Report of the *Sexual Health in over ForTy-Fives* (SHIFT) EU Interreg 2Seas Project survey of needs, awareness and attitudes towards sexual health among adults over the age of 45 who experience socioeconomic disadvantage

July 2020

Table of Contents

1. Introduction

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.

The following report will summarise the findings of a survey developed to establish an insight into the needs, awareness and attitudes towards sexual health and wellbeing among adults over the age of 45 in the 2Seas region.

1.1. Research aims

An online survey was distributed across the 2Seas region in order to gather an insight into the needs, attitudes and awareness towards sexual health and wellbeing, and current gaps in service provision for adults over the age of 45.

2. Methodology

An online survey was developed using the Qualtrics platform, 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. The online survey was published in three languages: French, Dutch and English, relevant to each country involved in the study. This facilitated a consideration of both cultural nuances and different sexual health service provision across the 2Seas region. Questions were developed using the knowledge and expertise of diverse stakeholders, with substantial experience in sexual health care provision and as support organisations for sexual health needs (e.g., NHS Trusts, Metro Charity UK; SoaAids Netherlands). Due to the taboo nature of sexual health, the survey was pilot-tested with a small group of the target population to ensure the suitability of questions, and adjusted accordingly.

The survey ran from 6th November 2019 (The Netherlands/Belgium) and 3rd October 2019 (UK), and closed on 3rd April 2020 for all countries. Partners in the UK, Belgium, and The Netherlands used their direct access to the target population to identify and recruit a sample of participants over the age of 45, via platforms such as social media and leaflet distribution. A total of 777 participants responded to the survey: 223 from Belgium, 317 from The Netherlands, and 237 from the UK.

Responses were divided according to socioeconomic status. Indicators used to identify those that may be at disadvantage are: highest education level below primary (level 0, equated across countries using the European Qualification Framework) and/or financial worry, reported by participants as worrying "very often" or "somewhat often" about struggling to keep up with their bills.

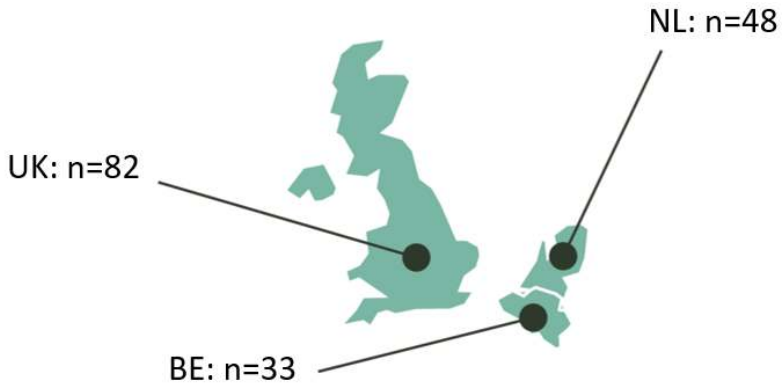
This paper reports on findings relevant to those that have been identified as **having potential socioeconomic disadvantage**.

3. Participant characteristics

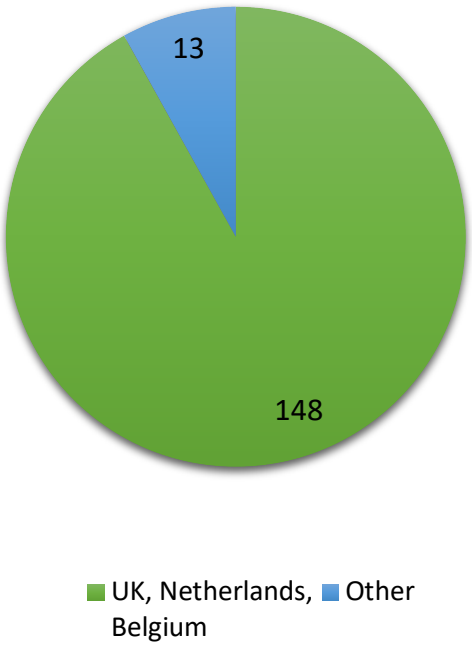
A total of 777 participants responded to the online survey. 163 respondents were identified as having low socioeconomic status. The findings from this population are reported below.

N= 163

Country of residence

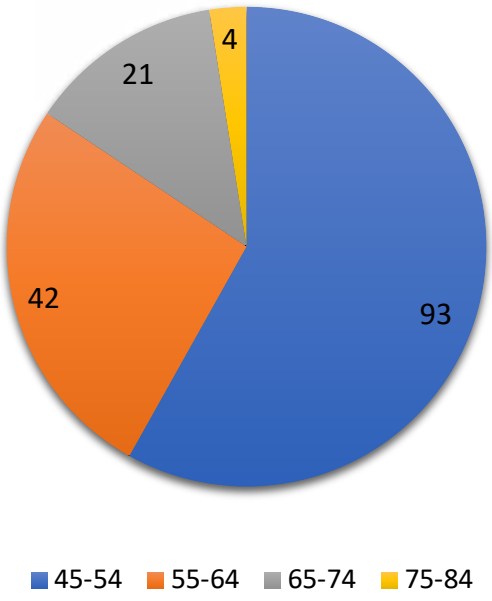


Country of birth

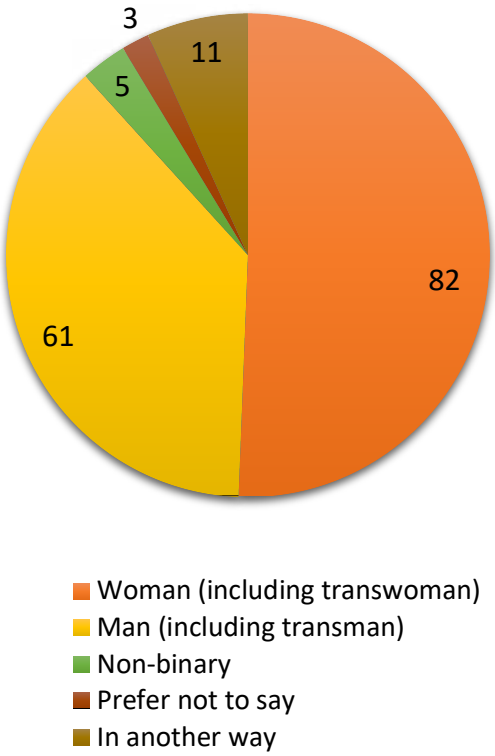


50% (n=82) of participants reside in the UK, while 29% (n=48) live in The Netherlands, and 20% (n=33) live in Belgium. Most participants were born within the UK, The Netherlands and Belgium (n=148, 92%). 8% (n=13) of respondents were born outside these regions, in countries such as Germany, Canada and Chile.

Age

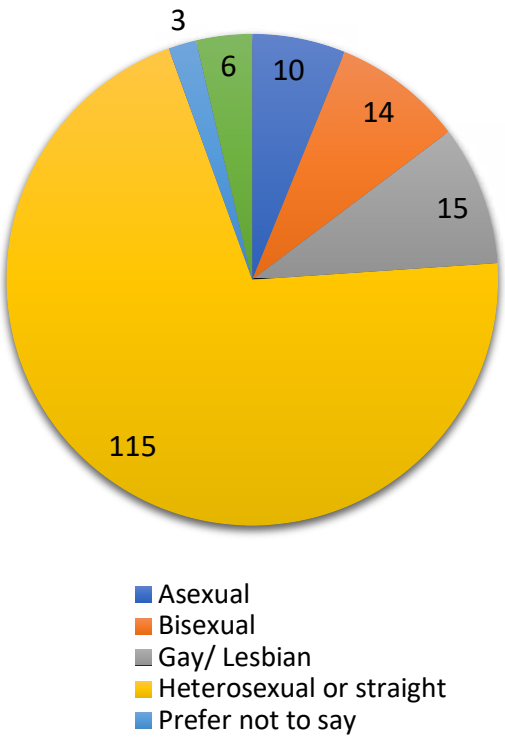


Gender

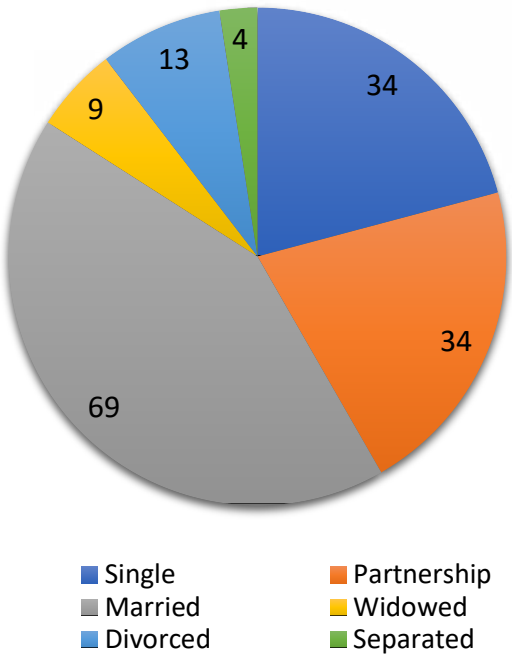


The mean age of participants was 55±9 years. Most participants were aged between 45 and 54 years, with 93 (58%) of respondents in this category. Only 3% of participants were over the age of 74. Half of respondents (n=82) identified as “woman (including transwoman)”. The 7% of participants selecting “in another way”, identified their gender as “man/male” or “woman/female” independently of transman or transwoman. One responded with “female, no gender”, and another as “normal”.

Sexual Orientation



Relationship status



115 (71%) of respondents were heterosexual or straight, while fewer participants were from LGBTQ+ groups. Regarding relationship status, "married" was the most common selection (n=69, 42%), followed by "partnership" (n=34, 21%) and "single" (n=34, 21%).

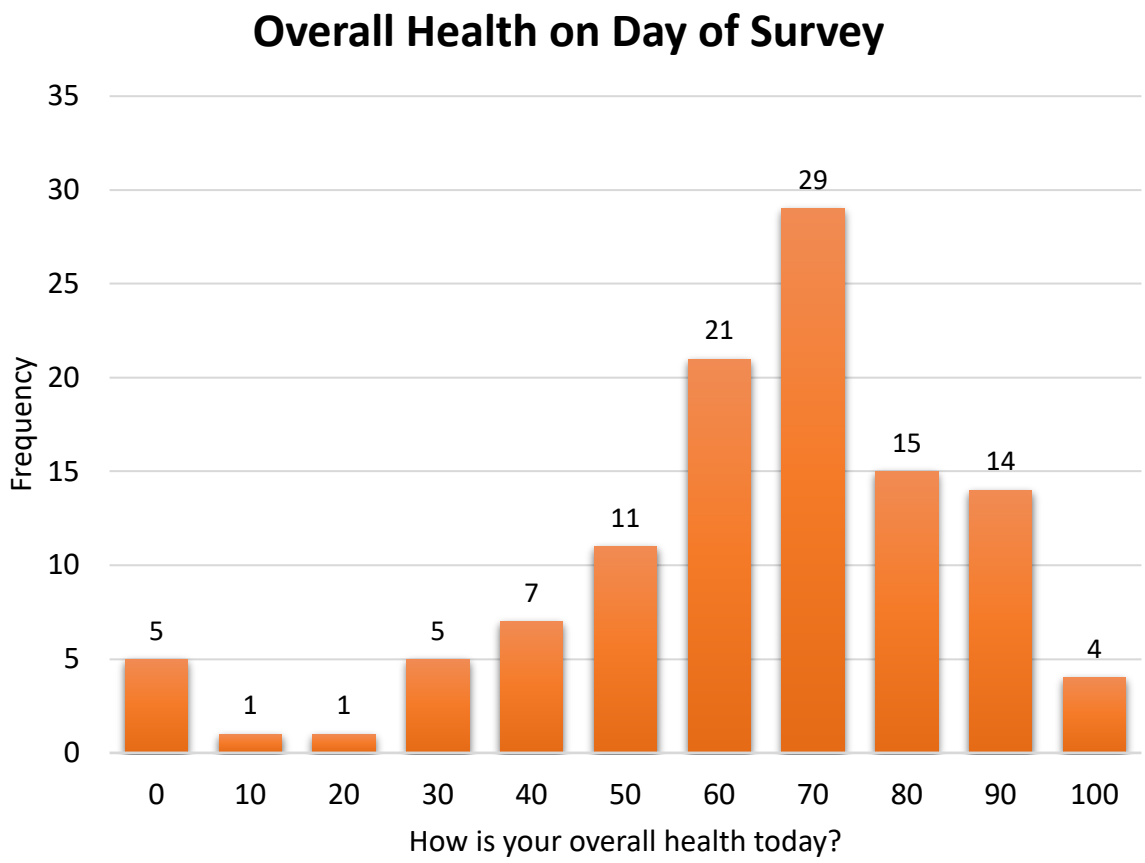
Health

Participant health was reported using dimensions of the EQ-5D-5L. Frequency of reported problems are displayed in the table below:

	Mobility n (%)	Self-care n (%)	Usual activities n (%)	Pain/ discomfort n (%)	Anxiety/ depression n (%)
No problems	73 (65)	92 (81)	70 (63)	42 (38)	46 (41)
Any problems*	40 (35)	21 (19)	42 (37)	70 (62)	66 (59)
Total	113 (100)	113 (100)	112 (100)	112 (100)	112 (100)

*Aggregated data for: slight problems, moderate problems, severe problems, extreme problems/ unable to do.

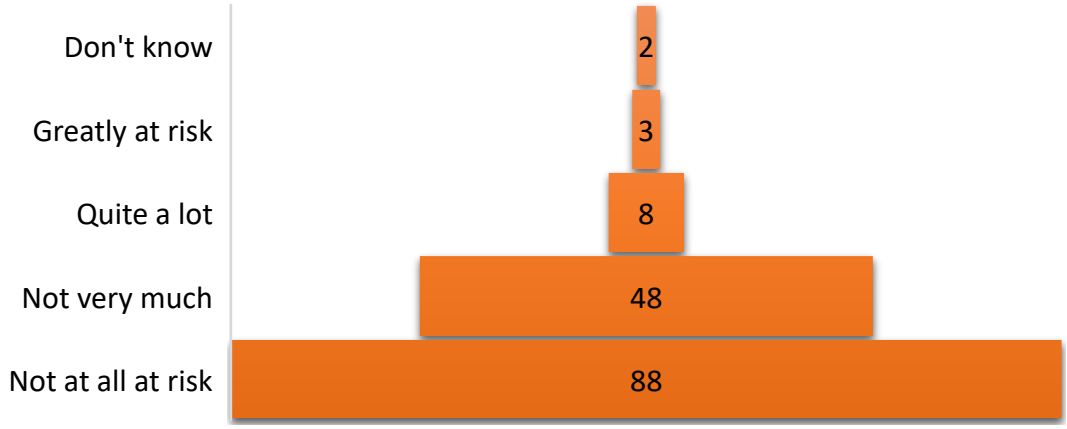
Participants were also asked to indicate their overall health on the day of survey completion using a 0-100 scale: 0 is “the worst health you can imagine” and 100 is “the best health you can imagine”. On average, respondents indicated their overall health on the day of survey completion as 63±23 out of 100.



4. Research findings

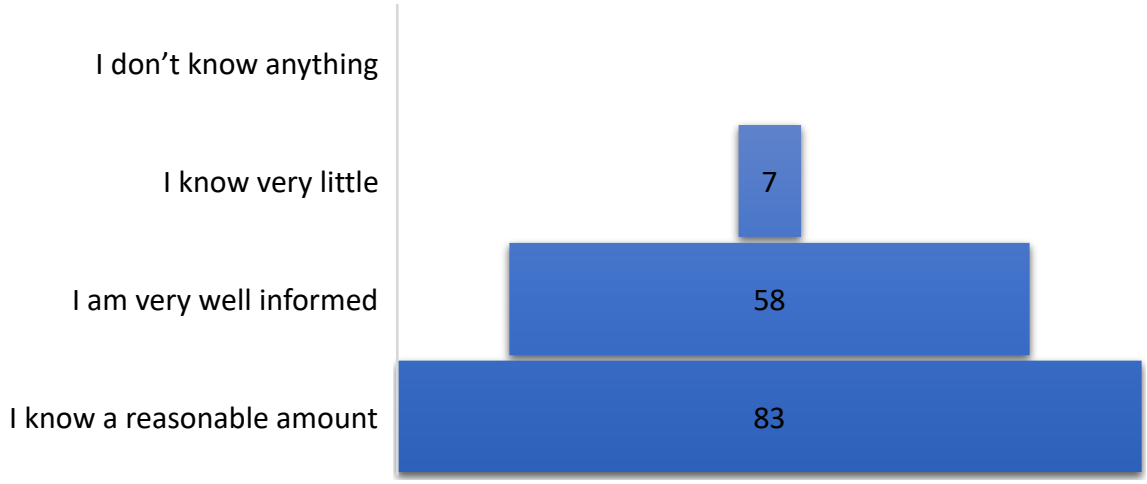
4.1. Perceived risk of contracting an STI (sexually transmitted infection)

Most participants express that their current sexual lifestyle leaves them “not at all at risk” (n=88, 59%), or “not very much at risk” (n=48, 32%) of contracting an STI, including HIV. Just 11 (7%) of participants believe they are “greatly” or “quite a lot” at risk.



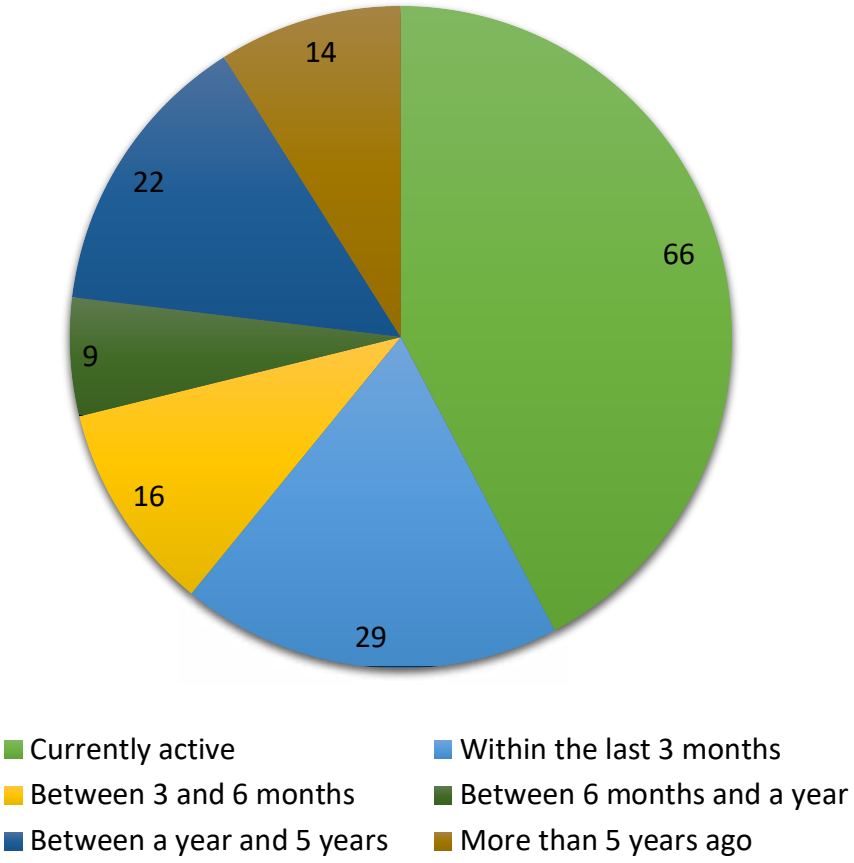
4.2. Knowledge and understanding

Respondents largely perceived their knowledge and understanding of sexual health and STIs to be good, with 56% (n=83) responding “I know a reasonable amount” and 39% (n=58) stating “I am very well informed”. On the other hand, no participants responded “I don’t know anything”, and just 7 (5%) expressed “I know very little” when it comes to knowledge and understanding of sexual health.



4.3. Practicing safe sex

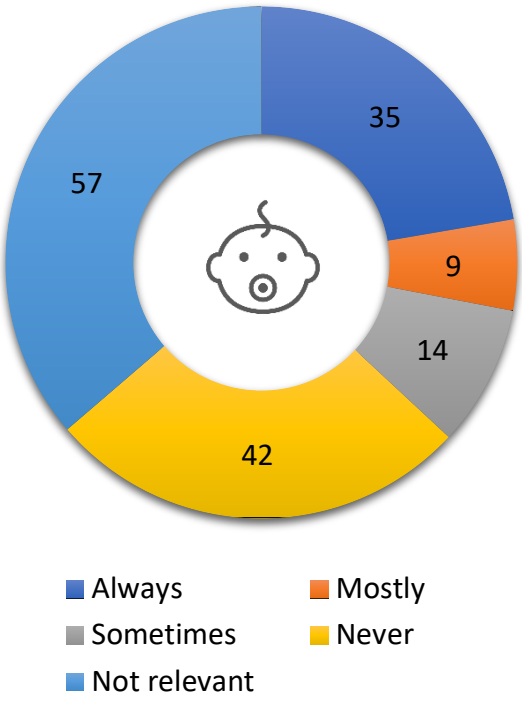
Last sexual activity



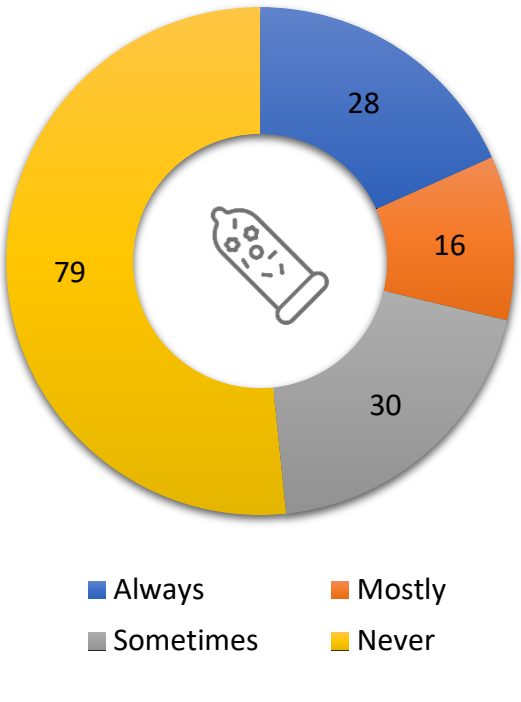
66 (42%) of respondents were “currently [sexually] active”, while 54 (35%) had been active with a partner(s) within the last year. Meanwhile, 14 participants (9%) were last sexually active “more than 5 years ago”.

Contraception use…

…to prevent unplanned pregnancy



…to prevent STIs



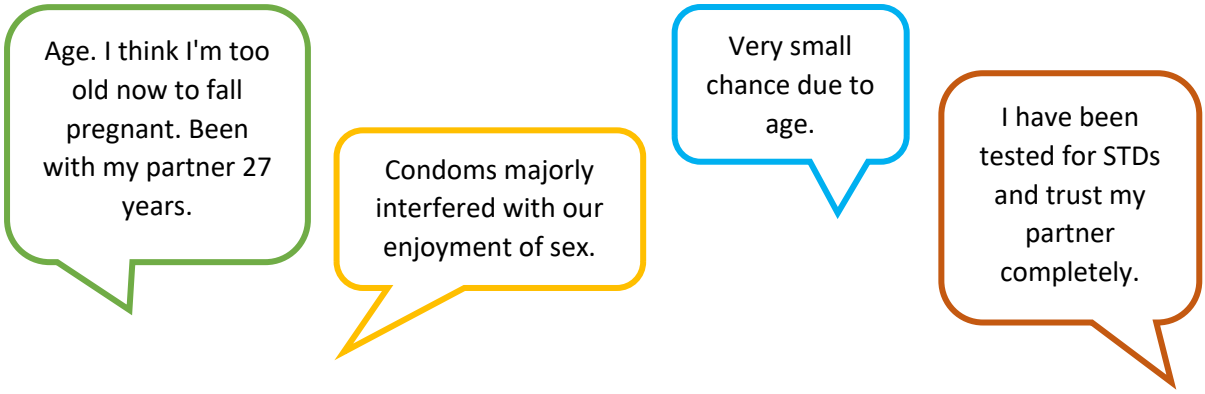
Most participants express that using contraception to prevent unplanned pregnancy is “not relevant” for them (n=57, 36%), or that contraception is “never” used for this reason (n=42, 27%). On the other hand, just over half of respondents (n=79, 52%) state that they “never” use contraception to prevent STIs, while 28 participants (18%) “always” use contraception for this reason.

Reasons contraception was not used

The two most common reasons for not using contraception to protect against STIs and unplanned pregnancy are “I am in a monogamous (exclusive to one) relationship” and “no risk of pregnancy”. The full list of possible responses is displayed below.

If you have been sexually active and did not take actions to prevent unplanned pregnancy or STIs, can you tell us why? (select all that apply)	Number of responses (%)
I am in a monogamous (exclusive to one) relationship	76 (32)
No risk of pregnancy	49 (21)
I have been sterilised/ had a hysterectomy/ been through the menopause and do not feel there is a risk	29 (12)
I don’t like condoms or contraceptives	25 (11)
Other	20 (8)
I am not at risk of contracting an STI	14 (6)
My partner(s) did not want me to use condoms	13 (6)
I am taking PrEP	4 (2)
Allergies	3 (1)
Condoms are too expensive	1 (0)
Embarrassment about discussing using condoms with partner	1 (0)
Condoms and/or contraceptives go against my beliefs	1 (0)
I don't know where to get condoms or contraceptives	0 (0)
Total responses	236 (100)

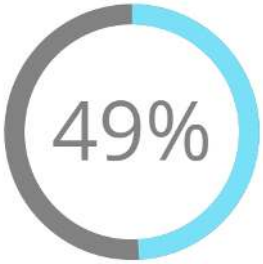
“Other” was selected by 20 participants, who explained their own reasons for not using contraception. Responses frequently comment on contraception interfering with the “enjoyment” of sex, or consider their risk of contracting an STI as low. Others cite age as the main reason they do not consider contraception necessary:



Testing, diagnosis and treatment for STIs

59 (46%) of participants have been tested for an STI at some point in their life, compared to 69 (54%) who have never been tested. Of respondents who had been tested, 29 (49%) have been diagnosed with an STI – similarly 29 participants had never been diagnosed with any STI. One participant selected "prefer not to say".

Have never been tested for an STI



Of those tested, have been diagnosed with an STI

The most common STI that had been treated by participants that had been tested was chlamydia (n=13, 21%), followed by hepatitis C (n=8, 13%). Two participants did not get treated for an STI after stating they had been diagnosed.

Have you ever been treated for any of the following STIs? (select all that apply)	Number of responses (%)
Chlamydia	13 (21)
Hepatitis C	8 (13)
Genital herpes	7 (11)
Pubic lice	7 (11)
Genital warts	6 (10)
Gonorrhoea	5 (8)
Scabies	4 (6)
Hepatitis B	3 (5)
HIV	3 (5)
Trichomonas vaginalis	3 (5)
I have never been treated for any STI	2 (3)
Molluscum contagiosum	1 (2)
Syphilis	1 (2)
Lymphogranuloma venereum	0 (0)
Mycoplasma genitalium	0 (0)
Total responses	63 (100)

4.4. Engagement with services

Awareness of sexual health services and STI testing locations

46%

are not aware of where their nearest sexual health service is located*

* Note that this figure only includes data collected from The Netherlands and UK.

In The Netherlands and UK, 54 (54%) of participants were aware of where their nearest sexual health service is located. Meanwhile, 46 (46%) were unaware. Across the 2Seas region, GP surgeries were found to be preferential for testing services, followed by sexual health services* and hospitals. Community based settings, including pharmacies, were less preferable. Four participants selected "other", suggesting locations such as gynaecologist and midwife.

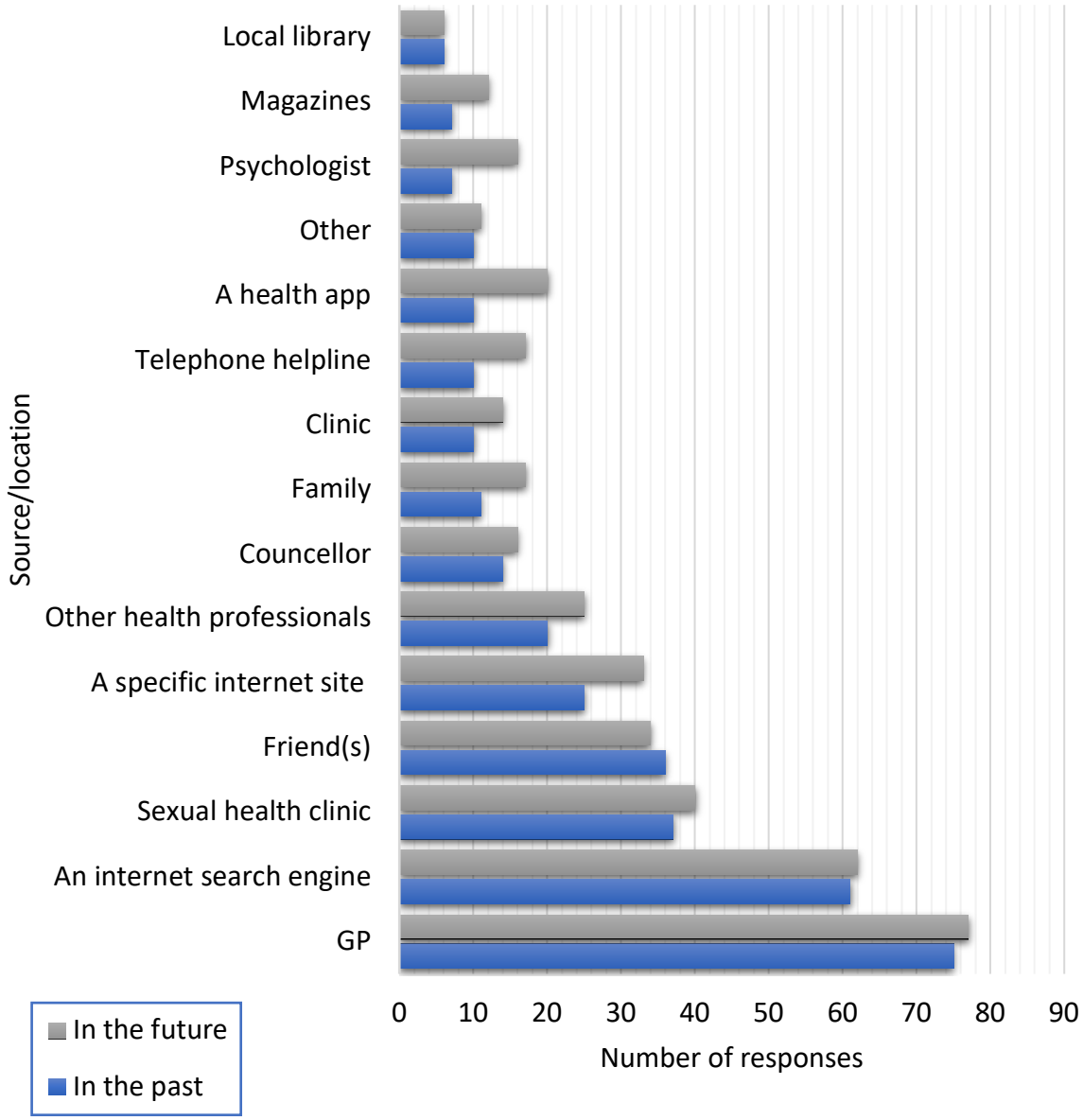
If you were in need of a STI or HIV test, would you get tested at the following places?	Number of responders selecting "yes" (%)
GP surgery	88 (26)
Sexual health clinic*	86 (25)
Hospital	63 (19)
Order home test kit online, results immediately available	32 (9)
Order home test kit online, results provided by text/phone	32 (9)
Pharmacy	15 (4)
Community setting (e.g. health fair)	11 (3)
Institute of Tropical Medicine Antwerp**	7 (2)
Other	4 (1)
Total responses	338 (100)

* this location was only an answer option in The Netherlands and UK surveys.

**this location was only an answer option in Belgium surveys.

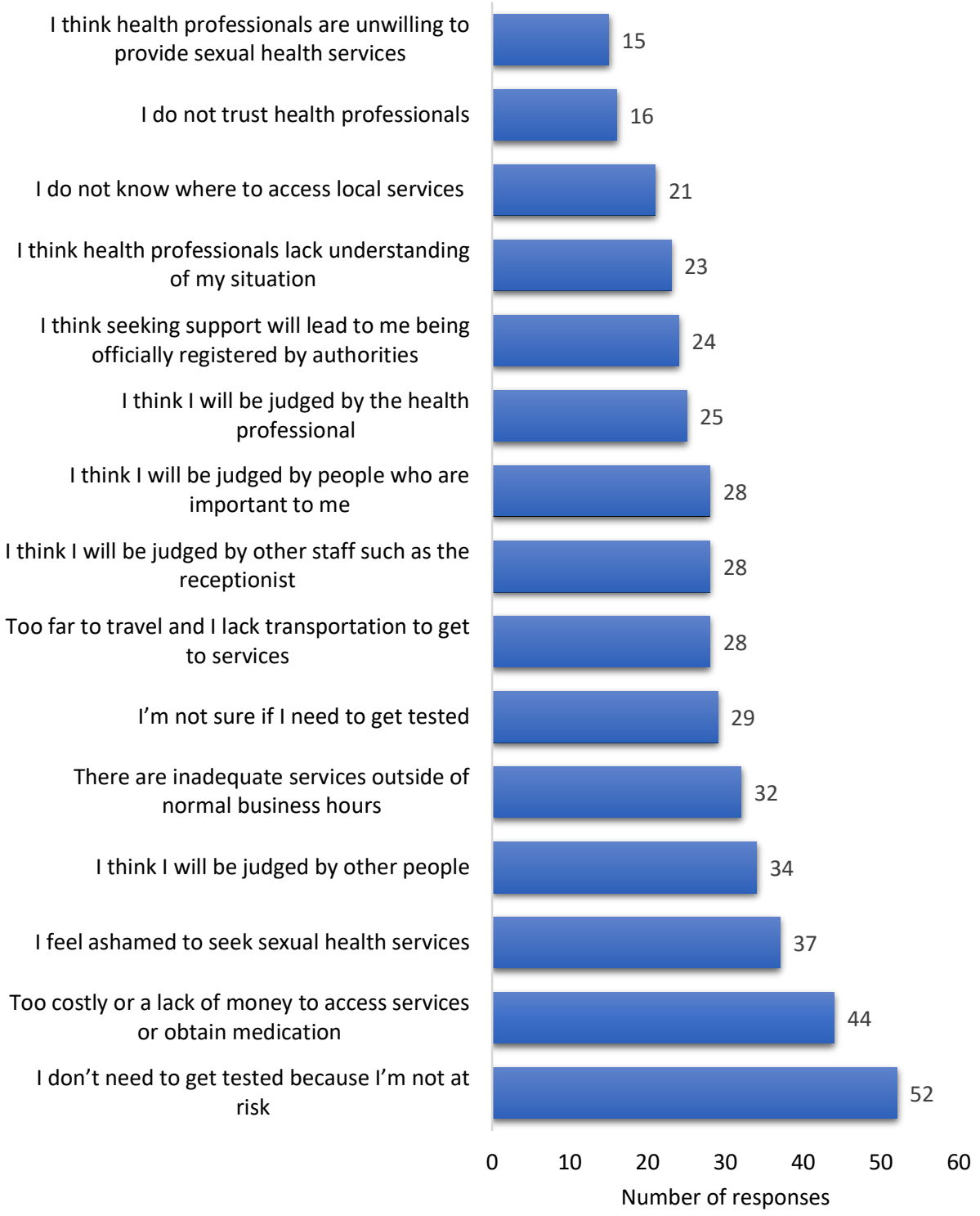
Seeking information and advice about sexual health

In the past, participants were most likely to seek information about sexual health from their GP, followed by an internet search engine, and sexual health clinic. These preferences change little when looking to the future: GP remains most favourable, followed by internet search engines, and sexual health clinic. Whilst preferences for most sources/locations are stronger when thinking about seeking future advice, “friend(s)” become less favourable in the future, than in the past.



Barriers to seeking assistance for sexual health from a health professional

Participants were asked what barriers would prevent them seeking assistance for sexual health from a health professional. The most common barrier to which participants answered "very true of me" or "somewhat true of me" was I don't need to get tested because I am not at risk", followed by "too costly or a lack of money to access services" and "I feel ashamed to seek sexual health services".



4.5. Communication

Comfort discussing sex and sexual health with partner(s)

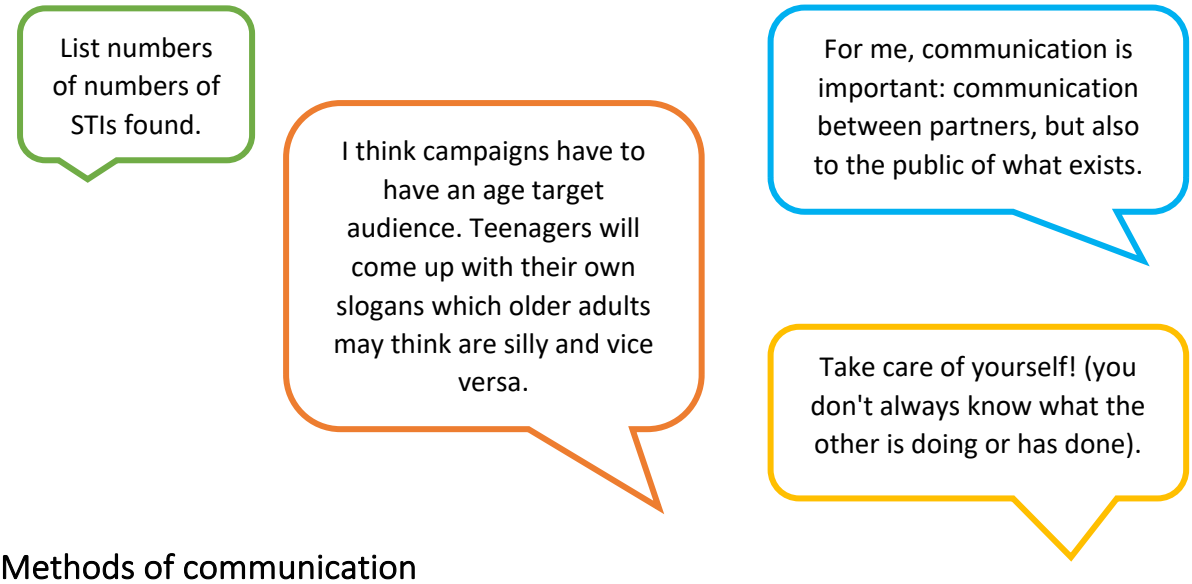
The majority of respondents were comfortable discussing sex and sexual health with their partner(s). On a scale of 0-10 (0 being completely uncomfortable, and 10 being completely comfortable), the mean score was 8.

Messages for encouraging good sexual health

Participants were given a selection of messages (listed in the table below) which could be used to encourage good sexual health (safer sex, and use of contraception for example). They selected those that they believe would be most effective. “STIs can affect you at any age” was the most popular message with 20% of responses, followed by “communication is key and it is best to be upfront with sexual partners”.

What message do you think would work best to encourage good sexual health? (select all that apply)	Number of responses (%)
STIs can affect you at any age.	64 (20)
Communication is key and it is best to be upfront with sexual partners	57 (18)
STIs can be present without symptoms	32 (10)
It’s not only younger people who need to think about practising safer sex	31 (10)
Even if you are past child-bearing age, safe is important because you can still get STIs	28 (9)
If you have other sexual concerns (e.g. erectile dysfunction, vaginal dryness, low libido) you can get support from sexual health services, but you still need to think about safe sex too.	28 (9)
Get checked regularly at free and confidential services, they see people of all ages	26 (8)
It’s important to get any STIs treated quickly, regardless of your age	26 (8)
Being prepared e.g. carrying condoms doesn’t mean you’re promiscuous: it’s just being sensible	23 (7)
I feel safer using condoms	4 (1)
Total responses	319 (100)

When encouraged to suggest their own messages, participants emphasise the importance of age-appropriate messages, communication and how stating facts and figures could prove effective:



Methods of communication

Participants were asked to select the communication methods they would find most effective for communicating about sexual health and local sexual health services. “Social media advertising” was most favourable, followed by “promotional materials in community settings” and “health professional raising subject during unrelated appointment”.

What do you think are the best ways to communicate about sexual health and local sexual health services? (select all that apply)	Number of responses (%)
Social media advertising (e.g. Facebook, twitter, Instagram	64 (20)
Promotional materials (e.g. posters/leaflets) in community settings e.g. libraries, GP surgeries, pharmacies, community centres	56 (18)
Health professional e.g. GP raising the subject during an unrelated appointment	43 (14)
Radio &/ Television – factual information e.g. news and documentaries	38 (12)
Public health/sexual health websites	36 (11)
Radio &/ Television – storylines in regular programmes (e.g. serial dramas, comedies)	25 (8)
Printed media e.g. newspapers and magazines	18 (6)
Online advertising on websites other than social media platforms	16 (5)
Email	11 (3)
Post	8 (3)
Total responses	315 (100)

What else could be done to encourage more people to access local sexual health services?

The concluding question of the survey was open ended to enable participants to share what else they thought would encourage more people over the age of 45 to access local sexual health services. There were 48 responses, some of which are shared below. Suggestions include ensuring sexual health campaigns are inclusive of minority and vulnerable groups:

ATTENTION to good representation of minorities (appearance, sexual orientation, etc.).

Emphasise to vulnerable groups and highlight the benefits (including free of charge and the reason for testing).

Broader publicity for groups who do not quickly find their way to them. So first, we need to figure out which groups they are.

Clear promotion and advertisement of services and campaigns is frequently mentioned as a necessity, as well as taking advantage of opportunities such as television advertising:

Advertise them in relevant places.

I don't watch them but soaps, programs like Love Island, Take Me Out - instead of advertising Nando's advertise safe sex, the script writers could do so much to get across public announcements, I think we are missing a trick.

More publicity of where to find local sexual health services, both through channels for citizens and for caregivers / welfare sector.

Another aspect mentioned by participants to encourage people to visit sexual health services is tackling feelings of shame, and emphasising/ ensuring the confidentiality of care provided:

Working within the NHS it's a very small community, it would be useful to know where to go for anonymity.

Combating fear constructed around this, and also among the care providers themselves.

Make it clear that there should be no shame because that is usually the biggest barrier.

The environment provided within sexual health services is expressed by respondents as essential to encourage people to attend, both in general, and when interacting with the healthcare professional:

Multiple participants point to the need for access to services to be improved, including in terms of cost, availability of appointments and physical access:

5. Summary

The overall summary is organised under four key SHIFT project targets: Awareness, Access, Knowledge, and Stigma.

Awareness: It is clear that increasing awareness is a key goal for any sexual health intervention model or programme with adults over-45. With respect to how to increase awareness social media advertising was highlighted as the communication methods they would find most effective for communicating about sexual health and local sexual health services. This was followed by "promotional materials in community settings" and "health professional raising subject during unrelated appointment". The number of respondents who stated that they were not at risk (n = 52) suggests that there might be a lack of awareness about potential sexual and wellbeing issues among a significant portion of the population with a socio-economic disadvantage. Awareness of where the local sexual health service was quite low with 46% participants stating that they did not know where it was. A low percentage (7%) of participants perceived themselves believed they were "greatly" or "quite a lot" at risk which could be positive but it could also possibly reflect a lack of awareness and knowledge of STIs and manner of transmission.

Knowledge: Participants reflected on messages that could be used to enhance knowledge and thus encourage good sexual health in over 45s and reported that it "STIs can affect you at any age" was a cardinal message along with "communication is key and it is best to be upfront with sexual partners". Just under half of the respondents had been tested for an STI in the past whereas over half had not suggesting that there is some way to go to increase knowledge about STIs in socio-economic disadvantaged populations.

Stigma: Shame was highlighted as the 'biggest barrier' in a qualitative comment. Moreover, 37 participants selected shame as a key concern for them. It was clear from the numbers reporting fear of being judged by important others who know them (n=28) and by health professionals (n=25) that stigma remains a crucial barrier to address in any sexual health promotion intervention.

Access: Increasing access to sexual health materials and services is critical and is a consistent theme throughout the survey responses. 21 participants reported that they were not even aware of where their local sexual health service was and if there was one. Another barrier expressed by participants as a barrier to seeking assistance from sexual health is cost of transport of education (n=44). One participant acknowledged public transportation to services as a potential barrier particularly from rural areas. Similarly, the availability of appointments may also limit attendance.