Report of the Sexual Health in over ForTy-Fives (SHIFT) EU Interreg 2Seas Region Project: The Barriers and Facilitators of Sexual Health and Wellbeing for Over 45s

Qualitative Findings

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across the 2Seas region, most interviews and focus groups took place virtually, via telephone or video call.

Transcripts 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 (Braun & Clarke, 2006). The process was aided using the NVivo software program and frequent meetings among the research team allowed reflection and deeper engagement with the data (Nowell, Norris, White & Moules, 2017).

Two distinct sub-populations within the over 45 age group were identified, with separate analysis taking place for each: 1) general over 45 population 2) over 45s facing one or more
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Heterosexual	15	-	15
Homosexual	3	-	3
Bisexual	2	-	2
Not reported	6	4	10
Single	6	-	6
Steady partner	6	2	8
Casual partners	2	-	2
Married	3	-	

Changes experienced with ageing

Our participants point to a wide range of changes experienced with age in regard to sexual health and wellbeing. While predominantly negative changes, some participants express positive changes that have arisen with age. They fall into six separate themes: 1) Female sexual health, 2) Male sexual health, 3) General health, 4) Psychological changes, 5) Relationship needs and wants, and 6) Sexual activity. Each is described in further detail below.

Female sexual health

Both male and female participants frequently mentioned the menopause as a poignant event with regard to sexual health, and within their relationship with partner(s). For example:

Male sexual health

Participants reported solely negative experiences with regard to male sexual health and ageing. One interviewee expresses frustration that while women have a name for "the menopause…men have to try and figure out what's happening".

Changes experienced by our participants include tiredness, and worries about performance due to physical problems such as erectile dysfunction. For instance:

-on

ce is important to you. And if you can't perform anymore

General health

According to participants, deterioration in general health, and the presence of comorbidities, can negatively impact upon sexual health as they age. Multiple health conditions are mentioned, such as diabetes, cardiovascular disease, and autoimmune disease. Evidently, general health has an impact on both ability and enjoyment of sex:

Relationship needs and wants

Psychological barriers

The attitudes, opinions, perceptions and emotions of our participants proved to be a barrier for some to visit sexual health services, practice safe sex and achieve good sexual health. These are grouped under psychological barriers, which divide into 10 themes such as perception of risk, perception of healthcare providers, and stigma. Each is explored below.

Sexual health vs. sexual pleasure

Some participants point to a dislike of contraception such as condoms, which prevents them from practicing safe sex. This is especially true for one respondent who explains that condoms add another barrier to sex in older age, alongside other insecurities:

"You should wear a condom but at the same time it stops me from having nice sex. There are so many issues anyway: you [illegible]

Relationships with partne

prevents sexual health for over 45s being discussed at all, some state that when the subject **is raised it is often in a "funny or jokey" way.** For example:

might

general attitude even though it is hypocritical. A worry that people might be disgusted that they were still sexually

ive me. Sex is something that we do not talk about. It's very secretive or

The next most common stigma is self-stigma – that is, stigma that has been internalised as a result of public attitudes. For example, participants frequently say their age group is too **"embarrassed" to talk about sex, others voice feelings of "shame" and even "fear" at the** thought of raising sexual health and sexuality:

don't have certain knowledge at their age? Loneliness? Maybe people are embarrassed that they don't have anyone to talk to about these things? Or maybe embarrassment about your own cluelessness. And in many groups especially many cultural groups sex is a very touchy

I think a doctor or

Service barriers

Many of the barriers participants describe relate to the services themselves. This theme is divided into four sub-themes: 1) Lack of tailored

was a man or rather multiple men, and the way this gentleman reacted told me that he thought it was very awkward. And a friend of mine had a GP who didn't even want to talk about

hetero side, and the LBGT side, and there are different

Unsure where t

Psychological facilitators

While the attitudes, opinions, perceptions and emotions of our participants proved to be a barrier for some, for others, they can facilitate visits to sexual health services, practices of safe sex and contribute to

symptoms up online first and identified what it appeared to be and then I looked up STI

Service facilitators

Alongside Psychological Facilitators, healthcare services can have a major influence on whether participants engage in services, and achieve good sexual health and wellbeing. Service Facilitators can be divided into many aspects; the sub-themes are explored below.

Characteristics of sexual health messaging

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A wide variety of methods to promote sexual health are suggested; one participant said **they "couldn't think of anywhere where you** **promote sexual health".** Many traditional methods of communication are mentioned, such as posters and leaflets in clinics, **emails or letters as "lots of older people aren't tech savvy". These could also be placed in** public spaces:

nd getting checked out for infections and staying safe, to put in the

you should make use of community centres, organize small-

-

Newspaper and magazines are commonly suggested. Another popular means is via TV adverts, talk shows and radio:

he press, radio, TV. If they hear it often enough, I think that could be a trigger to take the step.

the medium of television. To pay some more specific attention to certain items for example in Nieuwsuur [news

like I said, magazines and stuff. I think that would be a good

While social media is perhaps cited less than expected, for some partha8nopu3.99577(s)-,-1(s2975(t)-3. 38

Information, knowledge and content

Participants point to multiple gaps in knowledge and information which should be filled in order to facilitate good sexual health and access to health services. For example, some express certain knowledge or training that healthcare professionals should undertake. This relates to content, and also the benefit of sharing knowledge:

ce that means that there is more knowledge

Focus groups participants also believe more training for healthcare professionals is needed
to break the "taboo", and ensure they can provide the correct information:

or that the taboo is opened up... I'll tell my GP... I'd like it, if he knew a little more about

Another gap in knowledge that is frequently referred to by participants is signposting of services. Many explain that knowing where services are and what they provide would
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Past positive experiences of sexual health care

While past negative experiences of sexual health care can present a barrier to visiting services in the future, in contrast, positive experiences can facilitate seeking help and advice. **Participants reflect positively on the "efficiency" and "helpfulness" of service** providers. For example:

detailed knowledge about that but I have the idea that generally speaking

help. All you have to do is pick up your phone and there's help on the other end. In my case,

Sexual health support and provider characteristics

Interviewees suggest various characteristics of sexual health support and providers that could be adopted. For example, one participant describes the benefit of collaboration between services:

closely together to deal with complaints."

Others discuss the environment in which support and advice is given. Some participants **suggest the space should be "informal", "intimate", "open" and "safe". For instance:**

lights are very harsh. It shouldn't be an unpleasant room where you feel cold, where it is sterile."

"Since you are talking about something intimate you

need to make sure that the setting is intimate as well. With a small group of people, and a cup of tea

Confidentiality and privacy are clearly important to many participants, who explain, that for **older people,** "they appreciate dealing with these matters in private." Another says they **would like,** "the chance to ask questions anonymously".

"**Being able to tell** your story, and that it is accepted as being **your experience.**"

Participants also discuss the qualities and traits they would like to see in healthcare professionals. They value **being "heard" and their story "being accepted as [their] experience"**. It is important to our interviewees that while **providers need a "professional attitude", they should also adopt an "openness" to allow service user to ask** questions. For example:

While a poor patient-provider relationship can present a barrier to seeking help and advice, a good relationship can be a significant facilitator, and was referred to often **by participants. "trust" was a common foundation of a** good relationship. Participants expressed that having a healthcare professional of a similar age and same gender makes it easier to open up about sexual health:

Yes, so for me it's pretty easy with the GP. Maybe it's

groups differently. So you deal with people aged 45, 50 differently that people aged 70 plu

If you want to approach these people you need to do it with a good dose of respect for their

Country- specific findings

While the findings cannot be representative of each country due to the small number of participants, and nuances in translation, there are certain aspects of the results that appear more relevant to some countries' residents than others. Below, some of these aspects are raised, under each of the four overarching SHIFT focal points.

Access

The practical barriers of cost and appointment times were cited as a barrier for Dutch participants only. They also more frequently mention the need for tailored services, but this could be due to the fact that more Dutch participants were from LGBTQ+ populations and have experienced the need for tailored care more than heterosexual respondents.

Stigma

Healthcare professional stigma and self-stigma were referred to more often by UK participants, while societal stigma was noted most commonly by Dutch participants. Societal stigma was also the most cited type of stigma for Belgium interviewees. This could be due to cultural differences, and how sex is portrayed in each country.

Knowledge

Belgian participants express a lack of sexual health knowledge most often of all countries. Across every nation, however, participants are unsure where to go for sexual health advice and support, and agree that signposting to services is a key facilitator. Dutch respondents discuss most often the need for healthcare professionals to expand their knowledge and ensure that there is a good patient-provider relationship.

Awareness

Belgian and Dutch participants more frequently discuss the need for raising awareness of sexual health amongst their population. In contrast, participants from the UK more commonly suggest they are not at-risk of poor sexual health, or that sexual health is not a priority. Dutch participants suggest they are not at-risk of poor sexual health the least often of the three countries.

Summary

Across all countries, findings suggest:

Participants do not feel at risk of poor sexual health, for example STIs.

They are unsure why there is a need to visit a sexual health service.

GPs/doctors are the provider of choice.

Men and women have different experiences during the ageing process, but also appear to engage with services in different ways. Awareness should be made of these distinctions.

Tailored services should address the “social circumstances” of service users, to accommodate religious belief, sexual orientation, ethnicity and marital status, among many other characteristics.

The patient-provider relationship is key to encourage participants, and healthcare professionals, to discuss sexual health and wellbeing.

Participants suggest a more holistic view of sexual health that includes relationships and emotional issues as well as physical aspects. This report is one of few that addresses sexual pleasure as an essential component of sexual health and wellbeing. This must be acknowledged in practice.

The perception of sexual health services as only for diagnosing and treating STIs is prevalent.

Stigma remains a huge barrier to seeking help and advice for sexual health among over 45s. Feelings of shame and embarrassment, and worrying what others think are frequently referred to.

There are some considerations that need to be taking into account when reviewing these findings. There is vast variation and some contradictions that exist throughout the data. For

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