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

November 2020

Contents

Key discussion points

- Participants do not feel at risk of poor sexual health and they are unsure why there is a need to visit a sexual health service.
- GPs/doctors are the provider of choice.
- Tailored services should address the "social circumstances" of service users, to accommodate religious belief, sexual orientation, ethnicity and marital status, among many other characteristics.
- 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.
- 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.

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 qualitative data collection, which took place via individual interviews and focus groups from February to November 2020. This will build insight into the needs, awareness and attitudes towards sexual health and wellbeing among 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 February to November 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, Flemish 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 first group – **the general over 45 population**.

Participant characteristics

A total of 26 individual interviews and one focus group, consisting of four participants, were carried out with the general over 45 population in The Netherlands, Belgium and UK from February to November 2020. The 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	26	4	30
Location			
UK	12	-	12
Belgium	4	4	8
Netherlands	10	-	10
Age			
45- 54	15	2	17
55-64	6	1	7
65-74	5	-	5
Not reported	-	1	1
Gender			
Female	15	2	17
Male	11	2	13

Sexual Orientation			
Heterosexual	15	-	15
Homosexual	3	-	3
Bisexual	2	-	2
Not reported	6	4	10
Marital Status			
Single	6	-	6
Steady partner	6	2	8
Casual partners	2	-	2
Married	3	-	3
Divorced	2	1	3
Separated	1	-	1
Not reported	3	1	4
Employment			
Unemployed	1	-	1
Incapacity for work	2	2	4
Retired	4	-	4
Employed	19	2	21

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 wellbeing3) 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.

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:

"I don't think it's a secret that the menopause can cause problems for women - general ones like tiredness although that would obviously make you less inclined for sex, or hair loss which wouldn't affect it so much but more specifically sexual ones like pain when you're having sex, dryness of the vagina which I think is obviously a bit of a turn off for men and well as women."

"I don't think it's a secret that the menopause can cause problems for women"

Some respondents who are yet to experience the menopause, and its symptoms, talk with anxiety and apprehension about the experience:

"I hear from other people that you can have terrible night sweats, which really frightens me. because if you have a sexual partner for one night you are very conscious of what would happen if all of a sudden you would breakout in a sweat."

On the other hand, one interviewee expresses a positive to ageing in terms of female sexual health. They refer to a feeling of relief that contraception is no longer needed to avoid pregnancy:

"She was more relaxed about having sex … because she didn't have to … do anything about contraception."

"My ex-wife for instance felt a real sense of release when she was going through it she was more relaxed about having sex than she had ever been previously because she didn't have to take the pill or do anything about contraception."

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:

"As for men: They don't get… what's the nice word for when they don't get hard-on anymore?"

"Well as a man your performance is important to you. And if you can't perform anymore well, that will be a bit of an issue."

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:

"If I would have a different body that works as it should things would definitely be different. You know if I wouldn't have sore arms, sore legs. I would probably celebrate every day that we can have a great time with each other."

Psychological changes

Interviewees describe both positive and negative changes to how they think about sexual health, wellbeing and relationships as they age. Positive aspects include a sense of "letting-go", and "self-assurance" as they get older:

"You gain a certain peace, and more self-assurance. Part of the uncertainty is lost when you get older. Especially when you're in a relationship where you feel good, it becomes easier to talk about. Learning to feel good in your skin, that does happen."

"You gain a certain peace, and more self-assurance."

In contrast, the mentality of sexual health and ageing also has negative aspects. According to participants, ageing can lead to loneliness, due to loss of loved ones, and negative self-image, for example:

"…you lose the partner you've had for a long time. Clearly that is a negative effect…"

"The first thing I think of because it affects me personally is that you lose the partner you've had for a long time. Clearly that is a negative effect and it is all those things, physical, emotional and mental. Sex is the furthest thing from your mind at a time like that."

"It is quite depressing when you look in the mirror and you see this old man or, even worse, your father looking back at you."

Relationship needs and wants

Participants express that ageing can have a positive influence on relationship desires. For example, less focus is on the physical aspects of the relationship and more on the emotional needs:

"What gets more attention is the intimacy. Not so much the physical, but the emotional in fact, intimacy: the cosiness, being close to each other, holding on, hugging."

Sexual activity

Multiple interviewees refer to the negative effect ageing has on their sexual activity. They discuss the loss of libido, physical ability and sometimes feeling like "you can't be bothered":

"But both of you as you get older might find that you aren't up for it, if I can use that expression, as much as you used to be – loss of libido is the expression I think."

"I do acknowledge that physically I am less flexible. We're both ageing and we are both more easily tired in the evenings."

"Loss of libido is the expression I think"

In contrast, some participants express that ageing has have a positive influence on sexual activity. For example, their relationship has changed to become more intimate:

"So actually, by getting older, it certainly hasn't gone backwards. With me, it has actually improved. Because now I have a partner with whom I'm on the same wavelength. We both love to be intimate together, yes then you get more out of it."

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: your age, your insecurities about your body, the fact that you don't know somebody very well. And people around me say if you do get to know somebody a bit better then you can get rid of the condom and then the sex is a whole lot better as well."

Participants cite numerous reasons for why sexual health may not be a priority for them. A common reason is that using contraception is a "passion killer" in the "heat of the moment":

"You hear people talk about how they go out and take somebody home for a bit of boom boom boom, preferably unsafe, Because that's nice and easy. because as they say you're not taking a shower with your mac on."

"That's in the heat of the moment. During a relationship you would just stop practising safe sex. You do start out like a good boy using a condom and so on. But I hate these things. And when I have a one night stand I always make sure that I have a condom handy but it's not a priority for me."

Perception of at-risk sexual practices

One of the most prevalent themes amongst participants, is that they don't consider themselves at risk of poor sexual health due to having no risk of pregnancy, or perhaps being in a monogamous relationship. Some feel that "gay men" or "youngsters" are the only people at risk, while others state a general "lack of awareness" of the risks. For example:

"I imagine gay men might visit because they are more promiscuous and they run the risk of catching AIDS or HIV but I can't see why anybody else would need to go unless they developed some symptoms or something like that."

"Lack of awareness. It never crossed my mind to go and get tested until my friend suggested it would be a good idea and it never crossed my mind at all to start suggesting using condoms until she explained why."

"…you can't get pregnant anymore, so that's already not a risk…"

"In a committed relationship as well, that that you make love less safely, so that you trust more, yes, you can't get pregnant anymore, so that's already not a risk, so that's possible already; in my generation I think anyway, that remains a bit of the most important factor then regarding contraceptives and certainly condoms."

Perception of healthcare professionals and services

Multiple participants have a perception of healthcare professionals that prevents them from seeking help and advice to begin with. For example, the age and gender of GPs, or gynaecologists, may present as a barrier to some:

"Moreover, my GPs are very young. probably in his 30s. How can somebody in the 30s know where people in their 50s fail."

"Many gynaecologists are men and they do not have the insight into what it is to be a woman."

Others imagine services to be solely for diagnosing and treating STIs, or specifically for young adults, which prevents them visiting for other sexual health worries:

"I don't think many people would think to go along to a sexual health clinic, certainly not at my age, they would assume it's for contraception or abortion and things like that – for younger people is what I'm trying to say."

"I'd probably think that it was only for STI testing, although I think they do contraception as well, but mainly STI testing. I just envisage like a whole line of people standing outside the clinic waiting to be tested for any sexually transmitted diseases they might have."

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Personal attributes

Participants own personal attributes influence their feelings towards sexual health, and whether they seek support for it or not. While some did not wish to share a "weakness" by discussing sexual health issues, others described "stubbornness" or "risk" taking as reasons to not make sexual health a priority. For instance:

"I would be like well, I know what I'm doing. And I wouldn't be surprised if other people aged 50 and over are equally stubborn. Mind your own business."

"Not many people date to take such a step. You have to be assertive enough. You're exposing a weakness. Few people want to talk about weaknesses."

"I'm taking calculated risks."

Relationships with partner(s)

It is evident that for some participants, having partner(s) where they don't discuss sexual health can present a barrier to raising sexual health worries and concerns in general:

"And with someone I don't trust, I'll be very careful. Then I'll hold back. Then I know, this person doesn't need to know anything about me. Sometimes I'm a little too naïve, sometimes a little too open. I have to be careful what I say to who."

"I don't see that directly with a partner because I think that might be about things that you don't discuss so easily with your partner and that a partner can be barrier-raising there."

Sexual health decline accepted as a problem associated with old age

Multiple participants voice that negative changes to sexual health are "just part and parcel" of ageing. Therefore, they are less likely to seek help for any concerns, and may ignore them. For example:

"I think people of our age would be inclined to think that it is just something that happens and they need to find a way round whatever the issue is themselves."

"Well it's just you don't want to admit to yourself that you have it you're like well I can't have this you shouldn't have this and then you think well maybe this is just part and parcel to getting older."

"Maybe this is just part and parcel to getting older."

Deprioritising sexual health

Others explain that other aspects of their lives take priority over sexual health, such as work, children or money worries. For instance:

"So life and what happens to you along the way gets in the way of your sexual health and wellbeing. When you're young you don't imagine that anything would be more important than sexual gratification but that does change and quite quickly too once you have children."

"You know children worries, work worries, money worries. Everything begins to take priority over your sexual health."

Less commonly noted are reasons like "It is not a topic I think about very much", and "not everyone has a sex life". Therefore, sexual health is not a priority for these respondents.

Stigma

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

Social stigma is the most commonly reported, with participants worried about being judged by others. Not only for "using a sexual health clinic", which may be "linked to…infidelity", but also due to "a feeling that they shouldn't be having sex at their age", supporting false stereotypes that older people are asexual. While many participants believe that the "taboo"

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:

"They might be hesitant to go and say they want to talk about their sex lives because they might expect people not to take them seriously because older people aren't supposed to be having sex and they certainly aren't supposed to be wanting to enjoy it or have it with more than one person."

"Sex is something that we do not talk about. It's very secretive or it's very dirty…"

"Sex is for the young – it's hard to get away from that general attitude even though it is hypocritical. A worry that people might be disgusted that they were still sexually active."

"Sex is very similar to death, if you'll forgive me. Sex is something that we do not talk about. It's very secretive or it's very dirty, you know."

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:

"Well embarrassment, first and foremost. maybe they are ashamed of the fact that they 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 subject."

"Fear. In particular, if something maybe happened that wasn't OK, the fear that it would happen again. It remains very difficult for some people to talk about sexuality or sexual health."

"I know there could be some embarrassment, I mean me, at 67, going along to see my GP to say that I've got erection difficulties, I think I might worry that I wouldn't be taken seriously. It takes a lot for a man to admit that and to admit it to another man is even worse. "

Finally, some respondents discuss perceived stigma among healthcare professionals as a barrier to seeking sexual health support. Thoughts of being "laughed" at or "lectured" by healthcare professionals is one participant's concern, while another believes both sides would find it "embarrassing" to discuss sexual health:

"I think both sides would find it embarrassing talking about sex with an older person. It's something that most people don't talk about and don't even like to think about – I think a doctor or nurse, unless they were specially trained in this, would find it embarrassing discussing sex with somebody who is old enough to be their mother or father. "

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Service user lack of knowledge

The last psychological barrier that was discussed by participants was their own lack of knowledge about sexual health and sexuality, and why they would need to visit a healthcare professional about this subject in the first place. They explain how most of the knowledge they do have is limited to what they learnt at school:

"It is a target group that in terms of sex is really clueless. You find yourself making the same mistakes that you made when you were a teenager."

I think the knowledge, or yes what we know about it, is indeed limited to what we did or didn't learn in high school. That's what it comes down to in practice. But the story behind it, after high school, stops, in terms of information about sexuality, for us.

Others are unsure what services are provided by healthcare service with regard to sexual health:

"They would look for other issues you might have with regard to sexual health like my doctor did with me – actually I'm not sure that clinics offer all those facilities I think they're more limited to testing, treatment and prevention of diseases."

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) Past negative experiences 3) Practical barriers, and 4) Unsure where to go for advice or support. Below, each sub-theme is illustrated with example quotes.

Lack of tailored services

Some participants cite a lack of services tailored to their needs. For example, services may focus solely on young people, and not "differentiate" for older adults:

"Maybe it's to do with these people who are 45 and over that they think healthcare is not very accessible. But I don't think that healthcare organisations differentiate between age groups."

"I think now about raising awareness, that is almost always aimed at young people."

"I think now about raising awareness, that is almost always aimed at young people. So that you, I don't know, but I can't remember any campaigns lately around condom use or STIs, but that seems more like for young people."

"I think these clinics are geared to young …"

Other interviewees mention that limited gender-specific services present a barrier, especially for men:

"I think it's even harder as a man. Because as a woman, it is normal for you to see a gynaecologist. But to go to a urologist or a GP as a man with an erection problem, that's not so [easy]. I noticed that with my husband. He really had to overcome a barrier to go to the GP with his erection problem."

One participant explains that religious beliefs may need to be acknowledged in services:

"That does come with the moral dilemma of: what about the Bible belt? For every person who uses this service, there will be 50 saying: No, we don't want this because of the children and the church. So that's tricky. "

Past negative experiences of sexual healthcare

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 services. Many negative experiences relate to interactions with the provider. Respondents refer to experiences such as: healthcare professionals avoiding to raise the subject of sexual health, not being felt heard by the professional, experiences of discrimination and an inability to build a good patient-provider relationship. For instance:

"… a GP, who asked me about my sex partners and I told him it 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 STDs."

"A friend of mine had a GP who didn't even want to talk about STDs."

"I hate to say it but it's a double standard society. There is the hetero side, and the LBGT side, and there are different standards for us. For example, if I say that I'm married to my wife people [at the hospital] will often say 'oh, so you guys have a gay marriage'. And I always correct them saying no what I have is a marriage…"

"There have been times when I haven't felt heard and partly because of that I've had it for so long. The GP tried something and it helped temporarily. My gynaecologist didn't listen to me much at the time."

"He [GP] was a bit authoritarian. And I just didn't have the right click with him. To talk about such a matter."

Other negative experiences relate to past sexual health issues which weren't resolved. For example, a "misdiagnosis" or a treatment which "didn't work". One participant explains that after an "internal examination by a male gynaecologist" as a child, they have "developed a phobia" of visiting health professionals regarding sexual health, which still affects them today.

Focus group respondents also refer to previous negative experiences of sexual health provision. In this case it is in reference to the broken trust between them and the healthcare professional:

"Pff… had a very negative experience. I had a female GP, that I confided in, as you should. You tell her about things in the area of sexuality and you assume that's said in confidence. But then you later hear through someone else that it got out and that was the last straw."

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. Some participants discuss the cost of transport, consultations and medication as a barrier to care. For example:

"So I went to Turnhout, in Belgium for a, second opinion. But that's not reimbursed so you have pay a lot of money every time you go there for a consultation."

Other interviewees discuss how the short duration of appointments makes it difficult to raise the subject of sexual health:

"They need to make time for you. 10 minutes is not enough. If I need to go see my gynaecologist I have to schedule a triple appointment- it's impossible to come in and say

what you have to say within 10 minutes. … I think people are perfectly entitled to more time so that these examinations can take place nice and calmly."

Unsure where to go for advice or support

One of the most commonly cited service barriers is that respondents are "unsure" where to go for advice and information about sexual health, and what services are available for "people of my age":

"I don't really know what the sexual health service does for people of my age."

"I don't really have a clear picture of that, to be honest. Apart from the fact that you know that you can go to a urologist or sexual therapist or whatever. No, I can't say."

"I really wouldn't know where to go to."

"I don't live in Amsterdam or Rotterdam or any big city. So it will be different in my own area in a small municipality I really wouldn't know where to go to."

One focus group participant indicates that accessing advice or support for sexual health can be especially difficult for "people who are not educated, are trained or digitally proficient".

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 three sub-themes: 1) Perceived importance of sexual health on wider wellbeing, 2) Relationship(s), and 3) Sexual health worries.

Perceived importance of sexual health on wider wellbeing

One participant describes how sex can benefit mental wellbeing, and "make you feel better about yourself". Another talks about how sex lives have an impact on many things, which influence wellbeing:

"It amazes me that we don't talk about these things because it even has an economic impact: all these women divorcing which has a huge impact on the property market. all these houses they cost upwards from 300,000 euro's and I can't find myself a proper place to live. This means that our sex life has a huge impact on many things. So I think it's so important to talk about these things even when you're still together."

Relationship(s)

Relationships with child(ren), partner(s) and friend(s) appear for many participants to facilitate discussions around sexual health and encourage some to seek help and advice. For example:

"I have two adolescents living here, and we are very open in our discussions about sexuality - the boys too."

"She was really good and understanding and she suggested I should go and talk to the doctor about it."

"Well, one thing about this new relationship is that we talk – we talk about everything and I told her how I felt and she was really good and understanding and she suggested I should go and talk to the doctor about it."

"I have [female] friends with whom I am very close … they support me in that."

Relationships were the subject of a large part of the focus groups, with respondents referring to the benefit of "communication" between partners when resolving issues related to sexual health and wellbeing.

Sexual health worries

Worries about STIs, pregnancy and other sexual health issues such as erectile dysfunction are frequently described as a trigger for why over 45s may visit sexual healthcare providers, or be more conscious of practicing safe sex. For instance:

"If you mean am I running the risk of contracting an STI by sleeping with different men then yes, I am and, actually, I did contract an infection and went to a clinic about it. I looked the

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

"If they're anything like me they would only go if they were prompted to do so by something that had happened to them, you know, if they were having sexual problems of some sort or another."

"You do try to be mindful of your good health. I just had my first STD and I really am not looking for another one, thank you very much."

"I just had my first STD and I really am not looking for another one, thank you very much."

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

A range of characteristics of health messaging are suggested by participants to promote sexual health amongst their age group. Some even suggested their own messages:

"They need to say "hey, we're here for you, do you know what we do? No? Well, it's this, this and this. Get in touch" or something like that. And they need to add in "No judgement, no stigma" maybe not those exact words but something along those lines."

Others describe the type of imagery that could be used on resources such as making sure "older people are on posters", or display "a really positive image". They also encourage positivity from the language used:

"Yes, also, the positive [sides are discussed] or in a more cheerful way, not only about the complaints you have, but about experiencing sexuality in a positive way."

And that language is simple, without complex words, but also direct and open:

"Keep it simple and, and to the point, without using difficult words in fact."

Participants express the importance of messaging destigmatising and normalising sexual health – this also reinforces the fact that "stigma" was one of the most frequently reported barriers for our respondents. For example:

"For it to be just normal. That would help me tremendously."

"In Britain we have a very juvenile attitude to sex, it is something to snigger about and hide away, particularly if it involves older people. That all needs to be changed."

Make them feel that they won't be judged. Why should they be judged anyway just because they're older but society pretends that sex doesn't happen in old age.

"For it to be just normal. That would help me tremendously."

While some participants encourage the differentiation of sexual health communications for young and old, others would prefer to be provided with the same service:

"For me personally it always works best if you do not differentiate…I find that very easy and it doesn't make a difference to me whatsoever what age they are. So you're not going to reach me via website for older gay men. I would rather visit a website for younger gay men."

A wide variety of methods to promote sexual health are suggested; one participant said they "couldn't think of anywhere where you *couldn't* 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:

"We get little posters or leaflets about clinics and getting checked out for infections and staying safe, to put in the salon."

"You could give them a leaflet, but will they read it? So maybe you should make use of community centres, organize small-scale meetings."

"What would really work for me is a lovely poster in a bus shelter."

"For example the loos in restaurants, because they go to restaurants rather than two bars."

"What would really work for me is a lovely poster in a bus shelter - the way H&M does."

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

"Through a TV campaign. Because I think many people in that age group still watch the telly."

"The press, radio, TV…that could be a trigger to take the step."

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

"It would be good if more attention is paid to this also via the medium of television. To pay some more specific attention to certain items for example in Nieuwsuur [news show] …And the more general topics can be addressed in, like I said, magazines and stuff. I think that would be a good idea."

While social media is perhaps cited less than expected, for some participants, it still offers the best method of communication. For others, websites, from reliable sources, or that signpost to specialist help. For example:

"I also think, yes if it is through social media or something, I'd like more general information that you have links and can, yes, see movies or information that you then read yourself."

"Definitely websites with plenty of hyperlinks that refer people to specialist aid... Put up an advert on Facebook, or whatever. Or on the gay websites."

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:

"You expect them [healthcare professionals] to give you a bit more comprehensive information."

"I think if there are multiple doctors in a practice that means that there is more knowledge available. And they have to share 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 if you make sure that those few healthcare professionals can start training somewhere or that the taboo is opened up... I'll tell my GP... I'd like it, if he knew a little more about other things."

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 overcome a major barrier. For example:

"Show us where you can go to for what particular problem. Then at least people have some idea and that will lower the threshold [barrier] I think."

"Tell them why they need it. It's no good keeping it all quiet and hoping people will find out for themselves. They need to say "hey, we're here for you, do you know what we do? No? Well, it's this, this and this. Get in touch" or something like that."

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Lastly, participants talk about the content they would like in the information shared with them. This includes physical aspects, such as risks associated with sex in their age group, changes experienced when people age and how to manage these, but also includes broader wellbeing, such as relationships and sexuality. Not only do participants appear suggestive of a holistic view of sexual health, but also believe this could help normalise and destigmatise sexual health as awareness is raise:

"But actually, sexual health is much more than just about, yeah, I guess STI testing and contraception. It's actually about the whole person, not just about physical relationships but also the emotional side of sexual relationships. That is also something that could be discussed, the whole holistic view of it rather than just contraception, STI's."

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:

"I have no detailed knowledge about that but I have the idea that generally speaking everything has been very well organised in the Netherlands. If you need help, there's always help. All you have to do is pick up your phone and there's help on the other end. In my case, anyway. Never had any trouble getting help, ever."

"They were really efficient and didn't make me feel embarrassed or anything like that."

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:

"I think it would be good if there were more practices in which different disciplines work 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:

"Speaking for me it shouldn't be a place where the 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 and biscuits."

"Since you are talking about something intimate you need to make sure that the setting is intimate as well."

"So in itself, especially if I think that about the theme 'menopause' or something, you know that women will come for that theme, then that is, yes, a safe environment."

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".

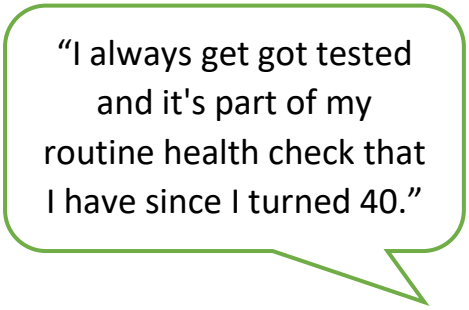
"Being able to tell your story, and that it is accepted as being your experience."

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:

"Being heard is really important. Being able to tell your story, and that it is accepted as being your experience. And that it's not minimized, you are not told it is 'not bad'."

While some participants believe the subject of sexual health should be raised by healthcare professionals: "I think they [healthcare professional] should proactively ask about these things more often", others believe that the patient should initiate the conversation: "I don't think they should bring it up unless you've indicated yourself that you're happy and willing to talk about these things."

A few participants suggest that making sexual health checks a part of routine health appointments would be a good way to address the topic. This could help normalise and encourage openness about the subject:



"I suppose, though, really it would be best coming from your doctor when you're there with him for anything really – whatever reason you've gone along, he or she could find a way to start a conversation about sexual health."

"I always get got tested and it's part of my routine health check that I have since I turned 40."

Other characteristics of provision recommended by interviewees include options for ongoing support:

"If necessary, they should be able to come a second time. And then it could be over the phone: I have another question. Yes, you have to answer that question. So that time, that further processing, is really important."

Opportunities to feedback their experiences to services would be useful for some:

"Afterwards, check with the organisers, whether it's the association or the service centre: look, have you heard any feedback from that? … So that you're actually doing an evaluation."

And also, opportunities to discuss sexual health with peers, such as "somebody my own age", or "in a similar situation". One participant suggests this could be an online forum:

"As I say, the online stuff that I found has been has been incredible because you're actually talking to people or lis-listening to people, more often or not, who have had exactly the same thing as you and you're hearing what they've gone through. What have they done about it."

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:

“Gender and also the age of your GP, but in general the relationship you have.”

Yes, so for me it's pretty easy with the GP. Maybe it's also because it's a woman and an older woman, yes older, I mean a little older than me. So then, suppose I were a man, it might already be harder with a female GP and my GP would have to be a man... so that might make a difference. Gender and also the age of your GP, but in general the relationship you have.”

GP or doctor is the most cited source of advice and support for sexual health by our participants. In fact, the word “doctor” was mentioned 109 times across the interview transcripts, and “GP” mentioned 252 times – much more than any other healthcare provider. Not only do participants refer to the “relationship” built with their GP/doctor, but also, they often “don’t know where to go”, so their doctor is an obvious choice, even if they are then referred elsewhere:

“I think I’d go to the doctor…I’d go there because he’s known me for years and I don’t think I’d be embarrassed and I don’t think he’d be embarrassed either.”

It should be noted that the role of GPs varies between countries. One participant points out “here in Holland we used to the GP having to give you a referral first.”, while in Belgium there are not dedicated sexual health services in the same way as UK or Netherlands, so this may influence where participants seek help.

Other locations for sexual health advice and support include “the internet”, pharmacies, “sexual health centres” or “clinics”, gynaecologists and independent organisations such as “Schorer”, “Roze [pink] help”, and “Metro”. For relationship problems, some participants suggest a “sex therapist” or “marriage guidance counsellor”. One focus group participant explains the support available in some work environments, for example in midwifery “you’re in an environment where all this is more able to be tailored about”.

Tailoring

The final service facilitator is tailoring provision for the needs of different sub-populations from the over 45 age group. 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. For example:

"I would think that the best way to reach people is by utilising their social circumstances."

"I would focus on the group who that's relevant for so like your divorcees."

"I think you should treat the different target groups differently. So you deal with people aged 45, 50 differently that people aged 70 plus."

"If you want to approach these people you need to do it with a good dose of respect for their religious beliefs. … here in the Netherlands they have been giving out information in multiple languages for years. And this is a must if you want to safeguard the health of the entire population. You should continue to do this however negatively certain political groups feel about this. I would think that the best way to reach people is by utilising their social circumstances."

"I think it is important in terms of sexual health, both for women and for men, that they can talk about it and that there are unambiguous places where you can go, such as that women's clinic."

Two participants describe the need for services and healthcare professionals to be sensitive to past trauma, for example:

"They are always sympathetic and also they know about my past. So they understand. This is the reason why I am still troubled by men…They have a particular technique that they work with and they deal with lots of different people who suffer from trauma. Not just people who have been abused, but also people who have lived in a war area, people who have seen dead people, like police officers, people who work on ambulances…"

Impact of COVID-19

The COVID-19 pandemic provided an unforeseen dimension to our qualitative research findings. It is clear that for some participants, the pandemic has changed their perspective on health and healthcare services, and also given them ideas for how sexual health could be communicated. Negative and positive aspects of the pandemic's influence on sexual health for over 45s are explored below.

Negative

Some of the negative aspects of the pandemic are that participants were unsure what sexual health provision is still available:

"I don't know whether you can go to the clinics either at the moment – maybe you'd have to do it online whilst we're under this virus."

Others describe how COVID-19 has impacted upon their sex life, for example changing the freedoms they have for finding partners, and impacting upon general wellbeing:

"I'm furloughed as you know and that has had an impact on my health altogether but also sexual health."

"Must say I hear many people around me say they have problems with this because of corona. People who want either a partner or sex."

Positive

For some interviewees, the pandemic has led them to pay more attention to their health, and be more open when discussing it, which has a positive affect on their sexual health too:

"I think that it's a positive outcome of this virus age that people are more open about things."

"I think that it's a positive outcome of this virus age that people are more open about things. In this day and age it's easy to talk about lots of different topics, so to your doctor and vice versa for the doctor it's also easier."

Also, participants appear to have ideas for sexual health communication, stemming from COVID-19 related health campaigns. For example, some participants mention they have found video-calls (in place of face-to-face meetings) for doctor appointments efficient and convenient, others suggest using similar health messaging:

"Some sort of information – I'm sure somebody could think up 3 catchy words like they've done for the Covid information ads".

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 example, while some participants want services tailored to their age, others don't want to be treated any differently from their younger counterparts. While some suggest healthcare professionals should initiate conversations about sexual health, others would prefer to raise the subject themselves. This demonstrates the personal nature of sexual health, and the heterogeneity of the over 45 population. Their perceptions and needs are shaped by their life experience, and their current circumstances such as the relationships they have with partner(s). Of course, this adds complexity to healthcare provision, but points to a necessity to incorporate versatility and diversity in sexual health services.

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