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 Who Face One or More Socioeconomic Disadvantage.

Qualitative Findings

February 2021

Contents

Key discussion points

- There is a significant lack of knowledge amongst participants, notably symptoms of poor sexual health, and knowledge about where services are and what provision is available.
- Sexual health messaging should focus on inclusivity and breaking age, sexuality and racial stereotypes.
- Involving community leaders in sexual health interventions is essential to overcome cultural taboos.
- It is evident that a range of sexual health services and messaging are required to reflect the heterogeneity and personal preferences of the over 45 population.

Background

SHIFT (Sexual Health In the over ForTy-fives) is part of the Interreg 2Seas Programme, receiving funding from the European Regional Development Fund. Running from 2019 to 2022, the project involves partners from across the "2Seas" region: UK, The Netherlands, and Belgium.

The objective of SHIFT is to empower people aged over 45 to participate in sexual health services, and improve their sexual health and wellbeing. There is an additional focus on socioeconomically disadvantaged groups across the 2Seas region. More information about the project can be found at https://www.interreg2seas.eu/en/shift.

The following report will summarise the findings from the second round of qualitative data collection, which took place via individual interviews and focus groups from September to December 2020. This will build insight into the needs, awareness and attitudes towards sexual health and wellbeing among socioeconomically disadvantaged adults over the age of 45 in the 2Seas region, further to the surveys which were distributed from November 2019 to April 2020.

Methodology

Semi-structured interviews and focus groups took place from September to December 2020 to identify key gaps in service provision and the needs of people over the age of 45 when it comes to their sexual health and wellbeing. Questions were developed with the combined knowledge and expertise of all partners, and considering the findings from surveys which collected responses from 777 people from the target population. The interviews and focus groups took place in the native language of each partner country: Dutch and English. All transcripts were translated to English prior to analysis. Following the unforeseen COVID-19 pandemic, and the various restrictions on social distancing and lockdown policies 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 socioeconomic disadvantage. Participants were divided into each group using the definition decided among project partners when SHIFT commenced that includes, for example, homeless population, migrants, and people living beyond the poverty line or in social isolation.

This report focuses on the second group – **over 45s facing one or more socioeconomic disadvantage.** The participants were recruited using the networks of the project partners, who reached ethnically, culturally and socially diverse populations including: people from ethnic minority groups, migrants, people with drug and alcohol problems, and people working in the sex industry.

Participant characteristics

A total of 94 individual interviews, and one focus group consisting of five participants, were carried out with over 45s facing one or more socioeconomic disadvantage in The Netherlands and UK from September to December 2020. Some demographic characteristics of this population are reported below.

Table 1: Demographic Characteristics of Participants

Demographic characteristic	**Number of participants**		**TOTAL**
	Individual interviews	**Focus group***	
N	94	5	99
Location			
UK	84	5	89
Netherlands	10	-	10
Age			
45- 54	47	-	47
55-64	23	-	23
65-74	14	-	14
75+	8	-	8
Not reported	2	5	7
Gender			
Female	47	5	52
Male	47	-	47
Ethnicity*			
White			
English, Welsh, Scottish, Northern Irish or British	8	-	8
Irish	1	-	1
Gypsy or Irish Traveller	-	-	-
Any other White background	-	-	-
Mixed or Multiple ethnic groups			
White and Black Caribbean	7	-	7
White and Black African	7	-	7
White and Asian	6	-	6
Any other Mixed or Multiple ethnic background	-	-	-
Asian or Asian British			
Indian	5	-	5

Pakistani	7	-	7
Bangladeshi	2	-	2
Chinese	3	-	3
Any other Asian background	4	-	4
Black, African, Caribbean or Black British			
African	10	-	10
Caribbean	11	-	11
Any other Black, African or Caribbean background	-	-	-
Other ethnic group			
Arab	-	-	-
Any other ethnic group	-	-	-
Not reported	23	5	28
Country of birth*			
Outside of 2Seas region	10	-	10
Not reported	84	5	89

*Limited demographic data was collected from the focus group to protect the anonymity of participants.

**Data on ethnicity was only recorded for UK participants.

***Data on country of birth was only recorded for Dutch participants. 2Seas region includes Belgium, The Netherlands and UK.

Research findings

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. The barriers and facilitators diverge into service and psychological themes. Within both service and psychological barriers and facilitators, there are multiple sub-themes which will be described below. Barriers and facilitators frequently interchange; a barrier to one participant may be a facilitator for another, and vice versa. Changes experienced with ageing, and the COVID-19 pandemic, add complexity and may influence the barriers and facilitators expressed by study participants.

Ageing and changes in sexual health and wellbeing

Our participants describe diverse experiences of ageing, and changes that occur with regard to their sexual health and wellbeing. While largely negative changes, some interviewees describe the positives ageing can have on sexual health and wellbeing. These changes fall into five sub-themes: 1) Female sexual health, 2) Male sexual health, 3) General health, 4) Psychological changes, and 5) Sexual activity.

Female sexual health

Participants mention both positive and negative changes with regard to female sexual health. Negative quotes largely concern the menopause; both men and women describe how the menopause has caused physical and psychological symptoms that affect their relationship and/or sexual activity:

"I'm in menopause and it's not going particularly well … If all that didn't change your attitude towards sex I don't know what would."

"I'm in menopause and it's not going particularly well. I've had just about all the issues I think, hot flushes, cold flushes, vaginal dryness, headaches, racing heart, desperate need to go to the toilet, painful sex, lowered libido. If all that didn't change your attitude towards sex I don't know what would."

"I think there is some depression involved [during the menopause] though as well because, in some cases, women do feel that they have ceased to be attractive."

In contrast, some participants describe benefits of ageing, in particular of going through the menopause. This can lead to "a new lease of life" for some, as they are no longer at risk of unintended pregnancy. Another respondent explains her libido has increased following the menopause. For example:

"I've heard that it can either increase your – what is it called – your libido or have the totally opposite effect and turn you off sex altogether. In my case it's increased it."

"Now I'm through it [the menopause] I'm having a great time, girl. Has it affected my sexual health? Well it's certainly made it more lively, lots more of it. Can't get pregnant you see."

Male sexual health

Interviewees cited predominantly negative experiences when talking about male sexual health and ageing. Multiple participants mention the risk of prostate cancer – symptoms of which can include "erection problems" and feeling "less of a man". Others refer to reduced libido and erectile dysfunction resulting in sexual dissatisfaction and negative feelings toward sex. For instance:

"Getting tired quicker, not being able to get or keep an erection as easily. Just a general lackadaisical attitude to everything, including sex."

Some participants discuss how having a vasectomy may affect physical and mental health. On the one hand one woman says men she has met who have had the procedure "are more likely to follow their [sexual] desires". Another participant explains:

"As far as vasectomies are concerned I would guess they would make you relax more because you can't father any more kids."

In contrast, others say it could present a problem if they began a new relationship and wanted to start a family:

"If your wife dies, you might want to marry again, somebody younger, and start a family but you can't do that."

One participant who has had a vasectomy has suffered health problems "for 9 months" since: "I have spoken to urologist, I have been to specialists, I am under the treatment of a physiotherapist for my muscles, pelvic floor specialist…".

General health

Comorbidities and the deterioration of health in general can negatively impact the sexual health and wellbeing of our participants as they age. For some, this may end their relationship:

"I've got all kinds of things wrong with me – diabetes, prostate issues, overweight. One of the relationships ended because I couldn't satisfy her often enough."

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Interviewees explain how health concerns can affect their ability as well as their enjoyment of sex:

"There's all sort of things that you get – arthritis, and that makes it hard for you to move around and be - you know what's it – be flexible and it's painful to move around as well – you might have a heart attack which means you have to be really careful afterwards and also a stroke, that stops you being flexible as well."

It is evident that medication can influence sexual health and wellbeing too. One participant explains that while taking anti-depressants, they had "very little desire for sex". Others explain:

"People start taking medication for things like high blood pressure and cholesterol and other things and that can have side effects on your sexual health like being slower to become aroused or not wanting sex as frequently as before, loss of libido or something isn't it."

Psychological changes

Interviewees describe both positive and negative changes with regard to how they think about themselves, relationships and sexual health and wellbeing. Negative aspects discussed include loneliness, worries and stresses associate with ageing, jobs and family life and negative self-image. These changes can lead to negative feelings toward sex, sexual health and sexual wellbeing. For example:

"You do become more of a worrier as you get older which leads to stress but you also have stress In your work or you can have if you have any sort of responsibility. You also get an increasing sense of your own mortality the older you get which I suppose is only natural really as you're getting closer to death … stress leads to all kinds of illnesses so I think we shouldn't be surprised if, as we get older, our sexual health suffers along with everything else."

"As you get older your body does too, obviously and so becomes less attractive so sex will not be so frequent and your sexual health will suffer."

In contrast, some participants explain how ageing has had a positive effect psychologically. Feeling "free" and "relaxed" for people of all sex is common, who no longer need to worry about unintended pregnancy:

"Uninterrupted and unprotected sex can be enjoyed fully without fear of getting pregnant or making someone pregnant. A joyful sense of freedom."

Others cite new found independence and self-confidence, whether they enjoy being single and discover they don't need a relationship, or because they want to try new things sexually with their partner(s). For instance:

"I left my last partner in my late 40s and I love living alone – I certainly wouldn't ask anybody to move in with me."

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"Being comfortable in your relationship, being more confident so you can ask for what you want and also in many cases knowing your partner's needs well."

Another frequently discussed positive of ageing is a shift towards more intimate relationships, that are less dependent on the physical act of sex. While this may accompany a reduced sex drive, some participants explain that "companionship" is an enjoyable new priority in loving relationships:

"Yes, well, ... you want to be loved. Yes, you're looking for warmth in someone … And that you're also noticed, so I think that's something, I think that is very important in a relationship. And not that it's solely purely about the sex."

Sexual activity

While ageing appears to largely reduce sexual activity for our participants, a minority describe how it has had a positive impact. For example, "relax[ing] sexually…because she [my partner] couldn't get pregnant" or "know[ing] what pleases each other". Most interviewees however explain that due to, for instance, "lack of desire", "tiredness" or "loss of interest", sexual activity has decreased. Another states:

"Familiarity breeds contempt, contempt the wrong word, but you know what I mean? The word, the longer you're someone who, the more you're used to them, therefore, excitement side of it dies off a bit. Unless you're really putting some effort in."

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 ten sub-themes, explored below.

Sexual health vs. sexual pleasure

Multiple interviewees explain that a dislike of using contraception can prevent them practicing safe sex. For example, one describes condoms as "too fiddly" while another states:

"I and, again, many of my friends, don't always use a condom – you must know what it's like, you know on the spur of the moment you might not have a condom with you and it's a bit of a passion killer to say, well we need to go to a shop and buy some protection."

Perception of risky sexual practices

A particularly prevalent theme amongst participants is they do not consider themselves at risk of poor sexual health. Multiple reasons are cited for this, with many explaining that because they are in monogamous relationship and/or have no risk of pregnancy, sexual health is not a priority. Some acknowledge that they haven't considered STI risks at all:

"It's funny though because, if I hadn't gone to the clinic it wouldn't have occurred to me to use a condom. When we were youngsters, condoms were just to stop pregnancy not to stop infections or if they were to stop infections we weren't told about it."

The perception that risky sexual practices are only of concern to young people, LGBTQ+ or those with multiple partners is common. Meanwhile, some participants simply state that the risk of STIs becomes less as one ages. For instance:

"I don't think there is much risk at our age, from having several partners, especially if you're, what is it, heterosexual and not gay. It might be risky if you're a gay man because HIV is still around isn't it and I think I'm right in saying it's worse in people of my ethnicity but I don't think I'm at risk with women."

"I'm not knocking around with youngsters and I'm not out prowling the streets or the clubs, picking up people when I've got no idea where they've been if you get my meaning. My partners are all people I've met properly, who I've been introduced to and who come from proper backgrounds so I don't think there's much danger."

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Gaps in participant sexual health knowledge and awareness

It is apparent that many of our participants have limited knowledge and awareness of sexual health with may prevent them from recognising poor sexual health, and/or seeking help, with one participant saying "I don't know what sexual health is", and another stating "I don't know what the [sexual health] clinics do". In some cases, interviewees put this down to a lack of sexual health education in school:

"Certainly, at school, at that time, you know, we're talking about late 60s 70s. You know, there was really no sexual education."

Others explain that people coming out of long-term relationships may be "unaware" of the risks, and the help and support that is available. For example, one participant says:

"People, older people who perhaps have come out of long-term relationships, perhaps a bit blasé about it. Not really, very well informed."

It is clear that even if a person over the age of 45 did want to seek help for a sexual health or wellbeing issue, they may be unsure where to go, how to make an appointment, or what service provision is available for them:

"I don't really know what levels of support are available."

"We tried to find a clinic but we didn't know where to start, how to make an appointment that sort of thing. We didn't know whether we had to be recommended by a GP."

"You know, some people having difficulty of various kinds with sexual issues especially if there were psychological or emotional issues might think that there was nothing that anybody could do to help them. They might think that they needed to sort it all out for themselves."

"I don't really know what levels of support are available."

A common misconception among interviewees is that services only provide diagnosis and treatment for STIs, and therefore they would not visit if they did not have signs of infection. They are frequently unsure whether sexual health clinics would provide more general advice on sexual health and wellbeing. For example:

"Clinics do what it says on the tin as they say, they test, they treat and they send you away."

Personal attributes

Some participants explain that "stubbornness" can sometimes prevent middle aged and older people from seeking advice for sexual health, believing they should be able to solve the problem themselves. One participant gives the example, "I've lived like this, so why should I have to go to the doctor or something?".

Deprioritising sexual health

Life pressures lead other priorities to move ahead of sexual health and wellbeing for some participants, such as work and looking after children, so sex and relationships are not on their mind. For example:

"I know all the books and things say you should not let it all go stale, keep it alive, they say but it is not so easy when you have other things in life pressing on you like money or job worries or something like that."

Relationships

A reluctance to discuss sex and sexual health with friends, family and partners can cultivate existing stigma, and discourage some to seek help and support. For example:

"These days, I don't think it was in the previous generation. You know, they always found it very difficult to talk about, talk about sex. I mean, my parents."

One participant explains that conversations about sex only come up "as a joke" amongst his friends, which is perhaps an example of the societal stigma that still exits.

Meanwhile, one interviewee says "if you trust somebody [your partner], it doesn't occur to you" to seek advice for sexual health as they explain there is limited risk of getting an STI.

Cultural norms and taboo

Cultural norms and taboos related to sex and sexual health is a prominent theme arising from our study, and a common barrier for participants seeking help and discussing sexual health and wellbeing. Participants from Asian and Black African and Caribbean backgrounds explain how their communities would "condemn" them if they visited a sexual health clinic, as it would be assumed they were "dirty" or had "done something wrong". The extreme stigma and taboo within these communities leads a "fear" of seeking help, which may lead to "punishment" if it were found out. For example:

"The terrible thing is that I would want to talk about it to my closest friend and my husband but that would be risking all sorts of bad reactions because it is all a taboo area. If it got out that I had been there would be all sorts of pressure on my husband to divorce me at the very least I would be stigmatised in the community. My life would be made very unpleasant."

"In my own case as a black African and I think it is the same for Caribbean and also with Asians, there is a lot of stigma attached to attending sexual health clinics and to getting tested for things like HIV, even though it is to everyone's benefit to do so. Some fear condemnation within their community, some fear the results as they don't know or aren't educated about how HIV, for instance progresses and that it isn't automatically a death sentence."

"There are still honour killings in communities like mine so you have to tread very carefully. I mean if it became know that you had contracted HIV for instance I dread to think what might happen."

"This is all very taboo in our culture. These things are not discussed and so in the case of Pakistani and Asian men and women it is a case of getting them to open up about sexual health."

"I wouldn't go anywhere because that [STI], whatever it was, would be my punishment."

One participant believes that they would deserve a sexual health illness if they had been unfaithful, and therefore wouldn't seek treatment at all:

"If I'd done something wrong like being unfaithful or something like that I wouldn't go anywhere because that, whatever it was, would be my punishment."

It is not only STIs and unintended pregnancy that carry a taboo, but also LGBTQ+ relationships, having multiple partners and the menopause. One participant explains that although his wife has been through the menopause, "we don't talk about things like this in Asian communities".

Such views lead some participants to seek help from GP surgeries outside of their community, to avoid being recognised; as one participant explains, "often the doctor is part of the community." Furthermore, it is frequently expressed by participants from BAME backgrounds that there is a stark contrast between their culture and others, for example "among the Dutch people in a circle of friends, a lot of jokes are made about it." Another says:

"White people in particular, are much more promiscuous and run all kinds of risks of becoming infected."

"In our culture we wouldn't have more than one partner anyway but people in other cultures, white people in particular, are much more promiscuous and run all kinds of risks of becoming infected. We would be classed as unclean if we did things like that."

Consequently, some participants believe that due to the strict rules regarding sex and relationships within their communities, it is other cultures that require sexual health provision, not their own:

"Other cultures are more lax though and they might need, oh I don't know, maybe advice on how to stay safe in a relationship."

Fear of diagnosis

While some of the fear cited by participants appears related to the broader stigma and taboos surrounding sexual health, it also reflects the uncertainty about diagnoses and what it might mean for them and their partner(s). This may prevent people seeking help and advice for sexual health worries and concerns. For instance:

"Fear of what they might find out they'd got [might prevent over 45s going to a clinic] – there are still some deadly diseases out there."

"Some people stuck with their complaints for a long time. That's not just with STDs, it's with other things too. So I do have experience with that, that some people are afraid to go to the doctor."

Stigma

Stigma is one of the biggest barriers facing our participants when it comes to seeking help and support for sexual health and wellbeing. Three types of perceived stigma were cited by participants: 1) social stigma, 2) self-stigma and 3) stigma among healthcare professionals.

Social stigma was the most quoted type of stigma throughout the interviews, with participants worried they will be "looked down on" or "judged" by others if they were to seek help for a sexual health concern, or even discuss the subject with others. This is heightened amongst BAME communities, with some participants explaining this stigma translates as "fear" for them:

"Fear. Fear of what the community would say. A feeling of shame, that they have disgraced the community and their family. Worry that they will be shunned."

This stigma also surrounds sexuality, with one transgender participant explaining:

"Unfortunately my wife can't accept what I am and she has turned the girls not only against me but against my parents as well… I think they're ashamed of me. But I don't regret it. I really feel that I am who I ought to be now or getting close to being that."

Many interviewees discuss the stigma that exits towards older age groups and sex, supporting misconceptions that this population is, or should be, asexual. For instance:

"There is also a bit of a taboo around talking about sex among the older age groups – I mean 60s and over – I think it's a parental thing – I don't like to think of my parents having sex and my kids don't like to think of us having sex."

"There's all those connotations of a dirty old man."

"There's all those connotations of a dirty old man. They might worry that's what people would think of them."

"I'm sure everybody hopes that when they get into their 70s or 80s they are still sexually active in some form or other but they don't want to think of other people of that age doing it. It's distasteful for some reason … I suppose it dates back to sex being for reproduction only so when you're out of that age group people, subconsciously or otherwise, think you shouldn't be doing it."

The second most cited stigma is self-stigma, whereby stigma has been internalised as a result of public attitudes. For example, participants often feel "embarrassed" and "shameful" at the thought of having an STI. Another explains they would be "feeling a bit stupid about not taking precautions". These thoughts present a barrier to seeking support and advice about sexual health and wellbeing – as one interviewee puts it, "some people would rather bury their head in the sand than know the truth."

"It was embarrassing at the clinic, I was only 47 at the time but there was a feeling that I shouldn't be needing to go there at my age, I don't know if that was my imagination but that's how I felt, maybe it was guilt."

The final type of stigma cited is that from the healthcare professionals. Some participants explain they have been made to feel "humiliated" and "judged" by the person who they have gone to for help or advice about sexual health:

"They felt ashamed and embarrassed to be going to a sexual health clinic for testing at their age and that the attitude of the staff of the clinic only made them feel worse."

"Believe me, I've been through some humiliating experiences with nurses and assistant GPs"

"You go into the consulting room and it's a bit like "hm, why are you needing to get this done" and the older you get they add on "at your age"."

"Discriminatory attitudes at clinics and in pharmacies is also something that deters them. I've had people in my surgery telling me that they felt ashamed and embarrassed to be going to a sexual health clinic for testing at their age and that the attitude of the staff of the clinic only made them feel worse."

Negative assumptions about healthcare professionals and services

Multiple participants assume that healthcare professionals will not understand their concerns, or take them seriously if they do seek advice or support for their sexual health and wellbeing. For example, one participant states:

"…with my doctor. They might not take you seriously – they do have a tendency to talk down to you as if you're a child…"

"You don't know how they would react to a 70 odd year old coming in and talking about sex. It would be hard enough with my doctor. They might not take you seriously – they do have a tendency to talk down to you as if you're a child – well some of them do anyway – that would make me walk out if they treated me like that."

Another participant worries about "burdening [their] GP with [their] problem", especially if they feel they should have "take[n] precautions" to prevent it.

A big concern for participants is that services will not be confidential. They may fear “they bump into someone they know” in the waiting room, or “the whole community” will find out via their doctor. This is commonly cited by BAME participants. Lack of confidentiality and anonymity is largely why interviewees would not visit a pharmacy for sexual health support as “everyone can hear what you have to say”.

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 services, 2) Previous negative experiences seeking advice and support, 3) Discrimination in services, and 4) Practical barriers.

Lack of tailored services

Participants discuss a lack of services tailored to their needs. For example, some say services "are geared towards young people", with no provision or sexual health promotion "that speaks to [their] generation". It can be "daunting" for some people over the age of 45 to visit sexual health services when they are only "staffed by young-ish people". Many participants agree that advertising for sexual health is also "aimed at younger people", leading to some feeling "neglected", even if they are aware that they need to be informed about the subject. For instance:

"Clinics aren't geared up to meet the needs of an older person. I imagine the older you get the more daunting the prospect is of going along to someone and saying, effectively, I want to talk about my sex life. There is no information out there talking about sexual issues and sexual health and saying what is on offer for older people."

"The clinics also from what I've read do seem to concentrate on younger folk even though they say their service is for anybody of any age, ethnicity or religion."

"We need advice on how to stay safe sexually and how to conduct ourselves in a new relationship but there is no information about sexual health and wellbeing targeted at us at all."

Others cite limited gender-specific services, with one expressing that "most of the services in sexual health seem to speak more to the male population than they do to the female population". Some interviewees say they would feel more comfortable visiting a healthcare professional about a sexual health concern if they were the same gender as them:

"There is no information out there talking about sexual issues and sexual health and saying what is on offer for older people."

"I think there's only your doctor and mine's a man as I said and I don't fancy going to him about sexual health issues even if I could get to see him. "

Multiple participants describe how language skills may present a barrier for some, who cannot understand information about sexual health and wellbeing:

"I have a lot of people in my area who don't speak Dutch … for them that's hard I think."

Another way in which services may discourage people to visit is by lacking ethnic diversity. One interviewee explains that services tend to be staffed by "mainly white" people. Meanwhile, another describes how they have seen services become less tailored for different sexualities:

"Lesbians have almost disappeared off this planet because we used to be just as an organisation ... be lesbian and gay men. Now we've got so many different forms of practise with LGBTQI and I'm sure they're gonna add another letter eventually."

Previous negative experiences seeking advice and support

Previous experiences of sexual healthcare evidently influence how participants feel about present services. Multiple responses cite past negative experiences of care as a barrier to seeking advice and

support now, as they influence their perceptions and attitude towards sexual healthcare. Some negative experiences involved interactions with healthcare professionals. One participant explains they were treated "as if they were a child", while another was made to feel as thought they were "a nuisance". For others, it was evident that the healthcare professional had a lack of knowledge and understanding about sexual health for people over the age of 45. For example:

"A woman of 73 asked for condoms at a Family Planning Clinic and was told she didn't need them as she wouldn't get pregnant, now I ask you did this person think she was so stupid that she didn't know she wouldn't get pregnant."

Similarly, one participant explains that a GP made assumptions about their sexuality, going on to say they felt "pressure as a lesbian to come out" to the healthcare professional as they asked about children and grandchildren.

Other interviewees discuss how sexual health services can be an unwelcoming environment:

"I did have an STI a couple of years ago and I went to a sexual health clinic. I got as far as the door and they were all so young and so white and so jolly with each other but not the customers or patients I should say, that I walked out and went to my doctor's surgery."

Another states that "it all feels a bit clinical". Therefore, it is clear that both negative interactions with healthcare professionals, and an unwelcoming environment in services can dissuade some people from attending again in the future.

Discrimination in services

Unfortunately, ageism and racism are mentioned by some participants as a barrier to accessing support for sexual health. Ageism is intertwined with the stigma surrounding sex in older age, and asexual stereotypes:

"I think ageism has an effect. It's endemic in our culture and many people's culture actually. Certain things you're supposed to be when you get over a certain age, and I certainly don't identify like that and not I do most of my peers."

"I think for me personally as an older woman, once your hair goes snow white, you automatically seem to become invisible."

"I felt he was judging me because of my age and also my colour so that was racism as well."

Others describe how the intersection of both ageism and racism can create a further barrier to services. For example:

"I think you might call it ageism – I felt he was judging me because of my age and also my colour so that was racism as well … You know the stereotype people have of black men they think we're always at it so that and my age combined with the fact I had a dodgy rash made him make a snap judgement I felt."

Practical barriers

"Practical barriers" refer to factors such as cost and appointment times, which may require intervention beyond the scope of the SHIFT project, however are still important to acknowledge as barriers to some service users. Appointment availability at healthcare providers such as sexual health clinics and GP surgeries and the length of appointments are prominent barriers to participants. Some feel they cannot discuss their sexual health concern in the 10-minute

consultation slot provided, while others struggle to get an appointment quickly, or at a convenient time. As a result, one participant suggests A&E might be the only option. For instance:

"If you were in need of help and advice or thought you had something wrong and your first instinct was your GP but you couldn't get an appointment, for most things you would go to A&E or a walk-in clinic, if there was one within striking distance."

"That brings up the question of the 10 minute consultation, is that long enough to get to the bottom of a problem?"

A barrier present for Dutch participants appears to be the cost of care or medication:

"At some point, he just had to buy Viagra. He had to pay 35 euros himself or something. It won't be reimbursed. That'll stop it, yes. That worried him, the money he didn't have. He didn't find that money to spend."

In contrast, some UK participants describe the benefits of the NHS, and not having to pay for care.

Additionally, disability and a lack of identification such as a passport are two further practical barriers to accessing services mentioned by two Dutch participants.

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 good sexual health. The theme Psychological facilitators divides into five sub-themes: 1) Worries about sexual health as a motivator for help-seeking, 2) Living through the HIV/AIDS epidemic, 3) Cultural openness, 4) Personal attributes and 5) Relationships.

Worries about sexual health as a motivator for help-seeking

Worries about STIs, unintended pregnancy and other issues such as erectile dysfunction and prostate cancer are a motivator for some participants to seek help for sexual health and wellbeing, and practice safe sex. STIs are the biggest worry for our participants, followed by sexual health problems associated with age, such as prostate cancer, lower libido and pain during sex. Worries about STIs appear heightened for those with multiple partners:

"A couple of my regular partners have contracted chlamydia and I have gone along to a clinic to get checked out. Fortunately, in both cases it has cleared up quite quickly and I haven't developed any noticeable symptoms."

"We both developed symptoms and got tested and we both had HIV. We don't know who was to blame because we were both at it at the same time but it doesn't matter who was to blame we learnt our lesson about unprotected sex and the importance of using condoms"

"We learnt our lesson about unprotected sex and the importance of using condoms"

Others explain they would likely look for more information if they needed advice, for instance:

"A declining sex, sorry, a decreasing sex drive. So, if you find that you still have the desire to make love but perhaps are not physically able to. I would imagine that would then lead you to visit a sexual health clinic - or at least probably look online and then seek further advice from a sexual health clinic."

"If I had an STD and I wanted it get it fixed, get better, then I'd talk to those people. With the GP or with someone from a clinic who has a lot of knowledge about this. Because I want to get better. Then I don't think it's such a problem. So I'm going to talk about it."

Living through the HIV/AIDS epidemic

Some interviewees explain that growing up through the HIV/AIDS epidemic has given them a heightened sense of awareness with regard to safe sex, and sexual health in general. This is more so the case for LGBTQ+ participants, with some explaining:

"With AIDS, there was more awareness. And then it was, you know, all kinds of that weren't really ever spoken about, and nobody really ever got, but all of a sudden, it was you know, crabs and chlamydia and syphilis, even gonorrhoea."

"I was in school when AIDS first came on the scene and we had it drummed into us that we must never have sex without a condom and that we should get checked out regularly and I did until the time I got together with my partner."

Cultural openness

In contrast to the cultural norms and taboos that present a barrier to discussing and seeking advice about sexual health, other participants explain that some cultures are more open about the subject. One describes how the British culture is less "vocal" about sexual health than in Africa where they grew up:

"I do shock some people sometimes, especially, I have to say, especially in this country, because in Africa, you're more vocal, and here it's more reserved."

"I do talk about sex a lot. And we [my friends] have a giggle and laugh. And, but I know I do shock some people sometimes, especially, I have to say, especially in this country, because in Africa, you're more vocal, and here it's more reserved."

For others it is the opposite – the country they have resettled in is more open about sex, leading them to be more aware of sexual health. For example:

"They [the Dutch] know a lot more about diseases and how to deal with sex, safe sex. Yes, before that, when I was in Iran, I didn't think about it that much. After that, I was much more afraid about getting AIDS or getting other diseases."

For one participant, they would like their own culture to be more open about the subject as they believe this would be beneficial for sexual health and wellbeing, stating:

"If our communities were more enlightened, more into the 21st century I would like to think that these things could be offered within the community itself, that our community leaders would do just that and take the lead in seeing that these things are not things to be ashamed about and should be brought out into the open but I can't see that happening in my lifetime."

Personal attributes

The attributes of some participants lead them to more readily discuss or seek help and advice for sexual health. An interviewee explains they "are upfront about everything", with another saying "I am just honest and open about it". Some describe how they are becoming more cautious about their sexual health, and their health in general, as they get older. For example:

"At my age, I guess you have to take care of yourself, put on a condom, make love safely, and when you're young you don't think about it, doing it safely."

Relationships

While relationships with friends, family and partners can dissuade some participants from visiting a sexual health provider, or talking about sex and sexual health, for some, they can be an encouragement. It is apparent that educating their children about sex can encourage participants to reflect on their own sexual health and wellbeing:

"It's funny because people over 45 are likely to be handing out advice themselves to their sons and daughters ... we should be practising what we are telling the youngsters and I think most of my community would be doing just that."

It also goes the other way, with some participants explaining how they are comfortable discussing sex with their own parents:

"My family are completely open – my mum is 70 and she talks to me about sexual health"

"My family are completely open – my mum is 70 and she talks to me about sexual health and things like that and I don't get disgusted or think there's something wrong."

Similarly, one interviewee “talks to [his] girlfriend about it”, and another is “very social” and talks to their friends about sex and any worries they may have.

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 six sub-themes, which are discussed below.

Information content

There are many elements that participants suggest should be incorporated in to the information provided to over 45s in order to facilitate good sexual health and access to health services. This relates to the content of sexual health promotion, and advice given at services, but also the guiding principles that should be included throughout all sexual health and wellbeing information shared.

Advice that participants would like to receive ranges from contraception, recognising symptoms and the risks associated with STIs, understanding the menopause and physical sexual health concerns, to emotional advice about relationships, dating and tackling a lowered sex drive. For instance:

"…advice on relationships, particularly starting a new one, advice about what is normal in sex"

"Safe sex, condoms, contraception, problems with sex as in physical or emotional problems, testing for STIs and treatment for the same, advice on relationships, particularly starting a new one, advice about what is normal in sex … particularly older people who may not have been with anybody new for several years if not decades because they've been in a one to one relationship – either married or co-habiting they might be unsure about certain positions or practices, they may have been asked to do something they aren't sure about or have had something done to them they aren't sure about."

More specifically, one participant who has had alcohol problems would like more information about how this affects her menopause, and how she can differentiate the symptoms. Similarly, another participant would like information about how her contraception has influenced the menopause.

Respondents also mention that they would like information about what to expect if they were to visit a sexual health service, for example by reading about other peoples' experiences to find out "what its like". This could help dispel the fear and discomfort surrounding sexual health provision.

The diversity of sexual health and wellbeing which many participants would like more information about, leads some to emphasise its holistic nature. One explains that healthcare professionals should "look at the whole context", including psychological aspects as well as physical.

Mirroring the major barrier of stigma that frequently prevents good sexual health and access to health services, there is a call by many to normalise and destigmatise the subject through the information and knowledge shared. For example, "by making it clear that it [sex] is a natural thing" and "there is nothing to be ashamed of". A way suggested to normalise sexual health is to involve people of all ages in education about sex in older age:

"I don't think it should be left until you are over 45 I think there should be a big information campaign aimed at all age groups making it clear that people of all ages can be sexually active."

As a significant gap in knowledge among service users regards what services are available and where they are located, there is a need to signpost sexual health provision more clearly. Participants explain:

"It's also important that it's advertised properly and posters and booklets are available. This is very important for letting people know exactly what's out there."

"If the state wants everybody over 45 to start seeking advice and support on sexual health they need to explain what it is and where you should go to get it. I think most people I know wouldn't have the faintest idea either what it was nor where to get it."

Sexual health part of routine health check

A popular suggestion from our participants is to include sexual health in routine health appointments, such as "well man and well woman checks", "breast cancer checks" and "cervical smears". Others would not mind if a doctor brought up the subject of sexual health at an unrelated appointment, or they may bring it up themselves just to "make sure everything is ok". This may encourage people who feel stigmatised in their community to receive advice or support for sex and sexual health, as it would be less obvious they were visiting a healthcare provider for this reason.

Practical facilitators

It is evident that location and appointment times are a key barrier, or facilitator, to engagement in services for our participants. For example:

"They could be open longer, have more appointments in the evening and at weekends."

"They could be open longer, have more appointments in the evening and at weekends. It's quite difficult to get along there if you work."

Referring to the importance of location, one participant explains:

"Then you might be able to walk in easier, it's close to home or you think well. It's much easier."

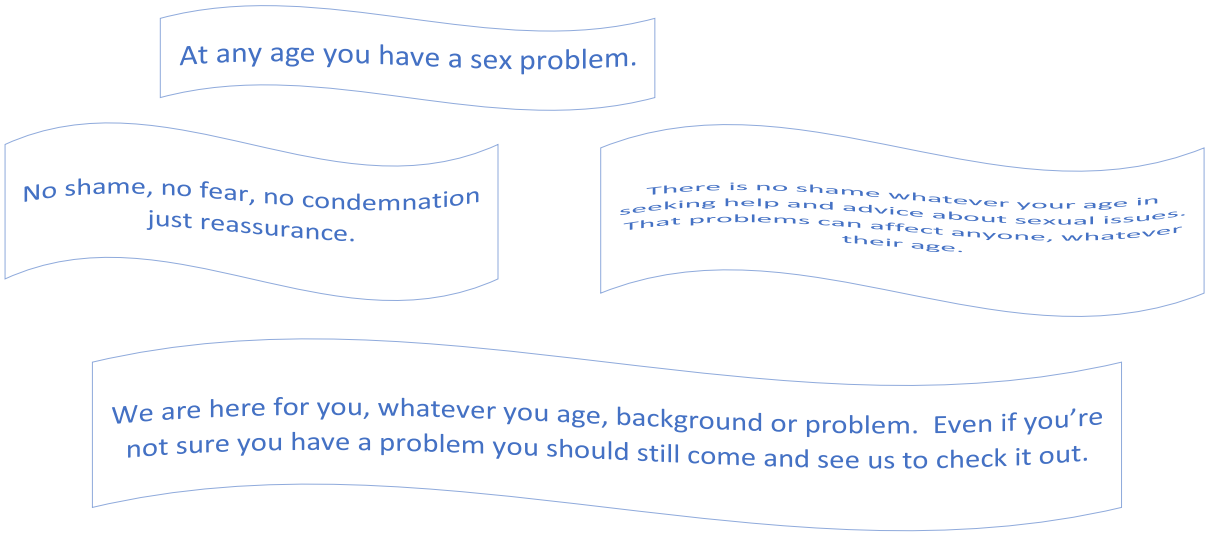
The participants in the focus group agree, with one describing the quality and availability of support a "postcode lottery".

Sexual health messaging

The type of language and imagery used in sexual health messaging and promotion can be central to successful engagement with our population. When asked for suggestions, participants explain different approaches such as "putting on a positive spin" and being "clear", with some preferring "straight talking" messages and others "humour". One explains:

"Different people react to different types of advertising, don't they, you know, so there might be a light-hearted approach, and needing to text somebody about it, or whatever, you know, you know, sort of jokey character or, you know, want to, you know, want some more information, or newly single? What to look after your sexual health or, you know, those types of messages."

Below are some suggestions of messages which could be present on sexual health promotion:



While interviewees sometimes suggest that images aren't necessary on sexual health promotion for over 45s, others think they could be useful. Diversity and showing "real" people and relationships is important for many:

"I'd like to see a lot more images on billboards on different posters in different places of older women being who they are"

"You need to portray all kind of different relationships, not just a cosy white haired heterosexual couple."

"Images need to be all age groups not just young and not middle-class white people only as well you have to include all ages, all ethnicities."

"You need to portray all kind of different relationships, not just a cosy white haired heterosexual couple."

One respondent suggests using famous faces could grab people's attention:

"Maybe they could use a face that everybody knows – Judy Dench or Maggie Smith and a male equivalent to front the whole thing.

A wide range of methods could be used to promote sexual health, ranging from traditional media such as magazines, TV adverts and posters in community settings like doctor's waiting rooms, coffee shops and on trains, to new media such as social media and text messages. It is evident that suggestions are down to personal preference, and therefore information campaigns for sexual health should be available on a range of platforms.

Sexual health support and provider characteristics

Interviewees suggest various characteristics of sexual health support and providers that could be adopted to facilitate engagement in services, and achieve good sexual health and wellbeing. Some suggestions concern the key attribute that healthcare professionals should have when interacting with patients. For example, there is large emphasis on the importance of "listening" to the experiences and concerns of over 45s, without "making assumptions". A participant describes what they find important when talking to their GP:

"The GP listens and remembers or mine does anyway, they're not all like that though. They don't judge, they don't look disgusted if you tell them something you might have done that might not be considered normal by society as a whole, they don't act as though you're abnormal for being gay, they don't act as though you should be in a permanent relationship, they don't act as though you shouldn't be enjoying sex at your age."

Others would like reassurance that they "won't be laughed at", or "judged" by the healthcare professional. Neither do respondents want to be "talked down to", as one says "we aren't kids, we've lived a life and we know our own bodies by now".

Some participants would like to visit a healthcare professional who has specialised training in sexual health, and therefore their GP may not provide the advice they need, but they could signpost to appropriate services:

"You'd be looking for someone who's professional in that area first. Or you could go to the GP and let the GP refer you to someone who is professional in this area."

Furthermore, multiple interviewees suggest that healthcare professionals should have more training about sexual health, and how to discuss the subject with people over the age of 45. For example:

"It would be nice if there was somebody who was a bit more clued in who understood that 56 year old men are still sexually active, whatever the colour of their skin – white men are too you know. I can't think of anybody else no, someone like social workers would be more understanding I think but that's not their area – I mean sexual health advice isn't their area is it?"

Others would like more awareness among healthcare professionals about the needs of different sexualities and genders:

"I think more age, gender and sexuality appropriate literature should be around and available and for people to be trained so they don't make that assumption all the time and don't just assume."

"I would be very comfortable at a hospital providing they have good knowledge of LGBTQ+ people."

It is not just healthcare professionals that require more training, some participants express that receptionists should be educated to stop "sniggering in the office", and so one does not feel like a "nuisance".

It would be good to have healthcare staff who are relatable to service users according to multiple participants. Whether they be of a similar age or the same gender or ethnicity, it would help facilitate open and honest discussions between the patient and provider. Developing a good patient-provider relationship is an essential aspect to care cited frequently by participants, who often explain they would feel "comfortable" talking about sexual health to a healthcare professional they have built a rapport with.

In contrast, some participants explain they would rather go somewhere "incognito"- such as a sexual health clinic or online, to protect their anonymity:

"They don't have to go to the GP, they are ashamed, can go online, anonymously."

It is apparent that reassuring service users that sexual health provision is confidential would be a vital facilitator. This is also the case when promoting sexual health as one participant explains:

"I mean, really embarrassing, you know, your wife suddenly, erm you know, reads your emails, and it's like, what are you doing?"

Being able to do STI tests at home or online allows some respondents to overcome the barrier of confidentiality. For example:

"In fact, I think you can get tested for STIs online now. That is perfect because it is anonymous you don't have to go through any agonising face to face meeting."

The environment in which sexual health support should be provided can evidently influence the experiences of people who visit. Some suggest a more "homely atmosphere" which may help people "relax". Another goes a step further, suggesting consultations could take place "in their own surroundings" at home. Citing both privacy and comfort, a respondent would prefer if "there wasn't a waiting room full of people".

Similar to those preferring a more informal environment, numerous interviewees would like the opportunity to chat with their peers to share experiences, or have occasions to talk openly about their sexual health "face-to-face" or in "group discussions" with healthcare professionals. For instance:

"More groups for older people, where you can go and… listen to other people and say how you feel."

"The surgery could send out an email or a text or put a notice on their website to say they are offering consultations on sexual health and wellbeing for the over 45s and then list out the sort of things sexual health and wellbeing covers and ask people to make an appointment to go along and have a chat, however trivial their concerns might seem."

"I think it would be a lot nicer regardless what your sexuality is if there was more groups for older people, where you can go and actually share your views and listen to other people and say how you feel."

"It's like a coffee morning, isn't it, creating that casual relaxed feeling and having a coffee and a bit of cake or something."

While some participants would feel comfortable with their healthcare provider initiating conversations about sexual health, the majority say that the service user should bring up the subject of sexual health themselves if they need to discuss it. Some explain it would be embarrassing, particularly for those from cultures which have strong taboos about sex. For example:

"It should be self-referral shouldn't it? Nobody should be bringing these things up if you haven't mentioned them yourself. As I say these things are not up for discussion in our society."

The final factor discussed by participants as important for sexual health support and provision is where it is located. Before seeking advice at physical locations, many would first check online as according to one participant, "you can find everything on Google". Some suggest third sector organisations such as METRO or Age UK, while others would go straight to their GP or a sexual health clinic if they had a concern. Dutch participants also mention The Rutger Foundation or the GGD, which provides support across all healthcare. Others suggest less conventional places like care homes, retirement communities, community centres or gyms could be platforms to provide advice. Pharmacies are only appropriate for a few participants, given they are "too public" for some.

Tailoring

The final service facilitator is tailoring provision for the needs of different sub-populations from the over 45 age group. This is particularly important for the diverse participants involved in this study.

Tailoring refers to adapting services for individual needs and preferences. This includes for relationship status, age, but also for LGBTQ+, ethnic minorities, religion and gender.

As would be expected give the target age group of SHIFT, adaptations to sexual health provision are needed to accommodate the needs of middle aged and older service users. Messaging should be tailored for over 45s, both in their delivery – for example accessible for "older people who are not as familiar with the digital age" – and with regard to imagery and language which should be "geared towards older" people, with a less specific focus on younger adults. An element which appears uncomfortable for over 45s who visit sexual health clinics, is that their waiting rooms are "full of youngsters". Respondents suggest running age-specific clinics. A couple go further, explaining that as over 45 is a large age group, "it would be better to split the age group so it was, say, 45 – 59 and then 60 plus or something like that because what is relevant to a 45 year old is not going to be relevant to an 80 year old". This age difference not only applies other service users, but also to healthcare staff. By having professionals who are closer to the age of patients, some respondents explain they would "feel less judged" and would perhaps "understand their experience" better. For example:

"I don't imagine a 70 year old would feel very comfortable in those clinics because it's full or it was full of youngsters waiting to be seen and the majority of the medical staff were young too. They need a greater age range there and they could also do a lot if they changed their attitude to take away this taboo or embarrassment of older people talking about their sexual habits and things."

"It was full of youngsters waiting to be seen and the majority of the medical staff were young too

Tailoring for different cultures and ethnicities is also necessary, according to participants. One explains:

"I think anybody trying to introduce this subject needs to make a good study of the community they are approaching, it's no good steaming in there and talking about things that go totally against their religious beliefs or community attitudes. It has to be approached gently and indirectly."

For some, it would be useful to raise awareness of how risks of STIs and other sexual health issues may vary according to ethnic group. For instance:

"HIV is more prevalent in African and Caribbean men than in the white population and there should be a drive for men to get checked out on a yearly basis."

"In the Asian communities, I think the best person would be community leaders."

Participants from Asian communities suggest that their community leaders need to be involved and educated to share information about the importance of sexual health and to begin shifting cultural norms and taboos. One participant suggests this approach could "lead to a local clinic for instance or discussions or talks or even workshops about sexual health". For many, getting community leaders onboard is the only approach deemed to be effective:

"In the Asian communities, I think the best person would be community leaders. You need to get them involved and convince them of the necessity for this service. That would be quite a hard job because you would have to change their whole attitude to sex and the kind of hush hush atmosphere that surrounds it in our communities."

"My guess would be that most people in most communities who need the support and advice of sexual health professionals would already go along and get it. As for communities like mine I don't think there is much you can do, you would have to change the views of the community leaders for a start and then it could filter down from there."

It is important to acknowledge that people from certain cultures would not visit a healthcare provider with the same background as them, for fear of judgement or being recognised:

"Somebody my age but not my background. I mean not Indian. I wouldn't want anybody from my community to know what I was doing. There would be a huge stigma attached. People would say what is she doing asking for advice or help on sexual health. I can't ever imagine myself going for it anyway"

With any information campaign, it is essential that the language is appropriate for the target population, for example one respondent explains that a "Turkish interpreter" was "very beneficial" at a recent workshop.

Another way in which services could be adapted, is to allow service users to see healthcare professionals that are of the same gender. Others suggest "women's groups" which could facilitate informal discussions with peers. Some would refuse to discuss sexual health with anyone who is not the same gender as them:

"In my case, Dutch women, or Surinamese, Moroccan, doesn't matter, as long as they're women. With a man, I wouldn't like that and don't want to do that."

"Dutch women, or Surinamese, Moroccan, doesn't matter, as long as they're women."

Similarly, other respondents would feel "more comfortable" in a healthcare setting specific for their sexual orientation so that their needs were catered for, and they were given the correct "advice and information".

In general, participants across the study emphasis a need for diversity across all social identities within services and on promotional materials for sexual health. This would ensure they were welcoming for all, and facilitate engagement in services, and achieve good sexual health and wellbeing.

Impact of COVID-19

The COVID-19 pandemic provided an unforeseen dimension to our qualitative research findings. For some participants, the crisis has provided an opportunity to look more closely at their health, including sexual health, while for others it has created uncertainty about service provision. Negative and positive aspects of the pandemic's influence on sexual health for over 45s are explored below.

Challenges

COVID-19 has led to challenges such as uncertainty about healthcare service availability and appointment times. For example:

"In my particular town, there is a sexual health drop-in clinic. In the town centre. I must admit currently, I don't know if they are open or whether you need appointments. It used to be a drop-in service, but obviously with the situation at present its probably an appointment only service."

"They're talking about local lockdowns and things like that, it's very scary. When you're worrying about things like that you don't exactly feel like sex, do you?"

For some respondents, the pandemic has led to increased stress, which may mean sex and sexual health is not their priority:

"Just at the moment it's all very worrying, that last bit, you know, whether you're going to lose your job… they're talking about local lockdowns and things like that, it's very scary. When you're worrying about things like that you don't exactly feel like sex, do you?"

Opportunities

On the other hand, there are some positives that have emerged during the pandemic. For example, participants explain they are more aware of their health now, and more cautious about avoiding illness and the impact their own health can have on others, leading them to practice safe sex:

"I think as you get older you get more cautious, I think. Getting an illness- now during coronary time even more. Then you think of more things than you used to. You want to make sure, you are preventing it, so to speak."

Others describe how COVID-19 has encouraged doctors to work together internationally, which will be a good thing for sexual health too.

Summary

Findings offer some insight into the four key elements the SHIFT project is seeking to improve: access, knowledge and awareness, and destigmatising. While many points are true for the general over 45 population, emphasis changes for those who face the intersection of age and another social identity such as race, class and gender which may put them at a socioeconomic disadvantage. Overall, it is evident that a range of sexual health services and messaging are required to reflect the heterogeneity and personal preferences of the over 45 population and encourage engagement in services and improve their sexual health and wellbeing.

Access

- Practical barriers to services include cost, inconvenient locations and limited appointment length and availability.
- Accessibility could be improved with increased signposting of services, and outreach into communities.
- A range of locations with both formal and informal environments would encourage over 45s to visit services.

Stigma

- Social stigma is the most commonly cited, especially among BAME participants. This is followed by self-stigma, with feelings of embarrassment and shame, and stigma among healthcare professionals.
- Stigma remains one of the biggest barriers to engagement in sexual health services and information.
- Involving community leaders in sexual health interventions is essential to overcome cultural taboos.
- Sexual health messaging should focus on inclusivity and breaking stereotypes.

Knowledge

- There is a significant lack of knowledge amongst participants, notably symptoms of poor sexual health, and knowledge about where services are and what provision is available.
- Healthcare professionals should more training to allow them to comfortably talk to over 45s about sexual health, and enable them to consider the particular experiences and circumstance of their patient.

Awareness

- Limited awareness about risks to sexual health may prevent help-seeking, and the practice of safe sex.
- Awareness is improved among cultures that openly discuss the subject of sexual health, and for those who have memories of the HIV/AIDS epidemic – particularly LGBTQ+ participants.
- It is important to educate over 45s about how sexual health and associated risks may vary according to social identity, for example ethnicity, sexual orientation, age and gender.
- COVID-19 has led some to become more aware of their own health, including sexual health.

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