wŜLJ2ℕJŰ 2₮ ŰfKŜ Sexual Health in over ForTy-Fives ó{ I LC¢ú 9 ¦ LyűŜℕJℕJŜƎ н{ŜI-ă wŜƎƛ2y′ tℕJ2ƨŜŎűY ¢fKŜ . I-ℕJℕJƛŜℕJă I-yŘ CI-ŎƛfƛűI-ű2ℕJă 2₮ {ŜËdzI-f I ŜI-fűK I-yŘ ² ŜftōŜƛyƎ ₮2ℕJ hØŜℕJ пpă ² K2 CI-ŎŜ hyŜ 2ℕJ a2ℕJŜ {2Ŏƛ2ŜŎ2y2Yˇ ƛŎ 5ƛăI-ŘØI-yűI-ƎŜφ

Qualitative Findings

February 2021

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

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

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

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

"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."

"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."

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.

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:

"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

"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

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".

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

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

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 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."

"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

“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

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" –

Impact of COVID-19

The COVID-19 pandemic provided an unforeseen dimension to our qualitative research findings. For some participants, the crisis has provided

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.

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