Report *Sexual Health in over ForTy-Fives* (SHIFT) EU Interreg 2Seas Region Project: Training needs of health and social care professionals

Qualitative report

September 2021

Contents

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 November 2020 to February 2021. This report will focus on the *training needs* identified by health and social care practitioners to address sexual health and wellbeing among adults over the age of 45 in the 2Seas region.

Methodology

Semi-structured interviews and focus groups took place from November 2020 to February 2021 to identify knowledge, skills and attitudes and training needs of health and social care professionals regarding the sexual health and wellbeing of people over the age of 45.

UK participants were recruited via East Sussex County Council and Kent Community Health NHS Foundation Trust. Belgian participants were recruited via networks of the AP and Odisee University Colleges.

Detailed demographic information on participant professional role, age and gender was not collected for all focus groups, therefore these characteristics were not used in the analysis.

A script and question guide for the focus groups were developed with the combined knowledge and expertise of all SHIFT partners, and considered the needs identified by over 45s themselves published in two reports (SHIFT July and November 2020).

The interviews and focus groups took place in the native language of each partner country; Dutch and English. Following the continuing health regulations due to the COVID-19 pandemic, all interviews and focus groups took place using virtual meeting software. Transcripts were analysed in the language in which they were conducted. Each transcript was independently analysed by two researchers (each researcher analysed 6/9 transcripts) following steps 1 to 3 of Braun and Clarke's (2006) six-step thematic analysis: 1) Familiarisation of Data, 2) Generating Initial Codes, 3) Searching for Themes. The final three steps were undertaken collectively by the three researchers: 4) Reviewing Themes, 5) Defining and Naming Themes, and 6) Producing the report. The process was aided using the Delve software program (Limpaecher & Ho, 2018) and frequent meetings among the research team allowed reflection and deeper engagement with the data (Nowell et al., 2017).

Focus group characteristics

A total of 9 focus groups were conducted with professionals from a wide range of health and social care professions.

Table 1: Demographic Characteristics of participants

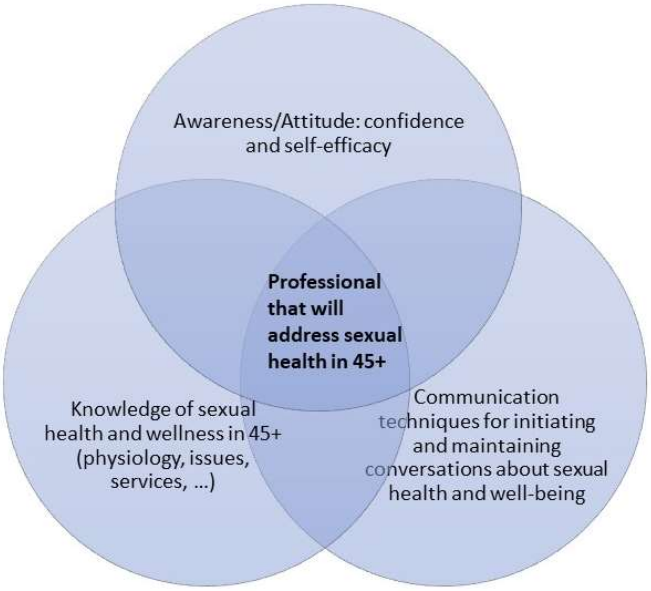
	Belgium	**UK**	**Total**
Number of focus groups	2	7	9
Number of participants	7	22	29
Profession (number of participants)			
	Belgium	**UK**	
Social care	**1**	**8**	**9**
Social worker		4	4
other	1	4	5
Health care	**6**	**14**	**20**
Medical health professional	2	2	4
Allied health professional	3	11	14
Mental health professional	1	1	2

Research Findings

Five over-arching themes were identified regarding training needs:

1) Attitude/awareness/confidence and self-efficacy needs
    a) Attitude
    b) Awareness
    c) Confidence and self-efficacy
2) Knowledge
3) Communication
    a) Communication and self-efficacy
4) (Limits of) the professional role
5) Form and delivery of training

Note on the themes



While five themes were identified, it is clear that for health and social care professionals to address sexual health and wellbeing in the 45+ group, there is an interaction and overlap between the first three themes; Attitude/awareness/confidence and self-efficacy needs, Knowledge and Communication (see figure above). Through the discussions in the focus groups it was clear that for instance, feeling confident was related to having enough knowledge about sexual health in the 45+. Another overlap was in confidence in one's communication techniques. Despite these linkages, as further explored in the *discussion*, each theme is distinct and merits its own analysis.

Awareness/Attitude: confidence and self-efficacy

These concepts are difficult to separate in the focus group discussion and analysis. When codes were reviewed, they frequently overlapped. If health and social care professionals (HSCP) are unaware that sexual health is relevant for over 45's, they are unlikely to identify or act on issues raised by clients. Furthermore, they are less likely to demonstrate an open attitude or feel confident addressing sexual health needs in this group. However, these are separate constructs and need to be addressed in the training offered to HSCP. In the subsections below we attempt to discuss the constructs individually using quotes for illustration.

Awareness:

The normalising of sexual health and wellbeing as a relevant issue for the 45+ population was raised. This was sometimes related to the HSCP's own age and life experiences when participants noted that HSCP themselves were often over 45 and therefore realised sexual health and wellbeing were relevant but had to confront their own beliefs and perspectives, accepting that clients may make decisions they themselves would not.

…but actually in our own service and our own staff, it would be really interesting to survey our own staff to see how many staff are accessing sexual health services honestly. Because if you're not accessing it yourself you're not really going to promote it to the patients or parents that you see… So I think the education starts with the people that are going in patients homes. (allied health professional, UK)

Furthermore, as further discussed in *knowledge* below, HSCP might not be mindful of the needs of a diverse population, be that LGBTI+ or different class or cultural backgrounds. Being aware of the needs of (specific) populations alone is insufficient, HSCP need to be conscious of their own stereotypes and judgements about sexuality and sexual activities. The quote below shows insight into the respondent's own challenges and implicit stereotypes about class (in this case) but not all professionals are so self-aware.

I think it just depends on the client … to be honest, um. I think if you've got an older lady, um, I don't know, that's kind of from a maybe more of a privileged background, I think you would, you would baulk at asking those questions because you think, oh, I can't say that to her. But I think I feel much more comfortable if the person was from a, you know, a much more working class, rough and ready background, I wouldn't have a problem then. I think it's just my problem. I struggle to ask those people. (other social care professional, UK)

Attitude: confidence and comfort addressing sexual health with 45+

Attitude towards sexual health and wellbeing in the over 45 population is related to *awareness* of the issue and confidence addressing it. Participant confidence and comfort addressing the sexual health needs of 45+ varied with job description and experience. The sample size and research design are insufficient to draw conclusions, the level of comfort and confidence expressed by participants was variable, ranging from high levels of discomfort and lack of confidence to seeing sexual health as part of the participants roles and responsibilities. Participants did identify the age and social position of over 45's as a particular obstacle.

*I just thought, well I am not going to ask some of the older people coming in [*if they would like a chlamydia screening*] … there was no way I was going to say to someone in their 40s, 50s, 60s would you like it?* (other social care professional, UK)

In the focus group that was the source of the above quote, HSCP discussed feeling intrusive and 'nosy' asking over 45s about sexual health. This was exacerbated if the client came from a background different to their own and perceived of as being more closed to discussing sex and sexual health (Muslim, Asian, etc), was of a different gender or class than the HSCP.

*Generally speaking, it's very, very difficult for me to start a conversation with a gentleman of any age, especially those – I would bring it down to 30-35. It is incredibly difficult. It is almost as if I'm making assumptions, being rude, yeah. But that may well be part and parcel of living in X and growing up here. (*medical professional, UK*)*

This indicates a need for training around common cultural stereotypes and acknowledgement (awareness) of them.

Participants reported that non-judgemental attitudes can be trained (see *communication*). This can be achieved by addressing taboos and common myths about sexual health, asking HSCP to reflect on their own stereotypes and preconceptions about sexual health, especially around STIs and HIV. These stereotypes and beliefs include awareness (see *awareness)* that sexual health is relevant for the over 45 population.

Different groups of HSCP identified the need to provide holistic care but acknowledged that sexual health is not always included. This will be addressed further in *professional role*; however, participants identified that training should counter the notion that it is intrusive to ask 45+ about sexual health, sexual orientation etc., rather these questions form part of a holistic approach to health and wellbeing. As the client may already be feeling shame or embarrassment, it is up to the HSCP to put them at ease. [see *communication* and *professional role*]

Yeah, I think to really open up to someone if they are going to be open about all their lifestyle, and everything, everything needs to be put there that they can feel comfortable about mentioning, because otherwise you're dealing with all so much percent of what they're trying to conquer and you're not seeing the real issue of the real. For some people it might be the same as we've been going, but for other people they might think thank goodness for that I can mention so and, or that relates to something else. (other social care professional, UK)

Though signposting is also discussed in the subsections on *knowledge*, *communication* and *professional* role; participants also identified that to be able to signpost, HSCP need to be aware of sexual health, believing it to be important and relevant (attitude) and having the confidence to address it. Signposting is thus a topic that cut across categories.

…so if we are going to signpost to sexual health services surely it should be something that's brought up and we know a bit more about, because like you say, it is lifestyle, it's part of our lives, or you know, it's something perhaps is hindering some body's wellbeing, and you know, and we want to make sure that they understand that there, although we're not experts on it, we can guide them... (other social care professional, UK)

Building trust and creating a respectful relationship with clients was also identified as an important skill that is underpinned by having an open attitude and the confidence to address issues around sexual health. Broaching the topic of sexual health for HSCP that do not primarily work in the area was seen as daunting and a question of having the confidence to do so.

En niet zozeer vanuit die preventieve blik van hoe gaat het met u, en hoe gaat het fysiek. Maar ook, hoe is uw seksuele beleving. Dat is volgens mij een minder evidente vraag om te stellen. (medical professional, B)

> *And not so much from that preventive view of how are you doing, and how are you doing physically. But also, how is your sexual experience. I think that's a less obvious question to ask.*

Confidence and self-efficacy were identified as lacking by most participants who did not work specifically in sexual health. This was divided into two parts, firstly, the *communication* skills and confidence to ask questions, and secondly the *knowledge* to be able to answer. [knowledge]. Not knowing how to answer questions was identified as an obstacle to raising the topic.

However, one participant suggested that HSCP could identify what skills and strategies they already had that could be transferred from one situation to another. This participant, who had little experience in sexual health, suggested that they could apply the same techniques used when confronted by other issues to address sexual health.

Participant: I think it's what we do … we say, "well actually let me go away and find out more for you"…

Facilitator: So you've got techniques already in place for other issues, so you could always employ those.

Participant: yeah…We could always go away and find out more, with one of our colleagues. (other social care professional, UK)

Knowledge needed to address sexual health with 45+

Primarily participants indicate that in order to discuss sexual health, they need basic general knowledge regarding sexual health and ageing, even for those who are medically trained. They particularly identified a need for a refresher course of physiological changes during e.g menopause and its consequences in women as well as for knowledge regarding normal sexual health, intimacy and relationships in various stages of life for women and men.

Nee, dat is een fysiologische gebeurtenis waar je weinig kennis over hebt omdat dat in de opleiding verpleegkunde niet aan bod komt. Ik heb nooit geleerd over de menopauze, wat dat teweegbrengt en welke invloed dat zou kunnen hebben op de seksualiteit (allied health professional, B)

> *No, that's a physiological event that you have little knowledge about because it is not covered in the nursing program. I never learned about menopause, the consequences of it and what impact that could have on sexuality*

Flemish health care providers especially mentioned their focus on or confidence with pathological issues rather than with normal health and ageing. Despite this fact, they feel less familiar with erectile dysfunction and its underlying factors in men 45+ as well as with the consequences of disease (chronic, mental...) and medication on sexual health for both men and women. Again mostly Flemish participants acknowledge an important lack of knowledge regarding specific groups and their sexual health: LGBTQ+, minorities, people with disabilities, … .

Mijn huisarts is tegen de 50 en zij heeft me gezegd dat ze 2 jaar geleden als arts voor het eerst een PowerPoint heeft gehad in de bijscholing over holibies en transgenders. Dat zegt dus al heel veel. Men kan denken dat iedereen dat al weet, maar dat is helemaal niet waar. (other social care professional, B).

> *My GP is nearly 50 and she told me that 2 years ago, as a doctor, for the first time she had a PowerPoint training on LGB and transgender people. So that says a lot. People might think that everyone already knows that, but that is not true at all (other social care professional, B)*

On some occasions participants mentioned that the diversity within the 45+ also needs awareness and attention.

45plus is wel een groot verschil met 70plus he (medical professional, B).

> *There is a big difference between 45plus and 70 plus eh*

Except for participants actively working in sexual health care, all participants mention a lack of knowledge or need for refresher courses regarding HIV and STI's, protective measures, risk behaviour assessment, adequate treatment and prevention. More specifically they question what is most applicable for this 45+ population. Participants who specialise in HIV field reported the ignorance of certain health care providers or even plain misinformation especially regarding HIV/AIDS.

HIV and misinformation that people aren't up to date with, you know, U=U [undetectable = untransmittable]*, if somebody's undetectable then they, you know, can't transmit the virus (medical professional, UK).*

In order to feel confident and act pro-actively participants need to know what to ask for and search for specifically, using brief questions as a guidance. Some participants would like to learn which life-events can lead to discussing sexual health without being intrusive.

Wat [andere participant] daarjuist vertelde over zowat de levensloop van 45plussers en de fases van het leven die ze doorlopen vind ik ook interessant om meer over te weten, omdat dat punten zijn die je kunt aangrijpen om een gesprek aan te gaan (medical professional, B).

> *What [other participant] just said about the life course of people over 45 and the phases of life they go through, I also find interesting to know more about, because those are points that you can use to start a conversation*

Besides general and specific knowledge participants indicate they also need training practice in order to be more confident [see *Communication* and *Form and delivery of training*].

Ultimately, participants emphasized the need for clear tools for signposting on both general as well as specific issues regarding sexual health. For some UK participants signposting ideally requires follow-up and enhances continuity of care, not just adding numbers or quota to a chart.

So I think education for us would be to know what services are out there and what …services are wanting what type of patients to walk-in (medical professional, UK).

Communication skills needed to address sexual health with 45+

Communication skills and training was frequently identified as an important part of training. This included how to raise the topic, active listening, taking a sexual history and other communication techniques. Participants identified that communications training would be a

refresher rather than new information, but that it would boost confidence (see *attitude/awareness/confidence and self-efficacy)*.

And you're in the point where actually you're not sure whether you're very much about to offend someone but you still need to have the conversation. That's a really struggle for me. So, as I said before, I think the communication is a big part of any kind of education package that would be put together. (medical professional, UK)

Participants identified that communication about sexual health and sexual orientation (instead of basic communication skills) was necessary. HSCP acknowledged that they did not have much experience of addressing sexual health and/or orientation and that it was not seen as part of 'normal' health and social care (see *attitude/awareness/confidence and self-efficacy)*.

Vorige week volgde ik nog een seminar in Engeland over seksualiteit zeer specifiek m.b.t. kanker, maar dan bv. bij transgenders, lesbiennes, homoseksuelen, a-seksuelen. Al die heel specifieke dingen. Ja, toen dacht ik ook stel je voor dat ik zo iemand bij mij had gehad, hoe zou ik daar dan mee omgegaan zijn…Het wordt rap gezegd die problematiek, maar eigenlijk is dat geen problematiek want het is heel normaal. Maar toch vinden we het abnormaal als we over seksualiteit met hen in communicatie moeten gaan. (allied health professional, BE)

> *Last week I attended a seminar in England on sexuality, very specifically about cancer, but also for transgender people, lesbians, homosexuals, asexual people. All those very specific things. Yes, then I thought I also imagine if I had had someone like that with me, how would I have dealt with that... It's [seen as] a problem, but actually it is not a problem because it's very normal. Yet we find it abnormal when we have communicate about sexuality with them.*

Communication and self-efficacy

Participants requested simple tools or guidelines to help asking questions and starting conversations. This too spanned *knowledge* and communication, identifying that information is insufficient for starting and/or continuing conversations.

Dus in een klinische situatie is het misschien wel interessant om wat eenvoudige tools bij de hand te hebben voor het geval je niet goed weet hoe je verder moet. Het is de spanning die er enerzijds is tussen kennis, die we zouden kunnen krijgen via antropologen en ervaringsdeskundigen, die heel veel hierover kunnen vertellen, maar anderzijds hebben we toch ook behoefte aan heel eenvoudige dingen die kunnen helpen om het gesprek verder te kunnen zetten. (medical professional, BE)

> *So in a clinical situation, it might be interesting to have some simple tools on hand in case you don't really know how to proceed. It is the tension that is there on the one hand between knowledge, which we could get through anthropologists and experience experts, who can tell a*

lot about this, but on the other hand we also need very simple things that can help to continue the conversation.

(Limits of) the professional role and sexual health in 45+

Overall participants identify general practitioners and specialists (gynaecologists, urologists, sexual health nurses) as the principle HSCPs in addressing sexual health in 45+, especially for relatively young (45-60), healthy and active clients . However, despite their key role, GP's were identified as already experiencing a large and diversified workload, potentially reducing this subject to something more superficial, and, due to contextual factors, time for and timing of consultations are very limited.

At the same time participants recognised that nurses and by extension any other primary care worker in close interaction with the client (social worker, physiotherapist, home care nurses...) might even have better and more confidential relationships that would facilitate broaching the subject. Participants suggested that even HSCP without medical knowledge but with adequate communication skills and appropriate training could have a role in discussing sexual health in 45+'s. They might be the first line observers to signal any problems or issues.

Het zijn die basis mensen die dikwijls heel belangrijk zijn om bepaalde punten te signaleren, vind ik (other social care worker, B).

It is those [primary] people who are often very important for signalling certain points, I think

Participants from diverse professional backgrounds considered providing information regarding sexual health as within their professional role. Sexual health is viewed as a part of daily life and fits within the perspective of holistic care. Most indicated that signposting is particularly important yet they suggested that they needed to be encouraged to do so and that some 'back-up' and extra support to rely on in case they run into difficult situations emerging from these discussions was needed.

So I think if we're going to have, um, if they want us to and encourage us to ask those questions I think we also need that extra support for dealing with the profile of those cases as well (other social care worker, UK).

But at the same time many seem ambivalent about their role or task. Though seeing sexual health and wellbeing as part of life, they mention they never thought about it nor acted to initiate discussion. Some participants mentioned that they never even considered it before the focus group and/or that they need to be encouraged to do so.

… It, it can come, it's not something we ask is it. It's not something we ask (other social care worker, UK).

Participants acknowledged that they should not address these issues in isolation. Discussing sexual health, as well as addressing it and finding solutions to problems, requires a multidisciplinary and/or interprofessional approach. Therefore, issues regarding transferability and confidentiality of data should be addressed and again adequate sign-posting is crucial. At the same time, transmitting information correctly within this approach can avoid unnecessary, repetitive and time-consuming assessments for both 45+ and their HSCP.

It's a multi-disciplinary approach (medical professional, UK).

Form and delivery of training

Participants were asked what they thought sexual health training should look like and a wide variety of answers were provided.

How to

There was no consensus about the form of the training. Several participants indicated that, although they are now more familiar with working online, online meetings and online education due to COVID, they still prefer live and face to face training. One UK focus group had a pronounced negative attitude toward online learning, the interaction between the participants, the 'hands-on'/practical approach and the exchange of experiences and ideas were regarded as very important in a live form of training.

However, other HSCP, and in particular the Belgian respondents, were in favour of remote training, be it in the form of an individual e-learning, or more interactively in small groups via teams or a combination of both. The practical and easily accessible aspect of this type of training was cited as an important advantage.

I love the online training, it's so much easier than getting a day off of work and trying to get to venues and stuff like that. Yeah, I'm all for online stuff. (Medical health professional, UK)

Blended learning, a method in which different modes of delivery are combined into one form of learning, was also suggested as a possible option. In this learning method, the more theoretical content is delivered by asynchronous distance learning or self-study, while the interactive, practical content can be taught live (face to face or via video-conferencing software).

Interaction with the trainer and other trainees was identified as very important, regardless of whether the training takes place live or online.

Length and timing

There was no clear preference in duration of the training, but participants often preferred short and easily accessible trainings.

"So if they could do a one day course where they were giving them the very basics that we should be able to explain to a patient that would suit me fantastically. We have a constant stream of new nurses, practice nurses coming in, so I think that you will find that if they did have a course it would be filled up quite quickly." (Medical health professional, UK)

Delivery of training

Various strategies were suggested on the delivery of training, acknowledging that there is no one delivery method that suits everyone. However, practical and work-based training, regardless of form, was identified as important.

*"I think that's a tricky one because it depends on people's learning styles. My first thought was practical but I'm a learn by doing sort of person, so for me- But other people do prefer things like e-learning and I think it needs to be embedded in sort of competencies as a standard thing, so throughout social work education and beyond in to the workforce, but also for staff in social work based roles that aren't qualified as well. So I think there needs to be some work based training. I always think that practical sessions like this are more useful, but again that's preference, personal preference." (*Social care professional, UK)

Participants also emphasized the importance of the strong focus on practice in the training, by integrating language and examples ready to use in practice that are practical and applicable for a variety of HSCP. In this context it was also considered important that the language used and offered in the training is inclusive for a wide variety of HSCP and applicable in practice, supported by work-based examples.

Various strategies for training method were identified in all focus groups, with role plays being both suggested as useful and as something to be avoided. As an alternative to the HSCP themselves role-playing, they suggested that watching experts or actors (live or video) portray authentic scenes would be a useful alternative. Several other teaching formats were cited including a quiz, theoretical lectures, peer learning, supervised group case studies and role model testimonials and testimonials of sexual health professionals.

A mixed interprofessional audience of participants was considered to be an advantage, in order to learn from each other's points of view and experiences. However, it is also important to be able to respond to specific needs of specific types of care providers regarding their provision of sexual health care.

"We doen dat op Europees niveau in de masterclass oncology nursing samen met de artsen en psychologen. Er is geen onderscheid tussen de beroepsgroepen we snijden het topic interprofessioneel aan. En zo kan je ook veel van elkaar leren." (Allied health professional, B)

> *At the European level in the oncology nursing masterclass, we do this together with doctors and psychologists. There is no distinction between the professional groups and we broach the topic interprofessionally. And so you can also learn a lot from each other.*

Who gives the training

In case of interaction with a trainer, it was perceived by the participants as very important that the training was offered by experts on the theme. After all, experts are well able to give specific examples, sharing their own knowledge and experiences. More specifically, sexual health nurses were considered suitable as well as healthcare workers with a speciality (eg learning disability, health visitors,...).

Part of basic training

Several participants in the UK and Belgium pointed out sexual health and wellbeing is insufficiently addressed during first level (pre-registration) training for various professions. They strongly suggested that the theme needs to be more explicitly addressed in basic educational programmes.

Discussion

Many of the focus group themes are consistent with what has previously been identified in the literature. Below we discuss some key points and compare them to recent studies.

Recent studies (Bauer et al., 2016; Ejegi-Memeh et al., 2021) and literature reviews (Zhang et al., 2020) show that older people want health care professionals to initiate discussions, but that HSCP find it difficult to do so. This was also raised by participants who cited sexual health and wellbeing as a key part of life, but who acknowledged that they had difficulty raising the issue, and outside a sexual health context, had not done so. (Wilschut et al., 2021) study of nursing students' knowledge and attitude regarding older adults' sexuality demonstrated that a positive attitude was insufficient to lead to discussion of sexual health in the clinical setting, role modelling and a sense of competence were also important. It is also important to note that using structured communication methods, such as the One-2-One method are important in order to gain client consent for and engagement in such conversations (Sensoa, 2021). .

This ambivalence is reflected also in the theme (Limitations of) professional role, where participants were not always certain that sexual health and wellbeing fell into their remit, though signposting was seen as an important part of many professional roles. Focus group participants confirmed that knowledge and skills training, including where to refer to, was important for pre and post-registration training. It is important to note that other barriers to discussing sexual health and wellbeing such as a lack of time and the organisation of health and social care services will not be addressed by increasing training.

In the focus groups, respondents frequently identified that a lack of knowledge affected perceived competence (self-efficacy) and affected their ability to actually address sexual health issues. They also linked confidence in communication skills with identifying sexual health needs and signposting issues on to other health and social care professionals. The intricate linking of these concepts is also frequently noted in the literature. This link between knowledge and confidence was also identified in Haesler et al., (2016) systematic review.

Haesler et al's review also reported that awareness and attitude were linked. Their findings showed that healthcare staff attitudes were influenced by both societal perceptions and their own experiences. Their personal characteristics and history also influence not only their awareness about sexual health in older people but their responses to it (Haesler et al., 2016, figure 3).

The focus group participants were clear that training was welcome and necessary, however no consensus as to the form of the training emerged from the data. This variation was also supported by Verrastro et al., (2020) literature review of sexual health education for medical and healthcare professionals and Morris et al's 2019 systematic review of addressing bias against LGBTQI+. However, despite the variety in length, delivery and even subject matter, they found that training did improve attitudes and enhance the professional's ability to address sexual health issues post participation. No single strategy or delivery was shown to be superior.

Several participants mentioned that sexual health should be embedded in the health and social sciences professions curricula instead of it being an optional module. Verrastro et al., (2020) noted that earlier integration in training gives the professional time to change their attitude and develop a sense of competence.

In contrast to UK participants, Flemish respondents more openly indicated that they lacked knowledge or confidence to address LGBTQI+ issues. Flanders has legalised same-sex marriage and LGBTQI+ communities are widely accepted but there is still evidence that these communities experience implicit and explicit bias (Morris et al., 2019) and suffer health disparities in Belgium (eg. suicide rates within the community) (Missiaen & Seynaeve, 2016).

Participants' suggestion that incorporating LGBTQI+ patient experiences/stories into the training and/or having people from diverse backgrounds teach as a powerful way to not only cognitively but emotionally connect (and reduce bias) with diverse groups is supported by Morris et al. (2019) and Sekoni et al. (2017).

Limitations

In the data collection, specific demographic information (age, gender, years in practice and specific profession) of participants was inconsistently collected. Additionally, given the sample size and convenience sampling, we do not propose causal links, but identify comments and trends raised in the focus groups.

Summary

- Awareness of sexual health and wellbeing for the 45+ group and confidence in addressing it is linked to knowledge.
- Clear gaps in knowledge around psychological and physiological ageing and the impact on sexual health and wellbeing as well as specialised knowledge of (risk) groups and specific conditions was identified.
- Professionals are looking for clear tools to initiate and guide conversations as well as to signpost to specialist services.
- Material should be accessible for integration into basic (first-level or preregistration) education programmes for health and social care professionals.
- There is no clear preference for method, style or timing of delivery of training to professionals. There is a clear demand for such support and training. Flexible and varied strategies will increase the chances of uptake of training.

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Four reports summarising quantitative and qualitative findings from the SHIFT survey of over 45's in the UK, Netherlands, Belgium and France are available to download: https://www.chi.ac.uk/research/institute-sport-research/health-and-wellbeing/shift

- Sexual Health and Wellbeing in over 45's Survey Report
- Sexual Health and Wellbeing in vulnerable populations Survey Report
- SHIFT Project Sexual Health in over 45s Qualitative Report
- SHIFT Project Sexual Health in Vulnerable Populations Qualitative Report