characteristics. The qualitative responses to open ended questions were explored and split into positive and negative comments. Further analysis of common themes took place to summarise the general feedback.

Qualitative

Peer Observations of Training

Peer Observations were carried out on WP3 Training Modules by the SHIFT project partners between August to October 2022 based on a collaborative model of peer observation. Four Peer Observers were recruited directly by project partners from across their organisations. Peer Observers were provided with a protocol to follow detailing the model of peer observation. A Qualtrics link was provided to record their observations, with prompts given based on the model detailed in the protocol (see Figure 5 and 6).

Data was downloaded from Qualtrics and an initial review took place to identify headline themes within each data set. The data was then grouped according to the prompts used and categorised into wider themes, with sub-themes and relationships within the themes explored.

Trainer interviews

Interviews took place over Zoom between September-October 2022. Project partners were asked to provide contact details of Trainers who had delivered Work Package 3 training, and recruitment contact was made with them via email.

All interviews were audio recorded and manually transcribed verbatim to ensure data familiarisation. Interview verbatim transcripts were analysed and reviewed by two independent researchers in order to identify codes and themes directed by identifying patterns in the data. Codes were generated by creating an overview of each extract to provide a ‘headline’ for each, and an interpretation of what the extract is saying. These codes were then categorised into wider themes, with the relationships between each code within the themes explored.

Analytics

VLE Analytics

The Virtual Learning Environment (VLE) which hosted the 'Start to Shift' online learning module was run on the Moodle platform. In creating an account on the platform, administrators are able to track a user's activity across the VLE. Analytic reports were compiled by the administrator of the Start to SHIFT Moodle page covering the period of March to October 2022. The raw report data was shared with the evaluation team for analysis.

Raw reports from the VLE were exported into Excel for cleaning and analysis. The reports were summarised to look at enrolments onto Start to SHIFT vs completions (measured as individuals viewing all 10 pages of the training module). More detailed frequencies of page views were also captured to identify popular vs least popular pages.

v. Post project

Qualitative

Partner Interviews

Interviews took place over Zoom between September-October 2022. Project partners were contacted via email to request their participation in a semi-structured interview. Data collection ceased once all project partners had been interviewed.

Qualitative data was analysed and reviewed by two independent researchers in order to identify codes and themes directed by identifying patterns in the data. All interviews were audio recorded and manually transcribed verbatim to ensure data familiarisation. Codes were generated by creating an overview of each extract to provide a 'headline' for each, and an interpretation of what the extract is saying. These codes were then categorised into wider themes, with the relationships between each code within the themes explored.

8. Needs Analysis and Model Development

a. Needs Analysis

A mixed-methods needs analysis was carried out in order to establish insight into the needs, awareness and attitudes towards sexual health and wellbeing among adults over the age of 45 (including those experiencing one or more socio-economic disadvantage) in the 2Seas region, and provide an evidence-driven approach to support the co-creation of a Sexual Health Model for this population.

i. Surveys

There was a total of 777 survey respondents in the 2Seas regions (UK, Belgium, France and Netherlands), 163 of which were classed as socio-economically vulnerable (WP2 population).

The survey found that only 8% / 7% of participants (WP1/WP2) believed they were at risk of contracting an STI or HIV, despite 68% / 52% (WP1/2) reporting that they never used contraception to prevent STIs. The two most common reasons for not using contraception to protect against STIs and unplanned pregnancy were monogamy and no perceived risk of pregnancy. 52% / 54% of participants (WP1/2) had never been tested for an STI. Of the 48% / 46% (WP1/2) who had been tested, nearly half had been diagnosed with an STI (42% / 49% - WP1/2). Awareness of sexual health services was fair, 58% / 54% (WP1/2) were aware where their nearest sexual health services were located. The biggest barrier to accessing services was a perceived lack of risk and shame/stigma.

ii. Interviews and focus groups

94 individual interviews and one focus group with five participants were carried out with the WP2 population (over 45 with one or more socio-economic disadvantage) in the Netherlands and UK. A further 26 individual interviews and one focus group with four participants was carried out with the WP1 population in the Netherlands and UK.

Four over-arching themes were identified: 1) Ageing and changes in sexual health and wellbeing, 2) Barriers to adaptive sexual health practices and wellbeing, 3) Facilitators to accessing sexual health services, and to the fulfilment of good sexual health and wellbeing, and 4) Impact of COVID-19 on sexual health and wellbeing. These themes were merged with the findings from the quantitative data to produce a final summary (below) which was used to inform the co-creation of the Sexual Health model with partners.

iii. Needs Analysis findings

The needs analysis summarised the findings into four key SHIFT project targets: Knowledge, Awareness, Access and Stigma, which formed the basis for the development of the COM-B Sexual Health model.

Knowledge: Participants perceived a lack of knowledge amongst health professionals, suggesting the need for a tailored training programme to increase sexual health knowledge and understanding of concerns and issues, with qualitative data in accordance with this and suggesting that signposting to services is a key facilitator. Both quantitative and qualitative data indicated a lack of sexual health knowledge across all countries. Only half of the participants reported having been tested for an STI in both work package 1 and 2 populations, and while this could represent good sexual health, it may indicate a lack of knowledge of STIs and the need for testing, particularly in light of some of the reasons given (e.g. no risk of pregnancy).

Awareness: A rather high percentage of participants were unaware where sexual health services were located, and despite believing they are well informed about sexual health, stated that they are unsure if they need to get tested or have a low risk of contracting STIs. This might suggest a need for increased awareness of risks for the over-45s (including those with socio-economic disadvantage), why testing is necessary and how and where to access and utilise sexual health services. Qualitative data suggests some differences between countries in risk perception for poor sexual health and therefore the need for raising awareness amongst SHIFT populations.

Access: In some 2Seas areas, such as the Netherlands, cost was an issue for participants where payment was required for sexual health services. Another prominent barrier was the limited availability of appointments outside usual business hours, which can hinder working adults' access to services. Participants suggested that access could be improved with increased signposting for services, and a range of locations using formal and informal services, to encourage over 45s to utilise services.

Stigma: Negative attitudes and stigma around Sexual Health was a key issue for over-45s and those with socio-economic disadvantages in the 2Seas region, with recognition of a need for inclusivity, more open conversations and the need for stigma-reducing strategies to increase acceptance of sexual health/wellbeing and to increase perceptions of accessing services as 'normal'. Qualitative data indicated that in different countries, there were different types of stigma reported- for example, societal stigma by Dutch participants, and Healthcare professional and self-stigma by UK participants.

b. Model Development

Following the evidence review, initial themes and findings from the Needs Analysis were summarised and presented to SHIFT delivery partners. Co-production team meetings were held as per the Figure below (Figure 10) resulting in a Sexual Health Model based on the COM-B model domains of Capability (Physical and Psychological), Opportunity (Physical and Social) and Motivation (Automatic and Reflective). This was further refined resulting in the final model (see Figure 3) and provided the basis for intervention activities and piloting. Partners were asked to consider interventions strategies that would be effective for the populations of WP1 and WP2, ensuring equity of approach regardless of background.

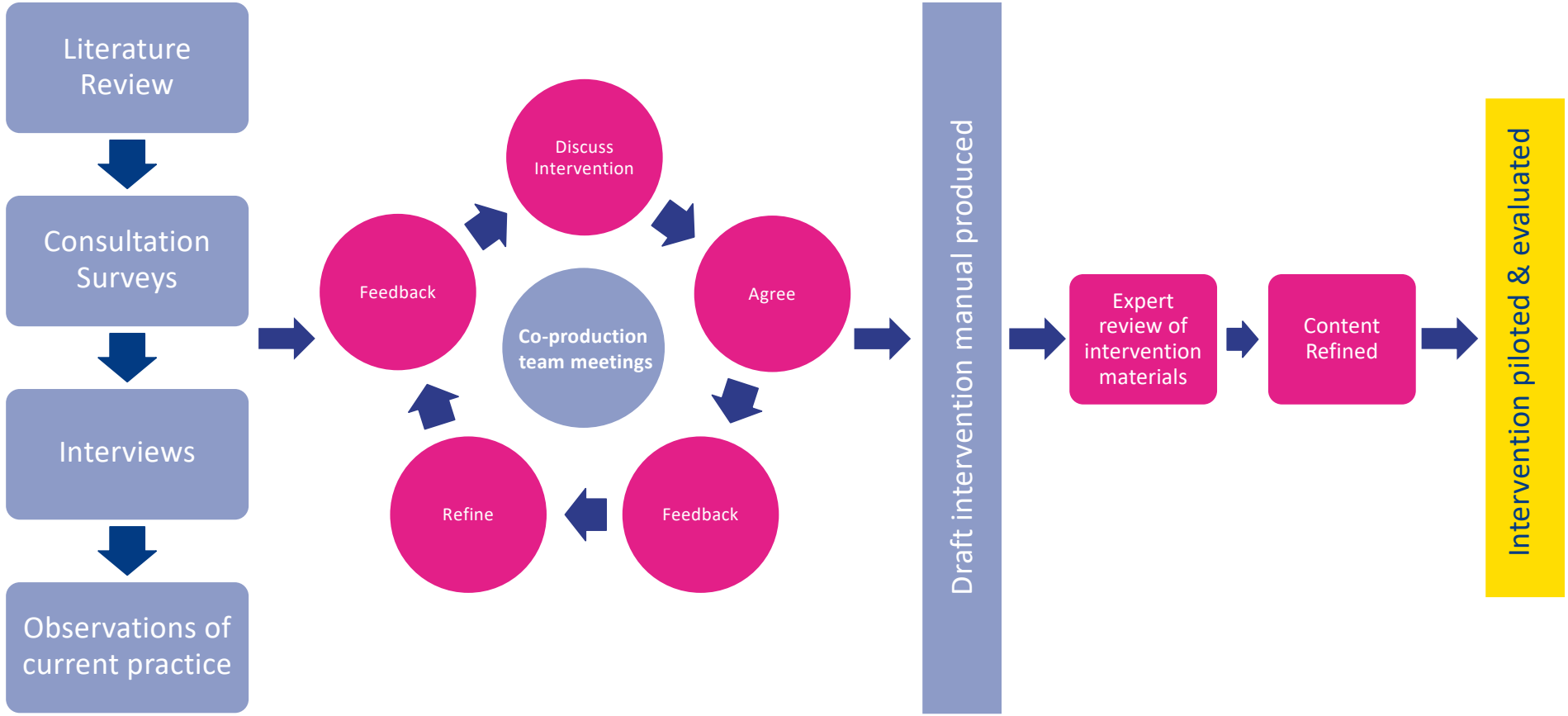


Figure 10. Co-Design Process.

9. Implementing the SHIFT Model

a. Summary of Outreach Activities

UK SHIFT outreach teams primarily targeted pre-existing events, groups and communities in which to deliver the outreach work utilising their own organisations ongoing work and collaborating with their partners from their professional networks. This varied between large-scale events such as PRIDE and a Summer County Show, as well as smaller more 'bespoke' communities or groups, such as homeless sessions and MSM (Men who have Sex with Men) Saunas. Data from UK delivery partners shows a high level of engagement with outreach services, ranging from distribution of health resources (leaflets, condoms, lube sachets) to general conversations as well as those more in-depth queries and concerns.

Table 8. UK Outreach Activities.

Outreach sessions (PRIDE events, Kent County Show, Royal Gurkha Regiment Information Day)	6
Health Bus Outreach sessions	3
Bespoke group sessions	2
Homeless drop-in sessions	2
MSM Sauna Outreach	12
TOTAL	**25**

Table 9. UK Outreach 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 Concerns	79
Homeless support	45

SHIFT outreach teams in the Netherlands targeted pre-existing groups and communities only, working specifically with populations that were known to be vulnerable and form part of the Work Package 2 demographic. This approach was adapted to fit with the particular concerns in accessing the more vulnerable communities and enabled outreach staff to reach them directly.

Table 10. Netherlands Outreach Activities.

De Mussen Outreach	20
Information sessions for clients of Foodbank	2
Undocumented migrants Outreach	1
TOTAL	**23**

b. List of Activities and Attendance

UK Outreach

Includes the following outcomes: general conversations with people who are high risk, conversations with people who are high risk whereby onward action or evaluation was taken, people who are high risk referred for HIV or STI testing, conversations with homeless people.

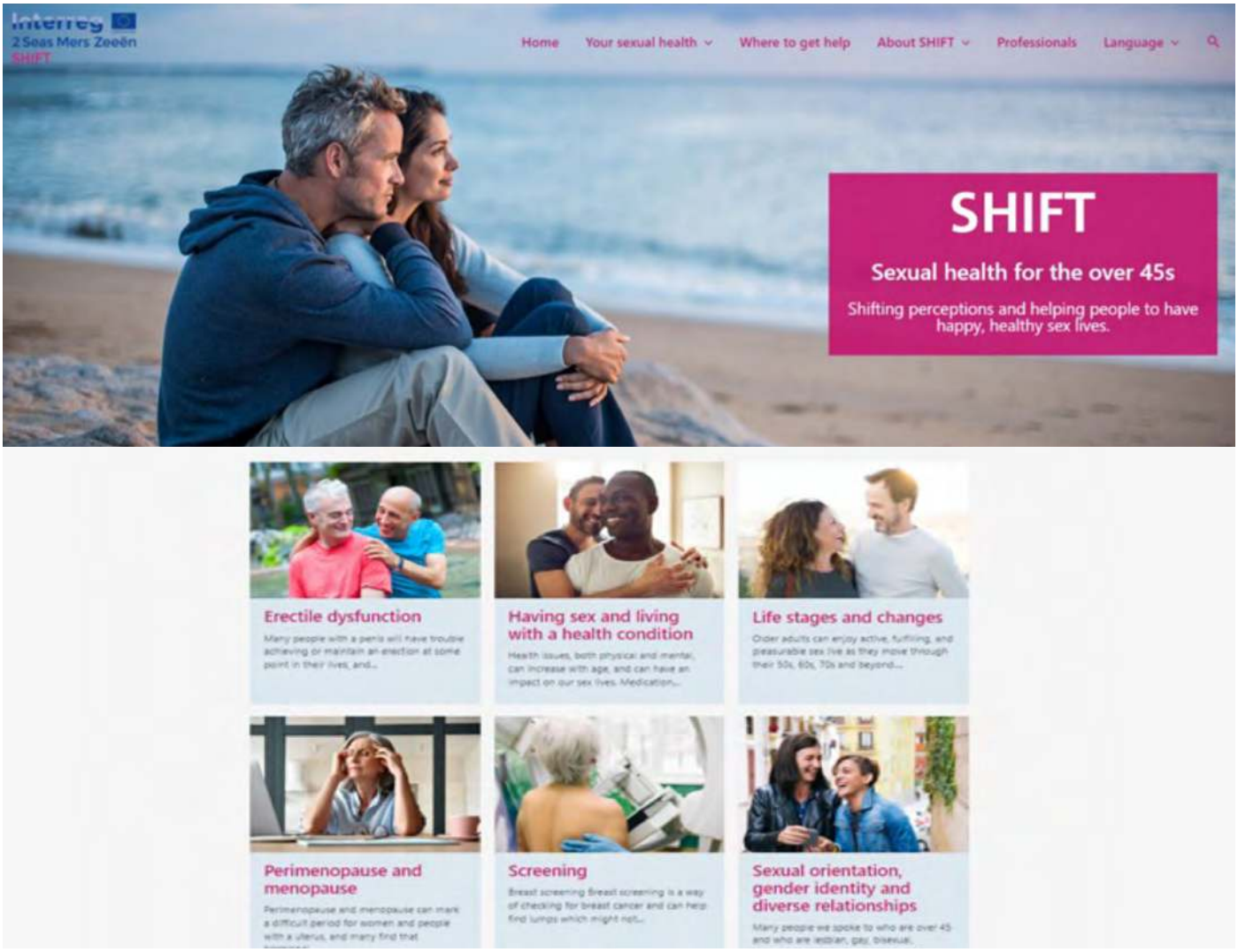
Table 11. UK Outreach Attendance.

Canterbury PRIDE	700
Kent County Show	500
Royal Gurkha Regiment Information Day	50
Brighton Outreach	60
Margate Outreach	28
Sittingbourne Outreach	129
Margate Pride	30
Rochester Pride	157
People living with HIV Event	10
Homeless drop-in sessions (Shelter and GP)	120
MSM Sauna Outreach	58
TOTAL	**1,842**

Table 12. Netherlands Outreach Attendance.

De Mussen Outreach	318
Information sessions for clients of Foodbank	14
Undocumented migrants Outreach	18

10. Outcome 1



Sexual Health Model to engage with people aged 45+

a. Website

i. Analytics - Demographics, Engagement

The SHIFT website analytics reported traffic of 49,000 events (user interactions such as page views or clicking a link) and 7,200 total users for the period May 2022 - January 2023, with 6.8 events per users, suggesting a good level engagement with the website content. Key SHIFT project events such as training, film screenings and outreach correspond with increased website traffic (Figure 11). Engagement time was good, ranging from 0m55s for all users to 1m04s for the SHIFT demographic suggesting that the website was engaging to this population.

Figure 11. SHIFT website traffic and key events (May 2022 - January 2023).

Users tended to be primarily from the United Kingdom (5,900) while other European countries also featured but to a much lesser extent (see Figure 12). The gender split was exactly 50% male/50% female for total users, with only slight deviations from this for the over and under 45s groups (see Figure 13) indicating a balanced representation in accessing the website from both genders (using pre-defined gender categories set by Google). Perimenopause and Menopause was also a highly viewed webpage by all users, reflecting feedback from outreach events where this was a common topic raised by participants and suggesting that it is an important point for discussion and support.

Figure 12. Total SHIFT website users by Country.

	All users	Users age 45+	Users age 44 and under
Users	49,000 events 7,200 users 6.8 events per user	3,100 events 509 users 6.5 events per users	2,200 events 329 users 7.1 events per user
Engagement time	0m55s	1m04s	0m55s
Gender	50% Male 50% Female	52.7% Male 47.3% Female	47.6% Male 52.4% Female
Device	67% Mobile 22.7% Desktop 10.3% Tablet	73.9% Mobile 17.1% Desktop 9% Tablet	77.6% Mobile 20.4% Desktop 2% Tablet
Top 5 Page Views	SHIFT Sexual Health- 9,258 Sex & Sexuality – 592 Professional- 575 Perimenopause- 516 Painful Sex- 449	SHIFT Sexual Health- 1,400 Painful Sex- 81 Erectile Dysfunction- 79 Sex & Sexuality- 63 Professional- 62	SHIFT Sexual Health – 1,200 Professionals- 129 Sex & Sexuality- 114 Menopause- 84 Painful Sex- 75

Figure 13. SHIFT Website Performance by Demographic Data.

b. Think Aloud - Usability and Effectiveness

The six individuals who participated in the Think Aloud study identified themselves as having no socio-economic disadvantage, as such they fall under the remit of Outcome One. There was an equal gender split and all participants identified as heterosexual or straight. Table 13 below outlines the full demographic details collected.

Table 13. Demographics from Outcome 1 Think Aloud Participants.

Demographics	
Gender	3 men (including transman) 3 women (including transwomen)
Age	Mean = 50.8 (SD = 3.45)
Relationship Status	4 married 1 partnership 1 single
Sexual Orientation	6 heterosexual or straight
Sexual Activity	3 currently active 2 active within the last 3 months 1 active between a year and 5 years

Figure 14 shows the mean time it took participants to complete the four search tasks. They were all completed reasonably quickly other than the search for the video. This took participants upwards of two minutes to locate, however one participant did skip this question. This indicates that most of the content on the website is logically arranged and signposted with headings, but the videos need to be more clearly placed.

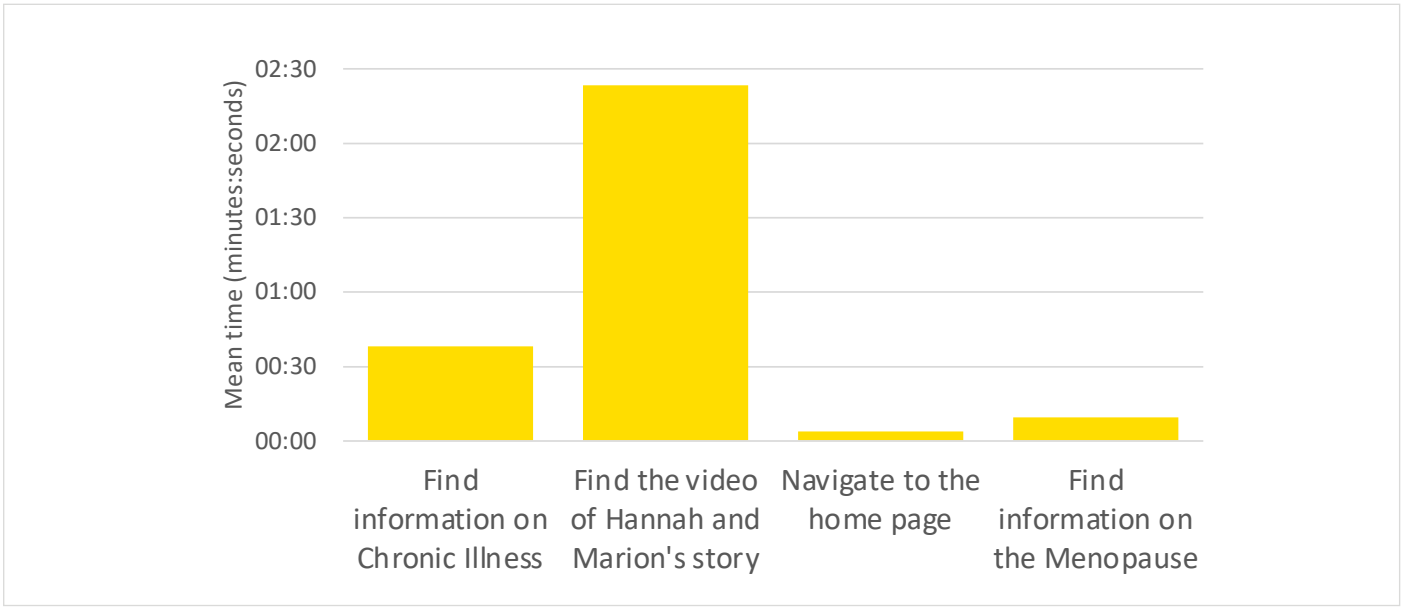


Figure 14. Mean time taken for Outcome 1 participants to complete the Think Aloud search tasks. Note. 1 participant missed the second task.

Throughout the completion of the Think Aloud, participants were also asked to give their opinions to four questions using a 1-5 Likert scale. Figure 15 outlines these. Participants indicated that first impressions of the website were good, they believed the information presented was credible and they found it very easy to navigate to the home page and find information on the menopause. These final two are supported by these tasks being the quickest for participants to complete.

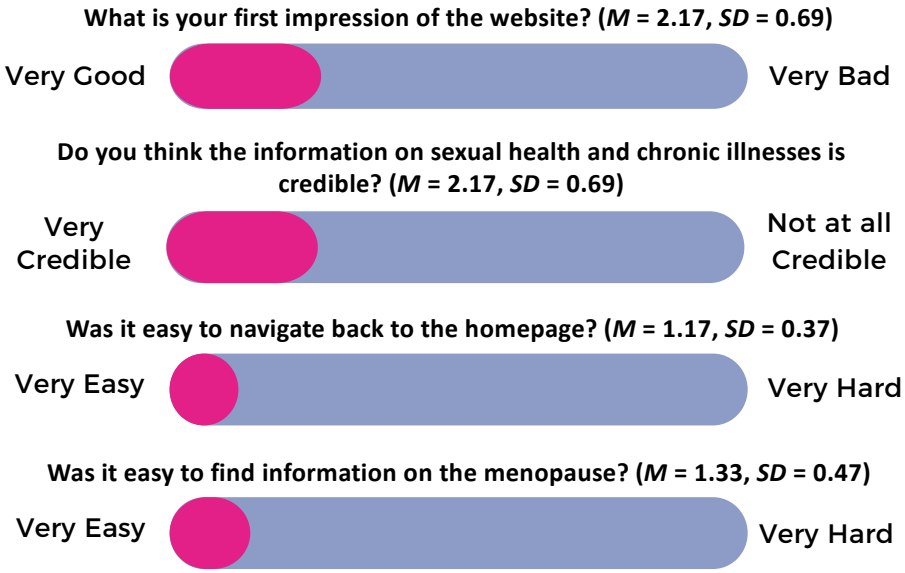


Figure 15. Likert scale responses to Think Aloud questions.

By the nature of the Think Aloud design, large volumes of qualitative data is collected. This was analysed to identify overarching themes across participants. See Figure 16 for a summary.

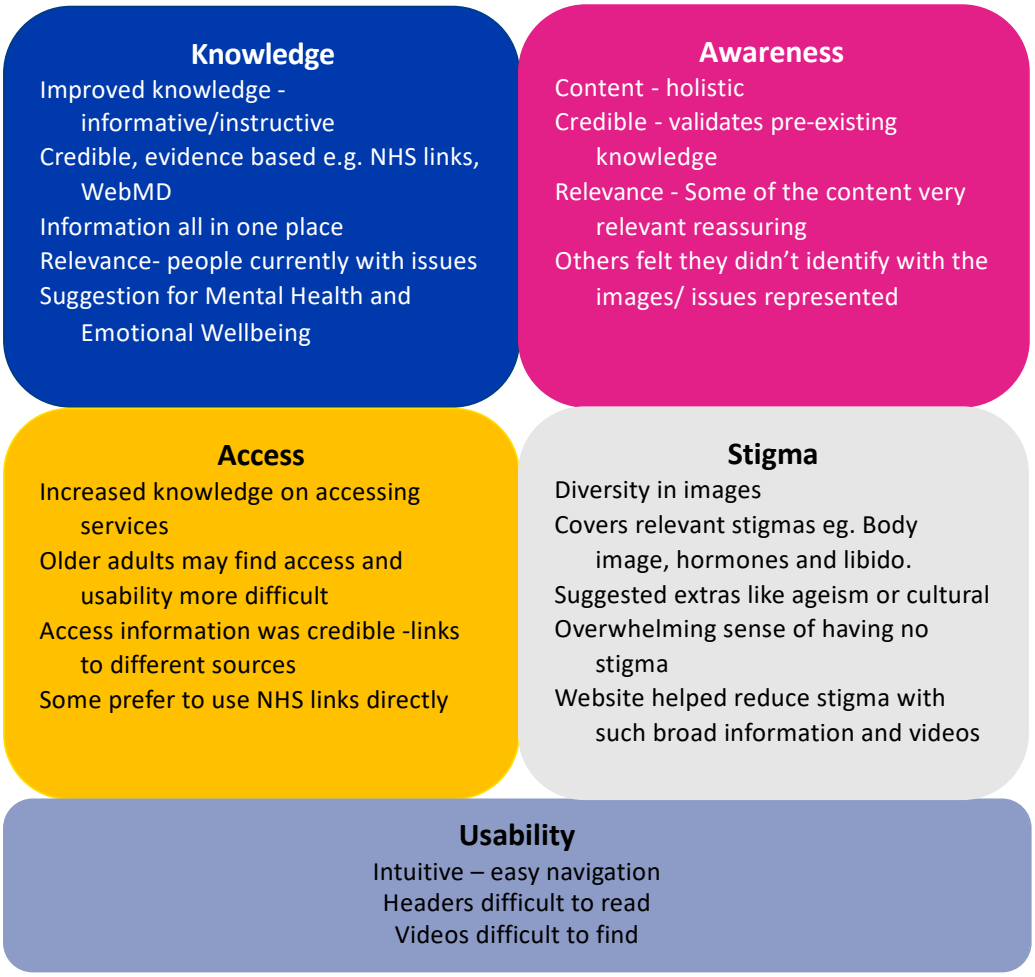


Figure 16. Qualitative data themes and summary from Outcome 1 think aloud.

Knowledge

Participants identified that the website contained lots of useful information which would help individuals aged 45+ improve their knowledge of sexual health and wellbeing. They identified the content on the website as being informative and instructive and coming from credible, evidenced based sources. They commended that all the information was located in one place and could see the relevance for their demographic. There were suggestions for further content, particularly surrounding mental health and emotional wellbeing.

Awareness

As well as targeting their knowledge, the website aimed to raise general awareness around sexual health and wellbeing issues. Participants commented on how the content approached sexual health and wellbeing issues in a holistic manner thereby validating their pre-existing knowledge. Many participants related to the content and felt it was reassuring to feel like they were not alone. A few, however, felt that they did not identify with the issues represented in the material.

Access

All participants commented on how the website increased their knowledge on accessing services. They however also commented on how older adults may find the usability and access to the website difficult. The links from the website to different sources were deemed to be credible, however some expressed a preference of using the NHS links directly.

Stigma

All the participants felt that they personally had no stigma towards sexual health and wellbeing of the over 45s but acknowledged that this is perhaps experienced by others. They commended the diversity in the images used across the website and the covering of relevant stigmas such as hormones and libido. Additional content surrounding other stigmas such as ageism or cultural stigma was suggested. Overall, they felt the website helped to reduce stigma and did this through the broad range of information and representative videos.

Usability

Largely feedback on the usability of the website was good. As identified in the previous data, the quantitative data was good and this is supported by the qualitative comments. Participants found the website intuitive and easy to navigate. As identified in the search tasks, participants commented that the videos were difficult to find and should be more clearly accessible. It was also identified that with the rolling photos on the home page, when some images were showing, the headers were difficult to read due to lack of colour contrast.

At the end of the protocol participants were asked to complete a final wrap up of the website expressing how their knowledge, awareness, access and stigma had changed following their engagement with the website. Participants all indicated that their knowledge, awareness, and access was greater than and their stigma was less than before engaging with the website (Figure 17).

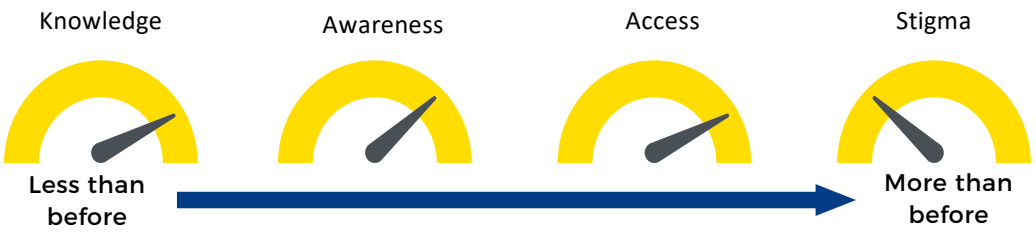


Figure 17. Participant ratings of their knowledge, awareness, access and stigma after engaging with the website.

a. Clinical Data

i. Local Case Study

Clinical data from Kent Community Health Sexual Services for patients over 45 for the period Jan-Oct 2022 indicates that there were fewer patients attending clinics compared to the same period in 2019 (12.8% reduction). These services include Sexual Health Clinics, Outreach Clinics, Psychosexual Services, Prisons and Targeted Outreach, and qualitative feedback from outreach partners in interviews suggested that COVID impacted face-to-face clinic attendance during the second time point.

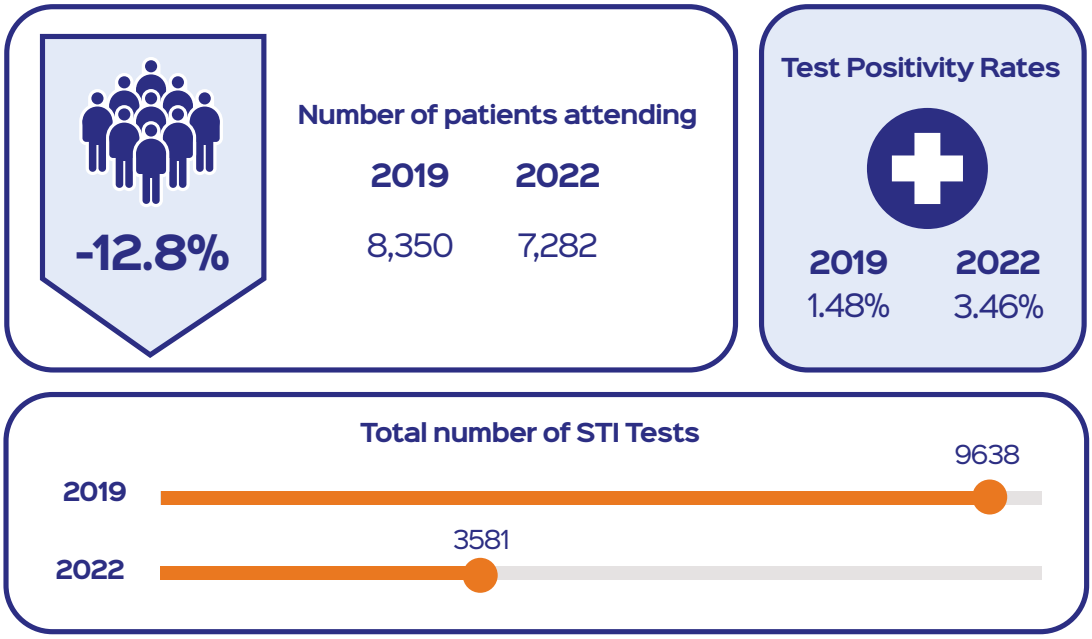


Figure 18. Clinical Data findings for the periods 2019 and 2022.

When comparing the same time period, data showed fewer number of tests for HIV, Chlamydia, Gonorrhoea or Syphilis (9,638 in 2019 compared to 3,581 in 2022). Test positivity rates for 2022 however had increased for these STIs from an average of 1.48% (2019) to 3.46% (2022) suggesting that while fewer numbers of patients were attending clinics and testing, there was an increase in the actual rates of positive tests amongst this group in 2022 compared to 2019 data. This was reflected in interviews with staff from the clinic who reported that it was challenging to access over 45s, particularly more vulnerable or hidden populations. The test positivity rates for chlamydia and gonorrhoea doubled, and syphilis tripled, despite less than half the number of tests compared to previous years, suggesting that there was an increase in actual STI positive patients accessing the support needed yet there was a sense from Clinic staff that further support was needed to support the demographic in prioritising their sexual health as a concern and prevention of STIs.

Table 14. STI Tests and Positivity Rates for KCHFT 2019 and 2022.

STI	STI Tests		Positivity Rates	
	2019	2022	2019	2022
Chlamydia	2534	917	2.59%	5.78%
Gonorrhoea	2533	927	2.34%	5.29%
HIV	2279	852	0%	0.12%
Syphilis	2292	885	0.80%	2.37%
TOTAL	9638	3581		

Outcome 1 Summary

The SHIFT website was viewed positively by the Work Package 1 demographic, who felt that it was a credible source of knowledge which offered a holistic approach to sexual health and wellbeing and complimented other sources of information such as NHS websites and GPs. Participants suggested that they themselves did not have any stigma towards older adults and sex, raising interesting questions about where the perception of stigma lies. The website traffic itself was driven primarily by SHIFT promotion with large spikes in traffic corresponding to key events. A good proportion of its audience was older adults suggesting good reach into the project's demographic, as well as an even gender split. Page views suggest that menopause is a key concern for this group, corresponding with findings from other outcomes. It is also noted that the professionals page had a high view suggesting that the website is not only being accessed by the SHIFT demographic, but also by those supporting them.

11. Outcome 2

Tailored SH&WB strategy to adapt model to engage with people aged 45+ experiencing socio-economic disadvantage

a. UK Outreach - MSM Sauna

i. Demographics and Content of Conversations

Men seen at the sauna clinic were nearly all aged over 45 years. Although the activities at the sauna were centred around sexual relations between men, it is interesting to note that 8.62% of the sample identified as heterosexual. Approximately equal numbers reported that they were married (39%) or single (42%). This evidence suggests that this demographic of the SHIFT population is not only distinct to other populations engaged in outreach support and activities but that there are also various sensitivities to consider when engaging in this work.

> **"What I have noted is that 80% of these people are over the age of 45 and many are married to women. On reflection this is a different demographic to what I was used to when I did outreach in a central London Sauna. In that sauna the demographic was definitely a "younger" clientele."**

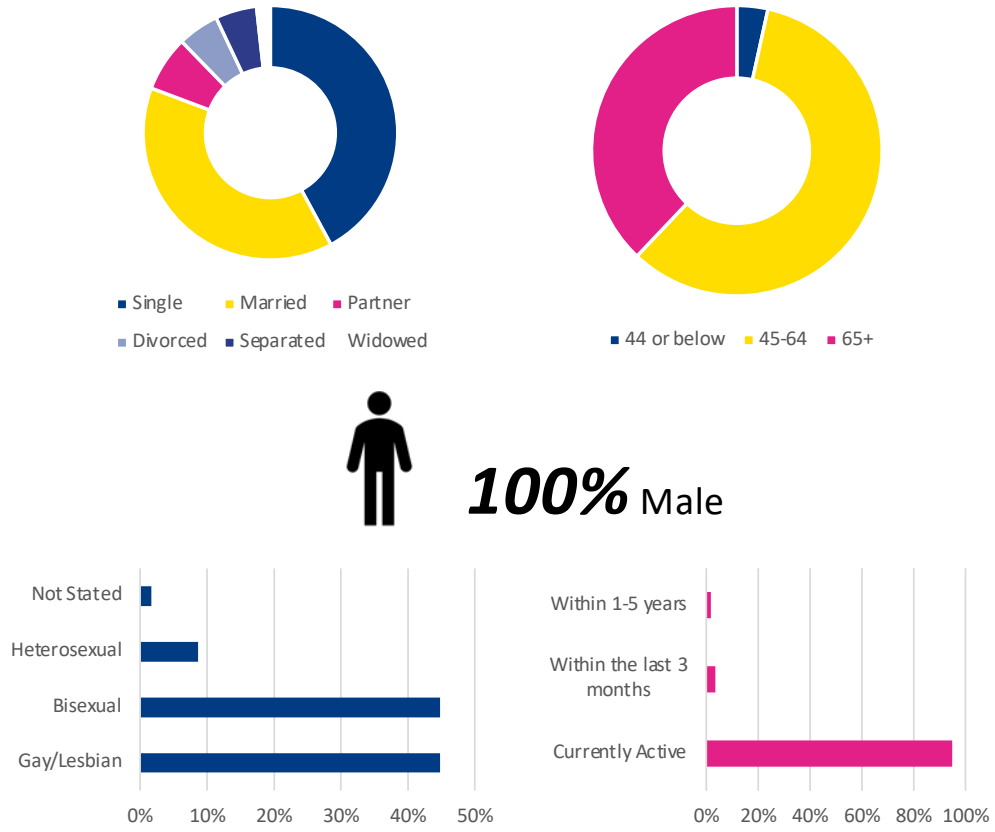


Figure 19. Demographic survey data for MSM Sauna outreach (n = 58).

In comparison to data from other outreach (such as PRIDE or community events) this population reported different reasons for engaging with the SHIFT outreach activities, which tended to be much more centred around sexual health, for example, concerns about STIs or to learn more about their sexual health. They were less likely to initiate conversations based on sexual wellbeing issues or to seek support on sexual wellbeing from a professional. Conversations were mostly based around STIs, HIV and general sexual health risks, as well as measures to support this such as examinations, provision of PREP (Pre-Exposure Prophylaxis) and Mpox (Monkeypox) vaccinations. Conversations centred around the emotional-complexity of a mismatch between their sexual identity and lifestyle and what one participant referred to as, his 'true self', and the negative impact this lifestyle has on their mental health. Other conversations concerned difficulties with sex including erection issues, pain from anal sex and loss of libido.

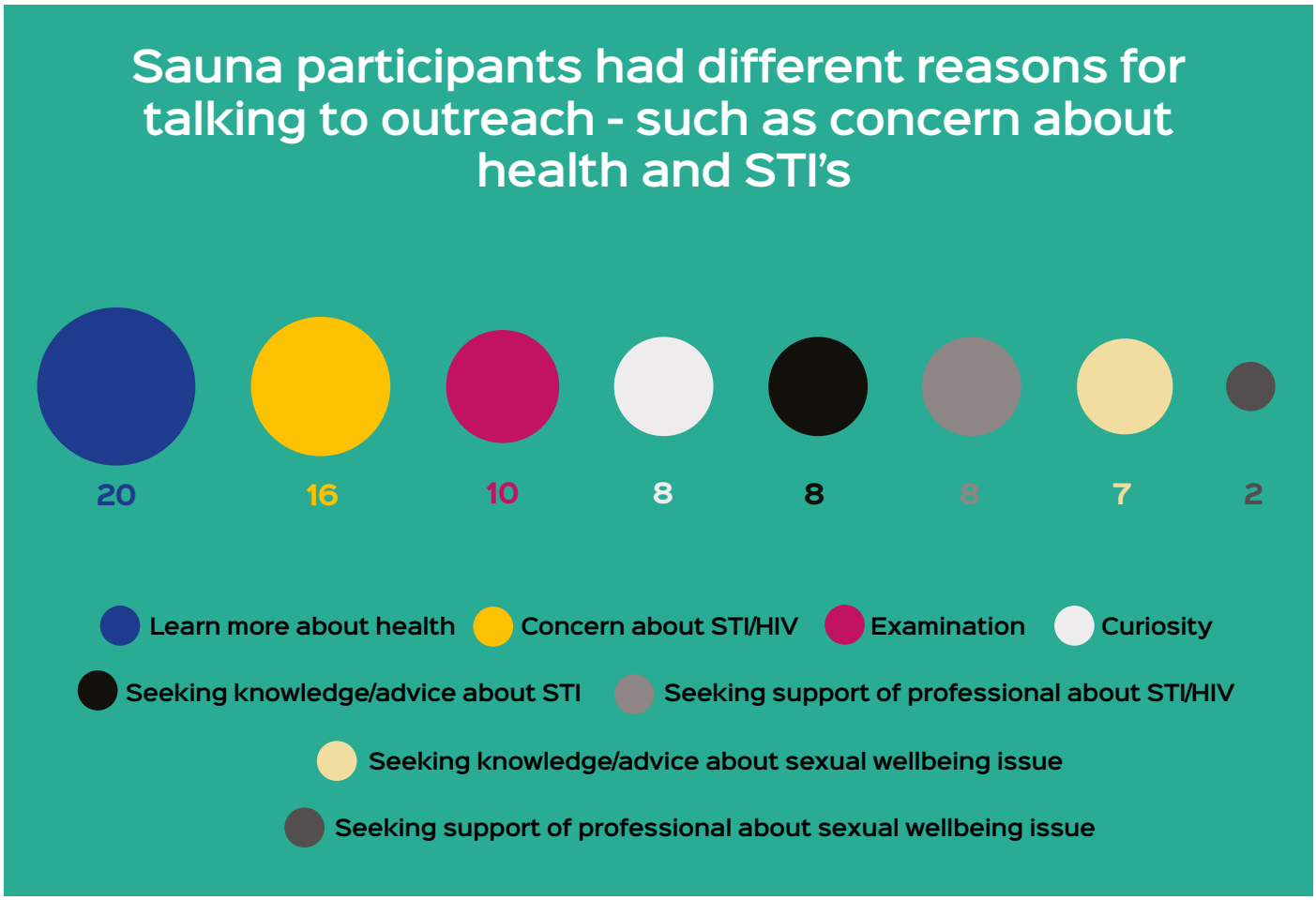


Figure 20. Sauna Participants Reasons for Talking to Outreach Services.

ii. Surveys - Intentions, SHIFT outcomes (K/A/A/S)

Survey data suggested that as a result of engaging with the MSM outreach service, there was an improvement in participant's knowledge, awareness and access to sexual health services, with access being the most improved (see Figure 21). This is perhaps not surprising for a demographic that is harder to reach, and as such may have been more reluctant to access traditional services such as Sexual Health Clinics. The stigma towards sexual health was also lowered as a result of engaging with the service. The Sexual Health Nurse reported conversations around self-stigma, with sauna users feeling that they were living a lie, particularly those who were married and visiting the saunas in secret. In an interview after outreach activities concluded, the Sexual Health Nurse concluded that access to previously 'hidden' demographics like this, and offering them support and advice that they would not otherwise access, was a powerful part of the SHIFT model delivery. This demonstrates the value of directly working with vulnerable populations in settings that they were most likely to engage in, and in the staff's own words, enabled them to "see the unseen".

> **"The gentleman is in his late 60's we discuss that he has been married to his wife for 38 years and that they haven't had sex for the last 5 years. He informs me that he is struggling with his mental health due to the fact that he is tired of "living a lie"."**

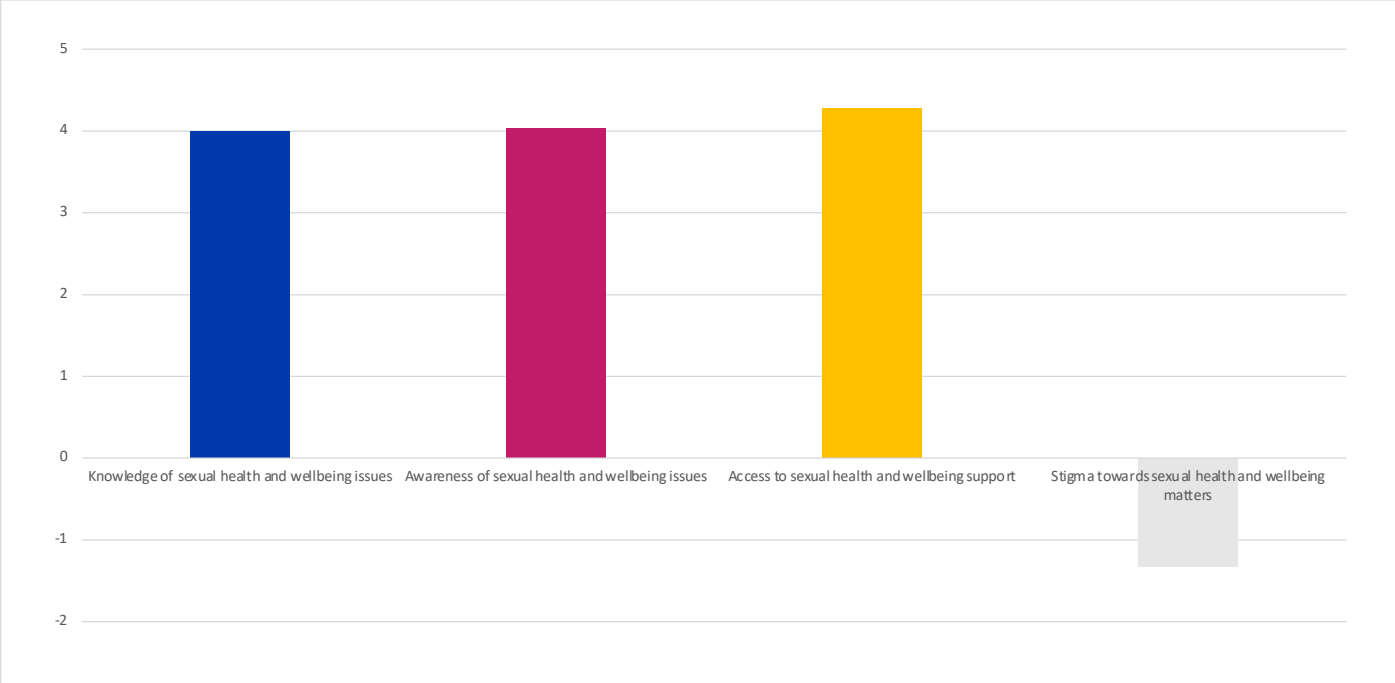
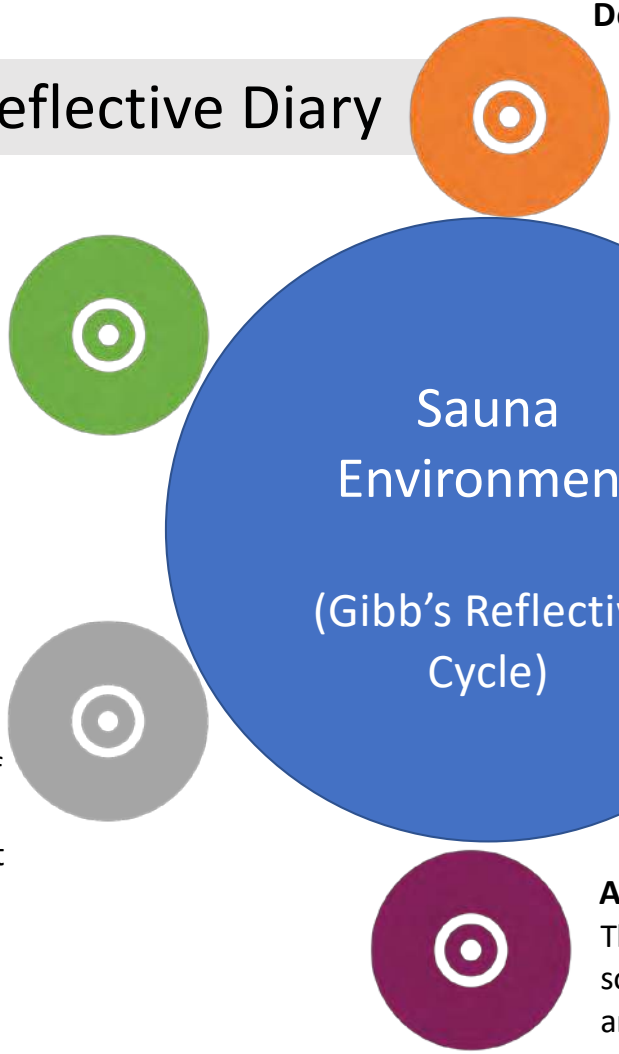


Figure 21. Knowledge, Awareness, Access and Stigma of Sauna participants.

Reflective diaries kept by the Sexual Health Nurse and analysed using Gibb's reflective cycle (see Figures 22 and 23) showed two particular domains of interest: client support and the sauna environment. The latter is particularly useful to consider when looking at the model of outreach staff going directly in to environments that are most commonly frequented by the demographic they wish to engage with. The diary entries suggested that unfamiliar environments, particularly ones with provocative stimuli (as in the sauna, such as pornographic videos and individuals in states of undress) take some time to de-sensitise to, and that part of doing so might involve discussions with and support from colleagues. The outreach diary also reflected on the specific demographic of sauna clients, commenting that many men are visiting in secret and keeping their sexual preferences hidden from loved ones. The Sexual Health Nurse reflected on the difficulties of this 'emotional work' of supporting clients whose mental health and wellbeing is impacted by 'living a lie', as well as the need for outreach services that this hidden demographic can access discretely and without any judgement or stigma. When establishing outreach services such as this in the future, it will be important to consider the support available for the outreach staff, perhaps by offering supervision or peer support from colleagues.

MSM Sauna- Reflective Diary



Description

….it has been over 6 years since my last sauna clinic. There is GBMSM (gay, bisexual men who have sex with men) porn playing on large screen TV's on every wall that you look. Potential patients are always in a various state of undress, either naked or with towels around their waist or over their shoulders.

Feelings

I had forgotten from previous experience how different it was working in this type of environment

Evaluation

I didn't expect this to take a while to get used to again but it does.

Analysis

There are times that I get distracted by some of the more extreme images that are played.

Conclusion

I also need to do some reflection and further see how with the help of colleagues de-sensitise myself from the constant images of porn that are also ever present.

Action

…eventually I assume I will become de-sensitised to this as I was before.

Figure 22. Sexual Health Nurse Reflective Diary Findings for MSM Sauna Outreach.

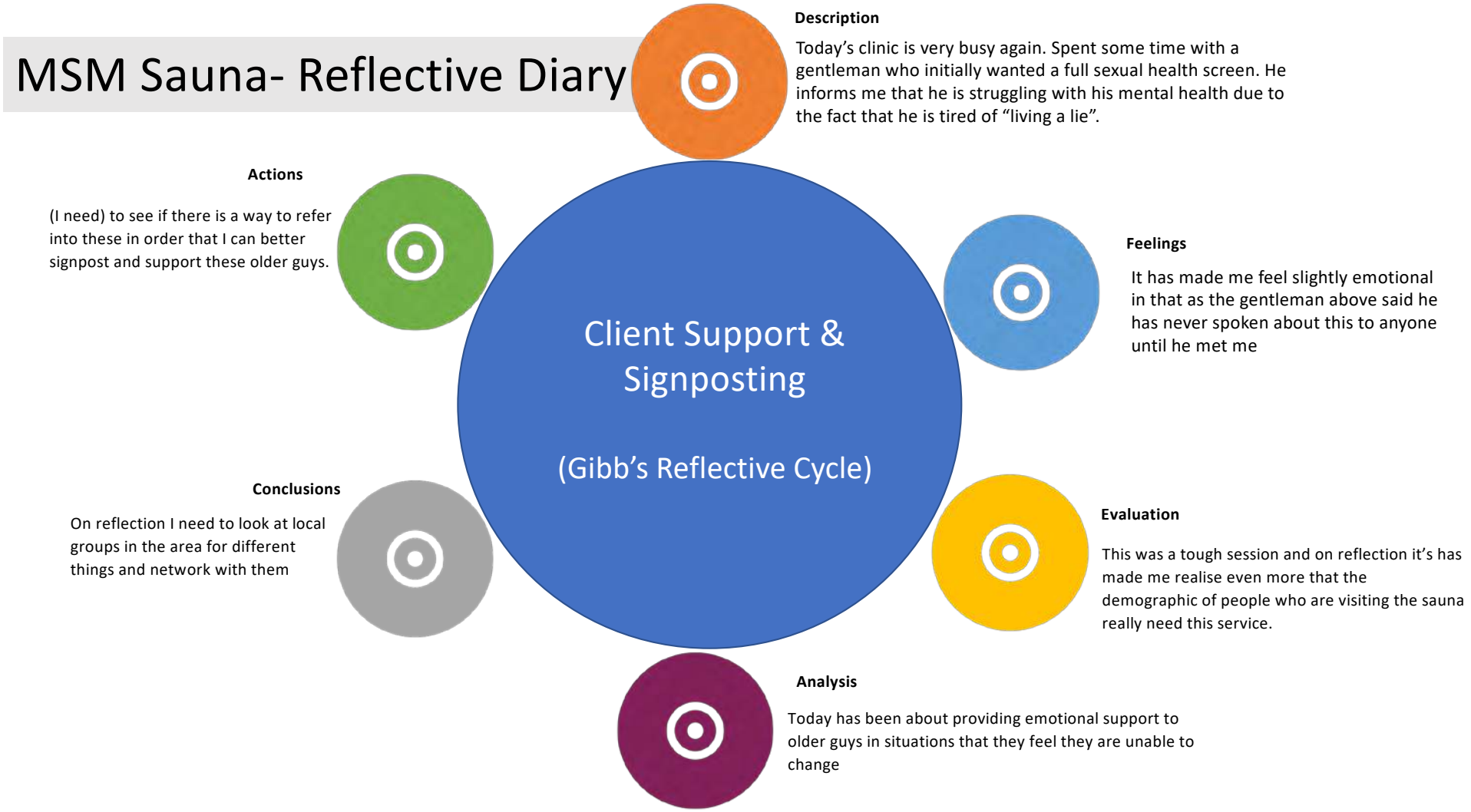


Figure 23. Sexual Health Nurse Reflective Diary Findings for MSM Sauna OutreachOutreach.

b. UK Outreach (WP2 Demographics only)

i. Demographics and content of conversations

Survey data was collected from four different outreach activities in the 2Seas region from 21 participants.

Just under two-thirds of the participants reported their gender as female (61.9%) with the majority (76.19%) fitting in to the lower-end of the SHIFT age range (45-64) and reported sexual orientation as heterosexual (61.9%). Relationship status and sexual activity was more diverse, with the latter also not always reported, reflecting perhaps some of the perceived stigmas of discussing intimate details with the outreach staff. The vast majority (90.5% of participants) reported a WP2 disadvantage, including: LGBTQ+, Low Income, Homeless, No formal education, Migrant, Non-native language speaker.

Table 15. UK Outreach Demographic Data.

UK Outreach Demographics (N=21)		
Gender	Male	33.33%
	Female	61.90%
	Non-Binary	4.76%
Age	44 or below	9.52%
	45-64	76.19%
	65+	14.29%
Relationship Status	Single	28.57%
	Married	47.62%
	Partner	4.76%
	Widowed	4.76%
	Unknown	14.29%
Sexual Orientation	Gay/Lesbian	23.81%
	Bisexual	14.29%
	Heterosexual	61.90%
Sexual Activity	Currently Active	23.81%
	Within the last 3 months	14.29%
	Within 3-6 months	14.29%
	Within 6 months- 1 year	9.52%
	More than 5 years	9.52%
	Unknown	28.57%

Participants tended to start conversations out of curiosity or knowledge-seeking about sexual wellbeing with SHIFT outreach staff. In contrast to the participants from the Saunas, they were less likely to start conversations about STIs or HIV. Similarly, the conversations they had with outreach staff tended to be about wellbeing issues or accessing support, rather than sexual risk or methods of protection, suggesting that perception of sexual risk and a subsequent need was lower in this group. Menopause was described by outreach staff as being the most critical unmet need and often the 'reason' for starting conversations – not just by women but also their partners. Issues included negative experiences of healthcare, cost of HRT, misdiagnosis (e.g. in perimenopause long before actual menopause but symptoms misdiagnosed as depression), no follow-up from healthcare providers. Outreach staff reported a sense from some participants that they were fine not having sex, demonstrating a mismatch between this and what research suggests regarding a decline in sexual satisfaction with ageing.

Outreach staff also recorded conversations with homeless or poorly housed participants, who reported difficulties accessing testing as well as contraception, due to the UK drive for 'at-home' services, which is not possible without an address.

Kent PRIDE Event.

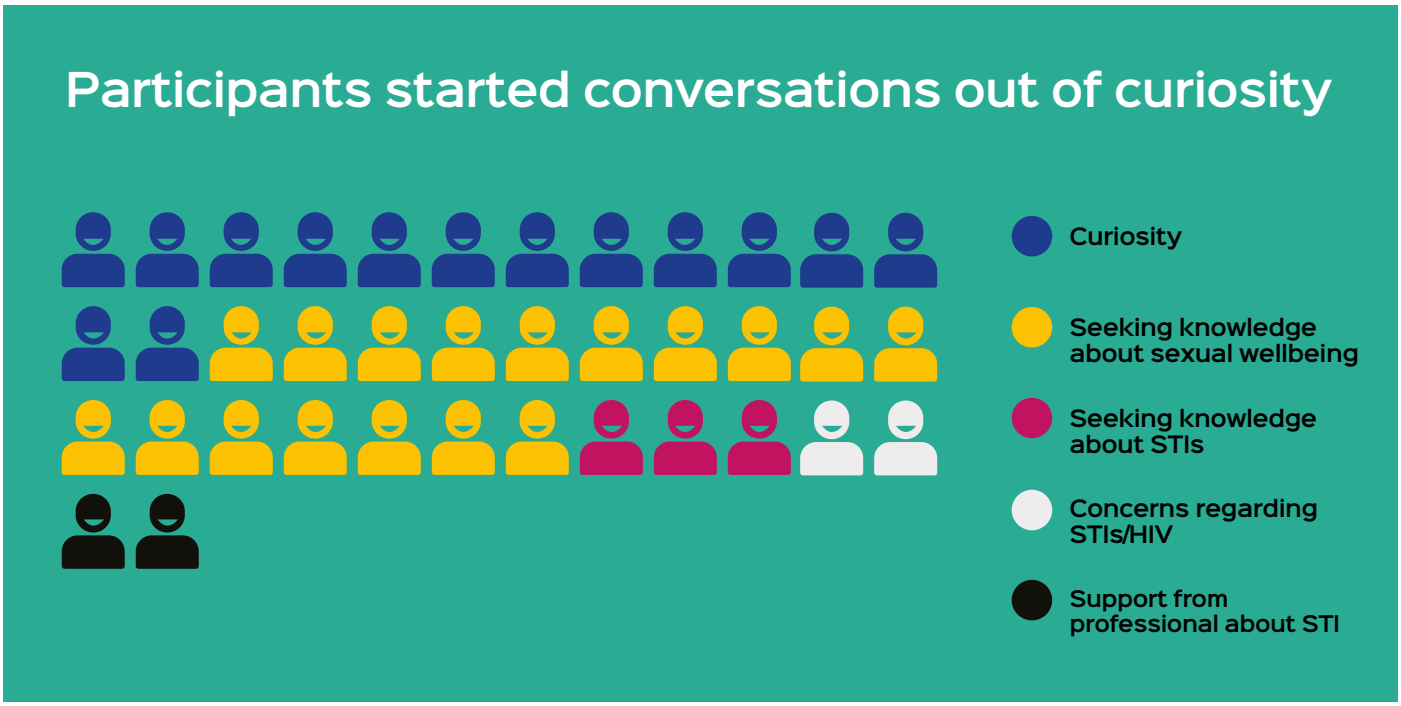


Figure 24. Outreach Participants Reasons for Conversations.

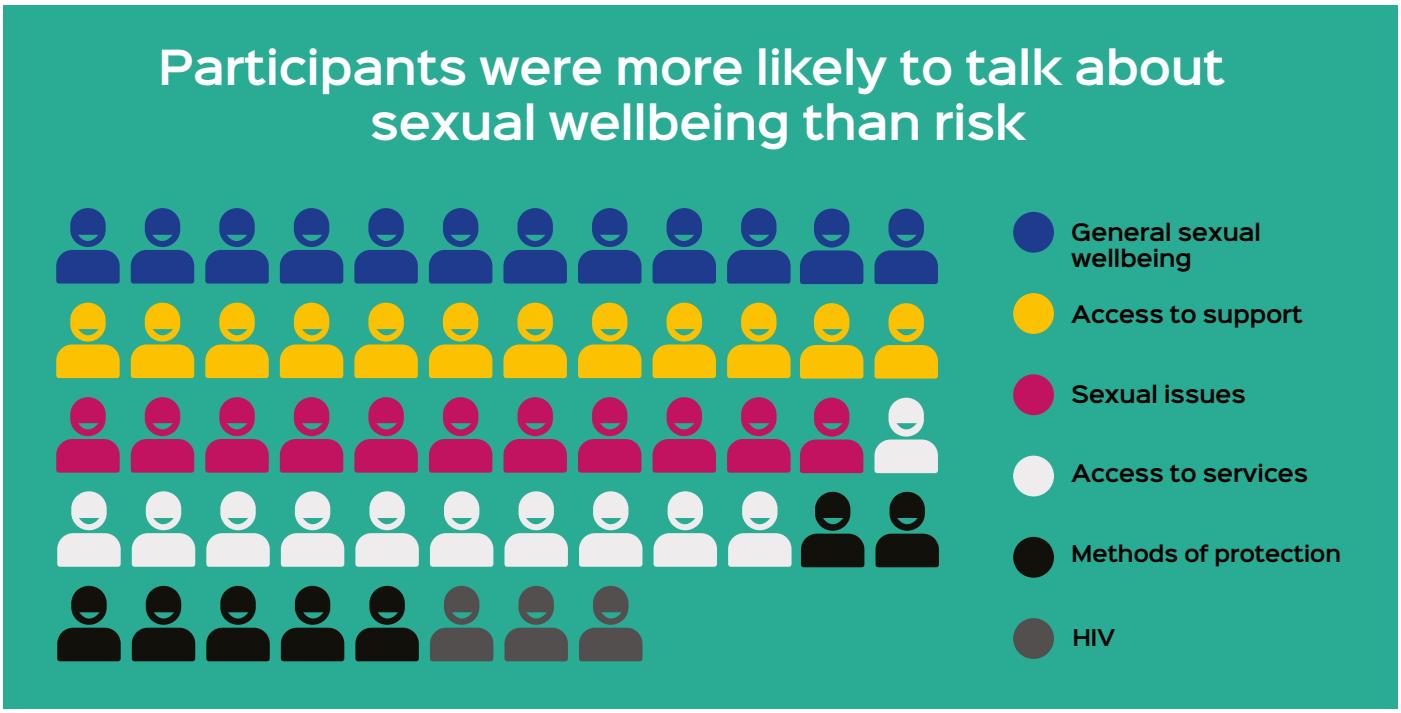


Figure 25. Outreach participants Content of Conversations.

ii. Surveys- Intentions, SHIFT outcomes (K/A/A/S)

Summary survey data suggests a positive effect on the four SHIFT domains of Knowledge, Awareness, Access and Stigma (see Figure 26) with a sizable increase in the first three areas. Unfortunately, the mean score for stigma was 1.05, meaning individuals' felt their stigma towards sexual health and wellbeing matters had increased somewhat, though this may be the result of some outliers.

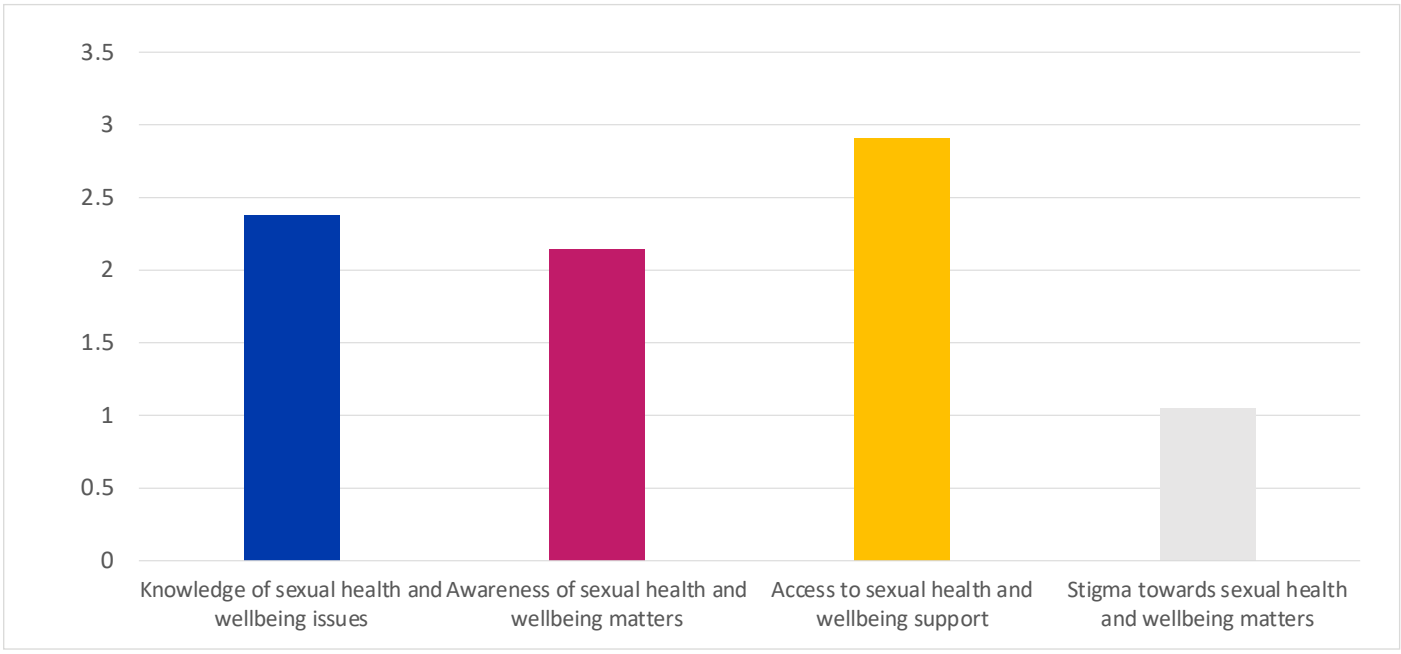


Figure 26. Outreach participants Knowledge, Awareness, Access and Stigma.

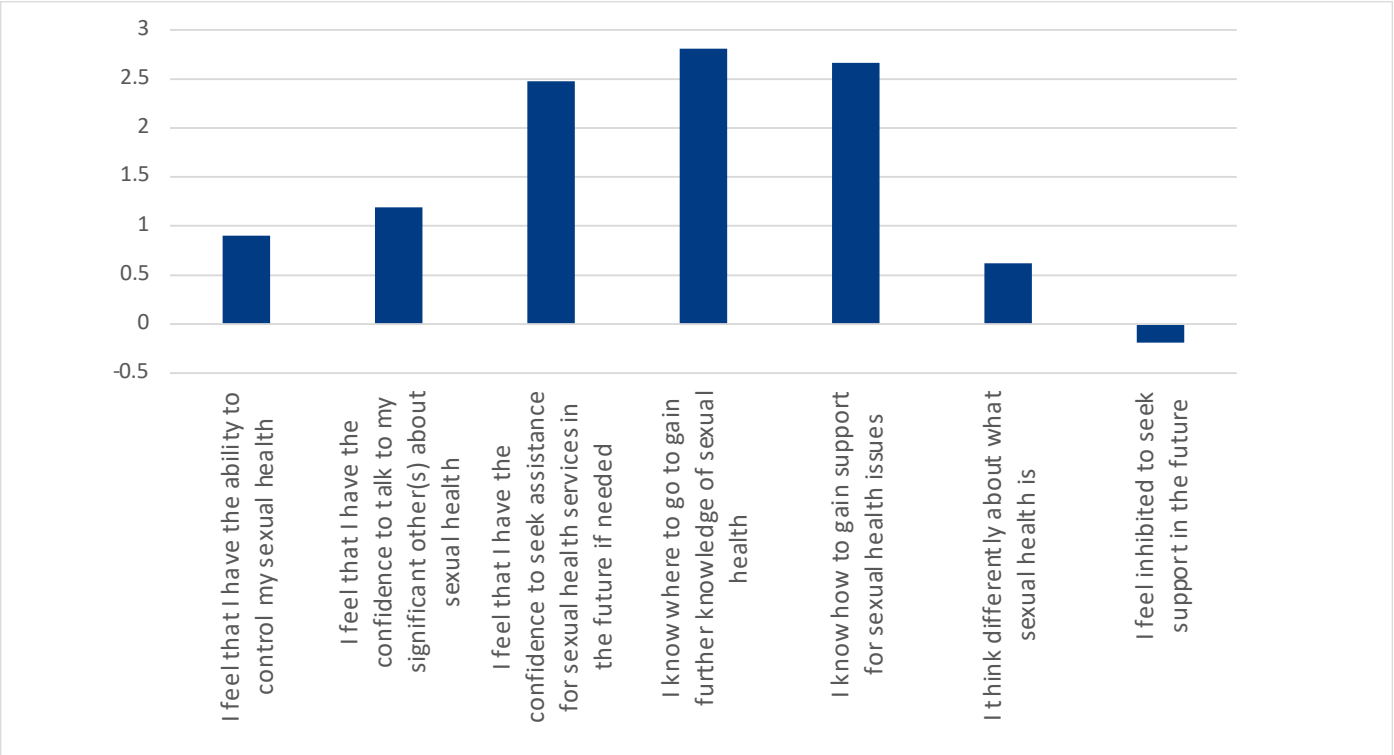


Figure 27. Mean Likert scale responses for outreach surveys, 'having engaged with the SHIFT project….'.

Respondents also reported their intention intentions to get tested for STIs remained largely unchanged (Mean 0.86, SD = 1.62). However, there were higher intentions to speak to a professional about their sexual health and wellbeing (Mean= 2.62, SD= 2.09) and higher confidence in where to go to access support (Mean = 2.67, SD = 1.85) or gain further knowledge (Mean =2.81, SD = 1.66). While this is a different population from that which participated in the Needs Analysis and therefore does not allow for a direct comparison, it is nonetheless indicative that the outreach activities were beneficial in encouraging this at-risk population to access further support. Interestingly, despite these intentions, recognition of personal sexual health risk remained largely unchanged (mean = 0.24, SD = 1.37) which reflects the findings from the need's analysis on low levels of recognition of personal risk, suggesting that this is an area where further work may still be needed.

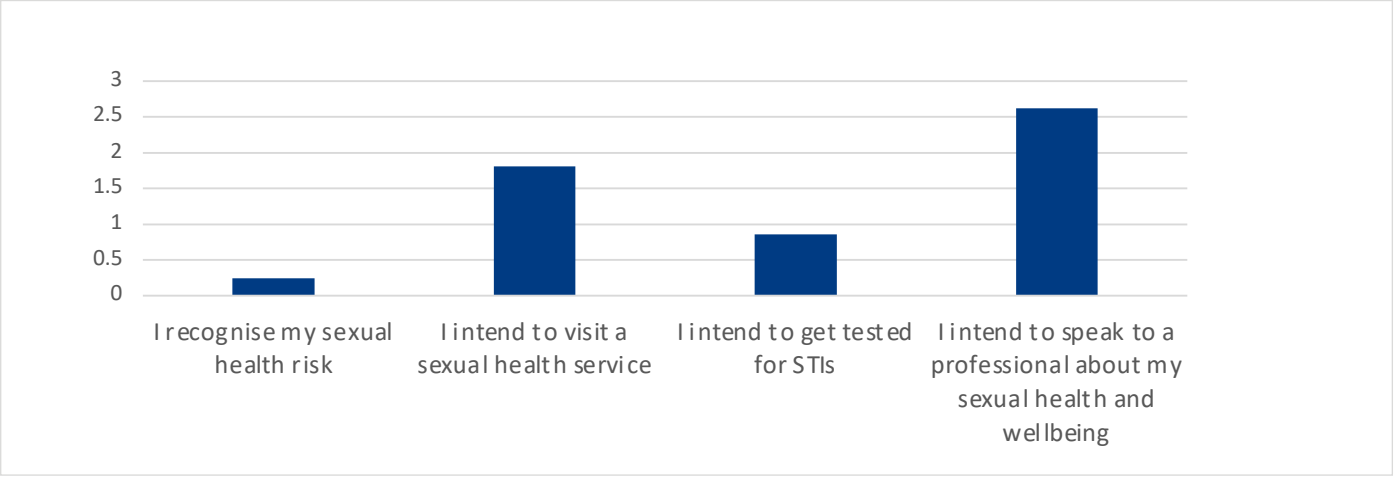


Figure 28. Mean Likert scale responses for outreach surveys, risk and intentions.

c. Netherlands Outreach

i. Frequencies and Demographics

Our Dutch partners conducted outreach work with De Mussen (community centre), STEK (food bank), and the Wereldhuis (direct translation is World House, targets undocumented migrants). Data in the form of observation forms completed by the meeting leader was collected at 23 meetings with over 300 attendees (see Table 16 below).

Table 16. Netherlands Outreach Activity Summary.

Outreach location	Number of meetings	Total attendees
De Mussen	20	318
STEK	2	14
Werelduis	1	18

Note. Total attendees refers to a count of all registered attendees for each event.
Participants may have attended more than one session, so this is not a count of individuals reached.

The Netherlands outreach programme included non-Native Dutch speakers, people from lower economic status and living in marginalised areas. The individuals reached came from diverse backgrounds, 31% were Moroccan, 13% Syrian, and 8% Somalian as seen in the chart below (Figure 29).

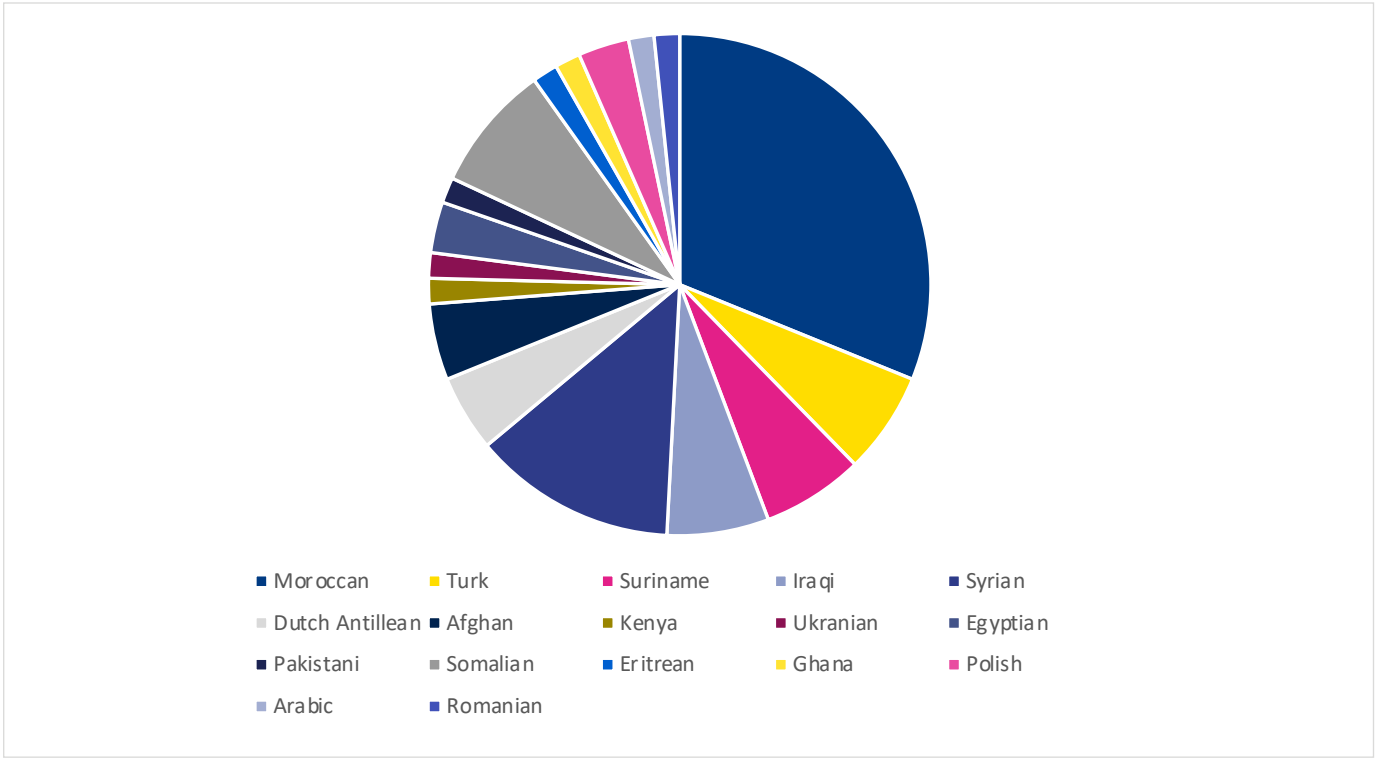


Figure 29. Pie chart depicting Netherlands outreach participant backgrounds.

The participants were largely women, with just 13 men being reached through the Werelduis meeting. Outreach targeted 'Mothers' and sports coaches. Recruitment for the Mothers Group was more successful than the coaches and therefore responsible for the majority female engagement.

The sessions covered numerous themes with contraception and menopause most often being discussed. Themes also included: sexual health, sexual orientation, forced marriage, sexual education of children, vaginal dryness, transgressive behaviour, sexual pleasure, sexual violence, self-love, healthy lifestyles, sexting, and sex toys.

Netherlands Outreach: Training Mothers group.

ii. Participant feedback

Participant feedback at the end of the session was noted by the session leader within the observation form. The responses can be grouped into four themes: general feedback, strong personal beliefs, lessons learnt, and continuing limited knowledge, awareness, access, and stigma.

General feedback

All participants had generally positive feedback following the sessions. Some commented that the meetings were "interesting" and that they "want to know more". One in particular summed up the key aims of the SHIFT project by saying:

> **"I'm happy I could share my story; I can't say it to my daughters and I don't have a sister to share these stories with"**

Strong personal beliefs

Many participants, though they engaged with the sessions maintained strong personal, often religious and cultural, beliefs. These were particularly prevalent when discussing topics of forced marriage ("I would still like my child to marry someone of my choice") and sexual orientation ("I'm a Muslim that's not how it should be").

The sessions showed success in educating participants, and many left the sessions with some key knowledge and awareness about their sexual health and wellbeing. Primarily, the key knowledge gained by participants concerned types of contraception ("I didn't know there was a female condom"), menopause ("I did not know that you could do something to stop hot flashes"), accessing services ("you can get free consultations at the Doctors of the World"), and good relationships ("communication is very important").

Continuing limited knowledge, awareness, access and stigma

As with the strong personal beliefs, despite engaging with the sessions, some participants still left with persistent negative attitudes or gaps in their knowledge. This was often reflected in the stigma still attached to sexual health and wellbeing in the over 45s ("I am ashamed to talk about it") as well as general limited knowledge ("pain and less sex drive is part of getting old and you can do nothing about it"), awareness ("we are not taught that sex is also meant to be fun"), and access ("there are many people who don't know where to turn").

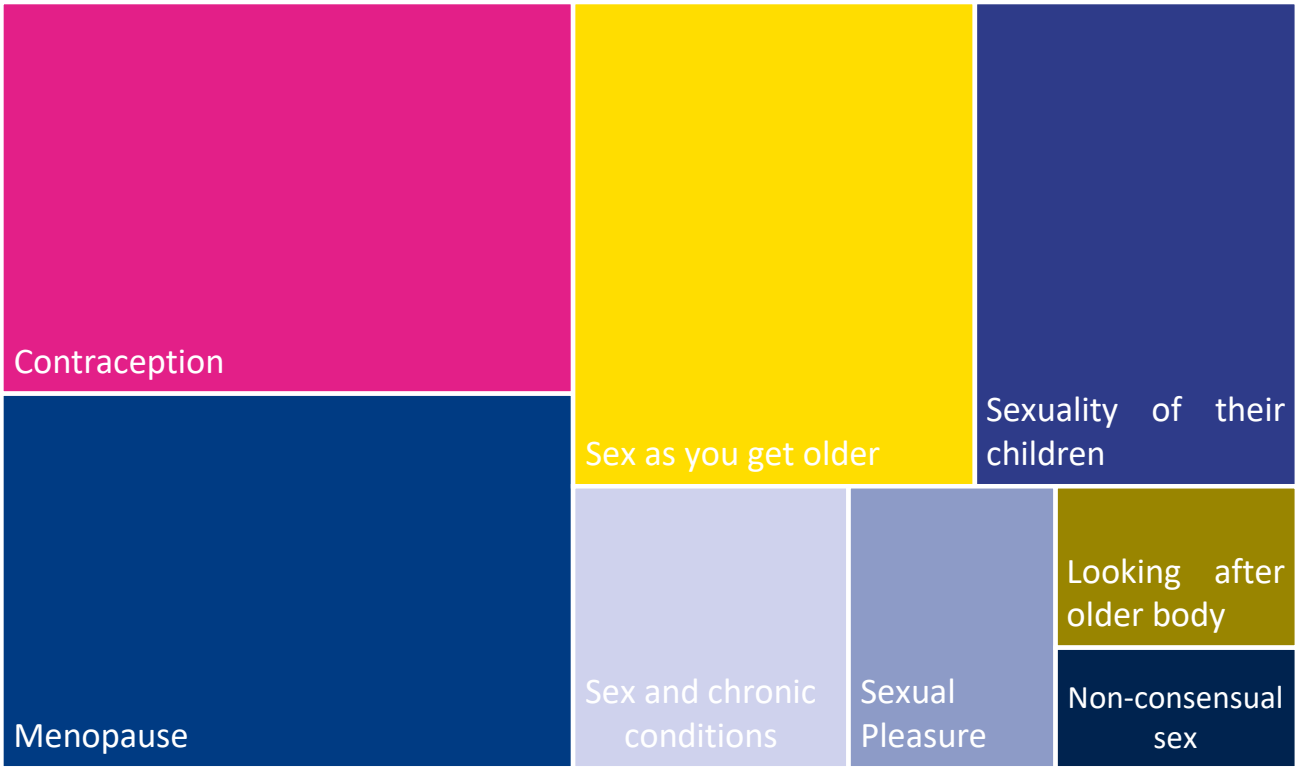


Figure 30. Netherlands outreach participants suggestions for future session topics.

Upon completion of the sessions, participants were also invited to indicate what topics they would like to see discussed in future sessions. These are outlined above in Figure 30, and are largely consistent with the sessions run, namely that contraception and menopause are the most popular topics. But other themes also were popular, interestingly sex as you get older was requested by a number of meetings and would tie in to some of the continuing limited knowledge outlined within the feedback on the previous page (i.e. the belief from one participant that "pain and less sex drive is part of getting old and you can do nothing about it").

d. Website

i. Think Aloud- Usability and Effectiveness

Four individuals that participated in the Think Aloud study identified themselves as having one or more socio-economic disadvantage, as such they fall under the remit of our second outcome. These participants all identified as women with three identifying as heterosexual or straight and one as gay or lesbian. Table 17 below outlines the full demographic details collected.

Table 17. Demographics from Outcome 2 Think Aloud Participants.

Demographics	
Gender	4 women (including transwomen)
Age	Mean = 48.75 (SD = 2.59)
Relationship Status	1 married 2 partnership 1 single
Sexual Orientation	3 heterosexual or straight 1 gay or lesbian
Sexual Activity	2 currently active 1 active within the last 3 months 1 active between 3 and 6 months
Socio-economic disadvantage	2 low income 1 migrant 1 LGBTQ+

Figure 31 shows the mean time it took participants to complete the four search tasks. One participant started and then failed to find the requested pages for the first two search tasks, so these averages are just with 3 participants. In line with one participant not being able to complete these two tasks, they were the two tasks that took the other participants the longest to complete. The search for the video took participants upwards of two minutes to locate and was the most difficult task based on these timings. The final two tasks were both completed in under 20 seconds, with the navigating to the home page taking on average 5 seconds. This indicates that most of the content on the website is logically arranged and signposted with headings, but the chronic illness information and SHIFT films need to be more clearly signposted or in a more prominent position on the website.

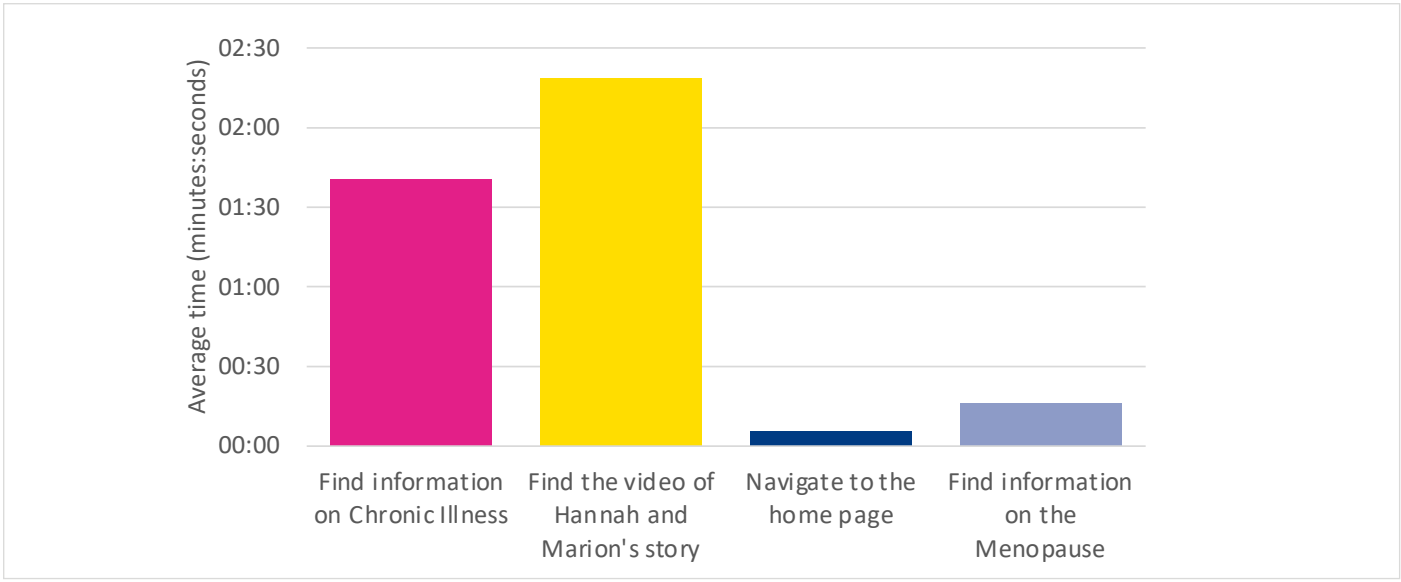


Figure 31. Graph showing the average time taken to complete think aloud search tasks. Note. 1 participant failed to complete the first task and another failed to complete the second.

Throughout the completion of the Think Aloud participants were also asked to give their opinions to four questions using a 1-5 Likert scale. Figure 32 outlines these. Participants indicated that first impressions of the website were good, they believed the information presented was credible and they found it very easy to navigate to the home page and find information on the menopause. These final two are supported by these tasks being the quickest for participants to complete.

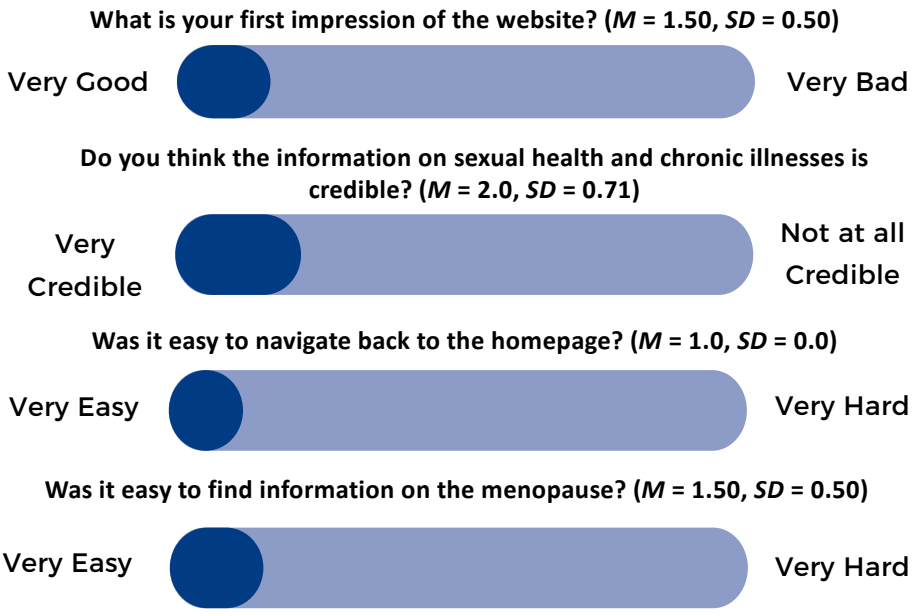


Figure 32. Average responses to the think aloud Likert scale questions.

By the nature of the Think Aloud design, large volumes of qualitative data is collected. This was analysed to identify overarching themes across participants. See Figure 33 for a summary.

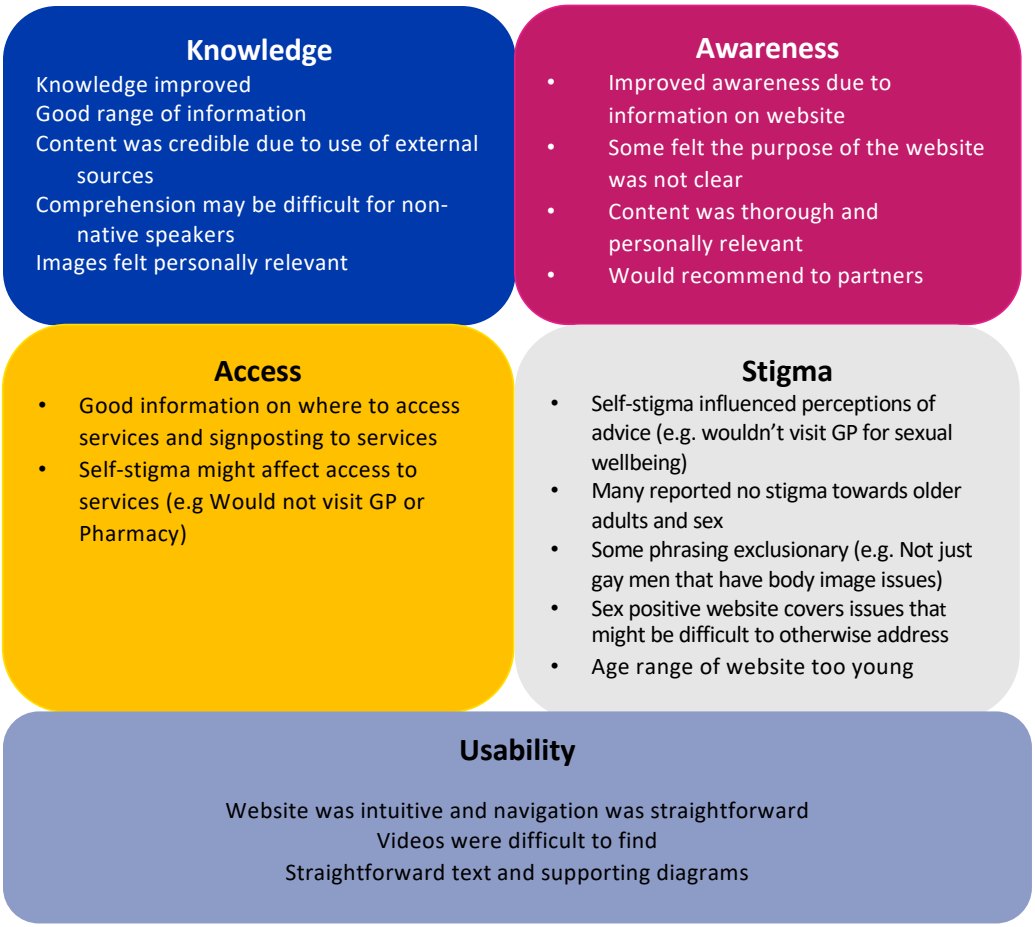


Figure 33. Qualitative data summary from outcome two think aloud participants.

Knowledge

Participants identified that the website contained a good range of information that improved their knowledge of sexual health and wellbeing. They identified the content on the website as being credible due to references to external sources. They felt the images were relevant personally but some highlighted how comprehension may be difficult for non-native speakers.

Awareness

As well as targeting their knowledge, the website aimed to raise general awareness around sexual health and wellbeing issues. Participants felt the information provided improved their awareness and that it was thorough and personally relevant. Some said they would recommend to their partners as a hub of information. Others, however, felt that the purpose of the website was not clear.

Access

All participants commented on how the website contained good information on where to access services. They also liked that there were clear signposts to services. They again highlighted what was previously established, that self-stigma might affect access to services. In other words, they would prefer online and would not visit their GP of pharmacy.

Stigma

As mentioned above, it was highlighted that self-stigma remains a barrier for crossing from online services to in-person ones. Many participants, however, felt they did not have stigma towards older adults and sex. They appreciated that having a sex positive website meant that issues could be covered that would be difficult to do otherwise. It was highlighted that the age range of the website was too young and should also cover much older adults also.

Usability

By and large, feedback on the usability of the website was good. Participants found the website intuitive and easy to navigate. They welcomed the straightforward text and supporting diagrams. As identified in the search tasks, participants commented that the videos were difficult to find and should be more clearly accessible.

At the end of the protocol participants were asked to complete a final wrap up of their reflections on the website, expressing how their knowledge, awareness, access and stigma had changed following their engagement with the website. Participants all indicated that their knowledge, awareness, and access was greater than and their stigma was less than before engaging with the website (Figure 34).

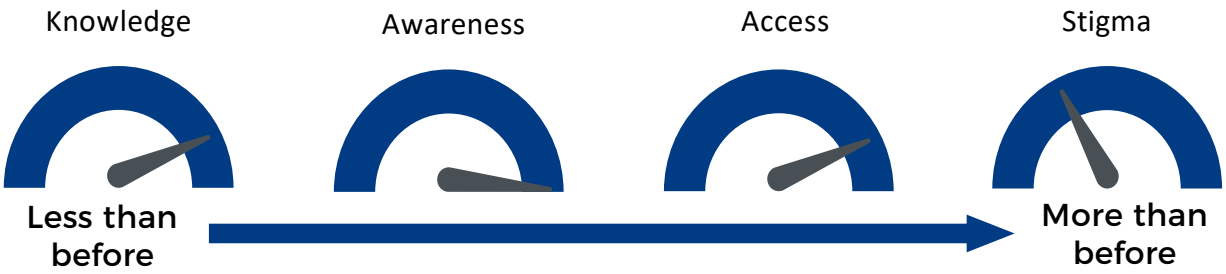


Figure 34. Participant ratings of their knowledge, awareness, access and stigma after engaging with the website.

e. SHIFT Project Assets

Over the duration of the project, partners kept records of connected organisations and charities that they kept informed or worked with in relation to the project. The following data represents the change in connections made from the start (2019) to the end (2022) of the project.

Table 18 contains descriptive information regarding who partners formed connections to.

Across the eight partner organisations, a total of 299 connections existed at the start of the project which increased to 457 by the project end, the average number of connections a partner had formed was 37.38 (+ 13.27) with the smallest partner network being 11 and the largest 56.

Table 18. Total number of partnerships made by Project Partners to other organisations and services between 2019 and 2022.

Project Partner	Start - 2019	End - 2022	Increase
2	38	62	24
3	33	45	12
4	56	106	50
5	34	64	30
6	49	83	34
8	36	39	3
9	42	44	2
10	11	14	3
Total	299	457	158
Mean	37.38	57.13	19.75
SD	13.27	28.38	17.64

Most partnerships of the English Partners were located within the same or adjacent counties, reflecting the geographic reach of their organisations. In the case of SOA Aids, the partnerships made were a balance between regional and national public sector organisations and charities. The Belgian academic partners tended to reflect professional networks and, therefore, were drawn from across Flanders.

There appeared to be little overlap of project partners having contact with the same organisations. The exception to the was large organisations and charities such as Doctors of the World, MIND UK (Mental Health Charity), Public Health England and UK Men's Sheds Association. Project partners had multiple connections within the large public sector organisations and multiple connections with branches of the same organisation of equivalent charities in different regions. As can be seen in Figure 35, additional contacts were made mainly with Public Sector, Charity and Professional body partners.

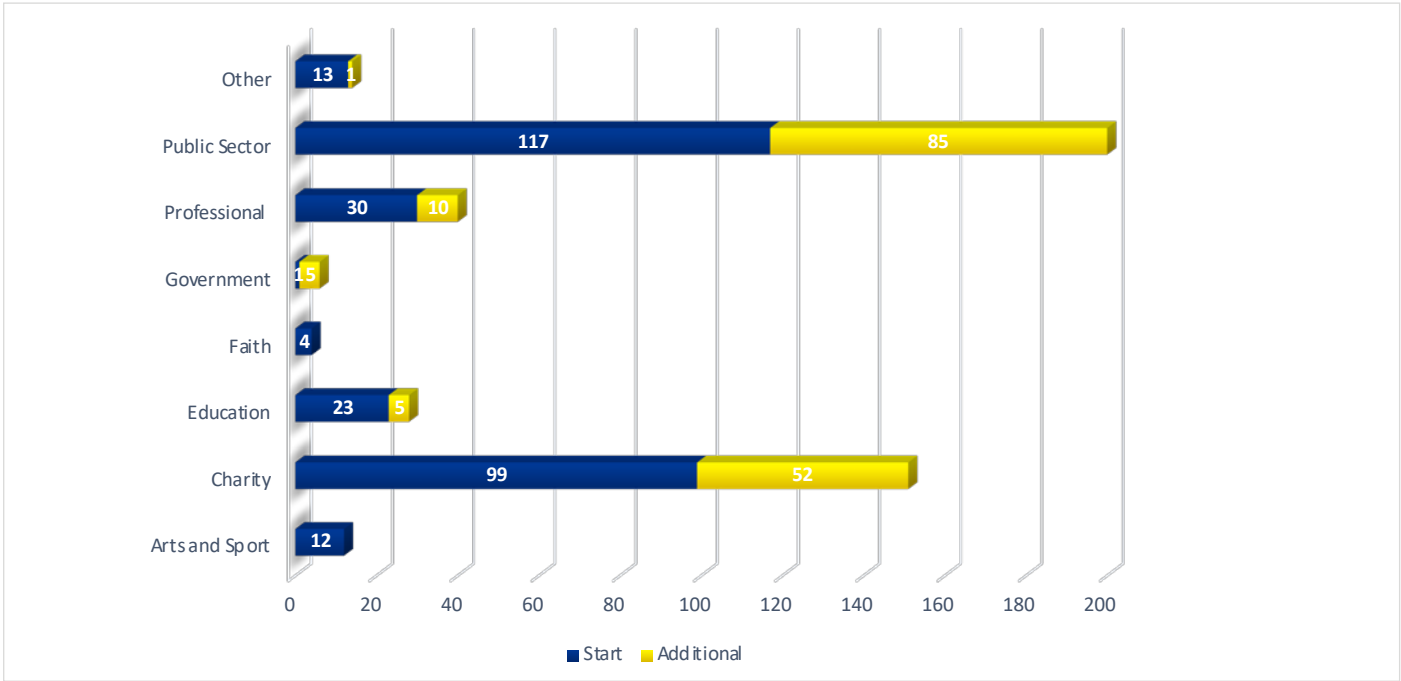


Figure 35. The types of partnerships made by Project Partners to other organisations and services between 2019 and 2022.

Partnerships recorded at the start of the SHIFT project were a reflection of each partners existing purpose. KCC and ESCC had many connections to other areas of their county council, sectors of the health service, local charities and community groups. KCHFT's partnerships were with other health services whereas Metro, was connected to other charities from a number of English counties in the 2 Seas region. Typically, university partners had more extensive connections to professional bodies and societies which provided connection to professionals in the health sector and wider workforce. As can be seen in Table 19, the focus of partner organisations were with a range of communities that fell within the remit of adults over the age of 45 and those from marginalised and vulnerable communities. Many of these connecting organisations and services focused on communities with multiple areas of need demonstrating the intersectionality of need experienced by individuals.

By 2022, partners had increased their connections into specific services, charities and organisations that had a specific focus on sexual health and wellbeing. In particular, partners had made contact with sexual health clinics and menopause specialist services and those working with people marginalised due to working in the sex industry or who had experienced domestic abuse or sexual violence. It can also be seen in Table 19, that connections were made with the health workforce to promote the project and training package. Additionally, services and charities that worked with the general over 45s population were approached.

Table 19. The focus communities of partnerships made by Project Partners to other organisations and services between 2019 and 2022.

Focus of Partners Organisation, Sector or Charity	2019	2022	Increase
Health Workers (Professionals, Researchers, Students)	43	79	36
Homeless (including Poverty, Migrant, Isolated)	58	77	19
LGBTQIA+	32	38	6
Living with Dementia	5	6	1
Living with HIV	6	7	1
Living in Custody	3	3	0
Mental Health	32	45	13
Older Adults (including Disability, LGBTQIA+)	26	31	5
Over 45s	29	59	30
Marginalised (including sex workers, asylum seekers, faith, disability, violence, poverty, slavery, looked after)	58	78	20
Sexual Health (including menopause, abortion)	3	27	24
Other (including advocacy and advisory)	4	7	3

Over the course of the SHIFT project, partners maintained contact with existing connections to inform them of the progress of the project. New contacts were made to ensure that their organisation had contact with other services and charities that could help reach workers and people within the target communities of the SHIFT project. There were a few examples of linking with government, national and international public health agencies.

Outcome 2 Summary

In general, for most types of outreach, there was an improvement in participant's Knowledge, Awareness, Access and Stigma.

There were some key differences seen in the variety of outreach. Direct outreach into the MSM Sauna Community was seen as a key success in accessing a typically hidden population. The demographic seen was a different profile to those at traditional sexual health clinics, and was primarily concerned with sexual risk. The emotional labour of this type of outreach was reflected upon and considered an important element for staff to be aware of.

The UK outreach tended to engage with more women than men, with menopause a key conversation starter for this group, although some reluctance to discuss their own sexual activity. Other conversations tended to be out of curiosity or about sexual wellbeing. Similarly, the Netherlands outreach was all women, with difficulties engaging the male population, and key topics of interest also being the menopause as well as contraception. Although a more reluctant population to engage, once the women were involved in outreach their engagement was good. The interest in menopause by the SHIFT demographic was reflected in the community assets, by the end of the project there was an increase in connections with Menopause services/organisations. Connections made by the project partners with sexual health and wellbeing focused organisations and services increased throughout the lifetime of the project, as well as for those working with marginalised Work Package 2 populations. There was also an increase in connections with the health workforce and those working with the over 45s generally.

The feedback on the website from the Work Package 2 demographic was positive, with suggestions that the website was credible, diverse and representative of different groups and issues. Self-stigma may prevent some of this group accessing healthcare through GP or pharmacies and so the website was a welcome source of information. There were some suggestions that comprehension may be difficult for non-native speakers.

12. Outcome 3

Two Sexual Health and Wellbeing training programmes for Sexual Health Professionals and Wider Workforce

a. General Engagement and Findings

All delivery partners conducted their own local training sessions (on their own or in collaboration with other partners) for the modules delivered live. Due to the impact of the COVID-19 pandemic, some were delivered in person and others delivered live but online. The Start to SHIFT module was a completely online asynchronous module that participants could complete in their own time. Table 20 below outlines the total numbers of participants that engaged with each training programme broken down by whether they were a Health Care Professional (HCP), part of the Wider Workforce (WW), or a student in a relevant training programme.

Table 20. Compiled numbers of individuals engaged with the training (taken from partner registration forms).

	HCP	WW	Students	Total
Training Programme 1				632
Assess and Communicate	169	78	77	324
Start to SHIFT	162	107	39	308
Training Programme 2				146
Embrace Difference	19	14	3	36
Reduce Risk	61	46	3	110
Total	411	245	122	778

Note. HCP = Health Care Professional, WW = Wider Workforce

Prior to completing the trainings, participants were asked to complete a survey to collect demographic information. Baseline assessments of their knowledge were also collected and will be discussed later in this section as the individual training programmes are explored. 201 responses were collected, with 160 participants based in the UK (120 working in the NHS) and 41 based in Belgium. Largely the individuals completing the trainings were female, though the general UK sample did achieve a slightly better gender balance (see Figure 36). As this portion of the project was targeting staff, attendance of the trainings was not limited to the over 45s. Despite this, it is interesting to note that over half (53%) of the participants did fall into our age bracket (see Figure 37).

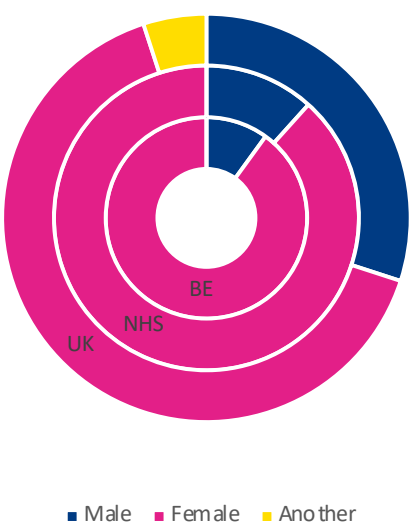


Figure 36. Gender distribution of participants completing the pre-training survey.

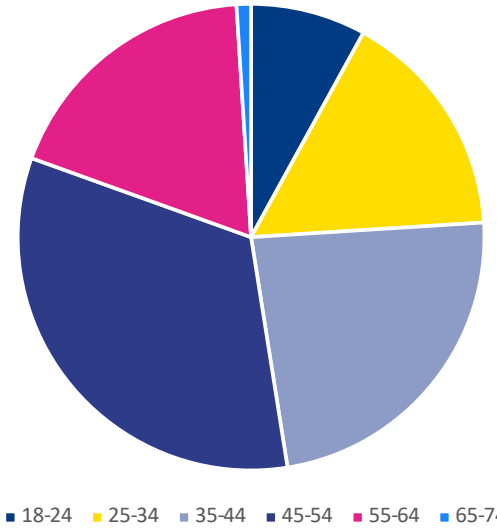


Figure 37. Age distribution of participants completing the pre-training survey.

The general opinions of participants with regards to the training was overwhelmingly positive, with 78% of participants strongly agreeing when asked about their overall satisfaction of the trainings delivered by the SHIFT project.

To explore their opinions of the training further, additional questions were asked to gather feedback on specific elements of the programmes. Participants were asked to rate whether they agreed with the following statements:

- I was satisfied with the length of the training module(s) (81% strongly agreed)
- The module(s) were interesting and intellectually stimulating (79% strongly agreed)
- The module(s) were well organised (80% strongly agreed)
- The content of the module(s) were relevant to the aims (81% strongly agreed)
- The module(s) have enhanced my ability to do my job well (66% strongly agreed)
- The module(s) have helped me to develop skills that will help my employability or career development (63% strongly agreed)

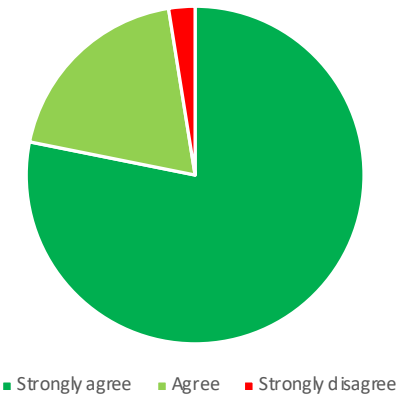


Figure 38. Distribution of responses from participants when asked if they were satisfied with the trainings overall.

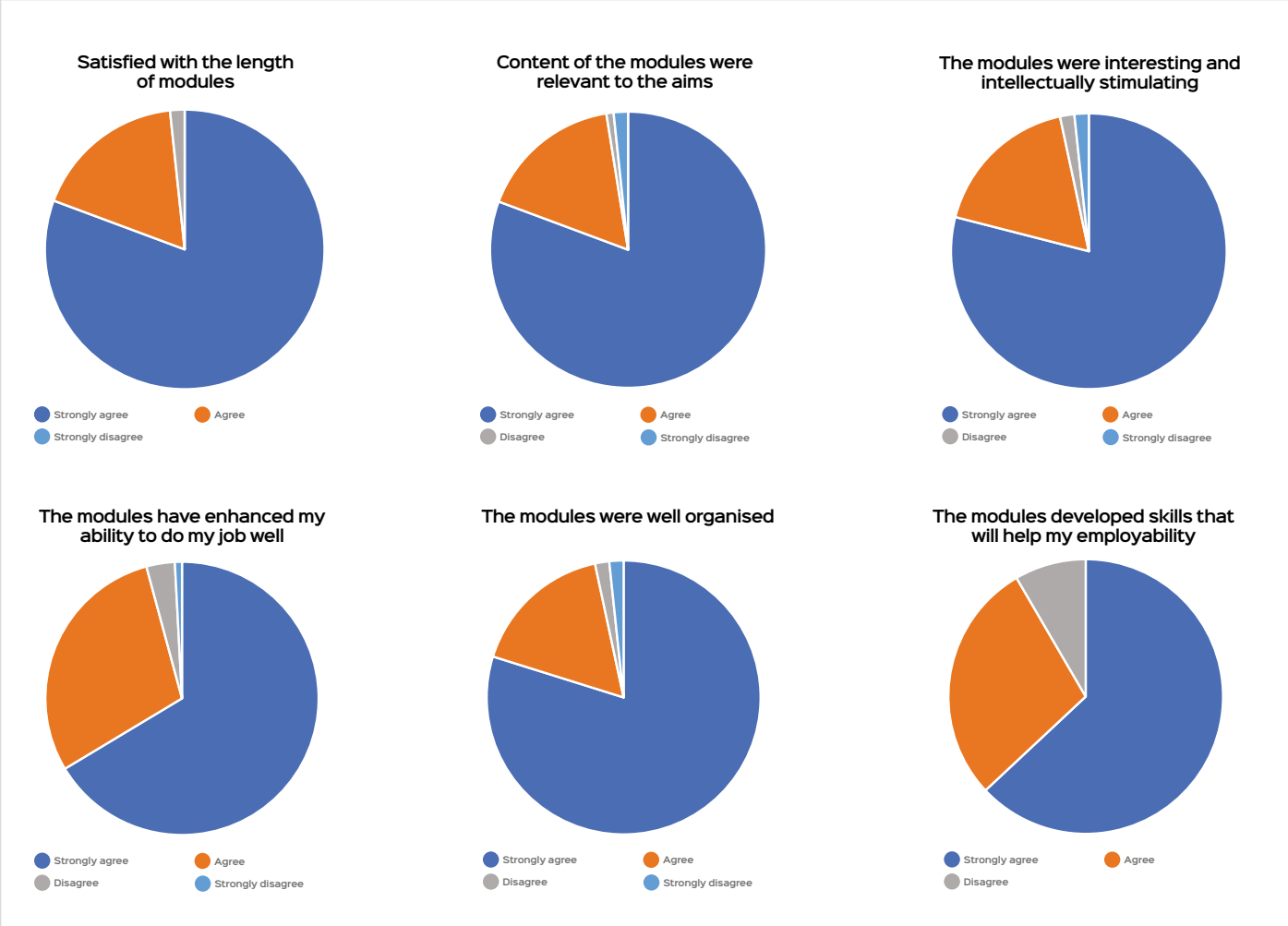


Figure 39. Summary of participants' general feedback from the post-training survey.

b. Programme 1 (Start to Shift, Assess & Communicate)

i. Start to SHIFT Virtual Learning Environment data

The Start to SHIFT module was hosted on the virtual learning platform Moodle. This allowed retrieval of analytic data from participants engagement with the platform as well as the survey data discussed in the next section.

The Start to SHIFT materials, were available for participants in either English of Dutch, so in this section English and Dutch/Flemish refers to the version of the training completed rather than the location of the participants.

The module was split over 10 pages of content that individuals were allowed to freely move between, i.e. you did not have to view them in any set order, nor complete a previous page in order to view the next one. Individuals who viewed each page at least once were deemed to have completed the module. Figure 40 breaks down the number of individuals that enrolled on the module in comparison to those who fully completed it. Interestingly, of the 233 individuals who enrolled, only 115 were deemed to have fully completed the module making the average completion rate less than 50% (49.4%).

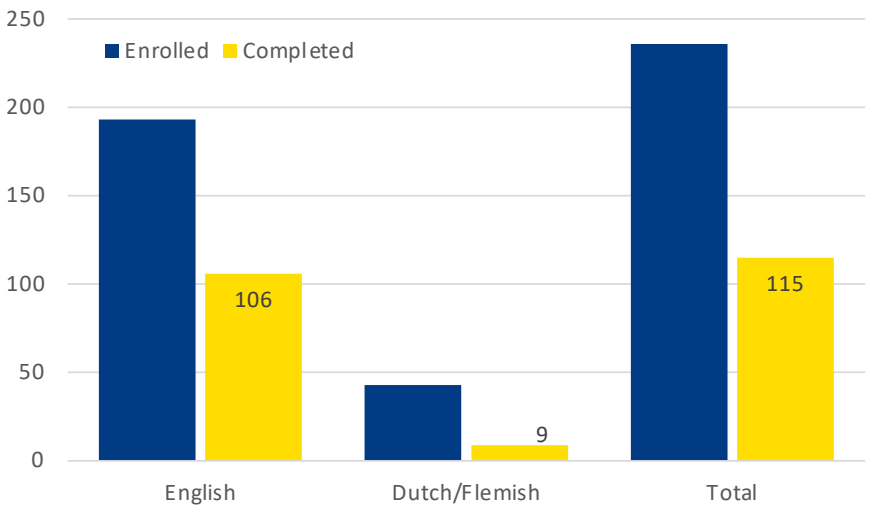


Figure 40. Total participants who enrolled vs completed the Start to SHIFT training. (Note. completion was defined as participants who had visited each page of the training programme at least once.)

Examining the data from the different pages further, you can see that the average engagement with each page individually was above 50% for the English translation, whereas the Dutch translation had lower engagement (see Table 21). As mentioned above, individuals were free to move between the pages as they wished with a navigation bar, but Table 21 presents the pages in the natural order they were seen on the platform. As expected, the introduction page was the most viewed and the debrief, what did I learn, page the least viewed.

Interestingly for the English translation, when you look at the engagement for the more topic specific pages presented in the middle, it does appear that participants were engaging with the pages that were most relevant to them rather than working through all the pages in order. For instance, the impact of chronic illness and medication was completed by fewer participants than the theoretical frameworks and referral option pages.

In contrast, in the Dutch translation, participants appeared to follow the expected viewing order of the pages as we can see a progressive drop off in engagement (i.e. each subsequent page is completed by fewer people) with the exception of the reflection on barriers where it appears fewer participants felt they needed to or perhaps weren't comfortable engaging with.

Table 21. Percentage of participants who completed each page of the training.

Training Pages	English	Dutch/ Flemish	Total
Introduction and Awareness	81%	51%	76%
How do I estimate my knowledge of sexual health?	77%	47%	73%
Biopsychosocial Model	78%	44%	73%
Theoretical framework on sexual experience and health	76%	42%	70%
Physiological aging in men and women and sexual well-being	70%	37%	65%
Impact of chronic illness and medication on sexual health	69%	35%	64%
Reflection barriers to discuss sexuality among the target group	72%	30%	65%
Tools for discussing sexual health	69%	35%	64%
Overview of referral options	70%	33%	64%
What did I learn during this e-learning?	58%	26%	53%
Overall	72%	38%	66%

Note. Participants could freely move between the pages.

ii. Survey - Competencies

When looking at participants pre- and post-training survey responses, we can see the impact of completing the modules from Programme 1.

Figure 41 highlights that participants felt their abilities increased across all the domains assessed, with the most prominent increases being shown in their knowledge and professional facilitators.

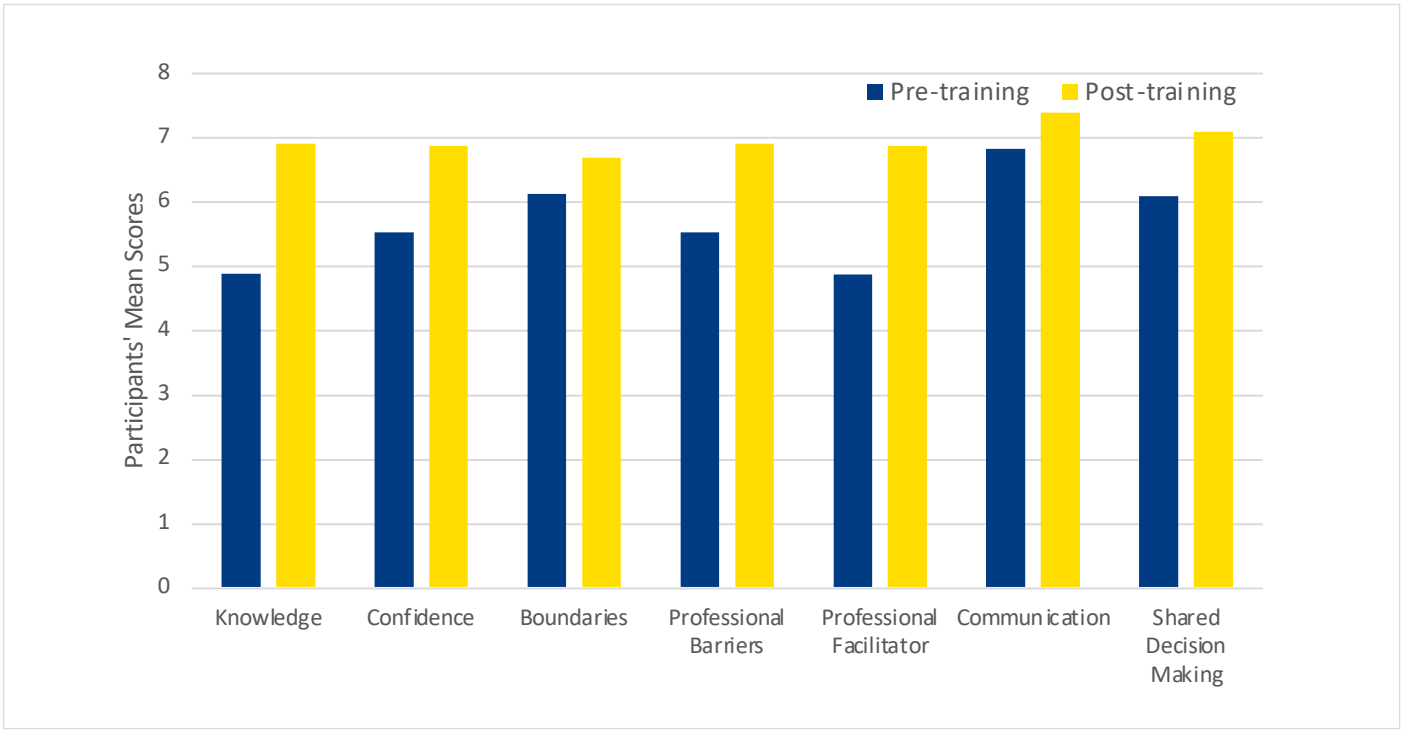


Figure 41. Pre- and Post-training survey responses for Start to SHIFT.

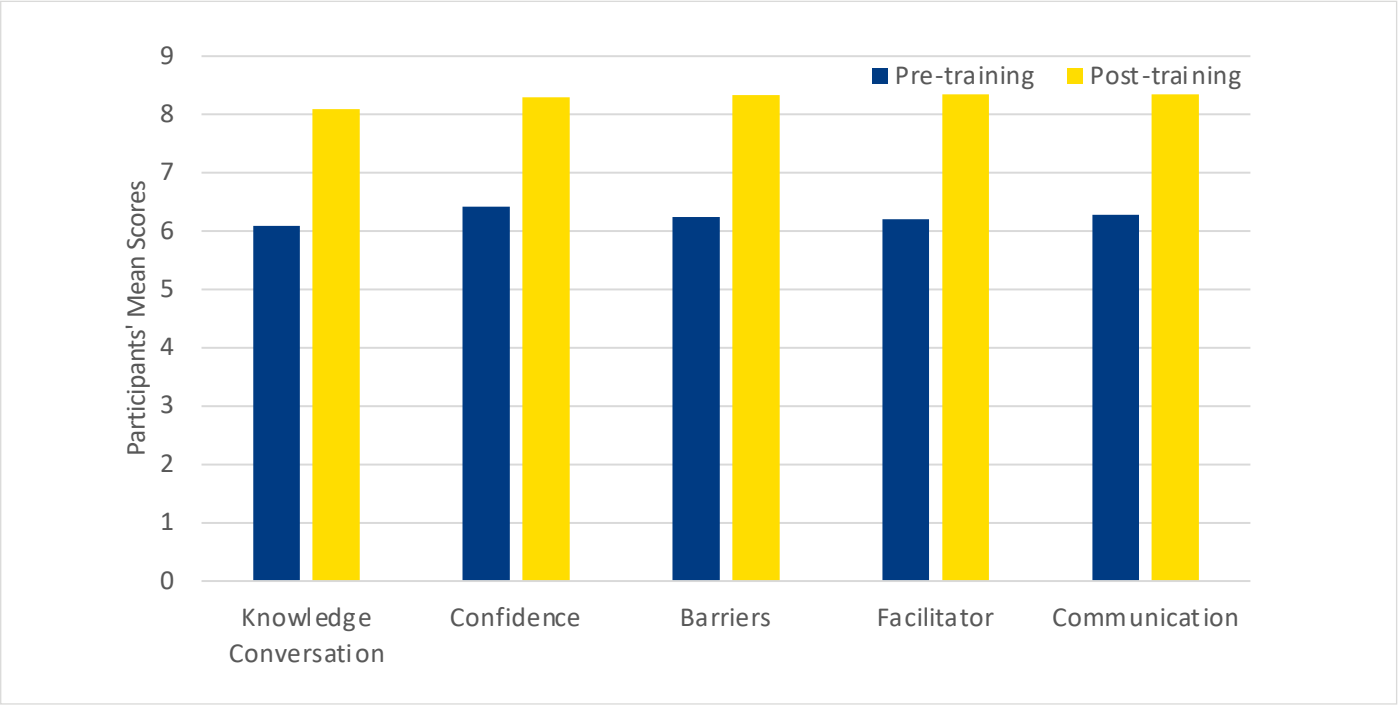


Figure 42. Pre- and Post-training survey responses for Assess and Communicate.

Figure 42 looks at the responses from the second module of Programme 1, Assess and Communicate, which was delivered as a mixture of face-to-face and live online sessions. As with the Start to SHIFT Reponses, we can see that on all the domains participants indicated that their competencies had increased following completion of training.

c. Programme 2 (Reduce Risk, Embrace Difference)

i. Survey - Competencies

Both the modules in Programme 2, Reduce Risk and Embrace Difference, were delivered as a combination of face-to-face and live online sessions.

Figure 43 details the responses from Reduce Risk. The domains focused on knowledge around risk s and risk reduction as well as the practitioners' confidence, awareness, and interpersonal skills. As with the other training programmes, participants indicated improvement on all the competencies assessed.

The summary responses for the Embrace Difference module can be seen in Figure 44. Again, we can see that participants rated that all the assessed competencies improved as a result of engaging in the training.

Figure 43. Pre- and Post-training survey responses for Reduce Risk.

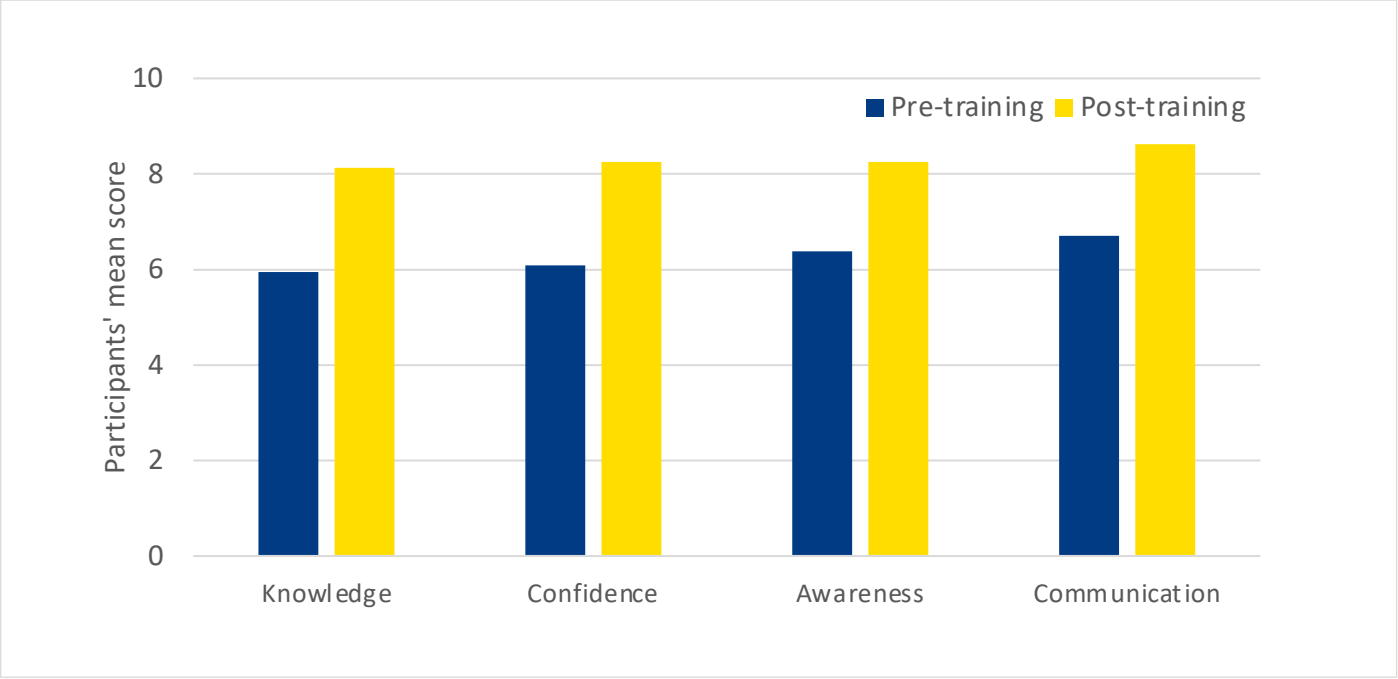


Figure 44. Pre- and Post-training survey responses for Embrace Difference.

d. Peer Observations of trainings

Four modules were peer-observed by SHIFT project partners, with group sizes ranging from 2-7 participants. The majority of modules were delivered online (75%) with the remaining module delivered face to face. The modules that were peer-observed were Assess & Communicate, and Reduce Risk (Start to Shift was run as an e-learning module only and Embrace Difference was not peer-observed).

Peer observations were reviewed and mapped to a Peer Observation cycle (see Figures 46 and 47) which indicated areas of interest that were specific to each of the modules evaluated.

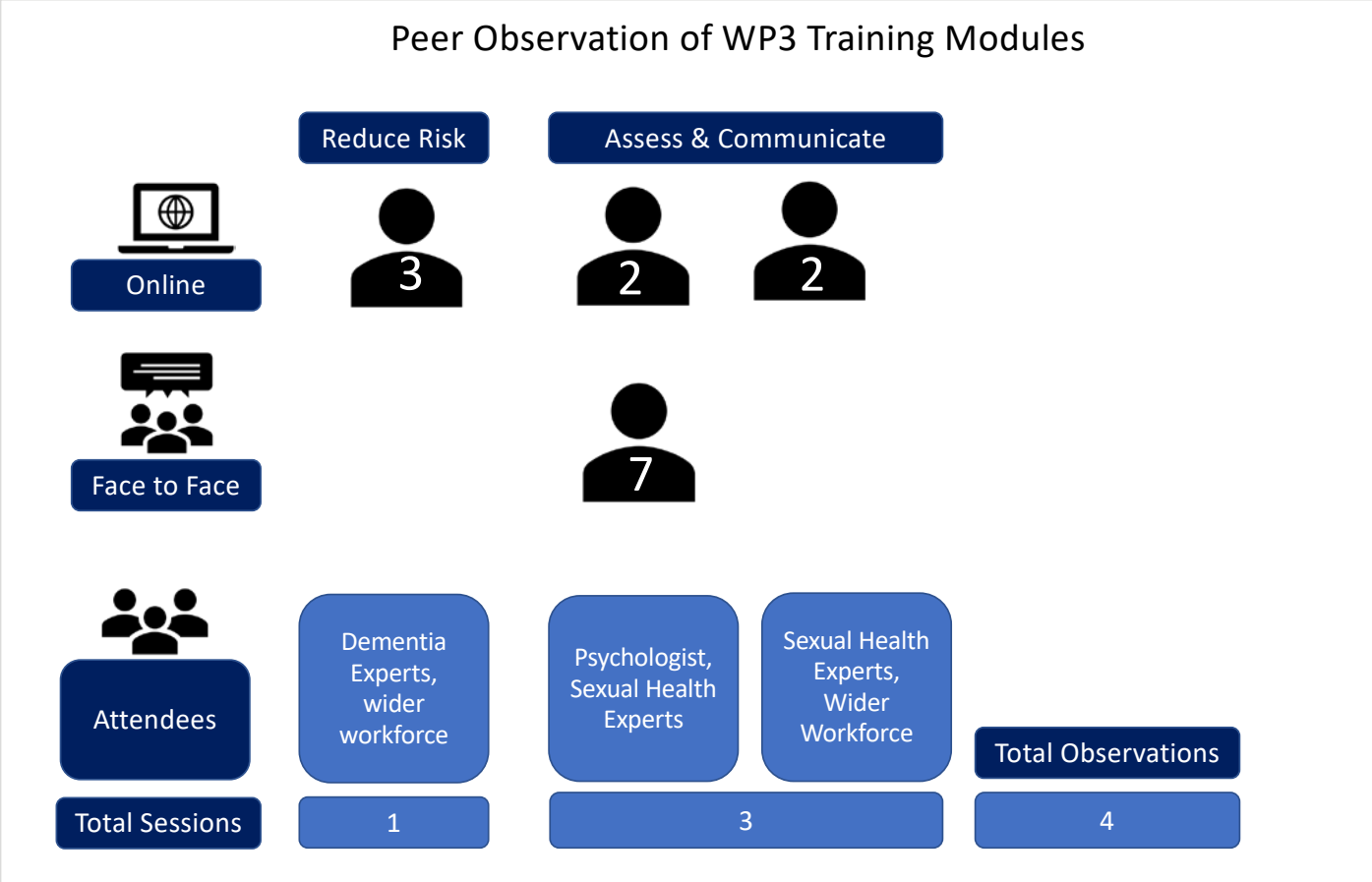


Figure 45. Peer Observations for Reduce Risk and Assess & Communicate.

Attendees tended to be from the wider workforce, such as Sexual Health Coordinators/ Programme Managers, Psychologists, and Dementia Experts.

Feedback from the peer observers indicated that sessional objectives, boundaries and ground rules were clearly stated at the beginning of the module and communicated by the trainers, particularly where adaptations were made to fit the participants' requirements or linked to their personal objectives. The majority of sessions observed were delivered online, observers reported working well with use of screen sharing and breakout rooms. Participants had been asked to complete the e-learning Start to Shift module prior to attending any training, and it was unclear whether this was consistently done as no checking of course completion was made prior to commencing the second module.

Partners reported difficulty with recruitment and low number of attendees, as well as issues with the timing of sessions. Some feedback suggested that holding training over two sessions was too long and tiring for participants and it would be better condensed in to one session. Additionally, where content was delivered face to face, peer feedback suggested timing would need to be closely monitored in order to deliver all content, again suggesting that the module was a reasonably full programme of content.

Peer feedback suggested that use of role-play was a popular learning strategy amongst participants and offered opportunities for groups to think together about scenarios and troubleshooting, allowing peer teaching to take place. There was a suggestion that this could be enhanced by including a more formal feedback mechanism after role-play exercises.

KCHFT Training Day (2022). Role play and peer teaching was reportedly a popular mechanism for learning.

Content was generally well received and regarded as appropriate to the learning objectives. Some observers suggested that adaptation may be required to meet different cultural differences, for example UK participants would be more familiar with Motivational Interviewing (Rollnick & Miller, 1995) compared to the One To One method (Borms & Vermeire, 2020) or use of data that is specific to the country in which the training is taking place. Additionally, trainers need to be responsive and adapt to group size and need, for example where groups are smaller a different approach to practice is required. The model of open communication within the sessions was effective; however, with a group of reluctant talkers, or with a less rich vocabulary, this may need to be adapted accordingly. Links to other modules could be made more specific, particularly where there are disagreements on terminology (for example, transgender issues can be referred to the Embrace Difference module).

The groups, despite their small size, were reported to be enthusiastic and engaged with the content and the composition of the groups was perceived as an advantage to elicit profound interactions between participants. Trainers were noted to be enthusiastic and highly knowledgeable about the topic and maintaining engagement.

There was a concern that the course content and delivery was 'sex-positive' and this might be off-putting to some participants who were less familiar with sexual health and wellbeing, Consequently, this suggested that the courses could be re-titled to be avoid any pre-existing stigma from deterring certain groups from enrolling or engaging fully. Additionally, not all participants had completed the Start to Shift e-learning module or found it too overwhelming in advance of attending the other modules.

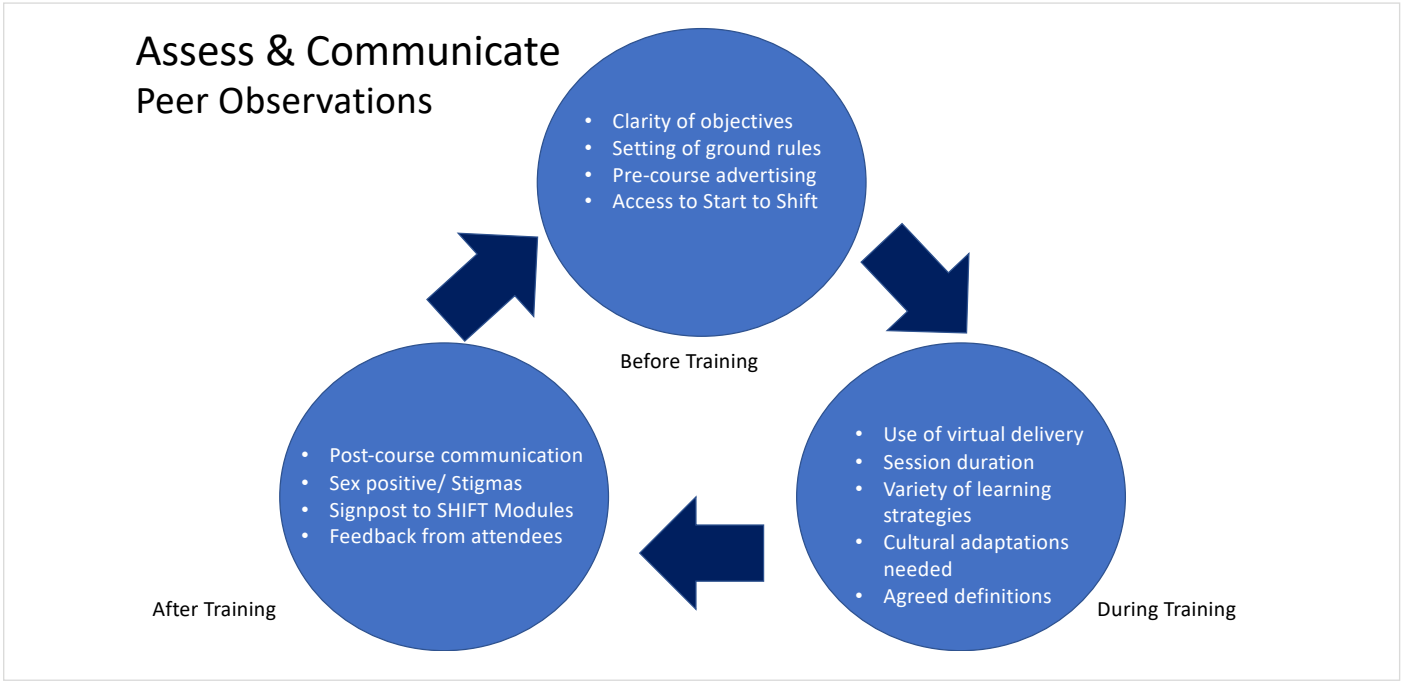


Figure 46. Peer Observations findings for Assess & Communicate

Figure 47. Peer Observations findings for Reduce Risk.

e. Trainer interviews

Eight Trainers from the WP3 training programme were interviewed and four themes (with five further subthemes) were identified from interview data. Responses have been anonymised for participant confidentiality.

Table 22. Overview of Themes and Sub-Themes from Trainer Interviews.

Theme	Attendance primarily healthcare professionals	Evolution of content	Organisational changes	Diversity
Sub-Themes		Practical Applications Online Training		Local Adaptations Tackling Taboos Diverse Integration of Perspectives

Attendance primarily healthcare professionals

Trainers reported in interviews that attendance at WP3 training events were primarily by healthcare workers with a prior interest in sexual health who wished to refresh their knowledge and, therefore, there was a positive-bias from those who attended towards wanting to learn more about this topic.

"You also have the self-selection people who have signed up for this because they wanted to talk about this. So, you're not necessarily targeting the people who have the most....." (P07)

Conversely, it was reportedly more difficult to recruit delegates from the wider workforce or non-sexual health areas:

"It was quite hard to find people who were motivated enough to follow the modules because I think most people don't think about the age group, and link it to sexuality, or make it a priority to learn more about it" (P03)

"How do you engage a busy workforce in this issue? How do you make it relevant to people who don't see that it has any relevance to its job?" (P10)

It was noted that the nature of some roles precluded them from participation or that the services themselves acted as a barrier to attending:

"There's hardly any time for assistants to do anything extra next to their normal job" (P06)

"They're on their knees as services. They're absolutely flat out and so we were attempting to dovetail the training in to their lunchbreaks, and to you know, to find ways where that would make it accessible to them" (P01)

It was suggested that participation could and should be encouraged by a wider workforce by improving access and integration to this area.

Evolution of Content

The development of the training courses was discussed by trainers as initially being in flux at the start of the project.

"In the beginning of the project, I felt like everybody was just doing stuff, but not really" (P08)

with the content being continually worked on and updated as the project goals became clearer and acted as the driver for the training content.

"First we just looked at what the goals were we had to go for" (P06)

It was suggested that the courses have continued to evolve as delivery has taken place and that future editions of the course would benefit from resources to support delivery.

"We should have a very clear facilitator's manual for each module". (P09)

Other participants felt that having practice sessions in order to refine content was an important part of the course development.

Practical applications

Feedback from trainers suggested that content which had practical applications and tools for course delegates was received positively.

"The good thing about that, the way it's structured and the way it encourages people to reflect on their current or previous practice is all of that stuff is absolutely perfect because it means people can see its application..... it feels is very applicable and sensible to their roles in practice" (P10)

"Some people... just wanted to have a framework within their organisation to actually move this forward and make it, make it mandatory within their systems" (P01)

The adoption of a framework or practical tools was viewed as an important method of supporting and enabling organisational and cultural shifts in engaging with the topic in the workplace.

Online Training

Trainers were generally positive about the use of online training, acknowledging that it is a format of training delivery that is more commonly used and offers advantages in terms of reach and access to courses. Participants also commented on the smaller nature of the groups that ran online, which enabled participants to share more freely:

"*There were more online than face to face eventually. So I think, of course it's more easy to just open your laptop and participate from home" (P03)*

".....maybe that wasn't going to be that wasn't going to be shared and maybe face to face, maybe in larger groups. It was a very it was a really interesting insight, which a very small, compact online group gave us" (P10)

However, it was acknowledged that not all participants prefer online training and that for some individuals this can act as a barrier to good communication:

"It was online, and they were in chat rooms and they did not know each other. They did not feel comfortable" (P07)

"It was more challenging because the engagement was a little bit less when it was online" (P03)

Organisational Changes

Implementing learning from the training through organisational changes were discussed by trainers as a consequence for delegates who attended the training:

"Especially the tips and tricks and the extra knowledge that we offered that made them that made them feel more confident and go back to their organisations." (P02).

Interview participants reported that delegates were more confident as a result of the training and motivated to take their learning back to their places of work and start conversations and adopt new policies.

Diversity

Trainers suggested that difference in languages and culture should be an important consideration when developing WP3 materials to use in different countries. It was suggested that there may be cultural nuances and that direct translation of materials may not always be clear. They also highlighted the difference in cultures between and within countries, and that these can sometimes be difficult to address:

"Sometimes I think culturally it is difficult to speak to some issues... I do wonder if some of the English context had been missed" (P10)

"Cultural diversity for example... none of them were familiar with that". (P02)

Consideration around the current levels of knowledge and diversity of training delegates was thought to be important in order to adapt delivery to best meet their needs.

Local Adaptations

Interview participants commented that the training materials provided a good starting point for delivering the training, but that consideration should be given to both the group of delegates as well as local nuances, both of which may require adaptations.

"there are some local priorities, and the trainer will probably need to make sure that kind of whatever's going on in the brought in the world at the time will be a focus. The trainer needs to consider that in their prep. Erm, and I don't think it is explicit in the in the course content or the preparation". (P10)

"I suppose what I've been doing is adapting, it was just trying to dovetail and make it meaningful for that particular audience" (P01)

Tackling Taboos

Some trainers reported that the topic of sexual health in over 45s was subject to pre-existing taboos and stigmas which limited participation and engagement in the trainings and for integrating into their practice:

"And many professionals said, Yeah, but I am convinced that I want to go beyond the taboos, but my general manager is not okay with it, or my colleagues are not okay with it". (P17)

"It is still a taboo. Many professionals say it has to be common that we can speak with older adults about their sexual and intimacy lives. But then when you ask them, well, talk about it now, yeah, it was online, and they were in chat rooms and they did not know each other. They did not feel very comfortable." (P17)

Some felt that this also limited the recruitment of delegates, in so far as they either did not hold it as a priority for training or were reluctant to communicate about it:

"I thought its nice, this SHIFT thing, but I don't know if the GP assistants are very interested in it " (P06)

Difficulties in recruitment seem to have been exacerbated by a reluctance to engage in conversations about sexual health, or seen as irrelevant to their role, and thus may have limited involvement in this group.

Diverse Integration of Perspectives

Trainers highlighted the importance of the diversity of perspectives and experience amongst delegates, and the need to integrate these in the training itself in order to not only help tackle stigma.

"Bit by bit to left field but that there needed to be that balance and that perspective". (P10)

There was also enthusiasm for integrating professional knowledge from the delegates themselves and to update the modules as an iterative process as a result of what was discussed in training:

"These people are also experts and actually all of the information they are giving us is also key to developing all of the trainings" (P08)

"We also learned from them....Which was great actually because we could add it into our module" (P03)

Trainers were enthusiastic about the holistic view of healthcare that the SHIFT model adopts and the balanced perspective this offers in trainings.

f. Film Screening Surveys

Films were rated by film screening participants (N = 18) from most to least impactful, and ranked accordingly (see Table 23). The film 'Chris and Marleen- Intimacy in relationships' was most frequently chosen by participants as the most impactful film (22.22%) although interestingly it also scored highest in the least impactful ranking (33.33%) suggesting that it was a film that elicited either very positive or negative feelings towards it. Other films were rated more moderately, with rankings distributed quite evenly across the remaining films. Karen (New relationships and STIs) was ranked third out of sixth 44.44% , suggesting that it is a film that participants felt ambivalent about.

"This is so important - keep on developing this."

Overall, the acceptability of the films to participants was very good. The most impactful film was described as thought provoking (94.45% of participants) and raising important issues (94.44%) and the least impactful film was still highly rated on this measure (thought provoking; 72.22% , important issues; 77.77%). Qualitative feedback suggested that the films were an appropriate length and the content was appropriate for the demographics. Suggestions were also made for further development of the films, including an iterative approach whereby local community groups and creatives continue to build on this work. Some feedback queried how best to maximise the impact of the film and promote effectively to the target audience, and also suggested that more topics were needed.

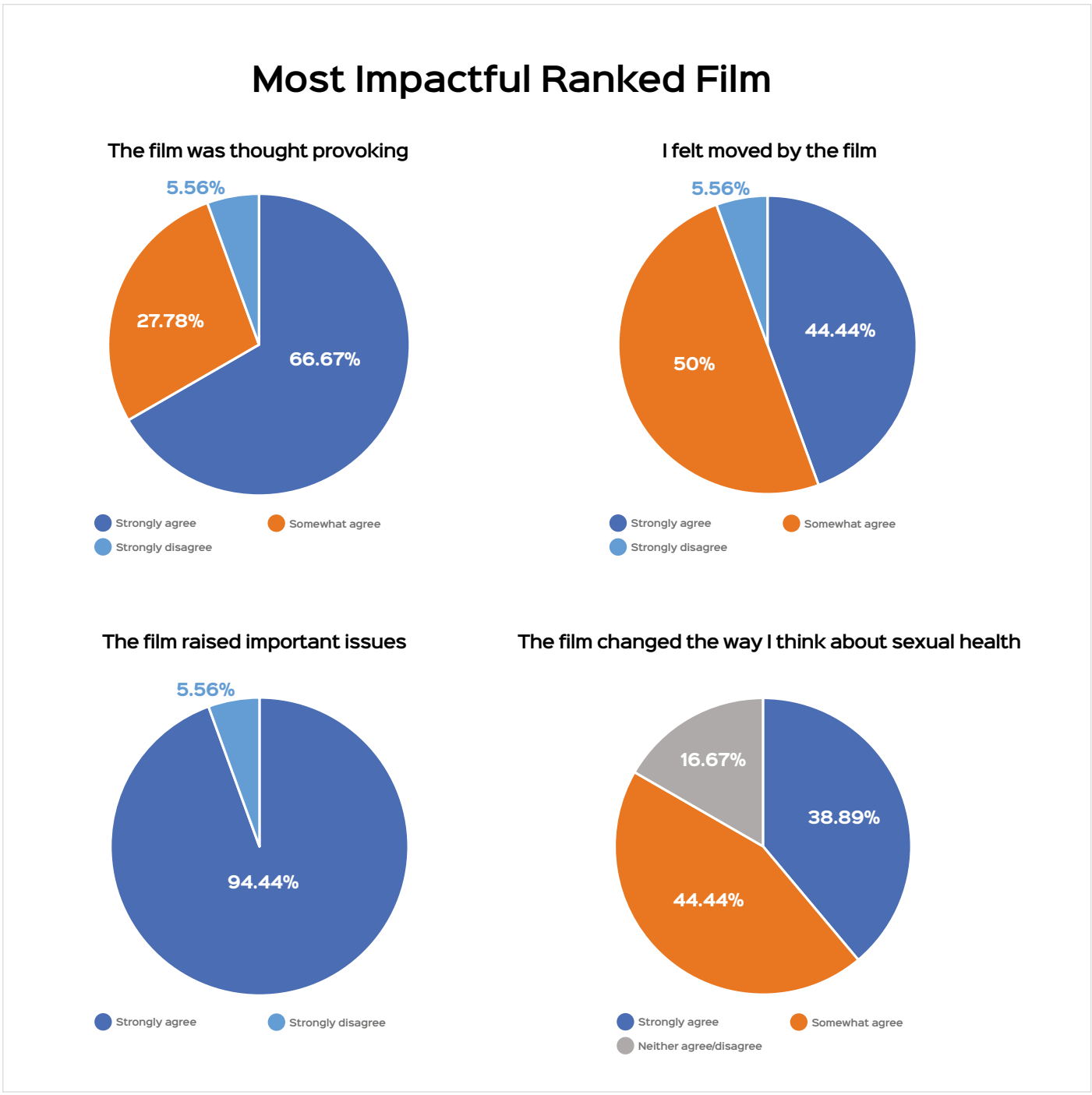


Figure 48. Most Impactful film survey ratings.

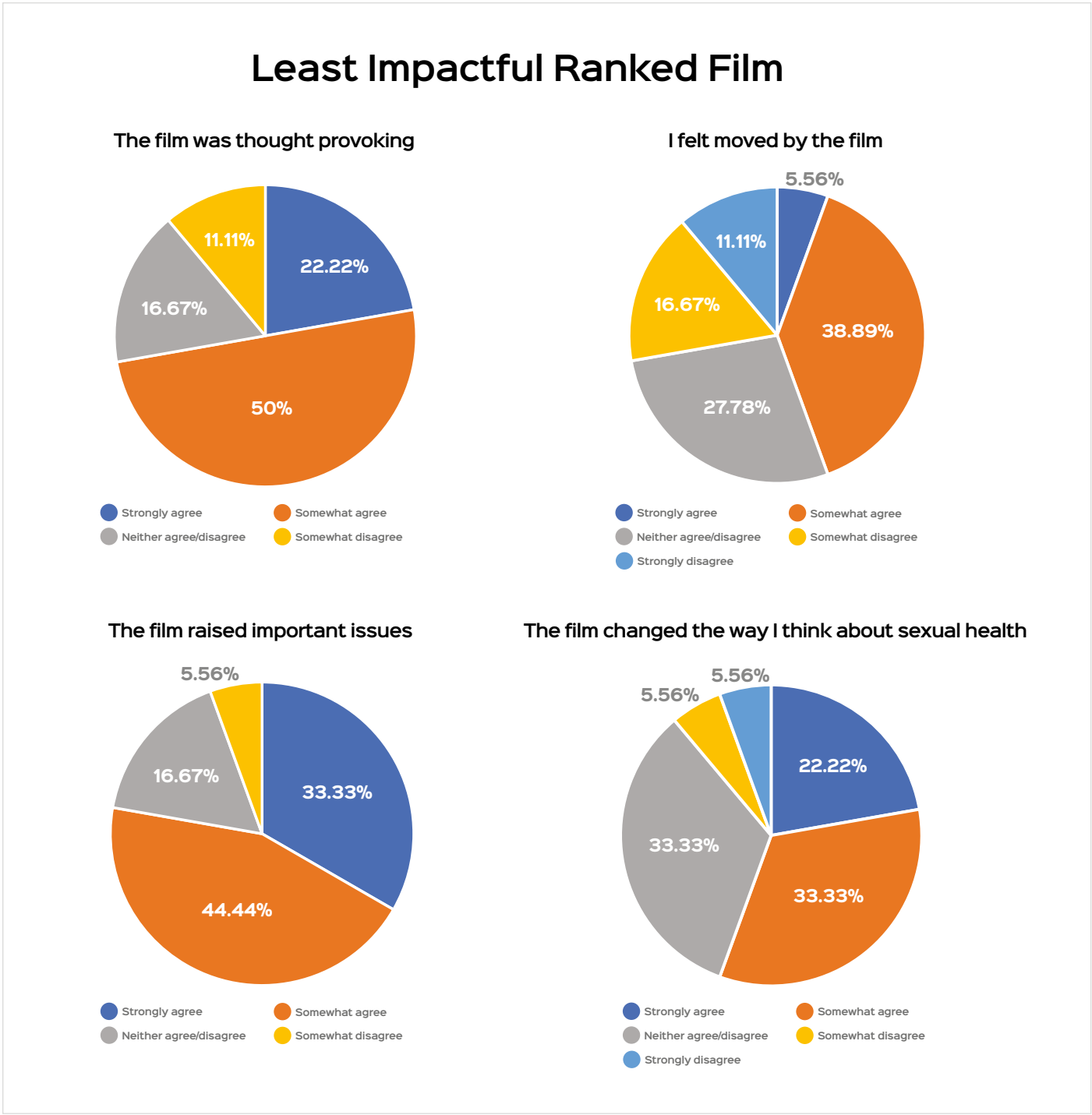


Figure 49. Least Impactful film survey ratings.

	Film	1st	2nd	3rd	4th	5th	6th
	Chris and Marleen (Intimacy in relationship)	22.22%	0%	0%	5.56%	38.9%	33.33%
	Marleen (Menopause)	16.67%	22.22%	22.22%	33.33%	5.56%	0%
	Myra and Lucas (New relationship and HIV)	16.67%	11.1%	22.22%	27.78%	11.11%	11.11%
	Hannah and Marion (Older adult STI check)	16.67%	22.22%	5.56%	22.22%	11.11%	22.22%
	Marco (Migrant and STI symptoms)	16.67%	22.22%	5.56%	5.56%	33.33%	16.67%
	Karen (New relationship and STIs)	11.1%	22.22%	44.44%	5.56%	0%	16.67%

Table 23. Film rankings from 1 (Most) to 6 (Least) Impactful ranked by survey participants.

Qualitative feedback

Positive

....Films would work well on social media, especially a platform like TikTok. It would also be very useful for volunteers in the health sector

Just that it was great, and very thought provoking

This is so important - keep on developing this

Excellent films, not too long, easy to understand.

Let community groups and local creatives build on them and develop the stories.....

Great event, loved the films

Areas for improvement

I don't think they should be any longer

I found the film about the couple struggling to communicate sexual needs and desires confusing. It's perhaps too big a topic to cover in a short time.

Cover more topics

How can we ensure these are promoted effectively to the target audience

Add further information links to end of films

Very fine balance in providing information and seeing menopause as a problem to be fixed

Outcome 3 Summary

WP3 trainings were accessed by more female than male professionals, with the vast majority reporting positive feedback on the content and for all modules, competencies improved from pre to post training.

Completion rates for the Start to Shift training differed between countries, as well as some differences in the way in which they accessed the online pages. Peer observation of the training sessions for other modules suggested some difficulties with recruitment and while the groups were small (but enthusiastic) there may have been a self-selection bias in attendance that requires further work on engaging with the populations less likely to attend. Some cultural adaptations may be needed to the materials, and this was also reflected through the trainer interviews. The trainers also similarly suggested that work is needed to engage the wider workforce in order to see this type of training as relevant to their role, and not just Healthcare Professionals.

Finally, the films were seen as a very positive recruitment tool for SHIFT. Work Package 3 demographics were overwhelmingly positive about the films and felt that they raised important, thought provoking issues, and further work should take place to maximise their impact and engage with more reluctant populations.

13. Partner experiences and COVID

Nine Project Partners from the SHIFT programme were interviewed and four themes (with twelve further subthemes) around the implementation of the model were identified from interview data (see Table 24). Partner quotes are not attributed in order to maintain anonymity.

Table 24. Overview of Themes and Sub-Themes from Partner Interviews.

Theme	Acceptability	Appropriateness	Feasibility	Future Adoption & Sustainability
Sub-Themes	Cultural Differences	Engagement	Recruitment	Mandated Training
	Equitable Access	Challenging Stigmas	Partnership working & collaboration	Direct Outreach
	Format of support	Raising Awareness	COVID	Dissemination

Acceptability

The overall acceptability of the model by all partners was good, with particular references being made to the advantage of a holistic approach that included the four domains of SHIFT (Knowledge, Awareness, Access and Stigma) and the accessibility and ease with which the model can be implemented. Some partners felt it would benefit from further guidance to aid understanding, such as reference guide or toolkit to support its use in practice.

"it's really easy to access…. We came through with those final four pillars, which are really understandable. So, in terms of knowledge, access, stigma and awareness- For me that I can't I can't I can't think of any other elements of the work that we've done that doesn't fit within those spheres"

Cultural and Individual differences

Cultural differences and subsequent adaptations were considered to be an important aspect of implementing the model by partners, with consideration given not just to the local and regional differences but also how this might differ across countries. Partners also emphasised individual differences in staff delivering training or outreach and the impact this might have on how they adapt the materials to meet the need of the unique SHIFT demographics.

"The key thing with training like this is to make it applicable locally to what you see or what your population is…"

"I think we need to emphasise for those who may not be educationalists, the fact when you deliver this training, that will need to become certain that adaptations to it… So, it's not necessarily changing the material, but it's adjusting it, how you deliver it"

Equitable Access

Partners reiterated the challenges of both recruiting and engaging with populations that are harder to reach, and in doing so to ensure that access to services and supports is equitable. They noted the particular challenge of reaching groups with disadvantages such as low health literacy as well as digital poverty which similarly restricts access to online support and services. They concluded the need for services to adapt to best fit the demographics they are serving, particularly where these are less likely to engage through traditional means such as sexual health clinics.

"It's trying to kind of enable people to access, you know, the health that they need. And if they don't, obviously, someone who shouts loudest and louder for something else will take their slot. And we know in terms of equity… we know that's an absolute disadvantage. And what SHIFT wants to do is promote equity."

Format of Support

The manner in which support was offered, either through training or outreach, was considered to be of prime importance when engaging with the SHIFT demographic. For example, trainings aimed at Healthcare professionals need to consider the impact of removing staff from clinical services to attend training and adapt the format of training to best fit these demands. The outreach similarly found differences in engagement according to the events attended and the format of some events were less successful in engaging with the SHIFT demographic. Partners suggested that local knowledge is used to implement the model in the manner best suited for the population being targeted.

"Getting time and permission to close service is a big commitment"

"I would say that what we really noticed was that when we were doing the stand-alone events it was a lot harder to engage people".

Appropriateness

The SHIFT Model of Sexual Health was designed to target the four main areas identified in the Needs Analysis as issues for people over 45 (and with socio-economic disadvantage) in their Knowledge, Awareness, Access and Stigma in sexual health and wellbeing. The model was generally seen as effective when used as a starting point for addressing these areas and individualising it to the person's unique characteristics:

"The best way of using Com-B is to use it in the background, to hang everything else. So, when I talking about SHIFT, when I'm talking about changing behaviour, it is trying to individually individualise it trying to make it relevant to people, and then using the Com-B model to kind of highlight the background".

Engagement

Partners suggested that engagement with the model was good overall, with some differences in demographics representing individual challenges in engagement, which required flexibility in how project staff adapted their approach.

"I think those events have been very, very successful in terms of, as you say, when we've when we've found a niche way in to dealing and presenting kind of sexual health to the over 45's".

It appeared that one challenge for the project was the initial engagement with specific SHIFT demographics, and establishing the 'niche' and trust between the project and individuals was key to success and engagement.

Challenging Stigmas

One of the project's aims was challenging stigmas and it was apparent from partner interviews that this included not only stigmas from or about individuals, but also stigmas that exist amongst professionals, all of which impact on the model's implementation. It was suggested that biases and stigma may impact on the engagement with the model, with self-selection bias acting as an influence and stigma still being pervasive unexpectedly.

"The professionals that came to the trainings were people who were specifically interested in sexual health. And I do feel we missed the people that aren't that comfortable in their professions talking about sexual health".

"I think it was interesting.... sometimes the language even the people were trying to be inclusive with words. Still came out as you know, a little bit judgemental".

Raising Awareness

Partner interviews suggested that raising awareness of the sexual health and wellbeing needs of the SHIFT demographics was key to the model implementation and understanding of its importance. Feedback suggests that while initially professionals may have had a reluctance to engage or a limited understanding of the issues, when they did engage with the model, the acceptability to these individuals was good and prompted further reflection about using it in their own practice:

"And then people kind of can see little light bulbs going off and little plates being turned when they think, okay, that's important, or maybe when I hear this again, in my clinical work, how they can, you know, apply it".

Partners also suggested that awareness of issues became broader and more holistic once they had engaged with the model, leading to a deeper understanding of the topic and the need for targeted support for the SHIFT demographic:

"And for a lot of people, I think it introduces it more as that that more bio social model of it. It's not a lot of people come to it as being a case of, Oh, right, that's sexual health, that's keeping healthy. Where are you with regards to sex and not catching anything? I know it's a lot more broader than that".

Feasibility

While the SHIFT model was thought to have good feasibility by partners, there was feedback that further support or training would be needed in order to have a full understanding of implementing it. It was felt that there were also some challenges to the project, both internal and external, which impacted on the feasibility of the model implementation although these were not felt to be insurmountable by the project partners.

"I think what needs to happen and what will happen before the project finishes is that I need to engage in the model and then train (redacted) on it so that they can, because it's a good model. But I need to just engage in it and articulate it".

Recruitment

Recruitment was identified by partners as one of the most significant challenges of the project, due to a mixture of short-timescales, COVID and difficulties engaging with the populations that would not typically engage with services such as these. Different recruitment strategies were piloted with varying success. Directly engaging with pre-existing groups for the 'hidden populations' was generally successful.

"I'm seeing a demographic that is kind of unseen in the world"

"That abundant ability for us to connect the project up with the type of people, with those cohorts of people that were finding it difficult to get in contact with the people who actually do need the SHIFT package, the service itself".

Short timescales hampered other efforts, with reflection that a longer lead time for marketing would have helped recruitment:

"There was real pressure because I felt that we were leaving it quite late to try and get an audience".

Other reflections included the difficulties in recruiting from a very busy population, such as medical professionals, who may not have the capacity to engage in the model. It was felt that online sessions were a helpful antidote to some of the recruitment difficulties this posed:

"The first line medical professionals as doctors' assistants, GP assistants are so very, very busy and so understaffed at the moment that it's very hard to get people to do the trainings"

"Online is a great way to deliver it. You know. I mean, it's really accessible for people. And again, I think it also widens the geography for people to attend".

The short films were also suggested as a good recruitment tool for starting conversations and bridging the gap for reluctant to engage individuals, between the initial contact and support:

"The films are excellent for engaging people into the project…."

Partnership working & collaboration

The benefits of partnership working and collaboration were emphasised by all partners interviewed as a significant contribution to, and benefit of, the SHIFT model and project itself. Partners lauded the benefits of not only a pan-European approach, but also the advantages of working across different sectors and the range of experience this brings to a project:

"The emphasis on the collaboration and multiple delivery partners. The emphasis on you know, everyone doing their bit to engage with the population or the project, that they're working on is really important".

"I really like the coming together of like local government, academia, community partnerships and clinicians".

It was noted that COVID presented challenges to partnership working, with a change in working practices and an adoption of more remote-working which at times frustrated efforts:

"I think also with COVID, the lack of in person meetings, I think as far as… definitely impacted on the delivery of the project, I think we do very, very well as a group when we're together".

COVID

COVID posed a significant challenge to several aspects of the project, particularly given the health sphere in which the project was based and the difficulties in engaging health professionals in the project who had conflicting demands:

"We wanted to target health care professionals and social care professionals who were largely really overwhelmed by what was going on with COVID. So, they just didn't have time to talk about sexual health and potential future things".

COVID also had an impact on project planning by the partners, with restrictions on face to face meetings influencing timescales of the activities, planning and problem solving:

"I think that in retrospect COVID probably had a big impact… because perhaps those were the things, we could have ironed out in the actual face to face meetings".

"I just think the overall impact of the project could have been a lot earlier and therefore a lot better".

Some partners reflected that the impact of COVID resulted in some positive aspects to the project, with the adaptation to online activities meaning that the website and training legacy and reach will be more profound than first anticipated:

"The drive for us to do more things online has definitely helped push the emphasis of the website. So, the legacy of the website will be very powerful, the legacy of SHIFT, there will be will be very powerful."

"If it hadn't been for COVID we wouldn't have even looked at an online version for training".

Future Adoption & Sustainability

Mandated Training

Some partners discussed the difficulties with recruiting for aspects of the model (such as training) that is not mandated and the differing perspectives and motivations that healthcare professionals might have on the importance of CPD (non-mandated) training. It was suggested that getting the training mandated or certified in some manner might alleviate some of these barriers for future adoption of the training.

"Not all colleagues are self-motivated to do the CPD. So, you may find that people who say it's not mandatory, it's not essential to... allied health professionals, and even some doctors wouldn't necessarily do that without some sort of, as you say, self-certifiable certificate".

Direct Outreach

Partners discussed at length the benefits of direct engagement with the communities with whom they are trying to reach, particularly where the demographics are vulnerable or less likely to engage and suggested that future outreach would benefit from adopting this approach. It was also suggested that, when this approach is successful and trust has been established between the communities and the staff, it gains momentum and demand for the services increases:

"...giving them a very personal and giving them a very accessible way to access the service outside of clinic. And I think that's a really important, good old-fashioned outreach".

"It has it's got busier and busier each time I go in, which is good, because now we're looking at doing once a fortnight instead of just once a month".

Dissemination

The partners identified the short films as a real strength of the project and a means for future dissemination about the project and recruiting the SHIFT demographic.

"I hope that those will be used beyond the project because I think I just think they're a really great way to engage people".

While the self-selection bias of those who engaged with the model was acknowledged, partners anticipated these groups of people will support further dissemination of the project:

"It's almost like preaching to the converted but it might develop them strongly more strongly to be champions for their local area so if they have more information they'd would be able to get that information to their colleagues".

14. Discussion

SHIFT Conclusions

The SHIFT Project was planned by nine Partner organisations across the Interreg 2Seas coastal regions of northern Belgium and The Netherlands, and south-eastern UK to develop a new co-created model of sexual health and wellbeing for over-45s and vulnerable groups, such as the homeless, migrants, asylum seekers, sex-workers, and LGBTQ+ community. The objective of co-creation was to listen to the expertise within a range of organisations and the voices from the communities they had access to, with the ambition of creating a model of sexual health delivery that met the needs of those, less well catered for by current services.

It is evident that there is a significant rise in Sexually Transmitted Infections (STIs) in middle-age and older adults, specifically in the 2Seas region and generally on a global scale. Coupled with this, the focus of sexual health policies has typically been centered on adolescents and younger adults, thereby largely neglecting the sexual health and wellbeing of middle-age and older adults (Traeen et al., 2017; Traeen et al., 2019). These factors, alongside an apparent lack of knowledge and awareness of good sexual health in the over 45s and vulnerable groups, highlighted the imperative for Partners to co-create the SHIFT Project initiative to develop models to deliver high-quality research- and practice-informed sexual health and wellbeing programmes to both these target populations. In addition, the training of healthcare professionals and the wider workforce who meet with these groups in a variety of settings was also incorporated into the SHIFT initiative. To bring about positive health behaviours and societal change four key pillars were addressed: (I) to raise awareness, (2) enhance knowledge, (3) reduce stigma, and (4) increase access to services relating to sexual health wellbeing in middle-age and older adults (over-45s).

No project exists in a vacuum and therefore it is worth noting the SHIFT project ran from 2019 to 2022 and the temporaneous events that occurred during this timeframe. The Covid-19 pandemic and associated lockdowns and social distancing measures deployed in various countries resulted in disruption in the dating practices of adults in each country. Associated with this were reported increases in cases of domestic violence (Ivandić et al., 2020; Usta et al., 2021). A study in the Netherlands, reported that whilst MSM reported less frequent use of PrEP during the first lockdown, once restrictions were lifted and during subsequent lockdowns, PrEP use and regular HIV testing was resumed thereby mitigating risk (Adam et al., 2021). In early 2021, the UK televised "It's a Sin" which dramatized the lives of gay men living in London in the 1980s when HIV-AIDs came to national and international awareness. A number of Partner organisations, noted the increase in reports of older adults who had lived through the 1980s speaking about their continued distress from these events. Burki (2021) suggested that the drama has led to a rise in HIV testing. An increased awareness and discourse regarding the menopause has been observed in the UK, in part due to a number of celebrity women communicating their lived experience, this has been observed to have generated a "menopause revolution" which has resulted in increased demand on the health service for recognition and support (Joseph et al., 2022; Howard, 2022).

SHIFT Project Legacy

A real strength of the SHIFT Project is that it leaves a durable legacy in a number of forms. First, the SHIFT Website has been launched to good effect with 49,000 events and 7,200 users recorded between May 2022 and January 2023, and facilitates delivery of the SHIFT Model to target populations, healthcare professionals and the wider workforce. Funding has been secured for the website over many years and thus the opportunity clearly presents itself to further develop and broaden relevant sexual health and wellbeing content but also to enhance the utility and user experience of the website itself. For example, it is apparent from the Think Aloud analysis that the website currently contains relevant content across a wide range of sexual health issues (e.g., STIs, menopause) and the content was generally accessible for the WP1 sample but rather more difficult for WP2 populations to access. This could reflect a challenge of higher levels of digital poverty and digital literacy in these vulnerable groups, and thus, it is not yet clear whether the current version of the SHIFT website meets the needs of vulnerable groups. More extensive consultation within these groups would reveal if a website is appropriate and if so, how the current content can be adapted. Second, the six SHIFT films represent a key project asset whose potential has not yet been fully realised. This is exciting. As these SHIFT films are fully accessible online in a variety of media platforms (e.g., smartphones, Tablets, pads, laptops), the conceivable reach across target populations and possible impact is considerable. The six films were rated very positively by attendees at both SHIFT Film screening events in East Sussex and Kent in the UK, with high acceptability. The SHIFT films utilise the power of narratives as a more effective way of presenting health messaging rather than more traditional public health warnings from governmental health agencies (Heley et al., 2020). Thirdly, the WP3 Training programme for healthcare professionals and the wider workforce is a pivotal facet of the SHIFT Project, with a largely successful rollout to date. The mix of in-person and online training modules appears to work well for maximising reach and accessibility for WP3 training. Role-play emerged as a key tool to demonstrate core aspects of the SHIFT model. Consideration of how Partner organisations raise awareness of the importance of training amongst their workforce and connected organisations needs further planning to increase the uptake of the training developed during the project.

Reflections on SHIFT Model target users

While it is clear that the SHIFT Model has reached a large amount of people to date which is a tangible positive outcome of the project, we note from the evaluation data that some target populations were underrepresented or not successfully accessed during the lifetime of the project funding. For example, it is very apparent that males were under recruited or were more reluctant to volunteer to participate in evaluation activities and outreach events. For example, WP2 outreach activities in The Netherlands were conducted solely with female participants and did not recruit males despite efforts made by the Partner organisation to recruit from exclusively male groups. It does mean that more work is needed to evaluate the acceptability and feasibility of the SHIFT Model for the male population. A further example was the Think Aloud evaluation study which examined participant's experiences and usability of the SHIFT website, when an even balance between males and females was sought in recruitment but very few males volunteered. Again, while the utility and content of the SHIFT website was viewed positively by participants, a caveat is that it was largely a female sample and there remains a question over whether males would rate the content of the SHIFT model and usability of the model as highly in terms of how it might service their specific needs or concerns. This lack of involvement from males is reflected in the general health literature where gender norms may limit how men access support services (Pascoe et al., 2018). Additionally, females were more highly represented than males in WP3 trainings, although that does likely reflect typical gender ratios in the healthcare and wider workforce in sexual health. However, more effort is needed to bring the SHIFT model training programme to the male wider workforce and healthcare professionals who meet with over 45s and vulnerable groups as the four training modules might need further adaptation based on their experiences and views of the modules. Finally, there is an acknowledgement that whilst Partner organisations recognised the fluid and socially constructed nature of gender, there was less input into the shaping of resources from the wider community.

In a somewhat related vein, the overall representativeness of WP3 trainees might be queried in respect of the targeted wider workforce along with healthcare professionals, given that the majority of attendees reported their occupational status as Sexual Health Coordinators/ Programme Managers, Psychologists and Dementia experts. Thus, more information is needed as to the efficacy of these four training modules in providing the wider workforce (e. g. Charity workers) with the requisite knowledge and tools of the SHIFT Model in order to successfully apply it with their clients and service users. This suggests that more work needs to be done prior to running SHIFT Model training sessions in order to raise awareness of the importance of this topic and why good sexual health is imperative to wellbeing in over-45s and vulnerable groups.

Use of pre-existing groups and communities

One particular point that emerged in evaluation activities was that the outreach activities tended to be centered on groups or communities that partners (particularly UK partners) already had pre-existing connections and relationships with, for example, from the large-scale PRIDE events to small-scale MSM Saunas. While efforts to reach the over-45s in different settings were observed by setting up SHIFT stalls at county agricultural shows (e.g., Kent, UK), perhaps greater efforts could have been made by project partners to work to build beyond existing connections and reach a greater proportion of the general population. Connections with other organisations could also have leveraged access to vulnerable groups such as homeless, asylum seekers, and sex workers both in terms of co-creation of the SHIFT Model but also in delivery of the model to these marginalised groups.

Possible Sex Positivity Bias

Large-scale projects with multiple partners from a variety of backgrounds (e.g., public health, medical, charity sector, academia) who come together with a common goal and vision are commonly vulnerable to be prone to certain biases or viewpoints. For SHIFT, one such potential bias that emerged in the project evaluation was a possibility of a sex-positive bias. In other words, this bias reflects an overwhelmingly positive view about sex and willingness to talk openly about sex and sex lives, the acceptance of a wide variety of sexual orientations, behaviours, and genders. This came through in a number of evaluation forums. For example, attendees at the SHIFT Film screening events in the UK were generally associated with sexual health or public health organisations, and were comfortable talking openly about sex, viewing films about sex, and reflecting on messages framed within the film narratives. We cannot make the assumption that the general adult population over 45 years or socio-economic disadvantaged groups would have such an overriding positive attitude towards sex or feel comfortable talking about sexual health issues in public. Similarly, participants for the Think Aloud study who viewed the SHIFT website, at least in the WP1 sample, volunteered as they were interested in sex and felt it an important part of their own lives. This was clear in the debriefing sessions with participants following the study. Therefore, we must be cautious in generalising about claims of user-friendliness and quality of content from a strongly sex positive sample.

This issue of sex positivity did not just arise with in WP1 and WP2 aspects, but also with healthcare workers and wider workforce who took part in WP3 training programme. As the attendees were typically working in public health and sexual health or psychological services settings, they likely signed up for the training modules due to their pre-existing interest in health and sexual health and wellbeing. This might partly account for the rather high baseline scores for knowledge and awareness of sexual health prior to trainings. It would be unlikely that, if a larger sample of the wider workforce was recruited that we would see a similarly high baseline level as we would expect that it would include workers with lower levels of knowledge about and awareness of sexual health needs, concerns, and issues in older adults and socio-economically disadvantaged groups.

Final Thoughts

To recapitulate the overarching context, the SHIFT Project clearly aimed to address an urgent societal need as growing awareness emerges of the importance of sexuality in later years (e.g., Coleman et al., 2021; Sinkovic & Towler, 2019; Sladden et al., 2021). The experience of sexual pleasure over the lifespan has been declared a human right by the World Association of Sexual Health (WAS, 2021). This increasing acknowledgment that social, psychological, and physical factors can influence changes in sexual health, sexuality, and sexual practice as people grow older which impacts wellbeing, quality of life, and relationship quality and satisfaction (Dalrymple et al., 2017; Sinković & Towler, 2019; Sladden et al., 2021) is a welcome step forward. However, awareness is only part of the picture, the World Health Organisation highlighted that sexual health services should be made available to all adults (WHO, 2015). The global rise in STIs in middle- and older-adults points to continued inequalities in sexual health care provision across the span of adulthood (Age UK; Davies, 2016; Ezhova et al., 2020; Traeen et al., 2019). Thus, the SHIFT Project adopted a holistic approach, acknowledging the need to address adverse outcomes of poor sexual health and practices, but also strongly emphasised the positive aspects of sexual health, pleasure, and wellbeing (Hogben et al., 2015; Mitchell et al., 2021).

The SHIFT Project has broadly achieved its aims to develop and test a co-created model of sexual health and wellbeing for adults over the age of 45 in the Interreg 2Seas region. It is clear that the diversity in partner organisations (e.g., public health bodies, clinicians, charity sector, academia) was a key strength of the project in terms of the breadth and depth of expertise in working with and understanding the needs of the target

populations. The SHIFT COM-B model is flexible and sufficiently adaptable to work well across clinical health service settings, charity organisations reaching socio-economically disadvantaged and vulnerable groups, and the wider workforce, and importantly, internationally and cross-culturally. A caveat must be offered, in that the accessibility, feasibility, and efficacy of the SHIFT Model with certain targeted socio-economically disadvantaged groups (e.g., migrants, asylum seekers, homeless, sex workers) is not yet established. The SHIFT Model is well on the way to reach to reach the set number target of people to access in the general over 45s adult population with the potential reach of the SHIFT website to be fully realised. There is certainly some scope for the SHIFT training programmes for professionals and wider workforce to possibly become widely embedded in general induction trainings and continual professional development programmes within numerous health and social contexts through relevant organisations. The expansion of each Project Partner's contacts to other agencies and organisations demonstrates the potential future reach of SHIFT training. With time, we expect that the impact of the SHIFT project will be the legacy resources created. Resources are in different European languages that are highly accessible and sharable, such as the six SHIFT films, the SHIFT website, and the SHIFT Training programmes. These resources will grow substantially to reach and meet the needs of middle- and older-adults in the 2Seas region but also across the European continent with the capacity for wider language translations in future.

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16. Contributions to SHIFT

Dr Ian Tyndall	University of Chichester	Evaluation Lead, management of evaluation, evaluation design, ethical approval, data collection, transcription, data analysis, report writing.
Victoria Giacomelli	University of Chichester	Day-to-day co-ordination of evaluation delivery, data collection, collation, transcription and analysis. Evaluation protocol formulation, ethical approval, report writing.
Isabelle Ball	University of Chichester	Day-to-day co-ordination of evaluation delivery, data collection, collation, transcription and analysis. Evaluation protocol formulation, ethical approval, report writing.
Dr Ruth Lowry	University of Essex	Evaluation consultancy, funding application, evaluation design, data analysis, report writing.
Prof Antonina Pereira	University of Chichester	Management of the research team and evaluation consultancy.
Dr Moitree Banerjee	University of Chichester	Ethical approval, Evaluation design, data analysis, report writing.
Dr Susan Churchill	University of Chichester	Ethical approval, Evaluation design, data analysis, report writing.
Tess Hartland	University of Chichester, Manchester University (from August 2021)	Data collection, collation, transcription and analysis, protocol formulation, ethical approval, report writing.
Prof Mike Lauder	University of Chichester	Management of the research team and finances.
Mrs Alison Davis	University of Chichester	Project support and admin.
Rebecca Gullet	University of Chichester	Project support and admin.
Riz Judkins	University of Chichester	Student Research Assistant.
Ashton Waterman	University of Chichester	Student Research Assistant.

17. About us (UoC)

The University of Chichester is a long-established, ambitious institution with a heritage of supporting local/ regional skills, from foundation (1839) to launch of its Tech Park (2018) and Nursing School (2021). Chichester is recognised for providing high-quality, student-centred Higher Education within a supportive community, actively encouraging those with barriers to HE to participate, succeed and contribute to West Sussex's economy as graduates.

The University is committed to undertake world-class research in all areas it is engaged with as an integral part of its mission to both create knowledge that is of societal and / or economic benefit - and to inform and to lead its learning and teaching pedagogies. As the only University in West Sussex, we are committed to play our full part in being a regional centre for economic development working in conjunction with the local enterprise partnership (Coast to Capital), local and national businesses from SMEs to global companies – and working in line with the Government's industrial strategy so as to play our full part in contributing to the national economy. This mission will encompass the training of graduates, knowledge transfer activities and other third-stream activity for the benefit of our students, graduates, alumni, employers within the region, entrepreneurs and wider business community for the economic benefit of all stakeholders aligned with the University.

Our prolific and vibrant Research Centre – the People & Well-being in the Everyday Research Centre (POWER) leads on the research front, through impactful research projects. We continuously engage in networking efforts, to develop and sustain fruitful partnerships with a national and international scope, bringing together a critical mass of expertise to address large-scale multi-disciplinary research challenges, strengthen research collaborations and knowledge transfer across disciplines and increase research capacity and profile.

We adopt a strategy that is heavily grounded in an inclusive and collaborative culture which values diversity and encourages approachability and sensitivity. Impact-building is at the forefront of our work, where all researchers (from early career researchers to experienced PIs and Professors) are active participants in the construction of new knowledge. This strategy is a vital cornerstone of our development, supporting our high levels of productivity and enhancing the visibility and reputation of our University. We have a demonstrable track record where high performing research teams are led and developed across complex organisational structures and competitive research environments, working in partnership with a range of Government Agencies, professional bodies and employers, ensuring that the University is appropriately represented in regional and national fora.

In sum, we present evidence of success under often challenging research contexts where we have nurtured outstanding interdisciplinary activity that operates at the forefront of knowledge and drives excellence in research and impact. But, most importantly, we have continuously committed to making a difference to the lives of our students, those we work with, and to the wider community.

UNIVERSITY OF CHICHESTER